11 Primary and community health

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Attachment tables

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

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

- Home and Community Care program services (see chapter 13, 'Aged care')
- public hospital emergency departments and outpatient services (see chapter 10, 'Public hospitals')
- community mental health services (see 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 health care and in the

detection and management of illness and injury, through direct service provision and referral to acute (hospital) or other healthcare services as appropriate.

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

- data are reported for the first time against the indicator 'management of asthma'
- data are reported for a new measure of the indicator 'management of diabetes'.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

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

General practice

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

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

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

Services provided in general practice include:

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

Definitions for common health terms are provided in section 11.5.

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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the Pharmaceutical Benefits Scheme (PBS) (DoHA 2008a). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, currently $5.00 for concession card holders and $31.30 for general consumers. The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted in line with inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or free for the rest of the calendar year. The 2008 safety net threshold is $1141.80 for general consumers and $290.00 for concession card holders (DoHA 2008b).

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

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 certain 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 states and territories play different roles in supporting dental services in Australia's mixed system of public and private dental health care. The states and territories have the main responsibility for the delivery of major public dental health care programs, primarily directed at children and disadvantaged adults. The Australian Government supports the provision of dental

services primarily through the 30 per cent private health insurance rebate. The Australian Government 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 full-time and part-time members of the Australian Defence Force. It also has a role in the provision of dental services through Community Controlled Aboriginal Medical Services. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.2 per cent of all encounters with GPs in 2007-08 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2008) (table 11.1).

Table 11.1 **GP encounters, by source of funding, 2007-08[a, b, c]**

	Number[d]	*Per cent of all encounters*[e]	*95% LCL*	*95% UCL*
GPs participating in the BEACH survey	953	..	..	..
Total encounters for which BEACH data were recorded	95 898	..	..	..
Encounters with missing data	8 311	..	..	..
Direct encounters	86 359	98.6	98.4	98.8
No charge	386	0.4	0.4	0.5
Medicare paid[f]	83 418	95.2	94.9	95.6
Workers compensation paid	2 000	2.3	2.1	2.5
Other paid (hospital, State, etc.)	577	0.7	0.5	0.8
Indirect encounters[g]	1 225	1.4	1.2	1.6

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2007 to March [b] An ‘encounter’ is any professional interchange between a patient and a GP (Britt et al. 2008). [c] Data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter. [d] Number of encounters after post stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] Indirect encounters are those at which the patient is not seen by the GP but that generate a prescription, a referral, a certificate or another service. .. Not applicable.

Source: Britt *et al.* (2008), *General practice activity in Australia 2007–08*, Cat. no. GEP 22; table 11A.1.

The Australian Government also provides funding for general practice services under initiatives such as:

- the Practice Incentives Program (PIP)
- the General Practice Immunisation Incentives Scheme (GPII)
- the Divisions of General Practice (DGP).

Australian Government expenditure on general practice in 2007-08 was $5.6 billion, or $264 per person (figure 11.26).

Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas; for example, hospital emergency departments, Indigenous primary healthcare and other community health services, and the Royal Flying Doctor Service. Thus, expenditure on general practice understates expenditure on primary healthcare, particularly in jurisdictions with large populations of Indigenous people and people living in rural and remote areas. The Health preface includes expenditure data for Indigenous primary and community health services for 2004-05.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $6.4 billion, or $301 per person, in 2007-08. Expenditure on the PBS was around $5.9 billion in 2007-08, of which 79.3 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, 2007-08 ($ million)[a]**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
PBS general[b]	406.5	291.3	237.6	128.3	91.4	24.3	25.0	7.1	1 211.6
PBS concessional[c]	1 631.8	1 184.3	884.0	388.1	414.3	136.0	47.8	14.4	4 700.6
PBS doctor's bag	4.8	3.2	3.0	1.0	1.0	0.3	0.2	0.1	13.5
PBS total	2 043.1	1 478.8	1 124.6	517.4	506.8	160.6	72.9	21.5	5 925.6
RPBS total[d]	157.0	96.2	101.3	35.5	34.5	13.5	6.8	0.9	445.6
Total	**2 200.1**	**1 575.0**	**1 225.8**	**552.8**	**541.2**	**174.1**	**79.7**	**22.4**	**6 371.3**
$ per capita	317.6	300.2	289.9	259.4	340.0	351.2	233.9	103.1	300.8

[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), derived from the PBS data system.

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 insurance premium rebates and non-government expenditure) (table 11.3).

In 2006-07, government expenditure on community and public health was $5.8 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 was $114 million in 2006-07, while State, Territory and local government expenditure was $519 million (table 11.3). In some states and territories, additional expenditure is incurred through schemes that fund the provision by private practitioners of public dental health services for eligible people.

Table 11.3 **Estimated funding on community and public health, and dental services, 2006-07 ($ million)**

	Australian Government						
	Direct outlays	*Premium rebates*[a]	*Total*	*State and local govt*	*Total govt*	*Non-govt*	*Total*
Community and public health[b]	1 469	–	1 469	4 322	5 792	304	6 095
Dental services[c]	114	414	528	519	1 047	4 690	5 737

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

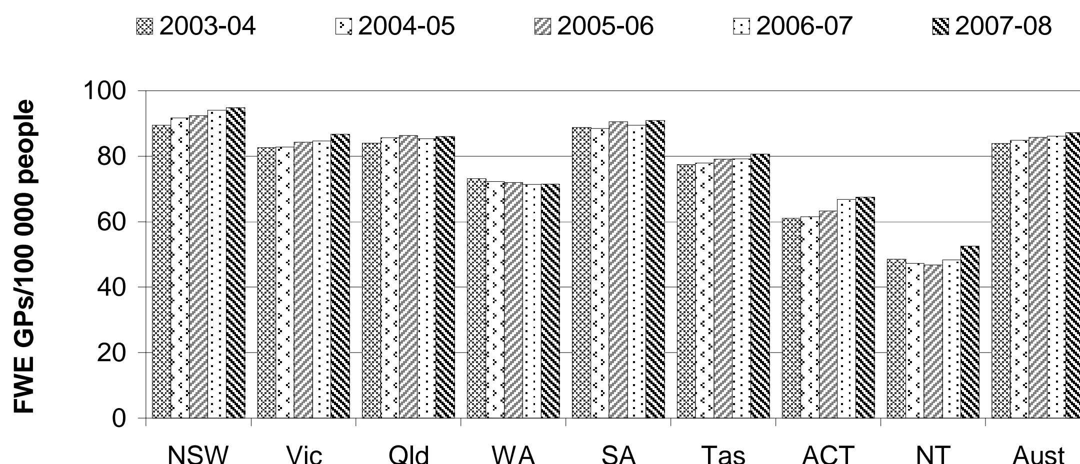
Source: AIHW (2008), *Health Expenditure Australia 2006-07*, Cat. no. HWE 42.

Size and scope

General practice

There were 26 212 vocationally recognised GPs and OMPs billing Medicare in Australia in 2007-08. On a full time workload equivalent (FWE) basis, there were 18 613 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 87.2 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 health care services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

Figure 11.1 **Availability of GPs (full time workload equivalent)[a]**



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

Source: DoHA (unpublished), derived from the MBS data system; table 11A.3.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 186 million services provided under the PBS and RPBS in 2007-08, amounting to 8.8 scripts per person. There were around 171 million services provided under the PBS in 2007-08, of which 85.7 per cent were concessional (table 11.4).

Table 11.4 **PBS and RPBS services, 2007-08 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	8.1	5.9	4.8	2.5	1.8	0.5	0.5	0.1	24.1
PBS concessional[b]	50.3	37.7	27.9	12.1	12.8	4.4	1.4	0.4	146.8
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.3
PBS total	58.5	43.6	32.7	14.6	14.5	4.9	1.9	0.6	171.3
RPBS total[c]	4.9	3.2	3.2	1.1	1.1	0.5	0.2	–	14.3
Total	**63.4**	**46.8**	**35.9**	**15.7**	**15.7**	**5.3**	**2.1**	**0.6**	**185.6**
Services per capita	9.2	8.9	8.5	7.4	9.8	10.7	6.1	2.9	8.8

[a] Includes PBS general ordinary and safety net. [b] Includes concessional ordinary and concessional free safety net. [c] Includes RPBS ordinary and RPBS safety net. – Nil or rounded to zero.

Source: DoHA (unpublished), derived from the PBS data system.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.52–11A.60 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 12 (Health management) 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. In WA, SA, Tasmania, and the NT, for example, general dental care (including preventative care) is provided for school children up to 18 years of age (tables 11A.56 [WA], 11A.57 [SA], 11A.58 [Tasmania] and 11A.60 [NT]).

States and territories also provide some general dental services and a limited range of specialist dental services to disadvantaged adults (holders of concession cards issued by Centrelink). In some 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). A number of jurisdictions indicated to the Review that they provided public dental services in 2007-08 targeted at disadvantaged people (tables 11A.52–11A.60).

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2008a). Treatment activities excluded from that report include 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 633 alcohol and other drug treatment services reported 2006-07 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). Of these, 305 (48.2 per cent) identified as government providers and 328 (51.8 per cent) identified as non-government providers (table 11A.8). All of the non-government providers received some government funding for 2006-07. There were 147 325 reported closed treatment episodes in 2006-07 (see section 11.5 for a definition of closed treatment episode). Clients seeking treatment for their own substance use, of whom 67.4 per cent were male, accounted for 140 475 closed treatment episodes (AIHW 2008a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (42.3 per cent). Cannabis was the next most common drug of concern (22.8 per cent), followed by opioids (14.4 per cent; heroin accounted for 10.6 per cent) and amphetamines (12.3 per cent) (AIHW 2008a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.52–11A.60.

Indigenous community healthcare services

Indigenous Australians use a range of primary health care services, including private general practitioners and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions.

These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2007-08, these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.52–11A.60).

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

For 2006-07, SAR data are reported for 146 Indigenous primary healthcare services (table 11A.4). Of these services, 54 (37.0 per cent) were located in remote or very remote areas (table 11A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.6). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Over 1.6 million episodes of healthcare were provided by participating services in 2006-07 (table 11.5). Of these, around 582 000 (35.2 per cent) were in remote or very remote areas (table 11A.5).

Table 11.5 **Estimated episodes of healthcare for Indigenous people by services for which SAR data are reported (‘000)[a]**

	NSW and ACT[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2002-03	423	130	234	337	140	20	216	1499
2003-04	430	169	267	302	142	22	280	1612
2004-05	415	151	254	274	145	23	323	1585
2005-06	505	179	240	281	101	29	347	1681
2006-07[c]	440	177	253	284	114	31	354	1652

[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 health care delivered over the phone are included. [b] Data for NSW and the ACT have been combined for confidentiality purposes. [c] 2006-07 data are preliminary results.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

The services included in the SAR data collection employed 2198 full time equivalent health staff (as at 30 June 2007). Of these, 1351 were Indigenous (61.5 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (3.2 per cent and 13.3 per cent, respectively) (table 11A.7).

11.2 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for primary and community health (box 11.1). The framework provides information on equity, effectiveness and efficiency, and distinguishes outputs from outcomes. This approach is consistent with the general performance indicator framework for this Review that has been agreed by the Steering Committee (see chapter 1). The framework will evolve as better indicators are developed and as the focus and objectives for primary and community health change. In particular, the Steering Committee plans to develop and report against more indicators relating to community health services.

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

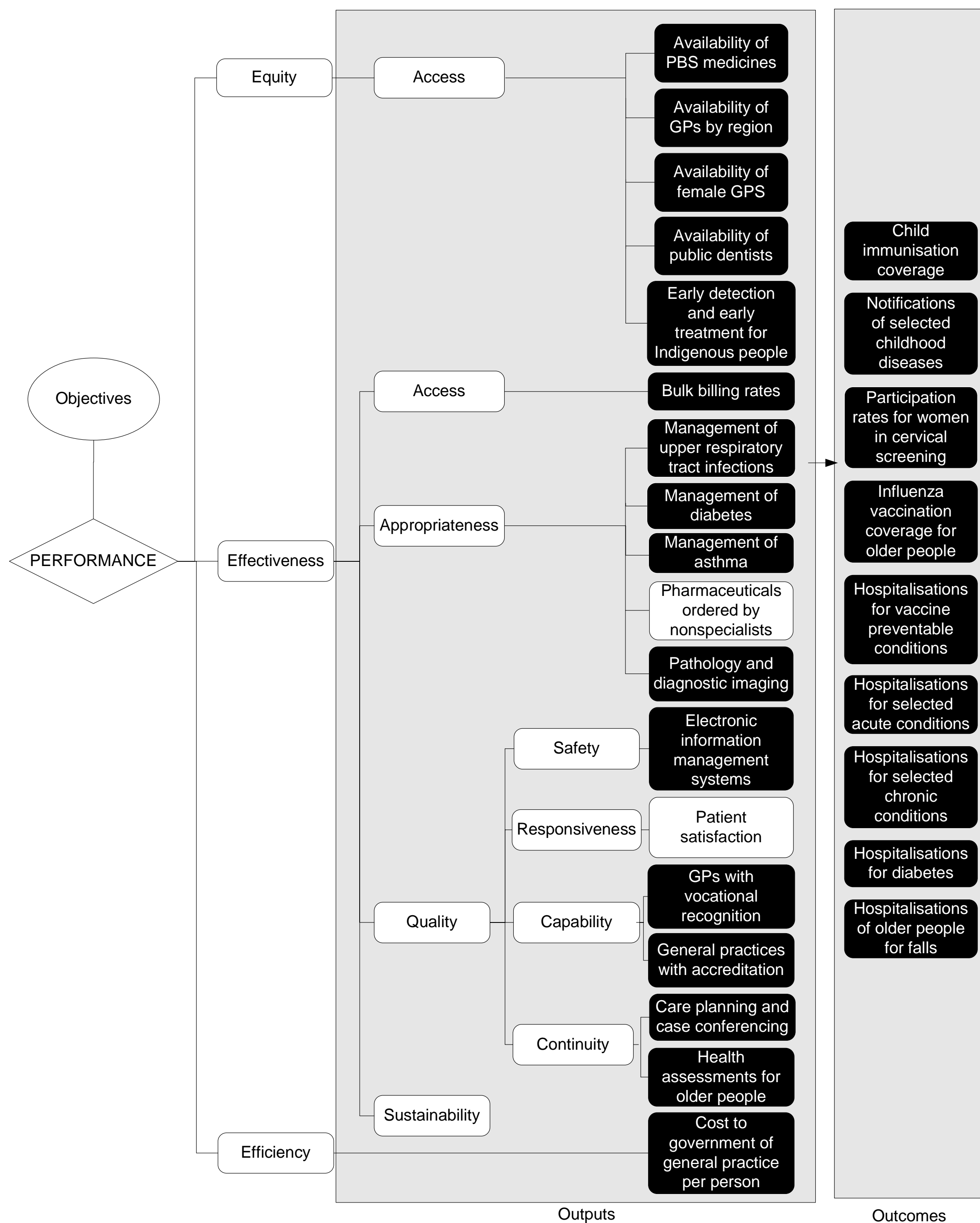
Primary and community health services aim to promote the health of Australians by:

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

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

The performance indicator framework shows which data are comparable in the 2009 Report (figure 11.2). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework.

Figure 11.2 Performance indicators for primary and community health



Key to indicators

Text — Data for these indicators comparable, subject to caveats to each chart or table

Text — Data for these indicators not complete or not directly comparable

Text — These indicators yet to be developed or data not collected for this Report

11.3 Key performance indicator results

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

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services may 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 2007).

Access

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

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

Availability of PBS medicines

'Availability of PBS medicines' is an indicator of governments' objective to provide equitable access to PBS medicines (box 11.2). 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 where they live or socioeconomic circumstance.

Box 11.2 **Availability of PBS medicines**

'Availability of PBS medicines' is measured in three ways:

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

'People per pharmacy by region' is defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions. A decrease in people per pharmacy may indicate greater availability of PBS medicines.

'PBS expenditure per person by region' is defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions. An increase in PBS expenditure per person may indicate improved availability of PBS medicines.

'The proportion of PBS prescriptions filled at a concessional rate' is defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. An increase in the proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people.

It is also important that there are not large discrepancies in these measures by region.

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

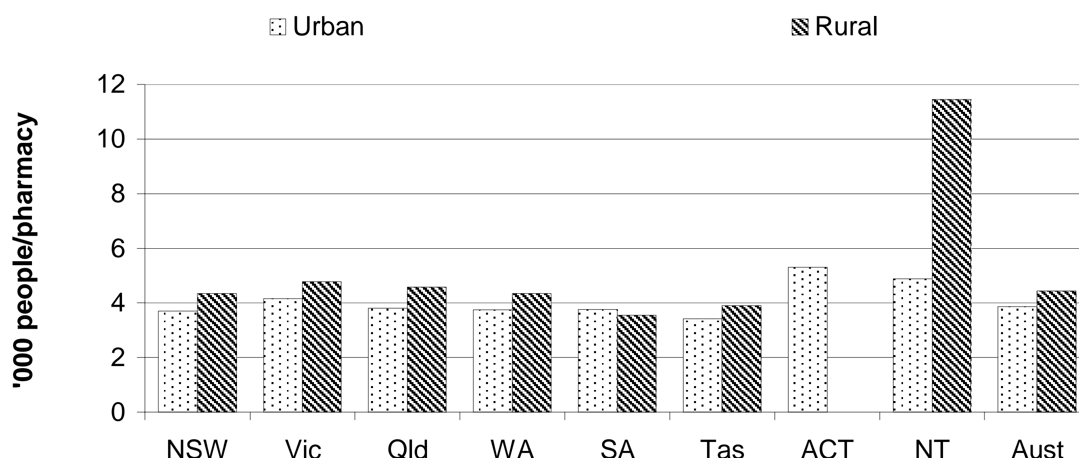
Data for this indicator are comparable.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3863 people per pharmacy in urban areas and 4436 in rural areas in 2007-08. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.3).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 71 medical practitioners and 224 hospitals — 71 private and 153 public[1] — approved to supply PBS medicines to the community in 2007-08. The medical practitioners as well as 74 of the public hospitals were located in rural areas (table 11A.9).

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

Figure 11.3 **People per pharmacy, 2007-08**[a]

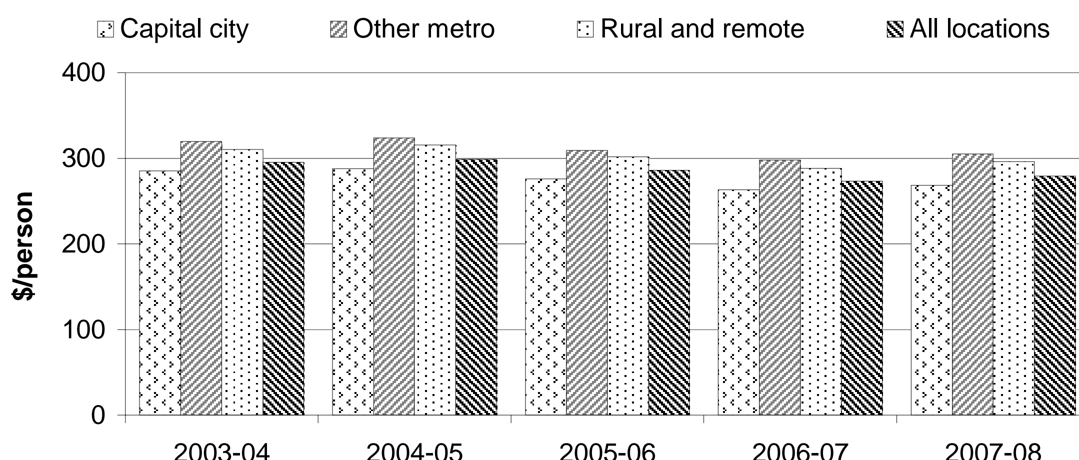


[a] Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PHARIA 1. Rural = PHARIA 2–6. The ACT has no rural statistical areas.

Source: DoHA (unpublished), derived from Medicare Australia, the ABS *2006 Census of Population and Housing* and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems; table 11A.9.

Nationally, PBS expenditure per person increased from $273 in 2006-07 to $279 in 2007-08 (figure 11.4). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2003-04 to 2007-08 (in 2007-08 dollars).

Figure 11.4 **PBS expenditure per person (2007-08 dollars)**[a]



[a] Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in 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), derived from the PBS data system; table 11A.11.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.9. These data are not available by regional location. Australia-wide, 85.7 per cent of prescriptions subsidised under the PBS were concessional in 2007-08.

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). Low availability may be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Low availability may also reduce bulk billing rates through reducing competition for patients. Australian, State and Territory governments seek to influence the availability of GPs by providing incentives for the recruitment and retention of GPs in rural and remote areas.

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.

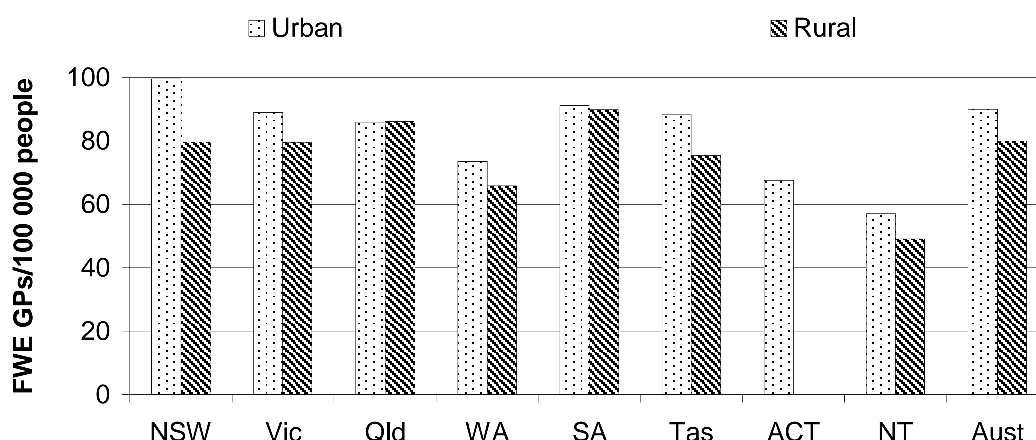
An increase in the availability of GPs may indicate improved access to GP services, particularly in rural and remote regions.

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

Data for this indicator are comparable.

In terms of FWE GPs per 100 000 people, there were more GPs available in urban than in rural areas in almost all states and territories in 2007-08 (figure 11.5). The bulk billed proportion of non-referred attendances was generally lower in rural and remote areas, excepting 'other remote' areas, than in capital cities and 'other metropolitan centres' (table 11A.20).

Figure 11.5 **Availability of GPs (full time workload equivalent), 2007-08**[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), derived from the MBS data system; table 11A.12.

Availability of female GPs

'Availability of female GPs' is an indicator of governments' objective to provide equitable access to GPs for women who prefer to discuss health matters with, and to receive primary healthcare from, a female GP (box 11.4).

Box 11.4 **Availability of female GPs**

'Availability of female GPs' is defined as the number of female FWE GPs per 100 000 females.

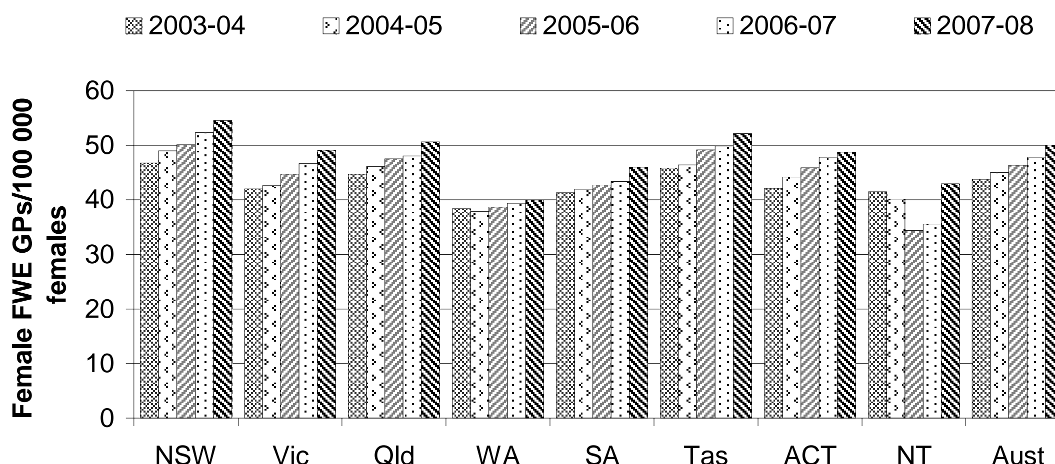
A higher rate means it is more likely that female patients who prefer to visit female GPs will have their preference met.

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

Data for this indicator are comparable.

In 2007-08, 38.7 per cent of Australia's GPs — 28.9 per cent of FWE GPs — were female (tables 11A.3 and 11A.13). The number of FWE GPs per 100 000 females increased from 43.8 to 50.0 in the period 2003-04 to 2007-08 (figure 11.6).

Figure 11.6 **Availability of female GPs (full time workload equivalent)[a]**



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

Source: DoHA (unpublished), derived from the MBS data system; table 11A.13.

Availability of public dentists

'Availability of public dentists' is an indicator of governments objective to provide equitable access to dental services. The availability (or supply) 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 (box 11.5).

Box 11.5 **Availability of public dentists**

'Availability of public dentists' is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region.

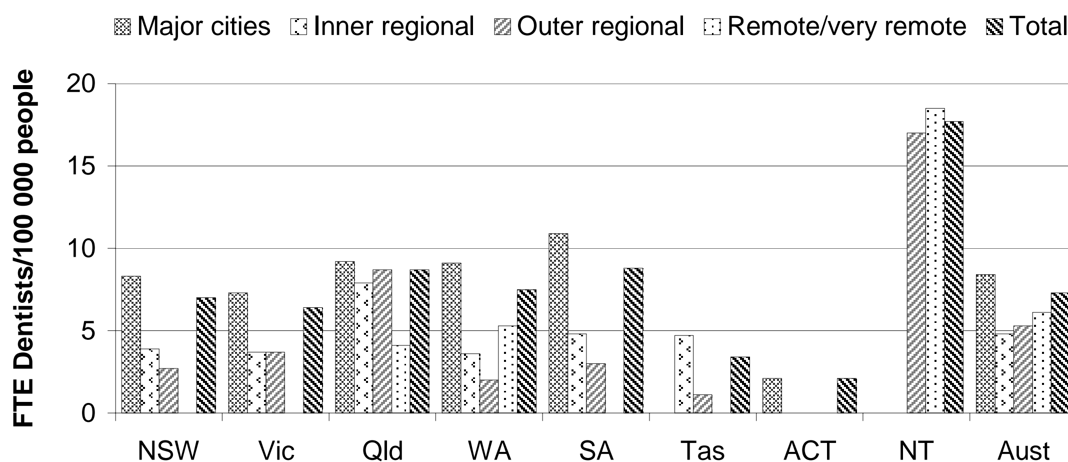
An increase in the availability of public dentists indicates improved access to dental services.

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

Data for this indicator are comparable.

Nationally, there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas in 2006 (figure 11.7; table 11A.14).

Figure 11.7 **Availability of public dentists, 2006[a, b, c]**



[a] FTE based on 40-hour week. [b] There were no public dentists in remote and very remote areas in Victoria or Tasmania. There were no public dentists in inner regional areas in the ACT. [c] Tasmania had no major cities. The ACT had no outer regional, or remote and very remote, areas. The NT had no major cities or inner regional areas.

Source: AIHW (unpublished), derived from the National dental labour force collection; table 11A.14.

Early detection and early treatment for Indigenous people

'Early detection and early treatment for Indigenous people' is an indicator of governments' objective to provide equitable access to primary and community healthcare services for Indigenous people (box 11.6).

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 2007a; SCRGSP 2007). Early detection and early treatment refers to the identification of individuals who are at high risk for, or in the early stages of, such conditions. Early detection and early treatment services provide opportunities for timely prevention and intervention measures, and their availability and uptake is understood to be a significant determinant of people's health.

Voluntary health assessments and checks are Medicare Benefit Schedule (MBS) items that allow GPs to undertake comprehensive examinations of patient health, including physical, psychological and social functioning. They are available for older Australians as well as for Indigenous people of all ages, as the prevalence of preventable and/or treatable conditions is high in both population groups.

Box 11.6 **Early detection and early treatment for Indigenous people**

‘Early detection and early treatment for Indigenous people’ is measured in four ways:

- Older people who received a voluntary health assessment by Indigenous status
- Older Indigenous people who received a voluntary health assessment, time series
- Indigenous people who received a voluntary health assessment or check by age group
- Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

‘Older people who received a voluntary health assessment by Indigenous status’ is defined as the proportion of older people who received a voluntary health assessment by Indigenous status. A reduction in the gap between the proportion of all older people and older Indigenous people that received a health assessment indicates improved access to early detection and early treatment services for Indigenous people.

‘Older Indigenous people who received a voluntary health assessment, time series’ is defined as the proportion of older Indigenous people who received a voluntary health assessment in successive years of a five year period. An increase is desirable as it indicates improved access to these services.

‘Indigenous people who received a voluntary health assessment or check by age group’ is defined as the proportion of Indigenous people who received a voluntary health assessment/check, in each of the three age groups for which they are available. A reduction in the gap between the proportion of Indigenous people in different age groups that received a health assessment/check may indicate more equitable access to early detection and treatment services within the Indigenous population.

‘Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services’ is defined as the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities in the services provided. An increase 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 health care services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.

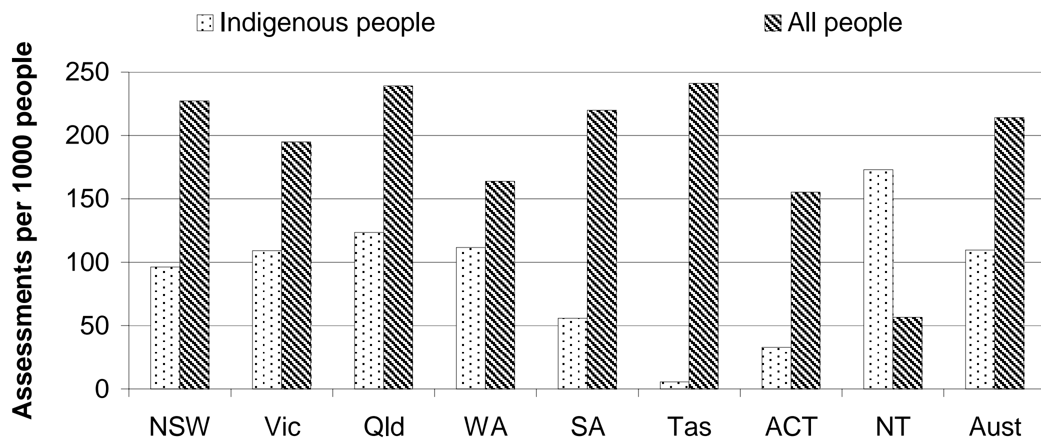
Data for this indicator are comparable.

For this indicator, 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 larger age range for Indigenous people 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').

Figure 11.8 shows that in 2007-08 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. 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, 2007-08[a, b]**

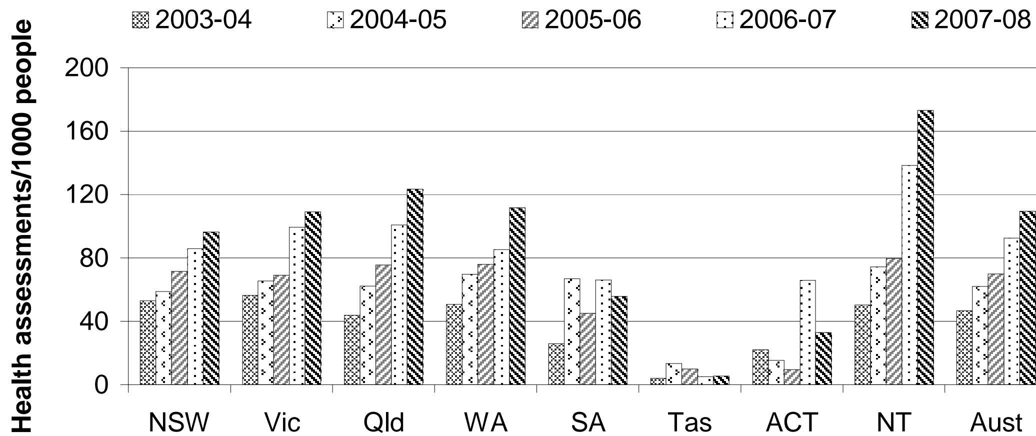


[a] Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. [b] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS 2004, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; ABS 2008, *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; table 11A.16.

Figure 11.9 shows that the proportion of older Indigenous people who received an annual health assessment steadily increased in most jurisdictions between 2003-04 and 2007-08. This indicates that access to early detection and early treatment services for this population has improved in these jurisdictions.

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



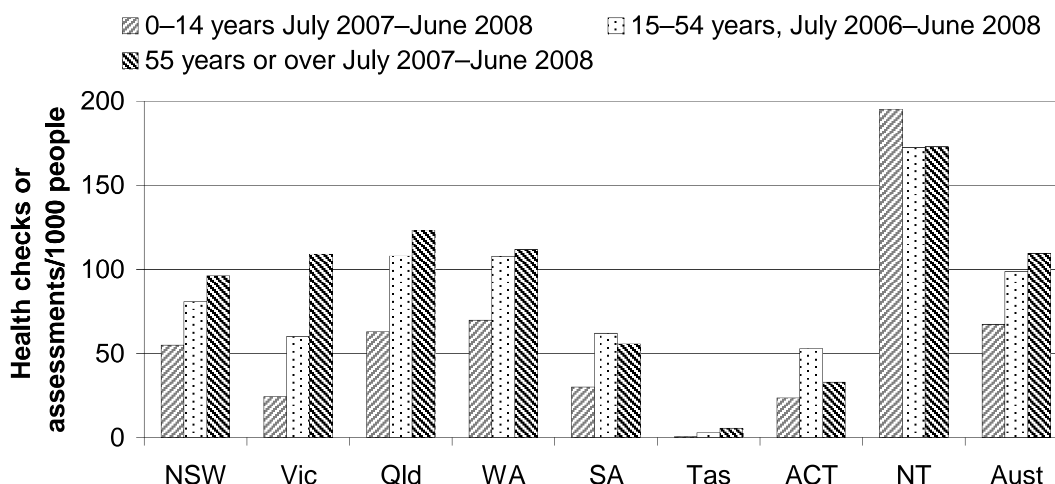
a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS 2004, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; ABS 2008, *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; table 11A.17.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004, and Indigenous children aged 0–14 years in May 2006. Health checks are available annually for children aged 0–14 years, and biennially for 15–54 year olds.

Figure 11.10 shows that the proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions. This may 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 2007a).

Figure 11.10 **Indigenous people who received a health check or assessment by age**[a, b]

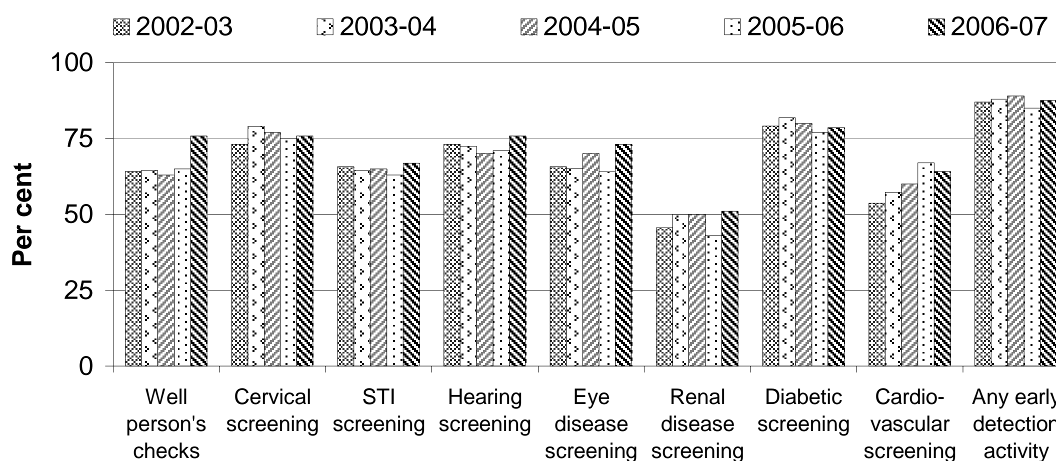


a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of 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 2007 to 30 June 2008. Health checks for 15–54 year olds are available biennially, and these data are for the period 1 July 2006 to 30 June 2008.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS 2004, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; ABS 2008, *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; table 11A.18.

Figure 11.11 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2006-07.

Figure 11.11 **Indigenous primary healthcare services for which SAR data are reported that provided early detection services**



Source: DoHA (unpublished), derived from the Service Activity Reporting data collection (SAR); table 11A.19.

Effectiveness

Access

'Bulk billing rates' is currently the only indicator reported against effectiveness and access.

Bulk billing rates

'Bulk billing rates' are an indicator of governments' objective to provide affordable access to GP services (box 11.7).

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

Box 11.7 **Bulk billing rates**

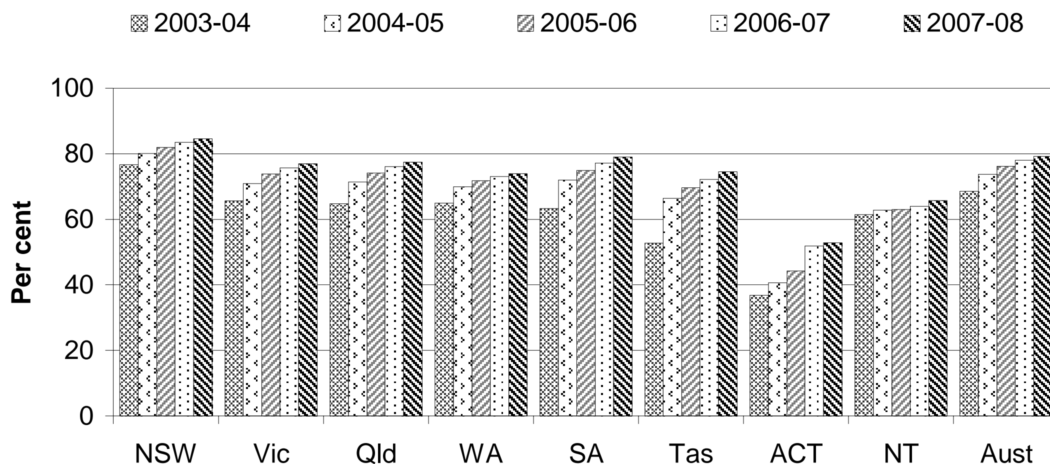
'Bulk billing rates' is defined as the number of non-referred attendances that were bulk billed as a proportion of all non-referred attendances.

A higher proportion of bulk billed attendances indicates greater affordability of GP services. However, 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.

Australia-wide, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 79.2 per cent in 2007-08. For all jurisdictions, this proportion increased in the period 2003-04 to 2007-08 (figure 11.12). The bulk billed proportion of non-referred attendances was highest in capital cities and other remote areas (table 11A.20).

Figure 11.12 **Non-referred attendances that were bulk billed**[a]



a Includes attendances by practice nurses since 2003-04.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.21.

Appropriateness

Four indicators of the appropriateness of GP services are reported:

- 'Management of upper respiratory tract infections'
- 'Management of diabetes'
- 'Management of asthma'

- ‘Pathology tests and diagnostic imaging ordered by non specialists.

Management of upper respiratory tract infections

‘Management of upper respiratory tract infections’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 11.8).

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.

Box 11.8 **Management of upper respiratory tract infections**

‘Management of upper respiratory tract infections’ is defined as the number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided to PBS concession card holders, per 1000 PBS concession card holders.

A downward trend in the prescription rate may indicate that GPs’ management of URTI more closely follows guidelines.

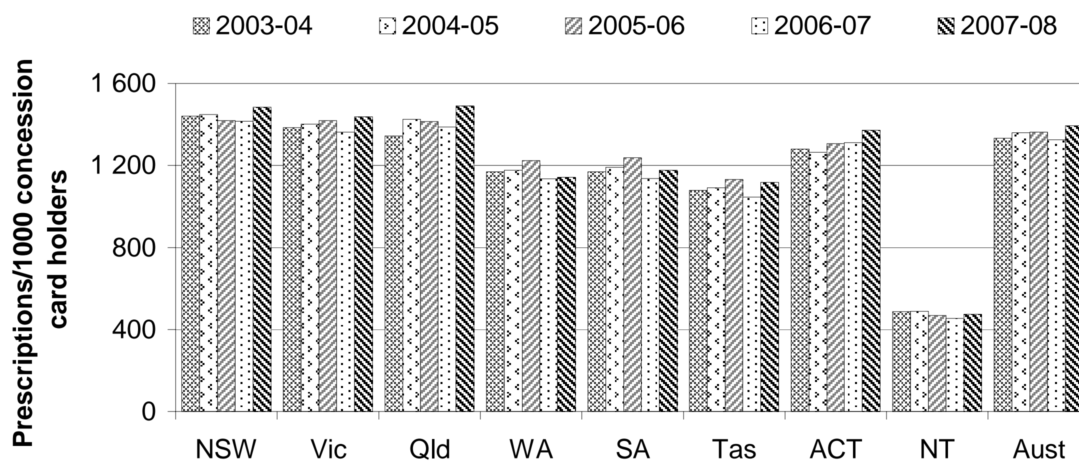
The selected antibiotics may be prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed. Data are available only for PBS concession card holders.

Data for this indicator are comparable.

Caution should be used in the interpretation of this indicator over time, as pharmaceutical needs of concession card holders may increase in complexity due to the effects of population ageing.

Australia-wide, the prescription rate for the oral antibiotics most commonly used to treat upper respiratory tract infection in 2007-08 was 1394 per 1000 PBS concession card holders. Prescription rates for these antibiotics fluctuated around the same level in most states and territories between 2003-04 and 2007-08 (figure 11.13).

Figure 11.13 **Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infection**



Source: DoHA (unpublished), derived from the PBS data system; table 11A.22.

Management of diabetes

'Management of diabetes' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.9).

Diabetes mellitus is a chronic disease of increasing prevalence. People with diabetes[2] are at high risk of serious complications such as cardiovascular, eye and kidney disease. Appropriate management in the primary and community health sector can prevent or minimise the severity of such complications (AIHW 2008b).

Patient compliance with measures to manage diabetes is also a critical determinant of the occurrence and severity of complications.

[2] Diabetes refers to diabetes mellitus. Diabetes insipidus is not considered here.

Box 11.9 **Management of diabetes**

The 'proportion of people with diabetes mellitus who have received an annual cycle of care within general practice' is defined as 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 number of people with diabetes is estimated by applying diabetes prevalence data from the ABS 2004-05 National Health Survey (NHS) to the estimated resident population. Estimates should be treated with caution due to the changing prevalence of diabetes over time.

A high proportion of people with diabetes who have received an annual cycle of care within general practice is desirable.

Various factors influence the uptake of MBS items by GPs. As appropriate management of diabetes by GPs who do not claim the rebates is not captured in this measure, these data should be considered as minimum estimates.

Data reported against this indicator are comparable.

Type 2 diabetes is the most common form of diabetes and is largely preventable. Diabetes has been identified as a National Health Priority Area for Australia.

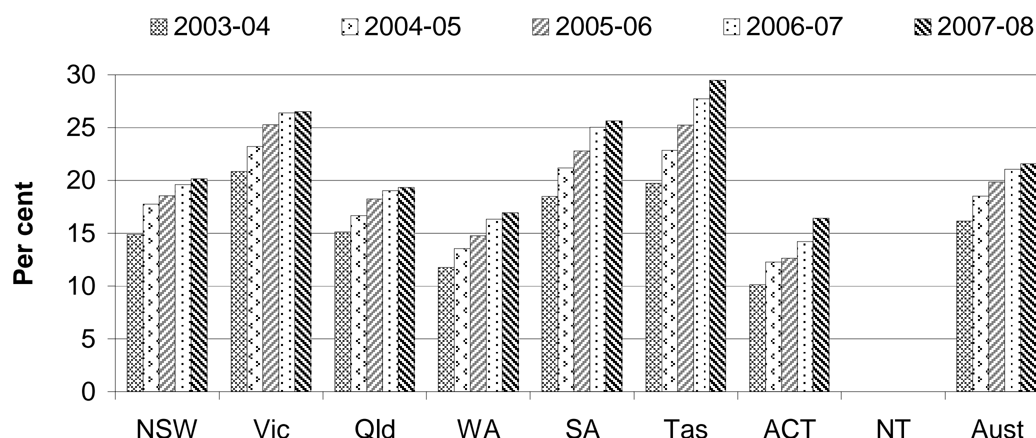
Since 2001, rebates have been available to GPs under the Medicare Benefits Scheme (MBS) on completion of a annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice.[3] The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007b).

The measure 'proportion of people with diabetes mellitus who have received an annual cycle of care within general practice' is reported for the first time against the indicator 'management of diabetes'.

The proportion of people with diabetes receiving a annual cycle of care within general practice increased for all jurisdictions for which data are available in the period 2003-04 to 2007-08 (figure 11.14). Nationwide, 21.6 per cent of people with diabetes received the annual cycle of care in 2007-08 (excluding the NT).

[3] An exception is the frequency of glycosolated heamoglobin (HbA1c) testing. Royal Australian College of General Practitioners (RACGP) clinical guidelines specify testing of HbA1c at least 6 monthly for adults and 3 monthly for children and adolescents. The MBS annual cycle of care requires only annual testing of HbA1c (with no differentiation according to age).

Figure 11.14 **People with diabetes mellitus who have received an annual cycle of care within general practice**[a, b, c, d]



[a] Data are minimum estimates as they do not account for GPs who provide the annual cycle of care but do not claim the MBS rebate. [b] The clinical guidelines are for Type 2 diabetes, while the MBS items do not specify a particular type of diabetes. Clinical guidelines represent the minimum level of care required. [c] Estimates for all years are based on 2004-05 NHS prevalence data. They should be treated with caution as the prevalence of diabetes changes over time. [d] 2004-05 NHS data are not available for the NT.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS (2006), *National Health Survey: Summary of Results; State Tables, 2004-05*, Cat. No. 4362.0; ABS (2008), *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; table 11A.23.

Management of asthma

'Management of asthma' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector. Data are reported for the first time in this Report against the measure 'proportion of people with asthma who have an asthma action plan' (box 11.10).

Asthma is a common chronic disease among Australians, particularly children, and is associated with wheezing and shortness of breath (ACAM 2008). Asthma may be intermittent or persistent, and varies in severity. Many symptoms of asthma respond readily to treatment. Asthma is an identified National Health Priority Area for Australia.

Written asthma action plans (AAP) enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms (ACAM 2008). This can prevent or reduce the severity of acute asthma episodes. AAPs have been associated with a reduction in hospitalisations and urgent GP visits

for asthma. AAPs have been included in clinical guidelines for asthma management for nearly 20 years (ACAM 2008).

Box 11.10 Management of asthma

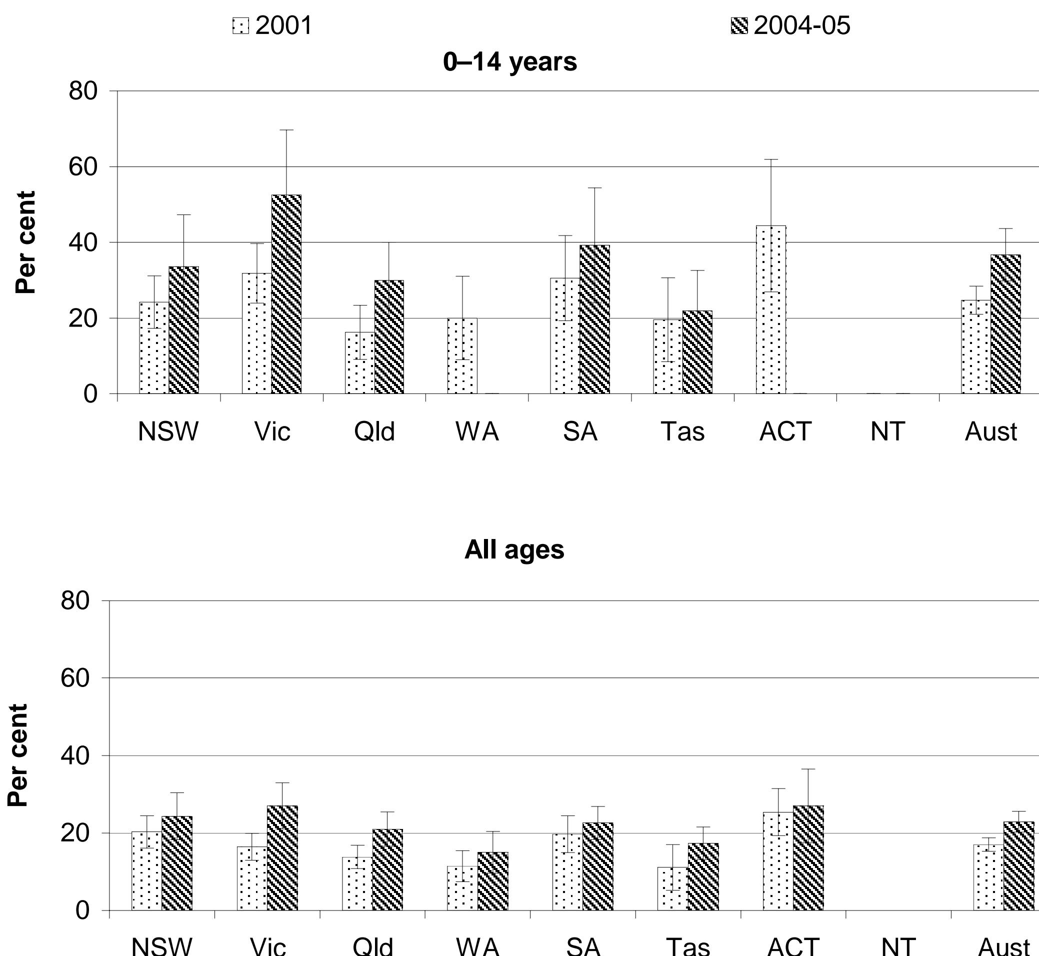
The 'proportion of people with asthma who have an asthma action plan' is defined as the number of people with asthma who have a written asthma action plan, divided by the estimated number of people with asthma.

A high proportion of people with asthma who have an asthma action plan is desirable.

Data reported against this indicator are comparable.

Australia wide, 22.9 per cent of NHS respondents with current asthma reported having a written asthma action plan (AAP) in 2004-05, compared with 17.0 per cent in 2001 (figure 11.15). Children aged 0–14 years with current asthma were most likely to report having an AAP in 2001 (24.7 per cent) and 2004-05 (36.7 per cent).

Figure 11.15 **Proportion of people with asthma who have a written asthma action plan[a, b]**



[a] Separate estimates for the NT are not available for this survey, but the NT sample contributes to the national estimates. [b] Data from the 2004-05 survey for children aged 0–14 years for WA and the ACT have relative standard errors greater than 50 per cent. They are considered too unreliable for general use and are not published, but the data contribute to the national estimates.

Source: ABS (unpublished), derived from the National Health Survey 2001, 2004-05; table 11A.24.

Pharmaceuticals ordered by non-specialists

'Pharmaceuticals ordered by non-specialists' has been identified as an indicator of governments' objective to ensure the appropriateness of primary healthcare services (box 11.11).

Box 11.11 Pharmaceuticals ordered by non-specialists

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

Data for this indicator were not available for the 2009 Report.

Pathology tests and diagnostic imaging ordered by non-specialists

'Pathology tests and diagnostic imaging ordered by non-specialists' is an indicator of governments' objective to ensure that primary healthcare services are appropriate (box 11.12).

Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Their underuse may contribute to the misdiagnosis of disease, and to relatively poor treatment decisions. Excessive use may 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.

Box 11.12 Pathology tests ordered and diagnostic imaging referrals by non-specialists (vocationally recognised GPs and OMPs)

Four measures of 'pathology tests ordered and diagnostic imaging referrals by non-specialists' are reported:

- 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.

High levels may indicate overreliance by GPs on these diagnostic tools, while low levels may indicate underuse.

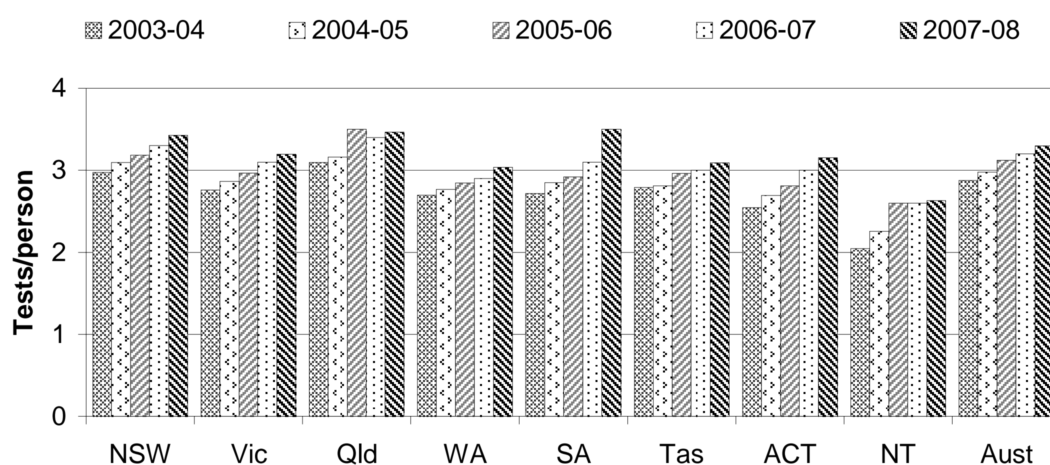
Data for this indicator are comparable.

Pathology tests and diagnostic imaging ordered by vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. While data for the total number of pathology tests ordered and diagnostic imaging referrals made by GPs are not available from Medicare, data are available for those that are rebated through Medicare. The number of pathology

tests ordered may be higher than the number rebated through Medicare (where multiple tests are ordered, rebates are provided only for the three most expensive tests). Radiologists may identify a need for more or different imaging procedures than those for which patients are referred. Information about differences between the number of pathology tests ordered and the number of rebates claimed, and differences between the number of imaging procedures ordered by GPs and the number of rebates claimed, is not available.

Nationally, the number of pathology tests ordered and rebated through Medicare per person increased from 2.9 in 2003-04 to 3.3 in 2007-08 (figure 11.16).

Figure 11.16 **Pathology tests ordered by GPs and rebated through Medicare**[a]

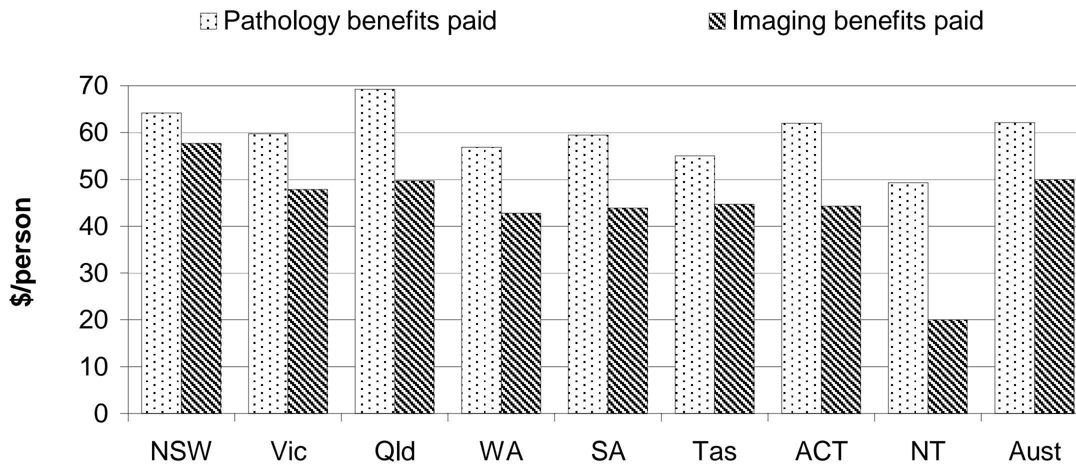


[a] Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

Source: : DoHA (unpublished), derived from the MBS data system and unpublished DVA data; table 11A.25.

Australian Government expenditure (under Medicare) on pathology tests amounted to $1.3 billion in 2007-08, equal to $62 per person. Nationally, Medicare benefits worth $1.1 billion were paid for diagnostic imaging in 2007-08, equal to $50 per person (figure 11.17).

Figure 11.17 **Benefits paid for pathology tests and diagnostic imaging, 2007-08[a]**

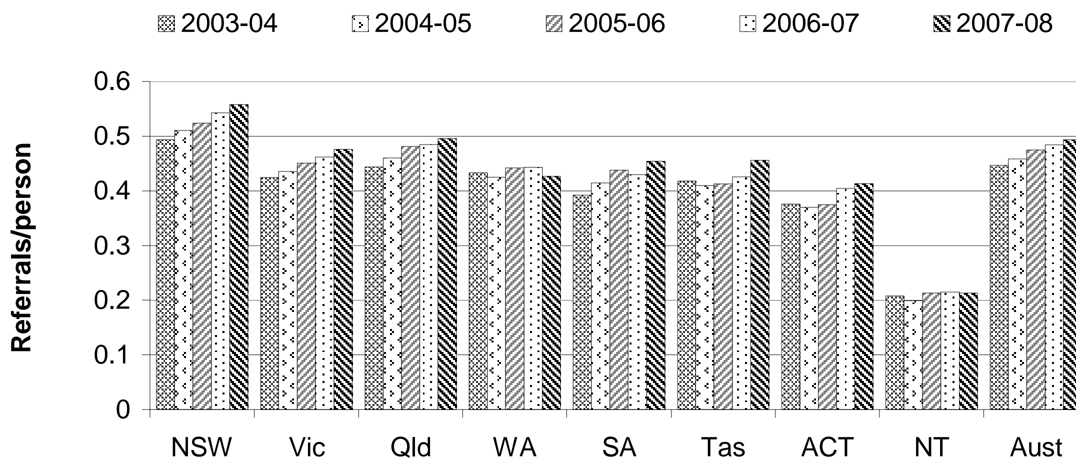


[a] Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

Source: DoHA (unpublished), derived from the MBS data system and unpublished DVA data; tables 11A.25 and 11A.26.

Nationally, there has been a gradual upward trend in the number of diagnostic imaging referrals per person between 2003-04 and 2007-08 (figure 11.18).

Figure 11.18 **Diagnostic imaging referrals from GPs[a]**



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

Source: : DoHA (unpublished), derived from the MBS data system and unpublished DVA data; table 11A.26.

Quality — safety

General practices with electronic information management systems

‘General practices with electronic information management systems’ is an indicator of governments’ objective to improve patient safety through minimising errors of prescribing and dispensing (box 11.13). Such errors may cause harm to patients through adverse drug reactions.

Electronic information management systems may also improve other aspects of quality by providing access to timely clinical data and improving the maintenance of patient health records. Use of such technology can, for example, facilitate best practice chronic disease management and preventative health activities such as screening (DHAC 2000).

Box 11.13 **General practices with electronic clinical information management systems**

‘General practices with electronic information management systems’ has two measures:

- the ‘proportion of practices enrolled in the Practice Incentives Program (PIP) that maintain secure electronic patient records’
- ‘the proportion of PIP practices that manage patient records predominantly using secure electronic management systems’.

An increase in these proportions may indicate that the likelihood of patient harm due to prescribing or dispensing errors in general practice is reduced.

The PIP does not include all practices in Australia. PIP practices covered around 81 per cent of Australian patients (measured as standardised whole patient equivalents) in 2006-07 (DoHA unpublished; table 11A.32).

Data for this indicator are comparable.

The Practice Incentives Program (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 the management of chronic disease.

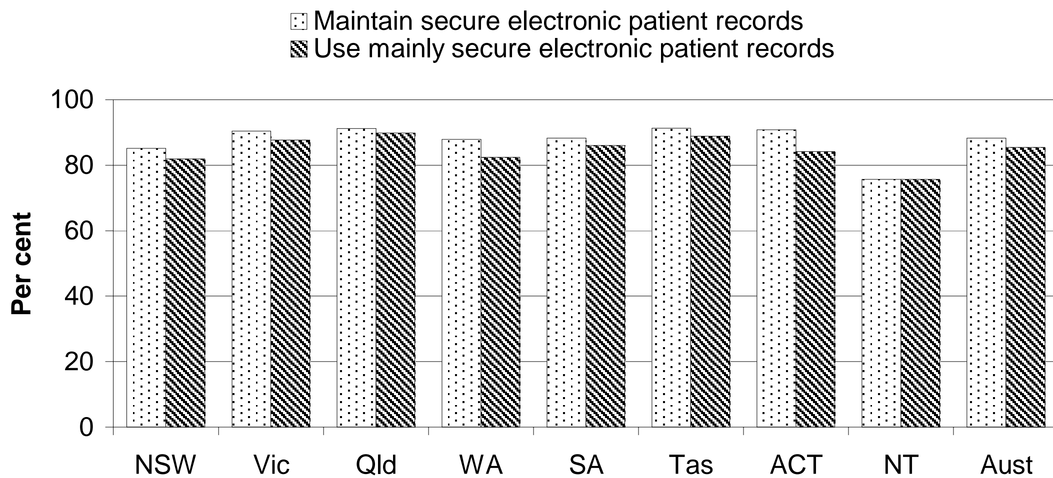
The PIP Information Management, Information Technology initiative provides two incentives to encourage the computerisation of practices:

- The first incentive requires that practices maintain electronic patient records, including clinical data on allergies/sensitivities for the majority of active patients, and implement appropriate information security measures
- The second incentive requires that practices, in addition, use electronic patient records to record and store clinical information on the majority of active patients, including current and past major diagnoses and current medications.

These replaced previous incentives for electronic prescribing and transmission of clinical data in November 2006. Data relating to previous incentives are reported in tables 11A.27 and 11A.28.

Australia-wide, 88.3 per cent of PIP practices maintained secure electronic patient records in May 2008. Patient records were managed predominantly using secure electronic management systems in 85.4 per cent of PIP practices (figure 11.19).

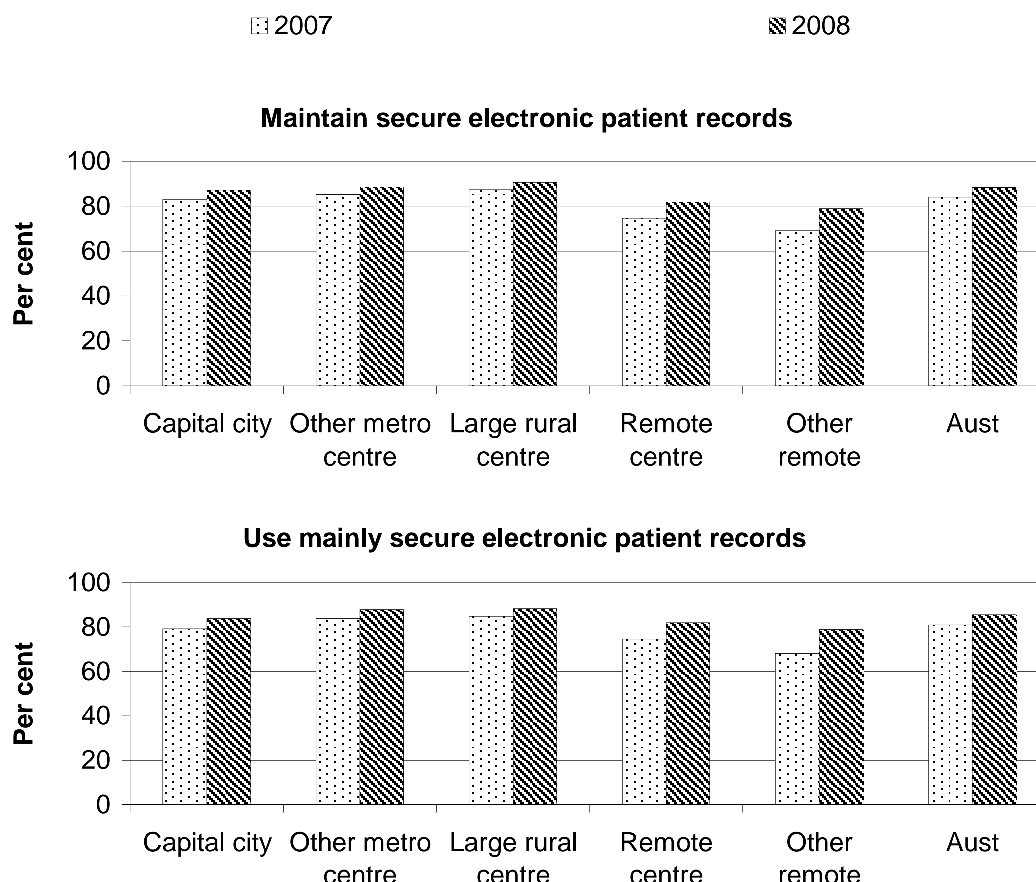
Figure 11.19 **PIP practices using computers for clinical purposes, May 2008**



Source: DoHA (unpublished), derived from the MBS and PIP data systems; table 11A.27.

There was an increase in the proportion of PIP practices that maintained secure electronic patient records, and that predominantly used secure electronic systems to manage patient records, in all areas from 2007 to 2008 (figure 11.20). For both incentives, the uptake by PIP practices in metropolitan and rural areas was higher than in remote areas and other remote areas. Remote practices in the NT have difficulty meeting accreditation requirements for PIP participation, which affects the coverage of these data.

Figure 11.20 PIP practices using computers for clinical purposes by area, May[a]



[a] Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more SLAs that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. SLA = statistical local area.

Source: DoHA (unpublished), derived from the MBS and PIP data systems; table 11A.28.

Quality — responsiveness

Patient satisfaction

'Patient satisfaction' has been identified for development as an indicator of governments' objective to ensure GP services are responsive to the needs of patients (box 11.14).

Box 11.14 **Patient satisfaction**

'Patient satisfaction' is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Quality — capability

Two indicators of the quality of GP services, relating to GPs' capability to provide services, are reported here: the proportion of GPs with vocational registration; and the proportion of general practices with accreditation.

GPs with vocational registration

'GPs with vocational registration' is an indicator of governments' objective to ensure the GP workforce has the capability to deliver high quality services (box 11.15). Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007).

Box 11.15 **GPs with vocational registration**

'GPs with vocational registration' is defined as the proportion of FWE GPs with vocational registration.

An increase in the proportion of FWE GPs with vocational registration may indicate an improvement in the capability of the GP workforce to deliver high quality services. However, GPs without vocational registration may deliver services of equally high quality.

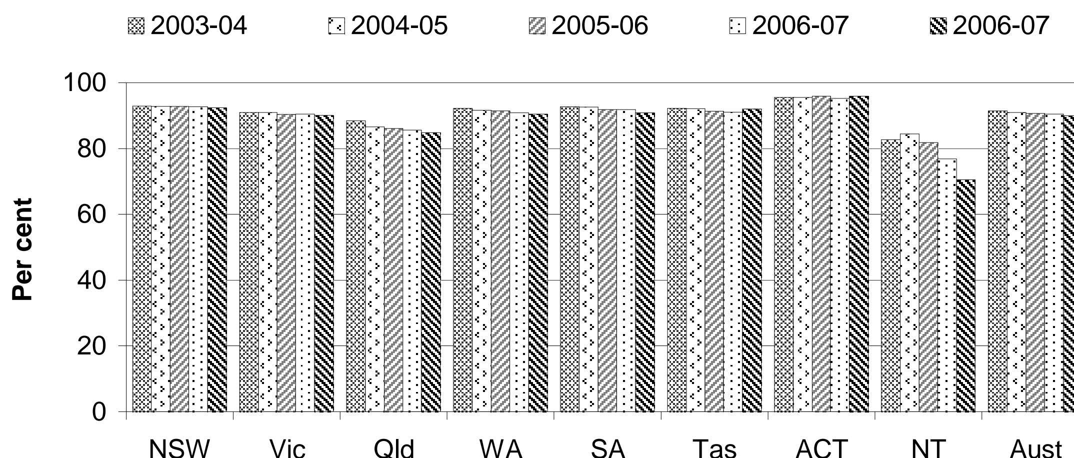
Data for this indicator are comparable.

Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the Royal Australian College of General Practitioners (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 2007-08 (figure 11.21). The proportion of FWE GPs

with vocational registration was highest in capital cities and other metro centres, and lowest in other remote areas, in 2007-08 (table 11A.29).

Figure 11.21 **GPs (full time workload equivalent) with vocational registration**



Source: DoHA (unpublished), derived from the MBS data system; table 11A.30.

General practices with accreditation

'General practices with accreditation' is an indicator of governments' objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.16). 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.

Box 11.16 **General practices with accreditation**

'General practices with accreditation' is defined as the number of general practices that are accredited as a proportion of all general practices in Australia.

An increase in the proportion of practices with accreditation may indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data for this indicator are comparable.

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

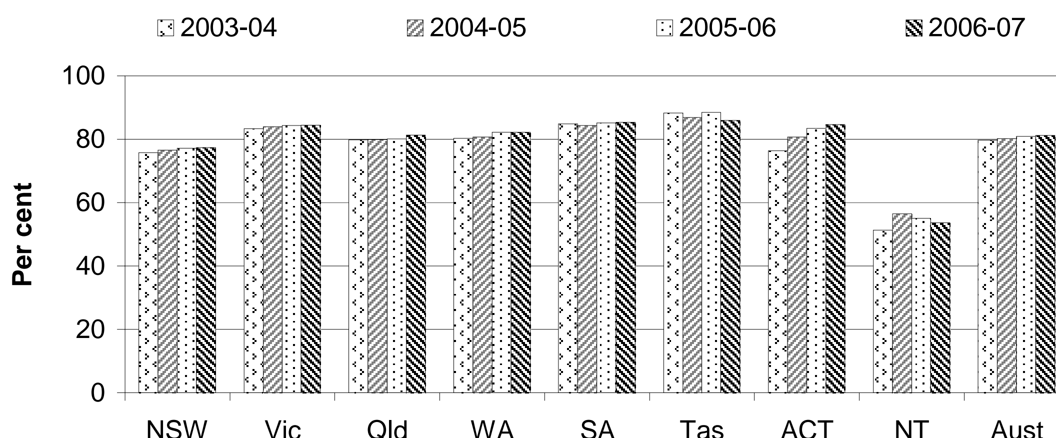
In June 2008, 4740 general practices — representing 65.3 per cent of general practices — were accredited Australia-wide (figure 11.22).

Figure 11.22 **General practices with accreditation, at 30 June**

Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service (PHC RIS), DoHA (unpublished), derived from the 2007-08 Annual Survey of Divisions of General Practice; table 11A.31.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Australia-wide, the proportion of patients — measured as standardised whole patient equivalents (SWPEs) — seen in PIP practices has varied little in the period from 2003-04 to 2006-07 (figure 11.23).

Figure 11.23 **Proportion of patients in 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), derived from the PIP and MBS data systems; table 11A.32.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the timely, coordinated provision of services that address the needs of individual patients. For example, chronic disease imposes a significant burden on the health and wellbeing of Australians. Patients may need 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 here: the use of care planning and case conferencing; and the use of health assessments for older people.

Care planning and case conferencing

'Care planning and case conferencing' is an indicator of governments' objective to improve the continuity of care provided to people with chronic or terminal medical conditions (box 11.17).

Chronic disease management items in the Medicare Benefits Schedule (MBS) allow for the preparation and regular review of care plans for individuals with chronic or terminal medical conditions, through GP managed or multidisciplinary team-based care. GPs with some experience using care planning and case conferencing may be

more likely to continue to use those options when they have the potential to improve patient care.

Box 11.17 **Care planning and case conferencing**

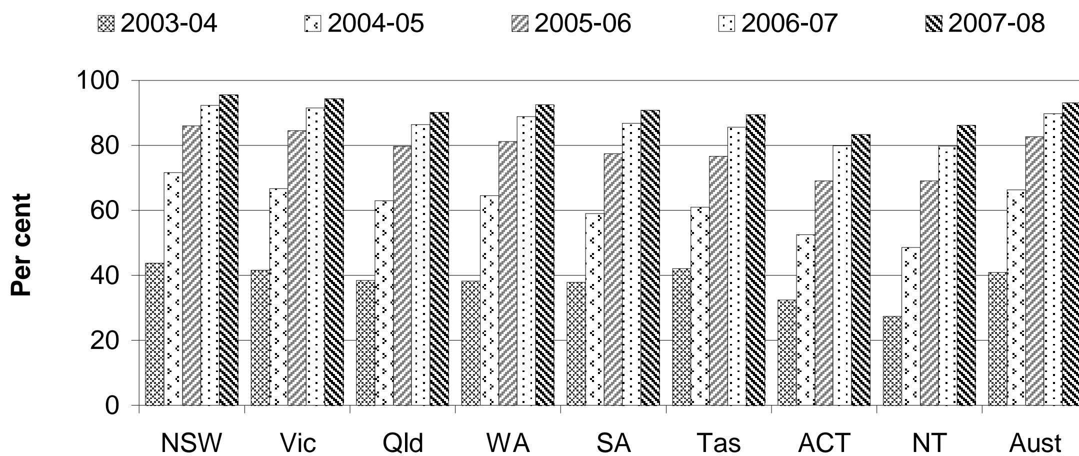
'Care planning and case conferencing' is defined as the proportion of GPs who used the Medicare Benefits Schedule (MBS) chronic disease management items for care planning or case conferencing at least once during a 12 month period.

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

Data for this indicator are comparable.

Nationally, 93.1 per cent of GPs used the chronic disease management items for care planning or case conferencing in 2007-08 (figure 11.24).

Figure 11.24 **GP use of chronic disease management Medicare items for care planning and case conferencing[a]**



a The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare initiative on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.33.

Health assessments for older people

'Health assessments for older people' is an indicator of governments' objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.18).

Annual voluntary health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.6).

Box 11.18 **Health assessments for older people**

'Health assessments for older people' is defined as the proportion of older people who received a voluntary health assessment. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities.

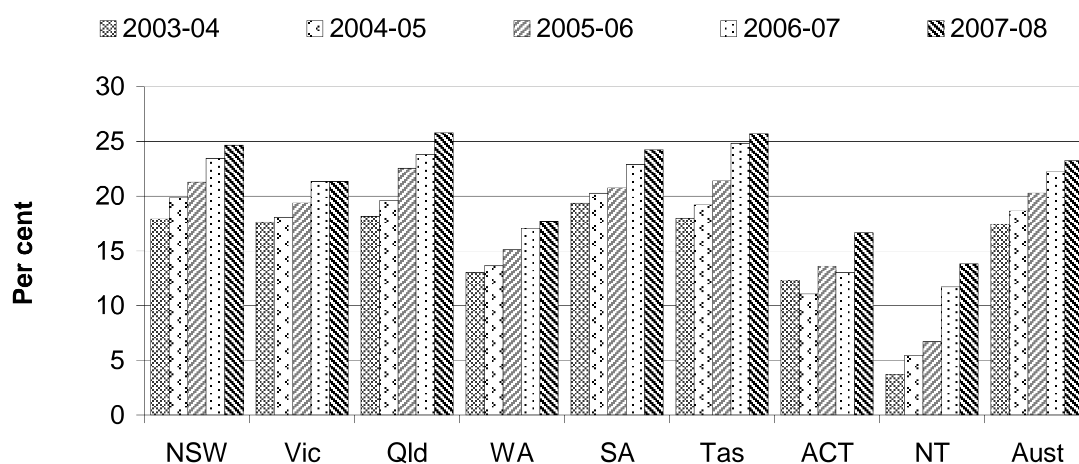
An increase in the proportion of eligible older people who received a voluntary health assessment may indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Data for this indicator are comparable.

The larger age range for Indigenous people 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 (see box 11.6).

There has been a steady increase in the proportion of older people receiving a voluntary health assessment in most jurisdictions, in the period 2003-04 to 2007-08. Nationwide, this proportion increased from 17.5 per cent in 2003-04 to 23.2 per cent in 2007-08 (figure 11.25).

Figure 11.25 **Older people who received a voluntary health assessment[a]**



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

Source: DoHA (unpublished), derived from the MBS data system; table 11A.34.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

The 'cost to government of general practice per person' is an indicator of governments' objective to provide primary healthcare services in an efficient manner (box 11.19).

Box 11.19 **Cost to government of general practice per person**

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

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

(Continued on next page)

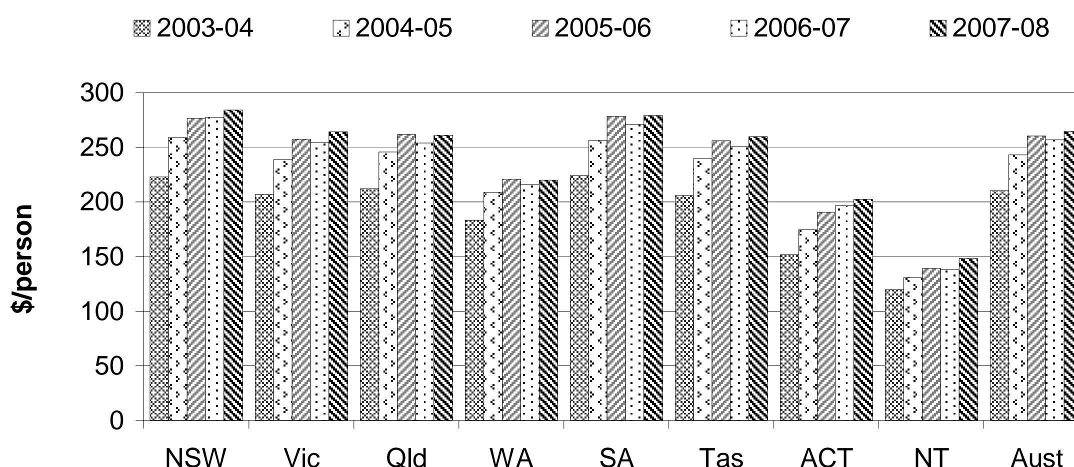
Box 11.19 **(Continued)**

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

Data for this indicator are comparable.

Nationally, the recurrent cost to the Australian Government of general practice was $264 per person in 2007-08 (figure 11.26).

Figure 11.26 **Australian Government real expenditure per person on GPs (2007-08 dollars)[a]**



a The data include Medicare, DVA, PIP, Divisions of General Practice (DGP) and General Practice Immunisation Incentives Scheme (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 (as opposed to specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations.

Source: DoHA (unpublished), derived from the MBS, PIP, GPII and DGP data systems, and unpublished DVA data; table 11A.2.

Outcomes

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

Indicators of both intermediate and final primary and community health outcomes are reported here. 'Child immunisation coverage' indicates the intermediate outcome of immunisation against disease (box 11.20). 'Notifications of selected childhood diseases' is an indicator of the final outcome — the incidence of diseases — that child immunisation can prevent (box 11.21). Also reported are outcome indicators related to cervical screening (box 11.22), influenza vaccinations for older people (box 11.23) and 'potentially preventable hospitalisations' (box 11.24).

Child immunisation coverage

'Child immunisation coverage' is an indicator of governments' objective to achieve high immunisation coverage levels for children, in order to prevent selected childhood diseases (box 11.20).

Box 11.20 **Child immunisation coverage**

'Child immunisation coverage' has two measures:

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

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

Data for this indicator are comparable.

Many providers deliver child immunisation services (table 11.6). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under seven years of age.

Data on valid vaccinations supplied to children under 7 years of age are shown in table 11.6. Around 91.2 per cent of Australian children aged 12 months to less than 15 months at 30 June 2008 were assessed as fully immunised (figure 11.27).

Table 11.6 **Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2008 (per cent)[a, b]**

Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
GP	84.0	52.9	82.6	63.8	68.8	86.6	40.9	3.4	70.9
Council	5.8	45.7	7.2	6.6	18.4	12.6	na	na	17.1
State or Territory health department	–	na	–	6.1	0.1	0.1	20.8	0.3	0.9
Flying doctor service	–	na	0.3	–	0.1	na	na	na	0.1
Public hospital	2.1	0.5	3.0	5.4	2.8	0.2	0.8	7.5	2.3
Private hospital	0.1	–	–	–	na	–	–	0.9	0.1
Indigenous health service	0.5	0.1	0.7	0.6	0.5	–	0.2	9.3	0.6
Indigenous health worker	–	na	0.5	na	0.1	na	na	0.2	0.1
Community health centre	7.4	0.8	5.7	17.6	9.3	0.6	37.3	78.3	8.0
Community nurse	na	–	na	na	na	na	–	na	–
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

a 1 January 1996 to 30 June 2008. Data relate to the State or Territory in which the immunisation provider was located. **b** A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. **c** Due to changes in provider classification in the ACT between 1996 and 2008, some vaccinations undertaken by ACT Health's Maternal and Child Health nurses are reported under 'State or Territory health departments' and some are reported under 'Community health centre'. The total proportion of vaccinations provided by ACT Health during this period was 58.1 per cent. **na** Not available. – Nil or rounded to zero.

Source: DoHA (unpublished), derived from the Australian Childhood Immunisation Register (ACIR); table 11A.35.

Figure 11.27 **Children aged 12 months to less than 15 months who were fully immunised[a, b, c]**

[a] Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. [b] The 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 may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished), derived from ACIR; table 11A.36.

Nationally, 92.8 per cent of children aged 24 months to less than 27 months at 30 June 2008 were assessed as being fully immunised (figure 11.28).

Figure 11.28 **Children aged 24 months to less than 27 months who were fully immunised[a, b, c]**

[a] Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare Australia (NCIRS 2000). [c] There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished), derived from ACIR; table 11A.37.

Notifications of selected childhood diseases

'Notifications of selected childhood diseases' is an indicator of governments' objective to improve population health outcomes through the prevention of selected childhood vaccine preventable diseases (box 11.21).

Measles, pertussis (whooping cough) and *Haemophilus influenzae* type b[4] are nationally notifiable diseases — that is, if they are diagnosed, there is a requirement to notify the relevant State or Territory authority. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs for one in 25 cases. The activities of GPs and community health services can influence the prevalence of these diseases through immunisation (and consequently the notification rates).

[4] *Haemophilus influenzae* type b is a bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008c).

Box 11.21 **Notifications of selected childhood diseases**

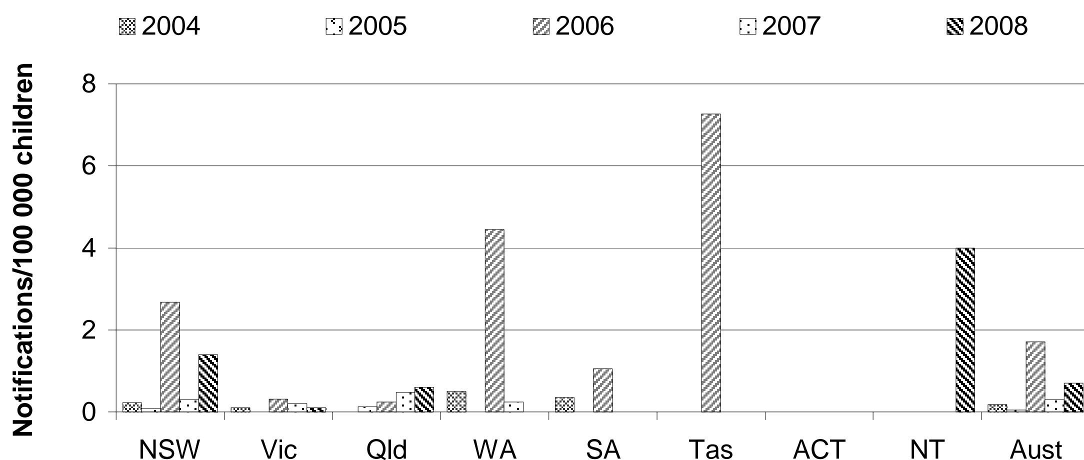
'Notifications of selected childhood diseases' is defined as the number of notifications for children aged 0–14 years per 100 000 children in that age group.

A reduction in the notification rate for the selected diseases indicates the effectiveness of the immunisation program.

Data for this indicator are comparable.

In 2008, there were 26 notifications of measles across Australia to 31 August (table 11A.38). This was the second time in the five year period 2004–2008 that notifications numbered more than 15 — there were 68 notifications in 2006. The national notification rate in 2008 was 0.7 per 100 000 children aged 0–14 years (figure 11.29).

Figure 11.29 **Notifications of measles per 100 000 children aged 0–14 years[a, b]**

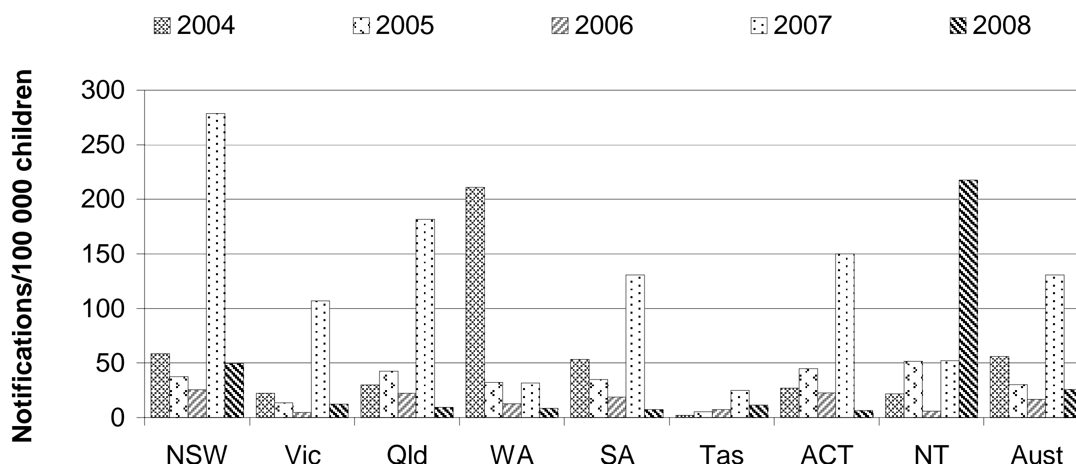


[a] Notifications for 2008 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished), derived from the National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.38.

Australia-wide, there were 1029 notifications for pertussis (whooping cough) across Australia to 31 August in 2008. The national notification rate in 2008 was 25.9 per 100 000 children aged 0–14 years (figure 11.30).

Figure 11.30 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years[a]**

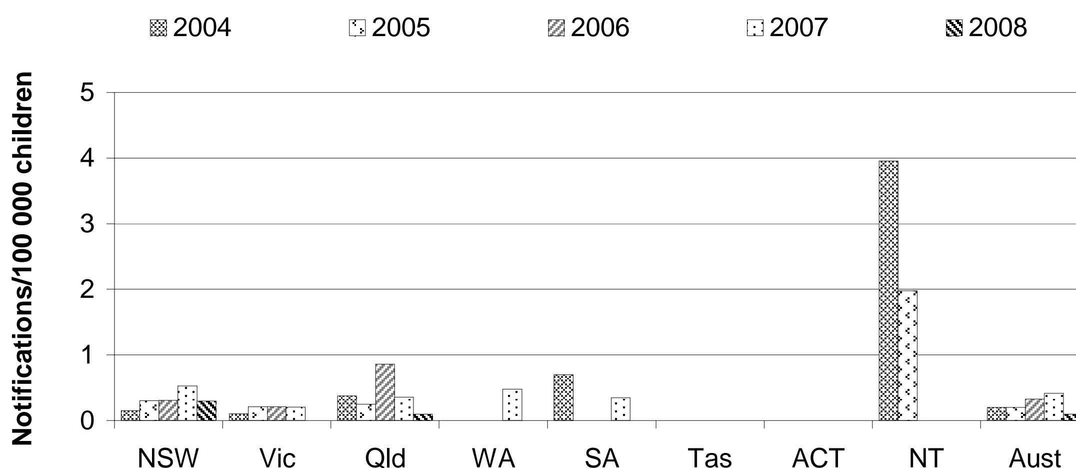


[a] Notifications for 2008 are to 31 August.

Source: DoHA (unpublished), derived from the NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.39.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2008, the notification rate Australia-wide to 31 August was 0.1 per 100 000 children aged 0–14 years (figure 11.31).

Figure 11.31 **Notifications of *Haemophilus influenzae* type b among children aged 0–14 years[a, b]**



[a] Notifications for 2008 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), derived from the NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.40.

Participation rates for women in cervical screening

'Participation rates for women in cervical screening' is an indicator of governments' objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.22).

It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) may be prevented if cell changes are detected and treated early (Mitchell, Hocking, 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.

Box 11.22 **Participation rates for women aged 20–69 years in cervical screening**

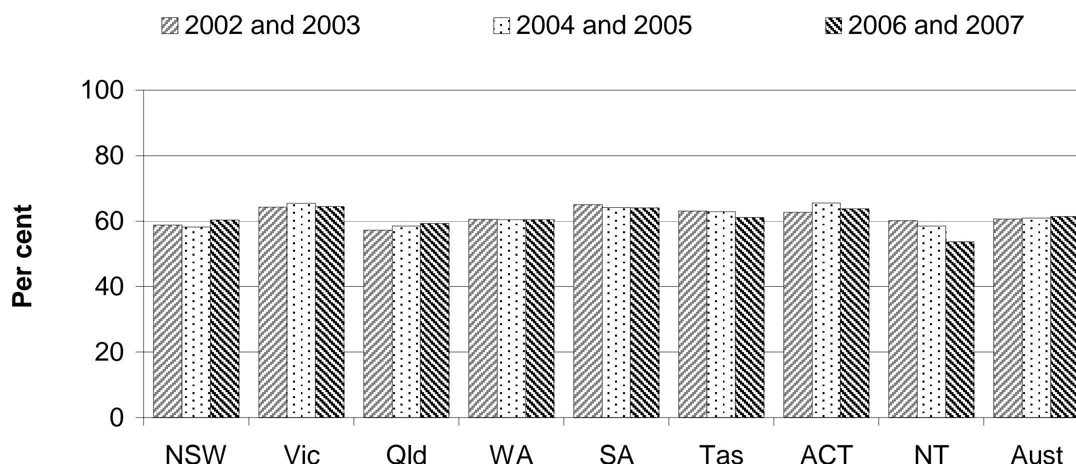
'Participation rates for women in cervical screening' is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all women aged 20–69 years.

An increase in the proportion of women aged 20–69 years who have been screened is desirable.

Data for this indicator are comparable.

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 61.5 per cent for the 24 month period 1 January 2006 to 31 December 2007 (figure 11.32). For most jurisdictions, participation rates have remained about the same since the screening period of 2002 and 2003.

Figure 11.32 **Participation rates for women aged 20–69 years in cervical screening[a, b, c, d]**



a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS estimated resident population 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** Number of women screened includes all women screened in each jurisdiction (not just those women resident in each jurisdiction), except for Victoria and the ACT.

Source: AIHW (2008), *Cervical screening in Australia 2005–2006*, Cat. no. CAN 36; AIHW (unpublished), derived from the Cervical Cytology Registry; table 11A.41.

Influenza vaccination coverage for older people

'Influenza vaccination coverage for older people' is an indicator of governments' objectives to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.23).

Each year, influenza and its consequences result in many older people being hospitalised, as well as a considerable number of deaths. Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). GPs provide the majority of influenza vaccinations for older people.

Box 11.23 **Influenza vaccination coverage for older people**

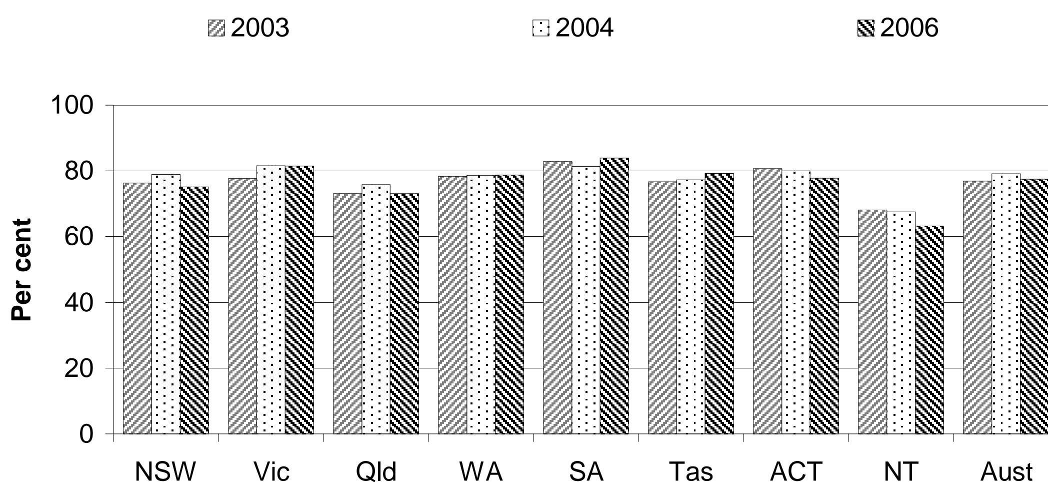
'Influenza vaccination coverage for older people' is defined as the proportion of people aged 65 years or over who have been vaccinated against influenza.

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.

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2005a). In 2006, 77.5 per cent of people in Australia aged 65 years or over were vaccinated against influenza.

Figure 11.33 **Influenza vaccination coverage, people aged 65 years or over[a]**



[a] The Adult Vaccination Survey was not conducted in 2005.

Source: AIHW 2004, 2005, *Influenza Vaccine Survey: Summary Results*, Cat. no. PHE 51, PHE 56; DoHA (unpublished), derived from the *2006 Adult Vaccination Survey*; table 11A.42.

Potentially preventable hospitalisations

Five indicators are reported for potentially preventable hospitalisations. The first three indicators — hospitalisations for vaccine preventable conditions, selected acute conditions and selected chronic conditions — were developed by the National Health Performance Committee, based on empirical research. The fourth relates to hospitalisations for diabetes and the fifth to the hospitalisation of older people for falls.

Box 11.24 **Potentially preventable hospitalisation indicators**

Potentially preventable hospitalisations refer to hospital admissions that may be avoided by appropriate management in the primary healthcare sector and/or the broader community. They include vaccine preventable, acute and chronic conditions, defined according to the Victorian Ambulatory Care Sensitive Conditions Study (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman et al. 1995; Weissman, Gatsonis and Epstein 1992) that had recently been the subject of systematic review and empirical analysis.

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards and the likelihood that a patient will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: NHPC (2004).

Data are reported against these indicators for Indigenous Australians as well as for all Australians. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005b) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous admitted patient data were of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification, the National Health Information Management Principal Committee (NHIMPC, now the National e-Health and Information Principal Committee [NEHIPC]) has approved Indigenous admitted patient data for NSW and Victoria as acceptable in quality for analytical purposes, from the 2004-05 reference year. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered to be acceptable for the purpose of analysis.

Reported data are not necessarily representative of other jurisdictions. Indigenous patients are underidentified, to an extent that varies across jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis.

Vaccine preventable hospitalisations

'Vaccine preventable hospitalisations' is an indicator of governments' objective to reduce hospitalisations for vaccine preventable conditions (box 11.25). The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations. Effective treatment of such conditions by primary health providers may also reduce hospitalisations.

Box 11.25 **Vaccine preventable hospitalisations**

'Vaccine preventable hospitalisations' is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions, per 1000 people. A reduction in hospital separation rates may indicate improvements in the effectiveness of the vaccination program.

Data are reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories. A reduction in the gap in hospital separation rates between Indigenous and all people may indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation for vaccine preventable conditions; for example, the number and virulence of influenza strains from year to year.

Data for this indicator are comparable.

Australia-wide, the age standardised hospital separation rate for all vaccine preventable conditions was 0.6 per 1000 people in 2006-07. Nationally, influenza and pneumonia accounted for 74.1 per cent of hospital separations for vaccine preventable conditions in 2006-07 (table 11.7).

Table 11.7 **Separations for vaccine preventable conditions, by state and territory of usual residence, per 1000 people, 2006-07[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust[b]*
Influenza and pneumonia	0.5	0.4	0.5	0.4	0.4	0.4	0.4	1.3	0.4
Other conditions	0.1	0.2	0.1	0.1	0.1	–	0.1	0.7	0.2
Total[c]	**0.6**	**0.6**	**0.6**	**0.5**	**0.5**	**0.5**	**0.4**	**2.0**	**0.6**

a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes other territories and excludes overseas residents and unknown state of residence. **c** Totals may not equal the sum of individual conditions due to rounding. – Nil or rounded to zero.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; table 11A.43.

The age standardised hospital separation rate of Indigenous people for all vaccine preventable conditions was 2.7 per 1000 Indigenous people in 2006-07 for NSW, Victoria, Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis only for these jurisdictions. Around 74 per cent of vaccine preventable separations for Indigenous people were accounted for by influenza and pneumonia in 2006-07 (table 11.8).

Table 11.8 **Separations of Indigenous people for vaccine preventable conditions, per 1000 Indigenous people, 2006-07[a, b]**

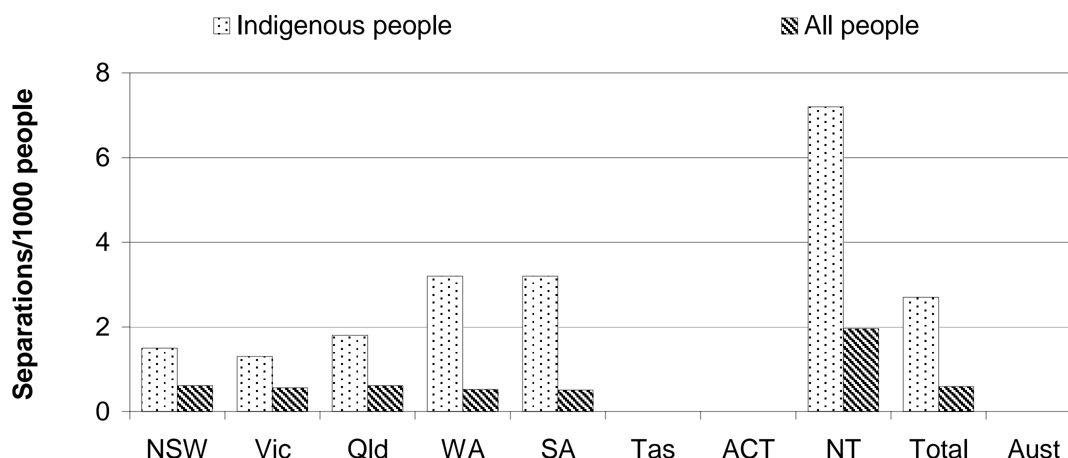
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[c]	*Total*[d]	*Aust*
Influenza and pneumonia	1.1	0.9	1.3	2.9	2.1	np	np	4.8	2.0	np
Other conditions	0.4	0.4	0.4	0.3	1.0	np	np	2.4	0.7	np
Total[e]	**1.5**	**1.3**	**1.8**	**3.2**	**3.2**	**np**	**np**	**7.2**	**2.7**	**np**

[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. Published data are not necessarily representative of Tasmania and the ACT. [c] NT data are for public hospitals only. [d] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis. [e] Totals may not equal the sum of individual conditions due to rounding. **np** not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.43.

The age standardised hospital separation rate of Indigenous people for vaccine preventable conditions was higher than that for all people in 2006-07 in all jurisdictions for which data were published (figure 11.34).

Figure 11.34 **Separations for vaccine preventable conditions, 2006-07[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. Published data are not necessarily representative of Tasmania and the ACT. **c** Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. **d** NT data for Indigenous people are for public hospitals only. **e** Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.43.

Age standardised hospital separation rate ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2006-07 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Victoria, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.46 and 11A.47).

Hospitalisations for selected acute conditions

'Hospitalisations for selected acute conditions' is an indicator of governments' objective to reduce hospitalisations due to acute conditions through the delivery of effective primary healthcare services (box 11.26).

Box 11.26 **Hospitalisations for selected acute conditions**

'Hospitalisations for selected acute conditions' is defined as the number of hospital separations for the following selected acute conditions per 1000 people: 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.

A reduction in hospitalisation separation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

The indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories. A reduction in the gap in hospital separation rates between Indigenous and all people may indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence hospitalisation rates.

Data for this indicator are comparable.

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis had the highest rates of hospitalisation nationally in 2006-07 (table 11.9).

Table 11.9 **Separations for potentially preventable acute conditions, by state and territory of usual residence, per 1000 people, 2006-07[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust[b]*
Appendicitis	0.2	0.2	0.1	0.2	0.2	0.1	0.2	0.2	0.2
Cellulitis	1.6	1.6	1.7	1.4	1.6	1.4	1.4	4.5	1.6
Convulsions and epilepsy	1.7	1.5	1.6	1.4	1.6	1.6	1.3	3.3	1.6
Dehydration and gastroenteritis	2.2	3.1	2.4	2.2	2.7	2.1	1.8	2.1	2.5
Dental conditions	2.3	2.8	2.7	3.5	3.1	1.8	1.6	2.0	2.7
Ear, nose and throat infections	1.6	1.4	1.6	1.5	2.4	1.3	1.2	2.3	1.6
Gangrene	0.1	0.3	0.2	0.2	0.2	0.2	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.3	0.3	0.2	0.2	0.2	0.3	0.5	0.3
Perforated/bleeding ulcer	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2
Pyelonephritis[c]	2.1	2.4	2.2	2.1	2.0	1.6	2.2	3.6	2.2
Total[d]	**12.3**	**13.7**	**13.0**	**13.1**	**14.3**	**10.4**	**10.4**	**19.5**	**13.0**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes other territories and excludes overseas residents and unknown state of residence. [c] Kidney inflammation caused by bacterial infection. [d] Totals may not equal the sum of individual components as more than one acute condition may be reported for a separation.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; table 11A.44.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was 31.1 per 1000 Indigenous people in 2006-07 for NSW, Victoria, Queensland, WA, SA and the NT combined. Over half of potentially preventable acute separations for Indigenous people were accounted for by convulsions and epilepsy, pyelonephritis, and cellulitis in 2006-07 (table 11.10).

Table 11.10 **Separations of Indigenous people for potentially preventable acute conditions, per 1000 Indigenous people, 2006-07[a, b]**

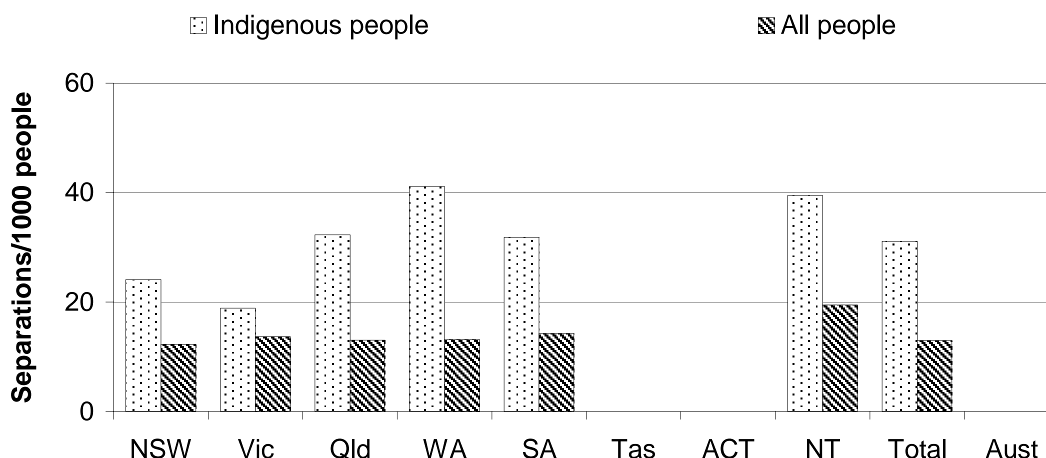
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[c]	*Total*[d]	*Aust*
Appendicitis	0.2	0.2	0.3	0.4	0.2	np	np	0.4	0.3	np
Cellulitis	3.5	2.1	5.4	6.0	4.4	np	np	7.1	4.8	np
Convulsions and epilepsy	6.1	4.7	6.5	10.4	8.0	np	np	10.4	7.4	np
Dehydration and gastroenteritis	3.1	2.6	4.4	3.6	3.9	np	np	3.3	3.6	np
Dental conditions	2.4	2.9	3.2	3.8	4.4	np	np	3.4	3.1	np
Ear, nose and throat infections	2.9	1.7	2.9	4.0	3.8	np	np	3.5	3.1	np
Gangrene	0.3	0.3	1.1	2.7	0.8	np	np	1.8	1.1	np
Pelvic inflammatory disease	0.4	0.2	0.5	0.9	0.8	np	np	1.3	0.6	np
Perforated/bleeding ulcer	0.6	0.1	0.4	0.5	0.5	np	np	0.4	0.5	np
Pyelonephritis[e]	4.6	4.0	7.7	8.9	5.2	np	np	7.9	6.5	np
Total[f]	**24.1**	**18.9**	**32.3**	**41.1**	**31.8**	**np**	**np**	**39.5**	**31.1**	**np**

[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. Published data are not necessarily representative of Tasmania and the ACT. [c] NT data are for public hospitals only. [d] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis. [e] Kidney inflammation caused by bacterial infection. [f] Totals may not equal the sum of individual conditions due to rounding. **np** not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.44.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was higher than that for all people in 2006-07 in all jurisdictions for which data were published (figure 11.35).

Figure 11.35 **Separations for potentially preventable acute conditions, 2006-07**[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. Published data are not necessarily representative of Tasmania and the ACT. [c] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.44.

Hospitalisations for selected chronic conditions

'Hospitalisations for selected chronic conditions' is an indicator of governments' objective to reduce hospitalisations due to selected chronic conditions through delivery of effective primary and community healthcare services (box 11.27).

Box 11.27 **Hospitalisations for selected chronic conditions**

'Hospitalisations for selected chronic conditions' is defined as the number of hospital separations for the following selected chronic conditions per 1000 people: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease. A reduction in hospitalisation separation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

(Continued on next page)

Box 11.27 **(Continued)**

This indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories. A reduction in the gap in hospital separation rates between Indigenous and all people may indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Data for this indicator are comparable.

Of the selected chronic conditions chronic obstructive pulmonary disease, congestive cardiac failure, asthma and angina had the highest rates of hospitalisation nationally in 2006-07 (except for diabetes complications). The hospitalisation rate for diabetes complications was more than three times higher than the rate for any of these conditions (table 11.11).

Table 11.11 **Separations for potentially preventable chronic conditions, by state and territory of usual residence, per 1000 people, 2006-07[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust[b]*
Angina	1.6	1.8	2.5	1.6	1.5	1.7	1.1	2.4	1.8
Asthma	2.0	1.9	1.4	1.4	2.6	1.4	1.2	1.5	1.8
Chronic obstructive pulmonary disease	2.5	2.5	2.7	2.2	2.8	2.4	1.7	5.5	2.6
Congestive cardiac failure	1.9	2.1	1.9	1.9	1.9	1.6	1.9	2.5	1.9
Diabetes complications	7.4	9.0	10.2	26.4	8.4	13.4	5.3	15.3	10.4
Hypertension	0.3	0.3	0.4	0.2	0.3	0.3	0.2	0.2	0.3
Iron deficiency anaemia	1.0	1.7	1.0	1.4	1.3	1.2	0.7	1.1	1.2
Nutritional deficiencies	–	–	0.0	0.0	–	0.0	–	0.1	0.0
Rheumatic heart disease[c]	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.8	0.1
Total[d]	**15.7**	**18.1**	**19.0**	**34.3**	**17.7**	**21.2**	**11.4**	**27.3**	**19.1**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes other territories and excludes overseas residents and unknown state of residence. [c] Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. [d] Totals may not equal the sum of individual components as more than one chronic condition may be reported for a separation. – Nil or rounded to zero.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; table 11A.45.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was 57.4 per 1000 Indigenous people in 2006-07 for NSW, Victoria, Queensland, WA, SA, and the NT combined. The quality of Indigenous identification is considered acceptable for the purpose of

analysis only for these jurisdictions. Excluding diabetes complications (discussed below), chronic obstructive pulmonary disease, congestive cardiac failure and angina had the highest potentially preventable chronic hospitalisation rates for Indigenous people in 2006-07 (table 11.12).

Table 11.12 **Separations of Indigenous people for potentially preventable chronic conditions, per 1000 Indigenous people, 2006-07[a, b]**

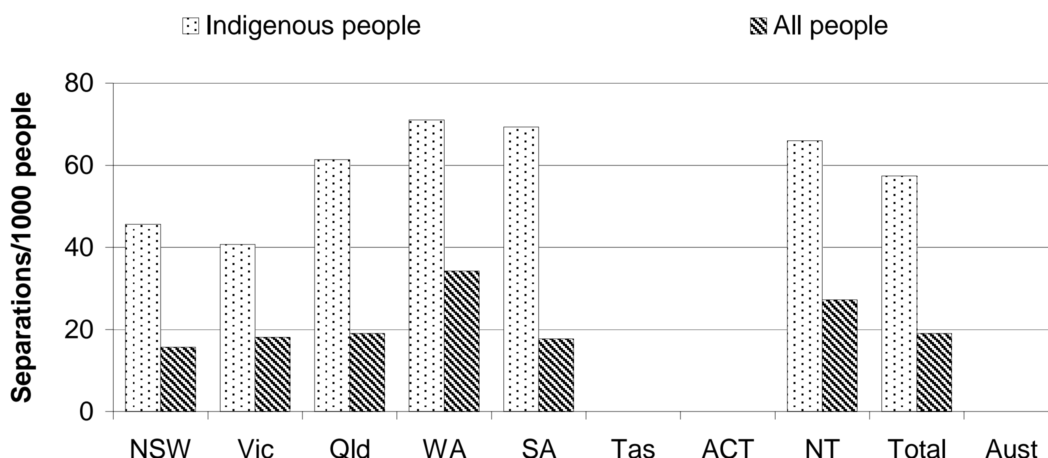
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT[c]*	*Total[d]*	*Aust*
Angina	5.2	6.4	7.9	5.8	4.0	np	np	4.5	5.9	np
Asthma	4.1	2.4	3.3	4.9	4.4	np	np	4.0	3.9	np
Chronic obstructive pulmonary disease	12.3	9.6	11.7	12.4	14.0	np	np	15.8	12.4	np
Congestive cardiac failure	5.0	2.6	7.7	8.7	7.1	np	np	7.1	6.5	np
Diabetes[e]	21.6	20.5	35.1	44.0	41.0	np	np	36.4	31.7	np
Hypertension	0.6	0.2	1.4	0.7	1.4	np	np	0.7	0.9	np
Iron deficiency anaemia	1.6	2.3	1.7	2.2	1.8	np	np	2.4	1.9	np
Nutritional deficiencies	–	0.1	–	–	–	np	np	0.1	–	–
Rheumatic heart disease[f]	0.2	0.4	0.8	0.9	2.0	np	np	1.7	0.8	np
Total[g]	**45.6**	**40.7**	**61.4**	**71.0**	**69.3**	**np**	**np**	**66.0**	**57.4**	**np**
Total excluding diabetes complications	28.8	24.1	34.6	35.7	34.6	np	np	36.4	32.3	np

[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. Published data are not necessarily representative of Tasmania and the ACT. [c] NT data are for public hospitals only. [d] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis. [e] Excludes separations with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes. [f] Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. [g] Totals may not equal the sum of individual conditions due to rounding. – Nil or rounded to zero. **np** not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.45.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was higher than that for all people in 2006-07 in all jurisdictions for which data were published (figure 11.36).

Figure 11.36 **Separations for potentially preventable chronic conditions, 2006-07[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. Published data are not necessarily representative of Tasmania and the ACT. [c] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.45.

Hospitalisations for diabetes

'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 11.28).

Box 11.28 **Hospitalisations for diabetes**

'Hospitalisations for diabetes' has two measures:

- Hospital separation rates for patients with diabetes mellitus as the principal diagnosis
- Hospital separation rates for patients with a lower limb amputation as well as a principal or additional diagnosis of diabetes.

(Continued on next page)

Box 11.28 **(Continued)**

Hospital separation rates are defined as hospital separations per 100 000 people. Rates are adjusted to account for differences in the age structures of State and Territory populations.

A reduction in these rates may indicate an improvement in GPs' and community health providers' management of patients' diabetes.

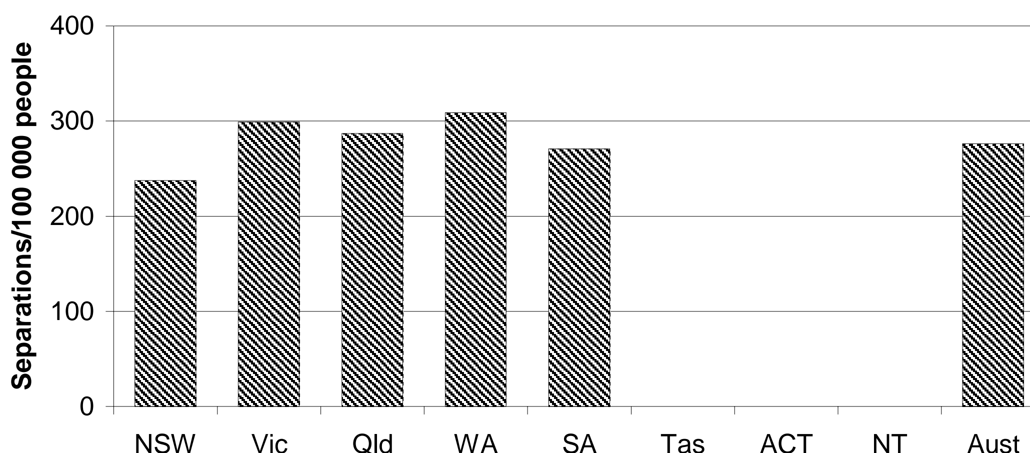
A comparison is made between Indigenous and all other people in the ratio of age standardised hospital separation rates of Indigenous people to all people. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Data for this indicator are comparable.

Australia-wide, the age standardised hospital separation rate in 2006-07 where the principal diagnosis was Type 2 diabetes mellitus was 276.3 separations per 100 000 people (figure 11.37).

Figure 11.37 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2006-07[a, b, c, d]**

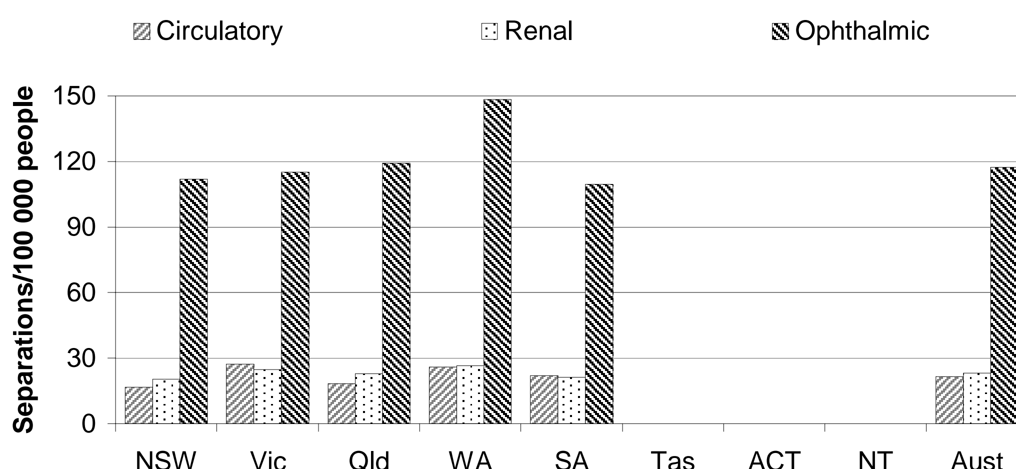


a Results for individual complications may be affected by small numbers, and need to be interpreted with care. **b** Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. **c** Morbidity data are coded under coding standards that may differ over time and across jurisdictions. **d** 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), derived from the National Hospital Morbidity Database; table 11A.48.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2006-07 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.38). Each patient may have one or more complication (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.38 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2006-07**[a, b, c, d]



[a] Results for individual complications may 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 may 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.

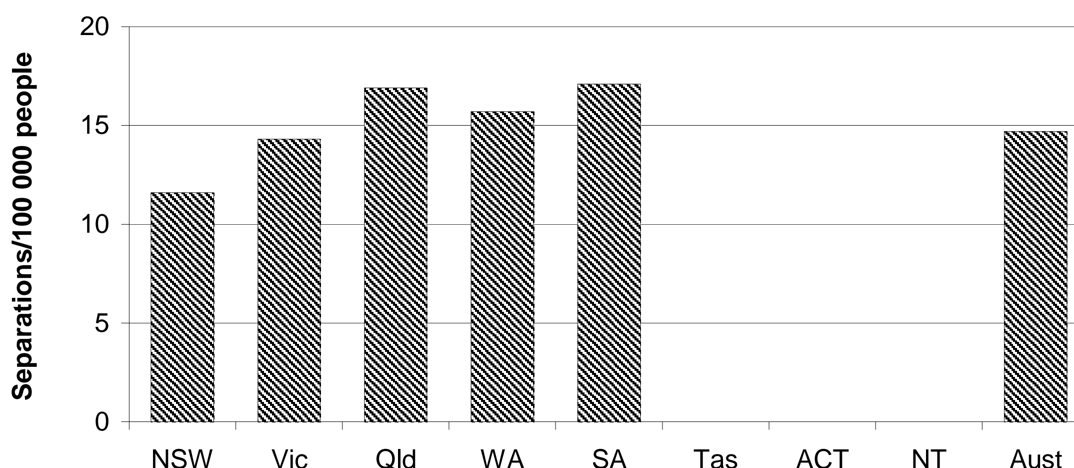
Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.48.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the substantial variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 48.4 per cent of separations for Type 2 diabetes were same day in 2006-07 (table 11A.49).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2006-07, there were 14.7 hospital separations per 100 000 people

(age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.39).

Figure 11.39 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2006-07[a, b, c]**



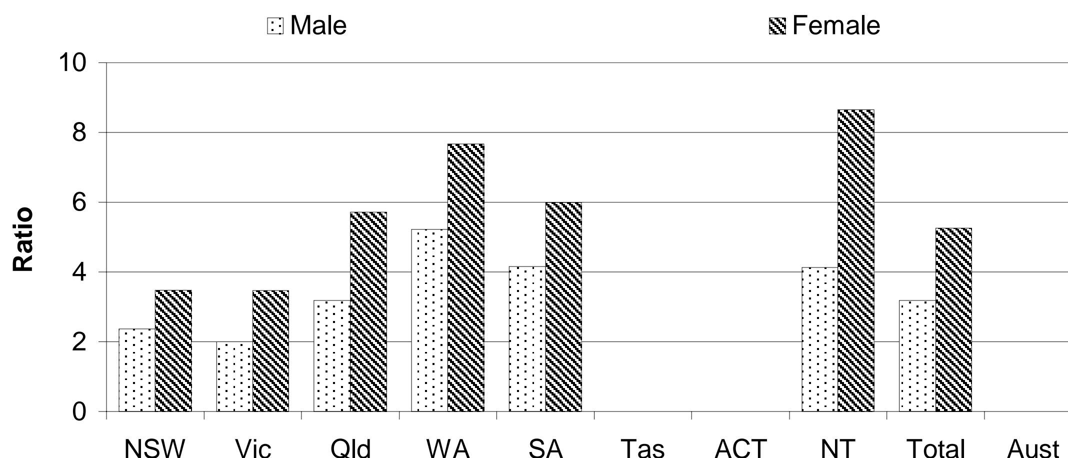
a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure 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), derived from the National Hospital Morbidity Database; table 11A.50.

Age standardised hospital separation ratios for all diabetes diagnoses[5] illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2006-07 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 the purpose of analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 3.2 times higher than those for all Australian males. The separation rate for Indigenous females was 5.3 times the rate for all females (figure 11.40).

5 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

Figure 11.40 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2006-07[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. Published data are not necessarily representative of Tasmania and the ACT. [f] NT data are for public hospitals only. [g] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; tables 11A.46 and 11A.47.

Hospitalisations of older people for falls

'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 11.29). Effective primary and community healthcare may reduce the likelihood of falls and/or assist in reducing the severity of injury.

Box 11.29 **Hospitalisation of older people for falls**

'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.

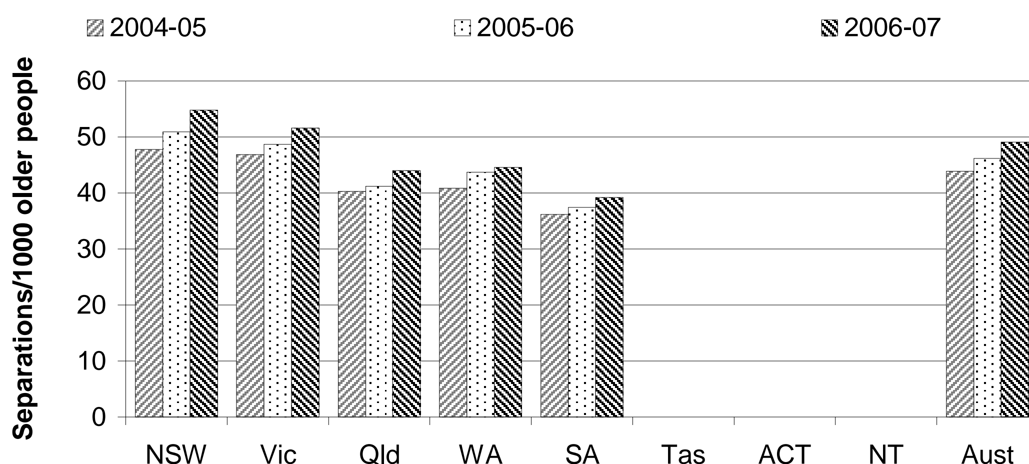
A reduction in the rate of hospitalisation due to falls may indicate improvements in the effectiveness of primary and community healthcare services provided to older people who are at risk of falls.

Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Data for this indicator are comparable.

In all jurisdictions for which data are published, separation rates for older people with injuries due to falls have gradually increased in the period 2004-05 to 2006-07 (figure 11.41). Nationally, the separation rate per 1000 older people increased from 43.9 in 2004-05 to 49.1 in 2006-07.

Figure 11.41 **Separations for older people with a reported external cause of falls**[a, b, c]



[a] Older people are defined as people aged 65 years or over. [b] 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. [c] Separation rates are crude rates using the estimated population aged 65 years or over at December 31 as the denominator.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.51.

11.4 Future directions in performance reporting

While the topic of this chapter is all primary and community health services, the indicators remain heavily focused on general practice services. This partly reflects the lack of data available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The Steering Committee has identified possible areas for which indicators may be available for inclusion in the 2010 Report or future reports. These include:

- dental health services
- community-based drug and alcohol treatment services
- additional indicators relating to the use of the MBS chronic disease management items.

In addition, the currently reported indicator ‘management of upper respiratory tract infection’ has been identified for reporting improvements.

The scope of this chapter may also be further refined to ensure the most appropriate reporting of primary health services against the Review’s terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the ‘Health preface’). The Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. The Steering Committee 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.

The completeness of Indigenous identification in hospital admitted patient statistics remains variable across states and territories. There has been some improvement, for example, data for NSW and Victoria are now considered to be of acceptable quality for the purpose of analyses, whereas on previous assessment this was not the case. The quality of data for Tasmania and the ACT is considered to be too poor for publication. Continued efforts to improve Indigenous identification are necessary in order to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. The AIHW is currently undertaking a project to develop best practice guidelines for identification.

Reform of Specific Purpose Payments

In December 2007, the Council of Australian Governments (COAG) agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The Australian Health Care Agreement was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of Health and Ageing, there is a National Health Care Agreement associated with the National Health Care SPP (COAG November 2008). Under the reforms, the National Health Care Agreement contains the objectives, outcomes, outputs and performance indicators for Health and Ageing services. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Health Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the National Health Care Agreement, National Health Care SPP and relevant NPs.

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 (AAP) 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 women aged 20–69 years who are screened for cervical cancer over a two year period.
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 the 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 111 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The Divisions of General Practice Program evolved from the former Divisions and Projects Grants Program established in 1992. The Divisions of General Practice Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of health care at the local level.

Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the Health Insurance Act 1973 (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (From 1996, vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners — medical practitioners who are not vocationally recognised GPs.
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes: assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; management of problems associated with adherence to treatment; and liaison with, or referral to, other agencies.
Immunisation coverage	A generic term indicating the proportion of a target population that is fully immunised with a particular vaccine or the specified vaccines from the National Immunisation Program for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (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 notified to 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 during a given period (period prevalence).

Proportion of GPs who are female
Number of all FWE GPs who are female, divided by the total number of FWE GPs.

Proportion of GPs with vocational 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 that have registered for accreditation through either of the two accreditation bodies, AGPAL and GPA ACCREDITATION plus, divided by the total number of practices in the Divisions of General Practice.

Proportion of general practices with electronic information management systems
Number of practices that maintain and/or use predominantly secure electronic patient records, that are registered under the PIP, divided by the total number of practices registered.

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

Reasons for encounter
The expressed demand of the patient for care, as perceived and recorded by the GP.

Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the Health Insurance Act 1973 (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' suffix (for example, table 11A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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11A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 11.5. Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat. Unsourced information was obtained from the Australian, State and Territory governments.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

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Table 11A.1 **Types of encounter, 2007-08 (a)**

	Number	*Per cent of encounters* (b) *(n= 95 858)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=86 359)*	*Per cent of Medicare-paid GP items (n=83 376)*
	no.	%	%	%	%	%
General practitioners	953	..	..	..	..	..
Direct encounters	86 359	98.6	98.4	98.8	100.0	..
No charge	386	0.4	0.4	0.5	0.4	..
MBS/DVA items of service (all) (c)	83 418	95.2	94.9	95.6	96.6	..
MBS/DVA items of service (GPs only)	83 376	95.2	94.8	95.5	96.5	100.0
Short surgery consultations	990	1.1	0.9	1.3	..	1.2
Standard surgery consultations	68 455	78.2	77.0	79.3	..	82.1
Long surgery consultations	8 231	9.4	8.8	10.0	..	9.9
Prolonged surgery consultations	559	0.6	0.5	0.8	..	0.7
Home visits	822	0.9	0.5	1.3	..	1.0
Hospital	130	0.1	0.1	0.2	..	0.2
Residential aged care facility	1 007	1.2	0.9	1.4	..	1.2
Health assessments	294	0.3	0.3	0.4	..	0.4
Chronic disease management items	451	0.5	0.4	0.6	..	0.5
Case conferences	6	–	–	–	..	–
GP mental health care items	682	0.8	0.7	0.9	..	0.8
Incentive payments	129	0.1	0.1	0.2	..	0.2
Other items	1 620	1.8	1.4	2.3	..	1.9
Practice nurse only items	27	–	–	0.1	–	..
Workers compensation	2 000	2.3	2.1	2.5	2.3	..
Other paid (hospital, state, etc.)	577	0.7	0.5	0.8	0.7	..

Table 11A.1 **Types of encounter, 2007-08 (a)**

	Number	*Per cent of encounters* (b) *(n= 95 858)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=86 359)*	*Per cent of Medicare-paid GP items (n=83 376)*
Indirect encounters (d)	1 225	1.4	1.2	1.6	..	..
Practice nurse only items	14	–	–	–	..	..
Practice nurse only items (unspecified)	2	–	–	–	..	..
Missing (e)	8 311	..	..	..	..	..
Total encounters	**95 898**	..	..	..	..	..

LCL = lower confidence limit; UCL = upper confidence limit; MBS=Medicare Benefits Schedule; DVA=Department of Veterans' Affairs.

(a) One Medicare item number counted per encounter (where applicable).

(b) Missing data removed from analysis.

(c) Includes 2 unspecified encounters at which a practice nurse item only was recorded.

(d) Six encounters involving chronic disease management or case conference items were recorded as indirect encounters.

(e) If the 'Patient not seen' box was ticked, and MBS items other than chronic disease management items or case conference items were recorded, those items were included as missing data.

.. Not applicable. – Nil or rounded to zero.

Source: Britt, H., Miller, G.C., Charles, J., Henderson, J., Bayram, C., Harrison, C., Valenti, L., Fahridin, S., Pan, Y., O'Halloran, J. 2008, *General practice activity in Australia 2007–08*, Cat. no. GEP 22, General practice series no. 22, AIHW, Canberra.

Table 11A.2 **Australian Government real expenditure per person on GPs (2007-08 dollars) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04	223	207	212	184	224	206	152	120	210
2004-05	259	239	246	209	256	240	175	131	243
2005-06	277	257	262	221	278	256	191	139	260
2006-07	277	255	254	216	271	251	196	138	257
2007-08	284	264	261	220	279	260	203	148	264

(a) The data include expenditure on Medicare Australia, the Practice Incentives Program (PIP), Department of Veterans' Affairs (DVA), Divisions of General Practice (DGP) and the General Practice Immunisation Incentives Scheme (GPII).

(b) DVA data include consultations by local medical officers (LMO), whether vocationally registered GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (as opposed to specialists) for procedural items. It is expected, however, that the amounts for LMO procedural services are small compared with payments for LMO consultations.

(c) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through accident and emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.

Source: Department of Health and Ageing (DoHA) (unpublished), derived from the MBS, PIP, GPII and DGP data systems, and unpublished DVA data.

Table 11A.3 Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP numbers (d)										
2003-04	no.	7 910	5 881	4 823	2 348	1 974	655	395	337	24 323
2004-05	no.	7 975	5 954	4 964	2 353	2 004	656	413	350	24 669
2005-06	no.	8 062	6 065	5 107	2 435	2 042	669	425	341	25 146
2006-07	no.	8 187	6 192	5 202	2 494	2 055	667	412	355	25 564
2007-08	no.	8 299	6 297	5 386	2 572	2 159	691	425	383	26 212
FWE GPs										
2003-04	no.	6 021	4 110	3 260	1 451	1 360	374	198	98	16 872
2004-05	no.	6 222	4 167	3 389	1 457	1 364	378	200	95	17 273
2005-06	no.	6 310	4 283	3 489	1 473	1 404	386	208	97	17 649
2006-07	no.	6 483	4 407	3 564	1 500	1 416	391	226	104	18 091
2007-08	no.	6 600	4 584	3 683	1 542	1 455	401	232	116	18 613
FWE GPs per 100 000 people										
2003-04	FWE GPs per 100 000 people	89.5	82.6	84.0	73.1	88.8	77.5	61.0	48.6	83.9
2004-05	FWE GPs per 100 000 people	91.7	82.8	85.6	72.3	88.5	77.9	61.5	47.2	84.9
2005-06	FWE GPs per 100 000 people	92.4	84.3	86.3	72.0	90.5	79.1	63.3	46.8	85.8
2006-07	FWE GPs per 100 000 people	94.1	84.7	85.4	71.4	89.5	79.2	66.8	48.3	86.1
2007-08	FWE GPs per 100 000 people	94.8	86.7	86.1	71.5	90.9	80.7	67.5	52.6	87.2

(a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(b) GP and FWE data include vocationally recognised GPs and other medical practitioners (OMPs).

(c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

(d) These data were current at September 2008 and may differ from data published subsequently by DoHA.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.4 Indigenous primary healthcare services for which service activity reporting (SAR) data are reported (number) (a), (b)

	NSW and ACT (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2002-03	26	21	26	21	8	5	27	134
2003-04	29	21	26	20	10	5	27	138
2004-05	28	22	26	20	13	5	27	141
2005-06	30	22	27	23	14	5	29	150
2006-07 (d)	28	22	28	25	10	6	27	146

(a) The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).

(b) The number of services that provide SAR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence SAR data reporting if there are changes in the types of services provided and/or reporting arrangements.

(c) Data for NSW and the ACT have been combined in order to avoid the identification of individual services.

(d) 2006-07 data are preliminary results.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

Table 11A.5 Services and episodes of healthcare by services for which service activity reporting (SAR) data are reported, by remoteness category (number) (a)

	Highly accessible	*Accessible*	*Moderately accessible*	*Remote*	*Very remote*	*Total*
Services						
2002-03	38	29	13	17	37	134
2003-04	41	30	13	14	40	138
2004-05	41	34	13	15	38	141
2005-06	44	36	15	16	39	150
2006-07 (b)	47	32	13	16	38	146
Episodes of healthcare						
2002-03	507 000	338 000	91 000	270 000	294 000	1 500 000
2003-04	572 000	345 000	110 000	207 000	378 000	1 612 000
2004-05	554 000	399 000	85 000	213 000	335 000	1 586 000
2005-06	644 000	388 000	92 000	243 000	317 000	1 684 000
2006-07 (b)	564 000	417 000	89 000	269 000	313 000	1 652 000

(a) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.

(b) 2006-07 data are preliminary results.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

Table 11A.6 Proportion of services for which service activity reporting (SAR) data are reported that undertook selected health related activities, 2006-07 (per cent) (a), (b), (c)

Activity	Per cent
Diagnosis and treatment of illness/disease	83
Management of chronic illness	89
Transportation to medical appointments	94
Outreach clinic services	66
24 hour emergency care	28
Monitoring child growth	72
School-based activities	84
Hearing screening	76
Pneumococcal immunisation	81
Influenza immunisation	83
Child immunisation	81
Women's health group	84
Support for public housing issues	67
Community development work	73
Legal/police/prison/advocacy services	63
Dental services	58
Involvement in steering groups on health	87
Participation in regional planning forums	69
Dialysis services	10

(a) The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).

(b) The denominator used in calculating the proportions is 'all SAR services for that year'. However, some services in the SAR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.

(c) Data for 2006-07 are preliminary results.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

Table 11A.7 Full time equivalent (FTE) health staff employed by services for which service activity reporting (SAR) data are reported, as at 30 June 2007 (number) (a), (b), (c)

	Indigenous staff	*Non-Indigenous staff*	*Total staff* (d)
Aboriginal health workers	727	13	740
Doctors	8	248	257
Nurses	52	339	391
Specialists	–	3	3
Emotional and Social Well Being staff (e)	171	61	232
Allied health professionals	3	43	46
Dentists	5	34	39
Dental assistants	41	18	59
Traditional healers	21	–	21
Substance misuse workers	84	28	112
Environmental health workers	23	5	28
Driver/field officers	161	22	184
Other health staff (f)	54	33	87
Total health staff (d)	**1 351**	**847**	**2 198**

(a) Preliminary results.

(b) The number of services that provide SAR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence SAR data reporting if there are changes in the types of services provided and/or reporting arrangements.

(c) FTE positions are rounded to the nearest whole number.

(d) Totals may not add due to rounding and cell suppression.

(e) Emotional and Social Well Being staff includes counsellors, social workers, psychologists and other emotional and social well being staff.

(f) Other health staff includes: hearing coordinators, eye health workers, nutrition workers, sexual health workers, youth workers, hospital liaison, masseurs, maternal health workers, domestic violence support workers, and family health workers.

– Nil or rounded to zero.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

Table 11A.8 Alcohol and other drug treatment services, by sector, 2006-07 (number)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government	194	–	56	13	35	3	1	3	305
Non-government	68	136	49	31	9	10	9	16	328
Total	**262**	**136**	**105**	**44**	**44**	**13**	**10**	**19**	**633**

– Nil or rounded to zero.

Source: AIHW (2008), *Alcohol and Other Drug Treatment Services in Australia 2006-07: Report on the National Minimum Data Set,* Cat. no. HSE 59, Drug Treatment Series no. 8, AIHW, Canberra.

Table 11A.9 Approved providers of PBS medicines, by urban and rural location, 2007-08 (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of pharmacies									
Urban	1 454	1 005	814	424	315	81	61	18	4 172
Rural	268	156	173	84	92	51	–	9	833
Number of people per pharmacy									
Urban	3 698	4 160	3 807	3 745	3 761	3 413	5 300	4 882	3 863
Rural	4 341	4 776	4 578	4 347	3 553	3 904	–	11 451	4 436
Number of approved medical practitioners									
Urban	–	–	–	–	–	–	–	–	–
Rural	22	3	16	18	4	7	–	1	71
Number of approved hospitals (b)									
Urban									
Private	21	23	16	3	3	1	3	1	71
Public	–	51	21	6	–	–	–	1	79
Rural									
Private	–	–	–	–	–	–	–	–	–
Public	–	12	59	–	–	–	–	3	74

(a) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PHARIA 1. Rural = PHARIA 2-6.

(b) The number of approved hospitals is reported by private/public status. PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.

– Nil or rounded to zero.

Source: DoHA (unpublished), derived from Medicare Australia, the ABS *2006 Census of Population and Housing* and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems.

Table 11A.10 **PBS services, 2007-08 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general (b)	no. '000	8 091	5 913	4 765	2 458	1 755	500	505	144	24 132
PBS concessional (c)	no. '000	50 262	37 652	27 854	12 112	12 756	4 356	1 388	448	146 828
PBS doctor's bag	no. '000	114	85	74	24	26	7	4	2	336
PBS total	no. '000	58 467	43 650	32 694	14 593	14 537	4 864	1 897	593	171 296
Proportion of concessional PBS services (b)	%	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7

(a) Excludes RPBS.

(b) Includes PBS general ordinary and safety net.

(c) Includes concessional ordinary and concessional free safety net.

Source: DoHA (unpublished), derived from the PBS data system.

Table 11A.11 PBS expenditure per person, by urban and rural location (2007-08 dollars) (a), (b)

	2003-04	*2004-05*	*2005-06*	*2006-07*	*2007-08*
Capital city	285.4	287.8	275.9	263.2	268.4
Other metro	319.6	323.6	309.0	297.8	305.0
Rural and remote	310.4	315.6	301.7	288.3	296.0
All locations	295.2	298.5	285.8	273.1	279.1

(a) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net, unknown free safety net and doctor's bag. Excludes RPBS.

(b) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the DoHA annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medications dispensed under s.100 of the *National Health Act 1953* [Cwlth]).

Source: DoHA (unpublished), derived from the PBS data system.

Table 11A.12 **Availability of GPs by region (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*
Number of GPs (f)									
Urban									
2003-04	6 514	4 516	2 809	1 700	1 466	338	na	139	17 482
2004-05	6 559	4 573	2 932	1 711	1 478	328	na	141	17 722
2005-06	6 633	4 658	3 019	1 765	1 510	332	na	132	18 049
2006-07	6 702	4 733	3 066	1 791	1 515	335	na	120	18 262
2007-08	6 098	4 802	3 166	1 855	1 572	352	383	138	18 655
Rural									
2003-04	1 791	1 365	2 014	648	508	317	na	198	6 841
2004-05	1 829	1 381	2 032	642	526	328	na	209	6 947
2005-06	1 854	1 407	2 088	670	532	337	na	209	7 097
2006-07	1 897	1 459	2 136	703	540	332	na	235	7 302
2007-08	1 850	1 495	2 220	717	587	339	..	245	7 557
Number of full time workload equivalent GPs									
Urban									
2003-04	5 065	3 212	1 961	1 123	1 029	170	na	49	12 608
2004-05	5 227	3 242	2 026	1 121	1 027	166	na	47	12 856
2005-06	5 283	3 335	2 105	1 132	1 060	171	na	48	13 135
2006-07	5 427	3 426	2 171	1 142	1 071	173	na	50	13 459
2007-08	5 274	3 551	2 241	1 166	1 080	179	232	54	13 778
Rural									
2003-04	1 154	898	1 299	328	331	204	na	49	4 263
2004-05	1 195	925	1 363	336	337	212	na	49	4 416
2005-06	1 234	948	1 384	341	343	215	na	48	4 514
2006-07	1 283	981	1 393	358	345	218	na	54	4 632
2007-08	1 327	1 033	1 441	376	375	222	..	61	4 835
Number of full time workload equivalent GPs per 100 000 people									
Urban									
2003-04	93.2	85.7	83.2	76.9	91.0	86.7	na	55.2	87.4
2004-05	95.2	85.4	84.0	75.7	90.1	83.7	na	53.6	88.0
2005-06	95.6	87.0	85.5	75.3	92.5	86.0	na	54.4	89.0
2006-07	97.2	87.3	85.4	73.9	91.5	86.0	na	53.7	89.4
2007-08	99.6	89.0	86.0	73.6	91.2	88.3	67.5	57.1	90.0
Rural									
2003-04	71.4	73.2	85.2	62.7	82.6	71.1	na	43.4	74.9
2004-05	73.6	74.8	88.1	63.0	83.9	73.9	na	42.4	76.9
2005-06	75.5	76.0	87.6	62.9	85.0	74.4	na	41.0	77.7
2006-07	77.8	76.8	85.4	64.3	83.7	74.6	na	44.3	78.0
2007-08	79.7	79.6	86.2	65.8	89.9	75.5	..	49.1	80.0

Table 11A.12 **Availability of GPs by region (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*

(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) FWEs are calculated for each practitioner by dividing the practitioner’s Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(c) GP and FWE data include vocationally recognised GPs and other medical practitioners (OMPs).

(d) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

(e) From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.

(f) These data were current at September 2008 and may differ from data published subsequently by DoHA.

na Not available. .. Not applicable.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.13 **Female GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs (d)										
2003-04	no.	2 829	2 091	1 768	853	680	252	181	151	8 805
2004-05	no.	2 876	2 191	1 834	865	689	264	194	166	9 079
2005-06	no.	2 978	2 262	1 915	898	723	264	205	156	9 401
2006-07	no.	3 085	2 351	1 978	940	741	270	198	161	9 724
2007-08	no.	3 164	2 435	2 075	982	793	290	210	188	10 137
Female FWEs GPs										
2003-04	no.	1 583	1 058	869	380	320	112	69	39	4 430
2004-05	no.	1 671	1 086	915	381	326	114	73	38	4 603
2005-06	no.	1 721	1 150	960	394	334	122	76	34	4 790
2006-07	no.	1 817	1 225	1 005	410	347	125	82	37	5 047
2007-08	no.	1 916	1 312	1 084	426	372	131	85	45	5 371
Female FWEs GPs as a proportion of all FWE GPs										
2003-04	%	26.3	25.7	26.7	26.2	23.5	30.0	34.9	40.2	26.3
2004-05	%	26.9	26.1	27.0	26.1	23.9	30.2	36.3	40.3	26.7
2005-06	%	27.3	26.8	27.5	26.8	23.8	31.5	36.6	34.8	27.1
2006-07	%	28.0	27.8	28.2	27.3	24.5	31.9	36.1	35.4	27.9
2007-08	%	29.0	28.6	29.4	27.6	25.6	32.7	36.4	39.2	28.9
Female FWE GPs per 100 000 females										
2003-04	per 100 000 females	46.8	42.0	44.7	38.4	41.3	45.8	42.1	41.5	43.8
2004-05	per 100 000 females	49.0	42.6	46.1	37.8	42.0	46.4	44.2	40.1	45.0
2005-06	per 100 000 females	50.1	44.7	47.5	38.7	42.7	49.2	45.9	34.4	46.3
2006-07	per 100 000 females	52.3	46.6	48.1	39.4	43.3	49.9	47.8	35.6	47.8
2007-08	per 100 000 females	54.6	49.1	50.6	40.0	46.0	52.1	48.8	42.9	50.0

Table 11A.13 **Female GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(a) FWEs are calculated for each practitioner by dividing the practitioner’s Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(b) GP and FWE numbers include vocationally recognised GPs and OMPs.

(c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

(d) These data were current at September 2008 and may differ from data published subsequently by DoHA.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.14 **Availability of public dentists (per 100 000 people)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (a)	*ACT* (b)	*NT* (c) (d)	*Aust*
FTE dentists per 100 000 population (e)									
2003									
Major cities	7.8	6.8	9.8	7.7	14.4	..	5.7	..	8.3
Inner regional	3.4	5.0	8.6	4.8	4.9	5.1	..	..	5.3
Outer regional	2.7	2.7	8.2	4.8	5.2	1.9	..	13.0	5.4
Remote and very remote	2.5	–	4.2	1.7	7.1	–	..	3.8	3.5
Total	**6.5**	**6.2**	**9.0**	**6.6**	**11.9**	**3.9**	**5.7**	**8.8**	**7.3**
2004 (f)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2005									
Major cities	7.8	6.5	10.1	8.9	12.6	..	6.4	..	8.3
Inner regional	3.8	3.6	9.2	5.5	5.8	4.4	..	..	5.3
Outer regional	2.5	1.9	7.5	2.2	3.9	0.8	..	7.7	4.3
Remote and very remote	2.4	–	7.5	9.4	4.6	–	..	5.7	6.6
Total	**6.6**	**5.6**	**9.3**	**7.8**	**10.4**	**3.1**	**6.4**	**6.8**	**7.2**
2006									
Major cities	8.3	7.3	9.2	9.1	10.9	..	2.1	..	8.4
Inner regional	3.9	3.7	7.9	3.6	4.8	4.7	..	..	4.8
Outer regional	2.7	3.7	8.7	2.0	3.0	1.1	..	17.0	5.3
Remote and very remote	–	–	4.1	5.3	–	–	..	18.5	6.1
Total	**7**	**6.4**	**8.7**	**7.5**	**8.8**	**3.4**	**2.1**	**17.7**	**7.3**

Table 11A.14 Availability of public dentists (per 100 000 people)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (a)	*ACT* (b)	*NT* (c) (d)	*Aust*

(a) There were no major cities in Tasmania.

(b) There were no outer regional, remote or very remote areas in the ACT.

(c) There were no major cities or inner regional areas in the NT.

(d) There was no 2003 data collection in the NT, and 2003 NT data are based on data from the 2002 NT collection.

(e) FTE based on 40 hour week.

(f) National dental labour force data are not available for 2004.

na Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (unpublished), derived from National dental labour force collections.

Table 11A.15 **Availability of public dental therapists (per 100 000 people)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
FTE dental therapists per 100 000 population (b)									
2003									
Major cities	1.7	1.7	6.2	6.4	5.5	..	5.0	..	3.2
Inner regional	3.8	2.4	7.9	8.8	6.2	8.3	–	..	5.1
Outer regional	2.4	1.4	6.5	7.0	7.6	10.4	..	10.3	4.9
Remote and very remote	–	–	6.7	3.2	3.6	–	..	3.7	3.1
Total	**2.1**	**1.8**	**6.6**	**6.6**	**5.8**	**8.8**	**5.0**	**7.3**	**3.7**
2004 (c)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2005 (d)									
Major cities	2.3	1.7	6.8	7.6	4.3	..	4.6	..	3.5
Inner regional	3.8	3.1	9.1	8.9	5.6	7.3	..	..	5.4
Outer regional	5.7	1.7	8.2	7.0	9.7	10.8	..	11.5	7.0
Remote and very remote	–	–	6.6	10.3	3.6	–	..	6.9	5.4
Total	**2.8**	**2.0**	**7.6**	**7.8**	**4.9**	**8.3**	**..**	**9.4**	**4.3**
2006 (c)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**

Table 11A.15 **Availability of public dental therapists (per 100 000 people)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*

(a) There was no 2003 data collection in the NT, and 2003 NT data are based on data from the 2002 NT collection.

(b) FTE based on 40 hour week.

(c) National dental therapist labour force data are not available for 2004 or 2006.

(d) Data for 2005 may overestimate number of dental therapists in some jurisdictions due to some respondents reporting to be both hygienists and therapists in primary location.

na Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (unpublished), derived from the National dental labour force collection.

Table 11A.16 **Voluntary annual health assessments for older people by Indigenous status (a) (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
2006-07										
Indigenous older people (a)										
Health assessments (d)	no.	995	237	989	461	140	7	15	629	3 473
Target population (e)	no.	11 594	2 383	9 817	5 411	2 117	1 383	228	4 546	37 504
Assessments per 1000 target population	no.	85.8	99.5	100.7	85.2	66.1	5.1	65.9	138.4	92.6
All older people (a)										
Health assessments (d)	no.	97 145	64 817	51 188	17 810	24 831	7 918	1 760	183	265 652
Target population (f)	'000	455	337	231	113	120	34	14	3	1 307
Assessments per 1000 target population	no.	213.7	192.5	221.5	158.0	206.6	232.5	121.4	58.2	203.2
2007-08										
Indigenous older people (a)										
Health assessments (d)	no.	1 155	271	1 256	628	123	8	8	813	4 262
Target population (e)	no.	11 995	2 482	10 176	5 623	2 208	1 448	243	4 698	38 898
Assessments per 1000 target population	no.	96.3	109.2	123.4	111.7	55.7	5.5	32.9	173.1	109.6
All older people (a)										
Health assessments (d)	no.	104 008	66 444	56 404	18 891	26 735	8 297	2 333	185	283 297
Target population (f)	'000	457	341	236	115	121	34	15	3	1 324
Assessments per 1000 target population	no.	227.4	194.9	239.1	164.0	220.1	241.2	155.4	56.5	214.0

(a) Older people are defined as Indigenous people aged 55 years and over and non-Indigenous people aged 75 years and over, excluding people living in residential aged care facilities.

(b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.

(c) Includes Other Territories.

Table 11A.16 **Voluntary annual health assessments for older people by Indigenous status (a) (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)

(d) Medicare items 700, 702, 704 and 706 are for annual health assessments for older people. Items 700 and 702 apply to non-Indigenous people, while items 704 and 706 apply to Indigenous people. Indigenous status is determined by self-identification.

(e) Projected population of Indigenous people aged 55 years and over at 31 December. Calculated as the average of the population projections (low series) at 30 June in the reported and preceding financial year. Projections are based on estimated resident population (ERP) at 30 June 2001 (ABS 2004).

(f) Estimated resident population aged 75 years or over at 31 December.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS (2004), *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; *Australian Demographic Statistics March Quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from the *2006 Census of Population and Housing*.

Table 11A.17 **Older Indigenous people who received an annual health assessment (per 1000 people) (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
2003-04										
Number of health assessments conducted	no.	556	118	387	246	49	5	4	205	1 570
Target population (d)	no.	10 488	2 097	8 827	4 844	1 899	1 245	181	4 068	33 673
Health assessments per 1000 people	no.	53.0	56.3	43.8	50.8	25.8	4.0	22.1	50.4	46.6
2004-05										
Number of health assessments conducted	no.	636	143	568	348	132	17	3	309	2 156
Target population (d)	no.	10 832	2 183	9 116	4 996	1 972	1 275	197	4 160	34 756
Health assessments per 1000 people	no.	58.7	65.5	62.3	69.7	67.0	13.3	15.3	74.3	62.0
2005-06										
Number of health assessments conducted	no.	800	158	713	394	92	13	2	345	2 517
Target population (d)	no.	11 192	2 285	9 442	5 187	2 040	1 321	212	4 336	36 040
Health assessments per 1000 people	no.	71.5	69.2	75.5	76.0	45.1	9.8	9.4	79.6	69.8
2006-07										
Number of health assessments conducted	no.	995	237	989	461	140	7	15	629	3 473
Target population (d)	no.	11 594	2 383	9 817	5 411	2 117	1 383	228	4 546	37 504
Health assessments per 1000 people	no.	85.8	99.5	100.7	85.2	66.1	5.1	65.9	138.4	92.6
2007-08										
Number of health assessments conducted	no.	1 155	271	1 256	628	123	8	8	813	4 262
Target population (d)	no.	11 995	2 482	10 176	5 623	2 208	1 448	243	4 698	38 898
Health assessments per 1000 people	no.	96.3	109.2	123.4	111.7	55.7	5.5	32.9	173.1	109.6

(a) Older Indigenous people are defined as aged 55 years and over, excluding people living in residential aged care facilities.

(b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.

(c) Includes Other Territories.

(d) Projected population of Indigenous people aged 55 years and over at 31 December. Calculated as the average of the population projections (low series) at 30 June in the reported and preceding financial years. Projections are based on the estimated resident population (ERP) at 30 June 2001.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS (2004), *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0.

Table 11A.18 Indigenous people who received a voluntary health check or assessment, by age (per 1000 people) (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
Child health checks (0–14 years) (c)										
Number of health checks conducted	no.	2 561	264	3 341	1 823	300	4	39	4 065	12 397
Target population	no.	46 552	10 879	53 077	26 112	9 975	6 844	1 648	20 814	184 076
Health checks per 1000 children	no.	55.0	24.3	62.9	69.8	30.1	–	23.7	195.3	67.3
Health checks (15–54 years) (d)										
Number of health checks conducted	no.	6 633	1 103	8 569	4 524	1 025	30	138	6 438	28 460
Target population	no.	82 150	18 361	79 374	42 000	16 516	10 593	2 615	37 351	288 393
Health checks per 1000 people	no.	80.7	60.1	108.0	107.7	62.1	2.8	52.8	172.4	98.7
Older people health assessments (55 years and over) (c)										
Number of health assessments conducted	no.	1 155	271	1 256	628	123	8	8	813	4 262
Target population	no.	11 995	2 482	10 176	5 623	2 208	1 448	243	4 698	38 898
Health assessments per 1000 people	no.	96.3	109.2	123.4	111.7	55.7	5.5	32.9	173.1	109.6

(a) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.

(b) Includes Other Territories.

(c) Health checks/assessments are available on an annual basis for these age groups. Data are for the 2007-08 financial year. Projected target population as at 31 December 2007. Calculated as the average of the population projections (low series) for 30 June 2007 and 2008. Projections are based on the estimated resident population (ERP) at 30 June 2001.

(d) Available on a biennial basis. Data are for the 24 month period 1 July 2006 to 30 June 2008. Projected target population (low series) at 30 June 2007, based on the ERP at 30 June 2001.

– Nil or rounded to zero.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS (2004), *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0.

Table 11A.19 Early detection activities provided by services for which service activity reporting (SAR) data are reported (a)

	Unit	*2002-03*	*2003-04*	*2004-05*	*2005-06*	*2006-07* (b)
Early detection activities provided						
Well person's checks	%	64	64	63	65	76
PAP smears/cervical screening	%	73	79	77	75	76
STI screening	%	66	64	65	63	67
Hearing screening	%	73	72	70	71	76
Eye disease screening	%	66	65	70	64	73
Renal disease screening	%	46	50	50	43	51
Diabetic screening	%	79	82	80	77	79
Cardiovascular screening	%	54	57	60	67	64
Any early detection activity	%	87	88	89	85	88

(a) The denominators used above are all SAR services for that year. However, some services in the SAR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care, such as health promotion.

(b) 2006-07 data are preliminary results.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

Table 11A.20 **Non-referred attendances that were bulk billed, by region (per cent) (a), (b)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Unknown*	*Aust*
2001-02	80.8	72.3	59.0	59.3	56.6	58.9	70.0	61.1	74.9
2002-03	75.0	67.5	53.4	54.1	53.2	57.9	70.5	58.8	69.5
2003-04	73.0	67.2	54.7	56.6	55.7	60.5	72.0	58.7	68.5
2004-05	76.4	71.4	65.1	67.6	67.8	65.9	77.0	43.0	73.8
2005-06	78.3	74.4	68.9	71.5	71.4	67.5	78.4	65.7	76.2
2006-07	79.8	76.9	71.5	74.3	73.8	70.1	79.9	81.8	78.0
2007-08	80.7	78.5	73.4	76.7	76.0	71.6	82.0	73.1	79.2

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

(b) Data include non-referred attendances undertaken by general practice nurses since 2003-04.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.21 **Non-referred attendances that were bulk billed (per cent) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1997-98	82.9	79.1	81.1	78.4	74.1	65.1	66.1	67.9	79.8
1998-99	82.4	78.9	80.9	77.6	74.1	63.0	65.6	65.2	79.4
1999-2000	82.4	78.6	80.3	76.7	74.2	61.6	63.0	65.4	79.1
2000-01	81.2	76.7	78.9	75.1	73.2	60.5	59.3	65.5	77.6
2001-02	79.8	73.4	75.3	71.9	69.6	58.5	51.2	63.9	74.9
2002-03	77.2	67.5	65.5	66.6	62.4	54.9	39.2	62.2	69.5
2003-04	76.7	65.7	64.7	65.0	63.3	52.7	36.8	61.5	68.5
2004-05	80.1	70.9	71.4	69.9	71.9	66.4	40.6	62.8	73.8
2005-06	81.9	73.8	74.1	71.8	74.9	69.6	44.2	63.0	76.2
2006-07	83.5	75.7	76.1	73.0	77.1	72.2	51.9	64.0	78.0
2007-08	84.5	77.0	77.5	73.9	79.0	74.5	52.8	65.7	79.2

(a) Data include non-referred attendances undertaken by general practice nurses since 2003-04.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.22 Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and dispensed to patients (per 1000 people with Pharmaceutical Benefits Scheme [PBS] concession cards) (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04										
Scripts	no.	2 339 379	1 748 225	1 297 581	533 513	513 080	167 226	65 968	21 413	6 686 385
Concession card holders	no.	1 623 022	1 262 959	965 017	456 322	438 967	155 013	51 512	44 033	5 014 400
Rate	per 1000 holders	1 441.4	1 384.2	1 344.6	1 169.2	1 168.8	1 078.8	1 280.6	486.3	1 333.4
2004-05										
Scripts	no.	2 326 004	1 755 455	1 348 240	523 706	512 769	162 848	63 916	22 136	6 715 074
Concession card holders	no.	1 606 563	1 252 515	945 992	444 818	430 703	149 320	50 530	45 317	4 937 298
Rate	per 1000 holders	1 447.8	1 401.5	1 425.2	1 177.3	1 190.5	1 090.6	1 264.9	488.5	1 360.1
2005-06										
Scripts	no.	2 283 357	1 784 315	1 320 604	528 534	530 665	167 685	64 561	21 909	6 701 630
Concession card holders	no.	1 608 699	1 257 335	934 262	432 120	428 740	148 220	49 397	46 716	4 916 273
Rate	per 1000 holders	1 419.4	1 419.1	1 413.5	1 223.1	1 237.7	1 131.3	1 307.0	469.0	1 363.2
2006-07										
Scripts	no.	2 307 886	1 746 773	1 295 091	476 343	491 201	155 715	63 700	21 067	6 557 776
Concession card holders	no.	1 629 411	1 282 538	933 358	419 986	432 096	148 963	48 571	46 445	4 951 158
Rate	per 1000 holders	1 416.4	1 362.0	1 387.6	1 134.2	1 136.8	1 045.3	1 311.5	453.6	1 324.5
2007-08										
Scripts	no.	2 421 288	1 845 823	1 378 421	474 572	508 618	165 177	66 379	21 383	6 881 661
Concession card holders	no.	1 631 850	1 283 233	924 595	415 333	431 965	147 868	48 388	45 046	4 936 791
Rate	per 1000 holders	1 483.8	1 438.4	1 490.8	1 142.6	1 177.5	1 117.1	1 371.8	474.7	1 394.0

Table 11A.22 Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and dispensed to patients (per 1000 people with Pharmaceutical Benefits Scheme [PBS] concession cards) (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year. GPs have tended to prescribe 90–98 per cent of each of these generic pharmaceuticals throughout this period with only minor additional variations by jurisdiction. Consequently, the 'all prescriptions' approach among concessional patients has been chosen for data presentation purposes. Any noticeable changes in trend will predominantly pick up changes in GP behaviour.

(b) Numbers of concession card holders were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs.

Source: DoHA (unpublished), derived from the PBS data system.

Table 11A.23 Proportion of people with diabetes that received a diabetes cycle of care (per cent) (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Total*
2003-04										
Cycles of care	no.	37 512	30 965	18 402	9 302	11 283	2 876	1 006	281	111 627
People with diabetes	no.	251 886	148 546	121 596	79 058	61 033	14 583	9 935	na	691 301
Received cycle of care	%	14.9	20.8	15.1	11.8	18.5	19.7	10.1	na	16.1
2004-05										
Cycles of care	no.	45 023	34 905	20 737	10 874	13 012	3 358	1 227	353	129 489
People with diabetes	no.	253 400	150 400	124 400	80 300	61 400	14 700	10 000	na	699 600
Received cycle of care	%	17.8	23.2	16.7	13.5	21.2	22.8	12.3	na	18.5
2005-06										
Cycles of care	no.	47 406	38 568	23 255	12 075	14 111	3 741	1 279	415	140 850
People with diabetes	no.	255 567	152 546	127 484	81 847	61 950	14 817	10 129	na	709 685
Received cycle of care	%	18.5	25.3	18.2	14.8	22.8	25.2	12.6	na	19.8
2006-07										
Cycles of care	no.	50 583	40 874	24 769	13 669	15 658	4 135	1 456	644	151 788
People with diabetes	no.	258 114	154 890	130 245	83 616	62 586	14 914	10 250	na	720 210
Received cycle of care	%	19.6	26.4	19.0	16.3	25.0	27.7	14.2	na	21.1
2007-08										
Cycles of care	no.	52 585	41 747	25 789	14 499	16 217	4 434	1 706	942	157 919
People with diabetes	no.	260 860	157 362	133 300	85 605	63 243	15 038	10 386	na	731 675
Received cycle of care	%	20.2	26.5	19.3	16.9	25.6	29.5	16.4	na	21.6

(a) Data are minimum estimates as they do not account for GPs who provide the annual cycle of care but do not claim the MBS items.

(b) While clinical guidelines are for Type 2 diabetes, the MBS items do not specify Type 2 diabetes. Clinical guidelines represent the minimum level of care required. While the minimum frequency of glycosolated heamoglobin (HbA1c) testing according to clinical guidelines is at least 6 monthly for adults and 3 monthly for children and adolescents, the MBS annual cycle of care requires only annual testing, irrespective of age.

(c) Estimates of the number of people with diabetes are based on 2004-05 NHS prevalence data for all years. They should be treated with caution as the prevalence of diabetes is changing over time.

Table 11A.23 **Proportion of people with diabetes that received a diabetes cycle of care (per cent) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Total*

(d) 2004-05 NHS data are not available for the NT.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS (2006) *National Health Survey: Summary of Results; State Tables, 2004-5*, Cat. no. 4362.0; ABS (2008), *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0.

Table 11A.24 Proportion of people with asthma that had a asthma action plan (per cent) (a)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2001										
0–14 years										
Value	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np	24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np	7.7
CI	%	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	np	± 3.7
15–64 years										
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	np	15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	np	6.5
CI	%	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	np	± 1.9
65 years and over										
Value	%	14.6	7.7	11.8	np	19.0	np	23.8	np	12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	np	22.1
CI	%	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	np	± 5.2
All ages										
Value	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	np	17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	np	5.3
CI	%	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	np	± 1.8
2004-05										
0–14 years										
Value	%	33.6	52.5	29.9	np	39.2	21.9	np	np	36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	np	9.6
CI	%	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	np	± 6.9
15–64 years										
Value	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	np	19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	np	6.9
CI	%	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	np	± 2.7
65 years and over										
Value	%	17.1	7.6	18.5	np	20.6	19.7	np	np	14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	np	17.5
CI	%	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	np	± 4.9
All ages										
Value	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	np	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	np	6.0
CI	%	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	np	± 2.7

(a) Separate estimates for the NT are not available for this survey, but the NT sample contributes to the national estimates. See paragraph 11 of Explanatory Notes in ABS (2006), *National Health Survey Summary of Results, 2004-05*, Cat. no. 4364.0. Separate estimates for WA and the ACT for ages 0–14 years are not available for the 2004-05 survey but contribute to the national estimates.

np Not published.

Source: ABS (unpublished), derived from the National Health Survey 2001, 2004-05.

Table 11A.25 **Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), and claimed through Medicare, real benefits paid (2007-08 dollars) and number of tests (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04										
Benefits paid										
Benefits paid	$m	414.5	280.3	266.5	115.5	86.8	26.1	18.1	9.0	1 216.8
Per person	$	61.6	56.3	68.7	58.2	56.7	54.1	56.0	44.5	60.5
Tests										
Number of tests	'000	20 017	13 726	12 010	5 352	4 159	1 346	824	412	57 846
Tests per person	no.	3.0	2.8	3.1	2.7	2.7	2.8	2.5	2.0	2.9
2004-05										
Benefits paid										
Benefits paid	$m	430.2	290.8	274.9	118.4	90.5	26.4	19.1	9.8	1 260.1
Per person	$	63.5	57.9	69.3	58.9	58.7	54.4	58.9	48.1	62.0
Tests										
Number of tests	'000	20 963	14 395	12 534	5 565	4 395	1 363	875	457	60 548
Tests per person	no.	3.1	2.9	3.2	2.8	2.9	2.8	2.7	2.3	3.0
2005-06										
Benefits paid										
Benefits paid	$m	434.0	294.8	298.5	119.9	90.2	27.4	19.6	11.2	1 295.6
Per person	$	63.5	58.0	73.9	58.6	58.2	56.1	59.6	54.2	63.0
Tests										
Number of tests	'000	21 766	15 059	14 154	5 819	4 524	1 446	921	536	64 225
Tests per person	no.	3.2	3.0	3.5	2.8	2.9	3.0	2.8	2.6	3.1
2006-07										
Benefits paid										
Benefits paid	$m	440.9	306.1	291.1	121.9	92.6	27.0	20.8	10.9	1 311.7
Per person	$	64.1	58.9	69.7	58.0	58.5	54.8	61.7	51.3	62.5
Tests										
Number of tests	'000	22 894	16 097	14 358	6 122	4 842	1 487	1 012	557	67 373
Tests per person	no.	3.3	3.1	3.4	2.9	3.1	3.0	3.0	2.6	3.2
2007-08										
Benefits paid										
Benefits paid	$m	447.0	315.9	296.3	122.6	95.2	27.4	21.4	10.8	1 325.8
Per person	$	64.2	59.8	69.3	56.9	59.5	55.0	62.0	49.3	62.1
Tests										
Number of tests	'000	23 860	16 905	14 819	6 550	5 603	1 537	1 086	578	70 361
Tests per person	no.	3.4	3.2	3.5	3.0	3.5	3.1	3.2	2.6	3.3

Table 11A.25 Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), and claimed through Medicare, real benefits paid (2007-08 dollars) and number of tests (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(a) DVA data are included for number of tests and benefits paid on pathology items.

(b) Standard DVA reports do not distinguish between the various providers who request pathology services and do not record numbers of tests but rather paid for items.

(c) In general, Medicare benefits are payable for a maximum of three tests performed on a specimen.

(d) Includes patient episode initiated items.

Source: DoHA (unpublished), derived from the MBS data system and unpublished DVA data.

Table 11A.26 Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs) and claimed through Medicare, real benefits paid (2007-08 dollars) and number of referrals (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04										
Benefits paid										
Benefits paid	$m	356.7	221.9	179.4	89.0	59.9	21.5	14.0	3.9	946.4
Per person	$	53.0	44.6	46.2	44.8	39.1	44.6	43.1	19.4	47.1
Referrals										
Number of referrals	'000	3 322	2 113	1 723	859	601	201	122	42	8 982
Referrals per person	no.	0.49	0.42	0.44	0.43	0.39	0.42	0.38	0.21	0.45
2004-05										
Benefits paid										
Benefits paid	$m	384.0	238.4	197.9	91.9	66.2	21.7	14.6	3.9	1018.7
Per person	$	56.7	47.5	49.9	45.7	42.9	44.7	44.9	19.5	50.1
Referrals										
Number of referrals	'000	3 459	2 186	1 824	855	639	199	120	40	9 322
Referrals per person	no.	0.51	0.44	0.46	0.43	0.41	0.41	0.37	0.20	0.46
2005-06										
Benefits paid										
Benefits paid	$m	391.3	245.7	206.8	95.2	69.3	21.6	14.7	4.2	1048.7
Per person	$	57.3	48.4	51.2	46.6	44.7	44.2	44.7	20.6	51.0
Referrals										
Number of referrals	'000	3 578	2 291	1 945	904	679	202	123	44	9 766
Referrals per person	no.	0.52	0.45	0.48	0.44	0.44	0.41	0.37	0.21	0.47
2006-07										
Benefits paid										
Benefits paid	$m	398.9	248.9	208.2	93.0	69.5	21.5	15.0	4.4	1059.5
Per person	$	57.9	47.8	49.9	44.3	44.1	42.9	44.3	20.6	50.4
Referrals										
Number of referrals	'000	3 739	2 403	2 023	903	702	210	137	46	10 162
Referrals per person	no.	0.54	0.46	0.48	0.44	0.43	0.43	0.40	0.21	0.48
2007-08										
Benefits paid										
Benefits paid	$m	401.7	252.8	212.5	92.2	70.3	22.2	15.3	4.4	1067.1
Per person	$	57.7	47.8	49.7	42.8	43.9	44.7	44.3	20.0	50.0
Referrals										
Number of referrals	'000	3 884	2 517	2 120	920	726	227	142	47	10 537
Referrals per person	no.	0.56	0.48	0.50	0.43	0.45	0.46	0.41	0.21	0.49

Table 11A.26 Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs) and claimed through Medicare, real benefits paid (2007-08 dollars) and number of referrals (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(a) DVA data are included for number of referrals and benefits paid on diagnostic imaging items.

(b) Standard DVA reports do not distinguish between the various providers diagnostic imaging services and do not record numbers of tests but rather items paid for. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

Source: DoHA (unpublished), derived from the MBS data system and unpublished DVA data.

Table 11A.27 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2004)	no.	1 626	1 142	885	386	376	130	72	29	4 646
Standardised whole patient equivalents (SWPE) (b)	no.	4 293 285	3 523 007	2 570 220	1 280 392	1 165 225	364 524	197 215	60 337	13 454 205
Electronic prescribing	no.	1 476	1 061	821	352	348	122	71	21	4 272
Share of PIP practices	%	91.0	93.0	93.0	91.0	93.0	94.0	99.0	72.0	92.0
Use computers to send and/or receive clinical data	no.	1 458	1 048	815	354	343	116	68	24	4 226
Share of PIP practices	%	90.0	92.0	92.0	92.0	91.0	89.0	94.0	83.0	91.0
PIP practices (May 2005)	no.	1 643	1 159	900	379	372	129	72	27	4 681
SWPE (b)	no.	4 341 865	3 541 197	2 579 927	1 273 454	1 160 497	360 017	200 382	56 691	13 514 030
Electronic prescribing	no.	1 502	1 092	852	356	349	123	71	20	4 364
Share of PIP practices	%	91.4	94.2	94.7	93.9	93.8	95.3	98.6	74.0	93.2
Use computers to send and/or receive clinical data	no.	1 488	1 073	841	354	345	117	67	22	4 307
Share of PIP practices	%	90.6	92.7	93.4	93.4	92.7	90.7	93.1	81.5	92.0
PIP practices (May 2006)	no.	1 679	1 163	917	388	362	129	73	34	4 745
SWPE (b)	no.	4 453 192	3 641 533	2 670 235	1 312 886	1 180 202	374 440	211 293	67 116	13 910 897
Electronic prescribing	no.	1 556	1 109	880	370	342	124	73	26	4 480
Share of PIP practices	%	92.7	95.4	96.0	95.4	94.5	96.1	100.0	76.5	94.4
Use computers to send and/or receive clinical data	no.	1 537	1 084	872	367	342	119	68	28	4 417
Share of PIP practices	%	91.5	93.2	95.1	94.6	94.5	92.2	93.2	82.4	93.1

Table 11A.27 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2007) (c)	no.	1 676	1 179	947	394	361	127	78	36	4 798
SWPE (b)	no.	4 468 264	3 761 795	2 752 485	1 356 627	1 200 227	370 994	245 940	68 654	14 224 986
Electronic prescribing	no.	1 347	1 018	829	331	297	110	69	28	4 029
Share of PIP practices	%	80.4	86.3	87.5	84.0	82.3	86.6	88.5	77.8	84.0
Use computers to send and/or receive clinical data	no.	1 299	981	812	302	291	106	64	28	3 883
Share of PIP practices	%	77.5	83.2	85.7	76.7	80.6	83.5	82.1	77.8	80.9
PIP practices (May 2008) (c)	no.	1 676	1 175	954	405	351	126	76	37	4 800
SWPE (b)	no.	4 513 662	3 807 184	2 813 260	1 374 436	1 189 015	373 550	255 778	69 858	14 396 743
Maintain secure electronic patient records	no.	1 427	1 063	870	356	115	115	69	28	4 238
Share of PIP practices	%	85.1	90.5	91.2	87.9	88.3	91.3	90.8	75.7	88.3
Use mainly secure electronic patient records	no.	1 373	1 031	857	334	302	112	64	28	4 101
Share of PIP practices	%	81.9	87.7	89.8	82.5	86.0	88.9	84.2	75.7	85.4

(a) Not all practices are involved in PIP, and the proportion may vary across jurisdictions.

(b) A standardised whole patient equivalent (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.

(c) In November 2006, the PIP incentives to encourage the computerisation of practices changed. 2007 and 2008 data are reported for the new incentives.

Source: DoHA (unpublished), derived from MBS and PIP data systems.

Table 11A.28 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b)

	Unit	Capital city	Other metro centre	Large rural centre	Small rural centre	Other rural	Remote centre	Other remote	Aust
PIP practices (May 2008)	no.	2 970	361	320	316	674	55	104	4 800
SWPE (c)	no.	8 991 044	1 173 637	1 047 947	1 178 838	1 768 797	124 560	111 920	14 396 743
Electronic prescribing									
Share of PIP practices (May 2004)	%	91	92	95	97	95	89	89	92
Share of PIP practices (May 2005)	%	92	93	97	97	95	87	93	93
Share of PIP practices (May 2006)	%	94	95	97	97	96	88	92	94
Maintain secure electronic patient records (d)									
Share of PIP practices (May 2007)	%	83	85	87	86	89	75	69	84
Share of PIP practices (May 2008)	%	87	89	91	91	93	82	79	88
Use of computers to send and/or receive clinical data									
Share of PIP practices (May 2004)	%	90	90	94	94	92	89	84	91
Share of PIP practices (May 2005)	%	92	91	96	95	93	89	85	92
Share of PIP practices (May 2006)	%	93	93	96	95	94	89	89	93
Use mainly secure electronic patient records (d)									
Share of PIP practices (May 2007)	%	79	84	85	85	86	75	68	81
Share of PIP practices (May 2008)	%	84	88	88	89	90	82	79	85

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

(b) Not all practices are involved in PIP, and the proportion may vary across jurisdictions.

(c) 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.

(d) In November 2006, the PIP incentives to encourage the computerisation of practices changed. The 2007 and data reported here are for the new incentives.

Source: DoHA (unpublished), derived from MBS and PIP data systems.

Table 11A.29 **Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent) (a), (b), (c)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
2003-04	93.7	93.0	90.0	86.7	83.8	71.2	68.3	91.4
2004-05	93.4	91.7	89.7	85.3	83.4	71.4	67.2	91.0
2005-06	93.1	90.3	90.7	84.2	83.1	68.2	72.9	90.6
2006-07	92.9	90.0	90.3	83.5	83.3	71.3	68.8	90.4
2007-08	92.7	89.9	87.6	82.2	83.1	71.0	65.5	90.0

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

(b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(c) FWE numbers were based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.30 Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
FWE GPs with vocational registration										
2003-04	no.	5 595	3 738	2 882	1 338	1 261	344	189	81	15 428
2004-05	no.	5 774	3 789	2 933	1 335	1 262	348	191	81	15 714
2005-06	no.	5 858	3 870	3 004	1 346	1 289	353	199	79	15 997
2006-07	no.	6 007	3 987	3 051	1 362	1 301	356	215	80	16 359
2007-08	no.	6 098	4 131	3 125	1 395	1 322	370	223	82	16 745
Proportion of FWE GPs with vocational registration										
2003-04	%	92.9	91.0	88.4	92.2	92.7	92.2	95.5	82.7	91.4
2004-05	%	92.8	90.9	86.6	91.7	92.6	92.1	95.5	84.4	91.0
2005-06	%	92.8	90.4	86.1	91.4	91.8	91.4	95.9	81.8	90.6
2006-07	%	92.7	90.5	85.6	90.8	91.8	91.0	95.2	76.9	90.4
2007-08	%	92.4	90.1	84.9	90.5	90.9	92.1	95.9	70.5	90.0

(a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(b) FWE numbers were based on doctors' practice location postcodes at which services were rendered within the reference period.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.31 General practices that are accredited at 30 June (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007										
Accredited										
AGPAL	no.	1 425	993	820	344	365	125	52	36	4 160
GPA Accreditation *plus*	no.	256	191	118	62	28	5	14	1	675
Total	**no.**	**1 681**	**1 184**	**938**	**406**	**393**	**130**	**66**	**37**	**4 835**
General practices	no.	2 829	1 707	1 278	591	564	172	94	126	7 361
Proportion accredited	%	59.4	69.4	73.4	68.7	69.7	75.6	70.2	29.4	65.7
Registered for accreditation (c)										
AGPAL	no.	1 533	1 029	883	372	384	130	54	43	4 428
GPA Accreditation *plus*	no.	274	210	135	82	35	6	15	3	760
2008										
Accredited										
AGPAL	no.	1 372	936	795	329	339	113	47	37	3 968
GPA Accreditation *plus*	no.	267	212	148	73	36	10	23	3	772
Total	**no.**	**1 639**	**1 148**	**943**	**402**	**375**	**123**	**70**	**40**	**4 740**
General practices (b)	no.	2 782	1 687	1 278	569	567	167	92	119	7 261
Proportion accredited	%	58.9	68.0	73.8	70.7	66.1	73.7	76.1	33.6	65.3
Registered for accreditation (c)										
AGPAL	no.	1 471	972	858	356	357	121	49	47	4 231
GPA Accreditation *plus*	no.	278	228	163	77	37	10	23	3	819

(a) Includes practices accredited by either of Australia's two accrediting bodies. Data from General Practice Australia Accreditation *plus* (GPA Accreditation *plus)* were reported for the first time in the 2008 Report.

Table 11A.31 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(b) Preliminary data for the total number of practices, collected by the Primary Health Care Research and Information Service (PHC RIS) for the 2007-08 Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June 2008". Data were provided by all Divisions of General Practice as required under contractual agreements with DoHA. Where Division amalgamations or liquidations have occurred, the practices in these catchments areas have been accounted for in the data to provide the most accurate estimate possible. Practices counted by location. Numbers of practices may vary between collection agencies depending on how a general practice is defined.

(c) Includes practices registered for accreditation but not yet accredited, in addition to accredited practices.

Source: Australian General Practice Accreditation Limited (AGPAL) (unpublished); GPA Accreditation *plus* (unpublished); PHC RIS, DoHA (unpublished), derived from the ASD (various years).

Table 11A.32 **General practice activity in PIP practices (per cent)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Proportion of SWPEs that are in PIP practices (a)										
2003-04	%	75.8	83.3	79.8	80.3	84.8	88.3	76.4	51.3	79.7
2004-05	%	76.6	83.9	79.9	80.7	84.3	86.9	80.7	56.5	80.2
2005-06	%	77.2	84.3	80.1	82.2	85.2	88.5	83.4	55.1	80.9
2006-07	%	77.4	84.4	81.3	82.2	85.4	86.0	84.6	53.6	81.2
Proportion of services provided by PIP practices (b)										
2003-04	%	73.3	81.2	79.3	79.5	83.9	87.4	75.3	51.7	78.0
2004-05	%	74.2	82.0	80.0	80.1	83.4	86.5	79.6	58.0	78.7
2005-06	%	75.2	82.7	80.2	81.7	84.8	88.4	82.7	56.6	79.6
2006-07	%	75.6	83.0	81.6	82.0	85.2	86.0	84.4	55.0	80.1

(a) 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.

(b) Services may vary in type and quality.

Source: DoHA (unpublished), derived from PIP and MBS data systems.

Table 11A.33 GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2003-04										
GPs using EPC items	no.	2 557	1 806	1 262	620	553	197	82	32	7 109
Total GPs	no.	5 846	4 343	3 281	1 622	1 461	468	253	117	17 391
GPs using EPC items	%	43.7	41.6	38.5	38.2	37.9	42.1	32.4	27.4	40.9
2004-05										
GPs using EPC items	no.	4 261	2 928	2 142	1 061	872	288	134	52	11 738
Total GPs	no.	5 946	4 387	3 403	1 644	1 478	472	255	107	17 692
GPs using EPC items	%	71.7	66.7	62.9	64.5	59.0	61.0	52.5	48.6	66.3
2005-06										
GPs using EPC items	no.	5 209	3 811	2 805	1 355	1 173	365	185	76	14 979
Total GPs	no.	6 056	4 509	3 521	1 669	1 514	476	268	110	18 123
GPs using EPC items	%	86.0	84.5	79.7	81.2	77.5	76.7	69.0	69.1	82.7
2006-07										
GPs using EPC items	no.	5 696	4 210	3 113	1 509	1 347	406	222	91	16 594
Total GPs	no.	6 171	4 599	3 601	1 698	1 552	474	278	114	18 487
GPs using EPC items	%	92.3	91.5	86.4	88.9	86.8	85.7	79.9	79.8	89.8
2007-08										
GPs using EPC items	no.	6 024	4 497	3 370	1 613	1 462	435	235	100	17 736
Total GPs	no.	6 303	4 763	3 739	1 744	1 610	486	282	116	19 043
GPs using EPC items	%	95.6	94.4	90.1	92.5	90.8	89.5	83.3	86.2	93.1

(a) The chronic disease management items include GP only care plans, multidisciplinary care plans (A15 subgroup 1) and case conferences (A15 subgroup 2, excluding items relating to consultant physician and psychiatrists). Services that qualify under the DVA National Treatment Account or services provided in public hospitals are not included.

(b) The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare initiative on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

(c) GPs are defined as those General Practitioners and Other Medical Practitioners who have claimed at least 1500 non-referred attendances in the relevant financial year. GPs are counted only in the state/territory where they claimed the most services - this prevents double counting.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.34 **Annual voluntary health assessments for older people (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04										
Older people assessed	no.	71 748	50 654	36 142	12 722	20 170	5 363	1 544	234	198 577
Older people	no.	400 419	287 538	199 193	97 759	104 187	29 850	12 524	6 288	1 137 812
Proportion assessed	%	17.9	17.6	18.1	13.0	19.4	18.0	12.3	3.7	17.5
2004-05										
Older people assessed	no.	81 442	53 349	40 165	13 778	21 553	5 859	1 431	354	217 931
Older people	no.	410 394	295 306	205 170	101 029	106 348	30 524	12 936	6 506	1 168 271
Proportion assessed	%	19.8	18.1	19.6	13.6	20.3	19.2	11.1	5.4	18.7
2005-06										
Older people assessed	no.	89 784	58 841	48 020	15 824	22 393	6 689	1 825	461	243 837
Older people	no.	421 961	303 532	212 939	104 851	107 957	31 263	13 401	6 892	1 202 857
Proportion assessed	%	21.3	19.4	22.6	15.1	20.7	21.4	13.6	6.7	20.3
2006-07										
Older people assessed	no.	97 823	64 954	52 133	18 260	24 922	7 918	1 769	807	268 586
Older people	no.	417 381	304 347	219 160	106 964	108 901	31 885	13 593	6 889	1 209 175
Proportion assessed	%	23.4	21.3	23.8	17.1	22.9	24.8	13.0	11.7	22.2
2007-08										
Older people assessed	no.	104 953	66 629	57 576	19 486	26 797	8 290	2 338	998	287 067
Older people	no.	426 052	312 277	223 264	110 204	110 519	32 268	14 045	7 224	1 235 916
Proportion assessed	%	24.6	21.3	25.8	17.7	24.2	25.7	16.6	13.8	23.2

(a) Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding people living in residential aged care facilities.

(b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.

Source: DoHA (unpublished), derived from the MBS data system.

Table 11A.35 Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2008 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Unknown	Aust
Valid vaccinations provided											
Divisions of General Practice	no.	24	144	3	15	283	na	na	13	na	482
GPs	no.	13 048 870	6 416 760	7 909 542	2 922 508	2 302 969	929 053	323 016	26 488	na	33 879 206
Council	no.	906 401	5 539 647	685 230	304 157	616 773	134 590	na	na	na	8 186 798
State or territory health department	no.	3	na	984	278 087	2 784	717	164 354	2 269	na	449 198
Flying doctor service	no.	3 671	na	30 124	8	3 903	na	na	na	na	37 706
Public hospital	no.	326 714	59 372	288 999	245 219	93 415	1 770	6 324	58 064	3 641	1 083 518
Private hospital	no.	14 528	98	1 693	70	na	105	39	7 194	na	23 727
Aboriginal health service	no.	74 286	14 803	66 529	28 341	15 255	4	1 491	72 006	na	272 715
Aboriginal health worker	no.	5 285	na	44 737	na	1 593	na	na	1 808	na	53 423
Community health centre	no.	1 146 974	90 873	548 876	804 172	312 882	6 318	294 134	604 478	1 899	3 810 606
Community nurse	no.	na	383	na	na	na	na	72	na	na	455
Total	**no.**	**15 526 756**	**12 122 080**	**9 576 717**	**4 582 577**	**3 349 857**	**1 072 557**	**789 430**	**772 320**	**5 540**	**47 797 834**
Proportion of total valid vaccinations											
Divisions of General Practice	%	–	–	–	–	–	na	na	–	na	–
GPs	%	84.0	52.9	82.6	63.8	68.8	86.6	40.9	3.4	na	70.9
Council	%	5.8	45.7	7.2	6.6	18.4	12.6	na	na	na	17.1
State or territory health department	%	–	na	–	6.1	0.1	0.1	20.8	0.3	na	0.9
Flying doctor service	%	–	na	0.3	–	0.1	na	na	na	na	0.1
Public hospital	%	2.1	0.5	3.0	5.4	2.8	0.2	0.8	7.5	66	2.3
Private hospital	%	0.1	–	–	–	na	–	–	0.9	na	0.1
Aboriginal health service	%	0.5	0.1	0.7	0.6	0.5	–	0.2	9.3	na	0.6

Table 11A.35 Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2008 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Aboriginal health worker	%	–	na	0.5	na	0.1	na	na	0.2	na	0.1
Community health centre	%	7.4	0.8	5.7	17.6	9.3	0.6	37.3	78.3	34	8.0
Community nurse	%	na	–	na	na	na	na	–	na	na	–
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) 1 January 1996 to 30 June 2007.

(b) Totals may not add as a result of rounding.

(c) Data reported by the State or Territory in which the immunisation provider is located.

na Not available. – Nil or rounded to zero.

Source: DoHA (unpublished), derived from the Australian Childhood Immunisation Register (ACIR).

Table 11A.36 Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fully immunised (e)									
30 June 2004	91.0	91.7	91.6	89.3	91.4	93.4	90.8	85.2	90.9
30 June 2005	90.6	91.8	90.8	90.0	91.1	91.2	95.7	91.9	91.0
30 June 2006	90.1	91.8	90.8	89.1	91.0	93.8	90.7	90.6	90.7
30 June 2007	91.5	91.8	90.9	88.9	90.5	91.4	94.3	91.1	91.2
30 June 2008	91.3	91.8	90.8	90.1	91.0	91.0	93.5	91.6	91.2
Immunised against (at 30 June 2008)									
Diphtheria, tetanus and pertussis	91.6	92.8	91.6	90.5	91.8	91.4	93.7	92.4	91.8
Polio	91.5	92.8	91.6	90.5	91.8	91.3	93.8	92.3	91.8
Haemophilus influenzae type b	94.7	94.8	93.9	94.2	94.3	94.0	95.8	95.6	94.5

(a) Coverage measured at 30 June for children turning 12 months of age by 31 March, by the 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 (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.

(d) NT immunisation records differ from ACIR records. This may stem from delays in notifications reaching and being processed by the Health Insurance Commission (HIC), or because the cohort method of reporting immunisation coverage does not allow for assessment of 'catch up' immunisation occurring after the assessment age of 12 months. Average delay times were greatest in the NT (Hull and McIntyre 2000).

(e) Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b and *Haemophilus influenzae* type b.

Source: DoHA (unpublished), derived from the Australian Childhood Immunisation Register (ACIR).

Table 11A.37 Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fully immunised (e)									
30 June 2004	90.4	92.3	91.8	90.6	92.7	94.9	90.0	94.5	91.7
30 June 2005	91.2	92.9	91.6	90.0	92.1	94.6	91.6	93.6	91.8
30 June 2006	91.7	93.5	92.2	91.3	92.2	93.6	94.2	94.4	92.4
30 June 2007	92.3	93.8	92.2	90.6	93.0	95.1	91.9	92.5	92.5
30 June 2008	92.5	93.6	92.6	91.2	93.3	93.4	94.8	94.7	92.8
Immunised against (at 30 June 2008)									
Diphtheria, tetanus and pertussis	94.9	95.9	94.9	93.8	95.4	95.1	96.7	96.1	95.1
Polio	94.8	95.8	94.8	93.7	95.3	95.1	96.6	96.1	95.0
Haemophilus influenzae type b	95.4	94.6	93.9	93.6	94.4	95.4	96.6	95.4	94.6
Measles, mumps and rubella	93.7	95.0	94.0	92.9	94.7	94.5	95.5	96.4	94.2

(a) Coverage measured at 30 June for children turning 24 months of age by 31 March, by the State or Territory in which the child was located.

(b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.

(d) NT immunisation records differ from ACIR records. This may stem from delays in notifications reaching and being processed by the HIC, or because the cohort method of reporting immunisation coverage does not allow for assessment of 'catch up' immunisation occurring after the assessment age of 12 months. Average delay times were greatest in the NT (Hull and McIntyre 2000).

(e) 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.

Source: DoHA (unpublished), derived from the Australian Childhood Immunisation Register (ACIR).

Table 11A.38 **Notifications of measles, children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
1996	no.	161	69	47	23	8	18	9	17	352
1997	no.	196	74	160	69	20	35	19	4	577
1998	no.	104	27	27	43	3	35	6	–	245
1999	no.	22	33	21	10	2	10	4	19	121
2000	no.	21	7	11	3	3	1	–	–	46
2001	no.	15	17	5	1	1	2	–	–	41
2002	no.	4	1	5	–	–	–	–	–	10
2003	no.	7	10	4	–	5	–	–	1	27
2004	no.	3	1	–	2	1	–	–	–	7
2005	no.	1	–	1	–	–	–	–	–	2
2006	no.	35	3	2	18	3	7	–	–	68
2007	no.	4	2	4	1	1	–	–	–	12
2008 (c)	no.	18	1	5	–	–	–	–	2	26
Notifications per 100 000 children (0–14 years)										
1996	per 100 000 children	12.3	7.3	6.4	5.9	2.7	17.0	13.3	34.5	9.0
1997	per 100 000 children	14.8	7.8	21.5	17.4	6.7	33.5	27.9	8.0	14.7
1998	per 100 000 children	7.8	2.8	3.6	10.8	1.0	34.2	8.9	–	6.2
1999	per 100 000 children	1.7	3.5	2.8	2.5	0.7	9.9	6.1	37.6	3.1
2000	per 100 000 children	1.6	0.7	1.4	0.7	1.0	1.0	–	–	1.2
2001	per 100 000 children	1.1	1.8	0.6	0.2	0.3	2.0	–	–	1.0
2002	per 100 000 children	0.3	0.1	0.6	–	–	–	–	–	0.3
2003	per 100 000 children	0.5	1.0	0.5	–	1.7	–	–	2.0	0.7
2004	per 100 000 children	0.2	0.1	–	0.5	0.3	–	–	–	0.2

Table 11A.38 **Notifications of measles, children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	per 100 000 children	0.1	–	0.1	–	–	–	–	–	0.1
2006	per 100 000 children	2.7	0.3	0.2	4.5	1.1	7.3	–	–	1.7
2007	per 100 000 children	0.3	0.2	0.5	0.2	–	–	–	–	0.3
2008 (c)	per 100 000 children	1.4	0.1	0.6	–	–	–	–	4.0	0.7

(a) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(b) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(c) Notifications are to 31 August.

– Nil or rounded to zero.

Source: DoHA (unpublished), derived from the National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0.

Table 11A.39 Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Notifications										
1996	no.	498	651	365	113	318	7	17	8	1 977
1997	no.	2 309	799	1 194	831	920	40	44	17	6 154
1998	no.	1 092	476	678	194	293	14	34	9	2 790
1999	no.	409	371	253	53	117	278	27	2	1 510
2000	no.	1 549	309	217	49	217	40	103	5	2 489
2001	no.	1 807	292	726	121	806	27	28	97	3 904
2002	no.	728	281	711	121	126	9	18	20	2 014
2003	no.	954	182	215	124	31	40	139	1	1 686
2004	no.	777	214	238	843	152	2	17	11	2 254
2005	no.	496	129	343	129	99	5	28	26	1 255
2006	no.	332	46	181	51	53	7	14	3	687
2007	no.	2 089	1 050	1 535	132	376	24	95	27	5 328
2008 (c)	no.	655	119	75	34	21	11	4	110	1 029
Notifications per 100 000 children (0–14 years)										
1996	per 100 000 children	38.0	68.7	49.6	28.8	106.2	6.6	25.1	16.2	50.5
1997	per 100 000 children	174.7	84.1	160.8	209.9	307.9	38.3	64.6	33.9	156.5
1998	per 100 000 children	82.2	49.9	90.6	48.7	98.4	13.7	50.5	17.8	70.7
1999	per 100 000 children	30.8	38.9	33.6	13.3	39.5	274.7	41.0	4.0	38.2
2000	per 100 000 children	116.0	32.3	28.5	12.2	73.8	40.1	157.1	9.9	62.8
2001	per 100 000 children	134.4	30.4	94.0	30.1	276.3	27.3	42.8	189.5	98.1
2002	per 100 000 children	54.4	29.3	91.0	30.3	43.5	9.2	27.7	39.4	50.6
2003	per 100 000 children	71.5	19.0	27.2	31.1	10.8	41.1	217.7	2.0	38.8
2004	per 100 000 children	58.6	22.3	29.8	210.9	53.2	2.1	26.9	21.8	55.9

Table 11A.39 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	per 100 000 children	37.6	13.5	42.5	32.3	34.9	5.2	44.8	51.5	30.2
2006	per 100 000 children	25.4	4.8	22.2	12.6	18.7	7.3	22.4	5.9	16.8
2007	per 100 000 children	278.5	107.0	181.7	31.7	130.8	24.9	150.1	52.2	130.7
2008 (c)	per 100 000 children	49.6	12.4	9.3	8.5	7.4	11.4	6.4	217.8	25.9

(a) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(b) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(c) Notifications are to 31 August.

Source: DoHA (unpublished), derived from the National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0.

Table 11A.40 **Notifications of *Haemophilus influenzae* type b, children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
		no.	no.	no.	no.	no.	no.	no.	no.	no.
Notifications										
1996	no.	10	8	8	1	6	1	2	3	39
1997	no.	11	7	12	3	2	2	–	3	40
1998	no.	11	2	6	5	1	2	–	–	27
1999	no.	8	4	5	1	3	–	1	2	24
2000	no.	4	2	7	–	1	–	–	–	14
2001	no.	6	2	2	1	2	–	–	3	16
2002	no.	5	1	1	6	2	–	–	2	17
2003	no.	4	1	3	1	1	–	–	2	12
2004	no.	2	1	3	–	2	–	–	2	10
2005	no.	4	2	2	–	–	–	–	1	9
2006	no.	4	2	7	–	–	–	–	–	13
2007	no.	7	2	3	2	1	–	–	2	17
2008 (c)	no.	4	–	1	–	–	–	–	–	5
Notifications per 100 000 children (0–14 years)										
1996	per 100 000 children	0.8	0.8	1.1	0.3	2.0	0.9	2.9	6.1	1.0
1997	per 100 000 children	0.8	0.7	1.6	0.8	0.7	1.9	–	6.0	1.0
1998	per 100 000 children	0.8	0.2	0.8	1.3	0.3	2.0	–	–	0.7
1999	per 100 000 children	0.6	0.4	0.7	0.3	1.0	–	1.5	4.0	0.6
2000	per 100 000 children	0.3	0.2	0.9	–	0.3	–	–	–	0.4
2001	per 100 000 children	0.4	0.2	0.3	0.2	0.7	–	–	5.9	0.4
2002	per 100 000 children	0.4	0.1	0.1	1.5	0.7	–	–	3.9	0.4
2003	per 100 000 children	0.3	0.1	0.4	0.3	0.3	–	–	4.0	0.3
2004	per 100 000 children	0.2	0.1	0.4	–	0.7	–	–	4.0	0.2

Table 11A.40 **Notifications of *Haemophilus influenzae* type b, children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	per 100 000 children	0.3	0.2	0.2	–	–	–	–	2.0	0.2
2006	per 100 000 children	0.3	0.2	0.9	–	–	–	–	–	0.3
2007	per 100 000 children	0.5	0.2	0.4	0.5	0.3	–	–	–	0.4
2008 (c)	per 100 000 children	0.3	–	0.1	–	–	–	–	–	0.1

(a) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(b) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(c) Notifications are to 31 August.

– Nil or rounded to zero.

Source: DoHA (unpublished), derived from the National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0.

Table 11A.41 Participation rates of women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d)

Age group (years)	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2002 and 2003									
20–24	45.3	49.8	49.9	51.7	52.9	59.3	49.5	59.4	49.0
25–29	56.7	61.3	57.2	60.2	63.1	63.7	59.0	61.6	59.0
30–34	62.2	65.8	59.9	64.1	67.4	66.0	65.4	61.3	63.4
35–39	62.7	66.9	59.9	64.5	68.1	65.7	64.6	62.5	63.9
40–44	62.8	67.3	60.2	64.4	68.1	65.7	65.2	60.6	64.1
45–49	64.2	69.8	61.1	64.8	70.1	65.5	66.7	63.5	65.6
50–54	61.6	68.0	58.5	61.6	67.2	63.1	65.8	61.1	63.1
55–59	64.3	72.6	60.4	63.1	70.9	66.7	71.1	65.6	66.2
60–64	54.2	62.0	51.2	54.0	62.7	56.3	63.4	51.2	56.4
65–69	45.9	54.2	44.9	47.3	54.3	49.1	53.6	44.5	48.8
70–74	17.0	17.8	21.7	17.9	19.9	14.1	16.8	26.9	18.3
75–79	6.6	6.6	9.1	6.6	8.0	5.1	4.9	10.8	7.1
80–84 (e)	2.0	2.2	3.0	2.0	2.2	1.7	1.9	4.2	2.2
Ages 20–84 years (f)	52.8	57.4	52.5	55.5	57.4	55.9	58.1	59.7	54.7
ASR	52.6	57.4	51.5	54.2	58.3	56.1	55.9	54.5	54.3
Ages 20–69 years	58.8	64.0	57.3	60.8	65.0	63.2	62.2	61.0	60.6
ASR	58.8	64.2	57.2	60.6	65.1	63.1	62.7	60.2	60.7
2003 and 2004									
20–24	44.0	48.5	48.9	50.4	51.8	57.2	48.9	58.6	47.8
25–29	55.6	60.3	56.7	58.8	62.7	62.4	59.4	60.9	58.1
30–34	61.1	65.8	59.9	63.2	66.7	64.6	65.9	59.9	62.8
35–39	62.2	67.3	60.2	63.5	68.0	64.6	65.5	62.4	63.8
40–44	62.7	68.4	61.0	63.2	68.4	63.7	66.0	60.8	64.3
45–49	64.0	70.7	62.2	64.4	70.2	65.9	66.9	62.4	65.9
50–54	62.0	69.7	59.8	61.2	68.5	62.8	66.8	61.5	64.0
55–59	64.1	73.7	62.0	63.0	70.9	65.8	68.2	64.5	66.6
60–64	54.3	64.0	53.0	53.7	63.3	55.3	61.8	50.9	57.2
65–69	45.9	56.0	46.3	47.4	55.0	48.1	52.8	46.1	49.6
70–74	16.1	16.3	20.9	16.8	19.3	13.2	17.6	22.0	17.3
75–79	5.8	5.4	8.5	5.9	7.6	4.6	5.2	10.5	6.3
80–84 (e)	1.7	1.7	2.7	2.0	2.0	1.5	1.9	3.6	1.9
Ages 20–84 years (f)	52.1	57.6	52.8	54.6	57.2	54.9	58.1	58.9	54.5
ASR	52.1	57.7	51.9	53.4	58.2	55.1	56.0	53.8	54.2
Ages 20–69 years	58.2	64.4	57.7	59.9	65.0	62.0	62.3	60.4	60.5
ASR	58.4	64.8	57.7	59.8	65.1	62.0	62.7	59.7	60.7

Table 11A.41 **Participation rates of women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d)**

Age group (years)	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004 and 2005									
20–24	43.4	48.5	49.1	51.3	50.3	57.5	51.6	57.6	47.7
25–29	55.0	60.2	56.8	58.4	60.8	64.6	61.9	60.6	57.8
30–34	60.9	66.4	60.4	63.2	65.8	64.6	68.0	58.9	62.9
35–39	62.5	68.4	61.0	64.5	67.1	65.8	68.9	60.8	64.4
40–44	62.8	69.4	61.6	64.0	67.4	65.3	67.7	59.0	64.8
45–49	64.0	71.8	63.4	65.4	69.4	66.1	69.1	61.1	66.5
50–54	62.3	70.4	61.4	62.3	68.0	64.5	68.2	60.7	64.7
55–59	63.9	73.8	62.8	64.6	70.1	66.5	74.8	62.1	66.9
60–64	54.3	64.9	54.3	54.1	62.0	56.4	65.3	50.8	57.7
65–69	45.6	56.2	46.3	48.4	55.8	47.1	56.1	44.2	49.7
70–74	15.6	16.4	27.3	16.1	19.9	13.0	17.3	14.8	17.0
75–79	5.5	5.0	10.5	5.3	7.7	4.4	5.8	9.5	5.9
80–84 (e)	1.6	1.6	3.2	2.0	1.9	1.2	1.7	3.0	1.8
Ages 20–84 years (f)	51.9	58.1	54.9	55.1	56.3	55.6	60.4	57.7	54.6
ASR	52.0	58.2	52.9	54.0	57.4	55.8	58.4	52.4	54.4
Ages 20–69 years	58.1	65.0	58.4	60.6	64.0	62.9	65.0	59.2	60.8
ASR	58.2	65.4	58.4	60.5	64.1	62.9	65.5	58.5	61.0
2005 and 2006									
20–24	43.1	47.1	48.1	51.3	50.8	56.7	48.7	50.3	47.0
25–29	53.9	57.8	55.5	57.9	60.4	61.5	58.0	53.9	56.3
30–34	61.1	64.3	59.3	62.8	65.8	64.2	64.0	55.8	62.1
35–39	62.7	66.6	60.2	64.2	67.1	64.8	66.5	56.7	63.7
40–44	62.6	67.6	60.5	64.1	67.5	65.3	66.9	56.7	64.0
45–49	64.6	70.8	62.8	65.4	69.6	65.8	67.6	57.9	66.3
50–54	63.3	70.3	60.6	62.7	68.6	65.3	68.5	56.6	64.9
55–59	65.6	74.4	62.6	65.4	72.2	66.7	73.9	58.3	67.8
60–64	55.9	64.8	54.1	54.4	62.5	56.5	65.4	48.1	58.2
65–69	47.6	57.8	46.9	49.5	56.5	48.7	58.8	43.2	51.1
70–74	15.6	16.1	19.4	16.2	20.1	12.8	18.6	13.7	16.8
75–79	5.4	4.6	6.7	5.3	7.6	3.9	6.0	8.1	5.6
80–84 (e)	1.4	1.5	2.0	1.9	2.1	1.0	1.4	2.5	1.6
Ages 20–84 years (f)	52.2	57.1	52.6	55.2	56.7	55.1	58.7	53.5	54.3
ASR	52.3	57.2	51.7	54.0	57.7	55.4	57.0	48.8	54.1
Ages 20–69 years	58.4	63.8	57.6	60.6	64.3	62.4	63.0	54.9	60.4
ASR	58.7	64.3	57.7	60.5	64.5	62.4	63.8	54.5	60.6

Table 11A.41 Participation rates of women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d)

Age group (years)	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006 and 2007									
20–24	44.7	47.3	50.3	52.0	50.3	54.3	51.0	51.2	48.0
25–29	55.9	57.9	57.7	59.1	60.3	59.9	58.7	53.9	57.5
30–34	62.2	63.8	60.6	62.3	64.6	62.3	63.9	54.4	62.4
35–39	64.1	66.6	61.7	63.5	66.3	63.1	65.9	55.5	64.3
40–44	64.0	67.6	61.7	63.2	66.8	63.4	65.8	55.0	64.5
45–49	66.9	71.5	64.4	65.3	69.4	65.1	67.3	57.3	67.5
50–54	65.0	70.6	62.0	62.5	68.4	63.8	67.8	54.3	65.7
55–59	67.9	75.0	64.7	65.5	71.9	66.3	74.3	57.9	69.1
60–64	58.1	65.2	55.4	54.6	62.7	56.6	64.8	47.8	59.4
65–69	49.1	57.9	48.0	48.3	56.5	49.5	57.9	42.3	51.7
70–74	16.0	15.9	18.8	16.0	20.5	12.4	16.4	14.6	16.7
75–79	5.2	4.4	6.2	5.0	7.3	3.6	4.4	6.4	5.3
80–84 (e)	1.3	1.4	1.9	1.7	2.1	0.9	0.9	2.2	1.5
Ages 20–84 years (f)	53.6	57.1	53.9	55.0	56.2	53.8	58.6	52.6	55.0
ASR	53.8	57.3	53.1	53.9	57.3	54.2	56.8	48.0	54.8
Ages 20–69 years	60.0	63.9	59.2	60.4	63.8	61.1	63.0	54.1	61.1
ASR	60.4	64.4	59.3	60.4	64.0	61.1	63.8	53.7	61.5

ASR = age standardised rate.

(a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population. Age-standardised rates are age-standardised to the Australian population at 30 June 2001.

(b) The eligible female population has been adjusted for the estimated proportion of women who have had a hysterectomy, using national hysterectomy fractions calculated using national data dereived from the Australian Bureau of Statistics 2001 National Health Survey.

(c) Excludes women who have opted off the cervical cytology register.

(d) With the exception of Victoria and the Australian Capital Territory, number of women screened includes all women screened in each jurisdiction, not just those women resident in each jurisdiction.

(e) The 80–84 years age group includes all women aged 80 years and over.

(f) The 20–84 years age group includes all women aged 20 years and over.

Source: AIHW (2007), *Cervical screening in Australia 2004-2005,* Cat. no. CAN 33, AIHW, Canberra; AIHW (unpublished), derived from the Cervical Cytology Registry.

Table 11A.42 Influenza vaccination coverage, people aged 65 years or over (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003										
People vaccinated	no.	663 100	499 300	327 700	171 800	186 200	51 600	23 200	5 400	1 928 300
Target population	no.	869 000	642 300	448 400	219 100	225 000	67 300	28 700	8 000	2 507 900
People vaccinated	%	76.3	77.7	73.1	78.4	82.8	76.7	80.7	68.1	76.9
2004										
People vaccinated	no.	715 500	541 200	352 500	181 100	187 800	53 200	24 200	5 900	2 061 500
Target population	no.	907 300	663 600	465 200	230 100	230 800	68 800	30 200	8 800	2 604 800
People vaccinated	%	78.9	81.6	75.8	78.7	81.4	77.3	80.0	67.5	79.1
2006										
People vaccinated	no.	709 800	564 600	364 100	193 700	199 800	57 300	25 100	6 200	2 120 500
Target population	no.	945 100	693 200	498 200	246 000	238 200	72 300	32 200	9 800	2 735 100
People vaccinated	%	75.1	81.4	73.1	78.7	83.9	79.2	77.8	63.3	77.5

(a) The Adult Vaccination Survey was not conducted in 2005.

Source: AIHW 2004, 2005, *Influenza Vaccine Survey: Summary Results*, Cat. no. PHE 51, PHE 56; DoHA (unpublished), derived from the 2006 Adult Vaccination Survey.

Table 11A.43 **Separations for selected vaccine preventable conditions, 2006-07 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Vaccine preventable conditions per 1000 people										
Influenza and Pneumonia	0.5	0.4	0.5	0.4	0.4	0.4	0.4	1.3	0.4	0.4
Other vaccine preventable conditions	0.1	0.2	0.1	0.1	0.1	0.0	0.1	0.7	0.2	0.2
Total	**0.6**	**0.6**	**0.6**	**0.5**	**0.5**	**0.5**	**0.4**	**2.0**	**0.6**	**0.6**
Vaccine preventable conditions per 1000 Indigenous people (f)										
Influenza and Pneumonia	1.1	0.9	1.3	2.9	2.1	np	np	4.8	2.0	np
Other vaccine preventable conditions	0.4	0.4	0.4	0.3	1.0	np	np	2.4	0.7	np
Total (g)	**1.5**	**1.3**	**1.8**	**3.2**	**3.2**	**np**	**np**	**7.2**	**2.7**	**np**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2008 *Australian hospital statistics 2006-07*.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence.

(e) NT data for Indigenous people are for public hospitals only.

(f) Data are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the five states and territory are not necessarily representative of the other jurisdictions.

(g) Total comprises only those jurisdictions referred to in note (f).

np Not published.

Source: AIHW (2008), *Australian hospital statistics 2006-07*; AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.44 **Separations for selected potentially preventable acute conditions, 2006-07 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Acute conditions per 1000 people										
Appendicitis with generalised peritonitis	0.2	0.2	0.1	0.2	0.2	0.1	0.2	0.2	0.2	0.2
Cellulitis	1.6	1.6	1.7	1.4	1.6	1.4	1.4	4.5	1.6	1.6
Convulsions and epilepsy	1.7	1.5	1.6	1.4	1.6	1.6	1.3	3.3	1.6	1.6
Dehydration and gastroenteritis	2.2	3.1	2.4	2.2	2.7	2.1	1.8	2.1	2.5	2.5
Dental conditions	2.3	2.8	2.7	3.5	3.1	1.8	1.6	2	2.7	2.7
Ear, nose and throat infections	1.6	1.4	1.6	1.5	2.4	1.3	1.2	2.3	1.6	1.6
Gangrene	0.1	0.3	0.2	0.2	0.2	0.2	0.1	0.7	0.2	0.2
Pelvic inflammatory disease	0.2	0.3	0.3	0.2	0.2	0.2	0.3	0.5	0.3	0.3
Perforated/bleeding ulcer	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.2
Pyelonephritis (f)	2.1	2.4	2.2	2.1	2	1.6	2.2	3.6	2.2	2.2
Total	**12.3**	**13.7**	**13**	**13.1**	**14.3**	**10.4**	**10.4**	**19.5**	**13**	**13**
Acute conditions per 1000 Indigenous people (g)										
Appendicitis with generalised peritonitis	0.2	0.2	0.3	0.4	0.2	np	np	0.4	0.3	np
Cellulitis	3.5	2.1	5.4	6	4.4	np	np	7.1	4.8	np
Convulsions and epilepsy	6.1	4.7	6.5	10.4	8	np	np	10.4	7.4	np
Dehydration and gastroenteritis	3.1	2.6	4.4	3.6	3.9	np	np	3.3	3.6	np
Dental conditions	2.4	2.9	3.2	3.8	4.4	np	np	3.4	3.1	np
Ear, nose and throat infections	2.9	1.7	2.9	4	3.8	np	np	3.5	3.1	np
Gangrene	0.3	0.3	1.1	2.7	0.8	np	np	1.8	1.1	np

Table 11A.44 **Separations for selected potentially preventable acute conditions, 2006-07 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Pelvic inflammatory disease	0.4	0.2	0.5	0.9	0.8	np	np	1.3	0.6	np
Perforated/bleeding ulcer	0.6	0.1	0.4	0.5	0.5	np	np	0.4	0.5	np
Pyelonephritis (f)	4.6	4	7.7	8.9	5.2	np	np	7.9	6.5	np
Total (h)	**24.1**	**18.9**	**32.3**	**41.1**	**31.8**	**np**	**np**	**39.5**	**31.1**	**np**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2008 *Australian hospital statistics 2006-07*.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence.

(e) NT data for Indigenous people are for public hospitals only.

(f) Kidney inflammation caused by bacterial infection.

(g) Data are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the five states and territory are not necessarily representative of the other jurisdictions.

(h) Total comprises only those jurisdictions referred to in note (g).

np Not published.

Source: AIHW (2008), *Australian hospital statistics 2006-07*; AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.45 Separations for selected potentially preventable chronic conditions, 2006-07 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Chronic conditions per 1000 people										
Angina	1.6	1.8	2.5	1.6	1.5	1.7	1.1	2.4	1.8	1.8
Asthma	2	1.9	1.4	1.4	2.6	1.4	1.2	1.5	1.8	1.8
Chronic obstructive pulmonary disease	2.5	2.5	2.7	2.2	2.8	2.4	1.7	5.5	2.6	2.6
Congestive heart failure	1.9	2.1	1.9	1.9	1.9	1.6	1.9	2.5	1.9	1.9
Diabetes complications (f)	7.4	9	10.2	26.4	8.4	13.4	5.3	15.3	10.4	10.4
Hypertension	0.3	0.3	0.4	0.2	0.3	0.3	0.2	0.2	0.3	0.3
Iron deficiency anaemia	1	1.7	1	1.4	1.3	1.2	0.7	1.1	1.2	1.2
Nutritional deficiencies	0	0	0	0	0	0	0	0.1	0	0
Rheumatic heart disease (g)	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.8	0.1	0.1
Total (h)	**15.7**	**18.1**	**19**	**34.3**	**17.7**	**21.2**	**11.4**	**27.3**	**19.1**	**19.1**
Total (excluding diabetes complications)	na	na	na	na	na	na	na	na	na	na
Chronic conditions per 1000 Indigenous people (i)										
Angina	5.2	6.4	7.9	5.8	4	np	np	4.5	5.9	np
Asthma	4.1	2.4	3.3	4.9	4.4	np	np	4	3.9	np
Chronic obstructive pulmonary disease	12.3	9.6	11.7	12.4	14	np	np	15.8	12.4	np
Congestive heart failure	5	2.6	7.7	8.7	7.1	np	np	7.1	6.5	np
Diabetes complications (f)	21.6	20.5	35.1	44	41	np	np	36.4	31.7	np
Hypertension	0.6	0.2	1.4	0.7	1.4	np	np	0.7	0.9	np
Iron deficiency anaemia	1.6	2.3	1.7	2.2	1.8	np	np	2.4	1.9	np
Nutritional deficiencies	0	0.1	0	0	0	np	np	0.1	0	np
Rheumatic heart disease (g)	0.2	0.4	0.8	0.9	2	np	np	1.7	0.8	np
Total (h) (j)	**45.6**	**40.7**	**61.4**	**71**	**69.3**	**np**	**np**	**66**	**57.4**	**np**

Table 11A.45 Separations for selected potentially preventable chronic conditions, 2006-07 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Total (excluding diabetes complications)	28.8	24.1	34.6	35.7	34.6	np	np	36.4	32.3	np

(a) Conditions defined by ICD-10-AM codes as in AIHW 2008 *Australian hospital statistics 2006-07*.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence.

(e) NT data for Indigenous people are for public hospitals only.

(f) Excludes separations with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes.

(g) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.

(h) Total does not sum to the individual categories as more than one chronic condition can be reported for a separation.

(i) Data are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the five states and territory are not necessarily representative of the other jurisdictions.

(j) Total comprises only those jurisdictions referred to in note (i).

na Not available. **np** Not published.

Source: AIHW (2008), *Australian hospital statistics 2006-07*; AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.46 Ratio of separations for Indigenous males to all males, 2006-07 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All causes	Number	24 226	4 557	27 937	21 128	8 225	np	np	24 056	110 129
	SHSR	1.76	1.31	2.22	3.10	2.78	np	np	5.82	2.34
	95% CI	1.73 to 1.78	1.27 to 1.35	2.2 to 2.25	3.05 to 3.14	2.72 to 2.84	np	np	5.74 to 5.89	2.33 to 2.36
Circulatory disease	Number	1 122	217	1 168	724	366	np	np	587	4 184
	SHSR	1.39	1.22	1.53	1.79	2.12	np	np	1.87	1.48
	95% CI	1.31 to 1.47	1.06 to 1.38	1.44 to 1.62	1.66 to 1.92	1.9 to 2.34	np	np	1.71 to 2.02	1.43 to 1.52
Coronary heart disease	Number	528	109	603	335	186	np	np	199	1 960
	SHSR	1.50	1.62	1.88	2.17	2.82	np	np	2.09	1.74
	95% CI	1.37 to 1.63	1.32 to 1.93	1.73 to 2.04	1.94 to 2.4	2.41 to 3.22	np	np	1.8 to 2.38	1.66 to 1.81
Rheumatic heart disease	Number	5	8	38	21	17	np	np	41	130
	SHSR	np	np	4.33	5.07	19.88	np	np	10.94	5.24
	95% CI	np	np	2.96 to 5.71	2.9 to 7.23	10.43 to 29.33	np	np	7.59 to 14.28	4.34 to 6.14
Self-harm	Number	210	39	165	113	68	np	np	92	687
	SHSR	2.92	2.79	2.45	3.06	3.87	np	np	2.88	2.92
	95% CI	2.52 to 3.31	1.92 to 3.67	2.07 to 2.82	2.49 to 3.62	2.95 to 4.79	np	np	2.29 to 3.46	2.7 to 3.13
All respiratory disease	Number	1 926	289	1 702	1 491	487	np	np	1 514	7 409
	SHSR	2.15	1.46	2.50	3.46	2.20	np	np	4.17	2.52
	95% CI	2.05 to 2.25	1.29 to 1.63	2.38 to 2.62	3.28 to 3.63	2 to 2.39	np	np	3.96 to 4.38	2.46 to 2.58
Infectious pneumonia	Number	352	53	431	449	94	np	np	593	1 972
	SHSR	1.92	1.41	4.41	6.55	3.20	np	np	6.85	3.95
	95% CI	1.72 to 2.12	1.03 to 1.79	4 to 4.83	5.95 to 7.16	2.55 to 3.85	np	np	6.29 to 7.4	3.77 to 4.12
Lung cancer	Number	19	9	39	22	11	np	np	25	125
	SHSR	0.82	np	1.45	1.55	1.14	np	np	0.87	1.29
	95% CI	0.45 to 1.19	np	1 to 1.91	0.9 to 2.19	0.47 to 1.81	np	np	0.53 to 1.22	1.07 to 1.52

Table 11A.46 Ratio of separations for Indigenous males to all males, 2006-07 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
Diabetes as a primary diagnosis	Number	387	60	494	351	132	np	np	258	1 682
	SHSR	2.92	1.94	3.82	5.21	4.86	np	np	3.77	3.68
	95% CI	2.63 to 3.22	1.45 to 2.43	3.48 to 4.16	4.66 to 5.75	4.03 to 5.68	np	np	3.31 to 4.23	3.5 to 3.86
All diabetes except where dialysis is the primary diagnosis	Number	2 090	393	2 540	2 056	817	np	np	1 765	9 661
	SHSR	2.37	2.00	3.18	5.22	4.16	np	np	4.13	3.18
	95% CI	2.26 to 2.47	1.8 to 2.2	3.06 to 3.31	5 to 5.45	3.88 to 4.45	np	np	3.93 to 4.32	3.12 to 3.24
All diabetes (f)	Number	2 650	441	3 180	8 543	867	np	np	1 765	17 446
	SHSR	2.85	2.03	3.31	13.54	4.28	np	np	4.13	5.13
	95% CI	2.74 to 2.96	1.84 to 2.22	3.2 to 3.43	13.25 to 13.83	4 to 4.57	np	np	3.93 to 4.32	5.06 to 5.21
Depressive disorder	Number	198	45	75	47	35	np	np	13	413
	SHSR	1.61	1.15	0.52	0.53	1.11	np	np	0.55	0.85
	95% CI	1.39 to 1.84	0.81 to 1.48	0.4 to 0.64	0.38 to 0.68	0.74 to 1.48	np	np	0.25 to 0.84	0.77 to 0.93
Anxiety disorder	Number	60	5	34	np	10	np	np	np	114
	SHSR	1.29	np	0.21	np	3.30	np	np	np	0.62
	95% CI	0.96 to 1.61	np	0.14 to 0.28	np	1.26 to 5.35	np	np	np	0.5 to 0.73
Substance use disorder	Number	465	29	171	89	31	np	np	6	791
	SHSR	3.80	1.77	1.92	3.69	4.79	np	np	np	2.72
	95% CI	3.45 to 4.14	1.13 to 2.42	1.63 to 2.2	2.92 to 4.46	3.1 to 6.48	np	np	np	2.53 to 2.91
Psychotic disorder	Number	1 089	211	666	640	265	np	np	238	3 109
	SHSR	3.21	2.14	2.06	3.65	3.18	np	np	2.27	2.53
	95% CI	3.02 to 3.4	1.85 to 2.43	1.9 to 2.22	3.36 to 3.93	2.8 to 3.57	np	np	1.98 to 2.56	2.44 to 2.62

Table 11A.46 Ratio of separations for Indigenous males to all males, 2006-07 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) The Total includes data only for NSW, Vic, QLD, WA, SA and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the five states and territory are not necessarily representative of the other jurisdictions.

(c) Data have been suppressed if the number of separations was less than five. The rate ratio and confidence interval have been suppressed if the number of separations was less than 20.

(d) The ratios are directly age standardised to the Australian estimated resident population at 30 June 2001.

(e) Patients aged 75 years and over are excluded.

(f) All diabetes refers to separations with either a principal or additional diagnosis of diabetes.

SHSR = Standardised Hospital Separation Ratio; CI = confidence interval.

np Not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.47 Ratio of separations for Indigenous females to all females, 2006-07 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All causes	Number	27 469	7 367	36 111	29 417	9 510	np	np	33 807	143 681
	SHSR	1.66	1.97	2.22	3.26	2.56	np	np	7.55	2.52
	95% CI	1.64 to 1.68	1.93 to 2.02	2.2 to 2.24	3.22 to 3.3	2.51 to 2.62	np	np	7.47 to 7.63	2.51 to 2.54
Circulatory disease	Number	911	212	1 158	696	330	np	np	522	3 829
	SHSR	1.68	1.61	2.33	2.46	2.56	np	np	2.32	1.99
	95% CI	1.57 to 1.79	1.4 to 1.83	2.2 to 2.47	2.28 to 2.65	2.29 to 2.84	np	np	2.12 to 2.52	1.93 to 2.05
Coronary heart disease	Number	389	103	488	239	143	np	np	154	1 516
	SHSR	2.72	3.20	3.36	3.49	4.32	np	np	2.95	3.06
	95% CI	2.45 to 2.99	2.58 to 3.82	3.06 to 3.66	3.05 to 3.93	3.61 to 5.03	np	np	2.48 to 3.41	2.91 to 3.21
Rheumatic heart disease	Number	18	6	66	42	27	np	np	73	232
	SHSR	2.80	np	6.17	13.22	25.94	np	np	10.11	9.27
	95% CI	1.51 to 4.1	np	4.68 to 7.66	9.22 to 17.22	16.16 to 35.73	np	np	7.79 to 12.43	8.08 to 10.46
Self-harm	Number	305	61	183	135	77	np	np	105	866
	SHSR	2.49	2.41	1.59	1.88	2.67	np	np	2.47	2.09
	95% CI	2.21 to 2.77	1.8 to 3.01	1.36 to 1.82	1.56 to 2.19	2.07 to 3.26	np	np	2 to 2.94	1.95 to 2.23
All respiratory disease	Number	1 915	307	1 793	1 503	515	np	np	1 673	7 706
	SHSR	2.58	1.82	2.95	4.34	2.83	np	np	5.84	3.11
	95% CI	2.46 to 2.69	1.62 to 2.03	2.82 to 3.09	4.12 to 4.56	2.59 to 3.08	np	np	5.56 to 6.12	3.04 to 3.18
Infectious pneumonia	Number	329	44	440	422	73	np	np	604	1 912
	SHSR	2.93	1.47	4.68	8.87	2.71	np	np	9.54	4.78
	95% CI	2.61 to 3.24	1.03 to 1.9	4.24 to 5.11	8.02 to 9.71	2.09 to 3.33	np	np	8.78 to 10.3	4.56 to 4.99
Lung cancer	Number	49	14	32	20	10	np	np	15	140
	SHSR	3.22	2.86	1.89	2.15	2.07	np	np	1.81	2.37
	95% CI	2.32 to 4.12	1.36 to 4.36	1.24 to 2.55	1.21 to 3.1	0.79 to 3.36	np	np	0.89 to 2.73	1.98 to 2.77

Table 11A.47 Ratio of separations for Indigenous females to all females, 2006-07 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
Diabetes as a primary diagnosis	Number	471	114	836	540	206	np	np	610	2 777
	SHSR	3.45	2.74	5.80	7.93	5.43	np	np	9.08	5.23
	95% CI	3.14 to 3.76	2.24 to 3.24	5.4 to 6.19	7.26 to 8.6	4.69 to 6.17	np	np	8.36 to 9.8	5.03 to 5.42
All diabetes except where dialysis is the primary diagnosis	Number	2 632	597	3 920	3 015	1 184	np	np	3 325	14 673
	SHSR	3.48	3.47	5.72	7.67	5.99	np	np	8.65	5.26
	95% CI	3.34 to 3.61	3.19 to 3.74	5.54 to 5.9	7.4 to 7.95	5.65 to 6.33	np	np	8.36 to 8.94	5.17 to 5.34
All diabetes (f)	Number	3 202	1 243	4 636	13 720	1 185	np	np	3 326	27 312
	SHSR	4.15	8.59	6.53	24.22	5.71	np	np	8.65	9.11
	95% CI	4.01 to 4.3	8.11 to 9.07	6.34 to 6.72	23.82 to 24.63	5.39 to 6.04	np	np	8.36 to 8.95	9 to 9.21
Depressive disorder	Number	286	92	99	116	73	np	np	18	684
	SHSR	1.18	1.00	0.35	0.68	1.68	np	np	1.26	0.64
	95% CI	1.05 to 1.32	0.79 to 1.2	0.28 to 0.42	0.56 to 0.8	1.29 to 2.06	np	np	0.68 to 1.84	0.59 to 0.69
Anxiety disorder	Number	32	8	33	22	7	np	np	–	102
	SHSR	1.14	np	0.62	1.06	np	np	np	–	0.76
	95% CI	0.75 to 1.54	np	0.41 to 0.84	0.61 to 1.5	np	np	np	..	0.61 to 0.91
Substance use disorder	Number	221	70	63	39	21	np	np	6	420
	SHSR	2.30	5.42	0.65	1.76	5.63	np	np	np	1.64
	95% CI	1.99 to 2.6	4.15 to 6.68	0.49 to 0.81	1.21 to 2.31	3.22 to 8.03	np	np	np	1.48 to 1.8
Psychotic disorder	Number	722	205	436	478	265	np	np	188	2 294
	SHSR	1.80	1.48	0.99	1.91	3.19	np	np	3.09	1.37
	95% CI	1.67 to 1.93	1.28 to 1.69	0.9 to 1.08	1.74 to 2.08	2.81 to 3.58	np	np	2.65 to 3.53	1.31 to 1.42

Table 11A.47 **Ratio of separations for Indigenous females to all females, 2006-07 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) The Total includes data only for NSW, Vic, QLD, WA, SA and NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the five states and territory are not necessarily representative of the other jurisdictions.

(c) Data have been suppressed if the number of separations was less than five. The rate ratio and confidence interval have been suppressed if the number of separations was less than 20.

(d) The ratios are directly age standardised to the estimated resident population at 30 June 2001.

(e) Patients aged 75 years and over are excluded.

(f) All diabetes refers to separations with either a principal or additional diagnosis of diabetes.

SHSR = Standardised Hospital Separation Ratio; CI = confidence interval.

.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.48 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2006-07 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Circulatory	16.7	27.3	18.3	26.0	22.0	np	np	np	21.5
Renal	20.3	24.8	22.9	26.5	21.3	np	np	np	23.1
Ophthalmic	111.9	115.1	119.2	148.4	109.6	np	np	np	117.3
Other specified	51.8	78.6	62.3	58.0	70.3	np	np	np	63.9
Multiple	32.4	48.6	61.7	47.9	43.6	np	np	np	46.6
No complications	4.1	4.5	2.4	2.0	3.9	np	np	np	3.7
Total	**237.4**	**299.1**	**287.0**	**308.9**	**270.7**	**np**	**np**	**np**	**276.3**

(a) The separation rates are per 100 000 persons, directly age standardised using the June 2001 Australian ERP.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(d) 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.

(e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(f) 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.

(g) Totals may not add as a result of rounding.

np Not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.49 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2006-07 (per cent) (a), (b), (c), (d), (e), (f)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Circulatory	12.0	19.2	14.6	17.5	10.7	np	np	np	16.1
Renal	14.2	12.6	14.2	15.2	11.0	np	np	np	13.7
Ophthalmic	91.8	89.2	93.2	82.3	89.1	np	np	np	90.0
Other specified	12.8	33.9	17.9	11.1	11.1	np	np	np	20.4
Multiple	10.3	14.5	25.2	8.7	7.1	np	np	np	16.2
Unspecified	–	–	20.0	–	–	np	np	np	20.0
No complications	43.8	43.4	30.7	11.9	17.9	np	np	np	37.2
Total	**50.2**	**48.9**	**49.8**	**45.1**	**42.5**	**np**	**np**	**np**	**48.4**

(a) Data are for the number of same day separations with the specified principal diagnosis, as a per cent of all separations with the specified principal diagnosis.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(d) 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.

(e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(f) 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.

– Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.50 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2006-07 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
ASR	per 100 000 people	11.6	14.3	16.9	15.7	17.1	np	np	np	14.7
Crude	per 100 000 people	12.7	15.6	17.3	15.7	20.6	np	np	np	15.8
Separations	no.	866	802	707	324	323	np	np	np	3 260

(a) Separation rates are directly age standardised to the Australian estimated resident 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) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(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.

ASR = Age standardised rate

np Not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.51 **Separation rates of older people for injuries due to falls, 2006-07 (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004-05									
Separations per 1000 older people	47.8	46.9	40.3	40.8	36.2	np	np	np	43.9
Number	42 865	31 095	18 992	9 459	8 363	np	np	np	114 233
2005-06									
Separations per 1000 older people	50.9	48.7	41.2	43.7	37.5	np	np	np	46.2
Number	46 425	32 921	20 058	10 409	8 780	np	np	np	122 797
2006-07									
Separations per 1000 older people	54.8	51.6	44.0	44.6	39.2	np	np	np	49.1
Number	50 938	35 649	22 078	10 954	9 358	np	np	np	133 504

(a) Excludes separations records for Hospital Boarders and Posthumous organ procurement.

(b) Older people are defined as people aged 65 years and over. In previous reporting against this indicator, older people were defined as people aged 75 years and over and Indigenous people aged 55 years and over.

(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.

(d) Separation rates are crude rates using the estimated population aged 65 years or over at December 31 as the denominator.

np Not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database.

Table 11A.52 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Regional Health Services	The program provides funding to rural communities of up to 5,000 people to support primary health care services.	Funding is provided under Outcome 6 - Rural Health	Staged financial and activity reports to DoHA are required from each project.
Rural Primary Health Projects	There are two streams in this program: 1. National Rural Primary Health Projects Program which funds primary care initiatives targeting remote regions. Typically the projects involve health education, workforce support, and health promotion. Basic services such as point of care testing are sometimes incorporated into individual projects where this is appropriate. 2. Building Healthy Communities Program which funds small remote communities for health promotion activities that target the key risk areas of obesity, harmful alcohol consumption, tobacco abuse, lack of exercise or injury.	Funding is provided under Outcome 6 - Rural Health	Staged financial and activity reports are required from each project.
Royal Flying Doctor Service (RFDS)	Australian Government funding to the RFDS aims to support the sustainable delivery of primary health care services to people in rural and remote communities. The RFDS delivers traditional services in rural and remote areas of Australia. This includes the provision of primary aeromedical evacuations, primary and community health care clinics, medical chests and remote consultations.	There is a separate budget line item for RFDS funding. Funding is provided under Outcome 6 - Rural Health	Financial and service activity reports are submitted regularly, in the context of a National Reporting Framework.

Table 11A.52 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Rural Women's GP Service (RWGPS)	The RWGPS provides access to primary health care services for women in rural and remote Australia who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities.	Funding is provided under Outcome 5 - Primary Care	Financial and service activity reports are submitted regularly, in the context of an agreed reporting framework.
More Allied Health Services	This Program funds Divisions of General Practice to improve access by rural and remote communities to a range of additional allied health professionals.	Funding is provided under Outcome 5 - Primary Care	Staged financial and activity reports are required from each project. Divisions also complete the annual survey for PHC RIS reporting.
Visiting Optometrists Scheme	The program aims to provide outreach optometric services to remote and very remote communities.	Funding is provided under Outcome 3 - Medicare Benefits	Staged income and expenditure statements and progress reports are required from each optometrist.

Source: Australian Government (unpublished).

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Child, Adolescent and Family services	Covering services such as youth health, paediatric allied health (physiotherapy, occupational therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services.	Area Health Services (AHS) receive block funding from NSW Health to provide health services to their population. Each AHS determines how much money is allocated to this program.	These services are measured as Non-Admitted Patient Occasions of Service - the number of occasions on which one or more health care professionals provides a service to a Non-admitted Patient - and reported by AHSs to the Department of Health on a quarterly basis.
Program of Appliances for Disabled People	Providing appropriate equipment, aids and appliances such as mobility and toileting aids to prevent inappropriate entry into institutional facilities.	The Department of Health allocates specific funding to AHSs for this program.	The services are required to provide waiting list reports twice a year.
Transport for Health	Providing financial assistance and transport arrangements for non-emergency transport for health-related issues.	The Department of Health allocates specific funding to AHSs for this program.	Quarterly reporting on key indicators, annual reporting on the implementation of the program.
Multicultural health services	Providing interpreter services, cultural competency training, direct service provision for refugees, planning of services to address or cater to the needs of culturally diverse communities.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Youth Health services	Providing education and health promotion programs, clinical services and planning of youth friendly services. Also providing specific health services for homeless and at-risk young people.	A mix of AHS and Australian Government funding.	As for Child, Adolescent and Family services.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Women's health services	Covering services and health promotion programs for women, such as mental health, violence prevention and pregnancy services and physical activity, smoking cessation and health improvement programs.	A mix of AHS funding and Australian Government funding allocated under the Public Health Outcomes Funding Agreement.	As for Child, Adolescent and Family services.
Physical Abuse and Neglect of Children services	Providing long-term and intensive counselling for families, and a range of interventions where physical abuse or neglect of a child is occurring.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Sexual Assault services	Providing crisis counselling and support for victims of assault, court preparation and community education programs.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Aboriginal health services	Covering services such as health information and education, counselling, pre and post natal programs, early childhood nursing and health promotion programs.	A mix of AHS, NSW Health (via grants to non-government organisations) and Australian Government funding.	As for Child, Adolescent and Family services.
Sexual Health services	Covering education, counselling, screening and the management of sexually transmitted diseases including HIV and Hepatitis A, B and C.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Aged Care services	Providing assessment and referral, case management, home nursing, allied health services such as physiotherapy, occupational therapy, social work, podiatry, chiropractic, orthotics and prosthetics, dietetics and nutrition, specialist services such as continence therapy and family support for the aged.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Palliative Care services	Providing holistic care for people who are terminally ill or dying, including clinical care in the home, counselling and support services.	A mix of AHS and Australian Government funding.	As for Child, Adolescent and Family services.
Dental services	Providing basic and emergency dental care in the community.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Community Acute/Post Acute Care services	Providing acute care in the community which is a substitution for hospitalisation, including medical, nursing, allied health services such as physiotherapy and occupational therapy, social work and pharmacy and personal care.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Community nursing	Providing generalist nursing care in the community.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Rehabilitation	Providing case management, allied health, prosthetic and home modification services in a community setting.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Eating disorder services	Providing case management, medical and counselling support services.	As for Child, Adolescent and Family services.	As for Child, Adolescent and Family services.
Non-Government Organisations	Providing a range of services such as Aboriginal Medical Centres, HIV/Aids, Women's Health, Diabetes, Drug and Alcohol services.	Funding allocations are via an annual grant program approved by the Minister for Health.	As for Child, Adolescent and Family services.

Source: NSW Government (unpublished).

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Community Health	The Community Health Program is implemented through Community Health Services (CHSs) by over 100 agencies operating from more than 300 sites across Victoria. CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses. Some CHS also provide a range of preventive and early intervention services for children and young people. In addition, CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Australian Government programs.	These services are funded under the Primary Health Funding Approach. Currently, the Approach includes two components (1) direct care and (2) health promotion.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Women's Health	The Women's Health Program aims to improve the health and wellbeing of all Victorian women (with an emphasis on those most at risk), through developing and disseminating health information and research, providing education and training resources for agencies and health professionals and supporting the implementation of health promotion programs in the local region. The Program works directly with women and in partnership with other organisations.	These services are funded under the Primary Health Funding Approach to provide health promotion. This Program is a combined State and Australian Government funding initiative.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Family Planning	Family planning services assist Victorians to make individual choices on sexual and reproductive health matters by providing services that are accessible, culturally relevant and responsive to people who experience difficulty accessing mainstream services.	These services are funded under the Primary Health Funding Approach that includes a component for direct care and a component for health promotion.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Family and Reproductive Rights Education	Family and Reproductive Rights Education Program works with communities that traditionally practise female genital mutilation to increase their access to primary health services, to improve the physical and emotional health and wellbeing of women, young girls and their families, and to encourage the health system to be more responsive to their needs.	These services are funded under the Primary Health Funding Approach, which include a component for direct care and a component for health promotion.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Innovative Health Services for Homeless Youth (IHSHY)	IHSHY is a Australian Government/State program that promotes health care for homeless and at risk young people. Funds are provided for innovative health and related services for homeless and otherwise at-risk young people that respond to their complex health needs and improve their access to mainstream health services. IHSHY provides a means of engaging young people who are homeless or marginalised and who may not otherwise access health services.	IHSHY is funded under a Special Purpose Payment (SPP), with state and territory governments matching the Australian Government's contribution.	Quantitative performance targets are set by the Department and monitored quarterly. IHSHY services are also required to complete an annual report containing qualitative and quantitative activities to the Australian Government.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Dental Health	Public dental services are provided by Community Health Services and the Royal Dental Hospital Melbourne. In some cases, dental care is provided by private clinicians through voucher schemes. The Dental Health Program supports undergraduate education of dental clinicians, including providing funding for clinical placements and scholarships.	Dental services are output funded using a funding formula.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Telephone Counselling	The initiative provides telephone counseling 24 hours a day, 7 days per week to provide individuals with support, information and referral.	Funding is provided to support seven Lifeline sites and one site for a statewide suicide prevention telephone counselling line. The Australian Government also contributes substantial funding to Lifeline.	Quantitative performance targets are set by the Department and monitored quarterly reporting.
NURSE-ON-CALL strategy	The NURSE-ON-CALL strategy provides a new 24 hour a day, 7 days per week, telephone based health advice and information line. Registered Nurses answer all calls and use evidence-based clinical decision support software systems to undertake triage and direct callers to the most appropriate level of health care for their symptoms. Since its launch in June 2006, over 704,400 calls have been answered, 11% of which were diverted from hospital EDs.	NURSE ON CALL is provided under a three-year contract arrangement with McKesson Asia-Pacific.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Drug Services	Provides a range of drug treatment services including withdrawal, rehabilitation, counselling and supported accommodation for people with substance abuse problems, these treatment services are also provided to offenders referred to treatment from the criminal justice system through the Drug Diversion program. A range of health protection services including Primary Health and needle and syringe services targeting drug users are also provided. The Program also oversees Pharmacotherapy services and delivers a range of drug prevention programs including those targeted at use of tobacco and alcohol as well as illicit drugs. Support and information is also provided for drug users and their families.	Funding and reporting for these services is managed in accordance with the Output Budgeting framework. Budget and performance for Drugs Services is reported as a separate Output in the Victorian Government budget papers. Most Drug Services are funded on the basis of unit priced service models and service providers are required to report against targets linked to the activity. Different activities are funded at different unit prices which recognise the costs to services of producing the outputs. These prices are applied universally to all service providers delivering those activities.	Performance information is collected and reported at the State level through Expenditure Review Committee reporting against the Budget Paper targets, DHS Annual Report and Growing Victoria Together reports, at a Whole of Victorian Government (WOVG) level through WOVG reporting on specific target groups including Women, Youth and Koori, at a Departmental level through Executive Performance reporting, at a National level, performance reporting is provided through National Minimum Data Sets, Report On Government Services, Australian Institute of Health and Welfare, Public Health Outcomes Funding Agreement (PHOFA), Council of Australian Government (COAG) reporting for National Illict Drug Strategy, Drug Diversion and Needle and Syringe Programs.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Primary and Community Health – Indigenous Services	Aboriginal community health services are provided through a range of Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services funded by the Department of Human Services (DHS), including community health centres, hospitals and non-Government organisations. The Victorian Aboriginal Health Service and other Aboriginal Medical Services provide a full range of medical and dental services. The Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership supports community health services and ACCHOs to work collaboratively to improve health outcomes for Aboriginal people in Victoria with, or at risk of, chronic disease. Oral Health Public Oral health services are targeted towards Health Care and Pensioner concession card holders. Priority access is given to preschool and primary school aged children and dependants of cardholders in years 7 and 8 or who have left formal schooling. There are several initiatives targeting Aboriginal people, including dental clinics at the Victorian Aboriginal Health Service and Rumbalara Aboriginal Cooperative.	DHS operates in a complex funding environment. Aboriginal community controled organisations are funded to provide direct services delivery by DHS and budgets are managed using three year service agreements. Funding can be provided either at the program level or via the eight regions.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Primary and Community Health – Indigenous Services *continued*	Drug and Alcohol treatment Alcohol and Drug treatment services are provided through both mainstream services and Aboriginal-specific services, located in ACCHOs. Mainstream alcohol and drug treatment services provide community based assessment, community and residential treatment and community rehabilitation programs. Agency based services include counselling, consultancy and continuing care service (outreach, day programs, post withdrawal linkages, supported accommodation, ante and post natal support, peer support, mobile overdose response, specialist pharmacology and education). Aboriginal-specific services include Koori Community Alcohol and Drug Resource Centres, Koori Community Alcohol and Drug Workers, the Koori Alcohol and Drug workforce development initiative and the Koori Youth Alcohol and Drug Healing Service.		

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Primary and Community Health – Indigenous Services *continued*	Maternal and Child Health The Koori Maternity Services Strategy, within the broader Maternity Services Strategy, aims to provide culturally appropriate support to Aboriginal women throughout pregnancy and in the postnatal period through the employment of Aboriginal Health Workers and midwives, outreaching from ACCHOs. The principal focus is on increased access to antenatal care, postnatal support, and hospital liaison for births as a means of improving health and wellbeing outcomes for Aboriginal women and babies. The Maternal and Child Health Service is a universal service for all Victorian families with children from birth to school age. The Service offers support, information and advice regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning. Aboriginal-specific Maternal and Child Health Services are provided through ACCHOs.		

Source: Victorian Government (unpublished).

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Poisons Information	A 24 hour service is provided nationally through links between centres in various states, for the provision of information and advice to assist in the management of poisoning and suspected poisoning, education and promotion of poisoning prevention.	These services are funded from Queensland Health Corporate and Health Service District funds.	The Poisons Information centre is required to provide periodic reports on the extent and nature of calls, substances and caller type.
Alcohol, Tobacco and Drug Services	Including a range of prevention, health promotion, assessment, counselling, early identification and intervention, treatment and educational services to minimise alcohol, tobacco and other drug related harm.	These services are funded through a range of programs or health services within the Queensland Health budget and Australian Government funds.	Performance targets and overall financial reporting are published in the annual report and the Service Delivery Statement.
Cancer Screening Services Unit	Responsible for the leadership, strategic planning, management and coordination of the state-wide population screening programs: BreastScreen Queensland Program (BSQ), Queensland Cervical Screening Program (QCSP) and Queensland Bowel Cancer Screening Program. Key functions of the Unit include state-wide strategic policy and protocols, coordination and planning, service development and support, quality assurance, performance management, communication and education, workforce development and training, monitoring, evaluation and research and linkages with follow up management and treatment.	Funding for cancer screening services is provided through state funds and the joint State/Australian Government Public Health Outcomes Funding Agreement (PHOFA).	Performance targets and overall financial reporting are published in the annual report and the Service Delivery Statement. Annual data reporting to the Australian Institute of Health and Welfare. Performance reports to BSQ Services undertaken three, six and twelve monthly. Statistical reports produced biennially for BSQ & QCSP.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Aboriginal and Torres Strait Islander Health	Queensland Health provided a range of primary and community health care services and activities, spanning the prevention, management and maintenance continuum that address particular needs of Indigenous communities. Including prevention, education and health promotion services for programs such as; men's and women's health programs; child and adolescent health services; alcohol, tobacco and other drug services; sexual health services; allied health services; and patient transport provided to increase access to health care.	Funding for these services is provided through the broader health program packages within the Queensland Health budget and through Queensland Health's specific commitments to Indigenous Health under the Chronic Disease Strategy and Indigenous Health Package*. *The Indigenous Health Package is a whole-of-government investment to implement Queensland Health's response to the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*.	Performance targets and overall financial reporting are reported annually. Reports are published in Queensland Health's Annual Report and Service Delivery Statements.
HIV/AIDS, Hepatitis C and Sexual Health (HAHCSH)	The program implements the whole of government Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011 in the strategic priority areas of: enabling environment; education and prevention; early detection, care management and treatment; training and professional development and research and surveillance. Programs are delivered through public, private and community based organisations, including 16 QH sexual health clinics and a range of prevention/education initiatives within QH coordinated across the Area Health Services by six coordinators.	Funded through the Public Health Outcomes Funding Agreement (PHOFA) and a combination of State and Australian Government funding programs.	Annual Progress Report to Cabinet on the Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011. PHOFA – particularly in relation to HIV/AIDS and Indigenous populations, Australian Government and State funding reporting requirements. Six monthly reports on activities by program coordinators. Six monthly funded NGO performance reports.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Oral Health Services	Services provided via Community and School Oral Health Services mobile and fixed clinics.	These services are funded from Queensland Health Corporate and Health Service District funds.	Performance targets and overall financial reporting are published in the annual report and the Service Delivery Statement.

Source: Queensland Government (unpublished).

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Dental Services			
School Dental Services	The School Dental Service provides free dental care to school children throughout the state ranging from pre-primary through to Year 11 and to Year 12 in remote localities. Care is provided by dental therapists under the supervision of dental officers from fixed and mobile dental clinics located at schools throughout WA. The program incorporates preventive strategies, including oral health education for school children. Non-general and specialist services are referred to the private sector where a child is eligible to attend a Government clinic for subsidised care.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: • Number of children enrolled and under care. • Dental Health status (number of decayed/missing/filled teeth). • Average cost of service per child.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of benefit/allowance from Centrelink or Department of Veteran Affairs) via • Public Dental Clinics Metropolitan and Country. • Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Schemes and the Private Orthodontic Subsidy scheme. • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people. • Aged Care Dental Program. This program provides dental care to residents of Registered Aged Care Facilities. Residents are eligible to receive free annual dental examinations and a care plan. Further treatment needs are advised and the patient is referred to an appropriate provider. Ongoing treatment is through one of the Government programs for eligible residents.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: • Access to dental treatment for eligible people. • Average waiting times. • Average cost of completed courses of adult dental care.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Primary and Community Health			
Maternal & Family	Child health services aim to promote improved health outcomes for babies, young children and their families across Western Australia through the provision of a range of universal and targeted programs. Services are delivered in Child Health Centres, community based centres and in the home environment. Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breast feeding and nutrition. The universal child health service begins with an early child health nurse visiting all mothers of new babies and a series of scheduled contacts for critical points in the child's development throughout the first four years. The service presents a unique opportunity to identify families experiencing difficulty in caring for their children and the early identification of children with developmental delays. New parent groups are offered support in the early transition to parenting and to foster peer support amongst community members with new infants. Other group services include Triple P, Teen Parents playgroups and Yarning groups for Aboriginal caregivers and their children.	The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions.	The program measure for all non-admitted patient services is Occasions of Service.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Maternal & Family (continued)	A pilot project enabling antenatal engagement of women by child health nurses was initiated in 2008. The aims of the project are to engage with pregnant women to improve attendance at ante natal services and to support the early identification and management of psychosocial difficulties. Groups at risk of poorer health outcomes, such as Aboriginal and Torres Strait Islander peoples and newly arrived refugees, are a particular focus of child health services. A targeted service was commenced in 2008 by the Aboriginal Health Team to offer an extended child health schedule delivered as a home visiting service within the metropolitan community. The Extended Early Family & Child Support Service, Best Beginnings and Community Mothers services are also offered to vulnerable individuals through home visiting models.		

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Child Development Service	Child development services provide a range of assessment, early intervention and therapy services to children with, or at risk of, developmental disorders and delay. Services are provided at various sites across the metropolitan area and within Western Australia Country Health Services by a range of professionals including speech pathologists, physiotherapists, occupational therapists, clinical psychologists, social workers, nurses, podiatrists, child care assistants, therapy assistants, audiologists, paediatricians and medical officers, along with administrative staff. Services are delivered out of a range of settings including community based child development centres, day-care, school and the home environment. Child development services also play a key role in health prevention and promotion through the delivery of community education, professional development and programs aimed at preventing the occurrence of a delay/disorder, minimising the impact of a disorder/delay and/or preventing the progression of a disorder/delay.	The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions.	The metropolitan Child Development Service is currently undergoing a major reform process including the implementation of a single information management system. The Child Development Information System (CDIS) is currently under development, with full rollout to all metropolitan sites by June 2009. The CDIS will enable collection of reliable and accurate data regarding referrals, client demographics, and clinical and service outcomes.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
School Health Service	School Health Services are provided by Community Health personnel employed by Health Services across WA. Personnel work closely with school communities to provide services which are universally available to all students. Contemporary School Health Services have a strong prevention focus, with roles that can be categorised into three integrated areas; health promotion, early detection and specialist health expertise. The workforce includes Community Health nurses, allied health, Aboriginal health workers and health promotion staff. Since 1998, there has been an agreement in place between the Department of Education and Department of Health which underpins the delivery of School Health Services. In 2007, the current Memorandum of Understanding (MOU) was established to clearly articulate the nature of School Health Services in a broader health promoting schools context. The MOU includes the establishment of Local Management Groups comprised of representatives from District Education Offices and Health Services (Population/Community Health). These Groups are responsible for developing Local Service Agreements and delivering school health services at the local level.	Budgets for School and Youth Health Services are based on historical precedent, however, more resources are needed in certain areas where there has been significant growth and/or there is significant socioeconomic disadvantage. Patterns of new schools opening, and increases in existing primary school populations provide a guide to determine growth in the target population. In the metropolitan area, the northern and southern coastal corridors, and some parts of the Swan and Canning districts appear to be areas of need. The Department of Education and Training partly funds School Health Services in WA, as agreed in the MOU between the two Departments.	The program measure for all non-admitted patient services is Occasions of Service.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
School Health Service (continued)	School Health Services use surveillance activities and assessments to identify and monitor the health status of school-aged children throughout their school life. This system of early detection aims to ensure that children who may be at risk of developing health problems are detected as early as possible. Surveillance activities and screening programs are delivered at a population (universal), group or individual level (targeted). School Health Services, with few exceptions, provide early detection services across Western Australia. The service is also responsible for delivering the school-based immunisation programs as detailed in the Department of Health's WA Vaccination Schedule. Schools include community kindergartens, and primary school students in the public, Catholic and Independent education systems. Almost all children are offered assessments and are referred to services when problems are identified. School health services have a strong presence in public secondary schools to provide primary health care for adolescents; health care planning for students with special issues; support for health-related curriculum; and, other school health promotion.		

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Youth at Risk	"At-risk" services specifically focus on children, adolescents, young people and their families who are socially and economically disadvantaged and who are more likely to experience poor health outcomes because of their circumstances. Focus groups include Aboriginal people, migrants, refugees and culturally and linguistically diverse groups. Services include; health surveillance, universal and targeted prevention, early identification and intervention, health promotion and education to improve health outcomes, disease control and immunisation, health care advice and specific family health programs. School health services and the joint Australian Government – State Innovation Health Services for Homeless Youth (IHSHY) program are the major service delivery vehicles for at-risk young people. Services for "at risk" populations have a strong focus on collaboration and coordination between other parts of the health system, other government and non government agencies to improve access to services and address the social determinants of health.	IHSHY program funds are allocated through service agreements with individual service providers.	Annual reporting on IHSHY service delivery and annual financial acquittals to Australian Government Department of Health and Ageing.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Youth at Risk (continued)	Health promotion and community development aims to facilitate community engagement and action to create healthy and sustainable environments and communities for children and their families. Health promotion practitioners work in partnership with community nursing staff, the community and local agencies to deliver health promotion initiatives in response to community needs.		
Ante natal care	Targeted ante natal programs aim to engage at risk families. Services are delivered in some regions within WA only using a combined child health centre and community based approach. The health and wellbeing of pregnant women is monitored with advice, treatment and guidance being offered where appropriate.	Program funding is provided to a range of providers including Area Health services and community controlled organisations.	The state program measure for all non-admitted patient services is Occasions of Service using HCARe.
Primary Care	Community health services provide a comprehensive primary care service in many rural and remote areas. These are generally in areas where there is no General Practitioner service and only remote access to hospital accident and emergency, and inpatient care.	Funding for these services is mainly via core state health funding to Area Health Services.	The state program measure for all non-admitted patient services is Occasions of Service using a module in HCARe.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Chronic Disease Management	A range of non hospital care is provided across the spectrum of Chronic Disease management. This includes diabetes and asthma management. The South Metropolitan and North Metropolitan Area Health Services run a self management and condition specific program for patients with COPD, Diabetes and CHF at high risk of hospitalisation. The program is multidisciplinary and educates patients on symptom monitoring, action planning and self efficacy as well as how to access health and social care services in a timely manner to prevent deterioration of their condition and ultimately reduce hospitalisation. The multidisciplinary teams include nursing, dietetics, occupational therapy, physiotherapy, podiatry and social work. Aboriginal Health Workers facilitate and improve access to services and programs for the Indigenous population. The service provides care co-ordination and planning, individual and group education and rehabilitation, and phone facilitation of action planning. Extensive collaboration and linkage with government community health services, non-government providers, Divisions of General Practice and GPs enables the team to integrate services to support ongoing patient self-management.	Funding for these services is mainly via core state health funding to Area Health Services.	The state program measure for all non-admitted patient services is Occasions of Service using a module in HCARe. In some areas quantitative and qualitative data is collected including client questionnaires and clinical outcome measures. Program measures include numbers of clients and referrals. Area health services also require quarterly reporting of HR, OSH and quality measures.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Primary Prevention	In regional WA, community health staff located in primary health teams are usually the primary providers of Primary Prevention programs. Local strategies and services often support national and state campaigns. These include reduction in tobacco use programs, drug and alcohol programs, good nutrition and physical activity programs.	Funding for these services is mainly via core state health funding to Area Health Services.	The state program measure for all non-admitted patient services is Occasions of Service using a module in HCARe.
Sexual health	Sexual health services are primarily the responsibility of community health staff with support and coordination from Public Health units in rural and remote WA. This includes small sexual health teams in the Kimberley, Pilbara and Goldfields regions of the WA Country Health Service, these being regions with endemic proportions of STIs within their populations.	Funding for these services is mainly via core state health funding to Area Health Services.	The state program measure for all non-admitted patient services is Occasions of Service using a module in HCARe.
Adult Allied Health - Peel and Rockingham Kwinana Health Service, South Metropolitan Area Health Service (SMAHS)	Community based individual and group therapies for adults with diabetes and diabetes related comorbidities, chronic pulmonary disease, cardiovascular disease, chronic pain, falls risk, obesity, rheumatic disease, orthopaedic dysfunction and musculoskeletal pain and dysfunction. Services include physiotherapy, occupational therapy, podiatry, social work, diabetes education, continence services and dietetics.	The Department of Health WA negotiates with Area Health Services using service specifications. Funding is provided directly to the Area Health Service.	Individual services collect and report qualitative and quantitative program data including: number of new referrals, waiting time and numbers of discharges.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Disease Management Unit, SMAHS	A multidisciplinary model of care which provides community based medical stabilisation with a general physician to improve chronic conditions and access to services. The service reduces the need for outpatient and emergency department presentations.	The Department of Health WA negotiates with Area Health Services using service specifications. Funding is provided directly to the Area Health Service.	The program measure for all non-admitted patient services is Occasions of Service.
Refugee Health Services, SMAHS	Community based services provided to refugees that are referred from the central Migrant Health Centre. A care plan is developed for each individual referred to the refugee health nurses. The nurses coordinate the referral and ongoing care of refugees ensuring that all the health issues are managed in the community. These services are delivered mainly in the home and the nurses act as an advocate for their clients ensuring they can navigate a very complex health system, including women's health, mental health and GP services.	The Department of Health WA negotiates with Area Health Services using service specifications. Funding is provided directly to the Area Health Service.	Quantitative and qualitative data are collected from services. Program measures include: client numbers, number of referrals, education and training provided to a range of health providers and key stakeholders about refugee health.
Diabetes Services (NMAHS)	Secondary prevention services are provided in community settings for people with diabetes. Individual and group interventions are provided by diabetes educators, dietitians, physiotherapists and podiatrists as well as transcultural workers.	The Program is funded by Department of Health WA via North Metropolitan Area Health Service, Public Health and Ambulatory Care directorate.	The program measure for all non-admitted patient services is Occasions of Service.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Community Physiotherapy Services, North Metropolitan Area Health Services (NMAHS)	Rehabilitation and functional physical activity programs for adults with chronic conditions living independently in the community. Programs aim at maximising client's mobility, ability and functional level, reducing complications of chronic conditions, reducing Health Care Utilisation and unplanned hospitilisations. All programs are group based and run in community settings. Programs include rehabilitation for clients with COPD or other respiratory disease, heart failure and other cardiac conditions, orthopaedic conditions, osteoporosis, arthritis, neurological conditions, increased falls risk and balance impairment, chronic back pain, general debility, age related reduction in physical activity.	The Program is funded by Department of Health WA via North Metropolitan Area Health Service, Public Health and Ambulatory Care directorate. The service is metropolitan area wide. Training and support is provided to West Australian Country Health Service clinicians as requested.	The program measure for all non-admitted patient services is Occasions of Service. Quantitative and qualitative data are collected and include client questionnaires and clinical outcome measures. Program measures include numbers of clients and referrals. Area health services also require quarterly reporting of HR, OSH and quality measures.
Chronic Obstructive Pulmonary Disease (COPD) linkage program	A tertiary-community based program providing community based, specialist medical, nursing and physiotherapy services to patients with severe COPD. The program replaces traditional outpatient appointments in the hospital setting to improve patient attendance and experience as well as ongoing care and support.	Funded through a tertiary hospital with accomodation and support services purchased from Divisions of General Practice.	Monthly and quarterly activity reports along with hospital admission comparisons of program patients against the COPD usual care patient group within WA Health.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
BreastScreen WA	Responsible for the leadership, strategic planning, management, coordination and service delivery of the state-wide breast cancer screening program. BreastScreen WA provides free mammograms to asymptomatic women over 40 years of age. The primary target group for the service is women aged 50 to 69 years. Services are provided at eight metropolitan clinics and by four mobile screening vans that visit outer metropolitan areas and country towns every two years.	Funding for cancer screening services is provided through state funds and the joint State/Australian Government Public Health Outcomes Funding Agreement (PHOFA).	Annual data reporting to the Australian Institute of Health and Welfare for BreastScreen Australia, six monthly to WA Department of Health and regular published statistical reports.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Aboriginal Health			
Primary Health Services	A range of primary health care services and programs are provided using a multidisciplinary approach in community settings focused on Aboriginal and Torres Strait Islander people. Aboriginal health teams provide a strong linkage point with other mainstream providers for an integrated approach.	Funding is provided directly to individual Aboriginal Health Service providers by means of a Service Level Agreement with the Department of Health WA.	Regular reporting is required. Financial reporting each quarter and activity reporting twice per year. Various output measures are specified.
Environmental Health	Support the provision of comprehensive environmental health programs for Indigenous people in WA.	Funding is provided directly to individual Aboriginal Health Service providers by means of a Service Level Agreement with the Department of Health WA.	Regular reporting is required. Financial reporting each quarter and activity reporting twice per year. Various output measures are specified.
Health Promotion	Provision of health promotion initiatives that include community wide education and community development activities.	Funding is provided directly to individual Aboriginal Health Service providers by means of a Service Level Agreement with the Department of Health WA.	Regular reporting is required. Financial reporting each quarter and activity reporting twice per year. Various output measures are specified.
Social and Emotional Wellbeing	Provide and refer to social and emotional well being services, including culturally secure information, support and advice services to Aboriginal communities, particularly those affected by family trauma, grief and loss, mental health problems, and those at risk of self harm, particularly youth.	Funding is provided directly to individual Aboriginal Health Service providers by means of a Service Level Agreement with the Department of Health WA.	Regular reporting is required. Financial reporting each quarter and activity reporting twice per year. Various output measures are specified.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Aboriginal Scholarship Scheme	The scholarship scheme promotes and fosters the development of Aboriginal people undertaking health education training.	Funding is provided to individual recipients by the Office of Aboriginal Health, Health Department WA	Evidence of academic achievement.
Australian Better Health Initiative for the delivery of Indigenous healthy lifestyles	The delivery of various programs and activities that target the prevention and reduction of chronic disease conditions in the Aboriginal community.	Funding is provided direct to individual Aboriginal Health Service Providers by means of a Service Level Agreement. The original source of funding is the Council of Australian Governments.	Regular reporting is required. Financial reporting each quarter and activity reporting twice per year. Various output measures are specified.
Alcohol and other drug services			
Alcohol and Other drug Services	Include a range of activites: prevention and early intervention; community based education programs and prevention campaigns and support for regional prevention networks. Treatment includes outpatient and inpatient withdrawal, assessment and counselling, rehabilitation, community based pharmacotherapy and supported accomodation. Treatment is also provided for people engaged in a range of diversion programs. Workforce development initiatives include education and training for a range of human service professionals in health, justice, child protection, community services and for specialist alcohol and drug workers. Clinical placements are also available. Indigenous workforce development includes nationally recognised certificate III programs for Aboriginal alcohol and drug workers.	Funding to the Drug and Alcohol Office (DAO) is allocated through WA Department of Health and funds are allocated within DAO to three main service delivery areas: direct government treatment services; prevention and workforce development; and non-government funded service providers.	DAO reports financial, performance indicator and information on activity and outcomes related to state government goals as a statutory authority, the Western Australian Drug and Alcohol Authority, in its Annual Report to Parliament. Performance reporting at state level is through the treasury budget statements and this is through WA Health as a service. At a national level, performance reporting is provided against Public Health Outcomes Funding Agreement and the Ministerial Council on Drug Strategy (through the Department of Health and Ageing).

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
School Drug Education	DAO funds the School Drug Education and Road Aware Program (SDERA) in Western Australia to offer a comprehensive program that emphasises professional development and community action. SDERA uses a range of initiatives including the development and distribution of curriculum material to all schools in WA, teacher professional development, support to schools in developing drug education programs and guidelines, engagement of parents and communities at a local level, evaluation and monitoring of outputs and regionally based consultancy support. The program also provides materials and support to implement the National Keeping in Touch Program for management of alcohol and drug problems within schools.	Funding is provided by the Prevention Branch of DAO to the Catholic Education Office that oversees the administration of the School Drug Education and Road Aware program. This program operates across all school sectors (government, independent and Catholic).	Annual reporting to DAO as part of contract management. A DAO representative also sits on the Board of Management and receives regular financial and progress updates through this.

Source: WA Government (unpublished).

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Early Childhood Development Services	Multidisciplinary interventions for children 0-4 years of age with or at risk of developmental delays. Service models are 1:1; group and supported playgroups options for families; and provided from primary health care centres. Children are prioritised according to levels of active adversity. Guardianship of the Minister and Aboriginal children are of the highest priority.	Recurrent State Government funding	Monthly activity and financial data reporting
Universal Home Visiting Program	An initial contact made by a child and family health nurse, often in the home, to all families following the birth of a baby where the goal is to promote optimal development through early access to child health services, parenting information and support pathways for families.	Recurrent State Government funding	Monthly activity and financial data reporting
Family Home Visiting Program	A two year nurse home visiting service comprising of up to 34 visits. The aim of the program is to ensure that children are provided with a foundation to develop to the best of their potential.	Recurrent State Government funding	Monthly activity and financial data reporting
Newborn Hearing Screening Program	Aim of the program is to screen all babies born in South Australia for significant hearing loss. Once diagnosed, the infant can be assessed for various treatments and interventions that will enable appropriate cognitive development.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Pregnancy to Parenting Programs	Offers support and education to families in the early pregnancy to early parenting period. Families are particularly targeted where there are vulnerable infant risk factors. One to one counselling and support particularly in relation to antenatal care, emotional well-being, psycho social issues, early parenting and child development. Services/activities provided include: antenatal education classes; postnatal reunion; young and pregnant; birth & babies; breastfeeding education; and postnatal support group.	Recurrent State Government funding	Monthly activity and financial data reporting
Vaccinations Program	Vaccinations offered as part of the National Immunisation Program for infants aged from 2 months to 4 years, except the 12 month vaccination which is referred to the general practitioner. Vaccinations are mostly offered at health check ages.	Australian and State Government funding	Immunisation providers enter data onto the Australian Childhood Immunisation Register as registered providers.
Early Intervention Program	Early childhood intervention consultants work within their local community to assist parents access support services for their children 0–8 yrs with a disability and/or developmental delay.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Child Development Program	Specialist paediatricians and allied health staff assess children in community and country locations with specific behavioural and cognitive issues which are impacting on the child's development. Referrals are made to appropriate specialists.	Recurrent State Government funding	Monthly activity and financial data reporting
Paediatric Rehabilitation Program	Provides paediatricians and rehabilitation specialists to community clinics to provide specialist medical assessment and intervention.	Recurrent State Government funding	Monthly activity and financial data reporting
Parents of Children with Disabilities Support Group – My Time	Providing parent support groups in South Australia for parents of children with disabilities. These support groups are held in local community venues.	Australian Government funding provided to a non-government organisation.	Reporting form the non-government organisation back to the Australian Government.
Youth Primary Health Care Services	Primary health care and sexual health services for youth are provided through community health services across country areas Community health workers work in partnership with Youth Advisory Committees through Local Councils to meet the needs of rural youth.	Recurrent State Government funding	Monthly activity and financial data reporting
Headspace	Mental health counselling program for young people.	Australian Government funding provided to a local Division of General Practice.	Division of General Practice reports activity and financial data direct to the Australian Government.

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Child and Adolescent Mental Health Services	Via a network of community based teams provides mental health services to children and young people up to 18 years and their families who are experiencing emotional, behavioural or psychiatric problems. This includes: a therapeutic service; child and family specialists (e.g., clinical psychologists, psychiatrists and social workers); individual or family counselling; and information, training and consultation to general practitioners, schools and other agencies.	Recurrent State Government funding	Monthly activity and financial data reporting
The Second Story Youth Health Service	Provides primary health services to young people aged 12–25 years from key population groups, including ATSI; young people under Guardianship of the Minister, in care, or involved in the justice system; young parents; newly arrived; at risk of harm, same-sex attracted, or risk of developing chronic disease. Services include health information, assessment and referral, medical and nursing clinics, counselling and group programs, and funded projects.	Recurrent State Government funding	Monthly activity and financial data reporting
Sexual Health Services	Services include sexual health information, assessment and referral, testing, and treatment which are provided in clinic, group and counselling settings.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Sexuality - Inside Out Program	Assessment, referral, counselling, group programs, drop-in program and health information for young same-sex attracted men 16–25 years.	Recurrent State Government funding	Monthly activity and financial data reporting
Men's Primary Health Care Services	A range of primary health care services and programs provided by multidisciplinary teams from community settings that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community.	Recurrent State Government funding	Monthly activity and financial data reporting
Northern Violence Intervention Program	Provision of services for men, women and children focussing on stopping men’s use of violence and maximising safety of women and children.	Recurrent State Government funding	Monthly activity and financial data reporting
Men's Health Project	Has a dedicated position for men’s health to facilitate the development and improvement of men’s health in country areas in line with Government Directions and best practice principles. The project officer provides leadership in assisting the translation of Men’s Health Strategic Framework into practice, and facilitating and encouraging collaboration between internal and external service providers. A SA Rural Men’s Health Alliance is established to progress men’s health issues in South Australia.	One year State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Women's Primary Health Care Services	A range of primary health care services and programs for women. Services include: health education/promotion; sexual health clinics; domestic violence counselling; and adult survivors of sexual assault. Services provided by multidisciplinary teams from community settings that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community. A number of specific women's health centres in the metropolitan area.	Recurrent State Government funding	Monthly activity and financial data reporting
Community Midwifery Program	Provision of antenatal, birthing (including home births) and postnatal services to vulnerable women in the northern Adelaide region.	Recurrent State Government funding	Monthly activity and financial data reporting
Maternal Health Program	Community health and primary health care programs for maternal health are provided through community health services to meet the needs relating to maternal issues. Anangu Bibi birthing initiative is provided from Pt Augusta. Country Health SA has established a Maternity Services Steering Committee with the intention of determining the most appropriate models of maternity service provision for country hospitals and health services.	Australian and State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Women's Health Statewide Service	Focuses on mental health and violence. This includes referral; counselling in the areas of anxiety and depression related to interpersonal trauma; disordered eating; a medical clinic for newly arrived women; health information and resource development; workforce development for SA; projects including specific Aboriginal Women's health project. Key populations include ATSI, CALD and rural and remote.	Recurrent State Government funding	Monthly activity and financial data reporting
HIV Positive Women's Project	Support to HIV positive and affected women via Women's Health Statewide Service.	Three year State Government funding	Monthly activity and financial data reporting
Female Genital Mutilation Project	Community development project targeting newly arrived communities from affected countries.	Three year State Government funding	Monthly activity and financial data reporting
BreastScreen SA	Provides breast cancer screening for women over the age of 40 years with the primary target age group being women aged 50 to 69 through screening mammography. Services are provided across six fixed clinics and three mobile units.	Recurrent Australian and State Government funding	Monthly activity and financial data reporting to State Government, and annual reporting to BreastScreen Australia
Indigenous Primary Health Care Services	A range of primary health care services and programs provided by multidisciplinary teams from community settings that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Kinship Program	Strengthening families initiative that holistically focuses on reducing the complexities and impacts of Illicit drug use for Aboriginal families in metropolitan Adelaide.	Recurrent Australian and State Government funding reviewed every two years.	Reporting requirements as per the National Strategic Framework for Aboriginal & Torres Strait Islanders, and SA Health's Monthly activity and financial data reporting.
Aboriginal Primary Health Care Access Program	A range of primary and secondary health care services (including: transport; parenting programs; clinical services; and child health checks) provided through general practice and allied health teams.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation
Healthy for Life Program	Services provided Includes chronic disease, and child and maternal health programs for Aboriginal people.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation
Indigenous Health Services	Indigenous health services are provided across country areas and are managed through community health or community controlled Aboriginal Health Services. Programs have been implemented in line with the National Framework for Improving the Health and Well-being of Aboriginal and Torres Strait Islanders, the SA Aboriginal Health Policy 2007 and Cultural Respect Framework for Aboriginal and Torres Strait Islanders.	Recurrent Australian and State Government funding	Reporting requirements as per the National Strategic Framework for Aboriginal & Torres Strait Islanders, and SA Health's Monthly activity and financial data reporting.
Community Nursing Services	A range of community nursing services are provided across country areas via home care nursing, palliative care and domiciliary care services.	Recurrent Australian and State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
School Dental Service	Regular preventively focused general dental care for pre-school aged, primary and secondary school children under 18 years of age.	Recurrent State Government funding	Monthly activity and financial data reporting
Community Dental Service	Emergency and general dental care (including dentures) for adult holders of a concession card and their dependents in public dental clinics and contracted through private providers.	Recurrent State Government funding	Monthly activity and financial data reporting
Specialist Dental Service	Specialist dental services for concession card holders provided in association with students of the University of Adelaide.	Recurrent State Government funding	Monthly activity and financial data reporting
Population Oral Health Program	Development and implementation of a Lift the Lip referral tool for general practitioners, nurses and childcare workers.	Recurrent State Government funding	Monthly activity and financial data reporting
Aged Care Oral Health Projects	Various projects to improve the oral health of certain aged care populations, both in residential care and community living.	Recurrent State Government funding	Monthly activity and financial data reporting
Aboriginal Dental Liaison Project	A program to increase attendance of Aboriginal and Torres Strait Islander people in mainstream dental services.	Recurrent State Government funding	Monthly activity and financial data reporting
Oral Health Care for People with Special Needs	Identification and referral to dental services of people living in Supported Residential Facilities.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Health Call Centre - *healthdirect*	Provides health advice and information to all South Australians via a free call service, available 24 hours a day, seven days per week, from everywhere in South Australia. Experienced, specially trained Registered Nurses provide: triage; information; and advice. Nurses use a computerised decision support system that is based on clinical guidelines to advise callers on the best action to take, and when to take it. Callers are also able to find out about their local health services.	Australian and State Government funding	Monthly activity and financial data reporting
SA Ambulance Service	South Australia has a total of 107 stations state wide which are staffed by both full-time paramedics and a network of volunteers. The services provided include: 000 emergency ambulances and paramedics; patient transport services to attend to non-emergency cases; education and training for salaried and voluntary staff; and community education (e.g.. care on the roads/ambulance perspective, what to do at a vehicle crash, seizures, snake bites, CPR, asthma, hot weather, cold weather, etc).	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Allied Health Services	A range of allied health services (including: speech pathology; occupational therapy; physiotherapy; social work; dietetic/nutrition; and podiatry) provided through primary health care centres including individual therapy, health information, education, group work and advocacy.	Recurrent State Government funding	Monthly activity and financial data reporting.
Alcohol and Drug Information Service	This service is a 24-hour telephone information, counselling, and referral service for the general public, concerned family and friends, students and health professionals.	Recurrent State Government funding	Quarterly and annual client activity reports
Service Centres for people with Alcohol and Drug related problems	Four metropolitan clinics and a number of locations across country South Australia provide free, confidential service, including: counselling, assessment and referral for people from any age group with alcohol and other drug related problems; counselling and support for family members and friends; specific services for Aboriginal and young people; and consultation, education and training for other professionals on alcohol and other drug issues.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
The Woolshed	The Woolshed, is a therapeutic community for men and women aged 16 years or over with significant alcohol and/or other drug-related problems. The community operates as a drug-free environment and assists residents to develop living, work and interpersonal skills through a highly structured program involving group and individual counselling sessions, education, craft and recreation activities.	Recurrent State Government funding	Monthly activity and financial data reporting
Clean Needle Program	This program is an important public health initiative aimed at reducing the spread of blood borne viruses, including Hepatitis B, Hepatitis C and HIV. Access to sterile injecting equipment through this program is vital to reduce the spread of blood borne viruses amongst injecting drug users and to reduce the risk of blood borne virus transmission to the broader community.	Recurrent Australian and State Government funding	Twelve monthly activity and financial data reporting to the Australian Government.
Aboriginal Substance Misuse Connection Program	This program is a dedicated alcohol and drug treatment service for Aboriginal people within the inner city of Adelaide with a focus on those who are homeless and have complex needs.	Recurrent State Government funding	Six monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
APY Lands Facility and Mobile Outreach Program	The facility provides a range of treatment and rehabilitation services for people on the APY Lands who are experiencing problems caused by substance misuse. Services aim to combat dependence and assist people to reintegrate into their communities.	Recurrent Australian and State Government funding	Quarterly activity and financial data reporting
Police Drug Diversion Initiative	This initiative provides for people apprehended by police for minor drug offences to be diverted from the criminal justice system into education, assessment and treatment.	Annual Australian Government funding	Quarterly client activity and annual financial reports to the Australian Government.
City Watch House Nursing Program	The aim of this service is to: ensure assessment, treatment and referral of people held in police custody at the City Watch House; encourage people detained at the City Watch House to seek treatment by capitalising on the reality that they have entered into the criminal justice system as a result of being apprehended for substance abuse issues and/or mental health/ behavioural problems; and reduce the risk of further offending by enabling people apprehended to link to appropriate mental health and community services prior to their release from the City Watch House.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Court Assessment and Referral Drug Scheme (CARDS) and Youth Court	Involves the referral of defendants appearing before a Magistrates Court or Youth Court, whose offending may be drug-related, into drug assessment and treatment. Individuals accepted on to the scheme are required to attend a minimum of four treatment sessions over a three month period.	Annual Australian Government funding	Annual activity and financial data reporting to Australian Government.
Tobacco Program	Tobacco Control Unit coordinates a range of tobacco control initiatives and community based programs such as Quit SA and the Tobacco Control Research and Evaluation Program.	Recurrent State Government funding	Monthly activity and financial data reporting
The Good Sports Program	The program works with community sporting clubs to assist them to manage alcohol responsibly in their venues. The program challenges community and club culture around excessive alcohol consumption, underage drinking and drink driving.	Recurrent State Government funding and grant from Motor Accident Commission	Activity and financial reports to State Government, Australian Drug Foundation and Motor Accident Commission
Driver Assessment Clinic	The clinic assesses drivers for alcohol and/or other drug dependency who have been referred by the Courts Administration Authority and the Registrar of Motor Vehicles.	Recurrent State Government funding	Annual attendance / non-attendance reports to Courts Administration Authority

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Sexual Health Services	A large non-government organisation receives Government funding towards providing a broad range of sexual and reproductive health services for and with the South Australian community within a Primary / Public Health Framework. This organisation provides comprehensive and confidential sexual health care including: contraceptive advice, supply and prescription; gynaecological issues; sexual health assessment; safer sex information; sexually transmitted infection checks and treatment; sexual relationship problems; women's health, including Pap smears, breast checks and menstrual issues; pregnancy testing, ECP supply; unplanned pregnancy options and counselling; fertility issues; and abuse and violence issues.	Recurrent State Government funding	Monthly activity and financial data reporting
Home Nursing Service	A large non-government organisation receives Government funding towards providing a 24 hour, seven day nursing services to people in their homes or residential care facilities. The services provided include: post acute care; palliative care and bereavement support; wound care; medication management; continence management; cystic fibrosis care; and stomal therapy. A 24 hour telephone based advice, information and support service is also provided to clients.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Metro Home Link	This service provides flexible packages of care to clients in metropolitan area in their place of residence (this includes residential care facilities). There are two types of care packages: home supported discharge; and hospital avoidance. Examples of services provided include: showering and personal care; transportation; medication management/ supervision; client observation in their own home; and linkages to ongoing longer term services, allied health; acute wound care, general practitioner home visits, physiotherapy, intravenous therapy, tracheostomy care and PEG care.	Recurrent State Government funding	Monthly activity and financial data reporting
Transitional Care Program	Provision of residential and community based care packages to assist older people with the transition from an acute service episode back to home.	Recurrent State Government funding	Monthly activity and financial data reporting
Chronic Disease Community Program	This program aims to improve the quality of life for people living with chronic diseases. It provides targeted and tailored care packages with self management support to assist people to better manage their health and well being, and integrated management plans are developed for all participants The program has a demonstrated impact on decreasing acute exacerbations of the chronic illness and a reduction in episodes of unplanned hospitalisation.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
GP Plus Practice Nurse initiative	Funding has been provided for a four year period to employ up to 50 practice nurses per year in general practices across the metropolitan area. These practice nurses are placed for a period of three to five months with the participating general practices. This initiative aims to: reduce workforce pressure on general practice in areas of high demand or areas with significantly high rates of chronic disease; to support general practitioners in the improved management of chronic conditions from early detection to complex co-morbidities; and to complement the role of the general practitioner by providing a variety of services, ranging from clinical care and service coordination, to maintaining good health through screening, health promotion and education for individuals and the community.	Four year State Government funding	Monthly activity and financial data reporting
Supported Residential Facilities (SRFs) Allied Health Program	Provision of allied health and nursing services to residents in SRFs who have complex health needs including disability, mental health and chronic conditions.	Annual State Government funding	Quarterly activity data reporting and yearly funding acquittal.

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Do It For Life Program	This program is a lifestyle modification program aimed at high risk adults with SNAPS risk factors (Smoking, Nutrition, Alcohol, Physical Inactivity and Stress). Eligible clients are from vulnerable and disadvantaged populations who are assessed at risk of developing chronic disease.	Recurrent State Government funding	Monthly activity and financial data reporting
Day Rehabilitation	Provision of a multidisciplinary allied health and rehabilitation service for people in the community on discharge from hospital.	Recurrent State Government funding	Monthly activity and financial data reporting
New Arrival Refugees Program	Specialist services providing a range of early intervention, prevention and community capacity building initiatives to improve access to health services for new arrival refugees. Services provided by multi-disciplinary teams from specialist service and other primary health care centres. Services include: medical and nursing clinics; health information/education; immunisation; counselling; and capacity building for other health providers.	Recurrent State Government funding	Monthly activity and financial data reporting

Source: SA Government (unpublished).

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Primary Health	Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities. Services vary from site to site based on community need and accessibility to similar services provided by government or a non-government provider. The size of sites also varies: small sites provide a limited range of services generally based around community nursing. CommunityHealth Centres offer a broader range of services in the community, while rural hospitals (including multi-purpose services/centres) provide inpatient care and, at a number of locations, residential aged care services. Rural hospitals (including multi-purpose services/centres) also provide community health services as part of the service mix.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania *Together*, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*

Primary Health (continued)	Specifically, the Tasmanian Government funds or contributes significantly to the funding of the following program areas: Rural inpatient facilities; Accident and Emergency and Ambulance Services (limited sites); Community Health Centres; Community Nursing; Day Centres; Palliative Care (community and inpatient); Aged Care Assessment Program; Continence Services; Allied Health Domiciliary and Community Care; Community Rehabilitation Unit (south only); Orthotics and Prosthetics Service; Community Equipment Scheme, Spinal Account and Continence Aids; Community Options Case Management services; Youth Health; Health Promotion; Community Recovery Coordination; General Practice.
	
	The Tasmanian Government oversees and delivers the following program areas:
	Multi-purpose Services/Centres
	Residential Aged Care
	Community Aged care Packages
	Rural Health Services
	    Regional Health services
	    More Allied Health Services Program
	    Medical Specialist Outreach Program		

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Oral Health Services	Oral Health Services provides emergency, general dental care, and dentures to eligible adults (holders of a Health Care or Pensioner Concession Card). Services are also provided to all children up to, but not including the age of 18. Oral Health Services also engages in health promotion and prevention activities to promote oral health on a population basis.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers, the Annual Report, and Tasmania *Together*. Performance reporting is also provided nationally through the Report On Government Services, the Australian Institute of Health and Welfare (via the Australian Research Centre for Population Oral Health), and to the Australian Health Ministers' Conference via the National Oral Health Plan Monitoring Group.
Population and Health Priorities	Population and Health Priorities focuses on population groups (including Indigenous health and women's and men's health) and implements programs aimed at preventing or reducing risk factors that lead to chronic conditions.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania *Together*, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Alcohol and Drug Services	Alcohol and Drug Services, which provides a range of specialist alcohol and other drug interventions and treatments at both individual and population levels.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania *Together*, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.
Public and Environmental Health Services	Public and Environmental Health Services monitors the health of the Tasmanian population, and implements programs to protect and promote health.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	As for Alcohol and Drug Services
Children and Family Services	Children and Family Services provides services for child protection, child health and parenting, psychological support and therapeutic services, family violence counselling and support, the community support program, which funds services provided by community sector organisations, and gambling support.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	As for Alcohol and Drug Services

Source: Tasmanian Government (unpublished).

Table 11A.59 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Alcohol and Drug Program	Provides consultation and liaison services in the acute sector. Liaison and clinical advice to other health professionals. Services to women on the program who are pregnant or have babies. Education and information to community groups and organisations	Through a designated budget	Monthly/Annual reports against output targets and budget
Corrections Health	Coordinates clinical service to adult remand and youth detention services. Policy advice to ACT Health on Corrections issues. Involvement in development of health service to ACT prison	Through a designated budget	Monthly/Annual reports against output targets and budget
Child, Youth and Women's Health Program	Child health checks and child health medical assessment, parenting education and support, childhood immunisation, audiometry and orthoptic screening, physiotherapy, occupational therapy, speech pathology, social work and psychology services , women's health service including cervical screening and counselling for women affected by violence, Child at Risk Health Unit, health care interpreting (Migrant Health Unit)	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 11A.59 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Dental Health Program	Provides adult and child and youth dental services to eligible clients, oral health promotion activities, oral health information and advice, assessments and restorative dental treatment, oral surgery under general anaesthetic, dentures and dental appliances, oral hygiene and dental emergency services	Through a designated budget	Monthly/Annual reports against output targets and budget
Continuing Care Program	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition and social work), acute, post acute and rapid response services, and specialist nursing assessments	Through a designated budget	Monthly/Annual reports against output targets and budget
Acute Support Program	Allied health and multidisciplinary diabetes servcies in the acute and community based settings - nutrition, occupational thetrapy, physiotherapy, psychology, social work and speech pathology; diabetes (primary and tertiary level programs)	Through a designated budget	Monthly/Annual reports against output targets and budget

Source: ACT Government (unpublished).

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Remote Health	Primary health care (PHC) services are delivered to the remote population of the Northern Territory through a network of 53 Remote Health Centres. Core PHC services include 24-hour emergency services, primary clinical care, population health programs, access to retrieval services, medical and allied health specialist services, and provision of essential medications.	These services are funded through an identified program within the NT Department of Health and Families budget. Additionally, Federal funding for a number of programs is provided through DoHA.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report. The Department of Health and Families has been working for some time the Australian Government Office of Aboriginal and Torres Strait Islander Health in the development of core primary health care indicators that will be collected by Government and non-Government remote primary health care providers across the NT.
Maternal/Child/Youth Health Services	Child and Family Health Nursing Services are provided through the Urban Community Health Branch. The aim of the service is to work in partnership with and support families to nurture the health and wellbeing of their children. This is achieved through provision of: • universal home visits for all new babies • key health and development assessments • parenting support and education through individual contact and groups such as Territory Parents Support and Sleep and Settling groups • childhood immunisations.	These services are funded through an identified program within the NT Department of Health and Families budget. Additionally, Federal funding is provided for family planning services through the Public Health Outcomes Funding Agreement (PHOFA).	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report. Additionally the Community Health Branch reports against the Palmerston Regional Plan.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Oral Health Services	Oral Health Services provides oral health promotion, screening and treatment to all children up to school-leaving age. Services to eligible adults are provided from remote community health centres and town-based clinics.	These services are funded through an identified program within the NT Department of Health and Families budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report.
Preventable Chronic Disease Services	Preventable Chronic Disease Services provides policy and professional advice and support to health professionals in both government and non-government services across the NT. This involves providing direction about early detection and management of chronic diseases, including the development of clinical guidelines, health systems, registers and recall systems, and quality improvement processes. The program also provides direction and support for primary prevention and health promotion for chronic disease risk factors.	These services are funded through an identified program within the NT Department of Health and Families budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Public Health Nutrition and Physical Activity services	Public health nutritionists provide training and support to primary health care teams to assist in the promotion of good nutrition to the community and in management of people with nutrition related conditions. In the urban areas, they offer individual and group consultations through community care centres. They also work with people outside the health sector to promote improved nutrition and better food supply, for example remote community stores.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Health Promotion Strategy Unit	The Health Promotion Strategy Unit (HPSU) is tasked with strengthening the capacity for effective health promotion across the Department of Health and Families (DHF). This involves facilitating a uniform understanding of health promotion across the DHF; reducing divisions between program areas by providing strategic and policy support to key staff; and a renewed commitment to the planning and development of a sustainable health promotion workforce through greater investment into research, evaluation, education and training.	These services are funded through an identified strategic unit within the NT Department of Health and Families budget.	Regular reporting against the 2008-2009 HPSU Business Plan. Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in the Department of Health and Families Annual Report.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Women's Health Strategy Unit	The Women's Health Strategy Unit (WHSU) develops strategic directions in partnership with government and community stakeholders. Ongoing focus in the past year has included implementation of the Department's Domestic and Family Violence Policy; recruitment of a Coordinator for the Women's Information Centre in Alice Springs; greater collaboration with Office of Women's Policy (OWP) regarding common work in the NT Women's Policy Framework, particularly with OWP moving to the Department; collaboration with OWP and the Health Promotion Strategy Unit regarding gender equity measures in line with the development of national men's and women's health policies.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Urban Community Health Services	The Community Health Branch provides services in mainly urban centres throughout the NT, including Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs. Services include Child Youth and Family Health Services, Community and Primary Care Services (including social work, palliative care, specialist nursing services and a community resource team), Hearing Services, School Health Services and Home Birth Services (Darwin and Alice Springs). All services provided by the Community Health Branch are accredited and the Branch is implementing a continuous improvement process through the development and implementation of new service models for Child and Family Health Services, Community and Primary Care and School Health Services. The Branch participates in regional and national primary health care reforms and seeks to improve access and equity to services for urban communities. The Branch also funds a number of non-government organisations to provide services to achieve outcomes within the areas of Child and Family Health, and Community and Primary Care.	These services are funded through an identified program within the NT Department of Health and Families budget. Additionally, Federal funding is provided for HACC services delivered through the Specialist Nursing program.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report. Additionally the Community Health Branch reports against the Palmerston Regional Plan.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
School Health Services	The aim of the school health service is to ensure school aged youth engage in their health and wellbeing to make informed choices that promote optimal future health and life outcomes. Health Promoting School Nurses support delivery of health education in: • smoking, alcohol and other drugs • nutrition • physical activity • health and well being • sexual health. They work with the school community to plan, develop, implement and evaluate school identified health promoting programs, policies and strategies.	These services are funded through an identified program within the NT Department of Health and Families budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report.
Hearing Services	Hearing services are provided in urban centres and remote communities and cover comprehensive diagnostic audiological and audiometric services, liaison with and education of other health professionals on management of hearing loss, and education of parents and teachers.	These services are funded through an identified program within the NT Department of Health and Families budget. Additionally, Federal funding is provided for hearing services through OATSIH.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Well Women's Cancer Screening	Well Women's Cancer Screening (WWCS) incorporates two national programs both of which aim to detect cancers at an early stage to prevent mortality and morbidity: 1. BreastScreen NT, which is a free breast x-ray screening program targeted at women with no breast symptoms aged 50 to 69 years. Clinics are provided in Alice Springs, Katherine, Tennant Creek, Darwin, Palmerston and Nhulunbuy. 2. The NT Cervical Screening Program encourages women between the ages of 20 and 69 who have been sexually active to have a pap smear every two years. The NT Pap Smear Register is a backup reminder system, sending women and their doctors a letter if they are overdue for their next pap smear. Unless they choose not to be, women are automatically placed on the register when they have a pap smear. It also funds a network of women's health educators across the NT.	These services are funded through an identified program within the NT Department of Health and Families budget. Additionally, Federal funding is provided for family planning services through the Public Health Outcomes Funding Agreement (PHOFA).	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report. Additionally the Community Health Branch reports against the Palmerston Regional Plan. WWCS prepares reports for PHOFA, National Aboriginal Health Performance Indicators, and annually the Productivity Commission, Safety Monitoring of the National Cervical Screening Guidelines, National accreditation standards, Australian Government National Public Health Expenditure Reports, the Australian Institute of Health and Welfare National Monitoring report for cervical and breastscreen.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	CDC Darwin provides rabies vaccine for pre-exposure prophylaxis to Australian Bat Lyssavirus to persons at risk due to occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and regional centres. Education programs are provided to the community and to occupational groups.	These services are funded through an identified program within the NT Department of Health and Families budget, with the Vaccine costs refunded by DOHA.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Sexual Health and Blood Borne Viruses Program	NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections and blood borne viruses such as HIV/AIDS and Hepatitis C.	The program is funded through an idenitifed budget within the Deparment of Health and Community Services. Some external funding is provided via the COAG initiative and OATSIH.	Reporting is against the business plan of the NT Sexual Health Advisory Group and the more detailed program business plan.
TB Control Unit	The TB Control Unit covers screening of high risk groups (contacts, refugees, prisoners, health workers, fisherpersons); monitoring and administration of directly observed treatment for active TB and leprosy; remote community visits to implement preventive and early diagnostic strategies (treatment of latent TB infection, community screening); and provision of information to the public, service providers and governments.	These services are funded through an identified program within the NT Department of Health and Families budget. Some external funding is provided via Customs and DIAC for the Illegal Foreign Fisherman (IFF).	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2007-08

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Rheumatic Heart Disease	NT wide program with the aim of reducing the burden of rheumatic heart disease amongst the Indigenous population by reducing the occurence of acute rheumatic fever. The program provides health professionals and community members with best practice support, education, resource development and supply and patient care.	These services are funded through an identified program within the NT Department of Health and Families budget. External funding is also provided via DOHA.	Performance measures against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report.

Source: NT Government (unpublished).