
10 Primary and community health

CONTENTS

10.1 Profile of primary and community health	10.2
10.2 Framework of performance indicators	10.16
10.3 Key performance indicator results	10.18
10.4 Future directions in performance reporting	10.94
10.5 Definitions of key terms	10.96
10.6 List of attachment tables	10.100
10.7 References	10.104

Attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). 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.

Primary and community health services include general practice, allied health services, dentistry, alcohol and other drug treatment, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services. Reporting in this chapter focuses mainly on general practice, primary healthcare services targeted to Aboriginal and Torres Strait Islander Australians, public dental services, drug and alcohol treatment and the PBS. The scope of this chapter does not extend to:

- public hospital emergency departments and outpatient services (reported in chapter 11, 'Public hospitals')
- community mental health services (reported in chapter 12, 'Mental health management')
- Home and Community Care program services (reported in chapter 13, 'Aged care' and chapter 14, 'Services for people with disability').

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in the prevention of ill health, the detection and management of illness and injury and the effective management of chronic disease —

through direct service provision and through referral to acute (hospital) or other healthcare services, as appropriate.

Improvements to reporting on primary and community health services in this edition include:

- expenditure data for primary healthcare services more closely approximate the services covered in this chapter than in previous reports
- data are reported for the first time for occupational therapists and psychologists working in the public sector
- data for the availability of male GPs are reported for the first time alongside data for the availability of female GPs
- the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP diabetes incentive is reported for the first time, in place of the proportion of people with diabetes who received an annual cycle of care within general practice
- updated data for asthma management by Indigenous status are reported
- extending time series for reporting on some indicators
- data quality information (DQI) is available for the first time for the indicator GPs with vocational registration and for the measure effectiveness of access to GPs — bulk billing rates.

10.1 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 provides some funding for private dental and allied health services — for the general community through the private health insurance rebate, and for people with specific conditions or needs (for example, mental illness) through DHS Medicare.

The Australian Government also funds a national network of 61 Medicare Locals. These are independent primary health care organisations, established under the National Health Reform agenda in 2011 and 2012, with responsibility to coordinate primary health care delivery and address health care needs and service gaps within their boundaries (AIHW 2014a). Following a review of Medicare Locals, they will be replaced from July 2015 with a smaller number of Primary Health Networks with the objective of improving the efficiency and effectiveness of medical services for patients at risk of poor health

outcomes and improving coordination of care, particularly for those with chronic and complex conditions.

Definitions for common health terms are provided in section 10.5.

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 providing ‘person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities’ (RACGP 2014a). 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 practitioners must be registered with the Medical Board of Australia. General practice data reported in this chapter relate mainly to services provided by those general practitioners who are recognised for Medicare as defined below:

- vocationally registered GPs — GPs who are 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 registered 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.

The Australian Government provides the majority of general practice income through DHS Medicare, including fee-for-service payments via the Medicare Benefits Schedule (MBS) and other payments. Through its funding role, the Australian Government seeks to influence the supply, regional distribution and quality of general practice services. State and Territory governments also provide some funding to influence general practice services, particularly regional distribution, within jurisdictions.

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 (Department of Health 2010). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2014 was \$6.00 for concession card holders and up to \$36.90 for general consumers (Department of Health 2014). The Australian Government pays the remaining cost of medicines eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year (Department of Health 2014).

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 2014 safety net threshold was \$1421.20 for general consumers and \$360.00 for concession card holders (Department of Health 2014).

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). There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Community health 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 has the main responsibility for Aboriginal and Torres Strait Islander primary healthcare services, which have the objective of addressing the disproportionate ill-health experienced by Aboriginal and Torres Strait Islander people. Around 60 per cent of these are Aboriginal and Torres Strait Islander community-controlled or managed — planned and governed by local Aboriginal and Torres Strait Islander communities with the aim of delivering holistic and culturally appropriate primary healthcare and health related services.

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 allied health services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with particular needs — for example, people with chronic conditions and complex care needs — and improves access to allied health services in rural and remote areas.

Nationally, there were 25.5 FTE occupational therapists and 31.5 FTE psychologists per 100 000 people working in the public sector in 2013 (table 10A.29).

Dental services

State and Territory governments and the Australian Government 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. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink. The Australian Government contributes to funding of public dental services through the National Partnership Agreement on Treating More Public Dental Patients that commenced in January 2013.

The Australian Government supports the provision of dental services primarily through the private health insurance rebate and through DHS Medicare. Through DHS Medicare, funding is available for a limited range of oral surgical procedures and, from January 2014, for private and public dental services provided to eligible children aged 2 to 17 years under the Child Dental Benefits Schedule. Funding of private dental services was also available through DHS Medicare for people with chronic conditions and complex care needs until 1 December 2012. Public and private dental services were available through DHS Medicare under the Teen Dental Plan until 31 December 2013. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force and has a role in the provision of dental services through Aboriginal and Torres Strait Islander Primary Health Care Services.

Funding

Overall primary and community health expenditure data for services approximating those covered in this chapter are available for the first time for the 2015 Report (table 10.1).

Nationally, government expenditure on primary and community health services, including public health, was \$30.2 billion in 2012-13, of which State, Territory and local governments provided 24.7 per cent and the Australian Government 75.3 per cent (table 10.1). In that year, Australian Government expenditure on dental services was \$1.6 billion, of which 60.8 per cent was through the DVA and the Department of Health.

State, Territory and local government expenditure on dental services was around \$700 million in 2012-13. Dental expenditure data by state and territory are provided in table 10A.7. 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 10.1 Estimated funding on Primary healthcare, 2012-13 (\$ million) (2012-13 dollars)^a

	<i>Australian Government</i>			<i>Total^d</i>	<i>State, Territory and local government</i>	<i>Total government^d</i>	<i>Non-government</i>	<i>Total government and non-government^d</i>
	<i>DVA</i>	<i>Department of Health and other^b</i>	<i>Premium rebates^c</i>					
Unreferred medical services	838	7419	..	8257	..	8257	1909	10166
Dental services	100	843	606	1550	657	2207	6500	8706
Other health practitioners	241	1160	287	1688	13	1701	3508	5209
Community health and other ^e	1	1181	–	1182	5909	7092	352	7444
Public health	..	1150	..	1150	884	2034	109	2143
Benefit-paid medications	429	7994	..	8423	..	8423	1547	9970
All other medications	..	507	22	529	..	529	8781	9309
Total	1608	20 255	915	22 779	7463	30 242	22706	52 948

^a Data are not comparable to other expenditure data reported in this chapter, which are expressed in 2013-14 dollars. ^b 'Other' comprises expenditure on the National Healthcare Agreement and health-related National Partnerships, capital consumption, estimates of the medical expenses tax offset and health research not funded by the Department of Health. ^c Expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. ^d Totals may not add due to rounding. ^e Includes expenditure on community health and other recurrent health services (not elsewhere classified). .. Not applicable. – Nil or rounded to zero.

Source: AIHW (Australian Institute of Health and Welfare) (2014), Health Expenditure Australia 2012-13, Cat. no. HWE 61.

General practice

The Australian Government funds the majority of general practice services, primarily through DHS Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.4 per cent of direct general practice encounters where a payment

source was recorded in 2013-14 were for services at least partly funded by Medicare or the DVA (Britt et al. 2014) (table 10.2).

Table 10.2 General practice encounters and funding sources, April 2013 to March 2014^{a, b}

	Number ^c	Per cent of all encounters ^d	95% LCL	95% UCL
Total encounters for which BEACH data were recorded ^e	88 151	100	..	..
Direct encounters	86 607	98.2	98.0	98.5
No charge	332	0.4	0.3	0.5
DHS Medicare or DVA paid	84 136	95.4	95.1	95.8
Workers compensation paid	1 537	1.7	1.6	1.9
Other paid (such as, hospital, State)	603	0.7	0.5	0.8
Indirect encounters ^f	1 542	1.7	1.5	2.0

LCL = lower confidence limit. UCL = upper confidence limit. DVA = Department of Veterans' Affairs. ^a An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals). ^b Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. ^c Number of encounters after post stratification weighting for GP activity and GP age and sex. ^d Missing data removed from analysis ($n = 7728$). ^e Includes 2 encounters for which direct/indirect was not specified. ^f For indirect encounters, the patient is not seen but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt et al. (2014) *General practice activity in Australia 2013-14*, Sydney University; table 10A.1.

The Australian Government also provides funding for general practice services under initiatives such as the Practice Incentives Program (PIP) and Medicare Locals. PIP provides financial incentives to eligible general practices to support quality care, and improve access and health outcomes (Australian Government DHS 2014).

Australian Government total expenditure on general practice in 2013-14 was \$7.9 billion (table 10A.2). This includes fee-for-service expenditure (\$7.3 billion, or 92 per cent of the total expenditure) through DHS Medicare and the Department of Veteran's Affairs (DVA), as well as expenditure on the PIP and Medicare Locals (around \$600 million, or 8 per cent of the total expenditure).

Age standardisation can be applied to fee-for-service expenditure on general practice to adjust for the effect of variations in age profiles on rates (see chapter 2 for details). The age-standardised expenditure on general practice per person was \$299 in 2013-14.

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, in hospital emergency departments, Aboriginal and Torres Strait Islander 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

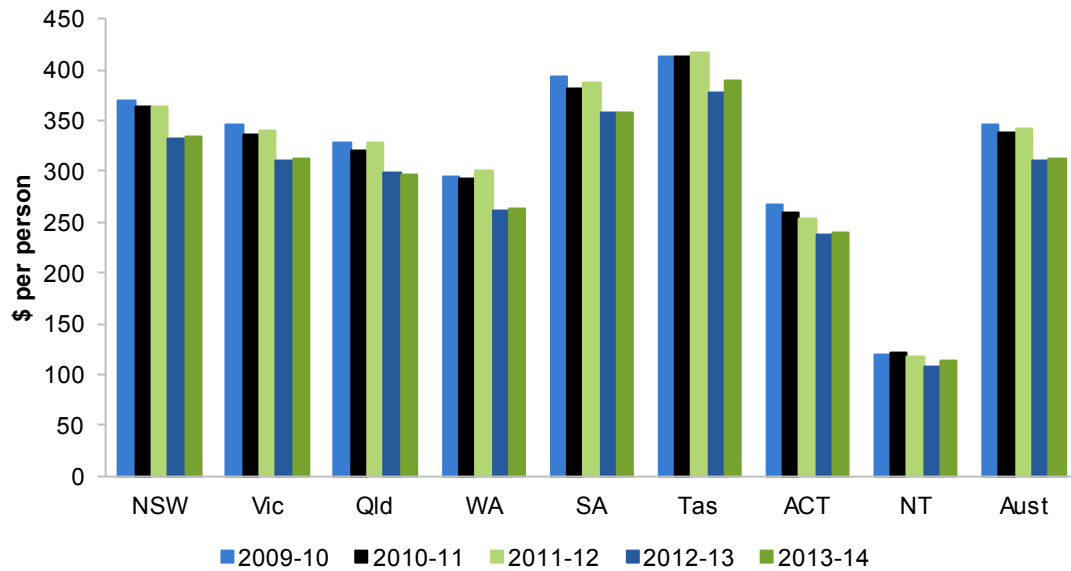
populations of Aboriginal and Torres Strait Islander Australians and people living in rural and remote areas.

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 medications through the PBS and RPBS was around \$7.7 billion in 2013-14 (tables 10A.4 and 10A.5). Expenditure on the PBS decreased from around \$7.7 billion (\$346 per person), to \$7.3 billion (\$313 per person) in the period 2009-10 to 2013-14 (in 2013-14 dollars) (figure 10.1). Over the same period, the proportion of PBS expenditure that is concessional rose from 77.9 to 78.5 per cent (tables 10A.4 and 10A.5). Data are presented for a ten year time series in Table 10A.4.

Figure 10.1 **PBS expenditure per person (2013-14 dollars)^{a, b, c, d, e, f, g}**



^a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details. ^b From 2012-13, rates are derived using the ABS (Australian Bureau of Statistics) 2011 Census based ERP for 31 December and are not comparable with rates in figure 10.6 which use the 30 June ERP. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable. ^c State and Territory data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications supplied to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$38.5 million for 2013-14, of which the NT accounted for 52.4 per cent [table 10A.6]). ^d Includes PBS general ordinary and safety net. ^e Includes PBS concessional ordinary and concessional free safety net. ^f Includes RPBS general ordinary and safety net. ^g Excludes PBS doctor's bag.

Source: Department of Health (unpublished) PBS Statistics; tables 10A.4 and 10A.5.

Community health services

In 2012-13, government expenditure on community health and public health was \$9.1 billion, of which State, Territory and local governments provided 74.4 per cent and the Australian Government 25.6 per cent (table 10.1).

Australian Government expenditure on Aboriginal and Torres Strait Islander Primary health care services was \$582 million in 2013-14 (table 10A.8).

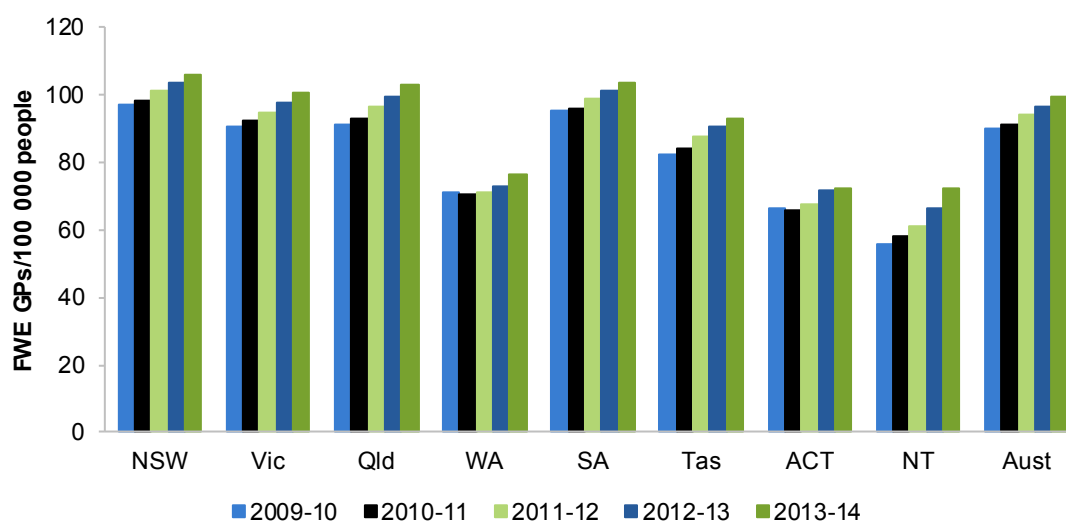
Size and scope

General practice

There were 32 401 vocationally registered GPs and OMPs — 23 194 on a full time workload equivalent (FWE) basis — billing Medicare Australia, based on MBS claims data, in 2013-14 (see section 10.5 for a definition of FWE). This equated to 99.5 FWE registered GPs and OMPs per 100 000 people (figure 10.2, table 10A.9). MBS claims data do not include services provided by GPs working in Aboriginal and Torres Strait Islander primary healthcare services, public hospitals and the Royal Flying Doctor Service. In addition, for some GPs — particularly in rural areas — MBS claims provide income 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 DHS Medicare.

Nationally, around 5889 general practitioner-type services per 1000 population were provided under DHS Medicare in 2013-14 (figure 10.3).

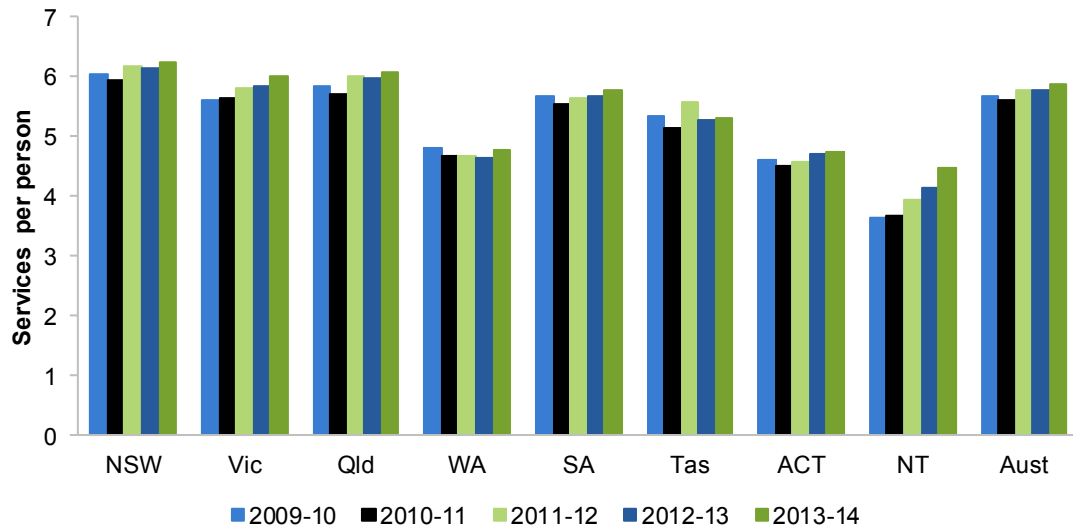
Figure 10.2 **Availability of GPs (full time workload equivalent)^{a, b}**



^a Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice. ^b ERPs used to derive rates are revised to the ABS' final 2011 Census rebased estimates for 31 December. See chapter 2 (table 2A.2) for details.

Source: Department of Health (unpublished) MBS Statistics; table 10A.9.

Figure 10.3 GP type service use^{a, b}



^a Rates are age standardised to the Australian population at 30 June 2001. Rates from 2011-12 are derived using ABS' 2011 Census based ERPs. Rates for previous years use ABS 2006 Census based ERPs. Rates derived using ERPs based on different Censuses are not comparable. See chapter 2 (table 2A.2) for details. ^b Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses. From 2013-14, includes non-referred attendances by nurse practitioners.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.10.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 210 million services — 89.3 per cent of which were concessional — were provided under the PBS in 2013-14 (table 10.3). This amounted to 9.0 filled prescriptions per person. A further 12 million services were provided under the RPBS in the same period.

Table 10.3 PBS and RPBS services, 2013-14 (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	7.2	5.3	4.4	2.6	1.6	0.5	0.5	0.1	22.1
PBS concessional ^b	63.7	47.9	36.5	15.4	16.1	5.4	1.8	0.6	187.3
PBS doctor's bag ^c	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	71.0	53.3	40.9	18.0	17.8	5.9	2.2	0.7	209.8
RPBS total ^d	4.1	2.6	3.0	1.0	0.9	0.4	0.2	0.0	12.3
Total	75.1	55.9	44.0	19.0	18.7	6.2	2.4	0.8	222.2
PBS services per person (no.) ^e	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0

^a Includes PBS general ordinary and safety net. ^b Includes PBS concessional ordinary and concessional free safety net. ^c Supplies to prescribers for use in a medical emergency. ^d Includes RPBS general ordinary and safety net. ^e Excludes PBS doctor's bag. – Nil or rounded to zero.

Source: Department of Health (unpublished) PBS Statistics; tables 10A.11 and 10A.12.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.107–10A.115 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 (Mental health management), 13 (Aged care services) and 14 (Services for people with disability).

Maternal and child health

All jurisdictions provide maternal and child health services. These 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 11 (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 preschool and secondary school students (tables 10A.107–10A.115).

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. The Australian Government contributes funding through the National Partnership Agreement on Treating More Public Dental Patients. 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 2013–14 targeted at disadvantaged people (tables 10A.107–10A.115). Current data are not available for use of public dental services for the 2015 Report — 2010 data are again reported in table 10.4.

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 10.4).

Table 10.4 Use of public dental services by service type, per 1000 people, 2010^{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	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4

^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 the number of people who used a public dental service at least once in the preceding 12 months, not for the 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) *Australian Demographic Statistics*, Cat. no. 3101.0; table 10A.13.

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. Data included here have been sourced from a report on the Alcohol and

Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) — a collection of data from publicly funded government and non-government treatment services (AIHW 2014b). Treatment activities are excluded from that collection if the agencies provide medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, are located within prisons or detention centres, or in acute care and psychiatric hospitals providing treatment only to admitted patients. While in scope, the majority of primary healthcare services for Aboriginal and Torres Strait Islander Australians that are funded by the Australian government do not report to the AODTS NMDS.

A total of 714 alcohol and other drug treatment agencies reported 2012-13 data to the AODTS–NMDS. Of these, 317 (44.4 per cent) identified as government providers and 397 (55.6 per cent) as non-government providers (table 10A.14). There were 162 362 reported closed treatment episodes in 2012-13 (table 10A.14) (see section 10.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 68.1 per cent of whom were male, accounted for 155 151 closed treatment episodes (table 10A.14) (AIHW 2014b).

Alcohol was the most commonly reported principal drug of concern (41.1 per cent), followed by cannabis (23.6 per cent), amphetamines (14.4 per cent) and heroin (8.3 per cent), in closed treatment episodes for clients seeking treatment for their own substance abuse. Additional drugs of concern were reported in 62.9 per cent of the episodes (AIHW 2014b).

Alcohol was the most common principal drug of concern in all states and territories. Cannabis was the second most common principal drug in all states and territories except SA, where amphetamines were more common and the NT, where volatile solvents were more common (AIHW 2014b). Further information on alcohol and other drug treatment services funded by governments is included in tables 10A.107–10A.115.

Aboriginal and Torres Strait Islander Primary Health Care Services

Aboriginal and Torres Strait Islander people use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Primary Health Care Services. The latter, available in all jurisdictions, provide comprehensive primary health care and/or substance use, social and emotional wellbeing and mental health services, to Aboriginal and Torres Strait Islander people. They are funded by Australian, State and Territory governments, with the Australian Government contributing the greater share.

In addition, other health programs for Aboriginal and Torres Strait Islander Australians are funded by a number of jurisdictions. In 2012-13, these programs included services such as health 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 10A.107–10A.115).

From the 2008-09 reporting period, data on Aboriginal and Torres Strait Islander primary healthcare services that receive funding from the Australian Government have been collected through the Online Services Report (OSR) questionnaire. Many of the services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent funding from all sources.

For 2012-13, OSR data are reported for 205 Aboriginal and Torres Strait Islander primary healthcare services (table 10A.15). Of these services, 92 (44.9 per cent) were located in remote or very remote areas (table 10A.16). They provided a range of primary healthcare services (table 10A.17 — historical data are reported in table 10A.18). 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. Around 3.1 million episodes of healthcare were provided by participating services in 2012-13 (table 10.5). Of these, around 1.4 million (45.4 per cent) were in remote or very remote areas (table 10A.16).

Table 10.5 Estimated episodes of healthcare for Aboriginal and Torres Strait Islander Australians 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	2 089
2009-10	542	185	379	409	192	36	26	622	2 391
2010-11	522	201	310	473	222	38	30	704	2 498
2011-12	516	234	475	462	216	44	34	641	2 621
2012-13	622	238	575	583	217	53	38	743	3 068

^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 is included, for example episodes at outstation visits, park clinics and satellite clinics. Episodes of healthcare delivered over the phone are included.

Source: AIHW (2014 and previous issues) *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results*, Cat. nos IHW 31, 56, 79, 104 and 139; table 10A.15.

The services included in the OSR data collection employed around 4344 full time equivalent healthcare staff (as at 30 June 2013). Of these, 2386 were Aboriginal and Torres Strait Islander Australians (54.9 per cent). The proportions of doctors and nurses employed by surveyed services who were Aboriginal and Torres Strait Islander Australians, while remaining relatively low, have increased in the period 2010–2013 — rising from 4.8 per cent to 7.2 per cent for doctors and from 10.4 per cent to 14.4 per cent for nurses (table 10A.19).

10.2 Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (box 10.1). 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* (NHA) covers the areas of health and aged care services, and health indicators in the *National Indigenous Reform Agreement* establish specific outcomes for reducing the level of disadvantage experienced by Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. The Steering Committee collates NIRA performance information for analysis by the Department of Prime Minister and Cabinet. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

Box 10.1 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.

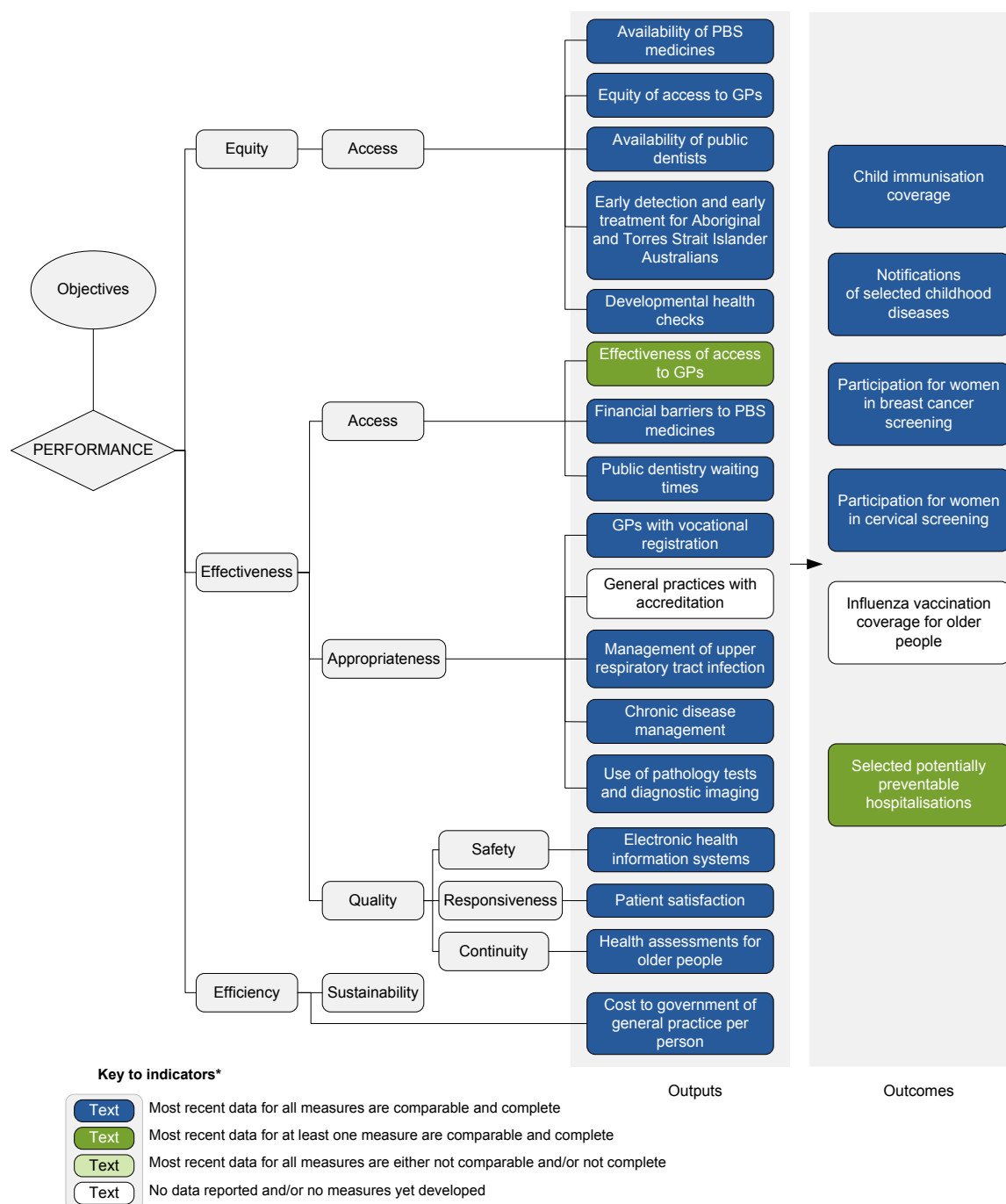
In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 10.4). The performance indicator framework shows which data are comparable in the 2015 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness from a Report-wide perspective (see section 1.6).

The Report's statistical context chapter 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) (chapter 2).

Figure 10.4 Primary and community health performance indicator framework



Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators, in addition to the material in the chapter and attachment tables. DQI in this Report cover the seven dimensions in the Australian Bureau of Statistics (ABS) data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and key data gaps and issues identified by the Steering Committee. All DQI for the 2015 Report can be found at www.pc.gov.au/rogs/2015.

10.3 Key performance indicator results

Different delivery contexts, locations and client factors may affect the equity, effectiveness and efficiency of primary and community 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 Aboriginal and Torres Strait Islander Australians relative to other Australians (SCRGSP 2014).

Access

Availability of PBS medicines

‘Availability of PBS medicines’ is an indicator of governments’ objective to provide equitable access to PBS medicines (box 10.2).

Box 10.2 Availability of PBS medicines

'Availability of PBS medicines' is defined by 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.

This indicator is difficult to interpret. A low or decreasing number of people per pharmacy may indicate greater availability of PBS medicines. High or increasing PBS expenditure per person may indicate improved availability of PBS medicines. A high or increasing 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 by region in these measures.

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.

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

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2014 for people per pharmacy by region and for 2013-14 for the measures PBS expenditure per person by region and proportion of PBS prescriptions filled at a concessional rate.

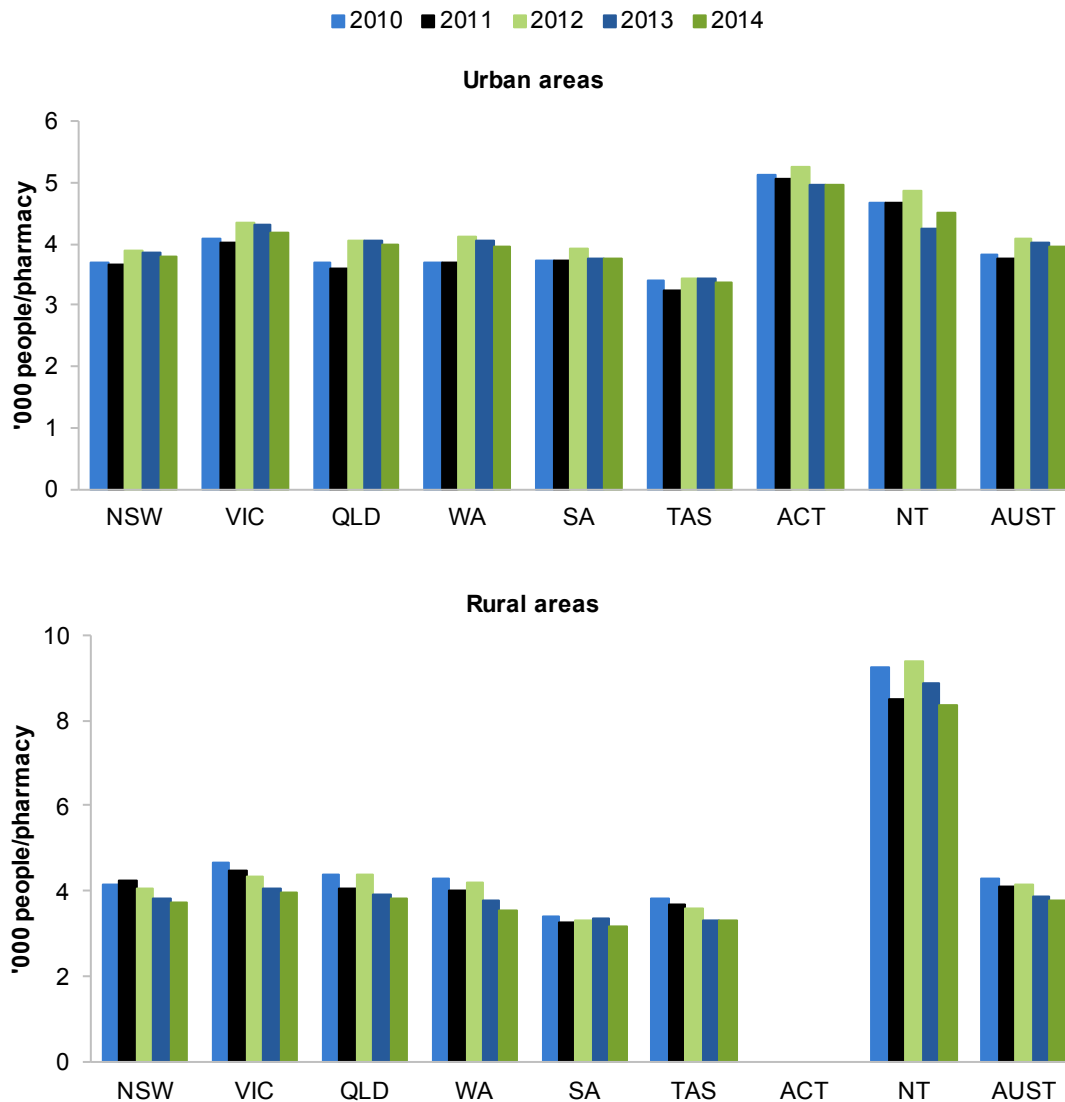
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, the number of people per pharmacy in rural areas decreased from 4277 to 3771 in the period 2010 to 2014, falling below the number of people per pharmacy in urban areas, which rose from 3814 to 3963 in the same period (figure 10.5).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 24 medical practitioners and 263 hospitals — 104 private and 159 public¹ — approved to supply PBS medicines to the community at 30 June 2014. The approved medical practitioners and 49 of the approved public hospitals were located in rural areas (table 10A.20).

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 10.5 People per pharmacy^{a, b, c, d, e}

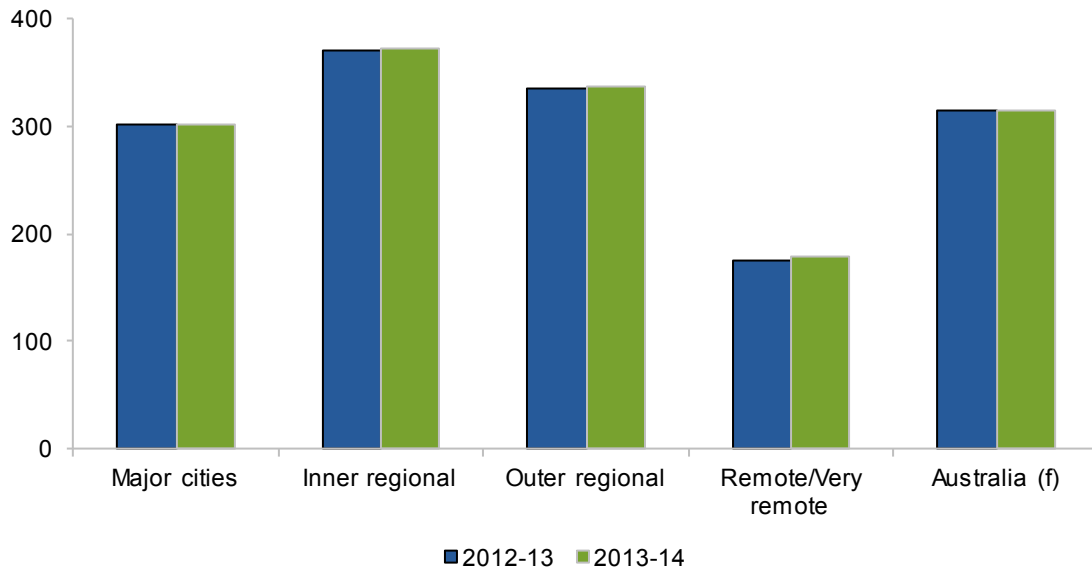


^a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. ^b Number of pharmacies as measured at 30 June is used to derive rates. ^c Excludes RPBS and doctor’s bag. ^d The ERP used to derive rates in the early and latter parts of this time series are based on different ABS Censuses. Rates derived using ERPs based on different Censuses are not comparable. ^e Care should be taken in using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).

Source: Department of Health (unpublished) derived from DHS Medicare, ABS (unpublished) 2006/2011 Census of Population and Housing and the University of Adelaide’s Australian Population and Migration Research Centre; table 10A.20.

Nationally, PBS expenditure per person was around \$315 in 2013-14 (figure 10.6). PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 10.6).

Figure 10.6 **PBS expenditure per person (2013-14 dollars)^{a, b, c, d}**



^a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See Chapter 2 (sections 2.5-6) for details. ^b Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. ^c Rates are derived using ABS 2011 Census based ERPs for 30 June and are not comparable with rates in figure 10.1 which are derived using 31 December ERPs. ^d Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health’s annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$38.5 million in 2013-14 [table 10A.6]).

Source: Department of Health (unpublished) PBS Statistics; table 10A.21.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 10A.11. These data are not available by regional location. Nationally, 89.3 per cent of prescriptions subsidised under the PBS were concessional in 2013-14.

Equity of access to GPs

‘Equity of access to GPs’ is an indicator of governments’ objective to provide equitable access to primary healthcare services (box 10.3).

Box 10.3 **Equity of access to GPs**

'Equity of access to GPs' is defined by two measures:

- availability of GPs by region, defined as the number of FWE GPs per 100 000 people, by region
- availability of GPs by sex, defined as the number of FWE GPs per 100 000 population, by sex.

High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region 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.

High or increasing availability of GPs of each sex means it is more likely that patients who prefer to visit GPs of their own sex for discussion of health matters and to receive primary care will have their preference met. Low availability of GPs of each sex can be associated with increased waiting times to see a GP, for patients who prefer to visit GPs of their own sex.

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 reported for this indicator are:

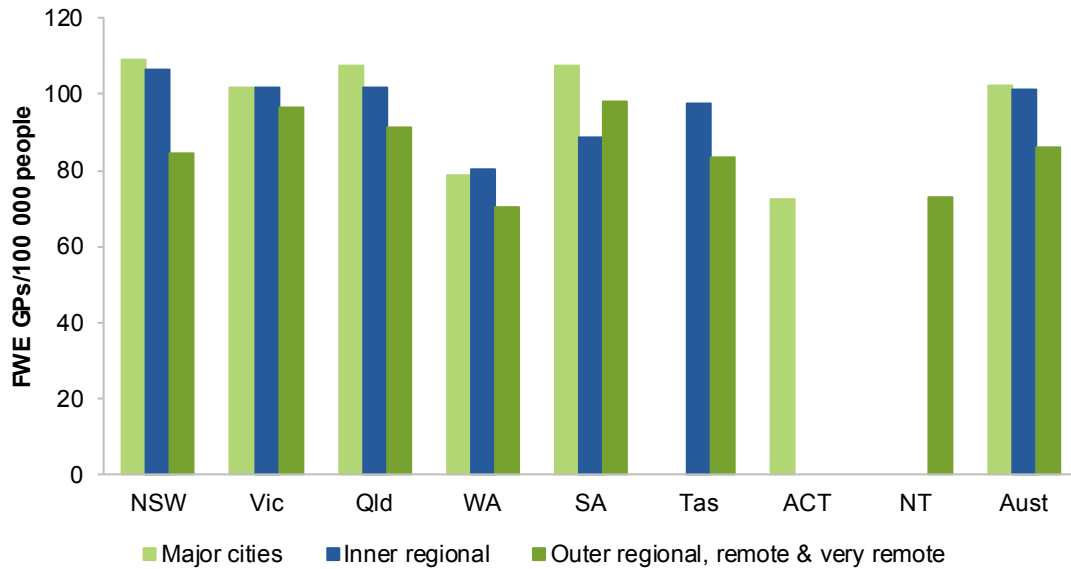
- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years for the measure availability of GPs by region
- comparable (subject to caveats) across jurisdictions and over time for the measure availability of GPs by sex
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Availability of GPs by region

In terms of FWE GPs per 100 000 people, there were more GPs available in major cities and inner regional areas than in outer regional, remote and very remote areas in most jurisdictions in 2013-14 (figure 10.7). The bulk billed proportion of non-referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 10A.34).

Figure 10.7 **Availability of GPs (full time workload equivalent), 2013-14^{a, b, c}**



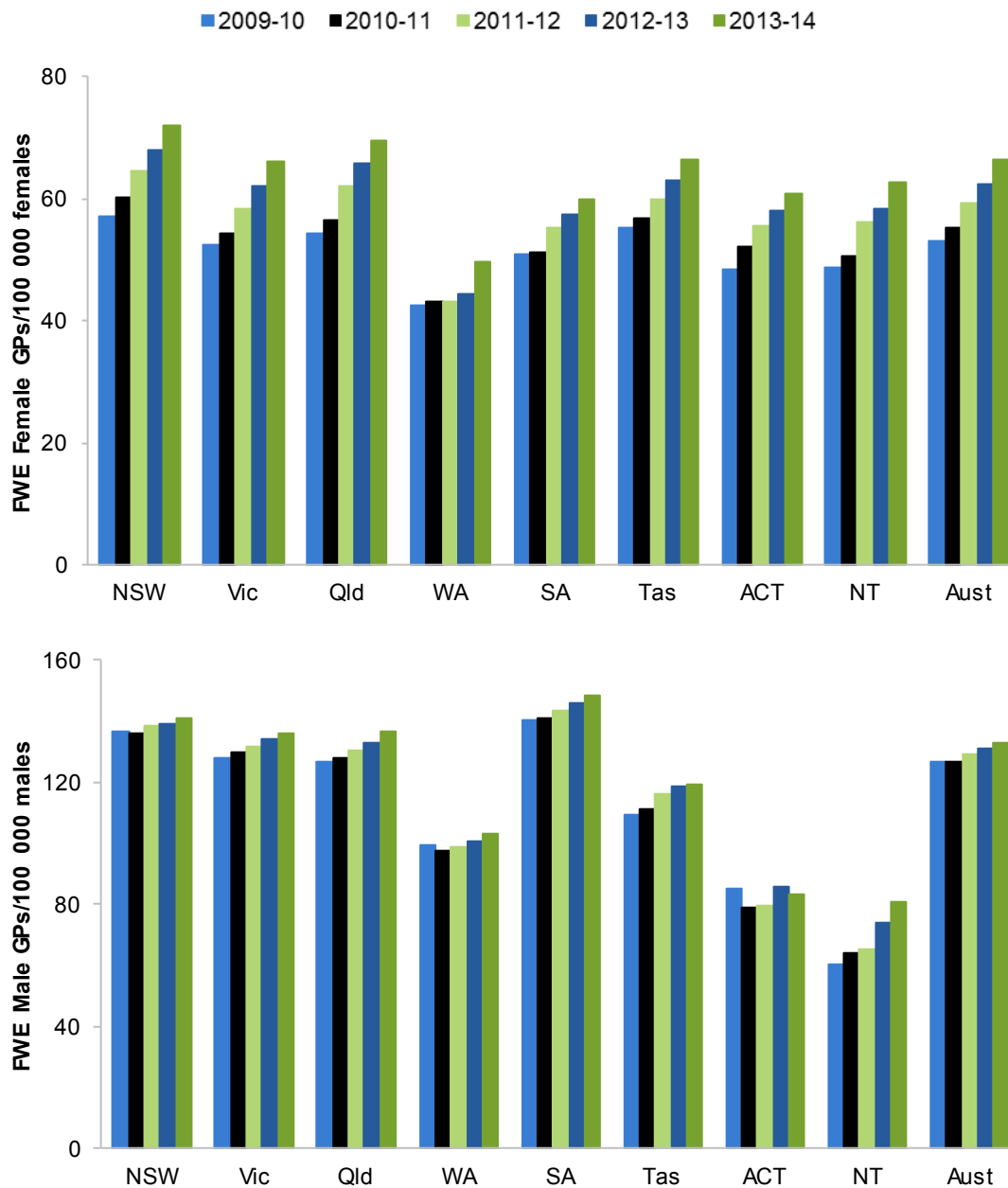
^a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. ^b FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. ^c There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. For the ACT, major cities includes inner regional areas.

Source: Department of Health (unpublished) MBS Statistics; table 10A.23.

Availability of GPs by sex

In 2013-14, 43.2 per cent of Australia's GPs — 33.5 per cent of FWE GPs — were female (table 10A.25). The number of FWE female GPs per 100 000 females increased from 53.2 to 66.3 in the period 2009-10 to 2013-14 (figure 10.8). In the same period, the number of FWE male GPs per 100 000 males increased from 126.3 to 132.9 (figure 10.8, table 10A.26). Data for female GPs are presented for a ten year time series in table 10A.25.

Figure 10.8 Availability of GPs by sex (full time workload equivalent)^a



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

Source: Department of Health (unpublished) MBS Statistics; tables 10A.25, 10A.26.

Availability of public dentists

‘Availability of public dentists’ is an indicator of governments’ objective to provide equitable access to dental services (box 10.4).

Box 10.4 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.

High or increasing availability of public dentists can indicate improved access to public dental services. 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.

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.

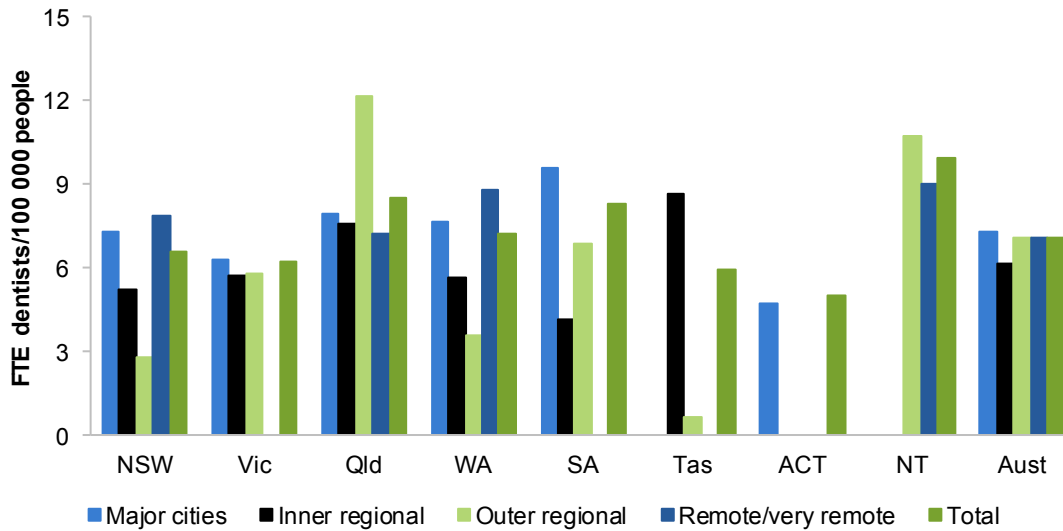
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period (2013).

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, there were 7.3 FTE public dentists per 100 000 people in major cities — more than in regional and remote/very remote areas — in 2013 (figure 10.9, table 10A.27). Nationally, the number of FTE public dental therapists per 100 000 people was highest in outer regional areas (5.8), followed by remote/very remote (4.7) and inner regional (4.6) and lowest in major cities (3.1) in 2013 (table 10A.28). Data for FTE dental hygienists and dental therapists are presented in table 10A.28.

Figure 10.9 Availability of public dentists, 2013^{a, b, c, d}



^a FTE based on 40 hours per week. ^b Public dentists include those working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. ^c There were no public dentists in remote or very remote areas in Victoria or Tasmania. Data for inner regional areas in the ACT are suppressed for confidentiality purposes. ^d Tasmania has no major cities. The ACT has no outer regional, remote or very remote areas. The NT has no major cities or inner regional areas.

Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.27.

Early detection and early treatment for Aboriginal and Torres Strait Islander Australians

'Early detection and early treatment for Aboriginal and Torres Strait Islander Australians' is an indicator of governments' objective to provide equitable access to primary and community healthcare services for Aboriginal and Torres Strait Islander Australians (box 10.5).

Box 10.5 Early detection and early treatment for Aboriginal and Torres Strait Islander Australians

'Early detection and early treatment for Aboriginal and Torres Strait Islander Australians' is defined as:

- the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection)
- the provision of appropriate and timely prevention and intervention measures (early treatment).

(Continued next page)

Box 10.5 (Continued)

Three measures of early detection and early treatment for Aboriginal and Torres Strait Islander Australians are reported:

- the proportion of older people who received a health assessment under DHS Medicare by Indigenous status
 - older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Aboriginal and Torres Strait Islander Australians 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 Aboriginal and Torres Strait Islander and other Australians (see the Health sector overview)
 - health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing.
- the proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment under DHS Medicare in successive years of a five year period
- the proportion of Aboriginal and Torres Strait Islander Australians who received a health assessment or check under DHS Medicare by age group — health assessment/checks are available for Aboriginal and Torres Strait Islander children (0–14 years), adults (15–54 years) and older people (55 years or over).

A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander and other Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Aboriginal and Torres Strait Islander Australians. An increase over time in the proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Aboriginal and Torres Strait Islander population.

This indicator provides no information about health assessments provided outside DHS Medicare. Such services are provided under service delivery models used, for example, in remote and very remote areas and therefore accessed predominantly by Aboriginal and Torres Strait Islander Australians. Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander Australians who received early detection and early treatment services.

Data reported for this indicator are:

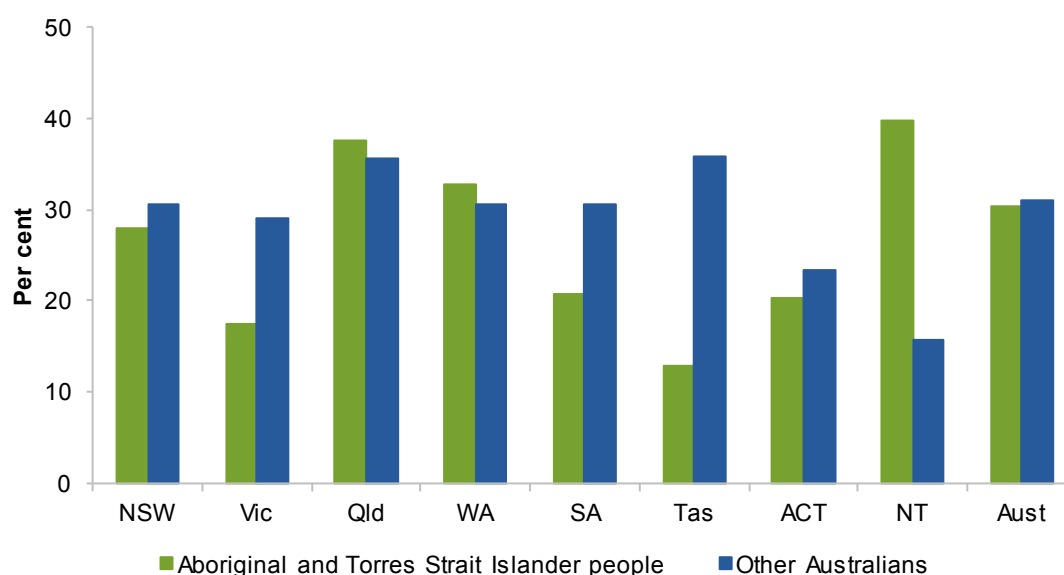
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2013-14.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The high prevalence of preventable and/or treatable health conditions in the Aboriginal and Torres Strait Islander population is strongly associated with relatively poor health outcomes for Aboriginal and Torres Strait Islander Australians (AIHW 2008a; SCRGSP 2014). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people's health.

Nationally, the proportion of older people receiving a health assessment was 30.4 per cent for Aboriginal and Torres Strait Islander people and 31.1 per cent for other Australians in 2013-14 (figure 10.10). There was considerable variation across States and Territories in the relative proportion of older people receiving a health assessment for these populations.

Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2013-14^{a, b, c, d}

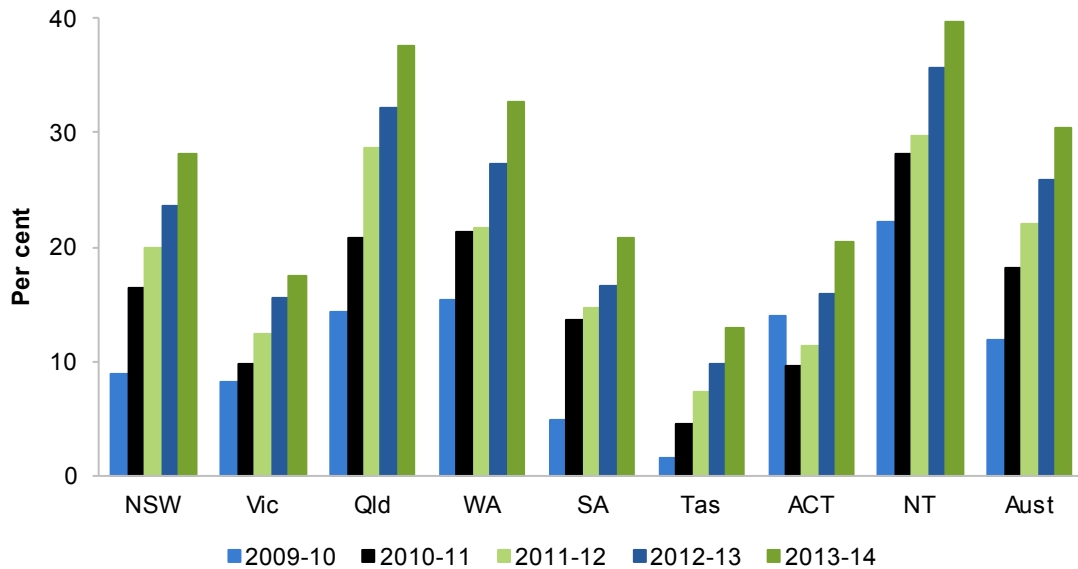


^a Older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over. ^b The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander Australians. ^c Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data for Aboriginal and Torres Strait Islander Australians are therefore likely to understate the proportion who access health assessments. ^d Rates are derived using the ABS' final 2011 Census rebased estimates and projections. See chapter 2 (tables 2A.2 and 2A.13-14) for details.

Source: Derived from Department of Health (unpublished) MBS Statistics, ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (various years) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.30.

The proportion of older Aboriginal and Torres Strait Islander Australians who received an annual health assessment increased in all jurisdictions between 2009-10 and 2013-14 (figure 10.11).

Figure 10.11 Older Aboriginal and Torres Strait Islander Australians who received an annual health assessment^{a, b, c}



^a For Aboriginal and Torres Strait Islander people, older is defined as aged 55 years or over. The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander Australians. ^b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data are therefore likely to understate the proportion who access health assessments. ^c Rates are revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.13-14) for details.

Source: Derived from Department of Health (unpublished) MBS data collection and ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; table 10A.31.

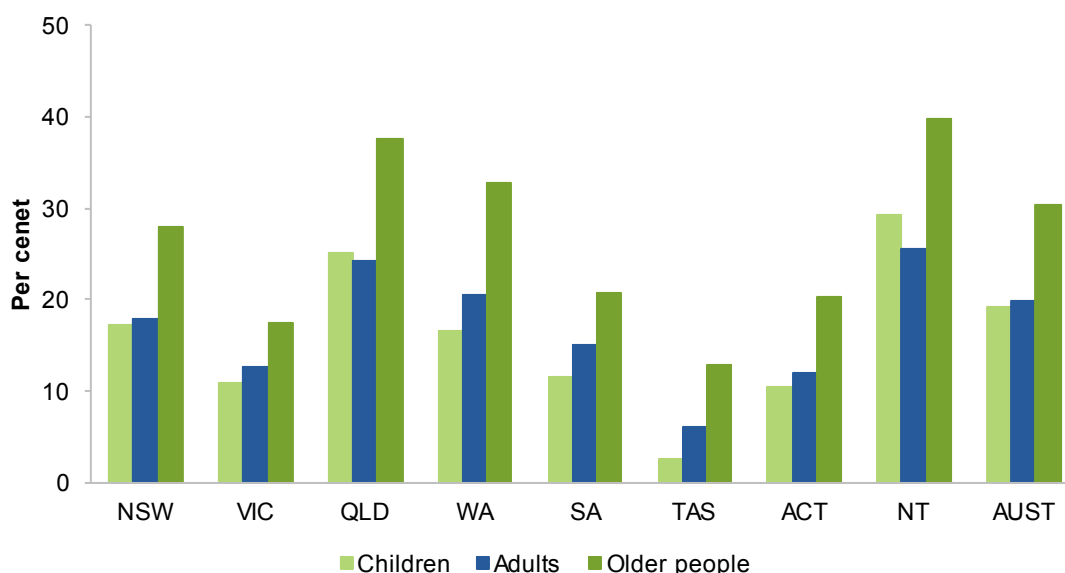
Health check MBS items were introduced for Aboriginal and Torres Strait Islander people aged 15–54 years in May 2004. Initially available biennially, since 1 May 2010 they have been available annually. Also available annually are health checks for Aboriginal and Torres Strait Islander children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Aboriginal and Torres Strait Islander 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 10.12). 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).

The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided selected early detection services, sourced from OSR data, was included in previous reports as a supplementary measure for this indicator. However, the data are no

longer available due to changes in the OSR data collection instrument, and the measure is not included in the 2015 Report.

Figure 10.12 **Aboriginal and Torres Strait Islander Australians who received a health assessment by age, 2013-14^{a, b, c}**



^a The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander Australians. ^b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data are therefore likely to understate the proportion who access health assessments. ^c Rates are derived using the ABS' final 2011 Census rebased estimates and projections. See chapter 2 (tables 2A.13-14) for details.

Source: Derived from Department of Health (unpublished) MBS Statistics and ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; table 10A.32.

Developmental health checks

'Developmental health checks' is an indicator of governments' objective to provide equitable access to early detection and intervention services for children (box 10.6).

Box 10.6 **Developmental health checks**

'Developmental health checks' is defined as the proportion of children who received a fourth year developmental health assessment under DHS Medicare, by health assessment type. The 'Healthy Kids Check' MBS health assessment item is available to children aged 3 or 4 years, while the 'Aboriginal and Torres Strait Islander Peoples Health Assessment' item is available to Aboriginal and Torres Strait Islander people of all ages.

A high or increasing proportion of children receiving a fourth year developmental health assessment is desirable as it suggests improved access to these services.

The proportion of Aboriginal and Torres Strait Islander children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Aboriginal and Torres Strait Islander children who received a fourth year developmental health assessment. The proportion of other children who received either a Healthy Kids Check (at the age of 3 or 4 years), or a Health assessment at the age of 5 years, is reported as a proxy for the proportion of other children who received a fourth year developmental health assessment.

Fourth year developmental health assessments are intended to assess children's physical health, general wellbeing and development. They enable 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 schooling.

This indicator provides no information about developmental health checks for children that are provided outside DHS Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, in maternal and child health services, community health centres, early childhood settings and the school education sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.

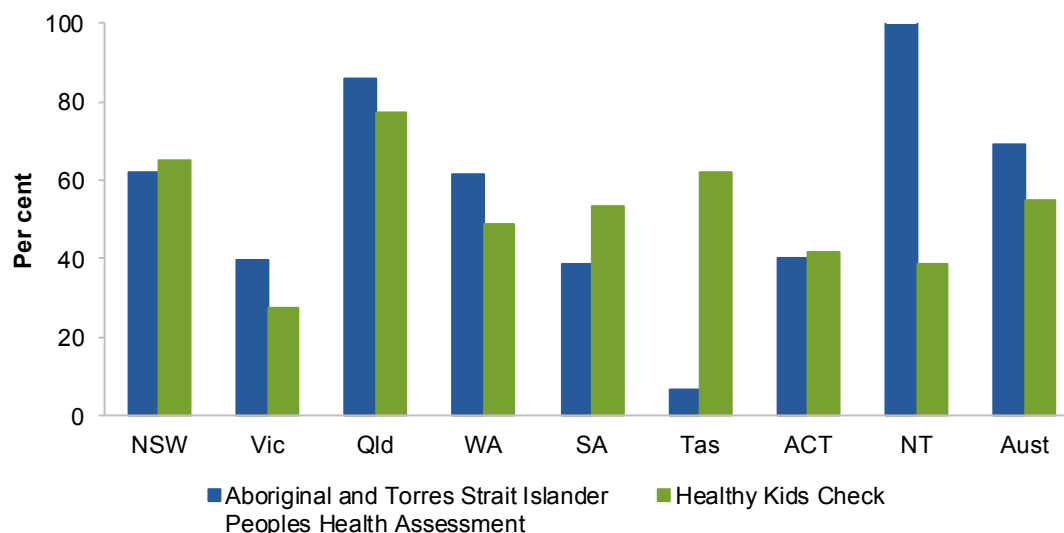
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data from 2012-13 are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, the proportion of children who received a fourth year developmental health check under DHS Medicare was 55.6 per cent in 2013-14 (table 10A.33). The proportion was higher for Aboriginal and Torres Strait Islander children than for other children in 2013-14, although there was considerable variation across jurisdictions (figure 10.13).

Figure 10.13 **Children who received a fourth year developmental health check, by health check type, 2013-14^{a, b, c, d, e, f, g}**



^a Limited to health checks available under DHS Medicare. ^b Aboriginal and Torres Strait Islander Peoples Health Assessment data include claims for MBS Item 715 for children aged 3–5 years. ^c Healthy Kids Check data include claims for MBS Items 701, 703, 705, 707 and 10 986 for children aged 3–5 years. ^d Children are counted once only. A child is counted only if not counted for a previous year. Where a child received both types of health check they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. ^e Healthy Kids Check data include Aboriginal and Torres Strait Islander children who received a Healthy Kids Check and do not receive a Aboriginal and Torres Strait Islander Peoples Health Assessment. ^f The denominator is the population of 4 year olds and is not directly comparable to the numerator, which is the sum of children who, for the first time at the age of 3, 4 or 5 years, received a health assessment under the MBS. Using this methodology, the estimated proportion of Aboriginal and Torres Strait Islander children in the NT who received a health check exceeds 100 per cent. ^g Rates are derived using the ABS' final 2011 Census rebased estimates and projections. See chapter 2 (tables 2A.2 and 2A.14) for details.

Source: Department of Health (unpublished) MBS Statistics; ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.33.

Effectiveness

Access

Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is an indicator of governments’ objective to provide effective access to primary healthcare services (box 10.7). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

Box 10.7 Effectiveness of access to GPs

'Effectiveness of access to GPs' is defined by four measures:

- bulk billing rates, defined as the number of GP visits that were bulk billed as a proportion of all GP visits
- 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
- GP waiting times, 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 less than 24 hours
 - 24 hours or more
- potentially avoidable presentations to emergency departments (interim measure), defined as:
 - the number of selected 'GP-type presentations' to emergency departments, where selected 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 high or increasing proportion of bulk billed attendances can indicate more affordable access to GP services. GP visits that are bulk billed do not require patients to pay part of the cost of the visit, while GP visits that are not bulk billed do. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and comparable over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

(Continued next page)

Box 10.7 (Continued)

A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and comparable over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Potentially avoidable presentations to emergency departments — an interim measure for this indicator — are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.

Data reported for this measure are:

- comparable (subject to caveats) within some jurisdictions over time but not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

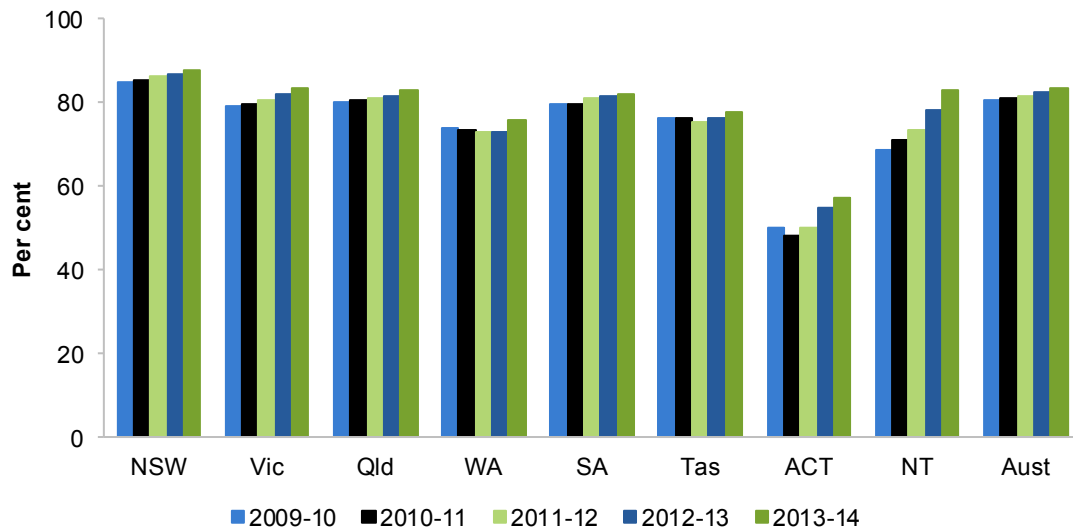
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Effectiveness of access to GPs — bulk billing rates

Patient visits to GPs are either bulk billed, or the patient is required to pay part of the cost of the visit. GP visits are classed as non-referred attendances under DHS Medicare. Where a patient is bulk billed they make no out-of-pocket contribution; the GP bills DHS Medicare 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 DHS Medicare rebate applies to most GP services.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 83.6 per cent in 2013-14. For most jurisdictions, this proportion increased in the period 2009-10 to 2013-14 (figure 10.14). The bulk billed proportion of non-referred attendances was highest in very remote areas and lowest in inner regional, outer regional and remote areas (table 10A.34). 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 10A.36).

Figure 10.14 GP visits that were bulk billed^{a, b}



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

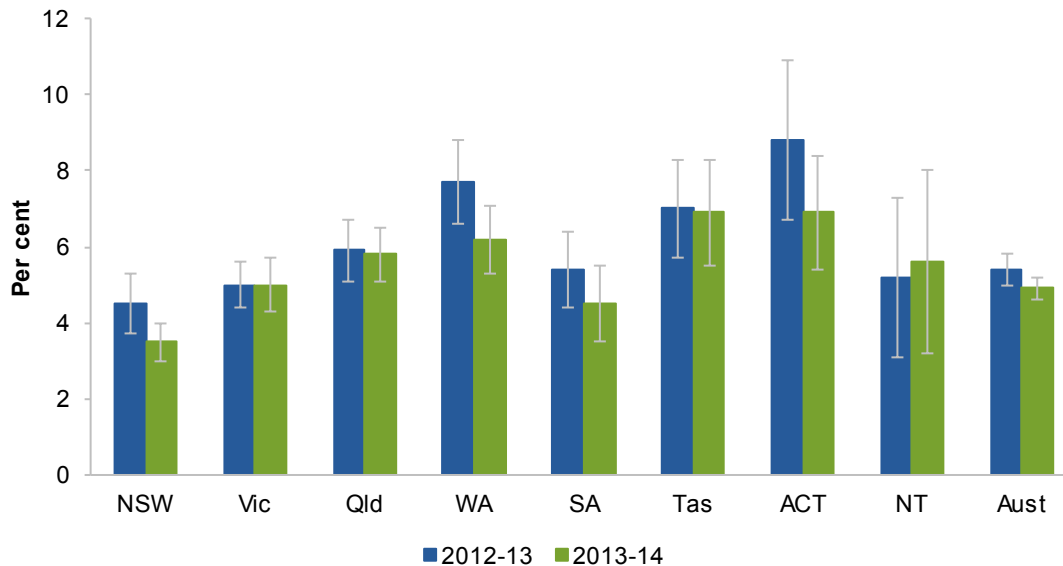
Source: Department of Health (unpublished) MBS Statistics; table 10A.36.

Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Timely access to healthcare services is important to people's health and wellbeing. Deferring or not visiting a GP can result in poorer health. Nationally, in 2013-14, 4.9 per cent of ABS Patient experience survey respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 10.15).

Data for Aboriginal and Torres Strait Islander Australians deferring access to GPs due to cost, collected for the first time from the ABS 2011-12 AATSIHS (Australian Aboriginal and Torres Strait Islander Health Survey), are presented in table 10A.38. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 10.15 People deferring visits to GPs due to cost^{a, b, c, d, e, f}



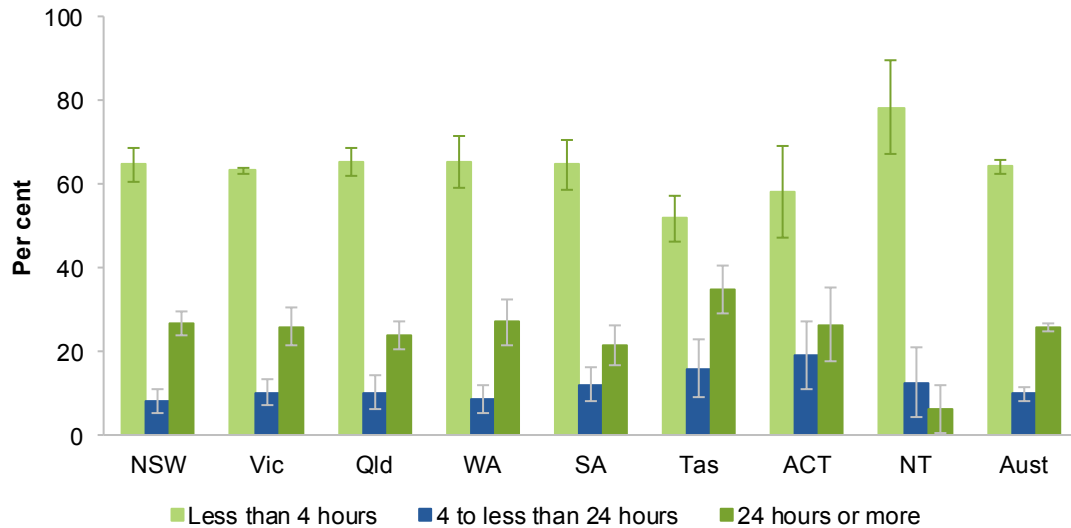
^a People aged 15 years or over. ^b Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. ^c Data are crude rates and may differ from data in previous reports in which rates were age-standardised. ^d Data for 2012-13 and 2013-14 are comparable. Data are not comparable with previous years due to a change in survey question wording and sequencing. ^e Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^f Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0; table 10A.37.

Effectiveness of access to GPs — GP waiting times

Nationally, 64.2 per cent of people who saw a GP for urgent care waited less than 4 hours in 2013-14 (figure 10.16). Around 10.0 per cent waited from 4 to less than 24 hours, and 25.8 per cent waited for 24 hours or more. Overall, 22.6 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 10A.40).

Figure 10.16 Hours waited for urgent treatment by a GP, 2013-14^{a, b, c, d, e, f}



^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 Data are comparable with data from 2011-12 but not with data for previous years due to a changed survey question. ^d Data are crude rates. ^e Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^f Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; table 10A.39.

Effectiveness of access to GPs — GP-type presentations to emergency departments

GP-type presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). It is important to note that these include appropriate presentations to emergency departments that can only be retrospectively categorised as ‘GP-type’. Factors contributing to GP-type presentations at emergency departments where this is not the case include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff.

Nationally, there were around 2.2 million GP-type presentations to public hospital emergency departments in 2013-14 (table 10.6).

Table 10.6 GP-type presentations to emergency departments, ('000)^{a, b, c, d}

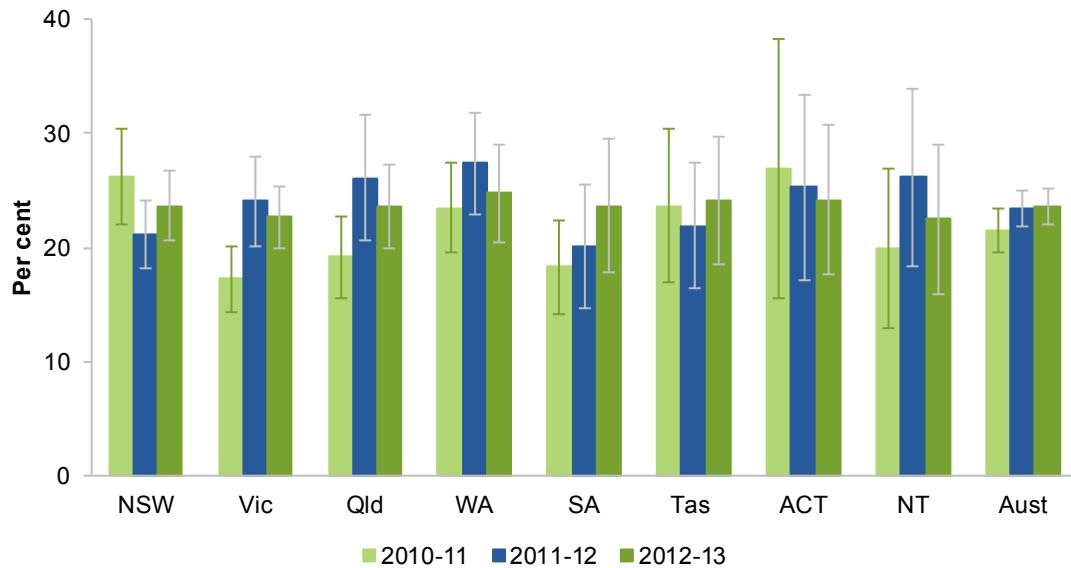
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2013-14	709.3	572.4	381.4	272.9	113.4	61.2	50.5	39.3	2 200.4

^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 This is an interim measure, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. Data include appropriate presentations to emergency departments, where the categorisation 'GP-type' can only be applied retrospectively. ^c Data are presented by State/Territory of usual residence of the patient. ^d Data are for peer group A and B public hospitals only, based on 2012-13 peer groups.

Source: AIHW (unpublished) National non-admitted emergency patient database; table 10A.41.

Nationally, 23.6 per cent of people who went to a hospital emergency department for their own health in 2012-13 thought at the time that care could have been provided at a general practice (figure 10.17).

Figure 10.17 **People visiting a hospital emergency department for care they thought could have been provided at a general practice^{a, b, c, d}**



^a Proportion of people aged 15 years or over who went to a hospital emergency department for their own health and at the time, thought the care could have been provided at a general practice. ^b Rates are age-standardised to the 2001 ERP. ^c Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. ^d Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0; table 10A.42.

Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure effective access to prescribed medicines (box 10.8).

Box 10.8 **Financial barriers to PBS medicines**

'Financial barriers to PBS medicines' is defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.

A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.

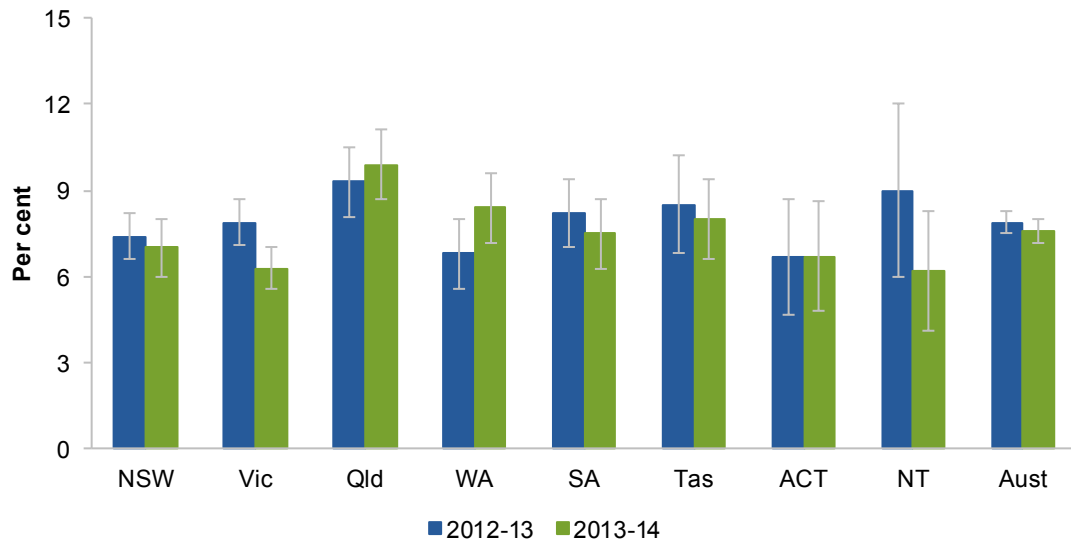
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, in 2013-14, 7.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 10.18). Data for Aboriginal and Torres Strait Islander Australians were collected for the first time from the ABS 2011-12 AATSIHS and are presented in table 10A.45. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 10.18 **People deferring purchase of prescribed medicines due to cost^{a, b, c, d}**



^a People 15 years or over who, in the last 12 months, were prescribed medication and delayed getting or did not get the medication due to cost. ^b Data are comparable over time from the 2010-11 reference year. Data are crude rates and may differ from data in previous reports which were age-standardised. ^c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey, 2012-13, 2013-14*, Cat. no. 4839.0; table 10A.43.

Public dentistry waiting times

‘Public dentistry waiting times’ is an indicator of governments’ objective to ensure timely access to public dental services for eligible people (box 10.9).

Box 10.9 Public dentistry waiting times

‘Public dentistry waiting times’ is defined as the time waited between being placed on a public dentistry waiting list and being seen by a dental professional. It is measured as the proportion of people on a public dental waiting list who received a public dental service within specified waiting time categories.

A high or increasing proportion of people waiting shorter periods to see a dental professional indicates more timely access to public dental services.

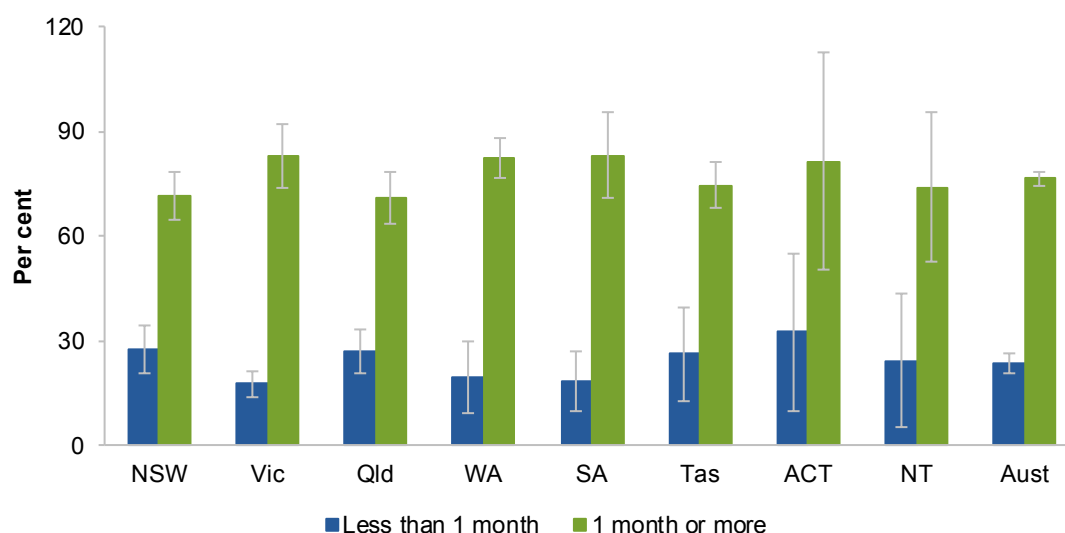
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but not over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Nationally, 23.4 per cent of people who were on a public dental waiting list waited for less than 1 month to see a dental professional at a government dental clinic in 2013-14 (figure 10.19). Data are presented by remoteness in table 10A.46. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.47 are not comparable to data for all Australians (see DQI for details).

Figure 10.19 Time waited for public dentistry services, 2013-14^{a, b, c, d, e}



^a Time waited for a public dental service, for people 15 years or over who were on a public dental waiting list in the last 12 months. ^b Data are not comparable with data for previous years. See DQI for further information. ^c Data are crude rates. ^d Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. ^e Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*; table 10A.45.

Appropriateness

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 10.10).

Box 10.10 **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 2014b).

A high or increasing proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. GPs without vocational registration may deliver services of equally high quality, however, their access to DHS Medicare rebates for the general practice services they provide is limited compared to vocationally registered GPs.

Data reported for this indicator are:

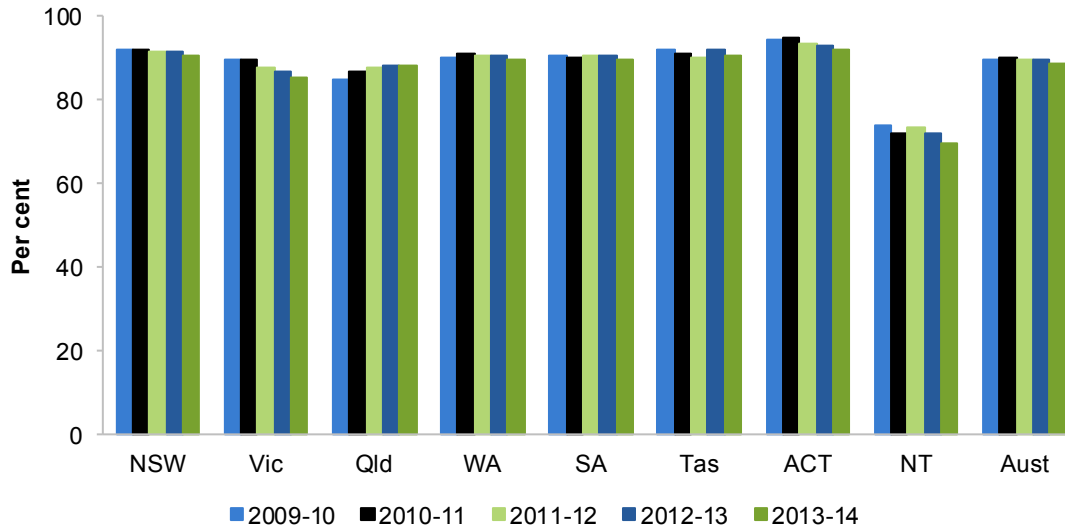
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

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 (from April 2007) the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. 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 meet mandated registration standards which include Continuing Professional Development in order to maintain registration.

Nationally, the proportion of FWE GPs with vocational registration decreased slightly, from 89.7 to 88.5 per cent, in the period 2009-10 to 2013-14 (figure 10.20). The proportion of FWE GPs with vocational registration was highest in major cities and lowest in remote areas in 2013-14 (table 10A.48).

Figure 10.20 **GPs (full time workload equivalent) with vocational registration^a**



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

Source: Department of Health (unpublished) MBS Statistics; table 10A.50.

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 10.11).

Box 10.11 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 independent third-party 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.

(Continued next page)

Box 10.11 (Continued)

A high or increasing 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 may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

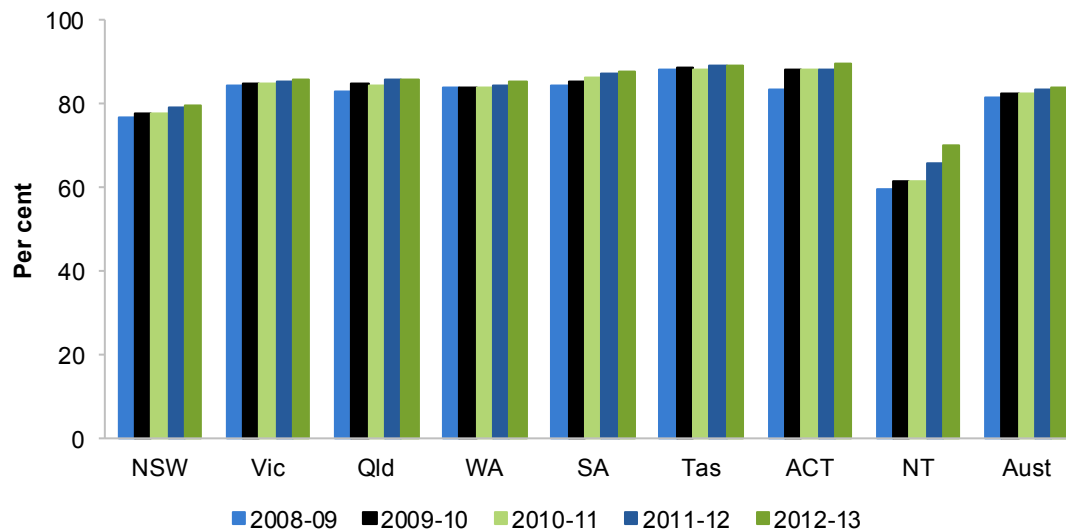
Data quality information for this indicator is under development.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation Pty Ltd.

Data are not available for the 2015 Report because no current source of data can be identified for the number of general practices. Data for 2011 and previous years were sourced from the annual survey of Divisions of General Practice, which ceased on transition from Divisions of General Practice to Medicare Locals. Historical data are reported in table 10A.51.

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 increased slightly in the period from 2008-09 to 2012-13 (figure 10.21).

Figure 10.21 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: Department of Health (unpublished) PIP and MBS data collections; table 10A.52.

Management of acute upper respiratory tract infection

‘Management of acute upper respiratory tract infection’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 10.12).

Box 10.12 Management of upper respiratory tract infection

'Management of acute upper respiratory tract infection' (URTI) is defined by two measures:

- filled GP prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) per 1000 people
- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.

Low or decreasing rates of prescription of the selected antibiotics and acute URTI GP visits where systemic antibiotics are prescribed can indicate that GPs' management of acute URTI more closely follows guidelines.

URTI without complication (acute URTI or the 'common cold') is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless often prescribed for their treatment. Unnecessarily high rates of antibiotic prescription have the potential to increase both pharmaceutical costs and antibiotic resistance in the community (Tamma and Cosgrove 2014).

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years for the measure filled GP prescriptions for selected antibiotics
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for the measure filled GP prescriptions for selected antibiotics is at www.pc.gov.au/rogs/2015. Data quality information for the measure acute URTI GP visits where systemic antibiotics are prescribed is under development.

Rate of prescription of selected antibiotics

Caution should be used in interpreting the rate of prescription of the selected antibiotics as the oral antibiotics most commonly prescribed to treat acute URTI are also prescribed for other illnesses. Information about the condition for which the antibiotics are prescribed is not available.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat acute URTI was 295 per 1000 people in 2013-14 (figure 10.22; table 10A.53).

Figure 10.22 **Rate of prescription of oral antibiotics used most commonly to treat acute upper respiratory tract infection^{a, b, c}**



^a Prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed. ^b Data are not limited to prescriptions for treatment of upper respiratory tract infection. ^c Data from 2012-13 are for all people and are not comparable with data for previous years that were limited to prescriptions provided to holders of concession cards, and are reported in table 10A.54.

Source: Department of Health unpublished, PBS Statistics; table 10A.53.

Proportion of GP visits for acute URTI where systemic antibiotics are prescribed

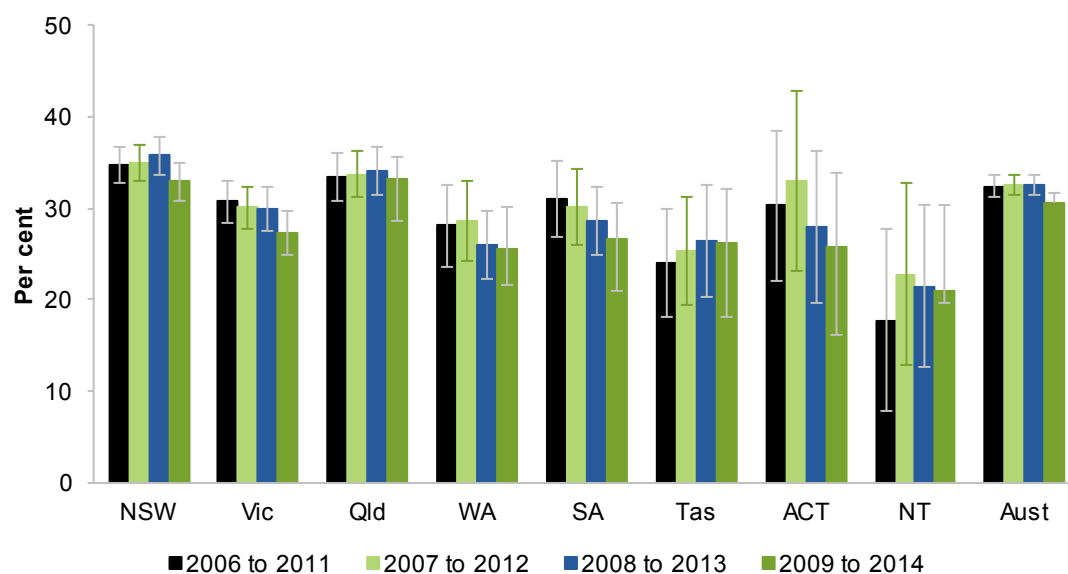
Data for the proportion of GP visits for acute URTI where systemic antibiotics are prescribed are available at State/Territory level, from the annual BEACH survey of general practice activity in Australia.

The BEACH survey collects information on the reason for the GP visit as well as the treatment prescribed or provided. This allows derivation of the proportion of visits to GPs for acute URTI for which systemic antibiotics were prescribed or supplied. Each year, the national BEACH sample comprises around 1000 GPs, each providing data for around 100 patient visits. Aggregation of data for a period of 5 years allows publication of data for all States and Territories (figure 10.23). This has some limitations — short-term change will be reflected only if substantive when averaged over a 5 year period, and proximate causes of change will not be directly identifiable. These limitations are to a degree mitigated by the reporting of data for each year in the reference period at the national level. This will assist in interpreting whether change reflected over rolling 5 year periods is due to substantive short-term change or to incremental change over several years.

The proportion of people presenting to GPs for acute URTI who were prescribed systemic antibiotics for its treatment decreased at the national level, from 32.4 per cent for

the 5 years April 2006 to March 2011 to 30.5 per cent for the 5 years April 2009 to March 2014, reflecting an overall decreasing trend in most states and territories for the same period (figure 10.23).

Figure 10.23 Proportion of acute URTI managements where systemic antibiotics were prescribed^{a, b}

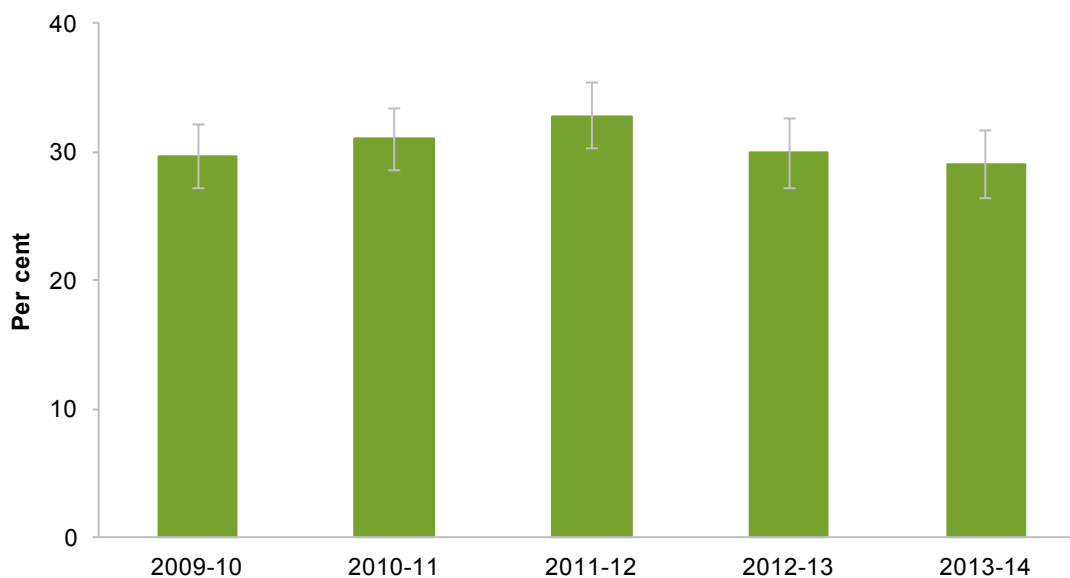


^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Source: Britt et al. (unpublished) BEACH Statistics; table 10A.55.

Nationally, the proportion of acute URTI presentations for which systemic antibiotics were prescribed by GPs, in each 12 month period from April to the following March increased from 29.6 per cent in 2009-10 to 32.8 per cent in 2011-12, decreasing to 29.0 in 2013-14 (figure 10.24).

Figure 10.24 **Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia^{a, b}**



^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Source: Britt et al. (unpublished) BEACH Statistics; table 10A.56.

Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 10.13).

Box 10.13 Chronic disease management

'Chronic disease management' is defined by four measures:

- management of diabetes — PIP diabetes incentive, defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP diabetes incentive
- management of diabetes — HbA1c, defined as the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes with HbA1c below 7 per cent, divided by the estimated number of people with diabetes)
- management of asthma, defined as the proportion of people with asthma who have a written asthma action plan
- care planning/case conferencing, 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.

A high or increasing proportion of PIP practices registered for the PIP diabetes incentive, people with diabetes with HbA1c below 7 per cent, people with asthma who have a written asthma action plan, and GPs who use chronic disease management items, is desirable.

Registration for the PIP diabetes incentive requires the implementation of management strategies for patients with diabetes that are based on RACGP clinical guidelines for appropriate Type 2 diabetes management in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

HbA1c measures the level of glucose in the blood averaged over the preceding three months. HbA1c levels below 7 per cent are indicative of appropriate management of diabetes in that period.

Written asthma action plans have been included in clinical guidelines for asthma management for around 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008).

A high or increasing 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. 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. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

(Continued next page)

Box 10.13 (Continued)

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions for management of diabetes — PIP diabetes incentive and for care planning/case conferencing. All required 2011-12 data are available for all jurisdictions for management of diabetes — HbA1c and management of asthma.

Data quality information (DQI) is at www.pc.gov.au/rogs/2015 for the measures management of diabetes — HbA1c and management of asthma. DQI is under development for for the measures management of diabetes — PIP diabetes incentive and care planning/case conferencing.

Reporting against this indicator has improved as the measure management of diabetes — PIP diabetes incentive is reported for the first time. Updated data for asthma management by Indigenous status are also reported.

Chronic diseases are generally long term and often progressive conditions, for example, diabetes and asthma. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).

Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent or minimise the severity of complications (AIHW 2008b, NHPAC 2006). Effective management requires the provision of timely, high quality healthcare to meet individual needs and provide continuity of care (Australian Government 2010). Effective management can have profound effects on individuals and on the broader health system. Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

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

Chronic disease management — diabetes

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 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

The PIP Diabetes incentive provides incentives to eligible practices to improve management of patients with diabetes. In order to register for the PIP Diabetes incentive, general practices are required to maintain an active patient register and recall and reminder system for all known patients with diabetes mellitus, and to agree to implement an annual cycle of care for patients with diabetes mellitus. The annual cycle of care is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice, which represent the minimum required level of care.

Nationally, 47.3 per cent of PIP practices were registered for the PIP diabetes incentive although there was considerable variation across States and Territories, in 2013-14 (figure 10.25).

Figure 10.25 PIP practices registered for the PIP diabetes incentive, 2013-14^a



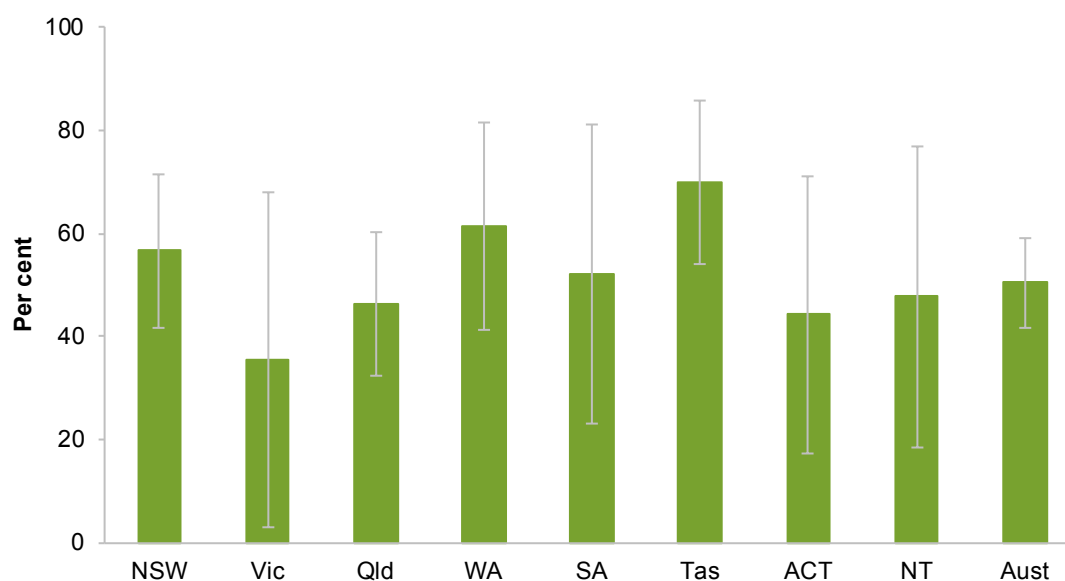
^a Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52).

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.57.

HbA1c (glycosolated haemoglobin) provides a measure of the average blood glucose level for the preceding three months. RACGP guidelines for management of diabetes indicate that HbA1c levels should be tested at least every 6 months. Nationally, 77.5 per cent of people with known diabetes had a HbA1c test in the previous 12 months (table 10A.58).

An outcome of appropriate management of diabetes, by the primary and community health care sector in conjunction with the patient, is a HbA1c level at or below 7 per cent. Nationally, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (figure 10.26).

Figure 10.26 People with known diabetes with HbA1c level 7 per cent or less^{a, b, c, d}



^a People aged 18 years to 69 years with known diabetes. Includes pregnant women. ^b Known diabetes based on fasting plasma glucose test results and self-reported information on diagnosis/medication use. ^c Rates are not age-standardised. ^d Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

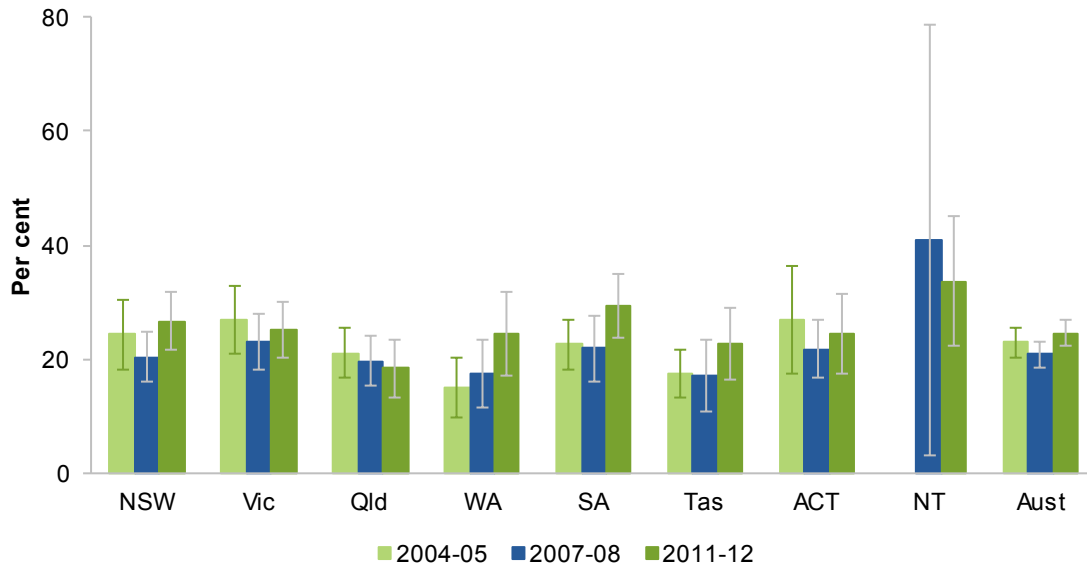
Source: ABS (unpublished) *Australian Health Survey, 2011-13* (2011-12 National Health Measures Survey component), Cat. No. 4364.0; table 10A.59.

Chronic disease management — asthma

Asthma, an identified National Health Priority Area for Australia, 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.

Nationally, the proportion of people with asthma reporting that they have a written asthma action plan was 24.6 per cent for people of all ages in 2011-12, a slight increase from 22.9 per cent in 2004-05 (figure 10.27). The proportion of people with asthma reporting that they have a written asthma action plan was higher for children aged 0–14 years than for other age groups in all jurisdictions (table 10A.60).

Figure 10.27 Proportion of people with asthma who have a written asthma action plan, all ages^{a, b, c, d}

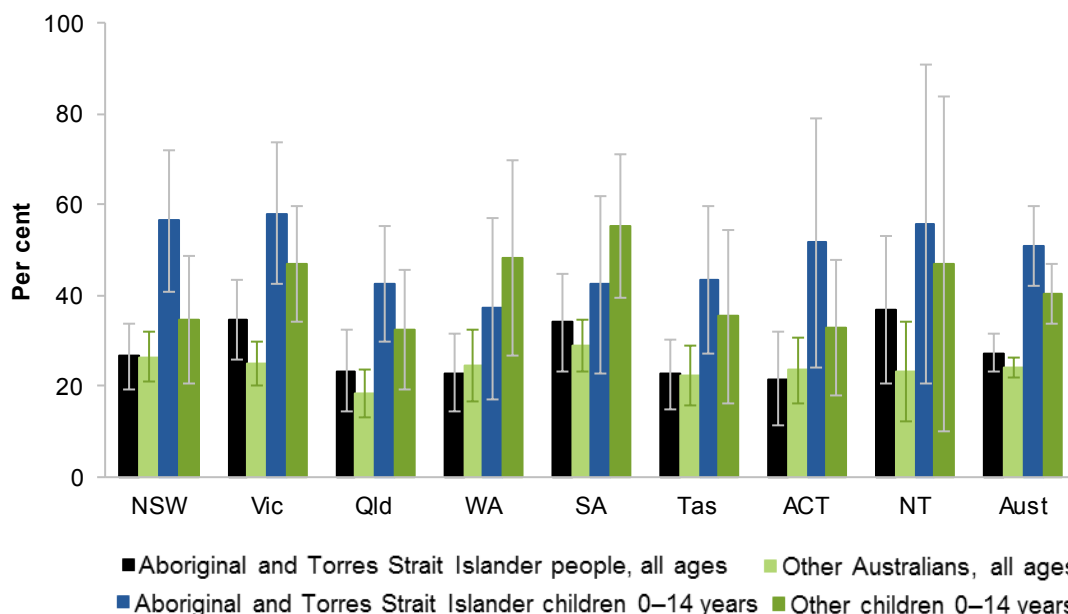


^a Rates are age standardised to the Australian population at 30 June 2001. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate. ^c Data for the NT should be used with care as the NHS (National Health Survey) excludes very remote areas and therefore around 23 per cent of the NT population. Data for the NT are not available for 2004-05. ^d Data for the NT for 2011-12 are not comparable to data for previous years due to the increased sample size.

Source: ABS (unpublished) *Australian Health Survey, 2011-2013* (2011-12 NHS component), Cat. No. 4364.0; ABS (unpublished) *National Health Survey, 2007-08, 2004-05*, Cat. No. 4364.0; table 10A.60.

Nationally, the proportion of Aboriginal and Torres Strait Islander people with asthma reporting that they have a written asthma action plan was 27.3 per cent for people of all ages and 50.9 per cent for children aged 0–14 years in 2012-13 (figure 10.28; table 10A.61). Data for people of all ages are reported by Indigenous status for 2004-05 and 2011–13 in table 10A.62. Data for people of all ages are reported by geographical region for 2007-08 in table 10A.63.

Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13^{a, b, c}



^a Rates for 'all ages' are age standardised to the Australian population at 30 June 2001. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate. ^c Data for 'other Australians' for the NT should be used with care as exclusion of very remote areas from the NHS translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Health Survey, 2011–13* (2011-12 NHS component), Cat. no. 4364.0; ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0; table 10A.61.

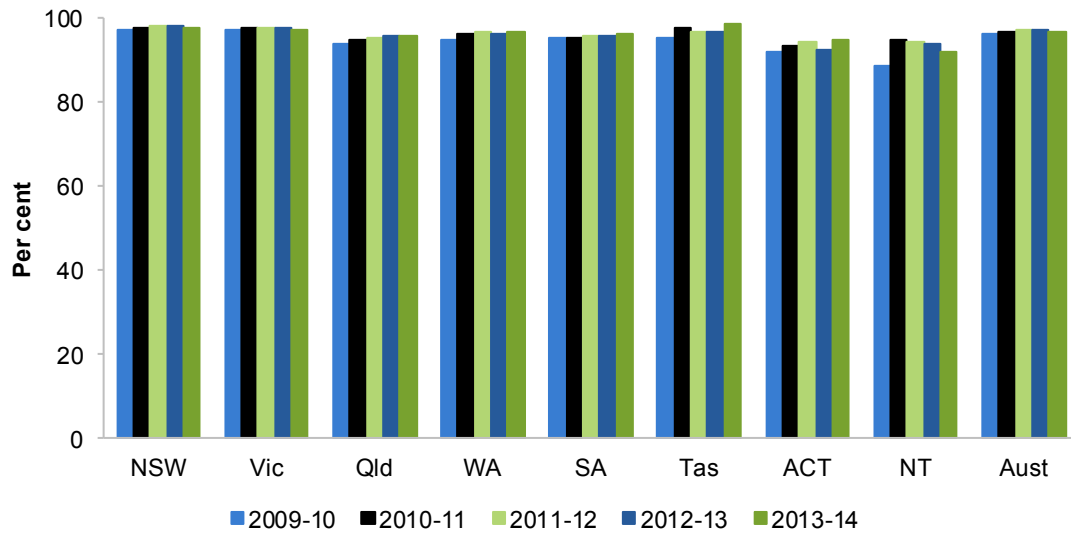
Chronic disease management — care planning and case conferencing

Individuals with chronic or terminal medical conditions commonly have complex, multidisciplinary care needs. Coordination of service provision to provide continuity of care and meet the changing needs of individuals over time is important in the effective management of such conditions. 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 planning and case conferencing.

Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing increased slightly — from 96.1 to 97.0 per cent — in the period 2009-10 to 2013-14 (figure 10.29).

Figure 10.29 **GP use of chronic disease management MBS items for care planning and case conferencing^{a, b}**



^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. ^b Additional chronic disease management MBS items have become available on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Source: Department of Health (unpublished) MBS Statistics; table 10A.64.

Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 10.14).

Box 10.14 Use of pathology tests and diagnostic imaging

'Use of pathology tests and diagnostic imaging' is defined by four measures:

- MBS items rebated through DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs, per person
- diagnostic imaging services provided on referral from vocationally registered GPs and OMPs and rebated through DHS Medicare, per person
- DHS Medicare benefits paid per person for pathology tests
- DHS Medicare benefits paid per person for diagnostic imaging.

This indicator needs to be interpreted with care as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Reporting differences across jurisdictions and over time contributes to consideration of these issues. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS Medicare is used as a proxy in reporting against this indicator.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS Medicare data reflect only those services provided and rebated.

Age-standardised rates are available from 2012-13. Historical data are crude rates and are provided in tables 10A.66 (pathology tests) and 10A.68 (diagnostic imaging).

Nationally, the number of rebated MBS items for pathology tests requested by GPs and eligible nurse practitioners was 3.5 per person in 2013-14 (figure 10.30).

Figure 10.30 **MBS items rebated through DHS Medicare for pathology tests requested by GPs, per person^{a, b}**

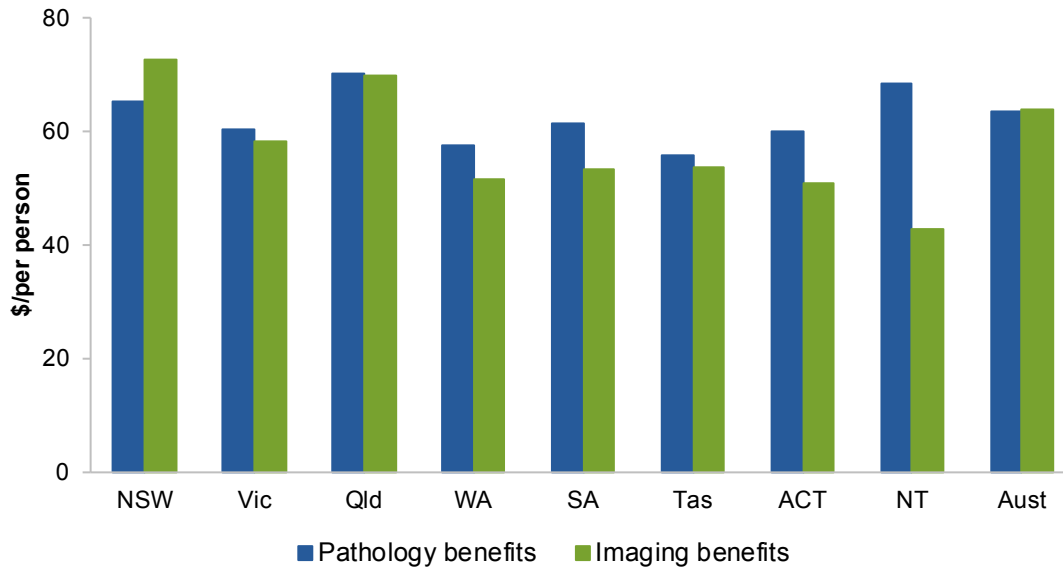


^a Data are age standardised to the 2001 Australian standard population. ^b Data include tests requested by vocationally registered GPs and OMPs and, from 2013-14, eligible nurse practitioners. Data include patient episode initiated items.

Source: Department of Health (unpublished) MBS and DVA data collections; table 10A.65.

Australian Government expenditure under DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs and eligible nurse practitioners amounted to \$1.6 billion — around \$64 per person — in 2013-14 (figure 10.31). Australian Government expenditure under DHS Medicare for diagnostic imaging tests requested by vocationally registered GPs and OMPs and eligible nurse practitioners was also \$1.6 billion in 2013-14 although expenditure per person was less for diagnostic imaging than for pathology tests in most jurisdictions (figure 10.31).

Figure 10.31 **Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare, 2013-14^a**

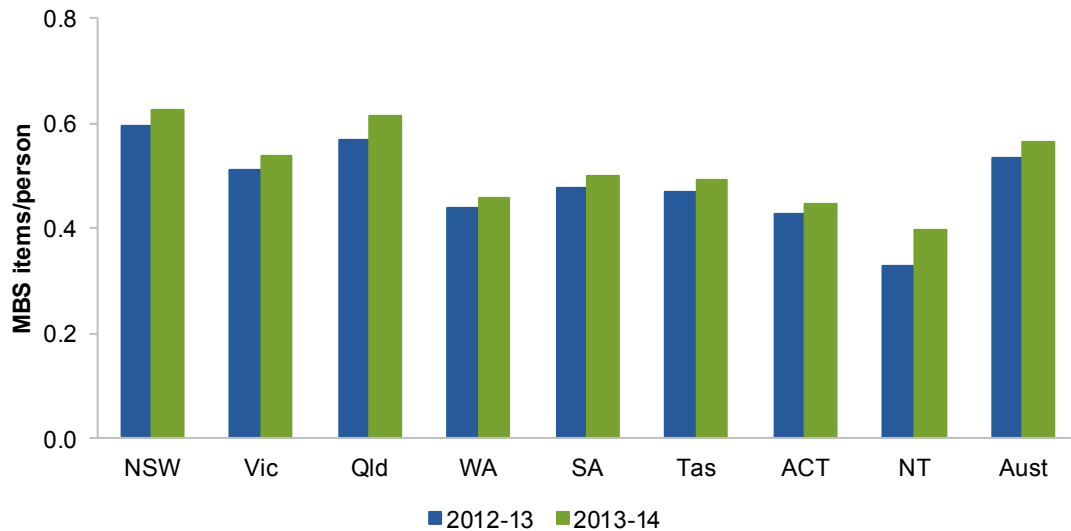


^a Includes benefits paid through DHS Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally registered GPs and OMPs and from eligible nurse practitioners.

Source: Department of Health (unpublished) MBS and DVA data collections; tables 10A.65 and 10A.67.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs and, for 2013-14, eligible nurse practitioners, was 0.54 per person in 2013-14 (figure 10.32).

Figure 10.32 **Diagnostic imaging services referred by GPs and rebated through DHS Medicare^{a, b}**



^a Data are age standardised to the 2001 Australian standard population. ^b Data include tests requested by vocationally registered GPs and OMPs and, from 2013-14, eligible nurse practitioners.

Source: Department of Health (unpublished) MBS and DVA data collections; table 10A.67.

Quality — safety

Electronic health information systems

‘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 10.15).

Box 10.15 **Electronic health information systems**

'Electronic health information systems' is defined as the proportion of general 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 83.0 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (Department of Health unpublished; table 10A.52).

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2014 data are available for all jurisdictions.

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).

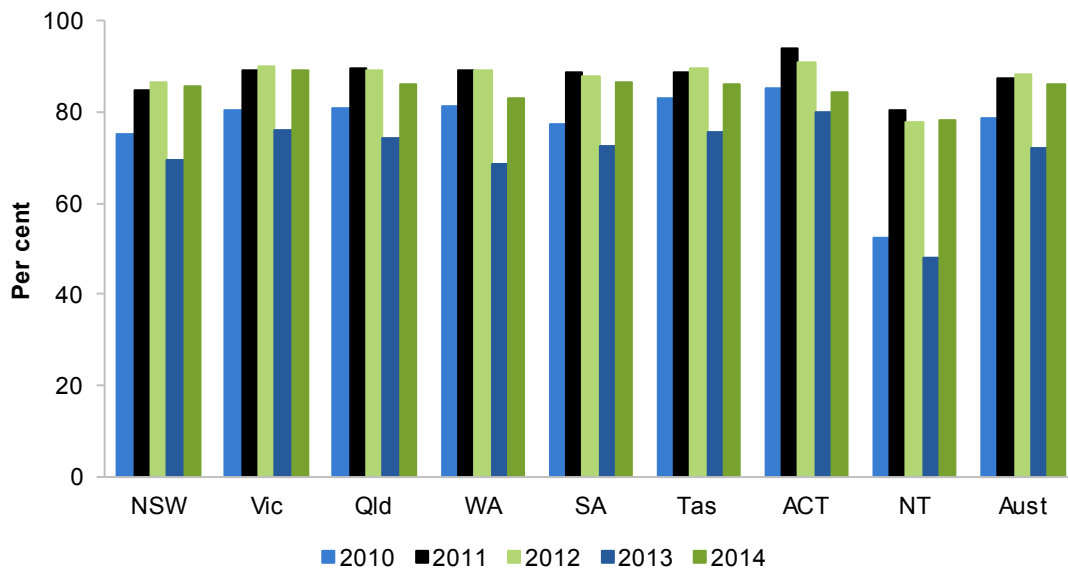
The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Accordingly, new eligibility requirements were introduced from 1 February 2013, requiring practices to:

- integrate healthcare identifiers into electronic practice records
- have a secure messaging capability
- use data records and clinical coding of diagnoses
- send prescriptions electronically to a prescription exchange service
- participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software.

Nationally, the proportion of PIP practices using electronic health systems was 86.3 per cent in May 2014, recovering most of the sharp decrease, from 88.3 per cent in May 2012 to 72.2 per cent in May 2013, that was associated with time taken to implement the new eligibility requirements for many practices (figure 10.33).

The proportion of PIP practices using electronic health systems increased in all areas between May 2013 and May 2014, remaining lower in remote and very remote areas than in other areas (figure 10.34).

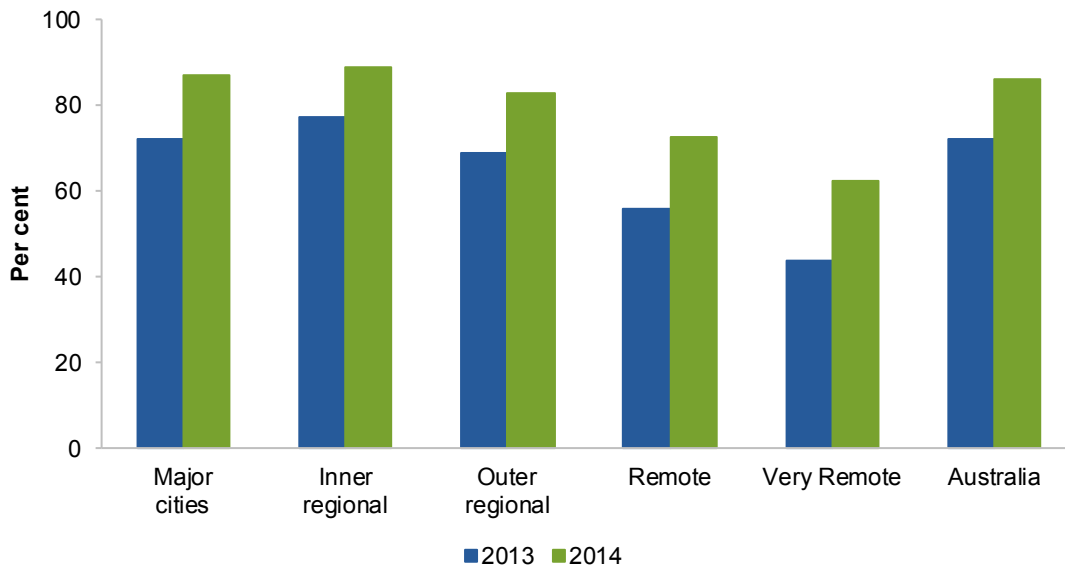
Figure 10.33 PIP practices using electronic health systems^a



^a Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52).

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.69.

Figure 10.34 PIP practices using electronic health systems by area^{a, b}



^a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. ^b Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52).

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.70.

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 10.16).

Box 10.16 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:

- experience with selected key aspects of GP care, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months
- experience with selected key aspects of dental professional care, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.

High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

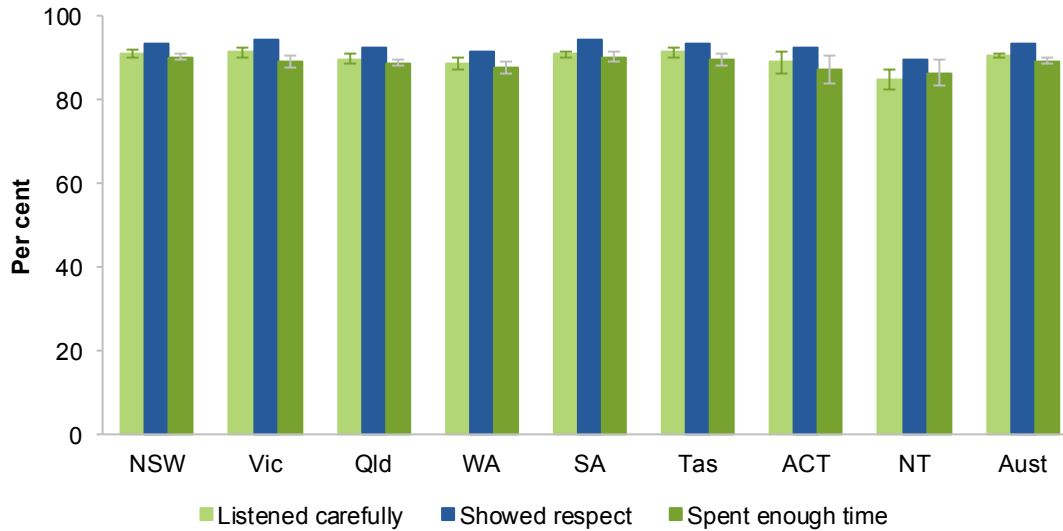
Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2013-14, the GP always or often (figure 10.35):

- listened carefully to them (90.6 per cent)
- showed respect (93.3 per cent)
- spent enough time with them (89.3 per cent).

Data are presented by remoteness area in tables 10A.72 and 10A.73. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.74 are not comparable to the data presented here (see DQI for details).

Figure 10.35 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2013-14^{a, b, c}



^a People aged 15 years or over who saw a GP in the last 12 months. ^b Data are crude rates. ^c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; tables 10A.72, 10A.73.

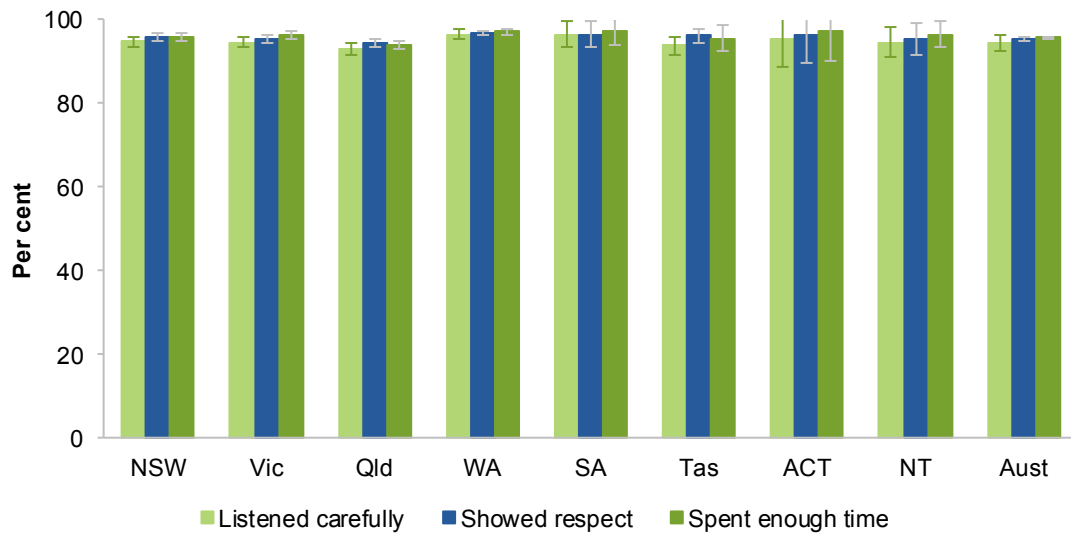
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that, in 2013-14, the dental professional always or often (figure 10.36):

- listened carefully to them (94.6 per cent)
- showed respect (95.5 per cent)
- spent enough time with them (95.7 per cent).

Data are presented by remoteness area in tables 10A.75 and 10A.76.

Figure 10.36 Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2013-14^{a, b, c}



^a People aged 15 years or over who saw a dental professional in the last 12 months. ^b Data are crude rates. ^c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; tables 10A.75, 10A.76.

Quality — continuity

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 10.17).

Box 10.17 **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 Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 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 10.5).

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 reported against this indicator are:

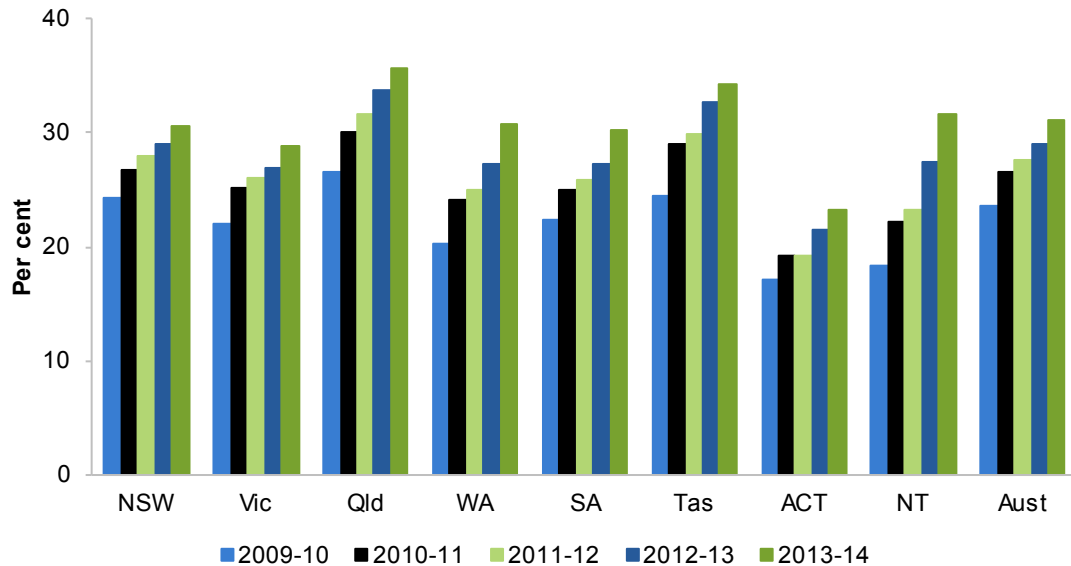
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

The targeted age range for Aboriginal and Torres Strait Islander Australians 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 Aboriginal and Torres Strait Islander and non-Indigenous populations (see the Health sector overview). Results for Aboriginal and Torres Strait Islander people are reported under equity indicators (box 10.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2009-10 to 2013-14. Nationally, this proportion increased from 23.5 per cent in 2009-10 to 31.1 per cent in 2013-14 (figure 10.37). Data are presented for an 8 year time series in table 10A.77.

Figure 10.37 Older people who received an annual health assessment^{a, b}



^a Older people are defined as non-Indigenous Australians aged 75 years or over and Aboriginal and Torres Strait Islander Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. ^b Rates are revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13-14) for details.

Source: Department of Health (unpublished) MBS Statistics; ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0; table 10A.77.

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 10.18).

Box 10.18 **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.

This indicator needs to be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.

Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. Consequently, costs for primary care are understated for jurisdictions where a large proportion of the population live in rural and remote areas.

Data reported for this indicator are:

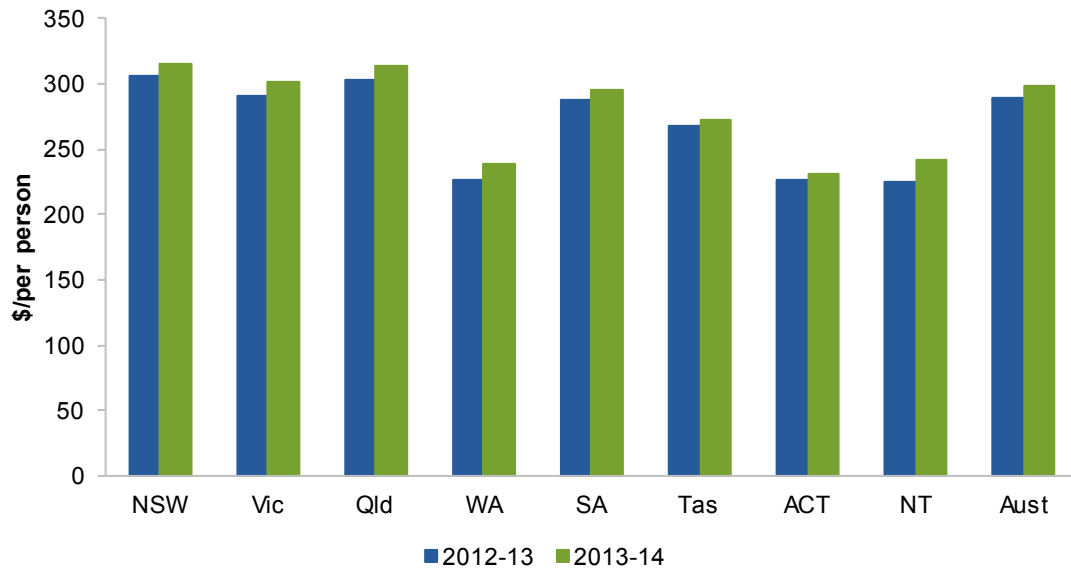
- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Data for this indicator have improved with the introduction of age-standardisation for fee-for-service expenditure data through DHS Medicare and the DVA from 2012-13. These data are not comparable with data for previous years that are not age-standardised and include expenditure on GP programs. Historical data are provided in table 10A.3.

Nationally, Australian Government fee-for-service expenditure on general practice was \$7.3 billion — \$299 per person — in 2013-14 (figure 10.38). Total Australian Government expenditure on general practice included PIP and Medicare Locals funding of a further \$600 million (table 10A.3).

Figure 10.38 **Australian Government fee-for-service expenditure per person on GPs (2013-14 dollars)^{a, b, c}**



^a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details. ^b Data are directly age-standardised to the 2001 Australian standard population. ^c Data include DHS Medicare and DVA payments.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished), DVA data collection; table 10A.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 10.19).

Box 10.19 Child immunisation coverage

'Child immunisation coverage' is defined by three measures:

- the 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, pertussis (whooping cough), polio, hepatitis b, *Haemophilus influenzae* type b and, from the quarter ending 31 December 2013, pneumococcal
- 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, 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 reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Many providers deliver child immunisation services (table 10.7). High immunisation coverage levels are encouraged through a range of measures, including incentives for parents that link immunisation to tax and childcare benefits and rebates. Incentives for providers were in place under the General Practice Immunisation Incentives Scheme to 30 June 2013.

Table 10.7 Valid vaccinations supplied to children under 7 years of age, by provider type, 2009–2014 (per cent)^{a, b, c}

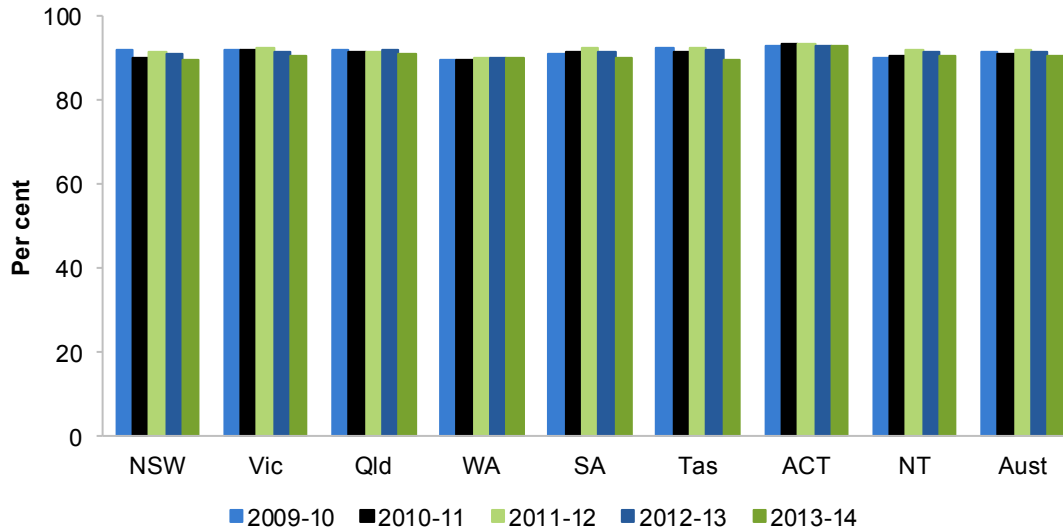
Provider	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	88.8	59.5	84.6	69.2	73.0	93.1	59.6	71.8	75.9
Council	3.2	38.8	5.8	3.6	18.5	6.4	–	–	13.5
State or Territory health department	–	–	–	4.9	–	–	1.2	0.1	0.6
Public hospital	0.9	1.2	2.8	1.3	0.7	0.4	0.3	2.4	1.5
Aboriginal and Torres Strait Islander health service / worker	0.5	0.2	0.3	0.4	0.7	–	–	6.8	0.7
Community health centre	6.5	0.3	6.0	20.5	7.0	0.1	38.9	18.8	7.7
Other ^d	0.1	–	0.5	0.1	0.1	–	–	0.1	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Data are for the period 1 July 2009 to 30 June 2014. ^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, Aboriginal and Torres Strait Islander Health Workers, community nurses, private hospitals and unknown. – Nil or rounded to zero.

Source: Department of Health (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 10A.78.

Nationally, the proportion of Australian children aged 12 months to less than 15 months who were assessed as fully immunised in 2013-14 — 90.4 per cent — fell below 91 per cent for the first time in the 5 year period from 2009-10 (figure 10.39).

Figure 10.39 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c}

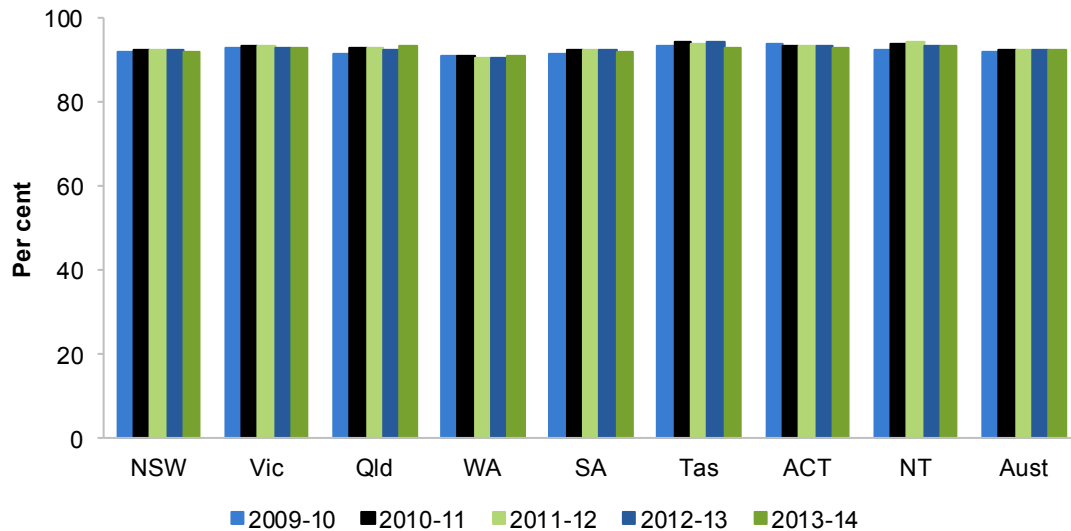


^a The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare. ^b There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). ^c Data are for financial years and may differ from previous reports which presented data for the June quarter.

Source: Department of Health (unpublished) ACIR data collection; table 10A.79.

Nationally, 92.4 per cent of children aged 24 months to less than 27 months were assessed as fully immunised in 2013-14 (figure 10.40).

Figure 10.40 Children aged 24 months to less than 27 months who were fully immunised^{a, b, c}

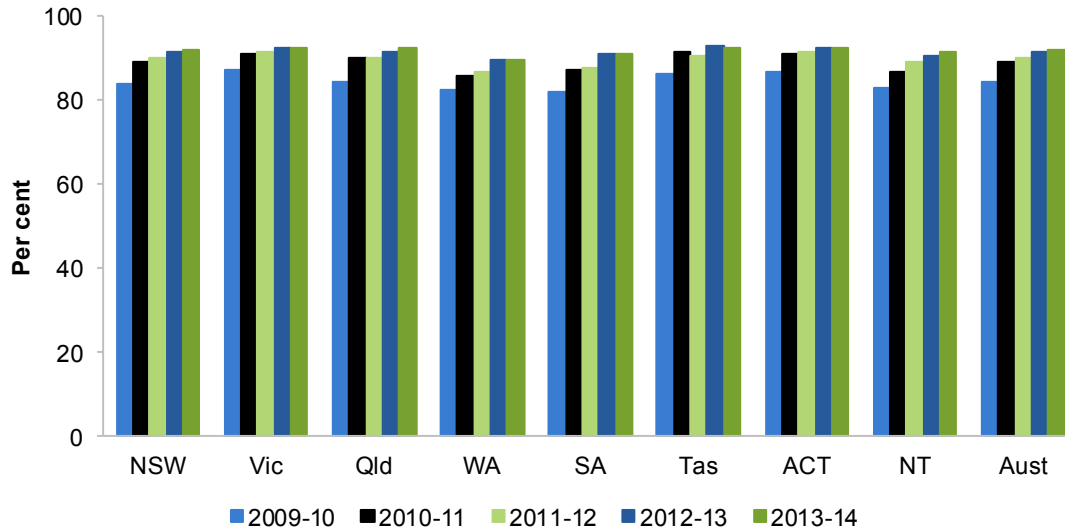


^a The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). ^b There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). ^c Data are for financial years and may differ from previous reports which presented data for the June quarter.

Source: Department of Health (unpublished) ACIR data collection; table 10A.80.

Nationally, the proportion of children aged 60 months to less than 63 months who were assessed as fully immunised rose from 84.6 to 92.0 per cent in the period 2009-10 to 2013-14 (figure 10.41).

Figure 10.41 **Children aged 60 months to less than 63 months who were fully immunised^{a, b, c}**



^a The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). ^b There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). ^c Data are for financial years and may differ from previous reports which presented data for the June quarter.

Source: Department of Health (unpublished) ACIR data collection; table 10A.81.

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 10.20).

Box 10.20 Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and invasive *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.

(Continued next page)

Box 10.20 (Continued)

A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and invasive *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 1 in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases (and consequently the notification rates) through immunisation.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.

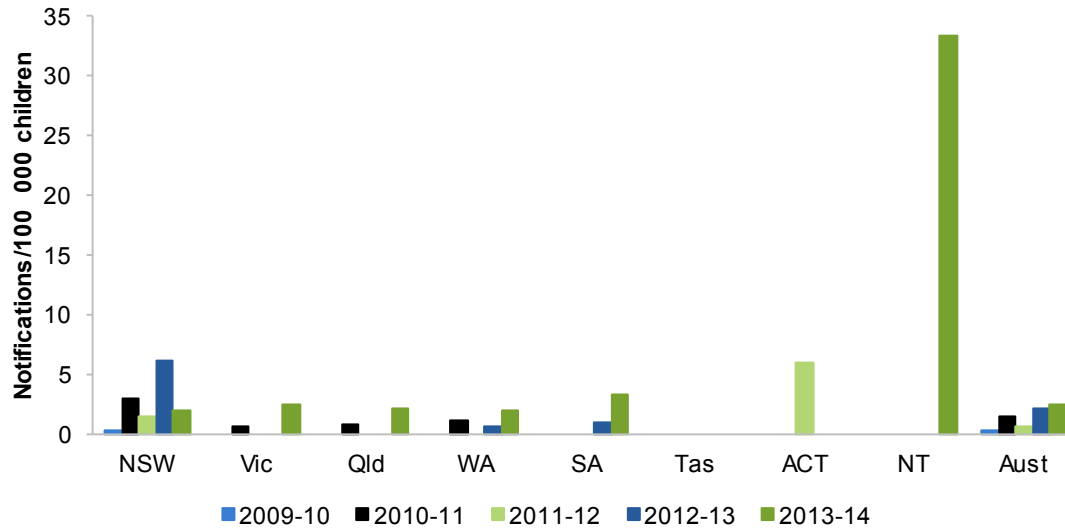
Data quality information for this indicator is under development.

Nationally, there were 113 notifications for measles for children aged 0–14 years in 2013-14 — a rate of 2.6 notifications per 100 000 children aged 0–14 years (figure 10.42). This was higher than for any other year in the period 2009-10 to 2013-14 (table 10A.82). Data are presented for an eight year time series in table 10A.82.

Nationally, notifications for pertussis (whooping cough) for children aged 0–14 years declined steadily from a peak of 18 200 (433 per 100 000 children 0–14 years) to less than 4000 (90 per 100 000 children 0–14 years) in the period 2010-11 to 2013-14 (figure 10.43). Data are presented for an eight year time series in table 10A.83.

In 2013-14, the national notification rate for invasive *Haemophilus influenzae* type b — 0.27 per 100 000 children aged 0–14 years — remained low, consistent with recent years (figure 10.44). Data are presented for an eight year time series in table 10A.84.

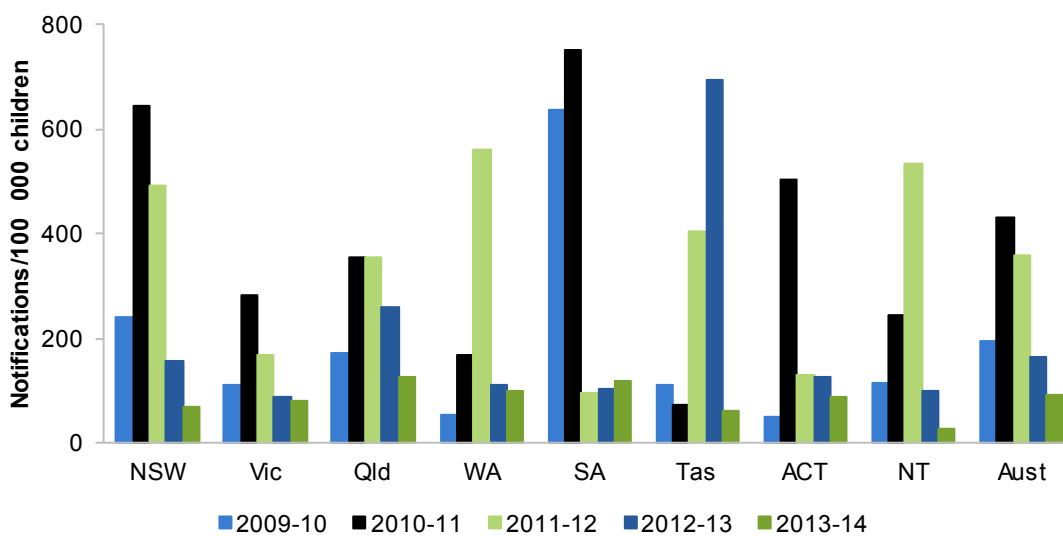
Figure 10.42 **Notifications of measles per 100 000 children aged 0–14 years^a**



^a Data are suppressed where the number of notifications reported for a jurisdiction is fewer than 5.

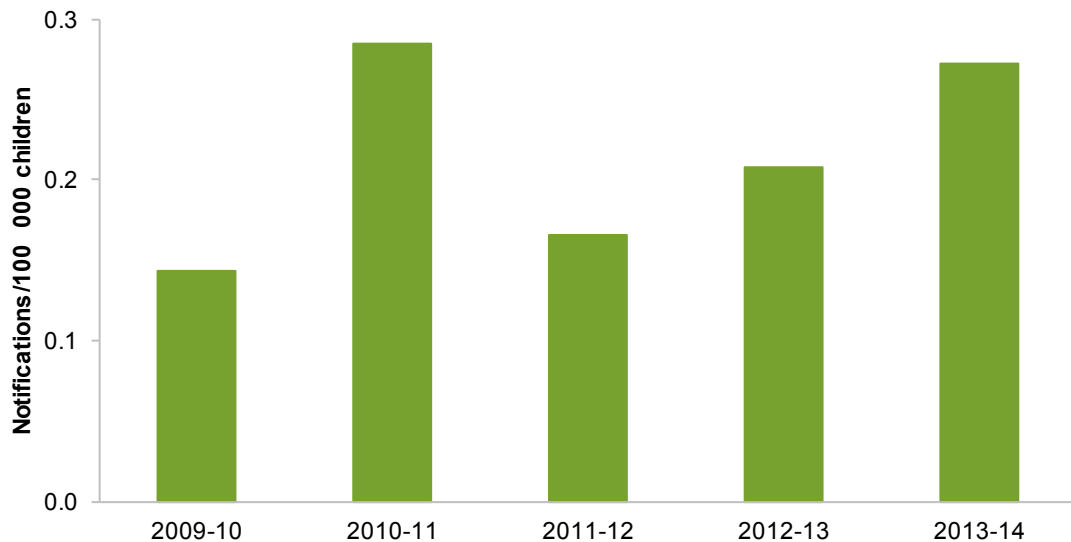
Source: Department of Health (unpublished) National Notifiable Diseases Surveillance System (NNDSS); ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.82.

Figure 10.43 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**



Source: Department of Health (unpublished) NNDSS, ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.83.

Figure 10.44 **Notifications of invasive *Haemophilus influenzae* type b per 100 000 children aged 0–14 years, Australia**



Source: Department of Health (unpublished) NNDSS, ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.84.

Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through the provision of early detection services (box 10.21).

Box 10.21 Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–69 years and reported as a rate.

A high or increasing participation rate is desirable.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2012 and 2013 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

Early detection of breast cancer is associated with improved morbidity and mortality outcomes. Early detection allows a wider range of treatment options — including less invasive procedures — and a higher likelihood of survival, than does later detection

(AIHW and NBCC 2007). The BreastScreen Australia Program is jointly funded by the Australian, State and Territory governments to undertake nationwide breast cancer screening. This is provided at no cost to the target group of women aged 50–69 years, for which it aims to achieve at least 70 per cent participation over a period of 24 months. Women aged 40–49 years and 70 years or over are also eligible for free screening.

An evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (Department of Health 2009). Further, the relatively high proportion of cancers detected early and treated with breast conserving surgery among Program participants was associated with reduced treatment related morbidity.

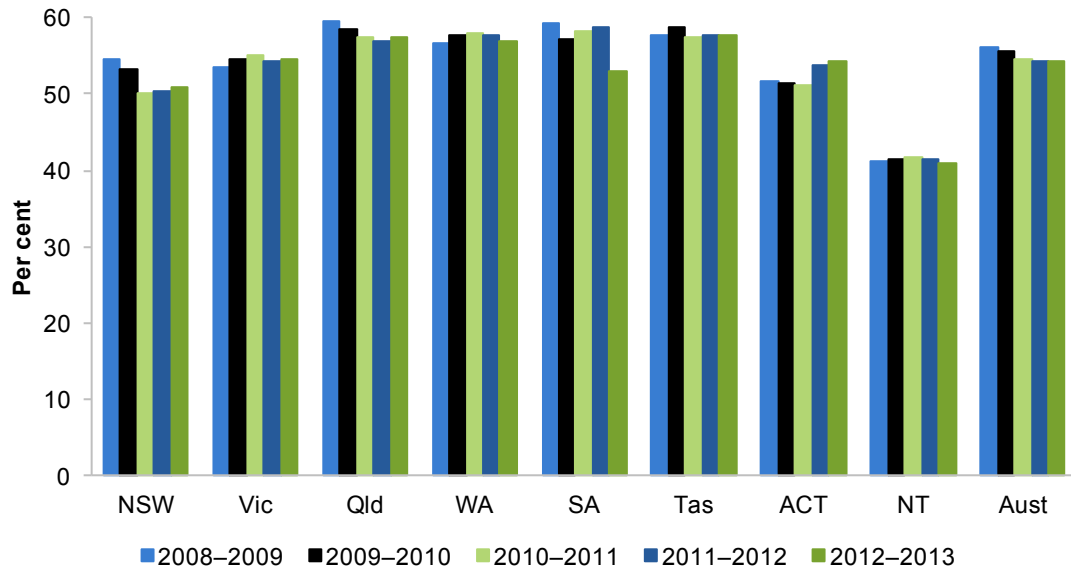
A decline in the national participation rate for women aged 50–69 years in BreastScreen Australia screening programs in the 24 month periods from 2008–2009 (56.0 per cent) to 2011–2012 (54.2 per cent) did not continue in the 24 month period 2012–2013 (54.3 per cent) (figure 10.45). These rates remain below the National Accreditation Standards aim of participation by 70 per cent of women in this age group.

Aboriginal and Torres Strait Islander women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services. Care needs to be taken when comparing data across jurisdictions as identification of Aboriginal and Torres Strait Islander women and NESB women varies, as does the collection of residential postcodes data. Updated State and Territory data for participation rate by remoteness area were unavailable for the 2015 Report — data for 2009–2010 and previous years, as well as national data for 2010–2011, are reported in table 10A.89.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 10.8. In the 24 month period 2012 and 2013, the national age standardised participation rate for Aboriginal and Torres Strait Islander women aged 50–69 years was 35.1 per cent (table 10A.87). A low participation rate can in part reflect under-reporting of Aboriginal and Torres Strait Islander status in screening program records.

In the 24 month period 2012 and 2013, the national age standardised participation rate for NESB women aged 50–69 years was 51.4 per cent, lower than the total participation rate in that age group (54.3 per cent) (table 10A.88).

Figure 10.45 Age standardised participation rate for women aged 50–69 years in BreastScreen Australia screening programs (24 month period)^{a, b, c, d, e}



^a The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. Data may differ from data published elsewhere reporting participation rates by screening jurisdiction. ^b The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. ERPs are revised to the ABS' final 2011 Census rebased ERPs and rates data may differ from previous reports. See Chapter 2 (table 2A.1) for details. ^c Rates are standardised to the 2001 ERP. ^d In general, women resident in the jurisdiction represent 99 per cent or more of the women screened in each jurisdiction. For the ACT, 2.2 per cent of those screened in the 2012–2013 reference period were not ACT residents, a decrease from 7–9 per cent in preceding reference periods associated with changed arrangements between NSW and the ACT. ^e Reduced participation rates for SA in 2012–2013 are associated with a temporary reduction in total women screened during a review of the Digital Mammography System and implementation of both the review findings and a new client information system.

Source: State and Territory governments (unpublished); ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; tables 10A.85, 10A.86.

Table 10.8 Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2012 and 2013 (24 month period) (per cent)^{a, b, c, d, e, f}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^d</i>	<i>NT</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander women ^e	31.3	30.4	45.0	34.4	27.4	28.8	28.2	28.8	35.1
NESB ^f	48.0	52.2	62.8	63.3	46.1	46.2	25.7	39.6	51.4
All women aged 50–69 years	50.9	54.6	57.3	56.8	53.0	57.8	54.4	41.0	54.3

^a First and subsequent rounds. ^b Rates are standardised to the Australian population at 30 June 2001. ^c Data reported for this measure are not directly comparable. ^d In general, women resident in the jurisdiction represent 98.9 per cent or more of the women screened in each jurisdiction, except for the ACT (where 2.2 per cent of those screened in the 2012–2013 reference period were not ACT residents). ^e Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. ^f NESB is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2011) *Australian Demographic Statistics, June*, Cat. no. 3201.0; ABS (2014) *Experimental Estimates and Projections, Aboriginal And Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *2011 Census of Population and Housing*; tables 10A.85–10A.88.

Participation for women in cervical screening

‘Participation 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 10.22).

Box 10.22 Participation for women in cervical screening

‘Participation for women in cervical screening’ is defined as the number of women aged 20–69 years who are screened over a two year period, divided by the estimated population of eligible women aged 20–69 years and reported as a rate. 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 reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2012 and 2013 are available for all jurisdictions.

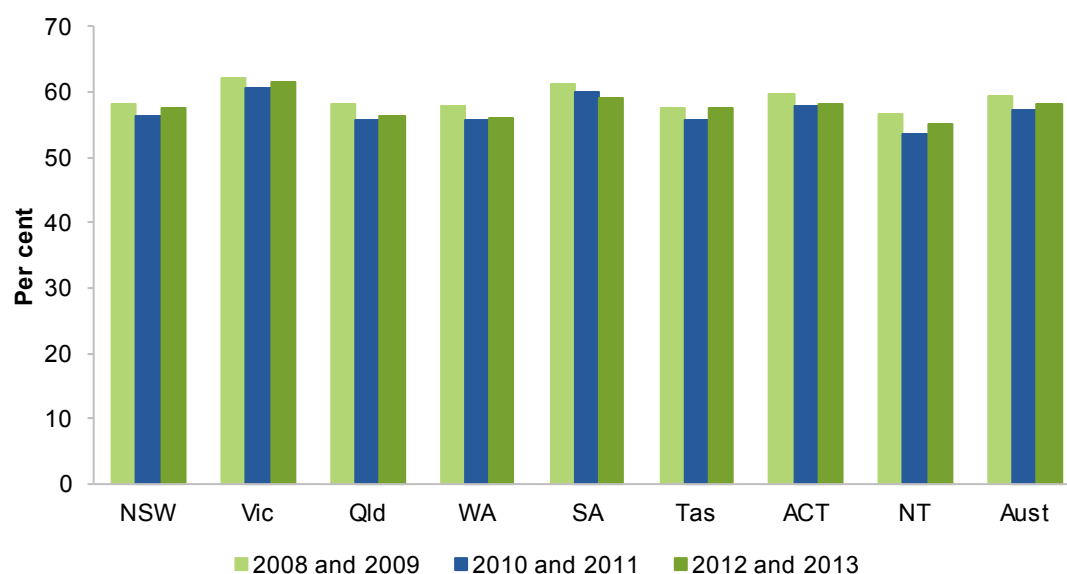
Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

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 (Department of Health 2012; 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 decreased from 59.3 per cent for the 24 month period 1 January 2008 to 31 December 2009 to 58.2 per cent for the period 1 January 2012 to 31 December 2013 (figure 10.46). Data are presented for a ten year time series in table 10A.90.

In 2011-12, around 53.4 per cent of Aboriginal and Torres Strait Islander women aged 20–69 years who responded to the National Aboriginal and Torres Strait Islander Health survey reported having a Pap smear at least every 2 years (table 10A.91).

Figure 10.46 Participation rates for women aged 20–69 years in cervical screening (24 month period)^{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 (based on the 2011 Census) in each calendar year in the reference period and age standardised to the 2001 Australian population. ^b Eligible female population adjusted for the estimated proportion who have had a hysterectomy. ^c Excludes women who have opted off the cervical cytology register. ^d Data include all women screened in the jurisdiction except for Victoria and the ACT, for which data include only residents of the jurisdiction (and immediate border residents).

Source: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 10A.90.

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 10.23).

Box 10.23 Influenza vaccination coverage for older people

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

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

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

Data quality information for this indicator is under development.

Influenza and pneumococcal disease vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (Department of Health 2013a). Free vaccines for all Australians aged 65 years or over and for Aboriginal and Torres Strait Islander people aged 50 years or over became available for influenza in 1999 and for pneumococcal disease in 2005.

Updated data were not available for non-Indigenous Australians for the 2015 Report — historical data are presented in tables 10A.92-10A.93. Nationally, 25.3 per cent of Aboriginal and Torres Strait Islander people aged 50 years or over were fully vaccinated against influenza and pneumococcal disease in 2011-12 (table 10A.94).

Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 10.24).

Box 10.24 Selected potentially preventable hospitalisations

'Selected potentially preventable hospitalisations' is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether.

Three measures of selected potentially preventable hospitalisations are reported (the first measure is reported against the indicator of the same name in the NHA):

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2012b; DHS 2002)
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2014a, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people's access to aged care services and other support.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time except for the measure potentially preventable hospitalisations for diabetes
- complete (subject to caveats) for the current reporting period except for the measure potentially preventable hospitalisations for diabetes, for which data are not published for Tasmania, the ACT and the NT. All other required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2015.

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

Studies have shown that hospitalisation rates for selected vaccine preventable, acute and chronic conditions are significantly affected by the availability of care in the primary and community healthcare sector (DHS 2002). These are conditions for which hospitalisation can potentially be avoided, through prevention of the condition — for example, through vaccination — or, prevention of exacerbations or complications requiring hospitalisation — through effective management of the condition in the primary and community healthcare sector. While not all hospitalisations for the selected conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation for these conditions.

Variation in hospitalisation rates data can also be affected by differences in hospital protocols for clinical coding and admission between and within jurisdictions. This

particularly affects diagnoses of dehydration and gastroenteritis and diabetes complications. The effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in Aboriginal and Torres Strait Islander communities. Caution should also be used in time series analysis because of revisions to clinical coding standards and improvements in data quality over time, as well as changes in hospital coding and admission protocols.

Data are age-standardised to account for differences in the age structures of the populations across states and territories.

Nationally, the age-standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 23.9 per 1000 people in 2012-13 (table 10.9). Of these, 49.5 per cent were for acute and 47.2 per cent for chronic conditions (table 10A.95). Data are presented disaggregated by Indigenous status in table 10A.96 and remoteness in table 10A.97. National data by Indigenous status and remoteness are presented in table 10A.98.

Table 10.9 Separations for selected potentially preventable hospitalisations per 1000 people, 2012-13^{a, b, c}

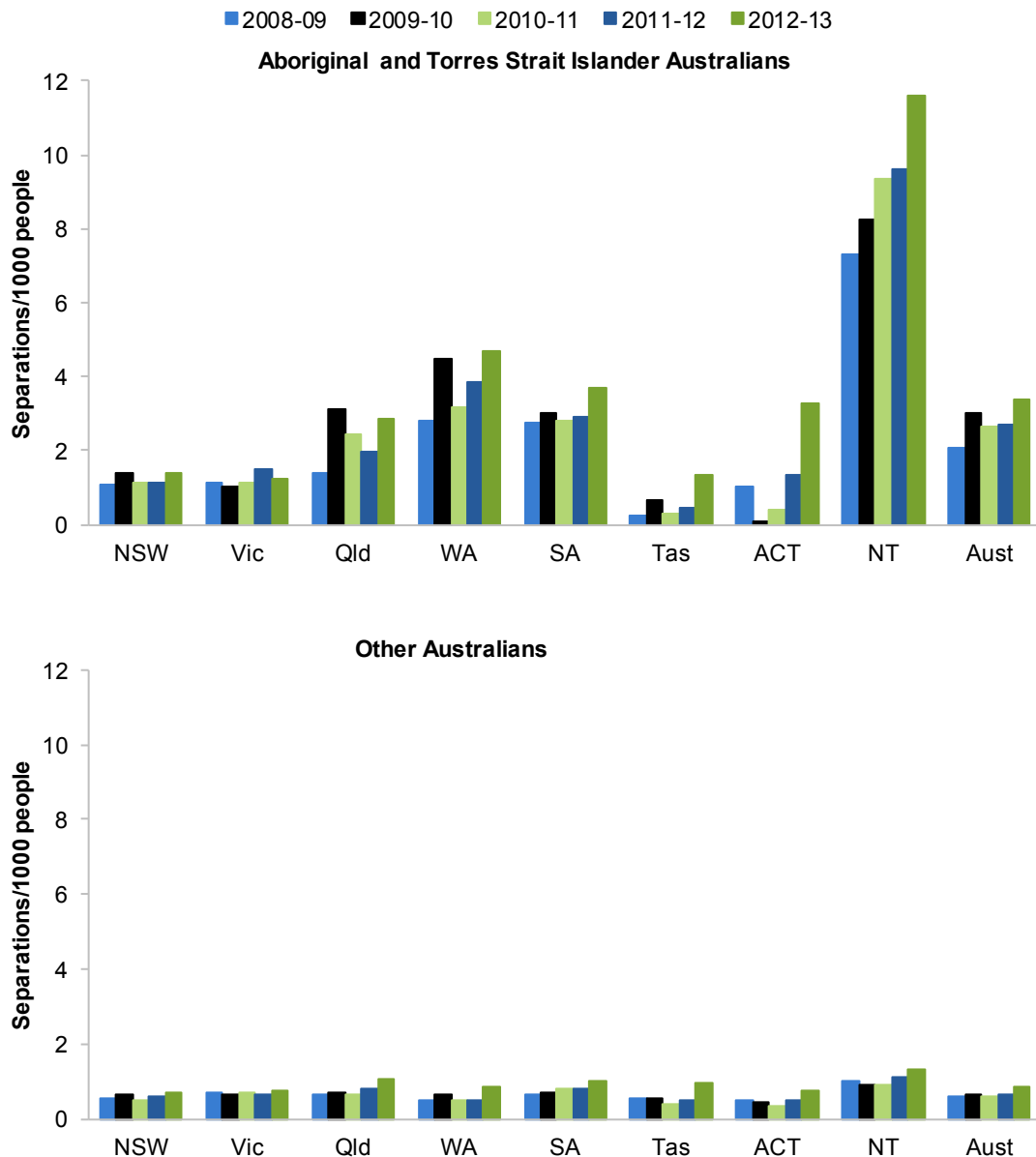
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^d</i>
Vaccine preventable conditions	0.7	0.8	1.1	1.0	1.1	1.0	0.8	3.7	0.9
Selected acute conditions ^e	10.8	10.2	13.8	13.6	13.6	9.9	9.3	20.5	11.8
Selected chronic conditions ^f	10.4	10.8	12.9	11.3	11.9	10.1	8.3	22.1	11.3
Total^{g, h}	21.9	21.7	27.7	25.7	26.4	20.8	18.2	45.8	23.9

^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 A nationally agreed revised definition of selected potentially preventable hospitalisations applies. See DQI for more information. ^d Includes other territories. Excludes overseas residents and unknown state of residence. ^e Selected acute conditions excluding dehydration and gastroenteritis. ^f Selected chronic conditions excluding diabetes complications (additional diagnoses only). ^g Total is all potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only). ^h Totals may not add as more than one condition may be reported for a separation.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.95.

Identification of Aboriginal and Torres Strait Islander people in hospital administrative data is considered acceptable for analysis in all states and territories from the 2010-11 reporting period. The age standardised hospital separation rate for vaccine preventable conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions in 2012-13 (figure 10.47). The age standardised hospital separation rate for the selected acute conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in almost all jurisdictions in 2012-13 (figure 10.48). The age standardised hospital separation rate for the selected chronic conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions in 2012-13 (figure 10.49).

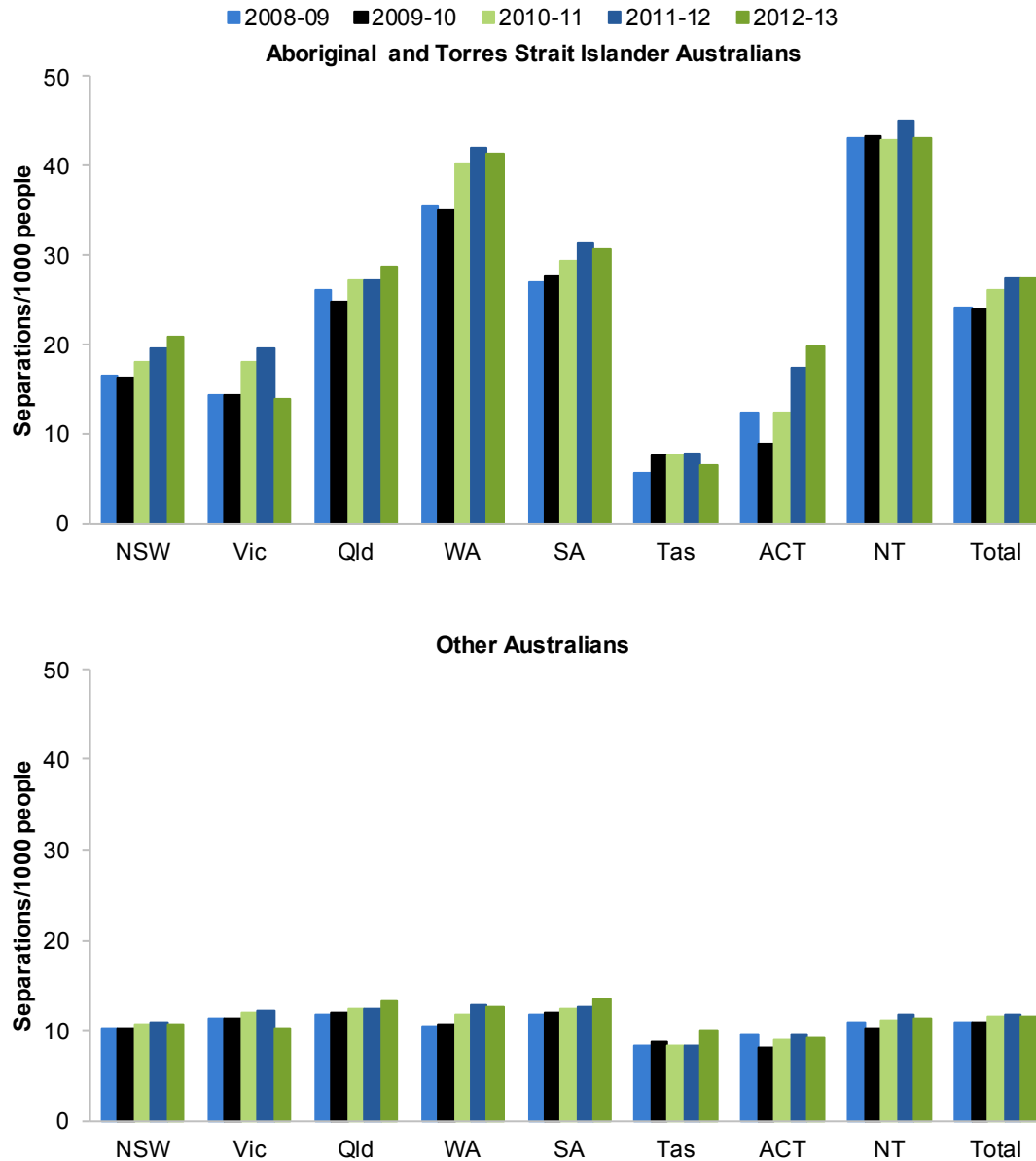
Figure 10.47 Separations for vaccine preventable conditions by Indigenous status^{a, b, c, d, e, f, g}



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Separation rates are based on State/Territory of usual residence. ^c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. ^d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. ^f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. ^g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 10A.95 and 10A.99.

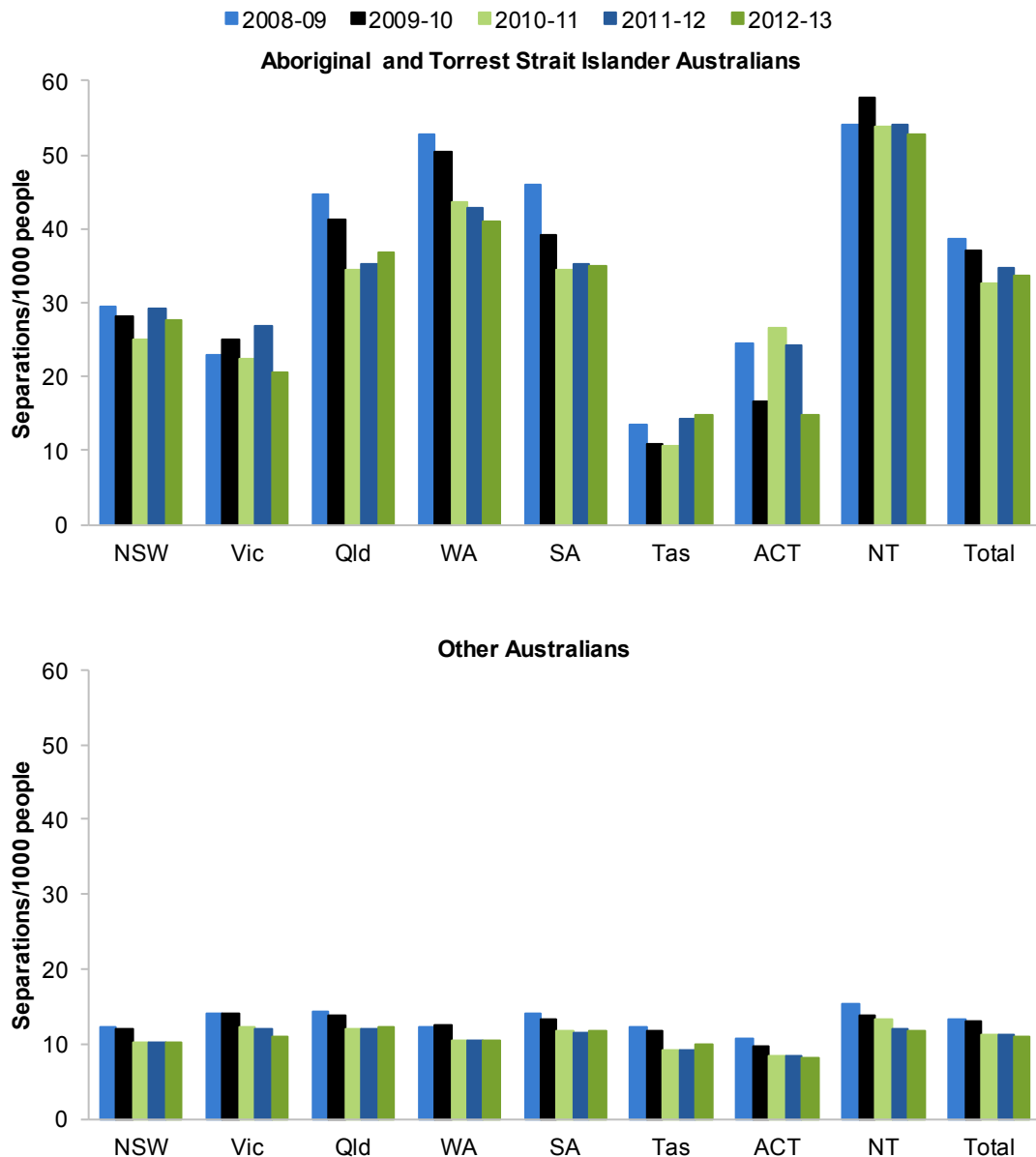
Figure 10.48 Separations for selected acute conditions by Indigenous status^{a, b, c, d, e, f, g}



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Separation rates are based on State/Territory of usual residence. ^c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. ^d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. ^f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. ^g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 10A.95 and 10A.100.

Figure 10.49 **Separations for selected chronic conditions by Indigenous status^{a, b, c, d, e, f, g}**



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Separation rates are based on State/Territory of usual residence. ^c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. ^d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. ^f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. ^g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 10A.95 and 10A.101.

Potentially preventable hospitalisations for diabetes

Diabetes is a chronic disease of increasing prevalence, and is an identified National Health Priority Area for Australia. People with diabetes 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.

The provision of high quality, appropriate and effective management of diabetes in the primary and community health sector can prevent or minimise the severity of diabetes complications, thereby reducing demand for hospitalisation (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Nationally, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 107.0 separations per 100 000 people in 2012-13 (figure 10.50).

Figure 10.50 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2012-13^{a, b, c}**

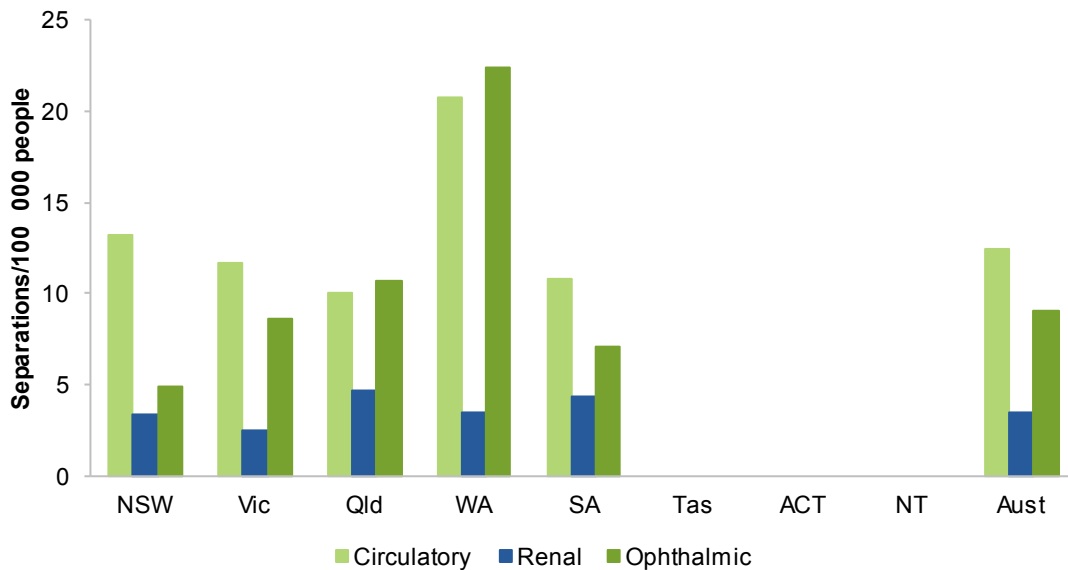


^a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^b Morbidity data are coded under coding standards that can differ over time and across jurisdictions — reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011–12 and 2012–13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. ^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 10A.103.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2012-13 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 10.51).

Figure 10.51 Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2012-13^{a, b, c, d, e}



^a Results for individual complications can be affected by small numbers, and need to be interpreted with care. ^b Patients can have one or more complication(s) for each separation. ^c 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. ^d Morbidity data are coded under coding standards that can differ over time and across jurisdictions — reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. ^e 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 10A.103.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but these data are 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, 24.6 per cent of separations for Type 2 diabetes were same day separations in 2012-13 (table 10A.104).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2012-13, there were 16.4 hospital separations per 100 000 people (age standardised) for

lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 10.52).

Figure 10.52 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13^{a, b, c}**



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes unspecified diabetes. Data 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. Reporting of diabetes increased by an average of 29.6 per cent as a principal diagnosis and 247 per cent as an additional diagnosis between 2011-12 and 2012-13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. ^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 10A.105.

Age standardised hospital separation ratios for diabetes (excluding separations for diabetes complications as an additional diagnosis) illustrate differences between the rate of hospital admissions for Aboriginal and Torres Strait Islander Australians and that for all Australians, taking into account differences in the age structures of the two populations. Rate ratios close to one indicate that Aboriginal and Torres Strait Islander Australians have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. A reduction in the gap in hospital separation rates between Aboriginal and Torres Strait Islander and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2012-13 between the separation rates for Aboriginal and Torres Strait Islander people and those for the total population for diabetes diagnoses (figure 10.53).

Figure 10.53 **Ratio of separation rates of Aboriginal and Torres Strait Islander people to all people for diabetes, 2012-13^{a, b, c, d, e, f, g}**



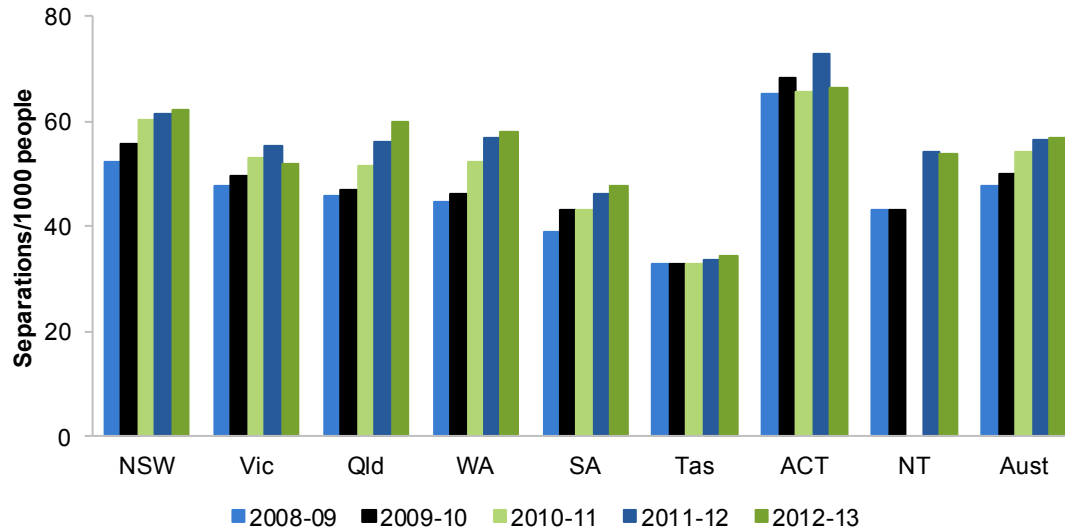
^a Excludes separations with diabetes complications as an additional diagnosis. ^b Ratios are directly age standardised to the Australian population at 30 June 2001. ^c Separation rates are based on state of usual residence. ^d Reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. ^e Patients aged 75 years or over are excluded. ^f Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^g NT data are for public hospitals only.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.102.

Potentially preventable hospitalisations of older people for falls

Falls were the leading external cause of unintentional injury in older Australians in 2011-12 (Tovell, Harrison & Pointer 2014). For people over 65 years, injurious falls accounted for one in ten days spent in hospital in 2009-10 (Bradley 2013). 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, increased from 47.7 in 2008-09 to 56.8 in 2012-13 (figure 10.54).

Figure 10.54 **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. ^d Data for the NT are not available for 2010-11 and are not included in the Australian total.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.106.

10.4 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. Allied health professional workforce data are anticipated to be available for the 2016 Report from the new National Registration and Accreditation Scheme. Priorities for future reporting on primary and community health services include:

- further improving the reporting of public 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.

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).

Aboriginal and Torres Strait Islander health

Barriers to accessing primary health services contribute to the poorer health status of Aboriginal and Torres Strait Islander Australians compared to other Australians (see the Health sector overview). The Steering Committee has identified primary and community health services for Aboriginal and Torres Strait Islander Australians 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 for Aboriginal and Torres Strait Islander Australians.

Continued efforts to improve the quality of Aboriginal and Torres Strait Islander data, particularly Aboriginal and Torres Strait Islander identification and completeness, are necessary to better measure the performance of primary and community health services in relation to the health of Aboriginal and Torres Strait Islander Australians. Work being undertaken by the ABS and the Australian Institute of Health and Welfare (AIHW) includes an ongoing program to improve identification of Aboriginal and Torres Strait Islander status in Australian, State and Territory government administrative systems.

10.5 Definitions of key terms

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:</i> ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW (Australian Institute of Health and Welfare), Canberra.</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.
Comparability	Data are considered comparable if, (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data are considered complete if all required data are available for all jurisdictions that provide the service.
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 were active until end June 2012. There were 109 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN).</p> <p>The Divisions of General Practice Program (DGPP) aims were to contribute to improved health outcomes for communities by working with GPs and other health service providers to improve the quality and accessibility of healthcare at the local level. From 30 June 2011, Medicare Locals progressively assumed responsibility for general practice support initiatives previously funded under the DGPP. The DGPP ceased on 30 June 2012.</p>
Full time workload equivalents (FWE)	<p>A measure of medical practitioner supply based on claims processed by DHS Medicare in a given period, calculated by dividing a practitioner's DHS Medicare billing by the mean billing of full time practitioners for that period.</p> <p>Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.</p>

Fully immunised at 12 months	A child who has, by the age of 1 year, completed: three doses of diphtheria, tetanus, pertussis vaccine; three doses of polio vaccine; two or three doses (depending on the type of vaccine used) of Hepatitis B vaccine; two or three doses (depending on the type of vaccine used) of <i>Haemophilus influenzae</i> type B vaccine; and, from the quarter ending 31 December 2013, pneumococcal disease.
Fully immunised at 24 months	A child who has, by the age of 2 years, received three or four doses (depending on the type of vaccine used) of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, three or four doses (depending on the type of vaccine used) of <i>Haemophilus influenzae</i> type B and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has, by the age of 5 years, received the necessary doses of diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella vaccines — four or five doses (depending on the type of vaccine used) of diphtheria, tetanus, pertussis vaccine, four doses of polio vaccine, three doses of Hepatitis B vaccine, three or four doses (depending on the type of vaccine used) of <i>Haemophilus influenzae</i> type B and two doses of measles, mumps and rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander health.
General practitioner (GP)	Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.
GP-type services	Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.
<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013b).
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.
Medicare Locals	Medicare Locals (MLs) are independent regional primary health care organisations with responsibility for supporting improved co-ordination of primary health care service delivery, as well as identifying and addressing gaps in primary health care services, across their regions (www.amlalliance.com.au/about-us , accessed 25 November 2013). Established progressively from 1 July 2011 under the National Health Reform agenda, the national network of 61 MLs and a national body, the Australian Medicare Local Alliance (AML Alliance), were operational at 1 July 2012.
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 DHS 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 (Department of Health 2013c). 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 registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 DHS 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.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under DHS Medicare for pathology tests requested by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging services performed on referral 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 registered, 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 Quality Practice Accreditation Pty Ltd), divided by the total number of practices.
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 DHS Medicare as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS 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: <ul style="list-style-type: none">• 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 registered general practitioner	A medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwth), 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 DHS Medicare billing from non-referred attendances.

10.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 10A.1	Types of encounter where a payment source was recorded, 2013-14
Table 10A.2	Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2013-14 dollars)
Table 10A.3	Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars)
Table 10A.4	Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars)
Table 10A.5	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars)
Table 10A.6	Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas
Table 10A.7	Expenditure on dental services (2012-13 dollars) (\$ million)
Table 10A.8	Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services
Table 10A.9	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 10A.10	Number of GP-type services used per 1000 people
Table 10A.11	PBS services
Table 10A.12	PBS services, by service type ('000)
Table 10A.13	Use of public dental services, by service type, 2010
Table 10A.14	Alcohol and other drug treatment services, 2012-13 (number)
Table 10A.15	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number)
Table 10A.16	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 10A.17	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2012-13 (per cent)
Table 10A.18	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent)
Table 10A.19	Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number)
Table 10A.20	Approved providers of PBS medicines, by urban and rural location, at 30 June
Table 10A.21	PBS expenditure per person, by remoteness area (2013-14 dollars)
Table 10A.22	PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2013-14 dollars)
Table 10A.23	Availability of GPs by region, 2013-14
Table 10A.24	Availability of GPs by region, 2004-05 to 2011-12
Table 10A.25	Availability of female GPs

Table 10A.26	Availability of male GPs
Table 10A.27	Availability of public dentists (per 100 000 people)
Table 10A.28	Availability of public dental hygienists and dental therapists (per 100 000 people)
Table 10A.29	Availability of public occupational therapists and psychologists (per 100 000 people)
Table 10A.30	Annual health assessments for older people by Indigenous status (per cent)
Table 10A.31	Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent)
Table 10A.32	Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)
Table 10A.33	Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
Table 10A.34	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 10A.35	Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent)
Table 10A.36	Non-referred attendances that were bulk billed by age (per cent)
Table 10A.37	People deferring access to GPs due to cost (per cent)
Table 10A.38	Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent)
Table 10A.39	Waiting time for GPs for an urgent appointment (per cent)
Table 10A.40	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 10A.41	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 10A.42	People attending a hospital emergency department who thought the care could have been provided at a general practice
Table 10A.43	People deferring access to prescribed medication due to cost (per cent)
Table 10A.44	Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent)
Table 10A.45	Waiting time for public dentistry (per cent)
Table 10A.46	Waiting time for public dentistry by remoteness, Australia
Table 10A.47	Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent)
Table 10A.48	Proportion of full time workload equivalent (FWE) GPs with vocational registration by region (per cent)
Table 10A.49	Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent)
Table 10A.50	Number and proportion of full time workload equivalent (FWE) GPs with vocational registration
Table 10A.51	General practices that are accredited at 30 June
Table 10A.52	General practice activity in PIP practices (per cent)
Table 10A.53	Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections

Table 10A.54	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2009-10 to 2011-12
Table 10A.55	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 10A.56	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia
Table 10A.57	Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive
Table 10A.58	Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)
Table 10A.59	Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent)
Table 10A.60	Proportion of people with asthma with a written asthma action plan, by age (per cent)
Table 10A.61	Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011-13
Table 10A.62	Proportion of people with asthma with a written asthma plan, by Indigenous status
Table 10A.63	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 10A.64	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 10A.65	Pathology tests requested by GPs, real benefits paid (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.66	Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.67	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.68	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.69	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.70	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 10A.71	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012
Table 10A.72	Client experience of GPs by remoteness, States and Territories
Table 10A.73	Client experience of GPs by remoteness, Australia
Table 10A.74	Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13
Table 10A.75	Client experience of dental professionals by remoteness, States and Territories
Table 10A.76	Client experience of dental professionals by remoteness, Australia
Table 10A.77	Annual health assessments for older people

Table 10A.78	Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014
Table 10A.79	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.80	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.81	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 10A.82	Notifications of measles, children aged 0–14 years
Table 10A.83	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 10A.84	Notifications of invasive Haemophilus influenzae type b, children aged 0–14 years
Table 10A.85	Participation rates for women in BreastScreen Australia (24 month period)
Table 10A.86	Participation rates for women in BreastScreen Australia by residential status, 2012 and 2013 (24 month period)
Table 10A.87	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.88	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.89	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 10A.90	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
Table 10A.91	Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent)
Table 10A.92	Influenza vaccination coverage, people aged 65 years or over
Table 10A.93	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
Table 10A.94	Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease
Table 10A.95	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 10A.96	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.97	Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (per 1000 people)
Table 10A.98	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia, 2012-13 (per 1000 people)
Table 10A.99	Separations for selected vaccine preventable conditions by Indigenous status, 2012-13 (per 1000 people)
Table 10A.100	Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people)
Table 10A.101	Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people)

Table 10A.102	Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2012-13
Table 10A.103	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2012-13 (per 100 000 people)
Table 10A.104	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2012-13 (per cent)
Table 10A.105	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13
Table 10A.106	Separation rates for older people for injuries due to falls
Community health services programs	
Table 10A.107	Australian Government, community health services programs
Table 10A.108	New South Wales, community health services programs
Table 10A.109	Victoria, community health services programs
Table 10A.110	Queensland, community health services programs
Table 10A.111	Western Australia, community health services programs
Table 10A.112	South Australia, community health services programs
Table 10A.113	Tasmania, community health services programs
Table 10A.114	Australian Capital Territory, community health services programs
Table 10A.115	Northern Territory, community health services programs

10.7 References

- ACAM (Australian Centre for Asthma Monitoring) 2008, *Asthma in Australia 2008*, Cat. no. ACM 14, AIHW (Australian Institute of Health and Welfare) Asthma Series 3, Canberra.
- Australian Government 2010, *Building a 21st Century Primary Health Care System — Australia's First National Primary Health Care Strategy*, Canberra.
- AIHW (Australian Institute of Health and Welfare) 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, *Diabetes: Australian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.
- 2014a, *Australia's health 2014*, Cat. no. AUS 178, Canberra.
- 2014b, *Alcohol and other drug treatment services in Australia 2012-13*, Cat. no. HSE 150, Drug treatment series no. 24, Canberra.
- AIHW and NBCC (National Breast Cancer Centre) 2007, *Breast cancer survival by size and nodal status in Australia*, Cat. no. CAN 34, Cancer series no. 39, AIHW, Canberra.

-
- Bradley, C. 2013, *Hospitalisations due to falls by older people, Australia 2009-10*, Cat. no. INJCAT 146, Injury research and statistics series no. 70, AIHW, Canberra.
- Britt, H., Miller, G.C, Henderson, J., Bayram, C., Harrison, C., Valenti, L., Wong, C., Gordon, J., Pollack, A.J., Pan, Y. and Charles, J. 2014, *General practice activity in Australia 2013-14*, General practice series no. 36, Sydney University Press, Sydney.
- Australian Government DHS (Department of Human Services) 2014, *Practice Incentives Program (PIP)* (<http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp#N10047>, accessed 15 October 2014)
- Department of Health (formerly the Department of Health and Ageing) 2009, *Evaluation of the BreastScreen Australia Program – Evaluation Final Report*, Australian Government, Canberra.
- 2010, *About the PBS*, www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-aboutus.htm-copy2 (accessed 24 September 2010).
- 2012, *The Pap smear*, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/papsmear (accessed 8 January 2014).
- 2013a, *The Australian Immunisation Handbook*, 10th edn, www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home (accessed 8 January 2014).
- 2013b, *Immunisation Myths and Realities: responding to arguments against immunisation*, 5th edn, www.health.gov.au/internet/immunise/publishing.nsf/Content/uci-myths-guideprov (accessed 8 January 2014).
- 2013c, *Australian national notifiable diseases list and case definitions*, www.health.gov.au/internet/main/publishing.nsf/Content/cda_surveil-nndss-dislist.htm (accessed 8 January 2014).
- 2014, *About the PBS*, <http://www.pbs.gov.au/info/about-the-pbs> (accessed 19 October 2014).
- DHS (Department of Human Services) Victoria 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. and 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, Canberra.

-
- NHPAC (National Health Priority Action Council) 2006, *National Chronic Disease Strategy*, Australian Government Department of Health, 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) 2014a, *What is General Practice?* <http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-general-practice> (accessed 21 January 2015).
- 2014b, *Becoming a GP in Australia*, <http://www.racgp.org.au/becomingagp/> (accessed 21 January 2015).
- SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, *Overcoming Indigenous Disadvantage: Key Indicators 2014*, Productivity Commission, Canberra.
- Tamma, P.D. and Cosgrove, S.E. 2014, *Let the games begin: the race to optimise antibiotic use*, *The Lancet Infectious Diseases*, vol. 14, no. 8, pp. 667-8.
- Tovell, A. Harrison, J.E. and Pointer, S. 2014, *Hospitalised injury in older Australians, 2011-12*, Injury research and statistics series no. 90. Cat. no. INJCAT 166, Canberra: AIHW.
- 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 11 August 2011).

10A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 10.5 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

Attachment contents

Table 10A.1	Types of encounter where a payment source was recorded, 2013-14
Table 10A.2	Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2013-14 dollars)
Table 10A.3	Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars)
Table 10A.4	Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars)
Table 10A.5	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars)
Table 10A.6	Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas
Table 10A.7	Expenditure on dental services (2012-13 dollars) (\$ million)
Table 10A.8	Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services
Table 10A.9	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 10A.10	Number of GP-type services used per 1000 people
Table 10A.11	PBS services
Table 10A.12	PBS services, by service type ('000)
Table 10A.13	Use of public dental services, by service type, 2010
Table 10A.14	Alcohol and other drug treatment services, 2012-13 (number)
Table 10A.15	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number)
Table 10A.16	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 10A.17	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2012-13 (per cent)
Table 10A.18	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent)
Table 10A.19	Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number)
Table 10A.20	Approved providers of PBS medicines, by urban and rural location, at 30 June
Table 10A.21	PBS expenditure per person, by remoteness area (2013-14 dollars)
Table 10A.22	PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2013-14 dollars)
Table 10A.23	Availability of GPs by region, 2013-14
Table 10A.24	Availability of GPs by region, 2004-05 to 2011-12
Table 10A.25	Availability of female GPs
Table 10A.26	Availability of male GPs
Table 10A.27	Availability of public dentists (per 100 000 people)
Table 10A.28	Availability of public dental hygienists and dental therapists (per 100 000 people)
Table 10A.29	Availability of public occupational therapists and psychologists (per 100 000 people)
Table 10A.30	Annual health assessments for older people by Indigenous status (per cent)

Attachment contents

Table 10A.31	Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent)
Table 10A.32	Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)
Table 10A.33	Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
Table 10A.34	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 10A.35	Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent)
Table 10A.36	Non-referred attendances that were bulk billed by age (per cent)
Table 10A.37	People deferring access to GPs due to cost (per cent)
Table 10A.38	Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent)
Table 10A.39	Waiting time for GPs for an urgent appointment (per cent)
Table 10A.40	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 10A.41	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 10A.42	People attending a hospital emergency department who thought the care could have been provided at a general practice
Table 10A.43	People deferring access to prescribed medication due to cost (per cent)
Table 10A.44	Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent)
Table 10A.45	Waiting time for public dentistry (per cent)
Table 10A.46	Waiting time for public dentistry by remoteness, Australia
Table 10A.47	Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent)
Table 10A.48	Proportion of full time workload equivalent (FWE) GPs with vocational registration by region (per cent)
Table 10A.49	Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent)
Table 10A.50	Number and proportion of full time workload equivalent (FWE) GPs with vocational registration
Table 10A.51	General practices that are accredited at 30 June
Table 10A.52	General practice activity in PIP practices (per cent)
Table 10A.53	Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections
Table 10A.54	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2009-10 to 2011-12
Table 10A.55	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 10A.56	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia

Attachment contents

Table 10A.57	Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive
Table 10A.58	Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)
Table 10A.59	Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent)
Table 10A.60	Proportion of people with asthma with a written asthma action plan, by age (per cent)
Table 10A.61	Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13
Table 10A.62	Proportion of people with asthma with a written asthma plan, by Indigenous status
Table 10A.63	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 10A.64	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 10A.65	Pathology tests requested by GPs, real benefits paid (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.66	Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items
Table 10A.67	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.68	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items
Table 10A.69	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.70	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 10A.71	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012
Table 10A.72	Client experience of GPs by remoteness, States and Territories
Table 10A.73	Client experience of GPs by remoteness, Australia
Table 10A.74	Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13
Table 10A.75	Client experience of dental professionals by remoteness, States and Territories
Table 10A.76	Client experience of dental professionals by remoteness, Australia
Table 10A.77	Annual health assessments for older people
Table 10A.78	Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014
Table 10A.79	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.80	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.81	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 10A.82	Notifications of measles, children aged 0–14 years
Table 10A.83	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 10A.84	Notifications of invasive Haemophilus influenzae type b, children aged 0–14 years
Table 10A.85	Participation rates for women in BreastScreen Australia (24 month period)

Attachment contents

Table 10A.86	Participation rates for women in BreastScreen Australia by residential status, 2012 and 2013 (24 month period)
Table 10A.87	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.88	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.89	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 10A.90	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
Table 10A.91	Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent)
Table 10A.92	Influenza vaccination coverage, people aged 65 years or over
Table 10A.93	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
Table 10A.94	Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease
Table 10A.95	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 10A.96	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.97	Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (per 1000 people)
Table 10A.98	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia, 2012-13 (per 1000 people)
Table 10A.99	Separations for selected vaccine preventable conditions by Indigenous status, 2012-13 (per 1000 people)
Table 10A.100	Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people)
Table 10A.101	Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people)
Table 10A.102	Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2012-13
Table 10A.103	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2012-13 (per 100 000 people)
Table 10A.104	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2012-13 (per cent)
Table 10A.105	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13
Table 10A.106	Separation rates for older people for injuries due to falls
Community health programs	
Table 10A.107	Australian Government, community health services programs
Table 10A.108	New South Wales, community health services programs
Table 10A.109	Victoria, community health services programs
Table 10A.110	Queensland, community health services programs

Attachment contents

- Table 10A.111** Western Australia, community health services programs
- Table 10A.112** South Australia, community health services programs
- Table 10A.113** Tasmania, community health services programs
- Table 10A.114** Australian Capital Territory, community health services programs
- Table 10A.115** Northern Territory, community health services programs

TABLE 10A.1

Table 10A.1 **Types of encounter where a payment source was recorded, 2013-14 (a), (b)**

	Number	Per cent of	Per cent of direct		Medicare/DVA-
		encounters (c)	encounters	encounters	paid
		(n = 88 151)	(n = 86 607)	(n = 86 607)	GP items
	no.	%	95% LCL	95% UCL	(n = 84 142)
			%	%	%
Direct encounters	86 607	98.2	98.0	98.5	100.0
No charge	332	0.4	0.3	0.5	0.4
MBS/DVA items of service (direct encounters only) (d)	84 136	95.4	95.1	95.8	97.1
MBS/DVA items of service (GPs only)	84 142	95.5	94.9	95.8	97.2
Short surgery consultations	1 654	1.9	1.6	2.2	–
Standard surgery consultations	66 304	75.2	74.0	76.5	0.8
Long surgery consultations	8 983	10.2	9.5	10.9	0.1
Prolonged surgery consultations	707	0.8	0.6	1.0	–
Home or institution visits (excluding RACF)	755	0.9	0.7	1.1	–
Residential aged care facility	1 558	1.8	1.2	2.3	–
Health assessments	355	0.4	0.3	0.5	–
Chronic disease management items	1 255	1.4	1.2	1.6	–
Case conferences	6	0.0	–	–	–
GP mental health care items	1 205	1.4	1.2	1.5	–
Attendances associated with practice incentive payments	159	0.2	0.1	0.2	–
Other items	1 201	1.4	0.1	0.7	–
Workers compensation	1 537	1.7	1.6	1.9	–
Other paid (hospital, State, etc.)	603	0.7	0.5	0.8	–

TABLE 10A.1

Table 10A.1 **Types of encounter where a payment source was recorded, 2013-14 (a), (b)**

	<i>Number</i>	<i>Per cent of encounters (c) (n = 88 151)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Per cent of direct encounters (n = 86 607)</i>	<i>Medicare/DVA-paid GP items (n = 84 142)</i>
Indirect encounters (e)	1 542	1.7	1.5	2.0	..	..
Direct/indirect encounter unspecified	2	–	–	–	..	..
Total encounters	88 151	100.0	..	..	..	..
MBS/DVA items of service (all encounters)	84 153	95.5			..	..

LCL=lower confidence limit; **UCL**=upper confidence limit; **MBS**=Medicare Benefits Schedule; **DVA**=Department of Veterans' Affairs; **RACF** = Residential aged care facility.

- (a) An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals).
- (b) One Medicare item number counted per encounter (where applicable).
- (c) Missing data removed from analysis ($n=7\ 728$).
- (d) Direct encounters are encounters where the patient is seen by the health professional. Includes direct encounters at which either a GP or other health professional item (or both) was recorded.
- (e) Indirect encounters are encounters where the patient is not seen but a service is provided (for example, a prescription or referral). Includes indirect encounters involving a GP or other health professional (or both). Includes five encounters involving chronic disease management or case conference items.
- .. Not applicable. – Nil or rounded to zero.

Source: Britt, H., Miller, G.C, Henderson, J., Bayram, C., Harrison, C., Valenti, L., Wong, C., Gordon, J., Pollack, A.J., Pan, Y. and Charles, J. 2014, *General practice activity in Australia 2013–14*, General practice series no. 36, Sydney University Press, Sydney.

Table 10A.2 Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2013-14 dollars) (a), (b), (c)

	<i>Unit</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 (d)</i>
Expenditure through DHS Medicare fee for service — total										
2012-13	\$m	2 374.6	1 728.0	1 425.1	562.2	519.2	150.4	84.2	47.0	6 890.7
2013-14	\$m	2 491.7	1 829.7	1 512.7	611.6	540.9	154.8	87.2	52.1	7 280.8
Expenditure through DHS Medicare fee for service — per person (ASR) (e), (f)										
2012-13	\$	305.6	290.4	302.4	226.5	287.3	267.2	226.9	224.9	288.4
2013-14	\$	314.8	301.2	314.2	238.6	295.6	272.5	230.7	241.4	298.6

ASR = age standardised rate. **DHS** = Department of Human Services (Australian Government).

(a) Age standardised expenditure per person data are available from the 2012-13 reference year. Data for previous years are provided in table 10A.3.

(b) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

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

(c) Data include expenditure on DHS Medicare and the DVA. Data exclude expenditure on the Practice Incentives Program (PIP), the General Practice Immunisation Incentive Scheme (GPPI) and Medicare Locals (ML). Data are not comparable with data in table 10A.3 that include this expenditure.

(d) Data for Australia includes expenditure on patients of unknown age.

(e) Expenditure per person is directly age standardised to the 2001 Australian standard population. Expenditure on Medicare Locals, GPPI and PIP is excluded as these are not related to age and cannot be age-standardised. Data are not comparable to previous years for which crude rates are reported (see table 10A.3).

(f) Rates are derived using the ABS first preliminary estimated resident population based on the 2011 Census.

Source: Department of Health unpublished, MBS statistics; DVA unpublished; table 2A.51.

TABLE 10A.3

Table 10A.3 **Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars) (a), (b), (c), (d), (e)**

	<i>Unit</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>
Expenditure (c)										
2006-07	\$m	2 226.3	1 543.6	1 235.8	528.3	499.7	144.2	77.5	34.6	6 289.9
2007-08	\$m	2 308.9	1 630.0	1 303.7	553.2	521.7	150.9	81.3	38.1	6 587.7
2008-09	\$m	2 301.1	1 634.8	1 322.6	548.2	524.2	147.8	80.6	38.2	6 597.6
2009-10	\$m	2 326.7	1 674.7	1 362.8	558.4	530.4	151.4	80.8	41.3	6 726.5
2010-11	\$m	2 333.1	1 695.8	1 383.4	558.2	528.1	151.3	80.6	43.5	6 773.9
2011-12	\$m	2 378.5	1 722.1	1 425.7	558.3	529.3	153.1	82.3	45.1	6 894.4
2012-13	\$m	2 553.8	1 873.5	1 544.1	624.3	572.9	168.6	90.5	59.8	7 487.5
2013-14 (e)	\$m	2 668.6	1 977.2	1 634.7	673.1	594.3	177.4	94.0	66.2	7 885.5
Expenditure per person (crude rates) (f)										
2006-07	\$	328.1	302.4	304.7	254.4	320.1	293.4	229.0	164.0	304.9
2007-08	\$	335.4	313.5	313.4	259.1	330.5	304.3	236.2	175.9	313.5
2008-09	\$	328.6	307.7	309.3	248.2	328.1	294.6	229.6	171.7	307.2
2009-10	\$	327.6	309.0	312.0	246.7	327.7	298.9	225.8	181.3	307.6
2010-11	\$	324.9	308.6	311.8	240.7	323.5	296.5	220.9	188.9	305.5
2011-12	\$	328.2	308.9	315.9	233.9	321.8	299.2	222.0	194.1	306.6
2012-13	\$	347.5	329.9	334.9	252.5	344.7	329.0	238.4	252.5	326.9
2013-14	\$	357.5	341.4	348.5	263.9	354.3	345.2	244.7	272.9	338.2

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Rates are derived using the ABS final 2011 Census rebased estimated resident population (ERP).

(c) Data include expenditure on Department of Human Services—Medicare, the Practice Incentives Program (PIP), the Department of Veterans' Affairs (DVA) and the General Practice Immunisation Incentive Scheme (GPPI). Data include expenditure on the Divisions of General Practice Program (DGPP) for 2011-12 and previous years. From 2012-13, total expenditure data include core operational expenditure on Medicare Locals (ML).

Table 10A.3 Australian Government total expenditure on GPs and expenditure per person (crude rates) (2013-14 dollars) (a), (b), (c), (d), (e)

<i>Unit</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>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-------------

- (d) From 2010-11, DVA data include expenditure only on specialist GPs. DVA data for 2009-10 and previous years include expenditure on all local medical officers (LMO). Other data include expenditure on vocationally registered GPs and other medical practitioners (OMPs).
- (e) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.
- (f) Expenditure data for 2011-12 and previous years are crude rates and are not comparable with data for 2012-13 and subsequent years, which are age-standardised. See table 10A.2 for age-standardised expenditure per person data for 2012-13.

Source: Department of Health unpublished, MBS, PIP, GPPII, DGPP, ML and DVA data collections; table 2A.51.

Table 10A.4

Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars) (a), (b), (c)

	<i>Unit</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>
PBS Total (d)										
2004-05	\$m	2 433.0	1 756.7	1 316.5	605.5	588.0	185.8	88.7	24.9	6 999.4
2005-06	\$m	2 348.5	1 710.4	1 273.6	585.9	581.5	184.1	85.3	24.7	6 793.9
2006-07	\$m	2 296.6	1 660.0	1 263.0	578.1	564.3	178.1	82.5	23.7	6 646.2
2007-08	\$m	2 384.0	1 725.6	1 312.2	603.7	591.3	187.4	85.1	25.1	6 914.4
2008-09	\$m	2 554.1	1 830.2	1 408.4	650.8	622.7	199.4	90.3	26.7	7 382.6
2009-10	\$m	2 658.0	1 907.6	1 476.0	669.4	643.9	208.8	94.8	27.2	7 685.8
2010-11	\$m	2 645.6	1 886.3	1 462.7	678.6	629.5	210.3	94.2	28.0	7 635.1
2011-12	\$m	2 643.9	1 897.5	1 486.5	717.5	638.0	213.5	94.1	27.7	7 718.7
2012-13	\$m	2 442.7	1 762.8	1 382.0	646.1	597.5	194.1	90.5	25.7	7 141.4
2013-14	\$m	2 503.9	1 815.8	1 395.6	672.7	599.9	200.7	92.4	27.6	7 308.6
RPBS Total (e)										
2004-05	\$m	218.6	135.6	137.3	47.1	47.2	18.7	8.8	1.2	614.4
2005-06	\$m	202.4	126.8	127.5	44.2	44.9	17.9	8.4	1.2	573.2
2006-07	\$m	187.4	117.1	120.4	41.7	41.6	16.0	7.8	1.0	533.1
2007-08	\$m	183.2	112.2	118.2	41.4	40.2	15.8	7.9	1.0	520.0
2008-09	\$m	184.3	109.9	119.0	41.3	40.1	15.6	8.0	1.0	519.3
2009-10	\$m	182.4	107.7	119.6	39.7	40.3	15.4	7.9	1.0	514.1
2010-11	\$m	168.9	97.8	113.5	37.4	35.6	14.3	7.5	0.9	475.8
2011-12	\$m	159.9	90.8	110.9	36.6	34.3	14.0	7.0	0.9	454.4
2012-13	\$m	140.6	78.1	98.7	31.1	28.9	12.1	6.5	0.8	396.8
2013-14	\$m	127.2	71.6	90.9	29.7	25.4	10.8	6.0	0.8	362.4
PBS and RPBS TOTAL										
2004-05	\$m	2 651.5	1 892.3	1 453.8	652.5	635.2	204.5	97.6	26.1	7 613.8
2005-06	\$m	2 550.9	1 837.2	1 401.1	630.1	626.4	202.0	93.7	25.8	7 367.2
2006-07	\$m	2 484.0	1 777.1	1 383.3	619.8	605.9	194.1	90.3	24.7	7 179.3

Table 10A.4

Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars) (a), (b), (c)

	<i>Unit</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>
2007-08	\$m	2 567.2	1 837.8	1 430.4	645.1	631.5	203.2	93.0	26.2	7 434.4
2008-09	\$m	2 738.4	1 940.1	1 527.5	692.1	662.8	215.1	98.3	27.7	7 901.9
2009-10	\$m	2 840.4	2 015.3	1 595.6	709.0	684.2	224.3	102.7	28.2	8 199.8
2010-11	\$m	2 814.5	1 984.0	1 576.3	716.0	665.1	224.6	101.6	28.9	8 111.0
2011-12	\$m	2 803.9	1 988.3	1 597.4	754.1	672.3	227.5	101.0	28.6	8 173.1
2012-13	\$m	2 583.3	1 840.9	1 480.7	677.2	626.4	206.2	97.0	26.5	7 538.2
2013-14	\$m	2 631.1	1 887.3	1 486.5	702.4	625.3	211.5	98.4	28.4	7 670.9
PBS total expenditure per person (f)										
2004-05	\$	357.78	348.55	331.79	300.13	380.87	381.93	272.69	123.09	343.27
2005-06	\$	345.18	335.50	313.82	287.08	372.26	376.18	255.91	117.89	329.85
2006-07	\$	334.36	320.75	304.97	277.41	357.48	361.58	244.69	111.07	318.11
2007-08	\$	343.34	328.21	309.53	282.80	370.72	377.29	249.05	115.16	325.71
2008-09	\$	361.93	340.41	322.97	294.71	385.56	397.91	259.07	119.88	340.34
2009-10	\$	368.90	346.39	329.25	294.36	393.41	412.57	266.59	119.14	346.23
2010-11	\$	363.12	337.04	320.81	292.39	380.78	412.25	259.72	121.43	339.02
2011-12	\$	364.18	339.79	328.75	300.11	387.20	416.73	253.32	118.82	342.69
2012-13	\$	331.72	309.70	299.00	260.84	358.78	378.20	238.04	107.95	311.11
2013-14	\$	334.65	312.86	296.79	263.23	356.95	389.87	240.08	113.25	312.72
Proportion of PBS expenditure that is concessional										
2004-05	%	79.8	79.8	79.4	77.8	81.4	84.6	66.0	66.8	79.6
2005-06	%	80.3	80.3	79.6	77.9	82.3	85.0	66.7	67.1	80.0
2006-07	%	80.8	80.8	80.0	77.2	82.4	84.9	66.8	68.6	80.4
2007-08	%	79.9	80.1	78.6	75.0	81.8	84.7	65.5	66.8	79.3
2008-09	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9
2009-10	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9

Table 10A.4

Australian government expenditure on the Pharmaceutical Benefits Scheme (2013-14 dollars) (a), (b), (c)

	<i>Unit</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>
2010-11	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
2011-12	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
2012-13	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5
2013-14	%	79.4	78.2	78.8	70.5	80.7	83.0	63.1	63.4	78.1

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) From 2012-13, rates are derived using the 31 December ABS 2011 Census based estimated resident population (ERP) for the reference year and differ from rates reported in table 10A.21 which use the June 30 ERP preceding the reference year. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.
- (c) 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 Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 10A.6]).
- (d) PBS total includes PBS general ordinary, general safety net, concessional ordinary, concessional safety net and doctor's bag.
- (e) Includes RPBS general ordinary and RPBS general safety net.
- (f) PBS expenditure per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</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>
<i>2009-10</i>										
PBS General Ordinary	\$m	479.8	348.6	295.1	160.3	106.8	33.0	30.8	9.2	1 463.6
PBS General Safety Net	\$m	76.4	52.8	43.7	21.8	14.2	4.2	4.4	0.6	218.1
<i>PBS General total</i>	\$m	556.1	401.4	338.8	182.1	121.0	37.3	35.2	9.8	1 681.7
PBS Concessional Ordinary	\$m	1 607.5	1 156.9	866.9	382.9	404.3	131.1	47.7	15.2	4 612.4
PBS Concessional Free Safety Net	\$m	489.4	345.6	267.0	103.3	117.5	40.1	11.7	2.1	1 376.7
<i>PBS Concessional total (a)</i>	\$m	2 096.8	1 502.5	1 133.9	486.2	521.8	171.2	59.4	17.3	5 989.2
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	5.0	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	5.0	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
PBS Total	\$m	2 658.0	1 907.6	1 476.0	669.4	643.9	208.8	94.8	27.2	7 685.8
RPBS Total (d)	\$m	182.4	107.7	119.6	39.7	40.3	15.4	7.9	1.0	514.1
PBS and RPBS TOTAL	\$m	2 840.4	2 015.3	1 595.6	709.0	684.2	224.3	102.7	28.2	8 199.8
PBS total expenditure per person (e)	\$	368.9	346.4	329.2	294.4	393.4	412.6	266.6	119.1	346.2
Proportion of PBS expenditure that is concessional	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
<i>2010-11</i>										
PBS General Ordinary	\$m	481.5	350.2	289.7	167.8	106.6	33.8	30.7	9.8	1 470.1
PBS General Safety Net	\$m	76.2	53.1	44.1	23.0	14.7	4.0	4.7	0.7	220.5
<i>PBS General total</i>	\$m	557.7	403.3	333.8	190.8	121.3	37.8	35.4	10.5	1 690.7
PBS Concessional Ordinary	\$m	1 591.9	1 131.4	856.6	381.3	389.0	132.6	47.0	15.2	4 545.0

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</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>
PBS Concessional Free Safety Net	\$m	491.1	347.8	268.9	105.4	118.2	39.5	11.6	2.2	1 384.7
<i>PBS Concessional total (a)</i>	\$m	2 083.0	1 479.2	1 125.5	486.7	507.1	172.1	58.6	17.4	5 929.7
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.8
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.8
PBS Total	\$m	2 645.6	1 886.3	1 462.7	678.6	629.5	210.3	94.2	28.0	7 635.1
RPBS Total (d)	\$m	168.9	97.8	113.5	37.4	35.6	14.3	7.5	0.9	475.8
PBS and RPBS TOTAL	\$m	2 814.5	1 984.0	1 576.3	716.0	665.1	224.6	101.6	28.9	8 111.0
PBS total expenditure per person (e)	\$	363.1	337.0	320.8	292.4	380.8	412.2	259.7	121.4	339.0
Proportion of PBS expenditure that is concessional	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
<i>2011-12</i>										
PBS General Ordinary	\$m	479.9	357.3	287.4	182.1	106.9	34.4	30.4	9.6	1 488.0
PBS General Safety Net	\$m	71.4	52.4	42.2	22.9	14.8	4.1	4.7	0.6	213.1
<i>PBS General total</i>	\$m	551.3	409.7	329.6	205.0	121.7	38.4	35.1	10.3	1 701.1
PBS Concessional Ordinary	\$m	1 587.2	1 128.1	876.2	402.3	392.1	133.8	46.7	15.2	4 581.5
PBS Concessional Free Safety Net	\$m	501.0	356.4	277.9	109.1	123.2	41.0	12.1	2.2	1 422.9
<i>PBS Concessional total (a)</i>	\$m	2 088.2	1 484.5	1 154.1	511.4	515.3	174.8	58.8	17.4	6 004.4
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</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>
PBS Doctors Bag	\$m	4.4	3.4	2.9	1.1	1.0	0.3	0.2	0.1	13.3
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	4.4	3.4	2.9	1.1	1.0	0.3	0.2	0.1	13.3
PBS Total	\$m	2 643.9	1 897.5	1 486.5	717.5	638.0	213.5	94.1	27.7	7 718.7
RPBS Total (d)	\$m	159.9	90.8	110.9	36.6	34.3	14.0	7.0	0.9	454.4
PBS and RPBS TOTAL	\$m	2 803.9	1 988.3	1 597.4	754.1	672.3	227.5	101.0	28.6	8 173.1
PBS total expenditure per person (e)	\$	364.2	339.8	328.7	300.1	387.2	416.7	253.3	118.8	342.7
Proportion of PBS expenditure that is concessional	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
<i>2012-13</i>										
PBS General Ordinary	\$m	431.8	330.4	256.5	166.3	98.6	29.1	29.2	8.6	1 350.5
PBS General Safety Net	\$m	59.3	40.2	32.9	18.2	12.5	3.2	3.9	0.5	170.6
<i>PBS General total</i>	\$m	491.1	370.6	289.3	184.4	111.1	32.3	33.1	9.1	1 521.0
PBS Concessional Ordinary	\$m	1 465.8	1 050.1	821.9	357.9	365.6	122.1	45.5	14.3	4 243.0
PBS Concessional Free Safety Net	\$m	480.9	338.3	267.5	102.7	119.6	39.5	11.8	2.1	1 362.4
<i>PBS Concessional total (a)</i>	\$m	1 946.7	1 388.4	1 089.4	460.6	485.2	161.5	57.2	16.4	5 605.5
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	4.9	3.8	3.3	1.1	1.2	0.3	0.2	0.1	14.9
<i>PBS Unknown free safety net plus Doctors bag</i>	\$m	4.9	3.8	3.3	1.1	1.2	0.3	0.2	0.1	14.9
PBS Total	\$m	2 442.7	1 762.8	1 382.0	646.1	597.5	194.1	90.5	25.7	7 141.4
RPBS Total (d)	\$m	140.6	78.1	98.7	31.1	28.9	12.1	6.5	0.8	396.8

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</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>
PBS and RPBS TOTAL	\$m	2 583.3	1 840.9	1 480.7	677.2	626.4	206.2	97.0	26.5	7 538.2
PBS total expenditure per person (e)	\$	331.7	309.7	299.0	260.8	358.8	378.2	238.0	107.9	311.1
Proportion of PBS expenditure that is concessional	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5
<i>2013-14</i>										
PBS General Ordinary	\$m	457.3	355.7	263.2	180.0	102.9	30.9	30.3	9.5	1 429.9
PBS General Safety Net	\$m	53.4	36.4	29.4	16.9	11.6	2.9	3.6	0.5	154.7
<i>PBS General total</i>	<i>\$m</i>	<i>510.7</i>	<i>392.1</i>	<i>292.7</i>	<i>196.9</i>	<i>114.5</i>	<i>33.8</i>	<i>33.9</i>	<i>10.0</i>	<i>1 584.6</i>
PBS Concessional Ordinary	\$m	1 498.0	1 075.0	826.2	368.7	364.5	125.7	46.0	15.3	4 319.4
PBS Concessional Free Safety Net	\$m	489.6	344.6	273.3	105.9	119.8	40.9	12.3	2.2	1 388.6
<i>PBS Concessional total (a)</i>	<i>\$m</i>	<i>1 987.6</i>	<i>1 419.7</i>	<i>1 099.6</i>	<i>474.5</i>	<i>484.2</i>	<i>166.6</i>	<i>58.3</i>	<i>17.5</i>	<i>5 708.0</i>
PBS Unknown Free Safety Net	\$m	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	\$m	5.6	4.0	3.4	1.3	1.2	0.3	0.2	0.1	16.0
<i>PBS Unknown free safety net plus Doctors bag</i>	<i>\$m</i>	<i>5.6</i>	<i>4.0</i>	<i>3.4</i>	<i>1.3</i>	<i>1.2</i>	<i>0.3</i>	<i>0.2</i>	<i>0.1</i>	<i>16.0</i>
PBS Total	\$m	2 503.9	1 815.8	1 395.6	672.7	599.9	200.7	92.4	27.6	7 308.6
RPBS Total (d)	\$m	127.2	71.6	90.9	29.7	25.4	10.8	6.0	0.8	362.4
PBS and RPBS TOTAL	\$m	2 631.1	1 887.3	1 486.5	702.4	625.3	211.5	98.4	28.4	7 670.9
PBS total expenditure per person (e)	\$	334.6	312.9	296.8	263.2	356.9	389.9	240.1	113.2	312.7
Proportion of PBS expenditure that is concessional	%	79.4	78.2	78.8	70.5	80.7	83.0	63.1	63.4	78.1

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2013-14 dollars) (a), (b), (c)**

	<i>Unit</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>
(a)	Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.									
(b)	From 2012-13, rates are derived using the 31 December ABS 2011 Census based estimated resident population (ERP) for the reference year and differ from rates reported in table 10A.21 which use the June 30 ERP preceding the reference year. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.									
(c)	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 Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwith] — costing \$36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 10A.6]).									
(d)	Includes RPBS ordinary and RPBS safety net.									
(e)	PBS expenditure per person excludes RPBS and PBS doctor's bag. – Nil or rounded to zero.									

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 10A.6 **Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas (a), (b), (c), (d)**

	<i>Unit</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 (d)</i>
2012-13	\$'000	105.0	–	6 691.1	10 534.2	808.9	89.0	–	18 978.5	37 206.6
2013-14	\$'000	93.7	–	6 845.3	10 363.0	905.6	110.9	–	20 194.8	38 513.4

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Includes expenditure on PBS medicines supplied in bulk under s.100 of the *National Health Act 1953* (Cwlth) to Aboriginal Health Services in remote and very remote areas.

(c) This program seeks to address identified barriers to accessing essential medicines experienced by Aboriginal and Torres Strait Islander people living in remote areas (see <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-faq> accessed 15 September 2014).

(d) Allocation to state and territory is based on location of the Aboriginal Health Service. Clients are not necessarily resident in the same state or territory.
– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

TABLE 10A.7

Table 10A.7 Expenditure on dental services (2012-13 dollars) (\$ million)

	<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>Total</i>
2012-13									
Government									
Australian Government									
DVA	34	17	30	10	9	2	-2	-	100
Department of Health and other (a)	390	197	157	21	61	9	6	3	843
Insurance premium rebates (b)	191	121	126	90	53	11	11	4	606
Total	614	335	313	121	123	22	15	7	1 550
State, Territory and Local Government	158	153	169	77	62	18	10	9	657
Total government	772	489	482	197	185	40	25	17	2 207
Non-government	1 852	2 197	870	993	272	108	132	75	6 500
Total government and non-government	2 624	2 686	1 352	1 190	457	149	157	92	8 706

DVA = Department of Veterans' Affairs

- (a) 'Department of Health and other' comprises Department of Health funded expenditure such as on MBS and PBS, and other Australian Government expenditure such as for the SPP associated with the National Healthcare Agreement and health-related NP payments, capital consumption, estimates of the medical expenses tax offset, and health research not funded by Department of Health.
- (b) Includes the 30-40 per cent rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.
- Nil or rounded to zero.

Source: AIHW 2014, *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61.

Table 10A.8 Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW/ACT</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	\$m	95.1	39.3	106.7	81.5	41.5	8.4	np	145.4	517.7
2010-11	\$m	97.9	42.3	99.4	91.2	45.2	8.8	np	135.4	520.3
2011-12	\$m	105.9	41.5	102.6	93.9	42.6	10.1	np	145.0	541.6
2012-13	\$m	109.3	43.4	95.0	90.9	45.5	9.8	np	141.3	535.3
2013-14	\$m	128.2	43.8	124.9	97.3	45.6	14.8	np	127.7	582.4

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Data reflect funding provided to all organisations for which primary function is primary health care and/or substance use and/or mental health services (excludes GST). Excludes funding to Peak bodies.

(c) Funding for Capital Works is not included.

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

np = Not published.

Source: Department of Health unpublished, table 2A.51.

TABLE 10A.9

Table 10A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	<i>Unit</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 numbers										
2004-05	no.	7 590	5 721	4 644	2 175	1 944	609	375	320	23 378
2005-06	no.	7 708	5 802	4 793	2 240	1 980	625	381	305	23 834
2006-07	no.	7 855	5 914	4 864	2 310	1 990	642	373	324	24 272
2007-08	no.	7 934	6 062	5 052	2 357	2 099	661	383	355	24 903
2008-09	no.	8 105	6 240	5 340	2 458	2 141	679	385	378	25 726
2009-10	no.	8 389	6 449	5 564	2 492	2 201	704	398	416	26 613
2010-11	no.	8 654	6 710	5 810	2 614	2 253	719	416	463	27 639
2011-12	no.	8 998	7 033	6 199	2 744	2 348	770	440	479	29 011
2012-13	no.	9 427	7 344	6 629	2 973	2 448	810	470	580	30 681
2013-14	no.	9 969	7 800	6 970	3 192	2 554	855	466	595	32 401
FWE GPs										
2004-05	no.	6 222	4 167	3 389	1 457	1 364	378	200	95	17 273
2005-06	no.	6 310	4 283	3 489	1 473	1 404	386	208	97	17 649
2006-07	no.	6 483	4 407	3 564	1 500	1 416	391	226	104	18 091
2007-08	no.	6 600	4 584	3 683	1 542	1 455	401	232	116	18 613
2008-09	no.	6 792	4 738	3 861	1 574	1 511	404	235	116	19 231
2009-10	no.	6 893	4 901	3 993	1 615	1 546	417	238	127	19 729
2010-11	no.	7 067	5 063	4 126	1 640	1 570	429	239	134	20 267
2011-12	no.	7 338	5 270	4 343	1 698	1 628	449	250	142	21 119
2012-13	no.	7 593	5 544	4 573	1 803	1 681	464	272	158	22 087
2013-14	no.	7 927	5 828	4 818	1 953	1 739	476	277	175	23 194
FWE GPs per 100 000 people (e)										
2004-05	per 100 000 people	93.3	84.1	87.5	73.1	89.0	78.0	60.7	46.8	86.2
2005-06	per 100 000 people	93.9	85.3	88.0	72.6	90.9	79.2	62.2	46.6	86.9
2006-07	per 100 000 people	95.5	86.3	87.9	72.2	90.7	79.6	66.9	49.1	87.7

TABLE 10A.9

Table 10A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	<i>Unit</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>
2007-08	per 100 000 people	95.9	88.2	88.5	72.2	92.2	81.0	67.5	53.4	88.6
2008-09	per 100 000 people	97.0	89.2	90.3	71.3	94.6	80.5	67.0	52.0	89.5
2009-10	per 100 000 people	97.1	90.4	91.4	71.3	95.5	82.4	66.6	55.6	90.2
2010-11	per 100 000 people	98.4	92.1	93.0	70.7	96.2	84.1	65.5	58.1	91.4
2011-12	per 100 000 people	101.2	94.5	96.2	71.1	99.0	87.8	67.6	61.0	93.9
2012-13	per 100 000 people	103.3	97.6	99.2	72.9	101.1	90.5	71.8	66.5	96.4
2013-14	per 100 000 people	106.2	100.6	102.7	76.6	103.7	92.7	72.0	72.3	99.5

- (a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (b) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.
- (e) Estimated Resident Populations (ERPs) used to derive rates are revised to the ABS' final 2011 Census rebased estimates for 31 December. See chapter 2 (table 2A.2) for details.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.10

Table 10A.10 Number of GP-type services used per 1000 people (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>
2008-09	5 951.8	5 491.1	5 656.2	4 740.2	5 519.4	5 072.6	4 494.6	3 363.1	5 552.9
2009-10	6 043.5	5 612.1	5 845.4	4 808.3	5 666.4	5 341.4	4 621.9	3 633.1	5 678.9
2010-11	5 956.6	5 631.5	5 705.4	4 676.2	5 554.2	5 154.3	4 520.8	3 670.6	5 598.9
2011-12	6 161.8	5 809.9	6 000.2	4 663.8	5 651.8	5 574.4	4 560.2	3 955.0	5 783.1
2012-13 (e)	6 125.6	5 839.5	5 968.5	4 626.3	5 690.2	5 268.3	4 705.6	4 156.1	5 767.6
2013-14	6 238.5	5 991.9	6 087.3	4 767.2	5 764.4	5 315.1	4 755.9	4 465.6	5 889.4

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

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

(c) From 2011-12, age-standardised rates are derived using the ABS estimated resident population (ERP) at 31 December, based on the 2011 Census. Rates for previous years are derived using the ABS ERP at 30 June preceding the reference year, based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

(d) DVA data are included.

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection.

TABLE 10A.11

Table 10A.11

PBS services

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS Total (b)										
2004-05	'000	58 751.2	42 867.3	32 156.7	14 851.4	14 314.0	4 777.0	1 971.1	589.8	170 278.5
2005-06	'000	57 822.1	42 716.2	31 508.1	14 609.4	14 319.8	4 838.5	1 918.6	590.0	168 322.6
2006-07	'000	58 050.4	42 583.8	32 008.2	14 571.3	14 144.5	4 723.0	1 881.9	572.6	168 535.5
2007-08	'000	58 467.4	43 649.9	32 693.8	14 593.3	14 537.4	4 864.0	1 897.3	592.9	171 296.0
2008-09	'000	62 123.6	46 221.7	34 874.5	15 602.7	15 319.6	5 089.4	1 990.4	614.1	181 836.1
2009-10	'000	62 716.4	46 882.6	35 292.2	15 531.6	15 727.3	5 115.7	2 024.2	621.5	183 911.5
2010-11	'000	64 112.6	47 935.7	36 242.5	15 976.2	15 837.6	5 296.6	2 106.1	635.0	188 142.3
2011-12	'000	65 896.3	49 189.6	37 910.2	17 107.8	16 445.8	5 563.3	2 112.7	647.4	194 873.1
2012-13	'000	66 639.3	49 861.2	38 932.6	16 735.9	16 821.3	5 494.5	2 156.6	664.1	197 305.4
2013-14	'000	70 984.7	53 297.9	40 920.3	18 041.8	17 752.1	5 856.6	2 238.5	724.1	209 816.0
RPBS Total (c)										
2004-05	'000	5 547.3	3 517.0	3 491.2	1 215.7	1 213.1	524.6	197.3	28.5	15 734.7
2005-06	'000	5 311.9	3 415.1	3 336.3	1 183.1	1 187.0	510.3	195.7	28.4	15 167.8
2006-07	'000	5 172.0	3 321.8	3 312.7	1 168.2	1 143.4	479.5	197.6	27.6	14 822.8
2007-08	'000	4 915.7	3 177.8	3 234.6	1 123.5	1 116.8	461.9	197.2	28.6	14 256.1
2008-09	'000	4 936.2	3 160.3	3 298.2	1 136.7	1 122.3	454.3	199.2	28.9	14 336.1
2009-10	'000	4 768.4	3 047.3	3 213.5	1 073.9	1 097.4	438.0	197.5	27.8	13 863.9
2010-11	'000	4 572.5	2 900.6	3 111.1	1 032.3	1 020.5	419.1	194.2	26.3	13 276.7
2011-12	'000	4 403.5	2 784.2	3 108.2	1 036.7	1 004.3	410.1	186.5	27.1	12 960.6
2012-13	'000	4 177.1	2 655.0	3 030.2	975.2	942.7	374.7	189.3	27.0	12 371.3
2013-14	'000	4 118.8	2 649.6	3 038.8	1 007.8	932.5	371.7	190.9	28.1	12 338.3
PBS and RPBS Total										
2004-05	'000	64 298.5	46 384.2	35 647.9	16 067.1	15 527.2	5 301.5	2 168.4	618.3	186 013.1
2005-06	'000	63 134.0	46 131.3	34 844.4	15 792.5	15 506.8	5 348.8	2 114.3	618.4	183 490.5
2006-07	'000	63 222.3	45 905.6	35 320.9	15 739.5	15 287.9	5 202.5	2 079.4	600.2	183 358.3

TABLE 10A.11

Table 10A.11

PBS services

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
2007-08	'000	63 383.1	46 827.7	35 928.4	15 716.9	15 654.2	5 325.9	2 094.5	621.5	185 552.2
2008-09	'000	67 059.8	49 382.0	38 172.8	16 739.4	16 441.9	5 543.7	2 189.6	643.0	196 172.2
2009-10	'000	67 484.8	49 929.9	38 505.8	16 605.6	16 824.6	5 553.8	2 221.7	649.3	197 775.4
2010-11	'000	68 685.0	50 836.3	39 353.6	17 008.5	16 858.1	5 715.8	2 300.3	661.3	201 418.9
2011-12	'000	70 299.8	51 973.8	41 018.4	18 144.4	17 450.1	5 973.4	2 299.3	674.5	207 833.7
2012-13	'000	70 816.4	52 516.1	41 962.8	17 711.1	17 764.1	5 869.2	2 345.9	691.1	209 676.6
2013-14	'000	75 103.5	55 947.5	43 959.2	19 049.6	18 684.6	6 228.3	2 429.4	752.2	222 154.3
PBS total services per person (d)										
2004-05	no.	8.6	8.5	8.1	7.4	9.3	9.8	6.0	2.9	8.3
2005-06	no.	8.5	8.4	7.8	7.2	9.2	9.9	5.8	2.8	8.2
2006-07	no.	8.5	8.2	7.7	7.0	9.0	9.6	5.6	2.7	8.1
2007-08	no.	8.4	8.3	7.7	6.8	9.1	9.8	5.6	2.7	8.1
2008-09	no.	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
2009-10	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
2010-11	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
2011-12	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
2012-13	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
2013-14	no.	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0
Proportion of PBS services that are concessional										
2004-05	%	83.0	83.3	83.1	81.6	85.3	87.2	68.6	70.0	83.1
2005-06	%	83.9	84.1	83.7	82.1	86.0	87.7	70.3	71.6	83.8
2006-07	%	85.4	85.6	84.8	83.0	87.2	88.8	72.5	74.4	85.2
2007-08	%	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7
2008-09	%	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
2009-10	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7

Table 10A.11 **PBS services**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
2010-11	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
2011-12	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
2012-13	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
2013-14	%	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwlth).

(b) Includes PBS general ordinary, general free safety net, concessional ordinary, concessional free safety net and doctor's bag.

(c) Includes RPBS general ordinary and RPBS general safety net.

(d) PBS services per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
<i>2009-10</i>										
PBS General Ordinary	'000	6 927	5 130	4 289	2 281	1 543	457	462	138	21 227
PBS General Safety Net	'000	1 714	1 148	914	449	330	96	95	15	4 763
<i>PBS General total</i>	'000	8 641	6 279	5 203	2 730	1 873	554	557	153	25 990
PBS Concessional Ordinary	'000	41 698	31 666	23 283	10 197	10 864	3 525	1 188	413	122 832
PBS Concessional Free Safety Net	'000	12 266	8 856	6 732	2 580	2 964	1 030	276	54	34 757
<i>PBS Concessional total (b)</i>	'000	53 963	40 521	30 015	12 777	13 828	4 555	1 463	467	157 589
PBS Unknown Free Safety Net	'000	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	'000	112	83	74	25	26	7	3	2	332
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	112	83	74	25	26	7	3	2	332
PBS Total	'000	62 716	46 883	35 292	15 532	15 727	5 116	2 024	621	183 912
RPBS Total (c)	'000	4 768	3 047	3 214	1 074	1 097	438	198	28	13 864
PBS and RPBS TOTAL	'000	67 485	49 930	38 506	16 606	16 825	5 554	2 222	649	197 775
PBS total services per person (d)	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
Proportion of PBS services that are concessional	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
<i>2010-11</i>										
PBS General Ordinary	'000	6 847	5 114	4 199	2 308	1 500	464	463	137	21 032
PBS General Safety Net	'000	1 747	1 196	956	480	345	97	105	16	4 943
<i>PBS General total</i>	'000	8 595	6 310	5 155	2 788	1 845	561	568	153	25 976
PBS Concessional Ordinary	'000	42 608	32 256	23 945	10 442	10 858	3 670	1 245	423	125 447

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS Concessional Free Safety Net	'000	12 798	9 283	7 065	2 723	3 109	1 058	290	57	36 382
<i>PBS Concessional total (b)</i>	'000	55 406	41 539	31 010	13 164	13 967	4 728	1 535	480	161 829
PBS Unknown Free Safety Net	'000	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	'000	112	86	77	24	26	8	4	2	338
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	112	86	77	24	26	8	4	2	338
PBS Total	'000	64 113	47 936	36 242	15 976	15 838	5 297	2 106	635	188 142
RPBS Total (c)	'000	4 572	2 901	3 111	1 032	1 020	419	194	26	13 277
PBS and RPBS TOTAL	'000	68 685	50 836	39 354	17 009	16 858	5 716	2 300	661	201 419
PBS total services per person (d)	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
Proportion of PBS services that are concessional	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
<i>2011-12</i>										
PBS General Ordinary	'000	6 867	5 130	4 232	2 445	1 514	465	447	139	21 239
PBS General Safety Net	'000	1 682	1 175	926	484	341	94	104	15	4 821
<i>PBS General total</i>	'000	8 549	6 305	5 158	2 929	1 855	559	550	155	26 060
PBS Concessional Ordinary	'000	43 912	33 102	25 259	11 300	11 296	3 885	1 256	433	130 442
PBS Concessional Free Safety Net	'000	13 329	9 700	7 421	2 853	3 270	1 112	303	58	38 047
<i>PBS Concessional total (b)</i>	'000	57 240	42 802	32 681	14 153	14 565	4 997	1 559	491	168 489
PBS Unknown Free Safety Net	'000	na	na	na	na	na	na	na	na	na
PBS Doctors Bag	'000	107	83	72	26	25	7	3	1	324

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	107	83	72	26	25	7	3	1	324
PBS Total	'000	65 896	49 190	37 910	17 108	16 446	5 563	2 113	647	194 873
RPBS Total (c)	'000	4 404	2 784	3 108	1 037	1 004	410	187	27	12 961
PBS and RPBS TOTAL	'000	70 300	51 974	41 018	18 144	17 450	5 973	2 299	674	207 834
PBS total services per person (d)	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
Proportion of PBS services that are concessional	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
<i>2012-13</i>										
PBS General Ordinary	'000	6 229	4 608	3 902	2 223	1 415	405	410	133	19 324
PBS General Safety Net	'000	1 535	1 037	849	442	317	81	97	14	4 371
<i>PBS General total</i>	'000	7 763	5 645	4 750	2 664	1 732	486	506	146	23 695
PBS Concessional Ordinary	'000	44 882	34 074	26 304	11 119	11 629	3 858	1 326	454	133 647
PBS Concessional Free Safety Net	'000	13 880	10 051	7 798	2 925	3 432	1 142	321	62	39 612
<i>PBS Concessional total (b)</i>	'000	58 762	44 125	34 102	14 045	15 061	5 001	1 647	516	173 259
PBS Unknown Free Safety Net	'000	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	'000	114	91	80	26	28	8	4	2	352
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	114	91	80	26	28	8	4	2	352
PBS Total	'000	66 639	49 861	38 933	16 736	16 821	5 495	2 157	664	197 305
RPBS Total (c)	'000	4 177	2 655	3 030	975	943	375	189	27	12 371
PBS and RPBS TOTAL	'000	70 816	52 516	41 963	17 711	17 764	5 869	2 346	691	209 677

TABLE 10A.12

Table 10A.12

PBS services, by service type ('000)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS total services per person (d)	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
<i>2013-14</i>										
PBS General Ordinary	'000	5 783	4 325	3 600	2 155	1 312	375	370	131	18 050
PBS General Safety Net	'000	1 414	966	782	415	295	76	92	14	4 053
<i>PBS General total</i>	'000	7 197	5 290	4 382	2 569	1 606	451	462	145	22 103
PBS Concessional Ordinary	'000	48 971	37 286	28 182	12 288	12 500	4 178	1 425	511	145 340
PBS Concessional Free Safety Net	'000	14 695	10 628	8 277	3 156	3 619	1 219	348	67	42 009
<i>PBS Concessional total (b)</i>	'000	63 667	47 914	36 459	15 444	16 119	5 397	1 772	577	187 349
PBS Unknown Free Safety Net	'000	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	'000	121	94	80	29	27	8	4	2	364
<i>PBS Unknown free safety net plus Doctors bag</i>	'000	121	94	80	29	27	8	4	2	364
PBS Total	'000	70 985	53 298	40 920	18 042	17 752	5 857	2 238	724	209 816
RPBS Total (c)	'000	4 119	2 650	3 039	1 008	933	372	191	28	12 338
PBS and RPBS TOTAL	'000	75 104	55 947	43 959	19 050	18 685	6 228	2 429	752	222 154
PBS total services per person (d)	no.	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0
Proportion of PBS services that are concessional	%	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwth).

Table 10A.12 **PBS services, by service type ('000)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
--	-------------	------------	------------	------------	-----------	-----------	------------	------------	---------------	-------------

(b) Includes PBS concessional ordinary and concessional free safety net.

(c) Includes RPBS general ordinary and RPBS general safety net.

(d) PBS services per person exclude RPBS and doctor's bag.

na Not available. – Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.13

Table 10A.13 Use of public dental services, by service type, 2010 (a), (b), (c), (d)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Dental services per 1000 population (ASR)									
Emergency services	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4
RSE (per cent)									
Emergency services	24.6	28.8	20.9	30.4	29.9	25.9	50.0	28.5	11.3
General services	13.8	12.0	11.9	9.0	10.2	8.1	17.5	9.3	5.0
All services	11.9	11.1	10.0	8.4	9.3	8.3	16.4	8.6	4.5
95 per cent CI									
Emergency services	± 4.6	± 5.9	± 11.0	± 7.4	± 7.8	± 14.9	± 14.3	± 14.3	± 3.2
General services	± 9.2	± 10.6	± 16.6	± 19.9	± 16.8	± 16.9	± 28.0	± 28.7	± 5.9
All services	± 10.2	± 12.0	± 19.2	± 20.9	± 17.8	± 22.0	± 31.0	± 30.8	± 6.5

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

- (a) Data are for number of people who used a public dental service at least once in the previous 12 months, not for number of services provided.
- (b) Type of service at the most recent visit. Emergency visit is a visit for relief of pain. Classification of service type as per Australian Dental Association Schedule of Dental Services.
- (c) Rates are age standardised to the Australian population as at 30 June 2001.
- (d) Limited to dentate persons aged 5 years or over.

Source: AIHW unpublished, National Dental Telephone Interview Survey 2010; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.14

Table 10A.14 **Alcohol and other drug treatment services, 2012-13 (number) (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (a)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Treatment services by sector										
Government	no.	186	–	56	14	48	7	1	5	317
Non-government (b), (c)	no.	59	129	77	54	45	10	9	14	397
Total	no.	245	129	133	68	93	17	10	19	714
Closed treatment episodes by sector										
Government	no.	26 197	–	18 923	2 475	6 566	1 570	2 383	1 177	59 291
Non-government (b), (c)	no.	9 105	54 184	11 641	18 139	4 757	768	2 033	2 444	103 071
Total	no.	35 302	54 184	30 564	20 614	11 323	2 338	4 416	3 621	162 362
Closed treatment episodes for client's own drug use by sex										
Male	no.	23 428	34 156	20 738	12 771	7 972	1 449	2 781	2 418	105 713
Female	no.	10 738	16 869	8 643	6 632	3 279	681	1 579	909	49 330
Total (d)	no.	34 177	51 112	29 385	19 405	11 254	2 130	4 360	3 328	155 151

(a) Includes only services that receive public funding.

(b) WA has a number of integrated services that include both government and non-government providers.

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

(d) Totals include episodes for people of unknown sex

– Nil or rounded to zero.

Source: AIHW 2014, *Alcohol and Other Drug Treatment Services in Australia 2012-13*, Cat. no. HSE 150, Drug Treatment Series no. 24.

TABLE 10A.15

Table 10A.15 **Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number) (a), (b), (c), (d), (e)**

<i>Unit</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>	
Aboriginal and Torres Strait Islander primary healthcare services										
2008-09	no.	39	24	31	28	14	10	2	57	205
2009-10	no.	50	26	33	37	13	10	1	53	223
2010-11	no.	56	25	37	35	15	11	1	55	235
2011-12	no.	52	25	37	35	13	9	1	52	224
2012-13	no.	45	24	28	31	14	7	1	55	205
Episodes of healthcare provided										
2008-09	'000	452	160	336	306	191	35	23	586	2 089
2009-10	'000	542	185	379	409	192	36	26	622	2 391
2010-11	'000	522	201	310	473	222	38	30	704	2 498
2011-12	'000	516	234	475	462	216	44	34	641	2 621
2012-13	'000	622	238	575	583	217	53	38	743	3 068

- (a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).
- (c) The number of services that provide OSR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.
- (d) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.
- (e) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

Source: AIHW 2014 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13*, Cat. no.s IHW 31, 56, 79, 104, 139.

Table 10A.16 Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number) (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Total</i>
Aboriginal and Torres Strait Islander primary healthcare services							
2008-09	no.	26	40	50	29	60	205
2009-10	no.	29	48	55	33	58	223
2010-11	no.	34	52	59	29	61	235
2011-12	no.	33	48	53	28	62	224
2012-13	no.	23	43	47	27	65	205
Episodes of healthcare provided							
2008-09	'000	290	313	539	503	444	2 089
2009-10	'000	364	395	583	557	491	2 391
2010-11	'000	399	413	496	532	658	2 498
2011-12	'000	436	460	493	560	671	2 621
2012-13	'000	555	557	563	652	741	3 068

- (a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).
- (c) Remoteness categories are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 *Census of population and housing*.
- (d) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.
- (d) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

Source: AIHW 2014 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13*, Cat. nos IHW 31, 56, 79, 104, 139.

Table 10A.17 Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2012-13 (per cent) (a), (b), (c), (d)

Diagnosis and treatment of chronic illness/diseases	88.8
Transport	89.3
24 hour emergency care	40.0
Child immunisation	85.4
Women's groups	51.7
Housing	82.9
Dental assessment/treatment	51.2
Regional health planning processes	87.3
Dialysis service on site	5.4

(a) Includes only services which report data for the Online Services Report (OSR).

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

(c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.

(d) The health related activities section of the OSR data collection instrument was extensively revised for the 2012-13 collection period and data are not comparable with data for previous years. From 2012-13, data are collected for a smaller range of health related activities. This does not indicate that activities undertaken by services in previous years are no longer provided. Data for previous years are provided in table 10A.18.

Source: AIHW 2014, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2012-13*, Cat. no. IHW 139.

Table 10A.18 Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent) (a), (b), (c), (d), (e)

	2008-09 (f)	2009-10	2010-11	2011-12
Diagnosis and treatment of illness/disease	85.0	82.1	81.2	80.4
Management of chronic illness	89.0	87.0	85.0	86.2
Transportation to medical appointments	86.0	87.0	88.5	90.2
Outreach clinic services	55.0	55.6	52.6	60.7
24 hour emergency care	31.0	27.8	23.5	28.1
Monitoring child growth	64.0	76.2	71.8	79.0
School-based activities	68.0	70.4	74.4	79.0
Hearing screening	72.0	74.9	70.9	76.3
Pneumococcal immunisation	76.0	74.9	70.9	69.6
Influenza immunisation	82.0	81.6	78.2	81.3
Child immunisation	81.0	81.6	76.9	80.8
Women's health group	77.0	76.2	78.2	78.1
Support for public housing issues	58.0	67.7	59.0	71.0
Community development work	60.0	66.8	65.4	75.0
Legal/police/prison/advocacy services	42.0	43.1	44.9	46.0
Dental services	52.0	48.9	45.3	53.1
Involvement in steering groups on health	77.0	81.2	79.5	86.2
Participation in regional planning forums	57.0	57.9	59.0	67.0
Dialysis services	4.0	6.3	4.7	3.6

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

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

(c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.

(d) The health related activities section of the OSR data collection instrument was extensively revised for the 2012-13 collection period and data for 2008-09 to 2011-12 are not comparable with data for 2012-13. From 2012-13, data are collected for a smaller range of selected health related activities (see table 10A.17). This does not indicate that particular activities are no longer undertaken by services.

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

(f) In 2008-09, 4 of 205 services reporting to the OSR collection did not provide valid data for this question. The denominator for 2008-09 is the number of services that provided valid data for this question (201).

Source: AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11 and 2011-12*, Cat. no.s IHW 31, 56,79,104.

Table 10A.19 **Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) (a), (b)**

	2010	2011	2012	2013
<i>Aboriginal and Torres Strait Islander staff</i>				
Aboriginal and Torres Strait Islander health workers	836.6	899.4	896.5	1 414.0
Aboriginal and Torres Strait Islander health practitioners (c)	..	..	..	74.0
Doctors	16.1	26.0	20.7	26.8
Nurses	72.2	72.9	101.3	119.6
Specialists	1.2	0.2	0.3	–
Counsellors/social workers	52.3	59.2	33.4	69.5
Other social and emotional wellbeing staff (d)	242.3	220.8	203.7	164.3
Allied health professionals (e)	49.7	31.8	58.1	6.1
Dentists	4.4	7.4	4.6	6.8
Dental assistants	47.9	43.9	46.2	52.4
Traditional healers	8.1	10.8	4.7	12.0
Sexual health workers	44.5	38.7	43.3	33.9
Substance misuse workers	77.5	101.2	104.7	100.3
Tobacco workers/coordinators (c)	..	..	..	66.0
Health promotion/prevention workers (c)	..	..	..	98.3
Environmental health workers	24.0	23.8	32.7	33.0
Driver/field officers	218.1	255.6	250.0	274.6
Other health staff (f)	6.0	142.3	145.8	349.7
Total Aboriginal and Torres Strait Islander st	1 700.9	1 933.9	1 946.0	2 385.8
<i>Non-Indigenous staff</i>				
Aboriginal and Torres Strait Islander health workers	30.7	14.0	34.3	11.5
Aboriginal and Torres Strait Islander health practitioners (c)	..	..	..	2.0
Doctors	319.3	335.4	331.8	347.8
Nurses	615.3	710.7	681.8	711.8
Specialists	7.4	13.0	12.1	16.9
Counsellors/social workers	84.6	89.1	40.6	213.7
Other social and emotional wellbeing staff (d)	66.2	97.6	82.5	85.5
Allied health professionals (e)	108.2	144.2	115.9	115.8
Dentists	39.8	48.7	55.8	60.7
Dental assistants	27.8	35.1	31.0	30.9
Traditional healers	0.0	3.1	0.5	–
Sexual health workers	20.0	16.6	11.7	12.7
Substance misuse workers	43.4	50.7	54.3	49.4

Table 10A.19 Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) (a), (b)

	2010	2011	2012	2013
Tobacco workers/coordinators (c)	..	..	..	25.9
Health promotion/prevention workers (c)	..	..	..	47.9
Environmental health workers	6.0	10.3	8.5	6.0
Driver/field officers	40.1	39.4	36.7	46.6
Other health staff (f)	–	67.5	25.4	173.0
Total non-Indigenous staff (g)	1 408.7	1 675.2	1 522.9	1 958.0
<i>Total health staff (d), (e)</i>				
Aboriginal and Torres Strait Islander health workers	867.4	913.4	930.8	910.1
Aboriginal and Torres Strait Islander health practitioners (c)	..	..	..	76.0
Doctors	335.4	361.4	352.5	374.6
Nurses	691.5	787.6	783.1	831.4
Specialists	8.7	13.2	12.3	16.9
Counsellors/social workers	136.8	148.3	74.0	283.2
Other social and emotional wellbeing staff (d)	309.5	319.4	286.2	249.8
Allied health professionals (e)	157.9	176.0	174.0	121.9
Dentists	44.2	56.1	60.5	67.5
Dental assistants	75.7	79.1	77.2	83.3
Traditional healers	8.2	13.9	5.2	12.0
Sexual health workers	64.5	55.3	55.0	46.6
Substance misuse workers	120.9	151.9	159.0	149.7
Tobacco workers/coordinators (c)	..	..	..	91.9
Health promotion/prevention workers (c)	..	..	..	146.2
Environmental health workers	30.0	34.1	41.2	39.0
Driver/field officers	258.2	294.9	286.7	321.2
Other health staff (f)	6.0	209.7	171.2	522.7
Total health staff (g), (h)	3 114.9	3 614.4	3 468.9	4 343.8

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

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

(c) Data for Aboriginal health practitioners, Tobacco workers/coordinators and Health promotion/ prevention workers were first collected for 2013.

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

Table 10A.19 Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) (a), (b)

	2010	2011	2012	2013
(e) Allied health professionals include diabetes educators and other patient educators, health program coordinators, nutrition workers, community care workers, child and family health workers, child protection workers, welfare workers, pharmacy assistants/technicians, Brighter Futures Program caseworkers, foster carers, Healthy for Life workers, sports and recreation workers, youth workers, and masseurs.				
(f) Other health staff' include: outreach workers, special program support workers, patient liaison officers, and other health-related positions.				
(g) Totals may not add due to rounding and cell suppression.				
(h) Totals include health staff for whom Indigenous status was not provided.				
.. Not applicable. – Nil or rounded to zero.				

Source: AIHW 2014 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2009-10, 2010-11, 2011-12 and 2012-13*, Cat. no.s IHW 56, 79, 104, 139.

TABLE 10A.20

Table 10A.20 **Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)**

	<i>NSW (c)</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust (e)</i>
Number of people per pharmacy									
Urban									
2010	3 700	4 082	3 701	3 691	3 725	3 409	5 131	4 681	3 814
2011	3 677	4 031	3 615	3 699	3 725	3 248	5 051	4 681	3 777
2012	3 891	4 363	4 059	4 116	3 921	3 445	5 243	4 861	4 082
2013	3 855	4 319	4 065	4 066	3 775	3 440	4 952	4 254	4 034
2014 (f)	3 803	4 199	4 002	3 970	3 754	3 368	4 952	4 504	3 963
Rural									
2010	4 172	4 655	4 386	4 305	3 405	3 836	..	9 272	4 277
2011	4 232	4 462	4 037	4 021	3 269	3 694	..	8 500	4 108
2012	4 051	4 344	4 381	4 202	3 287	3 593	..	9 374	4 148
2013	3 811	4 077	3 904	3 776	3 332	3 288	..	8 898	3 887
2014 (f)	3 735	3 981	3 821	3 531	3 147	3 288	–	8 342	3 771
Number of pharmacies									
Urban									
2010	1 447	1 022	832	430	318	81	63	19	4 212
2011	1 456	1 035	852	429	318	85	64	19	4 258
2012	1 462	1 047	844	441	320	84	68	20	4 286
2013	1 546	1 082	887	455	347	93	72	18	4 500
2014	1 567	1 113	901	466	349	95	72	17	4 580
Rural									
2010	284	162	185	85	96	52	..	11	876
2011	280	169	201	91	100	54	..	12	908
2012	300	179	204	99	103	57	..	12	955
2013	248	165	183	101	85	53	–	15	851
2014	253	169	187	108	90	53	–	16	877
Number of approved GPs — Rural (g)									
2010	11	3	8	23	2	5	..	1	53
2011	9	1	6	17	2	3	..	1	39
2012	11	9	5	11	1	4	..	–	41
2013	10	1	5	11	1	5	..	..	33
2014	8	1	4	7	1	3	–	–	24
Number of approved hospitals — urban (h)									
Public									
2010	–	53	27	8	8	–	–	1	97
2011	–	53	27	10	8	3	–	1	102
2012	–	53	27	12	8	3	–	1	104
2013	1	52	30	12	10	4	..	1	110
2014	1	52	29	13	10	4	–	1	110

Table 10A.20 **Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)**

	NSW (c)	Vic (c)	Qld	WA	SA	Tas	ACT	NT (d)	Aust (e)
Private									
2010	23	26	21	5	4	1	3	1	84
2011	22	28	24	5	4	1	4	1	89
2012	22	29	25	5	4	1	4	1	91
2013	26	29	25	4	6	1	3	1	95
2014	31	28	26	3	9	2	4	1	104
Number of approved hospitals — rural (h) (i)									
Public									
2010	–	13	63	–	–	–	..	4	80
2011	–	16	20	6	–	1	..	4	47
2012	–	18	22	6	–	1	..	4	51
2013	..	16	20	6	3	..	..	4	49
2014	–	16	20	6	3	–	–	4	49

- (a) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2-6. The ACT has no rural PhARIA areas.
- (b) The estimated resident populations (ERP) used to derive rates in the early and latter parts of this time series are based on different ABS Censuses. Rates derived using ERPs based on different Censuses are not comparable.
- (c) For 2013, one public hospital in NSW is a campus of a Victorian hospital participating in the Pharmaceutical Reforms.
- (d) Care should be taken using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).
- (e) Includes other territories
- (f) 118 pharmacies were reclassified as urban at 30 June 2013. Those pharmacies were classified as rural at 30 June 2012.
- (g) GPs in urban areas are not able to demonstrate that they are practising in an area where there is no pharmacist approved and therefore the category 'Number of approved GPs — Urban' is not applicable.
- (h) PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.
- (i) There were no PBS approved private hospitals in rural areas in the years 2009 to 2013.
.. Not applicable. – Nil or rounded to zero.

Source: Department of Health unpublished, derived from Department of Human Services, ABS unpublished *2006/2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre.

Table 10A.21 PBS expenditure per person, by remoteness area (2013-14 dollars) (a), (b), (c), (d), (e)

	<i>Unit</i>	2012-13	2013-14
<i>Total expenditure</i>			
Major cities	\$m	4 807.2	4 924.3
Inner regional	\$m	1 536.8	1 573.5
Outer regional	\$m	687.3	697.7
Remote	\$m	68.3	69.9
Very remote	\$m	24.7	25.1
Australia (f)	\$m	7 126.5	7 292.6
<i>Expenditure per person</i>			
Major cities	\$	301.2	301.8
Inner regional	\$	370.3	373.1
Outer regional	\$	335.9	337.5
Remote	\$	213.4	216.5
Very remote	\$	118.0	119.8
Australia (f)	\$	314.2	315.2

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.
- (c) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth].) Expenditure on medications dispensed to remote and very remote areas under s.100 was \$36.9 million in 2012-13.
- (d) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.
- (e) Rates are derived using the final ABS 2011 Census based estimated resident population (ERP). Rates in this table use the 30 June ERP preceding the reference year and differ from rates reported in tables 10A.4 and 10A.5 which use the December 31 ERP for the reference year.
- (f) Data for Australia includes Other Territories and expenditure that could not be allocated to a remoteness area.

Source: Department of Health unpublished, PBS Statistics; ABS 2013, *Regional Population Growth, Australia, 2012*, Cat. no. 3218.0.

Table 10A.22 **PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2013-14 dollars) (a), (b), (c), (d)**

	2009-10	2010-11	2011-12
Capital city	331.8	323.4	326.2
Other metropolitan	379.1	373.6	376.7
Rural and remote	369.3	364.4	370.3
All locations	346.2	339.0	342.7

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.
- (c) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk under s.100 of the *National Health Act 1953* [Cwlth]).
- (d) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 10A.23 **Availability of GPs by region, 2013-14 (a), (b), (c), (d), (e), (f)**

	NSW (f)	Vic (g)	Qld	WA	SA (h)	Tas (h)	ACT (e)	NT (h)	Aust
Number of GPs									
Major cities	7 232	5 821	4 088	2 302	1 815	..	466	..	21 724
Inner regional	2 083	1 644	1 307	273	276	613	np	..	6 196
Outer regional	654	335	1 195	266	345	205	..	212	3 112
Remote	np	np	159	198	118	37	..	383	683
Very remote	np	..	221	153	np	np	..	np	686
Total	9 969	7 800	6 970	3 192	2 554	855	466	595	32 401
Number of full time workload equivalent GPs									
Major cities	5 997	4 470	3 103	1 519	1 320	..	277	..	16 686
Inner regional	1 522	1 116	962	183	161	329	np	..	4 273
Outer regional	408	242	670	158	206	137	..	107	1 890
Remote	np	np	47	67	51	10	..	68	226
Very remote	np	–	36	27	np	np	..	np	119
Total	7 927	5 828	4 818	1 953	1 739	476	277	175	23 194
Number of full time workload equivalent GPs per 100 000 people									
Major cities	109.1	101.7	107.4	78.6	107.6	..	72.5	..	102.2
Inner regional	106.5	101.8	101.9	80.1	88.8	97.8	np	..	101.3
Outer regional	84.3	96.7	97.9	84.0	102.1	82.8	..	78.9	91.4
Remote	np	np	58.8	64.6	84.5	90.0	..	136.9	69.9
Very remote	np	..	60.6	40.5	np	np	..	np	56.9
Total	107.0	101.5	103.5	77.5	104.1	92.8	72.5	72.9	100.3

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which are based on a different classification.

(b) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.

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

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

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

(f) For NSW, remote and very remote area data are not reported for confidentiality reasons, but are included in outer regional area data.

(g) For Victoria, remote area data are not reported for confidentiality reasons, but are included in outer regional data.

(h) For SA, Tasmania and the NT, very remote area data are not reported for confidentiality reasons, but are included in remote area data.

(i) For the ACT, inner regional area data are not reported for confidentiality reasons, but are included in major cities data.

.. Not applicable. np Not published.

Table 10A.23 **Availability of GPs by region, 2013-14 (a), (b), (c), (d), (e), (f)**

	<i>NSW (f)</i>	<i>Vic (g)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (h)</i>	<i>Tas (h)</i>	<i>ACT (e)</i>	<i>NT (h)</i>	<i>Aust</i>
--	----------------	----------------	------------	-----------	---------------	----------------	----------------	---------------	-------------

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.24

Table 10A.24 **Availability of GPs by region, 2004-05 to 2011-12 (a), (b), (c), (d)**

	<i>NSW (e)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
Number of GPs									
Urban									
2004-05	6 266	4 413	2 794	1 620	1 443	308	np	127	16 971
2005-06	6 327	4 437	2 846	1 651	1 469	317	np	113	17 160
2006-07	6 412	4 508	2 884	1 698	1 463	313	np	116	17 394
2007-08	6 047	4 598	2 978	1 717	1 503	328	383	121	17 675
2008-09	6 184	4 738	3 142	1 797	1 550	340	385	139	18 275
2009-10	6 349	4 896	3 272	1 803	1 568	349	398	142	18 777
2010-11	6 530	5 043	3 340	1 826	1 592	346	416	160	19 253
2011-12	6 725	5 305	3 544	1 895	1 644	362	440	153	20 068
Rural									
2004-05	1 699	1 308	1 850	555	501	301	..	193	6 407
2005-06	1 762	1 365	1 947	589	511	308	..	192	6 674
2006-07	1 816	1 406	1 980	612	527	329	..	208	6 878
2007-08	1 887	1 464	2 074	640	596	333	..	234	7 228
2008-09	1 921	1 502	2 198	661	591	339	..	239	7 451
2009-10	2 040	1 553	2 292	689	633	355	..	274	7 836
2010-11	2 124	1 667	2 464	788	661	373	..	303	8 380
2011-12	2 273	1 728	2 655	849	704	408	..	326	8 943
Number of full time workload equivalent GPs									
Urban									
2004-05	5 227	3 242	2 026	1 121	1 027	166	np	47	12 856
2005-06	5 283	3 335	2 105	1 132	1 060	171	np	48	13 135
2006-07	5 427	3 426	2 171	1 142	1 071	173	np	50	13 459
2007-08	5 274	3 551	2 241	1 166	1 080	179	232	54	13 778
2008-09	5 411	3 662	2 357	1 186	1 118	179	235	56	14 204
2009-10	5 461	3 788	2 459	1 216	1 149	185	238	62	14 558
2010-11	5 567	3 897	2 518	1 222	1 166	186	239	66	14 861
2011-12	5 748	4 059	2 686	1 259	1 204	195	250	73	15 474
Rural									
2004-05	1 195	925	1 363	336	337	212	..	49	4 416
2005-06	1 234	948	1 384	341	343	215	..	48	4 514
2006-07	1 283	981	1 393	358	345	218	..	54	4 632
2007-08	1 327	1 033	1 441	376	375	222	..	61	4 835
2008-09	1 381	1 076	1 504	388	393	225	..	60	5 027
2009-10	1 431	1 113	1 534	399	397	232	..	65	5 171
2010-11	1 500	1 166	1 599	417	404	243	..	67	5 397
2011-12	1 590	1 211	1 658	439	424	254	..	69	5 645
Number of full time workload equivalent GPs per 100 000 people									
Urban									
2004-05	95.2	85.4	84.0	75.7	90.1	83.7	np	53.6	88.0

Table 10A.24 **Availability of GPs by region, 2004-05 to 2011-12 (a), (b), (c), (d)**

	NSW (e)	Vic	Qld	WA	SA	Tas	ACT (e)	NT	Aust
2005-06	95.6	87.0	85.5	75.3	92.5	86.0	np	54.4	89.0
2006-07	97.2	87.3	85.4	73.9	91.5	86.0	np	53.7	89.4
2007-08	99.6	89.0	86.0	73.6	91.2	88.3	67.5	57.1	90.0
2008-09	100.4	89.6	87.9	72.2	93.2	87.3	67.2	58.0	90.7
2009-10	99.0	90.3	89.0	71.7	94.5	89.4	66.7	61.8	90.7
2010-11	99.9	91.7	90.1	71.0	95.0	89.0	65.6	66.4	91.5
2011-12	103.2	95.5	96.1	73.2	98.1	93.6	68.8	73.1	95.3
Rural									
2004-05	73.6	74.8	88.1	63.0	83.9	73.9	..	42.4	76.9
2005-06	75.5	76.0	87.6	62.9	85.0	74.4	..	41.0	77.7
2006-07	77.8	76.8	85.4	64.3	83.7	74.6	..	44.3	78.0
2007-08	79.7	79.6	86.2	65.8	89.9	75.5	..	49.1	80.0
2008-09	81.6	80.9	87.5	65.5	93.1	75.6	..	46.9	81.3
2009-10	82.6	81.5	86.5	65.2	92.8	77.1	..	49.5	81.5
2010-11	85.7	84.3	89.1	67.3	93.4	80.4	..	51.1	84.1
2011-12	90.9	87.6	92.4	70.9	98.1	83.8	..	52.1	88.0

- (a) Geographical locations are based on the 1994 Rural, Remote and Metropolitan Areas 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) Data are not comparable with data from 2012-13, for which geographical location is based on the Australian Statistical Geography Standard 2011 (ASGS) classification.
- (c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).
- (d) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (e) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (f) From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.
- .. Not applicable. **np** Not published.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.25

Table 10A.25 **Availability of female GPs (a), (b), (c), (d)**

	<i>Unit</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>
Female GPs										
2004-05	no.	2 751	2 116	1 717	801	671	243	180	151	8 630
2005-06	no.	2 853	2 168	1 799	828	703	254	183	132	8 920
2006-07	no.	2 958	2 247	1 850	877	718	270	181	151	9 252
2007-08	no.	3 010	2 359	1 955	898	775	277	191	171	9 636
2008-09	no.	3 142	2 446	2 117	987	809	294	192	184	10 171
2009-10	no.	3 323	2 569	2 230	1 016	828	306	192	193	10 657
2010-11	no.	3 520	2 720	2 327	1 089	872	318	216	220	11 282
2011-12	no.	3 736	2 925	2 553	1 134	925	357	230	235	12 095
2012-13	no.	4 014	3 071	2 797	1 241	985	368	238	287	13 001
2013-14	no.	4 302	3 366	2 987	1 369	1 058	388	251	292	14 013
Female FWE GPs										
2004-05	no.	1 679	1 096	923	382	329	114	73	38	4 633
2005-06	no.	1 729	1 158	968	394	335	122	76	34	4 815
2006-07	no.	1 822	1 232	1 010	410	348	125	82	37	5 065
2007-08	no.	1 916	1 312	1 083	426	371	131	85	45	5 369
2008-09	no.	2 003	1 389	1 178	455	401	136	87	48	5 697
2009-10	no.	2 087	1 468	1 232	482	423	142	87	54	5 976
2010-11	no.	2 219	1 538	1 299	499	430	147	96	56	6 285
2011-12	no.	2 362	1 643	1 406	512	459	154	104	62	6 702
2012-13	no.	2 519	1 781	1 516	544	481	162	110	66	7 180
2013-14	no.	2 710	1 933	1 633	626	507	171	118	72	7 770
Female FWE GPs as a proportion of all FWE GPs										
2004-05	%	27.0	26.3	27.2	26.2	24.1	30.2	36.3	40.3	26.8
2005-06	%	27.4	27.0	27.7	26.8	23.8	31.5	36.5	34.8	27.3
2006-07	%	28.1	28.0	28.3	27.3	24.6	31.9	36.1	35.4	28.0

TABLE 10A.25

Table 10A.25 **Availability of female GPs (a), (b), (c), (d)**

	<i>Unit</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>
2007-08	%	29.0	28.6	29.4	27.6	25.5	32.7	36.4	38.8	28.8
2008-09	%	29.5	29.3	30.5	28.9	26.5	33.7	37.0	41.3	29.6
2009-10	%	30.3	30.0	30.8	29.9	27.4	34.1	36.6	42.7	30.3
2010-11	%	31.4	30.4	31.5	30.5	27.4	34.3	40.1	42.2	31.0
2011-12	%	32.2	31.2	32.4	30.2	28.2	34.3	41.3	43.7	31.7
2012-13	%	33.2	32.1	33.2	30.2	28.6	34.9	40.5	41.7	32.5
2013-14	%	34.2	33.2	33.9	32.0	29.2	36.0	42.6	41.0	33.5
Female FWE GPs										
2004-05	per 100 000 females	49.2	43.0	46.5	38.0	42.3	46.4	44.2	40.1	45.3
2005-06	per 100 000 females	50.3	44.7	47.2	38.6	42.1	49.0	44.9	33.2	46.2
2006-07	per 100 000 females	52.3	46.7	48.1	39.2	43.3	49.9	47.4	35.4	47.8
2007-08	per 100 000 females	54.4	48.9	50.4	39.7	45.7	52.1	48.6	42.4	49.8
2008-09	per 100 000 females	55.7	50.6	53.2	41.1	48.8	53.3	49.2	44.0	51.7
2009-10	per 100 000 females	57.1	52.4	54.3	42.5	50.9	55.2	48.5	48.7	53.2
2010-11	per 100 000 females	60.1	54.2	56.6	43.3	51.2	56.8	52.3	50.6	55.2
2011-12	per 100 000 females	64.7	58.3	62.1	43.2	55.2	60.0	55.5	56.1	59.3
2012-13	per 100 000 females	68.1	62.1	65.6	44.5	57.4	63.0	57.9	58.4	62.4
2013-14	per 100 000 females	72.1	66.1	69.4	49.6	60.0	66.4	61.0	62.7	66.3

- (a) From 2011-12, rates are computed by the Secretariat using first preliminary December 31 female ERP based on the 2011 Census. Rates for previous years are derived using ERPs based on the 2001 and 2006 Censuses. Rates derived using ERPs based on different Censuses are not comparable.
- (b) FWE is calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (c) GP and FWE numbers include vocationally registered GPs and other medical practitioners.
- (d) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.26

Table 10A.26 **Availability of male GPs (a), (b), (c), (d)**

	<i>Unit</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>
Male GPs										
2009-10	no.	5 064	3 881	3 336	1 475	1 375	398	206	221	15 956
2010-11	no.	5 134	3 990	3 483	1 525	1 381	401	200	243	16 357
2011-12	no.	5 262	4 108	3 646	1 610	1 423	413	210	244	16 916
2012-13	no.	5 413	4 273	3 832	1 732	1 463	442	232	293	17 680
2013-14	no.	5 667	4 434	3 983	1 823	1 496	467	215	303	18 388
Male FWE GPs										
2009-10	no.	4 806	3 433	2 762	1 132	1 123	275	151	72	13 754
2010-11	no.	4 847	3 525	2 828	1 140	1 140	282	143	77	13 982
2011-12	no.	4 976	3 627	2 937	1 186	1 169	295	147	80	14 417
2012-13	no.	5 074	3 762	3 056	1 259	1 199	302	162	92	14 906
2013-14	no.	5 217	3 895	3 186	1 328	1 231	305	159	104	15 424
Male FWE GPs as a proportion of all FWE GPs										
2009-10	%	69.7	70.1	69.2	70.1	72.6	66.0	63.4	56.7	69.7
2010-11	%	68.6	69.6	68.5	69.5	72.6	65.7	59.9	57.8	69.0
2011-12	%	67.8	68.8	67.6	69.8	71.8	65.7	58.7	56.3	68.3
2012-13	%	66.8	67.9	66.8	69.8	71.4	65.1	59.5	58.3	67.5
2013-14	%	65.8	66.8	66.1	68.0	70.8	64.0	57.4	59.0	66.5
Male FWE GPs										
2009-10	per 100 000 males	136.3	127.8	126.6	99.2	140.2	109.6	84.9	60.1	126.3
2010-11	per 100 000 males	136.0	129.5	127.7	97.6	141.0	111.1	78.9	63.9	126.7
2011-12	per 100 000 males	138.4	131.6	130.6	98.7	143.6	115.8	79.7	65.4	129.0
2012-13	per 100 000 males	139.1	133.9	132.8	100.8	145.7	118.2	85.7	73.8	130.7
2013-14	per 100 000 males	140.8	135.9	136.3	102.9	148.1	119.1	83.2	81.0	132.9

(a) Rates are computed by the Secretariat using the (first released) preliminary December 31 male ERP based on the 2011 Census.

Table 10A.26 **Availability of male GPs (a), (b), (c), (d)**

<i>Unit</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>
(b)	FWE is calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.								
(c)	GP and FWE numbers include vocationally registered GPs and other medical practitioners.								
(d)	GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.								

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.27

Table 10A.27 Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g)</i>	<i>ACT (g)</i>	<i>NT (g)</i>	<i>Aust (i)</i>
FTE dentists per 100 000 population (h)									
2009									
Major cities	7.7	7.6	11.1	7.5	11.8	..	9.5	..	8.6
Inner regional	4.9	4.9	8.6	6.1	5.4	7.6	–	..	6.0
Outer regional	3.9	4.7	8.3	4.0	2.1	1.8	..	16.6	5.9
Remote and very remote	3.2	–	9.9	10.9	2.0	–	..	6.2	7.7
Total	6.9	6.9	10.1	7.2	9.5	5.5	9.5	12.0	7.8
2010									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
2011									
Major cities	4.8	4.8	6.4	5.7	8.7	..	7.1	..	5.6
Inner regional	3.6	4.8	6.6	5.4	4.1	5.4	–	..	4.8
Outer regional	2.0	4.2	7.5	3.5	4.9	0.5	..	13.2	5.1
Remote/very remote	1.9	–	1.5	10.1	5.0	–	..	9.1	6.1
Total (i)	4.4	4.7	6.5	5.8	7.6	3.7	7.1	11.3	5.4
2012 (d), (j)									
Major cities	5.6	4.5	5.6	5.9	6.4	..	6.9	..	5.5
Inner regional	4.4	3.3	6.0	4.5	2.4	5.4	–	..	4.5
Outer regional	1.9	3.1	7.9	3.0	4.5	0.7	..	8.2	4.7
Remote/very remote	1.8	–	3.3	6.2	3.0	..	..	7.9	5.0
Total (i)	5.1	4.2	6.0	5.6	5.7	4.0	6.9	8.1	5.2
2013 (j)									

TABLE 10A.27

Table 10A.27 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g)</i>	<i>ACT (g)</i>	<i>NT (g)</i>	<i>Aust (i)</i>
Major cities	7.3	6.3	7.9	7.6	9.6	..	4.7	..	7.3
Inner regional	5.2	5.8	7.6	5.7	4.1	8.7	np	..	6.2
Outer regional	2.8	5.8	12.2	3.6	6.9	0.7	..	10.7	7.1
Remote/very remote	7.9	–	7.2	8.8	–	..	..	9.0	7.1
Total (i)	6.6	6.2	8.5	7.2	8.3	5.9	5.0	10.0	7.1

FTE = Full Time Equivalent

- (a) Data include dentists working in the public sector only – in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. Dentists who work in both the public and private sectors are not included.
- (b) From 2012, allocation to public sector is based on clinical hours worked. For 2011 and previous years, allocation to public sector is based on total hours worked.
- (c) Data are not available for 2010.
- (d) From 2011, allocation to State or Territory and to region is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated'.
- (e) Remoteness areas for 2011 and previous years are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS 2006 Census of population and housing. Data for 2012 are revised to remoteness areas defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing. Data for 2012 may differ to previous reports in which the 2006 Census based ASGC was used.
- (f) Remote/very remote includes Migratory areas.
- (g) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.
- (h) FTE based on a 40-hour week.
- (i) Total includes remoteness area 'unstated'.
- (j) Data for 2012 and 2013 exclude provisional registrants.

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

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.28

Table 10A.28 Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
2009 (g), (i)									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.2	–	0.2	0.6	0.7	..	0.5	..	0.2
Inner regional	–	–	–	–	–	–	–	..	..
Outer regional	0.1	–	0.5	–	–	–	..	1.4	0.2
Remote and very remote	0.8	–	–	–	–	–	..	–	..
Total (k)	0.1	–	0.2	0.4	0.5	–	0.5	0.8	0.2
FTE dental therapists per 100 000 population (k)									
Major cities	2.0	–	6.4	6.5	5.5	..	3.4	..	3.0
Inner regional	5.3	–	9.3	7.3	6.4	6.6	–	..	5.1
Outer regional	3.2	–	8.8	6.6	7.1	11.1	..	6.1	6.1
Remote and very remote	5.6	–	4.1	3.7	3.4	–	..	8.9	5.0
Total (k)	2.8	–	7.3	6.4	5.7	8.0	3.4	7.4	3.8
2010									
FTE dental hygienists per 100 000 population (k)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
FTE dental therapists per 100 000 population (k)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na

TABLE 10A.28

Table 10A.28 Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
2011									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.1	–	0.1	0.6	0.6	..	0.3	..	0.2
Inner regional	–	–	–	–	–	–	–	..	–
Outer regional	–	0.2	0.1	–	–	–	..	–	0.1
Remote/very remote	–	–	–	–	–	–	..	–	–
Total (l)	0.1	–	0.1	0.5	0.5	–	0.3	–	0.1
FTE dental therapists per 100 000 population (k)									
Major cities	1.7	1.3	5.2	4.9	3.8	..	2.5	..	2.8
Inner regional	3.4	2.3	6.8	7.9	8.8	6.6	–	..	4.6
Outer regional	2.5	1.6	6.0	8.4	6.1	9.1	..	9.4	5.4
Remote and very remote	2.6	–	4.0	7.0	6.5	–	..	4.5	5.1
Total (l)	2.1	1.5	5.6	5.6	4.8	7.2	2.5	7.6	3.4
2012 (e), (m)									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.2	0.1	0.1	0.4	0.8	..	0.2	..	0.2
Inner regional	0.1	–	–	–	–	–	–	..	–
Outer regional	–	0.3	0.1	–	–	–	..	–	0.1
Remote and very remote	–	–	–	–	–	–	..	1.3	0.3
Total (l)	0.1	0.1	0.1	0.3	0.6	–	0.2	0.6	0.2
FTE dental therapists per 100 000 population (k)									
Major cities	1.7	1.4	5.1	5.2	4.0	..	2.7	..	2.8
Inner regional	3.7	2.3	6.2	5.8	4.9	6.0	np	..	4.3
Outer regional	2.8	0.9	6.3	7.9	8.6	6.0	..	8.9	5.4
Remote/very remote	–	–	3.2	4.0	4.9	12.1	..	5.6	4.2
Total (l)	2.1	1.5	5.4	5.4	4.7	6.1	2.9	7.5	3.3

TABLE 10A.28

Table 10A.28 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
2013 (m)									
FTE dental hygienists per 100 000 population (k)									
Major cities	0.1	–	–	0.4	0.5	..	–	..	0.1
Inner regional	–	0.1	–	–	–	–	–	..	–
Outer regional	–	–	–	–	0.4	–	..	0.4	0.1
Remote/very remote	0.3	–	–	–	–	–	..	–	–
Total (l)	0.1	0.1	–	0.3	0.4	–	–	0.2	0.1
FTE dental therapists per 100 000 population (k)									
Major cities	1.9	2.2	4.8	5.3	4.7	..	4.3	..	3.1
Inner regional	3.8	2.1	6.6	6.4	6.5	7.9	–	..	4.6
Outer regional	2.7	2.6	6.5	7.1	9.4	8.1	..	8.7	5.8
Remote/very remote	–	–	4.4	4.4	5.5	7.1	..	7.0	4.7
Total (l)	2.3	2.2	5.4	5.5	5.5	8.0	4.3	7.9	3.7

FTE = Full Time Equivalent

- (a) Dual registered practitioners (practitioners registered as both dental therapists and dental hygienists) are included in dental therapists data and not in dental hygienists data.
- (b) Data include professionals working in the public sector only — in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and “other public” areas. Professionals who work in both the public and private sectors are not included.
- (c) From 2012, allocation to public sector is based on clinical hours worked. For 2011 and previous years, allocation to public sector is based on total hours worked.
- (d) Data are not available for 2010.
- (e) From 2011, allocation to State or Territory and region is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated'.
- (f) Remoteness areas for 2011 and previous years are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS 2006 Census of population and housing. Data for 2012 are revised to remoteness areas defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing. Data for 2012 may differ to previous reports in which the 2006 Census based ASGC was used.

Table 10A.28 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic (h)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (i)</i>	<i>ACT (i)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
--	------------	----------------	------------	-----------	-----------	----------------	----------------	---------------	-----------------

(g) Remote/very remote includes Migratory areas.

(h) Data are not available for Victoria for 2009 due to changes in Victoria's data collection form.

(i) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.

(j) 2009 data for Australia exclude data for Victoria.

(k) FTE based on a 40-hour week.

(l) Total includes remoteness area 'unstated'.

(m) Data from 2012 exclude provisional registrants.

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

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.29

Table 10A.29 Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld (g)	WA (g)	SA (g)	Tas (h)	ACT (h)	NT (h)	Aust
2011									
FTE psychologists per 100 000 population (i)									
Major cities	35.9	29.7	27.7	37.9	24.7	..	68.3	..	32.9
Inner regional	26.3	14.9	19.6	15.5	6.2	31.6	–	..	20.6
Outer regional	18.2	7.4	25.7	20.9	5.1	11.2	..	43.5	19.5
Remote and very remote	17.5	–	10.5	20.9	5.6	–	..	18.2	14.9
Total (j)	32.0	24.9	24.1	30.2	19.2	24.0	65.8	31.1	28.9
2012 (e), (m)									
FTE occupational therapists per 100 000 population (i)									
Major cities	23.6	29.6	na	na	na	..	np	..	16.6
Inner regional	21.9	26.9	na	na	na	np	np	..	16.3
Outer regional	np	21.5	na	na	na	np	..	33.7	8.2
Remote and very remote	np	–	na	na	na	np	..	14.2	3.8
Total	22.5	28.8	na	na	na	18.8	27.2	25.1	15.5
FTE psychologists per 100 000 population (i)									
Major cities	26.6	19.3	19.2	24.0	18.1	..	41.5	..	22.7
Inner regional	21.9	12.1	13.9	11.0	4.7	29.5	–	..	16.8
Outer regional	13.3	5.3	17.8	14.7	np	np	..	34.8	14.0
Remote/very remote	10.1	–	12.2	15.2	np	np	..	11.5	11.9
Total (j)	24.8	17.3	17.7	21.4	14.3	23.2	41.4	25.8	20.6
2013 (m)									
FTE occupational therapists per 100 000 population (i)									
Major cities	23.8	30.4	25.0	28.2	31.9	..	26.6	..	27.0
Inner regional	23.0	28.4	17.7	16.7	17.0	28.9	–	..	23.0
Outer regional	np	21.2	27.7	24.2	20.1	np	..	34.9	22.0
Remote/very remote	np	–	15.5	15.2	18.6	np	..	15.4	14.5

TABLE 10A.29

Table 10A.29 **Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f)**

	NSW	Vic	Qld (g)	WA (g)	SA (g)	Tas (h)	ACT (h)	NT (h)	Aust
Total (j)	23.0	29.6	23.7	25.9	28.3	22.4	26.6	26.3	25.5
FTE psychologists per 100 000 population (i)									
Major cities	39.4	32.6	27.8	37.8	np	..	np	..	35.1
Inner regional	30.6	22.1	20.0	17.4	np	34.3	np	..	24.6
Outer regional	20.2	7.2	28.2	19.8	np	np	..	48.7	21.1
Remote/very remote	22.2	–	8.3	18.2	np	np	..	22.1	15.0
Total (j)	36.4	29.6	25.7	33.3	21.4	27.3	71.0	37.1	31.5

FTE = Full Time Equivalent

- (a) Data are for professionals working in the public sector. For Occupational Therapists, data are based on clinical hours worked in the public sector. For Psychologists:
- data for 2011 are based on total hours worked
 - data for 2012 are based on clinical hours worked in the public sector
 - data for 2013 are based on hours worked in a direct client service role in the public sector.
- (b) Data exclude provisional registrants.
- (c) Occupational therapists joined the National Registration and Accreditation Scheme (NRAS) 1 July 2012. Hence, data are not available for previous years.
- (d) Remoteness areas are defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing.
- (e) Allocation to State or Territory and region is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated'.
- (f) Remote/very remote includes Migratory areas.
- (g) Occupational therapist workforce data are not available for 2012 for Queensland, WA or SA. Due to transitional arrangements to the National Registration and Accreditation Scheme, many occupational therapists were not required to renew their registration and so did not complete a workforce survey.
- (h) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.
- (i) FTE based on a 38-hour week.
- (j) Total includes remoteness area 'unstated', with the exception of 2012 data for occupational therapists.
- na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</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>
2008-09										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (h)	no.	17 726	3 868	13 432	6 329	2 994	2 168	286	5 133	51 967
Proportion of target population assessed	%	8.3	6.9	11.5	12.6	4.7	1.1	8.4	19.3	10.1
Non-Indigenous older people										
Number of people assessed (i)	no.	111 344	73 138	62 716	21 998	27 423	9 486	2 430	283	308 818
Target population (j)	no.	457 989	343 315	232 677	116 062	120 952	34 610	15 362	2 521	1 323 516
Proportion of target population assessed	%	24.3	21.3	27.0	19.0	22.7	27.4	15.8	11.2	23.3
2009-10										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population (h)	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion of target population assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
Non-Indigenous older people										
Number of people assessed (i)	no.	116 756	77 946	65 087	24 451	28 049	9 151	2 724	292	324 456
Target population (j)	no.	467 220	350 473	237 999	119 044	122 469	35 271	15 843	2 666	1 351 013
Proportion of target population assessed	%	25.0	22.2	27.3	20.5	22.9	25.9	17.2	11.0	24.0
2010-11										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465
Target population (h)	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</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>
Proportion of target population assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
Non-Indigenous older people										
Number of people assessed (i)	no.	130 114	90 493	74 576	29 865	31 394	10 976	3 169	302	370 889
Target population (j)	no.	478 253	358 105	244 178	122 815	123 854	35 826	16 360	2 825	1 382 248
Proportion of target population assessed	%	27.2	25.3	30.5	24.3	25.3	30.6	19.4	10.7	26.8
2011-12										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population (h)	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion of target population assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
Non-Indigenous older people										
Number of people assessed (i)	no.	137 445	96 176	79 933	31 879	32 887	11 499	3 271	314	393 404
Target population (j)	no.	487 126	365 944	250 898	126 677	125 660	36 643	16 919	3 023	1 412 742
Proportion of target population assessed	%	28.2	26.3	31.9	25.2	26.2	31.4	19.3	10.4	27.8
2012-13										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727
Target population (h)	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion of target population assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
Non-Indigenous older people										
Number of people assessed (i)	no.	146 182	101 897	87 240	35 745	35 332	12 887	3 818	373	423 474

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</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>
Target population (j)	no.	499 610	375 719	258 431	130 987	127 857	37 541	17 635	3 268	1 450 718
Proportion of target population assessed	%	29.3	27.1	33.8	27.3	27.6	34.3	21.7	11.4	29.2
2013-14										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	6 523	844	6 768	2 787	798	365	101	2 695	20 881
Target population (h)	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion of target population assessed	%	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4
Non-Indigenous older people										
Number of people assessed (i)	no.	156 390	111 656	94 872	41 535	39 648	13 741	4 265	547	462 654
Target population (j)	no.	510 562	385 295	266 773	135 602	130 089	38 318	18 316	3 481	1 488 095
Proportion of target population assessed	%	30.6	29.0	35.6	30.6	30.5	35.9	23.3	15.7	31.1

- (a) Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.
- (b) Indigenous status is determined by self-identification. Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander people.
- (c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data for Aboriginal and Torres Strait Islander Australians are therefore likely to understate the proportion who access health assessments.
- (d) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (f) Rates have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.

Table 10A.30 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</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>
(g)	Includes claims for MBS items 704, 706 and 715, for Aboriginal and Torres Strait Islander people aged 55 years or over.									
(h)	Derived population of Aboriginal and Torres Strait Islander people aged 55 years or over at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.									
(i)	Includes claims for MBS items 700, 702, 701, 703, 705 and 707, for people aged 75 years or over.									
(j)	Estimated population of non-Indigenous people aged 75 years or over as at 31 December, computed by subtracting the derived population of Aboriginal and Torres Strait Islander people aged 75 or over (see footnote (h)) from the December 31 ERP for all Australians aged 75 years or over. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Aboriginal and Torres Strait Islander population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.									

Source: Department of Health unpublished, MBS data collection; ABS various years, *Australian Demographic Statistics*, Cat. no. 3201.0; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.31

Table 10A.31 **Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</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 (g)</i>
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	16 856	3 666	12 669	5 996	2 870	2 066	247	4 923	49 324
Proportion of target population assessed	%	6.8	7.5	10.0	10.3	4.4	0.3	4.0	17.4	8.7
2008-09										
Number of people assessed	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population	no.	17 726	3 868	13 432	6 329	2 994	2 168	286	5 133	51 967
Proportion of target population assessed	%	8.3	6.9	11.5	12.6	4.7	1.1	8.4	19.3	10.1
2009-10										
Number of people assessed	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion of target population assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
2010-11										
Number of people assessed	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465
Target population	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868
Proportion of target population assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
2011-12										
Number of people assessed	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion of target population assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
2012-13										
Number of people assessed	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727

Table 10A.31 Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</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 (g)</i>
Target population	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion of target population assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
2013-14										
Number of people assessed	no.	6 523	844	6 768	2 787	798	365	101	2 695	20 881
Target population	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion of target population assessed	%	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4

- (a) Older Aboriginal and Torres Strait Islander people are defined as aged 55 years or over, excluding people living in residential aged care facilities.
- (b) Includes claims for MBS items 704, 706 and 715 for Aboriginal and Torres Strait Islander people aged 55 years or over. Indigenous status is determined by self-identification. Aboriginal and Torres Strait Islander people aged 75 years or over may have received a health assessment available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander people .
- (c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.
- (d) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (f) Target population is the derived population of Aboriginal and Torres Strait Islander people aged 55 years of over at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.
- (g) Includes Other Territories.

Source: Department of Health unpublished, MBS data collection; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

<i>Unit</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 (e)</i>
2009-10										
Children 0–14 years (f)										
Children assessed	no.	4 159	841	5 913	2 403	392	73	62	2 808	16 651
Target population	no.	75 637	16 552	69 806	30 913	12 846	8 582	1 974	22 764	239 157
Proportion assessed	%	5.5	5.1	8.5	7.8	3.1	0.9	3.1	12.3	7.0
Adults 15–54 years										
People assessed	no.	9 633	1 981	12 639	6 095	1 101	193	202	8 035	39 879
Target population	no.	108 367	24 656	98 192	48 429	20 142	12 605	3 508	39 892	355 929
Proportion assessed	%	8.9	8.0	12.9	12.6	5.5	1.5	5.8	20.1	11.2
Adults 55 years or over										
People assessed	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
2010-11										
Children 0–14 years (f)										
Children assessed	no.	6 046	801	8 349	2 371	476	112	68	3 933	22 156
Target population	no.	75 671	16 789	70 518	30 932	13 013	8 629	1 987	22 616	240 239
Proportion assessed	%	8.0	4.8	11.8	7.7	3.7	1.3	3.4	17.4	9.2
Adults 15–54 years										
People assessed	no.	11 073	1 614	11 844	5 020	1 325	315	150	6 599	37 940
Target population	no.	111 226	25 545	101 122	49 543	20 673	12 912	3 680	40 361	365 202
Proportion assessed	%	10.0	6.3	11.7	10.1	6.4	2.4	4.1	16.4	10.4
Adults 55 years or over										
People assessed	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</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 (e)</i>
Target population	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868
Proportion assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
2011-12										
Children 0–14 years										
Children assessed	no.	8 520	1 150	12 133	2 436	800	137	197	5 270	30 643
Target population	no.	75 697	17 008	71 105	30 934	13 123	8 669	2 007	22 513	241 139
Proportion assessed	%	11.3	6.8	17.1	7.9	6.1	1.6	9.8	23.4	12.7
Adults 15–54 years										
People assessed	no.	14 933	2 148	18 475	5 355	1 767	449	286	7 229	50 642
Target population	no.	114 004	26 419	104 124	50 694	21 205	13 250	3 819	40 967	374 626
Proportion assessed	%	13.1	8.1	17.7	10.6	8.3	3.4	7.5	17.6	13.5
Adults 55 years or over										
People assessed	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
2012-13										
Children 0–14 years										
Children assessed	no.	10 733	1 570	15 197	3 959	1 003	234	214	5 598	38 508
Target population	no.	75 863	17 171	71 812	31 038	13 205	8 733	2 006	22 498	242 410
Proportion assessed	%	14.1	9.1	21.2	12.8	7.6	2.7	10.7	24.9	15.9
Adults 15–54 years										
People assessed	no.	17 762	2 717	22 585	8 597	2 342	664	448	9 202	64 317
Target population	no.	116 702	27 292	107 067	51 912	21 734	13 598	3 961	41 703	384 118
Proportion assessed	%	15.2	10.0	21.1	16.6	10.8	4.9	11.3	22.1	16.7

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</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 (e)</i>
Adults 55 years or over										
People assessed	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727
Target population	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
2013-14										
Children 0–14 years										
Children assessed	no.	13 072	1 908	18 204	5 161	1 527	236	211	6 587	46 906
Target population	no.	76 189	17 360	72 773	31 147	13 311	8 823	2 019	22 487	244 192
Proportion assessed	%	17.2	11.0	25.0	16.6	11.5	2.7	10.5	29.3	19.2
Adults 15–54 years										
People assessed	no.	21 373	3 535	26 639	10 967	3 357	845	492	10 819	78 027
Target population	no.	119 324	28 149	109 829	53 172	22 250	13 909	4 099	42 416	393 298
Proportion assessed	%	17.9	12.6	24.3	20.6	15.1	6.1	12.0	25.5	19.8
Adults 55 years or over										
People assessed	no.	6 523	844	6 768	2 787	798	365	101	2 695	20 881
Target population	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion assessed	%	28.1	17.4	37.5	32.7	20.8	12.9	20.4	39.8	30.4

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

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

(c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

<i>Unit</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 (e)</i>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-----------------

(d) Target population is the derived population of Aboriginal and Torres Strait Islander people in the age group at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.

(e) Includes Other Territories.

Source: Department of Health unpublished, MBS data collection; ABS various years, *Australian Demographic Statistics*, Cat. no. 3201.0; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.33

Table 10A.33 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
2009-10										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	%	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (h)	%	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Total	%	20.6	6.9	28.5	16.3	10.5	19.2	12.3	29.2	17.8
2010-11										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	%	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (h)	%	25.7	7.1	34.4	16.3	12.5	22.8	12.8	31.2	20.7
Total	%	26.3	7.3	35.2	17.5	12.7	21.5	12.8	44.6	21.7
2011-12 (a), (i)										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	no.	2 326	338	3 198	774	204	47	61	1 367	8 315
Target population (e)	no.	5 173	1 188	4 897	2 150	883	609	123	1 545	16 559
Proportion of target population assessed	%	45.0	28.5	65.3	36.0	23.1	7.7	49.8	88.5	50.2
Healthy Kids Check (h)	no.	46 372	16 885	37 595	12 480	7 201	3 219	1 218	805	125 775
Target population (e)	no.	88 936	69 237	56 498	29 660	18 731	5 844	4 543	2 107	275 592
Proportion of target population assessed	%	52.1	24.4	66.5	42.1	38.4	55.1	26.8	38.2	45.6
Total	no.	48 698	17 223	40 793	13 254	7 405	3 266	1 279	2 172	134 090
Target population	no.	94 109	70 425	61 394	31 810	19 614	6 453	4 666	3 652	292 151
Proportion of target population assessed	%	51.7	24.5	66.4	41.7	37.8	50.6	27.4	59.5	45.9

TABLE 10A.33

Table 10A.33 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
2012-13 (a), (j)										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	no.	2 864	403	3 791	1 106	271	64	48	1 489	10 036
Target population (e)	no.	5 106	1 199	5 050	2 118	917	642	130	1 500	16 664
Proportion of target population assessed	%	56.1	33.6	75.1	52.2	29.6	10.0	37.1	99.3	60.2
Healthy Kids Check (h)	no.	56 223	21 201	42 969	14 021	9 502	3 668	1 823	931	150 338
Target population (e)	no.	90 363	70 506	58 037	30 663	19 013	5 856	4 755	2 162	281 380
Proportion of target population assessed	%	62.2	30.1	74.0	45.7	50.0	62.6	38.3	43.1	53.4
Total	no.	59 087	21 605	46 767	15 130	9 773	3 732	1 871	2 439	160 404
Target population	no.	95 469	71 705	63 087	32 781	19 929	6 497	4 885	3 662	298 044
Proportion of target population assessed	%	61.9	30.1	74.1	46.2	49.0	57.4	38.3	66.6	53.8
2013-14 (a), (j)										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	no.	3 206	471	4 397	1 290	354	42	57	1 714	11 531
Target population (e)	no.	5 182	1 191	5 131	2 103	919	625	142	1 450	16 746
Proportion of target population assessed (k)	%	61.9	39.5	85.7	61.3	38.5	6.7	40.3	118.2	68.9
Healthy Kids Check (h)	no.	59 486	19 662	45 372	15 377	10 169	3 578	2 063	858	156 565
Target population (e)	no.	91 582	71 916	58 606	31 431	19 119	5 750	4 976	2 232	285 636
Proportion of target population assessed	%	65.0	27.3	77.4	48.9	53.2	62.2	41.5	38.4	54.8

Table 10A.33 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
Total	no.	62 692.0	20 133.0	49 769.0	16 667.0	10 523.0	3 620.0	2 120.0	2 572.0	168 096.0
Target population	no.	96 763	73 107	63 737	33 534	20 038	6 375	5 117	3 682	302 381
Proportion of target population assessed	%	64.8	27.5	78.1	49.7	52.5	56.8	41.4	69.9	55.6

- a) Computed by the Secretariat from the 2011-12 reference period. Historical data were sourced from the National Healthcare Agreement and do not include underlying data. The considerable increase in proportion of target population assessed compared to previous years is associated with a considerable increase in the number of children receiving fourth year developmental health checks (Department of Health, pers. comm, 25 October 2012).
- (b) Reference year is based on the date the service was provided. Data may differ from other reports in which reference year is based on the date the claim was processed.
- (c) Patient allocation based on patient postcode at the date their last service was processed in the reference period. This is not necessarily where the service was received. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided.
- (d) Children are counted only once in the numerator.
- (e) From the 2010-11 reference period, children who received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period were counted against the Aboriginal and Torres Strait Islander health assessment.
- (f) Derived target populations as at 31 December are computed as the average of the 4 year old population estimates / projections at June 30 at each end of the reference year. For the Healthy Kids Check, the target population of non-Indigenous 4 year olds is computed by subtracting the derived population of Aboriginal and Torres Strait Islander 4 year olds from the derived 4 year old ERP. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13-14) for details.
- (g) Data for Aboriginal and Torres Strait Islander Child Health Checks are not published for Tasmania or the ACT for 2009-10 due to small numbers, but are included in the total for Australia.
- (h) Includes claims for Medicare Benefits Schedule (MBS) Item 708 (Aboriginal and Torres Strait Islander Child Health Check, available to 30 April 2010) and Item 715 (Aboriginal and Torres Strait Islander People's Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years for the 2012-13 reference period, and 3 or 4 years for the 2011-12 reference period. Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.

Table 10A.33 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
(a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (k)</i>	<i>Aust (e)</i>
(i)	Includes claims for MBS items 709 and 711 (Healthy Kids Check, available to 30 April 2010) and items 701, 703, 705, 707 and 10986 (Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years from 2011-12, and 3 or 4 years for data to 2010-11. Data do not include developmental health check activity conducted outside Medicare, such as State and Territory early childhood health assessments in preschools and community health centres. This is known to be a particular issue for several jurisdictions. For example, in Victoria, the Victorian Maternal and Child Health Service provided a 3.5 year old Key Ages and Stages consultation to 47 638 children in the 2011-12 financial year. Data include Aboriginal and Torres Strait Islander children who received a Healthy Kids Check and did not also receive a health check under MBS items 708 or 715.									
(j)	From 2011-12, data include Aboriginal and Torres Strait Islander and non-Indigenous children aged 3, 4 or 5 years who received a health assessment under the specified MBS items, provided they had not received such a check in a previous reference period. This constitutes a break in time series for the data. Data from 2011-12 should not be compared with data for previous years, which are limited to children aged 3 or 4 years.									
(k)	For the NT for 2013-14, data for the proportion of Aboriginal and Torres Strait Islander children who received a health check exceeds 100 per cent. This is largely because numerator and denominator are not directly comparable — children are eligible to receive this health assessment at the age of 3, 4 or 5 years. However, a child is eligible to receive it once only (children may also be eligible for other health checks) — hence, the denominator uses population estimates and projections for a single year of age — 4 years. Using this methodology, the total number of children aged 3, 4 and 5 years who received a check in 2013-14 exceeds the derived population of Aboriginal and Torres Strait Islander children aged 4 years.									

np Not published.

Source: Department of Health unpublished, MBS Statistics; ABS unpublished, *Australian demographic statistics*, Cat. no. 3101.0; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1996 to 2026*, B series, Cat. no. 3238.0.

Table 10A.34 Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Aust (e)</i>
2012-13						
0–15 years	89.4	88.3	88.7	91.6	92.5	89.2
16–64 years	78.6	72.3	73.7	74.4	83.1	77.0
65 years or over	90.5	88.8	89.7	92.0	94.0	90.1
All ages	83.3	79.6	80.5	81.3	86.6	82.3
2013-14						
0–15 years	90.2	89.8	90.3	92.4	94.7	90.2
16–64 years	80.3	74.5	76.0	75.7	86.2	78.9
65 years or over	90.7	88.9	89.8	91.7	95.2	90.2
All ages (f)	84.5	81.2	82.1	82.2	89.3	83.6

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

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

(c) Patient age at date of service.

(d) Allocation to remoteness area based on patients' Medicare enrolment postcode.

(e) Australia includes attendances where patient postcodes could not be allocated to a remoteness area.

(f) All ages includes attendances where patient age is unknown.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.35 Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)

	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
2006-07								
0-15 years	86.9	82.1	79.1	82.2	82.4	80.3	87.8	85.4
16-64 years	74.3	71.0	63.9	66.1	65.5	63.0	74.5	71.9
65 years or over	89.4	86.2	83.1	85.6	85.3	87.7	89.4	87.8
All ages	79.8	76.9	71.5	74.3	73.8	70.1	79.9	78.0
2007-08								
0-15 years	87.6	83.3	80.8	84.8	84.6	81.4	89.2	86.4
16-64 years	75.4	72.7	66.1	68.9	67.9	65.0	76.8	73.4
65 years or over	89.7	87.3	84.6	87.3	86.7	87.8	90.9	88.6
All ages	80.7	78.3	73.4	76.7	76.0	71.6	82.0	79.2
2008-09								
0-15 years	88.2	84.7	83.2	87.3	86.1	81.7	89.8	87.3
16-64 years	75.7	73.8	67.1	71.2	68.6	63.8	77.4	73.9
65 years or over	90.2	88.0	85.9	88.6	87.8	87.9	91.8	89.2
All ages	81.1	79.4	74.7	78.8	77.0	70.9	82.6	79.9
2009-10								
0-15 years	88.8	86.4	85.1	88.7	87.0	84.0	91.3	88.2
16-64 years	75.5	75.5	67.8	73.1	69.8	65.5	78.9	74.3
65 years or over	90.4	89.3	87.2	89.7	88.8	88.0	92.1	89.8
All ages	81.3	81.1	76.0	80.5	78.3	72.5	83.9	80.5
2010-11								
0-15 years	88.8	86.4	85.7	88.8	86.9	84.6	91.8	88.2
16-64 years	76.2	76.1	68.8	73.3	69.9	65.4	79.4	74.9
65 years or over	90.4	89.5	87.6	89.9	88.8	87.9	92.5	89.9
All ages	81.7	81.5	76.7	80.8	78.3	72.5	84.4	80.9
2011-12								
0-15 years	89.2	87.1	86.8	89.6	87.8	84.8	92.5	88.8
16-64 years	77.2	76.8	71.1	74.0	70.8	64.9	80.2	75.8
65 years or over	90.3	89.6	87.8	90.3	88.8	86.7	93.1	89.9
All ages	82.3	82.0	78.1	81.4	78.9	71.9	85.2	81.5

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Data are not comparable to data for 2012-13 and subsequent years which are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

Table 10A.35 **Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)**

	<i>Other metro Capital city centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
--	--	-----------------------------------	-----------------------------------	---------------------------------	--------------------------	----------------------------------	-------------

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

(d) Patient age at date of service.

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

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.36

Table 10A.36 **Non-referred attendances that were bulk billed by age (per cent)**
(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 (e)</i>
2005-06									
0-15 years	87.1	78.2	83.3	86.6	86.0	78.6	52.9	69.7	83.4
16-64 years	78.2	67.5	66.6	60.6	65.9	61.2	35.7	57.8	69.8
65 years or over	87.5	85.8	86.3	89.4	87.8	83.6	64.9	86.1	86.7
All ages	81.9	73.8	74.2	71.8	74.9	69.6	44.2	63.0	76.2
2006-07									
0-15 years	88.5	80.4	85.4	88.4	88.1	81.7	62.7	69.6	85.4
16-64 years	80.0	69.7	68.7	62.0	68.6	63.9	44.2	59.0	71.9
65 years or over	88.7	86.7	87.5	90.0	89.0	85.4	68.6	86.6	87.8
All ages	83.5	75.7	76.1	73.0	77.1	72.2	51.9	64.0	78.0
2007-08									
0-15 years	89.2	81.7	86.5	90.0	89.6	84.2	62.2	70.7	86.4
16-64 years	81.2	71.4	70.5	62.3	71.0	66.5	46.2	61.0	73.4
65 years or over	89.5	87.3	88.2	90.4	90.0	86.7	69.2	87.6	88.6
All ages	84.5	77.0	77.5	73.9	79.0	74.5	53.2	65.7	79.2
2008-09									
0-15 years	89.9	82.9	87.8	90.7	90.7	85.6	62.2	68.1	87.3
16-64 years	81.7	72.4	71.4	61.6	72.1	66.2	46.0	60.0	73.9
65 years or over	90.1	87.9	89.1	90.9	90.8	87.1	68.3	88.0	89.2
All ages	85.1	77.9	78.5	73.7	80.1	74.8	53.0	64.7	79.9
2009-10									
0-15 years	90.4	83.8	89.3	90.5	91.4	87.2	64.4	72.9	88.2
16-64 years	81.0	73.6	73.4	61.7	70.5	67.7	40.5	64.3	74.3
65 years or over	90.6	88.6	90.1	91.3	91.3	88.1	67.7	89.7	89.8
All ages	85.0	79.0	80.3	73.9	79.7	76.3	49.9	68.9	80.5
2010-11									
0-15 years	90.3	84.5	89.3	90.5	91.6	86.7	61.9	76.0	88.2
16-64 years	81.8	74.5	74.2	61.0	70.7	67.5	38.3	66.4	74.9
65 years or over	90.8	88.7	90.3	90.9	91.0	88.0	66.4	89.9	89.9
All ages	85.5	79.7	80.8	73.4	79.6	76.1	48.1	71.1	80.9
2011-12									
0-15 years	90.8	85.7	89.4	90.3	92.1	86.4	65.4	80.4	88.8
16-64 years	82.7	76.0	74.8	60.4	72.9	66.5	40.8	68.9	75.8
65 years or over	91.0	88.8	90.2	90.1	90.7	87.4	66.3	90.6	89.9
All ages	86.1	80.8	81.0	72.8	80.8	75.4	50.2	73.7	81.5
2012-13									
0-15 years	91.0	86.8	89.5	90.2	92.1	86.9	68.1	85.5	89.2

Table 10A.36 Non-referred attendances that were bulk billed by age (per cent)
(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 (e)</i>
16–64 years	83.7	77.7	75.7	61.0	73.9	67.4	47.9	73.9	77.0
65 years or over	91.3	89.2	90.4	89.7	90.6	88.3	66.5	91.2	90.1
All ages	86.8	82.1	81.7	73.0	81.4	76.4	55.0	78.2	82.3
2013-14									
0–15 years	91.6	88.1	90.6	91.5	92.4	88.1	69.6	89.8	90.2
16–64 years	85.1	79.2	77.7	65.5	75.3	68.9	50.5	79.3	78.9
65 years or over	91.5	89.3	90.6	89.6	90.2	88.5	67.1	91.6	90.2
All ages	87.9	83.2	83.1	75.7	82.2	77.7	57.2	82.8	83.6

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

(b) Patient age at date of service.

(c) Allocation to State/Territory based on patients' Medicare enrolment postcode.

(d) All ages includes attendances where patient age is unknown.

(e) Australia includes attendances where patient postcodes could not be allocated to a State/Territory.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.37 **People deferring access to GPs due to cost (per cent) (a), (b), (c), (d), (e), (f), (g)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
2012-13										
Proportion	%	4.5	5.0	5.9	7.7	5.4	7.0	8.8	5.2	5.4
RSE	%	8.7	6.3	7.0	7.4	9.5	9.6	12.1	20.5	3.3
95 per cent confidence interval	±	0.8	0.6	0.8	1.1	1.0	1.3	2.1	2.1	0.4
2013-14 (g)										
Proportion	%	3.5	5.0	5.8	6.2	4.5	6.9	6.9	5.6	4.9
RSE	%	7.6	6.9	6.2	7.5	11.7	10.4	11.3	21.8	2.9
95 per cent confidence interval	±	0.5	0.7	0.7	0.9	1.0	1.4	1.5	2.4	0.3

RSE = Relative standard error.

- (a) People aged 15 years or over who delayed or did not visit a GP at any time in the last 12 months due to cost.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (d) Data from 2012-13 are not comparable to data for previous years due to a change in question sequencing/wording. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable to data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.38 **Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Proportion	%	11.1	12.3	13.0	13.8	7.7	16.3	20.7	11.0	12.2
RSE (c)	%	24.5	28.4	26.9	20.7	43.8	23.9	24.3	40.2	10.2
95 per cent confidence interval	± %	5.3	6.9	6.8	5.6	6.6	7.6	9.9	8.7	2.4

RSE = Relative standard error.

- (a) Aboriginal and Torres Strait Islander people aged 15 years or over who reported needing to see a GP in the last 12 months and delayed doing so or did not do so because of cost, divided by the number of Aboriginal and Torres Strait Islander people aged 15 years or over who reported needing to see a GP in the last 12 months.
- (b) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data are not comparable with data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

Table 10A.39 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
2012-13										
Within four hours										
Proportion	%	63.9	63.7	66.2	61.5	65.2	53.9	60.0	51.9	63.8
RSE	%	2.5	3.1	3.2	4.5	2.5	6.3	7.6	10.0	1.3
95 per cent confidence interval	±	3.2	3.8	4.2	5.5	3.2	6.6	8.9	10.2	1.6
Four to less than 24 hours										
Proportion	%	9.5	11.7	11.2	11.8	13.5	15.4	13.2	13.8	11.2
RSE	%	11.1	11.8	13.8	15.3	10.8	12.9	21.3	25.3	5.1
95 per cent confidence interval	±	2.1	2.7	3.0	3.5	2.9	3.9	5.5	6.8	1.1
24 hours or more										
Proportion	%	26.5	24.5	22.6	26.8	21.2	30.7	26.9	34.3	25.0
RSE	%	5.4	7.5	7.5	9.0	8.1	10.4	13.0	13.9	3.1
95 per cent confidence interval	±	2.8	3.6	3.3	4.7	3.4	6.2	6.9	9.4	1.5
2013-14 (g)										
Within four hours										
Proportion	%	64.7	63.4	65.4	65.2	64.7	51.8	58.3	78.4	64.2
RSE	%	3.3	0.6	2.5	4.9	4.8	5.6	9.6	7.3	1.4
95 per cent confidence interval	±	4.1	0.7	3.2	6.2	6.0	5.7	11.0	11.2	1.7
Four to less than 24 hours										
Proportion	%	8.2	10.4	10.4	8.8	12.2	16.0	19.2	12.7	10.0
RSE	%	18.4	14.5	19.8	19.5	16.7	22.1	21.4	33.0	8.2
95 per cent confidence interval	±	2.9	3.0	4.0	3.4	4.0	6.9	8.1	8.2	1.6
24 hours or more										
Proportion	%	26.7	25.9	24.0	27.1	21.5	34.8	26.4	6.4	25.8
RSE	%	5.6	8.9	7.0	10.5	11.5	8.2	17.1	44.8	2.2
95 per cent confidence interval	±	2.9	4.5	3.3	5.6	4.9	5.6	8.8	5.6	1.1

RSE = relative standard error.

- (a) Time waited between making an appointment and seeing the GP for urgent medical care.
- (b) People aged 15 years or over who saw a GP for urgent medical care for their own health in the last 12 months. 'Urgent' as defined by respondent. Discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash).
- (c) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.

Table 10A.39 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
--	-------------	------------	------------	------------	-----------	-----------	------------	------------	---------------	-------------

(d) Data for 2013-14 are comparable with data for 2011-12 and 2012-13 but are not comparable with data for previous years, due to a change to the question wording in 2011-12. See data quality information at www.pc.gov.au/rogs/2015 for further detail.

(e) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

(f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.

(g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.40 **Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2012-13										
Proportion	%	20.2	21.2	17.5	24.4	20.5	22.5	22.0	22.0	20.5
RSE	%	3.1	3.0	4.6	4.4	4.8	5.3	7.3	9.0	1.9
95 per cent confidence interval	±	1.2	1.3	1.6	2.1	1.9	2.3	3.2	3.9	0.7
2013-14 (e)										
Proportion	%	23.9	22.6	19.2	24.5	21.9	23.4	25.1	26.5	22.6
RSE	%	2.6	3.0	3.7	4.7	3.7	4.8	6.3	8.4	1.5
95 per cent confidence interval	±	1.2	1.3	1.4	2.3	1.6	2.2	3.1	4.3	0.7

RSE = relative standard error.

- (a) Persons aged 15 years or over who saw a GP in the previous 12 months, excluding interviews by proxy.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data from 2012-13 are not comparable to data for previous years due to a change in question sequencing. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (d) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (e) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

TABLE 10A.41

Table 10A.41 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	<i>NSW</i> (d)	<i>Vic</i> (d)	<i>Qld</i>	<i>WA</i>	<i>SA</i> (e)	<i>Tas</i> (f)	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	648 937	542 164	380 947	193 353	112 517	55 644	44 535	34 703	2 012 800
2009-10	706 134	550 887	371 539	207 545	117 056	62 534	46 217	37 717	2 099 629
2010-11	692 778	555 140	375 169	263 845	117 525	60 182	48 485	42 303	2 155 427
2011-12	684 991	554 124	378 087	286 820	103 928	59 840	47 807	40 903	2 156 500
2012-13 (g)	692 774	574 874	383 924	271 878	112 801	61 600	46 627	39 813	2 184 291
2013-14 (h)	709 345	572 435	381 378	272 936	113 358	61 176	50 486	39 272	2 200 386

- (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 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not: admitted to the hospital, referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. Data include appropriate presentations to emergency departments that can only retrospectively be categorised as 'GP-type'.
- (b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.
- (c) Limited to peer group A and B public hospitals.
- (d) From 2009-10, data for the Albury Base Hospital (previously reported in NSW hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for NSW and Victoria.
- (e) For SA for 2008-09 and 2009-10, data include presentations for which the type of visit was not reported.
- (f) The Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B) for these data.
- (g) Data for 2012-13 have been revised using hospital classification into peer groups A and B based on 2012-13 peer groups and differ from data published in the 2014 Report which utilised hospital classification into peer groups A and B based on 2011-12 peer groups.
- (h) Data for 2013-14 are preliminary. Hospital classification into peer groups A and B is based on 2012-13 peer groups.

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

TABLE 10A.42

Table 10A.42 **People attending a hospital emergency department who thought the care could have been provided at a general practice (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2010-11										
Proportion	%	26.3	17.3	19.2	23.5	18.3	23.7	26.9	19.9	21.5
RSE	%	8.2	8.5	9.5	8.4	11.5	14.4	21.5	17.8	4.6
95% confidence interval	±	4.2	2.9	3.6	3.9	4.1	6.7	11.3	7.0	1.9
2011-12										
Proportion	%	21.2	24.1	26.1	27.4	20.2	21.9	25.3	26.2	23.5
RSE	%	7.3	8.2	10.7	8.3	13.5	12.7	16.4	15.2	3.4
95% confidence interval	±	3.0	3.9	5.5	4.5	5.4	5.5	8.1	7.8	1.6
2012-13										
Proportion	%	23.7	22.7	23.6	24.8	23.7	24.1	24.2	22.5	23.6
RSE	%	6.5	6.1	8.0	8.9	12.7	11.8	14.0	14.7	3.5
95% confidence interval	±	3.0	2.7	3.7	4.3	5.9	5.6	6.6	6.5	1.6

RSE = Relative standard error.

- (a) People aged 15 years or over who reported attending a hospital emergency department and thought at the time that the care received could have been provided at a general practice.
- (b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges except for ACT and NT, for which 15 year age ranges are used.
- (c) Excludes persons who responded "Don't know" whether care could have been provided at a GP
- (d) Data from 2011-12 exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions, but include very remote areas. Data for previous years exclude very remote areas which translates into the exclusion of around 23 per cent of the NT population — NT data for 2010-11 should therefore be used with care.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0.

Table 10A.43 **People deferring access to prescribed medication due to cost (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
2012-13										
Proportion	%	7.4	7.9	9.3	6.8	8.2	8.5	6.7	9.0	7.9
RSE	%	5.3	5.3	6.5	9.4	7.8	10.0	15.4	17.1	2.5
95 per cent confidence interval	±	0.8	0.8	1.2	1.2	1.2	1.7	2.0	3.0	0.4
2013-14 (g)										
Proportion	%	7.0	6.3	9.9	8.4	7.5	8.0	6.7	6.2	7.6
RSE	%	7.0	5.9	6.3	7.6	8.3	9.0	14.7	17.4	2.7
95 per cent confidence interval	±	1.0	0.7	1.2	1.2	1.2	1.4	1.9	2.1	0.4

RSE = Relative standard error.

- (a) People aged 15 years and over who received a prescription for medication from a GP in the last 12 months and delayed using or did not get medication at any time in the last 12 months due to the cost.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (d) Data for 2010-11 and subsequent reference years are comparable over time, but are not comparable with data for 2009 due to a change in the sequencing and wording of the survey question. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable to data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.44 **Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</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>
Proportion	%	24.4	36.3	47.0	45.2	35.3	46.5	24.1	22.8	34.6
RSE (c)	%	19.7	14.8	15.0	19.3	26.0	14.9	37.2	34.1	8.4
95 per cent confidence interval	±	9.4	10.5	13.8	17.1	18.0	13.5	17.6	15.2	5.7

RSE = Relative standard error.

- (a) Aboriginal and Torres Strait Islander people aged 15 years and over who received a prescription for medication in the last 12 months and delayed getting or did not get the medication due to the cost, divided by the number of Aboriginal and Torres Strait Islander people who received a prescription for medication in the last 12 months.
- (b) Rates are age-standardised to the 2001 estimated resident population (10 year ranges).
- (c) Estimates with RSEs between 25 and 50 per cent should be used with caution.
- (d) Data are not comparable to data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).
- (f) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

Table 10A.45 **Waiting time for public dentistry (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
2012-13 (d)										
Less than 1 month										
Proportion	%	33.9	30.9	29.8	35.9	16.1	32.2	30.4	41.3	30.8
RSE (c)	%	8.4	11.5	10.7	15.2	25.2	19.4	24.2	26.3	4.1
95% CI	±	5.6	7.0	6.3	10.7	7.9	12.3	14.4	21.3	2.5
1 month or more										
Proportion	%	66.1	69.1	70.2	64.1	83.9	67.8	69.6	58.7	69.2
RSE	%	4.3	5.1	4.5	8.5	4.8	9.2	10.6	18.5	1.8
95% CI	±	5.6	7.0	6.3	10.7	7.9	12.3	14.4	21.3	2.5
2013-14 (d), (g)										
Less than 1 month										
Proportion	%	27.6	17.8	27.2	19.7	18.4	26.2	32.5	24.4	23.4
RSE (c)	%	12.9	10.4	11.9	26.3	23.8	26.4	35.1	40.1	6.1
95% CI	±	6.9	3.6	6.4	10.2	8.6	13.6	22.4	19.2	2.8
1 month or more										
Proportion	%	71.6	82.8	70.9	82.4	83.2	74.7	81.5	73.9	76.5
RSE	%	5.0	5.6	5.4	3.6	7.5	4.6	19.6	14.8	1.5
95% CI	±	7.0	9.1	7.5	5.9	12.2	6.8	31.3	21.4	2.2

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

- (a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data for 2013-14 are not comparable with data for 2012-13 and previous years due to significant changes in question wording and sequencing. For the 2013-14 survey, respondents were for the first time asked to include waiting times for public dental services provided at a private dental clinic. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS (unpublished) *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.46 **Waiting time for public dentistry by remoteness, Australia (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Other (f)</i>	<i>Inner regional</i>	<i>Outer regional/ remote/very remote</i>	<i>Total</i>
2012-13 (d)						
Less than 1 month						
Proportion	%	31.9	29.3	30.3	27.6	30.8
RSE	%	6.6	10.1	9.9	17.2	4.1
95% CI	±	4.1	5.8	5.9	9.3	2.5
1 month or more						
Proportion	%	68.1	70.7	69.7	72.4	69.2
RSE	%	3.1	4.2	4.3	6.6	1.8
95% CI	±	4.1	5.8	5.9	9.3	2.5
2013-14 (d), (g)						
Less than 1 month						
Proportion	%	25.2	21.3	18.3	25.7	23.4
RSE	%	8.3	7.8	9.8	12.0	6.1
95% CI	±	4.1	3.2	3.5	6.0	2.8
1 month or more						
Proportion	%	74.2	78.8	81.3	74.5	76.5
RSE	%	2.9	1.5	3.5	2.7	1.5
95% CI	±	4.2	2.4	5.6	3.9	2.2

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

- (a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months for their own health.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data for 2013-14 are not comparable to data for 2012-13 and previous years. See data quality information at www.pc.gov.au/rogs/2015 for further detail.
- (e) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) 'Other' includes inner and outer regional, remote and very remote areas.
- (g) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.47 **Waiting times for public dentistry, Aboriginal and Torres Strait Islander people, by remoteness, Australia, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Aust (c)</i>
Less than 1 month					
Proportion	%	57.8	56.6	63.2	59.0
RSE	%	6.5	8.0	8.1	4.5
95% CI	±	7.4	8.9	10.0	5.2
1 month or more					
Proportion	%	29.5	33.8	21.2	28.0
RSE	%	14.2	13.7	19.8	9.1
95% CI	±	8.2	9.1	8.2	5.0

CI = confidence interval. **RSE** = relative standard error. Estimates with RSEs between 25 percent and 50 percent should be used with caution.

- (a) Aboriginal and Torres Strait Islander people aged 15 years or over who reported seeing a dental professional at a government dental clinic within specified waiting time categories for non-urgent treatment in the last 12 months, divided by the number of Aboriginal and Torres Strait Islander people aged 15 years or over who reported seeing a dental professional at a government dental clinic in the last 12 months.
- (b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges.
- (c) Includes persons in non-remote areas only, as the survey questions were not asked of people in remote areas.
- (d) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (NATSIHS component), Cat. no. 4727.0.

Table 10A.48 **Proportion of full time workload equivalent (FWE) GPs with vocational registration by region (per cent) (a), (b), (c), (d)**

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Aust</i>
2012-13	92.6	82.8	78.8	75.5	83.4	89.4
2013-14	91.7	80.9	78.8	78.3	79.8	88.5

- (a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.
- (b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.49 Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent) (a), (b), (c), (d)

	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
2003-04	93.7	93.0	90.0	86.7	83.8	71.2	68.3	91.4
2004-05	93.4	91.7	89.7	85.3	83.4	71.4	67.2	91.0
2005-06	93.1	90.3	90.7	84.2	83.1	68.2	72.9	90.6
2006-07	92.9	90.0	90.3	83.5	83.3	71.3	68.8	90.4
2007-08	92.7	89.9	87.6	82.2	83.1	71.0	65.5	90.0
2008-09	92.6	89.6	87.5	81.8	83.4	70.4	67.3	89.9
2009-10	92.6	89.6	87.1	80.2	83.3	68.9	69.6	89.7
2010-11	93.2	90.6	87.0	80.5	81.5	67.2	72.6	89.9
2011-12	92.8	90.9	86.6	80.3	80.8	67.6	73.5	89.6

- (a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.
- (b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.50 Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)

	<i>Unit</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>
FWE GPs with vocational registration										
2004-05	no.	5 774	3 789	2 933	1 335	1 262	348	191	81	15 714
2005-06	no.	5 858	3 870	3 004	1 346	1 289	353	199	79	15 997
2006-07	no.	6 007	3 987	3 051	1 362	1 301	356	215	80	16 359
2007-08	no.	6 098	4 131	3 125	1 395	1 322	370	223	82	16 745
2008-09	no.	6 260	4 284	3 265	1 414	1 376	372	223	86	17 279
2009-10	no.	6 346	4 402	3 389	1 455	1 403	385	224	94	17 699
2010-11	no.	6 490	4 528	3 574	1 494	1 418	390	227	96	18 216
2011-12	no.	6 725	4 630	3 810	1 542	1 474	405	234	104	18 924
2012-13	no.	6 928	4 819	4 040	1 636	1 524	428	253	114	19 742
2013-14	no.	7 184	4 981	4 242	1 748	1 557	432	254	122	20 521
Proportion of FWE GPs with vocational registration										
2004-05	%	92.8	90.9	86.6	91.7	92.6	92.1	95.5	84.4	91.0
2005-06	%	92.8	90.4	86.1	91.4	91.8	91.4	95.9	81.8	90.6
2006-07	%	92.7	90.5	85.6	90.8	91.8	91.0	95.2	76.9	90.4
2007-08	%	92.4	90.1	84.9	90.5	90.9	92.1	95.9	70.5	90.0
2008-09	%	92.2	90.4	84.6	89.8	91.1	92.0	95.0	74.2	89.9
2009-10	%	92.1	89.8	84.9	90.1	90.7	92.2	94.2	74.1	89.7
2010-11	%	91.8	89.4	86.6	91.1	90.3	90.9	94.8	71.8	89.9
2011-12	%	91.6	87.9	87.7	90.8	90.5	90.1	93.4	73.5	89.6
2012-13	%	91.3	86.9	88.4	90.7	90.7	92.2	93.0	72.1	89.4
2013-14	%	90.6	85.5	88.0	89.5	89.5	90.8	91.8	69.8	88.5

- (a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.
- (b) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (c) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.51

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</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>
2008										
Accredited										
AGPAL	no.	1 372	936	795	329	339	113	47	37	3 968
GPA Accreditation <i>plus</i>	no.	267	212	148	73	36	10	23	3	772
Total	no.	1 639	1 148	943	402	375	123	70	40	4 740
General practices	no.	2 782	1 687	1 278	569	567	167	92	119	7 261
Proportion accredited	%	58.9	68.0	73.8	70.7	66.1	73.7	76.1	33.6	65.3
Registered for accreditation (b)										
AGPAL	no.	1 471	972	858	356	357	121	49	47	4 231
GPA Accreditation <i>plus</i>	no.	278	228	163	77	37	10	23	3	819
2009										
Accredited										
AGPAL	no.	1 364	915	782	311	338	115	43	37	3 905
Quality Practice Accreditation	no.	315	262	182	86	42	15	22	5	930
Total	no.	1 679	1 177	964	397	380	130	65	42	4 835
General practices	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (b)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
Quality Practice Accreditation	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
Quality Practice Accreditation	no.	329	284	197	86	44	32	19	3	994
Total	no.	1 675	1 167	950	416	374	130	59	41	4 812
General practices	no.	2 731	1 691	1 266	569	525	158	91	120	7 151

TABLE 10A.51

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</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>
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
Quality Practice Accreditation	no.	343	291	214	89	44	32	19	4	1 036
2011										
Accredited										
AGPAL	no.	1 318	871	735	327	323	86	38	41	3 739
Quality Practice Accreditation	no.	340	296	206	93	48	33	21	7	1 044
Total	no.	1 658	1 167	941	420	371	119	59	48	4 783
General practices	no.	2 712	1 687	1 241	573	537	158	84	105	7 097
Proportion accredited	%	61.1	69.2	75.8	73.3	69.1	75.3	70.2	45.7	67.4
Registered for accreditation (b)										
AGPAL	no.	1 399	926	784	350	339	92	40	57	3 987
Quality Practice Accreditation	no.	373	334	241	102	49	38	23	9	1 169
2012										
Accredited										
AGPAL	no.	1 308	865	719	323	323	85	39	52	3 714
Quality Practice Accreditation	no.	439	344	280	109	65	42	23	10	1 312
Total	no.	1 747	1 209	999	432	388	127	62	62	5 026
General practices	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 403	932	781	345	337	87	41	58	3 984
Quality Practice Accreditation	no.	476	362	311	120	71	46	25	11	1 422
2013 (c)										
Accredited										

TABLE 10A.51

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</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>
AGPAL	no.	1 284	892	742	333	331	85	38	52	3 757
Quality Practice Accreditation	no.	625	462	382	160	91	59	34	15	1 828
Total	no.	1 909	1 354	1 124	493	422	144	72	67	5 585
General practices	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 352	941	784	347	332	86	46	55	3 943
Quality Practice Accreditation	no.	659	485	407	168	98	62	36	19	1 934
2014 (c)										
Accredited										
AGPAL	no.	1 271	908	748	349	321	84	41	54	3 776
Quality Practice Accreditation	no.	622	460	415	154	107	55	30	26	1 869
Total	no.	1 893	1 368	1 163	503	428	139	71	80	5 645
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 321	946	786	370	337	87	42	57	3 946
Quality Practice Accreditation	no.	663	490	449	167	109	59	30	27	1 994

(a) Includes practices accredited by either of Australia's two accrediting bodies. Quality Practice Accreditation manages the General Practice Australia ACCREDITATION *plus* accreditation program.

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

(c) Data for the total number of practices have not been available since 2010-11. Historical data were collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June". Data were provided by all Divisions of General Practice as required under contractual agreements with Department of Health. The ASD ceased with the transition from Divisions of General Practice to Medicare Locals and no other data source has been identified.

na Not available.

Table 10A.51 **General practices that are accredited at 30 June (a)**

	<i>Unit</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>
<i>Source:</i>	AGPAL (Australian General Practice Accreditation Limited) unpublished; Quality Practice Accreditation Pty Ltd unpublished; PHCRIS, Department of Health unpublished, ASD (various years).									

Table 10A.52 **General practice activity in PIP practices (per cent)**

	<i>Unit</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>
Proportion of SWPEs that are in PIP practices (a)										
2003-04	%	75.8	83.3	79.8	80.3	84.8	88.3	76.4	51.3	79.7
2004-05	%	76.6	83.9	79.9	80.7	84.3	86.9	80.7	56.5	80.2
2005-06	%	77.2	84.3	80.1	82.2	85.2	88.5	83.4	55.1	80.9
2006-07	%	77.4	84.4	81.3	82.2	85.4	86.0	84.6	53.6	81.2
2007-08	%	77.9	85.0	81.4	82.6	85.1	88.7	86.1	54.9	81.6
2008-09	%	78.5	85.3	82.6	83.7	84.4	88.7	83.4	56.9	82.1
2009-10	%	79.1	85.9	84.0	83.6	84.8	88.4	88.1	59.8	82.9
2010-11	%	79.1	85.8	84.3	83.6	86.0	88.1	88.2	60.5	83.0
2011-12	%	80.6	86.4	85.8	84.8	87.3	89.3	88.3	64.1	84.2
2012-13	%	81.2	86.6	85.7	85.7	87.6	89.2	89.4	66.2	84.6
Proportion of services provided by PIP practices (b)										
2003-04	%	73.3	81.2	79.3	79.5	83.9	87.4	75.3	51.7	78.0
2004-05	%	74.2	82.0	80.0	80.1	83.4	86.5	79.6	58.0	78.7
2005-06	%	75.2	82.7	80.2	81.7	84.8	88.4	82.7	56.6	79.6
2006-07	%	75.6	83.0	81.6	82.0	85.2	86.0	84.4	55.0	80.1
2007-08	%	76.3	83.9	81.8	82.9	85.3	88.8	85.4	56.2	80.8
2008-09	%	76.9	84.3	83.0	84.0	84.6	88.4	83.5	59.5	81.4
2009-10	%	77.9	85.0	84.7	84.0	85.3	88.5	88.1	61.7	82.4
2010-11	%	77.8	84.8	84.6	84.0	86.1	88.2	88.2	61.7	82.4
2011-12	%	79.1	85.4	86.0	84.5	87.3	89.3	88.3	65.6	83.4
2012-13	%	79.7	85.6	85.7	85.5	87.7	89.1	89.7	69.9	83.8

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

(b) Services may vary in type and quality.

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.53

Table 10A.53 **Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections (a), (b), (c)**

	<i>Unit</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>
2012-13										
All people										
Scripts	no.	2 340 481	1 768 423	1 434 337	472 595	532 288	169 921	67 108	20 855	6 806 008
Population (d)	no.	7 348 899	5 679 633	4 610 932	2 472 717	1 662 169	512 422	379 554	236 869	22 906 352
Rate	per 1000 people	318.5	311.4	311.1	191.1	320.2	331.6	176.8	88.0	297.1
2013-14										
All people										
Scripts	no.	2 381 870	1 880 698	1 371 143	479 066	519 983	161 838	67 432	22 366	6 884 396
Population (d)	no.	7 465 497	5 790 990	4 690 910	2 550 874	1 677 250	513 955	384 147	242 573	23 319 385
Rate	per 1000 people	319.1	324.8	292.3	187.8	310.0	314.9	175.5	92.2	295.2

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

(d) Estimated resident population at 31 December based on the ABS 2011 Census, first preliminary estimates.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.54

Table 10A.54 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2009-10 to 2011-12 (a), (b), (c), (d)**

	<i>Unit</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>
2009-10										
Scripts	no.	2 187 899	1 697 904	1 257 889	426 460	512 394	156 175	58 960	18 865	6 316 546
Concession card holders	no.	1 772 335	1 396 751	1 041 249	456 175	457 481	156 888	52 263	46 588	5 389 025
Rate	per 1000 holders	1 234.5	1 215.6	1 208.1	934.9	1 120.0	995.5	1 128.1	404.9	1 172.1
2010-11										
Scripts	no.	2 280 551	1 853 022	1 353 985	432 750	521 568	163 389	65 432	19 361	6 690 058
Concession card holders	no.	1 793 360	1 410 180	1 067 874	460 274	465 767	159 817	53 085	45 779	5 466 022
Rate	per 1000 holders	1 271.7	1 314.0	1 267.9	940.2	1 119.8	1 022.4	1 232.6	422.9	1 223.9
2011-12										
Scripts	no.	2 349 145	1 761 703	1 400 017	471 336	515 907	171 723	63 802	20 031	6 753 664
Concession card holders	no.	1 810 065	1 434 628	1 082 274	463 942	471 039	163 012	54 111	46 017	5 535 884
Rate	per 1000 holders	1 297.8	1 228.0	1 293.6	1 015.9	1 095.3	1 053.4	1 179.1	435.3	1 220.0

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

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

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.55

Table 10A.55 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b), (c)**

	<i>Unit</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>
2006 to 2011										
Systemic antibiotic prescribed	%	34.7	30.7	33.5	28.1	31.1	24.0	30.3	17.8	32.4
95 per cent confidence interval	±	2.0	2.3	2.6	4.5	4.2	5.9	8.2	9.9	1.2
Encounters for acute URTI management (c)	no.	9 761	6 145	4 388	1 970	1 882	562	641	180	26 025
2007 to 2012										
Systemic antibiotic prescribed	%	35.0	30.1	33.7	28.7	30.1	25.3	33.0	22.8	32.5
95 per cent confidence interval	±	1.9	2.3	2.6	4.3	4.1	5.9	9.9	10.0	1.2
Encounters for acute URTI management (c)	no.	10 384	6 215	4 473	1 979	1 852	542	527	149	26 619
2008 to 2013										
Systemic antibiotic prescribed	%	35.7	29.9	34.1	25.9	28.6	26.5	28.0	21.4	32.5
95 per cent confidence interval	±	2.0	2.3	2.6	3.7	3.7	6.1	8.3	8.8	1.2
Encounters for acute URTI management (c)	no.	10 330	6 003	4 643	2 163	1 673	502	510	140	26 454
2009 to 2014										
Systemic antibiotic prescribed	%	33.0	27.4	33.1	25.6	26.7	26.3	25.7	20.9	30.5
95 per cent confidence interval	±	2.0	2.3	2.5	4.5	3.9	5.8	8.1	9.5	1.2

Table 10A.55 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b), (c)**

	<i>Unit</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>
Encounters for acute URTI management (c)	no.	9 691	5 630	4 576	1 953	1 604	533	529	115	25 105

URTI = Upper respiratory tract infection.

- (a) Data are from April of the first year to March of the final year of each 5 year period.
 (b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.
 (c) A GP encounter is a professional interchange between a patient and a GP.

Source: Britt et al. unpublished, BEACH Statistics.

Table 10A.56 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia (a), (b), (c)**

	Unit	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Encounters for acute URTI management (c)	per 100 GP encounters	5.2	5.6	5.5	5.5	4.9	5.6	5.3	4.4
95 per cent confidence interval	±	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Systemic antibiotic prescribed for URTI management	%	32.2	29.9	39.0	29.6	31.0	32.8	29.9	29.0
95 per cent confidence interval	±	2.7	2.5	2.7	2.5	2.4	2.6	2.7	2.6

URTI = Upper respiratory tract infection.

(a) Data are for the period from April to the following March.

(b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.

(c) A GP encounter is a professional interchange between a patient and a GP.

Source: Britt et al. unpublished, BEACH Statistics.

TABLE 10A.57

Table 10A.57 Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive (a), (b)

	<i>Unit</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>
PIP practices (May 2014) (b)	no.	1 812	1 255	1 077	452	367	121	71	55	5 210
SWPE (c)	('000)	5 259	4 346	3 383	1 701	1 301	401	284	101	16 774
PIP Diabetes Incentive — uptake	no.	880	528	585	216	130	44	41	40	2 464
Share of PIP practices	%	48.6	42.1	54.3	47.8	35.4	36.4	57.7	72.7	47.3

- (a) Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).
- (b) In accordance with the purpose of the PIP Diabetes incentive to encourage general practices to provide earlier diagnosis and effective management of people with established diabetes mellitus, practices are required to maintain an active patient register and recall and reminder system for all known patients with diabetes mellitus, and to agree to implement a cycle of care for patients with diabetes mellitus.
- (c) A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.58 Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent) (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Proportion of people with known diabetes who had a HbA1c test in last 12 months										
Males	%	86.4	72.1	74.7	81.6	84.8	88.2	73.3	84.7	80.4
Females	%	66.9	91.1	58.9	82.6	100.0	85.0	83.2	94.8	73.0
Persons	%	78.4	79.9	69.2	82.1	88.2	86.8	79.1	91.1	77.5
Relative Standard Error (RSE)										
Males	%	12.1	31.7	11.6	15.9	13.2	15.1	42.5	26.7	5.9
Females	%	39.2	13.6	26.0	22.5	0.0	19.5	22.5	7.8	13.4
Persons	%	15.1	14.0	12.5	12.4	9.9	11.1	18.9	8.8	6.3
95% confidence interval										
Males	± %	20.6	44.8	17.0	25.4	22.0	26.1	61.1	44.2	9.2
Females	± %	51.4	24.2	30.0	36.3	0.0	32.6	36.7	14.5	19.1
Persons	± %	23.2	21.9	16.9	19.9	17.1	19.0	29.2	15.7	9.5

Estimates with RSEs between 25 percent and 50 percent should be used with caution.

- (a) Persons aged 18 years to 69 years. Includes pregnant women.
- (b) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. See data quality information for further detail.
- (c) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79% of people aged 18 years and over who participated in the National Health Measures Survey (NHMS) had fasted.
- (d) Rates are non-age standardised.
- (e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHMS component), Cat. no. 4364.0.

TABLE 10A.59

Table 10A.59 **Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
<i>Proportion</i>										
Males	%	66.2	41.2	48.5	65.3	41.6	67.4	73.9	23.2	53.8
Females	%	44.9	19.1	43.0	55.6	84.6	72.2	26.5	71.9	45.0
Total	%	56.7	35.5	46.4	61.3	52.1	69.9	44.3	47.7	50.5
<i>Relative standard error</i>										
Males	%	14.1	51.5	22.1	19.5	39.5	19.3	27.9	61.8	11.1
Females	%	31.6	88.0	18.5	30.8	13.9	15.6	63.2	27.6	15.8
Total	%	13.4	46.5	15.3	16.7	28.5	11.4	31.0	31.4	8.8
<i>95 per cent confidence interval</i>										
Males	±	18.3	41.7	21.0	24.9	32.2	25.5	40.3	28.1	11.8
Females	±	27.8	32.9	15.6	33.6	23.1	22.1	32.8	38.8	13.9
Total	±	14.9	32.4	13.9	20.1	29.1	15.7	26.9	29.3	8.7

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

(b) People aged 18 years to 69 years. Includes pregnant women.

(c) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use.

(d) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the National Health Measures Survey (NHMS) had fasted.

(e) Rates are not age standardised (they are crude rates).

(f) Denominator includes a small number of persons for whom test results were not reported.

(g) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Health Survey 2011-13*, (2011-12 NHMS component), Cat. no. 4364.0.

Table 10A.60 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e) Aust</i>
2001									
0–14 years									
Proportion	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np 24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np 7.7
95 per cent confidence interval	±	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	np ± 3.7
15–64 years									
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	np 15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	np 6.5
95 per cent confidence interval	±	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	np ± 1.9
65 years or over									
Proportion	%	14.6	7.7	11.8	np	19.0	np	23.8	np 12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	np 22.1
95 per cent confidence interval	±	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	np ± 5.2
All ages (crude rates)									
Proportion	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	np 17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	np 5.3
95 per cent confidence interval	±	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	np ± 1.8
2004-05									
0–14 years									
Proportion	%	33.6	52.5	29.9	np	39.2	21.9	np	np 36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	np 9.6
95 per cent confidence interval	±	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	np ± 6.9
15–64 years									
Proportion	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	np 19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	np 6.9
95 per cent confidence interval	±	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	np ± 2.7
65 years or over									
Proportion	%	17.1	7.6	18.5	np	20.6	19.7	np	np 14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	np 17.5

Table 10A.60 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e)</i>	<i>Aust</i>
95 per cent confidence interval	±	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	np	± 4.9
All ages (crude rates)										
Proportion	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	np	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	np	6.0
95 per cent confidence interval	±	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	np	± 2.7
2007-08										
0-14 years										
Proportion	%	46.5	61.6	41.4	29.0	56.1	41.6	47.3	np	47.8
RSE	%	16.3	9.8	17.1	28.1	17.1	20.6	17.1	np	7.6
95 per cent confidence interval	±	± 14.9	± 11.8	± 13.9	± 16.0	± 18.8	± 16.8	± 15.9	np	± 7.1
15-24 years										
Proportion	%	11.9	9.3	14.7	np	7.4	9.6	35.0	np	12.6
RSE	%	47.1	47.0	37.8	np	53.2	69.2	29.0	np	19.5
95 per cent confidence interval	±	± 11.0	± 8.6	± 10.9	np	± 7.7	13.0	± 19.9	np	± 4.8
25-44 years										
Proportion	%	13.8	6.1	14.1	17.0	8.1	11.8	11.3	np	11.5
RSE	%	27.3	35.6	32.6	36.7	35.9	36.8	26.4	np	15.7
95 per cent confidence interval	±	± 7.4	± 4.3	± 9.0	± 12.2	± 5.7	± 8.5	± 5.8	np	± 3.5
45-64 years										
Proportion	%	14.1	21.9	16.2	11.3	np	9.3	12.5	np	16.5
RSE	%	27.7	26.7	28.4	42.3	np	49.7	43.1	np	14.2
95 per cent confidence interval	±	± 7.7	± 11.5	± 9.0	± 9.4	np	± 9.1	± 10.6	np	± 4.6
65 years or over										
Proportion	%	20.0	18.8	13.9	np	np	12.1	15.1	np	17.9
RSE	%	26.0	33.9	35.3	np	np	47.9	53.2	np	15.9
95 per cent confidence interval	±	± 10.2	± 12.5	± 9.6	np	np	± 11.4	± 15.7	np	± 5.6
All ages (ASR) (f)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8

TABLE 10A.60

Table 10A.60 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e)</i>	<i>Aust</i>
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	±	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3
2011-12										
0-14 years										
Proportion	%	35.1	46.9	32.6	48.4	58.3	36.6	37.4	65.5	40.9
RSE	%	20.0	14.0	20.8	21.6	13.2	26.1	18.9	18.9	7.8
95 per cent confidence interval	±	± 13.7	± 12.9	± 13.3	± 20.5	± 15.1	± 18.7	± 13.9	± 24.2	± 6.2
15-24 years										
Proportion	%	15.5	20.4	np	31.0	27.2	np	np	np	18.6
RSE	%	47.3	35.9	np	32.4	38.7	np	np	np	18.8
95 per cent confidence interval	±	± 14.3	± 14.3	np	± 19.7	± 20.6	np	np	np	± 6.9
25-44 years										
Proportion	%	24.4	11.8	11.8	15.7	19.0	23.1	17.5	26.1	16.8
RSE	%	22.7	25.6	30.9	34.4	29.0	25.2	31.9	29.9	12.6
95 per cent confidence interval	±	± 10.8	± 5.9	± 7.2	± 10.6	± 10.8	± 11.4	± 10.9	± 15.3	± 4.1
45-64 years										
Proportion	%	22.6	27.9	21.9	15.7	20.5	15.7	19.0	16.5	22.6
RSE	%	23.9	20.8	23.1	33.4	26.7	32.9	30.9	40.6	10.8
95 per cent confidence interval	±	± 10.6	± 11.4	± 9.9	± 10.3	± 10.7	± 10.1	± 11.5	± 13.1	± 4.8
65 years or over										
Proportion	%	37.0	23.2	16.0	16.7	21.9	20.1	33.1	42.2	26.4
RSE	%	20.3	22.5	30.3	38.3	32.9	34.9	39.6	43.0	12.5
95 per cent confidence interval	±	± 14.7	± 10.2	± 9.5	± 12.6	± 14.1	± 13.7	± 25.6	± 35.6	± 6.5
All ages (ASR) (f)										
Proportion	%	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
RSE	%	9.7	9.9	13.8	15.2	9.5	14.2	14.6	17.0	4.5
95 per cent confidence interval	±	± 5.1	± 4.9	± 5	± 7.3	± 5.5	± 6.3	± 7	± 11.3	± 2.2

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

Table 10A.60 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c), (d), (e)</i>	<i>Aust</i>
(a)	Separate estimates for the NT are not available for the 2001 or 2004-05 surveys, and are available only for 'all ages' for the 2007-08 survey. However, NT data are included in national estimates.									
(b)	Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published. However, these data contribute to national estimates.									
(c)	Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.									
(d)	Data for the NT are not published for 2001 or 2004-05 as sample sizes were insufficient to provide reliable estimates, but are included in the Australian total. For the same reason, 2007-08 data for the NT are published only for all ages, although data by age are included in the Australian total.									
(e)	Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.									
(f)	For 'all ages', 2007-08 and 2011-12 data are age standardised to the Australian population at 30 June 2001. These data differ from previous reports which reported crude rates.									
	np Not published.									

Source: ABS 2009, *National Health Survey: Summary of Results, 2007-2008*, Cat. no. 4364.0; ABS 2009, *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. no. 4362.0; ABS unpublished, *National Health Survey 2001, 2004-05, 2007-08*, Cat. no. 4364.0; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

TABLE 10A.61

Table 10A.61 **Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 (a), (b), (c), (d)**

	<i>Unit</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>
Aboriginal and Torres Strait Islander people										
0-14 years										
Proportion	%	56.5	58.0	42.6	37.1	42.4	43.5	51.7	55.7	50.9
RSE	%	14.0	13.7	15.1	27.5	23.5	19.0	27.0	32.3	8.7
95 per cent confidence interval	±	15.5	15.6	12.6	20.0	19.5	16.2	27.4	35.2	8.7
15-34 years										
Proportion	%	11.2	28.2	12.4	23.6	27.8	19.3	22.2	26.4	16.3
RSE	%	31.0	26.3	42.6	30.5	34.2	31.2	42.4	69.7	14.1
95 per cent confidence interval	±	6.8	14.6	10.3	14.1	18.7	11.8	18.5	36.1	4.5
35-54 years										
Proportion	%	21.9	26.3	19.0	11.4	39.2	np	np	29.5	21.1
RSE	%	31.3	29.6	30.7	45.5	22.4	np	np	50.3	15.2
95 per cent confidence interval	±	13.4	15.2	11.4	10.2	17.2	np	np	29.1	6.3
55 yrs or over										
Proportion	%	28.1	32.8	24.6	24.5	28.4	np	np	51.4	28.6
RSE	%	33.8	30.4	55.5	56.2	48.8	np	np	26.3	19.0
95 per cent confidence interval	±	18.6	19.6	26.7	27.0	27.1	np	np	26.5	10.6
All ages (Crude rates)										
Proportion	%	30.5	37.2	24.3	24.2	34.9	25.1	27.5	40.5	29.4
RSE	%	13.3	12.1	16.7	18.4	14.1	15.7	21.9	19.3	7.3
95 per cent confidence interval	±	7.9	8.8	7.9	8.7	9.7	7.7	11.8	15.3	4.2
All ages (ASR) (e)										
Proportion	%	26.6	34.8	23.4	22.9	34.0	22.6	21.6	36.9	27.3
RSE	%	14.1	13.0	19.4	19.0	16.1	16.9	24.1	22.7	7.9
95 per cent confidence interval	±	7.3	8.8	8.9	8.5	10.8	7.5	10.2	16.4	4.2
Non-Indigenous people										
0-14 years										
Proportion	%	34.7	46.9	32.5	48.2	55.3	35.4	32.9	47.0	40.3
RSE	%	20.9	14.0	20.9	22.8	14.6	27.4	23.5	40.0	8.3
95 per cent confidence interval	±	14.2	12.9	13.3	21.5	15.8	19.0	15.1	36.9	6.5
15-34 years										
Proportion	%	18.8	15.5	12.3	25.9	18.5	17.7	20.8	24.6	17.3
RSE	%	23.2	24.7	40.0	30.0	38.4	43.0	31.3	43.9	14.5

Table 10A.61 **Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 (a), (b), (c), (d)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
95 per cent confidence interval	±	8.6	7.5	9.7	15.2	13.9	14.9	12.8	21.2	4.9
35-54 years										
Proportion	%	25.1	19.6	15.6	12.1	27.0	26.1	np	np	20.1
RSE	%	20.3	25.2	29.1	30.4	19.5	21.3	np	np	9.9
95 per cent confidence interval	±	10.0	9.7	8.9	7.2	10.3	10.9	np	np	3.9
55 yrs or over										
Proportion	%	30.4	23.8	16.7	18.8	20.4	11.4	np	np	23.8
RSE	%	16.5	19.1	23.9	29.9	26.7	35.6	np	np	9.0
95 per cent confidence interval	±	9.9	8.9	7.8	11.0	10.7	7.9	np	np	4.2
All ages (Crude rates)										
Proportion	%	26.6	24.4	18.1	21.7	27.3	22.3	23.5	20.6	23.7
RSE	%	9.9	9.9	14.7	17.1	11.2	14.2	15.0	24.8	4.6
95 per cent confidence interval	±	5.2	4.8	5.2	7.3	6.0	6.2	6.9	10.0	2.1
All ages (ASR) (e)										
Proportion	%	26.5	25.1	18.4	24.6	29.0	22.4	23.5	23.2	24.2
RSE	%	10.4	10.0	14.1	16.3	10.0	14.9	16.0	24.3	4.7
95 per cent confidence interval	±	5.4	4.9	5.1	7.9	5.7	6.5	7.4	11.0	2.2

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

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

(c) Excludes remote and very remote areas. Data on whether the respondent has a written asthma action plan was collected for non-remote respondents only in the National Aboriginal and Torres Strait Islander Health Survey.

(d) Data for Aboriginal and Torres Strait Islander people and for non-Indigenous people use different survey questions to define asthma as current. However, data are comparable.

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

np not published

Source: ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component), Cat. no. 4364.0.

Table 10A.62 **Proportion of people with asthma with a written asthma plan, by Indigenous status (a), (b), (c)**

	<i>Unit</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>
2004-05										
Aboriginal and Torres Strait Islander people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
95 per cent confidence interval	±	± 9.2	± 19.1	± 9.8	± 4.9	± 9.6	± 17.8	± 16.0	± 3.1	± 3.9
Non-Indigenous people										
Proportion	%	23.6	26.3	20.5	15.8	21.9	17.5	28.3	–	22.5
RSE	%	11.8	9.2	10.7	15.8	10.2	12.6	15.6	–	5.4
95 per cent confidence interval	±	± 5.5	± 4.8	± 4.3	± 4.9	± 4.4	± 4.3	± 8.6	–	± 2.4
2011–13										
Aboriginal and Torres Strait Islander people										
Proportion	%	26.6	34.8	23.4	22.9	34.0	22.6	21.6	36.9	27.3
RSE	%	14.1	13.0	19.4	19.0	16.1	16.9	24.1	22.7	7.9
95 per cent confidence interval	±	7.3	8.8	8.9	8.5	10.8	7.5	10.2	16.4	4.2
Non-Indigenous people										
Proportion	%	26.5	25.1	18.4	24.6	29.0	22.4	23.5	23.2	24.2
RSE	%	10.4	10.0	14.1	16.3	10.0	14.9	16.0	24.3	4.7
95 per cent confidence interval	±	5.4	4.9	5.1	7.9	5.7	6.5	7.4	11.0	2.2

RSE = relative standard error.

- (a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.
 (b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.
 (c) Rates are age standardised to the Australian estimated resident population at 30 June 2001.
 – Nil or rounded to zero.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *National Health Survey, 2004-05*, Cat. no. 4364.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey (National Aboriginal and Torres Strait Islander Health Survey component)*, Cat. no. 4727.0; ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

Table 10A.63 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
95 per cent confidence interval	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
95 per cent confidence interval	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
95 per cent confidence interval	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
95 per cent confidence interval	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (f)										
Proportion	%	na	na	na	na	na	na	na	na	na
RSE	%	na	na	na	na	na	na	na	na	na
95 per cent confidence interval	%	na	na	na	na	na	na	na	na	na
Total										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

RSE = relative standard error.

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

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

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

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

Table 10A.63 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
--	-------------	------------	------------	------------	-----------	-----------	------------	------------	---------------	-------------

(e) Data for the NT should be used with care as exclusion of very remote areas translates to exclusion of around 23 per cent of the NT population.

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

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

Source: ABS unpublished, *National Health Survey, 2007-08*, Cat. no. 4364.0.

Table 10A.64 GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)

	<i>Unit</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>
2008-09										
GPs using CDM items	no.	6 276	4 758	3 671	1 706	1 534	462	259	111	18 777
Total GPs	no.	6 488	4 931	3 937	1 807	1 638	492	292	122	19 707
GPs using CDM items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3
2009-10										
GPs using CDM items	no.	6 439	4 925	3 820	1 764	1 605	487	263	120	19 423
Total GPs	no.	6 617	5 061	4 064	1 858	1 683	511	286	135	20 215
GPs using CDM items	%	97.3	97.3	94.0	94.9	95.4	95.3	92.0	88.9	96.1
2010-11										
GPs using CDM items	no.	6 643	5 151	3 962	1 808	1 631	514	280	125	20 114
Total GPs	no.	6 806	5 277	4 168	1 875	1 712	526	299	132	20 795
GPs using CDM items	%	97.6	97.6	95.1	96.4	95.3	97.7	93.6	94.7	96.7
2011-12										
GPs using CDM items	no.	6 939	5 420	4 170	1 900	1 691	514	301	135	21 070
Total GPs	no.	7 084	5 538	4 378	1 963	1 761	531	319	143	21 717
GPs using CDM items	%	98.0	97.9	95.2	96.8	96.0	96.8	94.4	94.4	97.0
2012-13										
GPs using CDM items	no.	7 208	5 682	4 413	1 977	1 718	525	323	139	21 985
Total GPs	no.	7 354	5 818	4 601	2 055	1 794	543	349	148	22 662
GPs using CDM items	%	98.0	97.7	95.9	96.2	95.8	96.7	92.6	93.9	97.0
2013-14										
GPs using CDM items	no.	7 519	5 993	4 671	2 135	1 787	570	322	142	23 139
Total GPs	no.	7 705	6 149	4 874	2 203	1 859	578	340	154	23 862
GPs using CDM items	%	97.6	97.5	95.8	96.9	96.1	98.6	94.7	92.2	97.0

- (a) The chronic disease management (CDM) items include GP only care plans, multidisciplinary care plans (A15 subgroup 1) and case conferences (A15 subgroup 2, excluding items relating to consultant physicians and psychiatrists). Services that qualify under the DVA National Treatment Account or are provided in public hospitals are not included.
- (b) Additional chronic disease management MBS items are introduced from time-to-time and may impact on GP use of care planning or case conferencing MBS items.
- (c) GPs are defined as those General Practitioners and Other Medical Practitioners who have claimed at least 1500 non-referred attendances in the relevant financial year. GPs are counted only in the state/territory where they claimed the most services — this prevents double counting.

Source: Department of Health unpublished, MBS Statistics.

Table 10A.65 Pathology tests requested by GPs, real benefits paid (2013-14 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h)

	<i>Unit</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 (c)</i>
Benefits paid										
2012-13	\$m	499.9	358.6	319.7	139.4	108.7	31.7	22.4	14.5	1 494.8
2013-14	\$m	516.4	369.6	338.9	149.5	112.9	31.8	23.1	15.3	1 557.6
Benefits paid per person (ASR)										
2012-13	\$	64.3	59.9	67.5	55.5	59.7	56.1	59.2	66.5	62.3
2013-14	\$	65.3	60.4	70.1	57.6	61.3	55.8	60.2	68.5	63.6
MBS pathology items rebated										
2012-13	'000	27 177	20 092	17 469	7 788	6 431	1 829	1 176	774	82 737
2013-14	'000	28 199	20 808	18 310	8 333	6 657	1 857	1 214	829	86 213
MBS pathology items rebated per person (ASR)										
2012-13	no.	3.5	3.3	3.7	3.1	3.5	3.2	3.1	3.6	3.4
2013-14	no.	3.5	3.4	3.8	3.2	3.6	3.2	3.2	3.8	3.5

ASR = age standardised rate.

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 10A.66).
- (c) GPs are defined as vocationally recognised GPs and other medical officers (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.
- (f) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.
- (g) Estimated resident populations used to derive rates are first preliminary estimates based on the 2011 Census.
- (h) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

TABLE 10A.66

Table 10A.66 **Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h), (i)**

	<i>Unit</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>
2009-10										
Benefits paid										
Benefits paid	\$m	504.2	360.3	317.9	137.6	110.8	31.8	23.1	13.2	1 498.9
Per person	\$	69.6	64.8	70.1	59.6	67.4	62.7	64.4	57.1	66.9
MBS pathology items rebated										
Number	'000	25 774	18 690	15 935	7 164	6 055	1 693	1 128	671	77 110
Per person	no.	3.56	3.36	3.51	3.10	3.68	3.33	3.15	2.91	3.44
2010-11										
Benefits paid										
Benefits paid	\$m	465.5	329.0	291.5	128.8	101.8	29.4	21.0	12.4	1379.3
Per person	\$	64.8	59.9	65.7	55.5	62.4	57.6	57.5	53.7	62.2
MBS pathology items rebated										
Number	'000	25 364	18 372	15 940	7 201	6 026	1 669	1 098	676	76 347
Per person	no.	3.53	3.34	3.59	3.11	3.69	3.27	3.01	2.94	3.44
2011-12										
Benefits paid										
Benefits paid	\$m	487.8	342.2	309.9	134.1	104.4	30.3	22.3	13.8	1444.8
Per person	\$	67.3	61.4	68.7	56.2	63.5	59.2	60.1	59.4	64.3
MBS pathology items rebated										
Number	'000	26 520	19 235	16 900	7 487	6 217	1 733	1 172	748	80 012
Per person	no.	3.66	3.45	3.74	3.14	3.78	3.39	3.16	3.22	3.56

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

(b) Per person data for 2011-12 and previous years are crude rates and are not comparable to data for 2012-13 and subsequent years which are age standardised (see table 10A.65).

Table 10A.66 Pathology tests requested by GPs, real benefits paid, 2009-10 to 2011-12 (2013-14 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h), (i)

<i>Unit</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>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-------------

- (c) GPs are defined as vocationally recognised (specialist) GPs and other medical officers (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.
- (f) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.
- (g) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.
- (h) Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates. See chapter 2 (tables 2A.2) for details.
- (i) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

Table 10A.67 Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2013-14 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)

	<i>Unit</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 (c)</i>
Benefits paid										
2012-13	\$m	532.8	326.1	300.1	120.7	91.0	28.5	17.9	7.2	1 424.2
2013-14	\$m	583.2	356.4	338.8	133.1	99.3	31.1	19.3	8.9	1 570.2
Benefits paid per person (ASR)										
2012-13	\$	67.8	54.4	63.2	48.2	49.6	49.6	48.5	35.6	59.1
2013-14	\$	72.9	58.2	69.8	51.5	53.4	53.6	51.1	42.9	63.8
MBS diagnostic imaging items										
2012-13	'000	4 613	3 037	2 692	1 095	860	263	160	69	12 789
2013-14	'000	4 941	3 255	2 953	1 185	917	280	169	85	13 785
MBS diagnostic imaging items per person (ASR)										
2012-13	no.	0.59	0.51	0.57	0.44	0.48	0.47	0.43	0.33	0.54
2013-14	no.	0.63	0.54	0.61	0.46	0.50	0.49	0.45	0.40	0.56

ASR = age standardised rate.

- (a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.
- (b) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 10A.68).
- (c) GPs are defined as vocationally recognised (specialist) GPs and other medical officers (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) Estimated resident populations used to derive rates are first preliminary estimates based on the 2011 Census.
- (f) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections.

TABLE 10A.68

Table 10A.68 Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f), (g)

	<i>Unit</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>
2009-10										
Benefits paid										
Benefits paid	\$m	495.2	308.1	272.9	113.8	89.5	27.5	17.3	5.8	1330.1
Per person	\$	68.3	55.4	60.2	49.3	54.4	54.1	48.2	25.2	59.4
MBS diagnostic imaging items rebated										
Number	'000	4 087	2 691	2 324	982	798	240	143	53	11 320
Per person	no.	0.56	0.48	0.51	0.43	0.49	0.47	0.40	0.23	0.51
2010-11										
Benefits paid										
Benefits paid	\$m	476.6	288.4	266.7	109.3	84.8	25.6	15.7	5.4	1272.5
Per person	\$	66.4	52.5	60.1	47.1	52.0	50.1	43.0	23.6	57.4
MBS diagnostic imaging items rebated										
Number	'000	4 096	2 660	2 384	981	796	235	140	53	11 344
Per person	no.	0.57	0.48	0.54	0.42	0.49	0.46	0.38	0.23	0.51
2011-12										
Benefits paid										
Benefits paid	\$m	509.0	309.2	289.9	116.3	87.9	26.6	16.9	6.0	1361.8
Per person	\$	70.2	55.5	64.2	48.7	53.4	52.0	45.7	25.8	60.6
MBS diagnostic imaging items rebated										
Number	'000	4 377	2 867	2 583	1 044	824	245	149	58	12 145
Per person	no.	0.60	0.51	0.57	0.44	0.50	0.48	0.40	0.25	0.54

(a) Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details.

Table 10A.68 Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2013-14 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f), (g)

<i>Unit</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>
(b)	Per person data for 2011-12 and previous years are crude rates and are not comparable to data for 2012-13 and subsequent years which are age standardised (see table 10A.67).								
(c)	GPs are defined as vocationally recognised (specialist) GPs and other medical officers (OMPs).								
(d)	Includes Department of Veterans' Affairs (DVA) data.								
(e)	From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.								
(f)	Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.								
(g)	Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates. See chapter 2 (tables 2A.2) for details.								
<i>Source:</i> Department of Health unpublished, MBS and DVA data collections; table 2A.51.									

TABLE 10A.69

Table 10A.69 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	<i>Unit</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>
PIP practices (May 2010)	no.	1 700	1 209	981	409	354	123	67	38	4 881
SWPE (c)	no.	4 765 033	4 063 295	3 060 662	1 500 216	1 225 101	389 553	269 970	79 148	15 352 978
PIP eHealth Incentive — uptake	no.	1 280	971	793	333	274	102	57	20	3 830
Share of PIP practices	%	75.3	80.3	80.8	81.4	77.4	82.9	85.1	52.6	78.5
PIP practices (May 2011)	no.	1 664	1 178	957	409	338	123	66	46	4 781
SWPE (c)	no.	4 792 245	4 100 376	3 129 970	1 508 314	1 239 216	396 459	277 984	86 021	15 530 585
PIP eHealth Incentive — uptake	no.	1 412	1 050	856	364	299	109	62	37	4 189
Share of PIP practices	%	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6
PIP practices (May 2012)	no.	1 710	1 211	1 005	424	353	126	66	54	4 949
SWPE (c)	no.	4 948 168	4 213 416	3 260 160	1 562 809	1 276 083	402 315	279 439	90 413	16 032 803
PIP eHealth Incentive — uptake	no.	1 481	1 087	897	378	310	113	60	42	4 368
Share of PIP practices	%	86.6	89.8	89.3	89.2	87.8	89.7	90.9	77.8	88.3
PIP practices (May 2013)	no.	1 798	1 229	1 046	433	363	127	65	56	5 117
SWPE (c)	no.	5 129 251	4 207 334	3 319 305	1 619 421	1 300 886	399 791	270 671	90 909	16 337 568
PIP eHealth Incentive — uptake	no.	1 247	937	776	296	264	96	52	27	3 695
Share of PIP practices	%	69.4	76.2	74.2	68.4	72.7	75.6	80.0	48.2	72.2
PIP practices (May 2014) (b)	no.	1 812	1 255	1 077	452	367	121	71	55	5 210
SWPE (c)	no.	5 258 991	4 345 602	3 383 012	1 700 870	1 300 873	400 531	283 522	100 855	16 774 256
PIP eHealth Incentive — uptake	no.	1 553	1 117	926	375	318	104	60	43	4 496
Share of PIP practices	%	85.7	89.0	86.0	83.0	86.7	86.0	84.5	78.2	86.3

Table 10A.69 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

	<i>Unit</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>
(a)	Proportion of PIP practices registered for the PIP eHealth Incentive. Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).									
(b)	<p>In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements, as reflected in the sharp decrease in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 and the recovery in May 2014.</p> <p>Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.</p>									
(c)	A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.									

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.70 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b), (c)

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Australia</i>
PIP practices (May 2013)	no.	3 425	981	536	104	71	5 117
PIP eHealth Incentive — uptake	%	72.3	77.5	68.8	55.8	43.7	72.2
PIP practices (May 2014)	no.	3 484	1 012	546	99	69	5 210
PIP eHealth Incentive — uptake	%	86.9	88.9	82.8	72.7	62.3	86.3

- (a) Proportion of PIP practices registered for the PIP eHealth Incentive. Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).
- (b) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.
- (c) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 compared to historical data under previous requirements (see table 10A.70). Previously, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 10A.71 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012 (a), (b)**

	<i>Unit</i>	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural</i>	<i>Remote centre</i>	<i>Other remote</i>	<i>Aust</i>
PIP practices (May 2012)	no.	3 002	378	318	364	701	63	123	4 949
SWPE (c)	no.	10 057 467	1 358 563	1 145 718	1 315 196	1 890 771	147 831	117 257	16 032 803
PIP eHealth Incentive — uptake (d), (e)									
Share of PIP practices (May 2010)	%	77.8	79.7	83.1	80.2	81.0	66.1	63.9	78.5
Share of PIP practices (May 2011)	%	87.7	88.5	90.6	85.7	89.5	72.9	76.7	87.6
Share of PIP practices (May 2012)	%	88.4	90.0	89.6	87.6	90.3	74.6	74.0	88.3

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.51).

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

(d) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 (see tables 10A.68 and 10A.69).

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

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.72

Table 10A.72 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
2012-13										
GP always or often listened carefully										
Major cities										
Proportion	%	90.8	89.3	89.5	89.2	89.4	..	89.3	..	89.9
RSE	%	0.6	0.7	0.6	0.8	0.8	..	1.3	..	0.3
95% CI	± %	1.0	1.3	1.1	1.4	1.4	..	2.3	..	0.5
Other (d)										
Proportion	%	89.3	90.1	87.5	86.1	86.9	89.4	-	86.4	88.6
RSE	%	1.3	1.0	1.0	1.5	1.5	1.0	-	1.5	0.5
95% CI	± %	2.2	1.8	1.7	2.5	2.5	1.7	-	2.6	0.9
Total										
Proportion	%	90.4	89.5	88.8	88.5	88.8	89.4	89.3	86.4	89.5
RSE	%	0.5	0.6	0.5	0.6	0.8	1.0	1.3	1.5	0.2
95% CI	± %	0.8	1.1	0.9	1.1	1.3	1.7	2.3	2.6	0.4
GP always or often showed respect										
Major cities										
Proportion	%	93.8	93.2	92.4	92.6	92.9	..	93.0	..	93.2
RSE	%	0.4	0.6	0.4	0.6	0.6	..	1.1	..	0.2
95% CI	± %	0.8	1.0	0.7	1.1	1.1	..	1.9	..	0.4
Other (d)										
Proportion	%	92.8	92.2	90.9	90.6	90.3	92.0	-	90.6	91.8
RSE	%	0.8	0.8	1.1	1.4	1.3	0.9	-	1.2	0.4
95% CI	± %	1.4	1.5	1.9	2.5	2.4	1.7	-	2.2	0.7
Total										
Proportion	%	93.5	93.0	91.8	92.2	92.3	92.0	93.0	90.6	92.8
RSE	%	0.3	0.5	0.4	0.5	0.6	0.9	1.1	1.2	0.2
95% CI	± %	0.6	0.9	0.8	1.0	1.0	1.7	1.9	2.2	0.4
GP always or often spent enough time										
Major cities										
Proportion	%	89.8	88.0	88.4	87.5	88.1	..	85.9	..	88.6
RSE	%	0.7	0.8	0.7	0.8	1.1	..	1.5	..	0.3
95% CI	± %	1.2	1.3	1.2	1.3	1.9	..	2.5	..	0.6

TABLE 10A.72

Table 10A.72 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Other (d)										
Proportion	%	89.9	88.2	85.5	86.2	88.0	88.0	-	84.7	87.8
RSE	%	1.0	1.3	1.5	2.1	1.4	0.9	-	1.7	0.6
95% CI	± %	1.8	2.2	2.6	3.6	2.5	1.6	-	2.8	1.0
Total										
Proportion	%	89.9	88.0	87.3	87.2	88.1	88.0	85.9	84.7	88.4
RSE	%	0.5	0.6	0.6	0.7	1.0	0.9	1.5	1.7	0.3
95% CI	± %	0.9	1.0	1.1	1.3	1.7	1.6	2.5	2.8	0.5
2013-14 (e)										
GP always or often listened carefully										
Major cities										
Proportion	%	91.8	91.9	90.1	88.9	91.5	..	88.8	..	91.1
RSE	%	1.3	0.5	0.9	1.1	0.2	..	1.5	..	0.3
95% CI	± %	2.3	1.0	1.6	2.0	0.3	..	2.6	..	0.6
Other (d)										
Proportion	%	89.5	89.9	89.6	87.3	89.2	91.3	-	84.8	89.4
RSE	%	1.3	1.4	0.9	2.7	1.7	0.7	-	1.5	0.9
95% CI	± %	2.3	2.4	1.6	4.7	3.0	1.2	-	2.5	1.6
Total										
Proportion	%	91.2	91.3	89.8	88.6	90.9	91.3	89.1	84.8	90.6
RSE	%	0.5	0.7	0.8	0.9	0.5	0.7	1.5	1.5	0.3
95% CI	± %	0.9	1.3	1.3	1.5	0.8	1.2	2.6	2.5	0.6
GP always or often showed respect										
Major cities										
Proportion	%	94.2	94.6	92.9	91.8	94.9	..	92.3	..	93.7
RSE	%	1.2	0.6	0.7	0.8	1.5	..	1.0	..	0.3
95% CI	± %	2.2	1.0	1.4	1.5	2.8	..	1.7	..	0.5
Other (d)										
Proportion	%	91.2	93.0	92.7	90.6	92.3	93.5	-	89.6	92.1
RSE	%	1.2	1.1	0.9	2.2	1.5	0.6	-	1.0	0.6
95% CI	± %	2.2	2.0	1.6	3.8	2.8	1.1	-	1.8	1.2
Total										
Proportion	%	93.4	94.2	92.6	91.5	94.4	93.5	92.4	89.6	93.3
RSE	%	0.4	0.6	0.4	0.7	-	0.6	1.0	1.0	0.2
95% CI	± %	0.8	1.1	0.8	1.2	-	1.1	1.8	1.8	0.4

TABLE 10A.72

Table 10A.72 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
GP always or often spent enough time										
Major cities										
Proportion	%	91.0	89.3	89.6	87.3	90.7	..	87.2	..	89.7
RSE	%	1.3	0.8	0.6	1.0	0.6	..	1.9	..	0.5
95% CI	± %	2.3	1.4	1.1	1.8	1.2	..	3.2	..	0.8
Other (d)										
Proportion	%	88.2	88.1	88.0	88.7	89.3	89.7	-	86.3	88.3
RSE	%	1.0	0.9	1.0	2.2	1.5	0.8	-	1.8	0.7
95% CI	± %	1.7	1.6	1.7	3.9	2.6	1.5	-	3.1	1.2
Total										
Proportion	%	90.3	89.1	88.9	87.6	90.3	89.7	87.2	86.3	89.3
RSE	%	0.5	0.8	0.5	0.8	0.6	0.8	1.9	1.8	0.4
95% CI	± %	0.8	1.4	0.8	1.4	1.0	1.5	3.2	3.1	0.7

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

- (a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (d) 'Other' includes inner and outer regional, remote and very remote areas.
- (e) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.
- .. Not applicable. – Nil or rounded to zero.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.73 **Client experience of GPs by remoteness, Australia (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
2012-13						
GP always or often listened carefully						
Proportion	%	89.9	88.9	88.4	85.4	89.5
RSE	%	0.3	0.6	0.8	2.8	0.2
95% CI	± %	0.5	1.0	1.4	4.7	0.4
GP always or often showed respect						
Proportion	%	93.2	92.4	90.9	88.5	92.8
RSE	%	0.2	0.5	0.7	1.8	0.2
95% CI	± %	0.4	0.9	1.2	3.1	0.4
GP always or often spent enough time						
Proportion	%	88.6	88.2	87.5	84.3	88.4
RSE	%	0.3	0.7	1.0	2.6	0.3
95% CI	± %	0.6	1.2	1.7	4.4	0.5
2013-14 (d)						
GP always or often listened carefully						
Proportion	%	91.1	90.1	88.7	86.1	90.6
RSE	%	0.3	0.9	0.7	3.4	0.3
95% CI	± %	0.6	1.6	1.3	5.7	0.6
GP always or often showed respect						
Proportion	%	93.7	92.7	91.7	88.7	93.3
RSE	%	0.3	0.7	0.8	2.7	0.2
95% CI	± %	0.5	1.2	1.5	4.8	0.4
GP always or often spent enough time						
Proportion	%	89.7	88.7	88.1	86.0	89.3
RSE	%	0.5	0.7	1.6	4.5	0.4
95% CI	± %	0.8	1.2	2.7	7.6	0.7

RSE = Relative standard error. **95% CI** = confidence interval.

- (a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (d) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.74 **Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13 (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Total (e)</i>
2012-13 (e)					
GP always or usually listened carefully					
Proportion	%	89.8	88.8	86.4	88.5
RSE	%	1.4	1.9	2.3	1.0
95% CI	± %	2.5	3.3	3.9	1.8
GP always or usually showed respect					
Proportion	%	90.5	88.0	87.5	89.0
RSE	%	1.7	1.9	1.4	1.0
95% CI	± %	3.0	3.3	2.4	1.7
GP always or usually spent enough time					
Proportion	%	86.2	85.0	83.2	85.0
RSE	%	1.8	2.1	2.3	1.1
95% CI	± %	3.0	3.4	3.7	1.9

RSE = Relative standard error. **95% CI** = confidence interval.

- (a) Persons 15 years and over who saw a GP in the last 12 months for their own health (excluding interviews by proxy), reporting the GP always or usually listened carefully, showed respect, and spent enough time with them.
- (b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).
- (c) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.
- (d) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).
- (e) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

Table 10A.75 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
2012-13										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	96.3	94.6	94.5	95.5	95.3	..	95.1	..	95.3
RSE	%	0.5	0.6	0.5	0.6	0.6	..	0.9	..	0.3
95% CI	± %	1.0	1.1	1.0	1.1	1.1	..	1.7	..	0.5
Other (d)										
Proportion	%	94.0	92.7	93.1	95.3	91.9	94.5	-	92.4	93.5
RSE	%	0.9	1.3	0.8	1.3	2.5	0.8	-	1.6	0.5
95% CI	± %	1.6	2.3	1.5	2.3	4.5	1.4	-	2.8	0.9
Total										
Proportion	%	95.8	94.2	94.0	95.5	94.5	94.5	95.1	92.4	94.8
RSE	%	0.5	0.5	0.4	0.5	0.7	0.8	0.9	1.6	0.2
95% CI	± %	1.0	1.0	0.7	1.0	1.2	1.4	1.7	2.8	0.4
Dental professional always or often showed respect										
Major cities										
Proportion	%	97.0	96.3	95.6	96.5	96.8	..	96.0	..	96.5
RSE	%	0.4	0.5	0.6	0.5	0.5	..	0.8	..	0.3
95% CI	± %	0.8	1.0	1.2	1.0	1.0	..	1.5	..	0.6
Other (d)										
Proportion	%	95.4	93.6	95.2	96.9	94.9	96.1	-	94.8	95.1
RSE	%	0.6	1.2	0.8	1.1	1.5	0.5	-	1.3	0.3
95% CI	± %	1.2	2.2	1.5	2.1	2.7	1.0	-	2.3	0.7
Total										
Proportion	%	96.7	95.7	95.4	96.6	96.4	96.1	96.0	94.8	96.1
RSE	%	0.4	0.4	0.5	0.4	0.5	0.5	0.8	1.3	0.2
95% CI	± %	0.7	0.8	0.9	0.8	0.9	1.0	1.5	2.3	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	96.8	95.2	95.0	96.3	96.6	..	95.4	..	95.9
RSE	%	0.4	0.5	0.6	0.7	0.6	..	0.9	..	0.2
95% CI	± %	0.7	1.0	1.1	1.3	1.0	..	1.8	..	0.4
Other (d)										
Proportion	%	94.5	93.8	96.3	97.8	96.8	96.9	-	94.4	95.4
RSE	%	0.9	1.4	0.8	0.7	0.9	0.7	-	1.1	0.5
95% CI	± %	1.7	2.6	1.4	1.3	1.8	1.3	-	2.0	0.9

TABLE 10A.75

Table 10A.75 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Total										
Proportion	%	96.2	94.9	95.4	96.6	96.7	96.9	95.4	94.4	95.8
RSE	%	0.4	0.5	0.5	0.6	0.4	0.7	0.9	1.1	0.2
95% CI	± %	0.7	0.9	1.0	1.1	0.8	1.3	1.8	2.0	0.4
2013-14 (e)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.6	95.3	93.0	96.3	97.5	..	95.6	..	95.0
RSE	%	0.9	0.9	0.4	0.3	2.3	..	3.6	..	0.4
95% CI	± %	1.6	1.6	0.8	0.6	4.4	..	6.7	..	0.7
Other (d)										
Proportion	%	95.0	91.2	92.6	96.6	92.9	93.7	100.0	94.5	93.3
RSE	%	0.6	2.0	0.8	1.5	1.1	1.1	-	1.9	0.5
95% CI	± %	1.2	3.6	1.5	2.8	2.0	2.1	-	3.5	1.0
Total										
Proportion	%	94.8	94.5	92.9	96.5	96.5	93.7	95.4	94.5	94.6
RSE	%	0.6	0.7	0.8	0.6	1.6	1.1	3.6	1.9	1.0
95% CI	± %	1.2	1.3	1.4	1.1	3.0	2.1	6.8	3.5	1.9
Dental professional always or often showed respect										
Major cities										
Proportion	%	95.9	96.2	94.5	96.6	97.2	..	96.7	..	96.0
RSE	%	0.7	0.6	3.1	2.3	2.3	..	3.5	..	0.4
95% CI	± %	1.4	1.2	5.7	4.4	4.4	..	6.6	..	0.8
Other (d)										
Proportion	%	94.9	92.7	93.6	95.6	94.3	96.2	100.0	95.4	94.2
RSE	%	-	2.2	0.5	1.9	7.0	0.9	-	2.0	0.3
95% CI	± %	-	3.9	1.0	3.5	12.9	1.7	-	3.8	0.5
Total										
Proportion	%	95.8	95.3	94.2	96.7	96.5	96.2	96.3	95.4	95.5
RSE	%	0.6	0.6	0.5	0.3	1.6	0.9	3.5	2.0	0.2
95% CI	± %	1.1	1.1	0.9	0.5	3.0	1.7	6.6	3.8	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	95.6	96.9	94.0	96.9	98.1	..	96.6	..	96.0
RSE	%	0.6	0.7	3.2	2.3	0.2	..	3.6	..	0.3
95% CI	± %	1.1	1.3	5.9	4.4	0.4	..	6.8	..	0.5

Table 10A.75 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Other (d)										
Proportion	%	95.6	94.7	93.5	97.9	93.2	95.5	100.0	96.3	94.9
RSE	%	0.6	1.6	5.3	1.4	0.5	1.6	-	1.7	0.5
95% CI	± %	1.1	2.9	9.7	2.7	0.9	3.0	-	3.1	0.9
Total										
Proportion	%	95.7	96.3	93.9	97.1	97.0	95.5	97.1	96.3	95.7
RSE	%	0.5	0.6	0.5	0.4	1.7	1.6	3.6	1.7	0.1
95% CI	± %	1.0	1.1	0.9	0.8	3.2	3.0	6.9	3.1	0.2

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

- (a) Proportion of people who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions.
- (d) 'Other' includes inner and outer regional, remote and very remote areas.
- (e) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

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

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

Table 10A.76 **Client experience of dental professionals by remoteness, Australia (a), (b), (c)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
2012-13						
Dental professional always or often listened carefully						
Proportion	%	95.3	93.2	93.8	95.0	94.8
RSE	%	0.3	0.6	1.0	1.3	0.2
95% CI	± %	0.5	1.1	1.8	2.5	0.4
Dental professional always or often showed respect						
Proportion	%	96.5	94.6	96.0	96.8	96.1
RSE	%	0.3	0.5	0.6	1.2	0.2
95% CI	± %	0.6	0.9	1.1	2.3	0.5
Dental professional always or often spent enough time						
Proportion	%	95.9	95.0	96.2	95.8	95.8
RSE	%	0.2	0.6	0.7	1.4	0.2
95% 95% CI	± %	0.4	1.1	1.3	2.6	0.4
2013-14 (c)						
Dental professional always or often listened carefully						
Proportion	%	95.0	93.3	93.5	94.8	94.6
RSE	%	0.4	3.0	1.1	3.5	1.0
95% CI	± %	0.7	5.5	2.1	6.5	1.9
Dental professional always or often showed respect						
Proportion	%	96.0	94.1	94.3	95.2	95.5
RSE	%	0.4	0.3	1.2	3.5	0.2
95% CI	± %	0.8	0.6	2.3	6.5	0.5
Dental professional always or often spent enough time						
Proportion	%	96.0	95.1	94.5	95.8	95.7
RSE	%	0.3	3.0	1.4	2.7	0.1
95% 95% CI	± %	0.5	5.6	2.6	5.0	0.2

RSE = Relative standard error. **95% CI** = confidence interval.

(a) Proportion of persons who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.

(b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.

(c) For 2013-14, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, *Patient Experience Survey 2012-13, 2013-14*, Cat. no. 4839.0.

TABLE 10A.77

Table 10A.77 Annual health assessments for older people (a), (b), (c)

	<i>Unit</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>
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	457 509	333 152	235 712	116 423	120 858	35 603	14 772	7 126	1 321 206
Proportion assessed	%	21.38	19.48	22.15	15.69	20.70	22.23	11.86	11.09	20.33
2007-08										
Older people assessed	no.	104 776	66 478	57 405	19 384	26 741	8 301	2 337	1 039	286 461
Older people	no.	466 836	340 221	241 060	119 456	122 578	36 154	15 228	7 409	1 348 993
Proportion assessed	%	22.44	19.54	23.81	16.23	21.82	22.96	15.35	14.02	21.24
2008-09										
Older people assessed	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Older people	no.	475 715	347 182	246 109	122 391	123 946	36 778	15 647	7 654	1 375 483
Proportion assessed	%	23.71	21.14	26.11	18.63	22.24	25.86	15.68	16.67	22.83
2009-10										
Older people assessed	no.	118 408	78 283	67 140	25 472	28 202	9 187	2 770	1 478	330 940
Older people	no.	485 866	354 565	252 255	125 718	125 610	37 549	16 171	8 026	1 405 819
Proportion assessed	%	24.37	22.08	26.62	20.26	22.45	24.47	17.13	18.42	23.54
2010-11										
Older people assessed	no.	133 330	90 915	77 725	31 374	31 844	11 085	3 205	1 876	381 354
Older people	no.	497 907	362 416	259 291	129 883	127 157	38 225	16 736	8 434	1 440 116
Proportion assessed	%	26.78	25.09	29.98	24.16	25.04	29.00	19.15	22.24	26.48
2011-12										
Older people assessed	no.	141 601	96 734	84 521	33 511	33 396	11 684	3 319	2 078	406 844
Older people	no.	507 900	370 433	266 899	134 218	129 129	39 162	17 341	8 957	1 473 927
Proportion assessed	%	27.88	26.11	31.67	24.97	25.86	29.84	19.14	23.20	27.60
2012-13										
Older people assessed	no.	151 348	102 615	92 687	37 936	35 936	13 149	3 891	2 639	440 201
Older people	no.	521 589	380 362	275 409	139 019	131 501	40 200	18 095	9 611	1 515 491

TABLE 10A.77

Table 10A.77 Annual health assessments for older people (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Proportion assessed	%	29.02	26.98	33.65	27.29	27.33	32.71	21.50	27.46	29.05
2013-14										
Older people assessed	no.	162 913	112 500	101 640	44 322	40 446	14 106	4 366	3 242	483 535
Older people	no.	533 806	390 136	284 798	144 121	133 919	41 144	18 811	10 259	1 556 691
Proportion assessed	%	30.52	28.84	35.69	30.75	30.20	34.28	23.21	31.60	31.06

- (a) Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.
- (b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (c) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (d) Rates have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.
- (e) Derived target populations as at 31 December are computed as the average of the population estimates / projections at June 30 at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13-14) for details.

Source: Department of Health unpublished, MBS data collection; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.78

Table 10A.78 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014 (a), (b), (c)**

	<i>Unit</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 (d)</i>
Valid vaccinations provided										
GPs	no.	5 927 073	3 172 889	3 982 990	1 686 901	999 973	398 833	216 598	724 026	16 429 263
Council	no.	211 262	2 070 561	274 577	88 261	253 425	27 545	–	–	2 925 631
State or territory health department	no.	–	–	447	119 468	285	–	4 486	1 513	126 199
Public hospital	no.	61 176	61 562	132 613	31 622	9 562	1 672	1 019	24 276	324 672
Aboriginal health service	no.	34 977	9 086	12 121	10 248	10 271	52	–	68 879	145 634
Community health centre	no.	433 355	14 617	283 378	499 981	95 838	280	141 437	189 578	1 659 050
Other (e)	no.	3 383	2 047	23 258	1 283	733	–	–	552	34 383
Total	no.	6 671 226	5 330 762	4 709 384	2 437 764	1 370 087	428 382	363 540	1 008 824	21 644 832
Proportion of total valid vaccinations										
GPs	%	88.8	59.5	84.6	69.2	73.0	93.1	59.6	71.8	75.9
Council	%	3.2	38.8	5.8	3.6	18.5	6.4	–	–	13.5
State or territory health department	%	–	–	–	4.9	–	–	1.2	0.1	0.6
Public hospital	%	0.9	1.2	2.8	1.3	0.7	0.4	0.3	2.4	1.5
Aboriginal health service	%	0.5	0.2	0.3	0.4	0.7	–	–	6.8	0.7
Community health centre	%	6.5	0.3	6.0	20.5	7.0	0.1	38.9	18.8	7.7
Other (e)	%	0.1	–	0.5	0.1	0.1	–	–	0.1	0.2
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) 1 July 2009 to 30 June 2014.

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

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

(d) Includes data for unknown State or Territory.

Table 10A.78 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2009–2014 (a), (b), (c)**

<i>Unit</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 (d)</i>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-----------------

(e) Other includes Divisions of GP, Flying Doctors Services, Aboriginal Health Workers, Community nurses, Private hospitals and unknown providers.

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

Source: Department of Health unpublished, Australian Childhood Immunisation Register (ACIR) data collection.

Table 10A.79 Children aged 12 months to less than 15 months who were fully immunised (per cent) (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>
Fully immunised (e)									
2007-08	91.6	91.9	91.1	89.4	91.0	92.3	93.6	90.7	91.3
2008-09	91.7	91.9	90.9	89.5	91.6	91.5	93.9	90.1	91.4
2009-10	91.8	92.1	91.8	89.7	91.2	92.5	93.1	89.9	91.6
2010-11 (f)	90.1	92.0	91.6	89.5	91.4	91.5	93.5	90.6	91.2
2011-12	91.6	92.6	91.6	90.3	92.3	92.5	93.2	91.8	91.8
2012-13	90.8	91.7	92.0	90.2	91.3	92.2	92.8	91.5	91.3
2013-14 (g)	89.7	90.8	91.2	90.1	90.2	89.8	93.0	90.8	90.4
Immunised against (2013-14)									
Diphtheria, tetanus and pertussis	90.6	91.8	91.8	91.3	90.9	90.6	93.8	91.4	91.3
Polio	90.4	91.7	91.8	91.2	90.8	90.5	93.8	91.4	91.2
<i>Haemophilus influenzae</i> type b	90.3	91.5	91.7	91.0	90.7	90.3	93.5	91.3	91.1
Pneumococcal (g)	90.2	91.9	91.1	90.7	90.8	90.8	95.1	88.8	91.0

- (a) Coverage measured for children immunised at the age of 12 months to less than 15 months, by the State or Territory in which the child resided.
- (b) The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b, *Haemophilus influenzae* type b and, from the quarter ending 31 December 2013, pneumococcal.
- (f) Coverage rates were relatively low for the June 2011 quarter, associated with parents not receiving immunisation reminders due to administrative error. This may be reflected in relatively low coverage rates for 2010-11.
- (g) From the quarter ending 31 December 2013, immunisation against pneumococcal is included for assessment of children as fully immunised at 12 months.

Source: Department of Health unpublished, ACIR data collection.

Table 10A.80 Children aged 24 months to less than 27 months who were fully immunised (per cent) (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>
Fully immunised (e)									
2007-08	92.6	93.7	92.3	91.2	94.3	94.5	94.1	94.1	92.8
2008-09	92.6	93.7	92.1	90.9	92.6	93.7	94.2	93.8	92.6
2009-10	92.2	92.9	91.5	90.9	91.7	93.4	93.8	92.7	92.1
2010-11	92.4	93.5	92.9	91.0	92.6	94.2	93.5	94.1	92.7
2011-12	92.3	93.3	92.8	90.8	92.6	93.8	93.6	94.5	92.6
2012-13	92.3	93.1	92.6	90.6	92.5	94.2	93.2	93.4	92.4
2013-14	91.9	92.8	93.2	91.0	92.2	93.1	93.1	93.6	92.4
Immunised against (2013-14)									
Diphtheria, tetanus and pertussis	94.7	95.4	95.1	94.0	94.9	95.6	95.5	95.3	94.9
Polio	94.6	95.4	95.1	94.1	94.8	95.6	95.5	95.3	94.9
<i>Haemophilus influenzae</i> type b	93.9	94.5	94.5	93.1	93.9	94.6	94.8	95.0	94.1
Measles, mumps and rubella	93.7	94.4	94.5	93.0	94.1	94.4	94.6	95.1	94.0

- (a) Coverage measured for children immunised at the age of 24 months to less than 27 months, by the State or Territory in which the child resided.
- (b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b, hepatitis B and measles, mumps and rubella.

Source: Department of Health unpublished, ACIR data collection.

Table 10A.81 Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT NT</i> (d)	<i>Aust</i>	
Fully immunised (e)									
2007-08	81.4	85.8	84.0	79.6	78.9	82.9	88.2	82.9	82.8
2008-09	77.9	84.1	81.5	79.1	75.3	80.9	85.3	82.8	80.3
2009-10	83.7	87.2	84.5	82.3	81.9	86.4	86.9	82.8	84.6
2010-11	89.1	91.0	89.9	86.0	87.0	91.3	91.0	86.9	89.3
2011-12	90.0	91.4	90.3	86.8	87.6	90.8	91.5	89.3	90.0
2012-13	91.6	92.6	91.5	89.4	90.9	92.9	92.3	90.7	91.5
2013-14	92.2	92.5	92.3	89.8	91.0	92.7	92.7	91.4	92.0
Immunised against (2013-14)									
Diphtheria, tetanus and pertussis	92.7	93.1	92.7	90.4	91.5	93.4	93.3	91.9	92.4
Polio	92.6	92.9	92.6	90.3	91.4	93.2	93.2	91.7	92.4
Measles, mumps and rubella	92.6	92.9	92.7	90.3	91.6	93.5	92.9	92.0	92.4

- (a) Coverage measured for children immunised at the age of 60 months to less than 63 months, by the State or Territory in which the child resided.
- (b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) Children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio and measles, mumps and rubella.

Source: Department of Health unpublished, ACIR data collection.

TABLE 10A.82

Table 10A.82 **Notifications of measles, children aged 0–14 years (a), (b), (c)**

	<i>Unit</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>
Notifications										
2006-07	no.	np	–	np	np	–	–	–	–	4
2007-08	no.	18	np	4	np	np	–	–	np	27
2008-09	no.	3	18	20	np	–	np	–	–	44
2009-10	no.	5	np	np	np	np	–	–	–	11
2010-11	no.	40	6	7	5	–	–	np	np	61
2011-12	no.	20	np	–	np	–	–	4	–	27
2012-13	no.	85	np	np	3	3	–	–	np	95
2013-14	no.	29	26	20	10	10	–	–	18	113
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	0.1
2007-08	per 100 000 children	1.4	np	np	np	np	–	–	np	0.7
2008-09	per 100 000 children	np	1.8	2.3	np	–	np	–	–	1.1
2009-10	per 100 000 children	0.4	np	np	np	np	–	–	–	0.3
2010-11	per 100 000 children	2.9	0.6	0.8	1.1	–	–	np	np	1.4
2011-12	per 100 000 children	1.5	np	–	np	–	–	np	–	0.6
2012-13	per 100 000 children	6.1	np	np	np	np	–	–	np	2.2
2013-14	per 100 000 children	2.1	2.5	2.2	2.1	3.4	–	–	33.4	2.6

(a) Notification of the relevant State/Territory authority is required when measles is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for measles — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.

(b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.

(c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.

(d) Rates are derived using the ERP as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.

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

Table 10A.82 **Notifications of measles, children aged 0–14 years (a), (b), (c)**

<i>Unit</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>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-------------

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.83

Table 10A.83 Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c)

	<i>Unit</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>
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	677	181	95	36	41	9	5	82	1 126
2008-09	no.	8 161	681	955	205	586	205	59	162	11 014
2009-10	no.	3 275	1 094	1 496	242	1 841	108	32	60	8 148
2010-11	no.	8 784	2 832	3 147	744	2 183	68	335	129	18 222
2011-12	no.	6 719	1 716	3 178	2 564	279	384	87	280	15 207
2012-13	no.	2 144	928	2 369	529	305	660	88	52	7 075
2013-14	no.	977	857	1 163	489	349	59	63	14	3 971
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	22.9	9.5	13.6	8.0	13.7	7.3	12.6	np	14.8
2007-08	per 100 000 children	50.8	18.5	11.3	8.6	14.3	9.3	7.8	158.2	27.7
2008-09	per 100 000 children	607.1	68.8	110.6	47.4	203.4	211.2	91.3	309.7	266.6
2009-10	per 100 000 children	241.6	109.3	170.6	55.0	635.6	111.4	48.8	113.9	195.0
2010-11	per 100 000 children	644.2	280.5	355.3	166.2	751.7	70.6	504.9	245.8	432.5
2011-12 (d)	per 100 000 children	492.8	169.0	355.1	561.1	96.1	403.5	129.3	534.2	358.9
2012-13	per 100 000 children	155.1	89.2	258.9	111.6	103.7	694.9	126.1	97.7	163.6
2013-14	per 100 000 children	69.5	80.9	125.1	100.4	117.9	62.2	88.3	26.0	90.3

- (a) Notification of the relevant State/Territory authority is required when whooping cough is diagnosed. Diagnosis cannot always be confirmed using available tools. Therefore, the 'notified fraction' is likely to be only a proportion of the total number of cases. The notified fraction may vary between states and territories and over time.
- (b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Rates are derived using the ERP as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.
- np** Not published.

Table 10A.83 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c)**

<i>Unit</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>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-------------

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.84

Table 10A.84 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)**

	<i>Unit</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>
Notifications										
2006-07	no.	4	3	8	np	–	–	–	–	17
2007-08	no.	7	–	np	–	np	np	–	np	12
2008-09	no.	3	np	3	np	–	–	–	np	11
2009-10	no.	np	–	np	np	np	–	–	np	6
2010-11	no.	6	np	np	np	–	–	–	–	12
2011-12	no.	–	–	np	np	np	–	–	np	7
2012-13	no.	3	3	3	–	–	–	–	–	9
2013-14	no.	4	np	5	np	–	–	–	np	12
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	0.3	np	1.0	np	–	–	–	–	0.4
2007-08	per 100 000 children	0.5	–	np	–	np	np	–	np	0.3
2008-09	per 100 000 children	np	np	np	np	–	–	–	np	0.3
2009-10	per 100 000 children	np	–	np	np	np	–	–	np	0.1
2010-11	per 100 000 children	0.4	np	np	np	–	–	–	–	0.3
2011-12 (e)	per 100 000 children	–	–	np	np	np	–	–	np	0.2
2012-13	per 100 000 children	np	np	np	–	–	–	–	–	0.2
2013-14	per 100 000 children	np	np	0.5	np	–	–	–	np	0.3

- (a) Notification of the relevant State/Territory authority is required when invasive *Haemophilus influenzae* type b (Hib) is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for Hib — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.
- (b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Rates are derived using the Estimated Resident Populations (ERP) as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.

Table 10A.84 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)**

<i>Unit</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>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-------------

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

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.85

Table 10A.85 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
2008–2009									
40–44 years	6.5	5.1	25.2	11.0	10.0	22.9	6.2	3.3	11.0
45–49 years	11.5	9.8	38.7	21.7	20.0	35.7	10.1	12.3	18.8
50–54 years	49.1	48.3	55.7	52.8	55.9	50.5	42.6	36.0	51.1
55–59 years	56.1	54.4	60.5	57.2	58.8	58.9	54.5	42.0	57.1
60–64 years	58.6	58.5	62.8	60.0	63.5	63.3	58.5	46.4	60.3
65–69 years	56.9	56.6	61.4	59.2	61.5	62.2	56.3	43.5	58.6
70–74 years	15.2	24.1	55.4	20.6	25.3	21.3	21.9	9.6	26.5
75–79 years	7.0	8.5	20.7	11.4	13.6	9.8	9.6	5.2	10.9
80–84 years	2.8	2.9	5.5	4.3	5.2	3.6	3.1	2.1	3.7
85+ years	0.6	0.6	1.6	0.9	1.1	0.7	0.7	0.5	0.8
40+ years (ASR)	29.4	29.3	43.4	33.6	34.9	38.3	28.5	22.4	33.3
Ages 50–69 (ASR)	54.4	53.6	59.5	56.6	59.3	57.6	51.6	41.2	56.0
2009–2010									
40–44 years	6.2	4.9	23.7	10.5	9.0	22.7	6.8	3.0	10.4
45–49 years	10.8	9.8	37.8	21.6	19.1	37.2	10.9	11.3	18.4
50–54 years	46.9	49.9	54.5	53.9	53.0	51.9	42.1	35.5	50.5
55–59 years	55.0	54.9	59.1	57.8	57.1	59.9	53.6	42.5	56.5
60–64 years	58.4	59.8	62.1	61.8	61.4	65.0	58.2	46.9	60.4
65–69 years	56.7	56.8	60.5	60.1	59.9	62.1	57.2	45.0	58.3
70–74 years	16.1	19.5	54.9	20.9	25.0	18.6	23.4	9.6	25.6
75–79 years	7.0	8.1	20.0	11.8	13.9	9.3	9.9	4.3	10.8
80–84 years	2.8	2.9	5.4	4.5	5.5	3.6	2.9	2.6	3.7
85+ years	0.6	0.6	1.4	1.0	1.1	0.7	0.7	0.2	0.8
40+ years (ASR)	28.8	29.4	42.5	34.1	33.6	38.8	28.8	22.3	32.8
Ages 50–69 (ASR)	53.3	54.6	58.4	57.8	57.1	58.6	51.3	41.5	55.6
2010–2011									
40–44 years	5.7	5.0	21.7	10.1	8.6	22.3	7.2	2.7	9.8
45–49 years	9.8	10.6	36.6	21.5	18.6	36.8	11.9	10.2	18.0
50–54 years	43.1	51.1	53.5	53.8	53.2	50.0	41.1	34.8	49.3
55–59 years	51.5	54.6	57.9	57.9	58.3	58.5	53.0	43.5	55.1
60–64 years	55.9	59.6	61.5	62.3	63.3	64.7	59.2	48.3	59.6
65–69 years	54.6	57.6	59.9	60.4	61.9	60.5	57.3	43.9	57.9
70–74 years	15.6	17.3	54.3	21.1	25.4	16.7	20.7	9.1	24.8
75–79 years	6.8	8.0	19.7	12.2	14.1	9.0	9.4	4.6	10.7
80–84 years	2.7	2.9	5.5	4.8	6.0	3.6	3.0	2.9	3.8
85+ years	0.5	0.6	1.3	1.1	1.1	0.7	0.7	0.7	0.8
40+ years (ASR)	27.0	29.5	41.4	34.1	34.0	37.9	28.7	22.1	32.1
Ages 50–69 (ASR)	50.1	55.0	57.5	57.9	58.3	57.3	51.1	41.6	54.6

Table 10A.85 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
2011–2012									
40–44 years	6.1	6.3	21.1	10.3	9.0	22.4	8.7	2.5	10.2
45–49 years	10.0	12.9	36.0	22.1	18.6	37.3	13.8	9.9	18.6
50–54 years	42.6	50.4	52.5	53.7	54.2	50.5	43.0	35.8	48.7
55–59 years	51.8	53.7	57.8	57.6	58.5	58.3	56.3	41.8	54.7
60–64 years	56.2	58.4	60.8	61.6	62.9	64.0	63.2	46.6	59.0
65–69 years	55.8	57.0	59.8	60.6	62.3	62.7	59.0	45.8	58.0
70–74 years	16.3	20.0	54.3	21.7	26.3	17.2	21.4	10.2	25.8
75–79 years	7.5	9.0	20.2	13.1	15.8	9.1	10.6	5.3	11.5
80–84 years	2.9	3.4	5.6	5.3	6.8	3.6	3.3	2.0	4.1
85+ years	0.6	0.7	1.4	1.3	1.3	0.6	0.9	0.9	0.9
40+ years (ASR)	27.3	30.0	41.0	34.3	34.5	38.2	30.6	22.1	32.2
Ages 50–69 (ASR)	50.3	54.2	57.0	57.7	58.7	57.6	53.8	41.5	54.2
2012–2013									
40–44 years	6.8	8.9	21.7	11.3	9.6	24.2	10.6	8.6	11.6
45–49 years	10.7	14.9	36.1	22.6	18.1	38.6	16.9	16.1	19.6
50–54 years	44.3	51.1	52.7	53.0	49.2	51.1	44.2	36.8	49.3
55–59 years	51.5	53.9	57.4	56.7	52.1	57.2	55.9	41.4	54.3
60–64 years	56.5	58.3	61.9	60.6	57.0	63.9	63.2	44.8	59.1
65–69 years	56.1	57.6	60.5	59.7	56.7	64.1	61.1	43.9	58.3
70–74 years	25.5	25.3	54.3	22.6	28.1	19.0	27.9	15.3	30.9
75–79 years	8.6	11.0	21.0	14.3	17.0	10.2	11.5	7.1	12.8
80–84 years	3.1	4.4	6.0	5.9	7.2	4.0	3.7	3.1	4.6
85+ years	0.7	1.0	1.6	1.4	1.5	0.6	0.8	1.1	1.0
40+ years (ASR)	28.7	31.6	41.4	34.3	32.2	38.9	32.3	24.5	33.2
Ages 50–69 (ASR)	50.9	54.6	57.3	56.8	53.0	57.8	54.4	41.0	54.3

ASR = age standardised rate.

- (a) The participation rate is the number of women screened during the reference period as a percentage of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) ERP in each of the calendar years in the reference period. Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Participation rates for women 40 years or over and 50–69 years are age standardised to the 2001 Australian population standard.
- (c) Data include only women who were residents of the jurisdiction in which they were screened, with the exception of NSW where data include all women screened, whether or not they were residents of the jurisdiction. Data may differ from participation rates data published elsewhere that allocate women to jurisdictions based on the jurisdiction in which screening took place.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.

Table 10A.85 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
(e)	The fall in the participation rate for SA in 2012–2013 reflects a temporary reduction in the total number of women screened, instigated to best manage a Digital Mammography System Wide Review and implementation of the review recommendations, concurrent with the introduction of a new client information system. Going forward, BreastScreen SA anticipates a return to forecasted participation								
(f)	In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.								
(g)	Australia includes women screened in a jurisdiction not their jurisdiction of residence.								
<i>Source:</i>	State and Territory governments unpublished; ABS various years, <i>Population by Age and Sex, Australian States and Territories</i> , Cat. no. 3201.0.								

TABLE 10A.86

Table 10A.86 **Participation rates for women in BreastScreen Australia by residential status, 2012 and 2013 (24 month period)**

	<i>Unit</i>	<i>NSW (a)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (b)</i>	<i>NT</i>
40+ years									
Residents screened	no.	530 480	439 957	449 966	197 158	141 673	53 911	27 928	10 943
Non-residents screened	no.	5142	2210	1999	141	177	46	620	93
Non-residents screened (proportion)	%	1.0	0.5	0.4	0.1	0.1	0.1	2.2	0.8
Ages 50–69									
Residents screened	no.	440 454	355 201	301 171	153 786	110 291	39 740	22 286	8 596
Non-residents screened	no.	4643	1733	1352	126	135	32	474	87
Non-residents screened (proportion)	%	1.0	0.5	0.4	0.1	0.1	0.1	2.1	1.0

(a) Data for NSW exclude women who are not residents of NSW. However, data are not available for non-residents of NSW screened in NSW.

(b) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

Source: State and Territory governments unpublished.

Table 10A.87

Table 10A.87 Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA (e)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2008–2009									
Aged 40–49 years	5.7	3.0	21.3	10.5	8.3	14.2	6.4	3.7	10.6
Aged 50–59 years	27.8	19.8	42.0	23.6	26.2	31.8	29.3	24.9	30.3
Aged 60–69 years	34.2	29.1	46.1	29.5	29.8	39.4	63.1	29.3	35.9
Aged 70–79 years	9.3	9.5	29.9	14.0	15.8	13.6	31.6	5.6	14.9
Aged 80+ years	2.1	2.4	5.6	3.9	3.0	np	–	1.6	3.4
Age 40+ years (ASR)	17.1	13.1	31.5	17.5	17.7	np	25.8	14.2	20.6
Age 50–69 years (ASR)	30.3	23.5	43.6	25.9	27.6	34.8	42.6	26.6	32.5
2009–2010									
Aged 40–49 years	5.9	3.2	19.8	11.2	7.3	15.3	7.1	3.1	10.3
Aged 50–59 years	26.2	20.3	39.7	25.7	25.8	33.3	28.2	24.6	29.4
Aged 60–69 years	34.1	29.0	45.7	31.3	31.2	41.8	62.9	27.8	36.1
Aged 70–79 years	8.9	10.1	30.8	13.6	13.3	11.9	23.1	5.0	14.8
Aged 80+ years	2.2	3.3	4.3	3.5	2.0	np	–	2.0	3.1
Age 40+ years (ASR)	16.7	13.5	30.3	18.6	17.1	np	24.6	13.6	20.3
Age 50–69 years (ASR)	29.3	23.7	42.1	27.9	27.9	36.6	41.9	25.8	32.1
2010–2011									
Aged 40–49 years	5.8	4.6	19.3	12.1	6.7	14.4	6.9	3.0	10.3
Aged 50–59 years	25.2	22.7	38.8	27.9	26.8	27.7	29.2	25.4	29.3
Aged 60–69 years	33.1	29.2	45.5	34.3	28.8	39.0	52.4	28.1	35.8
Aged 70–79 years	8.7	8.4	32.0	13.5	12.4	13.7	33.3	6.1	15.1
Aged 80+ years	1.6	4.1	3.3	5.6	np	np	–	2.8	2.9
Age 40+ years (ASR)	16.1	14.5	30.0	20.1	np	np	24.3	14.1	20.2
Age 50–69 years (ASR)	28.3	25.2	41.4	30.4	27.6	32.1	38.3	26.5	31.9
2011–2012									
Aged 40–49 years	6.5	5.9	19.9	13.3	7.0	15.9	6.6	3.6	11.1
Aged 50–59 years	26.4	22.6	39.8	31.5	27.6	27.8	28.8	24.0	30.3
Aged 60–69 years	35.2	31.0	46.5	36.1	28.8	30.8	40.4	29.3	37.4
Aged 70–79 years	9.3	8.1	32.9	16.5	16.0	np	106.7	5.1	16.3
Aged 80+ years	2.4	2.6	4.0	6.0	0.6	–	–	2.3	3.0
Age 40+ years (ASR)	17.2	15.1	30.8	22.3	17.4	np	32.1	13.9	21.2
Age 50–69 years (ASR)	29.9	25.9	42.5	33.3	28.1	29.0	33.4	26.1	33.1
2012–2013									
Aged 40–49 years	7.2	7.4	22.3	13.6	6.7	18.1	8.6	10.5	12.9
Aged 50–59 years	27.9	26.8	41.8	32.2	25.3	30.5	27.9	27.3	32.0
Aged 60–69 years	36.6	36.0	49.9	37.8	30.5	26.2	28.7	31.1	39.7
Aged 70–79 years	12.8	12.9	33.8	16.8	15.1	np	np	10.3	18.7
Aged 80+ years	3.4	2.1	5.0	6.5	1.8	np	np	4.5	3.9
Age 40+ years (ASR)	18.7	18.2	33.0	23.0	16.9	np	np	18.4	23.1
Age 50–69 years (ASR)	31.3	30.4	45.0	34.4	27.4	28.8	28.2	28.8	35.1

Table 10A.87 Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	NSW	Vic (d)	Qld	WA (e)	SA	Tas	ACT (f)	NT	Aust
--	-----	---------	-----	--------	----	-----	---------	----	------

ASR = age standardised rate.

- (a) Rates are derived using populations that are revised to the ABS 2011 Census rebased population estimates and projections and may differ from previous reports.
- (b) The participation rate is the number of women resident in the catchment area screened in the reference period, divided by the number of women resident in the catchment area in the reference period based on Australian Bureau of Statistics (ABS) ERP data. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (c) Aboriginal and/or Torres Strait Islander women are women who self-identified as being of Aboriginal and/or Torres Strait Islander descent.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) Data for WA may include some Aboriginal and/or Torres Strait Islander women usually resident in the NT in WA catchment areas.
- (f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.
- Nil or rounded to zero. **np** Not published.

Source: State and Territory governments unpublished; ABS 2014, *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0.

Table 10A.88 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2008–2009									
Aged 40–49 years	7.6	3.1	30.6	14.3	12.6	12.3	2.9	5.4	9.5
Aged 50–59 years	47.1	28.5	59.7	58.2	51.2	28.1	20.4	33.6	43.1
Aged 60–69 years	52.0	39.8	67.5	67.3	66.8	41.2	26.8	44.2	50.9
Aged 70–79 years	7.7	11.2	40.6	13.9	14.3	8.6	4.4	7.4	12.6
Aged 80+ years	1.1	0.8	3.3	2.2	1.9	1.6	0.6	1.5	1.3
Aged 40+ years (ASR)	26.0	17.6	44.7	34.9	32.4	20.5	12.0	20.1	26.0
Aged 50–69 years (ASR)	49.0	33.0	62.8	61.8	57.3	33.3	22.9	37.8	46.2
2009–2010									
Aged 40–49 years	7.1	3.3	29.9	14.3	11.8	17.9	3.0	4.5	9.2
Aged 50–59 years	46.9	30.1	60.0	60.1	49.1	37.6	20.2	33.4	43.6
Aged 60–69 years	52.6	40.5	66.9	69.2	62.2	50.4	26.4	43.6	51.2
Aged 70–79 years	7.7	8.9	41.3	14.5	14.3	10.2	4.6	5.9	11.9
Aged 80+ years	1.1	0.7	3.3	2.1	1.8	1.9	0.5	2.1	1.3
Aged 40+ years (ASR)	25.8	17.9	44.5	35.9	30.7	26.9	12.0	19.5	26.0
Aged 50–69 years (ASR)	49.1	34.2	62.7	63.7	54.3	42.7	22.7	37.4	46.6
2010–2011									
Aged 40–49 years	7.6	4.9	29.0	14.3	11.6	19.7	3.1	4.1	9.8
Aged 50–59 years	46.4	40.7	59.3	59.4	48.3	37.9	20.6	34.6	46.5
Aged 60–69 years	52.9	48.9	65.7	69.7	60.4	50.9	27.3	43.0	54.0
Aged 70–79 years	7.6	8.7	41.1	14.7	14.2	11.0	4.1	6.6	11.8
Aged 80+ years	1.1	0.9	2.8	2.2	1.8	1.7	0.7	2.7	1.3
Aged 40+ years (ASR)	25.9	22.8	43.7	35.8	30.1	27.8	12.2	19.7	27.5
Aged 50–69 years (ASR)	49.0	43.9	61.8	63.4	53.1	43.0	23.3	38.0	49.4
2011–2012									
Aged 40–49 years	6.9	7.3	29.4	15.2	12.2	19.1	3.5	4.6	10.5
Aged 50–59 years	43.3	47.8	59.6	59.2	48.2	39.3	21.3	34.7	47.4
Aged 60–69 years	51.9	55.0	65.9	71.3	57.8	51.2	28.3	42.1	55.6
Aged 70–79 years	7.3	10.6	40.3	15.2	13.6	9.8	4.4	6.2	12.3
Aged 80+ years	0.9	1.2	3.2	2.5	2.2	2.1	0.8	1.6	1.5
Aged 40+ years (ASR)	24.6	27.0	43.9	36.4	29.7	27.9	12.8	19.6	28.3
Aged 50–69 years (ASR)	46.7	50.6	62.1	64.0	52.0	44.0	24.0	37.7	50.6
2012–2013									
Aged 40–49 years	7.2	8.9	30.4	16.0	12.1	19.9	5.7	13.0	11.4
Aged 50–59 years	44.4	49.5	60.2	58.6	43.4	43.2	22.8	37.9	48.2
Aged 60–69 years	53.5	56.4	66.8	70.5	50.2	50.9	30.2	42.3	56.3
Aged 70–79 years	13.0	12.8	39.3	15.9	14.6	11.5	6.4	10.6	15.3
Aged 80+ years	1.0	1.5	3.4	3.0	2.5	1.7	0.8	2.5	1.7
Aged 40+ years (ASR)	26.1	28.6	44.4	36.5	27.2	29.4	14.5	24.0	29.4
Aged 50–69 years (ASR)	48.0	52.2	62.8	63.3	46.1	46.2	25.7	39.6	51.4

Table 10A.88 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
--	------------	----------------	------------	-----------	-----------	----------------	----------------	-----------	-------------

ASR = age standardised rate. **NESB** = Non English speaking background.

- (a) The participation rate is the number of NESB women residents in the catchment area screened in the reference period, divided by the estimated number of NESB women resident in the catchment area in that period. The female NESB population estimate is derived by applying the NESB age distribution from the 2011 Census to the Australian Bureau of Statistics (ABS) female ERP data for the relevant year. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs and rates may differ from those published in previous reports. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1) for details.
- (c) NESB is defined as persons who speak a language other than English at home.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) An apparent drop in participation of NESB women in Tasmania occurred from the 2005–2006 screening period and coincided with a significant reduction in self-reporting of NESB status that followed a change in the client registration form in 2006. Since revision of the form in May 2009, both self-reporting of NESB status and participation rates are returning to earlier levels. The observed drop in participation, therefore, appears to reflect the drop in self reporting of NESB status rather than reduced participation.
- (f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

Source: State and Territory governments unpublished; ABS various years, *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; ABS unpublished, *2011 Census of Population and Housing*.

Table 10A.89 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2009–2010									
Major Cities									
Aged 40–49 years	7.8	7.0	29.7	16.3	13.5	..	9.2	..	12.8
Aged 50–59 years	49.0	50.9	54.4	57.2	53.5	..	48.8	..	51.7
Aged 60–69 years	55.3	57.1	59.3	61.9	58.3	..	59.6	..	57.5
Aged 70–79 years	10.7	13.2	37.7	15.5	17.7	..	18.0	..	17.0
Aged 80+ years	1.5	1.5	3.3	2.3	2.7	..	1.8	..	2.0
Age 40+ years (ASR)	27.5	28.4	40.9	34.5	32.3	..	29.6	..	31.2
Age 50–69 years (ASR)	51.3	53.2	56.2	59.0	55.3	..	52.8	..	53.9
Inner Regional									
Aged 40–49 years	9.1	7.9	27.3	14.2	13.7	29.6	np	..	15.0
Aged 50–59 years	52.4	55.1	55.1	53.2	55.5	56.3	np	..	54.2
Aged 60–69 years	60.1	61.5	61.8	61.9	65.5	64.0	np	..	61.5
Aged 70–79 years	13.4	16.6	39.5	20.7	23.6	13.3	np	..	20.5
Aged 80+ years	1.7	2.2	3.5	3.8	3.6	1.8	np	..	2.4
Age 40+ years (ASR)	30.0	31.2	40.8	33.4	35.0	38.6	np	..	33.8
Age 50–69 years (ASR)	55.2	57.5	57.6	56.4	59.3	59.1	np	..	56.9
Outer Regional									
Aged 40–49 years	13.2	10.2	34.5	13.7	17.2	31.0	..	6.6	21.4
Aged 50–59 years	52.7	55.7	61.5	51.8	59.2	54.4	..	42.4	55.8
Aged 60–69 years	60.3	61.6	65.3	59.6	65.0	62.6	..	50.6	62.1
Aged 70–79 years	16.7	18.9	43.1	22.6	25.7	16.0	..	6.5	24.7
Aged 80+ years	3.0	3.5	4.1	5.0	5.7	2.8	..	np	3.8
Age 40+ years (ASR)	32.1	32.5	46.2	32.8	37.4	38.6	..	23.8	37.1
Age 50–69 years (ASR)	55.5	58.0	62.9	54.7	61.3	57.4	..	45.6	58.2
Remote									
Aged 40–49 years	23.7	np	34.5	20.5	14.6	np	..	9.6	22.2
Aged 50–59 years	53.5	np	55.3	51.9	48.7	np	..	38.0	50.3
Aged 60–69 years	65.7	np	63.7	62.5	55.9	np	..	42.1	59.5
Aged 70–79 years	23.9	np	41.7	24.1	26.0	np	..	np	28.1
Aged 80+ years	np	np	6.3	np	6.1	np	..	np	6.1
Age 40+ years (ASR)	38.1	37.5	44.1	36.1	32.2	36.3	..	22.8	36.1
Age 50–69 years (ASR)	58.2	np	58.5	56.1	51.5	51.0	..	39.5	53.9
Very remote									
Aged 40–49 years	np	..	32.5	20.5	np	np	..	5.7	21.3
Aged 50–59 years	np	..	54.9	46.6	np	np	..	28.4	46.3
Aged 60–69 years	np	..	57.1	44.5	np	np	..	30.4	48.6
Aged 70–79 years	np	..	36.7	na	np	np	..	np	25.4
Aged 80+ years	np	..	np	np	np	np	..	np	5.0

Table 10A.89 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Age 40+ years (ASR)	49.0	..	41.6	30.5	30.5	np	..	16.1	32.4
Age 50–69 years (ASR)	np	..	55.7	45.8	45.6	np	..	29.0	47.2
2010–2011									
Major Cities									
Aged 40–49 years	na	na	na	na	na	na	na	na	12.3
Aged 50–59 years	na	na	na	na	na	na	na	na	50.8
Aged 60–69 years	na	na	na	na	na	na	na	na	57.0
Aged 70–79 years	na	na	na	na	na	na	na	na	16.7
Aged 80+ years	na	na	na	na	na	na	na	na	2.0
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	30.7
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	53.1
Inner Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	14.9
Aged 50–59 years	na	na	na	na	na	na	na	na	53.6
Aged 60–69 years	na	na	na	na	na	na	na	na	61.3
Aged 70–79 years	na	na	na	na	na	na	na	na	20.2
Aged 80+ years	na	na	na	na	na	na	na	na	2.4
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	33.5
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	56.5
Outer Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	20.7
Aged 50–59 years	na	na	na	na	na	na	na	na	55.0
Aged 60–69 years	na	na	na	na	na	na	na	na	61.4
Aged 70–79 years	na	na	na	na	na	na	na	na	24.9
Aged 80+ years	na	na	na	na	na	na	na	na	4.1
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	36.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	57.4
Remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	21.7
Aged 50–59 years	na	na	na	na	na	na	na	na	52.2
Aged 60–69 years	na	na	na	na	na	na	na	na	59.9
Aged 70–79 years	na	na	na	na	na	na	na	na	30.7
Aged 80+ years	na	na	na	na	na	na	na	na	6.9
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	37.0
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	55.2
Very remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	19.3
Aged 50–59 years	na	na	na	na	na	na	na	na	43.3

Table 10A.89 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Aged 60–69 years	na	na	na	na	na	na	na	na	49.5
Aged 70–79 years	na	na	na	na	na	na	na	na	28.0
Aged 80+ years	na	na	na	na	na	na	na	na	7.7
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	31.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	45.8

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) estimated resident population (ERP) in each of the calendar years in the reference period. Rates for '40+ years' and '50–69 years' are age standardised to the Australian population at 30 June 2001.
- (b) Periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (c) Data are suppressed where numerator is less than 5 or denominator is less than 1000.
- (d) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *Census of population and housing* for 2006. The accuracy of remoteness classifications decreases over time since the census year due to demographic changes within postcode boundaries. Sources of inaccuracy particularly affect rates based on small numbers and these should be interpreted with caution. Areas where rates are based on small numbers include very remote areas in NSW, SA and Tasmania, remote areas in Victoria and Tasmania, and inner regional areas in the ACT. Minor differences can result in apparently large variations where numerators are small numbers.
- (e) Women were allocated to a remoteness area based on postcode of usual residence. Some women's postcodes could not be matched to a remoteness area; these women were excluded from the state and territory calculations, but included in the state and territory and Australia totals. Some postcodes supplied by women may not accurately reflect their usual residence.
- (f) Data are not available for the 24 month periods 2007 and 2008, and 2011 and 2012. Data are not available for states and territories for the 24 month periods from 2010 and 2011.
- (g) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.2 per cent of women screened in the 24 months 2012–2013 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

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

Source: AIHW unpublished, derived from State and Territory data and ABS Census of population and housing.

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Target age group (20–69 years)									
Crude rates									
2005 and 2006	57.3	62.7	57.1	59.0	62.9	60.4	61.1	53.8	59.3
2006 and 2007	58.8	62.7	58.5	58.6	62.3	59.1	61.0	53.1	60.0
2007 and 2008	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
2008 and 2009	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
2009 and 2010	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
2010 and 2011	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
2011 and 2012	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
2012 and 2013	56.9	60.9	56.0	55.5	58.7	57.0	57.0	55.2	57.7
Age standardised rates									
2005 and 2006	57.3	62.9	57.1	58.8	63.0	60.5	61.5	53.1	59.3
2006 and 2007	58.9	63.0	58.5	58.5	62.5	59.3	61.3	52.3	60.1
2007 and 2008	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2
2010 and 2011	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
2012 and 2013	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2
By age group (years)									
2005 and 2006									
20–24	43.5	47.7	49.2	51.4	51.4	56.8	48.4	50.5	47.5
25–29	54.9	59.2	57.4	58.8	61.7	62.3	58.5	54.5	57.5
30–34	61.8	65.3	60.8	63.3	66.6	64.4	64.2	56.1	63.0
35–39	62.9	67.1	61.1	64.1	67.4	64.4	65.8	56.4	64.1
40–44	62.6	67.8	61.1	63.6	67.4	64.6	66.1	56.2	64.1
45–49	62.6	68.8	61.5	62.9	67.4	63.1	64.7	55.7	64.3
50–54	60.4	67.2	58.3	59.2	65.3	61.7	64.3	53.6	61.9
55–59	56.7	64.4	54.7	56.0	62.3	57.0	63.0	50.3	58.6
60–64	52.7	61.2	51.4	50.9	58.8	52.8	60.6	45.3	54.9
65–69	45.3	55.1	45.1	46.7	53.7	46.0	55.1	41.6	48.7
20–69 years	57.3	62.7	57.1	59.0	62.9	60.4	61.1	53.8	59.3
20–69 years (ASR)	57.3	62.9	57.1	58.8	63.0	60.5	61.5	53.1	59.3
2006 and 2007									
20–24	45.3	48.1	51.4	52.1	51.1	54.7	50.6	51.2	48.7
25–29	56.7	58.9	59.0	59.4	61.2	60.4	58.7	54.4	58.4
30–34	62.9	64.5	61.7	62.2	65.1	62.4	63.5	54.8	63.0
35–39	64.2	66.8	62.2	62.9	66.3	62.7	64.9	55.4	64.3
40–44	63.9	67.6	62.1	62.5	66.6	62.7	64.7	54.8	64.4

TABLE 10A.90

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
45–49	64.8	69.4	63.0	62.7	67.1	62.5	64.3	55.3	65.4
50–54	62.0	67.4	59.7	59.1	65.2	60.3	63.8	51.7	62.7
55–59	58.8	65.1	56.6	56.3	62.3	56.9	63.5	50.0	59.9
60–64	54.8	61.7	52.8	51.2	59.2	53.0	60.3	45.2	56.1
65–69	46.8	55.4	46.3	45.8	53.9	46.9	54.6	40.4	49.4
20–69 years	58.8	62.7	58.5	58.6	62.3	59.1	61.0	53.1	60.0
20–69 years (ASR)	58.9	63.0	58.5	58.5	62.5	59.3	61.3	52.3	60.1
2007 and 2008									
20–24	44.5	46.6	51.5	51.3	49.4	53.5	49.7	52.7	47.9
25–29	56.0	57.1	58.4	57.7	59.5	58.0	58.0	56.5	57.2
30–34	62.6	63.2	61.8	60.3	63.7	60.9	62.0	57.1	62.3
35–39	64.3	66.1	62.3	61.8	64.8	61.8	64.6	59.0	64.0
40–44	64.2	67.1	62.5	61.5	65.7	60.6	63.4	57.7	64.2
45–49	65.0	68.7	63.6	61.6	66.8	61.0	64.3	57.7	65.2
50–54	62.6	67.0	61.0	59.0	65.1	57.8	63.4	56.0	63.0
55–59	59.8	65.3	58.0	55.9	62.6	55.7	64.4	53.7	60.5
60–64	55.8	61.8	54.1	52.0	59.1	51.5	59.2	48.5	56.7
65–69	47.1	54.8	47.4	45.2	53.8	44.5	52.5	41.2	49.4
20–69 years	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
20–69 years (ASR)	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009									
20–24	42.1	44.2	48.8	50.2	47.4	51.6	46.6	52.4	45.6
25–29	53.5	55.5	56.2	56.8	57.8	56.2	55.3	56.5	55.3
30–34	61.1	63.3	60.9	60.6	62.8	60.5	60.8	58.6	61.6
35–39	63.2	66.2	61.7	62.1	64.9	61.2	62.7	59.3	63.6
40–44	63.2	67.3	62.1	62.3	65.4	60.5	63.5	61.2	64.0
45–49	64.0	69.0	63.1	62.1	66.3	61.5	64.0	60.0	64.9
50–54	61.9	67.8	61.2	60.1	65.2	59.1	62.8	59.1	63.2
55–59	59.9	66.3	58.4	56.7	62.8	57.0	63.9	53.8	61.0
60–64	56.1	63.2	54.7	53.5	59.8	53.0	61.1	50.4	57.6
65–69	47.9	55.5	47.8	45.4	53.5	45.7	52.8	43.3	50.0
20–69 years	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
20–69 years (ASR)	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010									
20–24	39.8	42.8	46.3	48.4	45.9	50.5	43.4	50.2	43.6
25–29	51.0	53.9	53.8	55.2	56.0	55.3	53.8	53.5	53.2
30–34	58.8	62.2	58.1	59.3	61.3	59.9	60.0	56.4	59.8
35–39	61.0	65.2	59.4	60.6	64.2	60.5	60.4	57.3	61.9
40–44	61.7	67.0	60.3	61.1	64.4	60.7	62.6	58.8	62.8

TABLE 10A.90

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
45–49	62.8	69.2	61.6	61.9	65.7	61.5	62.4	58.8	64.1
50–54	61.1	68.4	60.4	59.7	64.4	59.5	62.6	57.2	62.8
55–59	59.4	66.3	57.8	57.0	62.7	57.7	63.1	54.0	60.7
60–64	56.4	64.1	54.9	53.9	60.4	54.3	61.7	50.9	58.1
65–69	48.2	55.8	47.3	45.5	53.1	46.8	54.0	43.4	50.0
20–69 years	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
20–69 years (ASR)	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2
2010 and 2011									
20–24	39.3	41.7	44.9	46.9	45.0	49.8	40.9	49.0	42.6
25–29	50.4	52.3	52.1	53.2	55.1	54.6	52.9	52.2	52.0
30–34	57.9	59.8	56.3	57.1	61.3	57.6	57.7	54.6	58.2
35–39	60.1	63.4	57.8	58.6	63.1	58.4	60.0	56.3	60.4
40–44	61.2	65.6	58.8	59.2	64.1	59.1	60.4	55.9	61.7
45–49	62.3	68.2	60.8	60.7	65.6	58.6	61.8	57.6	63.4
50–54	61.8	67.7	60.0	58.8	64.2	57.0	63.9	55.4	62.6
55–59	59.4	65.8	57.6	56.5	63.1	56.4	62.4	54.8	60.5
60–64	57.3	64.4	55.6	54.0	61.1	52.9	62.5	50.9	58.6
65–69	48.9	55.7	47.5	45.8	53.3	44.7	55.2	42.7	50.3
20–69 years	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
20–69 years (ASR)	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012									
20–24	39.7	42.1	44.8	46.7	45.2	49.6	40.5	50.6	42.8
25–29	50.6	52.6	52.4	53.2	55.0	56.1	52.3	52.4	52.2
30–34	58.1	59.7	56.6	56.9	60.5	57.3	57.0	54.9	58.2
35–39	60.4	63.7	58.1	58.4	62.1	59.4	59.8	55.0	60.6
40–44	61.5	66.1	58.8	59.2	63.0	59.7	60.6	56.2	61.9
45–49	63.0	68.8	61.1	61.1	65.2	60.8	62.1	58.4	63.9
50–54	62.8	68.7	60.2	59.7	63.5	58.3	62.4	55.9	63.3
55–59	60.2	66.8	58.2	56.7	62.8	57.4	61.6	54.1	61.2
60–64	58.4	65.9	55.8	55.1	61.1	54.0	62.5	50.7	59.5
65–69	50.6	57.1	48.0	47.0	53.2	46.4	54.7	43.5	51.5
20–69 years	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
20–69 years (ASR)	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
2012 and 2013									
20–24	39.5	42.3	44.7	45.8	44.8	49.9	41.3	52.4	42.7
25–29	50.6	52.4	52.4	52.7	54.1	56.5	51.3	53.0	52.0
30–34	58.1	59.4	56.8	56.6	59.8	58.7	57.9	56.6	58.1
35–39	61.2	63.7	58.6	58.7	61.5	60.6	60.7	55.7	61.0
40–44	62.6	66.8	59.8	59.1	62.6	60.3	61.9	58.0	62.6

Table 10A.90 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
45–49	63.8	69.5	61.9	61.3	64.5	61.3	63.4	59.6	64.5
50–54	63.6	69.8	61.2	59.6	63.5	59.9	62.6	58.0	64.0
55–59	61.0	67.8	59.1	57.0	62.6	57.2	63.5	55.3	61.9
60–64	59.4	67.0	56.9	55.1	61.5	55.5	63.0	51.7	60.4
65–69	51.7	59.0	49.5	47.7	53.9	47.0	56.5	43.0	52.7
20–69 years	56.9	60.9	56.0	55.5	58.7	57.0	57.0	55.2	57.7
20–69 years (ASR)	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population based on the 2011 Census in each of the calendar years in the reference period. Age-standardised rates are standardised to the Australian population at 30 June 2001.
- (b) The eligible female population has been adjusted for the estimated proportion of women who have had a hysterectomy, using age-specific hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. Historical data may differ from data in previous reports for which hysterectomy fractions were estimated using a different methodology.
- (c) Data exclude women who have opted off the cervical cytology register.
- (d) Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (e) Number of women screened includes all women screened in each jurisdiction, except for Victoria and the ACT. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.
- (f) Data for Victoria include only residents of Victoria and, from the the period 2008 and 2009, immediate border residents.
- (g) Data for the ACT include only residents of the ACT and, from the period 2008 and 2009, immediate border residents.

Source: AIHW unpublished, State and Territory Cervical Cytology Registry data.

Table 10A.91 Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent)

	<i>Unit</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>
2004-05										
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4
2012-13										
Age standardised rate (a)	%	53.2	59.0	53.0	49.0	58.5	54.7	54.2	53.8	53.4
RSE	%	5.2	6.0	6.2	6.4	6.4	7.3	11.7	6.6	2.8
95 per cent confidence interval	%	± 5.5	± 6.9	± 6.5	± 6.2	± 7.4	± 7.9	± 12.4	± 7.0	± 2.9

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

TABLE 10A.92

Table 10A.92 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

	<i>Unit</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>
2003										
People vaccinated	'000	663	499	328	172	186	52	23	5	1 928
Target population	'000	869	642	448	219	225	67	29	8	2 508
People vaccinated	%	76.3	77.7	73.1	78.4	82.8	76.7	80.7	68.1	76.9
2004										
People vaccinated	'000	716	541	353	181	188	53	24	6	2 062
Target population	'000	907	664	465	230	231	69	30	9	2 605
People vaccinated	%	78.9	81.6	75.8	78.7	81.4	77.3	80.0	67.5	79.1
2006										
People vaccinated	'000	710	565	364	194	200	57	25	6	2 121
Target population	'000	945	693	498	246	238	72	32	10	2 735
People vaccinated	%	75.1	81.4	73.1	78.7	83.9	79.2	77.8	63.3	77.5
2009										
People vaccinated	'000	720	550	410	200	200	60	28	8*	2,200
Target population	'000	990	740	550	270	250	77	36	12	2 900
People vaccinated	%	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3*	74.6

(a) A '*' indicates a relative standard error (RSE) of more than 25 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) The Adult Vaccination Survey was not conducted in 2005, 2007, 2008 or 2010.

Source: AIHW 2004, 2005, 2011, *Adult Vaccination Survey: Summary Results*, Cat. no. PHE 51, PHE 56, PHE 135; Department of Health unpublished, 2006 Adult Vaccination Survey.

TABLE 10A.93

Table 10A.93 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

	<i>Unit</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>
Major city										
Proportion	%	48.9	50.6	52.0	46.2	55.0	..	50.4	..	50.2
RSE	%	4.4	4.5	4.8	7.2	5.2	..	6.0	..	2.4
95 per cent confidence interval	%	± 4.2	± 4.5	± 4.9	± 6.5	± 5.6	..	± 5.9	..	± 2.3
Inner regional										
Proportion	%	48.9	51.7	50.4	57.6	64.3	56.0	np	..	51.6
RSE	%	5.7	6.9	7.8	10.1	9.7	6.4	233.2	..	3.3
95 per cent confidence interval	%	± 5.4	± 7.0	± 7.7	± 11.5	± 12.2	± 7.0	np	..	± 3.4
Outer regional										
Proportion	%	49.9	53.5	46.2	51.5	39.8	47.9	..	41.7	48.9
RSE	%	9.0	13.5	11.5	17.7	17.5	9.9	..	7.3	4.2
95 per cent confidence interval	%	± 8.8	± 14.1	± 10.4	± 17.9	± 13.6	± 9.3	..	± 6.0	± 4.0
Remote, very remote (e)										
Proportion	%	56.3	np	66.4	np	46.3	40.8	..	58.3	57.3
RSE	%	35.7	124.6	17.3	53.0	36.0	44.9	..	16.0	10.9
95 per cent confidence interval	%	± 39.3	np	± 22.5	np	± 32.6	± 35.9	..	± 18.2	± 12.2
Total (f)										
Proportion	%	49.1	51.3	51.5	48.5	54.7	52.9	50.4	43.1	50.6
RSE	%	3.3	3.7	3.9	5.7	4.5	6.0	6.0	6.7	1.7
95 per cent confidence interval	%	± 3.2	± 3.7	± 3.9	± 5.4	± 4.8	± 6.2	± 5.9	± 5.7	± 1.7

Table 10A.93 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

<i>Unit</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>
-------------	------------	------------	------------	-----------	-----------	------------	------------	-----------	-------------

RSE = Relative standard error.

- (a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.
- (b) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 *Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.
- (c) Rates are age-standardised to the Australian population at 30 June 2001.
- (d) Estimates with relative standard errors (RSEs) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.
- (e) Remote and very remote categories have been aggregated due to small numbers.
- (f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.
- .. Not applicable. **np** Not published.

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

TABLE 10A.94

Table 10A.94 **Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease (a)**

	<i>Unit</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>
2004-05										
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2
2012-13										
Proportion	%	23.3	24.4	27.1	24.4	25.7	17.5	14.4	33.7	25.3
Relative standard error	%	11.9	16.6	13.6	14.7	18.4	20.5	41.3	14.5	6.3

- (a) Vaccinations against influenza and pneumococcal disease have been available free to Aboriginal and Torres Strait Islander people aged 50 years or over since 1999.
- (b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

TABLE 10A.95

Table 10A.95 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Vaccine-preventable conditions									
2007-08	0.6	0.7	0.7	0.7	0.9	0.4	0.7	2.7	0.7
2008-09	0.6	0.7	0.6	0.6	0.7	0.5	0.5	2.8	0.6
2009-10	0.6	0.6	0.8	0.7	0.7	0.6	0.5	2.9	0.7
2010-11	0.5	0.7	0.7	0.6	0.8	0.4	0.3	3.0	0.7
2011-12	0.6	0.7	0.8	0.6	0.8	0.5	0.5	3.2	0.7
2012-13	0.7	0.8	1.1	1.0	1.1	1.0	0.8	3.7	0.9
Acute conditions excluding dehydration and gastroenteritis									
2007-08	10.5	11.4	11.8	11.3	12.0	9.0	9.0	18.2	11.2
2008-09	10.2	11.2	12.2	11.3	11.9	8.2	9.7	20.2	11.2
2009-10	10.2	11.3	12.4	11.3	12.1	8.5	8.1	19.7	11.2
2010-11	10.7	11.9	12.9	12.7	12.6	8.3	9.1	20.2	11.8
2011-12	10.9	12.1	12.9	13.7	12.9	8.4	9.6	21.2	12.1
2012-13	10.8	10.2	13.8	13.6	13.6	9.9	9.3	20.5	11.8
Chronic conditions excluding diabetes complications (additional diagnoses only)									
2007-08	12.6	14.6	15.6	13.3	14.6	13.6	9.4	24.6	14.0
2008-09	12.3	14.0	14.8	13.2	14.2	12.3	11.0	24.0	13.5
2009-10	12.2	14.1	14.5	13.3	13.4	11.8	9.8	23.7	13.4
2010-11	10.2	12.1	12.5	11.2	11.7	9.2	8.7	23.3	11.4
2011-12	10.5	11.9	12.7	11.1	11.5	9.2	8.6	21.6	11.4
2012-13	10.4	10.8	12.9	11.3	11.9	10.1	8.3	22.1	11.3
All potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only) (f)									
2007-08	23.6	26.6	28.0	25.2	27.4	22.8	19.1	45.0	25.8
2008-09	23.0	25.9	27.6	25.0	26.7	20.9	21.1	46.6	25.3

Table 10A.95 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
2009-10	23.0	25.9	27.6	25.2	26.1	20.8	18.2	45.8	25.2
2010-11	21.4	24.6	26.0	24.4	25.0	17.8	18.1	45.9	23.8
2011-12	22.0	24.6	26.3	25.4	25.1	18.0	18.7	45.6	24.1
2012-13	21.9	21.7	27.7	25.7	26.4	20.8	18.2	45.8	23.9

- (a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.
- (b) Data have been revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for more detail.
- (c) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (d) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.
- (e) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.
- (f) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period.

Table 10A.96

Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld	WA	SA	Tas (f), (g)	ACT (f)	NT	Aust (d)
Vaccine preventable conditions									
Aboriginal and Torres Strait Islander people									
2007-08	1.1	1.1	1.6	3.7	3.0	0.6	1.4	7.2	2.3
2008-09	1.1	1.1	1.4	2.8	2.8	0.2	1.0	7.3	2.1
2009-10	1.4	1.0	3.1	4.5	3.0	0.6	0.1	8.3	3.0
2010-11	1.1	1.1	2.5	3.2	2.8	0.3	0.4	9.4	2.7
2011-12	1.1	1.5	2.0	3.8	2.9	0.4	1.3	9.6	2.7
2012-13	1.4	1.3	2.8	4.7	3.7	1.4	3.3	11.6	3.4
Other Australians (h)									
2007-08	0.6	0.7	0.7	0.6	0.9	0.4	0.7	1.1	0.7
2008-09	0.6	0.7	0.6	0.5	0.6	0.5	0.5	1.0	0.6
2009-10	0.6	0.6	0.7	0.6	0.7	0.6	0.5	0.9	0.6
2010-11	0.5	0.7	0.7	0.5	0.8	0.4	0.3	0.9	0.6
2011-12	0.6	0.7	0.8	0.5	0.8	0.5	0.5	1.1	0.7
2012-13	0.7	0.8	1.1	0.9	1.0	0.9	0.7	1.3	0.9
Acute conditions excluding dehydration and gastroenteritis									
Aboriginal and Torres Strait Islander people									
2007-08	17.2	13.4	25.8	39.4	27.7	6.1	12.7	38.0	24.4
2008-09	16.4	14.3	26.0	35.4	27.0	5.6	12.4	43.0	24.2
2009-10	16.2	14.3	24.9	35.0	27.6	7.5	8.9	43.3	23.9
2010-11	18.0	18.0	27.2	40.3	29.3	7.6	12.4	42.9	26.2
2011-12	19.6	19.6	27.2	42.0	31.4	7.9	17.4	45.1	27.4
2012-13	20.8	13.9	28.8	41.5	30.7	6.5	19.7	43.1	27.5
Other Australians (h)									
2007-08	10.4	11.5	11.4	10.4	11.8	9.1	9.0	10.6	10.9
2008-09	10.2	11.3	11.8	10.5	11.8	8.3	9.6	10.8	10.9
2009-10	10.2	11.4	12.0	10.6	11.9	8.6	8.0	10.3	10.9

Table 10A.96

Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld	WA	SA	Tas (f), (g)	ACT (f)	NT	Aust (d)
2010-11	10.6	11.9	12.4	11.8	12.4	8.3	9.0	11.2	11.5
2011-12	10.8	12.2	12.4	12.7	12.6	8.4	9.5	11.7	11.7
2012-13	10.7	10.3	13.3	12.7	13.4	10.0	9.1	11.4	11.4
Chronic conditions excluding diabetes complications (<i>additional diagnoses only</i>)									
Aboriginal and Torres Strait Islander people									
2007-08	29.9	21.3	44.1	57.2	50.2	11.7	23.9	52.4	39.1
2008-09	29.6	23.1	44.5	52.8	45.9	13.4	24.5	54.0	38.7
2009-10	28.2	25.0	41.2	50.5	39.1	10.9	16.6	57.7	37.1
2010-11	25.0	22.5	34.5	43.6	34.4	10.7	26.6	54.0	32.6
2011-12	29.3	26.7	35.2	43.0	35.3	14.3	24.3	54.0	34.8
2012-13	27.7	20.5	36.8	41.0	35.1	14.7	14.8	52.9	33.8
Other Australians (h)									
2007-08	12.5	14.8	15.0	12.4	14.5	13.6	9.3	16.6	13.7
2008-09	12.2	14.2	14.2	12.4	14.2	12.3	10.8	15.5	13.2
2009-10	12.1	14.2	13.9	12.4	13.3	11.8	9.6	13.8	13.1
2010-11	10.1	12.3	12.0	10.5	11.6	9.2	8.5	13.4	11.1
2011-12	10.3	12.0	12.1	10.4	11.5	9.1	8.5	11.9	11.1
2012-13	10.2	10.9	12.3	10.5	11.8	9.9	8.0	11.7	10.9
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)</i> (i)									
Aboriginal and Torres Strait Islander people									
2007-08	48.0	35.7	70.9	98.8	80.3	18.2	38.0	95.8	65.2
2008-09	46.9	38.3	71.2	89.6	75.1	19.1	37.9	102.6	64.3
2009-10	45.6	40.0	68.4	88.9	69.2	18.7	25.6	107.4	63.3
2010-11	44.0	41.4	63.6	86.4	66.1	18.6	39.5	104.3	60.9
2011-12	49.9	47.5	63.8	88.2	69.0	22.4	43.1	107.0	64.4
2012-13	49.7	35.5	67.7	86.4	68.8	22.2	36.6	105.3	64.0

Table 10A.96

Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)

	NSW	Vic	Qld	WA	SA	Tas (f), (g)	ACT (f)	NT	Aust (d)
Other Australians (h)									
2007-08	23.5	26.9	27.0	23.4	27.1	23.0	18.9	28.2	25.2
2008-09	22.9	26.1	26.6	23.3	26.5	21.1	20.9	27.2	24.6
2009-10	22.8	26.1	26.5	23.6	25.8	20.9	18.0	24.8	24.5
2010-11	21.2	24.8	25.0	22.7	24.8	17.8	17.8	25.4	23.2
2011-12	21.7	24.7	25.1	23.6	24.8	17.9	18.4	24.6	23.4
2012-13	21.5	21.8	26.4	24.0	26.0	20.8	17.8	24.4	23.1

- (a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.
- (b) Data have been revised in line with nationally agreed revisions to the definition of selected potentially preventable hospitalisations and may differ from previous reports. Further, population estimates and projections used to derive rates have been revised based on the 2011 Census. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for more detail.
- (c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.
- (d) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (e) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.
- (f) From 2010-11, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.
- (g) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.
- (h) Other Australians includes separations where Indigenous status was not stated.
- (i) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period. ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Series B, Cat. no. 3238.0.

TABLE 10A.97

Table 10A.97 **Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<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 (e)</i>
<i>Vaccine preventable conditions</i>									
Major cities	0.7	0.8	1.2	0.9	1.1	..	0.8	..	0.4
Inner regional	0.7	0.7	1.0	0.7	0.9	1.0	1.4	..	0.4
Outer regional	0.8	0.7	1.1	1.1	1.0	0.9	..	1.8	0.5
Remote	0.6	0.2	1.9	2.1	1.4	0.4	..	5.2	1.1
Very remote	1.5	..	1.7	2.2	2.7	0.6	..	7.7	1.6
<i>Acute conditions excluding dehydration and gastroenteritis</i>									
Major cities	10.2	9.7	12.7	12.9	13.0	..	9.3	..	5.5
Inner regional	12.3	11.6	14.5	12.3	13.6	9.6	11.7	..	6.2
Outer regional	13.9	13.2	15.8	14.4	16.4	10.2	..	12.5	7.1
Remote	21.1	17.6	21.1	20.6	13.4	12.5	..	30.2	10.4
Very remote	26.2	..	27.2	24.8	23.9	13.3	..	30.7	13.2
<i>Chronic conditions excluding diabetes complications (additional diagnoses only)</i>									
Major cities	9.4	10.6	12.1	10.5	11.2	..	8.3	..	5.2
Inner regional	11.8	11.1	13.7	11.6	11.1	10.1	8.4	..	5.9
Outer regional	14.7	12.5	14.0	13.8	15.4	10.0	..	15.6	6.9
Remote	22.3	12.1	16.6	15.9	12.7	10.2	..	26.3	8.8
Very remote	26.3	..	24.4	19.7	22.5	13.4	..	36.4	12.8
<i>All potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only) (g)</i>									
Major cities	20.3	21.0	25.7	24.1	25.2	..	18.2	..	11.1
Inner regional	24.7	23.3	29.1	24.5	25.6	20.6	20.0	..	12.5
Outer regional	29.4	26.3	30.7	29.1	32.6	21.0	..	29.8	14.4
Remote	44.0	30.0	39.5	38.4	27.4	23.1	..	60.8	20.1
Very remote	53.8	..	52.9	46.3	48.6	26.8	..	73.7	27.3

Table 10A.97 **Separations for selected potentially preventable hospitalisations by remoteness, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<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 (e)</i>
(a)	Rates are age-standardised to the Australian estimated resident population at 30 June 2001.								
(b)	Remoteness areas are defined using the ABS 2011 Census based Australian Standard Geographical Classification (ASGS). Not all remoteness areas are represented in each state or territory. Caution should be used in comparing 2012-13 data with earlier years in which remoteness areas were defined using a different geographical classification. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.								
(c)	There are: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.								
(d)	Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.								
(e)	Separation rates are based on state or territory and remoteness area of usual residence, not hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.								
(f)	Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.								
(g)	More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.								
	.. Not applicable. np Not published.								

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period.

Table 10A.98 Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)

	<i>Major cities</i>	<i>Inner regional/ Outer regional</i>	<i>Remote/ Very remote</i>
Vaccine-preventable conditions			
Aboriginal and Torres Strait Islander people			
2012-13	2.2	2.4	7.2
Other Australians (g)			
2012-13	0.9	0.8	1.2
Acute conditions <i>excluding dehydration and gastroenteritis</i> (c)			
Aboriginal and Torres Strait Islander people			
2012-13	18.5	23.3	49.3
Other Australians (g)			
2012-13	11.0	12.5	14.3
Chronic conditions <i>excluding diabetes complications as additional diagnoses</i> (c)			
Aboriginal and Torres Strait Islander people			
2012-13	22.4	34.2	49.3
Other Australians (g)			
2012-13	10.5	11.8	12.8
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications as additional diagnoses</i> (c)			
Aboriginal and Torres Strait Islander people			
2012-13	42.7	59.5	104.4
Other Australians (g)			
2012-13	22.3	25.0	28.2

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

(b) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

(c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small. See data quality information (DQI) at www.pc.gov.au/rogs/2015 for further detail.

(d) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.

(e) Separation rates are based on patient's usual residence (not hospital location).

(f) Separations for patients usually resident overseas are excluded.

(g) 'Other Australians' includes separations where Indigenous status was not stated.

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Residential Population, 30 June 2012; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, 30 June 2012, Series B, Cat. no. 3238.0.

TABLE 10A.99

Table 10A.99 **Separations for selected vaccine preventable conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Vaccine preventable conditions per 1000 Aboriginal and Torres Strait Islander people									
Pneumonia and Influenza (vaccine-preventable)	1.0	1.0	2.1	3.7	2.2	1.0	3.3	5.9	2.2
Other vaccine preventable conditions	0.4	0.3	0.7	1.0	1.6	0.3	–	5.8	1.2
Total	1.4	1.3	2.8	4.7	3.7	1.4	3.3	11.6	3.4
Vaccine preventable conditions per 1000 other Australians (i)									
Pneumonia and Influenza (vaccine-preventable)	0.5	0.5	0.8	0.7	0.8	0.7	0.5	0.7	0.6
Other vaccine preventable conditions	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.6	0.3
Total	0.7	0.8	1.1	0.9	1.0	0.9	0.7	1.3	0.9

(a) Data for 2012-13 are based on specifications that have been revised in alignment with the National Healthcare Agreement and are not comparable with data reported elsewhere (such as the AIHW's *Australian hospital statistics*) or with data in previous editions of this Report. Conditions are defined by ICD-10-AM codes that are available on request.

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

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

(d) Separation rates are based on state or territory of usual residence.

(e) Rates are derived using population estimates and projections based on the 2011 Census.

(f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data are for public hospitals only.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

(i) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(j) – Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.100

Table 10A.100 **Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Acute conditions per 1000 Aboriginal and Torres Strait Islander people									
Pneumonia (not vaccine-preventable)	0.1	0.3	0.1	0.2	0.1	–	0.1	0.1	0.1
Cellulitis	4.6	2.7	7.4	9.7	5.0	1.8	4.1	10.8	6.5
Convulsions and epilepsy	5.1	2.5	5.6	8.9	9.9	1.1	3.6	9.0	6.1
Eclampsia	–	–	–	–	–	–	–	–	–
Dental conditions	3.0	3.0	3.6	4.4	3.6	1.5	2.8	5.2	3.5
Ear, nose and throat infections	2.4	1.7	3.1	5.0	3.8	0.5	1.8	5.0	3.1
Gangrene	0.4	0.4	1.2	2.4	0.8	0.2	0.6	2.0	1.1
Pelvic inflammatory disease	0.4	0.3	0.6	1.0	0.6	0.2	0.4	1.2	0.6
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.4	0.2	0.2	0.4	0.3
Urinary tract infections, including pyelonephritis (i)	4.5	2.8	7.1	9.5	6.5	0.9	6.1	9.5	6.2
Total	20.8	13.9	28.8	41.5	30.7	6.5	19.7	43.1	27.5
Acute conditions per 1000 other Australians (j)									
Pneumonia (not vaccine-preventable)	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1
Cellulitis	2.1	1.7	2.7	1.9	2.4	1.7	1.6	3.5	2.1
Convulsions and epilepsy	1.4	1.2	1.7	1.3	1.6	1.4	1.3	1.2	1.4
Eclampsia	–	–	–	–	–	–	–	–	–
Dental conditions	2.3	2.7	2.8	3.9	3.8	3.4	2.1	2.1	2.8
Ear, nose and throat infections	1.6	1.3	1.9	1.8	2.2	1.2	1.0	1.5	1.6

Table 10A.100 **Separations for selected acute conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Gangrene	0.2	0.5	0.4	0.4	0.3	0.4	0.2	0.5	0.3
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Urinary tract infections, including pyelonephritis (i)	2.6	2.4	3.3	2.9	2.8	1.6	2.5	2.2	2.7
Total	10.7	10.3	13.3	12.7	13.4	10.0	9.1	11.4	11.4

(a) Data for 2012-13 are based on specifications that have been revised in alignment with the National Healthcare Agreement and are not comparable with data reported elsewhere (such as the AIHW's *Australian hospital statistics*) or with data in previous editions of this Report. Conditions are defined by ICD-10-AM codes that are available on request.

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

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

(d) Separation rates are based on state or territory of usual residence.

(e) Rates are derived using population estimates and projections based on the 2011 Census.

(f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data are for public hospitals only.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

(i) Pyelonephritis is kidney inflammation caused by bacterial infection.

(j) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

– Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.101

Table 10A.101 **Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Chronic conditions per 1000 Aboriginal and Torres Strait Islander people									
Angina	3.4	2.6	5.8	5.2	4.6	2.3	1.4	5.0	4.4
Asthma	2.2	1.9	2.5	3.8	2.9	0.6	1.1	2.9	2.5
Chronic obstructive pulmonary disease	11.2	7.2	10.9	8.1	10.6	4.7	3.7	15.1	10.6
Congestive heart failure	3.8	2.5	5.8	7.0	4.9	3.6	2.6	8.4	5.2
Diabetes complications (i)	4.2	3.4	7.8	10.9	8.0	1.6	3.6	8.9	6.5
Hypertension	0.7	0.5	1.0	1.0	0.7	0.2	–	0.7	0.8
Iron deficiency anaemia	1.8	2.3	2.1	3.5	2.0	1.9	1.6	3.2	2.3
Nutritional deficiencies	0.1	–	–	–	–	–	0.6	0.3	0.1
Rheumatic heart disease (j)	0.1	0.1	0.5	0.8	0.5	–	0.2	3.2	0.7
Bronchiectasis	0.3	0.0	0.4	0.6	0.8	–	–	5.2	0.9
Total (i), (k)	27.7	20.5	36.8	41.0	35.1	14.7	14.8	52.9	33.8
Chronic conditions per 1000 other Australians (l)									
Angina	1.6	1.3	2.2	1.8	1.8	1.2	1.1	2.8	1.7
Asthma	1.2	1.1	1.4	0.9	1.4	0.9	0.8	0.8	1.2
Chronic obstructive pulmonary disease	2.4	2.1	2.7	2.0	2.6	2.1	2.0	3.4	2.4
Congestive heart failure	1.9	2.1	2.0	1.8	1.9	1.7	1.6	1.8	2.0
Diabetes complications (i)	1.4	1.7	1.8	1.7	1.9	1.5	1.0	1.4	1.6
Hypertension	0.3	0.3	0.5	0.3	0.3	0.2	0.2	0.2	0.3
Iron deficiency anaemia	1.2	1.9	1.2	1.7	1.6	2.0	1.1	1.0	1.5
Nutritional deficiencies	–	–	–	–	–	–	0.1	0.1	–
Rheumatic heart disease (j)	0.1	0.1	0.1	0.1	0.1	–	0.1	0.1	0.1

Table 10A.101 **Separations for selected chronic conditions by Indigenous status, 2012-13 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Bronchiectasis	0.2	0.2	0.3	0.2	0.1	0.2	0.1	0.2	0.2
Total (i), (k), (l)	10.2	10.9	12.3	10.5	11.8	9.9	8.0	11.7	10.9

- (a) Data for 2012-13 are based on specifications that have been revised in alignment with the National Healthcare Agreement and are not comparable with data reported elsewhere (such as the AIHW's *Australian hospital statistics*) or with data in previous editions of this Report. Conditions are defined by ICD-10-AM codes that are available on request.
- (b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.
- (c) Separation rates are directly age standardised to the Australian population at 30 June 2001.
- (d) Separation rates are based on state or territory of usual residence.
- (e) Rates are derived using population estimates and projections based on the 2011 Census.
- (f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.
- (g) NT data for Aboriginal and Torres Strait Islander people and other Australians are for public hospitals only.
- (h) Data for Australia include all States and Territories and Australian residents of external Territories.
- (i) Excludes separations with an additional diagnosis of diabetes complications.
- (j) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.
- (k) Total may not sum to the individual categories as more than one chronic condition can be reported for a separation.
- (l) Data for non-Indigenous Australians include separations where Indigenous status was not stated.
- .. not applicable. – Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.102 **Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2012-13 (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT (b)</i>	<i>NT (b)</i>	<i>Total</i>
Diabetes as a principle diagnosis (h)	no.	622	127	1 245	585	214	35	20	629	3 477
	SHSR	3.94	2.48	5.68	7.02	4.88	1.31	5.44	6.51	5.16
All diabetes — excluding diabetes complications as an additional diagnosis (i)	no.	3 756	778	4 656	3 497	1 188	187	75	2 690	16 827
	SHSR	2.47	2.09	2.91	4.03	3.23	1.14	2.47	3.45	2.90
All diabetes (j)	no.	7 640	1 667	12 463	13 464	2 453	372	179	7 896	46 134
	SHSR	3.01	2.53	4.22	9.23	4.11	1.38	2.96	5.61	4.62

SHSR = Standardised Hospital Separation Ratio

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

(b) Data are available for Tasmania and the ACT for the first time. NT data are for public hospitals only.

(c) Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

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

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

(f) Separation rates are based on state of usual residence.

(g) Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.

(h) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

(i) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24' or Additional diagnosis in 'E109', 'E119', 'E139' or 'E149'.

(j) All diabetes refers to separations with either a principal or additional diagnosis of diabetes. Includes ICD-10-AM codes in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.103 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2012-13 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

	<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 (f)</i>
Circulatory	13.2	11.7	10.1	20.7	10.8	np	np	np	12.5
Renal	3.4	2.5	4.7	3.5	4.4	np	np	np	3.5
Ophthalmic	4.9	8.6	10.7	22.4	7.1	np	np	np	9.1
Other specified	37.8	40.3	53.6	43.5	59.1	np	np	np	44.0
Multiple	20.2	40.4	39.1	36.6	35.3	np	np	np	32.9
No complications	5.5	4.8	4.4	5.1	4.4	np	np	np	4.9
Total (g)	85.0	108.5	122.5	131.7	121.0	np	np	np	107.0

- (a) Rates are age standardised to the Australian resident population at 30 June 2001.
- (b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.
- (c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.
- (d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.
- (e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.
- (f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (g) Totals may not add as a result of rounding.
- (h) Reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in Australian Coding Standards. Therefore, data for 2012-13 are not comparable with data for previous years.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.104 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2012-13 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)

	<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 (g)</i>
Circulatory	13.6	11.8	15.4	32.7	10.2	np	np	np	16.2
Renal	14.8	17.5	18.3	22.2	22.7	np	np	np	18.6
Ophthalmic	80.6	88.4	92.4	90.0	87.9	np	np	np	88.8
Other specified	10.4	13.1	20.2	15.3	23.1	np	np	np	15.1
Multiple	9.3	35.4	22.4	6.6	19.7	np	np	np	21.6
No complications	38.0	40.1	32.3	31.5	44.2	np	np	np	37.5
Total	16.5	28.5	27.0	29.4	25.4	np	np	np	24.6

- (a) Data are for the number of same day separations with the specified principal diagnosis, as a per cent of all separations with the specified principal diagnosis.
- (b) Rates are age-standardised to the Australian resident population at 30 June 2001.
- (c) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.
- (d) Results for individual complications may be affected by small numbers, and need to be interpreted with care.
- (e) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.
- (f) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.
- (g) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (h) Reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in Australian Coding Standards. Therefore, data for 2012-13 are not comparable with data for previous years.

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

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 10A.105 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13 (a), (b), (c), (d), (e)**

	<i>Unit</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 (d)</i>
ASR	per 100 000 people	14.3	16.1	16.5	18.5	19.6	np	np	np	16.4
Separations	no.	1187	988	777	448	395	np	np	np	4 039

ASR = Age standardised rate

- (a) ASR rates are age standardised to the Australian estimated resident population at 30 June 2001.
- (b) Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation.
- (c) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.
- (d) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (e) Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.106

Table 10A.106 Separation rates for older people for injuries due to falls (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 (d)</i>
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	46 425	32 911	20 058	10 409	8 780	2 348	1 516	340	122 787
2006-07									
Separations per 1000 older people	51.6	48.5	43.0	43.8	35.8	32.7	52.2	47.8	46.7
Number of separations	50 938	35 649	22 078	10 954	9 358	2 455	1 697	375	133 504
2007-08									
Separations per 1000 older people	51.6	48.6	42.9	43.7	36.4	34.1	60.1	43.2	46.8
Number of separations	52 463	36 855	22 851	11 319	9 762	2 616	2 051	366	138 283
2008-09									
Separations per 1000 older people	52.4	47.6	45.7	44.6	39.0	32.9	65.0	43.2	47.7
Number	54 998	37 337	25 092	12 009	10 759	2 580	2 318	383	145 476
2009-10									
Separations per 1000 older people	55.9	49.5	47.1	46.2	43.0	32.8	68.2	43.3	50.1
Number of separations	60 117	39 885	26 759	12 877	12 059	2 638	2 546	408	157 289
2010-11									
Separations per 1000 older people	60.4	53.0	51.7	52.1	43.0	32.7	65.6	np	54.0
Number of separations	np	np	np	np	np	np	np	np	np
2011-12 (d)									
Separations per 1000 older people	61.6	55.2	56.2	56.8	46.0	33.7	73.0	54.0	56.5
Number of separations	68 833	45 953	32 782	16 539	13 297	2 845	2 858	513	183 620
2012-13									
Separations per 1000 older people	62.1	51.8	60.1	58.2	47.8	34.3	66.5	53.9	56.8
Number of separations	71 946	44 709	36 424	17 719	14 261	2 992	2 757	575	191 383

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

Table 10A.106 **Separation rates for older people for injuries due to falls (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 (d)</i>
--	------------	------------	------------	-----------	-----------	------------	------------	-----------	-----------------

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

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

(d) The Australian total for 2010-11 does not include NT data.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Fifth Community Pharmacy Agreement (5CPA)	5CPA provides more than \$15.6 billion over five years (1 July 2010 to 30 June 2015) for the dispensing of PBS medicines and to ensure vital medicines are accessible to the Australian community. The 5CPA includes \$663.4m over the life of the 5CPA for Professional Services and Programmes delivered by pharmacists, which promote access to services that assist patient medication management and support the quality use of medicine and through this, improve consumer health outcomes. A number of these programmes target particular population groups (such as the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people) and geographical settings (such as the Rural Pharmacy Workforce Programme).	Over \$14b for the dispensing of PBS medicines. \$950m for the Community Service Obligation funding pool, which supports the timely supply of medicines to all Australians. \$663.4m for a range of Programmes and Services that improve patient health outcomes.	<ul style="list-style-type: none"> • Data via PBS. • The Pharmacy Guild of Australia reports on a number of 5CPA programmes. • Department of Human Services reports on two programmes. • Reporting data or activity for 5CPA programmes by funding recipients.
Blood-borne Viruses and Sexually Transmissible Infection Prevention and Control	<p>The Commonwealth funds programs to support a coordinated national effort to address the risk and spread of viral hepatitis, sexually transmissible infections and HIV/AIDS.</p> <p>The Commonwealth Government works with partners including state and territory governments, research institutions and community-based organisations to reduce the risk and transmission of blood-borne viruses (BBV) and sexually transmissible infections (STI) as well as to improve the health outcomes of people living with or at risk of these diseases.</p>	State and Commonwealth Co-funded and coordinated at the national level to achieve program objectives and targets	<ul style="list-style-type: none"> • Routine reporting <ul style="list-style-type: none"> – quarterly – progress and annual reports • Additional <ul style="list-style-type: none"> - activity and program evaluation.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap – PBS Co-payment Measure	The Closing the Gap (CTG) Pharmaceutical Benefits Scheme Co-Payment Measure is funded through the Indigenous Australians' Health Programme. The CTG Measure improves access to Pharmaceutical Benefits Scheme medicines, by providing co-payment relief for Aboriginal and Torres Strait Islanders living with, or at risk of, chronic disease. Eligible general practices participating in the Practice Incentive Programme (PIP) under the Indigenous Health Incentive (IHI) and non-remote Indigenous Health Services (IHS) may participate in the Measure which commenced on 1 July 2010.	Commonwealth Department of Health	<ul style="list-style-type: none"> • The Department of Human Services records registration of PIP accredited GP practices and non-remote IHS, and eligible registered patients. • Expenditure data is reported monthly through DHS.
Royal Flying Doctor Service	The Australian Government funds the Royal Flying Doctor Service of Australia (RFDS) to provide essential primary health care service 'traditional services', that is emergency primary aeromedical evacuations, primary GP and nursing health clinics, remote consultations and medical chests in remote and very remote areas which are beyond the normal medical infrastructure in areas of market failure.	Commonwealth Department of Health	Reporting is quarterly for health, financial data and qualitative information.
Rural Womens GP Service Programme	The Rural Women's GP Service (RWGPS) aims to improve access to primary health care services for women in rural and remote Australia, who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities.	Commonwealth Department of Health to the Royal Flying Doctor Service to deliver the RWGPS.	Reporting quarterly by exception. Six monthly for full health, financial data and qualitative reporting.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rural Health Outreach Fund	<p>The Rural Health Outreach Fund (RHOF) improves access to medical specialist, allied health and GP and other health services for people living in rural and remote locations, by removing the financial disincentives incurred by health professionals who provide outreach services. This is achieved by meeting costs associated with delivering outreach services such as travel, accommodation, and venue hire.</p> <p>The RHOF addresses four health priorities - maternity and paediatric health; eye health; mental health; and support for chronic disease management. A range of health professionals are supported, including specialists such as paediatricians, psychiatrists, and surgeons; allied health professionals such as dietitians and occupational therapists; as well as GPs; nurses; and midwives.</p>	<p>Commonwealth Department of Health</p> <p>Delivered by jurisdictional fundholders.</p>	<p>Quarterly financial and service activity reports</p>
Stronger Futures in the Northern Territory	<p>Stronger Futures in the Northern Territory National Partnership Agreement – Health.</p> <p>This 10 year agreement includes an investment of over \$700 million and aims to address persistent challenges experienced accessing health care services for Aboriginal people in the Northern Territory. Funding supports improved access, coordination and health care service delivery in remote areas, including facilitating delivery of specialist, dental and audiology health services for high disease burden conditions such as oral health and hearing health.</p>	<p>Commonwealth Department of Health</p> <p>The programme is delivered by a range of Aboriginal Community Controlled Health Services, Non-Government Organisations and the Northern Territory Government.</p>	<p>Services undertake a quarterly review of progress against agreed plans. Organisations provide an annual report of service activity. Clinical primary health care service providers report biannually on national key performance indicators.</p>
Visiting Optometrist Scheme (VOS)	<p>The VOS improves access to optometric services for people living and working in rural and remote communities. This is achieved by addressing some of the financial disincentives incurred by participating optometrists providing outreach services, including travel, accommodation and facility fees.</p>	<p>Commonwealth Department of Health</p> <p>Delivered by optometrists.</p>	<p>Six monthly financial and activity reports.</p>

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Eye and Ear Health	<p>Ear Health The Healthy Ears – Better Hearing, Better Listening Programme improves access to ear and hearing health services for Indigenous Australian children and youth, with a focus on rural and remote locations, by providing multidisciplinary outreach services. This is achieved by meeting the costs associated with delivering outreach services, such as travel, accommodation and venue hire. A range of health professionals are supported, such as medical specialists, GPs, nurses, audiologists and speech pathologists.</p> <p>Eye Health The Trachoma National Partnership Agreement aims to eliminate trachoma by 2020 by improving trachoma screening and treatment activities. Trachoma occurs primarily in remote and very remote Aboriginal communities in the Northern Territory, South Australia and Western Australia.</p>	<p>Commonwealth Department of Health Delivered by jurisdictional fundholders.</p> <p>Commonwealth Department of Health and health departments in New South Wales, Northern Territory, Queensland, South Australia and Western Australia. Delivered by state governments.</p>	<p>Quarterly financial and service activity reports</p> <p>6 monthly reporting on activities and data collection through the Kirby Institute, University of NSW.</p>
Primary Health care Funding	<p>The Indigenous Australians' Health Programme supports Aboriginal community controlled health organisations and other Aboriginal medical services to provide Indigenous-specific comprehensive primary health care services including population health activities and clinical services, such as the treatment of acute illness, emergency care, management of chronic conditions, crisis intervention and referral. Funded organisations deliver services across the country, including in remote Aboriginal and Torres Strait Islander communities ensuring access to essential health services.</p>	<p>Funding is provided by the Department of Health. The programme is delivered by a range of Aboriginal community controlled health services, non-government organisations and some State and Territory health departments.</p>	<p>Organisations provide an annual report of service activity. Services providing clinical primary health care report biannually against agreed national key performance indicators.</p>

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian Nurse Family Partnership Programme	<p>The Australian Nurse Family Partnership Programme (ANFPP) is an evidence-based programme that aims to improve pregnancy outcomes by: helping women engage in good preventive health practices; supporting parents to improve their child's health and development; and helping parents develop a vision for their own future, including continuing education and finding work.</p> <p>The Programme is based on the US Nurse-Family Partnership® (NFP) model developed over the last 30 years by Professor David Olds and his team at the University of Colorado. In the 2014 Budget, the Australian Government provided additional funding from 2015-16 through the Better Start to Life approach for an additional 10 ANFPP sites to a total of 13 sites by 2018.</p>	Department of Health to three Aboriginal Community Controlled Health Organisations to deliver the programme - Wellington Aboriginal Corporation Health Service (Wellington, NSW), Wuchopperen Health Service (Cairns, QLD), and Central Australian Aboriginal Congress (Alice Springs, NT).	Australian Nurse Family Partnership Programme - Quarterly fidelity and progress reports as well as six monthly financial reports.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
National Partnership Agreement: Indigenous Early Childhood Development	<p>The National Partnership Agreement on Indigenous Early Childhood Development (NPA IECD) was one of a range of measures agreed to by the Council of Australian Governments (COAG) to achieve the target of Closing the Gap in Indigenous disadvantage. The NPA IECD provided funding over 6 years to June 2014, to specifically address the needs of Aboriginal and Torres Strait Islander Children in their early years.</p> <p>The NPA IECD comprised of three interrelated Elements:</p> <ul style="list-style-type: none"> • The Department of Prime Minister and Cabinet was responsible for Element 1 of the NPA IECD. • The Department of Health was responsible for the health components (Elements 2 and 3) of the NPA IECD. <p>- Element 2: (\$107m over 5 years) aimed to increase access to antenatal care, pre-pregnancy and teenage sexual and reproductive health services.</p> <p>- Element 3: (\$90.3m of Commonwealth Own Purpose Expenditure and \$75m of State Own Purpose Expenditure over 5 years) - to increase access to, and use of, maternal and child health services by Aboriginal and Torres Strait Islander families.</p> <p>Building on the achievements of the NPA IECD, the 2014-15 Commonwealth Budget commits \$25.9 million in 2014-15 for a new Indigenous Teenage Sexual and Reproductive Health and Young Parent Support measure to continue Indigenous teenage sexual and reproductive health and antenatal care services previously funded through the NPA IECD.</p>	<p>Funding was provided by the Australian Government and state and territory governments.</p> <p>Element 2: Funding is through payment transfers to states and territories who manage/deliver the programmes/services.</p> <p>Element 3: The Department of Health funds Aboriginal community controlled health organisations (ACCHOs) and primary health care organisations to deliver the New Directions programme.</p> <p>States and territories provide funding for Indigenous maternal and child health services.</p>	<p>A national evaluation was undertaken by Urbis Pty Ltd and the Final Report will be released in late 2014.</p> <p>An Annual Data Report on health performance indicators, commissioned by the Department of Health, is provided by the Australian Institute of Health and Welfare.</p>

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
New Directions: Mothers and Babies	<p>The New Directions: Mothers and Babies Services programme provides Aboriginal and Torres Strait Islander children and their mothers with access to antenatal care, standard information about baby care, practical advice and assistance with breastfeeding, nutrition and parenting; monitors developmental milestones, immunisation status and infections; and undertakes health checks for Indigenous children before starting school.</p> <p>The programme is being implemented in 85 sites across Australia. There are 15 organisations funded in urban locations, 38 in regional locations and the remaining 32 are in remote locations, 12 of which are remote service delivery sites. These services will expand from 85 to 136 sites by 2018 under the Australian Government's Better Start to Life approach.</p> <p>The New Directions: Mothers and Babies Services programme was the Commonwealth's contribution to Element 3 of the NPA IECD.</p>	Funding for New Directions: Mothers and Babies is provided by the Department of Health under Element 3 of the NPA IECD to ACCHOs and primary health care organisations.	Under the NPA IECD, the Commonwealth prepares an Annual Report for the preceding Financial year by 31 August each year
Indigenous Australians Health Programme	<p>The Aboriginal and Torres Strait Islander Chronic Disease Fund ceased on 30 June 2014 with activities continuing under the Indigenous Australians Health Programme (IAHP) from 1 July 2014.</p> <p>The chronic disease theme of the IAHP aims to improve the prevention, detection and management of chronic disease in Aboriginal and Torres Strait Islander peoples to close the gap in life expectancy. It provides funding for prevention programmes and community education to reduce the key risk factors that contribute to chronic disease; improved access to best practice chronic disease management and follow up care; and improved health services for use by Aboriginal and Torres Strait Islander people with, or at risk of, chronic disease.</p>	Commonwealth Department of Health -	Department of Health Annual Report

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian General Practice Training (AGPT) Program	<p>The AGPT program is the main pathway for achieving GP specialist qualifications in Australia. The AGPT program is a three to four year postgraduate vocational training program for medical graduates wishing to pursue a career in general practice. Registrars train to meet the standards for fellowship of either the Royal Australian College of General Practice (RACGP) or the Australian College of Rural and Remote Medicine (ACCRM).</p> <ul style="list-style-type: none"> • In 2014, all 1192 places on the AGPT were filled and 58% of doctors who applied were women. These doctors provide services to the local community while they train. • At least 50% of all AGPT training must occur in rural and remote areas 	<p>Commonwealth Department of Health and managed by General Practice Education Training</p> <p>The program is delivered by 17 Regional Training Providers (RTPs).</p>	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department in line with funding agreements between the Department and the RTPs. .
Remote Vocational Training Scheme	<p>The Remote Vocational Training Scheme (RVTS) is a four year programme delivering structured distance education and supervision to doctors providing general medical services in rural and remote locations throughout Australia.</p> <ul style="list-style-type: none"> • The RVTS vocational training supports doctors in rural/remote areas to gain Fellowship: of the RACGP and/or the ACRRM, and/or in Advanced Rural General Practice. The RVTS funds locum relief to allow doctors to attend face-to-face training. This ensures that solo doctor towns or small communities are not affected by doctors leaving for training requirements. • The funding supports 22 new training places each year for registrars training in RA 2-5 categories, with entry for an additional 10 registrars to train in Aboriginal and Community Controlled Health Services in 2014 and 2015. 	<p>Commonwealth Department of Health</p> <p>The program is delivered by RVTS Ltd through a funding agreement with the Department.</p>	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department four times a year in line with the funding agreement between the Department and RVTS Ltd. .

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Voluntary Dental Graduate Year Program	<p>The Voluntary Dental Graduate Year Programme (VDGYP) provides dental graduates with a structured programme for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity, particularly in the public sector.</p> <ul style="list-style-type: none"> • In 2014 placements are based across 43 locations. Of these locations, 21 are metropolitan areas, 16 are regional areas, 5 remote areas and 1 provide services across remoteness areas. • The VDGYP commenced first intake of 50 graduates in 2013. • Graduate placements are directed towards the public sector and areas of need, including rural areas 	The program is delivered by a national administrator Australian Information Technology Engineering Centre.	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department twice a year in line with the funding agreement between the Department and administrator.
Oral Health Therapist Graduate Year Program	<p>The Oral Health Therapist Graduate Year Programme (OHTGYP) provides oral health therapist graduates with a structured programme for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity, particularly in the public sector.</p> <ul style="list-style-type: none"> • The first cohort of 50 oral health therapist graduates commenced participation in the OHTGYP on 20 January 2014. • The first cohort commenced in January 2014. Placements are based across 43 locations. Of these locations, 20 are metropolitan areas, 19 are regional areas, 2 remote areas and 3 provide services across remoteness areas. • Graduate placements are directed towards the public sector and areas of need, including rural areas 	The program is delivered by a national administrator Australian Information Technology Engineering Centre.	<ul style="list-style-type: none"> • Financial and activity reports submitted to the Department twice a year in line with the funding agreement between the Department and administrator.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Aboriginal and Torres Strait Islander Health Workforce Services	<p>Funding is provided to four Aboriginal and Torres Strait Islander peak health organisations:</p> <ul style="list-style-type: none"> • Australian Indigenous Doctors Association; • Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; • National Aboriginal and Torres Strait Islander Health Worker Association; and • Indigenous Allied Health Australia <p>Aboriginal and Torres Strait Islander peak health organisations provide representation, advocacy, advice and support for the health workforce they represent and participate in the development and implementation of Aboriginal and Torres Strait Islander health workforce policy, priorities and programs.</p> <p>The support provided by Aboriginal and Torres Strait Islander peak health organisations assists in the recruitment and retention of Aboriginal and Torres Strait Islander health professionals, which has the potential to improve primary health care outcomes for those Aboriginal and Torres Strait Islanders who feel more comfortable seeing Indigenous health professionals when accessing some mainstream health services.</p>	Commonwealth Department of Health	Financial and activity reports submitted regularly to the Department in line with funding agreements between the Commonwealth and individual organisations.
General Practice Rural Incentive Programme	<p>The General Practice Rural Incentives Programme (GPRIP) provides financial incentives to encourage doctors to move to and/or remain in regional, rural and remote Australia. Payments are scaled to provide the greatest incentive to those living and working in the most isolated regions. Doctors and registrars receive a retention payment based on their length of service in a rural community, clinical workload and location of the practice.</p> <p>For more information go to www.ruralhealthaustralia.gov.au</p>	<p>Commonwealth Department of Health</p> <p>The programme is administered by the Department of Human Services- Medicare Australia</p>	Quarterly activity and financial reporting as well as annual activity and expenditure reports.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Nursing and Allied Health Rural Locum Scheme	The Nursing and Allied Health Rural Locum Scheme (NAHRLS) is a retention incentive strategy established in 2011. The NAHRLS addresses workload issues for nursing and allied health professionals working in rural and remote locations, by enabling leave for holiday and/or professional development. For more information go to www.nahrsls.com.au	Commonwealth Department of Health The programme is administered by Aspen Medical.	Quarterly activity and six monthly progress reports against deliverables. As well as annual activity and audited financial report. An annual work plan is submitted.
Dental Relocation and Infrastructure Support Scheme	The Dental Relocation and Infrastructure Support Scheme (DRISS) supports the distribution of dental services into regional and remote communities by providing relocation incentives and infrastructure support grants to dentists. The programme supports dentists to relocate to a more regional or remote location. For more information go to www.rhwa.org.au	Commonwealth Department of Health The programme is administered by Rural Health Workforce Australia.	An annual work plan plus a six month performance and financial report. Annual activity and financial reports.
International Recruitment Strategy	The International Recruitment Strategy (IRS) comprises four activities to support doctors in rural areas: 1. International Recruitment – a case managed recruitment service for overseas trained doctors (OTDs). 2. Additional Assistance Scheme – financial support for Australian and overseas trained doctors to assist their achievement of Fellowship qualifications. 3. The Rural Locum Relief Program – provides access to A2 Medicare rebates for doctors restricted by s19AA of the <i>Health Insurance Act 1973</i> (the Act). 4. The Five Year OTD Scheme – a retention service that offers the ability for OTDs to reduce the period of their restriction under s19AB of the Act.	Commonwealth Department of Health The programme is administered by Rural Health Workforce Australia.	A six month progress report on each component as well as annual activity and audited financial statement. In addition, the Five Year OTD scheme reports fortnightly.

Table 10A.107 **Australian Government, community health services programs***Programs funded by the Australian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rural Obstetric and Anaesthetic Locum Schemes	The Rural and Obstetric and Anaesthetic Scheme (ROALS) supports the rural specialist and general practitioner obstetric and anaesthetic workforce. The programme aims to improve rural workforce retention through the provision of subsidised locum services. The ROALS objective is to help maintain and improve access to quality obstetric and anaesthetic care for rural communities by supporting affordable locum relief to the rural obstetric and anaesthetic workforce. Specialist obstetricians and anaesthetists and GP obstetricians and anaesthetists located in Australian Standard Geographical Classification Remoteness Areas 2-5 locations are eligible to apply. For more information go to www.roals.org.au	Commonwealth Department of Health The program is administered by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.	Quarterly data and progress reports as well as annual activity and audited financial report. Steering Committee has policy oversight on the administration of the scheme.
Rural Locum Education Assistance Programme and Rural Procedural Grants Programme	The Rural Locum Education Assistance Programme (Rural LEAP) provides financial assistance to urban GPs who undertake emergency medicine training and commit to a 4 week (or 20 working days) paid general practice locum placement in rural location within a two (2) year period. Participants are required to undertake practice based GP locum positions located in ASGC-RA 2-5. These locum placements may be organised by the participant or through a locum agency. Rural Procedural Grants Programme (RPGP) aims to ensure the GP proceduralists in rural and remote areas sufficient financial support to access relevant training, up skilling and skills maintenance activities More information is available at www.acrrm.org.au or www.racgp.org.au	Commonwealth Department of Health The programme is administered jointly by the ACRRM and the RACGP who are responsible for assessing the eligibility of GPs and the training on offer. The Department of Human Services maintains a register of eligible GPs and tracking participation.	Rural Leap - twice yearly progress reports and an annual activity and financial report. A collaboration committee has policy oversight on the administration of the scheme. RPGP – twice yearly progress reports and an annual activity and financial report.

Source: Australian Government unpublished.

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services. Personal Health Record (PHR) - The NSW PHR (also known as 'the Blue Book') is distributed to all families with a newborn in NSW and provides a schedule of nine recommended child health checks from birth to four years of age. The PHR uses a joint parental-professional approach to detect or anticipate problems. Early Childhood Health Services provide a range of services to support good health outcomes of children, including parenting support and education, breastfeeding support, universal health home visiting, screening for postnatal depression and referral if necessary, and health and development advice for families with young children.	Local Health Districts (LHDs) receive block funding from the Department of Health to provide health services to their population. Each LHD determines how much money is allocated to this program.	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides services to a Non-admitted Patient is reported by LHDs to the Ministry of Health on a quarterly basis.

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Children's health and wellbeing	Children's Health and Wellbeing services include universal services provided to the whole population and targeted services. Universal services including Postnatal child and family health services such as early childhood health services and Universal Home Health Visiting.		Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
	Universal Health Home Visiting (UHHV) – is the offer of a home visit by a Child and Family Health Nurse to all families in NSW after the birth of their baby. At the UHHV the nurse assesses the baby's health and development, and identifies the level of support the family needs. The nurse can then link parents identified as requiring additional support to appropriate support and/or secondary services.	LHD funds	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
	Sustaining NSW Families is a program of nurse led structured evidenced based sustained health home visiting provided to vulnerable children at risk of poor developmental outcomes and their families in selected low socio-economic areas. The program actively supports parents' aspirational goals for themselves and their child and builds parenting capacity and secure parent/ child relationships. It is prevention and early intervention strategy which commences in the antenatal period and continues until child is 2 years of age with the aim of optimising child health and development outcomes. Services include bi-lingual nurses (English/Arabic and English/Mandarin) and services in a rural area with a focus on engaging vulnerable Aboriginal families.	Most funding is Keep Them Safe dedicated funding	Quarterly data reporting to Ministry of Health. Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.project Annual Reporting and six monthly financial acquittal.

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Children's health and wellbeing contd.	Health care needs of children in Out Of Home Care - coordination and provision of health development and wellbeing assessments, reviews and interventions of children and young people in OOHC. This state-wide project is being implemented in phases commencing with children/young people entering Statutory Out of Home care who are expected to remain in care for more than 90 days.	Keep Them Safe funding	
	Building Strong Foundations for Aboriginal Children Families and Communities is a culturally safe early childhood health service for Aboriginal children birth to school entry age and their families. It aims to support parents and communities to provide an environment that will optimise the health, development and wellbeing of their child so that children are ready able to engage fully in life and learning. It has close links to Aboriginal maternity services including NSW Aboriginal Mothers and Infants Health Services and New Directions as well as mains team services. Teams comprising Aboriginal Health Workers and Child and Family Health nurses provide the main frontline service. Seven new sites were funded late 2011/12 bringing total to 15 across NSW.	State program funding to selected sites.	Annual Reporting and six monthly financial acquittal.
Health Child Wellbeing Units	Health Child Wellbeing Units provide support and assistance to health mandatory reporters to assist them to identify and provide appropriate responses for children and young people at risk of significant harm and to determine what other supports should be put in place for vulnerable children and young people below this statutory reporting threshold.	Keep Them Safe 'protected item' funding.	Milestone reporting to Department of Premier and Cabinet. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Maternal and child health	<p>Maternity services are part of the core services provided by LHDs to their population. Community antenatal and postnatal care is provided including through shared care arrangements with GPs.</p> <p>Targeted programs for vulnerable populations include:</p> <ul style="list-style-type: none"> - Aboriginal Maternal and Infant Health Service (AMIHS) provides culturally appropriate antenatal and postnatal care up to 8 weeks, to Aboriginal mothers and babies. Mental health and drug and alcohol secondary services are being delivered in selected AMIHS sites across the state as part of the Indigenous Early Childhood Development National Partnership Agreement (IECD NP). Quit for new life, a smoking cessation intervention specifically for Aboriginal pregnant women is also being rolled out across AMIHS programs. 	LHD block funding and some IECD NP funds (Commonwealth)	<p>Varies by program. Some services measured as Non Admitted Patient Occasions of Service.</p> <p>Regular reports on activity, outcomes against indicators</p>

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Screening	<p>Domestic Violence Routine Screening - Women are routinely screened for recent or current domestic violence in antenatal and early childhood health services, and women aged 16 and over are screened in mental health and alcohol and other drugs services. Screening is an early identification and education strategy</p> <p>Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program includes the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies.</p> <p>Statewide Eyesight Preschooler Screening (StEPS) - is a free vision screening program for all four year old children in NSW. The program is designed to identify childhood vision problems early which cannot be detected by observation, behaviour, family history or vision surveillance. By identifying and treating vision problems during the critical visual development period, treatment outcomes can be maximised.</p>	<p>LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Domestic Violence Routine Screening funding is implemented within service agreement allocations.</p> <p>A mix of LHD and Australian Government funding.</p>	<p>A one-month data collection snapshot from all LHDs is conducted in November of each year. This provides information on outcomes such as screening and identification rates, and referrals. Domestic Violence Routine Screening is also included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.</p> <p>Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.</p>

Table 10A.108 **New South Wales, community health services programs***Programs funded by the NSW Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under Keep Them Safe (KTS) NSW Health committed to expanding services for children aged under 10 years who display problematic or harmful sexualised behaviour, including Aboriginal children. To increase service delivery, the Ministry of Health allocated KTS funding to enhance the Sparks program in the Hunter New England LHD, which is the only NSW Health specialist service responding to this client group. The Ministry is also developing a statewide policy directive and guidelines on best practice service delivery, including training requirements for staff, were necessary to resolve current issues and assist LHDs in their local responses to the target group.	LHD funding and Keep Them Safe 'protected item' funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
Sexual Assault Services	NSW Health's 55 Sexual Assault Services provide holistic specialist assistance to adult and child victims of sexual assault including supporting their psycho-social, emotional and cultural wellbeing. Free counselling, court support, medical and forensic examinations and medical treatment are available to anyone who has recently been sexually assaulted in NSW.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Sexual Assault Service funding is implemented within service agreement allocations.	Sexual Assault Services are included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.
Youth health and wellbeing	Provides education and health promotion programs, clinical services and planning of youth friendly services. Also provides specific health services for homeless and at risk young people.	A mix of LHD and Australian Government funding is allocated for Innovative Health Services for Homeless Youth (IHSHY).	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the LHDs to the Ministry of Health on a quarterly basis.

Source: NSW Government unpublished.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Care Partnerships (PCPs) Strategy	<p>Primary Care Partnerships (PCPs) are cross government funded voluntary alliances of health, human services providers and other organisations. There are 28 PCPs in Victoria which engage over 600 organisations. PCPs deliver local service system reforms to:</p> <ul style="list-style-type: none"> • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated; and • improve the management of chronic disease. <p>The strategy to improve the coordination of services is supported by a state-wide policy and operational framework and includes:</p> <ul style="list-style-type: none"> • state-wide practice standards and a continuous improvement manual • tools for screening, referral and coordinated care planning • data standards for sharing client health and care information embedded in agency client management software applications • e-referral systems to securely share client information with client consent. <p>PCPs identify local health and well being priorities and ways to address these priorities. 'Place based' partnership approaches are used to assess and engage with communities that experience significant disadvantage. Interventions may be targeted to particular population groups, for example, farmers, people with a refugee background and ethnic communities.</p>	Core funding provided by the Victorian Department of Health.	Suite of reports as part of the 2013-17 PCP Program Logic. This includes a four year strategic plan and impact oriented reports against each area of the PCP program logic.
Refugee Health Nurse Program	<p>The Refugee Health Nurse Program (RHNP) seeks to optimise the long-term health of refugees and asylum seekers by promoting accessible and culturally appropriate health care services that are innovative and responsive to their unique needs. The program supports a coordinated model of care, and acknowledges the importance of early identification and intervention in health issues in the early stages of settlement.</p>	The Victorian Government funds the RHNP through the Department of Health. Community health services are funded to deliver the RHNP.	Community health services funded under the RHNP report hours of service on a quarterly basis.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Refugee Health Nurse Program contd.	<p>The RHNP has three aims — to:</p> <ul style="list-style-type: none"> • increase refugee access to primary health services • improve the response of health services to refugees' needs • enable refugee individuals, families and communities to improve their health and wellbeing. <p>The RHNP builds the capacity of individuals, families and refugee communities to improve their health through: disease management and prevention; the development of referral networks and collaborative relationships with general practitioners and other health providers; connection with social support and orientation programs.</p>	<p>The Victorian Government funds the RHNP through the Department of Health. Community health services are funded to deliver the RHNP.</p>	<p>Community health services funded under the RHNP report hours of service on a quarterly basis.</p>
Dental Health Program	<p>Public dental services are provided to eligible Victorians through the Royal Dental Hospital of Melbourne, community health centres and rural hospitals.</p> <p>The following groups are eligible for state-funded public dental services:</p> <ul style="list-style-type: none"> • All children aged 0-12 years. • Young people aged 13-17 years who are, or are dependents of, health care or pensioner concession card holders. • Children and young families up to 18 years of age in out-of-home care provided by the Department of Human Services. • Youth justice clients in custodial care, up to 18 years of age. • Adults who are, or are dependents of, health care or pensioner concession card holders. • Refugees and Asylum Seekers. <p>Eligible clients presenting for care are assessed and those requiring routine care are placed on one of three waiting lists (general care, denture care and priority denture care). Priority clients are offered the next available appointment and are NOT reflected in waiting list numbers.</p>	<ul style="list-style-type: none"> • State funded public dental services are output funded and supported by an activity based funding model. • From 1 July 2013, with the implementation of the National Partnership Agreement on Treating More Public Dental Patients, the funding unit is a Dental Weighted Activity Unit (DWAU), calculated using the Australian Dental Association (ADA) three digit item codes and a weighting. 	<ul style="list-style-type: none"> • Performance targets are set by the department and monitored through various reporting mechanisms to demonstrate program delivery. Examples of targets are people treated, waiting times and quality measures. • Funded agencies delivering dental services are set DWAU targets based on their total service delivery funding. For performance monitoring, all activity (treatment items) are converted to DWAUs.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Dental Health Program contd.	<p>Priority groups are:</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islanders • Children and young people • Homeless people and people at risk of homelessness • Pregnant women • Refugees and asylum seekers • Registered clients of mental health and disability services. <p>People requiring urgent care are assessed, triaged and managed using the Emergency Care Demand Management System, and are offered an appointment.</p> <p>Fees for public dental services apply to people 18 years or over who are, or are dependents of, health care or pensioner concession card holders and to children 0–12 years who are not dependents of nor themselves health care or pensioner concession card holders. Inability to pay cannot be used as a basis for refusing a dental service to an eligible person. Exemption from fees for public dental services applies to :</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander people • Homeless people and people at risk of homelessness • Refugees and Asylum Seekers • Children/young people 0-17 years who are, or are dependents of, health care or pensioner concession card holders • Children and young people up to 18 years of age who are in Department of Human Services provided out-of-home care • Youth justice clients up to 18 years of age in custodial care • Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special developmental schools • Those receiving care from undergraduate students • Those experiencing financial hardship. 		

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
NURSE-ON-CALL	NURSE-ON-CALL is a statewide telephone-based health line that provides residents with timely access to health information, assistance and advice for the cost of a local phone call. The service operates 24 hours, 7 days a week and takes about 1000 calls per day. Registered nurses triage callers' symptoms and health issues so as to advise on health care needs. NURSE-ON-CALL also provides callers with health information and information about local health providers. In the after-hours period, approximately 160 eligible callers to NURSE-ON-CALL per day are transferred to the Commonwealth government's After Hours GP helpline.	NURSE-ON-CALL is delivered by Medibank Health Solutions under contract to the Department of Health.	Medibank Health Solutions provides the department with a number of monthly reports.
IHSY Program	The Innovative Health Services for Homeless Youth (IHSY) program is a Commonwealth/State funded initiative that promotes health care for young people who are homeless or at risk of homelessness. Funding is provided to community health services to deliver innovative and flexible health services for the target population. The services respond to the complex health needs and improve their access to mainstream health services. IHSY provides a means of engaging young people who may not otherwise access health services.	<ul style="list-style-type: none"> • Joint state/Commonwealth funded. IHSY is provided under the National Healthcare Agreement. • Community health services are funded to deliver the IHSY program. 	Community health services funded under the IHSY program report hours of service on a quarterly basis.
Maternal & Child Health	The Healthy Mothers, Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. The program is delivered by community health services in areas that have high numbers of births and higher rates of relative socioeconomic disadvantage.	<ul style="list-style-type: none"> • The Victorian Government funds the program through the Department of Health. • The 2014-15 budget provided \$2.5 million recurrent funding for this program. 	<ul style="list-style-type: none"> • Quantitative performance targets are set by the Department of Health and monitored quarterly. • The program was monitored through a formal evaluation completed in November 2014

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Maternal & Child Health contd.	<p>The objectives of the program are to:</p> <ul style="list-style-type: none"> • improve women's access and attendance at antenatal and post natal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. <p>Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their:</p> <ul style="list-style-type: none"> • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services. 		
Children's Health & Wellbeing	<p>Services for children and families within community health are based on evidence which identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services respond to the needs of young children and their families.</p> <p>Child health teams provide multidisciplinary care through a mix of group and individual interventions. Services promote positive health, growth and functioning within the community. Their focus is the provision of early interventions as well as to improve the capacity of parents and families to understand and manage the health and development needs of their child. Community health practitioners also support families to access additional services they may require in the community.</p>	The Victorian Government funds the program through the Department of Health.	Community health services providing child health services report hours of service as part of their overall community health program reporting on a quarterly basis

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Program	<p>The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 350 sites across Victoria. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers.</p> <p>CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses. In addition, community health prioritises services to population groups that are known to have poor health status, are subject to disadvantage or are at risk. These include people who are homeless or at risk of homelessness, refugees, Aboriginal people, people with an intellectual disability or a serious mental illness. Funding is provided for the provision of direct care, and for health promotion.</p> <p>CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.</p>	The Victorian Government funds the program through the Department of Health.	<ul style="list-style-type: none"> • Community health services report hours of service on a quarterly basis • CHSs report annually to their consumers, carers, community and other stakeholders through the Quality of Care report. • Agencies funded for health promotion are required to develop four year health promotion plans and report on those plans on an annual basis.

Table 10A.109 **Victoria, community health services programs***Programs funded by the Victorian Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Family Planning	Family planning services assist Victorians to make individual choices on sexual and reproductive health matters by providing services that are accessible, culturally relevant and responsive to people who experience difficulty accessing mainstream services. Family planning health promotion focuses on promoting the sexual and reproductive health of Victorians, with a focus on groups at higher risk of ill-health. Funding for family planning services is provided to community health services, and to a statewide service, Family Planning Victoria (FPV).	The Victorian Government funds the Family Planning program through the Department of Health.	<ul style="list-style-type: none"> • Community health services report hours of service on a quarterly basis • In line with broader Integrated Health Promotion Program requirements, agencies funded for family planning health promotion are required to submit a health promotion plan every four years and report on this plan annually.
Early Intervention in Chronic Disease (EliCD)	EliCD focuses upon community based early intervention services for people with chronic diseases. The aim of the initiative is to enhance existing capacity of community health services in supporting people with chronic disease in managing the impact of their condition including the physical, emotional and psychological impact of having a chronic disease. Services aim to reduce the impacts of chronic disease, slow disease progression and reduce potential/future hospitalisation. Models of care are multidisciplinary and provide self management support, care coordination, education, allied health and nursing.	These services are funded under the Primary Health Funding Approach	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.

Source: Victorian Government unpublished.

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Blood Borne Viruses and Sexually Transmissible Infections (BBVs and STIs)	<p>The program implements five national strategies:</p> <ol style="list-style-type: none"> 1. The Seventh National HIV Strategy 2014-2017; 2. The Second National Hepatitis B Strategy 2014-2017; 3. The Fourth National Hepatitis C Strategy 2014-2017; 4. The Third National Sexually Transmissible Infections Strategy 2014-2017; 5. The Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017. <p>Services and public health programs are delivered through public, non-government and private organisations including 16 Hospital and Health Services (HHSs) Sexual Health Clinics (are the SH clinics part of the HHSs?) providing preventative and clinical BBV and STI services.</p> <p>What are the outputs (missed brief ref above)? ie presume public health mostly educn? services – detection / treatment / notification?</p> <p>Clinical and funded non-government programs target groups most at risk of BBVs and STIs (e.g. men who have sex with men, injecting drug users, culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people and young people).</p> <p>The Queensland HIV Strategy 2013-2015 outlines the strategic direction for HIV prevention and management in Queensland. The draft Queensland Viral Hepatitis Strategy 2014-2017 and Queensland STI Strategy 2014-2017 will outline the strategic direction and priority actions for viral hepatitis and STI prevention, treatment and management.</p> <p>The HIV Foundation Queensland is tasked with leading the Queensland HIV prevention and testing response in conjunction with other Non-Government Organisations (NGOs) and the Department of Health.</p>	<p>Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.</p> <p>In 2013–14 HHS reported expenditure of \$48,446,512 for sexual health which encompasses programs for BBV and STIs.</p> <p>Delivered through public, non-government and private organisations including 16 Hospital and Health Services (HHSs) Sexual Health Clinics providing preventative and clinical BBV and STI services.</p>	<p>Six monthly performance reports on activities by funded NGO programs. Quarterly report provided to the BBV and STI Standing Committee (BBVSS).</p> <p>Commonwealth Indigenous funding reports.</p> <p>Notification data for BBVs and STIs provided for the NHA report.</p> <p>Annual reports on Queensland notification data produced by Department of Health.</p>

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Preventive Health Unit (PHU)	<p>PHU provides the Queensland Department of Health with expertise, leadership and innovative ideas to improve policy, systems, research, programs and services to encourage healthy behaviours and create environments supportive of health.</p> <p>PHU collaboratively works across the Department, with other agencies, non-government organisations and the private sector on a range of campaigns, and initiatives to deliver services aimed at empowering individuals, communities and institutions to create and live healthier lives. The strategies target the chronic disease risk factors of alcohol, tobacco, overweight and obesity, nutrition, physical inactivity and high blood pressure across population groups and in key settings, such as workplaces and schools.</p>	Queensland Department of Health Budget and National Partnership Agreement (NPA) on Preventive Health under the Healthy Workers and Healthy Children's Initiatives.	Reporting is through contractual performance reports; data collection; independent evaluations, NPA and internal reporting processes.
Retrieval Services and Counter Disaster (RSCD)	<p>The emergency retrieval and aero-medical transport of critically ill or injured patients across Queensland and the north coast of New South Wales (NSW) is coordinated by RSCD to improve access to, and the quality of available transport resources to support patients ranging from acute, urgent, high dependency care to non-urgent, low dependency care.</p> <p>These transport services are provided under state-wide service agreements in partnership with non-government organisations including: Royal Flying Doctor Service (RFDS), community helicopter providers and CareFlight Medical Services; and with Emergency Management Queensland and the Queensland Ambulance Service, Department of Community Safety and Australian Helicopters Pty Ltd.</p> <p>For patients who can travel by themselves and are required to travel away from their home to access specialist medical services, financial assistance is provided to eligible patients through the Patient Travel Subsidy Scheme (PTSS).</p>	<p>Funding source - State Output Revenue (except for the RFDS aero-medical services provided from the Cairns, Mt Isa and Charleville bases which are partially funded by the Commonwealth. RFDS also provides primary health care services funded by the Commonwealth).</p> <p>Budget oversight - RSCD Governance oversight - RSCD Delivered - RSCD</p>	<p>No patient transport reports are provided externally.</p> <p>Internally, activity reports are provided to the HHSs to assist in the monitoring of usage of road ambulance, fixed-and rotary wing aero-medical transport at HHS and facility level.</p> <p>PTSS activity and expenditure reports are provided monthly to HHSs and will be provided to Cabinet Budget Review Committee (CBRC) in the mid-year financial review 2014-15.</p>

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Enhanced Maternal and Child Health Service	The Queensland Department of Health is implementing the Enhanced Maternal and Child Health Service to ensure all families have access to two home visits in the first month post birth and community clinics at key stages during the first year of a child's life.	State government Delivered by state government, may be delivered in partnership with other providers. Maternal health expenditure was \$7,776,865 in 2013-14.	Quarterly reporting.
Child health services	A range of child health services are provided to children and young people aged 0-18 years and their families in the community. These services may include interventions such as child development checks, lactation support, parent information sessions; as well secondary and/or tertiary health services such as parenting and behaviour support, nutrition support, or referrals to other service providers. Services are available to all children and young people aged 0-18 years and their families as well as targeted services to particular or 'at risk' populations such as young parents, Aboriginal and Torres Strait Islander families, and refugee families.	State and Commonwealth government funding. Delivered by state government, may be delivered in partnership with other providers. HHSs reported \$116,768,840 expenditure for Child and Youth services in 2013-14.	Local HHS reporting arrangements are in place.
Alcohol, Tobacco and Other Drug Services	Alcohol and Other Drugs treatment services in Queensland are delivered through approximately 85 public and NGOs across the State. Residential and outclient treatment services are provided to people (from 12 years of age) who experience problematic alcohol and other drugs use. Services may include screening; clinical assessment and review; early and brief intervention; crisis intervention; withdrawal management and support; one-to-one counselling; group work; day programs; case management; relapse prevention; and aftercare. Clients may be referred from a Queensland HHSs, court or justice agency, health and community services, or self-referral. Alcohol and other drugs services are underpinned by the principles and priorities outlined in the National Drug Strategy 2010-2015.	Funded through State Output Revenue and Commonwealth funds. In 2013-14 HHSs reported expenditure of \$65,347,009 for Alcohol, Tobacco and Other Drugs.	National reporting through National Minimum Data Set (NMDS) processes - national publication is prepared from the NMDS.

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral health services	Oral health services are provided to eligible children and adults via community and school-based mobile and fixed public dental clinics. Services include general and specialist dental care, and health promotion and disease prevention activities.	Services are primarily funded by the Queensland Department of Health, with some Commonwealth funding. Services are delivered by HSSs.	Performance targets and overall financial reporting are published in Queensland Health's annual report and Service Delivery Statement.
Get Healthy Services	<p>Under an agreement with NSW Ministry of Health, Queensland has made the Get Healthy Information and Coaching Service (GHS) available to Queensland adults through 13Health (13 432584) or via www.gethealthy.qld.gov.au.</p> <p>The Service has been promoted through a range of channels to the broader community, community organisations, health service providers, workplaces and state and local government.</p>	<p>Funding for the Get Health Information and Coaching Service is provided through the NPA on Preventive Health, Healthy Workers initiative. This agreement was due to expire in June 2018 but the 2014–15 Commonwealth Budget proposed ceasing the NPA early, from 1 July 2014. The Queensland Minister for Health has committed to provide funding in 2014-15 to continue the initiatives funded under this NPA.</p>	Reports are received as per contractual requirements between Queensland Department of Health and NSW Ministry of Health.

Table 10A.110 **Queensland, community health services programs***Programs funded by the Queensland Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Queensland Aboriginal and Torres Strait Islander health investment strategy	<p>A range of primary and community health services are delivered across Queensland to improve the health outcomes of Aboriginal and Torres Strait Islander people and achieve the life expectancy and child mortality targets agreed through the Council of Australian Governments (COAG), including initiatives to strengthen the continuity of care between the acute and primary care settings.</p> <p>In 2013–14, 140 Aboriginal and Torres Strait Islander health initiatives and services were delivered by 16 HHSs and 19 Aboriginal and Torres Strait Islander community controlled health services and NGOs across Queensland. The range of initiatives and services included:</p> <ul style="list-style-type: none"> • Hospital liaison support, case coordination and assistance for Aboriginal and Torres Strait Islander people entering and exiting acute care • Community-based and outreach antenatal, postnatal and infant care services • Targeted sexual and reproductive health prevention, early intervention, detection and education for young people and adults • Multidisciplinary primary healthcare services for the early detection, treatment and management of chronic diseases • Respiratory, diabetes and renal outreach services for Aboriginal and Torres Strait Islander people living in rural and remote areas • Alcohol, tobacco and substance misuse harm prevention, early intervention and treatment targeting Aboriginal and Torres Strait Islander young people, and • Mental health services. 	Queensland Government and Australian Government funding responsibility (primary funding source Queensland Government—some funds provided by the Australian Government under the former Indigenous Early Childhood Development National Partnership Agreement—NPA).	Six monthly performance and financial reporting from the HHSs. Six monthly performance and quarterly financial reporting from the non-government sector.

Source: Queensland Government unpublished.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap in Indigenous Health Outcomes	<p>Closing the Gap programs previously funded under an NPA are now State funded and centred around the same five priority areas through the delivery of services to Indigenous communities throughout WA:</p> <p>Area 1 – Tackling Smoking Area 2 – Healthy Transition to Adulthood Area 3 – Making Indigenous Health Everyone’s business Area 4 – Primary Health Care Services that can deliver Area 5 – Fixing the gaps and improving the patient journey</p> <p>Area 1 Outcomes – Reduction in smoking prevalence and in the burden of tobacco related disease for Indigenous communities. Area 1 Outputs - Under this area, 10 State funded Tackling Smoking programs were successfully implemented throughout the state and all are delivering a range of strategies and activities for smoking cessation and/or prevention. Interventions include education, social marketing, brief intervention and smoking cessation quit groups. Area 2 Outcomes – Increased sense of social and emotional well being; Reductions in uptake of alcohol, tobacco and illicit drugs, rates of sexually transmissible infections, hospitalisations for violence and injury and reduce morbidity and mortality amongst Aboriginal men. Area 2 Outputs - Under this area, 23 programs continue to increase the access and uptake of services supporting social and emotional wellbeing among young Aboriginal people. Initiatives include self-esteem, sexual health and drugs and alcohol education, social marketing, training, counselling and peer mentorship and leadership strategies. Area 3 Outcomes - Increase health outcomes for Indigenous people in prison settings and Aboriginal men’s health.</p>	<ul style="list-style-type: none"> • Area 1 – State funded • Area 2 – State funded • Area 3 – State funded • Area 4 - State funded • Area 5 – State funded • Budget oversight WACHS Aboriginal Health Improvement Unit • Governance oversight WACHS Aboriginal Health Improvement Unit • Programs delivered by a mixture of government (WACHS and Metropolitan Area Health services) and non-government organisations (Aboriginal Community Controlled Health Organisations) 	<ul style="list-style-type: none"> • WACHS requires biannual reporting from all Closing the Gap programs. Service providers report on contract outputs and outcomes using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WACHS AHMU reports annually through AHMAC for CtG funded programs.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap in Indigenous Health Outcomes contd.	<p>Area 3 Outputs - Under this area, 14 programs continue to increase health outcomes for Aboriginal men and Aboriginal people in the prison settings and post-release. Ten of these are Aboriginal Health Community Re-Entry programs.</p> <p>Area 4 Outcomes - Improve access to quality primary health care; Increase the uptake of MBS-funded services; Implement best practice standards and accreditation and increase cultural competence of primary care services.</p> <p>Area 4 Outputs - Under this area, a suite of 25 state funded primary health care services continue to be delivered through culturally secure community health care settings with a focus on the prevention, early detection, treatment and self management of chronic disease.</p> <p>Area 5 Outcomes - Reduce average length of stay; Improve level of engagement to deliver better follow up and referrals; Improve patient satisfaction and health journey and reduce admissions and incomplete treatments.</p> <p>Area 5 Outputs - Under this area, 22 state funded programs continue to support access to patient transport services and improvements in continuum of care particularly for Aboriginal people living in rural and remote WA.</p>		

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
NPA Indigenous Early Childhood Development (IECD)	<p>The IECD NPA is centred around elements two and three.</p> <p>Element 2 Outcomes - Increase access to antenatal care, pre-pregnancy and teenage sexual and reproductive health for Indigenous women.</p> <p>Element 2 Outputs - Under this element, 14 programs continue to provide antenatal care services targeted at young Aboriginal women. These services include health promotion/prevention, early intervention (screening) and treatment services. Services provide education and support to reduce the harm associated with alcohol use during pregnancy and education, support and treatment for sexual and reproductive health.</p> <p>Element 3 Outcomes - Increase access to, and use of, maternal and child health services by Indigenous families.</p> <p>Element 3 Outputs - Under this element a further 13 programs continue to provide postnatal services and outreach programs with a focus on adolescent mothers and provide clinical policies, guidelines and standards of practice, and work force support and development to maternal and child health services delivering care to Aboriginal women. These services also include the provision of child health checks and immunisation services.</p>	<ul style="list-style-type: none"> • Element 2 - Commonwealth funded • Element 3 – State funded • Budget oversight WACHS Aboriginal Health Improvement Unit • Governance oversight WACHS Aboriginal Health Improvement Unit. • Programs delivered by a mixture of government (WACHS and Metropolitan Area Health services) and non-government organisations (Aboriginal Community Controlled Health Organisations) 	<ul style="list-style-type: none"> • WACHS requires biannual reporting from all COAG IECD programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WACHS AHU reports biannually to DoHA for IECD programs.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary health/chronic disease programs for Aboriginal communities	<p>WACHS Aboriginal Health Improvement Unit has carriage of several other (approximately 18 programs) contracted programs that provide primary health/chronic disease programs across the State in a community health care setting with a focus on the prevention, early detection, treatment and self management of chronic disease.</p> <p>Outcomes – the majority of these services aim to increase access to culturally appropriate primary health care services for Aboriginal people in WA.</p> <p>Outputs – Service outputs include the provision of 24hr accident and emergency, outpatient's clinics, management of chronic conditions, immunisation, health promotion, screening and associated treatment, maternal and child health and integration of service delivery.</p>	<ul style="list-style-type: none"> • Department of Health WACHS funding • Budget oversight WACHS contracting • Governance oversight WACHS Aboriginal Health Improvement Unit. • Programs delivered through Aboriginal Community Controlled Health Organisations (non-government). 	<ul style="list-style-type: none"> • WACHS requires biannual reporting from all Primary Health Care programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health – Community health services	<p>Community health services encompasses both child health services and school health services statewide across Western Australia, focussing on child health, growth and development in the early years and promoting wellbeing during childhood and adolescence. Universal and targeted services complement each other and families move between streams as their needs and circumstances dictate.</p> <p>Community health services serve as a gateway to a range of other early childhood services, such as child development services, parent and carer support, primary health care and social protection.</p> <p>Child health services aim to promote improved health outcomes for babies, young children and their families, through the provision of a range of universal and targeted prevention, early identification and intervention. Services are delivered in various settings including child health centres, in homes, parenting groups and other community venues.</p> <p>The WA universal Birth to School Entry community child health service offers child health nurse contacts to all mothers of new babies within 10 days of birth and an additional six contacts at critical points in the child's development throughout the first four years of life. Follow up checks are offered to individual families and groups according to need. Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, lactation, breastfeeding and nutrition.</p>	<p>State funding is provided for both child and school health services. Health services are responsible for delivering child health services.</p> <p>Agreement between the Department of Education and Department of Health which underpins the delivery of School Health Services.</p> <p>The Department of Education part funds School Health Services in WA, as agreed in the MOU between the Departments.</p>	<p>Services are reported as Occasions of Service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews.</p> <p>Quarterly reports against key performance indicators are provided to the Government.</p> <p>Service delivery reports are not accessible to the public.</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health – Community health services contd.	<p>Targeted services focus on engaging vulnerable children and families who are at greater risk of health and developmental issues, including Refugees, Aboriginal families and young parents with identified risks. Targeted programs include Best Beginnings which is delivered in collaboration with the Department for Child Protection and Family Support, and the Enhanced Aboriginal Child Health Schedule (EACHS). These programs provide a modified and expanded version of the Universal Child Health Contact Schedule. Families eligible to receive the EACHS are offered 15 scheduled contacts, from pregnancy to five years of age, in a culturally appropriate manner. Other targeted metropolitan services include Lactation Consultancy and Aboriginal ear health clinics, which provide children with otitis media or known suspected hearing problems with access to an Aboriginal Health Worker, Audiologist, Speech Pathologist and Ear, Nose and Throat specialist. This is to mitigate factors which might lead to ongoing poor health and education outcomes.</p> <p>School health services support school communities in enhancing the health and development of all students through selected health promotion strategies, early detection and specialist health expertise. Services are provided on school sites in collaboration with education providers.</p>		

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health – Community health services contd.	<p>Key elements of the program are universal health assessments at school entry to all students in government and non-government schools, follow-up checks, support to children in school with particular health needs, and health promotion for all students. In secondary government schools, the focus is more on health promotion (e.g. mental health, sexual health) and providing students with the opportunity to access a health professional who can advise, assess and refer, according to the presenting health issue. In Education Support Schools, nurses provide direct health care services for students with disabilities, many of which have multiple, severe disabilities.</p> <p>The Health Promoting Schools Framework provides a comprehensive, whole school approach in which the curriculum is supported by the environment and ethos of the school. Key components include curriculum, teaching and learning; school policies and approaches to health and wellbeing and school environment; and, partnerships with the wider school community.</p>		
Child and Adolescent Community Health – Child Development Service	<p>The metropolitan Child Development Service in Perth, Western Australia, provides community-based assessment and intervention services for children 0-18 years with (or at risk of) developmental delays and disorders.</p> <p>The Child Development Service also plays a key role in community education and professional development.</p> <p>The Child Development Service clinical workforce consists of a range of allied health and medical disciplines, including Speech Pathologists, Physiotherapists, Occupational Therapists, Clinical Psychologists, Social Workers and Paediatricians.</p>	<p>State funding is provided. Health Services are responsible for delivering child development services.</p>	<p>Services are reported as occasions of service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews. Quarterly reports against key performance indicators are provided to the Government. Service delivery reports are not accessible to the public.</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
School Dental Service	The School Dental Service provides free dental care to school children throughout the state ranging from pre-primary through to Year 11 and to Year 12 in remote localities. Care is provided by dental therapists under the supervision of dental officers from fixed and mobile dental clinics located at schools throughout WA. The program incorporates preventive strategies, which include oral health education for school children. Non-general and specialist services are referred. Costs may apply for this treatment.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: <ul style="list-style-type: none"> • Number of children enrolled and under care. • Dental health status i.e. number of decayed / missing / filled teeth. • Average cost of service per child.
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of a benefit/allowance from Centrelink or Department of Veterans' Affairs) via: <ul style="list-style-type: none"> • Public Dental Clinics Metropolitan and Country. • Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Scheme. • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people. Aged Care Dental Program. This program provides dental care to residents of Registered Aged Care Facilities. Residents are eligible to receive free annual screening dental examinations and a care plan. Further treatment needs are advised and the patient is referred to an appropriate provider. Ongoing treatment is through one of the Government programs for eligible residents.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: <ul style="list-style-type: none"> • Access to dental treatment for eligible people. • Average waiting times. • Average cost of completed courses of adult dental care.

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Familial Hypercholesterolaemia	<p>Familial Hypercholesterolaemia (FH) is the most common and serious form of inherited hyperlipidaemia. If untreated could lead to chronic illness and premature death from heart disease. FHWA is a cascade screening program to identify index cases of FH through the Lipid Disorders Clinic at Royal Perth Hospital. The program has been expanded to commence transition of care management of FH patients to Primary Care Providers according to an agreed protocol that ensures safety of the patients is maintained. It includes provision of education and training to primary care practitioners in FH cascade screening and management of FH.</p> <ul style="list-style-type: none"> • Specialised FH services, including specialised lipids nurses, administrative staff, consultants, specialised testing and treatment equipment; • Ongoing development and maintenance of a state-wide database of FH patients; • A central point of information access for GP's ongoing knowledge development; • Support and direction for a Patient Support Group. • Targeted screening and GP identification • Recruitment and training • Communication and education of GP's • Review of the current processes for identifying index cases and cascade screening to deliver an efficient public health service in contrast to having a process for research purposes • Centralised FH database • performance monitoring strategy and criteria to provide a benchmark for GP's and practice nurses to manage detection, testing and occasional referral to the FH specialist services. 	<p>Funding: Department of Health (DOH) WA Contract : Health Strategy Networks DOH WA Program delivery: Prof Gerald Watts, School of Medicine and Pharmacology, University of WA</p>	<p>Six monthly reports Contract reports not available to the public Publication of research reports associated with the project</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Metropolitan Health Lifestyle Project	<p>The Metropolitan Healthy Lifestyles Project Model is a coordinated patient-centred approach involving early patient identification, care co-ordination through general practice, trained clinic staff, supported allied health and community providers, clear referral pathways, and monitored patients to support lifestyle and risk modification for the target groups.</p> <p>The overall aim of the project is to provide practical support for people at risk of developing chronic disease, or those who have chronic disease to make informed lifestyle choices and healthy behaviour change within the Perth metropolitan area.</p> <p>The primary target populations are those newly diagnosed with type 2 diabetes and those with microalbuminuria. The secondary target population is people with multiple risk factors for coronary heart disease.</p> <ul style="list-style-type: none"> • Implementation of an integrated and regionally responsive model - Metropolitan Healthy Lifestyle Program (MHLP) to facilitate the referral of targeted population into healthy lifestyle programs. • Increase the identification and monitoring of the target population in primary health care. • Improved response and capacity of general practice to refer targeted population into lifestyle support programs. • Process and Outcome evaluation of the program to demonstrate the impact of the program on the community; • Economic evaluation of the program on cost effectiveness <p>Develop a long term funding model that outlines a viable alternative funding source(s) to meet ongoing funding requirements beyond the life of the contract</p>	<p>Funding: WA Department of Health</p> <p>Contract : Health Strategy Networks DOH WA</p> <p>Program delivery - Fremantle Medicare Local</p>	<p>Six monthly reports</p> <p>Evaluation report</p> <p>Contract reports not available to the public</p> <p>Publication of research evaluation component of the report available</p>

Table 10A.111 **Western Australia, community health services programs***Programs funded by the WA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Self-Management	<p>Develop, deliver and evaluate programs to coordinate diabetes services and multidisciplinary care for persons with diabetes.</p> <ul style="list-style-type: none"> • Enhance care, access to care closer to home and navigation of the local health system for people living with diabetes • Support the role of Medicare Locals to enhance service coordination in the community • Build the capacity of GPs, practice nurses and other appropriate existing service providers in the community to effectively deliver multidisciplinary care, including through promoting and assisting with the use of Chronic Disease Management Medicare Items and Medicare diabetes incentives • facilitating and encouraging access to self-management education, care and support with multidisciplinary input from appropriate health professionals • deliver self-management education programs and services • creating access to and linking with other local services/programs to provide holistic care and improve health outcomes for people living with diabetes, such as local government recreational services and support groups • integrating with WA Health services, including the development of referral pathways between tertiary, secondary and community based services, including coordinating clients referred from GPs, hospitals and Health Services to appropriate diabetes clinics/services in the metropolitan and regionals areas for ongoing management • identify service gaps in the local community and where viable, work to fill in those service gaps using existing service providers in the local community in the first instance • incorporate relevant WA Health Models of Care as appropriate. 	<p>Funding: DOH WA Contract : Health Strategy Networks DOH WA Program delivery –</p> <ul style="list-style-type: none"> • Medicare Locals • Diabetes WA 	<p>Six monthly reporting Evaluation report Contract reports not available to the public</p>

Source: WA Government unpublished.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Aboriginal Health Programs	<p>A number of primary health services are accessible across South Australia aimed at providing health care checks and improving the health outcomes of the Aboriginal community across metropolitan, regional and rural areas of SA. Services provided include:</p> <ul style="list-style-type: none"> • Aboriginal Primary Health Care Access Program • Kanggawodli providing short term pre and post-acute clinical support for rural and remote Aboriginal people. • Trachoma and Trichiasis screening service for Aboriginal residents living in the north and the west of the State. • Watto Purrinna Aboriginal Primary Health Care Service • Rheumatic Heart Disease Control Program • Sexual and reproductive health programs for Aboriginal young people. <p>Additionally, SA Health invests in specific programs contributing to closing the gap in Aboriginal life expectancy including:</p> <ul style="list-style-type: none"> • Primary Health Care program improving access for Aboriginal people to effective health care services including parenting programs, well health checks, transport to primary health care programs and allied health services. • Tackling Smoking initiative addressing smoking among Aboriginal people. The initiative includes the promotion of tobacco related health messages through the 'Give up smokes for good' social marketing campaign and the delivery of smoking cessation support through a network of dedicated staff in Aboriginal community controlled health services. 	<p>State and Commonwealth Government funding. COAG National Partnership Agreement and Project Agreement funding.</p>	<p>Monthly activity and financial data reporting. Quarterly activity and financial reporting, including annual and ongoing evaluation. Six monthly activity and financial data reporting.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Allied Health Services	A range of non-hospital based allied health services (including: speech pathology; physiotherapy; exercise physiology; occupational therapy; social work; psychology; dietetic/nutrition; and podiatry) are provided through the Local Health Networks (LHNs), providing individual therapy, health information, health promotion, group work and advocacy. Within these services are programs specifically targets at children's health and development, including the Allied Health Services in Children's Centres Program.	State Government funding.	Quarterly and annual client activity reports.
Child Health and Development Services	A number of services aimed at child development services are offered across South Australia, which include: <ul style="list-style-type: none"> • Early Childhood Development and Disability Services provide multi-disciplinary therapy and health interventions for children 0-5years of age (to school entry) with or at risk of developmental delays or with a disability. • Child Development Unit Program provides specialist paediatricians and allied health staff assess children in community and country locations with specific and more complicated physical, behavioural and cognitive issues which are impacting on the child's development. 	State Government funding. Grant funding from the Department of Communities and Social Inclusion (DCSI) & an in-kind contribution to the National Disability Insurance Scheme. Grant funding from the Ministerial Advisory Council for Students with Disabilities (MACSWD).	Monthly activity and financial data reporting. Reporting to DCSI and MACSWD.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Health and Development Services contd.	<ul style="list-style-type: none"> • Autism Diagnostic Service providing specialist paediatricians and allied health staff to undertake comprehensive assessments of children on the Autism Spectrum Disorder. • Registered Nurse Delegation of Care Program assesses children with complex health needs who mostly have a disability, develops health plans, trains, assesses and delegates care to health support workers to care for children in a variety of community settings. • Access Assistant Program provides children with complex health needs and disability with support to enable access to education in government and non-government schools. • Fragile Airways Program provides a State-wide in-home active overnight support for children with artificial airways (tracheostomy +/- ventilation) who may also have chronic/complex health care needs. • Child Protection services assess and treat children up to 18 years and their families where there are suspicions of child abuse and neglect, providing telephone consultations with Families SA, Police and health workers, providing forensic medical assessment and crisis psychosocial response, psychological and parenting assessments and therapy for children and families. 	<p>State Government funding.</p> <p>Grant funding from the Department of Communities and Social Inclusion (DCSI) & an in-kind contribution to the National Disability Insurance Scheme.</p> <p>Grant funding from the Ministerial Advisory Council for Students with Disabilities (MACSWD).</p>	<p>Monthly activity and financial data reporting.</p> <p>Reporting to DCSI and MACSWD.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Family Health Service	<p>From over 120 sites across the state, the Child and Family Health Service provide a range of child wellbeing, development and parenting supports for families of children 0-5 years of age. These include early parenting groups, 1:1 consultations, a residential feeding and settling service, and access to information via the telephone and internet. Specific services provided include:</p> <ul style="list-style-type: none"> • Universal Contact Visit offering a visit by a community Child and Family Health Nurse following the birth of a baby, enabling early identification of child health and developmental issues. • Family Home Visiting Program providing a nurse led preventative home visiting program undertaken over a period of two years focusing on supporting positive child development, enhancing the parent-infant relationship and ensuring the health and safety of infants. • Early Childhood Intervention Program where consultants work within the local community to assist parent access to support services for children aged 0-8 years with a disability and/or developmental delay. • Parenting SA providing information on quality parenting practices for parents and carers of children aged 0-18 years, through free printed Parent Easy Guides for mainstream, Aboriginal and migrant families, free public seminars, and grants to local parent groups. • Newborn and Children's Hearing Service providing the Universal Neonatal Hearing Screening and the Hearing Assessment service. • Early Child Parent Services providing therapeutic and family support services to families of children aged 0-3 years to improve infant wellbeing, enhance parental capacity and problem solving ability. 	Recurrent State Government funding.	Monthly activity and financial data reporting.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Chronic Disease Health Services	<p>A range of services are delivered aimed at managing and improving the health of chronic disease patients, including:</p> <ul style="list-style-type: none"> • inSCOPE Asthma and Chronic Obstructive Pulmonary Disease provides support and education for GPs to help manage patients more independently and provide alternate services to hospital for complex patients, identifying self-management plans & education and clear referral pathways for ED & Inpatient to ensure a transition to improved self-care. • Exercise Physiology for Heart Failure patients is a referral service for patients identified as having Chronic Heart Failure or Cardiomyopathies aiming to assist patients in improving function and fitness parameters, with a strong focus on self-management. • Multidisciplinary Ambulatory Care is an innovative multi-disciplinary consulting service that supports people with multiple and complex chronic conditions, who are at risk of being hospitalised, in a shared care approach with General Practitioners. • Better Care in the Community - Chronic Disease program provides more coordinated and targeted care for people with chronic disease living in country SA thereby avoiding the need for hospitalisation or an extended stay in hospital. 	State Government funding.	<p>Monthly activity and financial data reporting.</p> <p>Quarterly reporting to Department of Health (DH) about estimated admissions avoided.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Nursing	<p>A range of community nursing services are provided across metropolitan and country areas in settings including chronic disease and risk factor programs, mental health, pregnancy and antenatal care, palliative care, Diabetes Nurse Educators, breast care nursing and domiciliary care services. Other specific services include:</p> <ul style="list-style-type: none"> • Virtual Nursing Service provides specialist nursing care to assist patients with Tuberculosis who have complex medication management and compliance issues to prevent a prolonged public hospital admission. • Community Nursing Service provides longer term specialised nursing care, education, management and monitoring of clients in extended community care and palliative care. • Hospital and Health Care at Home providing short term flexible, rapid response service for clients in their homes/community or residential care facilities. • Community Geriatric Evaluation and Management Service facilitates transition/transfer from an acute setting to an alternative community setting or multidisciplinary short term in-home care for vulnerable older adults with complex health issues, and community care providers with comprehensive assessment, intervention and care planning. • Regional Falls Prevention Program provides a regional approach to falls prevention and support for complex fallers with the aim of reducing disability and hospital presentations 	State Government funding.	Monthly activity and financial data reporting.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Drug and Alcohol Service South Australia (DASSA)	<p>The Drug and Alcohol Service South Australia (DASSA) delivers a number of drug and alcohol related initiatives state-wide including:</p> <ul style="list-style-type: none"> • Drug and alcohol support for the Reunification Initiative providing services which aim to reduce the alcohol and other drug intake of parents involved in the program thereby contributing to a reduction in the numbers of children entering alternative care. • Withdrawal Management Service, offering assessment and inpatient medical detoxification for people withdrawing from alcohol and a range of other drugs. • Drug and Alcohol Services Program providing funding to non-government organisations to deliver counselling, residential and non-residential rehabilitation, sobering up services, Mobile Assistance Patrol services and family support services. • The Drug and Alcohol Services South Australia Consultation Liaison Service is a specialist medical and nursing service providing consultation and liaison clinicians in the acute care setting of major tertiary referral (public) hospitals. • Tobacco Cessation Service, providing the Quit SA service, smoking cessation support through telephone counselling, and internet based information. <p>Similarly community based drug and alcohol services provided include:</p> <ul style="list-style-type: none"> • Alcohol and drug information service, providing a telephone information, counselling, and referral service • Community service centres, providing counselling, assessment and referral services, and across Adelaide (4 clinics) and regional centres (13 clinics) 	Funding is provided through a mix of Commonwealth and State Government funding.	<p>Monthly activity and financial data reporting.</p> <p>Quarterly data and activity reports, appointment summary data and financial data reporting.</p> <p>Annual activity reporting.</p> <p>Annual attendance / non-attendance reports to Courts Administration Authority.</p> <p>National Minimum Data Set – Alcohol and Other Drug Treatment Services (NMDS-AODTS).</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Drug and Alcohol Service South Australia (DASSA) contd.	<ul style="list-style-type: none"> • The Woolshed, a therapeutic community for 18 years+ with significant alcohol and drug related problems aiming to develop living, work and interpersonal skills. • Day centres at Ceduna and Port Augusta provide diversionary activities and non-residential rehabilitation and support. • The Clean Needle Program, a public health initiative aimed at reducing the spread of blood borne viruses <p>Drug and alcohol services with a specific focus on the interaction with the criminal justice system include:</p> <ul style="list-style-type: none"> • The Police Drug Diversion Initiative, a service for people detected by police for simple possession drug offences to be diverted from the criminal justice system into a health intervention for education, assessment and treatment. • The Driver Assessment Clinic, assessing drivers for alcohol and/or other drug dependency who have been referred by the Courts Administration Authority. • The City Watch House Community Nursing Service, providing assessment, treatment, management and referral of people held in police custody at the City Watch House. <p>Services with a focus on drug and alcohol issues within the Aboriginal Community include:</p> <ul style="list-style-type: none"> • The Aboriginal Population Health Programs, which identify, develop and evaluate strategies that effectively respond to the needs of Aboriginal people and communities affected by substance misuse • The Aboriginal Connection Program, a dedicated drug and alcohol treatment service for Aboriginal clients with complex needs and who are at risk of homelessness, primarily based in metropolitan Adelaide • The APY Lands Substance Misuse Services provide a range of specialist treatment interventions for Anangu with problematic alcohol and other drug use. 		

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Homelessness Health Services	<p>Programs aimed to support the health of people experiencing homelessness include:</p> <ul style="list-style-type: none"> • Homeless nursing program provides specialised nursing care in the CBD for people experiencing homelessness in a walk in clinic setting providing multi-disciplinary care. • Street to Home provides outreach services for rough sleepers, comprehensive access and connection to health Services, intensive case management, GP and Psychiatry outreach, then transitioning to mainstream health and housing services. 	State Government funding. Partnership funding from the Department of Communities and Social Inclusion (DCSI).	Quarterly and annual activity and financial reporting. Commonwealth H2H National Data Collection Agency.
Maternal Health Programs	<p>A number of programs are accessible across South Australia aimed at providing support and services to pregnant women and their families, these include:</p> <ul style="list-style-type: none"> • Aboriginal Family Birthing Program providing culturally respectful and clinically safe continuity of care for Aboriginal women and their families during their pregnancy, birthing and for up to six weeks post natal by Aboriginal Maternal Infant Care (AMIC) workers in collaboration with maternity services personnel. • Community Midwifery Program providing antenatal, birthing and postnatal services to women across Country Health SA. • Pregnancy to Parenting Program offering support and education to families in the early pregnancy to early parenting period including counselling and support particularly in relation to antenatal care, emotional well-being, psycho social issues, early parenting and child development. 	Combination of Commonwealth and State Government funding.	Monthly activity and financial data reporting.
O'Brien St Practice	O'Brien St Practice offers both HIV medicine and Allied Health practise in HIV, HEP C and gay men's health services, as well as GP services to vulnerable inner city populations.	Combination of State Government and Medicare funding.	Monthly activity and financial data reporting.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral Health Services	<p>A significant number of oral health programs are undertaken state-wide by the South Australian Dental Service (SADS) with such initiatives including:</p> <ul style="list-style-type: none"> • The Community Dental Service and Clinical Placements Program, providing emergency and general dental care (including dentures) for adult holders of a concession card and their dependents in public dental clinics • The Population Oral Health Program, identifying and referral of high risk preschool children with evidence of early dental disease. • The School Dental Service, general and preventively focused dental care for all children under 18 years of age. <p>Additionally, oral health services are provided with a particular focus on vulnerable groups, including:</p> <ul style="list-style-type: none"> • Aged Care Oral Health Projects • Aboriginal Oral Health program • Homelessness and Oral Health Program • Services for newly arrived migrants with a refugee background. • Supported Residential Facilities Program 	<p>State Government funding.</p> <p>Commonwealth grant funding under the Encouraging Better Practice in Aged Care (EBPAC) initiative.</p> <p>Commonwealth funding under the National Partnership on Treating More Public Dental Patients.</p> <p>Commonwealth revenue under the Child Dental Benefits Schedule.</p>	<p>Monthly activity, waiting list and financial data reporting.</p> <p>Six monthly milestone reports to the Commonwealth.</p>
Palliative Care Services	<p>Palliative care services involving integrated care across in-hospital and out-of -hospital settings, linking with other primary care providers for people on an end of life care pathway, with a focus on supporting people to die in their place of choice.</p>	<p>State Government funding</p>	<p>Monthly activity and financial reporting.</p>

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rehabilitation Services	<p>Specific rehabilitation services provided across South Australia include:</p> <ul style="list-style-type: none"> • The Northern Rehabilitation Service provides maintenance of an individual's independence, function and ability through the provision of inpatient, Rehabilitation in the Home, and outpatient rehabilitation services. • Paediatric Rehabilitation Program provides Rehabilitation Consultant services to community clinics providing specialist medical assessment and intervention by multidisciplinary teams. 	State and Commonwealth Government funding.	Monthly and Annual reporting activity and financial reporting. Daily activity reporting re bed capacity.
Rural and Remote Services	<p>Services provided aiming to assist with patients in rural and remote areas of South Australia include:</p> <ul style="list-style-type: none"> • Country Access to Cardiac Health program provides improved access to cardiac rehabilitation services with a central referral point and telephone based program where no face-to-face program exists. • Country Home Link and Rapid Intensive Brokerage Support (RIBS) programs provide access to flexible services and equipment for country consumers to avoid the need for hospital admission to metropolitan hospital (Country Home Link) and country hospitals (RIBS). 	State Government funding.	Monthly activity and financial data reporting.
Screening Services	Port Pirie Lead Implementation Program monitors blood in lead levels of the Port Pirie community with a particular focus on pregnant women and children 0-5 years, provides intervention to reduce blood lead levels in children and pregnant women and provides ongoing community education around lead safe practices.	State Government funding.	Quarterly lead in blood data used as the basis of the Technical Paper produced by the Public Health Department of DH.

Table 10A.112 **South Australia, community health services programs***Programs funded by the SA Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Transition Care Program (TCP)	Provision of short term restorative residential aged care or community place for patients aged 65 + or 50 years for Indigenous patients, to assist with the transition from an acute hospital stay back to their own homes and/or to lower level residential aged care home, with an emphasis on restorative care and reducing functional decline.	Recurrent Commonwealth Government funding. State Government funding Contribution.	Monthly and Quarterly activity and financial data reporting.
Women's Health Services	Specialised women's health services are provided to Aboriginal and Torres Strait Islander women; newly arrived refugee and migrant women and vulnerable women with complex health and social circumstances who would not otherwise access health services. Services include engagement activities to create referral pathways and a culturally safe service, clinical health assessments and care planning, information and referral, self-management programs and psychosocial therapy, specialised clinical health treatment, co-ordination of care pathways.	State Government funding. Commonwealth government contribution through MBS (section 19(2) exemption).	Monthly activity and financial data reporting. Quarterly performance reporting.
Youth Health Services	Provides specialised health services to young people aged 12 – 25 years from key and vulnerable population groups providing services which include engagement pathways and a culturally safe service; clinical health assessments and care planning; information and referral; medical treatment, health programs and counselling to support young people to build their capacity to manage their own health.	State Government funding. Commonwealth government contribution through MBS (section 19(2) exemption).	Monthly activity and financial data reporting. Quarterly performance reporting.

Source : SA Government unpublished.

Table 10A.113 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2013-14*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities.</p> <p>Community Health Centres offer a variety of services including counselling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability and family and child health services.</p> <p>Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers.</p> <p>The size of sites also varies: small sites provide a limited range of services generally based around community nursing.</p>	<p>The majority of funding is allocated from the State budget. During 2013-14 Tasmanian Health Organisations (North, South and North West) were responsible for area spending and overseeing program delivery.</p> <p>Services are provided in accordance with the Tasmanian Government's Output Budgeting Framework.</p> <p>Services are funded through identified outputs within the DHHS budget.</p>	<p>Performance information is collected and reported at the State level through the Budget Papers, Annual Report and the quarterly Your Health and Human Services Progress Chart.</p> <p>National reporting through: National Minimum Data Sets; Report on Government Services; Australian Institute of Health and Welfare (AIHW); Australian Council of Healthcare Standards.</p>
	<p>Rural Health Facilities provide core primary health and community care services within a local community in addition to some inpatient sub-acute beds. In addition, some rural sites provide residential aged care and/or emergency services.</p>	<p>Australian Government funds</p>	<p>Reporting in accordance with specific program requirements.</p>
	<p>Palliative Care Services - specialist palliative care clinicians work within a consultancy framework across the health sector to support primary health service providers in urban and rural areas to provide quality palliative care.</p>		

Table 10A.113 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2013-14*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	Other Primary Health services include Aged Care Assessment Teams; Community Equipment Scheme; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Contenance Services; Day Centres and Health Promotion activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.	Australian Government and State funding	Reporting in accordance with specific program requirements.
	The Australian Government funds the Rural Health Outreach Fund (RHOF) and the Medical Outreach – Indigenous Chronic Disease Program (MO-ICDP) to provide a broad range of outreach medical, nursing and allied health services to rural and remote areas of Tasmania.	Australian Government funding.	
	Overcoming cultural/language barriers – The Tasmanian DHHS provides access to Interpreter Services for CALD clients in all health settings as required.	Services purchased on an ‘as needs’ basis	As above
	Overcoming geographical barriers – emergency services are provided at some rural sites and three sites also operate an ambulance service.		
	A range of services are provided on an outreach basis to rural communities from an urban hub – including allied health services, Aged Care Assessment Teams and Contenance Services.	Australian Government and State funding	As above

Table 10A.113 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2013-14*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Telehealth is available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs and external organisations.</p> <p>In addition to Australian Government contributions, the State provides funding to Health Recruitment Plus to assist recruitment and retention of rural general practitioners and to support rural medical practitioners to provide services to rural health facilities around Tasmania.</p>		
	<p>Overcoming socioeconomic barriers- a range of transport services to access health care is available to people who are transport disadvantaged either because of socioeconomic circumstances or because health and disability preclude use of their own or public transport.</p> <p>Any services that charge fees are means tested such that those in receipt of pensions and are health care card holders either pay a reduced fee or are exempt from fees.</p>	As above	As above
	<p>Overcoming social isolation barriers- day centres around the state provide social support and activities for the frail, aged and people with a disability.</p> <p>Community Health provides coordination of community recovery responsibilities covering the human and social elements of disaster recovery.</p>	As above	As above

Source: Tasmanian Government unpublished.

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Immunisation	<p>The Health Protection Service (HPS) is responsible for the Communicable Disease Control program which is responsible for responding to notifiable diseases in the ACT. HPS also coordinates and implements the National Immunisation Program (NIP) (reported in Chapter 11) and ACT vaccination programs across both public and private sectors in the ACT. HPS develops strategic and operational communicable disease control and immunisation policies for the ACT; provides outbreak control advice and clinical advice about immunisation to members of the public, immunisation providers and health care professionals; and provides education to health care professionals and immunisation providers.</p> <p>Vaccine is ordered and distributed to immunisation providers. Within the HPS, the Vaccine Management Unit (VMU) delivers NIP and ACT funded vaccine to Child Health clinics, general practices, hospitals and other immunisation providers. The VMU staff have an active role in ensuring that vaccines are stored within the recommended temperature range and remain viable. The temperature of all immunisation providers' fridges are continuously monitored using data loggers. Each fridge is inspected at least monthly and regular inventories and stock rotation of providers' fridges is undertaken by staff of the VMU. Vaccine use is monitored and policies implemented to ensure high immunisation coverage in eligible groups in the ACT.</p>	<p>Through a designated budget (program coordination and vaccine delivery). NIP vaccines are funded or provided by the Department of Health and Ageing (DoHA) as part of the National Partnership Agreement on Essential Vaccines.</p> <p>Designated budget for the purchase of vaccines and post exposure treatments.</p>	<p>Immunisation coverage in children – quarterly and annual reporting against targets and budgets. NIP vaccine usage levels are reported to the Department of Health and Ageing (DoHA) quarterly as part of the National Partnership Agreement on Essential Vaccines.</p> <p>HPS reports RIG usage to Communicable Disease Network Australia (CDNA).</p> <p>Evaluation of the General Practice influenza vaccination program conducted in 2013.</p> <p>At least monthly inventories of vaccines. Temperature readings recorded. Vaccine wastage reported.</p>

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Immunisation contd.	<p>HPS investigates notifiable disease outbreaks and provides advice to the community on measures to reduce the spread of communicable diseases. This includes the purchases stocks of rabies vaccine and immunoglobulin (RIG) for the post exposure treatment of: returning travellers bitten or scratched by animals in countries where rabies is prevalent; or people bitten or scratched by bats in Australia (Australian Bat Lyssavirus (ABL). HPS also stocks quantities of Hepatitis A vaccine for use in post exposure treatment of people exposed to Hepatitis A. Stocks of Normal Human Immunoglobulin, Zoster Immunoglobulin and measles, mumps and rubella (MMR) vaccine are also held by HPS for measles and varicella post exposure treatment.</p> <p>Hepatitis B is funded for intravenous drug users and sexual and household contacts of hepatitis B positive persons. The hepatitis B vaccine is distributed to all immunisation providers including corrections facilities, Aboriginal Medical Services, Youth Health Services and alcohol and drug units.</p> <p>MMR vaccine is funded and provided for all persons who do not have documented evidence of having received 2 doses of measles containing vaccine.</p> <p>To increase the level of immunity of frontline health care staff against circulating influenza viruses the ACT Government funds influenza vaccine for staff in General Practices.</p>		

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Intake	<p>Community Health Intake facilitates access to community health services by providing a single point of entry to services.</p> <p>The public can phone Community Health Intake for information about health services or to arrange appointments with health professionals in community settings.</p> <p>Health professionals can fax referral forms to Community Health Intake for processing.</p> <p>Community Health Intake also has a dedicated GP phone line which provides information about community health services, provides information about clients with existing referrals, and transfers GP calls to other services and programs.</p>	Funded by the ACT Government.	Monthly reporting to operational management

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Justice Health Services	<p>The Justice Health Service provides:</p> <ol style="list-style-type: none"> 1. The Justice Health Service represents a combination of the Justice Health Primary Team and Forensic Mental Health Services delivered at the Alexander Maconochie Centre (Adults), the Bimberi Youth Justice Centre (Adolescents and Youth) and the Periodic Detention Centre (Adults). The Forensic Mental Health Services also delivers services to the Courts and in the general Community. This program provides improved access to services by delivering at a minimum community equivalence in service availability via and integrated multidisciplinary care approach. 2. The Primary Health Team provides and coordinates clinical services at secondary and tertiary level to people in the Alexander Maconochie Centre (AMC) and Bimberi Youth Justice Centre (BYJC) respectively. 3. The Forensic Mental Health Services (FMHS) provides specialist forensic mental health services within the AMC and BYJC for people with moderate and severe mental illness. FMHS also provides Mental Health services at the Courts and to high risk and complex consumers in the Community via their Forensic Community Outreach Service (FCOS). 	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women, Youth and Children Community Health Programs	<p>Provides:</p> <ul style="list-style-type: none"> • Maternal and Child Health nursing services including universal first home visit, child health checks, early childhood immunisation, parenting education and support and intensive support in the home through a Parenting Enhancement Program. • Child Health Medical Officers and Community Paediatricians offering a secondary child health and development service. • Child at Risk Health Unit delivering specialist health services to children and young people, affected by abuse and neglect, along with their families and/or carers. Related to this, the CHP oversees child protection training for Canberra Hospital and Health Services. • IMPACT Program supporting pregnancy and families who have children up to 2yrs and are clients of Mental Health and/or are receiving Opioid Replacement Therapy. • School based programs including immunisation programs; kindergarten health checks, school youth health nurses; Healthcare Access at School supporting children with complex health issues in schools. • Asthma education, nurse audiometrists and orthoptic screening, social work physiotherapy, and nutrition services. • Women's Health Service providing nursing, medical and counselling services, including cervical screening, for women who experience significant barriers to accessing health services. 	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 10A.114 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Care, Division of Rehabilitation, Aged and Community Care	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition and social work), acute, post acute and rapid response services, specialist nursing assessments and self management of chronic conditions program.	Through a designated budget: <ul style="list-style-type: none"> • Some services HACC funded • Remainder ACT Government funded 	<p>Monthly and annual reports against a range of indicators including output targets, budget and quality indicators.</p> <p>The ACT Government Health Directorate's Annual Report includes Accountability Indicators related to the achievement of occasions of service targets for nursing and allied health services.</p> <p>HACC outputs data is reported quarterly and submitted six</p>

Source: ACT Government unpublished.

Table 10A.115 Northern Territory, community health services programs

Programs funded by the NT Government during 2013-14

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral Health Services	Oral Health Services provide free assessment and treatment to all children up to school-leaving age and to adults holding a current Healthcare or Pensioner Concession Card. Services are delivered from community and school based clinics (urban areas) and health centres and mobile trucks (remote communities). Services are also provided through the Special Needs clinic and treatment under general anaesthetic is provided in both urban and regional centres. Community level/ individual oral health promotion activities are also conducted. Training is provided to remote primary health care workers to facilitate early detection and prevention of dental disease.	Funding sources: <ul style="list-style-type: none"> • NT Department of Health • Australian Government via National Partnership Agreements (NPAs) Budget management/oversight by Director Oral Health. Governance oversight by Executive Director Territory-wide Services	Routine reporting: <ul style="list-style-type: none"> • Executive Monthly Performance Reports (internal) • Department of Health Annual Report, (public). Quarterly reporting (public) against: <ul style="list-style-type: none"> • NPA – Treating More Public dental patients • Stronger Futures NPA
Men's Health	The Men's Health Strategy Unit (MHSU) provides expert advice, leadership and strategic directions in men's health with a particular focus on Aboriginal male health. The MSHU leads the development of a men's health strategy and strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. The MHSU works to develop partnerships with key stakeholders from the Department, other government and non-government organisations, peak men's health bodies and Aboriginal community-controlled organisations, to improve men's knowledge, access and use of preventative health services. The MHSU plays a support role for Aboriginal Male Health Coordinators working in remote communities to engage men and undertake health promotion activities. It coordinates the delivery of urban based male health awareness activities through the 'Pitstop' program. It is involved in staff training on male health aimed at improving service capability for males. The MHSU also encourages and promotes the development of a research effort around gender and health to improve access and use of gendered data to inform program development.	Funding source: Northern Territory Government via Department of Health budget Budget spending/oversight by Director Health Development Branch. Program delivery (limited direct funding) by NT Department of Health and NGO service providers Governance oversight by Executive Director Territory-wide Services	Routine reporting: Department of Health Annual Report.

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Health Promotion Strategy Unit	<p>The core function of the Health Promotion Strategy Unit (HPSU) is to build and strengthen capacity for affective health promotion and prevention in the Department of Health (DoH) and its partners across government and non-government sectors.</p> <p>This involves:</p> <ul style="list-style-type: none"> • facilitating a uniform understanding of health promotion across government and non-government health and related sectors; • providing strategic and policy support to key stakeholders, staff and organisations and • a commitment to planning for health promotion through investment in research, program planning and evaluation, continuous quality improvement, social marketing, health promoting settings and developing sustainable education and training pathways. <p>A key focus is to:</p> <ul style="list-style-type: none"> • facilitate the implementation of the Northern Territory Health Promotion Framework; • support Health Promotion Training and Education offered by NT tertiary providers; • offer professional and workforce development options in health promotion for primary health care and NGO staff; • support health promotion settings approaches such as health promoting workplaces and health services; • provide health promotion information to professionals, communities and individuals in the NT; • work with research organisations on identifying affective strategies and enablers to develop a health literate system; • administer a planning and evaluation system (QIPPS) for health promotion programs in the DOH and its partners; • work with Menzies School of Health Research to roll out Health Promotion CQI tools for primary health care. 	<p>Funding source -NT Department of Health.</p> <p>Responsibility for managing and delivering:</p> <ul style="list-style-type: none"> - Program Leader Health Promotion is responsible for delivering the HPSU functions and program - Responsibility for providing health promotion activity in the NT is that of primary health care teams and NGOs - Budget spending/oversight by Director Health Development Branch. - Governance oversight by Executive Director Territory-wide Services 	<p>DoH Annual report</p> <ul style="list-style-type: none"> - 6 monthly QIPPS report to internal stakeholders - Evaluation reports of any professional development provided to organisations sending participants

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women's Health	<p>The Women's Health Strategy Unit (WHSU) engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders and coordinates and leads Department of Health responses to this work.</p> <p>WHSU instigates, leads and project manages key strategic pieces of work to progress priority women's health issues such as those for Aboriginal and Torres Strait Islander Women, Migrant and Refugee Women and Domestic and Family Violence responses.</p> <p>The Unit takes a strategic approach to gender as a key determinant of health both in the Department of Health, with other key stakeholders and services providers. In particular the Unit has an ongoing relationship with the Men's Health Unit, the Office of Women's and Men's Advancement, the Department of Attorney General and Justice and the Office of Multicultural Affairs in regards strategic approaches to access equity and outcomes for women's health and wellbeing in the Territory.</p> <p>The Unit has worked with maternity and women's health staff to support the development of consistent program approaches to women's health service delivery.</p> <p>The Unit has been the Department's representative on a whole of government Domestic and Family Violence Working Group and provided departmental feedback and input into the development of a Northern Territory Domestic and Family Violence Strategy.</p>	<p>Funding source Northern Territory Government via an identified program within the Department of Health budget.</p> <p>Budget spending/oversight by Director Health Development Branch.</p> <p>Governance oversight by Executive Director Territory-wide Services</p> <p>Program delivery via strong collaboration with NTG and NGO partners.</p>	<p>Routine reporting: Department of Health Annual Report, annual public.</p>

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Youth Health Strategy Unit	<p>The Healthy Under Five Kids Program is a universal well-child program that begins within 10 days of birth up to five years of age. The program provides health professionals with a standard set of child health and wellbeing assessments and scripted anticipatory guidance at each of the 10 to 13 visits. This allows health professionals to work with children, parents and families to detect early problems that may affect health or wellbeing, assess physical growth and development as well as the social environment and provide consistent evidence-based information to parents about SIDS, hygiene, communication, play, nutrition, child growth and development. Staff providing the assessments link families to other available community services. This program aligns with the NT Childhood Vaccination Schedule.</p> <p>The Child and Family Health Service is provided in NT urban areas by qualified Child Health Nurses. A very similar program is provided in remote areas by Remote Area Nurses and Aboriginal Health Practitioners, supported by visiting qualified child health nurses. From 2015 there will be a single NT schedule. Healthy Under 5 Kids – Partnering Families.</p> <p>The School Health Service works in NT urban government-funded Middle Schools (school years 7-9). Registered nurses work onsite within a Health Promoting Schools Framework and provide health promotion and education in line with the school curriculum and general school ethos to empower youth to make healthy choices. This program supports the NT Childhood Vaccination Schedule. Objective targeted: promoting health and preventing ill health. Population Group: NT Urban dwelling youth attending government funded Middle schools.</p>	<ul style="list-style-type: none"> • NT DOH - Child and Youth Health Strategy Unit provide overall program management • Funding is predominantly through NT Government Department of Health • New Directions Mothers and Babies (Commonwealth) funds a number of positions in specified remote communities • The Top End Area Health and Central Australian Area Health Service provide service delivery. • NT DOH has contracts with two Aboriginal Medical Services in the Katherine region to deliver this program. <ul style="list-style-type: none"> • NT DOH - Child and Youth Health Strategy Unit provide overall program management • NT Government Department of Health 	<ul style="list-style-type: none"> • NT DOH reports to NT Treasury on an Annual basis on this program • NT DOH Annual Report reports on this program annually • Monthly program coverage reporting from service providers to NT DOH <ul style="list-style-type: none"> • Financial reporting obligations within NT Department of Health

Table 10A.115 Northern Territory, community health services programs

Programs funded by the NT Government during 2013-14

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Youth Health Strategy Unit contd.	<p>The Healthy School-Age Kids Program is a health promotion and screening program provided to all school-age children in remote communities. The program includes an integrated approach to screening and health promoting activities from a number of different health service providers, non-government organisations as well as the schools. With the advent of improved medical records management and consistent health service delivery the scope of this program is likely to change over the next few years. This program supports the NT Childhood Vaccination Schedule.</p> <p>Objectives targeted:</p> <ul style="list-style-type: none"> • promoting health and preventing ill health • providing early detection and intervention <p>Population Group: NT remote dwelling school-age children.</p>	<ul style="list-style-type: none"> • NT DOH - Child and Youth Health Strategy Unit provide overall program management • Funding is predominantly through NT Government Department of Health • The Top End Area Health and Central Australian Area Health Service provide service delivery. • NT DOH has contracts with two Aboriginal Medical Services in the Katherine region to deliver this program 	<ul style="list-style-type: none"> • Program activity reports by community by event.
Public Health Nutrition and Physical Activity	<p>Services are delivered both by public health nutritionists usually located within multi-disciplinary teams, and policy officers based in the Strategy Unit.</p> <p>Public health nutritionists (PHNs) provide training and support to primary health care teams to promote healthy nutrition and regular physical activity to the community and assist with the management of people with nutrition related conditions. They also offer individual and group dietetic consultations through community care centres and health clinics in both urban and remote areas.</p>	<p>Funding sources</p> <p>NT Government</p> <ul style="list-style-type: none"> - Australian Government via NPAs - NT Medicare Local <p>Budget spending/oversight by Health Development Branch Directorate</p> <p>Governance oversight by Executive Director Territory-wide Services</p>	<p>Department of Health Annual Report, Urban and Remote Health Services Output reports (public).</p> <ul style="list-style-type: none"> - Quarterly (internal) and annual (public) reports to Australian Government - Monthly activity reporting to NT Medicare Local (internal/public)

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Chronic Conditions Strategy Unit (CCSU)	<p>The core function of CCSU is to support the chronic disease network across the Northern Territory to provide evidence-based practice within the framework outlined in the Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020 (NT CCPMS).</p> <p>CCSU holds annual Chronic Disease Network Conference to showcase and share current (best practice) approaches to care and to improve communication, coordination and collaboration around the provision of chronic condition programs and services across the network. This conference attracts on average 250 health practitioners from the NT and other jurisdictions.</p> <p>The current Implementation Plan (2014-2016) of the NT CCPMS has a strong focus on progressing social determinants of health (SDoH), which will include upskilling the health and non-health professionals to work within the SDoH framework.</p> <p>CCSU provides leadership by working closely with its partners within and outside the government health sector, which includes non-government and Aboriginal community controlled health services, to ensure a consistent approach to chronic care.</p>	<ul style="list-style-type: none"> • NTG funding via DoH budget • Australian Government – NPA (podiatry services) 	<ul style="list-style-type: none"> • Annual DoH Report • Annual Reporting of the Implementation Plan of NT CCPMS.

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Hearing Services	<p>The consequence of chronic ear disease in Indigenous people manifests as endemic hearing loss, which impacts on language and social learning and can flow on to academic underachievement, limitation in vocation and increased contact with the justice system. Access to services reflects this and from the total of 5665 hearing assessments provided, 68% were to Indigenous consumers.</p> <p>The systematic approach to hearing health involves integrating all resources to deliver connected pathways of care to communities. Hearing health services support community based primary health, early childhood and education strategies.</p> <p>Compelling evidence of effectiveness supports this model of care (see AIHW Stronger Futures in the Northern Territory: Hearing Health Service 2012-2013).</p> <p>Services are mostly provided in specialised hearing centres located in remote and urban community health centres, or hospital facilities. Hearing Health utilises Teleotology (a telehealth service) to improve access to specialist Ear, Nose and Throat services in remote areas with demonstrated cost and productivity benefits. Currently 80 per cent of ENT consultations to remote communities are provided through Teleotology.</p> <p>A Hearing Health Information Management System to provide clinical decision support and guidance to primary health practitioners, increase efficiencies in existing Teleotology processes and integrate all clinical data to support a shared care plan is currently being implemented.</p> <p>The Neonatal Hearing Screening program for permanent hearing loss is provided through all urban birthing hospitals. From 3220 births in public hospitals there was 99% coverage for this screening program.</p>	<p>Funding sources</p> <ul style="list-style-type: none"> - NTG Department of Health, and - Australian Government for additional ear health and hearing services for Indigenous children. <p>Budget spending/oversight by Directors of Health Development (remote areas) and Community Health Branches (urban areas)</p> <p>Governance oversight by Executive Director Territory-wide Services.</p> <p>Service delivery by Department of Health NT Hearing Program (Community Health) and Hearing Health Program (Health Development).</p>	<p>Routine reporting:</p> <ul style="list-style-type: none"> - Department of Health Annual Report (public). - Performance targets for Australian Government-funded programs and consented service event data shared with AIHW are published annually.

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health Care – Top End Health Service (PHC – TEHS) and Central Australia Health Service (PHC-CAHS)	<p>Remote Health delivers evidence based, best practice primary health care services to Aboriginal and non-Aboriginal people in remote areas from a network of 54 department-managed community health centres and collaborates with non-government Aboriginal community controlled health services. Remote Health's workforce consists of rural medical practitioners, remote area nurses, Aboriginal health practitioners, Aboriginal community workers and allied health professionals providing direct care to clients as a collaborative multidisciplinary team.</p> <p>Services include primary health care, 24 hour emergency care, medical evacuations, care and treatment for chronic disease and public health programs. In the remote setting, primary health care professionals work collaboratively with other departmental program professionals to deliver integrated and coordinated care, targeting preventable chronic disease, maternal child and youth health, oral and ear health, sexual health, mental health, alcohol and other drugs and aged and disability services.</p> <p>Remote Health manages the relationships between the Northern Territory and Australian Government agencies and non-government organisations involved in primary health care, and for developing sustainable systems for effective and efficient service delivery. Consultation also occurs with the community to foster and develop community capacity, facilitate community decision making, promote and support the employment of local people and establish effective governance systems so that health services can successfully and confidently make the full transition to community controlled entities.</p>	<p>FUNDING SOURCES:</p> <ol style="list-style-type: none"> Northern Territory Government via Department of Health budget Australian Government Department of Health (AG DoH) <ul style="list-style-type: none"> Primary Health Care base Northern Territory Stronger Futures <ul style="list-style-type: none"> Primary Health Care Child and Maternal Health Substance use Medicare Local NT Primary Health Care Initiative <p>Budget spending/oversight by Director Remote Health Branch.</p> <p>Governance oversight by Executive Director Territory-wide Services.</p> <p>Program delivered by</p> <ul style="list-style-type: none"> Remote Health services and Remote Health grant funded non-government Aboriginal community controlled organisations. 	<p>ROUTINE REPORTING:</p> <p>Bi-annual:</p> <ul style="list-style-type: none"> Financial report to AG DoH Written report to AG DoH Written report to Medicare Local NT ATSI nKPI reporting AG DoH NTAHKPI reporting to NT Department of Health and AG DoH Financial report to AG DoH <p>Annual:</p> <ul style="list-style-type: none"> NT Department of Health Annual Report (public). OSR Reporting to AG DoH

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Urban Health	<p>Child youth and family program operating within the urban setting delivers evidence-based best practice family-centred care. Child youth and family work force consists of clinical nurse specialists Nurse 3, with Child and Family Health nursing qualifications. There are two N5 Clinical Nurse Managers. The Child and Family nurses work under a family partnership model. Referrals are through the individual, hospitals and GPs, with linkages to government and non-government organisations including Family and Children services.</p> <p>Range of services:</p> <ul style="list-style-type: none"> • Universal home visits • Key age assessment (growth and development) • Extended visiting for vulnerable families • Early birds (new mothers) support program • Territory parent support (education program) • Breast feeding /nutrition support • EPDS screening (links to perinatal mental health) • Parenting support and advice • Referral to relevant services i.e. hearing, allied health, GP • Immunisations • Health promoting school nurses are Nurse 4s and operate out of middle schools. • Provide health promotion within the classroom • Immunisation program <p>Community health objectives targeted:</p> <ul style="list-style-type: none"> • promoting health and preventing illness • providing timely and high quality healthcare that meets individual needs, throughout the lifespan 	<p>FUNDING SOURCES: Northern Territory Government via Department of Health budget</p>	<p>Reporting, as requested; monthly from service centres internal</p>

Table 10A.115 Northern Territory, community health services programs

Programs funded by the NT Government during 2013-14

Program	Description	Budgetary context	Reporting
Urban Health contd.	<ul style="list-style-type: none"> • 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. Population groups served: The urban population of diverse cultures including English and non-English speaking families, also including refugees and new immigrants.		
Prison Health Care	<p>Prison Health delivers evidence based, best practice primary health care services to the inmates of Darwin Correctional Centre, Don Dale Centre and the Alice Springs Correctional Centre.</p> <p>The Prison Health workforce consists of medical practitioners, nurses, Aboriginal health practitioners and allied health professionals providing direct care to clients as a collaborative multidisciplinary team.</p> <p>Services include primary health care, 24 hour on call emergency care, medical evacuations, care and treatment for chronic disease and public health programs. In the prison setting, primary health care professionals work collaboratively with other departmental program professionals to deliver integrated and coordinated care, targeting preventable chronic disease, youth health, oral and ear health, sexual health, mental health, alcohol and other drugs and aged and disability services.</p> <p>Prison Health manages the relationships between itself and private allied health providers involved in primary health care service in the prisons. Consultation also occurs with the community, inmate advocate groups and the Department of Correctional Services to foster and develop effective governance systems.</p>	<p>FUNDING SOURCES:</p> <ol style="list-style-type: none"> 1. Northern Territory Government via Department of Health budget 2. Budget spending/oversight by Director Remote Health Branch. <p>Governance oversight by Executive Director Territory-wide Services.</p> <p>Program delivered by Remote Health services</p>	<p>ROUTINE REPORTING:</p> <p>Annual:</p> <ul style="list-style-type: none"> • NT Department of Health Annual Report (public).

Table 10A.115 Northern Territory, community health services programs

Programs funded by the NT Government during 2013-14

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Sexual Health and Blood Borne Viruses Program	<p>The Sexual Health and Blood-Borne Viruses (SHBBVU) Program is a NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections and blood borne viruses such as HIV/AIDS and Hepatitis C. Services include</p> <ul style="list-style-type: none"> • surveillance and public health response to notifiable sexually transmitted infections (STIs) and blood-borne viruses (BBVs) • sexual health education and health promotion • direct early detection and treatment clinical services • the needle syringe program • supporting delivery of culturally appropriate, gender-balanced and accessible educational and clinical services across the NT by services including primary health care services <p>Population groups served include young people and Aboriginal and Torres Strait Islander people as well as gay men, sex workers, travellers and mobile workers, people in custodial settings.</p>	<ul style="list-style-type: none"> • Funding sources NT Department of Health. OATSIH, Australian Government • Responsibility for managing/delivering program NT Department of Health (DoH) 	<p>OATSIH reporting requirements</p> <ul style="list-style-type: none"> • Annual Action Plan and Budget • 6 Month and 12 Month Financial Reports • Annual Progress Report - OATSIH Service Report <p>Biannual Australian Government report</p>
The Adolescent Sexuality Education Project (ASEP)	<p>The Adolescent Sexuality Education Project (ASEP) is a collaboration between the Northern Territory Department of Education and Department of Health in association with the Central Australia Aboriginal Congress. The ASEP is funded for one year (2014-15) by the Australian Government under the project agreement (PA) for Indigenous teenage sexual and reproductive health and young parents support to provide sexual and reproductive health education to young Indigenous adolescents in school and community settings across NT.</p>	<p>Funding Source:</p> <ul style="list-style-type: none"> • Australian Government <p>Responsibility for managing and delivering the program</p> <ul style="list-style-type: none"> • NT Department of Health 	<p>Routine reporting:</p> <p>6 monthly reporting to the Australian Government against project agreement milestones</p>

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	CDC provides education and (privately purchased) rabies vaccine for pre-exposure prophylaxis against Australian Bat Lyssavirus (ABL) to persons at risk of occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and some regional centres to those potentially exposed to both rabies virus and ABL. Education programs are provided to the community and to occupational groups to ensure people avoid contact with bats and seek appropriate treatment if bitten or scratched by bats or mammals overseas.	Funding sources: 1) NT Department of Health. 2) DoHA refunds 50% of the cost of rabies immunoglobulin administered to people who are bitten or scratched by bats only. Responsibility for managing and delivering the program • NT DoH,	Routine reporting: • NT Department of Health Annual Report, • information on post exposure prophylaxis use is reported to the Australian Government.
Tuberculosis	The Centre of Disease Control (CDC) is responsible for the management of tuberculosis (TB), leprosy and non-tuberculous mycobacteria in the NT. • home visits and interpreter services • education for at risk groups in the community - directly observed therapy (DOT) by a registered nurse is provided to prevent the development of drug resistant disease and client information sheets are available in many languages • medical clinics to monitor clients and contacts identify at risk people and screen for tuberculosis exposure in the prison, alcohol rehabilitation centres, renal units and age care • remote area visits with medical officers, registered nurses and radiologist • regular case meetings with acute care and remote support teams	Funding Sources: • NT Department of Health • Department of Immigration and Boarder Protection for the Illegal Foreign Fisherman (IFF) and Irregular Maritime Arrivals (IMAs). Responsibility for managing and delivering the program • NT DoH	Routine reporting: • NTG Estimates data reports, • NT Department of Health, Annual Report

Table 10A.115 **Northern Territory, community health services programs***Programs funded by the NT Government during 2013-14*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Trachoma	<p>The NT Trachoma Program undertakes trachoma control activities in all remote communities across the NT, with the aim of eliminating trachoma by 2020. Services are include:</p> <ul style="list-style-type: none"> • screening and treatment of all 5-9 year old Indigenous children in remote communities for active trachoma infection, including treating entire communities where required and screening (and where required, treatment) of Indigenous adults >40 for trichiasis, which can cause blindness • promotion of facial cleanliness and improving environments to prevent the transmission of infections. <p>Extensive community consultation, employment of community based workers and collaboration with the Indigenous Eye Health Unit are undertaken to ensure services are culturally appropriate and accessible.</p>	<p>Funding Source: Australian Government Partnership Agreement</p> <p>Responsibility for managing and delivering the program</p> <ul style="list-style-type: none"> • NT DoH; • NT Aboriginal Medical Services 	<p>Routine reporting: 6 monthly reporting to the Australian Government against PA milestones</p>
Rheumatic Heart Disease Control Program	<p>The Rheumatic Heart Disease (RHD) Control Program is a NT wide program that aims to reduce the burden of rheumatic heart disease among the Aboriginal population by reducing the occurrence of acute rheumatic fever (ARF) in remote and urban community settings. Health professionals and community members are provided best practice support, education, resource development and supply and patient care.</p> <p>The program works with community elders and interpreters to develop culturally appropriate resources and improve accessibility.</p> <p>The high turnover of remote area nursing staff and the reduction of a consistent GP service in remote areas are addressed by maintaining strong communication with regional health service management.</p>	<p>Funding Source: Australian Government PA</p> <p>Responsibility for managing and delivering the program NT DoH</p>	<p>Routine reporting: 12 monthly reporting against PA</p>

Source: NT Government unpublished.

Data quality information — Primary and community health, chapter 10

Data quality information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Primary and community health chapter. DQI for additional indicators will be progressively introduced in future reports.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI Contents

Availability of PBS medicines	3
Measure 1: People per pharmacy by region	3
Measure 2: PBS expenditure per person by region	4
Measure 3: Equity of access to PBS medicines	5
Measure 1: Availability of GPs by region	6
Measure 2: Availability of GPs by sex	8
Early detection and early treatment for Indigenous people	10
Proportion of children receiving a fourth year developmental health check	13
Effectiveness of access to GPs	15
Measure 1: Bulk billing rates	15
Measure 2: People deferring visits to GPs due to financial barriers	17
Measure 3: GP Waiting times	21
Measure 4: Selected potentially avoidable GP-type presentations to emergency departments	25
Financial barriers to PBS medicines	28
Public dentistry waiting times	32
GPs with vocational registration	36
Management of upper respiratory tract infections	38
Chronic disease management	40

Measure 1: Management of diabetes — HbA1c level	40
Measure 2: Management of asthma	43
Use of pathology tests and diagnostic imaging	46
Patient satisfaction	49
Health assessments for older people	53
Cost to government of general practice per person	55
Child immunisation coverage	57
Notifications of selected childhood diseases	59
Participation rates for women in cervical screening	61
Selected potentially preventable hospitalisations	63
Measure 1: Selected potentially preventable hospitalisations for vaccine preventable, acute and chronic conditions	63
Measure 2: Selected potentially preventable hospitalisations for diabetes	68
Measure 3: Potentially preventable hospitalisations of older people for falls	71

Availability of PBS medicines

Data quality information for this indicator has been developed by the Health Working Group with additional Steering Committee comments.

Measure 1: People per pharmacy by region

Indicator definition and description

Element	Equity — Access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	Definition <ul style="list-style-type: none">The estimated resident population (ERP) divided by the number of pharmacies, in urban areas and in rural areas Numerator: ERP for urban areas and for rural areas Denominator: Number of pharmacies in urban and in rural areas Computation: Numerator ÷ Denominator.
Data source/s	University of Adelaide's National Centre for Social Applications of Geographic Information Systems, using Department of Human Services, Medicare pharmacies data and ABS ERP data.

Data Quality Framework Dimensions

Institutional environment	Australian Government Department of Health, PBS data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists:
Relevance	Data are presented by State/Territory by urban and rural location. Urban and rural location for ERP is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year from 2012-13. For previous years, geographical location is based on the ABS Australian Standard Geographical Classification 2006 as at 30 June preceding the reference year. 'Urban' constitutes ASGS 'Major cities'. Rural constitutes inner regional, outer regional, remote and very remote areas combined. Urban and rural location for pharmacies is based on the Pharmacy Access/Remoteness Index of Australia (PhARIA) classification. PhARIA is a composite index that incorporates measurements of general remoteness based on the ASGS and previously the ASGC with a professional isolation component represented by the road distance to the five closest pharmacies. 'Urban' is equivalent to the ASGS 'Major cities'. Rural constitutes the remaining PhARIA categories (2 to 6) combined.
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	
Coherence	Estimates are compiled the same way across regions and over time. The ERPs used to derive rates differ across years. For data up to 2010-11 rates are derived using preliminary ERPs based on the 2006 Census. For data from 2011-12 rates are derived using ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics .
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home .

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">Data do not include Aboriginal Medical Services that can supply medications to people in remote and very remote areas under s.100 of the <i>National Health Act 1953</i>
------------------------------	---

[Cwlth] for the purpose of improving access to medicines for people in those areas. This has particular relevance for the NT, as 43.9 per cent of the population live in remote and very remote areas.

- Disaggregation of data by region is limited to 'Urban' (equivalent to major cities) and 'Rural' (all other areas). Further disaggregation of rural data would be of value.

Measure 2: PBS expenditure per person by region

Indicator definition and description

Element	Equity — Access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	<p>Definition:</p> <ul style="list-style-type: none"> • Expenditure on Pharmaceutical Benefits Scheme (PBS) medicines divided by the ERP, by remoteness area <p>Numerator: Expenditure on PBS medicines</p> <p>Denominator: ERP</p> <p>Computation: Numerator ÷ Denominator.</p>
Data source/s	<p>Numerator: Australian Government Department of Health, PBS Statistics</p> <p>Denominator: ABS ERP as at 30 June preceding the reference year from 2012-13.</p>

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	<p>Expenditure data are reported on a cash basis and are available by region only for general and concessional categories. Therefore, data exclude expenditure on doctor's bag and other categories administered under special arrangements, such as, medications dispensed to Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> (Cwlth) for the purpose of improving access to PBS medicines for Indigenous people and others located in those areas. This expenditure, \$38.5 million in 2013-14, is not suitable for computation of expenditure per person as 'catchment' areas for Aboriginal Medical Services cross regional boundaries.</p> <p>Geographical location is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification from 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification. This constitutes a break in time series; data from 2012-13 are not comparable with data for previous years.</p>
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	<p>Estimates are compiled the same way across regions.</p> <p>The change to ASGS based geographical location from 2012-13 from RRMA based geographical location for previous years constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years.</p> <p>Data are not directly comparable to data published in the Australian Government Department of Health annual report, which are prepared on an accrual accounting basis and include doctor's bag and other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth].)</p>
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics .
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home .

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">• Data are reported only at the national level; reporting by State/Territory is a priority• Data exclude medications supplied to Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth] for the purpose of improving access for Indigenous people and others located in those areas.• Geographical location is based on the ASGS 2011 classification system from 2012-13, a key improvement over the classification system used for previous years that was developed in 1994.
------------------------------	---

Measure 3: Equity of access to PBS medicines

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	Proportion of PBS prescriptions filled at a concessional rate Definition: <ul style="list-style-type: none">• The number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. Numerator: The number of PBS prescriptions filled at a concessional rate Denominator: The total number of prescriptions filled Computation: Numerator ÷ Denominator
Data source/s	Australian Government Department of Health, PBS Statistics.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are reported by State/Territory.
Timeliness	Reliable PBS supply data are available 16 weeks after the close of the reference period
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across jurisdictions and over time.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">• Data do not capture medicines supplied by Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth] for the purpose of improving access to medicines for Indigenous people and others located in these areas. This has particular relevance for the NT as around 43 per cent of the population live in these areas.
------------------------------	---

Equity of access to GPs

Data quality information for this indicator has been developed by the Health Working Group with additional Steering Committee comments.

Measure 1: Availability of GPs by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measure/s (computation)	Availability of general practitioners (GPs) by region. Definition: <ul style="list-style-type: none">• The number of Full-time Workload Equivalent (FWE) GPs per 100 000 people, by region. Numerator: Number of FWE GPs Denominator: Estimated Resident Population (ERP) by region. Computation: $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December in the reference year.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to Australian Government Department of Health.
Relevance	<p>Geographical location based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year from 2012-13.</p> <p>For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification — urban includes 'Capital city' and 'Other metropolitan area'; rural includes 'Large rural centres', 'Small rural centres', 'Other rural areas', 'Remote centres' and 'Other remote areas'. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>GP headcount and FWE figures include vocationally recognised as well as non vocationally recognised general practitioners.</p> <p>GP headcount is a count of all GPs who have provided at least one DHS, Medicare service during the reference period and have had at least one claim for a DHS, Medicare service processed during the same reference period.</p> <p>GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing DHS, Medicare. FWE is a standardised measure adjusted for the partial contribution of casual and part-time doctors and is a more reliable estimate of the GP workforce.</p> <p>FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full time doctors for the reference period.</p> <p>Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure. Example 2: A part-time GP billing half the services of the average for full time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.</p>

	<p>A GP can work at more than one location. Allocation of GP headcount to state or territory and region is based on the practice location at which the GP provided the most DHS, Medicare services during the reference period. FWE allocates activity based on the practice location at which services were rendered within the reference period.</p> <p>From 2007-08 to 2011-12 under the RRMA based geographical classification, data are reported separately for NSW and the ACT. Data for previous years for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.</p>
Timeliness	GP headcount and FWE figures are available 10 weeks after the close of the reference period.
Accuracy	<p>GP headcount figures include only those GPs that both claimed and provided a service in the reference period. A small number of GPs may provide services in one year for which all claims are not processed until the next year. As additional months or DHS, Medicare claims data are processed, a small number of providers will become eligible for inclusion in the headcounts. Revision of headcount figures will result in very small differences to published figures each year. FWE figures are not revised each year.</p> <p>Since the commencement of DHS, Medicare, practitioners have provided demographic information to DHS, Medicare including date of birth and gender. Demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare Australia. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data.</p> <p>To overcome the problems and biases posed by missing data, similar practitioners were grouped based on known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.</p>
Coherence	<p>The change in geographical location classification constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years.</p> <p>Estimates are compiled the same way across jurisdictions.</p>
Accessibility	Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The classification system used to allocate GPs to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994 • Data are reported for 5 regional categories from 2012-13, compared to only 2 broad regional categories for previous years.
------------------------------	---

Measure 2: Availability of GPs by sex

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs by sex
Measure/s (computation)	Availability of general practitioners (GPs) by sex. Definition: <ul style="list-style-type: none">• The number of Full-time Workload Equivalent (FWE) female GPs per 100 000 females• The number of FWE male GPs per 100 000 males Numerator: Number of FWE GPs by sex. Denominator: Estimated Resident Population (ERP) by sex. Computation: $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.
Relevance	FWE GP figures include vocationally recognised as well as non-vocationally recognised general practitioners. FWE is a standardised measure used to estimate the workforce activity of GPs, adjusting for the partial contribution of casual and part-time doctors. FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full-time doctors for the reference period. Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure. Example 2: A part-time GP billing half the services of the average for full time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.
Timeliness	FWE figures are available 10 weeks after the close of the reference period.
Accuracy	FWE figures are not revised each year. Since the commencement of DHS, Medicare, demographic information has been provided by practitioners to DHS, Medicare including date of birth and gender. The demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data. To overcome the problems and biases posed by missing data, similar practitioners were grouped based on the known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.
Coherence	Estimates are compiled the same way across jurisdictions and over time. For data to 2010-11, rates are derived using the ABS 2006 Census based ERP as at 30 June preceding the reference year. From 2011-12, rates are derived using the preliminary ABS 2011 Census based ERP as at 31 December in the reference year. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps The Steering Committee notes the following issues:

/issues

- Data are of acceptable accuracy.
- Data are reported for the first time for male as well as female GPs.

Early detection and early treatment for Indigenous people

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Early detection and early treatment for Indigenous people
Measure/s (computation)	
Measure 1	<p>Definition:</p> <ul style="list-style-type: none">The proportion of older people who received a health assessment by Indigenous status. <p>Numerator:</p> <ul style="list-style-type: none">The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period <p>Denominator:</p> <ul style="list-style-type: none">The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period. <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Measure 2	<p>Definition:</p> <ul style="list-style-type: none">The proportion of older Indigenous people who received a health assessment, time series. <p>Numerator: The number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>Denominator: The population of Indigenous people aged 55 years or over in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Measure 3	<p>Definition:</p> <ul style="list-style-type: none">The proportion of Indigenous people who received a health assessment, by age group. <p>Numerator:</p> <ul style="list-style-type: none">The number of people aged 0–14 years, 15–54 years, or 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period <p>Denominator:</p> <ul style="list-style-type: none">The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period. <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data sources (all measures)	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator: computed by the Secretariat using ERP data from the ABS.</p> <ul style="list-style-type: none">Total population: ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.For data by Indigenous status: ABS 2014, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026</i>, Cat. no. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	<p>MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.</p> <p>The indicator was calculated by the Secretariat using numerator data supplied by the Department of Health (Australian Government) and denominator data from the ABS.</p>
Relevance	<p>These measures relate to specific DHS, Medicare services for which claims data are available.</p> <p>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 because the life expectancy of Indigenous people is, on average, relatively low.</p> <p>Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received, and might not be where the service was provided.</p> <p>For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to each age group.</p> <p>Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.</p>
Timeliness	<p>MBS claims data are available within 14 days of the end of a month.</p>
Accuracy	<p>Data include all claims processed up to 12 months after the service is received. Current year data are preliminary and subject to revision in subsequent reports.</p> <p>Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.</p> <p>Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.</p> <p>Clients are counted once only in the reference period.</p> <p>Data do not include:</p> <ul style="list-style-type: none">• health assessment activity for which practitioners do not claim the rebate• services that qualify under the DVA National Treatment Account and services provided in public hospitals <p>Data have not been adjusted to account for known under-identification of Indigenous status in MBS data.</p> <p>Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.</p>
Coherence	<p>The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis. As of 1 May 2010:</p> <ul style="list-style-type: none">• MBS Items 704, 706, 708, 710 (age based Health Assessments for Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715)• MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received.

Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps The Steering Committee notes the following issues:

/issues

- No adjustment was made to this indicator to account for under-identification of Indigenous people in DHS, Medicare data.

Proportion of children receiving a fourth year developmental health check

Data quality information for this indicator has been prepared based on the Steering Committee's 2012 report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Developmental health checks.
Measure/s (computation)	<p>Proportion of children who have received a 4 year old development health check.</p> <p>Numerator: The number of people aged 3, 4 or 5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10 986 (Healthy Kids Check or Health Assessment) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period.</p> <p>Denominator: The population aged 4 years, estimated using ERP data from the ABS. It was calculated by multiplying the 0-4 years ERP disaggregated by Indigenous status by the percentage of children aged 4 years in this age group nationally.</p> <p>Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare Statistics data.</p> <p>Denominator: For total population: 2011 census based Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December derived by averaging the 30 June population at each end of the reference year.</p> <p>For data by Indigenous status: 2011 census based ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 31 December derived by averaging the 30 June population at each end of the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes claims made through the MBS under the <i>Human Services (Medicare) Act 1973</i>. These data are then regularly provided to Australian Government Department of Health.</p> <p>Data for 2009-10 and 2010-11 were calculated by Australian Government Department of Health, using a denominator supplied by the AIHW. Australian Government Department of Health drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) and then further comments were added by the AIHW, in consultation with Australian Government Department of Health.</p> <p>Data from 2011-12 are calculated by the Secretariat using numerator data supplied by Australian Government Department of Health and denominator data sourced from the ABS.</p>
Relevance	<p>The measure relates to specific identified DHS, Medicare services for which DHS, Medicare has processed a claim.</p> <p>The MBS items included in this indicator do not cover all developmental health check activity such as that conducted through state and territory early childhood health assessments in preschools and community health centres.</p>
Timeliness	MBS claims data are available within 14 days of the end of a month. The indicator relates to all claims processed in the reference year.
Accuracy	<p>As with any administrative system a small degree of error may be present in the data captured.</p> <p>Analyses by state/territory are based on postcode of residence of the client as recorded by DHS, Medicare at the date the last service was received in the reference period. This</p>

postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.

Data to 2010-11 are based on the date the claim was processed. From 2011-12, data are based on the date the service was rendered. From 2012 13, data include only services for which rebates were claimed in the reference year. This has minimal impact on the data.

Children who received more than one type of health check are counted once only in the calculations for this indicator. Where a child received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period, the child was counted once against the Aboriginal and Torres Strait Islander health assessment.

From 2011-12, children are counted only if they have not received a fourth year developmental health check in a previous reference period at the age of 3, 4 or 5 years.

MBS data presented for Aboriginal and Torres Strait Islander Peoples Health Assessments have not been adjusted to account for known under identification of Indigenous status.

Cells have been suppressed where the numerator is less than 10 for confidentiality reasons and where rates are highly volatile (for example, the denominator is very small) or data are known to be of insufficient quality (for example, where Indigenous identification rates are low).

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

As of 1 May 2010, the following changes to MBS items occurred:

The Healthy Kids Check Item 709 was replaced with four MBS health assessment items (based on time and complexity) that cover all ages — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). This renders it possible that health assessments for refugees and humanitarian entrants and for people with an intellectual disability (previously claimed under items 714, 718 or 719 and now claimed under the new MBS health assessment items) have been counted. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low for children aged 3–5 years.

A Healthy Kids Check provided by a practice nurse or a registered Aboriginal health worker on behalf of a medical practitioner (previously item 711) was replaced with MBS item number 10 986. The change to the MBS item number does not impact time series analysis.

The Aboriginal and Torres Strait Islander Child Health Check (previously item 708) was replaced by the Aboriginal and Torres Strait Islander People's Health Assessment (715) that has no designated time or complexity requirements and covers all ages. The change to the MBS item number does not impact time series analysis.

Accessibility

Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability

General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data do not include developmental health check activity conducted outside the MBS, for example, in preschools and community health centres. Accordingly, the indicator understates developmental health check activity.
- No adjustment was made to this indicator to account for under-identification of Indigenous children in DHS, Medicare data.

Effectiveness of access to GPs

Measure 1: Bulk billing rates

Data quality information has been developed for this measure by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	<p>Bulk billing rates</p> <p>Definition: The number of non-referred attendances to GPs that were bulk billed as a proportion of all non-referred attendances to GPs.</p> <p>Numerator: The number of non-referred attendances to GPs that were bulk billed.</p> <p>Denominator: The number of non-referred attendances to GPs.</p> <p>Computation: Expressed as a percentage.</p> <p>Disaggregations:</p> <ul style="list-style-type: none">• State/Territory by age• Region by age
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator: Australian Government Department of Human Services (DHS), Medicare data.</p>

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to DoHA.
Relevance	<p>These measures relate to DHS, Medicare services for which claims data are available.</p> <p>Data include non-referred attendances by general practice nurses.</p> <p>Disaggregation by region:</p> <p>From 2012-13, disaggregation by region is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification. For previous years, disaggregation by region is based on the Rural, Remote and Metropolitan Areas (RRMA) classification. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>RRMA categories are: Capital city — State and Territory capital city statistical divisions; Other metropolitan centre — one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre — statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; Small rural centre — SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; Other rural area — all remaining SLAs in the rural zone; Remote centre — SLAs in the remote zone containing populations of 5000 or more; Other remote area — all remaining SLAs in the remote zone.</p>
Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	<p>As with any administrative system a small degree of error may be present in the data captured.</p> <p>Allocation to jurisdiction/region: DHS, Medicare claims data used for statistical purposes</p>

are based on enrolment postcode of the client at time of processing the final claim in the reference period. This postcode may not be current if the client changed address but did not notify DHS, Medicare.

Allocation to age group: Allocation to age group is based on client date of birth in DHS, Medicare records at the date the service was received. Where client age is unknown, attendances are included in totals.

Allocation to reference period: Data include all claims processed in the reference period. Data are based on the date on which the MBS claim was processed by DHS, Medicare, not the date on which the service was rendered. The use of data based on when the claim was processed rather than when the service was rendered produces little difference in the total number of services included in the numerator for the reference period.

Coherence Estimates are compiled the same way across jurisdictions.

Disaggregation by State/Territory:

Rates are derived using the ABS ERP as at 30 June preceding the reference year.

From 2012-13, the ERP is based on the ABS 2011 Census.

For data for 2007-08 to 2011-12, the ERP is based on the ABS 2006 Census.

For data to 2006-07, the ERP is based on the ABS 2001 Census.

Rates derived using ERPs based on different Censuses are not comparable.

Disaggregation by region:

The change in geographical location classification constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- The classification system used to allocate data to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994
- Data are of acceptable accuracy.

Measure 2: People deferring visits to GPs due to financial barriers

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	People deferring access to GPs due to cost. Definition: Proportion of people that required GP treatment but deferred that treatment due to cost. Numerator: People reporting delaying/not seeing a GP in the last 12 months due to cost. Denominator: People aged 15 years or over who needed to see a GP in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p> <p>Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:</p> <ul style="list-style-type: none">• members of the Australian permanent defence forces• diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts• overseas residents in Australia• members of non-Australian defence forces (and their dependents)

- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality — For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95% confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

The standard errors for the key data items in this indicator are relatively low and provide reliable state and territory data as well as remoteness breakdowns. An exception to this would be data for the "other" remoteness category when cross classified by State, which can result in high RSEs. Caution should be used when interpreting these data.

Known Issues: Data were self-reported.

Explanatory footnotes are provided for each table.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data for 2013-14 are comparable to data for 2012-13 but not to data for previous years, due to a change in question ordering in 2012-13 which had a noticeable context effect. As a result, ABS recommends that this data item is not comparable over time. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2013-14 are comparable to data for 2012-13 but not for previous years. Comparable time series data is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.
- Data from the Patient Experience survey are not comparable with data from the 2012-13 NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.

Measure 3: GP Waiting times

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	GP Waiting Times Definition Length of time a patient needs to wait to see a GP for an urgent appointment. Numerator Number of people aged 15 years or over who reported seeing a GP for urgent medical care (for their own health) within specified waiting time categories (less than 4 hours, 4 to less than 24 hours, 24 hours or more). Denominator Number of people aged 15 years or over who saw a GP for urgent medical care (for their own health) in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Patient Experience Survey, ABS.

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
----------------------------------	--

Relevance

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).

Data Completeness: All data are available for this measure from this source.

Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience

Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality:

For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the waiting time category "4 hours or more but within 24 hours" breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Known Issues: Data was self-reported and interpretation of urgent medical care was left up the respondent.

The data is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Explanatory footnotes are provided for each table.

Coherence

Consistency over time: 2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Time series issues: 2013-14 is comparable to 2012-13 and 2011-12, but not before this (ie 2013-14 is not comparable to 2010-11 or 2009). This has been footnoted in the relevant tables. The reason for the comparability issues stem from a significant change in question wording and coding methodology in the 2011-12 Patient Experience Survey for the 'waiting times for GPs' questions, and this has had an impact on the data.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2011-12, 2012-13 and 2013-14 are comparable.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are based on waiting times for self-defined urgent medical care.
- Disaggregation of this measure by Indigenous status is a priority.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Measure 4: Selected potentially avoidable GP-type presentations to emergency departments

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Attendances at public hospital emergency departments that could have potentially been avoided through the provision of appropriate non-hospital services in the community.
Measure/s (computation)	<p>The number of presentations to public hospital emergency departments in hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals), where:</p> <ul style="list-style-type: none">• there was a type of visit of Emergency presentation (or, for SA for 2008-09 and 2009-10, Emergency presentation or Not reported)• a triage category of 4 or 5 was allocated• the patient did not arrive by ambulance or police or correctional vehicle; and• the patient was not admitted to the hospital, was not referred to another hospital, and did not die.
Data source/s	This indicator is calculated using data from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), based on the national minimum data set (NMDS) for Non-admitted patient emergency department care (NAPEDC).

Data Quality Framework Dimensions

Institutional environment The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

- www.aihw.gov.au/nhissc/
- <http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or B (Large hospitals). In 2012–13, hospitals in peer groups A and B provided about 86 per cent of all public hospital emergency presentations.

The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B.

The indicator includes only peer group A (Principal referral and Specialist women's and children's hospitals) and peer group B (Large hospitals).

The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council.

Timeliness

The reference period for these data is 2012-13 and 2013-14.

Accuracy

For 2012–13, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2013-14, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100 per cent for public hospitals in peer groups A and B although final coverage cannot be calculated until the 2013-14 National Public Hospital Establishments Database (NPHEd) data are available.

In the baseline year (2007-08), the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008-09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania.

From 2009-10, the data for the Albury Base Hospital (previously reported in New South Wales hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for New South Wales and Victoria.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence

The data reported for 2012-13 and 2013-14 are consistent with data reported for the NNAPEDCD for previous years for individual hospitals.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the NPHEd for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator is calculated using the same methodology as data published in Australian hospital statistics: emergency department care (report series) and the National healthcare agreement: performance report 2012-13.

However, 2012-13 data reported previously in these publications are different from the equivalent data published here because the hospitals classified as peer groups A and B were based on 2011-12, rather than 2012-13 peer groups.

Caution should be used in comparing these data with earlier years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Accessibility The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: Australian hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at www.aihw.gov.au/hospitals/.

Interpretability Metadata information for the NAPEDC NMDS and the NAPEDC DSS are published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the 2012-13 NNAPEDCD can be accessed on the AIHW website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/546749>

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals). Most of the hospitals in peer groups A and B are in major cities. Therefore, disaggregation by remoteness, socioeconomic status and Indigenous status should be interpreted with caution.
- For 2012-13, the coverage of the NNAPEDCD collection is complete for public hospitals in peer groups A and B. It is estimated that 2013-14 has similar coverage, although final coverage cannot be calculated until the 2013-14 NPHEd data are available.
- The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council, to be completed by the end of 2013.
- Caution should be used in comparing these data with earlier years as the number of hospitals classified as peer group A or B, and the peer group classification for a hospital, may vary over time.

Financial barriers to PBS medicines

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	
Measure/s (computation)	<p>People deferring purchase of prescribed medicines due to cost.</p> <p>Definition: Proportion of people that deferred purchase of prescribed medicines due to cost.</p> <p>Numerator: Number of people who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost.</p> <p>Denominator: Total number of people aged 15 years or over who received a prescription for medication from a GP in the last 12 months.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p>

**Relevance
(cont.)**

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEX included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEX sample only and estimates obtained using the combined MPHS PEX and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEX interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEX was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30,749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality:

For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the waiting time category "4 hours or more but within 24 hours" breakdowns are mostly greater than 25% and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Known Issues: Data was self-reported and interpretation of urgent medical care was left up the respondent.

The data is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Explanatory footnotes are provided for each table.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data for 2013-14 are comparable to data for 2012-13, 2011-12 and 2010-11, but not before this (ie not comparable to 2009). This is due to changes in question wording/sequencing in the patient experience survey. As a result, a time series can be started from 2010-11 onwards. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Public dentistry waiting times

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Public dentistry waiting times.
Measure/s (computation)	<p>Definition Waiting time between being placed on a public dentistry waiting list and being seen by a dental professional.</p> <p>Numerator: Number of people aged 15 years or over on a public dental waiting list who reported seeing a dental professional at a government dental clinic or, from 2013-14, attending a private dental clinic for a public dental service (for their own health) within specified waiting time categories (less than 1 month, 1 month or more).</p> <p>Denominator: Number of people aged 15 years or over who were on a public dentistry waiting list (for their own health) in the last 12 months.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on public dentistry waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p> <p>Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:</p> <ul style="list-style-type: none">• members of the Australian permanent defence forces• diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts• overseas residents in Australia

- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEX included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEX sample only and estimates obtained using the combined MPHS PEX and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEX interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEX was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEX and HSS were weighted separately and then combined to produce output.

Confidentiality:

For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

RSEs for this indicator are often greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Specifically, data for the "less than one month" waiting time category have high RSEs and should be used with caution.

Known Issues: This indicator may not cover those who saw a public dental professional but were not placed on a public dental waiting list.

Explanatory footnotes are provided for each table.

Coherence

Consistency over time: Data are not comparable over time, due to significant changes in question wording and sequencing in both the 2012-13 and 2013-14 surveys.

- In 2011-12, respondents were:
 - limited to those whose most recent dental visit was to a government clinic
 - instructed to exclude treatment for urgent dental care.
- From 2012-13:
 - treatment for urgent dental care was not excluded
 - respondents included all people who needed to see a dental professional
- In 2013-14, respondents:
 - were asked for the first time to include public dental services provided at a private dental clinic.

As a result, time series comparisons are not possible. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data publicly available. Tables showing waiting times for dental professionals are available in *Patient Experiences in Australia: Summary of Findings, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

The dental data available in 4839.0 are shown by SEIFA, remoteness, country of birth, self-assessed health status and whether has a long term health condition. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period and therefore should minimise any seasonality effects in the data.

Other Supporting information: The ABS Patient Experience data are published in Patient Experiences in Australia: Summary of Findings,

2011-12 and 2012-13 (Cat. no. 4839.0). This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in that publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2013-14 are not comparable with data for prior years due to changes in question wording and sequencing in the 2013-14 survey. Comparable time series data is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data from the Patient Experience survey are not comparable with data from the AATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

GPs with vocational registration

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Appropriateness
Indicator	GPs with vocational registration
Measure/s (computation)	<p>The proportion of general practitioners (GPs) with vocational registration.</p> <p>Definition: The number of Full-time Workload Equivalent (FWE) vocationally registered GPs divided by the number of FWE GPs and Other medical practitioners (OMP).</p> <p>Numerator: Number of FWE vocationally registered GPs.</p> <p>Denominator: Number of FWE vocationally registered GPs and OMPs.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p> <p>Disaggregations:</p> <ul style="list-style-type: none">• State/Territory• Region
Data source/s	Australian Government Department of Human Services (DHS), Medicare data.

Data Quality Framework Dimensions

Institutional environment	MBS data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to the Department of Health.
Relevance	<p>Data capture all vocationally registered GPs and OMPs.</p> <p>A vocationally registered GP is a medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwth), holds Fellowship of the RACGP, ACCRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances.</p> <p>An OMP is a medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances.</p> <p>Allocation of FWE GPs and OMPs to state or territory and region is based on the practice location at which services were rendered within the reference period.</p> <p>Disaggregation by region:</p> <p>From 2012-13, disaggregation by region is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification. For previous years, disaggregation by region is based on the Rural, Remote and Metropolitan Areas (RRMA) classification. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>RRMA categories are: Capital city — State and Territory capital city statistical divisions; Other metropolitan centre — one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre — statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; Small rural centre — SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; Other rural area — all remaining SLAs in the rural zone; Remote centre — SLAs in the remote zone containing populations of 5000 or more; Other remote area — all remaining SLAs in the remote zone. FWE is a standardised measure adjusted for the partial contribution of casual and part-time doctors and is a reliable estimate of the GP workforce. FWE is calculated by dividing</p>

	each doctor's DHS, Medicare billing by the average billing of full time doctors for the reference period.
Timeliness	GP FWE figures are available 10 weeks after the close of the reference period.
Accuracy	As with any administrative system a small degree of error may be present in the data captured.
Coherence	Estimates are compiled the same way across jurisdictions. For data by region, there is a break in time series between 2011-12 and 2012-13 due to the change in geographical location classification. Data from 2012-13 are not comparable with data for previous years.
Accessibility	Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The classification system used to allocate GPs to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994.
------------------------------	--

Management of upper respiratory tract infections

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Management of upper respiratory tract infections
Measure/s (computation)	<p>Definition: 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.</p> <p>Numerator: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed.</p> <p>Denominator: ERP</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>
Data source/s	<p>Numerator: Australian Government Department of Health Pharmaceutical Benefits Scheme (PBS) Statistics data.</p> <p>Denominator: ABS preliminary ERP based on the 2011 Census at 31 December in the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by Australian Government Department of Health and administered by the Department of Human Services (DHS), Medicare. Provisions governing the operation of the PBS are contained in the National Health Act 1953.</p> <p>The indicator was calculated by the Secretariat using the numerator data supplied by Australian Government Department of Health and ABS ERP.</p>
Relevance	<p>These measures relate to PBS subsidised oral antibiotics used most commonly in treating URTI: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names that were ordered by GPs and dispensed to patients were extracted for each reference period.</p> <p>These antibiotics are used to treat a range of conditions in addition to URTI. Data disaggregated by the condition being treated are not available. The proportion of these antibiotics prescribed for treatment of URTI is unknown.</p> <p>Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.</p>
Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	<p>PBS data from 2012-13 are complete. For previous years, PBS data for general patients was available only for items priced above the PBS general co payment (\$35.40 in 2012) and therefore, the majority of script data for these patients was missing.</p> <p>Data include only prescriptions provided by GPs and OMPs.</p>
Coherence	Data from 2012-13 are not comparable to data for previous years which were available only for concession card holders.
Accessibility	PBS Claims data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp .
Interpretability	Information on PBS data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp at the PBS item reports and PBS group reports links.

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• URTI is one of a range of conditions for which these antibiotics are prescribed. Data
------------------------------	---

-
- are not able to be disaggregated by condition.
- The availability of complete data on the selected antibiotics dispensed in the general population significantly improves data quality from 2012-13.

Chronic disease management

Management of diabetes — HbA1c level

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Chronic disease management
Measure/s (computation)	<p>Management of diabetes — HbA1c.</p> <p>Numerator: Number of people aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test, who have an HbA1c level of less than or equal to 7.0 per cent.</p> <p>Denominator: Number of persons aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	<p>For the 2014 reporting cycle, the denominator and numerator for this indicator use data from the 2011–12 National Health Measures Survey (NHMS) component of the Australian Bureau Statistics (ABS) Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope population derived from ERP.</p> <p>For information on scope and coverage, see the <i>Australian Health Survey: Users' Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The 2011–12 NHMS was collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.</p>
Relevance	<p>For this measure, the fasting plasma glucose test is used in the determination of people with known diabetes and the HbA1c test is used in the determination of effective management of diabetes.</p> <p>The 2011-12 NHMS uses a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of known diabetes.</p> <p>A respondent to the survey is considered to have known diabetes if they had ever been told by a doctor or nurse that they have diabetes and:</p> <ul style="list-style-type: none">• they were taking diabetes medication (either insulin or tablets) <p>or</p> <ul style="list-style-type: none">• their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L. <p>Persons with known diabetes who have an HbA1c result of less than or equal to 7.0 per cent are considered to be managing their diabetes effectively.</p> <p>The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.</p>

Timeliness The NHMS was conducted for the first time in 2011–13. Results from the 2011-12 NHMS were released in August 2013.

Accuracy The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.

All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 38 per cent went on to complete the biomedical component.

Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005).

In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.

As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

This indicator produces high levels of sampling error for some States and Territories when split by sex. Estimates for males and females in Victoria have RSEs greater than 50 per cent and should be considered unreliable for general use. Likewise, estimates for males in the Northern Territory and females in the Australian Capital Territory also have RSEs greater than 50 per cent.

Data for several State and Territories also have RSEs greater than 25 per cent, including the total for Victoria, SA, the ACT and the NT, and these estimates should be used with caution.

Coherence The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes management.

The 2009-10 Victorian Health Monitor (VHM) reported estimates of diabetes management based on the proportion of people with known diabetes meeting the HbA1c management target of less than or equal to 7.0 nmol/L. The VHM age-standardised rate (39 per cent) was similar to the NHMS rate for Victoria (36 per cent).

Accessibility See *Australian Health Survey: Biomedical Results for Chronic Disease* (Cat. no. 4364.0.55.005). Other information from this survey is also available on request.

Interpretability Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website.

Many health-related issues, including diabetes, are closely associated with age. However, numbers across age ranges were too few to do any meaningful age standardisation at the State/Territory level for this measure. Therefore the data presented are based on crude rates.

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data by Indigenous status are not available for this measure.

-
- The 2011-12 National Health Measures Survey (NHMS) was conducted for the first time as part of the 2011–13 Australian Health Survey (AHS), with participation voluntary in the NHMS. Of those who took part in the AHS, 38 per cent took part in the NHMS. The NHMS sample was found to be representative of the AHS population.
 - The NHMS does not include people living in very remote areas, which affects the comparability of the NT results.

Measure 2: Management of asthma

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Chronic disease management
Measure/s (computation)	Management of asthma Definition <ul style="list-style-type: none">• Proportion of people with asthma who have a written asthma action plan. Numerator: <ul style="list-style-type: none">• Estimated number of people with asthma with a written asthma action plan. Denominator: Estimated number of people with asthma. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Data reported for 2011–13 are from the ABS 2011–13 Australian Health Survey (AHS) (2011-12 National Health Survey (NHS) component) and the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (NATSIHS component). Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS. NHS data are weighted to benchmarks for the total NHS in-scope population, derived from the ERP. For information on NHS scope and coverage, see <i>ABS Australian Health Survey: Users' Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au . NATSIHS data are benchmarked to the estimated population of Aboriginal and Torres Strait Islander Australians (adjusted for the scope of the survey).

Data Quality Framework Dimensions

Institutional environment	The NHS and NATSIHS are collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.
----------------------------------	--

Relevance

The NHS 2011-12 and 2007-08 asked all respondents whether they had ever been told by a doctor or nurse that they have asthma, whether symptoms were present or they had taken treatment in the 12 months prior to interview, and whether they still had asthma. Those who answered yes to these questions were asked whether they had “a written asthma action plan, that is, written instructions of what to do if your asthma is worse or out of control”. A very small number of respondents who were sequenced around these questions may have reported current long-term asthma in response to later general questions about medical conditions. These people are included in and contribute to estimates of the prevalence of asthma, but information about written action plans was not collected from them.

In the 2012-13 NATSIHS, non-remote respondents who reported they have been told by a doctor that they have asthma, and who still get asthma or have had symptoms of asthma in the last 12 months were asked about written asthma action plans. In the 2004-05 NATSIHS, non-remote respondents who answered questions about having asthma ‘yes’ were asked about written asthma action plans.

In both the 2004-05 NHS and NATSIHS, respondents were asked if they had “a written asthma action plan”. If they queried the interviewer about what to include, they were told to include management plans developed in consultation with a doctor, cards associated with peak flow meters and medication cards distributed through chemists. In 2007, if they queried the interviewer, respondents were asked to include plans that were worked out in consultation with a doctor, but not cards associated with peak flow meters or medications cards handed out by chemists.

Ideally this indicator would relate to the proportion of people with moderate to severe asthma, as people with only very mild asthma are unlikely to require planned care. Consequently, there is no clear direction of improvement in this indicator: a lower proportion of people with asthma with an asthma care plan may simply mean that those people with asthma have less severe asthma (which would actually be a positive outcome).

Timeliness

The NHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

The NATSIHS is conducted every six years. Results from the 2012-13 survey were released in November 2013.

Accuracy

The NHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of people usually resident in very remote areas has a small impact on estimates, except for the Northern Territory, where such people make up approximately 23 per cent of the population. Results are weighted to account for non-response.

The response rate for the 2011-12 NHS was 85 per cent and for the 2007-08 NHS was 91 per cent.

The NATSIHS is conducted in all States and Territories and includes remote and non-remote areas. The 2012-13 sample was 9317 people/5371 households, with a response rate of 80 per cent. The 2004-05 sample was 10 000 people/5200 households, with a response rate of 81 per cent of households. Results are weighted to account for non-response.

As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

Coherence

Questions used in the 2011-12 and 2007-08 NHS to collect data for this indicator are consistent with the questions recommended for use by the Australian Centre for Asthma Monitoring (ACAM). Data for 2011-12 and 2007-08 are comparable over time (except for the Northern Territory) but are not comparable to data from the 2004-05 survey due to better alignment of questions and concepts with the ACAM recommendations since 2004-05.

Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size in 2011-12.

The NHS and NATSIHS collect a range of other health-related information (for example, information on smoking) that can be analysed in conjunction with data on asthma and asthma plans.

Accessibility See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

See *Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001) for an overview of results from the 2012-13 NATSIHS. Other information from the survey is available on request.

Interpretability Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide* on the ABS website.

Many health-related issues are closely associated with age, therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories and the Indigenous and non-Indigenous population. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of asthmatics who have an asthma management plan. However, there is no information about the severity of the condition and people with mild asthma are unlikely to require a written plan.
- NATSIHS data are only collected every six years. An assessment of the relative speed of change in outcomes is required to determine whether more regular data collection is necessary.
- The NHS does not include people living in very remote areas which affects the comparability of the NT results.

Use of pathology tests and diagnostic imaging

Data quality information has been developed for this measure by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Use of pathology tests and diagnostic imaging
Measure 1	<p>MBS items rebated through Department of Human Services (DHS), Medicare for pathology tests requested by general practitioners (GP), and Other Medical Practitioners (OMP), per person (age-standardised)</p> <p>Definition: The number of MBS items rebated through DHS, Medicare for pathology tests requested by specialist GPs and OMPs, per person (age standardised)</p> <p>Numerator: The number of MBS items rebated through DHS, Medicare for pathology tests requested by GPs and OMPs</p> <p>Denominator: Estimated Resident Population (ERP)</p> <p>Computation: Numerator ÷ Denominator, age-standardised</p>
Measure 2	<p>Diagnostic imaging services provided on referral from specialist GPs and OMPs and rebated through DHS, Medicare, per person (age standardised)</p> <p>Definition: The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs, per person (age standardised)</p> <p>Numerator: The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs</p> <p>Denominator: Estimated Resident Population (ERP)</p> <p>Computation: Numerator ÷ Denominator, age-standardised</p>
Measure 3	<p>DHS, Medicare benefits paid per person for pathology tests requested by GPs and OMPs (age-standardised).</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) to provide real expenditure, comparable over time.</p>
Measure 4	<p>DHS, Medicare benefits paid per person for diagnostic imaging referred by GPs and OMPs (age-standardised).</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) to provide real expenditure, comparable over time.</p>
Data source/s	<p>Numerator:</p> <ul style="list-style-type: none">• For MBS data: DHS, Medicare data.• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <p>Denominator: ABS ERP. For reference periods prior to and including 2009-10, ERP as at 30 June, based on the 2006 Census. From the 2010-11 reference year ABS ERP as at 31 December, based on the 2011 Census.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes and collects MBS data for:</p> <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to Australian Government Department of Health.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i>
----------------------------------	---

	<p>and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.</p> <p>MBS claims data are an administrative by-product of DHS, Medicare's fee for-service payment systems.</p> <p>For reference periods to 2009-10, Australian Government Department of Health provided raw data and rates inclusive of DVA data.</p> <p>From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.</p>
Relevance	<p>The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:</p> <ul style="list-style-type: none"> • Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'. • Diagnostic imaging services — all items in BTOS 'G'. <p>Claims are allocated to state/territory based on location at which the service was rendered.</p> <p>Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.</p>
Timeliness	<p>Data include all claims processed in the reference period.</p>
Accuracy	<p>Data are limited to claims for services requested/referred by GPs and, for MBS data, OMPs (DVA data include only services requested/referred by specialist GPs). Data do not include claims for services requested/referred by other medical specialists.</p> <p>Data include all claims processed in the reference period.</p> <p><u>Pathology tests</u></p> <p>The pathology episode cone applies to services requested by general practitioners for non-hospitalised patients:</p> <p>when more than three MBS pathology items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for three items — those with the highest schedule fees (there are some items exempted from the episode cone). Where additional tests performed in a patient episode are not rebated through DHS, Medicare, they are not included in the data. This results in some underreporting of the number of pathology tests conducted on request by GPs and OMPs.</p> <p>Data include Patient Episode Initiated Items.</p> <p><u>Diagnostic imaging</u></p> <p>Diagnostic imaging services provided and rebated through DHS, Medicare can differ from the services requested by GPs and OMPs.</p> <p>In certain circumstances, as defined by legislation, a radiologist can identify the need for, and perform, more or different diagnostic imaging services than are requested by a GP/OMP. The data reflect the services provided and rebated through DHS, Medicare, rather than the services requested by GPs/OMPs.</p>
Coherence	<p>Rates from 2012-13 are age-standardised to the 2001 Australian Standard Population. These data are not comparable to crude rates reported for previous years.</p> <p>Data were computed by Australian Government Department of Health for this indicator for reference years prior to and including 2009-10, using the 2006 Census based ERP as at 30 June preceding the reference year.</p> <p>From 2010-11, data are computed by the Secretariat from numerator data obtained separately from Australian Government Department of Health and the DVA, using the ERP as at 31 December based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.</p>
Accessibility	<p>Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.</p> <p>DVA data are not publically accessible.</p>
Interpretability	<p>General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1</p>

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Age-standardisation of rates from 2012-13 is a significant improvement. However, rates are not comparable with crude rates reported for previous years.
- This is a proxy measure — data are limited to those services rebated through DHS, Medicare that were provided in response to request/referral by GPs/OMPs.
- Provides information about relative requests/referrals for pathology tests and diagnostic imaging across jurisdictions and over time, but not the appropriateness thereof.

Patient satisfaction

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Quality — responsiveness
Indicator	Patient satisfaction/experience around key aspects of care they received.
Measure/s (computation)	<p>Measure a: people who saw a GP in the last 12 months reporting the GP always or often: listened carefully, showed respect, and spent enough time with them</p> <p>Definition: Proportion of people satisfied with selected aspects of GP/dentist care.</p> <p>Numerator: People who saw a GP/dentist in the last 12 months reporting the GP/dentist always or often: listened carefully; showed respect; spent enough time with them.</p> <p>Denominator: People who saw a GP/dentist for their own health in the last 12 months, excluding people who were interviewed by proxy.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p>

**Relevance
(cont.)**

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13 and 28 November 2014 for 2013-14.

Referenced Period: July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (the majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77 per cent (27 327 fully responding persons) while the response rate to HSS was 83 per cent (8541 fully responding persons) resulting in a total sample size of 35 868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30 749. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Confidentiality — For the first time in 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying

individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for remote/very remote breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

The data for this indicator is attitudinal, as it collects whether people felt they waited too long to get an appointment with a GP, and whether the person felt the health professional in question spent enough time with them, listened carefully and showed them respect (the 'patient satisfaction' questions).

Data is used from personal interviews only (i.e. excluding proxy interviews).

Explanatory footnotes are provided for each table.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data are comparable over time.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13 and 2013-14* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2013-14 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2013-14* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis**Key data gaps
/issues**

The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the 2012-13 NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Health assessments for older people

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Quality — Continuity
Indicator	Health assessments for older people
Measure/s (computation)	<p>Definition: The proportion of older people who received a health assessment.</p> <p>Numerator: The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of Indigenous people aged 55 years or over with an MBS claim for Items 704, 706 (Health assessment for older Aboriginal and Torres Strait Islander People) or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>Denominator: The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator – computed by the Secretariat using Australian Bureau of Statistics (ABS) 2011 Census based ERP:</p> <ul style="list-style-type: none">• ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.• ABS 2014, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026</i>, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	<p>MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.</p> <p>The indicator was calculated by the Secretariat using the numerator data supplied by Australian Government Department of Health and denominator data sourced from the ABS.</p>
Relevance	<p>These measures relate to specific DHS, Medicare services for which claims data are available.</p> <p>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 because the life expectancy of Indigenous people is, on average, relatively low.</p> <p>Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received.</p> <p>For services provided from 1 May 2010, age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to health assessments for older people and health assessments for older Indigenous people.</p> <p>Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.</p> <p>In the NT, MBS statistics do not necessarily fully reflect services supplied to Indigenous people as the claim rate is low due to a smaller number of GPs in remote areas.</p>

Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	<p>Data include only the services for which claims were processed in the reference year. This is not expected to significantly affect the data.</p> <p>Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.</p> <p>Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.</p> <p>Clients are counted once only in the reference period.</p> <p>Data do not include:</p> <ul style="list-style-type: none"> • health assessment activity where practitioners do not claim the rebate • services that qualify under the DVA National Treatment Account and services provided in public hospitals • people living in residential aged care facilities. <p>Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.</p>
Coherence	<p>The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis.</p> <p>As of 1 May 2010:</p> <ul style="list-style-type: none"> • MBS Items 704 and 706 (Health Assessments for older Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715) • MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). <p>For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received.</p> <p>Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.</p>
Accessibility	Information is available for MBS Claims data at www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
Interpretability	DHS, Medicare claims statistics are available at ww.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
<u>Data Gaps/Issues Analysis</u>	
Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data are of acceptable accuracy.

Cost to government of general practice per person

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost to government of general practice per person
Measure/s (computation)	Government Expenditure on GPs per person Definition: Cost to government of general practice per person in the population Numerator: Nominal expenditure on services rendered by GPs and OMPs. Denominator: Estimated Resident Population (ERP). Computation: Numerator ÷ Denominator, directly age-standardised from 2012-13; crude rates for previous years. Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) to provide real expenditure, comparable over time.
Data source/s	Numerator: <ul style="list-style-type: none">• For MBS data: Department of Human Services (DHS), Medicare data sourced by the Australian Government Department of Health• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December.

Data Quality Framework Dimensions

Institutional environment	DHS, Medicare processes and collects MBS data for: <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to Australian Government Department of Health.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA. MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems.
Relevance	The measure relates to: <ul style="list-style-type: none">• services provided by GPs and, for MBS data, OMPs (DVA data include only services provided by specialist GPs) for which DHS, Medicare has processed a claim. Claims allocated to state/territory based on location at which service rendered. Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through 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. From 2012-13, data exclude expenditure on services provided under the Practice incentive program (PIP), Medicare Locals and the General Practice Immunisation Incentive Scheme (GPiI) as these data cannot be subjected to age-standardisation.
Timeliness	Data include all claims processed in the reference period.
Accuracy	From 2012-13, DHS, Medicare data include claimed services by GPs and OMPs as well as by practice nurses or registered Aboriginal health workers for and on behalf of the

	GMP/OMP. For previous years, DHS, Medicare data also include services rendered under PIP, DGPP and GPII. DVA data are limited to claims for services provided by specialist GPs.
	Data include all claims processed in the reference period.
Coherence	Age-standardised rates reported from 2012-13 are not comparable with crude rates reported for previous years due to the effect of age standardisation and the exclusion of services rendered under PIP, DGPP and GPII from age standardised rates.
	Nominal State and Territory total expenditure data were computed by Australian Government Department of Health for the reference periods 2006-07 to 2009-10. From the 2010-11 reference period, DHS, Medicare and DVA nominal expenditure data are provided separately to and compiled by the Secretariat. These changes are expected to have negligible impact on the data.
	Expenditure per person data computed by the Secretariat using the 2011 Census-based ERP as at 31 December for all reference periods.
Accessibility	Information is available for MBS Claims data at www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
	DVA data are not publically accessible.
Interpretability	DHS, Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through 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.
------------------------------	--

Child immunisation coverage

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Child immunisation coverage.
Measure/s (computation)	<p>Proportion of children who are fully vaccinated at the age of:</p> <ul style="list-style-type: none">• 12 months to less than 15 months• 24 months to less than 27 months• 60 months to less than 63 months. <p>Definition: Proportion of children who are fully vaccinated at the specified ages.</p> <p>Numerator: children who turned 1, 2 and 5 years of age in the reference year who were recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) in the reference year.</p> <p>Denominator: number of children who turned 1, 2 and 5 years in the reference year registered on ACIR.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 children aged 1, 2 and 5 years.</p>
Data source/s	The Australian Childhood Immunisation Register (ACIR).

Data Quality Framework Dimensions

Institutional environment	<p>The ACIR is administered and operated by Australian Government Department of Human Services (DHS), Medicare. DHS, Medicare provides Australian Government Department of Health with quarterly coverage reports at the national and state level.</p> <p>Immunisations are notified to DHS, Medicare by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments.</p> <p>For information on the institutional environment of the ACIR, including the legislative obligations of the ACIR, financing and governance arrangements, and mechanisms for scrutiny of ACIR operations, please see www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.</p> <p>The tables for this indicator were prepared by DHS, Medicare and quality assessed by Australian Government Department of Health. Australian Government Department of Health drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies).</p>
Relevance	<p>The ACIR records details of vaccinations given to children under seven years of age who live in Australia.</p> <p>Children assessed as fully immunised at one year of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and, from the quarter ending 31 December 2013, pneumococcal.</p> <p>Children assessed as fully immunised at two years of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and measles, mumps and rubella.</p> <p>A child is assessed as fully immunised at five years of age if they have received immunisations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.</p> <p>There are possible gaps in coverage due to unknown vaccination status of children less than 5 years migrating to Australia. The extent of this is not currently quantifiable.</p> <p>The analyses by state/territory are based on postcode of residence of the child as recorded on ACIR.</p>

Timeliness	ACIR data are reported quarterly. Data are processed on 30 June in the reference year as a minimum 3-month lag period is allowed for late notification of immunisations to ACIR.
Accuracy	<p>Vaccination coverage rates calculated using ACIR data are believed to underestimate actual vaccination rates because of under-reporting by immunisation providers. However, the extent of any under-reporting has not been estimated.</p> <p>Provider notification payments and links to family assistance payments for parents have helped minimise under-reporting by providing a financial incentive for parents to vaccinate their children and for providers to notify the ACIR.</p> <p>The data contains minimal if any duplication of immunisations, as children are identified via their DHS, Medicare number. Approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.</p> <p>The ACIR covers virtually all children, particularly because participation in the ACIR is via an 'opt-out' arrangement.</p>
Coherence	The definitions of numerators and denominators have been consistent since the inception of the ACIR in 1996.
Accessibility	<p>Information contained in the indicator for disaggregation by Indigenous status and remoteness are not publicly accessible. Current total percentage and total numbers can be viewed on the DHS, Medicare web site.</p> <p>DHS, Medicare publishes current immunisation coverage from the ACIR on its website, www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp. Authorised immunisation providers can access detailed reports via a secured area of the DHS, Medicare web site.</p> <p>Immunisation coverage data derived from the ACIR have been reported in Communicable Disease Intelligence since early 1998. Data for 3 key milestone ages (12 months, 24 months and 5 years [6 years prior to 2008]), nationally and by jurisdiction are published quarterly.</p>
Interpretability	<p>Further information on the ACIR can be found at www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.</p> <p>Information on the National Immunisation Program and vaccinations can be found at www.immunise.health.gov.au.</p>

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The data used to calculate this indicator are from an administrative data collection — the Australian Childhood Immunisation Register (ACIR) —for which there is an incentive payment for notification, and there are further incentives for parents to have their child's vaccination status up to date. The Register is linked to the DHS, Medicare enrolment register, and approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age. • Data have been reported using the program definition of fully immunised for children aged 12 to 15 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and, from 2013-14, pneumococcal disease. • Data have been reported using the program definition of fully immunised for children aged 24 to 27 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b, and measles, mumps, and rubella. • Data have been reported using the program definition of fully immunised for children aged 60 to 63 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. • From 31 December 2014, reporting of vaccination coverage will be amended to include meningococcal C and varicella in the 24 to < 27 month cohort. • From 31 December 2017, reporting of vaccination coverage will be amended to remove the assessment of MMR in the 60 to < 63 month cohort. • Given these changes, trends in vaccination coverage rates over time need to be interpreted carefully.
------------------------------	---

Notifications of selected childhood diseases

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Notifications of selected childhood diseases.
Measure/s (computation)	<p>Measures:</p> <ul style="list-style-type: none">• Notifications of measles for children aged 0–14 years• Notifications of whooping cough (pertussis) for children aged 0–14 years• Notifications of invasive Haemophilus influenzae type b (Hib) for children aged 0–14 years <p>Definition: Number of notifications reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years by date of diagnosis, per 100 000 children aged 0–14 years for:</p> <ul style="list-style-type: none">• measles• whooping cough (pertussis)• invasive Haemophilus influenzae type b (Hib). <p>Numerator: number of notifications reported to the NNDSS for children aged 0–14 years in the reference period.</p> <p>Denominator: estimated resident population of children aged 0–14 years at 31 December in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 000 children aged 0–14 years.</p>
Data source/s	<p>Numerator: The National Notifiable Diseases Surveillance System (NNDSS)</p> <p>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 31 December in the reference period (ABS Australian Demographic Statistics (various years), Cat. no. 3101.0).</p>

Data Quality Framework Dimensions

Institutional environment	<p>The NNDSS is administered and operated by the Department of Health.</p> <p>Notifiable diseases are notified to the relevant State/Territory government health departments by clinicians and laboratories under jurisdictional public health legislation. The Department of Health receives data for these notifiable diseases under the National Health Security Act 2007.</p> <p>For information on the institutional environment of the NNDSS, including the legislative obligations of the NNDSS, financing and governance arrangements, and mechanisms for scrutiny of NNDSS operations, please see www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi2903q.htm.</p>
Relevance	<p>Nationally notifiable diseases require notification of the relevant State/Territory health authority upon diagnosis. Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions. State/Territory health authorities notify the NNDSS of notified cases.</p> <p>Allocation to State/Territory is by postcode of residence of the case as provided by the notifying doctor or laboratory.</p>
Timeliness	<p>State/Territory health authorities notify data to the NNDSS on a daily basis. Data include all notifications for the selected diseases for each reference period (financial year).</p>
Accuracy	<p>Measles and invasive Hib</p> <p>The 'notified fraction' represents the proportion of total cases for which notification is made. This is expected to be high for measles and invasive Hib as it is uncommon for either disease to go undiagnosed, due to the often severe presentations of the disease.</p>

Comprehensive follow up of the contacts of all cases also enables identification of cases.

Pertussis (whooping cough)

The notified fraction for whooping cough is likely to be only a proportion of the total number of cases that occur, as identification of pertussis is limited by patient and physician awareness, testing practices and in some cases, the united sensitivity of diagnostics tests. Pertussis is generally believed to be significantly under-diagnosed.

ERPs to 31 December 2010 are the ABS' final 2011 Census rebased ERPs. ERPs from 31 December 2011 are ABS first preliminary estimates based on the 2011 Census.

Data for the number of notifications are suppressed for confidentiality reasons where the number of notifications was less than 3.

Data for notification rates are suppressed where there were less than 5 notifications.

Coherence

Data are reported for each financial year in the period 2006-07 to 2012-13.

Changes in surveillance and testing methods over time and by jurisdiction may make comparisons both over time and across jurisdictions difficult. Changes in the national case definition criteria for establishing a case may affect the coherence of the data over time. The current NNDSS case definition, including historical edits, can be found at www.health.gov.au/casedefinitions.

Accessibility

The Department of Health publishes aggregated levels of data from the NNDSS on its website www9.health.gov.au/cda/source/cda-index.cfm. Data are updated on a daily basis.

Interpretability

The current NNDSS case definitions, including edits, can be found at www.health.gov.au/internet/main/publishing.nsf/Content/cdna-casedefinitions.htm.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Whooping cough notifications may undercount the actual number of cases that occur as diagnosis cannot always be confirmed using currently available diagnostic tools.

Participation rates for women in cervical screening

Data quality information for this indicator has been drafted by the AIHW, with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Participation rates for women in cervical screening.
Measure/s (computation)	<p>Definition:</p> <p>This indicator presents the number of women within the national target age group (20–69 years) screened in a 2 year period as a proportion of the eligible female population and age standardised to the Australian standard population at 30 June 2001.</p> <p>The eligible female population is the average of the Australian Bureau of Statistics (ABS) estimated resident female population for the 2 year reporting period. This population is adjusted for the estimated proportion of women who have had a hysterectomy using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p> <p>Numerator: Total number of women aged 20–69 years who were screened in the 2 year period.</p> <p>Denominator: Average number of women aged 20–69 years in the same 2 year period, adjusted using national hysterectomy fractions to exclude the estimated number of women who have had a hysterectomy.</p> <p>Computation/s: $100 \times (\text{Numerator} \div \text{Denominator})$ and age-standardised to the Australian population at 30 June 2001.</p>
Data source/s	<p>Numerator: State and territory cervical cytology registers.</p> <p>Denominator: ABS estimated resident population 2011 Census based (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The National Cervical Screening Program (NCSP) is a joint program of the Australian Government and State and Territory governments. The target age group is women aged 20–69 years.</p> <p>Cervical cytology registries in each state and territory are maintained by jurisdictional Program managers. Data are supplied to the registries from pathology laboratories. Data from cervical cytology registers are provided to the Australian Institute of Health and Welfare (AIHW) annually in an aggregated format.</p> <p>The NCSP is monitored annually. Results are compiled and reported at the national level by the AIHW in an annual Cervical screening in Australia report.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio. It is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website (www.aihw.gov.au).</p>
Relevance	<p>The data used to calculate this indicator are accurate and of high quality. The cervical cytology registers collect information on all Pap tests undertaken in Australia except where women advise the clinician they do not wish to have their data collected. The use of ERP based on Census data for denominators provide the most comprehensive data coverage possible. The data are entirely appropriate for this indicator.</p> <p>For participation by state and territory, the numerator is the number of women aged 20–69 years screened in each state and territory in the reference period, except for Victoria and the ACT where data are for residents (and some immediate border residents) of the jurisdiction only. Data are supplied as aggregated data by each state and territory. The denominator is the average of the ABS ERP for women aged 20–69 years in each State</p>

and Territory, adjusted to exclude the estimated number of women who have had a hysterectomy, using national hysterectomy fractions.

Caution is required when examining differences across states and territories of Australia due to the substantial differences in population, area, geographic structure, policies and other factors.

Timeliness The most recent data available for the 2015 RoGS report are based on the two-year calendar period 1 January 2012 to 31 December 2013. Data are presented as a rate for the two-year period to reflect the recommended screening interval.

Accuracy This indicator is calculated on data that have been supplied to the AIHW by individual state and territory registers. Prior to publication, the results of analyses are referred back to states and territories for checking and clearance. Any errors found by states and territories are corrected once confirmed. Thus participation by state and territory, based on the state or territory in which the woman was screened, is both robust and readily verified.

Women who opt off the cervical cytology register are not included in the participation data, but this is thought to only exclude around 1 per cent of all women screened.

Coherence Some of these data are published annually in Program monitoring reports prepared by the AIHW and are consistent across reports published at similar times.

Rates may differ from those presented in reports published in 2011 or previous years which are derived from ABS 2006 Census based ERPs.

Accessibility The NCSP annual reports are available via the AIHW website where they can be downloaded free of charge.

Interpretability While numbers of women screened are easy to interpret, calculation of age standardised rates with allowance for the proportion of the population who have had a hysterectomy is more complex and the concept may be confusing to some users. Information on how and why age-standardised rates have been calculated and how to interpret them as well as the hysterectomy fraction is available in all AIHW NCSP monitoring reports, example, Cervical screening in Australia 2011–2012.

Data Gaps/Issues Analysis

Key data gaps The Steering Committee notes the following issues:

/issues

- Hysterectomy fractions are derived from the AIHW National Hospitals Morbidity Database.
- Indigenous status is not collected by cervical cytology registers.

Selected potentially preventable hospitalisations

Measure 1: Selected potentially preventable hospitalisations for vaccine preventable, acute and chronic conditions

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome — Australians receive appropriate high quality and affordable hospital and hospital related care.
Indicator	Selected potentially preventable hospitalisations — Admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital services.
Measure/s (computation)	<p>Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions.</p> <p>The numerator is the number of separations for selected potentially preventable hospitalisations, for each of the following three groups and their sub-categories:</p> <ul style="list-style-type: none">• Vaccine-preventable conditions<ul style="list-style-type: none">- Pneumonia and influenza (vaccine-preventable)- Other vaccine preventable conditions (for example, tetanus, measles, mumps, rubella)- Total.• Acute conditions<ul style="list-style-type: none">- Cellulitis- Convulsions and epilepsy- Dental conditions- Ear, nose and throat infections- Eclampsia- Gangrene- Pelvic inflammatory disease- Perforated/bleeding ulcer- Pneumonia (not vaccine-preventable)- Urinary tract infections, including pyelonephritis- Total acute conditions• Chronic conditions<ul style="list-style-type: none">- Angina- Asthma- Bronchiectasis- Chronic obstructive pulmonary disease- Congestive heart failure- Diabetes complications (principal diagnosis only)- Hypertension- Iron deficiency anaemia- Nutritional deficiencies- Rheumatic heart disease- Total• Total selected potentially preventable hospitalisations.

The denominator is the Estimated Resident Population (ERP).

A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay

beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

Potentially preventable hospitalisations are defined by International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) diagnosis codes and/or Australian Classification of Health Interventions (ACHI) procedure codes in scope for each category of potentially preventable hospitalisations (see METeOR id 559032).

Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

Data source/s Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.

Denominators:

- For total population: ABS ERP as at 30 June 2012.
- For data by Indigenous status: ABS *Aboriginal and Torres Strait Islander Experimental Estimates and Projections Series B* as at 30 June 2012.
- For data by remoteness: ABS ERP as at 30 June 2011, by remoteness areas, as specified in the Australian Statistical Geography Standard 2011 (ASGS).
- For data by socioeconomic status: calculated by AIHW using the ABS Socio-Economic Indexes For Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) 2011 and ERP by Statistical Area 2 (SA2) as at 30 June 2012. Each SA2 in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The AIHW is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NHMD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

- <http://www.aihw.gov.au/nhissc/>
- <http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The analyses by state and territory, remoteness and socioeconomic status are based on the Statistical Area 2 (SA2) of usual residence of the patient, not the location of the hospital. Hence rates represent the number separations for patients living in each state/territory, remoteness area or Socio-Economic Indexes for Areas (SEIFA) population group (regardless of the jurisdiction of the hospital they were admitted to) divided by the total number of people living in that remoteness area or SEIFA group in the state/territory.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SA2 are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Timeliness

The reference period for this data set is 2012-13.

Accuracy

For 2012-13, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88 per cent of Indigenous Australians were identified correctly in hospital admissions data in the 2011-12 study period, and the 'true' number of separations for Indigenous Australians was about 9 per cent higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example where the denominator is very small. The following rule was applied:

Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

Coherence

The specification for this performance indicator was revised for the 2015 reporting period. The AIHW recalculated this indicator for the period 2007-08 to 2012-13 using the new specification. Therefore, the data are not comparable to data calculated in previous reporting periods.

For ICM-10-AM coding details, please refer to the specification for National Healthcare Agreement Performance Indicator 18 - Selected potentially preventable hospitalisations, 2015 (<http://meteor.aihw.gov.au/content/index.phtml/itemId/559032>)

The information presented for this indicator is calculated using the same methodology as data published in the *National healthcare agreement: performance report 2012–13*.

However, caution should be used when comparing data across reporting periods as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11, 2011-12 and 2012-13) and the associated Australian Coding Standards that resulted in fluctuations in the reporting of diagnoses for diabetes.

In addition, Tasmanian data are not comparable over time as 2008-09 data for Tasmania does not include two private hospitals that were included in 2007-08 and 2009-10 data reported in the National Healthcare Agreement performance reports.

Interpretation of the related performance benchmark over time is also problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time. Changes in a jurisdiction's denominator (separations) can artificially increase or decrease the results of the benchmark. Therefore the data provided in 2012-13 (and interim years) may not be directly comparable to the baseline data from which the target is based.

Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007-08 to 2009-10 include data from NSW, Vic, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2010-11 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007-08, 2008-09 and 2009-10 are not comparable to data for 2010-11 and subsequent years.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007-08 through to 2010-11 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. Data for 2012-13 are reported using SEIFA 2011 at the SA2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- *Australian hospital statistics* with associated Excel tables.
- Interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

These products may be accessed on the AIHW website at: www.aihw.gov.au/hospitals/.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate

interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and variation in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the NHMD can be accessed on the AIHW website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/568730>.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The National Hospital Morbidity Database (NHMD) is a comprehensive data set that has records for all separations of admitted patients from essentially all public and private hospitals in Australia
- The specification for this performance indicator was revised for the 2015 reporting period. The AIHW recalculated this indicator for the period 2007-08 to 2012-13 using the new specification. Therefore, the data are not comparable to data calculated in previous reporting periods.
- Caution should be used in comparing data across reporting periods as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11, 2011-12 and 2012-13) and the associated Australian Coding Standards resulted in fluctuations in the reporting of diagnoses for diabetes (chronic category affected). These changes should also be taken into consideration in interpretation of these data against the National Healthcare Agreement performance benchmark for potentially preventable hospitalisations.
- In addition, interpretation of the related performance benchmark over time is problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Remoteness data for 2011-12 and previous years are not directly comparable to remoteness data for 2012-13 and subsequent years.
- SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Measure 2: Selected potentially preventable hospitalisations for diabetes

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations.
Measure/s (computation)	<p>Selected potentially preventable hospitalisations for diabetes.</p> <p>The numerator is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups:</p> <ul style="list-style-type: none">• Circulatory complications (E11.5x)• Renal complications (E11.2x)• Ophthalmic complications (E11.3x)• Other specified complications (E11.0x, E11.1x, E11.4x, E11.6x)• Multiple complications (E11.7x)• No complications (E11.9x)• Total. <p>The denominator is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for diabetes are defined by ICD-10-AM diagnosis codes.</p> <p>Calculation is $100\ 000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 100 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 years combined.</p>
Data source/s	<p>Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p>Denominator: For total population: ABS Estimated Resident Population (ERP) as at 30 June 2011.</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals.</p> <p>The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental</p>

	<p>hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p>
Timeliness	The reference period for this data set is 2012-13.
Accuracy	<p>Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.</p> <p>For 2012-13 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. Variations in both admission and administration practices and policies mean that dialysis treatments may be counted as separations with diabetes complications by some hospitals and not others, reducing the comparability of the data at state and territory level. This is particularly significant for Indigenous people because of the high prevalence of diabetes in that population.</p> <p>Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small).</p>
Coherence	<p>The information presented for this indicator is calculated using the same methodology as other potentially preventable hospitalisations data published in Australian hospital statistics 2012-13 and the National healthcare agreement: performance report 2011-12.</p> <p>Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.</p> <p>Changes between the ICD-10-AM 5th edition (used in 2007-08), ICD 10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes.</p>
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables. • Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). <p>Some data are also included on the MyHospitals website.</p>
Interpretability	Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Further work is required to improve the comparability of data due to changes across editions of the ICD-10-AM.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Changes to Australian Coding Standards mean that data for 2012-13 are not comparable to data for previous years.

Measure 3: Potentially preventable hospitalisations of older people for falls

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations.
Measure/s (computation)	<p>Potentially preventable hospitalisations of older people for falls.</p> <p>The number of hospitalisations for people aged 65 years or over with a reported external cause of falls, per 1000 people.</p> <p>The numerator is the number of hospitalisations for people aged 65 years or over with a reported external cause of falls.</p> <p>The denominator is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for falls are defined by ICD-10-AM external cause codes (W00–W19).</p> <p>Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined.</p>
Data source/s	<p>Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p>Denominator: ABS Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period.</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p>

Timeliness	The reference periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12, 2012-13.
Accuracy	<p>For 2006-07 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free standing day hospital facility in the NT, and a small private hospital in Victoria.</p> <p>For 2007-08 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and a small private hospital in Victoria.</p> <p>For 2008-09 , almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and two private hospitals in Tasmania.</p> <p>For 2009-10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT and about 2400 separations for one public hospital in Western Australia. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. In addition, Western Australia was not able to provide about 10 600 separations for one private hospital.</p> <p>For 2010-11 and 2011-12, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. However, 2010-11 data were not available for the NT.</p> <p>For 2012-13, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.</p> <p>States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.</p> <p>Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small).</p>
Coherence	NT data are not available for 2010-11, and are excluded from the Australian total for that year. With this exception, data for this indicator are comparable over time.
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables. • Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). <p>Some data are also included on the MyHospitals website.</p>
Interpretability	Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in

service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

**Key data gaps
/issues**

The Steering Committee notes the following issues:

- NT data were not available for 2010-11.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.