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# 11 Primary and community health

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### **Attachment tables**

Attachment tables are identified in references throughout this Indigenous Compendium by an 'A' suffix (for example, in this chapter, table 11A.3). As the data are directly sourced from the 2010 Report, the Compendium also notes where the original table, figure or text in the 2010 Report can be found. For example, where the Compendium refers to '2010 Report, p. 11.15' this is page 15 of chapter 11 of the 2010 Report, and '2010 Report, table 11A.2' is attachment table 2 of attachment 11A of the 2010 Report. A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at ([www.pc.gov.au/gsp](http://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.

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## Indigenous data in the Primary and community health chapter

The Primary and community health chapter in the *Report on Government Services 2010* (2010 Report) contains the following information on Indigenous people:

- estimated episodes of healthcare by services for which SAR data are reported ('000), 2007-08
- older people who received an annual health assessment, 2008-09
- older people who received an annual health assessment (2004-05 to 2008-09)
- people who received a health check or assessment by age
- primary healthcare services for which SAR data are reported that provided early detection services (2003-04 to 2007-08)
- valid vaccinations supplied to children under 7 years of age, by provider type, 2004–2009 (per cent)
- separations for vaccine preventable conditions, 2007-08
- potentially preventable separations for selected acute conditions, 2007-08
- potentially preventable separations for selected chronic conditions, 2007-08
- ratio of separation rates to all people for all diabetes diagnoses, 2007-08.

The primary and community health attachment contains additional data relating to Indigenous people including:

- Indigenous primary healthcare services for which service activity reporting (SAR) data are reported (number), 2003-04 to 2007-08
- services and episodes of healthcare by Indigenous primary healthcare services for which service activity reporting (SAR) data are reported, by remoteness category (number) , 2003-04 to 2007-08
- proportion of Indigenous primary healthcare services for which service activity reporting (SAR) data are reported that undertook selected health related activities, 2007-08 (per cent)
- full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which service activity reporting (SAR) data are reported, as at 30 June 2008 (number)
- separations for selected vaccine preventable conditions by Indigenous status, 2007-08 (per 1000 people)
- separations for selected acute conditions by Indigenous status, 2007-08 (per 1000 people)

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- separations for selected chronic conditions by Indigenous status, 2007-08 (per 1000 people)
  - ratio of separations for Indigenous males to all males, 2007-08
  - ratio of separations for Indigenous females to all females, 2007-08.

### **Indigenous primary and community healthcare services**

Indigenous Australians use a range of primary and community healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments.

Additional health programs for Indigenous Australians are funded by a number of jurisdictions. In 2008-09, these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.15–11A.22 and 2010 Report, table 11A.59).

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

For 2007-08, SAR data are reported for 155 Indigenous primary healthcare services (table 11A.1). Of these services, 56 (36.1 per cent) were located in remote or very remote areas (table 11A.2). 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.3). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Over 1.8 million episodes of healthcare were provided by participating services in 2007-08 (table 11.1). Of these, around 641 000 (34.6 per cent) were in remote or very remote areas (table 11A.2).

**Table 11.1 Estimated episodes of healthcare for Indigenous people by services for which SAR data are reported ('000)<sup>a</sup>**

	<i>NSW and ACT<sup>b</sup></i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>Aust</i>
2003-04	430	169	267	302	142	22	280	1 612
2004-05	415	151	254	274	145	23	323	1 585
2005-06	505	179	240	281	101	29	347	1 681
2006-07	440	173	251	284	114	31	352	1 644
2007-08 <sup>c</sup>	420	167	267	306	111	36	543	1 850

<sup>a</sup> An episode of healthcare involves contact between an individual client and service staff to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare and/or information by staff. Outreach provision, for example episodes at outstation visits, park clinics and satellite clinics, is included. Episodes of healthcare delivered over the phone are included. <sup>b</sup> Data for NSW and the ACT have been combined for confidentiality purposes. <sup>c</sup> Preliminary results.

Source: DoHA (unpublished) SAR data collection; 2010 Report, table 11.5, p. 11.12.

The services included in the SAR data collection employed 2603 full time equivalent health staff (as at 30 June 2008). Of these, 1496 were Indigenous (57.5 per cent). The proportions of doctors and nurses employed by services surveyed who were Indigenous were relatively low (2.1 per cent and 9.7 per cent, respectively) (table 11A.4).

## Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for primary and community health in the 2010 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 11.1. The performance indicator framework shows which data are comparable in the 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

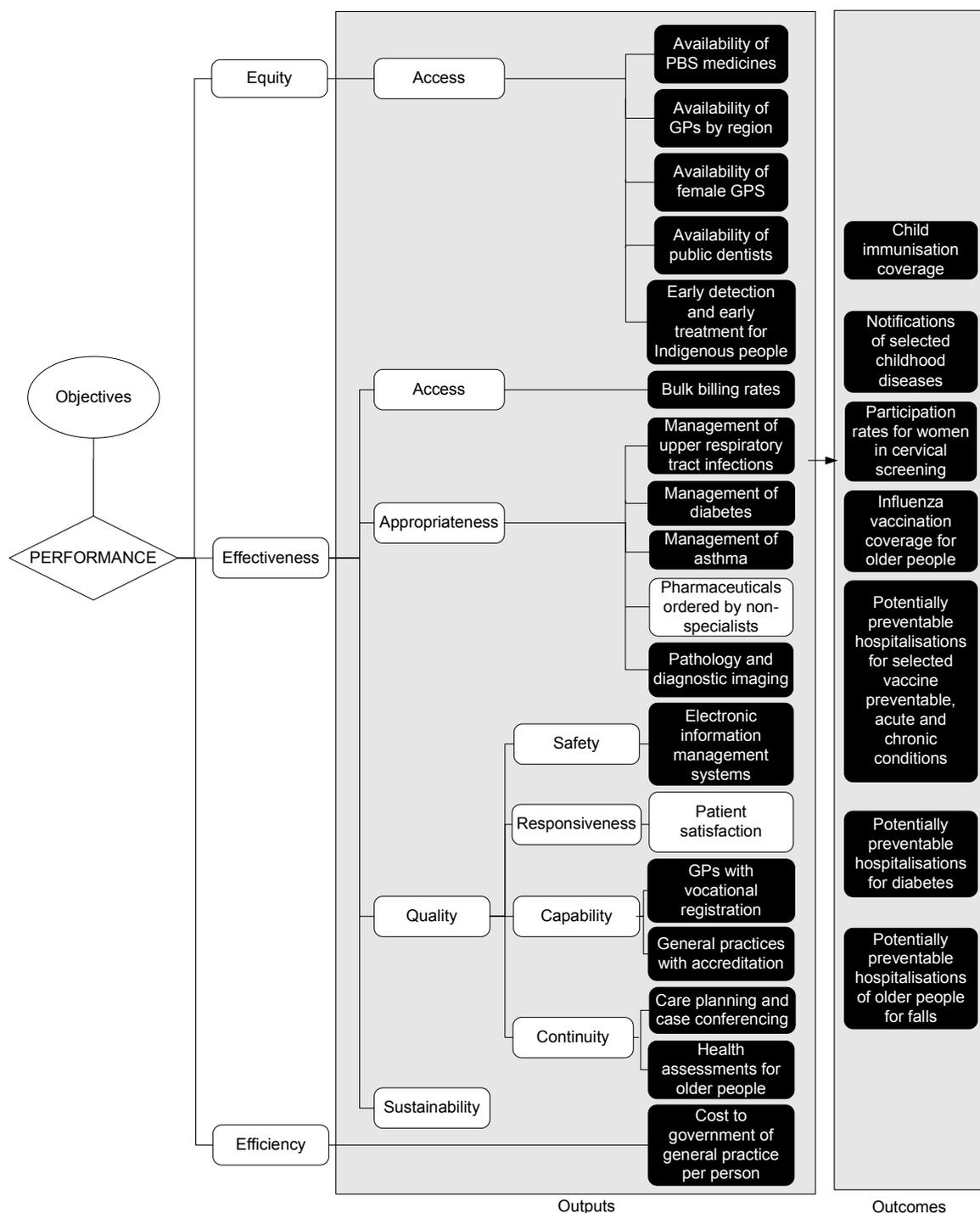
The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels,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

The Council of Australian Governments (COAG) has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see 2010 Report, chapter 1 for more detail on reforms to federal financial relations). The National Healthcare Agreement covers the areas of health and aged care services, while the National Indigenous Reform Agreement establishes specific outcomes for reducing the level

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of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council.

**Figure 11.1 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

Source: 2010 Report, figure 11.2, p. 11.15.

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For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see 2010 Report, chapter 1). Such issues have contributed to the generally poor health status of Indigenous people relative to other Australians (see the Health Preface and SCRGSP 2009).

### **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 11.1).

### Box 11.1 Early detection and early treatment for Indigenous people

'Early detection and early treatment for Indigenous people' is defined by the following four measures:

- Older people who received a voluntary health assessment by Indigenous status, defined as the proportion of older people who received a voluntary health assessment by Indigenous status. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous people become eligible for 'older' people's services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health preface).
- Older Indigenous people who received a voluntary health assessment, time series, defined as the proportion of older Indigenous people who received a voluntary health assessment in successive years of a five year period.
- Indigenous people who received a voluntary health assessment or check by age group, defined as the proportion of Indigenous people who received a voluntary health assessment/check, in each of the three age groups for which they are available (0–14 years, 15–54 years and 55 years or over).
- Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services, defined as the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities in the services provided.

A reduction in the gap between the proportion of all older people and older Indigenous people that received a health assessment indicates more equitable access to early detection and early treatment services for Indigenous people. An increase over time in the proportion of older Indigenous people who received a voluntary health assessment is desirable as it indicates improved access to these services. A reduction in the gap between the proportion of Indigenous people in different age groups that received a health assessment/check can indicate more equitable access to early detection and treatment services within the Indigenous population. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

This indicator provides no information about early detection and early treatment services that are not provided under Medicare. Such services are provided by salaried GPs in community health settings, hospitals and Indigenous-specific primary healthcare services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.

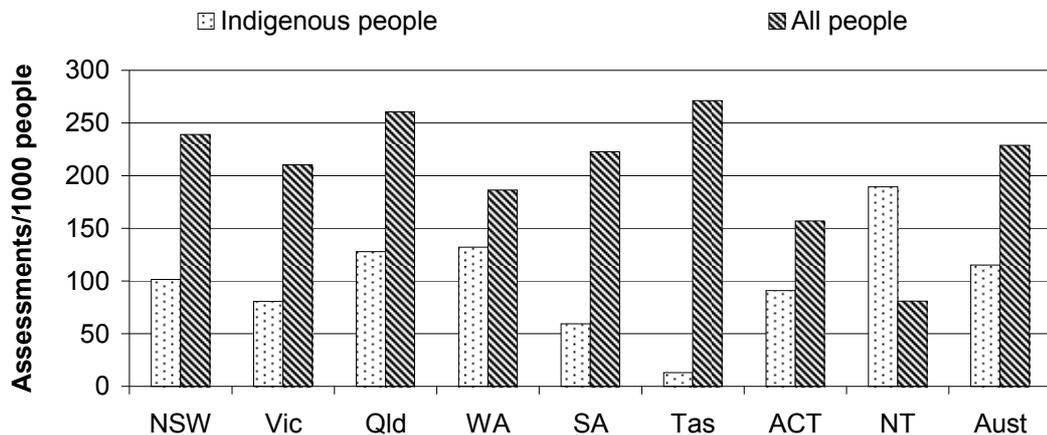
Data for this indicator are comparable.

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2008a; SCRGSP 2009). Early detection and early treatment refers to the identification of individuals who are at high risk for, or in the early stages of, such conditions. Early detection and early treatment services provide opportunities for timely prevention and intervention measures, and their availability and uptake is understood to be a significant determinant of people's health.

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

In 2008-09 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment (figure 11.2). This suggests that access to early detection and early treatment services may not be equitable.

**Figure 11.2 Older people who received an annual health assessment by Indigenous status, 2008-09<sup>a, b</sup>**

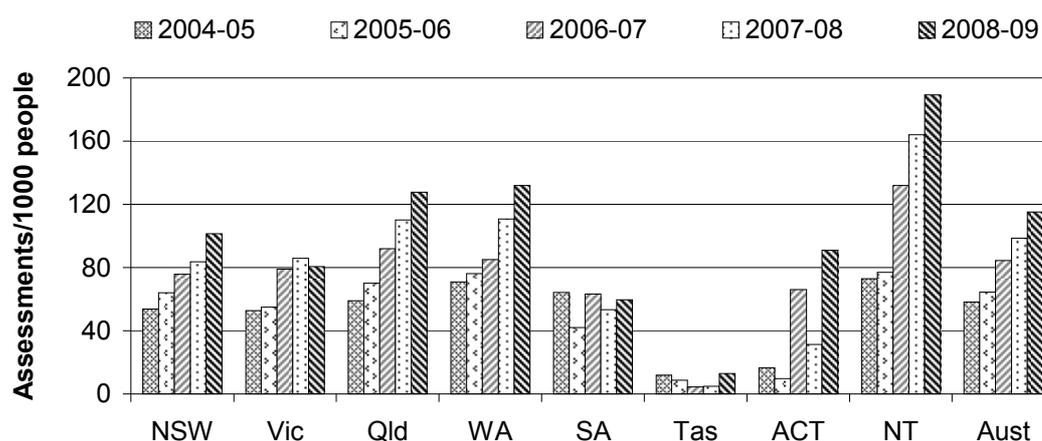


<sup>a</sup> Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. <sup>b</sup> Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people'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

Source: Derived from DoHA (unpublished) MBS data collection, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0 and ABS 2009 *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.5; 2010 Report, figure 11.8, p. 11.24.

The proportion of older Indigenous people who received an annual health assessment steadily increased in most jurisdictions between 2004-05 and 2008-09 (figure 11.3). This indicates that access to early detection and early treatment services for this population has improved in these jurisdictions and nationally.

**Figure 11.3 Older Indigenous people who received an annual health assessment<sup>a, b</sup>**



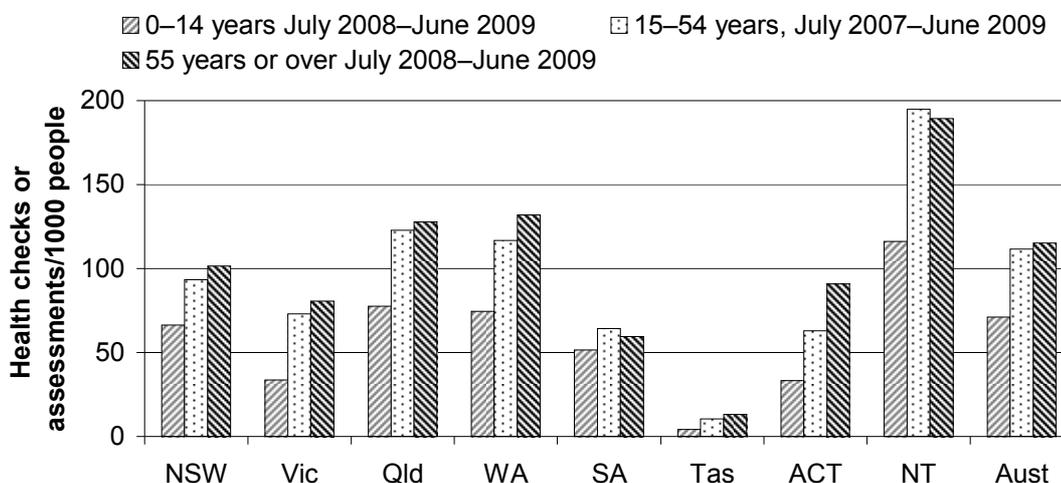
<sup>a</sup> Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people. <sup>b</sup> Historical rates in this figure may differ from those in previous Reports, as new ABS Indigenous population estimates and projections have been used following the 2006 Census of Population and Housing.

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.6; 2010 Report, figure 11.9, p. 11.25.

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

The proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.4). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

Figure 11.4 Indigenous people who received a health check or assessment by age<sup>a, b</sup>



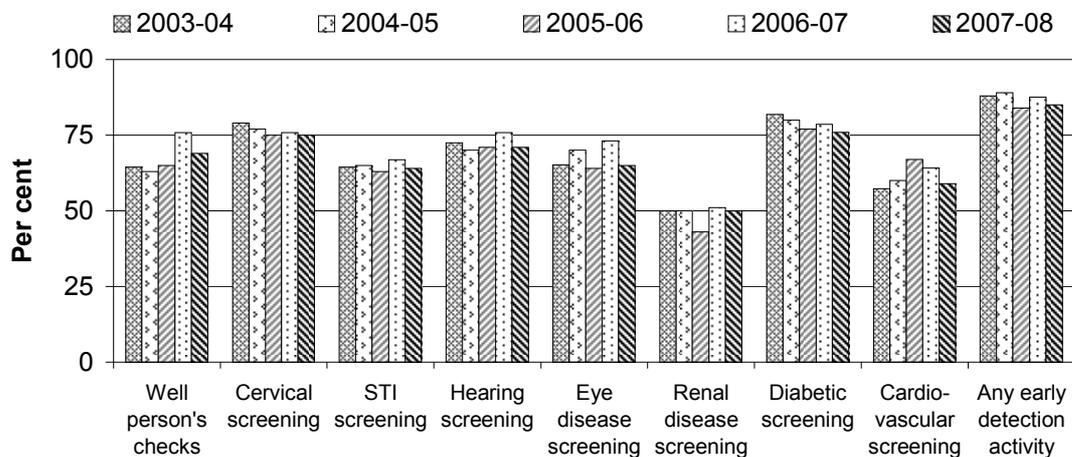
<sup>a</sup> Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average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

<sup>b</sup> Health checks for 0-14 year olds, and health assessments for those aged 55 years or over, are available annually. Data for these age groups are for the period 1 July 2008 to 30 June 2009. Health checks for 15-54 year olds are available biennially, and these data are for the period 1 July 2007 to 30 June 2009.

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.7; 2010 Report, figure 11.10, p. 11.26.

Figure 11.5 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2007-08.

**Figure 11.5 Indigenous primary healthcare services for which SAR data are reported that provided early detection services**



Source: DoHA (unpublished) SAR data collection; table 11A.8; 2010 Report, figure 11.11, p. 11.27.

Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

### Child immunisation coverage

Many providers deliver child immunisation services (table 11.2). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentive Scheme, which provides incentives for the immunisation of children under seven years of age.

**Table 11.2 Valid vaccinations supplied to children under 7 years of age, by provider type, 2004–2009 (per cent)<sup>a, b</sup>**

<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	86.0	56.0	83.0	66.0	69.0	90.0	50.0	5.0	73.0
Council	4.4	43.0	6.0	4.0	21.0	9.0	–	–	15.0
State or Territory health department	–	–	–	8.0	–	–	–	1.0	1.0
Flying doctor service	–	–	–	–	–	–	–	–	–
Public hospital	1.2	1.0	3.0	2.0	1.0	–	1.0	8.0	2.0
Private hospital	–	–	–	–	–	–	–	1.0	–
Indigenous health service	1.0	–	1.0	1.0	–	–	–	14.0	1.0
Indigenous health worker	–	–	–	–	–	–	–	–	–
Community health centre	8.0	–	7.0	19.0	9.0	1.0	49.0	71.0	8.0
Community nurse	–	–	–	–	–	–	–	–	–
<b>Total</b>	<b>100.0</b>								

<sup>a</sup> 1 July 2004 to 30 June 2009. Data relate to the State or Territory in which the immunisation provider was located. <sup>b</sup> A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. – Nil or rounded to zero.

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.9; 2010 Report, table 11.6, p. 11.49.

## Potentially preventable hospitalisations

Potentially preventable hospitalisations refer to hospital admissions that may be avoided through appropriate management in the primary healthcare sector and/or the broader community (AIHW 2008b, 2009) (2010 Report, box 11.24).

Data are reported against the two potentially preventable hospitalisations indicators by Indigenous status.:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions
- potentially preventable hospitalisations for diabetes.

The indicator 'potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions' combines three measures that in previous Reports were included as separate indicators — 'hospitalisations for vaccine preventable conditions', 'hospitalisations for selected acute conditions' and 'hospitalisations for selected chronic conditions'. This is consistent with current national reporting conventions, for example, the *National Healthcare Agreement*.

Adjustments are made to account for differences in the age structures of these populations across states and territories. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories.

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

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

*Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions*

‘Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.2).

**Box 11.2 Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions**

‘Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions’ is defined by three measures:

- Hospitalisations for vaccine preventable conditions, defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions, per 1000 people.
- Hospitalisations for selected acute conditions, defined as the number of hospital separations per 1000 people for the following conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

(Continued on next page)

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### Box 11.2 (Continued)

- Hospitalisations for selected chronic conditions, defined as the number of hospital separations per 1000 people for the following conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease.

Selected conditions are defined according to the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2009; DHS 2002).

Low or reducing separation rates for vaccine preventable conditions may indicate improvements in the effectiveness of the vaccination program. Low or reducing separation rates for selected acute conditions may indicate more effective treatment of these conditions in the primary and community healthcare sector. Low or reducing separation rates for selected chronic conditions may indicate more effective management of these conditions in the primary and community healthcare sector.

Data are reported for each measure for all people and by Indigenous status. A reduction in the gap in hospital separation rates between Indigenous and all people can indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions, for example, the underlying prevalence of conditions, patient compliance with treatment, and the number and virulence of influenza strains. Public health measures that are not reported in this chapter can also influence hospitalisation rates.

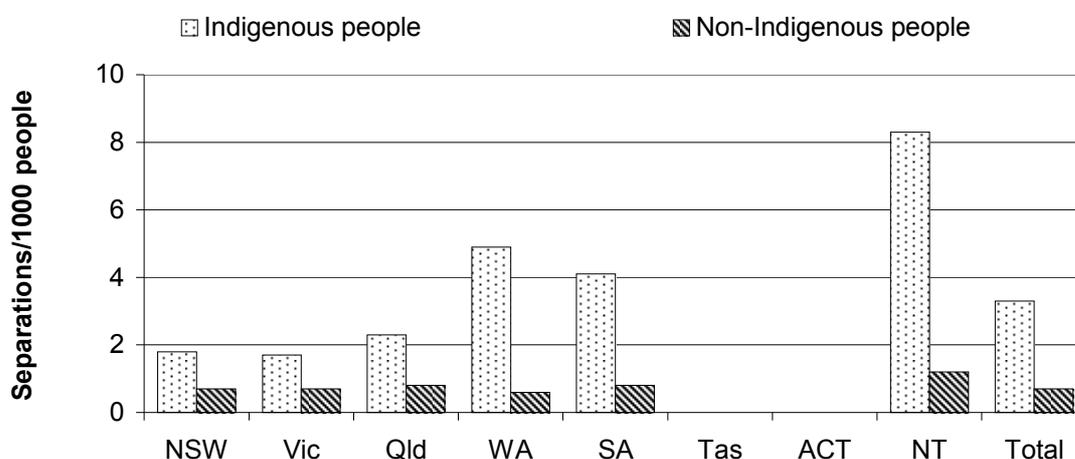
Data for this indicator are comparable.

### *Vaccine preventable hospitalisations*

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.7 per 1000 people in 2007-08. Nationally, influenza and pneumonia accounted for 78.9 per cent of hospital separations for vaccine preventable conditions in 2007-08 (2010 Report, table 11.7).

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.6).

**Figure 11.6 Separations for vaccine preventable conditions by Indigenous status, 2007-08<sup>a, b, c, d, e</sup>**



<sup>a</sup> Separation rates are directly age standardised to the Australian population at 30 June 2001. <sup>b</sup> Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. <sup>c</sup> Indigenous separation rates are based on state of hospitalisation while non-Indigenous rates are based on state of usual residence. <sup>d</sup> NT data for Indigenous people are for public hospitals only. <sup>e</sup> Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.10; 2010 Report, figure 11.34, p. 11.59.

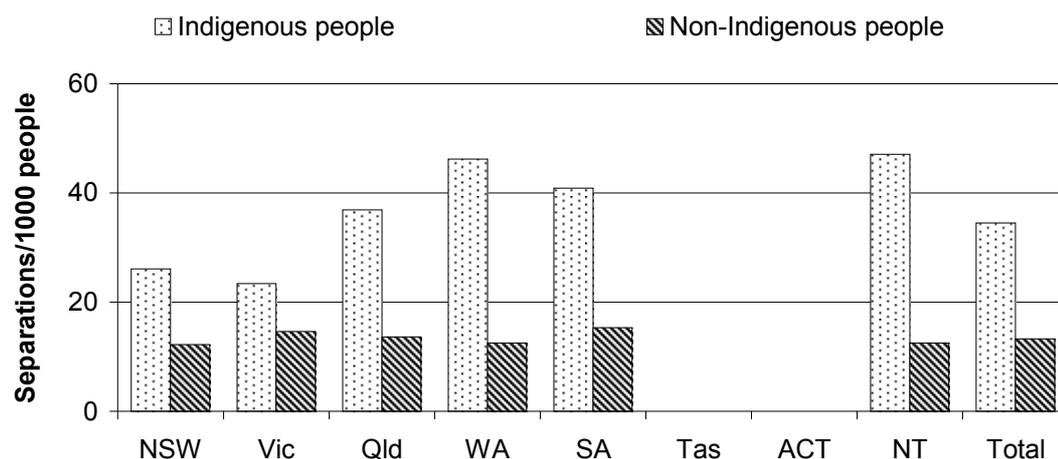
Age standardised hospital separation rate ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2007-08 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Victoria, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.13 and 11A.14).

### *Hospitalisations for selected acute conditions*

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis recorded the highest rates of hospitalisation nationally in 2007-08 (2010 Report, table 11.8).

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.7).

**Figure 11.7 Separations for selected acute conditions by Indigenous status, 2007-08<sup>a, b, c, d, e</sup>**



<sup>a</sup> Separation rates are directly age standardised to the Australian population at 30 June 2001. <sup>b</sup> Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. <sup>c</sup> Indigenous separation rates are based on state of hospitalisation while non-Indigenous rates are based on state of usual residence. <sup>d</sup> NT data for Indigenous people are for public hospitals only. <sup>e</sup> Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for analysis.

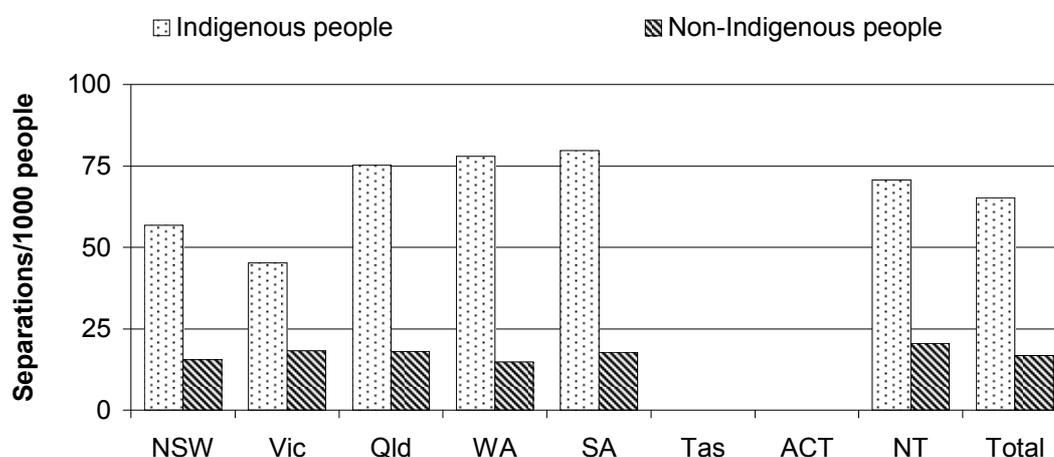
Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.11; 2010 Report, figure 11.35, p. 11.61.

### *Hospitalisations for selected chronic conditions*

Of the selected chronic conditions, diabetes complications, chronic obstructive pulmonary disease, congestive cardiac failure, asthma and angina recorded the highest rates of hospitalisation nationally in 2007-08. The hospitalisation rate for diabetes complications was more than three times higher than the rate for any other of the selected conditions (2010 Report, table 11.9).

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.8).

**Figure 11.8 Separations for selected chronic conditions by Indigenous status, 2007-08<sup>a, b, c, d, e</sup>**



<sup>a</sup> Separation rates are directly age standardised to the Australian population at 30 June 2001. <sup>b</sup> Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. <sup>c</sup> Indigenous separation rates are based on state of hospitalisation while non-Indigenous rates are based on state of usual residence. <sup>d</sup> NT data for Indigenous people are for public hospitals only. <sup>e</sup> Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.12; 2010 Report, figure 11.36, p. 11.62.

### *Potentially preventable hospitalisations for diabetes*

‘Potentially preventable hospitalisations for diabetes’ is an indicator of governments’ objective to reduce hospitalisations due to diabetes through the provision of high quality, appropriate and effective management of diabetes in the primary and community health sector (box 11.3).

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### **Box 11.3 Potentially preventable hospitalisations for diabetes**

'Potentially preventable hospitalisations for diabetes' is defined by two measures:

- the number of hospitalisations for diabetes mellitus as the principal diagnosis, per 100 000 people
- the number of hospitalisations for lower limb amputation with a principal or additional diagnosis of diabetes, per 100 000 people.

Rates are adjusted to account for differences in the age structures of State and Territory populations.

Low or reducing rates can indicate an improvement in GPs' and community health providers' management of patients' diabetes. A comparison is made between Indigenous and all other people in the ratio of age standardised hospital separation rates of Indigenous people to all people. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, patient compliance with measures to manage diabetes, and the underlying prevalence of diabetes.

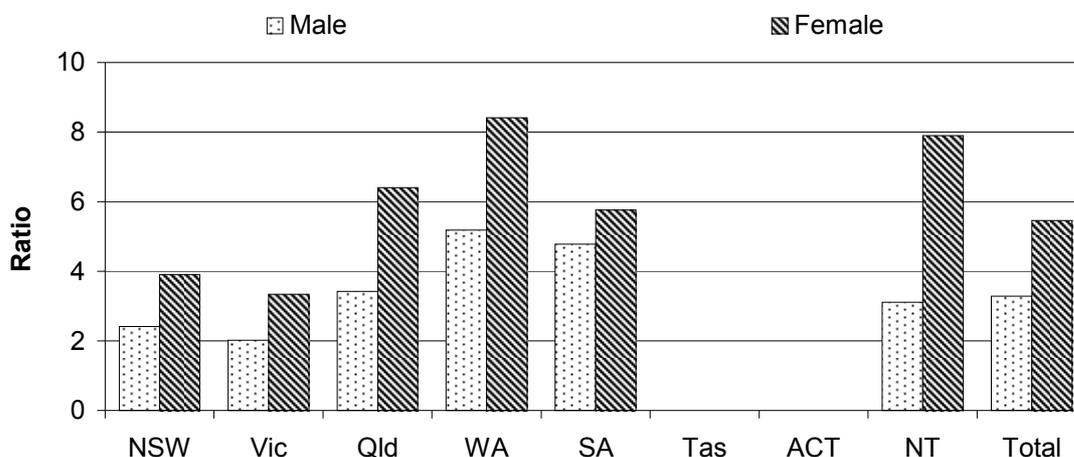
Data for this indicator are comparable.

Age standardised hospital separation ratios for all diabetes diagnoses<sup>1</sup> illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2007-08 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 3.3 times higher than the separation rate for all Australian males. The separation rate for Indigenous females was 5.5 times the rate for all females (figure 11.9).

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<sup>1</sup> 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

**Figure 11.9 Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2007-08<sup>a, b, c, d, e, f, g</sup>**



<sup>a</sup> Ratios are directly age standardised to the Australian population at 30 June 2001. <sup>b</sup> Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. <sup>c</sup> 'All diabetes' refers to separations with a principal and/or additional diagnosis of diabetes, except where dialysis is the principal diagnosis. <sup>d</sup> Patients aged 75 years and over are excluded. <sup>e</sup> Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. <sup>f</sup> NT data are for public hospitals only. <sup>g</sup> Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 11A.13 and 11A.14; 2010 Report, figure 11.40, p. 11.67.

## Future directions in performance reporting

### *Indigenous health*

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the Health preface). The Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting and will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers' Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people.

Continued efforts to improve Indigenous identification are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and

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AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems.

### *COAG developments*

#### *Report on Government Services alignment with National Agreement reporting*

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

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## Attachment tables

Attachment tables for data within this chapter are contained in the attachment to the Compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the primary and community health attachment). Attachment tables are on the Review website ([www.pc.gov.au/gsp](http://www.pc.gov.au/gsp)). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Compendium). The tables included in the attachment are listed below.

**Table 11A.1** Indigenous primary healthcare services for which service activity reporting (SAR) data are reported (number)

**Table 11A.2** Services and episodes of healthcare by Indigenous primary healthcare services for which service activity reporting (SAR) data are reported, by remoteness category (number)

**Table 11A.3** Proportion of Indigenous primary healthcare services for which service activity reporting (SAR) data are reported that undertook selected health related activities, 2007-08 (per cent)

**Table 11A.4** Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which service activity reporting (SAR) data are reported, as at 30 June 2008 (number)

**Table 11A.5** Voluntary annual health assessments for older people by Indigenous status

**Table 11A.6** Older Indigenous people who received an annual health assessment (per 1000 people)

**Table 11A.7** Indigenous people who received a voluntary health check or assessment, by age (per 1000 people)

**Table 11A.8** Early detection activities provided by Indigenous primary healthcare services for which service activity reporting (SAR) data are reported

**Table 11A.9** Valid vaccinations supplied to children under seven years of age, by type of provider, 2004–2009

**Table 11A.10** Separations for selected vaccine preventable conditions by Indigenous status, 2007-08 (per 1000 people)

**Table 11A.11** Separations for selected acute conditions by Indigenous status, 2007-08 (per 1000 people)

**Table 11A.12** Separations for selected chronic conditions by Indigenous status, 2007-08 (per 1000 people)

**Table 11A.13** Ratio of separations for Indigenous males to all males, 2007-08

**Table 11A.14** Ratio of separations for Indigenous females to all females, 2007-08

### Community health programs

**Table 11A.15** New South Wales, community health services programs

**Table 11A.16** Victoria, community health services programs

**Table 11A.17** Queensland, community health services programs

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- Table 11A.18** Western Australia, community health services programs  
**Table 11A.19** South Australia, community health services programs  
**Table 11A.20** Tasmania, community health services programs  
**Table 11A.21** Northern Territory, community health services programs

**Community health programs**

- Table 11A.15** Australian Government, community health services programs  
**Table 11A.16** New South Wales, community health services programs  
**Table 11A.17** Victoria, community health services programs  
**Table 11A.18** Queensland, community health services programs  
**Table 11A.19** Western Australia, community health services programs  
**Table 11A.20** South Australia, community health services programs  
**Table 11A.21** Tasmania, community health services programs  
**Table 11A.22** Northern Territory, community health services programs

**References**

- AIHW (Australian Institute of Health and Welfare) 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Health Services Series no. 25, Canberra.
- 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses*, AIHW Cat. no. IHW 22, Canberra.
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