
11 Primary and community health

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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 (GPPII)
- 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

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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)

	<i>Australian Government</i>				<i>State, Territory and local government</i>	<i>Total government</i>	<i>Non-government</i>	<i>Total government and non-government</i>
	<i>DoHA DVA</i>	<i>Insurance and other^a</i>	<i>premium rebates^b</i>	<i>Total^c</i>				
Community and public health ^d	2 189	4	1 189	6	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.

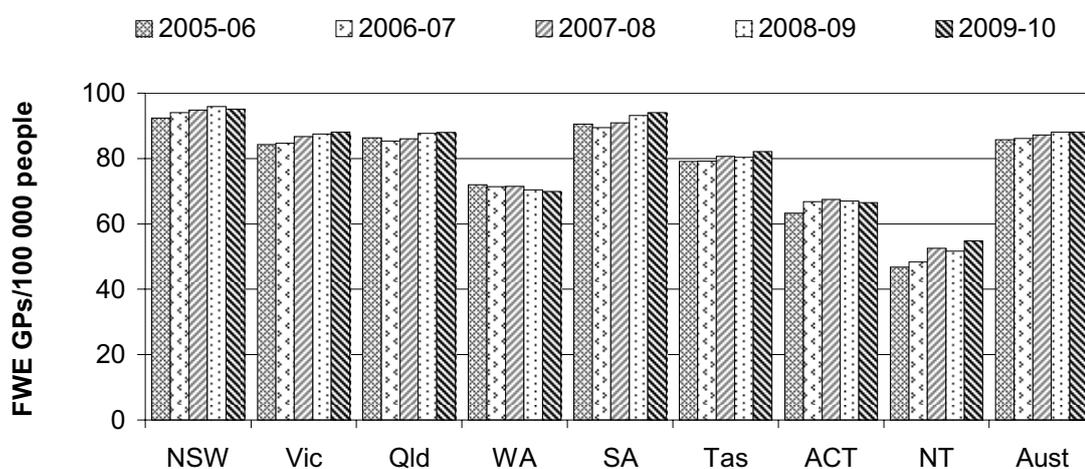
Source: AIHW (2010) *Health Expenditure Australia 2008-09*, Cat. no. HWE 51.

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

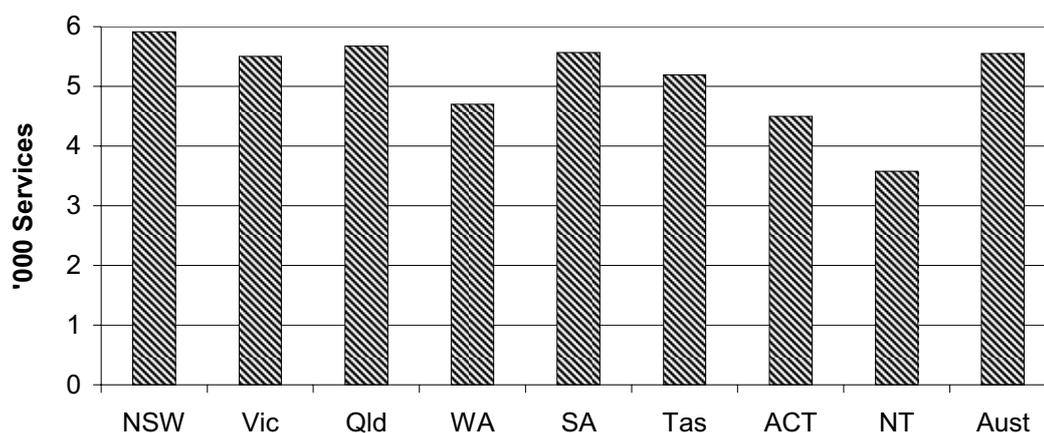


^a Data include vocationally recognised GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice.

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)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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:

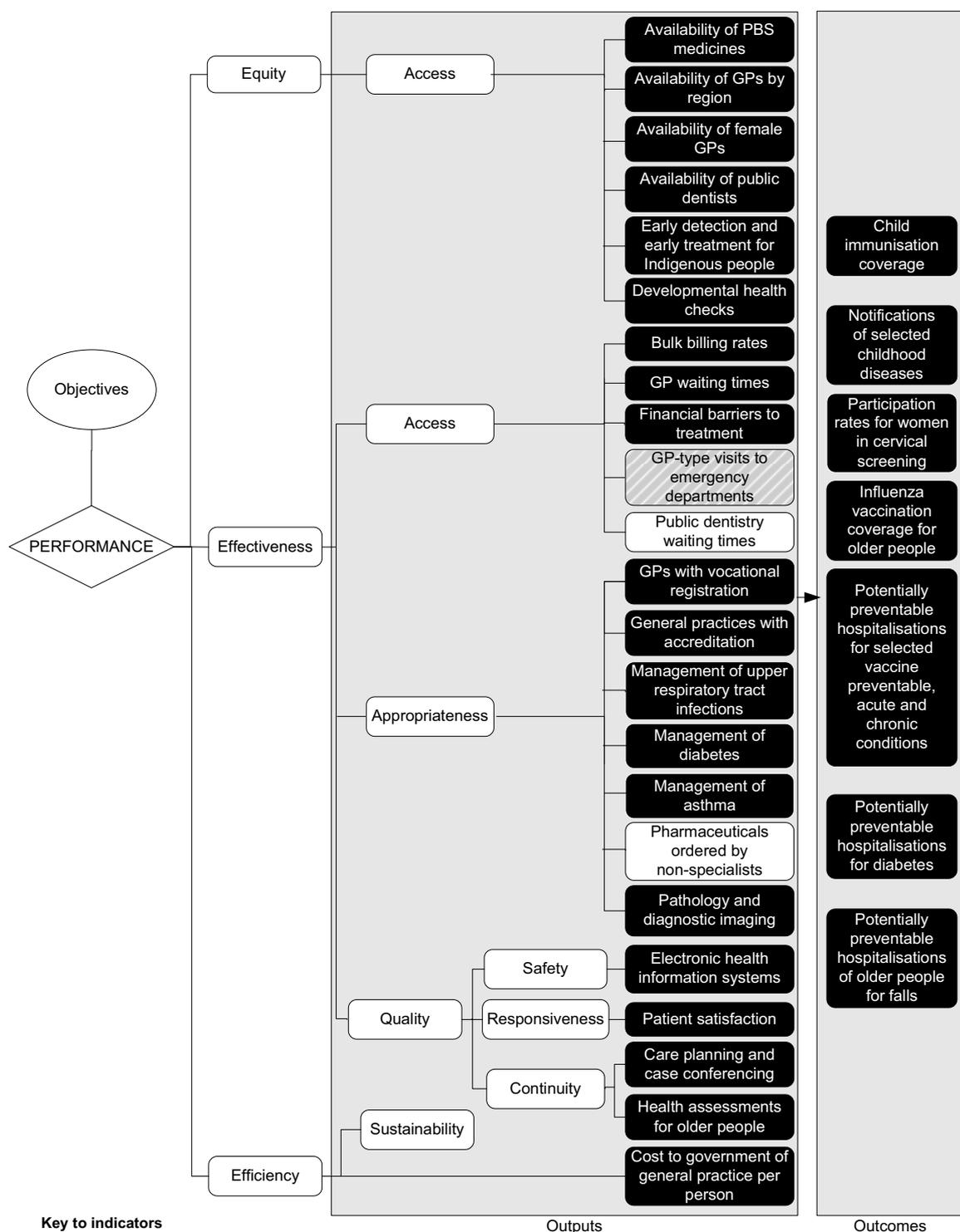
- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating 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



Key to indicators

- Text Data for these indicators comparable, subject to caveats to each chart or table
- Text Data for these indicators not complete or not directly comparable
- Text These indicators yet to be developed or data not collected for this Report

11.3 Key performance indicator results

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

Outputs

Outputs are the 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.

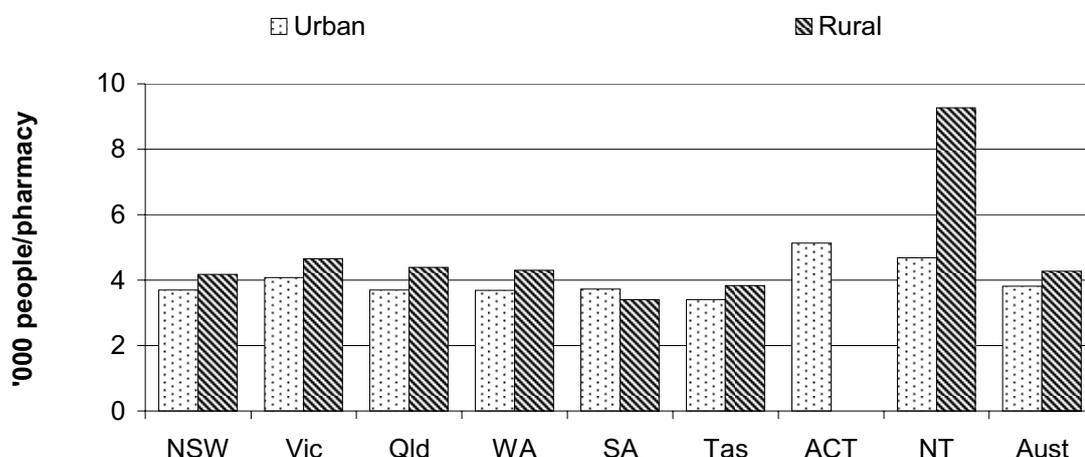
Data quality information for this indicator is under development.

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 public¹ — 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**

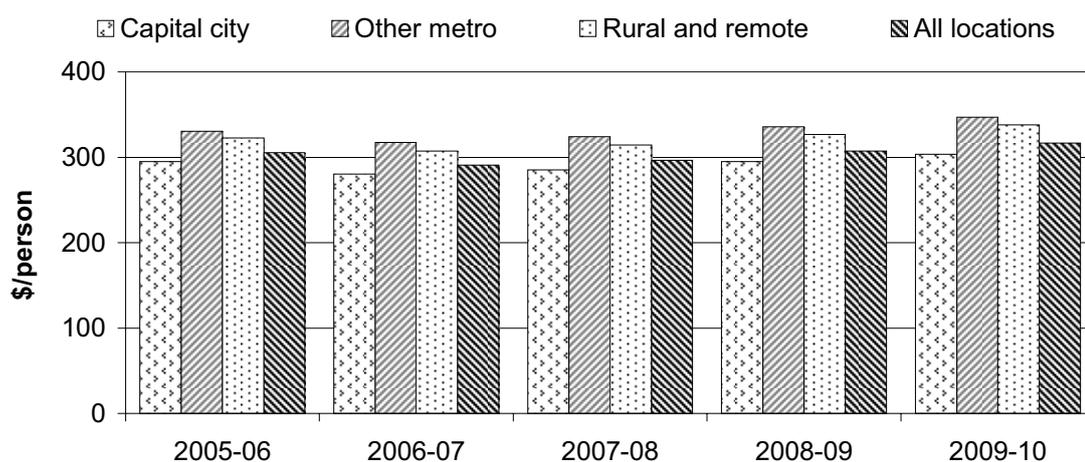


^a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2-6. The ACT has no rural PhARIA areas.

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* [Cwth]).

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.

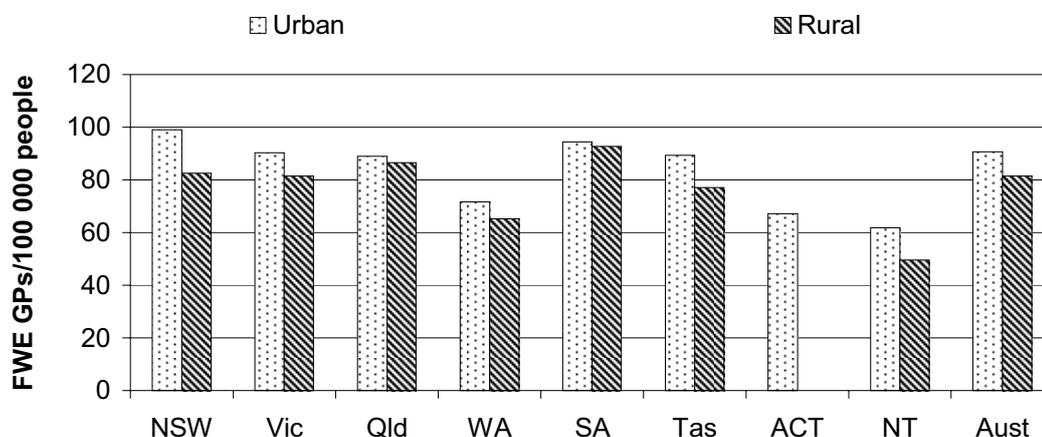
This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.

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.

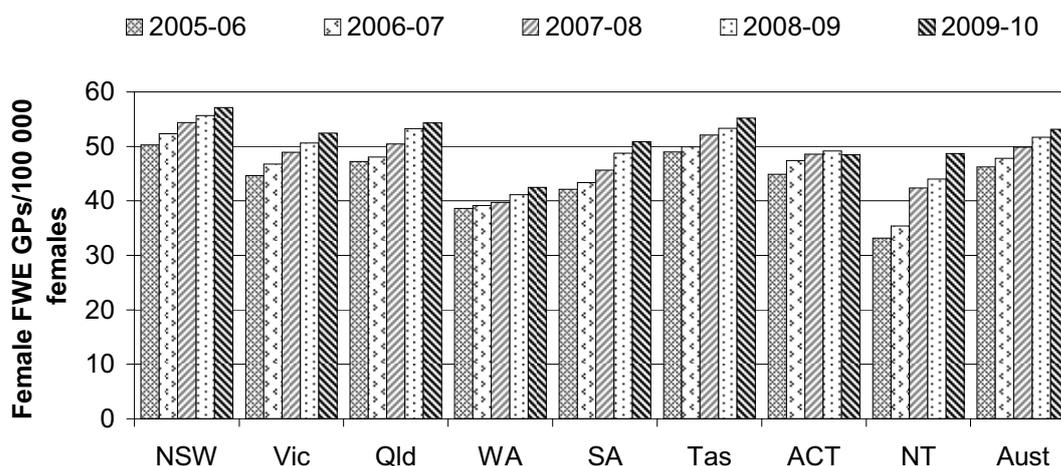
This indicator does not provide information on whether women are accessing female GPs or whether the services are appropriate for the needs of the people receiving them.

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.

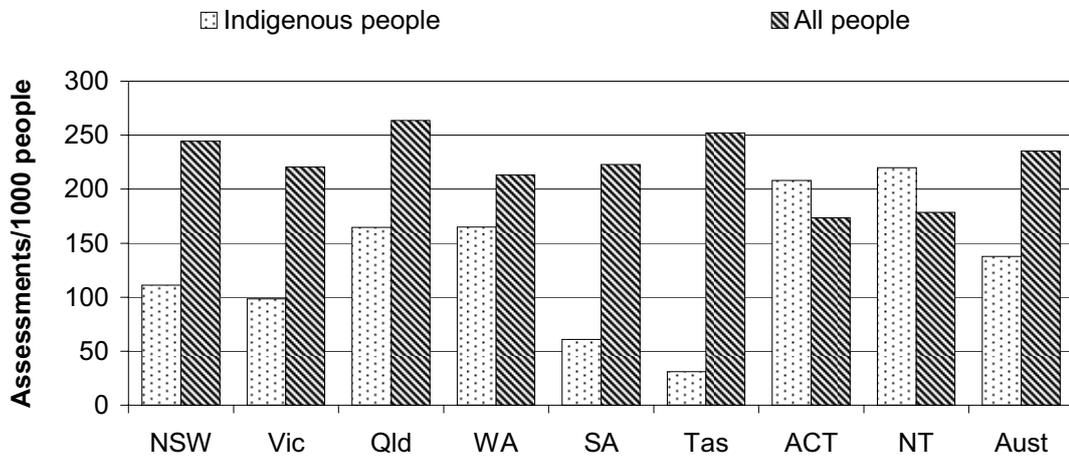
The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2008a; SCRGSP 2009). Early detection and early treatment refers to the identification of individuals who are at high 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}

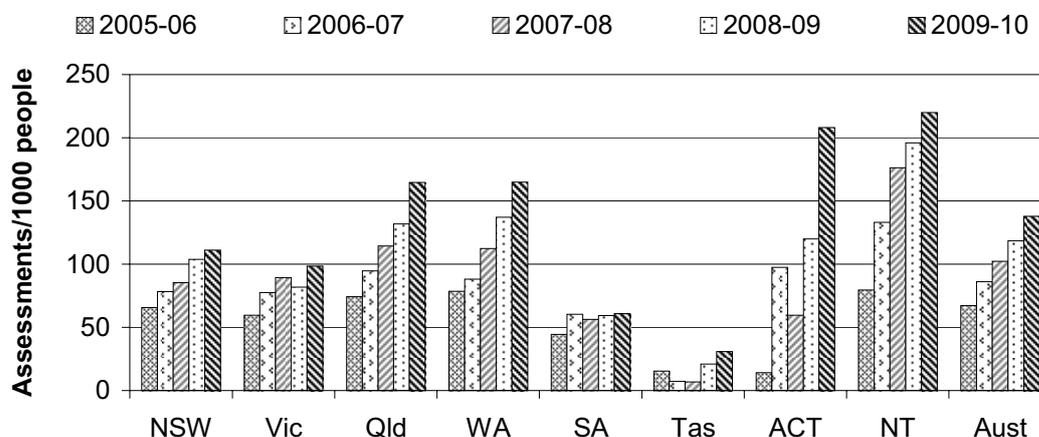


^a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. ^b Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This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



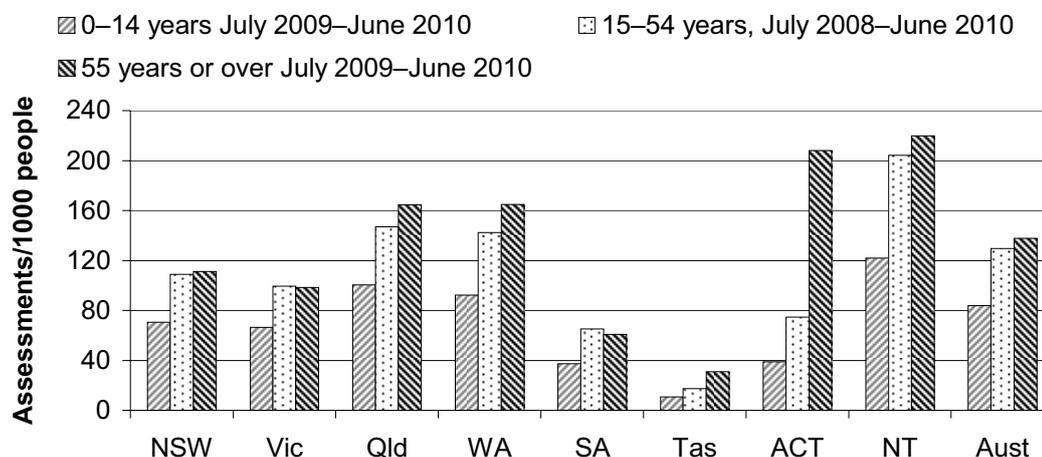
^a Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect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

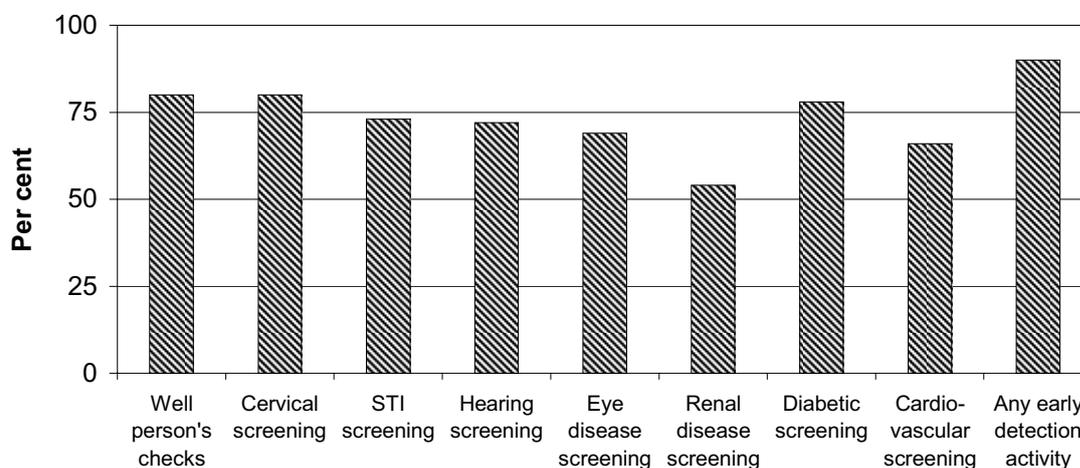


^a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy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

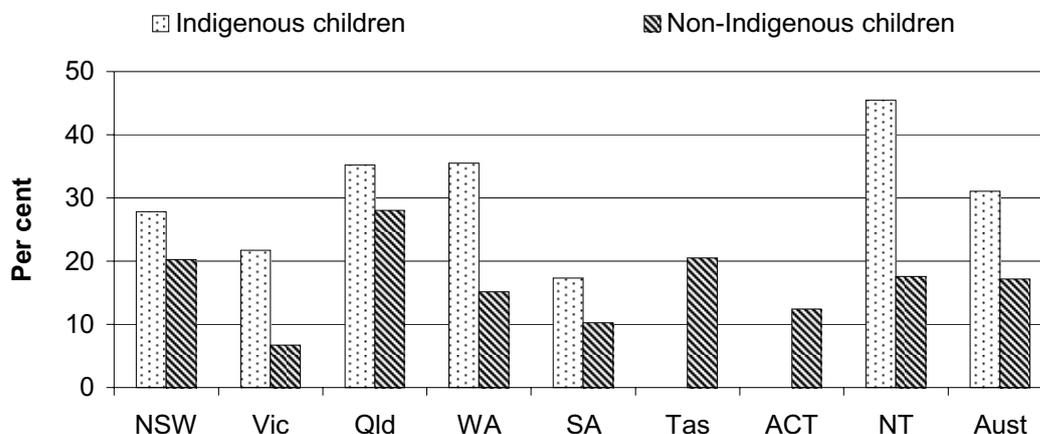
The fourth year developmental health check MBS item was introduced in 2008, and is intended to assess children's physical health, general well-being and development. It enables identification of children who are at high risk for, or have early signs of, delayed development and/or illness. Early identification 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.

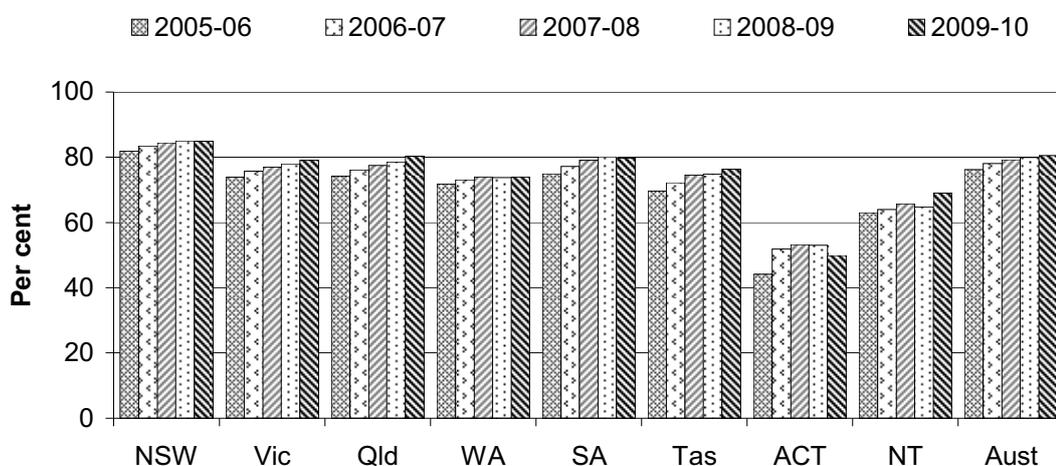
This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

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.

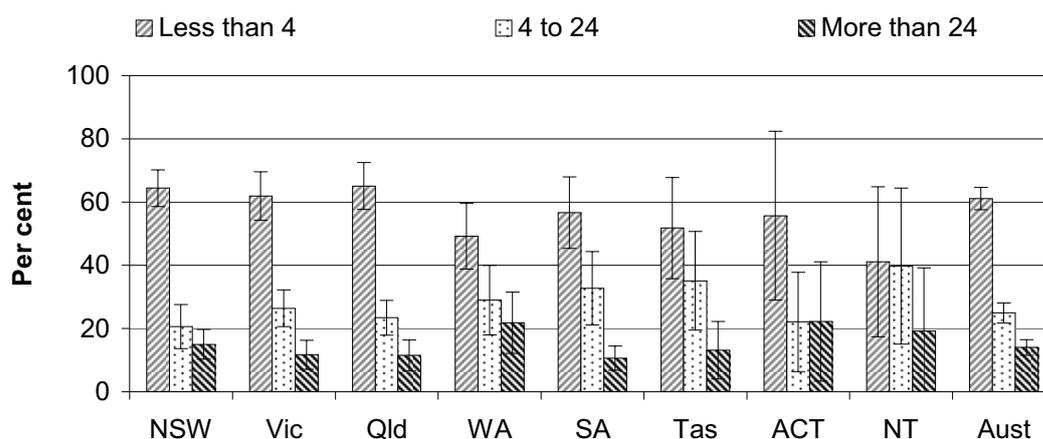
An increase in the proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

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.

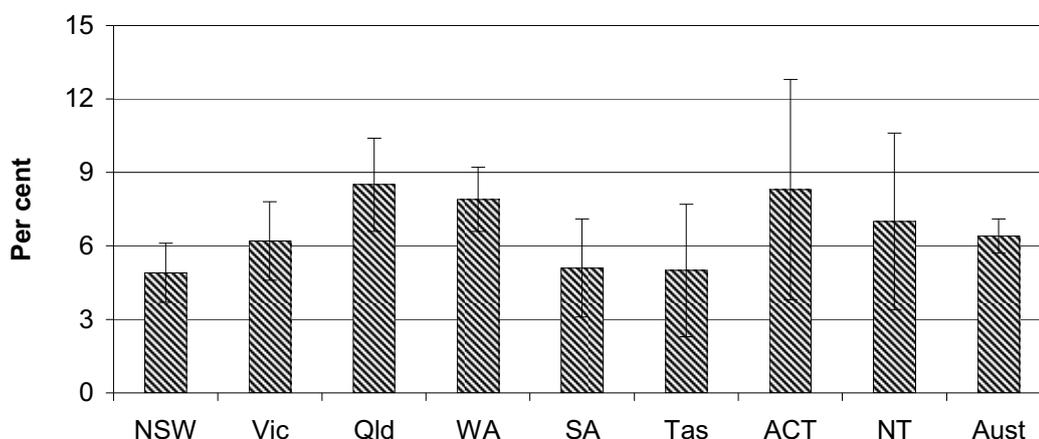
A lower proportion of people deferring treatment due to financial barriers indicates more widely affordable access to GPs and medications.

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}

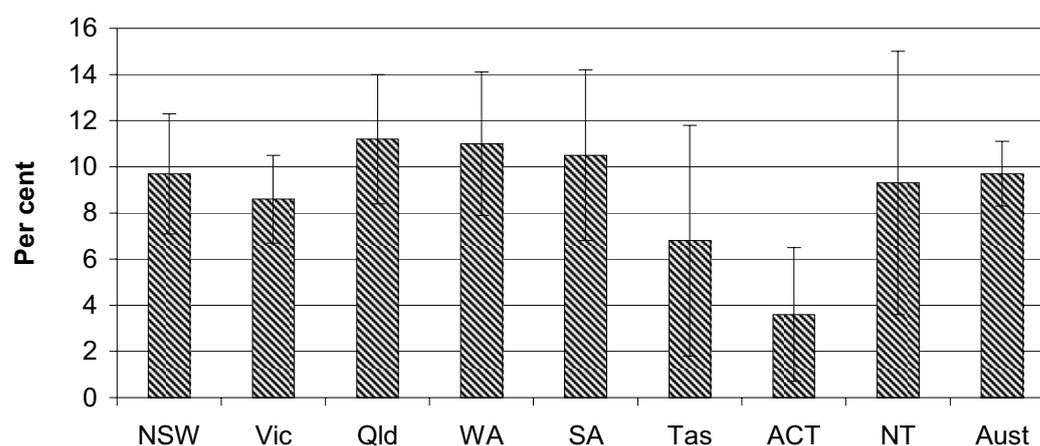


^a People aged 15 years or over. ^b Delayed visiting or did not visit a GP at any time in the previous 12 months. ^c Rates are age standardised to the Australian population at 30 June 2001. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

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}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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.

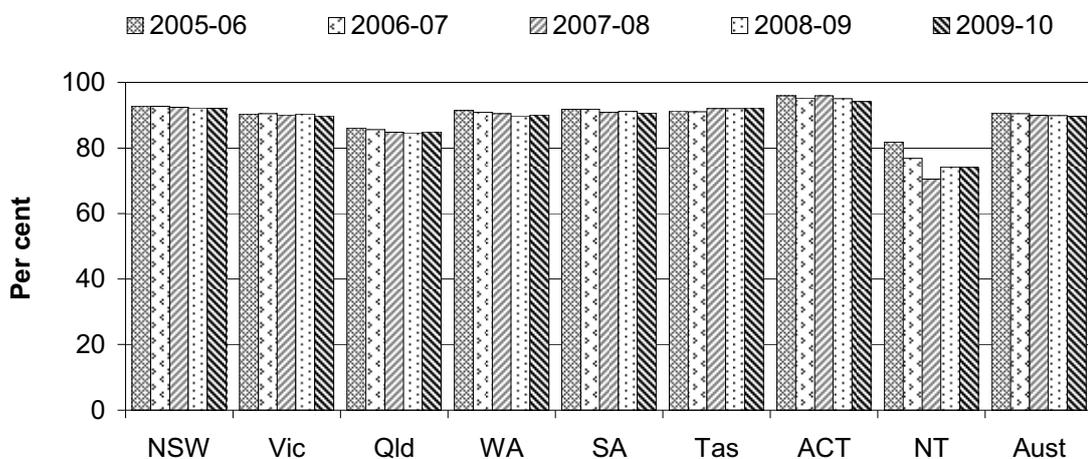
Data for this indicator are comparable.

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.

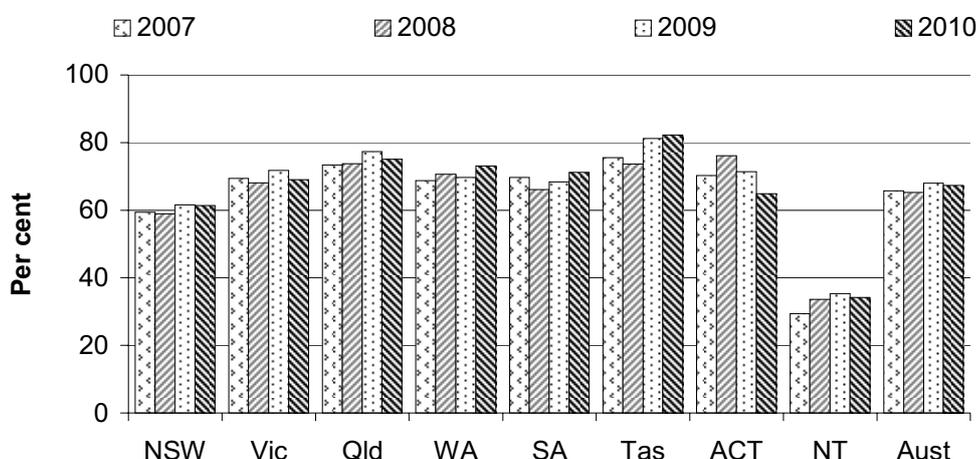
Data for this indicator are comparable.

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).

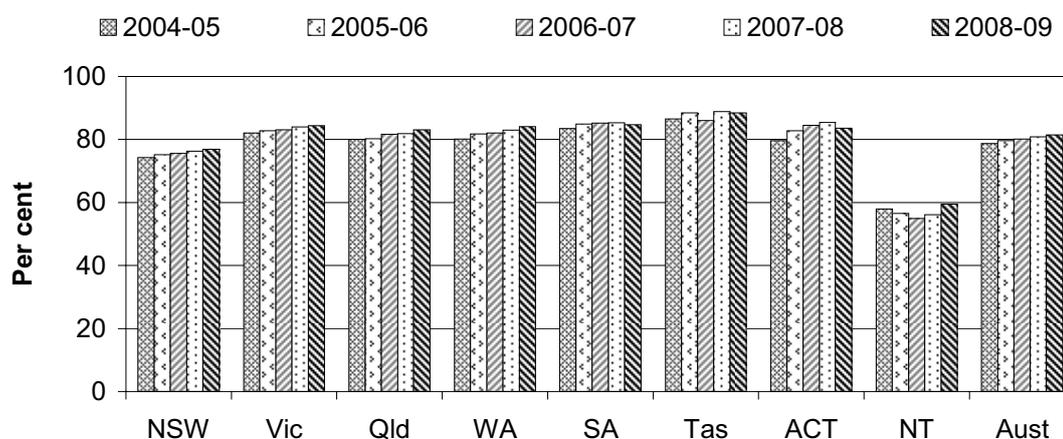
Figure 11.18 General practices with accreditation, at 30 June



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.

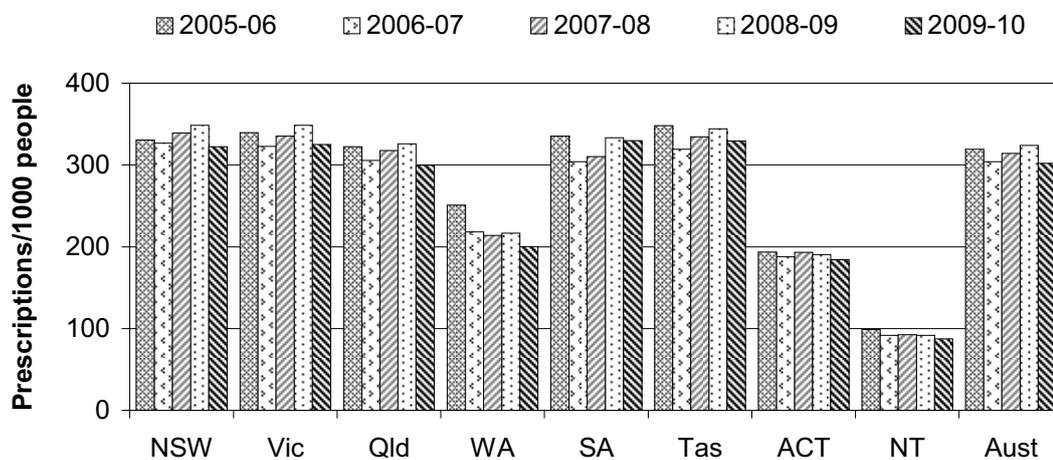
The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed.

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.

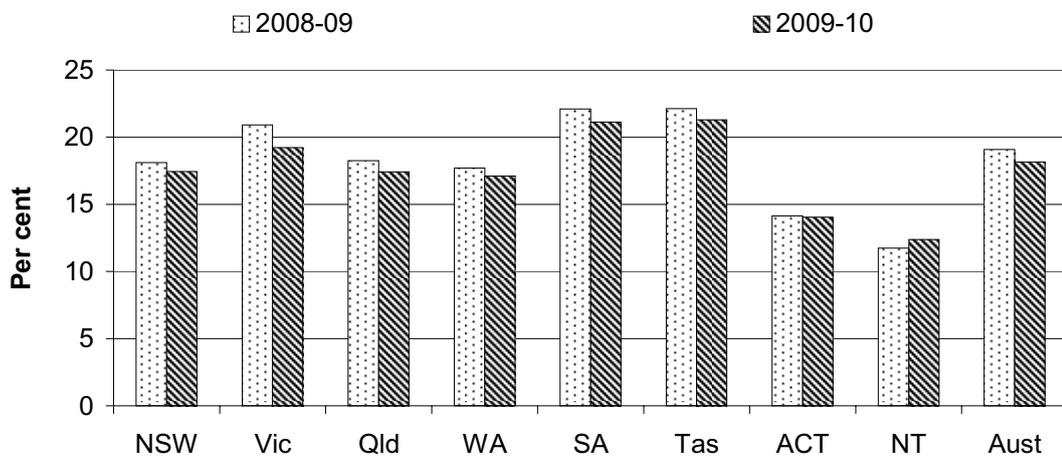
Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

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).

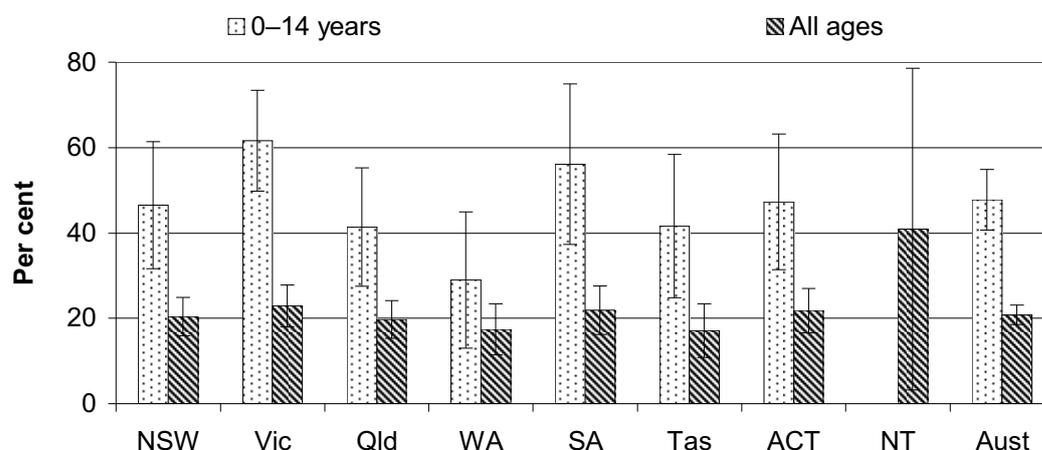
A high or increasing proportion of people with asthma who have a written asthma action plan is desirable.

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.

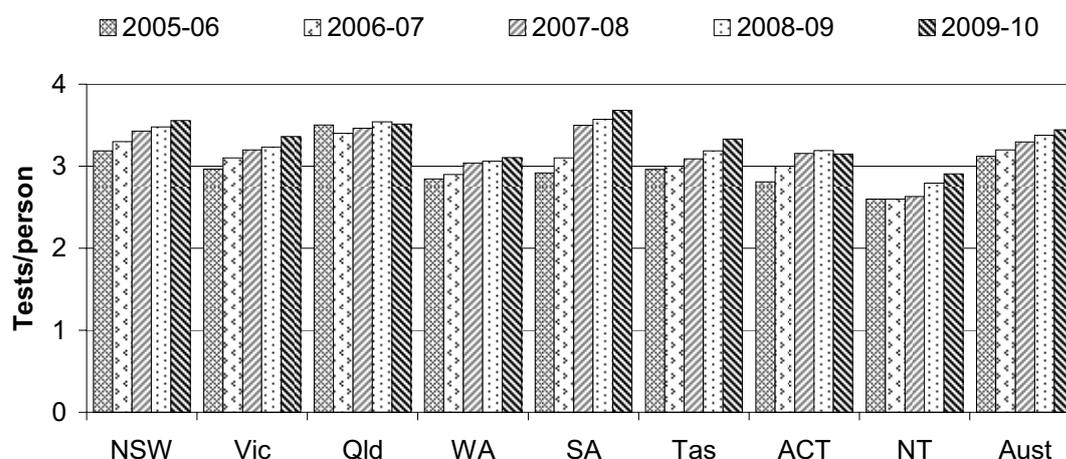
Data for this indicator are comparable.

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

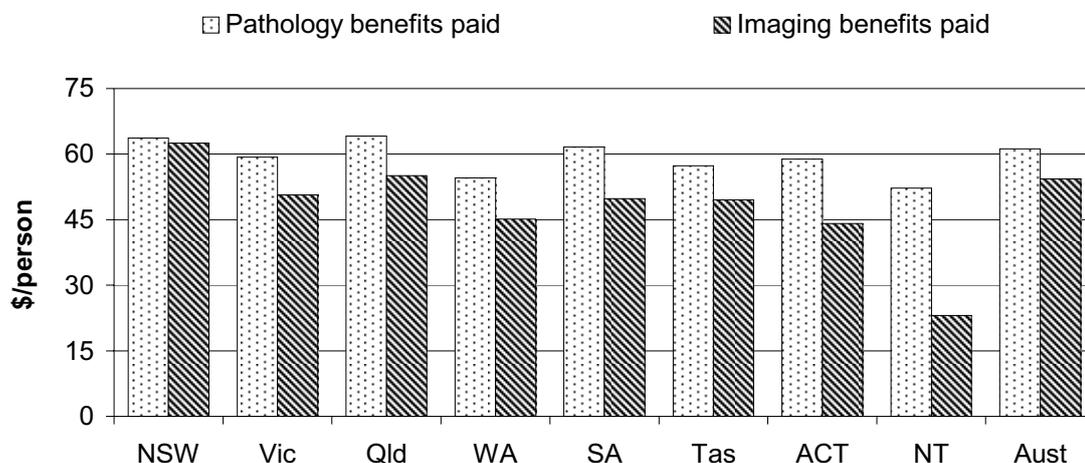


^a Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

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**

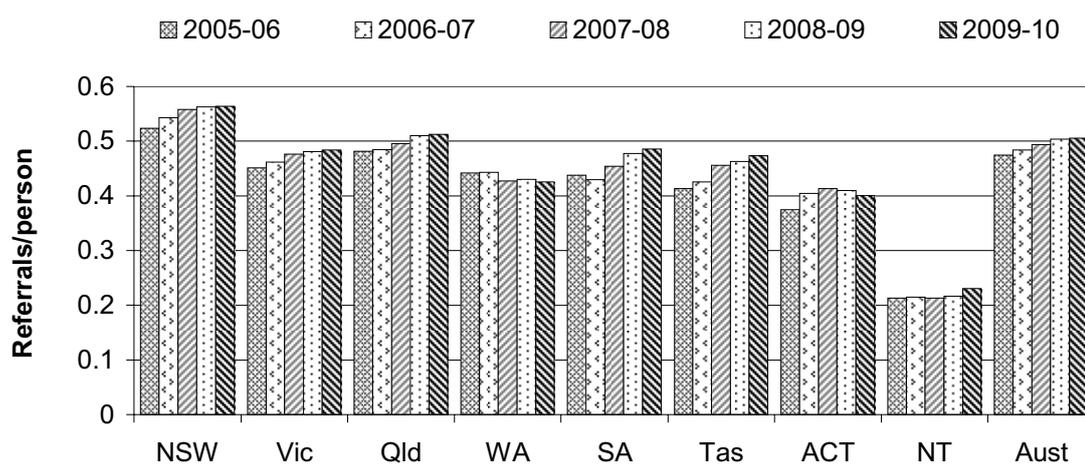


^a Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

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.

Quality — safety

General practices using electronic health information systems

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

Box 11.20 General practices using electronic health systems

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

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

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

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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

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

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

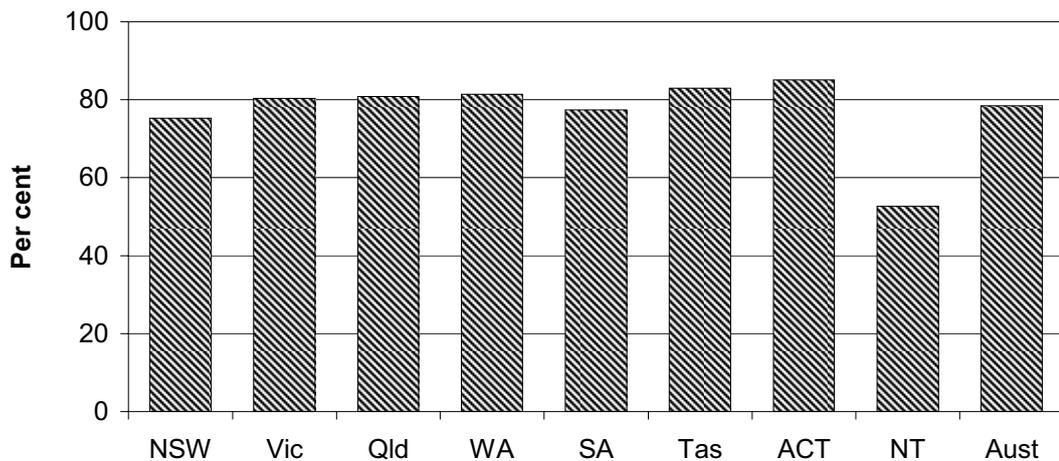
Information Management, Information Technology Incentive that had commenced in November 2006.

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

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

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

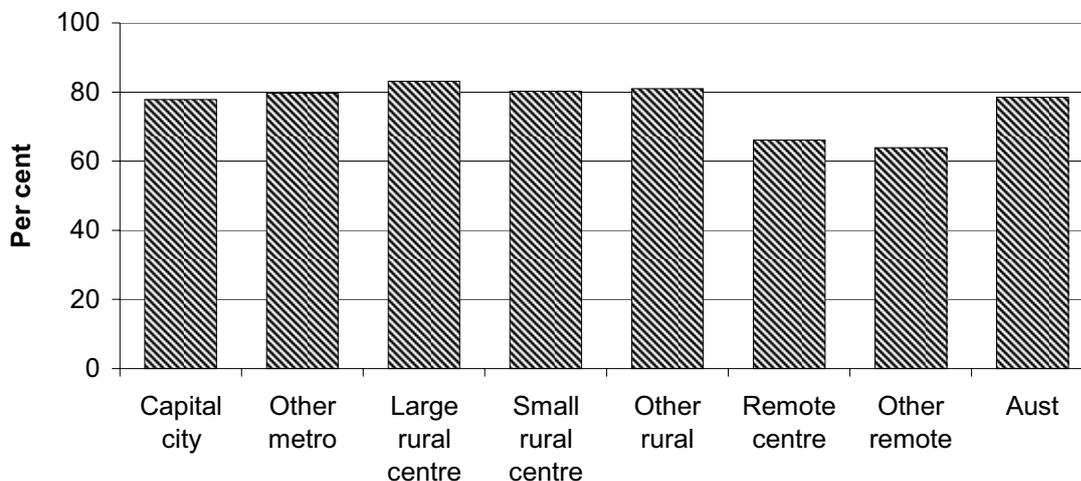
Figure 11.26 PIP practices using electronic health systems, May 2010



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

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

Figure 11.27 PIP practices using electronic health systems by area, May 2010^a



^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:

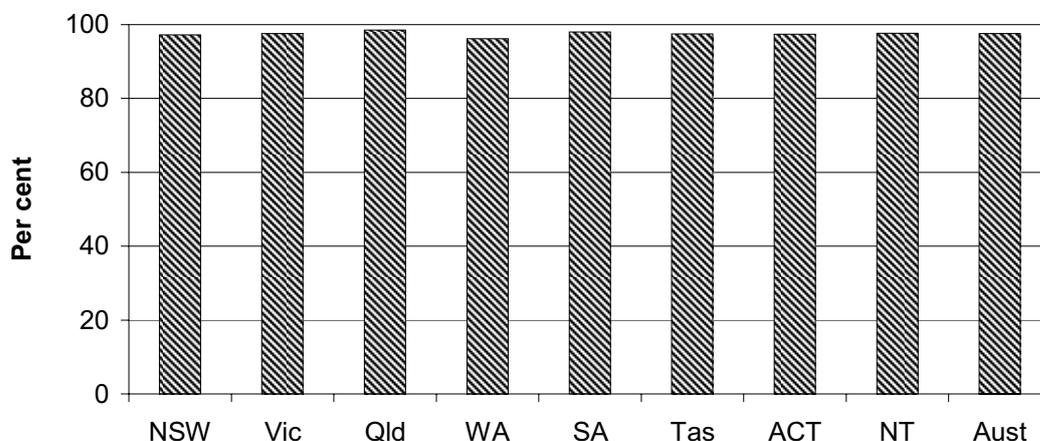
- 'proportion of people receiving a prescription for medication from a GP in the previous 12 months where reasons for the prescription were provided', defined as the number of people who received a prescription for medication from a GP in the previous 12 months where the GP provided reasons for the prescription, 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}

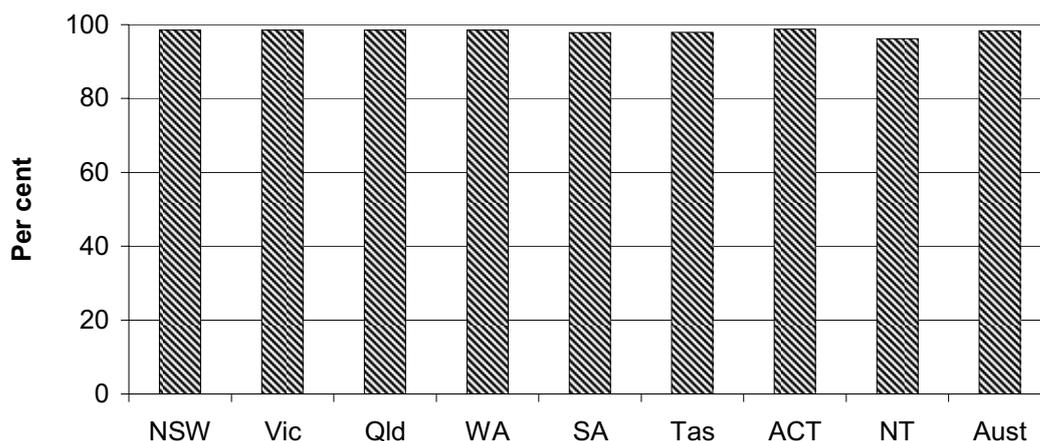


^a People aged 15 years or over who received a prescription for medication in the previous 12 months. ^b Rates are age standardised to the Australian population at 30 June 2001.

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.

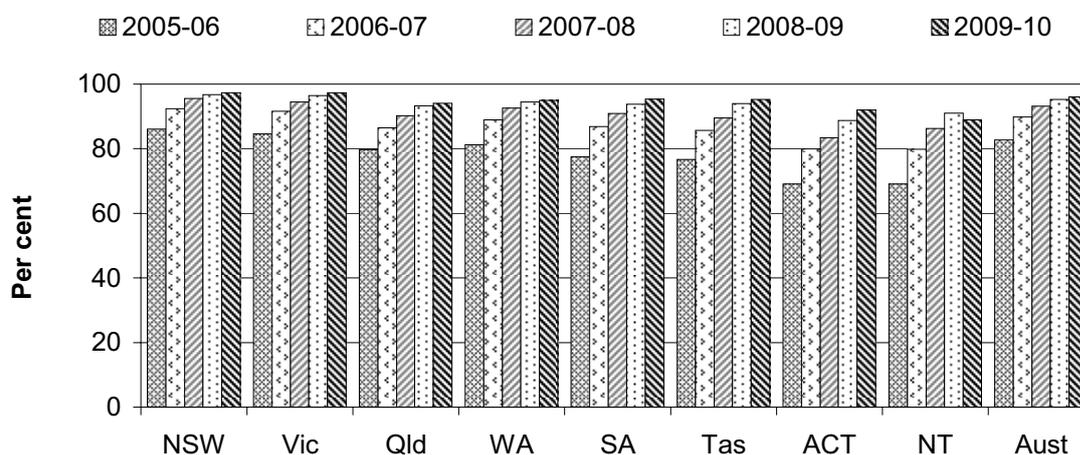
Data quality information for this indicator is under development.

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.

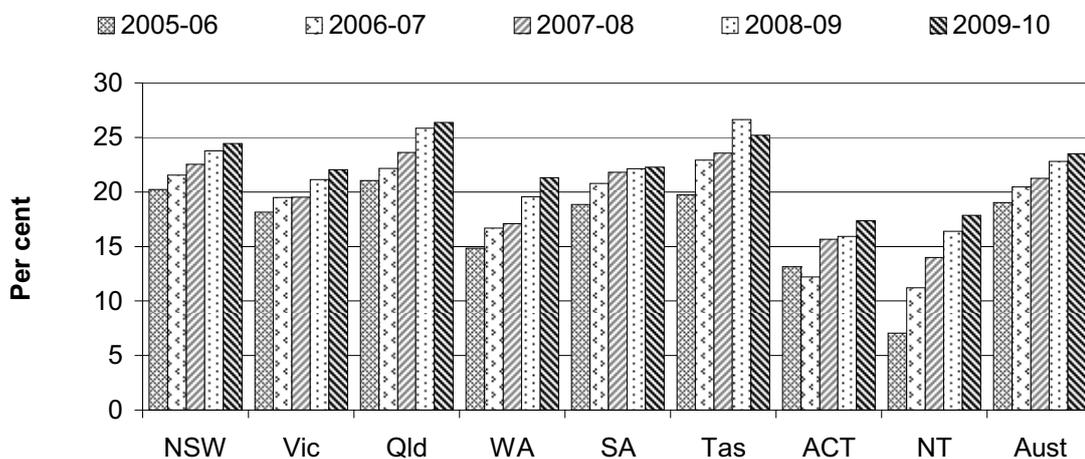
Data for this indicator are comparable.

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).

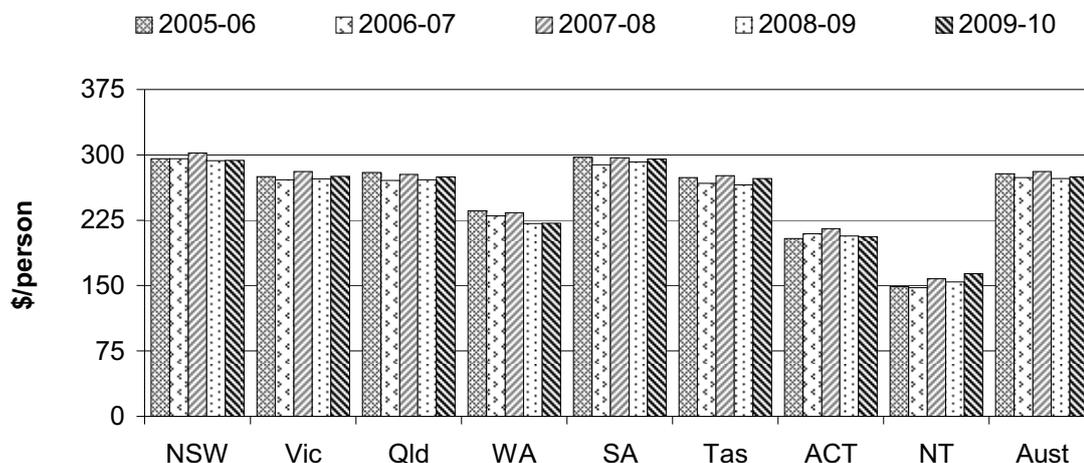
Data for this indicator are comparable.

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 GPPII 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, GPPII, 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}

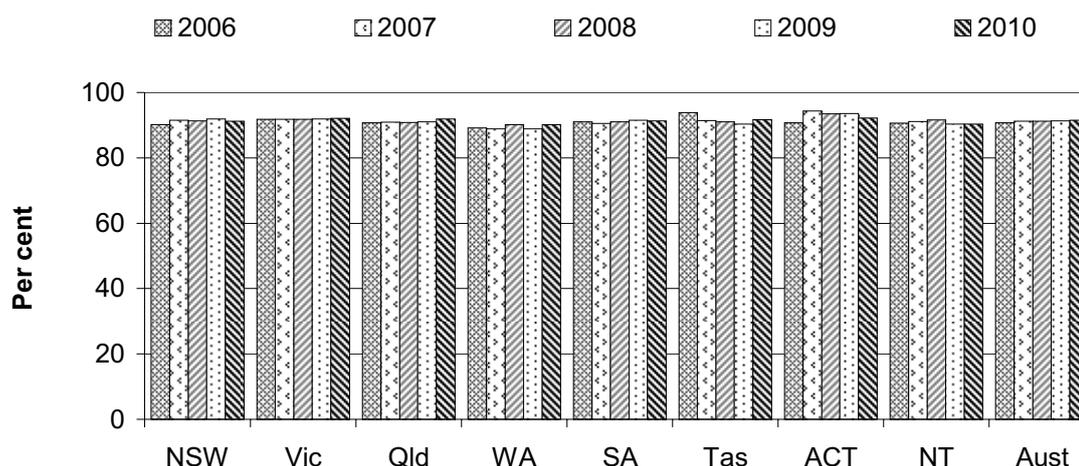
<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	84.5	53.4	82.8	64.7	69.3	87.4	43.0	4.6	71.4
Council	5.6	45.2	7.0	6.1	18.7	11.8	–	–	16.8
State or Territory health department	–	–	–	6.3	0.1	0.1	17.7	0.3	0.9
Public hospital	1.9	0.6	3.0	3.8	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								

^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}

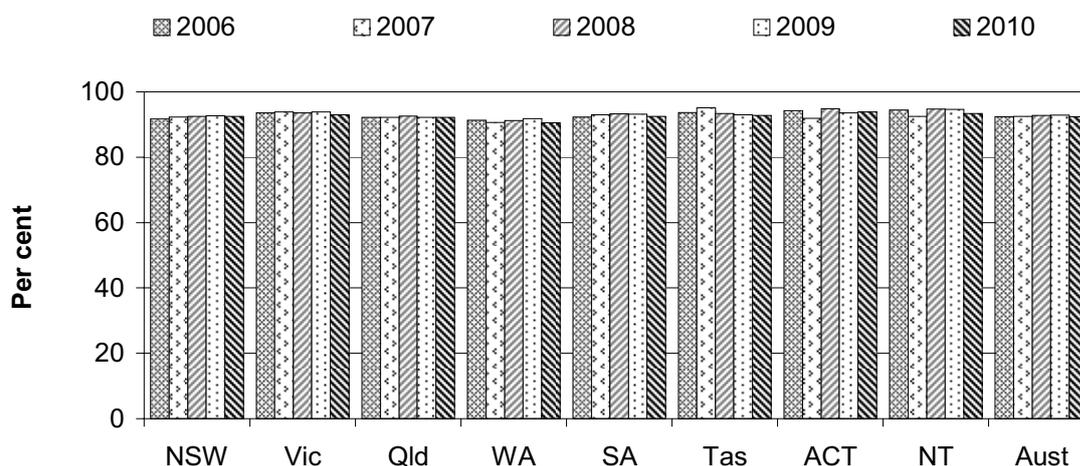


^a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. ^b The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over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

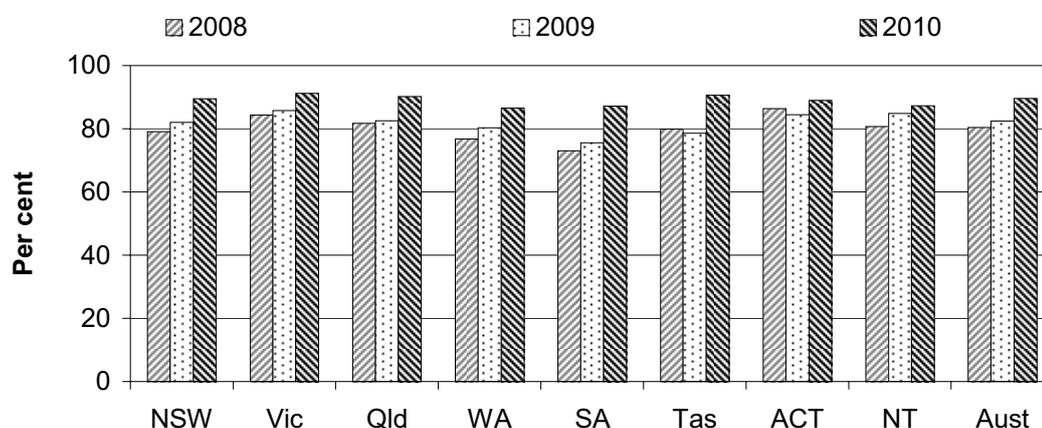


^a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children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

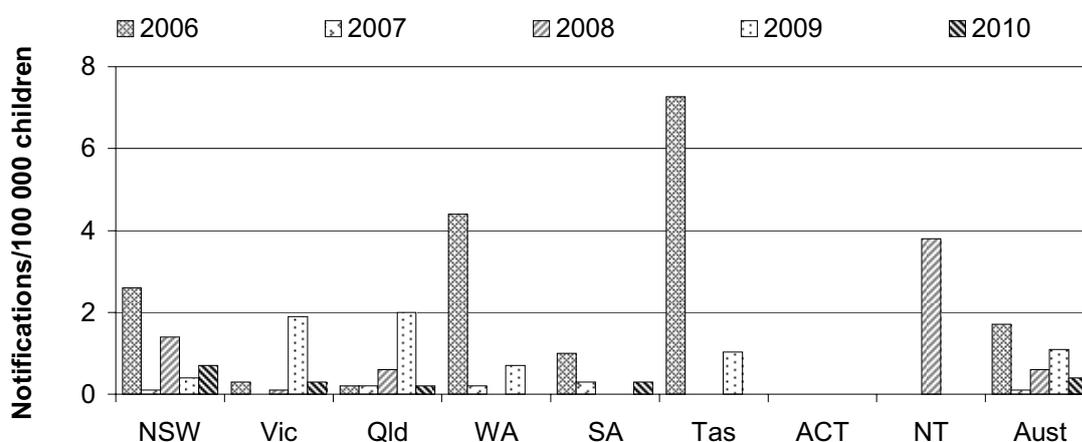
A low or reducing notification rate for the selected diseases indicates greater effectiveness of the immunisation program.

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}

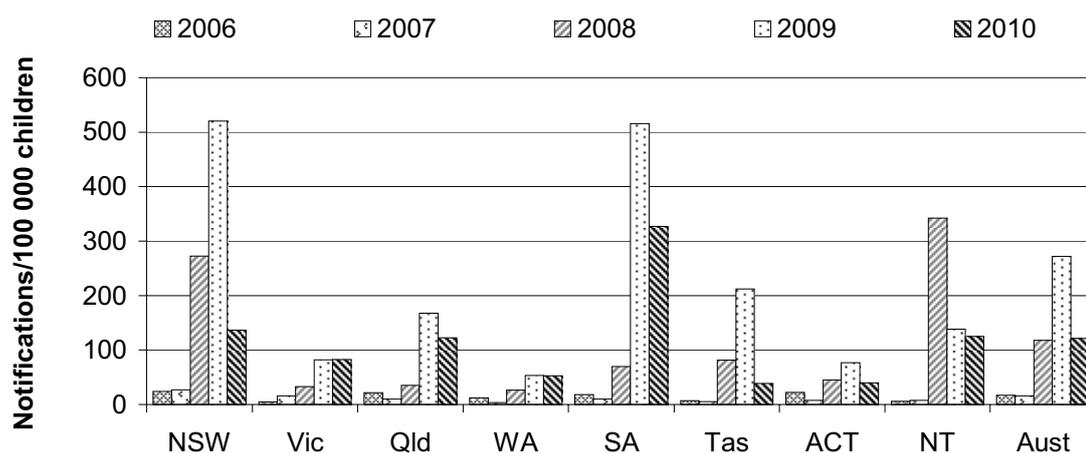


^a Notifications for 2010 are to 31 August. ^b Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

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

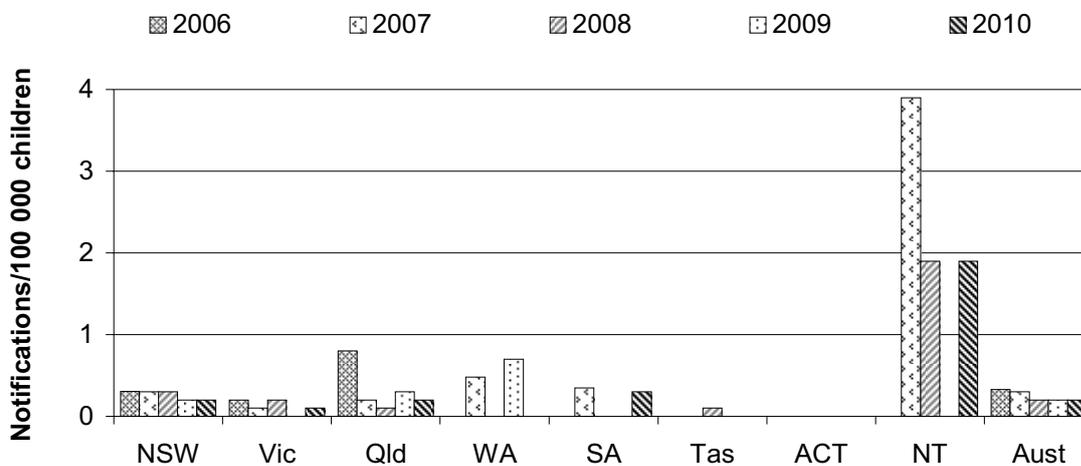


^a Notifications for 2010 are to 31 August.

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.

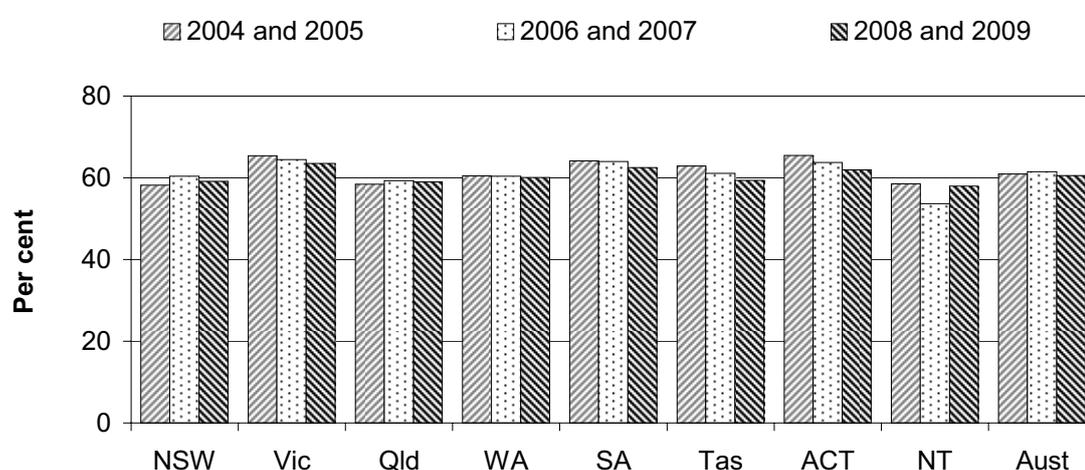
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

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.

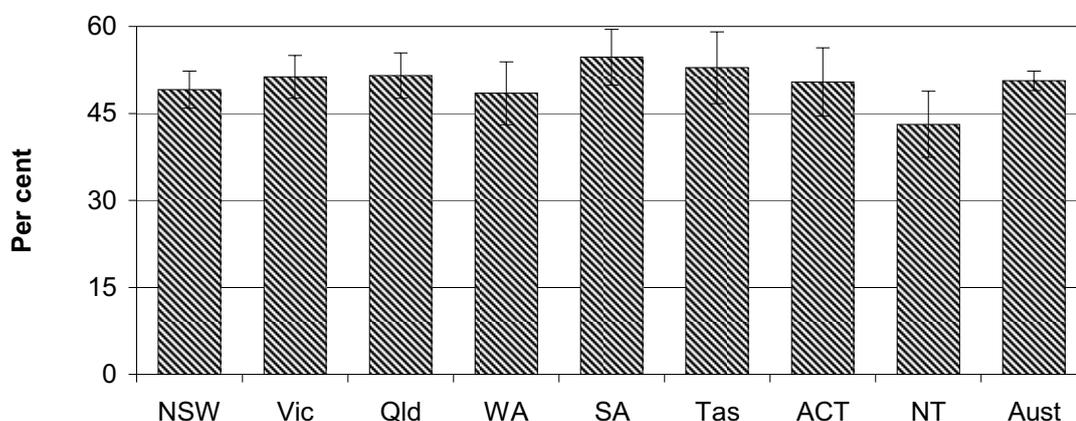
Data quality information for this indicator is under development.

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}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
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}

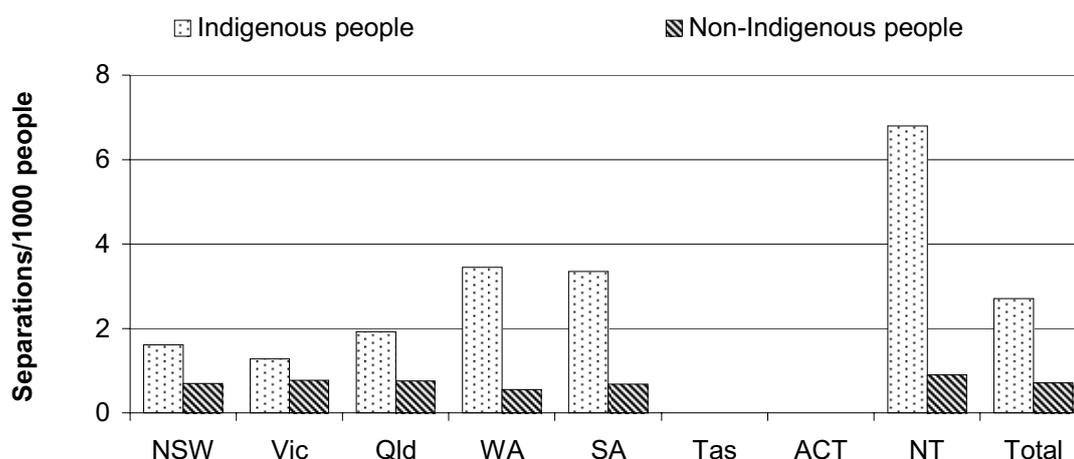
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust ^c
Influenza and pneumonia	0.5	0.5	0.6	0.5	0.6	0.5	0.4	1.6	0.5
Other conditions	0.2	0.3	0.1	0.2	0.2	0.1	0.1	0.8	0.2
Total^d	0.7	0.8	0.8	0.6	0.7	0.6	0.5	2.4	0.7

^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}

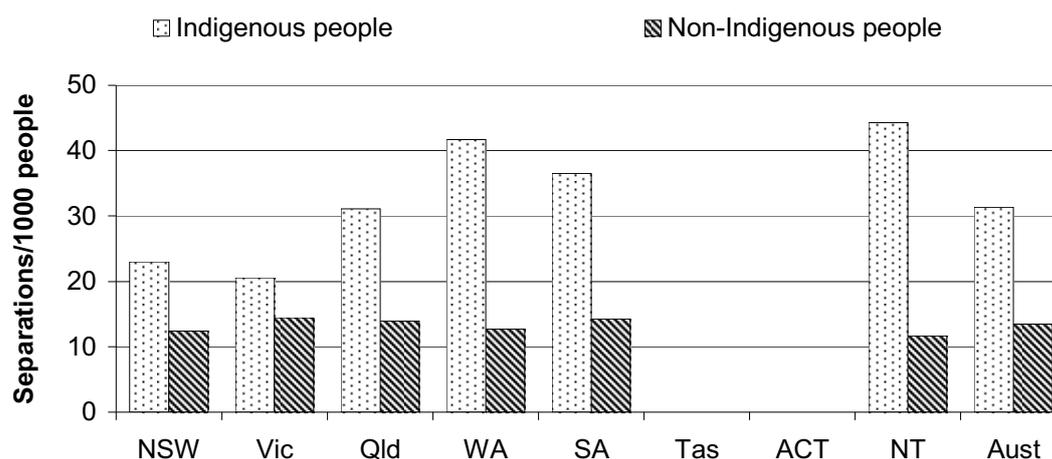
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust ^c
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.6	1.5	1.9	1.5	1.5	1.2	1.3	3.7	1.6
Convulsions and epilepsy	1.5	1.4	1.6	1.3	1.6	1.5	1.4	3.4	1.5
Dehydration and gastroenteritis	2.5	3.5	2.8	2.4	2.8	2.1	2.1	2.6	2.8
Dental conditions	2.3	3.1	2.7	3.6	3.2	1.8	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}

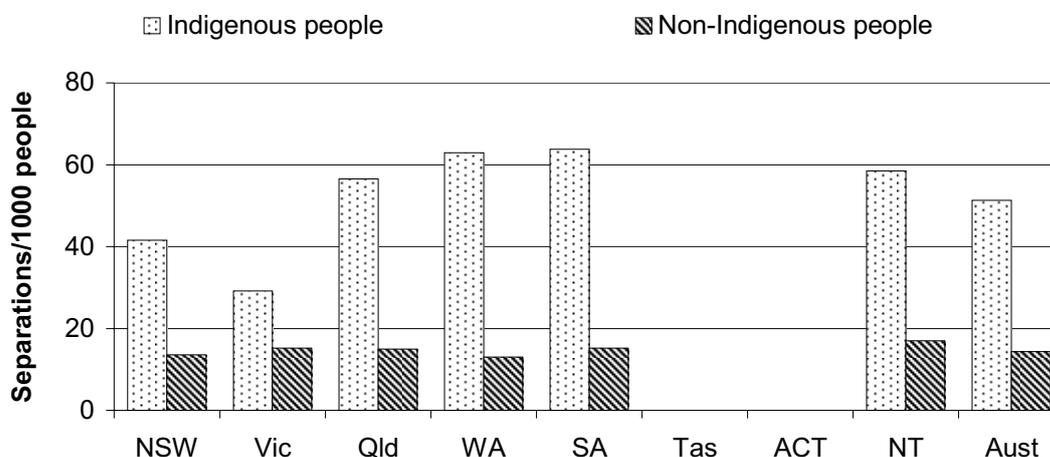
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Angina	1.2	1.4	2.0	1.3	1.4	1.4	1.0	2.3	1.5
Asthma	1.8	1.8	1.5	1.3	2.4	1.2	0.9	1.8	1.7
Chronic obstructive pulmonary disease	2.6	2.6	3.1	2.2	3.0	2.5	2.2	6.7	2.6
Congestive cardiac failure	1.8	2.1	1.9	1.8	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.

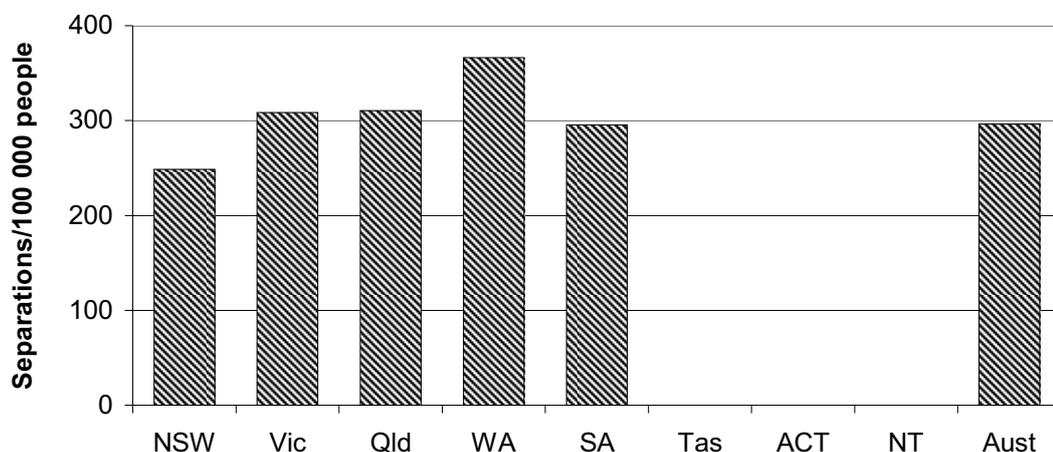
Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, patient compliance with measures to manage diabetes, and the underlying prevalence of diabetes.

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}



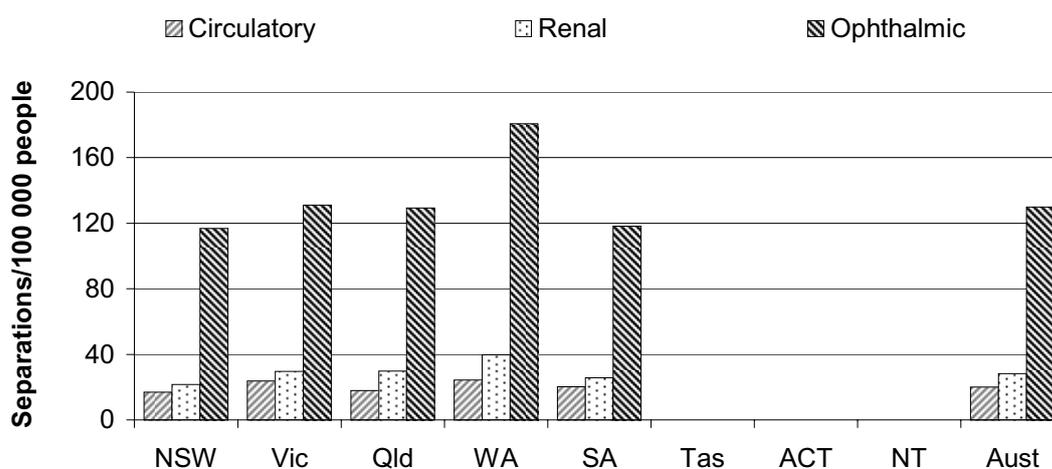
^a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^b Morbidity data are coded under coding 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}



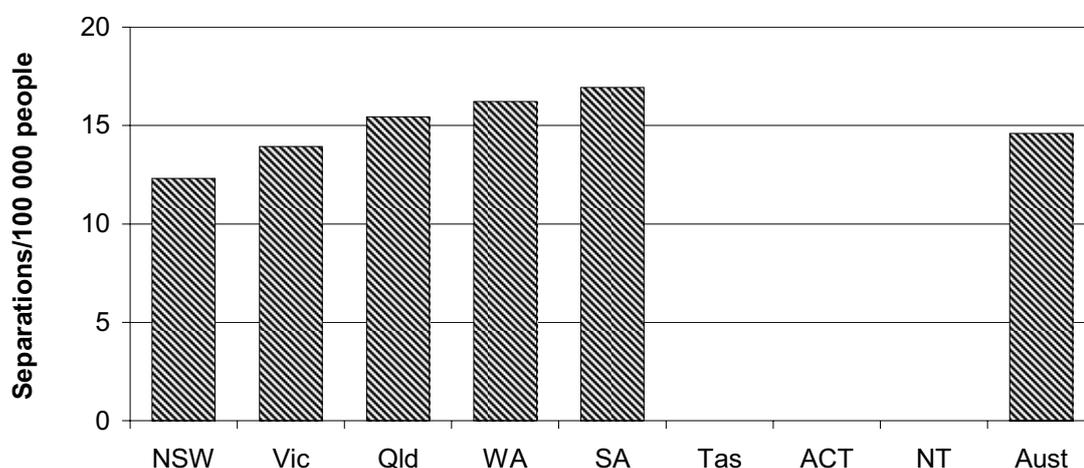
^a Results for individual complications can be affected by small numbers, and need to be interpreted with care. ^b Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat 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}**



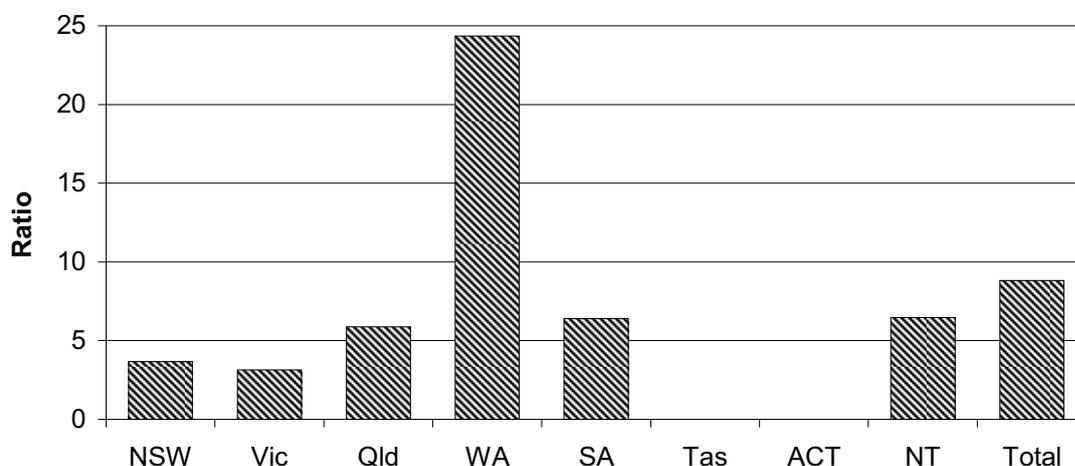
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 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 diagnoses² 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.

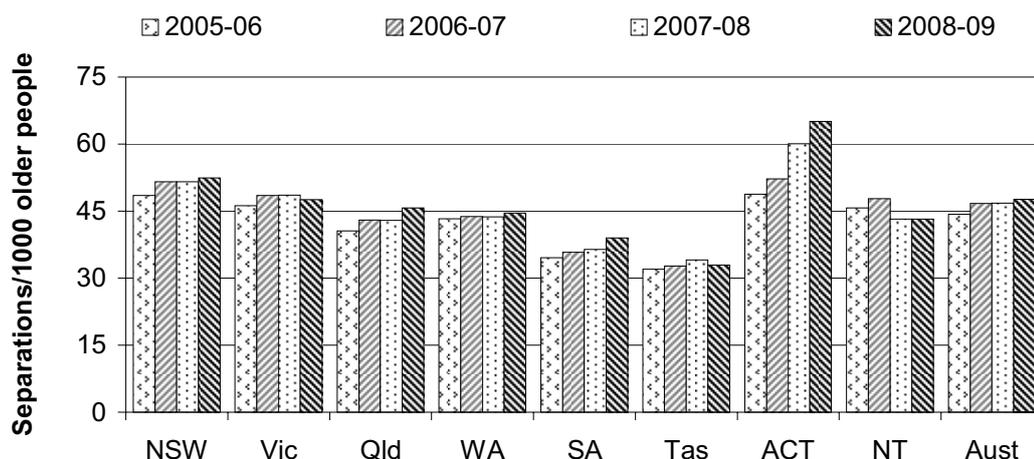
Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

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	<p>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.</p> <p>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.</p>
Asthma Action Plan	<p>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.</p> <p><i>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.</i></p>
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	<p>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).</p> <p>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.</p>
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, <i>Haemophilus influenzae</i> 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 <i>Health Insurance Act 1973</i> (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.
<i>Haemophilus influenzae</i> 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 <i>Haemophilus influenzae</i> 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: <ul style="list-style-type: none"> • 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 <i>plus</i>), 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).

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- Table 11A.51** Children aged 60 months to less than 63 months who were fully immunised (per cent)
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11.7 References

- ACAM (Australian Centre for Asthma Monitoring) 2008, *Asthma in Australia 2008*, Cat. no. ACM 14, AIHW Asthma Series 3, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Health Services Series no. 25, Canberra.
- 2007, *National indicators for monitoring diabetes: report of the Diabetes Indicators Review Subcommittee of the National Diabetes Data Working Group*, Cat. no. CVD 38, Diabetes series no. 6, Canberra.
- 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses*, AIHW Cat. no. IHW 22, Canberra.
- 2008b, *Australia's health 2008*, Cat. no. AUS 99, Canberra.
- 2008c, *Diabetes: Australian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.
- 2010a, *Alcohol and other drug treatment services in Australia 2008-09: report on the National Minimum Data Set*, Cat. no. HSE 92, Canberra.
- 2010b, *Australian hospital statistics 2008-09*, Cat. no. HSE 84, Canberra.
- 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.
- DoHA (Australian Government Department of Health and Ageing) 2004, *Australian national notifiable diseases list and case definitions*, www.health.gov.au/internet/wcms/publishing.nsf/Content/cda_surveil-nndss-dislist.htm#pagetop (accessed 12 September 2007).
- 2006, *The Pap smear*, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/papsmear#5 (accessed 12 October 2009).
- 2008, *Immunisation Myths and Realities: responding to arguments against immunisation*, 4th edn, Canberra.
- 2010a, *About the PBS*, www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-aboutus.htm-copy2 (accessed 24 September 2010).
- 2010b, *Pharmaceutical Benefits Safety Net Arrangements*, www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-pbs-phbensna.htm-copy2 (accessed 24 September 2010).
- DoHA and NHMRC (National Health and Medical Research Council) 2008, *The Australian Immunisation Handbook*, 9th edn, Canberra.

-
- DHS (Department of Human Services) 2002, *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*, Victorian Government, Melbourne.
- Hofmarcher, M., Oxley, H. and Rusticelli, E. 2007, *Improved Health System Performance through Better Care Coordination*, OECD Health Working Paper No. 30, OECD, Paris.
- Mitchell, H. Hocking, J. Saville, M. 2003, 'Improvement in protection of adenocarcinoma of the cervix resulting from participation in cervical screening', *Cancer Cytopathology*, vol. 99, no. 6, pp. 336–341.
- National Advisory Committee on Oral Health 2004, *Healthy mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013*, Report endorsed by the Australian Health Ministers' Conference, Government of South Australia, Adelaide.
- NCIRS (National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases) 2000, *Vaccine Preventable Diseases and Vaccination Coverage in Australia, 1993–1998*, University of Sydney, Royal Alexandra Hospital for Children and Australian Government Department of Health and Aged Care, Canberra.
- NHPAC (National Health Priority Action Council) 2006, *National Chronic Disease Strategy*, Australian Government Department of Health and Ageing, Canberra.
- Quality Improvement Council 1998, *Australian Health and Community Service Standards: Community and Primary Health Care Services Module*, Melbourne.
- RACGP (Royal Australian College of General Practitioners) 2005, *What is general practice?* www.racgp.org.au/whatisgeneralpractice (accessed 19 October 2008).
- 2007, *Vocational Training*, www.racgp.org.au/vocationaltraining (accessed 12 October 2009).
- SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra.
- Van Konkelenberg, R. Esterman, A. Van Konkelenberg, J. 2003, *Literature Reviews: Factors Influencing use of Emergency Departments and Characteristics of Patients Admitted Through Emergency Departments*, www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1002&context=ecc (accessed 15 October 2010).