
11 Primary and community health

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Attachment tables

Attachment tables are identified in references throughout this Indigenous Compendium by an 'A' suffix (for example, in this chapter, table 11A.3). As the data are directly sourced from the 2011 Report, the Compendium also notes where the original table, figure or text in the 2011 Report can be found. For example, where the Compendium refers to '2011 Report, p. 11.15' this is page 15 of chapter 11 of the 2011 Report, and '2010 Report, table 11A.2' is attachment table 2 of attachment 11A of the 2011 Report. 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.

The Primary and community health chapter (chapter 11) in the *Report on Government Services 2011* (2011 Report) reports on the performance of primary and community health services in Australia. Data are reported for Indigenous people for a subset of the performance indicators reported in that chapter — those data are compiled and presented here.

Chapter 11 in the 2011 Report focuses on general practice, primary healthcare services for Indigenous people, public dental services, drug and alcohol treatment, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services.

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

Indigenous data in the primary and community health chapter

The primary and community health chapter in the 2011 Report contains the following data items on Indigenous people:

- general practitioner-type service use
- Indigenous community healthcare services
- early detection and early treatment for Indigenous people
- proportion of children receiving a fourth year developmental health check
- potentially avoidable GP-type presentations to emergency departments
- management of asthma
- proportion of children fully immunised
- cervical screening rates

-
- potentially preventable hospitalisations.

Data for general practitioner-type service use by Indigenous status for 2008-09 and 2009-10 are presented in attachment table 11A.1.

Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2008-09, these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.21–11A.29).

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

For 2008-09, OSR data are reported for 205 Indigenous primary healthcare services (table 11A.2). Of these services, 89 (43.4 per cent) were located in remote or very remote areas (table 11A.3). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.4). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Over 2.0 million episodes of healthcare were provided by participating services in 2008-09 (table 11.1). Of these, around 947 000 (45.3 per cent) were in remote or very remote areas (table 11A.3).

Table 11.1 Estimated episodes of healthcare for Indigenous people by services for which OSR data are reported ('000)^a

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

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

Source: AIHW (unpublished) OSR data collection; 2011 Report, table 11.6, p. 11.13.

The services included in the OSR data collection employed 2764 full time equivalent health staff (as at 30 June 2009). Of these, 1551 were Indigenous (56.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (4.8 per cent and 9.3 per cent, respectively) (table 11A.5).

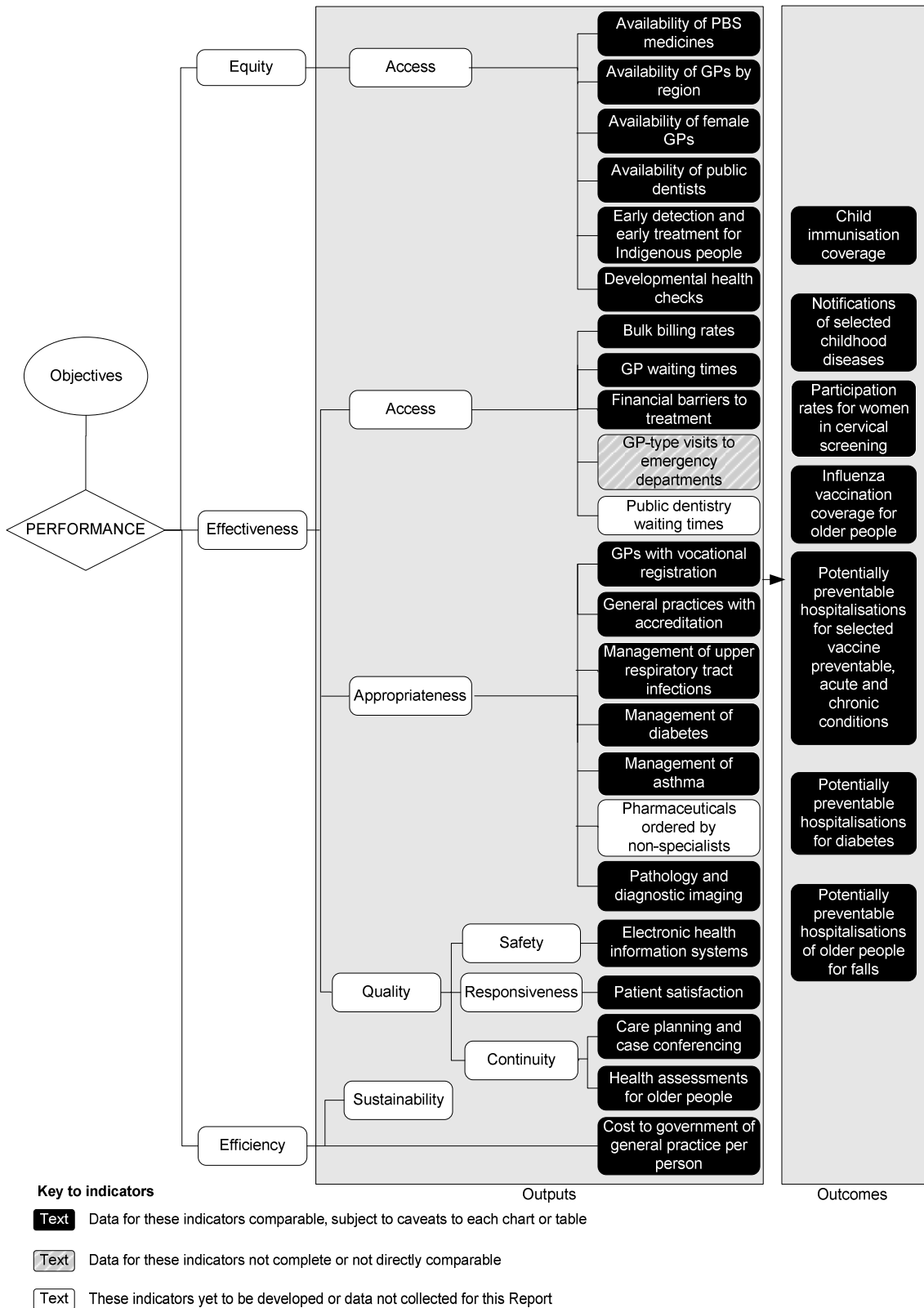
Framework of performance indicators

The performance indicator framework outlined in figure 11.1 is based on shared government objectives for primary and community health (2011 Report, box 11.1). Data for Indigenous people are reported for a subset of the performance indicators and are presented here. It is important to interpret these data in the context of the broader performance indicator framework. The framework shows which data are comparable. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Indicator boxes presented throughout the chapter provide information about the reported indicators. As these are sourced directly from the 2011 Report, they might include references to data not reported for Indigenous people and therefore not included in this Compendium.

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

Figure 11.1 Performance indicators for primary and community health



Source: 2011 Report, figure 11.3, p. 11.16.

Early detection and early treatment for Indigenous people

'Early detection and early treatment for Indigenous people' is an indicator of governments' objective to provide equitable access to primary and community healthcare services for Indigenous people (box 11.1).

Box 11.1 Early detection and early treatment for Indigenous people

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

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

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

(Continued on next page)

Box 11.1 (continued)

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

Data for this indicator are comparable.

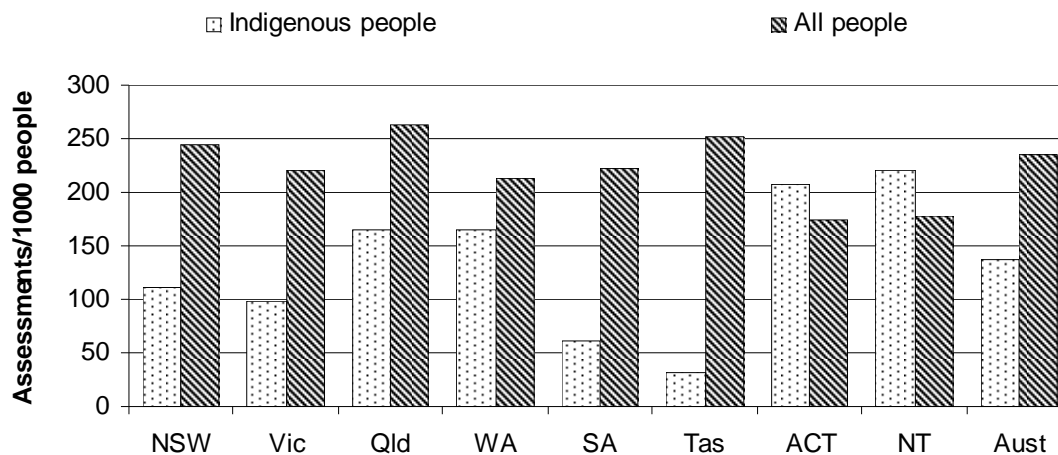
Data quality information for this indicator is under development.

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

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

In 2009-10 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment in most jurisdictions (figure 11.2). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.2 Older people who received an annual health assessment by Indigenous status, 2009-10^{a, b}

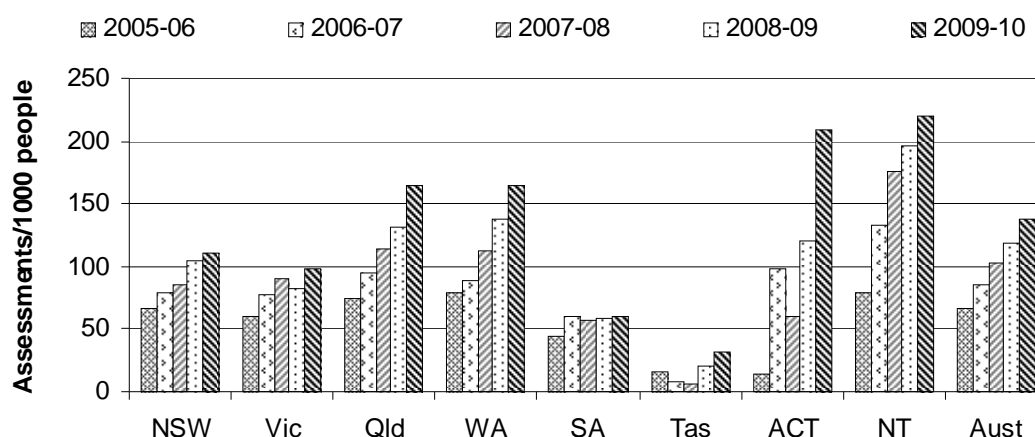


^a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. ^b Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This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

Source: Derived from DoHA (unpublished) MBS data collection, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0 and ABS (2009) *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.6; 2011 Report, figure 11.8, p. 11.25.

The proportion of older Indigenous people who received an annual health assessment increased in all jurisdictions between 2005-06 and 2009-10 (figure 11.3). This indicates that access to early detection and early treatment services for this population has improved.

Figure 11.3 Older Indigenous people who received an annual health assessment^{a, b}



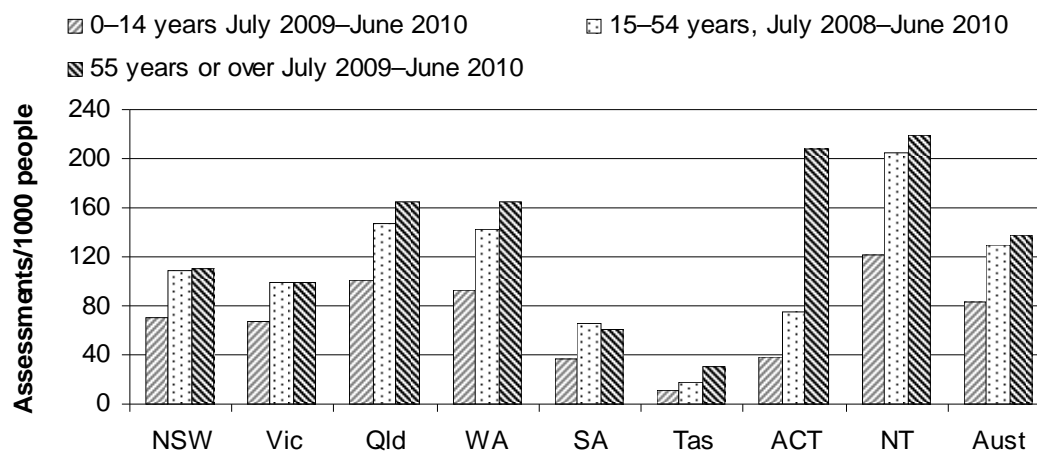
^a Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect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

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.7; 2011 Report, figure 11.9, p. 11.26.

Health check MB4 items were introduced for Indigenous people aged 15–54 years in May 2004. Initially available biennially, from 1 May 2010 they are available annually. Also available annually are health checks for Indigenous children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Indigenous population who received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.4). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

Figure 11.4 Indigenous people who received a health check or assessment by age^{a, b}

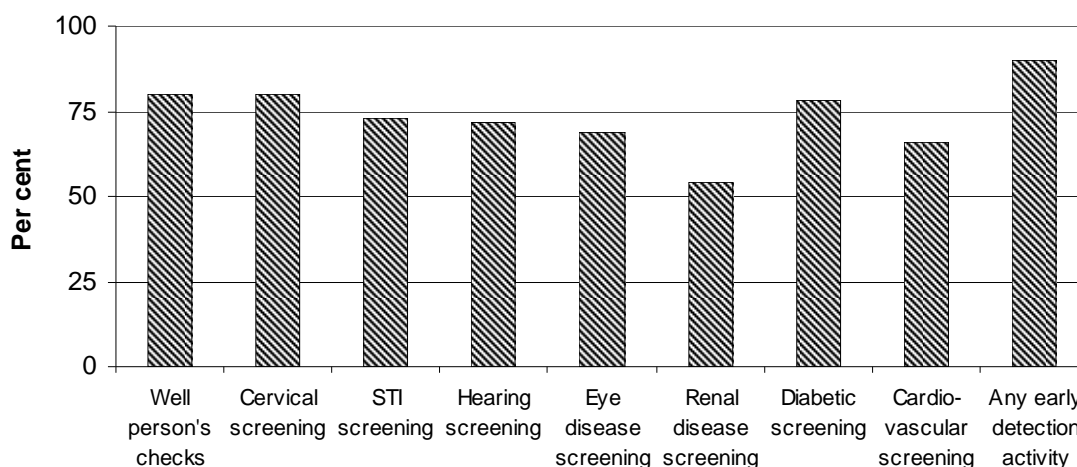


^a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy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

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.8; 2011 Report, figure 11.10, p. 11.27.

Figure 11.5 shows the proportion of Indigenous primary healthcare services for which OSR data are reported that provided various early detection services in 2008-09.

Figure 11.5 Indigenous primary healthcare services for which OSR data are reported that provided early detection services, 2008-09^a



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

Source: AIHW (unpublished) OSR data collection; table 11A.9; 2011 Report, figure 11.11, p. 11.28.

Proportion of children receiving a fourth year developmental health check

‘Proportion of children receiving a fourth year developmental health check’ is an indicator of governments’ objective to provide effective access to early detection and intervention services for children (box 11.2).

Box 11.2 Proportion of children receiving a fourth year developmental health check

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

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

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

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

Data for this indicator are comparable.

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

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

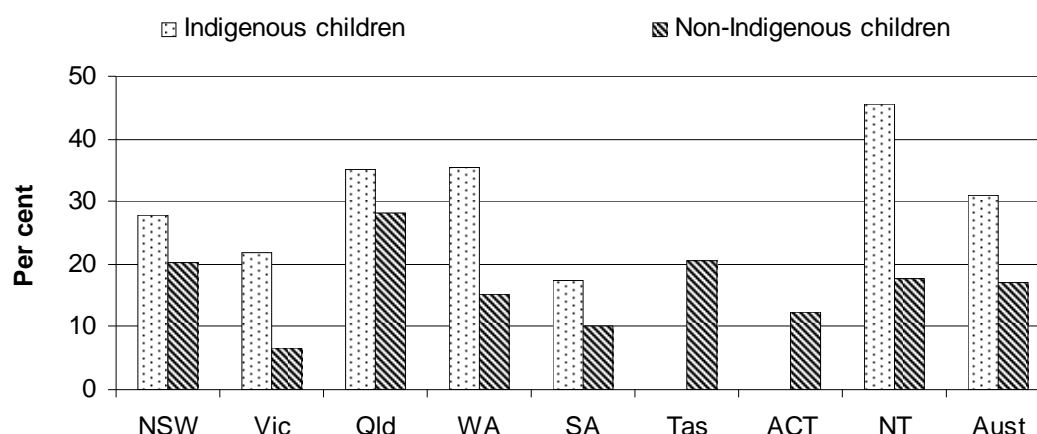
In all jurisdictions, developmental health checks for children around 4 years of age are also provided outside Medicare, in community settings such as maternal and child health services, community health centres, early childhood settings and the

schools sector. However, comparable data for developmental health checks conducted in these settings are not available for all jurisdictions.

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

Nationally, 17.8 per cent of children received a fourth year developmental health check under Medicare in 2009-10. The proportion of children that received the check was higher in the Indigenous population than in the general population in all jurisdictions for which data are available (figure 11.6).

Figure 11.6 Children who received a fourth year developmental health check, by Indigenous status, 2009-10^{a, b, c, d}



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

Source: DoHA (unpublished) MBS data collection; ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.10; 2011 Report, figure 11.12, p. 11.30.

Selected potentially avoidable GP-type presentations to emergency departments

‘Selected potentially avoidable GP-type presentations to emergency departments’ is an indicator of governments’ objective to ensure universal access to GP-type services in the community (box 11.3).

Box 11.3 Selected potentially avoidable GP-type presentations to emergency departments

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

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

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

Data for this indicator are not directly comparable.

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

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

Nationally, there were around 2.1 million GP-type presentations to public hospital emergency departments in 2009-10 (table 11.2). Data are presented by Indigenous status and remoteness in table 11A.11.

Table 11.2 GP-type presentations to emergency departments ('000)^{a, b, c}

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

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

Source: AIHW (unpublished) National non-admitted emergency patient database; table 11A.11; 2011 Report, table 11.7, p. 11.35.

Management of asthma

'Management of asthma' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.4).

Box 11.4 Management of asthma

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

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

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

Data reported against this indicator are comparable.

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

Data for the management of asthma are reported by Indigenous status for 2004-05 in table 11A.12.

Child immunisation coverage

‘Child immunisation coverage’ is an indicator of governments’ objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.5).

Box 11.5 Child immunisation coverage

‘Child immunisation coverage’ is defined by three measures:

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

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

Data for this indicator are comparable.

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

Many providers deliver child immunisation services (table 11.3). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentive Scheme, which provides incentives for the immunisation of children under seven years of age.

Table 11.3 Valid vaccinations supplied to children under 7 years of age, by provider type, 2005–2010 (per cent)^{a, b, c, d}

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

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

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.13; 2011 Report, table 11.8, p. 11.59.

Data for the proportion of children aged 60 months to less than 63 months who are fully immunised are presented by Indigenous status and remoteness in table 11A.14.

Participation rates for women in cervical screening

'Participation rates for women in cervical screening' is an indicator of governments' objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.6).

Box 11.6 Participation rates for women aged 20–69 years in cervical screening

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

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

Data for this indicator are comparable.

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

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

Data on the participation rate for Indigenous women aged 20 to 69 years in cervical screening collected in 2004-05 are presented in table 11A.15.

Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.7).

Box 11.7 Influenza vaccination coverage for older people

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

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

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

Pneumococcal disease is also a vaccine preventable disease that can result in hospitalisation and/or death. Free vaccinations against pneumococcal disease became available to older Australians in 2005.

Data for older Indigenous people who were fully vaccinated against both influenza and pneumococcal disease in 2004-05 are presented in table 11A.16.

Potentially preventable hospitalisations

Potentially preventable hospitalisations refer to hospital admissions that may be avoided through appropriate management in the primary healthcare sector and/or the broader community (AIHW 2008b, 2010) (box 11.8).

Box 11.8 Potentially preventable hospitalisation indicators

Potentially preventable hospitalisations include hospitalisations for:

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

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

Hospitalisation rates also reflect the underlying prevalence of the conditions (AIHW 2008b, 2010). In addition, some variation in rates can be due to different clinical coding and admission protocols.

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

Data are reported for Indigenous people for two indicators of potentially preventable hospitalisations:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions
- potentially preventable hospitalisations for diabetes

For data reported by Indigenous status, adjustments are made to account for differences in the age structures of the populations across states and territories. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data was of acceptable quality for analytical purposes only for hospitals in Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National e-Health and Information Principal Committee (NEHIPC) has approved NSW and Victorian Indigenous patient data as acceptable in quality for analytical purposes, from the 2004-05 reference year. More recently, the National Health Information Standards and Statistics Committee (a standing committee of NEHIPC) approved reporting of

data for Tasmania and the ACT by Indigenous status at the state and territory level for COAG reporting purposes. However, pending further examination of the quality of Indigenous identification for these jurisdictions, these data will not be included in national totals. This decision was taken too late to include most data for Tasmania and the ACT in this chapter for the 2011 Report. Efforts to improve Indigenous identification across states and territories are ongoing.

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

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

‘Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.9).

Box 11.9 Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

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

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

(Continued next page)

Box 11.9 (continued)

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

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

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

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

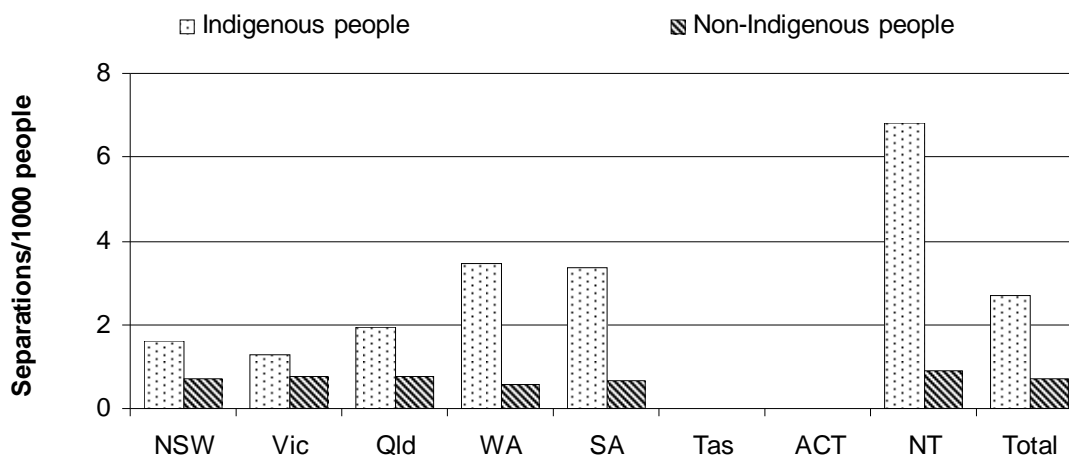
Data for this indicator are comparable.

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

Vaccine preventable hospitalisations

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.7).

Figure 11.7 **Separations for vaccine preventable conditions by Indigenous status, 2008-09^{a, b, c, d, e}**



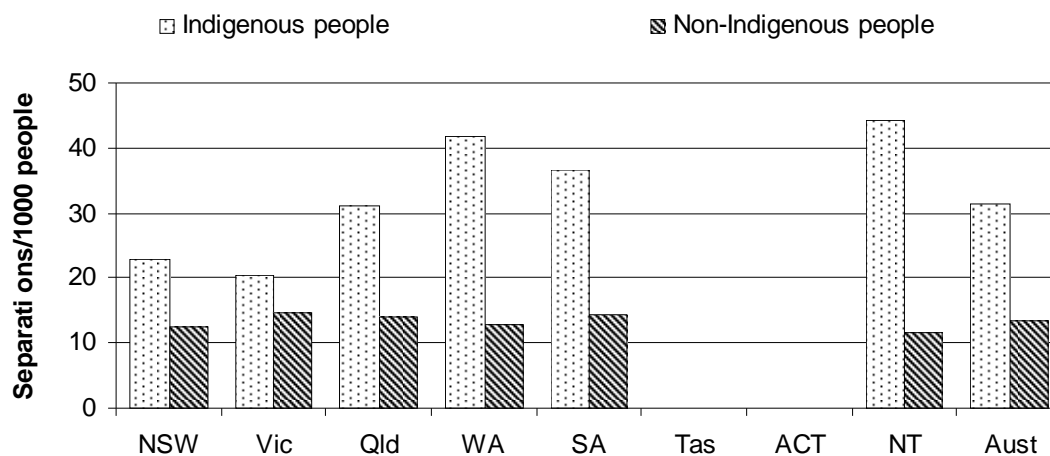
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^c Separation rates are based on State/Territory of usual residence. ^d NT data for Indigenous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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.17; 2011 Report, figure 11.41, p. 11.71.

Hospitalisations for selected acute conditions

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.8).

Figure 11.8 Separations for selected acute conditions by Indigenous status, 2008-09^{a, b, c, d, e}



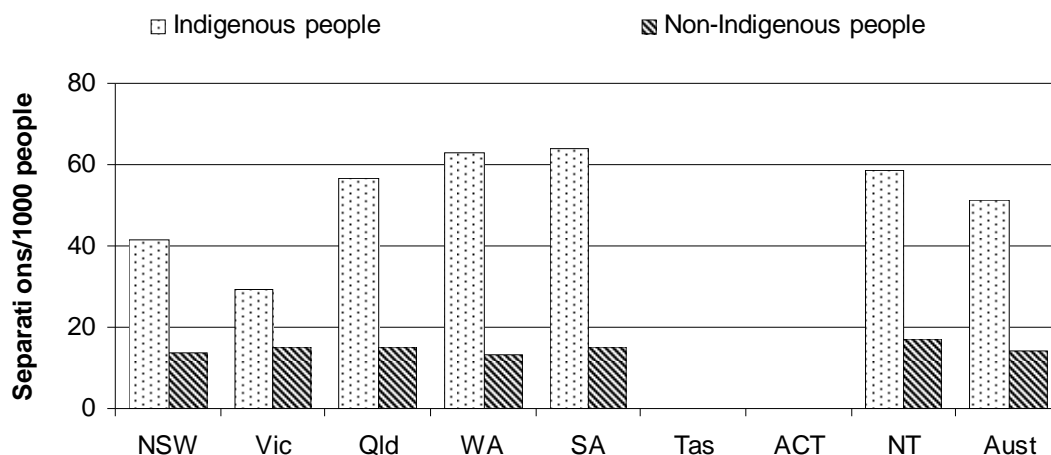
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^c Separation rates are based on State/Territory of usual residence. ^d NT data for Indigenous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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.18; 2011 Report, figure 11.42, p. 11.72.

Hospitalisations for selected chronic conditions

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people in 2008-09 in all jurisdictions for which data were published (figure 11.9).

Figure 11.9 **Separations for selected chronic conditions by Indigenous status, 2008-09^{a, b, c, d, e}**



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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.19; 2011 Report, figure 11.43, p. 11.74.

Potentially preventable hospitalisations for diabetes

‘Potentially preventable hospitalisations for diabetes’ is an indicator of governments’ objective to reduce hospitalisations due to diabetes through the provision of high quality, appropriate and effective management of diabetes in the primary and community health sector (box 11.10).

Box 11.10 Potentially preventable hospitalisations for diabetes

‘Potentially preventable hospitalisations for diabetes’ is defined by two measures:

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

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

(Continued next page)

Box 11.10 (continued)

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

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

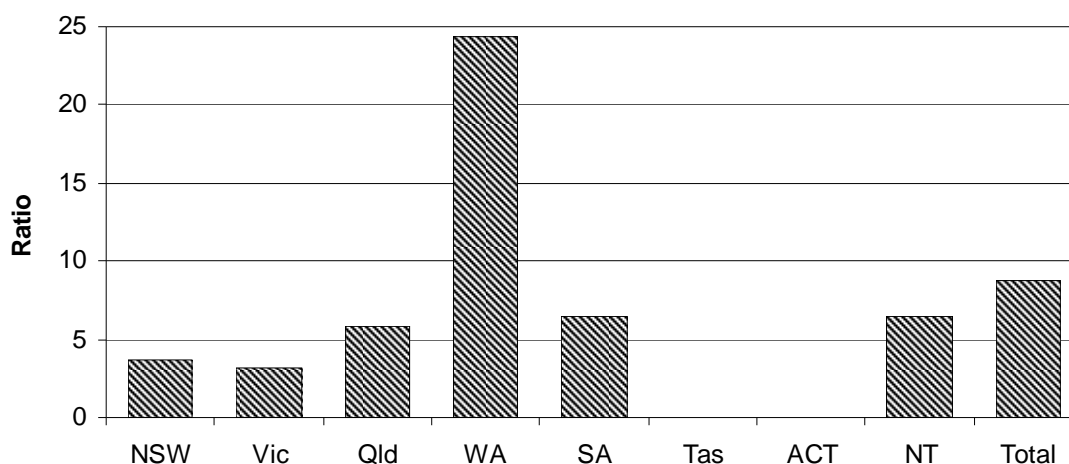
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Age standardised hospital separation ratios for all diabetes diagnoses¹ illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. There was a marked difference in 2008-09 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous people was 8.8 times higher than the separation rate for all Australian people (figure 11.10).

¹ 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

Figure 11.10 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2008-09^{a, b, c, d, e, f, g}**



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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.20; 2011 Report, figure 11.47, p. 11.78.

Future directions in performance reporting — Indigenous health

Priorities for future reporting on primary and community health services include improving the quality of Indigenous data, particularly Indigenous identification and completeness. Indigenous hospitalisation data for Tasmania and the ACT will be included in future reports. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

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

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

Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Asthma Action Plan	<p>An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.</p> <p><i>Source: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra.</i></p>
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Divisions of General Practice	<p>Geographically-based networks of GPs. There are 109 Divisions of General Practice (DGP), 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN).</p> <p>The DGP Program evolved from the former Divisions and Projects Grants Program established in 1992. The DGP Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of healthcare at the local level.</p>
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, <i>Haemophilus influenzae</i> type b, hepatitis B, and measles, mumps and rubella vaccines.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	<p>Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (from 1996 vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement.</p> <p>Other medical practitioners (OMP) — medical practitioners who are not vocationally recognised GPs.</p>

<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
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).
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Triage category	The urgency of the patient's need for medical and nursing care: <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 recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

List of attachment tables

Attachment tables for data within this chapter are contained in the attachment to the Compendium. These tables are identified in references throughout this chapter by a '11A' suffix (for example, table 11A.3). Attachment tables are provided on the Review website (www.pc.gov.au/gsp).

- Table 11A.1** GP-type service use per 1000 population
- Table 11A.2** Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, 2008-09 (number)
- Table 11A.3** Services and episodes of healthcare by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, by remoteness category, 2008-09 (number)
- Table 11A.4** Proportion of Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported that undertook selected health related activities, 2008-09 (per cent)
- Table 11A.5** Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, as at 30 June 2009 (number)
- Table 11A.6** Annual health assessments for older people by Indigenous status
- Table 11A.7** Older Indigenous people who received an annual health assessment (per 1000 people)
- Table 11A.8** Indigenous people who received a health check or assessment, by age (per 1000 people)
- Table 11A.9** Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, 2008-09 (per cent)
- Table 11A.10** Proportion of children receiving a fourth year developmental health check, 2009-10 (per cent)
- Table 11A.11** Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2009-10 (number)
- Table 11A.12** Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05
- Table 11A.13** Valid vaccinations supplied to children under seven years of age, by type of provider, 2005–2010
- Table 11A.14** Proportion of children aged five years who were fully vaccinated, by Indigenous status and remoteness, 30 June 2010 (per cent)
- Table 11A.15** Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a pap smear at least every 2 years, 2004-05 (per cent)
- Table 11A.16** Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05
- Table 11A.17** Separations for selected vaccine preventable conditions by Indigenous status, 2008-09 (per 1000 people)
- Table 11A.18** Separations for selected acute conditions by Indigenous status, 2008-09 (per 1000 people)

Table 11A.19	Separations for selected chronic conditions by Indigenous status, 2008-09 (per 1000 people)
Table 11A.20	Ratio of separations for Indigenous people to all people, diabetes, 2008-09
Table 11A.21	Australian Government, community health services programs
Table 11A.22	New South Wales, community health services programs
Table 11A.23	Victoria, community health services programs
Table 11A.24	Queensland, community health services programs
Table 11A.25	Western Australia, community health services programs
Table 11A.26	South Australia, community health services programs
Table 11A.27	Tasmania, community health services programs
Table 11A.28	Australian Capital Territory, community health services programs
Table 11A.29	Northern Territory, community health services programs

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