11 Primary and community health

CONTENTS

Attachment tables

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

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

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

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

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

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

11.1 Profile of primary and community health

Definitions, roles and responsibilities

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

General practice

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

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

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

Services provided in general practice include:

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

Definitions for common health terms are provided in section 11.5.

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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (DoHA 2010a). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, currently $5.40 for concession card holders and $33.30 for general consumers. The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2010 safety net threshold was $1281.30 for general consumers and $324.00 for concession card holders (DoHA 2010b).

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

Community health services

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

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health professionals are employed in community health services, allied health services are

delivered mainly in the private sector. Governments provide some funding for private services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under Medicare to patients with chronic conditions and complex care needs, and improves access to allied health services in rural and remote areas.

Dental services

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

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.5 per cent of all encounters with GPs in 2008-09 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2010) (table 11.1).

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

	Number[d]	*Per cent of all encounters*[e]	*95% LCL*	*95% UCL*
Total encounters for which BEACH data were recorded	93 862	100.0	..	..
Encounters with missing data	7 487	..	..	..
Direct encounters	92 352	98.4	98.1	98.7
Medicare paid[f]	89 201	95.0	94.6	95.5
Workers compensation paid	1 843	2.0	1.8	2.1
Other paid (for example, hospital, State)	821	0.9	0.6	1.1
Indirect encounters[g]	1 495	1.6	1.3	1.9

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2009 to March 2010. [b] An 'encounter' is any professional interchange between a patient and a GP (Britt *et al*. 2010). [c] Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. [d] Number of encounters after post stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] Indirect encounters are encounters at which the patient is not seen by the GP but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al*. (2010) *General practice activity in Australia 2009-10*, Cat. no. GEP 27; table 11A.1.

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

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

Australian Government expenditure on general practice in 2009-10 was $6.1 billion, or $275 per person (figure 11.32, table 11A.2).

Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas; for example, hospital emergency departments, Indigenous primary healthcare and other community health services and the Royal Flying Doctor Service. Thus, expenditure on general practice understates expenditure on primary healthcare, particularly in jurisdictions with large populations of Indigenous people and people living in rural and remote areas. The Health preface includes expenditure data for Indigenous primary and community health services for 2006-07.

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues such as

diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $7.5 billion, or $339 per person, in 2009-10. Expenditure on the PBS was around $7.0 billion in 2009-10, of which 77.9 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health preface.

Table 11.2 **PBS and RPBS expenditure, 2009-10 ($ million)[a]**

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

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

Source: DoHA (unpublished) PBS data collection.

Community health services

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

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

DoHA, was $481 million in 2008-09. State, Territory and local government expenditure on dental services in 2008-09 was $625 million. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 11.3 **Estimated funding on community and public health, and dental services, 2008-09 ($ million)**

	Australian Government							
	DVA	*DoHA and other*[a]	*Insurance premium rebates*[b]	*Total*[c]	*State, Territory and local government*	*Total government*	*Non-government*	*Total government and non-government*
Community and public health[d]	2	1 894	1	1 896	5 584	7 481	341	7 822
Dental services	103	378	426	907	625	1 532	5 183	6 715

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

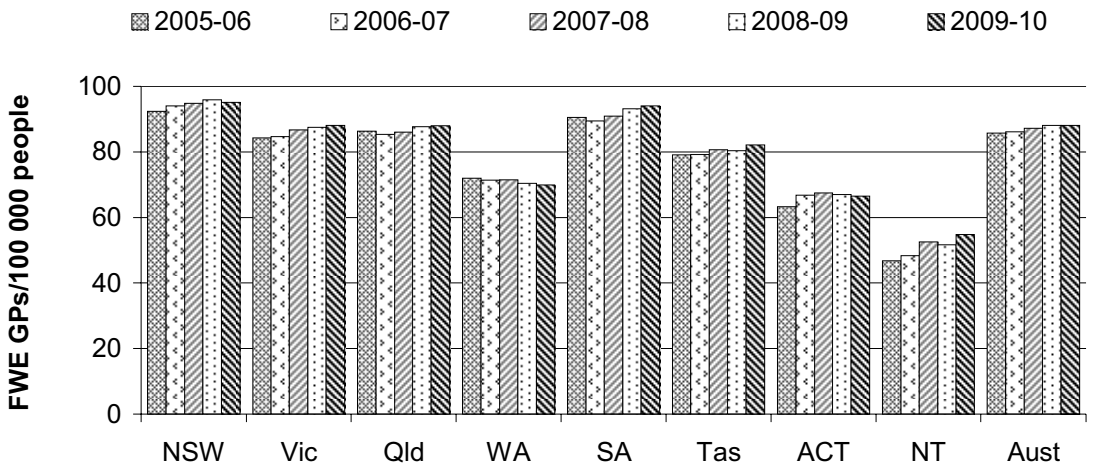
Source: AIHW (2010) *Health Expenditure Australia 2008-09*, Cat. no. HWE 51.

Size and scope

General practice

There were 26 613 vocationally recognised GPs and OMPs billing Medicare in Australia in 2009-10. On a full time workload equivalent (FWE) basis, there were 19 729 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 88.1 FWE recognised GPs and OMPs per 100 000 people (table 11A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous primary healthcare services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

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

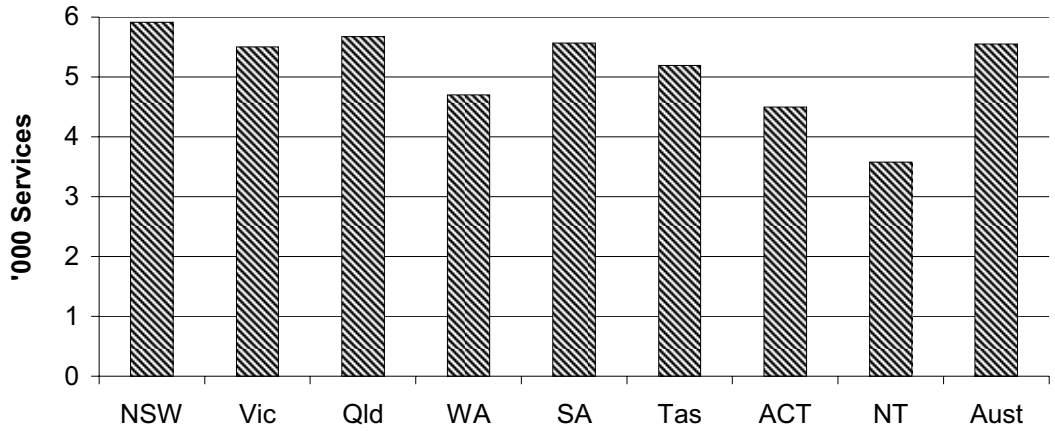


a Data include vocationally recognised GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice.

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

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

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



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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

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

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

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

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

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

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.71–11A.79 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

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

Maternal and child health

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

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students (tables 11A.71–11A.79).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2009-10 targeted at disadvantaged people (tables 11A.71–11A.79).

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

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

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

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

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

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2010a). Treatment activities excluded from that report include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

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

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

Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2008-09, these programs included services such as health

information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.71–11A.79).

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

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

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

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

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

Source: AIHW (unpublished) OSR data collection.

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

11.2 Framework of performance indicators

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

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

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

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

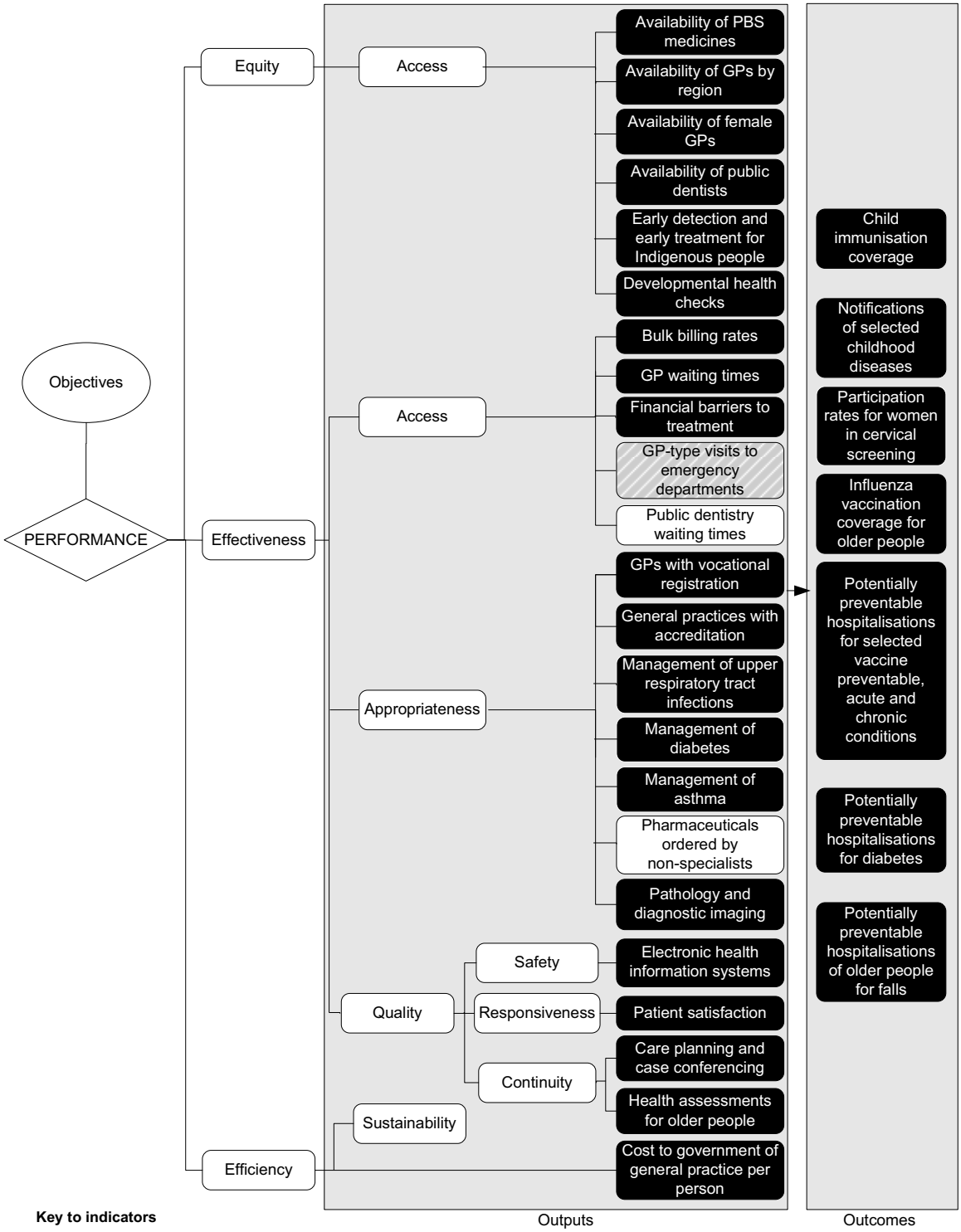
- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating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

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

The performance indicator framework shows which data are comparable in the 2011 Report (figure 11.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6). The Health preface explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability consistent with the standard Review framework.

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

Figure 11.3 **Performance indicators for primary and community health**



11.3 Key performance indicator results

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

Outputs

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

Equity

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

Access

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

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

Availability of PBS medicines

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

Box 11.2 **Availability of PBS medicines**

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

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

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

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

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

Data for this indicator are comparable.

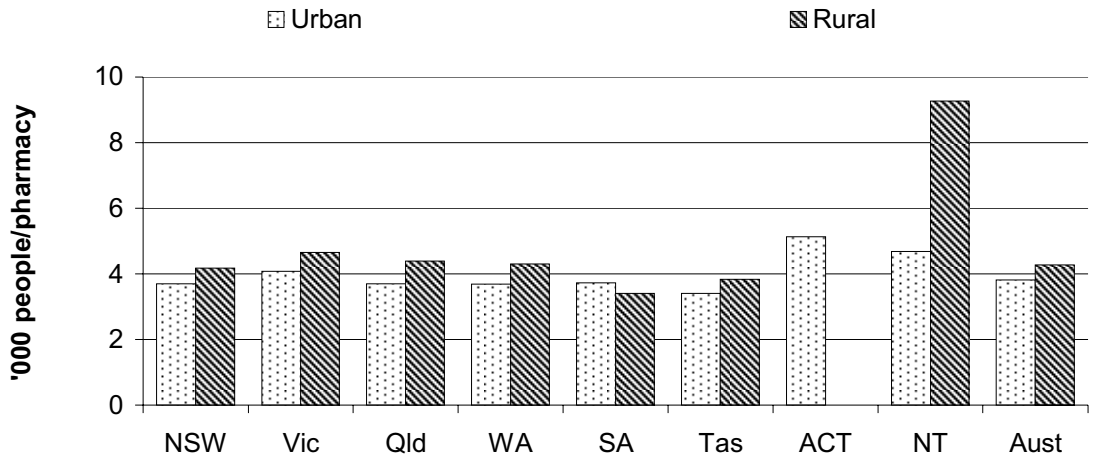
Data quality information for this indicator is under development.

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

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

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

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

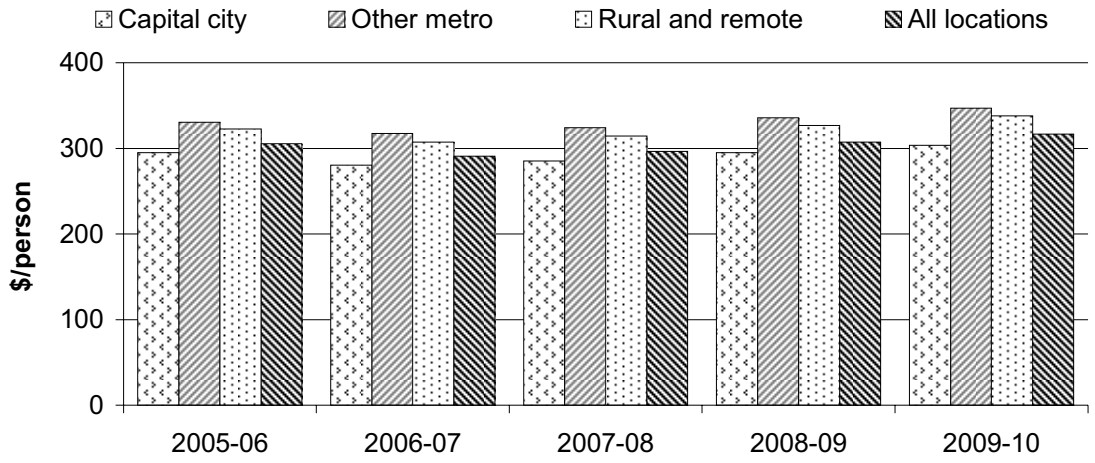


a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas.

Source: DoHA (unpublished) derived from Medicare Australia, ABS *2006 Census of Population and Housing* and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems; table 11A.12.

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

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



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

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

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

Availability of GPs by region

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

Box 11.3 **Availability of GPs by region**

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

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

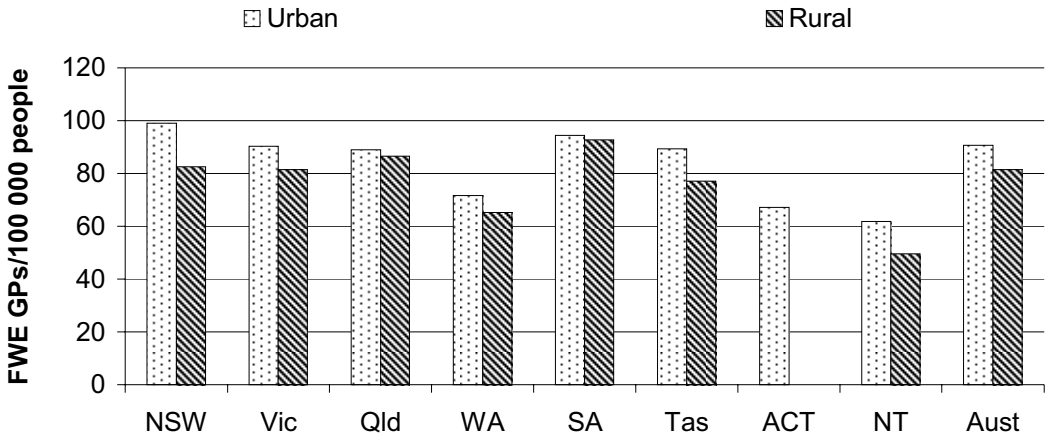
This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

Figure 11.6 **Availability of GPs (full time workload equivalent), 2009-10**[a, b, c]



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

Source: DoHA (unpublished) MBS data collection; table 11A.14.

Availability of female GPs

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

Box 11.4 **Availability of female GPs**

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

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

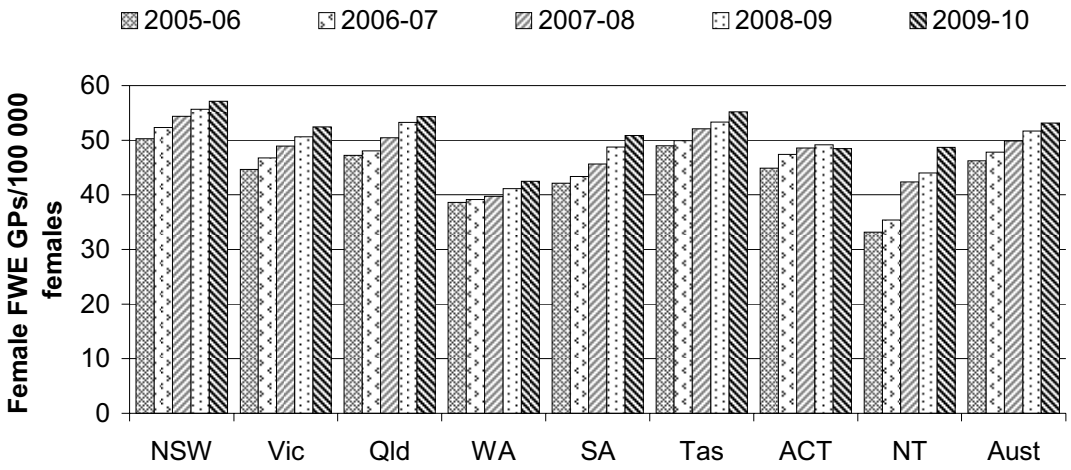
This indicator does not provide information on whether women are accessing female GPs or whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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



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

Source: DoHA (unpublished) MBS data collection; table 11A.15.

Availability of public dentists

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

Box 11.5 **Availability of public dentists**

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

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

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

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Early detection and early treatment for Indigenous people

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

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

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

- Older people who received a health assessment by Indigenous status, defined as the proportion of older people who received a health assessment by Indigenous status. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous people become eligible for 'older' people's services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health preface).
- Older Indigenous people who received a health assessment, defined as the proportion of older Indigenous people who received a health assessment in successive years of a five year period.

(Continued on next page)

Box 11.6 **(Continued)**

- Indigenous people who received a health assessment or check by age group, defined as the proportion of Indigenous people who received a health assessment/check, in each of the three age groups for which they are available (0–14 years, 15–54 years and 55 years or over).
- Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services, defined as the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities in the services provided.

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

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

Data for this indicator are comparable.

Data quality information for this indicator is under development.

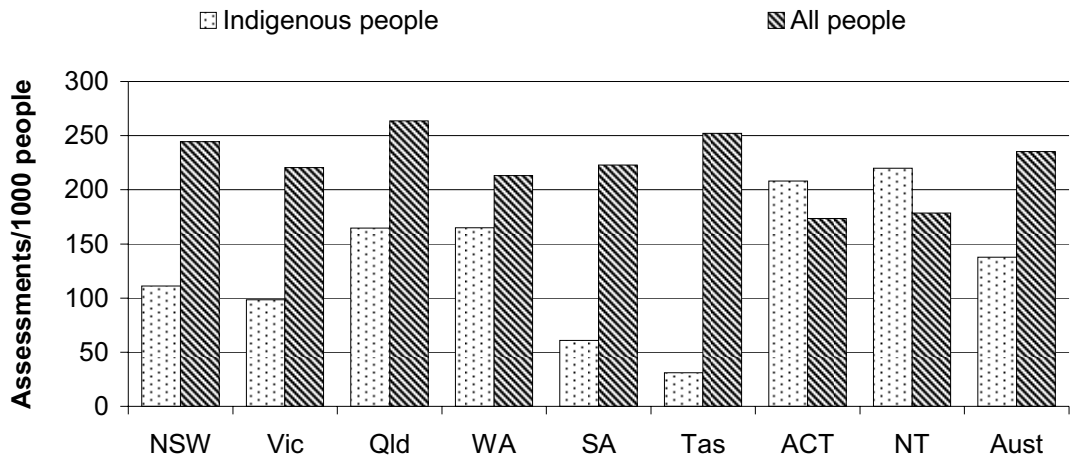
The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2008a; SCRGSP 2009). Early detection and early treatment refers to the identification of individuals who are at high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

Health assessments and checks are Medicare Benefits Schedule (MBS) items that allow GPs to undertake comprehensive examinations of patient health, including physical, psychological and social functioning. They are available for several

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

In 2009-10 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment in most jurisdictions (figure 11.8). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.8 **Older people who received an annual health assessment by Indigenous status, 2009-10[a, b]**

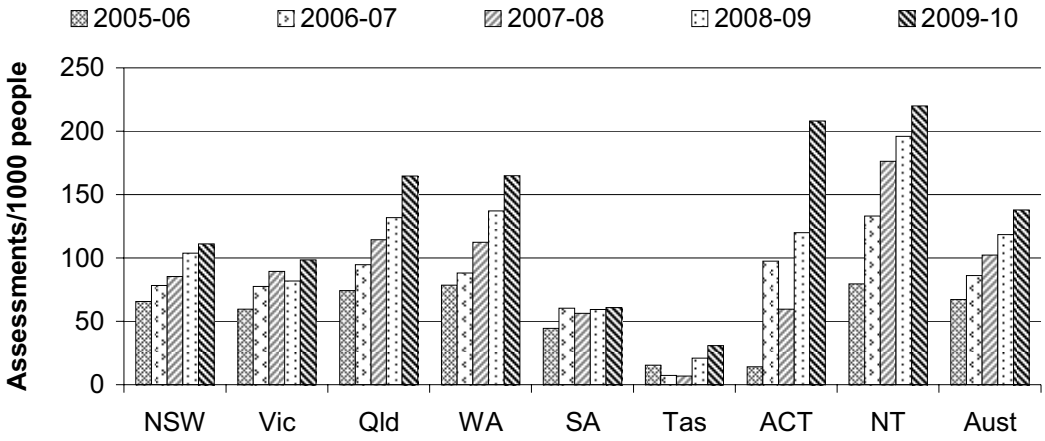


a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. **b** Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This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

Source: Derived from DoHA (unpublished) MBS data collection, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0 and ABS (2009) *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.18.

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

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



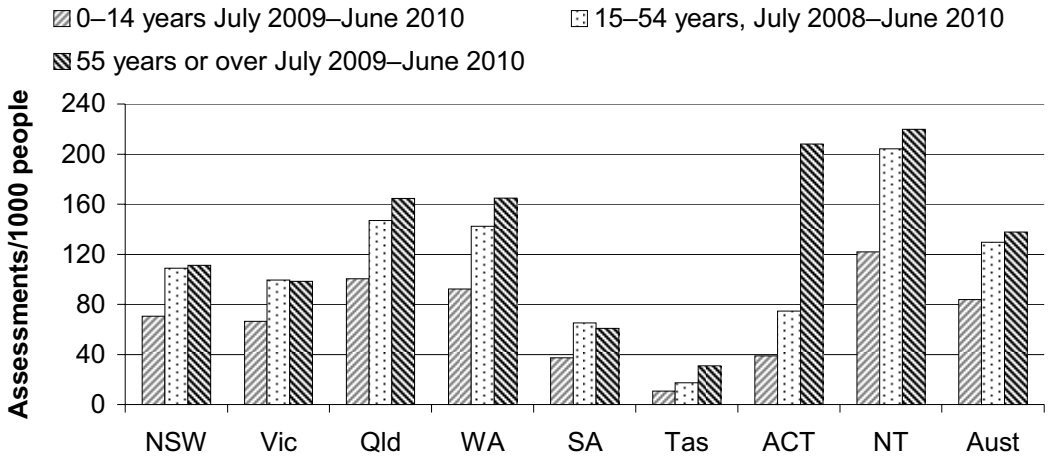
a Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect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

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.19.

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

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

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

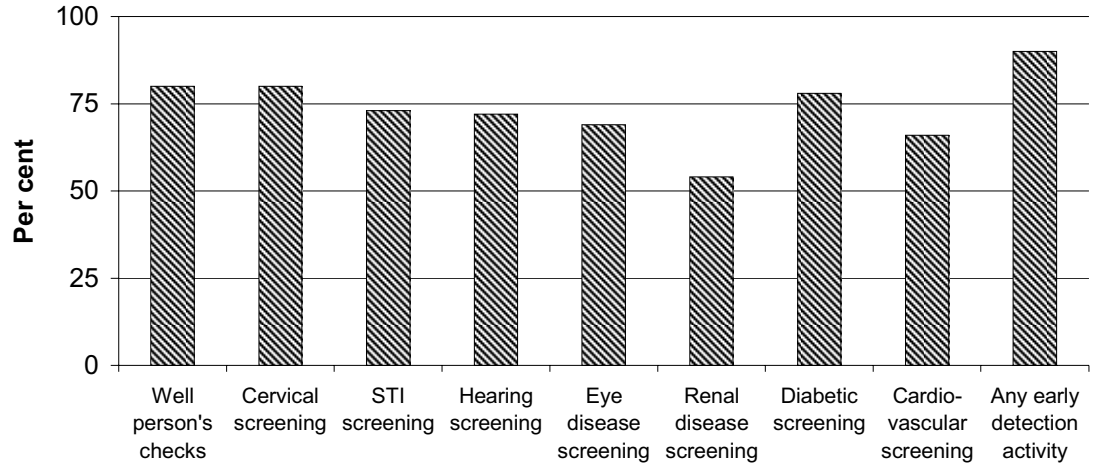


[a] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people.[b] Health checks for 0–14 year olds, and health assessments for those aged 55 years or over, are available annually. Data for these age groups are for the period 1 July 2009 to 30 June 2010. Health checks for 15–54 year olds were available biennially until 30 April 2010 (thereafter annually), and these data are for the period 1 July 2008 to 30 June 2010.

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

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

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



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

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

Proportion of children receiving a fourth year developmental health check

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

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

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

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

(Continued on next page)

Box 11.7 **(continued)**

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

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

Data for this indicator are comparable.

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

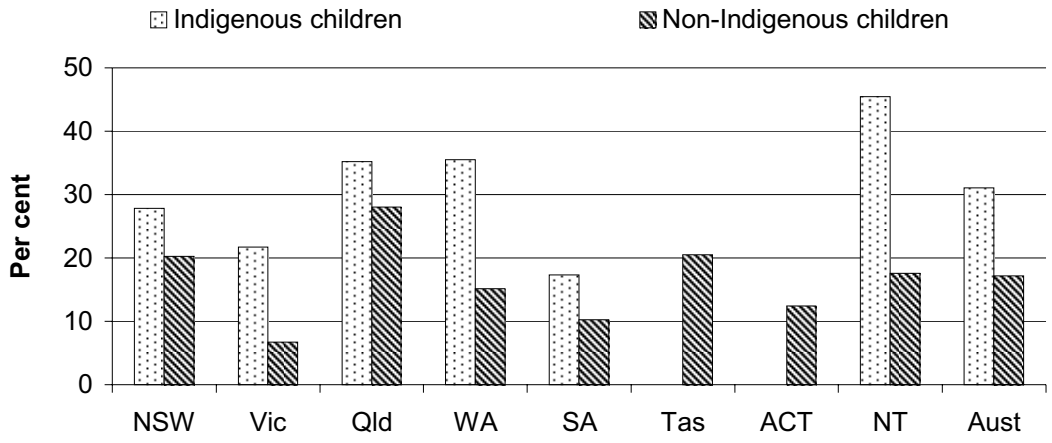
The fourth year developmental health check MBS item was introduced in 2008, and is intended to assess children's physical health, general well-being and development. It enables identification of children who are at high risk for, or have early signs of, delayed development and/or illness. Early identification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

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

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

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

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



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

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

Effectiveness

Access

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

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

Bulk billing rates

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

Box 11.8 **Bulk billing rates**

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

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

A higher proportion of bulk billed attendances indicates more affordable access to GP services.

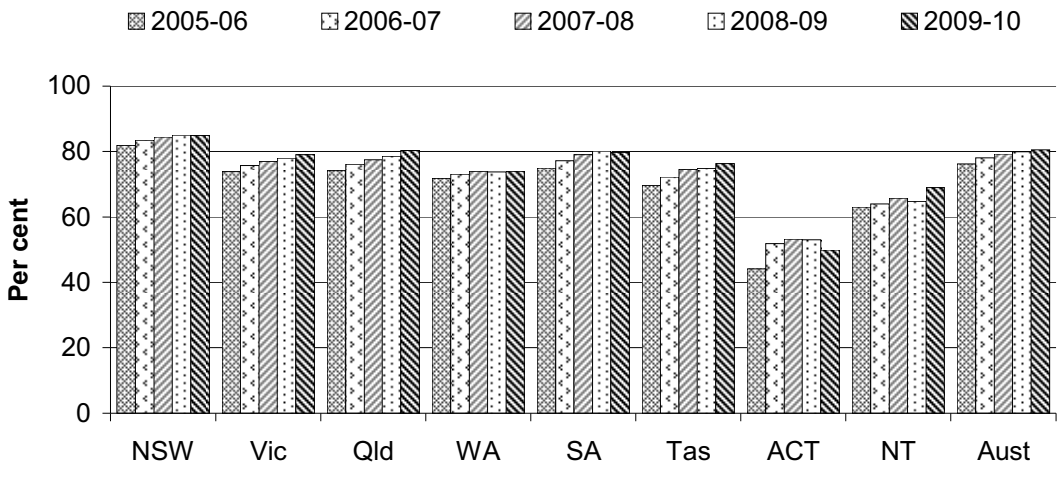
This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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



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

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

GP Waiting Times

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

Box 11.9 **GP Waiting Times**

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

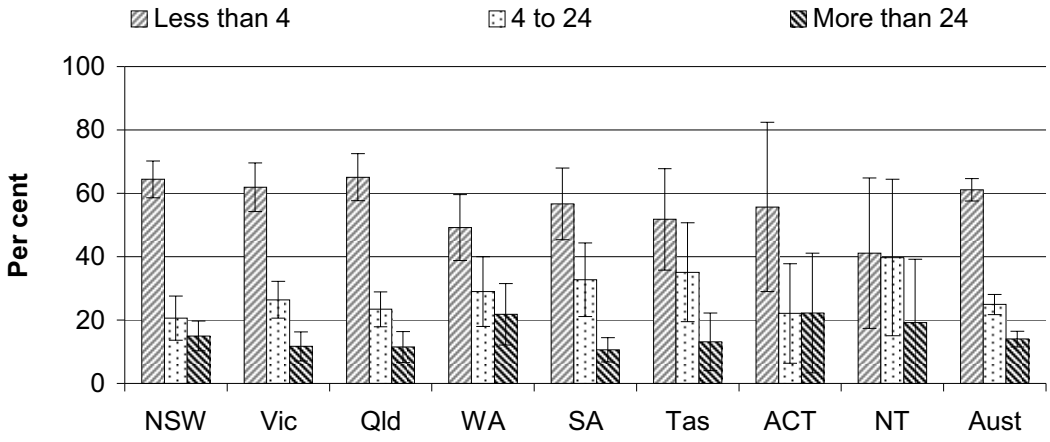
An increase in the proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

Data for this indicator are comparable.

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

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

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



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

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

People deferring treatment due to financial barriers

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

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

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

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

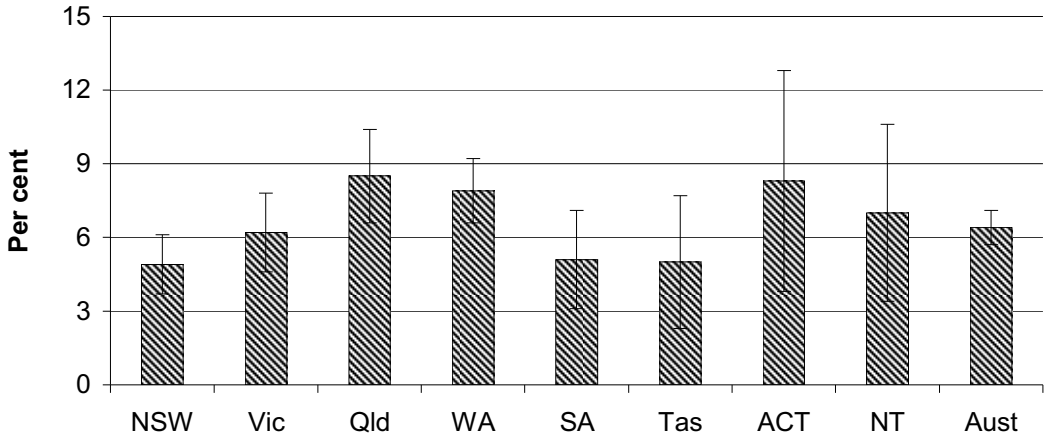
A lower proportion of people deferring treatment due to financial barriers indicates more widely affordable access to GPs and medications.

Data for this indicator are comparable.

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

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

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

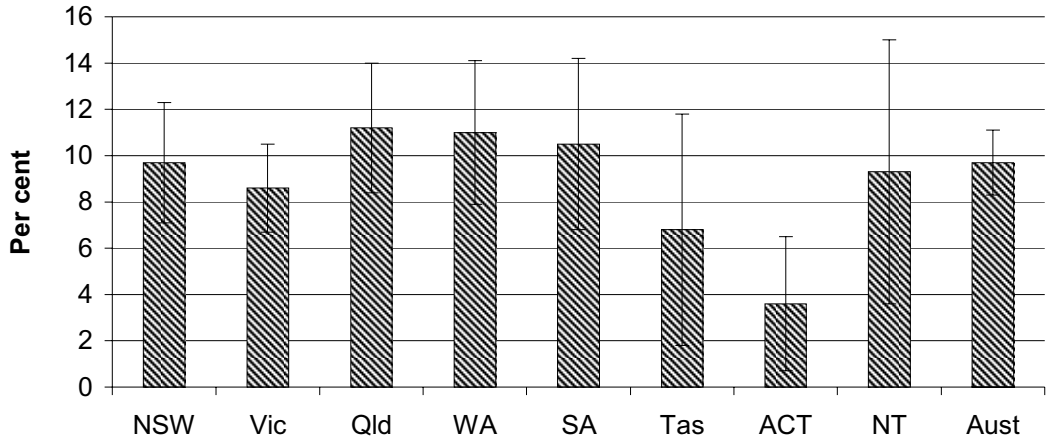


[a] People aged 15 years or over. [b] Delayed visiting or did not visit a GP at any time in the previous 12 months. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

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

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

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



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

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

Selected potentially avoidable GP-type presentations to emergency departments

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

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

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

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

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

Data for this indicator are not directly comparable.

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

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

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

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

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

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

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

Waiting times for public dentistry

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

Box 11.12 Waiting times for public dentistry

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

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

Appropriateness

Six indicators of the appropriateness of GP services are reported:

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

GPs with vocational registration

'GPs with vocational registration' is an indicator of governments' objective to ensure the GP workforce has the capability to deliver high quality services (box 11.13).

Box 11.13 **GPs with vocational registration**

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

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

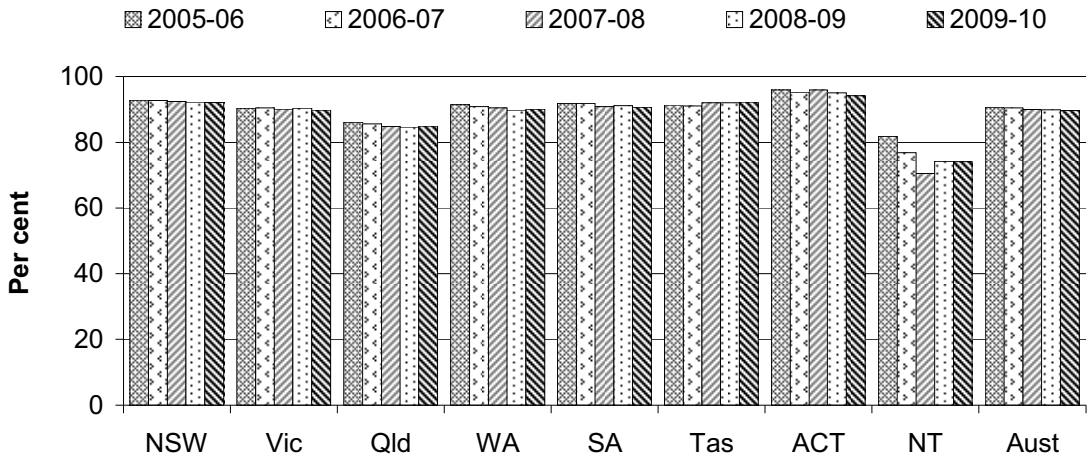
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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

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



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

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

General practices with accreditation

'General practices with accreditation' is an indicator of governments' objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.14).

Box 11.14 **General practices with accreditation**

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

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

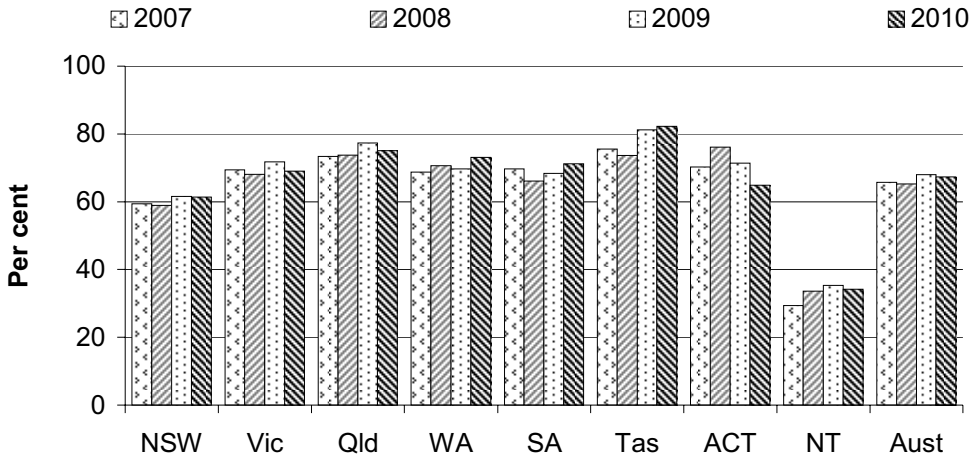
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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

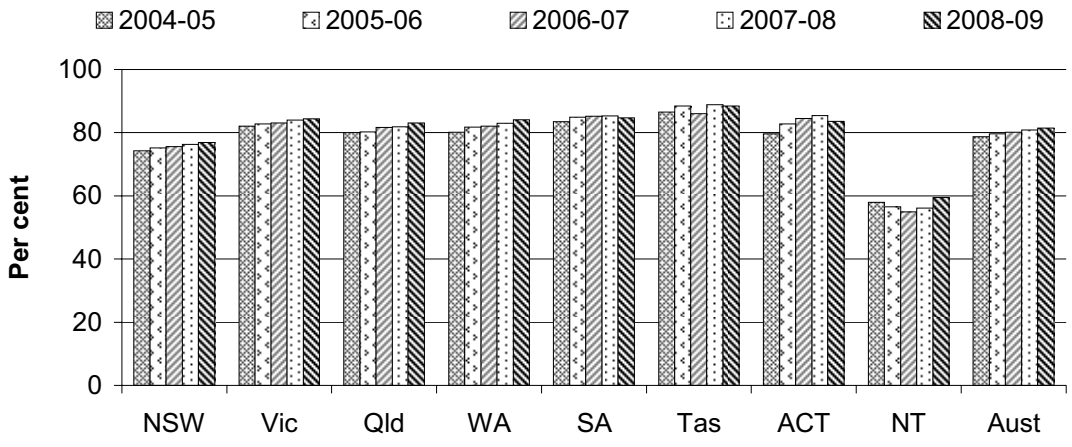
Figure 11.18 **General practices with accreditation, at 30 June**



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

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has been relatively constant in the period from 2004-05 to 2008-09 (figure 11.19).

Figure 11.19 **Proportion of general practice patient care provided by PIP practices[a]**



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

Source: DoHA (unpublished) PIP and MBS data collections; table 11A.34.

Management of upper respiratory tract infections

'Management of upper respiratory tract infections' is an indicator of governments' objective to ensure that antibiotics are used appropriately and effectively (box 11.15).

Box 11.15 **Management of upper respiratory tract infections**

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

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

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

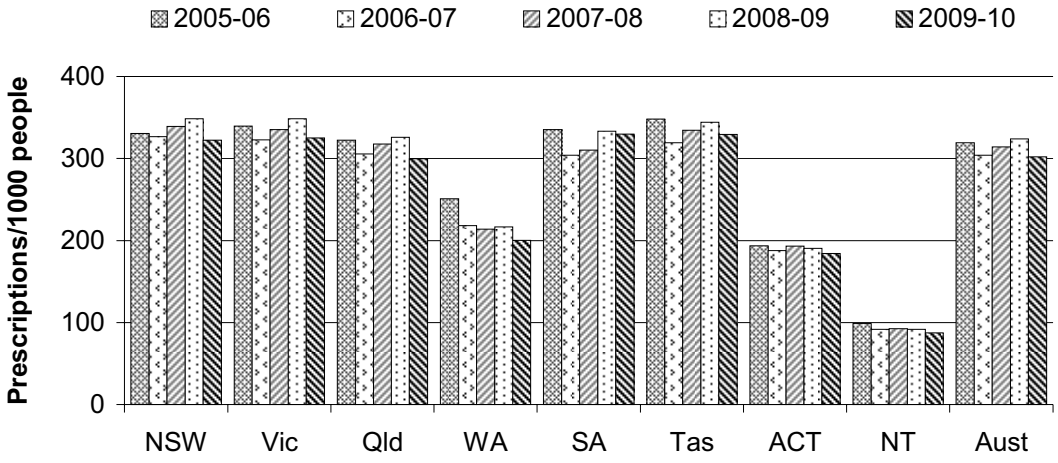
The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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



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

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

Management of diabetes

'Management of diabetes' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.16).

Box 11.16 **Management of diabetes**

'Management of diabetes' is defined by two measures:

- the proportion of people with diabetes mellitus who have received an annual cycle of care within general practice — the number of MBS items for completion of a cycle of care for patients with established diabetes mellitus that are claimed, divided by the estimated number of people with diabetes mellitus
- the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent — the number of people with diabetes mellitus with HbA1c below 7 per cent, divided by the estimated number of people with diabetes mellitus.

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

A high or increasing proportion of people with diabetes mellitus who have received an annual cycle of care within general practice is desirable. Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

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

Data reported against this measure are comparable.

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

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

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

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

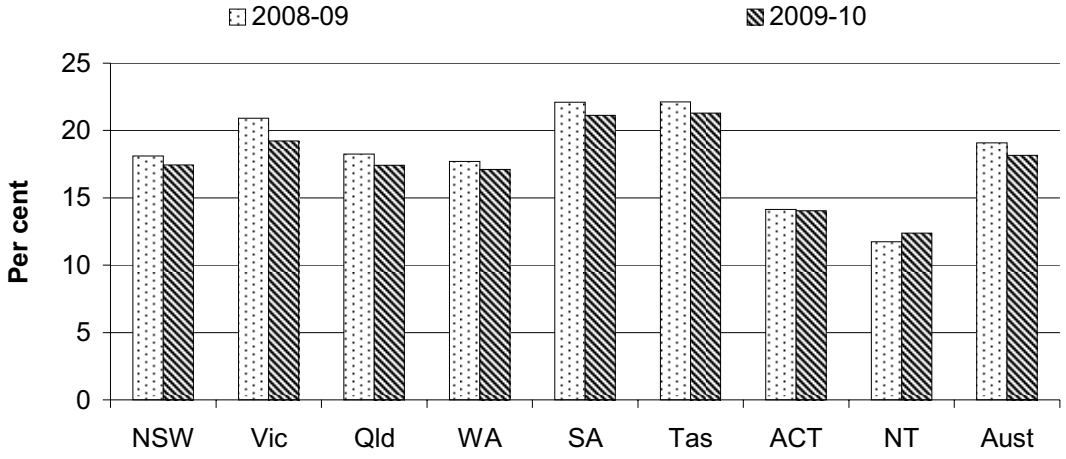
Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally

based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosolated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007).

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

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



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

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

Management of asthma

'Management of asthma' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.17).

Box 11.17 **Management of asthma**

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

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

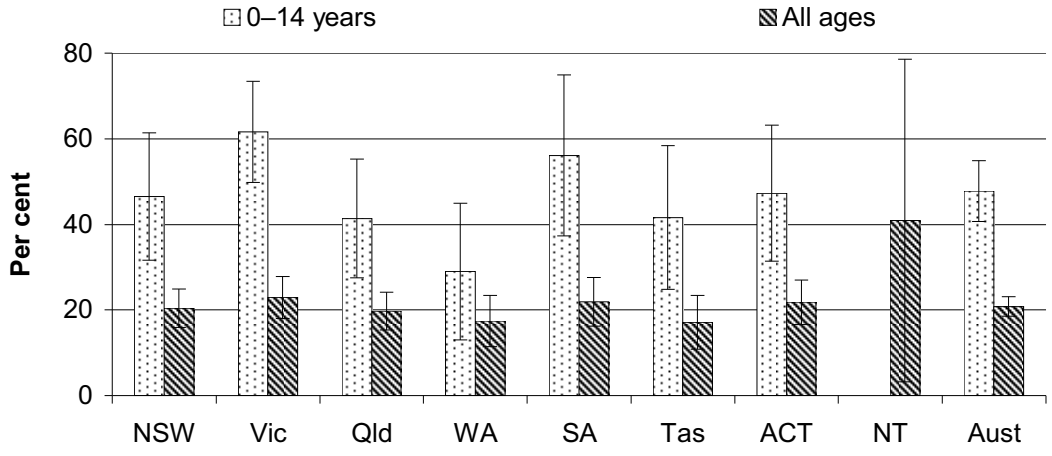
A high or increasing proportion of people with asthma who have a written asthma action plan is desirable.

Data reported against this indicator are comparable.

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

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

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



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

Source: ABS (2009) *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0; ABS (2009) *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. No. 4362.0; table 11A.37.

Pharmaceuticals ordered by non-specialists

'Pharmaceuticals ordered by non-specialists' has been identified as an indicator of governments' objective to ensure the appropriateness of primary healthcare services (box 11.18).

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

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

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

Pathology tests and diagnostic imaging ordered by non-specialists

'Pathology tests and diagnostic imaging ordered by non-specialists' is an indicator of governments' objective to ensure that primary healthcare services are appropriate (box 11.19).

Box 11.19 **Pathology tests ordered and diagnostic imaging referrals by non-specialists (vocationally recognised GPs and OMPs)**

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

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

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

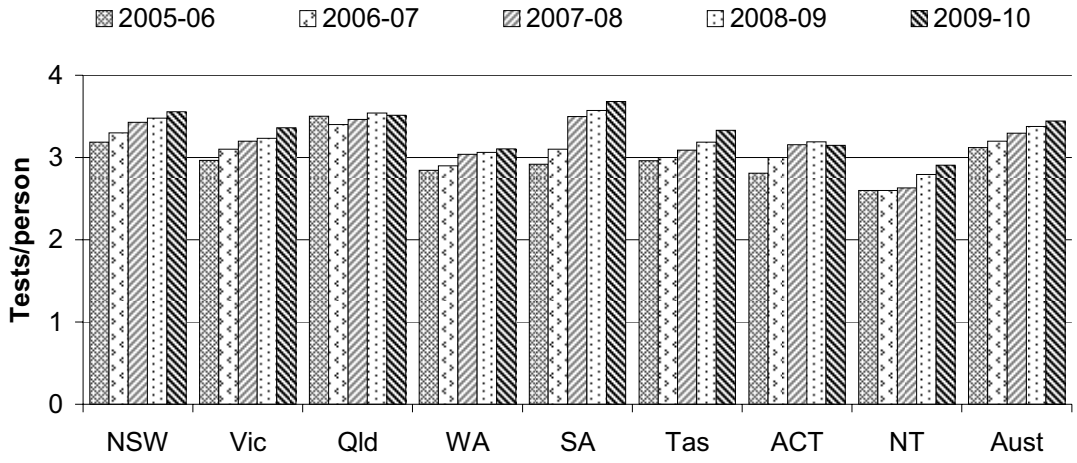
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Pathology tests and diagnostic imaging ordered by vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. While data for the total number of pathology tests ordered and diagnostic imaging referrals made by GPs are not available from Medicare, data are available for those that are rebated through Medicare. The number of pathology tests ordered can be higher than the number rebated through Medicare (where multiple tests are ordered, rebates are provided only for the three most expensive tests). Radiologists can identify a need for more or different imaging procedures than those for which patients are referred. Information about differences between the number of pathology tests ordered and the number of rebates claimed, and differences between the number of imaging procedures ordered by GPs and the number of rebates claimed, is not available.

Nationally, the number of pathology tests ordered and rebated through Medicare per person ranged from 3.1 to 3.4 in the period 2005-06 to 2009-10 (figure 11.23).

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

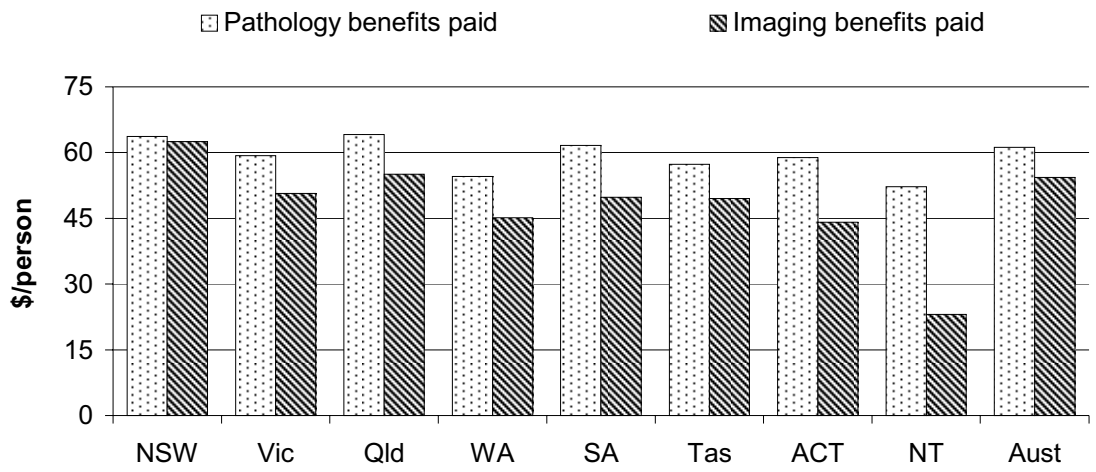


a Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

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

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

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

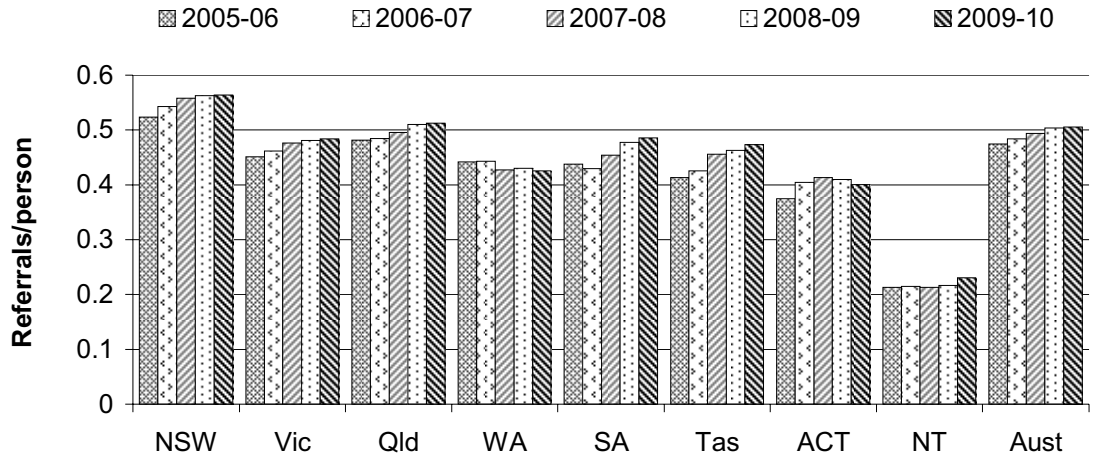


a Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

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

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

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



a Data relate to vocationally recognised GPs and OMPs.

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

General practices using electronic health information systems

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

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

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

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

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

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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

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

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

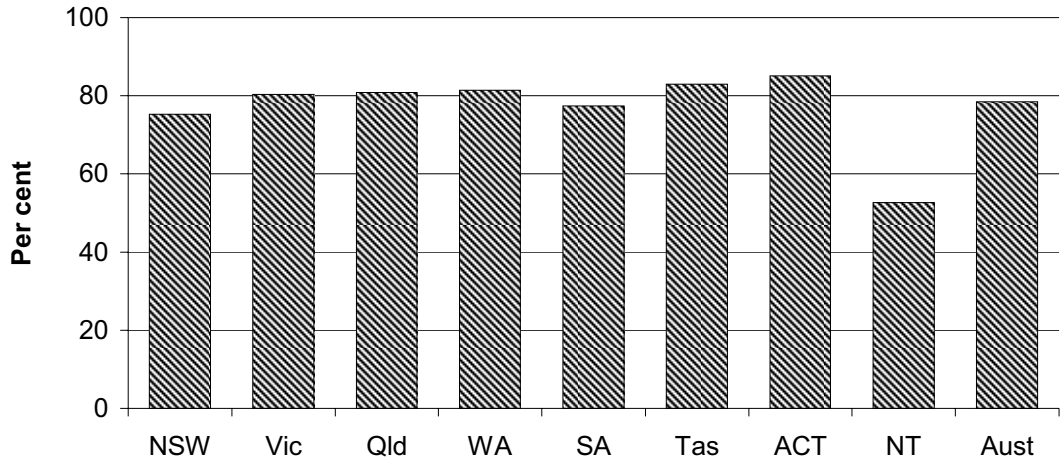
Information Management, Information Technology Incentive that had commenced in November 2006.

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

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

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

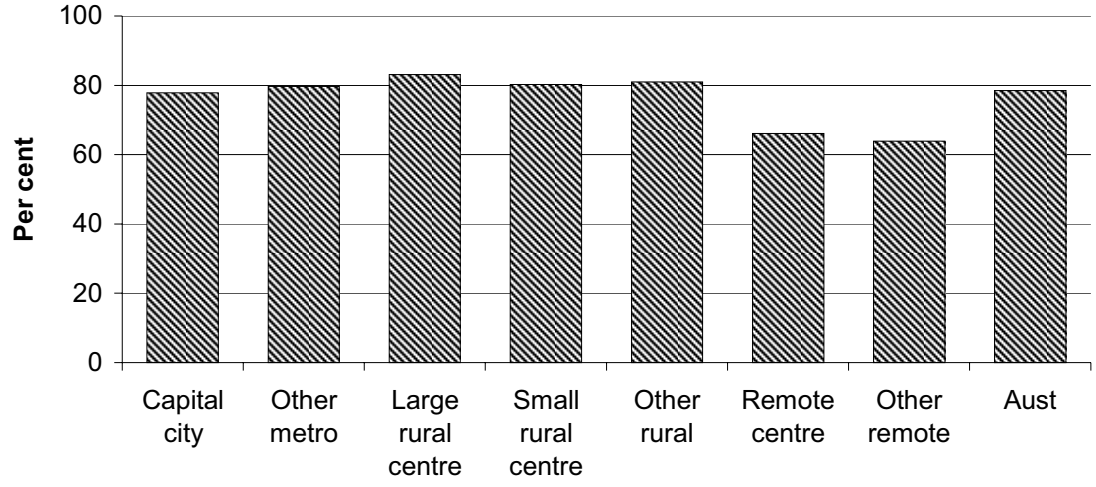
Figure 11.26 **PIP practices using electronic health systems, May 2010**



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

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

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



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

Source: DoHA (unpublished) MBS and PIP data collections; table 11A.43.

Quality — responsiveness

Patient satisfaction

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

Box 11.21 **Patient satisfaction**

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

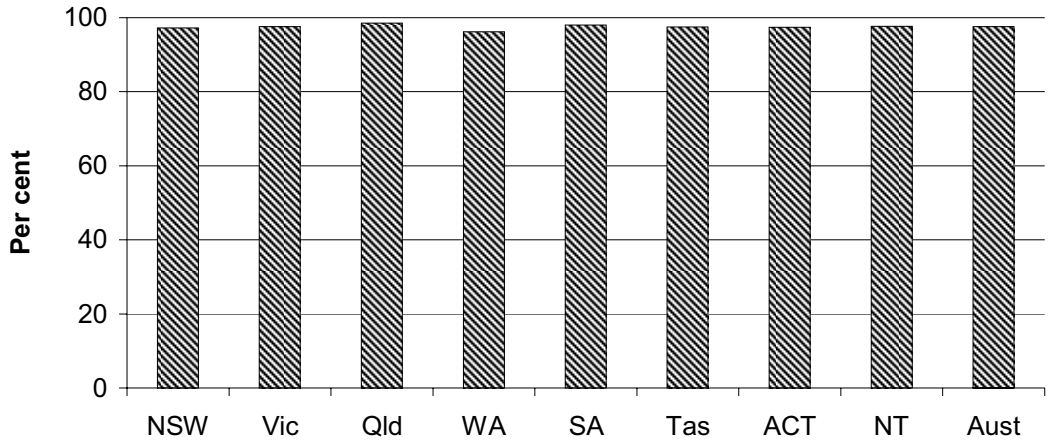
- 'proportion of people receiving a prescription for medication from a GP in the previous 12 months where reasons for the prescription were provided', defined as the number of people who received a prescription for medication from a GP in the previous 12 months where the GP provided reasons for the prescription,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

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

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

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

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

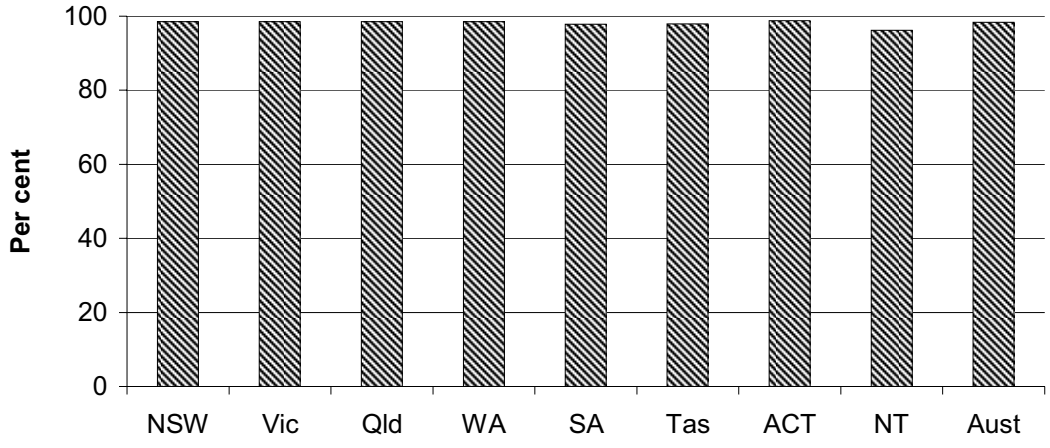


[a] People aged 15 years or over who received a prescription for medication in the previous 12 months. [b] Rates are age standardised to the Australian population at 30 June 2001.

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

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

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



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

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

Quality — continuity

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

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

Care planning and case conferencing

'Care planning and case conferencing' is an indicator of governments' objective to improve the continuity of care provided to people with chronic or terminal medical conditions (box 11.22).

Box 11.22 **Care planning and case conferencing**

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

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

Data for this indicator are comparable.

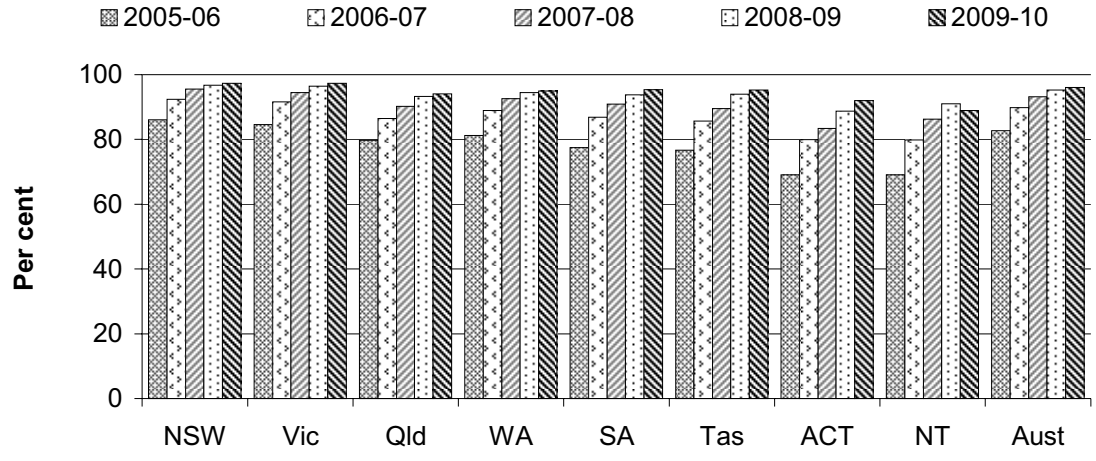
Data quality information for this indicator is under development.

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

Nationally, the proportion of GPs using chronic disease management MBS items for care planning or case conferencing increased from 82.7 in 2005-06 to 96.1 per cent

in 2009-10 (figure 11.30). The proportion has increased steadily in almost all jurisdictions in the period 2005-06 to 2009-10.

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



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

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

Health assessments for older people

'Health assessments for older people' is an indicator of governments' objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.23).

Box 11.23 **Health assessments for older people**

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

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

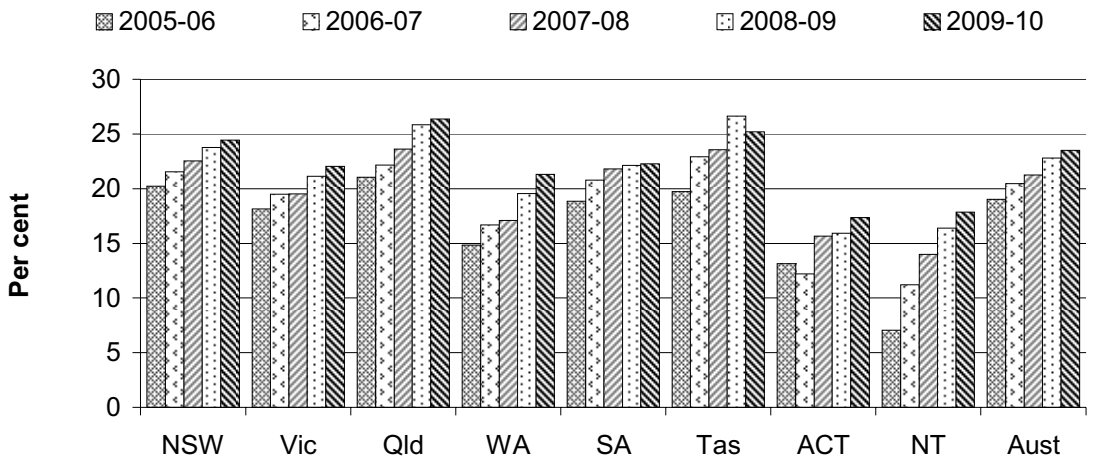
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

There has been a steady increase in the proportion of older people receiving a health assessment in most jurisdictions, in the period 2005-06 to 2009-10. Nationally, this proportion increased from 19.0 per cent in 2005-06 to 23.5 per cent in 2009-10 (figure 11.31).

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



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

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

Sustainability

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

Efficiency

Cost to government of general practice per person

'Cost to government of general practice per person' is an indicator of governments' objective to provide primary healthcare services in an efficient manner (box 11.24).

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

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

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

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

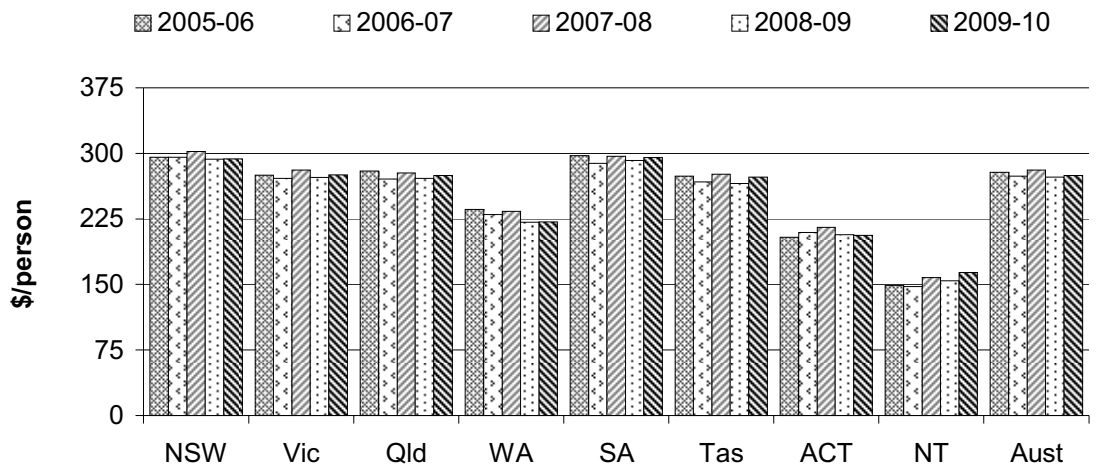
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

Nationally, the recurrent cost to the Australian Government of general practice was $275 per person in 2009-10 (figure 11.32).

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



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

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

Outcomes

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

Child immunisation coverage

'Child immunisation coverage' is an indicator of governments' objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.25).

Box 11.25 **Child immunisation coverage**

'Child immunisation coverage' is defined by three measures:

- 'proportion of children aged 12 months to less than 15 months who are fully immunised', where children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B
- 'the proportion of children aged 24 months to less than 27 months who are fully immunised', where children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella
- 'the proportion of children aged 60 months to less than 63 months who are fully immunised', where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

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

Data for this indicator are comparable.

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

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

Many providers deliver child immunisation services (table 11.8). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentive Scheme, which provides incentives for the immunisation of children under seven years of age.

Table 11.8 Valid vaccinations supplied to children under 7 years of age, by provider type, 2005–2010 (per cent)[a, b, c, d]

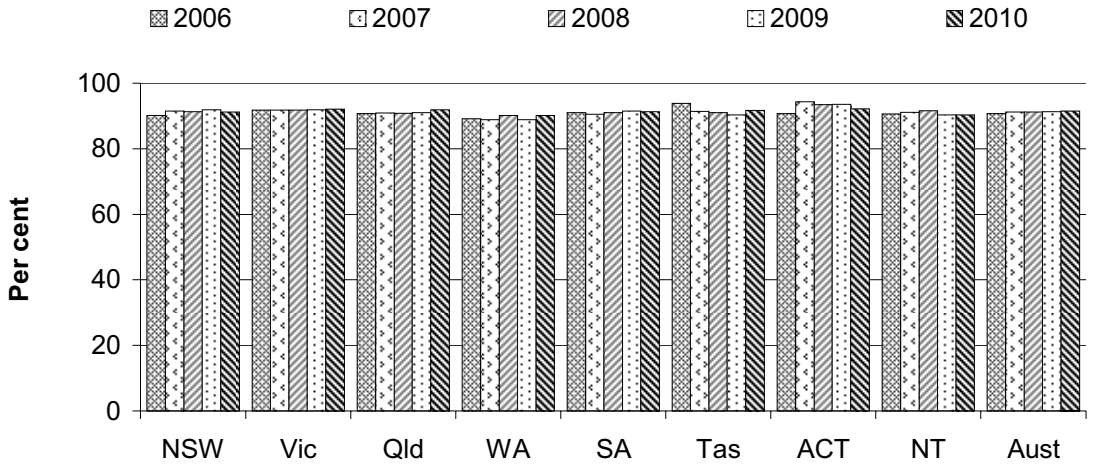
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	84.5	53.4	82.8	64.7	69.3	87.4	43.0	4.6	71.4
Council	5.6	45.2	7.0	6.1	18.7	11.8	–	–	16.8
State or Territory health department	–	–	–	6.3	0.1	0.1	17.7	0.3	0.9
Public hospital	1.9	0.6	3.0	3.8	2.5	0.2	0.8	7.5	2.1
Private hospital	0.1	–	–	–	–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

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

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

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

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

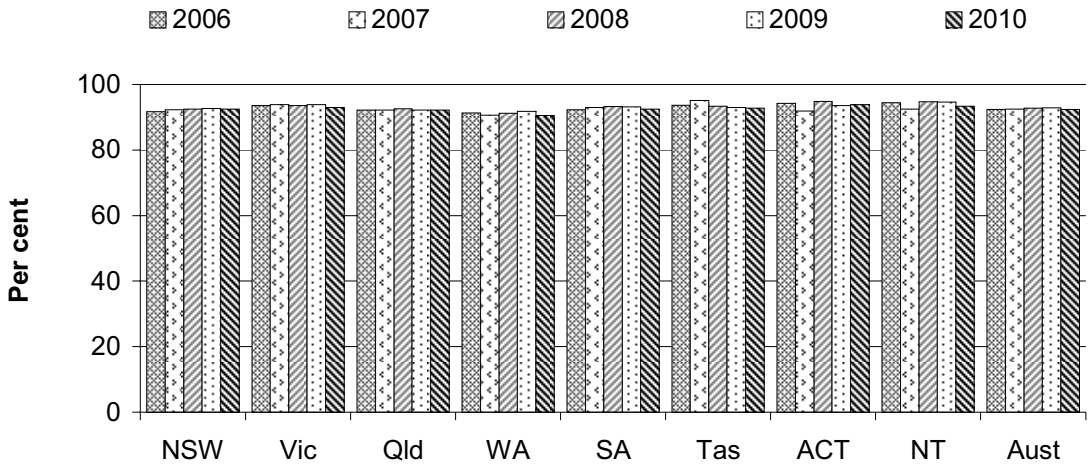


[a] Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. [b] The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over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

Source: DoHA (unpublished) ACIR data collection; table 11A.49.

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

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

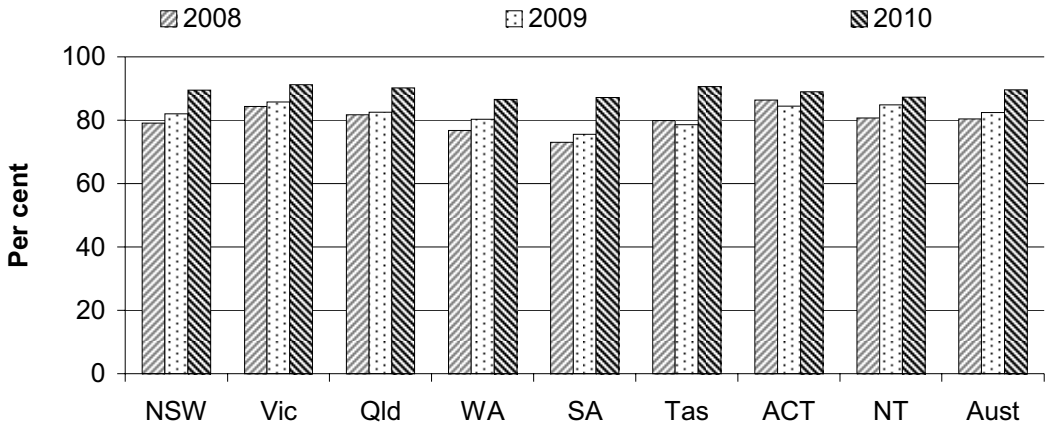


[a] Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children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

Source: DoHA (unpublished) ACIR data collection; table 11A.50.

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

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



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

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

Notifications of selected childhood diseases

'Notifications of selected childhood diseases' is an indicator of governments' objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 11.26).

Box 11.26 **Notifications of selected childhood diseases**

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

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

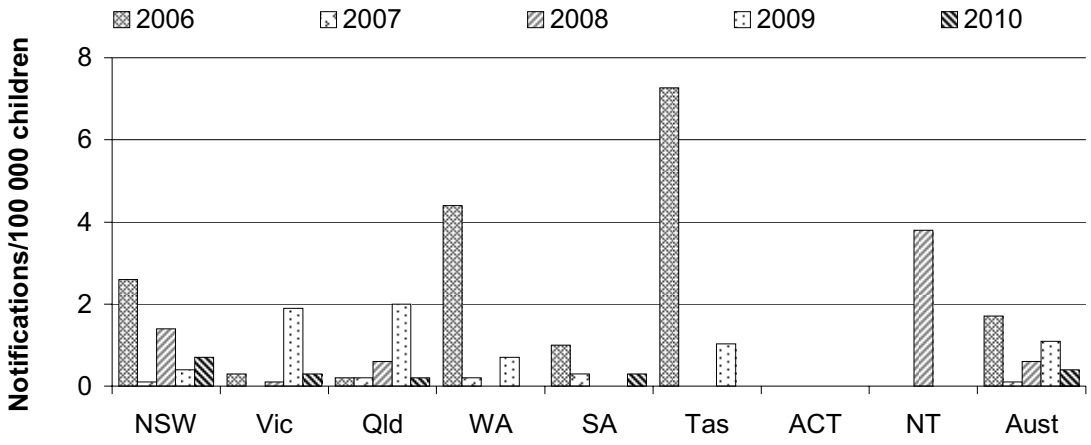
A low or reducing notification rate for the selected diseases indicates greater effectiveness of the immunisation program.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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

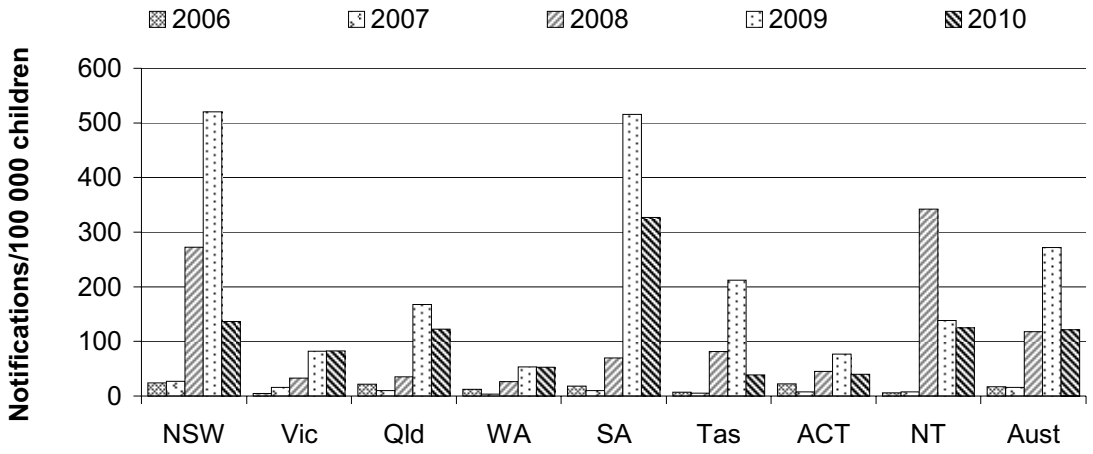


[a] Notifications for 2010 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

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

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

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



[a] Notifications for 2010 are to 31 August.

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

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

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

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

Source: DoHA (unpublished) NNDSS, *ABS Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.55.

Participation rates for women in cervical screening

'Participation rates for women in cervical screening' is an indicator of governments' objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.27).

Box 11.27 **Participation rates for women aged 20–69 years in cervical screening**

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

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

Data for this indicator are comparable.

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

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

providers offer cervical screening tests (pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 60.6 per cent for the 24 month period 1 January 2008 to 31 December 2009 (figure 11.39). For most jurisdictions, participation rates have remained relatively constant since the screening period of 2004 and 2005. Data for Indigenous women for 2004-05 are presented in table 11A.57.

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

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

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

Influenza vaccination coverage for older people

'Influenza vaccination coverage for older people' is an indicator of governments' objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.28).

Box 11.28 **Influenza vaccination coverage for older people**

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

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

Data for this indicator are comparable.

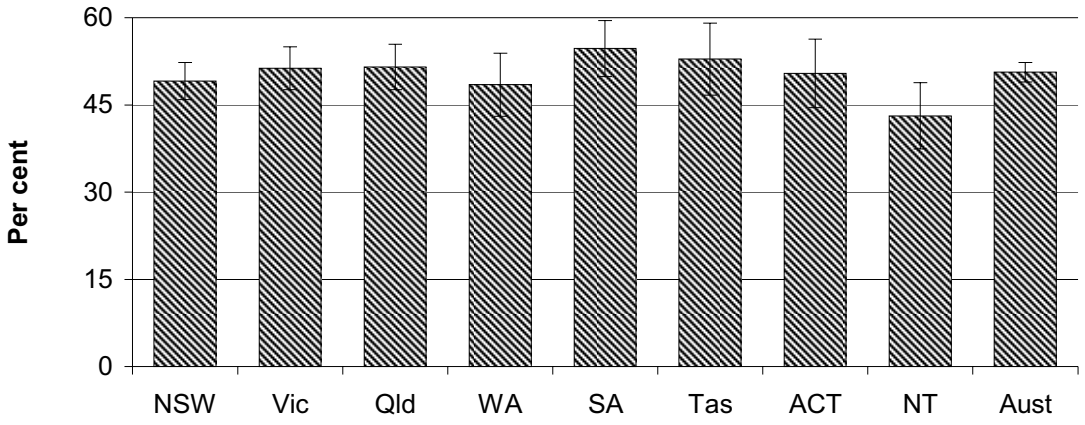
Data quality information for this indicator is under development.

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

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

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

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



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

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

Potentially preventable hospitalisations

Potentially preventable hospitalisations refer to hospital admissions that may be avoided through appropriate management in the primary healthcare sector and/or the broader community (AIHW 2008b, 2009b) (box 11.29).

Box 11.29 **Potentially preventable hospitalisation indicators**

Potentially preventable hospitalisations include hospitalisations for:

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

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

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

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

Three indicators of potentially preventable hospitalisations are presented:

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

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

Data are also reported against two potentially preventable hospitalisations indicators by Indigenous status. Adjustments are made to account for differences in the age structures of these populations across states and territories. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data was of acceptable quality for analytical purposes only for hospitals in Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National e-Health and Information Principal Committee (NEHIPC) has approved NSW and Victorian Indigenous patient data as acceptable in quality for analytical purposes, from the 2004-05 reference year. More recently, the National Health Information Standards and Statistics Committee (a standing committee of NEHIPC) approved reporting of data for Tasmania and the ACT by Indigenous status at the state and territory level for COAG reporting purposes. However, pending further examination of the quality of Indigenous identification for these jurisdictions, these data will not be included in national totals. This decision was taken too late to include most data for Tasmania and the ACT in this chapter for the 2011 Report. Efforts to improve Indigenous identification across states and territories are ongoing.

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

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

'Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions' is an indicator of governments' objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.30).

Box 11.30 **Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions**

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

- Hospitalisations for vaccine preventable conditions, defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions, per 1000 people.
- Hospitalisations for selected acute conditions, defined as the number of hospital separations per 1000 people for the following conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.
- Hospitalisations for selected chronic conditions, defined as the number of hospital separations per 1000 people for the following conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease.

Selected conditions are defined according to the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2010b; DHS 2002).

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

(Continued next page)

Box 11.30 **(continued)**

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

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

Data for this indicator are comparable.

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

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

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

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

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

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

Vaccine preventable hospitalisations

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

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

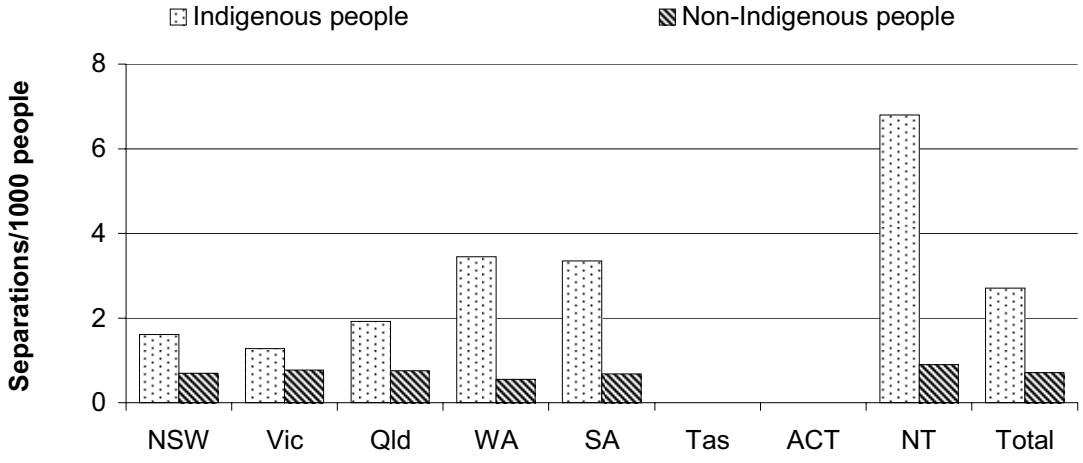
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.5	0.5	0.6	0.5	0.6	0.5	0.4	1.6	0.5
Other conditions	0.2	0.3	0.1	0.2	0.2	0.1	0.1	0.8	0.2
Total[d]	**0.7**	**0.8**	**0.8**	**0.6**	**0.7**	**0.6**	**0.5**	**2.4**	**0.7**

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

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

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

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



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

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

Hospitalisations for selected acute conditions

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

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

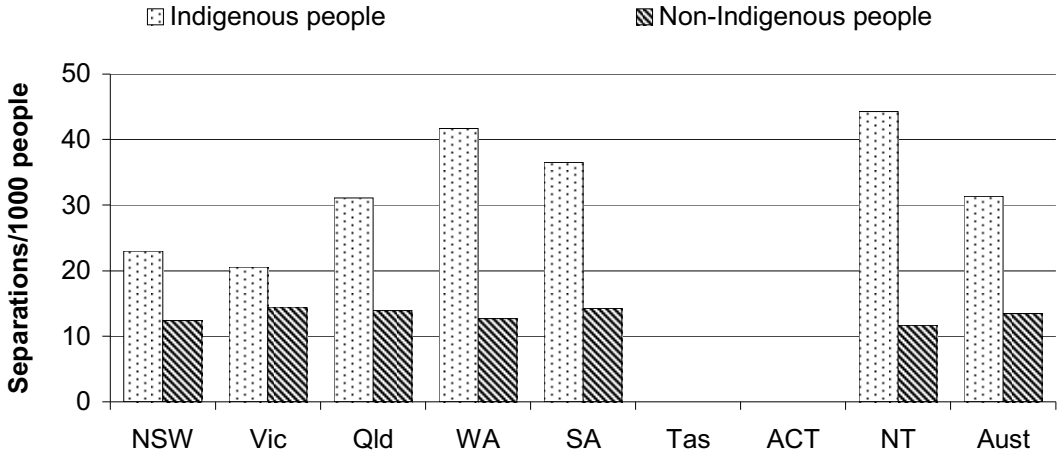
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.6	1.5	1.9	1.5	1.5	1.2	1.3	3.7	1.6
Convulsions and epilepsy	1.5	1.4	1.6	1.3	1.6	1.5	1.4	3.4	1.5
Dehydration and gastroenteritis	2.5	3.5	2.8	2.4	2.8	2.1	2.1	2.6	2.8
Dental conditions	2.3	3.1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

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

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

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

Figure 11.42 Separations for selected acute conditions by Indigenous status, 2008-09[a, b, c, d, e]



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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.64.

Hospitalisations for selected chronic conditions

Of the selected chronic conditions, diabetes complications, chronic obstructive pulmonary disease, congestive cardiac failure, asthma and angina recorded the highest rates of hospitalisation nationally in 2008-09. The hospitalisation rate for diabetes complications was more than four times higher than the rate for any other of the selected conditions except for chronic obstructive pulmonary disease (table 11.12).

Table 11.12 **Separations for selected chronic conditions per 1000 people, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.2	1.4	2.0	1.3	1.4	1.4	1.0	2.3	1.5
Asthma	1.8	1.8	1.5	1.3	2.4	1.2	0.9	1.8	1.7
Chronic obstructive pulmonary disease	2.6	2.6	3.1	2.2	3.0	2.5	2.2	6.7	2.6
Congestive cardiac failure	1.8	2.1	1.9	1.8	1.8	1.5	2.1	2.5	1.9
Diabetes complications	5.7	6.2	9.0	18.5	5.8	4.9	4.8	12.0	7.7
Hypertension	0.3	0.2	0.3	0.2	0.3	0.2	0.3	0.1	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.3	1.2	1.1	0.9	1.2	1.2
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	0.0
Rheumatic heart disease[d]	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.7	0.1
Total[e]	**13.9**	**15.3**	**18.5**	**26.0**	**15.5**	**12.6**	**11.7**	**26.0**	**16.5**

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

Source: AIHW (2010b) *Australian Hospital Statistics 2008-09*, Cat. no. HSE 84; table 11A.65.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.43).

Figure 11.43 **Separations for selected chronic conditions by Indigenous status, 2008-09**[a, b, c, d, e]

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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.65.

Potentially preventable hospitalisations for diabetes

'Potentially preventable hospitalisations for diabetes' is an indicator of governments' objective to reduce hospitalisations due to diabetes through the provision of high quality, appropriate and effective management of diabetes in the primary and community health sector (box 11.31).

Box 11.31 **Potentially preventable hospitalisations for diabetes**

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

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

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

(Continued next page)

Box 11.31 **(continued)**

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

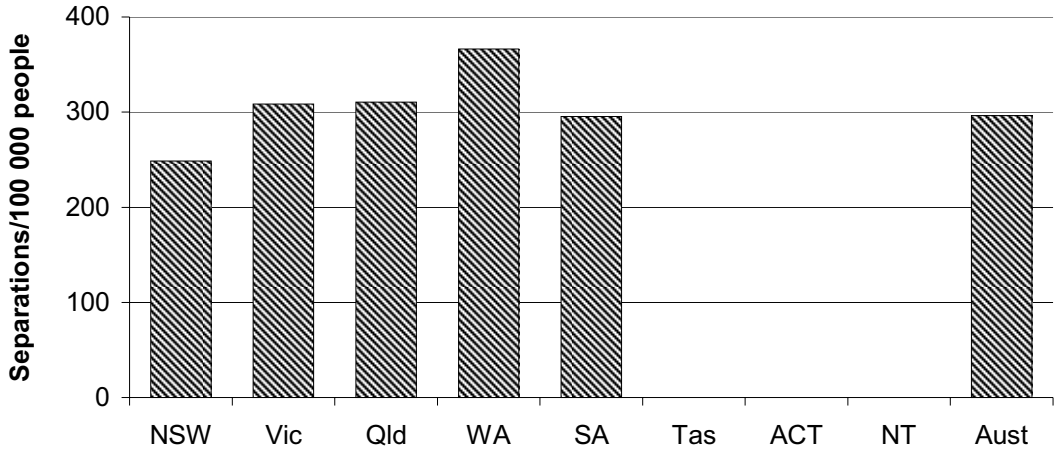
Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, patient compliance with measures to manage diabetes, and the underlying prevalence of diabetes.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the age standardised hospital separation rate in 2008-09 where the principal diagnosis was Type 2 diabetes mellitus was 296.3 separations per 100 000 people (figure 11.44).

Figure 11.44 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2008-09**[a, b, c]



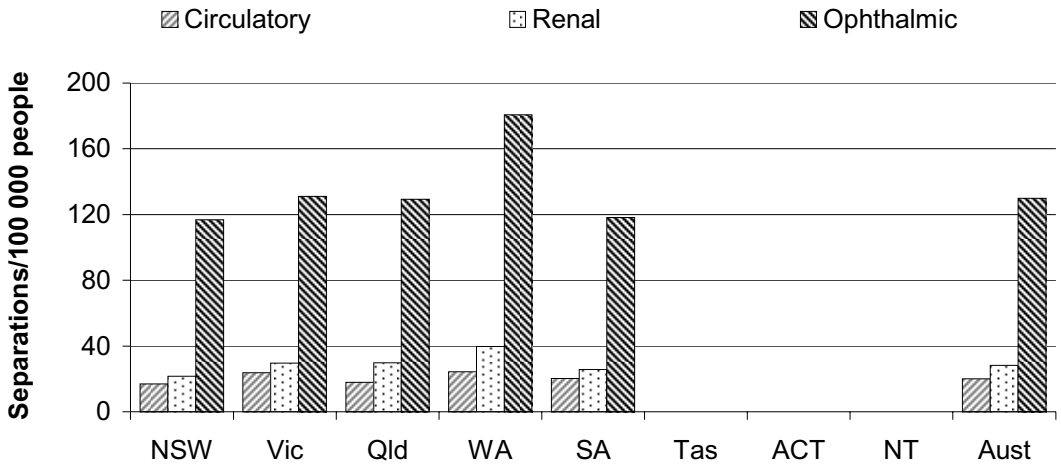
[a] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [b] Morbidity data are coded under coding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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.67.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2008-09 were ophthalmic, renal and circulatory complications.

Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.45). Each patient can have one or more complication(s) (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.45 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2008-09**[a, b, c, d]



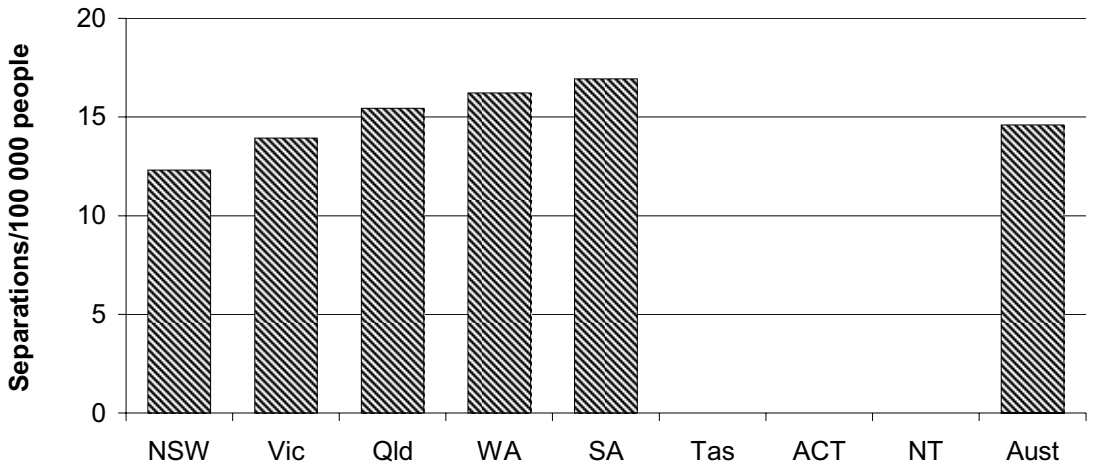
[a] Results for individual complications can be affected by small numbers, and need to be interpreted with care. [b] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.67.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 49.9 per cent of separations for Type 2 diabetes were same day separations in 2008-09 (table 11A.68).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2008-09, there were 14.6 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.46).

Figure 11.46 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2008-09[a, b, c]**



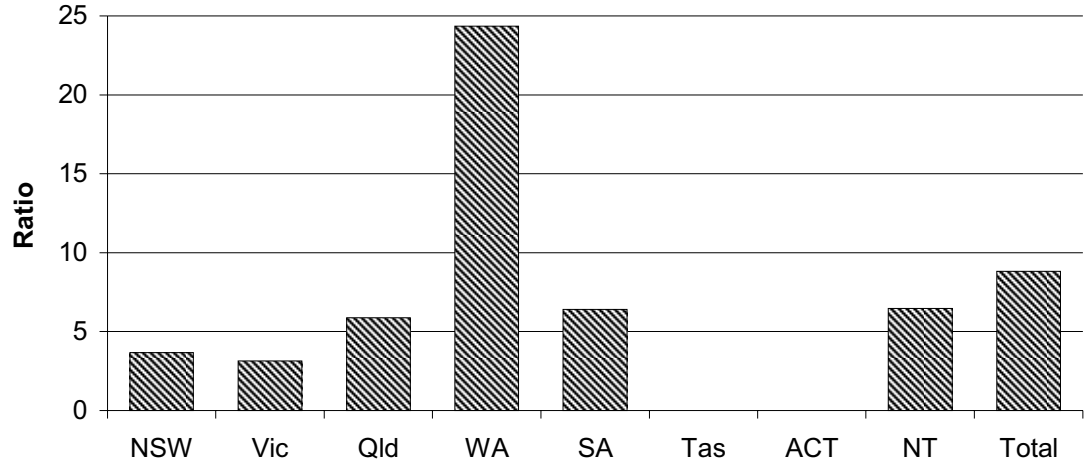
a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.69.

Age standardised hospital separation ratios for all diabetes diagnoses[2] illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. There was a marked difference in 2008-09 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous people was 8.8 times higher than the separation rate for all Australian people (figure 11.47).

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

Figure 11.47 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2008-09**[a, b, c, d, e, f, g]



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

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 11A.66.

Potentially preventable hospitalisations of older people for falls

'Potentially preventable hospitalisations of older people for falls' is an indicator of governments' objective to reduce preventable hospitalisations through the delivery of effective primary and community health services (box 11.32). Effective primary and community healthcare can reduce the likelihood of falls and/or assist in reducing the severity of injury.

Box 11.32 Potentially preventable hospitalisations of older people for falls

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

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

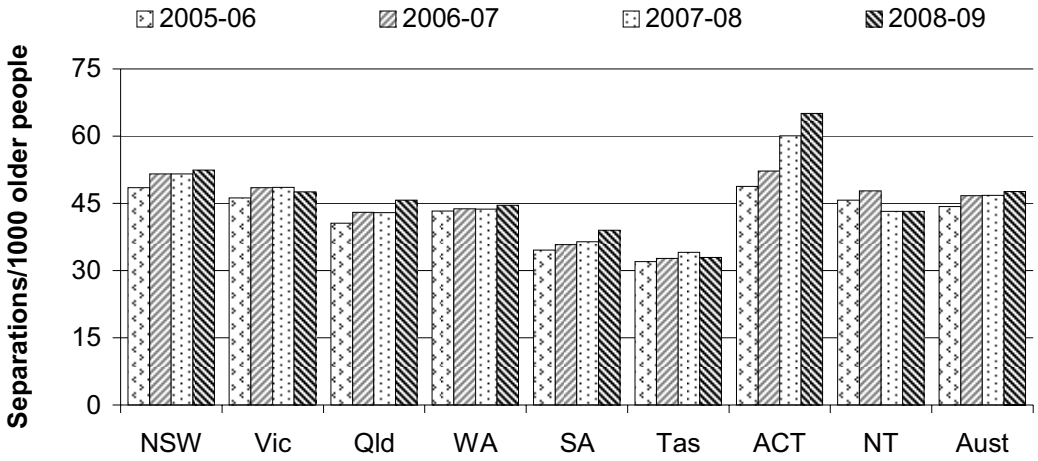
Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In most jurisdictions, age standardised separation rates for older people with injuries due to falls gradually increased in the period 2005-06 to 2008-09 (figure 11.48). Nationally, the separation rate per 1000 older people increased from 44.3 in 2005-06 to 47.7 in 2008-09.

Figure 11.48 Separations for older people with a reported external cause of falls[a, b, c]



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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.70.

11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Priorities for future reporting on primary and community health services include:

- improving the reporting of dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items
- improving the quality of Indigenous data, particularly Indigenous identification and completeness. Indigenous hospitalisation data for Tasmania and the ACT will be included in future reports. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

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

Indigenous health

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

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

COAG developments

Report on Government Services alignment with National Agreement reporting

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

Outcomes from review of Report on Government Services

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

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

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

11.5 Definitions of key terms and indicators

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

Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella vaccines.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (from 1996 vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally recognised GPs.
GP-type services	Non-referred attendances by vocationally recognised GPs and OMPs, and practice nurses.
***Haemophilus influenzae* type b**	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.

Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally recognised, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and GPA ACCREDITATION *plus*), divided by the total number of practices in the DGP.
Proportion of general practices with electronic health information systems	Number of PIP-registered practices that have taken up the eHealth PIP incentive, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.

Triage category	The urgency of the patient's need for medical and nursing care: • category 1 — resuscitation (immediate within seconds) • category 2 — emergency (within 10 minutes) • category 3 — urgent (within 30 minutes) • category 4 — semi-urgent (within 60 minutes) • category 5 — non-urgent (within 120 minutes).
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 List of attachment tables

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

Table 11A.1 Types of encounter, 2009-10

Table 11A.2 Australian Government real expenditure per person on GPs (2009-10 dollars)

Table 11A.3 Medical practitioners billing Medicare and full time workload equivalent GPs

Table 11A.4 GP-type service use

Table 11A.5 PBS services, 2009-10

Table 11A.6 Use of public dental services, by service type, 2008

Table 11A.7 Alcohol and other drug treatment services, by sector, 2008-09 (number)

Table 11A.8 Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, 2008-09 (number)

Table 11A.9 Services and episodes of healthcare by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, by remoteness category, 2008-09 (number)

Table 11A.10 Proportion of Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported that undertook selected health related activities, 2008-09 (per cent)

Table 11A.11 Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, as at 30 June 2009 (number)

Table 11A.12 Approved providers of PBS medicines, by urban and rural location

Table 11A.13 PBS expenditure per person, by urban and rural location (2009-10 dollars)

Table 11A.14 Availability of GPs by region

Table 11A.15 Availability of female GPs

Table 11A.16 Availability of public dentists (per 100 000 people)

Table 11A.17 Availability of public dental therapists (per 100 000 people)

Table 11A.18 Annual health assessments for older people by Indigenous status

Table 11A.19 Older Indigenous people who received an annual health assessment (per 1000 people)

Table 11A.20 Indigenous people who received a health check or assessment, by age (per 1000 people)

Table 11A.21 Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported. 2008-09 (per cent)

Table 11A.22 Proportion of children receiving a fourth year development health check, 2009-10

Table 11A.23 Non-referred attendances that were bulk billed, by region and age (per cent)

Table 11A.24 Non-referred attendances that were bulk billed by age (per cent)

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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

Attachment contents

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Table 11A.1 **Types of encounter, 2009-10 (a)**

	Number	*Per cent of encounters* (b) *(n= 93 862)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=92 352)*	*Per cent of Medicare-paid GP items (n=89 113)*
	no.	%	%	%	%	%
Direct encounters	92 352	98.4	98.1	98.7	100.0	..
MBS/DVA items of service (direct encounters only) (c)	89 201	95.0	94.6	95.5	96.6	..
MBS/DVA items of service (GPs only)	89 113	94.9	94.5	95.4	..	100.0
Short surgery consultations	1 987	2.1	1.8	2.4	..	2.2
Standard surgery consultations	73 075	77.9	76.6	79.1	..	82.0
Long surgery consultations	7 359	7.8	7.3	8.4	..	8.3
Prolonged surgery consultations	419	0.5	0.4	0.5	..	0.5
Home visits	604	0.6	0.5	0.8	..	0.7
Hospital	254	0.3	0.2	0.4	..	0.3
Residential aged care facility	1 128	1.2	0.9	1.5	..	1.3
Health assessments	324	0.4	0.3	0.4	..	0.4
Chronic disease management items	863	0.9	0.8	1.0	..	1.0
Case conferences	13	–	–	–	..	–
GP mental health care items	1 107	1.2	1.0	1.3	..	1.2
Incentive payments	150	0.2	0.1	0.2	..	0.2
Other items	1 829	2.0	1.2	2.7	..	2.1
Workers compensation	1 843	2.0	1.8	2.1	2.0	..
Other paid (hospital, state, etc.)	821	0.9	0.6	1.1	0.9	..

Table 11A.1 **Types of encounter, 2009-10 (a)**

	Number	*Per cent of encounters* (b) *(n= 93 862)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=92 352)*	*Per cent of Medicare-paid GP items (n=89 113)*
Indirect encounters (d)	1 495	1.6	1.3	1.9	..	..
Practice nurse only items (unspecified as direct or indirect)	15	–	–	–	..	..
Missing	7 487	..	..	..	..	..
Total encounters	**93 862**	**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 direct encounters at which either a GP or a practice nurse item (or both) was recorded.

(d) Five 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., O'Halloran, J. and Fahridin, S. 2010, *General practice activity in Australia 2009–10*, Cat. no. GEP 27, General practice series no. 27, AIHW, Canberra.

Table 11A.2 Australian Government real expenditure per person on GPs (2009-10 dollars) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06	295.6	275.2	279.9	236.0	297.3	273.8	203.9	148.8	278.2
2006-07	295.5	271.3	270.7	230.0	288.7	267.2	209.3	147.5	273.9
2007-08	302.1	280.8	277.5	233.7	296.8	276.3	215.2	157.7	281.1
2008-09	293.3	272.4	271.3	221.3	291.8	265.6	207.1	154.1	272.7
2009-10	293.7	275.6	274.8	221.4	295.1	272.7	206.4	163.8	274.8

(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), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP numbers										
2005-06	no.	7 708	5 802	4 793	2 240	1 980	625	381	305	23 834
2006-07	no.	7 855	5 914	4 864	2 310	1 990	642	373	324	24 272
2007-08	no.	7 934	6 062	5 052	2 357	2 099	661	383	355	24 903
2008-09	no.	8 105	6 240	5 340	2 458	2 141	679	385	378	25 726
2009-10	no.	8 389	6 449	5 564	2 492	2 201	704	398	416	26 613
FWE GPs										
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
2009-10	no.	6 893	4 901	3 993	1 615	1 546	417	238	127	19 729
FWE GPs per 100 000 people										
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
2009-10	per 100 000 people	95.1	88.1	88.0	70.0	94.0	82.1	66.5	54.8	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.

(d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: DoHA unpublished, MBS data collection.

Table 11A.4 GP-type service use per 1000 population (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09									
Indigenous status (e)									
Indigenous	6 288.7	6 580.0	5 081.4	4 056.4	6 178.8	5 517.0	5 586.1	3 219.4	5 248.0
Non-Indigenous	5 807.9	5 373.3	5 475.8	4 637.5	5 411.7	4 884.8	4 332.9	3 301.5	5 421.6
Remoteness of residence									
Major cities	6 224.5	5 567.8	5 720.7	4 828.5	5 559.1	..	4 358.0	..	5 714.9
Inner regional	4 803.4	4 911.2	5 394.5	4 634.3	5 072.3	4 942.2	5 520.9	..	4 971.3
Outer regional	4 599.4	4 542.2	4 903.2	4 161.2	5 159.0	4 879.0	..	3 712.9	4 658.8
Remote	5 502.3	5 063.0	4 612.1	3 445.2	4 729.8	4 904.1	..	2 141.5	4 069.9
Very remote	6 585.1	..	3 649.6	2 346.6	4 080.3	5 168.3	..	3 604.1	3 364.8
Total (f)	**5 814.2**	**5 372.8**	**5 474.3**	**4 625.9**	**5 412.6**	**4 911.6**	**4 359.8**	**3 309.4**	**5 416.4**
2009-10									
Indigenous status (e)									
Indigenous	6 524.5	6 895.4	5 485.3	4 498.4	6 524.4	5 992.6	5 400.7	3 869.6	5 627.1
Non-Indigenous	5 904.9	5 502.0	5 665.9	4 698.3	5 558.9	5 155.4	4 466.5	3 404.3	5 548.9
Remoteness of residence									
Major cities	6 291.0	5 687.0	5 936.5	4 891.5	5 709.2	..	4 493.1	..	5 829.0
Inner regional	5 016.5	5 064.7	5 516.5	4 694.0	5 255.7	5 236.0	5 965.8	..	5 143.8
Outer regional	4 702.5	4 716.6	5 148.4	4 230.9	5 281.5	5 138.9	..	3 934.1	4 834.5
Remote	5 599.9	5 049.7	4 833.8	3 504.2	4 906.1	5 081.1	..	2 272.0	4 211.7
Very remote	6 421.3	..	3 838.5	2 813.3	4 412.1	5 281.9	..	4 065.3	3 705.7
Total (f)	**5 916.7**	**5 503.4**	**5 675.2**	**4 701.9**	**5 565.7**	**5 190.9**	**4 494.8**	**3 579.7**	**5 552.2**

(a) Includes non-referred attendances by vocationally recognised GPs and OMPs, and practice nurses.

(b) Rates are age standardised to the Australian population as at 30 June 2001.

Table 11A.4 **GP-type service use per 1000 population (a), (b), (c), (d)**

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

(c) Denominator is the estimated resident population at 30 June.

(d) Disaggregation by State/Territory and remoteness area is based on the patient's postcode at the date their last service was processed in the reference period. This is not necessarily the location where the service was received.

(e) Medicare data presented by Indigenous status have been adjusted for under-identification in the Medicare Australia Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to Medicare Australia. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (50% nationally as at August 2010) varies across age-sex-remoteness-state/territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions.

(f) Total includes persons whose place of residence was not stated or who could not be assigned to a remoteness category.

.. Not applicable.

Source: DoHA unpublished, MBS data collection; ABS unpublished, *Australian demographic statistics*, Cat. no. 3101.0; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Series B, Cat. no. 3238.0, Canberra.

Table 11A.5 **PBS services, 2009-10 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general (b)	000	8 641	6 279	5 203	2 730	1 873	554	557	153	25 990
PBS concessional (c)	'000	53 963	40 521	30 015	12 777	13 828	4 555	1 463	467	157 589
PBS doctor's bag	'000	112	83	74	25	26	7	3	2	332
PBS total	'000	62 716	46 883	35 292	15 532	15 727	5 116	2 024	621	183 912
Proportion of concessional PBS services (b)	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7

(a) Excludes RPBS.

(b) Includes PBS general ordinary and safety net.

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

Source: DoHA unpublished, PBS data collection

Table 11A.6 Use of public dental services, by service type, 2008 (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Dental services per 1000 population (ASR)									
Emergency services	15.9	19.9	30.7	10.0	25.0	25.1	20.4	23.8	20.6
General services	39.6	53.4	92.1	125.6	70.0	101.7	75.1	145.4	68.3
All services	**55.5**	**73.3**	**122.8**	**135.6**	**95.0**	**126.8**	**95.5**	**169.2**	**88.9**
RSE (per cent)									
Emergency services	24.9	21.8	25.8	35.5	30.7	29.3	36.3	31.4	12.4
General services	16.8	15.0	11.3	9.4	16.6	13.5	16.9	11.5	6.0
All services	**13.7**	**12.2**	**10.2**	**8.9**	**14.1**	**12.1**	**14.6**	**10.3**	**5.3**

ASR = Age standardised rate. **RSE** = relative standard error.

(a) Data are for number of people who used a public dental service at least once in the previous 12 months, not for number of services provided.

(b) Type of service at the most recent visit. Emergency visit is a visit for relief of pain. Classification of service type as per Australian Dental Association Schedule of Dental Services.

(c) Rates are age standardised to the Australian population as at 30 June 2001.

(d) Limited to dentate persons aged 5 years or over

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished) Estimated Residential Population, 30 June.

Table 11A.7 Alcohol and other drug treatment services, by sector, 2008-09 (number)

	NSW (a)	*Vic*	*Qld*	*WA* (b)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government	188	–	47	5	39	7	1	4	291
Non-government (c), (d)	62	136	75	39	16	8	9	17	362
Total	**250**	**136**	**122**	**44**	**55**	**15**	**10**	**21**	**653**

(a) Data for NSW under-report the number of service providers.

(b) WA data are not directly comparable with other states and territories or previous years because of an increase in co-location and integration of government and non-government service providers.

(c) Includes agencies funded by DoHA under the Non-Government Organisation Treatment Grants Program.

(d) Includes only agencies that receive public funding.

– Nil or rounded to zero.

Source: AIHW 2010, *Alcohol and Other Drug Treatment Services in Australia 2008-09: report on the National Minimum Data Set,* Cat. no. HSE 92, Drug Treatment Series no. 10, Canberra.

Table 11A.8 Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, 2008-09 (number) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	39	24	31	28	14	10	2	57	205

(a) The OSR 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 OSR 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 OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.

(c) The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data for previous years due to changes in collection methodology.

Source: AIHW unpublished, OSR data collection.

Table 11A.9 Services and episodes of healthcare by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, by remoteness category, 2008-09 (number) (a), (b), (c)

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Total*
Services						
2008-09	26	40	50	29	60	205
Episodes of healthcare						
2008-09	290 000	313 000	539 000	503 000	444 000	2 089 000

(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) Remoteness categories are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing*.

(c) The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data for previous years due to changes in collection methodology.

Source: AIHW unpublished, OSR data collection.

Table 11A.10 Proportion of Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported that undertook selected health related activities, 2008-09 (per cent) (a), (b), (c)

Diagnosis and treatment of illness/disease	85
Management of chronic illness	89
Transportation to medical appointments	86
Outreach clinic services	55
24 hour emergency care	31
Monitoring child growth	64
School-based activities	68
Hearing screening	72
Pneumococcal immunisation	76
Influenza immunisation	82
Child immunisation	81
Women's health group	77
Support for public housing issues	58
Community development work	60
Legal/police/prison/advocacy services	42
Dental services	52
Involvement in steering groups on health	77
Participation in regional planning forums	57
Dialysis services	4

(a) The OSR 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 is the number of services that provided valid data for this question (201). Some services in the OSR 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) The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data for previous years due to changes in collection methodology.

Source: AIHW unpublished, OSR data collection.

Table 11A.11 Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, as at 30 June 2009 (number) (a), (b), (c)

	Indigenous staff	*Non-Indigenous staff*	*Total staff* (d), (e)
Aboriginal health workers	724	21	745
Doctors	16	317	333
Nurses	51	499	550
Specialists	–	5	5
Emergency workers	11	2	13
Counsellors/social workers	46	32	78
Other social and emotional wellbeing staff (f)	252	81	344
Allied health professionals (g)	77	90	181
Dentists	7	31	38
Dental assistants	40	18	58
Traditional healers	7	1	8
Sexual health workers	43	13	56
Substance misuse workers	59	40	99
Environmental health workers	22	5	27
Driver/field officers	196	33	229
Total health staff (d), (e)	**1 551**	**1 188**	**2 764**

(a) The number of services that provide OSR 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 OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.

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

(c) The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data for previous years due to changes in collection methodology.

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

(e) Total includes 36 FTE health staff for whom Indigenous status was not provided.

(f) 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. Total includes 11 FTE staff for whom Indigenous status was not provided.

(g) Total allied health professionals includes 14 FTE staff for whom Indigenous status was not provided.

– Nil or rounded to zero.

Source: AIHW unpublished, OSR data collection.

Table 11A.12 Approved providers of PBS medicines, by urban and rural location (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of people per pharmacy									
Urban									
2005-06	3 667	3 865	3 558	3 479	3 678	3 371	5 287	5 151	3 700
2006-07	3 746	4 153	3 812	3 767	3 851	3 443	5 672	3 714	3 888
2007-08	3 698	4 160	3 807	3 745	3 761	3 413	5 300	4 882	3 863
2008-09	3 690	4 118	3 715	3 770	3 773	3 451	5 214	4 941	3 836
2009-10	3 700	4 082	3 701	3 691	3 725	3 409	5 131	4 681	3 814
Rural									
2005-06	3 984	4 631	4 745	4 597	3 710	3 586	–	12 850	4 376
2006-07	4 250	4 794	4 611	4 237	3 658	3 856	–	15 509	4 446
2007-08	4 341	4 776	4 578	4 347	3 553	3 904	–	11 451	4 436
2008-09	4 232	4 803	4 459	4 255	3 632	3 911	–	9 272	4 367
2009-10	4 172	4 655	4 386	4 305	3 405	3 836	–	9 272	4 277
Number of pharmacies, 2009-10									
Urban	1 447	1 022	832	430	318	81	63	19	4 212
Rural	284	162	185	85	96	52	–	11	876
Number of approved medical practitioners, 2009-10									
Urban	–	–	–	–	–	–	–	–	–
Rural	11	3	8	23	2	5	–	1	53
Number of approved hospitals, 2009-10 (b)									
Urban									
Private	23	26	21	5	4	1	3	1	84
Public	–	53	27	8	8	–	–	1	97
Rural									
Private	–	–	–	–	–	–	–	–	–
Public	–	13	63	–	–	–	–	4	80

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

(b) 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.13 PBS expenditure per person, by urban and rural location (2009-10 dollars) (a), (b)

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*
Capital city	294.8	280.5	285.2	294.9	303.6
Other metro	330.3	317.3	324.1	335.8	346.8
Rural and remote	322.4	307.1	314.5	326.8	337.9
All locations	305.5	291.0	296.6	307.2	316.8

(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.14 **Availability of GPs by region (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
Number of GPs									
Urban									
2005-06	6 327	4 437	2 846	1 651	1 469	317	na	113	17 160
2006-07	6 412	4 508	2 884	1 698	1 463	313	na	116	17 394
2007-08	6 047	4 598	2 978	1 717	1 503	328	383	121	17 675
2008-09	6 184	4 738	3 142	1 797	1 550	340	385	139	18 275
2009-10	6 349	4 896	3 272	1 803	1 568	349	398	142	18 777
Rural									
2005-06	1 762	1 365	1 947	589	511	308	na	192	6 674
2006-07	1 816	1 406	1 980	612	527	329	na	208	6 878
2007-08	1 887	1 464	2 074	640	596	333	..	234	7 228
2008-09	1 921	1 502	2 198	661	591	339	..	239	7 451
2009-10	2 040	1 553	2 292	689	633	355	..	274	7 836
Number of full time workload equivalent GPs									
Urban									
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
2009-10	5 461	3 788	2 459	1 216	1 149	185	238	62	14 558
Rural									
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
2009-10	1 431	1 113	1 534	399	397	232	..	65	5 171
Number of full time workload equivalent GPs per 100 000 people									
Urban									
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
2009-10	99.0	90.3	89.0	71.7	94.5	89.4	66.7	61.8	90.7
Rural									
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
2009-10	82.6	81.5	86.5	65.2	92.8	77.1	..	49.5	81.5

Table 11A.14 **Availability of GPs by region (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*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) GP and FWE data include vocationally recognised GPs and other medical practitioners (OMPs).

(c) 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.

(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) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

(f) 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.15 **Availability of female GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs (d)										
2005-06	no.	2 853	2 168	1 799	828	703	254	183	132	8 920
2006-07	no.	2 958	2 247	1 850	877	718	270	181	151	9 252
2007-08	no.	3 010	2 359	1 955	898	775	277	191	171	9 636
2008-09	no.	3 142	2 446	2 117	987	809	294	192	184	10 171
2009-10	no.	3 323	2 569	2 230	1 016	828	306	192	193	10 657
Female FWEs GPs										
2005-06	no.	1 729	1 158	968	394	335	122	76	34	4 815
2006-07	no.	1 822	1 232	1 010	410	348	125	82	37	5 065
2007-08	no.	1 916	1 312	1 083	426	371	131	85	45	5 369
2008-09	no.	2 003	1 389	1 178	455	401	136	87	48	5 697
2009-10	no.	2 087	1 468	1 232	482	423	142	87	54	5 976
Female FWEs GPs as a proportion of all FWE GPs										
2005-06	%	27.4	27.0	27.7	26.8	23.8	31.5	36.5	34.8	27.3
2006-07	%	28.1	28.0	28.3	27.3	24.6	31.9	36.1	35.4	28.0
2007-08	%	29.0	28.6	29.4	27.6	25.5	32.7	36.4	38.8	28.8
2008-09	%	29.5	29.3	30.5	28.9	26.5	33.7	37.0	41.3	29.6
2009-10	%	30.3	30.0	30.8	29.9	27.4	34.1	36.6	42.7	30.3
Female FWE GPs										
2005-06	per 100 000 females	50.3	44.7	47.2	38.6	42.1	49.0	44.9	33.2	46.2
2006-07	per 100 000 females	52.3	46.7	48.1	39.2	43.3	49.9	47.4	35.4	47.8
2007-08	per 100 000 females	54.4	48.9	50.4	39.7	45.7	52.1	48.6	42.4	49.8
2008-09	per 100 000 females	55.7	50.6	53.2	41.1	48.8	53.3	49.2	44.0	51.7
2009-10	per 100 000 females	57.1	52.4	54.3	42.5	50.9	55.2	48.5	48.7	53.2

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

Table 11A.15 **Availability of female GPs (a), (b), (c), (d)**

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

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

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

(d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: DoHA unpublished, MBS data collection.

Table 11A.16 **Availability of public dentists (per 100 000 people) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (b)	*ACT* (c), (d)	*NT* (e)	*Aust*
FTE dentists per 100 000 population (f)									
2005									
Major cities	7.8	6.5	10.1	8.9	12.6	..	6.4	..	8.3
Inner regional	3.8	3.6	9.2	5.5	5.8	4.4	–	..	5.3
Outer regional	2.5	1.9	7.5	2.2	3.9	0.8	..	7.7	4.3
Remote and very remote	2.4	–	7.5	9.4	4.6	–	..	5.7	6.6
Total	**6.6**	**5.6**	**9.3**	**7.8**	**10.4**	**3.1**	**6.4**	**6.8**	**7.2**
2006									
Major cities	8.1	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**
2008									
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**

(a) National dental labour force data are not available for 2007 or 2008.

Table 11A.16 **Availability of public dentists (per 100 000 people) (a)**

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

(b) There were no major cities in Tasmania.

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

(d) ACT data for 2006 should be treated with caution due to low response rates (33 per cent).

(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.17 **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)									
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**
2008									
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.17 **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 registration is included here but may work prinicipally as a hygenist.

(b) National dental labour force data are not available for 2007 or 2008.

(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.18 **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)
2008-09										
Indigenous older people										
Number of people assessed (g)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (h)	no.	14 130	3 240	11 706	5 821	2 361	1 099	200	5 066	44 353
Proportion of target population assessed	per 1000 people	103.8	81.8	131.9	137.1	59.3	20.9	120.0	196.0	118.4
All older people										
Number of people assessed (i)	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Target population (j)	no.	474 661	347 313	248 638	116 589	124 579	35 713	15 401	7 786	1 376 687
Proportion of target population assessed	per 1000 people	237.7	211.3	258.4	195.5	221.2	266.3	159.3	163.9	228.1
2009-10										
Indigenous older people										
Number of people assessed (g)	no.	1 647	336	2 042	1 012	151	36	46	1 174	6 444
Target population (h)	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion of target population assessed	per 1000 people	111.1	98.5	164.6	165.0	60.9	30.9	208.1	219.9	137.9
All older people										
Number of people assessed (i)	no.	118 120	78 086	67 008	25 411	28 097	9 174	2 763	1 462	330 121
Target population (j)	no.	483 341	354 239	254 052	119 267	126 130	36 385	15 916	8 193	1 403 864
Proportion of target population assessed	per 1000 people	244.4	220.4	263.8	213.1	222.8	252.1	173.6	178.4	235.2

(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.18 **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 data may differ slightly from data in previous reports due to a change in the methodology used to derive population estimates.

(e) Allocation of patients to state or territory is 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) Includes claims for MBS items 704, 706 and 715 for Indigenous people aged 55 years or over.

(h) Projected population of Indigenous people aged 55 years or over at 30 June (B series). Projections are based on estimated resident population (ERP) at 30 June 2006.

(i) Includes claims for MBS items 700, 702, 701, 703, 705 and 707 for people aged 75 years or over.

(j) Estimated resident population aged 75 years or over at 30 June.

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 (2009) *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0, Canberra.

Table 11A.19 **Older Indigenous people who received an annual health assessment (per 1000 people) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
2005-06										
Number of people assessed	no.	798	166	730	395	94	14	2	346	2 545
Target population	no.	12 131	2 785	9 840	5 028	2 110	903	141	4 345	37 934
Proportion of target population assessed	per 1000 people	65.8	59.6	74.2	78.6	44.5	15.5	14.2	79.6	67.1
2006-07										
Number of people assessed	no.	1 001	227	988	468	131	7	15	614	3 451
Target population	no.	12 775	2 924	10 441	5 305	2 171	963	154	4 616	40 027
Proportion of target population assessed	per 1000 people	78.4	77.6	94.6	88.2	60.3	7.3	97.4	133.0	86.2
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	13 460	3 074	11 035	5 517	2 251	1 039	168	4 849	42 096
Proportion of target population assessed	per 1000 people	85.3	89.5	114.3	112.4	56.4	6.7	59.5	176.3	102.2
2008-09										
Number of people assessed	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population	no.	14 130	3 240	11 706	5 821	2 361	1 099	200	5 066	44 353
Proportion of target population assessed	per 1000 people	103.8	81.8	131.9	137.1	59.3	20.9	120.0	196.0	118.4
2009-10										
Number of people assessed	no.	1 647	336	2 042	1 012	151	36	46	1 174	6 444
Target population	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion of target population assessed	per 1000 people	111.1	98.5	164.6	165.0	60.9	30.9	208.1	219.9	137.9

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

Table 11A.19 **Older Indigenous people who received an annual health assessment (per 1000 people) (a), (b), (c), (d), (e), (f)**

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

(b) Includes claims for MBS items 704, 706 and 715 for 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 available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

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

(d) Allocation of patients to state or territory is 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.

(e) Historical rates may differ from rates in previous reports as new ABS Indigenous population estimates and projections have been used following the 2006 Census of Population and Housing.

(f) Target population is the projected target population at 30 June (B series), based on the estimated resident population (ERP) at 30 June 2006.

(g) Includes Other Territories.

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.20 **Indigenous people who received a 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.	4 139	836	5 836	2 396	390	73	62	2 780	16 512
Target population	no.	58 634	12 560	58 038	25 937	10 428	6 767	1 594	22 809	196 840
Proportion assessed	per 1000 children	70.6	66.6	100.6	92.4	37.4	10.8	38.9	121.9	83.9
Adults 15–54 years (e)										
People assessed	no.	9 633	1 981	12 639	6 095	1 101	193	202	8 035	39 879
Target population	no.	88 517	19 937	86 074	42 814	16 878	11 073	2 706	39 327	307 461
Proportion assessed	per 1000 people	108.8	99.4	146.8	142.4	65.2	17.4	74.6	204.3	129.7
Adults 55 years or over (d)										
People assessed	no.	1 647	336	2 042	1 012	151	36	46	1 174	6 444
Target population	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion assessed	per 1000 people	111.1	98.5	164.6	165.0	60.9	30.9	208.1	219.9	137.9

(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 2009-10 financial year. Projected target population at 30 June 2009 (B series), based on the estimated resident population (ERP) at 30 June 2006.

(e) Health checks available for adults 15–54 years on a biennial basis until 30 April 2010. From 1 May 2010 available annually. Data are for the 24 month period 1 July 2008 to 30 June 2010. Projected target population (B series) at 30 June 2009, 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.21 Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, 2008-09 (per cent) (a)

Early detection activities provided	
Well person's checks	80
PAP smears/cervical screening	80
STI screening	73
Hearing screening	72
Eye disease screening	69
Renal disease screening	54
Diabetic screening	78
Cardiovascular screening	66
Any early detection activity	90

(a) The denominator is the number of services that provided valid data for this question (201). Some services in the OSR 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.

Source: AIHW unpublished, OSR data collection.

Table 11A.22 **Proportion of children receiving a fourth year developmental health check, 2009-10 (per cent) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Type of health check									
Aboriginal and Torres Strait Islander Child Health Check (b)	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (c), (d)	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Remoteness of residence									
Major cities (e)	17.7	6.3	26.7	16.4	9.6	..	12.3	..	15.5
Inner regional	29.8	9.4	30.6	14.9	13.9	19.4	..	..	22.3
Outer regional	24.9	6.8	33.3	17.1	11.1	19.6	..	13.8	22.7
Remote/Very remote	45.6	np	25.1	17.1	13.0	10.0	..	46.2	27.0
Total (f)	**20.6**	**6.9**	**28.5**	**16.3**	**10.5**	**19.2**	**12.3**	**29.2**	**17.8**

(a) Patient allocation based on patient postcode at the date their last service was processed in the reference period. This is not necessarily the location where the service was received. Data are for number of patients receiving a health assessment/check rather than number of health assessments/ checks provided.

(b) Includes claims for Medicare Benefits Schedule (MBS) Item 708 (Aboriginal and Torres Strait Islander Child Health Check) and Item 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) for children aged three to five years.

(c) Includes claims for MBS items 709 and 711 (Healthy Kids Check) and items 701, 703, 705, 707 and 10986 (Health Assessment) for children aged three to five years. The MBS items included in this indicator measure do not cover all developmental health check activity such as that conducted through State and Territory early childhood health assessments in preschools and community health centres.

(d) Note this includes Indigenous children who have received a Healthy Kids Check.

(e) ACT Major cities includes a small number of children living in Inner regional ACT.

(f) Total includes persons whose place of residence was not stated or who could not be assigned to a remoteness category.

.. Not applicable. **np** Not published.

Source: DoHA unpublished, MBS data collection; ABS unpublished, *Australian demographic statistics*, Cat. no. 3101.0, Canberra; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, B series, Cat. no. 3238.0, Canberra.

Table 11A.23 **Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
2005-06								
0–15 years	85.4	79.3	76.0	79.1	79.7	76.2	86.3	83.4
16–64 years	72.5	68.3	61.2	63.0	62.8	60.9	73.0	69.8
65 years or over	88.6	84.6	81.3	83.8	83.5	86.0	87.8	86.7
All ages	78.3	74.4	68.9	71.6	71.4	67.5	78.4	76.2
2006-07								
0–15 years	86.9	82.1	79.1	82.2	82.4	80.3	87.8	85.4
16–64 years	74.3	71.0	63.9	66.1	65.5	63.0	74.5	71.9
65 years or over	89.4	86.2	83.1	85.6	85.3	87.7	89.4	87.8
All ages	79.8	76.9	71.5	74.3	73.8	70.1	79.9	78.0
2007-08								
0–15 years	87.6	83.3	80.8	84.8	84.6	81.4	89.2	86.4
16–64 years	75.4	72.7	66.1	68.9	67.9	65.0	76.8	73.4
65 years or over	89.7	87.3	84.6	87.3	86.7	87.8	90.9	88.6
All ages	80.7	78.3	73.4	76.7	76.0	71.6	82.0	79.2
2008-09								
0–15 years	88.2	84.7	83.2	87.3	86.1	81.7	89.8	87.3
16–64 years	75.7	73.8	67.1	71.2	68.6	63.8	77.4	73.9
65 years or over	90.2	88.0	85.9	88.6	87.8	87.9	91.8	89.2
All ages	81.1	79.4	74.7	78.8	77.0	70.9	82.6	79.9
2009-10								
0–15 years	88.8	86.4	85.1	88.7	87.0	84.0	91.3	88.2
16–64 years	75.5	75.5	67.8	73.1	69.8	65.5	78.9	74.3
65 years or over	90.4	89.3	87.2	89.7	88.8	88.0	92.1	89.8
All ages	81.3	81.1	76.0	80.5	78.3	72.5	83.9	80.5

(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

(c) Patient age at date of service.

(d) Allocation to state/territory based on patients' Medicare enrolment postcode.

Source: DoHA unpublished, MBS data collection.

Table 11A.24 Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
0–15 years	87.1	78.2	83.3	86.6	86.0	78.6	52.9	69.7	83.4
16–64 years	78.2	67.5	66.6	60.6	65.9	61.2	35.7	57.8	69.8
65 years or over	87.5	85.8	86.3	89.4	87.8	83.6	64.9	86.1	86.7
All ages	81.9	73.8	74.2	71.8	74.9	69.6	44.2	63.0	76.2
2006-07									
0–15 years	88.5	80.4	85.4	88.4	88.1	81.7	62.7	69.6	85.4
16–64 years	80.0	69.7	68.7	62.0	68.6	63.9	44.2	59.0	71.9
65 years or over	88.7	86.7	87.5	90.0	89.0	85.4	68.6	86.6	87.8
All ages	83.5	75.7	76.1	73.0	77.1	72.2	51.9	64.0	78.0
2007-08									
0–15 years	89.2	81.7	86.5	90.0	89.6	84.2	62.2	70.7	86.4
16–64 years	81.2	71.4	70.5	62.3	71.0	66.5	46.2	61.0	73.4
65 years or over	89.5	87.3	88.2	90.4	90.0	86.7	69.2	87.6	88.6
All ages	84.5	77.0	77.5	73.9	79.0	74.5	53.2	65.7	79.2
2008-09									
0–15 years	89.9	82.9	87.8	90.7	90.7	85.6	62.2	68.1	87.3
16–64 years	81.7	72.4	71.4	61.6	72.1	66.2	46.0	60.0	73.9
65 years or over	90.1	87.9	89.1	90.9	90.8	87.1	68.3	88.0	89.2
All ages	85.1	77.9	78.5	73.7	80.1	74.8	53.0	64.7	79.9
2009-10									
0–15 years	90.4	83.8	89.3	90.5	91.4	87.2	64.4	72.9	88.2
16–64 years	81.0	73.6	73.4	61.7	70.5	67.7	40.5	64.3	74.3
65 years or over	90.6	88.6	90.1	91.3	91.3	88.1	67.7	89.7	89.8
All ages	85.0	79.0	80.3	73.9	79.7	76.3	49.9	68.9	80.5

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

(b) Patient age at date of service.

(c) Allocation to state/territory based on patients' Medicare enrolment postcode.

Source: DoHA unpublished, MBS data collection.

Table 11A.25 Waiting time for GPs for an urgent appointment, 2009 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Within four hours										
Proportion of people	%	64.4	61.9	65.1	49.2	56.7	51.8	55.7	41.1	61.1
RSE	%	4.6	6.3	5.8	10.7	10.2	15.7	24.4	29.5	2.9
95 per cent confidence interval	%	± 5.8	± 7.7	± 7.4	± 10.4	± 11.3	± 16.0	± 26.7	± 23.7	± 3.5
Four to 24 hours										
Proportion of people	%	20.6	26.4	23.4	29.0	32.7	35.1	22.1	39.7	24.9
RSE	%	17.4	11.1	12.1	19.3	18.2	22.7	36.2	31.7	6.7
95 per cent confidence interval	%	± 7.0	± 5.8	± 5.5	± 11.0	± 11.6	± 15.6	± 15.7	± 24.7	± 3.2
More than 24 hours										
Proportion of people	%	15.0	11.7	11.5	21.8	10.6	13.1	22.2	19.2	14.0
RSE	%	16.1	20.0	21.7	22.6	18.4	35.6	43.4	53.2	9.1
95 per cent confidence interval	%	± 4.7	± 4.6	± 4.9	± 9.7	± 3.8	± 9.1	± 18.9	± 20.0	± 2.5

RSE = relative standard error.

(a) Time waited between making an appointment and seeing the GP for urgent medical care. 'Urgent' as defined by respondent.

(b) Persons aged 15 years or over who saw a GP for urgent medical care for their own health in the last 12 months.

(c) Rates are age-standardised to the 2001 estimated resident population.

(d) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, Patient Experience Survey 2009.

Table 11A.26 **Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment, 2009 (per cent) (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of people	%	18.5	16.2	14.0	25.9	17.1	19.4	22.0	16.9	17.8
Relative standard error	%	8.7	10.4	9.1	8.4	11.0	11.8	14.1	23.5	4.5
95 per cent confidence interval	%	± 3.2	± 3.3	± 2.5	± 4.3	± 3.7	± 4.5	± 6.1	± 7.8	± 1.6

(a) Persons aged 15 years or over who saw a GP in the previous 12 months.

(b) Rates are age standardised to the 2001 estimated resident population.

Source: ABS 2010, *Patient Experience Survey*

Table 11A.27 **People deferring access to GPs or prescribed medication due to cost, 2009 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
People delaying or not seeing a GP (d)										
Proportion	%	4.9	6.2	8.5	7.9	5.1	5.0	8.3	7.0	6.4
RSE	%	12.5	13.3	11.6	8.6	20.4	27.8	28.1	26.4	5.8
95 per cent confidence interval	%	± 1.2	± 1.6	± 1.9	± 1.3	± 2.0	± 2.7	± 4.5	± 3.6	± 0.7
People delaying or not getting a prescription (e)										
Proportion	%	9.7	8.6	11.2	11.0	10.5	6.8	3.6	9.3	9.7
RSE	%	13.6	11.3	13.0	14.5	18.2	37.3	41.4	31.4	7.2
95 per cent confidence interval	%	± 2.6	± 1.9	± 2.8	± 3.1	± 3.7	± 5.0	± 2.9	± 5.7	± 1.4

RSE = Relative standard error

(a) People who delayed using or did not use service at any time in the last 12 months due to cost.

(b) Rates are age standardised to the 2001 estimated resident population.

(c) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.

(d) People aged 15 years or over.

(e) People aged 15 years or over who received a prescription for medication in the last 12 months.

Source: ABS unpublished, Patient Experience Survey 2009.

Table 11A.28 **Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2009-10 (number) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009-10									
Indigenous status (d)									
Indigenous	24 517	6 777	23 151	8 529	2 302	1 759	950	11 490	79 475
Other Australians	653 205	544 132	348 211	198 922	114 696	46 078	45 232	24 386	1 974 862
Remoteness of residence (e)									
Major cities	470 016	374 989	218 051	143 138	109 194	. .	46 082	. .	1 361 470
Inner regional	188 020	151 287	92 331	41 250	4 697	28 179	47	. .	505 811
Outer regional	16 880	24 418	40 296	15 031	1 751	19 232	. .	19 977	137 585
Remote	1 128	205	18 700	1 597	515	348	. .	11 384	33 877
Very remote	126	. .	1 974	838	824	72	. .	4 436	8 270
Total (f)	**677 722**	**550 909**	**371 362**	**207 451**	**116 998**	**47 837**	**46 182**	**35 876**	**2 054 337**

(a) GP-type emergency department presentations were defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not admitted to the hospital, or referred to another hospital, or died.

(b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.

(c) Limited to peer group A and B public hospitals.

(d) The quality of the data reported for Indigenous status in emergency departments has not been formally assessed for completeness; therefore, caution should be exercised when interpreting these data.

(e) Remoteness areas are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT. Disaggregation by remoteness area is by usual residence of the patient.

(f) Total includes separations for which a remoteness area could not be assigned as the place of residence was unknown or not stated.

.. Not applicable.

Source: AIHW unpublished, National Non-admitted Emergency Department Care Database.

Table 11A.29 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	648 869	542 019	380 888	193 323	112 492	43 957	44 664	34 696	2 000 908
2009-10	677 722	550 909	371 362	207 451	116 998	47 837	46 182	35 876	2 054 337

(a) GP-type emergency department presentations were defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not admitted to the hospital, or referred to another hospital, or died.

(b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.

(c) Limited to peer group A and B public hospitals.

Source: AIHW unpublished, National Non-admitted Emergency Department Care Database.

Table 11A.30 **Emergency department presentations, 2009-10 (number) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Peer group A									
Triage category 4	511 880	417 975	346 469	144 432	116 397	37 007	43 346	44 172	1 661 678
Triage category 5	171 278	80 368	46 543	14 702	23 951	6 745	12 535	3 021	359 143
Peer group B									
Triage category 4	202 442	165 952	62 046	87 338	15 379	13 187	394	222	546 960
Triage category 5	52 540	66 126	18 380	11 956	3 083	4 112	127	105	156 429
Total	**938 140**	**730 421**	**473 438**	**258 428**	**158 810**	**61 051**	**56 402**	**47 520**	**2 724 210**

(a) GP-type emergency department presentations were defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not admitted to the hospital, or referred to another hospital, or died.

(b) Includes all triage category 4 and 5 emergency department presentations.

(c) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.

(d) Limited to peer group A and B public hospitals.

Source: AIHW unpublished, National Non-admitted Emergency Department Care Database.

Table 11A.31 **Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent) (a), (b), (c), (d)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
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
2009-10	92.6	89.6	87.1	80.2	83.3	68.9	69.6	89.7

(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) 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. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

(d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: DoHA unpublished, MBS data collection.

Table 11A.32 Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
FWE GPs with vocational registration										
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
2009-10	no.	6 346	4 402	3 389	1 455	1 403	385	224	94	17 699
Proportion of FWE GPs with vocational registration										
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
2009-10	%	92.1	89.8	84.9	90.1	90.7	92.2	94.2	74.1	89.7

(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 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.

(c) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: DoHA unpublished, MBS data collection.

Table 11A.33 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 (b)										
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 (b)										
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.33 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General practices	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 (b)										
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
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
GPA Accreditation *plus*	no.	329	284	197	86	44	32	19	3	994
Total	**no.**	**1 675**	**1 167**	**950**	**416**	**374**	**130**	**59**	**41**	**4 812**
General practices (c)	no.	2 731	1691	1 266	569	525	158	91	120	7 151
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
GPA Accreditation *plus*	no.	343	291	214	89	44	32	19	4	1 036

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

(c) Preliminary data for the total number of practices, collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June 2010". 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.

Source: AGPAL (Australian General Practice Accreditation Limited) unpublished; GPA Accreditation *plus* unpublished; PHCRIS, DoHA unpublished, ASD (various years).

Table 11A.34 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)										
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
2008-09	%	78.5	85.3	82.6	83.7	84.4	88.7	83.4	56.9	82.1
Proportion of services provided by PIP practices (b)										
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
2008-09	%	76.9	84.3	83.0	84.0	84.6	88.4	83.5	59.5	81.4

(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.35 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06										
All people										
Scripts	no.	2 241 894	1 726 357	1 303 139	511 127	522 930	170 047	64 330	20 609	6 560 433
Population	no.	6 786 435	5 085 505	4 043 814	2 037 272	1 559 372	488 495	332 380	208 407	20 544 064
Rate	per 1000 people	330.3	339.5	322.3	250.9	335.3	348.1	193.5	98.9	319.3
Concession card holders										
Scripts	no.	2 077 402	1 609 556	1 204 165	475 167	489 858	157 536	56 728	19 364	6 089 776
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	1 291.4	1 280.1	1 288.9	1 099.6	1 142.6	1 062.9	1 148.4	414.5	1 238.7
2006-07										
All people										
Scripts	no.	2 238 517	1 667 675	1 262 803	453 933	478 960	156 862	63 208	19 479	6 341 437
Population	no.	6 854 848	5 165 404	4 132 015	2 080 966	1 575 714	491 666	336 444	212 551	20 851 997
Rate	per 1000 people	326.6	322.9	305.6	218.1	304.0	319.0	187.9	91.6	304.1
Concession card holders										
Scripts	no.	2 094 059	1 565 747	1 173 830	424 053	450 880	145 928	56 164	18 513	5 929 174
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	1 285.2	1 220.8	1 257.6	1 009.7	1 043.5	979.6	1 156.3	398.6	1 197.5
2007-08										
All people										
Scripts	no.	2 348 914	1 758 425	1 343 951	455 865	493 842	165 831	65 874	20 122	6 652 824
Population	no.	6 926 990	5 246 079	4 228 290	2 130 797	1 591 930	495 772	340 818	217 559	21 180 632
Rate	per 1000 people	339.1	335.2	317.8	213.9	310.2	334.5	193.3	92.5	314.1

Table 11A.35 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Concession card holders										
Scripts	no.	2 205 326	1 659 769	1 253 684	425 233	466 324	155 078	58 827	19 128	6 243 369
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	1 351.4	1 293.4	1 355.9	1 023.8	1 079.5	1 048.8	1 215.7	424.6	1 264.7
2008-09										
All people										
Scripts	no.	2 454 836	1 868 691	1 417 699	477 244	537 433	172 202	66 287	20 327	7 014 719
Population	no.	7 041 393	5 364 796	4 349 529	2 204 040	1 612 002	500 278	347 843	221 682	21 643 987
Rate	per 1000 people	348.6	348.3	325.9	216.5	333.4	344.2	190.6	91.7	324.1
Concession card holders										
Scripts	no.	2 300 175	1 763 205	1 320 390	444 338	507 069	160 526	58 981	19 142	6 573 826
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	1 334.4	1 293.0	1 324.4	1 002.8	1 129.1	1 048.6	1 161.1	421.5	1 255.8
2009-10										
All people										
Scripts	no.	2 317 714	1 786 016	1 339 854	454 281	538 554	166 427	65 337	19 892	6 688 075
Population	no.	7 191 505	5 496 408	4 472 957	2 270 276	1 633 853	505 377	354 892	227 716	22 155 429
Rate	per 1000 people	322.3	324.9	299.5	200.1	329.6	329.3	184.1	87.4	301.9
Concession card holders										
Scripts	no.	2 187 899	1 697 904	1 257 889	426 460	512 394	156 175	58 960	18 865	6 316 546
Concession card holders	no.	1 772 335	1 396 751	1 041 249	456 175	457 481	156 888	52 263	46 588	5 389 025
Rate	per 1000 holders	1 234.5	1 215.6	1 208.1	934.9	1 120.0	995.5	1 128.1	404.9	1 172.1

Table 11A.35 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs (a), (b), (c)**

	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.

(b) Data include prescriptions ordered by vocationally recognised GPs and other medical practitioners (OMPs) and dispensed to patients.

(c) Estimated residential population at 31 December.

(d) Data are presented for all people for the first time. Data for concession card holders may differ from previous Reports, which included prescriptions ordered by other medical practitioners.

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

Source : DoHA unpublished, PBS data collection; ABS (Australian Bureau of Statistics) 2010, *Australian Demographic Statistics, December 2009* , Cat. no. 3101.0, Canberra.

Table 11A.36 Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09									
Major cities	15.7	20.4	17.4	18.4	20.0	..	14.2	..	17.8
Inner regional	25.5	23.3	20.6	18.0	26.3	21.1	np	..	23.1
Outer regional	20.9	19.0	20.2	18.6	29.0	24.5	..	11.6	21.0
Remote	17.5	27.3	12.9	6.4	27.4	15.4	..	10.3	14.4
Very remote	20.2	..	2.5	6.9	10.4	15.2	..	13.5	8.1
Total (g)	**18.1**	**20.9**	**18.2**	**17.7**	**22.1**	**22.1**	**14.1**	**11.7**	**19.1**
2009-10									
Major cities	15.1	18.6	16.5	17.6	19.1	..	14.1	..	16.8
Inner regional	24.2	21.7	19.7	16.3	25.6	20.7	np	..	21.9
Outer regional	20.6	17.0	19.3	20.2	26.8	22.8	..	12.0	20.2
Remote	16.6	24.1	11.5	6.2	27.6	13.8	..	11.3	13.9
Very remote	11.4	..	3.8	8.9	8.4	17.2	..	13.9	8.7
Total (g)	**17.4**	**19.2**	**17.4**	**17.1**	**21.1**	**21.3**	**14.0**	**12.4**	**18.1**

(a) Data do not account for GPs who provide the annual cycle of care but do not claim the MBS item.

(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) Denominator data (estimated number of people with diabetes) are from the National Diabetes Services Scheme (NDSS). NDSS registration is voluntary; the NDSS is estimated to cover 80 per cent to 90 per cent of people with diagnosed diabetes. Historical data may vary from previous reports for which denominator data were estimated using NHS prevalence data.

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing*. The accuracy of the classifications decreases over time due to changes in demographics within postcode boundaries in the intercensal periods. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Excludes records where postcode was invalid or did not map to a remoteness area, except for totals.

(f) Historical data may differ from previous Reports due to changed methodology associated with a change in data provider. Data reported here are not comparable with data in previous Reports.

(g) Total includes persons whose place of residence was not stated or who could not be assigned to a remoteness category.

.. Not applicable. **np** Not published.

Source: DoHA unpublished, MBS data collection; DoHA unpublished, NDSS database.

Table 11A.37 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2001										
0–14 years										
Proportion	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np	24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np	7.7
CI	%	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	np	± 3.7
15–64 years										
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	np	15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	np	6.5
CI	%	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	np	± 1.9
65 years or over										
Proportion	%	14.6	7.7	11.8	np	19.0	np	23.8	np	12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	np	22.1
CI	%	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	np	± 5.2
All ages (crude rates)										
Proportion	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	np	17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	np	5.3
CI	%	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	np	± 1.8
2004-05										
0–14 years										
Proportion	%	33.6	52.5	29.9	np	39.2	21.9	np	np	36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	np	9.6
CI	%	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	np	± 6.9
15–64 years										
Proportion	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	np	19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	np	6.9
CI	%	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	np	± 2.7
65 years or over										
Proportion	%	17.1	7.6	18.5	np	20.6	19.7	np	np	14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	np	17.5
CI	%	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	np	± 4.9
All ages (crude rates)										
Proportion	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	np	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	np	6.0
CI	%	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	np	± 2.7
2007-08										
0–14 years										
Proportion	%	46.5	61.6	41.4	29.0	56.1	41.6	47.3	np	47.8
RSE	%	16.3	9.8	17.1	28.1	17.1	20.6	17.1	np	7.6
CI	%	± 14.9	± 11.8	± 13.9	± 16.0	± 18.8	± 16.8	± 15.9	np	± 7.1

Table 11A.37 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
15–24 years										
Proportion	%	11.9	9.3	14.7	np	7.4	9.6	35.0	np	12.6
RSE	%	47.1	47.0	37.8	np	53.2	69.2	29.0	np	19.5
CI	%	± 11.0	± 8.6	± 10.9	np	± 7.7	13.0	± 19.9	np	± 4.8
25–44 years										
Proportion	%	13.8	6.1	14.1	17.0	8.1	11.8	11.3	np	11.5
RSE	%	27.3	35.6	32.6	36.7	35.9	36.8	26.4	np	15.7
CI	%	± 7.4	± 4.3	± 9.0	± 12.2	± 5.7	± 8.5	± 5.8	np	± 3.5
45–64 years										
Proportion	%	14.1	21.9	16.2	11.3	np	9.3	12.5	np	16.5
RSE	%	27.7	26.7	28.4	42.3	np	49.7	43.1	np	14.2
CI	%	± 7.7	± 11.5	± 9.0	± 9.4	np	± 9.1	± 10.6	np	± 4.6
65 years or over										
Proportion	%	20.0	18.8	13.9	np	np	12.1	15.1	np	17.9
RSE	%	26.0	33.9	35.3	np	np	47.9	53.2	np	15.9
CI	%	± 10.2	± 12.5	± 9.6	np	np	± 11.4	± 15.7	np	± 5.6
All ages (ASR) (c)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
CI	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

ASR = age standardised rate. **RSE** = relative standard error. **CI** = confidence interval.

(a) Separate estimates for the NT are not available for the 2001 or 2004-05 surveys, and are available only for 'all ages' for the 2007-08 survey. However, NT data are included in national estimates.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published. However, these data contribute to national estimates.

(c) For 'all ages', 2007-08 data are age standardised to the Australian population at 30 June 2001. These data differ from previous reports which reported crude rates.

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.38 Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
CI	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
CI	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
CI	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
CI	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (e)										
Proportion	%	na	na	na	na	na	na	na	na	na
RSE	%	na	na	na	na	na	na	na	na	na
CI	%	na	na	na	na	na	na	na	na	na
Total										
Proportion	**%**	**20.4**	**22.9**	**19.7**	**17.4**	**21.9**	**17.1**	**21.8**	**40.9**	**20.8**
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
CI	%	± 4.5	± 4.9	± 4.4	± 6	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

RSE = relative standard error. **CI** = confidence interval

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

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

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 Census of population and housing. The accuracy of the classifications decreases over time due to changes in demographics within postcode boundaries in the intercensal periods. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Very remote data were not collected in the 2007-08 National Health Survey.

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

Source: ABS unpublished, *National Health Survey, 2007-08.*

Table 11A.39 Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
CI	%	± 9.2	± 19.1	± 9.8	± 4.9	± 9.6	± 17.8	± 16.0	± 3.1	± 3.9
Non-Indigenous people										
Proportion	%	23.6	26.3	20.5	15.8	21.9	17.5	28.3	–	22.5
RSE	%	11.8	9.2	10.7	15.8	10.2	12.6	15.6	–	5.4
CI	%	± 5.5	± 4.8	± 4.3	± 4.9	± 4.4	± 4.3	± 8.6	–	± 2.4

RSE = relative standard error. **CI** = confidence interval

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.

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

– Nil or rounded to zero.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey*, 2004-05; ABS unpublished, *National Health Survey*, 2004-05.

Table 11A.40 Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), and claimed through Medicare, real benefits paid (2009-10 dollars) and number of tests (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06										
Benefits paid										
Benefits paid	$m	463.9	315.1	319.1	128.1	96.4	29.3	20.9	12.0	1 384.7
Per person	$	67.9	62.0	78.9	62.6	62.2	59.9	63.7	57.9	67.3
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	469.8	326.2	310.2	129.9	98.7	28.7	22.2	11.7	1 397.6
Per person	$	68.3	62.7	74.3	61.8	62.4	58.4	65.7	54.6	66.6
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	475.1	335.7	314.9	130.3	101.2	29.1	22.7	11.5	1 408.9
Per person	$	68.2	63.5	73.6	60.5	63.2	58.4	65.9	52.4	66.0
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	472.7	333.9	315.0	129.9	99.4	29.3	22.7	11.9	1 414.9
Per person	$	66.7	61.6	71.6	58.1	61.3	58.4	64.6	53.2	64.8
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
2009-10										
Benefits paid (e)										
Benefits paid	$m	461.4	329.7	290.8	125.9	101.4	29.1	21.1	12.1	1 371.5
Per person	$	63.7	59.3	64.1	54.5	61.7	57.3	58.9	52.2	61.2
Tests										
Number of tests	'000	25 774	18 690	15 935	7 164	6 055	1 693	1 128	671	77 110
Tests per person	no.	3.6	3.4	3.5	3.1	3.7	3.3	3.1	2.9	3.4

Table 11A.40 Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), and claimed through Medicare, real benefits paid (2009-10 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 pathology tests and benefits paid on tests.

(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 (PEI) Items.

(e) From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced . This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.

Source: DoHA unpublished, MBS and DVA data collections.

Table 11A.41 Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs) and claimed through Medicare, real benefits paid (2009-10 dollars) and number of referrals (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06										
Benefits paid										
Benefits paid	$m	418.2	262.5	221.0	101.8	74.1	23.1	15.7	4.5	1120.8
Per person	$	61.2	51.7	54.7	49.8	47.8	47.2	47.8	22.0	54.5
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	425.0	265.1	221.9	99.1	74.0	22.9	16.0	4.7	1128.9
Per person	$	61.7	50.9	53.2	47.2	46.9	45.7	47.2	22.0	53.7
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										
Be ABS unpublished,	$m	426.8	268.7	225.9	98.0	74.7	23.6	16.3	4.7	1134.0
Per person	$	61.3	50.8	52.8	45.5	46.7	47.5	47.1	21.3	53.1
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	426.0	265.8	231.8	98.4	77.1	23.6	15.7	4.7	1143.0
Per person	$	60.2	49.1	52.7	44.0	47.5	46.9	44.8	20.9	52.3
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
2009-10										
Benefits paid										
Benefits paid	$m	453.1	281.9	249.7	104.1	81.9	25.2	15.8	5.3	1217.1
Per person	$	62.5	50.7	55.0	45.1	49.8	49.5	44.1	23.1	54.3
Referrals										
Number of referrals	'000	4 087	2 691	2 324	982	798	240	143	4 087	11 320
Referrals per person	no.	0.56	0.48	0.51	0.43	0.49	0.47	0.40	0.23	0.51

Table 11A.41 Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs) and claimed through Medicare, real benefits paid (2009-10 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 of 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.42 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2007)	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
PIP practices (May 2008)	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)	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

Table 11A.42 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 2010) (c)	no.	1 700	1 209	981	409	354	123	67	38	4 881
SWPE (b)	no.	4 765 033	4 063 295	3 060 662	1 500 216	1 225 101	389 553	269 970	79 148	15 352 978
PIP eHealth Incentive — uptake (c)	no.	1 280	971	793	333	274	102	57	20	3 830
Share of PIP practices	%	75.3	80.3	80.8	81.4	77.4	82.9	85.1	52.6	78.5

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

(b) 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.

(c) In August 2009 the two-part PIP information management/information technology (IM/IT) incentive was replaced with the PIP eHealth incentive, intended to encourage general practices to keep up-to-date with the latest developments in eHealth. To be eligible for the PIP eHealth Incentive, practices must: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.
Data for 2007 to 2009 are presented for both parts of the PIP IM/IT incentive. Data for 2010 are presented for the eHealth incentive.
Data for the first PIP IM/IT incentive, which ended in November 2006, are available in previous Reports.

Source: DoHA unpublished, MBS and PIP data collections.

Table 11A.43 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 2010)	no.	3 006	369	314	339	689	56	108	4 881
SWPE (c)	no.	9 631 443	1 257 637	1 111 650	1 265 033	1 836 784	134 877	115 554	15 352 978
Maintain secure electronic patient records (d)									
Share of PIP practices (May 2007)	%	82.9	85.2	87.3	85.6	88.8	74.6	69.0	84.0
Share of PIP practices (May 2008)	%	87.2	88.6	90.6	90.8	92.7	81.8	78.9	88.3
Share of PIP practices (May 2009)	%	89.0	90.0	92.6	92.7	94.6	83.3	85.7	90.2
PIP eHealth Incentive — uptake (d)									
Share of PIP practices (May 2010)	%	77.8	79.7	83.1	80.2	81.0	66.1	63.9	78.5
Use mainly secure electronic patient records (d)									
Share of PIP practices (May 2007)	%	79.2	83.8	84.7	84.6	86.3	74.6	68.0	80.9
Share of PIP practices (May 2008)	%	83.7	87.8	88.1	89.2	90.2	81.8	78.9	85.4
Share of PIP practices (May 2009)	%	86.0	89.5	90.4	91.5	92.8	83.3	84.8	87.8

(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 August 2009 the two-part PIP information management / information technology (IM/IT) incentive was replaced with the PIP eHealth incentive, intended to encourage general practices to keep up-to-date with the latest developments in eHealth. To be eligible for the PIP eHealth Incentive, practices must: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.
Data for 2007 to 2009 are presented for both parts of the PIP IM/IT incentive. Data for 2010 are presented for the eHealth incentive.
Data for the first PIP IM/IT incentive, which ended in November 2006, are available in previous Reports.

Source: DoHA unpublished, MBS and PIP data collections.

Table 11A.44 **Proportion of people receiving a prescription for medication from a GP in the previous 12 months where the GP provided reasons for the prescription, 2009 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	97.2	97.6	98.5	96.2	98.0	97.5	97.4	97.7	97.6
Relative standard error	%	0.7	0.7	0.4	1.0	0.6	1.2	1.7	1.3	0.3
95 per cent confidence interval	%	± 1.4	± 1.2	± 0.8	± 1.9	± 1.1	± 2.4	± 3.3	± 2.5	± 0.6

(a) People aged 15 years or over who received a prescription for medication in the previous 12 months.

(b) Rates are age standardised to the 2001 estimated resident population.

Source: ABS 2010, *Patient Experience Survey 2009*

Table 11A.45 **Proportion of people who had a pathology or imaging test in the previous 12 months where the referring health professional explained the reasons for the most recent test, 2009 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	98.5	98.5	98.5	98.5	97.8	97.9	98.8	96.2	98.4
Relative standard error	%	0.6	0.6	0.4	0.5	0.7	0.8	1.3	2.0	0.3
95 per cent confidence interval	%	± 1.2	± 1.2	± 0.8	± 1.0	± 1.3	± 1.6	± 2.5	± 3.7	± 0.6

(a) People aged 15 years and over who had a pathology test for which they had been referred in the previous 12 months, (excluding tests had in hospital); and persons who had been referred to their most recent imaging test by a health professional (excluding tests had in hospital and dental tests).

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).

Source: ABS 2010, *Patient Experience Survey 2009*

Table 11A.46 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*
2005-06										
GPs using CDM 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 CDM items	%	86.0	84.5	79.7	81.2	77.5	76.7	69.0	69.1	82.7
2006-07										
GPs using CDM 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 CDM items	%	92.3	91.5	86.4	88.9	86.8	85.7	79.9	79.8	89.8
2007-08										
GPs using CDM 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 CDM items	%	95.6	94.4	90.1	92.5	90.8	89.5	83.3	86.2	93.1
2008-09										
GPs using CDM 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 CDM items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3
2009-10										
GPs using CDM items	no.	6 439	4 925	3 820	1 764	1 605	487	263	120	19 423
Total GPs	no.	6 617	5 061	4 064	1 858	1 683	511	286	135	20 215
GPs using CDM items	%	97.3	97.3	94.0	94.9	95.4	95.3	92.0	88.9	96.1

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

(b) The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing 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.47 **Annual health assessments for older people (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06										
Older people assessed	no.	89 865	58 677	47 959	15 733	22 279	6 647	1 825	471	243 456
Older people	no.	444 131	323 374	227 869	106 091	118 136	33 686	13 889	6 675	1 279 001
Proportion assessed	%	20.2	18.1	21.0	14.8	18.9	19.7	13.1	7.1	19.0
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	453 905	332 645	235 780	109 511	120 452	34 516	14 366	7 051	1 313 687
Proportion assessed	%	21.5	19.5	22.1	16.7	20.8	22.9	12.2	11.2	20.4
2007-08										
Older people assessed	no.	104 776	66 478	57 405	19 384	26 741	8 301	2 337	1 039	286 461
Older people	no.	465 178	340 681	242 938	113 364	122 641	35 236	14 923	7 429	1 348 079
Proportion assessed	%	22.5	19.5	23.6	17.1	21.8	23.6	15.7	14.0	21.2
2008-09										
Older people assessed	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Older people	no.	474 661	347 313	248 638	116 589	124 579	35 713	15 401	7 786	1 376 687
Proportion assessed	%	23.8	21.1	25.8	19.6	22.1	26.6	15.9	16.4	22.8
2009-10										
Older people assessed	no.	118 120	78 086	67 008	25 411	28 097	9 174	2 763	1 462	330 121
Older people	no.	483 341	354 239	254 052	119 267	126 130	36 385	15 916	8 193	1 403 864
Proportion assessed	%	24.4	22.0	26.4	21.3	22.3	25.2	17.4	17.8	23.5

(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 people receiving a health assessment rather than the number of health assessments provided.

(d) Historical data may differ slightly from previous reports due to a change in the methodology used to derive population estimates.

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

Table 11A.48 Valid vaccinations supplied to children under seven years of age, by type of provider, 2005–2010 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Valid vaccinations provided											
GPs	no.	15 382 156	7 595 823	9 485 436	3 582 528	2 725 859	1 097 160	399 435	41 911	na	40 310 308
Council	no.	1 012 753	6 427 107	799 259	339 174	735 260	148 781	na	na	na	9 462 334
State or territory health department	no.	3	na	1 396	347 676	3 006	718	164 414	3 175	na	520 388
Public hospital	no.	352 529	80 158	340 041	211 106	96 678	2 438	6 973	68 608	4 150	1 162 681
Private hospital	no.	14 534	108	2 058	70	na	105	41	8 288	na	25 204
Aboriginal health service	no.	89 103	18 231	72 119	31 650	18 687	20	1 491	97 895	na	329 196
Community health centre	no.	1 343 566	96 191	666 175	1 025 068	350 304	6 385	355 447	690 050	2 056	4 535 212
Other (d)	no.	9 846	2 873	84 611	710	6 035	na	72	2 119	na	106 296
Total	**no.**	**18 204 490**	**14 220 491**	**11 451 095**	**5 537 982**	**3 935 829**	**1 255 607**	**927 873**	**912 046**	**6 206**	**56 451 619**
Proportion of total valid vaccinations											
GPs	%	84.5	53.4	82.8	64.7	69.3	87.4	43.0	4.6	–	71.4
Council	%	5.6	45.2	7.0	6.1	18.7	11.8	–	–	–	16.8
State or territory health department	%	–	–	–	6.3	0.1	0.1	17.7	0.3	–	0.9
Public hospital	%	1.9	0.6	3.0	3.8	2.5	0.2	0.8	7.5	66.9	2.1
Private hospital	%	0.1	–	–	–	–	–	–	0.9	–	–
Aboriginal health service	%	0.5	0.1	0.6	0.6	0.5	–	0.2	10.7	–	0.6
Community health centre	%	7.4	0.7	5.8	18.5	8.9	0.5	38.3	75.7	33.1	8.0
Other (d)	%	0.1	–	0.7	–	0.2	–	–	0.2	0.2	0.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 11A.48 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2005–2010 (a), (b), (c)**

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

(a) 1 July 2005 to 30 June 2010.

(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.

(d) Other includes Divisions of GP, Flying Doctors' Services, Indigenous Health Workers, Community nurses and unknown providers.

– Nil or rounded to zero.

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

Table 11A.49 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 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
30 June 2010	91.2	92.1	91.9	90.1	91.3	91.7	92.2	90.3	91.5
Immunised against (at 30 June 2010)									
Diphtheria, tetanus and pertussis	91.7	92.7	92.3	90.5	91.9	92.2	93.2	91.6	92.0
Polio	91.7	92.7	92.3	90.5	91.9	92.1	93.2	91.6	92.0
Haemophilus influenzae type b	91.5	92.5	92.1	90.3	91.7	91.9	93.0	93.5	91.8

(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.50 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 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
30 June 2010	92.5	93.0	92.2	90.5	92.5	92.8	93.8	93.4	92.4
Immunised against (at 30 June 2010)									
Diphtheria, tetanus and pertussis	94.9	95.4	94.5	93.9	94.7	94.7	95.8	96.7	94.9
Polio	94.9	95.3	94.5	93.8	94.6	94.6	95.7	96.6	94.8
Haemophilus influenzae type b	95.1	95.1	94.3	93.2	94.4	94.6	95.4	94.5	94.7
Measles, mumps and rubella	93.8	94.5	93.8	92.8	93.9	94.5	94.9	95.2	93.9

(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.51 Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
Fully immunised (e)									
30 June 2008	79.1	84.3	81.7	76.8	73.0	79.9	86.4	80.7	80.4
30 June 2009	82.0	85.8	82.5	80.3	75.6	78.6	84.4	84.8	82.4
30 June 2010	89.5	91.2	90.2	86.6	87.2	90.6	89.0	87.3	89.6
Immunised against (at 30 June 2010)									
Diphtheria, tetanus and pertussis	90.0	91.6	91.0	87.5	87.6	91.1	89.9	88.0	90.2
Polio	90.0	91.6	90.9	87.5	87.6	91.0	90.1	88.0	90.1
Measles, mumps and rubella	89.8	91.4	90.7	87.1	87.5	91.0	89.2	87.7	89.9

(a) Coverage measured at 30 June for children turning 60 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 60 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.52 **Proportion of children aged five years who were fully vaccinated, by Indigenous status and remoteness, 30 June 2010 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous status									
Indigenous	85.4	88.4	87.0	80.6	76.3	89.0	90.9	90.0	85.7
Other Australians (c)	89.6	91.2	90.4	87.1	87.5	90.7	88.9	85.0	89.7
Remoteness of residence (d), (e)									
Major cities	89.3	91.1	89.9	86.3	86.4	..	89.0	..	89.3
Inner regional	90.4	91.8	90.3	87.4	86.6	90.0	91.1	..	90.3
Outer regional	89.4	90.0	91.3	87.0	91.2	91.9	..	83.0	89.8
Remote	87.0	79.6	89.6	88.9	94.2	81.6	..	89.4	89.4
Very remote	83.0	..	89.8	87.1	77.8	np	..	93.7	89.5

(a) Includes children born 1 January 2005 to 31 March 2005.

(b) Fully vaccinated is defined as having received all age appropriate immunisations for Diphtheria, Tetanus, Pertussis, Hepatitis B, Poliomyelitis, *Haemophilus influenzae* type b, Measles, Mumps and Rubella.

(c) Includes records for people whose Indigenous status is not known or not stated.

(d) Disaggregation by remoteness area is by usual residence of child. Remoteness area are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Excludes 43 records where postcode was invalid or did not map to a remoteness category.

.. Not applicable. **np** Not published

Source: DoHA unpublished, ACIR data collection.

Table 11A.53 Notifications of measles, children aged 0–14 years (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006	no.	35	3	2	18	3	7	–	–	68
2007	no.	1	–	2	1	1	–	–	–	5
2008	no.	18	1	5	–	–	–	–	2	26
2009	no.	5	19	18	3	–	1	–	–	46
2010 (c)	no.	10	3	2	–	1	–	–	–	16
Notifications per 100 000 children (0–14 years)										
2006	per 100 000 children	2.6	0.3	0.2	4.4	1.0	7.3	–	–	1.7
2007	per 100 000 children	0.1	–	0.2	0.2	0.3	–	–	–	0.1
2008	per 100 000 children	1.4	0.1	0.6	–	–	–	–	3.8	0.6
2009	per 100 000 children	0.4	1.9	2.0	0.7	–	1.0	–	–	1.1
2010 (c)	per 100 000 children	0.7	0.3	0.2	–	0.3	–	–	–	0.4

(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.

– 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.54 Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006	no.	324	46	180	51	53	7	14	3	678
2007	no.	360	155	86	14	29	5	5	4	658
2008	no.	3 630	325	306	113	202	79	29	179	4 863
2009	no.	6 989	829	1 485	235	1 504	207	50	73	11 372
2010 (c)	no.	1 830	835	1 085	231	954	38	26	66	5 065
Notifications per 100 000 children (0–14 years)										
2006	per 100 000 children	24.3	4.7	21.6	12.4	18.4	7.3	22.3	5.8	16.7
2007	per 100 000 children	27.0	15.8	10.1	3.4	10.1	5.2	7.9	7.7	16.1
2008	per 100 000 children	272.6	32.6	35.4	26.5	69.7	81.3	45.2	342.3	117.9
2009	per 100 000 children	520.3	82.2	167.5	53.6	515.8	212.1	76.9	138.1	271.8
2010 (c)	per 100 000 children	136.3	82.8	122.4	52.7	327.2	38.9	40.0	124.9	121.1

(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.

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

Table 11A.55 Notifications of *Haemophilus influenzae* type b, children aged 0–14 years (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006	no.	4	2	7	–	–	–	–	–	13
2007	no.	4	1	2	2	1	–	–	2	12
2008	no.	4	2	1	–	–	1	–	1	9
2009	no.	3	–	3	3	–	–	–	–	9
2010 (c)	no.	3	1	2	–	1	–	–	1	8
Notifications per 100 000 children (0–14 years)										
2006	per 100 000 children	0.3	0.2	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	0.1	–	–	0.1	–	1.9	0.2
2009	per 100 000 children	0.2	–	0.3	0.7	–	–	–	–	0.2
2010 (c)	per 100 000 children	0.2	0.1	0.2	–	0.3	–	–	1.9	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.56 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* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
2004 and 2005									
20–24	43.4	48.5	49.1	51.3	50.3	57.5	51.6	57.6	47.7
25–29	55.0	60.2	56.8	58.4	60.8	64.6	61.9	60.6	57.8
30–34	60.9	66.4	60.4	63.2	65.8	64.6	68.0	58.9	62.9
35–39	62.5	68.4	61.0	64.5	67.1	65.8	68.9	60.8	64.4
40–44	62.8	69.4	61.6	64.0	67.4	65.3	67.7	59.0	64.8
45–49	64.0	71.8	63.4	65.4	69.4	66.1	69.1	61.1	66.5
50–54	62.3	70.4	61.4	62.3	68.0	64.5	68.2	60.7	64.7
55–59	63.9	73.8	62.8	64.6	70.1	66.5	74.8	62.1	66.9
60–64	54.3	64.9	54.3	54.1	62.0	56.4	65.3	50.8	57.7
65–69	45.6	56.2	46.3	48.4	55.8	47.1	56.1	44.2	49.7
70–74	15.6	16.4	27.3	16.1	19.9	13.0	17.3	14.8	17.0
75–79	5.5	5.0	10.5	5.3	7.7	4.4	5.8	9.5	5.9
80 years or over	1.6	1.6	3.2	2.0	1.9	1.2	1.7	3.0	1.8
20 years or over	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
20–69 years	58.1	65.0	58.4	60.6	64.0	62.9	65.0	59.2	60.8
ASR	58.2	65.4	58.4	60.5	64.1	62.9	65.5	58.5	61.0
2005 and 2006									
20–24	43.1	47.1	48.1	51.3	50.8	56.7	48.7	50.3	47.0
25–29	53.9	57.8	55.5	57.9	60.4	61.5	58.0	53.9	56.3
30–34	61.1	64.3	59.3	62.8	65.8	64.2	64.0	55.8	62.1
35–39	62.7	66.6	60.2	64.2	67.1	64.8	66.5	56.7	63.7
40–44	62.6	67.6	60.5	64.1	67.5	65.3	66.9	56.7	64.0
45–49	64.6	70.8	62.8	65.4	69.6	65.8	67.6	57.9	66.3
50–54	63.3	70.3	60.6	62.7	68.6	65.3	68.5	56.6	64.9
55–59	65.6	74.4	62.6	65.4	72.2	66.7	73.9	58.3	67.8
60–64	55.9	64.8	54.1	54.4	62.5	56.5	65.4	48.1	58.2
65–69	47.6	57.8	46.9	49.5	56.5	48.7	58.8	43.2	51.1
70–74	15.6	16.1	19.4	16.2	20.1	12.8	18.6	13.7	16.8
75–79	5.4	4.6	6.7	5.3	7.6	3.9	6.0	8.1	5.6
80 years or over	1.4	1.5	2.0	1.9	2.1	1.0	1.4	2.5	1.6
20 years or over	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
20–69 years	58.4	63.8	57.6	60.6	64.3	62.4	63.0	54.9	60.4
ASR	58.7	64.3	57.7	60.5	64.5	62.4	63.8	54.5	60.6

Table 11A.56 **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* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
2006 and 2007									
20–24	44.7	47.3	50.3	52.0	50.3	54.3	51.0	51.2	48.0
25–29	55.9	57.9	57.7	59.1	60.3	59.9	58.7	53.9	57.5
30–34	62.2	63.8	60.6	62.3	64.6	62.3	63.9	54.4	62.4
35–39	64.1	66.6	61.7	63.5	66.3	63.1	65.9	55.5	64.3
40–44	64.0	67.6	61.7	63.2	66.8	63.4	65.8	55.0	64.5
45–49	66.9	71.5	64.4	65.3	69.4	65.1	67.3	57.3	67.5
50–54	65.0	70.6	62.0	62.5	68.4	63.8	67.8	54.3	65.7
55–59	67.9	75.0	64.7	65.5	71.9	66.3	74.3	57.9	69.1
60–64	58.1	65.2	55.4	54.6	62.7	56.6	64.8	47.8	59.4
65–69	49.1	57.9	48.0	48.3	56.5	49.5	57.9	42.3	51.7
70–74	16.0	15.9	18.8	16.0	20.5	12.4	16.4	14.6	16.7
75–79	5.2	4.4	6.2	5.0	7.3	3.6	4.4	6.4	5.3
80 years or over	1.3	1.4	1.9	1.7	2.1	0.9	0.9	2.2	1.5
20 years or over	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
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
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 years or over	1.2	1.3	1.6	1.5	1.8	0.9	1.0	2.5	1.4
20 years or over	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
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

Table 11A.56 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* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
2008 and 2009									
20–24	40.9	43.5	47.6	50.7	46.8	52.5	48.2	53.1	44.8
25–29	52.0	54.4	54.5	57.1	57.0	56.3	55.2	55.9	54.1
30–34	59.9	62.2	59.4	60.6	61.8	59.9	61.0	57.7	60.6
35–39	63.1	66.0	61.2	62.9	64.9	61.5	63.7	59.6	63.5
40–44	63.2	67.3	61.6	63.2	65.5	61.0	64.5	61.5	64.0
45–49	66.0	70.9	64.4	64.9	68.3	63.8	66.6	62.0	66.9
50–54	65.1	71.1	63.6	63.9	68.3	62.6	66.2	62.4	66.3
55–59	68.9	76.0	66.4	65.9	72.0	65.9	73.9	61.7	70.0
60–64	59.4	66.7	57.3	57.2	63.2	56.4	65.4	53.0	60.8
65–69	50.3	58.2	49.7	48.0	56.0	48.3	55.8	44.7	52.4
70–74	16.2	15.4	14.6	14.7	19.2	11.5	16.0	16.8	15.7
75–79	4.7	3.7	4.6	4.3	6.6	3.0	4.0	4.7	4.5
80 years or over	1.2	1.2	1.4	1.5	1.6	0.9	1.2	2.2	1.3
20 years or over	52.3	56.0	53.2	54.5	54.7	52.2	56.6	56.4	53.9
ASR	52.8	56.5	52.5	53.5	55.9	52.6	55.2	51.8	54.0
20–69 years	58.6	62.6	58.6	59.9	62.1	59.3	61.0	58.0	60.0
ASR	59.2	63.5	58.9	60.1	62.5	59.4	62.0	58.0	60.6

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 in each of the calendar years in the reference period.
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) Except where noted, number of women screened includes all women screened in each jurisdiction, not just those women resident in each jurisdiction. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.

(e) Data for Victoria include only residents of Victoria except for the period 2008 and 2009. Data for 2008 and 2009 may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.

(f) Data for the ACT includes only residents of the ACT. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.

Source: AIHW 2010, *Cervical screening in Australia 2007–2008*, Cat. no. CAN 50, AIHW, Canberra; AIHW unpublished, State and Territory Cervical Cytology Registry data.

Table 11A.57 Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a pap smear at least every 2 years, 2004-05 (per cent)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey*, 2004-05; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, 30 June 2004, Series B, Cat. no. 3238.0.

Table 11A.58 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. Data for 2009 were not available for influenza coverage only in time for the 2011 Report.

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

Table 11A.59 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumoccoccal disease, by remoteness, 2009 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major city										
Proportion	%	48.9	50.6	52.0	46.2	55.0	..	50.4	..	50.2
RSE	%	4.4	4.5	4.8	7.2	5.2	..	6.0	..	2.4
95 per cent confidence interval	%	± 4.2	± 4.5	± 4.9	± 6.5	± 5.6	..	± 5.9	..	± 2.3
Inner regional										
Proportion	%	48.9	51.7	50.4	57.6	64.3	56.0	np	..	51.6
RSE	%	5.7	6.9	7.8	10.1	9.7	6.4	233.2	..	3.3
95 per cent confidence interval	%	± 5.4	± 7.0	± 7.7	± 11.5	± 12.2	± 7.0	np	..	± 3.4
Outer regional										
Proportion	%	49.9	53.5	46.2	51.5	39.8	47.9	..	41.7	48.9
RSE	%	9.0	13.5	11.5	17.7	17.5	9.9	..	7.3	4.2
95 per cent confidence interval	%	± 8.8	± 14.1	± 10.4	± 17.9	± 13.6	± 9.3	..	± 6.0	± 4.0
Remote, very remote (e)										
Proportion	%	56.3	np	66.4	np	46.3	40.8	..	58.3	57.3
RSE	%	35.7	124.6	17.3	53.0	36.0	44.9	..	16.0	10.9
95 per cent confidence interval	%	± 39.3	np	± 22.5	np	± 32.6	± 35.9	..	± 18.2	± 12.2
Total (f)										
Proportion	%	**49.1**	**51.3**	**51.5**	**48.5**	**54.7**	**52.9**	**50.4**	**43.1**	**50.6**
RSE	%	3.3	3.7	3.9	5.7	4.5	6.0	6.0	6.7	1.7
95 per cent confidence interval	%	± 3.2	± 3.7	± 3.9	± 5.4	± 4.8	± 6.2	± 5.9	± 5.7	± 1.7

Table 11A.59 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumoccoccal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

RSE = Relative standard error.

(a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.

(b) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

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

(d) Estimates with relative standard errors (RSEs) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

(e) Remote and very remote categories have been aggregated due to small numbers.

(f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.

.. Not applicable. **np** Not published.

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

Table 11A.60 Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumoccoccal disease, 2004-05 (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2

(a) Vaccinations against influenza and pneumococcal disease have been available free to Indigenous people aged 50 years or over since 1999.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey,* 2004-05.

Table 11A.61 Separations for selected potentially preventable hospitalisations, 2008-09 (per 1000 people) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (d)	*ACT*	*NT*	*Aust*
Vaccine-preventable conditions	0.7	0.8	0.8	0.6	0.7	0.6	0.5	2.4	0.7
Acute conditions	12.4	14.3	14.2	13.4	14.4	10.1	11.5	21.0	13.5
Chronic conditions	13.9	15.3	18.5	26.0	15.5	12.6	11.7	26.0	16.5
Total (e)	**27.0**	**30.3**	**33.3**	**39.8**	**30.4**	**23.3**	**23.6**	**48.7**	**30.6**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2010 *Australian hospital statistics 2008-09*. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09) resulted in decreased reporting of additional diagnoses for diabetes, and changes in the reporting of gastroenteritis. Therefore caution should be used in comparisons of these data with earlier periods.

(b) Separations are based on the state or territory of usual residence of the patient. Excludes separations for patients usually resident overseas.

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

(d) Data for Tasmania do not include two private hospitals that account for approximately one eighth of Tasmania's total hospital separations.

(e) Totals may not sum to the individual categories as conditions in more than one category can be reported for a separation.

Source: AIHW unpublished, National Hospital Morbidity Database; AIHW 2010, *Australian hospital statistics 2008-09,* Cat. no. HSE 84, Canberra.

Table 11A.62 **Separations for selected potentially preventable hospitalisations by remoteness, 2008-09 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*
Vaccine preventable conditions									
Major cities	0.6	0.8	0.8	0.6	0.7	..	0.5	..	0.7
Inner regional	0.9	0.6	0.7	0.5	0.8	0.6	–	..	0.7
Outer regional	1.0	0.8	0.6	0.7	0.8	0.5	..	1.3	0.8
Remote	1.3	1.3	0.9	1.1	0.6	0.8	..	3.3	1.3
Very remote	1.4	..	1.4	1.5	2.8	2.2	..	4.4	2.4
Acute conditions									
Major cities	11.3	14.0	13.2	12.4	13.5	..	11.6	..	12.7
Inner regional	15.0	15.6	14.6	13.0	14.2	9.8	np	..	14.5
Outer regional	17.8	17.3	16.1	16.5	19.4	10.6	..	13.0	16.2
Remote	26.5	15.2	24.1	19.7	17.1	14.8	..	29.9	22.4
Very remote	28.3	..	32.1	27.2	29.9	17.7	..	32.0	30.4
Chronic conditions									
Major cities	12.7	15.1	16.8	22.3	14.6	..	11.9	..	15.2
Inner regional	15.9	16.0	21.7	27.2	15.0	12.2	np	..	17.5
Outer regional	19.6	18.8	19.5	30.8	21.5	13.6	..	19.8	20.2
Remote	31.8	19.8	24.5	76.5	15.2	16.0	..	34.7	38.7
Very remote	22.5	..	31.5	52.0	24.9	18.7	..	37.1	37.4
All potentially preventable hospitalisations (f)									
Major cities	24.6	29.8	30.7	35.3	28.6	..	23.9	..	28.4
Inner regional	31.7	32.1	36.9	40.6	29.9	22.5	np	..	32.6
Outer regional	38.2	36.7	36.1	47.8	41.5	24.6	..	33.8	37.0
Remote	59.5	36.3	49.3	97.0	32.8	31.6	..	67.0	62.1
Very remote	52.2	..	64.2	79.6	57.3	37.9	..	72.2	69.3

Table 11A.62 **Separations for selected potentially preventable hospitalisations by remoteness, 2008-09 (per 1000 people) (a), (b), (c), (d)**

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

(a) Conditions defined by ICD-10-AM codes as in AIHW 2010 *Australian hospital statistics 2008-09*.

(b) Regions are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(c) Separations are based on the usual residence of the patient. Excludes separations for patients usually resident overseas.

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

(e) Data for Tasmania do not include two private hospitals that account for approximately one eighth of Tasmania's total hospital separations.

(f) May not sum to the individual categories as more than one condition can be reported for a separation.

.. Not applicable. **np** Not published.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June 2008; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, 30 June 2008, Series B, Cat. no. 3238.0.

Table 11A.63 Separations for selected vaccine preventable conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT* (f)	*Total* (g)	*Aust*
Vaccine preventable conditions per 1000 Indigenous people (h)										
Influenza and Pneumonia	1.2	0.8	1.4	2.7	2.4	np	np	4.6	1.9	np
Other vaccine preventable conditions	0.4	0.5	0.5	0.7	0.9	np	np	2.3	0.8	np
Total	**1.6**	**1.3**	**1.9**	**3.4**	**3.3**	**np**	**np**	**6.8**	**2.7**	**np**
Vaccine preventable conditions per 1000 non-Indigenous people (h)										
Influenza and Pneumonia	0.5	0.5	0.6	0.4	0.5	np	np	0.6	0.5	np
Other vaccine preventable conditions	0.2	0.3	0.1	0.1	0.1	np	np	0.3	0.2	np
Total	**0.7**	**0.8**	**0.8**	**0.5**	**0.7**	**np**	**np**	**0.9**	**0.7**	**np**
Vaccine preventable conditions per 1000 people (all people) (i)										
Influenza and Pneumonia	0.5	0.5	0.6	0.5	0.6	0.5	0.4	1.6	0.5	0.5
Other vaccine preventable conditions	0.2	0.3	0.1	0.2	0.2	0.1	0.1	0.8	0.2	0.2
Total	**0.7**	**0.8**	**0.8**	**0.6**	**0.7**	**0.6**	**0.5**	**2.4**	**0.7**	**0.7**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2010 *Australian hospital statistics 2008-09*.

(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 are based on state or territory of usual residence.

(e) Data for Tasmania do not include two private hospitals that account for approximately one eighth of Tasmania's total hospital separations.

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

(g) Total for Indigenous people and for non-Indigenous people comprise data for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only).

Table 11A.63 Separations for selected vaccine preventable conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)

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

(h) Data for Indigenous people and for non-Indigenous people are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only). 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 six states and territory are not necessarily representative of the other jurisdictions.

(i) The rates presented for Indigenous people and non-Indigenous people are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

np Not published.

Source: AIHW 2010, *Australian hospital statistics 2008-09*, Cat. no. HSE 84, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.64 Separations for selected acute conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT* (f)	*Total* (g)	*Aust*
Acute conditions per 1000 Indigenous people (h)										
Appendicitis with generalised peritonitis	0.2	0.3	0.2	0.4	0.5	np	np	0.2	0.2	np
Cellulitis	2.9	2.6	5.1	6.3	4.0	np	np	5.6	4.4	np
Convulsions and epilepsy	5.8	4.6	6.2	9.4	11.5	np	np	10.6	7.4	np
Dehydration and gastroenteritis	3.5	3.5	3.6	5.2	5.3	np	np	4.8	4.0	np
Dental conditions	2.7	3.8	3.4	3.9	3.7	np	np	5.4	3.5	np
Ear, nose and throat infections	2.8	1.7	3.3	4.5	4.2	np	np	5.3	3.5	np
Gangrene	0.3	0.5	1.4	2.3	0.5	np	np	2.2	1.2	np
Pelvic inflammatory disease	0.4	0.4	0.5	1.0	0.8	np	np	1.0	0.6	np
Perforated/bleeding ulcer	0.5	0.2	0.3	0.3	0.6	np	np	0.4	0.4	np
Pyelonephritis (i)	4.0	3.0	7.1	8.4	5.5	np	np	9.0	6.1	np
Total	**23.0**	**20.6**	**31.1**	**41.7**	**36.5**	**np**	**np**	**44.3**	**31.3**	**np**
Acute conditions per 1000 non-Indigenous people (h)										
Appendicitis with generalised peritonitis	0.2	0.2	0.2	0.2	0.2	np	np	0.2	0.2	np
Cellulitis	1.6	1.5	1.8	1.3	1.4	np	np	2.7	1.6	np
Convulsions and epilepsy	1.5	1.4	1.5	1.1	1.5	np	np	1.3	1.4	np
Dehydration and gastroenteritis	2.5	3.5	2.8	2.4	2.8	np	np	1.7	2.8	np
Dental conditions	2.3	3.1	2.7	3.6	3.2	np	np	1.7	2.8	np
Ear, nose and throat infections	1.6	1.5	1.9	1.5	2.3	np	np	1.6	1.7	np

Table 11A.64 **Separations for selected acute conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT* (f)	*Total* (g)	*Aust*
Gangrene	0.1	0.3	0.2	0.2	0.2	np	np	0.3	0.2	np
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	np	np	0.3	0.2	np
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.2	np	np	0.2	0.2	np
Pyelonephritis (i)	2.3	2.4	2.4	2.1	2.3	np	np	1.8	2.3	np
Total	**12.4**	**14.5**	**13.9**	**12.7**	**14.3**	**np**	**np**	**11.7**	**13.4**	**np**
Acute conditions per 1000 people (all people) (j)										
Appendicitis with generalised peritonitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.6	1.5	1.9	1.5	1.5	1.2	1.3	3.7	1.6	1.6
Convulsions and epilepsy	1.5	1.4	1.6	1.3	1.6	1.5	1.4	3.4	1.5	1.5
Dehydration and gastroenteritis	2.5	3.5	2.8	2.4	2.8	2.1	2.1	2.6	2.8	2.8
Dental conditions	2.3	3.1	2.7	3.6	3.2	1.8	2.2	3.2	2.8	2.8
Ear, nose and throat infections	1.6	1.5	1.9	1.6	2.3	1.3	1.2	2.9	1.7	1.7
Gangrene	0.1	0.3	0.2	0.2	0.2	0.2	0.1	0.7	0.2	0.2
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.2	0.2	0.3	0.2	0.2	0.2
Pyelonephritis (i)	2.2	2.4	2.5	2.1	2.2	1.4	2.5	3.7	2.3	2.3
Total	**12.4**	**14.3**	**14.2**	**13.4**	**14.4**	**10.1**	**11.5**	**21.0**	**13.5**	**13.5**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2010 *Australian hospital statistics 2008-09*. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09) resulted in changes in the reporting of gastroenteritis. Caution should be used in comparisons of these data with earlier periods.

Table 11A.64 **Separations for selected acute conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)**

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

(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 are based on state or territory of usual residence.

(e) Data for Tasmania do not include two private hospitals that account for approximately one eighth of Tasmania's total hospital separations.

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

(g) Total for Indigenous people and for non-Indigenous people comprises data for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only).

(h) Data for Indigenous people and for non-Indigenous people are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only). 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 six states and territory are not necessarily representative of the other jurisdictions.

(i) Kidney inflammation caused by bacterial infection.

(j) The rates presented for Indigenous people and non-Indigenous people are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

np Not published.

Source: AIHW 2010, *Australian hospital statistics 2008-09*, Cat. no. HSE 84, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.65 **Separations for selected chronic conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT* (f)	*Total* (g)	*Aust*
Chronic conditions per 1000 Indigenous people (h)										
Angina	3.7	3.7	6.0	5.7	4.8	np	np	4.3	4.8	np
Asthma	3.5	2.7	3.2	4.8	6.1	np	np	3.0	3.6	np
Chronic obstructive pulmonary disease	11.9	7.8	11.7	11.2	18.3	np	np	18.0	12.6	np
Congestive heart failure	5.2	2.8	7.7	7.6	5.1	np	np	5.6	6.1	np
Diabetes complications (i)	18.2	11.4	30.2	38.2	31.2	np	np	29.0	26.0	np
Hypertension	0.7	0.3	0.9	0.5	0.9	np	np	0.3	0.7	np
Iron deficiency anaemia	1.4	2.5	1.8	1.9	0.9	np	np	2.3	1.8	np
Nutritional deficiencies	0.1	–	0.1	0.1	–	np	np	0.2	0.1	np
Rheumatic heart disease (j)	0.3	0.1	0.7	0.6	0.3	np	np	1.8	0.6	np
Total (k)	**41.5**	**29.1**	**56.6**	**62.9**	**63.8**	**np**	**np**	**58.5**	**51.3**	**np**
Total (excluding diabetes complications)	26.7	19.9	32.1	32.4	36.4	np	np	35.4	30.3	np
Chronic conditions per 1000 non-Indigenous people (h)										
Angina	1.2	1.5	2.0	1.2	1.4	np	np	1.6	1.5	np
Asthma	1.8	1.8	1.5	1.2	2.4	np	np	1.5	1.7	np
Chronic obstructive pulmonary disease	2.6	2.6	3.0	2.1	3.0	np	np	3.7	2.7	np
Congestive heart failure	1.9	2.2	1.9	1.8	2.0	np	np	1.5	2.0	np
Diabetes complications (i)	5.3	5.9	5.8	5.9	5.5	np	np	8.5	5.6	np
Hypertension	0.3	0.2	0.3	0.2	0.3	np	np	0.1	0.3	np
Iron deficiency anaemia	1.0	1.6	1.1	1.3	1.2	np	np	0.9	1.2	np
Nutritional deficiencies	–	–	–	–	–	np	np	–	–	np
Rheumatic heart disease (j)	0.1	0.1	0.1	0.1	0.1	np	np	0.2	0.1	np
Total (k)	**13.6**	**15.2**	**15.0**	**13.0**	**15.2**	**np**	**np**	**17.0**	**14.4**	**np**

Table 11A.65 **Separations for selected chronic conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT* (f)	*Total* (g)	*Aust*
Total (excluding diabetes complications)	8.9	10.1	10.0	7.9	10.4	np	np	9.5	9.4	np
Chronic conditions per 1000 people (all people) (l)										
Angina	1.2	1.4	2.0	1.3	1.4	1.4	1.0	2.3	1.5	1.5
Asthma	1.8	1.8	1.5	1.3	2.4	1.2	0.9	1.8	1.7	1.7
Chronic obstructive pulmonary disease	2.6	2.6	3.1	2.2	3.0	2.5	2.2	6.7	2.6	2.6
Congestive heart failure	1.8	2.1	1.9	1.8	1.8	1.5	2.1	2.5	1.9	1.9
Diabetes complications	5.7	6.2	9.0	18.5	5.8	4.9	4.8	12.0	7.7	7.7
Hypertension	0.3	0.2	0.3	0.2	0.3	0.2	0.3	0.1	0.3	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.3	1.2	1.1	0.9	1.2	1.2	1.2
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	–	–
Rheumatic heart disease (j)	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.7	0.1	0.1
Total (k)	**13.9**	**15.3**	**18.5**	**26.0**	**15.5**	**12.6**	**11.7**	**26.0**	**16.5**	**16.5**
Total (excluding diabetes complications)										

(a) Conditions defined by ICD-10-AM codes as in AIHW 2010 *Australian hospital statistics 2008-09*. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

(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 are based on state or territory of usual residence.

(e) Data for Tasmania do not include two private hospitals that account for approximately one eighth of Tasmania's total hospital separations.

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

(g) Total for Indigenous people and for non-Indigenous people comprises data for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only).

Table 11A.65 **Separations for selected chronic conditions by Indigenous status, 2008-09 (per 1000 people) (a), (b), (c), (d)**

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

(h) Data for Indigenous people and for non-Indigenous people are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only). 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 six states and territory are not necessarily representative of the other jurisdictions.

(i) Data for Indigenous people and for non-Indigenous people exclude separations with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes.

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

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

(l) The rates presented for Indigenous people and non-Indigenous people are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

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

Source: AIHW 2010, *Australian hospital statistics 2008-09*, Cat. no. HSE 84, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.66 Ratio of separations for Indigenous people to all people, diabetes, 2008-09 (a), (b), (c), (d), (e), (f)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
Diabetes as a primary diagnosis	no.	844	169	1 714	991	358	np	np	793	4 869
	SHSR	2.76	1.77	4.84	5.65	4.70	np	np	3.72	4.11
	95% CI	2.57 to 2.94	1.51 to 2.04	4.61 to 5.07	5.3 to 6	4.21 to 5.18	np	np	3.46 to 3.98	3.99 to 4.22
All diabetes except where dialysis is the primary diagnosis	no.	3 013	567	5 366	16 005	958	np	np	3 038	28 947
	SHSR	3.97	3.79	6.23	29.63	7.26	np	np	7.90	10.54
	95% CI	3.82 to 4.11	3.48 to 4.1	6.06 to 6.39	29.17 to 30.09	6.8 to 7.72	np	np	7.62 to 8.18	10.42 to 10.67
All diabetes (g)	no.	3 857	736	7 080	16 996	1 316	np	np	3 831	33 816
	SHSR	3.67	3.14	5.88	24.35	6.41	np	np	6.46	8.82
	95% CI	3.55 to 3.78	2.91 to 3.36	5.75 to 6.02	23.99 to 24.72	6.06 to 6.76	np	np	6.26 to 6.66	8.72 to 8.91

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

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

(b) Data are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only). 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. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.67 Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2008-09 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Circulatory	17.0	23.8	18.0	24.3	20.3	np	np	np	20.1
Renal	21.6	29.6	29.8	39.7	25.6	np	np	np	28.2
Ophthalmic	116.9	131.1	129.4	180.8	118.1	np	np	np	129.9
Other specified	51.2	69.3	71.8	59.1	77.5	np	np	np	63.8
Multiple	37.1	50.1	58.7	60.2	49.2	np	np	np	50.2
No complications	4.8	4.5	2.9	2.3	4.4	np	np	np	4.0
Total	**248.6**	**308.4**	**310.6**	**366.4**	**295.3**	**np**	**np**	**np**	**296.3**

(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.68 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2008-09 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Circulatory	12.1	18.8	31.5	15.2	6.1	np	np	np	18.2
Renal	11.5	16.4	23.1	28.7	9.9	np	np	np	17.7
Ophthalmic	94.0	91.0	92.1	86.7	90.3	np	np	np	91.7
Other specified	10.8	28.4	26.2	14.4	13.5	np	np	np	20.0
Multiple	7.2	11.9	16.4	12.1	7.6	np	np	np	13.3
No complications	31.5	48.8	24.0	26.9	39.0	np	np	np	36.1
Total	**49.7**	**50.6**	**51.1**	**50.6**	**43.0**	**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.

(h) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09) resulted in decreased reporting of additional diagnoses for diabetes and diabetes complications. Therefore, caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.69 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2008-09 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
ASR	per 100 000 people	12.3	13.9	15.4	16.2	16.9	np	np	np	14.6
Crude	per 100 000 people	13.8	15.2	15.9	16.3	20.6	np	np	np	15.8
Separations	no.	971	818	690	359	332	np	np	np	3 412

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.

(e) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09) resulted in decreased reporting of additional diagnoses for diabetes and diabetes complications. Therefore, caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.70 **Separation rates of older people for injuries due to falls (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (d)	*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 of separations	46 425	32 911	20 058	10 409	8 780	2 348	1 516	340	122 787
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 of separations	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
2008-09									
Separations per 1000 older people	52.4	47.6	45.7	44.6	39.0	32.9	65.0	43.2	47.7
Number of separations	54998	37337	25092	12009	10759	2580	2318	383	145476

(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.

(d) Data for Tasmania do not include two private hospitals that account for approximately one eighth of Tasmania's total hospital separations.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Rural Primary Health Services program	The Rural Primary Health Services (RPHS) program funds a range of organisations to provide additional primary and allied health care services and preventative health projects in rural and remote communities. The actual services delivered depend on the identified needs of the communities covered. The RPHS Program commenced from 1 January 2010 and consolidates four rural primary and allied health care programs - Regional Health Services (RHS), More Allied Health Services (MAHS), Multi-purpose Centres (MPC) and Building Healthy Communities in Remote Australia (BHC). See separate briefs for MPC and Preventative Health Initiative (PHI). There are 173 RPHS (plus 32 MPCs that will transition) delivering services in approximately 1700 small rural and remote communities.	Funding is provided under Outcome 6 — Rural Health	Financial and activity reports are required from each project at 6 and 12 months. Divisions of General Practice also complete the annual survey for PHC RIS reporting.
Closing the Gap-Indigenous services in rural and regional areas	This pilot program, announced in the 2009 Budget, will provide $11.0 million over 4 years for the provision of mobile dental infrastructure and dental services to rural and regional Indigenous communities. Three initial projects identified by a consultant have been implemented from mid-2010. These projects will be completed by December 2012, with evaluation to be completed by June 2013.	Funding is provided under Outcome 13 — Acute Care Funding for individual projects may be provided in partnership with the states and territories or with not-for-profit organisations.	Six monthly progress reports are required from each project.

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

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.
Visiting Optometrist Scheme	The program aims to improve the access of people living and working in rural and remote communities to optometric services. Additional funding under the Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes measure became available in 2009-10 for an expansion of the Scheme. This will provide for new and increased numbers of optometrist visits to Indigenous communities.	Funding is provided under Outcome 3 — Medicare Benefits	Staged income and expenditure statements and progress reports are required from each optometrist.

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Medical Specialist Outreach Assistance Program (MSOAP)	MSOAP was established to improve access to medical specialist services for people living in rural and remote locations. The MSOAP complements medical specialist services provided by the State Government and private providers by encouraging specialists to deliver outreach services to targeted areas of need in rural and remote Australia. This is achieved by meeting costs associated with delivering outreach services such as travel, accommodation, and venue hire. An expansion of the MSOAP, focusing on chronic disease in Aboriginal and Torres Strait Islander commuities, also supports allied health professionals and general practitioners as part of a multidisciplinary team approach to care.	Funding is provided under Outcome 6 — Rural Health	Financial and service activity reports are submitted regularly in the context of an agreed reporting framework.

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Children's health and wellbeing	Under the Better Arthritis & Osteoporosis Care initiative Arthritis Australia administered a four year program of juvenile arthritis camps targeting children from culturally and linguistically diverse communities, and providing young adult education workshops.	Funding is provided under Outcome 10 — Health system capacity and quality	Financial and service activity reports are submitted every six months in the context of an agreed reporting framework
	Under the Asthma Management Program (AMP), Asthma Australia is funded to deliver the Asthma Child and Adolescent Program (ACAP) which targets children and adolescents, emphasising asthma information and emergency training for staff in preschools and schools, and including a focus on parents and on self-management for adolescents. The program includes messages about chronic respiratory conditions linked to asthma, such as allergy and rhinitis.	Funding is provided under Outcome 10 — Health system capacity and quality	Financial and service activity reports are submitted every four months in the context of an agreed reporting framework.
Objective: Promoting health and preventing illness, early detection			
Risk Factor and lifestyle programs	Under the Better Arthritis & Osteoporosis Care initiative Arthritis Australia's awareness-raising program aimed to provide a national arthritis multicultural initiative focusing on the Greek and Chinese communities. The program resulted in increased awareness through national media promotion. It attracted significant consumer response; an increased number of calls to Arthritis Australia's call centre, an increased number of downloads of arthritis factsheets from its website and the production of a number of self-management consumer resources.	Funding is provided under Outcome 10 — Health system capacity and quality	Financial and service activity reports are submitted every six months in the context of an agreed reporting framework

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	Under the Better Arthritis & Osteoporosis Care initiative Osteoporosis Australia developed and administered, the 'Prevent the next fracture' awareness program, an osteoporosis self-management training module, a national osteoporosis multicultural initiative, a vitamin D and Calcium awareness program, a national dissemination project for the healthy bones schools kit, a national osteoporosis risk factors awareness program, and a National Patient Support program. The program resulted in increased awareness-raising through the production of a number of self-management consumer resources, and also resulted in a peak number of multilingual factsheet downloads.	Funding is provided under Outcome 10 — Health system capacity and quality	Financial and service activity reports are submitted every six months in the context of an agreed reporting framework
	The Preventative Health Initiative (PHI) component of the Rural Primary Health Services program provides funding for preventative health activities that assist communities to find local solutions to local problems. Funding is targeted to remote and very remote communities or communities in rural areas which demonstrate high health needs and limited access to health services. Funding allocated for PHI is $18.054 million (GST excl) in the 3.5 years from 1 January 2010. This is part of $311.6 million (GST excl) funding for the RPHS program.	Funding is provided under Outcome 6 — Rural Health	Financial and activity reports are required from each project at 6 and 12 months.

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Disease Management	Under the Asthma Management Program (AMP), Asthma Australia is being funded to deliver the Community Support Program (CSP) which aims to target people with asthma, their family and community carers to increase awareness of best practice asthma management and empower them to take a more proactive role in the self-management of their asthma. The program includes messages about other linked respiratory conditions, such as allergy, rhinitis and chronic obstructive pulmonary disease (COPD). In addition, the program has a strong focus on prevention, especially in lower socio-economic areas and develops innovative ways to best practice messages to priority groups, in particular older Australians, Indigenous Australians, culturally and linguistically diverse peoples and people in rural and remote communities.	Funding is provided under Outcome 10 — Health system capacity and quality	Financial and service activity reports are submitted every four months in the context of an agreed reporting framework.

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Primary Care Education	Under the Asthma Management Program (AMP), the National Asthma Council (NAC) Australia is being funded to deliver the GP and Allied Health Professional Asthma and Respiratory Education Program. The program provides best-practice asthma management education nationally to primary health care practitioners — general practitioners and allied health professionals including practice nurses, Indigenous health workers, pharmacists and asthma educators. Opportunities for training and support are provided through the Divisions of General Practice nationally. Training is conducted in major cities and in regional and rural areas through workshops incorporating a range of interactive learning activities.	Funding is provided under Outcome 10 — Health system capacity and quality	Financial and service activity reports are submitted every four months in the context of an agreed reporting framework
Prevention of type 2 diabetes	The lifestyle modification program component of the Prevention of Type 2 Diabetes Program targets people aged 40–49 years and Aboriginal and Torres Strait Islander people aged 15–54 years, who are assessed as being at 'high risk' of developing type 2 diabetes with the aim to reduce or delay their progression to type 2 diabetes.	Funding is provided under Outcome 1 — Population Health	Financial and service activity reports are submitted regularly, in the context of an agreed reporting framework.

Table 11A.71 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Oral health	The Medicare Teen Dental Plan (MTDP) provides up to $157 per eligible teenager towards an annual preventative dental check. The preventative dental check includes a suite of services that promotes good oral health, including an oral examination and, if required, x-rays, a scale and clean, fluoride treatment, oral hygiene instruction, dietary advice and/or fissure sealing. Approximately 1.3 million teenagers 12–17 years of age are eligible for dental services each year under the program. Eligible teenagers include 12 to 17 year olds in families receiving Family Tax Benefit Part A; or teenagers receiving Youth Allowance, Abstudy, Disability Support Pension, Parenting Payment, Special Benefit, Carer Payment, Double Orphan Pension or support under certain Veterans' education and training assistance schemes. The Medicare Chronic Disease Dental Scheme (CDDS) provides up to $4250 over two consecutive calendar years in Medicare benefits for dental services for people with a chronic medical condition and complex care needs and whose oral health is impacting on their general health. Those dental services covered by the CDDS are listed in the Medicare Benefits Schedule for Dental Services.	Funding for the MTDP and the CDDS is provided by the Australian Government through the Department of Health and Ageing under Outcome 3 — Access to Medical Services. Benefits for services under the programs are administered by Medicare Australia.	The Department provides information on these programs through its Annual Report. Data on the number of services and benefits paid under each program is published monthly on the Medicare Australia website.

Source: Australian Government unpublished.

Table 11A.72 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
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 services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
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 services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.
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 services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.

Table 11A.72 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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, AHS block funding and Commonwealth funding (Indigenous Health-National Partnership Agreement)	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.
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.

Table 11A.72 New South Wales, community health services programs

Programs funded by the NSW Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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.
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 per cent 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.72 New South Wales, community health services programs

Programs funded by the NSW Government during 2009-10

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.	In 2009-10 funding for these initiatives changed from a Commonwealth/State program under the Public Health Outcomes Funding Agreement to block funding under the Australian Health Care Agreement.AHS receive block funding from the Department of Health to provide health services to their population. AHSs are expected to maintain the levels of funding that were previously allocated under the PHOFA 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 services to a Non-admitted Patient and reported by the AHSs to the Department of Health on a quarterly basis.

Table 11A.72 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2009-10

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 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 mix of AHS and Australian Government funding is allocated for Innovative Health Services for Homeless Youth (IHSHY).	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.72 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
EnableNSW programs	The EnableNSW programs incorporate: • Program of Appliances for Disabled People • Prosthetic Limb Service • Home Respiratory Programs. These programs provide assistive technology including mobility, self care and communication devices, respiratory devices, prosthetic limbs and attendant care to assist people with a disability to live in and participate in the community.	The Department of Health allocates specific funding to the AHSs for this program. NSW funding provided.	The services are required to provide quarterly waiting list reports. Health Support Services Annual Report The EnableNSW Advisory Council annual report.
Dementia services planning	Provides state-wide dementia policy, planning, care services and workforce development. The NSW Dementia Services Framework 2010–2015 is being developed by NSW Health and Ageing, Disability and Home Care, Department of Human Services NSW. Within the context of a rapidly ageing population, the Framework will set the direction for developing quality dementia care in NSW.	The Department has been funded under the NSW Dementia Action Plan 2007–09.	Department of Health Annual report.

Table 11A.72 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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. The Carers (Recognition) Act 2010 was introduced into the Legislative Assembly on 21 April 2010 by the Minister for Health. It was assented to on 19 May 2010. As required under the Act, NSW Department of Health will continue to take action that reflects the principles of the NSW Carers Charter including developing strategies to ensure that the views and needs of carers and the views, needs and best interests of persons for whom they care are taken into account across the continuum of health care services. Note that as from July 2010 carer's policy, planning and funding have transferred from NSW Department of Health to Ageing, Disability and Home Care, Department of Human Services NSW. The transfer includes responsibility for the NSW Carers Action Plan 2007–2012 and for the NSW Carers (Recognition) Act 2010. NSW Department of Health will continue to lead the Family and Carers Mental Health Program, monitor Area Health Service Carers Support Services and provide policy input from a health perspective.	NSW Carers Action Plan 2007–2012.	Annual Reports on activities by AHSs to the Department of Health.

Source: NSW Government unpublished.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Primary Care Partnerships (PCPs) strategy	Cross government funded voluntary alliances of heath and human services provider organisations known as Primary Care Partnerships (PCPs). There are 30 PCPs in Victoria which engage a total of 1200 organisations. The PCPs deliver local service system reforms to: • improve the coordination of services • improve the way health promotion is planned, delivered and evaluated • improve the management of chronic disease. The strategy to improve the coordination of services is supported by a statewide policy and operational framework and includes: • 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 by the Victorian Department of Health. Additional funding provided by other government departments includes the Victorian Department of Justice and the Victorian Department of Planning and Community Development.	Suite of reports as part of the 2009–2012 PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the PCP program logic.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming cultural / language barriers			
Primary Care Partnerships (PCPs) strategy	The PCP strategy to improve the coordination of services to overcome cultural/language barriers includes consumer privacy information brochure and consent form for the disclosure of health and care information is available in over 40 community languages. The local work of PCPs may target specific population groups. For example farmers, people with a refugee background and ethnic communities. The interventions targeted to address the health and wellbeing needs of these groups may include strategies to overcome cultural/language barriers.	Core funding provided by the Victorian Department of Health. Additional funding provided by other government departments includes the Victorian Department of Justice and the Victorian Department of Planning and Community Development.	Suite of reports as part of the 2009–2012 PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the PCP program logic.
Refugee Health Nurse Program	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. Funding is provided to community health services in areas that have high numbers of newly arrived refugees, to employ community health nurses specialising in refugee and migrant health issues. These nurses work directly with refugee communities to improve their health and wellbeing, as well as local service providers to develop a responsive and effective service response for refugee clients. The RHNP also funds a workforce support training program and 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 Integrated Care Branch of the Department of Health is responsible for program development and resource allocation. The department's regional offices monitor program delivery and performance. 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 Integrated Care Branch of the Department of Health.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol and Other Drug Treatment	The Victorian Department of Health funds agencies to provide a range of adult and youth (aged 12 -21 years) treatment services. Programs include: • Counselling, Consultancy and Continuing Care • Withdrawal Services • Post Withdrawal Linkages • Rehabilitation • Alcohol and Drugs (AOD) Supported Accommodation • Pharmacotherapy Services • Mobile Drug Safety • Mobile Overdose Response • Peer Support • Youth Outreach • Parent Support Programs. Drug Prevention Services include: • Family Counselling • Local Initiatives. Health Protection Services include: • Needle and Syringe Programs • Primary Health Services. Treatment services are also provided to offenders referred to treatment from the criminal justice system though the forensic drug treatment and drug diversion program. The 2008-09 State Budget provided over $37.2 million over four years for the implementation of *Restoring the balance-Victoria's Alcohol Action Plan 2008-2013* which includes new prevention, early intervention and treatment services.	The Department of Health funded the following agencies to deliver alcohol and other drug treatment services: • 23 community health services • 21 hospitals • 4 local governments • 61 non-government organisations • 2 universities. Mental Health Drugs and Regions Division of the Department of Health is responsible for overseeing program delivery and budgets.	All funded activities involve a range of accountability and reporting requirements with targets set against each activity. The 'Episode of Care (EOC)' is the main measurement unit and agencies are required to report against EOC targets on a quarterly basis. Information relevant to activity and performance monitoring is collected through a range of channels including Alcohol and Drug Information System (ADIS), and HealthSMART. The outputs collected contribute to a range of national datasets, as well as performance measurement and monitoring against commonwealth, state and departmental targets.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Services for Koori Communities - alcohol and drug treatment services	Koori-specific alcohol and drug treatment services are provided to Aboriginal people who are affected (either directly or indirectly), or who are at risk of being affected, by alcohol and/or other drugs. 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.	Funding is provided through Community Health Services, Aboriginal community controlled health organisations and non-government organisations. Mental Health, Drugs and Regions Division of the Victorian Department of Health is responsible for overseeing program delivery and budgets. Also see: Aboriginal Health.	In 2006, Department of Human Services (DHS) Executive endorsed the *Improving the Way DHS works with Aboriginal community controlled organisations* initiative. This work identified the need for DHS to simplify funding and reporting requirements for Aboriginal organisations. With the creation of the new Department of Health the Executive is committed to continuing with this project and there has been progression towards simplifying and streamlining funding. Also see: Aboriginal Health.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	Koori Community Alcohol and Drug Workers undertake a number of activities to reduce the use of, and harm caused by, drug and alcohol in their communities. These activities include health promotion, information provision, education activities, development and maintenance of community linkages, referrals and counselling. These workers liaise with services in an advocacy role on behalf of the service user. Seven Koori community alcohol and drug resource centres are funded through Aboriginal Community Controlled Health Organisations. The centres were developed as an alternative to incarceration in police cell for people found drunk in public. In the 2010-11 State Budget an additional $4.5 million was provided for services in Shepparton, Bairnsdale and Mildura to strengthen medical and health support with increased nursing capacity. A whole-of-government Koori alcohol action plan is currently under development to prevent and reduce the harm of alcohol misuse and family violence in Koori communities and will encompass prevention, early intervention and treatment.		
Oral Health Program	Public Oral health services are targeted towards Health Care and Pensioner concession cardholders. 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.	Dental services are output funded using a funding formula. Also see: Aboriginal Health.	Performance targets are set by the Department of Health and monitored through various reporting mechanisms to demonstrate program delivery. Examples of targets are people treated, waiting times and quality measures. Also see: Aboriginal Health.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming geographical barriers			
Primary Care Partnerships (PCPs) strategy	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 placed-based initiatives. 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.	Core funding provided by the Victorian Department of Health. Additional funding provided by other government departments includes the Victorian Department of Justice and the Victorian Department of Planning and Community Development.	Suite of reports as part of the 2009–2012 PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the PCP program logic.
NURSE-ON-CALL	NURSE-ON-CALL (NOC) is a statewide telephone-based health line that provides residents of Victoria with timely access to health information, assistance and advice for the cost of a local phone call. The service operates 24 hours, 7 days a week and takes about 1,000 calls per day. NURSE-ON-CALL nurses provide callers with one or a combination of: • triage • health information • information or advice about local health providers.	NOC is contracted to Medibank Health Solutions or MHS (formerly McKesson Asia-Pacific Pty Ltd). The costs paid for the contract are based on call volume.	MHS provide the Victorian Department of Health with a number of monthly reports. These provide data about call volumes, call arrival patterns, call outcome and caller demographics.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming socio-economic 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 Victorian Department of Health and monitored through various reporting mechanisms to demonstrate program delivery. Examples of targets are people treated, waiting times and quality measures.
Overcoming social isolation barriers			
Primary Care Partnerships (PCPs)	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.	Core funding provided by the Victorian Department of Health. Additional funding provided by other government departments includes the Victorian Department of Justice and the Victorian Department of Planning and Community Development.	Suite of reports as part of the 2009–2012 PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the PCP program logic.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
IHSHY program	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.	IHSHY is provided under the National Healthcare Agreement with state and territory governments matching the Commonwealth's contribution.	Quantitative performance targets are set by the Victorian Department of Health and monitored quarterly.
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 provided in areas of highest need that have high numbers of births, higher rates of relative socioeconomic disadvantage and lower service availability. The objectives of the program are to: • improve women's access and attendance at antenatal and post natal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their: • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services.	The Victorian Government funds the program through the Department of Health. The Integrated Care Branch of the Department of Health is responsible for program development and resource allocation. Department of Health regional offices monitor the performance of the program. Funding of this program continues until June 2012.	Quantitative performance targets are set by the Department of Health and monitored quarterly. The performance of the program is also being monitored through a formal evaluation due for completion in mid 2011.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Women's health and wellbeing	The Victorian Women's Health Program aims to improve the health and wellbeing of all Victorian women (with an emphasis on those most at risk), through the development and implementation of targeted health promotion interventions. The dual strategy of delivering gender-specific health promotion interventions while working to improve mainstream services' responses to women is a key aspect of the women's health program.	Prior to 2009-10, funding was provided through the Public Health Funding Outcomes Agreement. From 2009-10, funding is provided under the National Healthcare Agreement. The Prevention and Population Health Branch of the Victorian Department of Health administers the funding for the program. Department of Health regional offices monitor program delivery. There are 12 women's health services funded through the Women's Health Program in Victoria. They include nine regional services, and three statewide services.	Women's health services are required to develop 3 year health promotion plans and report on those plans on an annual basis.
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.	IHSHY is provided under the National Healthcare Agreement with state and territory governments matching the Commonwealth's contribution.	Quantitative performance targets are set by the Department of Health and monitored quarterly.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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.	The Victorian Government funds the program under the *Primary Health Funding Approach* which includes two components: (1) direct care and (2) health promotion.	Performance targets are set by the Department of Health and monitored quarterly. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
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. Under the new National Partnerships Agreement on Essential Vaccines (NPA) 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 2010, 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. As per the NPA the Commonwealth has begun tendering for vaccines. Victoria complements this by providing subsidies and incentive programs to local government. Health Protection Branch in the Victorian Department of Health has responsibility for the Immunisation Program.	Under the NPA, Victoria reports against a range of performance measures such as coverage in a range of cohorts, and wastage and leakage. 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 93 per cent of two year olds are considered fully vaccinated.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Screening	The Screening and Cancer Prevention Unit oversees and delivers population based screening programs and cancer prevention initiatives in Victoria. The screening programs include the national cervical, breast and bowel cancer screening programs, newborn screening and prenatal screening. The Unit has a strong focus on improving participation and addressing health inequities in under screened and non-screened communities. The Unit delivers: leadership and expert advice on screening issues to the Department of Health Victoria and relevant stakeholders; strategic policy development and planning; performance monitoring and trend analysis of programs; improvements in the evidence-based approach to screening policy and programs; capacity building initiatives in health services and screening providers; and supports recruitment and social marketing initiatives.	Funding for cancer screening programs is provided by the Victorian and Commonwealth Governments. Funding for newborn and prenatal screening is provided by the Victorian Government. Initiatives to improve participation by under-screened communities are funded through *Victoria's Cancer Action Plan 2008-2011* .	Annual cancer screening data is reported to the Australian Institute of Health and Welfare and the Productivity Commission, reports against targets agreed in Victorian-Commonwealth funding agreements are provided to Department of Health and Ageing as required, and screening data is reported to a range of Victorian Government and Department of Health Victoria publications.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objectives: ***- Providing timely and high quality healthcare that meets individual needs throughout the lifespan — directly, and/or by facilitating access to 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.***			
Community Health Program	The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 400 sites across Victoria. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers. 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 Victorian Department of Health 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.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Family Planning	Family planning services assist Victorians to make individual choices on sexual and reproductive health matters by providing services that are accessible, culturally relevant and responsive to people who experience difficulty accessing mainstream services.	Prior to 2009-10, funding was provided through the Public Health Funding Outcomes Agreement. From 2009-10, funding is provided under the National Healthcare Agreement. The Prevention and Population Health Branch of the Victorian Department of Health administers the funding for the program in relation to health promotion. The Integrated Care Branch of the department administers funding in relation to direct care service provision.	Agencies funded for family planning health promotion are required to develop 3 year health promotion plans and report on those plans on an annual basis.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Health	Aboriginal community health services are provided through a range of Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services funded by the Victorian Department of Health (department), including community health centres, hospitals and non-government organisations. The Victorian Aboriginal Health Service and other Aboriginal Cooperatives provide a range of medical services. The department is implementing the Closing the Health Gap initiative around two key targets Close the gap in life expectancy within a generation and halve the gap in mortality rates for Aboriginal children under five by 2018. The department is focusing in five key areas of: • Tackling smoking • Delivering primary health care services • Fixing the gaps and improving the patient journey • Healthy transition to adulthood • Making Indigenous health everyone's business. The department has developed a statewide implementation plan, outlining how it will respond to the five priority reform areas addressing 17 key health priority areas. 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 developing chronic disease through health promotion, prevention, early intervention, and ongoing care.	The department has reviewed its funding processes and has reduced activities to five, with the intention to reduce the administrative burden on Aboriginal organisations. The department funds ACCHOs to provide direct service delivery and budgets are managed using three year service agreements. Funding can be provided either at the program level or via the eight regions. Specific funding for Aboriginal programs has been allocated through the COAG Closing the Health Gap strategy.	Performance targets are negotiated between the department and ACCHOs and are monitored through various reporting mechanisms which are being reviewed to support the reduced administrative functions for ACCHOs.

Table 11A.73 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Early Intervention in Chronic Disease	EIiCD focuses upon community based early intervention services for people with chronic diseases. The initiative invests in both Community Health Services and Primary Care Partnerships. The aim of the initiative is to enhance existing capacity of community health services in supporting people with chronic disease in managing the impact of their condition including the physical, emotional and psychological impact of having a chronic disease.	These services are funded under the Primary Health Funding Approach	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are both quantitative and qualitative.
Family and Reproductive Rights Education program (FARREP)	Family and Reproductive Rights Education Program works with communities that traditionally practice female genital mutilation to eradicate the practice through behavioural and cultural change. The program also works with health service providers and other relevant stakeholders to raise awareness about the practice.	Prior to 2009-10, funding was provided through the Public Health Funding Outcomes Agreement. From 2009-10, funding is provided under the National Healthcare Agreement. The Prevention and Population Health Branch of the Victorian Department of Health administers the funding for the program.	Agencies funded for FARREP are required to contribute to a three year statewide FARREP health promotion plan and report against that plan on an annual basis.

Source: Victorian Government unpublished.

Table 11A.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

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 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.	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.
	- 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.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming geographical barriers			
Patient Transport	The Patient Transport Reform Unit (PTRU) and Contract and Aeromedical Services Unit (CASU) provide 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 Units works collaboratively with Retrieval Services Queensland (RSQ), 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.
BreastScreen Queensland Program	The free BreastScreen Queensland Program has a state wide network of 11 Screening and Assessment Services which includes six mobiles, two relocatable and 19 satellite services. The sixth mobile, which is 4 wheel drive was specifically designed for rural and remote areas to provide access to women in these areas. The 4 wheel drive truck services Cape York, the Torres Strait and other remote areas of the State. The mobile service covers the whole State including out to the boarders with NSW, SA and NT. These areas include a significant number of Indigenous communities. The BSQ Service covers over 200 locations on a 2 yearly schedule. Each screening episode is linked to an assessment centre for timely follow up.	Funding for BreastScreen Queensland is provided through the Australian Healthcare Agreement (ACHA) and Queensland State funding.	Data on the BSQ Program including participation, cancer detection and other National Accreditation Standards are collected and reported Nationally and Statewide via Australian Institute of Health and Welfare (AIHW) monitoring reports, Report of Government Services (ROGS report), Service Delivery Statements (SDS), Chief Health Officer reports. Statistical reports are produced biennially for BSQ Services Statewide.

Table 11A.74 Queensland, community health services programs

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Women's health and wellbeing	The Mobile Women's Health Service (MWHS) provides an important outreach health service to women in rural and remote communities, including Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds, who may be geographically or socially isolated. The service is based in 15 locations across Queensland and consists of a specially trained clinical nurse consultant who works as a sole practitioner to provide services that assist in the prevention, early detection and management of women's health issues. In some locations an Indigenous Women's Health Worker works with the nurse to assist in meeting the needs of local Indigenous women.	Funding for the MWHS is provided through state funding and the Australian Government via the Australian Healthcare Agreement (ACHA).	Mobile Women's Health Nurses provide activity data each six months which is reviewed at a program level.
	The Healthy Women's Initiative (HWI) aims to improve health outcomes for Aboriginal and Torres Strait Islander women by implementing an integrated healthy women's initiative focusing on cervical screening and women's health.	Funding for the HWI is provided through state funding and the Australian Government via the Australian Healthcare Agreement (ACHA) and Indigenous Early Childhood Development National Partnership Agreement (IECDNPA).	Healthy Women's Initiative health workers provide activity data each six months which is reviewed at a program level. Reporting also occurs for the IECDNPA through Maternal and Child Health Branch.

Table 11A.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	Universal Post-natal Contact Services Initiative: - Antenatal screening for psychosocial risk factors and health-related behaviours to identify families at risk early in pregnancy and refer/address issues which can impact on ECD - Follow-up post-natal contact (telephone or home visit) within a week of discharge from hospital - Newborn and Family Drop-in Services in 18 communities, providing flexible, open-plan environments for families with newborns up to 8 weeks old to access health professional advice, health promotion information and interact with other parents. Linked with EYC, NGOs, Community Child Health Centres - 24 hour, 7 day a week telephone advice and support on infant and child health issues through 13 HEALTH	$29.7 million over four years (2007-2011) and $12.4 million recurrent allocated to program – distributed across Health Service Districts	6 monthly reporting by HSD on: - per cent of women offered antenatal screening - per cent of women receiving postnatal contact - number of families accessing NFDS - family, staff and stakeholder satisfaction with NFDS services.

Table 11A.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Men's health and wellbeing	The Pit Stop Men's Health Program was developed by Western Australia's Gayscone Population Health Unit and uses a masculine concept, being the car, attached to a series of men's health screening tests. The purpose of the Program is to improve access to relevant health information, address chronic disease risk factors and promote local preventative health services. The Queensland Bowel Cancer Screening Program is currently piloting the delivery of Pit Stop in workplaces targeting outdoor workers, partnering with Queensland Transport and Main Roads and a small number of regional councils. The project is due for completion at the end of 2010 and will be evaluated prior to further rollout. Some ad-hoc community based Pit Stops have also be undertaken (eg. at Bunnings Warehouse sites in South East Queensland for Men's Health Week). In addition to the Queensland Bowel Cancer Screening Program, Pit Stop is also being implemented by other community health and health promotion units within Queensland Health particularly in regional and rural areas.	The Queensland Bowel Cancer Screening Program Pit Stops were provided with state funding in 2009-2010 to assist with infrastructure and establishment costs of the program. Other non-QBCSP Pit Stops are funded through Health Service District budgets	Evaluation data is generated from each QBCSP Pit Stop and will be collated as part of a broader evaluation of these specific Pit Stops at the end of 2010.

Table 11A.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Youth health and wellbeing	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.
Immunisation	The Queensland Health Immunisation 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; coordination and planning; procurement and distribution of funded vaccines; funding and coordination of the School Based Vaccination Program; provision of information and advice to service providers; quality assurance; monitoring of adverse events following immunisation; communication and education; resource development and dissemination; enhancement of the state immunisation database and monitoring, evaluation and research.	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.

Table 11A.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Screening	Cancer Screening Services Branch (CSSB) 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.
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.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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.
Alcohol 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 (the Strategy)* in the strategic priority areas of - enabling environment - education and prevention - early detection, care management and treatment - training and professional development - research and surveillance. Programs are delivered through public, non-government and private organisations, including 16 Queensland Health Sexual Health Clinics providing sexual health and blood-borne virus services. A range of prevention/education initiatives within Queensland Health are coordinated across Queensland by six regional HAHCSH coordinators.	Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State funding programs	Annual Progress Report on the Strategy endorsed by the Premier, reporting on progress against the Key Indicators and priority area performance indicators. Six monthly reports on activities are provided by the HAHCSH Coordinators and funded NGOs delivering services and programs under contract . Other government departments involved in the Strategy provide annual activity reports to QH. There are two program specific NHA indicators against which Qld reports annually. Reports produced for other Commonwealth funding programs (e.g. Closing the Gap, NPA) as required.

Table 11A.74 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Offender Health Services	Offender Health Services (OHS) provide primary health care services to prisoners incarcerated in the eleven publically-run correctional centres across Queensland. The care provided aims to be of a standard comparable to that available to the general community provided through the Queensland public health care system. Offender Health Services supports prisoners to stay healthy and when they are sick and need care, to provide or facilitate access to high quality and safe services provided by Queensland Health.	Offender Health Services is a statewide service funded by Queensland Health out of state funding.	No specific reports are produced. Information is provided to the Australian Institute of Health and Welfare (AIHW) for the production of *The Health of Australia's Prisoners*.

Source: Queensland Government unpublished.

Table 11A.75 **Western Australia, community health services programs**

Programs funded by the WA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Community Health 'at risk' Services (statewide)	"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. Community health services and the joint Commonwealth – State Innovative Health Services for Homeless Youth (IHSHY) program are the major service delivery vehicles for at-risk children and young people. Services for "at risk" populations have a strong focus on collaboration and coordination between other parts of the health system, other government and non government agencies to improve access to services and address the social determinants of health.	Community health services are funded by the Department of Health and funding is provided directly to individual area health services or regions. IHSHY program funds are allocated through service agreements with individual service providers.	The program measure for all non-admitted patient services in Occasions of Service. Annual reporting on IHSHY service delivery and annual financial acquittals to Commonwealth Department of Health and Ageing.
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of benefit / allowance from Centrelink or Department of Veteran Affairs) via: - Public Dental Clinics Metropolitan and Country - Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Scheme - In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people - Aged Care Dental Program. This program provides dental care to residents of Registered Aged Care Facilities. Residents are eligible to receive free annual screening 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.75 **Western Australia, community health services programs**

Programs funded by the WA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
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. The universal child health service 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. Groups at risk of poorer health outcomes such as Aboriginal and Torres Strait Islanders people and newly arrives refugees, are a particular focus. Other service strategies include group work, intensive home visiting services in partnership with other agencies to at-risk families and enhanced services to certain groups with higher health needs such as Aboriginal and refugee families.	The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions.	The program measure for all non-admitted patient services is Occasions of Service.

Table 11A.75 **Western Australia, community health services programs**

Programs funded by the WA Government during 2009-10

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, and 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.	Agreement between the Department of Education 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. The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions.	The program measure for all non-admitted patient services is Occasions of Service.

Table 11A.75 **Western Australia, community health services programs**

Programs funded by the WA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
School Dental Service	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. Costs may apply for this treatment.	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.
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. Child development services also play a key role in health prevention and promotion. Services are provided by a range of disciplines including speech pathologists, physiotherapists, occupational therapists, clinical psychologists, social workers, nurses, podiatrists, child care assistants, therapy assistants, audiologists, paediatricians and medical officers. Services are delivered in community based settings such child development centres, day-care, school and the home environment.	The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions. In the 2010 the WA Government committed an additional $50 Million over 4 years to strengthen these services.	Child Development Information System (CDIS) enables routine management and performance reporting.

Source : WA Government unpublished.

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
General			
GP Plus Health Care Centres (Centres) and GP Plus Super Clinics (Clinics)	The Centres and Clinics 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. They 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. While the GP Plus Centres are financed solely by the State (including capital and operating funding), the Super Clinics are jointly funded by the Australian and South Australian Governments.	Recurrent and Capital State Government funding (Centres) Joint Australian and South Australian Government Capital funding (Clinics) In house programs State Recurrent	Monthly activity and financial data reporting
GP Plus Services	In the Metropolitan and Country Health Regions, there are a range of programs aimed at reducing growth in demand on acute services by preventing admissions to hospital and providing appropriate discharge to services closer to where people live in the home or the community.	Ongoing State Government Project Funding (GP Plus Services Fund)	Quarterly activity and financial data reporting
Allied health services	A range of allied health services are provided by the Metropolitan and Country Health Regions (including speech pathology, occupational therapy, physiotherapy, social work, dietetic/nutrition, psychology and podiatry) through primary healthcare centres including individual therapy, health information, education, group work and advocacy.	Recurrent State Government funding. In the country, funding for allied health services comes from a range of sources	Quarterly and annual client activity reports

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*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
	Both Country Health SA and the Metropolitan Health Region provide the Police Drug Diversion Initiative. This program provides for people apprehended by police for minor drug offences to be diverted from the criminal justice system into education, assessment and treatment.	Annual Australian Government funding	Quarterly client activity and annual financial reports to the Australian Government
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

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*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
Hospital Avoidance and Early Discharge packages	This service, a GP Plus Services Program, provides flexible packages of care to clients in metropolitan area in their place of residence (this includes residential care facilities). There are two types of care packages: home supported discharge; and hospital avoidance. Examples of services provided include: showering and personal care; transportation; medication management/supervision; client observation in their own home; and linkages to ongoing longer term services, allied health; acute wound care, general practitioner home visits, physiotherapy, intravenous therapy, tracheostomy care and PEG care.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Sexual Health	A large non-government organisation receives government funding to provide a broad range of sexual and reproductive health services within a primary / public health framework. The organisation provides comprehensive and confidential sexual health care including: contraceptive advice, supply and prescription; gynaecological issues; sexual health assessment; safer sex information; sexually transmitted infection checks and treatment; sexual relationship problems; women's health, including Pap smears, breast checks and menstrual issues; pregnancy testing, ECP supply; unplanned pregnancy options and counselling; fertility issues; and abuse and violence issues.	Recurrent State Government funding	Quarterly activity and financial reporting data
Children's Centres	Children's Centres for Early Childhood Development and Parenting bring together care, education, health, community development activities and family services for families and their children from birth to eight years of age. Children's Centres help parents and children to get the support they need within their own community. Each children's centre is tailored to meet the needs of the local community.	Funding for staffing and facilities of Children's Centres is managed by Department of Education and Children's Services. SA Health & Department of Families and Communities as primary partner agencies direct community services to be provided from these Centres (from existing budgets).	Biannual reports to the Interministerial Committee for Early Childhood.

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Overcoming cultural/language barriers			
Closing the Gap on Indigenous Health Outcomes National Partnership Agreement	This agreement presents a range of primary prevention, health promotion, environmental health and primary health care programs for Aboriginal and Torres Strait Islander people across the state.	State and Australian Government funding until end 2012/13	Monthly activity and financial data reporting
Indigenous Early Childhood Development National Partnership (IECD NP) Agreement	The National Partnership Agreement on Indigenous Early Childhood Development consists of three elements: • Element 1: Integration of Early childhood services through the development of Children and Family Centres. Administered by Department of Education and Children's Services. • Element 2: Increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health. Administered by SA Health. • Element 3: Increased access to and use of maternal and child health services by Indigenous families. Administered by SA Health.	State and Australian Government funding (inc capital and ongoing) until end 2013/14	Various internal and external activity reporting occurs on a monthly, quarterly, biannual and annual basis.
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, wellbeing programs, clinical services; and adult and child health checks) provided through Kokotinna Tappangga and Purrunna Waiingga in the central northern metropolitan area and through general practice and allied health in country South Australia.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Primary Health Care Services and Aboriginal Health	A range of primary health care services and programs provided by multidisciplinary teams from community settings across metropolitan and country South Australia that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community. These services include transport, parenting programs, clinical services and child health checks.	In metropolitan areas, 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 the Cultural Respect Framework for Aboriginal and Torres Strait Islanders.	In country South Australia, recurrent Australian and State Government funding	Reporting requirements as per the National Strategic and SA Health's monthly activity and financial data reporting.
	In metropolitan areas, Aboriginal Family Clinics is offered, providing sessions at three primary health care sites including medical care, including health care checks.	Mix of recurrent State Government funding and COAG funding	Monthly activity and financial data reporting
	Additionally, in the Central Northern metropolitan areas deliver a service titled Kanggawodli which provides short term pre and post acute clinical support for rural and remote Aboriginal people.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Population Health Programs – Drug and Alcohol Services	The Principal Consultant, Aboriginal Population Health Programs is responsible for the identification, development and evaluation, The Aboriginal Programs Unit is responsible for identifying, developing and evaluating of 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. This is 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 until December 2013	Six monthly activity and financial data reporting
APY Lands Substance Misuse Services	The aim of the service is to have a presence on the APY Lands, Health Regions providing a range of alcohol and other drugs residential and non residential diversionary programs and information for Anangu to contribute to the wellness of the individual, kinship networks and communities. The service comprises of a transitional residential care program, an assertive mobile outreach program and a diversionary/day program (Amata).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

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

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. Examples of services provided under these packages include: showering and personal care; transportation; medication management/supervision; client observation in their own home; and linkages to ongoing longer term services, allied health; acute wound care, general practitioner home visits, physiotherapy, intravenous therapy, tracheostomy care and PEG care.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

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
Universal Contact Visit	A program offered to families following the birth of a baby and involves a visiting child and family health nurse. 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, waiting list 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, waiting list 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.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and Child Health (NB this includes programs co-funded under IECD NP)	Primary health care centres provide a number of programs such as • Antenatal Shared Care Program, including Aboriginal specific antenatal, birthing and postnatal programs.	Recurrent State Government funding	Monthly activity and financial data reporting
	• A community midwifery program provides antenatal, birthing (including home births) and postnatal services to vulnerable women in metropolitan and country South Australia.	Recurrent State Government funding	Monthly activity and financial data reporting
	• Pregnancy to parenting programs in the metropolitan area to 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
	• Aboriginal Family Birthing Program is a culturally respectful and clinically safe program providing continuity of care of Aboriginal women during their pregnancy, birthing and up to six weeks postnatally. Pregnant women are supported by a partnership team comprising a midwife and an Aboriginal health worker. These workers are part of a broader team to ensure that pregnant Aboriginal women receive the level of care they require and that care is provided close to or in the woman's home. This program is available in the metropolitan area and currently in two country areas with expansion to other country areas underway.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	• The Maternal Health Program in country South Australia includes community health and primary health care programs for maternal health which are provided through community health services to meet the needs relating to maternal issues. Aboriginal family birthing initiatives are established in Pt Augusta and Whyalla with expansion to other Country Health SA sites in 2010. Country Health SA has established a Maternity Services Steering Committee with the intention of determining the most appropriate models of maternity service provision for country hospitals and health services.	Commonwealth and State Government funding	Monthly activity and financial data 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 are 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 most vulnerable in the community. A number of specific women's health centres in the metropolitan area provide a range of primary health care services and programs for women. • Includes services that focus on: health education/promotion; sexual health clinics; well women clinics; mental health and therapeutic and lifestyle counselling interventions; risk factor and chronic conditions self management group programs, domestic violence and support for some specific groups of women (e.g. older women, same sex attracted women, Indigenous women and multicultural women).	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	• 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 (i.e. a public health agency) focuses on mental health and those effected by violence, as well as specific cultural groups • The Southern Women's Health Service (i.e. metropolitan Adelaide) offers primary health care services for women are provided through community health services across country areas.		
Men's health and wellbeing	Across metropolitan and country South Australia, there are 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. • In country South Australia, there is the support of Men's Shed Programs • In the northern metropolitan area, the 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
	• In country South Australia, a "Men in Communities Program" for Country Health South Australia was established in 2008 to provide support for men's psychological health and well being and in coping with the stress associated with prevailing impact of drought. This program is part of the South Australian Government's Drought Initiatives.	One year State Government funding	Ongoing formal evaluation of Men's Programs and monthly financial and activity reporting.

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

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 via a network of community based teams provides mental health services to children and young people up to 18 years and their families who are experiencing emotional, behavioural or psychiatric problems. This includes: a therapeutic service; child and family specialists, 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 Aboriginal and Torres Strait Islander peoples; 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
	• The Early Intervention Pilot Program, in partnership with South Australian Police and Office of Crime, Statistics and Research (OCSAR), is a diversion program targeting young people aged under 10 - 17 who have been detected 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

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	• Headspace is a mental health counselling program for young people provided in the metropolitan area.	Commonwealth funding provided to a local Division of General Practice	Division of General Practice reports activity and financial data direct to Commonwealth
	• Primary health care, sexual health, mental health and drug and alcohol services for young people are provided through community health services and at a youth health service that shortly will become part of the GP Plus Health Care Centre Marion.	Recurrent State Government funding	Monthly activity and financial data reporting
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. Country Health SA only provides Financial data 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

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*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. • Early childhood development services are multidisciplinary interventions for children 0-4 years of age with, or at risk of, developmental delays. These services are delivered by both metropolitan and country Health Regions. Service models are 1:1; group and supported playgroups options for families; and provided from primary health care centres. Children are prioritised according to levels of active adversity. Guardianship of the Minister and Aboriginal children are of the highest priority. • In the country, specialist paediatricians and allied health staff assess children in community and country locations with specific behavioural and cognitive issues which are impacting on the child's development. Referrals are made to appropriate specialists.	Recurrent State Government funding	Monthly activity and financial data reporting
	• Children's Centres for Early Child hood Development and Parenting are an across Government initiative proving service hubs throughout the state where a range of education, care, health, community development and family support services are available for families with young children aged up to eight years. Children's centres are primarily based in educational settings where families attending education and care programs can access a range of services that support parenting and promote early childhood development.	Funding for staffing and facilities managed by Department of Education and Children's Services. SA Health & Department of Families and Communities as primary partner agencies direct community services to be provided from Centres (from existing budgets).	6monthly reports to the Interministerial Committee for Early Childhood.

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*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	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 by Breast Screen SA 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
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 Funding	Monthly activity and financial data reporting

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*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
	The Do it for life Program is a statewide lifestyle modification program aimed at high risk adults with SNAPS risk factors (Smoking, Nutrition, Alcohol, Physical Inactivity and Stress). Specifically trained lifestyle workers assist clients to change behaviours to reduce the risk of developing chronic disease. Adults who score 12 or more on the AUSDRISK scale are eligible and people from vulnerable and disadvantaged populations are prioritised for service.	Commonwealth and State Government Funding over five years Recurrent State Government funding subject to outcomes review	Quarterly activity and financial data reporting
	The Eat Well Be Active Healthy Weight Strategy for South Australia 2006-2010 provides the overarching framework for action and reinforces our whole of Government mandate that promotes action across multiple, targeted settings and sectors, including but not limited to education, transport, urban planning, primary industries, Local Government and community services. Under this framework a range of initiatives have been funded which promote healthy eating (including breastfeeding) and physical activity. These programs fall under 4 main strategy areas being community education, school and community based programs, policy and legislation and building capacity through research, evaluation and workforce development.	Recurrent State Government funding; Australian Government funding provided through for the Measure Up campaign and for Healthy Workers initiatives Joint Australian (non recurrent) and State Government (recurrent) funding	Regular financial and activity reports to the State Government.

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	OPAL (Obesity Prevention and Lifestyle) is a significant new childhood obesity prevention initiative. Local councils support communities by coordinating activities and making changes to local services to make sure healthy choices are easy for community members. OPAL has commenced in six South Australian communities and this will grow to 20 communities by 2012. Every six months new information about healthy eating and physical activity will be provided to communities around South Australia.	Non-recurrent State Government funding	Annually to the Australian Government; Regular financial and activity reports to the State Government.
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. This initiative aims to reduce workforce pressure on general practice in areas of high demand or areas with significantly high rates of chronic disease; to support general practitioners in the improved management of chronic conditions from early detection to complex co-morbidities; and to complement the role of the general practitioner by providing a variety of services, ranging from clinical care and service coordination, to maintaining good health through screening, health promotion and education for individuals and the community. This program is delivered in both Metropolitan and Country Heath Regions.	Recurrent State Government funding (pending review)	Monthly financial and activity data reporting

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

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
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
	• The Transition Care Program provides case management and slow stream restorative care for older people on exit from hospital. The package transitions hospital patients from an acute service back to the community resulting in decreased hospital length of stay and improved patient outcomes.	Recurrent State and Commonwealth Government Funding	Quarterly activity and financial data reporting. Annual Financial statements
	• In Adelaide's central and northern suburbs the Transition Care Program (TCP) Plus provides care for clients who are seeking placement from hospital in a residential facility and case management to assist with finding a permanent placement.	Recurrent State Government Funding and fees to referrers	Monthly activity and financial data reporting
	• Tregenza House provides short term post acute restorative support within a home like environment.	Recurrent State Government funding	Monthly activity and financial data reporting
	• In country South Australia, there is the provision of residential and community based care packages to assist older people with the transition from an acute service episode back to home.		

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*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
Regional Falls Prevention Program	In Adelaide's Metro areas, a regional approach/ program to falls prevention and support for complex fallers with the aim of reducing disability and hospital presentations.	One-off and recurrent 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 reporting

Table 11A.76 **South Australia, community health services programs**

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	The City Watch House Community Nursing Service (CWHCNS) provides assessment, treatment, management and referral of people held in police custody at the City Watch House. It is recognised that the first 24 hours in custody people are at the most risk for impulsive behaviours due to situational crisis, intoxication, mental health issues and withdrawal from substances. The CWHCNS assists South Australian Police in managing physical and mental health issues of detainees held in custody. The CWHCNS provides consultation, liaison and referral to community services for detainees which includes Drug and Alcohol Services South Australia, Mental Health Services, Street-to-Home Program, general practitioners, Aboriginal Prisoners & Offenders Support Services and other Government and non-Government services.	Recurrent State Government funding	Quarterly data and activity reports 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	Annual activity 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	Annual activity and financial data reporting
	The Good Sports Program helps community sporting clubs manage the sale and consumption of alcohol in their venues. The program challenges community and club culture around risky alcohol service and consumption, underage drinking and drink driving. Training of volunteer bar staff and multiple capacity building strategies are utilised.	Recurrent State Government funding and grant from Motor Accident Commission	Activity and financial reports to State Government, Australian Drug Foundation and Motor Accident Commission

Table 11A.76 South Australia, community health services programs

Programs funded by the SA Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
	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.	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 In both country and metropolitan areas to be diverted from the criminal justice system into education, assessment and treatment.	Funded under the National Health Care Agreement	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
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. As both training for staff and a program for community, the oral health program has developed and implemented a Lift the Lip referral tool for general practitioners, nurses and childcare workers.	Recurrent State Government funding	Monthly activity and financial data reporting
Sexual Assault	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.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

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, North West) are responsible for area spending and overseeing program delivery. Services are 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, 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 Reporting in accordance with program specific requirements.

Table 11A.77 Tasmania, community health services programs

Programs funded by the Tasmanian Government during 2009-10

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. **Youth Health Services** offer young people aged 12 -24 years a flexible and confidential service including information, education, support, referral and counselling. **Other Primary Health services** include Aged Care Assessment Teams, Community Equipment Scheme, Community Rehabilitation Services, Community Therapy Services, (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry) Continence Services, 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.		
	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	
Overcoming cultural/language barriers			
Interpreter Services	Tasmanian DHHS provides access to Interpreter Services for CALD clients in all health settings as required.	Services are purchased on an as needs basis	

Table 11A.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

Program area	*Description*	*Budgetary context*	*Reporting*
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.		
Telehealth services	Telehealth available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs 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.		

Table 11A.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

Program area	*Description*	*Budgetary context*	*Reporting*
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
Community Recovery Coordination	Community Health provides coordination of the Agency's community recovery responsibilities covering the human and social elements of disaster recovery	As per comments under general section	As per comments under general section
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	
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 and Australian government funding. Services delivered and managed within an Area Health Service framework.	

Table 11A.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

Program area	*Description*	*Budgetary context*	*Reporting*
Chronic Disease Demonstration Service (Diabetes type 2)	Chronic Disease Demonstration Service (Type 2 Diabetes) provides multi disciplinary care for individuals referred by GPs 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.		
Community Equipment Scheme, Spinal Account and Continence Aids	The CES and Spinal Account 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.		

Table 11A.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

Program area	*Description*	*Budgetary context*	*Reporting*
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.		
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
Other programs			
Alcohol and Drug Services	Alcohol and Drug Services provide 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.

Table 11A.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

Program area	*Description*	*Budgetary context*	*Reporting*
Disability, Child, Youth and Family Services	Disability, Child, Youth and Family Services provides a range of services including Disability, Child Protection, Out-of-Home Care, Adoptions, Child Health and Parenting, Youth Justice, Targeted Youth Support, Gambling Support, and Family, Violence and Counselling Services. The newly implemented Gateway and Integrated Family Support Services and other reform initiatives have directed a greater focus on intervening earlier, and better integration of the delivery of child protection and family support services. Recent engagement of Gateway Services for people with a disability, their families and carers will provide a single point of access and thereby aid system navigation and coordination for this client group.	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 Tasmania Together, Budget Papers, Departmental Annual Reports and Activity and Performance Information reports. Performance information is also reported at the national level through National Minimum Data Sets, the Report on Government Services, the Australian Institute of Health and Welfare, and the National Disability Agreement.
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.77 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2009-10

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

Source: Tasmanian Government unpublished.

Table 11A.78 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
General			
Corrections Health	Provides Primary Health Care services and coordinates clinical services at secondary and tertiary level to adult and youth detention services through the Alexander Maconochie Centre and Bimberi Youth Justice Centre respectively.	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
Child, Youth & Women's Health Program	Provides Maternal and Child Health nursing services including universal first home visit, child health checks, parenting education and support and vulnerable families program. Child Health Medical Officers; early childhood immunisation and school based immunisation programs; kindergarten health checks, audiometrists and orthoptic screening; school youth health nurses; specialised services for children dependent on respiratory technology, physiotherapy; social work and nutrition services. Women's Health service includes women's health assessment, 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

Table 11A.78 Australian Capital Territory, community health services programs

Programs funded by the ACT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation	• Within the Health Protection service, the Vaccine Delivery Service (VDS) delivers National Immunisation Program (NIP) vaccine to ACT Maternal Child Health clinics and General practices. The VDS staff assist practice and clinic staff to monitor storage conditions of vaccine to ensure cold chain standards are maintained as per National guidelines. • Communicable Disease Control (CDC) purchases stocks of Rabies vaccine and immunoglobulin (RIG) for the post exposure treatment of Rabies (overseas travellers/travellers returning home) and Australian Bat Lyssavirus (ABL). CDC also stocks small quantities of Hepatitis A vaccine for use in the event of an Hepatitis A outbreak. • To improve vaccination rates of refugees (mostly ineligible for vaccines on the NIP), CDC holds small quantities of Inactivated Polio (IPOL) and Adult Diptheria,Tetanus (ADT) vaccine.	Through a designated budget	CDC report RIG usage to Communicable Disease Network Australia (CDNA). Certain vaccine usage levels are reported to DoHA monthly and an internal database tracks all deliveries via batch numbers.
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 in community based clinics and under general anaesthetic; dentures and dental appliances; oral hygiene; domiciliary dental services 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 organizations.	Through a designated budget	Monthly/Annual reports against output targets and budget

Source: ACT Government unpublished.

Table 11A.79 Northern Territory, community health services programs

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Maternal and child health/ Children's health and wellbeing/ Youth health and wellbeing	The role of Maternal Child Youth Health services is to promote and support delivery of current, evidence-based programs in remote Aboriginal communities. Remote Outreach Midwives provide clinical expertise, share knowledge and information through education and orientation to staff and provide clinical services in communities without on-site midwives. The Midwifery Group Practice is an urban-based midwifery model that provides continuity of care to Aboriginal women residing in seven remote Top End communities, when they travel to Darwin to give birth. Care and education is provided in the later part of pregnancy, through labour and birth and the early postnatal period by midwives and Aboriginal Health Workers. The role of child health services is to promote well child health through evidenced-based programs that provide a platform for screening, monitoring for growth and development, vaccination and health promotion, including the opportunity to work in partnership with parents to share information and advice. Child Health Nurses and Child Health Aboriginal Health Workers provide clinical expertise, share knowledge and information by providing education and orientation to staff, and work collaboratively to support school based health and screening programs. Community-based Child Health Workers reside in some communities, providing support to remote Health Centre staff and visiting staff and engaging community members in child health activities and evidence-based child health programs. Community-based Strong Women Workers work in some communities, in collaboration with remote staff, to provide bi-cultural education and advice to pregnant women, new mothers and young girls to promote healthier lifestyles and improve outcomes for both women and babies.	These services are funded through an identified program within the NT Department of Health and Families budget and Northern Territory Closing The Gap funds. Some funding is also provided through the Council of Australian Government Indigenous Early Childhood Development National Partnership Agreement.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report. Performance milestones against the Indigenous Early Childhood Development National Partnership Agreement Implementation Plan.

Table 11A.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Women's health and wellbeing	The Women's Health Strategy Unit (WHSU) engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders and coordinates the Department of Health and Families' responses to this work; project manages key strategic pieces of work to progress priority women's health issues such as those for Aboriginal and Torres Strait Islander Women, Migrant and Refugee Women and Domestic and Family Violence; manages the work of the Women's Information Service (WISe) in Alice Springs and acts as a source of information and leadership across the Department in regards all aspects of women's health.	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.
Men's health and wellbeing	The newly established Men's Health Strategy Unit (MHSU) will employ the Men's Health Program Leader and the Aboriginal Male Health Advisor. The MHSU will provide expert advice, leadership and strategic directions in men's health with a particular focus on Aboriginal Male Health. The Unit will also lead the development of a men's health strategy and the strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. The MHSU will work in collaboration to develop partnerships with key stakeholders from DHF, non-government organisations, peak men's health agencies and Aboriginal community-controlled organisations. The MHSU will work in partnership with the Women's Health Strategy Unit to improve policy development and territory-wide planning, evaluation and resource development specific to men's and women's health. The MHSU will support the co-ordination and integration of Aboriginal men's health programs across other Units, Branches and Division's within DHF by adopting a life course approach.	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.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation	CDC provides education and (privately purchased) rabies vaccine for pre-exposure prophylaxis against Australian Bat Lyssavirus (ABL) to persons at risk of occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and some regional centres to those potentially exposed to both rabies virus and ABL. Education programs are provided to the community and to occupational groups.	The post exposure program is funded through an identified budget within the Department of Health and Families. DoHA refunds 50% of the cost of rabies immunoglobulin administered to people who are bitten or scratched by bats only.	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.
Screening	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.
	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 cho	These services are funded through an identified program within the Australian Health Care Agreement.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Families Annual Report. WWCS prepares reports for 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 AIHW National Monitoring report for cervical and breastscreen.

Table 11A.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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 Home 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.
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.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Remote Health	The role of Remote Health is to ensure that evidence-based, best practice primary health care services are delivered to the remote population throughout the Northern Territory. Services are delivered through Departmental Health Centres (54), non-government organisations (some funded by the Department), and independent community-controlled organisations. 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 multi-disciplinary health teams at remote Health Centres throughout the Northern Territory. Around 90% 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 e.g. tourists.	Remote Health services are funded through an identified program within the NT Dept of Health & Families budget. External funding is provided by the Dept of Health & Ageing through the Office of Aboriginal & Torres Strait Islander Health (OATSIH) under the Enhanced Health Services Delivery Initiative (EHSDI).	Reporting - performance targets against 6 agreed Priority Action Areas: (1) Promote Good Health and Manage Chronic Disease, (2) Prevent Outbreaks of Disease (3) Promote Safety, Reduce Injuries and Reduce Suicide (4) Improve Men's Health and Wellbeing (5) Build a Healthier Workforce (6) Addressing Climate Change Impacts on Health and Wellbeing . A suite of core Primary Health Care indicators have been developed in conjunction with OATSIH, and reported against by DHF and non-Government remote primary health care providers across the Northern Territory. Financial reports are published in the DHF Annual Report.

Table 11A.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Preventable Chronic Disease Services	The Chronic Conditions Strategy Unit provides policy and professional advice and support to policy makers and health professionals in both government and non-government services in the NT. The NT Chronic Conditions Prevention and Management Strategy 2010-2020 was developed as a joint process by both government and non government groups, and there is a shared commitment to using this strategy for service planning and delivery across the NT. The Strategy Unit works with policy makers and service providers to implement the strategy which has focus on social determinants and primary prevention, as well as system improvements for early detection and disease management. A governance structure for implementation of the strategy includes a cross government group with working groups to develop specific aspects and embed system change.	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. Chronic disease indicators included in the NT Aboriginal health KPI's. A monitoring and evaluation framework is currently being finalised and an annual report will be provided to the CCPMS governance group.
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 commitment to the planning for sustainable health promotion through investment into research, program planning, evaluation, and developing education and training pathways. 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. HPSU also provides jurisdictional leadership in relation to the national preventative health agenda.	These services are funded through an identified unit 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.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
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, and in remote communities they provide group education through health centres, women's centres etc. 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.
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 EHSDI 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.

Table 11A.79 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2009-10

Program	*Description*	*Budgetary context*	*Reporting*
Other programs			
Oral Health	Oral Health Services provide free assessment and treatment to all children up to school-leaving age and to adults holding a current 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. Additional reporting associated with National Partnership Agreements provided to the Australian Government.
Alcohol and other drugs	The Alcohol and Other Drugs Program (AODP) develops policies, strategies and programs to prevent and respond to the misuse of alcohol, tobacco and other drugs. The AODP includes policy development and legislative compliance, community development, accredited training, services development and treatment and care services and programs.	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 Health Protection 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 programs 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.

Source: NT Government unpublished.