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## 10 Primary and community health

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in providing preventative care, diagnosis and treatment of illness, and referral to other healthcare services.

In Australia, general practices are an important source of primary healthcare. The services they provide include: diagnosing and treating illness (both chronic and acute); providing preventative care through to palliative care; referring patients to consultants, allied health professionals, community health services and hospitals; and acting as gatekeepers for other healthcare services (DHFS 1996).

Community health services usually consist of multidisciplinary teams of salaried health professionals who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). They are either provided directly by governments (including local governments) or funded by government and managed by a local health service or community organisation. State and Territory governments are responsible for most community health services. There is no national strategy for community health, and there is considerable variation in the services provided across jurisdictions. The Australian Government's main role in the community health services covered in this chapter is in health services for Indigenous people.

Problems with accessing primary and community health services have contributed to the generally poor health status of Indigenous people relative to other Australians (see the 'Health preface' and SCRGSP 2005).

The following significant improvement has been made in the reporting of primary and community health in this Report:

- Indigenous data are now reported for the 'hospitalisations for vaccine preventable conditions' and 'hospitalisations for diabetes' indicators.

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## **Indigenous data in the primary and community health chapter**

The primary and community health chapter in the *Report on Government Services 2006* (2006 Report) contains the following information on Indigenous people:

- a description of community healthcare services aimed specifically at Indigenous people
- information on the use of general practice services and the ten most common health problems managed at encounters with general practitioners (GPs)
- hospitalisation rates for vaccine preventable conditions and diabetes.

### *Supporting tables*

Supporting tables for data within the primary and community health chapter of this compendium are contained in attachment 10A of the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the primary and community health attachment). As the data are directly sourced from the 2006 Report, the compendium also notes where the original table, figure or text in the 2006 Report can be found. For example, where the compendium refers to '2006 Report, p. 10.15' this is page 15 of chapter 10 of the 2006 Report, and '2006 Report, table 10A.2' is attachment table 2 of attachment 10 of the 2006 Report.

## **Indigenous community healthcare services**

Indigenous Australians utilise a range of primary health care services in Australia including private general practitioners, Indigenous-specific primary health care services and community health services. (The use of general practice services by Indigenous people is discussed separately below.) There are Indigenous-specific primary health care services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding for Indigenous-specific primary health care services is provided by Australian, State and Territory governments.

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In addition to the Indigenous-specific primary health care services, specific health programs for Indigenous Australians are funded by jurisdictions. The following jurisdictions indicated to the Review that in 2004-05 they had community health programs aimed specifically at Indigenous people.

- NSW provided Indigenous health services, such as health information and education, counselling, pre and post natal programs, early childhood nursing and health promotion programs (table 10A.11).
- Queensland provided primary and community healthcare services and activities that address prevention and health management/maintenance for Indigenous communities. Services offered include: disease/illness prevention and promotion services; men's and women's health programs; child and adolescent health services; alcohol, tobacco and other drug services; sexual health services; allied health services; and patient transport provided to increase access to healthcare (table 10A.13).
- SA provided a range of Indigenous health services provided through multidisciplinary teams from community health who work with Indigenous communities. Services provided by SA include strategies to improve Indigenous mental health, improve nutrition standards and reduce tobacco use (table 10A.15).
- Tasmania provided population and health priorities programs to prevent and manage chronic conditions such as diabetes and cardiovascular diseases, and to promote nutrition, physical activity and injury prevention in identified population groups, including the Indigenous population (table 10A.16).

All other jurisdictions treat Indigenous people through their mainstream community programs (tables 10A.12, 10A.14, 10A.17 and 10A.18).

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

For 2003-04, SAR data are reported for 138 Indigenous primary healthcare services (table 10A.1). Of these services, 54 (39.1 per cent) were located in remote or very remote areas (table 10A.2). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 10A.3).

An episode of healthcare is defined in the SAR data collection as contact between an individual client and a service by one or more staff to provide healthcare. Over 1.6 million episodes of healthcare were provided by participating services in 2003-04 (table 10.1). Of these, around 585 000 (36.3 per cent) were in remote or very remote areas (table 10A.2).

The services included in the SAR data collection employed approximately 1713 full time equivalent health staff (as at 30 June 2004). Of these health staff, 1091 were Indigenous (63.7 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous, however, were relatively low (3.3 per cent and 12.4 per cent respectively) (table 10A.4).

**Table 10.1 Estimated Indigenous episodes of healthcare by surveyed services ('000)<sup>a</sup>**

	<i>NSW and ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>Aust</i>
2000-01	349	131	187	327	147	12	189	1342
2001-02	357	136	214	313	144	18	233	1416
2002-03	423	130	234	337	140	20	216	1499
2003-04	430	169	267	302	142	22	280	1612

<sup>a</sup> An episode of healthcare involves contact between an individual client and a service by one or more staff, for the provision of healthcare. Group work is not included. Transport is included only if it involves provision of healthcare/information by staff. Episodes of healthcare provided at outreach locations are included — for example, episodes at outstation visits, park clinics and satellite clinics — as are episodes delivered over the phone.

Source: DHA SAR (unpublished); 2006 Report, p. 10.13, table 10.5.

## Use of general practice services by Indigenous people

An overview of health factors and outcomes for Indigenous people is provided in the 'Health preface'. Data on national expenditure on general practice services for Indigenous people in 2001-02 (the most recent year for which expenditure data are available by Indigenous status) indicate:

- expenditure on Medicare per Indigenous person was about 39 per cent of expenditure per non-Indigenous person
- expenditure on the PBS per Indigenous person was about 33 per cent of expenditure per non-Indigenous person
- Indigenous Australians used secondary/tertiary care (such as hospitals) at a higher rate than they used primary care and at a higher rate than that used by non-Indigenous people (AIHW 2005; see 'Health preface').

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Data from the annual BEACH survey indicate the nature of encounters between Indigenous people and GPs. It is uncertain whether all patients are asked the Indigenous identification question and therefore these data may under-represent the actual number of GP encounters with Indigenous Australians. In addition, these data need to be treated with care because the BEACH survey was not designed to produce reliable results for Indigenous people and may under-identify them. For these reasons, the 2003 BEACH survey aggregated Indigenous data over a five year period to improve reliability.

Over the period 1998-99 to 2002-03, 5476 encounters between Indigenous patients and GPs were recorded in the BEACH survey (table 10A.5). This represented 1.1 per cent of GP encounters in the study over this period. By comparison, the proportion of Indigenous people in the Australian population was 2.4 per cent at June 2001 the midpoint of this period (tables A.2 and A.6). Extrapolating these results to all GP/patient encounters across Australia suggests there was an annual average of around 1.1 million encounters between Indigenous patients and GPs over the five years to 2002-03 (Britt *et al.* 2003).

The most common health problem managed in GP encounters with Indigenous people over the five years of the BEACH survey was diabetes, which accounted for 7.1 per 100 GP encounters with Indigenous people, compared with 2.8 per 100 GP encounters with all people. Other problems with significantly higher management rates in GP encounters with Indigenous people included acute otitis media/myringitis, asthma, and pre- and post-natal care (table 10.2). Further information about the location, remoteness and management activities of BEACH survey encounters between Indigenous patients and GPs is included in tables 10A.6, 10A.7 and 10A.8.

Table 10.2 **Selected health problems in encounters with GPs, by Indigenous status, 1998-99 to 2002-03**

<i>Problems managed</i>	<i>Indigenous people's encounters</i>			<i>All encounters</i>		
	<i>Rate (n=5476)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Rate (n=502 100)</i>	<i>95% LCL</i>	<i>95% UCL</i>
	no./100	no./100	no./100	no./100	no./100	no./100
Diabetes <sup>a</sup>	7.1	6.0	8.2	2.8	2.7	2.9
Hypertension <sup>a</sup>	6.7	5.7	7.7	8.8	8.6	9.0
Upper respiratory tract infection	5.7	4.8	6.5	6.0	5.9	6.2
Asthma	4.3	3.6	5.0	2.9	2.8	3.0
Acute bronchitis/ bronchiolitis	3.8	3.2	4.5	2.8	2.7	2.8
Depression <sup>a</sup>	3.4	2.9	3.9	3.8	3.7	3.9
Immunisation (all) <sup>a</sup>	3.3	2.6	3.9	4.8	4.6	5.0
Acute otitis media/ myringitis	3.1	2.5	3.6	1.4	1.4	1.5
Back complaint <sup>a</sup>	2.2	1.7	2.6	2.6	2.5	2.7
Pre- and post-natal check <sup>a</sup>	2.1	1.5	2.5	1.0	0.9	1.0
Subtotal	41.7	..	..	..	..	..
<b>Total problems<sup>b</sup></b>	<b>147.7</b>	<b>143.7</b>	<b>151.6</b>	<b>148.1</b>	<b>147.3</b>	<b>148.9</b>

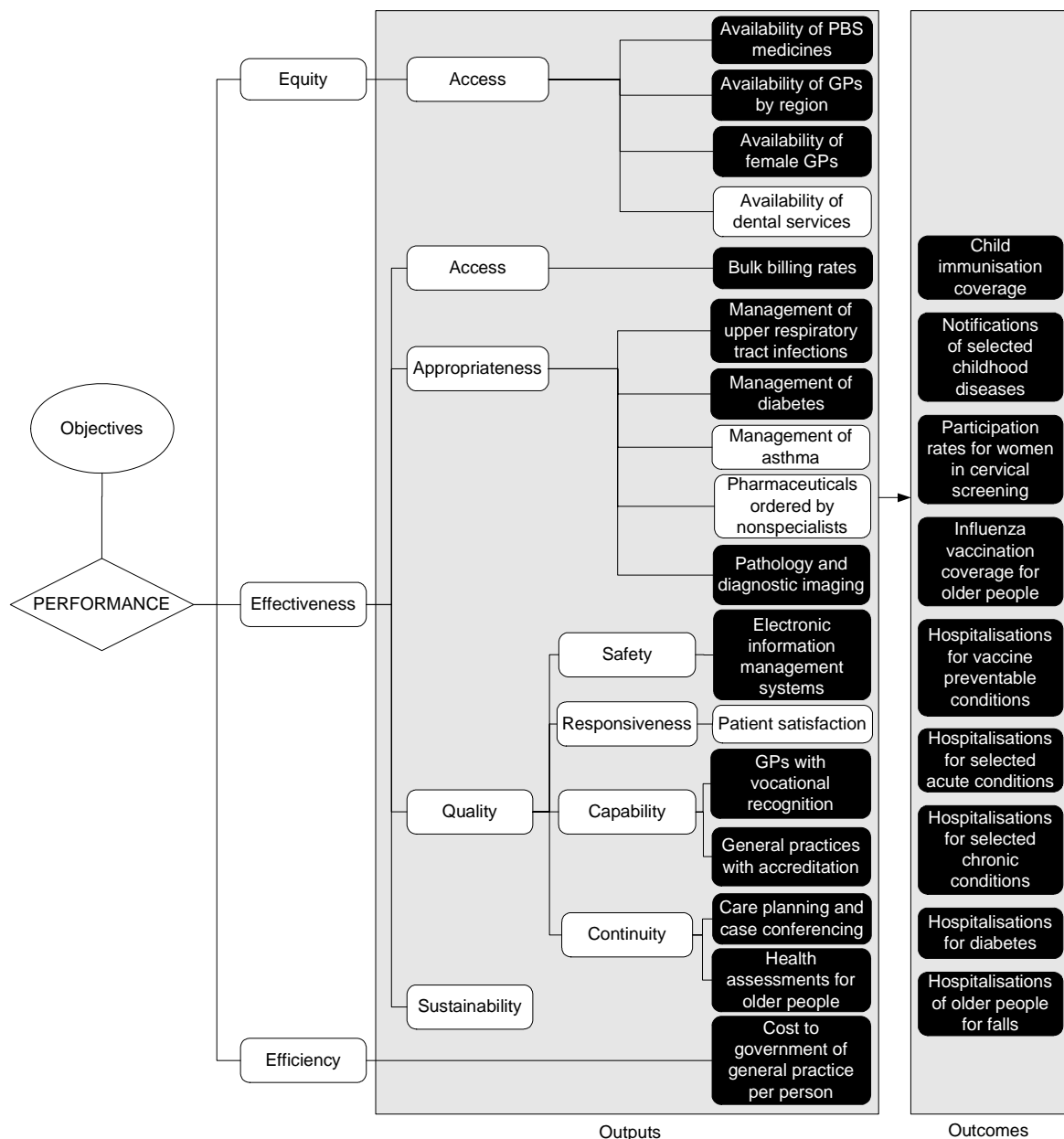
LCL = lower confidence level. UCL = upper confidence level. <sup>a</sup> Includes multiple primary care classification codes. <sup>b</sup> Total problems managed is greater than 100, because more than one problem can be managed per encounter. .. Not applicable.

Source: Britt *et al.* (2003); table 10A.5; 2006 Report, p. 10.14, table 10.6.

## Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for primary and community health in the 2006 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 10.1. The performance indicator framework shows which data are comparable in the 2006 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Figure 10.1 Performance indicators for primary and community health



**Key to indicators**

- Text** Provided on a comparable basis for this Report subject to caveats in each chart or table
- Text** Information not complete or not directly comparable
- Text** Yet to be developed or not collected for this Report

Source: 2006 Report, p. 10.17, figure 10.3.

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## Vaccine preventable hospitalisations

‘Vaccine preventable hospitalisations’ is an indicator of primary and community healthcare outcomes (box 10.1).

### Box 10.1 Vaccine preventable hospitalisations

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations.

This indicator is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions per 100 000 people. (Adjustments are made to account for differences in the age structure of populations across states and territories.)

A reduction in hospitalisation rates may indicate improvements in the effectiveness of the vaccination program. Effective treatment by primary health providers may also reduce hospitalisations.

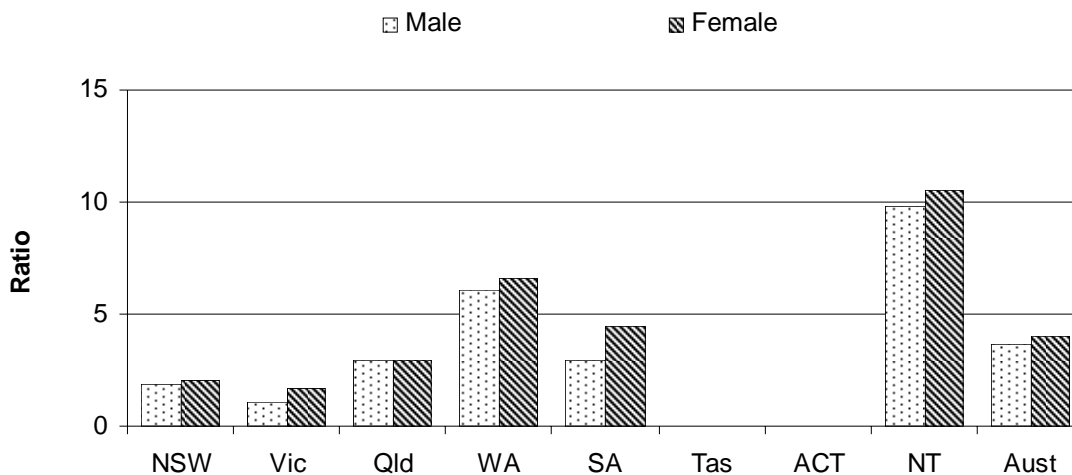
A comparison of Indigenous people and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation for vaccine preventable conditions. Examples are the number and virulence of influenza strains from year to year.

Standardised hospital separation ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. These data were previously reported in chapter 9 ‘Public hospitals’. For both males and females, there was a marked difference in 2003-04 between the separation rate for Indigenous people and those for the total population for infectious pneumonia diagnoses. The separation rate for Indigenous males was 3.7 times higher than those for all Australian males. The separation rate for Indigenous females was 4.0 times the rate for all females (figure 10.2).



**Figure 10.2 Ratio of age standardised hospital separation rates of Indigenous people to all people for infectious pneumonia, 2003-04<sup>a, b, c, d, e</sup>**



<sup>a</sup> The ratios are indirectly age standardised using the Census based estimated resident population of Indigenous males at 30 June 2001, the hospital separation rates for Australian males aged 0–74 years for 2000-01 and the male population at 30 June 2001. <sup>b</sup> Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from WA, SA and the NT are considered to be of acceptable quality. <sup>c</sup> Data for Tasmania and the ACT are not available, given the small size of the Indigenous population in those jurisdictions. <sup>d</sup> These data do not signal the performance of hospitals, but reflect a range of factors such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations (see appendix A). <sup>e</sup> NT data is for public hospitals only.

Source: AIHW (unpublished); tables 10A.9 and 10A.10; 2006 Report, p. 10.50, figure 10.26.

## Hospitalisations for diabetes

‘Hospitalisations for diabetes’ is an indicator of primary and community healthcare outcomes (box 10.2).

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### Box 10.2 Hospitalisations for diabetes

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for diabetes.

Hospital separation rates for patients with diabetes mellitus as the principal diagnosis, and for patients with a lower limb amputation and a principal or additional diagnosis of diabetes are reported. These rates are calculated per 100 000 people and adjusted to account for differences in the age distribution of State and Territory populations.

A reduction in these rates may indicate an improvement in GPs and community health providers' management of patients' diabetes.

A comparison of Indigenous and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

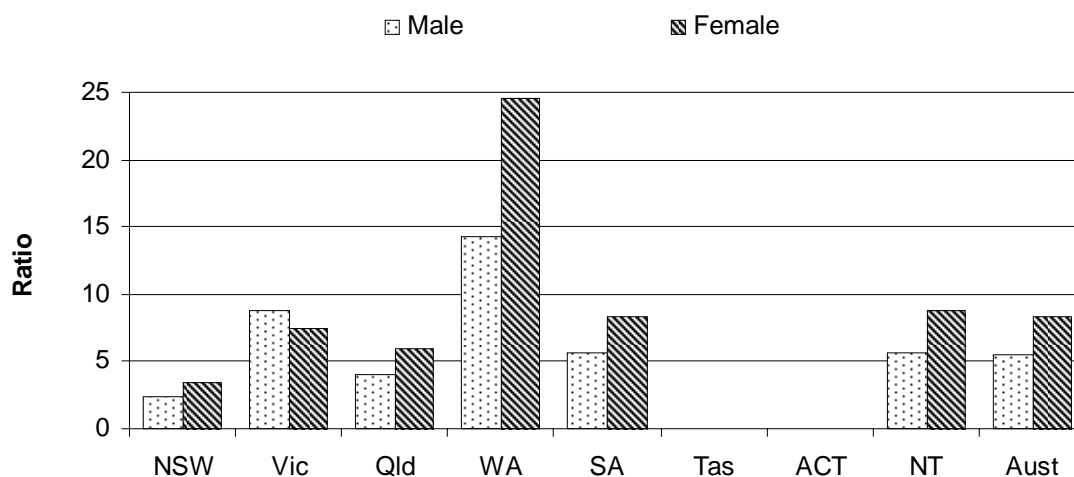
Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Standardised hospital separation ratios for all diabetes diagnoses illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. These data were previously reported in chapter 9 'Public hospitals'. For both males and females there was a marked difference in 2003-04 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses.<sup>1</sup> The separation rate for Indigenous males was 5.5 times higher than those for all Australians males. The separation rate for Indigenous females was 8.3 times the rate for all females (figure 10.3). The 'Health preface' contains data on deaths from diabetes for Indigenous people.

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<sup>1</sup> 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes.

**Figure 10.3 Ratio of age standardised hospital separation rates of Indigenous people to all people for all diabetes diagnoses, 2003-04<sup>a, b, c, d, e, f</sup>**



<sup>a</sup> The ratios are indirectly age standardised using the Census based estimated resident population of Indigenous males at 30 June 2001, the hospital separation rates for Australian males aged 0–74 years for 2000-01 and the male population at 30 June 2001. <sup>b</sup> Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from WA, SA and the NT are considered to be of acceptable quality. <sup>c</sup> Data for Tasmania and the ACT are not available, given the small size of the Indigenous population in those jurisdictions. <sup>d</sup> ‘All diabetes’ refers to separations with either a principal or additional diagnosis of diabetes. <sup>e</sup> These data do not signal the performance of hospitals, but reflect a range of factors such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations (see appendix A). <sup>f</sup> NT data are for public hospitals only.

Source: AIHW (unpublished); tables 10A.9 and 10A.10; 2006 Report, p. 10.57, figure 10.30.

## Future directions in performance reporting

### *Indigenous health*

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the ‘Health preface’). In recognition of this issue, the Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. Accordingly, the Steering Committee will examine options for including indicators of the accessibility of primary and community health services to Indigenous people. The Aboriginal and Torres Strait Islander Health Performance Framework that is being developed by the Standing Committee on Aboriginal and

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Torres Strait Islander Health will help inform the selection of future indicators of primary and community health services to Indigenous people (see the 'Health preface').

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## Supporting tables

Supporting tables for data within this chapter are contained in the attachment to the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the primary and community health attachment). The tables included in the attachment are listed below.

- Table 10A.1** Indigenous primary healthcare services for which service activity reporting (SAR) data is reported (number)
- Table 10A.2** Services and episodes of healthcare by services for which service activity reporting (SAR) data is reported, by remoteness category (number)
- Table 10A.3** Proportion of services for which service activity reporting (SAR) data is reported that undertook selected health related activities, 2003-04 (per cent)
- Table 10A.4** Full time equivalent health staff employed by services for which service activity reporting (SAR) data is reported, as at 30 June 2004 (number)
- Table 10A.5** Most frequent individual problems managed (in decreasing order of frequency for all encounters with Indigenous people 1998-99 to 2002-03)
- Table 10A.6** Practice location of GPs who saw Indigenous people compared with total GP sample
- Table 10A.7** Distribution of encounters with Indigenous and all people, by region (rural, remote and metropolitan areas [RRMA]), 1998–2003 (per cent)
- Table 10A.8** Summary of patient morbidity and management at encounters with Indigenous Australians and in the total sample
- Table 10A.9** Male Indigenous separations, by type, 2003-04
- Table 10A.10** Female Indigenous separations, by type, 2003-04
- Table 10A.11** New South Wales, community health services programs
- Table 10A.12** Victoria, community health services programs
- Table 10A.13** Queensland, community health services programs
- Table 10A.14** Western Australia, community health services programs
- Table 10A.15** South Australia, community health services programs
- Table 10A.16** Tasmania, community health services programs
- Table 10A.17** Australian Capital Territory, community health services programs
- Table 10A.18** Northern Territory, community health services programs

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## References

- AIHW (Australian Institute of Health and Welfare) 2005, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People 2001-02*, Cat. no. HWE 30, Canberra.
- Britt, H, Miller, G.C., Knox, S., Charles, J., Valenti, L., Henderson, J., Pan, Y., Bayram, C. and Harrison C. 2003, *General Practice Activity in Australia 2002-03*, Cat. no. GEP 14, Australian Institute of Health and Welfare, Canberra.
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