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Volume 2:

Health; Community services; Housing and homelessness

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

Volume 1

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PART B EARLY CHILDHOOD, EDUCATION AND TRAINING

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Volume 2

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Acronyms and abbreviations

AACR	Australasian Association of Cancer Registries
AAGR	average annual growth rates
AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ACAM	Australian Centre for Asthma Monitoring
ACAP	Aged Care Assessment Program
ACARA	Australian Curriculum and Assessment Reporting Authority
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
ADE	Australian Disability Enterprise
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
AHO	Aboriginal Housing Office (NSW)
AHURI	Australian Housing and Urban Research Institute
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
ALGA	Australian Local Government Association
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
ATSI	Aboriginal and Torres Strait Islander
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

CDSMAC	Community and Disability Services Ministers' Advisory Council
CEaCS	Childhood Education and Care Survey
CFA	Country Fire Authority
CFCs	Child and Family Centres
CHIP	Community Housing and Infrastructure Program
CI	confidence interval
CIS	Complaints Investigation Scheme
CMHC	Community Mental Health Care
CNOS	Canadian National Occupancy Standard
COAG	Council of Australian Governments
CoD	Causes of Death
CPG	Court Practitioners Group
CRA	Commonwealth Rent Assistance
CRC	COAG Reform Council
CRS	Commonwealth Rehabilitation Services
CRS	Complaints Resolution Scheme
CRYPAR	Coordinated Response to Young People at Risk
CSASAW	Commonwealth-State Agreement for Skilling Australia's Workforce
CSDWG	Children's Services Data Working Group
CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file
DCIS	ductal carcinoma in situ
DDHCS	Department of Disability, Housing and Community Services
DEEWR	Department of Education, Employment and Workplace Relations

DES	Disability Employment Services
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
DPEM	Department of Police and Emergency Management (Tas)
DPIE	Department of Primary Industries and Energy
DQI	data quality information
DSE	Department of Sustainability and Environment
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	EACH Dementia
ECD	Early Childhood Development
ECDSG	Early Childhood Data Sub Group
ECEC	Early Childhood Education and Care
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
FLAG	Flexible Learning Advisory Group
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
HbA1c	glycosolated haemoglobin
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
JAS-ANZ	Joint Accreditation System of Australia and New Zealand
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
MPS	multi-purpose services
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
NA	National Agreement
na	not available
NAHA	National Affordable Housing Agreement
NAP	National Assessment Program
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
NBESP	Nation Building – Economic Stimulus Plan
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
NDSS	National Diabetes Services Scheme
NEA	National Education Agreement
NEAT	Department of Natural Resources Environment and the Arts
NEHIPC	National E-Health Information Principal Committee
NESB	non-English speaking background
NHA	National Healthcare Agreement
NHCDC	National Hospital Cost Data Collection
NHHN	National Health and Hospitals Network
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
NHSC	National Housing Supply Council
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
NMVTRC	National Motor Vehicle Theft Reduction Council
NNDSS	National Notifiable Diseases Surveillance System
no.	number
NOOSR	National Office of Overseas Skills Recognition
NP	National Partnership
np	not published
NPAH	National Partnership Agreement on Homelessness
NPAs	National Partnership Agreements
NPC	National Preschool Census
NQC	National Quality Council
NQF	National Quality Framework for Early Childhood Education and Care
NRAS	National Rental Affordability Scheme
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
NSMHWB	National Survey of Mental Health and Wellbeing
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

NVEAC	National VET Equity Advisory Council
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
OSR	OATSIH Services Reporting
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
PHOFAs	Public Health Outcome Funding Agreements
PIP	Practice Incentives Program
PIRP	Preschool Investment and Reform Plan
PISA	Program for International Student Assessment
PKI	Public Key Infrastructure
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
RBA	Reserve Bank of Australia
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
SAB	Staphylococcus Aureus (including Methicillin Resistant Staphylococcus Aureus) Bacteraemia
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
SD	Statistical Division
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
SEW	Survey of Education and Work
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
SMR	standardised mortality ratios
SOMIH	state owned and managed Indigenous housing
SPP	special purpose payment
SPP	Specific Purpose Payment
SPRC	Social Policy Research Centre
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAFE	technical and further education
Tas	Tasmania
TAS	Tasmanian Ambulance Service
TCP	Transition Care Program
TFS	Tasmania Fire Service
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
TVET	technical and vocational education and training
UCC	user cost of capital
UCL	upper confidence limit
URTI	upper respiratory tract infection
USAR	Urban Search and Rescue
U-Turn	U-Turn diversionary program for young motor vehicle offenders

VCAT	Victorian Civil and Administrative Tribunal
VET	vocational education and training
VF	ventricular fibrillation
VHC	Veterans’ Home Care
Vic	Victoria
VT	ventricular tachycardia
WA	Western Australia
WGIR	Working Group on Indigenous Reform
WHO	World Health Organisation
YPIRAC	Younger people in residential aged care

Glossary

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

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

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

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

PART E

HEALTH

E Health preface

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this preface by an 'EA' suffix (for example, table EA.3). A full list of attachment tables is provided at the end of this preface, and the attachment tables are available 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). This 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.

Major improvements in reporting in the Health preface this year include:

- inclusion of the following measures to align this Report with National Healthcare Agreement (NHA) and National Indigenous Reform Agreement (NIRA) indicators
  - reporting data for the net growth in the health workforce for selected professions
  - reporting data for the proportion of people who accessed health services by health status
  - reporting data on health risk factors, such as rates of risky alcohol consumption, smoking and obesity, for states and territories (previously only national data were reported)
  - reporting data on the incidence of selected cancers
  - reporting infant (0–1 year), child (1–4 year) and total infant and child (0–4 year) mortality (previously only infant mortality was reported)
  - reporting data for potentially avoidable deaths
  - reporting data for low birth weight babies by Indigenous status of mother
- expansion of time series data reporting in some attachment tables.

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

The Australian, State, Territory and local governments spent $63.1 billion (expressed in 2008-09 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 2008-09. These areas of health care activity accounted for 83.8 per cent of government recurrent health expenditure in 2008-09 (table EA.4).

Total public health expenditure by Australian, State and Territory governments on breast cancer screening was $175 million in 2008-09 (table 12A.6). This includes funding by the Australian Government to states and territories through the Public Health Outcome Funding Agreements (PHOFAs). This funding mechanism will change for future years with funding under the NHA from 2009-10. Government recurrent expenditure on specialist mental health services was estimated to be around $5.6 billion in 2008-09 (tables 12A.28 and 12A.29). 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 optometric services (the Medicare Benefits Schedule [MBS]); selected medications (under the Pharmaceutical Benefits Scheme [PBS]); and public hospital funding (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 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 (NAs) to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The NHA covers the area of Health, and health indicators in the NIRA establish 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). Revisions have been made to the performance indicators reported in this preface to align with the performance indicators in the NAs.

COAG, with the exception of WA, agreed to establish the National Health and Hospitals Network (NHHN) in April 2010. Under the NHHN, from July 2011 the Australian Government becomes the majority funder of the health and hospitals system, including 60 per cent of the efficient price of public hospital services, capital, research and training, and 100 per cent of primary care equivalent outpatient services. The Australian Government will also assume full policy and funding responsibility for primary health care and aged care, including the Home and Community Care Program (except in Victoria and WA).

As part of the NHHN, the Australian Government and states/territories (except WA) have also agreed to a National Partnership Agreement on Improving Public Hospital Services, that will provide additional funding for capital, facilitation and reward funding for elective surgery and emergency departments, funding for a subacute beds guarantee and a flexible funding pool that can be utilised across all three areas.

The NHHN will establish an Independent Hospital Pricing Authority to set the national efficient price of all public hospital services, a National Performance Authority to report on public health sector performance, and the expansion of the Australian Commission on Safety and Quality in Health Care to set and monitor national quality and safety standards.

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:

- through the NHA and NHHN, to fund a large part of 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 hearing services for eligible Australians through the Australian Government Hearing Services Program
- funding the Medicare Safety Net.

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

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

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

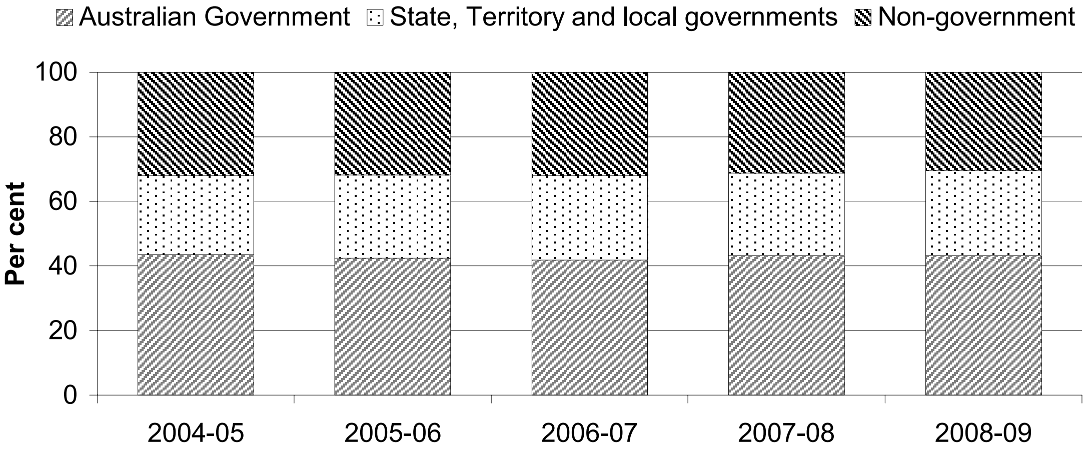
Funding

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]) and the NHHN to the states and territories (except WA) 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 2008-09, the Australian, State, Territory and local governments spent $78.5 billion on total health services, which represents 69.6 per cent of total health expenditure. The Australian Government accounted for the largest proportion of health care expenditure — $48.7 billion or 43.2 per cent of the total in 2008-09. State, Territory and local governments contributed $29.8 billion or 26.4 per cent of total health expenditure in that year (AIHW unpublished). These shares have remained relatively constant over the past 10 years. The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and tables EA.1 and EA.7).

Figure E.1 **Total health expenditure, by source of funds (2008-09 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 (unpublished) Health expenditure database; table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $112.8 billion in 2008-09 (table EA.1). This total was estimated to account for 9.0 per cent of gross domestic product in 2008-09, a slight increase from the previous year (8.8 per cent) and an increase of 1.2 per cent from the 7.8 per cent of GDP in 1998-99 (AIHW 2010d). This indicates that health expenditure grew faster than the economy as a whole over the decade to 2008-09.

The growth of total health expenditure over the past decade was largely the result of increased expenditure by Australian, State, Territory and local governments, which grew proportionally faster than expenditure by non-government sources. Between 1998-99 and 2008-09, the average annual rate of growth in real expenditure was 5.3 per cent for the Australian Government, 6.7 per cent for State, Territory and local governments, and 4.6 per cent for non-government sources (table EA.1).[1]

The introduction of programs supporting private health insurance was a significant factor in the increase in expenditure by the Australian Government in the late 1990s. On 1 January 1999, the Australian Government replaced the Private Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Australian Government expenditure on the rebate has increased each year from $2.6 billion in 2004-05 to $3.6 billion in 2008-09 in current prices (that is, not adjusted for inflation) (AIHW unpublished).

The Extended 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 Extended Medicare Safety Net expenditure was $414.1 million in the year ending 31 December 2008 (DoHA unpublished).

Public hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2008-09. 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 $33.4 billion, of which governments paid $30.8 billion (figure E.2). Public hospitals accounted for 40.9 per cent of government recurrent expenditure on health care services in 2008-09. Medical services accounted for $15.5 billion of government expenditure (20.6 per cent of total recurrent health expenditure) and medications accounted for $7.8 billion (10.4 per cent) (table EA.2).

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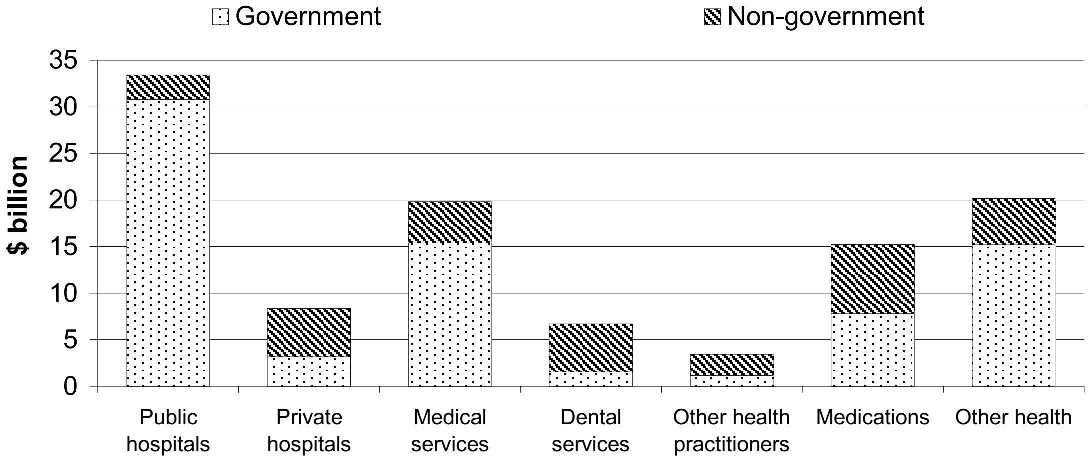
[1] There was a break in series due to differences in definitions of public hospital and public hospital services between 2002-03 and 2003-04.

Figure E.2 **Recurrent health expenditure, by area of expenditure, 2008-09**[a, b, c, d, e, f]



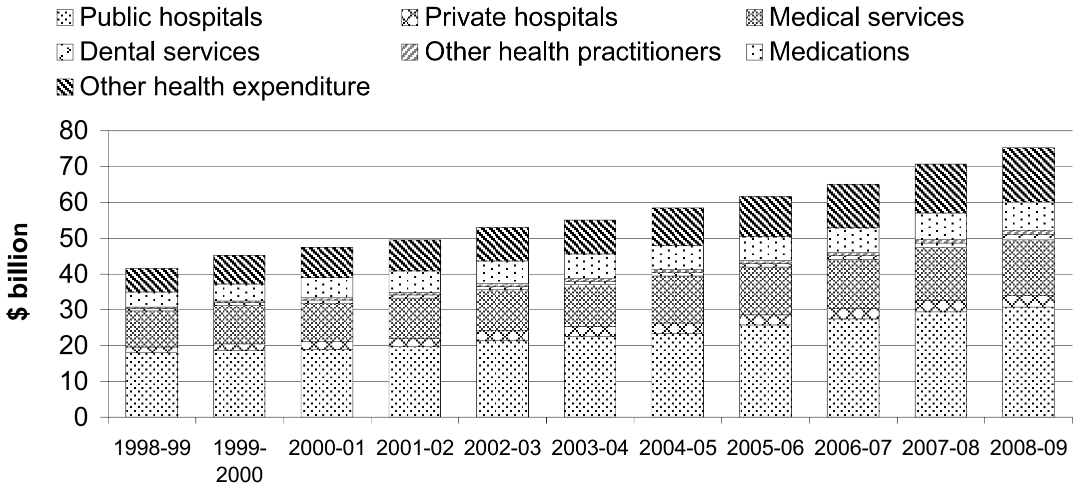
[a] Government funding of recurrent health expenditure has been adjusted for non-specific tax expenditure. [b] Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of care provided to public hospital inpatients and 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 (unpublished) Health expenditure database; tables EA.2 and EA.3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen from 43.7 per cent in 1998-99 to 40.9 per cent in 2008-09. 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 8.9 per cent between 1998-99 and 2008-09 (albeit from a relatively low base), compared with 6.3 per cent for medications and 5.4 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 1998-99 to 2008-09. Government expenditure on private hospitals increased from 3.3 per cent of government health expenditure in 1998-99 to 4.3 per cent in 2008-09, and the proportion of expenditure on medication also increased slightly, from 10.2 per cent to 10.4 per cent over the same period (table EA.2).

Figure E.3 **Government recurrent expenditure, by area of expenditure (2008-09 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 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).

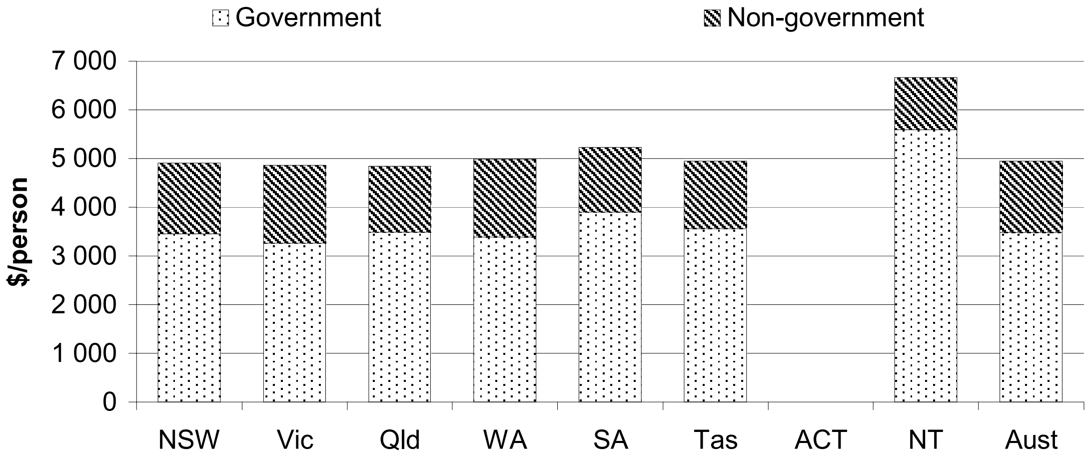
Source: AIHW (unpublished) Health expenditure database; table EA.2.

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 2008-09 (expressed in 2008-09 dollars) was $5212 (table EA.5). Total health expenditure per person in Australia increased from $4528 in 2004-05 to $5212 in 2008-09 (expressed in 2008-09 dollars) (table EA.5). The average annual growth rate in average health expenditure per person (expressed in 2008-09 dollars) from 2004-05 to 2008-09 was 3.6 per cent (table EA.5).

Government real recurrent health expenditure per person in Australia increased from $2887 in 2004-05 to $3477 in 2008-09 (expressed in 2008-09 dollars). Non-government recurrent expenditure per person in Australia rose from $1325 in 2004-05 to $1471 in 2008-09 (expressed in 2008-09 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, 2008-09 a, b, c



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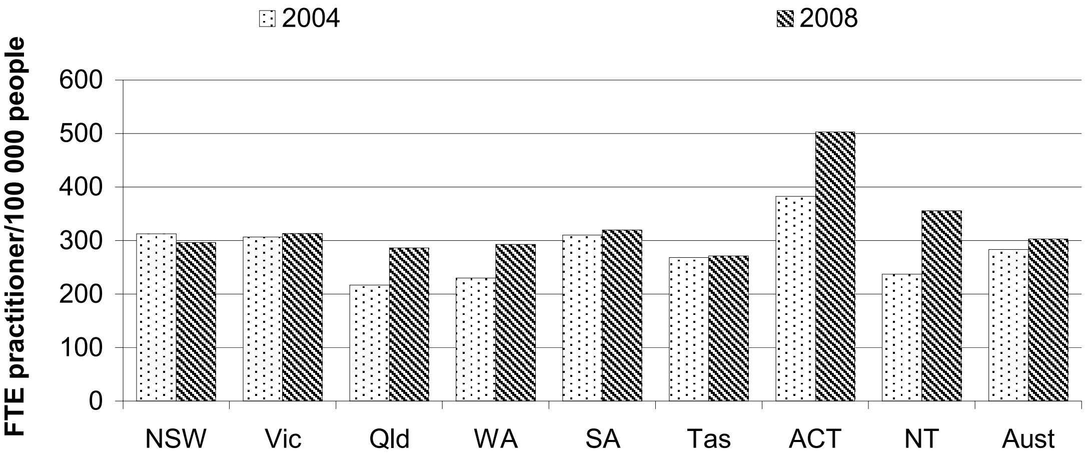
[a] Includes expenditure on ambulance services (reported in chapter 9). [b] Government expenditure includes expenditure by the Australian, State, Territory and local governments. [c] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditure for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

Source: AIHW (unpublished) Health expenditure database; table EA.6.

Health workforce

In 2008, there were 68 689 registered medical practitioners in Australia working in medicine. A further 1742 were in the medical labour force but on extended leave or looking for work. The majority of employed practitioners working in medicine were clinicians (93.3 per cent), of whom 37.5 per cent were primary care practitioners (mainly general practitioners), 35.0 per cent were specialists, 13.8 per cent were specialists-in-training, 12.3 per cent were hospital non-specialists and 1.4 per cent were other clinicians (AIHW 2010b). 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]

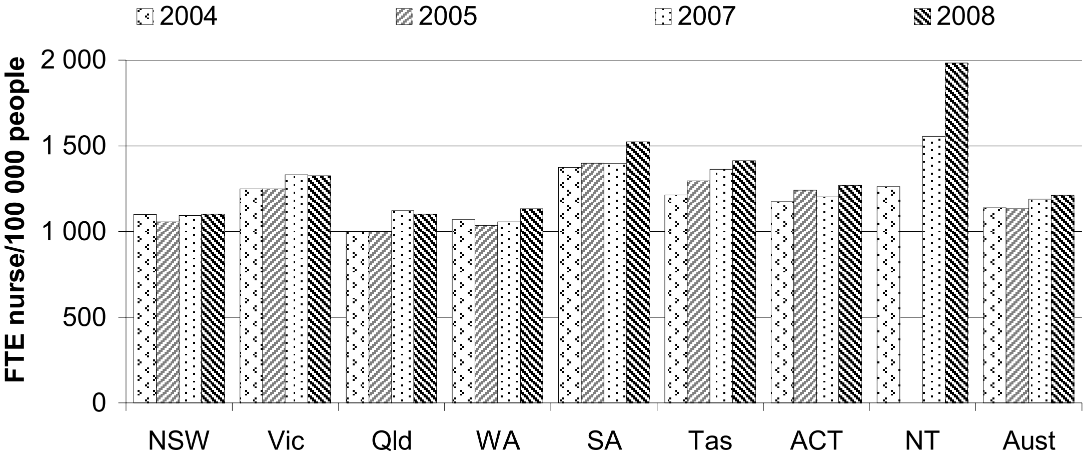


[a] FTE rate (FTE per 100 000 people) is based on standard full-time working week of 45 hours. [b] Number of ‘employed medical practitioners’ does not include medical practitioners on extended leave.

Source: AIHW (2010) *Medical Labour Force 2008*, AIHW Bulletin no. 82, AIHW Cat. no. AUS 131; AIHW (2006) *Medical Labour Force 2004*, AIHW Cat. no. HWL 39, National Health Labour Force Series no. 38; 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 between 2004 and 2008 arose from both an increase in the number of nurses employed and an increase in average hours worked (AIHW 2010c).

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



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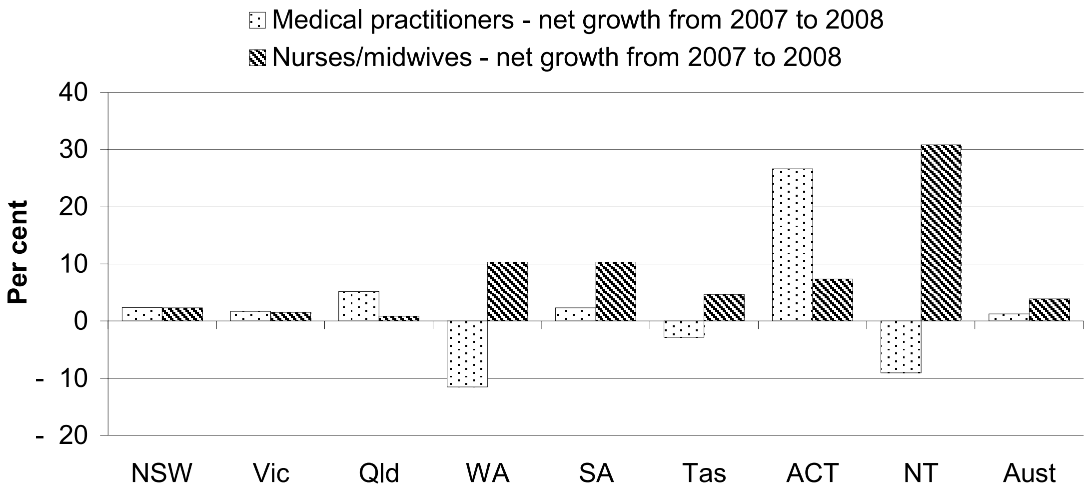
[a] FTE nurse rate (per 100 000 people) based on a 35-hour week. [b] Number of 'employed nurses' does not include nurses on extended leave. [c] Data for 2006 are not available.

Source: AIHW (2010) *Nursing and Midwifery Labour Force 2008*, AIHW Bulletin no. 81, AIHW Cat. no. AUS 130; 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 (2006) *Nursing and Midwifery Labour Force 2005*, AIHW Cat. no. HWL 38, National Health Labour Force Series no. 37; table EA.9.

The net growth of the health workforce can give an indication of the sustainability of the health system and its ability to respond and adapt to future needs. At the national level, the medical practitioners and nurse/midwife FTE health workforces grew from 2007 to 2008, although growth varied across states and territories. At the national level, the nursing workforce grew at a faster rate than the medical workforce (figure E.7). Health workforce growth from 2007 to 2008 by selected professions by clinical/non-clinical status are reported in table EA.11.

Figure E.7 **Net growth in health workforce, selected professions, 2007 to 2008[a, b]**



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

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

Overview of Indigenous health

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

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 higher risk of experiencing social and economic disadvantage, which may negatively affect health behaviours and outcomes. 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 Australians, including health determinants and health care access, which significantly affect health outcomes. These include the *Aboriginal and Torres Strait Islander Health Performance Framework — 2008 Report*

(DoHA 2008), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (Australian Bureau of Statistics [ABS] and AIHW 2008), *Overcoming Indigenous Disadvantage: Key Indicators 2009* (SCRGSP 2009), *National Aboriginal and Torres Strait Islander Social Survey, 2008* (ABS 2009d), *Expenditure on health for Aboriginal and Torres Strait Islander people 2006-07* (AIHW 2009), and *Australia's Health 2010* (AIHW 2010a).

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 2009, apparent retention rates for Indigenous full-time students were 90.9 per cent from years 7 or 8 to year 10 and 50.1 per cent to year 12. This compares with apparent retention rates for non-Indigenous students of 100.0 per cent to year 10 and 77.7 per cent to year 12. Apparent retention rates for Indigenous students from the beginning of secondary school to year 12 increased from 45.3 per cent in 2005 to 50.1 per cent in 2009, while the rate for non-Indigenous Australians remained steady at around 77 per cent (see chapter 4, table 4A.127).

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, this was still three times the rate for non-Indigenous Australians of 5 per cent. This is 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 26 per cent of the total prisoner population in 2009-10 (see chapter 8, table 8A.1). After adjusting for age differences, Indigenous adults were 14 times as likely as non-Indigenous adults to be imprisoned in 2009-10 (see chapter 8, table 8A.4), compared to 10 times as likely in 2000 (SCRGSP 2009). 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 2007-08, the age standardised rate of Indigenous people aged 18 years and over who were daily cigarette smokers was 45 per cent, compared to 18.9 per cent for non-Indigenous people aged 18 years and over (ABS unpublished). 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, 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 these, 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

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[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.

[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.

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).

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. For many publicly funded health services there is incomplete information available about service users and, in particular, their Indigenous status.

For privately funded services, this information is frequently unavailable. For those services that do collect information on Indigenous status the data are not always accurate. This may be because Indigenous identification is voluntary and not all Indigenous patients choose to identify as Indigenous and some providers may not optimise collection of data on Indigenous status.

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. The definition of health expenditure has changed and no longer includes expenditure on high care residential aged care, which is now classified as welfare expenditure.

The most recent estimates of health services expenditure for Indigenous people are for 2006-07 (AIHW 2009). The ratio of Indigenous to non-Indigenous health and high care residential aged care expenditure per person in 2006-07 was 1.25. This means that $1.25 was spent per person on health for Indigenous people for every dollar spent for non-Indigenous people.

The average Indigenous/non-Indigenous total health expenditure per person ratio increased between 2004–05 and 2006–07 from 1.17 to 1.25. The increase can be explained by growth in expenditure for Indigenous people in areas such as public hospital services and Medicare funded medical services (AIHW 2009).

The major feature of the difference in total health expenditure per person between Indigenous and non-Indigenous people is the reliance of Indigenous people on public hospitals and community health services. Although Indigenous people used few private hospital services, as their private insurance membership was low, overall hospital expenditure (public and private hospital) per Indigenous person was 72 per cent higher than for non-Indigenous people (AIHW 2009, table E.1). Spending on community health services was six and a half times that for non-Indigenous people. In contrast, per person expenditure on medical services, medications and dental services was half or less than that for non-Indigenous people (table E.1). This is partly because Indigenous people have much lower incomes compared to non-Indigenous people and, like many low income people, use more public hospital services and less private specialist medical services. Approximately 70 per cent of Indigenous households are in the lowest two household income quintiles (AIHW 2009).

The difference between average health expenditure on Indigenous and non-Indigenous people reflects, among other things, the differences in the average costs of providing goods and services to the two populations. For example, a higher proportion of Indigenous people live in remote and very remote regions in Australia where the costs of providing health goods and services are higher than for those people who live in capital cities or inner regional areas.

Table E.1 Expenditure on health and high care residential aged care services for Indigenous and non-Indigenous people, 2006-07

	Expenditure ($ million)				*Expenditure per person ($)*		
Area of expenditure	*Indigenous*	*Non-Indigenous*	*Total*	*Indigenous share (%)*	*Indigenous*	*Non-Indigenous*	*Ratio*
Total hospital services	1 483.1	33 687.6	35 170.7	4.2	2 838.3	1 654.6	1.72
Public hospital services[a]	1 450.9	26 565.3	28 016.2	5.2	2 776.6	1 304.8	2.13
Admitted patient services[b]	1 123.5	20 817.0	21 940.5	5.1	2 150.0	1 022.4	2.10
Non-admitted patient services	327.4	5 748.3	6 075.7	5.4	626.5	282.3	2.22
Private hospitals[c]	32.3	7 122.3	7 154.5	0.5	61.7	349.8	0.18
Patient transport services	115.9	1 672.4	1 788.3	6.5	221.8	82.1	2.70
Medial services	220.8	16 544.5	16 765.3	1.3	422.6	812.6	0.52
Medicare services	193.2	13 441.1	13 634.3	1.4	369.7	660.2	0.56
Other	27.6	3 103.4	3 131.0	0.9	52.9	152.4	0.35
Dental services	72.9	5 676.2	5 749.1	1.3	139.5	278.8	0.50
Community health services	620.1	3 706.2	4 326.4	14.3	1 186.7	182.0	6.52
Other professional services	22.3	3 250.8	3 273.1	0.7	42.8	159.7	0.27
Public health	110.9	1 700.2	1 811.0	6.1	212.2	83.5	2.54
Medications	129.4	12 481.0	12 610.3	1.0	247.5	613.0	0.40
Aids and appliances	21.0	3 004.6	3 025.6	0.7	40.3	147.6	0.27
Research	32.1	2 317.0	2 349.1	1.4	61.5	113.8	0.54
Health administration	75.7	2 294.0	2 269.7	3.2	144.8	112.7	1.29
Other health services (nec)[d]	5.5	141.9	147.4	3.7	10.5	7.0	1.51
Total health	**2 909.7**	**86 476.4**	**89 386.1**	**3.3**	**5 568.5**	**4 247.3**	**1.31**

(Continued on next page)

Table E.1 **(Continued)**

	Expenditure ($ million)				Expenditure per person ($)		
Area of expenditure	*Indigenous*	*Non-Indigenous*	*Total*	*Indigenous share (%)*	*Indigenous*	*Non-Indigenous*	*Ratio*
High care residential aged care	66.7	6 305.1	6 371.8	1.0	127.6	309.7	0.41
Total health and high care residential aged care	**2 976.4**	**92 781.5**	**95 757.9**	**3.1**	**5 696.1**	**4 557.0**	**1.25**

[a] Public hospital services exclude dental services, community health services, patient transport services, public health and health research undertaken by the hospital. [b] Admitted patient expenditure estimates allow for Indigenous under-identification, except for Tasmania. [c] Include State/Territory government expenditure for services provided for public patients in private hospitals ($249.5 million). [d] Other health services (not elsewhere classified) include expenditure on health services such as family planning.

Source: AIHW (2009) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2006-07*, Cat. no. HWE 48, Health and Welfare Expenditure Series no. 39, Canberra.

In 2006-07, governments provided 93.4 per cent of the total funding for Indigenous health care spending and 68.2 per cent of the health care funding for non-Indigenous people. For Indigenous health spending, the states and territories contributed around $1.5 billion or 51.4 per cent of total funding, and around $1.2 billion or 42.0 per cent of total funding came from the Australian Government. Non-government sources contributed around $193 million, or 6.6 per cent of total funding (table E.2).

Table E.2 **Total funding for health and high care residential aged care for Indigenous and non-Indigenous people, 2006-07**

Source of funding	*Amount ($ million)*			
	Indigenous	*Non-Indigenous*	*Total*	*Indigenous share (%)*
State and Territory governments	1 495.8	20 861.6	22 357.4	6.7
Australian Government	1 220.7	38 107.3	39 328.1	3.1
Direct Australian Government	720.5	24 869.4	25 589.9	2.8
Indirect through Australian State/Territory governments	487.4	9 406.4	9 893.8	4.9
Indirect through non-government[a]	12.8	3 831.5	3 844.3	0.3
All governments	*2 716.5*	*58 968.9*	*61 685.4*	*4.4*
Non-government	193.2	27 507.5	27 700.7	0.7
Total health	**2 909.7**	**86 476.4**	**89 386.1**	**3.3**
Australian Government funded high care residential aged care	43.8	4 769.3	4 813.1	0.9
Non-government funded high care residential aged care	22.9	1 535.7	1 558.6	1.5
Government funded health and high care residential aged care	2 760.3	63 738.2	66 498.5	4.2
Total health and high care residential aged care	**2 976.4**	**92 781.4**	**95 757.9**	**3.1**

[a] 'Indirect through non-government' data include private health insurance rebates of $3073 million for all Australians, Special Purpose Payments (SPPs) covering high specialised drugs in private hospitals and other payments.

Source: AIHW (2009) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2006-07*, Cat. no. HWE 48, Health and Welfare Expenditure Series no. 39, Canberra.

On a per person basis, the level of funding from Australian State and Territory governments, was much higher for Indigenous people than for non-Indigenous people (table E.3). The average amount of funding was $5199 per Indigenous person and $2896 per non-Indigenous person.

In 2006–07, Australian Government funding for health services was around 25 per cent more per person for Indigenous people than for non-Indigenous people. State and Territory governments funding was almost three times as much per person for Indigenous people as for non-Indigenous people (table E.3).

Table E.3 **Funding per person for health and high care residential aged care for Indigenous and non-Indigenous people, 2006–07**

Source of funding	*Funding per person ($)*		
	Indigenous	*Non-Indigenous*	*Ratio*
State and Territory governments	2 862.5	1 024.6	2.79
Australian Government	2 336.2	1 871.7	1.25
Direct Australian Government	1 378.8	1 221.5	1.13
Indirect through Australian State/Territory governments	932.8	462.0	2.02
Indirect through non-government[a]	24.5	188.2	0.13
All governments	*5 198.7*	*2 896.3*	*1.79*
Non-government	369.8	1 351.0	0.27
Total health	**5 568.5**	**4 247.3**	**1.31**
Australian Government funded high care residential aged care	83.9	234.2	0.36
Non-government funded high care residential aged care	43.7	75.4	0.58
Government funded health and high care residential aged care	*5 282.6*	*3 130.5*	*1.69*
Total health and high care residential aged care	**5 696.1**	**4 557.0**	**1.25**

[a] 'Indirect through non-government' data include private health insurance rebates ($147.1 per Australian in 2006-07). This category also includes SPPs which cover highly specialised drugs provided in private hospitals, along with other payments.

Source: AIHW (2009) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2006-07*, Cat. no. HWE 48, Health and Welfare Expenditure Series no. 39, 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 2008).

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.8). 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 2008).

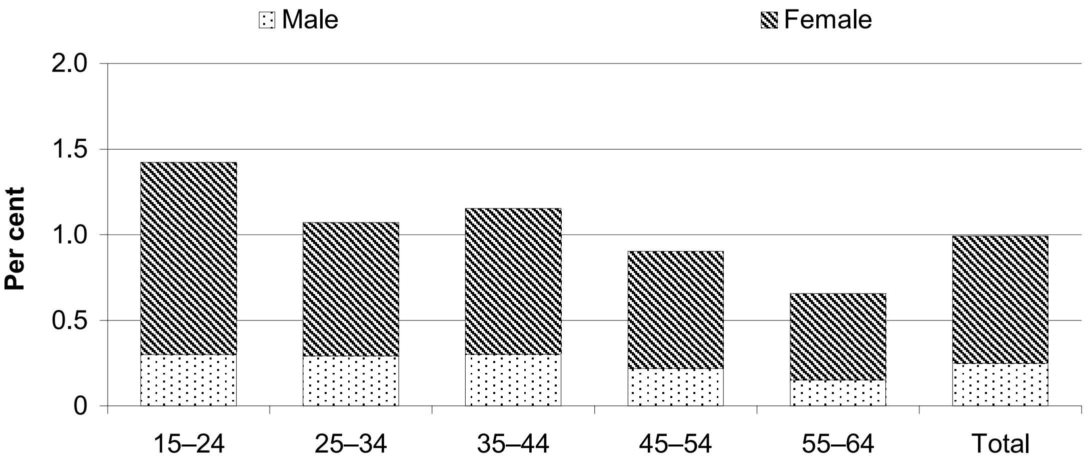
Figure E.8 **Indigenous health workforce as a proportion of total health workforce, by jurisdiction, 2006**[a, b]

[a] Aged 15 years and over. [b] Australian total data include other territories.

Source: ABS (unpublished), ABS (2007) *2006 Census of Population and Housing*, Canberra; table EA.12.

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.9).

Figure E.9 **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.13.

Indigenous health workforce by occupation

In 2006, there were 103 Indigenous people working as medical practitioners and 1446 Indigenous people working as nurses (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) (table EA.15). 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 generalist members of primary care teams, or hospital liaison officers (table EA.15). These data are from the 2006 Census of Population and Housing. Data for 2007 on the proportion of medical practitioners and nurses/midwives that were Indigenous are available from the AIHW Health Labour Force Surveys and are reported in table EA.16.

Table E.4 Proportion of the health workforce that is Indigenous, by occupation groupings, 2006[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]	
	%	%	%	%	%	%	%	%	%	no.
Occupation groupings[c]										
Medical practitioners	0.2	0.1	0.2	0.1	0.2	0.5	0.3	0.6	0.2	103
Medical imaging workers	0.2	0.1	0.3	–	0.4	–	–	–	0.2	19
Dental workers	0.8	0.2	1.2	0.4	0.4	0.9	0.8	1.9	0.7	203
Nursing workers	0.9	0.3	0.9	0.5	0.4	1.3	0.4	1.9	0.7	1 446
Pharmacists	–	0.1	0.2	0.2	–	–	–	–	0.1	13
Allied health workers	0.8	0.2	0.9	0.7	0.8	1.1	0.6	4.2	0.7	454
Complementary therapists	0.5	0.3	0.8	0.8	0.3	3.1	–	–	0.5	87
Other health workers	2.3	0.7	3.4	2.8	2.0	3.7	1.3	27.2	2.4	3 145
Total Indigenous health workforce as proportion of total health workforce	**1.1**	**0.3**	**1.4**	**1.1**	**0.8**	**1.7**	**0.6**	**8.8**	**1.0**	**..**
	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.
Total Indigenous health workforce	**1 933**	**456**	**1 472**	**563**	**354**	**216**	**51**	**422**	**5 470**	**5 470**

[a] Proportions exclude persons who did not state their Indigenous status. [b] Includes Other Territories (Christmas Island, Cocos (Keeling) Islands, and Jervis Bay Territory). [c] Occupation groupings are based on those used in AIHW Health and Community Services Labour Force, 2006. .. Not applicable. – Nil or rounded to zero.

Source: ABS (unpublished), *2006 Census of Population and Housing*, Cat. no. 2068.0; table EA.14.

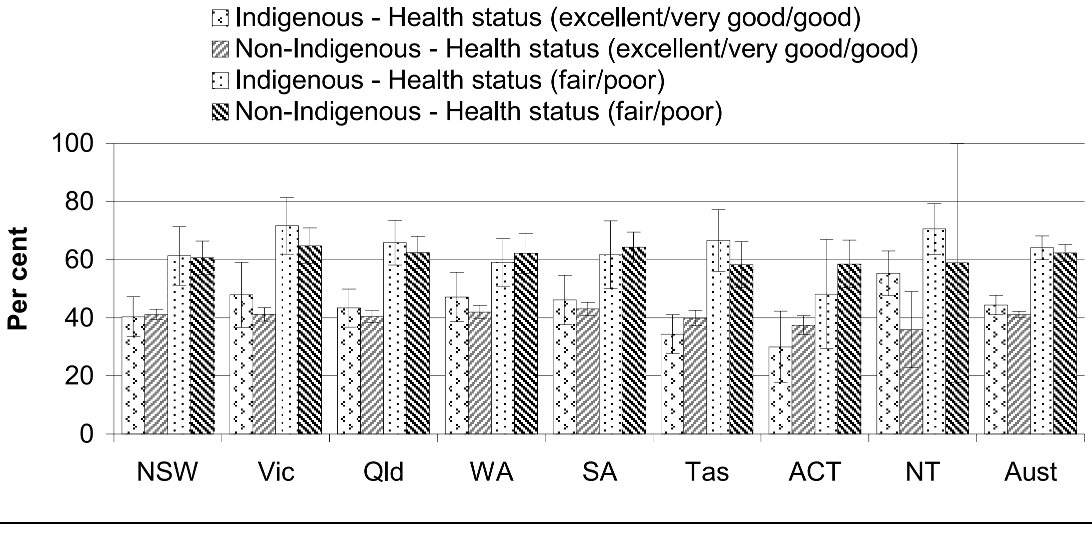
Self-assessed health

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 2008). 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 2008).

Data from the National Health Survey show that 41.8 per cent of Australians who reported their health status as being excellent/very good/good accessed health services in 2004-05, while health services were accessed by 62.6 per cent of people who reported their health status as being fair/poor (tables EA.17 and EA.18). There was little difference between the percentages of Indigenous and non-Indigenous people reporting excellent/very good/good health status who accessed health services or between Indigenous and non-Indigenous people reporting fair/poor health status who accessed health services in 2004-05 (figure E.10). The proportion of people who accessed health services by health status, remoteness and SEIFA are reported in tables EA.21–EA.24.

Figure E.10 **Proportion of people who accessed health services by health status and Indigenous status, 2004-05**[a, b, c, d, e]



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

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

Data 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 2009a), 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 used to adjust 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. Therefore, 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, dietary habits and exercise, or other factors such as high body mass, smoking, and alcohol consumption. The National Health Survey 2007-08 collected data on these risk factors (ABS 2009b), which are presented in this section. 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 has been identified as a cause of lung cancer and a range of other chronic diseases. Nationally, the age standardised rate of lung cancer was 43.3 new cases per 100 000 people in 2007. Bowel cancer, which has been linked to diet, occurred at a rate of 62.4 new cases per 100 000 people in 2007 (tables EA.37 and EA.38). Other cancers such as melanoma are also preventable. The incidence of these cancers for 2007, along with breast and cervical cancer, are reported in tables EA.37–39.

Body mass

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 National Health and Medical Research Council (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).

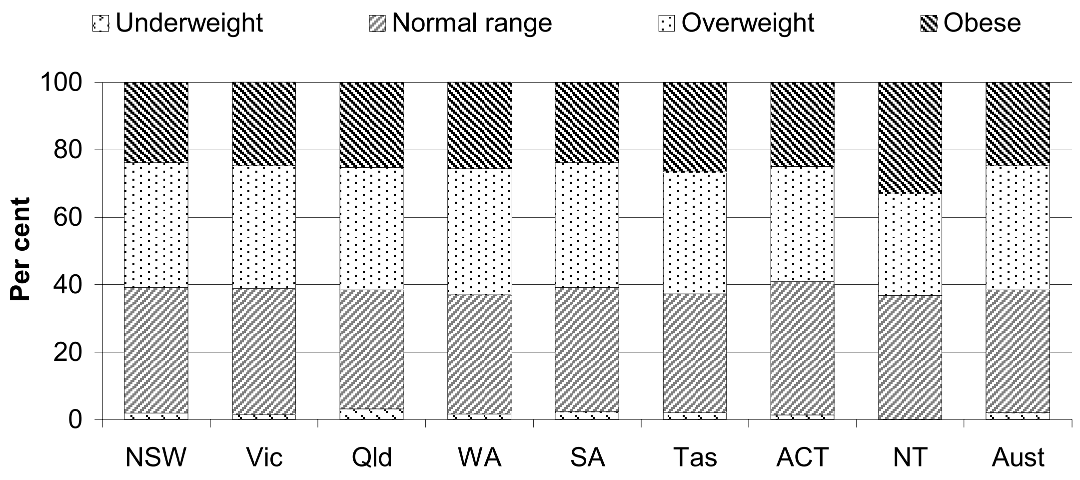
Over a third of Australians' measured BMI was in the overweight range and almost a quarter were obese in 2007-08 (figure E.11). The percentage of people who were obese tended to be higher in remote (35.0 per cent) and outer regional areas (31.3 per cent), than in major cities (22.5 per cent) and inner regional areas

(27.6 per cent) (table EA.25). RSEs and 95 per cent confidence intervals for rates of obesity for adults and children, by remoteness, in 2007-08 are presented in table EA.26.

The percentage of people who were obese tended to be higher in older age groups, peaking at age 70–74 for males (34.2 per cent) and at age 55–64 for females (33.4 per cent). There was a slightly higher percentage of obese males (25.6 per cent) than females (24.0 per cent) (table EA.27). RSEs and 95 per cent confidence intervals for rates of obesity for adults and children, by sex and age, in 2007-08 are presented in table EA.28.

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

Figure E.11 **Proportion of adults in BMI categories, 2007-08**[a, b, c, d]



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[a] Adults are defined as persons aged 18 years and over. Children are defined as persons aged 5–17 years. [b] Obesity for adults is defined as BMI equal to or greater than 30. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years. [c] Measured persons only. [d] Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults, selected ranges from 5–17 for children).

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

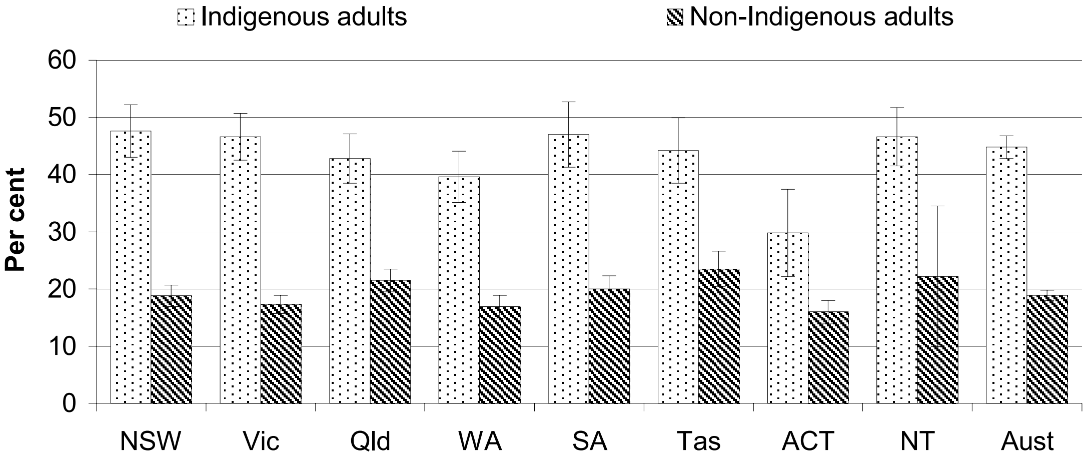
Diet and exercise are also important behaviours that can reduce health risks and improve health outcomes. The NHMRC Australian dietary guidelines recommend a minimum of two serves of fruit per day for adults and five serves of vegetables (NHMRC 2003). A serve of fruit is approximately 150 grams of fresh 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. 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 a moderate level of exercise and 6.2 per cent a high level of exercise (NHMRC 2003).

Smoking

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2007 (ABS 2010a). 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 19.1 per cent of the population in 2007-08. Nationally, Indigenous people had higher age standardised rates of daily smoking (44.8 per cent) than non-Indigenous people (18.9 per cent). There were some variations in the age standardised rates of smoking among the jurisdictions (figure E.12 and table EA.33). Daily smokers accounted for 27.3 per cent of the population in remote geographical areas, gradually decreasing as remoteness of residence decreases, accounting for 25.7 per cent of the population in outer regional areas, 20.1 per cent in inner regional areas and 17.6 per cent in major cities (table EA.32).

Figure E.12 **Proportion of adults who are daily smokers, by Indigenous status, 2007-08**[a, b, c, d]



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

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

Alcohol consumption

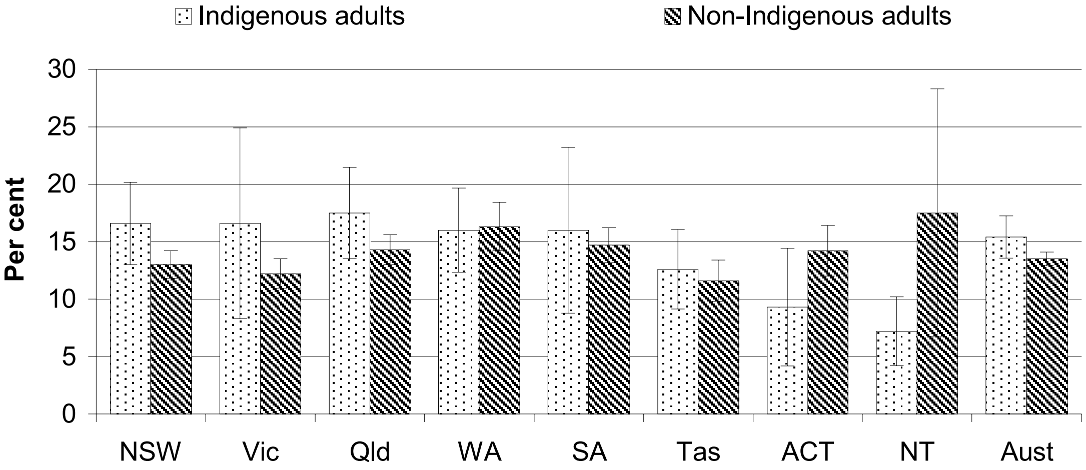
Excessive long term alcohol consumption increases the risk of heart disease, stroke, liver cirrhosis and some types of cancers. Further, it can contribute to injury and death through accidents, violence, suicide and homicide and also to financial problems, family breakdown, child abuse and neglect.

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 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).

Nationally, 13.1 per cent of Australian adults were at risk of long term harm from alcohol in 2007-08. The age standardised rates varied among jurisdictions (table EA.34). Nationally, the age standardised proportion of adults at risk of long term harm from alcohol was higher for Indigenous people (15.4 per cent) than for non-Indigenous people (13.5 per cent) in 2004-05. There were some variations in the age standardised rates for proportion of Indigenous adults at risk of long term harm from alcohol among jurisdictions (figure E.13 and table EA.36).

Adults who are at risk of long term harm from alcohol accounted for 26.0 per cent of the population in remote geographical areas, and this percentage gradually decreased as remoteness of residence decreased in 2007-08. Adults who are at risk of long term harm from alcohol accounted for 15.8 per cent of the population in outer regional areas, 14.9 per cent of the population in inner regional areas and 11.8 per cent in major cities (table EA.35).

Figure E.13 **Proportion of adults at risk of long term harm from alcohol, by Indigenous status, 2004-05**[a, b, c, d]



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[a] Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (10 year ranges from 0). [b] Risky/high risk alcohol consumption in the long term. [c] Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use. [d] The ACT Indigenous estimate should be treated with caution.

Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Social Survey*, 2008; ABS (unpublished) *National Health Survey,* 2007-08; table EA.36.

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 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. The National Health Performance Framework was reviewed by the National Health Performance Committee and a revised framework was agreed by the National Health Information Standards and Status Committee in 2009.

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, and has again sought to align with the revised National Health Performance Framework for this Report. 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 three subdimensions of quality — safety, responsiveness and continuity — and, second, it includes an extra dimension of efficiency — sustainability (figure E.14). 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
- *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).

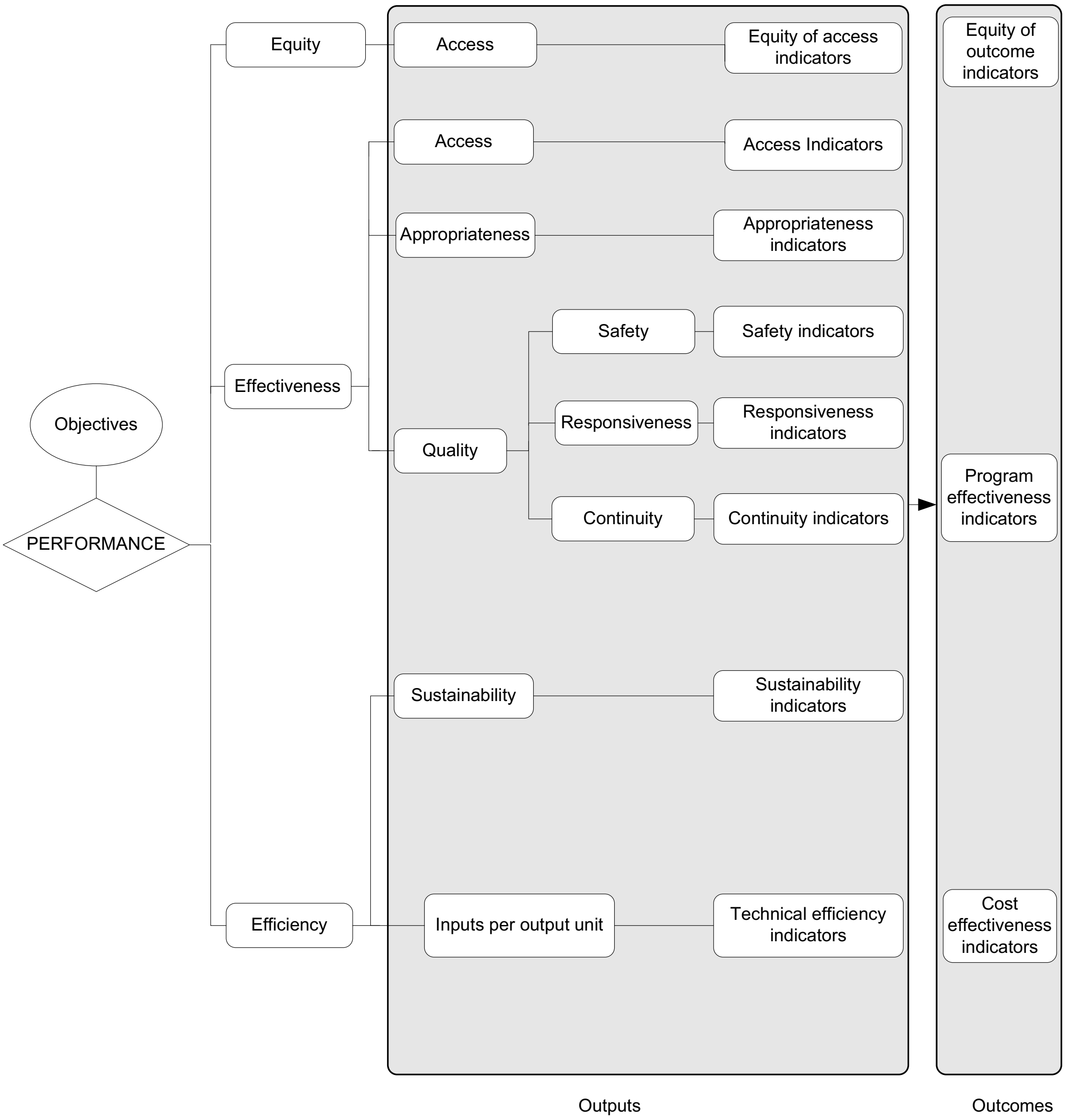
Alignment with the revised National Health Performance Framework this year has meant that when compared to previous reports, the capability dimension is no longer included in the framework and the sustainability dimension is now reported under efficiency rather than effectiveness.

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.14 **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.

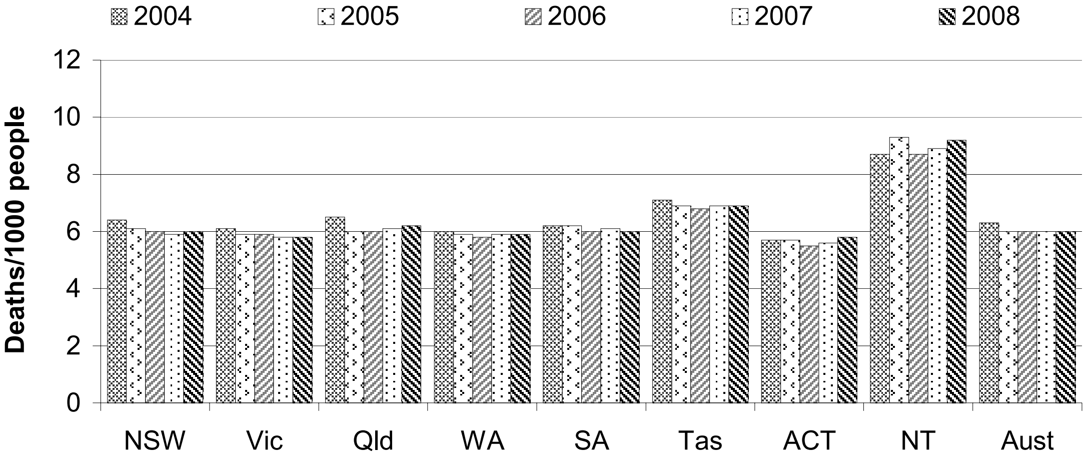
Data on health outcomes presented in this preface include mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population as a whole.

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 143 900 deaths in Australia in 2008 (ABS 2009a), which translated into an age standardised mortality rate of 6.0 deaths per 1000 people (figure E.15). Death rates over the last 20 years have declined for all states and territories (ABS 2009a).

Figure E.15 **Mortality rates, age standardised**[a, b, c, d]



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

Source: ABS (2009) *Deaths 2008*, Australia, Cat. no. 3302.0, AusInfo, Canberra; table EA.40.

Indigenous mortality rates

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

Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, data are presented for the five year period 2004–2008. 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 the 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 2004–2008 (figure E.16 and table EA.40). Due to identification

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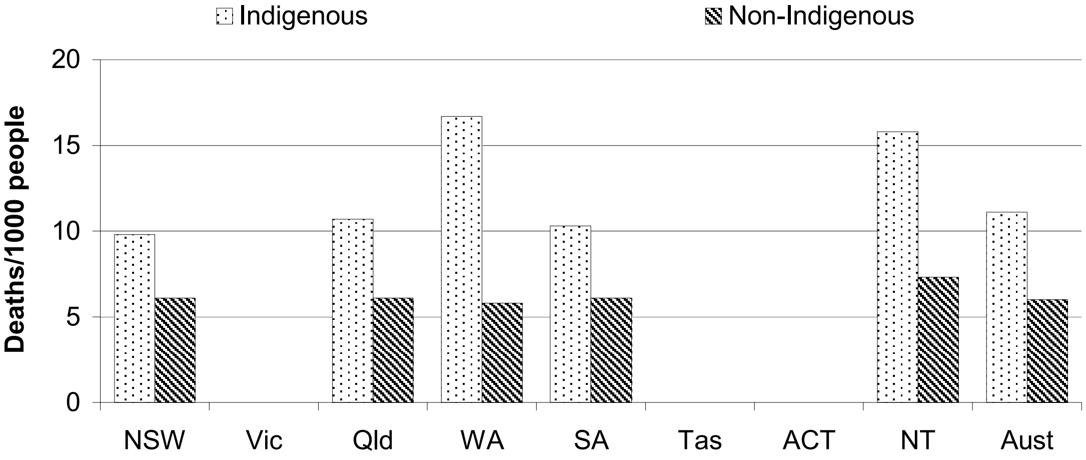
[4] The term ‘coverage’ refers to the number of Indigenous deaths registered as a percentage of the number of expected deaths based on experimental Indigenous population estimates and projections from the 2006 Census.

completeness issues, mortality rates presented here are likely to be under-estimates of the true mortality of Indigenous Australians (ABS and AIHW 2008).

Figure E.16 **Mortality rates, age standardised, by Indigenous status, five year average, 2004–2008**[a, b, c, d]



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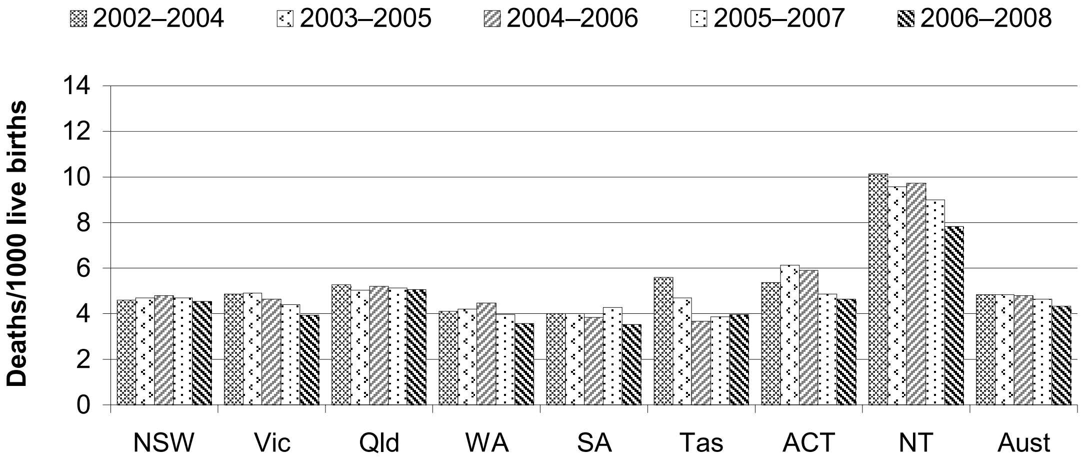
[a] Deaths are based on year of registration of death. [b] Deaths per 1000 standard population. Standardised death rates use total persons in the 2001 Australian population as the standard population. [c] The unusually high Indigenous mortality rate for WA in 2008 is under investigation by the ABS. [d] 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, 2008*; table EA.40.

Infant and child 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 as an average over three years to reduce the volatility inherent in the annual rates due to small numbers of deaths and annual fluctuations. The infant mortality rate in Australia declined from an average of 4.8 deaths per 1000 live births over the period 2002–2004 to 4.3 deaths per 1000 live births over the period 2006–2008 (figure E.17). For the period 2007–2009, the infant mortality rate was an average of 4.2 deaths per 1000 live births (table EA.42).

Figure E.17 **Infant mortality rate, three year average**[a, b]



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

Source: ABS (2009) *Deaths Australia, 2008, Australia,* Cat. no. 3302.0, Canberra; table EA.41.

The child mortality rate is defined as the number of deaths of children between one and four years of age in a calendar year per 100 000 of the population. Child mortality rates are presented as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations. The Australian child mortality rate was 21.0 deaths per 100 000 of the population in 2007–2009. The mortality rate for infants and children combined (those aged 0 to 4 years) was 105.9 deaths per 100 000 of the population in 2007–2009 (table EA.42).

Indigenous infant and child mortality rates

For WA, SA and the NT, longer-term trends suggest that the mortality rate for Indigenous infants decreased by 47 per cent between 1991 and 2006 (ABS 2009a). Despite this significant improvement, infant mortality rates for Indigenous children are still markedly higher than for non-Indigenous children in Australia.

For the period 2005–2009, the average infant mortality rate for Indigenous children was higher (8.9 deaths per 1000 live births) than for non-Indigenous children (4.2 deaths per 1000 live births) (table EA.43). For the same period, the average child mortality rate for Indigenous children was also higher (56.1 deaths per 100 000 of the population) than for non-Indigenous children (20.3 deaths per 100 000 of the population) (table EA.44). The combined infant and child average child mortality rate for Indigenous children was 234.7 deaths per 100 000 of the population compared to 103.7 deaths per 100 000 of the population for non-Indigenous children (table EA.45).

Major causes of death

The most common causes of death among Australians in 2008 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.46). In 2008, malignant neoplasms (cancers) were the underlying cause of death in 30 per cent of all registered deaths and ischaemic heart disease was the underlying cause in a further 16 per cent of deaths (ABS 2010a).

Table E.5 **Age standardised mortality rates by major cause of death (deaths per 100 000 persons), 2008**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Certain infectious and parasitic diseases	10.3	6.3	6.8	6.5	8.7	6.1	8.2	28.2	8.2
Neoplasms	178.0	182.3	188.5	175.6	184.5	205.7	167.8	229.6	182.1
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.9	2.2	1.7	2.8	2.7	2.0	1.4	1.0	2.1
Endocrine, nutritional and metabolic diseases	21.4	25.9	26.4	26.2	24.4	32.4	22.4	83.5	24.7
Mental and behavioural disorders	25.4	26.6	22.4	25.0	25.9	32.8	29.5	42.9	25.5
Diseases of the nervous system	22.2	25.3	24.0	29.9	27.8	26.9	34.7	24.9	24.8
Diseases of the eye and adnexa	–	–	–	0.1	0.1	–	–	–	0.1
Diseases of the ear and mastoid process	–	–	–	–	–	–	–	–	–
Diseases of the circulatory system	205.2	185.3	207.2	183.7	190.3	221.5	186.9	214.9	197.6
Diseases of the respiratory system	48.0	45.1	47.5	43.0	45.1	57.5	35.5	88.4	46.8
Diseases of the digestive system	20.5	20.5	20.4	21.2	19.9	24.7	19.6	40.9	20.7
Diseases of the skin and subcutaneous tissue	2.1	1.3	1.3	1.6	1.3	1.3	1.1	2.9	1.6
Diseases of the musculoskeletal system and connective tissue	4.8	4.4	4.7	5.1	4.1	8.0	9.8	8.2	4.8

(Continued on next page)

Table E.5 **(Continued)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Diseases of the genitourinary system	13.8	12.6	13.4	11.8	14.9	12.3	14.4	38.2	13.5
Pregnancy, childbirth and the puerperium	–	–	0.1	–	–	–	–	–	–
Certain conditions originating in the perinatal period	3.2	2.3	3.1	1.4	2.0	2.1	5.6	4.4	2.7
Congenital malformations, deformations and chromosomal abnormalities	2.8	2.7	3.4	2.1	2.6	2.0	1.1	2.6	2.8
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	5.3	3.3	9.2	5.1	3.2	3.3	3.9	8.2	5.4
External causes of morbidity and mortality	34.9	37.3	41.0	47.0	39.5	49.3	37.3	100.1	39.2
Total	**600.1**	**583.5**	**621.1**	**588.3**	**596.9**	**688.0**	**579.2**	**919.3**	**602.5**

[a] Age standardised to the Australian population as at 30 June 2001. [b] Australian total includes 'Other territories'. – Nil or rounded to zero.

Source: ABS (2010) *Causes of Death Australia, 2008*, Cat. no. 3303.0, Canberra; table EA.46.

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT), death rates were significantly higher for Indigenous Australians than for non-Indigenous Australians in 2004–08. In particular, Indigenous people died: from endocrine, metabolic and nutritional disorders at a rate of up to 6.3 times that for non-Indigenous people; from kidney diseases at a rate of up to 5.1 times that for non-Indigenous people; from digestive diseases at a rate of up to 4.7 times that for non-Indigenous people; and from infectious and parasitic diseases at a rate of 3.2 times that for non-Indigenous people (tables E.6 and EA.47).

Table E.6 Age standardised mortality rate ratios of Indigenous to non-Indigenous people by major cause of death, 2004–2008[a, b, c, d, e, f]

	NSW	*Qld*	*WA*	*SA*	*NT*	*Total*[g]
Circulatory diseases	2.0	2.2	3.7	2.6	3.9	2.5
Neoplasms (cancer)	1.2	1.5	1.9	1.2	1.7	1.5
External causes of morbidity and mortality	1.6	2.0	3.7	3.1	2.7	2.6
Endocrine, metabolic and nutritional disorders	3.0	6.6	9.3	4.5	7.4	6.3
Respiratory diseases	2.2	2.2	4.7	2.7	4.2	3.0
Digestive diseases	3.3	3.8	7.1	4.0	5.9	4.7
Kidney Diseases	2.7	4.4	6.8	4.0	11.3	5.1
Conditions originating in the perinatal period	1.5	2.0	3.1	2.6	3.1	2.1
Infectious and parasitic diseases	1.9	3.3	5.1	2.4	4.4	3.2
Nervous system diseases	1.2	1.1	2.4	2.2	3.1	1.6
Other causes[h]	1.6	1.9	4.4	1.7	3.0	2.3
All causes	**1.7**	**2.2**	**3.6**	**2.3**	**3.4**	**2.5**

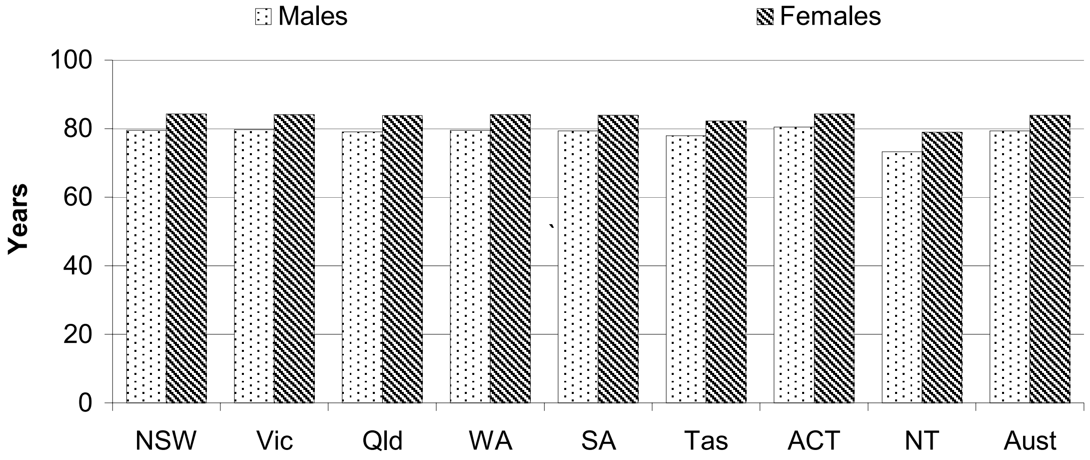
[a] Age standardised to the Australian population as at 30 June 2001. [b] Rate ratio is the crude Indigenous rate divided by the non-Indigenous rate. [c] Although most deaths of Indigenous people are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these data are likely to underestimate the Indigenous ‘all causes’ mortality rate. [d] Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have acceptable levels of Indigenous identification in mortality data. [e] Data are presented in five-year groupings due to the volatility of small numbers each year. [f] Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. [g] Total includes only those five states and territories of residence that are considered to have acceptable levels of Indigenous identification in mortality data (NSW, Queensland, WA, SA and the NT). [h] 'Other causes' consist of all conditions excluding the selected causes displayed in the table.

Source: ABS (unpublished) *Causes of Death Australia, 2008*, Cat. No. 3301.0; table EA.47.

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 2009a). It has risen steadily in each decade since, reaching 79.3 years for males and 83.9 years for females in 2007–2009 (figure E.18).

Figure E.18 **All Australians average life expectancy at birth, 2007–2009**[a]



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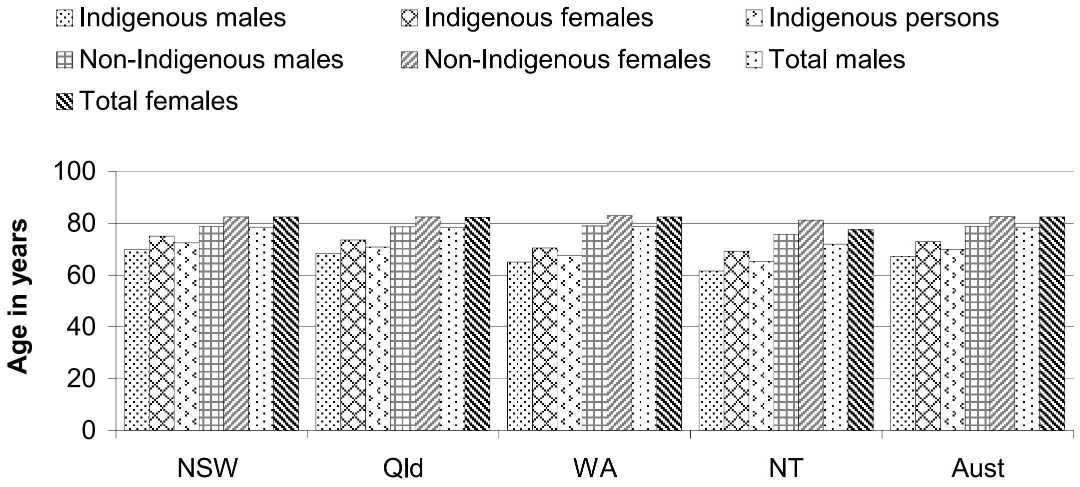
[a] Figures for Australia include 'other territories'.

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

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.19 and table EA.49). 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.19 and table EA.49).

Figure E.19 **Estimated life expectancies at birth, by Indigenous status and sex, 2005–2007 (years)**[a, b, c]



[a] Indigenous estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths in these jurisdictions. [b] Life tables are constructed separately for Males and Females. Life tables were not constructed for Persons, therefore life expectancy estimates for Persons are a weighted combination of Male and Female life expectancies. [c] Australian total includes all states and territories.

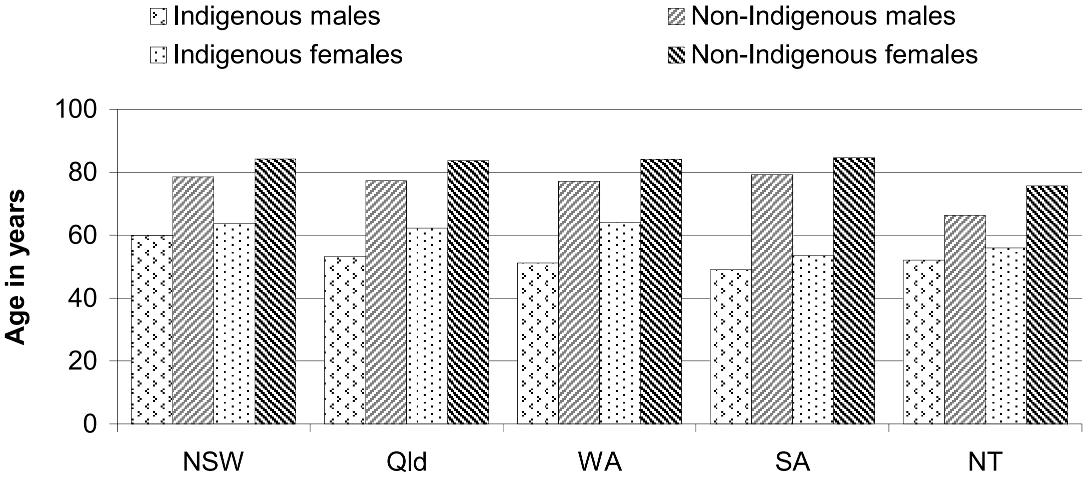
Source: ABS (2009), *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005–2007*, Australia, Cat. no. 3302, Canberra; table EA.49.

Median age at death

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 2008, the median age at death was 78.1 and 84.0 years of age, respectively (figure E.20 and table EA.50). In the jurisdictions for which data were available for Indigenous people the median age at death for male Indigenous Australians was between 49.0 and 59.9 years of age. The median age at death for female Indigenous Australians was between 53.5 and 64.0 years of age (figure E.20 and table EA.50).

Figure E.20 **Median age at death, by sex and Indigenous status, 2008**[a, b]



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[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 (2009) *Deaths Australia, 2008*, Cat. no. 3302.0, AusInfo, Canberra; table EA.50.

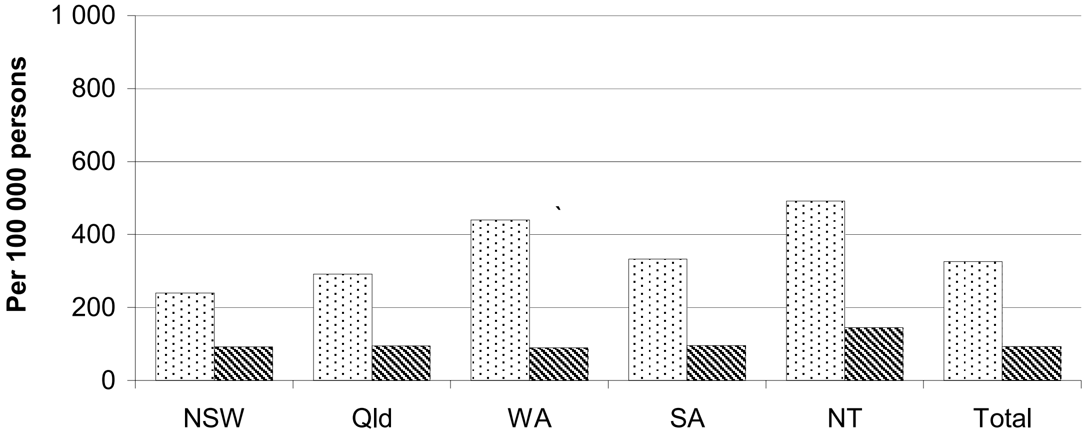
Potentially avoidable deaths

Potentially avoidable deaths comprise potentially preventable deaths (deaths amenable to screening and primary prevention, such as immunisation) and deaths from potentially treatable conditions (deaths amenable to therapeutic interventions). Avoidable deaths reflect the effectiveness of the current preventative health activities in the health sector. Indigenous people had significantly higher death rates from potentially avoidable, both preventable and treatable deaths. Nationally, for Indigenous people there were 541.6 potentially avoidable deaths per 100 000 people aged under 75 years over the period 2004–2008, comprising 325.9 potentially preventable deaths per 100 000 people and 215.6 treatable deaths per 100 000 people. Nationally, for non-Indigenous people there were 156.0 potentially avoidable deaths per 100 000 people aged under 75 years over the period 2004–2008, comprising 93.3 potentially preventable deaths per 100 000 people and 62.7 treatable deaths per 100 000 people (figure E.21 and table EA.52). Single year data are presented in table EA.51.

Figure E.21 Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, 2004–08[a, b, c, d, e, f]

⛆ Indigenous people ▧ Non-Indigenous people

Potentially preventable deaths



Potentially treatable deaths

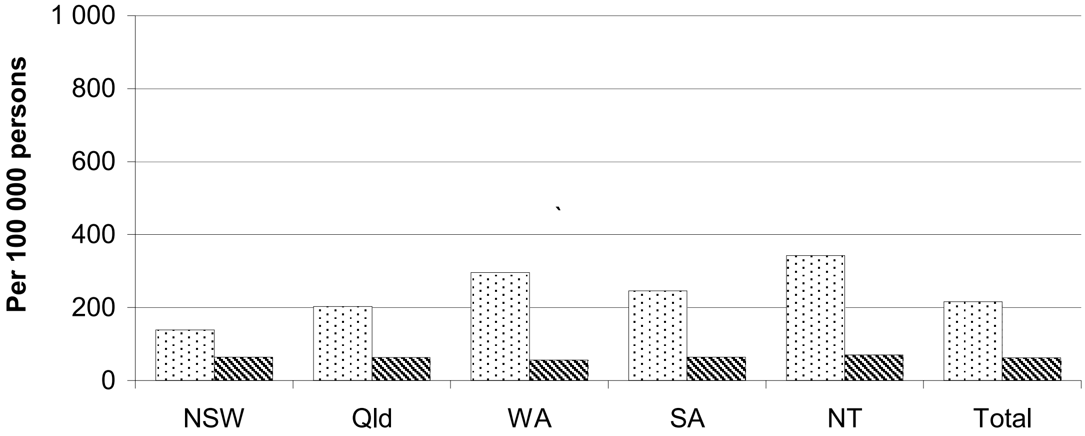


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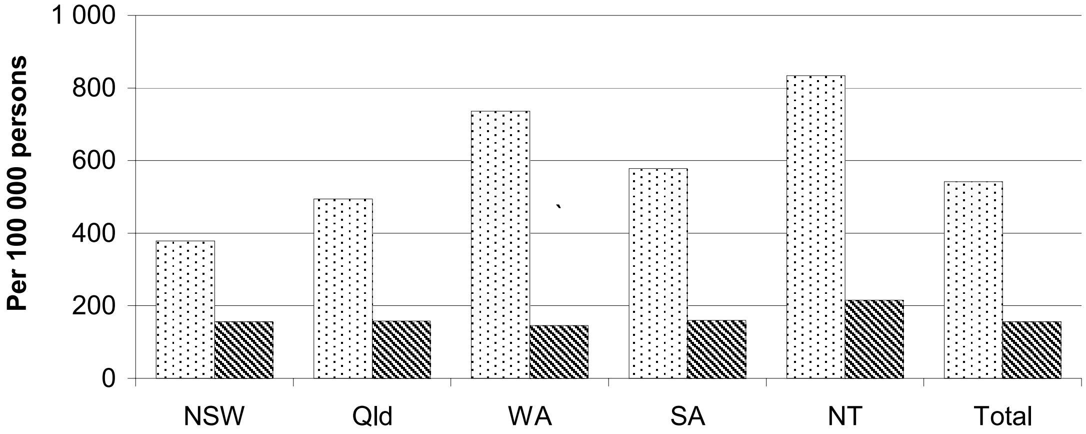
Figure E.21 **(Continued)**

All potentially avoidable deaths



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[a] Age standardised to the Australian population as at 30 June 2001. [b] Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of Indigenous identification in mortality data. [c] Data are presented in five-year groupings due to the volatility of small numbers each year. [d] Total includes only those five states and territories of residence that are considered to have acceptable levels of Indigenous identification in mortality data (NSW, Queensland, WA, SA and the NT). [e] Preventable deaths are those which are amenable to screening and primary prevention such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector. [f] Deaths from potentially treatable conditions are those which are amenable to therapeutic interventions, and reflect the safety and quality of the current treatment system.

Source: ABS (unpublished) *Causes of Deaths, Australia, 2008*, Cat. no. 3303.0; table EA.52.

Birthweight of babies

The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2008, 92.0 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Sullivan 2010). The average birthweight for all live births was 3377 grams in 2008 (table EA.53). The average birthweight for liveborn babies of Indigenous mothers was 3196 grams in 2008 (table EA.54). This was 189 grams lighter than the average of 3385 grams for liveborn babies of non-Indigenous mothers (Laws and Sullivan 2010).

Babies' birthweight is defined as low if they weigh less than 2500 grams, very low if they weigh less than 1500 grams and extremely low if they weigh less than 1000 grams (Laws and Sullivan 2010). In 2008, 6.1 per cent of all liveborn babies in Australia weighed less than 2500 grams. This included 1.0 per cent of babies who weighed less than 1500 grams (table EA.53).

Among live babies born to Indigenous mothers in 2008, the proportion with low birthweight was over twice that of those born to non-Indigenous mothers (figure E.22). The number and proportion of live-born singleton babies of low birthweight for the period 2006–2008 are presented in table EA.56.

Figure E.22 **Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2008**[a, b, c, d]

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[a] Low birthweight is defined as less than 2500 grams. [b] Disaggregation by State/Territory is by place of usual residence of the mother. [c] Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated. [d] Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birthweight.

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

Future directions

The Steering Committee intends to replace this preface with a Health sector summary and continue to expand reporting on the characteristics of the Health sector. In particular, developments that span various health services, such as Indigenous health reporting, will be considered. Ongoing investigation of cross-cutting issues might allow improved reporting for health services as a whole.

Each chapter (public hospitals, primary and community health and health management issues) contains a service specific section on future directions in performance reporting. The aim of this section is to provide an insight into other related and overarching developments on reporting in the health sector.

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

COAG developments

Report on Government Services alignment with National Agreement reporting

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the Report in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework’ and the ‘Review of the performance indicators and their associated measures’. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

List of 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 Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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10 Public hospitals

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' 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 from the Review website at www.pc.gov.au/gsp.

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

Major improvements in reporting on public hospitals this year include:

- inclusion of the following measures to align this Report with National Healthcare Agreement (NHA) and National Indigenous Reform Agreement (NIRA) indicators:
  - ‘unplanned/unexpected readmissions within 28 days of selected surgical admissions’ has replaced the ‘unplanned readmission rates’ indicator
  - ‘healthcare associated *Staphylococcus aureus* bacteraemia in acute care hospitals’ has replaced the ‘surgical site infection rates’ indicator
  - an indicator for ‘falls resulting in patient harm in hospitals’ has been included
  - an indicator for ‘intentional self harm in hospitals’ has been included.
- the ‘patient satisfaction’ indicator now includes information previously reported on responsiveness under the output indicator ‘patient satisfaction surveys’
- revisions to the definitions of two sentinel event categories to align with national definitions endorsed by Health Ministers in 2009, improving data comparability across states and territories
- better quality data for reporting on the indicator ‘vaginal birth following a previous caesarean’, with full coverage of births according to national definitions
- inclusion of some ‘data quality information’ (DQI) documentation.

10.1 Profile of public hospitals

Definition

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

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

- teaching and research activities.

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

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, subacute 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.

subacute care: interdisciplinary clinical care in which the need for care depends primarily on the patient's functional status and quality of life rather than the underlying medical diagnosis or the patient's prospects of recovery from illness. Subacute care includes rehabilitation, palliative care and some mental health care, as well as geriatric evaluation and management and psychogeriatric care. Common to all is the patient no longer meets criteria for classification as 'acute', but still requires therapeutic, clinically-intense and goal-directed care.

non-acute care: includes maintenance care and newborn care.

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: an 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).

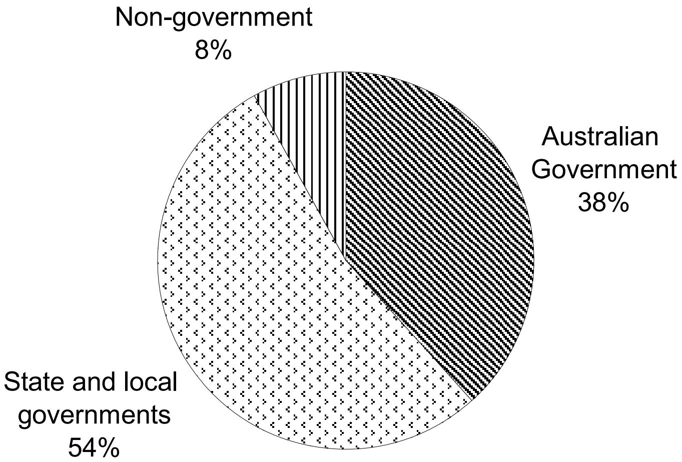
Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $31.3 billion in 2008-09 (table 10A.1).

The majority of total public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2008-09, 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 68.0 per cent to 80.0 per cent across jurisdictions (AIHW 2010a).

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 92.1 per cent of funding for public hospitals in 2008-09 (figure 10.1). Public hospitals accounted for 40.9 per cent of government recurrent expenditure on health services in 2008-09 (AIHW 2010b).

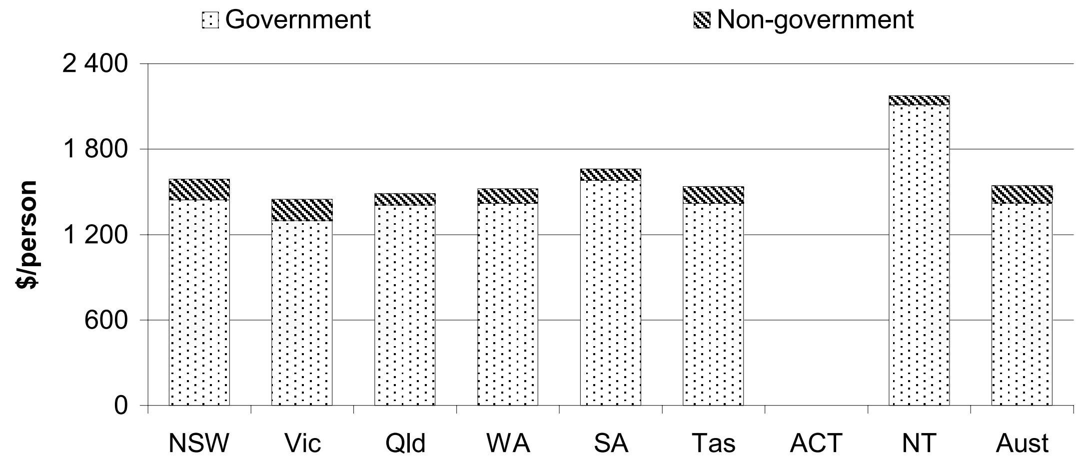
Figure 10.1 **Recurrent expenditure, public hospitals, by source of funds, 2008-09**



Source: AIHW (unpublished), Health expenditure database.

In 2008-09, public hospitals received $2.6 billion from non-government sources (which equates to $122.30 dollars per person) — an amount that accounted for 7.9 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 2008-09 (figure 10.2).

Figure 10.2 **Source of public hospital recurrent expenditure, 2008-09**[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.

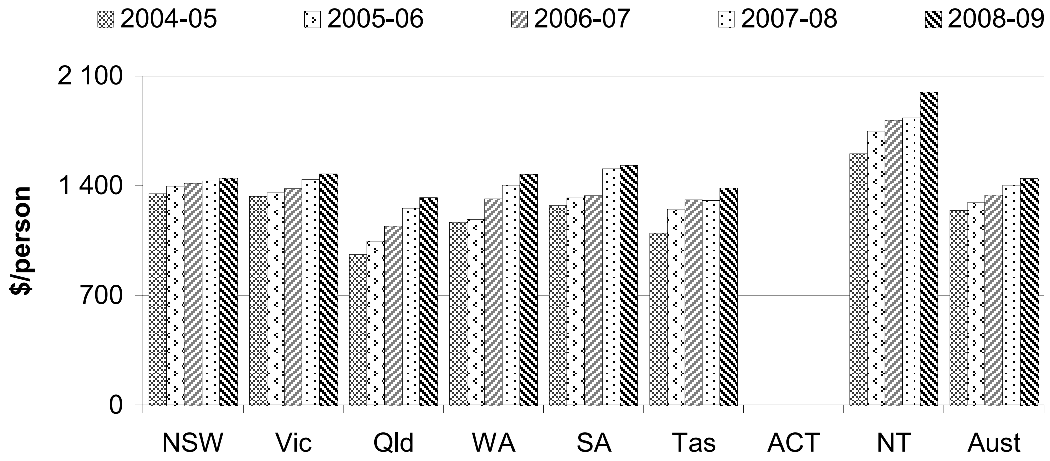
Source: AIHW (unpublished), Health expenditure database; ABS (unpublished), Australian Demographic Statistics, December Quarter 2009, Cat. no. 3101.0; table 10A.2.

Expenditure data in figures 10.1 and 10.2 are from *Health Expenditure Australia 2008-09* (AIHW 2010b) and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2008-09* (AIHW 2010a). 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 2008-09, government real recurrent expenditure on public hospitals was $1446 per person for Australia, up from $1242 in 2004-05 (in 2008-09 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) (2008-09 dollars)**[a, b, c, d, e, f, g]



[a] Expenditure data exclude depreciation and interest payments. [b] Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. [c] Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2010b). [d] Queensland pathology services were purchased from a Statewide pathology service rather than being provided by hospital employees. [e] Data for WA from 2006-07 include expenditure for public patients at Joondalup and Peel Health Campuses. Expenditures for these patients are not included in previous years. [f] For Tasmanian hospitals for 2004-05 and 2005-06, data for one hospital are not included. [g] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 41, 50, 55, 71 and 84; AIHW (2010), *Health expenditure Australia 2008–09*, Health and Welfare Expenditure Series No. 42, Cat. no. HWE 51. Canberra, AIHW; ABS (unpublished), Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; table 10A.3.

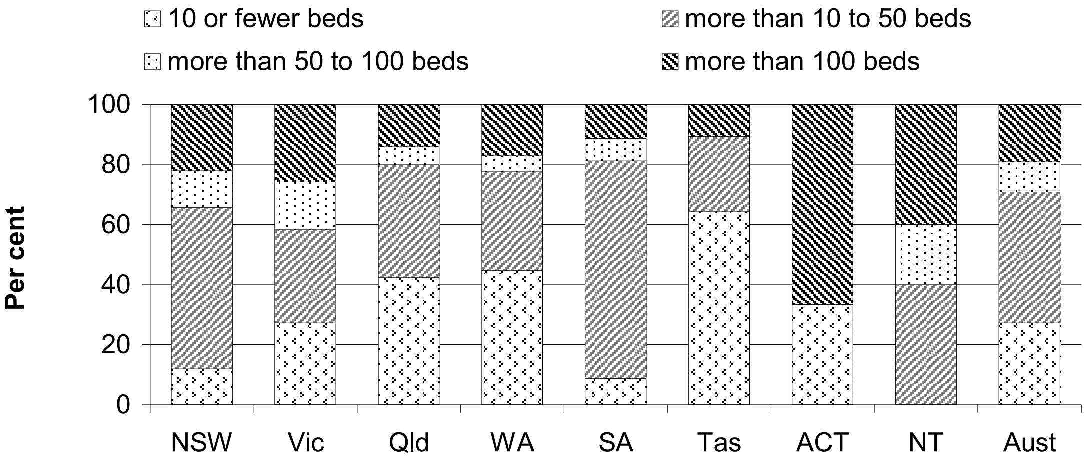
Size and scope of sector

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 2008-09, Australia had 756 public hospitals (table 10A.4) (including 19 psychiatric hospitals) (AIHW 2010a). Although 71.2 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 16.1 per cent of total available beds (figure 10.4 and table 10A.4).

Figure 10.4 **Public hospitals, by size, 2008-09**[a, b, c, d, e]



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[a] The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of hospital buildings or campuses. [b] Size is based on the average number of available beds. [c] The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services. [d] The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database. [e] Tasmania and the ACT did not have hospitals with more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds.

Source: AIHW (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.4.

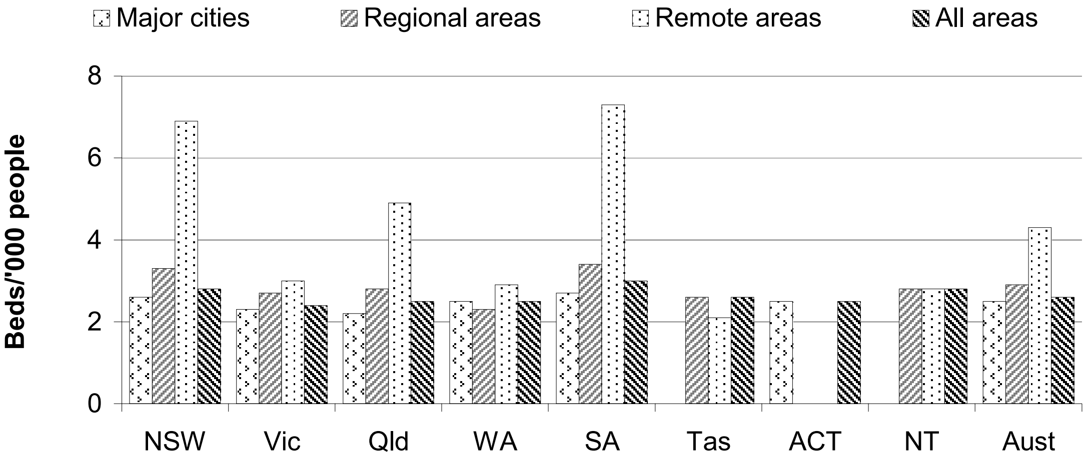
Beds

There were 56 478 available beds for admitted patients in public hospitals in 2008-09 (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 2010a). Admission practices vary across states and territories and change over time which can cause differences in whether patients are treated as admitted or non-admitted.

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, 2008-09**[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 2010a). [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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.5.

Total separation rates

There were approximately 4.9 million separations from public (non-psychiatric) hospitals in 2008-09 (table 10A.6). Nationally, this translates into 218.8 separations per 1000 people (figure 10.6).

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

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[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 41, 50, 55, 71 and 84; table 10A.7.

Same day separations in public (non-psychiatric) hospitals increased by 4.2 per cent between 2007-08 and 2008-09, 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 2007-08 and 2008-09 (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 2008-09 (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, 2008-09[a]**

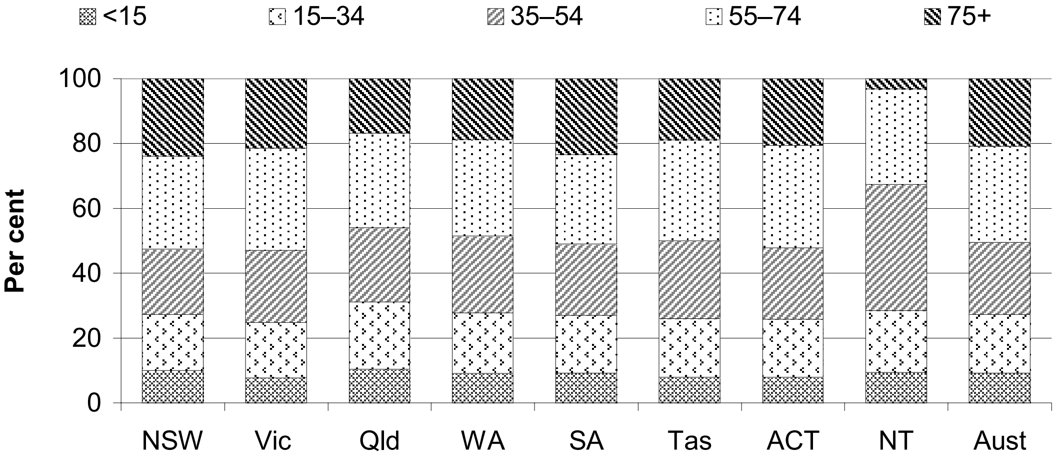
[a] 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG version 5.1 categories.

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 (50.5 per cent) in 2008-09, even though they accounted for only 24.6 per cent of the estimated resident population at 31 December 2008 (figure 10.8 and AIHW 2010a). 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, 2008-09**[a]



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[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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; 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 hospitals in 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. More recently, the National Health Information Standards and Statistics Committee (a standing committee of NEHIPC) approved reporting of data for Tasmania and the ACT by Indigenous status at the state and territory level for COAG reporting purposes. However, pending further examination of the quality of Indigenous identification for these jurisdictions, these data will not be included in national totals. This decision was taken too late to include most data for Tasmania and the ACT in this chapter for the 2011 Report. 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 2008-09, separations for Indigenous people accounted for around 3.6 per cent of total separations and 5.6 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 2.4 per cent of the population in these jurisdictions (tables AA.2 and AA.7). Most separations involving Indigenous patients (92.3 per cent) in these jurisdictions occurred in public hospitals (table 10.1).

Table 10.1 Separations, by Indigenous status of patient and hospital sector, 2008-09[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]
Public hospital separations (‘000)									
Indigenous	56.8	12.7	68.7	41.0	18.5	2.5	2.0	66.2	263.8
Non-Indigenous	1 434.8	1 357.1	797.7	426.5	339.6	90.0	86.2	29.2	4 384.8
Not reported	14.4	9.9	16.9	–	16.5	2.4	1.6	–	57.7
Total	**1 506.0**	**1 379.6**	**883.3**	**467.4**	**374.5**	**94.9**	**89.9**	**95.4**	**4 706.3**
Private hospital separations (‘000)									
Indigenous	1.5	0.7	4.4	14.4	1.0	np	np	np	22.1
Non-Indigenous	886.0	800.2	733.2	347.7	240.3	np	np	np	3 007.3
Not reported	19.8	10.1	76.3	–	14.2	np	np	np	120.5
Total	**907.2**	**811.0**	**813.9**	**362.2**	**255.5**	**np**	**np**	**np**	**3 149.8**
Indigenous separations as proportion of total separations (%)									
Public hospitals	3.8	0.9	7.8	8.8	4.9	2.6	2.2	69.4	5.6
Private hospitals	0.2	0.1	0.5	4.0	0.4	np	np	np	0.7
All hospitals	**2.4**	**0.6**	**4.3**	**6.7**	**3.1**	**np**	**np**	**np**	**3.6**
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous	97.5	94.7	93.9	73.9	94.8	np	np	np	92.3
Non-Indigenous	61.8	62.9	52.1	55.1	58.6	np	np	np	59.3

[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. [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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.10.

In 2008-09, on an age standardised basis, 763.3 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 221.3 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*[c]	*Qld*[c]	*WA*[c,d]	*SA*[c]	*Tas*	*ACT*	*NT*[c]	*Total*[e]
2004-05									
Indigenous people	np	np	733.6	821.5	822.2	np	np	1 441.0	907.0
Total population	193.3	238.3	188.1	195.2	225.3	np	np	456.2	208.1
2005-06									
Indigenous people	495.6	np	745.4	845.2	875.0	np	np	1 548.0	792.1
Total population	203.2	243.4	186.2	196.4	228.4	np	np	479.1	213.6
2006-07									
Indigenous people	528.0	624.3	756.7	876.5	929.3	np	np	1 584.8	787.5
Total population	206.0	246.7	190.2	218.4	232.6	np	np	480.1	218.8
2007-08									
Indigenous people	550.5	629.8	785.7	869.4	908.9	np	np	1 670.7	807.7
Total population	202.8	247.8	195.7	215.1	216.4	np	np	486.4	217.6
2008-09									
Indigenous people	511.5	535.8	732.5	817.3	950.5	np	np	1 656.0	763.3
Total population	205.6	249.5	204.4	215.8	217.7	np	np	495.5	221.3

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.

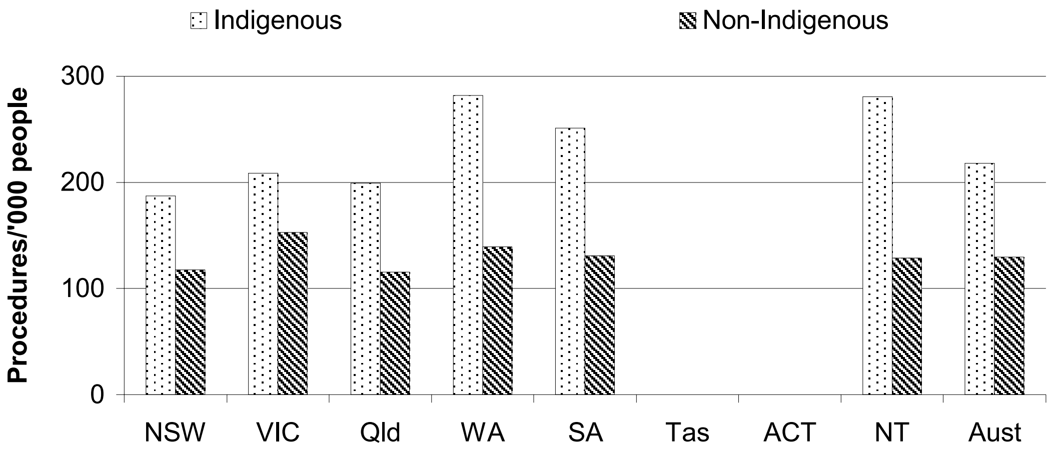
Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.11.

Separations with a procedure recorded for Indigenous patients

Hospitalisations with a procedure reported both by jurisdiction and by remoteness are presented in figures 10.9 and 10.10, 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 2008–June 2009, excluding hospitalisations for care involving dialysis, Indigenous people had higher rates of hospitalisations with a procedure reported for all states and territories and for each remoteness category (figures 10.9 and 10.10).

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 **Hospitalisations with a procedure reported, public hospitals, July 2008–June 2009**[a, b, c]



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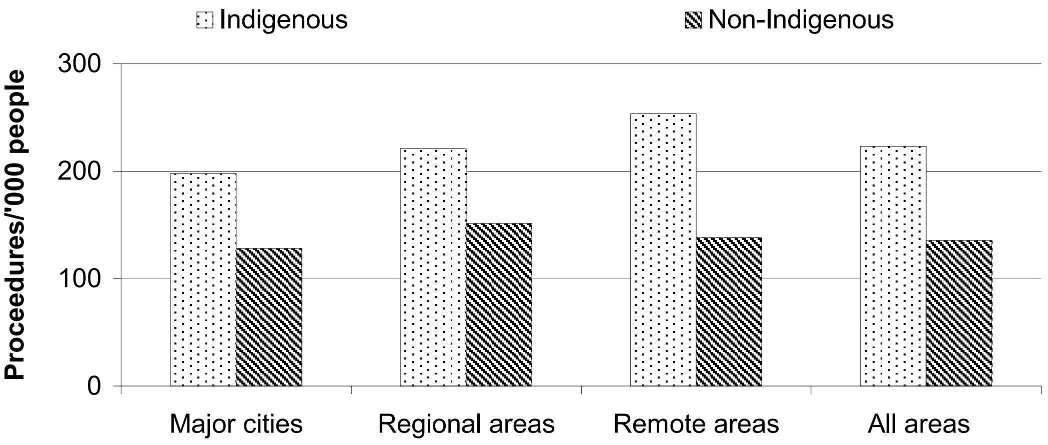
[a] Includes all patients treated in public hospitals and public patients treated in private hospitals. Private hospital data for NT were not available therefore results for NT include public hospital data only. [b] The AIHW advised that only data for NSW, Victoria, Queensland, WA, SA and the NT are 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 10.10 **Hospitalisations with a procedure reported, public hospitals, July 2008–June 2009**[a, b]



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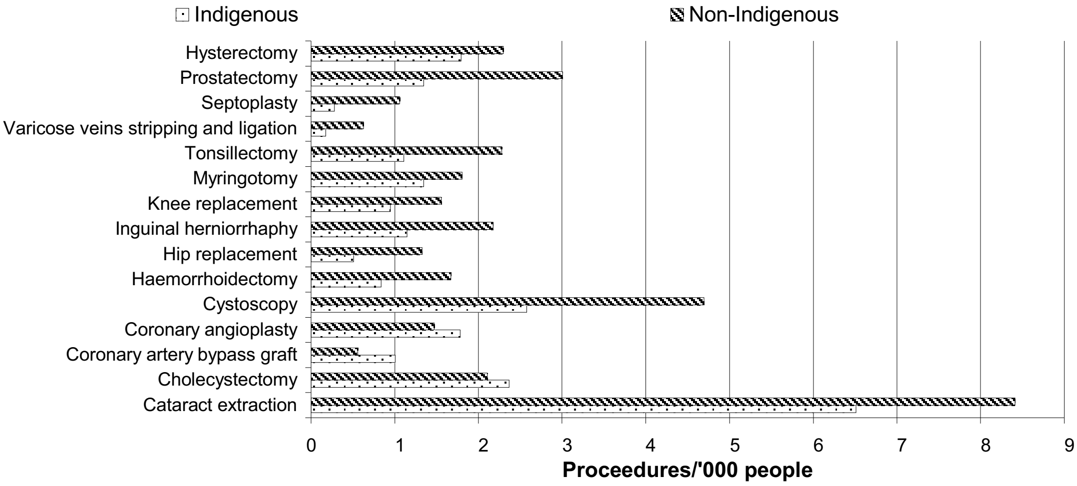
[a] Includes all patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. Private hospital data for NT were not available therefore results for NT include public hospital data only. [b] 'All diagnoses' excludes care involving dialysis.

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

Data for NSW, Victoria, Queensland, WA, SA and NT public hospitals for selected procedures are presented in figure 10.11. In the period July 2008–June 2009, Indigenous people had lower rates of hospital procedures for a number of selected procedures (figure 10.11).

Figure 10.11 **Selected hospital procedures, public hospitals, July 2008–June 2009**[a]



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[a] Includes patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT.

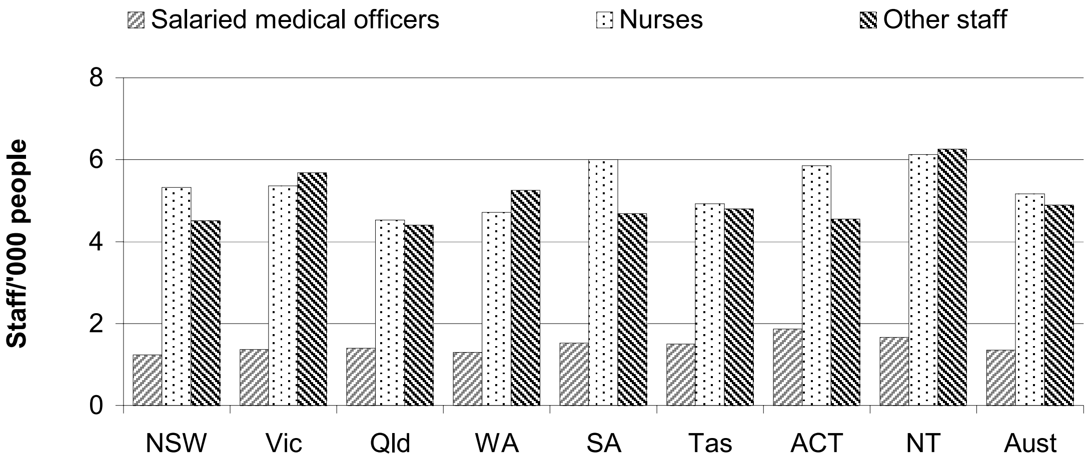
Source: AIHW (unpublished), National Hospital Morbidity Database, table 10A.12.

While Indigenous people have higher rates of separations and hospitalisations with a procedure recorded per 1000 of the population than non-Indigenous people, Indigenous people are actually less likely to undergo procedures while in hospital than non-Indigenous people. 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, 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.

Staff

In 2008-09, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.2 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 2010a).

Figure 10.12 **Average FTE staff per 1000 people, public hospitals, 2008-09**[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 2008 (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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; 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 5.0 million acute, subacute and non-acute separations in public hospitals in 2008-09. Of these, acute separations accounted for 95.9 per cent, newborns with some qualified days accounted for 1.2 per cent and rehabilitation care accounted for 1.6 per cent (table 10A.16). Palliative care, non-acute care and other care made up the remainder. Public psychiatric hospitals accounted for around 0.2 per cent of total separations in public hospitals in 2008-09. Of the total number of separations in public (non-psychiatric) hospitals, 50.4 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 2008-09. These 10 AR-DRGs accounted for 17.5 per cent of all overnight acute separations.

Table 10.3 Ten AR-DRGs (version 5.2) with the most overnight acute separations, public hospitals, 2008-09[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	4.8	4.6	4.4	3.3	3.9	5.0	3.6	4.4
Chest Pain	2.2	2.0	2.7	1.7	2.5	1.7	1.4	1.8	2.2
Caesarean Delivery W/O Catastrophic or Severe CC	1.8	1.9	2.2	1.9	1.6	1.8	1.8	1.6	1.9
Oesophagitis, Gastroent & Misc Digestive Systm Disorders Age>9 W/	2.0	1.7	1.9	1.8	2.0	1.7	1.5	1.2	1.9
Cellulitis (Age >59 W/O Catastrophic or Severe CC) or Age <60	1.4	1.3	1.9	1.9	1.3	1.2	1.3	4.6	1.6
Antenatal and Other Obstetric Admission	1.3	1.1	1.6	1.6	1.1	1.4	1.5	2.6	1.4
Abdominal Pain or Mesenteric Adenitis W/O CC	1.1	1.2	1.0	1.1	1.0	1.0	0.8	0.7	1.1
Vaginal Delivery Single Uncomplicated W/O Other Condition	1.1	0.6	1.6	1.0	0.8	1.1	1.1	1.4	1.1
Respiratory Infections/Inflammations W/O CC	1.1	0.9	1.1	1.1	0.9	1.1	0.9	1.7	1.0
Chronic Obstructive Airways Disease W/O Catastrophic or Severe CC	1.1	0.8	1.1	1.0	1.1	1.4	0.7	1.3	1.0
Total overnight separations accounted for by top 10 AR-DRGs (%)	**17.6**	**16.2**	**19.7**	**17.5**	**15.6**	**16.3**	**16.1**	**20.6**	**17.5**
Total overnight acute separations ('000)[c]	**806**	**558**	**419**	**214**	**198**	**43**	**36**	**35**	**2 309**

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 (17.8 per cent of all patient days recorded) in 2008-09. Schizophrenic disorders associated with mental health legal status accounted for the largest number of patient days, followed Tracheostomy or Ventilation greater than 95 hours (table 10.4 and table 10A.18).

Table 10.4 Ten AR-DRGs (version 5.2) with the most patient days, public hospitals, 2008-09[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient days for AR-DRGs as a proportion of patient days (%)									
Schizophrenia Disorders W Mental Health Legal Status	3.0	3.2	4.2	3.6	3.1	2.1	2.5	2.5	3.3
Tracheostomy or Ventilation >95 hours	2.3	2.5	2.4	2.0	2.6	2.7	2.0	2.0	2.4
Vaginal Delivery W/O Catastrophic or Severe CC	2.2	2.4	2.3	2.4	1.7	1.8	2.5	2.2	2.2
Major Affective Disorders Age <70 W/O Catastrophic or Severe CC	2.0	1.9	1.9	2.6	2.6	2.1	2.9	1.0	2.1
Schizophrenia Disorders W/O Mental Health Legal Status	2.1	1.6	1.0	1.7	1.5	4.0	1.1	0.5	1.7
Caesarean Delivery W/O Catastrophic or Severe CC	1.4	1.5	1.6	1.5	1.3	1.2	1.4	1.5	1.4
Chronic Obstructive Airways Disease W Catastrophic or Severe CC	1.3	1.3	1.4	0.8	1.4	1.0	0.7	1.3	1.3
Cellulitis (Age >59 W/O Catastrophic or Severe CC) or Age <60	1.1	1.1	1.4	1.6	1.1	0.9	1.1	3.1	1.2
Dementia and Other Chronic Disturbances of Cerebral Function	1.0	1.2	0.7	1.0	1.4	3.6	0.4	0.6	1.1
Respiratory Infections/Inflammations W Catastrophic CC	1.1	1.4	0.8	0.7	1.1	0.8	0.8	1.1	1.1
Ten AR-DRGs with the most patient days (%)	**17.6**	**18.1**	**17.8**	**17.9**	**17.8**	**20.2**	**15.4**	**15.9**	**17.8**
Total patient days ('000)[c]	**4 468**	**2 920**	**2 045**	**1 111**	**1 068**	**264**	**176**	**193**	**12 246**

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 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 49.2 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2008-09 (table 10.5). In addition, public hospitals also delivered 340 889 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 2008-09, accident and emergency services comprised 14.6 per cent of all individual occasions of service to non-admitted patients. 'Other medical, surgical and obstetric services' (24.2 per cent), 'pathology services' (17.6 per cent) and 'pharmacy' (10.2 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, 2008-09**[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	10.9	20.3	14.2	17.3	25.2	13.9	16.9	27.8	14.6
Pathology	14.6	9.5	35.7	10.3	..	23.4	6.1	21.1	17.6
Radiology and organ imaging	4.1	8.3	9.1	9.9	10.9	8.4	13.3	14.6	7.0
Pharmacy[c]	16.2	6.1	5.7	4.4	..	11.0	0.2	8.2	10.2
Other medical/surgical/ obstetric	23.7	21.7	23.7	16.7	43.6	34.6	52.1	26.2	24.2
Mental health	3.4	9.0	0.9	1.4	0.9	0.2	0.3	..	3.3
Dental	2.2	3.4	..	0.3	0.4	0.2	..	..	1.6
Allied health	3.4	13.8	5.9	22.3	8.6	8.2	4.4	2.1	7.6
Other non-admitted services									
Community health	7.0	4.5	1.6	11.3	0.3	0.1	2.9	..	5.3
District nursing[d]	6.7	3.0	1.1	3.6	0.3	–	..	..	4.1
Most common types of non-admitted patient care (%)	**92.4**	**99.6**	**97.9**	**97.5**	**90.3**	**99.8**	**96.2**	**100.0**	**95.4**
Total occasions of service for non-admitted patients ('000)	**22 103**	**7 559**	**10 739**	**4 528**	**2 107**	**1 055**	**604**	**465**	**49 161**

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

Source: AIHW (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; 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 2011 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 (NAs) to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NHA covers the area of health, and health indicators in the NIRA establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the NAs.

Box 10.2 **Objectives for public hospitals**

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

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

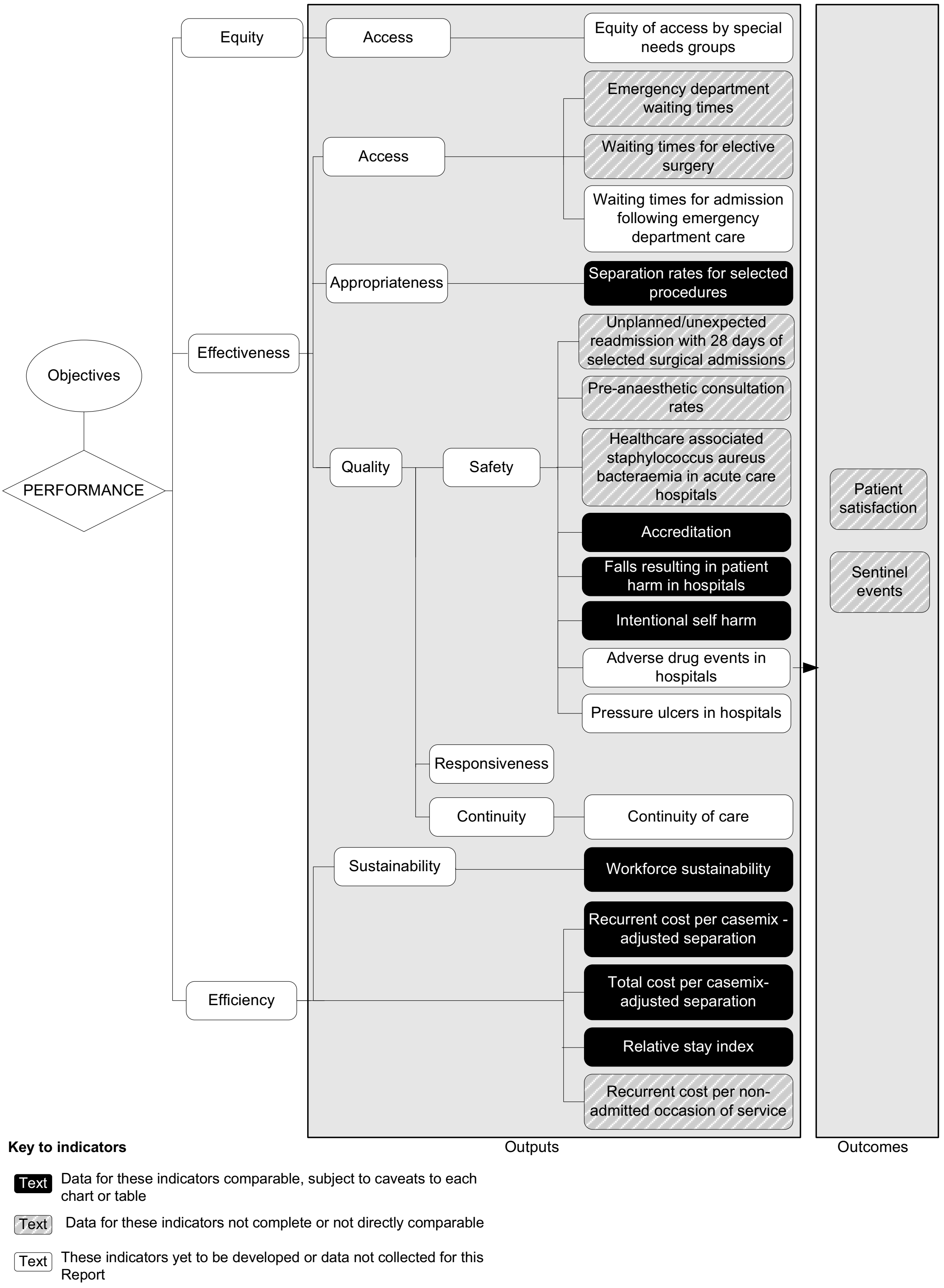
The framework has been revised to either add or replace some indicators:

- unplanned/unexpected readmissions within 28 days of selected surgical admissions has replaced the unplanned readmission rates indicator
- healthcare associated *Staphylococcus aureus* bacteraemia in acute care hospitals has replaced the surgical site infection rates indicator
- falls resulting in patient harm in hospitals and intentional self harm in hospitals have been added

- waiting times for admission following emergency department care, adverse drug events in hospitals, and pressure ulcers in hospitals have been added but data are not included in this Report
- the ‘Patient satisfaction’ indicator now includes responsiveness information previously reported on under the indicator ‘Patient satisfaction surveys’, which has been removed from the 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 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 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 by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services throughout Australia and New Zealand.

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

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

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

(Continued next page)

Box 10.4 **(Continued)**

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.

Data quality information for this indicator is under development.

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 2008-09, 100 per cent of patients in triage category 1 were seen within the clinically appropriate timeframe, and 77 per cent of patients in triage category 2 were seen within the clinically appropriate timeframe. For all triage categories combined, 70 per cent of patients were seen within triage category timeframes (table 10.6).

Emergency department waiting times are reported for peer group A and B hospitals in the attachment for 2008-09 (table 10A 21). Waiting times are also reported by Indigenous status and remoteness for peer group A and B hospitals for 2008-09. Nationally, there was little difference between Indigenous and non-Indigenous people in the percentages of patients treated within national benchmarks across the triage categories, although there were variations across states and territories for some triage categories (table 10A.22). At the national level, there was variation in waiting times across triage categories by remoteness, although there was less variation for the most serious category of resuscitation (table 10A.23).

Table 10.6 Emergency department patients seen within triage category timeframes, public hospitals, 2008-09 (per cent)[a]

Triage category	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1 — Resuscitation[b]	100	100	99	99	100	99	100	100	100
2 — Emergency	80	82	72	69	75	76	85	62	77
3 — Urgent	68	74	59	53	59	54	53	48	64
4 — Semi-urgent	73	68	65	62	62	61	53	49	67
5 — Non-urgent	90	86	88	89	83	87	78	89	88
Total	**75**	**73**	**66**	**62**	**64**	**62**	**60**	**54**	**70**
Data coverage[c]	83	88	72	72	67	89	100	100	80

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

Source: AIHW (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.20.

Waiting times for admission following emergency department care

‘Waiting times for admission following emergency department care’ is an indicator of governments’ objective to provide accessible services (box 10.5).

Box 10.5 Waiting times for admission following emergency department care

Waiting times for admission following emergency department is currently expected to measure the percentage of patients who present to a public hospital emergency department and are admitted to the same hospital, whose time in the emergency department is less than 8 hours.

Waiting times for admission following emergency department care has been identified as a key area for development in future Reports. This indicator is being developed as part of the NHA reporting process.

Waiting times for elective surgery

‘Waiting times for elective surgery’ is an indicator of governments’ objective to provide accessible services (box 10.6).

Box 10.6 **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.

Data quality information for this indicator is under development.

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 2008-09, 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 2010a). In 2008-09, 14.0 per cent of patients who were removed from waiting lists were removed for reasons other than elective admission (AIHW 2010a).

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 2008-09, 90 per cent of patients were admitted within 220 days and 50 per cent were admitted within 34 days (table 10.7). The proportion of patients who waited more than a year was 2.9 per cent. Nationally, waiting times at the 50th percentile increased by six days between 2004-05 and 2008-09, from 29 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.24).

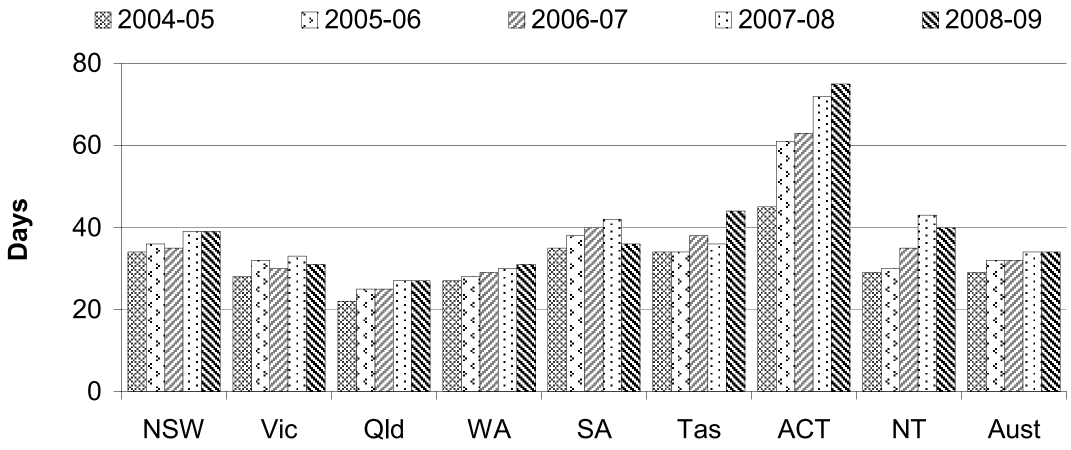
Table 10.7 **Elective surgery waiting times, public hospitals, 2008-09**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of days waited at:										
50th percentile	no.	39	31	27	31	36	44	75	40	34
90th percentile	no.	283	194	133	174	207	448	378	256	220
Proportion who waited more than 365 days	%	2.5	2.9	1.8	2.0	2.7	13.1	10.6	5.6	2.9
Estimated coverage of elective surgery separations[a]	%	100.0	78.0	98.0	85.0	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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.24.

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 41, 50, 55, 71 and 84; table 10A.24.

Attachment 10A includes data on ‘elective surgery waiting times’ by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times by Indigenous status and by remoteness for 2008-09 (tables 10A.24–10A.28). Nationally, Indigenous people had longer waiting times for elective surgery than non-Indigenous people at the 50^{th} and 90^{th} percentiles for many of the procedures reported (table 10A.26). Those living in very remote areas also had longer waiting times than those in major cities at the 50^{th} and 90^{th} percentiles at the national level (table 10A.27).

‘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 2008-09 are shown in table 10.8. The states and territories with lower proportions of patients in category 1 tended to have smaller proportions of patients in this category who were ‘not seen on time’. NSW, Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had low proportions of patients in category 1 who had extended waits (tables 10.8, 10A.29, 10A.31 and 10A.41).

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

Under the National Health and Hospitals Network — National Partnership Agreement on Improving Public Hospital Services, a review will be conducted of the elective surgery categories, focusing on safety issues and practical impediments to achieving the targets that have been set under this agreement from 2014 onwards. The review will be auspiced by Health Ministers and involve senior clinical input.

Table 10.8 **Classification of elective surgery patients, by clinical urgency category, 2008-09 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Patients on waiting lists								
Category 1	3.4	3.3	8.6	8.5	5.1	7.5	2.3	12.6
Category 2	17.7	47.3	46.1	35.5	23.3	54.5	54.0	47.2
Category 3	78.9	49.4	45.3	56.0	71.6	38.0	43.7	40.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Patients admitted from waiting lists								
Category 1	28.3	27.6	39.6	30.6	33.2	36.6	28.3	45.6
Category 2	32.4	46.3	44.0	34.0	31.6	35.9	50.1	36.6
Category 3	39.3	26.1	16.4	35.4	35.1	27.5	21.6	17.8
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.29, 10A.31, 10A.33, 10A.35, 10A.37, 10A.39, 10A.41 and 10A.43. 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 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 28.3 per cent were classified to category 1, of whom 7.2 per cent had an extended wait
- 32.4 per cent were classified to category 2, of whom 14.5 per cent had an extended wait
- 39.3 per cent were classified to category 3, of whom 6.4 per cent had an extended wait.

Overall in NSW, 9.2 per cent of all patients experienced extended waits (table 10.8 and table 10A.29).

Of patients admitted from waiting lists in Victoria in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 27.6 per cent were classified to category 1, of whom zero per cent had an extended wait
- 46.3 per cent were classified to category 2, of whom 27.0 per cent had an extended wait
- 26.1 per cent were classified to category 3, of whom 7.9 per cent had an extended wait.

Overall in Victoria, 14.6 per cent of all patients experienced extended waits (table 10.8 and table 10A.31).

Of patients admitted from waiting lists in Queensland in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 39.6 per cent were classified to category 1, of whom 13.0 per cent had an extended wait
- 44.0 per cent were classified to category 2, of whom 18.4 per cent had an extended wait
- 16.4 per cent were classified to category 3, of whom 8.7 per cent had an extended wait.

Overall in Queensland, 14.7 per cent of all patients experienced extended waits (table 10.8 and table 10A.33).

Of patients admitted from waiting lists in WA in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 30.6 per cent were classified to category 1, of whom 14.1 per cent had an extended wait
- 34.0 per cent were classified to category 2, of whom 24.7 per cent had an extended wait
- 35.4 per cent were classified to category 3, of whom 4.5 per cent had an extended wait.

Overall in WA, 14.3 per cent of all patients experienced extended waits (table 10.8 and table 10A.35).

Of patients admitted from waiting lists in SA in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 33.2 per cent were classified to category 1, of whom 17.4 per cent had an extended wait
- 31.6 per cent were classified to category 2, of whom 15.6 per cent had an extended wait
- 35.1 per cent were classified to category 3, of whom 7.2 per cent had an extended wait.

Overall in SA, 13.2 per cent of all patients experienced extended waits (table 10.8 and table 10A.37).

Of patients admitted from waiting lists in Tasmania in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 36.6 per cent were classified to category 1, of whom 27.1 per cent had an extended wait
- 35.9 per cent were classified to category 2, of whom 48.2 per cent had an extended wait
- 27.5 per cent were classified to category 3, of whom 28.5 per cent had an extended wait.

Overall in Tasmania, 35.1 per cent of all patients experienced extended waits (table 10.8 and table 10A.39).

Of patients admitted from waiting lists in the ACT in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 28.3 per cent were classified to category 1, of whom 5.9 per cent had an extended wait
- 50.1 per cent were classified to category 2, of whom 54.9 per cent had an extended wait
- 21.6 per cent were classified to category 3, of whom 24.8 per cent had an extended wait.

Overall in the ACT, 34.5 per cent of all patients experienced extended waits (table 10.8 and table 10A.41).

Of patients admitted from waiting lists in NT in 2008-09, the percentage of patients classified to each category and the percentage with an extended wait were:

- 45.6 per cent were classified to category 1, of whom 24.3 per cent had an extended wait

- 36.6 per cent were classified to category 2, of whom 41.6 per cent had an extended wait
- 17.8 per cent were classified to category 3, of whom 19.7 per cent had an extended wait.

Overall in the NT, 29.8 per cent of all patients experienced extended waits (table 10.8 and table 10A.43).

All jurisdictions also provided data on urgency category waiting times by clinical specialty (tables 10A.30, 10A.32, 10A.34, 10A.36, 10A.38, 10A.40, 10A.42 and 10A.44).

Effectiveness — appropriateness

Separation rates for selected procedures

'Separation rates for selected procedures' is an indicator of the appropriateness of public hospital services (box 10.7).

Box 10.7 **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.

Data quality information for this indicator is under development.

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 2008-09 were caesarean sections, prostatectomies and hysterectomies (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.45 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, 2008-09**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[d]
Procedure/diagnosis									
Coronary artery bypass	0.58	0.62	0.71	0.35	0.65	0.41	0.67	..	0.59
Coronary angioplasty	1.51	1.62	1.43	1.53	1.48	1.43	2.89	..	1.53
Caesarean section:									
separation rate	8.40	8.40	9.90	9.80	9.20	9.00	8.90	8.70	8.90
separations per 100 in-hospital births[e]	29.80	31.20	33.50	33.70	33.30	29.90	28.70	28.60	31.50
Cholecystectomy	2.12	2.19	2.31	2.03	2.31	1.85	2.32	1.66	2.17
Hip replacement	1.25	1.43	1.20	1.49	1.54	1.48	2.37	0.77	1.35
Hysterectomy[f]	2.25	2.20	2.67	2.39	2.84	2.62	2.85	1.74	2.39
Tonsillectomy	2.16	2.13	2.37	2.68	2.82	1.38	3.20	0.93	2.28
Myringotomy	1.50	1.84	1.74	2.27	3.16	1.16	2.67	1.10	1.83
Knee replacement	1.66	1.37	1.72	1.75	1.85	1.17	2.60	0.91	1.62
Prostatectomy	3.01	3.44	2.71	2.60	2.91	2.38	4.29	1.71	3.00

[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. .. Not applicable.

Source: AIHW (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.45.

Effectiveness — quality

There is no single definition of quality in healthcare, but the Australian Commission on Safety and Quality in Health Care (ACSQHC) has defined quality as 'the extent to which the properties of a service or product produces a desired outcome' (Runciman 2006). No single indicator can measure quality across all providers. An alternative approach is to identify and report on aspects of quality of care. The aspects of quality recognised in the performance indicator framework are safety, responsiveness and continuity. Data are reported against safety but not responsiveness or continuity.

There has been considerable debate and research to develop suitable indicators of the quality of healthcare both in Australia and overseas. All Australian health ministers agreed to the establishment of the Australian Council for Safety and Quality in Health Care in January 2000, with a view to taking a systematic approach to assessing and improving the quality of healthcare. The Australian Council for Safety and Quality in Health Care was replaced in January 2006 by the ACSQHC. A key objective of the ACSQHC is to achieve safe, effective and responsive care for consumers. The ACSQHC has maintained the Council's focus on improving the safety 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.
- Victorian hospitals are required to publish annual quality care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, pressure wound monitoring and prevention, patient satisfaction and consumer participation in health care decision making.
- Queensland Health publishes the Queensland Health Annual report, which includes clinical indicator results for the largest 58 public hospitals spanning the medical, surgical, obstetrics, gynaecology and mental health areas. Queensland Health also publishes the Quarterly public hospitals performance report which amongst other measures includes patient satisfaction results.
- Both the WA and Tasmanian health departments' annual reports include information on 'unplanned re-admission rates' and WA also includes a section on patient satisfaction.

- SA Health publishes an annual report on patient safety which provides a summary of the types of incidents that occurred in public hospitals, actions taken on coronial findings and progress against priority areas in The South Australian Patient Safety Framework and Strategy 2007-2011.
- ACT Health publishes quarterly reports that include data on unplanned readmissions, unplanned returns to operating theatre and hospital acquired infection rates.

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).

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

‘Unplanned/unexpected readmissions within 28 days of selected surgical admissions’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.8). This indicator has been included in the report for the first time this year and replaces the previously reported ‘unplanned readmission rates indicator’.

Box 10.8 **Unplanned/unexpected readmissions within 28 days of selected surgical admissions**

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

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

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

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

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. The unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event. This does not include all possible unplanned/unexpected readmissions, so the indicator is likely to be an under-estimate.

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.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Unplanned/unexpected readmissions within 28 days of selected surgical admissions in public hospitals in 2008-09 are reported in table 10.10. Unplanned/unexpected readmissions are reported by Indigenous status and remoteness in table 10A.47. The measure reported for this indicator is significantly different from that reported previously in this Report. Both the method of calculating the indicator and the data source have changed. The new measure uses the same specifications and data as the corresponding NHA measure. The quality of this measure is improved from that included in previous reports and data are not comparable with previous reports.

Table 10.10 Unplanned/unexpected readmissions within 28 days of selected surgical admissions in public hospitals, per 1000 separations, 2008-09[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Surgical procedure prior to separation									
Knee replacement	25.0	27.7	42.5	15.9	15.1	np	np	np	27.7
Hip replacement	18.7	21.7	33.5	14.2	16.8	21.3	np	np	21.8
Tonsillectomy and Adenoidectomy	24.1	29.7	29.8	30.2	40.4	50.1	np	np	29.5
Hysterectomy	34.9	36.7	36.9	32.1	38.1	44.9	np	np	36.9
Prostatectomy	39.1	25.7	43.6	33.8	33.4	23.8	np	np	33.8
Cataract surgery	3.6	4.7	4.1	3.2	5.6	np	np	28.9	4.5
Appendicectomy	28.0	20.6	25.5	28.0	37.2	36.8	28.1	29.5	26.4

[a] Total rates for Australia do not include WA. **np** Not published.

Source: AIHW (unpublished) Admitted Patient Care National Minimum Data Set; table 10A.46.

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 10.9).

Box 10.9 **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.

Data quality information for this indicator is under development.

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 10.10).

Box 10.10 **Reporting of ACHS clinical indicators**

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

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

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

Shrunken rates are used rather than actual rates because actual rates of zero per cent and 100 per cent 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).

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 10.11.

Box 10.11 **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.

(Continued next page)

Box 10.11 **(Continued)**

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

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

stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 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 2008 (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.49.

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.48.

Safety — healthcare associated Staphylococcus aureus bacteraemia in acute care hospitals

'Healthcare associated *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) in acute care hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.12). This indicator replaces the 'Surgical site infection rates' indicator reported previously.

Box 10.12 **Healthcare associated *Staphylococcus aureus* bacteraemia in acute care hospitals**

‘Healthcare associated SAB in acute care hospitals’ is the number of SAB patient episodes associated with acute care public hospitals divided by the number of patient days for public acute care hospitals reporting for the SAB indicator expressed as a rate per 10 000 patient days.

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

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

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- an invasive instrumentation or incision related to the SAB was performed within 48 hours
- SAB is associated with neutropenia (<1x109/L) contributed to by cytotoxic therapy.

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

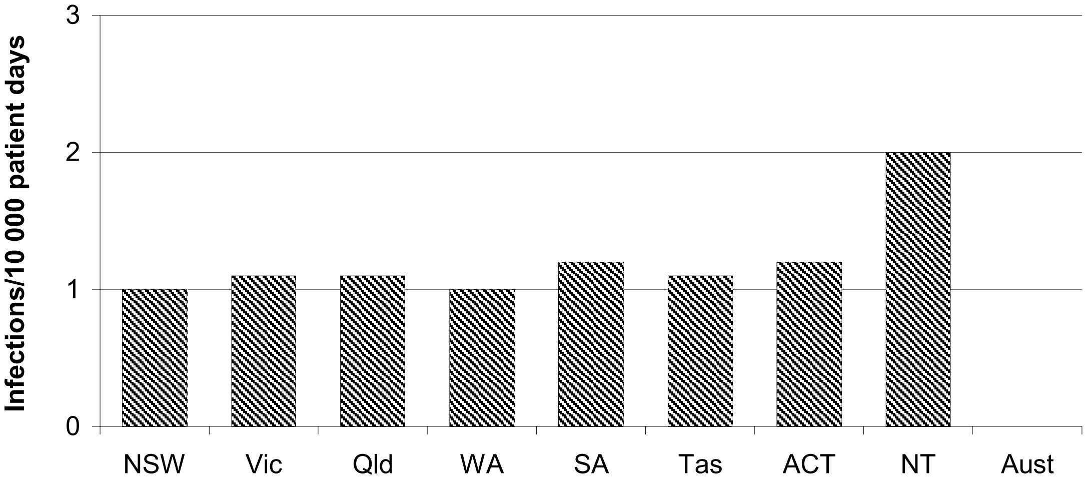
Healthcare associated SAB episodes can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures. Low ‘Healthcare associated SAB in acute care hospitals’ rates are consistent with the quality standards required in the public hospital sector.

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

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Healthcare associated SAB in acute care hospitals per 10 000 patient days is reported in figure 10.15.

Figure 10.15 **Healthcare associated SAB in public acute care hospitals, 2009-10**[a, b, c]



[a] Comprises both Methicillin resistant *Staphylococcus aureus* and Methicillin sensitive staphylococcus aureus. [b] The calculation of an Australian total is not appropriate as NSW data are not comparable with other jurisdictions. [c] The SAB patient episodes were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). No denominator is available to describe the total admitted and non-admitted patient activity of public hospitals. However, the number of patient days for admitted patient activity is used as the denominator to take into account the large differences between the sizes of the public hospital sectors among the jurisdictions. The comparability of the SAB rates among jurisdictions and over time is limited because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity. The amount of hospital activity that patient days reflect varies among jurisdictions and over time because of variation in admission practices.

Source: AIHW unpublished; table 10A.50.

Safety — 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 10.16.

Box 10.13 **Accreditation**

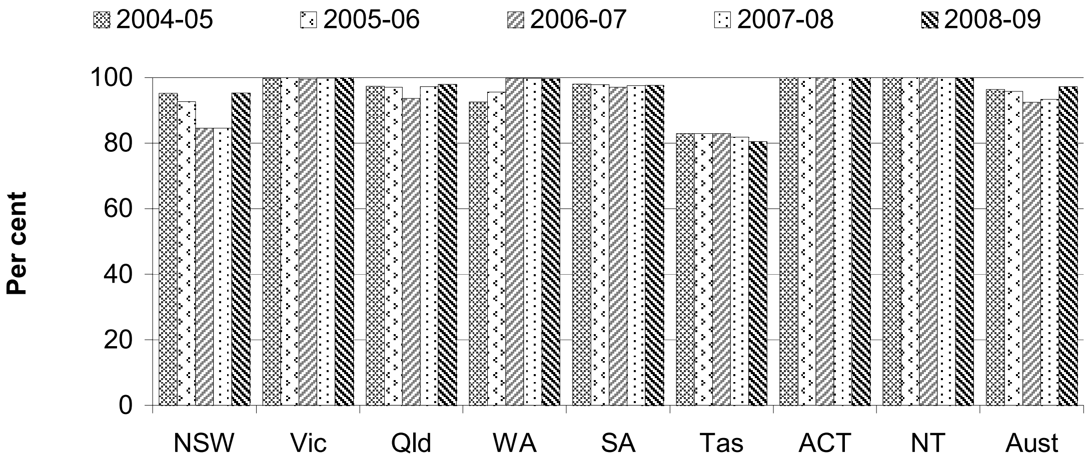
'Accreditation' is defined as the ratio of accredited beds to all beds in public hospitals. The number of beds indicates the level of hospital capacity or activity. 'Accreditation' signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry 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.

Data quality information for this indicator is under development.

Figure 10.16 **Proportion of accredited beds, public hospitals**[a, b]



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[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 41, 50, 55, 71 and 84; table 10A.51.

Safety — falls resulting in patient harm in hospitals

'Falls resulting in patient harm in hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.14). This indicator has been included for the first time in this Report.

Box 10.14 **Falls resulting in patient harm in hospitals**

Falls occurring in health care settings and resulting in patient harm treated in hospital is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area divided by the total number of hospital separations and is expressed as a rate per 1000 separations.

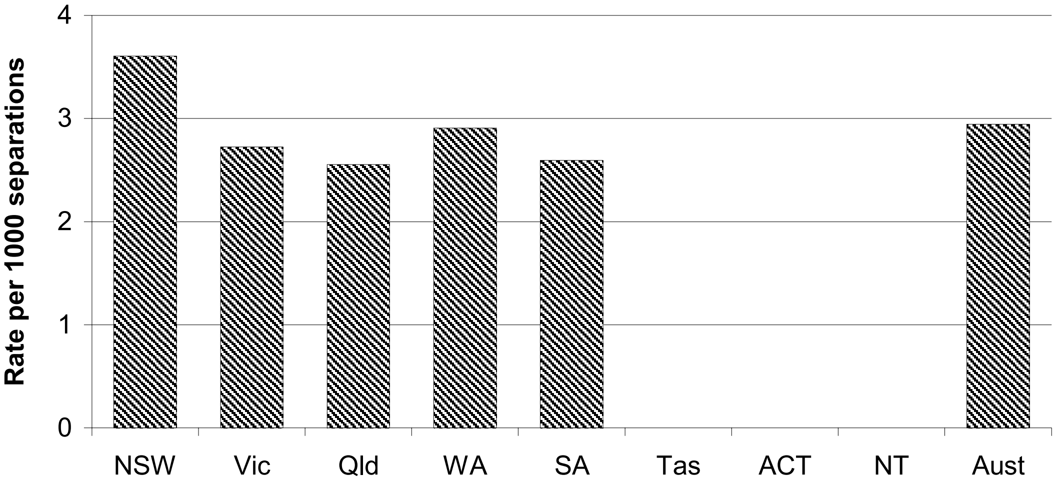
A high number of falls resulting in patient harm in hospitals can indicate hospital system and process deficiencies that compromise the quality and safety of public hospitals. Falls resulting in patient harm in hospitals can result in serious consequences for individual patients and place a significant burden on the health system.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The indicator defines a fall in hospital as a fall for which the place of occurrence is coded as health service area. The health service area as a place of occurrence is broader in scope than hospitals as it includes other health care settings such as day surgery centres or hospices. Data could therefore be an overestimate as they include falls in health care settings other than hospitals. Falls resulting in patient harm in public health care settings varied across states and territories in 2008-09 with a national rate of 2.9 falls per 1000 separations (figure 10.17).

Figure 10.17 **Falls resulting in patient harm in public health care settings, 2008-09**[a, b, c]



[a] Around 25 per cent of the records of separations involving falls did not have a code assigned for the place of occurrence. Consequently, the recorded number of falls occurring in hospitals may be an under-estimate. [b] If there is more than one external cause reported, there is uncertainty about whether the place of occurrence 'health service area' relates to the fall, or to the other external cause. As a consequence, there may be some over-counting in the calculation of the data reported. [c] Data for Tasmania, the ACT and the NT are not published.

Source: AIHW unpublished; table 10A.52.

Safety — intentional self harm in hospitals

'Intentional self harm in hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.15). This indicator has been included for the first time in this Report.

Box 10.15 **Intentional self harm in hospitals**

Intentional self harm in hospitals is defined as the number of hospital separations with an external cause code for intentional self harm and a place of occurrence of health service divided by the total number of hospital separations and is expressed as a rate per 1000 separations.

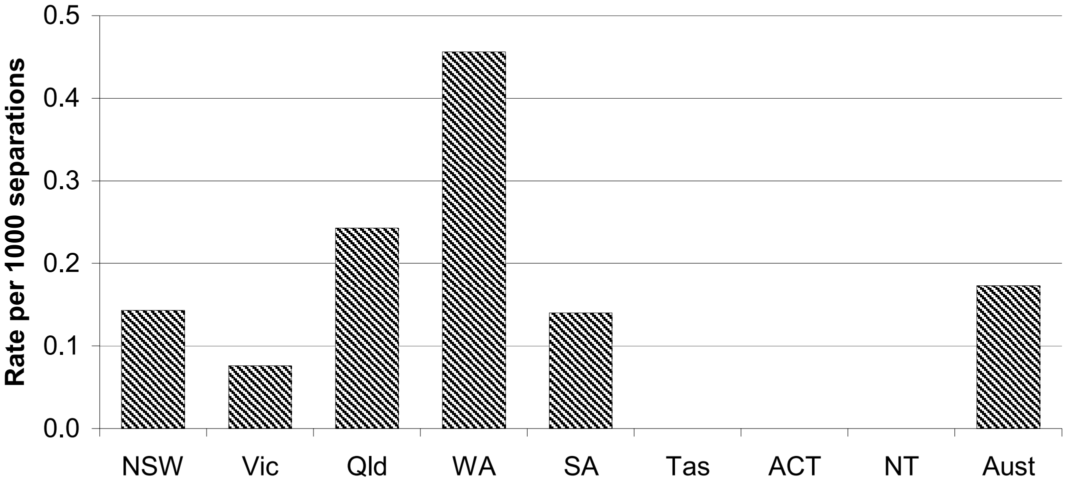
Self harm in hospitals can result in serious consequences for individual patients. A high rate of self harm can indicate hospital system and process deficiencies that compromise the quality and safety of public hospitals.

Data reported for this indicator are complete and directly comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The indicator defines intentional self harm in hospital as being one for which the place of occurrence is coded as health service area. The health service area as a place of occurrence is broader in scope than hospitals as it includes other health care settings such as day surgery centres or hospices. Data could therefore be an overestimate as they include intentional self harm in health care settings other than hospitals. Nationally in 2008-09 occurrences of intentional self harm in public health care settings was around 0.2 per 1000 separations (figure 10.18).

Figure 10.18 **Intentional self harm in public health care settings, 2008-09**[a, b, c, d]



[a] Around 30 per cent of all separations involving intentional self harm did not have a code assigned for the place of occurrence. Consequently, the recorded number of intentional self harm incidents occurring in hospitals may be an under-estimate. [b] If there is more than one external cause reported, there is uncertainty about whether the place of occurrence 'health service area' relates to intentional self harm, or to the other external cause. As a consequence there may be some over-counting in the calculation of the data reported. [c] Separations with a principal diagnosis of an injury or poisoning have been excluded on the assumption that the self-harm occurred prior to admission to hospital. However, it is possible that some of these separations would have involved self-harm that occurred in hospital. [d] Data for Tasmania, the ACT and the NT are not published.

Source: AIHW unpublished; table 10A.53.

Safety — adverse drug events in hospitals

'Adverse drug events in hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.16).

Box 10.16 **Adverse drug events in hospitals**

Adverse drug events in hospitals is currently expected to measure the number of separations with an adverse drug event occurring in hospital divided by total separations from hospital expressed as a rate.

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

Safety — pressure ulcers in hospitals

‘Pressure ulcers in hospitals’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.17).

Box 10.17 **Pressure ulcers in hospitals**

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

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

Responsiveness

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

Continuity — continuity of care

‘Continuity of care’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.18).

Box 10.18 **Continuity of care**

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

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

Sustainability

Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services (box 10.19).

Box 10.19 **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 10.25). 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.

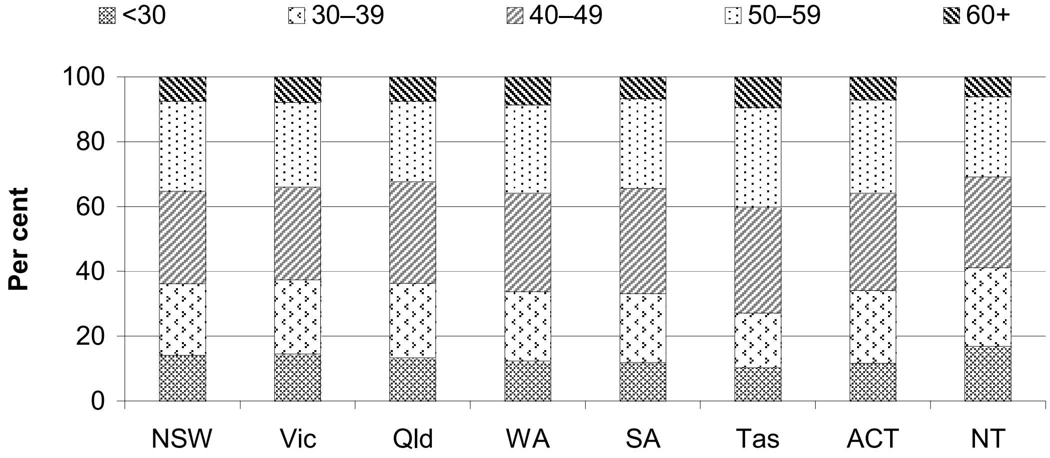
Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Source: National Health Performance Committee (2004).

The age profile of the nursing workforce for 2008 (which includes midwives) for each jurisdiction is shown in figure 10.19. Nursing workforce data by remoteness area for 2008 are shown in figure 10.20.

Figure 10.19 **Nursing workforce, by age group, 2008**[a]



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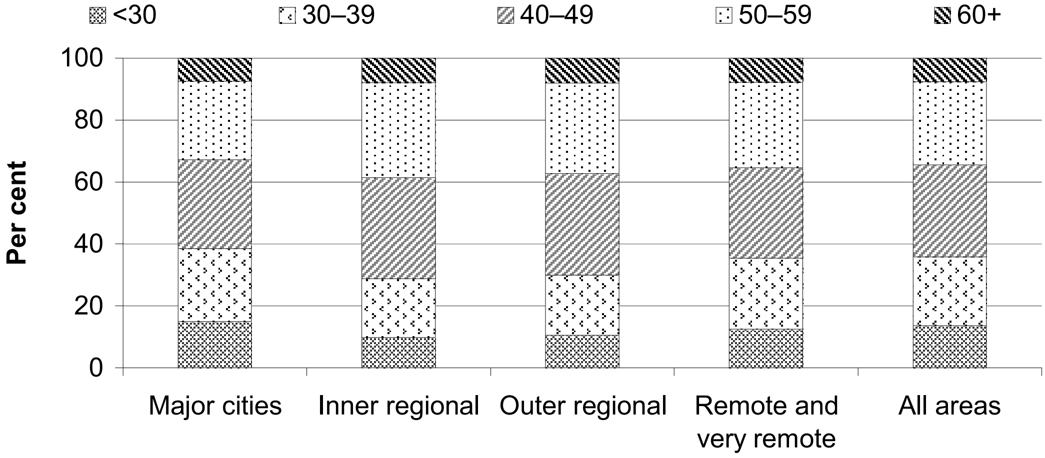
[a] Includes registered and enrolled nurses (including midwives) who are employed in nursing, on extended leave and looking for work in nursing.

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

Figure 10.20 **Nursing workforce, by age group and remoteness area, 2008**[a]



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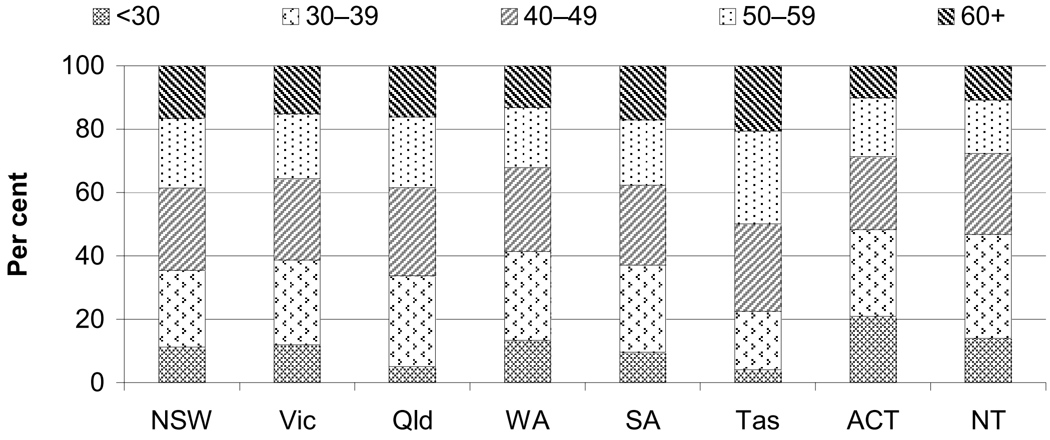
[a] Includes registered and enrolled nurses (including midwives) who are employed in nursing, on extended leave and looking for work in nursing.

Source: AIHW (unpublished) *Nursing and Midwifery Labour Force Survey*; table 10A.54.

The age profile of the medical practitioner workforce in 2008 for each jurisdiction is shown in figure 10.21. Medical practitioner workforce data for 2008 by remoteness area are shown in figure 10.22.

Figure 10.21 Medical practitioner workforce, by age group, 2008[a]



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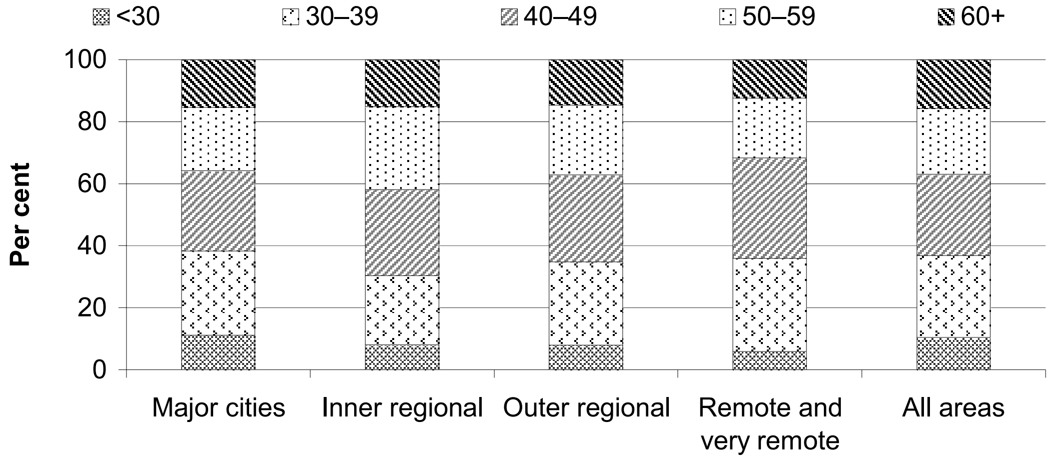
[a] Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.

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

Figure 10.22 Medical practitioner workforce, by age group and remoteness area, 2008[a]



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[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.56.

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 10.20). 'Recurrent cost per casemix-adjusted separation' data are presented in figure 10.23.

Box 10.20 **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 (4.1 per cent of total separations in 2008-09 (table 10A.16)), so the same cost weights for acute care are applied to non-acute separations. The admitted patient cost proportion is an estimate only.

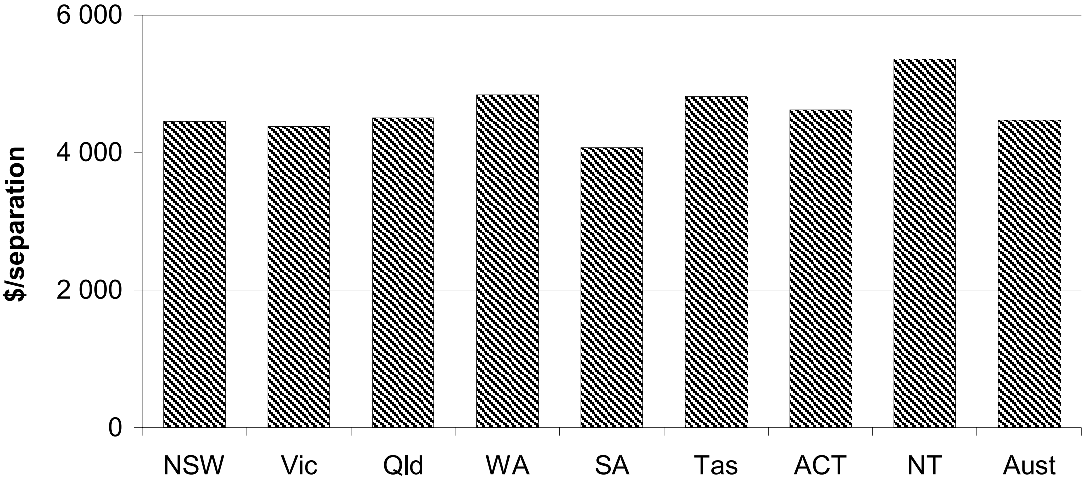
Some jurisdictions have developed experimental cost estimates for non-psychiatric acute patients which are also reported here. Separations for non-acute patients and psychiatric acute care patients are excluded from these estimates because AR-DRG cost weights are a poor predictor of these separations.

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.

Data quality information for this indicator is under development.

Figure 10.23 **Recurrent cost per casemix-adjusted separation, 2008-09**[a, b, c, d, e, f, g]

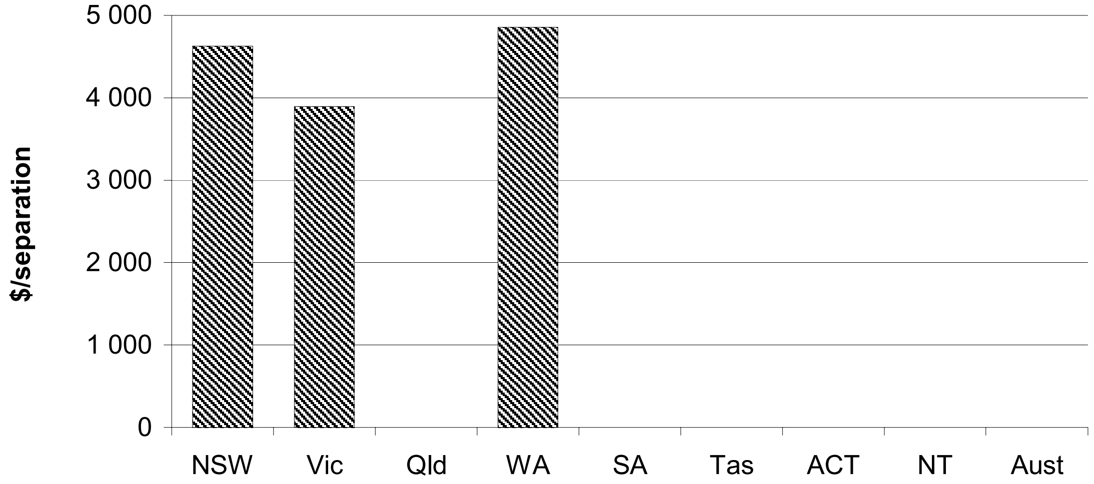


[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Cost Data Collection, based on acute and 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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.58.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.24). (These estimates relate to a subset of the selected public hospitals reported in figure 10.23 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 10.20). The effect of restricting the analysis to acute non-psychiatric admitted patients was to increase the estimated recurrent cost per casemix-adjusted separation for the subset of hospitals by 3.9 per cent for NSW and 0.3 per cent for WA, and to decrease this cost by 11.1 per cent for Victoria (AIHW 2010a).

Figure 10.24 Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2008-09[a, b, c, d]



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

Source: AIHW (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.58.

'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 85 hospitals representing this group had an average of 41 493 separations each at a cost of $4501 (table 10A.59 and table 10.12). Data for each of the hospital peer groups are presented in table 10.12. Detailed data for all peer groups are presented in table 10A.59.

Table 10.12 Recurrent cost per casemix-adjusted separation, by hospital peer group, 2008-09[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Hospital peer group									
Principal referral and Specialist women's and children's	4 465	4 426	4 579	4 852	4 124	4 713	4 624	5 287	4 501
Large	4 283	3 946	3 693	4 248	3 903	np	..	..	4 156
Medium	4 434	4 098	4 003	5 138	3 696	..	..	..	4 315
Small acute	4 991	5 277	4 883	5 784	4 531	4 355	..	5 912	5 162
All hospitals[d]	**4 454**	**4 380**	**4 507**	**4 842**	**4 074**	**4 817**	**4 624**	**5 361**	**4 471**

[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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.59.

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 10.21).

Box 10.21 **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 10.20).

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.

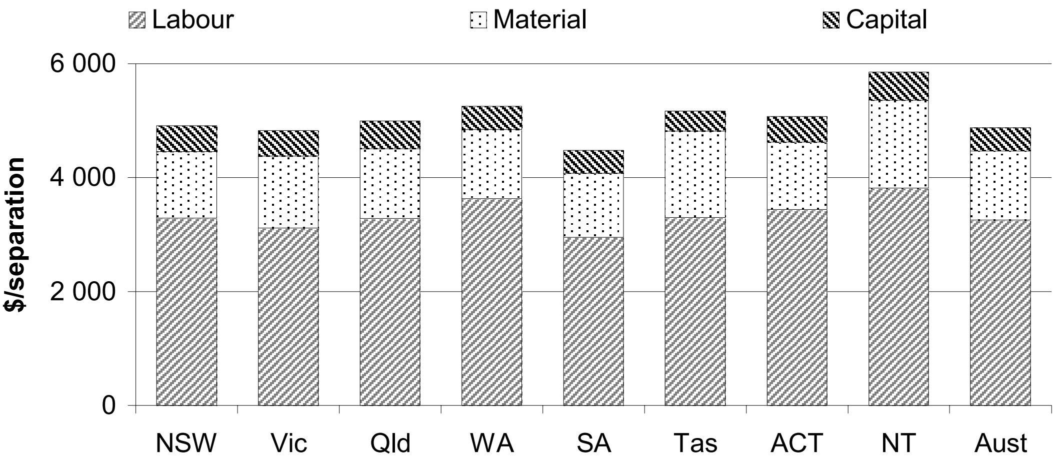
A lower 'total cost per casemix-adjusted separation' can reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as cost is not necessarily related to quality and efficiency.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospital services. Results for this indicator in 2008-09 are reported in figure 10.25. Labour costs accounted for the majority of costs in all jurisdictions.

Figure 10.25 **Total cost per casemix-adjusted separation, public hospitals, 2008-09**[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.58). [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.60). [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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; State and Territory governments (unpublished); tables 10A.58 and 10A.60.

Relative stay index

'Relative stay index' is an indicator of governments' objective to deliver services efficiently (box 10.22).

Box 10.22 **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).

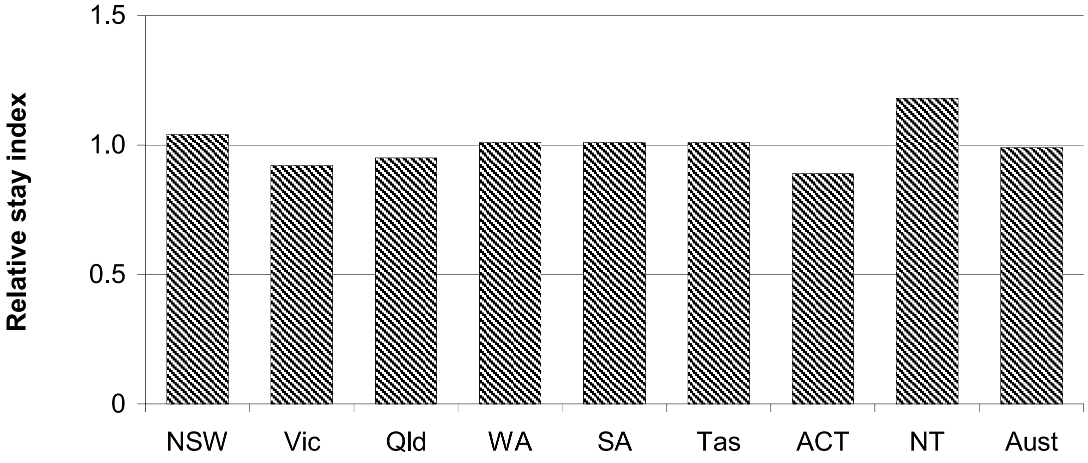
States and territories vary in their thresholds for classifying patients as either same day admitted patients or outpatients. These variations affect the ‘relative stay index’.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Data for this indicator are reported in figure 10.26. The ‘relative stay index’ is reported by patient election status and by medical, surgical and other AR-DRGs in tables 10A.61 and 10A.62 respectively.

Figure 10.26 **Relative stay index, public hospitals, 2008-09**[a, b]



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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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; table 10A.61.

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 10.23).

Box 10.23 **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.

Data quality information for this indicator is under development.

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2008-09 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was $175 for 2.3 million occasions, the outpatient cost per occasion of service was $99 for 16.0 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $107 for 21.2 million occasions (table 10A.63).
- In WA, the emergency department cost per occasion of service was not available. The outpatient cost per occasion of service was $203 for 3.0 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $213 for 3.7 million occasions (table 10A.65).
- In SA, the emergency department cost per occasion of service was $365 for 511 000 occasions, the outpatient cost per occasion of service was $291 for 1.4 million occasions and the overall cost per occasion of service (emergency plus outpatient) was $310 for 1.9 million occasions (table 10A.66).
- In Tasmania, the emergency department cost per occasion of service was $451 for 142 000 occasions. The outpatient cost per occasion of service was $206 for

486 000 occasions. An overall cost per occasion of service was not available (table 10A.67).

- In the ACT, the emergency department cost per occasion of service was $637 for 102 000 occasions, the outpatient cost per occasion of service was $268 for 288 000 occasions and the overall cost per occasion of service (emergency plus outpatient) was $368 for 390 000 occasions (table 10A.68).

Victoria collects data on the basis of cost per non-admitted patient encounter. An encounter includes the clinic visit and all ancillary services provided within a 30 day period either side of the clinic visit. The average cost per encounter was $167 for 1.3 million encounters in 2008-09 (table 10A.64).

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 205 public hospitals for all types of public hospital outpatient clinics (tier 0). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2008-09 was $269 for 11.9 million occasions (table 10A.69). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 10.13). These tier 1 outpatient clinics data were provided by 177 public hospitals. Emergency department data, provided by 159 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 10.14).

Table 10.13 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2008-09[a, b, c, d, e]

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

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

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.71.

Table 10.14 Emergency department average cost per occasion of service, public hospitals, by triage class, 2008-09 (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	1 535	1 545
Admitted triage 2	851	861
Admitted triage 3	702	713
Admitted triage 4	585	589
Admitted triage 5	422	420
Non-admitted triage 1	815	847
Non-admitted triage 2	561	565
Non-admitted triage 3	462	472
Non-admitted triage 4	343	349
Non-admitted triage 5	221	217
Did not wait[g]	41	42
Total	**438**	**451**

[a] Not all hospitals that submit data to the NHCDC submit emergency department data. The emergency department national database contains only acute hospitals with emergency department cost and activity. [b] Based on data from 159 public sector hospitals. [c] Victorian emergency department data are not included. [d] Costing and admission practices vary across jurisdictions and hospitals. [e] Depreciation costs are included. [f] Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. [g] 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.70.

Outcomes

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

Patient satisfaction

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are high quality and responsive to individual patient needs (box 10.24). The 'Patient satisfaction' indicator now includes information previously reported on responsiveness under the output indicator 'Patient satisfaction surveys'.

Box 10.24 **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. 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).

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.

This indicator also provides information on how jurisdictions used patient satisfaction surveys to improve public hospital quality in recent years. If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients' needs. 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.

Data quality information for this indicator is under development.

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 and improvements to services arising from patient satisfaction surveys:

- In NSW, a mailout survey was conducted in each of February 2007, 2008, and 2009 of overnight admitted patients, day only patients, paediatric admitted patients, outpatients, non-admitted emergency patients, community health patients and adult rehabilitation admitted patients in public health services. The 2009 sample size was 216 000 and the response rate was 38.4 per cent. In 2009, 91 per cent of patients rated their care 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. In 2010 the survey was conducted on a monthly basis throughout the year for the admitted patient and emergency department categories, and provided for internet, mail and telephone responses to the survey questionnaire.
  - Service quality is improved by NSW Area Health Services producing an annual action plan in response to the survey and using data to inform Statewide service improvement programs. Key performance indicator results from the survey are included in area health service performance agreements (table 10A.72).
- In Victoria, surveying of adult in-patients in public acute hospitals began in 2000 and in sub-acute hospitals in 2005. Surveys are distributed each month and results are reported to health services on a six monthly basis using the Victorian Patient Satisfaction Monitor. The survey conducted between July and December 2009, using a mailout questionnaire and online surveying, had a sample size of 36 038 and a response rate of 38.7 per cent. The overall care index was 78.4 out of a possible range of 20–100, which is a rating of 'good to very good'. The overall care index is derived from 25 questions across six sub-indices of care. These indices comprise access and admission, general patient information,

treatment information, complaints management, physical environment and discharge and follow-up. The consumer participation indicator score (willingness of staff to listen, opportunity to ask questions and the way staff involved you in decisions about your care) was 79.7.

  - Service quality is improved by Victorian hospitals developing quality improvement strategies targeting the three 'priority to improve' areas from their survey results. These are based on items that most closely relate to overall satisfaction and if addressed are most likely to improve the overall care index score.
  - Each health service is required to report to their community on their overall care index and the consumer participation indicator in their annual quality of care report. In addition, an annual report on the Victorian Patient Satisfaction Monitor is available to the public on the web site www.health.vic.gov.au/patsat (table 10A.73).

- In Queensland, the 'Having a baby in Queensland pilot survey' was conducted in November 2009 by inviting participants to complete a survey booklet, online, or by telephone with trained telephone interviewers. The sample size was 2384 and the response rate was 29 per cent. Respondents were asked about a number of aspects of the quality of their care during pregnancy, labour, birth and postnatal care. Between 83 and 96 per cent of respondents were satisfied with each of these aspects of care.
  - Individual facility survey reports will be provided to district CEOs to assist in the planning and identification of service improvement initiatives. The process to take place will be as follows:
    - 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.74).
- In WA, a computer assisted telephone interview survey was conducted from July 2009 to June 2010 for admitted patients and emergency department patients. The sample size was 6347 admitted patients and 2585 emergency patients, and the response rate was 92 per cent for both admitted and emergency patients. For the 2009-10 Admitted Patient Survey, the overall score of satisfaction was 78.6, an improvement from 77.8 in 2008-09. For emergency patients in 2009-10, the

overall satisfaction score was 77.0, improving from the 2007-08 result of 75.7. Results from 2008-09 cannot be used in comparison with 2009-10 for the emergency patient survey as only tertiary hospital emergency departments were surveyed that year, which is not a comparable group to that surveyed in 2009-10.

  - Service quality is improved in WA by each participating hospital receiving 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.75).

- In SA, a computer assisted telephone interview survey was conducted between August 2008 and November 2008 of adult patients aged over 16 years who received between 1 to 34 nights of care in the SA public hospital system in June (metropolitan hospitals) and between May and July (country hospitals). The sample size was 4785 and the response rate was 73.2 per cent. The overall satisfaction score was 88.0 (scored from 0 to 100, being least to most satisfied).
  - Service quality is improved in SA by identifying sub-groups of patients who are either less or more satisfied with hospital care which in turn highlight gaps in services that affect SA hospital patients and assist hospital administrators to set priorities for allocation of resources (table 10A.76).
- Tasmania is reviewing its approach to conducting consumer satisfaction surveys and therefore has not conducted a Statewide survey for this reporting period. While a Statewide system is under development local surveys are being conducted by individual services, however, data and information from these surveys are not available at time of reporting (table 10A.77).
- In the ACT a number of surveys have been conducted in the past year with the two most recent being between October and December 2009 and between January and June 2010 using mailout questionnaires of consenting patients who are discharged from the hospital during the reporting period. The sample size of the 2009 surveys, for example, in one hospital were 186 patients with a 27 per cent response rate and 298 patients with a 30 per cent response rate. In another hospital the sample size was 644 patients with a response rate ranging between 27 and 57 per cent in five different areas. Sample size and response information from the 2010 survey are not yet available. Patients of the 2009 survey, for

example, in one hospital returned a mean satisfaction score of 4.04 (where 1 = very dissatisfied and 5 = very satisfied) when asked to consider their satisfaction with all aspects of their experience with the health service. Results from the 2010 survey are not yet available.

  - Data from the 2009 survey has been used to identify and make improvements in service provision to consumers and provide an opportunity for quality improvement by benchmarking against similar services in Australia (table 10A.78).

- In the NT, surveys of admitted patients in public acute hospitals and some clinic patients were conducted at various times of the year in 2010 using various methods. Sample sizes and response rates varied. Some results were as follows:
  - 91 per cent were told why they were in hospital
  - 89 per cent said medical explanations were provided when necessary
  - 68 per cent were told about services that were available to them
  - 51 per cent were told about their rights and responsibilities
  - 0.4 per cent were advised of how to complain.
  - Service quality is improved in the NT from survey results. Aboriginal liaison officers now have a private area for patients to be able to meet with them. Additional DVD players have been purchased to play DVDs created to show patients what to expect in hospital and patient care assistants and Aboriginal liaison officers have been trained in their use. Ward pamphlets have been created and there is increased distribution of brochures outlining patient rights and how patients can make complaints (table 10A.79).

Sentinel events

‘Sentinel events’ is an indicator of governments’ objective to deliver public hospital services that are safe and of high quality (box 10.25).

Box 10.25 **Sentinel events**

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

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

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

A 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.

Data quality information for this indicator is under development.

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.

In 2007 the AIHW, in conjunction with the ACSQHC, published a report that included national sentinel event data for 2004-05 (AIHW and ACSQHC 2007). The report notes that reporting practices differ between jurisdictions and as a result the data are not considered comparable across jurisdictions.

Numbers of sentinel events for 2008-09 are reported below. As larger states and territories will tend to have more sentinel events than smaller ones, the numbers of separations and individual occasions of service are also presented below to provide context to the reported sentinel events in terms of numbers of patients treated.

- In NSW there were 6 procedures involving the wrong patient or body part, 2 suicides of patients in inpatient units, 16 cases of retained instruments or other material after surgery requiring re-operation or further surgical procedure, 2 intravascular gas embolisms resulting in death or neurological damage, 1 haemolytic blood transfusion reaction resulting from ABO incompatibility and 1 medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs. Sentinel events in all other categories were reported as zero (table 10A.80). In NSW in 2008-09 there were around 1.5 million separations (table 10A.6) and around 22.1 million individual occasions of service (table 10A.19).
- In Victoria there were 7 suicides of patients in inpatient units, 3 retained instruments or other material after surgery requiring re-operation or further surgical procedure, 1 haemolytic blood transfusion reaction resulting from ABO incompatibility, 1 medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 3 maternal deaths or cases of serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.81). In Victoria in 2008-09 there were around 1.4 million separations (table 10A.6) and around 7.6 million individual occasions of service (table 10A.19).
- In Queensland there were 2 procedures involving the wrong patient or body part, 2 suicides of patients in inpatient units, 1 retained instrument or other material after surgery requiring re-operation or further surgical procedure, 6 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 2 maternal deaths or cases of serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.82). In Queensland in 2008-09 there were around 883 000 separations (table 10A.6) and around 10.7 million individual occasions of service (table 10A.19).
- In WA there were 3 suicides of patients in inpatient units, 3 retained instruments or other material after surgery requiring re-operation or further surgical procedure, 2 haemolytic blood transfusion reactions resulting from ABO

incompatibility, 2 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 1 maternal death or serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.83). In WA in 2008-09 there were around 467 000 separations (table 10A.6) and around 4.5 million individual occasions of service (table 10A.19).

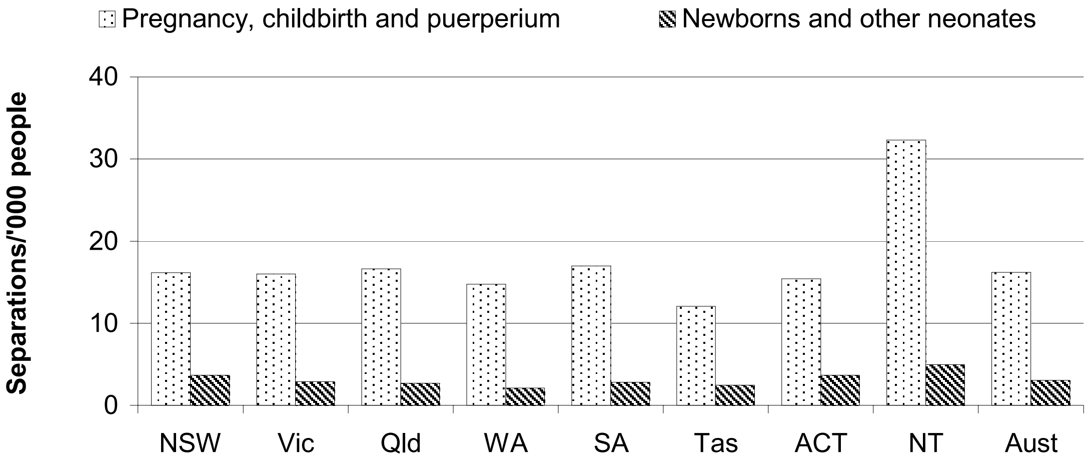
- In SA there were 6 suicides of patients in inpatient units, 7 retained instruments or other material after surgery requiring re-operation or further surgical procedure and 2 maternal deaths or serious morbidity associated with labour or delivery. There were no events reported in the other categories (table 10A.84). In SA in 2008-09 there were around 375 000 separations (table 10A.6) and around 2.1 million individual occasions of service (table 10A.19).
- In Tasmania sentinel events in all categories were reported as zero (table 10A.85). In Tasmania in 2008-09 there were around 95 000 separations (table 10A.6) and around 1.1 million individual occasions of service (table 10A.19).
- In the ACT sentinel events in all categories were reported as zero (table 10A.86). In the ACT in 2008-09 there were around 90 000 separations (table 10A.6) and around 604 000 individual occasions of service (table 10A.19).
- In the NT sentinel events in all categories were reported as zero (table 10A.87). In the NT in 2008-09 there were around 95 000 separations (table 10A.6) and around 465 000 individual occasions of service (table 10A.19).

Data for 2007-08 are reported in tables 10A.80–10A.88. Australian totals are in table 10A.88.

10.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 8.8 per cent of total acute separations in public hospitals (table 10A.90) and around 10.6 per cent of the total cost of all acute separations in public hospitals in 2008-09 (table 10A.89). Figure 10.27 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2008-09.

Figure 10.27 **Separation rates for maternity services, public hospitals, 2008-09**[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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat no. HSE 84; ABS (unpublished), Australian Demographic Statistics, December Quarter 2009, Cat. no. 3101.0; tables AA.2 and 10A.90.

In Australian public hospitals in 2008-09, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (30.0 per cent) (tables 10A.90 and 10A.91). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (4.4 per cent of all separations) (table 10.3) and the third highest cost of all separation categories ($452.8 million) (table 10A.91).

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 2007, 2008 and 2009 (table 10.15).

Table 10.15 **Mean age of mothers at time of giving birth, public hospitals**

	NSW	*Vic*[a]	*Qld*[b]	*WA*	*SA*[c]	*Tas*	*ACT*[d]	*NT*
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	27.0	28.0	24.5
Second birth	30.2	30.0	28.1	28.6	29.5	29.6	30.2	26.4
Third birth	31.5	31.5	29.7	32.0	31.0	31.7	31.9	28.5
All births	29.8	29.6	27.9	28.2	29.1	29.2	29.8	26.8
2009								
First birth	27.9	27.7	25.6	26.2	27.0	na	27.8	24.1
Second birth	30.4	30.0	28.3	28.6	29.6	na	30.2	26.8
Third birth	31.6	31.5	29.9	32.0	31.1	na	31.1	28.6
All births	29.9	29.6	28.0	28.3	29.1	na	29.5	26.9

[a] Data for Victoria for 2009 are preliminary. [b] The 2006 data exclude mothers whose age was 'not stated'. [c] Age is based on exact age (years) to 4 decimal places. [d] ACT 2009 data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. **na** Not available.

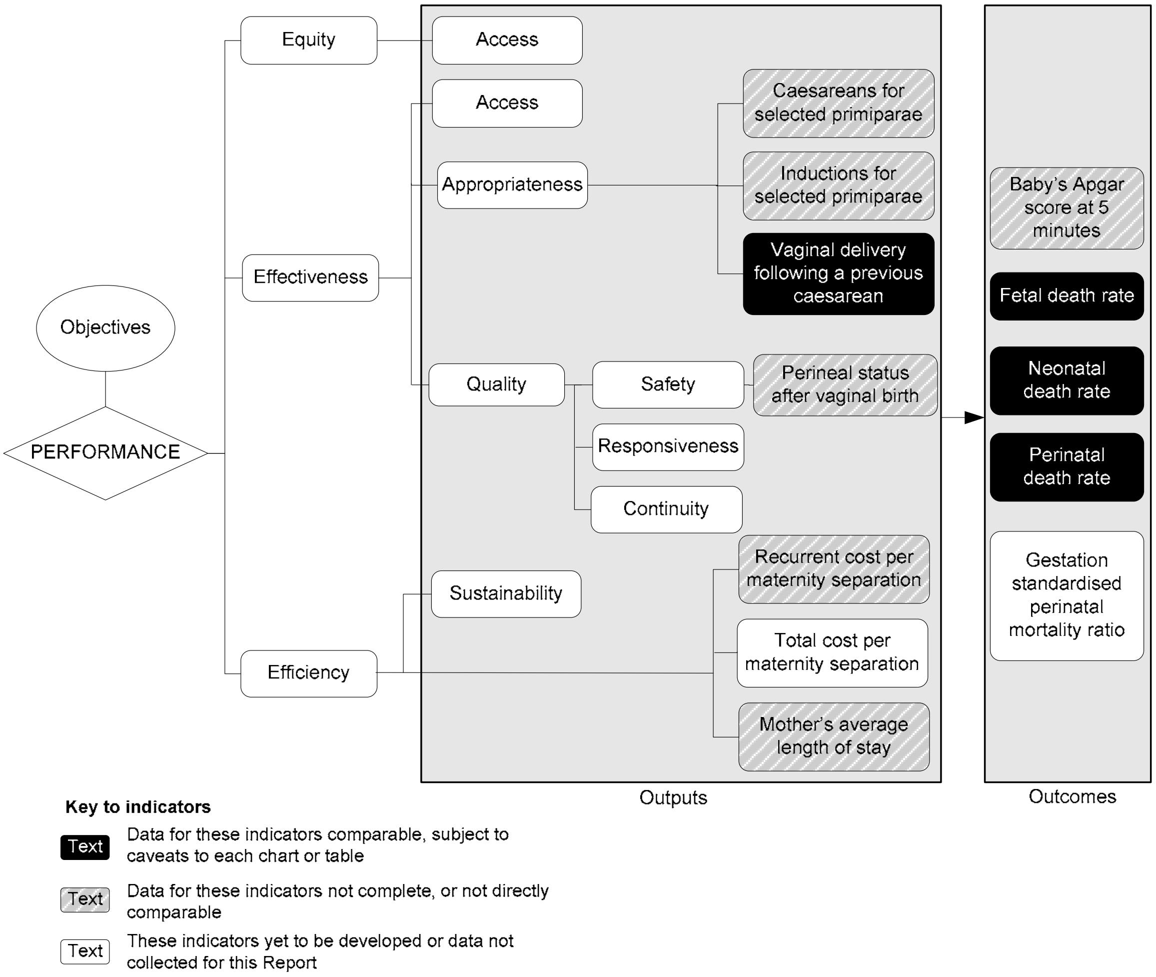
Source: State and Territory governments (unpublished).

10.5 Framework of performance indicators for maternity services

The performance framework for maternity services is outlined in figure 10.28, 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 2011 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 10.28 **Performance indicators for maternity services**



10.6 Key performance indicator results for maternity services

Outputs

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

Equity — access

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

Effectiveness — access

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

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

'Caesareans for selected primiparae' and 'Inductions for selected primiparae' are indicators of the appropriateness of maternity services in public hospitals (box 10.26).

Box 10.26 **Caesareans and inductions for selected primiparae**

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

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

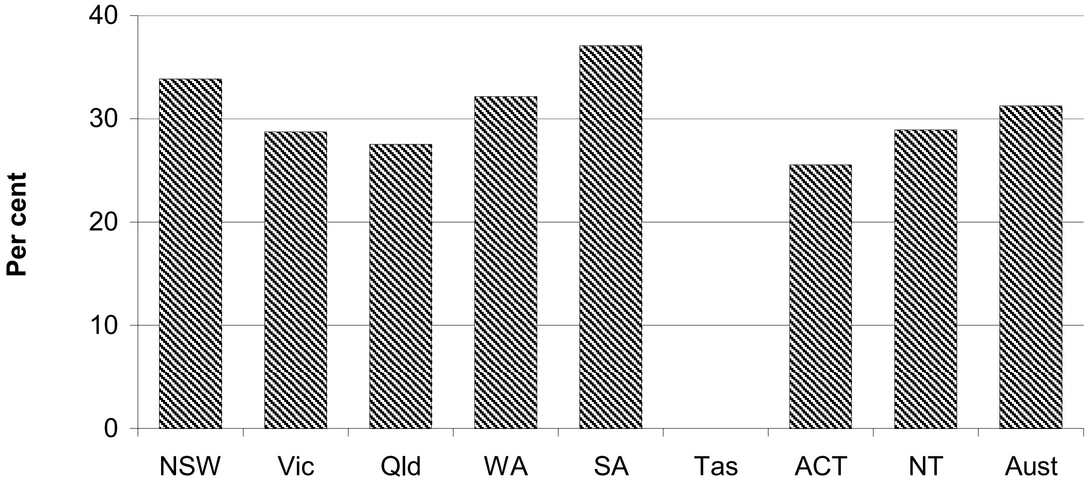
Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is under development.

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

Induction rates for selected primiparae in public hospitals are reported in figure 10.29. Induction rates for private hospitals are shown in table 10A.92 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.93–10A.100.

Figure 10.29 **Inductions for selected primiparae, public hospitals, 2009**[a, b, c, d]

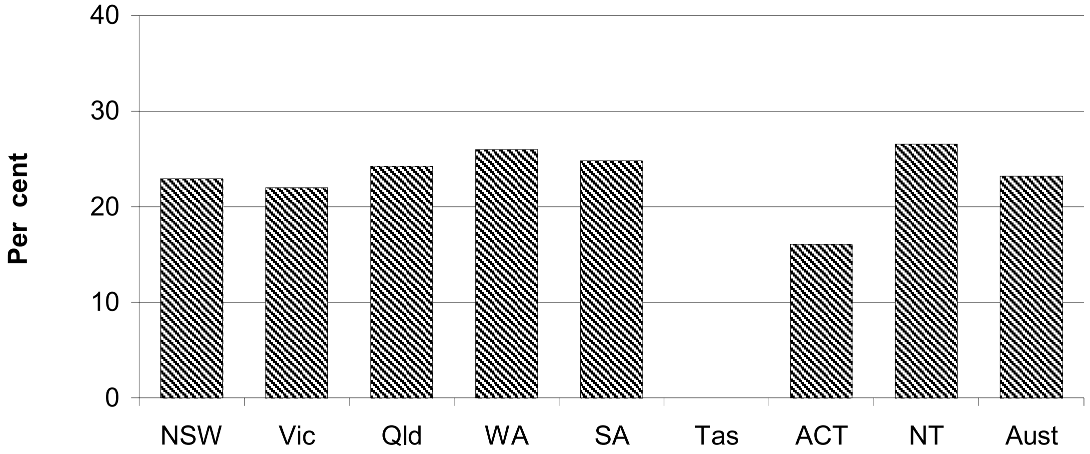


[a] Data for Victoria are preliminary. [b] Data for Tasmania are not available. [c] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. [d] Rate for Australia includes only jurisdictions for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

Source: State and Territory governments (unpublished); table 10A.92.

Caesarean rates for selected primiparae in public hospitals are reported in figure 10.30. Caesarean rates for private hospitals are shown in table 10A.92 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.93–10A.100.

Figure 10.30 **Caesareans for selected primiparae, public hospitals, 2009**[a, b, c, d]



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

Source: State and Territory governments (unpublished); table 10A.92.

Vaginal birth following previous caesarean

'Vaginal birth following a previous caesarean' is an indicator of the appropriateness of maternity services in public hospitals (box 10.27).

Box 10.27 **Vaginal birth following a previous caesarean**

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

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

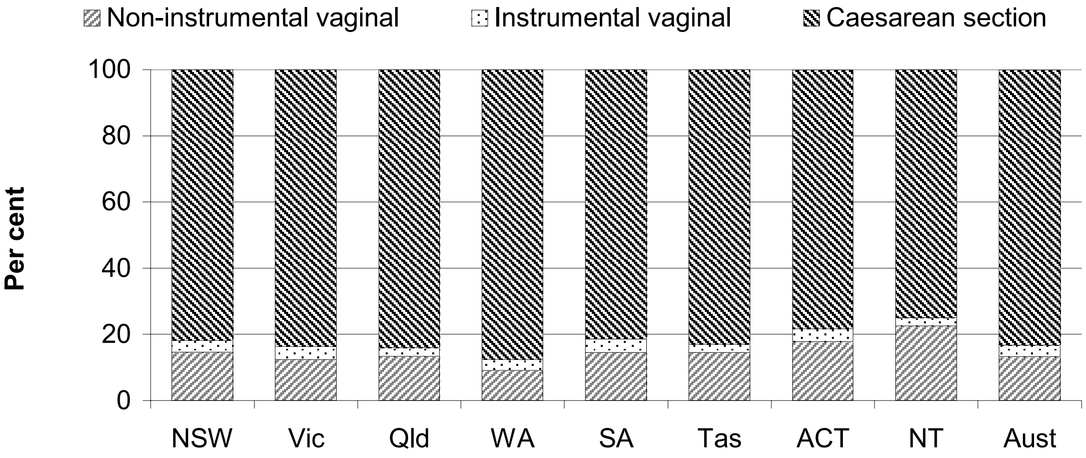
Data reported for this indicator are comparable subject to caveats.

Data quality information for this indicator is under development.

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

The measure reported for this indicator is significantly different from that reported previously in this Report. Both the method of calculating the indicator and the data source have changed. The quality of this measure is greatly improved with full coverage of births according to national definitions. Data are not comparable with previous Reports. Nationally, of women that had a previous caesarean section, 16.7 per cent had either an instrument or non-instrument vaginal delivery as their current method of birth, while 83.2 per cent had another caesarean section (figure 10.31).

Figure 10.31 **Multiparous mothers who have had a previous caesarean section by current method of birth, 2008**[a, b, c, d]



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[a] For multiple births, the method of birth of the first born baby was used. [b] Data present method of birth for multiparous women who have had a previous caesarean, not only women who had a previous caesarean section. [c] For NSW, Victoria, WA and the NT non-instrumental vaginal includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. [d] Instrumental vaginal birth includes forceps and vacuum extraction.

Source: Laws P.J., Li Z., Sullivan E.A., (2010), *Australia's Mothers and Babies 2008*, AIHW Cat. No. PER 50, AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 24), Sydney; table 10A.101.

Effectiveness — quality

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

Safety — perineal status after vaginal birth

‘Perineal status after vaginal birth’ is an indicator of governments’ objective to provide safe and high quality services (box 10.28).

Box 10.28 **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).

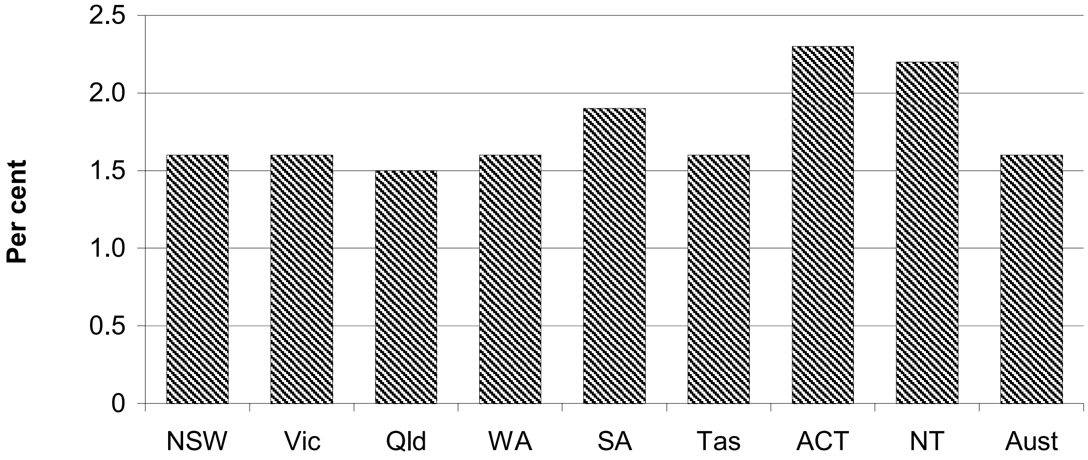
Perineal lacerations caused by childbirth are painful, take time to heal and can result in ongoing discomfort and debilitating conditions such as faecal incontinence. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management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

Data quality information for this indicator is under development.

The proportion of mothers with third or fourth degree lacerations to their perineum following vaginal births is shown in figure 10.32. 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.102.

Figure 10.32 **Perineal status — mothers with third or fourth degree lacerations after vaginal births, 2008**[a, b]



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

Source: Laws P.J., Li Z., Sullivan E.A., (2010), *Australia's Mothers and Babies 2008*, AIHW Cat. No. PER 50, AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 24), Sydney; table 10A.102.

Responsiveness, continuity

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

Efficiency — sustainability

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

Efficiency

Recurrent cost per maternity separation

'Recurrent cost per maternity separation' is an indicator of governments' objective to deliver cost effective services (box 10.29).

Box 10.29 **Recurrent cost per maternity separation**

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

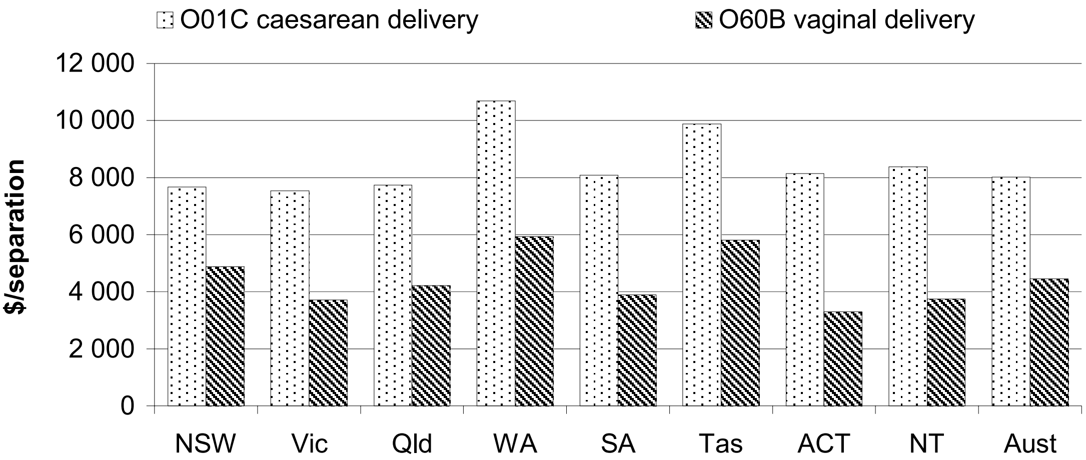
Lower 'recurrent costs per maternity separation' can reflect higher efficiency in providing maternity services to admitted patients. However, this is only likely to be the case where the low cost maternity services are provided at equal or superior effectiveness.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.33). Data for a number of other maternity related AR-DRGs are shown in table 10A.103. 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 10.33 **Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2008-09**[a, b]



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[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 (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.103.

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 10.30).

Box 10.30 **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 10.31).

Box 10.31 **Mother's average length of stay**

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

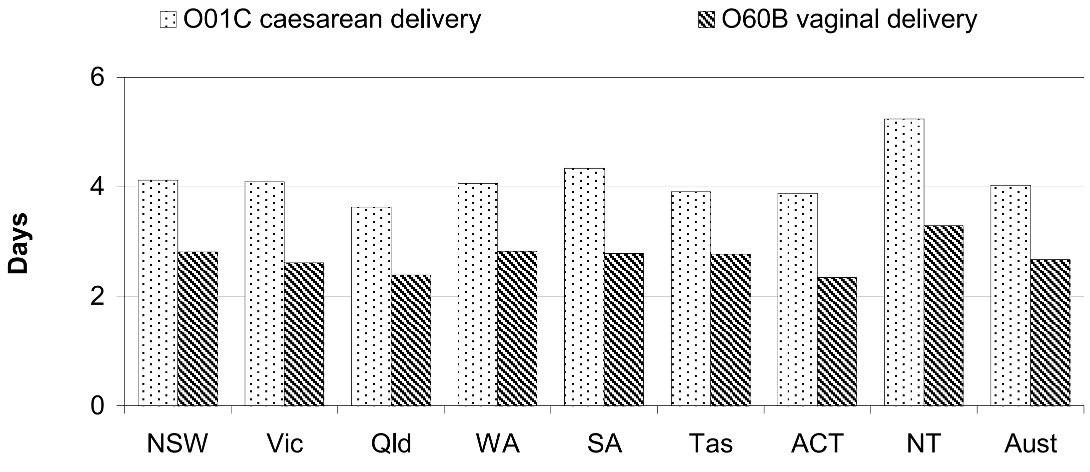
Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care. The indicator is not adjusted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

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data are 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 10.34).

Figure 10.34 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2008-09**[a]



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

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.103.

Outcomes

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

Apgar score

‘Apgar score at five minutes’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.32).

Box 10.32 **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 10.16. The range of Apgar scores for 2005 to 2009 are reported in table 10A.104.

Table 10.16 Live births with an Apgar score of 3 or lower, 5 minutes post-delivery, public hospitals, 2009

Birthweight (grams)	*Unit*	*NSW*	*Vic*[a]	*Qld*	*WA*	*SA*	*Tas*	*ACT*[b]	*NT*
Less than 1500	no.	829	628	530	319	222	na	55	52
Low Apgar	%	19.1	16.5	16.2	9.1	9.5	na	9.1	23.1
1500-1999	no.	933	628	616	321	260	na	57	61
Low Apgar	%	1.2	16.5	0.8	1.9	1.5	na	5.3	1.6
2000-2499	no.	2 847	1 985	1 837	825	669	na	161	204
Low Apgar	%	0.6	0.5	0.8	0.4	0.1	na	1.2	–
2500 and over	no.	67 545	46 453	39 738	16 311	13 345	na	3 261	2 749
Low Apgar	%	0.2	0.2	0.2	0.1	0.1	na	0.2	0.1

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

Source: State and Territory governments (unpublished); table 10A.104.

Fetal death rate

'Fetal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.33).

Box 10.33 **Fetal death rate**

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

'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.

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.

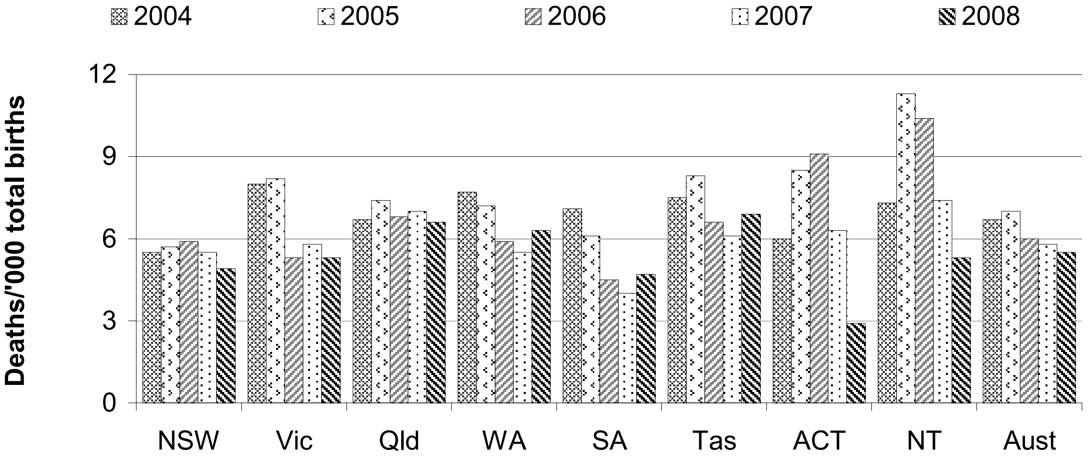
Differences in the 'fetal death rate' between jurisdictions are likely to be due to factors outside the control of maternity services for admitted patients. To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general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

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Fetal death rates are reported in figure 10.35. Nationally, fetal death rates have declined slightly over the period 2004–2008. National time series for fetal death rates for the period 1996 to 2008 are included in table 10A.107. Fetal deaths rates by the Indigenous status of the mother are shown in figure 10.38.

Figure 10.35 **Fetal death rate**[a, b]



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

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

Neonatal death rate

'Neonatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.34).

Box 10.34 **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.

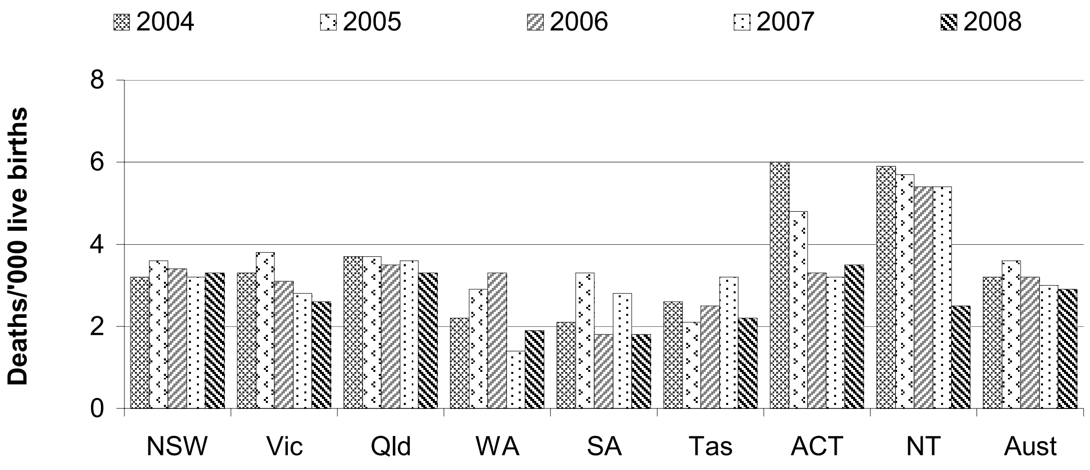
Low 'neonatal death rates' can indicate high quality maternity services. The rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Neonatal death rates are reported in figure 10.36. Nationally, neonatal death rates have declined slightly over the period 2004–2008. National time series for neonatal death rates for the period 1996 to 2008 are included in table 10A.107. Neonatal death rates by the Indigenous status of the mother are shown in figure 10.38.

Figure 10.36 **Neonatal death rate**[a]



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[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.106.

Perinatal death rate

'Perinatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.35).

Box 10.35 **Perinatal death rate**

A perinatal death is a fetal or neonatal death (boxes 10.33 and 10.34).

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.

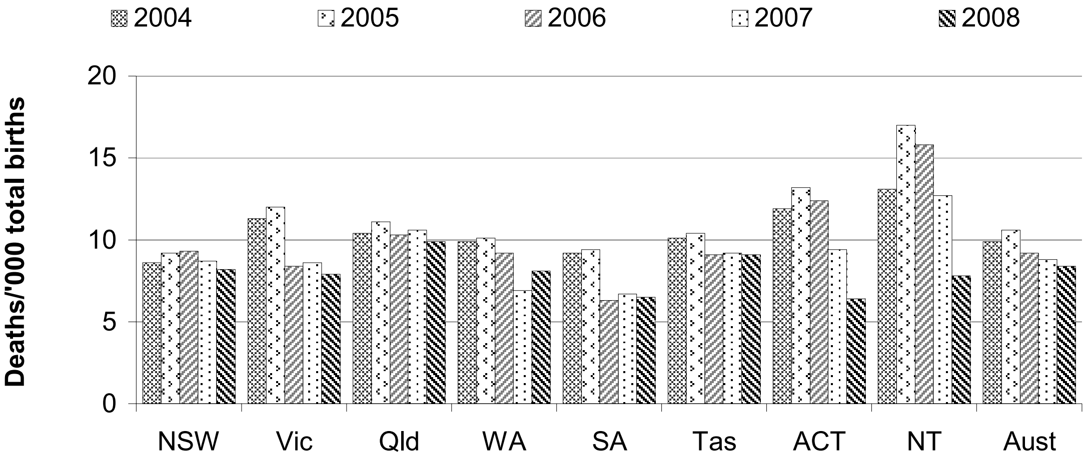
The caveats that apply to fetal and neonatal death rates also apply to perinatal death rates.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Perinatal death rates are shown in figure 10.37. Perinatal death rates by the Indigenous status of the mother are shown in figure 10.38. National time series for perinatal death rates for the period 1996 to 2008 are included in table 10A.107.

Figure 10.37 **Perinatal death rate**[a, b]



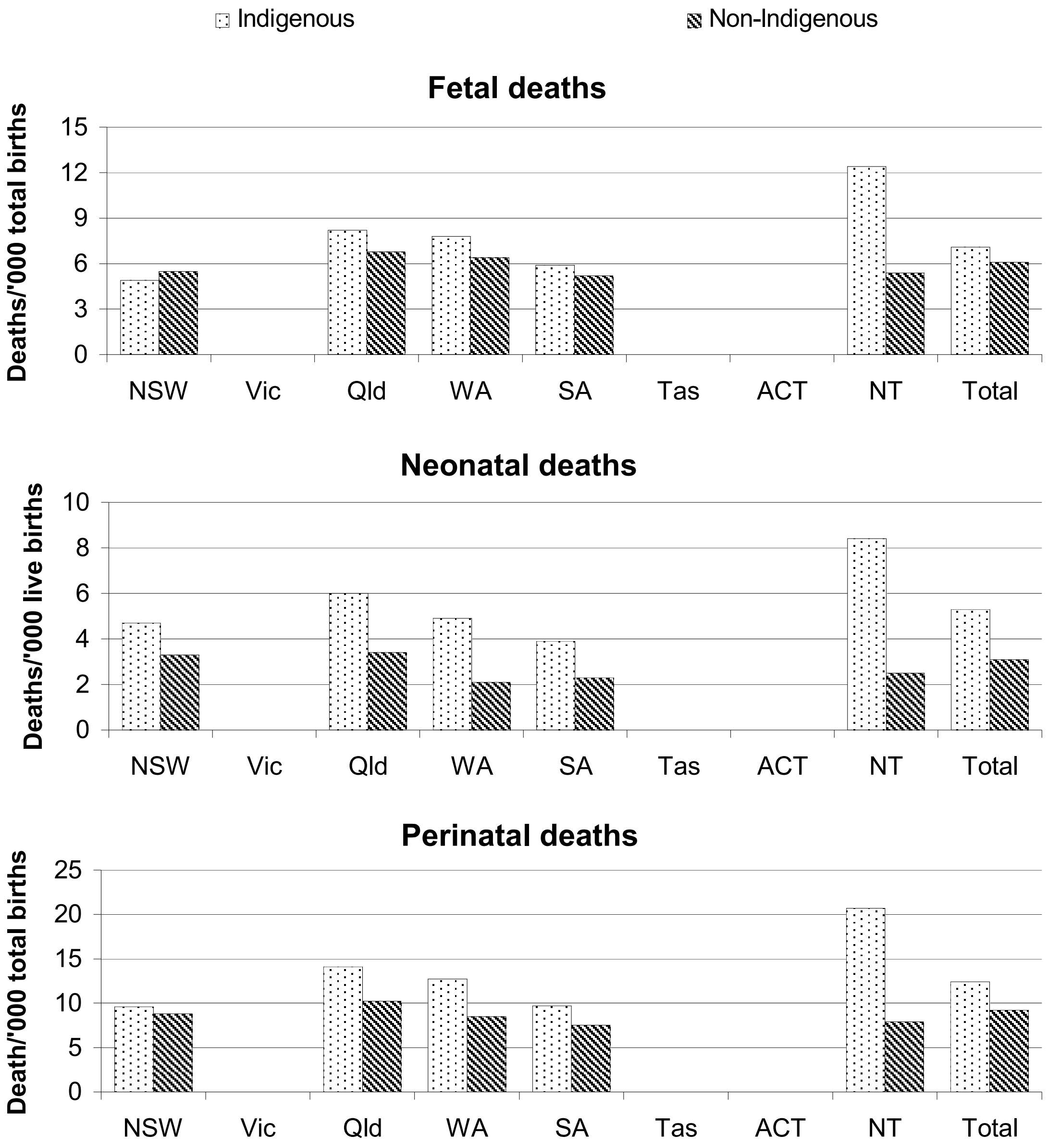
[a] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths. [b] The ACT and Australian total may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to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

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

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 higher than those for non-Indigenous people (figure 10.38).

Figure 10.38 **Fetal, neonatal and perinatal deaths, by Indigenous status of mother 2004–2008[a]**



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[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.109.

Gestation standardised perinatal mortality ratio

The Steering Committee has identified Gestation standardised perinatal mortality ratio as an indicator of the outcomes of maternity services (box 10.36).

Box 10.36 **Gestation standardised perinatal mortality ratio**

This measure of perinatal mortality (box 10.35) 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 2011 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, two aspects of quality — responsiveness and continuity — and the efficiency subdimension of sustainability.
- Improving currently reported indicators for public hospitals and maternity services where data are not complete or not directly comparable. There is scope to improve reporting of the quality and access dimensions of the public hospitals framework, and the output indicators for maternity services.
- Improving the reporting of elective surgery waiting times by urgency category in order to achieve greater comparability across jurisdictions in assessing the extent to which patients are seen within a clinically desirable period and improving timeliness of the data.
- Improving the reporting of quality and safety indicators in both the public hospitals and maternity services frameworks.
- Improving the quality of Indigenous data, particularly completeness and Indigenous identification. Indigenous hospitalisation data for the ACT and Tasmania will be included in future reports. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

Report on Government Services alignment with National Agreement reporting

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the Report on Government Services in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the 'Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

10.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can receive acute, subacute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 is based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment can be radical and is frequently costly.
Community health 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.
Multiparous	A pregnant women who had at least one previous pregnancy resulting in a live birth or stillbirth
Non-acute care	Includes maintenance care and newborn care.
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A ‘third degree’ laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A ‘fourth degree’ laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 2008).
Perineal status	The state of the perineum following a birth.
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).
Subacute care	Interdisciplinary therapeutic clinically-intense and goal-directed care in which the need for care depends primarily on the patient's functional status and quality of life rather than the underlying medical diagnosis or the patient's prospects of recovery from illness. Subacute care includes rehabilitation, palliative care and some mental health care, as well as geriatric evaluation and management and psychogeriatric care. Common to all is the patient no longer meets criteria for classification as 'acute', but still requires therapeutic, clinically-intense and goal-directed care.
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 List of 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 Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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11 Primary and community health

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an '11A' 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 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.

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

- addition of the following indicators and measures to align this Report with *National Healthcare Agreement* (NHA) and *National Indigenous Reform Agreement* (NIRA) indicators
  - an additional equity — access indicator 'developmental health checks'
  - two additional effectiveness — access indicators 'GP waiting times' and 'GP-type visits to emergency departments'
  - measures for the quality — responsiveness indicator 'patient satisfaction'
  - an additional measure for the outcome indicator 'child immunisation coverage', reflecting immunisation coverage for children aged 60–63 months
- data for the effectiveness — access indicator 'bulk billing rates' are reported by age for the first time
- data reported against the effectiveness — appropriateness indicator 'management of upper respiratory tract infections' are improved in terms of specificity and completeness
- inclusion of some 'data quality information' (DQI) documentation.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by governments include general practice, community health services, the PBS and public dental services. The Australian 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.

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 2010a). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, currently $5.40 for concession card holders and $33.30 for general consumers. The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted 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 2010 safety net threshold was $1281.30 for general consumers and $324.00 for concession card holders (DoHA 2010b).

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 Indigenous Primary Health Care Services. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.5 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*. 2010) (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*
Total encounters for which BEACH data were recorded	93 862	100.0	..	..
Encounters with missing data	7 487	..	..	..
Direct encounters	92 352	98.4	98.1	98.7
Medicare paid[f]	89 201	95.0	94.6	95.5
Workers compensation paid	1 843	2.0	1.8	2.1
Other paid (for example, hospital, State)	821	0.9	0.6	1.1
Indirect encounters[g]	1 495	1.6	1.3	1.9

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2009 to March 2010. [b] An 'encounter' is any professional interchange between a patient and a GP (Britt *et al*. 2010). [c] Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. [d] Number of encounters after post stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] 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*. (2010) *General practice activity in Australia 2009-10*, Cat. no. GEP 27; 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 2009-10 was $6.1 billion, or $275 per person (figure 11.32, table 11A.2).

Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas; for example, 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 2006-07.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $7.5 billion, or $339 per person, in 2009-10. Expenditure on the PBS was around $7.0 billion in 2009-10, 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, 2009-10 ($ million)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[b]	508.9	367.3	310.0	166.6	110.7	34.1	32.2	9.0	1 538.8
PBS concessional[c]	1 918.6	1 374.8	1 037.5	444.9	477.5	156.7	54.4	15.9	5 480.1
PBS doctor’s bag	4.6	3.4	3.0	1.0	1.1	0.3	0.2	0.1	13.6
PBS total	2 432.1	1 745.5	1 350.5	612.5	589.2	191.1	86.7	24.9	7 032.5
RPBS total[d]	166.9	98.5	109.5	36.3	36.9	14.1	7.3	0.9	470.4
Total	**2 599.0**	**1 844.0**	**1 460.0**	**648.8**	**626.1**	**205.2**	**94.0**	**25.8**	**7 502.8**
$ per person	361.4	335.5	326.4	285.8	383.2	406.1	264.9	113.2	338.6

[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 2008-09, government expenditure on community and public health was $7.5 billion, of which State, Territory and local governments provided 74.6 per cent, and the Australian Government 25.4 per cent (table 11.3). Australian Government direct outlay expenditure on dental services, predominantly through the DVA and

DoHA, was $481 million in 2008-09. State, Territory and local government expenditure on dental services in 2008-09 was $625 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, 2008-09 ($ 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	1 894	1	1 896	5 584	7 481	341	7 822
Dental services	103	378	426	907	625	1 532	5 183	6 715

[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.

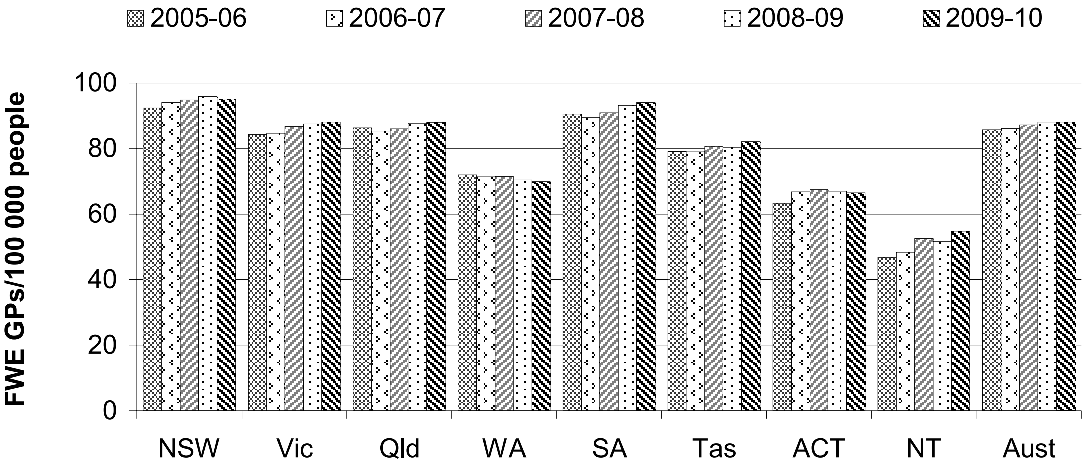
Source: AIHW (2010) *Health Expenditure Australia 2008-09*, Cat. no. HWE 51.

Size and scope

General practice

There were 26 613 vocationally recognised GPs and OMPs billing Medicare in Australia in 2009-10. On a full time workload equivalent (FWE) basis, there were 19 729 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]



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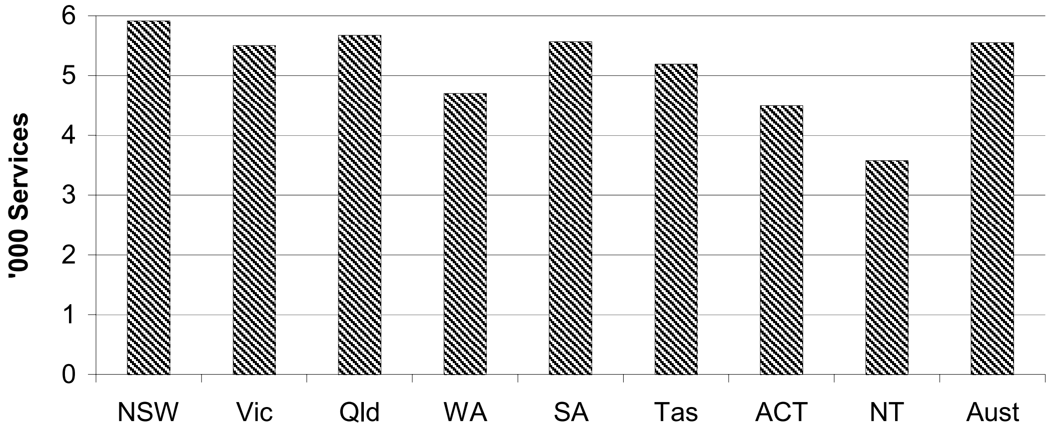
[a] Data include vocationally recognised GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice.

Source: DoHA (unpublished) MBS data collection; table 11A.3.

Nationally, around 5550 general practitioner-type services were provided per 1000 population under Medicare in 2009-10 (figure 11.2).

Figure 11.2 **GP-type service use per 1000 people, 2009-10**[a, b]



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[a] Rates are age standardised to the Australian population at 30 June 2001. [b] Includes non-referred attendances by vocationally recognised GPs and OMPs, and practice nurses.

Source: DoHA (unpublished) MBS data collection; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.4.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 198 million services provided under the PBS and RPBS in 2009-10, amounting to 8.9 prescriptions per person. There were around 184 million services provided under the PBS in 2009-10, of which 85.7 per cent were concessional (table 11.4).

Table 11.4 **PBS and RPBS services, 2009-10 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	8.6	6.3	5.2	2.7	1.9	0.6	0.6	0.2	26.0
PBS concessional[b]	54.0	40.5	30.0	12.8	13.8	4.6	1.5	0.5	157.6
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.3
PBS total	62.7	46.9	35.3	15.5	15.7	5.1	2.0	0.6	183.9
RPBS total[c]	4.8	3.0	3.2	1.1	1.1	0.4	0.2	–	13.9
Total	**67.5**	**49.9**	**38.5**	**16.6**	**16.8**	**5.6**	**2.2**	**0.6**	**197.8**
PBS services per person[d]	9.4	9.1	8.6	7.3	10.3	11.0	6.3	2.9	8.9

[a] Includes PBS general ordinary and safety net. [b] Includes concessional ordinary and concessional free safety net. [c] Includes RPBS ordinary and RPBS safety net. [d] Excludes RPBS and PBS doctor's bag. – Nil or rounded to zero.

Source: DoHA (unpublished) PBS data collection; table 11A.5.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.71–11A.79 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.71–11A.79).

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 2009-10 targeted at disadvantaged people (tables 11A.71–11A.79).

Nationally, around 90 public dental services were provided per 1000 people in 2008. Of these, around 23 per cent were emergency services (table 11.5).

Table 11.5 **Use of public dental services by service type, per 1000 people, 2008**[a, b, c, d]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Emergency services[e]	15.9	19.9	30.7	10.0	25.0	25.1	20.4	23.8	20.6
General services	39.6	53.4	92.1	125.6	70.0	101.7	75.1	145.4	68.3
All services	**55.5**	**73.3**	**122.8**	**135.6**	**95.0**	**126.8**	**95.5**	**169.2**	**88.9**

[a] Rates are age standardised to the Australian population at 30 June 2001. [b] Limited to dentate people aged 5 years or over. [c] Data are for number of people who used a public dental service at least once in the preceding 12 months, not for number of services provided. [d] Type of service at the most recent visit. [e] Emergency visit is a visit for relief of pain.

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished) *2006 Census of Population and Housing*; table 11A.6.

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 2010a). 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 653 alcohol and other drug treatment services reported 2008-09 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). Of these, 291 (44.6 per cent) identified as government providers and 362 (55.4 per cent) identified as non-government providers (table 11A.7). All of these non-government providers received some government funding for 2008-09. There were 143 672 reported closed treatment episodes in 2008-09 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 68.0 per cent of whom were male, accounted for 138 027 closed treatment episodes (AIHW 2010a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (45.8 per cent). Cannabis was the next most common drug of concern (22.5 per cent), followed by heroin (10.3 per cent) and amphetamines (9.2 per cent) (AIHW 2010a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.71–11A.79.

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 2008-09, 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.71–11A.79).

Data on Indigenous primary healthcare services that receive funding from the Australian Government are collected through the OATSIH Services Reporting (OSR) questionnaire (the OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from the 2008-09 reporting period). Many of these services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent the health related activities, episodes and workforce funded from all sources.

For 2008-09, OSR data are reported for 205 Indigenous primary healthcare services (table 11A.8). Of these services, 89 (43.4 per cent) were located in remote or very remote areas (table 11A.9). 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.10). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Over 2.0 million episodes of healthcare were provided by participating services in 2008-09 (table 11.6). Of these, around 947 000 (45.3 per cent) were in remote or very remote areas (table 11A.9).

Table 11.6 **Estimated episodes of healthcare for Indigenous people by services for which OSR data are reported ('000)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	452	160	336	306	191	35	23	586	2089

[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.

Source: AIHW (unpublished) OSR data collection.

The services included in the OSR data collection employed 2764 full time equivalent health staff (as at 30 June 2009). Of these, 1551 were Indigenous (56.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (4.8 per cent and 9.3 per cent, respectively) (table 11A.11).

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 (CRC). Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the National Agreements.

Box 11.1 **Objectives for primary and community health**

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

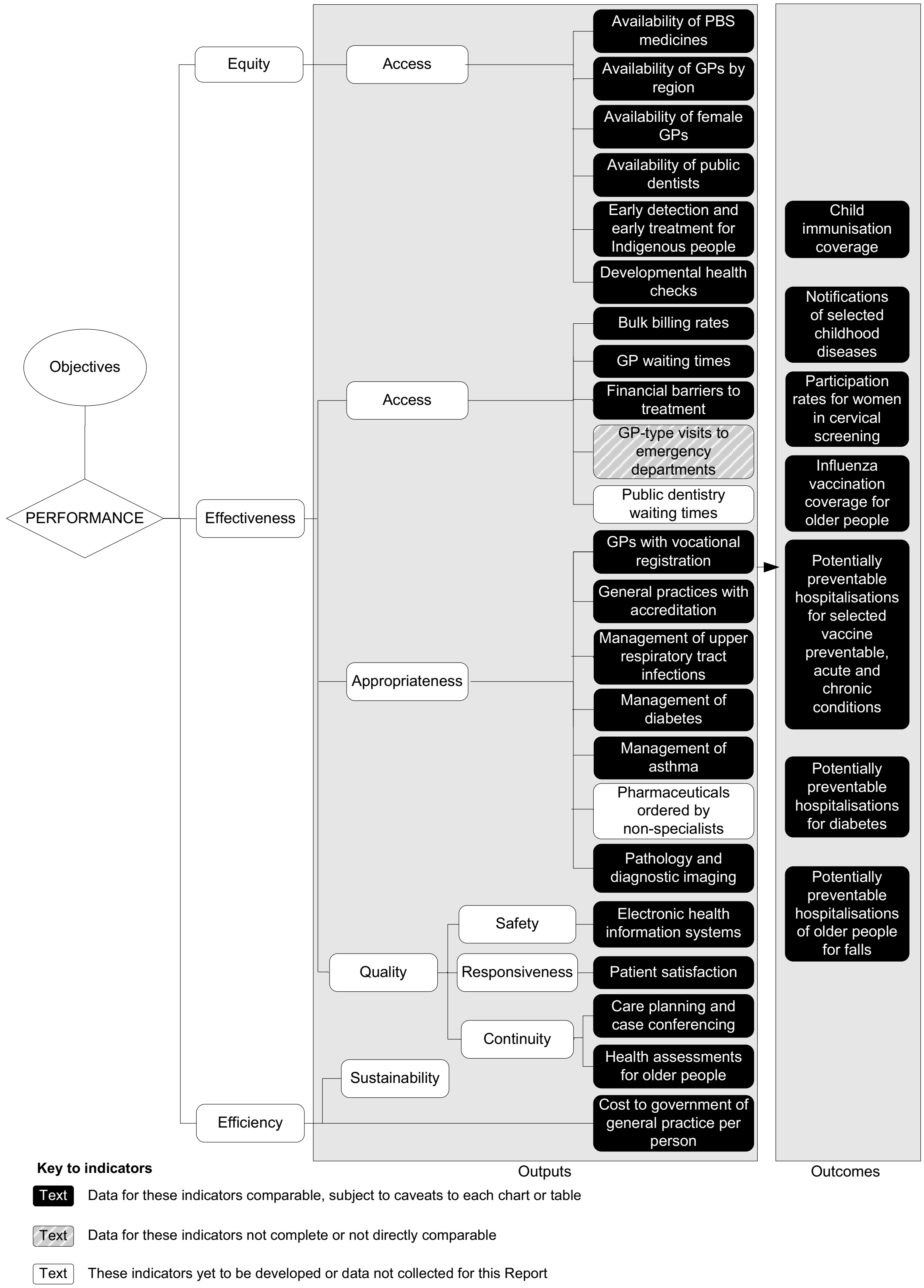
- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating 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 2011 Report (figure 11.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6). The Health preface explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability 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 11.3 **Performance indicators for primary and community health**



11.3 Key performance indicator results

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

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous people relative to other Australians (see the Health Preface and SCRGSP 2009).

Access

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

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

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.

Data quality information for this indicator is under development.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3814 people per pharmacy in urban areas and 4277 in rural areas in 2009-10. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.4, table 11A.12).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 53 medical practitioners and 261 hospitals — 84 private and 177 public[1] — approved to supply PBS medicines to the community in 2009-10. The medical practitioners as well as 80 of the public hospitals were located in rural areas (table 11A.12).

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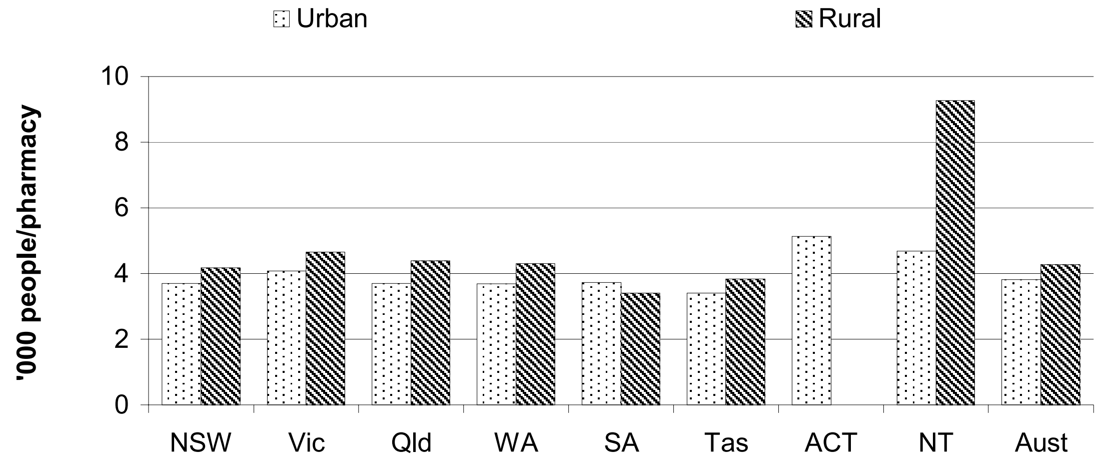
[1] PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.

Figure 11.4 **People per pharmacy, 2009-10**[a]



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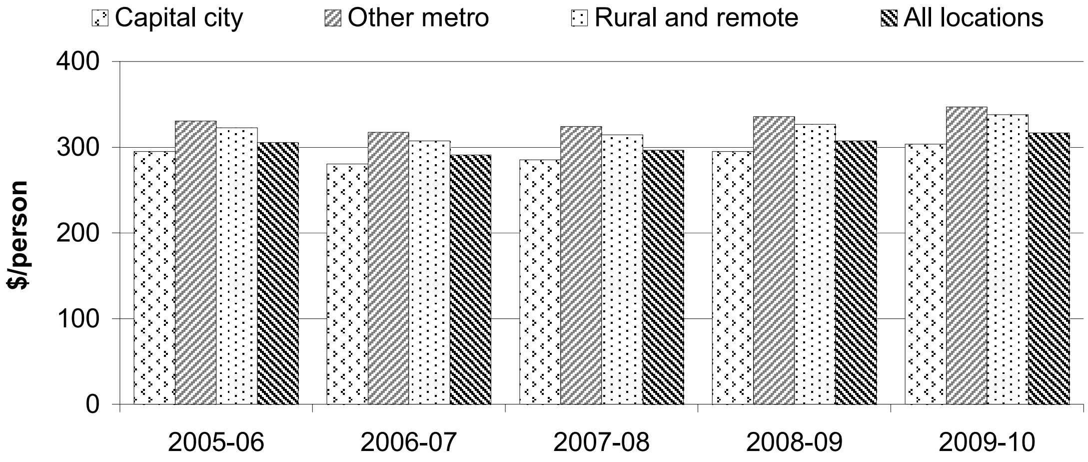
[a] Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas.

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.12.

Nationally, PBS expenditure per person increased from $307 in 2008-09 to $317 in 2009-10 (figure 11.5). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2005-06 to 2009-10 (in 2009-10 dollars).

Figure 11.5 **PBS expenditure per person (2009-10 dollars)**[a]



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[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.13.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.5. These data are not available by regional location. Nationally, 85.7 per cent of prescriptions subsidised under the PBS were concessional in 2009-10.

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.

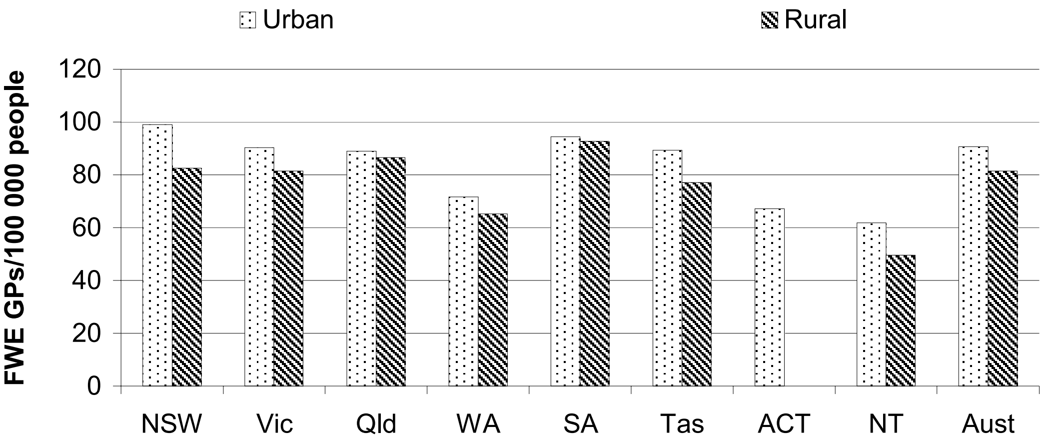
This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In terms of FWE GPs per 100 000 people, there were more GPs available in urban areas than in rural areas in all states and territories in 2009-10 (figure 11.6). The bulk billed proportion of non-referred attendances was generally lower in large rural and remote centres, than in capital cities, other metropolitan centres and 'other remote' areas (table 11A.14).

Figure 11.6 **Availability of GPs (full time workload equivalent), 2009-10**[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.14.

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.

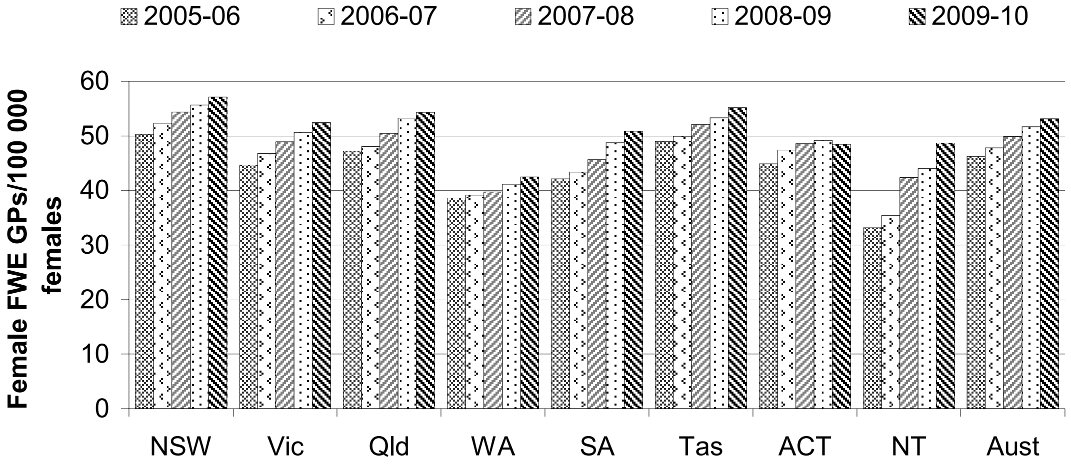
This indicator does not provide information on whether women are accessing female GPs or whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In 2009-10, 40.0 per cent of Australia's GPs — 30.3 per cent of FWE GPs — were female (tables 11A.3 and 11A.15). The number of FWE GPs per 100 000 females increased from 46.2 to 53.2 in the period 2005-06 to 2009-10 (figure 11.7).

Figure 11.7 **Availability of female GPs (full time workload equivalent)**[a]



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[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.15.

Availability of public dentists

'Availability of public dentists' is an indicator of governments objective to provide equitable access to dental services (box 11.5). Updated data were not available for the 2011 Report. Data for previous years are reported in table 11A.16.

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 increased access to public 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 quality information for this indicator is under development.

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 health assessment by Indigenous status, defined as the proportion of older people who received a 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 health assessment, defined as the proportion of older Indigenous people who received a health assessment in successive years of a five year period.

(Continued on next page)

Box 11.6 **(Continued)**

- Indigenous people who received a health assessment or check by age group, defined as the proportion of Indigenous people who received a 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.

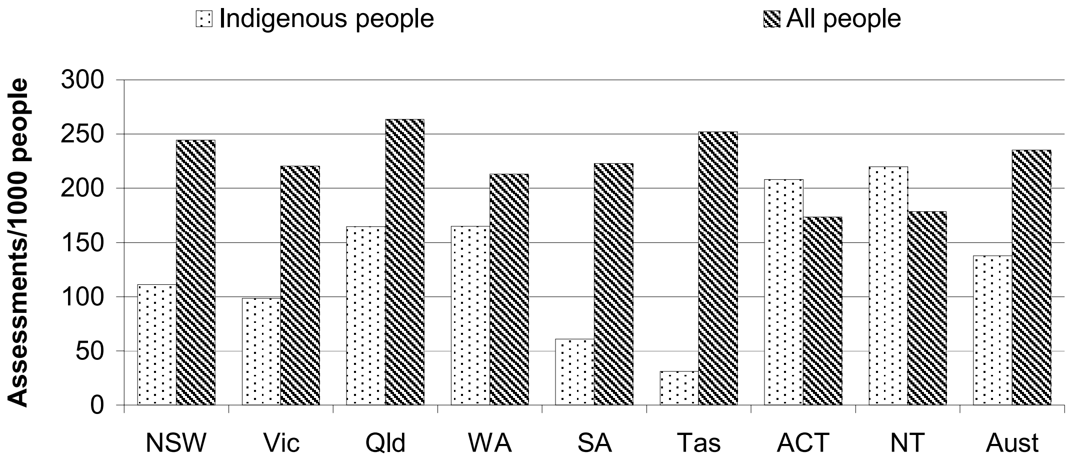
Data quality information for this indicator is under development.

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2008a; SCRGSP 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.

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 several population groups that have a high prevalence of preventable and/or treatable conditions, including older Australians and Indigenous people of all ages.

In 2009-10 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 in most jurisdictions (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, 2009-10[a, b]**



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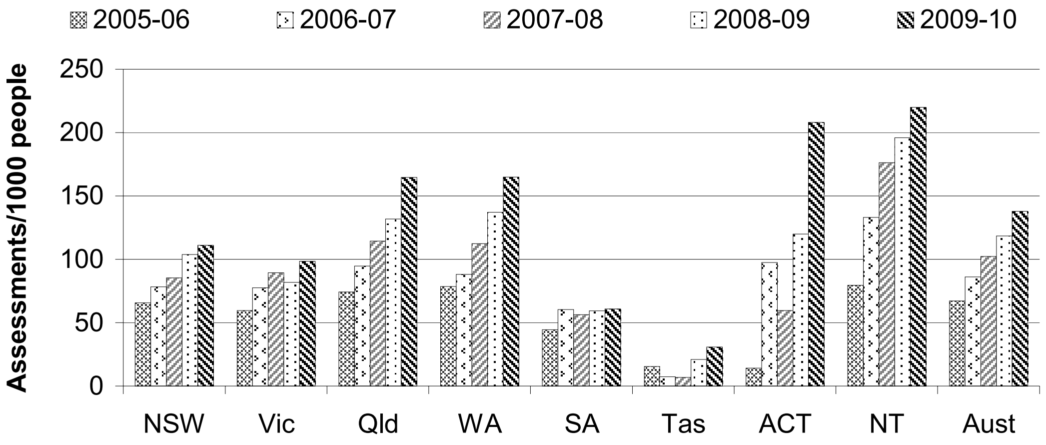
[a] Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. [b] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This 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.18.

The proportion of older Indigenous people who received an annual health assessment increased in all jurisdictions between 2005-06 and 2009-10 (figure 11.9). This indicates that access to early detection and early treatment services for this population has improved.

Figure 11.9 **Older Indigenous people who received an annual health assessment**[a, b]



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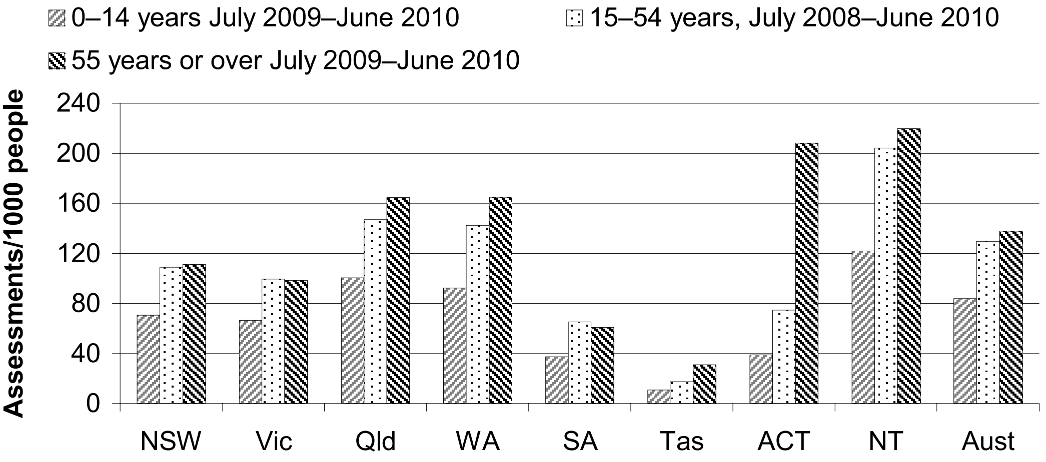
[a] Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly 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.19.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004. Initially available biennially, from 1 May 2010 they are available annually. Also available annually are health checks for Indigenous children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Indigenous population who received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.10). 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]

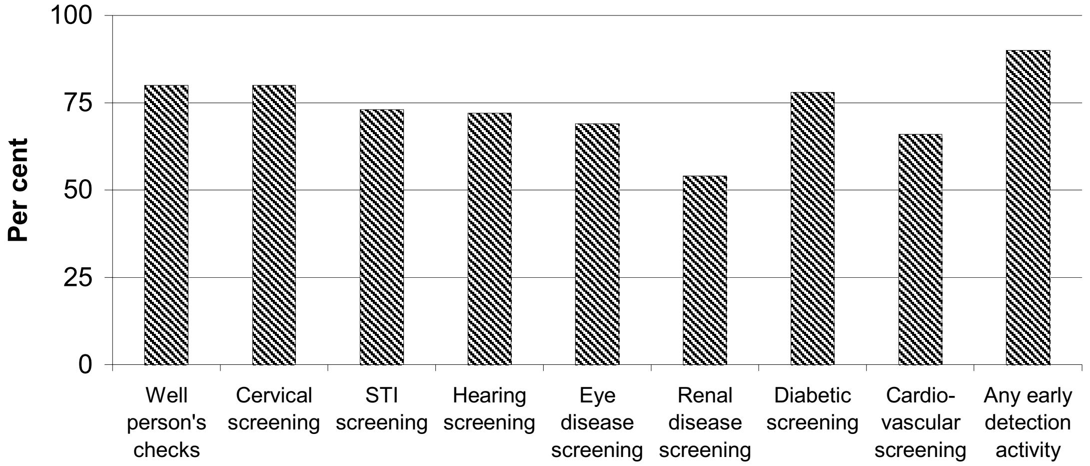


[a] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the ‘all older people’ MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy 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 2009 to 30 June 2010. Health checks for 15–54 year olds were available biennially until 30 April 2010 (thereafter annually), and these data are for the period 1 July 2008 to 30 June 2010.

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.20.

Figure 11.11 shows the proportion of Indigenous primary healthcare services for which OSR data are reported that provided various early detection services in 2008-09.

Figure 11.11 Indigenous primary healthcare services for which OSR data are reported that provided early detection services, 2008-09[a]



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[a] The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from the 2008-09 reporting period. Historical SAR data are published in previous reports.

Source: AIHW (unpublished) OSR data collection; table 11A.21.

Proportion of children receiving a fourth year developmental health check

'Proportion of children receiving a fourth year developmental health check' is an indicator of governments' objective to provide effective access to early detection and intervention services for children (box 11.7).

Box 11.7 Proportion of children receiving a fourth year developmental health check

'Proportion of children receiving a fourth year developmental health check' is defined as the number of children aged 3, 4 or 5 years who received a 'Healthy Kids Check' (introduced in 2008) or a 'Aboriginal and Torres Strait Islander Child Health Check' provided under Medicare, divided by the eligible population of children aged 4 years. Healthy Kids Checks are available to children aged 3, 4 or 5 years, while Aboriginal and Torres Strait Islander Child Health Checks are available to Indigenous children aged 0–14 years.

An increase over time in the proportion of children receiving a fourth year developmental health check is desirable as it suggests improved access to these services.

(Continued on next page)

Box 11.7 (continued)

The type of check forms a proxy for Indigenous status. A reduction in the gap between the proportion of Indigenous children and non-Indigenous children who received a fourth year developmental health check can indicate more equitable access to early detection and early treatment services for Indigenous children.

This indicator provides no information about developmental health checks for children that are provided outside Medicare. Such services are provided in the community, for example, maternal and child health services, community health centres, early childhood settings and the schools sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

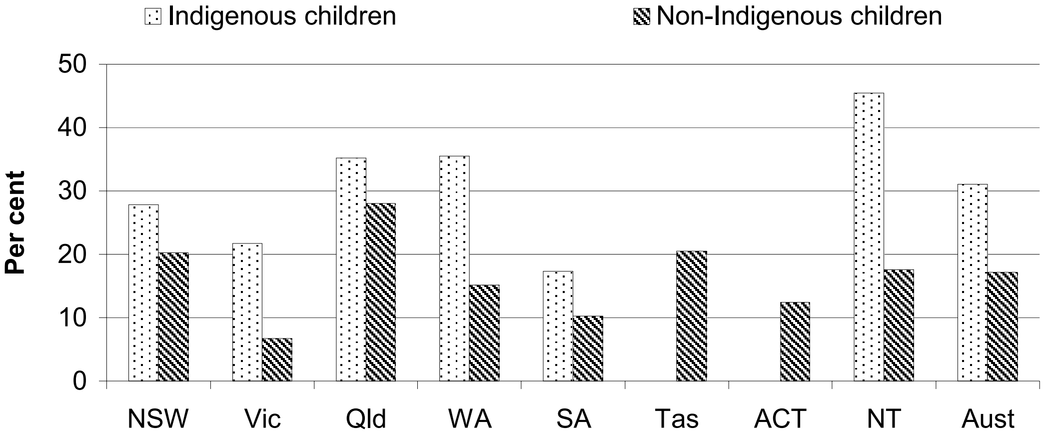
The fourth year developmental health check MBS item was introduced in 2008, and is intended to assess children's physical health, general well-being and development. It enables identification of children who are at high risk for, or have early signs of, delayed development and/or illness. Early identification provides the opportunity for timely prevention and intervention measures that can ensure that children are healthy, fit and ready to learn when they start school.

In all jurisdictions, developmental health checks for children around 4 years of age are also provided outside Medicare, in community settings such as maternal and child health services, community health centres, early childhood settings and the schools sector. However, comparable data for developmental health checks conducted in these settings are not available for all jurisdictions.

The proportion of children who received the 'Aboriginal and Torres Strait Islander Child Health Check' (introduced in 2006) is used as a proxy for the proportion of Indigenous children who received a developmental health check. This should be considered a minimum estimate as it excludes Indigenous children who received a check under a 'Healthy Kids Check' MBS item. Similarly, while 'Healthy Kids Checks' are used as a proxy for checks received by non-Indigenous children, the data include Indigenous children who received this check.

Nationally, 17.8 per cent of children received a fourth year developmental health check under Medicare in 2009-10. The proportion of children that received the check was higher in the Indigenous population than in the general population in all jurisdictions for which data are available (figure 11.12).

Figure 11.12 **Children who received a fourth year developmental health check, by Indigenous status, 2009-10**[a, b, c, d]



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[a] Limited to health checks available under Medicare. [b] Data for Indigenous children include claims for MBS Item 708 (Aboriginal and Torres Strait Islander Child Health Check) and Item 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) for children aged 3–5 years. [c] Data for non-Indigenous children include claims for MBS Items 709 and 711 (Healthy Kids Check) and Items 701, 703, 705, 707 and 10 986 (Health Assessment) for children aged 3–5 years. [d] Data for Indigenous children are not published for Tasmania or the ACT.

Source: DoHA (unpublished) MBS data collection; ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.22.

Effectiveness

Access

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

- 'bulk billing rates'
- 'GP waiting times'
- 'people deferring recommended treatment due to financial barriers'
- 'selected potentially avoidable GP-type presentations to emergency departments'.

Bulk billing rates

'Bulk billing rates' is an indicator of governments' objective to provide affordable access to GP services (box 11.8).

Box 11.8 **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 more affordable access to GP services.

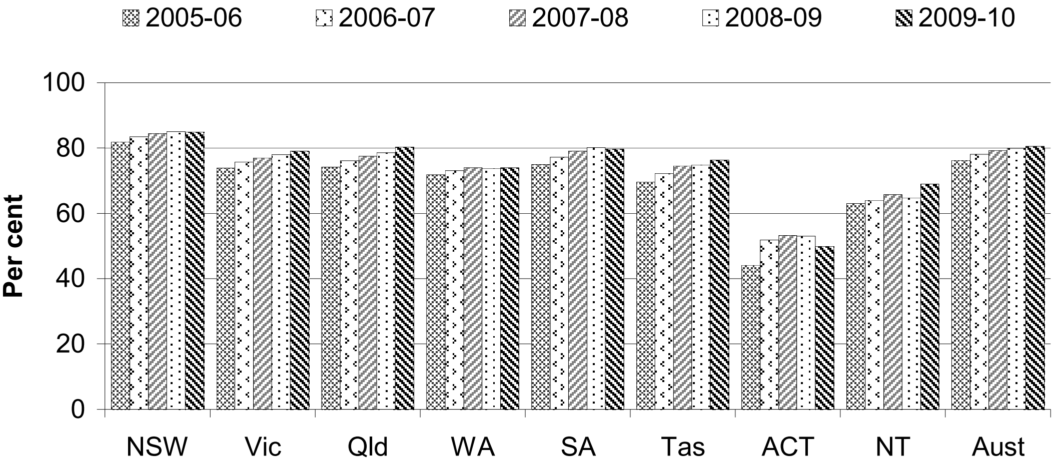
This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 80.5 per cent in 2009-10. For all jurisdictions, this proportion increased in the period 2005-06 to 2009-10 (figure 11.13). The bulk billed proportion of non-referred attendances was highest in 'other remote areas' and capital cities (table 11A.23). The bulk billed proportion of non-referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 11A.24).

Figure 11.13 **Non-referred attendances that were bulk billed**[a, b]



[a] Includes attendances by practice nurses. [b] Allocation to State/Territory based on patients' Medicare enrolment postcode.

Source: DoHA (2010) *Medicare Statistics - June Quarter 2010*; table 11A.24.

GP Waiting Times

GP Waiting Times

'GP waiting times' is an indicator of governments' objective to provide timely access to GP services (box 11.9).

Box 11.9 **GP Waiting Times**

'GP Waiting Times' is defined as the number of people who saw a GP for urgent medical care within specified waiting time categories in the previous 12 months, divided by the number of people who saw a GP for urgent medical care in the previous 12 months. Specified waiting time categories are less than 4 hours, 4 to 24 hours and more than 24 hours.

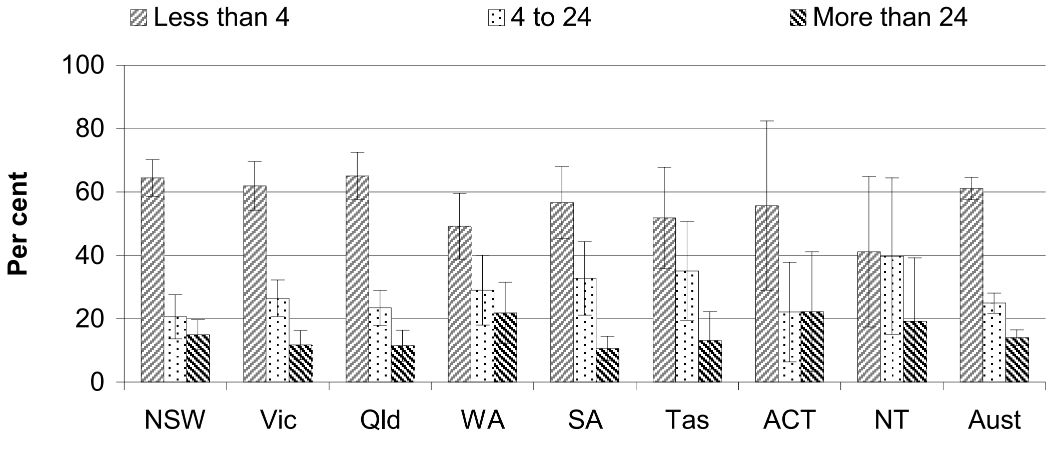
An increase in the proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, around 60 per cent of people waited less than four hours to see a GP for urgent care (figure 11.14). Around 25 per cent waited from four to less than 24 hours, and 14 per cent waited for more than 24 hours. For visits to GPs not requiring urgent care, around 18 per cent of people waited longer than they felt was acceptable to get an appointment (table 11A.26).

Figure 11.14 **Hours waited for urgent treatment by GP, 2009**[a, b, c, d]



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[a] People aged 15 years or over who saw a GP for urgent medical care for their own health in the previous 12 months. [b] Time waited between making an appointment and seeing the GP for urgent medical care. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) Patient Experience Survey 2009; table 11A.25.

People deferring treatment due to financial barriers

'People deferring treatment due to financial barriers' is an indicator of governments' objective to ensure affordable access to primary and community health services (box 11.10).

Box 11.10 **People deferring treatment due to financial barriers**

People deferring treatment due to financial barriers is defined by two measures:

- 'people deferring visits to GPs due to financial barriers', defined as the proportion of people who delayed seeing or did not see a GP due to cost
- 'people deferring purchase of prescribed medicines due to financial barriers', defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.

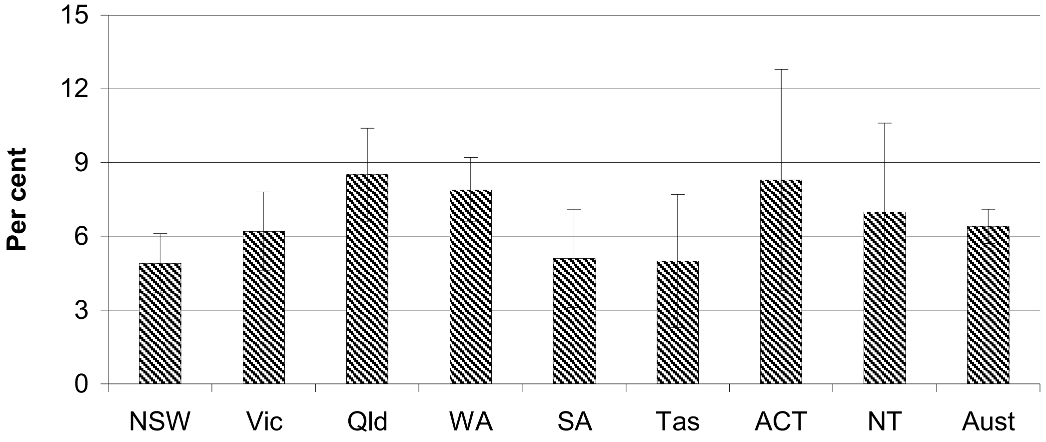
A lower proportion of people deferring treatment due to financial barriers indicates more widely affordable access to GPs and medications.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Timely access to healthcare services and medicines is important to people's health and wellbeing. Deferring or not visiting a GP and deferring or not purchasing medicines can result in poorer health. Nationally, 6.4 per cent of respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 11.15).

Figure 11.15 **People deferring visits to GPs due to cost, 2009**[a, b, c, d]



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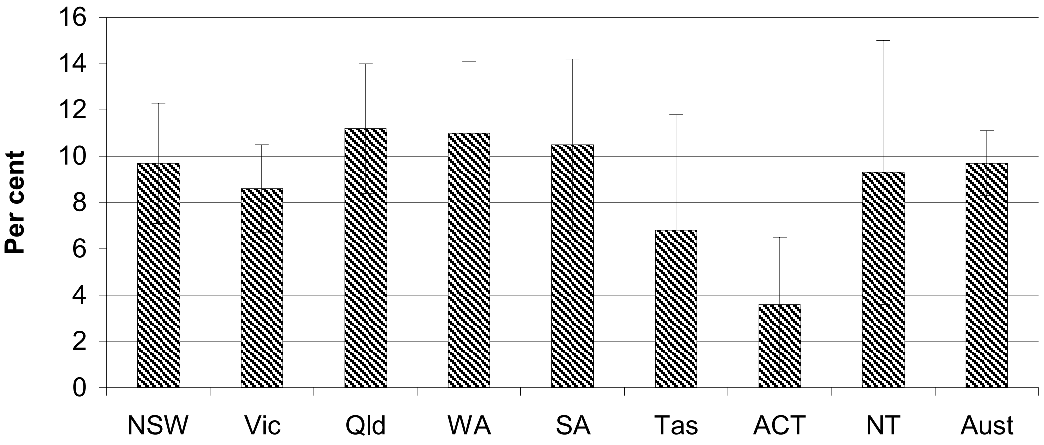
[a] People aged 15 years or over. [b] Delayed visiting or did not visit a GP at any time in the previous 12 months. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2009*; 11A.27.

Nationally, 9.7 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 11.16).

Figure 11.16 **People deferring purchase of prescribed medicines due to cost, 2009**[a, b, c, d]



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[a] People aged 15 years or over who received a prescription for medication in the previous 12 months. [b] Delayed purchasing or did not purchase prescribed medicines at any time in the previous 12 months. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2009*; 11A.27.

Selected potentially avoidable GP-type presentations to emergency departments

'Selected potentially avoidable GP-type presentations to emergency departments' is an indicator of governments' objective to ensure universal access to GP-type services in the community (box 11.11).

Box 11.11 Selected potentially avoidable GP-type presentations to emergency departments

Selected potentially avoidable GP-type presentations to emergency departments' is defined as the number of 'GP-type presentations' to emergency departments divided by the total number of presentations to emergency departments, where 'GP-type presentations' are those:

- allocated to triage category 4 or 5
- not arriving by ambulance, with police or corrections
- not admitted or referred to another hospital
- who did not die.

A decrease in the proportion of presentations that are GP-type presentations can indicate better access to primary and community health care. A decrease can also indicate a reduction in reliance on emergency departments for the treatment of such conditions.

Data for this indicator are not directly comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

'GP-type' presentations are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). One of several factors contributing to 'GP-type' presentations at emergency departments is perceived or actual lack of access to GP services. Other factors include proximity of emergency departments and trust for emergency department staff.

Nationally, there were around 2.1 million GP-type presentations to public hospital emergency departments in 2009-10 (table 11.7). Data are presented by Indigenous status and remoteness in table 11A.28.

Table 11.7 GP-type presentations to emergency departments ('000)[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009-10	677.7	550.9	371.4	207.5	117.0	47.8	46.2	35.9	2054.3

[a] GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of semi-urgent or non-urgent, and where the episode end status was not admitted to the hospital, or referred to another hospital, or died. [b] Data are presented by State/Territory of usual residence of the patient. [c] Data are for peer group A and B public hospitals only.

Source: AIHW (unpublished) National non-admitted emergency patient database; table 11A.28.

Waiting times for public dentistry

'Waiting times for public dentistry' is an indicator of governments' objective to ensure timely access to public dental services for eligible people (box 11.12).

Box 11.12 **Waiting times for public dentistry**

'Waiting times for public dentistry' is defined as the median waiting time (in days) from being placed on a public dentistry waiting list to an offer of care for dental treatment being made.

Data for this indicator were not available for the 2011 Report.

Appropriateness

Six indicators of the appropriateness of GP services are reported:

- 'GPs with vocational registration'
- 'General practices with accreditation'
- 'Management of upper respiratory tract infections'
- 'Management of diabetes'
- 'Management of asthma'
- 'Pathology tests and diagnostic imaging ordered by non-specialists'.

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 11.13).

Box 11.13 **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.

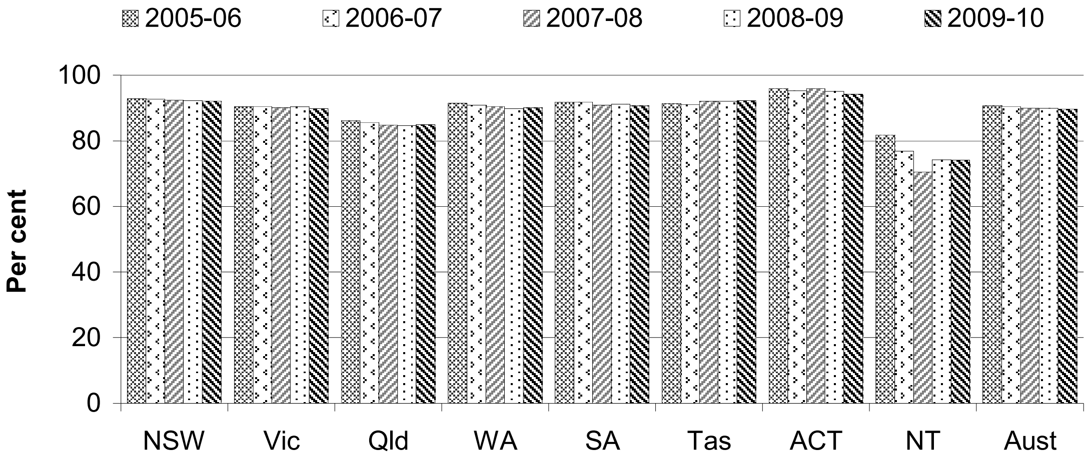
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2009-10 (figure 11.17). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in remote areas, in 2009-10 (table 11A.31).

Figure 11.17 **GPs (full time workload equivalent) with vocational registration**[a]



[a] FWE GP numbers include vocationally recognised GPs and OMPs billing Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.

Source: DoHA (unpublished) MBS data collection; table 11A.32.

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 11.14).

Box 11.14 **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.

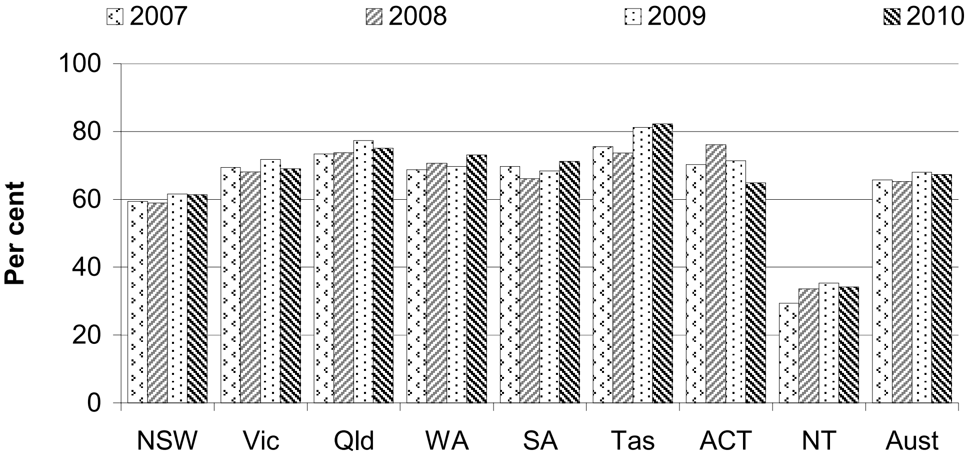
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and General Practice Australia ACCREDITATION *plus* (GPA Accreditation *plus*).

In June 2010, 4812 general practices — representing 67.3 per cent of general practices — were accredited nationally (figure 11.18).

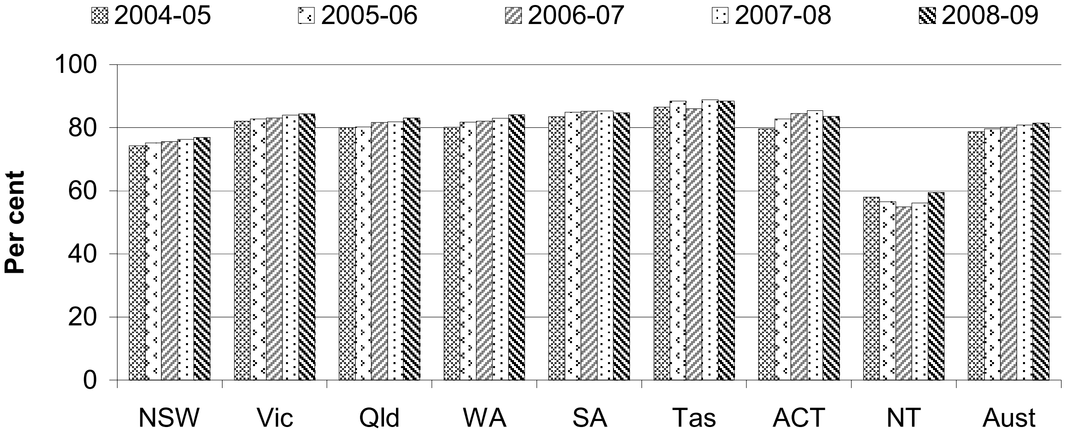
Figure 11.18 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice 2009-10*; table 11A.33.

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 2004-05 to 2008-09 (figure 11.19).

Figure 11.19 **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.34.

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 11.15).

Box 11.15 **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 per 1000 people.

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.

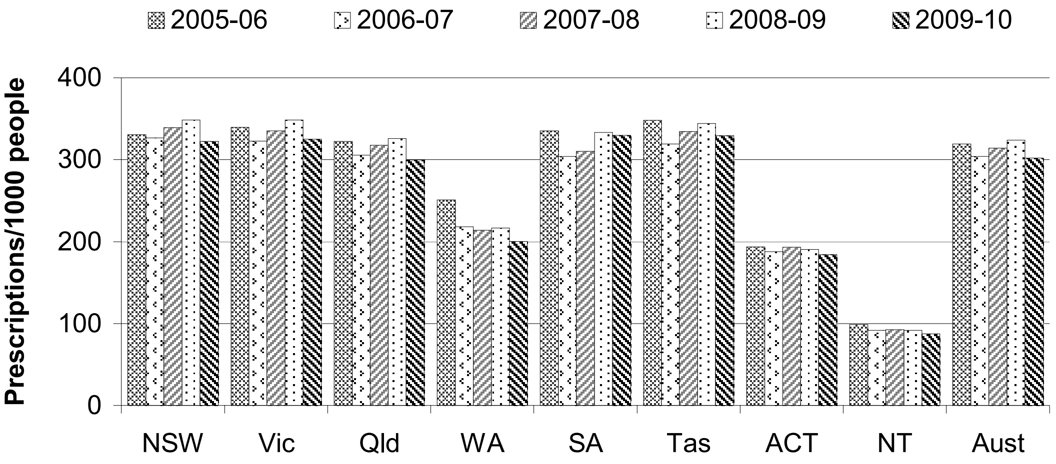
The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Data are reported for the first time for all people — previous reports presented data only for concession card holders. Nationally, the prescription rate for the oral antibiotics most commonly used to treat upper respiratory tract infection was 302 per 1000 people in 2009-10 (figure 11.20). Prescriptions for concession card holders accounted for 94.4 per cent of those dispensed (table 11A.35).

Figure 11.20 Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infection[a]



[a] Prescriptions ordered by vocationally recognised GPs and other medical practitioners (OMPs) and dispensed to patients.

Source: DoHA (unpublished) PBS data collection; table 11A.35.

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 11.16).

Box 11.16 **Management of diabetes**

'Management of diabetes' is defined by two measures:

- the proportion of people with diabetes mellitus who have received an annual cycle of care within general practice — 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 proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent — the number of people with diabetes mellitus with HbA1c below 7 per cent, divided by the estimated number of people with diabetes mellitus.

The MBS annual cycle of care is generally based on RACGP clinical guidelines for the appropriate management of Type 2 diabetes in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008c).

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 measure are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

HbA1c measures the average level of glucose in the blood over the past three months. A high or increasing proportion of people with diabetes with HbA1c below 7 per cent is desirable.

Data for this measure were not available for the 2011 Report.

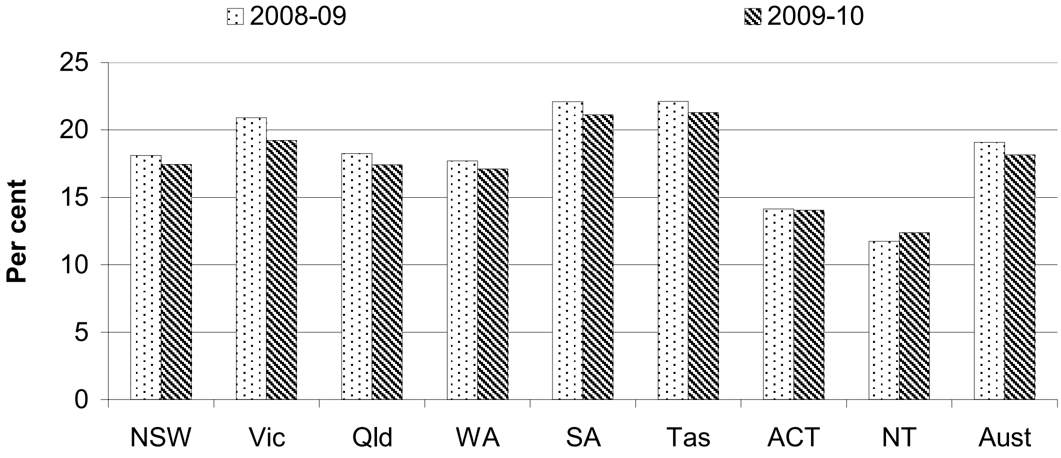
Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of 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 2007).

Nationally, 18.1 per cent of people with diabetes received the annual cycle of care in 2009-10 (figure 11.21). Data are reported by geographical region in table 11A.36.

Figure 11.21 **People with diabetes mellitus who have received an annual cycle of care within general practice, 2009-10**[a, b, c]



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[a] GPs may provide the annual cycle of care but not claim the MBS rebate. Various factors influence the uptake of MBS items by GPs. [b] Clinical guidelines are for Type 2 diabetes, while the MBS items do not specify a particular type of diabetes. [c] Historical data differ from previous reports due to a change in methodology associated with a change in data provider.

Source: DoHA (unpublished) MBS data collection; DoHA (unpublished) National Diabetes Services Scheme (NDSS) data collection; table 11A.36.

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 11.17).

Box 11.17 **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).

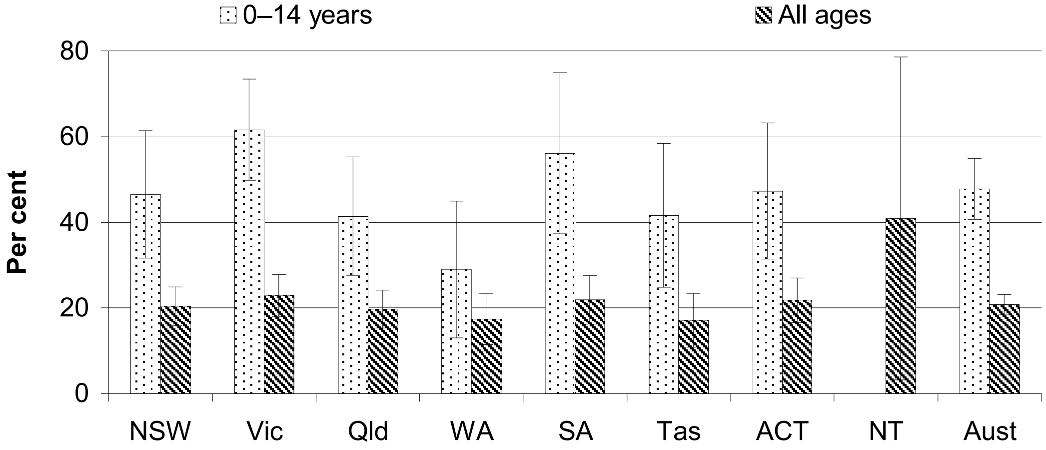
A high or increasing proportion of people with asthma who have a written asthma action plan is desirable.

Data reported against this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the age standardised proportion of people with current asthma who reported having a written asthma action plan in 2007-08 was 20.8 per cent for all ages and 47.8 per cent for children aged 0–14 years (figure 11.22). Data are reported by geographical region in table 11A.38. Data for 2004-05 are reported by Indigenous status in table 11A.39.

Figure 11.22 **Proportion of people with asthma who have a written asthma action plan, 2007-08**[a, b, c]



[a] Rates for ‘all ages’ are age standardised to the Australian population at 30 June 2001. [b] Separate estimates for 0–14 years are not available for the NT, but the NT sample contributes to the national estimates. [c] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (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; table 11A.37.

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 11.18).

Box 11.18 **Pharmaceuticals ordered by non-specialists**

'Pharmaceuticals ordered by non-specialists' is yet to be defined.

Data for this indicator were not available for the 2011 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 11.19).

Box 11.19 **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.

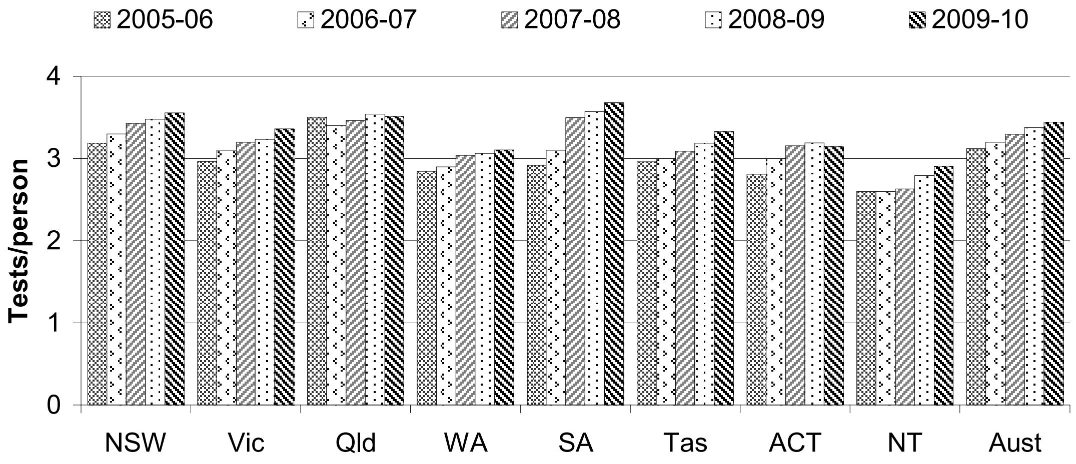
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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 ranged from 3.1 to 3.4 in the period 2005-06 to 2009-10 (figure 11.23).

Figure 11.23 **Pathology tests ordered by GPs and rebated through Medicare**[a]



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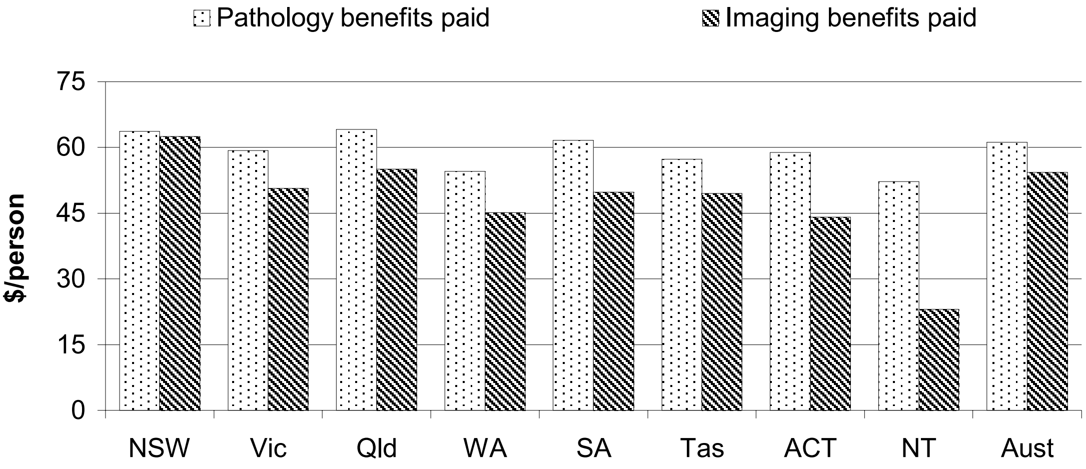
[a] Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.40.

Australian Government expenditure (under Medicare) on pathology tests amounted to around $1.4 billion in 2009-10, or $61 per person. Nationally, Medicare benefits worth $1.2 billion were paid for diagnostic imaging in 2009-10, around $54 per person (figure 11.24).

Figure 11.24 **Benefits paid for pathology tests and diagnostic imaging, 2009-10**[a]



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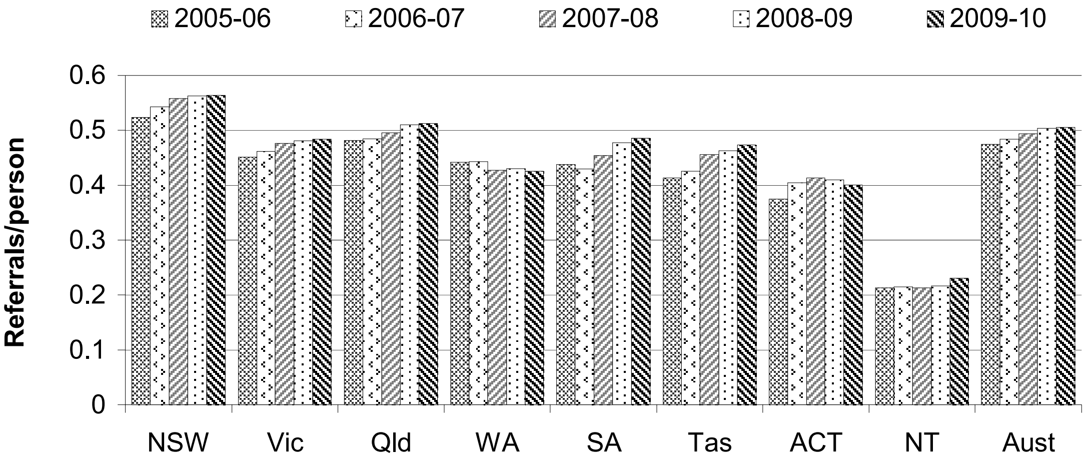
[a] Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; tables 11A.40 and 11A.41.

Nationally, the number of diagnostic imaging referrals per person has increased between 2005-06 and 2009-10 (figure 11.25).

Figure 11.25 **Diagnostic imaging referrals from GPs**[a]



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[a] Data relate to vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.41.

Quality — safety

General practices using electronic health information systems

‘General practices using electronic health information systems’ is an indicator of governments’ objective to improve patient safety through enhanced access to patient health information at the point of care and the more efficient coordination of care across multiple providers and services (box 11.20).

Box 11.20 **General practices using electronic health systems**

‘General practices using electronic health information systems’ is defined as the proportion of practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP eHealth incentive.

A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.

The PIP does not include all practices in Australia. PIP practices provided around 82 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2008-09 (DoHA unpublished; table 11A.34).

Data for this indicator are comparable.

Data quality information for this indicator is under development.

The use of electronic health information systems can, for example, facilitate best practice chronic disease management as well as minimise errors of prescribing and dispensing that can cause adverse drug reactions (Hofmarcher, Oxley and Rusticelli 2007).

The PIP provides financial incentives to general practices to support quality care, and improve access and health outcomes. The PIP promotes activities such as:

- use of electronic 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 eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in eHealth. It replaced, in August 2009, the PIP

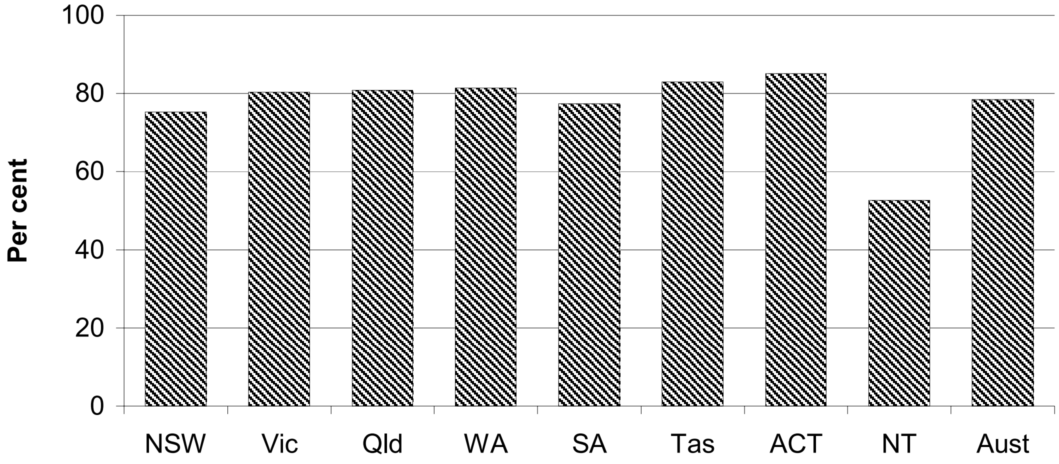
Information Management, Information Technology Incentive that had commenced in November 2006.

To be eligible for the PIP eHealth Incentive, practices must:

- have a secure messaging capability provided by an eligible supplier
- have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate
- provide practitioners from the practice with access to a range of key electronic clinical resources.

Nationally, 78.5 per cent of PIP practices used electronic health systems in May 2010 (figure 11.26).

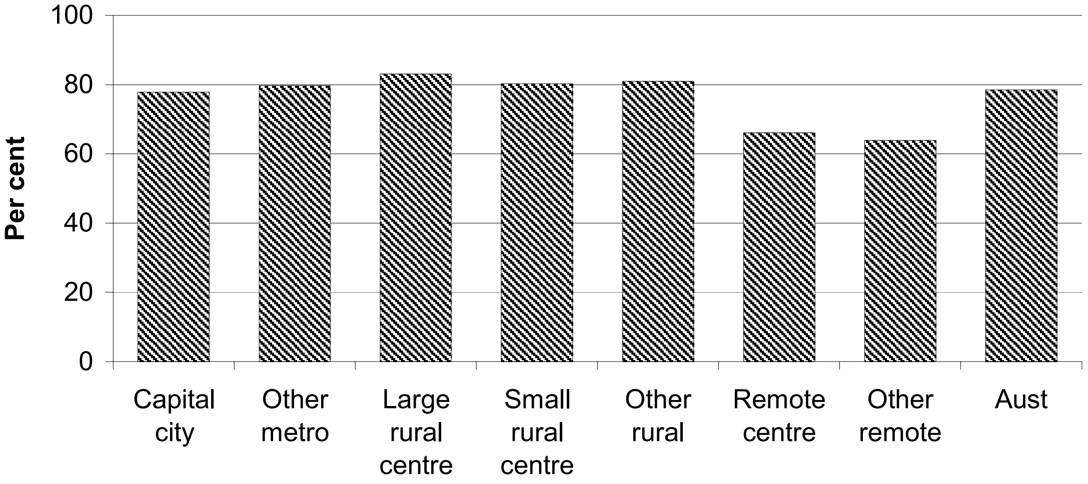
Figure 11.26 **PIP practices using electronic health systems, May 2010**



Source: DoHA (unpublished) MBS and PIP data collections; table 11A.42.

The proportion of PIP practices using electronic health systems in remote areas was lower than in urban and rural areas in May 2010 (figure 11.27).

Figure 11.27 **PIP practices using electronic health systems by area, May 2010**[a]



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[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.43.

Quality — responsiveness

Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective to ensure primary and community health services are high quality and account for individual patient needs (box 11.21).

Box 11.21 **Patient satisfaction**

‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of and/or satisfaction around ‘key aspects of care’ — that is, aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:

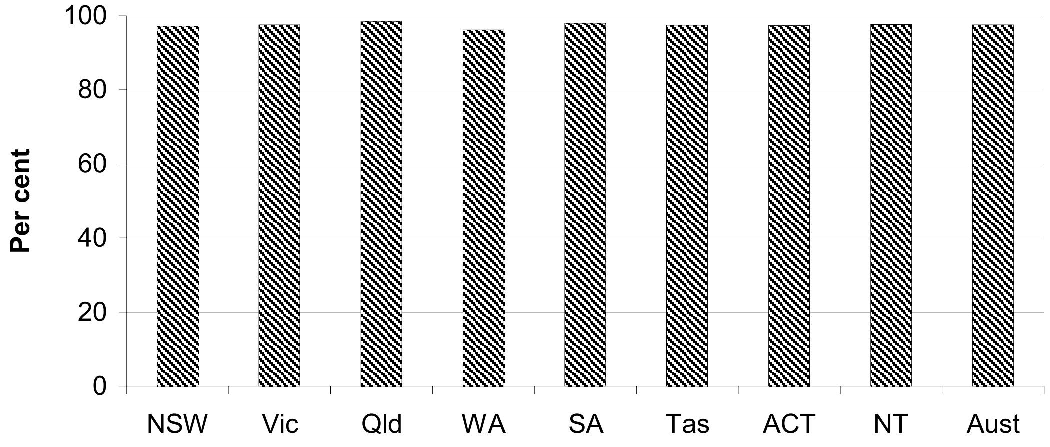
- ‘proportion of people receiving a prescription for medication from a GP in the previous 12 months where reasons for the prescription were provided’, defined as the number of people who received a prescription for medication from a GP in the previous 12 months where the GP provided reasons for the prescription, divided by the number of people receiving a prescription for medication from a GP in the previous 12 months
- ‘proportion of people who had a pathology or imaging test in the previous 12 months where the referring health professional explained the reasons for the most recent test’, defined as the number of people who had a pathology or imaging test in the previous 12 months where reasons for the most recent test were explained, divided by the number of people who had a pathology or imaging test in the previous 12 months.

High proportions suggest that patients experienced health professionals’ communication of reasons for prescribing medicine, or for having pathology or imaging tests, as satisfactory.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, 97.6 per cent of respondents receiving a prescription from a GP were provided with reasons for the prescription by the prescribing GP in 2009 (figure 11.28). There was little variation among states and territories.

Figure 11.28 **Reasons for prescription explained, 2009**[a, b]



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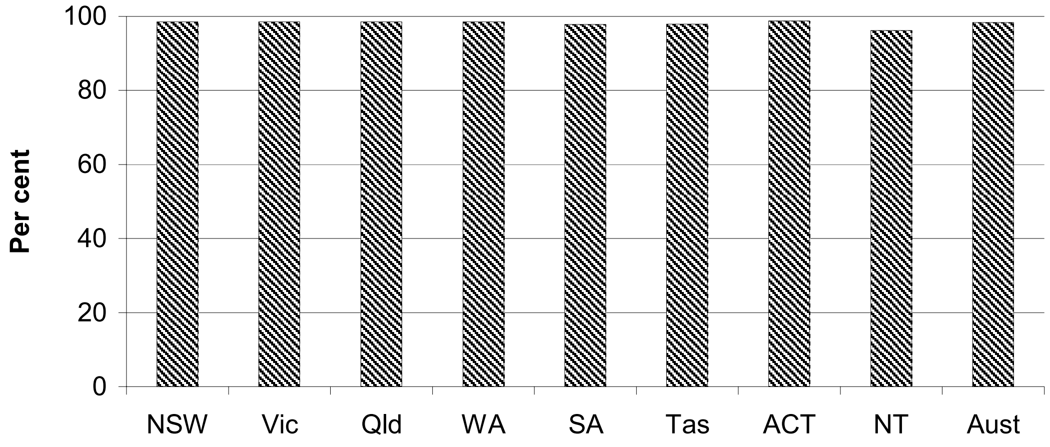
[a] People aged 15 years or over who received a prescription for medication in the previous 12 months. [b] Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (2010) *Patient Experience Survey*; table 11A.44.

Nationally, 98.4 per cent of respondents were provided with reasons for having a pathology or imaging test by the referring healthcare professional in 2009 (figure 11.29). There was little variation among states and territories.

Figure 11.29 **Reasons for tests explained, 2009** [a, b]



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[a] People aged 15 years or over who had a pathology test for which they had been referred in the past year, (excluding tests had in hospital); and people who had been referred to their most recent imaging test by a health professional (excluding tests had in hospital and dental tests). [b] Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (2010) Patient Experience Survey; table 11A.45.

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 11.22).

Box 11.22 **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.

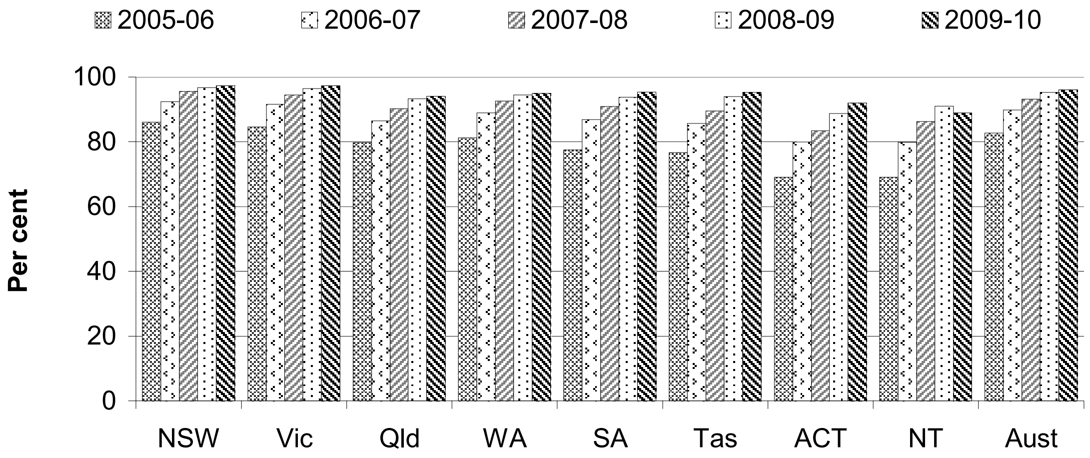
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Additional chronic disease management MBS items have been introduced on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Nationally, the proportion of GPs using chronic disease management MBS items for care planning or case conferencing increased from 82.7 in 2005-06 to 96.1 per cent in 2009-10 (figure 11.30). The proportion has increased steadily in almost all jurisdictions in the period 2005-06 to 2009-10.

Figure 11.30 **GP use of chronic disease management Medicare items for care planning and case conferencing**[a]



[a] The Strengthening Medicare initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP.

Source: DoHA (unpublished) MBS data collection; table 11A.46.

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 11.23).

Box 11.23 **Health assessments for older people**

‘Health assessments for older people’ is defined as the proportion of older people who received a health assessment. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Annual health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient’s health. Health assessments cover the patient’s health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.6).

A high or increasing proportion of eligible older people who received a health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

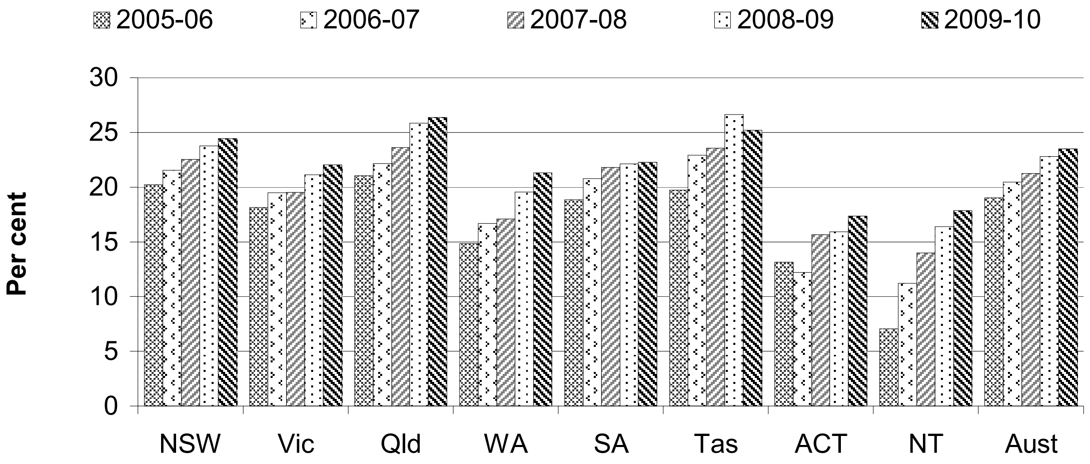
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The targeted age range for Indigenous people of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health 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 health assessment in most jurisdictions, in the period 2005-06 to 2009-10. Nationally, this proportion increased from 19.0 per cent in 2005-06 to 23.5 per cent in 2009-10 (figure 11.31).

Figure 11.31 **Older people who received a health assessment**[a]



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[a] Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Data may differ from previous reports due to revision of denominator data.

Source: DoHA (unpublished) MBS data collection; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS 2009 *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.47.

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 11.24).

Box 11.24 **Cost to government of general practice per person**

‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.

A lower or decreasing cost per person can indicate higher efficiency. However, this is likely to be the case only where the lower cost is associated with services of equal or superior effectiveness.

This indicator needs to be interpreted with care 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).

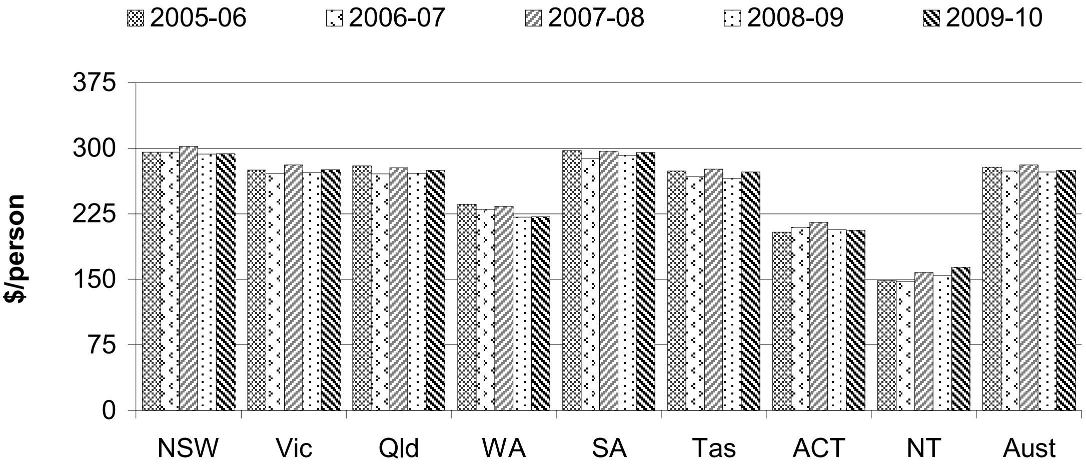
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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 $275 per person in 2009-10 (figure 11.32).

Figure 11.32 **Australian Government real expenditure per person on GPs (2009-10 dollars)**[a]



[a] 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 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 11.25).

Box 11.25 **Child immunisation coverage**

'Child immunisation coverage' is defined by three 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
- 'the proportion of children aged 60 months to less than 63 months who are fully immunised', where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data for this indicator are comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Data for children aged 60 months to less than 63 months are included for the first time in the 2011 Report.

Many providers deliver child immunisation services (table 11.8). 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 11.8 **Valid vaccinations supplied to children under 7 years of age, by provider type, 2005–2010 (per cent)**[a, b, c, d]

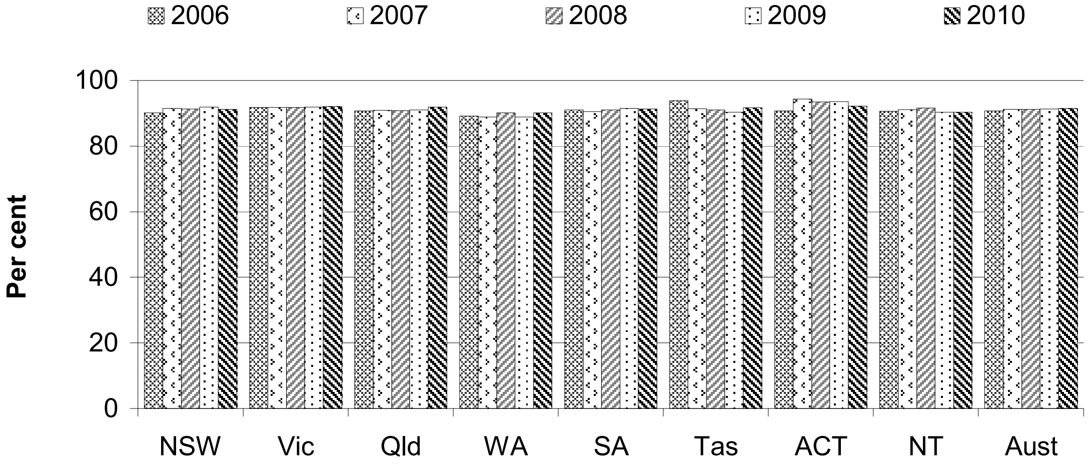
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	84.5	53.4	82.8	64.7	69.3	87.4	43.0	4.6	71.4
Council	5.6	45.2	7.0	6.1	18.7	11.8	–	–	16.8
State or Territory health department	–	–	–	6.3	0.1	0.1	17.7	0.3	0.9
Public hospital	1.9	0.6	3.0	3.8	2.5	0.2	0.8	7.5	2.1
Private hospital	0.1	–	–	–	–	–	–	0.9	–
Indigenous health service	0.5	0.1	0.6	0.6	0.5	–	0.2	10.7	0.6
Community health centre	7.4	0.7	5.8	18.5	8.9	0.5	38.3	75.7	8.0
Other[d]	0.1	–	0.7	–	0.2	–	–	0.2	0.2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

[a] Data are for the period 1 July 2005 to 30 June 2010. [b] Data are based on State/Territory in which the immunisation provider was located. [c] A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. [d] Other includes Divisions of GP, Flying Doctors' Services, Indigenous Health Workers, Community nurses and unknown. – Nil or rounded to zero.

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.48.

Around 91.5 per cent of Australian children aged 12 months to less than 15 months at 30 June 2010 were assessed as fully immunised (figure 11.33).

Figure 11.33 **Children aged 12 months to less than 15 months who were fully immunised**[a, b, c]

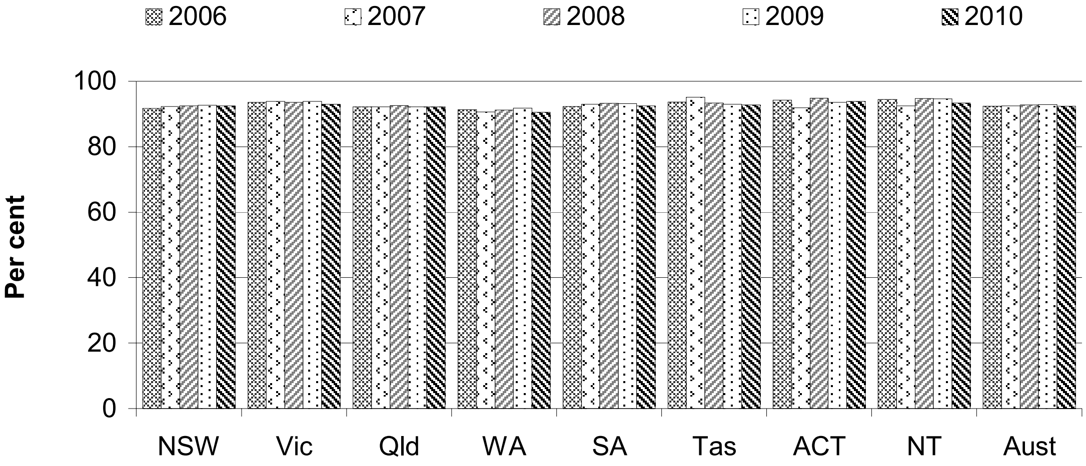


[a] Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. [b] The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 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.49.

Nationally, 92.4 per cent of children aged 24 months to less than 27 months at 30 June 2010 were assessed as being fully immunised (figure 11.34).

Figure 11.34 **Children aged 24 months to less than 27 months who were fully immunised**[a, b, c]

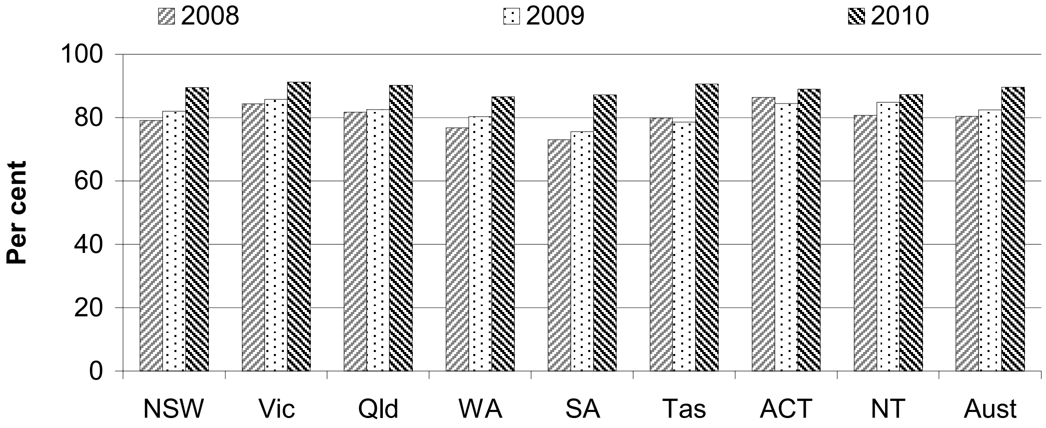


[a] Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children 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.50.

Nationally, 89.6 per cent of Australian children aged 60 months to less than 63 months at 30 June 2010 were assessed as fully immunised (figure 11.35). Data are presented by Indigenous status and remoteness in table 11A.52.

Figure 11.35 Children aged 60 months to less than 63 months who were fully immunised[a, b, c, d]



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[a] Coverage measured at 30 June for children turning 60 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare Australia (NCIRS 2000). [c] There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). [d] Data for this age group were first available in 2008.

Source: DoHA (unpublished) ACIR data collection; table 11A.51.

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 11.26).

Box 11.26 **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).

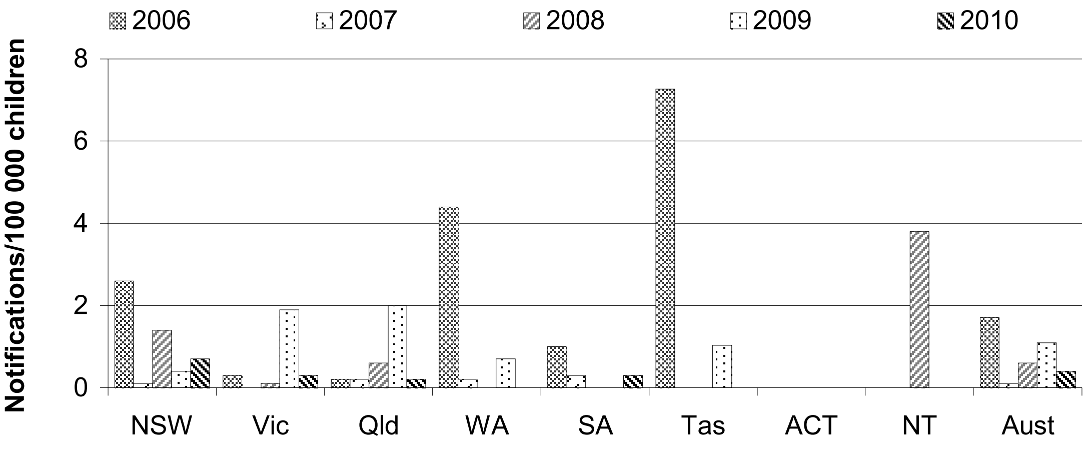
A low or reducing notification rate for the selected diseases indicates greater effectiveness of the immunisation program.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In 2010, there were 16 notifications of measles across Australia to 31 August (table 11A.53). This was the second time in the five year period 2006–2010 that notifications numbered less than 25 — there were 5 notifications in 2007. The national notification rate in 2010 was 0.4 per 100 000 children aged 0–14 years (figure 11.36).

Figure 11.36 **Notifications of measles per 100 000 children aged 0–14 years**[a, b]

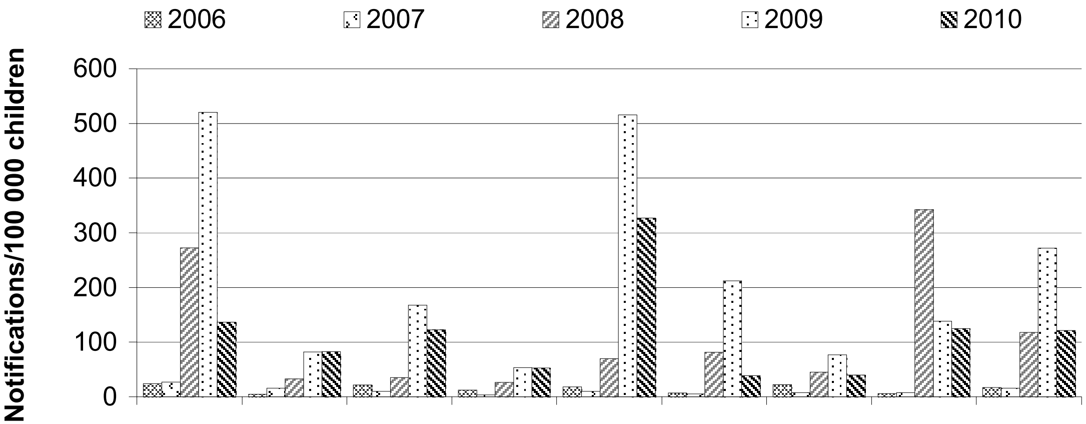


[a] Notifications for 2010 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.53.

Nationally, there were 5065 notifications for pertussis (whooping cough) to 31 August in 2010. The national notification rate in 2010 was 121.1 per 100 000 children aged 0–14 years (figure 11.37).

Figure 11.37 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**[a]

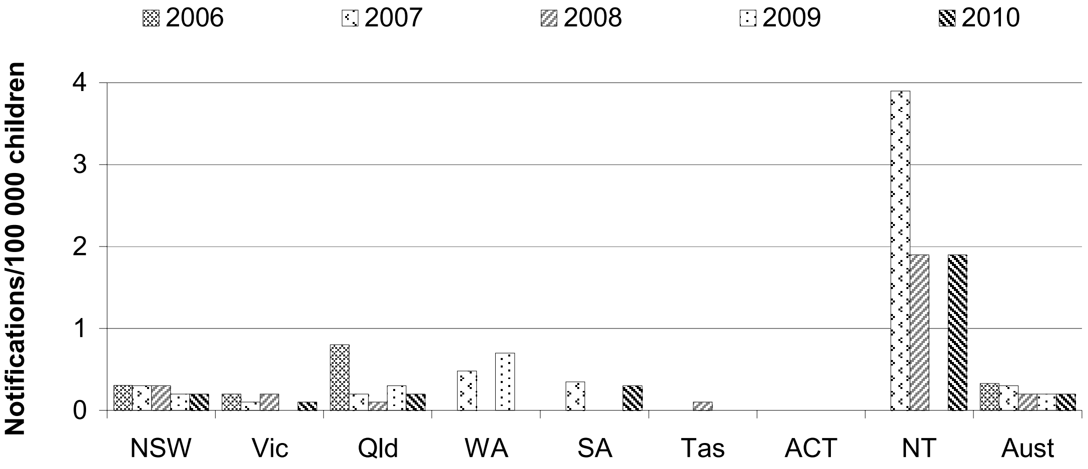


[a] Notifications for 2010 are to 31 August.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.54.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2010, the notification rate nationally to 31 August was 0.2 per 100 000 children aged 0–14 years (figure 11.38).

Figure 11.38 **Notifications of *Haemophilus influenzae* type b per 100 000 children aged 0–14 years**[a, b]



[a] Notifications for 2010 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.55.

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 11.27).

Box 11.27 **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.

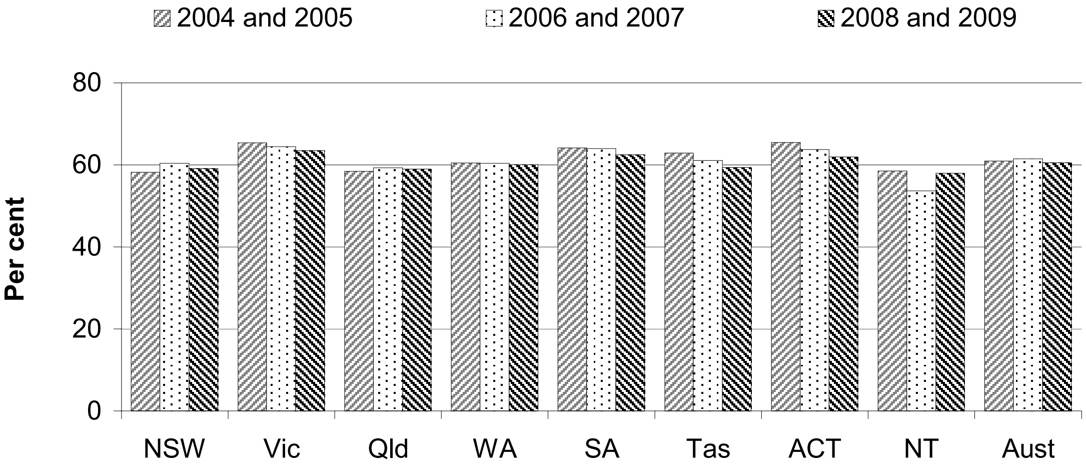
Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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 60.6 per cent for the 24 month period 1 January 2008 to 31 December 2009 (figure 11.39). For most jurisdictions, participation rates have remained relatively constant since the screening period of 2004 and 2005. Data for Indigenous women for 2004-05 are presented in table 11A.57.

Figure 11.39 **Participation rates for women aged 20–69 years in cervical screening**[a, b, c, d]



[a] Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP in each calendar year in the reference period and age standardised to the 2001 Australian population. [b] Eligible female population adjusted for estimated proportion who have had a hysterectomy. [c] Excludes women who have opted off the cervical cytology register. [d] Data include all women screened except for Victoria and the ACT, where data are based on residence.

Source: AIHW (2009) *Cervical screening in Australia 2007–2008*, Cat. no. CAN 50; AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.56.

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 11.28).

Box 11.28 **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.

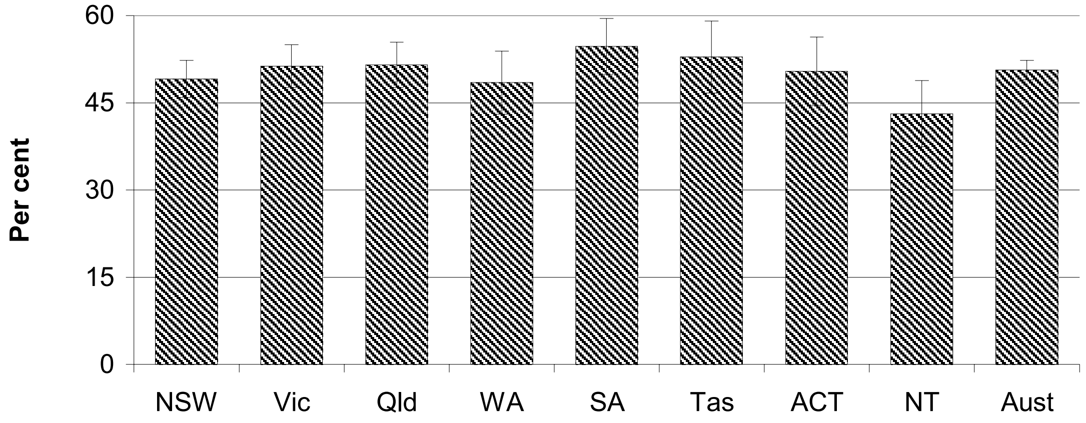
Data quality information for this indicator is under development.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the National Influenza Vaccine Program for Older Australians. GPs provide the majority of these vaccinations.

Updated data were not available for this measure in time for the 2011 Report (historical data are presented in table 11A.58). However, data were available for older adults fully vaccinated against both influenza and pneumococcal disease. Pneumococcal disease is also a vaccine preventable disease that can result in hospitalisation and/or death. Free vaccinations against pneumococcal disease became available to older Australians in 2005.

Nationally, 50.6 per cent of eligible people were fully vaccinated against both influenza and pneumococcus in 2009 (figure 11.40). Data for Indigenous people for 2004-05 are presented in table 11A.60.

Figure 11.40 **People aged 65 years or over fully vaccinated against influenza and pneumococcal disease**[a]



[a] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: AIHW (unpublished) 2009 Adult Vaccination Survey; table 11A.59.

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 11.29).

Box 11.29 **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 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 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 hospitals in Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National e-Health and 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. More recently, the National Health Information Standards and Statistics Committee (a standing committee of NEHIPC) approved reporting of data for Tasmania and the ACT by Indigenous status at the state and territory level for COAG reporting purposes. However, pending further examination of the quality of Indigenous identification for these jurisdictions, these data will not be included in national totals. This decision was taken too late to include most data for Tasmania and the ACT in this chapter for the 2011 Report. Efforts to improve Indigenous identification across states and territories are ongoing.

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 11.30).

Box 11.30 **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.
- 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 2010b; 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.

(Continued next page)

Box 11.30 **(continued)**

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.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the age standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 30.6 per 1000 people in 2008-09 (table 11.9). Of these, 54.9 per cent were for chronic and 43.2 per cent for acute conditions (table 11A.61). Data are presented disaggregated by remoteness in table 11A.62.

Table 11.9 **Separations for selected potentially preventable hospitalisations per 1000 people, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Vaccine preventable conditions	0.7	0.8	0.8	0.6	0.7	0.6	0.5	2.4	0.7
Selected acute conditions	12.4	14.3	14.2	13.4	14.4	10.1	11.5	21.0	13.5
Selected chronic conditions	13.9	15.3	18.5	26.0	15.5	12.6	11.7	26.0	16.5
Total[d]	**27.0**	**30.3**	**33.3**	**39.8**	**30.4**	**23.3**	**23.6**	**48.7**	**30.6**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories. Excludes overseas residents and unknown state of residence. [d] Totals may not add as more than one condition may be reported for a separation.

Source: AIHW (2010b) *Australian Hospital Statistics 2008-09*, Cat. no. HSE 84; table 11A.61.

Vaccine preventable hospitalisations

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.7 per 1000 people in 2008-09. Nationally, influenza and pneumonia accounted for 73.7 per cent of hospital separations for vaccine preventable conditions in 2008-09 (table 11.10).

Table 11.10 Separations for vaccine preventable conditions per 1000 people, 2008-09[a, b]

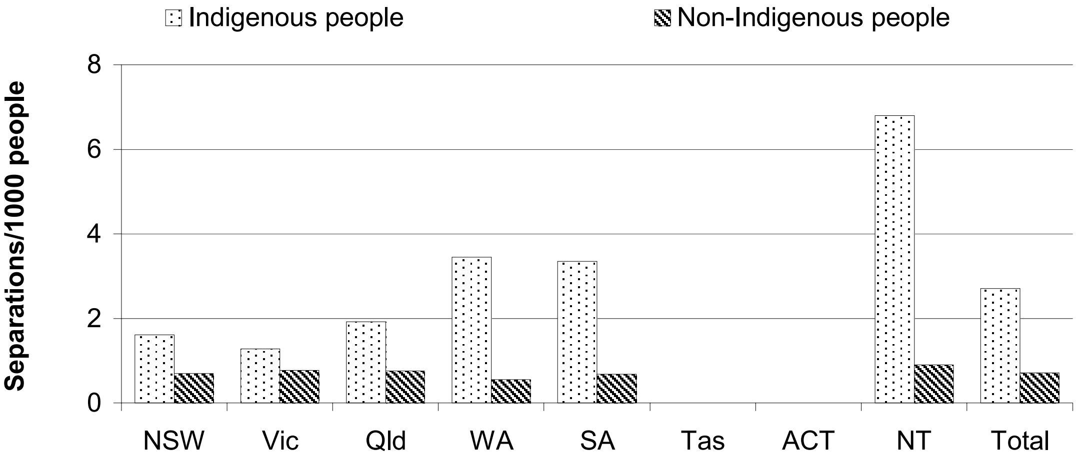
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.5	0.5	0.6	0.5	0.6	0.5	0.4	1.6	0.5
Other conditions	0.2	0.3	0.1	0.2	0.2	0.1	0.1	0.8	0.2
Total[d]	**0.7**	**0.8**	**0.8**	**0.6**	**0.7**	**0.6**	**0.5**	**2.4**	**0.7**

[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 (2010b) *Australian Hospital Statistics 2008-09*, Cat. no. HSE 84; table 11A.63.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.41).

Figure 11.41 Separations for vaccine preventable conditions by Indigenous status, 2008-09[a, b, c, d, e]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Separation rates are based on State/Territory of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.63.

Hospitalisations for selected acute conditions

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis recorded the highest rates of hospitalisation nationally in 2008-09 (table 11.11).

Table 11.11 **Separations for selected acute conditions per 1000 people, 2008-09**[a, b]

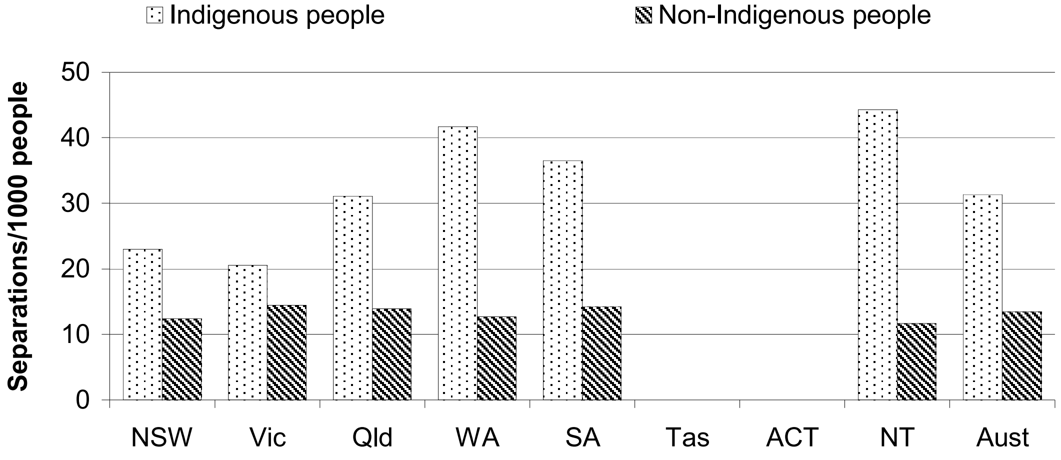
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.6	1.5	1.9	1.5	1.5	1.2	1.3	3.7	1.6
Convulsions and epilepsy	1.5	1.4	1.6	1.3	1.6	1.5	1.4	3.4	1.5
Dehydration and gastroenteritis	2.5	3.5	2.8	2.4	2.8	2.1	2.1	2.6	2.8
Dental conditions	2.3	3.1	2.7	3.6	3.2	1.8	2.2	3.2	2.8
Ear, nose and throat infections	1.6	1.5	1.9	1.6	2.3	1.3	1.2	2.9	1.7
Gangrene	0.1	0.3	0.2	0.2	0.2	0.2	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.2	0.2	0.3	0.2	0.2
Pyelonephritis[d]	2.2	2.4	2.5	2.1	2.2	1.4	2.5	3.7	2.3
Total[e]	**12.4**	**14.3**	**14.2**	**13.4**	**14.4**	**10.1**	**11.5**	**21.0**	**13.5**

[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 (2010b) *Australian Hospital Statistics 2008-09*, Cat. no. HSE 84; table 11A.64.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.42).

Figure 11.42 **Separations for selected acute conditions by Indigenous status, 2008-09**[a, b, c, d, e]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Separation rates are based on State/Territory of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.64.

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 2008-09. The hospitalisation rate for diabetes complications was more than four times higher than the rate for any other of the selected conditions except for chronic obstructive pulmonary disease (table 11.12).

Table 11.12 **Separations for selected chronic conditions per 1000 people, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.2	1.4	2.0	1.3	1.4	1.4	1.0	2.3	1.5
Asthma	1.8	1.8	1.5	1.3	2.4	1.2	0.9	1.8	1.7
Chronic obstructive pulmonary disease	2.6	2.6	3.1	2.2	3.0	2.5	2.2	6.7	2.6
Congestive cardiac failure	1.8	2.1	1.9	1.8	1.8	1.5	2.1	2.5	1.9
Diabetes complications	5.7	6.2	9.0	18.5	5.8	4.9	4.8	12.0	7.7
Hypertension	0.3	0.2	0.3	0.2	0.3	0.2	0.3	0.1	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.3	1.2	1.1	0.9	1.2	1.2
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	0.0
Rheumatic heart disease[d]	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.7	0.1
Total[e]	**13.9**	**15.3**	**18.5**	**26.0**	**15.5**	**12.6**	**11.7**	**26.0**	**16.5**

[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 (2010b) *Australian Hospital Statistics 2008-09*, Cat. no. HSE 84; table 11A.65.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.43).

Figure 11.43 **Separations for selected chronic conditions by Indigenous status, 2008-09**[a, b, c, d, e]

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Separation rates are based on State/Territory of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.65.

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 11.31).

Box 11.31 **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.

(Continued next page)

Box 11.31 **(continued)**

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.

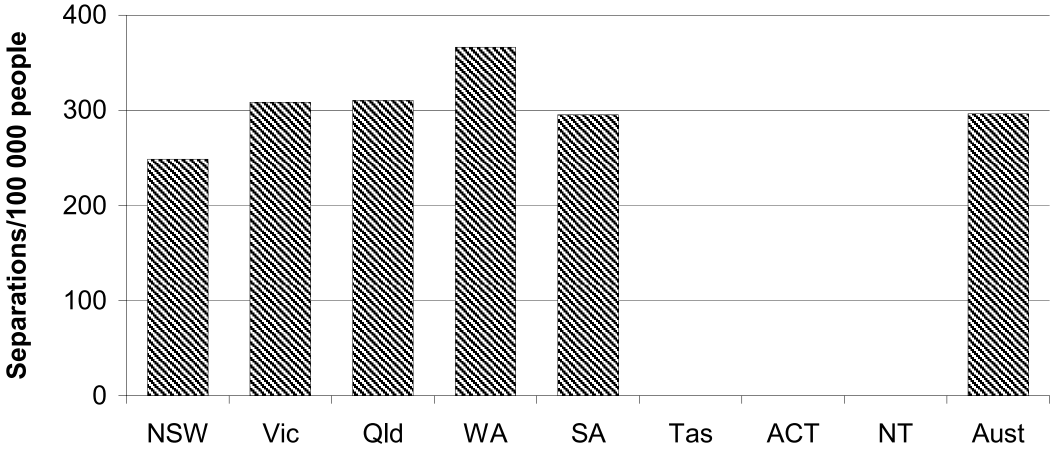
Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, patient compliance with measures to manage diabetes, and the underlying prevalence of diabetes.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the age standardised hospital separation rate in 2008-09 where the principal diagnosis was Type 2 diabetes mellitus was 296.3 separations per 100 000 people (figure 11.44).

Figure 11.44 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2008-09**[a, b, c]



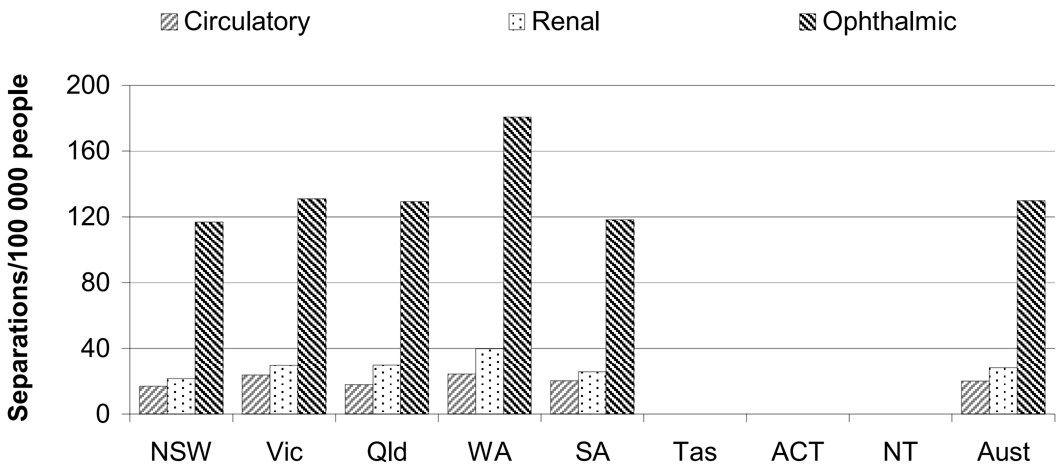
[a] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [b] Morbidity data are coded under coding 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.67.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2008-09 were ophthalmic, renal and circulatory complications.

Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.45). Each patient can have one or more complication(s) (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.45 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2008-09**[a, b, c, d]



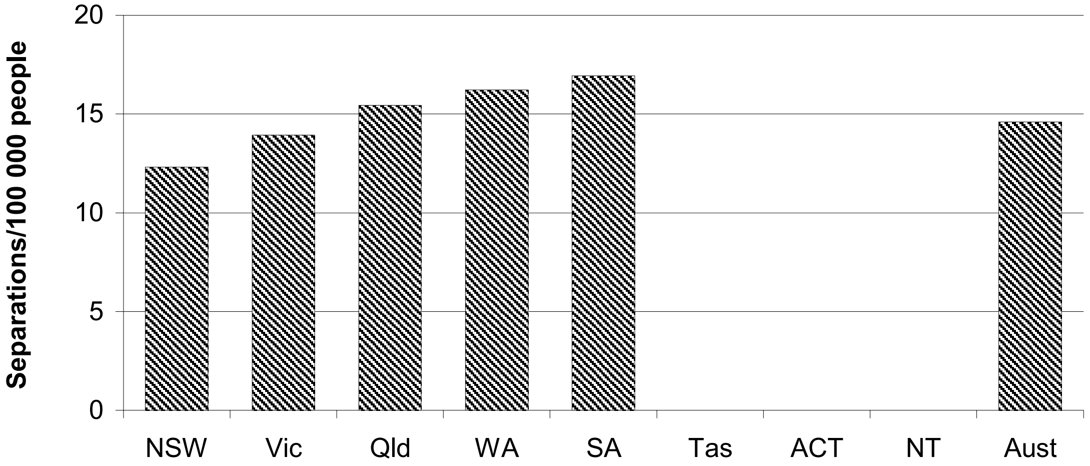
a Results for individual complications can be affected by small numbers, and need to be interpreted with care. **b** Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than 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.67.

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 2008-09 (table 11A.68).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2008-09, there were 14.6 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.46).

Figure 11.46 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2008-09**[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.69.

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. There was a marked difference in 2008-09 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 people was 8.8 times higher than the separation rate for all Australian people (figure 11.47).

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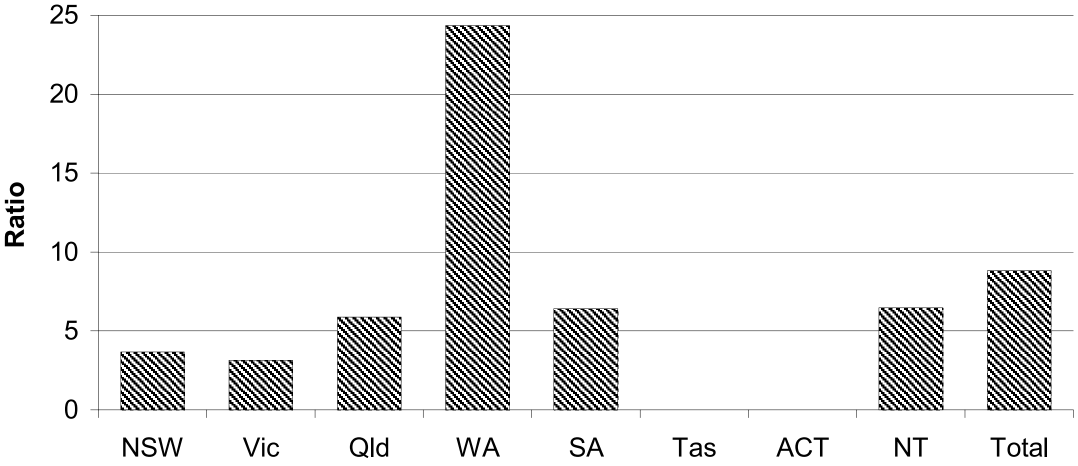
[2] ‘All diabetes’ refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

Figure 11.47 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2008-09**[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.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 11A.66.

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 11.32). Effective primary and community healthcare can reduce the likelihood of falls and/or assist in reducing the severity of injury.

Box 11.32 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.

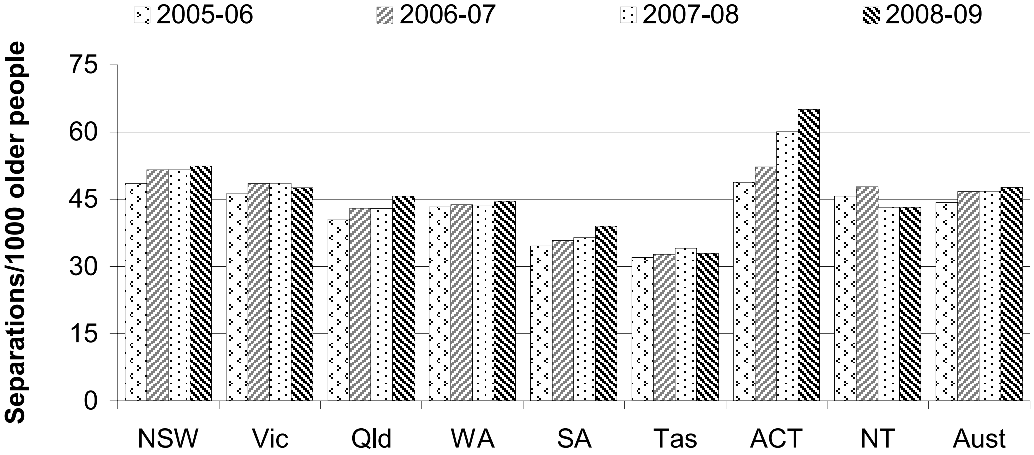
Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In most jurisdictions, age standardised separation rates for older people with injuries due to falls gradually increased in the period 2005-06 to 2008-09 (figure 11.48). Nationally, the separation rate per 1000 older people increased from 44.3 in 2005-06 to 47.7 in 2008-09.

Figure 11.48 Separations for older people with a reported external cause of falls[a, b, c]



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[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.70.

11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Priorities for future reporting on primary and community health services include:

- improving the reporting of dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items
- improving the quality of Indigenous data, particularly Indigenous identification and completeness. Indigenous hospitalisation data for Tasmania and the ACT will be included in future reports. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

The scope of this chapter can also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the Health 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

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the 'Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

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.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella vaccines.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population’ of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the *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 (OMP) — medical practitioners who are not vocationally recognised GPs.
GP-type services	Non-referred attendances by vocationally recognised GPs and OMPs, and practice nurses.
***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 health information systems	Number of PIP-registered practices that have taken up the eHealth PIP incentive, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.

Triage category	The urgency of the patient’s need for medical and nursing care: • category 1 — resuscitation (immediate within seconds) • category 2 — emergency (within 10 minutes) • category 3 — urgent (within 30 minutes) • category 4 — semi-urgent (within 60 minutes) • category 5 — non-urgent (within 120 minutes).
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the *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 List of 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 Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 11A.1	Types of encounter, 2009-10
Table 11A.2	Australian Government real expenditure per person on GPs (2009-10 dollars)
Table 11A.3	Medical practitioners billing Medicare and full time workload equivalent GPs
Table 11A.4	GP-type service use
Table 11A.5	PBS services, 2009-10
Table 11A.6	Use of public dental services, by service type, 2008
Table 11A.7	Alcohol and other drug treatment services, by sector, 2008-09 (number)
Table 11A.8	Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, 2008-09 (number)
Table 11A.9	Services and episodes of healthcare by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, by remoteness category, 2008-09 (number)
Table 11A.10	Proportion of Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported that undertook selected health related activities, 2008-09 (per cent)
Table 11A.11	Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, as at 30 June 2009 (number)
Table 11A.12	Approved providers of PBS medicines, by urban and rural location
Table 11A.13	PBS expenditure per person, by urban and rural location (2009-10 dollars)
Table 11A.14	Availability of GPs by region
Table 11A.15	Availability of female GPs
Table 11A.16	Availability of public dentists (per 100 000 people)
Table 11A.17	Availability of public dental therapists (per 100 000 people)
Table 11A.18	Annual health assessments for older people by Indigenous status
Table 11A.19	Older Indigenous people who received an annual health assessment (per 1000 people)
Table 11A.20	Indigenous people who received a health check or assessment, by age (per 1000 people)
Table 11A.21	Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported. 2008-09 (per cent)
Table 11A.22	Proportion of children receiving a fourth year development health check, 2009-10
Table 11A.23	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 11A.24	Non-referred attendances that were bulk billed by age (per cent)

Community health programs

11.7 References

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12 Health management issues

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' 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 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:

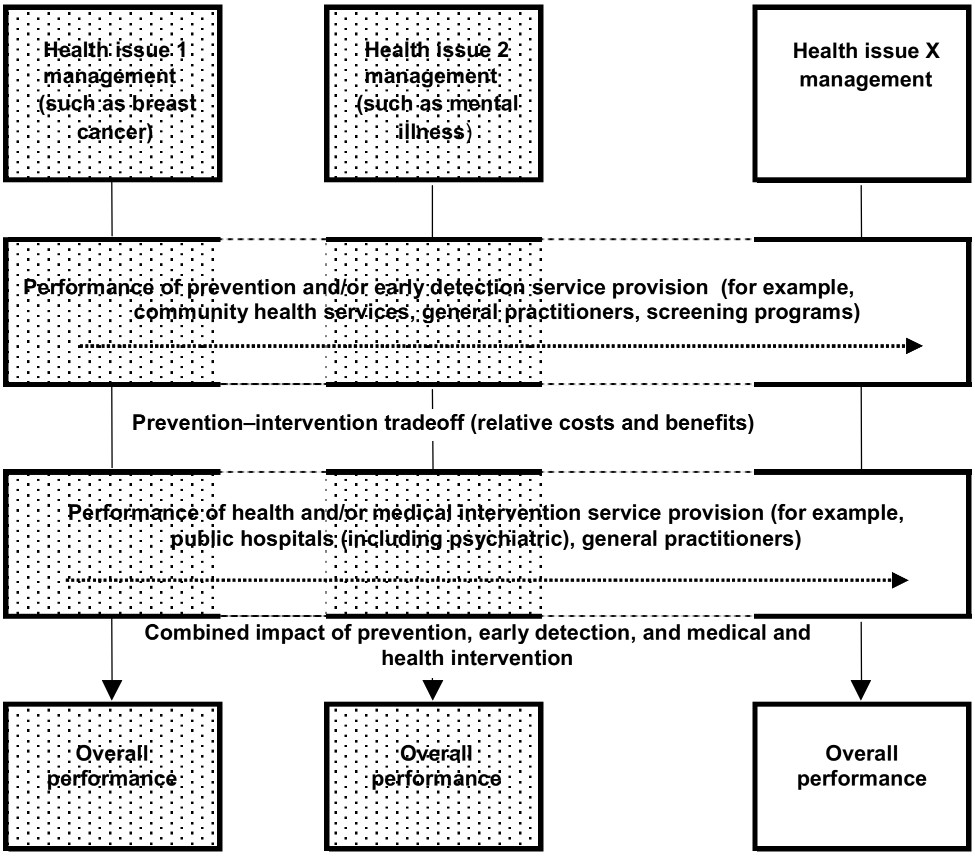
- reporting data for the equity — access indicator ‘Participation rate of women from selected community groups in the BreastScreen Australia Program’, improving its timeliness, as the most recent previous data reported were for the 24 month period 2005 and 2006
- refined reporting on the effectiveness — appropriateness mental health indicator ‘services reviewed against the national standards’, by inclusion of data on additional categories relating to the achievement of standards
- reporting of an additional measure for the effectiveness — quality mental health indicator ‘collection of outcomes information’
- inclusion of the following indicator to align this Report with the *National Healthcare Agreement* (NHA)
  - ‘clinical mental health service use by special needs groups’, which measures access to mental health services by geographic location, Indigenous status and by the Socio-Economic Index for Areas (SEIFA)
- inclusion of some ‘data quality information’ (DQI) documentation.

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’ in this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach is summarised in figure 12.1.

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 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). Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the National Agreements.

12.3 Breast cancer

Profile

Breast cancer is a disease whereby abnormal cells in the lobules (where milk is produced) or the ducts (which carry milk to the nipple) 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 2009). If left untreated, most invasive cancers (tumours) are life-threatening (AIHW 2009). 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.

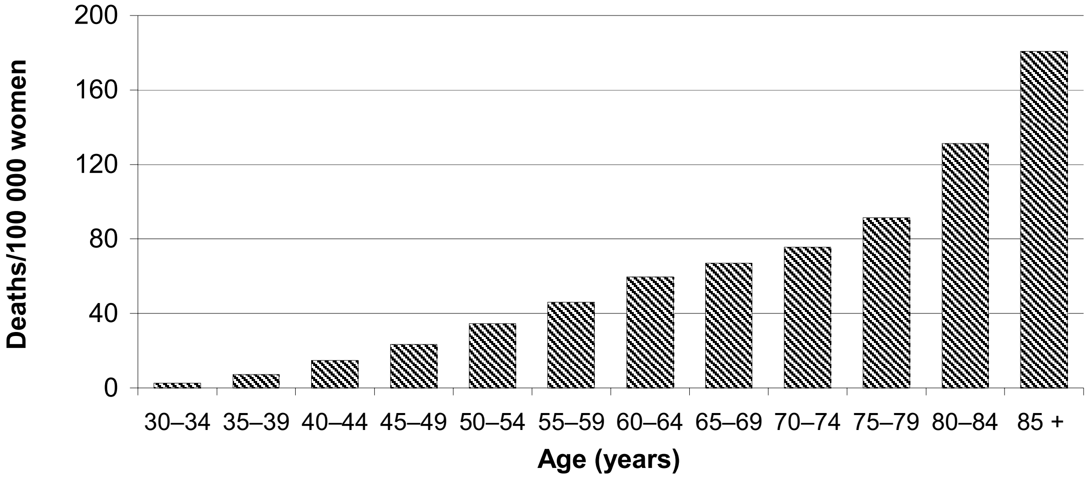
Screening round (first): a woman's first visit to a BreastScreen Australia service.

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 2774 female deaths in 2008, making it one of the most common causes of death from cancer for females (ABS 2010). The strong relationship between age and the mortality rate from breast cancer is shown for the period 2004–2008 in figure 12.2. For women aged 40–44 years at diagnosis the annual average mortality rate over this period was 14.7 per 100 000, whereas for women aged 75–79 years at diagnosis, the annual average mortality rate was 91.4 per 100 000.

Figure 12.2 **Annual average mortality rates from breast cancer, by age group, 2004–2008**

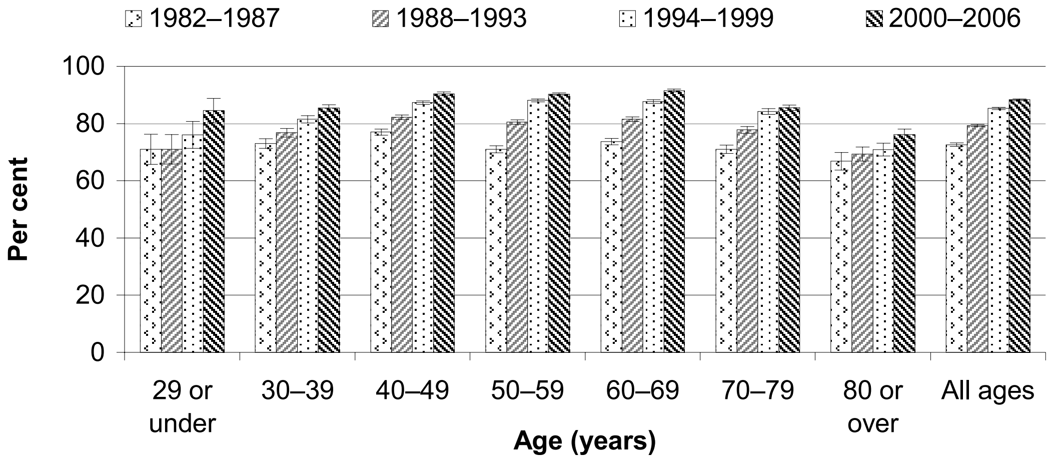


Source: Australian Bureau of Statistics (ABS) (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; table 12A.1.

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

Excluding non-melanoma skin cancer, breast cancer is the most common cancer affecting Australian women (AIHW 2010a). In 2006, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in 11 (AIHW and NBOCC 2009). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 11 555 over the period 1999–2003 to an annual average of 12 299 over the period 2003–2007 (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]

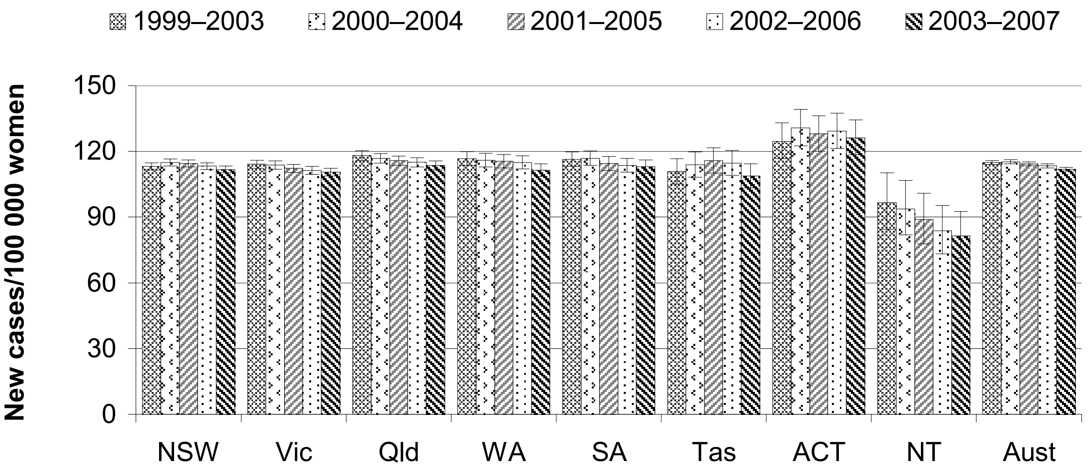
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1999–2003	3 900	2 899	2 147	1 088	990	288	184	59	11 555
2000–2004	4 033	2 948	2 197	1 114	1 011	302	197	60	11 863
2001–2005	4 087	2 970	2 254	1 142	1 011	314	198	61	12 037
2002–2006	4 107	3 007	2 313	1 169	1 023	317	204	59	12 201
2003–2007	4 121	3 048	2 358	1 163	1 037	308	204	60	12 299

[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: Australian Institute of Health and Welfare (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 1999–2003 to the period 2003–2007 fluctuated between 114.9 and 111.8 per 100 000 women.

Figure 12.4 Annual average age standardised incidence rates of breast cancer for women of all ages[a, b]

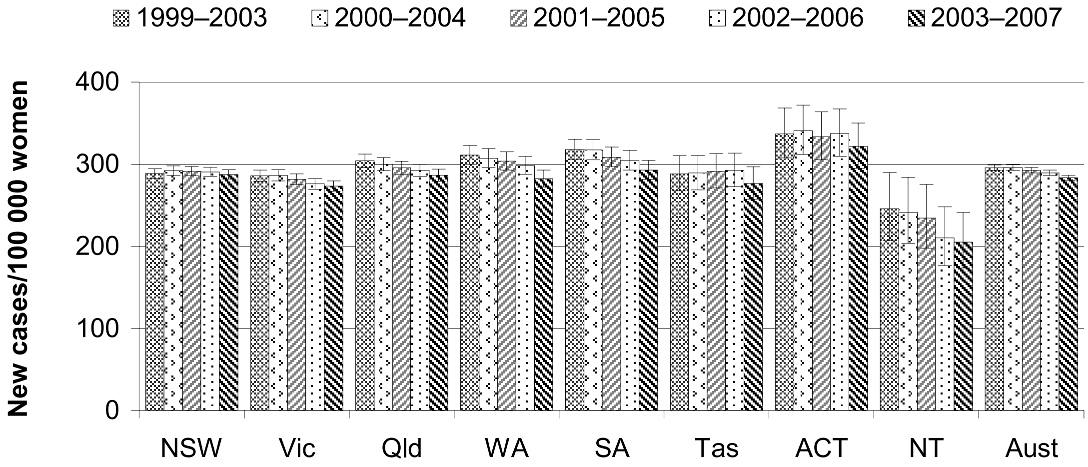


[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

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.

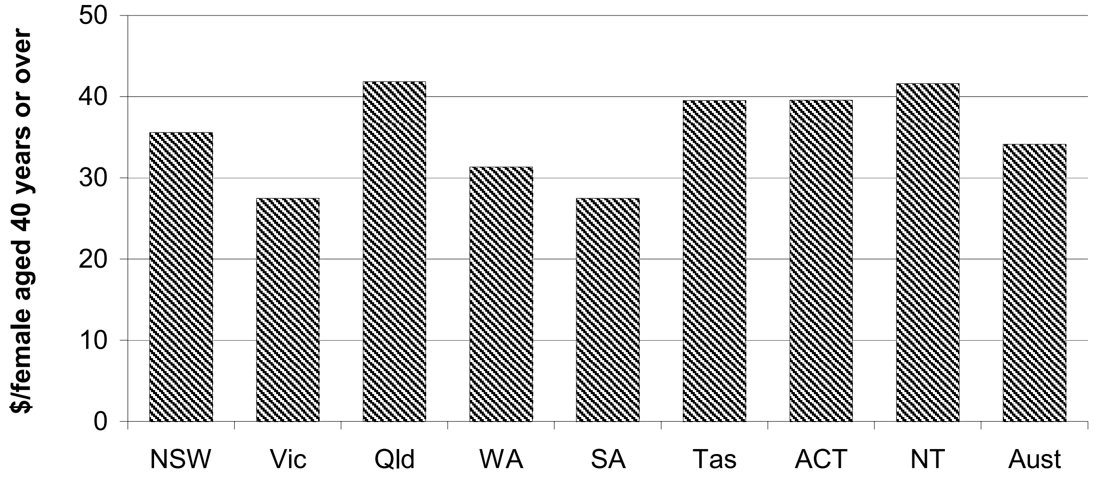
Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The Program includes health promotion activities, information provision, counselling, and data collection across the screening and assessment pathways. Assessment services funded under the BreastScreen Australia Program include fine needle aspiration (FNA) and core biopsies and, in some states and territories, open biopsies.

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 2010 (AIHW 2010a).

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 $175 million on breast cancer screening in 2008-09 (table 12A.6). Nationally, government expenditure on breast cancer screening per woman aged 40 years or over was estimated to be around $34 (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, 2008-09**[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 provides information about the size of the BreastScreen Australia Program. Over 886 000 women in this age group were screened in 2009, compared with around 827 500 in 2005 (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*
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
2009	262 957	190 710	223 079	91 292	72 736	26 773	13 507	5 019	886 073

[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 2008-09 are presented in table 12.3.

Table 12.3 Separation rates for selected AR-DRGs related to breast cancer, public hospitals, 2008-09 (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	3.4	3.3	3.1	2.9	3.3	2.2	3.2	1.3	3.2
Minor procedures for malignant breast conditions	1.0	1.1	1.1	0.8	0.9	0.7	0.8	0.5	1.0
Skin, subcutaneous tissue and breast plastic operating room procedures	2.9	3.7	3.8	3.4	5.8	3.2	2.2	2.2	3.6
Other skin, subcutaneous tissue and breast procedures	11.9	23.5	17.6	20.1	20.8	14.4	7.5	12.4	17.4
Malignant breast disorders (Age >69 W CC) or W (Catastrophic or Severe CC)	0.6	0.6	0.4	0.5	0.8	0.5	0.6	np	0.5
Malignant breast disorders (Age>69 W/O CC) or W/O (Catastrophic or Severe CC)	0.2	0.6	0.3	1.8	0.7	0.4	0.4	np	0.5
All conditions[c]	**2 074.6**	**2 507.3**	**1 960.1**	**2 059.6**	**2 251.4**	**1 853.9**	**2 412.4**	**4 248.6**	**2 193.0**

W=with. W/O=without. CC=complications and co-morbidities. [a] Care needs to be taken when comparing jurisdictions because admission practices vary. [b] AR-DRG version 5.2. [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 2008. **np** Not published.

Source: AIHW (2010) *Australian hospital statistics 2008-09*, Cat. no. HSE 84; 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**

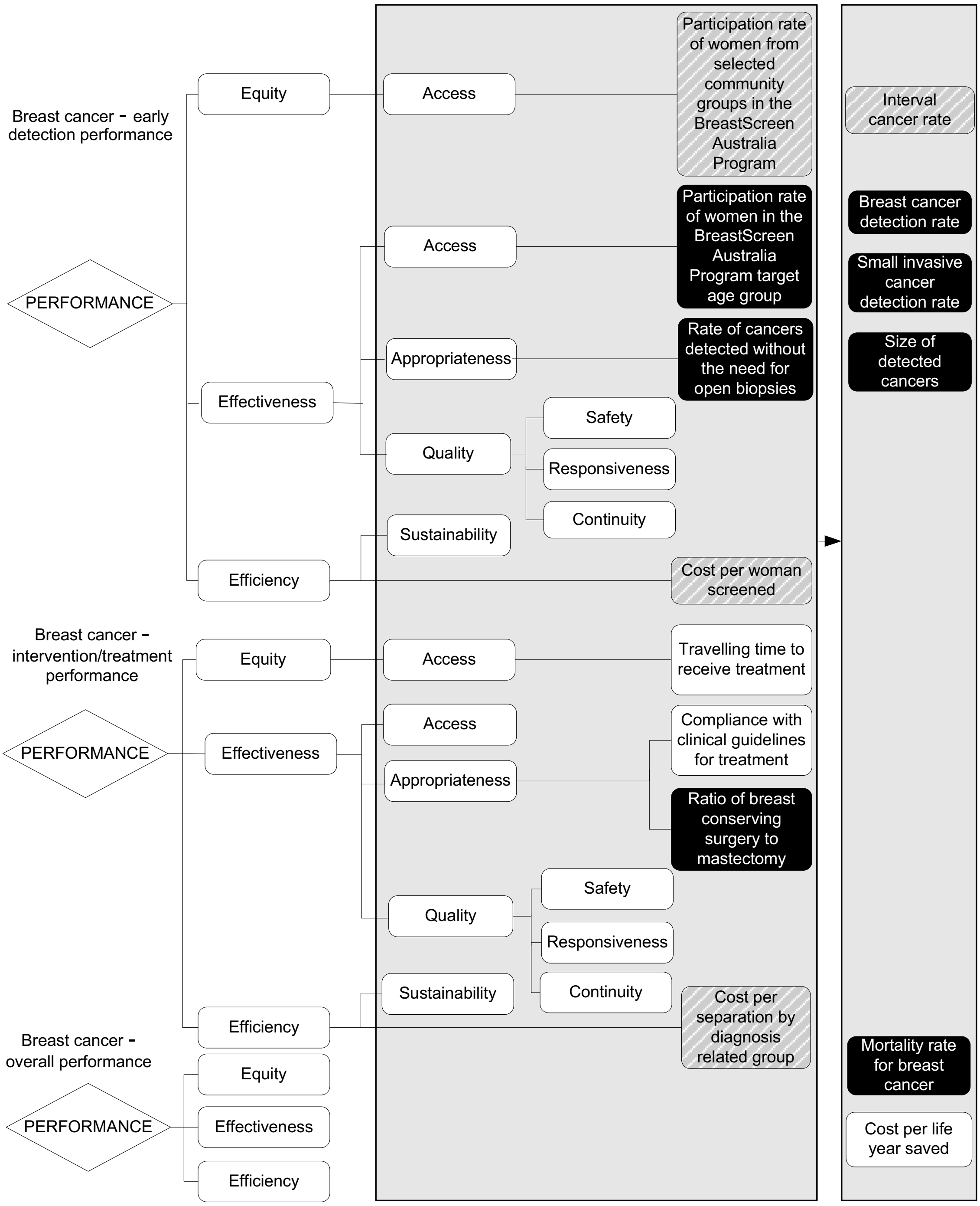
The objectives for breast cancer detection and management are:

- 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 2011 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 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

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 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.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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 2008 and 2009, the national age standardised participation rate for Indigenous women aged 50–69 (36.5 per cent) was below the total participation rate in that age group (55.2 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records. For NESB women for the same 24 month period and age group, the national participation rate of 47.6 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, and in the collection of residential postcodes data.

Table 12.4 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2008 and 2009 (24 month period) (per cent)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous[c]	37.0	27.4	48.5	28.4	32.8	51.7	49.1	24.0	36.5
NESB[d]	52.7	32.6	68.9	65.1	55.4	34.8	15.7	24.7	47.6
Major cities and inner regional[e]	53.4	53.3	57.2	56.6	58.2	58.4	53.7	..	54.9
Outer regional, remote and very remote[e]	56.2	58	62.8	55.7	60.7	55.8	..	41.1	57.7
All women aged 50–69 years	54.0	53.0	58.4	56.7	58.6	57.4	53.8	41.3	55.2

[a] First and subsequent rounds. [b] Rates are standardised to the 2001 Australian population standard. [c] Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. [d] NESB is defined as speaking a language other than English at home. [e] Remoteness areas are classified according to the Australian Standard Geographical classification (ASGC). The ASGC is a measure of the remoteness of a location from the services provided by large towns or cities. Not all remoteness areas are represented in each State or Territory. .. Not applicable.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2009*, Cat. no. 3201.0; ABS (unpublished) *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *2006 Census of Population and Housing*; AIHW (unpublished) derived from State and Territory data; tables 12A.9–12A.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.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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 55.2 per cent in the 24 month period 2008 and 2009. At a national level, the participation rate has been relatively steady since the 24 month period 2004 and 2005, 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] For the 2008–2009 reference period, women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction except the ACT (92.2 per cent). [c] The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. [d] Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2009*, 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.

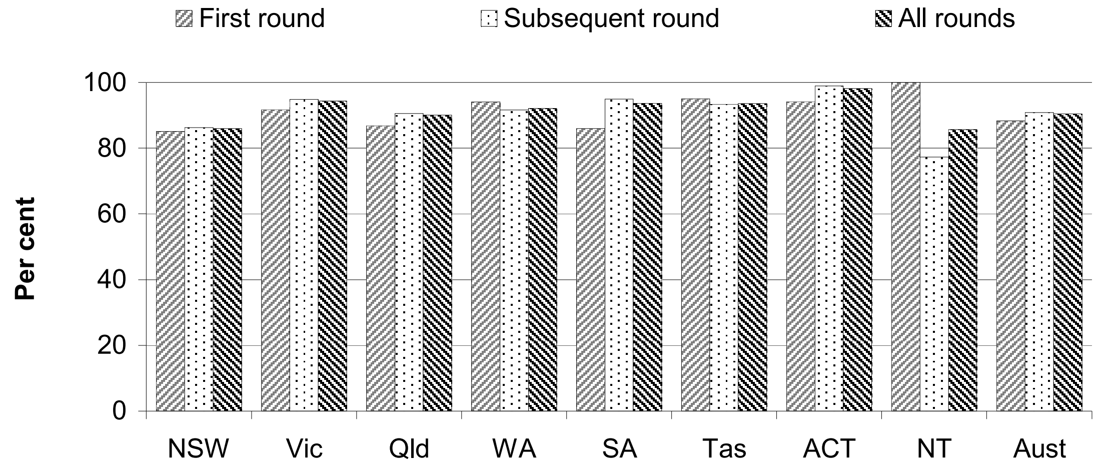
Data quality information for this indicator is under development.

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 cancer 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 2009, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 88.3 per cent nationally. For women attending a subsequent round the rate was 90.9 per cent nationally, 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, 2009



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.

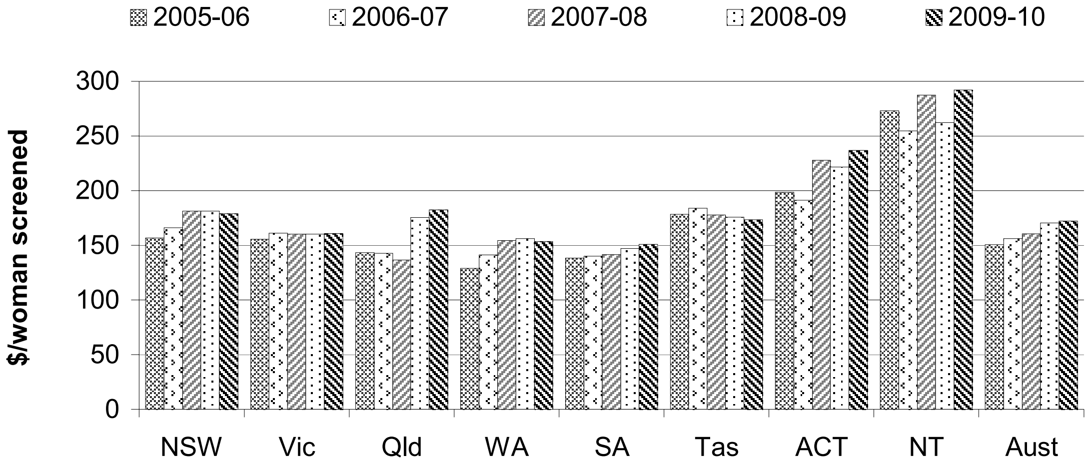
Caution should be used when interpreting this indicator. While a low or decreasing cost per woman screened can reflect high or increasing efficiency, it can also reflect low or decreasing quality of service. Cost per women screened can also be influenced by characteristics of the target population, for example, the number and type of barriers to service access.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

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 2009-10 was around $172.

Figure 12.10 **Real cost per woman screened, BreastScreen Australia services (2009-10 dollars)[a, b, c]**



[a] Real expenditure based on the ABS gross domestic product price deflator (2009-10 = 100) (table AA.26). [b] Data for NSW do not include subsidies. [c] ACT historical data differ from those published in previous reports due to a methodological change applied to data from 2007-08 onwards, therefore, these data are not comparable to data for years up to and including 2006-07.

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 2011 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 2011 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.

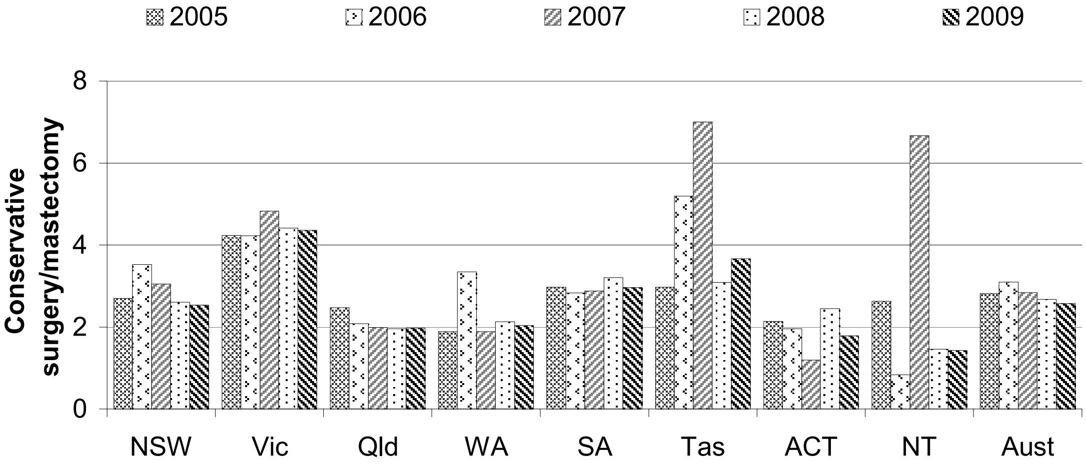
Data quality information for this indicator is under development.

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 2009, the ratio of conserving surgery to mastectomy averaged 2.6:1 nationally, but varied across jurisdictions (figure 12.11).

Figure 12.11 **Ratio of conserving surgery to mastectomy**[a, b]



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[a] Applies for women of all ages diagnosed by the Breastscreen 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.

Data quality information for this indicator is under development.

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 $7193 per separation in 2008-09 and minor procedures for malignant breast conditions cost $3468 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, 2008-09 (dollars)**[a, b, c, d, e]

AR-DRG	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major procedures for malignant breast conditions									
	6 306	7 000	7 843	9 757	6 121	7 682	7 071	9 433	7 193
Minor procedures for malignant breast conditions									
	2 941	3 244	4 198	3 937	3 816	3 663	3 417	2 874	3 468
Malignant breast disorders (Age >69 W CC) or W (Catastrophic or Severe CC)									
	6 087	4 459	8 546	6 085	5 329	6 777	8 942	np	5 938
Malignant breast disorders (Age>69 W/O CC) or W/O (Catastrophic or Severe CC)									
	2 115	3 219	2 647	1 725	2 188	4 846	1 583	np	2 406

W = with. W/O = without. CC = complications and co-morbidities. **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 5.2. **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** Relatively low numbers of separations in smaller State/Territories (Tasmania, the NT and the ACT) make comparisons of average cost per patient with other jurisdictions unreliable. **e** In accordance with NHCDC method, depreciation and some other capital costs are included in these figures, except in the case of Victoria which does not include depreciation. **np** Not published.

Source: DoHA (2010) *National Hospital Cost Data Collection Cost Report Round 13 (2008-09), v5.2*; table 12A.18.

Outcomes

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

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 low or decreasing 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.

Data quality information for this indicator is under development.

An interval cancer is an invasive breast cancer diagnosed in the interval following a negative breast cancer screening result (that is, no cancer detected) and before the next scheduled screening examination. The interval is a 24 month period in the case of routine screening, and a shorter period in the case that more frequent screening is recommended (AIHW 2010a). The cancer may or may not have been present at the most recent screening episode.

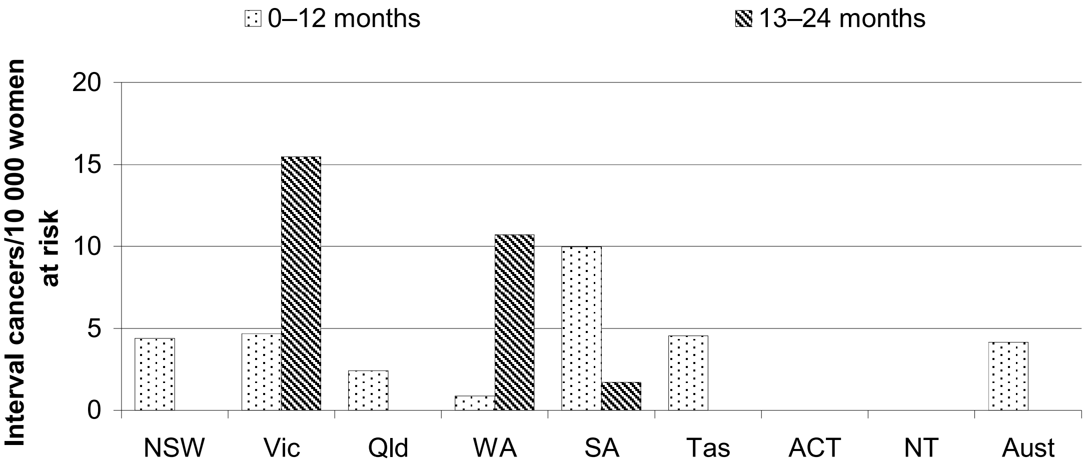
There is a time lag in data availability for this indicator. Interval cancer can be detected up to 24 months following a routine negative screening episode. It can then be several months before the diagnosis of invasive cancer is recorded in the cancer registry. BreastScreen Australia programs identify 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 2006.

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.

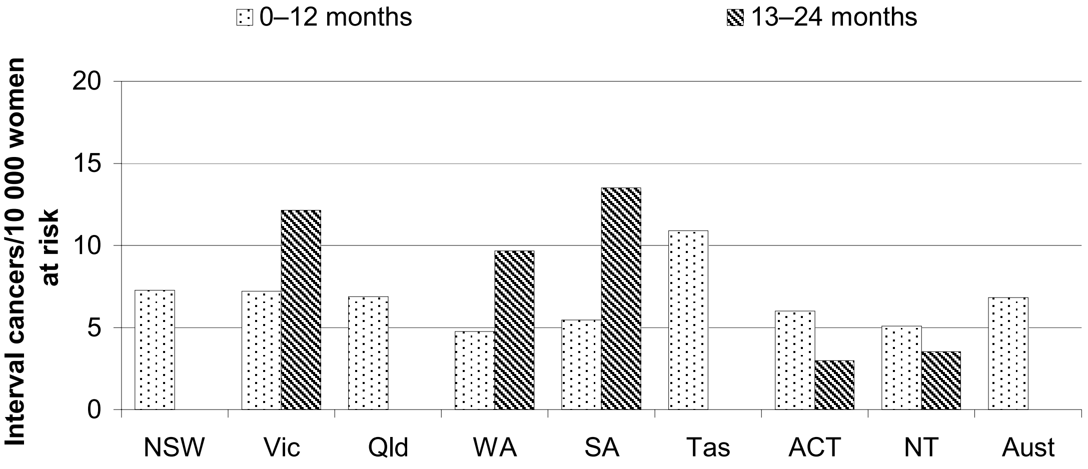
Figure 12.12 presents the age standardised interval cancer rate by screening round and time since screened for women aged 50–69 years.

Figure 12.12 **Age standardised interval cancer rate, women aged 50–69 years, 2006**[a, b, c]

First screening round



Subsequent screening round



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[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 2008. [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] No interval cancers were reported for women aged 50–69 years in the ACT and the NT in the first round for 0–12 and 13–24 months. Data were not available for NSW, Queensland or Tasmania in the first or subsequent round for 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 or increasing rate of breast cancer detection is desirable in terms of the effectiveness of breast screening services (although a high or increasing *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.

Data quality information for this indicator is under development.

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.

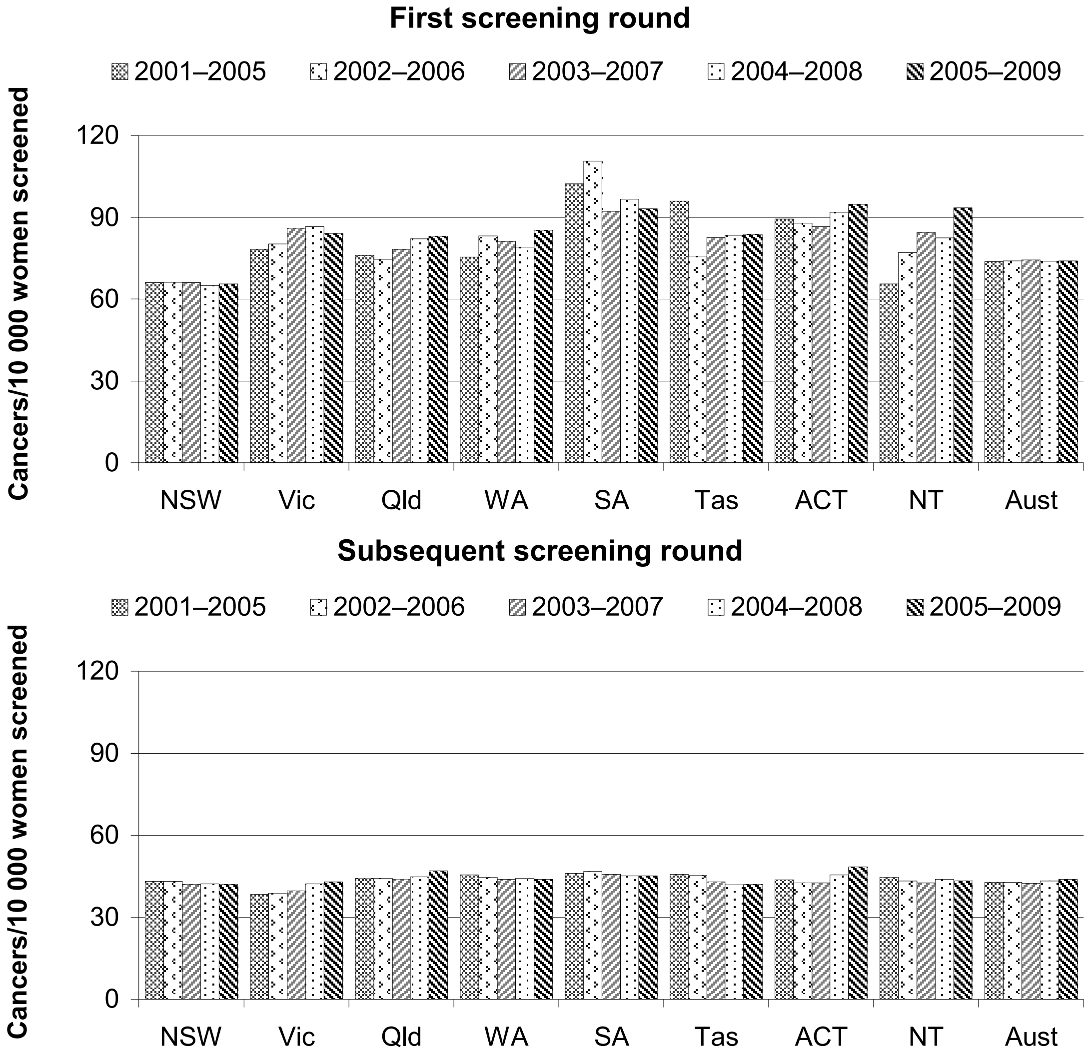
BreastScreen Australia National Accreditation Standards for detection rates are based on expected Australian rates (BreastScreen Australia 2004):

- 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 2005–2009, the age standardised invasive breast cancer detection rate was 74.1 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 43.9 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]



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[a] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 2008.

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 or increasing 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.

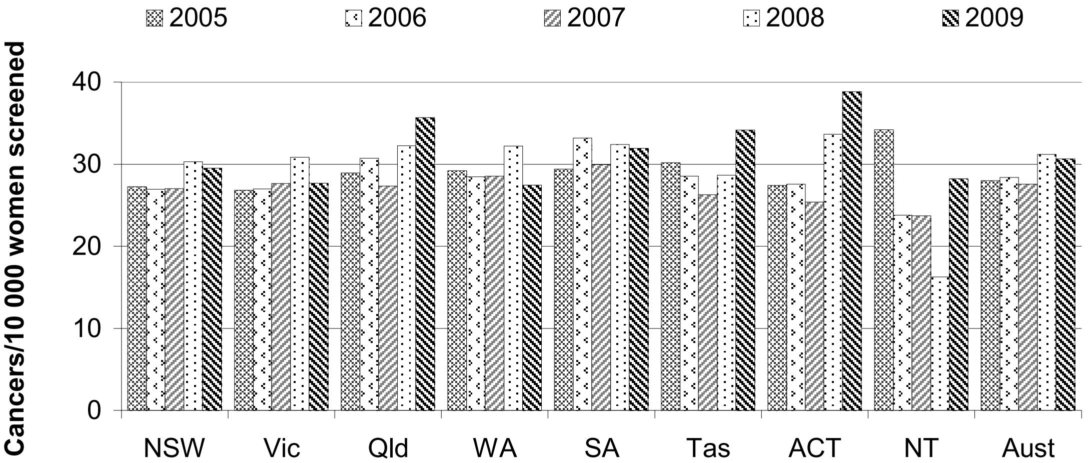
Data quality information for this indicator is under development.

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 2009 are reported in figure 12.14. The rate for Australia was 30.6 cancers per 10 000 women aged 50–69 years attending screening in 2009 — 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 millimetres 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 2008.

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 or increasing rates of detection of small cancers, relative to rates of detection of large cancers, are desirable.

Data reported for this indicator are comparable.

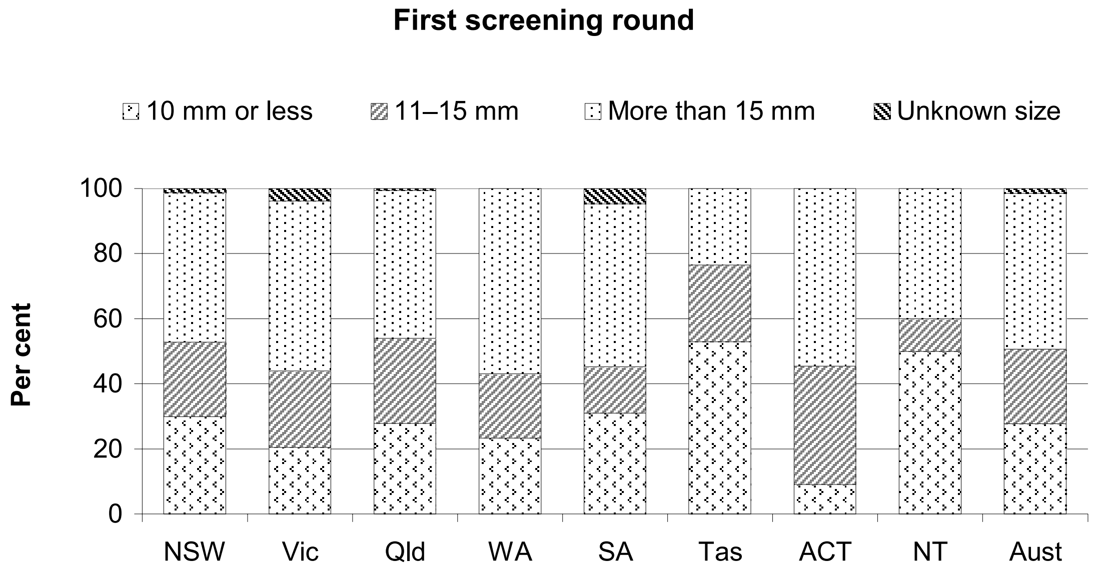
Data quality information for this indicator is under development.

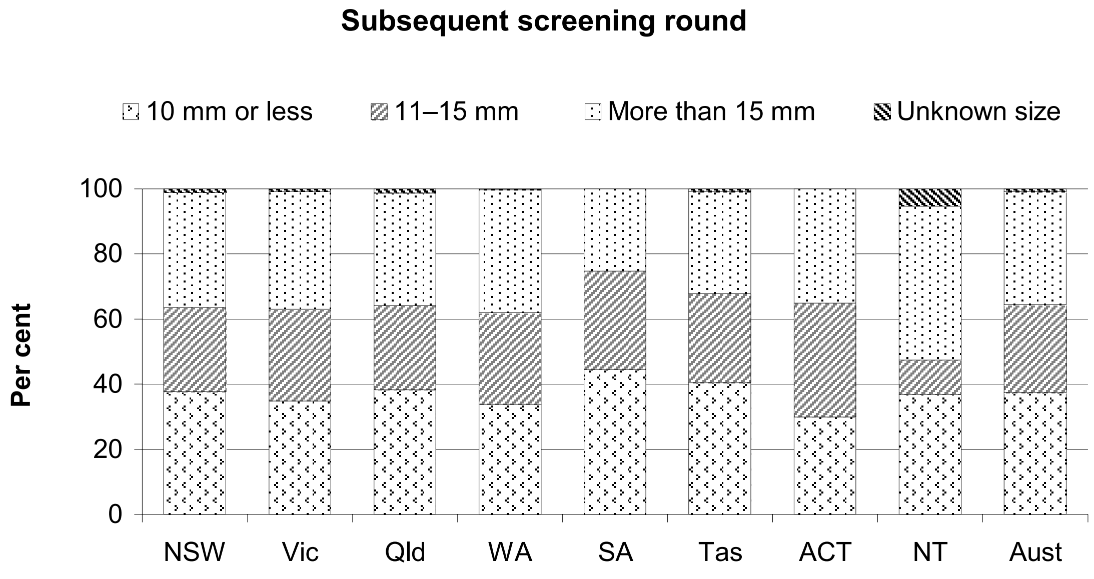
Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, as well as some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998; DoHA 2009a).

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 2009.

Figure 12.15 **Detected invasive cancers, women aged 40 years or over, by screening round and size of cancer 2009**[a, b, c]





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[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 with other jurisdictions.

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 low or decreasing mortality rate for breast cancer is desirable.

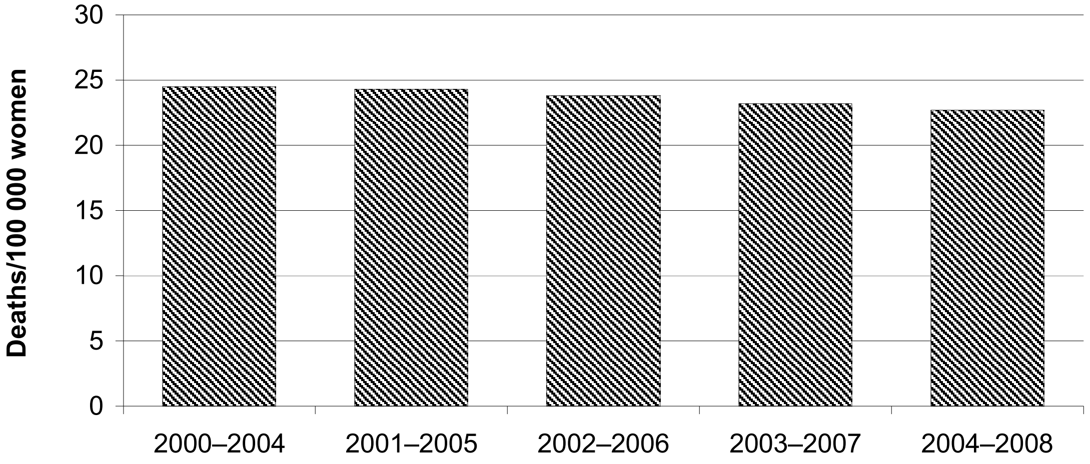
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

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 24.5 per 100 000 women in the period 2000–2004 to 22.7 per 100 000 women in the period 2004–2008 (figure 12.16).

Figure 12.16 **Annual average age standardised mortality rate from breast cancer, all ages**[a, b]

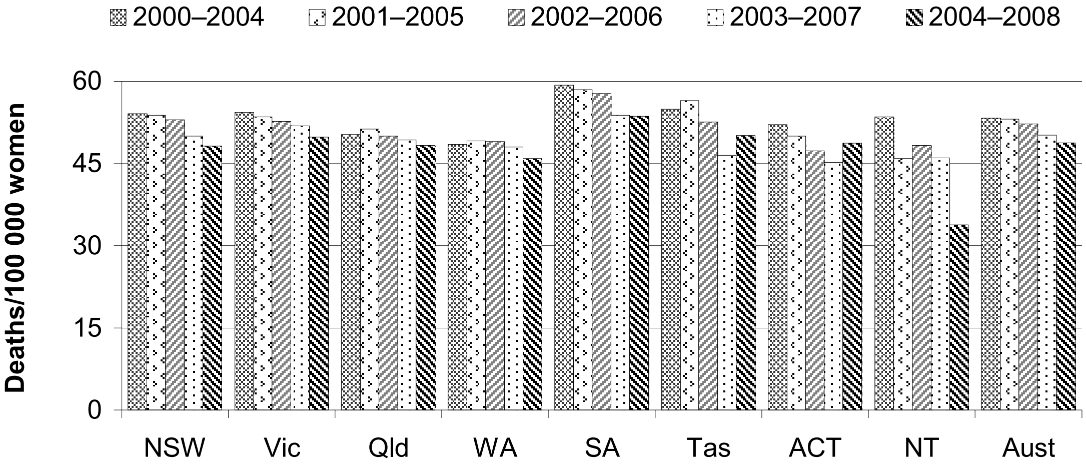


[a] Age standardised to the Australian population at 30 June 2001. [b] Historical data may differ from previous reports due to a change in data provider — data for reference periods to 2002–2006 were previously provided by the AIHW. Variation in methodology between data providers may result in slightly different data.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; table 12A.1.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 53.3 per 100 000 women over the period 2000–2004 to 48.8 per 100 000 women over the period 2004–2008 (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] Historical data may differ from previous reports due to a change in data provider — data for reference periods to 2002–2006 were previously provided by the AIHW. Variation in methodology between data providers may result in slightly different data.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; 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 2011 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 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 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 2007 *National Survey of Mental Health and Wellbeing* (NSMHWB). The term mental disorder is used when referring directly to NSMHWB data (as it is used in that survey). Elsewhere, the term mental illness is used to describe the illness associated with mental disorders.

The NSMHWB 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 NSMHWB, 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 NSMHWB 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.68). 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 NSMHWB, in 2007, people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (table 12A.23). Data collected under the NSMHWB on the impact of mental illness on an individual’s functioning and quality of life relating to level of disability, days out of role and suicidal behaviours are also included in table 12A.23.

According to the 2007-08 National Health Survey (NHS), a significantly higher proportion of females reported high/very high levels of psychological distress than males in 2007-08 (14.4 ± 1.1 per cent compared with 9.6 ± 0.9 per cent) (table 12A.24). The proportion of high/very high levels of psychological distress was also higher for people aged 18–64 years, than for people aged 65 years or over (table 12A.24). 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 people reported high levels of psychological distress (AHMAC 2008). This was more than twice the proportion for non-Indigenous adults (13 per cent).

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 with 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). 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 (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers)
- Pharmaceutical Benefits Scheme (PBS) funded mental health related medications
- other specific programs designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health related services through the Medicare Safety Net, the Department of Veteran's Affairs (DVA) and the Private Health Insurance Premium Rebates.

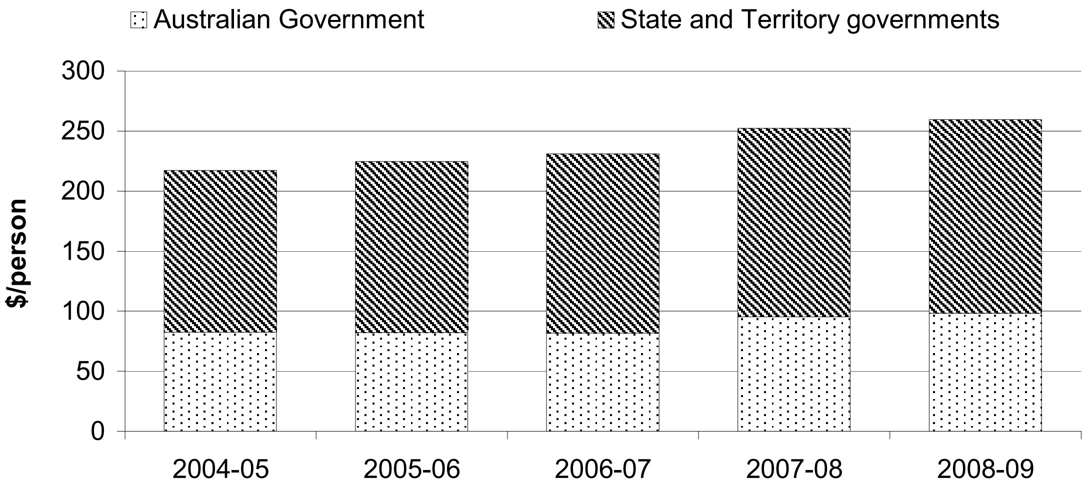
Until 1 July 2009, the Australian Government provided State and Territory governments with base grants and specific funding to undertake reforms in the directions advocated by the *National Mental Health Strategy* (NMHS) for mental health services under the Australian Health Care Agreements (AHCA) (DoHA 2007). The Australian Government now provides a special purpose payment (SPP) to State and Territory governments under the new NHA. According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have budget flexibility to allocate funds within that sector as they deem appropriate.

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 $5.6 billion was allocated to mental health services in 2008-09 (tables 12A.28 and 12A.29). State and Territory governments made the largest contribution ($3.5 billion, or 62.1 per cent), although this included some Australian Government base grant funds under the AHCA (table 12A.29). The Australian Government spent $2.1 billion or 37.9 per cent of total mental health services government recurrent expenditure (table 12A.28). Real Australian Government expenditure per person increased from an average of $83 in 2004-05 to $98 in 2008-09. Nationally, average State and Territory governments' expenditure per person in 2008-09 was $161, an increase from $135 in 2004-05 (figure 12.18).

Figure 12.18 **Real government recurrent expenditure on mental health services per person (2008-09 dollars)[a, b]**



[a] Real expenditure for all years (2008-09 dollars), using the implicit price deflator for non-farm gross domestic product (table 12A.78) 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.77). [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.

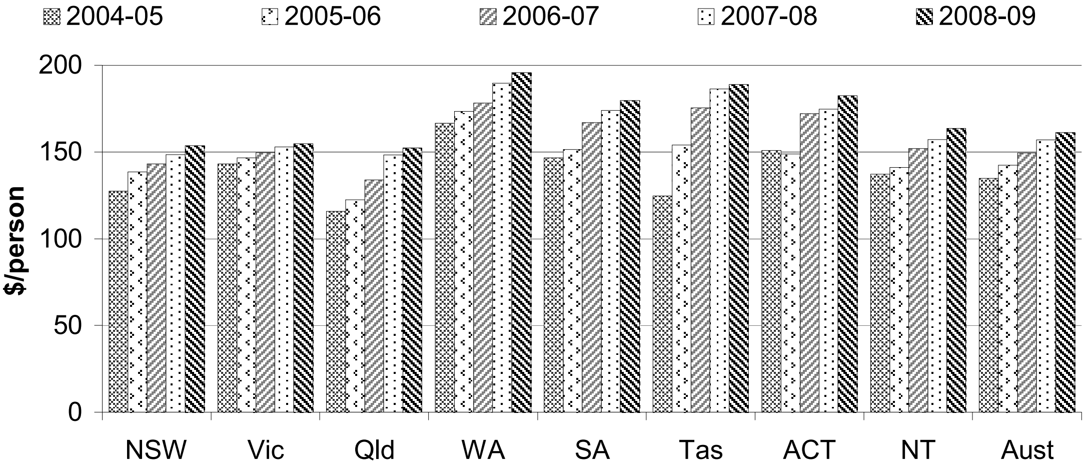
The largest component of Australian Government expenditure on mental health services in 2008-09 was expenditure under the PBS for mental health-related medications ($742.2 million). Expenditure on PBS mental health-related medications decreased by an annual average rate of 0.5 per cent between 2004-05 and 2008-09 and decreased from 45.2 per cent of Australian Government expenditure on mental health services in 2004-05 to 34.9 per cent in 2008-09 (table 12A.28). The decrease in expenditure on mental health-related medications 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 2008-09, the next largest component of Australian Government expenditure for mental health services was MBS payments for consultant psychiatrists (11.7 per cent) followed by expenditure on MBS payments for clinical psychologists and other allied health professionals (11.5 per cent). The residual included DoHA managed programs and initiatives (9.2 per cent), GPs (8.1 per cent), Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) managed programs and initiatives (6.7 per cent), DVA managed programs and initiatives (7.3 per cent), grants to states and territories under the

AHCA (3.7 per cent), private health insurance premium rebates (2.8 per cent) research (3.0 per cent) and the National Suicide Prevention Program (1.0 per cent) (table 12A.28).

Real expenditure per person at State and Territory governments' discretion has increased over time (figure 12.19). Data in figure 12.19 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. The data are referred to as expenditure 'at State and Territory governments' discretion'. Data on NMHS and DVA funding are reported in table 12A.33. The data in figure 12.19 also exclude depreciation. Estimates of depreciation are presented in table 12A.32. Data on expenditure 'at State and Territory governments' discretion' excluding revenue from other sources (including patient fees and reimbursement by third party compensation insurers) are presented in table 12A.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 over time.

Figure 12.19 **Real recurrent expenditure at the discretion of State and Territory governments (2008-09 dollars)**[a, b, c]



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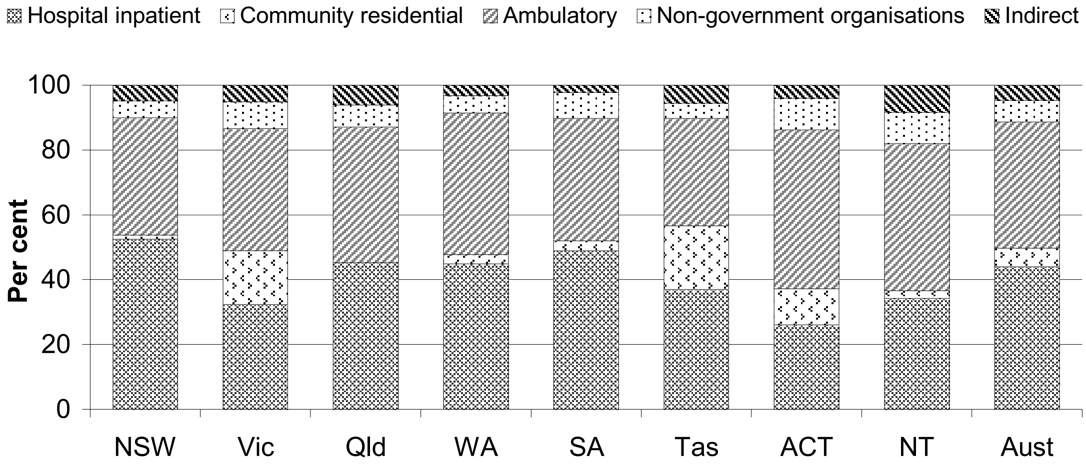
[a] Real expenditure (2008-09 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.77). [b] Estimates of State and Territory governments' spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government 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 12.20 shows how State and Territory governments' recurrent expenditure was distributed across the range of mental health services in 2008-09.

Figure 12.20 State and Territory governments’ recurrent expenditure, by service category, 2008-09[a, b, c, d]



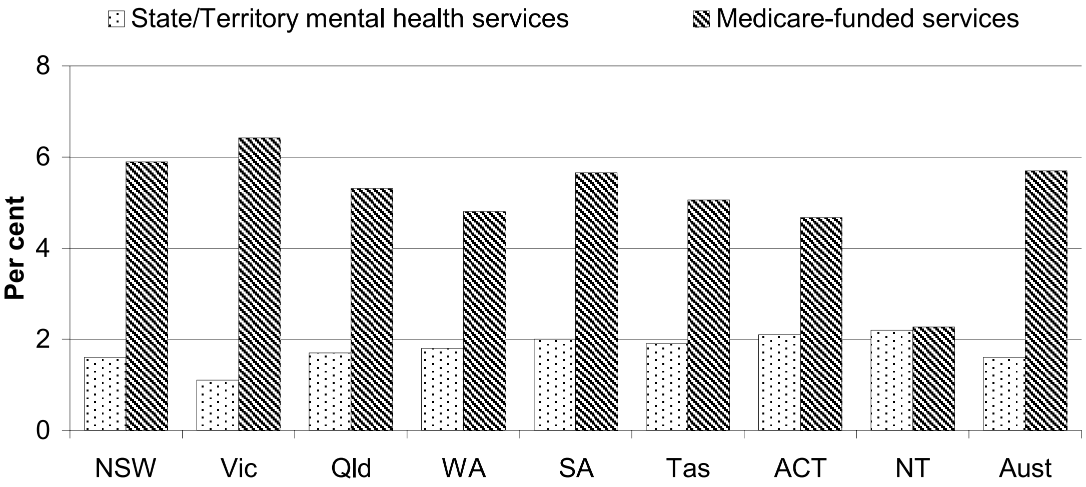
[a] Includes all State and Territory governments’ expenditure on mental health services, regardless of source of funds. [b] Depreciation is excluded. Depreciation estimates are reported in table 12A.32. [c] The differential reporting of clinical service providers and non-government organisations artificially 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 2008-09, 5.7 per cent and 1.6 per cent of the total population received Medicare-funded and State and Territory clinical mental health care services, respectively (figure 12.21). These data need to be interpreted carefully. Data for State and Territory mental health services are based on people who received one or more service contacts provided by public sector community mental health services (most people who have received a State and Territory inpatient service have also received a service contact with a public sector community mental health service). States and territories also differ in the way they count the number of people under care (AHMC 2011).

Figure 12.21 **Population receiving clinical mental health services, by service type, 2008-09**[a, b, c]

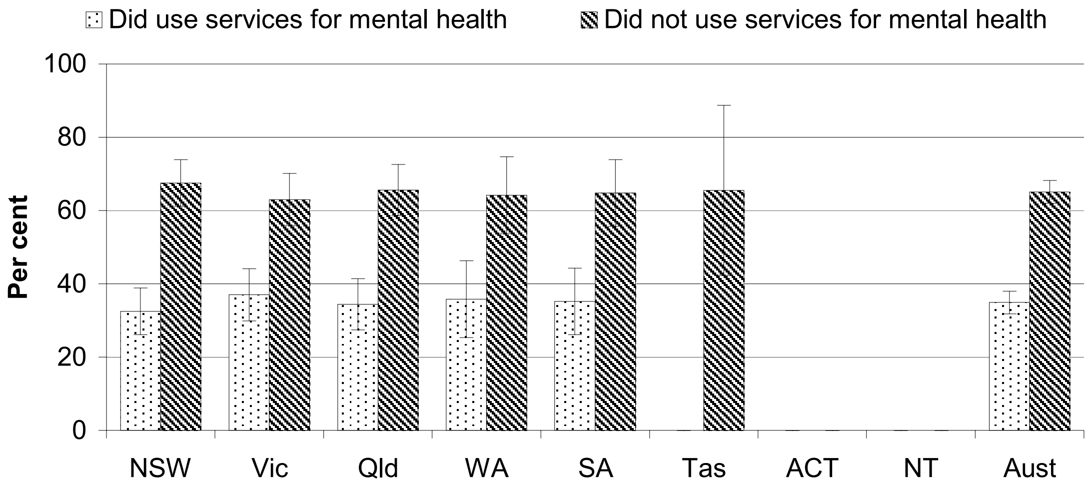


a Rates are age-standardised to the Australian population as at 30 June 2001. **b** For state and territory mental health services, counts are of people receiving one or more service contacts provided by public sector community mental health services. SA and Tasmania submitted data that were not based on unique patient identifiers or data matching approaches. Therefore caution needs to be taken when making jurisdictional comparisons. **c** MBS services are those specific mental health services provided under Medicare by psychiatrists, clinical psychologists, GPs, other allied health services. The specific Medicare items included are detailed in table 12A.37. Persons seen by more than one provider type are counted only once.

Source: State and Territory governments (unpublished) CMHC data; DoHA (unpublished) Medicare Statistics data; 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 12.22). 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 12.22 **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 NSMHWB,* Cat. no. 4326.0; table 12A.35.

According to the NSMHWB, 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 with 40.2 per cent of those with moderate mental disorders and 17.9 per cent of people with mild mental disorders (Slade *et al.* 2009). For people who did not use services, the NSMHWB 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

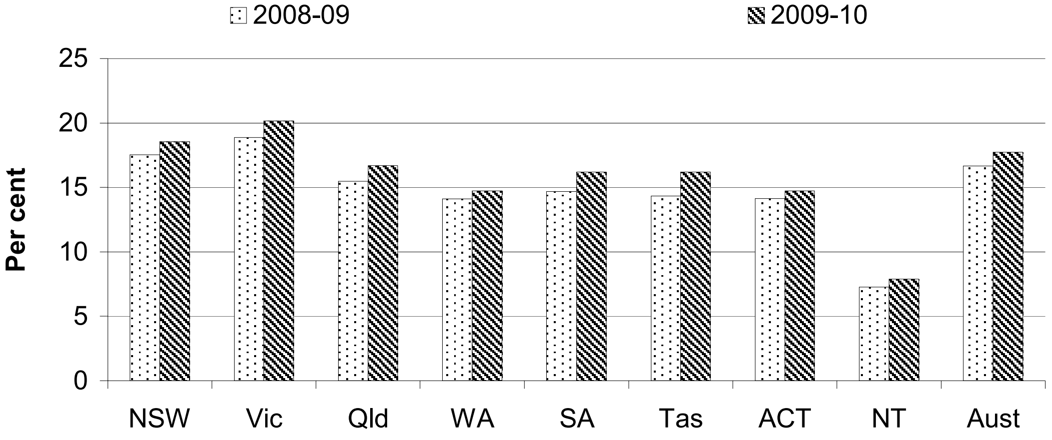
MBS-subsidised mental health services are mental health services provided by a GP, psychiatrist or an allied health professional (psychologist, social worker, occupational therapist, mental health nurse and Aboriginal health worker) on a fee-for-service basis that are partially or fully funded under Medicare. GPs provide mental health-related services under specific mental health MBS items (GP Mental

Health Care and Focussed Psychological Strategies) and through other mental health-related encounters, such as through a standard surgery consultation.

In 2008-09, there were 2.5 million services provided by psychologists, 2.0 million services provided by psychiatrists, 1.6 million services provided by GPs (under specific mental health MBS items) and around 150 000 services provided by other allied health professionals (table 12A.40). This was equivalent to 115.0 psychologist services, 90.9 psychiatrist services, 73.9 GP services and 6.9 other allied health services per 1000 people in the population (table 12A.40).

The proportion of the estimated population with a mental illness who had a GP mental health treatment plan was 17.7 nationally in 2009-10 (figure 12.23). Data on the age-specific numbers of people who had a GP mental health treatment plan are in table 12A.39.

Figure 12.23 **People with a mental illness who had a GP mental health treatment plan**[a, b, c]



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[a] People with a mental illness are those aged 16–84 with selected 12-month mental disorders as captured through the 2007 NSMHWB. People with a selected 12-month mental disorder experienced symptoms in the 12 months prior to the survey interview. [b] Rates are age standardised to the Australian population aged 16–84 years as at 30 June 2001. [c] As of 1 July 2009, a diagnosis of mental illness was required to access these plans, and the item name changed to GP mental health treatment plan. During 2008-09, a diagnosis of mental illness was not required to access a GP mental health care plan. Therefore 2008-09 and 2009-10 data are not directly comparable. As of 1 January 2010, a new MBS item has been introduced for patients of GPs who have not undertaken mental health skills training. Changes have been made to the existing MBS item to allow patients of GPs who have undertaken mental health skills training to access a higher rebate. As both of these items relate to the preparation of a GP mental health treatment plan they are both included in 2009-10 data.

Source: DoHA (unpublished) Medicare Statistics data; ABS (unpublished) *Estimated Residential Population*; ABS (unpublished) *2007 NSMHWB*; table 12A.38.

Information on GP mental health-related encounters is also available from the *Bettering the Evaluation and Care of Health* (BEACH) survey data. Data for the BEACH survey are collected from a sample of 1000 GPs. Under the BEACH, a mental health-related encounter is defined as one at which a mental health-related problem is managed.

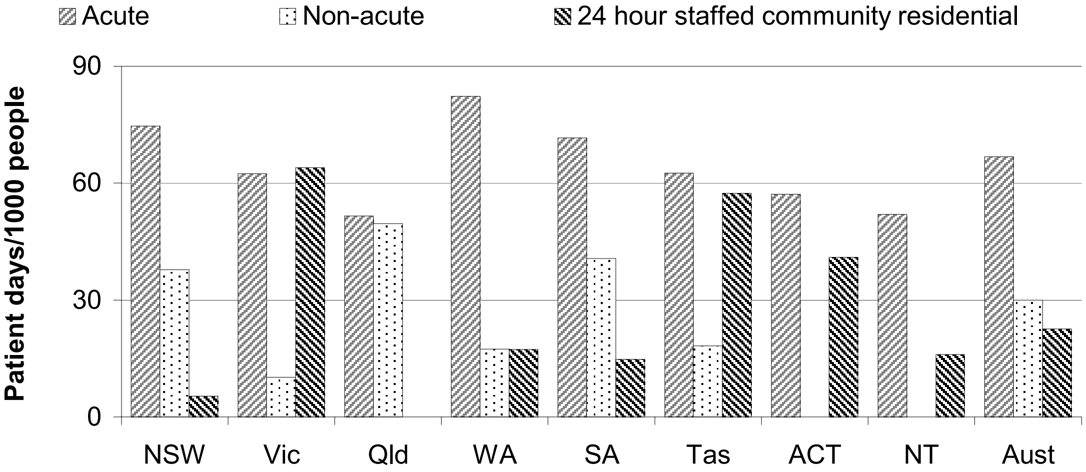
In 2008–09, 11.7 per cent of all GP encounters reported for the BEACH data were mental health-related encounters. The BEACH survey asks GPs to record an MBS item for each encounter. These encounters were most often recorded as standard surgery consultations (over 90 per cent of all encounters for which an MBS item was recorded). The GP mental health-specific MBS items represented 9.2 per cent of total MBS items recorded for mental health-related encounters in the 2008–09 BEACH survey (AIHW 2010b).

In 2008-09, on average 12.4 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 (4.3 per 100 GP encounters). Anxiety (1.9 per 100 GP encounters) and sleep disturbance (1.6 per 100 GP encounters) were the next most common psychological problems managed. In 2008-09, depression was the fifth most frequently managed problem by a GP (Britt *et al.* 2009). 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 12.24 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 12.24, but other types of community services are not covered.

Figure 12.24 **Accrued mental health patient days, 2008-09**[a, b]



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[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.41.

Other measures of service activity include separations for admitted patient care, episodes for community residential care and contacts for community mental health services. The latest available data on this service activity are:

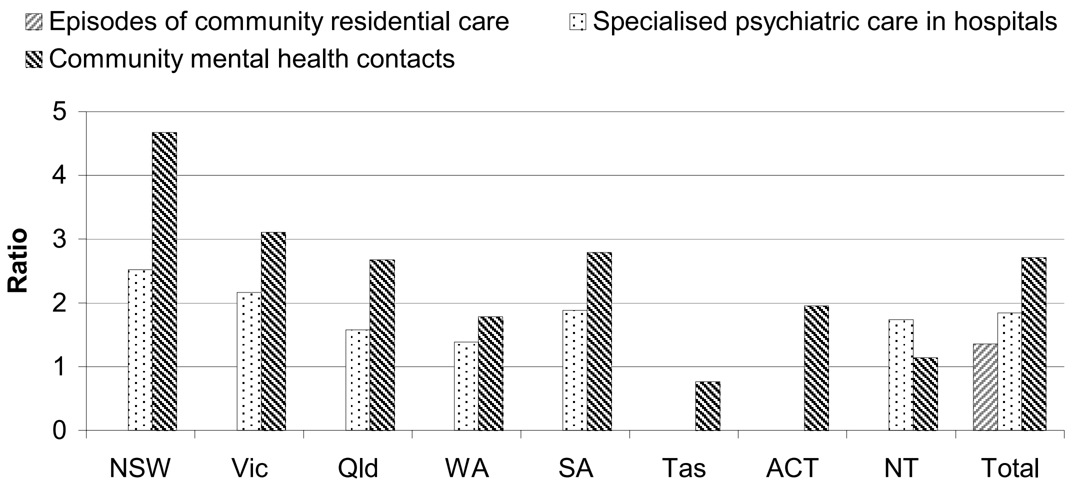
- in 2007-08, there were 78 919 separations with specialised psychiatric care in public acute hospitals and 12 723 specialised psychiatric care separations in public psychiatric hospitals (table 12A.42). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (21.9 per cent in public acute hospitals and 22.3 per cent in public psychiatric hospitals) (table 12A.42). There were a further 3982 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 1145 in public psychiatric hospitals (AIHW 2010b)
- in 2007-08, there were 3222 episodes of community residential mental health care. Schizophrenia accounted for the largest proportion of these episodes as a principal diagnosis (53.4 per cent) (AIHW 2010b)
- in 2008-09, there were 6.3 million community mental health care patient contacts, equivalent to 291.7 contacts per 1000 people (table 12A.53). 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. Data on the number and rate of contacts for 2007-08 are in table 12A.43. For those contacts where a principal diagnosis was available, the largest proportion was for schizophrenia (31.5 per cent) (AIHW 2010b).

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 1.4 times more likely to have an episode of community residential care, 1.8 times more likely to receive specialised psychiatric care in hospitals (both public and private hospitals) and 2.7 times more likely to have a community mental health contact than non-Indigenous people (figure 12.25). Table 12A.44 contains further information on use of these services by Indigenous status. Data for episodes of community residential care by Indigenous status are not available across jurisdictions for 2007-08.

Figure 12.25 **Ratio of Indigenous to non-Indigenous specialised mental health service use, 2007-08**[a, b, c, d, e, f]



[a] Data for episodes of community residential care by Indigenous status are not available across jurisdictions for 2007-08. National data should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. [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 were reported by the following states and territories to be of acceptable quality: 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 include people whose Indigenous status was ‘not stated’. [d] Data for specialised psychiatric care in hospitals includes both public and private hospitals (except for the NT that are for public hospitals only). [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 Tasmania and the ACT for specialised psychiatric care in hospitals.

Source: AIHW (2010) *Mental Health Services in Australia 2007–08*, Mental health series no. 12, Cat. no. HSE 88, (internet only tables); table 12A.44.

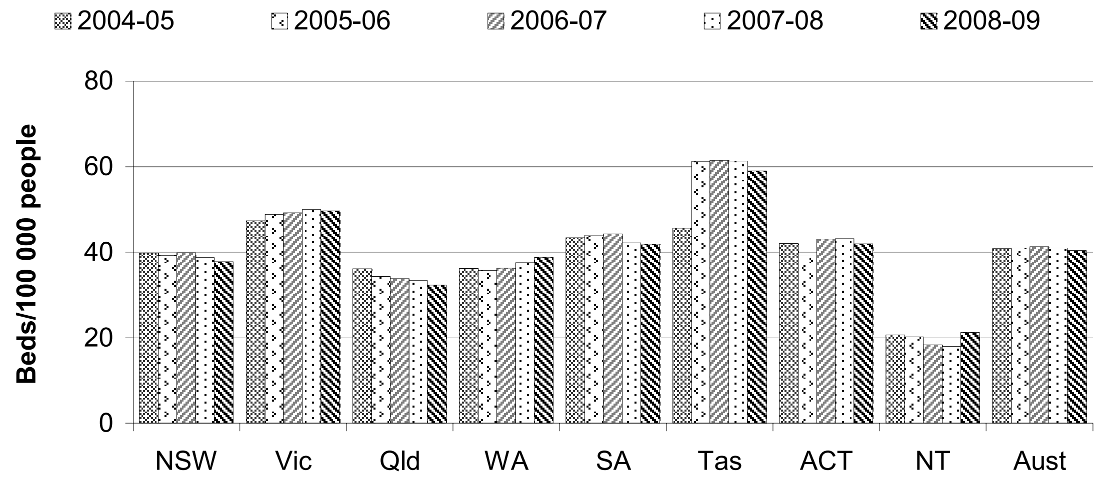
State and Territory publicly funded specialised mental health services — mental health beds

Beds are counted as those immediately available for use by admitted patients if required. They are available for use immediately — or within a reasonable period of time — if located in a suitable place for care with nursing or other auxiliary staff available.

Available beds are counted differently across years. For 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 12.26 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined.

Figure 12.26 **Mental health beds in public hospitals and publicly funded community residential units**[a, b, c, d]



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[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 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.45.

Figure 12.27 presents the number of beds by service setting for 2008-09. These data show the differences in service mix across states and territories.

Figure 12.27 **Available beds, by service setting, 2008-09**[a, b]

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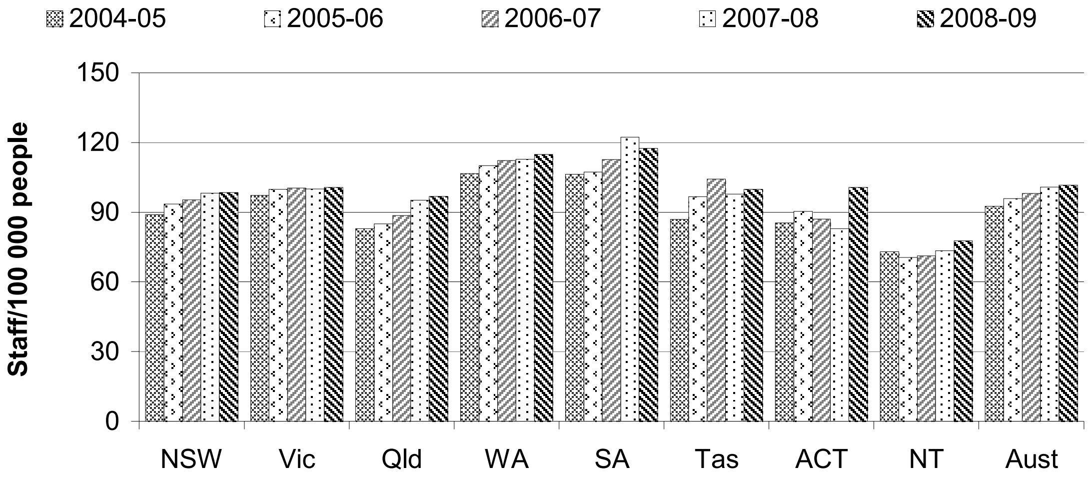
[a] Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. [b] Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.45.

State and Territory publicly funded specialised mental health services — staff

Figure 12.28 reports full time equivalent (FTE) health professional direct care staff per 100 000 people.

Figure 12.28 **FTE health professional direct care staff**[a]



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[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.46.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2008-09, 65.3 nurses per 100 000 people were working in specialised mental health services, compared with 24.1 allied health care staff and 12.3 medical staff (table 12A.46). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 12A.47.

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 represent a paraphrased interpretation of aspects of the National Mental Health Policy 2008.

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 and builds on reforms begun under the first three plans (the first operated from 1993–1998, the second from 1998–2003 and the third from 2003–2008). The 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. A series of measures have been identified to monitor progress under the Action Plan. Australian Health Ministers agreed to report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes. Governments also agreed to an independent evaluation and review of the Plan after 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 people. 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 2011 Report (figure 12.29). 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.

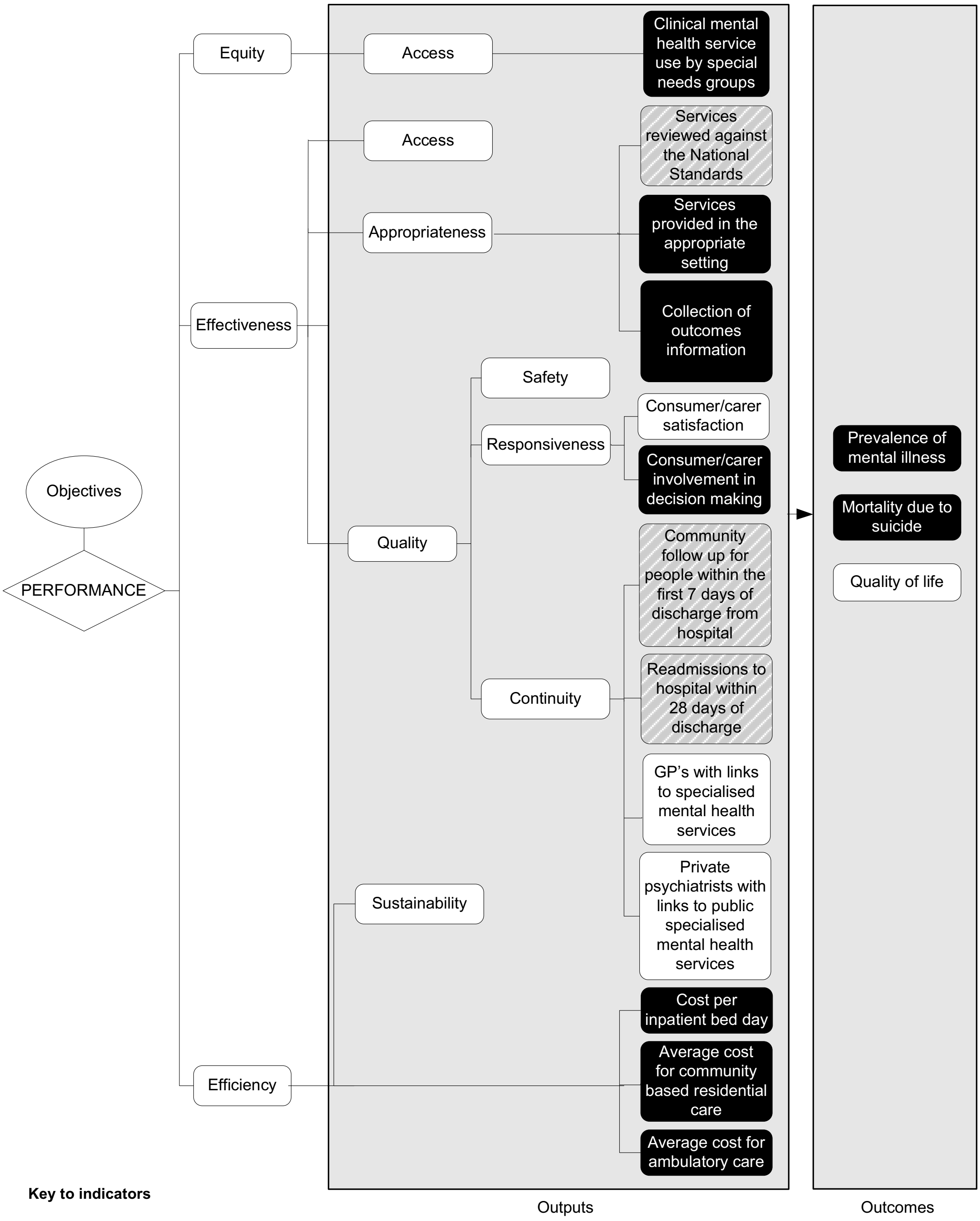
Some changes have been made to the mental health framework for the 2011 Report.

- A new indicator ‘clinical mental health service use by special needs groups’ has been added to the framework and data are reported.
- The following three indicators previously considered not complete or not comparable are now considered comparable with caveats:
  - services provided in the appropriate setting
  - average cost for community-based residential care
  - average cost for ambulatory care.

Other reporting changes for the 2011 Report, comprise reporting of a second measure under the ‘Collection of outcomes information’ indicator and improved reporting on the ‘Services reviewed against the National Standards’ indicator by the inclusion of data on additional categories.

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 12.29 **Performance indicators for mental health management**



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

Key performance indicator results

Outputs

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

Equity — Clinical mental health service use by special needs groups

'Clinical mental health service use by special needs groups' is an indicator of governments' objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.19).

Box 12.19 **Clinical mental health service use by special needs groups**

'Clinical mental health service use by special needs groups' is defined by two measures:

- proportion of the population in a special needs group using State and Territory mental health services, compared with the proportion for those outside the special needs group
- proportion of the population in a special needs group using MBS-funded ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion for those outside the special needs group.

The special needs groups reported are Indigenous people, people from outer regional, remote and very remote locations and people residing in low socio-economic areas.

Interpretation of this indicator is ambiguous. This indicator does not measure access according to need, that is, according to the prevalence of mental illness across special needs groups. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The proportions of the population using State or Territory mental health services in 2008-09, by special needs groups are reported in figure 12.30. The results at the national level show that the proportion of the population using State and Territory mental health services is higher:

- for Indigenous people, than for non-Indigenous people (figure 12.30a)
- in very remote locations, than in other locations (figure 12.30b)
- for people in the three most disadvantaged quintiles (1, 2 and 3), than the more advantaged quintiles (figure 12.30c).

These results, which are based on State and Territory governments' community mental health care data, should be interpreted with care, whereby:

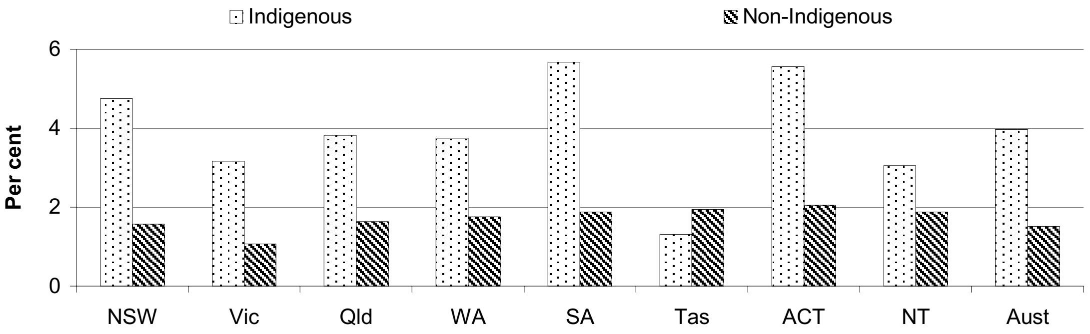
- people receiving only admitted and/or residential services from State and Territory mental health services are not included in the proportion of people accessing services or in rates of service use
- there is no identifier to distinguish 'treatment' versus 'non-treatment' service contacts in the community mental health care data set
- jurisdictions differ in their collection and reporting of community mental health care data — there are variations in local business rules and in the interpretation of the national definitions.

The proportions of the population using MBS-funded ambulatory mental health services, by special needs groups are reported in figure 12.31. The results at the national level show that the proportion of the population using MBS-funded ambulatory mental health services is lower:

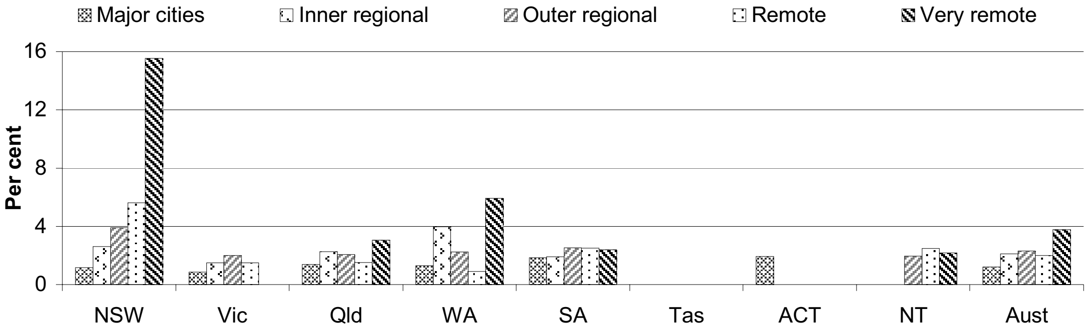
- for Indigenous people, than for non-Indigenous people (figure 12.31a)
- in remote and very remote locations than in other locations (figure 12.31b)
- for those in the most disadvantaged SEIFA quintile 1, than for those in the more advantaged quintiles (figure 12.31c).

Figure 12.30 **Population using State and Territory mental health services, by special needs groups, 2008-09**[a, b, c, d, e, f]

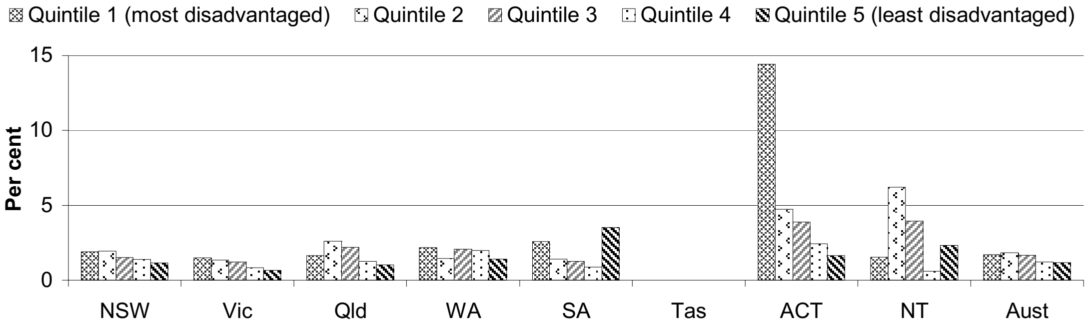
(a) Indigenous status



(b) Geographic location



(c) SEIFA

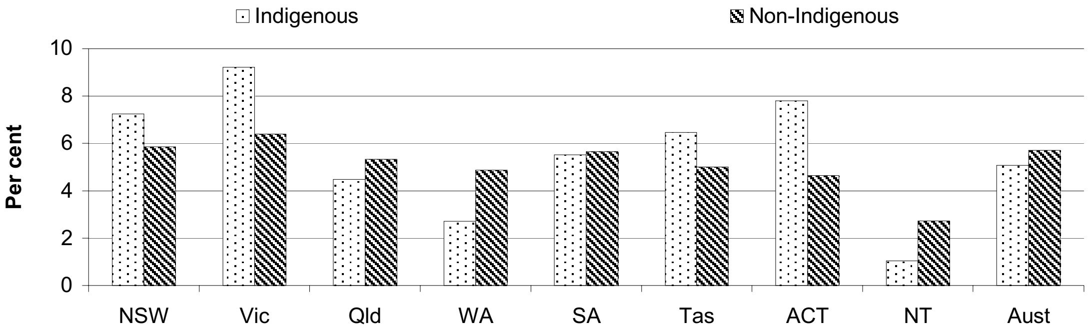


SEIFA = Socio-Economic Indexes for Areas. [a] Proportions are age-standardised to the Australian population as at 30 June 2001. [b] Counts for State and Territory mental health services are counts of people receiving one or more service contacts provided by public sector community mental health services. SA and Tasmania submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. [c] The geographic location and SEIFA data should be interpreted with caution as the methodology used to allocate remoteness and SEIFA varies across jurisdictions. Due to system-related issues impacting data quality, Tasmania is unable to provide data by remoteness or SEIFA area. [d] Victoria does not have very remote locations. [e] The ACT does not have outer regional, remote or very remote locations. ACT data are not available for inner regional areas. [f] The NT does not have major cities or inner regional locations.

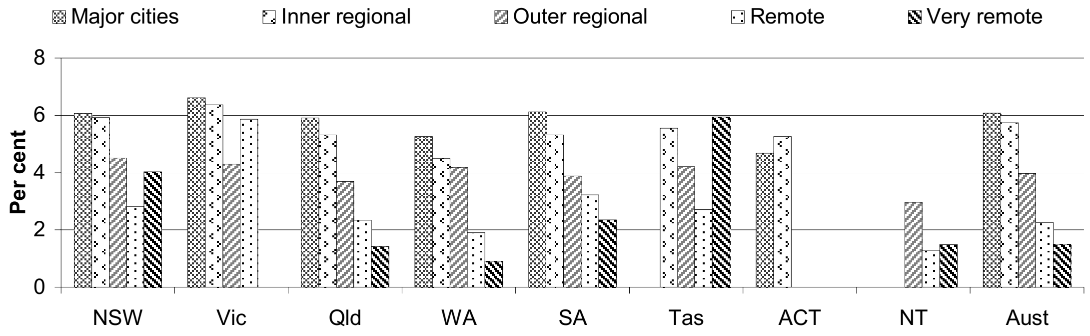
Source: State and Territory governments (unpublished) CMHC data; tables 12A.48–50.

Figure 12.31 **Population using MBS-funded ambulatory mental health services, by special needs groups, 2008-09**[a, b, c, d]

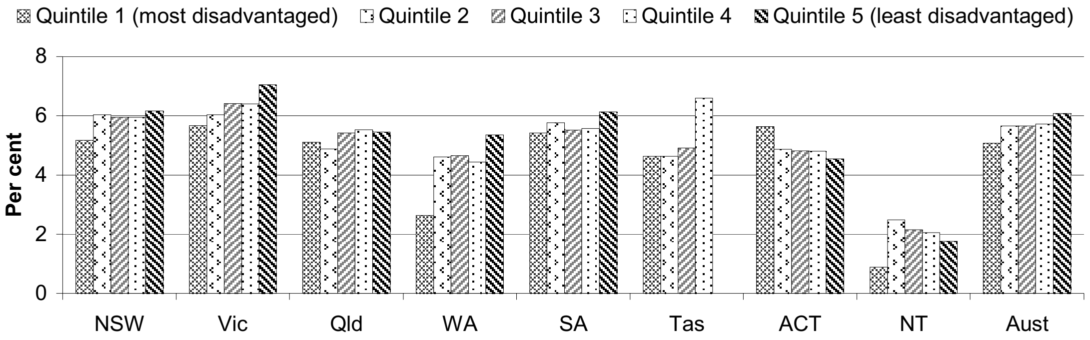
(a) Indigenous status



(b) Geographic location



(c) SEIFA



SEIFA = Socio-Economic Indexes for Areas. [a] Proportions are age-standardised to the Australian population as at 30 June 2001. [b] MBS services are those specific mental health services provided under Medicare. The specific Medicare items included are detailed in table 12A.37. [c] Victoria does not have very remote areas. Tasmania does not have major cities. ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. [d] Data are not published for Quintile 5 for Tasmania.

Source: DoHA (unpublished) Medicare Statistics data; tables 12A.48–50.

Further data on the use of State and Territory mental health services and MBS-funded ambulatory mental health services are in tables 12A.51–56. Data on the use of private hospital mental health services are also contained in tables 12A.37 and 12A.48–51.

Effectiveness — access

The Steering Committee has identified effectiveness–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. This indicator has been improved for the 2011 Report by the inclusion of data on additional categories for level 3 and level 4.

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, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all National Standards for Mental Health Services
- *Services at level 2* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all National Standards.
- *Services at level 3* — the number of specialised public mental health services that are (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3.

A high or increasing proportion of 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.

(Continued next page)

Box 12.20 (continued)

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Revised NSMHS were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. A National Standards Implementation Strategy and Plan will provide guidance for jurisdictional implementation. The Standards have been broadened to include non-government community mental health services and private office-based services as well as the specialist mental health system.

Box 12.21 outlines the previous NSMHS against which services were reviewed for the latest available results reported in table 12.6. 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 and were assessed as meeting 'all Standards' (level 1) or as meeting 'some but not all Standards' (level 2). Table 12.6 also shows the number of specialised public mental health services that are either in the process of being reviewed by an external accreditation agency but the outcomes are not known, or booked for review by an external accreditation agency (level 3) and those that do not meet criteria detailed under levels 1 to 3 (level 4).

Table 12.6 **Specialised public mental health services reviewed against the NSMHS, 30 June 2009 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*	*ACT*	*NT*
Level 1	87.0	100.0	90.7	48.6	45.3	46.2	100.0	100.0
Level 2	2.8	–	2.5	31.4	1.7	11.5	–	–
Level 3	9.1	–	3.4	14.3	47.9	34.6	–	–
Level 4	1.1	–	3.4	5.7	5.1	7.7	–	–

[a] NSW, Queensland, SA, Tasmania and the ACT report at the service unit level. Victoria, WA and the NT report at the organisation level. The Australia proportions are not reported for this reason. [b] WA data include public sector services only. – Nil or rounded to zero.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.57.

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 spent 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 comparable.

Data quality information for this indicator is under development.

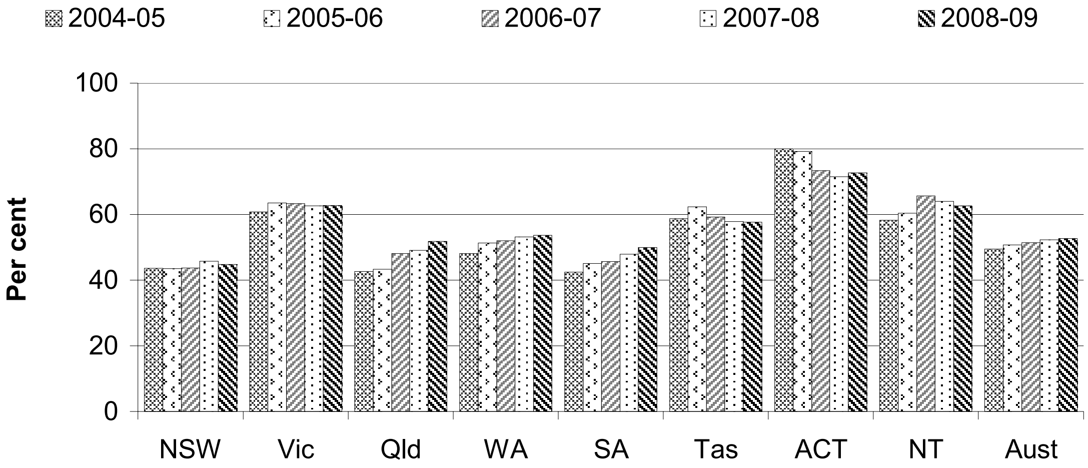
The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. 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 2004-05 to 2008-09.

Figure 12.32 **Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services**[a, b, c]

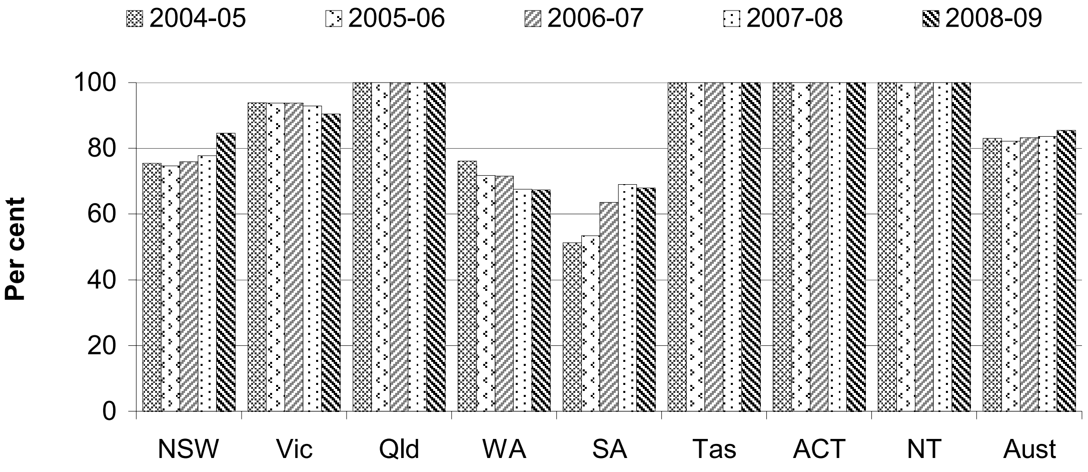


[a] Community-based expenditure includes expenditure on ambulatory, non-government and adult community residential services. Aged care community residential expenditure is excluded to improve comparability. [b] Total expenditure on mental health services excludes indirect/residual expenditure that could 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.58.

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.

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.58.

Appropriateness — collection of outcomes information (interim indicator)

'Collection of outcomes information' is an indicator of governments' objective that consumer outcomes be monitored (box 12.23). It is an interim process indicator, reflecting the capability of services in establishing systems to collect consumer outcomes information. Information on consumer outcomes will be reported when they become available. A new measure has been introduced for the 2011 Report, on the proportion of specialised mental health service episodes with completed outcomes data.

Box 12.23 **Collection of outcomes information (interim indicator)**

‘Collection of outcomes information (interim indicator)’ is defined by two measures:

- the proportion of specialised mental health services that have introduced routine collection of consumer outcomes information
- the proportion of specialised public mental health services episodes with completed outcome measures data, by client type (people in ongoing community care, people discharged from community care and people discharged from hospital).

High or increasing proportions of services that are collecting consumer outcomes information is desirable. High or increasing proportions of episodes for which consumer outcomes information is collected is also desirable.

Data reported for this indicator are comparable.

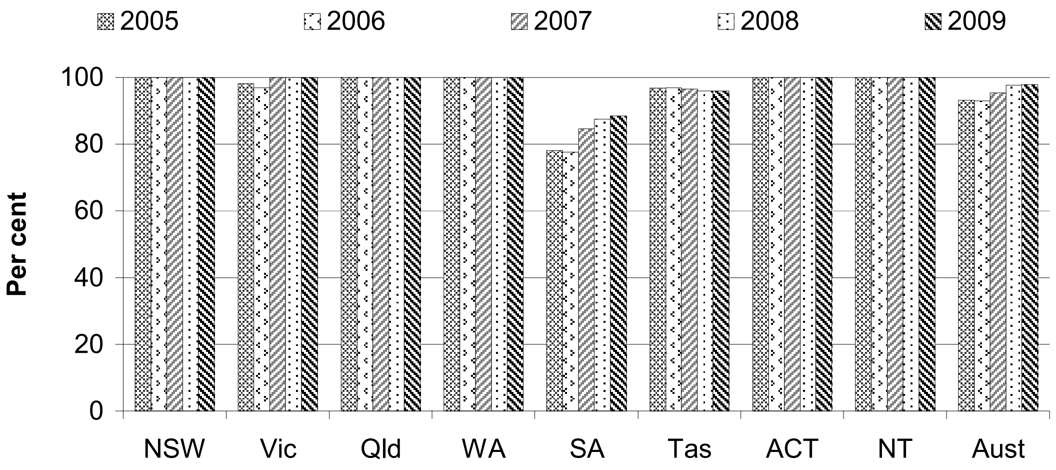
Data quality information for this indicator is under development.

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 12.34. The estimated proportions of specialised public mental health service episodes for which consumer outcomes information is collected are shown in figure 12.35.

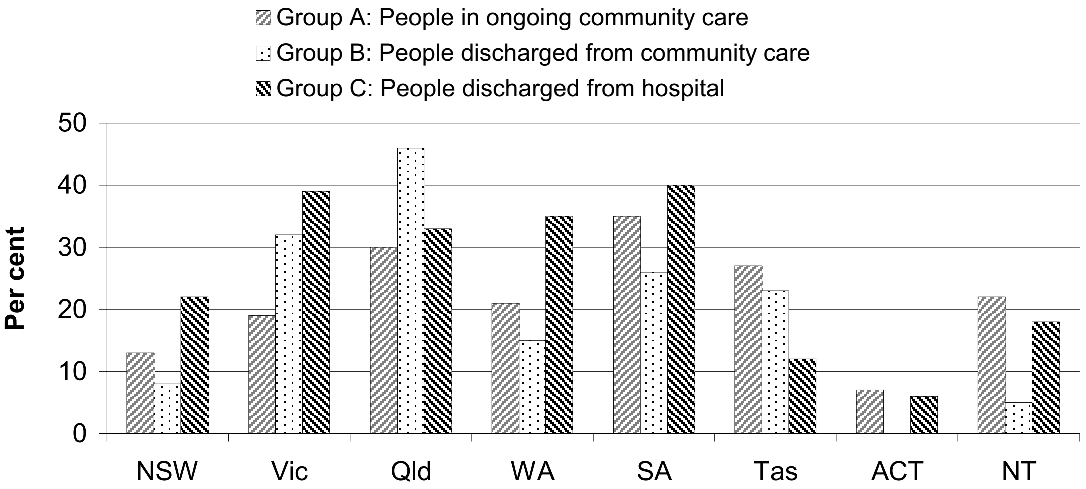
Figure 12.34 Specialised mental health services that routinely collect consumer outcomes measures, June[a]



[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.60.

Figure 12.35 Estimated proportion of episodes for which 'complete' consumer outcome measures were collected, 2007-08[a, b]



[a] These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government (DoHA). To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a 'matching pair' — that is, a beginning and end rating are needed to enable an outcome score to be determined. [b] For the ACT, due to a technical issue, the proportion of matched pairs for people in a community episode of care was below the statistical threshold for a meaningful comparison.

Source: AHMC (2011) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2008-09*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (unpublished); table 12A.61.

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 12.24). 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 12.24 **Consumer and carer satisfaction**

‘Consumer and carer satisfaction’ is yet to be defined.

Data for this indicator were not available for the 2011 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 12.25). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.25 **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 arrangements in place 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.

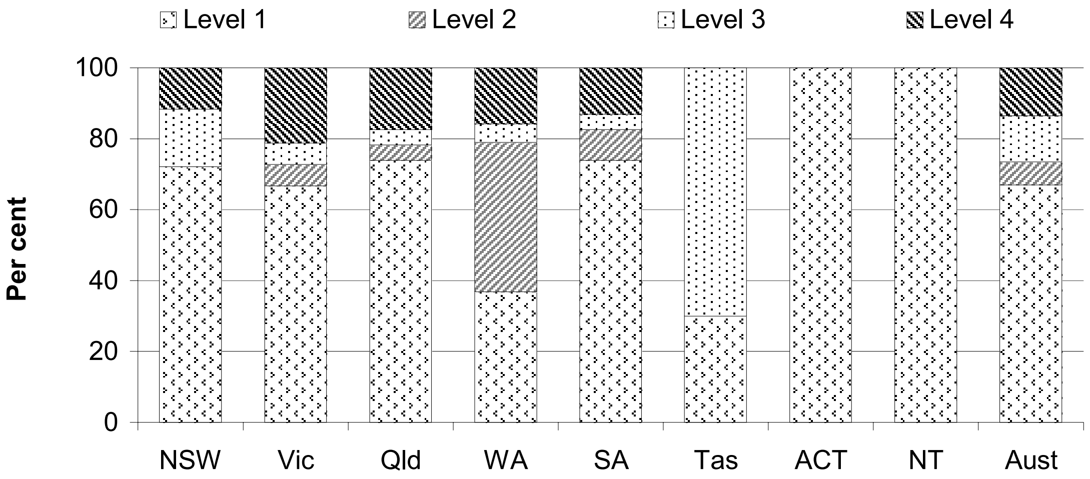
A high or increasing proportion of organisations with level 1 arrangements is desirable, while a high or increasing proportion of organisations with level 4 arrangements is undesirable. High or increasing numbers of paid FTE consumer/carer consultants implies a greater opportunity for consumers and carers to be involved in decision making.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Figure 12.36 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.

Figure 12.36 Organisations with consumer participation in decision making, 2008-09[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.59.

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
2008-09	33.9	31.6	32.3	14.3	33.3	10.2	–	–	29.4
Paid carer consultants per 10 000 clinicians									
2005-06	4.3	23.0	1.2	–	–	–	–	–	0.8
2006-07	13.2	26.2	2.5	–	–	–	–	–	11.3
2007-08	10.2	29.5	3.7	3.2	9.5	–	–	–	12.4
2008-09	14.8	26.5	6.3	2.0	12.5	10.2	–	–	13.9

– Nil or rounded to zero.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.59.

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.

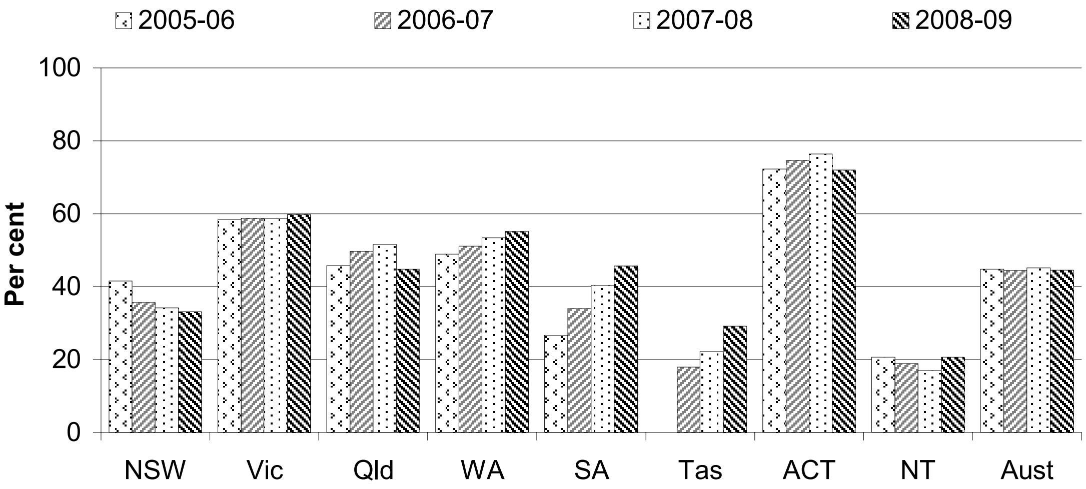
Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 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 12.37.

Figure 12.37 **Community follow up for people within the first 7 days of discharge from hospital**[a, b, c, d]



[a] Data for 2005-06 to 2007-08 are for the full year, but data for 2008-09 are based on the first 9 months of the year. Data for 2007-08 have been revised and will differ from those in the 2010 Report. [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 immaterial). Contacts made on the day of discharge are also excluded. [c] Data are not comparable across jurisdictions. SA and Tasmania are not able to accurately track post-discharge follow up between hospitals and community service organisations, due to the lack of unique patient identifiers or data matching systems. Results for these jurisdictions could appear 'lower' relative to jurisdictions that are able to track utilisation across services. [d] Tasmanian data for 2005-06 are not available.

Source: AHMC (2011) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2008-09*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (unpublished); table 12A.62.

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 quality information for this indicator is under development.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.38.

Figure 12.38 Readmissions to hospital within 28 days of discharge[a, b, c]

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[a] Data for 2005-06, 2006-07 and 2007-08 are for the full year, but data for 2008-09 are based on the first 9 months of the year. Data for 2007-08 have been revised. [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 (2011) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2008-09*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (unpublished); table 12A.63.

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 2011 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 2011 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)

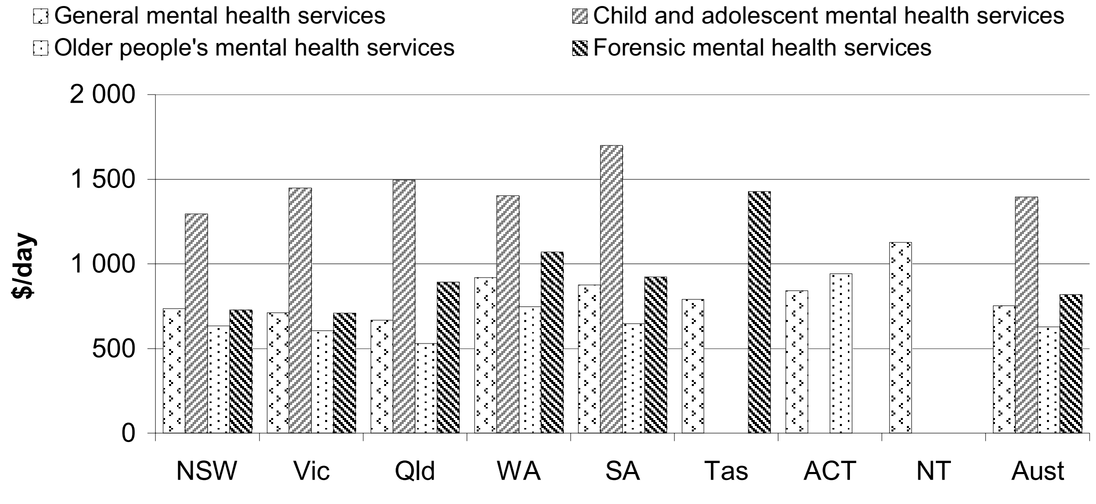
This indicator does not account for differences in the client mix and average length of stay. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. Longer 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.

Data quality information for this indicator is under development.

Inpatient costs per day are presented in figures 12.39 (by inpatient target population) and 12.40 (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 12.39 **Average recurrent cost per inpatient bed day, public hospitals, by target population, 2008-09**[a, b, c, d, e, f]



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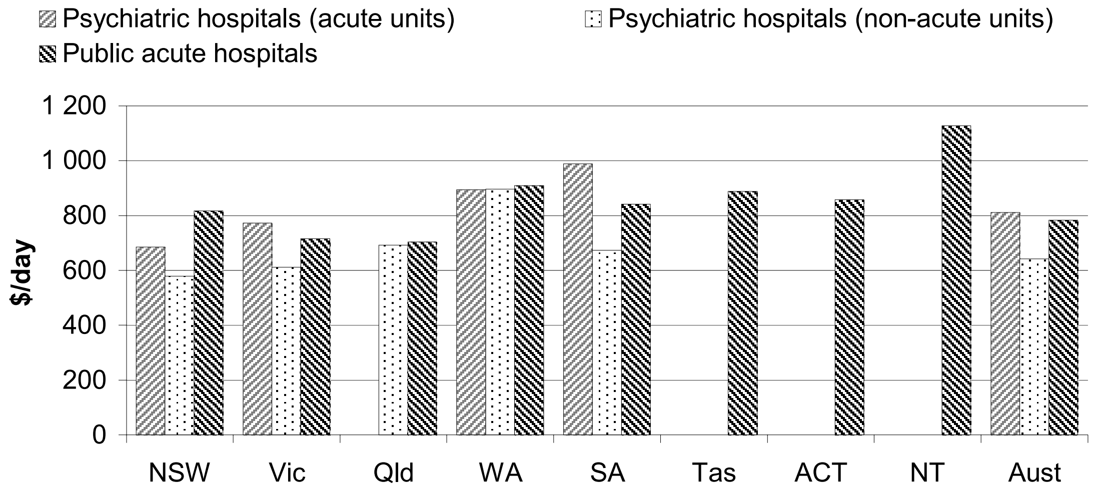
[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Queensland provides older people's mental health services using a variety of different service models, including extended treatment services co-located with other services. These different service models are all reported as older people's mental health services, which lowers the average patient day costs, and limits comparability with the costs of jurisdictions that report these services differently. [d] Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people's mental health services. [e] The ACT does not have separate forensic or child and adolescent mental health inpatient services. [f] The NT has general mental health services only.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.64.

Figure 12.40 Average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2008-09[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.65.

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 comparable.

Data quality information for this indicator is under development.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community 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-based residential services is presented in table 12.8. For general adult units in 2008-09, the average cost to government per patient day for 24 hour staffed community-based residential services was an estimated $405 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was $153 nationally. For State or Territory governments that had community-based older people’s care units in 2008-09, the average recurrent cost to government per patient day for 24 hour staffed community residential services was $327 nationally (table 12.8).

Table 12.8 **Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2008-09**[a, b]

	NSW	*Vic*	*Qld*[c]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General adult units									
24 hour staffed	295	450	..	319	357	516	469	247	405
Non-24 hour staffed	198	138	..	96	322	242	87	..	153
Older people's care units									
24 hour staffed	176	322	..	..	..	493	228	..	327
Non-24 hour staffed	209	..	..	..	..	..	..	..	209

[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Queensland does not fund community 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.66.

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.

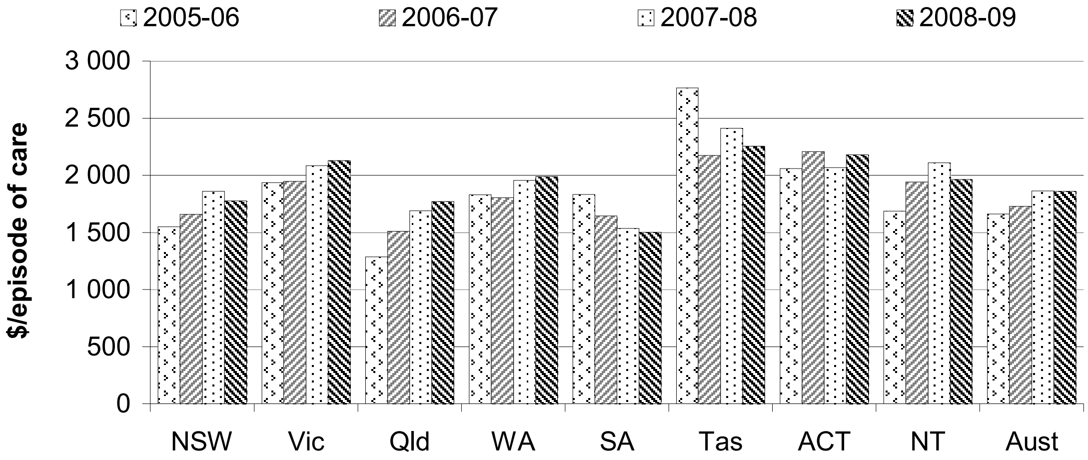
The measures do not account for differences in the client mix. The client mix in community care can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community settings.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Average recurrent cost per episode of ambulatory care data are shown in figure 12.41 and average treatment days per episode of ambulatory care data are shown in figure 12.42.

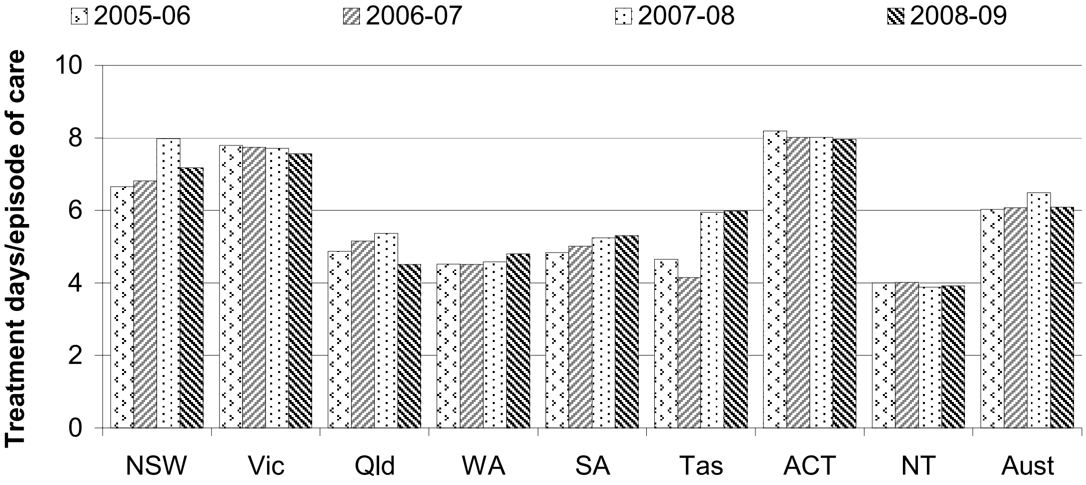
Figure 12.41 **Average recurrent cost per episode of ambulatory care (2008-09 dollars)[a, b]**



[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.67.

Figure 12.42 **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.67.

Outcomes

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

The output indicators reported above focus on specialised mental health services funded by State and Territory governments (although the indicator 'client use of services by special needs groups' includes measures of access to MBS-funded services). The outcome indicators identified and/or reported here are not direct measures of the outcomes for people who access these services. The outcomes identified and/or reported here tend to reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The 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 illness' is an indicator of governments' objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.33).

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.

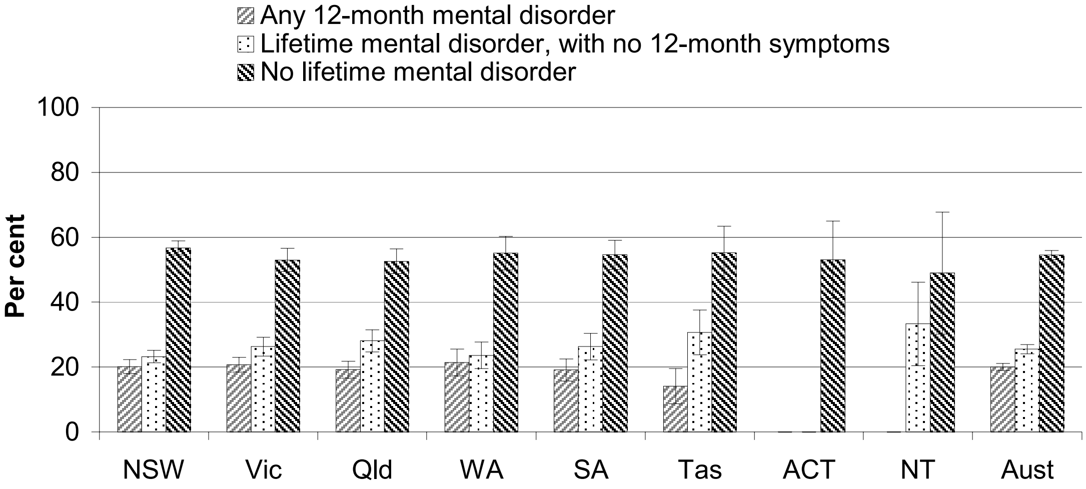
Reduction in prevalence can be brought about by preventative efforts to stop an illness occurring, or by increasing access to effective treatments for those in whom the illness has begun (AHMC 2008). Many of the risk and protective factors that impact on the development of mental health problems and 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 quality information for this indicator is under development.

Data on the prevalence of mental illness are available from the ABS 2007 NSMHWB. The 2007 NSMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level, however, some jurisdictional data are available and are reported in figure 12.43. 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 12.43 **Prevalence of mental disorders, 2007**[a, b]



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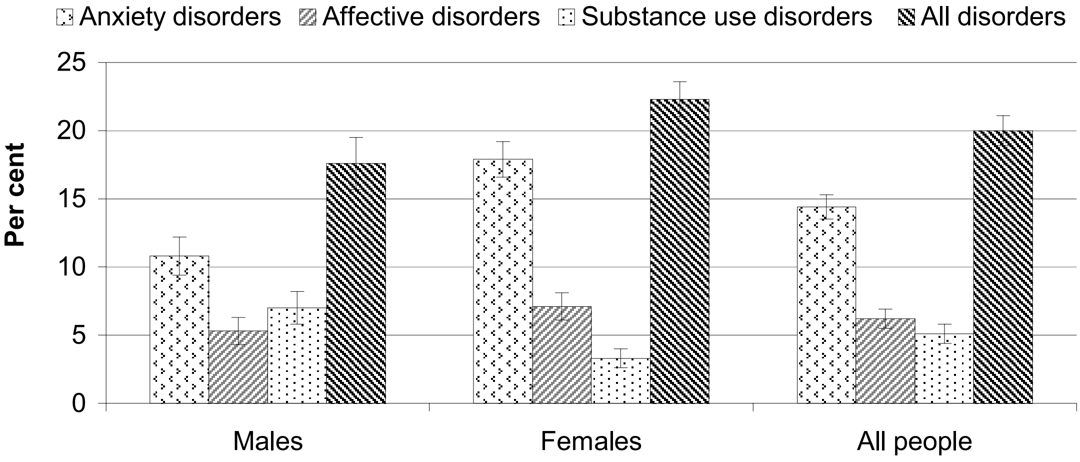
[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] Estimates with RSEs greater than 25 per cent are not published.

Source: ABS (unpublished) *2007 NSMHWB,* Cat. no. 4326.0; table 12A.68.

There were differences in the prevalence of 12-month mental disorders between males and females (figure 12.44). 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 12.45). 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 12.44 **Prevalence of 12-month mental disorders, by sex, 2007**[a, b, c]



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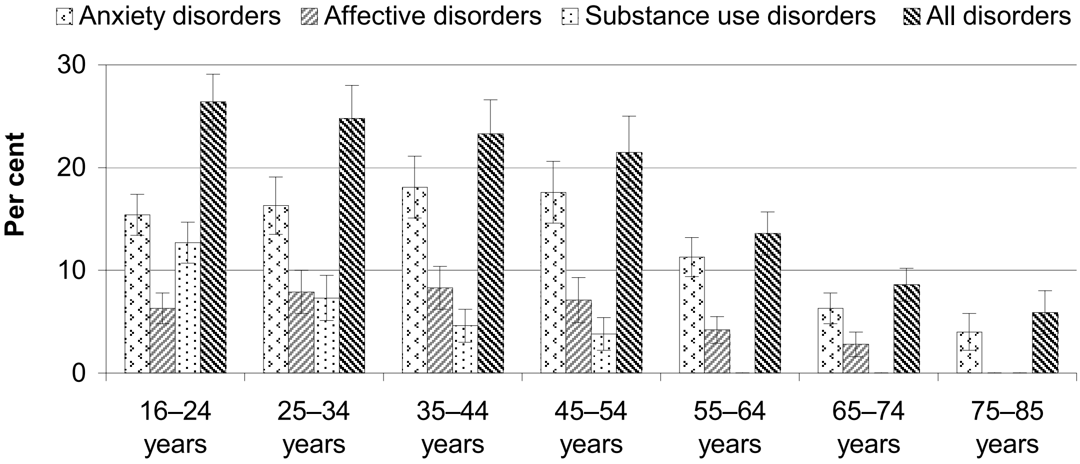
[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] A person can have more than one mental disorder. Therefore, the components might not add to the total of all disorders. [c] People who had a mental disorder with symptoms in the 12 months prior to the survey.

Source: ABS (unpublished) *2007 NSMHWB,* Cat. no. 4326.0; table 12A.69.

Figure 12.45 **Prevalence of 12-month mental disorders, by age, 2007**[a, b, c, d]



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[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 NSMHWB,* Cat. no. 4326.0; table 12A.70.

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.

Data quality information for this indicator is under development.

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 Causes of Death data are the source of suicide statistics in this chapter (ABS 2010). There are two developments that have improved the quality of ABS' Causes of Death data for the two most recent years of data:

- processing improvements
- a revisions process.

Two processing improvements, relating to the way the ABS codes coroner certified deaths, have been introduced to the Causes of Death collection for the release of the preliminary 2008 data. 'Cause of death' codes are now better assigned to coroner certified cases and all 2008 Causes of Death data have been positively impacted by these improvements (ABS 2010).

All coroner certified deaths registered after 1 January 2007 are subject to a revisions process. The revisions process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD-10 codes over time (ABS 2010). Each years data will be released as preliminary, revised and final.

Table 12.9 compares the ABS 2007 preliminary, 2007 revised and 2008 preliminary suicide data across jurisdictions. The revisions for 2007 data have impacted most significantly on Queensland suicide data.

Table 12.9 **Number of suicides, preliminary and revised**

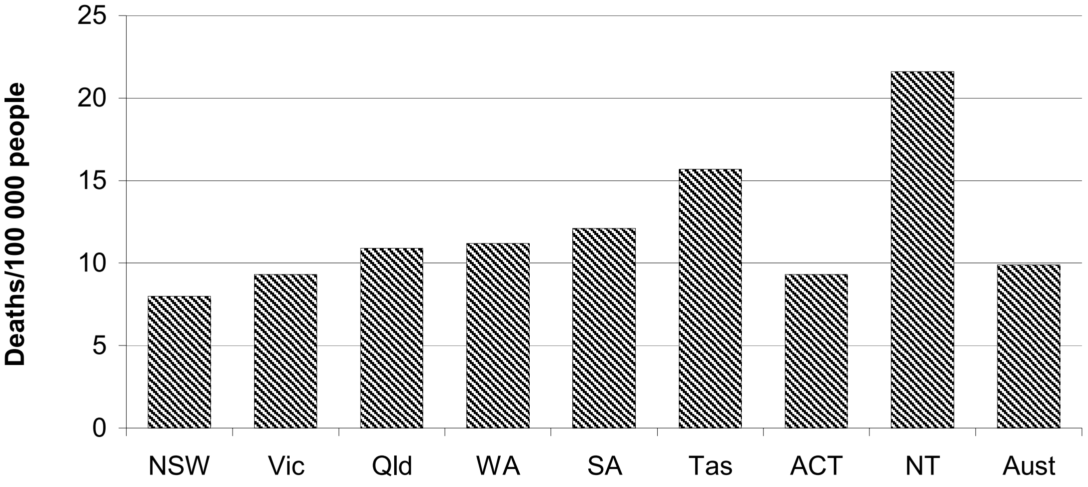
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
2007								
Preliminary	551	438	285	254	202	66	31	54
Revised	553	443	445	257	202	67	31	56
2008								
Preliminary	553	505	507	297	176	75	35	42

Source: ABS 2010, *Causes of Deaths, Australia 2008*, Cat. no. 3303.0, Canberra.

In the period 2004–2008, 10 244 deaths by suicide were recorded in Australia (table 12A.73) — equivalent to 9.9 deaths per 100 000 people (figure 12.46). The rate for males (15.6 per 100 000 males) was around 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 nine times the female rate (figure 12.47). Table 12A.74 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

Nationally the suicide rate in the period 2004–2008 was higher in rural areas. There were 9.0 suicides per 100 000 people in capital cities and 10.7 suicides per 100 000 people in urban centres, compared with 12.3 suicides per 100 000 people in rural areas in Australia (figure 12.48).

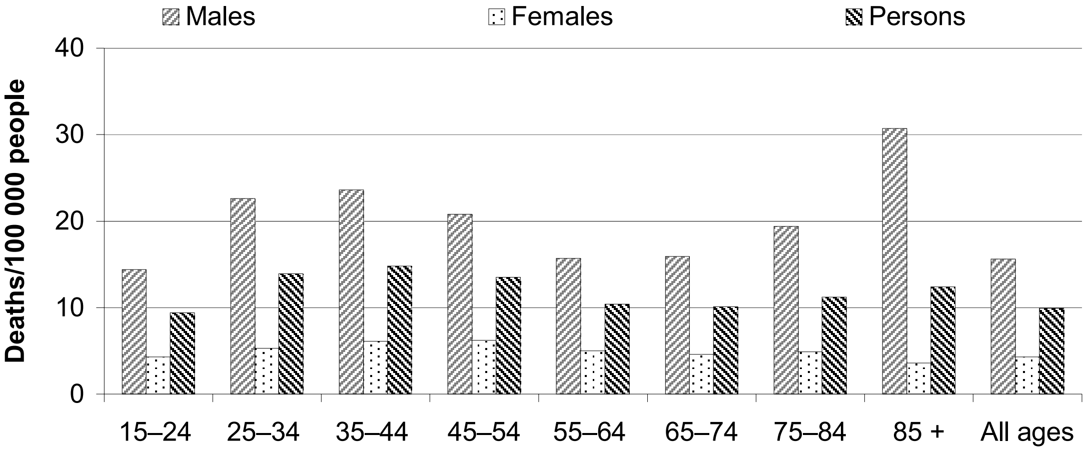
Figure 12.46 **Suicide rates, 5 year average, 2004–2008**[a, b, c]



[a] Suicide deaths include ICD-10 codes X60-X84 and Y87.0. [b] The death rate is age standardised to the mid-year 2001 population. [c] Causes of death data for 2007 have been revised and are subject to further revisions. Causes of death data for 2008 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.73.

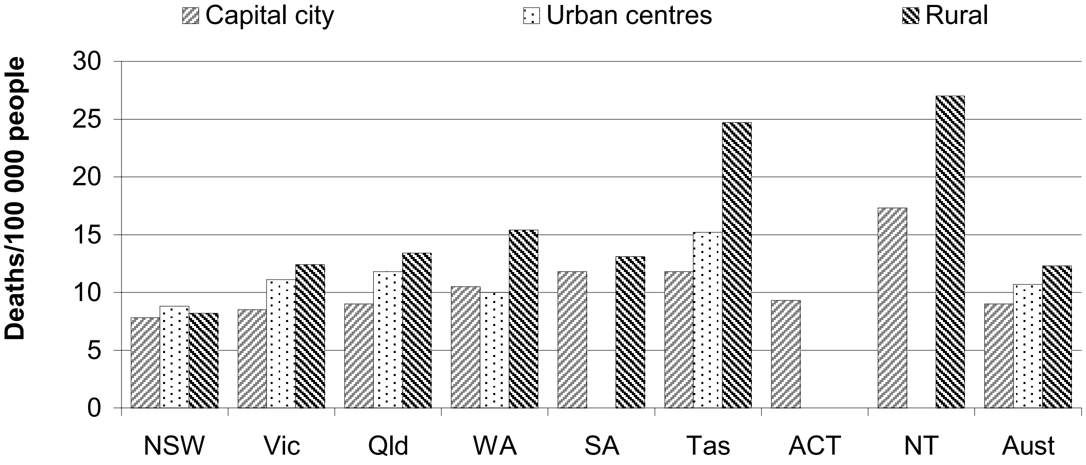
Figure 12.47 **Suicide rates, by age and sex, 2004–2008**[a, b, c]



[a] Suicide deaths include ICD-10 codes X60-X84 and Y87.0. [b] Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2004–2008. [c] Causes of death data for 2007 have been revised and are subject to further revisions. Causes of death data for 2008 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.72.

Figure 12.48 **Suicide rates, by area, 2004–2008**[a, b, c, d, e]



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[a] Area categories are defined as follows: 'capital cities' — comprising capital city statistical divisions; 'urban centres' — based on 'statistical districts' that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states or territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); 'rural' — balance of State (or Territory), that is all areas other than capital cities and urban centres. [b] The suicide rate is 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. [e] Causes of death data for 2007 have been revised and are subject to further revisions. Causes of death data for 2008 are preliminary and subject to a revisions process.

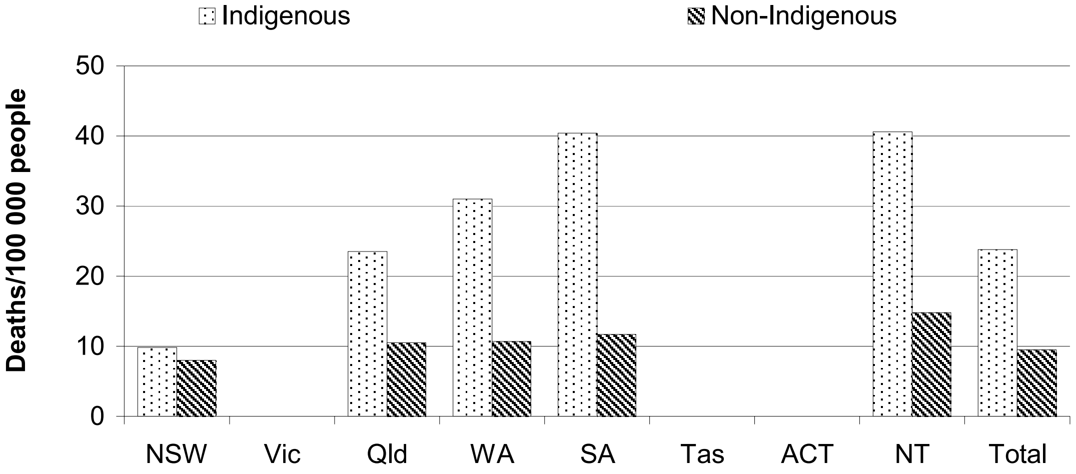
Source: ABS (unpublished) *Causes of Deaths, Australia,* Cat. no. 3303.0; table 12A.75.

Tables 12A.71–75 contain single year time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.49). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous people during the period 2004–2008, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The Health preface discusses the quality of Indigenous mortality and other data.

Figure 12.49 **Suicide rates, by Indigenous status, 2004–2008**[a, b, c, d]



[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. [c] Causes of death data for 2007 have been revised and are subject to further revisions. Causes of death data for 2008 are preliminary and subject to a revisions process. [d] Total relates to the jurisdictions for which data are reported: NSW, Queensland, WA, SA and the NT.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.76.

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 2011 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 on mental health include:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- revising the performance indicator framework to ensure reporting remains consistent with government policy objectives for mental health and other mental health performance reporting exercises.

COAG developments

Report on Government Services (RoGS) alignment with National Agreement (NA) reporting

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of RoGS

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework’ and the ‘Review of the performance indicators and their associated measures’. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

12.6 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this section of the Report.

Australian Government comments

“COAG, with the exception of Western Australia, agreed to establish the National Health and Hospitals Network (NHHN) in April 2010. Under the Network, the Commonwealth becomes the majority funder of the health and hospitals system, including 60 per cent of the efficient price of public hospital services, capital, research and training, and 100 per cent of primary care equivalent outpatient services. The Commonwealth will also assume full policy and funding responsibility for primary health care and aged care, including the Home and Community Care Program (except in Victoria and WA). The Commonwealth will fund these new arrangements using funds allocated to the National Healthcare Specific Purpose Payment, retaining and dedicating around one-third of GST, and an additional top-up payment of $15.6 billion between 2014-15 and 2019-20.

The NHHN also devolves governance of the health and hospitals system to new local institutions — Local Hospital Networks (LHNs) and Medicare Locals. Aged care one-stop shops will be established to work with LHNs and Medicare Locals to ensure care is integrated at the local level across the acute, primary and aged care sectors. The 2010-11 Budget formally commits the Commonwealth to $7.4 billion of initiatives from the COAG reform package, including:

- $250 million to expand the capacity of public hospital emergency departments by undertaking infrastructure projects and $500 million to ensure that people do not spend longer than 4 hours being treated in a public hospital emergency department, when clinically appropriate
- $150 million to boost elective surgery capacity in public hospitals and $650 million to facilitate and reward the staged achievement of national access guarantees and national access targets for public elective surgery patients
- $1.6 billion in capital and recurrent funding to deliver 1316 subacute beds and $200 million in flexible capital funding, for emergency departments, elective surgery and subacute areas, which jurisdictions will have the flexibility to direct to their highest-priority needs
- $1.2 billion for improved access to GPs and primary health care through the establishment of Medicare Locals, a new diabetes initiative and primary care infrastructure funding
- $1.1 billion for workforce initiatives such as doubling GP training places, more specialists, more practice nurses and more support for allied health
- $649 million for a national aged care package to improve care and access to primary care and $149 million for more youth friendly mental health services and flexible care packages for patients with severe mental illness
- $236.5 million to establish an Independent Hospital Pricing Authority to set the national efficient price of all public hospital services, a National Performance Authority to report on public health sector performance, and the expansion of the Australian Commission for Safety and Quality in Health Care to set and monitor national quality and safety standards.”

New South Wales Government comments

The NSW public health system is, like many others, under pressure from sustained increases in demand for services. It is a significant challenge for all health systems to continue to provide high quality health care to a growing and ageing population with increasingly complex and chronic conditions.

In the face of these pressures, the health system continues to perform, through the dedicated effort of staff and the innovative work being undertaken. We have introduced a range of initiatives to help provide the people of NSW with access to the health care they need and to reduce the impact of chronic disease, avoid ill health and live healthier lives.

We are 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. Our health system aims to provide ready access to health services while keeping patients and their carers informed and involved in decisions.

Health Priority Task Forces actively support the health system to develop and implement new policy directions and service improvements in high priority areas, including:

- Children and Young People's Health
- Chronic, Aged and Community Health
- Critical Care
- Greater Metropolitan Clinical Taskforce
- Maternal And Perinatal Health
- Mental Health
- Population Health
- Rural and Remote Services
- Sustainable Access.

In response to the increasing levels of service demand the NSW Government increased its funding for operating and capital needs to the NSW health system by $969 million, to $11.7 billion in 2008-09, an increase of 9.0 per cent on the previous year.

The NSW Government has supported the National Health Reform initiatives and is working collaboratively with the Commonwealth on implementing strategies that will focus on improving public hospital services, building on existing strengths of our current system together with free and ready access to best-practice healthcare for public patients, and to ensure that our public health system is sustainable.

Victorian Government comments

Achieving the best health and wellbeing for all Victorians is the vision of the new Department of Health in Victoria, focusing on hospital performance, mental health, prevention and better addressing the needs of Victoria's ageing population.

While Victorians have one of the best health systems in the world, measured by longevity of life and survival rates for cancer and heart disease, the challenges of our growing and ageing population and the rise of chronic disease demand continued improvements in the delivery of health services.

Victoria's primary health sector is well established and provides significant access to services for vulnerable groups in the community, promoting good health and intervening early to maximise health outcomes. Primary Care Partnerships, which engage 1200 organisations across the state, continue to be a core component of the health care sector. New partnerships in areas such as heart disease are an example of our commitment to innovation in patient care while also planning for the growing demand that health services will face. Better coordination and integration within the system, greater accountability within hospitals and improved planning and delivery of services now and into the future remain strong priorities.

Significant investment in treating more people for elective surgery has ensured that the number of patients waiting longer than recommended is at a 12-year low. More Victorians received elective surgery in the last year than ever before. The Victorian Government continues to focus on elective surgery activity and on reducing long waits for patients. In the 12 months to June 2010, there were 155 326 elective surgery admissions. Over 4500 more patients were admitted compared with the previous year, representing a 3 per cent increase in elective surgery procedures performed. This reduction comes at a time when Victoria's public hospitals are admitting more than 1.4 million patients per year, compared with one million in 1999-2000. Victoria's emergency departments also continue to perform well, with the lowest (jointly) median wait time for treatment in the country.

In addition to this, as part of the Government's commitment to responding to mental health needs, in 2010-11 Victoria will spend over $1 billion for specialist mental health services in support of the *Because Mental Health Matters: Mental Health Reform Strategy 2009–2019*. New services in 2010-11 include youth early intervention teams, a 24 hour state-wide Mental Health Advice Line, enhanced mental health triage services, a new approach for coordination of care for people with severe mental illness and multiple needs, and a number of capital development projects.

Victoria is also managing an unprecedented capital works program that involves building and upgrading more than 30 hospitals, health services and ambulance stations across Victoria.

Queensland Government comments

“ Despite the challenges presented by a difficult fiscal environment and rapidly increasing population, Queensland has made encouraging progress towards meeting the ambitious *Toward Q2: Tomorrow’s Queensland* health targets to cut obesity, smoking, heavy drinking and unsafe sun exposure by one-third and to have the shortest public hospital waiting times in Australia.

Queensland has seen a 14 per cent decrease since 2007 in smoking among adults and a 16 per cent increase in consumption of the recommended two or more serves of fruit per day. Since 2004, the number of adults performing sufficient physical activity for health benefit has increased by 36 per cent.

Queensland has also seen notable improvements in public hospital waiting times, including a reduction in the number of patients waiting longer than one year for elective surgery from 2618 in early January 2010 to 216 at 30 June 2010 and an increase in elective surgery activity from 125 412 in 2008-09 to 126 487 in 2009-10. The total number of ‘long wait’ patients at 1 July 2010 was the lowest ever and 12 per cent lower than last year. To improve the efficient use of emergency departments, Queensland has committed $145.2 million to expand hospital emergency departments and implement the *Patient Flow Strategy*. Good patient flow is important for improving patient access and quality of care by reducing unnecessary delays and improving access across the health service, including emergency admissions to inpatient beds.

Queensland has committed unprecedented levels of funding to develop health infrastructure, including $5.1 billion towards establishing new tertiary hospitals on the Gold Coast and Sunshine Coast, and a new Children’s Hospital in Brisbane. Redevelopments at Cairns, Mt Isa, Rockhampton, Townsville and Mackay Hospitals are underway at a total cost of $1.4 billion.

Queensland has also committed $15 million over 3 years to non-government organisations to build or enhance accommodation for patients travelling for treatment; and $159.6 billion to develop and deliver clinical solutions to support patient care, infrastructure and telecommunication services and continued delivery of the *eHealth* program. Queensland has expanded its Statewide Telehealth network with over 820 systems throughout the state — a 51 per cent increase in Telehealth use for non-admitted patients in 2010-11 since 2009-10.

To enhance the quality of and access to mental health services, Queensland commenced implementation of the *Queensland Plan for Mental Health 2007–2017*, which has seen over 510 additional staff recruited since 2007-08 including Service Integration Coordinators to improve mental health service coordination across Government, non-government and private sector services.

Queensland has allocated $337 million over four years toward Indigenous health initiatives focused on achieving Indigenous health care equality. In 2010, Queensland supported this investment with the launch of *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033*, a long term policy, accountability framework and triennial implementation plan. ”

Western Australian Government comments

> WA Health continues to provide a first-class public health service for the Western Australian community, driving reform and service improvement and preparing for the challenges of the future.
>
> Increasing demand for health services presents ongoing challenges. WA Health is matching increased activity levels with safety and quality improvement. The State Government has provided an additional $1.1 billion over five years to meet activity and cost growth, allowing WA Health to move forward from a strong and stable financial base while accommodating demand increases flowing from projected population growth.
>
> WA Health remains engaged in the national health reform process, working to ensure that WA's health system benefits from future reforms and that WA's needs are adequately reflected in national agreements.
>
> WA Health has finalised the *WA Health Strategic Intent 2010–2015* which sets out our vision, mission and values and outlines the scope of our work in delivering health services to nearly 2.3 million Western Australians. The Strategic Intent's four pillars, listed below, will focus and guide our efforts:
>
> - *Caring for individuals and the community* — WA Health has exceeded our elective surgery target, while decreasing median wait times for admission to metropolitan public hospitals. The second phase of the Safety and Quality Investment for Reform (SQuIRE) program has already delivered significant improvements in key clinical practice areas, and net savings to the WA public health system.
> - *Caring for those who need it most* — Aboriginal health is a key priority and action area with a raft of new initiatives funded through National Partnership Agreements to improve the health and lifestyles of Aboriginal people in rural and remote areas. A number of general reforms and initiatives are underway to streamline the patient's journey through the health system and ensure quality and timely care is available in the most appropriate setting.
> - *Making best use of funds and resources* — Activity Based Funding and Management (ABF/M) has commenced the first stage of operation, allowing the funding of health services on the basis of projected activity. ABF/M provides a clearer link between the dollars spent and services provided to patients and the community. WA Health is continuing to move ahead with a massive hospital building and redevelopment program.
> - *Supporting our team* — WA Health is working to increase the capacity of our existing workforce and ensure a sustainable supply of skilled personnel into the future, including the enhancement of our Aboriginal workforce.
>
> The *Clinical Services Framework (2010–2020)* provides a detailed blueprint to guide health service planning over the coming decade.
>
> A Mental Health Commission, a stand-alone public sector agency, has been established with considerable effort in facilitation provided by WA Health.

South Australian Government comments

Since *South Australia's Health Care Plan 2007-2016* and the GP Plus Program were implemented, growth in inpatient activity has dropped steadily each financial year since, to just 1.86 per cent from 2008-09 to 2009-10 compared with 4.65 per cent from 2005-06 to 2006-07. The Health Care Plan set a target to reduce growth to 2 per cent per annum, and this has been achieved. The Health Care Plan also set a target to reduce average length of multiday inpatient stay to 6.5 days by the forecast horizon of 2011-12. The metropolitan multiday inpatient average length of stay in 2005-06 was 7.4 days, this has reduced steadily each financial year and in 2009-10 was just 6.99 days. GP Plus Service Funds are provided to each Health Region to enable them to implement programs that reduce unnecessary acute care. Significant effort has been made to track the impact of GP Plus Service Funds on the performance of the health system. These achievements are evident in reduced growth in inpatient separations and reduced average length of inpatient stay.

December 2009 saw the formal establishment of the South Australian Health and Medical Research Institute (SAHMRI), which will provide opportunities for cross-disciplinary co-operation and establish SA as a leader in health and medical research. Concept designs for the SAHMRI building were released in February 2010, and work has commenced on a research strategy for the institute.

In 2009-10 SA Health made significant progress towards a number of infrastructure projects of great importance to future delivery of health care to South Australians. The development of the new Royal Adelaide Hospital continued. Demolition and preparatory works for the new $130 million mental health facility at Glenside commenced in May 2010, with the new facilities scheduled to be completed by mid-2012. A 20-bed aged acute ward was opened at the Lyell McEwin Hospital, and upgrades were made to the 20-bed acute ward of the Noarlunga Health Centre. In early 2010 the building of the first Community Mental Health Centre commenced. The department's program of redevelopment continued to modernise and expand the capacity of SA's metropolitan hospitals. In 2009-10, $16.9 million was allocated for the Lyell McEwin Hospital redevelopment, $32.8 million was also invested for the continued redevelopment and expansion of operating theatres and the emergency and intensive care units at the Flinders Medical Centre.

The SA Health Smoke Free Policy was introduced in 2010, and prohibits smoking in all South Australian public health facilities. The 'Health in all Policies' planning process is continuing to be promoted across government.

A Safe Drinking Water Bill has been drafted, and public consultation on the Bill commenced. The Bill will enhance the protection of public health by providing clear standards for drinking water quality and guidance on compliance with the Australian Drinking Water Guidelines. Public consultation was also undertaken as part of the review of the *Public and Environmental Health Act 1987*, with a revised South Australian Public Health Bill in Parliament in late 2010.

Tasmanian Government comments

“ During 2008-09, Tasmania’s health system achieved significant progress despite facing increased demand for services. This increasing demand is related to Tasmania’s ageing population and high rates of chronic disease.

Emergency Departments throughout Tasmania are experiencing increased demand as demonstrated by the increase in the number of presentations in 2008-09. Despite this increased growth, the proportion of patients seen within the recommended timeframes for category 1 patients has remained steady and the proportion of category 2 patients seen on time has increased, when compared with 2007-08.

Through Tasmania’s *Elective Surgery Improvement Plan*, the Tasmanian Government has provided an additional $8.4 million to improve elective surgery access in 2009 and 2010. Tasmania’s *Elective Surgery Improvement Plan* has delivered a broad range of initiatives across both policy and operational areas. In late 2009, the Tasmanian Government reaffirmed its commitment to improving elective surgery waiting times, becoming a signatory of the National Partnership Agreement on the *Elective Surgery Waiting List Reduction Plan*. Under Stage 3 of this Plan, Tasmania will receive a total of $6 million and is on track to receive an additional $3.7 million for sustaining the high levels of elective surgery throughput. The $6 million is being targeted to continue to improve patient flow and reduce the number of patients who have waited longer than is clinically recommended.

In 2009, the Tasmanian Government released *Building the Foundations for Mental Health and Wellbeing, A Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention Approaches in Tasmania*. An immediate priority under the framework is the development of a Suicide Prevention Strategy for Tasmania.

Despite ongoing difficulty in recruiting radiologists and radiographers, participation rates and the number of women screened for breast cancer have increased. A number of strategies are underway in Tasmania to address the radiologist workforce shortages through training and recruitment, and a national committee has been established to develop short, medium and long-term solutions to the shortage of radiographers.

In 2010, Tasmania, along with all Australian State and Territory governments (apart from WA), agreed to a suite of reforms that will change the way health care is funded and delivered in Australia into the future. These national reforms build on changes Tasmania has been putting in place through Tasmania’s Health Plan. While there is broad agreement to the principles of national health reform, many details are still being worked through and resolved at the national level. There are many important decisions to be made, that will have an impact on how the reforms will be implemented in Tasmania. ”

Australian Capital Territory Government comments

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

In February 2009, ACT Health as an entire organisation, was awarded full four year accreditation by the Australian Council Healthcare Standards (ACHS). This makes ACT Health the first health jurisdiction in Australia to be fully accredited — from head office right through to all service delivery units, including the Canberra Hospital.

The year 2008-09 showed the ACT Government’s commitment to deliver services at record levels to more patients and consumers than in the previous year. Overall public hospital inpatient activity recorded growth of 11 per cent from 2007-08.

In the year 2008-09, the ACT’s bed capacity increased by 2.8 per cent from 851 beds in 2007-08 to 875 in 2008-09.

One of the ACT Government funded initiatives to address the emergency department waiting times is to establish Australia’s first public, nurse-led Walk-in-Centre which has now been operational since May 2010. This service provides the community with access to free treatment and care for minor illnesses.

In 2008–2009 the ACT Government embarked on the Capital Asset Development Program (CADP) to revitalise and ready the ACT health system for an expected increase in health care demand over the next 10 to 15 years. The CADP involves the overhaul and expansion of all aspects of the ACT health system.

To date the ACT Government has committed nearly $500 million to the CADP which is ultimately expected to cost over $1 billion over 10 years.

Construction on several projects is well underway including a new Women’s and Children’s Hospital; a new Adult Acute Mental Health Inpatient Unit; and a new multi-storey car park at the Canberra Hospital. At the Canberra Hospital work has been completed on two new operating theatres; a Mental Health Assessment Unit; a nurse-led Walk-in-Centre; a Neurosurgical Intra-operative Magnetic Resonance Imaging suite and a Surgical Assessment and Planning Unit. At Calvary Hospital a new intensive care facility and an operating theatre have also been completed.”

Northern Territory Government comments

The NT Department of Health and Families is working to improve Territorian's access to timely health and family services. Aboriginal Territorians comprise the majority of the department's clients and a majority of Aboriginal Territorians live outside the major population centres. The demography and geography of the NT demand innovative solutions. Shared electronic health records and secure health messaging are two of the ways the department is delivering better services to Territorians where they live. The NT has introduced both systems for a majority of Aboriginal people living in remote parts of the Territory.

Working collaboratively with Flinders University, Charles Darwin University and the Australian Government the department has helped to create the opportunity for Territorians to complete medical training close to home. This collaboration extends to new approaches to secure the cultural competence of medical, nursing and social work graduates. These developments will assist in the retention of locally trained staff and improve the quality of care provided to Territorians.

To enable Aboriginal clients to better understand the journeys that they may have to take such as; going to hospital, having surgery or giving birth, new educational resources and new efforts have been introduced to improve the patient's awareness and understanding.

Improvements in the level of service have also been achieved. During the year the Department launched intensified services to reduce wait times. For dental clients this resulted in a decrease of waiting times for majority of clients who required an assessment for general dental treatment. Working with the Fred Hollows Foundation an intensive service was conducted to improve access to ophthalmic procedures.

12.7 Definitions of key terms and indicators

AR-DRG v5.2 (Australian refined diagnosis related group, version 5.2)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v5.2 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health 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 — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original date of admission or discharge. Key definitional rules include the following: • For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24 hour basis.

Staffing categories (mental health)

Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis.

Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.

Enrolled nurses: Refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and

	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 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' suffix (for example, table 12A.3 is attachment table 3). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Breast cancer

Mental health

Table 12A.23	Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent)
Table 12A.24	Level of psychological distress K10, 2007-08 (per cent)
Table 12A.25	Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent)
Table 12A.26	Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
Table 12A.27	Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
Table 12A.28	Real estimated Australian Government expenditure on mental health services (2008-09 dollars) ($'000)
Table 12A.29	Real estimated recurrent expenditure at the discretion of State and Territory governments (2008-09 dollars)
Table 12A.30	Real Australian Government recurrent expenditure on mental health services per person (2008-09 dollars)
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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 2010a; 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 however, 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) and Homelessness services (chapter 17).

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).

In the 2011 Report, the Supported Accommodation Assistance Program (SAAP) will no longer be reported in Protection and Support services (chapter 15). SAAP will now be reported in Homelessness services (chapter 17), which will be included in the Report for the first time in 2011.

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).

Major improvements in reporting in the community services preface this year include:

- revising the expenditure section text and data on the community services sector, improving its timeliness by two years and its coverage to a broader set of services
- updated data and information on projections of demographics and their effects on demand for community services.

Another major revision is the removal of Supported Accommodation Assistance Program (SAAP) reporting from this preface. Overview material on SAAP has been relocated to section G of this Report, the new 'Housing and homelessness' sector summary.

Other major improvements in reporting on community services this year are identified in each of the service-specific community services chapters.

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 funders and providers of community services (AIHW 2005). However, community services funded solely by local government are not included in 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, out-of-home care services, intensive family support services 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. Family support and early intervention (assessment and referral) services are funded by State and Territory governments and services are primarily delivered by non-government organisations
- specialist disability services are funded largely 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
- Home and Community Care (HACC) services are funded primarily by the Australian Government and delivered primarily by the State and Territory governments.

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 Home and Community Care National Service Standards.

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.

Community Services Australia, 2008-09 (ABS 2010a) compiles, from a directly collected ABS survey, data on community services expenditure incurred by governments and non-government (for-profit and not-for-profit) organisations in providing services to assist members of the community with special needs including personal and social support, residential care and other social assistance services (covering organisations mainly engaged in providing a wide variety of social support services directly to their clients, including, but not limited to, welfare services, disabilities assistance and adult day care centre operation).

It estimates that during 2008-09 there was $25.2 billion spent on direct community services activities and a further $4.0 billion on non-direct and related community services activities. Total expenditure on direct activities comprised $13.8 billion by not-for-profit organisations, $6.7 billion by for-profit organisations, $3.8 billion by Australian, State and Territory government organisations and $0.9 billion by local government. In addition, Australian, State and Territory government organisations provided funding of $9.5 billion to other private organisations and self-employed contractors for the direct provision of community services:

- Personal and social support comprises activities relating to information, advice and referral, individual and family support, independent and community living support and support in the home. During 2008–09, total expenditure on personal and social support was $5.9 billion which accounted for 24 per cent of all direct community services expenditure. Not-for-profit organisations contributed the majority of this with $4.3 billion. The main components of personal and social support expenditure were $1.6 billion for individual and family support, $1.5 billion for support in the home, and $1.5 billion for other personal and social support
- Direct expenditure on residential care for 2008–09 was $12.6 billion. Not-for-profit organisations had the largest allocation with $7.2 billion, followed by for-profit organisations with $3.3 billion, and government organisations with $2.0 billion. Aged and disability care was the most significant activity within residential care, contributing $10.3 billion to total expenditure. The main components of this were high care contributing $6.8 billion (66 per cent), and low care contributing $3.5 billion (34 per cent), of which not-for-profit organisations accounted for $3.3 billion (48 per cent) and $2.5 billion (73 per cent) respectively.

Related information for earlier years is available in *Welfare expenditure Australia 2005-06* (AIHW 2007a).

In 2008-09, social security and welfare expenditure also continued to be a significant area of government spending. Social security and welfare expenditure of $135.9 billion amounted to 30.7 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 ($78.0 billion), followed by welfare services ($54.0 billion), and other services ($4.0 billion) (ABS 2010c).

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, out-of-home care services and intensive family support services.

Each chapter includes more detailed analysis of expenditure items reported.

Recurrent expenditure included in the Report

Total Australia, State and Territory government recurrent expenditure on community services covered by this Report was estimated to be $19.6 billion in 2009-10 (table F.1). This was equivalent to 1.5 per cent of GDP in that year, and 8.4 per cent of total government outlays (table F.1 and ABS 2010b).

Table F.1 **Real government recurrent expenditure on community services (2009-10 dollars)**[a, b, c, d e, f]

	Unit	*Aged care services*	*Services for people with disability*	*Child protection services*	*Total*
2005-06	$m	8 770.7	4 543.8	1 703.5	15 018.0
2006-07	$m	9 377.3	4 835.9	1 950.9	16 164.2
2007-08	$m	9 821.5	5 029.6	2 223.4	17 074.4
2008-09	$m	10 212.0	5 316.9	2 514.3	18 043.2
2009-10	$m	11 013.6	5 747.7	2 820.1	19 581.4
Increase 2005-06 to 2009-10	%	25.6	26.5	65.5	30.4

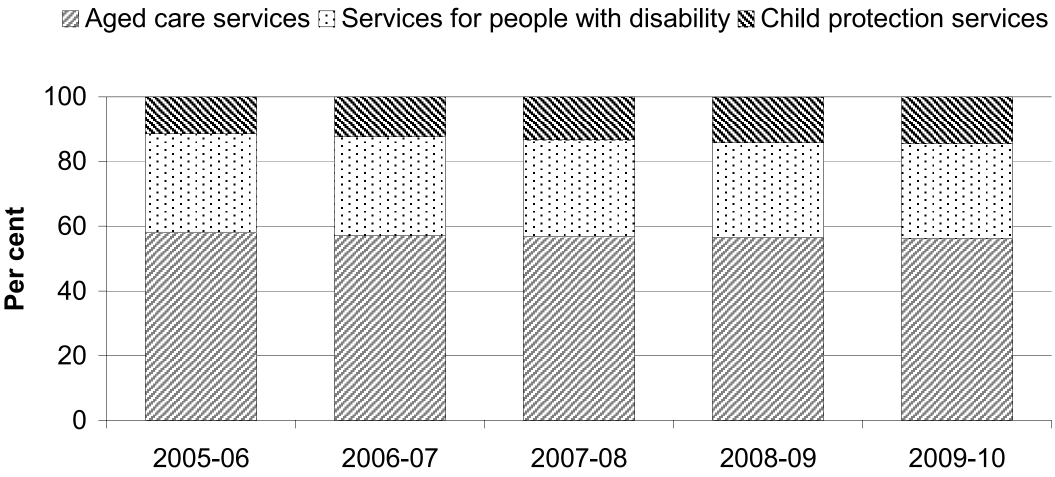
[a] Data for 2005-06 to 2008-09 have been adjusted to 2009-10 dollars using the gross domestic product (GDP) price deflator in table AA.26 of appendix A. [b] Data for aged care services published in the 2008, and earlier, reports differ due to revised data and the inclusion of additional expenditure items in the 2008 and later reports. The 2010 and 2011 reports included new expenditure data for the Community Visitors Scheme, the Innovative Care Pool, CALD programs and Specific Purpose Payments. [c] Totals may not add as a result of rounding. [d] See box F.2 for the major programs included in expenditure for each service. [e] More detailed expenditure data can be found in the relevant chapters of the Report. [f] Child protection services include child protection, out-of-home care and intensive family support services.

Source: Australian, State and Territory governments (unpublished); tables 13A.6, 14A.4, 15A.1 and AA.26.

Between 2005-06 and 2009-10, real government recurrent expenditure on community services increased by $4.6 billion, or 30.4 per cent. The largest proportional increase in real expenditure was on child protection, out-of-home care and intensive family support services (hereafter referred to as child protection services), which increased by 65.5 per cent between 2005-06 and 2009-10. The largest absolute dollar increase for a particular service between 2005-06 and 2009-10 was $2.2 billion for aged care services (table F.1).

In 2009-10, 56.2 per cent of government recurrent expenditure on community services related to aged care services, 29.4 per cent related to services for people with disability, and 14.4 per cent related to child protection services. These proportions have been fairly consistent from 2005-06 to 2009-10 (figure F.1).

Figure F.1 **Government recurrent expenditure on community services**[a, b, c]



[a] Data for aged care services published in the 2008 and earlier reports differ due to revised data and additional expenditure items collected for aged care services for the 2009 and future 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. [c] Child protection services include child protection, out-of-home care and intensive family support services.

Source: Australian, State and Territory governments (unpublished); tables 13A.6, 14A.4 and 15A.1.

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 2009-10. This is expenditure by State and Territory governments and Australian Government expenditure available for reporting at the State and Territory level.

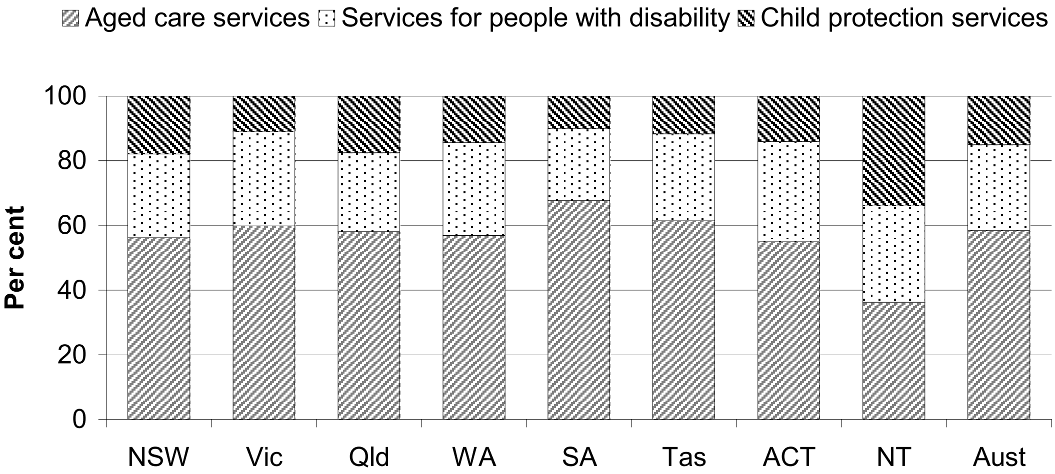
Table F.2 Government recurrent expenditure on community services, 2009-10[a, b, c, d, e, f]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Recurrent expenditure on community services										
Aged care services	$m	3 594.0	2 765.6	2 076.1	957.2	1 072.7	299.7	130.9	64.0	10 960.2
Services for people with disability	$m	1 657.2	1 352.8	866.3	484.4	354.4	131.4	73.6	53.2	4 973.1
Child protection services	$m	1 141.9	503.5	625.8	241.4	157.5	57.0	33.3	59.6	2 820.1
Total	**$m**	**6 393.1**	**4 621.9**	**3 568.2**	**1 683.0**	**1 584.7**	**488.1**	**237.8**	**176.8**	**18 753.5**
Proportion of recurrent expenditure by service										
Aged care services	%	56.2	59.8	58.2	56.9	67.7	61.4	55.0	36.2	58.4
Services for people with disability	%	25.9	29.3	24.3	28.8	22.4	26.9	30.9	30.1	26.5
Child protection services	%	17.9	10.9	17.5	14.3	9.9	11.7	14.0	33.7	15.0
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[g]										
Expenditure per person	$	889.0	840.9	797.7	741.3	969.9	965.8	670.0	776.3	846.4

[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 ($53.3 million in aged care services and $774.6 million in services for people with disability). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. [c] See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. [d] Totals may not add due to rounding. [E] Expenditure for aged care does not include capital expenditure. [F] Child protection services include child protection, out-of-home care and intensive family support services. [g] Population at 31 December 2009.

Source: Australian, State and Territory governments (unpublished); tables 13A.5, 14A.4, 15A.1 and AA.2.

Figure F.2 Government recurrent expenditure on community services, 2009-10 (per cent)[a, b, c]

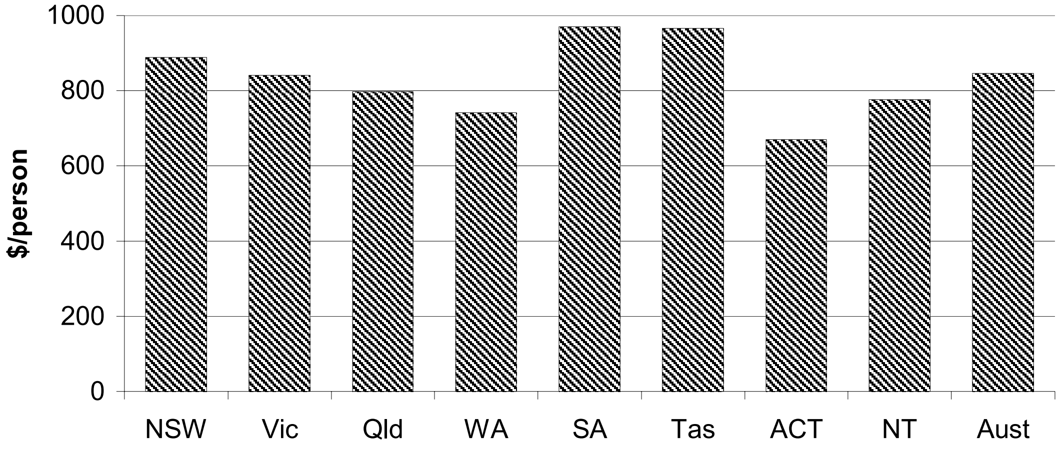


[a] Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. [b] See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. [c] Child protection services includes child protection, out-of-home care and intensive family support services.

Source: Australian, State and Territory governments (unpublished); table F.2.

In 2009-10, community services government recurrent expenditure was $846 per person nationally. Expenditure varied across jurisdictions (figure F.3).

Figure F.3 **Government recurrent expenditure on community services, per person in the population, 2009-10**[a, b, c]



[a] Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. [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. [c] Population at 31 December 2009.

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 2009. Almost 11 000 organisations were providing community services. These included 5 809 not for profit organisations, 4 638 for profit organisations, and 520 government organisations (ABS 2010a).

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. Over half a million people were employed by organisations providing community services, 78 per cent of whom were female. Most employees were aged between 26 and 46 years and over 42 per cent were employed on a permanent part time basis.

There were 325 440 volunteers assisting community services organisations during 2008-09, providing 78 hours of voluntary services on average (ABS 2010a).

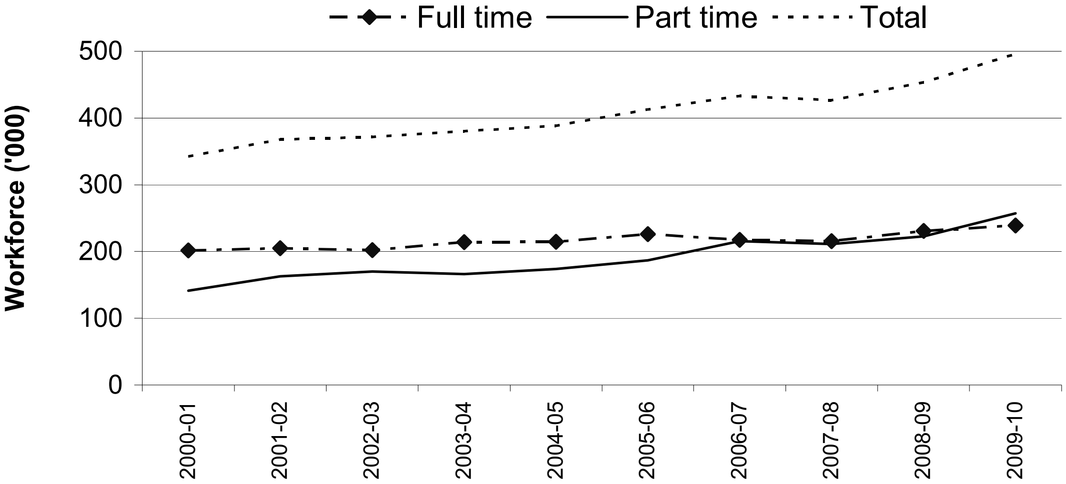
Subsequent developments in the community services workforce can be observed through ABS labour force survey data. These data provide a quarterly estimate of the full and part time workforce for the community services sector, within the broader industry classifications 'residential care services' and '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 and 2011 reports, ABS labour force data are based on the revised 2006 ANZSIC. Therefore, workforce data included prior to the 2010 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 2000-01 to 2009-10. Employment in the community services industry has grown from 342 600 people (58.8 per cent full time and 41.2 per cent part time) to 496 100 people (48.1 per cent full time and 51.9 per cent part time). This represents an average annual increase in employment in the community services sector of 4.2 per cent (figure F.4).

Figure F.4 **Full time, part time and total employment in residential care and other social assistance services, 2000-2001 to 2009-10** [a]



[a] Time series workforce data have been re-cast using the 2006 ANZSIC and are not comparable to workforce data included prior to the 2010 Report.

Source: ABS 2009, *Labour Force*, *Australia, Detailed, Quarterly, May 2009*, Cat. no. 6291.0.55.003, Canberra.

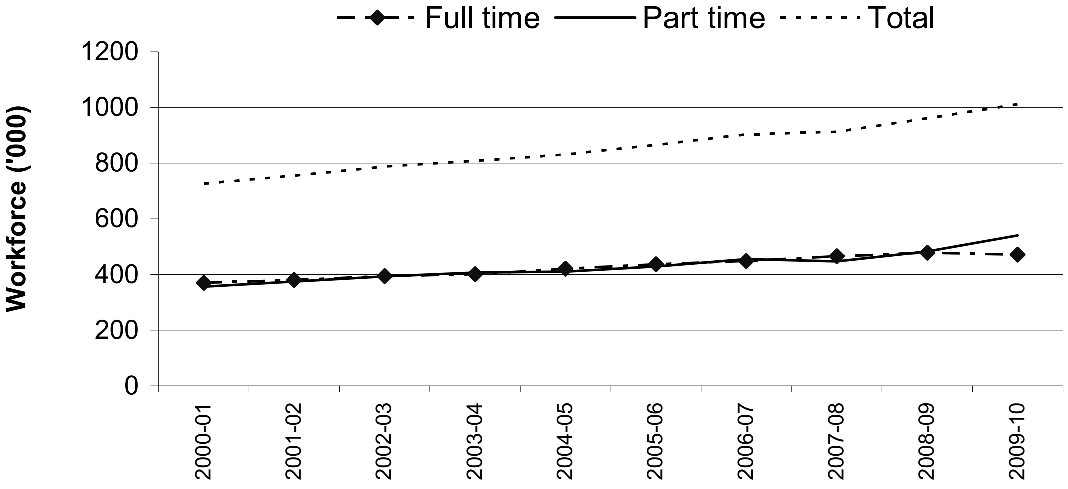
Caution should be exercised in using these data to estimate the size of the community services workforce. The number of people employed in a particular industry does not necessarily reflect the number of people employed in particular occupations. Employment in occupations typically associated with community 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 2000-01 to 2009-10. 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 726 900 people (51.0 per cent full time and 49.0 per cent part time) to 1 011 100 people (46.6 per cent full time and 53.4 per cent part time). This represents an average annual increase in employment in ‘community and personal service occupations’ of 3.7 per cent (figure F.5).

Figure F.5 **Full time, part time and total employment in community and personal service occupations, 2000-2001 to 2009-10**



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 (ABS forthcoming) are expected to be available in 2011.

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 2010, approximately 508 600 people were receiving Carer Allowance and 168 900 people were receiving Carer Payment (Australian Government unpublished; table 14A.1). 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 (Australian Government unpublished; table 14A.1).

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 third Intergenerational Report (Australian Government 2010a) 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 government finances (box F.3).

Box F.3 **Future demographics and the *Intergenerational Report 2010***

Projections in the *Intergenerational Report 2010* show that over the next 40 years:

- the Australian population will continue to increase in size but at slightly lower rates than over the past 40 years, with a higher proportion of older people. The proportion of those over 65, 13.5 per cent in 2010, is predicted to reach 23 per cent of the population by 2050
- economic growth per person will slow as the proportion of the population of traditional working age falls
- substantial fiscal pressures will emerge due to predicted costs of climate change and projected increases in government spending, particularly in the areas of health, age related pensions and residential 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. Projected growth in real GDP, however, is expected to slow relative to the past 40 years.

Source: Australian Government (2010a).

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 initiatives across Australian, State and Territory governments such as *A Stronger, Fairer Australia – a new social inclusion strategy* (Australian Government 2010b).

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: 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 September 2009, the Australian Government launched the Australian Institute for Population Ageing Research (AIPAR), based at the University of New South Wales. The AIPAR will bring together cross-disciplinary research on the issue of population ageing to inform economic and social policy. The AIPAR will also maintain a 'Longevity Index' to track the extent to which Australians are able to maintain their living standards over their lifetime (UNSW 2009).

On 30 April 2009, COAG endorsed *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020* ("the National Framework"). The National Framework argues that Australia needs to think more broadly about the notion of 'protecting children'. Rather than defining 'protecting children' as a statutory response to abuse and neglect, the National Framework contends protecting children should be seen as a community and cross-sector responsibility. The National Framework is intended to deliver a more integrated response to protecting Australia's children and emphasises the role of government, the non-government sector, and the community in achieving these aims. As reporting for the National Framework progresses, the Steering Committee will consider the suitability of some of the high-level, cross-sector performance indicators in the National Framework for inclusion in the Community services sector summary in the 2012 Report.

There are also links between community services and other government services. Access to effective community services can influence outcomes for clients of education, health, housing and justice sector services. In turn, access to these other service areas can affect community services outcomes.

The community services and health sectors are closely related and their effective interaction assists the provision of services in both sectors. The disability sector is also strongly linked to health services by the needs of clients, as people with disability tend to have a larger number of poor health conditions than the general population (AIHW 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 carers are also important recipients of HACC assistance. The HACC National Program Guidelines note that the Program provides funding for services that support both frail aged people and younger people with disability and their carers:

- who live at home and whose capacity for independent living is at risk
- who are at risk of premature or inappropriate admission to long term residential care (Australian Government 2007).

The HACC program is jointly funded by the Australian Government and State and Territory governments under the HACC Review Agreement. In 2008-09, government expenditure on the HACC program was around $1.9 billion. The Australian Government provided 61 per cent of funding and the State and Territory governments 39 per cent (table 13A.9). The HACC Review Agreement and the associated Special Purpose Payment (SPP) will cease from 30 June 2011. Commencing 1 July 2011, the Australian Government will assume funding and program responsibility for aged care including HACC services provided to people aged 65 years or over (aged 50 years or over for Indigenous Australians) for states and territories (with the exception of Victoria and WA). States and territories will assume responsibility for funding and regulating HACC services delivered to people aged under 65 years (aged 50 years or under for Indigenous Australians) (COAG 2010a; COAG 2010b).

In 2009-10, 22.7 per cent of HACC clients were aged under 65 years (down from 23.2 per cent in 2007-08). Analysis of data from the HACC program in 2009-10 indicates that clients aged under 65 years were significantly over-represented in particular assistance types, including respite care (68.6 per cent), case management (51.1 per cent), carer counselling support (45.5 per cent) and personal care (42.5 per cent) (DoHA unpublished). In 2009-10, 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 2006-07. In 2009-10, 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 replace this preface with a Community services sector summary and continue to expand reporting 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.

Each chapter (aged care, services for people with disability and protection and support services) contains a service specific section on future directions in performance reporting. The aim of this section is to provide an insight into other related and overarching developments on reporting in the community services sector.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the Report in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the 'Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'.

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13 Aged care services

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '13A' 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 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.

Major improvements in reporting on aged care services this year include:

- reporting new measures for the indicator 'compliance with service standards in community care' for the Community Aged Care Packages (CACP), Extended

Aged Care at Home (EACH), EACH Dementia (EACH-D) and the National Respite for Carers Program (NRCP) programs

- inclusion of the following indicators/measures to align this Report with National Healthcare Agreement (NHA) aged care indicators:
  - operational aged care places
  - selected adverse events in residential aged care
  - hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care
- expansion of time series data reporting in some attachment tables, in particular five years of data are now reported for most aged care expenditure and Home and Community Care (HACC) data
- inclusion of some 'data quality information' (DQI) documentation.

Older Australians are also users of other government services covered in this Report, including disability services (chapter 14), specialised mental health services (chapter 12), and housing assistance (chapter 16). Understanding the relationship between the health system and the aged care system is of particular importance (preface E and chapters 10–12), given that people aged 65 years or over account for around 50 per cent of all patient days in public hospitals (AIHW 2009). Interactions between health and aged care services are critical for the performance of both systems: for example, the number of operational residential aged care places can affect demand for public hospital beds, and throughput of older patients in acute and sub-acute care has a substantial effect on demand for residential and community aged care.

13.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients, as distinct from specific age criteria. Nevertheless, in the absence of more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Particular groups (notably Indigenous people) can require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. People aged 70 years or over plus Indigenous people aged 50–69 years are used as a proxy 'target' population for aged care services in this Report. The Australian Government uses this population as a ‘planning population’ to allocate aged care places under the *Aged Care Act 1997*. Nationally, the proportion of the population who are in this category was 9.8 per cent, although the proportion varies across jurisdictions (tables 13A.1 and 13A.2).

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The services covered include:

- assessment and information services, which are largely provided by the Aged Care Assessment Program (ACAP)
- residential care services, which provide permanent high level and low level care, and respite high/low level care
- community care services, including home-based care and assistance to help older people remain, or return to, living independently in the community as long as possible. These services include:
  - HACC program services
  - CACP
  - flexible care services provided under the EACH and the EACH-D programs
  - services provided by the Department of Veterans’ Affairs (DVA) under the Veterans’ Home Care (VHC)[1] and Community Nursing programs
- community care respite services, which include HACC respite and centre-based day care services and services provided under the NRCP
- services provided in mixed delivery settings, which are designed to provide flexible care or specific support:
  - flexible care services, which address the needs of care recipients in ways other than that provided through mainstream residential and community care — services are provided under the Transition Care Program (TCP), Multi-purpose Service Program (MPS), Innovative Care Pool and National Aboriginal and Torres Strait Islander Flexible Aged Care Program
  - specific support services, which are provided to address particular needs such as those under the Long Stay Older Patients initiative and in Day Therapy Centres.

The formal publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more

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[1] Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC.

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

The funding and regulation of aged care services are predominantly the role of the Australian Government (although all three levels of government are involved). The *Aged Care Act 1997*, together with the accompanying *Aged Care Principles*, are the main regulatory instruments establishing the aged care framework. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability (Productivity Commission 2010).

Aged Care Assessment Program

The Australian Government established the ACAP in 1984. An assessment and approval by an Aged Care Assessment Team (ACAT) is mandatory to be eligible for admission to Australian Government subsidised residential care (including respite) or to receive a CACP, EACH package, EACH-D package or enter the TCP. People can also be referred by 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).

The Australian Government has oversight of policy and guidelines, and provides grants to State and Territory Governments specifically to operate ACATs. State and Territory governments are responsible for the day to day operation and administration of the ACAP, including the provision of the necessary accommodation and some support services. The scope and practice of the ACATs differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a hospital or a community service) and this has an effect on program outputs.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.1).

Box 13.1 **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 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 of the initiative has enabled the implementation of a range of Australian, State and Territory governments' activities to improve the timeliness, quality and consistency of ACAT recommendations. Many of the activities from earlier years were continued in 2009-10. Additional activities that were implemented include:

- the capacity for ACATs to electronically submit the Aged Care Client Record to Medicare Australia
- the development and delivery of the ACAP National Training Strategy
- national training resources (including national orientation and delegation training resources in administrative law for ACAT by the Senior Commonwealth Lawyer in hard and electronic formats)
- a national ACAP Conference held in May 2010
- legislation changes to reduce the amount of unnecessary reassessments by ACATs
- a project to identify a set of validated assessment tools
- the development of an overarching Implementation Plan for the recommendations of the National Review of ACATs
- improved communication to ACATs by enhancing the format and content of written communications with ACATs nationally.

State and Territory governments also continue to undertake a range of projects to improve the timeliness, consistency and quality of ACAT assessments.

Source: Department of Health and Ageing (DoHA) (unpublished).

Residential care services

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.2).

Box 13.2 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In February 2007, the Australian Government announced an increase in the provision ratio to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. More detail is provided in box 13.10.

Under the arrangements:

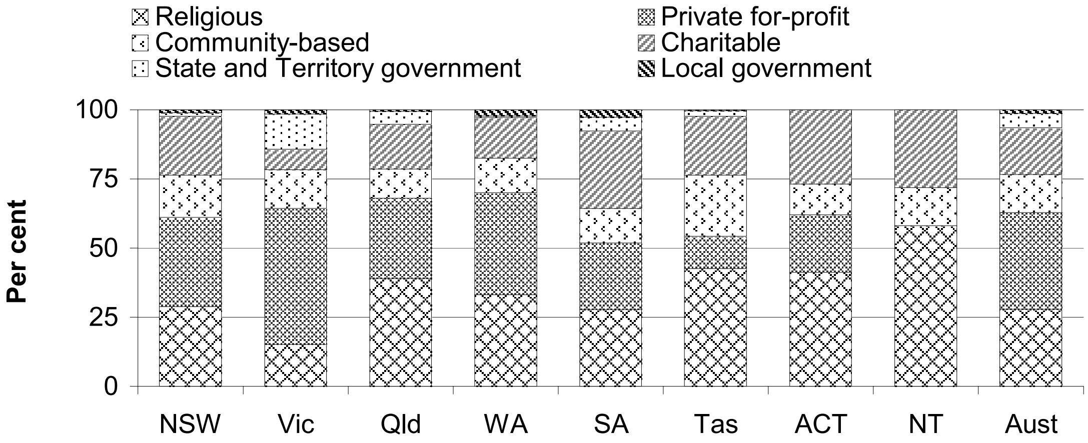
- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria 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 1997* as a provider of aged care
- principles (regulations) created under the *Aged Care Act 1997* establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the administration of medicines and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Industrial relations arrangements and outcomes vary between and within jurisdictions.

Source: DoHA (unpublished).

Religious and private for-profit organisations were the main providers of residential care at June 2010, accounting for 27.9 per cent and 35.0 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and charitable organisations accounted for a further 13.7 per cent and 16.9 per cent respectively. State, Territory and local governments provided the remaining 6.4 per cent (figure 13.1).

Figure 13.1 **Ownership of operational residential places, June 2010**[a, b]



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[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.

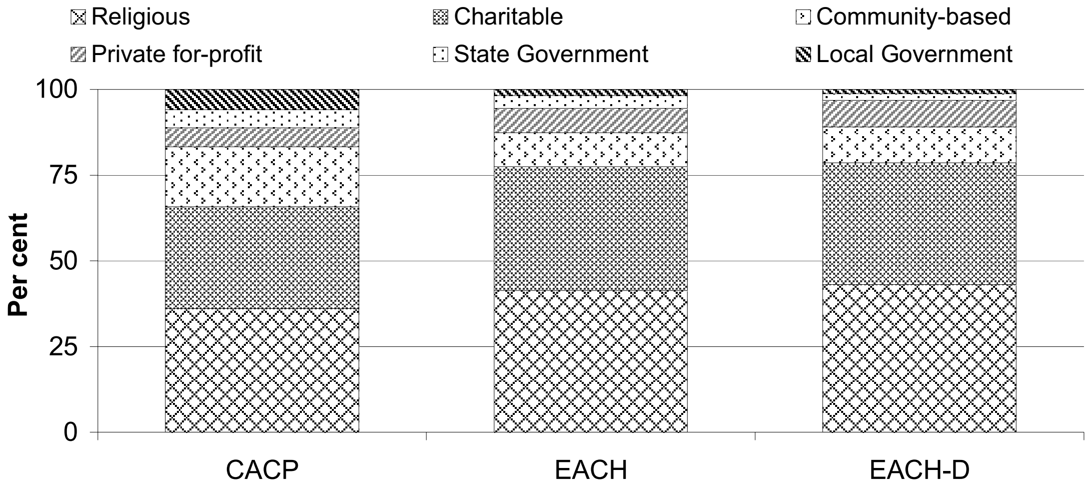
Source: Department of Health and Ageing (DoHA) (unpublished); table 13A.16.

Community care services

The main community care programs reported in this chapter are the HACC, CACP, EACH, EACH-D and the VHC programs. The HACC program is a joint Australian Government, and State and Territory governments’ initiative administered under the *Home and Community Care Act 1985* (DoHA 2009). The State and Territory governments provide the day to day management and the Australian Government has a broad strategic policy role. HACC service providers vary from small community-based groups to large charitable and public sector organisations.

The Australian Government (Department of Health and Ageing [DoHA]) is primarily responsible for the policy oversight and regulation of the CACP, EACH and EACH-D programs. Religious and charitable organisations were the main providers of Australian Government subsidised community care places across the three programs at June 2010 (figure 13.2). EACH and EACH-D services are considered flexible care under the *Aged Care Act 1997*, but because of their nature are classified in this chapter as community care.

Figure 13.2 **Operational CACP, EACH and EACH-D places, by provider type, June 2010**[a, b]



[a] 'Community-based' organisations provide a service for an identifiable community based on locality or ethnicity, not for financial gain. [b] 'Charitable' organisations provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: DoHA (unpublished).

The Australian Government (DVA) is primarily responsible for policy oversight and regulation of the VHC programs and community nursing services for veterans and war widows/widowers. These services are delivered either by organisations contracted by DVA or through arrangements with State and Territory governments. There were 78 304 people approved for VHC services in 2009-10 and 31 713 people receiving community nursing services (table 13A.13). This includes services provided to assist carers.

Services provided in mixed delivery setting — flexible care services

Flexible care provided under the *Aged Care Act 1997* includes EACH and EACH-D packages (described above), the TCP, MPS and innovative care places.

- The TCP is jointly funded by the Australian, State and Territory governments. Its operation is overseen by the Transition Care Working Group, which includes representatives from all State and Territory governments and the Australian Government. Within the framework of the program, State and Territory governments as the approved providers develop their own service delivery models.
- MPS are a joint initiative between the Australian Government and State and Territory governments. Australian Government aged care funding is combined with State and Territory governments funding for health and aged care to bring a

flexible mix and range of aged care and health services together under one management structure. State and local governments are the major providers of MPS, which are primarily located in small rural hospital settings (DoHA 2009).

- The Aged Care Innovative Pool is designed to test new approaches to providing aged care. At the beginning of each financial year, the Australian Government's Minister for Ageing determines the flexible care subsidy rates for the Innovative Pool pilots. Innovative Pool program service providers are Approved Providers from the community care sector across five states (DoHA 2009). Further information on the TCP, MPS, and innovative care places is provided in box 13.3.

Box 13.3 **Flexible care programs**

Transition care

The TCP provides goal-oriented, time-limited and therapy-focused care to help eligible older people complete their recovery after a hospital stay. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than prematurely enter residential care
- optimise the functional capacity of those older people who are discharged from transition care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

Transition care can be provided either in a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is 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 TCP on clients and systems and its cost effectiveness has been undertaken. Key findings of the evaluation were that functional improvement occurred and that older people who received transition care had fewer readmissions to hospital and were less likely to move into permanent residential aged care (DoHA 2008).

Multi-purpose services (MPS)

The MPS Program supports the integration and provision of health and aged care services for small rural and remote communities. Some health, aged and community care services may not be viable in a small community if provided separately. By bringing the services together, economies of scale are achieved to support the services.

(Continued next page)

Box 13.3 **(continued)**

Innovative care

The Aged Care Innovative Pool supports the development and testing of flexible models of service delivery in areas where mainstream aged care services might not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the Innovative Pool, which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded and operate outside the regulatory framework of the *Aged Care Act 1997*. Aboriginal and Torres Strait Islander people also access mainstream services under the *Aged Care Act 1997*, including those managed by Aboriginal and Torres Strait Islander organisations.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program aims to provide quality, flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. Flexible Aged Care services deliver a mix of residential and community aged care services to meet the needs of the community.

Some services managed by non-Indigenous approved providers also have significant numbers of Aboriginal and Torres Strait Islander clients. All aged care services that are funded under the *Aged Care Act 1997* are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services 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.

Services provided in mixed delivery setting — specific support

A range of programs designed to meet specific support needs of older people across care settings are funded and operate outside the regulatory framework of the *Aged Care Act 1997*. The Day Therapy Centre Program, for example, provides a wide range of therapy services to frail older people living in the community and to residents of Australian Government funded residential aged care facilities.

The Australian Government established, funds and oversights most of these programs. The Long Stay Older Patient Initiative is one exception. This program was established as part of the COAG national health and aged care agenda. The Australian Government has funded State and Territory governments to provide services under this initiative since 2006-07 (box 13.4).

Box 13.4 **Long Stay Older Patient Initiative**

From July 2006, a four-year program commenced to 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.

From July 2010, the initiative was extended for a further two years.

Source: COAG (2006); Federal Budget (2010-11).

Funding

Recurrent expenditure on aged care services reported in this chapter was $11.0 billion in 2009-10 (table 13.1). Table 13.1 does not include all State and Territory government expenditure, for example, the experimental estimates of expenditure on non-HACC post acute packages of care (table 13A.11), or any Australian Government or State and Territory government capital expenditure (table 13A.12).

Table 13.1 Recurrent expenditure on aged care services reported in the Aged care services chapter, 2009-10

Expenditure category	*$ million*
Assessment and information services[a]	96.7
Residential care services[b]	7 289.6
Community care services[c]	3 168.9
Services provided in mixed delivery settings[d]	458.4
Total	**11 013.6**

[a] Assessment and information services include only Australian Government expenditure. [b] Residential care services include DoHA and DVA (including payroll tax supplement) and State and Territory governments' expenditure. [c] Community care services include HACC, CACP, EACH, EACH-D, NRCP, Community care grants, VHC, DVA Community Nursing and Assistance with Care and Housing for the Aged. [d] Services provided in mixed delivery settings include MPS, TCP, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Day Therapy Centres, Continence Aids 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: DoHA (unpublished); State and Territory governments (unpublished); table 13A.5.

Assessment services

There were 112 ACATs (111 Australian Government funded) at 30 June 2010 (DoHA unpublished). In 2009-10, the Australian Government provided funding of $75.6 million nationally for the aged care assessment program (table 13A.7). Australian Government ACAT expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was $35 nationally during 2009-10 (table 13A.7). State and Territory governments also contribute funding for ACATs, but this expenditure is not included in the chapter.

Aged care assessment program activities and costs for 2008-09 are reported in table 13A.77.

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 $7.1 billion in 2009-10, comprising DoHA expenditure of $6.0 billion (table 13A.8) and DVA expenditure of $1.1 billion (table 13A.8).

Australian Government basic subsidy

The Australian Government annual basic subsidy for each occupied place varies according to clients' levels of dependency and includes the Conditional Adjustment Payment (CAP). The CAP was introduced in 2004-05 as part of the Australian Government's initial response to the Review of Pricing Arrangements in Residential Aged Care. The amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount. Since 2008-09, the percentage has been set at 8.75 per cent.

At June 2010, the average annual subsidy per residential place, including the CAP, was $39 516 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.17.

Table 13.2 **Average annual Australian Government basic subsidy (all levels) per occupied place at June 2010**[a]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Subsidy level (includes CAP)	$	39 624	39 419	38 256	39 164	42 534	38 139	38 452	39 672	39 516

[a] See footnotes to table 13A.17 for further information.

Source: DoHA (unpublished); table 13A.17.

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.17.

Table 13.3 **Dependency levels of permanent residents, June 2010**[a, b, c]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportions of residents										
Aged Care Funding Instrument										
Activities of daily living										
High	%	37.4	32.7	31.6	32.8	35.3	31.2	31.3	41.0	34.0
Medium	%	28.8	31.5	27.1	31.4	25.7	29.0	28.5	24.8	28.0
Low	%	27.0	26.8	30.6	26.8	32.6	28.7	31.6	28.6	28.8
Nil	%	6.9	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	%	43.2	43.9	37.8	45.1	49.3	33.5	46.4	32.7	42.9
Medium	%	24.4	25.4	24.5	24.9	25.5	23.4	23.2	30.5	24.8
Low	%	19.6	19.5	21.8	19.5	17.5	24.8	17.8	24.9	19.9
Nil	%	12.8	11.2	15.9	10.6	7.7	18.3	12.6	12.0	12.4
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Complex health care										
High	%	17.1	18.0	14.2	15.3	23.5	17.9	16.4	19.8	17.3
Medium	%	30.3	31.4	27.3	32.7	32.0	25.8	33.1	24.6	30.3
Low	%	36.8	36.4	39.6	38.0	34.1	39.0	34.3	36.3	37.1
Nil	%	15.7	14.2	18.9	14.0	10.4	17.2	16.1	19.3	15.3
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Numbers of residents										
Total High	no.	39 975	29 588	20 170	9 532	11 937	2 807	1 222	316	115 547
Total Low	no.	17 339	13 413	9 754	4 326	3 856	1 451	588	121	50 848
All High/Low	**no.**	**57 314**	**43 001**	**29 924**	**13 858**	**15 793**	**4 258**	**1 810**	**437**	**166 395**

[a] See footnotes to table 13A.17 for further information. [b] Totals may not add as a result of rounding. [c] Information on the Aged Care Funding Instrument (ACFI) and the characteristics of residents is provided in box 13.5.

Source: DoHA (unpublished); table 13A.17.

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement). Reported expenditure in these three categories was $192.5 million in 2009-10 (table 13A.8).

Capital expenditure

The Australian Government provided $35.2 million in 2009-10 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.12). In addition, capital expenditure by some State and Territory governments on residential aged care services in 2009-10 was $13.6 million (table 13A.12).

Capital expenditure on aged care services in 2009-10 is summarised in table 13A.12. 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 (table 13.4). More detailed data are in the attachment tables referenced. Data on Australian, State and Territory governments' expenditure per person in the target population by jurisdiction are contained in table 13A.6. Recipients of community care services can also contribute towards the cost of their care.

Total government expenditure on HACC under the HACC Review Agreement was $1.9 billion in 2009-10, consisting of $1.2 billion from the Australian Government and $757.7 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.9). Recipients of HACC services can also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending $508.7 million on the program in 2009-10 (table 13.4). CACPs are also partly funded by client contributions. The Australian Government also funds flexible care services under the EACH and EACH-D programs, spending $206.0 million and $99.6 million respectively on these programs in 2009-10 (table 13.4). EACH and EACH-D packages are also partly funded by client contributions.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $200.0 million in 2009-10 (table 13.4). The NRCP assisted 143 387 people in 2009-10 (table 13A.15). A breakdown of Australian Government expenditure on NRCP by State and Territory is reported in table 13.4.

Table 13.4 Governments' expenditure on selected community care programs, 2009-10 ($million)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
HACC expenditure by the Australian, State and Territory governments under the HACC Review Agreement									
	588.4	472.5	429.2	196.7	162.2	54.7	28.8	12.0	1 944.5
Australian Government expenditure									
CACP	175.2	131.8	83.9	44.2	45.0	13.5	6.8	8.4	508.7
EACH	67.2	53.4	32.5	21.8	16.3	5.9	5.4	3.6	206.0
EACH-D	33.3	24.7	16.0	10.2	8.5	3.5	2.1	1.2	99.6
NRCP	63.8	44.3	34.9	17.3	17.4	6.7	9.6	5.9	200.0

Source: DoHA (unpublished); table 13A.5.

The DVA also provided $90.8 million for the VHC program and $109.6 million for veterans community nursing services during 2009-10 (table 13A.9). VHC recipients can also contribute towards the cost of these services.

Services provided in mixed delivery settings

Five types of flexible care are provided under the *Aged Care Act 1997* (EACH and EACH-D packages, TCP, MPS and innovative care places). Expenditure relating to EACH and EACH-D is reported above. The Australian, State and Territory governments fund the TCP. In 2009-10, the Australian Government spent $107.5 million and the State and Territory governments spent $84.6 million on the TCP (table 13A.10). The Australian Government also funds the MPS program (in conjunction with State and Territory governments) and the Innovative Care Pool. In 2009-10, the Australian Government spent $104.5 million and $3.2 million on these programs, respectively (table 13A.10). In addition to expenditure on these five flexible care programs, the Australian Government spent $23.4 million on Indigenous specific services delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Australian Government expenditure data by jurisdiction on a range of other services provided in mixed delivery settings targeting older people are contained in table 13A.10. Australian Government expenditure on these programs was $97.7 million in 2009-10. These programs include Day Therapy Centres, Continence Aids Assistance Scheme, the National Continence Management Strategy, Dementia Education and Support, Community Visitors Scheme and Culturally and Linguistically Diverse aged care (CALD) (table 13A.10). In addition, Australian Government expenditure on the Long Stay Older Patient Initiative (see box 13.4) was $37.5 million in 2009-10 (table 13A.5).

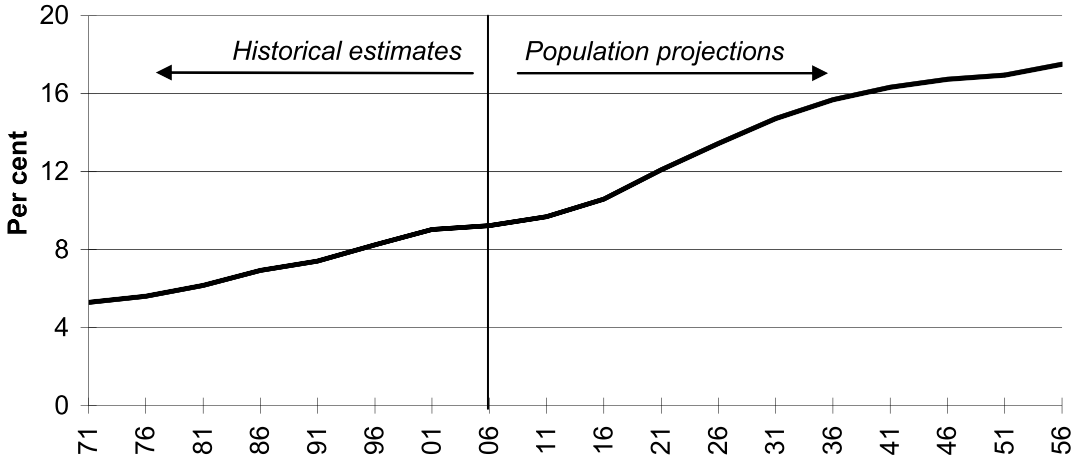
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 13.3). The proportion of older people is 9.6 per cent nationally but varies across jurisdictions (figure 13.4). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males in the total population (except the NT) (table 13A.1).

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 more likely to live alone.

Figure 13.3 **People aged 70 years or over as a proportion of the total population**[a]



[a] Population projections are derived from the ABS ‘B’ series population projections.

Source: ABS (2008) *Australian Historical Population Statistics, 2008*, Cat. no. 3105.0.65.001, Canberra; ABS (2008) *Population Projections Australia 2006–2101*, Cat. no. 3222.0, Canberra.

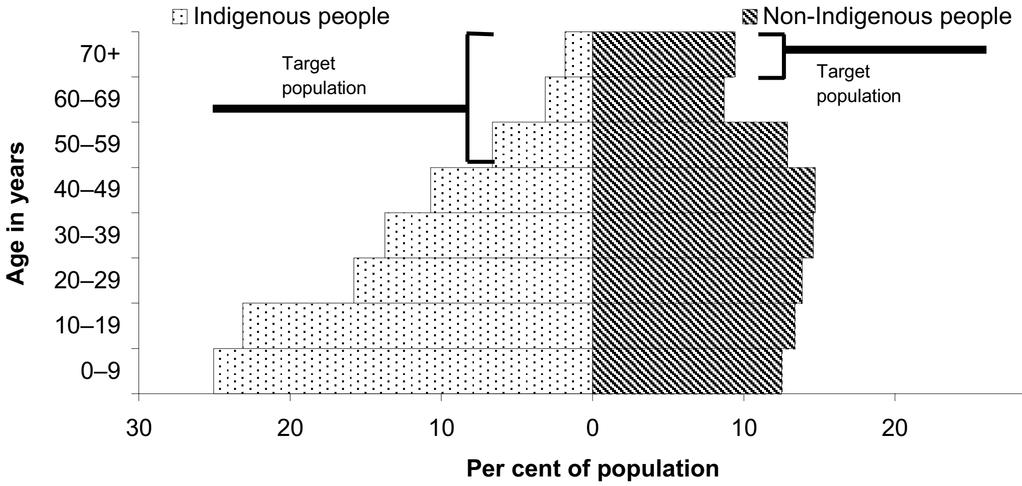
Figure 13.4 **Estimated proportion of population aged 70 years or over, by gender, June 2010**

Source: Population projections prepared by the ABS using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and DoHA (unpublished); table 13A.1.

Characteristics of older Indigenous people

The DoHA estimates that about 67 107 Indigenous people were aged 50 years or over in Australia at 30 June 2010 (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 13.5). Estimates show life expectancy at birth in the Indigenous population is around 11.5 years less for males and 9.7 years less for females when compared with the total Australian population (ABS 2009). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 13.5 **Age profile and target population differences between Indigenous and other Australians, June 2006**

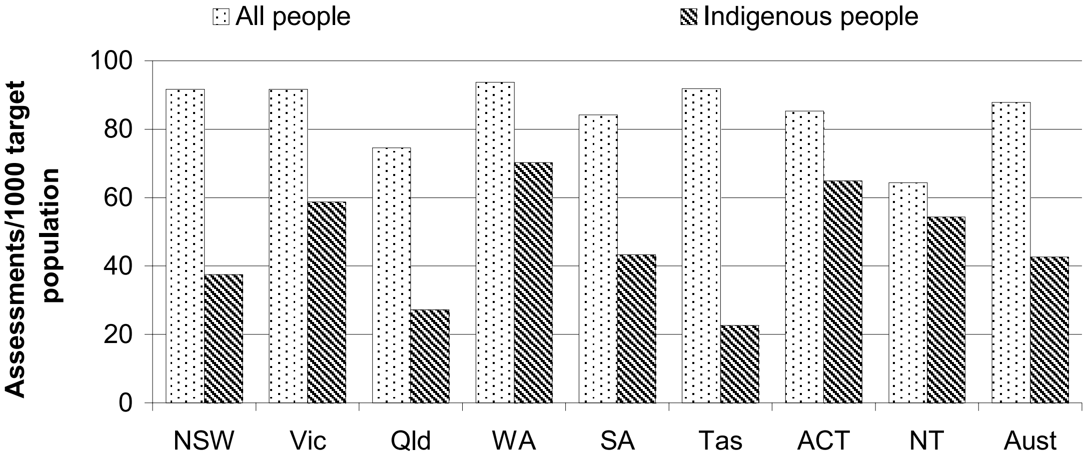


Source: ABS (2008) *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, June 2006, Cat. no. 3238.0.55.001, Canberra.

Aged Care Assessments

Aged care assessments are designed to assess the care needs of older people and assist them to gain access to the most appropriate type of care. The number of assessments of people aged 70 years or over and Indigenous people aged 50–69 years per 1000 target population varied across jurisdictions in 2008-09. The national rate was 87.8 assessments per 1000 people aged 70 years or over and Indigenous people aged 50-69 years. The rate for Indigenous people was 42.7 per 1000 Indigenous people aged 50 years or over (figure 13.6). Data on the numbers and rates of assessment for people of all ages by age group, Indigenous status, remoteness of residence and Socio-Economic Indexes for Areas (SEIFA), are in table 13A.65.

Figure 13.6 **Aged Care Assessment Team assessment rates, 2008-09**[a, b, c, d, e]

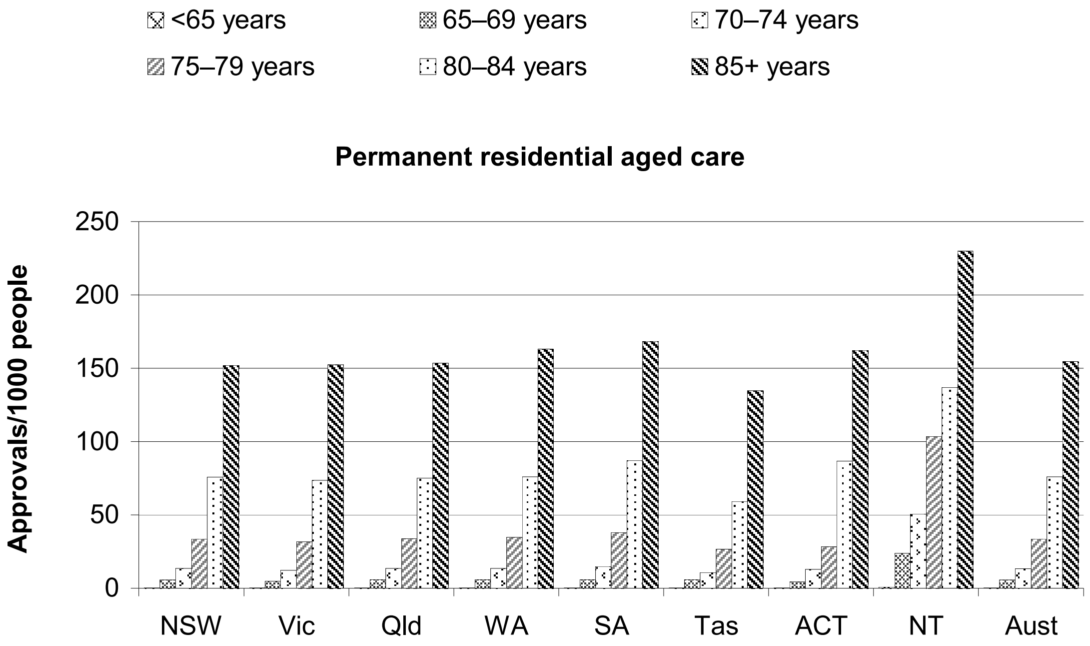


[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. [c] 'Indigenous' includes all assessments of Indigenous 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.63 for further explanation of these data.

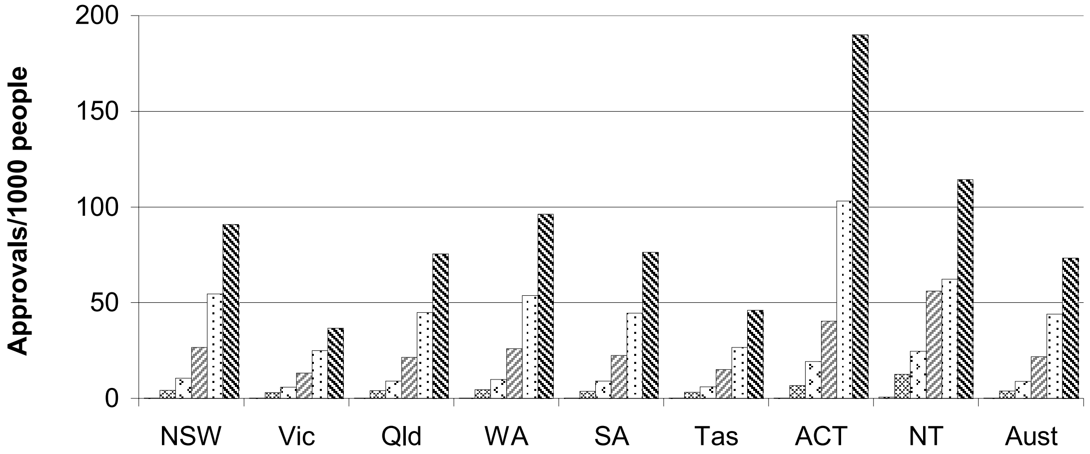
Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.63.

ACAT assessments that result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH-D). The approval rates for both residential and community care services vary across jurisdictions and increase with age (table 13A.64 and figure 13.7). 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 13.7 **Age-specific approval rates, per 1000 people in the population, 2008-09**[a, b]



Community care (CACP, EACH and EACH-D) programs



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[a] Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. [b] The age category population data for this figure are derived from ABS estimated resident population figures as at 30 June 2009.

Source: DoHA (unpublished); table 13A.64.

Residential care services

Residential care services provide permanent high level and low level care and respite high/low level care:

- high care combines nursing care with the types of services provided in low care such as accommodation, support services (cleaning, laundry and meals) and personal care services
- low care focuses on personal care services, accommodation, support services (cleaning, laundry and meals) and some allied health services such as physiotherapy — nursing care can be given when required
- respite provides short term residential high/low care on a planned or emergency basis (DoHA 2009).

At June 2010, there were 2773 residential aged care services (table 13A.18). Low care services are generally smaller (as measured by number of places) than high care services. At June 2010, 62.1 per cent of low care services had 60 or fewer places (table 13A.20), compared with 31.4 per cent of high care services (table 13A.21).

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 179 749 mainstream operational places (excludes flexible care places) in residential care services (78 075 in predominantly high care services, 4377 in predominantly low care services and 97 297 in services with a mix of high care and low care residents) at June 2010 (tables 13A.18–21). Box 13.5 contains information on the planning and allocation of residential aged care places and how the Aged Care Funding Instrument is used to appraise a resident’s needs as high or low care.

Box 13.5 **Planning and allocation of residential aged care places and the Aged Care Funding Instrument**

Planning and allocating of places

The *Aged Care Act 1997* (part 2.2) details the processes for planning and allocating Australian Government subsidised services to meet residential aged care needs and community care needs. Planning 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.

Aged Care Funding Instrument and the characteristics of residents

Aged Care Assessment Teams (ACATs) assess and approve clients for residential and community care. ACAT approvals for residential care can limit the approval for some residents to low care. Following this, approved providers of age care homes appraise the level of a resident's care needs using the ACFI.

The ACFI measures each resident's need for care (high, medium, low or nil) in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The ACFI was introduced on 20 March 2008 and replaced the Resident Classification Scale (RCS).

Residents are classified as high or low care based on the resident's level of approval for care (determined by an ACAT) and on the approved provider's appraisal of the resident's care needs against the ACFI, in the following manner:

- Residents who have not yet received an ACFI appraisal are classified using their ACAT assessment.
- Residents whose ACAT approval is not limited to low care, are classified as high care[a] if they are appraised under the ACFI as:
  - High in Activities of Daily Living, or
  - High in Complex Health Care, or
  - High in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domains; or
  - Medium in at least two of the three domains.
- All other residents appraised under the ACFI are classified as low care residents.

[a] From 1 January 2010, the definition for high care under the ACFI has changed to make it more like it was before the ACFI was introduced (see www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-factsheets.htm).

(Continued next page)

Box 13.5 **(continued)**

- In addition, residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range are classified as 'interim low' until the ACAT low care restriction is removed, or the ACFI High status is confirmed by a subsequent assessment or review.

Residents care needs may change over time. Under 'ageing-in-place', a low care resident who becomes high care at a later date is able to remain within the same service.

The combined number of all operational high care and low care residential places per 1000 people aged 70 years or over at June 2010 was 86.8 (42.8 high care and 44.0 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 2006 and 2010 (table 13A.24).

Table 13.5 **Operational high care and low care residential places, 30 June 2010**[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	41.6	40.2	37.6	49.0	45.0	34.5	50.7	42.8
Low care places	no.	42.5	46.3	44.6	43.4	43.4	39.6	45.9	40.4	44.0
Total places	**no.**	**87.5**	**87.9**	**84.8**	**81.1**	**92.4**	**84.5**	**80.3**	**91.1**	**86.8**
Proportion of places										
High care places	%	51.4	47.3	47.4	46.4	53.1	53.2	42.9	55.6	49.3
Low care places	%	48.6	52.7	52.6	53.6	46.9	46.8	57.1	44.4	50.7

[a] Excludes places that have been 'approved' but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. [b] For this Report, Australian Government planning targets are based on providing 88 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [c] Includes residential places categorised as high care or low care. [d] See table 13A.24 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2009-10. [e] Data in this table may not add due to rounding.

Source: DoHA (unpublished); table 13A.24.

Age specific usage rates for permanent residential aged care services, by jurisdiction and remoteness, at 30 June 2010 are included in tables 13A.35 and 13A.42 respectively. Age specific usage rates for these permanent residential services combined with community care program services (CACP, EACH and EACH-D) are in tables 13A.40 and 13A.44. Indigenous age specific usage rates for all these services by remoteness category are in table 13A.45.

During 2009-10, the number of older clients (aged 70 years or over plus Indigenous people aged 50–69 years) who received either high or low care in a residential aged care facility was 200 812 nationally for permanent care and 41 300 nationally for respite care. These figures reflect the number of older individuals who utilised these services during the year, for any length of time (table 13A.4). Data on the number of younger people aged under 65 years who used permanent residential care during 2009-10 are in table 13A.41.

Community care services

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, CACP, EACH, EACH-D and VHC programs have become increasingly important components of the aged care system. The distinctions between the HACC, CACP, EACH and EACH-D programs are summarised in table 13.6. VHC program services are described below.

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	$1.9 billion funding in 2009-10 At least 893 224 clients in 2009-10[c]	$508.7 million funding in 2009-10 43 360 operational places[d] in 2009-10	$305.5 million funding in 2009-10 8170 operational places in 2009-10

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC clients at the lower end of the scale would not be assessed as eligible for residential care, for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have needs that would exceed the level available under CACPs and EACH. [c] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2009-10 differed across jurisdictions and ranged from 91 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported. [d] The number of operational places includes CACPs and flexible community places. See note (d) to table 13A.15.

Source: DoHA (unpublished); tables 13A.4, 13A.5 and 13A.15.

Services provided under the HACC program include domestic assistance, home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.6). During 2009-10, the HACC program delivered approximately 12 909 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 13A.46). Some further information on HACC services is contained in box 13.6.

Box 13.6 **Home and Community Care Services**

Home and Community Care (HACC) services are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal 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.

In 2009-10, 69.4 per cent of the program's recipients were aged 70 years or over, but the program was also an important source of community care for younger people with disability and their carers, with 10.7 per cent of recipients under 50 years of age (table 13A.59). (Chapter 14 reports on services for people with disability that 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.)

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. The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2006 and June 2010, from 17.8 to 20.0 (table 13A.25).

The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care (EACH-D provides high level care to people with complex care needs associated with dementia). The total combined number of EACH and EACH-D packages per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2006 and June 2010, from 1.6 to 3.8 (table 13A.25).

Age specific usage rates for CACP, EACH and EACH-D, by jurisdiction and remoteness, at 30 June 2010 are included in tables 13A.39 and 13A.43 respectively. Age specific usage rates for these community care program services (CACP, EACH and EACH-D) combined with permanent residential services are in tables 13A.40 and 13A.44. Indigenous age specific usage rates for all these services by remoteness category are in table 13A.45.

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 number of older clients (aged 70 years or over plus Indigenous people aged 50–69 years) who received HACC, CACP, EACH and EACH-D services in 2009-10 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. Data on the number of younger of people aged under 65 years who used CACP, EACH and EACH-D services during 2009-10 are in table 13A.41.

Table 13.7 **Number of community aged care older clients, by program, 2009-10**

Program	*Number of clients*
HACC	625 765
CACP	53 802
EACH	6 989
EACH-D	3 487

Source: DoHA (unpublished); table 13A.4.

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 78 304 people approved for VHC services in 2009-10 (table 13A.13)[2]. The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours provided per year for veterans who were eligible to receive home care services was 51.9 nationally in 2009-10 (figure 13.8).

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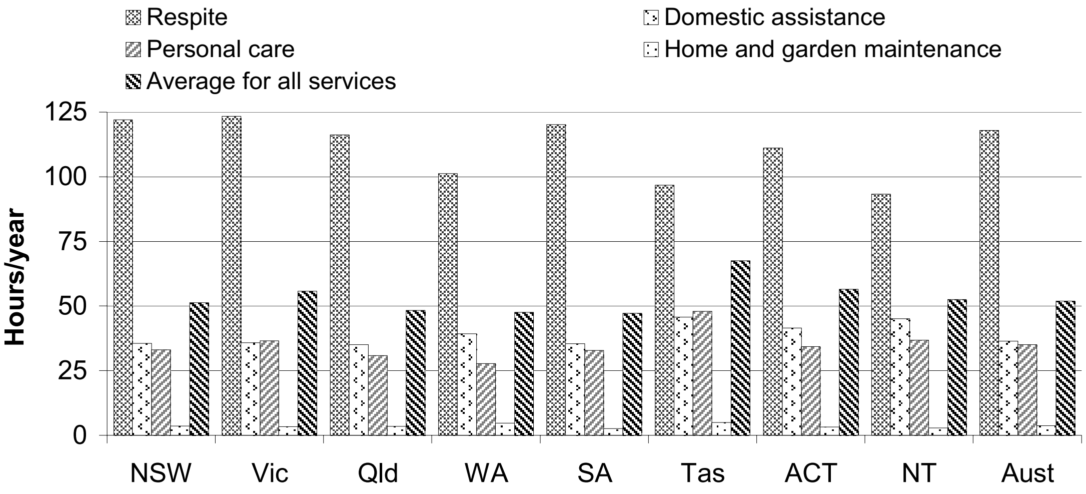
[2] DVA data include veterans of all ages.

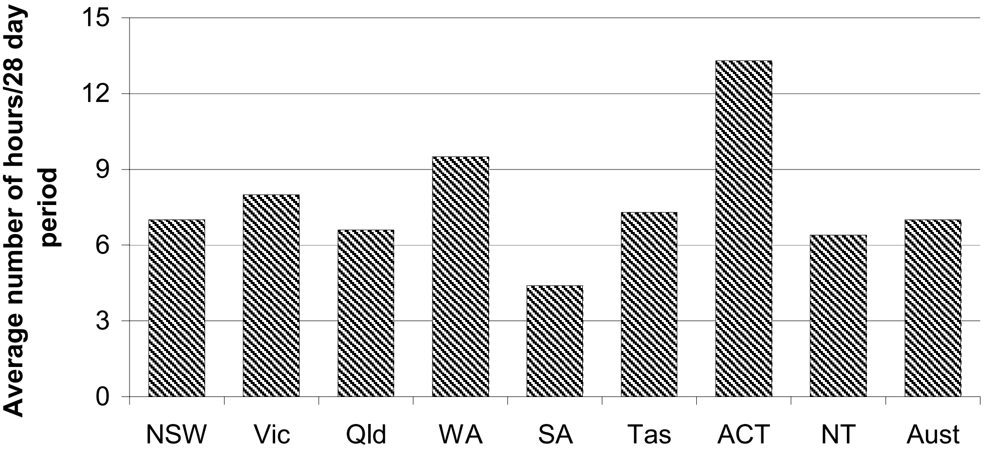
Figure 13.8 Average number of hours approved for Veterans' Home Care, 2009-10



Source: DVA (unpublished); table 13A.13.

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post acute, support and maintenance, personal care, medication management and palliative care. In 2009-10, 31 713 veterans received these services (table 13A.13), and the average number of hours provided for each recipient was 7.0 nationally per 28 day period (figure 13.9).

Figure 13.9 Average number of hours provided for DVA Community Nursing, 2009-10



Source: DVA (unpublished); table 13A.13.

Services provided in mixed delivery setting

Information on the size/scope of a selection of the programs delivering services in mixed delivery settings is outlined below:

- At 30 June 2010, the Australian Government had allocated 3349 places to transition care, of which 2698 were operational, amongst 84 services across all jurisdictions. The average length of stay in 2009-10 was 60 days nationally (table 13A.82). Transition care will expand to up to 4000 places by 2011-12.
- At 30 June 2010, there were 129 operational MPS services with a total of 3120 operational flexible aged care places. Some of the MPS services serve more than one location (DoHA unpublished).
- At 30 June 2010, there were 29 aged care services funded to deliver over 650 flexible aged care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA unpublished).
- During 2009-10, 81 415 people were assisted through the Continence Aids Assistance Scheme (DoHA unpublished).
- During 2008-09, 160 026 people received Day Therapy Program services from 139 providers (DoHA unpublished).

13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 13.7).

COAG has agreed six National Agreements (NAs) to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The NHA covers the area of health and aged care. The Agreement include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council. Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the NHA.

Box 13.7 **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
- person-centred.

These objectives are consistent with the Australian, State and Territory governments' long-term aged care objectives articulated under the NHA: that 'older Australians receive appropriate high quality and affordable health and aged care services' (COAG 2009).

The performance indicator framework shows which data are comparable in the 2011 Report (figure 13.10). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

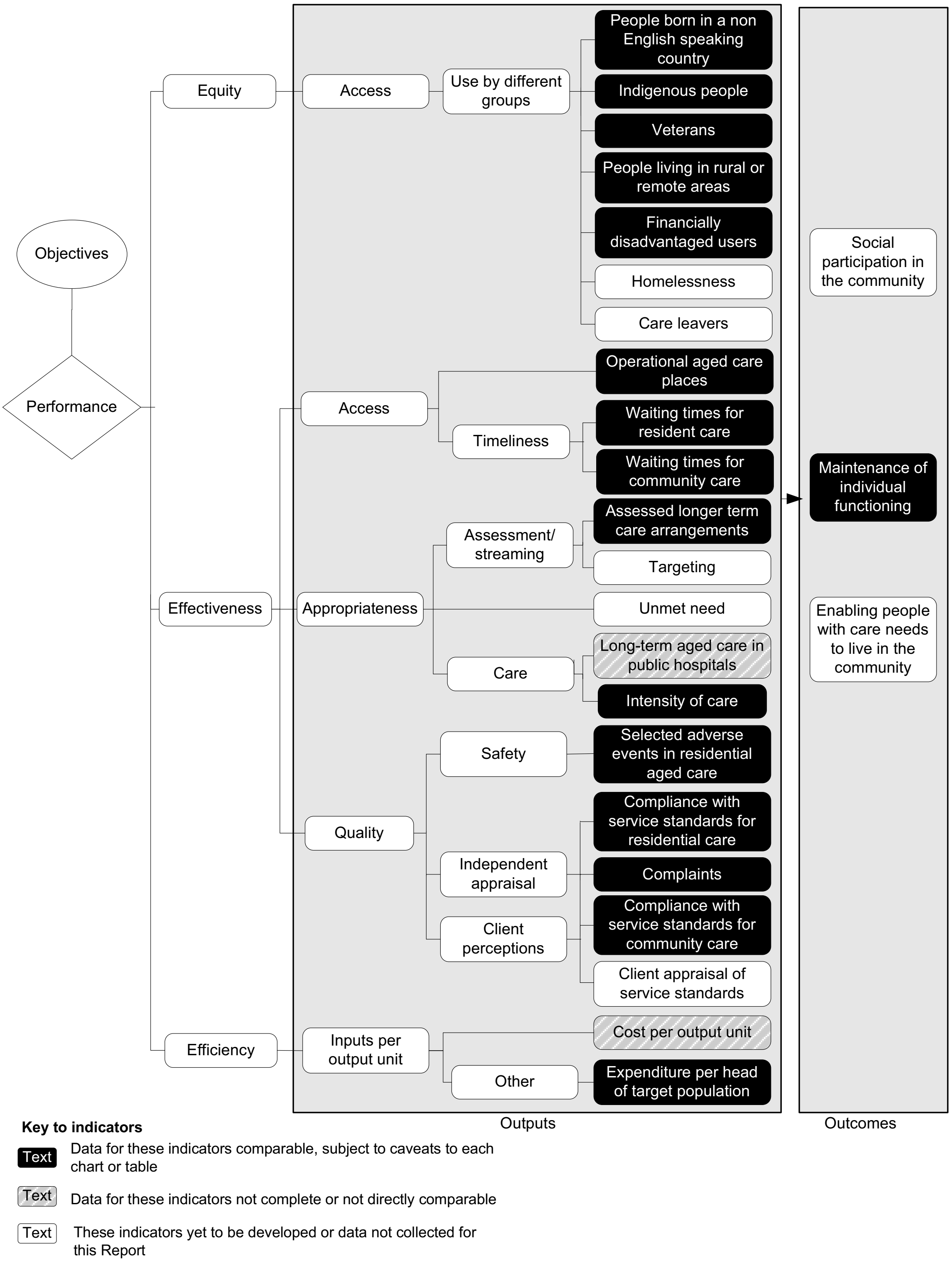
Some changes have been made to the aged care framework for the 2011 Report.

- Two measures have been added under the indicator on 'Use by different groups': 'homelessness' and 'care leavers'. These are additional special needs groups that have been defined under the *Aged Care Act 1997* and the Allocation Principles. Data will be included in future reports.
- Two new indicators have been added to the framework and data are reported for:
  - operational aged care places
  - selected adverse events in residential aged care.

Other changes to performance reporting for the 2011 Report include:

- additional measures under the indicators 'long-term aged care in public hospitals' and 'compliance with service standards for community care'
- additional time series data for the indicators 'intensity of care' and 'expenditure per head of target population'.

Figure 13.10 **Performance indicators for aged care services**



13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services.

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

Outputs

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

Equity — Access

Use by different groups

'Use by different groups' is an indicator of governments' objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.8).

Box 13.8 **Use by different groups**

‘Use by different groups’ is defined by eight measures:

- variation in the proportion of people accessing residential services, HACC, CACPs, EACH and EACH-D services who are born in a non-English speaking country, from the proportion of people in the target population who are born in a non-English speaking country
- variation in the proportion of people accessing residential services, HACC, CACPs, EACH and EACH-D services who are Indigenous, from the proportion of people in the target population who are Indigenous
- the number of people born in non-English speaking countries using residential services, CACPs, EACH and EACH-D, divided by the number of people born in non-English speaking countries aged 70 years or over, 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, and EACH-D services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population) 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 veterans aged 70 years or over in residential care divided by the total number of eligible veterans aged 70 years or over, where a veteran is defined as a DVA Gold or White card holder
- access to HACC services for people living in rural or remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas
- the rate of contacts with Commonwealth Respite and Carelink Centres for Indigenous people benchmarked against the rate for all people
- the number of new residents classified as concessional or assisted or supported, divided by the number of new residents.

(Continued next page)

Box 13.8 **(continued)**

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional, assisted or supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to, or higher than, the minimum rates are desirable.

Use by different groups is a proxy indicator of equitable access. Various groups are identified by the *Aged Care Act 1997* and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, veterans (including widows and widowers of veterans), homelessness and care leavers.

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 reported for this indicator are comparable.

Data quality information for two measures (access to residential aged care services by Indigenous people and people born in a mainly non-English speaking country and access to aged care community programs by Indigenous people and people born in a mainly non-English speaking country) defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Data quality information for the other measures is under development.

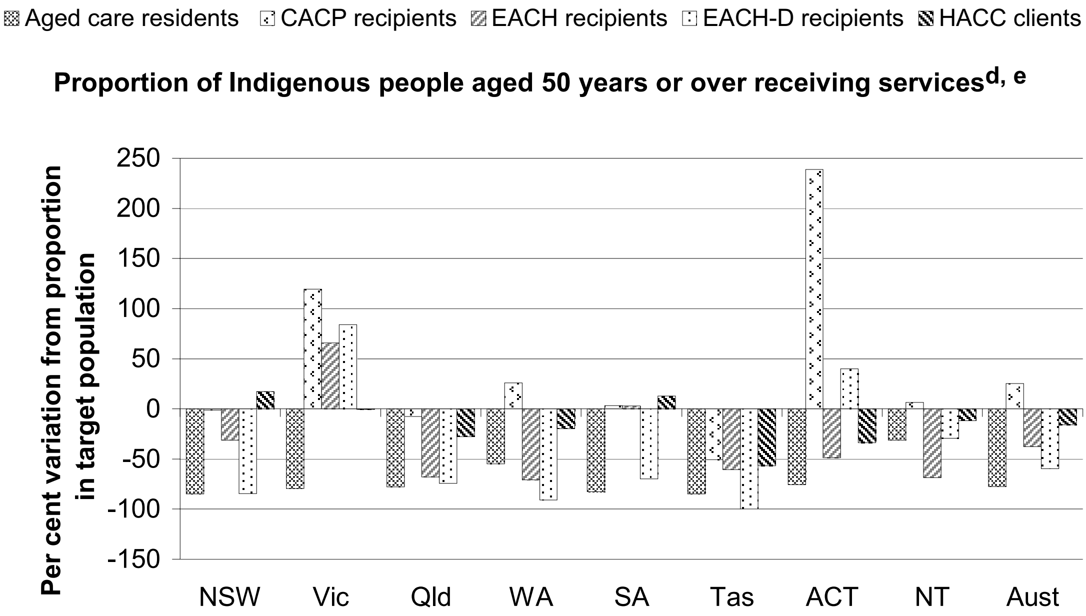
Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

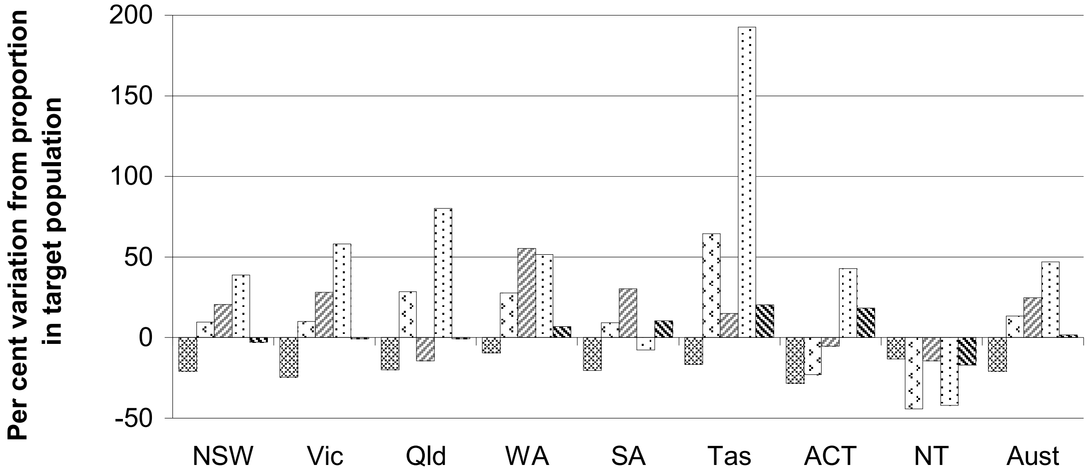
Access to residential care services, HACC, CACP, EACH and EACH-D services by Indigenous people and people born in a mainly non-English speaking country

In comparison to their proportion of the target population as a whole, Indigenous people are under-represented in access to residential care, HACC, EACH and EACH-D services, whereas people born in a mainly non-English speaking country are under-represented in access to residential care (figure 13.11).

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 with the proportion of this group in the target population. People born in a mainly non-English speaking country are also over-represented in the EACH and EACH-D program compared with the proportion of the group in the target population. Figure 13.11 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 will 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, a negative percentage will be observed (figure 13.11).

Figure 13.11 **Variation in the proportions of special needs target populations accessing aged care services from their proportion in the target population as a whole, June 2010[a, b, c]**


Proportion of Indigenous people aged 50 years or over receiving services[d, e]


Proportion of people born in a mainly non-English speaking country aged 70 years or over receiving services

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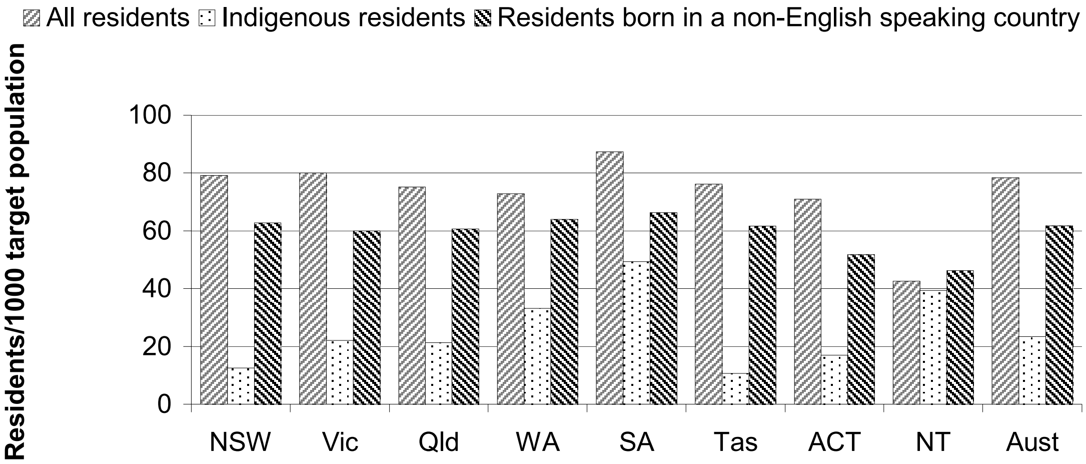
[a] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2009-10 differed across jurisdictions and ranged from 91 per cent to 100 per cent. Consequently, actual service levels were higher than stated. [b] Reports provisional HACC data that have not been validated and may be subject to revision. [c] Some of these proportions are calculated using small numbers. In particular, this applies to the proportions for EACH and EACH-D. One example is the Tasmanian EACH-D proportion for people born in a mainly non-English speaking country which is calculated using a number between 10 and 20. See table 13A.30 for more details. [d] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of CACP recipients results in a very high provision ratio. [e] Excludes National Aboriginal and Torres Strait Islander Flexible Aged Care Program recipients.

Source: DoHA (unpublished); table 13A.30.

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 2010, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (23.4 and 61.8 per 1000 of the relevant target populations respectively), compared with the population as a whole (78.4 per 1000) (figure 13.12).

Figure 13.12 **Residents per 1000 target population, 30 June 2010**[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.

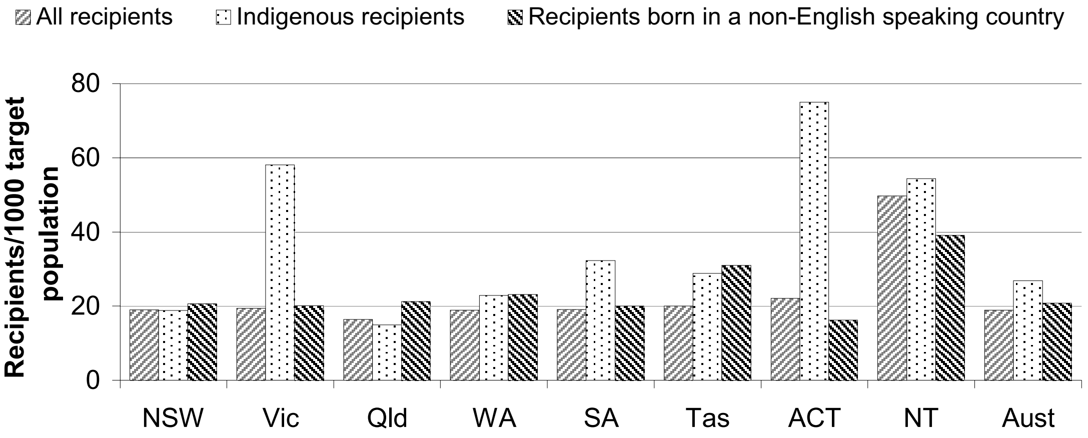
Source: DoHA (unpublished); tables 13A.28, 13A.31 and 13A.33.

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.29, 13A.32, 13A.34, 13A.35, 13A.40, 13A.42, 13A.44-45).

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 26.8 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 20.8 nationally. These figures compare to a total of 18.9 per 1000 of the target population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.13).

Figure 13.13 Community Aged Care Package recipients per 1000 target population, 30 June 2010[a, b, c, d, e]



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[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.

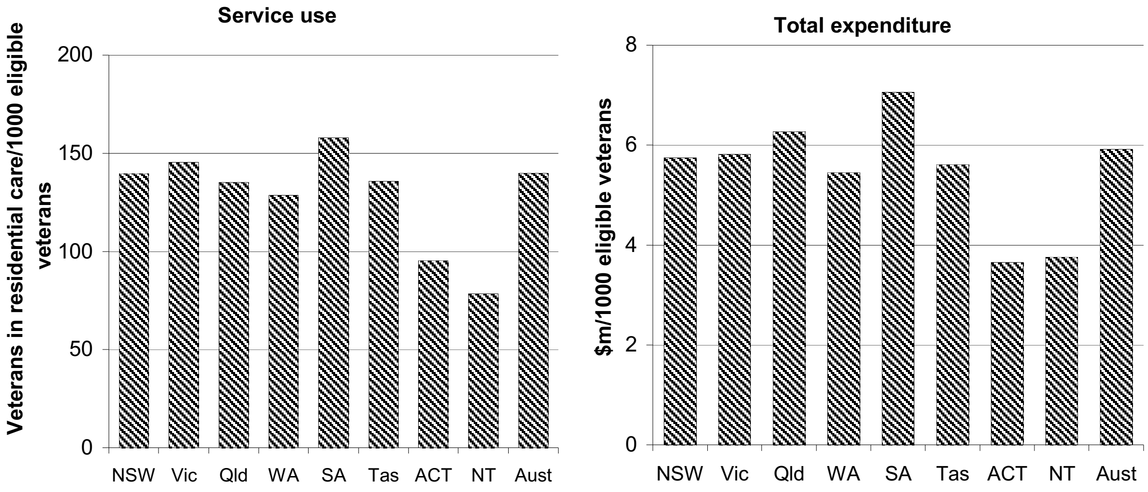
Source: DoHA (unpublished); tables 13A.28, 13A.31 and 13A.33.

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.39-40 and 13A.43–45).

Access by veterans

The total number of veterans 70 years or over who were in the DVA treatment population at 30 June 2010 was 180 803 (table 13A.14). The number of veterans in residential care per 1000 eligible veterans aged 70 years or over at 30 June 2010 was 139.8 (figure 13.14). Nationally, total DVA expenditure on residential aged care subsidy per person aged 70 years or over was $507 in 2009-10 (table 13A.14).

Figure 13.14 **Number of veterans aged 70 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 70 years or over, 2009-10**[a, b, c]



[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 2010. [c] Veterans 70 years or over includes those whose age is unknown.

Source: DVA (unpublished); DoHA (unpublished); table 13A.14.

Access to the HACC program

HACC services are provided in the client's home or community for people with moderate, severe or profound disability and their carers. The focus of this chapter is all people 70 years or over and Indigenous people aged 50–69 years. The proportion of HACC clients aged 70 years or over during 2009-10 was 69.4 per cent (table 13A.59).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 12 909 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 4703 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, 2009-10 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]

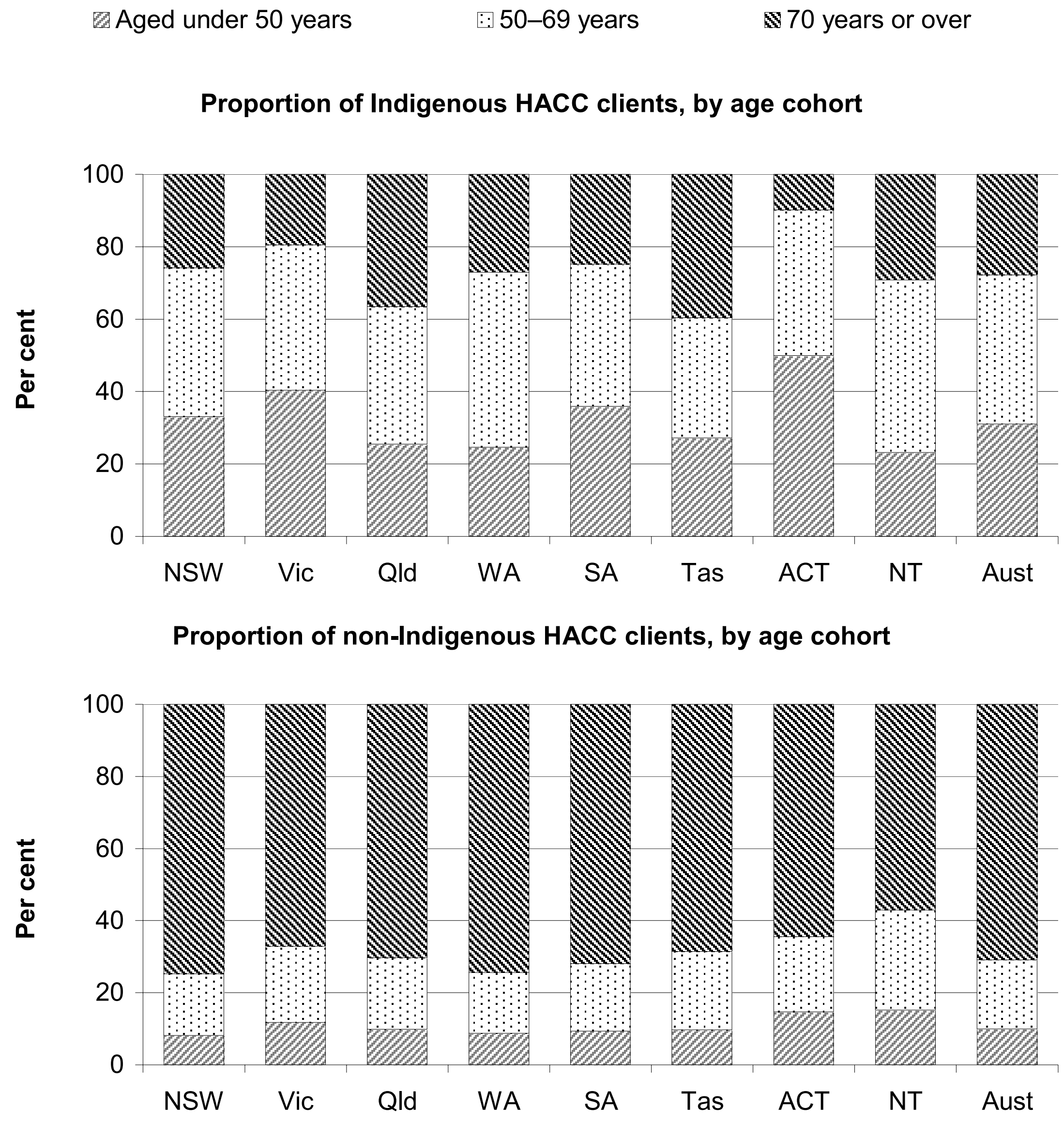
	NSW[d]	*Vic*	*Qld*	*WA*	*SA*[e]	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported Minimum Data Set data									
	96	96	96	91	99	98	100	96	96
Total hours (no.)[f]									
Major cities	10 538	14 019	14 394	15 230	13 277	..	12 002	..	12 882
Inner regional	8 820	16 686	11 783	12 935	11 373	12 260	..	..	12 009
Outer regional	11 382	20 794	13 501	18 374	13 257	10 081	..	9 076	14 051
Remote	15 314	31 544	19 151	16 397	17 585	10 908	..	10 266	16 737
Very remote	13 676	..	20 663	25 597	30 902	22 050	..	16 145	21 196
All areas	**10 217**	**15 076**	**13 781**	**15 403**	**13 281**	**11 565**	**12 002**	**11 722**	**12 909**
Total meals (no.)[g]									
Major cities	3 227	4 457	4 694	3 542	6 724	..	2 736	..	4 165
Inner regional	4 429	6 026	5 187	3 542	4 123	5 082	..	..	4 957
Outer regional	6 263	6 503	5 051	5 725	8 305	5 669	..	5 256	6 081
Remote	8 254	9 456	8 491	8 709	9 027	6 421	..	13 294	9 119
Very remote	10 791	..	9 681	19 831	15 099	9 472	..	29 462	18 300
All areas	**3 803**	**4 948**	**4 999**	**4 215**	**6 717**	**5 322**	**2 736**	**15 216**	**4 703**

[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.46–51) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.53–58). [b] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2009-10 differed across jurisdictions and ranged from 91 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] NSW service levels for 2009-10 are higher than the service levels reported in this table. Processes causing the under reporting are being investigated. [e] Validation processes for SA and the HACC MDS differ. As a result, actual service levels may be up to 5 per cent higher or lower than stated. [f] See table 13A.46 for a full list of categories. [g] Includes home meals and centre meals. .. Not applicable.

Source: DoHA (unpublished) *Home and Community Care Minimum Data Set 2009-10*; DoHA (unpublished) *HACC National Data Repository*; tables 13A.46–51.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2009-10. 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 27.8 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.8 per cent (figure 13.15).

Figure 13.15 Recipients of HACC services by age and Indigenous status, 2009-10[a, b]



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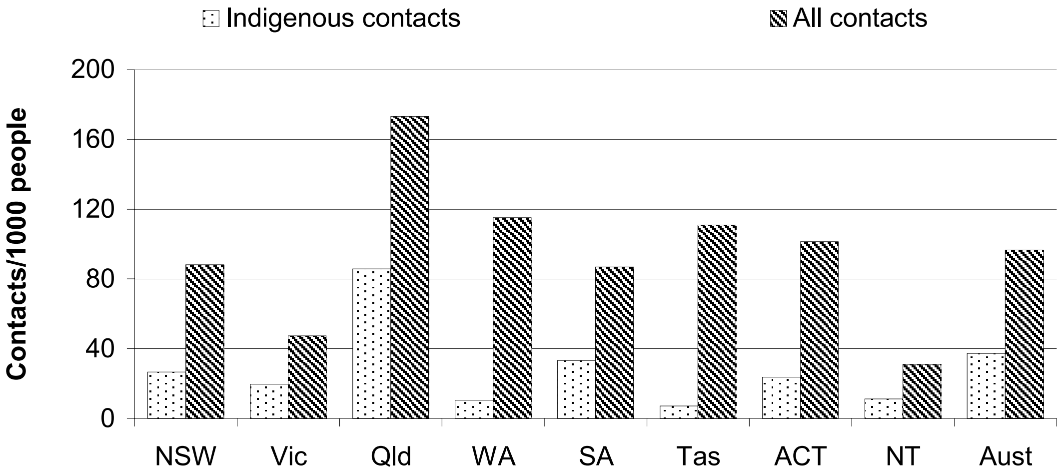
[a] Reports provisional HACC data that have not been validated and may be subject to revision. [b] The proportion of HACC clients with unknown Indigenous status differed across jurisdictions. Nationally, the proportion of all HACC clients with unknown Indigenous status was 8.6 per cent (table 13A.59).

Source: DoHA (unpublished); table 13A.60.

Access by Indigenous people to Commonwealth Respite and Carelink Centres

Commonwealth Respite and Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Respite and Carelink Centres at 30 June 2010, was 37.3 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years or over). The rate for all Australians was 96.6 per 1000 people in the target population (people aged 70 years or over plus Indigenous people aged 50–69 years). These figures varied across jurisdictions (figure 13.16).

Figure 13.16 **Commonwealth Respite and Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2010**[a, b, c, d]



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[a] Contacts include phone calls, visits, emails and facsimiles. [b] 'Indigenous contacts' refer to contacts by Indigenous people per 1000 Indigenous people in the target population. [c] 'All contacts' refers to contacts per 1000 target population. [d] People making contact self identify as Indigenous. Therefore, there is likely to be substantial under-reporting of Indigenous status.

Source: DoHA (unpublished); table 13A.62.

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 13.9).

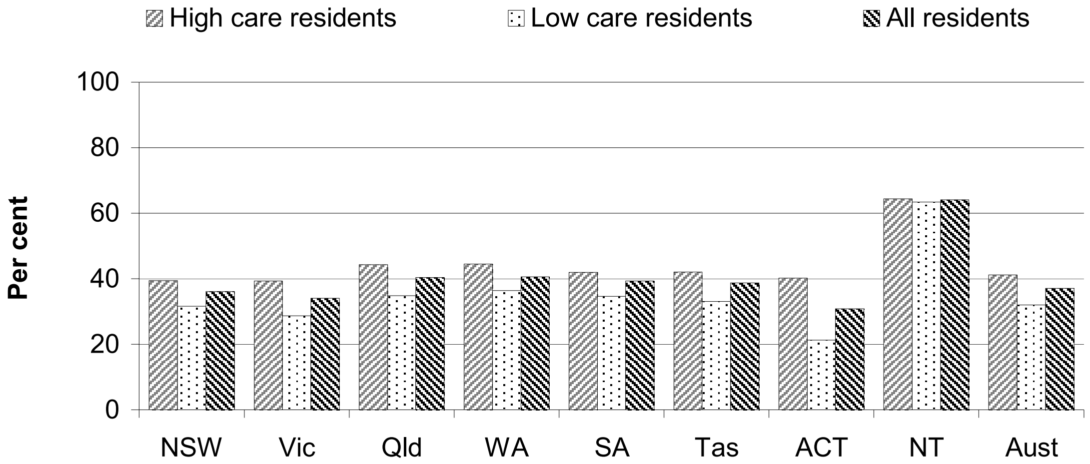
Box 13.9 **Supported residents**

In 2008, new arrangements governing residents' contributions to their accommodation costs and the supplements the Australian Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. These new arrangements only apply to residents who first entered permanent residential care on or after 20 March 2008, or who re-entered care on or after 20 March 2008, after a break in care of more than 28 days.

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for 'concessional' or 'assisted' resident status.

The proportion of all new residents classified as supported residents during 2009-10 was 37.1 per cent nationally but varied across jurisdictions (figure 13.17). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.17 **New residents classified as supported residents, 2009-10**[a]



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[a] Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-entered care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (20 March 2008 to 19 March 2010 — $91 910.40 and from 20 March 2010 — $93 910.40).

Source: DoHA (unpublished); table 13A.36.

Effectiveness — level of access

Operational aged care places

‘Operational aged care places’ is an indicator of governments’ objective to provide frail older Australians with access to a range of aged care services that can meet their care needs (box 13.10). The 2011 Report is the first time this indicator has been reported. This indicator does not include places that have been approved, but are not yet operational.

Box 13.10 **Operational aged care places**

‘Operational aged care places’ is defined by two measures, the number of operational places (by type) per 1000 people:

- aged 70 years or over
- aged 70 years or over plus Indigenous people aged 50–69 years.

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in the number of Australian Government subsidised aged care places in line with growth in the aged population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The framework aims to achieve and maintain a national provision ratio of 113 operational aged care places per 1000 of the population aged 70 years or over by June 2011. Within this overall target provision ratio of the 113 places per 1000 people aged 70 years or over:

- 44 places (39 per cent) should be residential high care — designed to meet the needs of residents equivalent to high care[a]
- 44 places (39 per cent) should be residential low care — designed to meet the needs of residents equivalent to low care
- 25 places (22 per cent) should be community care, with 4 of these places (around 3.5 per cent of total places) being for high level community care — designed to enable those with high/low care needs to continue living in, or return to, the community (DoHA unpublished)[a].

[a] In 2010, the target for high level community care was temporarily increased from 4 to 5 places, while the target for high level residential care was temporarily adjusted to 43 places per 1000 people aged 70 years or over. This was to ensure that the overall target ratio is achieved in 2011, together with the balance of 48 high care and 65 low care places (DoHA 2010).

(Continued next page)

Box 13.10 **(continued)**

For this Report, in recognition of poorer health among Indigenous communities and that planning in some cases also takes account of the Indigenous population aged 50–69 years, the provision ratio is also reported in terms of operational places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. A provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).

In general, provision ratios across state and territories, and across regions, that are broadly similar to the overall target provision ratios are desirable as it indicates that all frail older Australians have access to a similar level and mix of services to meet their care needs.

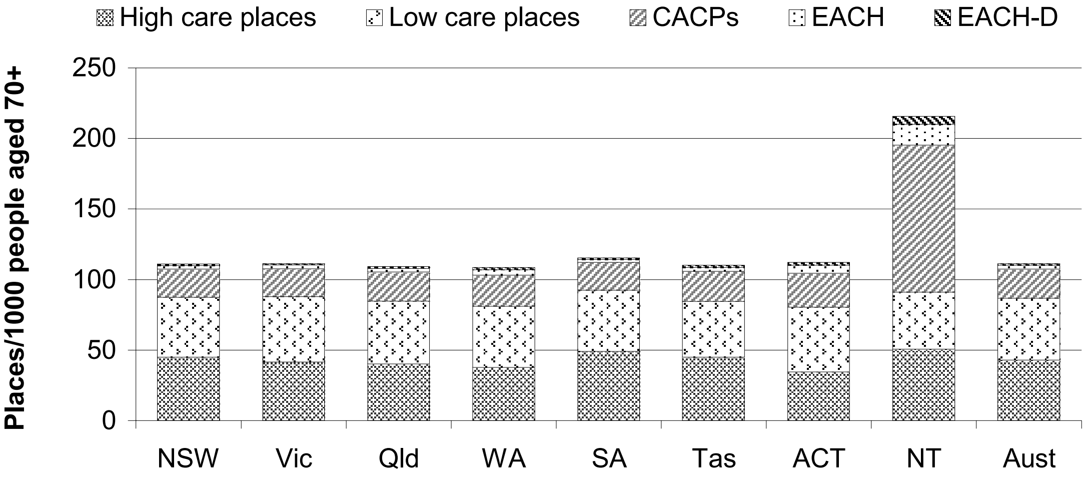
This indicator does not provide information on whether the overall target provision ratios are adequate or provide an appropriate mix of services relative to need.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the combined number of high care residential places, low care residential places, CACPs, flexible care places (including EACH and EACH-D, but excluding Transition Care places) and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2010, was 111.3 per 1000 people aged 70 years or over (figure 13.18). Transition Care places add an additional 1.3 per 1000 people aged 70 years or over; however, these places are not included in the target of 113 places (table 13A.24). The number of operational aged care places per 1000 people aged 70 years or over by care type was:

- 42.8 places (38.5 per cent of total) for residential high care
- 44.0 places (39.5 per cent of total) for residential low care
- 24.5 places (22.0 per cent of total) for community care — 20.6 places for CACPs and 3.9 places for EACH and EACH-D combined (3.5 per cent of total places) (figure 13.18).

Figure 13.18 **Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over, 30 June 2010**[a, b, c, d, e, f, g, h]



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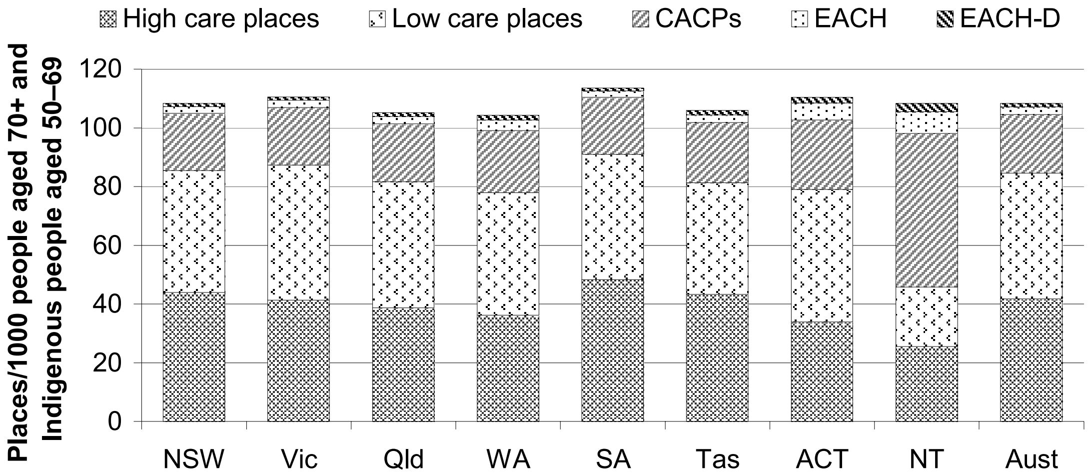
[a] Excludes places that have been approved but are not yet operational. [b] Ageing in place may result in some low care places being filled by high care residents. [c] For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by June 2011. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [d] Includes residential places categorised as high care or low care. [e] CACPs, EACH and EACH-D packages are included in the Australian Government planning targets. [f] 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 included in the provision ratio. [h] See table 13A.24 for further information regarding the calculation of provision ratios.

Source: DoHA (unpublished); table 13A.24.

The number of operational aged care places can also be shown using a population that incorporates Indigenous people aged 50–69 years (figure 13.19). Use of this ‘adjusted’ population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 13.19 Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June 2010[a, b, c, d, e, f, g]



[a] Excludes places that have been approved but are not yet operational. [b] Ageing in place may result in some low care places being filled by high care residents. [c] CACPs, EACH and EACH-D packages are included in the Australian Government planning targets. [d] Includes residential places categorised as high care or low care [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. [f] 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, see table 13A.25.

Source: DoHA (unpublished); table 13A.25.

Data on the number of residential and community care operational aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by planning region and remoteness are in tables 13A.26-27.

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 proportion of people who entered residential high care within three months of their ACAT approval. 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 influenced by factors that cannot be categorised as ‘waiting’ time and not all ‘waiting’ time is included. Some examples 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.

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.

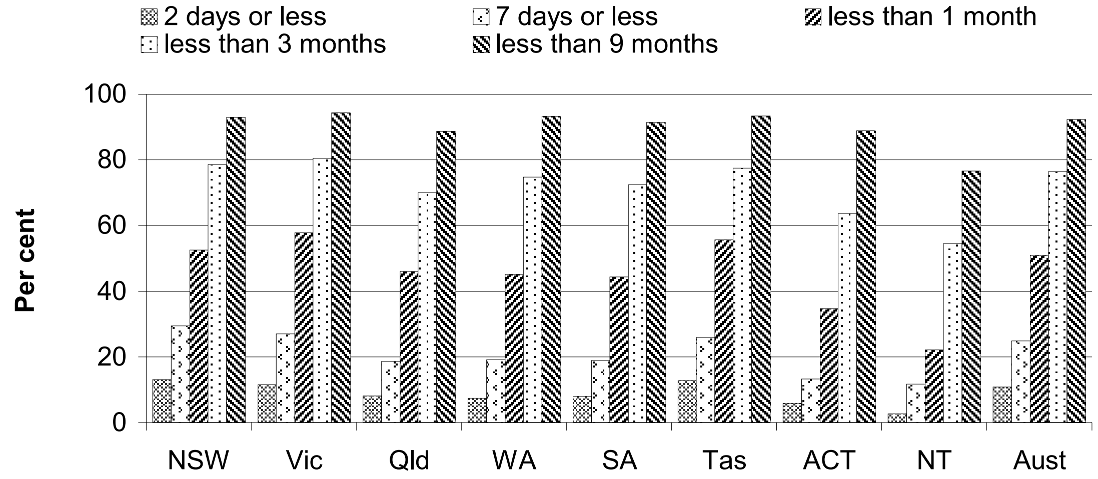
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Overall, 24.9 per cent of all people entering residential high care during 2009-10 did so within 7 days of being approved by an ACAT compared with 26.3 per cent in 2008-09. In 2009-10, 50.9 per cent entered within one month of their ACAT approval and 76.4 per cent entered within 3 months of their approval compared with 56.3 per cent and 81.2 per cent respectively in 2008-09. These proportions varied across jurisdictions (figure 13.20 and table 13A.66). The median time for entry into high care residential services was 29 days in 2009-10 compared with 23 days in 2008-09 (table 13A.66).

Nationally, a greater proportion of people entering high care residential services entered within 3 months of approval (76.4 per cent), compared with the proportion entering low care residential services within that time (63.3 per cent). These proportions varied across jurisdictions (table 13A.66).

Figure 13.20 **People entering high care residential care within specified time periods of their ACAT approval, 2009-10**[a]



[a] Includes residential places categorised as high care.

Source: DoHA (unpublished); table 13A.66.

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.

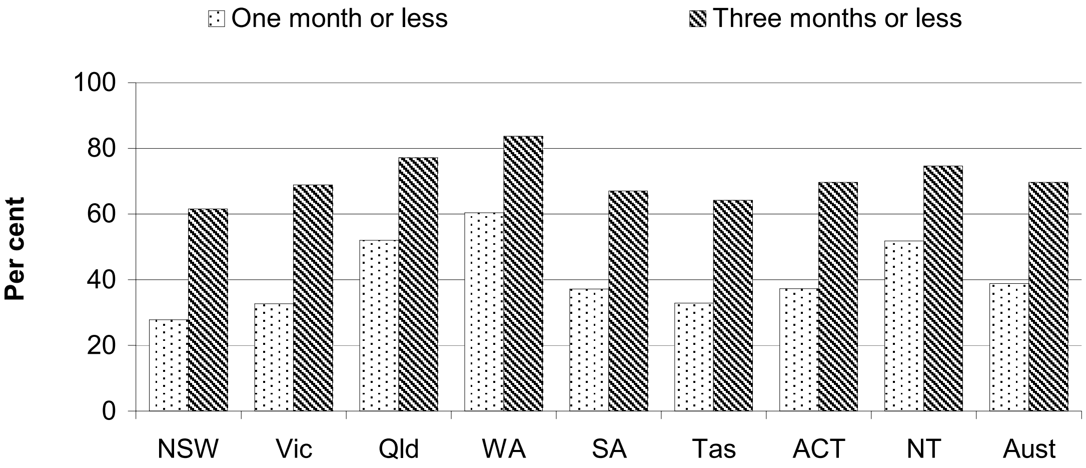
This indicator needs to be interpreted with care. Some ACAT approved clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Overall, 69.7 per cent of all people receiving a CACP during 2009-10 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 38.8 per cent started receiving a CACP within one month of their ACAT approval (figure 13.21).

Figure 13.21 **People commencing a CACP within one or three months of their ACAT approval, 2009-10**



Source: DoHA (unpublished); table 13A.66.

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.

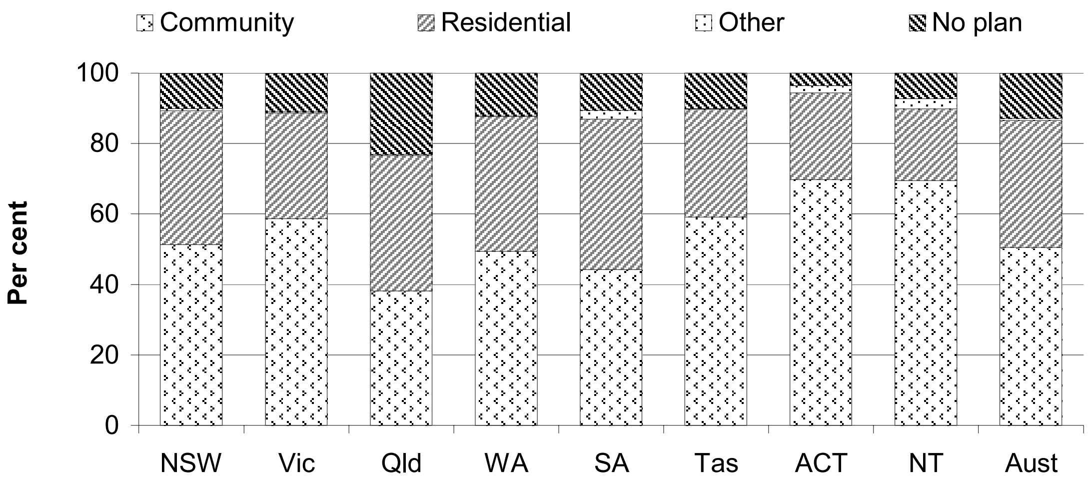
The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences 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.

Data quality information for this indicator is under development.

The national proportion of ACAT clients approved for residential care in 2008-09 was 36.0 per cent and the proportion recommended to remain in the community was 50.5 per cent (figure 13.22). No long term plan was made for 12.8 per cent, which included deaths, cancellations and transfers.

Figure 13.22 **Recommended longer term living arrangements of ACAT clients, 2008-09**[a]



[a] 'No plan' includes deaths, cancellations and transfers.

Source: DoHA (unpublished) *Ageing and Aged Care Data Warehouse* from *Aged Care Assessment Program Minimum Data Set*; table 13A.67.

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 2011 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, 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 need for assistance was not fully met (table 13A.68 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). A new measure for this indicator is reported for the first time in the 2011 Report ‘proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care’.

Box 13.16 **Long term aged care in public hospitals**

‘Long term aged care in public hospitals’ is defined by two measures:

- the proportion of completed ‘aged care type’ hospital separations for people aged 70 years or over plus Indigenous people aged 50–69 years for which the length of stay was 35 days or longer, where ‘aged care type’ hospital separations are defined as:
    - the care type was maintenance, and
    - the diagnosis (either principal or additional) was either person awaiting admission to residential aged care service or need for assistance at home and no other household member able to render care.
- the proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care, where the:
    - care type was maintenance, and
    - diagnosis (either principal or additional) was person awaiting admission to residential aged care service, and
    - separation mode was discharge/transfer to another acute hospital or to residential aged care (unless this is usual place of residence); statistical discharge, that is a change in care type; the patient died; discharge/transfer to other health care accommodation (including mother craft hospitals and another psychiatric hospital); left against medical advice/discharge at own risk or statistical discharge from leave (for more detail see note (b) figure 13.24).

Lower proportions of hospital stays of 35 days or more and lower proportions of patient days used by people waiting for residential aged care are desirable.

Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

These measures should be interpreted with care.

- Patients who have not completed their period of acute care in a hospital are not included.
- Although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.

(Continued next page)

Box 13.16 **(continued)**

- Reported hospital separations and patient days do not necessarily reflect the full length of hospital stay for an individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then two separations are reported for that patient.
- For the first measure, the code 'need for assistance at home and no other household member able to render care' may also be used for respite care for aged care residents or those receiving community care, and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.
- The measures do not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.
- The measures are regarded as proxies, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future reports.

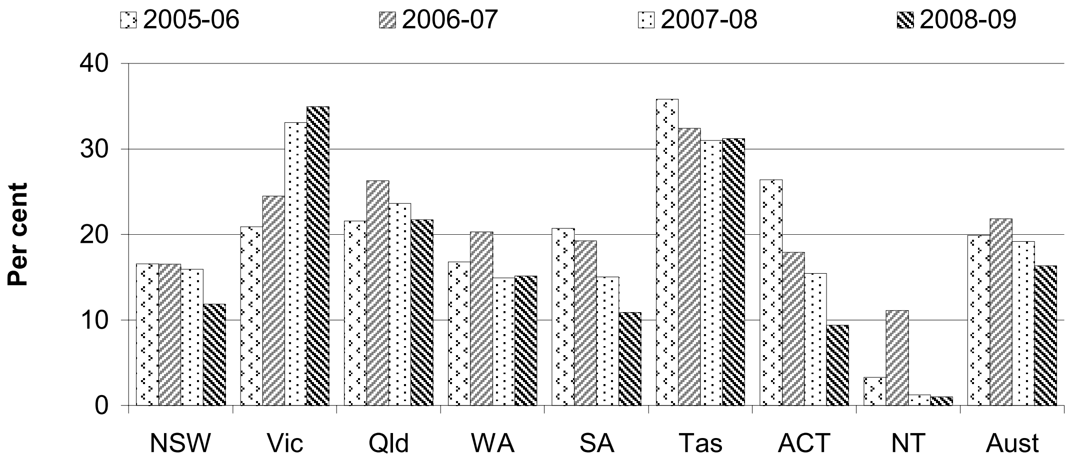
Data reported for this indicator are not directly comparable.

Data quality information for one measure (proportion of all patient days used by patients who are waiting for residential aged care) is at www.pc.gov.au/gsp/reports/rogs/2011.

Data quality information for the other measure is under development.

The proportion of separations for 'aged care type' patients (as defined in box 13.16) aged 70 years or over plus Indigenous people aged 50–69 years whose separation was 35 days or longer was 16.3 per cent nationally, in 2008-09. The proportions varied across jurisdictions (figure 13.23). 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 (10 968 separations of a total of 1.5 million nationally) (table 13A.69).

Figure 13.23 **Proportion of separations for 'aged care type' public hospitals patients that were 35 days or longer**[a, b, c, d, e, f, g]



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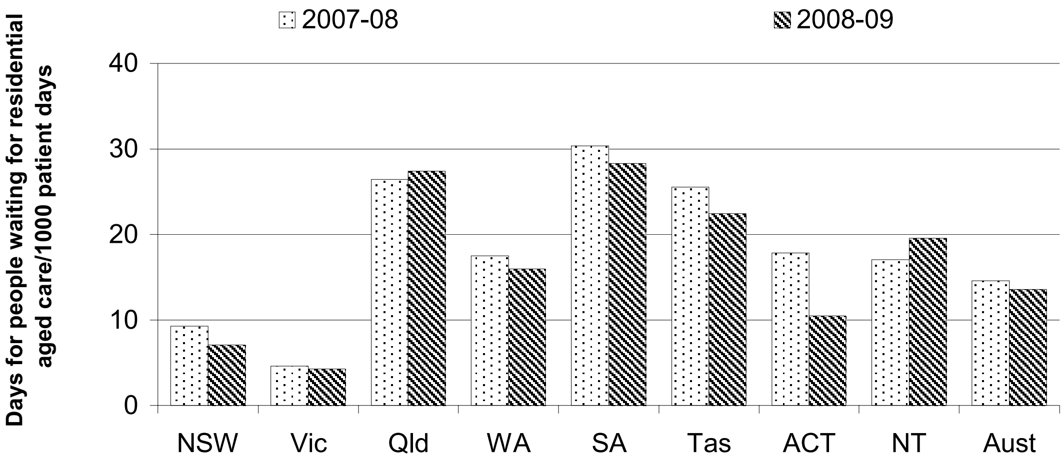
[a] Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care' and where the separation lasted 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.69.

The proportion of all hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care (as defined in box 13.16) was 13.6 per 1000 patient days nationally, in 2008-09 (figure 13.24).

Figure 13.24 **Hospital patient days used by patients waiting for residential aged care**[a, b, c, d, e, f]



[a] Data include overnight hospital separations only. [b] Numerator data include patients with a care type of maintenance, and diagnosis (either principal or additional) was 'person awaiting admission to residential aged care service', and separation mode was 'discharge/transfer to another acute hospital'; 'discharge, transfer to residential aged care (unless this is usual place of residence); 'statistical discharge—type change'; 'died'; 'discharge/transfer to other health care accommodation (including mother craft hospitals)' or 'left against medical advice/discharge at own risk; statistical discharge from leave; discharge/transfer to (an)other psychiatric hospital'. [c] Includes patients of all ages. [d] Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care. [e] Diagnosis codes may not be applied consistently across jurisdictions or over time. [f] These data only account for completed unlinked separations. An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient's hospital stay. Data on patient days relate to the defined separations and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.70.

Intensity of care

'Intensity of care' is an indicator of governments' objective to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.17). (See box 13.18 for background information on the 'ageing in place' policy.)

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 1997* aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.18).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care services system over time.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, from June 2002 to June 2010, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 59.7 per cent to 86.1 per cent (figure 13.25). In June 2010, the proportion was higher in major cities (86.0 per cent), inner regional areas (86.6 per cent), outer regional areas (84.9 per cent), remote areas (90.1 per cent), than in very remote areas (81.8 per cent) (table 13A.37).

Box 13.18 **Ageing in place in residential care**

In its Objects, the *Aged Care Act 1997* aims to:

> *... encourage diverse, flexible and responsive aged care services that:*
>
> *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
>
> *(ii) facilitate the independence of, and choice available to, those recipients and carers.*

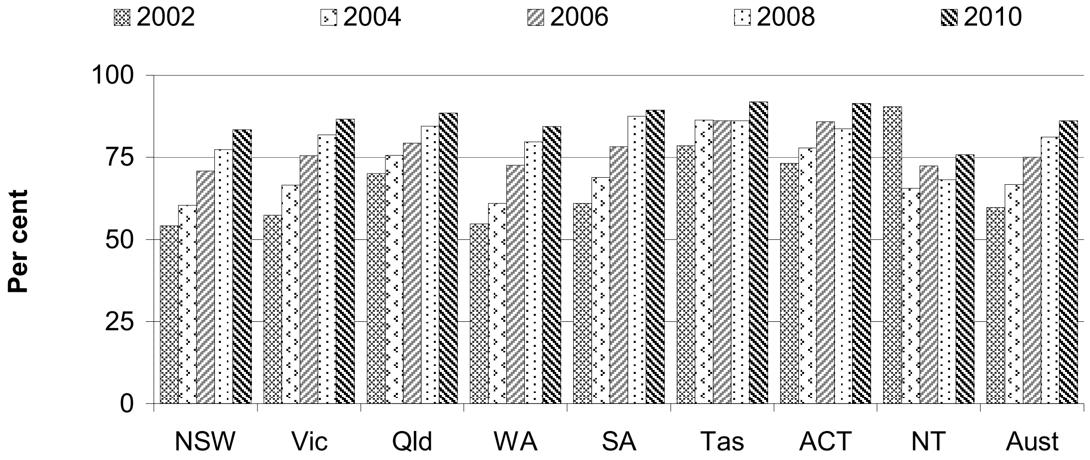
Further, the *Aged Care Act 1997* explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.

The *Aged Care Act 1997* does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure.

Source: DoHA (unpublished).

Figure 13.25 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**[a]



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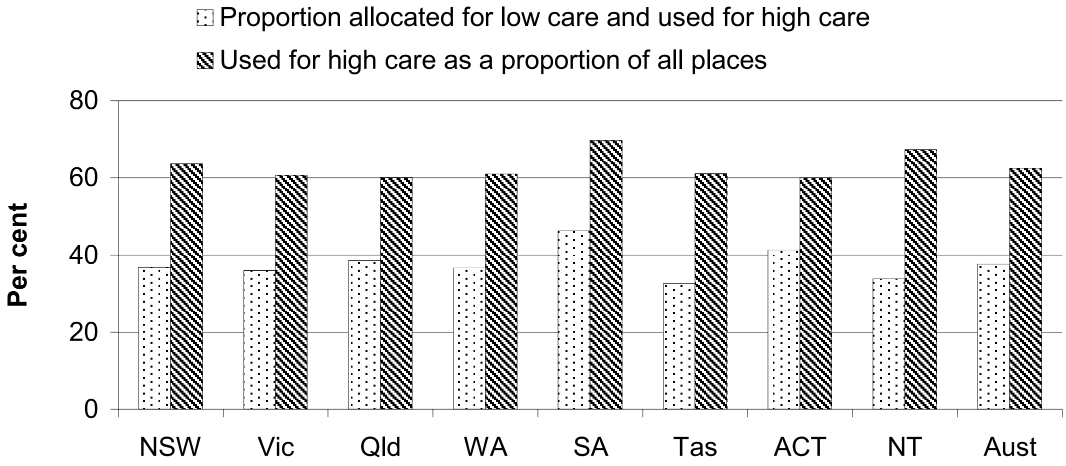
[a] Full ten years of data for this indicator are in attachment 13A.37.

Source: DoHA (unpublished); table 13A.37.

Nationally, 37.6 per cent of low care places in 2009-10 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 62.5 per cent (figure 13.26). These data are provided by remoteness area in table 13A.38.

Figure 13.26 **Utilisation of operational residential places, 30 June 2010**[a]



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[a] Includes residential places categorised as high care or low care.

Source: DoHA (unpublished); table 13A.38.

Effectiveness — quality

Selected adverse events in residential aged care

‘Selected adverse events in residential aged care’ is an indicator of governments’ objective to provide residential care services that are safe and of high quality by preventing and minimising the harm associated with adverse events in residential aged care (box 13.19). Falls in residential aged care that resulted in a hospital admission are the only adverse events reported on for the 2011 Report. (See box 13.20 for background information on falls in residential aged care.) As data for other adverse events (such as pressure ulcers) become available they will also be included.

Box 13.19 **Selected adverse events in residential aged care**

'Selected adverse events in residential aged care' is defined by the number of hospital separations for falls in residential aged care services per 10 000 resident occupied place days. Falls that occurred in residential aged care, but did not result in hospitalisation are not included.

Low or decreasing rates of hospital separations for falls in residential aged care services per 10 000 resident occupied place days are desirable.

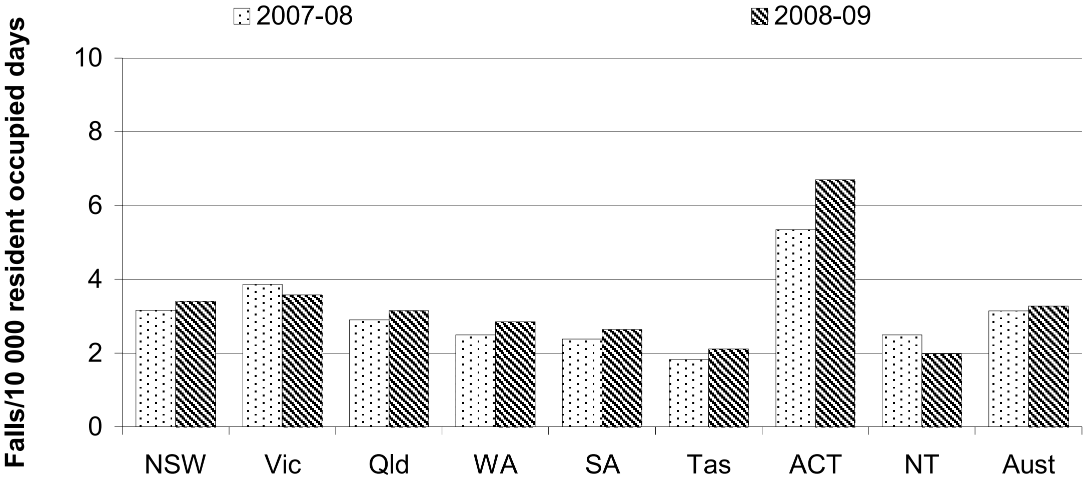
Not all falls are preventable. An excessively custodial and risk-averse approach to preventing falls that infringes on a older person's autonomy and limits rehabilitation is also not appropriate. Interventions that prevent falls or mitigate harm from falls, but do not limit autonomy or rehabilitation are the most desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, in 2008-09 there were 3.3 hospital separations for falls in residential aged care services per 10 000 resident occupied place days (figure 13.27). These data are provided by Indigenous status, remoteness area and SEIFA in table 13A.71.

Figure 13.27 **Hospitalisations for falls in residential aged care**[a]



[a] Number of hospital separations involving one or more falls in an aged care facility, not the number of falls.

Source: AIHW (unpublished); table 13A.71.

Box 13.20 **Falls in residential aged care**

Falls are the most common cause of serious injury among older Australians and the most common reason for injuries that result in hospital admission (Pointer S, Harrison J and Bradley C 2003; AIHW 2007). For older people who are hospitalised, the largest proportion of injuries are to the hip and thigh. Of these hip and thigh injuries, a significant proportion are fractures. The second most common injuries are to the head (Bradley C and Pointer S 2009).

Analysis of data for 2005-06 on hospitalisations for falls of people aged 65 years or over shows that the rate was more than five times higher for people in aged care facilities than for those who lived in the community (Bradley C and Pointer S 2009). There were differences and similarities in the types of falls experienced by older people in these settings. A high proportion of falls for both groups were from slipping, tripping, stumbling and other falls on the same level. However, the proportion of falls from beds in aged care facilities was twice that of falls from beds in the home. In comparison, the proportion of falls in the home attributed to falls on and from stairs or steps was nearly ten times the proportion for those living in aged care facilities (Bradley C and Pointer S 2009).

There are a number of risk factors for residents falling in aged care facilities (many of these risks will also apply in other settings). A person's risk of falling increases as their number of risk factors accumulate. Risk factors can be related to:

- a person's behaviour or condition — some examples include wandering behaviour, cognitive impairment and multiple drug use
- the environment or a person's interaction with the environment — relocation between settings and environmental hazards (ACSQHC 2009).

The Australian Commission on Safety and Quality in Health Care (ACSQHC) have identified four components for best practice for fall prevention and harm minimisation in residential aged care: (1) implementing standard falls prevention strategies; (2) identifying falls risks; (3) implementing interventions targeting these risks to prevent falls and (4) preventing injury to those people who do fall (ACSQHC 2009). According to the ACSQHC, while the body of knowledge about the risk of falls and how to reduce these falls is growing, a combination of interventions tailored to the individual appear to be effective for reducing the risk of falls. In the residential aged care setting, there is also evidence that certain single interventions, such as hip protectors, vitamin D and calcium supplementation, or medication reviews, prevent fractures or reduce the risk of falls in some residents (ACSQHC 2009).

Source: ACSQHC (2009); Pointer S, Harrison J and Bradley C (2003); AIHW (2007); Bradley C and Pointer S (2009).

Compliance with service standards for residential care

'Compliance with service standards for residential care' is an indicator of governments' objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.21).

Box 13.21 **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 next page)

Box 13.21 (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.

Data quality information for this indicator is under development.

Accreditation decisions and further information relating to the accreditation standards and ACSAA are publicly available (ACSAA 2009). The accreditation process is summarised in box 13.21.

At 30 June 2010, 90.4 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 2010[a, b]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Re-accreditation period										
<2 years	%	4.0	4.6	4.8	4.7	8.1	–	20.0	37.5	5.0
2 years or more (but <3 years)	%	1.9	3.7	6.8	8.2	8.1	3.8	–	12.5	4.6
3 years	%	94.1	91.7	88.4	87.1	83.7	96.2	80.0	50.0	90.4
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total re-accredited services	**no.**	**324**	**350**	**249**	**85**	**86**	**26**	**10**	**8**	**1 138**

[a] Data at 30 June 2010 relate only to re-accreditations, and do not include accreditation periods for 28 commencing services. Earlier reports (up to June 2007 data) included both initial accreditations and re-accreditations. [b] Note that 'accreditation period' shows the decision in effect at 30 June 2010. Data in this table will not necessarily be consistent with the accreditation decisions made in 2009-10, because those decisions may not yet have taken effect, or may have been superseded. – Nil or rounded to zero.

Source: ACSAA (unpublished); table 13A.72.

Nationally, as at 30 June 2010, 99.5 per cent of residential aged care services were compliant with building certification, fire safety, and privacy and space requirements (table 13.10).

Table 13.10 Residential aged care services compliant with building certification, fire safety and privacy and space requirements at 30 June 2010

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[a]	*Aust*
Total residential services	no	886	774	480	244	267	82	26	14	2 773
Total compliant services	no	880	774	474	243	267	82	26	14	2 760
Proportion of compliant services	**%**	**99.3**	**100.0**	**98.8**	**99.6**	**100.0**	**100.0**	**100.0**	**100.0**	**99.5**

[a] NT data are variable due to small numbers.

Source: DoHA (2010) *Report on the Operation of the Aged Care Act 2007, 1 July 2009 – 30 June 2010*, Canberra.

Complaints

'Complaints' is an indicator of governments' objective to ensure aged care services provide a high quality of care (box 13.22).

Box 13.22 **Complaints**

‘Complaints’ is defined as the number of breaches under the *Aged Care Act 1997* identified by the Complaints Investigation Scheme (CIS) per 1000 residents.

A low or decreasing rate of breaches is desirable.

This indicator is a proxy of the quality of care. It counts the number of breaches identified by the CIS. Official complaints may indicate dissatisfaction about an element of the service provided, but do not always result in the finding of a breach.

The CIS investigates any potential breach of an approved provider’s responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, the Aged Care Standards and Accreditation Agency, police, nursing and medical registration boards). The CIS is able to issue Notices of Required Action where an approved provider is found to be in breach of their responsibilities under the *Aged Care Act 1997* and where the breach has not been rectified immediately.

The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system and perceptions of the effectiveness of the complaints system.

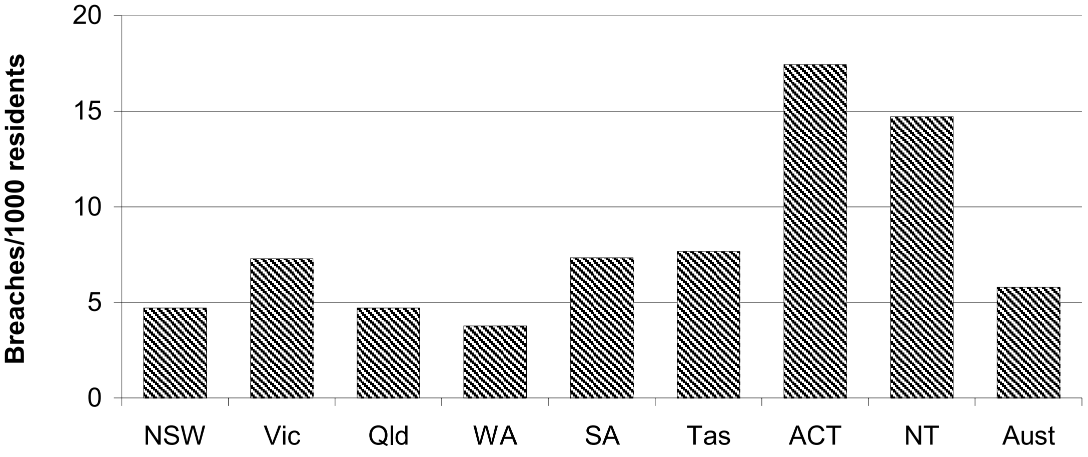
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

From 1 July 2009 to 30 June 2010, the CIS identified 931 breaches under the *Aged Care Act 1997* (table 13A.73). The number of breaches identified per 1000 residents from 1 July 2009 to 30 June 2010 was 5.8 nationally. This varied across jurisdictions (figure 13.28).

In the period 1 July 2009 to 30 June 2010, DoHA received 13 166 contacts of which 8055 were within the scope of the CIS to investigate, although not all of these were complaints. Of the 8055 in scope cases dealt with by the CIS, 96.5 per cent related to residential care services (DoHA unpublished).

Figure 13.28 **Complaints Investigation Scheme breaches, 2009-10**[a, b]



[a] Data for NT and ACT are variable due to small numbers. [b] Data relate to permanent residents as at 31 December 2009.

Source: DoHA (unpublished); table 13A.73.

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 13.23). Measures for compliance with service standards for community care are reported for the first time for CACP, EACH, EACH-D and NRCP services.

Box 13.23 **Compliance with service standards for community care**

'Compliance with service standards for community care' is defined by four measures:

- the number of HACC agencies appraised against the standards as a percentage of the total number of HACC agencies
- the proportions of HACC agencies which achieve high, good, basic, or poor ratings, and the average score in each jurisdiction
- the number of reviews against program standards for community aged care services (CACP, EACH, EACH-D and NRCP) as a proportion of total services to be reviewed
- the proportion of community aged care services (CACP, EACH, EACH-D and NRCP) which received ratings for:
  - Outcome 1 — effective process and systems in place
  - Outcome 2 — some concerns about effectiveness of processes and systems in place
  - Outcome 3 — significant concerns about effectiveness of processes and systems in place.

A high proportion of HACC agencies appraised, higher ratings and high average scores are desirable. A high proportion of community aged care services reviewed and a high proportion reviewed who achieved an outcome 1 (effective processes and systems in place) are desirable.

The indicator monitors the extent to which individual agencies are complying with service agreement standards/program standards. The HACC National Service Standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC National Service Standards Instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews. This indicator also measures the percentage of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

A total of 3469 HACC agencies were identified for appraisal over the four year period 2006-07 to 2009-10. The number of these agencies appraised was 3285 (94.7 per cent). This proportion varied across jurisdictions (table 13.11). The outcomes of these appraisals was a national average score of 17.5 out of 20 (table 13.12).

Table 13.11 HACC National Service Standards appraisals over the four year period ending 2009-10[a]

	Unit	NSW[b]	Vic	Qld[c]	WA	SA	Tas	ACT[d]	NT[e]	Aust[c]
Appraisals	no.	1 527	437	917	225	195	72	30	16	3 285
HACC agencies	no.	1 610	461	783	278	195	72	30	40	3 469
Proportion of agencies assessed	%	94.8	94.8	100.0	80.9	100.0	100.0	100.0	40.0	94.7

[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] The NSW Health reviews undertaken during 2009-10 were a representative sample of all NSW Health HACC funded services and covered all service types and geographic areas to determine any variations. This sample was used to validate the self-assessment completed by 100 per cent of NSW Health HACC funded services. All HACC services were reviewed using a comprehensive monitoring tool between November 2005 and June 2009. That monitoring activity verified non-government organisations self-assessment against the HACC instrument. Remaining services to be appraised are mainly community transport services due to complete in December 2010. [c] 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 783 Queensland agencies. [d] Quality Assessments in the ACT occurred in 2008-09 only. [e] 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 period ending 2009-10 (number)[a, b, c]

	NSW	Vic	Qld[d]	WA	SA	Tas[e]	ACT[f]	NT	Aust
High (17.5 – 20)	1 065	237	703	88	114	30	18	3	2 258
Good (15 – 17.4)	227	92	145	40	43	11	9	4	571
Basic (10 -14.9)	202	77	60	87	30	16	3	7	482
Poor (less than 10)	33	31	9	10	8	15	–	2	108
Average score	17.7	16.5	18.6	15.0	17.0	14.9	17.6	14.3	17.5

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. [b] The results of the appraisals will reflect the individual approaches adopted by each State and Territory. [c] For details about the method of determining the average score, see table 13A.76. [d] In Queensland, some agencies were reviewed twice in the four year period. This table includes outcomes of all appraisals during the cycle. [e] One agency in Tasmania declined to participate in the appraisal process and was therefore scored as zero. [f] Quality Assessments in the ACT occurred in 2008-09 only. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 13A.76.

Nationally, a total of 618 community aged care organisations providing CACP, EACH, EACH-D and NRCP services were to be reviewed in 2009-10 (table 13A.74). Of these services, 98.8 per cent were reviewed nationally and this proportion varied across jurisdictions (table 13.13). The proportion of the reviews for which an outcome 1 — effective processes and systems in place — was achieved was 78.7 per cent (table 13.13).

Table 13.13 Compliance with service standards for community aged care services — CACP, EACH, EACH-D and NRCP, 2009-10 (per cent)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of services reviewed[a]									
	103.8	131.5	85.0	105.0	50.0	96.5	60.0	141.6	98.8
Proportion of reviews achieving relevant outcomes									
Outcome 1[b]	73.8	86.3	80.3	76.2	70.6	92.9	100.0	64.7	78.7
Outcome 2[c]	7.5	8.2	16.1	14.3	17.6	7.1	–	35.3	12.1
Outcome 3[d]	18.7	5.5	3.6	9.5	11.8	–	–	–	9.2

[a] In some states and territories, more services were reviewed than the annual target for 2009-10. [b] Outcome 1 is effective processes and systems in place. [c] Outcome 2 is some concerns about the effectiveness of processes and systems in place. [d] Outcome 3 is significant concerns about the effectiveness of processes and systems in place. – Nil or rounded to zero.

Source: DoHA (unpublished); tables 13A.74-75.

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 13.24).

Box 13.24 Client appraisal of service standards

'Client appraisal of service standards' is yet to be defined.

Data for this indicator were not available for the 2011 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 13.25).

Box 13.25 **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.

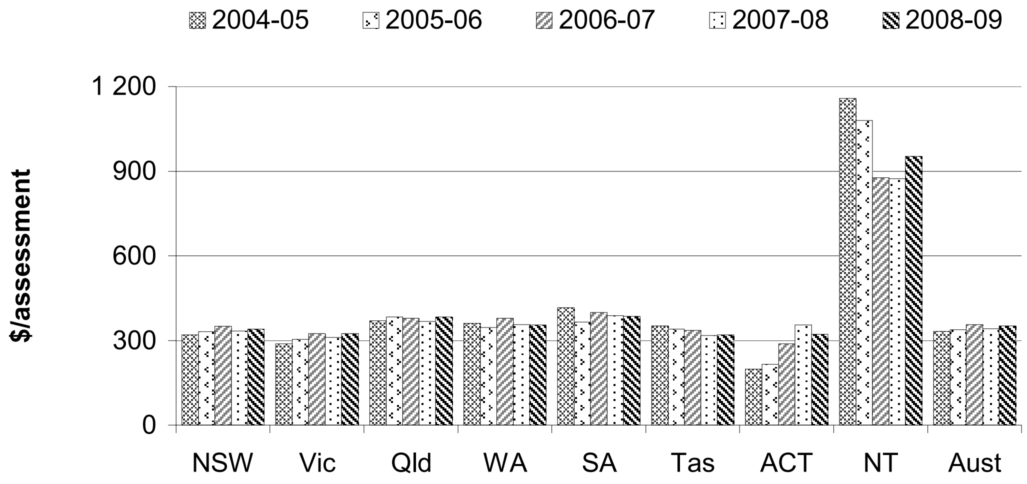
Cost per ACAT assessment has been developed as a proxy and work is in progress to measure efficiency for ACATs.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Australian Government expenditure per aged care assessment during 2008-09 averaged $352 nationally (figure 13.29). Nationally, real expenditure increased between 2004-05 to 2008-09. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.29 **Australian Government expenditure on aged care assessments, per assessment (2008-09 dollars)**[a, b, c]



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[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.77.

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 13.26).

Box 13.26 **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 care services, HACC and CACP services.

This is a proxy indicator of efficiency and needs to be interpreted with care as it measures cost per target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment can reflect improving efficiency or a decrease in service standards.

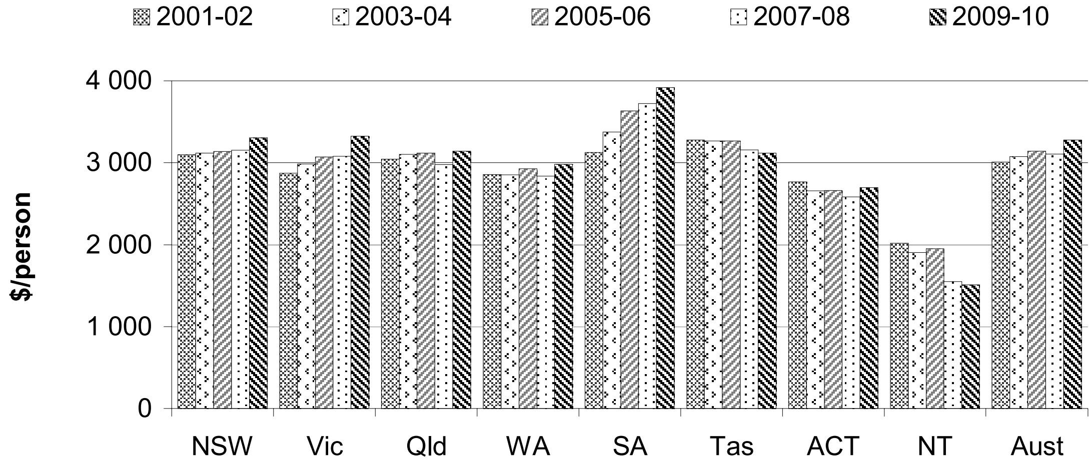
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

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 increased from $3010 in 2001-02 to $3280 in 2009-10 (figure 13.30). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure nationally was $3228 in 2009-10 (table 13A.78).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2009-10 was $2785 including the payroll tax supplement and $2742 excluding the payroll tax supplement (table 13A.8). DVA expenditure on residential care per person aged 70 years or over in 2009-10 was $507 including the payroll tax supplement and $500 excluding the payroll tax supplement (table 13A.14).

Figure 13.30 Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)[a, b, c]



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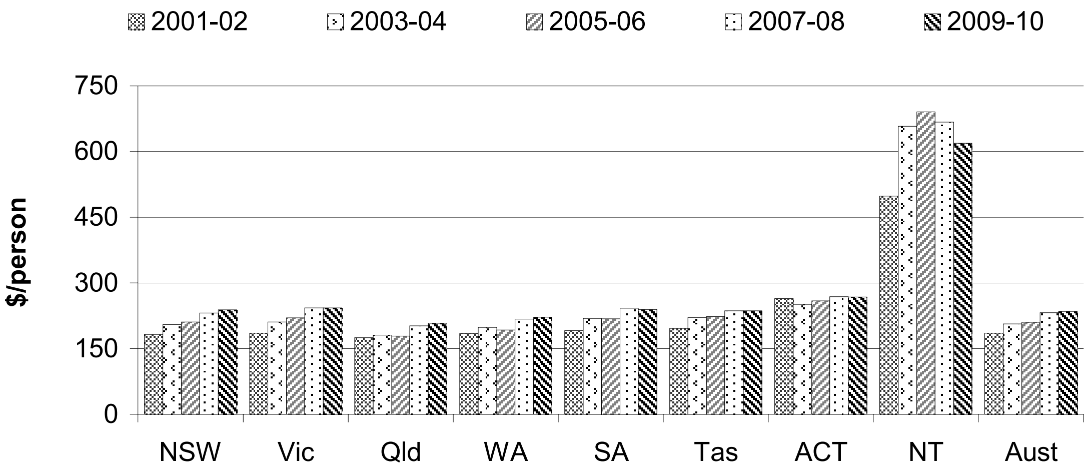
[a] Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. [b] Population data for years prior to 2008, are from population projections by SLA for 2002–2022 based on 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008, are from preliminary population projections by SLA for 2006–2026 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009, are from population projections by SLA for 2007–2027 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information. [c] Full ten years of data for this indicator are in attachment 13A.78.

Source: DoHA (unpublished); DVA (unpublished); table 13A.78.

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 2009-10. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $185 in 2001-02 to $235 in 2009-10 (figure 13.31).

Figure 13.31 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)**[a, b]



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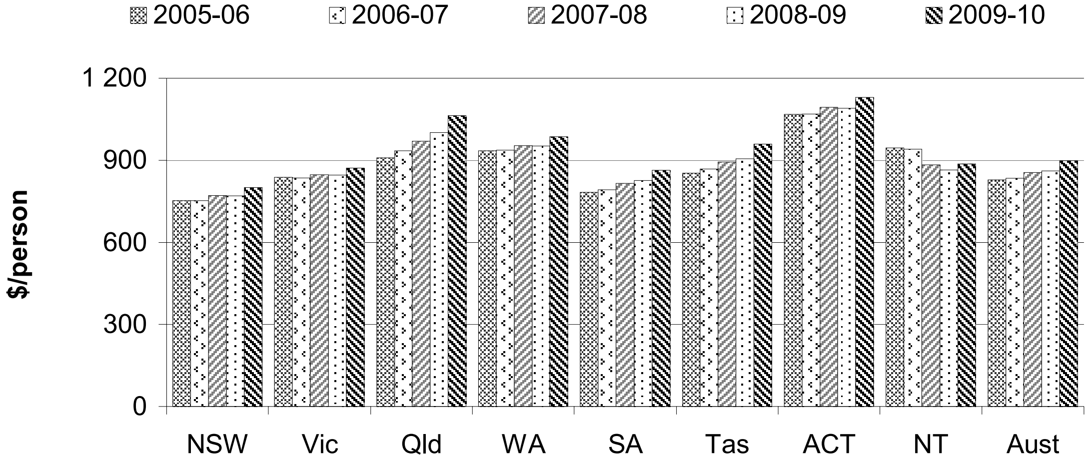
[a] Population data for years prior to 2008, are from population projections by SLA for 2002–2022 based on 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008, are from preliminary population projections by SLA for 2006–2026 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009, are from population projections by SLA for 2007–2027 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information. [b] Full ten years of data for this indicator are in attachment 13A.81.

Source: DoHA (unpublished); table 13A.81.

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 was $899 in 2009-10, higher than expenditure in 2005-06 which was $829 (figure 13.32). 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.79.

Figure 13.32 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2009-10 dollars)**[a, b, c, d, e]



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[a] People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person in the HACC target population is contained in table 13A.79. HACC target population data are in table 13A.52. [b] These data represent expenditure under the HACC Review Agreement only. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] Expenditure reflects an equalisation strategy. [e] Population data for years prior to 2008, are from population projections by SLA for 2002–2022 based on 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008, are from preliminary population projections by SLA for 2006–2026 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009, are from population projections by SLA for 2007–2027 based on 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.80.

Outcomes

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

Social participation in the community

‘Social participation in the community’ has been identified for development as an indicator of governments’ objective to encourage the wellbeing and independence of frail older people (box 13.27).

Box 13.27 **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 13.28).

Box 13.28 **Maintenance of individual functioning**

‘Maintenance of individual functioning’ is defined as improvement in TCP client’s level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the TCP to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).

This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client’s level of functioning. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions.

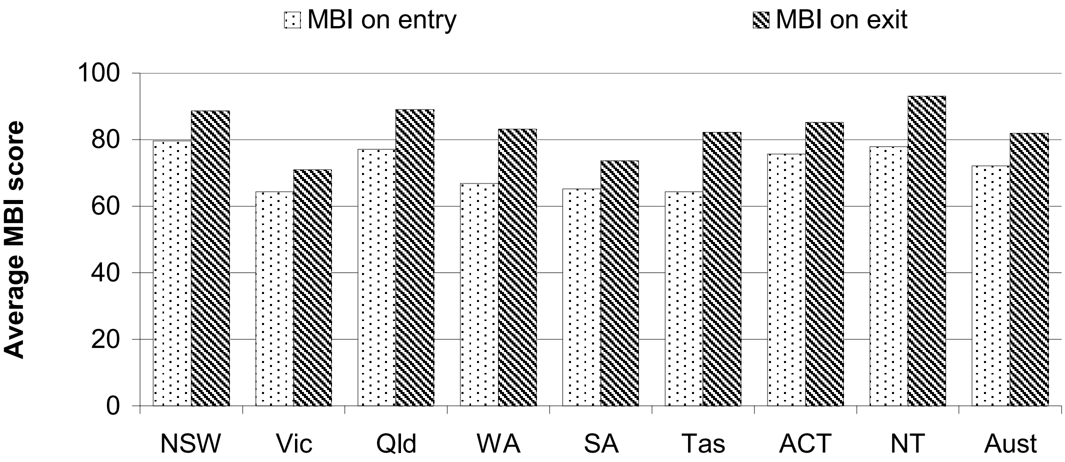
The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual functioning.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

The average MBI score on entry to the TCP in 2009-10 was 72.1 nationally. The average MBI score on exit from the TCP was 82.0 nationally. These results varied across jurisdictions (figure 13.33).

Figure 13.33 **Transition Care Program — average Modified Barthel Index score on entry and exit, 2009-10**[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 TCP recipients who successfully completed a transition care episode.

Source: DoHA (unpublished); table 13A.82.

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 13.29).

Box 13.29 **Enabling people with care needs to live in the community**

'Enabling people with care needs to live in the community' is yet to be defined.

Higher rates of people with care needs remaining and participating in the community are more desirable.

When developed for future Reports, this indicator will show the extent to which older people's entry to residential care is delayed and the extent to which older people participate in community, cultural or leisure activities.

13.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting available. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- improved reporting of waiting times for residential aged care
- improved reporting of long term aged care in public hospitals
- inclusion of additional data on adverse events in residential aged care as they become available
- further development of outcome indicators.

COAG Developments

Report on Government Services alignment with National Agreement reporting

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework’ and the ‘Review of the performance indicators and their associated measures’. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

13.5 Jurisdictions’ comments

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

Australian Government comments

During 2009-10, the Commonwealth commenced work on the development of a national aged care system that will provide better support for older Australians including training for aged care workers, more aged care places and choice, improved health care services and protection for older Australians. The Council of Australian Governments agreed to major reforms to the funding and operational roles and responsibilities in the aged care sector. Under this system the Commonwealth will become the sole funder and regulator of aged care services, including Home and Community Care services (with the exception of Victoria and Western Australia) through to high level residential care.

The Commonwealth also commenced work to implement improved information and access to services for older Australians and their families and providing $300 million in loans to support the development of an additional 2500 aged care places supporting an estimated 3600 people per year once fully implemented. Work has commenced to provide assistance over four years to improve the viability of rural and regional community care providers by increasing the viability supplement for eligible providers. More than 280 sub-acute beds, or their equivalents, are being constructed, in new and existing Multi-Purpose Services, supporting up to 5400 people a year and increasing the availability of more appropriate care options for long stay older patients in rural and remote areas. Funding is being provided to help states and territories meet the cost of long stay older patients in public hospitals, through the allocation of 2000 time-limited flexible aged care places to states and territories to support older people in hospitals. The Commonwealth is also improving consumers quality of life, independence and satisfaction with opportunities for care recipients and carers to be more active in shaping their care and services through 1200 Consumer Directed Care packages in Commonwealth-funded community care programs. The Aged Care Complaints Investigation Scheme is expanding the means through which complaints can be resolved by working with the aged care sector to establish alternate methods of resolution.

The Australian Government recognises that there are challenges facing the aged care sector and that reform is essential to build a more sustainable system that older Australians can rely on, providing high quality, affordable care into the future. The reforms the Government are introducing are the first step. The Prime Minister, the Hon Julia Gillard MP, has identified continued reform of the aged care system as a second term priority for the Government. This is why it asked the Productivity Commission to examine all aspects of Australia’s aged care system, and to develop detailed options to ensure it can meet the challenges facing it in coming decades. The Government is looking forward to the conclusions from the Productivity Commission’s inquiry and to working with the industry and older people to reform aged care so that older people can continue to receive the quality care they deserve.

New South Wales Government comments

All NSW Government agencies continue to work on strategic priority activities identified in the *NSW Towards 2030: planning for our changing population*. This is facilitating a coordinated approach to population ageing and demographic change by the NSW Government, together with business and the community.

As part of the National Health and Hospitals Reform, NSW Health is working with the Commonwealth on opportunities to improve the integration of specialist health services for older people within the national aged care system. This includes managing the transition of full funding and policy responsibility for the Aged Care Assessment Program to the Commonwealth by July 2012. Major progress is also being made towards enhancing the e-business capability of all 38 Aged Care Assessment Teams in NSW through implementation of the electronic Aged Care Client Record (eACCR).

NSW Health is successfully expanding its jointly-funded Transition Care Program designed to provide time-limited low intensity therapy and support to older people following hospitalisation. At 30 June 2010, NSW had 934 Transitional Aged Care places operating in NSW in both residential and community settings.

Funding under the 2006 COAG Long Stay Older Patients program continues to enable AgedCare Services in Emergency Teams to improve the clinical care and management of older people who present to a NSW public hospital Emergency Department. It also supports the provision of Acute to Aged-Related Care Services targeting early and appropriate identification of the discharge support needs of older people admitted to hospital.

In 2009-10, the NSW Home and Community Care (HACC) program continued to expand with a total budget of $588 million, an increase of $42 million, or 7.7 per cent, over 2008-09. The *Better Practice Project* was established as part of the commitment by NSW to introduce client focused service delivery and independence models of support within the HACC program. Under this initiative, NSW piloted four regional demonstrations and partnered with Aged and Community Services NSW and ACT to deliver an Awareness Raising Education Program with a focus on innovation and better practices in HACC.

The Home Care Service, a major HACC service provider in NSW, achieved a 95 per cent satisfaction rating in its 2010 Client Satisfaction Survey. This high level of satisfaction was found across all client groups and all survey participants expressed high levels of satisfaction with the attitude of staff, service standards and reliability.

In March 2010, the Community Care Access Centre celebrated two years of operation for the people of the Hunter Local Government Area. During the two-year period, the Access Centre received 20 978 new referrals, performed 20 684 community care assessments and made 22 599 e-referrals to HACC services on behalf of clients and carers.

Victorian Government comments

This year has seen important discussion and negotiation between jurisdictions on alternatives for future policy and funding responses and responsibilities in aged care.

COAG discussion of health reform led to very significant changes including the transfer of all funding and policy responsibility for the Home and Community Care (HACC) Program to the Commonwealth in every jurisdiction that has agreed to the health and aged care reforms, other than Victoria. The Victorian Government will retain responsibility for jointly funding and managing HACC Services for older people, younger people with disabilities and their carers, recognising the strength of and unique characteristics of the program in this State.

Victoria will continue to work with the Commonwealth on advancing the national reform agenda in aged care, noting that models proposed to be put in place such as 'one stop shops' would need to provide demonstrably improved navigation of the service system and enhanced assessment processes for older people to be supported.

The Productivity Commission's inquiry into the challenges facing Australia's aged care system is a further important milestone in establishing an optimal framework to meet future aged care needs. Victoria has made a submission outlining a variety of concerns regarding the current structure of the Commonwealth aged care system.

Key issues from Victoria's perspective include:

- aged care system integration — across the range of community-based and residential service types and with other systems (such as hospital and disability)
- importance of state/local governments as system managers — for example HACC
- rural viability of aged care services
- funding and regulation, particularly of residential aged care and especially high care.

Supported residential services (SRS) provide privately-run care and accommodation to people who need support in everyday life. New legislation has been introduced to improve the protection, safety and wellbeing of people living in SRS.

A Victorian charter supporting people in care relationships was launched in June 2010. The charter recognises and respects the vital role all carers play in the Victorian community.

Three guides have been developed to support older Victorians: *Living at home, your choices*, and *Residential care, your choices*, provide information and options for older Victorians and their families and carers, and *On my terms ... alone at home with care needs*, is a resource for services service providers.

Queensland Government comments

- Queensland has continued to support the programs and services that improve the quality of life of older people and their carers.
- The Department of Communities has led the development of “Positively Ageless – Queensland Seniors Strategy 2010–2020” and the “10-year plan for supporting Queenslanders with a disability”. These plans identify priority areas and key initiatives for older people, particularly those who are vulnerable, disadvantaged or socially isolated, and people with a disability.
- In 2009-10, Queensland continued to address priorities identified in the HACC Triennial Plan 2008–2011 including improving service accessibility and delivery for Aboriginal and Torres Strait Islander people, people with dementia, carers, people who are homeless or living in boarding houses and hostels and people from culturally and linguistically diverse communities.
- The Queensland Community Services Skilling Plan has delivered expanded training and skill development for HACC workers, volunteers and clients in Queensland. A pilot program, Nutrition for One or Two, helped frail aged men and women to reignite their interest in eating and preparing nutritious food.
- A review of the Access Point program in Rockhampton identified that improved efficiency would be gained by changing to a single regional service provider model. Queensland now plans to expand the program state-wide.
- Queensland has continued to implement places approved under the Transition Care Program. As at 30 June 2010, 606 places were operational. During 2009-10, Queensland Health contributed over $16 million towards the cost of Transition Care.
- Queensland Health continued to implement local based initiatives under the Long Stay Older Patients’ Program. Initiatives include capital works at 22 rural sites and Hospital in the Home and Nursing Home, Interim Care, Early Intervention and Hospital Avoidance across metropolitan and major provincial sites.
- Queensland supports 20 State owned and operated residential aged care facilities. In 2009-10, the State Government contributed nearly $90 million of an overall expenditure of over $162 million. Capital expenditure of nearly $10 million was made to upgrade these facilities and Multi Purpose Health Services.
- During 2009-10, Queensland rolled-out the electronic submission of all aged care assessments undertaken by 17 Aged Care Assessment Teams across Queensland.
- Queensland also contributed $10 million in 2009-10 for the Healthier Ageing Program aimed at addressing lifestyle factors impacting on the health of older people. Funding of $800 000 was provided for the Strengthening Aged Care initiative.

Western Australian Government comments

“ Western Australia’s approach to the development and implementation of services for older people continues to focus on the vision of independence, wellbeing and quality of life.

The WA Home and Community Care (HACC) Program “Assessment Framework Service Redesign” framework released in 2009 was followed by a series of consultation forums and in early 2010; Reference Groups were established to support the development and implementation of the Assessment Framework. An expression of interest has been called to identify the service providers that will take on the role of Regional Assessment Services.

The Friend In Need–Emergency (FINE) scheme is a metropolitan based partnership between public hospitals and community care that targets older and chronically-ill patients and gives them an alternative to an emergency department presentation or admission to hospital. As well as keeping people at home the FINE scheme assists in timely, safe and effective discharge of patients from public hospitals. It supports a range of services including the Silver Chain Home Hospital; a strengthened network of care coordination; and community based home care packages. The WA Health Residential Care Line Outreach has been integrated into the FINE scheme and, together with Silver Chain Home Hospital services, provides enhanced clinical support options to Residential Aged Care Facilities in metropolitan Perth.

There has also been a focus on the growth of sub-acute care services across the state, especially in rural and remote geographical areas where services are minimal or undeveloped. This work has included expansion of consultant geriatric visiting services and the establishment of a consultant psycho-geriatric visiting service in rural areas. The establishment of Day Therapy Units and outreach community based physiotherapy in key regional centres is also an important development. The work has also included a particular emphasis on Rehabilitation in the Home (RITH) in metropolitan regions, establishment of outreach multidisciplinary rehabilitation clinics for specialist clinical groups such as Amputee and Parkinson’s Disease patients and the establishment of regional secondary stroke units.

The ‘Long Stay Older Patients’ initiative (LSOPI) has continued to operate across the state with a focus on strengthening existing hospital strategies through the continued funding of the emergency department Care Coordination Teams (CCT). The major focus of the CCTs includes screening for any condition associated with ageing that may impact on the person’s functional wellbeing which could lead to admission to hospital. Early identification of these risks assists with care planning and early introduction of support services and treatment interventions to prevent future emergency department attendance, hospital admission and functional decline. The LSOPI has also provided the catalyst for raising awareness and changing the culture of aged care in emergency departments and raised the profile of aged care service delivery along the Eldercare Pathway. ”

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’.

In keeping with the national community care reforms and COAG’s initiative to improve access to community care, SA 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 SA Home and Community Care (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 SA HACC program continued to expand, with $12.5 million in additional funding bringing the total budget to $162.2 million in 2009-10.

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
- older people from culturally and linguistically diverse (CALD) backgrounds and their carers
- 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 $8.9 million in 2009-10. Funding was also allocated for specific projects for carers and to implement the State-wide Dementia Action Plan.

Tasmanian Government comments

- Under the national health reforms, the Australian Government will take over full responsibility for the planning, funding and provision of aged care. States and territories, however, will still be required to make a significant contribution to hospital and other services providing care to older people.
- Both the direct and the broader service demand issues posed by population ageing are now a central focus of social and economic planning within Australia and internationally. Those issues are of particular concern for Tasmania, with current projections by the Australian Bureau of Statistics indicating that, by 2021, this state will have 20.8 per cent of its population aged 65 years or older, a considerable 3.6 per cent higher than the national average of 17.2 per cent.
- While demand for community services is increasing, evidence confirms better outcomes for older people and lower costs to governments through enabling older people to live independently and as long as possible in their own homes. The Tasmanian Government is committed to that principle, and in 2010 it fully matched the Australian Government's growth offer of 8.37 per cent in the Home and Community Care (HACC) Program.
- While longer term service reform planning is essential, existing service models must be recurrently resourced and where necessary enhanced, in the short to medium term. Tasmania has continued to make a considerable investment in 2009-10 with both the jointly-funded Transition Care and the Long Stay Older Patients programs, aimed at diverting older people away from, or reducing their stay, in acute care.
- 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.
- The subacute care element of the National Partnership Agreement (NPA) on Hospital and Health Workforce Reform requires Tasmania to implement strategies to grow subacute services by 20 per cent over the life of the NPA. The State has already made solid progress in the first year of the Agreement and has completed a number of projects under its implementation plan. Both the Statewide Aged Care and Rehabilitation and the Palliative Care Clinical Networks have been successfully established with ongoing project support. Palliative care services have been expanded and innovative models of other subacute care have been implemented, or are being developed, across the three service regions.
- Tasmania has also signed up to a two-year funding and implementation plan with the Australian Government, under the NPA on Health Services, to improve existing services, develop arrangements for a one-stop shop model and to consider the future arrangements for the Aged Care Assessment Teams in the context of the broader national health and aged care reforms.

Australian Capital Territory Government comments

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- The ACT has one of the fastest growing populations of people aged 60 years or over in Australia. Growth of the ACT population is expected to rise from 15.8 per cent in 2020 to 22 per cent by 2030. The ACT Government has implemented a Strategic Plan for Positive Ageing (2010–2014) with the vision that Canberra will be an age-friendly city.
- Ageing of the ACT and the regional population has influenced the planning of infrastructure through the Capital Asset Development Project. *Your health — our priority* is a $1 billion plus redevelopment of our health infrastructure. The aim is to revitalise and ready the ACT health system to respond to growing health service demand through to 2022 and beyond.
- As part of the forward design, ACT Health is working with our consumers, clinicians and staff to develop the way forward for our health services and to design the facilities needed to deliver them. Plans developed to date are the critical care, Cancer Services, Mental Health Services, Diabetes, Corrections health and Surgical Services plans. Other services plans are currently underway including the Rehabilitation and Aged Care Plan 2010–2015.
- In recognition of General Practitioner (GP) access difficulties, a GP in-hours locum service to support GPs and residents of residential aged care facilities is to be implemented. The service will operate from 8am to 6pm Monday – Friday (excluding public holidays). The service will receive referrals from GPs to the locum service who will provide primary care to patients in residential aged care facilities or to those clients who are home bound.
- In 2009-10, an additional $2.3 million was provided to support people to remain independent in the community through the Home and Community Care program. Services expanded included domestic assistance, personal care and home modifications.
- The Australian Government commitment to work with the States and Territories to improve transition from hospital to aged care allocates an additional 2000 transition care places for older Australians, including Aboriginal and Torres Strait Islander people. This initiative has enabled the expansion of the ACT transition care program to 41 places in 2009-10.

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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 Northern Territory is the largest in Australia. The NT's projected growth rate for people aged 65 years or 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 2009-10, the benefits in streamlined reporting, as a result of the amalgamation of Community Government Councils to larger Shire Councils, began to be realised. There was minimal impact on service delivery under the new arrangements.

In 2009-10, the numbers of allocated places under the Transition Care Program were increased by seven to bring the NT's total allocation to 29. The additional seven places are community based, increasing the flexibility of the program in the NT. There are now 13 community based places and 16 residential based places (four each in Darwin and Alice Springs and eight in Katherine).

The NT operated six Aged Care Assessment Teams (ACATs) during 2009-10. 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 Home and Community Care (HACC) funding pool of $12.0 million for 2009-10. A mix of Non-Government, Local Government and State Government providers delivered support to the frail aged and younger people with disabilities and their carers through fifty three different 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	An adjusted subsidy reduction supplement is a payment made by State governments to some public sector residential care operators to offset the effect of the Australian Government's adjusted subsidy reduction. The adjusted subsidy reduction reduces the daily rate of Residential Care Subsidy paid by the Australian Government in respect of certain residential aged care places owned by State governments or State public sector organisations. The rate of the reduction is determined by the relevant Commonwealth Minister from 1 July each year, in accordance with section 44-19 of the *Aged Care Act 1997*.
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: • high in Activities of Daily Living, or • high in Complex Health Care, or • high in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domain, or • medium in at least two of the three domains. All other ACAT approval and ACFI appraisal combinations result in a classification of low level care. A resident's care needs may change over time resulting in a change in classification from low to high level care (ageing in place).
In-home respite	A short term alternative for usual care.

People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self-care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*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 List of attachment tables

Attachment tables are identified in references throughout this chapter by an '13A' suffix (for example, table 13A.3 is table 3). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 13A.22 Proportion of residential aged care places, by location in high care, low care and mixed care services

Table 13A.23 Operational number of aged care places, 30 June ('000)

Table 13A.24 Operational number of aged care places per 1000 people aged 70 years or over, 30 June

Table 13A.25 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.26 Operational number of residential and community aged care services per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, by planning region

Table 13A.27 Operational number of residential and community aged care services per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, by remoteness

Table 13A.28 Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June

Table 13A.29 Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by locality, 30 June

Table 13A.30 Aged care recipients from special needs groups, June 2010 (per cent)

Table 13A.31 Aged care recipients from a non-English speaking country, 30 June

Table 13A.32 Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 70 years or over by locality, 30 June

Table 13A.33 Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients, 30 June

Table 13A.34 Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over by locality, 30 June

Table 13A.35 Permanent aged care residents at June 2010: age-sex specific usage rates per 1000 people by jurisdiction

Table 13A.36 Proportion of new permanent residents classified as concessional, assisted or supported residents (per cent)

Table 13A.37 Ageing in place: residents changing from low care to high care in the same facility

Table 13A.38 Utilisation of residential aged care places, by remoteness category, June 2010

Table 13A.39 CACP EACH and EACH-D recipients at June 2010: age-sex specific usage rates per 1000 people by jurisdiction

Table 13A.40 Permanent aged care residents, CACP, EACH and EACH-D recipients at June 2010: age-sex specific usage rates per 1000 people by jurisdiction

Table 13A.41 Number of younger people with a disability using residential, CACP, EACH and EACH-D aged care services

Table 13A.42 Permanent aged care residents at June 2010: age-sex specific usage rates per 1000 people by remoteness

Table 13A.43 CACP, EACH and EACH-D recipients at June 2010: age-sex specific usage rates per 1000 people by remoteness

Table 13A.44	Permanent aged care residents, CACP, EACH and EACH-D recipients at June 2010: age-sex specific usage rates per 1000 people by remoteness
Table 13A.45	Indigenous permanent residents classified as high or low care and Indigenous CACP, EACH and EACH-D at June 2010: age-sex specific usage rates per 1000 people by remoteness
Table 13A.46	HACC services received per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years
Table 13A.47	HACC services received within major cities per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years
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13.8 References

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14 Services for people with disability

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a ‘14A’ 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 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 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***

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 people 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.

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

(Continued on next page)

Box 14.1 **(Continued)**

- 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 and NDA (2008-09), objectives for both Agreements are included
- Financial data for 2009-10 include expenditure on services under the NDA that were not included under the CSTDA, for example, aids and equipment funding and expenditure on ‘assistance for younger people in residential aged care’
- Results based on the National Minimum Data Set (NMDS) service user data for 2008-09 (the latest year for which data are available) are reported using the specifications developed and agreed under the CSTDA and the NDA.

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 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.

Major improvements in the reporting of services for people with disability this year include:

- reporting ‘assistance for younger people in residential aged care’ as an indicator for the first time and including additional measures in attachment tables
- reporting on inclusion of people in need of assistance with independent living (AIL) or assistance with work, education and community living (AWEC) for the indicator ‘Service use by severity of disability’
- reporting WA data for the ‘client and carer satisfaction’ with specialist disability services indicator for the first time
- extended time series for CSTDA data in the attachment tables
- alignment with relevant NDA indicators, including:
  - additional data disaggregations for specific age groups and sex for the access to appropriate services on the basis of relative need indicators.

14.1 Profile of disability services

Service overview

Government assistance for people with disability and their carers comprises provision of specialist disability services, access to mainstream services and provision of income support. Definitions of disability are provided in box 14.2.

Box 14.2 **Definitions of disability**

The United Nation’s *Convention on the Rights of Persons with Disabilities,* ratified by Australia on 17 July 2008, defines ‘persons with disabilities’ as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The World Health Organisation (WHO) defines ‘disabilities’ as impairments, activity limitations, and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives (WHO 2009).

The third CSTDA (2003, p. 9) defines ‘people with disabilities’ as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long-term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self care/management
- mobility
- communication.

The NDA does not have a specific definition of ‘people with disability’.

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 specific core activity limitation (mild, moderate, severe and profound)
- with a schooling or employment restriction
- with a disability, but without a specific limitation or restriction — includes people who need assistance with health care, cognition and emotion, paperwork, transport, housework, property maintenance or meal preparation.

(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.

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 alternative forms of communication*
  - advocacy services enable people with disability to increase their control over their lives by representing their interests and views in the community
  - information services provide accessible information to people with disability, their carers, families and related professionals about disabilities, specific and mainstream services and equipment; and promote the development of community awareness
  - alternative forms of communication for people who are by reason of their disability, unable to access information provided in a print medium
- *other support services* that include research and evaluation, and training and development projects.

Mainstream services

Mainstream services are services provided to the community as a whole. Governments acknowledge that specialist disability services are complemented by mainstream services. Under the NDA, all Australian governments have agreed to 'strive' to ensure that all people with disability have access to mainstream government services within their jurisdictions. It is recognised that improved outcomes for people with disability, their families and their carers, are contingent upon the effective coordination of efforts across government services. Some mainstream services give priority to people with disability (for example, public housing) or have programs to meet the special needs of people with disability (for example, school education).

Income support and allowances

Income support for people with disability and their carers contributes to the outcomes of the NDA. The Australian Government is responsible for the provision of income support targeted to the needs of people with disability, their families and carers (box 14.3). Income support is provided to those who meet the relevant eligibility criteria. Income support payments and allowances include the Disability Support Pension, Carer Payment, Carer Allowance, Sickness Allowance, Mobility Allowance 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 2009-10 (on an accrual basis) amounted to $11.6 billion for the Disability Support Pension, $2.3 billion for the Carer Payment, $1.5 billion for the Carer Allowance, $83.7 million for the Sickness Allowance, $124.0 million for the Mobility Allowance and $152.3 million for the Child Disability Assistance Payment. The Carer Supplement was not paid in 2009-10 (Australian Government unpublished).

At 30 June 2010, there were around 792 600 recipients of the Disability Support Pension, 168 900 recipients of the Carer Payment, 508 600 recipients of the Carer Allowance, 57 300 recipients of the Mobility Allowance, 6700 recipients of the Sickness Allowance and 152 400 recipients of the Child Disability Assistance Payment (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 NDA objective and outcomes
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with State and Territory governments
- ensuring that Commonwealth legislation and regulations are aligned with the national policy, reform directions and the *United Nations Convention on the Rights of 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:

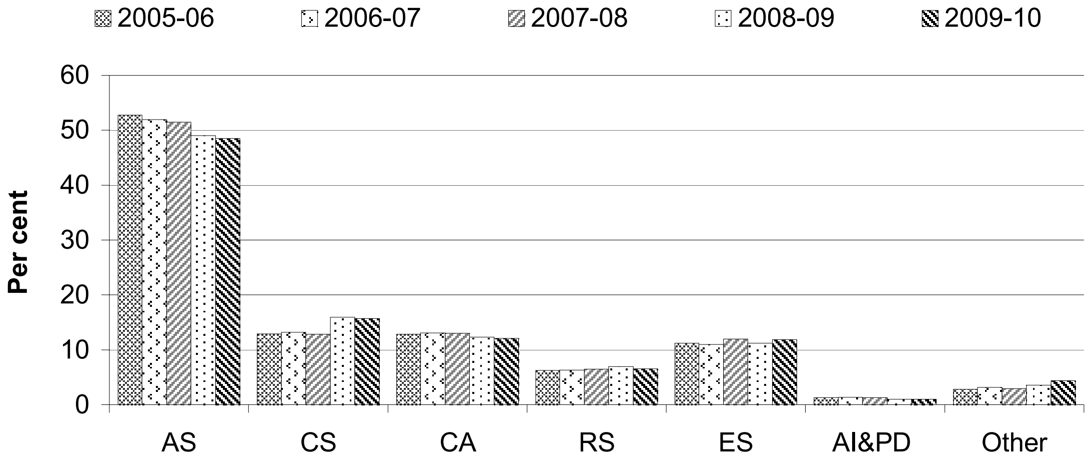
- development of national policy and reform directions to meet the agreed objectives and outcomes of the NDA
- funding and pursuing research that provides an evidence base for national policy and reform directions
- developing and implementing reforms to improve outcomes for Indigenous people with disability
- 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 NDA. Total government expenditure on these services was $5.7 billion in 2009-10 — a real increase of 8.1 per cent on the expenditure in 2008-09 ($5.3 billion) (table 14A.4). State and Territory governments funded the majority of this expenditure in 2009-10 (70.8 per cent, or $4.1 billion). The Australian Government funded the remainder (29.2 per cent, or $1.7 billion), which included $903.7 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 NDA was $5.3 billion in 2009-10 (table 14A.8). The distribution of direct government expenditure varied across jurisdictions. The main areas of State and Territory government expenditure were accommodation support services (48.5 per cent of total direct service expenditure) and community support (15.7 per cent of total direct service expenditure) (figure 14.1). Employment services were the main area of Australian Government expenditure in 2009-10 (11.8 per cent of total direct service expenditure and 86.7 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) 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).

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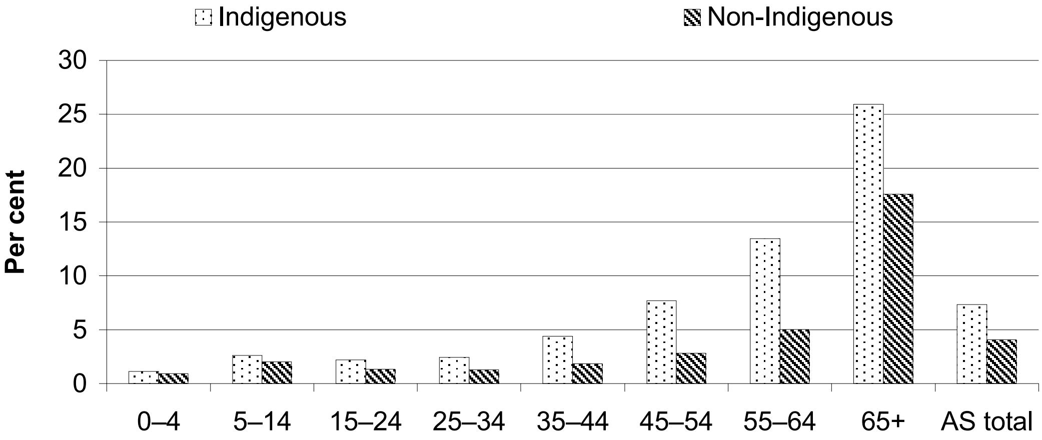
[1] The acronym ASSNP is the variable name used by the ABS to define 'core activity need for assistance'. It appears to incorporate a shortened version of 'assistance need' and the letter 'P' indicates that the classification describes a characteristic of a person. This acronym is used throughout the 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.

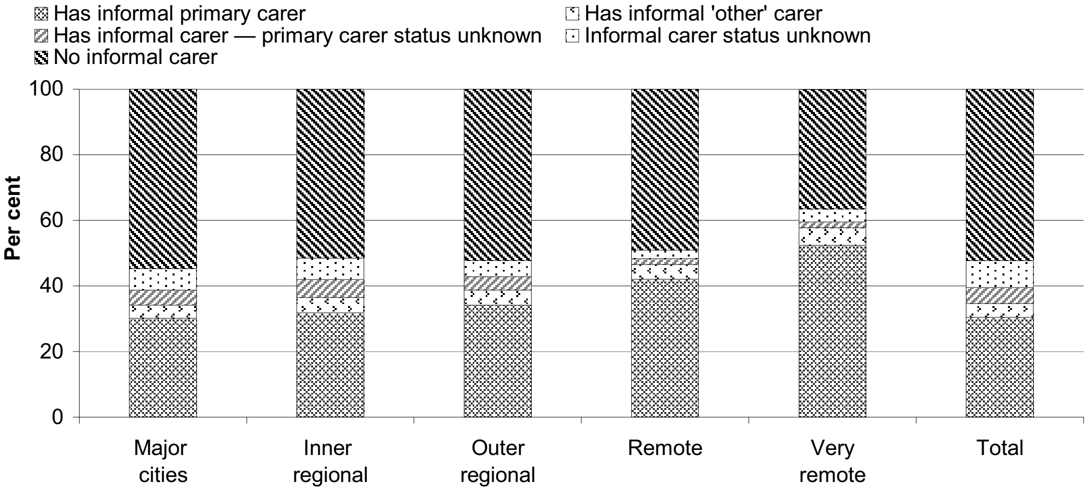
Information on informal carers is available from the ABS SDAC and for CSTDA/NDA service users from the NMDS. The definition of informal carers differs slightly across these data collections:

- 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/NDA funded specialist disability services in 2008-09, 39.5 per cent reported having an informal carer and 30.4 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/NDA funded specialist disability services, by whether they had an informal carer and geographic location, 2008-09**[a, b, c]



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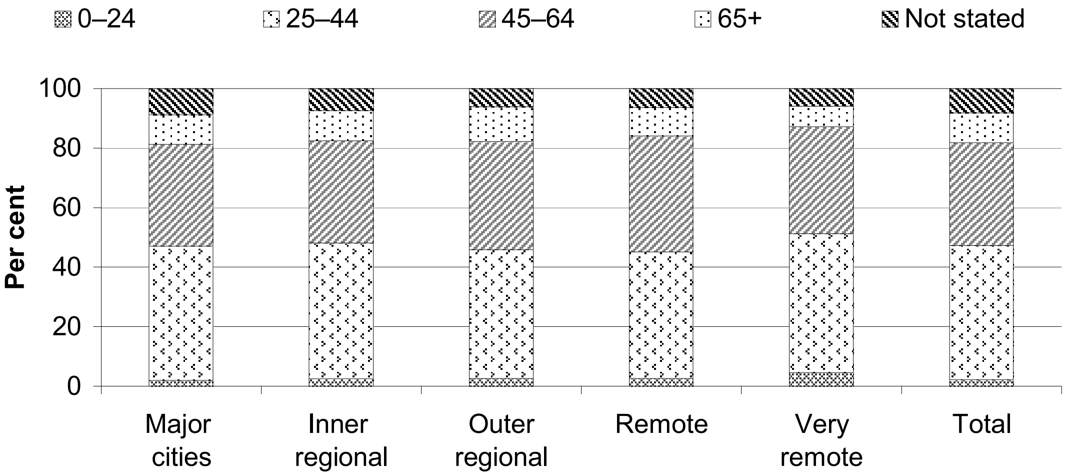
[a] Total includes data for service users whose location was not collected/identified. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] Data relating to primary carers are not reported for 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/NDA funded specialist disability services, by location, 2008-09**[a, b]



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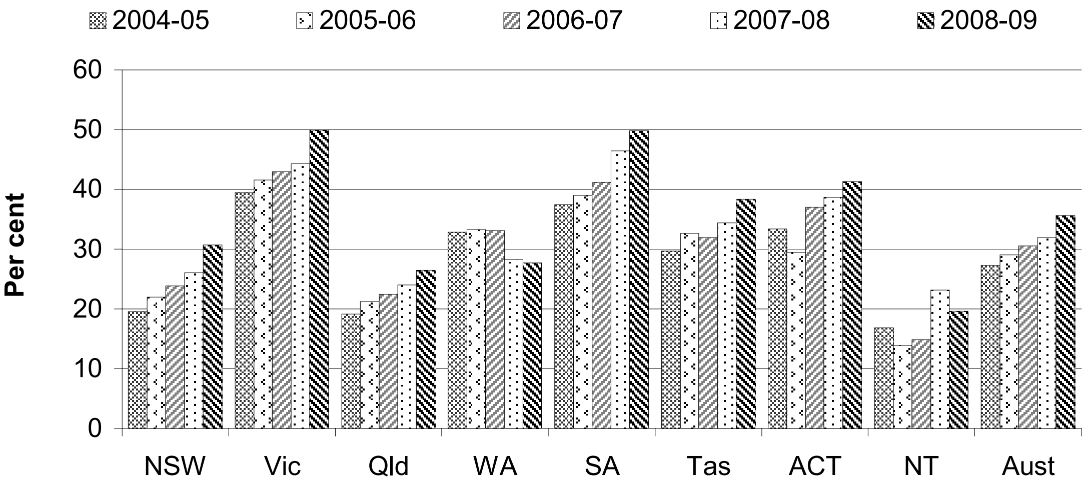
[a] Total includes data for service users whose location was not collected/identified. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; table 14A.3.

Use of CSTDA/NDA funded services

In 2008-09 266 066 people were reported as using specialist disability services provided under the CSTDA/NDA (excluding service users who received specialist psychiatric disability services only) (table 14A.12). Nationally, this is 35.6 per cent of the estimated potential population (unrevised method) (see section 14.7 for information on how the potential population is defined) (figure 14.5).

Figure 14.5 **Users of CSTDA/NDA funded specialist disability services as a proportion of the estimated potential population (unrevised method)**[a, b, c]



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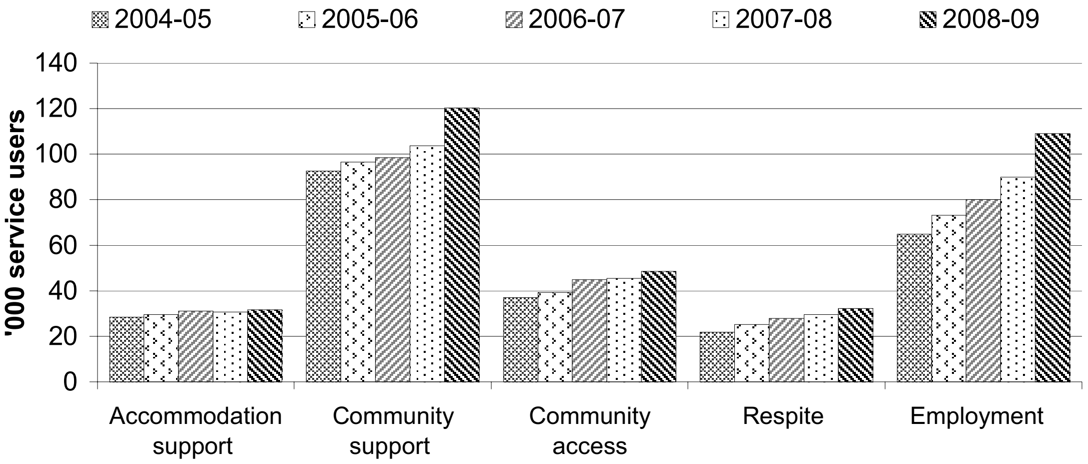
[a] See section 14.7 for information on how the potential population is defined. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] For the ACT, improved data capture for therapy services resulted in an increased service user count in 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 (2011) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement,* Cat. no. DIS 58; AIHW (2010a) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA* Cat. no. DIS (56 and previous publications); table 14A.12.

Service user numbers varied across service types. Accommodation support, community access, community support and respite services reported a total of 172 264 users and employment services reported a total of 109 002 users, in 2008-09 (figure 14.6).

Figure 14.6 **Users of CSTDA/NDA funded specialist disability services, by service type[a, b]**

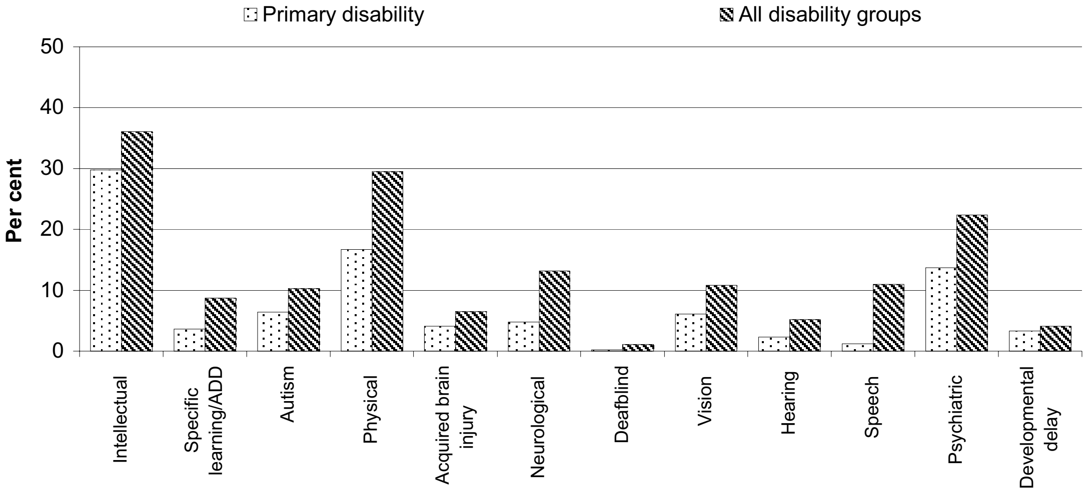


[a] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [b] See table 14A.12 for detailed notes relating to these data.

Source: AIHW (unpublished) *CSTDA NMDS*; table 14A.12.

In 2008-09, the most commonly reported disability of CSTDA/NDA service users was an intellectual disability (36.1 per cent of service users, including 29.8 per cent who reported it as their primary disability) (figure 14.7).

Figure 14.7 **CSTDA/NDA funded specialist disability service users, by disability group, 2008-09[a, b]**



[a] Data need to be interpreted with care due to a number of factors affecting data quality. [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.

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). Revisions have been made to the performance indicators reported in this chapter to align with developments in reporting for performance indicators in the National Agreements.

Box 14.4 Objective of government funded services for people with disability

Performance data for this year's Report cover services provided under the third CSTDA and the NDA. 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

(Continued on next page)

Box 14.4 **(Continued)**

- 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).

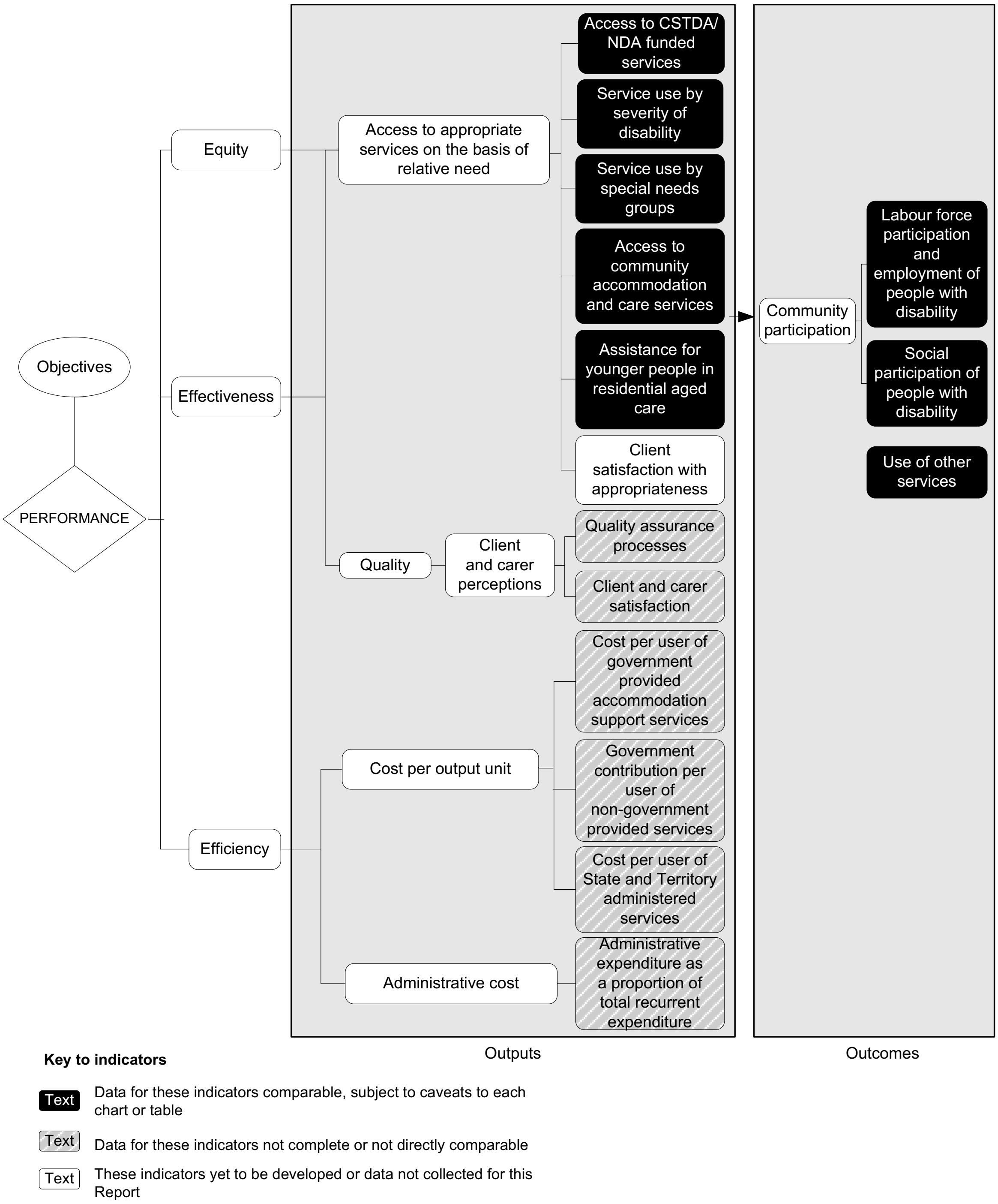
The performance indicator framework shows which data on services for people with disability are comparable in the 2011 Report (figure 14.8). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from 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 14.8 **Performance indicators for services for people with disability**



14.3 Key performance indicator results

The performance indicator results reported in this chapter relate to both CSTDA and also NDA funded services. 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 (this collection will be renamed the Disability Services NMDS in future reports).

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)
- the variability between states and territories of services funded under the NDA and those funded under other programs or sectors.

Outputs

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

Equity and effectiveness — access to appropriate services on the basis of relative need

The following equity and effectiveness access indicators are reported:

- 'Access to CSTDA/NDA funded services'
- 'Service use by severity of disability'
- 'Service use by special needs groups'
- 'Access to community accommodation and care services'.

Access to CSTDA/NDA funded services

'Access to CSTDA/NDA 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* and *National Disability Agreement* funded services**

'Access to CSTDA/NDA funded services' is defined as the number of people using a particular CSTDA/NDA funded service divided by the 'potential population' (unrevised method) for that service. The potential population (unrevised method) is an estimate that broadly indicates the number of people with the potential to require specialist disability services at some time.

The potential population (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) using a particular CSTDA/NDA service suggests greater access to that service.

Not all people in the estimated 'potential population' (unrevised method) will need the service or seek to access the service in the relevant period. In addition, this indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or accessed by those most in need.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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 (unrevised method):

- for people aged under 65 years for accommodation support, community support, community access and respite services
- for people aged 15–64 years for employment services.

Data on users of CSTDA/NDA funded services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.15).

Nationally, 4.2 per cent of the estimated potential population (unrevised method) were using CSTDA/NDA funded accommodation support services in 2008-09 (figure 14.9).

Data on users of CSTDA/NDA funded accommodation support services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.17).

Figure 14.9 **Users of CSTDA/NDA funded accommodation support services as a proportion of the estimated potential population (unrevised method)[a, b, c]**

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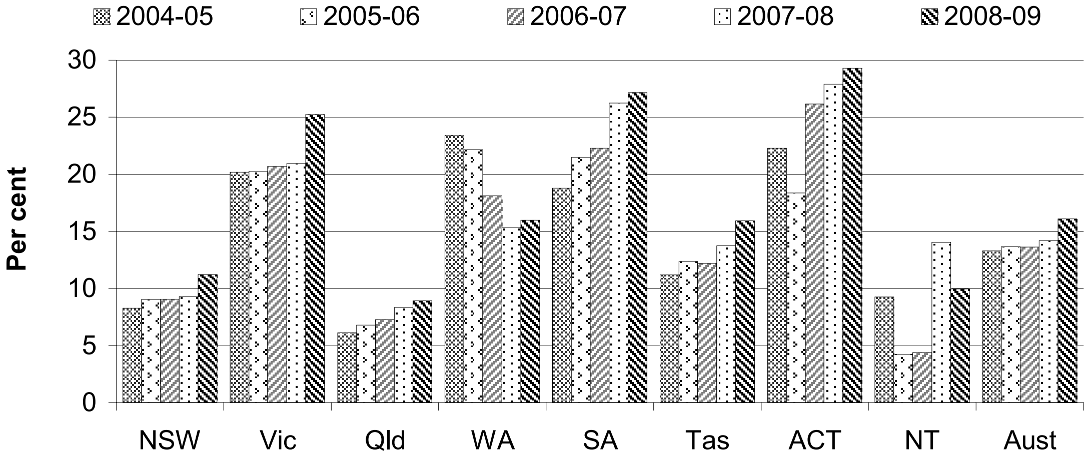
[a] See table 14A.16 for detailed notes relating to service user data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2011) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement,* Cat. no. DIS 58; AIHW (2010a), *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.16.

Nationally, 16.1 per cent of the estimated potential population (unrevised method) were using CSTDA/NDA funded community support in 2008-09 (figure 14.10).

Data on users of CSTDA/NDA funded community support as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.19).

Figure 14.10 **Users of CSTDA/NDA funded community support services as a proportion of the estimated potential population (unrevised method)**[a, b, c, d, e, f]



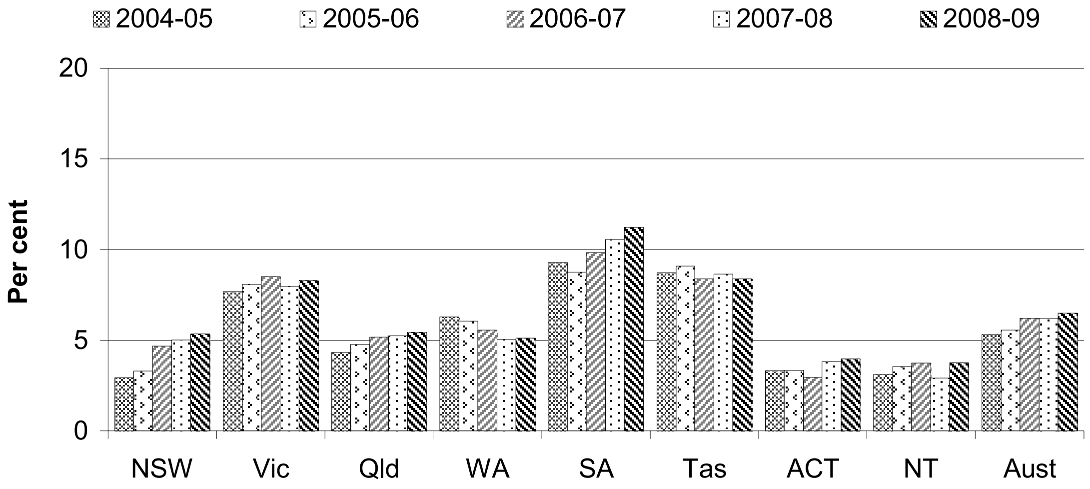
[a] See table 14A.18 for detailed notes relating to service user data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [d] For WA, the decrease in the number between 2006-07 and 2007-08 is due to a refining of the counting rules that has led to the exclusion of some data. [e] For the ACT, improved data capture for therapy services resulted in an increased service user count in 2004-05. The decrease in the community support services rate for 2005-06 was due to the incomplete data collection for therapy services. [f].For Victoria, additional agencies reporting clients and the change of data capturing for the Individualised Support Packages under the Community Support category resulted in an increase in the count of service users in 2008-09.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2011) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreemen*t, Cat. no. DIS 58; AIHW (2010a) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.18.

Nationally, 6.5 per cent of the estimated potential population (unrevised method) were using CSTDA/NDA funded community access services in 2008-09 (figure 14.11).

Data on users of CSTDA/NDA funded community access services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.21).

Figure 14.11 **Users of CSTDA/NDA funded community access services as a proportion of the estimated potential population (unrevised method)**[a, b, c]



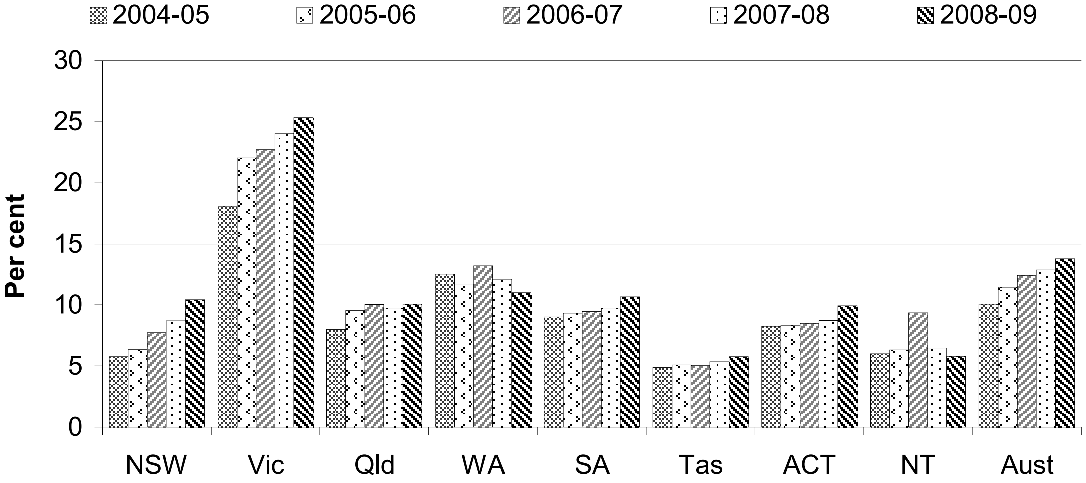
[a] See table 14A.20 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2011) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement,* Cat. no. DIS 58; AIHW (2010a*) 2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.20.

Nationally, 13.8 per cent of the estimated potential population (unrevised method) who reported having a primary carer were using CSTDA/NDA funded respite services in 2008-09 (figure 14.12).

Data on users of CSTDA/NDA funded respite services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.23).

Figure 14.12 **Users of CSTDA/NDA funded respite services as a proportion of the estimated potential population (unrevised method) for respite services**[a, b, c]



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[a] See table 14A.22 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

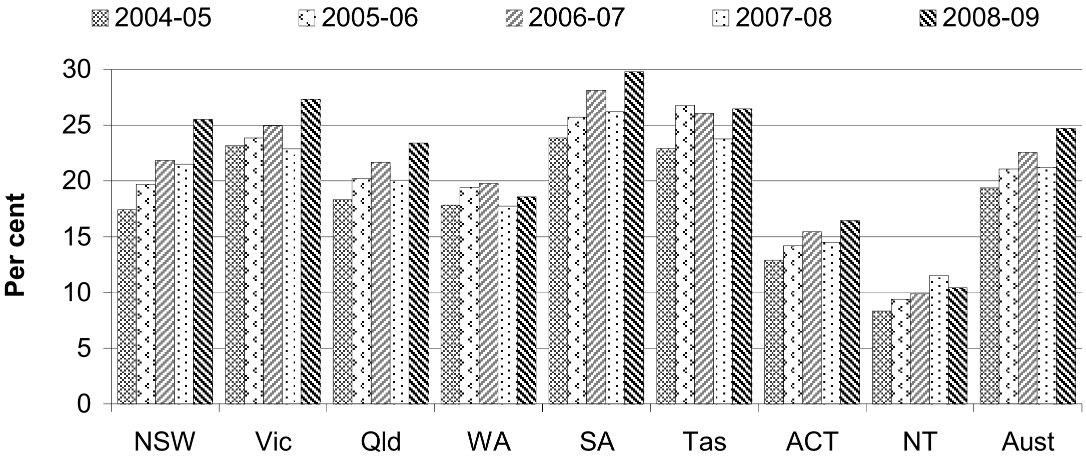
Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2011) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement,* Cat. no. DIS 58; AIHW (2010a) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.22.

Nationally, 24.7 per cent of the estimated potential population (unrevised method) for CSTDA/NDA funded employment services were using these services in 2008-09 (figure 14.13).

Data on users of CSTDA/NDA funded open employment services as a proportion of the estimated potential population (revised method) are also available disaggregated by age and sex (table 14A.25).

Data on users of CSTDA/NDA funded supported employment services as a proportion of the estimated potential population (revised method) are also available disaggregated by age and sex (table 14A.26).

Figure 14.13 Users of CSTDA/NDA funded employment services as a proportion of the estimated potential population (unrevised method) for employment services[a, b, c]



[a] See table 14A.24 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data for 2007-08 and 2008-09 are not comparable with previous years as the potential populations (unrevised method) for that year were derived using labour force participation rates for people aged 15–64 years, not the participation rate for people aged 15 years and over that was used in previous years. Applying the participation rate for people aged 15–64 years to derive the 2007-08 and 2008-09 data increased the number of people in the estimated potential population (unrevised method) relative to previous years (by around 15 per cent).

Source: AIHW (2011*) Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement,* Cat. no. DIS 58; AIHW (2010a) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.24.

Service use by severity of disability

'Service use by severity of disability' is an indicator of governments' objective to use available resources to provide services to people on the basis of relative need, where need for services is assumed to vary according to the need for help with the activities of daily living (ADL) and for help with activities of independent living (AIL) or activities of work, education and community living (AWEC) (box 14.6). This indicator provides additional information for interpreting the access to CSTDA/NDA funded accommodation support, community support, community access, employment and respite services measures reported above.

Data on the need for assistance are derived using information on the level of support needed in one or more of the following support areas for:

- ADL – self care, mobility, and communication (the core support areas)
- AIL – interpersonal interactions and relationships, learning, applying knowledge and general tasks and demands; and domestic life

- AWEC – education, community (civic) and economic life; and work.

Service users who need help with ADL, or AIL, or AWEC reported always/sometimes needing help in one or more of these, however, only people who need help with ADL are ‘conceptually comparable’ with people who have a profound or severe core activity limitation. Service users who did not need help with ADL, or AIL, or AWEC, reported needing no support in the major life areas.

Box 14.6 **Service use by severity of disability**

‘Service use by severity of disability’ is defined as the proportion of people who access CSTDA/NDA funded services, by need for help with ADL, or AIL, or AWEC. Four categories are reported:

- need help with ADL
- need help with AIL, or AWEC but not ADL
- does not need assistance and information on ADL, AIL or AWEC
- not stated/collected.

Measures are reported for accommodation support, community support, community access, employment and respite services.

A higher or increasing proportion of people using a particular service type who need help with ADL suggests greater access to this service type for those with the greatest level of need.

This indicator does not provide information on whether services are appropriate for the needs of the people receiving them or appropriately targeted based on relative need taking into account access to other formal support and access to informal support networks. The need for services is assumed to vary according to the need for help with ADL, or AIL, or AWEC. Data on ADL, AIL and AWEC are self/carer identified, not based on formal clinical assessments of individual limitations. There are other factors that may also be important in determining relative need, such as the complexity of a service user’s needs in other activity areas.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

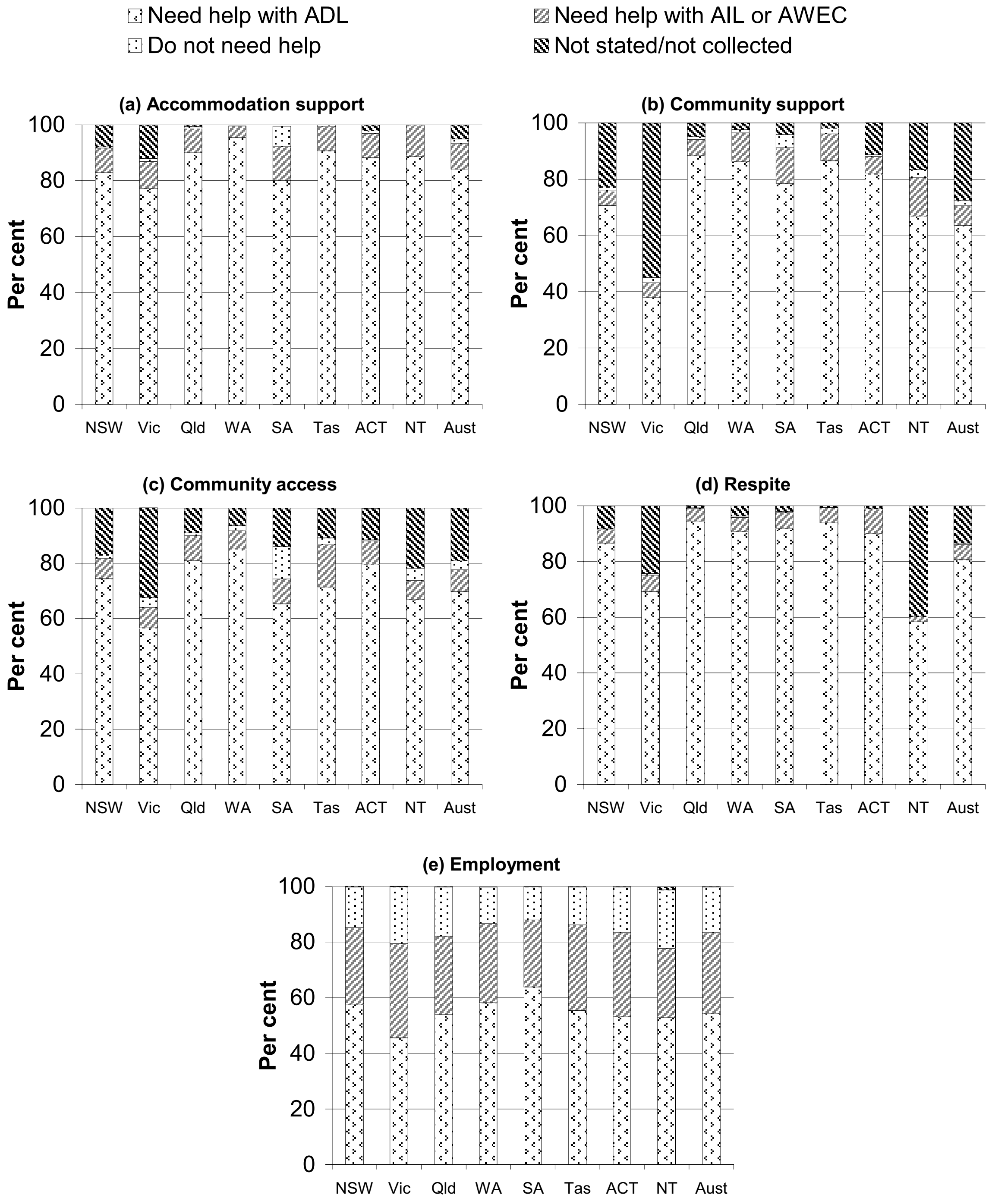
Nationally, in 2008-09:

- 84.2 per cent of users of CSTDA/NDA funded accommodation support services needed help with ADL, 9.1 per cent required assistance with AIL or AWEC but not with ADL, 1.7 per cent did not report need for any assistance in major life areas and for 5.0 per cent information on need for assistance was not collected/not stated (figure 14.14a)

- 63.6 per cent of users of CSTDA/NDA funded community support services needed help with ADL, 7.0 per cent required assistance with AIL or AWEC, but not with ADL, 1.9 per cent did not report need for any assistance in major life areas and for 27.5 per cent information on need for assistance was not collected/not stated (figure 14.14b)
- 69.7 per cent of users of CSTDA/NDA funded community access services needed help with ADL, 8.1 per cent required assistance with AIL or AWEC, but not with ADL, 3.3 per cent did not report need for any assistance in major life areas and for 18.9 per cent information on need for assistance was not collected/not stated (figure 14.14c)
- 80.7 per cent of users of CSTDA/NDA funded respite services needed help with ADL, 5.4 per cent required assistance with AIL or AWEC, but not with ADL, 0.5 per cent did not report need for any assistance in major life areas and for 13.4 per cent information on need for assistance was not collected/not stated (figure 14.14d)
- 54.2 per cent of users of CSTDA/NDA funded employment services needed help with ADL, 29.2 per cent required assistance with AIL or AWEC, but not with ADL, 16.4 per cent did not report need for any assistance in major life areas and for 0.2 per cent information on need for assistance was not collected/not stated (figure 14.14e).

Data on users of CSTDA/NDA funded services as a proportion of the estimated potential population (revised method) are also available (tables 14A.27, 14A.29, 14A.31, 14A.33, 14A.35, 14A.37 and 14A.38).

Figure 14.14 **Users of CSTDA/NDA funded services, by need for help with Activities of Daily Living, 2008-09**[a, b, c, d]



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[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.28, 14A.30, 14A.32, 14A.34 and 14A.36 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. [d] Need help with AIL or AWEC does not include people who also need help with ADL.

Source: AIHW (unpublished) *CSTDA NMDS*; tables 14A.28, 14A.30, 14A.32, 14A.34 and 14A.36.

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’ (unrevised method). The potential population (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) in a particular special needs group, compared to the proportion of service users per 1000 potential population (unrevised method) 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 (unrevised method)) in a special needs group should not differ significantly from the proportion of service users per 1000 people (or per 1000 potential population (unrevised method)) 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/NDA 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/NDA 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.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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 (unrevised method):

- 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 (unrevised method) 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 (unrevised method)

- 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

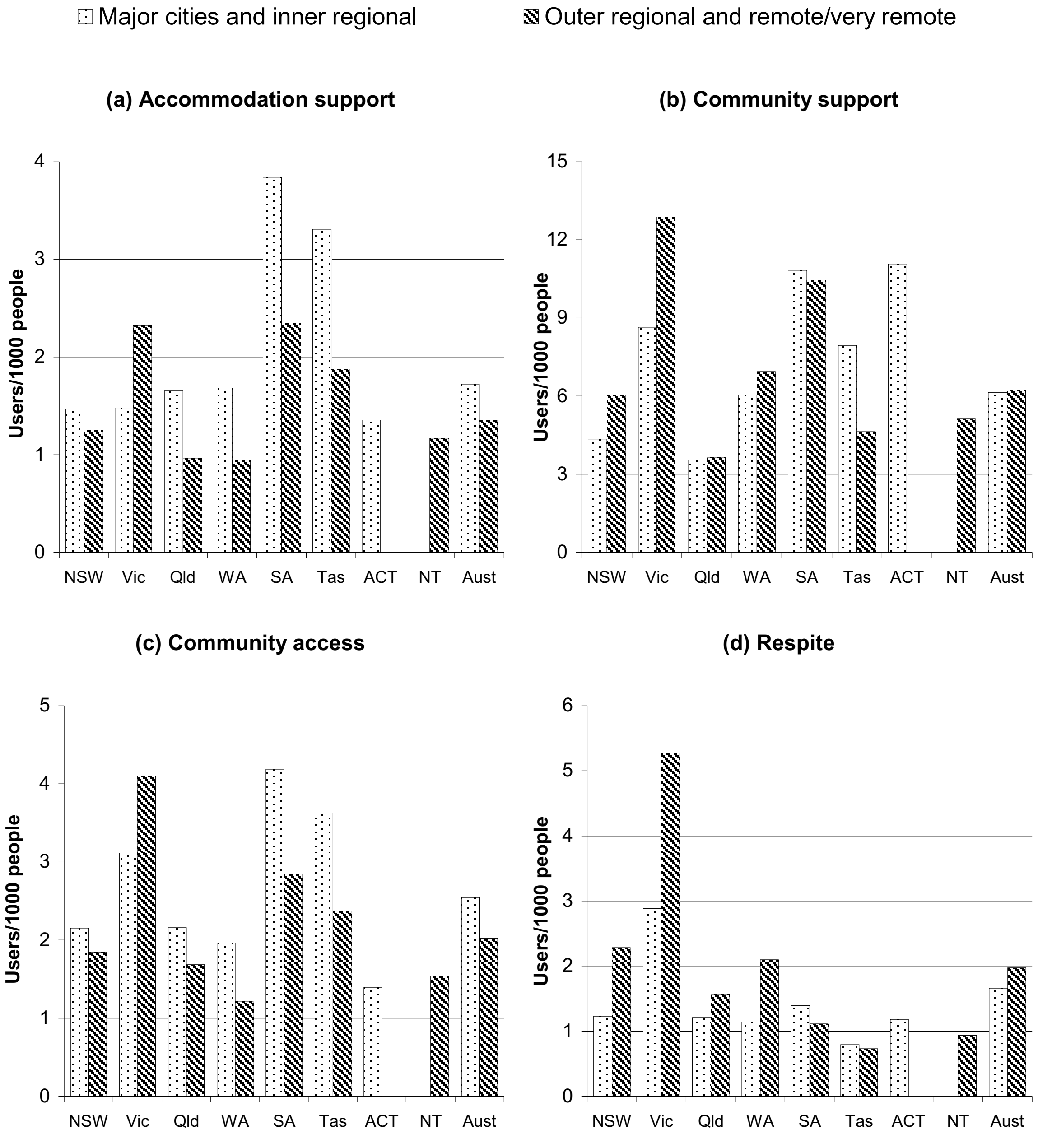
Nationally, in 2008-09, the proportion of the outer regional and remote/very remote population who used CSTDA/NDA funded accommodation support services was 1.4 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (1.7 service users per 1000 population) (figure 14.15a). The proportion of the outer regional and remote/very remote potential population (unrevised method) who used CSTDA/NDA funded accommodation support services (31.9 service users per 1000 potential population (unrevised method)) was lower than that of the major cities and inner regional potential population (unrevised method) who used these services (43.3 service users per 1000 potential population (unrevised method)) (figure 14.16a).

Nationally, in 2008-09, the proportion of the outer regional and remote/very remote population who used CSTDA/NDA funded community support services was 6.2 service users per 1000 population, higher than the proportion of the major cities and inner regional population who used these services (6.1 service users per 1000 population) (figure 14.15b). The proportion of the outer regional and remote/very remote potential population (unrevised method) who used CSTDA/NDA funded community support services (146.8 service users per 1000 potential population (unrevised method)) was higher than the proportion of the major cities and inner regional potential population (unrevised method) who used these services (154.5 service users per 1000 potential population (unrevised method)) (figure 14.16b).

Nationally, in 2008-09, the proportion of the outer regional and remote/very remote population who used CSTDA/NDA 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 (2.5 service users per 1000 population) (figure 14.15c). The proportion of the outer regional and remote/very remote potential population (unrevised method)who used CSTDA/NDA funded community access services (47.6 service users per 1000 potential population (unrevised method)) was lower than the proportion of the major cities and inner regional potential population (unrevised method) who used these services (64.1 service users per 1000 potential population (unrevised method)) (figure 14.16c).

Nationally, in 2008-09, the proportion of the outer regional and remote/very remote population who used CSTDA/NDA funded respite services was 2.0 service users per 1000 population), higher than the proportion of the major cities and inner regional population who used these services (1.7 service users per 1000 population) (figure 14.15d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data from the 2006 Census for the special needs groups.

Figure 14.15 Users of State and Territory administered CSTDA/NDA funded services per 1000 people, by geographic location, 2008-09[a, b, c, d]



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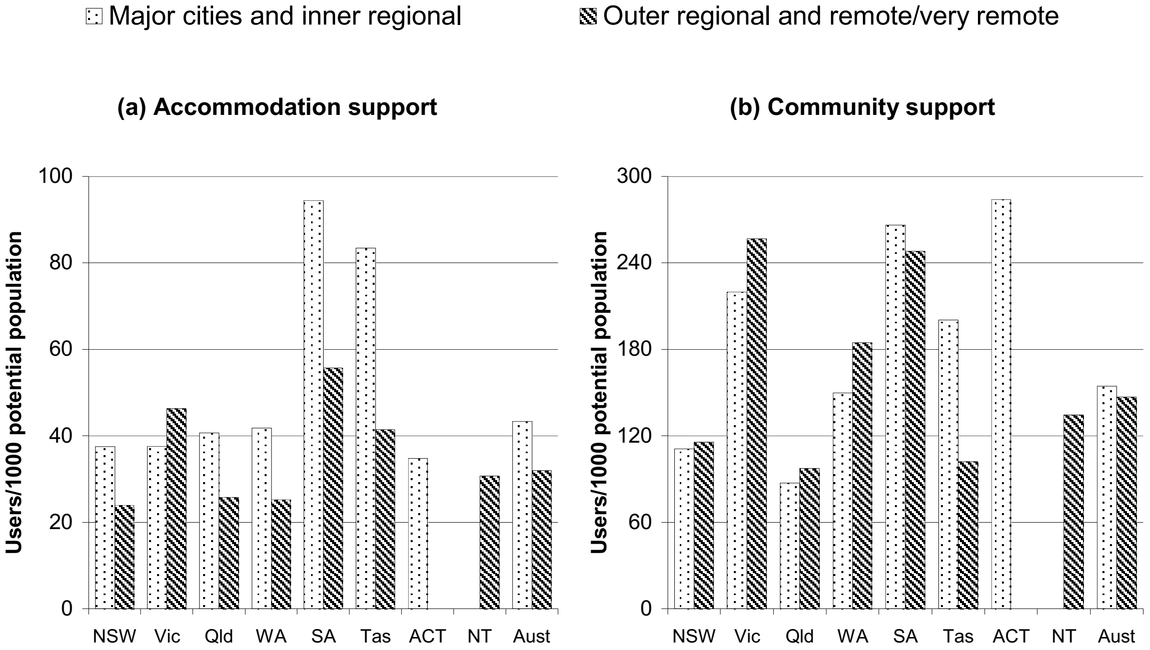
[a] See tables 14A.39, 14A.40, 14A.41 and 14A.42 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] The ACT does not have outer regional and remote/very remote areas. [d] The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (unpublished) derived from ABS *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS *Population by Age and Sex, Regions of Australia, 2008*; Cat. no. 3235.0, *Labour Force Australia,* 2008, Cat. no. 6291.0.55.001; tables 14A.39, 14A.40, 14A.41 and 14A.42.

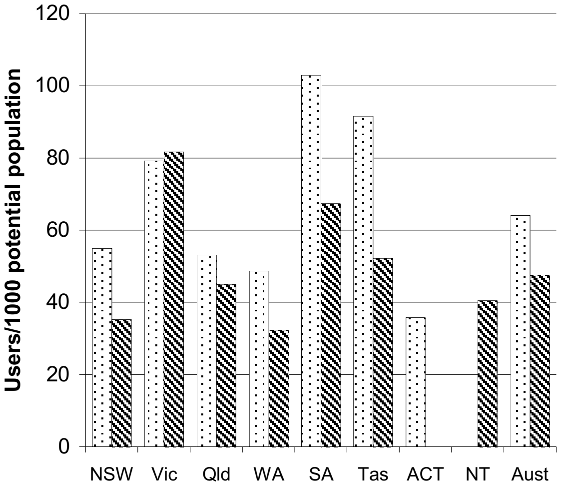
Figure 14.16 **Users of State and Territory administered CSTDA/NDA funded services per 1000 potential population (unrevised method), by geographic location, 2008-09**[a, b, c, d, e, f]



(a) Accommodation support

(b) Community support

(c) Community access



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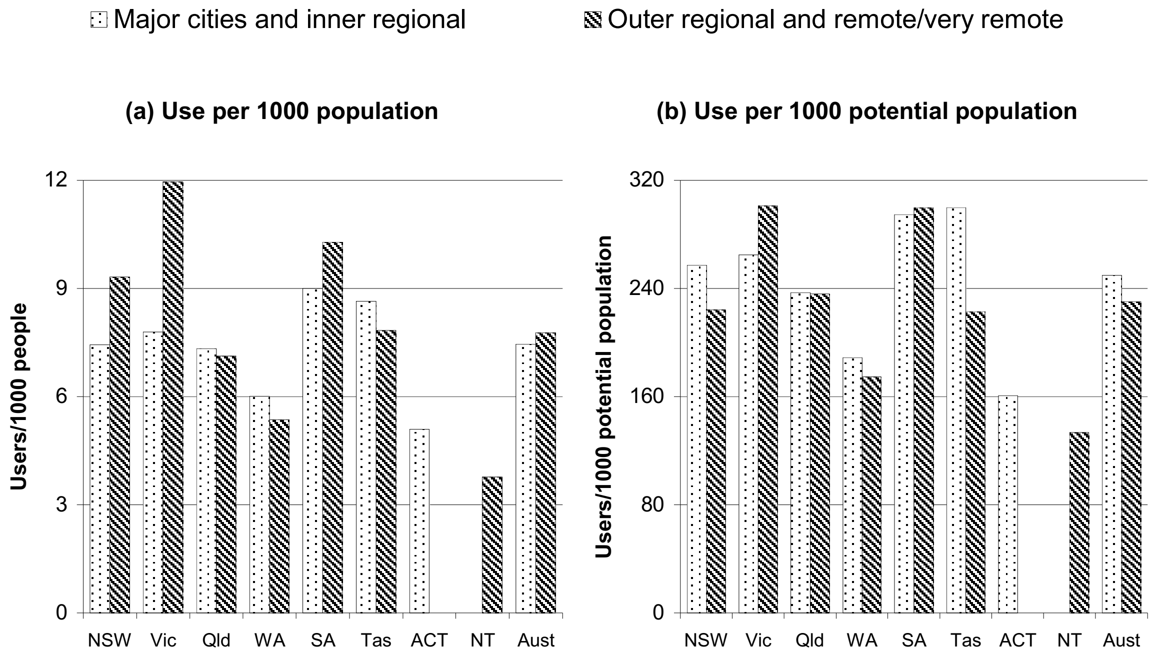
[a] See tables 14A.39, 14A.40 and 14A.41 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [d] The ACT does not have outer regional and remote/very remote areas. [e] The NT does not have major cities and inner regional areas. [f] ACT data for service users per 1000 Indigenous potential population (unrevised method) are not published as they are based on a small number of service users.

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 *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS *Population by Age and Sex, Regions of Australia, 2008*; Cat. no. 3235.0, *Labour Force Australia,* 2008, Cat. no. 6291.0.55.001; tables 14A.39, 14A.40 and 14A.41.

Nationally, in 2008-09, the proportion of the outer regional and remote/very remote population who used CSTDA/NDA funded employment services (7.8 service users per 1000 population) was higher than that of the major cities and inner regional population (7.5 service users per 1000 population) (figure 14.17a). The proportion of the outer regional and remote/very remote potential population (unrevised method) who used CSTDA/NDA funded employment services (230.3 service users per 1000 potential population (unrevised method)) was higher than that of the major cities and inner regional potential population (unrevised method) (249.6 service users per 1000 potential population (unrevised method)) (figure 14.17b).

Figure 14.17 **Users of CSTDA/NDA funded employment services, by geographic location, 2008-09**[a, b, c, d]



[a] See table 14A.43 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] The ACT does not have outer regional and remote/very remote areas. [d] The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) 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 2008*, Cat. no. 6291.0.55.001, ABS *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS *Population by Age and Sex, Regions of Australia, 2007*, Cat. no. 3235.0; table 14A.43.

Service use by special needs groups — Indigenous people

Nationally, in 2008-09, the proportion of the Indigenous population who used CSTDA/NDA 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 14.18a). The proportion of the Indigenous potential population (unrevised method) who used CSTDA/NDA funded accommodation support services (39.5 service users per 1000 potential population (unrevised method)) was lower than the non-Indigenous potential population (unrevised method) who used these services (41.3 service users per 1000 potential population (unrevised method)) (figure 14.19a).

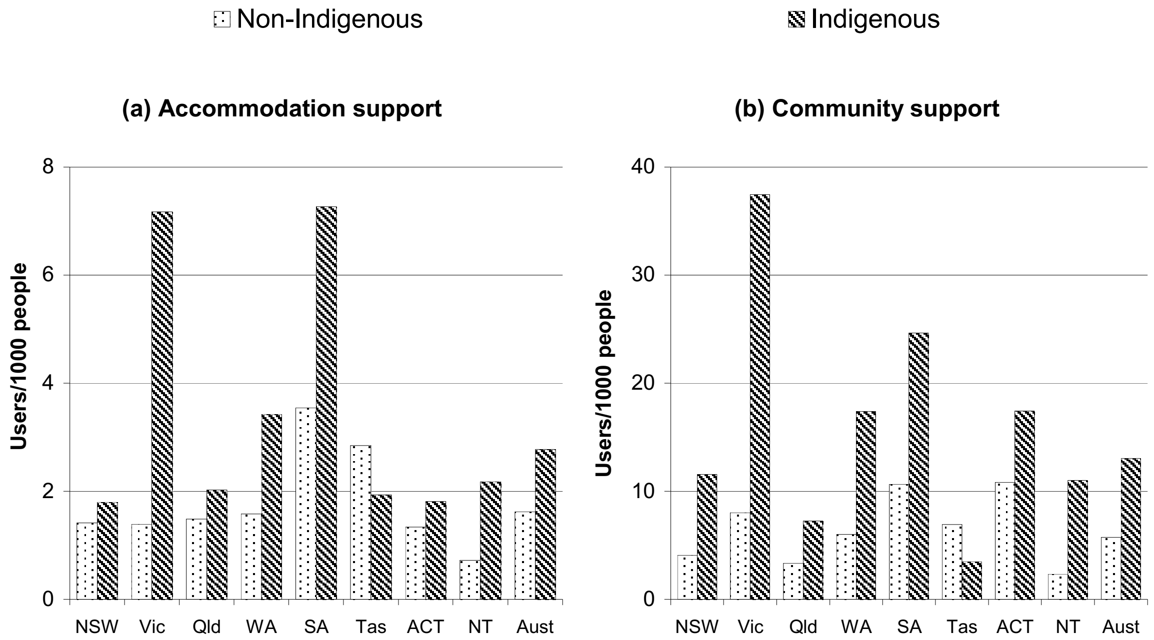
Nationally, in 2008-09, the proportion of the Indigenous population who used CSTDA/NDA funded community support services was 13.1 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (5.7 service users per 1000 population) (figure 14.18b). The proportion of the Indigenous potential population (unrevised method) who used CSTDA/NDA funded community support services (185.8 service users per 1000 potential population (unrevised method)) was higher than the proportion of the non-indigenous potential population (unrevised method) who used these services (146.4 service users per 1000 potential population (unrevised method)) (figure 14.19b).

Nationally, in 2008-09, the proportion of the Indigenous population who used CSTDA/NDA funded community access services was 3.4 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 14.18c). The proportion of the Indigenous potential population (unrevised method) who used CSTDA/NDA funded community access services (49.0 service users per 1000 potential population (unrevised method)) was lower than the proportion of the non-Indigenous potential population (unrevised method) who used these services (58.9 service users per 1000 potential population (unrevised method)) (figure 14.19c).

Nationally, in 2008-09, the proportion of the Indigenous population who used CSTDA/NDA funded respite service was 3.7 users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 population) (figure 14.18d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups, data on people with a ASSNP who had a primary carer are needed. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data from the 2006 Census for the special needs groups.

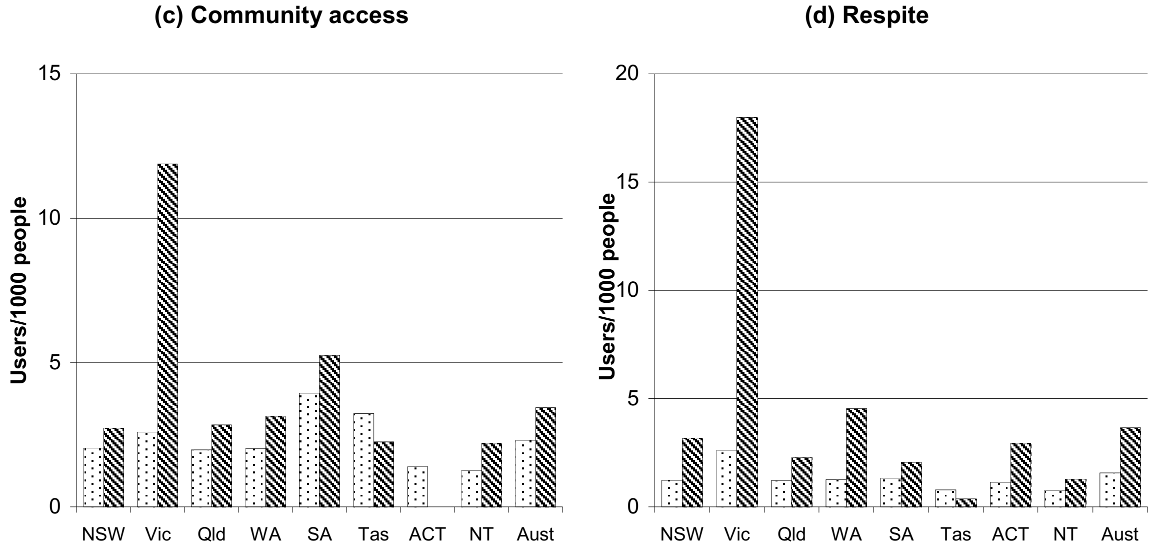
Data on users of CSTDA/NDA disability support services as a proportion of the Indigenous estimated potential population (revised method) are also available disaggregated by age (table 14A.44).

Figure 14.18 Users of State and Territory administered CSTDA/NDA funded services per 1000 people, by Indigenous status, 2008-09[a, b, c]



(a) Accommodation support

(b) Community support



(c) Community access

(d) Respite

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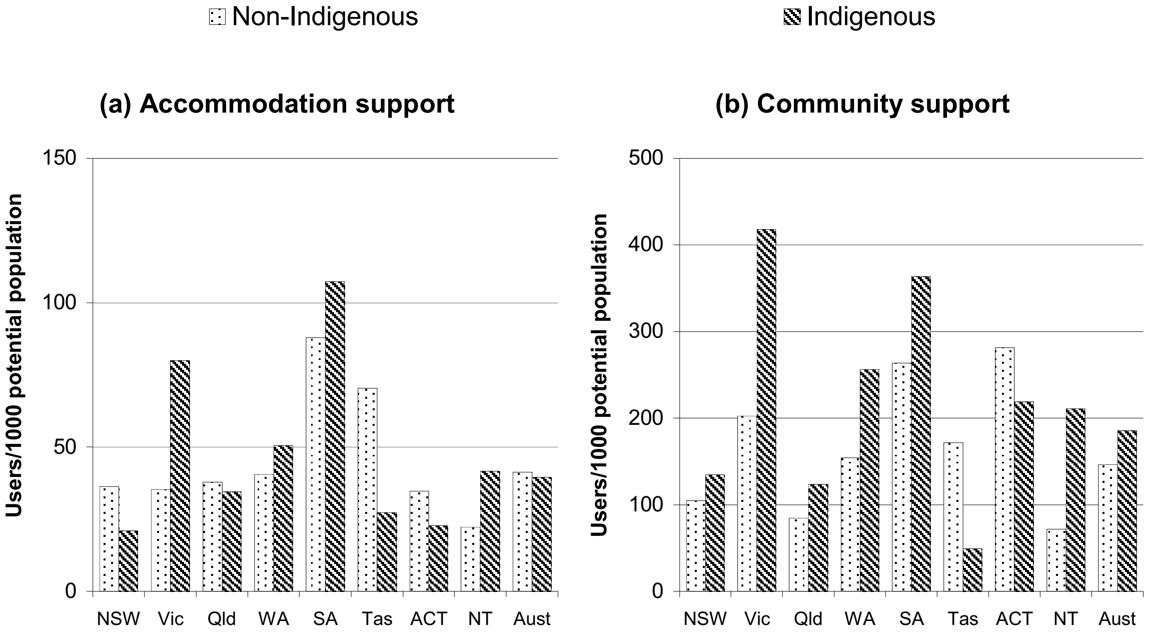
[a] See tables 14A.45, 14A.46, 14A.47 and 14A.48 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] ACT data for service users per 1000 Indigenous 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, *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021,* Cat. no. 3238.0; tables 14A.45, 14A.46, 14A.47 and 14A.48.

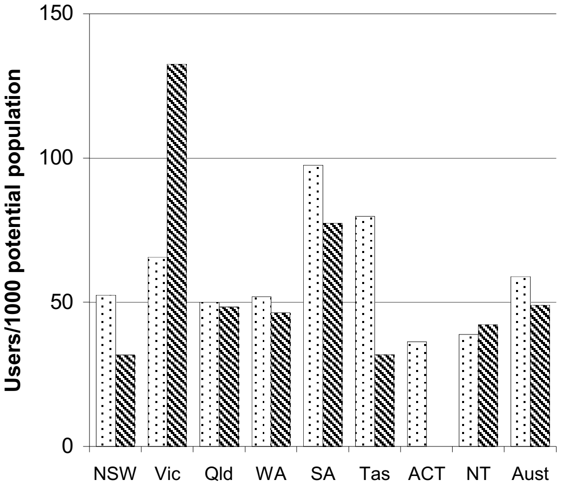
Figure 14.19 **Users of State and Territory administered CSTDA/NDA funded services per 1000 potential population (unrevised method), by Indigenous status, 2008-09**[a, b, c]



(a) Accommodation support

(b) Community support

(c) Community access



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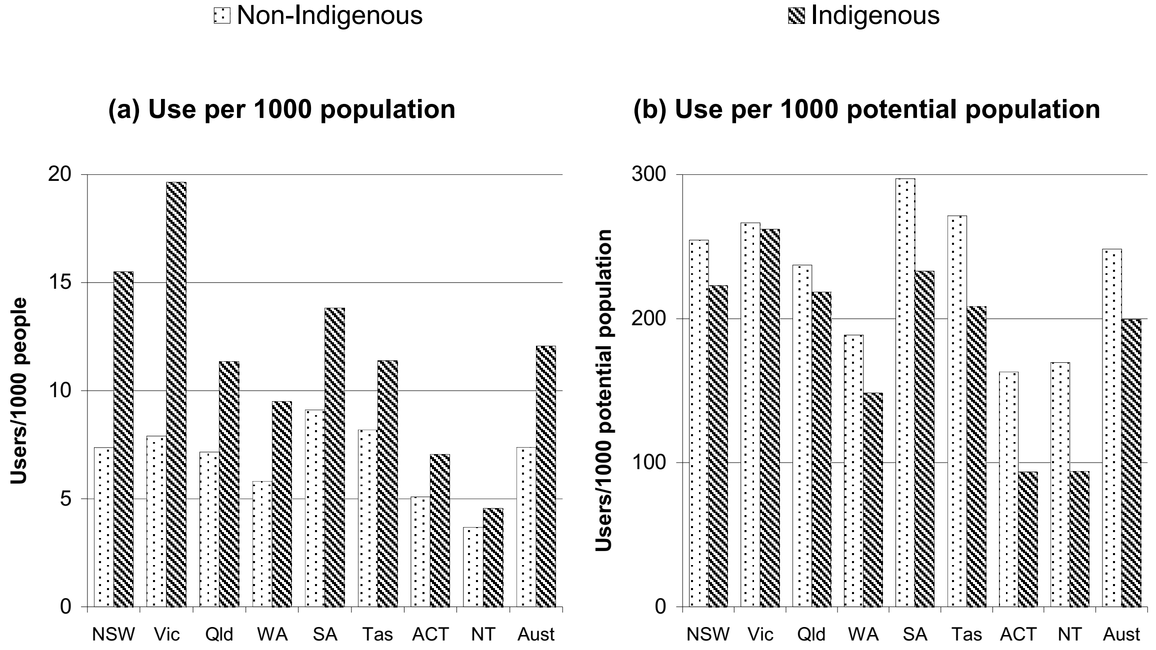
[a] See tables 14A.45, 14A.46 and 14A.47 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [d] ACT data for service users per 1000 Indigenous potential population (unrevised method) 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 (unpublished) derived from ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007,* Cat. no. 3201.0, *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021,* Cat. no. 3238.0; tables 14A.45, 14A.46, 14A.47.

Nationally, in 2008-09, the proportion of the Indigenous population who used CSTDA/NDA funded employment services (12.1 service users per 1000 population) was higher than that of the non-Indigenous population (7.4 service users per 1000 population) (figure 14.20a). The proportion of the Indigenous potential population (unrevised method) who used CSTDA/NDA funded employment services (199.5 service users per 1000 potential population (unrevised method)) was lower than that of the non-Indigenous potential population (unrevised method) (248.4 service users per 1000 potential population (unrevised method)) (figure 14.20b).

Data on users of CSTDA/NDA funded open employment services as a proportion of the Indigenous estimated potential population (revised method) are also available disaggregated by age (table 14A.50). Data on users of CSTDA/NDA funded supported employment services as a proportion of the Indigenous estimated potential population (revised method) are also available disaggregated by age (table 14A.51).

Figure 14.20 **Users of CSTDA/NDA funded employment services, by Indigenous status, 2008-09**[a, b]



[a] See table 14A.49 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) 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 2008*, Cat. no. 6291.0.55.001, ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0, *Australian Demographic Statistics, 2008,* Cat. no. 3101.0 and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007*, Cat. no. 3201.0; table 14A.49.

Service use by special needs groups — people born in a non-English speaking country

Nationally, in 2008-09, the proportion of people born in a non-English speaking country who used CSTDA/NDA 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 14.21a). The proportion of the potential population (unrevised method) born in a non-English speaking country who used CSTDA/NDA funded accommodation support services (12.9 users per 1000 potential population (unrevised method)) was lower than the proportion of people born in an English speaking country who used these services (45.7 service users per 1000 potential population (unrevised method)) (figure 14.22a).

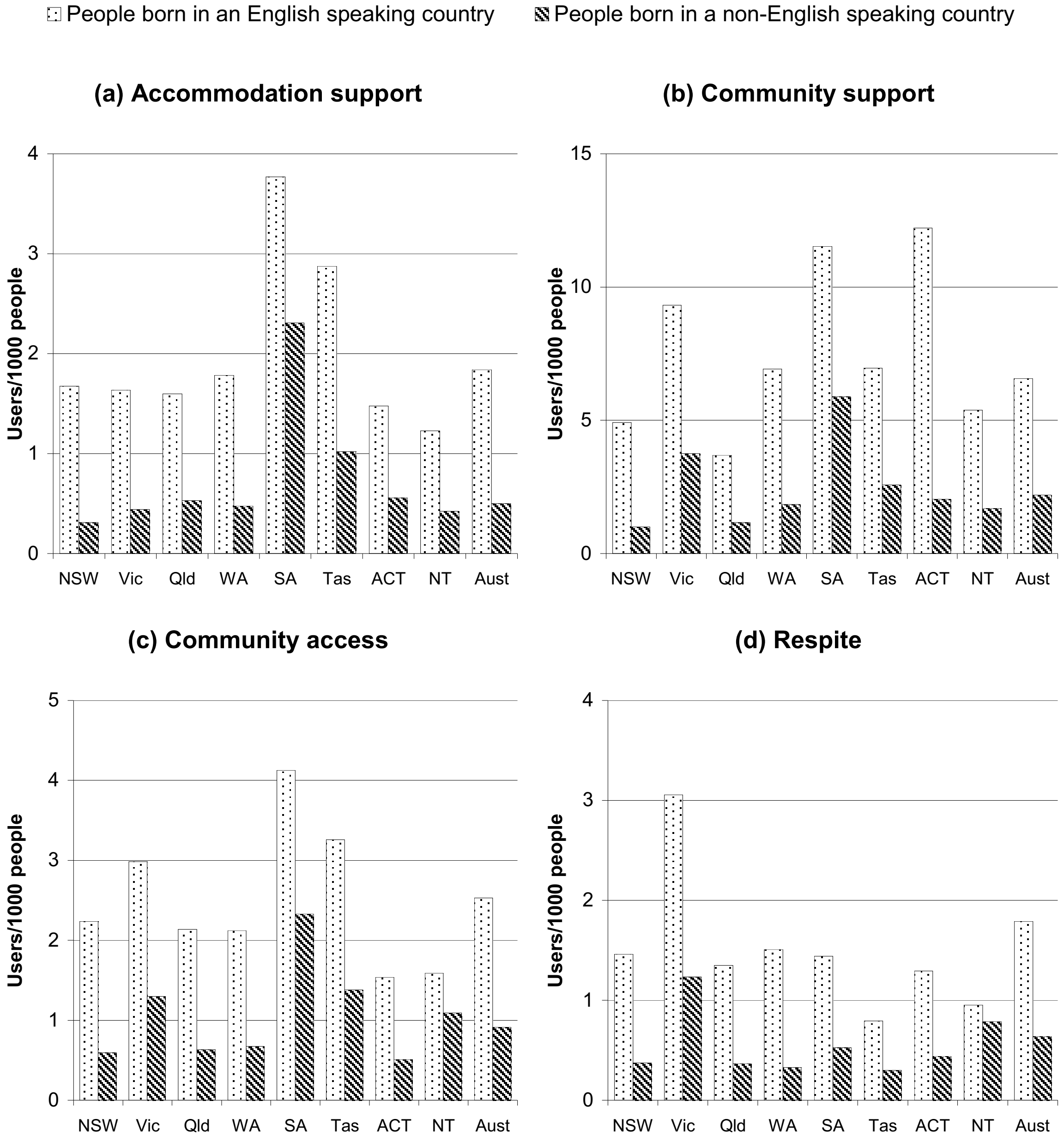
Nationally, in 2008-09, the proportion of people born in a non-English speaking country who used CSTDA/NDA funded community support services was 2.2 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (6.6 service users per 1000 population) (figure 14.21b). The proportion of the potential population (unrevised method) born in a non-English speaking country who used community support services (56.8 service users per 1000 potential population (unrevised method)) was lower than the proportion of people born in an English speaking country who used these services (163.2 service users per 1000 potential population (unrevised method)) (figure 14.22b).

Nationally, in 2008-09, the proportion of people born in a non-English speaking country who used CSTDA/NDA 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 14.21c). The proportion of the potential population (unrevised method) born in a non-English speaking country who used community access services (23.6 service users per 1000 potential population (unrevised method)) was lower than the proportion of people born in an English speaking country who used these services (62.8 service users per 1000 population) (figure 14.22c).

Nationally, in 2008-09, the proportion of people born in a non-English speaking country who used CSTDA/NDA 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 (1.8 service users per 1000 population) (figure 14.21d). Access to respite as a proportion of the potential population (unrevised method) is not reported. To derive an estimate of the respite potential populations (unrevised method) across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data from the 2006 Census for the special needs groups.

Data for users of disability support services as a proportion of estimated potential population (revised method) are also available disaggregated by country of birth and remoteness (tables 14A.52, 14A.54, 14A.56, 14A.58 and 14A.60).

Figure 14.21 **Users of State and Territory administered CSTDA/NDA funded services per 1000 people, by country of birth, 2008-09**[a, b]



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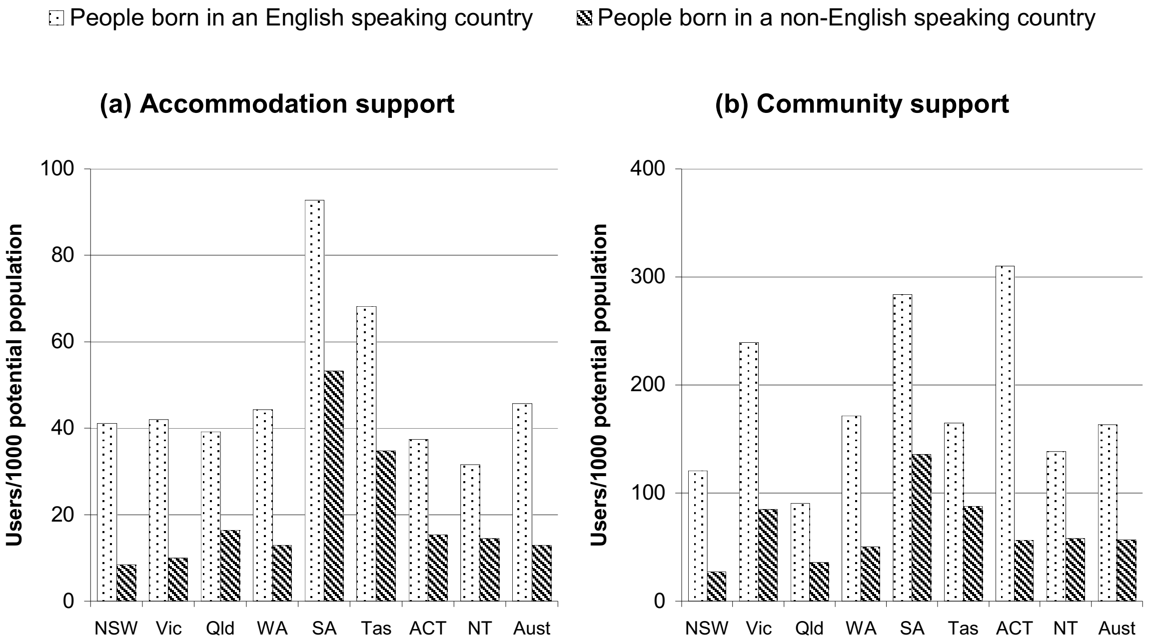
[a] See tables 14A.53, 14A.55, 14A.57 and 14A.59 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

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 2008,* Cat. no. 3201.0, *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery*, *June 2008*, Cat. no. 6291.0.55.001; tables 14A.53, 14A.55, 14A.57 and 14A.59.

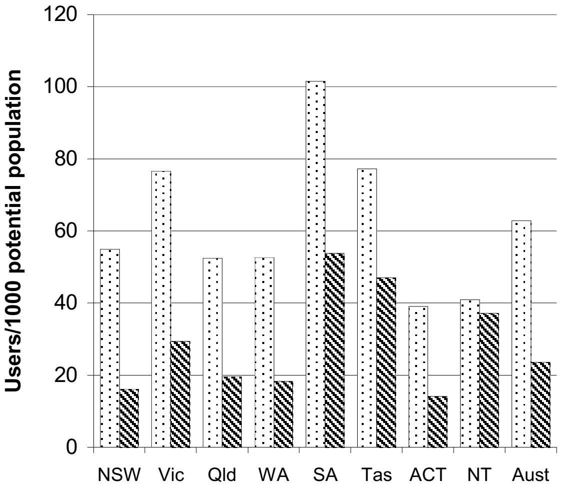
Figure 14.22 **Users of State and Territory administered CSTDA/NDA funded services per 1000 potential population (unrevised method), by country of birth, 2008-09**[a, b]



(a) Accommodation support

(b) Community support

(c) Community access



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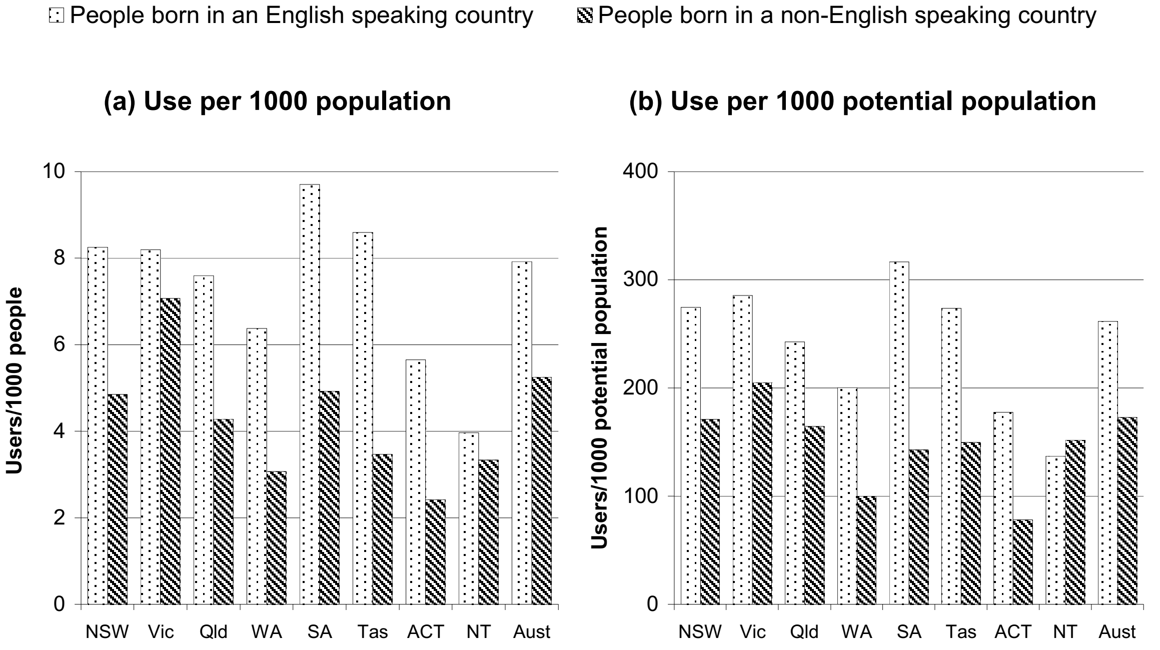
[a] See tables 14A.53, 14A.55 and 14A.57 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *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 2008,* Cat. no. 3201.0, *Australian Demographic Statistics, 2008,* Cat. no. 3101.0, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery*, *June 2008*, Cat. no. 6291.0.55.001; tables 14A.53, 14A.55 and 14A.57.

Nationally, in 2008-09, the proportion of people born in a non-English speaking country who used CSTDA/NDA funded employment services (5.3 service users per 1000 population) was lower than that of people born in an English speaking country (7.9 service users per 1000 population) (figure 14.23a). The proportion of the potential population (unrevised method) of people born in a non-English speaking country who used CSTDA/NDA funded employment services (172.7 service users per 1000 potential population (unrevised method)) was lower than that of the potential population (unrevised method) of people born in an English speaking country (261.4 service users per 1000 potential population (unrevised method)) (figure 14.23b).

Data on users of CSTDA/NDA funded open employment services are also available disaggregated by country of birth and remoteness (table 14A.62). Data on users of CSTDA/NDA funded supported employment services are also available disaggregated by country of birth and remoteness (table 14A.63).

Figure 14.23 **Users of CSTDA/NDA funded employment services, by country of birth, 2008-09**[a, b]



(a) Use per 1000 population

(b) Use per 1000 potential population

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[a] See table 14A.61 for detailed notes relating to these data. [b] See section 14.7 for information on how the potential population is defined. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) 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 2008*, Cat. no. 6291.0.55.001, *Australian Demographic Statistics, 2008,* Cat. no. 3101.0 and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007,* Cat. no. 3201.0; table 14A.61.

Access to community accommodation and care services

'Access to community accommodation and care services' is an indicator of governments' objective to assist people with disability to live as valued and participating members of the community (box 14.8). Governments provide or fund accommodation support services to people with disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The services provided in other community settings are attendant care/personal care, in home accommodation support, alternative family placement and other accommodation support.

State and Territory governments generally seek, if possible, to provide accommodation support services to people with disability outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with disability to be involved in their community.

Box 14.8 **Access to community accommodation and care services**

'Access to community accommodation and care services' is defined as the number of people using a CSTDA/NDA funded community accommodation and care service divided by the total number of people using CSTDA/NDA funded accommodation support services (excluding people who use specialist psychiatric disability services only).

A higher proportion of people accessing CSTDA/NDA 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.

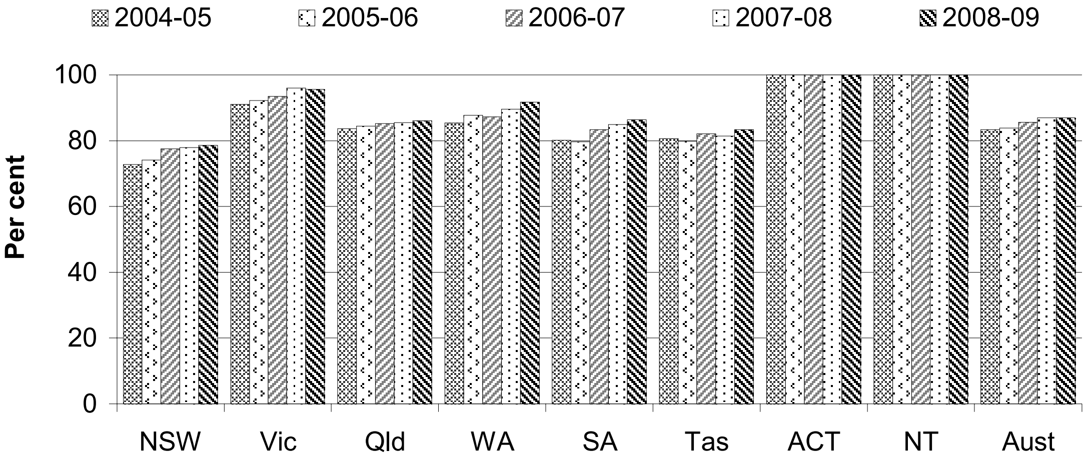
CSTDA/NDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted on the basis of relative need.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, 86.9 per cent of users of CSTDA/NDA funded accommodation support services received community accommodation and care services in 2008-09 (figure 14.24).

Figure 14.24 **Users of community accommodation and care services as a proportion of all CSTDA/NDA funded accommodation support service users**[a, b]



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[a] See table 14A.64 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.64.

Assistance for younger people in residential aged care

'Assistance for younger people in residential aged care' is an indicator of governments' objective to provide services to people with disability that are appropriate to their needs (box 14.9).

Box 14.9 **Assistance for younger people in residential aged care**

'Assistance for younger people in residential aged care' is defined by two measures:

- the percentage change in numbers of younger people in residential aged care
- the proportion of service users in the Younger People in Residential Aged Care program (YPIRAC) who have achieved program objectives since inception.

(Continued on next page)

Box 14.9 **(Continued)**

There are 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.

There are three objectives that correspond to three of the four groups:

- Objective 1 — People moving out of residential aged care to more age-appropriate supported disability accommodation
- Objective 2 — People at risk diverted from inappropriate admission to residential aged care
- Objective 3 — People provided with enhanced services within a residential aged care setting, for whom residential aged care is the only available, suitable supported accommodation option.

A low or decreasing proportion of younger people in residential aged care and a high or increasing proportion of service users in the YPIRAC program who have achieved program objectives is desirable.

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. The YPIRAC program has since been incorporated into the NDA and in future years will no longer be a separate program however the objectives of the YPIRAC program will continue to be maintained.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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 2008-09, there were a total of 817 YPIRAC service 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, 2008-09[a, b]

	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	352	98.3	75	20.9	261	72.9	358	100.0
Group 2	188	93.1	49	24.3	136	67.3	202	100.0
Group 3	227	98.7	..	..	<120	<52.2	230	100.0
Group 4	27	100.0	..	..	<5	<18.5	27	100.0
Total	**794**	**97.2**	**124**	**15.2**	**518**	**63.4**	**817**	**100.0**

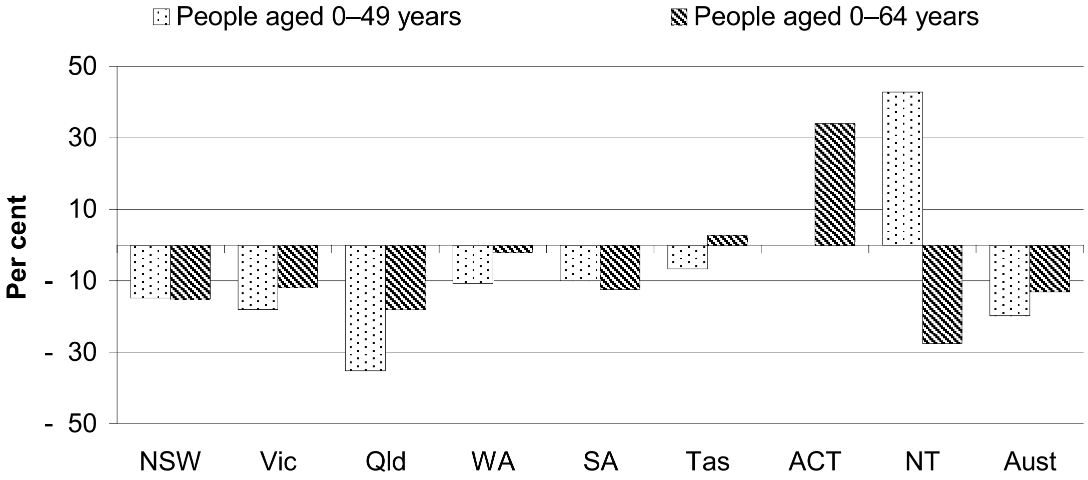
[a] Totals may not be the sum of the components as services users may have accessed more than one service type during the period. .. Not applicable. [b] Box 14.9 contains definitions of Groups 1-4.

Source: AIHW (2010b) *Younger People with Disability in Residential Aged Care program: report on the 2008-09 Minimum Data Set*, Disability series, Cat. no. DIS 57.

On 30 June 2009, there were 808 people aged under 50 years living in permanent residential aged care nationally (table 14A.65). This is a 19.8 per cent decrease on the number of people aged under 50 years living in permanent residential aged care on 30 June 2006 (figure 14.25). These data need to be interpreted with care as some younger people choose to remain in residential aged care for a variety of reasons such as:

- their physical and nursing needs can be best met in residential aged care
- they are satisfied with their current living situation (that is, it is the preferred facility)
- the facility is located close to family and friends
- it is a familiar home environment.

Figure 14.25 Younger people in residential aged care, percentage change in numbers between 2006–2009, by age group[a, b, c]

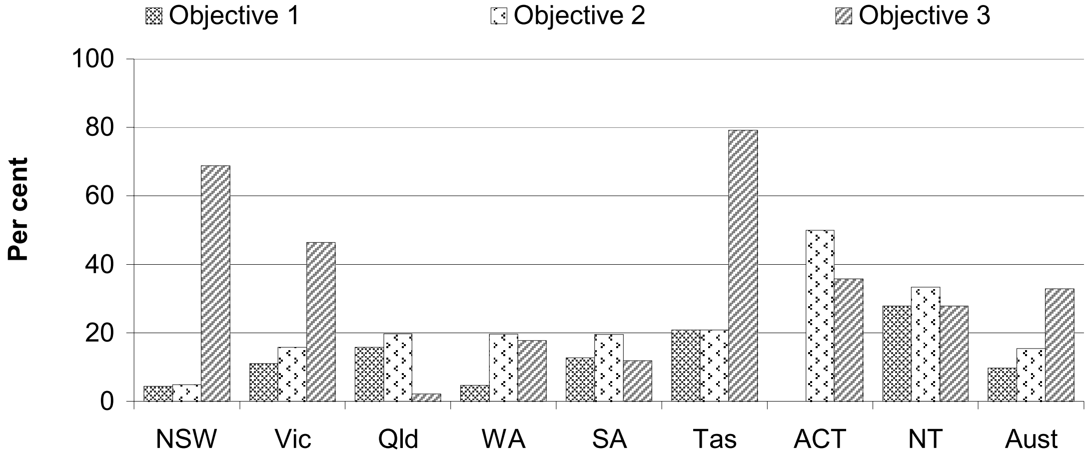


[a] Data are for permanent residents in aged care. [b] These data should be interpreted with care (particularly for the NT). There may be issues related to the age of Indigenous residents being incorrectly recorded. An assessment of the data set in the NT has previously shown that approximately half of Indigenous people's ages were incorrectly recorded. [c] The percentage change for the number of people aged 0–49 years in the ACT is not reported due to confidentiality.

Source: Derived from AIHW (2010b) *Younger People with Disability in Residential Aged Care program: Final report on the 2008–09 Minimum Data Set*, Disability series, Cat. no. DIS 57; table 14A.65.

A total of 947 younger people have participated in the YPIRAC program since its inception in 2006. Objectives of the YPIRAC program are listed in box 14.9. A total of 9.7 per cent (92 service users) have achieved objective 1, 15.4 per cent (146 service users) have achieved objective 2 and 32.8 per cent (311 service users) have achieved objective 3 (figure 14.26, table 14A.67).

Figure 14.26 Proportion of service users in the program for younger people in residential aged care who have achieved program objectives since inception to June 2009[a, b, c]



[a] Services user numbers are adjusted for individuals who received services in more than one jurisdiction therefore State and Territory totals may not add to the Australian total. [b] Service users may have received services in more than one collection period and may have had different target groups and residential settings recorded in different years. The most recently provided target group and residential setting were used to determine whether services users have achieved program objectives. [c] Box 14.9 contains definitions of Objectives 1-3.

Source: Derived from AIHW (2010b) *Younger People with Disability in Residential Aged Care program: Final report on the 2008–09 Minimum Data Set*, Disability series, Cat. no. DIS 57; table 14A.67.

Data on younger people admitted to residential aged care, younger people who separated from permanent residential aged care and the number of younger people receiving residential aged care are also available (tables 14A.68–70).

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 2011 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 or increasing proportion of disability service outlets that have been assessed against the standards (and are found to be compliant) suggests an improvement in the quality of government delivered or funded specialist disability services.

This indicator does not provide information on whether the standards or the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

A set of eight minimum National Disability Service Standards were developed in 1992 in the context of the first Commonwealth State Disability Agreement (box 14.12). 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.79)
- 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.71–78)

- 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.71–78).

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.

Standard 6 Valued status

Each person with a disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

Standard 7 Complaints and disputes

Each consumer is free to raise and have resolved, any complaints or disputes he or she may have regarding the agency or the service.

Standard 8 Service management

Each agency adopts sound management practices which maximise outcomes for consumers.

The quality assurance processes differ across jurisdictions. Most processes include some form of self-assessment. Many expect, or are working toward implementing, an external third party audit/certification process.

Data on quality assurance processes in 2009-10 are reported in box 14.13. These results should be interpreted with reference to tables 14A.71–79 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 was introduced.

Box 14.13 **Quality assurance processes for specialist disability services 2009-10**[a]

Quality assurance processes data reported relate to CSTDA/NDA funded services.

Australian Government

The Australian Government funded a total of 422 disability employment organisations, comprising 1825 outlets, operating across Australia at 30 June 2010. Of these:

- Disability Employment Services (DES) funded by the Department of Education, Employment and Work Place Relations (DEEWR) made up 215 (50.9 per cent) of the 422 organisations. DES also accounted for 1496 (81.9 per cent) of total outlets. Of the 215, 67 (30.7 per cent) DES organisations operated as dual (both DEEWR and The Department of Families, Housing, Community Services and Indigenous Affairs [FaHCSIA]) funded employment services.

Australian Disability Enterprises (ADEs) funded by FaHCSIA made up 207 (49.1 per cent) of the 422 disability employment organisations, with 330 (18.1 per cent) outlets. Of the 207, 67 (32.5 per cent) ADE organisations operated as dual funded employment services.

All disability employment organisations are audited against 12 Disability Service Standards. Of DEEWR's 215 DES organisations, 11 are new. Those new services have until March 2011 to become certified and they are currently in the process of preparing for their first audit.

(Continued on next page)

Box 14.13 **(Continued)**

Beside the 11 new organisations, every DES and ADE organisation is certified. The combined expenditure for Quality Assurance Contributions to both DEEWR and FaHCSIA funded organisations in 2009-10 was $2 563 250. Of this, $1 436 750 was for DEEWR funded services and $1 126 500 was for ADEs.

NSW, Victoria, Queensland, WA, SA and the ACT

Different quality assurance processes were in place in NSW, Victoria, Queensland, WA, SA and the ACT in 2009-10. The evaluation processes relate to both government and non-government service outlets, although in some jurisdictions the requirements are different across service sectors.

NSW

All NSW non-government organisation providers are required annually to revalidate ongoing compliance with Standards. In 2009-10 96 per cent of providers reported compliance with Standards. An action plan is developed for any required remedial action. The information return provided is assessed using a risk monitoring tool to determine the level of intervention required to support the provider. The extent of intervention required to support a provider is based on a range of factors including output and financial reporting, complaints, self assessments and implementation of agreed plans for improvement.

Victoria

In a survey of quality plans, 94 per cent of residential accommodation support services outlets reported a minimum of two planned quality improvement activities in the forthcoming year.

Queensland

The Disability Sector Quality System introduced on 1 July 2004, requires all disability service providers recurrently funded by the Department of Communities, to achieve certification through an external certification body accredited by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). Each year service providers undergo annual surveillance audits to ensure that certification is maintained and that a continuous improvement plan has been developed. The quality system also provides a framework to support service providers to develop, implement and maintain their own quality management system. The assessment process relates to both government and non-government service providers.

Of the established 244 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 10 new service providers who are in the process of implementing their quality management systems in preparation for external audit.

Evaluation processes relate to both government and non-government service outlets.

(Continued on next page)

Box 14.13 **(Continued)**

WA

Of all independent evaluations of service providers conducted in 2009-10, 88 per cent were found to be fully compliant with all assessed Disability Services Standards.

All those found to be non-compliant were given required actions in order to improve service quality to and remain eligible for funding.

SA

In SA, non-government service providers are required to meet quality assurance criteria before they can provide NDA funded services. From 2006-07 this included participation in an independently audited quality assurance system. As at June 2010, 83 per cent of grant-funded agencies are engaged in the Service Excellence Framework, with a further 2 per cent being exempt from quality improvement requirements.

Disability SA, the government disability services provider, self-assesses against the Business Excellence Framework adopted across all areas of the Department for Families and Communities. In addition, certain Disability SA outlets meet specific quality assurance system requirements in relation to catering, aged care and Home and Community Care services, where applicable.

ACT

In 2009-10 the ACT continued implementation of the quality improvement framework for all services delivered by Government and Community Sector service providers. All individual agencies 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, Victorian, 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 or increasing proportion of clients and carers satisfied is desirable, as it suggests the service received was of a higher quality and better met the needs and goals of the client (or carer).

Data reported for this indicator are neither complete nor directly comparable.

Data are available for reporting for Victoria, Queensland, WA, 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**

Client and carer satisfaction processes data reported relate to CSTDA/NDA funded services.

Victoria

In Victoria, the Department of Human Services, under the Disability Services Respite activity specification, has a quality measure requirement to complete an annual Carer Satisfaction Survey. The result of this survey is used to inform program directions and is reported to the Department of Treasury and Finance.

The Respite Carer Satisfaction Survey 2009-10 sought feedback from carers on the range of respite services available, provided by both the Department of Human Services and Community Service Organisations and identified that:

- 66 per cent of carers were satisfied with respite services
- 14 per cent of carers were dissatisfied with respite services
- 20 per cent of carers reported neither being satisfied nor dissatisfied.

The key findings of the survey were that carers were very satisfied with areas related specifically to respite service delivery, such as respite staff and respite houses. Carers were less satisfied with other factors such as availability, complaint procedures and being offered a range of respite options.

The Department of Human Services has committed to undertake a range of projects aimed at improving respite supports in Victoria, including the development of a plan to ensure that a wide range of supports are able to meet the diversity of families/carers needs into the future.

(Continued on next page)

Box 14.15 **(Continued)**

Queensland

Queensland conducted its most recent survey for *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.

WA

Western Australia conducted a carer and client satisfaction survey in March 2010. In this survey, a total of 1016 telephone interviews were completed. Of these, 129 (13 per cent) were service users and 887 (87 per cent) were carers responding on behalf of service users. This survey was previously undertaken biennially but from 2011 will be undertaken annually.

Overall service user satisfaction was 81 per cent. For individual services, reported satisfaction was:

- 95 per cent for accommodation
- 75 per cent for supported community living
- 85 per cent for community support
- 78 per cent for respite
- 87 per cent for recreation and day options
- 73 per cent for local area coordination

(Continued on next page)

Box 14.15 **(Continued)**

SA

The Disability SA component of the Department for Families and Communities Customer Satisfaction Survey was conducted in February 2010. The survey was previously undertaken every six months with whole-of-government results published on South Australia's Strategic Plan website. From 2011 the survey will be undertaken annually.

A total of 172 people responded to the February 2010 survey, of which 34 per cent were clients of Disability SA and 66 per cent were family carers or advocates.

The results of the customer satisfaction survey indicated that:

- 73 per cent of respondents were satisfied with the accessibility of the service provided
- 69 per cent were satisfied with the amount of time it took to get the service provided
- 36 per cent, overall, were very satisfied
- 38 per cent were satisfied with the quality of service delivery
- 69 per cent said they were satisfied with the amount of time it took to get the service/product they needed from Disability SA.

Tasmania

No survey was conducted in Tasmania in 2009-10. 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 2010 the ACT conducted several client satisfaction surveys of government provided disability services including CSTDA 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:

- 74 per cent for accommodation support services
- 68 per cent for respite service users.
- 89.5 per cent for community support users.

Source: Victorian, Queensland, WA, SA, Tasmanian and the ACT governments (unpublished).

Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- '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 2009-10 expenditure data provided by Australian, State and Territory governments. However, as 2009-10 service user data from the NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported for 2008-09. Expenditure data might differ from information reported elsewhere (such as in departmental annual reports) because the financial counting rules and definitions used to calculate expenditure can differ. Data in this Report might also differ from information reported elsewhere because the data here exclude users of specialist psychiatric disability services.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The jurisdictional expenditure data included in this chapter do not yet include the user cost of capital, and so do not reflect the full costs of government funded services (User cost of capital is defined in chapter 2).

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Concerns remain over the comparability of the results, because jurisdictions use different methods of data collection (table 14A.80).

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/NDA accommodation support services in:

- institutional/residential settings
- group homes
- other community settings.

Holding other factors constant (such as service quality and accessibility), a low or decreasing government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. 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.

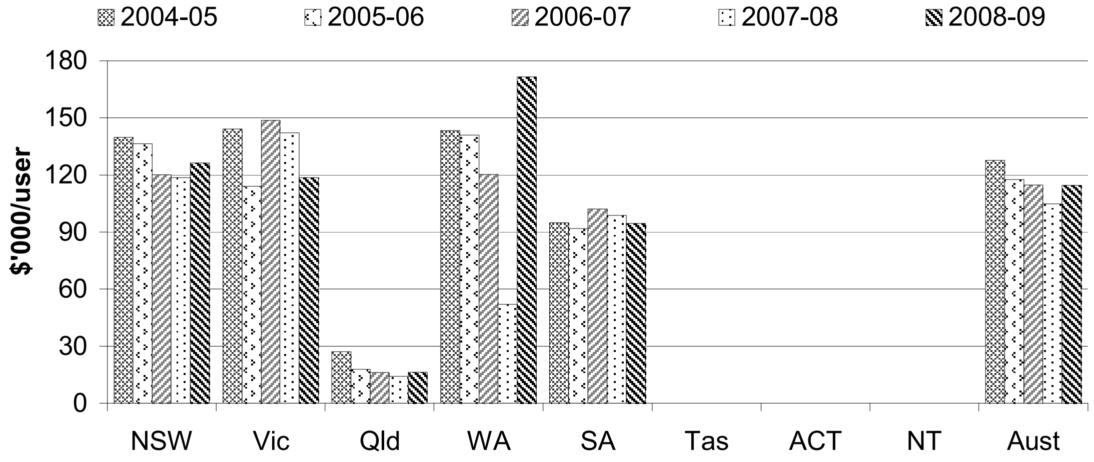
Data quality information for this indicator is under development.

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 $115 393 per service user in 2008-09 (figure 14.27).

Figure 14.27 Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2008-09 dollars)[a, b, c, d, e, f]



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[a] See table 14A.81 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] Government and non-government sectors have not been accurately recorded in the NSW DS MDS over the years. Some non-government providers have been coded as government and this will affect the comparability of the number of service users from government and non-government sectors over time. [d] Queensland data include funding provided by the Department of Communities only. [e] There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT. [f] Real dollars are previous years' expenditure in current year's dollars after basing expenditure on the ABS GDP price deflator 2008-09 =100 (table AA.26).

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.81.

Estimated annual government expenditure per user of government provided accommodation support services in group homes and other community settings for 2008-09 are reported in table 14A.81.

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/NDA service user. Measures are reported for the following non-government provided services:

- accommodation support services in:
  - institutional/residential settings
  - group homes
  - other community settings
- employment services (reported per employment service user assisted).

Holding other factors constant (such as service quality and accessibility), a low or decreasing government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of users. Similarly, low or declining expenditure per unit of output can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

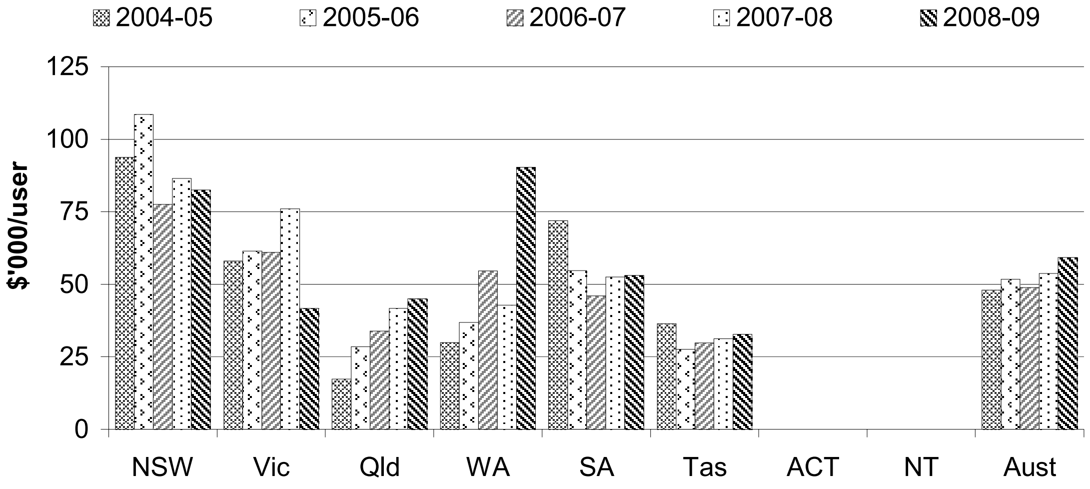
Data quality information for this indicator is under development.

The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Government contribution per user of non-government provided services — accommodation support services in institutional/residential settings

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was $56 214 per service user in 2008-09 (figure 14.28).

Figure 14.28 **Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2008-09 dollars)**[a, b, c, d, e, f]



[a] See table 14A.81 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] Government and non-government sectors have not been accurately recorded in the NSW DS MDS over the years. Some non-government providers have been coded as government and this will affect the comparability of the number of service users from government and non-government sectors over time. [d] The Victorian cost per service user for 2004-05 is overstated due to a significant proportion of service users having moved from institutional settings to community based and individualised settings, while expenditure continued to be similar to previous years [e] There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT. [f] Real dollars are previous years' expenditure in current year's dollars after basing expenditure on the ABS GDP price deflator 2008-09 =100 (table AA.26).

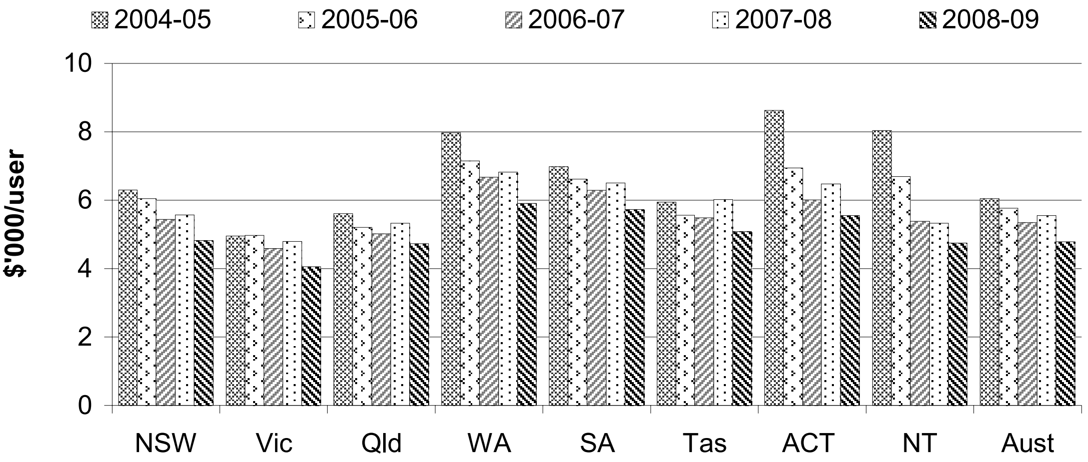
Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.81.

Estimated annual government funding per user of non-government provided accommodation support services in group homes and other community settings for 2008-09 are reported in table 14A.81.

Government contribution per employment service user assisted

Nationally, for all employment services, estimated government expenditure per service user assisted was $4788 in 2008-09 (figure 14.29). Nationally, estimated annual government expenditure per service user in 2008-09, by employment service type, was $3621 on open services (employed or seeking employment in the open labour market) and $9279 on supported services (employed by the service provider) (table 14A.83).

Figure 14.29 **Government contribution per employment service user assisted (2008-09 dollars)**[a, b, c]



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[a] See table 14A.82 for detailed notes relating to these data. [b] Cost per employment service user data reported here might differ from those reported in the Australian Government's annual report, where different rules are used to count the number of employment service users. [c] Real dollars are previous years' expenditure in current year's dollars after basing expenditure on the ABS GDP price deflator 2008-09 =100 (table AA.26).

Source: Australian Government (unpublished); AIHW (unpublished) *CSTDA NMDS;* table 14A.82.

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/NDA 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 low or decreasing government expenditure per service user reflects a more efficient provision of this service.

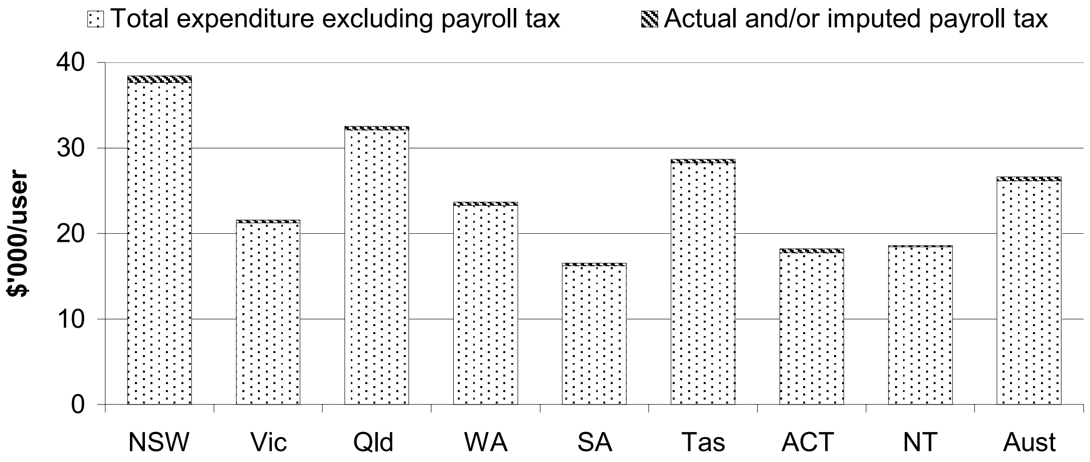
Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total estimated government expenditure per user of CSTDA/NDA State and Territory administered specialist disability services in 2008-09 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was $26 247 excluding payroll tax and $26 684 including actual and/or imputed payroll tax (figure 14.30).

Figure 14.30 Estimated annual government expenditure per user of CSTDA/NDA State and Territory administered services, 2008-09[a, b, c, d]



[a] In some jurisdictions (NSW, Victoria, SA, Queensland, Tasmania and the NT), payroll tax data are actual; in other jurisdictions (WA and ACT), payroll tax data are imputed. [b] Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. [c] Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. [d] In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.84.

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.80). 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.

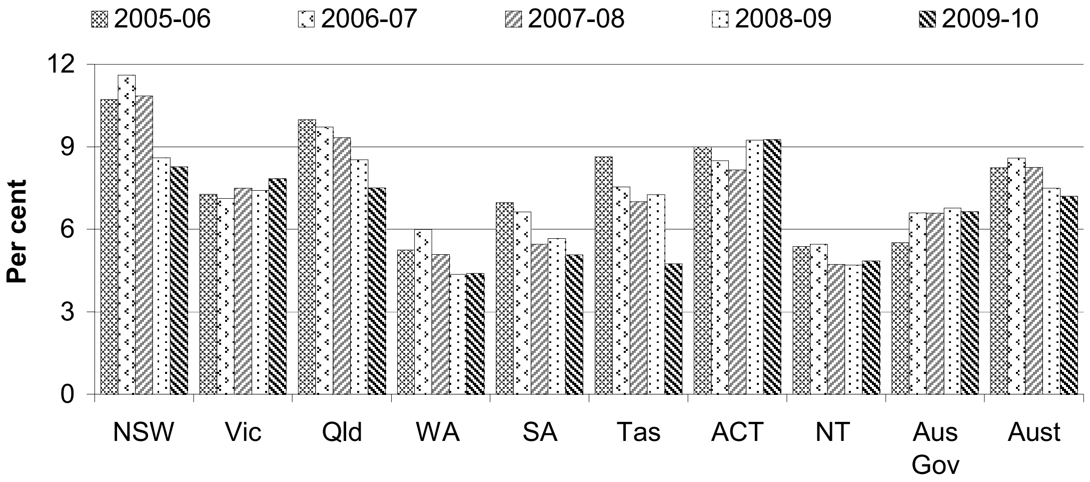
Efficiency data are difficult to interpret. Although high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining 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.

Data quality information for this indicator is under development.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) decreased from 7.5 per cent in 2008-09 to 7.2 per cent in 2009-10 (figure 14.31). When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total NDA expenditure was 7.1 per cent in 2009-10 (table 14A.85). Real total CSTDA/NDA expenditure is reported in table 14A.7, both excluding and including actual or imputed payroll tax amounts.

Figure 14.31 Administrative expenditure as a proportion of total recurrent expenditure[a, b, c, d, e, f]



[a] See table 14A.80 for an explanation of different methods of apportioning departmental costs. [b] Data exclude payroll tax. [c] Australian Government administrative expenditure is an estimate, based on average staffing levels. [d] The decrease in NSW administrative expenditure as a proportion of total recurrent expenditure on services in 2008-09 reflects an improved overhead allocation model which results in better allocation of funding to direct and non-direct service expenditures. [e] The decrease in WA administrative expenditure in 2007-08 mainly reflects the abolition of the capital user charge by the Department of Treasury and Finance. [f] In Tasmania, reduction in administrative expenditure for 2009-10 was due to improved processes for aligning administrative and direct service delivery expenditure.

Source: Australian, State and Territory governments (unpublished); table 14A.85.

Outcomes

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

The following outcome indicators are included in the performance framework:

- ‘Labour force participation and employment of people with disability’
- ‘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.

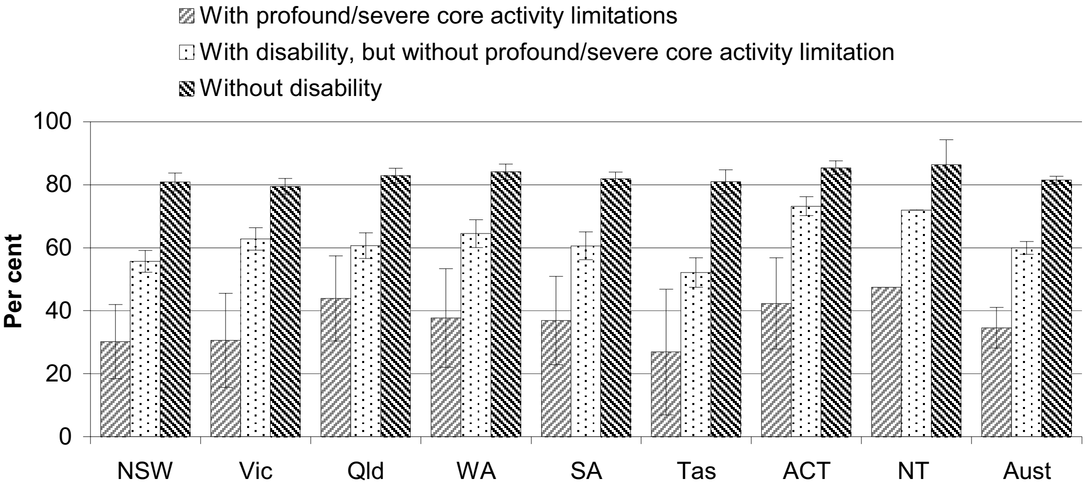
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Labour force participation

Nationally, in 2009, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation (34.6 ± 4.0 per cent) was statistically significantly lower than the rate for other people with disability (without a profound or severe core activity limitation) (60.0 ± 2.0 per cent) and the rate for people without a disability (81.5 ± 0.5 per cent) (figure 14.32). 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.86–93.

Figure 14.32 Estimated labour force participation rates of people aged 15–64 years, by disability status, 2009[a, b, c]



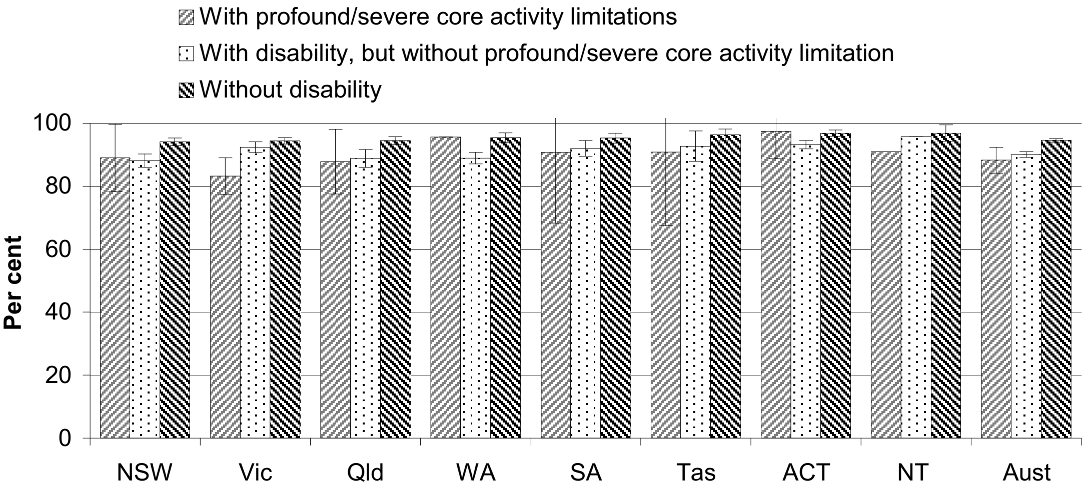
[a] Due to differences in collection methodology, the data collected by the ABS Disability Module (used in the Survey of Education and Training Experience) relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed Survey of Disability, Ageing and Carers — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between Disability, Ageing and Carers surveys. [b] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. [c] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS *Survey of Education and Training Experience* (unpublished); table 14A.88.

Employment

Nationally, in 2009, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation (88.3 ± 4.6 per cent) was similar to the rate for other people with disability (but without a profound or severe core activity limitation) (90.0 ± 1.7 per cent) and the rate for people without a disability (94.6 ± 0.3 per cent) (figure 14.33). 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. 86–93.

Figure 14.33 **Estimated employment rates of people aged 15–64 years, by disability status, 2009**[a, b, c]



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[a] Due to differences in collection methodology, the data collected by the ABS Disability Module (used in the Survey of Education and Training Experience) relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed Survey of Disability, Ageing and Carers — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between Disability, Ageing and Carers surveys. [b] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. [c] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS *Survey of Education and Training Experience* (unpublished); table 14A.88.

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 2011 Report.

Data quality information for this indicator is under development.

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.94). Other data on participation of people with disability in selected social and community activities are reported in tables 14A.94–99.

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.

Updated data for this indicator were not available for the 2011 Report.

Data quality information for this indicator is under development.

'Use of other services' data reported elsewhere in this Report

Data on the participation of people with disability in various government services are incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for children's services (chapter 3); VET (chapter 5); public, community and State owned and managed Indigenous housing and Commonwealth Rent Assistance (chapter 16). In addition, the following chapters include data on services provided to people with disability:

- ‘School education’ (chapter 4) reports data on students with disability in the student body mix
- ‘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.

Further alignment between the Report and NA indicators will occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

14.5 Jurisdictions' comments

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

Australian Government comments

During 2009-10 the Australian Government funded over 23 000 supported places for people with disability in 330 Australian Disability Enterprise (ADE) outlets across Australia.

The Australian Government released a discussion paper, Inclusion for People with Disability through Sustainable Supported Employment, on 16 July 2010. Consultations with people with disability, their families and carers in addition to feedback from the ADE sector and other interested stakeholders will help shape a new ten year Vision for supported employment, to be released in 2011.

A review of costs the Australian Government pays to service providers to deliver supported employment is due for completion in 2011.

Research titled Ageing and Australian Disability Enterprises was undertaken and released in September 2010. The Australian Government has been working with State and Territory jurisdictions to test retirement options for ageing workers in ADEs.

The Australian Government implemented a 12 month red tape reduction trial for ADEs in July 2010. A pause on Disability Maintenance Instrument reassessments, which determine funding levels for a worker with disability for a two year period, is underway.

A redesign of the www.australiandisabilityenterprises.com.au website has been completed to improve functionality and now includes information for Australian Government Buyers. Buyer's Kits were distributed to State, Territory and Australian Government Departments and Agencies, to assist in promoting government purchasing from ADEs.

The new Disability Employment Services — Employment Support Service commenced on the 1 March 2010. The Employment Support Service assists job seekers with permanent disability and an assessed need for long-term, regular support in the workplace. Job seekers receive tailored services that are flexible and responsive to both their needs and those of employers.

As at 30 June 2010 there were 207 organisations delivering Employment Support Services from 1131 sites. From 1 March to 30 June 2010 there were 14 145 participants commenced in the Employment Support Service program.

From 1 July 2009 to 28 February 2010 the Disability Employment Network (DEN) capped stream provided assistance to 52 900 participants and the DEN uncapped stream assisted 30 119 participants. The proportion on DEN job seekers who achieved a sustainable employment outcome (8 hours of work per week for 26 weeks) in the capped stream was 34.2 per cent and in the uncapped stream was 23.9 per cent.

New South Wales Government comments

During the fourth year of Stronger Together: A new direction for disability services in NSW 2006–2016, real and tangible benefits were realised in the experiences of people with a disability, their families and their carers. The NSW disability budget maintained strong growth in 2009-10, at a total of $1.66 billion, an increase of 6 per cent over the previous year.

The NSW Government is committed to seeing that the right mix of formal and informal support is available to people with a disability and their families and carers in a way that allows them to plan and make their own life choices. Under Stronger Together, the service shift from higher intensity services to lower intensity services aims to support people to remain within their communities and prevent the need for crisis responses. Analysis commissioned by the NSW Government shows that the service shift has enhanced the opportunities for people with a disability to exercise choice and decision making through expanding the range of service types and support delivery modes. This has also lead to increased efficiency in service provision.

Under Stronger Together, the NSW Government invested more than $1 billion in service expansions and improvement over the first four years. In 2009-10, almost 7900 children received early childhood intervention services and 1500 families accessed the Family Assistance Fund to strengthen their capacity to provide ongoing care for a child or young person with a disability. An estimated 7400 people received community living support from government provided and funded organisations. The three-year project to transfer all 30 state-operated day programs to non-government organisations was completed.

The establishment of the $17 million Industry Development Fund (IDF) was to promote and support the disability sector and a service system that improves services for people with a disability and their families. During 2009–10 a series of extensive consultations with non government organisations resulted in the publication of the NSW Disability Services Sector – Directions for Industry Development.

The NSW Integrated Services Program for Clients with Challenging Behaviour, began as a pilot program in partnership with NSW Health and Housing NSW in September 2005 and became recurrently funded in 2009-10. This program is achieving a wide range of positive outcomes for individuals and the service system.

Through community consultations and research, the NSW Government has prioritised as a strategic direction improvements to services for Indigenous people with a disability, their families and communities. This led to the development of the Aboriginal Service Delivery Model.

The NSW Government understands the vital role carers play in supporting people with a disability. New Directions for Disability Respite Services in NSW was developed to form an overarching strategic framework to guide future expansion and reform of disability respite services.

Victorian Government comments

In 2009-10 Victoria has continued to increase the availability of disability support services and to consolidate and extend its achievements in disability reform.

Areas of particular focus in 2009-10 have been:

- A new funding option for Individual Support Packages to allow direct funding of individuals or their representatives for their support was rolled out Statewide in February. Developmental work for the roll out of Victoria's new Statewide financial intermediary service was also completed
- Respite services have been enhanced through a new on-line service. Respite Victoria, was launched in April to provide families, carers and people with a disability with access to the latest information regarding carer and respite services and supports from the Australian Government, the State and local government
- Verification of service quality through the state wide roll out of independent monitoring against the Standards for Disability Services in Victoria allow service quality, including personal outcomes, to be measured, monitored, confirmed and continually improved. Independent monitoring uses auditing by certification bodies accredited by the JAS-ANZ, to verify compliance with the standards
- Full implementation of the Senior Practitioner strategy to protect the rights of people with disability subject to restrictive interventions and compulsory treatment
- Continued to expand the availability of self-directed supports
- Strengthened transition to employment support by providing additional resources to improve an increased focus on early planning with schools
- Provided additional support to non-government services to enhance their capacity in the areas of strategic and business planning and efficiency, and to transition to self-directed support
- Rolled out Stage 2 of the *my future, my choice* initiative through committing $13.8 million for the development of 13 community-based housing developments for young people in or at risk of entering nursing homes
- Delivered a further 13 accommodation facilities in Stage 3 of Disability Services Strategic Refurbishment and Realignment program
- Allocated funding to disability service providers for the establishment of disability community services which are collocated with other community facilities, to increase participation opportunities for people with a disability
- Continued to work with the sector to implement workforce strategies that will enhance the quality of life of Victorians with a disability, whilst ensuring a vibrant and sustainable industry for the future.

Queensland Government comments

The Queensland Government is continuing to pursue a broad agenda of promoting rights and equity of access for people with disability and their carers, including improvements to the accessibility and responsiveness of the State's specialist disability service system as well as investing in early intervention initiatives.

The draft 10 Year Plan for Supporting Queenslanders with a Disability was released for public consultation. The plan sets out the Queensland Government's vision for, and commitment to, achieving better outcomes for Queenslanders with a disability over the next 10 years. Proposed priorities include strategies and ideas for creating communities where everyone has equitable access to public spaces, transport, services, employment, education and sport, as well as artistic and cultural activities.

Queensland implemented critical reforms such as the Investing in Positive Futures initiative. This initiative supports adults with an intellectual or cognitive disability who exhibit behaviour that may cause harm or that presents a serious risk of harm to themselves or others and who are subject to restrictive practices. In 2009-10:

- the Specialist Response Service worked with service providers to assess clients and develop positive behaviour support plans that consequently reduce the need for restrictive practices
- service providers reported a 65 per cent reduction in the use of restrictive practices such as chemical, mechanical or physical restraints and restricting access to objects.

Queensland also continued to implement Growing Stronger reforms to provide more transparent and equitable support for people with a disability, more effective provision of funding and standard assessment procedures for specialist disability services applicants. Growing Stronger has commenced and is being implemented in a progressive rollout across the state. Initial reactions to the new intake, assessment and support linking processes have been positive.

Queensland focussed on early intervention services for individuals and families to provide support and assistance before problems become more serious or complex. Key programs such as the Autism Early Intervention Initiative, Family Support Program and Family and Early Childhood Services are helping families of children with a disability strengthen their capacity to care for children and assist them to reach their full potential.

In June 2010, Queensland released the Building Bright Futures Action Plan for Children with a disability (aged 0-8 years). This plan outlines our commitments to children over the next three years.

Western Australian Government comments

The WA Government’s ongoing commitment towards providing support to individuals and families with disabilities was acknowledged when the Commission was presented with a Premier’s Award for the Local Area Coordination Program in the category of strengthening families and communities. This innovative and people-focused program is helping individuals, families and local communities to work together and support good lives for everyone.

The allocation of substantial additional growth funding ($80.8 million over four years) continues to reflect the WA Government’s commitment to disability services.

Key initiatives for 2009-2010 include:

- Implementation of a long-term disability strategy Count Me In: Disability Future Directions, which has underpinned the development of the Commission’s 2011–2016 strategic plan
- Implementation of the new Community Living initiative, an innovative approach to create low cost options tailored to the individual needs and aspirations of people with disability, to enable them to live good lives in their local community
- Providing alternative accommodation and support for 42 younger people with disability deemed at risk of entering residential care by the end of 2010-2011, through the Young People in Residential Aged Care program
- The first of five new respite centres to be built across the state opened in Broome
- $1.32 million allocated through the Equipment for Living grants to fund specialist equipment outside the State Community Aids and Equipment Program
- Consolidation of the Commission’s metropolitan and regional service teams into one directorate to ensure seamless provision of services to all Western Australians with disability, their families and carers
- Implementation of a Quality Management Framework that uses individual focussed outcomes and performance indicators to ensure services achieve positive outcomes for people with disability, their families and carers
- Agreement and support for the Australian Disability Parking Scheme including a national permit design and minimum standards for eligibility time concessions
- The awarding of $250 000 in grants to 16 local governments to implement the You’re Welcome Access initiative.

South Australian Government comments

Disability SA, in partnership with non-government organisations, aims to create a better life for South Australians with disabilities by providing disability services that support individuals, their families and carers, and by increasing access to State Government Services.

Service improvements will focus on increasing levels of choice, control and flexibility.

Highlights for 2009-10 include:

- The SA Government announced the development of a “blueprint” for long term disability reform, due in July 2011. This work will be complemented by a review of the Disability Services Act 1993
- One of SA’s priorities was to expand the range of accommodation options for people with disability. The focus was on clients with complex needs and challenging behaviour that may place them or their community at risk. Accommodation particularly suited to their needs was developed, as well as the provision of a range of services to stabilise them in their existing accommodation
- The commencement of self-managed funding. The first phase of self-managed funding in South Australia provides 50 people with disabilities the opportunity to transfer their existing support package into a self-managed funding arrangement. This first phase, which is being independently evaluated, is an important step in the development of South Australia’s self-managed funding system for the future
- Disability SA worked closely with SA Health to achieve improved outcomes for people with disabilities in the hospital system awaiting discharge. Protocols were developed to that the departments can work together when planning discharge from hospital for mutual clients
- The commencement of a new assessment system for the supported residential facilities sector to ensure people unsuited to Supported Residential Facilities are not placed there
- Disability SA developed a new resource, Licence to Cook. The training kit will be used to train support staff who support people with severe disabilities who often have specialist dietary requirements, as well as an increased risk of choking whilst eating
- Non-government organisations are significant partners with the Department. New extended three year agreements (increased from one year) were implemented from 1 July 2010. This enables organisational stability, long-term planning and more stable service delivery.

Tasmanian Government comments

In 2009-2010 Tasmania continued the implementation of the Disability Operational Framework launched in February 2009.

The Framework is reforming the Tasmanian Disability Services system to support greater responsiveness to the needs of Tasmanians with disability and a stronger alignment with contemporary best practice, both nationally and internationally.

A number of initiatives were undertaken in 2009-2010 to support this reform. This includes:

- the provision of Gateway Services for people with disability which commenced in June 2010. The Gateways provide a single access point for family support and specialist disability services in each of the four regional areas in Tasmania. There is a state-wide telephone number which directs client to their local Gateway for referral, assessment, information and advice
- continuing activity by the regional Area Advisory Groups to plan for services at an area level
- the devolution of children's respite services to the community sector following an extensive needs analysis. The new services provide an expanded and more flexible service for children and their families
- planning for outsourcing of adult respite services to the community sector in 2011
- finalisation of the Resource Allocation and Unit Pricing Project which has resulted in a new, more efficient framework for funding which is based on an equitable and transparent mechanism allowing the identification and distribution of resources to ensure the delivery of high quality services to people with disability in Tasmania
- the delivery of an additional 70 individual support packages, 134 extra Community Access packages, respite support for 65 people and 17 new accommodation places
- completion of a project to identify innovative service delivery for community access in Tasmania which provided the basis for the outsourcing of direct government services which will begin in 2011
- the finalisation of a review of equipment provision in Tasmania with implementation to begin in 2011
- a Review of the Disability Services Act which will seek the approval of the Tasmanian parliament in 2011.

Australian Capital Territory Government comments

In 2009-10 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 2009-10 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
- Under the new policy framework Future Directions: Towards Challenge 2014 initiative Disability ACT has worked collaboratively with individuals, carers and stakeholders and delivered key achievements against the six strategic priorities. Disability ACT worked with Housing ACT to complete a special purpose household in Narrabundah for people aged under 50 years with complex and medical care needs. This was a commitment under the Bilateral Agreement with the Commonwealth Government related to the Young People in Residential Aged Care Program
- Disability ACT has worked with ACT Health to transition long-stay patients out of hospital to the community and continues to progress a policy framework to improve the efficiency and coordination of planning and support provision for transition to the community for long-term hospital patients who have complex and ongoing needs
- Disability ACT supported the Stepping Stones for Life coalition of families to establish supported accommodation options for people with disability living with ageing parents. The initiative showcases how service responses can be developed around the uniquely different needs of small numbers of people
- The ACT Government endorsed the ACT Government Policy Framework for Children and Young People with Disability and their Families. During 2009-2010 Disability ACT implemented this policy by progressing the development of an Out of Home Care framework to respond to children and young people with disabilities requiring accommodation and support and developing an individualised service response to support multi agency coordination and planning
- Disability ACT enhanced its relationship with the ACT Social Enterprise Hub to foster self-employment opportunities for people with disability in the ACT. The Hub is a partnership between Social Ventures Australia, Price Waterhouse Coopers, Disability ACT, ACT Health, the ACT Mental Health Community Coalition and The Snow Foundation.

Northern Territory Government comments

The Northern Territory Government recognises that people with a disability need extra support to participate as citizens within their communities. The disability support provision is based on contemporary practice underpinned by partnerships and collaborative approaches. Principles that guide services include: person centered, culture secure, collaborative, outcomes driven, future focused, equitable, sustainable, flexible and responsive. The Northern Territory's vision is for a society where people with disabilities have productive and fulfilling lives as valued members of their communities.

During 2009-10 the NT continued to implement reforms identified in the 2006 Review of the Disability Services System.

An Office of Disability opened in Darwin to complement the Office in Alice Springs which had been operating since 2007. These shop fronts provide a dedicated central point of contact with a 1800 number. Staff used a standardised assessment tool to determine eligibility. The individualised support planning approach continued to ensure access to services is streamlined for clients and equitable across the NT.

Established service providers from interstate have commenced operation in the Northern Territory. These organisation bring a level of expertise which will assist in increasing standards in disability services.

An exciting innovation saw the creation of two new supported accommodation services in Alice Springs which allowed 30 clients to move from a clustered group home model into group homes that are more integrated into the general community. As a result of this change in model, clients are able to participate more generally in the life of the community.

In 2009-10, additional funding was allocated to increase the capacity of Day Options and Post School Options services by an additional 47 full time equivalent (FTE) places Northern Territory-wide (35 in Alice Springs and 12 in Darwin).

Most services for people with a disability in remote areas are provided under the jointly NT and Australian Government funded Home and Community Care (HACC) Program. The HACC funding pool for 2009-10 was $12.016 million which funded 53 services for some 3500 clients. Statistics on these services are not captured in this Report.

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.

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 2010a).

'Not stated' rates for individual data items vary between jurisdictions (AIHW 2010a). 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 2010a).

Other issues

Service user data/data items not collected

Service user data are not collected for the following CSTDA/NDA 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/NDA funded service types. In some jurisdictions (Victoria, Queensland and WA), specialist psychiatric disability services are funded specifically to provide such support (AIHW 2010a). Nationally, in 2008-09, there were 13 308 people who used only specialist psychiatric disability services (AIHW unpublished). Data for these services are included in other publications on the CSTDA NMDS, such as AIHW (2010a). 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 2010a). 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 2010a).

Deriving potential populations (unrevised method) for the special needs groups

Potential populations (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method) 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 (unrevised method)
- There are a number of potential sources of error related to the Census that stem from failure to return a Census form or failure to answer every applicable question. Information calculated from 2006 Census data exclude people for whom data item information is not available. As with any collection, should the characteristics of interest (for example, ASSNP and/or special needs group status) of the people excluded differ from those people included, a potential for bias is introduced. In particular, for Indigenous estimates, differential undercount of Indigenous Australians across states and territories may introduce bias into the results that would affect the comparability of estimates across jurisdictions, if those missed by the Census had a different rate of disability status to those included.

14.7 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services	People using the following CSTDA/NDA accommodation support services: group homes; attendant care/personal care; in-home accommodation support; alternative family placement and other accommodation support (types 1.04–1.08), as a proportion of all people using CSTDA/NDA accommodation support services (excludes service users of specialist psychiatric disability services only). See AIHW (2009) for more information on service types 1.04–1.08.
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the disability service system as a whole (including the regional program management and administration, the central policy and program management and administration, and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on a service that has been already counted in the direct expenditure on the service) — divided by the denominator — total government expenditure on services for people with disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers (except major capital grants).
Core activities as per the 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/NDA 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 (unrevised method) 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/NDA 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' (unrevised method). 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 2010a).

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

Not needing assistance with, and has no difficulty performing, core

limitation	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 (unrevised method)	Potential population estimates are used as the denominators for the performance measures reported under the indicator ‘access to CSTDA/NDA 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/NDA 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/NDA 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/NDA 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/NDA funded services (AIHW 2006).

Potential Population (revised method)

Potential population estimates are used as the denominators for the performance measures reported to COAG under National Disability Agreement reporting requirements.

The ‘potential population’ is the number of people aged under 65 with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. In practice, the number of people with profound or severe core activity limitation is used as the basis to measure the potential population (see definition of core activities above).

The potential population for State/Territory delivered disability support services is measured by the number of people aged under 65 years who have a profound or severe core activity limitation. Briefly, the 2003 national age- and sex- specific rates of profound or severe core activity limitation are applied to the age and sex structure of each jurisdiction in the current year, to give an ‘expected current estimate’ of people with a profound or severe core activity limitation in that jurisdiction. No Indigenous weight or scaling factor is used. The potential population for CSTDA/NDA funded employment services is measured by the number of people aged 15-64 years with a profound or severe core activity limitation, and is calculated using the same method. No Indigenous weight or scaling factor is used. There is no adjustment for labour force participation.

The method used to calculate the Indigenous potential population is to apply adjusted national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of the Indigenous population of each jurisdiction in the current year. The national age- and sex- specific rates of profound or severe core activity limitation are adjusted by the rate ratio of the Indigenous rate need for assistance to the all persons rate of need for assistance with core activities, as calculated from the Census. Estimates of potential population by country of birth and Remoteness Area are calculated by applying Census distributions of country of birth and Remoteness Area for people who need assistance with core activities to the age and sex structure of the jurisdictional potential population.

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/NDA. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA/NDA.
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/NDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.

Service user	A service user is a person with disability who receives a CSTDA/NDA 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/NDA 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/NDA 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/NDA 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/NDA 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/NDA 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 List of 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 Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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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 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.

Improvements to the reporting of protection and support services this year include:

- consistent reporting of child protection activity data for the age range 0-17 years (prior to 2009-10, the rates of children subject to notifications, investigations and substantiations were calculated for children aged 0–16 years, while the rates of children on care and protection orders and in out-of-home care were calculated for children aged 0-17 years)
- six jurisdictions reporting performance data for the effectiveness indicator ‘safety in out-of-home care’, compared with five previously
- seven jurisdictions reporting proportions of expenditure across child protection Pathway activity groups, compared with five previously
- for the first time, five jurisdictions reporting experimental unit cost data for four Pathways activity groups
- for the first time, reporting a figure for the efficiency indicator ‘Out-of-home care expenditure per placement night’
- the inclusion of updated data regarding the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving national reading and numeracy benchmarks relative to all children
- where applicable, child protection, out-of-home care and intensive family support services data are reported, disaggregated by the categories ‘Indigenous’, ‘non-Indigenous’, ‘unknown Indigenous status’ and ‘total children’
- performance data are reported for five new juvenile justice performance indicators, ‘group conferencing outcomes’, ‘assaults in custody’, ‘self-harm and attempted suicide in custody’, ‘completion of orders’, and ‘centre utilisation’
- where data are available, a 10 year time series is reported for all child protection and juvenile justice indicators in attachment tables.

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 2006). The final report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (2007), identified child sexual abuse as a significant issue for many of the remote NT Aboriginal communities consulted as part of the Inquiry. The final report of the WA Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), also found high levels of violence and child abuse within Aboriginal communities in WA.

The Report of the Board of Inquiry into the Child Protection System in the Northern Territory *Growing them strong, together* also observed the presence of multiple risk factors in Aboriginal communities, including lack of adequate housing, financial security and education. However, Aboriginal communities also possessed protective factors which can safeguard children and families from psychological distress, such as spirituality and connection to land, family and culture (Bamblett, Bath and Roseby 2010).

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and 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.

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 $277.0 million in 2009-10. This expenditure has increased in real terms each year from $81.7 million in 2005-06 (table 15A.26). This represents an average annual increase in expenditure of 35.7 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 included in this Report, but intended for inclusion in future editions, are known as child protection treatment and support services. These services target at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may focus on either early intervention or reunification support.

(Continued on next page)

Box 15.1 **(Continued)**

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services.

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. The AIHW is expected to release a report on this study by end-2010.

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 2009-10). These services may be delivered by the government, non-government organisations, and in some cases, by for-profit providers. State and Territory governments, responsible for child protection, investigate and assess reports, provide or refer families to support services, and intervene where necessary (including making court applications when an order is required to protect a child, and placing children in out-of-home care).

Box 15.2 **Child protection and out-of-home care services**

NSW	Department of Human Services (DHS)
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)

Other areas of government also have roles in child protection and provide services for children who have come into contact with relevant departments for protective reasons. These include:

- education and child care services, which provide services for children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services
- police 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.

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 monitoring and oversight functions for children in the child protection system, including regularly visiting children in out-of-home care, receiving and investigating complaints and monitoring child outcomes. The Department of Communities (Child Safety Services) has a complaints management system so that clients, family members, advocates and members of the 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 has been extended across all placement service providers.
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).

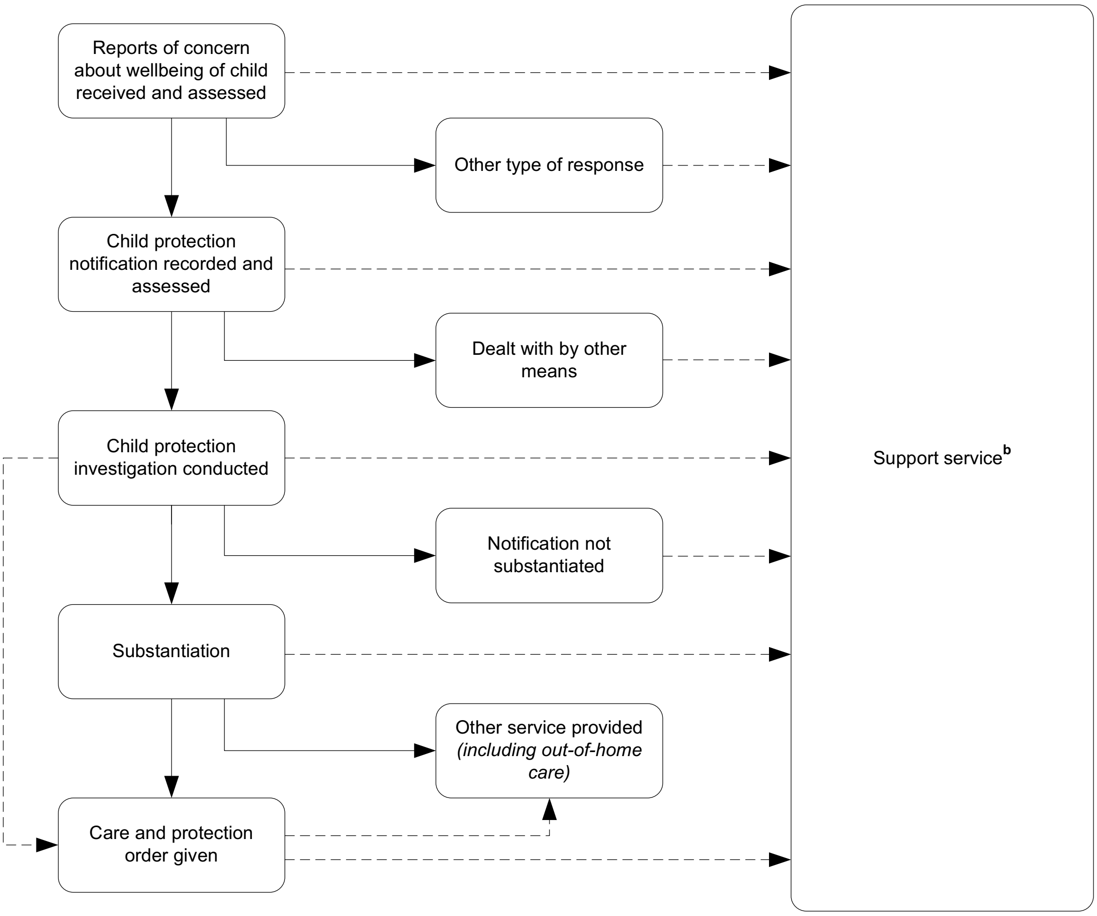
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions, which has some implications for the comparability of child protection data (Holzer and Bromfield 2008). However, the broad processes in child protection systems are similar (figure 15.1).

State and Territory departments with responsibility for child protection are advised of concerns about the wellbeing of children through reports to these departments. Reports may be made by people mandated to report or by other members of the community. Individuals and organisations mandated to report vary across states and territories, and may include medical practitioners, police services, school teachers and principals. These reports are assessed and classified as child protection notifications, child concern reports, or matters requiring some other kind of response. In most jurisdictions, police were the most common source of notifications in 2009-10. The second most common source of notifications varied across jurisdictions and included social workers and school personnel (AIHW 2011).

Figure 15.1 **The child protection system**[a]



[a] Dashed lines indicate that clients may or may not receive these services, depending on need and service availability. [b] Support services include family support or family preservation services provided by departments responsible for child protection and referrals to other agencies.

Source: State and Territory governments (unpublished).

Notification

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.

Most jurisdictions assess incoming reports to determine whether they meet the threshold for recording a notification. Notifications are subsequently investigated based on the policies and practices in each jurisdiction. 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).

Prior to 2009-10, the rates of children subject to notifications, investigations and substantiations were calculated for children aged 0–16 years, while the rates of children on care and protection orders and in out-of-home care were calculated for children aged 0-17 years. From the 2009-10 period onwards, all child protection data are reported for the age range 0-17 years.

Nationally, 187 314 children aged 0–17 years were the subject of child protection notifications in 2009-10. The rate of notifications per 1000 children in the population aged 0–17 years was 36.8 in 2009-10 (table 15A.8). The total number of notifications for each jurisdiction for 2009-10 (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, 31 295 children aged 0–17 years were the subject of a substantiation in 2009-10. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–17 years was 6.1 (table 15A.8). The number and rate of children who were the subject of a substantiation has fluctuated since 2005-06. Nationally, 34 336 children aged 0-16 were the subject of a substantiation in 2005-06. This represented a rate of 7.6 per 1000 children in the population aged 0–16 years (prior to 2009-10, substantiation data were collected for children aged 0-16 years) (table 15A.8).

Nationally, 8334 Indigenous, 22 335 non-Indigenous children and 626 children of unknown Indigenous status were the subject of substantiations in 2009-10. The rate of children who were the subject of a substantiation per 1000 children in the target population aged 0–17 years was 35.3 for Indigenous children and 4.6 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, 37 730 children aged 0–17 years were on care and protection orders at 30 June 2010. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 7.4 (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 2006. At 30 June 2006, 26 215 children were the subject of a care and protection order, which represented a rate of 5.4 per 1000 children in the population aged 0–17 years (table 15A.8).

Nationally, 11 451 Indigenous, 26 215 non-Indigenous and 64 children of unknown Indigenous status were on care and protection orders at 30 June 2010. The rate of children on care and protection orders per 1000 children in the target population aged 0–17 years was 48.3 for Indigenous children and 5.4 for non-Indigenous children (table 15A.8).

Further information regarding children on care and protection orders is included in the attachment tables. Table 15A.6 identifies the number of children admitted to and discharged from care and protection orders by Indigenous status, 2009-10. Table 15A.7 identifies the number of children on care and protection orders by type of order and Indigenous status at 30 June 2010.

Out-of-home care

Out-of-home care is one of a range of services provided to children and families where there is a need to provide safe care for a child. Children are placed in out-of-home care as a last resort when it is not in their best interests to remain with their family (for example, because they are not safe or because no one is able or willing to provide care). Where children are placed in out-of-home care, placement with the extended family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006). Continued emphasis is placed on improving case planning and case management processes to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Nationally, 35 895 children were in out-of-home care at 30 June 2010. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 7.0 (table 15A.16). The number and rate of children aged 0–17 years in out-of-home care has increased since 2006. At 30 June 2006, 25 454 children were in out-of-home care. This represented a rate of 5.3 per 1000 children in the population aged 0–17 years (table 15A.16).

Nationally, 11 468 Indigenous children and 24 279 non-Indigenous children were in out-of-home care at 30 June 2010. The rate of children in out-of-home care per 1000 children in the target population aged 0–17 years was 48.4 for Indigenous children and 5.0 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 2010. 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 2010. 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 2010. Table 15A.20 identifies the number of children who exited care during 2009-10, by Indigenous status and length of time spent in care.

Funding

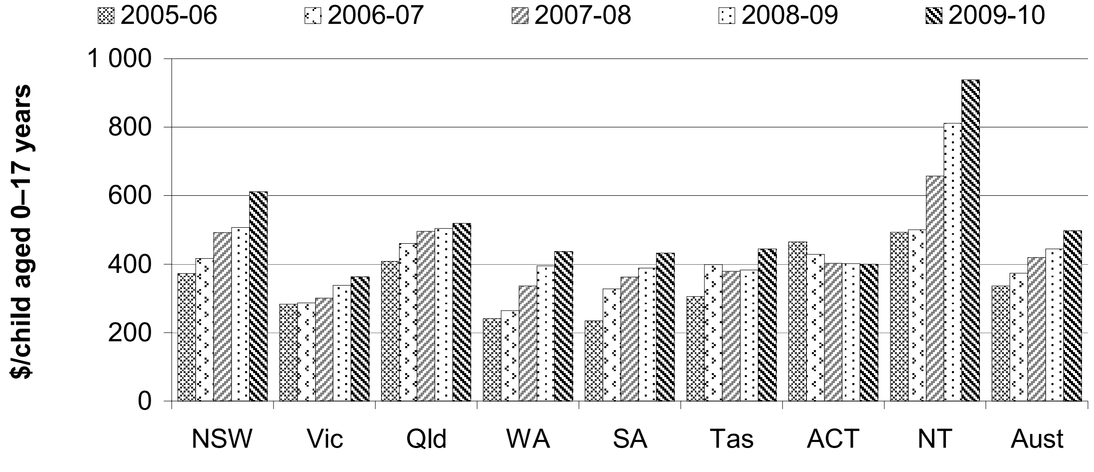
Recurrent expenditure on child protection and out-of-home care services was approximately $2.5 billion across Australia in 2009-10 — a real increase of $296.3 million (13.2 per cent) from 2008-09. Of this expenditure, out-of-home care services accounted for the majority (64.9 per cent, or $1.7 billion). Nationally, annual real expenditure on child protection and out-of-home care services has increased by $921.3 million from $1.6 billion since 2005-06, an average annual increase over the 4 year period of 11.9 per cent (table 15A.1).

In 2009-10, real recurrent expenditure per child aged 0–17 years in child protection and out-of-home care services was $498 nationally (figure 15.2). Real recurrent expenditure per child aged 0–17 years increased in most jurisdictions between 2005-06 and 2009-10 and has increased nationally each year since 2005-06. In 2005-06 the real recurrent expenditure per child aged 0–17 years was $336 (table 15A.1). This represents an average annual increase over the 4 year period of 10.3 per cent.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be 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 (2009-10 dollars)**[a]



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[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.

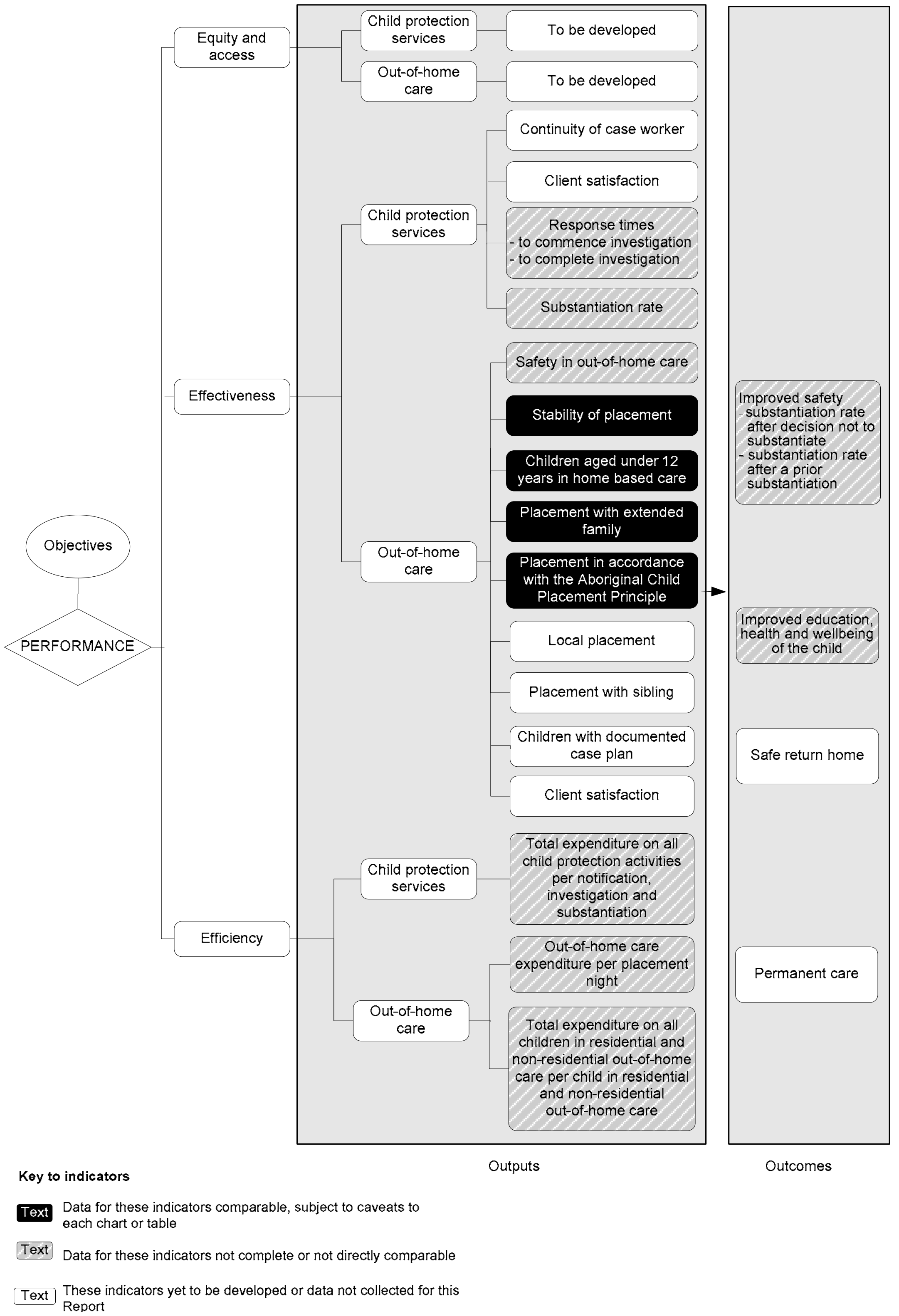
Child protection and out-of-home care services should be provided in an efficient and effective manner.

The performance indicator framework shows which data are comparable in the 2011 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 and out-of-home care 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 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 with child protection and out-of-home care services.

Box 15.8 **Developments in client satisfaction**

NSW A large scale evaluation is being undertaken of the Brighter Futures early intervention program, which targets vulnerable families with children under 9 years of age. As part of the evaluation, a sample of 2484 families participated in the family survey, which assessed satisfaction with the services provided. The survey was conducted from August 2007 to 30 June 2009. Interviewed families were overwhelmingly positive about the Brighter Futures program, and generally satisfied with the services they received. Respondents were asked (using a scale from 1 to 5, with 1 being ‘completely dissatisfied‘ and 5 ‘completed satisfied‘), their degree of service satisfaction. Respondents consistently reported a high level of satisfaction (on average, 5 or ‘completely satisfied’) with the quality of services and the amount of help they received from Brighter Futures, which was sustained over the three waves of surveys.

Vic Survey findings of child protection clients and families in 2001 on their experience of child protection identified areas for practice improvement and a range of strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. A further survey of child protection, out-of-home care and intensive family support services clients is to take place in 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 Children in state care in Queensland are visited regularly by the Commission for Children and Young People and Child Guardian’s Community Visitors (CVs) to independently assess their safety and wellbeing. CVs work to resolve issues locally and are able to escalate more serious concerns. Children are also surveyed every two years by the Commission. Several age-appropriate questionnaires are used to determine satisfaction with current placements, case workers and the child protection system. Information is also gathered on placement histories, education and health needs, participation in decision-making, and planning for transition to independent living for those aged 16 years and over.

(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. In summary, 63 per cent of carers reported that the department met their needs as a carer in the previous 12 months, while 66 per cent of carers reported that they were confident to manage as a carer in the future. New carers indicated that the most useful additional support they could have received was 'mentoring by an experienced carer'. Where children were new to care, carers indicated that the most useful assistance they could have received was 'better access to caseworkers'. The Department introduced new complaints policy and procedures in March 2008. Formal monitoring of service standards has continued and all districts were assessed by June 2009. A pilot standards monitoring regime for residential and non-government placement services was completed in June 2009. As a result of a positive outcome for 2009-10, residential and placement services completed a self assessment. External on-site monitoring commenced in July 2010. 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 The SA Office of the Guardian 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. The Office of the Guardian has developed a *Charter of Rights for Children and Young People in Care* and this has been tabled in Parliament. Amendments have been made to the *Children's Protection Act 1993* to provide for a Youth Advisory Committee, established and appointed by the Guardian for Children and Young People. A second Foster Carers' Relation Survey was conducted in 2009: a total of 322 carers completed a mail-out survey. The majority of respondents were satisfied with their interactions with the department, reporting that they were treated fairly, thought staff were competent and were provided with the information they needed.

(Continued on next page)

Box 15.8 **(Continued)**

Tas	Tasmania engaged the CREATE Foundation to report on the views of children in care as part of the 'Be Heard' project, which concluded on 30 June 2010. Of the 96 children in care who were interviewed, 88 children or 92 per cent reported that they felt very or quite comfortable about their participation in the project. CREATE has prepared a report on the key findings as well as proposing recommendations which seek to improve the experiences of children while in out-of-home care. The Department is working with CREATE to implement these recommendations. In March 2010 the Commissioner for Children commenced a child visitor's pilot. The Commissioner has recruited and trained 12 volunteers who are visiting 18 children in care on a monthly basis. Each visitor asks the child a series of questions based on the Charter of Rights for Tasmanian children and young people in out-of-home care. The visitor also spends time with the child participating in an activity of the child's choice. The pilot is to be undertaken for a period of one year and will be independently evaluated.
ACT	The Department of Disability, Housing and Community Services entered into a research partnership *Community Capacity Building in Child Protection Through Responsive Regulation*. This research, which commenced in 2006, seeks to develop a regulatory framework for child protection that effectively manages escalating notification rates and addresses the challenge of how and when governments can intervene in individuals' lives without undermining the goodwill essential for such interventions to be successful. One of the studies undertaken as part of this research partnership examines parents' experiences of their encounters with the child protection system. This study is scheduled for completion in 2011.
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 (in the 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.

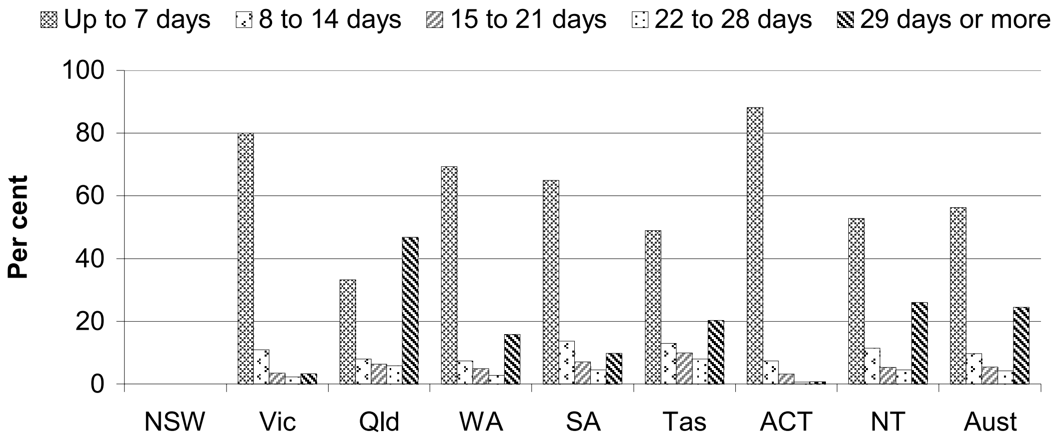
This indicator needs to be interpreted with care as jurisdictions record notifications at different stages in response to a report, and jurisdictions have policy and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern.

Data reported for this indicator are neither directly comparable nor complete.

Data quality information for this indicator is under development.

For most jurisdictions, the majority of investigations were commenced within seven days of notification in 2009-10 (figure 15.4).

Figure 15.4 **Proportion of investigations commenced, by time taken to commence investigation (2009-10)**[a, b]



[a] Data for NSW are not available. [b] See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.14.

Child protection services — response time to complete investigation

‘Response time to complete investigation’ is an indicator of governments’ objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and completing investigations in a timely manner (box 15.10).

Box 15.10 **Response time to complete investigation**

‘Response time to complete investigation’ is defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is completed (that is, the date an investigation outcome is determined by a department).

A short or decreasing length of time between recording a notification and completing an investigation is desirable. The length of time between recording a notification and completing an investigation indicates the effectiveness of the department in conducting investigations in a timely manner.

This indicator needs to be interpreted with care as jurisdictions record notifications at different stages in response to a report, and jurisdictions have policy and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern. Furthermore, while investigations should be conducted in a timely manner, it is important that expediency does not undermine a thorough and accurate assessment of the case. In addition, a number of factors outside the control of a department can affect the timeliness of investigations, including involvement by external parties (for example, police, schools) and an inability to locate a child and/or family.

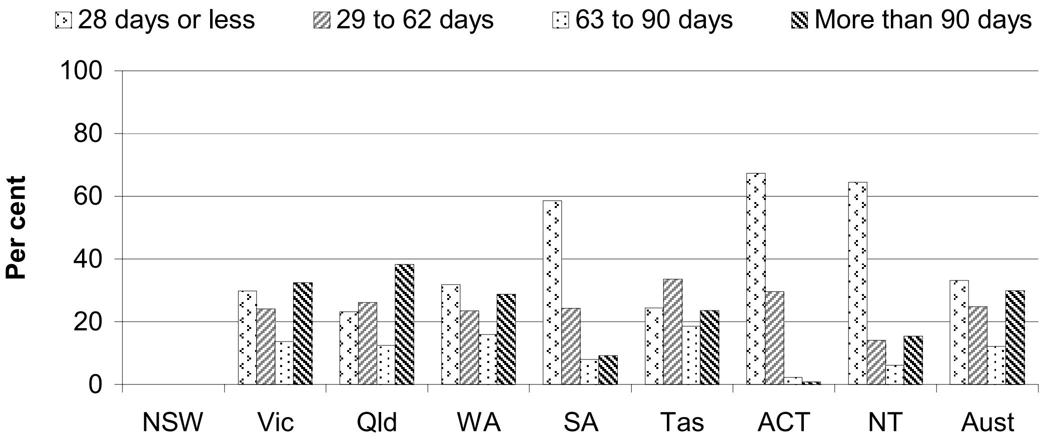
Data reported for this indicator are neither directly comparable nor complete.

Data quality information for this indicator is under development.

Investigation is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification and makes an assessment about the harm or degree of harm to the child, and his or her protective needs. An investigation includes sighting or interviewing the subject child where it is practical to do so.

Response times to complete investigations varied across jurisdictions in 2009-10. Nationally, 33.2 per cent of investigations were completed in 28 days or less, followed by 29.9 per cent in more than 90 days, 24.8 per cent in 29 to 62 days, and 12.1 per cent in 63 to 90 days (figure 15.5).

Figure 15.5 **Proportion of investigations finalised, by time taken to complete investigation (2009-10)**[a, b]



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[a] Data for NSW are not available. [b] See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.15.

Child protection services — substantiation rate

‘Substantiation rate’ is an indicator of governments’ objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred or is at risk of occurring (box 15.11).

Box 15.11 **Substantiation rate**

'Substantiation rate' is defined as the proportion of finalised investigations where harm or risk of harm was confirmed.

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.

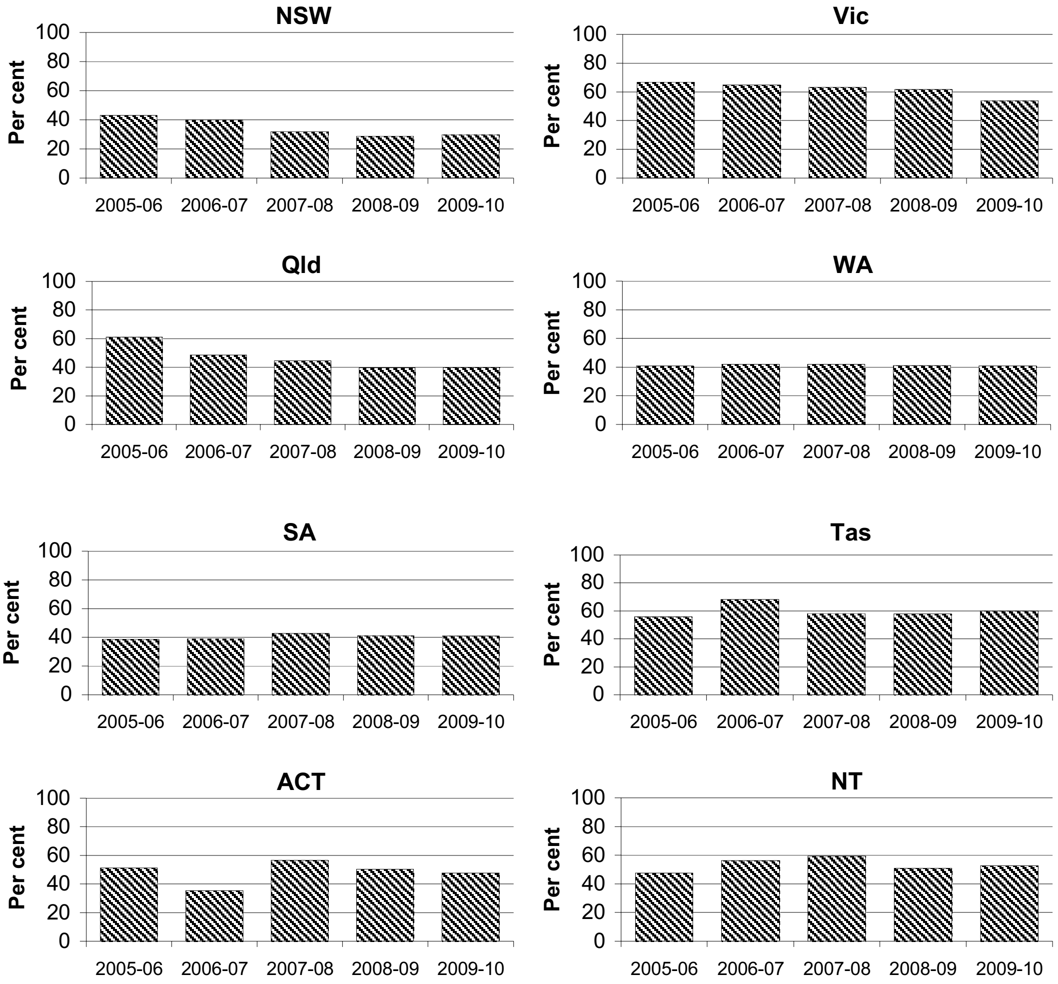
The rate of finalised investigations that were substantiated is influenced by a range of factors and might fluctuate because of policy, funding and practice changes, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.6).

Figure 15.6 **Proportion of finalised child protection investigations that were substantiated**[a, b]



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[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. [b] See source tables for detailed footnotes.

Source: AIHW (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.

Data quality information for this indicator is under development.

Nationally, in 2009-10, 0.7 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, 2009-10[a, b, c]

	Unit	*NSW*	*Vic*	*Qld*[d]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Children in care who were the subject of a substantiation	no.	na	41	228	7	9	23	15	na	323
Children aged 0-17 in at least one care placement during the year	no.	18 967	8 324	8 130	3 537	2 711	1 121	765	820	44 375
Children in care who were the subject of a substantiation as a proportion of all children in care	%	na	0.5	2.8	0.2	0.3	2.1	2.0	na	0.7

[a] Data reported for this indicator are not comparable due to differences in policies, practices and reporting methods. [b] Data are not available for NSW and the NT. [c] See source table for detailed footnotes. **na** Not available. [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.

Source: AIHW (unpublished), *Children in Out-of-Home Care, Australia* 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 2009-10. Data are grouped according to the length of time in care (less than 12 months and 12 months or more).

Box 15.13 **Stability of placement**

'Stability of placement' is defined as the proportion of children who had 1 or 2 placements during a period of continuous out-of-home care.

A low number of child placements (1 or 2) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements and placements with siblings.

Children can have multiple short term placements for appropriate reasons (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better compatibility between a child and family. It is not desirable for a child to stay in an unsatisfactory or unsupportive placement. Also, older children are more likely to have multiple placements as they move towards independence and voluntarily seek alternate placements.

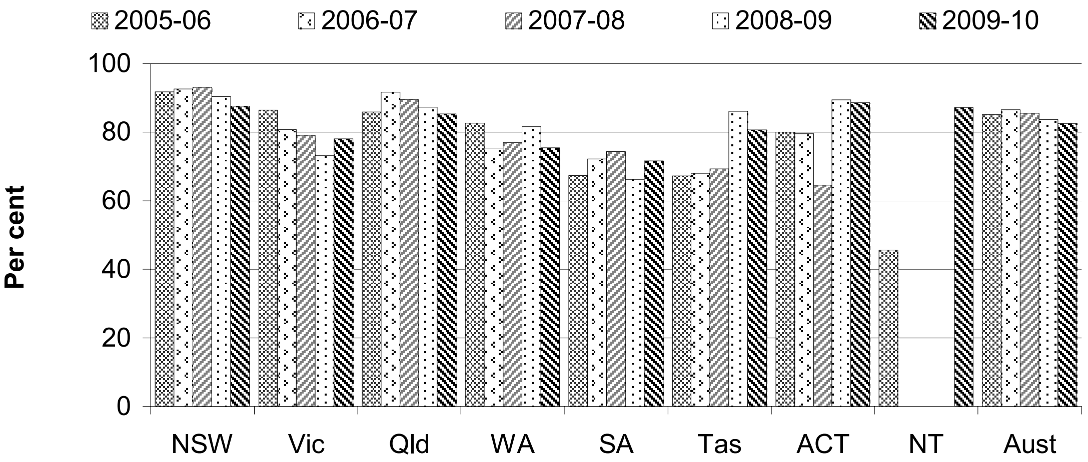
Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using a cohort of children on exit from care rather than longitudinally tracking a cohort of children on their entry into care: an exit cohort is biased to children who stayed a relatively short time in care and thus were more likely to have experienced fewer placements.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, 82.6 per cent of the children on a care and protection order who exited care after less than 12 months in 2009-10 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]

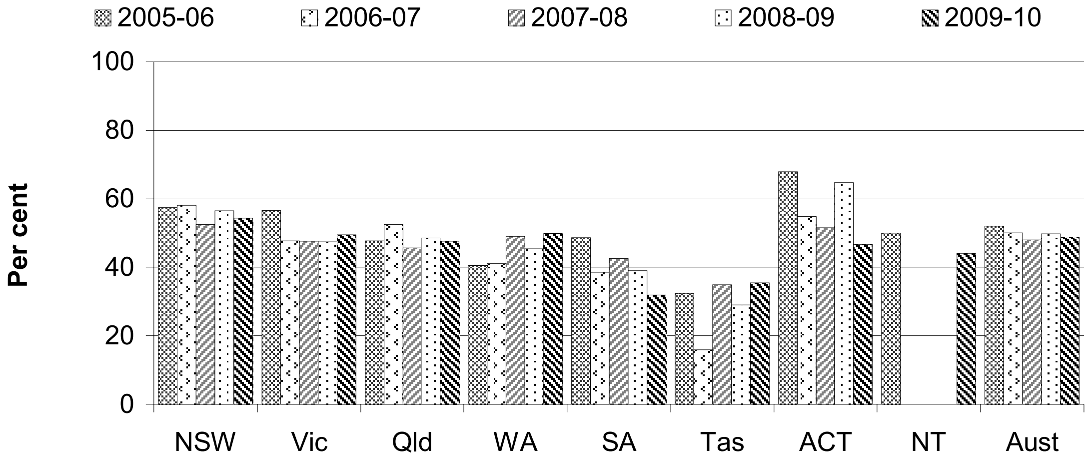


[a] Data refer to children exiting care during the relevant financial year. [b] See source table for detailed footnotes. [c] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. [d] The apparent decline in the proportion for the ACT in 2007-08 was impacted on by the small number of children involved and the placement of large sibling groups. [e] NT data for 2006-07 to 2008-09 were not available.

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 2009-10 after 12 months or more who had experienced 1 or 2 placements was 48.8 per cent nationally but varied across jurisdictions (figure 15.8).

Figure 15.8 **Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements**[a, b, c, d]



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[a] Data refer to children exiting care during the relevant financial year. [b] See source table for detailed footnotes. [c] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. [d] NT data for 2006-07 to 2008-09 are not available.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* 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 recipients (box 15.14).

Box 15.14 **Children aged under 12 years in home-based care**

'Children aged under 12 years in home-based care' is defined as the number of children aged under 12 years placed in home-based care divided by the total number of children aged under 12 years in out-of-home care.

A high or increasing rate for this indicator is desirable. This indicator should be interpreted in conjunction with other placement indicators.

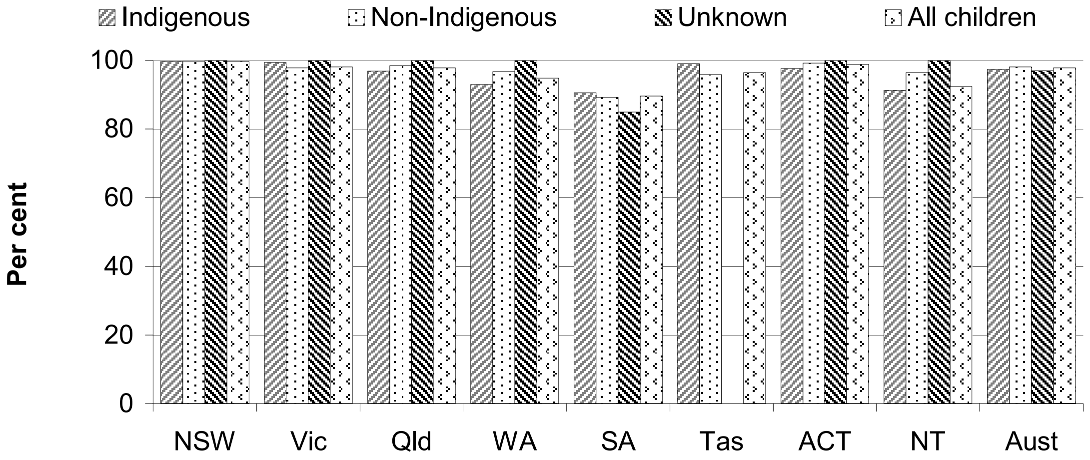
Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential or institutional care environments.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the proportion of all children aged under 12 years in care who were placed in home-based care at 30 June 2010 was 97.9 per cent. In most jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was similar to that of non-Indigenous children (figure 15.9).

Figure 15.9 **Proportion of children aged under 12 years in out-of-home care who were in a home-based placement, by Indigenous status, 30 June 2010**[a]



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[a] See source table for detailed footnotes.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* 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.

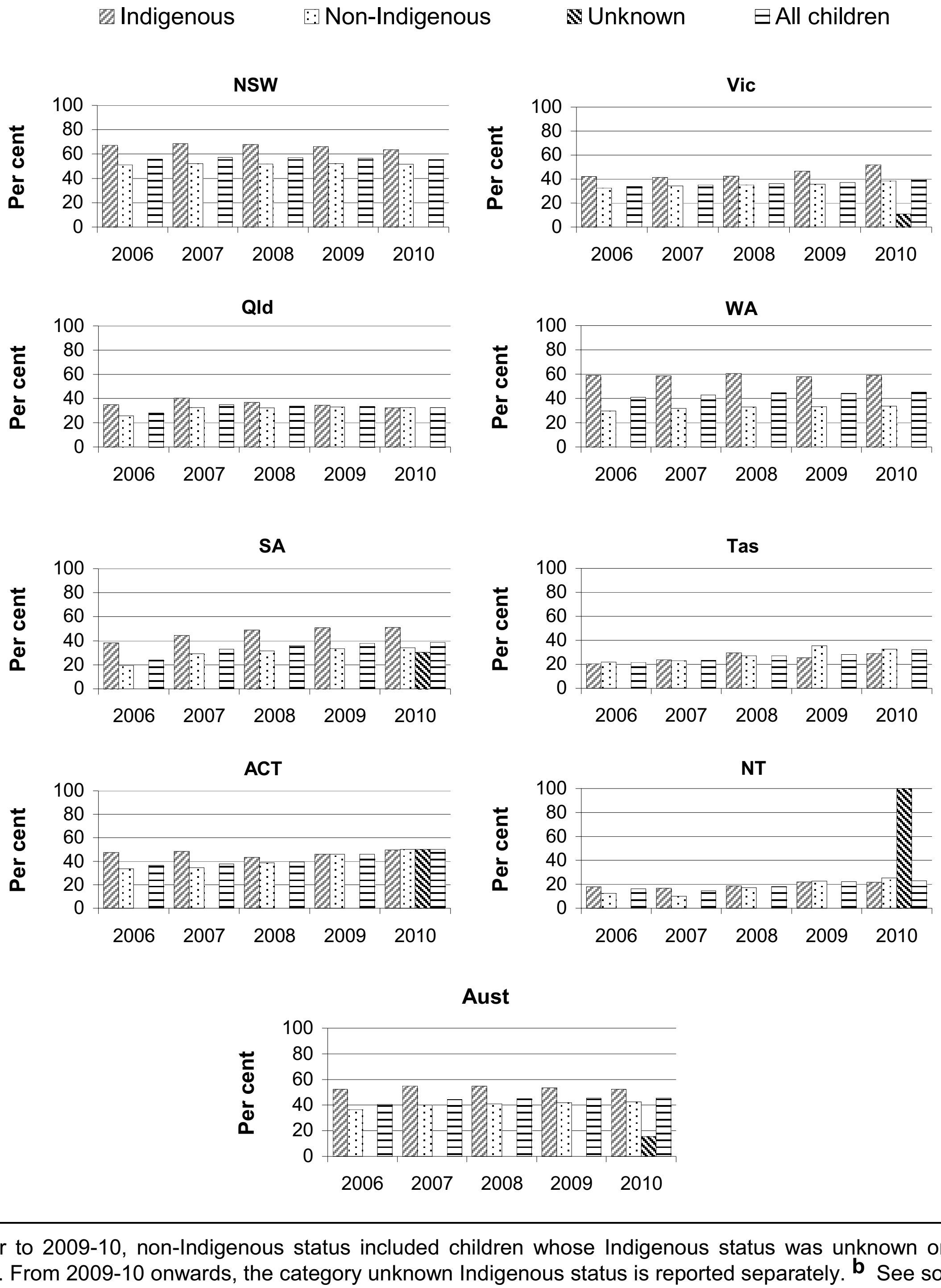
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Figure 15.10 shows the proportion of children placed with relatives or kin by Indigenous status. Although these data are comparable, each jurisdiction is shown separately for simpler presentation. The proportion of children placed with relatives or kin at 30 June 2010 was greater for Indigenous children than for non-Indigenous children in most jurisdictions (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, b, c]



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[a] Prior to 2009-10, non-Indigenous status included children whose Indigenous status was unknown or not stated. From 2009-10 onwards, the category unknown Indigenous status is reported separately. [b] See source table for detailed footnotes. [c] The NT figure of 100 per cent of children of ‘unknown’ Indigenous status in home-based care at 30 June 2010 is for two children who were in care at that time.

Source: AIHW (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.

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 reflect whether the hierarchy was followed in the consideration of the best placement for the child, nor whether consultation was had with appropriate Indigenous individuals or organisations.

A high or increasing proportion of children placed in accordance with the principle is desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997) the following hierarchy of placement options should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child's extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child's Indigenous community
- placement with other Indigenous people.

All jurisdictions have adopted this principle in both legislation and policy.

Nationally, at 30 June 2010, 53.0 per cent of Indigenous children in out-of-home care were placed with relatives/kin (40.6 per cent with Indigenous relatives/kin and 12.4 per cent with non-Indigenous relatives/kin). A further 17.5 per cent of Indigenous children in out-of-home care were placed with other Indigenous carers or in Indigenous residential care (figure 15.11).

The proportion of Indigenous children in out-of-home care at 30 June 2010 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 2010**[a, b, c]

Relative/Kin = Placed with relative/kin. Other Indigenous = Placed with other Indigenous carer or Indigenous residential care. Other = Not placed with relative/kin, other Indigenous carer or Indigenous residential care. [a] Excludes Indigenous children living independently and those whose living arrangements were unknown. [b] Data for Tasmania and the ACT relate to a small number of Indigenous children (138 and 125 respectively) in care at 30 June 2010. [c] See source table for detailed footnotes.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* 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 2011 Report.

Data quality information for this indicator is under development.

Out-of-home care — placement with sibling

‘Placement with sibling’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.18).

Box 15.18 **Placement with sibling**

‘Placement with sibling’ is defined as the proportion of children who are on orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high or increasing rate of placement with siblings is desirable. Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together may not be appropriate.

Data collection for this indicator is under development. Data were not available for the 2011 Report.

Data quality information for this indicator is under development.

Out-of-home care — children with documented case plan

‘Children with documented case plan’ is an indicator of governments’ objective to provide services that meet the needs of the recipients (box 15.19).

Box 15.19 **Children with documented case plan**

‘Children with documented case plan’ is defined as the proportion of children on an order and in out-of-home care who have a documented case plan.

A high or increasing rate is desirable because all children should have a case plan. The quality of a case plan must also be considered as the existence of a case plan does not guarantee that appropriate case work to meet a child’s needs is occurring.

Case planning is essential to structured and purposeful work to support children’s optimal development. Case plans outline intervention goals such as improved parent-child attachments, reunification or other forms of permanency, and set out the means to achieve these goals, such as frequency of family contact and any remedial or special services considered appropriate for the individual child. Case plans also allow for the monitoring of a child’s time in care.

Data collection for this indicator is under development. Data were not available for the 2011 Report.

Data quality information for this indicator is under development.

Out-of-home care — client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of recipients (box 15.20).

Box 15.20 **Client satisfaction**

'Client satisfaction' is yet to be defined.

This indicator has been identified for development and reporting in future.

Some information on jurisdictions' development of initiatives which may assist to measure client satisfaction in the future is included in box 15.8.

Efficiency

Understanding the efficiency of child protection systems broadly — and the different components of child protection systems, such as early intervention and out-of-home care services — enables State and Territory governments to identify key service cost drivers. Efficiency measures coupled with outcome measures ultimately enable State and Territory governments to compare the relative cost effectiveness of broad system approaches and the cost effectiveness of different components of child protection systems.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services have several limitations, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments. This has resulted in variations in the processes and emphases placed on different service delivery paradigms, such as different approaches to diversionary options
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify resources directed specifically to child protection services, out-of-home care services and other support services for families. This is due in part to the historic structure of information systems and the embedding of government agencies responsible for child protection services within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

As a result of these limitations, cost allocations reflect the historic nature of information systems and do not necessarily provide an accurate reflection of the costs involved in provision of various child protection and out-of-home care services.

In April 2002, the Review initiated a project to improve efficiency data for a national framework of protection and support pathways (the 'Pathways' project) (box 15.21). Until this can be fully implemented, reporting on efficiency has been limited to proxy indicators (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.

(Continued on next page)

Box 15.21 **(Continued)**

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).

Experimental data relating to the proportion of expenditure across each activity group are included in table 15.2. These data are preliminary and are subject to further analysis and refinement for future Reports. Experimental unit cost data for four Pathways activity groups are presented in table 15.3. Due to different internal management systems, there can be significant variation across jurisdictions in relation to specific activities or expenditures that are included in each activity group.

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 proportion of expenditure allocated to Activity group 8 (Out-of-home care) is the most significant and varies from 35 per cent to 62 per cent across reporting jurisdictions.

Table 15.2 Proportion of expenditure by activity group — experimental estimates (per cent)[a, b, c]

	AG1	*AG2*[d]	*AG3*	*AG4*	*AG5*	*AG6*	*AG7*	*AG8*	*Total*[d]
NSW (2009-10)	5	15	8	9	7	3	7	45	**100**
Vic (2005-06)	3	24	4	5	4	7	8	44	**100**
Qld (2009-10)	4	4	10	5	8	8	9	53	**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**
Tas (2009-10)[f]	3	8	7	8	3	16	21	35	**100**
ACT (2009-10)	5	11	7	3	2	5	5	62	**100**
NT (2009-10)	na	na	na	na	na	na	na	na	**100**

AG = Activity Group (box 15.21). [a] Data are rounded to the nearest whole number. Totals may not add to 100 due to rounding. [b] Participating jurisdictions' experimental data relate to expenditure allocations across different years. AG definitions have been refined over time, therefore, experimental estimates from earlier years are not strictly comparable with more recent data. [c] Experimental percentage allocations are derived from total expenditure allocations which vary from totals used to derive costs presented elsewhere in the chapter. [d] Expenditure items included in calculating proportional expenditure for AG2 can vary across jurisdictions, for example the inclusion/exclusion of expenditure on services outsourced to non-government organisations. [e] The WA Department for Communities funds and provides a substantial amount of AG2 services. These data are not included in the above estimates. It is anticipated that these data will be included in future years. [f] The allocation of indirect expenditure in Tasmania was based on a survey of only one region. There is a need for the survey to be repeated at a State-wide level to reduce the possibility of regional differences distorting results. **na** Not available.

Source: State and Territory governments (unpublished).

Table 15.3 presents experimental unit cost data for four activity groups. Unit cost data will be provided for remaining activity groups once appropriate activity data are agreed.

Table 15.3 **Activity group unit costs — experimental data**[a, b]

	Unit	*NSW*[c]	*Vic*	*Qld*[c]	*WA*[d]	*SA*	*Tas*[c]	*ACT*[c]	*NT*
AG1-Cost per notification[e]	$	435	na	1 047	1 809	na	195	165	na
AG2[f]	$	na	na	na	na	na	na	na	na
AG3 [f]	$	na	na	na	na	na	na	na	na
AG4-Cost per investigation[g]	$	1 129	na	1 316	4 446	na	2 811	575	na
AG5 [f]	$	na	na	na	na	na	na	na	na
AG6-Cost per order issued	$	8 811	na	7 047	5 427	na	6 600	3 177	na
AG7 [f]	$	na	na	na	na	na	na	na	na
AG8-Cost per placement night[h]	$	111	na	129	129	na	70	120	na

AG = Activity Group (box 15.21). [a] Data are rounded to the nearest whole number. [b] Experimental unit costs are based on jurisdictions' total expenditure for each activity group, including direct and indirect costs such as staffing, other overheads etc. [c] Experimental data relate to the 2009-10 financial year. [d] Experimental data relate to the 2008-09 financial year. [e] Jurisdictions count notifications at different points in response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications and hence the unit cost for notifications is not comparable across jurisdictions. [f] Unit costs for AGs 2, 3, 5 and 7 will be included once appropriate counting rules are agreed. [g] Jurisdictions differ in the way notifications and investigations are defined and the requirements for conducting an investigation. [h] Cost per placement night should be interpreted with caution due to the effect of different proportions of children in residential out-of-home care across jurisdictions. **na** Not available.

Source: State and Territory governments (unpublished).

Total expenditure on all child protection activities per notification, investigation and substantiation

'Total expenditure on all child protection activities, per notification', 'total expenditure on all child protection activities, per investigation', and 'total expenditure on all child protection activities, per substantiation' are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of public resources (box 15.22).

Box 15.22 **Total expenditure on all child protection activities per notification, investigation and substantiation**

'Total expenditure on all child protection activities per notification, investigation and substantiation' is defined as:

- total expenditure on all child protection activities divided by the number of notifications
- total expenditure on all child protection activities divided by the number of investigations
- total expenditure on all child protection activities divided by the number of substantiations.

Low or decreasing expenditure per notification/investigation/substantiation can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care. Because each of these proxy indicators is based on total expenditure on child protection activities, they do not represent, and cannot be interpreted as, unit costs for notifications, investigations or substantiations. These proxy indicators cannot be added together to determine overall cost of child protection services.

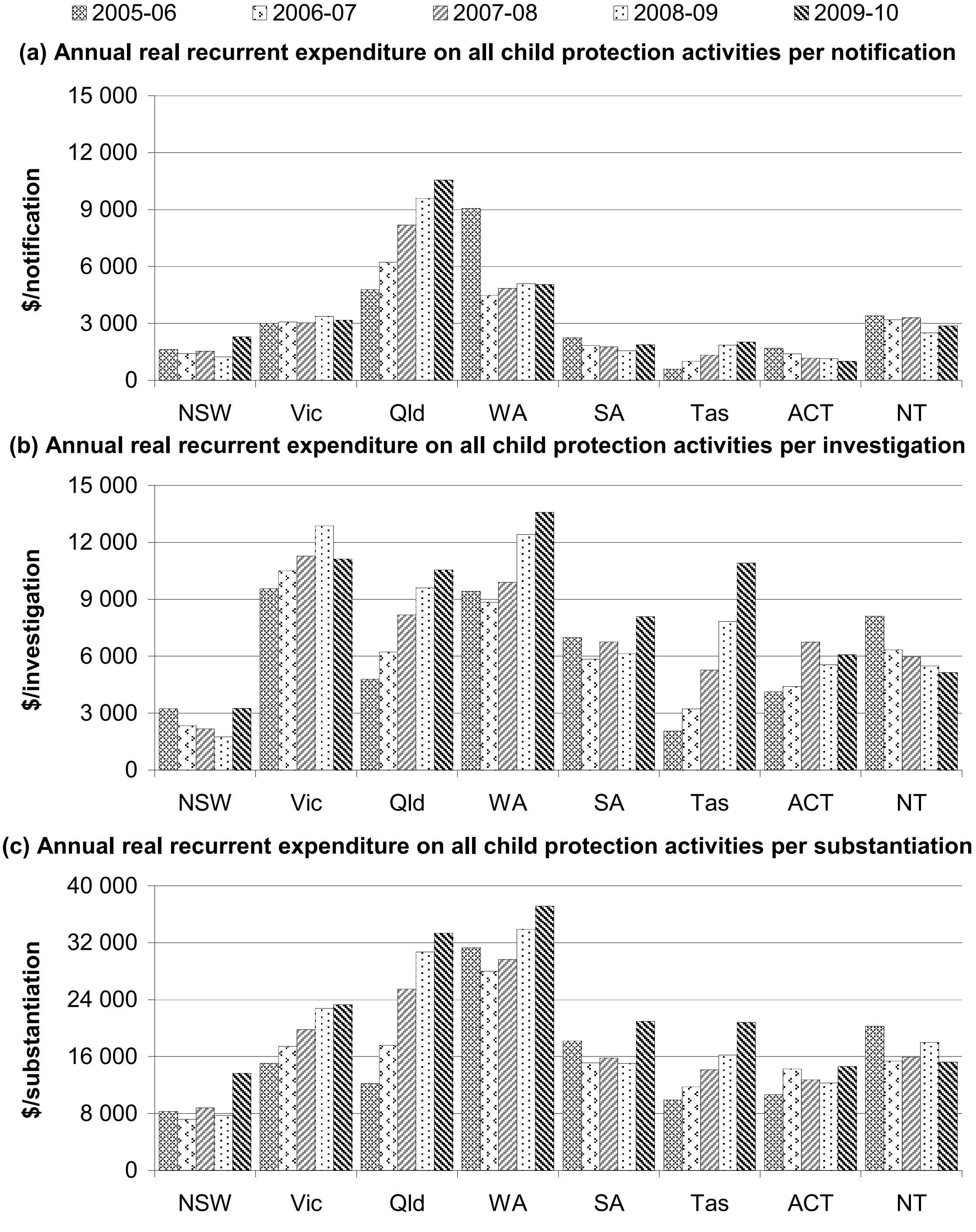
More comprehensive and accurate efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is underway to develop a national activity-based costing method, the Pathways project, that will allow this type of reporting from existing information systems (box 15.21). Experimental data using the Pathways method are included in Table 15.3. The following proxy data will be replaced by Pathways unit cost data once the Pathways method is refined and implemented nationally.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total expenditure on all child protection activities per notification, per investigation and per substantiation from 2005-06 to 2009-10 varied across jurisdictions (figure 15.12).

Figure 15.12 **Child protection efficiency indicators (2009-10 dollars)**[a, b]



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[a] Real expenditure based on ABS gross domestic product price deflator (2009-10 = 100) (table AA.26). [b] See source table for detailed 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.

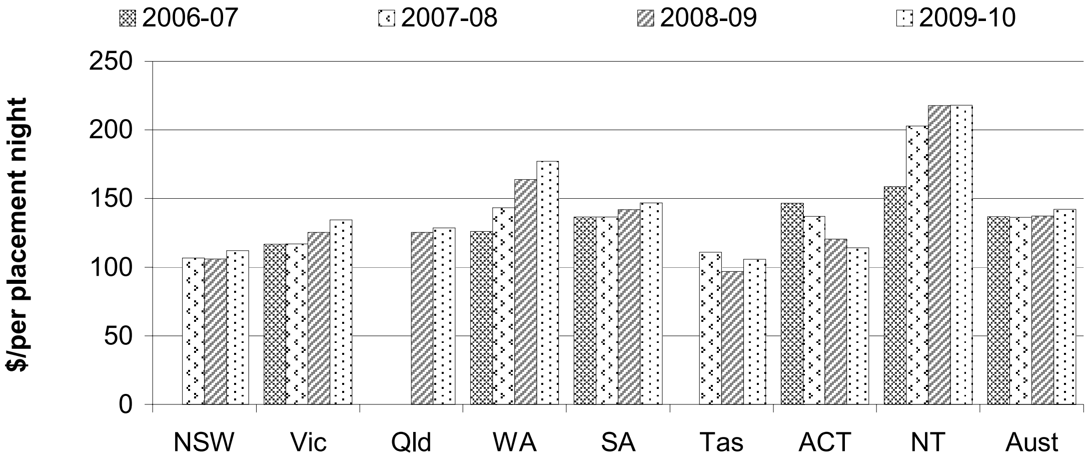
Low or decreasing expenditure per placement night can suggest more efficient services but may indicate lower service quality or different service delivery models. Further, in some cases, efficiencies may not be able to be realised due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Out-of-home care expenditure per placement night varied across jurisdictions (figure 15.13).

Figure 15.13 **Out-of-home care expenditure per placement night (2009-10 dollars)** [a, b, c]



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[a] These data should not be interpreted as unit costs for Activity Group 8 as they are derived using reported program expenditure and not activity group expenditure. [b] Caution should be used when interpreting results due to the variety of activities included in out-of-home care services. [c] See source table for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.32.

These indicative unit costs are derived using total real recurrent program expenditure on out-of-home care services (table 15A.1) and not expenditure allocated to an activity group.

Total expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care

'Total expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care' are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of public resources (box 15.24).

Box 15.24 **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.

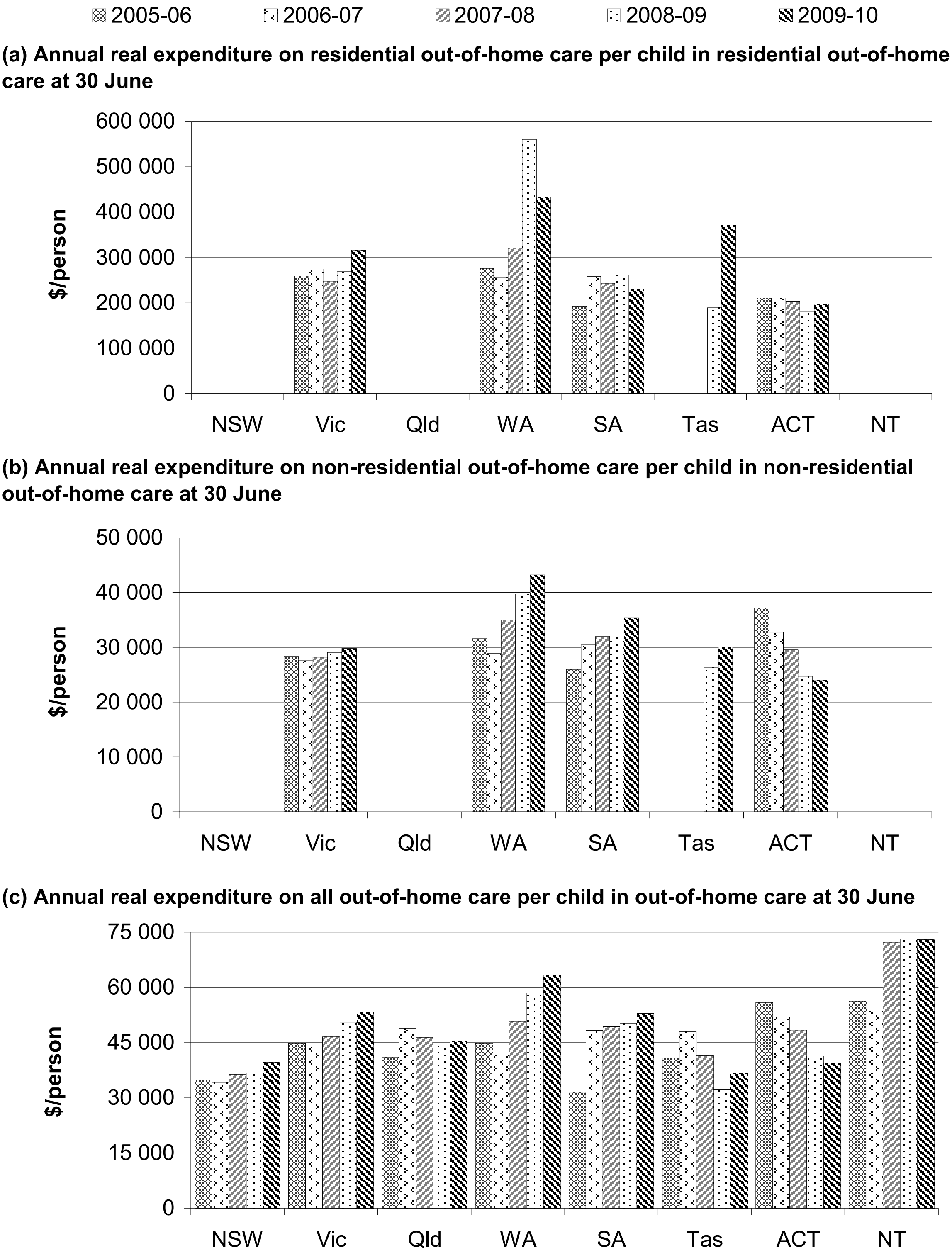
Low or decreasing expenditure per child in care can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care as they do not represent a measure of unit costs. Expenditure per child in 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.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total expenditure on residential care and non-residential care for the period 2005-06 to 2009-10, per child in residential care and non-residential care at 30 June, varied across jurisdictions (figures 15.14(a) and figure 15.14(b)). Total expenditure on all out-of-home care per child in care at 30 June for 2005-06 to 2009-10 also varied across jurisdictions (figure 15.14(c)).

Figure 15.14 **Out-of-home care efficiency indicators (2009-10 dollars)** a, b, c



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[a] Real expenditure based on ABS gross domestic product price deflator (2009-10 = 100) (table AA.26). [b] NSW, Queensland, and the NT could not disaggregate expenditure on out-of-home care. Tasmania could only disaggregate these data from 2008-09 onwards. [c] See source table for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

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

Improved safety — substantiation rate after decision not to substantiate

'Improved safety — 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.

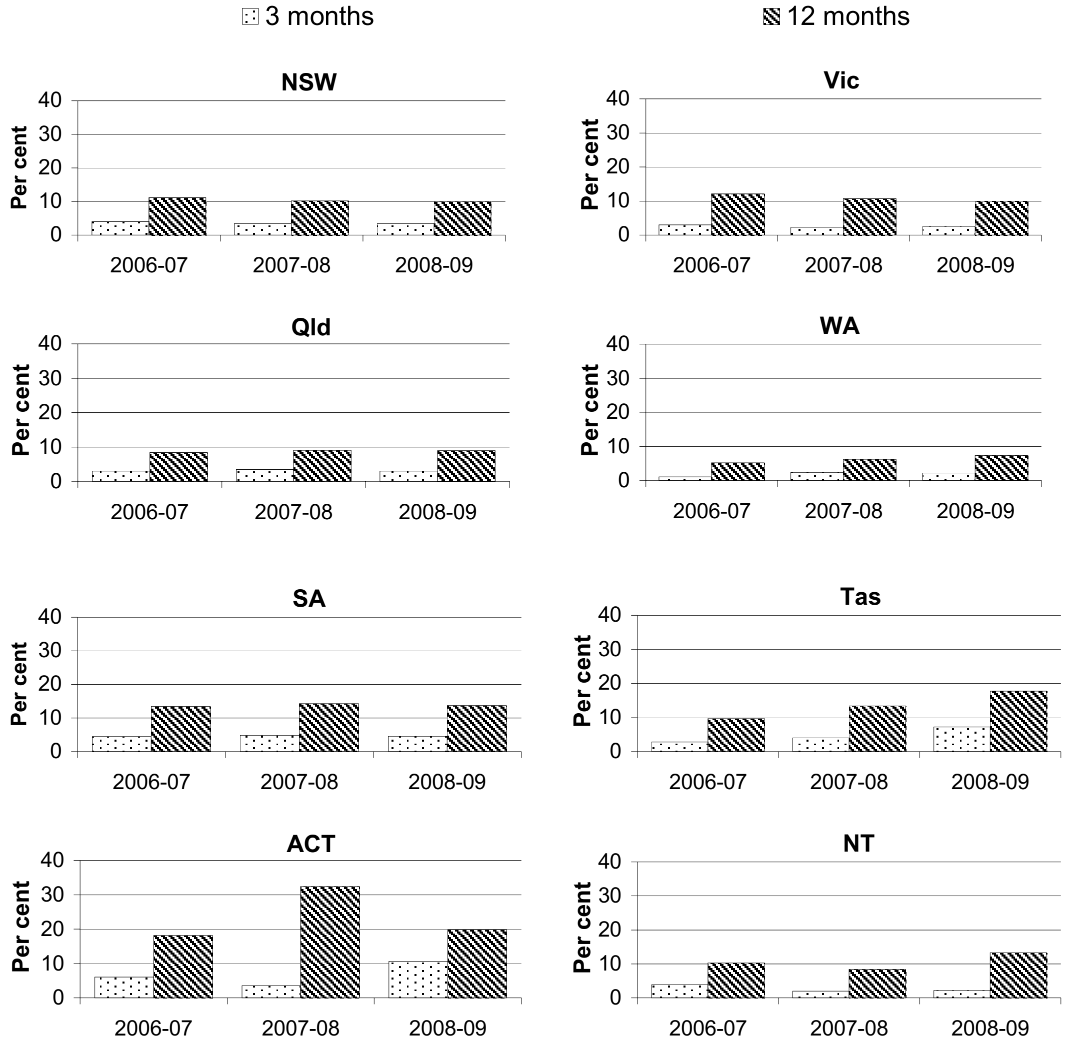
A low or decreasing rate for this indicator is desirable. However, reported results can be affected by the finalisation of investigations, factors beyond the control of child protection services, or a change in circumstances after the initial decision not to substantiate was made. A demonstrable risk 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 quality information for this indicator is under development.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.15).

Figure 15.15 **Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiate**[a, b, c]



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[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. [b] 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. [c] See source tables for detailed footnotes.

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 after a prior substantiation

'Improved safety — resubstantiation rate after a prior substantiation' 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 after a prior substantiation**

'Improved safety — resubstantiation rate after a prior substantiation' is defined as the proportion of children who were the subject of a substantiation in the previous financial year, who were subsequently the subject of a further substantiation within the following 3 or 12 months. The year reported relates to the year of the original substantiation.

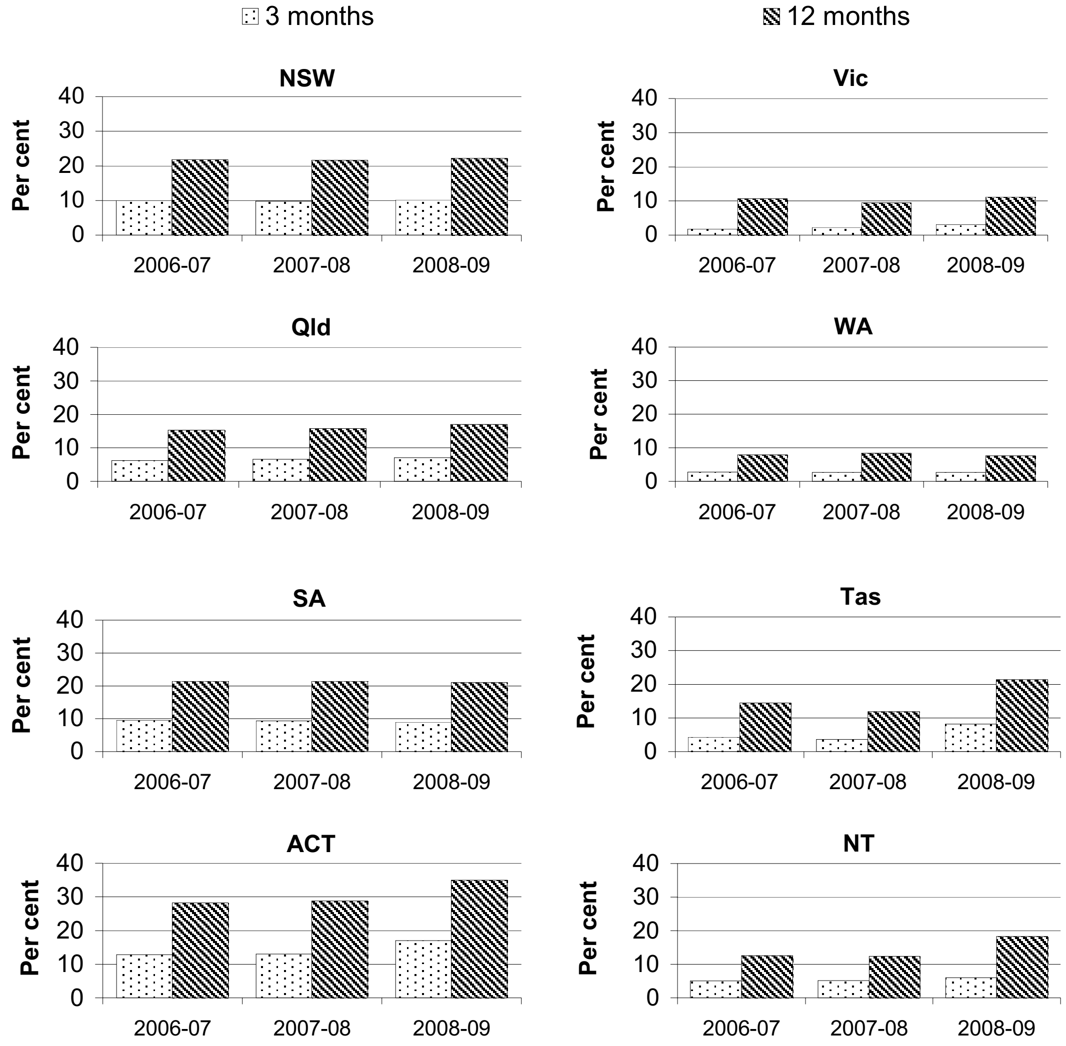
A low or decreasing rate for this indicator is desirable. This indicator partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm. However, reported results can be affected by the finalisation of investigations or factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm). This indicator should be considered with other outcome indicators.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.16).

Figure 15.16 Improved safety — resubstantiation rate within 3 or 12 months of a prior substantiation[a, b, c]



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[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. [b] 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. [c] See source table for detailed footnotes.

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 of children on guardianship or custody orders.

A high or increasing rate at which children’s educational outcomes are improving is desirable.

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.

Data quality information for this indicator is under development.

For the 2011 Report, data are reported for the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving national reading and numeracy benchmarks in 2003, 2004, 2005 and 2006 relative to all children (attending government and non-government schools). The proportion of children on guardianship or custody orders achieving national reading and numeracy benchmarks in 2003, 2004, 2005 and 2006 varied significantly across jurisdictions (see tables 15A.11–15A.13). However, with few exceptions, the proportion of children on orders achieving national reading and numeracy benchmarks was less — at times significantly less — than all students.

Safe return home

‘Safe return home’ is an indicator of governments’ objective to remove the risk of harm to the child while maintaining family cohesion (box 15.28).

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 has initiated a number of national projects to improve the gaps in child protection reporting and to monitor the comparability of child protection data. Such projects, approved by the National Community Services Information Management Group (NCSIMG) and funded by the Community and Disability Services Ministerial Council (CDSMC), include: Educational Outcomes for Children on Orders; Scoping of a Treatment and Support Services data collection; and the development of a unit-record based Carer data module. It is expected that these projects, along with the development of a child based unit-record data collection, will improve child protection reporting.

COAG developments

National framework for protecting Australia's children 2009—2020

On 30 April 2009, COAG endorsed *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020* ("the National Framework"). The National Framework argues that Australia needs to move from seeing 'protecting children' as a response to abuse and neglect to one of promoting the safety and wellbeing of children. The National Framework is intended to deliver a more integrated response to protecting Australia's children and emphasises the role of government, the non-government sector, and the community in promoting the safety and wellbeing of children.

The National Framework 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.

National standards for out-of-home care

Under the National Framework, Australian governments have committed to developing and implementing National Standards for Out-of-Home Care ("the National Standards"). In early-2010, national consultations were undertaken in all capital cities, and five regional locations, to inform the development of the National Standards. In June 2010, Community and Disability Services Ministers agreed to finalise a working document comprising draft National Standards for community consultation. The draft working paper was released in July 2010 (National Framework Implementation Working Group, Community and Disability Services Ministers Advisory Council 2010).

The draft National Standards relate to areas impacting on the outcomes and experiences of children in out-of-home care, including health, education, case planning, connection to family, transitioning from care, training and support for carers, belonging and identity, and stability and safety. The Steering Committee will keep a watching brief on the development of the National Standards, particularly insofar as identifying ways in which the Report's child protection and out-of-home care performance indicator framework can reflect and report consistently with the National Standards.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the Report in December 2009. Those recommendations implemented during 2010 are reflected in the Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework’ and the ‘Review of the performance indicators and their associated measures’. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables where 10 year time series are not yet reported
- developing data quality information documents for performance indicators
- developing mini-case studies.

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 intended to reduce and prevent crime
- non-government and community service providers who may work with juvenile justice agencies to provide services and programs for young people under supervision.

The majority of young people who come into contact with the juvenile justice system do not become clients of statutory juvenile justice agencies. Instead, young people are diverted through a range of mechanisms including contact with police (who have the authority to issue warnings, formal cautions and infringement notices for minor offences) and the courts (which can issue non-supervised orders for minor offences).

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 15.30).

Roles and responsibilities

Responsibility for the provision of juvenile justice services in Australia resides with State and Territory governments. The relevant department in each State and Territory responsible for funding and/or providing juvenile justice services in 2009-10 is listed in box 15.30. 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). The AJJA is a Standing Committee of the Community and Disability Services Ministerial Advisory Council (CDSMAC).

Box 15.30 **Government departments responsible for the delivery of juvenile justice services**

NSW	Department of Human Services (DHS)
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 6.3).

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 2008-09, 12 197 young people experienced juvenile justice supervision in Australia. Of these young people, 10 835 experienced community-based supervision, 4714 experienced detention-based supervision, with some young people experiencing both (AIHW forthcoming).[1] During 2008-09, 140 young people experienced juvenile justice detention-based supervision in the NT (NT government unpublished).

Nationally, 88.6 per cent of young people aged 10–17 years who were supervised by juvenile justice services on 30 June 2010 were in the community (figure 15.17). These data do not include juveniles aged 10–17 years who were supervised in the adult correctional system. Further, 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.

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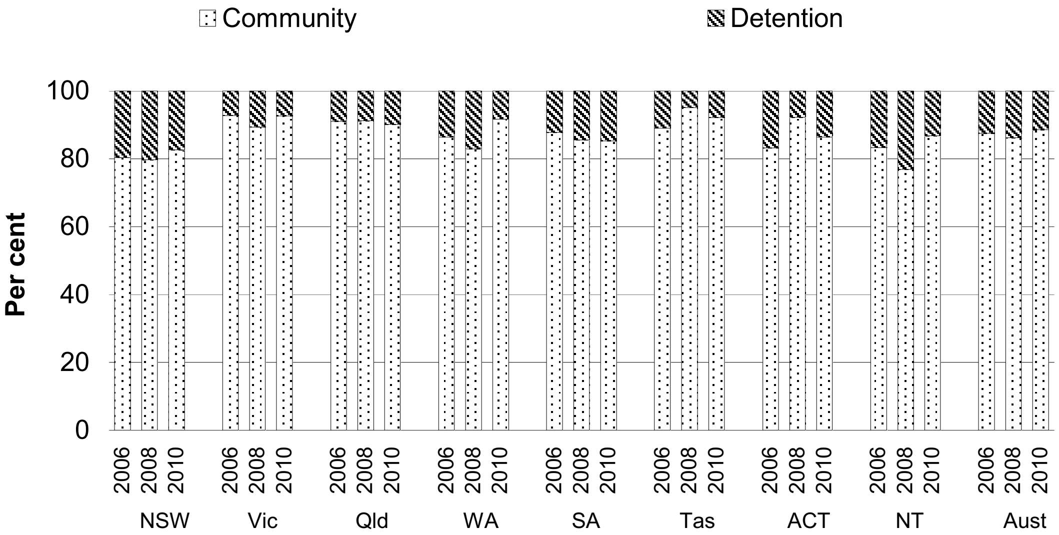
[1] These Australian totals exclude WA and the NT.

Figure 15.17 Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres, at 30 June[a]



[a] 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 numbers and rates reported.

Nationally, the daily average number of people aged 10–17 years in juvenile detention centres increased from 646.8 to 771.0 between 1999-2000 and 2008-09 (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*
2008-09	361.3	63.3	110.0	128.5	47.0	25.0	10.8	25.3	771.0
2007-08	338.0	63.0	143.3	154.0	55.0	24.0	13.3	23.8	814.3
2006-07	276.5	48.0	138.0	131.5	41.8	19.3	14.3	26.3	695.5
2005-06	243.8	52.5	126.8	115.0	39.0	26.5	12.8	17.3	633.5
2004-05	218.0	52.5	89.0	109.8	57.8	32.5	14.5	21.5	595.5
2003-04	209.0	61.5	90.8	121.5	49.5	26.3	17.8	13.3	589.5
2002-03	220.0	63.8	96.0	106.3	65.3	24.8	16.5	23.5	616.0
2001-02	216.5	62.3	88.5	107.5	55.5	26.8	17.3	15.8	590.0
2000-01	222.5	61.8	87.0	103.0	59.3	43.3	17.0	17.0	610.8
1999-00	251.3	63.3	111.5	116.3	47.3	31.3	11.0	15.0	646.8

[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.

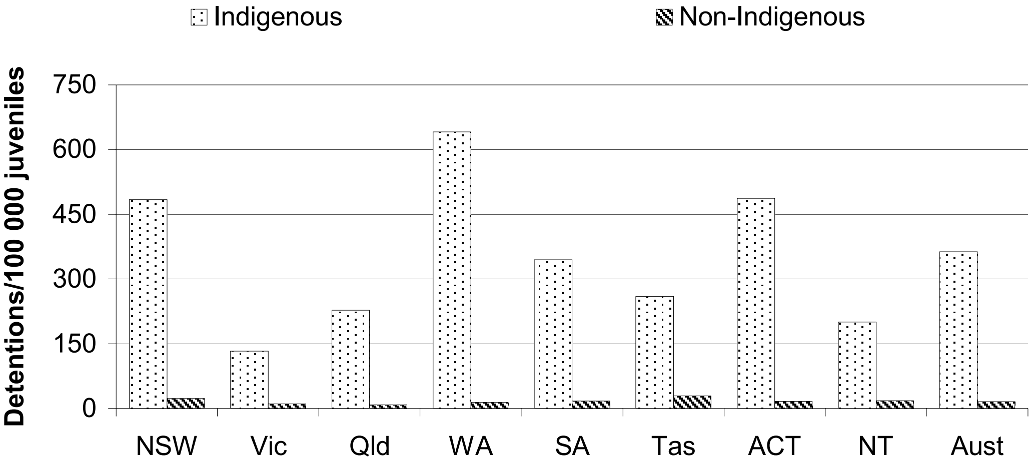
The average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years increased from 30.4 per 100 000 in 1999-2000 to 33.8 per 100 000 in 2008-09, with rates varying across jurisdictions (table 15A.171).

Nationally, females made up 8.5 per cent of the total population of juvenile detention centres at 30 June 2009. Males made up 91.5 per cent of the total population of juvenile detention centres at 30 June 2009 (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 411.5 in 2008-09 (table 15A.173). Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2008-09 was 370.9 per 100 000 Indigenous people aged 10–17 years. The rate for the non-Indigenous population aged 10–17 years in 2008-09 was 16.1 per 100 000 non-Indigenous people aged 10–17 years (table 15A.174). The over-representation of Indigenous young people in detention across jurisdictions in 2008-09 is shown in figure 15.18.

Figure 15.18 **Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people, 2008-09**[a, b]



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[a] Rates of detention for Indigenous and non-Indigenous people in NSW in each quarter in 2008-09 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 15.31).

Box 15.31 **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.

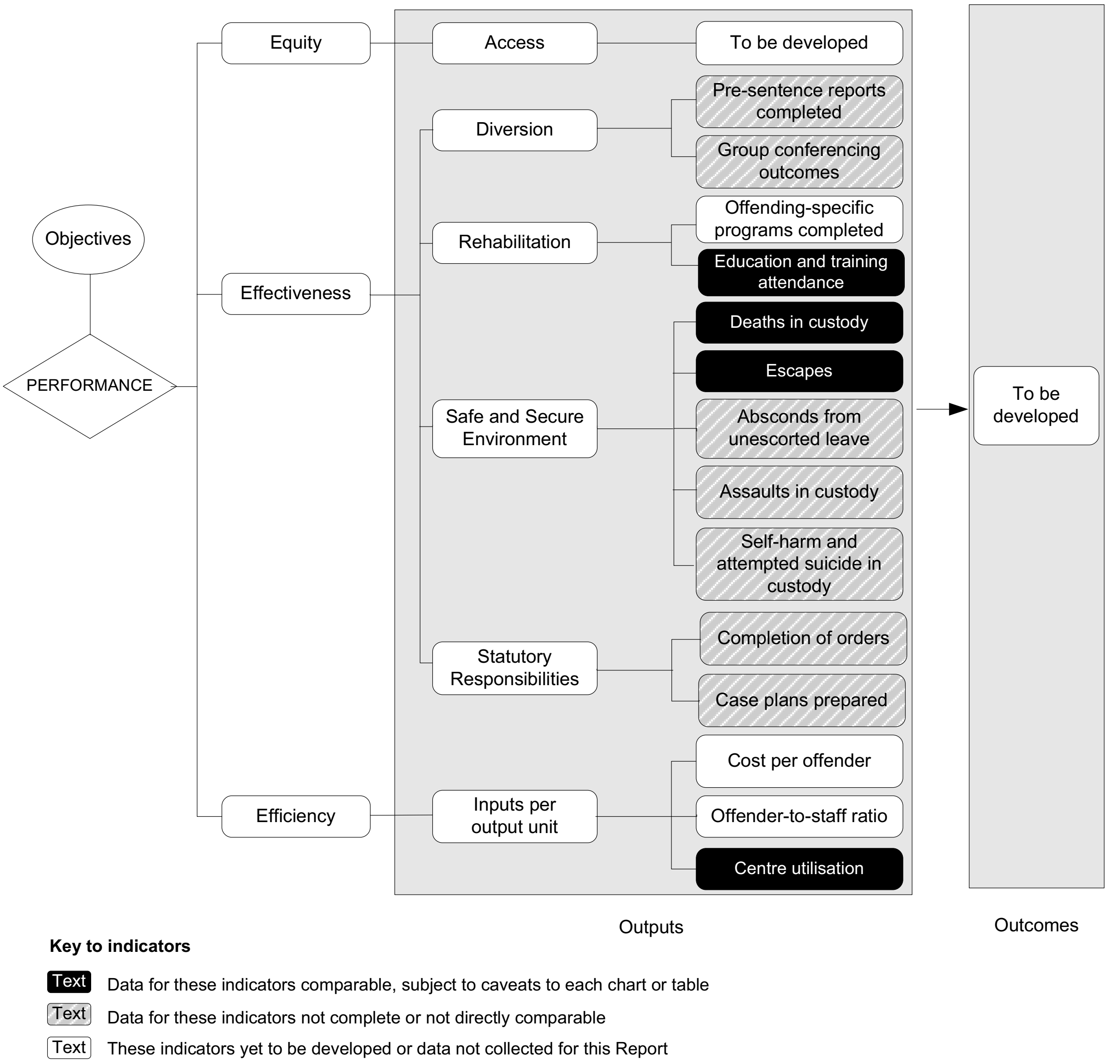
Juvenile justice services should be provided in an equitable, efficient and effective manner.

A performance indicator framework for juvenile justice services was included for the first time in the 2009 Report (figure 15.19). Further development of the framework and reporting for indicators included in the framework is being undertaken according to a staged process. Data for 11 performance indicators are included in this Report along with supporting text which includes relevant caveats and commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

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 15.19 Performance indicators for juvenile justice services



Outputs

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

Equity and access

Equity and access indicators are a key area for further development in future reports. These will be indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources. These indicators are under development.

Effectiveness

Diversion — pre-sentence reports completed

'Pre-sentence reports completed' is an indicator of governments' objective to ensure that accurate and timely advice is provided to the court to inform decision-making (box 15.32).

Box 15.32 **Pre-sentence reports completed**

'Pre-sentence reports completed' is defined as the number of written reports provided by juvenile justice agencies to a court in response to a request for a pre-sentence report, as a proportion of all court requests to juvenile justice agencies for written pre-sentence reports.

A pre-sentence report is a written report that provides a court with pertinent information about the assessed factors that contributed to a young person's offence and explores programs and services that could be provided to address a young person's offending behaviour. A pre-sentence report is prepared when ordered by a court after a young person has pleaded or has been found guilty of an offence.

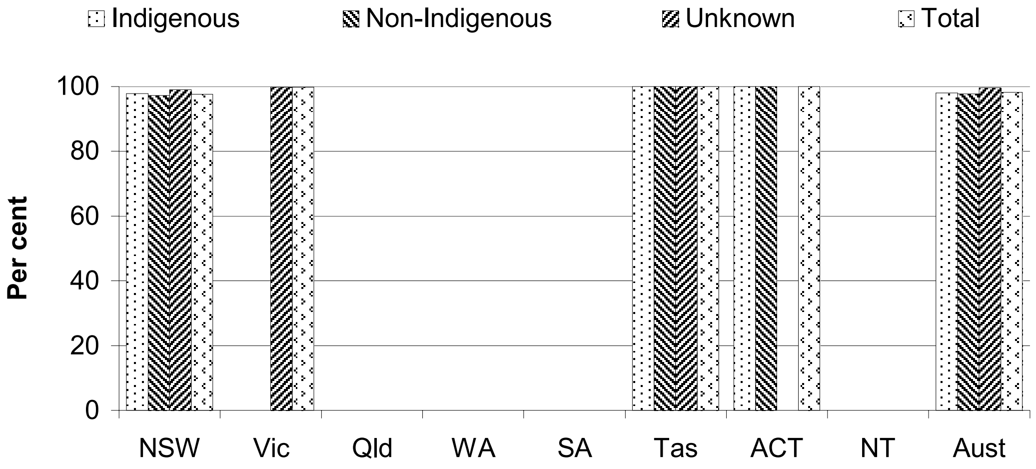
A high or increasing percentage of pre-sentence reports completed is desirable.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

The percentage of pre-sentence reports completed varied across jurisdictions (figure 15.20). Nationally, 98.3 per cent of all court requests for pre-sentence reports were completed.

Figure 15.20 Proportion of pre-sentence reports completed by juvenile justice agencies, by Indigenous status (2009-10)[a, b, c, d]



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[a] Data were not available for SA and the NT. [b] Queensland could not provide the denominator for this indicator, hence proportions could not be calculated. [c] WA data were affected by a time lag which resulted in an artificially greater number of completed court reports than requests for court reports. Consequently, these data are excluded from the national average. [d] Refer to table 15A.176 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.176.

Diversion — group conferencing outcomes

'Group conferencing outcomes' is an indicator of governments' objective to divert young people from the juvenile justice system and address their offending needs (box 15.33).

Box 15.33 **Group conferencing outcomes**

'Group conferencing outcomes' is defined as the number of young people who receive group conferencing and who as a result reach an agreement, as a proportion of all young people who receive group conferencing.

A high or increasing rate for this indicator is desirable.

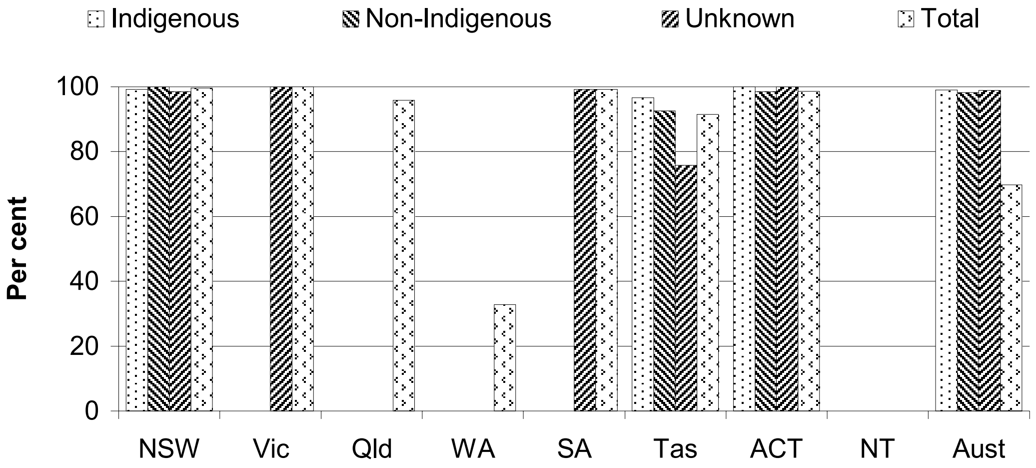
Group conferences are decision-making forums that aim to minimise the progression of young people into the juvenile justice system, and provide restorative justice. Data for this indicator should be interpreted with caution as the provision of group conferencing differs across jurisdictions in relation to: (a) its place in the court process (for example, whether young people are referred by police before court processes begin, or by the court as an alternative to sentencing), (b) the consequences for young people if they do not comply with the outcome plans of a conference, and (c) eligibility for group conferencing.

Data reported for this indicator are not complete.

Data quality information for this indicator is under development.

The proportion of group conferences resulting in an agreement varied across jurisdictions (figure 15.21). Nationally, 69.8 per cent of all concluded group conferences resulted in an agreement.

Figure 15.21 **Proportion of group conferences resulting in an agreement, by Indigenous status (2009-10)**[a, b, c]



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[a] Data were not available for the NT. [b] WA and Qld were able to disaggregate the number of concluded group conferences by Indigenous status, but not the number of group conferences resulting in an agreement by Indigenous status. Therefore, proportions are only calculated for the total number of group conferences resulting in agreement for these jurisdictions. Further, with the exception of the total number of concluded group conferences and total number of group conferences resulting in agreement, disaggregated data for WA and Qld are excluded from national totals. [c] Refer to table 15A.177 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.177.

Rehabilitation — offending-specific programs completed

‘Offending-specific programs completed’ is an indicator of governments’ objective to provide program interventions that are designed to rehabilitate young offenders and reintegrate them into their community (for example, the Changing Habits and Reaching Targets program, drug counselling programs, sex offender treatment programs) (box 15.34).

Box 15.34 **Offending-specific programs completed**

‘Offending-specific programs completed’ is defined as the percentage of young people who completed an offending-specific program while completing a supervised sentenced order (whether a community-based order or a detention order) as a proportion of all young people completing a supervised sentenced order who were assessed as requiring an offending-specific program to address their criminogenic behaviour.

A high or increasing rate of offending-specific programs completed is desirable.

Data for this indicator were not available for the 2011 Report. Offending-specific programs data are expected to be available for inclusion in the 2012 Report.

Data quality information for this indicator is under development.

Box 15.35 provides information regarding offending-specific programs in operation in each jurisdiction.

Box 15.35 **Offending-specific programs**

NSW	The Violence Offender Program (VOP) addresses the criminogenic needs of violent offenders, thereby reducing their offending behaviours, contact with the justice system and rates of recidivism. The Sexual Offending Program (SOP) provides comprehensive, individualised assessment for adolescents convicted of offences of a sexual nature, as well as individual and group interventions. The Alcohol and Other Drug (AOD) Program aims to address the needs of clients whose pattern of alcohol and other drug use is related to their offending behaviour. The Intensive Supervision Program (ISP) focuses on juveniles who commit serious and/or repeat offences, or whose severe antisocial behaviour increases their likelihood of offending. ISP is based on the Multisystemic Therapy Model that has delivered significant reductions in the long-term rates of re-offending in Western Australia, New Zealand, the US, Canada and nine countries throughout Europe. ‘Dthina Yuwali’ is an Aboriginal-specific staged AOD program based on the relationship between substance use and pathways to offending.

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Box 15.35 **(Continued)**

Vic Victoria offers a range of offending-specific programs in conjunction with a comprehensive individualised case planning framework (including assessment and client service planning). ‘Changing Habits and Reaching Targets’ (CHART) is a structured intervention program which challenges offending behaviour. CHART is used as part of casework intervention with individuals or in small groups. The ‘Male Adolescent Program for Positive Sexuality’ is an intensive individual, group and family treatment program for young people found guilty of sexual offences. The ‘Be Real About Violence’ and ‘Relationships and Violence’ programs address violent offending and related behaviours by increasing offenders’ understanding of patterns of violence and by their pro-social coping skills. The ‘Motor Vehicle Offending Program’ is provided in conjunction with the Transport Accident Commission and Road Trauma Support Unit. It addresses specific behaviours related to motor vehicle offences. Victoria is also currently developing a program that addresses knife offending.

Qld In the Queensland youth justice system, a young person’s risk, needs and protective factors are assessed using the Youth Level of Service Case Management Inventory (YLS-CMI) to determine both suitability for programs and outcome efficacy. Queensland has implemented two State-wide programs in regional service centres and in youth detention that address offending behaviour — CHART and ‘Aggression Replacement Training’ (ART). Both programs are informed by a sound evidence base and are being evaluated. Additionally, Queensland’s two youth detention centres and 16 youth justice service centres develop tailored offending-specific programs that must align with the Queensland Youth Justice Intervention Framework. This framework details the process for the development, implementation and evaluation of programs at a service level. The framework encompasses developmental interventions, support services, court orders and bail support interventions for delivering holistic responses to young people.

WA WA offers a range of offending-specific programs to address the needs of young offenders. Programs are run on an as needs basis according to suitability criteria for specific programs. Examples of the offending-specific programs provided in WA include: ‘Healthy Relationships’, which explores adolescent relationships and issues such as sexism, stereotypes and consent; ‘Protective Behaviours’, which examines safety warning signs and discusses who young people can turn to for help; ‘Drumbeat’, a therapeutic program which incorporates music; and other conflict, parenting and sex education programs. These programs can be conducted in community settings, but are most commonly conducted in custodial settings.

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Box 15.35 **(Continued)**

SA SA offers offending-specific programs in addition to individualised case management programs to address assessed client risk and need. 'Systematic Training for Anger Reduction' (STAR) is based on principles of cognitive behaviour therapy. The program seeks to assist young people to develop awareness about anger and skills of self control. The 'Problem-solving: Learning Usable Skills' program (Plus+) employs cognitive-behavioural methods of problem solving, skill-training and self-management, which have been shown to be effective in reducing juvenile offending. The Victim Awareness program raises awareness of the effects of crime on individuals and the community. The 'Alcohol and Other Drug' (AOD) program explores the risks of offending while under the influence of AOD. Moral Reconation Therapy (Little and Robinson 1988), which seeks to develop concern for social rules and others, is also used. The SA Police Safe Driving program targets 'high speed' drivers with the aim of reducing motor vehicle crime.

Tas The Youth Justice Service in Tasmania has used an Electronic Risk Assessment Tool (ERAT) for over eight years. As a replacement for the ERAT, Tasmania will be piloting the Youth Level of Service Case Management Inventory risk assessment tool as well as the CHART case management tool. These tools will support a structured and integrated supervision model to address offending, conduct formal reviews and trigger further activity. Tasmania has a court mandated diversion program which provides assessment, case management and treatment for offenders with illicit drug problems. Youth Justice provides case management services for young offenders who are eligible for this program. In addition, Tasmania is exploring the possibility of developing a bail options program to address the needs of young people who are placed on bail. In lieu of other offending-specific programs, Tasmania sources expertise from private professionals and programs across a range of Government services.

ACT The ACT's main offending-specific program is CHART, which is designed specifically for young people assessed as moderate to high-risk of re-offending. This behaviour program is used by youth justice staff as part of their casework intervention either with individuals or with small groups of two to three clients. CHART is evidence-based and is informed by the 'What Works' approach to offender rehabilitation. This approach is characterised by the application of five basic principles of good practice for effective interventions: risk, needs, responsivity, program integrity and professional discretion. The other ACT offending-specific program is 'Triple R'—Respectful, Responsible Relationships Program, which is provided by ACT Corrective Services for youth justice clients who have been convicted of sexual offences.

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Box 15.35 **(Continued)**

NT The NT's main offending-specific programs are the 'Anger Management Program' and 'Cognitive Skills Program'. Both programs are based on cognitive behavioural therapy and are designed to provide a basic understanding of thoughts, feelings, actions and consequences. In facilitating these programs, caseworkers use a 'hands on' approach incorporating role plays and artwork to discuss issues. Caseworkers take this approach because the vast majority of juveniles undertaking these programs are Indigenous with low literacy levels. Other treatment programs which address sexual offending and alcohol and drug use are also provided either by caseworkers or by external agencies.

Source: State and Territory governments (unpublished).

Rehabilitation — education and training attendance

'Education and training attendance' is an indicator of governments' objective to provide program interventions in education and training to rehabilitate young offenders and increase their chances of successfully re-integrating into the community (box 15.36).

Box 15.36 **Education and training attendance**

'Education and training attendance' is defined by two measures:

- the number of young people of compulsory school age in detention attending an education course, as a percentage of all young people of compulsory school age in detention
- the number of young people not of compulsory school age in detention attending an education or training course, as a percentage of all young people not of compulsory school age in detention.

Compulsory school age refers to specific State and Territory government 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.

A high or increasing percentage of young people attending education and training is desirable.

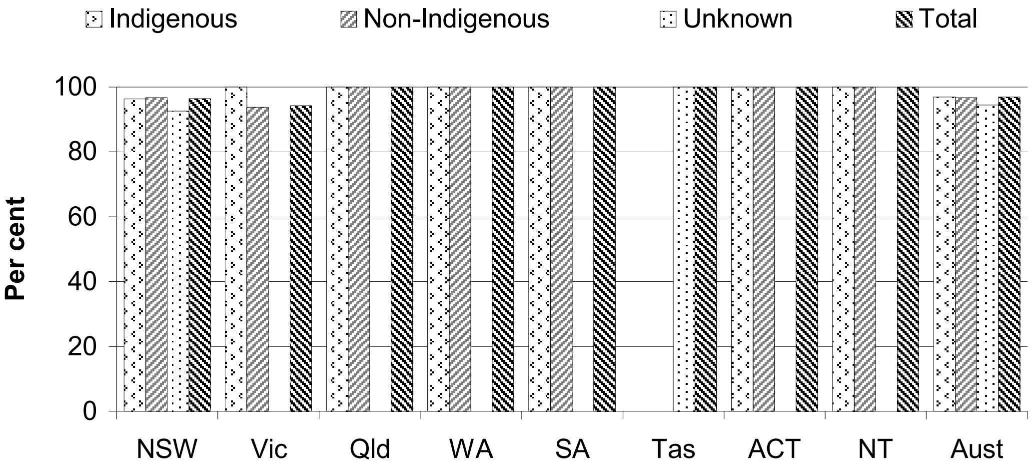
Exclusions include young people not under juvenile justice supervision (for example, in police custody) and young people whose situation might exclude their participation in education programs (including young people who are: on temporary leave such as work release, medically unable to participate, in isolation, and on remand or sentenced for fewer than 7 days).

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, all young people of compulsory school age in detention were attending an education course in 2009-10 (table 15A.179). There was variation across jurisdictions in the proportion of young people *not* of compulsory school age attending an accredited education or training course. Nationally, 96.9 per cent of young people in detention not of compulsory school age were attending an accredited education or training course (figure 15.22).

Figure 15.22 Proportion of young people in detention not of compulsory school age attending an accredited education or training course, by Indigenous status (2009-10)[a]



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[a] Refer to table 15A.179 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.179.

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 15.37).

Box 15.37 Deaths in custody

'Deaths in custody' is defined as the number of young people who died while in custody.

A zero or decreasing deaths in custody rate is desirable.

The scope of this indicator is restricted to those young people who died while in the legal and/or physical custody of a juvenile justice agency and those who died in, or en route to, an external medical facility as a result of becoming ill or being injured in custody (even if not escorted by juvenile justice agency workers).

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

No young people died while in the legal or physical custody of an Australian juvenile justice agency in 2009-10 (table 15A.178).

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 15.38).

Box 15.38 **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 of the juvenile justice agency. An escape from an escorted movement is defined as the failure of a young person to remain in the custody of a supervising juvenile justice worker or approved service provider during a period of escorted movement.

An escape is counted each time a young person escapes. For example, if a young person escapes three times in a counting period, three escapes are recorded. If three young people escape at the same time, three escapes are recorded.

A zero escape rate is desirable.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

Nationally, there was a total of 11 escapes from juvenile justice detention in 2009-10, which was equivalent to 0.3 escapes per 10 000 young people in juvenile justice detention in 2009-10 (table 15.5). The number of escapes from detention varied across jurisdictions.

Table 15.5 Rate and number of escapes from juvenile justice detention centres, by Indigenous status (2009-10)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate per 10 000 custody nights									
Indigenous	0.4	–	–	–	–	3.4	–	1.0	0.3
Non-Indigenous	–	–	–	–	–	–	–	–	0.3
Unknown	–	1.1	–	–	–	..	..	..	–
Total	0.2	0.9	–	–	–	1.0	–	1.0	0.3
Number of escapes									
Indigenous	3.0	–	–	–	–	1.0	–	1.0	5.0
Non-Indigenous	–	6.0	–	–	–	–	–	–	6.0
Unknown	–	–	–	–	–	–	–	–	–
Total	3.0	6.0	–	–	–	1.0	–	1.0	11.0

[a] Refer to table 15A.180 for detailed footnotes. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.180.

Nationally, there was a total of three escapes from escorted movements in 2009-10, which was equivalent to 1.9 escapes per 10 000 periods of escorted movement (table 15.6). The number of escapes from escorted movement varied across jurisdictions.

Table 15.6 Rate and number of escapes from escorted movement, by Indigenous status (2009-10)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate per 10 000 periods of escorted movement									
Indigenous	3.8	–	–	–	–	–	–	–	1.6
Non-Indigenous	5.4	–	–	–	–	–	–	–	2.5
Unknown	–	–	–	–	–	–	–	–	–
Total	4.6	–	–	–	–	–	–	–	1.9
Number of escapes									
Indigenous	1.0	–	–	–	–	–	–	–	1.0
Non-Indigenous	2.0	–	–	–	–	–	–	–	2.0
Unknown	–	–	–	–	–	–	–	–	–
Total	3.0	–	–	–	–	–	–	–	3.0

[a] Refer to table 15A.180 for detailed footnotes. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.180.

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 15.39).

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 15.39 **Absconds from unescorted leave**

'Absconds from unescorted leave' is defined as the number of young people who have unescorted temporary leave and fail to return to custody, as a proportion of all young people who have unescorted temporary leave.

A zero or low, or decreasing rate of absconds from unescorted leave is desirable.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

Nationally, there were two absconds from unescorted leave in 2009-10, which is equivalent to 0.7 absconds from unescorted leave per 1000 periods of unescorted leave (table 15.7).

Table 15.7 **Rate and number of absconds from unescorted leave, by Indigenous status (2009-10)**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate per 1 000 periods of unescorted leave									
Indigenous	–	90.9	..	..	..	–	–	na	1.1
Non-Indigenous	–	–	..	..	55.6	–	–	na	0.6
Unknown	–	–	..	..	..	–	–	na	–
Total	–	1.2	..	..	55.6	–	–	na	0.7
Number of absconds									
Indigenous	–	1.0	–	–	–	–	–	–	1.0
Non-Indigenous	–	–	–	–	1.0	–	–	–	1.0
Unknown	–	–	–	–	–	–	–	–	–
Total	–	1.0	–	–	1.0	–	–	–	2.0

a Unescorted leave is not undertaken in Queensland or WA. **b** Data for the number of unescorted leaves undertaken were not available from the ACT and the NT. **c** Refer to table 15A.181 for detailed footnotes. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.181.

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 15.40).

Box 15.40 **Assaults in custody**

‘Assaults in custody’ is defined by two measures:

- the rate of detainees and staff (by Indigenous status) who are seriously assaulted (that is, sustain an injury that requires overnight hospitalisation and any act of sexual assault) due to an act perpetrated by one or more detainees, as a proportion of the number of detainees in custody
- the rate of detainees and staff (by Indigenous status) who are assaulted (that is, sustain an injury, but do not require hospitalisation) due to an act perpetrated by one or more detainees, as a proportion of the number of detainees in custody.

A zero or low, or decreasing assaults in custody rate is desirable.

Data reported for this indicator are not complete.

Data quality information for this indicator is under development.

Nationally, 4 detainees were reported as injured in custody due to a serious assault in 2009-10 (table 15.8). Proportions varied across jurisdictions. No staff were reported as injured due to a serious assault in 2009-10 (table 15A.182).

Table 15.8 **Rate and number of detainees injured as a result of a serious assault, by Indigenous status (2009-10)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Number of detainees injured as a result of a serious assault								
Indigenous	1.0	na	1.0	na	na	–	–	–
Non-Indigenous	2.0	na	–	na	na	–	–	–
Unknown	–	na	–	na	na	–	–	–
Total	3.0	na	1.0	na	na	–	–	–
Rate per 10 000 custody nights								
Indigenous	0.1	na	0.3	na	na	–	–	–
Non-Indigenous	0.2	na	–	na	na	–	–	–
Unknown	–	na	–	na	na	–	–	–
Total	0.2	na	0.2	na	na	–	–	–

[a] Data were not available for Victoria, WA and SA. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.182.

Nationally, 82 detainees were reported as injured in custody due to an assault in 2009-10 (table 15.9). Proportions varied across jurisdictions.

Table 15.9 Rate and number of detainees injured as a result of an assault, by Indigenous status (2009-10)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*
Number of detainees injured as a result of an assault								
Indigenous	11.0	na	18.0	na	na	na	7.0	10.0
Non-Indigenous	11.0	na	3.0	na	na	na	6.0	1.0
Unknown	1.0	na	–	na	na	14.0	–	–
Total	23.0	na	21.0	na	na	14.0	13.0	11.0
Rate per 10 000 custody nights								
Indigenous	1.5	na	6.0	na	na	na	np	10.3
Non-Indigenous	1.4	na	1.4	na	na	na	np	12.3
Unknown	3.3	na	–	na	na	–	–	–
Total	1.4	na	4.1	na	na	13.8	np	10.5

[a] Data were not available for Victoria, WA and SA. [b] Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. [c] The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate per 10 000 custody nights due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.183.

Nationally, 64 staff were reported as injured due to an assault while supervising detainees in 2009-10 (table 15.10). Proportions varied across jurisdictions.

Table 15.10 **Rate and number of staff injured as a result of an assault, by Indigenous status (2009-10)**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[d]	*NT*
Number of staff injured as a result of an assault								
Indigenous	3.0	na	6.0	–	na	na	–	2.0
Non-Indigenous	13.0	na	7.0	1.0	na	na	9.0	5.0
Unknown	9.0	na	–	na	na	9.0	–	–
Total	25.0	na	13.0	1.0	na	9.0	9.0	7.0
Rate per 10 000 custody nights								
Indigenous	0.4	na	2.0	–	na	na	–	2.1
Non-Indigenous	1.6	na	3.2	0.6	na	na	np	61.7
Unknown	29.8	na	–	na	na	–	–	–
Total	1.6	na	2.5	0.2	na	8.9	np	6.7

[a] Data were not available for Victoria and SA. [b] Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. [c] Data report the Indigenous status of staff who were reported as injured due to an assault. [d] The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate per 10 000 custody nights due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.183.

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 15.41).

Box 15.41 **Self-harm and attempted suicide in custody**

'Self-harm and attempted suicide in custody' is defined by four measures:

- the number of incidents of self-harm or attempted suicide in custody requiring hospitalisation
- the number of incidents of self-harm or attempted suicide in custody that did not require hospitalisation
- the number of detainees who self-harmed or attempted suicide in custody and required hospitalisation
- the number of detainees who self-harmed or attempted suicide in custody but did not require hospitalisation.

The number of incidents of self-harm and the number of detainees who self-harm will differ when one detainee has self-harmed on two or more occasions as each occasion will be counted as a separate incident.

A zero or low, or decreasing self-harm and attempted suicide in custody rate is desirable.

Data reported for this indicator are not complete.

Data quality information for this indicator is under development.

Nationally, 3 detainees in 3 separate incidents were reported as having self-harmed or attempted suicide in custody requiring hospitalisation in 2009-10. Proportions varied across jurisdictions (tables 15.11 and 15.12).

Table 15.11 **Rate and number of detainees who self-harmed in custody and required hospitalisation, by Indigenous status (2009-10)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Number of detainees who self-harmed in custody and required hospitalisation								
Indigenous	1.0	na	–	na	na	–	–	–
Non-Indigenous	1.0	na	–	na	na	–	–	–
Unknown	1.0	na	–	na	na	–	–	–
Total	3.0	na	–	na	na	–	–	–
Rate per 10 000 custody nights								
Indigenous	0.1	na	–	na	na	–	–	–
Non-Indigenous	0.1	na	–	na	na	–	–	–
Unknown	3.3	na	–	na	na	–	–	–
Total	0.2	na	–	na	na	–	–	–

[a] Data were not available for Victoria, WA and SA. [b] Refer to table 15A.184 for detailed footnotes. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.184.

Table 15.12 Rate and number of incidents of self-harm in custody that required hospitalisation, by Indigenous status (2009-10)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Number of incidents of self-harm in custody that required hospitalisation								
Indigenous	1.0	na	–	na	na	–	–	–
Non-Indigenous	1.0	na	–	na	na	–	–	–
Unknown	1.0	na	–	na	na	–	–	–
Total	3.0	na	–	na	na	–	–	–
Rate per 10 000 custody nights								
Indigenous	0.1	na	–	na	na	–	–	–
Non-Indigenous	0.1	na	–	na	na	–	–	–
Unknown	3.3	na	–	na	na	–	–	–
Total	0.2	na	–	na	na	–	–	–

[a] Data were not available for Victoria, WA and SA. [b] Refer to table 15A.184 for detailed footnotes. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.184.

Nationally, 57 detainees were reported as having self-harmed or attempted suicide in 72 separate incidents during 2009-10, none of which required hospitalisation (tables 15.13 and 15.14). Proportions varied across jurisdictions.

Table 15.13 Rate and number of detainees who self-harmed in custody but did not require hospitalisation, by Indigenous status (2009-10)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*
Number of detainees who self-harmed in custody but did not require hospitalisation								
Indigenous	17.0	na	3.0	na	na	–	7.0	2.0
Non-Indigenous	20.0	na	1.0	na	na	–	3.0	na
Unknown	2.0	na	–	na	na	2.0	–	2.0
Total	39.0	na	4.0	na	na	2.0	10.0	2.0
Rate per 10 000 custody nights								
Indigenous	2.3	na	1.0	na	na	–	np	2.1
Non-Indigenous	2.5	na	0.5	na	na	–	np	na
Unknown	6.6	na	–	na	na	–	–	–
Total	2.5	na	0.8	na	na	2.0	np	1.9

[a] Data were not available for Victoria, WA and SA. [b] Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. [c] The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate per 10 000 custody nights due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.184.

Table 15.14 Rate and number of incidents of self-harm in custody that did not require hospitalisation, by Indigenous status (2009-10)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*
Number of incidents of self-harm in custody that did not require hospitalisation								
Indigenous	17.0	na	5.0	na	na	–	12.0	–
Non-Indigenous	20.0	na	1.0	na	na	–	7.0	–
Unknown	2.0	na	–	na	na	6.0	–	2.0
Total	39.0	na	6.0	na	na	6.0	19.0	2.0
Rate per 10 000 custody nights								
Indigenous	2.3	na	1.7	na	na	–	np	–
Non-Indigenous	2.5	na	0.5	na	na	–	np	–
Unknown	6.6	na	–	na	na	–	–	–
Total	2.5	na	1.2	na	na	5.9	np	1.9

[a] Data were not available for Victoria, WA and SA. [b] Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. [c] The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate per 10 000 custody nights due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.184.

Statutory responsibilities — completion of orders

'Completion of orders' is an indicator of governments' objective to rehabilitate young offenders and reintegrate them into their community (box 15.42).

Box 15.42 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.

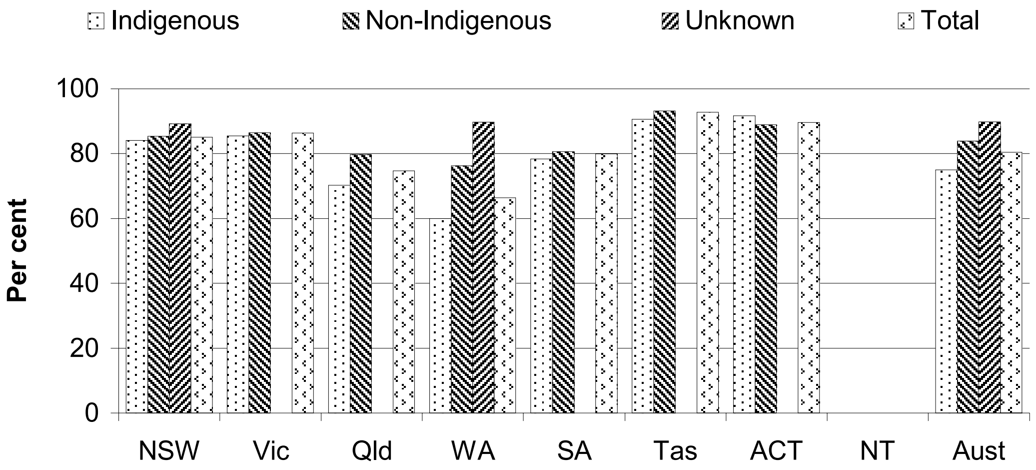
A high or increasing proportion of orders successfully completed is desirable. However, where offenders are non-compliant and pose a risk, breach action (an unsuccessful completion) may be warranted. As a result, a completion rate less than 100 per cent may not necessarily indicate poor performance, and may reflect appropriate supervision of young people on community-based supervision orders.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

Nationally, 80.4 per cent of community-based orders were successfully completed in 2009-10. The proportion of community-based orders successfully completed varied across jurisdictions (figure 15.25).

Figure 15.23 **Proportion of orders successfully completed, by Indigenous status (2009-10)**[a, b]



[a] Data were not available for the NT. [b] Refer to table 15A.185 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.185.

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 15.43).

Box 15.43 **Case plans prepared**

‘Case plans prepared’ is defined as the number of eligible young people who had a documented case plan prepared or reviewed within six weeks of commencing:

- a sentenced detention order, as a proportion of all young people commencing a sentenced detention order
- a sentenced community-based order, as a proportion of all young people commencing a sentenced community-based order.

An eligible young person is one who is serving a sentenced order that requires case management.

A high or increasing rate of case plans prepared is desirable.

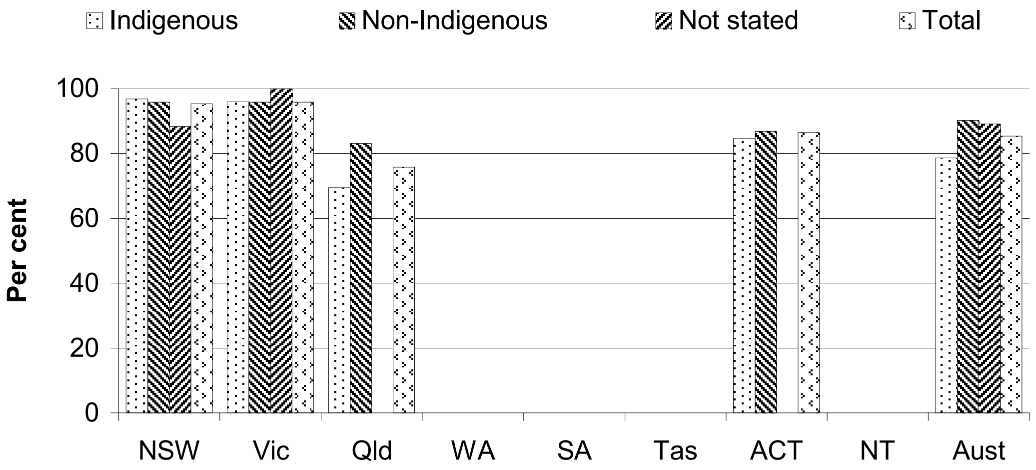
Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

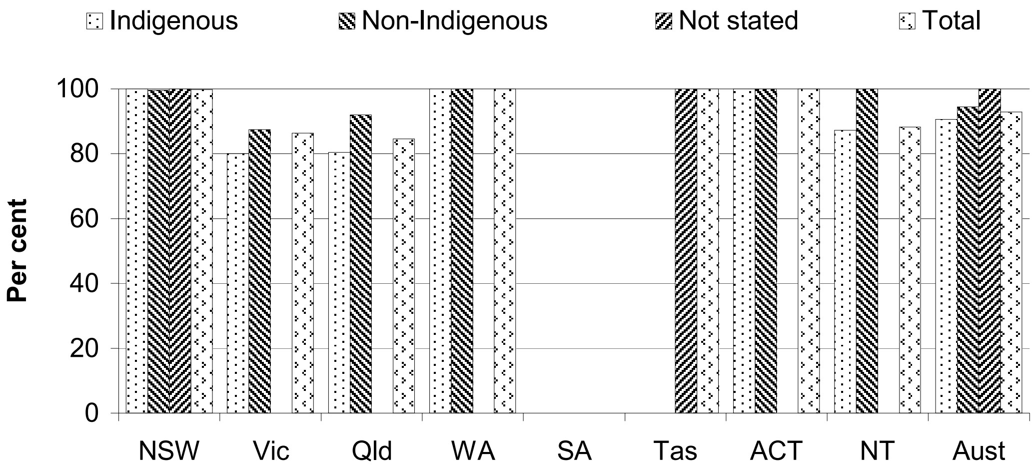
Nationally, 85.4 per cent of case plans were prepared within six weeks of commencing a sentenced community-based order in 2009-10 (figure 15.26(a)). Nationally, 92.9 per cent of case plans were prepared within six weeks of commencing a sentenced detention order in 2009-10 (figure 15.26(b)). Proportions varied across jurisdictions.

Figure 15.24 Proportion of case plans prepared within 6 weeks of commencing sentenced detention orders and sentenced community-based orders, by Indigenous status (2009-10)[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]



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[a] Refer to table 15A.186 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.186.

Efficiency

Cost per offender

'Cost per offender' is an indicator of governments' objective to provide juvenile justice services in an efficient manner (box 15.44).

Box 15.44 **Cost per offender**

'Cost per offender' is yet to be defined.

Data for this indicator were not available for the 2011 Report. Cost per offender data are expected to be available for inclusion in the 2012 Report.

Data quality information for this indicator is under development.

Offender-to-staff ratio

'Offender-to-staff ratio' is an indicator of governments' objective to provide juvenile justice services in an efficient manner (box 15.45).

Box 15.45 **Offender-to-staff ratio**

'Offender-to-staff ratio' comprises two measures:

- the number of young people requiring community-based supervision relative to the number of community-based staff
- the number of young people in detention relative to the number of detention centre staff.

The number of offenders relative to the number of staff provides a measure of efficient resource management by juvenile justice agencies. A high or increasing ratio (that is, a higher number of offenders per staff member) suggests better performance towards achieving efficient resource management. However, this indicator needs to be interpreted with caution as a lower or decreasing offender-to-staff ratio may result in more effective performance, particularly with high risk young offenders who possess significant offence-related needs. Further, in some cases, efficiencies may not be possible due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data for this indicator were not available for the 2011 Report. Offender-to-staff ratio data are expected to be available for inclusion in the 2012 Report.

Data quality information for this indicator is under development.

Centre utilisation

‘Centre utilisation’ is an indicator of governments’ objective to provide juvenile justice services in an efficient manner (box 15.46).

Box 15.46 **Centre utilisation**

‘Centre utilisation’ is defined as the number of detainees in all detention centres as a proportion of the number of permanently funded beds. This indicator partially measures both effective and efficient performance.

Detention centres operating at higher capacities is desirable from an efficient resource management perspective. However, detention centres operating at or above capacity might be ineffective due to the consequences for rehabilitation when centres are over crowded. Centres also need to make provision for separately detaining various classes of young offenders (for example, 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.

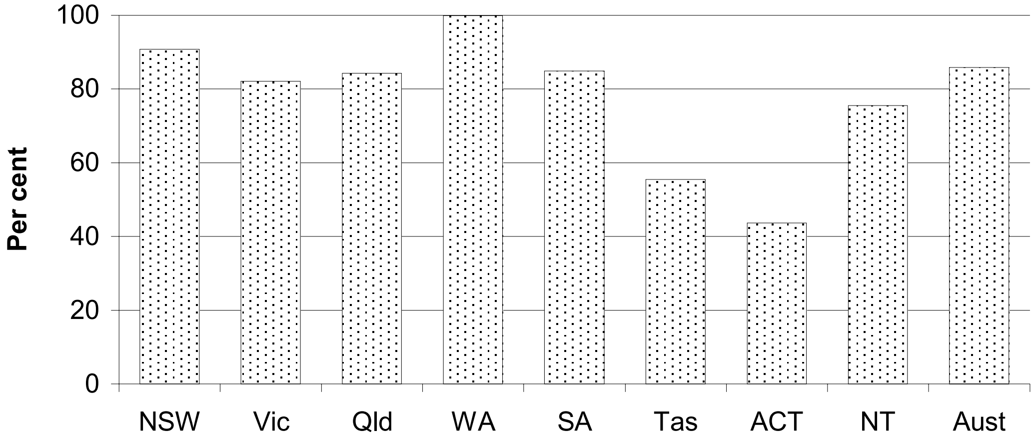
This indicator also has application to the efficient use of publicly funded resources. Centres that are built at a point in time need to be able to justify significant under use, if that occurs in future years, where that under use cannot reasonably be explained by the factors listed above.

Data reported for this indicator are comparable and complete.

Data quality information for this indicator is under development.

Nationally, 85.8 per cent of centre capacity (that is, permanently funded beds) was utilised in 2009-10. Proportions varied across jurisdictions (figure 15.27).

Figure 15.25 **Centre utilisation rate (2009-10)**[a]



[a] Refer to table 15A.187 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.187.

Outcomes

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

Outcome indicators for juvenile justice services are yet to be developed. The Steering Committee has identified outcome indicators as an important element of the juvenile justice performance indicator framework to develop for future reports.

15.7 Future directions in juvenile justice reporting

The Juvenile Justice Research and Information Group (JJ RIG), a working group of the AJJA, is responsible for developing national performance indicators for juvenile justice. The indicators are being developed in stages. The remaining items of development include: refinement of reporting for existing indicators, the development and refinement of an expenditure data collection tool to enable comparable, national reporting for agreed efficiency indicators, and the identification of suitable outcome measures for future reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the 'Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

15.8 Jurisdictions' comments

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

New South Wales Government comments

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Child protection and out-of-home care

On 3 March 2009, the NSW Government launched *Keep Them Safe: A shared approach to child wellbeing,* a five year action plan to reform the child protection system in response to Justice James Wood’s *Report of the Special Commission of Inquiry into Child Protection Services in NSW*. The NSW Government has allocated $750 million over five years to implement this plan.

On 24 January 2010 the main provisions of the *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009* were proclaimed, including:

- new provisions that allow prescribed agencies to directly exchange information relating to child welfare and wellbeing rather than via Community Services
- the new ‘risk of significant harm’ threshold for child protection intervention
- new indicators relating to non-attendance at school suggesting that a child may be at risk of significant harm
- alternate reporting arrangements through the establishment of Child Wellbeing Units in key mandatory reporting government agencies
- changes to Children’s Court processes.

Juvenile justice

In 2009, Juvenile Justice became part of the NSW Department of Human Services, in recognition of the links between social disadvantage and engagement in criminal behaviour.

The juvenile justice system in NSW continued to see significant numbers of young people on remand for short periods of time. Juvenile Justice has increased bail services to assist young people in attaining bail. The Bail Assistance Line was established and community organisations have been contracted to provide support services to young offenders granted bail by police.

The Intensive Supervision Program continued to grow with 38 of 40 families enrolled for the year successfully completing the ISP. Twelve of these families were Aboriginal and Torres Strait Islander, and all twelve successfully completed the program. The Intensive Supervision Program is being evaluated by the Bureau of Crime Statistics and Research.

NSW is the first jurisdiction in Australia to form its own juvenile justice drug dog detection unit. The dogs were purchased from the Australian Customs breeding program and were trained to undertake searches in juvenile justice detention centres and screen visitors.

Juvenile Justice introduced a new information reporting system during 2009–10. The Strategic Information Service provides a more sophisticated analysis of data for reporting back to the government and the community.

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Victorian Government comments

Child protection and out-of-home care

Child protection and placement services have been the subject of external scrutiny during 2009–10 and a number of operational improvements are being made in response to recommendations arising from these inquiries, including stronger quality assurance and improvement processes and an independently chaired Child Protection Practice Standards and Compliance Committee.

Capacity issues have been addressed through significant additional funding for child protection, placement and family services, including Child FIRST. Child protection practitioners are being further supported in their practice by the development of the Best Interests Case Practice Model and improved practice resources such as the well regarded *Child Development and Trauma Guide.*

In 2009–10, Victoria launched *Directions for out-of-home care,* a five year strategic reform agenda for Victoria's out-of-home care system. The reform strategy is designed to further embed a child-centred service model that meets the individual needs of vulnerable children and families. These comprehensive reforms will see a greater focus on therapeutic care and tailored care responses, which focus on:

- providing intensive family based interventions to divert children from entering care and enhance timelier reunification
- building a broader range of placement options for children requiring care
- improving the outcomes and life chances for children placed in care.

Juvenile justice

The Victorian Government committed $22 million over four years in the 2010–11 Budget to address the underlying causes of youth crime by intervening earlier with at risk youth and diverting them away from the criminal justice system. This initiative has an emphasis on tackling the increasing street knife culture and aims to better support at risk young people to achieve positive life outcomes. It comprises three key activities: an additional 55 youth workers, including a rapid response service to work with police in youth crime hotspots, a new behaviour change program, and an intensive bail support pilot.

An evaluation of the youth justice group conferencing program has been completed and has delivered positive preliminary findings regarding the program's effectiveness in relation to diversion and reducing recidivism. Group Conferencing is a restorative justice program for young people appearing in the Children's Court where the Magistrate is considering imposing a supervised statutory order.

Queensland Government comments

Child protection and out-of-home care

The Queensland Government allocated $55 million over four years to the Helping Out Families Initiative to provide appropriate early support to vulnerable families who have been referred to Child Safety Services, but do not require ongoing tertiary intervention. The initiative includes:

- increased family support services
- enhanced domestic and family violence services
- an increased Health Home Visiting program for children 0-3 years
- improved child safety regional intake processes to support practice changes and increase capacity to meet demand.

The Queensland Government has refocussed its child protection investment in Indigenous child protection services. The refocus includes $8.5 million for new early intervention and Indigenous family support programs to help address the challenges for Aboriginal and Torres Strait Islander families early on, thereby reducing the number of Indigenous children placed in out-of-home care. More than $45 million is also being invested over four years to establish Safe House services in 11 Indigenous communities to keep young people safe and connected to their culture and communities. These facilities will deliver up to 66 additional placements and provide vital family support services in remote Indigenous communities.

Juvenile justice

The Queensland Government continued to address the causes of youth offending through the delivery of evidence based initiatives within a contemporary legislative framework. On 29 March 2010, the amended Youth Justice Act 1992 commenced, resulting in a strengthened approach to the application of curfews, an increase in the minimum detention times for young people sentenced to life imprisonment for multiple murders (from 15 to 20 years) and powers for police to arrest young people and take them to court when Youth Justice Conferencing fails or an agreement is breached.

Offence-focussed programs were delivered by Youth Justice Services and Youth Detention Centres while non-government organisations were funded to deliver specialist counselling services and services to address the developmental needs of young people in the youth justice system. A new, fully supervised accommodation service for young people exiting youth detention was developed and will commence operating in Townsville in late 2010. Implementation of Aggression Replacement Training (ART) and Changing Habits and Reaching Targets (CHART) programs was evaluated during 2009 with findings informing improved program delivery and development of resources for Indigenous young people and young people with low literacy levels. An outcomes evaluation of these two programs has now commenced. The Youth Justice Conferencing program continues to experience growth with a record number of referrals to the program during 2009-10.

Western Australian Government comments

Child protection and out-of-home care

The Department continued to embed child protection reforms, which began in 2007. Assessment and investigation processes have been revised to promote better targeting of responses to children referred to the Department. This is consistent with the Department’s differential response model, a process supported by the Signs of Safety child protection practice framework.

Key initiatives in child protection and family support included: interagency early intervention for at-risk newborn babies; co-location of domestic violence officers with the Western Australia Police; family and domestic violence case management and coordination services; a pilot of pre-hearing conferences aimed at reaching agreements in protection and care matters; and expansion of the income management child protection measure to all metropolitan districts as a tool to address neglect, reunification, and leaving care matters.

The Department’s residential care services are being reformed and expanded into three tiers of service delivery responding to different children’s need levels. The number of out-of-home care placements provided by the non-government sector in family group homes (tier one) has been increased to 60 places with a further 12 places to open 2010-11. Legislative amendments to introduce a secure care facility are currently before the State Parliament. Health care planning is being rolled out state-wide, to ensure initial and annual health, mental health and dental checks for children in care.

The Permanency Planning framework was implemented on 1 July 2010 to ensure care planning to maximise stability and a sense of permanency for children and young people in the care of the CEO, either through reunification or long term out-of-home care. Legislative amendments enabling the introduction of special guardianship orders are currently before the State Parliament.

Juvenile justice

The WA Department of Corrective Services works to prevent young people from entering the formal justice system through diversion. During 2009–10, Youth Justice Services created four integrated youth justice offices in the metropolitan area through a realignment of Community and Youth Justice and the separation of youth justice services from adult community corrections. Following the success of regional youth justice services in the Kalgoorlie and Geraldton regions, $43.86 million was provided through the Western Australian Royalties for Regions Program to expand regional youth justice services into the West Kimberley by January 2011, the East Kimberley by April 2011 and the Pilbara by July 2011. The services provided in these regions will include juvenile justice teams to help steer at-risk young people away from the justice system, after hours outreach family support services and after hours bail services.

An across agency Western Australian Youth Justice Framework is near completion and the Department of Corrective Services has developed a range of targets and performance measures for youth justice services.

South Australian Government comments

Child protection and out-of-home care

South Australia's *Keeping Them Safe* reform program is built on the premise of a shared responsibility across Government and the whole community to ensure that children and young people are safe from harm and that, as far as practicable, all children and young people are cared for in a way that allows them to reach their full potential. To that end, government has committed additional funding for prevention and early intervention through the establishment of Children's Centres to provide integrated services for vulnerable children and families. The establishment of the Stronger Families, Safer Children program has resulted in government and non-government agencies working together to support families with highly complex needs who are at risk of having their children placed in out-of-home care. Across sector Information Sharing Guidelines are supporting collaborative practice.

The implementation of a new electronic connected client case management system during 2009–10 has been accompanied by policy and practice changes, with a greater emphasis on sustained intervention with families where children's safety is at high risk.

The Directions for Alternative Care in South Australia 2010–13 has been developed in an endeavour to move the alternative care sector forward with a shared vision and purpose. The Directions builds on the work already occurring to increase placement options for children and young people in care and will address both the immediate and future demand on the alternative care sector. Placement capacity has been increased through the purpose build of two new community residential care facilities.

Juvenile justice

In responding to recommendations arising from the To Break the Cycle Report delivered by Monsignor David Cappo in 2007, DFC has worked with other key stakeholders in delivering significant reform of youth justice in South Australia. The Department for Families and Communities continues to participate in the Community Protection Panel process that ensures effective monitoring and whole of Government management approaches are applied to serious offending by young people.

The Department for Families and Communities has reached agreement with the Youth Court of South Australia and the Magistrates Court of South Australia about trialling Home Detention in Port Augusta.

The Government has investigated options to replace the Magill Youth Training Centre (YTC) and in September 2009, announced that through the sale of the land at Magill and a portion of land adjacent to Sudholz and Grand Junction Roads, the Magill YTC would be replaced with a new facility at Goldsborough Road, Cavan. Construction will commence in late 2010.

Tasmanian Government comments

Child protection and out-of-home care

Reforms to the Tasmanian child protection, family support and out-of-home care (OOHC) services continue to be implemented by Children and Youth Services, with a focus on early intervention by increasing the support infrastructure for vulnerable families.

The Gateway and Integrated Family Support Services have been operating since August 2009, supporting children and families in need through a single point of access within each of the four service delivery areas across the State. This major reform is underpinned by legislative changes that facilitate greater integration of services and improve the exchange of information.

Additional legislative amendments have improved community and statutory services' response to prenatal concerns, and enhanced stability through increased options for permanent care arrangements.

Reform of OOHC services is underway, with rostered care being outsourced in September 2010. Community services, in partnership with experienced interstate agencies, will be providing Therapeutic Residential Care. Children in the statutory child protection system also have increased access to therapeutic interventions to enhance their opportunities to overcome the effects of trauma.

Juvenile justice

Youth justice services in Tasmania are focused on case management practices to meet the needs of young people who engage in youth offending. Evolving partnerships with key stakeholders seek to enhance collaborative and integrated service delivery.

The electronic risk assessment tool YLS/CMI (Youth Level Service/Case Management Inventory) is being piloted, and staff members have undertaken training in the use of this tool. This complements the implementation of the cognitive and behavioural case management tool CHART (Changing Habits and Reaching Targets) across all service centres. The Community Supervision Practice Pilot is further driving the reform of practice supervision and the development of practice guidelines. Quality assurance practices are also being integrated into the delivery of community youth justice services.

Within the community, non-government organisations are being selected to provide Targeted Youth Support Services. This initiative aims to prevent escalation into the statutory system for young people displaying multiple risk factors by providing individualised, intensive, and targeted support.

A review of the Youth Justice Act 1997 has been guided by a Project Steering Committee. The period of consultation with stakeholders and the public has been completed, and revisions to the legislation are currently being drafted. Change to supportive legislation has created an independent advocate for young people in custody.

Australian Capital Territory Government comments

Child protection and out-of-home care

- In April 2009, amendments to the Adoptions Act 1993 were passed. These amendments ensured consistency with the *Children and Young People Act 2008* in particular with regard to permanency planning for children and young people in out-of-home care.
- 2009–10 has also seen a continued focus on improving collaborative service delivery, early intervention and a focus on the rights of the child. The ACT Charter of Rights for Children and Young People in Out of Home Care was launched. Care and Protection Services also worked with ACT Health to assist families prenatally through maternity services. There has also been a continued focus on the needs of vulnerable families.
- Practice continues to be guided by a quality assurance framework, a supervision framework and a case management framework to improve and integrate service delivery across agencies.
- The ACT also continues to participate in related national initiatives, including the development of the National Framework for Protecting Australia's Children and the Indigenous Early Childhood Development National Partnership.

Juvenile justice

- In 2010, the ACT Government commenced work to strengthen policy and services to support young people on bail and divert them from remand wherever possible. A discussion paper was developed. It reviewed ACT legislation, policy and services relevant to diverting young people from entering or continuing in the justice system. The paper highlighted areas for improvement in the ACT and considered a range of possible measures for adoption by the ACT. This work continues in 2010–11.
- In 2009–10, a risk assessment tool was implemented within Youth Justice. The evidence-based risk assessment tool, the Youth Level of Service/Case Management Inventory, is designed to measure a range of dynamic factors known to be related to recidivism. The use of this tool will assist in developing Youth Justice case management plans, targeting the identified risks/needs of the young person and engaging the young person's identified strengths. It is envisaged this assessment will also assist in identifying those young people considered at low risk of re-offending who may benefit most from diversion from the criminal justice system.
- In 2009–10, the ACT continued its focus on equipping young people in detention at Bimberi Youth Justice Centre with vocational and life skills to enable their successful transition back into the community. Young people have participated in a range of education, training and vocational programs including woodwork, bricklaying, and a barista program and various living skills programs.

Northern Territory Government comments

Child protection and out-of-home care

The Northern Territory's child protection operations were significantly enhanced in 2009–10, in response to further increases in demand and complexity.

Achievements in child protection operations in 2009–10 included the announcement of funding for an additional 76 child protection staff, expansion of the Child Abuse Taskforce, and the implementation of Structured Decision Making tools in the Central Intake System. Targeted family support services were established in partnership with three Aboriginal organisations – the Central Australian Aboriginal Congress in Alice Springs; Larrakia Nation Aboriginal Corporation in Darwin; and Wurili Wurlingjang Aboriginal Health Service in Katherine. These targeted family support services are delivered via the non-government sector with out-posted child protection staff.

Additionally, a key partnership with the Department of Justice's Community Justice Centre saw the commencement of the Northern Territory's first Family Group Conferencing service in Alice Springs. The pilot Family Group Conferencing Service is funded through the Transforming Alice Springs program, and will specifically address issues facing Aboriginal families.

An Interdepartmental Child Protection Policy and Planning Group was established to support inter-agency collaboration in improving the safety and well-being of children in the Northern Territory.

In November 2009, the Board of Inquiry into the Child Protection System in the Northern Territory was established by the Northern Territory Government to investigate and report on the Northern Territory's child protection system. In launching the Inquiry, the Government acknowledged that the system had faced significant challenges and that measures were needed to alleviate mounting pressures. Dr Howard Bath, Professor Muriel Bamblett and Dr Rob Roseby were appointed to the Board of Inquiry.

Juvenile justice

The Family Responsibility Program (FRP), a key initiative of the Northern Territory Government's Youth Justice Strategy, has continued to expand to support families to address youth behavioural problems where family circumstances are causing or contributing to the behavioural issues.

The Darwin and Alice Springs Family Support Centres are fully operational. The Darwin Family Support Centre has secured the co-location of a Police Officer and Department of Education and Training Officer. A Child Protection Practitioner will soon be co-located at the Centre. The new positions will strengthen the whole-of-government approach, building on the collaborative work that has already occurred.

15.9 Definitions of key terms and indicators

Child protection and out-of-home care services

Activity Group 1 (pathways) Receipt and assessment of initial information about a potential protection or support issue	Activities that are typically associated with receipt and assessment of initial information including receipt and recording of information, review of department databases, initial assessment of information and decisions about the appropriate response. This activity can also include consultation, with possible provision of advice. Activities by non-government organisations (NGO) may be included if appropriate.
Activity Group 2 (pathways) Provision of generic/non-intensive family support services	Activities that are typically associated with provision of lower level family support services at various stages including identification of family needs, provision of support services and diversionary services, some counselling and active linking of the family to support networks. Services are funded by government but can be delivered by either the relevant agency or a NGO. This bundle of services does not involve planned follow-up by the relevant agency after initial service delivery. The services will be delivered under voluntary arrangements between the relevant agency and family. Clients may receive these services more than once.
Activity Group 3 (pathways) Provision of intensive family support services	Activities that are typically associated with provision of complex or intensive family support services including provision of therapeutic and in-home supports such as counselling and mediation, modelling of positive parenting strategies, referrals to intensive support services that may be provided by NGOs, advocacy on behalf of clients and intensive support for a family in a residential setting. This includes protection and treatment support services. These services may be provided if diversionary services are inappropriate to the case and may lead to statutory services being provided to the client.
Activity Group 4 (pathways) Secondary information gathering and assessment	Activities that are typically associated with secondary information gathering and assessment are currently counted as ‘investigations’ in the Report on Government Services. As part of this activity group a decision may be made to substantiate or not substantiate. Information gathering activities include: • sighting the child • contacting people with relevant information about the child or family (for example, teachers, police, support services) • interviewing the child, sibling(s) and parents • observing family interactions • obtaining assessments of the child and/or family • conducting family group conferences • liaising with agencies providing services to the child and family • recording a substantiation or non-substantiation decision • case conferences with partners and contributors in the investigation and assessment process.
Activity Group 5 (pathways) Provision of short-term protective intervention and coordination services for children not on an order	Activities that are typically associated with provision of short-term protective intervention and coordination services including: • working with the family to address protective issues • developing networks of support for the child • monitoring and reviewing the safety of the child • monitoring and reviewing family progress against case planning

	goals • case conferences with agencies providing services to the child and/or family, internal discussions and reviews • specialist child-focused therapeutic support.
Activity Group 6 (pathways) Seeking an order	Activities that are typically associated with seeking orders (court orders or voluntary/administrative orders) including: • preparing applications for the order • preparing reports for the court • obtaining assessment reports to submit to the court • informing parties to the court proceedings, including parents, the child, and lawyers • informing and briefing legal counsel or internal court groups • going through internal pre-court review processes • attending court • conducting family group conferences.
Activity Group 7 (pathways) Provision of protective intervention, support and coordination services for children on an order	Activities that are typically associated with provision of longer-term protective intervention and coordination services including: • monitoring the child or young person's progress and development (for example, social development and education progress) and undertaking activities that facilitate progress and development • meeting any specific requirements of any court order • reviewing appropriateness of the order for the circumstances of the child or young person. This usually occurs at intervals established by the court or in legislation • reporting back to court • long term cases involving out-of-home care.
Activity Group 8 (pathways) Provision of out-of-home care services	Activities that are typically associated with provision of out-of-home care services including: • finding suitable placement(s) for the child • assisting the child or young person to maintain contact with his/her family • in some cases, staff payments for recruiting and training carers • assessing suitability of potential kinship carers • assisting the child or young person to maintain contact with their family • working to return the child home • assisting the child or young person as they prepare to leave care as the end of the order approaches.
Care and protection orders	Care and protection orders are legal orders or arrangements which give child protection departments some responsibility for a child's welfare. The scope of departmental involvement mandated by a care and protection order is dependent on the type of order, and can include: • responsibility for overseeing the actions of the person or authority caring for the child • reporting or giving consideration to the child's welfare (for example, regarding the child's education, health, religion, accommodation and financial matters). Types of care and protection orders: • Finalised guardianship or custody orders – involve the transfer of legal guardianship to the relevant state or territory department or non-government agency. These orders involve considerable

intervention in a child’s life and that of his or her family, and are sought only as a last resort. Guardianship orders convey responsibility for the welfare of a child to a guardian (for example, regarding a child’s education, health, religion, accommodation and financial matters). Guardianship orders do not necessarily grant the right to the daily care and control of a child, or the right to make decisions about the daily care and control of a child, which are granted under custody orders. Custody orders generally refer to orders that place children in the custody of the state or territory, or department responsible for child protection or non-government agency. These orders usually involve the child protection department being responsible for the daily care and requirements of a child, while his or her parent retains legal guardianship. Custody alone does not bestow any responsibility regarding the long-term welfare of the child.

- Finalised third party parental responsibility orders – transfer all duties, powers, responsibilities and authority parents are entitled to by law, to a nominated person(s) considered appropriate by the court. The nominated person may be an individual such as a relative or an office of the state or territory department. Third party parental responsibility may be ordered when a parent is unable to care for a child, and as such parental responsibility is transferred to a relative. ‘Permanent care orders’ are an example of a third party parental responsibility order and involve the transfer of guardianship to a third party carer. It can also be applied to the achievement of a stable arrangement under a long-term guardianship order to 18 years without guardianship being transferred to a third party. These orders are only applicable in some jurisdictions.
- Finalised supervisory orders – give the department responsible for child protection some responsibility for a child’s welfare. Under these orders, the department supervises and/or directs the level and type of care that is to be provided to the child. Children under supervisory orders are generally under the responsibility of their parents and the guardianship or custody of the child is unaffected. Finalised supervisory orders are therefore less intrusive than finalised guardianship orders but require the child’s parent or guardian to meet specified conditions, such as medical care of the child.
- Interim and temporary orders – generally cover the provision of a limited period of supervision and/or placement of a child. Parental responsibility under these orders may reside with the parents or with the department responsible for child protection. Orders that are not finalised (such as an application to a court for a care and protection order) are also included in this category, unless another finalised order is in place.
- Administrative arrangements – are agreements between a parent (or parents) and the relevant child protection department, which have the same effect as a court order in transferring custody or guardianship. These arrangements can also allow a child to be placed in out-of-home care without going through the courts.

Children are counted only once, even if they are on more than one care and protection order.

Child A person aged 0–17 years.

Child at risk A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of

	prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.
Child concern reports	Reports to departments responsible for child protection regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.
Children in out-of-home care during the year	The total number of children who were in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.
Dealt with by other means	A notification that is responded to by means other than an investigation, such as the provision of advice or referral to services.
Exited out-of-home care	Where a child does not return to care within two months.
Family based care	Home-based care (see 'Out-of-home care').
Family group homes	Family group homes are care settings that provide care to children in a departmentally or community sector agency provided home. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance by a government authority or non-government organisation for the child's support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person's spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome of 'substantiated' or 'not substantiated' is recorded by 31 August.
Investigation in process	Where an investigation is commenced but an outcome is not recorded by 31 August.
Investigation closed – no outcome possible	Where an investigation is commenced but is not able to be finalised in order to reach the outcome of 'substantiated' or 'not substantiated'. These files would be closed for administrative purposes. This may happen in instances where the family has relocated.
Length of time in continuous out-of-	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

home care	considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child. Notifications can be counted at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services. There are five main out-of-home care placement types: • Residential care – where placement is in a residential building with paid staff. • Family group homes – provide care to children in a departmentally or community sector agency provided home. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care. • Home-based care – where placement is in the home of a carer who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child. This is broken down into three subcategories: (1) *Relative/kinship care* – includes family members (other than parents) or a person well known to the child and/or family (based on a pre-existing relationship) who is reimbursed (or who has been offered but declined reimbursement) by the state/territory for the care of the child; (2) *foster care* – where the care is authorised and carers are reimbursed (or were offered but declined reimbursement) by the state/territory and supported by an approved agency. There are varying degrees of reimbursement made to foster carers; (3) *other* – home-based care which does not fall into either of the above categories. • Independent living – including private board and lead tenant households. • Other – includes placements that do not fit into the above categories and unknown living arrangements. This includes boarding schools, hospitals, hotels/motels and defence force.
Relatives/kin	Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).
Respite care	Respite care is a form of out-of-home care that is used to provide short-term accommodation for children whose parents are ill or unable to care for them on a temporary basis. Not all jurisdictions can identify which children in out-of-home care are in respite care. Children may also be placed in respite care while being placed with a foster carer.

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.

15.10 List of 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 Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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Single jurisdiction data Tas

Single jurisdiction data ACT

Single jurisdiction data NT

Juvenile justice data

15.11 References

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PART G

HOUSING AND HOMELESSNESS SERVICES

G Housing and homelessness services sector summary

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this sector summary by a ‘GA’ suffix (for example, table GA.3). A full list of attachment tables is provided at the end of this sector summary, and the attachment tables are available on the Review website at www.pc.gov.au/gsp.

Introduction

This sector summary provides an introduction to the ‘Housing’ (chapter 16) and ‘Homelessness services’ (chapter 17) chapters of this Report. It provides an overview of the ‘housing and homelessness’ sector, presenting both contextual information and high level performance information.

Major improvements in reporting on housing and homelessness this year are identified in each of the service-specific housing and homelessness chapters.

Housing assistance and services to people who are homeless and at risk of homelessness are closely interconnected:

> The concepts of 'homelessness' and 'housing' are culturally bound, and … in order to define homelessness it is necessary to identify shared community standards about minimum housing (Homelessness Australia 2010).

This is reflected in the National Affordable Housing Agreement (NAHA), which is focussed on achieving improved housing outcomes for all Australians and funds many housing and homelessness services (COAG 2008a).

Shelter is a fundamental human need, and housing assistance is an important element of governments' social policy and welfare frameworks. Australian, State and Territory governments — both together and separately — assist people to meet their housing needs through direct services, funding support and other initiatives, including assistance for people who are homeless or at risk of homelessness (AIHW 2010). Many non-government organisations also provide housing assistance and services to people who are homeless or at risk of homelessness (National Homelessness Information Clearinghouse 2010).

Sector scope

This Report includes detailed information on six specific services currently in operation in Australia (box G.1). Public housing, State owned and managed Indigenous housing (SOMIH), Community housing, Indigenous community housing (ICH) and Commonwealth Rent Assistance (CRA) are reported in chapter 16. Homelessness services provided under the Supported Accommodation Assistance Program (SAAP) are reported in chapter 17.[1]

Governments also provide housing support through various forms of home purchase assistance and other private rental assistance, but these are not considered in detail in this Report (see appendix G.1).

'Social housing' is a broad term that includes public housing, SOMIH, community housing, Indigenous community housing and crisis and transitional housing. Crisis and transitional housing are not separately identified in this Report, but may be indirectly reported for some jurisdictions through other forms of social housing. In this sector summary, 'housing assistance' refers to social housing plus CRA.

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[1] Government funded or provided Specialist Homelessness Services (SHS) will be reported in Chapter 17 of future editions of this Report, when data are available.

Box G.1 Housing and homelessness services sector activities

This Report focuses on services provided under the NAHA (and formerly the Commonwealth State Housing Agreement and SAAP V agreement):

- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.
- *State owned and managed Indigenous housing*: dwellings owned and managed by State housing authorities that are allocated only to Indigenous households.
- *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 local government.
- *Indigenous community housing*: dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional and remote areas.
- *Commonwealth Rent Assistance*: 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.
- *Supported Accommodation Assistance Program* and *Specialist Homelessness Services* (SHS): provide assistance to individuals and families who are homeless or at risk of becoming homeless to enhance personal or family functioning. The SAAP V agreement ceased operation on 31 December 2008 and was replaced by the NAHA on 1 January 2009. This Report presents data for SAAP-like services, as data for specialist homelessness services (under NAHA) are not yet available.

Source: Chapters 16 and 17.

The term ‘homelessness’ can be used to describe the extent to which housing needs are unmet, including people without conventional accommodation and those staying in accommodation that is below minimum community standards (box G.2).

Box G.2 **Scope of homelessness**

The most widely accepted, broad definition of homelessness describes three categories of homelessness:

- *Primary homelessness* is experienced by people without conventional accommodation (for example, sleeping rough or in improvised dwellings).
- *Secondary homelessness* is experienced by people who frequently move from one temporary shelter to another (for example, emergency accommodation, youth refuges, 'couch surfing').
- *Tertiary homelessness* is experienced by people staying in accommodation that is below minimum community standards (for example, boarding housing and caravan parks).

The Commonwealth Advisory Committee on Homelessness adopted tertiary homelessness (incorporating primary and secondary homelessness) as the general definition of homelessness. This broad definition differs from the SAAP-specific definition of a 'homeless person' in chapter 17:

> A person who does not have access to safe, secure and adequate housing. A person is considered to not have such access if the only housing to which he or she has access:
>
> – has damaged, or is likely to damage, the person's health
>
> – threatens the person's safety
>
> – marginalises the person by failing to provide access to adequate personal amenities or the economic and social supports that a home normally affords
>
> – places the person in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing
>
> – is of unsecured tenure.
>
> A person is also considered homeless if living in accommodation provided by a SAAP agency or some other form of emergency accommodation.

Source: Chamberlain & MacKenzie (2008); Homelessness Australia (2010); Chapter 17.

Social and economic factors affecting demand for services

Factors that create a need for housing and homelessness services include shortage of affordable housing, long term unemployment and financial hardship, mental health issues, substance abuse and family and relationship breakdown. Among women, domestic and family violence is the main reason for seeking help from specialist homelessness services (Homelessness Taskforce 2008, p.viii).

Government assistance, as well as a range of other factors, influence housing and homelessness outcomes. Appendix G.1 presents information on some of these factors, including housing affordability and home ownership, to provide context for government assistance in the sector.

Profile

Detailed profiles for each of the six services comprising the housing and homelessness services sector are reported in chapters 16 and 17, and cover:

- size and scope of the individual service types
- roles and responsibilities of each level of government
- funding and expenditure.

Descriptive statistics

Descriptive statistics for the housing and homelessness sector are included in table G.1. Additional descriptive data for each jurisdiction are presented in tables GA.2–GA.4.

Funding

The NAHA provides funding for housing and homelessness services. NAHA funding is based on outcomes rather tied to programs, so it is not possible to identify funding used for specific programs. In 2009-10, the Australian Government provided $2.1 billion to State and Territory governments for housing and homelessness services through the NAHA Specific Purpose Payment (SPP) and related National Partnership agreements (Social Housing, Homelessness and Remote Indigenous Housing) (table GA.5).

Expenditure data presented in table G.1 reflect Australian, State and Territory government expenditure for housing and homelessness services in 2008-09. More information on government expenditure can be found in chapters 16 and 17.

Table G.1 Housing and homelessness services sector, descriptive statistics, Australia, 2008-09[a, b]

	PH	*SOMIH*	*CH*	*ICH*[c]	*CRA*[d]	*SAAP*	*Total*
Net recurrent expenditure ($m)	2 141.8	78.1	361.5	73.0	2 621.4	413.6	5 657.6
No. dwellings	336 464	12 056	43 739	19 607	..	..	..
No. clients ('000)	..	..	..	..	1 038	126	..
Average cost of providing assistance:							
per dwelling ($)	6 366	8 484	8289	5 256	..	..	..
per client ($)	..	..	..	..	2 525	3 288	..

PH = Public housing; **SOMIH** = State owned and managed Indigenous housing; **CH** = Community housing; **ICH** = Indigenous community housing; **CRA** = Commonwealth Rent Assistance; **SAAP** = Supported Accommodation Assistance Program.

[a] Data for 2009-10 are available for PH, SOMIH, CRA and SAAP and these are presented in chapters 16 and 17. [b] Data may not be comparable across jurisdictions or service areas and comparisons could be misleading. Chapters 16 and 17 provide further information. [c] Data for ICH are likely to be underestimated because complete data were not available for all jurisdictions. The number of ICH dwellings presented are all funded dwellings, but the average cost per ICH dwelling reflects dwellings for which details are known. Nationally in 2008-09, there were 13 888 dwellings for which details were known. [d] Income units for CRA are presented as 'clients'. **..** Not applicable.

Source: Chapters 16 and 17; table GA.1.

Service-sector objectives

The overarching service sector objectives in box G.3 draw together the objectives from each of the six specific services, as well as reflecting the objectives set out in the NAHA. More detailed objectives can be found in chapters 16 (housing) and 17 (homelessness services).

Box G.3 **Objectives for housing assistance and homelessness services**

The overarching objective of housing assistance and homelessness services is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. Further, government services are to be provided in a collaborative, equitable and efficient manner.

The specific objectives of the services that comprise the housing and homelessness services sector are summarised below:

- *Public housing, SOMIH,* and *community housing* aim to assist people unable to access alternative suitable housing options, through the delivery of affordable, appropriate, flexible and diverse social housing. *Indigenous community housing* aims are similar, and aim to contribute to Indigenous community wellbeing (chapter 16)
- *CRA* aims to assist with the cost of renting private housing for low and middle-income individuals in receipt of income support or family assistance payments (chapter 16)
- *SAAP*/specialist homelessness services aim to provide transitional supported accommodation and a range of related support services, to help people who are homeless or at imminent risk of homelessness to achieve self-reliance and independence (chapter 17).

Source: COAG (2008a), Chapters 16 and 17.

Headline performance indicator framework

Each of the six services in the housing and homelessness sector have a performance indicator framework that reflects the process used by service providers to transform inputs into outputs and outcomes in order to achieve desired policy and program objectives (see chapters 16 and 17). This sector summary includes a headline performance indicator framework with key performance indicators that relate to the overarching service sector objectives (figure G.1).

The headline performance indicator framework is made up of the following elements:

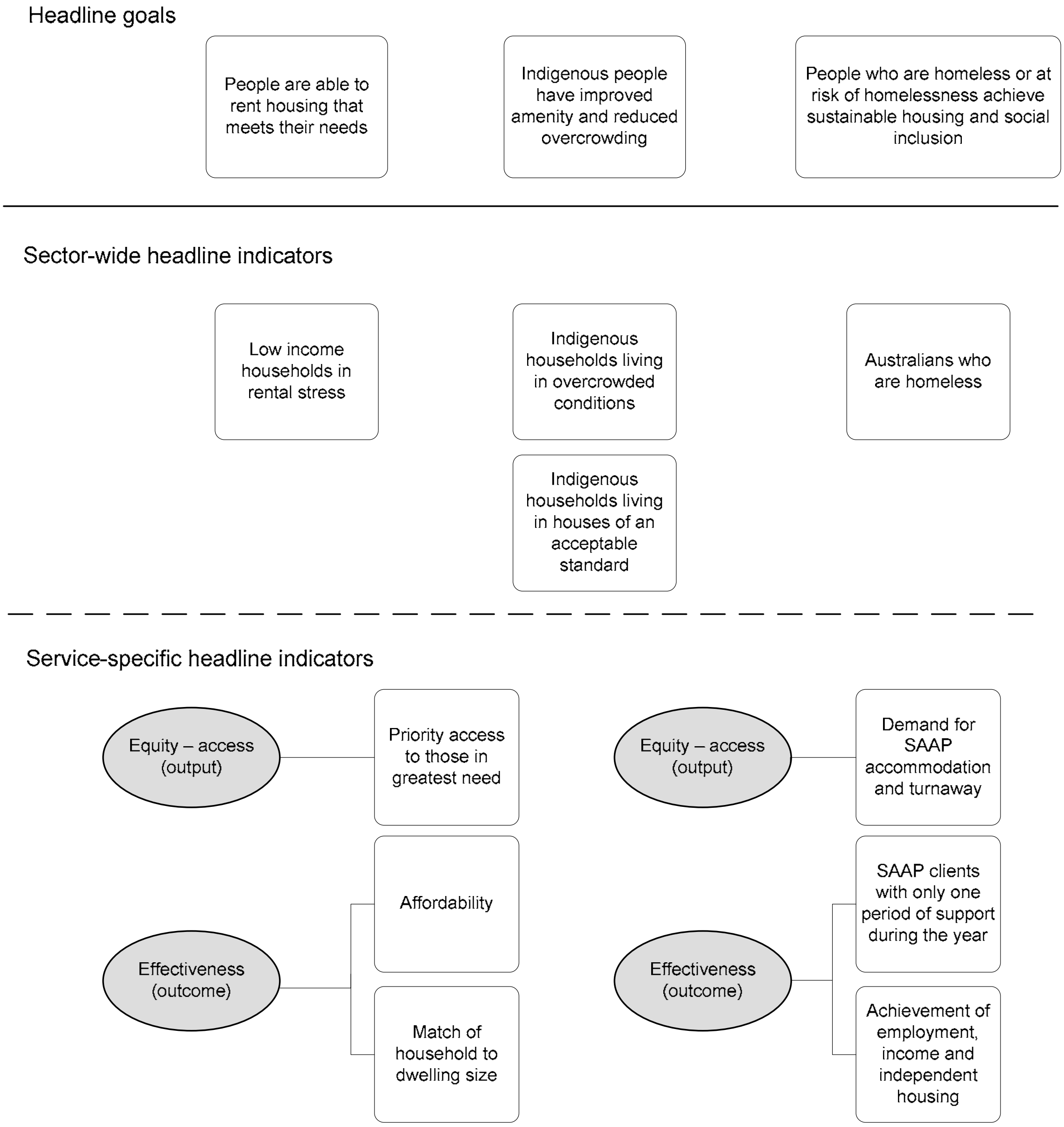
- Headline goals — three headline goals are based on the key objectives of housing and homelessness services and reflect the outcomes in the NAHA.
- Sector-wide headline indicators — four sector-wide headline indicators reflect high level indicators identified in the NAHA and the National Partnership Agreement on Homelessness.

- Service specific headline indicators — six high level indicators are drawn from the five service specific indicator frameworks in the housing and homelessness chapters (chapters 16 and 17). These frameworks reflect the equity, effectiveness and efficiency elements of RoGS performance reporting, and include output and outcome indicators.

Summary data for sector-wide headline indicators and service specific headline indicators are reported in this sector summary. Chapters 16 and 17 and their associated attachment tables provide further information, including:

- additional performance indicators
- additional disaggregation of many indicators by Indigenous status, remoteness, disability, language background, sex and age.

Figure G.1 Housing and homelessness services headline performance indicator framework



Sector-wide headline performance indicators

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

Low income households in rental stress

'Low income households in rental stress' is an indicator of governments' objective to provide affordable housing to assist people who are unable to access suitable housing (box G.4).

Box G.4 **Low income households in rental stress**

'Low income households in rental stress' is defined as the proportion of low income households spending more than 30 per cent of their gross household income on rent.

Low income households are defined as those in the bottom 40 per cent of equivalised disposable household incomes (that is, the bottom two income quintiles). Equivalised disposable income is an indicator of disposable household income after taking into account household size and composition (ABS 2010a). Household income and rent expenditure exclude Commonwealth Rent Assistance.

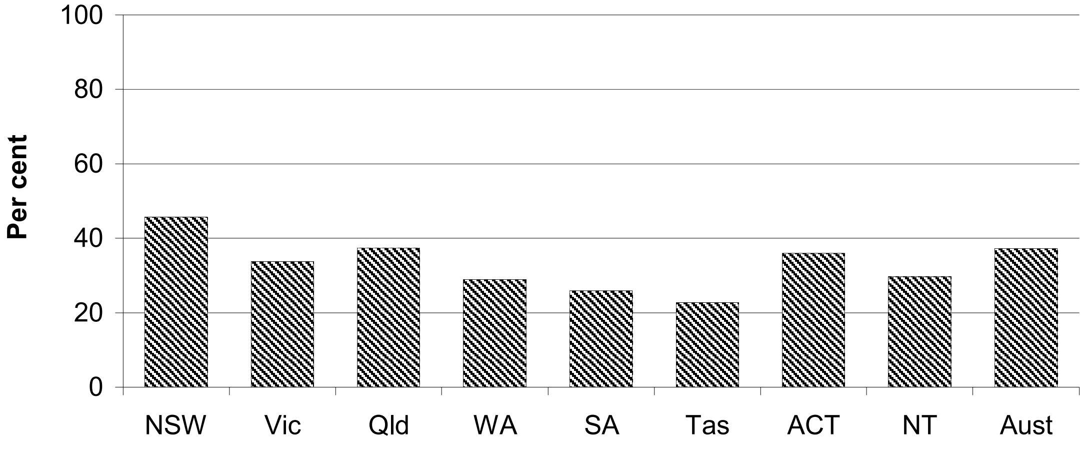
A low or decreasing proportion of households in rental stress implies greater housing affordability.

The 'affordability' indicators for public housing and SOMIH, community housing, Indigenous community housing and CRA (chapter 16) provide additional information on rental stress in social housing and for those receiving CRA.

Data reported for this indicator are comparable and complete. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, 37.2 per cent of low income households were in rental stress in 2007-08, but this varied across jurisdictions (figure G.2).

Figure G.2 **Proportion of low income households in rental stress, 2007-08**



Source: ABS (unpublished) *Survey of Income and Housing* 2007-08; table GA.6.

Indigenous households living in overcrowded conditions

'Indigenous households living in overcrowded conditions' is an indicator of governments' objective to ensure all Australians have access to affordable, safe, appropriate and sustainable housing (box G.5). Governments have a specific interest in improving the amenity and reducing overcrowding for Indigenous people, particularly those living in remote and discrete communities (COAG 2008a).

Box G.5 **Indigenous households living in overcrowded conditions**

'Indigenous households living in overcrowded conditions' is defined as the proportion of Indigenous households living in overcrowded conditions. Overcrowding is deemed to occur if one or more bedrooms are required to meet the Canadian National Occupancy Standard.

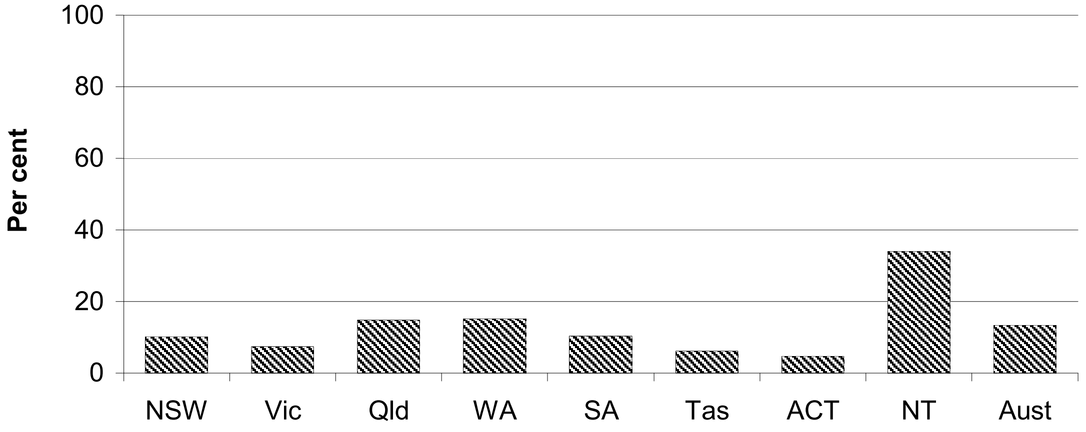
A low or decreasing proportion of households living in overcrowded conditions is desirable.

'Match of dwelling to household size' indicators for public housing and SOMIH, community housing and Indigenous community housing (chapter 16) provide additional relevant information on overcrowding in social housing.

Data for this indicator are neither comparable nor complete. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Overcrowding is a particular issue for Indigenous households, as a much higher proportion of Indigenous people live in overcrowded conditions than other Australians (SCRGSP 2009). Nationally in 2008, 13.4 per cent of Indigenous households were living in overcrowded conditions (figure G.3).

Figure G.3 **Proportion of Indigenous households living in overcrowded conditions, 2008**



Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Social Survey 2008;* table GA.7.

Indigenous households living in houses of an acceptable standard

‘Indigenous households living in houses of an acceptable standard’ is an indicator of governments’ objective to ensure all Australians have access to affordable, safe and sustainable housing (box G.6). Governments have a specific interest in improving the amenity and reducing overcrowding for Indigenous people, particularly those living in remote and discrete communities, and those in social housing (COAG 2008a).

Box G.6 **Indigenous households living in houses of an acceptable standard**

‘Indigenous households living in houses of an acceptable standard’ is defined as the proportion of households living in houses of an acceptable standard. Two measures are reported:

- proportion of Indigenous households living in houses of an acceptable standard
- proportion of Indigenous households living in social housing of an acceptable standard.

A house is assessed as being of an acceptable standard if it has all four basic facilities working: for washing people; for washing clothes/bedding; for storing/preparing food; and sewerage; and not more than two major structural problems.

A high or increasing proportion of Indigenous households living in houses of an acceptable standard is desirable.

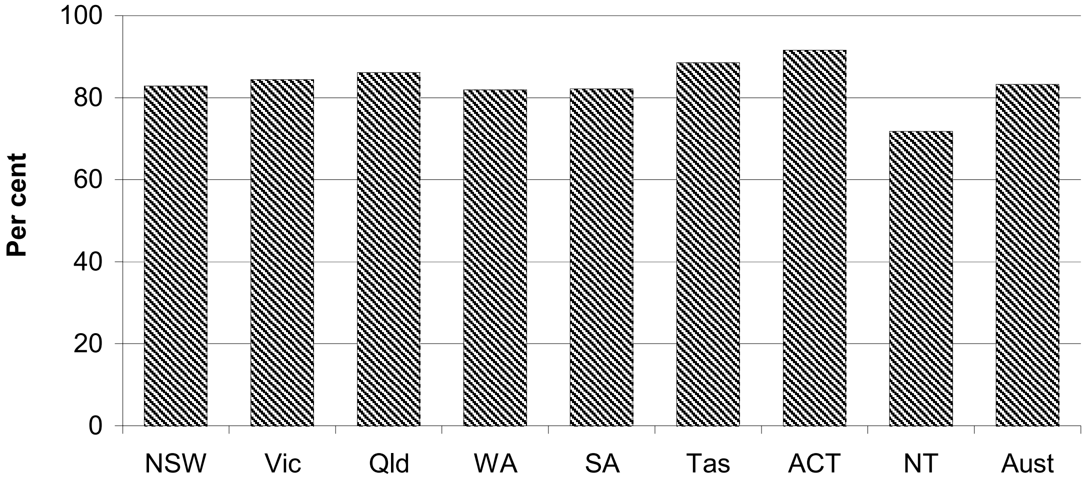
Information relating to ‘amenity/location’ for public housing, SOMIH and community housing, and ‘dwelling condition’ and ‘connection to water, sewerage and electricity’ for Indigenous community housing are presented in chapter 16.

Data for this indicator are comparable but not complete. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Data for this indicator are reported for Indigenous households living in households of an acceptable standard, as there are currently no data available for reporting on acceptable standard for social housing. Australian, State and Territory governments are working to improve reporting on acceptable standard for social housing and additional data may be available for reporting in future reports.

In 2008, 83.2 per cent of Indigenous households were living in houses of an acceptable standard (figure G.4).

Figure G.4 **Proportion of Indigenous households living in houses of an acceptable standard, 2008**



Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Social Survey 2008;* table GA.8.

Australians who are homeless

'Australians who are homeless' is an indicator of governments' objective to ensure all Australians have access to affordable, safe and sustainable housing (box G.7).

Box G.7 **Australians who are homeless**

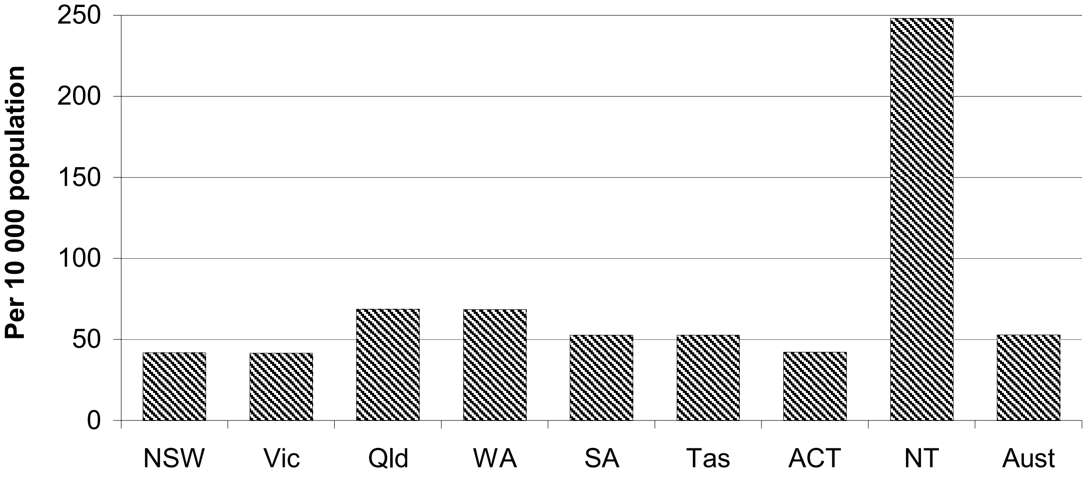
'Australians who are homeless' is defined as the proportion of Australians who are homeless (including primary, secondary and tertiary forms of homelessness; see box G.2 for definitions), calculated as number of people who are homeless divided by the number of Australians.

A low or decreasing proportion of Australians who are homeless is desirable.

Data for this indicator are comparable and complete. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally in 2006, 52.7 Australians per 10 000 people in the population were homeless on Census night (figure G.5). Of the homeless, an estimated 16 per cent, or 16 375 people, were identified as sleeping rough (Homelessness Taskforce 2008, pp. 4-5; ABS 2007). There are some difficulties associated with identifying and counting homeless people in the population and these data should be interpreted with care.

Figure G.5 **Rate of homelessness, 2006 (per 10 000 population)**



[a] Future editions of this Report will include time series data for this measure to identify trends in the homeless population over time.

Source: ABS (2006) *Census of Population and Housing*, Cat. No. 2068.0; AIHW (unpublished) *SAAP Client Collection 2006*; McKenzie and Chamberlain (2006) *National Census of Homeless School Students*, FAHCSIA, Canberra; table GA.9.

Service-specific headline performance indicators

This section includes high level indicators from the five service specific indicator frameworks in the housing and homelessness chapters: public housing and SOMIH (figure 16.3); community housing (figure 16.16); Indigenous community housing (figure 16.23); CRA (figure 16.25); and SAAP services (figure 17.3). The selected indicators reflect the equity and effectiveness elements of the service specific indicator frameworks, and provide a balance of output and outcome indicators.

Housing assistance

The indicators presented in this section are drawn from the public housing and SOMIH, community housing and CRA frameworks in chapter 16.

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 G.8).

Box G.8 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.

Data for this indicator are reported for public housing, SOMIH, and community housing.

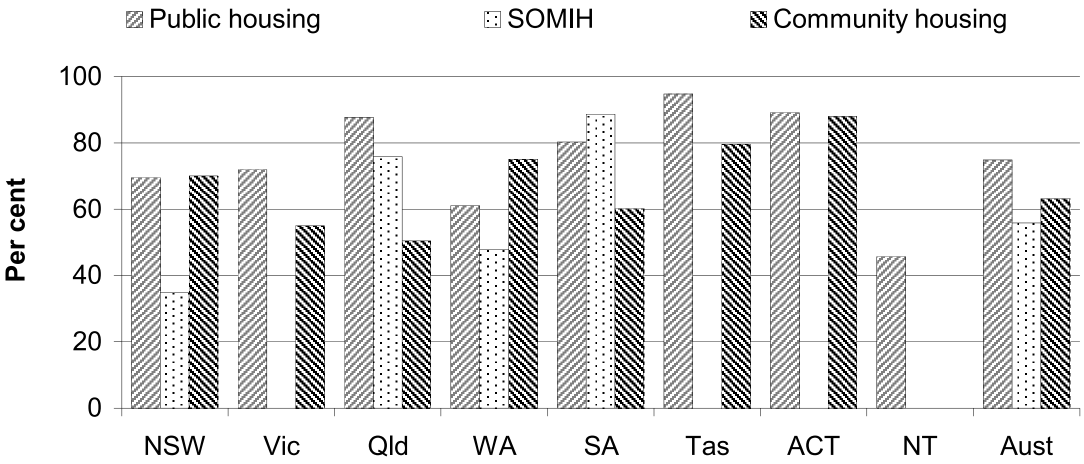
High or increasing values for these measures, particularly for short time frames, indicate a high degree of access for those households in greatest need.

Data reported for this indicator are not directly comparable. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Chapter 16 contains further information pertinent to the interpretation of this indicator.

Nationally in 2009-10, 74.9 per cent of new public housing allocations, 55.9 per cent of new SOMIH allocations and 63.1 per cent of new community housing allocations were to those in greatest need (figure G.6).

Figure G.6 Proportion of new allocations to those in greatest need, 2009-10[a, b]



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[a] Data may not be comparable across jurisdictions or service areas and comparisons could be misleading. [b] There is no SOMIH in Victoria, ACT and the NT. Data were not available for SOMIH in Tasmania and for community housing in the NT.

Source: Chapter 16; tables 16A.3, 16A.18 and 16A.31.

Affordability

'Affordability' is an indicator of governments' objective to provide affordable housing to assist people who are unable to access suitable housing (box G.9).

Box G.9 **Affordability**

'Affordability' is defined as tenants' ability to access suitable housing. Two measures of affordability are reported:

- proportion of low income households spending more than 30 per cent of their income in rent, for public housing, SOMIH and community housing
- proportion of CRA income units spending more than 30 per cent of their income on rent, with and without CRA.

There are no measures of affordability defined for Indigenous community housing.

Low income households are those in the bottom 40 per cent of equivalised gross household incomes. Equivalised disposable income is an indicator of disposable household income after taking into account household size and composition (ABS 2010a).

Households in public housing and SOMIH who do not receive rental rebates are included in this measure.

A low or decreasing value implies greater housing affordability.

Data reported for this indicator are neither comparable nor complete. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Chapter 16 contains additional measures of affordability and further information pertinent to the interpretation of this indicator.

Income data for some households are not updated annually and this may result in overestimating the proportions of household income spent on rent. Differences in the treatment of CRA in rent assessment (CRA should be excluded, but is included for some households) can affect the comparability of results for community housing.

Nationally in 2009-10, the proportion of low income households spending more than 30 per cent of their income in rent was 1.3 per cent for public housing, 0.8 per cent for SOMIH and 18.4 per cent for community housing (table G.2).

In 2010, the payment of CRA reduced the proportion of CRA recipients who spend more than 30 per cent of their income on rent from 71.4 per cent (without CRA) to 42.1 per cent (with CRA) (table G.2).

Table G.2 **Measures of affordability**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of low income households spending more than 30 per cent of income in rent, 2009-10									
Public housing	0.1	3.9	–	1.1	1.7	0.2	0.9	5.9	1.3
SOMIH	0.1	..	–	2.0	2.2	–	..	..	0.8
Community housing	12.9	20.3	na	59.7	7.1	28.0	23.6	na	18.4
Proportion of CRA income units spending more than 30 per cent of income on rent, 2010									
Without CRA	72.8	70.1	73.0	71.0	64.5	67.6	75.7	70.3	71.4
With CRA	43.0	39.3	45.1	44.1	35.2	33.6	53.0	43.6	42.1

[a] Data may not be comparable across jurisdictions or service areas and comparisons could be misleading. Chapter 16 provides further information. .. Not applicable. **na** Not available. – Nil or rounded to zero.

Source: Chapter 16; tables 16A.12, 16A.26, 16A.39 and 16A.74.

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 G.10).

Box G.10 **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.

Data are reported for the proportions of public housing, SOMIH, community housing and Indigenous community housing dwellings that are overcrowded.

Overcrowding is measured using the Canadian National Occupancy Standard and is deemed to have occurred if one or more additional bedrooms are required to meet the standard. For Indigenous community housing, overcrowding is deemed to have occurred if two or more additional bedrooms are required to meet the standard.

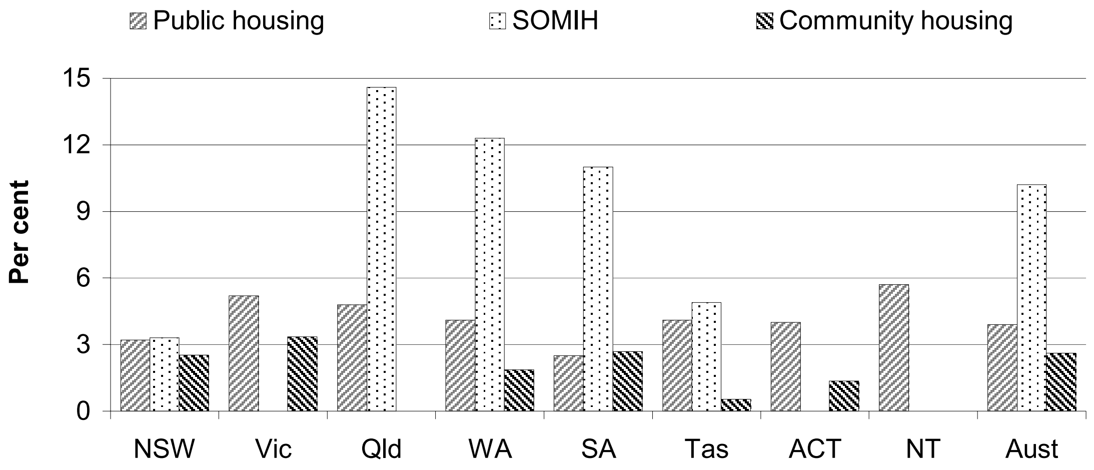
A low or decreasing proportion of overcrowded dwellings is desirable.

Data reported for this indicator are comparable. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2011.

Chapter 16 contains further information pertinent to the interpretation of this indicator.

Nationally in 2009-10, 3.9 per cent of households in public housing, 10.2 per cent of SOMIH households, and 2.6 per cent of households in community housing were overcrowded (figure G.7). Data for overcrowding in Indigenous community housing are reported in table 16A.50.

Figure G.7 **Proportion of households in social housing that are overcrowded, 2009-10**[a]



[a] Data may not be comparable across jurisdictions or service areas and comparisons could be misleading. Chapter 16 provides further information. [b] There is no SOMIH in Victoria, ACT and the NT. Community housing data were not available for Queensland and the NT.

Source: Chapter 16; tables 16A.13, 16A.27 and 16A.40.

Homelessness services

The indicators presented in the following section are drawn from the SAAP services framework in the chapter 17. Future editions of this Report will include data (when available) from the specialist homelessness services data collection, and incorporate any performance indicator framework developments to reflect the NAHA and related National Partnership Agreement on Homelessness.

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 G.11).

Box G.11 **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 are reported:

- turn-away as the proportion of people requiring new SAAP accommodation
- turn-away as the proportion of total demand for SAAP accommodation.

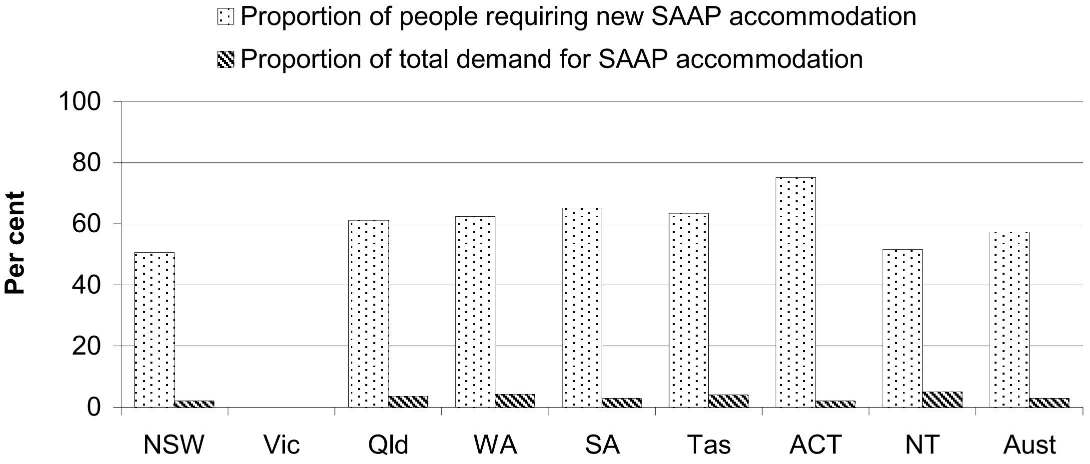
A decreasing proportion of people turned away from SAAP services is desirable.

Data reported for this indicator are comparable across jurisdictions. Data quality information for this indicator is under development.

Chapter 17 contains additional measures and further information pertinent to the interpretation of this indicator.

Nationally in 2008-09, 57.4 per cent of adults and unaccompanied children requesting immediate new SAAP accommodation on a given day were turned away, but only 2.9 per cent of all adults and unaccompanied children who made valid requests for SAAP accommodation could not be accommodated (figure G.8). The latter proportion of people turned away includes people who requested ongoing accommodation and who were already accommodated.

Figure G.8 **Proportion of adults and unaccompanied children turned-away, 2008-09**[a]



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[a] Data for Victoria are not available. See notes to tables 17A.7 and 17.8 for more detailed caveats about these data.

Source: Chapter 17; tables 17A.7 and 17A.8.

Achievement of employment, income and independent housing on exit

‘Achievement of employment, income and 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 G.12).

Box G.12 **Achievement of employment, income and independent housing on exit**

‘Achievement of employment, income and independent housing on exit’ is defined as the number of closed support periods in which SAAP clients who requested assistance for, and maintained or achieved, employment, income and independent housing, as a proportion of the total number of closed support periods in which SAAP clients sought assistance in these matters. A support period refers to the period of time a SAAP client has an ongoing relationship with a SAAP agency.

Three measures are reported:

- the proportion of closed support periods in which SAAP clients who sought assistance for employment were employed after SAAP support
- the proportion of closed support periods in which SAAP clients who sought income assistance (for a pension or benefit) had a source of income after SAAP support
- the proportion of closed support periods in which SAAP clients who sought assistance for housing were living in independent housing after SAAP support.

Data are presented before and after SAAP support. A high or increasing proportion of clients who achieved employment, income and independent housing after SAAP support is desirable.

Data reported for this indicator are comparable. Data quality information for this indicator is under development.

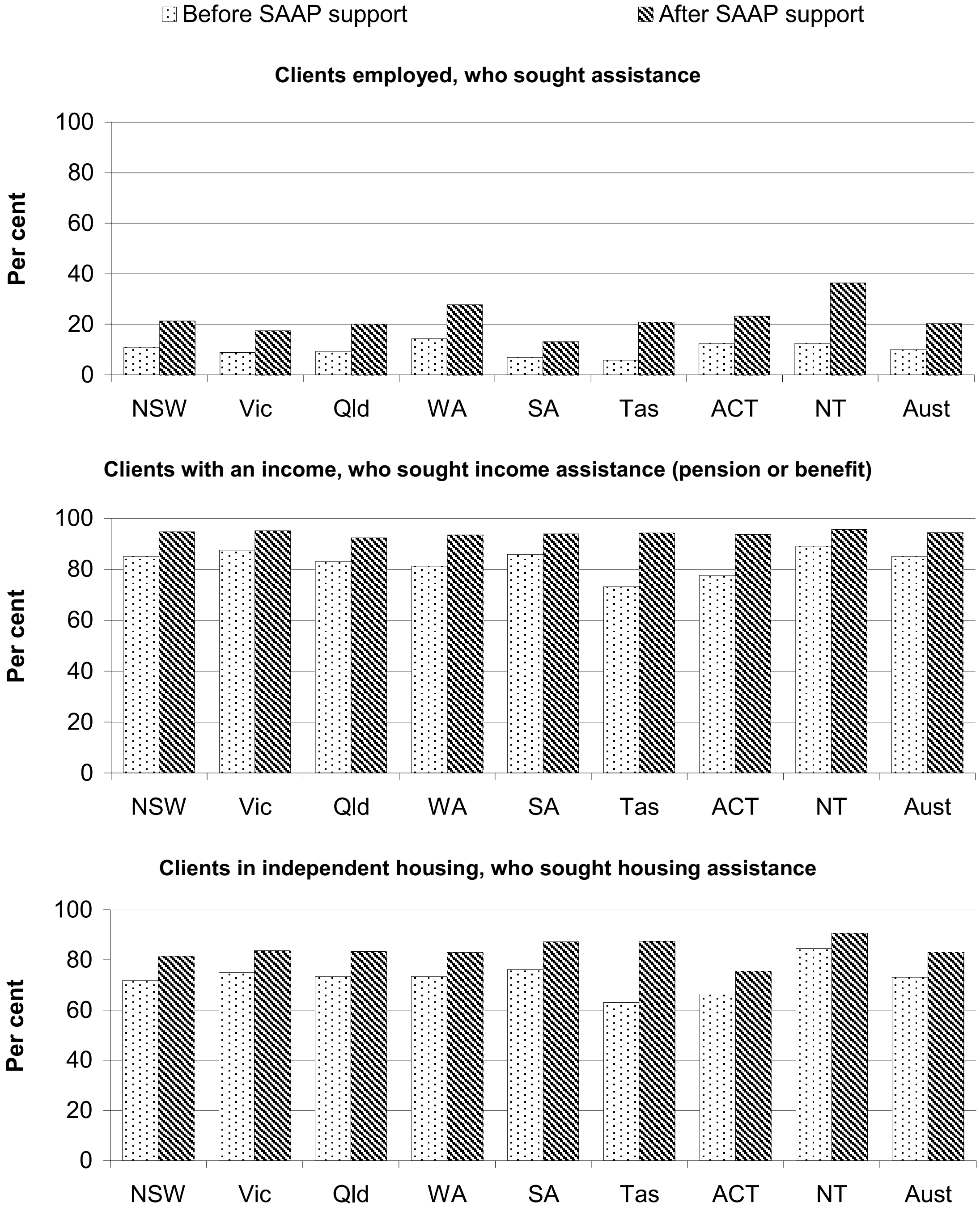
Chapter 17 contains additional measures and further information pertinent to the interpretation of this indicator.

Nationally in 2008-09:

- 20.3 per cent of SAAP clients who sought assistance with employment were employed after receiving SAAP support, compared to 10.0 per cent before SAAP support
- 94.4 per cent of SAAP clients who sought income assistance (for a pension or benefit) had an income after receiving SAAP support, compared to 85.1 per cent before SAAP support

- 83.2 per cent of SAAP clients who sought assistance with housing were in independent housing after receiving SAAP support, compared to 73.1 per cent before SAAP support (figure G.9).

Figure G.9 **Proportions of SAAP clients who sought assistance for, and achieved, employment, income and independent housing, before and after SAAP support, 2008-09**[a]



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[a] See notes to tables 17A.7 and 17.8 for more detailed caveats about these data.

Source: Chapter 17; tables 17A.21, 17A.23 and 17A.29.

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 G.13).

Box G.13 **SAAP clients with only one period of support within a year**

'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 as a proportion of all SAAP clients.

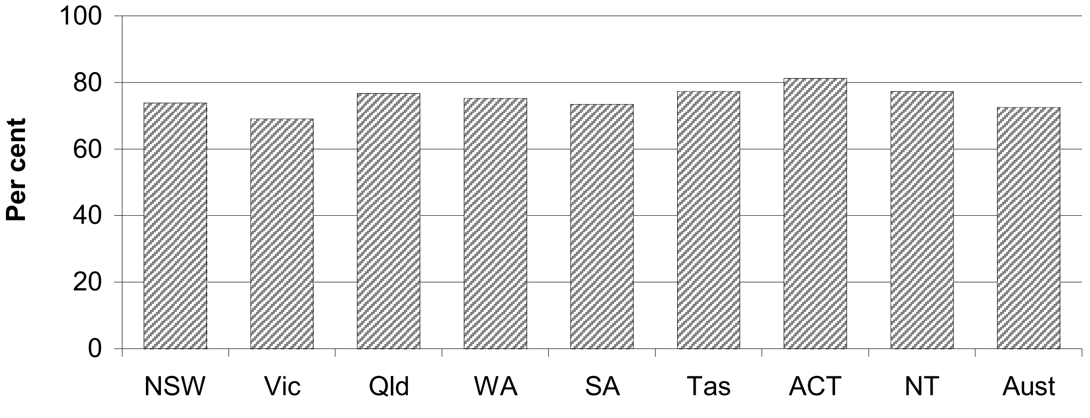
A high or increasing proportion of clients with only one support period during the year is desirable.

Data reported for this indicator are comparable. Data quality information for this indicator is under development.

Chapter 17 contains additional measures and further information pertinent to the interpretation of this indicator.

Nationally, 72.6 per cent of SAAP clients had only one support period in 2008-09, though this varied across jurisdictions (figure G.10).

Figure G.10 **Proportion of SAAP clients with only one period of support within 2008-09**



Source: Chapter 17; table 17A.25.

Cross-cutting and interface issues

Australian and international research illustrates the health and welfare implications of housing and homelessness, identifying a strong association between housing, health status and living standards (Morris 2010; Quine et al 2004; Waters 2001). A lack of adequate and affordable housing results in housing stress and homelessness, and is detrimental to people's physical and mental health (Morris 2010). Homelessness affects life expectancy and homeless people are estimated to live 15–20 years less than the mainstream population (Quine et al 2004).

The provision of housing assistance and homelessness services can improve people's education, health and employment outcomes, crime and community cohesion (King 2002; AHURI 2008). There is evidence to suggest effective housing assistance programs reduce the burden on health and justice services, leading to reduced expenditure for hospital, ambulance, police and court services (AHURI 2008).

National research developments

The National Homelessness Research Agenda 2009–2013 was released on 20 November 2009. The Agenda provides a framework for building a cohesive evidence base to prevent and respond to homelessness. It reflects the Australian Government's strategic research priorities and lists key research questions for the development of an evidence base to drive reforms (FaHCSIA 2010).

The Australian Housing and Urban Research Institute's (AHURI) national research agenda for 2011 reflects the integrated, 'whole of housing system' approach of the housing and homelessness policy environment and emphasises the importance of establishing the links between the housing system and the broader social context (AHURI 2010). Eight strategic research issues are identified and research responding to these strategic issues will assist national housing policy development.

Future directions in performance reporting

The Steering Committee has included this housing and homelessness sector summary in this Report for the first time and will continue to expand reporting on the characteristics of this sector. In particular, data developments spanning housing and homelessness services will be considered. Ongoing investigation of cross-cutting issues might allow improved reporting for housing and homelessness services as a whole.

Each chapter (Housing and Homelessness services) contains a service-specific section on future directions in performance reporting. The aim of this section is to provide an insight into other related and overarching developments on reporting in the housing and homelessness sector.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the Report in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the 'Review of the general performance indicator framework' and the 'Review of the performance indicators and their associated measures'. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

List of attachment tables

Attachment tables are identified in references throughout this service sector summary by a 'GA' suffix (for example, table GA.3). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Appendix G.1 Housing and homelessness contextual information

Housing market demand, supply and affordability

The housing market encompasses rented accommodation, home ownership and investment, and a range of factors influence housing market outcomes.

Factors affecting the demand for housing include population growth, household income and employment, investor demand, household preferences for size, quality and location of housing, the price and availability of housing, government taxes, concessions and transfers, and the cost and availability of finance (NHSC 2010).

A range of factors influence the supply of housing, including land release and development processes, construction and infrastructure costs, government taxes, concessions and transfers, and the availability and price of land (NHSC 2010). The availability of credit to finance the development of new housing may also affect the supply of housing (RBA 2009).

An efficient housing market refers to achieving a balance between housing supply and demand (CRC 2010, p. 75). Nationally in 2009, there was an estimated cumulative gap between underlying demand for housing and housing supply, as a proportion of growth in underlying demand, of 14.7 per cent and an estimated 178 400 dwellings were required in Australia to meet growth in demand (NHSC 2010, tables 7.2 and 7.3).

Housing affordability

A shortage of affordable housing is likely to affect demand for housing and homelessness services. Governments provide support to ensure people can access affordable rental housing, either in the private market or in social housing, and many governments provide support to those purchasing houses, particularly first home buyers (box G.14).

Box G.14 **Government assistance for affordable housing**

A range of government initiatives and programs are designed to help households to pay for their housing and to increase the supply of affordable housing. These initiatives and programs have implications for the gap between housing demand and supply, and include:

- direct assistance to first home buyers through schemes such as the First Home Owners Grant and the First Home Owners Boost. These schemes are funded by the Australian Government and administered by State and Territory governments
- stamp duty concessions or exemptions for first home buyers
- incentives to save for first home ownership through the First Home Saver Accounts
- State and Territory Government funding to assist low income households with home purchases or mortgage repayments
- Commonwealth Rent Assistance paid on an ongoing basis to income support and family tax benefit recipients in the private rental market
- funding for provision and management of social (public and community) housing and related reforms through the National Affordable Housing Agreement
- incentives for institutional investors and community housing providers to build new affordable rental properties
- Commonwealth, State and Territory land and planning measures to increase the supply of affordable housing
- Housing Affordability Fund grants to improve planning and infrastructure provision.

Source: Australian, State and Territory Governments (unpublished).

The Housing chapter (chapter 16) reports on government assistance for social housing and Commonwealth Rent Assistance, but does not report on government assistance for purchasing housing. Information on housing affordability by region in Australia is available in the *2010–2011 State of the Regions Report: the housing shortage and housing affordability* (ALGA 2010).

Affordable housing for low and moderate income households

Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).

Housing stress is considered to occur when households spend more than 30 per cent of their income on rent or mortgage payments. Nationally in 2007-08, 37.2 per cent of low income households were experiencing rental stress and 36.0 per cent of low income households were experiencing mortgage stress (tables GA.6 And GA.10). These data should be interpreted with care because Australian household real incomes have increased strongly over time, allowing households to devote a larger proportion of their income to housing while still maintaining their living standards (RBA 2008).

The proportion of homes sold that are affordable by low and moderate income households indicates whether people can purchase affordable housing. Nationally in 2009-10, 41.9 per cent of homes sold were affordable by low and moderate income households (table GA.10).

Home ownership and government assistance to home buyers

In 2007-08, 68.3 per cent of Australian households owned or were purchasing a home (table GA.10). Home ownership is not necessarily an aspiration for all Australian households, but is often considered desirable because of the benefits associated with home ownership, including wealth accumulation and security of tenure (CRC 2010, p.60). The rate of home ownership in Australia is similar to many developed countries, but is comparatively higher than some European countries and this reflects different cultural and economic incentives, such as income security for retirement (ABS 2010b; Frick and Headey 2009).

Governments provide financial assistance to people purchasing homes, particularly first home owners and low income home owners. Nationally in 2009-10, 168 562 people received the First Home Owner Scheme grant. Of these first home buyers, 139 023 received the First Home Owner Boost (table GA.10).

Appendix G.2 Results for all indicators

Box G.15 **Understanding indicator results**

Data presented for indicators and measures in the tables in this appendix are sourced from chapters 16 and 17. Information to assist interpreting these data can be found in the indicator interpretation boxes in chapters 16 and 17, and in the footnotes in attachment 16A and 17A.

Table G.3 **Performance indicators for public housing, 2009-10**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*Source*
Special needs										
%	64.3	60.5	72.4	62.1	70.0	65.7	51.5	66.8	65.3	16A.2
Priority access to those in greatest need										
%	69.5	72.0	87.7	61.0	80.3	94.8	89.2	45.7	74.9	16A.3
Net recurrent cost per dwelling										
$	7 237	5 000	6 154	7 179	6 653	7 656	8 106	12 059	6 691	16A.4
Occupancy rates										
%	98.9	96.2	98.7	97.0	95.7	98.3	98.9	95.1	97.7	16A.5
Turnaround time										
days	29.4	30.1	27.1	17.3	24.6	27.4	36.1	95.9	28.8	16A.6
Rent collection rate										
%	100.0	99.0	100.3	101.2	99.8	99.0	99.5	103.8	99.9	16A.7
Amenity/location[c]										
Amenity important and meeting needs										
%	79.7	78.6	84.7	84.8	84.7	79.8	78.4	82.6	81.6	16A.8
Location important and meeting needs										
%	86.5	87.4	89.9	87.9	87.8	85.2	83.8	86.4	87.5	16A.9
Affordability[d]										
Average weekly rental subsidy										
$	145	98	152	75	103	87	225	158	127	16A.10
Low income households spending more than 30 per cent of their income on rent										
%	0.1	3.9	–	1.1	1.7	0.2	0.9	5.9	1.3	16A.12
Match of dwelling to household size (overcrowding)[d]										
%	3.2	5.2	4.8	4.1	2.5	4.1	4.0	5.7	3.9	16A.13
Customer satisfaction (satisfied or very satisfied with overall service)[c]										
%	64.2	74.5	84.4	73.9	81.6	68.0	75.0	74.3	73.1	16A.15

[a] Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with interpreting data presented in this table. [b] Some data are derived from detailed data in Chapter 16 and Attachment 16A. [c] Data are for 2010. [d] Data are as at 30 June 2010. **na** Not available. – Nil or rounded to zero.

Source: Chapter 16 and Attachment 16A.

Table G.4 **Performance indicators for SOMIH, 2009-10**[a, b]

		NSW	*Qld*	*WA*	*SA*	*Tas*	*Total*	*Source*
Special needs								
	%	52.2	56.7	38.5	55.3	61.5	51.3	16A.17
Priority access to those in greatest need								
	%	34.8	75.8	48.0	88.7	na	55.9	16A.18
Net recurrent cost per dwelling								
	$	9 152	9 211	9 058	13 079	7 163	9 657	16A.19
Occupancy rates								
	%	98.1	94.8	95.5	92.4	97.7	95.8	16A.20
Turnaround time								
	Days	28.1	43.6	21.3	29.1	40.7	30.5	16A.21
Rent collection rate								
	%	101.5	101.5	104.5	100.7	101.7	101.8	16A.22
Amenity/location[c]								
Amenity important and meeting needs								
	%	75.3	82.6	77.8	77.2	79.6	78.1	16A.23
Location important and meeting needs								
	%	87.1	91.6	86.3	89.1	89.6	88.7	16A.23
Affordability[d]								
Average weekly rental subsidy								
	$	106	159	93	124	99	123	16A.24
Low income households spending more than 30 per cent of their income on rent								
	%	0.1	–	2.0	2.2	–	0.8	16A.26
Match of dwelling to household size (overcrowding)[d]								
	%	3.3	14.6	12.3	11.0	4.9	10.2	16A.27
Customer satisfaction (satisfied or very satisfied with overall service)[c]								
	%	58.6	74.8	60.2	57.9	72.8	63.5	16A.23

a Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with interpreting data presented in this table. **b** Some data are derived from detailed data in Chapter 16 and Attachment 16A. **c** Data are for 2007. **d** Data are as at 30 June 2010. **na** Not available. – Nil or rounded to zero.

Source: Chapter 16 and Attachment 16A.

Table G.5 **Performance indicators for community housing, 2009-10**[a, b]

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
Special needs											
	%	76.3	48.8	55.5	46.6	59.6	71.4	49.4	na	60.2	16A.30
Priority access to those in greatest need											
	%	70.0	55.1	50.5	75.1	60.1	79.6	88.0	na	63.1	16A.31
Net recurrent cost per dwelling[c]											
	$	9 299	9 008	4 962	7 870	7 294	16 835	7 248	na	8 289	16A.32
Occupancy rates[d]											
	%	98.7	93.5	95.2	92.3	94.3	95.3	95.7	100.0	96.0	16A.33
Rent collection rate[c]											
	%	96.6	99.1	99.0	98.8	100.3	99.7	95.8	na	98.1	16A.34
Amenity/location[d]											
Amenity important and meeting needs											
	%	83.2	85.2	83.1	84.9	86.9	91.0	88.9	na	84.7	16A.35
Location important and meeting needs											
	%	87.6	89.7	87.2	87.6	88.5	94.5	94.5	na	88.3	16A.36
Affordability[e]											
	%	12.9	20.3	na	59.7	7.1	28.0	23.6	na	18.4	16A.39
Match of dwelling to household size (overcrowding)[e]											
	%	2.5	3.3	na	1.9	2.7	0.5	1.4	na	2.6	16A.40
Customer satisfaction (satisfied or very satisfied with overall service)[d]											
	%	76.7	79.2	81.4	78.7	84.3	90.4	78.0	na	79.1	16A.41

[a] Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with interpreting data presented in this table. [b] Some data are derived from detailed data in Chapter 16 and Attachment 16A. [c] Data are for 2008-09. [d] Data are for 2010. [e] Data are as at 30 June 2010. **na** Not available.

Source: Chapter 16 and Attachment 16A.

Table G.6 **Performance indicators for Indigenous community housing, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust Gov*	*Aust*	*Source*
Connection to utilities (%)											
Water	–	–	–	–	–	..	–	na	–	na	16A.43
Sewerage	–	–	–	–	–	..	–	na	–	na	16A.44
Electricity	–	–	–	–	0.8	..	–	na	–	na	16A.45
Dwelling condition[c] *(%)*											
Repair	18.8	24.7	26.3	27.9	22.4	30.6	..	21.0	..	23.4	16A.46
Replace	2.7	4.5	5.9	10.1	5.8	–	..	10.2	..	7.2	16A.46
Net recurrent cost per dwelling											
$	5 986	5 901	3 705	6 338	3 276	..	10 088	na	7 501	5 256	16A.47
Occupancy rates											
%	99.2	97.9	96.8	89.8	87.7	..	100.0	na	95.3	96.5	16A.48
Rent collection rate											
%	90.4	94.1	115.8	64.2	60.3	..	100.0	115.6	97.9	96.3	16A.49
Match of dwelling to household size (overcrowding)[c]											
%	25.1	0.8	32.5	na	31.8	..	–	na	13.7	na	16A.50

[a] Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with interpreting data presented in this table. [b] Some data are derived from detailed data in Chapter 16 and Attachment 16A. [c] Data are as at 30 June 2009. **..** Not applicable. **na** Not available. **–** Nil or rounded to zero.

Source: Chapter 16 and Attachment 16A.

Table G.7 **Performance indicators for Commonwealth Rent Assistance, at 4 June 2010**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*Source*
Income unit type — single, no dependant children										
Single, no dependant children										
%	38.1	40.3	35.0	37.6	40.8	40.7	37.2	38.4	38.0	16A.54
Special needs (as a proportion of all CRA recipients)										
Indigenous CRA recipients										
%	4.6	1.5	5.2	3.5	2.5	5.0	2.1	17.8	3.9	16A.58
Recipients of both disability support pension and CRA										
%	20.1	21.1	18.9	18.1	20.9	21.9	13.8	22.1	19.9	16A.58
Geographic spread of CRA customers										
Average fortnightly entitlement – capital cities										
$	100.42	97.2	98.31	96.63	95.93	99.98	91.33	97.55	97.92	16A.68
Maximum rate										
%	71.8	69.5	76.3	72.7	66.4	66.7	79.3	73.9	72.0	16A.69
Number and outcome of appeals										
Original decision affirmed or appeal dismissed										
no.	..	..	..	..	..	..	..	..	346	16A.70
Duration of payments										
Income units at the beginning and at the end of the year										
no.	267 691	170 856	187 116	59 126	56 288	19 126	4 735	2 640	767 604	16A.71
Running costs (per 1000 customers)										
$	..	..	..	..	..	..	..	..	38 623	16A.72
Running costs to total outlays										
%	..	..	..	..	..	..	..	..	1.5	16A.73
Affordability										
Proportion of income units receiving CRA paying more than 30 per cent of income on rent										
With CRA	43.0	39.3	45.1	44.1	35.2	33.6	53.0	43.6	42.1	16A.74
Without CRA	72.8	70.1	73.0	71.0	64.5	67.6	75.7	70.3	71.4	16A.74

[a] Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with interpreting data presented in this table. [b] Some data are derived from detailed data in Chapter 16 and Attachment 16A. **..** Not applicable.

Source: Chapter 16 and Attachment 16A.

Table G.8 **Performance indicators for SAAP services, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*Source*
Demand for SAAP accommodation and turn-away										
Turn-away as proportion of people requiring new, immediate SAAP accommodation										
%	50.5	na	61.2	62.4	65.2	63.5	75.2	51.6	57.4	17A.7
Turn-away as % of total demand for SAAP accommodation										
%	2.1	na	3.7	4.3	2.9	4.1	2.1	5.1	2.9	17A.8
Access of Indigenous people to SAAP service										
Representation among all accommodated SAAP clients										
%	16.8	7.8	22.1	38.0	22.8	12.6	12.4	68.6	21.9	17A.9
Representation among people whose valid requests for accommodation were unmet										
%	23.7	na	32.4	48.5	23.3	10.3	11.1	66.7	30.6	17A.9
Access of people from non-English speaking backgrounds to SAAP service										
Representation among all accommodated SAAP clients										
%	13.6	19.1	7.1	11.1	8.0	4.7	19.6	4.2	11.6	17A.10
Representation among people whose valid requests for accommodation were unmet										
%	11.2	na	3.1	13.2	5.8	3.4	22.2	3.7	7.2	17A.10
Development of agreed support plan										
%	68.2	52.4	63.6	55.6	67.4	54.9	70.1	69.8	60.7	17A.11
Match of needs of clients (provided only)										
%	83.0	80.0	81.1	88.1	78.8	85.0	66.7	90.7	82.0	17A.13
Cost per completed support period										
$	2 410	1 620	2 780	2 870	2 660	2 670	7 760	2 470	2 330	17A.17
Cost per client										
$	3 170	2 720	3 480	3 520	3 310	3 170	7 380	3 140	3 270	17A.18
Cost per day of support										
$	27	30	45	31	28	29	43	35	31	17A.19
Achievement of employment on exit (change in employed)										
%	10.4	8.6	10.8	13.4	6.2	15.0	10.7	23.9	10.3	17A.23
Achievement of Income on exit (change in has income)										
%	9.6	7.8	9.4	12.4	8.2	21.1	16.0	6.6	9.2	17A.29
Achievement of independent housing on exit (change in independent housing)										
%	9.8	8.7	9.9	9.6	11.0	24.5	9.1	6.1	10.1	17A.21
SAAP clients with only one period of support within a year										
%	73.8	69.1	76.7	75.3	73.4	77.4	81.2	77.3	72.6	17A.25
Goals achieved on exit on service (all or most goals achieved)										
%	74.9	65.9	58.6	47.0	60.5	47.9	58.5	66.8	65.3	17A.31

[a] Caveats for these data are available in Chapter 17 and Attachment 17A. Refer to the indicator interpretation boxes in chapter 17 for information to assist with interpreting data presented in this table. [b] Some data are derived from detailed data in Chapter 17 and Attachment 17A. **na** Not available.

Source: Chapter 17 and Attachment 17A.

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CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '16A' 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 Review website at www.pc.gov.au/gsp.

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing and rent assistance. Governments provide housing assistance because many Australian households face problems in acquiring or accessing suitable private accommodation — either through renting from a private landlord or through owner occupation — for reasons of cost, discrimination, availability, location and/or adequacy. The Australian, State and Territory governments share responsibility for housing assistance.

This chapter focuses on the performance of governments in providing:

- social housing: comprising public housing, State owned and managed Indigenous housing (SOMIH), community housing, and Indigenous community housing (ICH)
- Commonwealth Rent Assistance (CRA).

These social housing services are provided under the National Affordable Housing Agreement (NAHA) and its predecessor, the Commonwealth State Housing Agreement (CSHA) (box 16.1). CRA contributes to NAHA, and previously CSHA, outcomes.

Box 16.1 National Affordable Housing Agreement and Commonwealth State Housing Agreement

The NAHA came into effect on 1 January 2009 and is a broad, ongoing agreement that provides a framework to improve housing affordability and homelessness outcomes for Australians. The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation (COAG 2009).

In relation to housing assistance, the parties to the NAHA agreed to a range of outcomes, including:

- providing social housing; assistance to people in the private rental market; and home purchase assistance
- improving coordination across housing related programs to make better use of existing housing stock and assets
- improving the integration between housing and human services, including health and disability services.

The CSHA, which concluded on 31 December 2008, was 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 the agreement was to provide appropriate, affordable and secure housing for those who most need it, for the duration of their need. It included bilateral agreements between the Australian and each State and Territory government and an overarching multilateral agreement.

Source: FaCS (2003); 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:

- assistance to people who are homeless or at risk of homelessness (chapter 17)

- services delivered by governments and community organisations to promote independent living, including mental health services (chapter 12), some aged care services, such as the Home and Community Care program (chapter 13), and services for people with a disability (chapter 14).

Major improvements in the chapter this year include:

- inclusion of new measures for the 'affordability' outcome indicator for public housing, SOMIH and community housing to align with NAHA performance reporting
- adopting the Canadian National Occupancy Standard for reporting the 'match of household to dwelling size' outcome indicator for public housing, SOMIH and community housing, to align with NAHA performance reporting
- expansion of time series data reporting in some attachment tables
- inclusion of some 'data quality information' documentation.

Data in this Report reflect housing assistance provided under the NAHA and the CSHA. Data for 2009-10 relate to the NAHA, data for 2008-09 relate to both the NAHA and CSHA, and data for 2007-08 and preceding years relate to the CSHA.

Data on public housing, SOMIH, community housing and ICH were obtained from State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data tables that are available on the AIHW website (AIHW 2011). 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 the National Social Housing Survey of public housing, SOMIH and community housing tenants.

Housing assistance not reported

This chapter does not cover all types of government assistance for housing. Government services and programs not reported in this chapter include:

- services and programs for people who are homeless or at risk of homelessness (reported in chapter 17)
- government home purchase assistance, such as the First Home Owners Grant
- government assistance in relation to housing supply, including the provision of crisis and transitional housing (such as the former Crisis Accommodation Program that provided capital funding for accommodation for homeless people), the National Rental Affordability Scheme (NRAS) and the Housing

Affordability Fund (which are Australian Government initiatives to increase the supply of affordable housing)

- community housing not funded by the NAHA, or previous CSHA
- programs not covered by the NAHA, or previous CSHA, 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)
- private rent assistance funded by State and Territory governments
- some Indigenous specific housing and infrastructure assistance.

16.1 Profile of housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2007-08 Survey of Income and Housing identified 8.1 million households in Australia, where 'household' is classified as 'a person living alone' or as a group of people who usually live in the same private dwelling (ABS 2009). Of these households, 68.3 per cent owned or were purchasing their own home, 23.9 per cent rented in the private sector, 4.5 per cent rented from public rental accommodation, 1.3 per cent rent from another landlord type (including community housing) and 2.0 per cent were in other tenure types (table 16A.86).

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.8 people between 1971 and 2006, while the proportion of single person households increased from 18.1 per cent to 24.4 per cent over this period (ABS 2007).

The average Indigenous household is larger than the average non-Indigenous household. In 2006, the average non-Indigenous Australian household size was 2.6 people, whereas the average household with at least one Indigenous person was 3.4 people (ABS 2007).

Roles and responsibilities

Australian, State and Territory governments share responsibility for housing assistance provided under the NAHA, and the previous CSHA. Each level of government has different roles and responsibilities in housing and housing assistance:

- The Australian Government provides CRA and influences the housing market through direct and indirect means, including financial sector regulations, taxation and home purchase assistance.
- State and Territory governments administer and deliver housing services, such as public housing, community housing, SOMIH and other Indigenous housing. They also provide financial support to renters through private rental assistance and to buyers through home purchase assistance, and some jurisdictions provide home lending programs. State and Territory governments are also responsible for land use and supply policy, urban planning and development policy, housing-related taxes and charges (such as land taxes and stamp duties) and residential tenancy legislation and regulation.
- Local governments are responsible for building approval, urban planning and development processes and may be involved in providing community housing.

Funding

Australian, State and Territory governments spent at least $7.1 billion on housing assistance during 2009-10. This included Australian Government expenditure of $2.9 billion for CRA and State and Territory government net recurrent expenditure of $4.2 billion for housing assistance (tables 16A.99 and 16A.100).

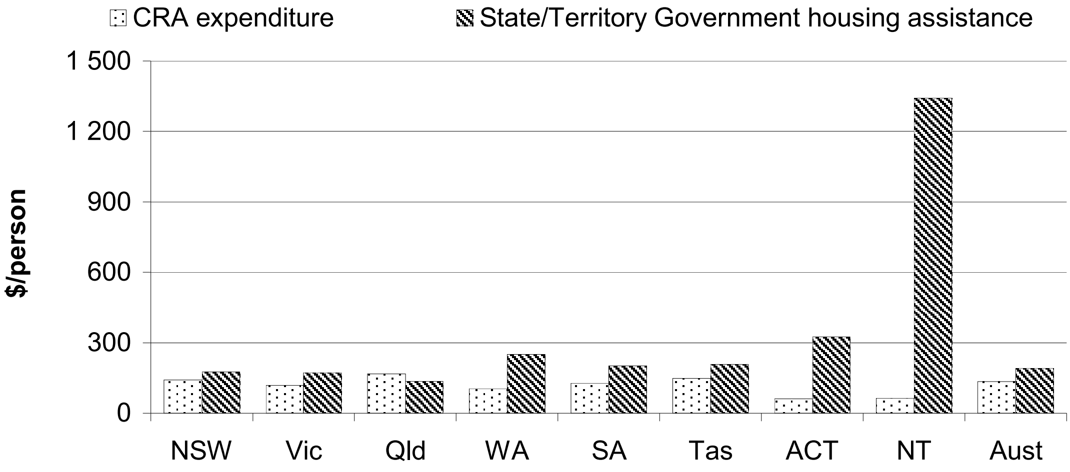
In addition to funding CRA, the Australian Government provides funding to State and Territory governments for housing assistance through the NAHA Specific Purpose Payment (SPP) and related National Partnership agreement payments, and the Nation Building Economic Stimulus Package to aid the construction of new social housing dwellings and repairs and maintenance of existing dwellings. This funding is reflected in data for State and Territory government net recurrent expenditure.

NAHA funding is outcome based and not tied to specific programs and the amount of funding under the NAHA SPP for housing assistance cannot be ascertained. In 2009-10, the Australian Government provided $200 million for the National Partnership Agreement on Social Housing, $610.6 million for the National Partnership on Remote Indigenous Housing, and $3.9 billion through the social housing initiative component of the Nation Building Economic Stimulus Package (table GA.5).

State and Territory government net recurrent expenditure for housing assistance of $4.2 billion in 2009-10 included $2.2 billion for public housing and $115.4 million for SOMIH (table 16A.100). This expenditure also includes funding for community housing organisations and other related housing expenditure, but excludes home purchase assistance, homelessness services and other housing assistance not covered in this Report.

Figure 16.1 illustrates government net recurrent expenditure on selected housing assistance per person in the population. Nationally in 2009-10, Australian Government expenditure on CRA was $134 per person and State and Territory Government expenditure on housing assistance was $192 per person, though this varied across jurisdictions (figure 16.1).

Figure 16.1 **Government expenditure on selected housing assistance, per person in the population, 2009-10**[a]



[a] The Australian Government provides funding to State and Territory governments for housing assistance which is included in State and Territory government expenditure data.

Source: FaHCSIA (unpublished); State and Territory governments (unpublished); tables 16.A.99 and 16A.100.

Governments provide funding for the construction of social housing dwellings. State and Territory government capital expenditure was $4.1 billion in 2009-10 and was partly funded by the Australian Government through the NAHA SPP and Nation Building Economic Stimulus Package (table 16A.100).

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance vary within and across jurisdictions. The forms of housing assistance reported in this chapter are outlined in box 16.2.

Box 16.2 **Forms of housing assistance**

Social housing is a broad term that includes public housing, SOMIH, community housing, Indigenous community housing and crisis and transitional housing. Crisis and transitional housing are not separately identified in this Report, but may be indirectly reported through other forms of social housing.

Public housing: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.

State owned and managed Indigenous housing (SOMIH): dwellings owned and managed by State housing authorities that are allocated only to Indigenous households.

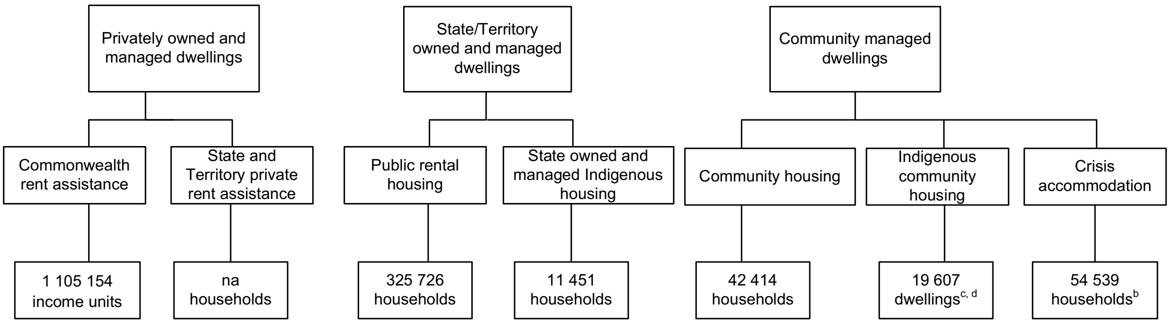
Community housing: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that have received capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.

Indigenous community housing (ICH): dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional and remote areas.

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.

Figure 16.2 illustrates the range of government assistance to renters.

Figure 16.2 **Assistance across the rental sector, 2010**[a]



[a] Additional dwellings funded by programs that are not covered by the NAHA are not included. [b] For year ending 30 June 2009. [c] At 30 June 2009. [d] Includes permanent dwellings managed by funded/actively registered and unfunded/not actively registered ICH organisations.

Source: Australian, State and Territory governments (unpublished); AIHW (2011) *Housing assistance tables;* AIHW (2010) *Indigenous housing indicators 2008-09;* AIHW (2010) *Crisis Accommodation program 2008-09,* Cat. no. HOU 228; FaHCSIA (unpublished); tables 16A.1, 16A.16, 16A.29, 16A.42 and 16A.53.

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. Public housing is generally provided to people on low incomes and to those with special needs, and aims to provide a choice of housing location, physical type and management arrangements. At 30 June 2010, there were 325 726 households occupying 325 673 public housing dwellings (table 16A.1). Data on the proportion of households residing in public housing are reported in table 16A.89.

The NAHA, and previously the CSHA, is the main source of funding for public housing, but NAHA does not separately identify the amount of funding for public housing[1].

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. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.93.

Details of multiple family composition, non rebated and other public households excluded from data in this chapter are presented in table 16A.101.

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[1] NAHA funding is based on outcomes and is not tied to specific programs.

State owned and managed Indigenous housing

State owned and managed Indigenous housing dwellings are defined as those rental housing dwellings owned and managed by government and allocated only to Indigenous Australians (AIHW 2006). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. At 30 June 2010, there were 11 952 SOMIH dwellings (table 16A.16). SOMIH is partly funded under the NAHA, but the amount of this funding cannot be ascertained[2].

In NSW, a separate statutory organisation — the Aboriginal Housing Office (AHO) — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing.

In Victoria, the SOMIH program ended on 30 September 2009 when management of tenancies in those properties was transferred to other programs. There are no SOMIH dwellings reported for Victoria in 2009-10. Under the transition to independence strategy for Aboriginal Housing Victoria (AHV), most tenants of SOMIH dwellings agreed to have their tenancy transferred to AHV management and these dwellings and tenancies are now classified as Indigenous community housing. A small number of SOMIH tenants and properties transferred to public housing.

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.

Details of multiple family composition, non rebated and other public households excluded from SOMIH data in this chapter are presented in table 16A.102.

Community housing

Community housing is delivered by not for profit organisations that develop, own and/or manage affordable rental housing for people on low or moderate incomes. Community housing organisations typically receive some form of government assistance, such as direct funding or the provision of land and property, but a number of community housing organisations are entirely self-funded. Increasingly, community housing organisations are seeking funding through alternative means, such as leveraging and partnership arrangements.

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[2] NAHA funding is based on outcomes and is not tied to specific programs.

A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in providing affordable housing. Community housing programs may also establish links between housing and services managed at the community level, including services for people with a disability, and home and community care. It is also intended to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

The role of community housing in the housing sector is expanding, driven primarily by changes in government policy to encourage the sector to play a larger role in the provision of affordable housing (Productivity Commission 2010). Community housing organisations are working in partnership with the Australian, State and Territory Governments and the private sector to increase the supply of affordable housing, and many of the new dwellings constructed under the NRAS and other Australian Government social housing initiatives will be owned or managed by community housing organisations.

Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in scale, organisational structure and financing arrangements, and the extent to which the community or government has management responsibility and ownership of the housing stock. Table 16A.90 lists the community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing 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, private sector and other organisations provide resources in cooperation with State and Territory governments, or groups of community housing providers who form partnerships to maximise growth opportunities, share resources and/or manage risk
- *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

(Continued next page)

Box 16.3 (Continued)

- *State and Territory government housing entities*: community housing organisations established and controlled by State and Territory governments
- *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).
- *broad service delivery*: welfare organisations provide housing and other services, such as aged care and disability services
- *specialist providers*: community housing providers with a specific purpose or function, such as tenancy management, housing development, or for specific target groups
- *vertically integrated providers of affordable housing*: providers that are involved in all stages of providing affordable housing, from construction to property and tenancy management.

Source: Australian, State and Territory governments (unpublished).

There were 44 328 community housing tenancy rental units in Australia at 30 June 2010 (table 16A.29)[3]. Table 16A.91 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 Australian, State and Territory governments that is managed and delivered by ICH organisations. The commencement of the NAHA on 1 January 2009 resulted in changes to the funding and administrative arrangements for ICH.

Previously under the CSHA, the Australian Government provided funding for ICH through programs such as the Aboriginal Rental Housing Program (ARHP), Community Housing and Infrastructure Program (CHIP) and the National Aboriginal Health Strategy. State and Territory governments also provided funding

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[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.103 and related data quality information.

for ICH, and funding and administrative arrangements for ICH varied across jurisdictions.

From 1 January 2009, ICH was funded through the NAHA and associated National Partnership Agreement on Remote Indigenous Housing. State Governments assumed responsibility for ICH in urban and regional areas and the Australian Government no longer directly funded ICH organisations.

At the time data for this Report were collected (2008-09 and preceding years), the Australian Government funded and administered ICH in Victoria, Queensland and Tasmania. The Victorian and Queensland governments also administered some ICH. In the five remaining jurisdictions — NSW, WA, SA, the ACT and the NT — funding from the applicable State or Territory and the Australian Government was combined and the State or Territory government had sole responsibility for the administration of ICH.

Descriptive information on ICH are contained in table 16A.42.

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 may also include mooring and site fees (for boats and caravans) and payments for retirement village services.

CRA is paid at 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a customer’s family situation and number of children (table 16.1). 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 16.1 **Eligibility and payment scales for CRA, 20 March 2010 to 19 September 2010 ($ 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	100.80	252.00	113.40
Single, no children, sharer	100.80	201.60	75.60
Couple, no dependent children	164.40	307.07	107.00
Single, one or two dependent children	132.86	310.57	133.28
Single, three or more dependent children	132.86	333.71	150.64
Partnered, one or two dependent children	196.56	374.27	133.28
Partnered, three or more dependent children	196.56	397.41	150.64
Partnered, illness separated, no dependent children	100.80	252.00	113.40
Partnered, temporarily separated, no dependent children	100.80	243.47	107.00

[a] Further information pertinent to these data is provided in table 16A.52.

Source: FaHCSIA (unpublished); table 16A.52.

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 1 105 154 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 4 June 2010 (table 16A.53). The proportion of CRA recipients by income unit type is presented in table 16A.54. Data on the number and proportion of Indigenous income units receiving CRA by income unit type are presented in tables 16A.55 and 16A.56, respectively.

The average payment across Australia at 4 June 2010 was $98 per fortnight (approximately $2546 per year). There was relatively little variation in the average level of assistance across locations, even though rents varied considerably by location (table 16A.68).

Diversity of State and Territory public housing, SOMIH and community housing

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different

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[4] Dependent children are defined throughout this chapter as those for whom the person or partner receives Family Tax Benefit part A at more than the base rate.

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 urban, regional and remote area concentration, and the various eligibility criteria for the different assistance types. The policy contexts of public housing and SOMIH are summarised in tables 16A.104 and 16A.105, respectively.

Urban, regional and remote concentrations

The proportion of public housing located in urban, regional and remote areas, using the Australian Standard Geographical Classification remoteness area structure (ASGC remoteness areas), is shown in table 16.2.

Table 16.2 **Public housing — regional and remote area concentrations, at 30 June 2010 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	82.9	72.2	67.3	70.0	77.4	..	99.9	..	72.9
Inner regional	13.8	22.7	16.4	9.6	6.7	73.2	0.1	..	16.0
Outer regional	3.0	5.1	14.1	9.9	14.0	26.0	..	70.2	8.9
Remote	0.3	–	1.7	7.3	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 these data is provided in table 16A.1. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2011) *Housing assistance tables*; table 16A.1.

The proportions of SOMIH located by ASGC remoteness areas are shown in table 16.3.

Table 16.3 **SOMIH — regional and remote area concentrations, at 30 June 2010 (per cent)**[a]

	NSW	*Qld*	*WA*	*SA*	*Tas*	*Total*
Major cities	41.9	13.8	28.0	59.7	..	33.1
Inner regional	32.5	18.8	8.0	7.5	83.4	21.7
Outer regional	19.9	39.8	21.0	17.6	16.6	25.2
Remote	5.0	10.2	20.8	5.2	–	9.2
Very remote	0.7	17.5	22.2	10.1	–	10.8

[a] Further information pertinent to these data is provided in table 16A.16. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2011) *Housing assistance tables*; table 16A.16.

The proportions of community housing located by ASGC remoteness areas are shown in table 16.4.

Table 16.4 Community housing — regional and remote area concentrations, at 30 June 2010 (per cent)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	66.9	74.5	47.0	66.4	85.7	..	99.7	..	65.7
Inner regional	24.9	21.6	22.3	11.9	8.4	67.9	0.3	..	21.2
Outer regional	8.0	3.7	21.4	12.2	4.6	30.5	..	58.6	10.0
Remote	0.2	0.2	3.8	7.3	1.2	1.6	..	37.9	1.9
Very remote	–	..	5.5	2.2	0.1	–	..	3.4	1.2

[a] Further information pertinent to these data is provided in table 16A.29. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2011) *Housing assistance tables*; table 16A.29.

Eligibility criteria

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions (table 16A.104). In most cases, jurisdictions require that applicants are Australian citizens or permanent residents and do not own or part own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. Most jurisdictions provide security of tenure after an initial probationary period and most jurisdictions have periodic reviews of eligibility. Rebated rents result in the majority of households paying no more than 25 per cent of their assessable income in rent (the rent to income ratio), though definitions of assessable income vary across jurisdictions. Tenants who do not provide updated income information may forfeit their rebate and be required to pay market rent.

Eligibility criteria for access to SOMIH are generally consistent with those for public housing once an applicant has been confirmed as Indigenous (table 16A.105). Terms of tenure are the same as those for public housing for most jurisdictions.

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction.

Waiting lists

All State and Territory governments prioritise access to social housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation.

The management of waiting lists varies across jurisdictions. NSW, Queensland, WA and the ACT have adopted a common social housing waiting list, rather than segmenting by public housing, SOMIH and community housing. The remaining jurisdictions (Victoria, SA, Tasmania and the NT) are expected to use a common social housing waiting list by July 2011.

Private rental markets

Tight private rental markets were evident in June 2010, with vacancy rates in capital cities below 3 per cent in most jurisdictions (table 16A.87). Capital city median rents in the private market varied across jurisdictions. Data for median rents for three bedroom houses and two bedroom flats or units in the June quarter of 2010 are reported in table 16A.88.

16.2 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 housing assistance. The framework for housing assistance reflects the national objectives of the NAHA and its predecessor, the CSHA, (box 16.4) and is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 that has been agreed by the Steering Committee.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The NAHA includes a set of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the NAHA.

Separate performance indicator frameworks are presented for public housing and SOMIH, community housing, ICH and CRA to reflect different service objectives and methods of service delivery, but there are some common performance indicators across these frameworks. The performance of housing assistance is reported against the performance indicator framework in figures 16.3, 16.16, 16.23 and 16.25.

Different delivery contexts and locations influence the equity, effectiveness and efficiency of housing assistance. Appendix A contains short statistical profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Box 16.4 **Objectives for social housing**

The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation.

The guiding principles of the CSHA (2003) included maintaining a social housing sector and providing appropriate housing assistance, improving housing outcomes for Indigenous people, improving links with other programs and support to people with complex needs, promoting social and economic participation, managing housing programs efficiently and effectively, ensuring cooperative relationships between levels of governments, and promoting a national approach to affordable housing.

The objective for Indigenous housing is to improve housing outcomes for Ingenious people, especially those living in remote Indigenous communities.

Source: FaCS (2003); COAG (2009).

The National Reporting Framework (NRF) was developed to provide a framework for reporting across all Indigenous housing programs, and to enable reporting on the outcomes of *Building a Better Future: Indigenous Housing to 2010 strategy* (FaCSIA 2001).

The performance indicators for CRA differ from those for social housing because CRA has different objectives and delivery methods. The CRA performance indicator framework in figure 16.25 is based on the CRA objective outlined in box 16.5.

Box 16.5 **Objective of CRA**

The objective of CRA is to assist with the cost of renting private housing for low and middle-income individuals and families in receipt of income support or family assistance payments. This assistance should be delivered in an equitable and efficient manner.

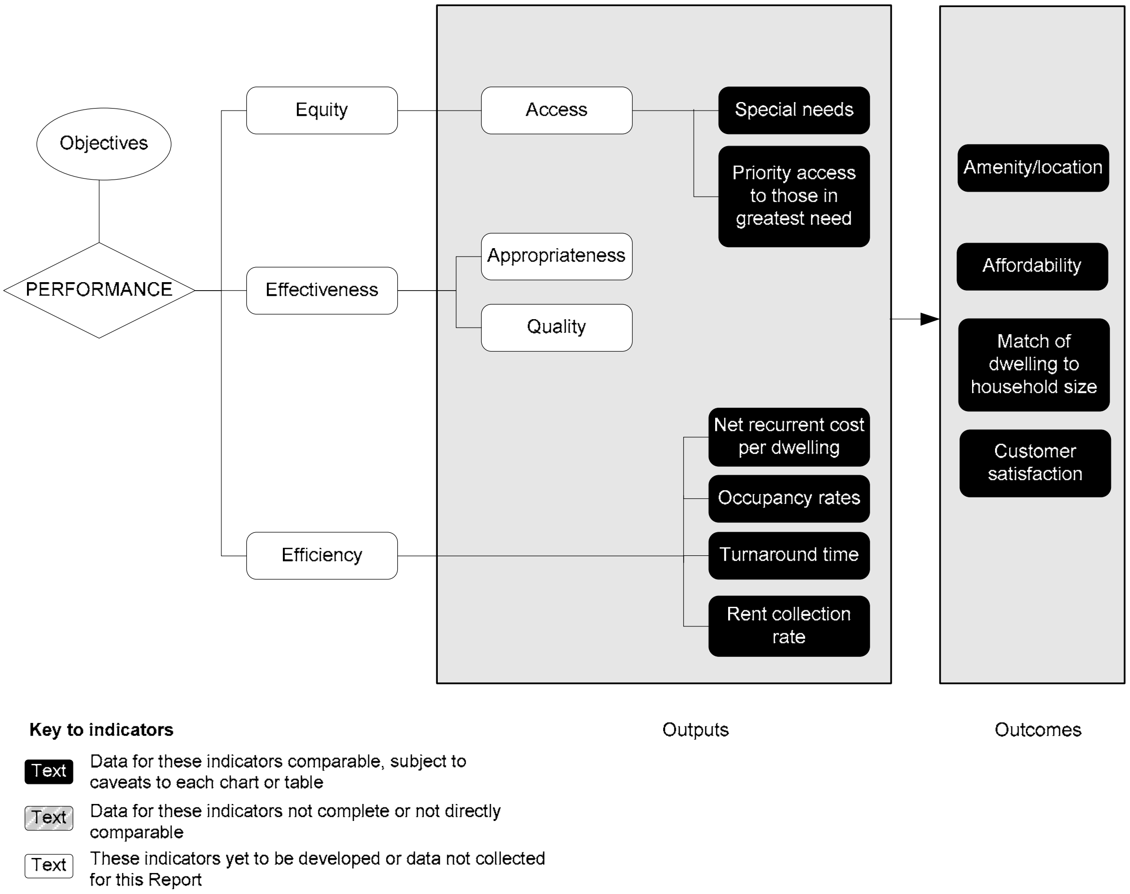
16.3 Key performance indicator results

Generally, performance indicator results are comparable between public housing and SOMIH, but public housing and SOMIH results are not comparable to community housing and ICH because of differences in data quality and coverage. More information is provided in each indicator interpretation box.

Public housing and SOMIH

The performance indicator framework for public housing and SOMIH is presented in figure 16.3.

Figure 16.3 **Performance indicators for public housing and SOMIH**



Different delivery contexts, locations and differing tenant needs can affect the performance of public housing and SOMIH reported in this chapter. For example, SOMIH dwellings are more likely than public or community housing dwellings to be located in regional or remote areas (tables 16.2, 16.3 and 16.4). Care therefore needs to be taken in comparing performance indicator results, and the qualifications presented with the data need to be considered.

Some descriptive data on public housing are included in table 16A.1 and descriptive data on SOMIH are included in table 16A.16. As outlined in section 16.1, Victoria (from 2009-10), 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 services delivered, while outcomes are the impact of these services on the status of an individual or group (see chapter 1, section 1.5).

Special needs

'Special needs' is an indicator of governments' objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.6).

Box 16.6 **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.

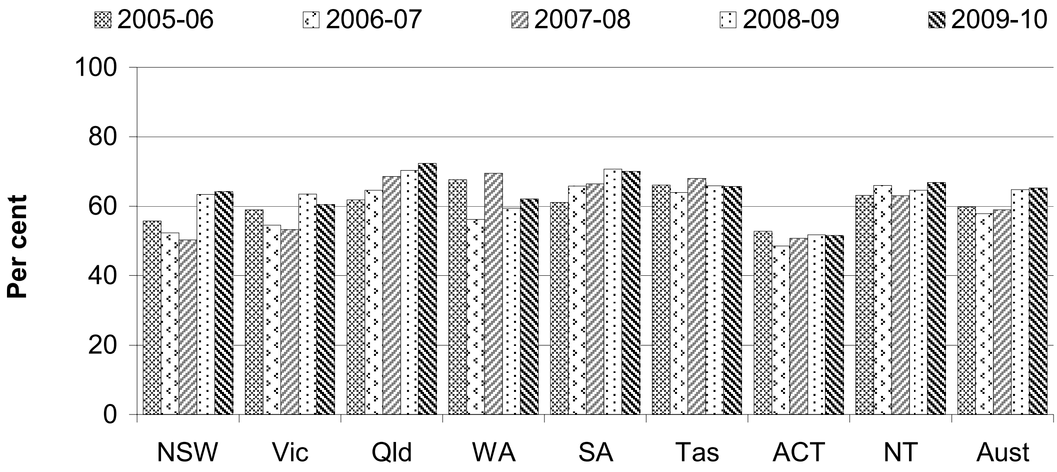
A high or increasing proportion indicates a high degree of access by these special needs households.

Data for public housing cannot be compared with those of SOMIH or community housing.

Data reported for this indicator are comparable across jurisdictions, but not over time. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally in 2009-10, 65.3 per cent of new public housing tenancies were allocated to households with special needs, increasing from 59.8 per cent in 2005-06 (figure 16.4).

Figure 16.4 **Public housing — new tenancies allocated to households with special needs (per cent)** [a]

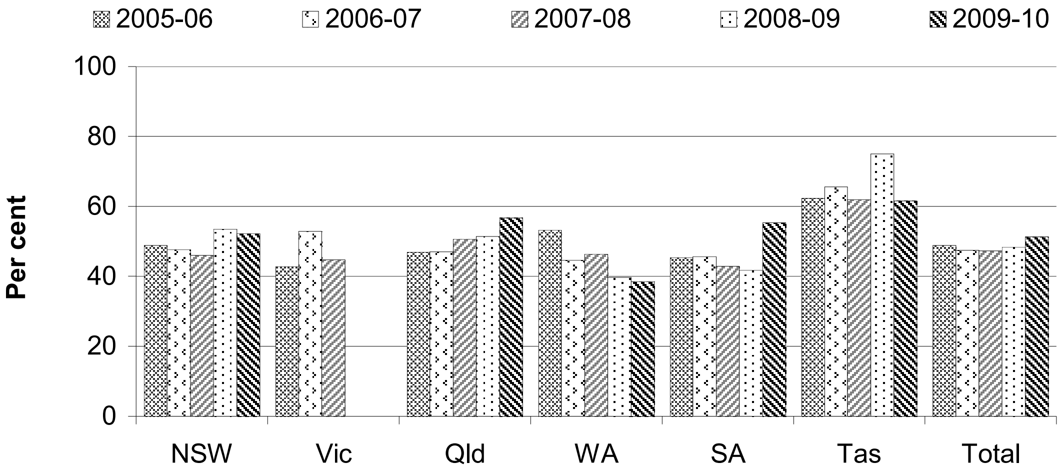


[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.2 provides further information.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.2.

Nationally in 2009-10, 51.3 per cent of new tenancies for SOMIH were allocated to special needs households, increasing from 48.8 per cent in 2005-06 (figure 16.5).

Figure 16.5 **SOMIH — new tenancies allocated to households with special needs (per cent)**[a, b]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.17 provides further information. [b] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.17.

Priority access to those in greatest need

'Priority access to those in greatest need' is an indicator of governments' objective to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes ensure that those in greatest need have priority access to housing (box 16.7).

Box 16.7 **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 proportion of new allocations that were to households in greatest need
- the proportion of new allocations to those in greatest need that were waiting for periods of less than three months; three months to less than six months; six months to less than one year; one year to less than two years; two years or more. These percentages are not cumulative because time to allocation reflects greatest need allocations as a percentage of all new allocations for the time period.

High or increasing values for these measures, particularly for short time frames, indicate a high degree of access for those households in greatest need.

Data reported for this indicator are comparable across jurisdictions, but not over time. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Differences in State and Territory housing assessment policies can influence comparability for this indicator.

Nationally in 2009-10, 74.9 per cent of new allocations for public housing were to those in greatest need (table 16.5). Of all new households that were allocated public housing within three months at 30 June 2010, 83.4 per cent were households in greatest need (table 16.5).

Table 16.5 Public housing — proportion of new allocations to those in greatest need, for year ending 30 June 2010[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of new allocations to those in greatest need in:									
Under 3 months	86.2	74.4	92.3	57.6	88.8	93.1	94.6	34.0	83.4
3 < 6 months	85.9	71.5	89.9	82.5	87.9	97.0	93.5	77.5	84.9
6 months to < 1 year	80.8	74.2	84.9	80.9	83.2	98.4	90.6	61.3	81.5
1 < 2 years	63.3	76.3	81.0	79.9	82.0	94.9	86.9	57.7	74.8
2+ years	40.0	56.1	82.6	19.5	42.4	80.6	75.0	27.9	44.7
Overall	**69.5**	**72.0**	**87.7**	**61.0**	**80.3**	**94.8**	**89.2**	**45.7**	**74.9**

[a] Further information pertinent to these data is provided in table 16A.3.

Source: AIHW (2011) *Housing assistance tables*; table 16A.3.

Nationally, the proportion of new allocations to those in greatest need for 2009-10 for SOMIH was 55.9 per cent. Of all new households that were allocated SOMIH within three months at 30 June 2010, 62.0 per cent were households in greatest need (table 16.6).

Table 16.6 SOMIH — proportion of new allocations to those in greatest need, for year ending 30 June 2010 (per cent)[a]

	NSW	*Qld*	*WA*	*SA*	*Tas*	*Total*
Proportion of new allocations to those in greatest need in:						
Under 3 months	46.2	75.3	36.1	93.1	na	62.0
3 < 6 months	57.4	84.5	88.9	85.7	na	74.2
6 months to < 1 year	36.7	70.7	73.2	100.0	na	59.7
1 < 2 years	14.1	73.2	64.7	83.3	na	49.7
2+ years	23.6	78.6	13.0	66.7	na	27.4
Overall	**34.8**	**75.8**	**48.0**	**88.7**	**na**	**55.9**

[a] Further information pertinent to these data is provided in table 16A.18. **na** Not available.

Source: AIHW (2011) *Housing assistance tables*; table 16A.18.

Efficiency

Net recurrent cost per dwelling

'Net recurrent cost per dwelling' is an indicator of governments' objective to undertake efficient and cost effective management (box 16.8).

Box 16.8 **Net recurrent cost per dwelling**

‘Net recurrent cost per dwelling’ is defined as 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. Data quality information for this indicator is under development.

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 cost of capital (the cost of the funds tied up in the capital used to provide public housing and SOMIH; discussed further at box 16.9).

Due to a high level of capital expenditure in housing, cost per dwelling is predominantly driven by the cost of capital. Caution must therefore be used when interpreting the indicator because the cost of capital and service delivery models differ across jurisdictions. Treatment of assets by housing agencies for each jurisdiction is presented in table 16A.92.

Box 16.9 **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. There is no uniform accounting framework for social housing under the NAHA and there may be variability in data reported in this chapter.

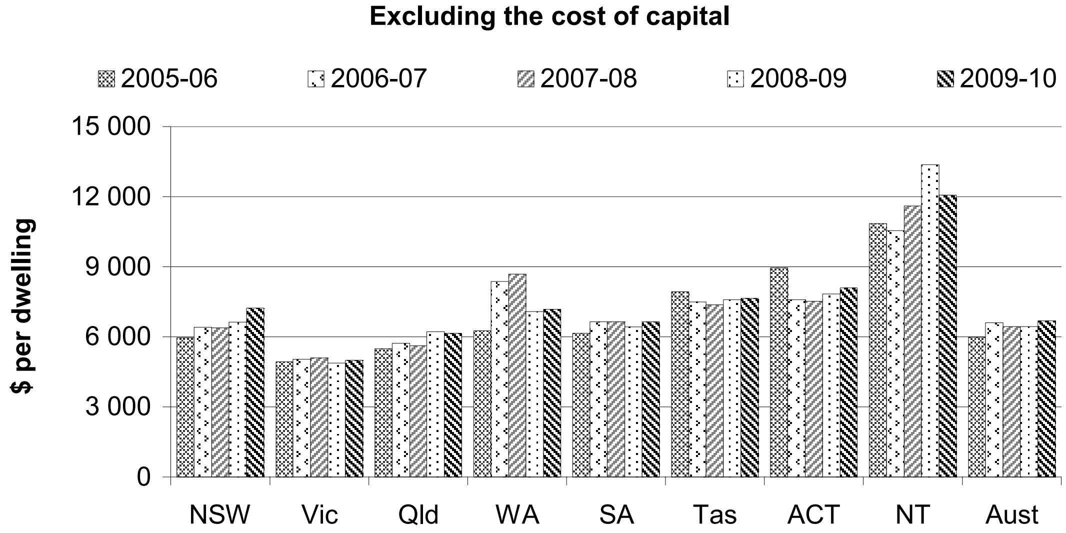
Source: SCRCSSP (2001).

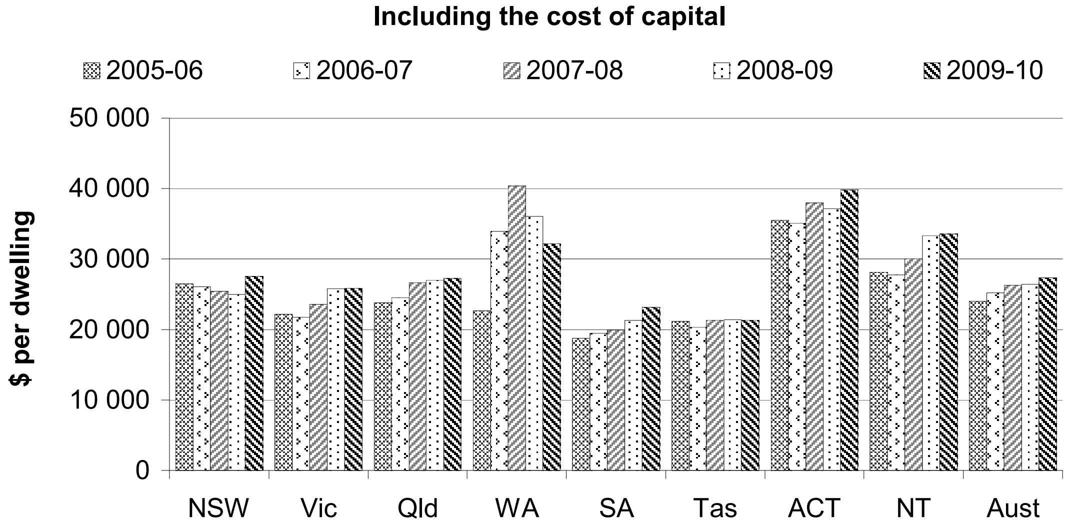
Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than for other jurisdictions or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, 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 in 2009-10, net recurrent cost per dwelling (excluding the cost of capital) for public housing was $6691 and the direct cost per dwelling including capital costs was $27 345 (figure 16.6).

Figure 16.6 **Public housing — cost of providing assistance per dwelling (2009-10 dollars)**[a, b]





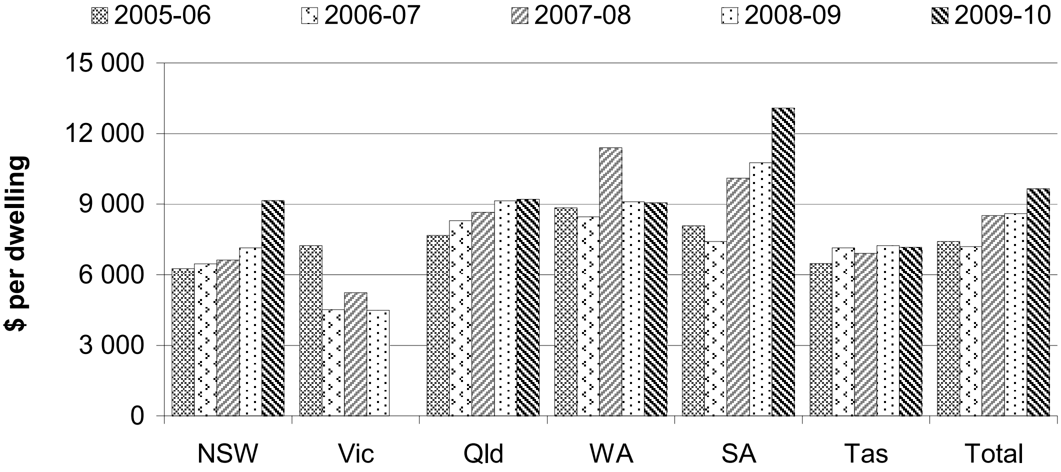
[a] Further information pertinent to these data is provided in table 16A.4. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2009-10 = 100) table AA.26.

Source: State and Territory governments (unpublished); tables 16A.4 and AA.26.

Nationally, the net recurrent cost of providing assistance (excluding the cost of capital) per dwelling for SOMIH was $9657 in 2009-10 (figure 16.7). 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 that for SOMIH, because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

SOMIH dwellings are 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.

Figure 16.7 **SOMIH — net recurrent cost of providing assistance per dwelling (2009-10 dollars)**[a, b, c]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.19 provides further information. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2009-10 = 100) table AA.26. [c] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10.

Source: State and Territory governments (unpublished); tables 16A.19 and AA.26.

Occupancy rate

'Occupancy rate' is an indicator of governments' objective to ensure efficient housing utilisation (box 16.10).

Box 16.10 **Occupancy rate**

‘Occupancy rate’ is defined as the proportion of occupied rental housing stock. The term ‘occupied’ refers to rental housing stock occupied by tenants who have a tenancy agreement with the relevant housing authority.

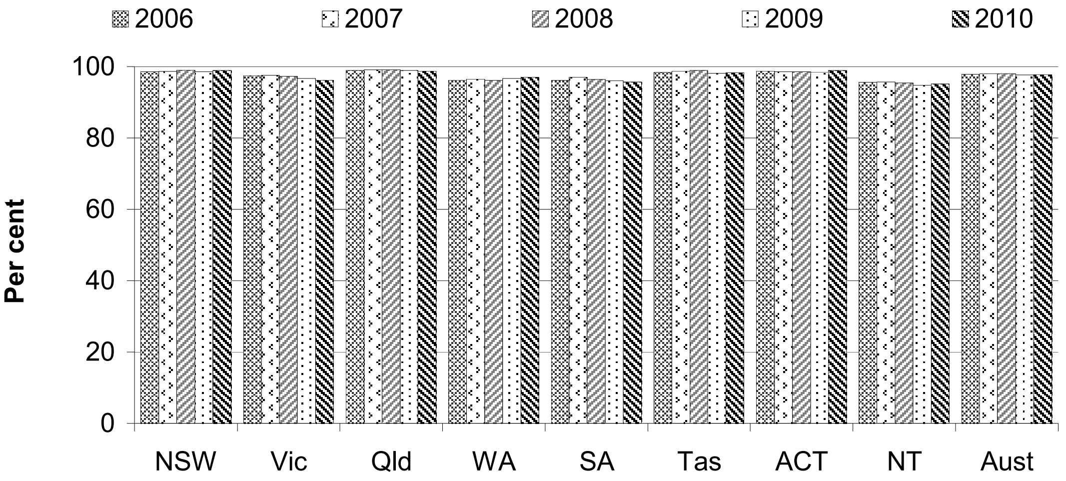
A high or increasing proportion suggests greater efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply and demand.

Data reported for this indicator are comparable. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The national average proportion of total public housing rental stock occupied at 30 June 2010 was 97.7 per cent (figure 16.8). At the national level, occupancy rates have remained at or above 96.6 per cent since 2001 (table 16A.5).

Figure 16.8 **Public housing — occupancy rates, at 30 June (per cent)**[a]



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[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.5 provides further information.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.5.

The national average proportion of SOMIH stock occupied at 30 June 2010 was 95.8 per cent (figure 16.9). At the national level, occupancy rates have remained at or above 95.2 per cent since 2001 (table 16A.20).

Figure 16.9 **SOMIH — occupancy rates, at 30 June (per cent)**[a, b]

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.20 provides further information. [b] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.20.

Turnaround time

'Turnaround time' is an indicator of governments' objective to undertake efficient and cost effective management (box 16.11).

Box 16.11 **Turnaround time**

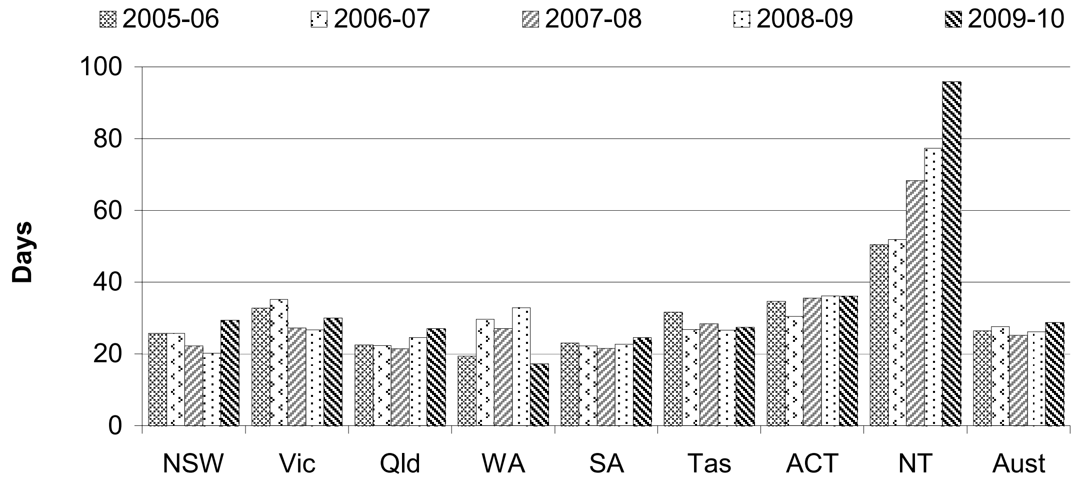
'Turnaround time' is defined as the average time taken for occupancy of available dwelling stock to rent through normal processes. A low or decreasing turnaround time suggests efficient housing allocation.

'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. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the average number of days for vacant stock to remain unallocated in 2009-10 was 29 days for public housing (figure 16.10) and 31 days for SOMIH (figure 16.11).

Figure 16.10 **Public housing — average turnaround time**[a]



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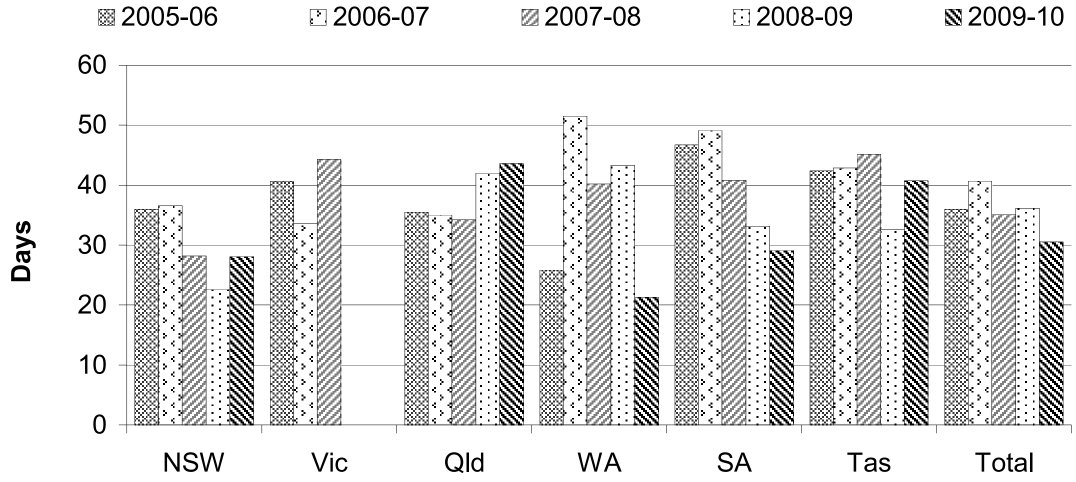
[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.6 provides further information.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.6.

Figure 16.11 **SOMIH — average turnaround time**[a, b]



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[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.21 provides further information. [b] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.21.

Rent collection rate

'Rent collection rate' is an indicator of governments' objective to undertake efficient and cost effective management (box 16.12).

Box 16.12 **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. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the rent collection rate in 2009-10 is 99.9 per cent for public housing (table 16.7) and 101.8 per cent for SOMIH (table 16.8).

Table 16.7 **Public housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
2009-10	100.0	99.0	100.3	101.2	99.8	99.0	99.5	103.8	99.9

a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.7 provides further information.

Source: State and Territory Governments (unpublished); table 16A.7.

Table 16.8 **SOMIH — rent collection rate (per cent)a**

	NSW	*Vic*[b]	*Qld*	*WA*	*SA*	*Tas*	*Total*
2005-06	100.5	99.7	99.7	104.3	94.7	103.8	100.0
2006-07	101.8	97.3	97.3	105.3	103.0	102.1	100.6
2007-08	96.8	99.6	99.6	104.3	103.7	99.8	99.0
2008-09	99.8	97.2	97.2	103.6	99.7	99.0	99.7
2009-10	101.5	..	101.5	104.5	100.7	101.7	101.8

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.22 provides further information. [b] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10. **..** Not applicable.

Source: State and Territory Governments (unpublished); table 16A.22.

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 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 16.13).

Box 16.13 **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. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Data for this indicator are sourced from the National Social Housing Survey, which seeks to determine tenants' level of satisfaction with various aspects of service and to measure housing outcomes. The survey asked public housing and SOMIH tenants whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. Data from the 2010 survey are reported for public housing and data from the 2007 survey are reported for SOMIH.

Caution should be used when comparing the public housing and SOMIH results, due to the different demographic profile of Indigenous tenants and the different time periods and methods for data collection. Information on public housing was collected through mail-out, online and telephone surveys, and information on SOMIH was collected via interviews. These differences may affect the comparability of the results.

Nationally in 2010, 81.6 per cent of public housing tenants for whom amenity was important reported that their needs were met. Of those public housing tenants for whom location was important, 87.5 per cent reported that their needs were met (tables 16A.8 and 16A.9).

Nationally in 2007, 78.1 per cent of SOMIH tenants for whom amenity was important felt that their needs were met. For SOMIH tenants for whom location was important, 88.7 per cent felt that their needs were met (table 16A.23).

The precision of survey estimates depends on the survey sample size and further information can be found in tables 16A.15 and 16A.23.

Affordability

'Affordability' is an indicator of governments' objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.14).

Box 16.14 **Affordability**

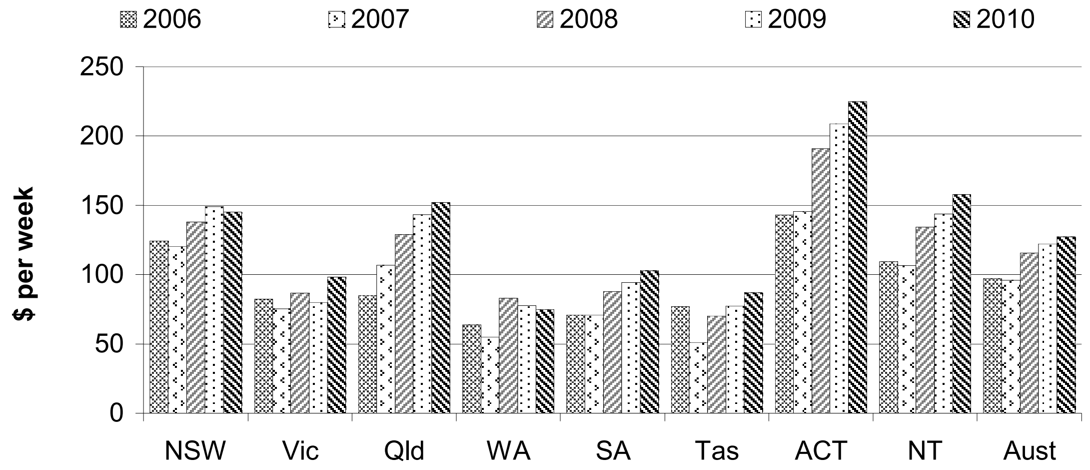
‘Affordability’ is defined as tenants’ financial ability to access suitable housing. Two measures of affordability are reported:

- Average weekly rental subsidy per rebated household, calculated as the total rental rebate amount divided by the total number of rebated households:
  - The amount of a rental rebate is influenced by market rent. High market rents will result in high rental rebates and low market rents will result in low rental rebates. A high or increasing value might imply that governments are spending more to ensure housing affordability.
- The proportion of low income households in public housing or SOMIH spending more than 30 per cent of their income in rent:
  - Low income households are defined as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).
  - Households in public housing and SOMIH who do not receive rental rebates are included in this measure.
  - A low or decreasing value implies greater housing affordability.

Data reported for this indicator are comparable but not complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, the average weekly subsidy per rebated household in public housing was $127 at 30 June 2010, increasing from $97 at 30 June 2006, but this varied across jurisdictions (figure 16.12).

Figure 16.12 **Public housing — average weekly subsidy per rebated household at 30 June (2009-10 dollars)**[a, b]



[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.10 provides further information. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2009-10 = 100) table AA.26.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; tables 16A.10 and AA.26.

Nationally at 30 June 2010, 97.7 per cent of all households in public housing were low income households (table 16A.11) and 1.3 per cent of those low income households were spending more than 30 per cent of their income on rent (table 16.9). Income data for some households are not updated annually and this may result in overestimating the proportion of household income spent on rent. More information on the proportion of income paid in rent by low income households is provided in table 16A.93.

Table 16.9 **Public housing — proportion of low income households spending more than 30 per cent of their income in rent, at 30 June (per cent)**[a]

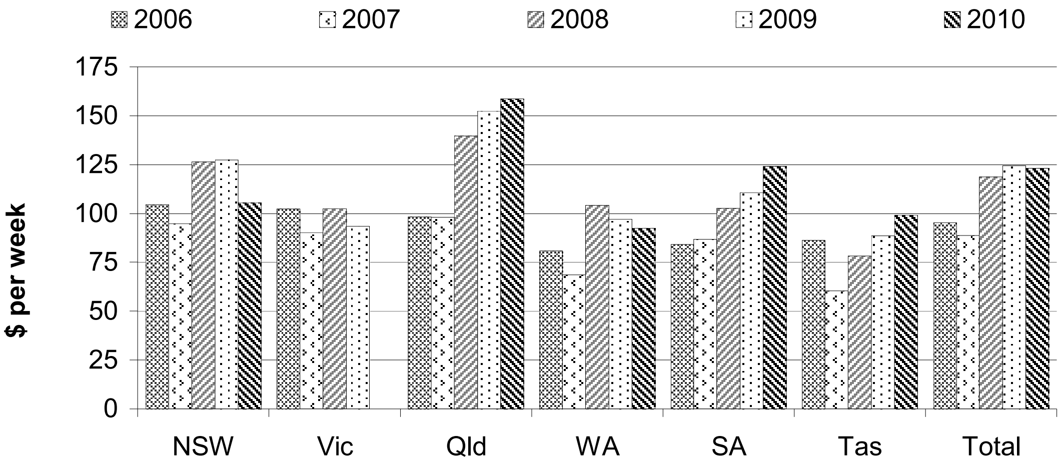
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010	0.1	3.9	–	1.1	1.7	0.2	0.9	5.9	1.3

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.12 provides further information. – Nil or rounded to zero.

Source: AIHW (2011) *Housing assistance tables*; table 16A.12.

Nationally at 30 June 2010, the average weekly subsidy per rebated household in SOMIH was $123, increasing from $95 at 30 June 2006, but this varied across jurisdictions (figure 16.13).

Figure 16.13 **SOMIH — average weekly subsidy per rebated household, at 30 June (2009-10 dollars)**[a, b, c]



[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.24 provides further information. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2009-10 = 100) table AA.26. [c] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.24.

Nationally at 30 June 2010, 95.0 per cent of all households in SOMIH were low income households (table 16A.25) and 0.8 per cent of those low income households were spending more than 30 per cent of their income on rent (table 16.10). Income data for some households are not updated annually and this may result in overestimating the proportion of household income spent on rent. More information on the proportion of income paid in rent by SOMIH tenants is provided in table 16A.94.

Table 16.10 **SOMIH — proportion of low income households spending more than 30 per cent of their income in rent, at 30 June (per cent)**[a]

	NSW	*Qld*	*WA*	*SA*	*Tas*	*Total*
2010	0.1	–	2.0	2.2	–	0.8

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.26 provides further information. – Nil or rounded to zero.

Source: AIHW (2011) *Housing assistance tables*; table 16A.26.

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 16.15).

Box 16.15 **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. Overcrowding is measured using the Canadian National Occupancy Standard (CNOS) (box 16.16) and is deemed to have occurred if one or more additional bedrooms are required to meet the standard.

Data are reported for the proportion of households that are overcrowded. A low or decreasing proportion of overcrowded households is desirable.

Data reported for this indicator are comparable across jurisdictions and complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Box 16.16 **Canadian National Occupancy Standard**

The Canadian National Occupancy Standard (CNOS) provides a way of measuring overcrowding in dwellings and it specifies that:

- no more than two people shall share a bedroom
- parents or couples may share a bedroom
- children under 5 years, either of the same sex or opposite sex may share a bedroom
- children under 18 years of the same sex may share a bedroom
- a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex
- single adults 18 years and over and any unpaired children require a separate bedroom.

Households living in dwellings where this standard cannot be met are considered to be overcrowded. The CNOS allows for comparing the number of bedrooms required with the actual number of bedrooms in the dwelling and is sensitive to both household size and household composition.

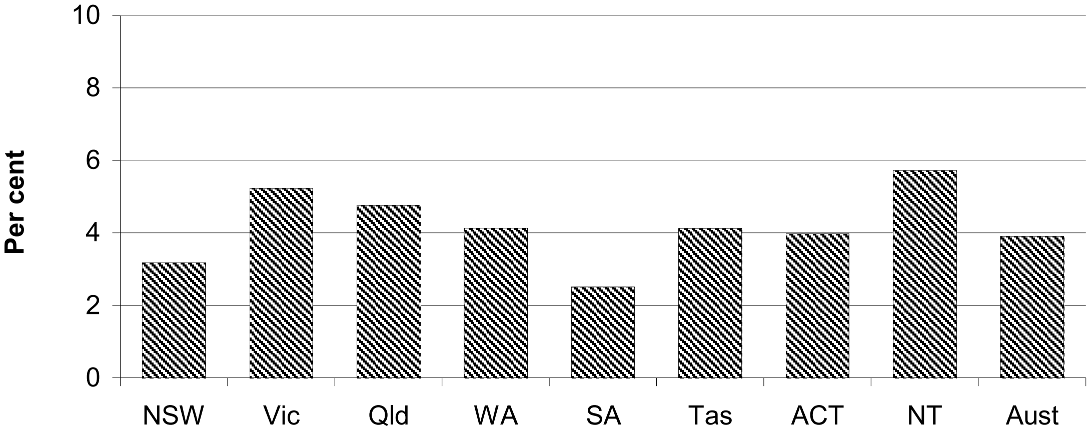
Source: ABS (2006).

State and Territory governments' housing authorities bedroom entitlement policies may differ from the CNOS.

Reporting on overcrowding for public housing and SOMIH for 2010 is based on the CNOS but these data are not directly comparable with data for earlier years presented in tables 16A.13 and 16A.27 due to a change in the reporting standard. Reporting prior to 2010 is based on a proxy occupancy standard where overcrowding is deemed to occur if an additional two or more bedrooms are required to meet the standard (compared to one or more additional bedrooms required using the CNOS).

At 30 June 2010, 3.9 per cent of households in public housing were overcrowded, though this varied across jurisdictions (figure 16.14).

Figure 16.14 **Public housing — proportion of overcrowded households, at 30 June 2010**[a]

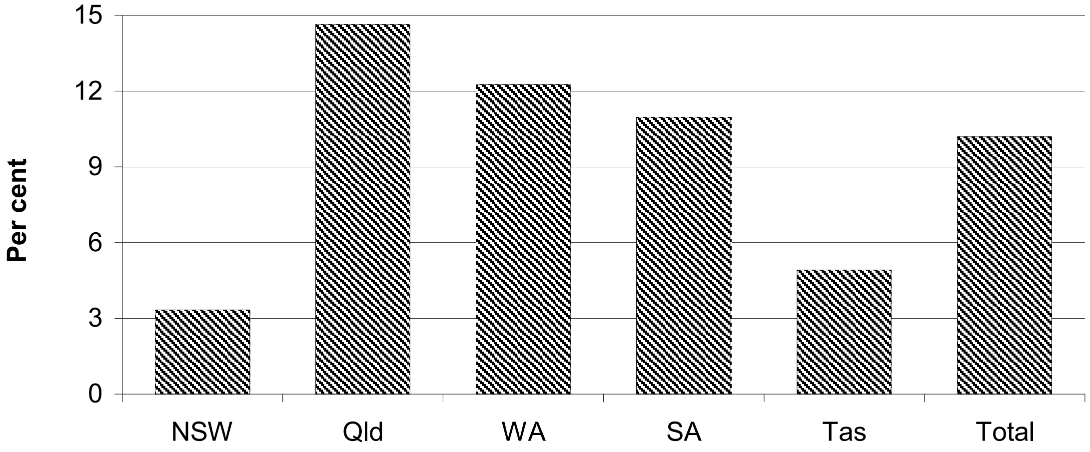


[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.13 provides further information.

Source: AIHW (2011) *Housing assistance tables*; table 16A.13.

At 30 June 2010, 10.2 per cent of SOMIH households were overcrowded, though this varied across jurisdictions (figure 16.15).

Figure 16.15 **SOMIH — proportion of overcrowded households, at 30 June 2010**[a, b]



[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.27 provides further information. [b] All SOMIH dwellings in Victoria were transferred to other housing programs and there are no SOMIH dwellings in Victoria in 2009-10.

Source: AIHW (2011) *Housing assistance tables*; table 16A.27.

Information on Indigenous people living in overcrowded conditions in public housing by remoteness area are presented in table 16A.14. Similar information for SOMIH are presented in table 16A.28.

In contrast to households with overcrowding, some public housing and SOMIH dwellings are underutilised. Data on public housing and SOMIH households with underutilisation are presented in tables 16A.96 and 16A.97.

Customer satisfaction

'Customer satisfaction' is an indicator of governments' objective to provide housing assistance that is appropriate for different households (box 16.17).

Box 16.17 **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 quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

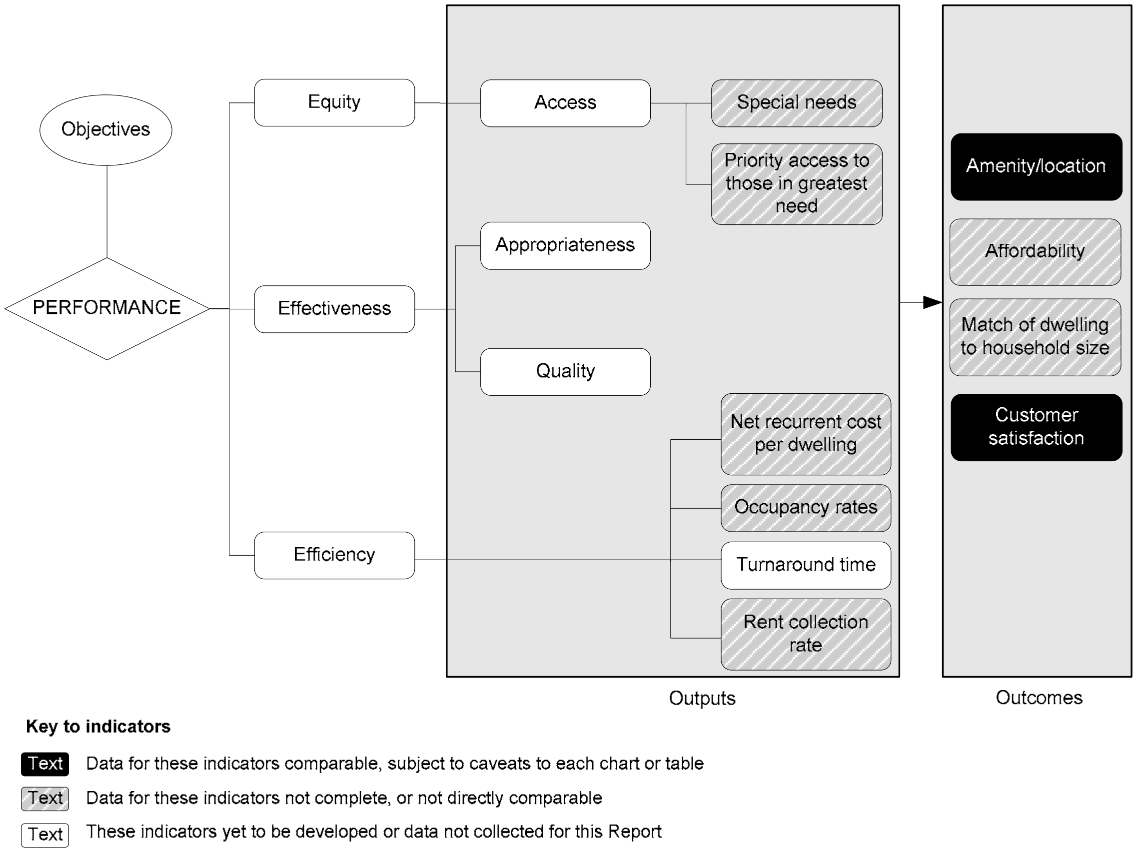
Data for this indicator are sourced from the National Social Housing Survey. Data from the 2010 survey are reported for public housing and data from the 2007 survey are reported for SOMIH.

Nationally in 2010, 73.1 per cent of tenants in public housing were either satisfied or very satisfied (45.9 per cent and 27.2 per cent, respectively) with the service provided (table 16A.15). Nationally in 2007, 63.5 per cent of SOMIH respondents were either satisfied or very satisfied (44.5 per cent and 19.0 per cent, respectively) with the service provided (table 16A.23).

Community housing

The performance indicator framework for community housing is presented in figure 16.16. Performance indicator results are not directly comparable across public housing and SOMIH, community housing and ICH.

Figure 16.16 **Performance indicators for community housing**



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
- 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.

Queensland and the NT provide only administrative data and data from the National Social Housing Survey, as these jurisdictions do not conduct other surveys of its providers.

For the community housing provider survey data, varying response rates and 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.103 and related data quality information outline the survey response rates and associated information for each jurisdiction for each year.

Some descriptive data on community housing are contained in table 16A.29. Table 16A.90 lists State and Territory programs included in the community housing data collection.

Outputs

The following indicators measure the outputs of community housing. Outputs are the services delivered, while outcomes are the impact of these services on the status of an individual or group (see chapter 1, section 1.5).

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 16.18).

Box 16.18 **Special needs**

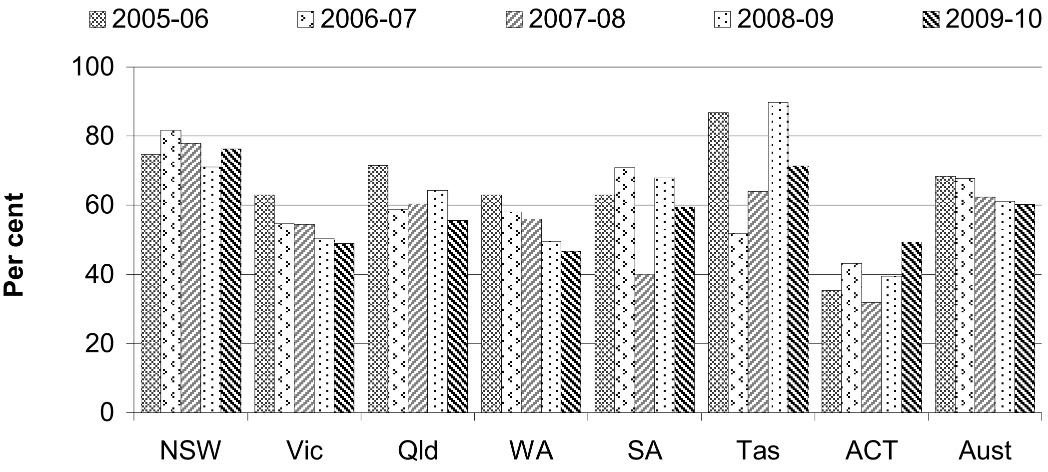
'Special needs' is defined as the proportion of new tenancies allocated to special needs households. The proportion of new tenancies with special needs are reported as a proxy for measuring all households with special needs. Special needs households are defined as those households that have either a 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 neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally in 2009-10, 60.2 per cent of new tenancies were allocated to special needs households (figure 16.17).

Figure 16.17 **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. Table 16A.30 provides further information. [b] Data for the NT are not available.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.30.

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 16.19).

Box 16.19 **Priority access to those in greatest need**

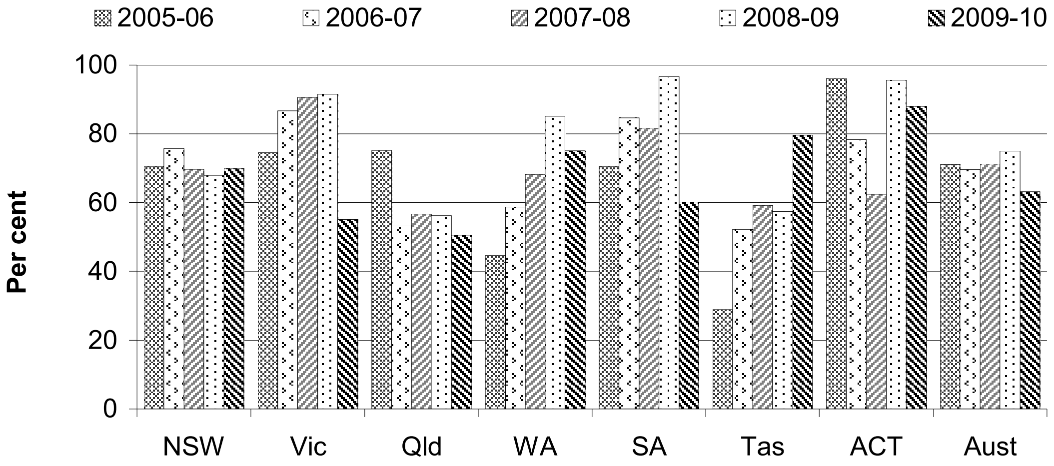
‘Priority access to those in greatest need’ is defined as the proportion of new allocations of housing to those in greatest need. Greatest need households are defined as households that at the time of allocation are either homeless, in housing inappropriate to their needs, or in housing that is adversely 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 neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Differences in community housing allocation policies can influence comparability for this indicator across jurisdictions. Nationally in 2009-10, 63.1 per cent of new allocations were to those in greatest need (figure 16.18).

Figure 16.18 **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. Table 16A.31 provides further information. [b] Data for the NT are not available.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.31.

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 16.20).

Box 16.20 **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.

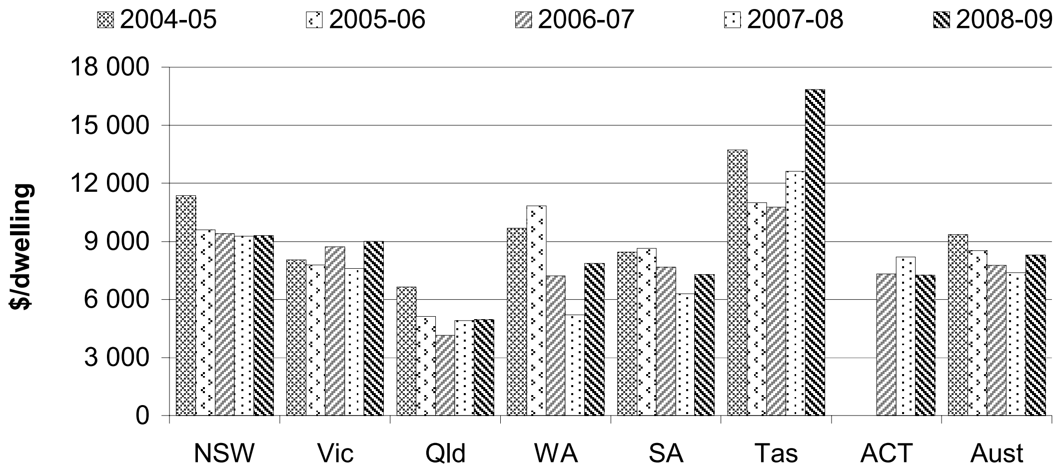
The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data reported for this indicator are neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Capital cost data for community housing are not included as there are no data available on the value of assets. Data on net recurrent cost per dwelling for community housing are reported with a one year lag to allow community housing providers an extra year to collate financial data.

Nationally, the net recurrent cost per dwelling at 30 June 2009 was $8289 (figure 16.19).

Figure 16.19 **Community housing — net recurrent cost per dwelling (2008-09 dollars)**[a, b, c]



[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.32 provides further information. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2008-09 = 100) table AA.26. [c] Data for the ACT were not available prior to 2006-07. Data for the NT are not available.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; tables 16A.32 and AA.26.

Occupancy rate

'Occupancy rate' is an indicator of governments' objective to measure the efficiency of housing utilisation (box 16.21).

Box 16.21 **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 community housing organisation.

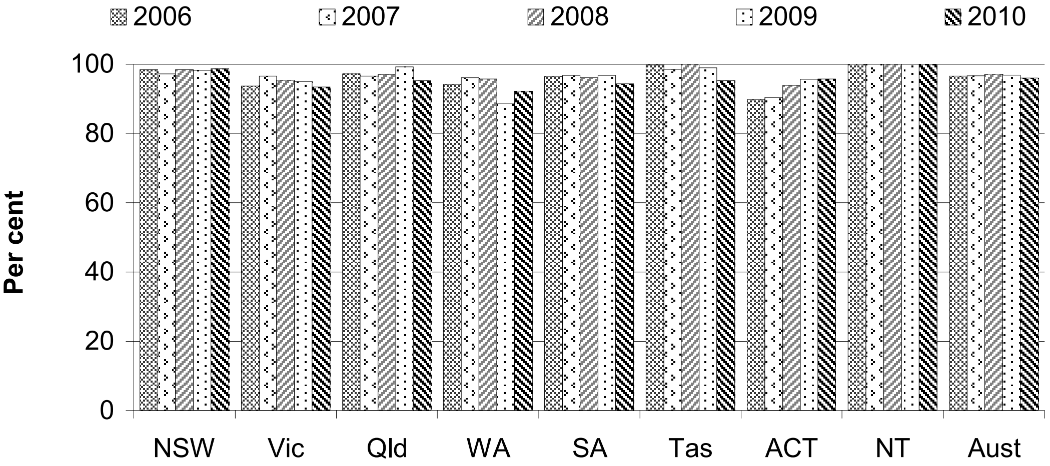
A high or increasing occupancy rate suggests high efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply.

Data reported for this indicator are not directly comparable. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, 96.0 per cent of community housing dwellings were occupied at 30 June 2010 (figure 16.20). The NT occupancy rates are based on the assumption that all dwellings are occupied.

Figure 16.20 **Community housing — occupancy rates (per cent)**[a]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.33 provides further information.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.33.

Turnaround time

'Turnaround time' is an indicator of governments' objective to undertake efficient and cost effective management (box 16.22).

Box 16.22 **Turnaround time**

'Turnaround time' is defined as the average time taken in days for normal vacant dwellings to be occupied. A low or reducing turnaround time suggests efficient housing allocation.

The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone.

'Normal' vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management.

Data for this indicator were not available for the 2011 Report.

Rent collection rate

'Rent collection rate' is an indicator of governments' objective to undertake efficient and cost effective management (box 16.23).

Box 16.23 **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 neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

For community housing, data on the rent collection rate are reported with a one year lag to allow community housing providers an extra year to collate financial data (table 16.11). 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.

Nationally, the rent collection rate for community housing was 98.1 per cent in 2008-09 (table 16.11).

Table 16.11 **Community housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
2008-09	96.6	99.1	99.0	98.8	100.3	99.7	95.8	na	98.1

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.34 provides further information. **na** Not available.

Source: AIHW (2006, 2008, 2009) *CSHA national data report*; AIHW (2010, 2011) *Housing assistance tables*; table 16A.34.

Outcomes

The following indicators measure the outcomes of community housing. Outcomes are the impact of services on the status of an individual or group, while outputs are the services delivered (see chapter 1, section 1.5).

Amenity/location

‘Amenity/location’ is an indicator of governments’ objective to provide housing assistance that is appropriate to the needs of different households (box 16.24).

Box 16.24 **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 not complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Data for this indicator are sourced from the 2010 National Social Housing Survey, which seeks to determine tenants’ level of satisfaction with various aspects of service and measure housing outcomes. The survey asked community housing tenants 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 in 2010, 84.7 per cent of community housing tenants for whom amenity was important reported that their needs were met. For those tenants for whom location was important, 88.3 per cent reported that their needs were met (tables 16A.35 and 16A.36). The precision of survey estimates depends on the survey sample size and further information is presented table 16A.41.

Affordability

‘Affordability’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.25).

Box 16.25 **Affordability**

'Affordability' is defined as tenants' financial ability to access suitable housing. A measure of affordability is reported as the proportion of low income households in community housing spending more than 30 per cent of their income in rent.

Low income households are defined as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).

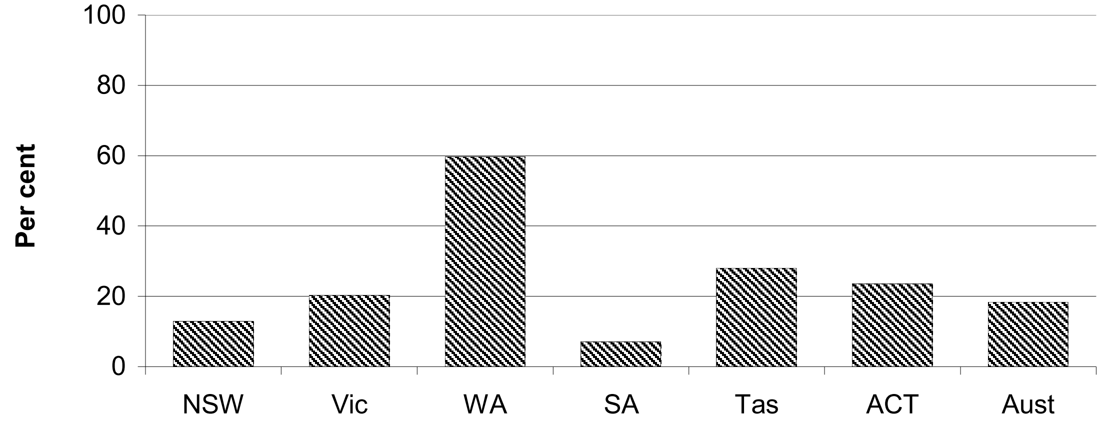
A low or decreasing proportion indicates greater housing affordability.

Data reported for this indicator are neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Differences in the treatment of CRA in rent assessment can affect the comparability of this indicator's reported results. Although CRA should be excluded from household income, data for some households may include CRA in household income.

Nationally in 2010, 92.9 per cent of all households in community housing were low income households (table 16A.38) and 18.4 per cent of low income households in community housing were spending more than 30 per cent of their income on rent (figure 16.21).

Figure 16.21 **Community housing — proportion of low income households spending more than 30 per cent of their income in rent, 2010**[a, b]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.39 provides further information. [b] Data for Queensland and the NT were not available.

Source: AIHW (2011) *Housing assistance tables*; table 16A.39.

The proportion of household income remaining after paying rent was 75.0 per cent nationally in 2010 but this varied across jurisdictions (table 16A.37). More information on affordability for community housing is presented in table 16A.95.

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 16.26). The objectives of community housing providers in providing housing assistance may be different to those of governments.

Box 16.26 **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. Overcrowding is measured using the CNOS (box 16.16) and is deemed to have occurred if one or more additional bedrooms are required to meet the standard.

A low or decreasing proportion of overcrowded households is desirable.

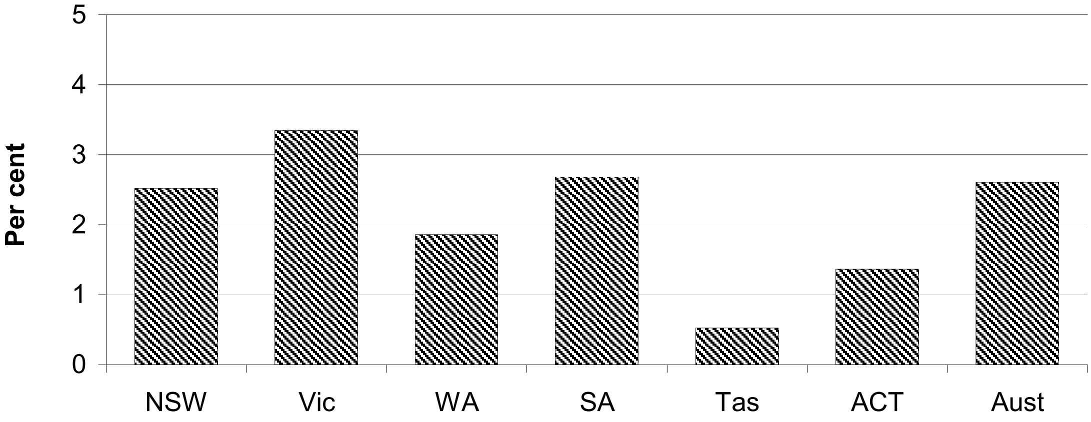
Data reported for this indicator are neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

State and Territory governments' housing authorities bedroom entitlement policies may differ from the CNOS.

Reporting on overcrowding for community housing for 2009-10 is based on the CNOS but these data are not directly comparable to data for earlier years presented in table 16A.40. Reporting prior to 2009-10 is based on a proxy occupancy standard where overcrowding is deemed to occur if an additional two or more bedrooms are required to meet the standard (compared to one or more additional bedrooms required using the CNOS).

Nationally in 2010, 2.6 per cent of community housing dwellings were overcrowded (figure 16.22). Data for previous years reported using the proxy occupancy standard are presented in tables 16A.40.

Figure 16.22 **Community housing — proportion of overcrowded households, 2010**[a, b]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.40 provides further information. [b] Data for Queensland and the NT were not available.

Source: AIHW (2011) *Housing assistance tables*; table 16A.40.

In contrast to households with overcrowding, some community housing dwellings are underutilised. Data on underutilisation in community housing are presented in table 16A.98.

Customer satisfaction

'Customer satisfaction' is an indicator of governments' objective to provide housing assistance that is appropriate to different households (box 16.27).

Box 16.27 **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.

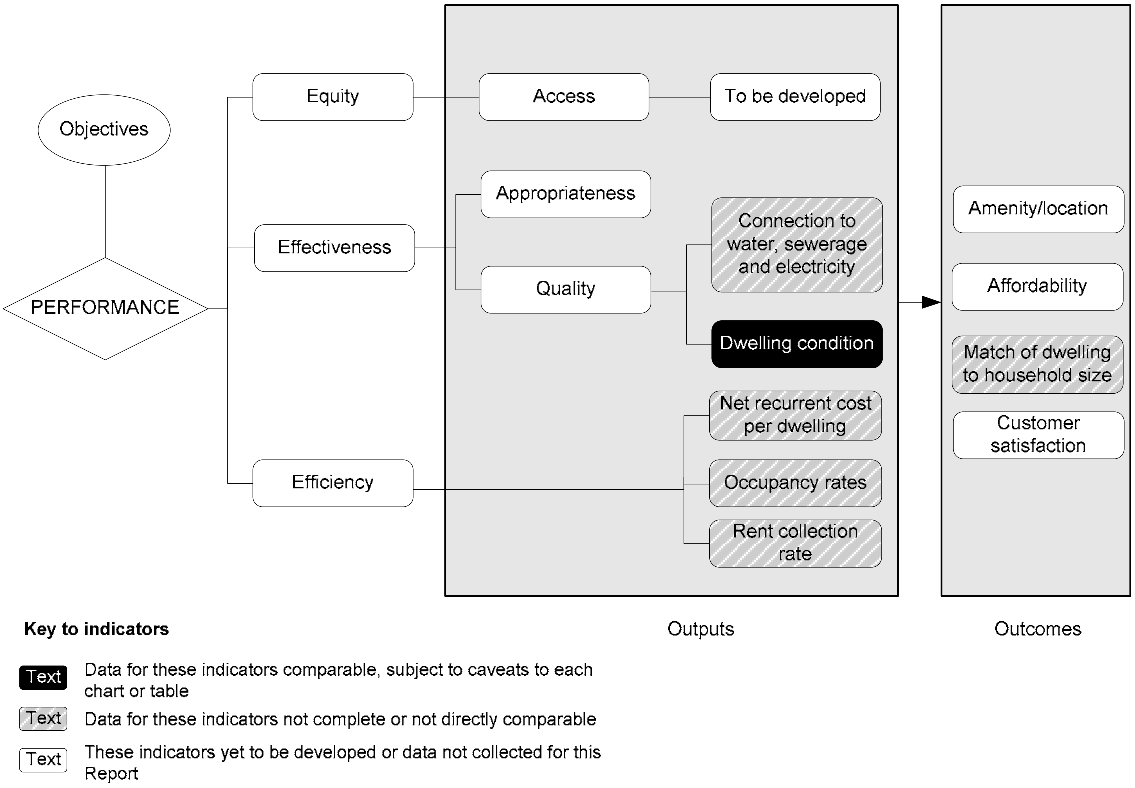
Data reported for this indicator are comparable but not complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Data for this indicator are from the 2010 National Social Housing Survey. Nationally in 2010, 79.1 per cent of tenants were satisfied or very satisfied (41.0 per cent and 38.1 per cent, respectively) with the services provided by their community housing organisation (table 16A.41).

Indigenous community housing

The performance indicator framework for ICH is presented in figure 16.23. Performance indicator results are not directly comparable across public housing and SOMIH, community housing and ICH.

Figure 16.23 **Performance indicators for ICH**



Data for ICH should be interpreted with caution as complete data were not available for all jurisdictions.

Outputs

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

Equity — access

Access indicators measure equitable access to ICH (box 16.28).

Box 16.28 **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 16.29).

Box 16.29 **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. Separate measures are reported for water, sewerage and electricity.

A low or decreasing percentage suggests high housing quality.

Data reported for this indicator are not directly comparable. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The proportions of Indigenous community houses not connected to water, sewerage and electricity are presented in tables 16A.43–45. In 2008-09, almost all of the ICH dwellings for which data were available were connected to water and sewerage for each reporting jurisdiction.

Dwelling condition

‘Dwelling condition’ is an indicator of governments’ objective to provide quality housing (box 16.30).

Box 16.30 **Dwelling condition**

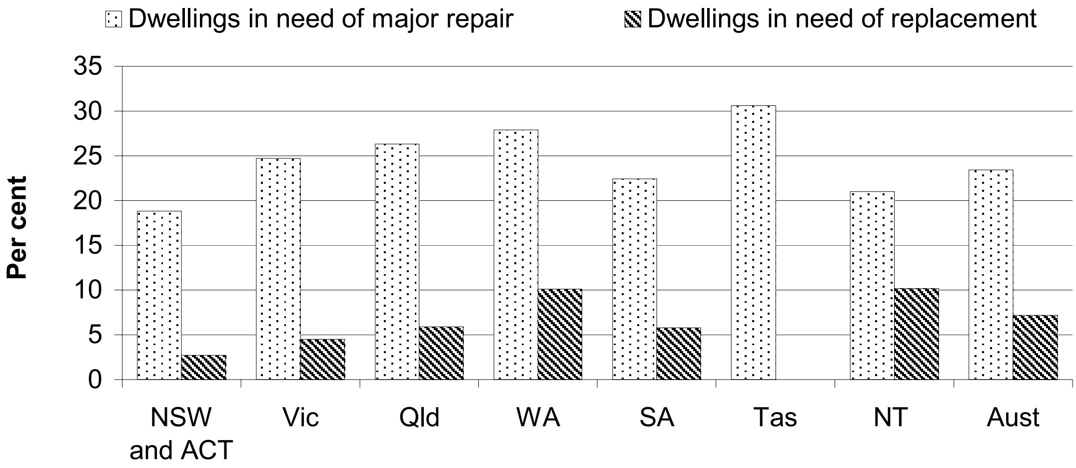
'Dwelling condition' is defined as the proportion of ICH dwellings in poor condition and in need of major repair or replacement. It is measured as the number of permanent ICH dwellings in need of either major repair or replacement as a percentage of the total number of permanent dwellings.

A low or decreasing proportion suggests higher housing quality.

Data reported for this indicator are comparable. Data quality information for this indicator is under development.

Nationally, there were 23.4 per cent of ICH dwellings in need of major repair and 7.2 per cent of dwellings in need of replacement in 2006 (figure 16.24).

Figure 16.24 **ICH — proportion of dwellings in need of major repair and dwellings in need of replacement, 2006**[a]



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[a] The proportion of dwellings in need of replacement in Tasmania was nil, or rounded to zero.

Source: ABS (2007) *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities 2006*; table 16A.46.

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 16.31).

Box 16.31 **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 neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally in 2008-09, the net recurrent cost per ICH dwelling was $5256 (table 16.12). Net recurrent cost data may be underestimated and should be interpreted with caution because complete data were not available for all jurisdictions.

Table 16.12 **ICH — net recurrent cost per dwelling (2008-09 dollars)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*[c]	*Aust*
2005-06	8 014	..	na	na	7 397	..	25 766	652	7 916	na
2006-07	8 694	..	3 584	na	3 561	..	na	na	na	5 451
2007-08	6 919	3 164	7 161	13 831	2 708	..	7 169	na	8 299	7 841
2008-09	5 986	5 901	3 705	6 338	3 276	..	10 088	na	7 501	5 256

[a] Data were presented in current prices based on the Australian Bureau of Statistics (ABS) Gross Domestic Product price deflator (index) (2008-09 = 100) table AA.26. [b] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.47 provides further information. [c] Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. **na** Not available. **..** Not applicable.

Source: AIHW (2007, 2009, 2010 and unpublished) *Indigenous Community Housing data collection*; table 16A.47.

Occupancy rate

‘Occupancy rate’ is an indicator of governments’ objective to provide efficient housing utilisation (box 16.32).

Box 16.32 **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 neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

Nationally, 96.5 per cent of ICH were occupied at 30 June 2009, though this varied across jurisdictions (table 16.13). These data may be underestimated and should be interpreted with caution because complete data were not available for all jurisdictions.

Table 16.13 **ICH — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
2006	96.6	..	95.7	77.9	88.3	..	95.7	87.0	94.1	89.6
2007	98.3	..	100.0	91.0	89.0	..	100.0	na	94.9	96.2
2008	96.0	99.1	98.1	na	93.3	..	100.0	100.0	96.6	98.3
2009	99.2	97.9	96.8	89.8	87.7	..	100.0	na	95.3	96.5

a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.48 provides further information. **..** Not applicable. **na** Not available.

Source: AIHW (2007, 2009, 2010 and unpublished) *Indigenous Community Housing data collection*; table 16A.48.

Rent collection rate

‘Rent collection rate’ is an indicator of governments’ objective to provide efficient and cost effective management of housing (box 16.33).

Box 16.33 **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 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 neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The national rent collection rate in 2008-09 was 96.3 per cent, though this varied across jurisdictions (table 16.14). These data may be underestimated and should be interpreted with caution because complete data were not available for all jurisdictions.

Table 16.14 **ICH — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*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
2008-09	90.4	94.1	115.8	64.2	60.3	..	100.0	115.6	97.9	96.3

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.49 provides further information. **..** Not applicable.

Source: AIHW (2007, 2009, 2010 and unpublished) *Indigenous Community Housing data collection;* table 16A.49.

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 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 16.34).

Box 16.34 **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 2011 Report.

Affordability

‘Affordability’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.35).

Box 16.35 **Affordability**

‘Affordability’ is defined as the extent to which low income households are paying a large share of their income in rent.

A measure of affordability for ICH was included in previous reports. New measures of affordability will be considered as a key area for development in future reports.

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 16.36).

Box 16.36 **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. Overcrowding is measured using the CNOS (refer to box 16.16) and, for ICH, is deemed to occur if two or more bedrooms are required to meet the standard.

A low or decreasing proportion of overcrowded households is desirable.

Data reported for this indicator are neither comparable nor complete. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

State and Territory government's housing authorities bedroom entitlement policies may differ from the CNOS.

Data for overcrowding are not comparable across public housing, SOMIH, community housing and ICH due to different thresholds for determining overcrowding — one or more bedrooms for public housing, SOMIH and community housing; and two or more bedrooms for ICH.

Data for some jurisdictions are based on the proxy occupancy standard, rather than the CNOS. The proportions of ICH households that were overcrowded at 30 June are presented in table 16.15. These data may be underestimated and should be interpreted with caution because complete data were not available for all jurisdictions.

Table 16.15 **ICH — proportion overcrowded households (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
2009	25.1	0.8	32.5	na	31.8	..	–	na	13.7	na

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.50 provides further information. [b] Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA surveys. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2007, 2009, 2010 and unpublished) *Indigenous Community Housing data collection;* table 16A.50.

Data on the number of bedrooms needed for people living in overcrowded conditions in Indigenous community housing are presented in table 16A.51. Data on overcrowding in Indigenous community housing by remoteness area are not available for reporting.

Customer satisfaction

'Customer satisfaction' is an indicator of governments' objective to provide housing assistance that is appropriate to different households (box 16.37).

Box 16.37 **Customer satisfaction**

‘Customer satisfaction’ is defined as satisfaction with the overall quality of service provided.

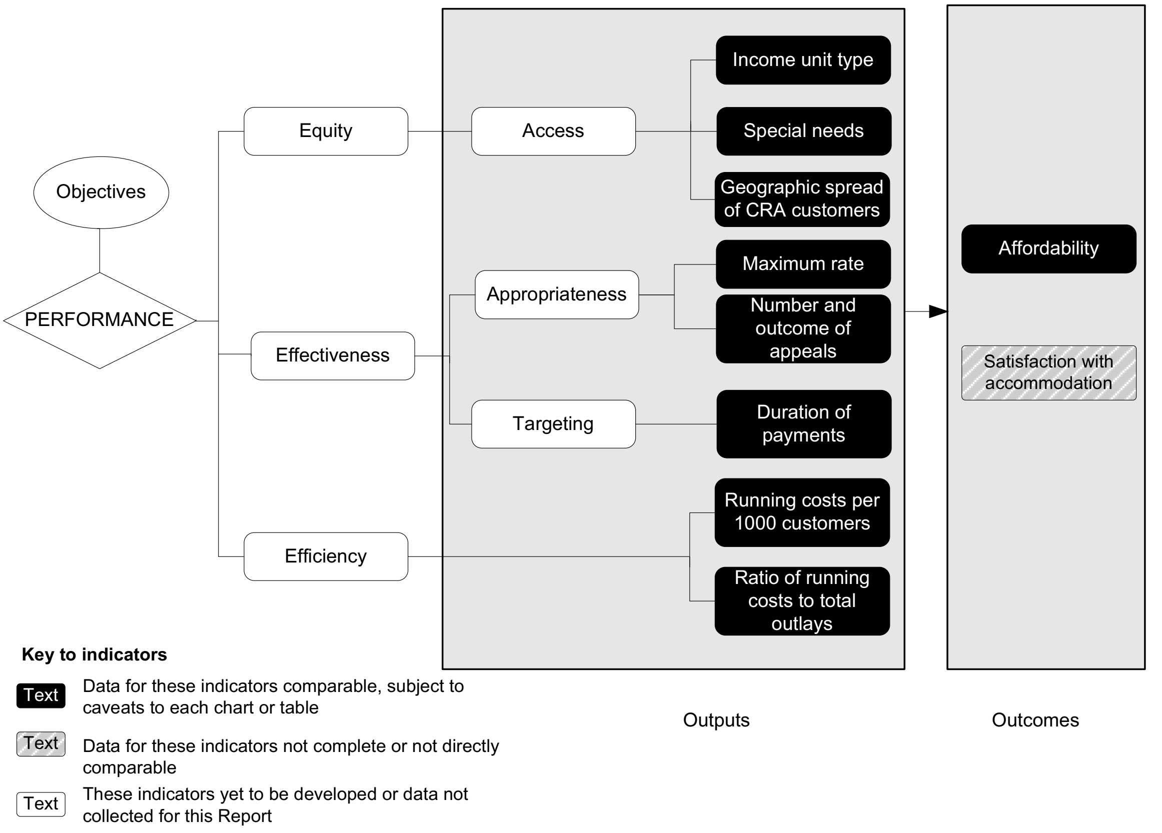
A higher proportion of satisfied tenants can imply better housing assistance provision.

Data for this indicator were not available for the 2011 Report.

Commonwealth Rent Assistance

The performance indicator framework for CRA is presented in figure 16.25.

Figure 16.25 **Performance indicators for CRA**



Data for CRA recipients are for individuals and families paid CRA by Centrelink under social security or family assistance law. These data do not include equivalent payments made by the Department of Veterans Affairs, or payments made with Abstudy on behalf of DEEWR.

Important eligibility requirements for CRA (which is paid automatically once eligibility has been established) are the receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A, and the liability to pay private rent.

Outputs

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

Equity — access

Income unit type

'Income unit type' is an indicator of the CRA's guiding principle to provide financial assistance in an equitable manner (box 16.38).

Box 16.38 **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).

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 for this indicator are difficult to interpret. CRA is a demand driven payment whose mix of customers depends upon eligibility for the primary payment.

Data reported for this indicator are comparable. Data quality information for this indicator is under development.

Nationally, there were 1 105 154 income units entitled to receive CRA at 4 June 2010, of which 42 797 (or 3.9 per cent) self identified as Indigenous. Single people with no children represented approximately 52.6 per cent of income units receiving CRA and 39.2 per cent of Indigenous income units receiving CRA (table 16.16). Further information on income units, including data for each jurisdiction, are presented in tables 16A.53–16A.56.

Table 16.16 **Income units receiving CRA, by income unit type, at 4 June 2010**[a]

Type of income unit	*Income units*	*CRA recipients*	*Indigenous income units*	*Indigenous CRA recipients*
	no.	%	no.	%
Single, no dependent children	420 368	38.0	12 977	30.3
Single, no children, sharer	161 220	14.6	3 800	8.9
Single, one or two dependent children	201 704	18.3	11 006	25.7
Single, three or more dependent children	42 184	3.8	3 773	8.8
Partnered, no dependent children	96 242	8.7	2 549	6.0
Partnered, one or two dependent children	124 210	11.2	5 010	11.7
Partnered, three or more dependent children	56 184	5.1	3 500	8.2
Partnered, illness or temporarily separated	3 042	0.3	156	0.4
Total	**1 105 154**	**100.0**	**42 797**	**100.0**

[a] Further information pertinent to these data is provided in tables 16A.53–16A.56. .. Not applicable.

Source: FaHCSIA (unpublished); tables 16A.53–16A.56.

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 16.39).

Box 16.39 **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 where the primary and/or secondary member receives Disability Support Pension, or is aged 24 years or under, or 75 years or over, or that have 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. Data quality information for this indicator is under development.

Table 16.17 illustrates the proportion of special needs income units receiving CRA at 4 June 2010 by jurisdiction.

Table 16.17 Proportion of income units with special needs, at 4 June 2010[a, b]

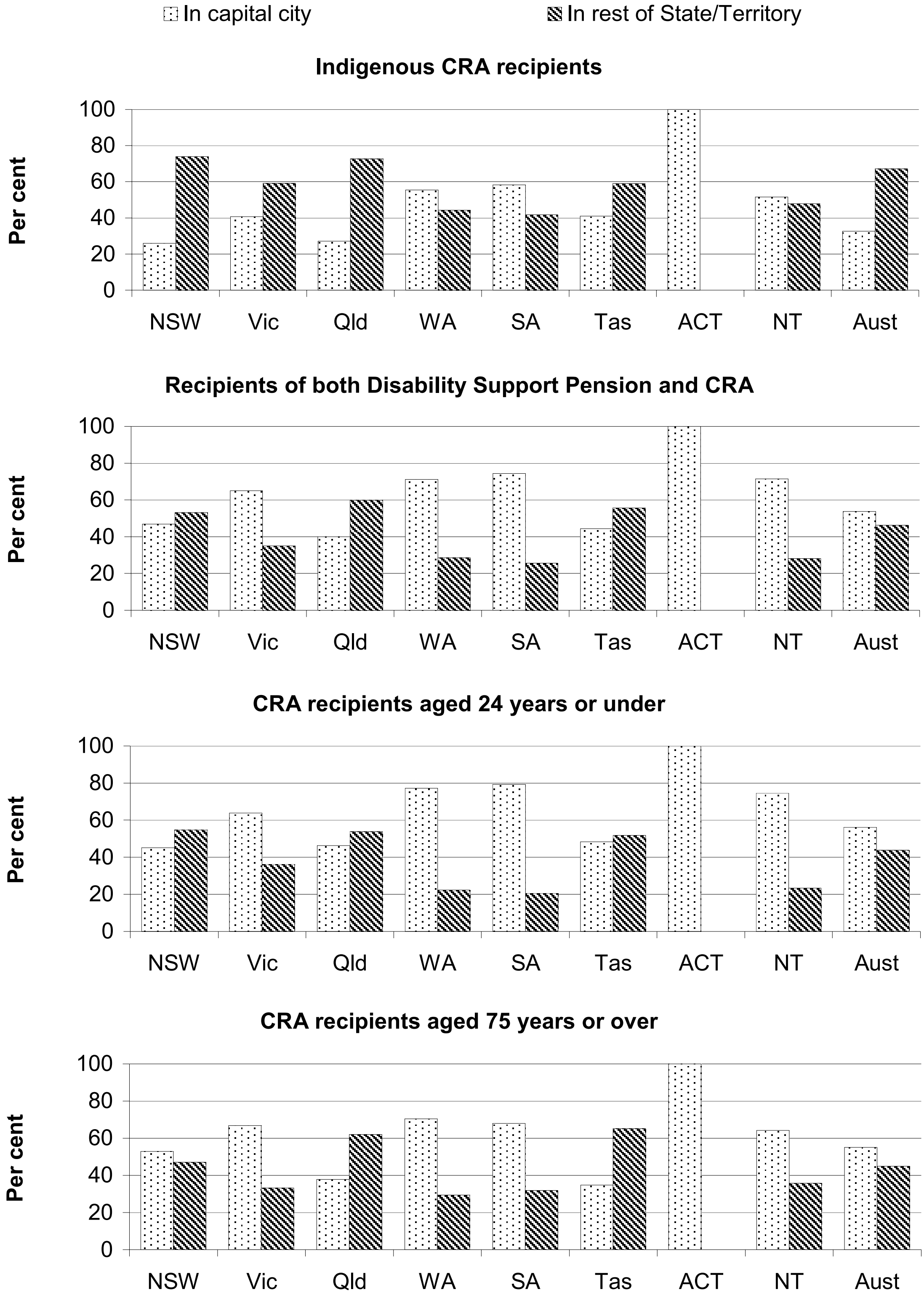
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Non-Indigenous CRA recipients as a proportion of:									
all CRA income units	95.4	98.5	94.8	96.5	97.5	95.0	97.9	82.2	96.1
estimated resident population	97.7	99.3	96.4	96.6	98.1	96.0	98.7	69.8	97.4
Indigenous CRA recipients as a proportion of:									
all CRA income units	4.6	1.5	5.2	3.5	2.5	5.0	2.1	17.8	3.9
estimated resident population	2.3	0.7	3.6	3.4	1.9	4.0	1.3	30.2	2.6
CRA recipients also receiving Disability support pension as a proportion of:									
all CRA income units	20.1	21.1	18.9	18.1	20.9	21.9	13.8	22.1	19.9
estimated resident population	1.1	0.9	1.2	0.7	1.0	1.2	0.3	0.5	1.0
CRA recipients aged 24 years or under as a proportion of:									
all CRA income units	12.9	14.5	15.7	15.9	15.9	19.2	32.2	15.2	14.7
estimated resident population	0.7	0.7	1.0	0.6	0.8	1.1	0.8	0.4	0.7
CRA recipients aged 75 years and over as a proportion of:									
all CRA income units	8.3	8.2	7.8	9.1	9.6	7.8	4.9	3.8	8.3
estimated resident population	0.4	0.4	0.5	0.4	0.5	0.4	0.1	0.1	0.4

[a] Further information pertinent to these data is provided in table 16A.58. [b] Income units can be included in more than one 'special needs' group.

Source: FaHCSIA (unpublished); ABS (unpublished) Population by age and sex, Australian States and Territories, Cat. no. 3201.0; ABS (2007) *2006 Census of Population and Housing*; ABS (2008) *Population Projections, Australia, 2006 –2101*, Cat. no. 3222.0; table 16A.58.

Information on the geographic location of special needs income units is presented in figure 16.26. Overall, most income units receiving CRA resided in capital cities (57.4 per cent), while the remaining 42.5 percent residing lived in the rest of the State or Territory, though this varied across jurisdictions (table 16A.57). For Indigenous income units receiving CRA, 67.3 per cent were located in the rest of the State or Territory, while 32.6 per cent resided in capital cities (figure 16.26).

Figure 16.26 **Geographic location of income units with special needs, at 4 June 2010**[a]



Indigenous CRA recipients

Recipients of both Disability Support Pension and CRA

CRA recipients aged 24 years or under

CRA recipients aged 75 years or over

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[a] Further information pertinent to these data is provided in table 16A.58.

Source: FaHCSIA (unpublished); table 16A.58.

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 16.40).

Box 16.40 **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. Data quality information for this indicator is under development.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support payment or more than the base rate of the Family Tax Benefit are mapped in tables 16A.59–16A.67. Information on the average CRA entitlement across locations is contained in table 16A.68. Nationally in 2010, the average fortnightly CRA entitlement is $98 (table 16A.68).

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 4 June 2010 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 16.41).

Box 16.41 **Maximum rate**

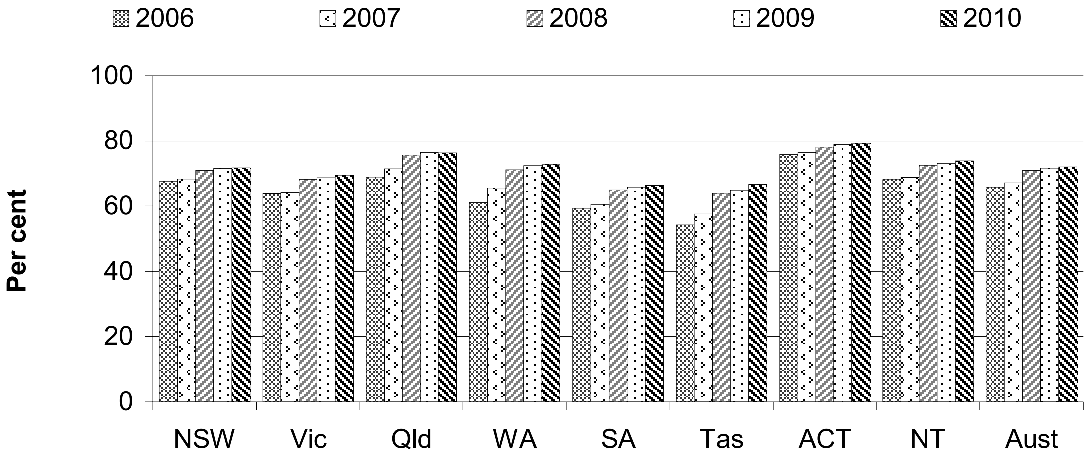
'Maximum rate' is defined as the proportion of income units paying enough rent to be eligible for the maximum rate of CRA.

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. Data quality information for this indicator is under development.

At 4 June 2010, 72.0 per cent of income units receiving CRA across Australia paid enough rent to be eligible for the maximum rate of CRA (figure 16.27). Nationally, there is an upward trend in the proportion of income units receiving CRA between 2001 and 2010 (table 16A.69).

Figure 16.27 **Proportion of income units receiving CRA paying enough rent to receive maximum assistance**[a]



[a] Further information pertinent to these data is provided in table 16A.69.

Source: FaHCSIA (unpublished); table 16A.69.

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 16.42).

Box 16.42 **Number and outcome of appeals**

'Number and outcome of appeals' is defined as the proportion of all CRA appeals finalised, where the original decision is affirmed.

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. Data quality information for this indicator is under development.

There were 617 finalised appeals to an authorised review officer in 2009-10, which represented approximately 0.06 per cent of income units receiving CRA. The original decision was affirmed, or appeal dismissed, for 56.1 per cent of finalised appeals to an authorised review officer, 62.4 per cent of appeals to the Social Security Appeals Tribunal and 42.9 per cent of appeals to the Administrative Appeals Tribunal (table 16.18).

Table 16.18 **Outcome of all CRA appeals finalised in 2009-10**[a]

Outcome	*Appeals to ARO*		*Appeals to SSAT*		*Appeals to AAT*	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	346	56.1	68	62.4	6	42.9
Original decision set aside	136	22.0	30	27.5	1	7.1
Original decision varied	99	16.1	2	1.8	–	–
Appeal withdrawn	36	5.8	9	8.3	7	50.0
Total finalised	**617**	**100.0**	**109**	**100.0**	**14**	**100.0**

ARO = Authorised Review Officer. SSAT = Social Security Appeals Tribunal. AAT = Administrative Appeals Tribunal. [a] Further information pertinent to these data is provided in table 16A.70. – Nil or rounded to zero.

Source: FaHCSIA (unpublished); table 16A.70.

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 16.43).

Box 16.43 **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. Data quality information for this indicator is under development.

Nationally, 1 038 137 income units were entitled to receive CRA payments at 5 June 2009, and 1 105 154 income units were entitled to receive CRA at 4 June 2010. Out of those, 767 604 income units or 69.5 per cent were receiving CRA at both times, implying a high degree of dependence on CRA. The remaining 337 550 income units (30.5 per cent) started to receive CRA during the year and were receiving assistance at the end of the year (table 16.19). Other income units received assistance for only part of the year.

Table 16.19 **Duration of CRA payments, by State and Territory, 2009-10 (number)[a]**

	Number of income units at the beginning of the year (5 June 2009)	*Number of income units at the end of the year (4 June 2010)*	*Number of same income units at the beginning and the end of the year*
NSW	353 939	374 031	267 691
Victoria	230 738	244 335	170 856
Queensland	254 994	275 151	187 116
WA	83 118	89 326	59 126
SA	75 647	80 261	56 288
Tasmania	26 307	27 740	19 126
ACT	8 147	8 887	4 735
NT	5 176	5 351	2 640
Total	**1 038 137**	**1 105 154**	**767 604**

[a] Further information pertinent to these data is provided in table 16A.71.

Source: FaHCSIA (unpublished); table 16A.71.

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 16.44).

Box 16.44 **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. Data quality information for this indicator is under development.

Nationally, the running costs per 1000 customers were $38 623 for 2009-10. (table 16A.72). Running costs have decreased each year since 2006-07.

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 16.45).

Box 16.45 **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. Data quality information for this indicator is under development.

Nationally, the ratio of running costs to total outlays was 1.5 per cent for 2009-10 (table 16A.73). The ratio of running costs to total outlays has decreased each year since 2006-07.

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 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 16.46).

Box 16.46 **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.

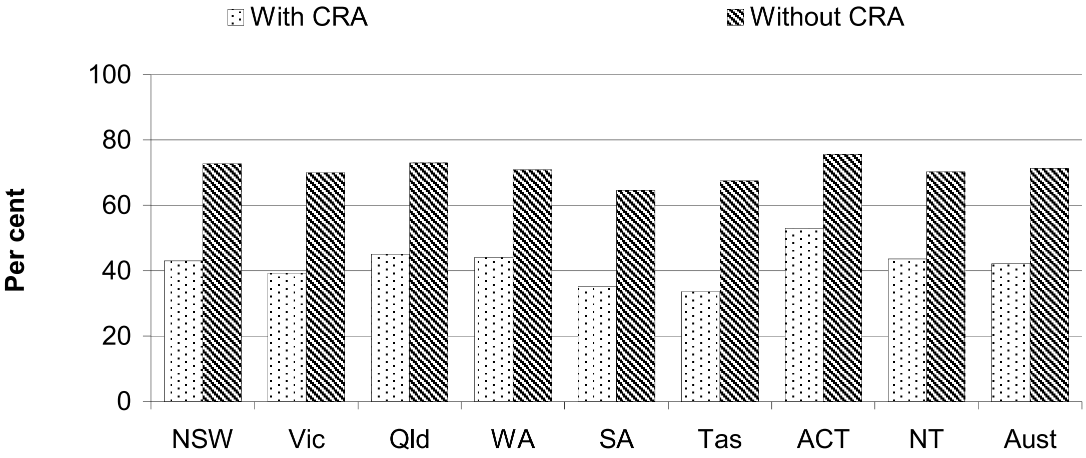
Data reported for this indicator are comparable. Data quality information for this indicator is under development.

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 receiving Disability Support Pension, income units aged 24 years or under, and income units aged 75 years or over is presented in tables 16A.74–16A.84.

Nationally, 42.1 per cent of income units receiving CRA spent more than 30 per cent of their income on rent at 4 June 2010. If CRA were not payable, 71.4 per cent of income units receiving CRA would have paid more than 30 per cent of their income on rent (figure 16.28). Table 16A.75 shows the proportions of CRA recipients spending more than 30 per cent of their income on rent, with and without CRA, since 2001.

Without CRA, 31.0 per cent of recipients across Australia would have spent more than 50 per cent of their income on rent. With CRA, the proportion falls to 14.0 per cent (table 16A.84).

Figure 16.28 **Income units paying more than 30 per cent of income on rent, with and without CRA, at 4 June 2010**[a]



[a] Further information pertinent to these data is provided in table 16A.74.

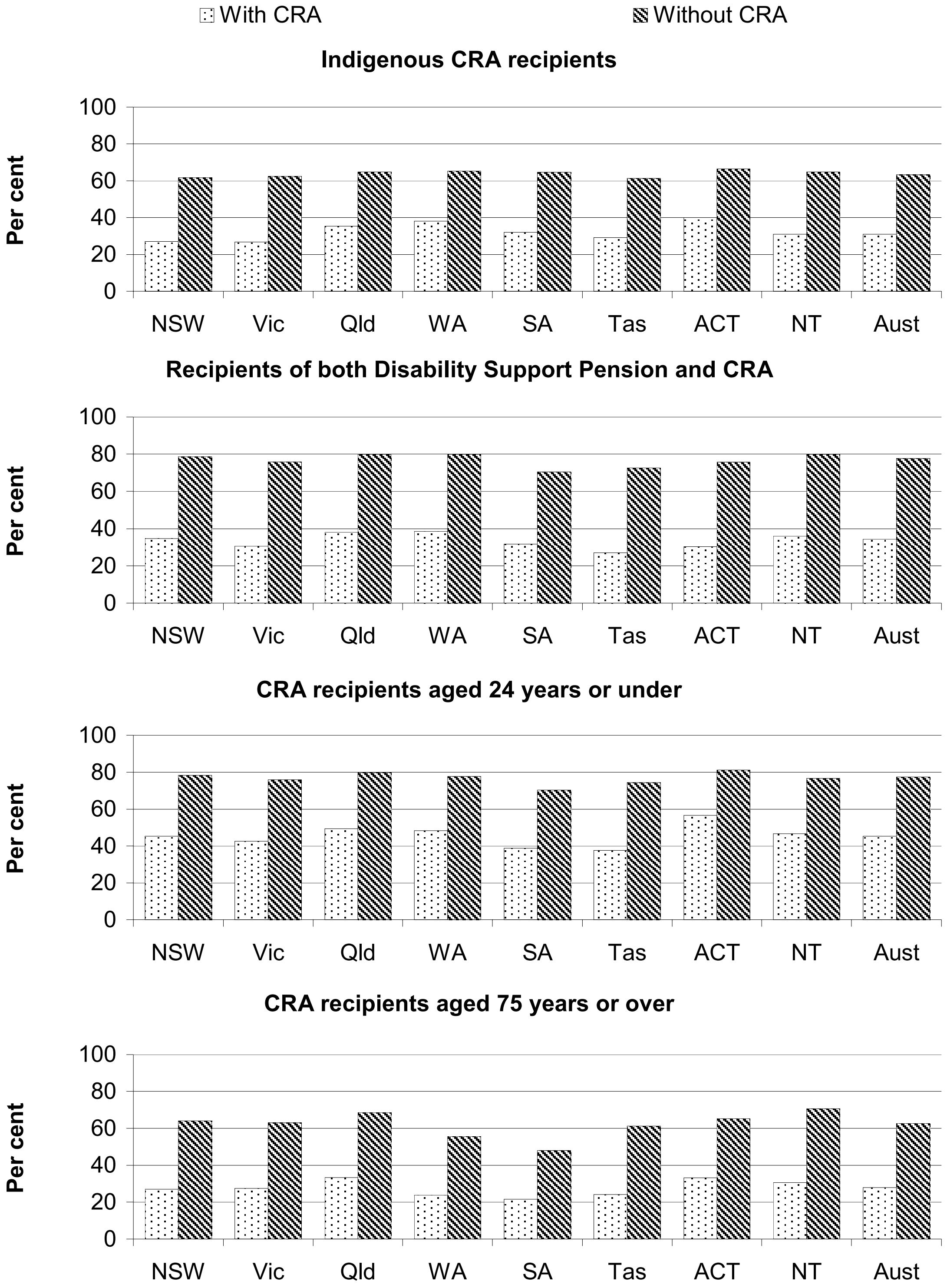
Source: FaHCSIA (unpublished); table 16A.74.

Figure 16.29 shows the affordability outcomes for Indigenous income units receiving CRA, income units with a member receiving Disability Support Pension, income units with a member aged 24 years or under and income units with a member aged 75 years or over. Nationally at 4 June 2010, if CRA were not payable:

- 63.3 per cent of the Indigenous income units receiving CRA would have spent more than 30 per cent of income on rent. With CRA, this proportion decreases to 31.0 per cent
- 77.6 per cent of all income units with a member receiving a Disability Support Pension would have spent more than 30 per cent of income on rent. With CRA, this proportion decreases to 34.4 per cent
- 77.4 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. With CRA, this proportion decreases to 45.3 per cent
- 62.7 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. With CRA, this proportion decreases to 27.8 per cent (figure 16.29).

Further information on the proportion of income units spending more than 50 per cent of income on rent, with and without CRA, are presented in table 16A.84.

Figure 16.29 **Income units paying more than 30 per cent of income on rent, with and without CRA, at 4 June 2010**[a]



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[a] Further information pertinent to these data is provided in tables 16A.76–16A.82.

Source: FaHCSIA (unpublished); table 16A.76, 16A.78, 16A.80, and 16A.82.

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 16.47).

Box 16.47 **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. Data quality information for this indicator is under development.

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 8) conducted in 2008-09, are presented in table 16.20. In 2008-09, 81.7 per cent of people expressed some level of satisfaction with the home in which they lived (25.0 per cent were totally satisfied), 83.2 per cent were satisfied with the neighbourhood in which they lived (22.3 per cent were totally satisfied) and 60.8 per cent were satisfied the feeling of being part of the local community (12.9 per cent were totally satisfied) (table 16.20).

Table 16.20 Satisfaction with home, neighbourhood and being part of the local community (per cent), 2008-09

	Totally dissatisfied	*Dissatisfied*	*Neither satisfied nor dissatisfied*	*Satisfied*	*Totally satisfied*
Home lived in[a]	1.2	10.0	7.1	56.7	25.0
Neighbourhood lived in[b]	0.3	7.4	9.1	60.9	22.3
Feeling of being part of the local community[a]	2.4	18.2	18.7	47.9	12.9

[a] Satisfaction with home in which lived and feeling of being part of the local community were based on 730 valid responses. [b] Satisfaction with neighbourhood was based on 728 valid responses.

Source: FaHCSIA (unpublished); table 16A.85.

16.4 Future directions in performance reporting

Report on Government Services alignment with NAHA reporting

Further alignment between the Report and NAHA indicators might occur in future reports as a result of developments in NAHA reporting.

Outcomes of the review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework’ and the ‘Review of the performance indicators and their associated measures’. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

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 and Homelessness Working Group will continue to improve the quality of 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 National Affordable Housing Agreement (NAHA) commenced on 1 January 2009. It provides a framework for governments to work together to improve housing affordability, reduce homelessness and reduce Indigenous housing disadvantage. As part of the Agreement, governments have committed to undertake reforms in the housing sector, including: improving integration between the homelessness service system and mainstream services; reducing concentrations of disadvantage that exist in some social housing estates; improving 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 National Partnership Agreement on Social Housing has provided $400 million over two years to increase the supply of social housing by at least 1600 dwellings. The National Partnership Agreement on Homelessness is providing $1.1 billion over four years for better services and specialist supported housing. The National Partnership Agreement on Remote Indigenous Housing 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 $5.6 billion over three and a half 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 around 80 000 existing social housing dwellings. This includes significant repairs and maintenance to more than 12 000 social housing dwellings that are currently vacant or will become uninhabitable without this work.

The Australian Government has continued to implement 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; and increases to the First Home Owners Grant, the First Home Owners Boost, the Commonwealth Financial Counselling Program and Centrelink’s Financial Information Service.

COAG has also endorsed a housing supply and affordability reform agenda to be led by Treasurers, including planning and zoning governance reforms, residential development infrastructure charges, the efficiency of housing supply and land release targets, as well as examining the impact of government policies and legislation on housing supply and demand.

Commonwealth Rent Assistance (CRA) is a non-taxable income support supplement payable to individuals and families 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 122 000 properties. The community housing sector's role in the provision of social housing continues to grow with over 20 000 properties now being managed in this sector. The Aboriginal Housing Office currently owns nearly 4 300 properties and registered and non-actively registered Aboriginal housing providers manage more than 4 400 properties.

NSW is working with the Australian and other State and Territory governments to improve housing affordability and to reduce homelessness through a national reform agenda under the National Affordable Housing Agreement, related National Partnerships and the National Partnership on the Nation Building Economic Stimulus Plan.

Housing Pathways was introduced in April 2009 and established a single application system for housing assistance provided by Housing NSW, the Aboriginal Housing Office and housing associations across NSW. This means that applicants only need to fill out a single social housing application form and are put on a single housing register. Housing Pathways is making it simpler, fairer and easier for people to apply for and be matched with housing assistance.

NSW is well on target to deliver its share of new social housing under the 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.

Implementation of the five 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. It is currently expected that this target will be reached in 2012-13.

The NSW Aboriginal Housing Office has developed new initiatives to help the Aboriginal community housing sector to better meet the needs of its tenants and communities through the *Build and Grow Aboriginal Community Housing Strategy*. A key element has been the introduction of a new state-wide standard for Aboriginal housing and tenancy management.

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. The NSW Government's Affordable Rental Housing State Environmental Planning Policy was introduced in October 2009 and focuses on increasing the supply and diversity of affordable housing by encouraging developers to supply new affordable housing and facilitating more affordable forms of development.

Victorian Government comments

“ During 2009-10, Victoria has made excellent progress in delivering more and better affordable rental housing across Victoria and has worked with partners to provide ongoing services and support for homeless people and people living in public and social housing.

Through the Australian Government’s Nation Building Economic Stimulus Plan, Victoria is currently delivering 4500 new homes across Victoria and a total of eight major redevelopment projects to redevelop outdated public housing neighbourhoods.

During 2009-10, Victoria built or bought around 3000 new public and social housing properties across metropolitan Melbourne and Victoria’s major regional centres. New homes are located close to services, schools and transport so people have the opportunity and support to thrive in the community.

Victoria also completed major upgrades to more than 3700 public and social housing properties during 2009-10, making homes safer and more comfortable for residents, improving common areas used by residents as well as extending the life of ageing properties.

The Public Tenant Employment Program and the Neighbourhood Renewal program created more than 870 jobs and 1600 training opportunities for public housing tenants and residents of disadvantaged areas during 2009-10. The programs recognise that public housing communities are home to many people who have skills, experience and a desire to work but who often need training and support to find the right opportunity.

Evidence has shown that Victoria’s Neighbourhood Renewal project has helped residents in project areas transform their communities into places where people feel a sense of belonging, can live with pride and see a positive future. Eight Neighbourhood Renewal projects reached the end of the eight-year program in 2009-10 and the department is progressing on the next stage to ensure there is a long-term plan in place to support residents’ vision for the future.

Victoria has also delivered on the National Rental Affordability Scheme which will provide eligible Victorians rental homes at 20 per cent below market rates. Homes became available during 2009-10 and by June 2012, 7500 new homes are scheduled for completion.

Victoria has also been improving environmental sustainability, with all new constructed public housing properties built to 5-Star standard, featuring 5-Star building fabric and 5-Star plumbing. The result is a reduction in greenhouse gas emissions and greater energy bill savings for low income residents. ”

Queensland Government comments

Queensland is committed to delivering a social housing system that provides safe, affordable and appropriate housing for Queenslanders for the duration of their housing need. During 2009-10, the Department of Communities continued to provide Queenslanders with low-to-moderate incomes and who had housing needs with access to assistance through the One Social Housing System. It provided more than 65 800 households with social housing and assisted 194 203 households to access or sustain private market tenure.

Under the Nation Building Jobs Plan – Social Housing Initiative, Queensland expended $492.8 million, completed 359 dwellings and commenced construction on 3075 dwellings due for completion by June 2012. The majority of these will be owned and/or managed by the not-for-profit sector, significantly growing this sector. It also undertook a large-scale maintenance and repair program.

Queensland is committed to the implementation of the National Affordable Housing Agreement and supporting National Partnership Agreements. Under the National Partnership Agreement on Social Housing, Queensland is expending $80.1 million over two years to complete construction on 79 dwellings and commence construction on a further 217 dwellings. Since its commencement 72 dwellings have been tenanted.

Under the 10 year National Partnership Agreement on Remote Indigenous Housing, Queensland addresses overcrowding, homelessness, poor housing conditions and housing shortages in remote Indigenous communities by building more than 1100 new dwellings and upgrading more than 1200 homes. During 2009-10, land and infrastructure plans were developed for Queensland's 16 discrete Indigenous Councils and significant progress was made in establishing 40-year leases with Councils to improve property and tenancy management.

In terms of private market assistance provided by Queensland:

- RentConnect assisted 1177 households to find and secure a tenancy in the private market
- a total of 62 new loans were provided to home purchasers experiencing difficulties in obtaining loans from a financial institution and to those wishing to purchase a share of their social rental property
- non-profit organisations and local councils were funded to provide tenant advice and advocacy services and assisted 79 753 households
- bond loans were provided to 18 198 households to move into private rental accommodation and 521 rental grants to assist households with the costs of moving
- under the National Rental Affordability Scheme, approximately 3900 dwellings are approved, 296 dwellings available and 286 dwellings tenanted as at 30 June 2010. The Scheme is expected to supply up to 10 000 new affordable rental dwellings across Queensland.

Western Australian Government comments

In the current economy, the housing market remains volatile and has a major flow-on to all of the Housing Authority’s services from affordable land development to public rental, bonds and home ownership. To lessen the impact on Western Australians, the Housing Authority is looking at new ways of doing business, as well as continuously strengthening and improving existing programs.

One of the Department’s biggest challenges for the 2009-10 financial year was to continue the State and Federal social housing stimulus packages, creating projects of unprecedented magnitude for the Housing Authority. The Department is on target to deliver 2803 new dwellings and a substantial number of refurbishments by the end of 2010.

In the area of Aboriginal housing, the Housing Authority delivered 89 homes in remote communities, of which 78 were connected to services, by the required deadline and on budget. This was well above the target of 75 houses to be built by 30 June 2010.

In addition to the delivery of the new homes, 150 refurbishments were completed.

Creating Aboriginal employment opportunities was a key component of this program, and the Aboriginal employment target of 20 per cent participation was exceeded across the construction and refurbishment programs.

A range of factors continue to increase the demand for social housing. These include the increased cost of housing, supporting community living for people with disabilities and other high needs, and an ageing housing stock.

While the Housing Authority manages some 36 000 residential tenancies, there remains a growing waiting list for social housing and the Authority has had to search beyond traditional methods to find solutions to reduce that list.

The Housing Authority has forged new partnerships with community housing organisations throughout the State as a way of delivering new housing economically.

The Housing Authority is deploying some innovative solutions such as Housing Direct. Housing Direct is a new central communication point for the Authority, clients and suppliers that has improved our efficiency in delivering services to tenants and contractors. It has won two State awards as judged by the Australian Teleservices Association.

The Housing Authority has developed an ambitious Affordable Housing Strategy that sets the blueprint for a range of initiatives to deliver an additional 20 000 new dwellings by 2020.

South Australian Government comments

Housing SA maintained 49 173 lettable public, Aboriginal and community housing properties for South Australians during 2009-10, as well as providing assistance to 21 445 customers to help secure affordable private rental accommodation. The number of customers receiving private rental assistance through Housing SA substantially increased from the 2008-09 year (up 22.5 per cent), as did the average value of bonds (up 14.4 per cent). The number of new applications for public and Aboriginal housing increased 5.5 per cent, reversing a previous declining trend. Allocations to new tenants increased slightly to 2457 during the year, with over 75 per cent of new allocations to customers in greatest need.

An increase in allocations can be attributed to the impact of investment in social housing through the Nation Building – Economic Stimulus Plan (NBESP). A major component of NBESP was to build 173 new homes by the end of 2009-10. Housing SA exceeded this target by constructing over 200 homes. Over 500 homes were also upgraded during this period.

Housing SA is dedicated to creating affordable housing options for South Australians. The Affordable Housing Innovations Fund was established to facilitate the delivery of innovative affordable housing solutions to low to moderate income South Australians. In an environment where public housing opportunities are declining, these projects will continue to deliver affordable housing options to a variety of target groups. A number of projects were implemented throughout the year to facilitate the growth of the not-for-profit sector. The past decade has seen an expansion of approximately 75 per cent in this sector and a further 50 per cent growth in the next five years is expected.

By the end of 2009-10, 15 per cent affordable housing commitments had been included in a number of government land releases through the Affordable Housing Planning Policy, representing over 1800 affordable homes upon project completions. The intent of the policy is to secure at least 15 per cent affordable housing opportunities in all significant new developments.

South Australia has continued to benefit from funding committed through the National Affordable Housing Agreement and associated Implementation Plans. Projects funded through the National Partnership Agreement on Social Housing will deliver approximately 100 housing outcomes in partnership with not-for-profit organisations, with 22 homes completed at the end of 2009-10. Funding through the agreement will also help progress the Woodville West urban renewal project through property purchases.

Thirty-three new houses were constructed in APY communities through the National Partnership Agreement on Remote Indigenous Housing and a further 61 existing houses were refurbished across the state. Capital works also have a focus on generating local Aboriginal employment and in 2009-10, this centred mainly on external works such as fencing, shade structures and fire pits. Households are linked to home living skills programs upon allocation which will improve the likelihood of healthy homes and successful tenancies.

Tasmanian Government comments

“Governments play an important role in the provision of affordable housing to the community, in particular, in assisting the most vulnerable. While housing affordability is a complex issue underpinned by wider macro-economic influences, jurisdictions play a critical role in the provision of public housing, affordable home purchase options, private rent assistance and facilitating the supply of land for further increase affordable housing stock.

During 2009-10, Housing Tasmania focused on increasing the supply of affordable housing across a range of tenure forms, improving the amenity of existing homes, and reforming, developing and strengthening homeless services in the State. Achievements in the homelessness area are reported in the Homelessness services chapter.

Achievements for the year include the purchase of a new Supported Residential Facility; the release of land for the construction of affordable housing; and the upgrading of Out of Home Care facilities, Disability Group Homes and Neighbourhood Houses throughout the State.

In addition to this, the state continued to manage NRAS allocations, the construction of new homeless facilities and the roll-out of capital projects funded through the Nation Building Economic Stimulus Plan’s Social Housing Initiative. Works also commenced on the development of land following an allocation from the Australian Government’s Housing Affordability Fund. This project will deliver new affordable homes and a children’s access centre to an area of identified high needs.

Under the Private Rental Support Scheme, 3984 households received financial assistance during the year, representing a 7.2 per cent increase compared to the previous year. In addition, 6203 households received non-financial assistance such as advocacy, referral or information. A further 1200 households were assisted by the Private Rental Tenancy Support Scheme, which provides advice and tenancy support to people in the private rental market. This represents an increase of 38 per cent compared to the previous year.

A comprehensive Property Assessment Survey was undertaken during the year, with the amenity and condition of 92.6 per cent of all properties being assessed and recorded. The completion of this process will inform forward planning of maintenance schedules and associated budget estimates. Further, with the implementation of a new Asset Information Management System early in 2010-11, Housing Tasmania will be able to better analyse the portfolio and make informed decisions about future asset management and reform priorities.”

Australian Capital Territory Government comments

During 2009-10, the ACT continued the implementation of initiatives to meet the reforms required under the National Affordable Housing Agreement, the associated National Partnership Agreements and the Nation Building and Jobs Plan economic stimulus package. These initiatives built on the reforms already introduced by the ACT Government, including effectively targeting housing assistance to those most in need in the community, particularly young people, Aboriginal and Torres Strait Islander families, and continuing the property redevelopment program, including exiting the larger multi-unit properties.

The ACT commenced construction of over 400 dwellings under the Nation Building and Jobs Plan and Partnership Agreements on Social Housing and Homelessness. Sixty-two of these dwellings were completed by 30 June 2010. A further 86 properties under the Nation Building and Jobs Plan will be completed by December 2010 and the remainder will be completed by June 2011. The dwellings will assist homeless families, specifically larger families and Aboriginal and Torres Strait Islander families and will create many new exit points from crisis accommodation.

The ACT targeted some of the new dwellings specifically to older tenants through the construction of aged person accommodation close to community facilities, such as shops and doctors as well as close to transport links, allowing tenants to ‘age in place’. The family homes vacated by these older tenants will then be used to house families experiencing homelessness who are on the public housing waiting list.

The ACT also trialled a house extensions program for Indigenous families experiencing overcrowding in their current properties. Building extensions were provided to five houses tenanted by Indigenous families, providing a variety of additions such as bedroom, bathroom and living spaces. This enabled the families to stay in their property and remain connected to the supports and community they had established in their neighbourhoods.

New tenancy related programs were established to meet the housing and related needs of specific clients groups, including the Staying at Home After Leaving Violence project and the Helping Our Senior Tenants program.

The Staying at Home After Leaving Violence project was implemented to review policy and procedures and establish pathways for women and children who have been subject to violence to remain in their public housing property.

The Helping Our Senior Tenants program was implemented in November 2009, to gain a greater understanding of the circumstances and needs of older tenants in public housing properties. This then allows Housing ACT to tailor appropriate responses and ensure collaboration with areas such as Health and Aged Care to provide appropriate wrap around supports.

Housing ACT continued its long commitment to maintaining public housing stock numbers. By doing so Housing ACT can continue to provide affordable secure housing to those people most in need in the ACT community.

Northern Territory Government comments

In September 2009, the Territory Government released the *Territory 2030 Strategic Plan*. The plan aims to achieve a balanced housing market across all market segments and to increase the availability of appropriate and affordable housing. The Territory Government is continuing to roll out *Housing the Territory* which incorporates action to increase land supply, houses for purchase, houses for rent and public housing.

As part of the *Land to Grow* component, a 20 year land release program and accelerated land releases for residential housing across the Territory will substantially increase housing supply. Planning has also commenced for the new Town of Weddell. The Territory Government has committed to reserve 15 per cent of all new land releases for social and affordable housing.

New Places to Rent will see an Affordable Housing Rental Company established and a public housing complex in the Darwin region redeveloped to supply public and affordable rental dwellings. The Territory Government is also supporting the roll out of the National Rental Affordability Scheme (NRAS) and sought Expressions of Interest in early 2010 to develop a 3.5 hectare site in Palmerston for a housing complex that reserves more than 50 per cent of dwellings for NRAS.

Substantial investment is being made under *New Public Housing*:

- Up to $1.7 billion in Commonwealth funds and $240 million in Territory Government funding to support a construction and refurbishment program in remote communities under the National Partnership Agreement on Remote Indigenous Housing that will substantially reduce rates of overcrowding.
- Under the Nation Building and Jobs Plan, the Social Housing Initiative will provide $59.7 million to construct 208 new units of accommodation and refurbish 136 existing public housing properties. Twenty two dwellings have been constructed under Stage One and 297 dwellings upgraded. Stage Two will deliver an additional 186 units with 12 units of accommodation already constructed.
- Territory Government funding of $49 million will deliver an additional 150 new homes, including three seniors villages and accommodation to support homeless people transitioning into stable housing.

As part of *New Places to Buy*, Homestart NT is assisting low to moderate income earners purchase their own home. For the 2009-10 financial year, 145 households were assisted to buy a home. In May 2010, the Territory Government increased stamp duty exemptions for first home buyers and introduced a new concession for senior Territorians, veterans, pensioners and carers. The Government is also offering affordable house and/or land options for eligible Territorians to purchase in new Darwin suburbs.

16.6 Definitions of key terms

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.
Assessable income	The income used to assess eligibility for housing assistance and to calculate the rental housing rebate that allows a household to pay a rent lower than the market rent. Definition may vary across jurisdictions.
Canadian National Occupancy Standard (CNOS)	A measure of the appropriateness of housing which is sensitive to both household size and composition. The CNOS specifies that: • no more than two people shall share a bedroom • parents or couples may share a bedroom • children under 5 years, either of the same sex or opposite sex may share a bedroom • children under 18 years of the same sex may share a bedroom • a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex • single adults 18 years and over and any unpaired children require a separate bedroom.
Depreciation costs	Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset (as per the Australian Accounting Standards 13–17).
Disability (as per the ABS Survey of Disability Ageing and Carers)	Any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.
Dwelling	A structure or a discrete space within a structure intended for people to live in or where a person or group of people live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop provided the dwelling is in residential use.
Greatest need	Low income households that at the time of allocation were subject to one or more of the following circumstances: • homelessness • their life or safety being at risk in their accommodation • their health condition being aggravated by their housing • their housing being inappropriate to their needs • their rental housing costs being very high.
Household	For the purpose of the public, community, SOMIH and ICH collections,

	the number of tenancy agreements is the proxy for counting the number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling.
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.
Low income household	Low income households are generally defined in this Report as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Equivalised gross income is an indicator of disposable household income after taking into account household size and composition.
Maintenance costs	Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes day-to-day maintenance reflecting general wear and tear, cyclical maintenance, performed as part of a planned maintenance program and other maintenance, such as repairs as a result of vandalism.
Market rent	Aggregate market rent that would be collected if the public rental housing properties were available in the private market.
New household	Households that commence receiving assistance 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 one or more bedrooms are required to meet the Canadian National Occupancy Standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need.
Principal tenant	The person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental payments.
Proxy occupancy standard	A measure of the appropriateness of housing related to the household size and tenancy composition. The measure specifies the bedroom requirements of a household.

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.

Rebated household	A household that receives housing assistance and pays less than the market rent value for the dwelling.
Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.
Special needs household	Low income households that have either a household member with disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. For SOMIH, special needs households are those that have either a

	household member with disability or a principal tenant aged 24 years or under, or 50 years or over.
Tenancy rental unit	A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.
Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income. CRA payments are not included as income.
Transfer household	A household, either rebated or market renting, that relocates (transfers) from one 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 CNOS.
Untenantable dwelling	A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.

Commonwealth Rent Assistance

Dependent child	Dependent child is one in respect of whom an adult member of the income unit receives Family Tax Benefit part A (FTB (A)) at more than the base rate. At June 2010, children aged 16 or older attract the base rate of FTB (A) only, so are not included in the count of dependent children. Some children aged under 16 years may also only attract the base rate of FTB (A) because of the maintenance income test, the maintenance action test, or because they are overseas.
Income support recipient	Recipients in receipt of a payment made under social security law. The main income support payments administered by FaHCSIA are Age Pension, Disability Support Pension and Carer Payment, while the main income support payments administered by Department of Education, Employment and Workplace Relations are Newstart Allowance, Youth Allowance, Abstudy, Parenting Payment (Single) and Parenting Payment (Partnered). Family Tax Benefit is paid under family assistance law and is not an income support payment.
Income unit	An income unit may consist of: • a single person with no dependent children • a sole parent with one or more dependent children • a couple (married, registered or defacto) with no dependent children • a couple (married, registered or defacto) with one or more dependent children. A non-dependent child living at home, including one who is receiving an income support payment in their own right, is regarded as a separate income unit. Similarly, a group of non-related adults sharing accommodation are counted as separate income units.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. The primary payment is determined using a hierarchy of payment types, with

	precedence given to pensions, then other social security payments and then the Family Tax Benefit part A. No extra weight is given to the payment type with which CRA is paid. Specifically, the hierarchy for the main payments is: • Disability Support Pension • Carer Payment • Age Pension • Parenting Payment (Single) • Newstart Allowance • Youth Allowance • Austudy • Parenting Payment (Partnered) • Family Tax Benefit part A.
Rent	Amount payable as a condition of occupancy of a person's home. Rent includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and cannot separately identify the amount paid for lodgings, two thirds of the payment is deemed to be for rent.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to only a single person (with no dependent children) who shares a major area of accommodation. The lower rate does not apply to those receiving Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings. A person is not regarded as a sharer solely because he or she shares with a child (of any age) if the child does not receive 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. It includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. It does not include: • one-time payments • arrears payments • advances • Employment or Education Entry Payments • Mobility Allowance • Baby Bonus • Child Care Tax Rebate. In most cases, private income reflects the person's current circumstances. Taxable income for a past financial year or an estimate of taxable income for the current financial year is used where the income unit receives more than the minimum rate of the Family Tax Benefit part A but no income support payment.

16.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by an '16A' suffix (for example, table 16A.3). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Public housing

SOMIH

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17 Homelessness services

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '17A' suffix (for example, table 17A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Homelessness has multiple causes. Some of the social factors associated with homelessness include a shortage of affordable housing, family and relationship breakdown, unemployment and financial hardship, mental health problems, and drug and alcohol abuse (Australian Government 2008a; COAG Reform Council 2010).

Since 1985, the Australian Government and State and Territory governments have funded the Supported Accommodation Assistance Program (SAAP) as a significant part of Australia's response to the problem of homelessness. SAAP assists individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. SAAP services aim to alleviate difficulties faced by people who are homeless or at risk of homelessness and reduce the potential for their recurrence.

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) and the *National Partnership Agreement on Homelessness* (NPAH) (COAG 2008a; 2008b). 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 and the NPAH provide a framework for the Australian Government and State and Territory governments to work together to improve housing affordability and homelessness outcomes for Australians. The overarching 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 and the NPAH agreed to a range of objectives and outcomes, including:

- providing 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
- 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
- prevention and early intervention to break the cycle of homelessness
- improving and expanding the service response to homelessness (COAG 2008a; 2008b).

Data agencies, the Australian Government and State and Territory governments are currently developing a new homelessness data collection to report on performance indicators contained in the NAHA and associated partnership agreements. The new homelessness data collection is anticipated to be operational by 1 July 2011, with data for the 2011-12 period expected to be available for reporting in the 2013 Report. In the interim, the SAAP data collection will continue and will be used to inform proxy measures for a number of NAHA performance indicators. Due to a 12-month lag in SAAP reporting, this report includes SAAP service data for the 2008-09 period, with some financial data reported for the 2009-10 period.

Improvements to the reporting of SAAP services this year include:

- the creation of a new homelessness-specific chapter in the revised Housing and homelessness section of the Report, which includes a new Housing and homelessness sector summary
- reporting five year time series in attachment tables for all measures with available data
- the inclusion of expanded expenditure information for 2008-09 and 2009-10 to more accurately report the full cost to government of funding and/or providing homelessness services, including funding for service delivery and administrative expenditure
- the inclusion of additional data to align this Report with the NAHA: (a) the proportion of Australians who are homeless and (b) the proportion of SAAP clients who required SAAP housing or accommodation support more than once.

17.1 Profile of homelessness services

Supported Accommodation Assistance Program

SAAP 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 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 2005-10, 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 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, 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.

SAAP and the link with other services

In 2008-09, 79 100 children accompanied a parent or guardian who received substantial SAAP support (AIHW 2010).[1] 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). 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.

Close links also exist between SAAP and other forms of housing assistance reported in the Housing chapter of the Report (chapter 16). Some individuals and families used 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.[2] For example, in 2008-09, approximately 15.0 per cent of former SAAP clients, who had requested assistance with obtaining or maintaining independent housing, had moved to public housing (table 17A.21). The new Housing and homelessness sector summary examines the interconnections across these sectors in greater detail.

Size and scope

On Census night in 2006, there were approximately 105 000 homeless people (that is, approximately one in every 190 Australians) (Chamberlain and MacKenzie 2008). This figure includes people who were without conventional accommodation (for example, sleeping rough), who were living in temporary shelter (for example,

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[1] 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 17.6 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.

[2] Social housing is generally understood to include public and community housing. For further information on these forms of housing assistance, see chapter 16 (box 16.2).

youth refuges or ‘couch surfing’), and who were staying in accommodation that is below minimum community standards (for example, boarding houses and caravan parks). According to the Counting the Homeless 2006 report, SAAP provided accommodation to approximately 19 per cent of the homeless population on Census night in 2006 (Chamberlain and MacKenzie 2008).

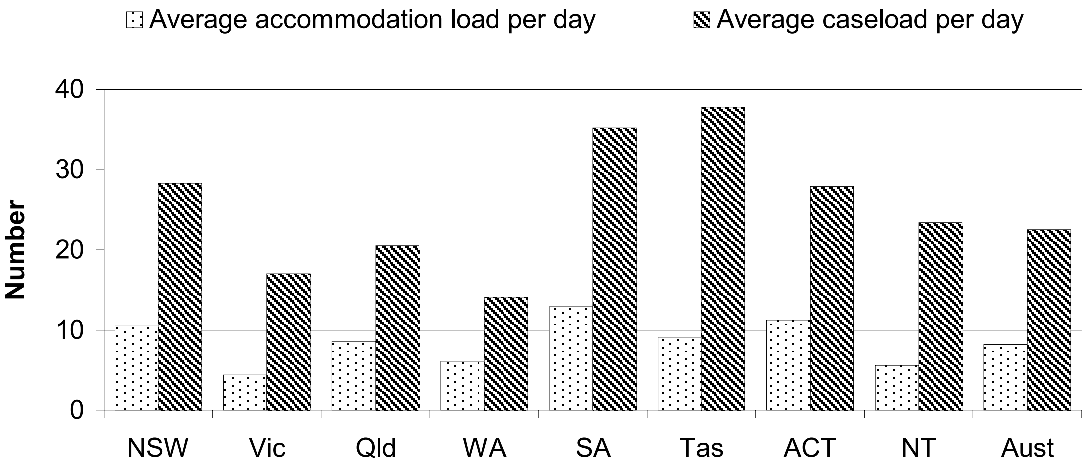
SAAP agencies provided a range of support services to various client groups throughout the year, including families, single men and women, and unaccompanied children and young people. Nationally, in 2008-09, SAAP agencies provided support to 204 900 people. Of the 204 900 people who received SAAP support, 125 800 were clients and 79 100 were accompanying children (AIHW 2010).

In 2008-09, 1532 agencies were funded under the SAAP/NAHA, including non-government, community and local government agencies (AIHW 2010) (table 17A.2). Services were delivered in 2008-09 by SAAP agencies targeting:

- young people (34.3 per cent of agencies)
- women escaping domestic violence (22.9 per cent)
- families (8.6 per cent)
- single men (6.2 per cent)
- single women (2.8 per cent)
- multiple client groups (25.2 per cent) (table 17A.2).

Nationally, the daily average accommodation load and caseload per agency was 8.2 and 22.5 respectively, although this varied across jurisdictions in 2008-09 (figure 17.1).

Figure 17.1 **Average accommodation load and caseload per day, 2008-09**[a]



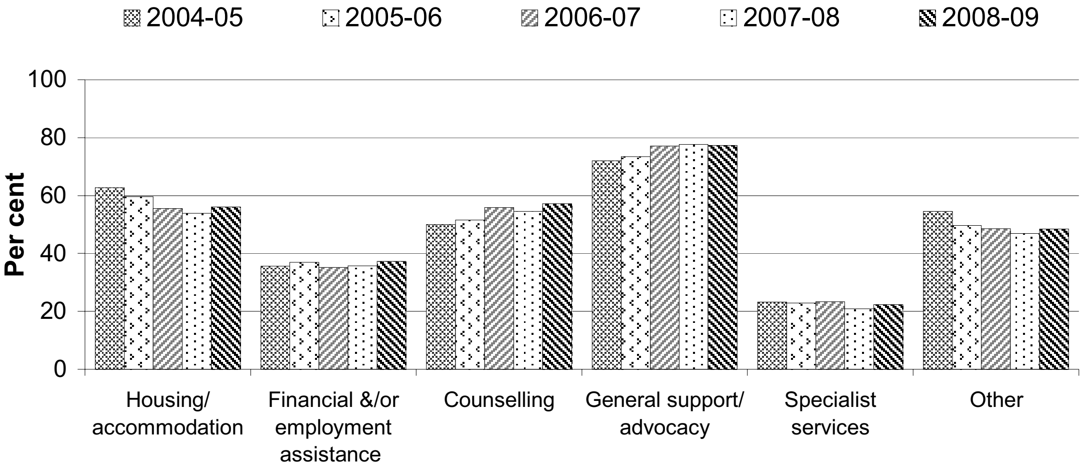
[a] See notes to table 17A.20 for descriptions of how accommodation load and caseload are estimated.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 17A.20.

SAAP agencies varied in the types of services they delivered. In 2008-09, SAAP agencies were most commonly designed to provide medium term to long term supported accommodation (40.6 per cent of agencies) and crisis or short term supported accommodation (32.2 per cent of agencies). SAAP agencies also provided services other than accommodation, such as outreach support, day support, and telephone information and referral. The proportions of SAAP agencies designed to deliver particular types of services remained relatively stable from 2004-05 to 2008-09 (table 17A.3).

Housing and accommodation services were provided in 56.1 per cent of support periods. General support and advocacy (77.3 per cent), counselling (57.2 per cent), financial and employment assistance (37.3 per cent), and specialist services (22.3 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 17.2). For example, in 2004-05, housing and accommodation constituted 62.7 per cent of support periods and counselling (formerly ‘personal support’) constituted 50.0 per cent.

Figure 17.2 **Services received during a SAAP support period**[a]



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[a] Totals do not add to 100 per cent because agencies may provide more than one type of service during a single support period.

Source: AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09*. Cat no. HOU 219; table 17A.1.

Roles and responsibilities

SAAP was jointly funded by the Australian, State and Territory governments until December 2008. State and Territory governments were responsible for the day-to-day management of the program, including the distribution of funding to SAAP funded agencies. Non-government agencies delivered most SAAP services with some local government participation.

Funding

Recurrent government expenditure on specialist homelessness services for the period 2009-10 was approximately $461.1 million (table 17A.5): 97.3 per cent of this funding supported agencies to provide services for people who are homeless or at risk of homelessness, while 2.7 per cent of this funding was directed to State and Territory governments' administrative costs (table 17A.4). Nationally, real recurrent funding per head of population increased modestly from 2005-06 to 2009-10 (table 17A.6). These figures varied across jurisdictions.

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). Where possible, the Steering Committee has included these funds for the 2008-09 and 2009-10 reporting periods.

17.2 Framework of performance indicators for the Supported Accommodation Assistance Program

The performance indicator framework for the Supported Accommodation Assistance Program is based on shared government objectives for SAAP services (box 17.1).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NAHA covers the area of housing and homelessness and includes a set of performance indicators for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). Revisions have been made to the performance indicators reported in this chapter to align with the homelessness specific performance indicators in the NAHA.

Box 17.1 **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:

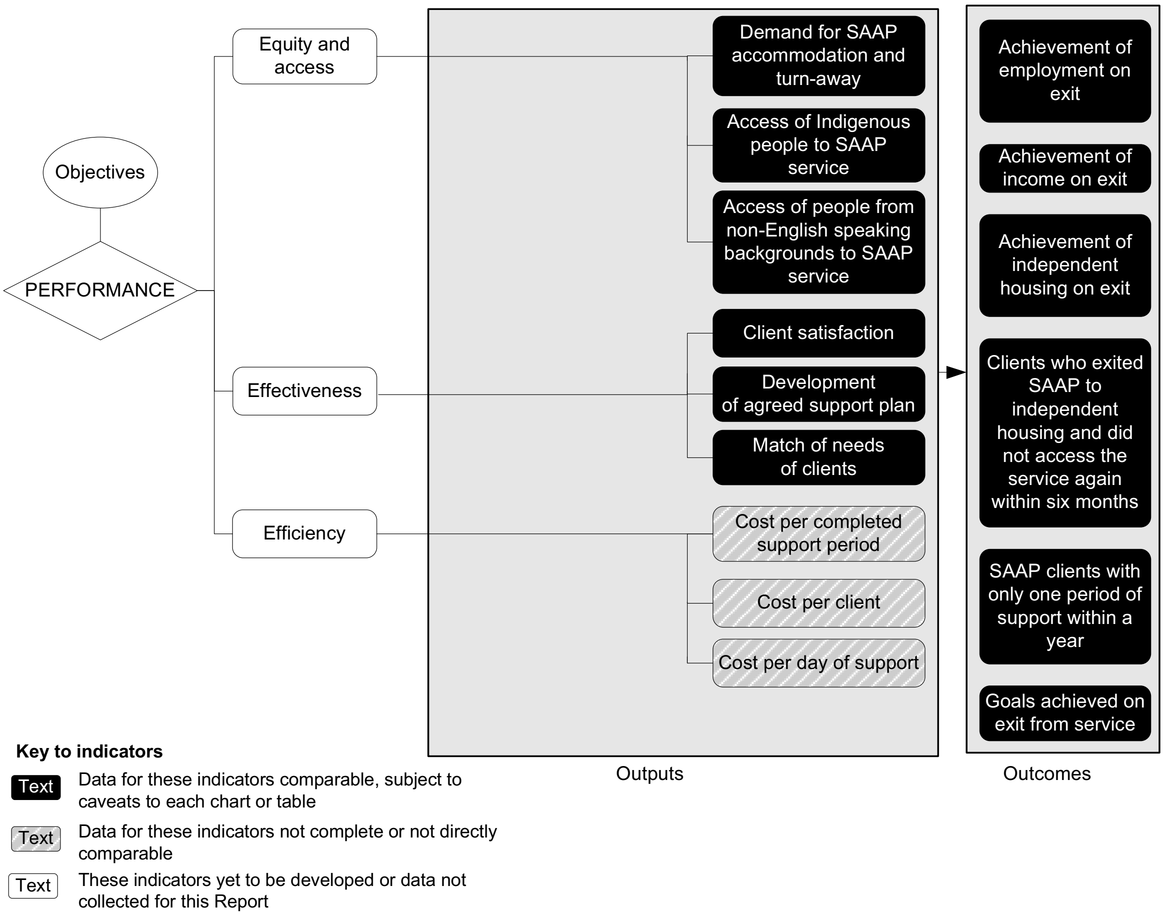
- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

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 17.3). The performance indicator framework shows which data are comparable in the 2011 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

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

Figure 17.3 **Performance indicators for SAAP services**



17.3 Key Supported Accommodation 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 17.2).

Box 17.2 **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 2008-09, clients consented to provide personal details for the SAAP client collection in 85.0 per cent of support periods, while 94.0 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 2010).

Outputs

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

Equity and access

Demand for 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 17.3).

Box 17.3 **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 decreasing proportion of people turned away from SAAP services 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 quality information for this indicator is under development.

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,[3] or where assistance offered by an agency is refused. For the Client

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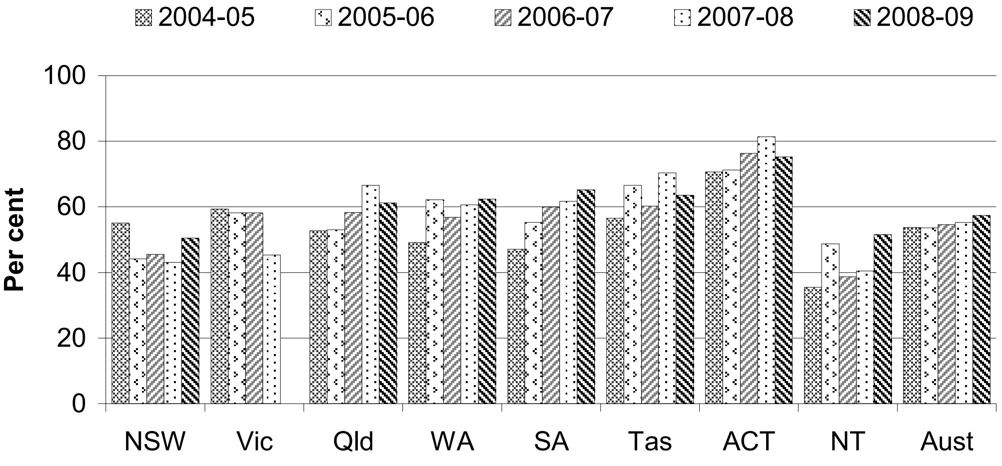
[3] 'No fee-free accommodation available' refers to situations where the person/group is not given accommodation because they cannot meet the financial requirements (for example, fees) for that accommodation.

Collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

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 17A.7-8).

Data on the proportion of people with valid requests for SAAP accommodation who were turned away are reported for the years 2004-05 to 2008-09. Nationally, 57.4 per cent of adults and unaccompanied children requesting immediate new SAAP accommodation on a given day were turned away in 2008-09. This proportion varied across jurisdictions (figure 17.4).

Figure 17.4 **Turn-away of adults and unaccompanied children as a proportion of people requiring new SAAP accommodation**[a, b, c, d, e]



[a] A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by 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] Data for Victoria for 2008-09 were not available. As a result, turn-away data for 2008-09 cannot be compared directly with those of previous years. [e] See notes to table 17A.7 for more detailed data caveats.

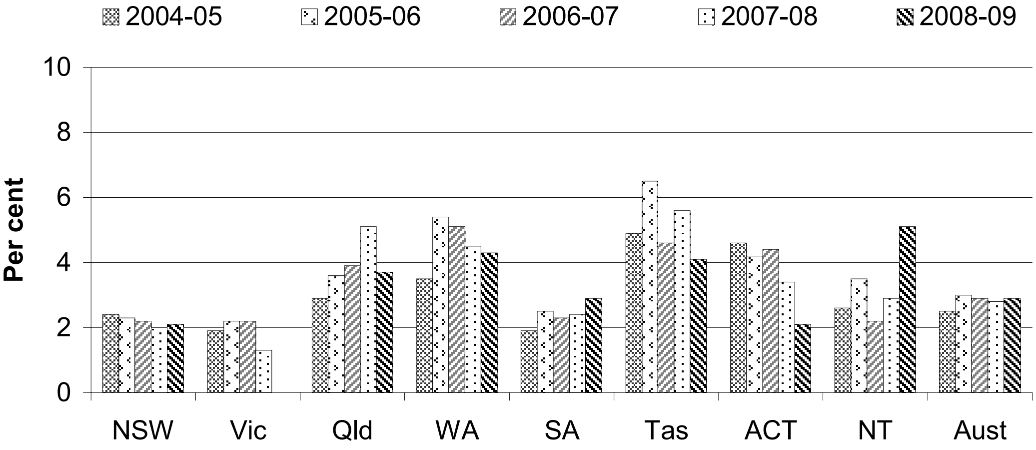
Source: AIHW (2010) *Demand for government-funded specialist homelessness accommodation 2008-09: A report from the SAAP national data collection.* Cat. No. HOU 230; table 17A.7.

Nationally, the number of adults and unaccompanied children who made valid requests for SAAP accommodation but could not be accommodated accounted for

2.9 per cent of the total demand for SAAP accommodation in 2008-09 (total demand includes all accommodated adults and unaccompanied children) (figure 17.5). 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 (57.4 per cent) and (b) the percentage of people turned away on a given day as a proportion of total demand for SAAP accommodation (2.9 per cent) suggests that SAAP agencies provide a significant number of clients with continuing accommodation.

Figure 17.5 **Turn-away of adults and unaccompanied children as the proportion of total demand for SAAP accommodation**[a, b, c, d, e]



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[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] Data for Victoria for 2008-09 were not available. As a result, turn-away data for 2008-09 cannot be compared directly with those of previous years. [e] See notes to table 17A.8 for more detailed data caveats.

Source: AIHW (2010) *Demand for government-funded specialist homelessness accommodation 2008-09: A report from the SAAP national data collection.* Cat. No. HOU 230; table 17A.8.

Nationally, requests for SAAP accommodation were not met for a number of reasons in 2008-09, including lack of available accommodation (59.9 per cent), no vacancies at the referral agency (24.5 per cent), type of accommodation requested is not provided (6.8 per cent) and insufficient staff (0.9 per cent) (table 17A.16).

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 17.4).

Box 17.4 **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 Indigenous people whose valid requests for accommodation are met is desirable. Where the proportion of Indigenous people with unmet SAAP accommodation needs is higher than the proportion of people who received SAAP accommodation who were Indigenous, services might not be achieving equality of service access for Indigenous people.

The indicator measures the extent to which the demand for assistance from Indigenous people is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance might be provided).

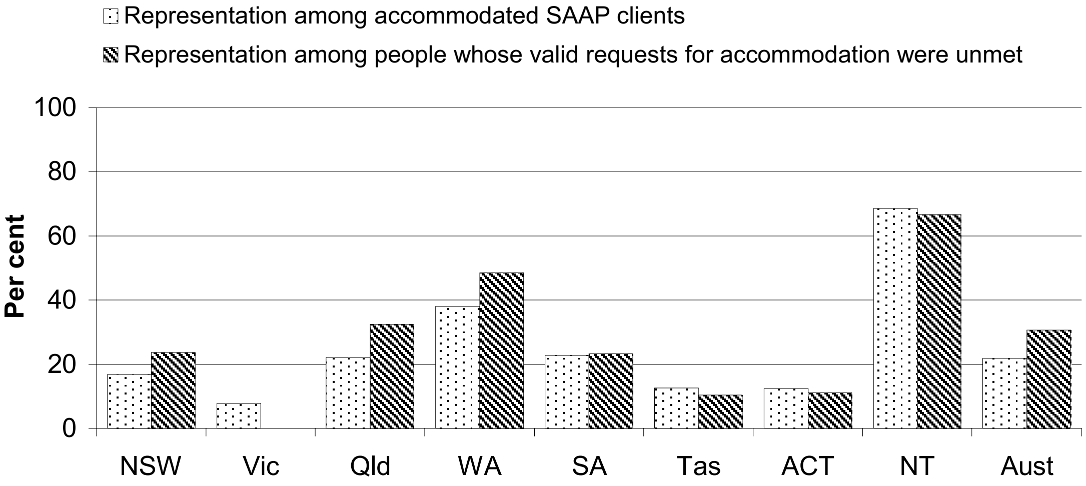
Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people) is particularly important.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, Indigenous people made up 30.6 per cent of all people whose valid requests for accommodation did not result in accommodation assistance in 2008-09 — a proportion greater than Indigenous clients among all accommodated SAAP clients (21.9 per cent). This result varied across jurisdictions (figure 17.6).

Figure 17.6 **Proportion of Indigenous people among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2008-09**[a, b]



[a] Turn away data for Victoria in 2008-09 were not available. [b] See notes to table 17A.9 for details of data definitions.

Source: SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); *Source*: AIHW (2010) *Demand for government-funded specialist homelessness accommodation 2008-09: A report from the SAAP national data collection.* Cat. No. HOU 230; table 17A.9.

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 17.5).

Box 17.5 **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 people from non-English speaking backgrounds whose valid requests for accommodation are met is desirable. Where the proportion of people from non-English speaking backgrounds with unmet SAAP accommodation needs is higher than the proportion of people who received SAAP accommodation who were from non-English speaking backgrounds, services might not be achieving equality of service access for people of non-English speaking backgrounds.

(Continued on next page)

Box 17.5 (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).

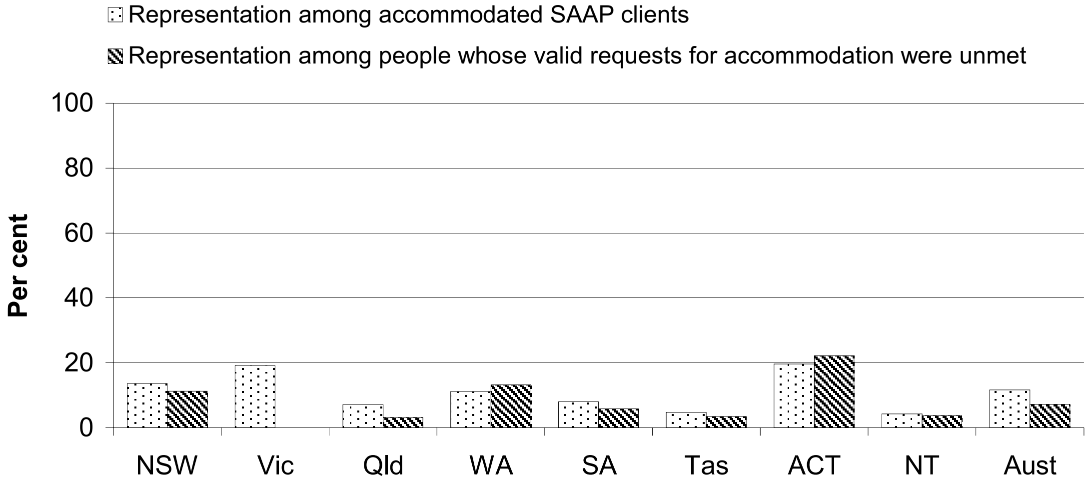
Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as people from non-English speaking backgrounds) is particularly important.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the proportion of people from non-English speaking backgrounds among all people whose valid requests for accommodation did not result in accommodation assistance was 7.2 per cent in 2008-09 — lower than that of people from non-English speaking backgrounds among all accommodated SAAP clients (11.6 per cent). This result varied across jurisdictions (figure 17.7).

Figure 17.7 Proportion of people from non-English speaking backgrounds among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2008-09[a, b]



[a] Turn away data for Victoria in 2008-09 were not available. [b] See notes to table 17A.10 for details of data definitions.

Source: SAAP NDCA *Client* and *Demand for Accommodation Collections* (unpublished); *Source*: AIHW (2010) *Demand for government-funded specialist homelessness accommodation 2008-09: A report from the SAAP national data collection.* Cat. No. HOU 230; table 17A.10.

Effectiveness

Client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of SAAP recipients (box 17.6).

Box 17.6 **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 quality information for this indicator is under development.

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 17.7).

Box 17.7 **Development of agreed support plan**

'Development of agreed support plan' is defined as the number of closed support periods with an agreed support plan divided by the total number of closed support periods. A closed support period is a support period that had finished on or before 30 June. Data are reported for all SAAP clients, and separately for Indigenous clients.

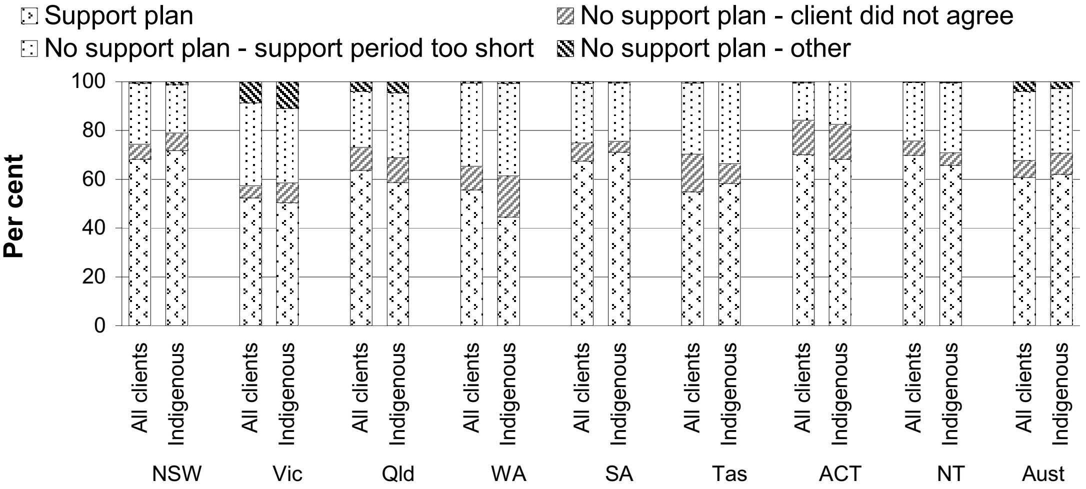
A high proportion of support periods with agreed support plans is desirable. However, in some instances, a support plan may be judged to be inappropriate (such as when a support period is short term).

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, there was an agreed support plan for 60.7 per cent of closed support periods for all clients in 2008-09 (compared to 62.1 per cent for Indigenous clients). These proportions varied across jurisdictions (figure 17.8).

Figure 17.8 **Closed support periods, by the existence of a support plan, 2008-09[a]**



[a] See notes to tables 17A.11-12 for more details of data definitions.

Source: SAAP NDCA *Client Collection* (unpublished); AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09.* Cat no. HOU 219; tables 17A.11-12.

Match of needs of clients

'Match of needs of clients' is an indicator of governments' objective to ensure that SAAP services meet client's individual needs (box 17.8).

Box 17.8 **Match of needs of clients**

'Match of needs of clients' is defined as the number of distinct services required by clients that are provided, as well as those referred to another agency, divided by the total number of distinct services required by SAAP clients.

A high proportion of clients who received services they needed, or who were referred to another agency, is desirable.

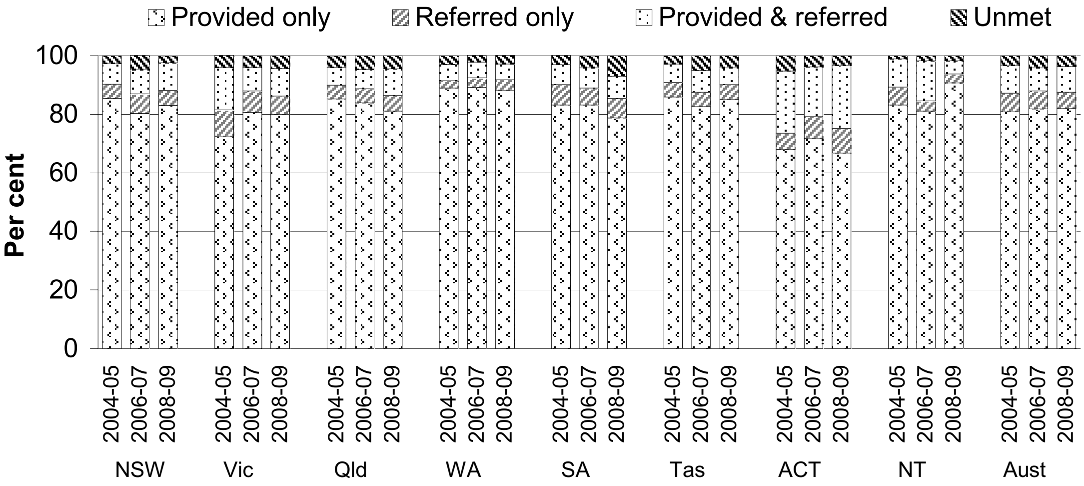
The range of services needed by SAAP clients is broad (ranging from meals to laundry facilities to long term accommodation), so the effect of not providing these services varies. Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking backgrounds.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

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 96.3 per cent in 2008-09 (figure 17.9).

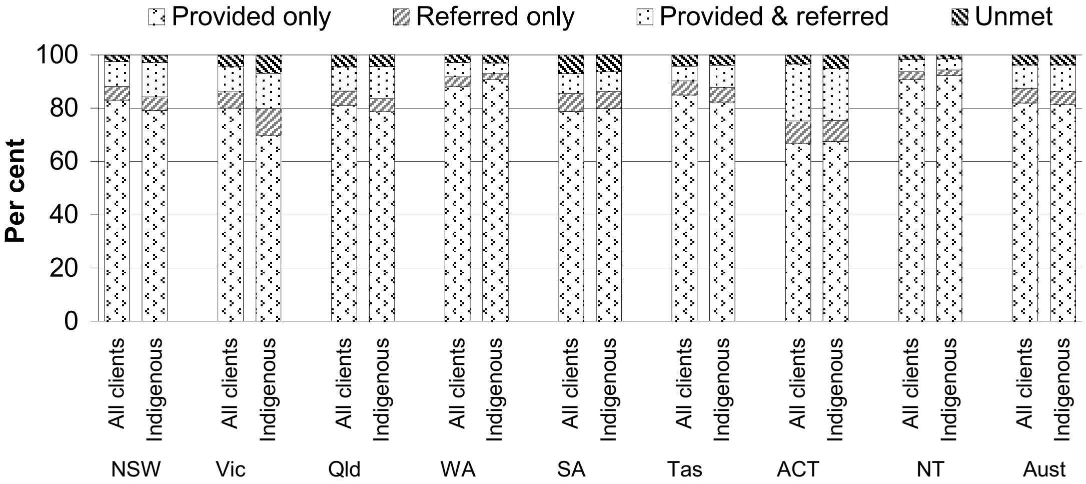
Figure 17.9 **SAAP clients, by met and unmet support needs**



Source: AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09*. Cat no. HOU 219. AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09 State/territory supplementary tables*. Cat no. HOU 222; table 17A.13.

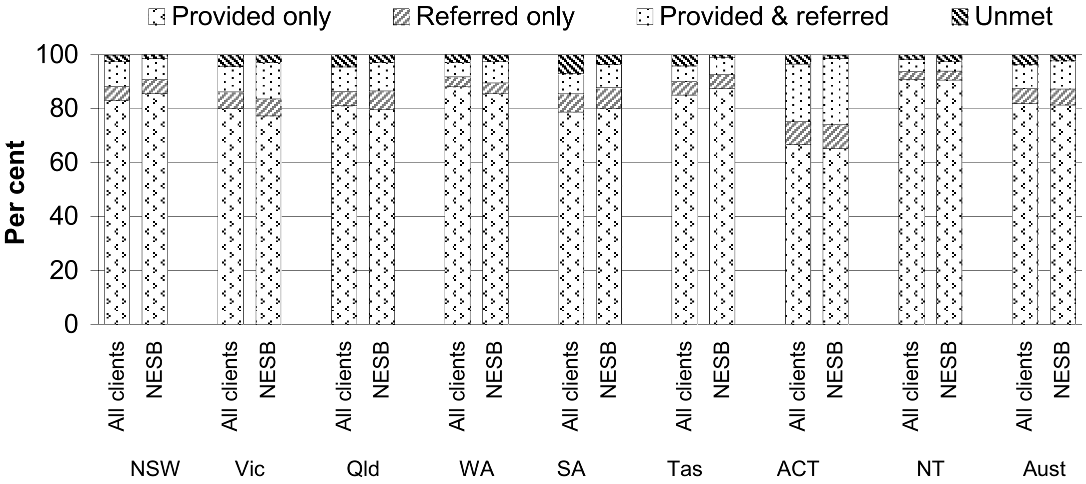
The proportions for Indigenous clients (96.3 per cent) and clients from a non-English speaking background (97.7 per cent) who received services in 2008-09 were the same or similar to that for all clients (96.3 per cent). These proportions varied across jurisdictions (figures 17.10-11).

Figure 17.10 Indigenous clients, by met and unmet support needs, 2008-09



Source: SAAP NDCA *Client Collection* (unpublished); AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09.* Cat no. HOU 219; tables 17A.13-14.

Figure 17.11 Clients from non-English speaking backgrounds, by met and unmet support needs, 2008-09



NESB = Non-English speaking background.

Source: SAAP NDCA *Client Collection* (unpublished); AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09.* Cat no. HOU 219; tables 17A.13 and 17A.15.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Differences in expenditure data across jurisdictions might to some extent reflect differences in the way in which these data are compiled rather than true variations in expenditure.

Cost per completed support period

'Cost per completed support period' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of public resources (box 17.9).

Box 17.9 **Cost per completed support period**

'Cost per completed support period' is defined as total expenditure on 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.

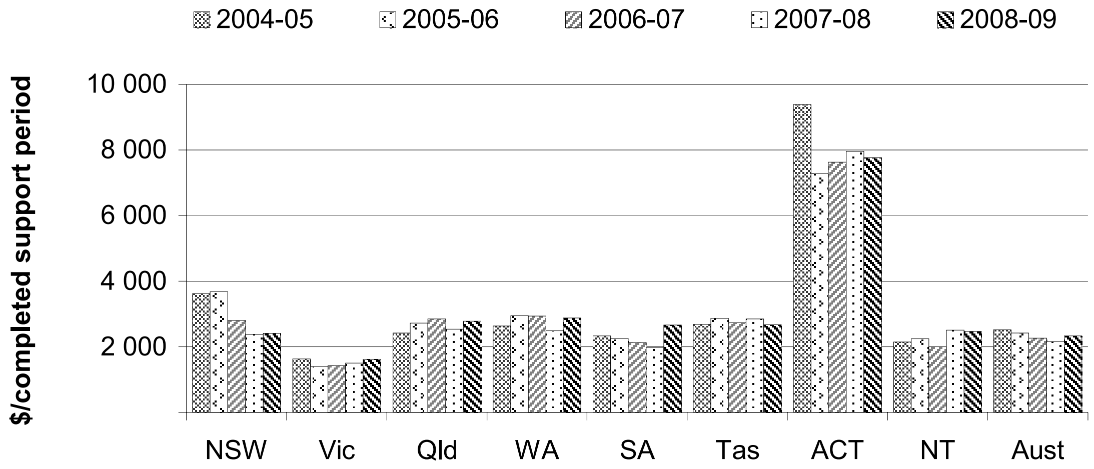
This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP was provided under the CSHA through a special purpose program (the CAP) until end-December 2008, when all funding was rolled into the NAHA.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The recurrent cost per completed support period (excluding potential clients and accompanying children) averaged $2330 nationally and varied across jurisdictions in 2008-09 (figure 17.12).

Figure 17.12 Real recurrent cost per completed support period (2008-09 dollars)[a]



[a] See notes to table 17A.17 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 17A.17.

Cost per client

‘Cost per client’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of public resources (box 17.10).

Box 17.10 **Cost per client**

‘Cost per client’ is defined as total expenditure on 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.

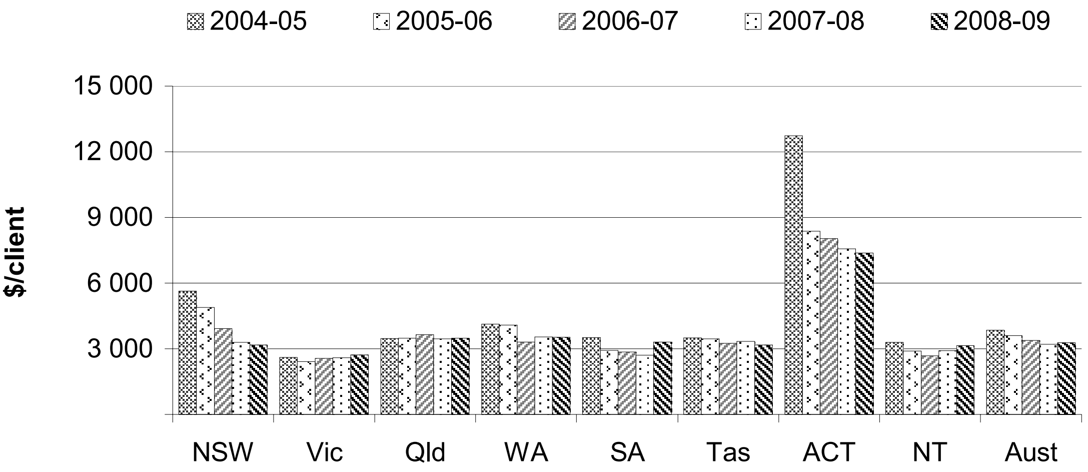
This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP was provided under the CSHA through a special purpose program (the CAP) until end-December 2008, when all funding was rolled into the NAHA.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Nationally, the recurrent cost per client accessing SAAP services was $3270 and varied across jurisdictions in 2008-09 (figure 17.13).

Figure 17.13 **Real recurrent cost per client accessing SAAP services (2008-09 dollars)**[a]



[a] See notes to table 17A.18 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 17A.18.

Cost per day of support

‘Cost per day of support’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of public resources (box 17.11).

Box 17.11 **Cost per day of support**

'Cost per day of support' is defined as total expenditure on 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.

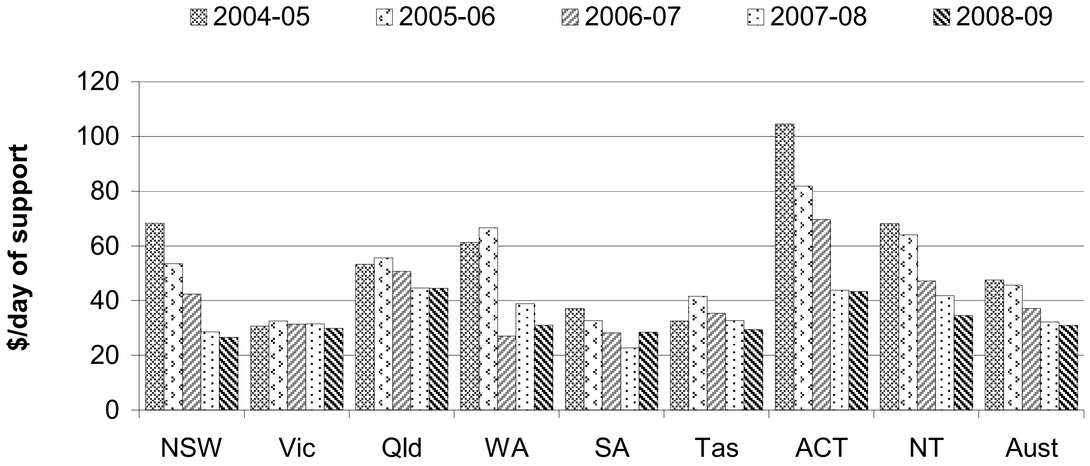
This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP was provided under the CSHA through a special purpose program (the CAP) until end-December 2008, when all funding was rolled into the NAHA.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The recurrent cost per day of support for SAAP clients averaged $31 nationally and varied across jurisdictions in 2008-09 (figure 17.14).

Figure 17.14 **Real recurrent cost per day of support for clients (2008-09 dollars)[a]**



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[a] See notes to table 17A.19 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 17A.19.

Outcomes

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

An important outcome of 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, Australian governments commissioned a research project to examine the impact of SAAP services on client self-reliance. The report based on this project, *Measuring the Impact of SAAP-funded Homelessness Services on Client Self-reliance* (FaHCSIA 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 17.12).

Box 17.12 **Achievement of employment on exit**

'Achievement of employment on exit' is defined as the number of closed support periods for 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.

Data quality information for this indicator is under development.

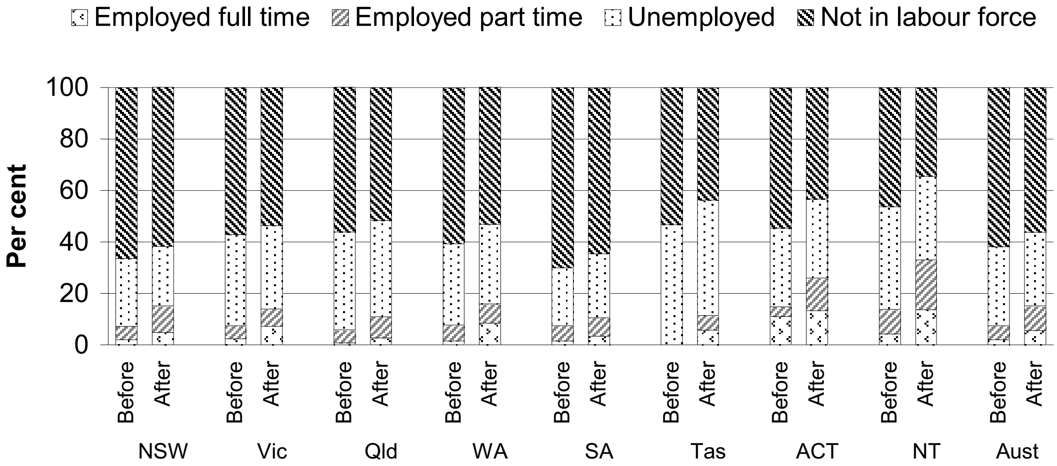
Nationally, of those clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2008-09, the proportion of clients who were employed either full time or part time increased from 10.0 per cent before support to 20.3 per cent after support (7.0 per cent full time and 13.3 per cent part time). The proportion of clients who were unemployed decreased from 34.0 per cent before support to 30.2 per cent after support. The proportion of clients who were not in the labour force decreased from 56.1 per cent before support to 49.5 per cent after support. Proportions varied across jurisdictions (figure 17.15(a), table 17A.23).

Nationally, of those Indigenous clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2008-09, the proportion of clients who were employed either full time or part time increased from 7.4 per cent before support to 15.1 per cent after support (5.6 per cent full time and 9.5 per cent part time). The proportion of clients who were unemployed decreased from 30.7 per cent before support to 28.6 per cent after support. The proportion of clients who were not in the labour force decreased from 61.9 per cent before support to 56.3 per cent after support. These proportions varied across jurisdictions (figure 17.15(b) and table 17A.24).

Figure 17.15 Changes in labour force status of clients who needed assistance to obtain/maintain employment and training before/after SAAP support, 2008-09[a]

(a) All SAAP clients

(b) Indigenous SAAP clients



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[a] Data are for people who requested assistance with obtaining or maintaining employment when entering SAAP services.

Source: SAAP NDCA *Client Collection* (unpublished); tables 17A.23-24.

Achievement of income on exit

‘Achievement of income on exit’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 17.13).

Box 17.13 **Achievement of income on exit**

'Achievement of income on exit' is defined as the number of closed support periods for 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.

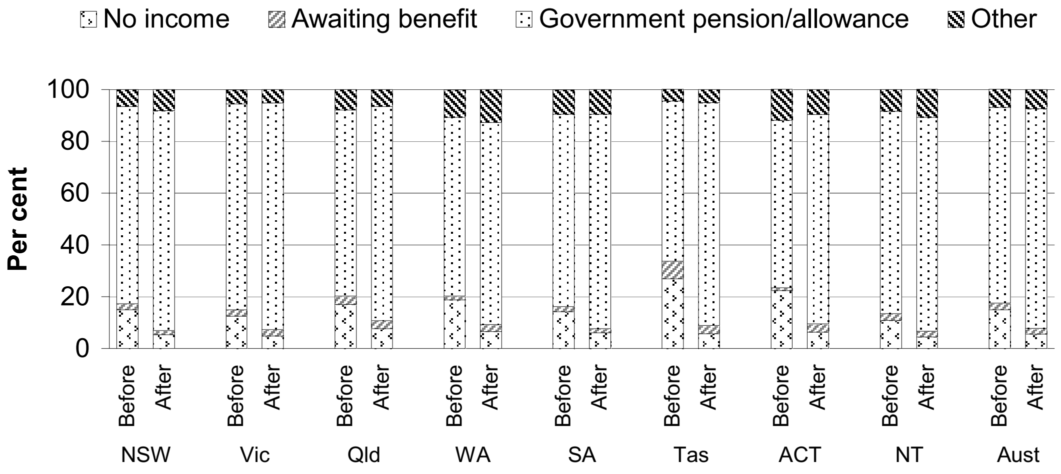
This indicator compares these clients' income status before and after they received SAAP support. A client's independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from SAAP services.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

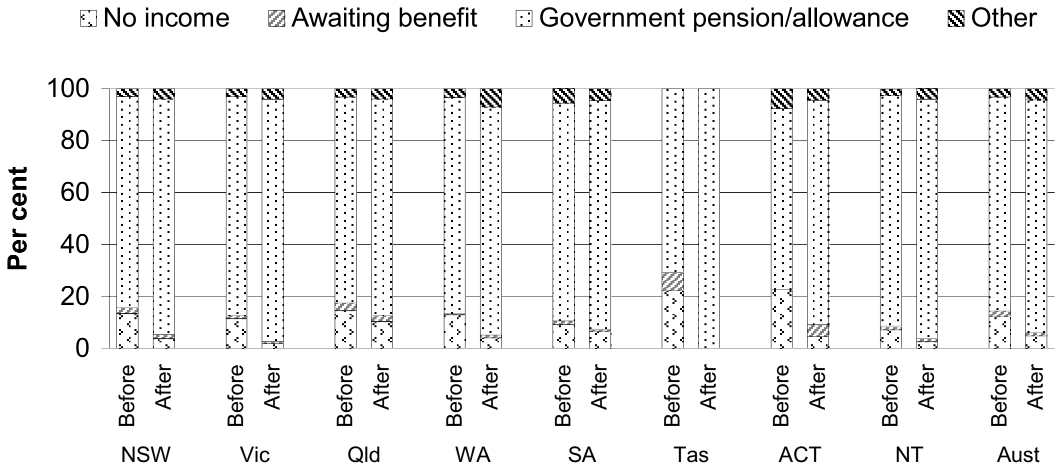
Nationally, in 2008-09, 14.9 per cent of SAAP support periods in which clients who requested income assistance did not have income prior to SAAP assistance. After SAAP assistance, the proportion of SAAP support periods in which clients who had requested income assistance and had no income was 5.6 per cent (figure 17.16). The proportion of Indigenous clients who did not have income and requested income assistance also decreased after SAAP assistance (from 12.3 per cent to 4.7 per cent nationally) (figure 17.17). Both before and after SAAP assistance, the income source for the majority of SAAP clients was a government pension/benefit (figures 17.16 and 17.17).

Figure 17.16 Source of income immediately before/after SAAP support of clients who needed assistance to obtain/maintain a pension or benefit, 2008-09



Source: SAAP NDCA *Client Collection* (unpublished); table 17A.29.

Figure 17.17 Source of income immediately before/after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit, 2008-09



Source: SAAP NDCA *Client Collection* (unpublished); table 17A.30.

Achievement of independent housing on exit

‘Achievement of independent housing on exit’ is an indicator of governments’ objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 17.14).

Box 17.14 **Achievement of independent housing on exit**

‘Achievement of independent housing on exit’ is defined as the number of closed support periods in which clients who requested assistance with obtaining or maintaining independent housing achieved independent housing, divided by the total number of closed support periods in which clients requested assistance obtaining or maintaining independent housing.

A high or increasing proportion of 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.

Data quality information for this indicator is under development.

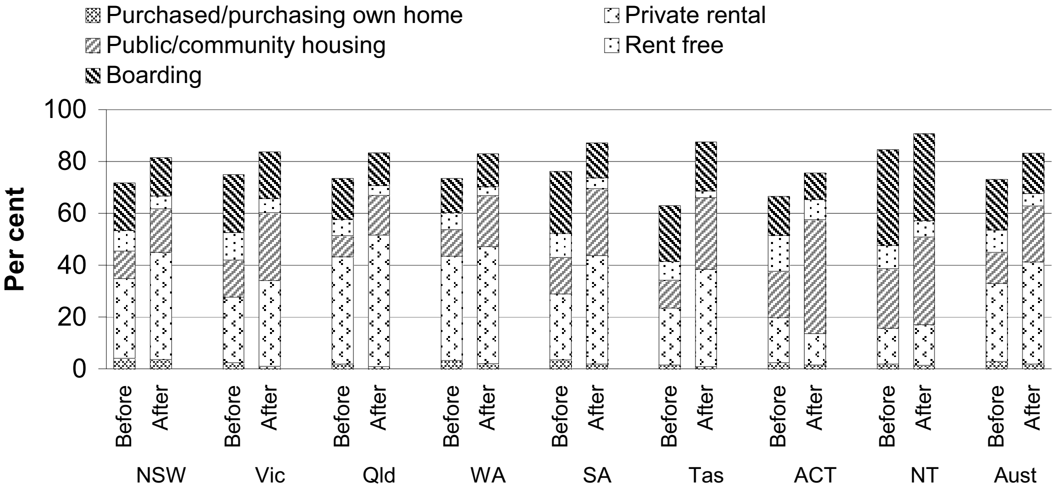
Nationally, 83.2 per cent of closed support periods in which clients requested assistance with obtaining or maintaining independent housing achieved independent housing in 2008-09. This included clients who moved or returned to private rental housing (39.3 per cent), to public or community rental housing (21.7 per cent), and those who were boarding (15.5 per cent) (figure 17.18a).

Among Indigenous clients, on a national basis, 84.2 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2008-09, including those who moved or returned to private rental housing (27.4 per cent), to public or community rental housing (31.4 per cent), and who were boarding (19.7 per cent) (figure 17.19a).

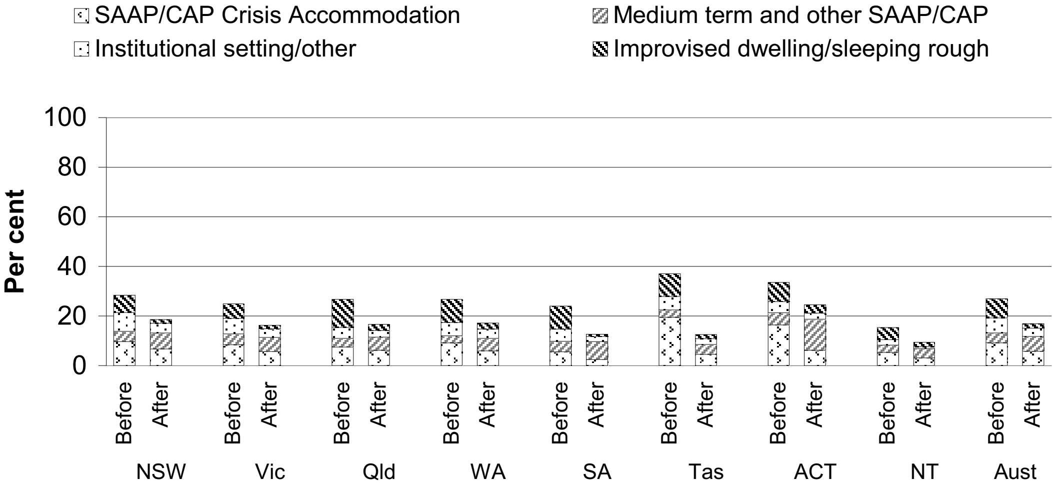
Closed support periods in which clients did not achieve independent housing included those who moved to, or continued to live in, short to medium term SAAP accommodation and other forms of non-independent accommodation (figure 17.18b and 17.19b).

Figure 17.18 Accommodation type before and after SAAP support, for clients who requested assistance with obtaining or maintaining housing, all SAAP clients, 2008-09

(a) Independent housing



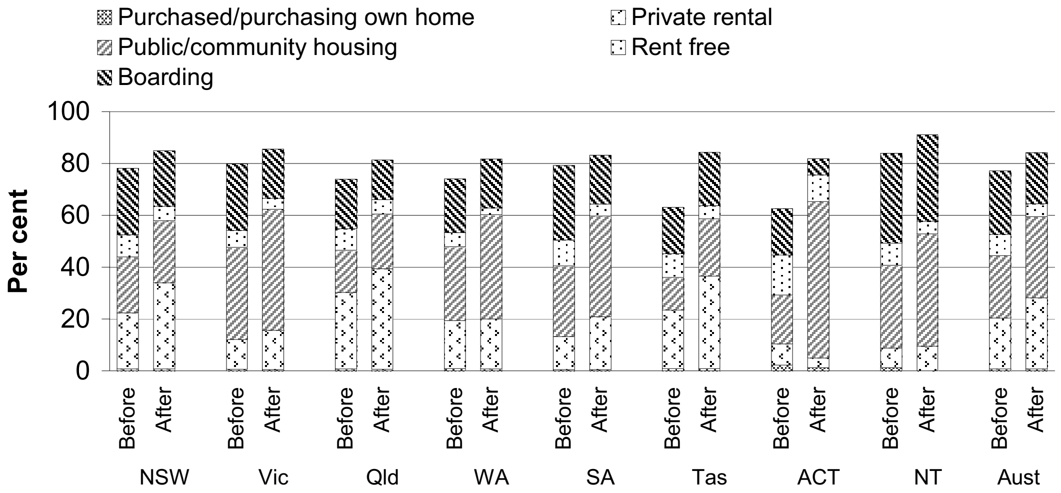
(b) Non-independent housing



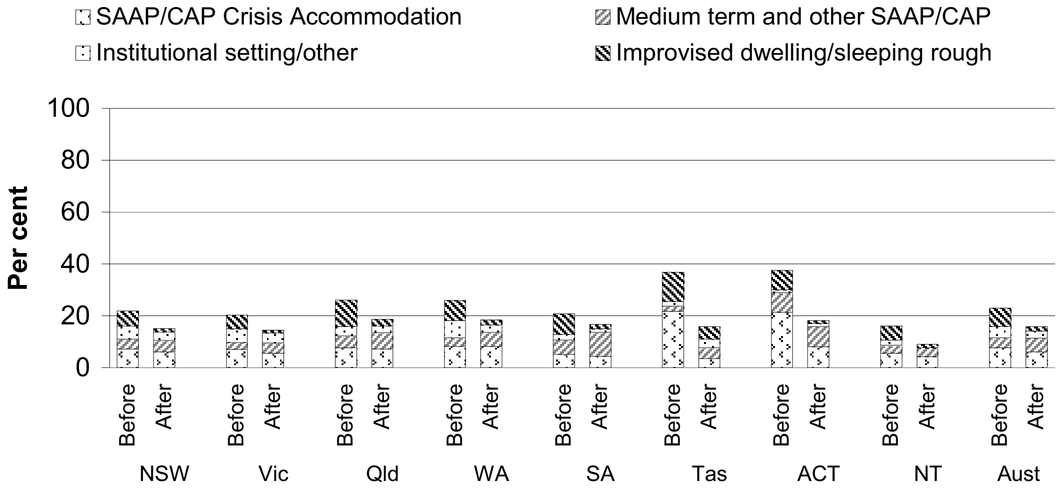
Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); tables 17A.21.

Figure 17.19 Accommodation type before and after SAAP support, for clients who requested assistance with obtaining or maintaining housing, Indigenous SAAP clients, 2008-09

(a) Independent housing



(b) Non-independent housing



Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); tables 17A.22.

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 17.15).

Box 17.15 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.

Data quality information for this indicator is under development.

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 17.2. 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 17A.27). 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 17.16).

Box 17.16 **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’ comprises two measures.

1. 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.
2. The number of clients who more than once required SAAP housing or accommodation support (as distinct from other types of SAAP support such as employment assistance and counselling), divided by the number of SAAP clients who required SAAP housing or accommodation support. Data are reported for all SAAP clients, and separately for Indigenous clients. This measure was introduced in the 2011 Report for consistency with the proxy measure used to enumerate the NAHA indicator ‘proportion of people experiencing repeat periods of homelessness’.

A high or increasing proportion of clients with only one support period during the year is desirable. Consistent with this objective, a low or decreasing number of SAAP clients who more than once required SAAP housing or accommodation support specifically is desirable.

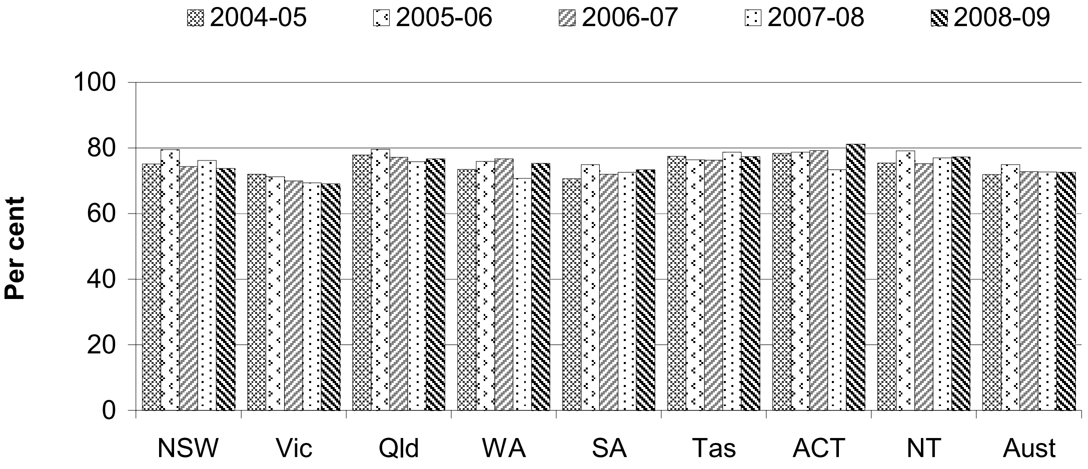
Many of the problems and barriers that lead people into homelessness are not easily fixed (FaHCSIA 2008a). Therefore, a number of SAAP clients might access SAAP services several times before their needs are met on a permanent basis (for example, moving from crisis accommodation to medium term accommodation).

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, 72.6 per cent of SAAP clients had only one support period in 2008-09 (figure 17.20). The proportion for Indigenous clients was similar (72.4 per cent) (table 17A.26).

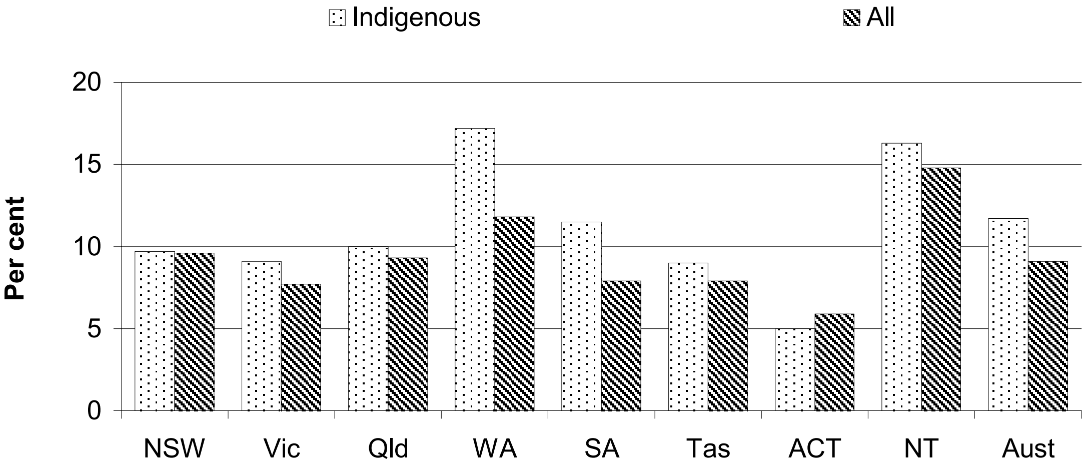
Figure 17.20 Proportion of SAAP clients with only one period of support within a year



Source: AIHW (2010) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2008-09.* Cat no. HOU 219; table 17A.25.

Nationally, 9.1 per cent of all SAAP clients more than once required SAAP housing or accommodation support in 2008-09 (as distinct from other types of SAAP support such as employment assistance and counselling). The proportion for Indigenous clients was higher (11.7 per cent). Proportions varied across jurisdictions (table 17A.28).

Figure 17.21 Proportion of SAAP clients who more than once in 2008-09 required SAAP housing or accommodation support



Source: SAAP NDCA *Client Collection* (unpublished); Steering Committee for the Review of Government Service Provision (forthcoming); table 17A.28.

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 17.17).

Box 17.17 **Goals achieved on exit from service**

'Goals achieved on exit from service' is defined as the proportion of clients who reported that their case management goals were fully or mostly achieved by the end of their support period, divided by the total number of clients with case management goals in a given period.

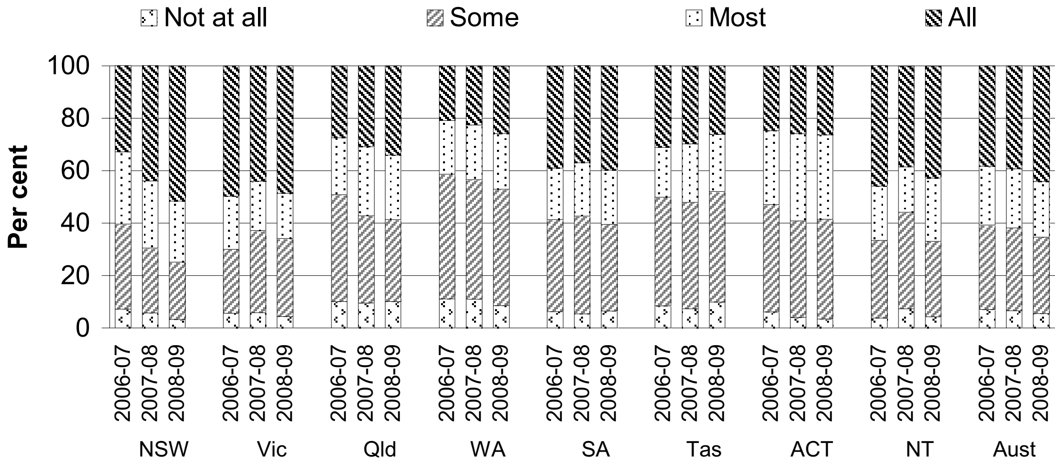
A high or increasing proportion of achieved goals is desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, case management goals were fully or mostly achieved by the end of the support period for 65.3 per cent of clients in 2008-09 (figure 17.22).

Figure 17.22 **Goals achieved on exit from SAAP service**



Source: SAAP NDCA *Client Collection* (unpublished); table 17A.31.

17.4 Future directions in homelessness services performance reporting

Homelessness data developments

Data agencies, the Australian Government and State and Territory governments are currently developing a new homelessness data collection to report on performance indicators contained in the NAHA and associated partnership agreements. It is expected that the new homelessness data collection will be operational by 1 July 2011. While the new data collection is being developed, an interim SAAP collection will continue until end-June 2011.

The measurement of service delivery in the new homelessness data collection will be based on clients rather than support periods. Therefore, once the new homelessness data collection is operational, data in this Report will be measured on the basis of clients rather than support periods, necessitating a break in ROGS SAAP/homelessness time series data.

COAG developments

Report on Government Services alignment with National Agreement reporting

Further alignment between the Report and NA indicators might occur in future reports as a result of developments in NA reporting.

Outcomes from review of Report on Government Services

COAG endorsed recommendations of a review of the RoGS in December 2009. Those recommendations implemented during 2010 are reflected in this Report.

Further recommendations will be reflected in future Reports, including implementation of Independent Reference Group and Steering Committee recommendations arising from the ‘Review of the general performance indicator framework’ and the ‘Review of the performance indicators and their associated measures’. The 2012 Report and later editions will continue:

- lengthening time series data in attachment tables
- developing data quality information documents for performance indicators
- developing mini-case studies.

17.5 Jurisdictions’ comments

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

Australian Government comments

“ The Australian Government has progressed a series of programs, initiatives and reforms in pursuit of objectives and targets in ‘The Road Home: A national approach to reducing homelessness’.

For example, 105 ‘Reconnect’ services (including 11 Indigenous services and 13 services targeting newly arrived young people) are in operation. ‘Reconnect’ is a $23.5 million community-based early intervention program supporting young people aged 12 to 18 years who are homeless, or at risk of homelessness.

FaHCSIA, in partnership with Centrelink and community agencies, delivers ‘HOME Advice’ in 8 locations throughout Australia. This $1.4 million program assists families facing difficulty to maintain tenancies or home ownership.

‘A Place to Call Home’ is a $300 million commitment to build over 600 dwellings, many of which will follow innovative housing models including common ground and foyer facilities with wrap-around support services. ‘A Place to Call Home’ is funded by $150 million of state and territory funds and $150 million of matched funding from the Commonwealth.

Under the $11.4 million National Homelessness Research Agenda, Research Partnership Agreements worth $4 million are shared equally across the University of Queensland, Swinburne University of Technology and Flinders University in South Australia. Projects funded under the agenda will focus on rough sleeping, improving the service delivery system for the most vulnerable groups (including service integration), improving understanding of homelessness and the effectiveness of interventions, and longitudinal data development.

The Prime Minister’s Council on Homelessness (established 2009) has met seven times. In June 2010, the Council led ‘The Road Home—Progress and Lessons’ exhibition which brought together over 200 policy and program managers from government and non-government organisations, practitioners, research experts and policy advocates.

Progress will be measured in part by the development of a new data collection system for Specialist Homelessness Services (SHS), new national minimum data sets, the ABS review of the ‘Counting the Homeless’ methodology and Centrelink’s introduction of a homelessness indicator. These initiatives will compliment the count of the homeless population derived from the 2011 Census.

The Australian Government has committed a further $78.83 million over four years to double the capacity (30 up to 60 sites) of ‘headspace’, a youth friendly mental health service. In addition, specialist ‘Job Services Australia’ providers will deliver specialist services from 39 locations to people who are homeless or at risk of homelessness.

Other initiatives such as the introduction of weekly payments via Centrelink, targeted residential care capital grants, ‘Access to Allied Psychological Services’ program and the Social Housing Initiative are further examples of the Australian Government’s efforts to reduce homelessness. ”

New South Wales Government comments

- The NSW Homelessness Action Plan 2009–2014 sets the direction for state-wide reform of the homelessness service system to achieve better outcomes for people who are homeless or at risk of homelessness. Through the Action Plan, the NSW Government is re-aligning existing service delivery to increase the focus of the service system on prevention and long-term accommodation and support, rather than crisis intervention.
- The NSW and Australian Governments are jointly investing an additional $284 million to tackle homelessness under the National Partnership Agreement on Homelessness. In addition, the NSW Government has committed a further $108.7 million, bringing the total commitment to $392.2 million. The NSW Homelessness Action Plan is aligned with the National Partnership Agreement, and incorporates all of the activities funded under the Agreement.
- A key component of the NSW Homelessness Action Plan is the development of 10 Regional Homelessness Action Plans, which were released in August 2010. Regional Action Plans will deliver the broad policy directions of the NSW Homelessness Action Plan in the context of local needs, priorities and opportunities. These plans were developed in consultation with representatives from across the homelessness service system including the government and non-government sector.
- In NSW, there are 356 Specialist Homelessness Services funded under the National Affordable Housing Agreement, which has replaced the Supported Accommodation Assistance Program. These services include crisis accommodation and support to people who are homeless or at risk of homelessness targeting women and children escaping domestic violence, young people, single adults and families.
- The NSW Government has established a Premier's Council on Homelessness, as a peak advisory body to Government in relation to homelessness. The Council provides high-level policy advice to the Premier and relevant Ministers on responses to homelessness. Members include people who have a wealth of experience dealing with the issues that lead to homelessness and the experiences of people living on the streets. The NSW Premier formally announced membership of the Council in February 2010.
- NSW is also implementing an extensive evaluation and research strategy to build on its understanding of homelessness and the impact of its activities. This project is linked to the Australian Government's evaluation and research agenda, with a particular focus on assessing the effectiveness and efficiency of NSW initiatives undertaken as part of the National Partnership on Homelessness. Several activities designed to build this evidence base are incorporated in the NSW Homelessness Action Plan.

Victorian Government comments

“ Victoria works with more than 140 not-for-profit organisations to assist approximately 50 000 people each year who are facing homelessness to find housing, reconnect with the community and rebuild their lives.

From 1 July 2009, the Australian Government and all states and territories entered into a four-year National Partnership Agreement on Homelessness. This contributes $156.8 million to Victoria’s homelessness services over five years to address and prevent homelessness.

As a result, there are 20 new initiatives underway, including the reform, restructure and expansion of youth homelessness services, increased housing with specialised support for people experiencing recurring homelessness, and family violence programs that support women and children to remain safely in the family home.

During 2009–10 the rollout of the ‘Opening Doors’ service model continued across Victoria. ‘Opening Doors’ aims to ensure people are able to access services they need in their area without having to knock on more than one door. Local services are working together to support vulnerable people experiencing homelessness or who are in danger of becoming homeless. A 24-hour state-wide telephone service has been established to connect people to local services wherever they are.

‘A right to safety and justice: Strategic framework’ was developed in 2009–10 to guide continuing family violence reform in Victoria. The framework will guide improvements to Victoria’s response to violence against women over the next 10 years. ”

Queensland Government comments

The Queensland Department of Communities continues to work in partnership with and fund non-government organisations under the National Affordable Housing Agreement (NAHA) and National Partnership Agreement on Homelessness (NPAH) to deliver services to people experiencing homelessness, and those at risk of homelessness.

In 2009-10, $77.4 million in grants were provided to 237 services under the NAHA for the provision of specialist homelessness support and accommodation services. These services are provided for a wide range of identified target groups including young people, families, single adults and women and children escaping domestic and family violence.

Under the NPAH, $202.4 million has been committed over five years, in partnership with the Australian Government, to reduce homelessness. In 2009-10, $34.6 million dollars was invested across Queensland in new and expanded services and reform activities to help people who are homeless transition to stable accommodation.

The Queensland Government's Implementation Plan identifies 31 initiatives funded under the NPAH, designed to make a substantial contribution towards reducing homelessness. Fifteen of these 31 initiatives commenced service delivery in 2009-10.

The Implementation Plan combines an increased focus on prevention and early intervention, and delivery of housing solutions with appropriate support. Under 'A Place To Call Home', 143 new homes are being acquired in Queensland for individuals and families experiencing, or at risk of, homelessness over the life of the agreement. In 2009-10, the Department added 30 dwellings to the portfolio and housed and supported 75 individuals and/or families, helping them to stop cycling in and out of homelessness services.

New 'housing first' service models, including the Brisbane Common Ground and Street to Home initiatives, have been established to provide responses to people who are sleeping rough and/or experiencing chronic homelessness. Funding for 15 HomeStay Services also builds on Queensland's existing investment in Early Intervention Services.

Western Australian Government comments

“In Western Australia, homelessness accommodation and support services continue to provide a critical safety net for people experiencing homelessness. There are 122 services recurrently funded through the National Affordable Housing Agreement (NAHA) to provide accommodation and/or a range of supports for people at risk of, or experiencing homelessness.

In 2009–10, the Department for Child Protection, as the lead agency with responsibility for homelessness, arranged for a smooth transition of contract arrangements for non-government services from the Supported Accommodation Assistance Program (SAAP) to the NAHA. Specialist homelessness services have been encouraged to reform in line with the NAHA. In addition, as contracts with service providers are renewed, reference to NAHA and the importance of providing better integrated services is being incorporated.

In Western Australia, the National Partnership Agreement on Homelessness (NPAH) provides $135 million over four years in new and expanded support services, capital and land. The WA Implementation Plan is well under way and approximately 110 new full time equivalent workers are in place throughout the state.

The new NPAH programs have been developed in consultation with relevant government agencies and specialist homelessness services to ensure service models are relevant to the needs of people at risk of, or experiencing homelessness. The quality of service provision will be monitored through contracting processes and supported through regular forums for sharing best practice.

The Western Australian Council on Homelessness was established in 2010. The Council promotes integrated responses with non-government, government and mainstream services to ensure a more connected and responsive service system. The Council is made up of community and academic representatives with ex-officio members from key government departments.

The Western Australian Homelessness State Plan *Opening Doors to Address Homelessness* was developed by the Western Australian Council on Homelessness and key agencies working with people experiencing homelessness. The State plan will inform the development of regional action plans which will provide a focus on the response to homelessness and work to build a more integrated service system.

Contracts for all metropolitan services and the majority of rural and remote services have now been finalised.”

South Australian Government comments

“The National Partnership Agreement on Homelessness (NPAH) Implementation Plan for South Australia commits to a reformed homelessness sector. The Department for Families and Communities (DFC) has systematically incorporated all effort, including the NPAH, National Affordable Housing Agreement (NAHA), A Place to Call Home (APTCH) Initiative, and Nation Building-Economic Stimulus Plan (NBESP) into the formation of an integrated and streamlined service sector. The planned strategic reforms are making the most of additional funding so that provision of specialist homelessness services, mainstream services and housing are targeted, integrated, coordinated, sustainable and measurable.

Services are being consolidated into regional responses and have been tendered as part of the new service system, ensuring that new programs are not an ‘add on’ to existing services, but rather become an integrated part of South Australia’s response to homelessness. The major elements of the reforms are being undertaken in two stages with Stage 1 completed by 1 July 2010 and Stage 2 completed by 1 December 2010.

Under the NBESP, approximately 630 dwellings are being built in South Australia to assist homeless people. Of these, 515 are provided with individualised support packages, and 121 are allocated to specific program responses. The new Supportive Housing Program aims to provide a ‘housing first’ response to people in greatest need who are experiencing homelessness. The dwellings have been specifically built to target youth, domestic violence, families, adults, and older people and will assist tenants to maintain their tenancy and to source long-term sustainable housing options.

DFC has also partnered with the Attorney General’s Department to establish a separate domestic violence service system (linked with the specialist homelessness service system), in order to appropriately respond to legislative and policy changes in the area of violence against women and children. When finalised, the restructured specialist Domestic and Aboriginal Family Violence service sector will have 20 programs with targeted regional responses across South Australia.

South Australia has initiated a number of reforms to work towards its commitment to reduce Aboriginal Homelessness by 33 per cent by 2013, including:

- at least 20 per cent of homelessness services’ clients are to be Aboriginal or Torres Strait Islander people
- addressing issues of Aboriginal mobility, homelessness and family violence through a specific APY Lands response and a ‘Safe Tracks’ strategic framework to enable the linking of the contributions of all government departments and community sectors.”

Tasmanian Government comments

In 2009-10, the Tasmanian Government made significant progress towards the implementation of initiatives under the National Partnership Agreement on Homelessness, Tasmanian Implementation Plan. Extensive effort went into the development of new initiatives with an emphasis on best practice, research evidence and financial modelling. This will ensure that new initiatives address service gaps and achieve desired client outcomes.

The major initiatives developed in the 2009-10 period focus on assisting people exiting statutory or institutional care with multiple and complex needs. These targeted programs, ‘Same House Different Landlord’ (tenancy and property management) and ‘Specialist Intervention Tenancy Services’ (specialist support services), will enhance the way services are provided and increase residential stability for clients, which will provide client with a more sustainable future.

The Tasmanian Government is committed to addressing homelessness and is on track to achieve the target of halving primary homelessness by providing 193 additional units of accommodation by December 2010.

This commitment has included significant capital development of specialist homelessness services accommodation and supported residential facilities throughout the State. These investments were funded from a range of sources, including the *Nation Building Economic Stimulus Plan* and the State Government $60 million Housing Fund. Works have been completed or are nearing completion on at least five facilities within the state.

Through the Tasmanian Homelessness Plan, government is working towards further integrated facilities and targeted services under a number of service models, while making fundamental improvement to service coordination.

The 2009-10 year laid the groundwork for the delivery of a significant amount of targeted accommodation and homelessness support services in 2010-11. This work included the development of the finalised Tasmanian Homeless Plan 2010–2013: *Coming in from the cold*.

Australian Capital Territory Government comments

The ACT provides high quality homelessness services through an integrated and comprehensive system of support that meets the needs of clients, sustains tenancies and provides access to affordable housing, including public and community housing.

In 2009, the ACT committed to specific targets under the National Partnership Agreement on Homelessness (NPAH) as part of a national effort to halve homelessness by 2020. The ACT Government has implemented a range of comprehensive reforms in partnership with specialist homelessness and mainstream services to reduce homelessness, including a common waiting list for social and affordable housing and a centralised intake service to ensure that applicants for housing assistance and homelessness services can access the services through a single entry point without the need to approach multiple service providers.

The Joint Pathways Group comprising senior non-government and government representatives continues to work in partnership to address systemic service reform and practice issues in responding to homelessness. The Group also seeks to build connections between homelessness services and the wider mainstream services system, such as mental health, employment services and education.

In November 2009, Housing and Community Services published *The Road Map: A discussion paper on the way forward for ACT homelessness services and related services*, to promote discussion on reform directions and the implementation of new initiatives. The feedback from the discussion paper was used to identify the changes that are required across the service delivery system as well as assisting in the development of new initiatives under the NPAH.

New initiatives established in 2009–10 include, a men's managed accommodation and outreach support program for men exiting detention, the 'Street to Home' initiative which coordinates services to people living on the streets, including support to up to 20 rough sleepers, and the Building Housing Partnerships Supportive Sustaining Tenancy Service.

The Building Housing Partnerships Supportive Sustaining Tenancy Service will provide intensive case management for 700 clients across a range of tenures including social housing, private rental and home ownership. The service will have a strong focus on early intervention and prevention, targeting those at risk of losing their housing and becoming homeless.

In 2009–10, seven *A Place to Call Home* dwellings were provided. The ACT accelerated the provision of housing under the *A Place to Call Home* initiative, funding the acquisition of land for the first ten dwellings over 2008-09 and 2009-10. Of the seven dwellings completed last year, three dwellings were allocated to Aboriginal and Torres Strait Islander families.

Northern Territory Government comments

During 2009–10, 22 non-government organisations were funded $10.2 million to deliver 50 specialist homelessness services across the Northern Territory under the National Affordable Housing Agreement.

Under the National Partnership Agreement on Homelessness (NPAH), the NT has established a number of new initiatives including the ‘A Place to Call Home’ program, ‘Street to Home’ projects for chronic rough sleepers, youth homelessness programs and assistance for people leaving corrections services.

A review has been conducted of the Territory’s approach under the NPAH to improve the targeting and spread of initiatives. Subject to final agreement, this will see additional programs and services delivered from 2010–11 onwards, such as:

- short and medium term accommodation and support options
- accommodation and support for people travelling into regional centres to access services
- youth homelessness programs and programs designed for people exiting correctional centres.

The NT Government has also commenced a homelessness profile study that will provide an evidence-base for strategic, place-based responses to homelessness in the Darwin, Alice Springs and Katherine regions.

Data from the 2008–09 SAAP National Data Collection indicate that children in the NT are more likely to accompany an adult accessing specialist homelessness support than children in any other jurisdiction. The focus on children is particularly relevant due to significant reforms to the NT’s service system following the release of the Board of Inquiry’s Report into the NT’s Care and Protection System, ‘Growing them strong, together’ released in October 2010.

Through Australian Government stimulus funding and NT Government investment, additional facilities from which to deliver homelessness services are being constructed and include:

- increased managed and supported accommodation in Darwin for single women, single men, and women and children escaping domestic violence
- a short term managed accommodation facility in Alice Springs providing a mix of units, cabins, tents and open camping areas for up to 150 people
- two new managed and supported accommodation facilities, one each in Alice Springs and Darwin, with accompanying support services to enhance people’s ability to access, maintain and secure tenancies in either the private or public rental market.

17.6 Definitions of key terms and indicators

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	Services specifically designed to assist women and women

domestic violence services	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.

17.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by an ‘17A’ suffix (for example, table 17A.3 is table 3). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

SAAP data

Table 17A.23	Closed support periods: Labour force status of clients who needed employment and training assistance, before and after SAAP support
Table 17A.24	Closed support periods: Labour force status of Indigenous clients who needed employment and training assistance, before and after SAAP support
Table 17A.25	SAAP clients who exited from the service and who returned to SAAP agencies before the end of that year
Table 17A.26	Indigenous SAAP clients who exited from the service and who returned to SAAP agencies before the end of that year
Table 17A.27	Indicative estimates of clients exiting to independent housing and not returning within six months
Table 17A.28	Proportion of SAAP clients who more than once had a housing/accommodation need identified by a SAAP agency worker, by Indigenous status
Table 17A.29	Source of income immediately before and after SAAP support of all clients who needed assistance to obtain/maintain a pension or benefit
Table 17A.30	Source of income immediately before and after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit
Table 17A.31	The extent that clients case management goals have been achieved

17.8 References

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