11 Primary and community health

CONTENTS

Attachment tables

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

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

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

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

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

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

11.1 Profile of primary and community health

Definitions, roles and responsibilities

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

General practice

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

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

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

Services provided in general practice include:

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

Definitions for common health terms are provided in section 11.5.

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

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

While the majority of GPs provide services as part of a general practice, some are employed by hospitals, community health services or other organisations.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (DoHA 2009a). The PBS aims to provide affordable,

reliable and timely access to prescription medicines for all Australians. Users make a co-payment, currently $5.30 for concession card holders and $32.90 for general consumers. The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2009 safety net threshold was $1264.90 for general consumers and $318.00 for concession card holders (DoHA 2009b).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the Department of Veterans' Affairs (DVA). Drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

Community health services

Community health services usually comprise multidisciplinary teams of salaried health and allied health professionals, who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). The services may be provided directly by governments (including local governments) or indirectly, through a local health service or community organisation funded by government. State and Territory governments are responsible for most community health services. The Australian Government's main role in the community health services covered in this chapter is in health services for Indigenous people. In addition, the Australian Government provides targeted support to improve access to community health services in rural and remote areas. There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under Medicare to patients with chronic conditions and complex care needs, and improves access to allied health services in rural and remote areas.

Dental services

The Australian Government and the State and Territory governments have different roles in supporting dental services in Australia's mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for the delivery of major public dental programs, primarily directed at children and disadvantaged adults. The Australian Government supports the provision of dental services primarily through the private health insurance rebate, and also provides Medicare funding for dental services for patients with chronic conditions and complex care needs, and for a limited range of medical services of an oral surgical nature. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force. It also has a role in the provision of dental services through Community Controlled Aboriginal Medical Services. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.2 per cent of all encounters with GPs in 2008-09 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2009) (table 11.1).

Table 11.1 **GP encounters, by source of funding, 2008-09**[a, b, c]

	Number[d]	*Per cent of all encounters*[e]	*95% LCL*	*95% UCL*
GPs participating in the BEACH survey	1011	..	..	..
Total encounters for which BEACH data were recorded	96 688	100.0	..	..
Encounters with missing data	6 197	..	..	..
Direct encounters	89 185	98.6	98.3	98.8
No charge	424	0.5	0.4	0.6
Medicare paid[f]	86 118	95.2	94.8	95.6
Workers compensation paid	1 950	2.2	2.0	2.3
Other paid (for example, hospital, State)	707	0.8	0.5	1.0
Indirect encounters[g]	1 303	1.4	1.2	1.7

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2008 to March 2009. [b] An 'encounter' is any professional interchange between a patient and a GP (Britt *et al*. 2009). [c] Data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter. [d] Number of encounters after post stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] Indirect encounters are encounters at which the patient is not seen by the GP but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al*. (2009) *General practice activity in Australia 2008-09*, Cat. no. GEP 25; table 11A.1.

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

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

Australian Government expenditure on general practice in 2008-09 was $5.8 billion, or $269 per person (figure 11.26).

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

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education

programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues such as diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as private health insurance, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $7.0 billion, or $325 per person, in 2008-09. Expenditure on the PBS was around $6.6 billion in 2008-09, of which 77.9 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health preface.

Table 11.2 **PBS and RPBS expenditure, 2008-09 ($ million)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[b]	479.4	341.7	287.8	155.2	105.5	30.7	29.1	8.5	1 437.8
PBS concessional[c]	1 791.3	1 285.5	963.8	423.6	448.3	146.7	51.2	15.2	5 125.6
PBS doctor's bag	5.0	3.5	3.3	1.1	1.1	0.3	0.2	0.1	14.5
PBS total	2 275.7	1 630.7	1 254.9	579.8	554.9	177.7	80.5	23.8	6 577.9
RPBS total[d]	164.2	98.0	106.1	36.8	35.7	13.9	7.1	0.9	462.7
Total	**2 439.9**	**1 728.6**	**1 361.0**	**616.6**	**590.6**	**191.6**	**87.6**	**24.7**	**7 040.6**
$ per person	346.5	322.2	312.9	279.8	366.4	383.0	251.8	111.2	325.3

a State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the DoHA annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as dispensing conducted under s.100 of the *National Health Act 1953* [Cwlth]). **b** Includes PBS general ordinary and safety net. **c** Includes concessional ordinary and concessional free safety net. **d** Includes RPBS ordinary and RPBS safety net.

Source: DoHA (unpublished) PBS data collection.

Community health services

Overall government expenditure data for the community health services covered in this chapter are not available. Expenditure data reported here also cover services such as food safety regulation and media campaigns to promote health awareness, as well as private dental services (funded by health insurance premium rebates and non-government expenditure) (table 11.3).

In 2007-08, government expenditure on community and public health was $7.0 billion, of which State, Territory and local governments provided 71.5 per cent,

and the Australian Government 28.5 per cent (table 11.3). Australian Government direct outlay expenditure on dental services, predominantly through the DVA and DoHA, was $222 million in 2007-08. State, Territory and local government expenditure on dental services in 2007-08 was $580 million. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 11.3 **Estimated funding on community and public health, and dental services, 2007-08 ($ million)**

	Australian Government							
	DVA	*DoHA and other*[a]	*Insurance premium rebates*[b]	*Total*[c]	*State, Territory and local government*	*Total government*	*Non-government*	*Total government and non-government*
Community and public health[d]	2	1 996	1	1 998	5 009	7 008	451	7 459
Dental services	108	114	423	645	580	1 225	4 881	6 106

[a] 'Other' comprises Australian Government expenditure on capital consumption and health research not funded by DoHA. [b] Government expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. [c] Totals may not add due to rounding. [d] Includes expenditure on other recurrent health services (not elsewhere classified) in addition to expenditure on community and public health services.

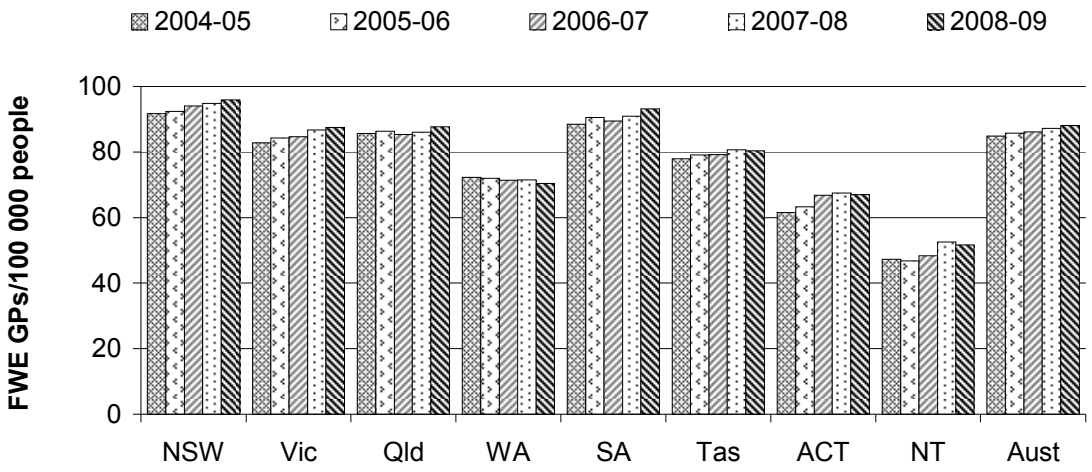
Source: AIHW (2009) *Health Expenditure Australia 2007-08*, Cat. no. HWE 46.

Size and scope

General practice

There were 25 726 vocationally recognised GPs and OMPs billing Medicare in Australia in 2008-09. On a full time workload equivalent (FWE) basis, there were 19 231 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 88.1 FWE recognised GPs and OMPs per 100 000 people (table 11A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous primary healthcare services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

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



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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 196 million services provided under the PBS and RPBS in 2008-09, amounting to 9.1 prescriptions per person. There were around 182 million services provided under the PBS in 2008-09, of which 85.3 per cent were concessional (table 11.4).

Table 11.4 **PBS and RPBS services, 2008-09 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	8.8	6.3	5.3	2.7	1.9	0.6	0.6	0.2	26.3
PBS concessional[b]	53.2	39.8	29.5	12.8	13.4	4.5	1.4	0.5	155.1
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	62.1	46.2	34.9	15.6	15.3	5.1	2.0	0.6	181.8
RPBS total[c]	4.9	3.2	3.3	1.1	1.1	0.5	0.2	–	14.3
Total	67.1	49.4	38.2	16.7	16.4	5.5	2.2	0.6	196.2
Services per person	9.5	9.2	8.8	7.6	10.2	11.1	6.3	2.9	9.1

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

Source: DoHA (unpublished) PBS data collection.

Community health services

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

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

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 12 (Health management issues) and 13 (Aged care).

Maternal and child health

All jurisdictions provide maternal and child health services through their community health programs. These services include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs. Performance indicators for maternity services in public hospitals are reported in chapter 10 (Public hospitals).

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students (tables 11A.52–11A.60).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions

provided public dental services in 2008-09 targeted at disadvantaged people (tables 11A.52–11A.60).

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2009a). Treatment activities excluded from that report include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 658 alcohol and other drug treatment services reported 2007-08 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). Of these, 330 (50.2 per cent) identified as government providers and 328 (49.8 per cent) identified as non-government providers (table 11A.8). All of these non-government providers received some government funding for 2007-08. There were 153 998 reported closed treatment episodes in 2007-08 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.7 per cent of whom were male, accounted for 147 721 closed treatment episodes (AIHW 2009a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (44.5 per cent). Cannabis was the next most common drug of concern (21.6 per cent), followed by opioids (14.5 per cent — heroin accounted for 10.5 per cent) and amphetamines (11.2 per cent) (AIHW 2009a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.52–11A.60.

Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic

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

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

For 2007-08, SAR data are reported for 155 Indigenous primary healthcare services (table 11A.4). Of these services, 56 (36.1 per cent) were located in remote or very remote areas (table 11A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.6). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Over 1.8 million episodes of healthcare were provided by participating services in 2007-08 (table 11.5). Of these, around 641 000 (34.6 per cent) were in remote or very remote areas (table 11A.5).

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

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

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

Source: DoHA (unpublished) SAR data collection.

The services included in the SAR data collection employed 2603 full time equivalent health staff (as at 30 June 2008). Of these, 1496 were Indigenous (57.5 per cent). The proportions of doctors and nurses employed by services surveyed who were Indigenous were relatively low (2.1 per cent and 9.7 per cent, respectively) (table 11A.7).

11.2 Framework of performance indicators

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

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

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

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

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

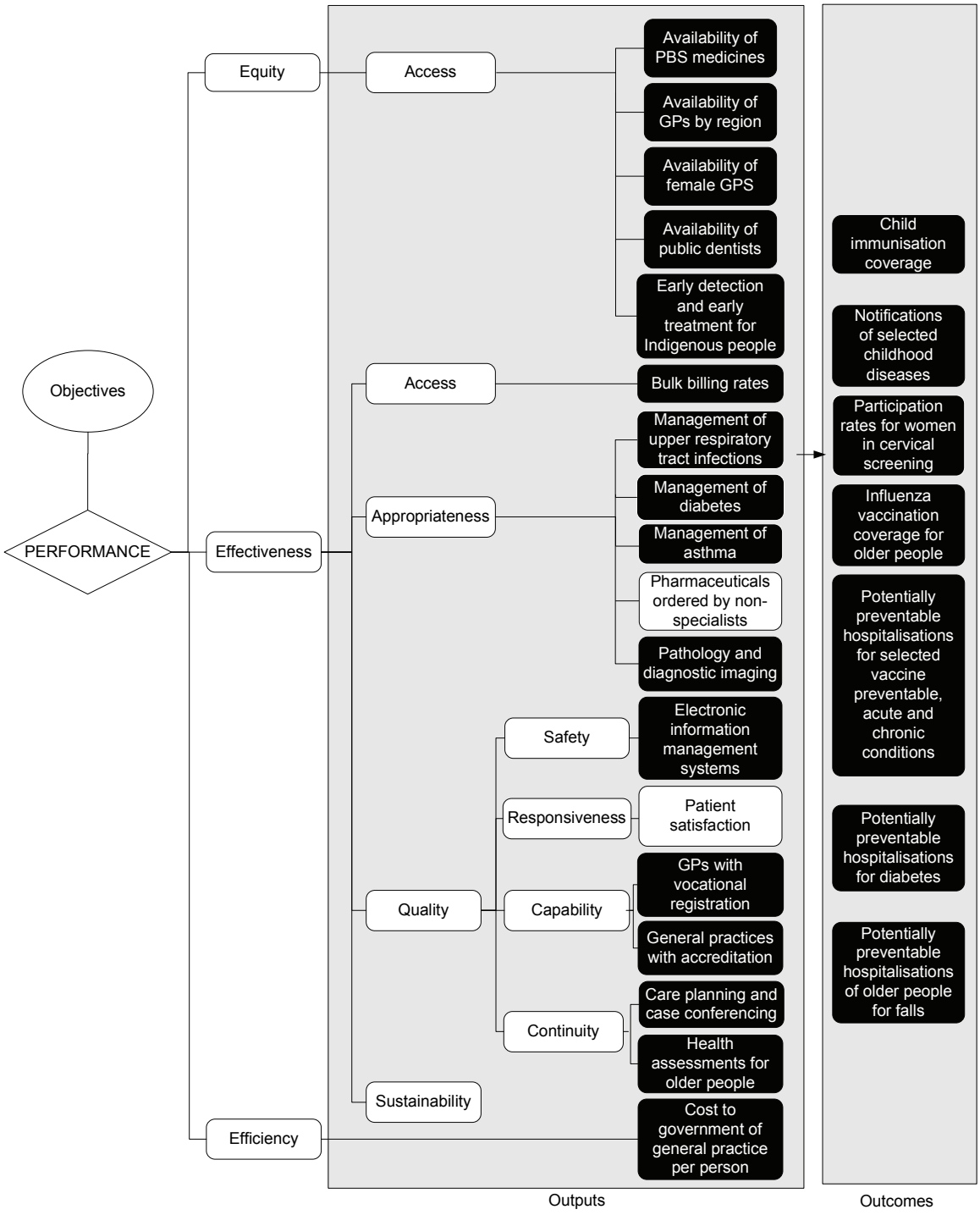
- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals' healthcare needs.

In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 11.2). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6). The Health preface explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability consistent with the standard Review framework.

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

Figure 11.2 **Performance indicators for primary and community health**



Key to indicators

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

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

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

11.3 Key performance indicator results

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

Outputs

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

Equity

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

Access

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

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

Availability of PBS medicines

'Availability of PBS medicines' is an indicator of governments' objective to provide equitable access to PBS medicines (box 11.2).

Box 11.2 Availability of PBS medicines

'Availability of PBS medicines' is defined by the following three measures:

- 'People per pharmacy by region', defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions.
- 'PBS expenditure per person by region', defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions.
- 'Proportion of PBS prescriptions filled at a concessional rate', defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.

Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health and medicines should be available to those who require them, regardless of residential geolocation or socioeconomic circumstance.

A decrease in people per pharmacy may indicate greater availability of PBS medicines. An increase in PBS expenditure per person may indicate improved availability of PBS medicines. An increase in the proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people. It is also important that there are not large discrepancies in these measures by region.

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

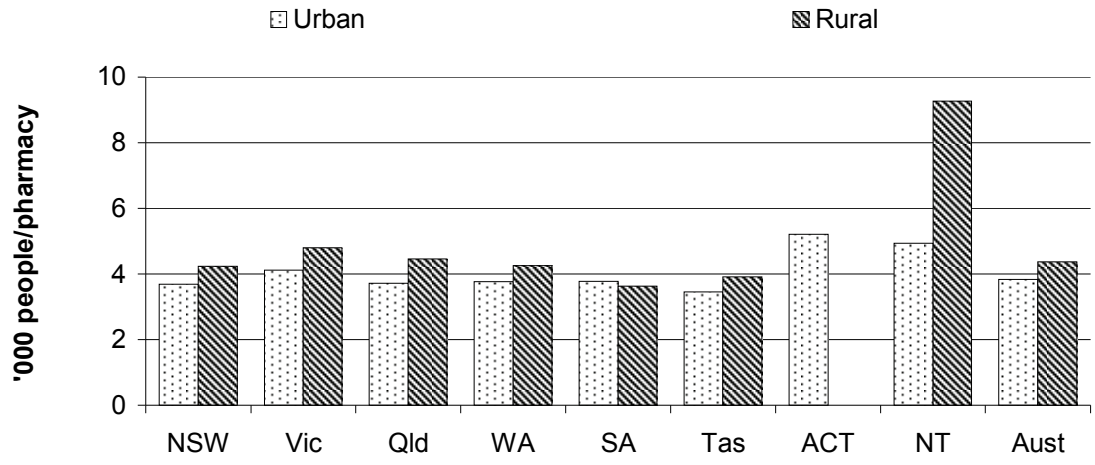
Data for this indicator are comparable.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3836 people per pharmacy in urban areas and 4367 in rural areas in 2008-09. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.3).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 60 medical practitioners and 250 hospitals — 80 private and 170 public[1] — approved to supply PBS medicines to the community in 2008-09. The medical practitioners as well as 78 of the public hospitals were located in rural areas (table 11A.9).

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

Figure 11.3 **People per pharmacy, 2008-09**[a]

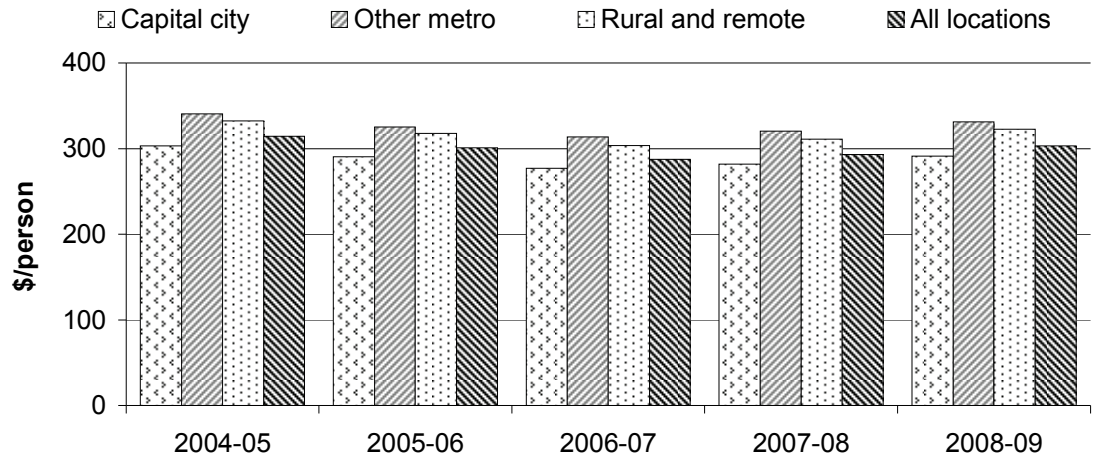


[a] Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PHARIA 1. Rural = PHARIA 2–6. The ACT has no rural statistical areas.

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

Nationally, PBS expenditure per person increased from $293 in 2007-08 to $303 in 2008-09 (figure 11.4). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2004-05 to 2008-09 (in 2008-09 dollars).

Figure 11.4 **PBS expenditure per person (2008-09 dollars)**[a]



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

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

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.10. These data are not available by regional location. Nationally, 85.3 per cent of prescriptions subsidised under the PBS were concessional in 2008-09.

Availability of GPs by region

'Availability of GPs by region' is an indicator of governments' objective to provide equitable access to primary healthcare services (box 11.3).

Box 11.3 **Availability of GPs by region**

'Availability of GPs by region' is defined as the number of FWE GPs per 100 000 people, by region.

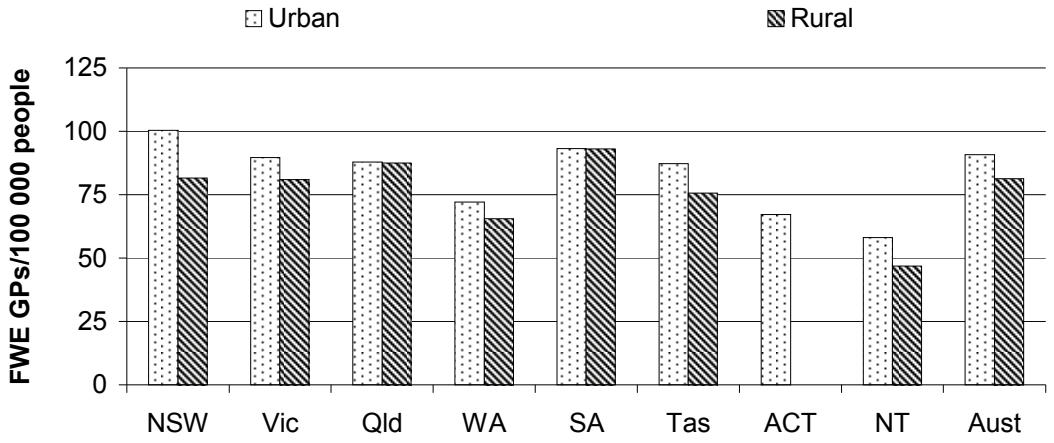
Low availability of GPs can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas. An increase in the availability of GPs can indicate improved access to GP services.

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

Data for this indicator are comparable.

In terms of FWE GPs per 100 000 people, there were more GPs available in urban areas than in rural areas in almost all states and territories in 2008-09 (figure 11.5). The bulk billed proportion of non-referred attendances was generally lower in rural and remote areas, excepting 'other remote' areas, than in capital cities and 'other metropolitan centres' (table 11A.20).

Figure 11.5 **Availability of GPs (full time workload equivalent), 2008-09**[a, b, c]



[a] Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas. [b] FWE GP numbers include vocationally recognised GPs and OMPs billing Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. [c] The ACT has no rural areas.

Source: DoHA (unpublished) MBS data collection; table 11A.12.

Availability of female GPs

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

Box 11.4 **Availability of female GPs**

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

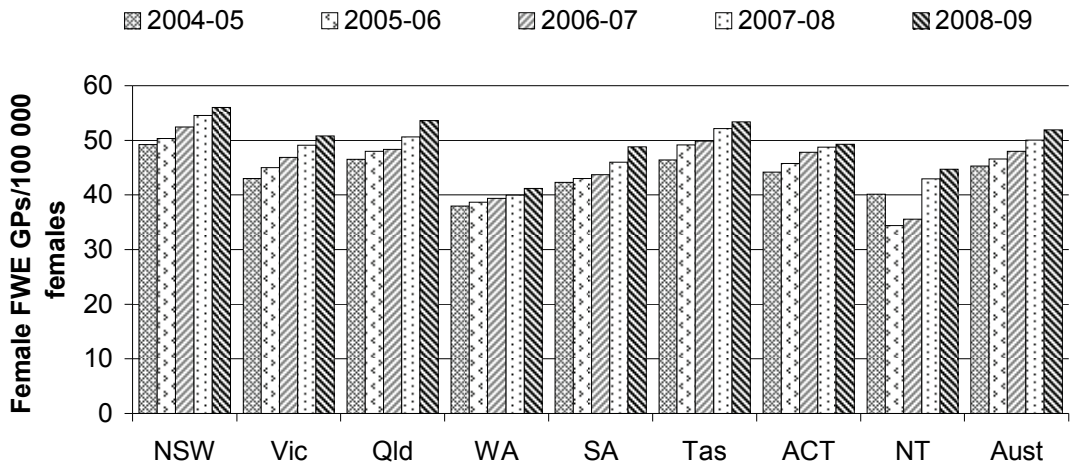
A higher rate means it is more likely that female patients who prefer to visit female GPs will have their preference met.

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

Data for this indicator are comparable.

In 2008-09, 39.5 per cent of Australia's GPs — 29.6 per cent of FWE GPs — were female (tables 11A.3 and 11A.13). The number of FWE GPs per 100 000 females increased from 45.3 to 51.9 in the period 2004-05 to 2008-09 (figure 11.6).

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



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

Source: DoHA (unpublished) MBS data collection; table 11A.13.

Availability of public dentists

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

Box 11.5 **Availability of public dentists**

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

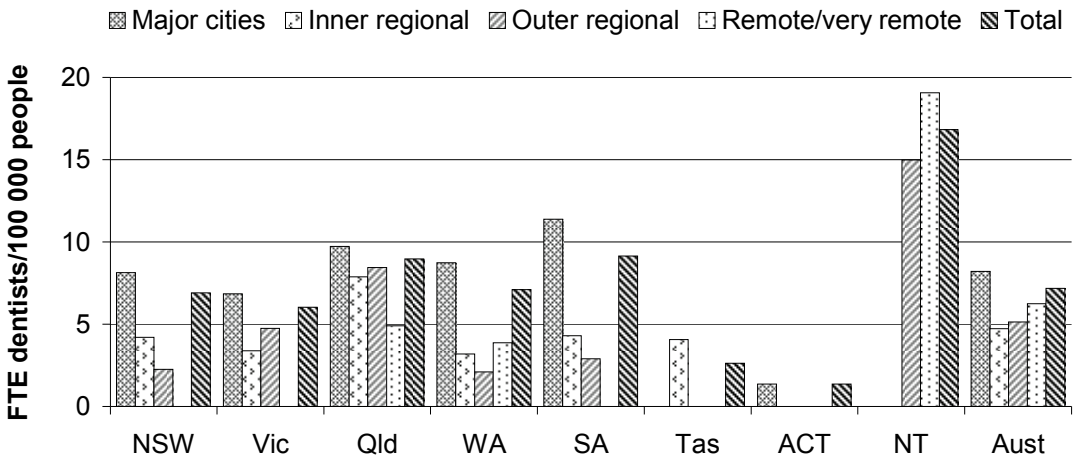
The availability of public dentists by region affects people's access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist. An increase in the availability of public dentists indicates improved access to dental services.

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

Data for this indicator are comparable.

Data for 2007 were not available for this indicator. Nationally, there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas in 2006 (figure 11.7, table 11A.14).

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



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

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

Early detection and early treatment for Indigenous people

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

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

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

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

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

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

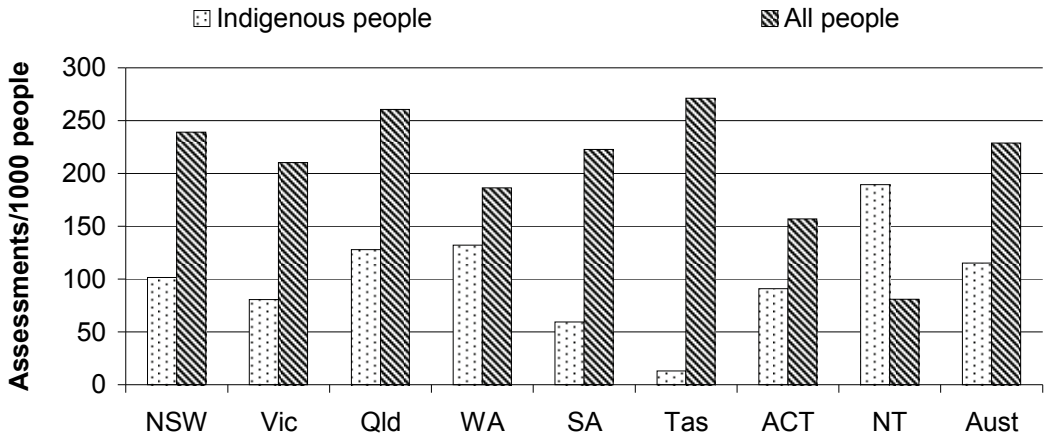
Data for this indicator are comparable.

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

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

In 2008-09 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment (figure 11.8). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.8 Older people who received an annual health assessment by Indigenous status, 2008-09[a, b]

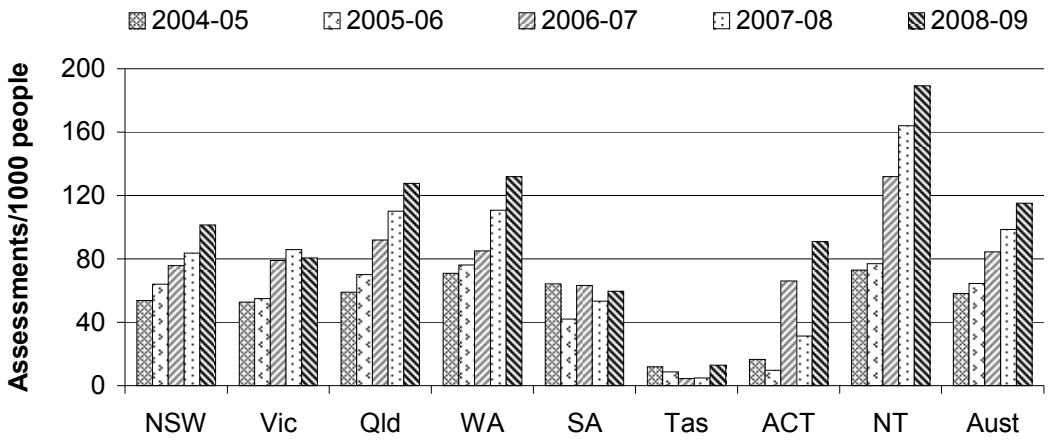


a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. **b** Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This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

Source: Derived from DoHA (unpublished) MBS data collection, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0 and ABS 2009 *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.16.

The proportion of older Indigenous people who received an annual health assessment steadily increased in most jurisdictions between 2004-05 and 2008-09 (figure 11.9). This indicates that access to early detection and early treatment services for this population has improved in these jurisdictions and nationally.

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



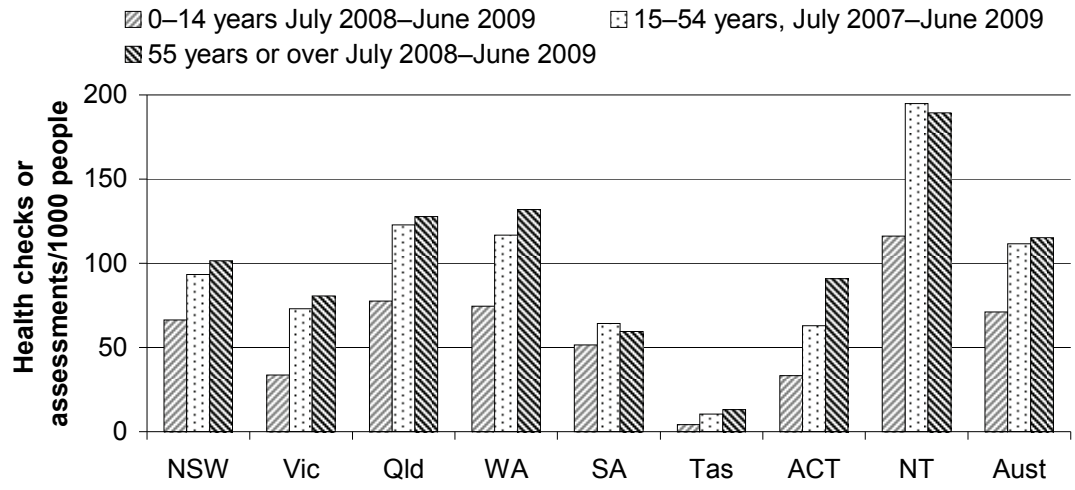
a Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect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

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.17.

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

The proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.10). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

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

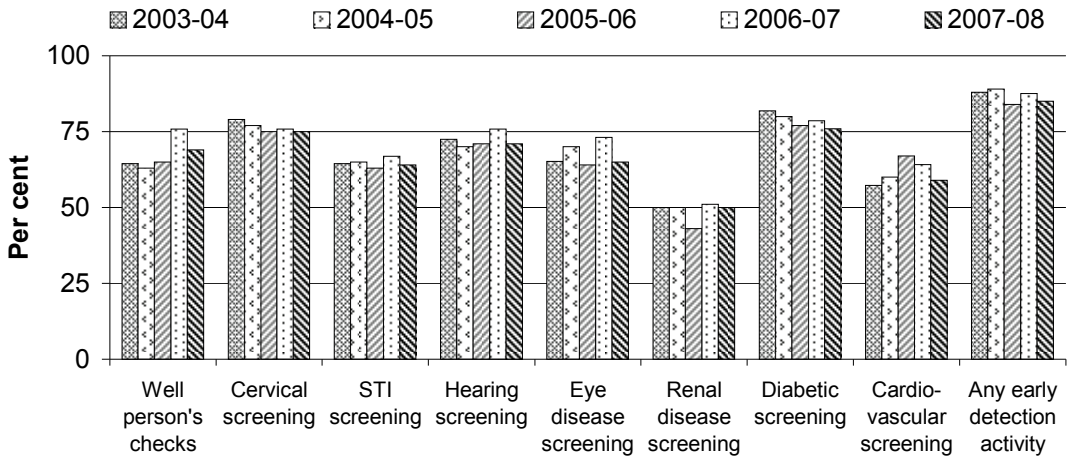


a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people. **b** Health checks for 0–14 year olds, and health assessments for those aged 55 years or over, are available annually. Data for these age groups are for the period 1 July 2008 to 30 June 2009. Health checks for 15–54 year olds are available biennially, and these data are for the period 1 July 2007 to 30 June 2009.

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.18.

Figure 11.11 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2007-08.

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



Source: DoHA (unpublished) SAR data collection; table 11A.19.

Effectiveness

Access

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

Bulk billing rates

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

Box 11.7 **Bulk billing rates**

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

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

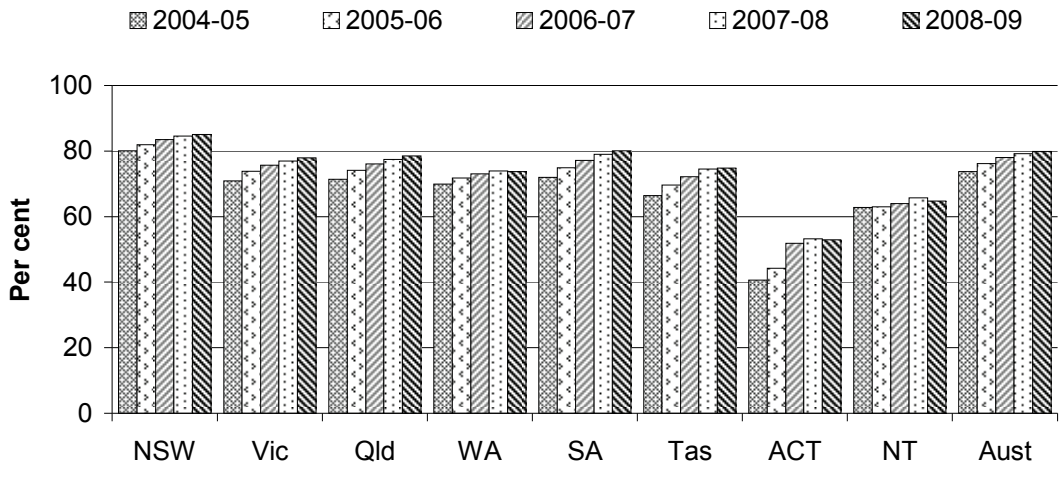
A higher proportion of bulk billed attendances indicates greater affordability of GP services.

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

Data for this indicator are comparable.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 79.9 per cent in 2008-09. For all jurisdictions, this proportion increased in the period 2004-05 to 2008-09 (figure 11.12). The bulk billed proportion of non-referred attendances was highest in capital cities and other remote areas (table 11A.20).

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



a Includes attendances by practice nurses.

Source: DoHA (2009) *Medicare Statistics - June Quarter 2009*; table 11A.21.

Appropriateness

Four indicators of the appropriateness of GP services are reported:

- 'Management of upper respiratory tract infections'
- 'Management of diabetes'
- 'Management of asthma'
- 'Pathology tests and diagnostic imaging ordered by non-specialists'.

Management of upper respiratory tract infections

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

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

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

Upper respiratory tract infection (URTI) without complication is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless frequently prescribed for viral infections. Unnecessarily high rates of antibiotic prescription for URTI have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community.

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

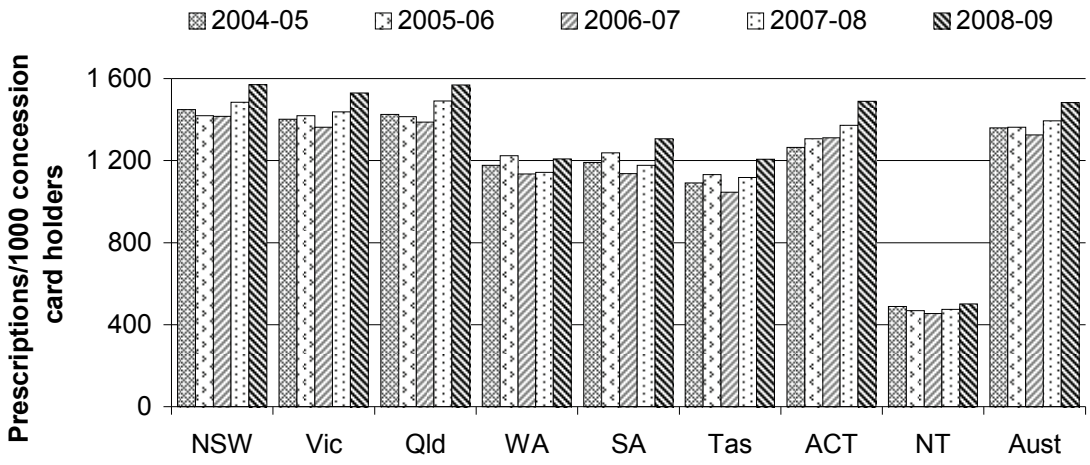
The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed. Data are available only for PBS concession card holders.

Data for this indicator are comparable.

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

Nationally, the prescription rate for the oral antibiotics most commonly used to treat upper respiratory tract infection in 2008-09 was 1483 per 1000 PBS concession card holders. Prescription rates for these antibiotics appear overall to have increased in most states and territories between 2004-05 and 2008-09 (figure 11.13).

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



Source: DoHA (unpublished) PBS data collection; table 11A.22.

Management of diabetes

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

Box 11.9 **Management of diabetes**

'Management of diabetes' is defined as the proportion of people with diabetes mellitus who have received an annual cycle of care within general practice. This is the number of MBS items for completion of a cycle of care for patients with established diabetes mellitus that are claimed, divided by the estimated number of people with diabetes mellitus.

The MBS annual cycle of care is generally based on RACGP clinical guidelines for the management of Type 2 diabetes in general practice. A high or increasing proportion of people with diabetes mellitus who have received an annual cycle of care within general practice is desirable. Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

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

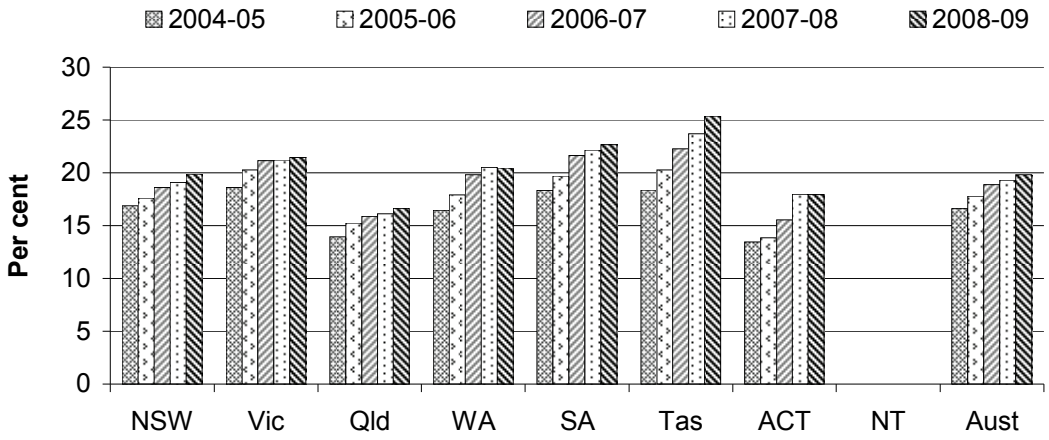
Data reported against this indicator are comparable.

Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Appropriate management in the primary and community health sector can prevent or minimise the severity of such complications (AIHW 2008c). Type 2 diabetes is the most common form of diabetes and is largely preventable.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosolated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007b).

The proportion of people with diabetes mellitus receiving an annual cycle of care within general practice increased for all jurisdictions for which data are available in the period 2004-05 to 2008-09 (figure 11.14). Nationwide, 19.8 per cent of people with diabetes received the annual cycle of care in 2008-09 (excluding the NT).

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



a Data are minimum estimates as GPs may provide the annual cycle of care but not claim the MBS rebate. **b** Clinical guidelines are for Type 2 diabetes, while the MBS items do not specify a particular type of diabetes. **c** The number of people with diabetes is estimated by applying diabetes prevalence data from the ABS 2007-08 National Health Survey (NHS) to the ERP. Estimates should be treated with caution as the prevalence of diabetes changes over time. Historical estimates may differ from previous Reports, which reported estimates based on 2004-05 NHS prevalence data. **d** 2007-08 NHS data are not available for the NT.

Source: Derived from Medicare Australia (2009) *MBS Item Statistics Reports*; ABS (2009) *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0; ABS (2009) *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. No. 4362.0; ABS (2009) *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.23.

Management of asthma

'Management of asthma' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.10).

Box 11.10 **Management of asthma**

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

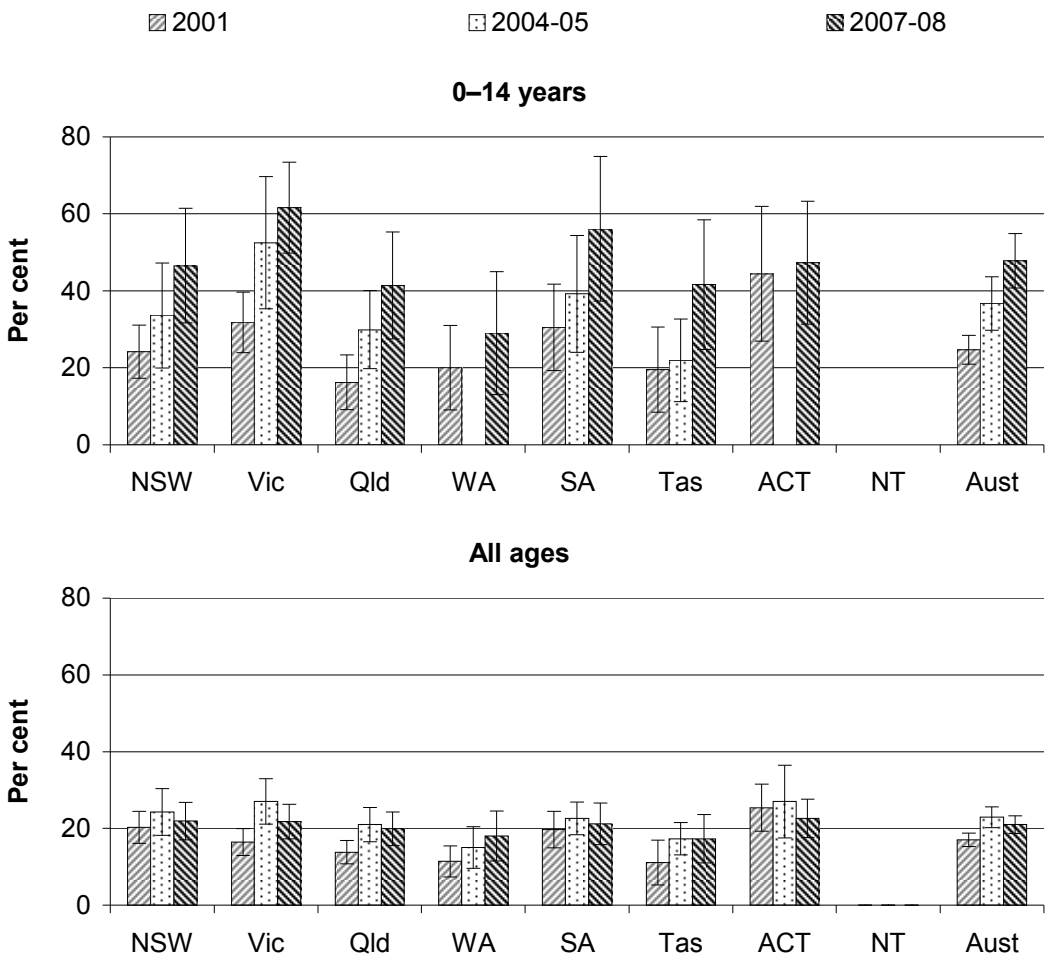
Asthma is an identified National Health Priority Area for Australia. It is a common chronic disease among Australians, particularly children, and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity. Written asthma action plans enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, preventing or reducing the severity of acute asthma episodes (ACAM 2008). Written asthma action plans have been associated with a reduction in hospitalisations and urgent GP visits for asthma and have been included in clinical guidelines for asthma management for nearly 20 years (ACAM 2008).

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

Data reported against this indicator are comparable.

Nationally, the proportion of NHS respondents with current asthma who reported having a written asthma action plan was 21.0 per cent in 2007-08, compared with 17.0 per cent in 2001 and 22.9 per cent in 2004-05 (figure 11.15). The proportion of children aged 0–14 years with current asthma who reported having a written asthma action plan rose from 24.7 per cent in 2001 to 36.7 per cent in 2004-05 and 47.8 per cent in 2007-08.

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



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

Source: ABS (2009) *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0; ABS (2009) *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. No. 4362.0; ABS (unpublished) *National Health Survey 2001, 2004-05,* Cat. no. 4364.0; table 11A.24.

Pharmaceuticals ordered by non-specialists

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

Box 11.11 **Pharmaceuticals ordered by non-specialists**

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

Data for this indicator were not available for the 2010 Report.

Pathology tests and diagnostic imaging ordered by non-specialists

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

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

'Pathology tests ordered and diagnostic imaging referrals by non-specialists' is defined by the following four measures:

- pathology tests ordered by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- diagnostic imaging referrals by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- Medicare benefits paid per person for pathology tests
- Medicare benefits paid per person for diagnostic imaging.

Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Low levels of use can contribute to the misdiagnosis of disease, and to relatively poor treatment decisions. High levels of use can reflect overreliance on tools to support the diagnostic process. What constitutes appropriate levels of use cannot be determined. However, reporting differences across jurisdictions and over time contributes to the discussion of these issues.

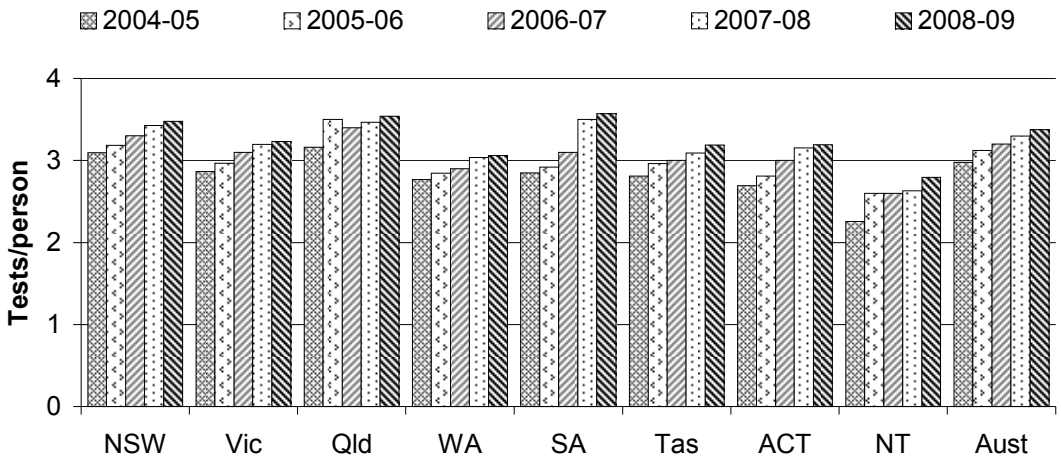
Data for this indicator are comparable.

Pathology tests and diagnostic imaging ordered by vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. While data for the total number of pathology tests ordered and diagnostic imaging referrals made by GPs are not available from Medicare, data are available for those that are rebated through Medicare. The number of pathology tests ordered can be higher than the number rebated through Medicare (where multiple tests are ordered, rebates are provided only for the three most expensive

tests). Radiologists can identify a need for more or different imaging procedures than those for which patients are referred. Information about differences between the number of pathology tests ordered and the number of rebates claimed, and differences between the number of imaging procedures ordered by GPs and the number of rebates claimed, is not available.

Nationally, the number of pathology tests ordered and rebated through Medicare per person increased from 3.0 in 2004-05 to 3.4 in 2008-09 (figure 11.16).

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

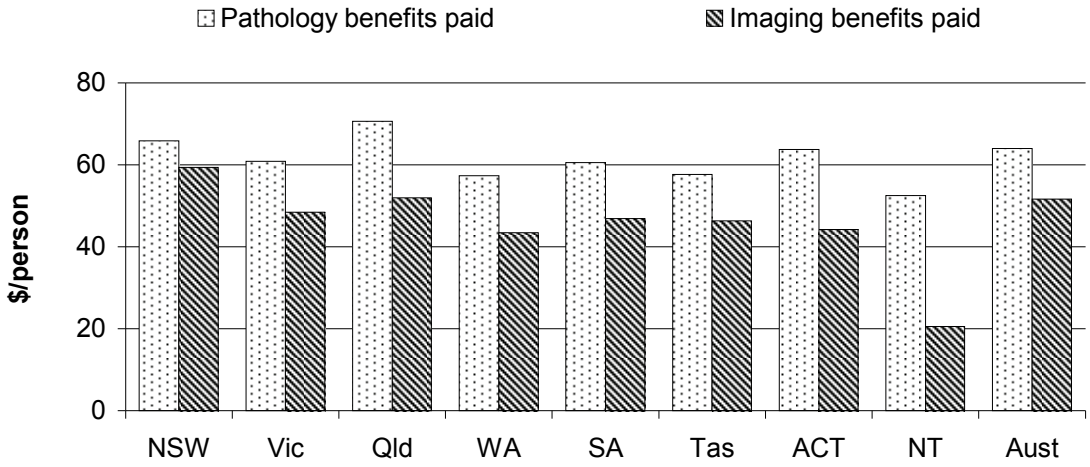


a Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.25.

Australian Government expenditure (under Medicare) on pathology tests amounted to $1.4 billion in 2008-09, equal to $64 per person. Nationally, Medicare benefits worth $1.1 billion were paid for diagnostic imaging in 2008-09, equal to $52 per person (figure 11.17).

Figure 11.17 **Benefits paid for pathology tests and diagnostic imaging, 2008-09[a]**

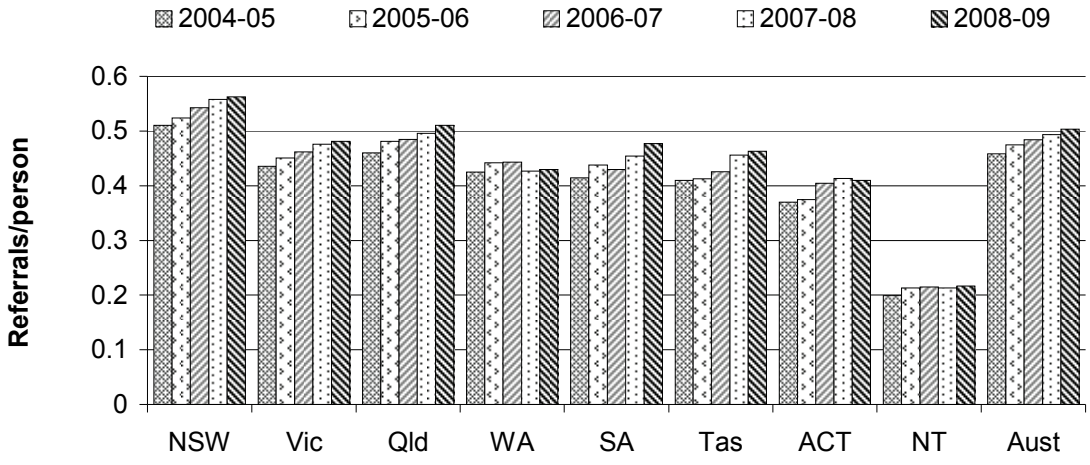


a Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; tables 11A.25 and 11A.26.

Nationally, there has been a gradual upward trend in the number of diagnostic imaging referrals per person between 2004-05 and 2008-09 (figure 11.18).

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



a Data relate to vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.26.

General practices with electronic information management systems

'General practices with electronic information management systems' is an indicator of governments' objective to improve patient safety through minimising prescribing and dispensing errors that can cause adverse drug reactions (box 11.13).

Box 11.13 General practices with electronic information management systems

'General practices with electronic information management systems' is defined by the following two measures:

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

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

The PIP does not include all practices in Australia. PIP practices provided around 82 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2007-08 (DoHA unpublished; table 11A.32).

Data for this indicator are comparable.

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

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

- use of electronic information management systems
- the provision of after hours care
- teaching medical students
- employment of practice nurses
- improving management for patients with diabetes and/or asthma.

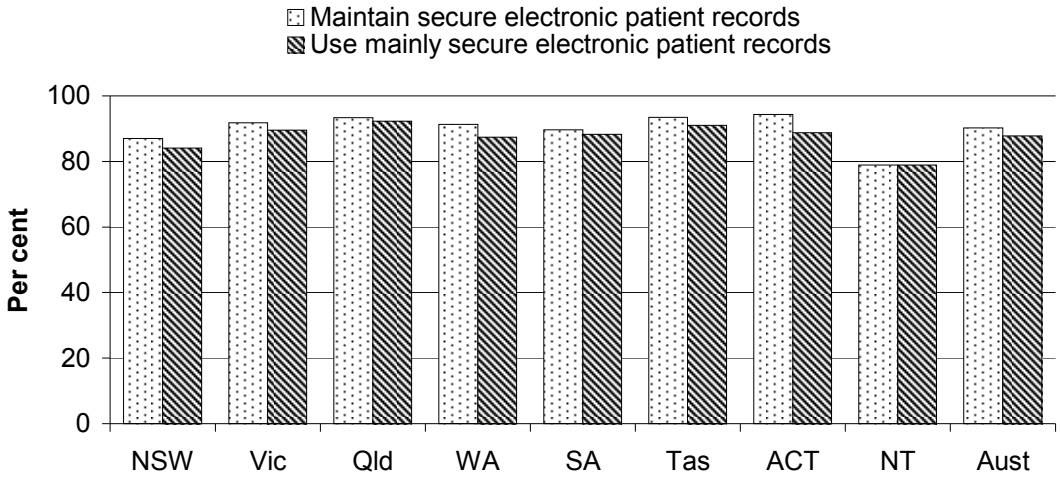
The PIP Information Management, Information Technology Incentive was available from November 2006 to August 2009, when it was replaced with the new PIP eHealth Incentive. It provided two payment tiers to encourage the computerisation of practices:

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

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

Nationally, 90.2 per cent of PIP practices maintained secure electronic patient records in May 2009. Patient records were managed predominantly using secure electronic management systems in 87.8 per cent of PIP practices (figure 11.19).

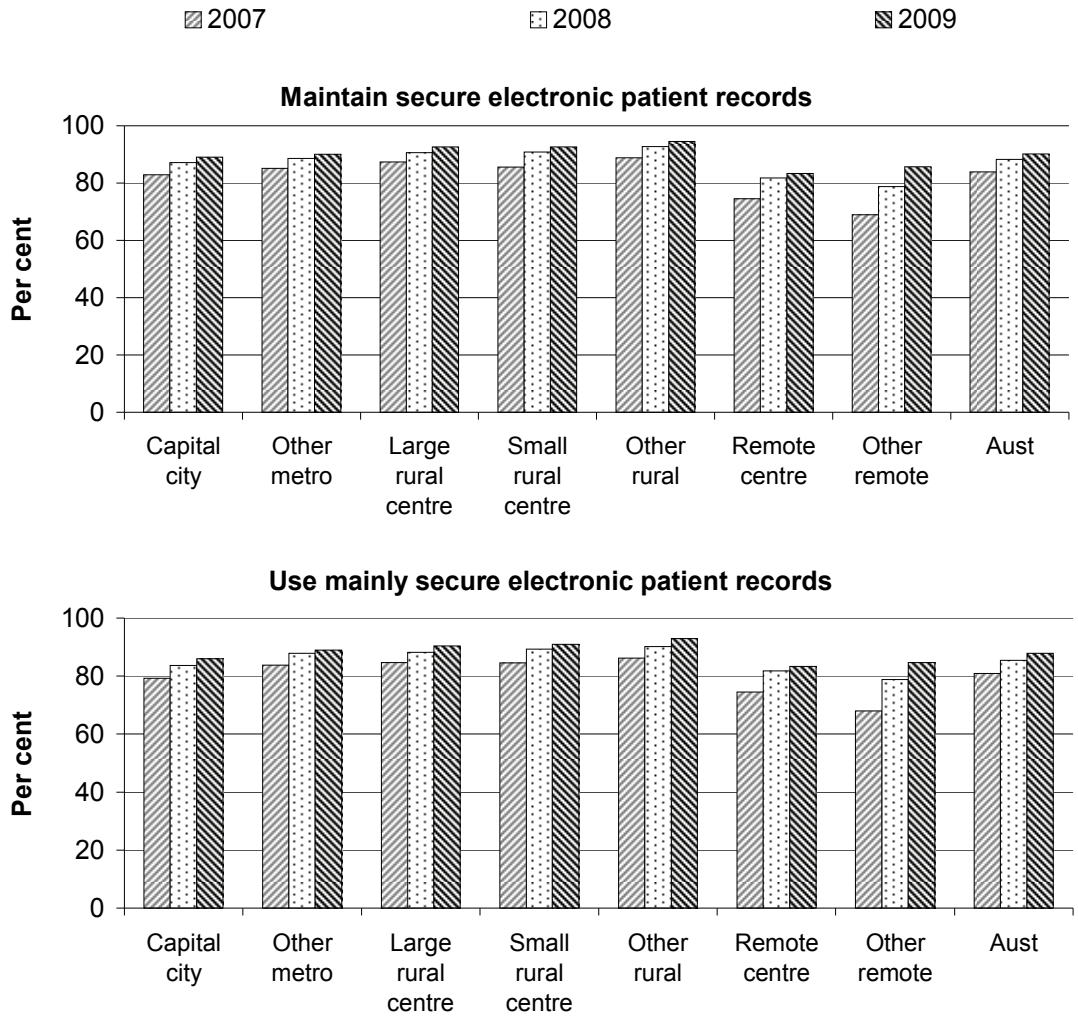
Figure 11.19 **PIP practices using computers for clinical purposes, May 2009**



Source: DoHA (unpublished) MBS and PIP data collections; table 11A.27.

There was an increase in the proportion of PIP practices that maintained secure electronic patient records, and that predominantly used secure electronic systems to manage patient records in all geographical areas from 2007 to 2009 (figure 11.20).

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



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

Source: DoHA (unpublished) MBS and PIP data collections; table 11A.28.

Quality — responsiveness

Patient satisfaction

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

Box 11.14 Patient satisfaction

'Patient satisfaction' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Quality — capability

Two indicators of the quality of GP services, relating to GPs' capability to provide services, are reported:

- 'proportion of GPs with vocational registration'
- 'proportion of general practices with accreditation'.

GPs with vocational registration

'GPs with vocational registration' is an indicator of governments' objective to ensure the GP workforce has the capability to deliver high quality services (box 11.15).

Box 11.15 GPs with vocational registration

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

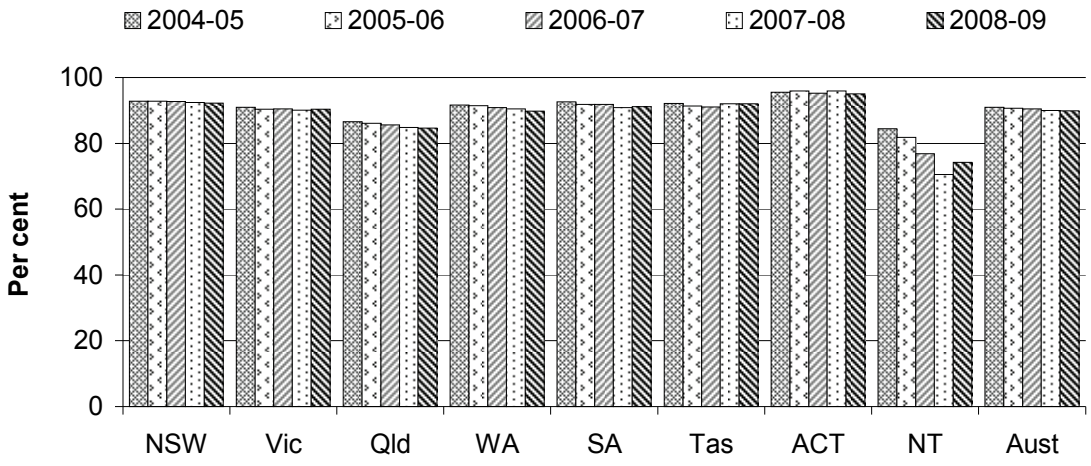
Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007). An increase in the proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. However, GPs without vocational registration can deliver services of equally high quality.

Data for this indicator are comparable.

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

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2008-09 (figure 11.21). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in other remote areas, in 2008-09 (table 11A.29).

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



Source: DoHA (unpublished) MBS data collection; table 11A.30.

General practices with accreditation

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

Box 11.16 **General practices with accreditation**

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

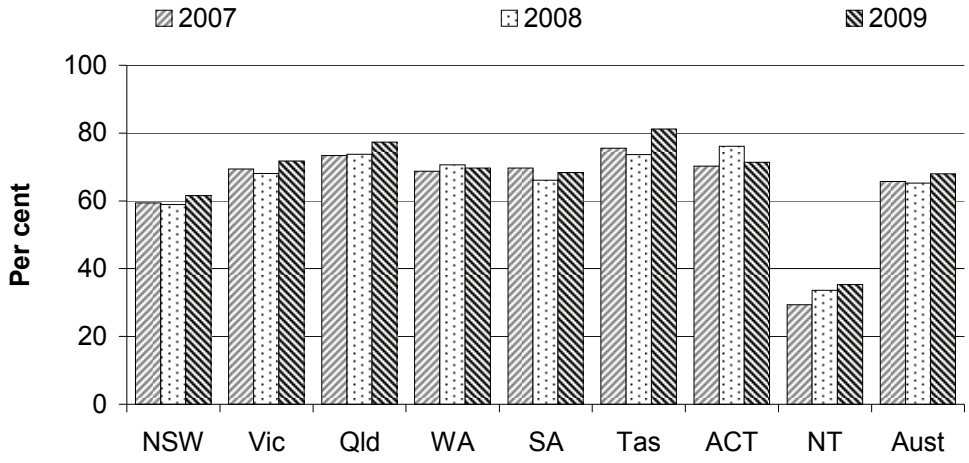
Accreditation of general practice is a voluntary process of peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards. An increase in the proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation can deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data for this indicator are comparable.

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

In June 2009, 4835 general practices — representing 68.0 per cent of general practices — were accredited nationally (figure 11.22).

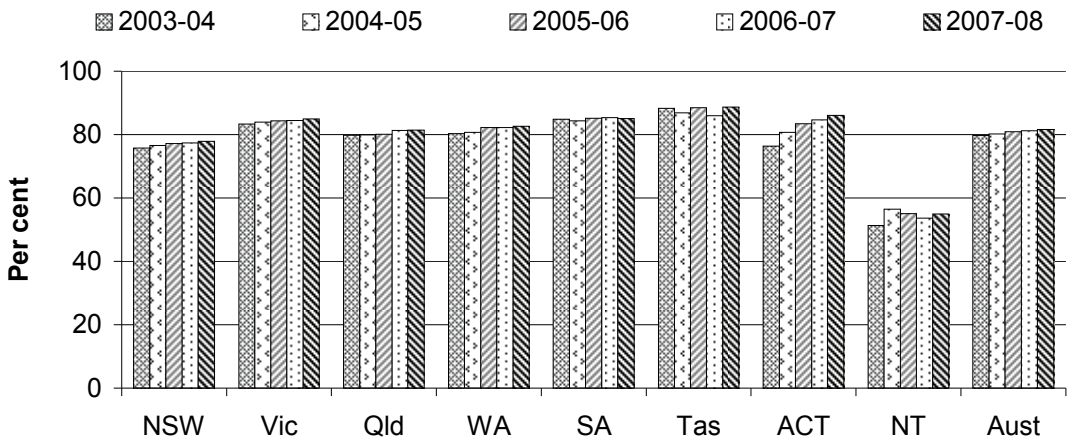
Figure 11.22 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice* 2008-09; table 11A.31.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has been relatively constant in the period from 2003-04 to 2007-08 (figure 11.23).

Figure 11.23 **Proportion of general practice patient care provided by PIP practices[a]**



a Patients are measured as SWPEs. A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: DoHA (unpublished) PIP and MBS data collections; table 11A.32.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the timely, coordinated provision of services that address the needs of individual patients. For example, chronic disease imposes a significant burden on the health and wellbeing of Australians. Patients can require a range of services from within and outside the health sector. Continuity of care can help prevent or delay the progression of many circulatory, respiratory, endocrine, nutritional and metabolic diseases (NHPAC 2006). Two indicators of this aspect of the quality of GP services are reported:

- 'use of care planning and case conferencing'
- 'use of health assessments for older people'.

Care planning and case conferencing

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

Box 11.17 **Care planning and case conferencing**

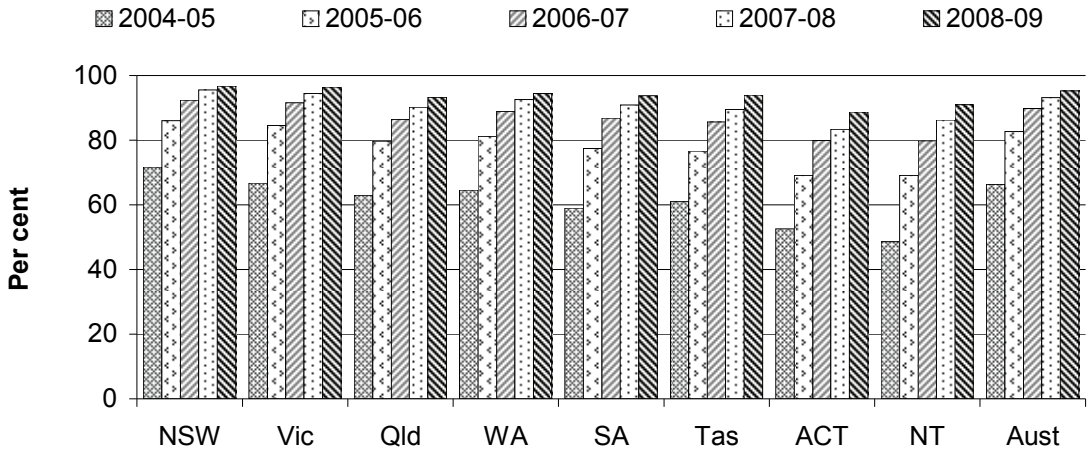
'Care planning and case conferencing' is defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.

Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team-based care. An increase in the proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs.

Data for this indicator are comparable.

Nationally, 95.3 per cent of GPs used the chronic disease management items for care planning or case conferencing in 2008-09 (figure 11.24).

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



a The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing between 2004-05 and 2005-06 can reflect increasing awareness of the Strengthening Medicare initiative, introduced on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

Source: DoHA (unpublished) MBS data collection; table 11A.33.

Health assessments for older people

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

Box 11.18 **Health assessments for older people**

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

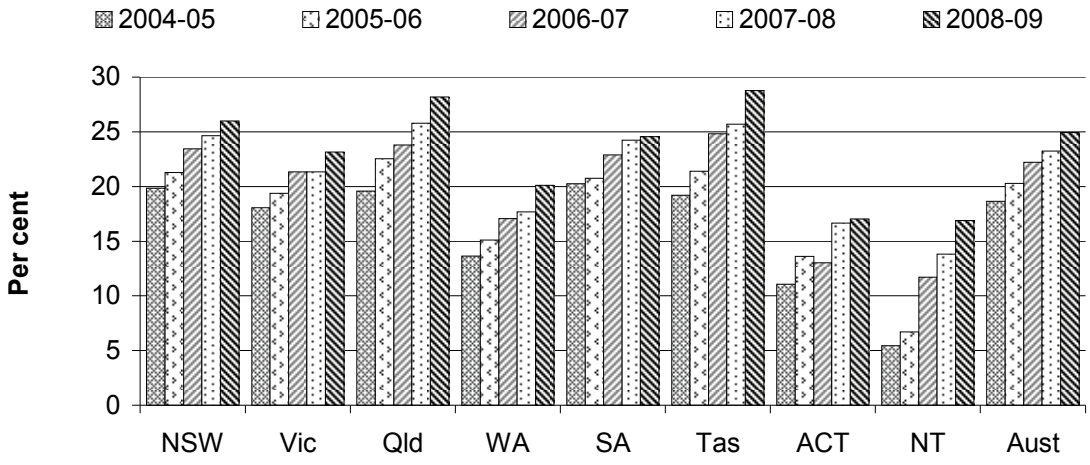
Annual voluntary health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.6). An increase in the proportion of eligible older people who received a voluntary health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Data for this indicator are comparable.

The targeted age range for Indigenous people of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health preface). Results for Indigenous people are reported under equity indicators (box 11.6).

There has been a steady increase in the proportion of older people receiving a voluntary health assessment in most jurisdictions, in the period 2004-05 to 2008-09. Nationwide, this proportion increased from 18.7 per cent in 2004-05 to 24.9 per cent in 2008-09 (figure 11.25).

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



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

Source: DoHA (unpublished) MBS data collection; table 11A.34.

Sustainability

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

Efficiency

Cost to government of general practice per person

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

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

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

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

(Continued on next page)

Box 11.19 **(Continued)**

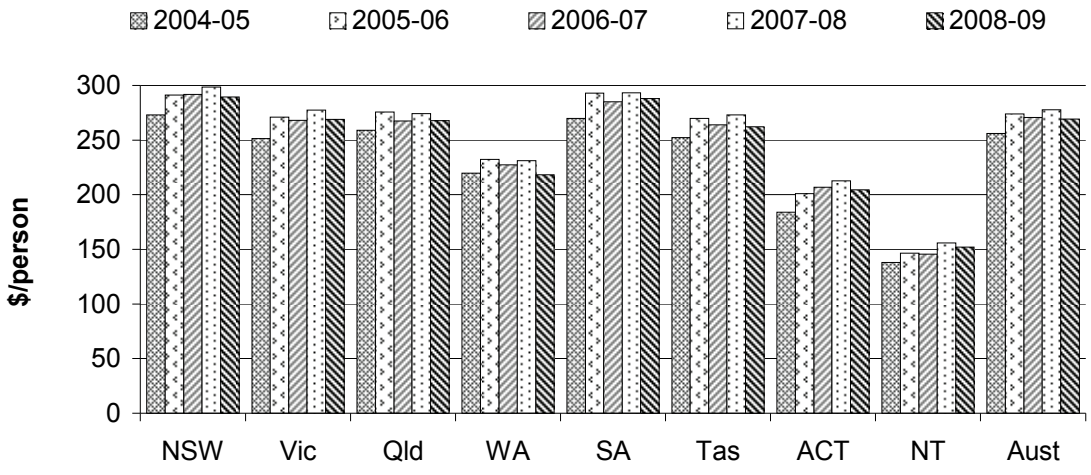
This indicator needs to be interpreted with care because a lower cost per person can reflect service substitution between primary healthcare and hospital services or specialist services (at potentially higher cost than primary care).

Data for this indicator are comparable.

This indicator does not include costs for all primary healthcare services. Some primary healthcare services are provided by salaried GPs in community health settings, particularly in rural and remote areas, through accident and emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Nationally, the recurrent cost to the Australian Government of general practice was $269 per person in 2008-09 (figure 11.26).

Figure 11.26 **Australian Government real expenditure per person on GPs (2008-09 dollars)[a]**



a The data include Medicare, DVA, PIP, DGP and GPII payments. DVA data cover consultations by local medical officers (LMOs), whether vocationally recognised GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (distinct from specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations.

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

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5). Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

Child immunisation coverage

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

Box 11.20 **Child immunisation coverage**

'Child immunisation coverage' is defined by two measures:

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

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

Data for this indicator are comparable.

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

Table 11.6 Valid vaccinations supplied to children under 7 years of age, by provider type, 2004–2009 (per cent)[a, b]

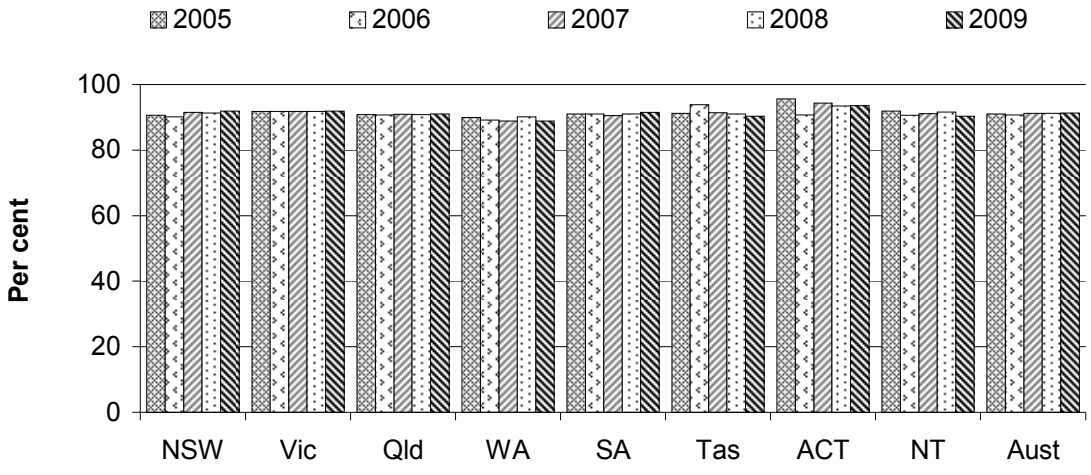
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	86.0	56.0	83.0	66.0	69.0	90.0	50.0	5.0	73.0
Council	4.4	43.0	6.0	4.0	21.0	9.0	–	–	15.0
State or Territory health department	–	–	–	8.0	–	–	–	1.0	1.0
Flying doctor service	–	–	–	–	–	–	–	–	–
Public hospital	1.2	1.0	3.0	2.0	1.0	–	1.0	8.0	2.0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

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

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.35.

Around 91.3 per cent of Australian children aged 12 months to less than 15 months at 30 June 2009 were assessed as fully immunised (figure 11.27).

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

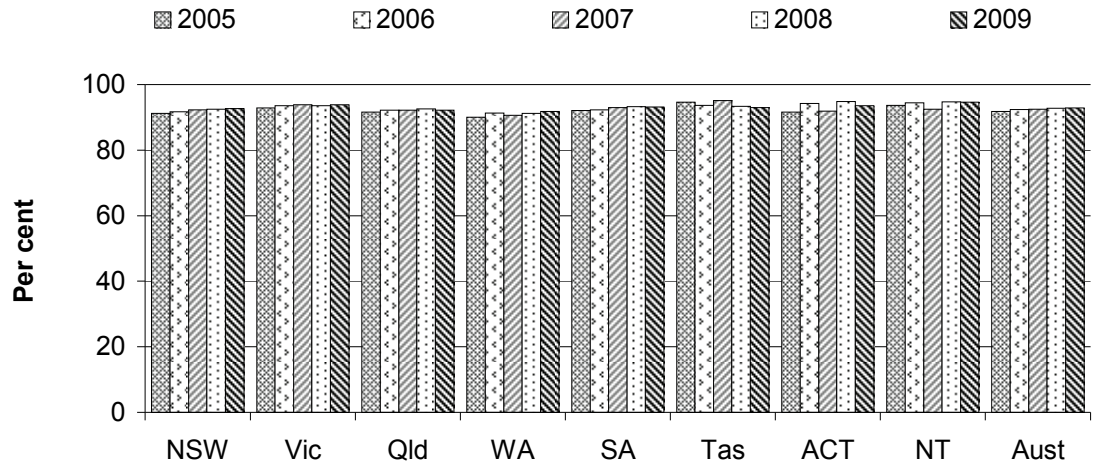


[a] Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. [b] The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over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

Source: DoHA (unpublished) ACIR data collection; table 11A.36.

Nationally, 92.9 per cent of children aged 24 months to less than 27 months at 30 June 2009 were assessed as being fully immunised (figure 11.28).

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



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

Source: DoHA (unpublished) ACIR data collection; table 11A.37.

Notifications of selected childhood diseases

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

Box 11.21 **Notifications of selected childhood diseases**

'Notifications of selected childhood diseases' is defined as the number of notifications of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

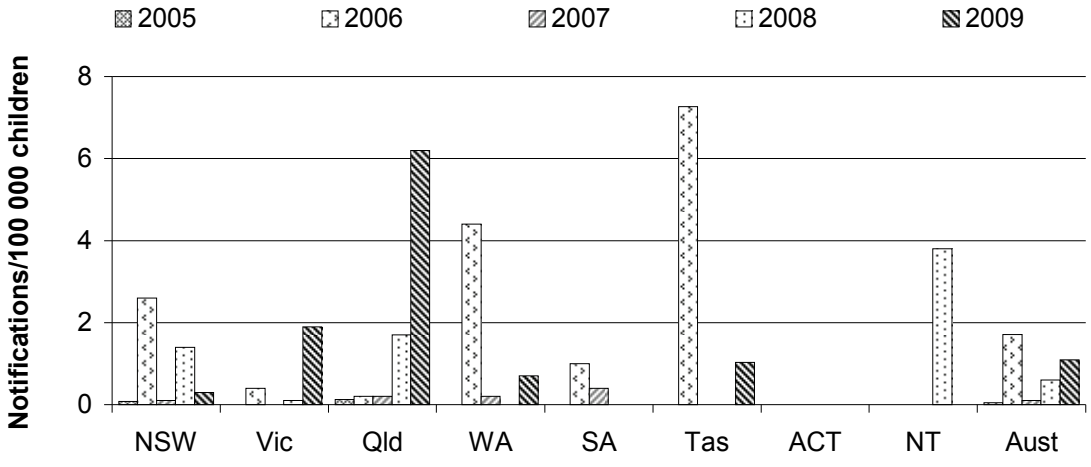
Measles, pertussis (whooping cough) and *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in one in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases through immunisation (and consequently the notification rates).

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

Data for this indicator are comparable.

In 2009, there were 45 notifications of measles across Australia to 31 August (table 11A.38). This was the third time in the five year period 2005–2009 that notifications numbered more than 25 — there were 68 notifications in 2006 and 26 in 2008. The national notification rate in 2009 was 1.1 per 100 000 children aged 0–14 years (figure 11.29).

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

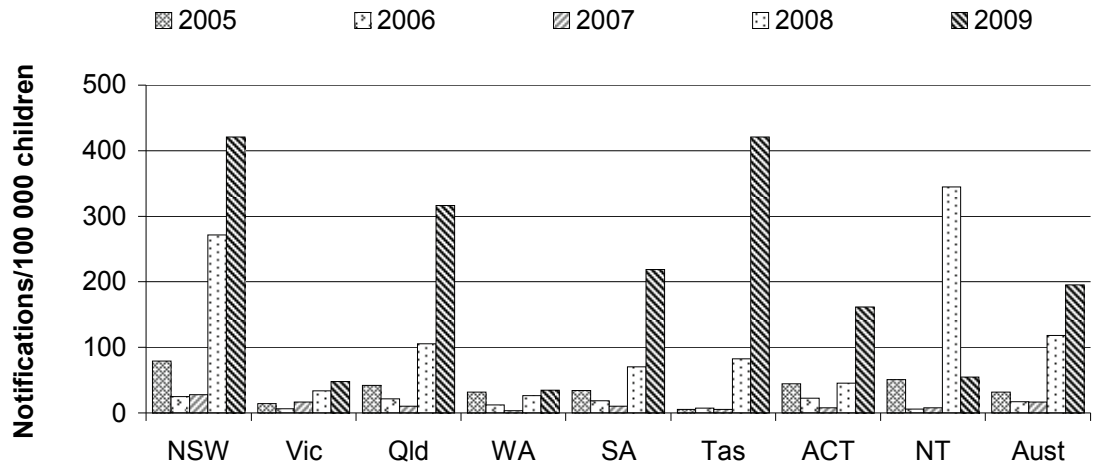


[a] Notifications for 2009 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.38.

Nationally, there were 8045 notifications for pertussis (whooping cough) to 31 August in 2009. The national notification rate in 2009 was 195.4 per 100 000 children aged 0–14 years (figure 11.30).

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



a Notifications for 2009 are to 31 August.

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

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2009, the notification rate nationally to 31 August was 0.2 per 100 000 children aged 0–14 years (figure 11.31).

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

a Notifications for 2009 are to 31 August. **b** Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished) NNDSS, *ABS Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.40.

Participation rates for women in cervical screening

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

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

'Participation rates for women in cervical screening' is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all eligible women aged 20–69 years. Eligible women are those who have not had a hysterectomy.

A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.

Data for this indicator are comparable.

It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated early (DoHA 2006; Mitchell, Hocking and Saville 2003). A range of healthcare providers offer cervical screening tests (pap smears). The National Cervical

Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 61.2 per cent for the 24 month period 1 January 2007 to 31 December 2008 (figure 11.32). For most jurisdictions, participation rates have remained relatively constant since the screening period of 2003 and 2004.

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

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

Source: AIHW (2009) *Cervical screening in Australia 2006–2007*, Cat. no. CAN 43; AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.41.

Influenza vaccination coverage for older people

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

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

'Influenza vaccination coverage for older people' is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza. This does not include pandemic influenza such as H1N1 Influenza (commonly known as 'swine flu').

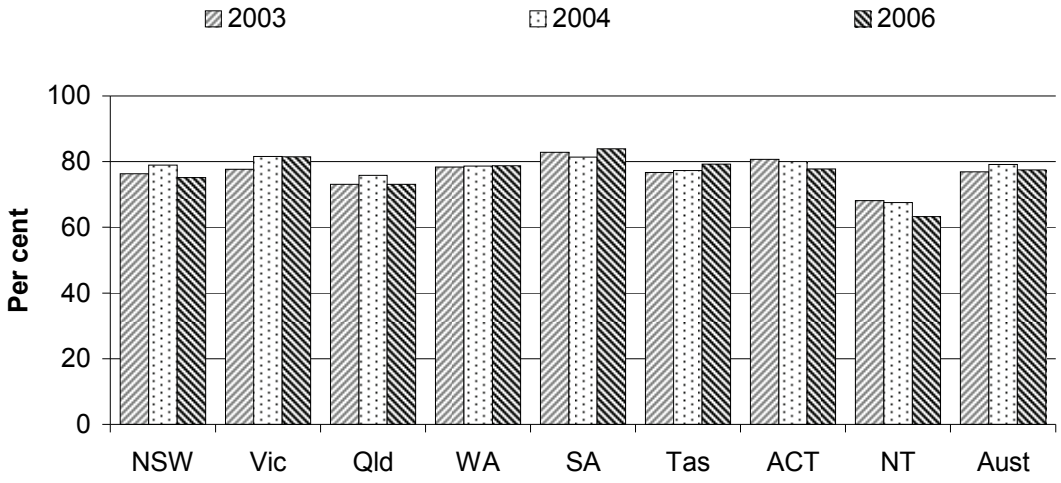
Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths. An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications.

Data for this indicator are comparable.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). GPs provide the majority of influenza vaccinations for older people.

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2005a). In 2006, 77.5 per cent of people in Australia aged 65 years or over were vaccinated against influenza (figure 11.33).

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



a The Adult Vaccination Survey was not conducted in 2005, 2007 or 2008.

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

Potentially preventable hospitalisations

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

Box 11.24 **Potentially preventable hospitalisation indicators**

Potentially preventable hospitalisations include hospitalisations for:

- preventable illness and injury
- potentially preventable exacerbations and/or complications of illness and injury.

Studies have shown that a significant proportion of variation between geographic areas in hospitalisation rates for selected vaccine preventable, acute and chronic conditions is explained by the availability of care in the primary and community healthcare sector (DHS 2002).

Hospitalisation rates also reflect the underlying prevalence of the conditions (AIHW 2008b, 2009b). In addition, some variation in rates can be due to different clinical coding and admission protocols.

While not all hospitalisations for these conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation.

Three indicators of potentially preventable hospitalisations are presented:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

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

Data are also reported against the first two potentially preventable hospitalisations indicators by Indigenous status. Adjustments are made to account for differences in the age structures of these populations across states and territories. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The *Improving the Quality of Indigenous Identification*

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

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

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

'Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions' is an indicator of governments' objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.25).

Box 11.25 **Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions**

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

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

(Continued on next page)

Box 11.25 **(Continued)**

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

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

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

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

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

Data for this indicator are comparable.

Vaccine preventable hospitalisations

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

Table 11.7 **Separations for vaccine preventable conditions per 1000 people, 2007-08[a, b]**

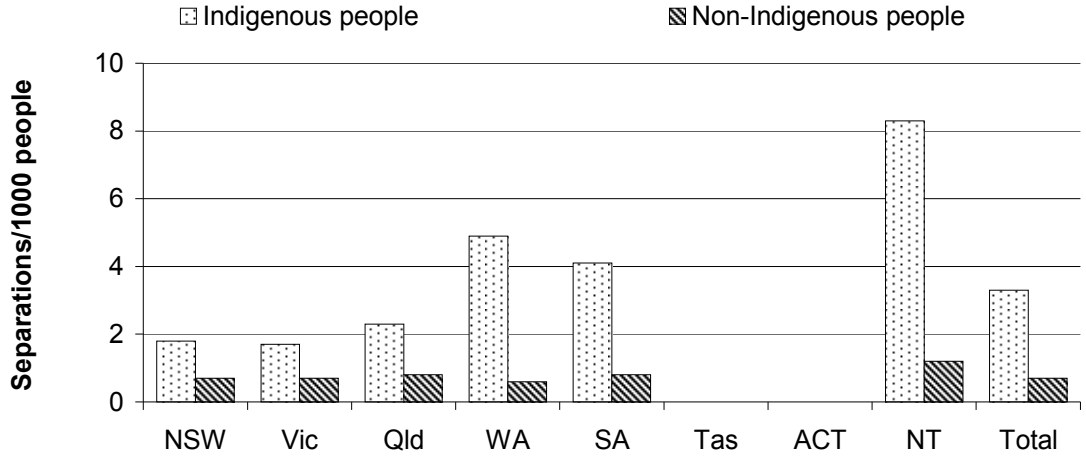
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.5	0.5	0.7	0.5	0.7	0.4	0.7	1.7	0.6
Other conditions	0.1	0.2	0.1	0.1	0.1	0.0	0.1	0.6	0.2
Total[d]	0.7	0.7	0.8	0.6	0.8	0.4	0.8	2.3	0.7

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on state/territory of usual residence. [c] Includes other territories and excludes overseas residents and unknown state of residence. [d] Totals may not add due to rounding.

Source: AIHW (2009) *Australian Hospital Statistics 2007-08*, Cat. no. HSE 71; table 11A.43.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.34).

Figure 11.34 **Separations for vaccine preventable conditions by Indigenous status, 2007-08**[a, b, c, d, e]



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

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

Age standardised hospital separation rate ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2007-08 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Victoria, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.46 and 11A.47).

Hospitalisations for selected acute conditions

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

Table 11.8 **Separations for selected acute conditions per 1000 people, 2007-08[a, b]**

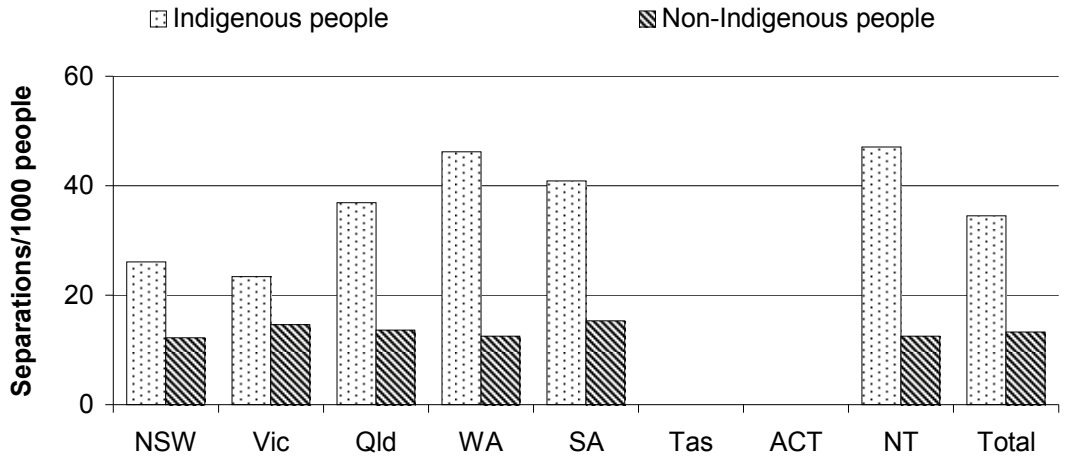
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2
Cellulitis	1.7	1.7	1.9	1.5	1.5	1.4	1.3	3.7	1.7
Convulsions and epilepsy	1.6	1.5	1.6	1.3	1.6	1.7	1.4	3.1	1.6
Dehydration and gastroenteritis	2.1	3.1	2.5	2.1	3.5	2.2	1.7	2.0	2.5
Dental conditions	2.4	3.1	2.7	3.4	3.2	1.9	2.0	2.2	2.8
Ear, nose and throat infections	1.7	1.6	1.8	1.7	2.5	1.4	1.2	2.1	1.7
Gangrene	0.1	0.3	0.2	0.3	0.2	0.2	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.5	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.2
Pyelonephritis[d]	2.1	2.4	2.3	2.1	2.1	1.7	2.2	3.3	2.2
Total[e]	**12.3**	**14.3**	**13.6**	**13.1**	**15.2**	**11.0**	**10.5**	**17.9**	**13.3**

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

Source: AIHW (2009) *Australian Hospital Statistics 2007-08*, Cat. no. HSE 71; table 11A.44.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.35).

Figure 11.35 **Separations for selected acute conditions by Indigenous status, 2007-08**[a, b, c, d, e]



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

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

Hospitalisations for selected chronic conditions

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

Table 11.9 Separations for selected chronic conditions per 1000 people, 2007-08[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.4	1.7	2.4	1.4	1.6	1.4	1.1	2.4	1.7
Asthma	1.9	1.9	1.7	1.5	2.6	1.5	1.0	1.4	1.8
Chronic obstructive pulmonary disease	2.6	2.6	2.9	2.4	3.1	2.7	1.5	6.3	2.7
Congestive cardiac failure	1.9	2.2	2.0	1.7	1.9	1.7	1.8	2.3	2.0
Diabetes complications	7.0	9.3	10.3	29.0	7.6	12.6	5.5	13.2	10.6
Hypertension	0.3	0.2	0.3	0.2	0.3	0.3	0.1	0.1	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.4	1.0	1.4	0.7	0.7	1.2
Nutritional deficiencies	–	–	0.0	0.0	–	0.0	–	0.1	0.0
Rheumatic heart disease[d]	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.8	0.1
Total[e]	**15.2**	**18.4**	**19.7**	**36.6**	**16.9**	**20.9**	**11.1**	**25.5**	**19.2**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on state/territory of usual residence. [c] Includes other territories. Excludes overseas residents and unknown state of residence. [d] Includes acute rheumatic fever as well as the chronic disease. [e] Totals may not add as more than one chronic condition may be reported for a separation. – Nil or rounded to zero.

Source: AIHW (2009) *Australian Hospital Statistics 2007-08*, Cat. no. HSE 71; table 11A.45.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.36).

Figure 11.36 Separations for selected chronic conditions by Indigenous status, 2007-08[a, b, c, d, e]

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

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

Potentially preventable hospitalisations for diabetes

'Potentially preventable hospitalisations for diabetes' is an indicator of governments' objective to reduce hospitalisations due to diabetes through the provision of high quality, appropriate and effective management of diabetes in the primary and community health sector (box 11.26).

Box 11.26 **Potentially preventable hospitalisations for diabetes**

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

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

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

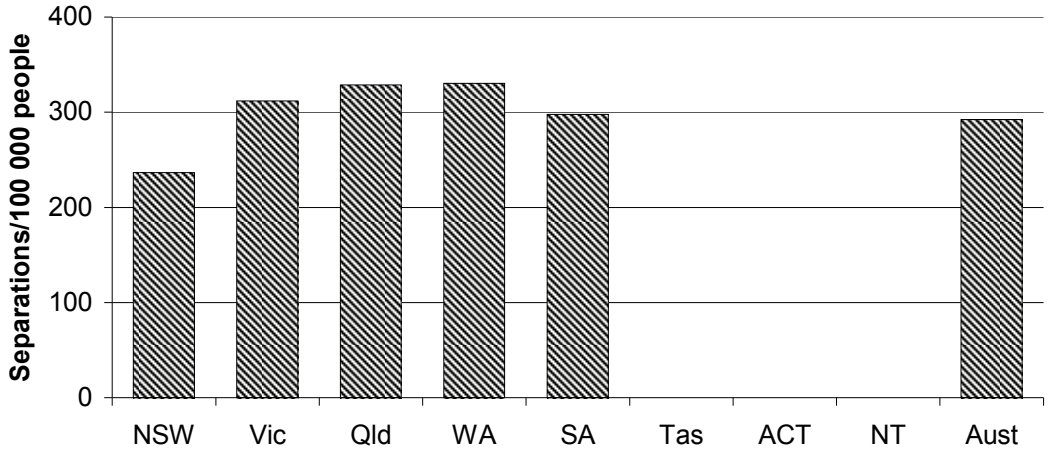
Low or reducing rates can indicate an improvement in GPs' and community health providers' management of patients' diabetes. A comparison is made between Indigenous and all other people in the ratio of age standardised hospital separation rates of Indigenous people to all people. Rate ratios close to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

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

Data for this indicator are comparable.

Nationally, the age standardised hospital separation rate in 2007-08 where the principal diagnosis was Type 2 diabetes mellitus was 292.3 separations per 100 000 people (figure 11.37).

Figure 11.37 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2007-08**[a, b, c]

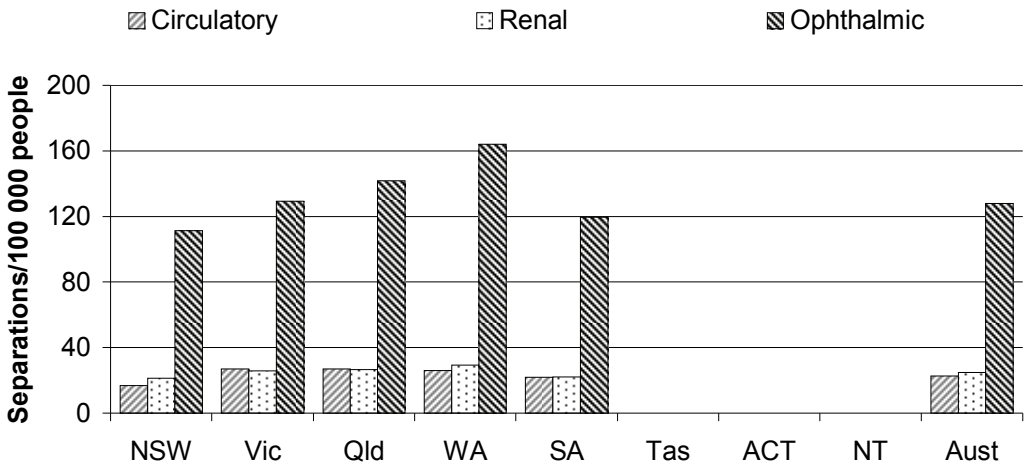


[a] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [b] Morbidity data are coded under coding standards that can differ over time and across jurisdictions. [c] Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

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

The three most common complications from Type 2 diabetes that led to hospitalisation in 2007-08 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.38). Each patient can have one or more complication(s) (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.38 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2008-09**[a, b, c, d]



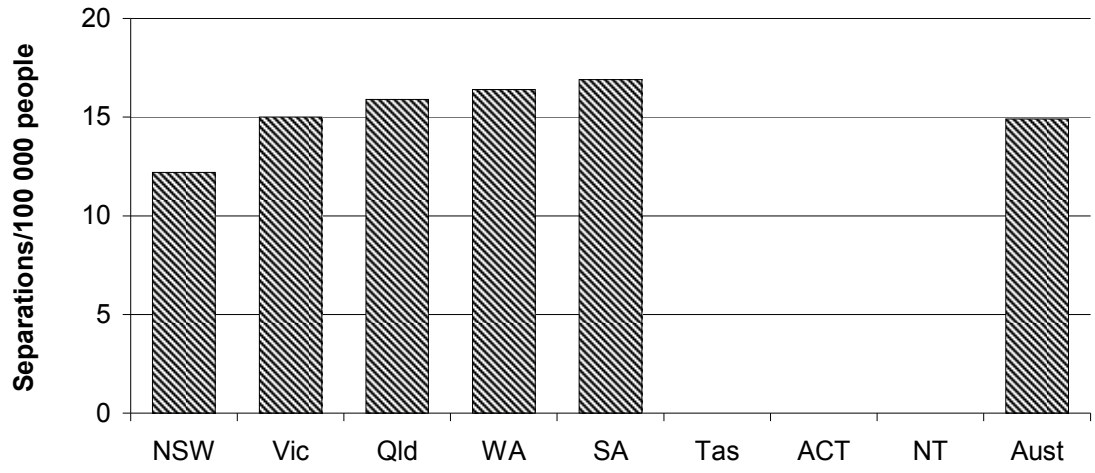
[a] Results for individual complications can be affected by small numbers, and need to be interpreted with care. [b] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [c] Morbidity data are coded under coding standards that can differ over time and across jurisdictions. [d] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

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

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 49.9 per cent of separations for Type 2 diabetes were same day separations in 2007-08 (table 11A.49).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2007-08, there were 14.9 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.39).

Figure 11.39 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2007-08**[a, b, c]



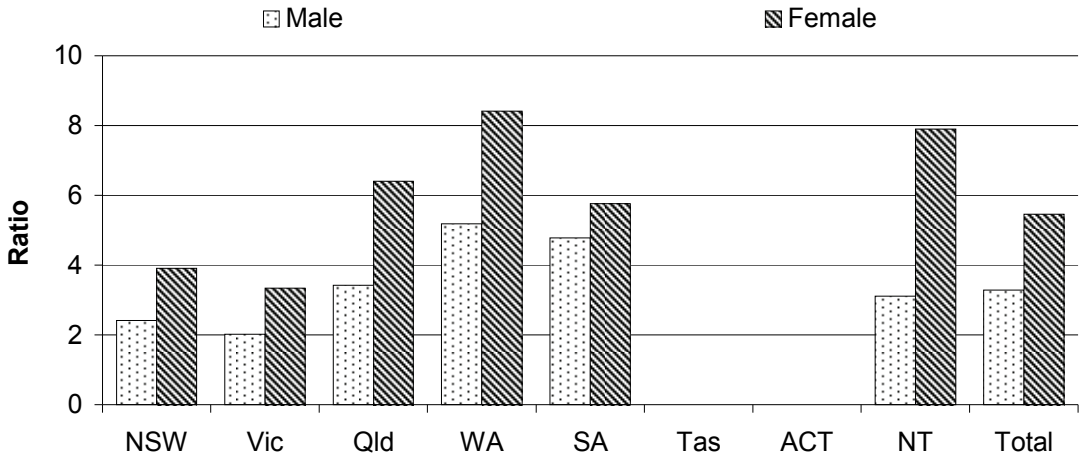
[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. [c] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.50.

Age standardised hospital separation ratios for all diabetes diagnoses[2] illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2007-08 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 3.3 times higher than the separation rate for all Australian males. The separation rate for Indigenous females was 5.5 times the rate for all females (figure 11.40).

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

Figure 11.40 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2007-08**[a, b, c, d, e, f, g]



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

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

Potentially preventable hospitalisations of older people for falls

'Potentially preventable hospitalisations of older people for falls' is an indicator of governments' objective to reduce preventable hospitalisations through the delivery of effective primary and community health services (box 11.27). Effective primary and community healthcare can reduce the likelihood of falls and/or assist in reducing the severity of injury.

Box 11.27 **Potentially preventable hospitalisations of older people for falls**

'Potentially preventable hospitalisations of older people for falls' is defined as the number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as aged 65 years or over for this indicator.

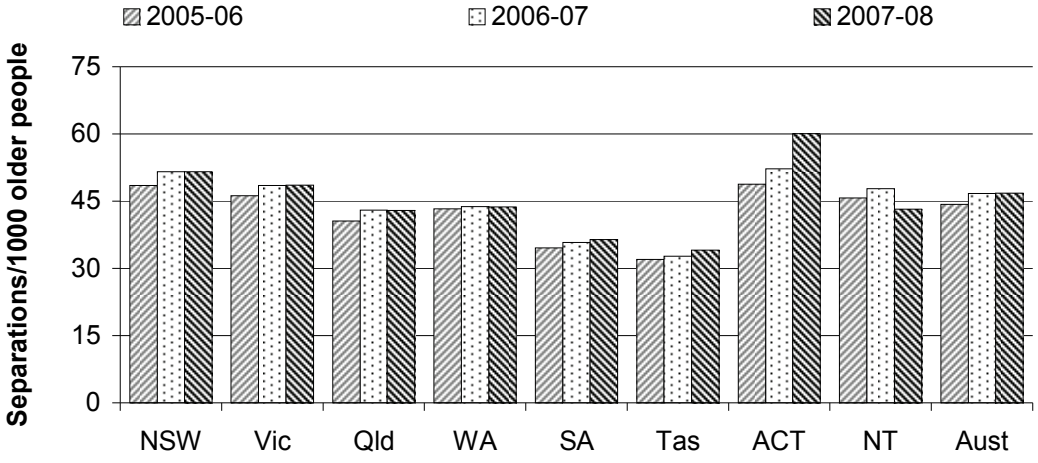
A low or reducing rate of hospitalisation due to falls can indicate improvements in the effectiveness of primary and community healthcare services provided to older people who are at risk of falls or, have fallen.

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

Data for this indicator are comparable.

In all jurisdictions for which data are published, age standardised separation rates for older people with injuries due to falls have gradually increased in the period 2005-06 to 2007-08 (figure 11.41). Nationally, the separation rate per 1000 older people increased from 44.3 in 2005-06 to 46.8 in 2007-08.

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



[a] Older people are defined as people aged 65 years or over. [b] Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. [c] Excludes separations records for hospital boarders and posthumous organ procurement.

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

11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of data available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The Steering Committee has identified possible areas for which indicators may be available for inclusion in the 2011 Report or future reports. These include:

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

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

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

Indigenous health

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

Continued efforts to improve Indigenous identification are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems.

COAG developments

Report on Government Services alignment with National Agreement reporting

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

Outcomes from review of Report on Government Services

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

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

11.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma Action Plan	An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional. *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, *Australian asthma indicators: Five-year review of asthma monitoring in Australia*. Cat. no. ACM 12, AIHW, Canberra.
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. There are 109 Divisions of General Practice (DGP), 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The DGP Program evolved from the former Divisions and Projects Grants Program established in 1992. The DGP Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of healthcare at the local level.
Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.

Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (from 1996 vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners — medical practitioners who are not vocationally recognised GPs.
***Haemophilus influenzae* type b**	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.

Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally recognised, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and GPA ACCREDITATION *plus*), divided by the total number of practices in the DGP.
Proportion of general practices with electronic information management systems	Number of practices that maintain and/or use predominantly secure electronic patient records, that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 Attachment tables

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

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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).

Attachment contents

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Community health programs

Table 11A.1 **Types of encounter, 2008-09 (a)**

	Number	*Per cent of encounters* (b) *(n= 96 688)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=89 185)*	*Per cent of Medicare-paid GP items (n=86 069)*
	no.	%	%	%	%	%
General practitioners	1 011	..	..	..	..	..
Direct encounters	89 185	98.6	98.3	98.8	100.0	..
No charge	424	0.5	0.4	0.6	0.5	..
MBS/DVA items of service (all) (c)	86 118	95.2	94.8	95.6	96.6	..
MBS/DVA items of service (GPs only)	86 069	95.1	94.7	95.5	..	100.0
Short surgery consultations	1 387	1.5	1.3	1.8	..	1.6
Standard surgery consultations	72 235	79.8	78.9	80.8	..	83.9
Long surgery consultations	6 588	7.3	6.8	7.8	..	7.7
Prolonged surgery consultations	389	0.4	0.3	0.6	..	0.5
Home visits	767	0.9	0.7	1.0	..	0.9
Hospital	165	0.2	0.1	0.3	..	0.2
Residential aged care facility	1 082	1.2	0.9	1.5	..	1.3
Health assessments	295	0.3	0.3	0.4	..	0.3
Chronic disease management items	811	0.9	0.8	1.0	..	0.9
Case conferences	12	–	–	–	..	–
GP mental health care items	867	1.0	0.8	1.1	..	1.0
Incentive payments	147	0.2	0.1	0.2	..	0.2
Other items	1 325	1.5	1.2	1.8	..	1.5
Practice nurse only items	36	–	–	0.1	–	..
Workers compensation	1 950	2.2	2.0	2.3	2.2	..
Other paid (hospital, state, etc.)	707	0.8	0.5	1.0	0.8	..

Table 11A.1 **Types of encounter, 2008-09 (a)**

	Number	*Per cent of encounters* (b) *(n= 96 688)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=89 185)*	*Per cent of Medicare-paid GP items (n=86 069)*
Indirect encounters (d)	1 303	1.4	1.2	1.7	..	..
Practice nurse only items	9	–	–	–	..	..
Practice nurse only items (unspecified)	3	–	–	–	..	..
Missing	6 197	..	..	..	..	..
Total encounters	**96 688**	**100.0**	..	..	..	..

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 36 indirect encounters at which a practice nurse item only was recorded and 3 unspecified encounters at which a practice nurse item was recorded.

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

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

Source: Britt, H., Miller, G.C., Charles, J., Henderson, J., Bayram, C., Pan, Y., Valenti, L., Harrison, C., Fahridin, S. and O'Halloran, J. 2009, *General practice activity in Australia 2008–09*, Cat. no. GEP 25, General practice series no. 25, AIHW, Canberra.

Table 11A.2 Australian Government real expenditure per person on GPs (2008-09 dollars) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004-05	273	251	259	220	270	252	184	138	256
2005-06	291	271	276	232	293	270	201	147	274
2006-07	292	268	267	227	285	264	207	146	271
2007-08	299	278	274	231	293	273	213	156	278
2008-09	290	269	268	218	288	262	204	152	269

(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 Incentive 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: DoHA (Department of Health and Ageing) unpublished, MBS, PIP, GPII, DGP and DVA data collections.

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										
2004-05	no.	7 590	5 721	4 644	2 175	1 944	609	375	320	23 378
2005-06	no.	7 703	5 802	4 777	2 252	1 980	628	379	313	23 834
2006-07	no.	7 846	5 920	4 872	2 304	2 000	631	374	325	24 272
2007-08	no.	7 948	6 057	5 051	2 359	2 100	660	383	345	24 903
2008-09	no.	8 108	6 229	5 334	2 467	2 139	676	384	389	25 726
FWE GPs										
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
2008-09	no.	6 792	4 738	3 861	1 574	1 511	404	235	116	19 231
FWE GPs per 100 000 people										
2004-05	per 100 000 people	91.7	82.8	85.6	72.3	88.5	77.9	61.5	47.2	84.9
2005-06	per 100 000 people	92.4	84.3	86.3	72.0	90.5	79.1	63.3	46.8	85.8
2006-07	per 100 000 people	94.1	84.7	85.4	71.4	89.5	79.2	66.8	48.3	86.1
2007-08	per 100 000 people	94.8	86.7	86.1	71.5	90.9	80.7	67.5	52.6	87.2
2008-09	per 100 000 people	95.9	87.5	87.7	70.4	93.2	80.4	67.0	51.7	88.1

(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.

Source: DoHA unpublished, MBS data collection.

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*
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	28	22	28	25	10	6	27	146
2007-08 (d)	29	23	30	30	10	7	26	155

(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) 2007-08 data are preliminary results.

Source: DoHA unpublished, Service Activity Reporting (SAR) data collection.

Table 11A.5 Services and episodes of healthcare by Indigenous primary healthcare 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						
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	47	32	13	16	38	146
2007-08 (b)	52	34	13	16	40	155
Episodes of healthcare						
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	560 000	415 000	87 000	269 000	312 000	1 643 000
2007-08 (b)	562 000	561 000	86 000	311 000	330 000	1 850 000

(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) 2007-08 data are preliminary results.

Source: DoHA unpublished, SAR data collection.

Table 11A.6 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) (a), (b), (c)

Diagnosis and treatment of illness/disease	86
Management of chronic illness	88
Transportation to medical appointments	92
Outreach clinic services	63
24 hour emergency care	28
Monitoring child growth	72
School-based activities	79
Hearing screening	71
Pneumococcal immunisation	79
Influenza immunisation	80
Child immunisation	79
Women's health group	80
Support for public housing issues	65
Community development work	68
Legal/police/prison/advocacy services	55
Dental services	58
Involvement in steering groups on health	83
Participation in regional planning forums	66
Dialysis services	7

(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 2007-08 are preliminary results.

Source: DoHA unpublished, SAR data collection.

Table 11A.7 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) (a), (b), (c)

	Indigenous staff	*Non-Indigenous staff*	*Total staff* (d)
Aboriginal health workers	743	22	765
Doctors	6	275	281
Nurses	50	466	516
Specialists	–	6	6
Qualified counsellors/social workers	32	25	57
Other social and emotional wellbeing staff (d)	182	98	280
Allied health professionals	2	49	51
Dentists	5	38	43
Dental assistants	41	19	60
Traditional healers	22	–	22
Substance misuse workers	97	28	125
Environmental health workers	19	8	27
Driver/field officers	197	23	220
Other health staff (e)	100	50	150
Total health staff (f)	**1 496**	**1 107**	**2 603**

(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) Other social and emotional wellbeing staff includes: Bringing Them Home and Link Up counsellors, psychologists, mental health workers and other social and emotional wellbeing staff.

(e) Other health staff includes: sexual health workers, diabetes educators and other patient educators, health program coordinators, nutrition workers, community care workers, child and family health workers, child protection workers, welfare workers, pharmacy assistants/technicians, Brighter Futures Program caseworkers, foster carers, Healthy for Life workers, sports and recreation workers, youth workers and masseurs.

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

– Nil or rounded to zero.

Source: DoHA unpublished, SAR data collection.

Table 11A.8 Alcohol and other drug treatment services, by sector, 2007-08 (number)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government	201	–	59	19	41	6	1	3	330
Non-government	67	138	47	32	8	10	9	17	328
Total	**268**	**138**	**106**	**51**	**49**	**16**	**10**	**20**	**658**

– Nil or rounded to zero.

Source: AIHW 2009, *Alcohol and Other Drug Treatment Services in Australia 2007-08: report on the National Minimum Data Set,* Cat. no. HSE 73, Drug Treatment Series no. 9, Canberra.

Table 11A.9 **Approved providers of PBS medicines, by urban and rural location, 2008-09 (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of pharmacies									
Urban	1 451	1 013	829	421	314	80	62	18	4 188
Rural	280	157	182	86	90	51	–	11	857
Number of people per pharmacy									
Urban	3 690	4 118	3 715	3 770	3 773	3 451	5 214	4 941	3 836
Rural	4 232	4 803	4 459	4 255	3 632	3 911	–	9 272	4 367
Number of approved medical practitioners									
Urban	–	–	–	–	–	–	–	–	–
Rural	16	3	10	21	2	7	–	1	60
Number of approved hospitals (b)									
Urban									
Private	23	25	19	4	4	1	3	1	80
Public	–	53	26	6	6	–	–	1	92
Rural									
Private	–	–	–	–	–	–	–	–	–
Public	–	12	62	–	–	–	–	4	78

(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, 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, 2008-09 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general (b)	000	8 842	6 348	5 267	2 742	1 869	555	550	155	26 327
PBS concessional (c)	'000	53 160	39 783	29 524	12 833	13 422	4 526	1 436	457	155 141
PBS doctor's bag	'000	122	91	84	28	29	9	4	2	368
PBS total	'000	62 124	46 222	34 875	15 603	15 320	5 089	1 990	614	181 836
Proportion of concessional PBS services (b)	%	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3

(a) Excludes RPBS.

(b) Includes PBS general ordinary and safety net.

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

Source: DoHA unpublished, PBS data collection

Table 11A.11 PBS expenditure per person, by urban and rural location (2008-09 dollars) (a), (b)

	2004-05	*2005-06*	*2006-07*	*2007-08*	*2008-09*
Capital city	303.0	290.4	277.1	281.9	291.1
Other metro	340.7	325.4	313.5	320.4	331.4
Rural and remote	332.3	317.6	303.4	310.9	322.6
All locations	314.3	300.9	287.5	293.2	303.2

(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, PBS data collection

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									
Urban									
2004-05	6 266	4 413	2 794	1 620	1 443	308	na	127	16 971
2005-06	6 340	4 467	2 860	1 670	1 474	318	na	117	17 246
2006-07	6 430	4 530	2 910	1 695	1 470	318	na	110	17 463
2007-08	6 098	4 626	2 994	1 729	1 521	333	383	122	17 806
2008-09	6 215	4 751	3 162	1 798	1 547	342	384	142	18 341
Rural									
2004-05	1 699	1 308	1 850	555	501	301	na	193	6 407
2005-06	1 742	1 335	1 917	582	506	310	na	196	6 588
2006-07	1 790	1 390	1 962	609	530	313	na	215	6 809
2007-08	1 850	1 431	2 057	630	579	327	..	223	7 097
2008-09	1 893	1 478	2 172	669	592	334	..	247	7 385
Number of full time workload equivalent GPs									
Urban									
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
2008-09	5 411	3 662	2 357	1 186	1 118	179	235	56	14 204
Rural									
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
2008-09	1 381	1 076	1 504	388	393	225	..	60	5 027
Number of full time workload equivalent GPs per 100 000 people									
Urban									
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
2008-09	100.4	89.6	87.9	72.2	93.2	87.3	67.2	58.0	90.7
Rural									
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
2008-09	81.6	80.9	87.5	65.5	93.1	75.6	..	46.9	81.3

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.

na Not available. .. Not applicable.

Source : DoHA unpublished, MBS data collection.

Table 11A.13 **Availability of female GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs (d)										
2004-05	no.	2 751	2 116	1 717	801	671	243	180	151	8 630
2005-06	no.	2 848	2 165	1 801	830	702	252	182	139	8 919
2006-07	no.	2 955	2 256	1 864	868	722	260	181	146	9 252
2007-08	no.	3 022	2 344	1 960	898	775	281	189	167	9 636
2008-09	no.	3 152	2 445	2 108	986	809	292	189	187	10 168
Female FWEs GPs										
2004-05	no.	1 679	1 096	923	382	329	114	73	38	4 633
2005-06	no.	1 728	1 158	969	394	336	122	76	34	4 817
2006-07	no.	1 822	1 232	1 011	410	350	125	82	37	5 067
2007-08	no.	1 916	1 312	1 084	426	372	131	85	45	5 371
2008-09	no.	2 002	1 389	1 178	454	401	136	87	48	5 695
Female FWEs GPs as a proportion of all FWE GPs										
2004-05	%	27.0	26.3	27.2	26.2	24.1	30.2	36.3	40.3	26.8
2005-06	%	27.4	27.0	27.8	26.8	24.0	31.5	36.5	34.8	27.3
2006-07	%	28.1	28.0	28.4	27.3	24.7	31.9	36.1	35.4	28.0
2007-08	%	29.0	28.6	29.4	27.6	25.6	32.7	36.4	39.2	28.9
2008-09	%	29.5	29.3	30.5	28.8	26.5	33.7	37.0	41.6	29.6
Female FWE GPs per 100 000 females										
2004-05	per 100 000 females	49.2	43.0	46.5	38.0	42.3	46.4	44.2	40.1	45.3
2005-06	per 100 000 females	50.3	45.0	48.0	38.7	43.0	49.2	45.7	34.4	46.6
2006-07	per 100 000 females	52.4	46.9	48.4	39.4	43.7	49.9	47.8	35.6	48.0
2007-08	per 100 000 females	54.6	49.1	50.6	40.0	46.0	52.1	48.8	42.9	50.0
2008-09	per 100 000 females	56.0	50.8	53.6	41.2	48.8	53.4	49.3	44.7	51.9

Table 11A.13 **Availability of 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.

Source: DoHA unpublished, MBS data collection.

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

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (b)	*ACT* (c)	*NT* (d)	*Aust*
FTE dentists per 100 000 population (e)									
2004									
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 (e)									
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	8.1	6.9	9.7	8.7	11.4	..	1.4	..	8.2
Inner regional	4.2	3.4	7.9	3.2	4.3	4.1	–	..	4.7
Outer regional	2.3	4.8	8.4	2.1	2.9	–	..	15.0	5.1
Remote and very remote	–	–	4.9	3.9	–	–	..	19.1	6.2
Total	**6.9**	**6.0**	**9.0**	**7.1**	**9.1**	**2.6**	**1.4**	**16.8**	**7.2**
2007									
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.14 **Availability of public dentists (per 100 000 people) (a)**

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

(a) National dental labour force data are not available for 2004 or 2007.

(b) There were no major cities in Tasmania.

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

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

(e) FTE based on 40-hour week.

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

Source: AIHW unpublished, National dental labour force collection.

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

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT* (d)	*NT* (e)	*Aust*
FTE dental therapists per 100 000 population (f)									
2004									
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	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**	**4.6**	**9.4**	**4.3**
2006									
Major cities	1.9	1.7	6.4	6.1	4.7	..	4.0	..	3.4
Inner regional	3.7	2.8	7.9	8.3	6.4	7.8	–	..	5.1
Outer regional	3.0	2.4	6.7	7.3	8.2	9.2	..	8.8	5.8
Remote and very remote	2.7	–	2.8	3.3	3.2	–	..	7.4	3.7
Total	**2.3**	**2.0**	**6.7**	**6.3**	**5.3**	**8.1**	**4.0**	**8.0**	**3.9**
2007									
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) (a) (b)**

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

(a) Overestimation in some jurisdictions is expected due to double counting of dual registered therapists/hygenists. A respondent who reports dual registeration is included here but may work prinicipally as a hygenist.

(b) National dental labour force data are not available for 2004 or 2007.

(c) There were no major cities in Tasmania.

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

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

(f) FTE based on 40-hour week.

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

Source: AIHW unpublished, National dental labour force collection.

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

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
2007-08										
Indigenous older people										
Number of people assessed (g)	no.	1 154	271	1 253	628	123	8	8	813	4 258
Target population (h)	no.	13 795	3 157	11 371	5 669	2 306	1 677	256	4 958	43 225
Proportion of target population assessed	per 1000 people	83.7	85.8	110.2	110.8	53.3	4.8	31.3	164.0	98.5
All older people										
Number of people assessed (i)	no.	103 793	66 357	56 322	18 858	26 674	8 281	2 330	185	282 800
Target population (j)	no.	457 419	340 923	235 934	115 223	121 493	34 397	15 011	3 275	1 323 714
Proportion of target population assessed	per 1000 people	226.9	194.6	238.7	163.7	219.6	240.7	155.2	56.5	213.6
2008-09										
Indigenous older people										
Number of people assessed (g)	no.	1 469	268	1 540	789	144	23	26	985	5 244
Target population (h)	no.	14 476	3 326	12 056	5 978	2 420	1 766	286	5 203	45 547
Proportion of target population assessed	per 1000 people	101.5	80.6	127.7	132.0	59.5	13.0	90.9	189.3	115.1
All older people										
Number of people assessed (i)	no.	111 227	73 150	62 602	21 993	27 418	9 473	2 426	274	308 563
Target population (j)	no.	465 177	347 760	240 280	117 935	123 078	34 920	15 454	3 386	1 348 037
Proportion of target population assessed	per 1000 people	239.1	210.3	260.5	186.5	222.8	271.3	157.0	80.9	228.9

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

(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.

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

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

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

(d) Historical rates 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.

(e) Allocation of patients to state based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.

(f) Includes Other Territories.

(g) Health assessments for Indigenous people aged 55 years or over (Medicare items 704 and 706). Indigenous status is determined by self-identification.

(h) Projected population of Indigenous people aged 55 years or over at 31 December. Calculated as the average of the population projections (B series) at 30 June in the reported and preceding financial year. Projections are based on estimated resident population (ERP) at 30 June 2006 (ABS 2009).

(i) Health assessments for people aged 75 years or over (Medicare items 700 and 702).

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

Source: DoHA unpublished, MBS data collection; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 1991 to 2021,* Cat. no. 3238.0, Canberra; ABS unpublished, *2006 Census of Population and Housing*.

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

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
2004-05										
Number of people assessed	no.	634	143	566	348	132	17	3	309	2 152
Target population (f)	no.	11 801	2 716	9 580	4 912	2 056	1 421	181	4 232	36 929
Proportion of target population assessed	per 1000 people	53.7	52.7	59.1	70.8	64.2	12.0	16.6	73.0	58.3
2005-06										
Number of people assessed	no.	798	157	710	394	90	13	2	345	2 509
Target population (f)	no.	12 453	2 855	10 141	5 167	2 141	1 505	205	4 481	38 981
Proportion of target population assessed	per 1000 people	64.1	55.0	70.0	76.3	42.0	8.6	9.8	77.0	64.4
2006-07										
Number of people assessed	no.	994	237	988	460	140	7	15	624	3 465
Target population (f)	no.	13 118	2 999	10 738	5 411	2 211	1 590	227	4 733	41 062
Proportion of target population assessed	per 1000 people	75.8	79.0	92.0	85.0	63.3	4.4	66.1	131.9	84.4
2007-08										
Number of people assessed	no.	1 154	271	1 253	628	123	8	8	813	4 258
Target population (f)	no.	13 795	3 157	11 371	5 669	2 306	1 677	256	4 958	43 225
Proportion of target population assessed	per 1000 people	83.7	85.8	110.2	110.8	53.3	4.8	31.3	164.0	98.5
2008-09										
Number of people assessed	no.	1 469	268	1 540	789	144	23	26	985	5 244
Target population (f)	no.	14 476	3 326	12 056	5 978	2 420	1 766	286	5 203	45 547
Proportion of target population assessed	per 1000 people	101.5	80.6	127.7	132.0	59.5	13.0	90.9	189.3	115.1

(a) Older Indigenous people are defined as aged 55 years or over, excluding people living in residential aged care facilities. Indigenous status is determined by self-identification.

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

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

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

(c) Allocation of patients to state based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.

(d) Historical rates 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.

(e) Includes Other Territories.

(f) Projected population of Indigenous people aged 55 years or over at 31 December. Calculated as the average of the population projections (B series) at 30 June in the reported and preceding financial years. Projections are based on the estimated resident population (ERP) at 30 June 2006.

Source: DoHA unpublished, MBS data collection; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 1991 to 2021*, Cat. no. 3238.0, Canberra.

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* (c)
Children 0–14 years (d)										
Children assessed	no.	3 882	421	4 474	1 934	536	28	53	2 642	13 970
Target population	no.	58 523	12 521	57 723	25 947	10 388	6 760	1 589	22 741	196 261
Proportion assessed	per 1000 children	66.3	33.6	77.5	74.5	51.6	4.1	33.4	116.2	71.2
Adults 15–54 years (e)										
People assessed	no.	8 049	1 413	10 242	4 878	1 059	113	166	7 512	33 432
Target population	no.	86 222	19 363	83 415	41 759	16 480	10 752	2 636	38 566	299 327
Proportion assessed	per 1000 people	93.4	73.0	122.8	116.8	64.3	10.5	63.0	194.8	111.7
Adults 55 years or over (d)										
People assessed	no.	1 469	268	1 540	789	144	23	26	985	5 244
Target population	no.	14 476	3 326	12 056	5 978	2 420	1 766	286	5 203	45 547
Proportion assessed	per 1000 people	101.5	80.6	127.7	132.0	59.5	13.0	90.9	189.3	115.1

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

(b) Allocation of patients to state/territory based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided. Indigenous status is determined by self-identification.

(c) Includes Other Territories.

(d) Child health checks for children 0–14 years and older people's health assessments for people 55 years or over are available on an annual basis. Data are for the 2008-09 financial year. Projected target population as at 31 December 2008, calculated as the average of the population projections (B series) for 30 June 2008 and 2009. Projections are based on the estimated resident population (ERP) at 30 June 2006.

(e) Health checks are available for adults 15–54 years on a biennial basis. Data are for the 24 month period 1 July 2007 to 30 June 2009. Projected target population (B series) at 30 June 2008, based on the ERP at 30 June 2006.

Source: DoHA unpublished, MBS data collection; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021,* Cat. no. 3238.0, Canberra.

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

	Unit	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08 (b)*
Early detection activities provided						
Well person's checks	%	64	63	65	76	69
PAP smears/cervical screening	%	79	77	75	76	75
STI screening	%	64	65	63	67	64
Hearing screening	%	72	70	71	76	71
Eye disease screening	%	65	70	64	73	65
Renal disease screening	%	50	50	43	51	50
Diabetic screening	%	82	80	77	79	76
Cardiovascular screening	%	57	60	67	64	59
Any early detection activity	%	88	89	84	88	85

(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) 2007-08 data are preliminary results.

Source: DoHA unpublished, SAR 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*
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	78.3	73.4	76.7	76.0	71.6	82.0	95.8	79.2
2008-09	81.1	79.4	74.7	78.8	77.0	70.9	82.6	74.3	79.9

(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

Source: DoHA unpublished, MBS data collection.

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

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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	53.2	65.7	79.2
2008-09	85.1	77.9	78.5	73.7	80.1	74.8	53.0	64.7	79.9

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

Source: DoHA 2009, *Medicare Statistics - June Quarter 2009* , http://www.health.gov.au/internet/main /publishing.nsf/Content/medstat-jun09-contents (accessed 18 November 2009).

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*
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
2008-09										
Scripts	no.	2 706 263	2 085 196	1 564 572	535 089	586 981	184 723	75 617	22 748	7 761 189
Concession card holders	no.	1 723 776	1 363 619	996 938	443 090	449 110	153 092	50 798	45 412	5 234 695
Rate	per 1000 holders	1 570.0	1 529.2	1 569.4	1 207.6	1 307.0	1 206.6	1 488.6	500.9	1 482.6

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, PBS data collection.

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*
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.	266 873	187 510	148 807	66 094	70 997	18 295	9 113	na	780 223
Received cycle of care	%	16.9	18.6	13.9	16.5	18.3	18.4	13.5	na	16.6
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.	269 155	190 185	152 496	67 367	71 633	18 440	9 231	na	791 469
Received cycle of care	%	17.6	20.3	15.2	17.9	19.7	20.3	13.9	na	17.8
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.	272 016	193 368	156 112	68 937	72 419	18 564	9 361	na	804 167
Received cycle of care	%	18.6	21.1	15.9	19.8	21.6	22.3	15.6	na	18.9
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.	275 400	196 800	160 000	70 700	73 200	18 700	9 500	na	818 200
Received cycle of care	%	19.1	21.2	16.1	20.5	22.2	23.7	18.0	na	19.3
2008-09										
Cycles of care	no.	55 522	43 026	27 306	14 912	16 776	4 790	1 734	1 108	165 174
People with diabetes	no.	279 267	200 630	164 025	72 882	74 050	18 885	9 660	na	833 845
Received cycle of care	%	19.9	21.4	16.6	20.5	22.7	25.4	17.9	na	19.8

(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 for all years are based on 2007-08 NHS prevalence data. They should be treated with caution as the prevalence of diabetes changes over time. Historical data may differ from previous Reports, which reported estimates based on 2004-05 NHS prevalence data.

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) 2007-08 NHS data are not published for the NT.

na Not available.

Source: Medicare Australia 2009, *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 23 October 2009); ABS 2009, *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0, Canberra; ABS 2009, *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. No. 4362.0, Canberra; ABS 2009, *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0, Canberra.

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

	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	na	24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	na	7.7
CI	%	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	na	± 3.7
15–64 years										
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	na	15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	na	6.5
CI	%	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	na	± 1.9
65 years or over										
Value	%	14.6	7.7	11.8	np	19.0	np	23.8	na	12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	na	22.1
CI	%	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	na	± 5.2
All ages										
Value	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	na	17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	na	5.3
CI	%	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	na	± 1.8
2004-05										
0–14 years										
Value	%	33.6	52.5	29.9	np	39.2	21.9	np	na	36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	na	9.6
CI	%	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	na	± 6.9
15–64 years										
Value	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	na	19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	na	6.9
CI	%	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	na	± 2.7
65 years or over										
Value	%	17.1	7.6	18.5	np	20.6	19.7	np	na	14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	na	17.5
CI	%	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	na	± 4.9
All ages										
Value	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	na	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	na	6.0
CI	%	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	na	± 2.7
2007-08										
0–14 years										
Value	%	46.5	61.6	41.4	29.0	56.1	41.6	47.3	na	47.8
RSE	%	16.3	9.8	17.1	28.1	17.1	20.6	17.1	na	7.6
CI	%	± 14.9	± 11.8	± 13.9	± 16.0	± 18.8	± 16.8	± 15.9	na	± 7.1

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

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
15–24 years										
Value	%	11.9	9.3	14.7	np	7.4	9.6	35.0	na	12.6
RSE	%	47.1	47.0	37.8	np	53.2	69.2	29.0	na	19.5
CI	%	± 11.0	± 8.6	± 10.9	np	± 7.7	13.0	± 19.9	na	± 4.8
25–44 years										
Value	%	13.8	6.1	14.1	17.0	8.1	11.8	11.3	na	11.5
RSE	%	27.3	35.6	32.6	36.7	35.9	36.8	26.4	na	15.7
CI	%	± 7.4	± 4.3	± 9.0	± 12.2	± 5.7	± 8.5	± 5.8	na	± 3.5
45–64 years										
Value	%	14.1	21.9	16.2	11.3	np	9.3	12.5	na	16.5
RSE	%	27.7	26.7	28.4	42.3	np	49.7	43.1	na	14.2
CI	%	± 7.7	± 11.5	± 9.0	± 9.4	np	± 9.1	± 10.6	na	± 4.6
65 years or over										
Value	%	20.0	18.8	13.9	np	np	12.1	15.1	na	17.9
RSE	%	26.0	33.9	35.3	np	np	47.9	53.2	na	15.9
CI	%	± 10.2	± 12.5	± 9.6	np	np	± 11.4	± 15.7	na	± 5.6
All ages										
Value	%	21.9	21.8	19.9	18.0	21.2	17.3	22.6	na	21.0
RSE	%	11.3	10.6	11.2	18.4	13.1	18.6	11.4	na	5.7
CI	%	± 4.9	± 4.5	± 4.4	± 6.5	± 5.4	± 6.3	± 5.0	na	± 2.3

RSE = relative standard error.

(a) Separate estimates for the NT are not available for this survey, but the NT sample contributes to the national estimates.

(b) Data with RSEs greater than 50 per cent are considered too unreliable for general use and are not published. However, these data contribute to national estimates.

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

Source: ABS 2009, *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0, Canberra; ABS 2009, *National Health Survey: Summary of Results*; *State Tables*, *2007-08*, Cat. No. 4362.0, Canberra; ABS unpublished, *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*
2004-05										
Benefits paid										
Benefits paid	$m	453.0	306.2	289.4	124.7	95.2	27.8	20.2	10.3	1 326.7
Per person	$	66.9	61.0	73.0	62.0	61.8	57.3	62.0	50.7	65.3
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	457.0	310.4	314.3	126.2	95.0	28.8	20.6	11.8	1 364.1
Per person	$	66.9	61.1	77.8	61.7	61.3	59.0	62.8	57.1	66.3
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	464.1	322.3	306.5	128.3	97.5	28.4	21.9	11.5	1 380.7
Per person	$	67.4	62.0	73.4	61.1	61.6	57.7	64.9	53.9	65.8
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	469.6	331.9	311.2	128.8	100.0	28.7	22.4	11.3	1 392.7
Per person	$	67.5	62.8	72.7	59.8	62.5	57.8	65.1	51.8	65.2
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
2008-09										
Benefits paid										
Benefits paid	$m	466.6	329.5	310.9	128.2	98.1	29.0	22.4	11.8	1 396.5
Per person	$	65.9	60.8	70.7	57.3	60.5	57.6	63.8	52.5	63.9
Tests										
Number of tests	'000	24 632	17 515	15 582	6 847	5 793	1 602	1 121	626	73 719
Tests per person	no.	3.5	3.2	3.5	3.1	3.6	3.2	3.2	2.8	3.4

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, MBS and DVA data collections.

Table 11A.26 Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs) and claimed through Medicare, real benefits paid (2008-09 dollars) and number of referrals (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004-05										
Benefits paid										
Benefits paid	$m	404.4	251.0	208.3	96.7	69.7	22.8	15.4	4.2	1072.5
Per person	$	59.7	50.0	52.6	48.1	45.2	47.1	47.3	20.5	52.8
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	411.9	258.6	217.7	100.3	73.0	22.7	15.4	4.5	1104.1
Per person	$	60.3	50.9	53.9	49.0	47.1	46.5	47.1	21.7	53.7
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	419.8	262.0	219.2	97.9	73.1	22.6	15.8	4.6	1115.2
Per person	$	61.0	50.3	52.5	46.6	46.4	45.2	46.6	21.7	53.1
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	421.9	265.6	223.2	96.8	73.8	23.4	16.1	4.6	1120.9
Per person	$	60.6	50.2	52.2	45.0	46.1	47.0	46.5	21.0	52.5
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
2008-09										
Benefits paid										
Benefits paid	$m	420.5	262.3	228.8	97.1	76.1	23.3	15.5	4.6	1128.1
Per person	$	59.4	48.4	52.0	43.4	46.9	46.3	44.2	20.6	51.7
Referrals										
Number of referrals	'000	3 985	2 605	2 246	961	774	233	144	49	10 997
Referrals per person	no.	0.56	0.48	0.51	0.43	0.48	0.46	0.41	0.22	0.50

Table 11A.26 Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs) and claimed through Medicare, real benefits paid (2008-09 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, MBS and DVA data collections.

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 2005)	no.	1 643	1 159	900	379	372	129	72	27	4 681
Standardised whole patient equivalents (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
PIP practices (May 2007)	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
Maintain secure electronic patient records	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 mainly secure electronic patient records	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

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 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	310	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
PIP practices (May 2009) (c)	no.	1 682	1 170	958	404	358	123	71	38	4 804
SWPE (b)	no.	4 620 481	3 919 305	2 923 278	1 434 363	1 206 788	383 933	257 381	74 852	14 820 381
Maintain secure electronic patient records	no.	1 464	1 074	894	369	321	115	67	30	4 334
Share of PIP practices	%	87.0	91.8	93.3	91.3	89.7	93.5	94.4	79.0	90.2
Use mainly secure electronic patient records	no.	1 414	1 048	884	353	316	112	63	30	4 220
Share of PIP practices	%	84.1	89.6	92.3	87.4	88.3	91.1	88.7	79.0	87.8

(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. From 2007, data are reported for the new incentives.

Source: DoHA unpublished, MBS and PIP data collections.

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 2009)	no.	2 965	361	312	328	679	54	105	4 804
SWPE (c)	no.	9 264 878	1 207 898	1 083 716	1 224 314	1 799 678	126 671	113 226	14 820 381
Electronic prescribing									
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
Share of PIP practices (May 2009)	%	89	90	93	93	95	83	86	90
Use of computers to send and/or receive clinical data									
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
Share of PIP practices (May 2009)	%	86	89	90	91	93	83	85	88

(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. From 2007, data are reported for the new incentives.

Source: DoHA unpublished, MBS and PIP data collections.

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*
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
2008-09	92.6	89.6	87.5	81.8	83.4	70.4	67.3	89.9

(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, MBS data collection.

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										
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
2008-09	no.	6 260	4 284	3 265	1 414	1 376	372	223	86	17 279
Proportion of FWE GPs with vocational registration										
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
2008-09	%	92.2	90.4	84.6	89.8	91.1	92.0	95.0	74.2	89.9

(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, MBS data collection.

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	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
2009										
Accredited										
AGPAL	no.	1 364	915	782	311	338	115	43	37	3 905
GPA Accreditation *plus*	no.	315	262	182	86	42	15	22	5	930
Total	**no.**	**1 679**	**1 177**	**964**	**397**	**380**	**130**	**65**	**42**	**4 835**

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

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General practices (b)	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (c)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
GPA Accreditation *plus*	no.	333	286	193	91	44	17	23	7	994

(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.

(b) Preliminary data for the total number of practices, collected by the Primary Health Care Research and Information Service (PHC RIS) for the 2008-09 Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June 2009". 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: AGPAL (Australian General Practice Accreditation Limited) unpublished; GPA Accreditation *plus* unpublished; PHCRIS, DoHA unpublished, 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
2007-08	%	77.9	85.0	81.4	82.6	85.1	88.7	86.1	54.9	81.6
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
2007-08	%	76.3	83.9	81.8	82.9	85.3	88.8	85.4	56.2	80.8

(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, MBS and PIP data collections.

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*
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
2008-09										
GPs using EPC items	no.	6 276	4 758	3 671	1 706	1 534	462	259	111	18 777
Total GPs	no.	6 488	4 931	3 937	1 807	1 638	492	292	122	19 707
GPs using EPC items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3

(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 between 2004-05 and 2005-06 may reflect increasing awareness of the Strengthening Medicare initiative, introduced on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

(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, MBS data collection.

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

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004-05										
Older people assessed	no.	81 436	53 345	40 161	13 774	21 552	5 858	1 431	354	217 911
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.	89 782	58 837	48 015	15 823	22 391	6 689	1 825	461	243 823
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	22.5	15.1	20.7	21.4	13.6	6.7	20.3
2006-07										
Older people assessed	no.	97 820	64 950	52 129	18 260	24 922	7 918	1 769	807	268 575
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.	104 947	66 628	57 575	19 486	26 797	8 289	2 338	998	287 058
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
2008-09										
Older people assessed	no.	112 695	73 418	64 142	22 782	27 562	9 496	2 452	1 259	313 806
Older people	no.	433 569	317 287	227 517	113 229	112 300	33 023	14 403	7 456	1 258 845
Proportion assessed	%	26.0	23.1	28.2	20.1	24.5	28.8	17.0	16.9	24.9

(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.

(c) Data are for number of health assessments provided rather than number of patients receiving a health assessment.

Source: DoHA unpublished, MBS data collection.

Table 11A.35 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2004–2009 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Valid vaccinations provided											
Divisions of General Practice	no.	6	21	–	8	41	–	–	–	–	76
GPs	no.	5 545 421	2 895 204	3 691 432	1 376 782	1 006 214	389 988	161 416	17 111	–	15 083 568
Council	no.	284 557	2 208 652	282 701	93 572	300 490	39 289	–	–	–	3 209 261
State or territory health department	no.	–	–	727	159 346	1 495	–	36	1 598	–	163 202
Flying doctor service	no.	1 290	–	10 739	281	873	–	–	–	–	13 183
Public hospital	no.	76 403	44 149	124 483	40 997	9 913	867	1 711	25 596	1 228	325 347
Private hospital	no.	24	43	491	–	–	–	14	2 949	–	3 521
Aboriginal health service	no.	31 721	8 831	27 054	13 788	8 680	7	178	48 534	–	138 793
Aboriginal health worker	no.	2 212	–	19 205	–	1	–	–	824	–	22 242
Community health centre	no.	496 332	25 503	300 247	405 649	128 882	2 619	156 487	241 883	473	1 758 075
Community nurse	no.	–	238	–	–	–	–	17	–	–	255
Unknown	no.	–	1 131	–	–	–	–	–	–	–	1 131
Total	**no.**	**6 437 966**	**5 183 772**	**4 457 079**	**2 090 423**	**1 456 589**	**432 770**	**319 859**	**338 495**	**1 701**	**20 718 654**
Proportion of total valid vaccinations											
Divisions of General Practice	%	–	–	–	–	–	–	–	–	–	–
GPs	%	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

Table 11A.35 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2004–2009 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Flying doctor service	%	–	–	–	–	–	–	–	–	–	–
Public hospital	%	1.2	1.0	3.0	2.0	1.0	–	1.0	8.0	72	2.0
Private hospital	%	–	–	–	–	–	–	–	1.0	–	–
Aboriginal health service	%	1.0	–	1.0	1.0	–	–	–	14.0	–	1.0
Aboriginal health worker	%	–	–	–	–	–	–	–	–	–	–
Community health centre	%	8.0	–	7.0	19.0	9.0	1.0	49.0	71.0	28	8.0
Community nurse	%	–	–	–	–	–	–	–	–	–	–
Unknown	%	–	–	–	–	–	–	–	–	–	–
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) 1 July 2004 to 30 June 2009.

(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.

– Nil or rounded to zero.

Source: DoHA unpublished, Australian Childhood Immunisation Register (ACIR) data collection.

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 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
30 June 2009	91.9	91.9	91.0	88.9	91.5	90.3	93.6	90.3	91.3
Immunised against (at 30 June 2009)									
Diphtheria, tetanus and pertussis	92.2	92.3	91.3	89.5	91.8	90.6	94.0	90.6	91.7
Polio	92.1	92.3	91.3	89.4	91.7	90.6	94.0	90.5	91.6
Haemophilus influenzae type b	94.7	94.8	94.2	93.3	94.8	93.0	95.5	94.8	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, ACIR data collection.

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 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
30 June 2009	92.7	93.8	92.2	91.8	93.2	93.0	93.6	94.6	92.9
Immunised against (at 30 June 2009)									
Diphtheria, tetanus and pertussis	95.0	95.7	94.6	94.3	95.1	94.8	95.5	96.5	95.0
Polio	95.0	95.7	94.5	94.3	95.1	94.9	95.5	96.5	95.0
Haemophilus influenzae type b	95.3	94.8	93.7	94.0	94.3	94.9	95.6	95.1	94.6
Measles, mumps and rubella	93.8	94.8	93.4	93.3	94.5	93.8	94.5	96.2	94.0

(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, ACIR data collection.

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

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2005	no.	1	–	1	–	–	–	–	–	2
2006	no.	35	3	2	18	3	7	–	–	68
2007	no.	1	–	2	1	1	–	–	–	5
2008	no.	18	1	5	–	–	–	–	2	26
2009 (c)	no.	4	19	18	3	–	1	–	–	45
Notifications per 100 000 children (0–14 years)										
2005	per 100 000 children	0.1	–	0.1	–	–	–	–	–	0.1
2006	per 100 000 children	2.6	0.4	0.2	4.4	1.0	7.3	–	–	1.7
2007	per 100 000 children	0.1	–	0.2	0.2	0.4	–	–	–	0.1
2008	per 100 000 children	1.4	0.1	1.7	–	–	–	–	3.8	0.6
2009 (c)	per 100 000 children	0.3	1.9	6.2	0.7	–	1.0	–	–	1.1

(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, National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0, Canberra.

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										
2005	no.	497	140	343	129	98	5	28	26	1 266
2006	no.	333	49	180	51	53	7	14	3	690
2007	no.	368	162	86	14	29	5	5	4	673
2008	no.	3 615	335	305	113	203	80	29	180	4 860
2009 (c)	no.	5 609	478	915	148	633	157	35	70	8 045
Notifications per 100 000 children (0–14 years)										
2005	per 100 000 children	79.0	14.4	41.8	31.9	34.2	5.2	44.5	50.6	31.5
2006	per 100 000 children	25.0	6.2	21.6	12.4	18.4	7.3	22.3	5.8	17.0
2007	per 100 000 children	27.6	16.5	10.2	3.4	10.1	5.2	7.9	7.7	16.5
2008	per 100 000 children	271.4	33.7	105.4	26.5	70.2	82.5	45.4	344.5	118.0
2009 (c)	per 100 000 children	421.1	48.0	316.2	34.7	218.8	421.1	161.8	54.8	195.4

(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, NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0, Canberra.

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*
Notifications										
2005	no.	4	2	2	–	–	–	–	1	9
2006	no.	4	2	7	–	–	–	–	–	13
2007	no.	4	1	2	2	1	–	–	2	12
2008	no.	4	2	1	–	–	1	–	1	9
2009 (c)	no.	3	–	3	3	–	–	–	–	9
Notifications per 100 000 children (0–14 years)										
2005	per 100 000 children	0.3	0.2	0.2	–	–	–	–	1.9	0.2
2006	per 100 000 children	0.3	0.3	0.8	–	–	–	–	–	0.3
2007	per 100 000 children	0.3	0.1	0.2	0.5	0.3	–	–	3.9	0.3
2008	per 100 000 children	0.3	0.2	0.3	–	–	0.1	–	1.9	0.2
2009 (c)	per 100 000 children	0.2	–	1.0	0.7	–	–	–	–	0.2

(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, NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0, Canberra.

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*
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
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

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*
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
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

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*
2007 and 2008									
20–24	43.8	46.1	50.5	51.9	48.8	54.0	50.7	52.9	47.4
25–29	55.0	56.2	56.9	57.8	58.5	57.8	57.9	55.9	56.3
30–34	61.9	62.4	60.6	60.4	62.9	60.6	62.4	56.5	61.6
35–39	64.4	65.9	61.8	62.6	64.9	62.3	65.6	59.5	64.0
40–44	64.3	67.0	61.9	62.2	65.8	61.2	64.5	58.0	64.3
45–49	67.1	70.7	65.1	64.3	68.9	63.4	67.0	60.0	67.3
50–54	65.8	70.2	63.4	62.5	68.3	61.2	67.1	59.0	66.1
55–59	68.9	75.0	66.1	65.0	72.1	64.6	75.0	61.8	69.7
60–64	59.1	65.4	56.8	55.5	62.6	54.9	63.4	50.9	60.1
65–69	49.4	57.3	49.2	47.7	56.3	47.0	55.5	42.8	51.7
70–74	16.1	15.7	16.9	15.6	20.1	11.3	15.1	16.1	16.3
75–79	4.9	4.0	5.4	4.6	6.9	3.2	4.5	5.2	4.9
80–84 (e)	1.2	1.3	1.6	1.5	1.8	0.9	1.0	2.5	1.4
Ages 20–84 years (f)	53.6	56.3	54.2	54.2	55.4	52.2	57.8	55.3	54.7
ASR	53.9	56.6	53.4	53.2	56.5	52.7	56.1	50.5	54.6
Ages 20–69 years	60.0	63.0	59.5	59.6	62.8	59.4	62.3	56.8	60.8
ASR	60.5	63.6	59.8	59.7	63.1	59.4	63.0	56.5	61.2

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 2009, *Cervical screening in Australia 2006–2007*, Cat. no. CAN 43, AIHW, Canberra; AIHW unpublished, State and Territory Cervical Cytology Registry data.

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, 2007 or 2008.

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

Table 11A.43 Separations for selected vaccine preventable conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Vaccine preventable conditions per 1000 non-Indigenous people										
Influenza and Pneumonia	0.6	0.5	0.7	0.5	0.7	np	np	1.0	0.6	0.6
Other vaccine preventable conditions	0.1	0.2	0.1	0.1	0.1	np	np	0.2	0.2	0.2
Total	**0.7**	**0.7**	**0.8**	**0.6**	**0.8**	**np**	**np**	**1.2**	**0.7**	**0.7**
Vaccine preventable conditions per 1000 Indigenous people (f)										
Influenza and Pneumonia	1.5	1.3	1.9	4.1	3.8	np	np	6.2	2.6	np
Other vaccine preventable conditions	0.3	0.5	0.4	0.8	0.4	np	np	2.1	0.6	np
Total (g)	**1.8**	**1.7**	**2.3**	**4.9**	**4.1**	**np**	**np**	**8.3**	**3.3**	**np**
Vaccine preventable conditions per 1000 people (all people)										
Influenza and Pneumonia	0.5	0.5	0.7	0.5	0.7	0.4	0.7	1.7	0.6	0.6
Other vaccine preventable conditions	0.1	0.2	0.1	0.1	0.1	0.0	0.1	0.6	0.2	0.2
Total (g)	**0.7**	**0.7**	**0.8**	**0.6**	**0.8**	**0.4**	**0.8**	**2.3**	**0.7**	**0.7**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2009 *Australian hospital statistics 2007-08*.

(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) Separation rates for Indigenous people are based on state of hospitalisation, while rates for non-Indigenous people 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 2009, *Australian hospital statistics 2007-08*, Cat. no. HSE 71, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.44 **Separations for selected acute conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Acute conditions per 1000 non-Indigenous people										
Appendicitis with generalised peritonitis	0.2	0.2	0.2	0.2	0.2	np	np	0.3	0.2	0.2
Cellulitis	1.6	1.7	1.9	1.4	1.5	np	np	3.5	1.7	1.7
Convulsions and epilepsy	1.6	1.5	1.5	1.1	1.5	np	np	1.0	1.5	1.5
Dehydration and gastroenteritis	2.1	3.2	2.5	2.0	3.5	np	np	1.7	2.5	2.5
Dental conditions	2.3	3.1	2.7	3.4	3.2	np	np	1.4	2.8	2.8
Ear, nose and throat infections	1.6	1.6	1.8	1.6	2.5	np	np	1.6	1.7	1.7
Gangrene	0.2	0.3	0.2	0.2	0.2	np	np	0.5	0.2	0.2
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	np	np	0.3	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.3	np	np	0.2	0.2	0.2
Pyelonephritis (f)	2.2	2.5	2.3	2.1	2.1	np	np	2.1	2.3	2.3
Total	**12.2**	**14.6**	**13.6**	**12.5**	**15.3**	**np**	**np**	**12.5**	**13.3**	**13.3**
Acute conditions per 1000 Indigenous people (g)										
Appendicitis with generalised peritonitis	0.1	0.1	0.3	0.4	0.2	np	np	0.3	0.2	np
Cellulitis	3.8	2.8	6.7	8.0	5.0	np	np	6.6	5.4	np
Convulsions and epilepsy	6.3	5.1	6.5	9.7	10.5	np	np	11.0	7.4	np
Dehydration and gastroenteritis	3.4	4.0	4.8	4.9	9.4	np	np	4.9	4.5	np
Dental conditions	3.0	3.5	3.3	4.0	4.5	np	np	4.3	3.5	np
Ear, nose and throat infections	3.3	2.2	3.5	4.4	3.7	np	np	3.7	3.4	np

Table 11A.44 **Separations for selected acute conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Gangrene	0.4	0.3	1.1	3.7	0.6	np	np	4.0	1.5	np
Pelvic inflammatory disease	0.4	0.3	0.6	1.2	0.3	np	np	1.3	0.7	np
Perforated/bleeding ulcer	0.5	0.1	0.8	0.5	0.2	np	np	0.2	0.5	np
Pyelonephritis (f)	5.0	5.0	9.3	9.4	6.6	np	np	10.9	7.4	np
Total (h)	**26.1**	**23.4**	**36.9**	**46.2**	**40.9**	**np**	**np**	**47.1**	**34.5**	**np**
Acute conditions per 1000 people (all people)										
Appendicitis with generalised peritonitis	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2
Cellulitis	1.7	1.7	1.9	1.5	1.5	1.4	1.3	3.7	1.7	1.7
Convulsions and epilepsy	1.6	1.5	1.6	1.3	1.6	1.7	1.4	3.1	1.6	1.6
Dehydration and gastroenteritis	2.1	3.1	2.5	2.1	3.5	2.2	1.7	2.0	2.5	2.5
Dental conditions	2.4	3.1	2.7	3.4	3.2	1.9	2.0	2.2	2.8	2.8
Ear, nose and throat infections	1.7	1.6	1.8	1.7	2.5	1.4	1.2	2.1	1.7	1.7
Gangrene	0.1	0.3	0.2	0.3	0.2	0.2	0.1	0.7	0.2	0.2
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.5	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2
Pyelonephritis (f)	2.1	2.4	2.3	2.1	2.1	1.7	2.2	3.3	2.2	2.2
Total	**12.3**	**14.3**	**13.6**	**13.1**	**15.2**	**11.0**	**10.5**	**17.9**	**13.3**	**13.3**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2009 *Australian hospital statistics 2007-08* .

(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.

Table 11A.44 **Separations for selected acute conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)**

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

(d) Separation rates for Indigenous people are based on state of hospitalisation, while rates for non-Indigenous people 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 2009, *Australian hospital statistics 2007-08*, Cat. no. HSE 71, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.45 **Separations for selected chronic conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Chronic conditions per 1000 non-Indigenous people										
Angina	1.7	2.2	2.9	1.7	2.0	np	np	2.6	2.1	2.1
Asthma	1.8	1.9	1.6	1.4	2.5	np	np	1.3	1.8	1.8
Chronic obstructive pulmonary disease	2.5	2.6	2.9	2.3	3.0	np	np	4.4	2.6	2.6
Congestive heart failure	2.5	3.0	2.6	2.2	2.7	np	np	2.4	2.6	2.6
Diabetes complications (f)	6.5	7.8	7.4	6.6	7.3	np	np	9.9	7.1	7.1
Hypertension	0.3	0.2	0.3	0.1	0.3	np	np	0.1	0.3	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.4	1.0	np	np	0.7	1.2	1.2
Nutritional deficiencies	–	–	–	–	–	np	np	–	–	–
Rheumatic heart disease (g)	0.1	0.1	0.2	0.1	0.1	np	np	0.1	0.1	0.1
Total (h)	**15.5**	**18.2**	**18.0**	**14.8**	**17.7**	**np**	**np**	**20.5**	**16.8**	**16.8**
Total (excluding diabetes complications)	10.0	11.6	11.6	9.2	11.5	np	np	11.7	10.7	10.7
Chronic conditions per 1000 Indigenous people (i)										
Angina	6.9	6.1	11.3	8.8	8.0	np	np	7.4	8.2	np
Asthma	4.1	2.9	4.0	4.9	4.7	np	np	3.5	3.9	np
Chronic obstructive pulmonary disease	14.9	10.4	14.6	14.1	16.1	np	np	18.3	14.4	np
Congestive heart failure	9.6	5.6	13.2	14.7	10.3	np	np	8.5	10.6	np
Diabetes complications (f)	24.7	19.8	37.1	41.4	43.6	np	np	34.6	31.6	np
Hypertension	0.6	0.4	1.0	0.6	1.5	np	np	0.2	0.7	np
Iron deficiency anaemia	1.2	2.7	1.6	2.2	1.2	np	np	1.8	1.6	np
Nutritional deficiencies	–	–	0.1	–	–	np	np	0.1	–	np
Rheumatic heart disease (g)	0.4	0.4	0.7	0.6	1.0	np	np	1.8	0.7	np
Total (h) (j)	**56.8**	**45.2**	**75.2**	**78.0**	**79.7**	**np**	**np**	**70.7**	**65.2**	**np**

Table 11A.45 **Separations for selected chronic conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Total*	*Aust*
Total (excluding diabetes complications)	37.7	28.6	46.5	45.8	42.8	np	np	41.6	40.2	np
Chronic conditions per 1000 people (all people)										
Angina	1.4	1.7	2.4	1.4	1.6	1.4	1.1	2.4	1.7	1.7
Asthma	1.9	1.9	1.7	1.5	2.6	1.5	1.0	1.4	1.8	1.8
Chronic obstructive pulmonary disease	2.6	2.6	2.9	2.4	3.1	2.7	1.5	6.3	2.7	2.7
Congestive heart failure	1.9	2.2	2.0	1.7	1.9	1.7	1.8	2.3	2.0	2.0
Diabetes complications (f)	7.0	9.3	10.3	29.0	7.6	12.6	5.5	13.2	10.6	10.6
Hypertension	0.3	0.2	0.3	0.2	0.3	0.3	0.1	0.1	0.3	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.4	1.0	1.4	0.7	0.7	1.2	1.2
Nutritional deficiencies	–	–	0.0	0.0	–	0.0	–	0.1	0.0	0.0
Rheumatic heart disease (g)	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.8	0.1	0.1
Total (h) (j)	**15.2**	**18.4**	**19.7**	**36.6**	**16.9**	**20.9**	**11.1**	**25.5**	**19.2**	**19.2**
Total (excluding diabetes complications)										

(a) Conditions defined by ICD-10-AM codes as in AIHW 2009 *Australian hospital statistics 2007-08*.

(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) Separation rates for Indigenous people are based on state of hospitalisation, while rates for non-Indigenous people 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 may not sum to the individual categories as more than one chronic condition can be reported for a separation.

Table 11A.45 **Separations for selected chronic conditions by Indigenous status, 2007-08 (per 1000 people) (a), (b), (c), (d)**

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

(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).

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

Source : AIHW 2009, *Australian hospital statistics 2007-08* , Cat. no. HSE 71, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.46 Ratio of separations for Indigenous males to all males, 2007-08 (a), (b), (c), (d), (e), (f)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All causes	Number	25 213	5 116	31 598	23 590	8 056	np	np	25 701	121 544
	SHSR	1.83	1.35	2.26	3.12	2.67	np	np	–	–
	95% CI	1.81 to 1.85	1.32 to 1.39	2.24 to 2.29	3.08 to 3.16	2.61 to 2.73	np	np		
Circulatory disease	Number	1 202	216	1 350	776	387	np	np	530	4 559
	SHSR	1.50	1.15	1.73	1.89	2.26	np	np	0.97	1.56
	95% CI	1.42 to 1.59	1 to 1.3	1.64 to 1.83	1.76 to 2.02	2.03 to 2.48	np	np	0.88 to 1.05	1.51 to 1.6
Coronary heart disease	Number	571	108	678	342	218	np	np	186	2 152
	SHSR	1.72	1.50	2.07	2.32	3.49	np	np	0.89	1.90
	95% CI	1.58 to 1.87	1.21 to 1.78	1.92 to 2.23	2.08 to 2.57	3.03 to 3.95	np	np	0.76 to 1.02	1.82 to 1.99
Rheumatic heart disease	Number	12	6	34	27	8	np	np	60	147
	SHSR	3.34	np	3.70	6.37	np	np	np	9.12	5.71
	95% CI	1.45 to 5.24	np	2.46 to 4.95	3.97 to 8.78	np	np	np	6.81 to 11.42	4.79 to 6.64
Self-harm	Number	207	68	191	94	59	np	np	108	743
	SHSR	2.62	5.24	2.41	2.02	3.42	np	np	2.17	2.74
	95% CI	2.27 to 2.98	3.99 to 6.48	2.07 to 2.75	1.61 to 2.43	2.55 to 4.3	np	np	1.76 to 2.58	2.54 to 2.93
All respiratory disease	Number	2 060	383	2 151	1 573	503	np	np	1 605	8 393
	SHSR	1.97	1.83	2.51	3.36	2.10	np	np	3.04	2.43
	95% CI	1.88 to 2.05	1.64 to 2.01	2.41 to 2.62	3.19 to 3.52	1.91 to 2.28	np	np	2.89 to 3.19	2.38 to 2.49
Infectious pneumonia	Number	347	66	530	488	88	np	np	633	2 175
	SHSR	2.04	2.29	3.38	6.22	2.36	np	np	5.35	3.63
	95% CI	1.83 to 2.26	1.74 to 2.84	3.09 to 3.66	5.67 to 6.77	1.86 to 2.85	np	np	4.93 to 5.77	3.48 to 3.79
Lung cancer	Number	45	7	60	21	12	np	np	17	163
	SHSR	2.03	np	2.44	1.47	1.54	np	np	0.45	1.80
	95% CI	1.44 to 2.63	np	1.82 to 3.05	0.84 to 2.09	0.67 to 2.4	np	np	0.24 to 0.66	1.53 to 2.08

Table 11A.46 **Ratio of separations for Indigenous males to all males, 2007-08 (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
Diabetes as a primary diagnosis	Number	361	56	524	341	197	np	np	287	1 779
	SHSR	2.94	1.83	3.38	4.49	5.71	np	np	2.09	3.41
	95% CI	2.63 to 3.24	1.35 to 2.31	3.09 to 3.66	4.01 to 4.97	4.91 to 6.51	np	np	1.85 to 2.33	3.25 to 3.57
All diabetes except where dialysis is the primary diagnosis	Number	2 089	389	2 889	2 230	981	np	np	1 869	10 581
	SHSR	2.41	2.02	3.42	5.18	4.78	np	np	3.11	3.28
	95% CI	2.31 to 2.52	1.82 to 2.22	3.3 to 3.55	4.97 to 5.4	4.48 to 5.08	np	np	2.97 to 3.25	3.21 to 3.34
All diabetes (g)	Number	2 948	708	3 644	10 170	1 189	np	np	1 870	20 762
	SHSR	3.33	2.98	3.67	14.23	5.98	np	np	3.11	5.79
	95% CI	3.21 to 3.45	2.76 to 3.2	3.55 to 3.79	13.95 to 14.5	5.64 to 6.32	np	np	2.97 to 3.26	5.71 to 5.87
Depressive disorder	Number	177	24	100	38	49	np	np	17	408
	SHSR	1.14	0.76	0.80	0.50	1.99	np	np	0.75	0.80
	95% CI	0.97 to 1.31	0.46 to 1.07	0.64 to 0.95	0.34 to 0.66	1.43 to 2.55	np	np	0.4 to 1.11	0.73 to 0.88
Anxiety disorder	Number	48	16	47	7	11	np	np	0	155
	SHSR	1.12	1.38	0.32	np	3.57	np	np	0.00	0.77
	95% CI	0.8 to 1.43	0.71 to 2.06	0.23 to 0.41	np	1.46 to 5.68	np	np	0 to 0	0.65 to 0.89
Substance use disorder	Number	402	24	168	83	35	np	np	8	722
	SHSR	3.00	1.46	1.77	2.59	7.18	np	np	np	2.21
	95% CI	2.71 to 3.3	0.87 to 2.04	1.51 to 2.04	2.03 to 3.14	4.8 to 9.55	np	np	np	2.05 to 2.38
Psychotic disorder	Number	1 008	173	696	598	288	np	np	262	3 061
	SHSR	3.97	2.59	3.00	4.97	4.40	np	np	2.99	3.29
	95% CI	3.72 to 4.21	2.2 to 2.97	2.78 to 3.23	4.57 to 5.37	3.89 to 4.91	np	np	2.63 to 3.36	3.18 to 3.41

Table 11A.46 Ratio of separations for Indigenous males to all males, 2007-08 (a), (b), (c), (d), (e), (f)

	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 or over are excluded.

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

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

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

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

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.47 Ratio of separations for Indigenous females to all females, 2007-08 (a), (b), (c), (d), (e), (f)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All causes	Number	28 976	7 854	37 707	31 227	10 390	np	np	35 862	154 896
	SHSR	1.71	2.05	2.37	3.55	3.02	np	np	6.82	2.62
	95% CI	1.69 to 1.73	2.01 to 2.1	2.34 to 2.39	3.51 to 3.59	2.96 to 3.08	np	np	6.75 to 6.9	2.61 to 2.64
Circulatory disease	Number	1 062	228	1 292	621	346	np	np	542	4 164
	SHSR	2.06	1.88	2.56	2.36	2.89	np	np	2.14	2.14
	95% CI	1.93 to 2.18	1.64 to 2.13	2.42 to 2.7	2.17 to 2.55	2.59 to 3.2	np	np	1.96 to 2.32	2.08 to 2.21
Coronary heart disease	Number	423	90	562	238	160	np	np	162	1 664
	SHSR	2.87	2.73	3.64	3.75	5.16	np	np	1.87	3.15
	95% CI	2.6 to 3.15	2.17 to 3.3	3.34 to 3.94	3.27 to 4.23	4.36 to 5.96	np	np	1.59 to 2.16	3 to 3.31
Rheumatic heart disease	Number	27	9	53	22	16	np	np	75	203
	SHSR	4.42	np	5.08	7.02	12.28	np	np	16.87	7.22
	95% CI	2.75 to 6.09	np	3.71 to 6.45	4.09 to 9.96	6.26 to 18.3	np	np	13.05 to 20.69	6.23 to 8.21
Self-harm	Number	329	52	205	141	85	np	np	113	972
	SHSR	2.61	2.00	1.60	1.76	2.98	np	np	2.09	2.12
	95% CI	2.33 to 2.9	1.46 to 2.55	1.38 to 1.82	1.47 to 2.05	2.35 to 3.61	np	np	1.7 to 2.48	1.99 to 2.25
All respiratory disease	Number	2 198	331	2 060	1 565	601	np	np	1 571	8 465
	SHSR	3.11	2.05	2.96	4.56	3.24	np	np	5.28	3.23
	95% CI	2.98 to 3.24	1.83 to 2.27	2.83 to 3.09	4.34 to 4.79	2.98 to 3.5	np	np	5.02 to 5.54	3.17 to 3.3
Infectious pneumonia	Number	346	63	442	447	107	np	np	572	1 996
	SHSR	2.74	2.45	3.59	8.13	3.82	np	np	8.93	4.19
	95% CI	2.46 to 3.03	1.84 to 3.05	3.25 to 3.92	7.38 to 8.88	3.09 to 4.54	np	np	8.2 to 9.67	4.01 to 4.38
Lung cancer	Number	37	np	43	14	10	np	np	14	131
	SHSR	1.84	np	2.57	1.25	2.76	np	np	0.88	1.92
	95% CI	1.24 to 2.43	np	1.8 to 3.33	0.59 to 1.9	1.05 to 4.47	np	np	0.42 to 1.35	1.59 to 2.25

Table 11A.47 **Ratio of separations for Indigenous females to all females, 2007-08 (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
Diabetes as a primary diagnosis	Number	488	99	938	506	190	np	np	581	2 863
	SHSR	4.04	2.53	5.73	6.86	4.89	np	np	6.50	5.02
	95% CI	3.68 to 4.4	2.03 to 3.03	5.36 to 6.1	6.27 to 7.46	4.2 to 5.59	np	np	5.97 to 7.03	4.84 to 5.2
All diabetes except where dialysis is the primary diagnosis	Number	2 848	642	4 539	3 242	1 163	np	np	3 203	15 834
	SHSR	3.91	3.34	6.40	8.41	5.76	np	np	7.90	5.46
	95% CI	3.77 to 4.06	3.08 to 3.6	6.21 to 6.58	8.12 to 8.7	5.42 to 6.09	np	np	7.63 to 8.18	5.38 to 5.55
All diabetes (g)	Number	3 571	1 199	5 426	15 294	1 164	np	np	3 205	30 214
	SHSR	4.60	7.70	7.55	26.15	5.76	np	np	7.90	9.45
	95% CI	4.45 to 4.76	7.27 to 8.14	7.35 to 7.75	25.74 to 26.57	5.43 to 6.09	np	np	7.63 to 8.18	9.34 to 9.55
Depressive disorder	Number	218	95	149	115	87	np	np	21	701
	SHSR	1.06	1.16	0.62	0.77	1.96	np	np	1.13	0.72
	95% CI	0.92 to 1.2	0.93 to 1.4	0.52 to 0.72	0.63 to 0.91	1.55 to 2.37	np	np	0.65 to 1.61	0.67 to 0.77
Anxiety disorder	Number	47	30	36	16	13	np	np	np	154
	SHSR	1.36	2.29	0.68	0.60	4.37	np	np	np	0.96
	95% CI	0.97 to 1.75	1.47 to 3.11	0.46 to 0.91	0.3 to 0.89	1.99 to 6.74	np	np	np	0.81 to 1.11
Substance use disorder	Number	272	23	68	54	24	np	np	np	446
	SHSR	2.75	0.97	0.81	2.23	6.75	np	np	np	1.58
	95% CI	2.42 to 3.07	0.58 to 1.37	0.62 to 1	1.64 to 2.83	4.05 to 9.45	np	np	np	1.43 to 1.72
Psychotic disorder	Number	638	221	440	419	219	np	np	213	2 177
	SHSR	2.84	3.24	2.20	3.90	4.74	np	np	4.58	2.51
	95% CI	2.62 to 3.06	2.81 to 3.66	2 to 2.41	3.52 to 4.27	4.11 to 5.36	np	np	3.96 to 5.19	2.4 to 2.61

Table 11A.47 **Ratio of separations for Indigenous females to all females, 2007-08 (a), (b), (c), (d), (e), (f)**

	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 or over are excluded.

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

(g) 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, National Hospital Morbidity Database.

Table 11A.48 Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2007-08 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Circulatory	16.7	27.0	26.9	26.0	21.8	np	np	np	22.6
Renal	21.2	25.8	26.6	29.3	22.1	np	np	np	24.9
Ophthalmic	111.3	129.3	141.7	164.0	119.6	np	np	np	127.9
Other specified	50.5	76.5	76.9	60.4	77.7	np	np	np	66.4
Multiple	33.0	48.5	53.5	48.4	52.5	np	np	np	46.7
No complications	3.8	4.7	3.1	2.2	4.1	np	np	np	3.7
Total	**236.5**	**311.9**	**328.7**	**330.4**	**297.7**	**np**	**np**	**np**	**292.3**

(a) Rates are age standardised to the Australian resident population at 30 June 2001.

(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, 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, 2007-08 (per cent) (a), (b), (c), (d), (e), (f), (g)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Circulatory	12.8	17.3	33.2	12.5	9.9	np	np	np	18.5
Renal	13.6	11.3	11.3	15.9	16.2	np	np	np	13.0
Ophthalmic	92.6	90.8	93.8	85.7	89.9	np	np	np	91.2
Other specified	12.1	32.2	26.9	15.1	15.8	np	np	np	22.4
Multiple	6.9	12.6	14.1	6.8	10.8	np	np	np	12.6
Unspecified	25.0	77.8	–	–	–	np	np	np	42.1
No complications	52.0	50.0	18.7	23.4	28.2	np	np	np	41.5
Total	**50.0**	**50.5**	**52.3**	**48.1**	**44.8**	**np**	**np**	**np**	**49.9**

(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) Rates are age-standardised to the Australian resident population at 30 June 2001.

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

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

(e) 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.

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

(g) 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, National Hospital Morbidity Database.

Table 11A.50 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2007-08 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
ASR	per 100 000 people	12.2	15.0	15.9	16.4	16.9	np	np	np	14.9
Crude	per 100 000 people	13.4	16.3	16.2	14.5	22.7	np	np	np	16.0
Separations	no.	932	860	687	311	362	np	np	np	3 389

ASR = Age standardised rate

(a) ASR rates are 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.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.51 **Separation rates of older people for injuries due to falls, 2007-08 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	46425	32911	20058	10409	8780	2348	1516	340	122787
2006-07									
Separations per 1000 older people	51.6	48.5	43.0	43.8	35.8	32.7	52.2	47.8	46.7
Number	50938	35649	22078	10954	9358	2455	1697	375	133504
2007-08									
Separations per 1000 older people	51.6	48.6	42.9	43.7	36.4	34.1	60.1	43.2	46.8
Number	52463	36855	22851	11319	9762	2616	2051	366	138283

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

(b) Older people are defined as people aged 65 years or over.

(c) Separation rates are age standardised to the the Australian population aged 65 years or over at 30 June 2001.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

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

Programs funded by the Australian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Regional Health Services	The program provides funding to rural communities of up to 5,000 people to support primary health care services. This program will be consolidated into the Rural Primary Health Services program as of 1 January 2010, as announced in the 2009 Budget.	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. This program will be consolidated into the Rural Primary Health Services program as of 1 January 2010, as announced in the 2009 Budget.	Funding is provided under Outcome 6 - Rural Health	Staged financial and activity reports are required from each project.

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

Programs funded by the Australian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Royal Flying Doctor Service (RFDS)	Commonwealth 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.
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 6 - Rural Health	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. This program will be consolidated into the Rural Primary Health Services program as of 1 January 2010, as announced in the 2009 Budget.	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 improve the access of people living and working in rural and remote communities to optometric services.	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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
General			
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation therapy, social work and counseling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services.	AHS receive block funding from the Department of 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 professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
Overcoming cultural/language barriers			
Multicultural health services	Provides interpreter services, cultural competency training, direct services provision for refugees, planning of services to address or cater to the needs of culturally diverse communities.	AHS receive block funding from the Department of 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 professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Health Services	Covering services such as health information and education, counseling, pre and post natal programs, early childhood nursing, health promotion programs, specialised child sexual assault counseling services (primarily in rural and remote locations).	A mix of AHS, NSW Health (via grants to non-government organisations) and Australian Government Funding.	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
Overcoming geographical barriers			
Transport for Health	Provides financial assistance and transport arrangements of non-emergency transport health related issues. Includes the specific program Isolated Patients Transport and Accommodation Service.	AHSs receive block funding for this program.	Quarterly reporting on key indicators, annual reporting on the implementation of the program
Child Abuse and Sexual Assault Forensic and Medical services	This program area provides forensic and medical services for victims of sexual assault and child abuse and ensuring these services are culturally competent. Particular focus on improving access in rural and remote communities.	Combination of Department of Health allocation and AHS block funding.	AHS report on service provision via a payment determinations for a fee to be payable to non-salaried medical practitioners in rural Area Health Services conducting medical examinations for sexual assault victims.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Other			
Sexual Assault Services	Providing crisis counselling and support for victims of assault, court preparation and community education programs.	AHS receive block funding from the Department of 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 professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
Child Protection Counselling Services (also known as 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.	AHS receive block funding from the Department of 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 professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
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.	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Maternal health	Maternity services include programs and initiatives directed toward: - Workforce expansion and education to enhance access to locally provided clinical maternity education to improve the strength and capacity of the workforce. The increase in birth rate across NSW is up to 30% in some AHSs. - maternity service model of care reform, risk assessment, tiered networks and collaborative working arrangements that will allow women to easily transition from one level to another as required - strategies to promote normal birth in NSW, reduce unnecessary caesarean sections - enhanced services to improve early pregnancy care, including early pregnancy resources.	AHS block funding and some Department of Health funds allocated.	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require regular reports on recruitment and expenditure.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Child health and wellbeing	Services and programs cover: - Postnatal maternal, child and family services such as Aboriginal Maternal and Infant Health Service, and Universal Health Home Visiting - Child and Family nurses and Aboriginal Health workers working together to create linkages for Aboriginal babies and mothers from targeted maternity services into child health services under the Building Strong Foundations program for children 0-5 years. - Indigenous Early Childhood Development Strategy Lead implementation of Indigenous child and family centres (element 1) and sexual health and antenatal care (element 2).	A mix of AHS and Australian Government funding.	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require regular reports on recruitment and expenditure.
Women's health and wellbeing	Covers services and health promotion programs for women, including violence prevention and pregnancy services.	A mix of AHS funding and Australian Government funding allocated under the Public Health Outcomes Funding agreement.	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.

Table 11A.53 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Men's health and wellbeing	Covers education and health promotion programs for men, including information and referral services.	AHS receive block funding from the Department of 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 professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
Youth health and wellbeing	Provides education and health promotion programs, clinical services and planning of youth friendly services. Also provides specific health services for homeless and at risk young people.	A mid of AHS and Australian Government funding.	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
Screening	Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program included the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies.	A mix of AHS and Australian Government funding.	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.

Table 11A.53 New South Wales, community health services programs

Programs funded by the NSW Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
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 the AHSs for this program. NSW and Australian Government funding provided.	The services are required to provide waiting list reports twice a year.
Other			
Dementia services planning	Provides state-wide dementia policy, planning, care services and workforce development.	The Department has been funded under the NSW Dementia Action Plan 2007– 09.	Department of Health Annual report.
Carers services	Covers carers programs and support, in partnership with non-government organisations, and workforce development to enhance the lives of carers and the people they care for.	NSW Carers Action Plan 2007– 2012.	Annual Reports on activities by AHSs to the Department of Health.
Child protection initiatives	Child protection initiatives such as the Joint Investigation Response Team (JIRT) program which is an interagency collaborative response to serious child abuse reports, where the concerns reported may constitute a criminal offence.	The Department of Health allocates specific funding to the AHSs for this program.	Annual report provided to the State Management Group and Justice and Human Services CEOs.

Source: NSW Government unpublished.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
General			
Primary care Partnerships	Cross government funded voluntary alliances of heath and human services provider organisations known as Primary Care Partnerships (PCPs). There are 31 PCPs in Victoria. The PCPs deliver local service system reforms to: • improve access to services • improve the way health promotion is planned, delivered and evaluated • improve the management of chronic disease The strategy to improve access to services is supported by a range of enablers including: • Statewide policy and operational framework • Statewide practice standards and a continuous improvement manual • Tools for screening, referral and coordinated care planning • Data standards for sharing client health and care information embedded in agency client management software applications E-referral systems to securely share client information with client consent.	Core funding provided the Victorian Department of Health. Additional funding provided by other government departments including the Victorian Department of Justice.	Suite of reports as part of the PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the program logic.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming cultural/language barriers			
Primary care Partnerships	The PCP program incorporates other statewide enablers to overcome cultural/language barriers which include: • Privacy information brochure and consent (for information disclosure) form available in over 40 community languages The strategic planning work of PCPs requires the identification of local health and well being priorities (which includes overcoming cultural and language barriers).	As above	As above

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Refugee health nurse program (RHNP)	The Refugee Health Nurse Program (RHNP) supports the provision of a coordinated model for refugee health care with complementary and multiple entry points. The RHNP has three aims: • To increase refugee access to primary health services. • To improve the response of health services to refugees' needs. • To enable refugee individuals, families and communities to improve their health and wellbeing. The RHNP employs community health nurses specialising in refugee and migrant health issues. These nurses work directly with newly arrived refugee communities to improve their health and wellbeing and establish good relationships between these communities, community health services and local GPs. The nurses also work on building the capacity of community health services and GPs to respond appropriately and comprehensively to refugee people's health needs. The RHNP also funds a Refugee Health Nurse Facilitator who works with the funded agencies to build capacity and provide secondary consultations.	• The Victorian Government funds the RHNP through the Department of Health. • The Primary Health Branch of the Department of Health is responsible for program area spending and is broadly responsible for overseeing program delivery. • Department of Health regional offices closely monitor program delivery. • Community health services are funded to deliver the RHNP.	• Agencies funded under the RHNP report hours of service on a quarterly basis. • This information is provided to the Primary Health Branch. • This information is not available to the public.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Indigenous Australians	Aboriginal community health services are provided through a range of Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services funded by the Department of Health (DOH), 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.	DOH operates in a complex funding environment. Aboriginal community controlled organisations are funded to provide direct services delivery by DOH 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
	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.	Specific funding for Aboriginal programs has been allocated through the COAG Closing the Gap strategy.	
	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 year 7 and 8 or who have left formal schooling. There are several Aboriginal-specific initiatives, including dental clinics at the Victorian Aboriginal Health Service and Rumbalara Aboriginal Cooperative.		

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming geographical barriers			
Primary care Partnerships	The strategic planning work of PCPs requires the identification of local health and well being priorities and ways to address these priorities. This may include overcoming geographical barriers. PCPs with Neighbourhood Renewal areas are encouraged to focus on these sites as a priority setting for their catchment planning, while being mindful of the need to include other communities and population groups that experience disadvantage. Other PCPs are encouraged to use similar 'place based' partnership approaches as a means of assessing and engaging with communities that experience significant disadvantage.	As above	As above
NURSE-ON-CALL	NURSE-ON-CALL (NOC) is a statewide health assistance line designed to provide residents of Victoria with timely access to health information, assistance and advice. The service operates 24 hours a day. In 2008-09 NOC answered 340 000 calls, 65 per cent of which were metropolitan and 35 per cent rural. Women comprised 76 per cent of callers, predominantly in the age group 30–34 years. Of the calls, 34 per cent were to do with concerns about children aged 4 years or less.	NOC is contracted to McKesson Asia Pacific Pty Ltd. The costs for contract are paid based on a formula that provides for an availability component and a variable component based on call volume.	McKesson provide the department with monthly reports. The data includes call numbers and patterns for contract management, call outcome and caller demographics

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming socioeconomic barriers			
Dental health program	Public dental health care is available to children and disadvantaged adults. Children up the age of 12 have priority access to public dental care. Priority access is also provided to children aged 13–17 who are dependants or holders of health care or pensioner concession cards. The service is free for dependants or holders of a health care or pensioner concession card. Health care and pensioner concession cardholders and their dependants over the age of 18 are also eligible for public dental care.	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.
Overcoming social isolation barriers			
Primary care Partnerships	The strategic planning work of PCPs requires the identification of local health and well being priorities, and ways to address these. This may include overcoming social isolation barriers. PCPs with 'Neighbourhood Renewal' areas are encouraged to focus on these sites as a priority setting for their catchment planning, while being mindful of the need to include other communities and population groups that experience disadvantage. Other PCPs are encouraged to use similar 'place based' partnership approaches as a means of assessing and engaging with communities that experience significant disadvantage.	As above	As above

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
IHSHY program	The Innovative Health Services for Homeless Youth (IHSHY) program aims to improve the health outcomes of homeless and otherwise at-risk youth aged 12–24 years and their dependents through the provision of specialized health services and improved access to mainstream health services.	IHSHY is funded under a Special Purpose Payment (SPP), with state and territory governments matching the Commonwealth'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 Commonwealth.
Objective: Promoting health and preventing illness, early detection			
Maternal and Child health	The *Healthy Mothers, Healthy Babies* program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. Services are targeted in areas of highest need that have high numbers of births, higher rates of relative socioeconomic disadvantage and lower service availability.	This program is funded by the State under the *Primary Health Funding Approach* which 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.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Women's health and wellbeing	The Victorian Women's Health Program aims to improve the health and well being of all Victorian women (with an emphasis on those most at risk), through the development and dissemination of health information and research and through the provision of community and professional education. These activities take place directly with women and in partnership with the health and community sectors. The dual strategy of delivering gender-specific health services whilst working to improve mainstream services remains a key aspect of women's health.	• In 2008-09, funding was provided through the Public Health Funding Outcomes Agreement. • From 2009-10, it will be provided under the National Healthcare Agreement. • The Primary Health Branch of the Department of Health is responsible for program area spending and is broadly responsible for overseeing program delivery. • Department of Health regional offices closely monitor program delivery.	• Women's health services funded under the program report hours of service on a quarterly basis. • This information is provided to the Primary Health Branch. • Women's health services also develop, implement evaluation, and report on 1-year health promotion operational plans.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Youth health and wellbeing	The Innovative Health Services for Homeless Youth (IHSHY) program is a Commonwealth/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.	Up to 2008-09, IHSHY was funded under a Special Purpose Payment, with state and territory governments matching the Commonwealth's contribution. From 2009-10, IHSHY will be provided under the National Healthcare Agreement with state and territory governments matching the Commonwealth'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 Commonwealth.
Children's health and wellbeing	Multidisciplinary child health teams based in community health services which respond to developmental delays and other child health conditions. The Kids Life! program aims to improve the health behaviours of families with an overweight primary school aged child/children and to reduce the degree of excess weight of participating children.	These services are funded by the State under the *Primary Health Funding Approach* which 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.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation	Immunisation policy is a shared responsibility between the Commonwealth and State and Territory Governments. The Commonwealth sets the national immunisation agenda by developing, recommending and directing policy, research and evaluation activities on the advice of expert committees and research centres. States are responsible for program implementation which includes vaccine purchase and distribution, and ensuring adequate service provision, monitoring and evaluation. The new National Partnerships Agreement on Essential vaccines the Commonwealth continues to provide funding to State and Territory governments for the purchase of vaccines listed on the National Immunisation Program (NIP). States currently conduct their own procurement process to purchase vaccines and provide them free of charge to eligible persons. In Victoria, immunisation is carried out by general practitioners and local government. As at 30 June 2009, 55 per cent was undertaken by GPs and 45 per cent by local government.	The Commonwealth provides funding for the purchase of vaccines as well as some funding for service delivery. Victoria complements this by providing subsidies and incentive programs to local government. Public Health has responsibility for the Immunisation Program.	Under the AIA, Victoria reports annually against a range of performance measures such as coverage in a range of cohorts, and wastage and leakage. In addition, Victoria provides and annual acquittal of Commonwealth funds. Victoria is leading the country in immunisation by consistently achieving the highest coverage at each of the three key milestones (12 months, 2 years and 5 years). For example 94 per cent of two year olds are considered fully vaccinated.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Screening			
1.National Bowel Cancer Screening Program (NBCSP)	The NBCSP is a Commonwealth initiative and works in partnership with state and territory governments. The NBCSP provides population screening for bowel cancer using faecal occult blood tests (FOBT) followed by referral for participants with a positive FOBT result to further clinical services, usually colonoscopy, through the 'usual care' system. As part of the usual model of care in the provision of colonoscopy services, State and Territory Governments manage colonoscopies and related histopathology and after care when provided through public hospitals. The Victorian government committed $14 million over four years to implement the NBCSP in Victoria. The funding supports the Victorian implementation including funding for: • 16 designated public health services to put systems in place to identify program participants and provide timely access to assessment colonoscopies generated by the NBCSP. • Colonoscopy Service Redesign projects to maximise future system capacity to respond to the NBCSP. • Cancer Council Victoria (CCV) to undertake targeted recruitment and awareness activities and to conduct a survey of bowel cancer knowledge, perceptions and screening behaviours in the Victorian community. • General Practice Victoria (GPV) was funded to provide a coordinated communication and education program to support GPs.	Program responsibility sits with Cancer Prevention and Screening Section in the Health Development Unit, Public Health. Funding sources are: • ERC funding to support implementation in Victoria (see above) • Commonwealth funding for projects and to implement the participant follow-up function in Victoria	The Australian Institute of Health and Welfare (AIHW) produces annual monitoring reports for the Program. These reports are publically available at http://www.aihw.gov.au/publications/index.cfm/title/10665 Funded projects with the Commonwealth are evaluated and reported to the Commonwealth. These reports are not released publically.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
	Victoria is also undertaking a number of related projects that are funded by the Commonwealth. These are: • Pilot project to develop and evaluate a community focused screening pathway for Aboriginal and Torres Strait Islander Communities ($173,000) • Implement participant follow-up function in Victoria to improve local follow-up of participants ($1,331,694 over three years to provide adequate staffing and associated resources to undertake the participant follow-up) • National project to develop a draft quality framework for the NBCSP ($120,000) • Project to improve data return to the national registry by general practitioners, colonoscopists, pathologists and health services ($20,000).		

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
2. Improving cancer screening participation in under-screened population groups	Victoria's Cancer Action Plan 2008 – 2011 identifies increasing participation rates in population-based cancer screening programs as a priority. VCAP targets include improving participation rates by 10 per cent in under-screened population groups, including Aboriginal and Torres Straight Islander (ATSI) communities and culturally and linguistically diverse (CALD) groups. A four year under-screened/non-screened strategy has been developed to identify groups of people that are participating in cancer screening programs at a lower rate than the desired eligible screening program population, or not at all. The implementation of the strategy will involve: • Undertaking data analysis to determine who is (and is not) participating in screening • Developing systems to measure baseline participation rates for ATSI and CALD community groups in cervical screening • Undertaking evidence informed interventions at a local level that build on work currently being undertaken by screening services • Developing, trialling and evaluating recruitment strategies in identified low-screening Local Government Areas and population subgroups, including CALD and ATSI.	ERC 2008-09, part of $150 million VCAP Cancer Prevention and Screening Section, Health Development Unit, Public Health Branch is responsible for overseeing the program.	Reporting to the VCAP Implementation Committee

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
3. Newborn Screening Written consent pilot project	The Department of Health is undertaking a pilot project to trial a written informed consent model in newborn screening. Newborn screening involves a 'heel prick' test where a few drops of a newborn baby's blood are tested for a number of rare but serious conditions including phenylketonuria, cystic fibrosis and congenital hypothyroidism. The project aims to improve information provided to parents to support them to make a decision about screening and ensure they can make an informed choice about how their babies' health information may be used. A core component of this project has been the development of a comprehensive e-learning tool for midwives and students. This tool is designed to increase knowledge about the Program and expand the ability of midwives to discuss screening with parents. It also provides clinical information about techniques for collecting good samples.	Cancer Prevention and Screening Section, Health Development Unit, Public Health Branch is responsible for program oversight.	
4. PapScreen Victoria: campaign and resources	PapScreen Victoria, part of the Cancer Council Victoria, have been funded $240,000 to develop a new media campaign and information resources aimed at increasing participation in cervical screening among under- and non-screened women	$240 000 Public Health Branch budget	
Other	The Aboriginal Health Promotion and Chronic Care (AHPACC) aims to improve the health outcomes for Aboriginal Victorians with chronic disease, or at risk of developing chronic disease through health promotion, prevention, early intervention, and ongoing care.		

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objectives:			
Providing timely and high quality healthcare that meets individual needs throughout the lifespan			
Ensuring continuity of care where more than one service type and/or ongoing services are required			
Community Health Program	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. CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth 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.

Table 11A.54 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Other			
Alcohol and other drugs	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 alcohol as well as prescribed and 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 and 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, DOH 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 Illicit Drug Strategy, Drug Diversion and Needle and Syringe Programs.

Source: Victorian Government unpublished.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Overcoming cultural/language barriers			
Muticultural Services	Muticultural Services are responsible for the leadership, planning, management and coordination of the *Strategic Plan for Multicultural Health 2007-12*. Key state-wide services developed, managed, implemented and monitored by Multicultural Services are:		The development and implementation of a multicultural action plan is a whole-of-government requirement. Multicultural Services reports annually to the Queensland Government. Internal reporting is conducted bi-annually.
	- The Queensland Health Interpreter Service (QHIS) is a statewide interpreter service to provide interpreters for all patients of low-English proficiency. QHIS is supported by Interpreter Services Information System (ISIS), an online interpreter coordination system, Interpreter Quality Officers and District coordinators.	The Queensland Health Interpreter Service is a wholly state-funded service.	
	- Refugee Health Queensland is a statewide service with refugee health clinics established in South and North Brisbane, Logan, Toowoomba, Cairns and Townsville. The service provides standard initial assessments for all refugees and humanitarian entrants arriving in Queensland, including public health screening and catch-up vaccinations, GP referrals and coordination of ongoing care. Multicultural Services manages the contract and provides ongoing monitoring and support.	Mater Health Services has been contracted until 2011 for a statewide refugee health service.	Refugee Health Queensland submits quarterly and annual reports to Queensland Health (Multicultural Services).

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming geographical barriers			
Integrated Patient Transport Unit (IPTU)	The Integrated Patient Transport Unit (IPTU) provides leadership for the patient transport reform agenda which aims to improve access to and the quality of available transport resources for patient transport ranging from acute, urgent, high dependency care to non-urgent, low dependency care. The Unit works collaboratively with Retrieval Services Queensland, transport service providers and local health services to integrate all elements of the patient transport system including: the Patient Travel Subsidy Scheme; patient accommodation grants; road ambulance patient transport services; aeromedical transport and retrieval services under contract to Royal Flying Doctor Service (RFDS) and Careflight Medical Services and in partnership with Emergency Management Queensland, Department of Community Safety.	These services are funded by the State. In three rural bases Commonwealth funds support the delivery of primary health care services provided by the RFDS.	No reports are provided externally. Internally, activity reports are provided to the Health Service Districts to assist in the monitoring of utilisation of road ambulance and fixed-wing aeromedical transport at a district and facility level.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
School Based Youth Health Nurse (SBYHN) Program	The School Based Youth Health Nurse (SBYHN) Program enables the health and education sectors to work collaboratively with state secondary school communities to promote health and support schools to implement health promotion initiatives that meet the school's specific requirements. It also provides an opportunity for students, parents and members of the school community to access a health professional for matters relating to youth health within the school setting. The SBYHN role encompasses: whole of school health promotion across a number of population health priority areas (including healthy eating, physical activity, mental health, sun safety, drug education and sexual health education); individual consultations with young people, assessment and referral to appropriate services; and advocacy.	The Program is funded from Queensland Health Corporate and Health Service District funds.	School Based Youth Health Nurses provide activity data each school term which is reviewed at a program level.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation	The program is responsible for implementing the National Immunisation Program Schedule in Queensland to reduce the incidence of vaccine preventable disease in the community. This includes: strategy and policy development and oversight of implementation; maintaining quality controls over immunisation service delivery; coordinating storage and distribution of funded vaccines; coordinating the School Based Vaccination Program; provision of information and advice to service providers; monitoring adverse events following immunisation; collaboration with the Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) on the Queensland Health Care Worker vaccination program; resource development and dissemination; and maintaining and enhancing the state immunisation database.	Funding for immunisation services is provided through state funds, and through Australian Government funding via the National Partnership Agreement on Essential Vaccines.	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement. Annual performance targets are also reported directly to the Australian Government according to set benchmarks in the National Partnership Agreement.
Screening	Cancer Screening Services Branch is 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 (QBCSP). Key functions of the Branch include state-wide strategic policy and protocols, coordination and planning, service development and support, quality assurance, performance monitoring, 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 Australian Healthcare Agreement.	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement. Annual data is reported to the Australian Institute of Health and Welfare. Performance reports to BSQ Services are undertaken three, six and twelve monthly. Statistical reports are produced biennially for BSQ, QCSP and QBCSP.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal and Torres Strait Islander Health	Queensland Health provides 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. These include prevention, education and health promotion services for programs such as: men's and women's health programs including the Healthy Women's Initiative which focuses on increasing participation in cervical screening; 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 State funds.	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Environmental Health Worker and Animal Management Worker Programs	The programs are responsible for implementation of strategies for Commonwealth and State whole of government priority areas for Indigenous Health. They work at improving environmental health conditions to influence health outcomes. The programs provide funding to Aboriginal and Torres Strait Islander local governments to employ local workers to implement environmental health programs. These programs monitor environmental health conditions and workers collaborate with the community and local governments to improve environmental health conditions. Queensland Health actively supports the Indigenous workers employed by local governments by organising training, mentoring and workshops.	State grant money funds the programs. - The Environmental Health Worker funding is managed by the Department of Infrastructure and Planning. - The Animal Management Worker funding is managed by Queensland Health. Aboriginal and Torres Strait Islander local governments are responsible for program delivery. Queensland Health is responsible for overseeing delivery of the Environmental Health Worker program and is jointly responsible with the Department of Employment, Economic Development and Innovation for overseeing delivery of the Animal Management program.	Reporting against Commonwealth and State reporting requirements for both programs in terms of both funding and performance targets. Reporting through Tridata, Overcoming Indigenous Disadvantage, National Strategic Framework for Aboriginal and Torres Strait Islander Health, Queensland Government Implementation Plan, Partnerships Qld and the Queensland Health Annual Report. Reporting for the Animal Management Program is also included in the Looking After Country Together whole of government project, led by the Department of Environment and Resource Management.
Other:			
Oral Health Services	Services are 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 Queensland Health's annual report and Service Delivery Statement.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol, Tobacco and Other Drug Services	These services include 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 Commonwealth funds.	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement.
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 Queensland Health sexual health clinics and a range of prevention/education initiatives within Queensland Health coordinated across Queensland by six coordinators.	Funded through the Australian Healthcare Agreement and a combination of State and Commonwealth funding programs.	Annual Progress Report to Cabinet on the *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011* against strategy performance indicators. Commonwealth and State funding reporting requirements. Six monthly reports on activities by program coordinators. Six monthly funded NGO performance reports.
Offender Health Services	Offender Health Services is committed to delivering health and medical services to offenders in Queensland correctional centres that is consistent with services available in the community. Services provided include: • Primary health care medical services • Nursing interventions • Mental health • Dental • Optometry • Indigenous sexual health • Health promotion.	Offender Health Services is State funded; however, a small amount of Commonwealth funding provides Indigenous specific sexual health services.	Offender Health Services reports through standard Queensland Health processes only.

Table 11A.55 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
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.

Source: Queensland Government unpublished.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Overcoming cultural/language barriers			
Aboriginal 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.
Aboriginal 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.
Community Drug Service Teams	WACHS is funded to provide the community drug service in the Midwest, Pilbara and Kimberley. These teams provide a free and confidential counselling and support service for those with alcohol and other drug issues.	Funding is allocated to WACHS from the Drug and Alcohol Office (DAO).	Reporting is based on 6-monthly activity and financial statements submitted to DAO.
Pilbara Aboriginal Drug and Alcohol (PADAP)	The WACHS Community Drug Service Team also incorporates the Pilbara Aboriginal Drug and Alcohol Program (PADAP) which provides treatment and support services to Aboriginal people in the Pilbara with drug and alcohol problems, referred as part of the Department of Employment Workplace Relations (DEWR) work ready program. The Program staff consists of one coordinator and up to five Aboriginal Alcohol and Drug workers.	WACHS is contracted by the Drug and Alcohol Office (DAO) using funding from the Office of Aboriginal and Torres Strait Islander Health (OATSIH).	Reporting is based on 6-monthly activity and financial statements submitted on behalf of WACHS by DAO to OATSIH.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Child Health Interim Schedule	A comprehensive schedule of maternal and child contacts for Aboriginal and Torres Strait Islander families with young children (0-5 years) in the Perth metropolitan area and some country regions. The approach builds on and strengthens the existing universal child health schedule by offering additional visits to families who do not wish to access mainstream child health services or those families who need additional support. A total of 20 contacts are offered during the first five years of life.	State funding is provided directly to individual area health services or regions. Area health services or regions are responsible for delivering Aboriginal child health services.	Services are reported as Occasions of Service for non-admitted patients (HCARe). Reports are produced for service planning and reviews. Process and impact evaluation will be carried out in 2009.
Community Health 'at risk' Services (statewide)	Community health provides services for "at risk" populations that 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. "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. Target 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. An example of 'at risk' services include the Child and Adolescent Community Health Refugee and Migrant Health Team, who provide specialised services to meets the health and developmental needs of refugee children, adolescents and their families in the Perth metropolitan area.	State funding is provided directly to individual area health services or regions. Area health services or regions are responsible for delivering 'at risk' services.	Services are reported as Occasions of Service for non-admitted patients (HCARe). Reports are produced for service planning and reviews.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming geographical barriers			
WA Country Health Service (WACHS) Health Promotion Program	Health Promotion practitioners are based within regional public and/or primary health units coordinate health promotion programs. These practitioners work with internal and external stakeholders with a focus on enabling and building the capacity of individuals, communities and select populations to promote health. Key areas for programs include: - Tobacco; - Mental health; - Alcohol; - Nutrition; and - Physical activity.	Funding for these services is mainly via core state health funding to Area Health Services. External funding (Commonwealth, - ABHI, and RHS) also funds some health promotion practitioners in WACHS.	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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Subsidised Dental Care	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; and - 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; and • 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
WA Community Child Health Service (statewide)	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. WA offers a universal child health service that begins with a 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.	State funding is provided directly to individual area health services or regions. Area health services or regions are responsible for delivering child health services.	Services are reported as Occasions of Service for non-admitted patients (HCARe). Reports are produced as required for service planning and reviews Services are evaluated every three years.
WA Country Health Service (WACHS) programs	A range of women's health services are provided across WACHS in partnership with other government and non-government agencies which include: - Sexual Transmitted Infection screening and treatment; and - Pap smear screening.	State funding is provided directly to area health service or regions.	Services are reported as Occasions of Services for non-admitted patients (HCARe).

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Pit Stop Men's Health WACHS program	Pit Stop Men's Health program encourages men to have regular health checkups through attaching the concept of mechanical tune-ups for their cars to their own health. WACHS developed the package and distributes the package to a variety of government, non-government and community organisations across Australia who delivers the program. WACHS also delivers the program.	State funding was provided to set up the program.	Reporting provided on an annual basis.
Aboriginal 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Innovation Health Services for Homeless Youth (IHSHY) program	IHSHY is a program targeted to reach young people at high risk who are not accessing mainstream health services. IHSHY services in WA target young people at high risk aged between 12 and 25, with flexibility at both ends of the age range in accordance with individual needs. They are delivered by a range of non-government and government agencies. There are currently 8 IHSHY services in WA, examples include: - Street Doctor: provides visible, accessible and non-judgmental mobile medical and related services to street present populations in the central Perth and Midland areas; and - Adolescent Mother Support Services: provides ante-natal and post-natal support to adolescent mothers aged 17 and under in the Perth metropolitan area.	IHSHY program funds are jointly funded by State and Commonwealth, with funds allocated through service agreements with individual service providers. IHSHY services are delivered by both non-government and government agencies. Child and Adolescent Community Health is responsible for overseeing delivery of services.	Annual reporting on IHSHY service delivery and annual financial acquittals to Commonwealth Department of Health and Ageing.
Child and Adolescent Community Health (CACH) Promotion Program (metropolitan)	CACH health promotion practitioners work in partnership with clinicians within CACH, the local community and agencies to identify and implement group and community level responses to identified issues to deliver better health outcomes. The health promotion role provides a mechanism for interaction between health services, community members and other sectors, supporting and leading partnership development, health advocacy, policy development and review.	State funding is provided directly to CACH responsible for delivering the community health service within the metropolitan area.	Reports are produced for service planning and reviews. Annual reported to CACH Management.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
WA Community School Health Services (statewide)	School Health Services aim to promote healthy development and wellbeing so students may reach their full potential. Services are delivered by community health nurses, allied health, Aboriginal health workers and health promotion staff. 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. 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 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. Lifestyle Triple P is an example of an innovative program being piloted in WA School Health Services. The program provides lifestyle-specific parent training to families with overweight or obese children aged 5 to 10 years.	State funded program. Agreement between the Department of Education and Training and Department of Health which underpins the delivery of School Health Services. The Department of Education and Training part funds School Health Services in WA, as agreed in the MOU between the Departments. Area health services or regions are responsible for delivering school health services.	Services are reported as Occasions of Service for non-admitted patients (HCARe). Reports are produced as required for service planning and reviews. Narrative reports are also produced as required.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
WA Health Schools Project (WAHSP) (statewide)	The WAHSP aims to promote and facilitate the implementation of best practice healthy eating and physical activity initiatives in schools. The project works with targeted schools to incorporate healthy eating and physical activity into school policies, facilitate community and school based initiatives, establish and strengthen existing partnerships, and support the development of healthy school environments to contribute to the prevention of obesity and chronic disease. Examples of WAHSP initiatives include but are not limited to: • School kitchen gardens; • Encourage schools to become 'Crunch & Sip' schools; • Promote and assist schools to support state wide media campaigns; • Parent education sessions; • Child education sessions; • Healthy school breakfast programs; and • Provide equipment to undertake physical activity during class and breaks.	Australia Better Health Initiative (ABHI) funded til 2010.	Annual reporting to ABHI.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
School Dental	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, which include oral health education for school children. Non-general and specialist services are referred to the private sector or 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 i.e. number of decayed / missing / filled teeth; and • Average cost of service per child.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
School Drug Education & Road Aware Program (SDERA)	The Drug and Alcohol Office (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 utilises a range of initiatives including: • the development and distribution of curriculum material to all schools in Western Australia; • 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. Annual reporting to DAO as part of contract management.
WA Country Health Service (WACHS) immunisation program	WACHS is the primary provider of child and school immunisation schedules. They are also a significant provider in the adult program.	State and Commonwealth funding.	HCARe, AICR and year 7 database reporting occasions of service and coverage.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
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 National Health Agreement (NHA).	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.
WA Community Health Child Development Services	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.	State funding is provided directly to individual area health services or regions that are responsible for delivering the service.	From 2010 the Child Development Information System (CDIS) will enable routine management and performance reporting.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
WA Country Health Service (WACHS)	A range of screening services are provided across WACHS in partnership with other government and non-government agencies including: · Trachoma and trichiasis; · Aboriginal ear program; and · Lifestyle risk factor (in some areas).	State and Commonwealth funding.	HCARe reporting occasions of service. Trachoma data base.
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.
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.
Violence and Child Abuse Prevention	Intergovernmental Summit on Violence and Child Abuse in Indigenous Communities (2006) resulted in funding to The Drug and Alcohol Office (DAO) in order to provide additional resources to regional Community Drug Service Teams (Wheatbelt, Goldfields, Midwest, and Kimberley). It also provides for Aboriginal workforce development activity at DAO.	Funding is allocated to DAO from the Office of Aboriginal and Torres Strait Islander Health (OATSIH).	Reporting is based on 6-monthly activity and financial statements submitted by DAO to OATSIH.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objectives:			
Providing timely and high quality healthcare that meets individual needs throughout the lifespan			
Ensuring continuity of care where more than one service type and/or ongoing services are required			
Chronic Disease Management	A range of non-hospital care is provided across the spectrum of chronic disease management including diabetes management and asthma management. The South Metropolitan and North Metropolitan Area Health Services also run condition specific programs for patients with Chronic Pulmonary Disease (COPD), diabetes and Congestive Heart Failure (CHF) at high risk of hospitalisation. The program is multi-disciplinary and educates patients on symptom monitoring, action planning and self efficacy as well as supporting access to 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 Liaison Officers 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 physical rehabilitation, and 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. SMAHS is reporting hospital service utilisation before and after participation to the Area Health Service for consideration of effectiveness.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Disease Management Unit	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 for a complex group of patients with multiple co-morbidities.	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.
Chronic Obstructive Pulmonary Disease (COPD) Linkage program	A tertiary-community based program providing community based specialist medical, nursing and physiotherapy services to patients with 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 accommodation and support services provided through Area Health Service Arrangements.	Monthly and quarterly activity reports along with hospital admission comparisons of program patients against the COPD usual care patient group within WA Health.
Adult Allied Health – Peel and Rockingham Kwinana Health Service, SMAHS	Community based individual and group therapies for adults with diabetes and diabetes related co morbidities such as, 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, occasions of service and numbers of discharges.
Sexual health services WA Country Health Service (WACHS)	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 Kimberly, 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.

Table 11A.56 **Western Australia, community health services programs**

Programs funded by the WA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol Office (DAO)	The Drug and Alcohol Office (DAO) provides or contracts a statewide network of services relating to prevention, treatment, professional education and training. **Prevention** includes a range of activities: • prevention and early intervention programs and services; • community based education programs; and • public health prevention campaigns and support for regional prevention networks. **Treatment** includes: • outpatient and inpatient withdrawal; • assessment and counseling; • rehabilitation; • community-based pharmacotherapy; • supported accommodation; and • treatment 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; and • Indigenous workforce development including nationally recognised certificate III programs for Aboriginal alcohol and drug workers. **Information** services include: • Alcohol and Drug Information Service (ADIS); • Parent Drug Information Service (PDIS); and • Library and Resource Centre.	Funding to DAO is allocated through WA Department of Health. 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 (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 the National Health Agreement (NHA) and the Ministerial Council on Drug Strategy (through the Department of Health and Ageing).

Source : WA Government unpublished.

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
General			
GP Plus Health Care Centres	The Centres provide a focal point within the community where a range of primary health care service providers work together to enable improved coordination and delivery of care. The centres operate in collaboration with local general practitioners and make it easier for the local community to access a broader range of allied health, mental health, drug and alcohol, nurse practitioner, counselling and other support services closer to home.	Recurrent State Government funding	Monthly activity and financial data reporting
Drug and Alcohol Services	Four metropolitan clinics which provide free, confidential services, 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. Services also provided across a number of locations in country South Australia. Includes 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	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Ambulance Services	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.	Recurrent State Government funding	Monthly activity and financial data reporting
Home nursing	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
Sexual Health	A large non-government organisation which receives government funding towards providing a broad range of sexual and reproductive health services within a primary / public health framework. 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 reporting data

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming cultural/language barriers			
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
Aboriginal Primary Health Care Access Program	A range of primary and secondary health care services (including: transport, parenting programs, clinical services; and adult and child health checks) provided through general practice and allied health teams in rural areas through Kokotinna Tappangga and Purrunna Waiingga in metropolitan areas.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation
Aboriginal 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
	Across country areas services 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 Commonwealth and State Government funding	Reporting requirements as per the National Strategic and SA Health's monthly activity and financial data reporting.

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Programs – Drug and Alcohol Services	The Aboriginal Programs Unit is responsible for identifying, developing and evaluating state wide strategies and systems that effectively respond to the needs of Aboriginal people and communities affected by substance misuse, including tobacco, alcohol, illicit drugs, pharmaceuticals and volatile substances. Undertaken in partnership with Aboriginal organisations and communities.	Recurrent State Government funding	Monthly activity and financial data reporting
Aboriginal Substance Misuse Connection Program	A dedicated alcohol and drug treatment service for Aboriginal people within the inner city of Adelaide with a focus on those who have complex needs and are homeless.	Recurrent State Government funding	Six monthly activity and financial data reporting
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 Commonwealth and State Government funding	Quarterly activity and financial data reporting
Aboriginal health	Services provided include chronic disease, and child and maternal health programs for Aboriginal people in rural areas.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation
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 Commonwealth and State Government funding reviewed every two years	Monthly activity data reporting to State Government, six monthly activity data and yearly funding acquittal to Australian Government

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*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
Drugs and young people	Designed to respond to drug use among young Aboriginal people in the Adelaide metropolitan area. Aim of the project is to work with at least twenty four young Aboriginal people aged ten to seventeen at any one time and collect data for research and evaluation to inform future planning and service delivery.	Funded for 18 months pending outcome of independent evaluation currently in progress.	Ongoing quarterly activity and financial data reporting to the Department of Premier and Cabinet Social Inclusion Unit and Steering Committee.
Overcoming geographical barriers			
Community Nursing Services	A range of community nursing services are provided across country areas via home care nursing, palliative care, continence nursing, breast care and domiciliary care services.	Recurrent Australian and State Government funding	Monthly activity and financial data reporting
Country Home Link	This service provides flexible packages of care to clients in country areas in their place of residence, including residential care facilities. There are two types of care packages: home supported discharge and hospital avoidance.	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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Family Home Visiting	A nurse led preventative parenting home visiting program for up to two years that focuses on ensuring the health and safety of infants, providing child development, enhancing the parent-infant relationship and connecting families to community supports.	Recurrent State Government funding	Monthly activity and financial data reporting
Postnatal Home Visit	Offered to families by a child and family health nurse following the birth of a baby. The service enables family, child development and health issues to be identified early and 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
Overcoming socioeconomic barriers			
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
Overcoming social isolation barriers			
Street to Home Program	A primary health care service for people sleeping rough.	Funded by SA Health and Department of Families and Communities under a three year agreement. Current agreement runs from 2009 to 2012	State – monthly Australian Government – via Supported Accommodation Assistance Program (SAAP) National Data Collection Agency

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and child health	Primary health care centres provide a number of programs such as • Antenatal Shared Care Program, including Aboriginal specific antenatal, birthing and postnatal programs. • A community midwifery program provides antenatal, birthing (including home births) and postnatal services to vulnerable women in the northern Adelaide region • Pregnancy to parenting programs offer support and education to families where there are vulnerable infant risk factors, in the early pregnancy to early parenting period, including counselling antenatal education classes; postnatal reunion; young and pregnant; birth and babies; breastfeeding education; and postnatal support group.	Recurrent State Government funding	Monthly activity and financial data reporting
	• A culturally appropriate Aboriginal birthing initiative is provided from Pt Augusta.	Commonwealth 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Women's health and wellbeing	A number of specific women's health centres in the metropolitan area provide a range of primary health care services and programs for women • Services include: health education/promotion; sexual health clinics; well women clinics; mental health and therapeutic and lifestyle counselling interventions; chronic conditions self management group programs and multicultural women's support and advocacy. • Support is offered to some specific groups of women such as older women, same sex attracted women, indigenous women, women of newly arrived communities from countries which practice female genital mutilation) • Women's Health Satewide focuses on mental health and violence	Recurrent State Government funding	Monthly activity and financial data reporting
	Primary health care services for women are provided through community health services across country areas.	Recurrent State Government funding	Monthly activity and financial data reporting
Men's health and wellbeing	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: • Men's shed programs • Northern Violence Intervention Program provides services for men, women and children focussing on stopping men's use of violence and maximising safety of women.	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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Youth health and wellbeing	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 • Child, Adolescent Mental Health Services and 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, 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 health information, assessment and referral, sexual health, medical and nursing clinics, counselling and group programs Clients are 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.	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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
	The Early Intervention Pilot Program, in partnership with SAPOL, is a diversion program targeting young people aged under 18 who have been apprehended for offences related to alcohol and drugs. The program diverts the target group from the criminal justice system into the health system for attendance at a health assessment and alcohol information session with a qualified health professional.	Three year Commonwealth Government funding	Six monthly progress reports
	Headspace is a mental health counselling program for young people.	Commonwealth funding provided to a local Division of General Practice	Division of General Practice reports activity and financial data direct to Commonwealth
Children's health and wellbeing	Child development, rehabilitation and early intervention programs are provided from primary health care centres • Specialist paediatricians, rehabilitation specialists and allied health staff assess children with specific behavioural and cognitive issues. Referrals are made to appropriate specialists. • 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. Children are prioritised according to levels of active adversity. Guardianship of the Minister and Aboriginal children are of the highest priority. • Early Intervention programs provide for early childhood intervention consultants work within their local community to assist parents access support services for their children 0–8 years 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
	School dental services provide 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
	Child protection and advocacy services assess and treat children from birth to 18 years and their families where there are suspicions of child abuse and neglect. Provide telephone consultations with Families SA, Police and health workers; undertakes interagency strategy discussions, provides forensic medical assessment and crisis psychosocial response; psychological and parenting assessments; therapy for children and families.	Recurrent State Government funding	Monthly activity and financial data reporting
Immunisation	Vaccinations offered as part of the National Immunisation Program.	Commonwealth and State Government funding	Providers enter data onto the Australian Childhood Immunisation Register as registered providers
Screening	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 Commonwealth and State Government funding	Monthly activity and financial data reporting to State Government, and annual reporting to BreastScreen Australia
	Newborn Hearing Screening Program aims 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Risk factor and lifestyle programs	The chronic disease community program aims to improve the quality of life for people living with chronic diseases. It provides targeted and tailored care packages with self managed 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 Project Funding	Quarterly activity and financial data reporting
	Lifestyle and behavioural modification program which targets individuals identified at high risk of developing a preventable chronic disease.	Recurrent State Government Project Funding	Quarterly activity and financial data reporting
	A multi-strategy community-based childhood obesity prevention program involving community groups, schools and preschools, sporting clubs, retailers and others.	Commonwealth and State Government Project Funding over 5 years	Quarterly activity and financial data reporting
Objectives:			
Providing timely and high quality healthcare that meets individual needs throughout the lifespan			
Ensuring continuity of care where more than one service type and/or ongoing services are required			
GP Plus Practice Nurse Initiative	Practice nurses are placed in general practice to support general practitioners in the improved management of chronic conditions from early detection to complex co-morbidities.	State Government funding over 7 years	Monthly financial and activity data reporting

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Health Call Centre	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.	Commonwealth and State Government funding	Monthly activity and financial data reporting
Hospital avoidance and early discharge	Provides flexible packages of care to clients in the 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.	Recurrent Commonwealth and State Government funding	Monthly activity and financial data reporting
Transition from hospital to community	Provision of residential and community based care packages to transition hospital patients from an acute service back to the community resulting in decreased hospital length of stay and improved patient outcomes.	Recurrent Commonwealth and State Government funding	Monthly activity and financial data reporting
Support to Residential Facilities (SRFs)	Provision of allied health and nursing services to residents in SRFs who have complex health needs including disability, mental health and chronic conditions.	Tri annual State Government funding	Quarterly activity data reporting and yearly funding acquittal
HACC Services	Country Health SA provides services to the frail aged and younger disabled. Services include provision of equipment, in home support, transport, activity programs, day centres and community nursing.	Recurrent Commonwealth Funding	Quarterly financial and client activity.

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Regional Falls Prevention Program	Provides a regional approach to falls prevention and support for complex fallers with the aim of reducing disability and hospital presentations.	One off State Government Funding	Monthly activity and financial data reporting
Parents of Children with Disabilities Support Group	Providing parent support groups in South Australia for parents of children with disabilities. These support groups are held in local community venues.	Commonwealth funding provided to a non-government organisation	Reporting from the non-government organisation back to the Commonwealth
Other programs			
Alcohol and other drugs	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
	City Watch House Nursing Program involves the assessment, treatment and referral of people held in police custody at the City Watch House and encourages people detained and referred by SAPOL to the DASSA nurse at the City Watch House to seek treatment.	Recurrent State Government funding	Monthly activity and financial data reporting
	The Driver Assessment 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	Monthly activity and financial data reporting

Table 11A.57 **South Australia, community health services programs**

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
	Drug and Alcohol Services SA , 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 works with community sporting clubs to assist them 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
	Day centres at Ceduna and Port Augusta provide a range of day care and non-residential rehabilitation and support services for people living in these communities to augment their sobering-up centres and mobile assistance patrols.	Recurrent Commonwealth Government funding	Six monthly activity and annual financial data reporting
	The Police Drug Diversion 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 Commonwealth
	The Clean Needle Program aims to reduce the spread of blood borne viruses, including Hepatitis B, Hepatitis C and HIV, amongst injecting drug users and the broader community. Includes access to sterile injecting equipment.	Recurrent Commonwealth and State Government funding	Twelve monthly activity and financial data reporting to the Commonwealth

Table 11A.57 South Australia, community health services programs

Programs funded by the SA Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Child Protection	Child Protection and Advocacy Service provide assessment and treats children from birth to 18 years and their families where there are suspicions of child abuse and neglect. Provide telephone consultations with Families SA, Police and health workers; undertakes interagency strategy discussions, provides forensic medical assessment and crisis psychosocial response; psychological and parenting assessments; therapy for children and families.	Recurrent State Government funding	Monthly activity and financial data reporting
Oral Health	Various aged care oral health projects to improve the oral health of certain aged care populations, both in residential care and community living, by identification and referral to dental services. Oral health program to develop and implement of a Lift the Lip referral tool for general practitioners, nurses and childcare workers.	Recurrent State Government funding	Monthly activity and financial data reporting
Sexual health	Rape and Sexual Assault Service provides 24 hour crisis response for recent sexual assault (age 16 or above) which can include crisis counselling; ongoing counselling and support; medical care and follow up medical care; collection of forensic evidence; group programmes; education, training and consultation for workers.	Recurrent State Government funding	Monthly activity and financial data reporting

Source: South Australian Government unpublished.

Table 11A.58 Tasmania, community health services programs

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
General			
Primary Health	Primary Health brings together a wide range of community and rural health services to meet both the needs of individuals and local communities. **Community Health Centres** offer a variety of services including counseling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability, and family and child health services. 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. **Rural Health Facilities** provide core primary health and community care services within a local community in addition to some inpatient sub acute beds. In addition some rural sites provide residential aged care and or accident and emergency services.	The majority of funding is allocated from the State budget. Area Health Services – North, South, N.West responsible for area spending and overseeing program delivery. Services are provided in accordance with the Tasmanian Government's Output Budgeting framework.	Performance Information is collected and reported at the State level through Budget Papers, Annual Report, Key Activity and Performance Information reports and Tasmania Together. As required performance reporting is provided nationally through: National Minimum Data Sets, Reports on Government Services, Australian Institute of Health and Welfare, National Healthcare Agreement, and Australian Council of Healthcare Standards

Table 11A.58 Tasmania, community health services programs

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Primary Health *contd.*	**Palliative Care Services** – specialist palliative care clinicians work within a consultancy framework across the whole health sector to support primary health service providers in urban and rural areas to provide quality palliative care.	Services are funded through identified outputs within the DHHS budget.	As above
	Youth Health Services offer young people aged 12 -24 years a flexible and confidential service including information, education, support, referral and counselling.		As above
	Other Primary Health services include Aged Care Assessment Teams, Community Equipment Scheme, Community Options Service, Community Rehabilitation Services, Community Therapy Services, (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry) Continence Services, Community Care, Day Centres, and Health Promotion Activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.		As above
	Home and Community Care Services provide a comprehensive range of community based services to frail older people and younger people with a disability and their carers to enhance independence of clients and avoid admission to inappropriate care settings.	Jointly funded by the Australian and Tasmanian Governments	In accordance with HACC MDS requirements

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Primary Health *contd.*	**Regional Health Services** The Australian Government Rural Primary Health Program funds a number of rural health and well being programs in a number of rural communities. Programs include Multipurpose Services/Centres, Rural Health Services, More Allied Health Services (MAHS), Medical Specialist Outreach Assistance Program (MSOAP).	Australian Government funds	Reporting in accordance with program specific requirements
Overcoming cultural/language barriers			
Interpreter Services	Tasmanian DHHS provides access to Interpreter Services for NESB clients in all health settings as required.	Services are purchased on an as needs basis	
Overcoming geographical barriers			
	Tasmania's Health Plan is based on explicit principles for sustainable service design. If services can be provided safely, effectively and efficiently then they should be delivered locally. Where centralization of services is necessary because of quality, cost and sustainability considerations access will be facilitated through patient and care support and service accountability arrangements.	As per comments under general section	As per comments under general section
	A range of services are provided on an outreach bases to rural communities from an urban hub such as Allied Health services, Aged Care Assessment Teams, Continence Services, MAHS, MSOAP.		
Rural Health Facility Emergency Response	Accident and Emergency services provided at some rural sites and three sites also operate an ambulance service.		

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Telehealth services	Telehealth available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGO's and external organizations.		
Transport Services	A range of transport services to access health care is available to people who are transport disadvantaged either because of socio-economic circumstances or because health and disability preclude use or their own or public transport.		
Overcoming socioeconomic barriers			
	Any Primary Health Servicess that charge fees are means tested such that those in receipt of pensions and are health care card holders either pay a reduced fee or are exempt from fees.	As per comments under general section	As per comments under general section
Overcoming social isolation barriers			
Day Centres	Providing social support and activities for the frail, aged and people with a disability at DHHS Day Centre's around the State.	As per comments under general section	As per comments under general section
Emergency Management/Community Recovery Coordination	Emergency Management is responsible for whole of Agency coordination of DHHS diverse range of crisis and consequence management responsibilities and provides specialist advice as required.		
Other			
Residential Aged Care	Rural Health Facilities including multi-purpose services/centres provide residential aged care services where a viable non government provider is not available.	Australian Government funds that are supplemented by State government funding	

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Community Aged Care packages	Packages of low level care to assist clients to live independently in the community.	Australian Government funds	
Objective: Promoting health and preventing illness, early detection			
Youth health and wellbeing	Youth Health Services work with young people 12-24 yrs providing individual services targeted to young people who are vulnerable or 'at risk' and through group and community programs for young people.	State government funding Services delivered and managed within an Area Health Service framework	
Diabetes type 2 Demonstration Service	Type 2 Diabetes Primary Health Demonstration Service provides multi-disciplinary care for individuals referred by GP's in Northern Tasmania.		
Health Promotion Framework	Working in Health Promoting Ways: A Strategic Framework for DHHS establishes DHHS commitment to promoting safe, healthy individuals, workplaces and communities.		
Objectives:			
Providing timely and high quality healthcare that meets individual needs throughout the lifespan			
Ensuring continuity of care where more than one service type and/or ongoing services are required			
Palliative Care	Provides comprehensive assessment of the person seeking palliative care including pain and symptom management, emotional, social, spiritual, psychological and practical support.	As per comments under general section	As per comments under general section
Continence Services	Specialist assessment and prescribing of continence aids and appliances for clients over the age of 6 years.		
Orthotics & Prosthetics Service (OPST)	OPST provides inpatient and outpatient prosthetic and orthotic services for clients across hospital and community settings.		

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Community Equipment Scheme, Spinal Account and Continence Aids	The CES and Spinal A/c provides standard and non-standard equipment and continence aids for clients to assist mobility and activities of daily living, surgical footwear, communication devices and minor home modifications for clients assessed and referred by an authorised clinician as part of their clinical management.		
Community Options Case Management Services (COS)	COS provides specialist case management services for complex, high needs clients from within the HACC target group. The model provides flexible, innovative and creative support to people with complex life situations.		
General Practice (GPs)	Provides funding to General Practice Workforce Tasmania to assist recruitment and retention of rural general practitioners. Provide support and contracts rural medical practitioners to provide services to rural health facilities around Tasmania. Provide funding to GP Assist to support after hours medical support service for rural GPs.		
Aged Care Assessment Program	Aged Care Assessment Teams comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care needs.	Jointly funded by Australian and State Governments	As per funding agreement requirements

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
Other programs			
Oral health	Oral Health Services Tasmania 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 Tasmania 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.

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
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, Annual Report and Key Activity and Performance Information reports. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania *Together*, Australian Institute of Health and Welfare, National Healthcare Agreement and Australian Council of Healthcare Standards.
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, Annual Report and Key Activity and Performance Information reports. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania *Together*, Australian Institute of Health and Welfare, National Healthcare Agreement and Australian Council of Healthcare Standards.

Table 11A.58 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2008-09

Program area	*Description*	*Budgetary context*	*Reporting*
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.	Performance Information is collected and reported at the state level through Budget Papers, Annual Report and Key Activity and Performance Information reports. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania *Together*, Australian Institute of Health and Welfare, National Healthcare Agreement and Australian Council of Healthcare Standards.
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. Work has commenced to establish Gateway and Integrated Family Support Services in each of the four service areas across the state. Gateway Services will provide a single well publicised access point to receive referrals from community members and professionals and connect children and families in need with Integrated Family Support Services.	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, Annual Report and Key Activity and Performance Information reports. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania Together, Australian Institute of Health and Welfare, and National Healthcare Agreement.

Source: Tasmanian Government unpublished.

Table 11A.59 Australian Capital Territory, community health services programs

Programs funded by the ACT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
General			
Corrections Health	Provides and coordinates clinical services to adult and youth detention services through the Alexander Maconochie Centre and Bimberi Youth Justice Centre respectively. Provides policy advice to ACT Health on corrections issues.	Through a designated budget	Monthly/Annual reports against output targets and budget
Child, Youth & Women's Health Program	Provides child health checks and child health medical assessment; parenting education and support, supporting breastfeeding; childhood immunisation; audiometry and orthoptic screening; school youth health nurses; 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; and health care interpreting through the Migrant Health Unit.	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, social work and community-based cancer psychosocial services) - acute, post acute and rapid response services; specialist nursing assessments and self management of chronic conditions program.		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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Other programs			
Oral health	The Dental health Program provides adult and child & 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
Alcohol and other drugs	The Alcohol and Drug Program provides consultation and liaison and withdrawal services; liaison and clinical advice to 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

Source: ACT Government unpublished.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Remote Health	The role of the Remote Health Branch is to ensure that evidence-based, best practice primary health care services are delivered to the remote population throughout the Northern Territory from 54 remote health centres. Services include the provision of 24-hour emergency care, primary clinical care, population health programs, referral and access to retrieval, medical and allied health specialist services, provision of essential medications and management of chronic illness. Services are delivered by multidisciplinary health teams at remote health centres located throughout the NT. Around 90 per cent of all consultations and health contacts at remote health centres are with Aboriginal people. However, services are equally accessible to non-Aboriginal residents and non-residents, such as tourists.	These services are funded through an identified program within the NT Department of Health and Families budget. Some external funding is provided by the Department of Health and Ageing through the Office of Aboriginal and Torres Strait Islander Health	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 timewith the Commonwealth 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 beginning in 2009.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Maternal/Child/ Youth Health Services	The role of the Remote Outreach Midwives includes sharing evidence based information and providing education to Remote Area Nurses/Midwives and providing clinical expertise and services in the absence of a midwife. The Midwifery Group Practice is an urban based continuity of midwifery care model that will further enhance current maternity services to women residing in the Wadeye and Maningrida communities. Child health services such as growth promotion and monitoring, vaccination, general child health advice and support, are provided by registered nurses in town-based community care centres and by nurses and Aboriginal Health Workers in remote community health centres. Remote health staff are supported by visiting child health nurses, Aboriginal Health Workers and District Medical Officers and some communities have a resident community child health worker. Antenatal care is available in all remote health centres and enhanced by the Strong Women, Strong Babies, Strong Culture Program.	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.
Oral Health Services	Oral Health Services provide free assessment and treatment to all children up to school-leaving age and to adults holding a curent Healthcare Concession Card or Pensioner Concession Card. Services are provided from community and school based clinics in urban areas and in clinics in health centres and mobile trucks in remote communities. Community level and individual oral health promotion activities are also conducted.	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.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Preventable Chronic Disease Services	Preventable Chronic Disease Services provide 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 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. Chronicd disease indicators included in the new Aboriginal health KPI's.
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 and physical activity to the community, and in management of people with nutrition related conditions. In urban areas, they offer individual and group consultations through community care centres. They also work with agencies outside the health sector to promote regular participation in physical activity and improved nutrition and better food supply, for example in 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.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
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 & 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. A key focus has been to build relationships with educational institutions and research bodies. The HPSU has a key role in providing leadership in relation to Priority Area Action 1 in the DHF Corporate Plan, which relates to promoting and protecting good health and preventing injury.	These services are funded through an identified unit within the NT Department of Health and Families budget. Additional funding has been provided through the Expanding Health Service Delivery Initiative (2008-2010) for Senior Health Promotion Officers.	Regular reporting against the 2008-2009 HPSU Business Plan. Reporting against the Expanded Health Service Delivery Initiative (EHSDI). Performance targets against key aspects of Divisional and Corporate Plans. Financial reports are published in the Department of Health and Families Annual Report. We are also in the process of rolling-out a web-based health promotion Quality Improvement Program Plannning System (QIPPS) across the Health Services Division, which supports a co-ordinated evidence-based approach to best-practice in health promotion.The application of QIPPS is now incoporated into the Corporate Plan.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
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.
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 also 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.

Table 11A.60 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Well Women's Cancer Screening	Well Women's Cancer Screening 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. 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.
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 (ABL) to persons at risk due to occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and regional centres to those potentially exposed to both rabies virus (overseas) and ABL. Education programs are provided to the community and to occupational groups.	The program is funded through an identified budget within the Department of Health and Families. DoHA refunds 50 per cent of the cost of rabies immunoglobulin adminstered to people who are bitten or scratched by bats	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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Rheumatic Heart Disease	NT wide program aims to reduce 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. Extermal 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.
Objectives:			
Providing timely and high quality healthcare that meets individual needs throughout the lifespan			
Ensuring continuity of care where more than one service type and/or ongoing services are required			
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). 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 Hone And Community Care 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 2008-09

Program	*Description*	*Budgetary context*	*Reporting*
Hearing Services	Hearing Services are provided in remote communities and urban centres and include identification of ear and hearing problems related to health and education failure as well as referral and follow-up for ENT services. Additional services include comprehensive diagnostic audiological evaluations of adults and children, and in conjunction with other agencies, the management of hearing loss and educational sequelae. A Neonatal Screening Program for permanent hearing loss is also operating in urban centres.	Services are funded as an identified program within the NT Department of Health and Families. Additional funding to support audiological and ENT services has been provided through the AG Intervention and Closing the Gap funding. Additional funding for remote visits and training is provided 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.
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 operates five sexual health clinics, known as Clinic 34, in the major towns which cover urban, rural and remote areas. The program funds community based organisations supporting sexual health work. Other community based organisations are funded to operate needle and syringe and provide harm reduction initiatives, community and peer support and education.	The program is funded through an identified budget within the Department of Health and Families. Some external funding is provided via OATSIH.	Reporting is against the business plan of the NT Sexual Health Advisory Group and the more detailed Sexual Health and Blood Borne Virus Unit 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.

Source: NT Government unpublished.