11 Primary and community health

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.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 Indigenous people, 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 10, '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’).

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 through referral to acute (hospital) or other healthcare services, as appropriate.

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

- reporting a number of indicators with similar characteristics as separate measures under new high level indicators
- publication of updated data for the equity — access indicator ‘availability of public dentists’
- reporting against the outcome indicator ‘participation for women in breast cancer screening’ for the first time in this chapter
- removal of the effectiveness — appropriateness indicator ‘pharmaceuticals ordered by non-specialists’. Data have never been reported for this indicator and it was not expected that they would become available
- data reported by financial year for the outcome indicator ‘notifications of selected childhood diseases’, increasing the timeliness of reporting
- additional ‘data quality information’ (DQI) documentation.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

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

Definitions for common health terms are provided in section 11.5.

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 2011). General practice is the business structure within which one or more general practitioners (GPs) and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by GPs or corporate entities.

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

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

Services provided in general practice include:

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

The Australian Government provides the majority of general practice income through 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 are responsible for registering and licensing GPs in their jurisdiction. Some also provide additional incentives for GPs to work in rural and remote areas.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (DoHA 2010). The PBS aims to provide affordable,

reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2011 was $5.60 for concession card holders and $34.20 for general consumers (DoHA 2011). The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2011 safety net threshold was $1317.20 for general consumers and $336.00 for concession card holders (DoHA 2011).

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

Community health services

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

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with chronic conditions and complex care needs, and improves access to allied health services in rural and remote areas.

Dental services

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

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The 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 all encounters with GPs in 2010-11 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2011) (table 11.1).

Table 11.1 **GP encounters, by source of funding, 2010-11[a, b, c]**

	Number[d]	*Per cent of all encounters*[e]	*95% LCL*	*95% UCL*
Total encounters for which BEACH data were recorded	87 953	100.0	..	..
Encounters with missing data	7 886	..	..	..
Direct encounters	86 652	98.5	98.3	98.8
No charge	370	0.4	0.3	0.5
Medicare paid[f]	83 920	95.4	95.0	95.8
Workers compensation paid	1 703	1.9	1.8	2.1
Other paid (for example, hospital, State)	659	0.8	0.6	0.9
Indirect encounters[g]	1 295	1.5	1.2	1.7

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2010 to March 2011. [b] An encounter is any professional interchange between a patient and a GP (Britt *et al*. 2011). [c] Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. [d] Number of encounters after post stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] For indirect encounters, the patient is not seen by the GP but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al*. (2011) *General practice activity in Australia 2010-11*, Sydney University; table 11A.1.

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

- the Practice Incentives Program (PIP)
- the General Practice Immunisation Incentives Scheme (GPII)
- the Divisions of General Practice Program (DGPP) — from 30 June 2012, Medicare Locals will assume responsibility for general practice support initiatives previously funded under the DGPP.

Australian Government expenditure on general practice in 2010-11 was $6.4 billion, or $287 per person (figure 11.33, table 11A.2).

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

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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $7.8 billion in 2010-11. Expenditure on the PBS was around $7.3 billion — or $326 per person — in 2010-11, of which 77.7 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health sector summary.

Table 11.2 **PBS and RPBS expenditure, 2010-11 ($ million)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[b]	536.0	387.6	320.8	183.4	116.6	36.4	34.0	10.1	1 624.7
PBS concessional[c]	2 001.8	1 421.6	1 081.6	467.7	487.3	165.4	56.3	16.7	5 698.4
PBS doctor's bag	4.7	3.5	3.3	1.0	1.0	0.3	0.2	0.1	14.2
PBS total	**2 542.4**	**1 812.7**	**1 405.7**	**652.1**	**605.0**	**202.1**	**90.5**	**26.9**	**7 337.4**
RPBS total[d]	162.3	94.0	109.1	36.0	34.2	13.7	7.2	0.9	457.3
PBS and RPBS Total	**2 704.7**	**1 906.7**	**1 514.8**	**688.1**	**639.2**	**215.9**	**97.6**	**27.8**	**7 794.7**
PBS $ per person[e]	349.0	323.9	308.3	281.0	365.9	396.2	249.6	116.7	325.8

a 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 DoHA's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed under s.100 of the *National Health Act 1953* [Cwlth]). **b** Includes PBS general ordinary and safety net. **c** Includes PBS concessional ordinary and concessional free safety net. **d** Includes RPBS general ordinary and safety net. **e** Excludes RPBS and PBS doctor's bag.

Source: DoHA (unpublished) PBS Statistics; table 11A.3.

Community health services

Total government expenditure data reported here includes expenditure on services that are beyond the scope of this chapter, such as, food safety regulation, media campaigns to promote health awareness and private dental services (funded by health insurance premium rebates and non-government expenditure) (table 11.3). Disaggregated expenditure data relating only to the services covered in this chapter are not available.

In 2009-10, government expenditure on community and public health was $7.9 billion, of which State, Territory and local governments provided 76.0 per cent, and the Australian Government 24.0 per cent (table 11.3). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the DVA and DoHA, was $761 million. State, Territory and local government expenditure on dental services was $628 million in 2009-10. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 11.3 **Estimated funding on community and public health, and dental services, 2009-10 ($ million)**

	Australian Government							
	DVA	*DoHA and other*[a]	*Insurance premium rebates*[b]	*Total*[c]	*State, Territory and local government*	*Total government*	*Non-government*	*Total government and non-government*
Community and public health[d]	2	1792	1	1795	5673	7467	389	7856
Dental services	107	654	495	1257	628	1885	5805	7690

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

Source: AIHW (2011) Health Expenditure Australia 2009-10, Cat. no. HWE 55.

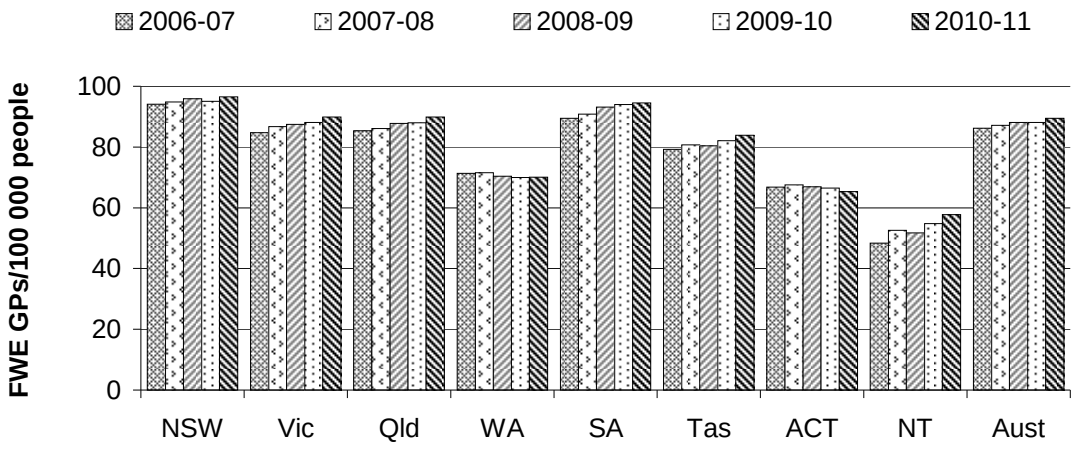
Size and scope

General practice

There were 27 639 vocationally recognised GPs and OMPs billing Medicare Australia, based on MBS claims data, in 2010-11. On a full time workload equivalent (FWE) basis, there were 20 267 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 89.5 FWE recognised GPs and OMPs per 100 000 people (table 11A.4). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous primary healthcare services and public hospitals. In addition, 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 Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

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



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

Source: DoHA (unpublished) MBS Statistics; table 11A.4.

Nationally, around 5599 general practitioner-type services were provided per 1000 population under Medicare in 2010-11 (figure 11.2).

Figure 11.2 **GP-type service use[a, b]**

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

Source: DoHA (unpublished) MBS Statistics; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.5.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 201 million services provided under the PBS and RPBS in 2010-11, amounting to 9.0 prescriptions per person. There were around 188 million services provided under the PBS in 2010-11, of which 86.0 per cent were concessional (table 11.4).

Table 11.4 **PBS and RPBS services, 2010-11 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	8.6	6.3	5.2	2.8	1.8	0.6	0.6	0.2	26.0
PBS concessional[b]	55.4	41.5	31.0	13.2	14.0	4.7	1.5	0.5	161.8
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.3
PBS total	64.1	47.9	36.2	16.0	15.8	5.3	2.1	0.6	188.1
RPBS total[c]	4.6	2.9	3.1	1.0	1.0	0.4	0.2	–	13.3
Total	**68.7**	**50.8**	**39.4**	**17.0**	**16.9**	**5.7**	**2.3**	**0.7**	**201.4**
Services per person[d]	9.4	9.1	8.7	7.3	10.2	11.2	6.4	2.9	9.0

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

Source: DoHA (unpublished) PBS Statistics; table 11A.6.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.81–11A.89 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) and 13 (Aged care services).

Maternal and child health

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

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students (tables 11A.81–11A.89).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2010-11 targeted at disadvantaged people (tables 11A.81–11A.89).

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 11.5).

Table 11.5 **Use of public dental services by service type, per 1000 people, 2010[a, b, c, d]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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 11A.7.

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2011a). Treatment activities excluded from that report include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 671 alcohol and other drug treatment agencies reported 2009-10 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). Of these, 307 (45.8 per cent) identified as government providers and 364 (54.2 per cent) identified as non-government providers (table 11A.8). All of the non-government providers received some government funding for 2009-10. There were 146 786 reported closed treatment episodes in 2009-10 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.8 per cent of whom were male, accounted for 140 769 closed treatment episodes (AIHW 2011a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (47.9 per cent). Cannabis was the next most common drug of concern (23.2 per cent), followed by heroin (9.9 per cent) and amphetamines (7.1 per cent) (AIHW 2011a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.81–11A.89.

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 2009-10, 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.81–11A.89).

Data on Indigenous primary healthcare services that receive funding from the Australian Government are collected through the OATSIH Services Reporting (OSR) questionnaire (the OSR data collection replaced 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 2009-10, OSR data are reported for 223 Indigenous primary healthcare services (table 11A.9). Of these services, 91 (40.8 per cent) were located in remote or very remote areas (table 11A.10). 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.11). 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 2.4 million episodes of healthcare were provided by participating services in 2009-10 (table 11.6). Of these, over 1 million (43.9 per cent) were in remote or very remote areas (table 11A.10).

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

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	452.0	160.0	336.0	306.0	191.0	35.0	23.0	586.0	2 089.0
2009-10	542.4	184.8	378.8	408.8	191.6	36.2	25.7	622.4	2 390.7

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 (unpublished) OSR data collection.

The services included in the OSR data collection employed 3115 full time equivalent health staff (as at 30 June 2010). Of these, 1701 were Indigenous (54.6 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (4.8 per cent and 10.4 per cent, respectively) (table 11A.12).

11.2 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for primary and community health (box 11.1). The framework 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 Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with health performance indicators in the NHA.

Box 11.1 Objectives for primary and community health

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

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

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

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 11.3). The performance indicator framework shows which data are comparable in the 2012 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6).

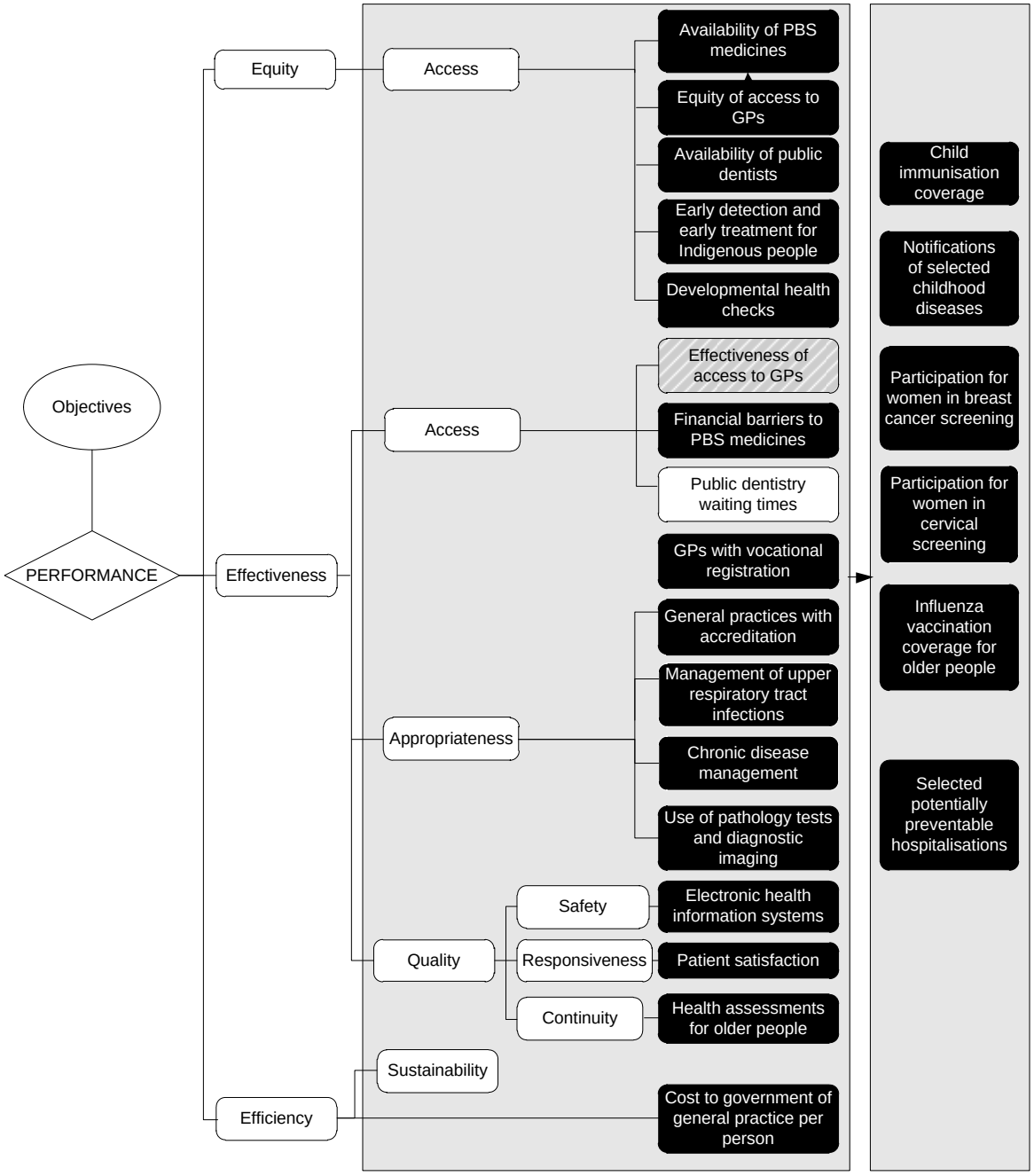
The framework has been revised to report a number of indicators with similar characteristics as separate measures under new high level indicators:

- 'Availability of GPs by region' and 'availability of female GPs' are reported as separate measures under the 'equity of access to GPs' indicator
- 'Bulk billing rates', 'people deferring visits to GPs due to financial barriers', 'GP waiting times' and 'selected potentially avoidable GP-type presentations to emergency departments' are reported as separate measures under the 'effectiveness of access to GPs' indicator
- 'Management of diabetes', 'management of asthma' and 'care planning and case conferencing' are reported as separate measures under the 'chronic disease management' indicator
- 'Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions', 'potentially preventable hospitalisations for diabetes' and 'potentially preventable hospitalisations of older people for falls' are reported as separate measures under the 'selected potentially preventable hospitalisations' indicator.

In addition, the indicator 'participation for women in breast cancer screening', reported in the Breast cancer framework in chapter 12 'Health management issues' in previous editions of this Report, is now included in the Primary and community health performance indicator framework.

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

Figure 11.3 **Primary and community health performance indicator framework**



Key to indicators

Text — Data for these indicators comparable, subject to caveats to each chart or table

Text — Data for these indicators not complete or not directly comparable

Text — These indicators yet to be developed or data not collected for this Report

11.3 Key performance indicator results

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

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous people relative to other Australians (SCRGSP 2011).

Access

Availability of PBS medicines

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

Box 11.2 **Availability of PBS medicines**

'Availability of PBS medicines' is defined by 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 in these measures by region.

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 for this indicator are comparable.

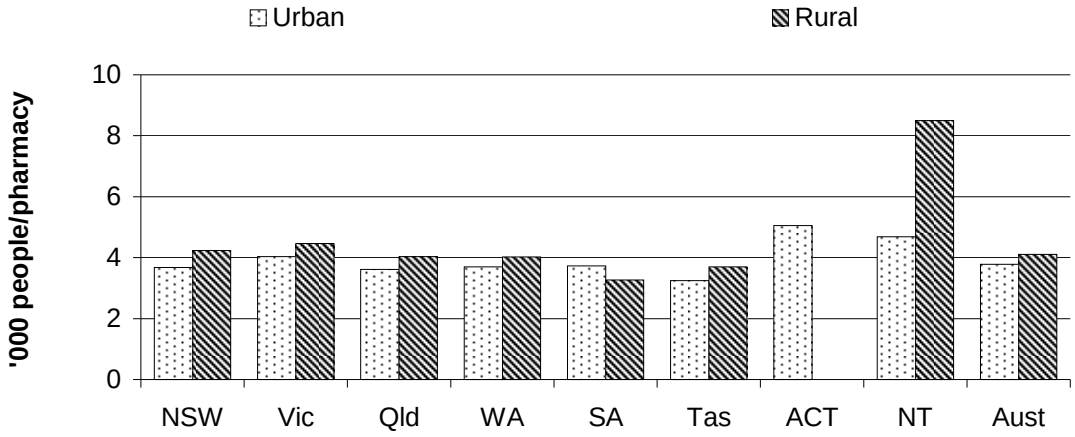
Data quality information for this indicator is under development.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3777 people per pharmacy in urban areas and 4108 in rural areas in 2010-11. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.4, table 11A.13).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 39 medical practitioners and 238 hospitals — 89 private and 149 public[1] — approved to supply PBS medicines to the community in 2010-11. The approved medical practitioners and 47 of the approved public hospitals were located in rural areas (table 11A.13).

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

Figure 11.4 **People per pharmacy, 2010-11[a, b]**

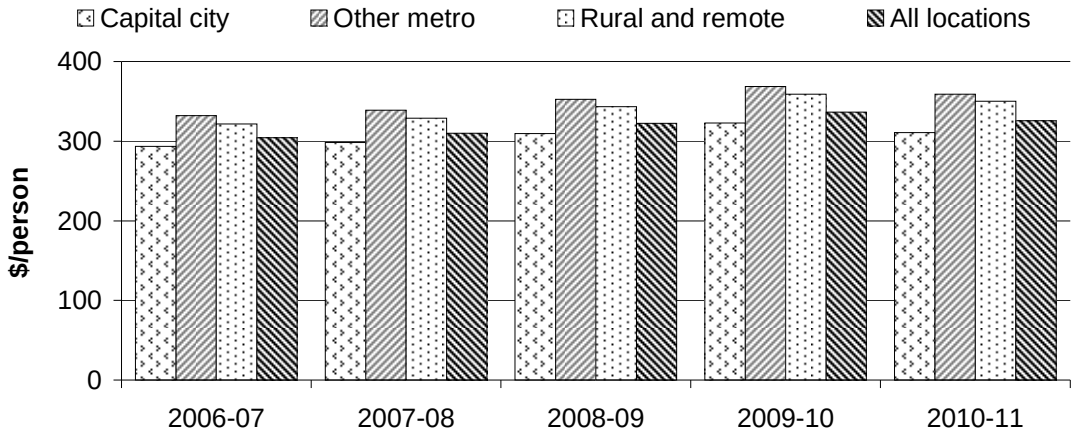


a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. **b** Excludes RPBS and doctor's bag.

Source: DoHA (unpublished) derived from Medicare Australia, ABS *2006 Census of Population and Housing* and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems; table 11A.13.

Nationally, PBS expenditure per person decreased from $337 in 2009-10 to $326 in 2010-11 (in 2010-11 dollars) (figure 11.5). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2006-07 to 2010-11 (in 2010-11 dollars).

Figure 11.5 **PBS expenditure per person (2010-11 dollars)[a]**



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

Source: DoHA (unpublished) PBS Statistics; table 11A.14.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.6. These data are not available by regional location. Nationally, 86.0 per cent of prescriptions subsidised under the PBS were concessional in 2010-11.

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 11.3).

Box 11.3 **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 female GPs', defined as the number of female FWE GPs, per 100 000 females.

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 female GPs means it is more likely that female patients who prefer to visit female GPs will have their preference met. Low availability of female GPs can similarly be associated with increased waiting times to see a GP, for women who prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

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

Data for this indicator are comparable.

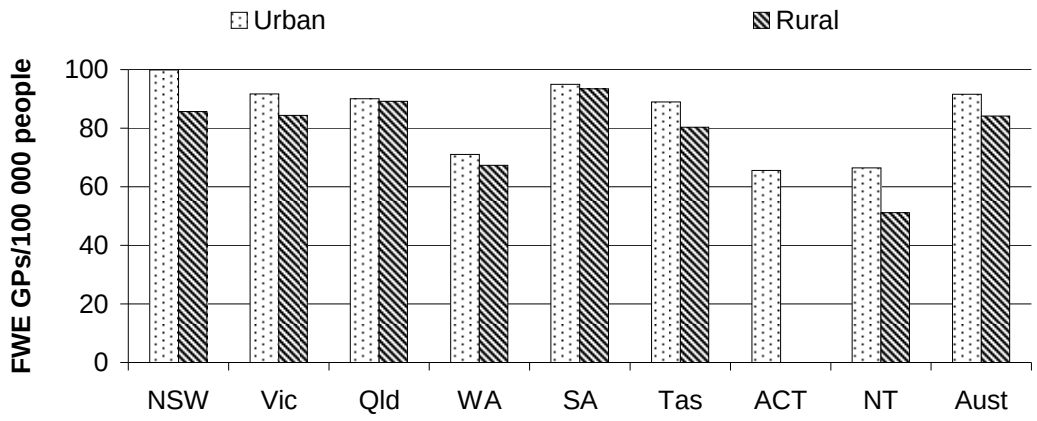
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Equity of access to GPs — availability of GPs by region

In terms of FWE GPs per 100 000 people, there were more GPs available in urban areas than in rural areas in all states and territories in 2010-11 (figure 11.6). The bulk billed proportion of non-referred attendances was generally lower in rural and

remote centres, than in capital cities, other metropolitan centres and 'other remote' areas (table 11A.24).

Figure 11.6 **Availability of GPs (full time workload equivalent), 2010-11[a, b, c]**



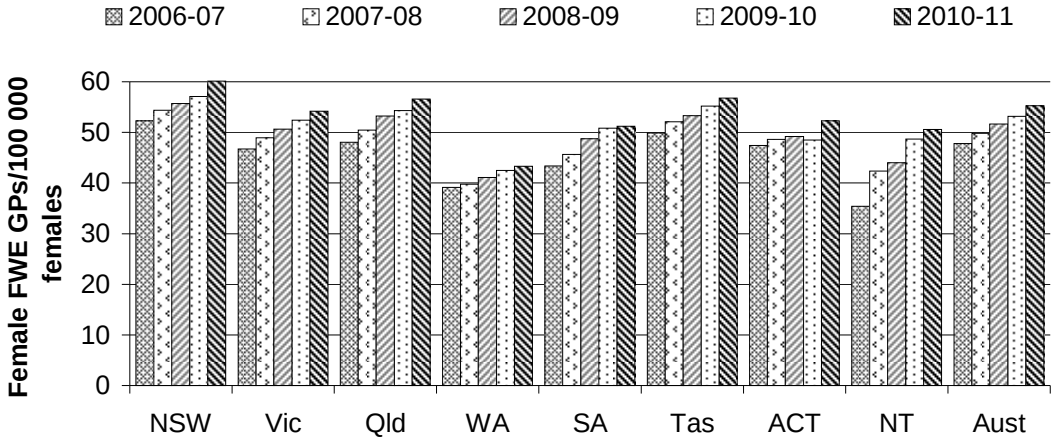
a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas. **b**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

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

Equity of access to GPs — availability of female GPs

In 2010-11, 40.8 per cent of Australia's GPs — 31.0 per cent of FWE GPs — were female (tables 11A.4 and 11A.16). The number of FWE GPs per 100 000 females increased from 47.8 to 55.2 in the period 2006-07 to 2010-11 (figure 11.7).

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



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

Source: DoHA (unpublished) MBS Statistics; table 11A.16.

Availability of public dentists

'Availability of public dentists' is an indicator of governments' objective to provide equitable access to dental services (box 11.4).

Box 11.4 **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.

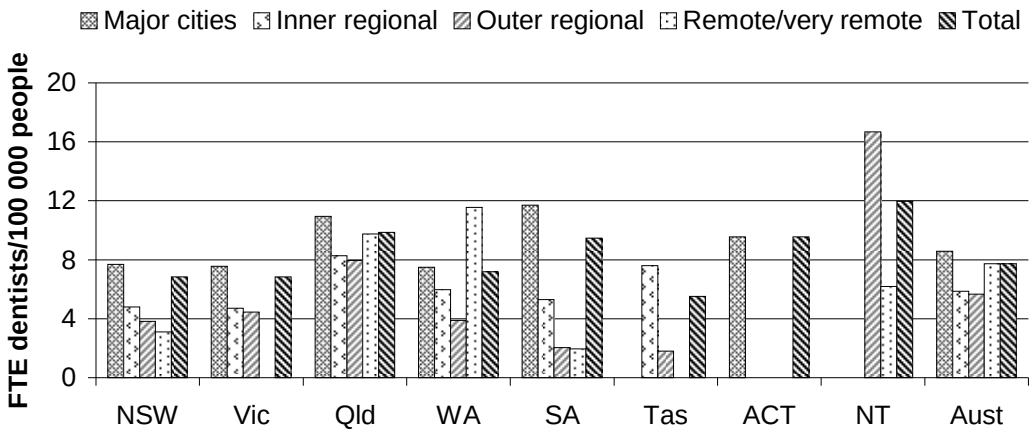
This indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas in 2009 (figure 11.8, table 11A.17). Data for FTE dental therapists are presented in table 11A.18.

Figure 11.8 **Availability of public dentists, 2009**[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 and very remote areas in Victoria or Tasmania. There were no public dentists in inner regional areas in the ACT. [d] Tasmania has no major cities. The ACT has no outer regional, or remote and very remote, areas. The NT has no major cities or inner regional areas.

Source: AIHW (unpublished) National dental labour force collection; table 11A.17.

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 11.5).

Box 11.5 **Early detection and early treatment for Indigenous people**

'Early detection and early treatment for Indigenous people' 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 prevention and intervention measures in a timely fashion (early treatment).

Four measures of early detection and early treatment for Indigenous people are reported:

- The proportion of older people who received a health assessment by Indigenous status, where
  - 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 sector summary)
  - 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 Indigenous people who received a health assessment in successive years of a five year period.
- The proportion of Indigenous people who received a health assessment or check by age group — health assessment/checks are available for Indigenous children (0–14 years), adults (15–54 years) and older people (55 years or over).
- The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

A low or decreasing gap between the proportion of all older people and older Indigenous people who received a health assessment can indicate 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 health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Indigenous people in different age groups who 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 next page)

Box 11.5 **(Continued)**

This indicator provides no information about the proportion of people who receive early detection and early treatment services that are not listed in the MBS. Such services are provided by salaried GPs in community health settings, hospitals and Aboriginal and Torres Strait Islander 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.

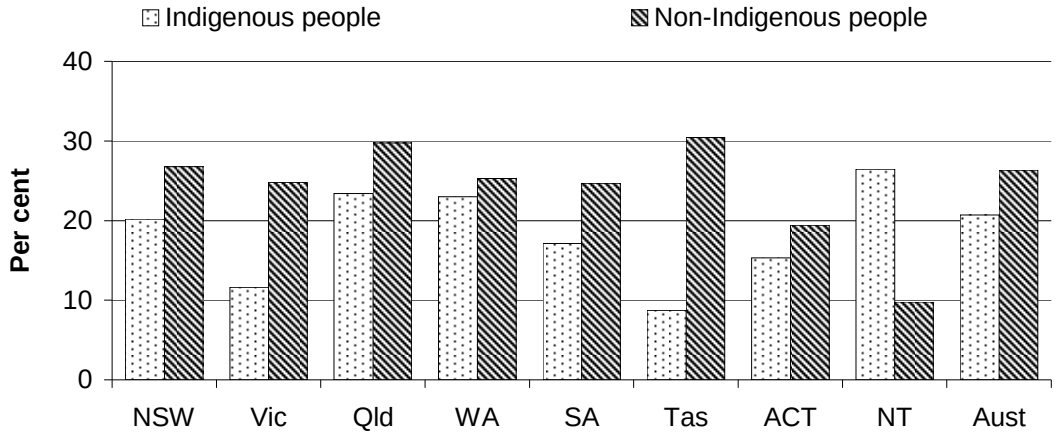
Data for this indicator are comparable.

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 2011). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people's health.

In 2010-11, the proportion of Indigenous older people who received an annual health assessment was lower than the proportion of non-Indigenous older people who received an annual health assessment in all jurisdictions except the NT (figure 11.9). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.9 **Older people who received an annual health assessment by Indigenous status, 2010-11[a, b]**

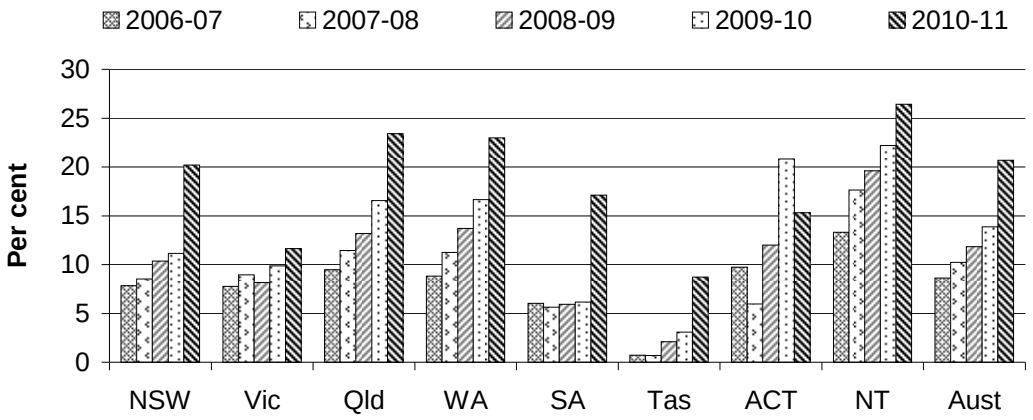


a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. **b** Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may receive a health assessment under the 'all older people' MBS items. This is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

Source: Derived from DoHA (unpublished) MBS Statistics, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (2010) *Australian demographic statistics June quarter 2010*, Cat. no. 3101.0; table 11A.19.

The proportion of older Indigenous people who received an annual health assessment increased in most jurisdictions between 2006-07 and 2010-11 (figure 11.10).

Figure 11.10 **Older Indigenous people who received an annual health assessment[a]**



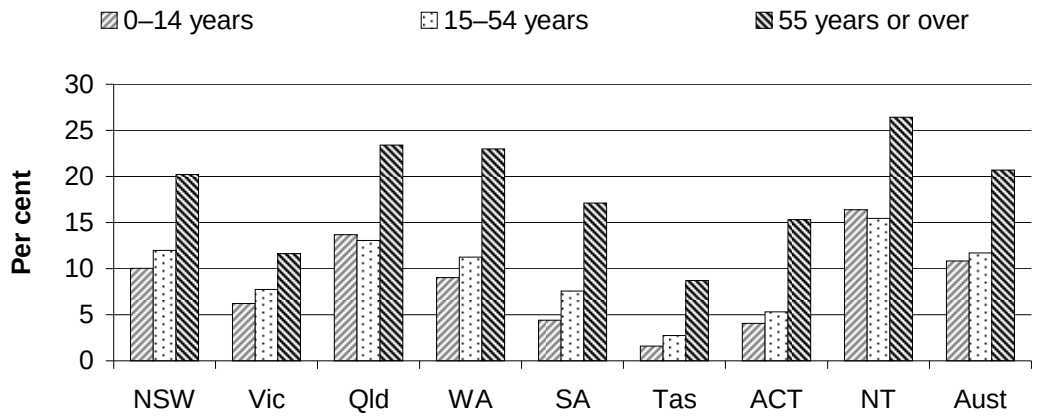
a Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may receive a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions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

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

Health check MBS items were introduced for Indigenous 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 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 11.11). 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 11.11 **Indigenous people who received a health check or assessment by age, 2010-11[a]**

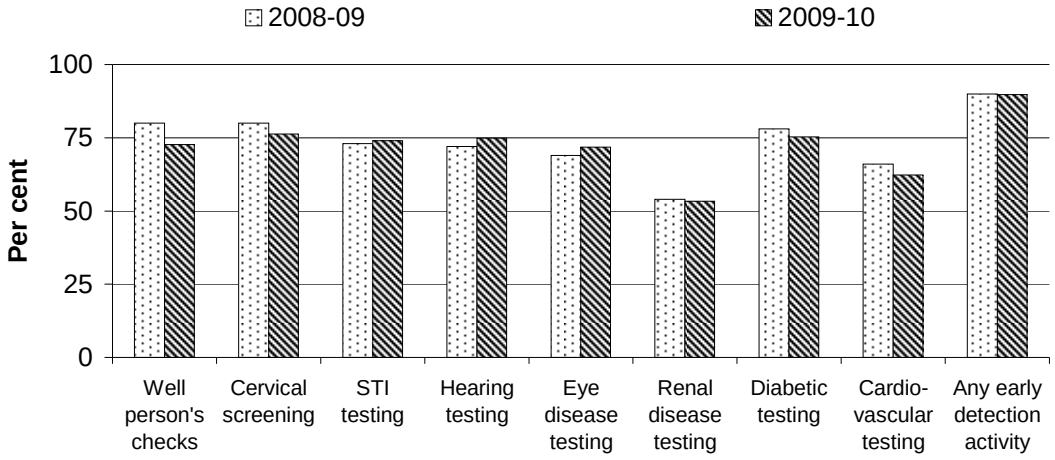


a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of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

Source: Derived from DoHA (unpublished) MBS Statistics and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.21.

Figure 11.12 shows the proportion of Indigenous primary healthcare services for which OSR data are reported that provided various early detection services in 2008-09 and 2009-10.

Figure 11.12 **Indigenous primary healthcare services for which OSR data are reported that provided early detection services[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.22.

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 11.6).

Box 11.6 **Developmental health checks**

'Developmental health checks' is defined as the proportion of children who received a fourth year developmental health check under Medicare, by health check type. Health check type is considered as a proxy for Indigenous status. The 'Healthy Kids Check' MBS health assessment item is available to children aged 3, 4 or 5 years, while the 'Aboriginal and Torres Strait Islander Peoples Health Assessment' item is available to Indigenous children aged 0–14 years.

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

The proportion of Indigenous children aged 3, 4 or 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is considered as a proxy for the proportion of Indigenous children who received a fourth year developmental health check. This should be considered a minimum estimate as the data exclude checks received by Indigenous children under the Healthy Kids Check item.

Fourth year developmental health checks 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.

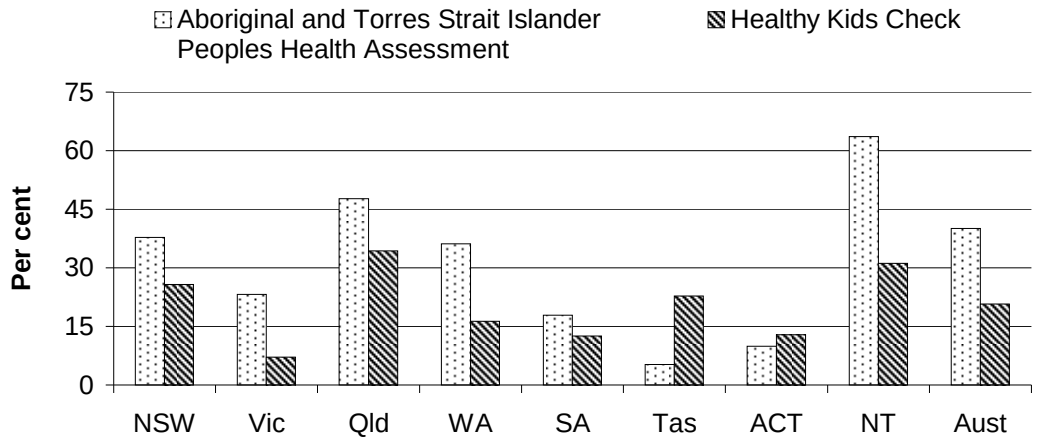
This indicator provides no information about developmental health checks for children that are provided outside Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community 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 for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, 21.7 per cent of children received a fourth year developmental health check under Medicare in 2010-11. The proportion of Indigenous children who received an Aboriginal and Torres Strait Islander Peoples Health Assessment was higher than the proportion of children who received a Healthy Kids Check in most jurisdictions (figure 11.13).

Figure 11.13 **Children who received a fourth year developmental health check, by health check type, 2010-11[a, b, c, d, e]**



a Limited to health checks available under 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; where a child received both types of health check during the reference period they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. **e** Healthy Kids Check data include Indigenous children who received a Healthy Kids Check provided they did not also receive a Aboriginal and Torres Strait Islander Peoples Health Assessment during the reference period.

Source: DoHA (unpublished) MBS Statistics; 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.23.

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 11.7). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

Box 11.7 **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 24 hours
  - more than 24 hours
- 'selected potentially avoidable GP-type presentations to emergency departments', 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 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.

A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs. A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs. A low or decreasing proportion of GP-type presentations to emergency departments can indicate better access to primary and community health care.

Data for the first three measures of this indicator are comparable, while data for the fourth measure 'selected potentially avoidable GP-type presentations to emergency departments' are not directly comparable.

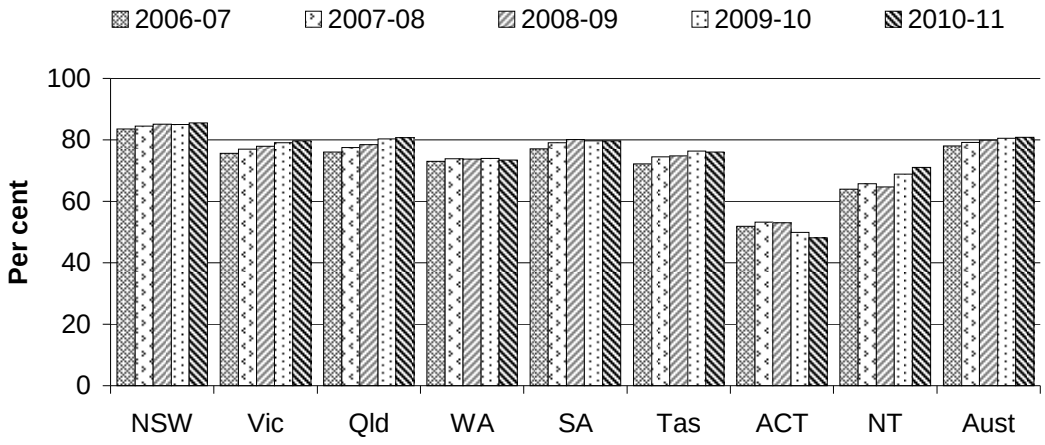
Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

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 Medicare. Where a patient is bulk billed they make no out-of-pocket contribution; the GP bills Medicare Australia directly and, since 1 January 2005, receives 100 per cent of the Schedule fee (the patient rebate) as full payment for the service. The 100 per cent Medicare rebate applies to most GP services.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 80.9 per cent in 2010-11. For most jurisdictions, this proportion increased in the period 2006-07 to 2010-11 (figure 11.14). The bulk billed proportion of non-referred attendances was highest in 'other remote areas', 'capital cities' and 'other metropolitan centres' (table 11A.24). The bulk billed proportion of non-referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 11A.25).

Figure 11.14 **GP visits that were bulk billed[a, b]**



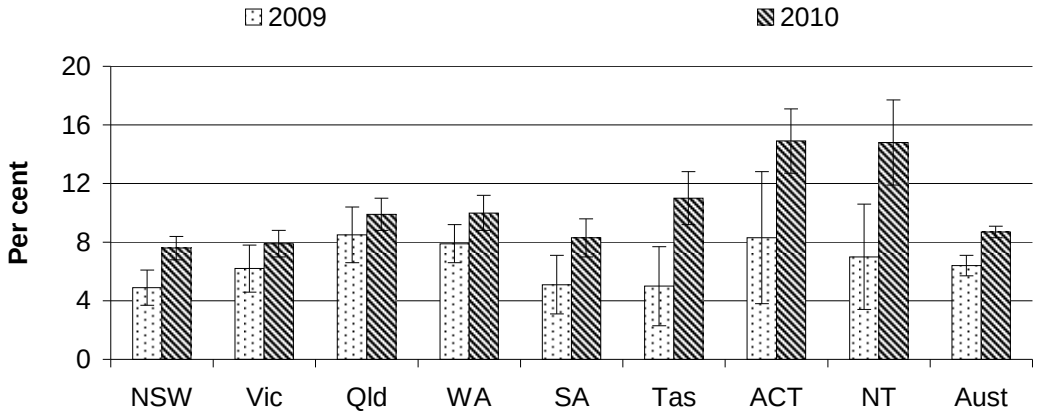
a Includes attendances by practice nurses. **b** Allocation to State/Territory based on patients' Medicare enrolment postcode.

Source: DoHA (unpublished) MBS Statistics; table 11A.25.

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 2010, 8.7 per cent of respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 11.15).

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



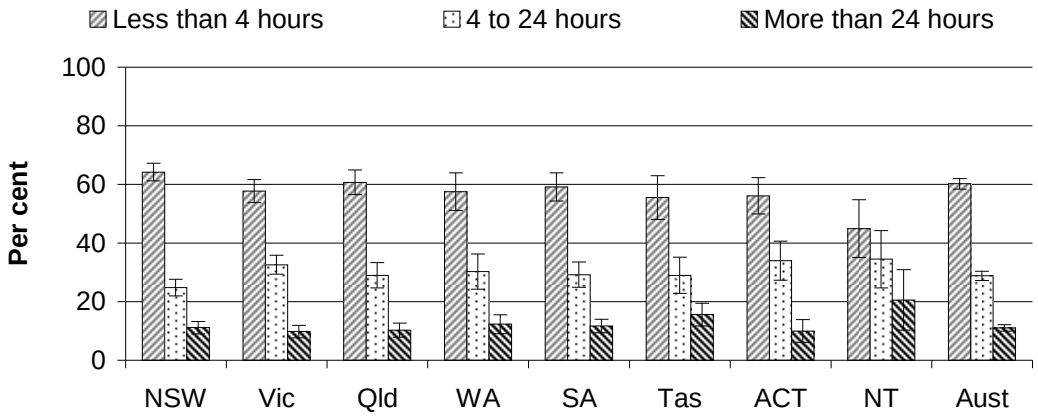
[a] People aged 15 years or over. [b] Delayed visiting or did not visit a GP at any time in the previous 12 months. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey* 2009, 2010-11; table 11A.26.

Effectiveness of access to GPs — GP waiting times

Nationally, 60.2 per cent of people who saw a GP for urgent care waited less than 4 hours in 2010 (figure 11.16). Around 28.8 per cent waited from 4 to less than 24 hours, and 11.0 per cent waited for more than 24 hours. For visits to GPs not requiring urgent care, 15.5 per cent of people waited longer than they felt was acceptable to get an appointment (table 11A.28).

Figure 11.16 **Hours waited for urgent treatment by GP, 2010**[a, b, c, d]



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

Source: ABS (unpublished) *Patient Experience Survey 2010-11*; table 11A.27.

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). 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 2010-11 (table 11.7). Data are presented by Indigenous status and remoteness in table 11A.29.

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

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11	712.6	554.9	375.0	213.9	117.4	47.6	48.5	42.3	2112.2

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. 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. **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.30.

Financial barriers to PBS medicines

'Financial barriers to PBS medicines' is an indicator of governments' objective to ensure effective access to prescribed medicines (box 11.8).

Box 11.8 **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.

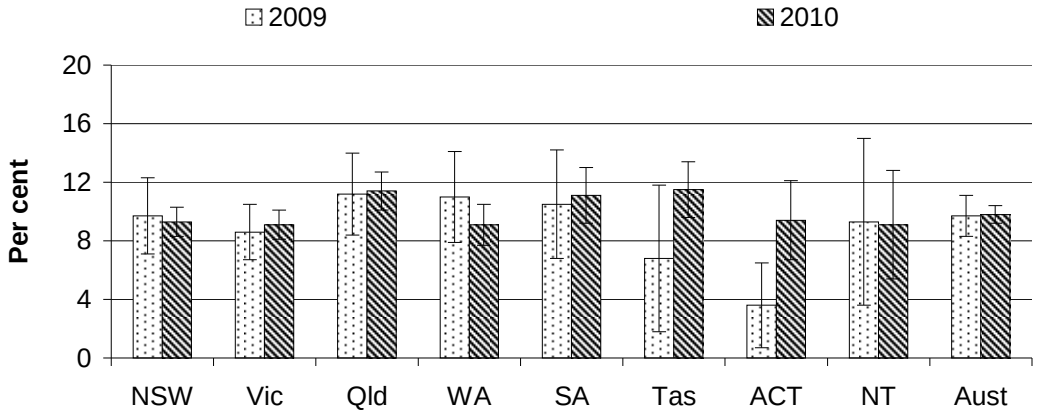
A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, in 2010, 9.8 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 11.17).

Figure 11.17 **People deferring purchase of prescribed medicines due to cost**[a, b, c, d]



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

Source: ABS (unpublished) *Patient Experience Survey 2009, 2010-11*; table 11A.32.

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 11.9).

Box 11.9 Public dentistry waiting times

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

Data for this indicator were not available for the 2012 Report.

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 11.10).

Box 11.10 **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 2007).

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. However, GPs without vocational registration can deliver services of equally high quality.

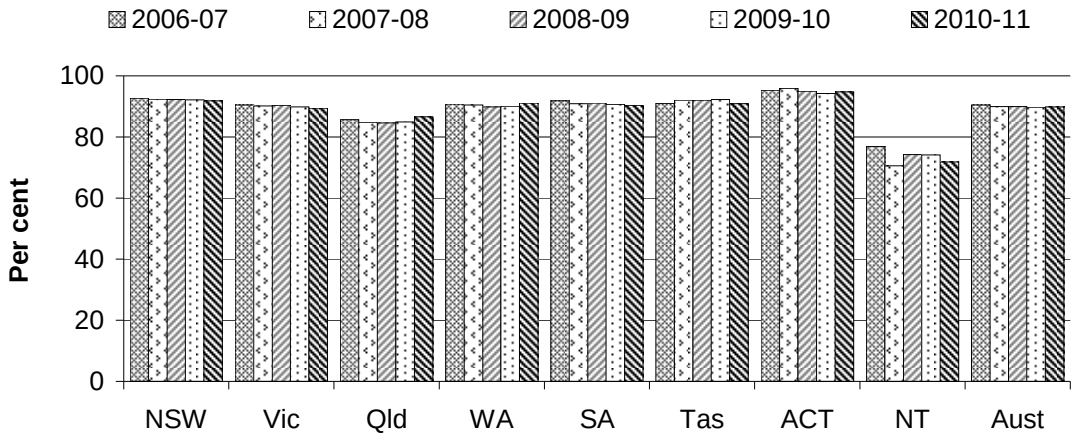
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2010-11 (figure 11.18). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in remote areas, in 2010-11 (table 11A.33).

Figure 11.18 **GPs (full time workload equivalent) with vocational registration[a]**



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

Source: DoHA (unpublished) MBS Statistics; table 11A.34.

General practices with accreditation

'General practices with accreditation' is an indicator of governments' objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.11).

Box 11.11 **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 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.

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

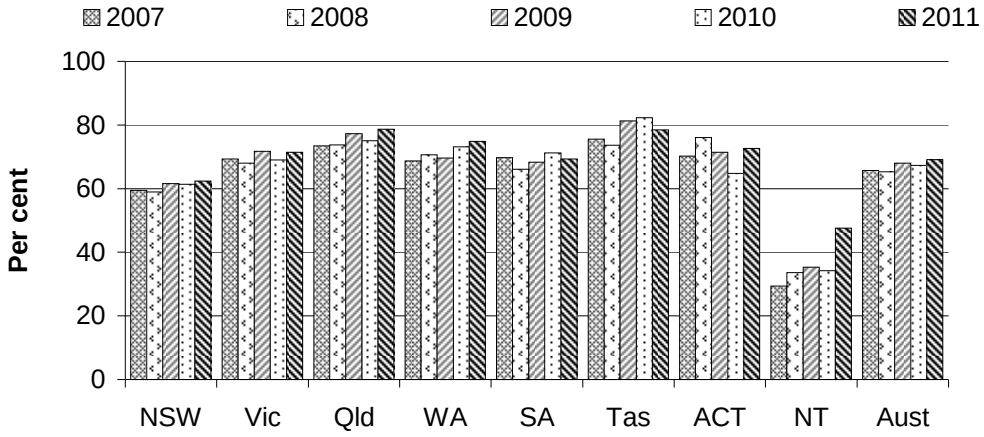
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

In June 2011, 4908 general practices — representing 69.2 per cent of general practices — were accredited nationally (figure 11.19).

Figure 11.19 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice 2010-11*; table 11A.35.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has been relatively constant in the period from 2005-06 to 2009-10 (figure 11.20).

Figure 11.20 **Proportion of general practice patient care provided by PIP practices[a]**

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

Source: DoHA (unpublished) PIP and MBS data collections; table 11A.36.

Management of upper respiratory tract infections

'Management of upper respiratory tract infections' is an indicator of governments' objective to ensure that antibiotics are used appropriately and effectively (box 11.12).

Box 11.12 **Management of upper respiratory tract infections**

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

A low or decreasing prescription rate can indicate that GPs' management of URTI more closely follows guidelines.

URTI without complication is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless frequently prescribed for viral infections. Unnecessarily high rates of antibiotic prescription for URTI have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community. The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed. Data are reported for PBS concession card holders because complete data are not available for prescriptions provided to non-PBS concession card holders.

Data for this indicator are comparable.

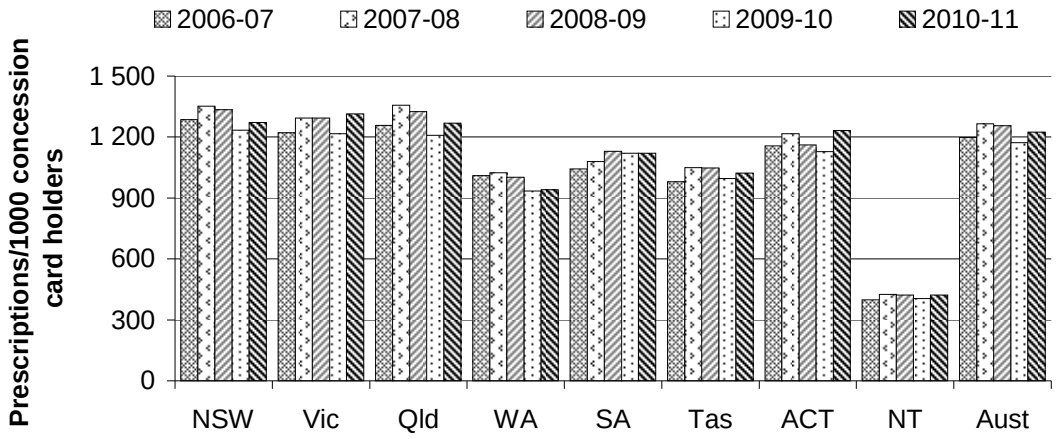
Data quality information for this indicator is under development.

Caution should be used in the interpretation of this indicator over time, as pharmaceutical needs of concession card holders can increase in complexity due to the effects of population ageing.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat URTI was 1224 per 1000 PBS concession card holders in 2010-11 (figure 11.21).

Further information on GP use of antibiotics in the management of URTI is available from the annual BEACH survey of general practice activity in Australia. Nationally, the proportion of acute URTI problems for which antibiotics were prescribed dropped from 42.0 per cent in 1998-99 to 32.4 per cent in 2009-10 (Britt *et al*. 2010).

Figure 11.21 **Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infection[a, b]**



[a] Prescriptions ordered by vocationally recognised GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders. [b] Data are not limited to prescriptions for treatment of upper respiratory tract infection.

Source: DoHA (unpublished) PBS Statistics; table 11A.37.

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 11.13).

Box 11.13 **Chronic disease management**

'Chronic disease management' is defined by three measures:

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

(Continued next page)

BOX 11.13 **(Continued)**

- '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 people with diabetes mellitus who have received an annual cycle of care within general practice is desirable. The MBS annual cycle of care for patients with diabetes is generally based on RACGP clinical guidelines for the appropriate management of Type 2 diabetes in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications. Data should be considered as minimum estimates as appropriate management of diabetes mellitus by GPs who do not claim the rebates is not captured. Various factors influence the uptake of MBS items by GPs.

A high or increasing proportion of people with diabetes with HbA1c below 7 per cent is desirable. HbA1c measures the level of glucose in the blood averaged over the preceding three months. Data for this measure were not available for the 2012 Report.

A high or increasing proportion of people with asthma who have a written asthma action plan is desirable. Written asthma action plans have been included in clinical guidelines for asthma management for nearly 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, and 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.

Data reported against this indicator are comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

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 2008c, 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

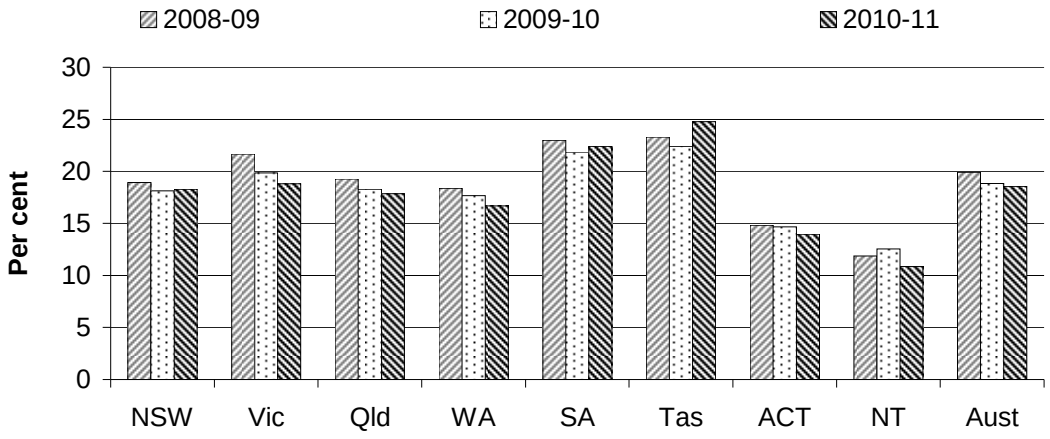
Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, 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 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosolated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007).

Nationally, 18.6 per cent of people with diabetes received the annual cycle of care in 2010-11 (figure 11.22). Data are reported by geographical region in table 11A.38.

Figure 11.22 **People with diabetes mellitus who have received an annual cycle of care within general practice, 2009-10[a, b]**



a GPs may provide the annual cycle of care but not claim the MBS rebate. Various factors influence the uptake of MBS items by GPs. **b** Historical data differ from previous reports due to the inclusion of DVA data for the first time.

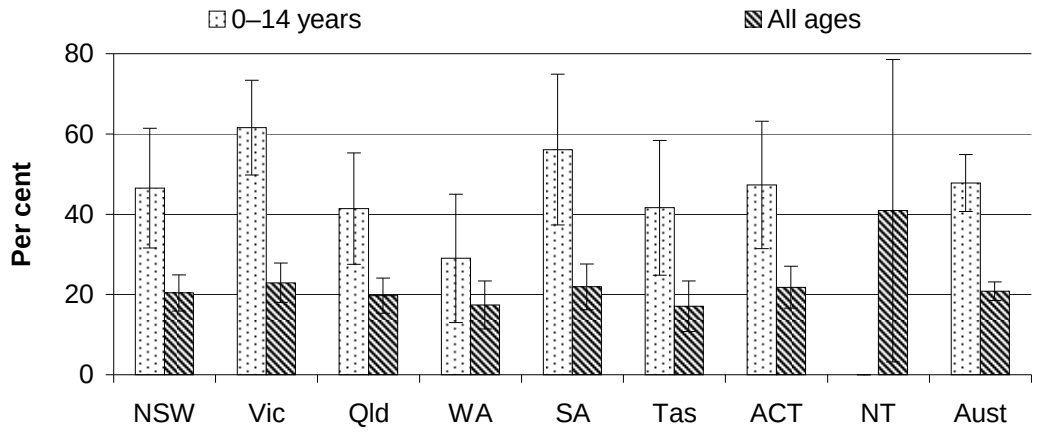
Source: DoHA (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; DoHA (unpublished) National Diabetes Services Scheme (NDSS) data collection; table 11A.38.

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 age standardised proportion of people with current asthma who reported having a written asthma action plan in 2007-08 was 20.8 per cent for all ages and 47.8 per cent for children aged 0–14 years (figure 11.23). Data are reported by geographical region in table 11A.40. Data for 2004-05 are reported by Indigenous status in table 11A.41.

Figure 11.23 **Proportion of people with asthma who have a written asthma action plan, 2007-08[a, b, c]**



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

Source: ABS (unpublished) *National Health Survey, 2007-2008*, Cat. No. 4364.0; table 11A.39.

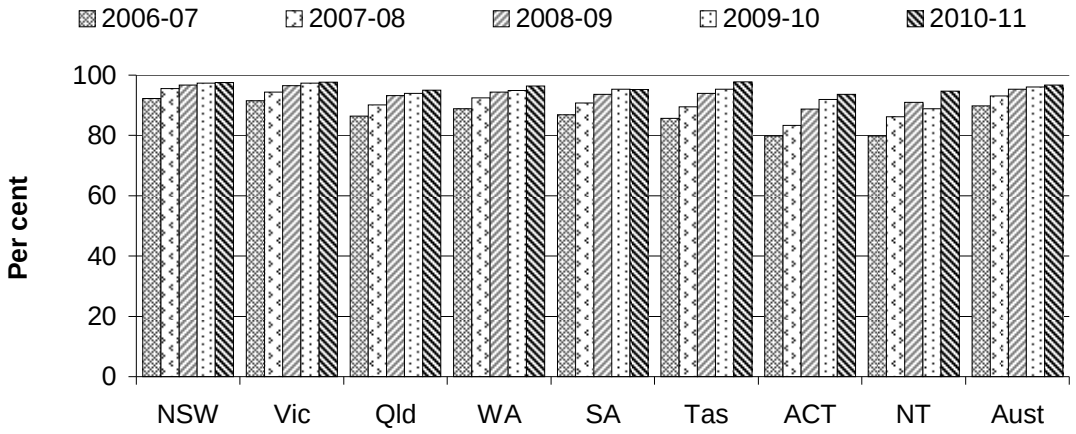
Chronic disease management — care planning and case conferencing

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 using chronic disease management MBS items for care planning or case conferencing increased from 89.8 in 2006-07 to 96.7 per cent in 2010-11 (figure 11.24). The proportion increased steadily in almost all jurisdictions in the period 2006-07 to 2010-11.

Figure 11.24 **GP use of chronic disease management MBS items for care planning and case conferencing[a]**



a The Strengthening Medicare initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. Additional chronic disease management MBS items have been introduced on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Source: DoHA (unpublished) MBS Statistics; table 11A.42.

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 11.14).

Box 11.14 **Use of pathology tests and diagnostic imaging**

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

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

(Continued next page)

Box 11.14 **(Continued)**

This indicator cannot be interpreted 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.

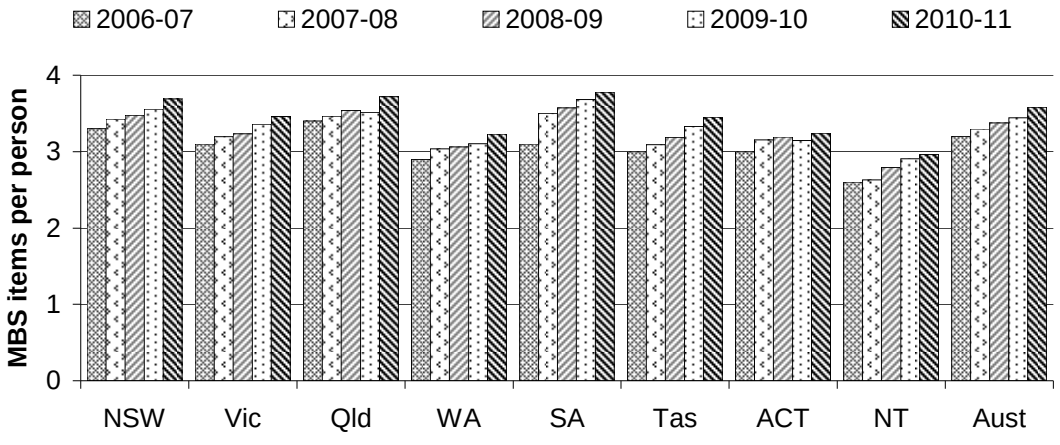
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Pathology and diagnostic imaging services performed at the request of vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. The 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 — Medicare data reflect the services provided and rebated, rather than the services requested.

Nationally, the number of rebated MBS items for pathology tests requested by GPs ranged from 3.2 to 3.6 per person in the period 2006-07 to 2010-11 (figure 11.25).

Figure 11.25 **MBS items rebated through Medicare for pathology tests requested by GPs[a]**



a Data include tests requested by vocationally recognised GPs and OMPs. Data include patient episode initiated items.

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

Australian Government expenditure (under Medicare) for pathology tests requested by vocationally recognised GPs and OMPs amounted to $1.4 billion, or around $62 per person, in 2010-11. Nationally, Medicare benefits worth $1.3 billion — around $57 per person — were paid for diagnostic imaging services provided on referral from vocationally recognised GPs and OMPs, in 2010-11 (figure 11.26).

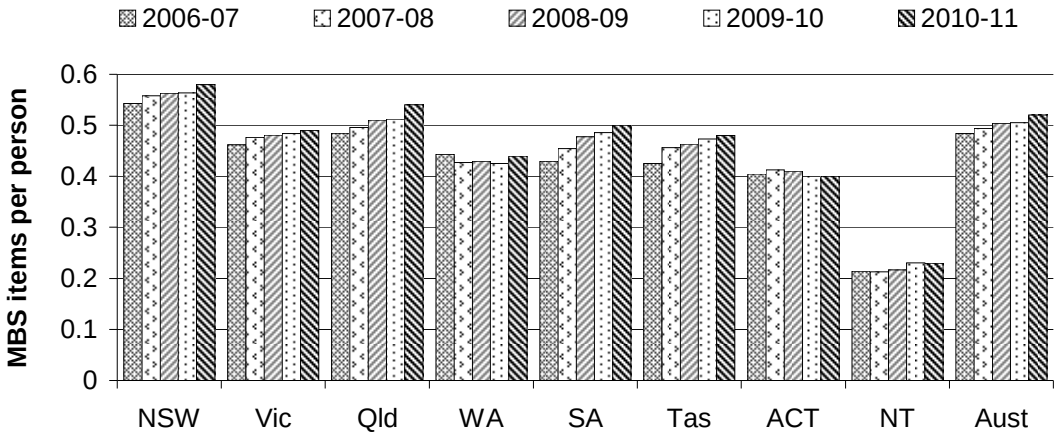
Figure 11.26 **Benefits paid for pathology tests and diagnostic imaging, 2010-11[a]**

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

Source: DoHA (unpublished) MBS and DVA data collections; tables 11A.43 and 11A.44.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs ranged from 0.48 to 0.52 per person in the period 2006-07 to 2010-11 (figure 11.27).

Figure 11.27 **Diagnostic imaging services referred by GPs and rebated through Medicare[a]**



a GPs include vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.44.

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 11.15).

Box 11.15 **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 82.8 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (DoHA unpublished; table 11A.36).

Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

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

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

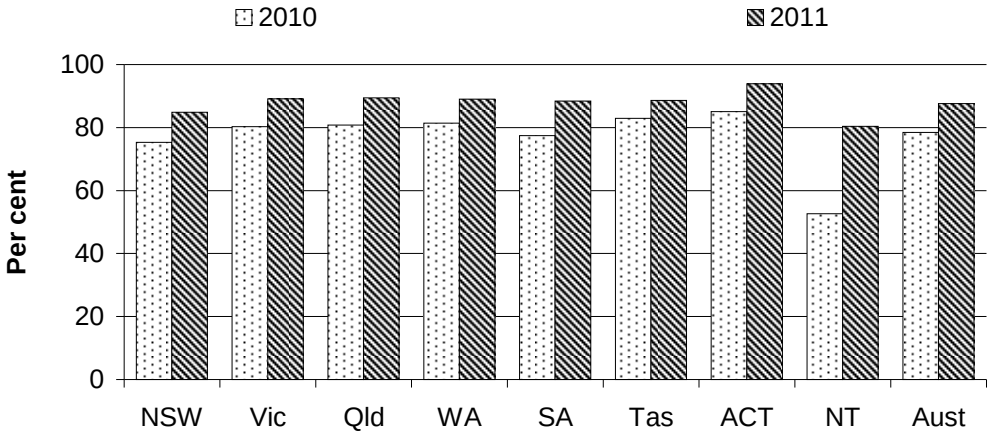
The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. It replaced, in August 2009, the PIP Information Management, Information Technology Incentive that had commenced in November 2006.

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

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

Nationally, 87.6 per cent of PIP practices used electronic health systems in May 2011, an increase from 78.5 per cent in May 2010 (figure 11.28).

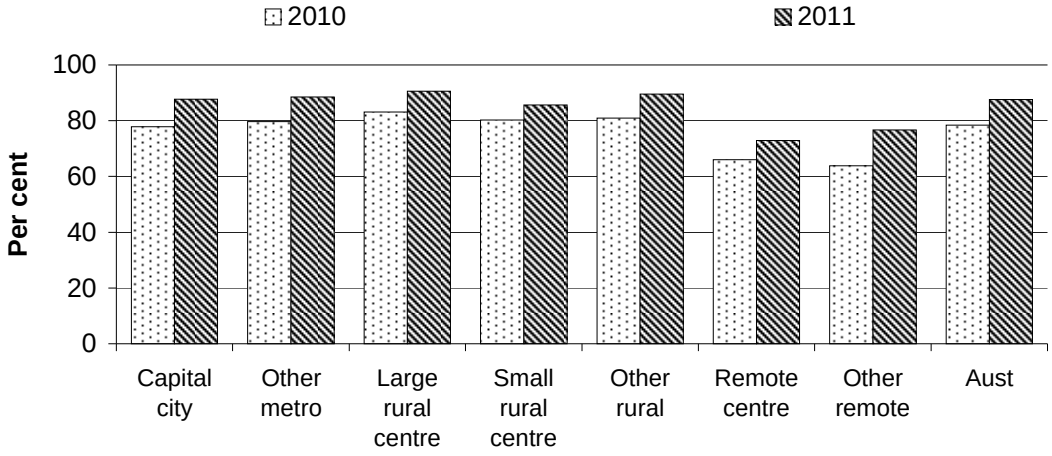
Figure 11.28 **PIP practices using electronic health systems**



Source: DoHA (unpublished) MBS and PIP data collections; table 11A.45.

The proportion of PIP practices using electronic health systems in remote areas was lower than in urban and rural areas in May 2011 (figure 11.29).

Figure 11.29 **PIP practices using electronic health systems by area[a]**



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

Source: DoHA (unpublished) MBS and PIP data collections; table 11A.46.

Quality — responsiveness

Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective to ensure primary and community health services are high quality and account for individual patient needs (box 11.16).

Box 11.16 **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 quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that the GP always or often (figure 11.30):

- listened carefully to them (89.1 per cent)
- showed respect (92.2 per cent)
- spent enough time with them (87.2 per cent).

Data are presented by remoteness area in tables 11A.47 and 11A.48.

Figure 11.30 **Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2010[a, b]**

a People aged 15 years or over who or over who saw a GP in the last 12 months. **b** Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (2011) *Patient Experience Survey*; tables 11A.47, 11A.48.

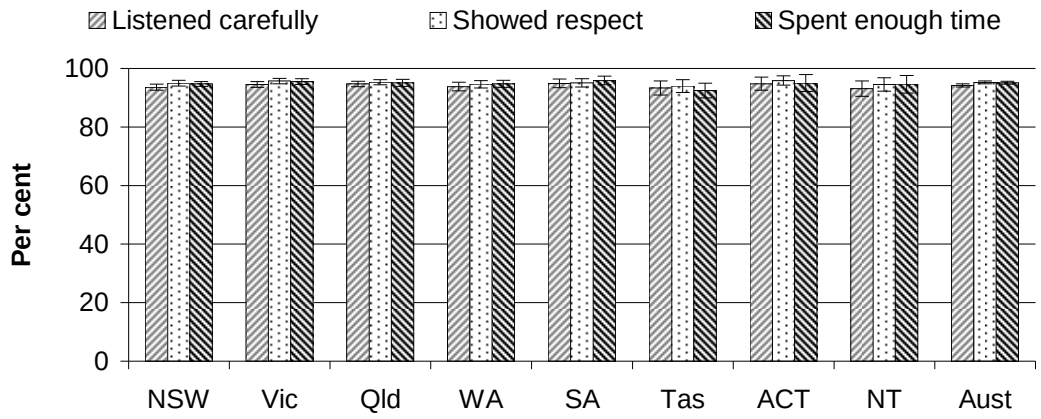
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that the dental professional always or often (figure 11.31):

- listened carefully to them (94.2 per cent)
- showed respect (95.2 per cent)
- spent enough time with them (95.1 per cent).

Data are presented by remoteness area in tables 11A.49 and 11A.50.

Figure 11.31 **Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2010** [a, b]



a People aged 15 years or over who saw a dental professional in the last 12 months. **b** Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (2011) *Patient Experience Survey*; tables 11A.49, 11A.50.

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 11.17).

Box 11.17 **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 non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Annual health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.5).

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.

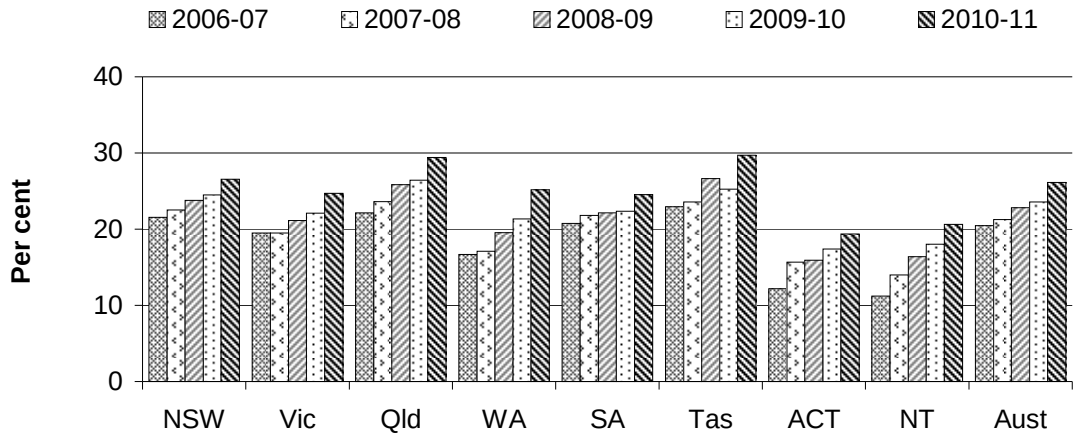
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The targeted age range for Indigenous people of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector summary). Results for Indigenous people are reported under equity indicators (box 11.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2006-07 to 2010-11. Nationally, this proportion increased from 20.5 per cent in 2006-07 to 26.2 per cent in 2010-11 (figure 11.32).

Figure 11.32 **Older people who received a health assessment[a]**



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

Source: DoHA (unpublished) MBS Statistics; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS 2010 *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.51.

Sustainability

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

Efficiency

Cost to government of general practice per person

'Cost to government of general practice per person' is an indicator of governments' objective to provide primary healthcare services in an efficient manner (box 11.18).

Box 11.18 **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.

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

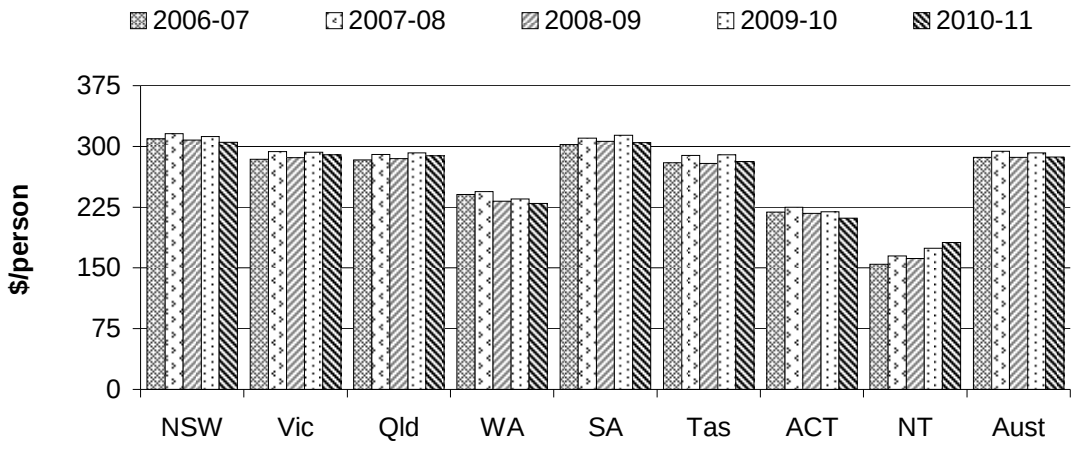
This indicator needs to be interpreted with care. A lower cost per person can reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense. This indicator does not include costs for primary healthcare services provided by salaried GPs in 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.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the recurrent cost to the Australian Government of general practice was $287 per person in 2010-11 (figure 11.33).

Figure 11.33 **Australian Government real expenditure per person on GPs (2010-11 dollars)[a]**



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

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

Outcomes

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

Child immunisation coverage

'Child immunisation coverage' is an indicator of governments' objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.19).

Box 11.19 **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, 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/2012.

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

Table 11.8 **Valid vaccinations supplied to children under 7 years of age, by provider type, 2006–2011 (per cent)[a, b, c, d]**

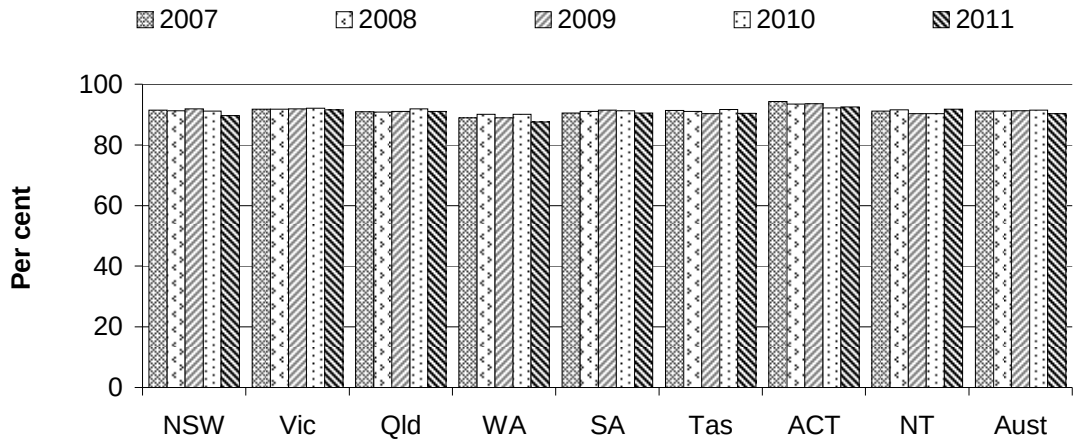
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	84.8	53.7	82.9	65.1	69.5	87.7	44.1	5.2	71.7
Council	5.4	44.9	6.9	6.0	18.7	11.5	–	–	16.6
State or Territory health department	–	–	–	6.3	0.1	0.1	16.5	0.4	0.9
Public hospital	1.9	0.6	3.0	3.6	2.3	0.2	0.7	7.5	2.0
Private hospital	0.1	–	–	–	–	–	–	0.9	–
Indigenous health service	0.5	0.1	0.6	0.6	0.5	–	0.2	11.5	0.6
Community health centre	7.3	0.7	5.9	18.5	8.7	0.5	38.5	74.4	8.0
Other[d]	–	–	0.7	–	0.1	na	–	0.2	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 2006 to 30 June 2011. **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. **na** Not available. – Nil or rounded to zero.

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.52.

Around 90.3 per cent of Australian children aged 12 months to less than 15 months at 30 June 2011 were assessed as fully immunised (figure 11.34).

Figure 11.34 **Children aged 12 months to less than 15 months who were fully immunised[a, b, c, d]**

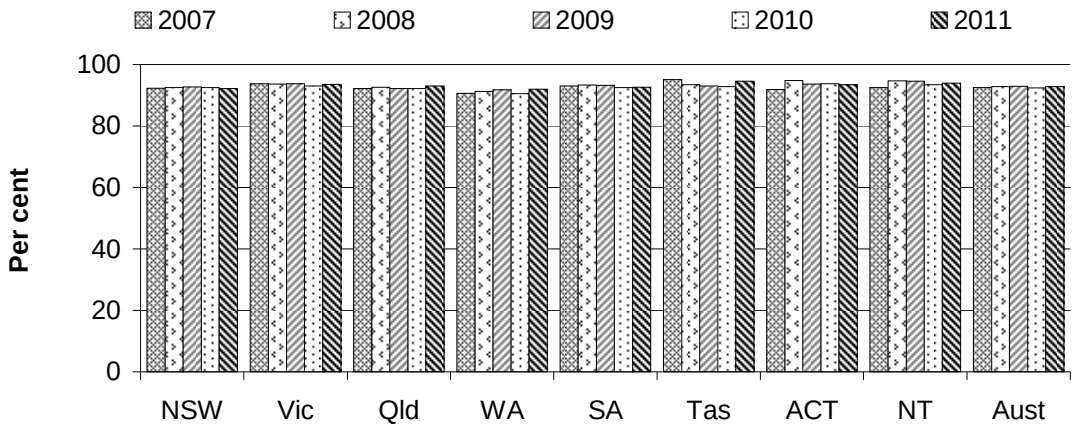


a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. **b** The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare. **c** There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). **d** Relatively low coverage rates for the June 2011 quarter are associated with parents not receiving immunisation reminders due to administrative error.

Source: DoHA (unpublished) ACIR data collection; table 11A.53.

Nationally, 92.8 per cent of children aged 24 months to less than 27 months at 30 June 2011 were assessed as being fully immunised (figure 11.35).

Figure 11.35 **Children aged 24 months to less than 27 months who were fully immunised[a, b, c]**

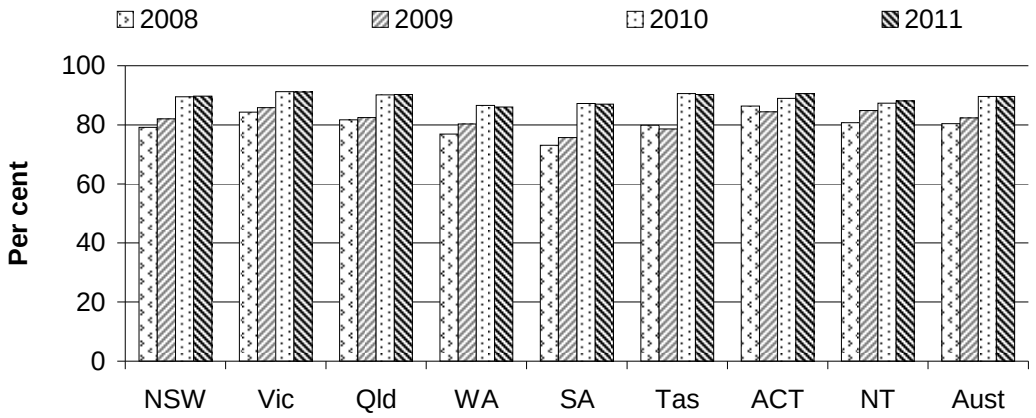


a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. **b** The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children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

Source: DoHA (unpublished) ACIR data collection; table 11A.54.

Nationally, 89.6 per cent of Australian children aged 60 months to less than 63 months at 30 June 2011 were assessed as fully immunised (figure 11.36). Data are presented by Indigenous status and remoteness in table 11A.56.

Figure 11.36 **Children aged 60 months to less than 63 months who were fully immunised[a, b, c, d]**



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

Source: DoHA (unpublished) ACIR data collection; table 11A.55.

Notifications of selected childhood diseases

'Notifications of selected childhood diseases' is an indicator of governments' objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 11.20).

Box 11.20 **Notifications of selected childhood diseases**

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

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

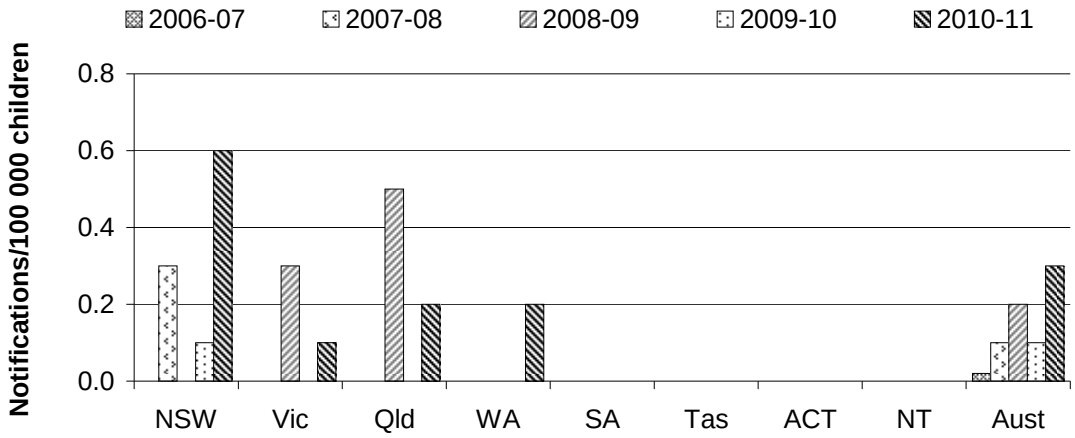
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Data are presented by financial year for the first time in the 2012 Report, improving the timeliness of reporting.

In 2010-11, there were 61 notifications of measles across Australia (table 11A.57). This was the highest number of notifications in the five year period 2006-07 to 2010-11. The national notification rate was 0.3 per 100 000 children aged 0–14 years in 2010-11 (figure 11.37).

Figure 11.37 **Notifications of measles per 100 000 children aged 0–14 years[a]**

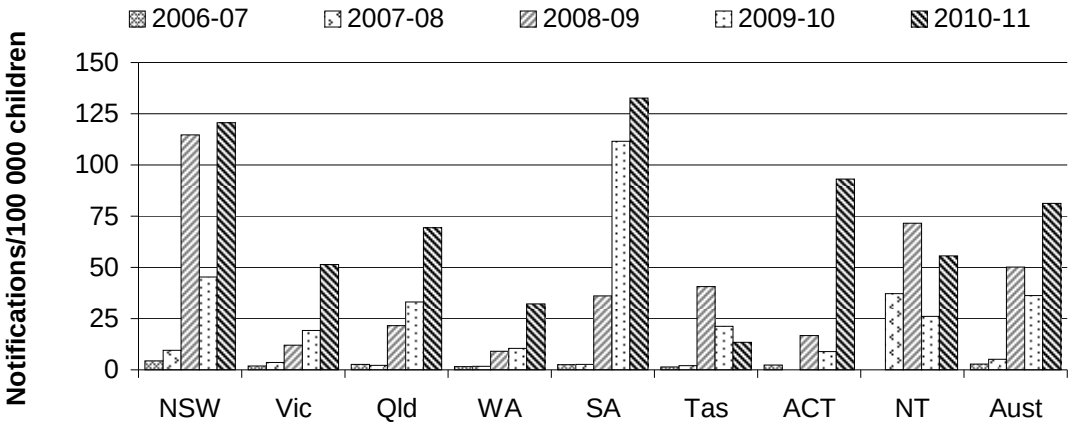


a Data are suppressed where there are fewer than 5 notifications.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.57.

Nationally, there were over 18 000 notifications for pertussis (whooping cough) in 2010-11. The national notification rate in 2010-11 was 81.3 per 100 000 children aged 0–14 years (figure 11.38).

Figure 11.38 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years[a]**

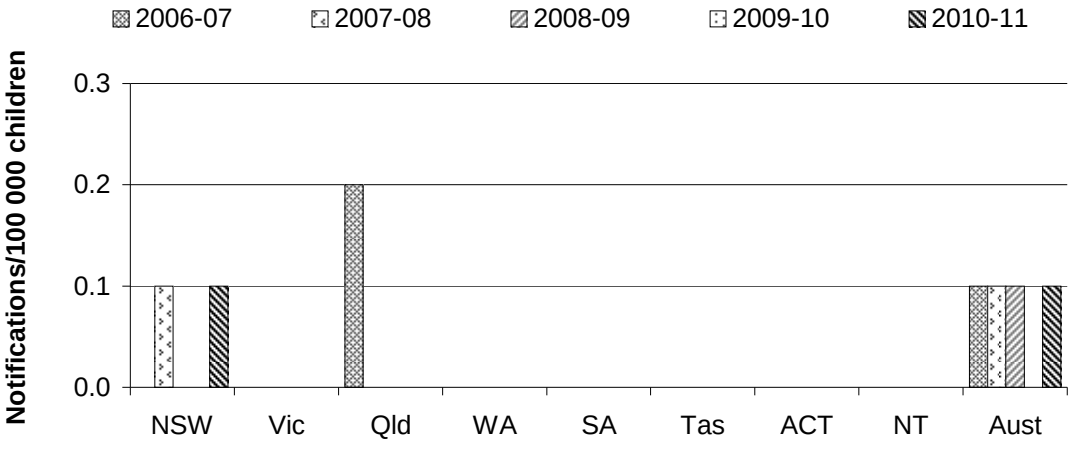


a Data are suppressed where there are fewer than 5 notifications.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.58.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2010-11, the notification rate nationally was 0.1 per 100 000 children aged 0–14 years (figure 11.39).

Figure 11.39 **Notifications of *Haemophilus influenzae* type b per 100 000 children aged 0–14 years[a]**



a Data are suppressed where there are fewer than 5 notifications.

Source: DoHA (unpublished) NNDSS, *ABS Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.59.

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 11.21).

Box 11.21 **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 for this indicator are comparable.

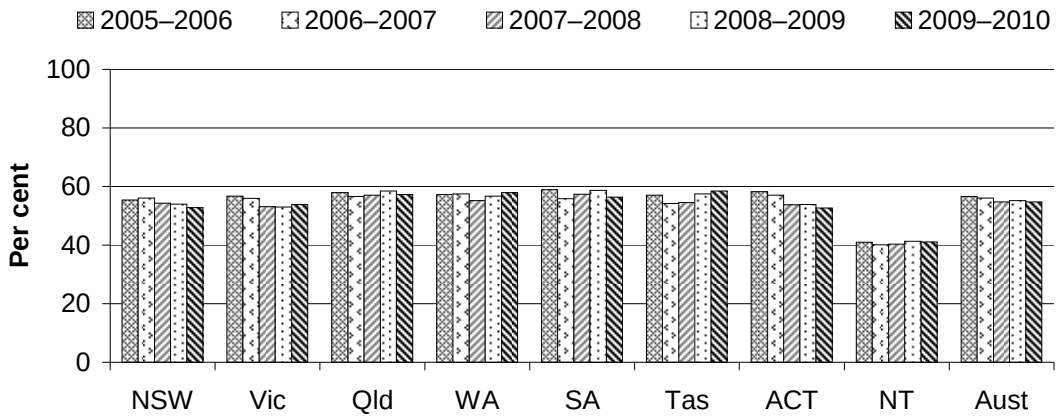
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

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. It aims to achieve at least 70 per cent participation in screening over a period of 24 months in the target group of women aged 50–69 years. Women aged 40–49 years and 70 years or over can also access the program.

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 (DoHA 2009). Further, the relatively high proportion of cancers that are detected early, and treated by breast conserving surgery, was associated with reduced treatment related morbidity for Program participants.

The national participation rate for women aged 50–69 years in BreastScreen Australia screening programs was 54.8 per cent in the 24 month period 2009 and 2010, well below the 70 per cent aim under the National Accreditation Standards (figure 11.40).

Figure 11.40 **Age standardised participation rate for women aged 50–69 years in BreastScreen Australia screening programs (24 month period)[a, b, c, d]**



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. **b** For the 2009–2010 reference period, women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction except the ACT (92.2 per cent). **c** The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. **d** Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2008, 2009, 2010) *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0; tables 11A.60, 11A.61.

Indigenous 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.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.9. In the 24 month period 2009 and 2010, the national age standardised participation rate for Indigenous women aged 50–69 years (36.2 per cent) was below the total participation rate in that age group (54.8 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records (table 11A.62). For NESB women for the same 24 month period and age group, the national participation rate of 49.2 per cent was also lower than that of the national total female population (table 11A.63). Data for participation by remoteness are presented in table 11A.64. Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data, and in the collection of residential postcodes data.

Table 11.9 **Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2009 and 2010 (24 month period) (per cent)[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[d]	*NT*	*Aust*
Indigenous[e]	35.8	27.7	47.0	30.5	33.2	53.2	49.6	23.6	36.2
NESB[f]	55.3	33.8	68.8	67.2	52.4	44.7	15.3	38.2	49.2
Major cities and inner regional[e]	52.3	54.2	56.6	58.6	56.0	59.1	52.7	..	54.6
Outer regional, remote and very remote[g]	55.8	58.0	62.0	54.2	58.7	57.2	..	41.2	57.1
All women aged 50–69 years	52.8	53.9	57.3	57.9	56.4	58.4	52.7	41.1	54.8

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** Women resident in the jurisdiction represent over 99 per cent of women screened in each jurisdiction except the ACT (92.2 per cent). **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. **g** 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. .. Not applicable.

Source: State and Territory governments (unpublished); ABS (2010) *Population by Age and Sex, Australian States and Territories*, June 2010, Cat. no. 3201.0; ABS (unpublished) Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021, Cat. no. 3238.0; ABS (unpublished) 2006 Census of Population and Housing; AIHW (unpublished) derived from State and Territory data; tables 11A.60– 11A.64.

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 11.22).

Box 11.22 **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.

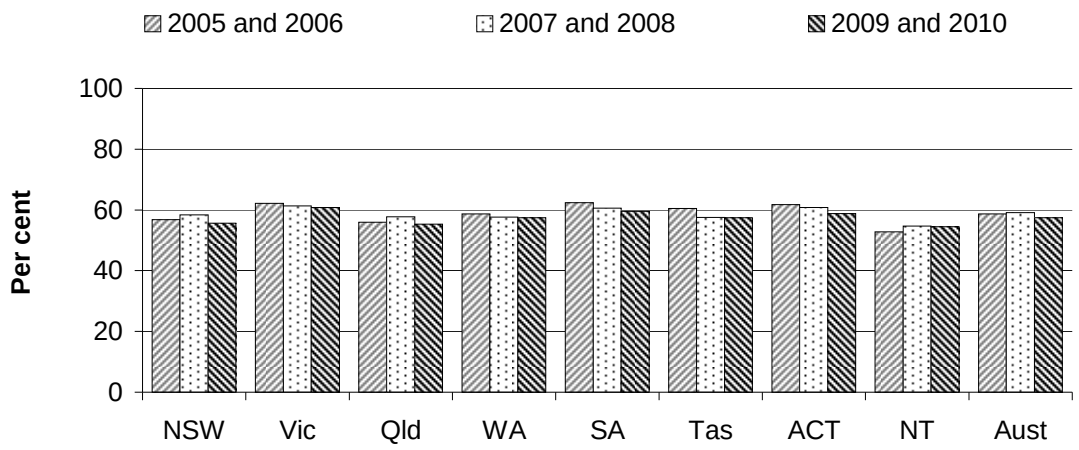
Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

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

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 57.4 per cent for the 24 month period 1 January 2009 to 31 December 2010 (figure 11.41). For most jurisdictions, participation rates have dropped slightly since the screening period of 2005 and 2006. Data for Indigenous women for 2004-05 are presented in table 11A.66. Data for women by remoteness are presented in table 11A.67.

Figure 11.41 **Participation rates for women aged 20–69 years in cervical screening[a, b, c, d]**



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

Source: AIHW (2011) *Cervical screening in Australia 2008–2009*, Cat. no. CAN 57; AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.65.

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 11.23).

Box 11.23 **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. This does not include pandemic influenza such as H1N1 Influenza (commonly known as 'swine flu').

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 for this indicator are comparable.

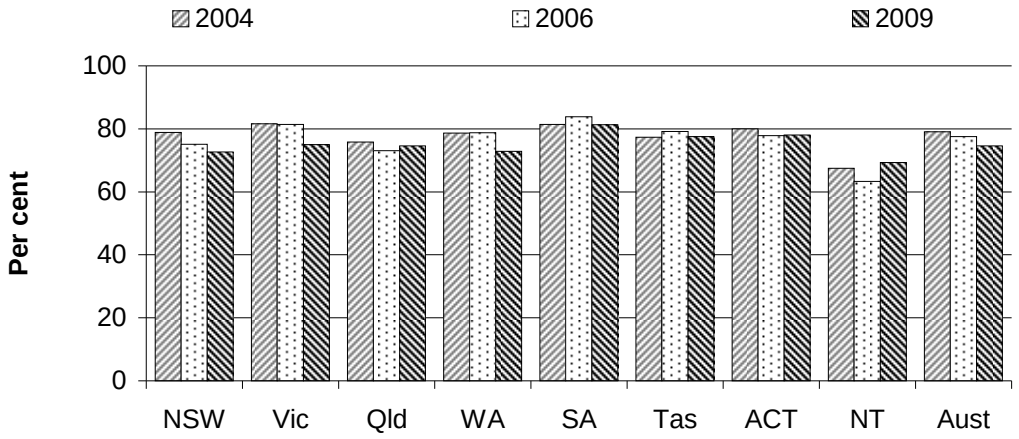
Data quality information for this indicator is under development.

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.

Nationally, 74.6 per cent of eligible people were fully vaccinated against influenza in 2009 (figure 11.42).

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 adults fully vaccinated against both influenza and pneumococcal disease are presented by remoteness in table 11A.69. Data for Indigenous people fully vaccinated against influenza and pneumococcal disease in 2004-05 are presented in table 11A.70.

Figure 11.42 **People aged 65 years or over fully vaccinated against influenza[a]**



a The Adult Vaccination Survey was not conducted in 2005, 2007, 2008 or 2010.

Source: AIHW 2005, 2011 *Adult Vaccination Survey: summary results*, Cat. no. PHE 56, PHE 135; DoHA (unpublished) 2006 Adult Vaccination Survey; table 11A.68.

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 11.24).

Box 11.24 **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:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions, as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2011b; 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 2008b, 2011b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people's access to aged care services and other support.

Data for this indicator are comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

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 — particularly for diagnoses of

dehydration and gastroenteritis and diabetes complications. This effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in Indigenous communities. Because of improvements in data quality over time, caution also should be used in time series analysis.

Data presented by Indigenous status are adjusted to account for differences in the age structures of these populations across states and territories.

Nationally, the age standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 30.4 per 1000 people in 2009-10 (table 11.10). Of these, 53.4 per cent were for chronic and 44.5 per cent for acute conditions (table 11A.71). Data are presented disaggregated by remoteness in table 11A.72.

Table 11.10 **Separations for selected potentially preventable hospitalisations per 1000 people, 2009-10[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Vaccine preventable conditions	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8
Selected acute conditions	12.9	14.4	14.7	13.7	14.6	10.7	9.8	21.1	13.8
Selected chronic conditions	13.6	15.1	18.6	23.1	14.4	12.1	10.4	26.1	16.0
Total[d]	**27.1**	**30**	**34**	**37.5**	**29.7**	**23.4**	**20.7**	**49**	**30.4**

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

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.71.

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2009-10. Nationally, influenza and pneumonia accounted for 73.7 per cent of hospital separations for vaccine preventable conditions in 2009-10 (table 11.11).

Table 11.11 **Separations for vaccine preventable conditions per 1000 people, 2009-10[a, b]**

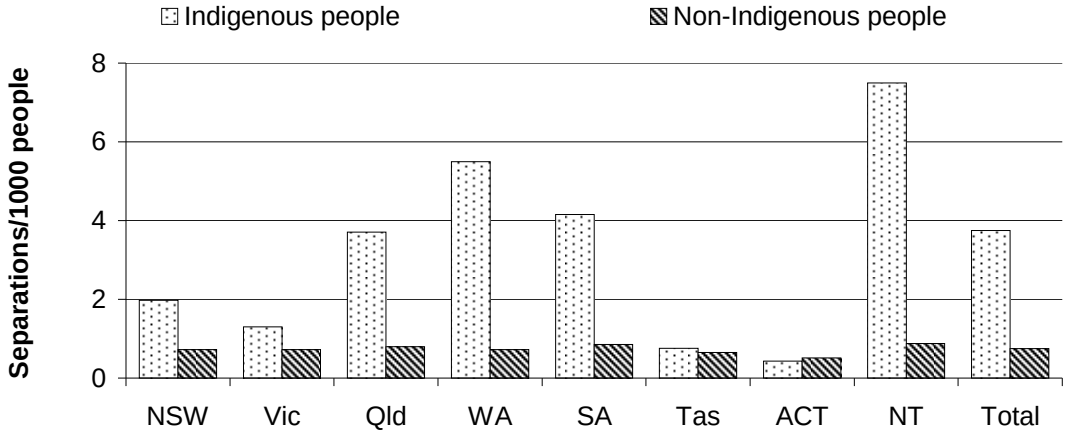
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.6	0.5	0.7	0.7	0.7	0.6	0.4	1.9	0.6
Other conditions	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.5	0.2
Total[d]	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8

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

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.73.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2009-10, in most jurisdictions (figure 11.43).

Figure 11.43 **Separations for vaccine preventable conditions by Indigenous status, 2009-10[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 (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.73.

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis recorded the highest rates of hospitalisation nationally in 2009-10 (table 11.12).

Table 11.12 **Separations for selected acute conditions per 1000 people, 2009-10[a, b]**

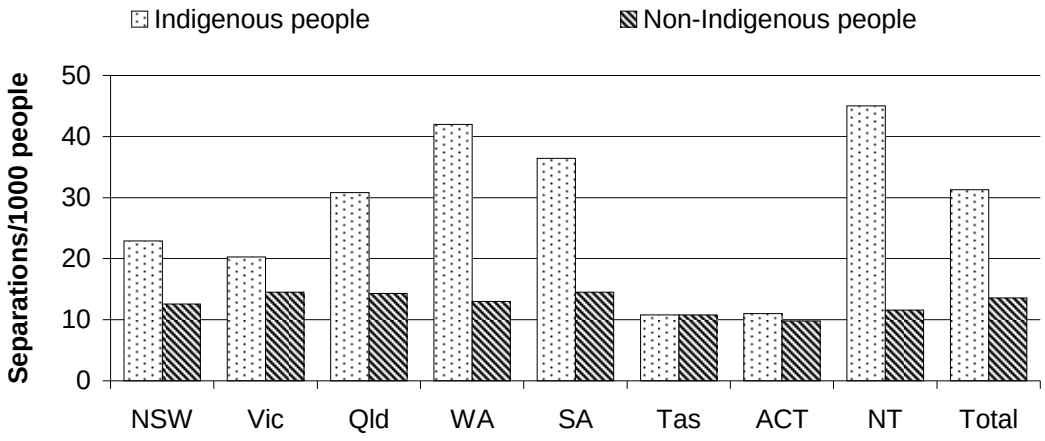
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.8	1.7	2.0	1.4	1.6	1.4	1.4	3.8	1.8
Convulsions and epilepsy	1.5	1.4	1.6	1.4	1.7	1.3	1.2	3.5	1.5
Dehydration and gastroenteritis	2.7	3.4	3.0	2.6	2.8	2.2	1.9	3.2	2.9
Dental conditions	2.3	3.1	2.9	3.6	3.2	2.3	1.8	2.8	2.8
Ear, nose and throat infections	1.6	1.4	1.8	1.6	2.1	1.3	1.0	2.9	1.6
Gangrene	0.1	0.3	0.2	0.2	0.2	0.3	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis[d]	2.3	2.4	2.6	2.3	2.3	1.5	1.8	3.4	2.4
Total[e]	**12.9**	**14.4**	**14.7**	**13.7**	**14.6**	**10.7**	**9.8**	**21.1**	**13.8**

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

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.74.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people, in 2009-10, in most jurisdictions (figure 11.44).

Figure 11.44 **Separations for selected acute conditions by Indigenous status, 2009-10**[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 (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.74.

Of the selected chronic conditions, congestive cardiac failure, diabetes complications, asthma, hypertension and chronic obstructive pulmonary disease recorded the highest rates of hospitalisation nationally in 2009-10. The hospitalisation rates for congestive cardiac failure and diabetes complications were around two times higher than the rate for any other of the selected conditions except for asthma (table 11.13).

Table 11.13 **Separations for selected chronic conditions per 1000 people, 2009-10[a, b]**

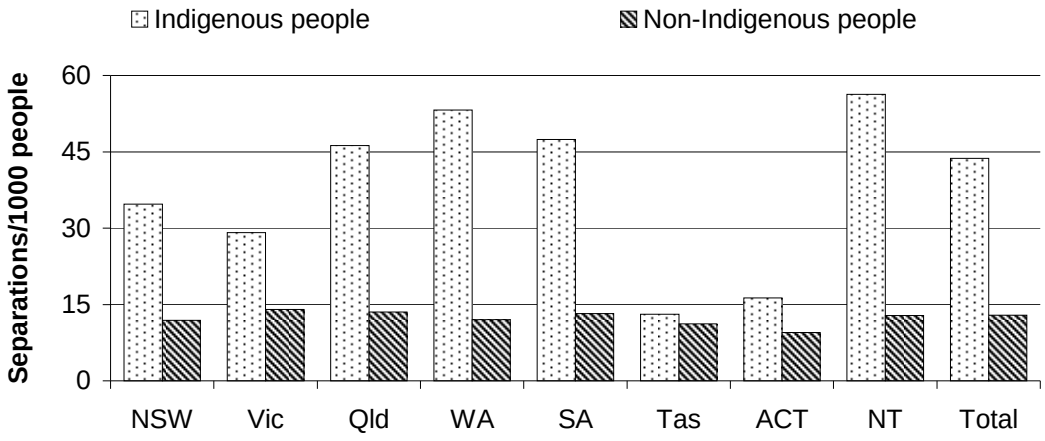
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.2	1.4	1.9	1.4	1.3	1.0	0.9	2.4	1.4
Asthma	1.9	1.9	1.8	1.3	2.5	1.2	1.1	1.9	1.8
Chronic obstructive pulmonary disease	2.6	2.5	3.0	2.2	2.7	2.5	2.0	6.3	2.6
Congestive cardiac failure	1.7	2.1	1.9	1.9	1.8	1.5	1.9	2.9	1.9
Diabetes complications	5.2	5.8	9.2	15.5	4.8	4.8	4.0	12.1	7.1
Hypertension	0.3	0.2	0.4	0.2	0.3	0.2	0.2	0.3	0.3
Iron deficiency anaemia	1.0	1.6	1.0	1.3	1.3	1.3	0.8	1.0	1.2
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1	0.1	<0.1
Rheumatic heart disease[d]	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.9	0.1
Total[e]	**13.6**	**15.1**	**18.6**	**23.1**	**14.4**	**12.1**	**10.4**	**26.1**	**16.0**

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

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.75.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people, in 2009-10, in all jurisdictions (figure 11.45).

Figure 11.45 **Separations for selected chronic conditions by Indigenous status, 2009-10**[a, b, c, d, e, f]



[a] Excludes separations with diabetes complications as an additional diagnosis. [b] Separation rates are directly age standardised to the Australian population at 30 June 2001. [c] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [d] Separation rates are based on State/Territory of usual residence. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. [f] Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.75.

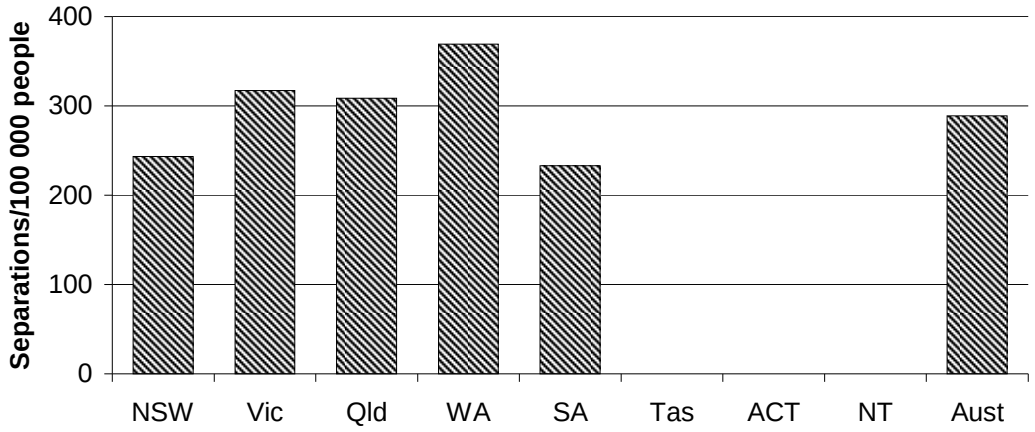
Potentially preventable hospitalisations for diabetes

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 2008c). 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 288.8 separations per 100 000 people in 2009-10 (figure 11.46).

Figure 11.46 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2009-10[a, b, c]**

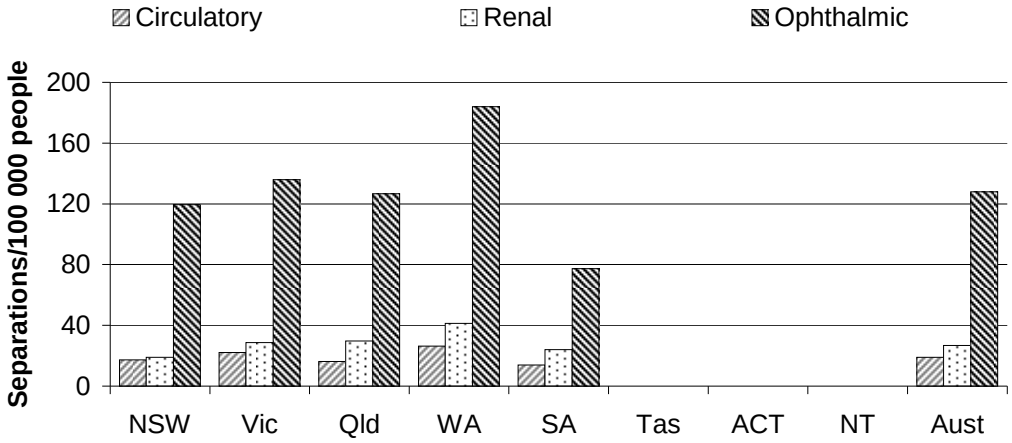


a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. **b** Morbidity data are coded under coding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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2009-10 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.47).

Figure 11.47 **Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2009-10**[a, b, c, d, e]



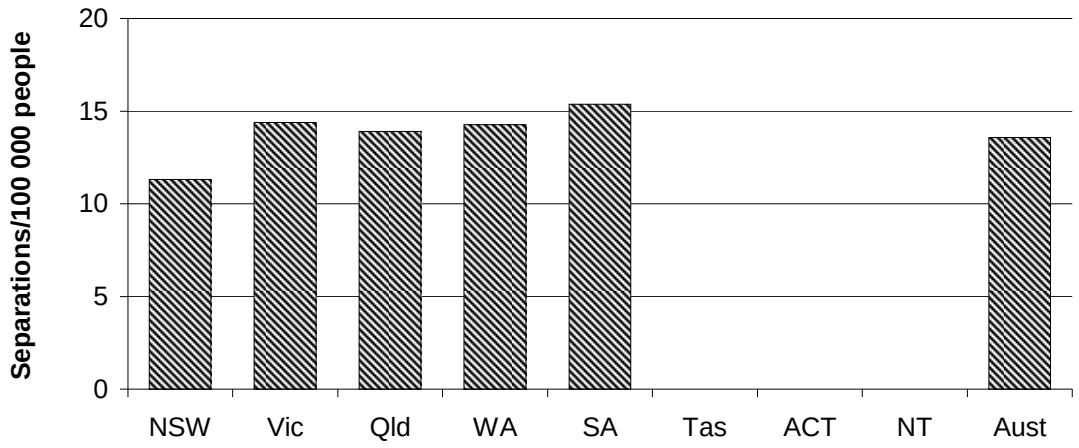
[a] Results for individual complications can be affected by small numbers, and need to be interpreted with care. [b] Patients can have one or more complication(s) for each separation. [c] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of 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. [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 11A.77.

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, 51.6 per cent of separations for Type 2 diabetes were same day separations in 2009-10 (table 11A.78).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2009-10, there were 13.6 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.48).

Figure 11.48 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2009-10[a, b, c]**



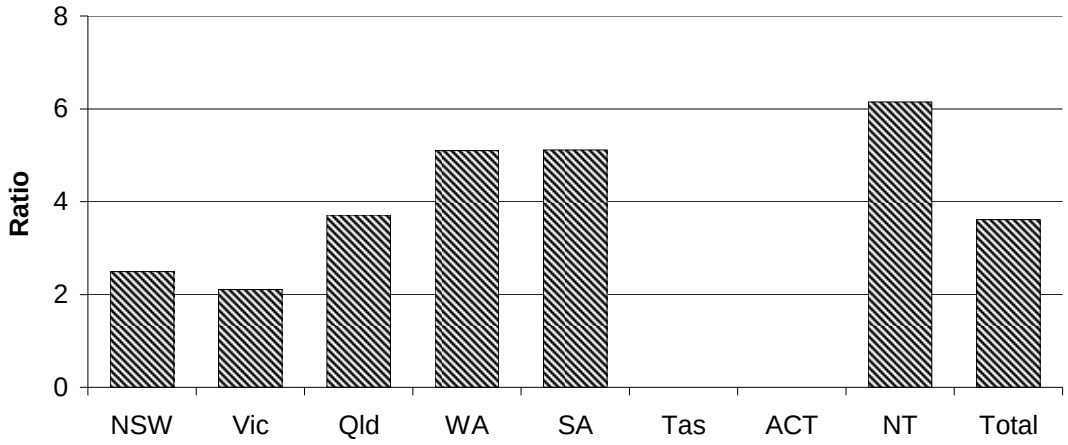
a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.79.

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 Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. A reduction in the gap in hospital separation rates between Indigenous and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2009-10 between the separation rates for Indigenous people and those for the total population for 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 3.6 times higher than the separation rate for all Australian people (figure 11.49).

Figure 11.49 **Ratio of separation rates of Indigenous people to all people for diabetes, 2009-10**[a, b, c, d, e, f, g]



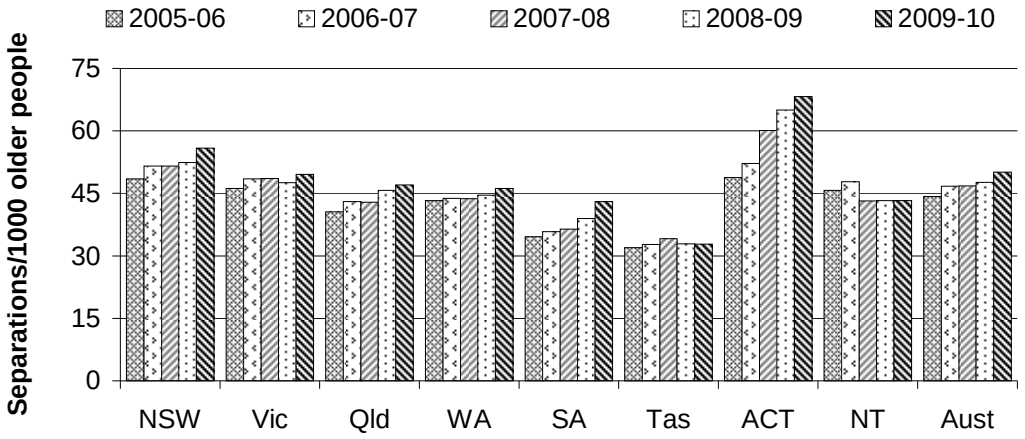
[a] Excludes separations with diabetes complications as an additional diagnosis. [b] Ratios are directly age standardised to the Australian population at 30 June 2001. [c] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. [d]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

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 11A.76.

Potentially preventable hospitalisations of older people for falls

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 in the period 2005-06 to 2009-10 in most jurisdictions (figure 11.50). Nationally, the separation rate per 1000 older people increased from 44.3 in 2005-06 to 50.1 in 2009-10.

Figure 11.50 **Separations for older people with a reported external cause of falls[a, b, c]**



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

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.80.

11.4 Future directions in performance reporting

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

- improving the reporting of 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
- improving the quality of Indigenous data, particularly Indigenous identification and completeness. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

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

Indigenous health

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

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

COAG developments

Outcomes from review of Report on Government Services

COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council. A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NHA. The reviews will be concluded by June 2012. The recommendations of the review of the NHA will be considered by the Steering Committee and may be reflected in future reports.

11.5 Definitions of key terms and indicators

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

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

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

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

11.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 11A.1	Types of encounter, 2010-11
Table 11A.2	Australian Government real expenditure on GPs ($ million) (2010-11 dollars)
Table 11A.3	Australian government expenditure on the Pharmaceutical Benefits Scheme, 2010-11 ($ million)
Table 11A.4	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 11A.5	GP-type service use per 1000 people
Table 11A.6	PBS services, 2010-11 ('000)
Table 11A.7	Use of public dental services, by service type, 2010
Table 11A.8	Alcohol and other drug treatment agencies, by sector, 2009-10 (number)
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11A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 11.5 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.

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

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Table 11A.1 **Types of encounter, 2010-11 (a)**

	Number	*Per cent of encounters* (b) *(n= 87 953)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=86 652)*	*Per cent of Medicare-paid GP items (n=83 903)*
	no.	%	%	%	%	%
Direct encounters	86 652	98.5	98.3	98.8	100.0	..
No charge	370	0.4	0.3	0.5	0.4	..
MBS/DVA items of service (direct encounters only) (c)	83 920	95.4	95.0	95.8	96.8	..
MBS/DVA items of service (GPs only)	83 903	95.4	95.0	95.8	..	100.0
Short surgery consultations	1 910	2.2	1.9	2.5	..	2.3
Standard surgery consultations	69 299	78.8	77.7	79.8	..	82.6
Long surgery consultations	6 545	7.4	6.9	8.0	..	7.8
Prolonged surgery consultations	410	0.5	0.4	0.6	..	0.5
Home or institution visits (excluding RACF)	990	1.1	0.8	1.5	..	1.2
Residential aged care facility	1 292	1.5	1.1	1.8	..	1.5
Health assessments	309	0.4	0.3	0.4	..	0.4
Chronic disease management items	871	1.0	0.9	1.1	..	1.0
Case conferences	3	–	–	–	..	–
GP mental health care items	1 022	1.2	1.0	1.3	..	1.2
Attendances associated with practice incentive payments	150	0.2	0.1	0.2	..	0.2
Other items	1 102	1.3	1	1.5	..	1.3
Workers compensation	1 703	1.9	1.8	2.1	2.0	..
Other paid (hospital, state, etc.)	659	0.8	0.6	0.9	0.8	..

Table 11A.1 **Types of encounter, 2010-11 (a)**

	Number	*Per cent of encounters* (b) *(n= 87 953)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n=86 652)*	*Per cent of Medicare-paid GP items (n=83 903)*
Indirect encounters (d)	1 295	1.5	1.2	1.7	..	..
Other health professional only items (unspecified as direct or indirect)	7	–	–	–	..	..
Missing	7 886	..	..	..	..	..
Total encounters	**87 953**	**100.0**	..	..	..	..

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

(a) One Medicare item number counted per encounter (where applicable).

(b) Missing data removed from analysis.

(c) Includes direct encounters at which either a GP or a practice nurse item (or both) was recorded.

(d) Five encounters involving chronic disease management or case conference items were recorded as indirect encounters.

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

Source: Britt, H., Miller, G.C., Charles, J., Henderson, J., Bayram, C., Pan, Y., Valenti, L., Harrison, C., O'Halloran, J., Zhang, C., Fahridin, S. 2011, *General practice activity in Australia 2010-11* , General practice series no. 29, Sydney University Press, Sydney.

Table 11A.2 Australian Government real expenditure on GPs ($ million) (2010-11 dollars) (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Expenditure										
2006-07	$m	2130.6	1477.2	1182.7	505.6	478.2	138.0	74.1	33.1	6019.6
2007-08	$m	2198.5	1552.1	1241.4	526.8	496.7	143.7	77.5	36.3	6273.0
2008-09	$m	2181.2	1549.6	1253.6	519.6	496.9	140.1	76.4	36.2	6253.7
2009-10	$m	2262.4	1628.4	1325.1	543.0	515.8	147.2	78.6	40.2	6540.7
2010-11	$m	2219.6	1617.2	1311.3	531.5	503.1	143.2	76.6	41.7	6444.2
Expenditure per person										
2006-07	$	309.2	283.9	283.3	240.7	302.1	279.6	219.0	154.3	286.6
2007-08	$	315.8	293.6	290.2	244.4	310.3	288.9	225.0	164.9	293.9
2008-09	$	308.0	286.1	284.9	232.3	306.4	278.8	217.4	161.8	286.4
2009-10	$	312.1	292.8	292.1	235.3	313.6	289.8	219.3	174.1	292.0
2010-11	$	305.2	289.5	288.3	229.4	304.8	281.3	211.6	181.5	286.7

(a) Data are presented in current prices based on the Australian Bureau of Statistics (ABS) Gross Domestic Product price deflator (index) (2010-11 dollars), table AA.39.

(b) The data include expenditure on Medicare Australia, the Practice Incentives Program (PIP), Department of Veterans' Affairs (DVA), Divisions of General Practice Program (DGPP) and the General Practice Immunisation Incentive Scheme (GPII).

(c) DVA data include consultations by local medical officers (LMO), whether vocationally registered GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (as opposed to specialists) for procedural items. It is expected, however, that the amounts for LMO procedural services are small compared with payments for LMO consultations.

(d) 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.

Source: DoHA (Department of Health and Ageing) unpublished, MBS, PIP, GPII, DGPP and DVA data collections; table AA.39.

Table 11A.3 Australian government expenditure on the Pharmaceutical Benefits Scheme, 2010-11 ($ million) (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS General Ordinary	462.7	336.5	278.4	161.2	102.4	32.5	29.5	9.5	1 412.8
PBS General Safety Net	73.2	51.1	42.4	22.1	14.2	3.9	4.5	0.7	211.9
PBS General total	536.0	387.6	320.8	183.4	116.6	36.4	34.0	10.1	1 624.7
PBS Concessional Ordinary	1 529.8	1 087.3	823.2	366.4	373.8	127.5	45.2	14.6	4 367.7
PBS Concessional Free Safety Net	472.0	334.3	258.4	101.3	113.6	38.0	11.1	2.1	1 330.7
PBS Concessional total	2 001.8	1 421.6	1 081.6	467.7	487.3	165.4	56.3	16.7	5 698.4
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctor's Bag	4.7	3.5	3.3	1.0	1.0	0.3	0.2	0.1	14.2
PBS Unknown free safety net plus Doctor's bag	4.7	3.5	3.3	1.0	1.0	0.3	0.2	0.1	14.2
PBS Total	**2 542.4**	**1 812.7**	**1 405.7**	**652.1**	**605.0**	**202.1**	**90.5**	**26.9**	**7 337.4**
RPBS Total (b)	162.3	94.0	109.1	36.0	34.2	13.7	7.2	0.9	457.3
PBS and RPBS TOTAL	**2 704.7**	**1 906.7**	**1 514.8**	**688.1**	**639.2**	**215.9**	**97.6**	**27.8**	**7 794.7**
PBS total expenditure per person ($) (c)	349.0	323.9	308.3	281.0	365.9	396.2	249.6	116.7	325.8
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

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

(b) Includes RPBS ordinary and RPBS safety net.

(c) PBS expenditure per person excludes RPBS and PBS doctor's bag.

– Nil or rounded to zero.

Source: DoHA (unpublished) PBS Statistics; table AA.39.

Table 11A.4 Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP numbers										
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
FWE GPs										
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
FWE GPs per 100 000 people										
2006-07	per 100 000 people	94.1	84.7	85.4	71.4	89.5	79.2	66.8	48.3	86.1
2007-08	per 100 000 people	94.8	86.7	86.1	71.5	90.9	80.7	67.5	52.6	87.2
2008-09	per 100 000 people	95.9	87.5	87.7	70.4	93.2	80.4	67.0	51.7	88.1
2009-10	per 100 000 people	95.1	88.1	88.0	70.0	94.0	82.1	66.5	54.8	88.1
2010-11	per 100 000 people	96.5	89.9	89.9	70.1	94.6	83.9	65.4	57.7	89.5

(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 recognised GPs and other medical practitioners (OMPs).

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

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

Source: DoHA unpublished, MBS Statistics.

Table 11A.5 GP-type service use per 1000 people (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09									
Indigenous status (e)									
Indigenous	6 288.7	6 580.0	5 081.4	4 056.4	6 178.8	5 517.0	5 586.1	3 219.4	5 248.0
Non-Indigenous	5 807.9	5 373.3	5 475.8	4 637.5	5 411.7	4 884.8	4 332.9	3 301.5	5 421.6
Remoteness of residence (f) (g)									
Major cities	6 345.1	5 671.6	5 907.0	4 936.8	5 661.3	..	4 491.9	..	5 839.1
Inner regional	4 980.6	5 066.0	5 578.6	4 713.3	5 199.3	5 104.8	5 905.6	..	5 139.9
Outer regional	4 769.9	4 696.6	5 063.6	4 394.9	5 276.7	5 034.0	..	3 779.3	4 811.5
Remote	5 658.6	5 241.4	4 749.2	3 524.0	4 836.3	5 053.6	..	2 182.5	4 184.8
Very remote	6 731.1	..	3 659.1	2 372.1	4 142.0	5 357.0	..	3 612.7	3 454.1
Total (h)	**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									
Indigenous status (e)									
Indigenous	6 524.5	6 895.4	5 485.3	4 498.4	6 524.4	5 992.6	5 400.7	3 869.6	5 627.1
Non-Indigenous	5 904.9	5 502.0	5 665.9	4 698.3	5 558.9	5 155.4	4 466.5	3 404.3	5 548.9
Remoteness of residence (f) (g)									
Major cities	6 401.4	5 782.5	6 112.2	4 992.3	5 805.2	..	4 619.3	..	5 944.2
Inner regional	5 182.0	5 206.3	5 687.3	4 842.8	5 377.3	5 389.8	6 418.1	..	5 300.8
Outer regional	4 858.1	4 859.8	5 294.7	4 337.6	5 391.4	5 281.8	..	4 002.7	4 974.8
Remote	5 736.5	5 202.6	4 966.7	3 566.1	5 011.0	5 182.5	..	2 310.7	4 315.7
Very remote	6 551.2	..	3 949.0	2 835.6	4 470.0	5 453.8	..	4 073.5	3 780.0
Total (h)	**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									
Indigenous status (i)									
Indigenous	na	na	na	na	na	na	na	na	na

Table 11A.5 GP-type service use per 1000 people (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Non-Indigenous	na	na	na	na	na	na	na	na	na
Remoteness of residence (f) (g)									
Major cities	6 300.6	5 782.2	5 971.1	4 819.6	5 683.2	..	4 519.6	..	5 853.3
Inner regional	5 146.0	5 258.5	5 502.0	4 744.6	5 287.1	5 163.6	5 319.4	..	5 232.1
Outer regional	4 730.5	4 979.8	5 159.5	4 303.9	5 329.6	5 174.2	..	4 044.9	4 901.3
Remote	5 416.5	5 149.8	4 906.7	3 580.9	4 740.1	4 724.4	..	2 330.8	4 214.6
Very remote	6 182.4	..	3 947.3	2 880.5	4 549.0	5 383.6	..	4 011.6	3 771.7
Total (h)	**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**

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

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

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

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

(e) DVA data are not available by Indigenous status. MBS data presented by Indigenous status for 2008-09 and 2009-10 have been adjusted for under-identification in the Medicare Australia Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. The statistics are derived from those Indigenous people who have voluntarily identified as Indigenous to Medicare Australia, and may not be representative of the broader Indigenous population. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this may not account for all differences in service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (50 per cent nationally as at August 2010) varies across age-sex-remoteness-state/territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions.

(f) 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 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.

(g) Historical data for remoteness of residence may differ from previous reports as data include services provided under the DVA for the first time. Data reported here are not comparable with data in previous Reports. DVA data are not available by Indigenous status.

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

Table 11A.5 **GP-type service use per 1000 people (a), (b), (c), (d)**

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

(i) Data are not available by Indigenous status for 2010-11 as Indigenous population estimates required to determine the appropriate adjustments for 2010-11 Voluntary Indigenous Identification (VII) data were not available when this measure was calculated.

.. Not applicable. **na** Not available.

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

Table 11A.6 **PBS services, 2010-11 ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS General Ordinary	6 847	5 114	4 199	2 308	1 500	464	463	137	21 032
PBS General Safety Net	1 747	1 196	956	480	345	97	105	16	4 943
PBS General total	8 595	6 310	5 155	2 788	1 845	561	568	153	25 976
PBS Concessional Ordinary	42 608	32 256	23 945	10 442	10 858	3 670	1 245	423	125 447
PBS Concessional Free Safety Net	12 798	9 283	7 065	2 723	3 109	1 058	290	57	36 382
PBS Concessional total (a)	55 406	41 539	31 010	13 164	13 967	4 728	1 535	480	161 829
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	112	86	77	24	26	8	4	2	338
PBS Unknown free safety net plus Doctors bag	112	86	77	24	26	8	4	2	338
PBS Total	64 113	47 936	36 242	15 976	15 838	5 297	2 106	635	188 142
RPBS Total (b)	4 572	2 901	3 111	1 032	1 020	419	194	26	13 277
PBS and RPBS TOTAL	68 685	50 836	39 354	17 009	16 858	5 716	2 300	661	201 419
PBS total services per person (no.) (c)	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

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

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

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

Source: DoHA unpublished, PBS Statistics.

Table 11A.7 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 confidence interval									
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.

(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) ABS (unpublished), *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 11A.8 Alcohol and other drug treatment agencies, by sector, 2009-10 (number)

	NSW (a)	*Vic*	*Qld*	*WA* (b)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government	195	–	51	10	42	5	1	3	307
Non-government (c), (d)	63	138	67	42	17	11	9	17	364
Total	**258**	**138**	**118**	**52**	**59**	**16**	**10**	**20**	**671**

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

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

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

(d) Includes only agencies that receive public funding.

– Nil or rounded to zero.

Source: AIHW 2011, *Alcohol and Other Drug Treatment Services in Australia 2009-10: report on the National Minimum Data Set,* Cat. no. HSE 114, Drug Treatment Series no. 14, Canberra.

Table 11A.9 Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported (number) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	39	24	31	28	14	10	2	57	205
2009-10	50	26	33	37	13	10	1	53	223

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

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

(c) The OSR data collection 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 unpublished, OSR data collection.

Table 11A.10 Services and episodes of healthcare by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, by remoteness category (number) (a), (b), (c)

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Total*
Services						
2008-09	26	40	50	29	60	205
2009-10	29	48	55	33	58	223
Episodes of healthcare						
2008-09	289 955	312 960	539 318	502 819	443 842	2 088 894
2009-10	363 823	395 027	583 324	557 037	491 463	2 390 674

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

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

(c) The OSR data collection 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 unpublished, OSR data collection.

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

	2008-09 (d)	*2009-10* (e)
Diagnosis and treatment of illness/disease	85.0	82.1
Management of chronic illness	89.0	87.0
Transportation to medical appointments	86.0	87.0
Outreach clinic services	55.0	55.6
24 hour emergency care	31.0	27.8
Monitoring child growth	64.0	76.2
School-based activities	68.0	70.4
Hearing screening	72.0	74.9
Pneumococcal immunisation	76.0	74.9
Influenza immunisation	82.0	81.6
Child immunisation	81.0	81.6
Women's health group	77.0	76.2
Support for public housing issues	58.0	67.7
Community development work	60.0	66.8
Legal/police/prison/advocacy services	42.0	43.1
Dental services	52.0	48.9
Involvement in steering groups on health	77.0	81.2
Participation in regional planning forums	57.0	57.9
Dialysis services	4.0	6.3

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

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

(c) The OSR data collection 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.

(d) The denominator is the number of services that provided valid data for this question (201 for 2008-09).

(e) The denominator is the number of services that provided valid data for this question (223 for 2009-10).

Source: AIHW unpublished, OSR data collection.

Table 11A.12 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 2010 (number) (a), (b), (c)

	Indigenous staff	*Non-Indigenous staff*	*Total staff* (d), (e)
Aboriginal health workers	837	31	867
Doctors	16	319	335
Nurses	72	615	691
Specialists	1	7	9
Counsellors/social workers	52	85	137
Other social and emotional wellbeing staff (f)	242	66	309
Allied health professionals (g)	50	108	158
Dentists	4	40	44
Dental assistants	48	28	76
Traditional healers	8	0	8
Sexual health workers	45	20	64
Substance misuse workers	78	43	121
Environmental health workers	24	6	30
Driver/field officers	218	40	258
Other health staff (e)	6	–	6
Total health staff (d), (e)	**1 701**	**1 409**	**3 115**

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

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

(c) The OSR data collection 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.

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

(e) Totals include health staff for whom Indigenous status was not provided.

(f) 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.

(g) 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.

– Nil or rounded to zero.

Source: AIHW unpublished, OSR data collection.

Table 11A.13 Approved providers of PBS medicines, by urban and rural location (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
Number of people per pharmacy									
Urban									
2006-07	3 746	4 153	3 812	3 767	3 851	3 443	5 672	3 714	3 888
2007-08	3 698	4 160	3 807	3 745	3 761	3 413	5 300	4 882	3 863
2008-09	3 690	4 118	3 715	3 770	3 773	3 451	5 214	4 941	3 836
2009-10	3 700	4 082	3 701	3 691	3 725	3 409	5 131	4 681	3 814
2010-11	3 677	4 031	3 615	3 699	3 725	3 248	5 051	4 681	3 777
Rural									
2006-07	4 250	4 794	4 611	4 237	3 658	3 856	..	15 509	4 446
2007-08	4 341	4 776	4 578	4 347	3 553	3 904	..	11 451	4 436
2008-09	4 232	4 803	4 459	4 255	3 632	3 911	..	9 272	4 367
2009-10	4 172	4 655	4 386	4 305	3 405	3 836	..	9 272	4 277
2010-11	4 232	4 462	4 037	4 021	3 269	3 694	..	8 500	4 108
Number of pharmacies, 2010-11									
Urban	1 456	1 035	852	429	318	85	64	19	4 258
Rural	280	169	201	91	100	54	..	12	908
Number of approved medical practitioners, 2010-11									
Urban	na	na	na	na	na	na	na	na	na
Rural	9	1	6	17	2	3	..	1	39
Number of approved hospitals, 2010-11 (c)									
Urban									
Private	22	28	24	5	4	1	4	1	89
Public	–	53	27	10	8	3	–	1	102
Rural									
Private	–	–	–	–	–	–	..	–	–
Public	–	16	20	6	–	1	..	4	47

(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) Includes other territories

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

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

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

Table 11A.14 PBS expenditure per person, by urban and rural location (2010-11 dollars) (a), (b), (c)

	2006-07	*2007-08*	*2008-09*	*2009-10*	*2010-11*
Capital city	293.5	298.2	309.7	322.7	310.8
Other metro	332.1	338.9	352.6	368.6	359.0
Rural and remote	321.4	328.8	343.2	359.1	350.2
All locations	304.5	310.1	322.6	336.7	325.8

(a) Data are presented in current prices based on the Australian Bureau of Statistics (ABS) Gross Domestic Product price deflator (index) (2010-11 dollars), table AA.39.

(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 DoHA annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medications dispensed under s.100 of the *National Health Act 1953* [Cwlth]).

Source: DoHA unpublished, PBS Statistics; table AA.39.

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

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*
Number of GPs									
Urban									
2006-07	6 412	4 508	2 884	1 698	1 463	313	na	116	17 394
2007-08	6 047	4 598	2 978	1 717	1 503	328	383	121	17 675
2008-09	6 184	4 738	3 142	1 797	1 550	340	385	139	18 275
2009-10	6 349	4 896	3 272	1 803	1 568	349	398	142	18 777
2010-11	6 530	5 043	3 340	1 826	1 592	346	416	160	19 253
Rural									
2006-07	1 816	1 406	1 980	612	527	329	na	208	6 878
2007-08	1 887	1 464	2 074	640	596	333	..	234	7 228
2008-09	1 921	1 502	2 198	661	591	339	..	239	7 451
2009-10	2 040	1 553	2 292	689	633	355	..	274	7 836
2010-11	2 124	1 667	2 464	788	661	373	na	303	8 380
Number of full time workload equivalent GPs									
Urban									
2006-07	5 427	3 426	2 171	1 142	1 071	173	na	50	13 459
2007-08	5 274	3 551	2 241	1 166	1 080	179	232	54	13 778
2008-09	5 411	3 662	2 357	1 186	1 118	179	235	56	14 204
2009-10	5 461	3 788	2 459	1 216	1 149	185	238	62	14 558
2010-11	5 567	3 897	2 518	1 222	1 166	186	239	66	14 861
Rural									
2006-07	1 283	981	1 393	358	345	218	na	54	4 632
2007-08	1 327	1 033	1 441	376	375	222	..	61	4 835
2008-09	1 381	1 076	1 504	388	393	225	..	60	5 027
2009-10	1 431	1 113	1 534	399	397	232	..	65	5 171
2010-11	1 500	1 166	1 599	417	404	243	na	67	5 397
Number of full time workload equivalent GPs per 100 000 people									
Urban									
2006-07	97.2	87.3	85.4	73.9	91.5	86.0	na	53.7	89.4
2007-08	99.6	89.0	86.0	73.6	91.2	88.3	67.5	57.1	90.0
2008-09	100.4	89.6	87.9	72.2	93.2	87.3	67.2	58.0	90.7
2009-10	99.0	90.3	89.0	71.7	94.5	89.4	66.7	61.8	90.7
2010-11	99.9	91.7	90.1	71.0	95.0	89.0	65.6	66.4	91.5
Rural									
2006-07	77.8	76.8	85.4	64.3	83.7	74.6	na	44.3	78.0
2007-08	79.7	79.6	86.2	65.8	89.9	75.5	..	49.1	80.0
2008-09	81.6	80.9	87.5	65.5	93.1	75.6	..	46.9	81.3
2009-10	82.6	81.5	86.5	65.2	92.8	77.1	..	49.5	81.5
2010-11	85.7	84.3	89.1	67.3	93.4	80.4	na	51.1	84.1

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

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

(a) Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas.

(b) GP and FWE data include vocationally recognised GPs and other medical practitioners (OMPs).

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

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

(e) From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.

na Not available. .. Not applicable.

Source: DoHA unpublished, MBS Statistics.

Table 11A.16 **Availability of female GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs										
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
Female FWEs GPs										
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
Female FWEs GPs as a proportion of all FWE GPs										
2006-07	%	28.1	28.0	28.3	27.3	24.6	31.9	36.1	35.4	28.0
2007-08	%	29.0	28.6	29.4	27.6	25.5	32.7	36.4	38.8	28.8
2008-09	%	29.5	29.3	30.5	28.9	26.5	33.7	37.0	41.3	29.6
2009-10	%	30.3	30.0	30.8	29.9	27.4	34.1	36.6	42.7	30.3
2010-11	%	31.4	30.4	31.5	30.5	27.4	34.3	40.1	42.2	31.0
Female FWE GPs										
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

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

Table 11A.16 **Availability of female GPs (a), (b), (c)**

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

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

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

Source: DoHA unpublished, MBS Statistics.

Table 11A.17 **Availability of public dentists (per 100 000 people) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT* (d), (e)	*NT* (f)	*Aust*
FTE dentists per 100 000 population (g)									
2006									
Major cities	8.1	6.9	9.7	8.7	11.4	..	1.4	..	8.2
Inner regional	4.2	3.4	7.9	3.2	4.3	4.1	–	..	4.7
Outer regional	2.3	4.8	8.4	2.1	2.9	–	..	15.0	5.1
Remote and very remote	–	–	4.9	3.9	–	–	..	19.1	6.2
Total	**6.9**	**6.0**	**9.0**	**7.1**	**9.1**	**2.6**	**1.4**	**16.8**	**7.2**
2009									
Major cities	7.7	7.6	10.9	7.5	11.7	..	9.6	..	8.6
Inner regional	4.8	4.7	8.3	6.0	5.3	7.6	–	..	5.9
Outer regional	3.8	4.4	8.0	3.9	2.0	1.8	..	16.7	5.7
Remote and very remote	3.1	–	9.7	11.5	2.0	–	..	6.2	7.7
Total	**6.8**	**6.9**	**9.9**	**7.2**	**9.5**	**5.5**	**9.6**	**12.0**	**7.7**

(a) Data include dentists working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas.

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

(c) There are no major cities in Tasmania.

(d) There are no outer regional, remote or very remote areas in the ACT.

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

(f) There are no major cities or inner regional areas in the NT.

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

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

Source: AIHW unpublished, National dental labour force collection.

Table 11A.18 **Availability of public dental therapists (per 100 000 people) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (g)	*Aust* (h)
FTE dental therapists per 100 000 population (i)									
2006									
Major cities	1.9	1.7	6.4	6.1	4.7	..	4.0	..	3.4
Inner regional	3.7	2.8	7.9	8.3	6.4	7.8	–	..	5.1
Outer regional	3.0	2.4	6.7	7.3	8.2	9.2	..	8.8	5.8
Remote and very remote	2.7	–	2.8	3.3	3.2	–	..	7.4	3.7
Total	**2.3**	**2.0**	**6.7**	**6.3**	**5.3**	**8.1**	**4.0**	**8.0**	**3.9**
2009									
Major cities	2.0	na	6.3	6.4	5.5	..	3.5	..	3.0
Inner regional	5.1	na	8.9	7.2	6.3	6.6	–	..	5.0
Outer regional	3.1	na	8.4	6.3	6.9	11.1	..	6.2	5.9
Remote and very remote	5.4	na	4.1	4.0	3.3	3.5	..	8.9	5.0
Total	**2.7**	**na**	**7.1**	**6.4**	**5.6**	**8.0**	**3.5**	**7.4**	**3.7**

(a) Data include dual registered practitioners (practitioners registered as both dental therapists and dental hygienists).

(b) Public sector includes public dental hospital, school dental service, general dental service, defence forces, tertiary education and 'other public' areas.

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

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

(e) There are no major cities in Tasmania.

(f) There are no outer regional, remote or very remote areas in the ACT.

(g) There are no major cities or inner regional areas in the NT.

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

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

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

Source: AIHW unpublished, National dental labour force collection.

Table 11A.19 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
2008-09										
Indigenous older people										
Number of people assessed (g)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (h)	no.	14 130	3 240	11 706	5 821	2 361	1 099	200	5 066	44 353
Proportion of target population assessed	%	10.4	8.2	13.2	13.7	5.9	2.1	12.0	19.6	11.8
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.	460 531	344 073	236 932	110 768	122 218	34 614	15 201	2 720	1 332 334
Proportion of target population assessed	%	24.2	21.3	26.5	19.9	22.4	27.4	16.0	10.4	23.2
2009-10										
Indigenous older people										
Number of people assessed (g)	no.	1 652	337	2 053	1 021	153	36	46	1 185	6 483
Target population (h)	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion of target population assessed	%	11.1	9.9	16.5	16.6	6.2	3.1	20.8	22.2	13.9
Non-Indigenous older people										
Number of people assessed (i)	no.	116 753	77 945	65 082	24 451	28 048	9 151	2 724	292	324 446
Target population (j)	no.	468 520	350 827	241 647	113 133	123 651	35 221	15 695	2 854	1 357 123
Proportion of target population assessed	%	24.9	22.2	26.9	21.6	22.7	26.0	17.4	10.2	23.9
2010-11 (k)										
Indigenous older people										
Number of people assessed (g)	no.	3 152	416	3 072	1 481	445	108	36	1 487	10 197
Target population (h)	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271

Table 11A.19 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Proportion of target population assessed	%	20.2	11.6	23.4	23.0	17.1	8.7	15.3	26.4	20.7
Non-Indigenous older people										
Number of people assessed (i)	no.	127 494	88 937	73 629	29 304	30 841	10 840	3 135	295	364 475
Target population (j)	no.	476 109	358 361	247 555	115 965	124 871	35 632	16 146	3 018	1 383 553
Proportion of target population assessed	%	26.8	24.8	29.7	25.3	24.7	30.4	19.4	9.8	26.3

(a) Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.

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

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

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

(e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.

(f) Includes Other Territories.

(g) Includes claims for MBS items 704, 706 and 715, for Indigenous people aged 55 years or over.

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

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

(j) Estimated population of non-Indigenous people aged 75 years or over at 30 June, computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over.

(k) 2010-11 data are preliminary data.

Source: DoHA unpublished, MBS Statistics; ABS 2008, 2009, 2010 Population by Age and Sex, Australian States and Territories, various years, Cat. no. 3201.0, Canberra; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0, Canberra.

Table 11A.20 Older Indigenous people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
2006-07										
Number of people assessed	no.	1 001	227	988	468	131	7	15	614	3 451
Target population	no.	12 775	2 924	10 441	5 305	2 171	963	154	4 616	40 027
Proportion of target population assessed	%	7.8	7.8	9.5	8.8	6.0	0.7	9.7	13.3	8.6
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	13 460	3 074	11 035	5 517	2 251	1 039	168	4 849	42 096
Proportion of target population assessed	%	8.5	8.9	11.4	11.2	5.6	0.7	6.0	17.6	10.2
2008-09										
Number of people assessed	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population	no.	14 130	3 240	11 706	5 821	2 361	1 099	200	5 066	44 353
Proportion of target population assessed	%	10.4	8.2	13.2	13.7	5.9	2.1	12.0	19.6	11.8
2009-10										
Number of people assessed	no.	1 652	337	2 053	1 021	153	36	46	1 185	6 483
Target population	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion of target population assessed	%	11.1	9.9	16.5	16.6	6.2	3.1	20.8	22.2	13.9
2010-11 (h)										
Number of people assessed	no.	3 152	416	3 072	1 481	445	108	36	1 487	10 197
Target population	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271
Proportion of target population assessed	%	20.2	11.6	23.4	23.0	17.1	8.7	15.3	26.4	20.7

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

Table 11A.20 Older Indigenous people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)

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

(b) Includes claims for MBS items 704, 706 and 715 for Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

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

(d) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.

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

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

(g) Includes Other Territories.

(h) 2010-11 data are preliminary data.

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

Table 11A.21 Indigenous people who received a health check or assessment, by age, 2010-11 (per cent) (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
Children 0–14 years (f)										
Children assessed	no.	5 903	785	8 038	2 350	464	109	65	3 769	21 483
Target population	no.	58 907	12 610	58 815	26 023	10 496	6 794	1 601	22 979	198 298
Proportion assessed	%	10.0	6.2	13.7	9.0	4.4	1.6	4.1	16.4	10.8
Adults 15–54 years										
People assessed	no.	10 869	1 596	11 566	4 934	1 309	313	148	6 191	36 926
Target population	no.	90 790	20 574	88 688	43 805	17 308	11 387	2 785	40 057	315 532
Proportion assessed	%	12.0	7.8	13.0	11.3	7.6	2.7	5.3	15.5	11.7
Adults 55 years or over										
People assessed	no.	3 152	416	3 072	1 481	445	108	36	1 487	10 197
Target population	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271
Proportion assessed	%	20.2	11.6	23.4	23.0	17.1	8.7	15.3	26.4	20.7

(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) 2010-11 data are preliminary data.

(d) Target population is the projected target population for the age group at 30 June (B series), based on the estimated resident population at 30 June 2006.

(e) Includes Other Territories.

(f) Excludes health checks provided under the Northern Territory Intervention.

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

Table 11A.22 Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported (a), (b)

	Unit	*2008-09*	*2009-10*
Early detection activities provided			
Well person's checks	%	80.0	72.7
PAP smears/cervical screening	%	80.0	76.2
STI testing	%	73.0	74.0
Hearing testing	%	72.0	74.9
Eye disease testing	%	69.0	71.8
Renal disease testing	%	54.0	53.4
Diabetic testing	%	78.0	75.3
Cardiovascular testing	%	66.0	62.3
Any early detection activity	%	90.0	89.7

(a) 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.

(b) The denominator is the number of services that provided valid data for this question (201 services in 2008-09; 223 (all) services in 2009-10).

Source: AIHW unpublished, OSR data collection.

Table 11A.23 **Proportion of children receiving a fourth year developmental health check (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009-10									
Type of health check									
Aboriginal and Torres Strait Islander Child Health Check (c) (d)	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (e)	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Remoteness of residence									
Major cities (f)	17.7	6.3	26.7	16.4	9.6	..	12.3	..	15.5
Inner regional	29.8	9.4	30.6	14.9	13.9	19.4	..	..	22.3
Outer regional	24.9	6.8	33.3	17.1	11.1	19.6	..	13.8	22.7
Remote/Very remote	45.6	np	25.1	17.1	13.0	10.0	..	46.2	27.0
Total (g)	**20.6**	**6.9**	**28.5**	**16.3**	**10.5**	**19.2**	**12.3**	**29.2**	**17.8**
2010-11									
Type of health check (h) (i)									
Aboriginal and Torres Strait Islander Child Health Check (c)	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (e)	25.7	7.1	34.4	16.3	12.5	22.8	12.8	31.2	20.7
Remoteness of residence									
Major cities (f)	23.1	6.9	32.9	17.6	11.7	..	12.8	..	18.9
Inner regional	37.6	8.4	37.5	16.0	16.4	23.4	..	..	26.7
Outer regional	29.2	9.4	42.8	19.3	14.4	18.4	..	22.6	28.3
Remote/Very remote	46.4	np	27.4	16.8	15.4	8.7	..	69.0	32.7
Total (g)	**26.3**	**7.3**	**35.2**	**17.5**	**12.7**	**21.5**	**12.8**	**44.6**	**21.7**

(a) 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.

(b) Children are counted only once in the numerator.

Table 11A.23 **Proportion of children receiving a fourth year developmental health check (per cent) (a), (b)**

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

(c) 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 three to five years.

(d) Data for Indigenous children are not published for Tasmania or the ACT for 2009-10.

(e) 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 three to five years. 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. Data include Indigenous children who received a Healthy Kids Check and did not also receive a health check under MBS item 715.

(f) For the ACT, Major Cities includes Inner regional areas.

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

(h) For 2010-11, 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.

(i) For 2010-11, data are suppressed where fewer than 10 children received health checks.

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

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

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

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
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

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

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

(c) Patient age at date of service.

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

Source: DoHA unpublished, MBS Statistics.

Table 11A.25 Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c)

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

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

(b) Patient age at date of service.

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

Source: DoHA unpublished, MBS Statistics.

Table 11A.26 People deferring access to GPs due to cost (per cent) (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009										
Proportion	%	4.9	6.2	8.5	7.9	5.1	5.0	8.3	7.0	6.4
RSE	%	12.5	13.3	11.6	8.6	20.4	27.8	28.1	26.4	5.8
95 per cent confidence interval	%	± 1.2	± 1.6	± 1.9	± 1.3	± 2.0	± 2.7	± 4.5	± 3.6	± 0.7
2010-11										
Proportion	%	7.6	7.9	9.9	10.0	8.3	11.0	14.9	14.8	8.7
RSE	%	5.5	5.7	5.5	6.4	8.2	8.2	7.5	9.9	2.2
95 per cent confidence interval	%	± 0.8	± 0.9	± 1.1	± 1.2	± 1.3	± 1.8	± 2.2	± 2.9	± 0.4

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

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

Source: ABS unpublished, Patient Experience Survey 2009, 2010-11.

Table 11A.27 Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2009										
Within four hours										
Proportion	%	64.4	61.9	65.1	49.2	56.7	51.8	55.7	41.1	61.1
RSE	%	4.6	6.3	5.8	10.7	10.2	15.7	24.4	29.5	2.9
95 per cent confidence interval	%	± 5.8	± 7.7	± 7.4	± 10.4	± 11.3	± 16.0	± 26.7	± 23.7	± 3.5
Four to 24 hours										
Proportion	%	20.6	26.4	23.4	29.0	32.7	35.1	22.1	39.7	24.9
RSE	%	17.4	11.1	12.1	19.3	18.2	22.7	36.2	31.7	6.7
95 per cent confidence interval	%	± 7.0	± 5.8	± 5.5	± 11.0	± 11.6	± 15.6	± 15.7	± 24.7	± 3.2
More than 24 hours										
Proportion	%	15.0	11.7	11.5	21.8	10.6	13.1	22.2	19.2	14.0
RSE	%	16.1	20.0	21.7	22.6	18.4	35.6	43.4	53.2	9.1
95 per cent confidence interval	%	± 4.7	± 4.6	± 4.9	± 9.7	± 3.8	± 9.1	± 18.9	± 20.0	± 2.5
2010-11										
Within four hours										
Proportion	%	64.2	57.7	60.7	57.5	59.1	55.5	56.1	44.9	60.2
RSE	%	2.4	3.4	3.6	5.7	4.2	6.8	5.6	11.1	1.6
95 per cent confidence interval	%	± 3.0	± 3.9	± 4.2	± 6.4	± 4.8	± 7.4	± 6.2	± 9.8	± 1.8
Four to 24 hours										
Proportion	%	24.8	32.6	29.0	30.3	29.2	29.0	34.0	34.5	28.8
RSE	%	5.8	5.1	7.5	10.2	7.6	10.8	10.1	14.5	2.9
95 per cent confidence interval	%	± 2.8	± 3.2	± 4.3	± 6.0	± 4.3	± 6.2	± 6.7	± 9.8	± 1.6
More than 24 hours										
Proportion	%	11.1	9.8	10.3	12.3	11.7	15.6	10.0	20.6	11.0
RSE	%	9.5	10.8	11.8	13.2	9.9	12.7	20.2	25.6	5.1
95 per cent confidence interval	%	± 2.1	± 2.1	± 2.4	± 3.2	± 2.3	± 3.9	± 3.9	± 10.3	± 1.1

RSE = relative standard error.

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

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

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

Table 11A.27 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d)**

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

(d) 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.

Source : ABS unpublished, Patient Experience Survey 2009, 2010-11.

Table 11A.28 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)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009										
Proportion	%	18.5	16.2	14.0	25.9	17.1	19.4	22.0	16.9	17.8
RSE	%	8.7	10.4	9.1	8.4	11.0	11.8	14.1	23.5	4.5
95 per cent confidence interval	%	± 3.2	± 3.3	± 2.5	± 4.3	± 3.7	± 4.5	± 6.1	± 7.8	± 1.6
2010-11										
Proportion	%	16.1	15.6	12.8	16.1	16.9	18.8	19.3	17.6	15.5
RSE	%	4.6	3.9	5.4	5.5	5.4	5.3	7.1	9.8	2.2
95 per cent confidence interval	%	± 1.4	± 1.2	± 1.4	± 1.7	± 1.8	± 2.0	± 2.7	± 3.4	± 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) Rates are age standardised to the 2001 estimated resident population.

Source: ABS unpublished, Patient Experience Survey 2009, 2010-11.

Table 11A.29 Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2010-11 (number) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11									
Indigenous status (d)									
Indigenous	26 267	6 921	23 033	8 896	3 833	1 962	1 096	13 483	82 433
Other Australians	686 348	547 970	351 969	204 979	113 583	45 668	47 412	28 786	1 933 635
Remoteness of residence (e)									
Major cities	500 562	376 756	214 427	154 384	109 455	..	48 290	..	1 403 874
Inner regional	192 050	153 904	99 783	41 568	4 582	29 433	47	..	521 367
Outer regional	16 387	24 002	42 308	15 139	1 777	17 761	..	24 871	142 245
Remote	1 234	206	16 777	1 641	482	349	..	12 547	33 236
Very remote	125	..	1 687	939	969	85	..	4 838	8 643
Total (f)	**712 615**	**554 891**	**375 002**	**213 875**	**117 416**	**47 630**	**48 508**	**42 269**	**2 112 206**

(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, or referred to another hospital, or died. This definition is an interim measure, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector.

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

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

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

(e) Remoteness areas are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There 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. Disaggregation by remoteness area is by usual residence of the patient.

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

.. Not applicable.

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

Table 11A.30 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA* (d)	*Tas*	*ACT*	*NT*	*Aust*
2008-09	648 869	542 019	380 888	193 323	112 492	43 957	44 664	34 696	2 000 908
2009-10 (e)	705 661	550 995	371 434	207 465	117 014	47 841	46 221	35 877	2 082 508
2010-11	712615	554891	375002	213875	117416	47630	48508	42269	2112206

(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, or 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.

(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) For SA for 2008-09 and 2009-10, data include presentations for which the type of visit was not reported.

(e) Data for 2009-10 have been revised using hospital classification into peer groups A and B based on 2009-10 peer groups and differ from data published in the 2011 Report which utilised hospital classification into peer groups A and B based on 2008-09 peer groups.

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

Table 11A.31 Emergency department presentations, 2010-11 (number) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Peer group A									
Triage category 4	533 631	439 283	355 958	170 253	116 321	np	np	52 944	1 731 110
Triage category 5	175 880	85 396	45 506	16 439	22 643	np	np	4 319	364 119
Peer group B									
Triage category 4	227 543	173 316	64 772	73 400	16 388	np	np	238	592 135
Triage category 5	55 080	43 395	15 886	9 377	4 115	np	np	80	136 477
Total	**992 134**	**741 390**	**482 122**	**269 469**	**159 467**	**62 133**	**59 545**	**57 581**	**2 823 841**

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

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

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

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

Table 11A.32 People deferring access to prescribed medication due to cost (per cent) (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009										
Proportion	%	9.7	8.6	11.2	11.0	10.5	6.8	3.6	9.3	9.7
RSE	%	13.6	11.3	13.0	14.5	18.2	37.3	41.4	31.4	7.2
95 per cent confidence interval	%	± 2.6	± 1.9	± 2.8	± 3.1	± 3.7	± 5.0	± 2.9	± 5.7	± 1.4
2010-11										
Proportion	%	9.3	9.1	11.4	9.1	11.1	11.5	9.4	9.1	9.8
RSE	%	5.3	5.3	5.8	8.1	8.8	8.4	14.6	20.8	2.9
95 per cent confidence interval	%	± 1.0	± 1.0	± 1.3	± 1.4	± 1.9	± 1.9	± 2.7	± 3.7	± 0.6

RSE = Relative standard error.

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

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

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

Source: ABS unpublished, Patient Experience Survey 2009, 20010-11.

Table 11A.33 **Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent) (a), (b), (c), (d)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
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

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

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

(c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

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

Source: DoHA unpublished, MBS Statistics.

Table 11A.34 Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
FWE GPs with vocational registration										
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
Proportion of FWE GPs with vocational registration										
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

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

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

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

Source: DoHA unpublished, MBS Statistics.

Table 11A.35 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007										
Accredited										
AGPAL	no.	1 425	993	820	344	365	125	52	36	4 160
GPA Accreditation *plus*	no.	256	191	118	62	28	5	14	1	675
Total	**no.**	**1 681**	**1 184**	**938**	**406**	**393**	**130**	**66**	**37**	**4 835**
General practices	no.	2 829	1 707	1 278	591	564	172	94	126	7 361
Proportion accredited	%	59.4	69.4	73.4	68.7	69.7	75.6	70.2	29.4	65.7
Registered for accreditation (b)										
AGPAL	no.	1 533	1 029	883	372	384	130	54	43	4 428
GPA Accreditation *plus*	no.	274	210	135	82	35	6	15	3	760
2008										
Accredited										
AGPAL	no.	1 372	936	795	329	339	113	47	37	3 968
GPA Accreditation *plus*	no.	267	212	148	73	36	10	23	3	772
Total	**no.**	**1 639**	**1 148**	**943**	**402**	**375**	**123**	**70**	**40**	**4 740**
General practices	no.	2 782	1 687	1 278	569	567	167	92	119	7 261
Proportion accredited	%	58.9	68.0	73.8	70.7	66.1	73.7	76.1	33.6	65.3
Registered for accreditation (b)										
AGPAL	no.	1 471	972	858	356	357	121	49	47	4 231
GPA Accreditation *plus*	no.	278	228	163	77	37	10	23	3	819
2009										
Accredited										
AGPAL	no.	1 364	915	782	311	338	115	43	37	3 905
GPA Accreditation *plus*	no.	315	262	182	86	42	15	22	5	930
Total	**no.**	**1 679**	**1 177**	**964**	**397**	**380**	**130**	**65**	**42**	**4 835**

Table 11A.35 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General practices	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (b)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
GPA Accreditation *plus*	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
GPA Accreditation *plus*	no.	329	284	197	86	44	32	19	3	994
Total	**no.**	**1 675**	**1 167**	**950**	**416**	**374**	**130**	**59**	**41**	**4 812**
General practices	no.	2 731	1691	1 266	569	525	158	91	120	7 151
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
GPA Accreditation *plus*	no.	343	291	214	89	44	32	19	4	1 036
2011										
Accredited										
AGPAL	no.	1 318	871	735	327	323	86	38	41	3 739
GPA Accreditation *plus*	no.	373	334	241	102	49	38	23	9	1 169
Total	**no.**	**1 691**	**1 205**	**976**	**429**	**372**	**124**	**61**	**50**	**4 908**
General practices (c)	no.	2 712	1687	1 241	573	537	158	84	105	7 097
Proportion accredited	%	62.4	71.4	78.6	74.9	69.3	78.5	72.6	47.6	69.2
Registered for accreditation (b)										
AGPAL	no.	1 399	926	784	350	339	92	40	57	3 987
GPA Accreditation *plus*	no.	373	334	241	102	49	38	23	9	1 169

Table 11A.35 **General practices that are accredited at 30 June (a)**

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

(a) Includes practices accredited by either of Australia's two accrediting bodies.

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

(c) Preliminary data for the total number of practices, collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June 2011". Data were provided by all Divisions of General Practice as required under contractual agreements with DoHA. Where Division amalgamations or liquidations have occurred, the practices in these catchments areas have been accounted for in the data to provide the most accurate estimate possible. Practices counted by location. Numbers of practices may vary between collection agencies depending on how a general practice is defined.

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

Table 11A.36 General practice activity in PIP practices (per cent)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of SWPEs that are in PIP practices (a)										
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
Proportion of services provided by PIP practices (b)										
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

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

(b) Services may vary in type and quality.

Source: DoHA unpublished, MBS and PIP data collections.

Table 11A.37 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 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
Scripts	no.	2 094 059	1 565 747	1 173 830	424 053	450 880	145 928	56 164	18 513	5 929 174
Concession card holders	no.	1 629 411	1 282 538	933 358	419 986	432 096	148 963	48 571	46 445	4 951 158
Rate	per 1000 holders	1 285.2	1 220.8	1 257.6	1 009.7	1 043.5	979.6	1 156.3	398.6	1 197.5
2007-08										
Scripts	no.	2 205 326	1 659 769	1 253 684	425 233	466 324	155 078	58 827	19 128	6 243 369
Concession card holders	no.	1 631 850	1 283 233	924 595	415 333	431 965	147 868	48 388	45 046	4 936 791
Rate	per 1000 holders	1 351.4	1 293.4	1 355.9	1 023.8	1 079.5	1 048.8	1 215.7	424.6	1 264.7
2008-09										
Scripts	no.	2 300 175	1 763 205	1 320 390	444 338	507 069	160 526	58 981	19 142	6 573 826
Concession card holders	no.	1 723 776	1 363 619	996 938	443 090	449 110	153 092	50 798	45 412	5 234 695
Rate	per 1000 holders	1 334.4	1 293.0	1 324.4	1 002.8	1 129.1	1 048.6	1 161.1	421.5	1 255.8
2009-10										
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

Table 11A.37 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 (a), (b), (c), (d)

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

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) 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 recognised 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: DoHA unpublished, PBS Statistics.

Table 11A.38 Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09									
Major cities	16.3	21.0	18.4	19.1	20.8	..	14.9	..	18.5
Inner regional	27.0	24.4	21.8	19.1	27.8	22.3	np	..	24.4
Outer regional	22.0	20.0	21.1	19.3	30.2	25.6	..	11.9	22.0
Remote	17.9	28.8	13.4	6.6	28.6	15.9	..	10.4	14.8
Very remote	20.2	..	2.7	6.9	10.4	16.5	..	13.5	8.2
Total (h)	**18.9**	**21.7**	**19.3**	**18.4**	**23.0**	**23.3**	**14.8**	**11.9**	**19.9**
2009-10									
Major cities	15.6	19.1	17.3	18.2	19.7	..	14.7	..	17.4
Inner regional	25.6	22.7	20.7	17.1	26.7	21.9	np	..	23.0
Outer regional	21.4	17.7	20.2	20.8	27.7	23.8	..	12.3	21.0
Remote	17.2	26.1	11.9	6.4	28.8	14.9	..	11.4	14.4
Very remote	11.4	..	4.1	8.9	8.5	18.4	..	13.9	8.9
Total (h)	**18.1**	**19.9**	**18.3**	**17.7**	**21.9**	**22.4**	**14.7**	**12.5**	**18.9**
2010-11									
Major cities	15.9	18.1	17.0	16.3	20.2	..	14.0	..	17.0
Inner regional	25.7	21.8	20.2	16.1	30.5	24.8	np	..	23.0
Outer regional	20.0	16.0	19.2	22.0	26.4	25.3	..	11.0	20.1
Remote	13.2	17.9	14.5	11.0	27.0	15.6	..	9.6	14.9
Very remote	10.3	..	3.9	17.8	8.5	np	..	11.3	9.4
Total (h)	**18.3**	**18.8**	**17.9**	**16.7**	**22.4**	**24.8**	**14.0**	**10.9**	**18.6**

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

(b) While clinical guidelines are for Type 2 diabetes, the MBS items do not specify Type 2 diabetes. Clinical guidelines represent the minimum level of care required. While the minimum frequency of glycosolated heamoglobin (HbA1c) testing according to clinical guidelines is at least 6 monthly for adults and 3 monthly for children and adolescents, the MBS annual cycle of care requires only annual testing, irrespective of age.

(c) Denominator data (estimated number of people with diabetes) are from the National Diabetes Services Scheme (NDSS). NDSS registration is voluntary; the NDSS is estimated to cover 80 per cent to 90 per cent of people with diagnosed diabetes. Interpretation of rates over time should not be undertaken as the denominator increases each year with the increased coverage of the NDSS.

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing*. Accuracy of the classifications decreases over intercensal periods due to changes in demographics within postcode boundaries over time. Not all remoteness areas are represented in each state or territory. 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.

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

(f) Historical data may differ from previous reports as data include services provided under the DVA for the first time. Data reported here are not comparable with data in previous Reports.

(g) Data have been suppressed where the numerator is less than 10.

Table 11A.38 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g)**

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

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

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

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

Table 11A.39 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2001										
0–14 years										
Proportion	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np	24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np	7.7
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
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

Table 11A.39 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
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) (c)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

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

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

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

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

Table 11A.39 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

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

np Not published.

Source : ABS 2009, *National Health Survey: Summary of Results, 2007-2008* , Cat. No. 4364.0, Canberra; ABS 2009, *National Health Survey: Summary of Results* ; *State Tables* , *2007-08* , Cat. No. 4362.0, Canberra; ABS unpublished, *National Health Survey 2001, 2004-05, 2007-08* .

Table 11A.40 Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
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 (e)										
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	± 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.

Table 11A.40 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

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

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

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

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

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

Table 11A.41 Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
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

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; ABS unpublished, *National Health Survey* , 2004-05.

Table 11A.42 GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
GPs using CDM items	no.	5 696	4 210	3 113	1 509	1 347	406	222	91	16 594
Total GPs	no.	6 171	4 599	3 601	1 698	1 552	474	278	114	18 487
GPs using CDM items	%	92.3	91.5	86.4	88.9	86.8	85.7	79.9	79.8	89.8
2007-08										
GPs using CDM items	no.	6 024	4 497	3 370	1 613	1 462	435	235	100	17 736
Total GPs	no.	6 303	4 763	3 739	1 744	1 610	486	282	116	19 043
GPs using CDM items	%	95.6	94.4	90.1	92.5	90.8	89.5	83.3	86.2	93.1
2008-09										
GPs using CDM items	no.	6 276	4 758	3 671	1 706	1 534	462	259	111	18 777
Total GPs	no.	6 488	4 931	3 937	1 807	1 638	492	292	122	19 707
GPs using CDM items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3
2009-10										
GPs using CDM items	no.	6 439	4 925	3 820	1 764	1 605	487	263	120	19 423
Total GPs	no.	6 617	5 061	4 064	1 858	1 683	511	286	135	20 215
GPs using CDM items	%	97.3	97.3	94.0	94.9	95.4	95.3	92.0	88.9	96.1
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

(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 : DoHA unpublished, MBS Statistics.

Table 11A.43 Pathology tests requested by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2010-11 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
Benefits paid										
Benefits paid	$m	491.6	341.3	324.6	135.9	103.3	30.1	23.2	12.2	1 462.5
Per person	$	71.4	65.6	77.7	64.7	65.3	61.1	68.8	57.1	69.7
MBS pathology items rebated										
Number	'000	22 894	16 097	14 358	6 122	4 842	1 487	1 012	557	67 373
Per person	no.	3.30	3.10	3.40	2.90	3.10	3.00	3.00	2.60	3.20
2007-08										
Benefits paid										
Benefits paid	$m	496.7	351.0	329.2	136.2	105.8	30.4	23.7	12.0	1 473.1
Per person	$	71.4	66.4	77.0	63.2	66.1	61.1	68.9	54.8	69.0
MBS pathology items rebated										
Number	'000	23 860	16 905	14 819	6 550	5 603	1 537	1 086	578	70 361
Per person	no.	3.43	3.20	3.46	3.04	3.50	3.09	3.16	2.63	3.30
2008-09										
Benefits paid										
Benefits paid	$m	496.3	350.6	330.8	136.4	104.4	30.8	23.8	12.5	1 485.6
Per person	$	70.1	64.7	75.2	61.0	64.4	61.3	67.8	55.9	68.0
MBS pathology items rebated										
Number	'000	24 632	17 515	15 582	6 847	5 793	1 602	1 121	626	73 719
Per person	no.	3.48	3.23	3.54	3.06	3.57	3.19	3.19	2.79	3.38
2009-10										
Benefits paid										
Benefits paid	$m	490.3	350.4	309.1	133.8	107.8	31.0	22.4	12.8	1 457.5
Per person	$	67.6	63.0	68.1	58.0	65.5	60.9	62.6	55.5	65.1
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 (e)										
Benefits paid	$m	470.2	330.2	295.2	128.0	101.1	29.6	21.3	12.0	1 387.5
Per person	$	64.7	59.1	64.9	55.2	61.3	58.1	58.8	52.0	61.7
MBS pathology items rebated										
Number	'000	26 831	19 351	16 937	7 479	6 246	1 755	1 171	680	80 451
Per person	no.	3.69	3.46	3.72	3.23	3.78	3.45	3.24	2.96	3.58

Table 11A.43 Pathology tests requested by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2010-11 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e)

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

(a) Data are presented in current prices based on the Australian Bureau of Statistics (ABS) Gross Domestic Product price deflator (index) (2010-11 dollars), table AA.39.

(b) DVA data are included for number of MBS pathology items rebated and for benefits paid.

(c) Standard DVA reports do not distinguish between the various providers who request pathology services.

(d) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen. Additional tests can be performed but not rebated — these are not included in the data.

(e) 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.

Source : DoHA unpublished, MBS and DVA data collections; table AA.39.

Table 11A.44 Diagnostic imaging referred by vocationally recognised GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2010-11 dollars) and number of rebated MBS imaging items (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
Benefits paid										
Benefits paid	$m	444.7	277.5	232.2	103.7	77.5	23.9	16.7	4.9	1181.3
Per person	$	64.6	53.3	55.6	49.4	49.1	47.9	49.4	23.0	56.2
MBS diagnostic imaging items rebated										
Number	'000	3 739	2 403	2 023	903	702	210	137	46	10 162
Per person	no.	0.54	0.46	0.48	0.44	0.43	0.43	0.40	0.21	0.48
2007-08										
Benefits paid										
Benefits paid	$m	446.3	280.9	236.1	102.4	78.1	24.7	17.0	4.9	1185.7
Per person	$	64.1	53.1	55.2	47.6	48.8	49.7	49.2	22.2	55.5
MBS diagnostic imaging items rebated										
Number	'000	3 884	2 517	2 120	920	726	227	142	47	10 537
Per person	no.	0.56	0.48	0.50	0.43	0.45	0.46	0.41	0.21	0.49
2008-09										
Benefits paid										
Benefits paid	$m	447.3	279.1	243.4	103.3	80.9	24.8	16.5	4.9	1200.1
Per person	$	63.2	51.5	55.3	46.2	49.9	49.3	47.0	21.9	55.0
MBS diagnostic imaging items rebated										
Number	'000	3 985	2 605	2 246	961	774	233	144	49	10 997
Per person	no.	0.56	0.48	0.51	0.43	0.48	0.46	0.41	0.22	0.50
2009-10										
Benefits paid										
Benefits paid	$m	481.5	299.6	265.4	110.7	87.0	26.8	16.8	5.7	1293.4
Per person	$	66.4	53.9	58.5	47.9	52.9	52.6	46.9	24.5	57.7
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	480.7	291.7	271.0	110.0	85.8	26.0	15.8	5.4	1286.5
Per person	$	66.1	52.2	59.6	47.5	52.0	51.0	43.7	23.3	57.2
MBS diagnostic imaging items rebated										
Number	'000	4 243	2 757	2 474	1 011	824	245	144	54	11 752
Per person	no.	0.58	0.49	0.54	0.44	0.50	0.48	0.40	0.23	0.52

Table 11A.44 Diagnostic imaging referred by vocationally recognised GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2010-11 dollars) and number of rebated MBS imaging items (a), (b), (c)

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

(a) Data are presented in current prices based on the Australian Bureau of Statistics (ABS) Gross Domestic Product price deflator (index) (2010-11 dollars), table AA.39.

(b) DVA data are included for number of referrals and benefits paid on diagnostic imaging items.

(c) Standard DVA reports do not distinguish between the various providers of diagnostic imaging services and do not record numbers of tests but rather items paid for.

Source : DoHA unpublished, MBS and DVA data collections; table AA.39.

Table 11A.45 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2007)	no.	1 676	1 179	947	394	361	127	78	36	4 798
SWPE (c)	no.	4 468 264	3 761 795	2 752 485	1 356 627	1 200 227	370 994	245 940	68 654	14 224 986
Maintain secure electronic patient records	no.	1 347	1 018	829	331	297	110	69	28	4 029
Share of PIP practices	%	80.4	86.3	87.5	84.0	82.3	86.6	88.5	77.8	84.0
Use mainly secure electronic patient records	no.	1 299	981	812	302	291	106	64	28	3 883
Share of PIP practices	%	77.5	83.2	85.7	76.7	80.6	83.5	82.1	77.8	80.9
PIP practices (May 2008)	no.	1 676	1 175	954	405	351	126	76	37	4 800
SWPE (c)	no.	4 513 662	3 807 184	2 813 260	1 374 436	1 189 015	373 550	255 778	69 858	14 396 743
Maintain secure electronic patient records	no.	1 427	1 063	870	356	310	115	69	28	4 238
Share of PIP practices	%	85.1	90.5	91.2	87.9	88.3	91.3	90.8	75.7	88.3
Use mainly secure electronic patient records	no.	1 373	1 031	857	334	302	112	64	28	4 101
Share of PIP practices	%	81.9	87.7	89.8	82.5	86.0	88.9	84.2	75.7	85.4
PIP practices (May 2009)	no.	1 682	1 170	958	404	358	123	71	38	4 804
SWPE (c)	no.	4 620 481	3 919 305	2 923 278	1 434 363	1 206 788	383 933	257 381	74 852	14 820 381
Maintain secure electronic patient records	no.	1 464	1 074	894	369	321	115	67	30	4 334
Share of PIP practices	%	87.0	91.8	93.3	91.3	89.7	93.5	94.4	79.0	90.2
Use mainly secure electronic patient records	no.	1 414	1 048	884	353	316	112	63	30	4 220
Share of PIP practices	%	84.1	89.6	92.3	87.4	88.3	91.1	88.7	79.0	87.8

Table 11A.45 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

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

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

(b) In August 2009 the two-part PIP information management/information technology (IM/IT) incentive was replaced with the PIP eHealth incentive, intended to encourage general practices to keep up-to-date with the latest developments in eHealth. To be eligible for the PIP eHealth Incentive, practices must: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.
Data for 2007 to 2009 are presented for both parts of the PIP IM/IT incentive. Data for 2010 and 2011 are presented for the eHealth incentive.
Data for the first PIP IM/IT incentive, which ended in November 2006, are available in previous reports.

(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: DoHA unpublished, MBS and PIP data collections.

Table 11A.46 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b)**

	Unit	Capital city	Other metro centre	Large rural centre	Small rural centre	Other rural	Remote centre	Other remote	Aust
PIP practices (May 2011)	no.	2 904	365	307	342	688	59	116	4 781
SWPE (c)	no.	9 713 502	1 302 915	1 119 534	1 275 718	1 855 630	143 215	120 071	15 530 585
Maintain secure electronic patient records (d)									
Share of PIP practices (May 2007)	%	82.9	85.2	87.3	85.6	88.8	74.6	69.0	84.0
Share of PIP practices (May 2008)	%	87.2	88.6	90.6	90.8	92.7	81.8	78.9	88.3
Share of PIP practices (May 2009)	%	89.0	90.0	92.6	92.7	94.6	83.3	85.7	90.2
PIP eHealth Incentive — uptake (d)	%								
Share of PIP practices (May 2010)		77.8	79.7	83.1	80.2	81.0	66.1	63.9	78.5
Share of PIP practices (May 2011)	%	87.7	88.5	90.6	85.7	89.5	72.9	76.7	87.6
Use mainly secure electronic patient records (d)									
Share of PIP practices (May 2007)	%	79.2	83.8	84.7	84.6	86.3	74.6	68.0	80.9
Share of PIP practices (May 2008)	%	83.7	87.8	88.1	89.2	90.2	81.8	78.9	85.4
Share of PIP practices (May 2009)	%	86.0	89.5	90.4	91.5	92.8	83.3	84.8	87.8

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

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

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

Table 11A.46 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b)**

	Unit	Capital city	Other metro centre	Large rural centre	Small rural centre	Other rural	Remote centre	Other remote	Aust

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

Source : DoHA unpublished, MBS and PIP data collections.

Table 11A.47 **Proportion of persons 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, by remoteness, by State and Territory 2010-11 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Proportion of persons who saw a GP in the last 12 months reporting the GP always or often listened carefully to them									
					proportion (per cent)				
Remoteness									
Major cities	%	90.5	90.1	88.6	89.5	88.8	na	na	na
Other (c)	%	88.1	87.3	87.2	88.9	84.7	na	na	na
Total	**%**	**89.8**	**89.4**	**88.0**	**89.3**	**88.0**	**88.6**	**87.6**	**83.3**
					relative standard error (per cent)				
Remoteness									
Major cities	%	0.9	0.8	1.0	0.9	1.1	na	na	na
Other (c)	%	1.1	1.2	1.0	1.5	2.1	na	na	na
Total	**%**	**0.7**	**0.7**	**0.8**	**0.7**	**0.9**	**1.2**	**1.8**	**2.3**
					95 per cent confidence interval (± per cent)				
Remoteness									
Major cities	± %	1.5	1.4	1.7	1.5	1.8	na	na	na
Other (c)	± %	2.0	2.1	1.7	2.6	3.5	na	na	na
Total	**± %**	**1.2**	**1.2**	**1.4**	**1.3**	**1.5**	**2.1**	**3.1**	**3.7**
Proportion of persons who saw a GP in the last 12 months reporting the GP always or often showed respect to them									
					proportion (per cent)				
Remoteness									
Major cities	%	93.9	92.5	91.4	92.2	92.1	na	na	na
Other (c)	%	92.2	90.6	90.2	92.2	88.8	na	na	na
Total	**%**	**93.4**	**92.1**	**91.0**	**92.2**	**91.4**	**91.2**	**91.6**	**86.1**

Table 11A.47 **Proportion of persons 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, by remoteness, by State and Territory 2010-11 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
					relative standard error (per cent)				
Remoteness									
Major cities	%	0.5	0.6	0.8	0.8	0.7	na	na	na
Other (c)	%	0.8	1.2	1.2	1.3	1.8	na	na	na
Total	**%**	**0.5**	**0.5**	**0.6**	**0.7**	**0.5**	**1.0**	**1.4**	**2.1**
					95 per cent confidence interval (± per cent)				
Remoteness									
Major cities	%	1.0	1.1	1.4	1.5	1.2	na	na	na
Other (c)	%	1.5	2.1	2.1	2.4	3.1	na	na	na
Total	**%**	**0.8**	**1.0**	**1.2**	**1.2**	**0.9**	**1.8**	**2.5**	**3.5**
Proportion of persons who saw a GP in the last 12 months reporting the GP always or often spent enough time with them									
					proportion (per cent)				
Remoteness									
Major cities	%	88.6	86.9	87.8	86.7	85.7	na	na	na
Other (c)	%	86.8	87.8	85.2	88.7	84.4	na	na	na
Total	**%**	**88.0**	**87.2**	**86.8**	**87.2**	**85.4**	**85.7**	**85.1**	**82.9**
					relative standard error (per cent)				
Remoteness									
Major cities	%	0.8	1.0	0.9	0.9	1.2	na	na	na
Other (c)	%	1.2	1.3	1.4	1.4	2.4	na	na	na
Total	**%**	**0.7**	**0.7**	**0.8**	**0.8**	**1.0**	**1.3**	**1.9**	**2.5**

Table 11A.47 **Proportion of persons 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, by remoteness, by State and Territory 2010-11 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
					95 per cent confidence interval (± per cent)				
Remoteness									
Major cities	± %	1.3	1.6	1.5	1.5	2.0	na	na	na
Other (c)	± %	2.1	2.3	2.3	2.4	4.0	na	na	na
Total	**± %**	**1.2**	**1.2**	**1.4**	**1.3**	**1.7**	**2.2**	**3.2**	**4.1**

(a) Persons 15 years and over who saw a GP in the last 12 months for their own health, excluding interviews by proxy.

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

(c) Includes inner and outer regional and remote areas. Very remote data were not collected in the 2010-11 Patient Experience Survey.

na Not available.

Source: ABS unpublished, Patient Experience Survey 2010-11.

Table 11A.48 Proportion of persons 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, by remoteness, 2010-11 (a) (b)

	Aust			
	%	*relative standard error of proportion (per cent)*	*95 per cent confidence interval of proportion (± per cent)*	*number ('000)*
Proportion of persons who saw a GP in the last 12 months reporting the GP always or often listened carefully to them				
Remoteness of residence				
Major cities	89.8	0.3	0.6	8 855.1
Inner regional	87.7	0.7	1.2	2 583.2
Outer regional	86.8	0.9	1.6	1 018.5
Remote	87.8	1.9	3.2	159.7
Total (c)	**89.1**	**0.3**	**0.5**	**12 616.5**
Proportion of persons who saw a GP in the last 12 months reporting the GP always or often showed respect to them				
Remoteness of residence				
Major cities	92.7	0.3	0.6	9 144.9
Inner regional	91.6	0.6	1.0	2 681.5
Outer regional	89.5	1.0	1.7	1 047.6
Remote	91.8	1.6	2.9	167.7
Total (c)	**92.2**	**0.3**	**0.6**	**13 041.5**
Proportion of persons who saw a GP in the last 12 months reporting the GP always or often spent enough time with them				
Remoteness of residence				
Major cities	87.5	0.4	0.7	8 642.5
Inner regional	87.0	0.8	1.4	2 558.5
Outer regional	84.9	1.2	2.0	1 001.4
Remote	87.2	1.9	3.3	159.4
Total (c)	**87.2**	**0.3**	**0.5**	**12 361.8**

(a) Persons 15 years and over who saw a GP in the last 12 months for their own health, excluding interviews by proxy.

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

(c) Very remote data were not collected in the 2010-11 Patient Experience Survey.

Source: ABS unpublished, Patient Experience Survey 2010-11.

Table 11A.49 **Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory 2010-11 (a) (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often listened carefully to them									
					proportion (per cent)				
Remoteness									
Major cities	%	94.1	95.0	95.4	93.8	95.0	na	na	na
Other (c)	%	91.6	92.3	93.4	94.2	95.0	na	na	na
Total	**%**	**93.6**	**94.5**	**94.7**	**93.8**	**94.9**	**93.3**	**94.8**	**93.1**
					relative standard error (per cent)				
Remoteness									
Major cities	%	0.6	0.5	0.6	1.0	0.7	na	na	na
Other (c)	%	1.5	1.3	0.9	1.3	1.8	na	na	na
Total	**%**	**0.5**	**0.5**	**0.5**	**0.8**	**0.8**	**1.3**	**1.2**	**1.4**
					95 per cent confidence interval (± per cent)				
Remoteness									
Major cities	± %	1.1	1.0	1.1	1.8	1.4	na	na	na
Other (c)	± %	2.7	2.4	1.7	2.5	3.3	na	na	na
Total	**± %**	**1.0**	**1.0**	**0.9**	**1.5**	**1.5**	**2.4**	**2.2**	**2.6**

Table 11A.49 **Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory 2010-11 (a) (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often showed respect to them									
					proportion (per cent)				
Remoteness									
Major cities	%	95.2	96.1	96.1	94.4	95.4	na	na	na
Other (c)	%	93.9	94.2	94.0	95.7	94.6	na	na	na
Total	**%**	**95.0**	**95.7**	**95.3**	**94.6**	**95.1**	**94.0**	**95.9**	**94.5**
					relative standard error (per cent)				
Remoteness									
Major cities	%	0.6	0.5	0.5	0.9	0.7	na	na	na
Other (c)	%	1.1	1.3	0.9	1.1	1.8	na	na	na
Total	**%**	**0.5**	**0.5**	**0.5**	**0.7**	**0.8**	**1.2**	**0.9**	**1.2**
					95 per cent confidence interval (± per cent)				
Remoteness									
Major cities	%	1.1	0.9	0.9	1.6	1.4	na	na	na
Other (c)	%	2.1	2.4	1.7	2.1	3.3	na	na	na
Total	**%**	**1.0**	**0.9**	**0.9**	**1.3**	**1.4**	**2.2**	**1.6**	**2.3**

Table 11A.49 **Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory 2010-11 (a) (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often spent enough time with them									
					proportion (per cent)				
Remoteness									
Major cities	%	94.9	96.0	95.8	94.5	96.4	na	na	na
Other (c)	%	94.0	93.7	93.5	95.8	94.6	na	na	na
Total	**%**	**94.7**	**95.5**	**95.1**	**94.8**	**95.9**	**92.5**	**95.0**	**94.6**
					relative standard error (per cent)				
Remoteness									
Major cities	%	0.6	0.5	0.8	0.8	0.7	na	na	na
Other (c)	%	0.9	1.3	1.1	1.2	2.1	na	na	na
Total	**%**	**0.4**	**0.5**	**0.6**	**0.7**	**0.8**	**1.4**	**1.5**	**1.6**
					95 per cent confidence interval (± per cent)				
Remoteness									
Major cities	± %	1.1	1.0	1.6	1.4	1.2	na	na	na
Other (c)	± %	1.7	2.5	1.9	2.2	3.9	na	na	na
Total	**± %**	**0.8**	**1.0**	**1.2**	**1.2**	**1.5**	**2.5**	**2.9**	**3.0**

(a) Persons 15 years and over who saw a dental professional in the last 12 months for their own health, excluding interviews by proxy.

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

(c) Includes inner and outer regional and remote areas. Very remote data were not collected in the 2010-11 Patient Experience Survey.

na Not available.

Source: ABS unpublished, Patient Experience Survey 2010-11.

Table 11A.50 Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2010-11 (a), (b)

	Aust			
	%	*relative standard error of proportion (per cent)*	*95 per cent confidence interval of proportion (± per cent)*	*number*
Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often listened carefully to them				
Remoteness of residence				
Major cities	94.7	0.3	0.6	5 835.8
Inner regional	92.9	0.6	1.0	1 453.4
Outer regional	92.2	1.2	2.1	583.4
Remote	96.6	1.7	3.2	99.3
Total (c)	**94.2**	**0.3**	**0.5**	**7 972.0**
Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often showed respect to them				
Remoteness of residence				
Major cities	95.6	0.3	0.6	5 894.3
Inner regional	94.4	0.5	0.9	1 475.8
Outer regional	93.7	1.0	1.8	594.5
Remote	97.2	1.6	3.0	99.7
Total (c)	**95.2**	**0.2**	**0.5**	**8 064.3**
Proportion of persons who saw a dental professional in the last 12 months reporting the dental professional always or often spent enough time with them				
Remoteness of residence				
Major cities	95.5	0.3	0.6	5 893.6
Inner regional	94.1	0.6	1.1	1 474.0
Outer regional	93.3	1.1	2.1	593.2
Remote	96.8	1.5	2.8	99.8
Total (c)	**95.1**	**0.3**	**0.5**	**8 060.6**

(a) Persons 15 years and over who saw a dental professional for their own health in the last 12 months, excluding interviews by proxy.

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

(c) Very remote data were not collected in the 2010-11 Patient Experience Survey.

Source : ABS unpublished, Patient Experience Survey 2010-11.

Table 11A.51 **Annual health assessments for older people (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	453 905	332 645	235 780	109 511	120 452	34 516	14 366	7 051	1 313 687
Proportion assessed	%	21.55	19.51	22.14	16.68	20.77	22.93	12.20	11.20	20.45
2007-08										
Older people assessed	no.	104 776	66 478	57 405	19 384	26 741	8 301	2 337	1 039	286 461
Older people	no.	465 178	340 681	242 938	113 364	122 641	35 236	14 923	7 429	1 348 079
Proportion assessed	%	22.52	19.51	23.63	17.10	21.80	23.56	15.66	13.99	21.25
2008-09										
Older people assessed	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Older people	no.	474 661	347 313	248 638	116 589	124 579	35 713	15 401	7 786	1 376 687
Proportion assessed	%	23.77	21.13	25.84	19.55	22.12	26.63	15.93	16.39	22.81
2009-10										
Older people assessed	no.	118 405	78 282	67 135	25 472	28 201	9 187	2 770	1 477	330 929
Older people	no.	483 341	354 239	254 052	119 267	126 130	36 385	15 916	8 193	1 403 864
Proportion assessed	%	24.50	22.10	26.43	21.36	22.36	25.25	17.40	18.03	23.57
2010-11 (e)										
Older people assessed	no.	130 646	89 353	76 701	30 785	31 286	10 948	3 171	1 782	374 672
Older people	no.	491 718	361 938	260 684	122 408	127 470	36 871	16 381	8 643	1 432 824
Proportion assessed	%	26.57	24.69	29.42	25.15	24.54	29.69	19.36	20.62	26.15

(a) Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding people living in residential aged care facilities.

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

(c) Data are for number of people receiving a health assessment rather than the number of health assessments provided.

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

(e) 2010-11 data are preliminary data.

Source: DoHA unpublished, MBS data collection; ABS 2010, *Australian Demographic Statistics*, Cat. no. 3101.0; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 1991 to 2021*, Cat. no. 3238.0, Canberra.

Table 11A.52 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2006–2011 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Valid vaccinations provided											
GPs	no.	16 559 515	8 209 746	10 268 447	3 911 491	2 937 735	1 177 853	441 073	50 509	na	43 556 369
Council	no.	1 057 658	6 864 622	855 738	358 665	792 050	154 640	na	na	na	10 083 373
State or territory health department	no.	3	na	1 455	377 438	3 077	717	164 956	3 453	na	551 099
Public hospital	no.	364 519	91 024	366 095	216 349	98 773	2 745	7 142	73 417	4 369	1 224 433
Private hospital	no.	14 538	108	2 215	70	na	105	41	8 689	na	25 766
Aboriginal health service	no.	95 706	19 983	74 547	32 840	20 199	25	1 491	112 489	na	357 280
Community health centre	no.	1 431 950	98 795	724 156	1 110 280	368 102	6 419	384 628	728 850	2 159	4 855 339
Other (d)	no.	10 469	3 505	89 612	1 023	6 200	na	72	2 211	na	113 092
Total	**no.**	**19 534 358**	**15 287 783**	**12 382 265**	**6 008 156**	**4 226 136**	**1 342 504**	**999 403**	**979 618**	**6 528**	**60 766 751**
Proportion of total valid vaccinations											
GPs	%	84.8	53.7	82.9	65.1	69.5	87.7	44.1	5.2	na	71.7
Council	%	5.4	44.9	6.9	6.0	18.7	11.5	–	–	na	16.6
State or territory health department	%	–	–	–	6.3	0.1	0.1	16.5	0.4	na	0.9
Public hospital	%	1.9	0.6	3.0	3.6	2.3	0.2	0.7	7.5	66.9	2.0
Private hospital	%	0.1	–	–	–	–	–	–	0.9	na	–
Aboriginal health service	%	0.5	0.1	0.6	0.6	0.5	–	0.2	11.5	na	0.6
Community health centre	%	7.3	0.7	5.9	18.5	8.7	0.5	38.5	74.4	33.1	8.0
Other (d)	%	–	–	0.7	–	0.1	na	–	0.2	na	0.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 11A.52 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2006–2011 (a), (b), (c)**

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

(a) 1 July 2006 to 30 June 2011.

(b) Totals may not add as a result of rounding.

(c) Data reported by the State or Territory in which the immunisation provider is located.

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

– Nil or rounded to zero.

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

Table 11A.53 Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
Fully immunised (e)									
30 June 2007	91.5	91.8	90.9	88.9	90.5	91.4	94.3	91.1	91.2
30 June 2008	91.3	91.8	90.8	90.1	91.0	91.0	93.5	91.6	91.2
30 June 2009	91.9	91.9	91.0	88.9	91.5	90.3	93.6	90.3	91.3
30 June 2010	91.2	92.1	91.9	90.1	91.3	91.7	92.2	90.3	91.5
30 June 2011 (f)	89.7	91.6	91.0	87.6	90.5	90.4	92.5	91.8	90.3
Immunised against (at 30 June 2011) (f)									
Diphtheria, tetanus and pertussis	90.2	92.1	91.4	88.2	90.9	90.7	93.2	92.0	90.8
Polio	90.1	92.1	91.3	88.1	90.9	90.6	93.2	91.9	90.7
Haemophilus influenzae type b	90.0	91.9	91.2	88.1	90.8	90.5	93.0	91.8	90.6

(a) Coverage measured at 30 June for children turning 12 months of age by 31 March, by the State or Territory in which the child was located.

(b) The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.

(d) NT immunisation records differ from 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 and *Haemophilus influenzae* type b.

(f) Relatively low coverage rates for the June 2011 quarter are associated with parents not receiving immunisation reminders due to administrative error.

Source: DoHA unpublished, ACIR data collection.

Table 11A.54 Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
Fully immunised (e)									
30 June 2007	92.3	93.8	92.2	90.6	93.0	95.1	91.9	92.5	92.5
30 June 2008	92.5	93.6	92.6	91.2	93.3	93.4	94.8	94.7	92.8
30 June 2009	92.7	93.8	92.2	91.8	93.2	93.0	93.6	94.6	92.9
30 June 2010	92.5	93.0	92.2	90.5	92.5	92.8	93.8	93.4	92.4
30 June 2011	92.2	93.5	93.0	92.0	92.6	94.6	93.4	94.0	92.8
Immunised against (at 30 June 2011)									
Diphtheria, tetanus and pertussis	94.6	95.6	94.9	94.1	94.7	95.8	95.3	96.0	94.9
Polio	94.6	95.6	94.8	94.1	94.7	95.8	95.3	96.0	94.9
Haemophilus influenzae type b	95.0	95.7	95.1	94.3	94.8	96.4	95.6	95.5	95.1
Measles, mumps and rubella	93.5	94.7	94.3	93.4	93.8	95.5	94.5	95.6	94.0

(a) Coverage measured at 30 June for children turning 24 months of age by 31 March, by the State or Territory in which the child was located.

(b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.

(d) NT immunisation records differ from 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, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B and measles, mumps and rubella.

Source: DoHA unpublished, ACIR data collection.

Table 11A.55 Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
Fully immunised (e)									
30 June 2008	79.1	84.3	81.7	76.8	73.0	79.9	86.4	80.7	80.4
30 June 2009	82.0	85.8	82.5	80.3	75.6	78.6	84.4	84.8	82.4
30 June 2010	89.5	91.2	90.2	86.6	87.2	90.6	89.0	87.3	89.6
30 June 2011	89.7	91.1	90.3	86.0	87.0	90.3	90.6	88.1	89.6
Immunised against (at 30 June 2011)									
Diphtheria, tetanus and pertussis	90.1	91.6	90.8	86.6	87.4	91.2	91.5	88.8	90.1
Polio	90.1	91.5	90.7	86.6	87.4	91.2	91.4	88.8	90.0
Measles, mumps and rubella	90.0	91.4	90.6	86.5	87.3	90.4	91.0	88.8	89.9

(a) Coverage measured at 30 June for children turning 60 months of age by 31 March, by the State or Territory in which the child was located.

(b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.

(d) NT immunisation records differ from 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, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

Source: DoHA unpublished, ACIR data collection.

Table 11A.56 Proportion of children aged five years who were fully vaccinated, by Indigenous status and remoteness (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous status									
2010									
Indigenous	85.4	88.4	87.0	80.6	76.3	89.0	90.9	90.0	85.7
Other Australians (d)	89.6	91.2	90.4	87.1	87.5	90.7	88.9	85.0	89.7
2011									
Indigenous	85.9	86.5	88.5	84.0	78.7	89.0	90.9	88.7	86.5
Other Australians (d)	89.8	91.1	90.4	86.2	87.3	90.4	90.6	87.7	89.7
Remoteness of residence (e)									
2010 (f)									
Major cities	89.3	91.1	89.9	86.3	86.4	..	89.0	..	89.3
Inner regional	90.4	91.8	90.3	87.4	86.6	90.0	91.1	..	90.3
Outer regional	89.4	90.0	91.3	87.0	91.2	91.9	..	83.0	89.8
Remote	87.0	79.6	89.6	88.9	94.2	81.6	..	89.4	89.4
Very remote	83.0	..	89.8	87.1	77.8	np	..	93.7	89.5
2011 (g)									
Major cities	89.9	91.2	90.3	85.1	86.3	..	90.6	..	89.5
Inner regional	89.5	90.9	89.9	87.7	88.8	90.1	np	..	89.8
Outer regional	87.9	90.8	90.7	87.2	88.8	91.1	..	85.7	89.3
Remote	87.1	98.6	90.0	88.9	89.7	80.9	..	87.9	88.9
Very remote	90.0	..	91.0	90.4	83.9	np	..	93.7	91.3

(a) Includes children who turn 5 years old between 1 January and 31 March of the reference year.

(b) Fully vaccinated is defined as having received age appropriate immunisation against diphtheria, tetanus, pertussis, hepatitis B, poliomyelitis, measles, mumps and rubella.

(c) Data are suppressed where numerator is less than10.

Table 11A.56 **Proportion of children aged five years who were fully vaccinated, by Indigenous status and remoteness (per cent) (a), (b), (c)**

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

(d) Data for Other Australians include records for children where Indigenous status is not known or not stated.

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

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

(g) Excludes 1 record where postcode did not map to a remoteness category.

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

Source: DoHA unpublished, ACIR data collection.

Table 11A.57 Notifications of measles, children aged 0–14 years (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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	3	np	np	np	–	–	–	12
2010-11	no.	40	6	7	5	–	–	np	np	61
Notifications per 100 000 children (0–14 years)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	–
2007-08	per 100 000 children	0.3	np	np	np	np	–	–	np	0.1
2008-09	per 100 000 children	np	0.3	0.5	np	–	np	–	–	0.2
2009-10	per 100 000 children	0.1	np	np	np	np	–	–	–	0.1
2010-11	per 100 000 children	0.6	0.1	0.2	0.2	–	–	np	np	0.3

(a) Notifications are presented by financial year for the first time in this report.

(b) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(c) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(d) Data are suppressed where there are fewer than 5 notifications.

– Nil or rounded to zero. **np** Not published.

Source: DoHA unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0, Canberra.

Table 11A.58 Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	668	191	95	36	41	10	5	82	1 128
2008-09	no.	8 179	655	955	205	587	205	59	162	11 007
2009-10	no.	3 281	1 067	1 497	240	1 834	108	32	60	8 119
2010-11	no.	8 737	2 853	3 130	739	2 180	68	334	128	18 169
Notifications per 100 000 children (0–14 years)										
2006-07	per 100 000 children	4.4	1.8	2.7	1.6	2.5	1.4	2.3	np	2.8
2007-08	per 100 000 children	9.5	3.6	2.2	1.7	2.6	2.0	–	37.2	5.2
2008-09	per 100 000 children	114.7	12.0	21.6	9.1	36.1	40.7	16.7	71.6	50.1
2009-10	per 100 000 children	45.3	19.2	33.1	10.5	111.5	21.3	8.9	26.1	36.3
2010-11	per 100 000 children	120.7	51.4	69.3	32.2	132.6	13.4	93.1	55.7	81.3

(a) Notifications are presented by financial year for the first time in this report.

(b) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(c) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(d) Data are suppressed where there are fewer than 5 notifications.

– Nil or rounded to zero. **np** Not published.

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

Table 11A.59 Notifications of *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
Notifications per 100 000 children (0–14 years)										
2006-07	per 100 000 children	np	np	0.2	np	–	–	–	–	0.1
2007-08	per 100 000 children	0.1	–	np	–	np	np	–	np	0.1
2008-09	per 100 000 children	np	np	np	np	–	–	–	np	0.1
2009-10	per 100 000 children	np	–	np	np	np	–	–	np	–
2010-11	per 100 000 children	0.1	np	np	np	–	–	–	–	0.1

(a) Notifications are presented by financial year for the first time in this report.

(b) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(c) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(d) Data are suppressed where there are fewer than 5 notifications.

– Nil or rounded to zero. **np** Not published.

Table 11A.60 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (f)	*Aust*
2005–2006									
40–44 years	5.9	6.6	25.9	11.8	10.8	22.2	0.4	5.8	11.3
45–49 years	10.6	11.6	38.1	22.9	20.1	34.4	8.7	15.1	18.8
50–54 years	52.6	54.5	54.4	53.2	56.0	51.6	48.6	35.6	53.5
55–59 years	56.0	56.7	58.7	58.6	58.5	59.5	62.4	43.6	57.3
60–64 years	57.7	59.4	60.4	60.1	62.2	60.5	65.5	45.6	59.4
65–69 years	56.9	58.1	60.7	59.7	61.0	59.9	61.8	41.7	58.6
70–74 years	12.5	50.3	53.2	19.9	23.6	50.6	23.6	9.9	32.3
75–79 years	7.2	15.7	18.7	10.3	12.7	11.5	8.8	7.8	12.3
80–84 years	2.9	3.0	4.7	3.7	4.1	4.0	3.5	2.4	3.4
85+ years	0.6	0.6	1.4	0.9	0.7	0.6	0.6	0.9	0.8
40+ years									
ASR	29.4	33.7	42.4	34.1	34.6	40.1	30.4	23.4	34.1
Ages 50–69									
ASR	55.4	56.8	58.0	57.3	58.9	57.1	58.3	41.0	56.7
2006–2007									
40–44 years	6.4	5.8	25.4	11.4	10.0	21.2	1.1	5.1	11.0
45–49 years	12.0	10.9	37.4	22.4	19.4	32.7	8.4	13.5	18.8
50–54 years	52.7	53.1	52.3	54.3	51.2	48.0	50.8	35.3	52.4
55–59 years	56.9	55.8	57.7	58.3	56.7	57.3	60.1	43.3	56.9
60–64 years	58.8	59.0	59.6	59.6	59.9	57.8	61.5	43.1	59.1
65–69 years	57.6	57.8	59.5	60.1	58.6	57.1	58.9	41.3	58.2
70–74 years	13.4	45.3	52.7	19.3	23.9	48.9	18.7	9.0	31.1
75–79 years	7.2	16.9	18.5	10.6	12.9	11.6	8.6	6.1	12.6
80–84 years	2.8	2.9	4.7	4.1	4.4	4.3	2.7	2.0	3.5
85+ years	0.7	0.6	1.3	0.9	0.8	0.7	0.3	0.6	0.8
40+ years									
ASR	30.1	32.8	41.6	34.0	33.1	38.2	29.5	22.5	33.7
Ages 50–69									
ASR	56.0	55.9	56.6	57.5	55.8	54.2	57.0	40.2	56.1
2007–2008									
40–44 years	6.3	5.3	25.2	11.1	10.2	22.0	3.8	4.2	10.9
45–49 years	11.6	10.2	37.3	21.5	20.0	34.0	9.7	13.2	18.6
50–54 years	50.1	48.0	53.6	52.1	53.1	47.7	45.7	34.8	50.4
55–59 years	55.4	54.1	57.8	55.2	57.6	56.7	57.0	42.7	55.6
60–64 years	58.0	57.7	60.0	57.8	61.5	59.3	59.0	45.5	58.6
65–69 years	56.5	56.2	59.2	58.0	60.2	58.7	58.2	41.2	57.4
70–74 years	13.5	33.2	52.8	19.7	25.2	34.0	18.3	8.6	27.9
75–79 years	6.7	13.2	19.4	10.8	13.5	11.2	8.6	4.9	11.7
80–84 years	2.6	2.9	5.0	4.1	5.0	3.9	2.7	2.7	3.5

Table 11A.60 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (f)	*Aust*
85+ years	0.6	0.6	1.3	0.9	0.9	0.6	0.4	0.3	0.8
40+ years									
ASR	29.2	30.2	41.8	32.8	34.0	37.6	28.7	22.2	32.8
Ages 50–69									
ASR	54.4	53.1	57.1	55.2	57.4	54.5	53.8	40.3	54.8
2008–2009									
40–44 years	6.5	5.1	24.8	11.1	9.9	22.9	6.7	3.4	10.9
45–49 years	11.4	9.7	38.1	21.9	19.8	35.6	10.9	12.4	18.6
50–54 years	48.9	47.8	54.8	53.2	55.4	50.6	44.9	36.6	50.6
55–59 years	55.4	53.5	59.1	57.1	57.9	58.5	56.5	42.1	56.0
60–64 years	58.1	57.8	61.6	59.8	62.8	63.0	61.0	46.5	59.4
65–69 years	56.6	56.1	60.6	59.1	60.9	62.1	58.3	42.9	57.9
70–74 years	15.1	23.8	54.3	20.5	25.0	21.3	22.1	9.6	26.1
75–79 years	7.0	8.5	20.5	11.4	13.6	9.9	9.9	5.0	10.8
80–84 years	2.8	2.9	5.5	4.3	5.2	3.6	3.1	2.0	3.7
85+ years	0.6	0.6	1.5	0.9	1.0	0.7	0.7	0.5	0.8
40+ years									
ASR	29.2	28.9	42.7	33.7	34.5	38.3	29.8	22.5	32.8
Ages 50–69									
ASR	54.0	53.0	58.4	56.7	58.6	57.4	53.8	41.3	55.2
2009–2010									
40–44 years	6.2	4.9	23.3	10.6	9.0	22.8	7.2	3.0	10.3
45–49 years	10.7	9.7	37.0	21.8	18.9	37.1	11.5	11.3	18.2
50–54 years	46.7	49.4	53.6	54.4	52.5	51.9	43.8	35.8	49.9
55–59 years	54.3	54.0	57.7	57.8	56.2	59.5	54.7	42.3	55.4
60–64 years	57.7	58.8	60.6	61.7	60.4	64.4	59.7	45.9	59.3
65–69 years	56.4	56.5	59.8	60.2	59.3	62.2	58.2	43.9	57.8
70–74 years	16.0	19.2	53.6	20.8	24.6	18.4	23.4	9.0	25.1
75–79 years	7.0	8.2	19.8	11.9	13.9	9.4	10.1	4.2	10.7
80–84 years	2.8	2.9	5.4	4.6	5.5	3.6	3.0	2.5	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	28.5	29.0	41.6	34.2	33.2	38.7	29.6	22.1	32.4
Ages 50–69									
ASR	52.8	53.9	57.3	57.9	56.4	58.4	52.7	41.1	54.8

ASR = age standardised rate.

(a) The participation rate is the number of women resident in the jurisdiction who were screened during the reference period, divided by the number of women resident in the jurisdiction, using the ABS estimated resident population (ERP) — except for Tasmania and the NT for which data include all women screened in the jurisdiction. The ERP is 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.

(b) Rates are expressed as the percentage of the eligible female population. Rates for '40 plus years' and '50–69 years' are age standardised to the 2001 Australian population standard.

Table 11A.60 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

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

(c) Historical rates in this table may differ from those in previous reports, as historical population data have been revised using Final Rebased Estimated Resident Population (ERP) data following the 2006 Census of Population and Housing.

(d) Data may differ from that published elsewhere which allocate women to jurisdictions based on the jurisdiction in which screening took place.

(e) 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.

(f) For Tasmania and the NT, data include all women screened in the jurisdiction, whether or not they were resident in the jurisdiction.

(g) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where around 7–8 per cent (7.8 per cent in 2009–2010) of women screened are not ACT residents.

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

Table 11A.61 **Participation rates for women in BreastScreen Australia by residential status, 2009 and 2010 (24 month period)**

	Unit	*NSW* (a)	*Vic*	*Qld*	*WA* (a)	*SA*	*Tas*	*ACT*	*NT*
40+ years									
Residents screened	no.	496 781	381 413	424 719	178 205	139 920	51 196	24 048	9 084
Non-residents screened	no.	na	1 930	2 191	455	160	71	2 034	75
Non-residents screened (proportion)	%	na	0.5	0.5	0.3	0.1	0.1	7.8	0.8
Ages 50–69									
Residents screened	no.	424 539	326 742	279 611	140 647	110 952	37 480	20 157	7 794
Non-residents screened	no.	na	1 574	1 549	na	125	53	1 672	67
Non-residents screened (proportion)	%	na	0.5	0.6	na	0.1	0.1	7.7	0.9

(a) Data for the number of women screened by jurisdiction of residence are not available for NSW or for WA for women aged 50–69 years. However, the number of residents from other jurisdictions that are screened in NSW and WA is negligible in relation to the total number of women screened.

Source: State and Territory governments unpublished.

Table 11A.62 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b)**

	NSW	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (d)	*NT*	*Aust*
2005–2006									
Aged 40–49 years	4.6	3.0	25.4	12.8	7.5	16.8	4.1	5.6	12.0
Aged 50–59 years	32.1	28.9	46.1	27.8	31.4	32.3	38.8	21.3	33.8
Aged 60–69 years	41.1	32.5	48.9	36.3	31.6	np	np	25.0	39.1
Aged 70–79 years	9.5	21.4	28.5	23.1	9.9	np	np	8.6	17.0
Aged 80+ years	2.1	1.3	4.7	6.6	2.1	np	np	1.7	3.4
Age 40+ years (ASR)	19.2	17.8	34.3	22.1	18.3	np	np	13.5	22.9
Age 50–69 years (ASR)	35.6	30.3	47.2	31.1	31.5	np	np	22.7	35.9
2006–2007									
Aged 40–49 years	5.5	3.2	24.2	13.9	8.6	12.4	2.8	5.3	11.9
Aged 50–59 years	34.0	27.0	43.7	28.9	31.8	30.8	31.0	22.1	33.7
Aged 60–69 years	42.0	33.4	45.9	37.4	33.1	39.7	47.1	22.8	38.5
Aged 70–79 years	10.1	18.8	28.4	18.9	9.5	np	np	8.0	16.4
Aged 80+ years	1.8	–	4.5	8.2	4.1	np	–	1.6	3.4
Age 40+ years (ASR)	20.2	17.1	32.6	22.5	19.2	np	np	13.2	22.7
Age 50–69 years (ASR)	37.1	29.5	44.5	32.2	32.3	34.3	37.4	22.4	35.6
2007–2008									
Aged 40–49 years	6.6	3.1	24.7	14.3	9.9	12.6	5.8	4.6	12.5
Aged 50–59 years	34.5	23.9	45.2	27.2	30.8	29.0	23.5	22.6	33.7
Aged 60–69 years	40.8	33.3	48.3	36.5	32.8	55.6	76.0	25.0	39.0
Aged 70–79 years	10.1	15.7	30.6	18.7	13.4	np	np	7.1	16.8
Aged 80+ years	1.8	0.6	5.4	7.8	3.1	np	–	1.6	3.6
Age 40+ years (ASR)	20.5	15.8	34.0	21.9	19.8	np	np	13.3	23.0
Age 50–69 years (ASR)	37.0	27.6	46.4	30.8	31.6	39.5	44.2	23.5	35.8
2008–2009									
Aged 40–49 years	7.2	3.7	24.6	12.0	10.1	16.3	6.8	3.7	12.5
Aged 50–59 years	34.3	23.9	47.1	26.6	31.9	36.2	25.3	22.8	34.5
Aged 60–69 years	41.1	32.8	50.6	31.1	34.1	75.6	85.7	25.8	39.6
Aged 70–79 years	11.1	12.4	32.1	14.4	22.1	np	np	5.3	16.9
Aged 80+ years	2.7	2.5	6.7	3.8	4.1	np	–	1.6	4.1
Age 40+ years (ASR)	20.9	15.6	35.2	19.2	21.6	np	np	13.0	23.4
Age 50–69 years (ASR)	37.0	27.4	48.5	28.4	32.8	51.7	49.1	24.0	36.5
2009–2010									
Aged 40–49 years	7.4	4.1	22.9	12.8	8.9	17.8	7.3	3.0	12.1
Aged 50–59 years	32.5	24.4	44.8	29.0	31.5	37.5	26.9	22.8	33.7
Aged 60–69 years	40.8	32.9	50.5	32.8	35.8	77.4	84.4	25.0	39.9
Aged 70–79 years	10.4	12.9	33.2	14.1	17.7	np	np	4.3	16.5
Aged 80+ years	3.0	3.7	np	3.8	3.0	np	np	2.1	np
Age 40+ years (ASR)	20.4	16.0	np	20.4	20.7	np	np	12.5	np
Age 50–69 years (ASR)	35.8	27.7	47.0	30.5	33.2	53.2	49.6	23.6	36.2

Table 11A.62 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b)**

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

ASR = age standardised rate.

(a) 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 period is 24 months.

(b) Indigenous is defined as women who have self-identified as being of Aboriginal and/or Torres Strait Islander descent.

(c) 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.

(d) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where around 7–8 per cent (7.8 per cent in 2009–2010) of women screened are not ACT residents.

– Nil or rounded to zero. **np** Not published.

Source : State and Territory governments unpublished; ABS unpublished, *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021* , Cat. no. 3238.0.

Table 11A.63 **Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b)**

	NSW	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas* (d)	*ACT* (e)	*NT*	*Aust*
2005–2006									
Aged 40–49 years	8.2	4.4	34.3	18.3	14.7	15.6	4.9	9.2	10.8
Aged 50–59 years	50.3	33.9	65.2	62.7	55.5	31.7	49.1	36.3	47.5
Aged 60–69 years	52.9	43.2	69.7	68.9	62.4	43.1	56.9	42.5	52.6
Aged 70–79 years	8.5	23.0	40.4	13.6	12.9	24.2	12.9	9.2	17.3
Aged 80+ years	1.6	0.8	2.9	2.1	1.5	2.2	1.9	1.6	1.5
Aged 40+ years (ASR)	27.3	21.7	47.8	37.8	33.3	25.2	27.2	22.1	28.6
Aged 50–69 years (ASR)	51.3	37.5	67.0	65.1	58.2	36.2	52.2	38.8	49.5
2006–2007									
Aged 40–49 years	9.2	4.2	33.9	17.7	13.5	8.3	2.5	8.7	10.9
Aged 50–59 years	54.5	33.2	63.2	63.0	51.9	18.2	34.0	36.1	48.3
Aged 60–69 years	55.1	41.4	67.8	67.6	57.3	28.3	36.5	38.4	51.7
Aged 70–79 years	8.5	23.2	40.1	13.1	12.9	19.8	6.7	9.2	17.2
Aged 80+ years	1.6	1.0	2.8	2.1	1.3	1.7	0.8	1.6	1.5
Aged 40+ years (ASR)	29.2	21.2	46.7	37.4	30.9	15.7	17.7	21.1	28.7
Aged 50–69 years (ASR)	54.7	36.5	65.0	64.8	54.0	22.2	35.0	37.0	49.7
2007–2008									
Aged 40–49 years	8.8	3.9	34.7	17.1	14.1	7.6	1.8	8.0	10.7
Aged 50–59 years	52.9	31.5	66.0	60.8	53.5	18.5	16.8	37.1	47.1
Aged 60–69 years	53.2	39.2	67.5	65.1	57.4	27.7	18.1	40.7	49.7
Aged 70–79 years	8.3	18.6	42.1	13.4	14.3	12.5	2.7	8.1	15.7
Aged 80+ years	1.2	1.0	3.1	2.0	1.7	1.9	0.6	1.8	1.4
Aged 40+ years (ASR)	28.3	19.6	48.0	36.1	31.8	14.5	8.9	21.4	27.7
Aged 50–69 years (ASR)	53.0	34.6	66.6	62.5	55.1	22.2	17.3	38.5	48.1
2008–2009									
Aged 40–49 years	8.4	3.5	36.8	17.4	14.8	16.3	2.0	4.5	10.7
Aged 50–59 years	52.2	30.0	69.0	63.3	54.6	32.0	15.2	22.2	46.7
Aged 60–69 years	53.4	36.7	68.8	67.9	56.6	39.0	16.6	28.4	49.0
Aged 70–79 years	8.7	12.4	43.6	13.8	15.0	8.4	3.9	2.6	13.7
Aged 80+ years	1.3	0.9	3.4	2.3	2.2	1.9	0.5	0.3	1.5
Aged 40+ years (ASR)	28.0	17.7	49.9	37.5	32.4	22.6	8.4	13.1	27.2
Aged 50–69 years (ASR)	52.7	32.6	68.9	65.1	55.4	34.8	15.7	24.7	47.6
2009–2010									
Aged 40–49 years	7.9	3.7	35.8	17.4	13.9	23.7	2.1	5.6	10.5
Aged 50–59 years	54.0	31.6	69.3	65.5	52.4	42.8	14.4	36.1	48.3
Aged 60–69 years	57.2	37.2	68.1	69.9	52.6	47.7	16.7	41.4	50.6
Aged 70–79 years	9.0	9.7	44.3	14.4	14.9	9.9	3.8	5.1	13.0
Aged 80+ years	1.3	0.8	3.5	2.3	2.1	2.3	0.5	2.0	1.5
Aged 40+ years (ASR)	29.1	18.0	49.7	38.5	30.7	29.8	8.2	20.1	27.7
Aged 50–69 years (ASR)	55.3	33.8	68.8	67.2	52.4	44.7	15.3	38.2	49.2

Table 11A.63 **Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b)**

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

ASR = age standardised rate.

(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 2006 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 period is 24 months.

(b) NESB is defined as persons who speak a language other than English at home.

(c) 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.

(d) An apparent drop in participation of NESB women in Tasmania from the 2005–2006 screening period 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.

(e) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where around 7–8 per cent (7.8 per cent in 2009–2010) of women screened are not ACT residents.

Source : State and Territory governments unpublished; ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0; ABS unpublished, *2006 Census of Population and Housing* .

Table 11A.64 **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)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
2005–2006 (h)									
Major Cities									
Aged 40–49 years	8.2	8.9	31.3	16.6	14.8	na	5.0	na	13.4
Aged 50–59 years	52.7	55.6	54.0	55.3	56.3	na	54.4	na	54.4
Aged 60–69 years	55.2	59.0	57.7	59.3	60.7	na	61.0	na	57.7
Aged 70–79 years	9.5	32.3	34.3	14.1	16.1	na	13.1	na	20.6
Aged 80+ years	1.8	1.6	3.0	2.1	2.2	na	1.9	na	2.0
Age 40+ years (ASR)	28.6	33.5	40.8	33.4	33.7	na	29.4	na	32.8
Age 50–69 years (ASR)	53.6	56.9	55.4	56.7	58.0	na	56.8	na	55.6
Inner Regional									
Aged 40–49 years	7.8	9.0	29.2	15.7	15.2	27.2	6.7	na	15.6
Aged 50–59 years	58.6	54.6	58.1	56.5	59.9	54.3	117.8	na	57.1
Aged 60–69 years	63.5	59.7	64.9	64.0	69.1	59.5	90.1	na	63.0
Aged 70–79 years	10.4	34.9	38.5	17.4	21.1	30.7	14.3	na	25.3
Aged 80+ years	1.5	2.3	3.1	3.2	2.9	2.0	20.6	na	2.2
Age 40+ years (ASR)	31.6	33.8	42.9	34.8	37.0	39.1	..	na	35.8
Age 50–69 years (ASR)	60.4	56.5	60.6	59.2	63.3	56.2	107.9	na	59.3
Outer Regional									
Aged 40–49 years	9.4	12.2	36.5	15.7	19.0	29.2	na	9.6	21.9
Aged 50–59 years	57.2	59.0	62.4	57.5	61.7	56.6	na	42.3	58.8
Aged 60–69 years	61.4	64.1	65.8	62.1	66.9	62.5	na	51.4	63.5
Aged 70–79 years	11.9	38.6	39.8	19.6	23.8	33.9	na	7.6	27.1
Aged 80+ years	2.2	3.2	3.7	3.4	3.4	3.2	na	1.2	3.0
Age 40+ years (ASR)	31.6	37.4	47.0	35.1	38.8	41.3	na	25.1	38.8
Age 50–69 years (ASR)	58.7	60.9	63.7	59.2	63.5	58.6	na	45.8	60.5
Remote									
Aged 40–49 years	11.8	9.2	38.1	23.8	20.9	32.3	na	14.9	24.7
Aged 50–59 years	54.0	45.7	61.4	54.7	66.1	58.4	na	47.2	57.4
Aged 60–69 years	58.0	56.5	64.8	62.3	71.9	60.8	na	51.0	62.9
Aged 70–79 years	13.6	31.8	41.4	23.8	30.8	34.8	na	13.7	28.5
Aged 80+ years	4.5	6.0	5.4	5.0	6.2	1.9	na	2.5	5.1
Age 40+ years (ASR)	31.4	30.5	47.2	37.8	42.6	42.2	na	29.1	39.6
Age 50–69 years (ASR)	55.6	49.7	62.7	57.7	68.1	59.0	na	48.5	59.5
Very remote									
Aged 40–49 years	12.4	na	40.9	25.6	22.8	50.4	na	8.4	25.0
Aged 50–59 years	61.6	na	55.9	48.9	53.6	71.9	na	27.9	47.1
Aged 60–69 years	66.5	na	58.6	48.5	53.1	70.6	na	24.4	48.6
Aged 70–79 years	18.7	na	35.3	27.9	24.9	39.5	na	7.6	26.5
Aged 80+ years	6.1	na	3.3	5.4	5.6	15.6	na	1.3	4.4

Table 11A.64 **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)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Age 40+ years (ASR)	36.2	na	44.7	35.1	35.6	57.5	na	16.2	34.0
Age 50–69 years (ASR)	63.8	na	56.9	48.6	53.3	71.3	na	26.8	47.6
2008–2009 (i)									
Major Cities									
Aged 40–49 years	8.2	7.2	30.7	16.2	14.6	..	8.7	..	13.3
Aged 50–59 years	50.4	50.1	55.1	55.4	56.4	..	50.1	..	52.2
Aged 60–69 years	55.4	56.6	59.3	59.9	60.8	..	60.2	..	57.5
Aged 70–79 years	10.3	15.8	37.5	15.2	17.9	..	17.1	..	17.6
Aged 80+ years	1.5	1.5	3.3	2.3	2.6	..	2.0	..	2.0
Age 40+ years (ASR)	28.0	28.6	41.4	33.6	33.9	..	29.8	..	31.6
Age 50–69 years (ASR)	52.2	52.5	56.6	57.1	58.1	..	53.8	..	54.1
Inner Regional									
Aged 40–49 years	9.8	7.5	28.8	14.7	14.3	29.5	np	..	15.5
Aged 50–59 years	54.5	53.0	56.9	51.7	55.7	55.0	np	..	54.5
Aged 60–69 years	60.8	60.0	62.1	59.2	65.3	63.4	np	..	61.2
Aged 70–79 years	12.6	18.7	39.8	19.6	22.9	14.8	np	..	20.7
Aged 80+ years	1.8	2.1	3.5	3.3	3.4	1.9	np	..	2.4
Age 40+ years (ASR)	30.9	30.5	41.9	32.5	35.0	38.3	np	..	34.0
Age 50–69 years (ASR)	56.8	55.6	58.8	54.5	59.3	58.1	np	..	57.0
Outer Regional									
Aged 40–49 years	13.5	10.5	36.5	14.9	16.7	29.5	..	7.3	22.1
Aged 50–59 years	54.4	55.9	62.3	55.5	57.2	53.4	..	42.6	56.6
Aged 60–69 years	60.6	61.6	65.8	61.2	63.5	61.5	..	50.0	62.2
Aged 70–79 years	15.7	21.8	42.7	22.6	23.5	18.1	..	7.0	24.7
Aged 80+ years	2.8	3.3	4.1	5.0	5.1	2.8	..	np	3.6
Age 40+ years (ASR)	32.6	33.1	47.2	34.5	36.1	38.0	..	24.0	37.6
Age 50–69 years (ASR)	56.7	58.0	63.6	57.6	59.5	56.3	..	45.5	58.7
Remote									
Aged 40–49 years	22.6	np	35.8	21.2	18.6	np	..	9.8	23.2
Aged 50–59 years	57.7	np	57.1	52.5	64.8	np	..	37.4	53.9
Aged 60–69 years	66.6	np	63.5	61.0	71.7	np	..	42.3	62.5
Aged 70–79 years	19.9	np	42.9	23.3	31.0	np	..	np	28.8
Aged 80+ years	np	np	6.8	np	7.0	np	..	np	5.9
Age 40+ years (ASR)	38.4	37.8	45.3	36.0	41.5	36.8	..	22.7	38.1
Age 50–69 years (ASR)	61.1	np	59.5	55.8	67.4	53.4	..	39.2	57.2
Very remote									
Aged 40–49 years	np	..	35.3	20.4	np	np	..	6.8	22.8
Aged 50–59 years	np	..	58.1	43.5	np	np	..	28.4	47.2
Aged 60–69 years	np	..	58.1	40.8	np	np	..	31.1	49.3

Table 11A.64 **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)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Aged 70–79 years	np	..	38.3	np	np	np	..	np	27.2
Aged 80+ years	np	..	np	np	np	np	..	np	5.4
Age 40+ years (ASR)	52.3	..	43.8	29.1	34.4	np	..	16.7	33.5
Age 50–69 years (ASR)	np	..	58.0	42.5	51.6	np	..	29.2	48.0
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

Table 11A.64 **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)**

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

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 2001 (2005–2006 data) and for 2006 (2008–2009 and 2009–2010 data). ASGC boundaries based on the 2001 Census differ from boundaries based on the 2006 Census — data for 2005–2006 are not comparable with data for 2008–2009 and 2009–2010. In addition, 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. Some postcodes supplied by women may not accurately reflect their usual residence.

(f) Data are not available for the 24 month periods 2006 and 2007, and 2007 and 2008.

(g) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where around 7–8 per cent (7.8 per cent in 2009–2010) of women screened are not ACT residents.

(h) For the period 2005–2006, the eligible female population is calculated as the average of the 2005 ERP and an estimate of the 2006 ERP based on previous population patterns.

(i) Data for the period 2008–2009 have been revised and may differ from previous reports.

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 11A.65 Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)

Age group (years)	*NSW*	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
2005 and 2006									
20–24	42.9	46.9	48.1	51.0	50.7	56.5	48.4	50.1	46.8
25–29	54.2	58.3	56.1	58.4	60.9	62.0	58.5	54.0	56.7
30–34	61.3	64.6	59.6	63.1	66.1	64.4	64.5	55.9	62.3
35–39	62.4	66.3	60.0	63.9	66.8	64.4	66.2	56.3	63.4
40–44	62.0	67.0	60.0	63.4	66.8	64.6	66.4	56.0	63.4
45–49	62.1	68.1	60.3	62.8	66.9	63.1	65.0	55.6	63.7
50–54	59.8	66.4	57.2	59.1	64.8	61.7	64.6	53.4	61.3
55–59	56.1	63.7	53.6	55.9	61.8	57.0	63.3	50.1	58.0
60–64	52.2	60.5	50.5	50.7	58.3	52.8	61.0	45.2	54.4
65–69	44.9	54.5	44.3	46.6	53.3	46.0	55.4	41.4	48.2
20–69 (crude rates)	56.7	62.0	56.0	58.8	62.3	60.4	61.3	53.6	58.6
20–69 (ASR)	56.7	62.2	56.0	58.6	62.4	60.5	61.8	52.8	58.7
2006 and 2007									
20–24	44.5	47.3	50.2	51.9	50.4	54.6	50.7	50.8	47.9
25–29	55.8	57.9	57.5	59.1	60.4	60.1	58.7	53.8	57.4
30–34	62.2	63.7	60.4	62.0	64.5	62.3	63.8	54.4	62.3
35–39	63.6	66.0	61.1	62.9	65.8	62.7	65.3	55.2	63.7
40–44	63.2	66.8	60.9	62.4	66.0	62.7	65.0	54.4	63.7
45–49	64.2	68.6	61.8	62.6	66.6	62.5	64.5	55.0	64.7
50–54	61.4	66.6	58.5	59.0	64.5	60.2	64.0	51.3	62.0
55–59	58.2	64.3	55.5	56.1	61.6	56.8	63.6	49.6	59.2
60–64	54.4	61.0	51.8	51.1	58.7	53.0	60.5	44.8	55.5
65–69	46.4	54.7	45.4	45.7	53.4	46.8	54.7	40.1	48.9
20–69 (crude rates)	58.2	61.9	57.3	58.5	61.7	59.1	61.1	52.7	59.2
20–69 (ASR)	58.3	62.2	57.3	58.4	61.9	59.2	61.5	52.0	59.3
2007 and 2008									
20–24	43.5	45.8	50.1	51.5	48.4	53.8	50.5	52.7	47.1
25–29	54.8	56.1	56.8	57.7	57.3	58.0	57.9	56.0	56.2
30–34	61.8	62.3	60.5	60.3	62.9	60.6	62.3	56.5	61.5
35–39	63.8	65.4	61.3	62.0	64.7	61.8	65.0	58.9	63.5
40–44	63.5	66.3	61.2	61.4	65.2	60.5	63.6	57.2	63.5
45–49	64.4	67.9	62.4	61.7	66.1	60.9	64.4	57.4	64.5
50–54	62.1	66.3	59.8	59.0	64.0	57.8	63.3	55.7	62.4
55–59	59.1	64.3	56.6	55.7	61.4	55.4	64.3	53.0	59.7
60–64	55.3	61.1	53.2	51.9	57.5	51.4	59.4	47.8	56.2
65–69	46.7	54.2	46.5	45.1	52.4	44.4	52.6	40.7	48.9
20–69 (crude rates)	58.1	61.0	57.7	57.7	60.4	57.4	60.5	55.4	58.9
20–69 (ASR)	58.3	61.4	57.7	57.7	60.6	57.5	60.8	54.7	59.1

Table 11A.65 Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)

Age group (years)	*NSW*	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
2008 and 2009									
20–24	40.9	43.5	47.6	50.7	46.8	52.5	48.2	53.1	44.8
25–29	52.1	54.6	54.6	57.2	57.2	56.5	55.3	56.1	54.3
30–34	60.0	62.3	59.5	60.7	61.9	60.0	61.1	57.8	60.7
35–39	62.7	65.5	60.8	62.5	64.5	61.1	63.3	59.2	63.1
40–44	62.6	66.5	60.9	62.5	64.8	60.4	63.8	60.8	63.3
45–49	63.4	68.1	61.9	62.3	65.6	61.3	63.9	59.6	64.2
50–54	61.5	67.1	60.0	60.3	64.5	59.1	62.6	58.9	62.6
55–59	59.0	65.1	56.9	56.5	61.7	56.5	63.4	52.9	60.0
60–64	55.6	62.4	53.6	53.5	59.1	52.7	61.2	49.6	56.9
65–69	47.6	55.0	47.0	45.4	53.0	45.7	52.8	42.3	49.6
20–69 (crude rates)	56.8	60.8	56.8	58.1	60.1	57.3	59.4	56.7	58.2
20–69 (ASR)	57.2	61.3	57.0	58.1	60.4	57.5	59.9	56.1	58.6
2009 and 2010									
20–24	38.3	42.0	45.0	49.1	45.4	51.6	45.9	51.2	42.8
25–29	49.5	53.0	52.1	56.0	55.5	56.2	53.9	53.3	52.2
30–34	57.4	60.9	56.6	59.5	60.3	59.3	60.5	55.3	58.6
35–39	60.5	64.6	58.4	61.2	63.8	60.4	61.2	56.9	61.4
40–44	61.1	66.4	59.3	61.5	63.8	60.6	63.1	58.8	62.3
45–49	62.1	68.2	60.3	62.2	65.0	61.2	62.2	58.4	63.4
50–54	60.7	67.7	59.3	60.2	63.6	59.4	62.2	57.1	62.3
55–59	58.5	65.2	56.4	57.0	61.6	57.3	62.2	53.3	59.8
60–64	55.7	63.0	53.6	53.9	59.4	53.8	61.4	49.3	57.2
65–69	48.0	55.5	46.8	45.7	52.6	46.8	53.9	42.0	49.8
20–69 (crude rates)	55.2	60.2	55.0	57.3	59.2	57.2	58.2	54.8	57.0
20–69 (ASR)	55.6	60.8	55.3	57.5	59.5	57.4	58.8	54.5	57.4

ASR = age standardised rate.

(a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population in each of the calendar years in the reference period.
Age-standardised rates are age-standardised to the Australian population at 30 June 2001.

(b) The eligible female population has been adjusted for the estimated proportion of women who have had a hysterectomy, using 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) 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.

Table 11A.65 Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)

Age group (years)	*NSW*	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*

(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 the period 2008 and 2009, immediate border residents.

Source: AIHW 2011, *Cervical screening in Australia 2008–2009*, Cat. no. CAN 57, AIHW, Canberra; AIHW unpublished, State and Territory Cervical Cytology Registry data.

Table 11A.66 Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004–05 (per cent)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source : ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey* , 2004-05; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* , 30 June 2004, Series B, Cat. no. 3238.0.

Table 11A.67 **Cervical screening rates among women aged 20 to 69 years, by remoteness (24 month period) (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008–2009									
Major Cities	57.3	61.3	58.2	59.0	59.1	..	59.9	..	58.9
Inner Regional	59.2	60.5	54.4	56.7	61.6	59.0	np	..	58.3
Outer Regional	55.9	61.9	56.5	58.3	55.6	54.7	..	58.6	57.1
Remote	51.6	48.6	51.4	51.5	64.4	np	..	70.4	56.5
Very remote	73.1	..	52.1	48.8	74.5	np	..	66.4	57.1
Total (f), (g)	**57.4**	**61.1**	**57.0**	**58.1**	**60.1**	**57.3**	**60.0**	**56.5**	**58.6**
2009–2010									
Major Cities	55.8	60.9	56.6	58.5	58.3	..	59.0	..	57.9
Inner Regional	57.0	60.0	52.1	55.1	60.4	58.8	np	..	56.8
Outer Regional	53.9	59.9	54.9	56.8	53.8	54.4	..	56.1	55.4
Remote	50.1	53.4	49.5	52.2	63.3	np	..	67.9	55.0
Very remote	70.5	..	52.4	48.3	76.3	np	..	66.1	57.1
Total (f), (g)	**55.8**	**60.7**	**55.3**	**57.5**	**59.2**	**57.3**	**58.9**	**55.0**	**57.4**

(a) Rates are the number of women aged 20 to 69 years screened as a proportion of the average of the ABS estimated resident population for each calendar year in the reference period for women aged 20 to 69 years (adjusted for the estimated proportion of women who have had a hysterectomy), and age-standardised to the Australian population as at 30 June 2001 using five year age groups.

(b) Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.

(c) Due to cross-border issues, participation rates for WA, SA and the NT could not be accurately calculated and should be treated as estimates with potentially significant levels of error. This particularly affects remote and very remote areas in SA and the NT.

(d) Women were allocated to a remoteness area based on postcode of usual residence. Not all remoteness areas are represented in each State or Territory. Some women's postcodes could not be matched to a remoteness area; these women were excluded from state and territory calculations, but included in state and territory and Australia totals. State or Territory of residence was difficult to establish for some women. Some postcodes supplied by women may not accurately reflect their usual residence.

(e) Data are suppressed where numerator is less than 5 or denominator is less than 1000.

(f) Total includes women for which remoteness could not be assigned as the place of residence was unknown, not stated or could not be allocated.

(g) State and territory totals may differ from those in table 11A.62 which are based on jurisdiction of screening and not jurisdiction of residence.

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

Source: AIHW (unpublished) State and Territory cervical cytology register data; ABS (unpublished) Estimated Resident Population, 2009-2010.

Table 11A.68 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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, Canberra; DoHA unpublished, 2006 Adult Vaccination Survey. DoHA (unpublished) 2006 Adult Vaccination Survey.

Table 11A.69 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumoccoccal disease, by remoteness, 2009 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major city										
Proportion	%	48.9	50.6	52.0	46.2	55.0	..	50.4	..	50.2
RSE	%	4.4	4.5	4.8	7.2	5.2	..	6.0	..	2.4
95 per cent confidence interval	%	± 4.2	± 4.5	± 4.9	± 6.5	± 5.6	..	± 5.9	..	± 2.3
Inner regional										
Proportion	%	48.9	51.7	50.4	57.6	64.3	56.0	np	..	51.6
RSE	%	5.7	6.9	7.8	10.1	9.7	6.4	233.2	..	3.3
95 per cent confidence interval	%	± 5.4	± 7.0	± 7.7	± 11.5	± 12.2	± 7.0	np	..	± 3.4
Outer regional										
Proportion	%	49.9	53.5	46.2	51.5	39.8	47.9	..	41.7	48.9
RSE	%	9.0	13.5	11.5	17.7	17.5	9.9	..	7.3	4.2
95 per cent confidence interval	%	± 8.8	± 14.1	± 10.4	± 17.9	± 13.6	± 9.3	..	± 6.0	± 4.0
Remote, very remote (e)										
Proportion	%	56.3	np	66.4	np	46.3	40.8	..	58.3	57.3
RSE	%	35.7	124.6	17.3	53.0	36.0	44.9	..	16.0	10.9
95 per cent confidence interval	%	± 39.3	np	± 22.5	np	± 32.6	± 35.9	..	± 18.2	± 12.2
Total (f)										
Proportion	%	**49.1**	**51.3**	**51.5**	**48.5**	**54.7**	**52.9**	**50.4**	**43.1**	**50.6**
RSE	%	3.3	3.7	3.9	5.7	4.5	6.0	6.0	6.7	1.7
95 per cent confidence interval	%	± 3.2	± 3.7	± 3.9	± 5.4	± 4.8	± 6.2	± 5.9	± 5.7	± 1.7

Table 11A.69 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumoccoccal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

RSE = Relative standard error.

(a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.

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

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

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

(e) Remote and very remote categories have been aggregated due to small numbers.

(f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.

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

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

Table 11A.70 Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumoccoccal disease, 2004-05 (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error (RSE)	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2

(a) Vaccinations against influenza and pneumococcal disease have been available free to Indigenous people aged 50 years or over since 1999.

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

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

Table 11A.71 Separations for selected potentially preventable hospitalisations, 2009-10 (per 1000 people) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Vaccine-preventable conditions	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8
Acute conditions	12.9	14.4	14.7	13.7	14.6	10.7	9.8	21.1	13.8
Chronic conditions	13.6	15.1	18.6	23.1	14.4	12.1	10.4	26.1	16.0
Total (d)	**27.1**	**30.0**	**34.0**	**37.5**	**29.7**	**23.4**	**20.7**	**49.0**	**30.4**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2011 *Australian hospital statistics 2009-10*. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09) resulted in decreased reporting of additional diagnoses for diabetes, and changes in the reporting of gastroenteritis. Therefore caution should be used in comparisons of these data with earlier periods.

(b) Separations are based on the state or territory of usual residence of the patient. Excludes separations for patients usually resident overseas.

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

(d) Totals may not sum to the individual categories as conditions in more than one category can be reported for a separation.

Source: AIHW 2011, *Australian hospital statistics 2009-10,* Cat. no. HSE 107, Canberra.

Table 11A.72 **Separations for selected potentially preventable hospitalisations by remoteness, 2009-10 (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Vaccine preventable conditions									
Major cities	0.7	0.7	0.9	0.7	0.8	..	0.5	..	0.7
Inner regional	0.9	0.7	0.7	0.7	0.8	0.7	np	..	0.8
Outer regional	1.1	0.7	0.9	1.3	1.3	0.7	..	1.3	1.0
Remote	1.1	0.9	2.3	1.8	1.1	np	..	2.9	1.8
Very remote	1.9	..	1.9	2.9	2.9	np	..	5.2	3.1
Acute conditions — excluding dehydration and gastroenteritis									
Major cities	9.2	10.6	10.7	10.5	11.2	..	7.9	..	10.1
Inner regional	11.6	12.4	12.3	10.5	11.0	8.2	np	..	11.6
Outer regional	13.1	12.7	12.9	12.6	15.7	9.3	..	10.3	12.6
Remote	18.4	16.4	22.1	16.1	11.5	11.6	..	25.8	18.4
Very remote	21.6	..	22.9	20.7	23.0	8.1	..	28.5	23.9
Chronic conditions — excluding diabetes complications as additional diagnosis only									
Major cities	11.1	13.7	13.5	11.6	12.6	..	9.6	..	12.4
Inner regional	13.3	13.9	13.8	13.9	12.9	10.9	np	..	13.4
Outer regional	16.5	14.9	15.1	15.8	16.8	11.8	..	16.0	15.3
Remote	21.9	14.6	21.3	18.3	13.5	15.6	..	28.5	20.1
Very remote	20.8	..	26.0	22.9	21.8	7.6	..	34.7	26.8
All potentially preventable hospitalisations — excluding dehydration and gastroenteritis and additional diagnoses of diabetes complications (f)									
Major cities	21.0	25.0	24.9	22.7	24.6	..	17.9	..	23.1
Inner regional	25.7	26.9	26.7	25.0	24.6	19.7	np	..	25.6
Outer regional	30.5	28.1	28.8	29.5	33.6	21.6	..	27.4	28.8
Remote	41.3	31.7	45.2	35.9	25.9	27.4	..	56.7	40.0
Very remote	43.9	..	50.4	46.1	47.7	16.5	..	67.1	53.2

Table 11A.72 **Separations for selected potentially preventable hospitalisations by remoteness, 2009-10 (per 1000 people) (a), (b), (c), (d), (e)**

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

(a) Conditions defined by ICD-10-AM codes as in AIHW 2011 *Australian hospital statistics 2009-10*.

(b) Regions are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There 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.

(c) Separations are based on the usual residence of the patient. Excludes separations for patients usually resident overseas.

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

(e) Rates are suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

(f) May not sum to the individual categories as more than one condition can be reported for a separation.

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

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June 2009.

Table 11A.73 Separations for selected vaccine preventable conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*
Vaccine preventable conditions per 1000 Indigenous people (g)										
Influenza and Pneumonia	1.7	0.9	3.2	5.1	3.6	0.7	0.4	5.9	3.2	np
Other vaccine preventable conditions	0.3	0.4	0.5	0.5	0.5	0.1	–	1.6	0.6	np
Total	**2.0**	**1.3**	**3.7**	**5.5**	**4.2**	**0.8**	**0.4**	**7.5**	**3.7**	**np**
Vaccine preventable conditions per 1000 non-Indigenous people (g)										
Influenza and Pneumonia	0.6	0.5	0.6	0.6	0.6	0.6	0.5	0.6	0.6	np
Other vaccine preventable conditions	0.1	0.2	0.2	0.1	0.2	0.1	0.1	0.3	0.2	np
Total	**0.7**	**0.7**	**0.8**	**0.7**	**0.9**	**0.7**	**0.5**	**0.9**	**0.8**	**np**
Vaccine preventable conditions per 1000 people (all people) (h)										
Influenza and Pneumonia	0.6	0.5	0.7	0.7	0.7	0.6	0.4	1.9	0.6	0.6
Other vaccine preventable conditions	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.5	0.2	0.2
Total	**0.7**	**0.7**	**0.9**	**0.8**	**0.9**	**0.7**	**0.5**	**2.4**	**0.8**	**0.8**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2011 *Australian hospital statistics 2009-10* .

(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) Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

(f) NT data for Indigenous and non-Indigenous people are for public hospitals only.

(g) Total for Indigenous people and for non-Indigenous people comprise data for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes.

Table 11A.73 Separations for selected vaccine preventable conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*

(h) The rates presented for Indigenous people and non-Indigenous people are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

– Nil or rounded to zero. **np** Not published.

Source : AIHW 2011, *Australian hospital statistics 2009-10* , Cat. no. HSE 107, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.74 Separations for selected acute conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*
Acute conditions per 1000 Indigenous people (g)										
Appendicitis with generalised peritonitis	0.2	0.1	0.2	0.4	0.2	–	0.1	0.1	0.2	np
Cellulitis	3.3	2.7	5.8	6.4	4.0	1.3	0.8	6.5	4.9	np
Convulsions and epilepsy	5.1	4.1	5.5	11.2	13.5	1.8	2.7	11.1	7.0	np
Dehydration and gastroenteritis	3.7	3.4	4.2	5.6	4.8	1.7	0.9	5.6	4.4	np
Dental conditions	2.8	3.5	3.2	3.7	3.6	2.3	3.8	5.0	3.4	np
Ear, nose and throat infections	2.9	1.8	3.3	4.3	3.4	1.2	1.2	5.3	3.5	np
Gangrene	0.3	0.6	1.1	1.2	0.8	0.7	–	2.0	0.9	np
Pelvic inflammatory disease	0.3	0.5	0.6	0.9	0.5	0.3	0.3	1.1	0.6	np
Perforated/bleeding ulcer	0.4	0.2	0.5	0.4	0.2	0.3	–	0.5	0.4	np
Pyelonephritis (h)	4.0	3.3	6.4	8.1	5.4	1.2	1.2	7.9	5.8	np
Total	**22.9**	**20.3**	**30.8**	**42.0**	**36.4**	**10.8**	**11.0**	**45.0**	**31.3**	**np**
Total — excluding dehydration and gastroenteritis	19.2	16.9	26.6	36.5	31.6	9.1	10.1	39.4	27.0	np
Acute conditions per 1000 non-Indigenous people (g)										
Appendicitis with generalised peritonitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	np
Cellulitis	1.6	1.7	1.9	1.3	1.6	1.4	1.4	2.6	1.7	np
Convulsions and epilepsy	1.5	1.4	1.4	1.1	1.5	1.3	1.2	1.2	1.4	np

Table 11A.74 **Separations for selected acute conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*
Dehydration and gastroenteritis	2.7	3.4	3.0	2.5	2.8	2.2	2.0	2.0	2.9	np
Dental conditions	2.2	3.1	2.8	3.5	3.1	2.3	1.8	1.5	2.8	np
Ear, nose and throat infections	1.5	1.4	1.7	1.5	2.1	1.3	1.0	1.5	1.6	np
Gangrene	0.1	0.3	0.2	0.2	0.2	0.3	0.1	0.3	0.2	np
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	np
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	np
Pyelonephritis (h)	2.3	2.5	2.6	2.2	2.4	1.5	1.8	1.9	2.4	np
Total	**12.6**	**14.5**	**14.3**	**13.0**	**14.5**	**10.8**	**9.8**	**11.6**	**13.6**	**np**
Total — excluding dehydration and gastroenteritis	9.9	11.1	11.3	10.5	11.6	8.6	7.9	9.6	10.7	np
Acute conditions per 1000 people (all people) (i)										
Appendicitis with generalised peritonitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.8	1.7	2.0	1.4	1.6	1.4	1.4	3.8	1.8	1.8
Convulsions and epilepsy	1.5	1.4	1.6	1.4	1.7	1.3	1.2	3.5	1.5	1.5
Dehydration and gastroenteritis	2.7	3.4	3.0	2.6	2.8	2.2	1.9	3.2	2.9	2.9
Dental conditions	2.3	3.1	2.9	3.6	3.2	2.3	1.8	2.8	2.8	2.8
Ear, nose and throat infections	1.6	1.4	1.8	1.6	2.1	1.3	1.0	2.9	1.6	1.6
Gangrene	0.1	0.3	0.2	0.2	0.2	0.3	0.1	0.7	0.2	0.2

Table 11A.74 **Separations for selected acute conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis (h)	2.3	2.4	2.6	2.3	2.3	1.5	1.8	3.4	2.4	2.4
Total	**12.9**	**14.4**	**14.7**	**13.7**	**14.6**	**10.7**	**9.8**	**21.1**	**13.8**	**13.8**
Total — excluding dehydration and gastroenteritis	10.0	11.0	11.7	11.2	11.8	8.6	7.9	18.0	10.9	10.9

(a) Conditions defined by ICD-10-AM codes as in AIHW 2011 *Australian hospital statistics 2009-10* . Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09 and 2009-10) resulted in changes in the reporting of gastroenteritis. Caution should be used in comparisons of these data with earlier periods.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

(f) NT data for Indigenous and non-Indigenous people are for public hospitals only.

(g) Total for Indigenous people and for non-Indigenous people comprise data for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes.

(h) Kidney inflammation caused by bacterial infection.

(i) The rates presented for Indigenous people and non-Indigenous people are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

– Nil or rounded to zero. **np** Not published.

Source : AIHW 2011, *Australian hospital statistics 2009-10* , Cat. no. HSE 107, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.75 **Separations for selected chronic conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*
Chronic conditions per 1000 Indigenous people (g)										
Angina	3.4	3.6	5.2	5.5	3.9	1.5	–	5.0	4.5	np
Asthma	3.8	2.8	3.4	4.5	4.2	1.0	1.1	3.6	3.7	np
Chronic obstructive pulmonary disease	12.9	9.0	11.2	11.6	14.6	4.9	6.0	17.7	12.7	np
Congestive heart failure	3.9	2.4	7.4	7.4	4.2	1.2	–	7.2	5.7	np
Diabetes complications (h)	8.3	9.5	16.1	20.7	17.4	3.6	6.0	17.3	13.9	np
Hypertension	0.7	0.2	1.0	0.6	0.9	0.1	–	0.3	0.7	np
Iron deficiency anaemia	1.4	1.5	1.3	2.1	1.7	0.7	3.2	2.3	1.6	np
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	–	np
Rheumatic heart disease (i)	0.2	0.1	0.5	0.8	0.4	–	–	2.7	0.7	np
Total (j)	**34.7**	**29.1**	**46.2**	**53.2**	**47.4**	**13.1**	**16.3**	**56.3**	**43.7**	**np**
Total — excluding diabetes complications	26.4	19.6	30.1	32.4	30.0	9.5	10.3	39.0	29.7	np
Chronic conditions per 1000 non-Indigenous people (g)										
Angina	1.2	1.4	1.8	1.3	1.3	1.0	0.9	1.7	1.4	np
Asthma	1.9	1.9	1.7	1.2	2.5	1.3	1.1	1.4	1.8	np
Chronic obstructive pulmonary disease	2.5	2.5	2.9	2.0	2.7	2.4	1.9	3.1	2.5	np
Congestive heart failure	1.8	2.2	1.9	1.8	1.9	1.5	1.9	1.5	1.9	np
Diabetes complications (h)	3.2	4.0	3.7	4.1	3.1	3.5	2.6	4.2	3.6	np
Hypertension	0.3	0.2	0.4	0.2	0.3	0.2	0.2	0.2	0.3	np
Iron deficiency anaemia	1.0	1.6	1.0	1.3	1.3	1.3	0.8	0.6	1.2	np
Nutritional deficiencies	–	–	–	–	–	–	–	–	–	np
Rheumatic heart disease (i)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	np

Table 11A.75 **Separations for selected chronic conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*
Total (j)	**11.9**	**14.0**	**13.5**	**12.0**	**13.2**	**11.2**	**9.5**	**12.8**	**12.9**	**np**
Total — excluding diabetes complications	8.7	10.0	9.8	7.9	10.1	7.7	6.8	8.6	9.3	np
Chronic conditions per 1000 people (all people) (k)										
Angina	1.2	1.4	1.9	1.4	1.3	1.0	0.9	2.4	1.4	1.4
Asthma	1.9	1.9	1.8	1.3	2.5	1.2	1.1	1.9	1.8	1.8
Chronic obstructive pulmonary disease	2.6	2.5	3.0	2.2	2.7	2.5	2.0	6.3	2.6	2.6
Congestive heart failure	1.7	2.1	1.9	1.9	1.8	1.5	1.9	2.9	1.9	1.9
Diabetes complications	5.2	5.8	9.2	15.5	4.8	4.8	4.0	12.1	7.1	7.1
Hypertension	0.3	0.2	0.4	0.2	0.3	0.2	0.2	0.3	0.3	0.3
Iron deficiency anaemia	1.0	1.6	1.0	1.3	1.3	1.3	0.8	1.0	1.2	1.2
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1	0.1	<0.1	<0.1
Rheumatic heart disease (i)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.9	0.1	0.1
Total (j)	**13.6**	**15.1**	**18.6**	**23.1**	**14.4**	**12.1**	**10.4**	**26.1**	**16.0**	**16.0**
Total — excluding diabetes complications	8.8	9.8	10.1	8.4	10.0	7.7	6.9	15.7	9.4	9.4

(a) Conditions defined by ICD-10-AM codes as in AIHW 2011 *Australian hospital statistics 2009-10*. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09 and 2009-10) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Table 11A.75 **Separations for selected chronic conditions by Indigenous status, 2009-10 (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (f)	*Total* (g)	*Aust*

(f) NT data for Indigenous and non-Indigenous people are for public hospitals only.

(g) Total for Indigenous people and for non-Indigenous people comprise data for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes.

(h) Diabetes complications data for Indigenous people and for non-Indigenous people exclude separations with an additional diagnosis of diabetes complications.

(i) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.

(j) Total may not sum to the individual categories as more than one chronic condition can be reported for a separation.

(k) The rates presented for Indigenous people and non-Indigenous people are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

– Nil or rounded to zero. **np** Not published.

Source: AIHW 2011, *Australian hospital statistics 2009-10*, Cat. no. HSE 107, Canberra; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.76 Ratio of separations for Indigenous people to all people, diabetes, 2009-10 (a), (b), (c), (d), (e), (f)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
Diabetes as a primary diagnosis (g)	no.	807	250	1 667	963	314	np	np	846	4 847
	SHSR	2.51	2.28	4.48	5.09	4.97	np	np	5.74	3.89
	95% CI	2.34 to 2.68	2 to 2.56	4.27 to 4.7	4.77 to 5.41	4.42 to 5.52	np	np	5.36 to 6.13	3.78 to 4
All diabetes — excluding diabetes complications as an additional diagnosis (h)	no.	1 147	293	1 974	1 228	414	np	np	1 021	6 077
	SHSR	2.49	2.11	3.71	5.10	5.11	np	np	6.15	3.61
	95% CI	2.35 to 2.64	1.86 to 2.35	3.55 to 3.87	4.61 to 5.59	4.82 to 5.4	np	np	5.77 to 6.52	3.52 to 3.7
All diabetes (i)	no.	3 400	776	8 065	13 381	1 311	np	np	4 192	31 125
	SHSR	3.60	3.00	6.41	20.68	7.19	np	np	9.65	8.47
	95% CI	3.48 to 3.72	2.79 to 3.22	6.27 to 6.55	20.33 to 21.03	6.8 to 7.58	np	np	9.35 to 9.94	8.38 to 8.56

SHSR = Standardised Hospital Separation Ratio; **CI** = confidence interval.

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) Data are for NSW, Vic, QLD, WA, SA and the NT only (NT data are for public hospitals only). Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the six states and territory are not necessarily representative of the other jurisdictions.

(c) Data have been suppressed if the number of separations was less than five. The rate ratio and confidence interval have been suppressed if the number of separations was less than 20.

(d) Ratios are directly age standardised to the Australian estimated resident population at 30 June 2001.

(e) Patients aged 75 years or over are excluded.

(f) Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence.

(g) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or O24'.

(h) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24' or Additional diagnosis in 'E109', 'E119', 'E139' or 'E149'

(i) All diabetes refers to separations with either a principal or additional diagnosis of diabetes. Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09 and 2009-10) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.77 Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2009-10 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Circulatory	17.2	22.1	16.2	26.4	14.0	np	np	np	18.9
Renal	18.9	28.7	29.8	41.3	24.0	np	np	np	26.7
Ophthalmic	119.6	135.9	126.6	184.1	77.3	np	np	np	128.0
Other specified	48.9	73.0	74.2	59.2	71.0	np	np	np	63.3
Multiple	34.8	52.9	58.6	55.0	42.7	np	np	np	48.1
No complications	3.9	4.3	3.2	3.1	3.8	np	np	np	3.7
Total	**243.4**	**317.1**	**308.6**	**369.1**	**232.9**	**np**	**np**	**np**	**288.8**

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

(b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.

(c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.

(e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

(g) Totals may not add as a result of rounding.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.78 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2009-10 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Circulatory	16.5	11.7	25.5	16.0	13.4	np	np	np	16.5
Renal	10.6	13.7	22.9	33.4	10.3	np	np	np	18.4
Ophthalmic	94.5	91.1	93.9	88.4	88.5	np	np	np	92.3
Other specified	13.5	36.7	27.6	14.6	15.2	np	np	np	23.7
Multiple	10.5	16.4	22.1	8.0	6.8	np	np	np	15.3
No complications	40.4	50.4	26.8	21.1	45.6	np	np	np	39.1
Total	**53.1**	**52.7**	**52.7**	**51.8**	**38.3**	**np**	**np**	**np**	**51.6**

(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) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09 and 2009-10) resulted in decreased reporting of additional diagnoses for diabetes and diabetes complications. Therefore, caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.79 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2009-10 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
ASR	per 100 000 people	11.3	14.4	13.9	14.3	15.4	np	np	np	13.6
Crude	per 100 000 people	12.6	15.8	14.2	14.4	18.5	np	np	np	14.7
Separations	no.	902	869	637	327	302	np	np	np	3 246

ASR = Age standardised rate

(a) ASR rates are age standardised to the Australian estimated resident population at 30 June 2001.

(b) Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation.

(c) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(d) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

(e) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09 and 2009-10) resulted in decreased reporting of additional diagnoses for diabetes and diabetes complications. Therefore, caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.80 **Separation rates of older people for injuries due to falls (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	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

(a) Excludes separations records for Hospital Boarders and Posthumous organ procurement.

(b) Older people are defined as people aged 65 years or over.

(c) Separation rates are age standardised to the the Australian population aged 65 years or over at 30 June 2001.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
After Hours GP Helpline	The After Hours GP Helpline aims to improve community access to after hours primary care services. Callers to the telephone-based service are initially triaged by a nurse and, where appropriate, transferred to a general practitioner staffing the helpline. The general practitioner will, where possible, assist the patient to self-manage their health concern at home. Where self-management is not possible, and a patient's condition cannot wait until the next day, callers will be directed to the most appropriate after hours health service in their community. The helpline became operational on 1 July 2011 and is available in the ACT, NSW, the NT, SA and WA. It will be available in Queensland from early 2012, building on the existing 13HEALTH nurse triage, information and advice telephone service. Negotiations are underay for access to the after hours GP helpline through Victoria's NURSE-ON-CALL service. Access to after hours GP telephone advice in Tasmania is available through the GP Assist service.	Funding is provided under Outcome 5 – Primary Care.	Service activity reports submitted regularly in the context of an agreed reporting framework.
Practice Incentives Program (PIP)	The Practice Incentives Program (PIP) aims to support quality care and improve access and health outcomes for patients by encouraging continued improvements in general practice through financial incentives. PIP programs to increase access to services include:	Funding is provided under Outcome 5 – Primary Care.	Annual Report.
PIP After Hours Incentive	- the PIP After Hours Incentive – encourages general practitioners to provide quality after hours services;		

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
PIP Cervical Screening Incentive	- the PIP Cervical Screening Incentive – aims to increase participation in the National Cervical Screening Program. Financial incentives are provided to help increase overall cervical screening rates, particularly targeting under-screened women (i.e. women aged between 20 and 69 years who have not had a Pap smear in the last four years). This will assist to improve the early detection of cervical abnormalities, thereby reducing mortality from cervical cancer.		
Primary Health Care (Office for Aboriginal and Torres Strait Islander Health)	The Primary Health Care program supports Community Controlled Organisations to improve community access to a broad range of clinical and population health services. Organisations funded under this program must deliver primary health care services and/or advocacy services tailored to the needs of the community. These services include population health activities; and clinical services including the treatment of acute illness, emergency care, the management of chronic conditions, and crisis intervention and referral. The program is delivered by a range of Aboriginal Community Controlled Health Services, non government organisations and some state and territory health departments.	Funding is provided under Outcome 8 – Indigenous Health.	Organisations provide an annual report of service activity and a quarterly review of progress against agreed plans. From 2012, services will report biannually against agreed national key performance indicators.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Closing the Gap – Improving Indigenous Access to Mainstream Primary Care Program	The Improving Indigenous Access to Mainstream Primary Care Program improves access to culturally sensitive mainstream primary care for Aboriginal and Torres Strait Islander people. Funding is provided for Indigenous Health Project Officer and Aboriginal and Torres Strait Islander Outreach Worker positions in the Divisions of General Practice Network. This program is administered by Rural and Regional Health Australia.	Commonwealth contribution to the National Partnership Agreement – Closing the Gap. Funding is provided under Outcome 8 – Indigenous Health.	Six monthly financial and activity reports. Sentinel Sites Evaluation.
Closing the Gap – Urban Specialist Outreach Assistance Program	The Urban Specialist Outreach Assistance Program provides medical specialist outreach services that focus primarily on the management and treatment of chronic disease for Aboriginal and Torres Strait Islander people living in urban areas (Australian Standard Geographical Classification – Remoteness Areas 1 and 2). The program is currently available in New South Wales, Queensland, Victoria and Western Australia. It is anticipated that it will commence in South Australia, Tasmania and the Australian Capital Territory in 2011-12. (The Northern Territory is not eligible under the program as it has no Remoteness Areas 1 or 2.) This program is administered by Rural and Regional Health Australia.	Commonwealth contribution to the National Partnership Agreement – Closing the Gap. Funding is provided under Outcome 8 – Indigenous Health.	Six monthly financial and activity reports. Sentinel Sites Evaluation.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
ENT specialist follow-up	The Closing the Gap – Northern Territory – Indigenous health and related services measure funds ear, nose and throat (ENT) follow-up services targeted at children living in prescribed areas of the Northern Territory with a referral from a child health check or from a subsequent follow-up service (for example, a primary health care consultation or an audiological check). Services are also provided to children less than 16 years of age living in prescribed areas with an identified need, such as a referral from a source other than an NTER Child Health Check. The NT Department of Health is funded under the Closing the Gap National Partnership Agreement to complete ENT specialist follow-up consultations, including surgery for children with an outstanding ENT referral from a child health check.	Funding is provided under Outcome 8 – Indigenous Health.	Service activity and financial reports provided in the context of an agreed reporting framework.
Medical Specialist Outreach Assistance Program	The Medical Specialist Outreach Assistance Program (MSOAP) improves access to medical specialist services for people living in rural and remote locations, by removing the financial disincentives incurred by specialists who provide outreach services. This is achieved by meeting costs associated with delivering outreach services such as travel, accommodation, and venue hire.	Funding for MSOAP is provided under Outcome 6 – Rural Health.	Quarterly financial and service activity reports.
	An expansion of the MSOAP, focusing on chronic disease in Aboriginal and Torres Strait Islander communities, supports specialists, allied health professionals and general practitioners as part of a multidisciplinary team. This program is administered by Rural and Regional Health Australia.	Funding for MSOAP Indigenous Chronic Disease is provided under Outcome 8 – Indigenous Health.	Sentinel Sites Evaluation (for MSOAP-Indigenous Chronic Disease only).

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
PIP Rural Loading	The PIP Rural Loading provides payments to practices with a main practice location situated outside capital cities and other major metropolitan centres. The rural loading recognises the difficulties of providing care in rural and remote areas, often with little professional support.	Funding is provided under Outcome 5 – Primary Care.	Annual Report.
PIP Procedural General Practitioner Payment	The PIP General Practitioner payment aims to encourage general practitioners in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services.	Funding is provided under Outcome 5 – Primary Care.	Annual Report.
Remote Area Health Corps	The key objective of the Remote Area Health Corps is to recruit and deploy urban-based health professionals for short-term work placements in remote Northern Territory Aboriginal communities. By supporting remote Northern Territory Aboriginal health services (providing additional workforce resources they would not normally have), the program assists them to provide enhanced health care services to clients.	Funding is provided under Outcome 8 – Indigenous Health.	Financial and service activity reports submitted regularly in the context of an agreed reporting framework.
Royal Flying Doctor Service	Australian Government funding to the Royal Flying Doctor Service supports the sustainable delivery of primary health care services to people in rural and remote communities, including the provision of primary aeromedical evacuations, primary and community health care clinics, medical chests and remote consultations. This program is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 6 –Rural Health.	Financial and service activity reports submitted regularly in the context of a National Reporting Framework.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Rural Primary Health Services program	The Rural Primary Health Services Program funds a range of organisations to provide additional primary and allied health care services and preventative health projects in rural and remote communities. The program's flexibility enables funded organisations to identify, and respond to, identified community need. This program is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 5 –Primary Care.	Six and 12 month financial and activity reports are required for each project.
	From 1 July 2011, the Rural Primary Health Services program was consolidated into the newly created Regionally Tailored Primary Health Care through Medicare Locals flexible fund, with potential to drive improved access to, and integration across, primary health care, as well as helping to address the difficulty in recruiting and retaining suitably qualified staff for primary health care service delivery in rural and remote areas.		Divisions of General Practice completion of the annual survey for Primary Health Care Research Information Service reporting.
Rural Women's GP Service	The Rural Women's GP Service provides access to primary health care services for women in rural and remote Australia who currently have little or no access to a female general practitioner, by facilitating the travel of female general practitioners to these communities. The program is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 6 – Rural Health.	Financial and service activity reports submitted regularly in the context of an agreed reporting framework.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Visiting Optometrists Scheme	The Visiting Optometrists Scheme improves the access of people living and working in rural and remote communities to optometric services. This is achieved by addressing some of the financial disincentives incurred by participating optometrists providing outreach services, including travel, accommodation and facility fees. The scheme was expanded in 2010 to provide new and increased numbers of optometrist visits to rural and remote Indigenous communities. The scheme is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 3 – Access to Medical Services.	Six monthly financial and activity reports.
Mobile Outreach Service Plus	Mobile Outreach Service Plus (MOS Plus), which is managed by the NT Department of Children and Families, provides culturally safe counselling and support to Aboriginal and Torres Strait Islander children experiencing trauma from any form of child abuse, their families and communities in remote areas of the Northern Territory. In addition MOS Plus teams provide external professional development for community service staff, community education sessions and opportunities for a range of community-level meetings. Funding also supports the provision of training and workforce development for remote primary health care practitioners and community workers on child abuse and related trauma and mandatory reporting requirements.	Funding is provided under Outcome 8 – Indigenous Health.	Service activity reports submitted quarterly in the context of an agreed reporting framework in the MOS Plus Implementation Plan under the National Partnership Agreement on Health Services.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Maternal and child health	The National Maternity Services Plan recognises the importance of maternity services within the health system and provides a strategic national framework to guide policy and program development across Australia for the period 2010-15.	The Australian Health Ministers' Conference funded the development and publication of the Plan.	An Annual Report to Health Ministers for consideration and endorsement.
	The plan focuses on primary maternity services during the antenatal, intrapartum and six-week postnatal period for women and their babies. Access, service delivery, workforce and infrastructure are four key priority areas identified in the plan.	Responsibility to fund and implement various action items rests with the Australian Government; individual state and territory governments; and all jurisdictions through the Australian Health Ministers' Advisory Council.	
	The Australian Nurse Family Partnership Program is an intensive home visiting program that aims to improve health outcomes for women pregnant with an Aboriginal and/or Torres Strait Islander child. It does this by helping women to engage in good preventative health practices; supporting parents to improve their child's health and development; and helping parents to develop a vision for their own future, including continuing education and finding work.	Funding is provided under Outcome 8 – Indigenous Health.	Action Plan and Fidelity Reports provided quarterly. Financial reporting required every 6 months
	The Indigenous Early Childhood Development National Partnership (IECD NP) has three elements, two of which (Elements 2 and 3) relate to health service delivery.	Element 2 of the IECD NP is funded via a Specific Purpose Payment to states and territories.	Financial and activity reports required from each jurisdiction twice a year.
	Element 2 provides funding to state and territory governments to increase access to antenatal care, pre-pregnancy and teenage sexual and reproductive health.	Funding is provided under Outcome 8 – Indigenous Health.	

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and child health continued	The Australian Government contribution to Element 3 is the New Direction Mothers and Babies Services Program which aims to provide Aboriginal and Torres Strait Islander mothers and their children with increased access to antenatal and postnatal care, including information and advice on nutrition, smoking and other drug use, which will contribute to managing low birth weights. State and territory governments contribute funding to local child and maternal health services as their contribution to Element 3.		
	The Medical Specialist Outreach Assistance Program was expanded in 2010-11 to improve access to high quality, safe, evidence-based maternity care for women and their families in rural and remote areas, primarily for the antenatal and postnatal stages of pregnancy. Care is provided by multidisciplinary teams that may include midwives, medical specialists, general practitioners, Aboriginal Health Workers, and allied health professionals. Funding is provided to remove the financial disincentives incurred by health professionals in providing outreach services. This program is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 6 – Rural Health.	Quarterly financial and service activity reports.
	Strong Fathers Strong Families promotes the role of Aboriginal and Torres Strait Islander males in family life. The program encourages men to actively participate in their children's and families' lives, particularly in the antenatal period and early childhood development years.	Funding is provided under Outcome 8 – Indigenous Health.	Financial and activity reports required from each jurisdiction twice a year.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Women's health and wellbeing	Australian Government funding to the Jean Hailes Foundation for Women's Health supports the promotion of health and wellbeing for women, and education and research in the areas of menopause, hormone replacement therapy, cardiovascular disease in women, pre-menstrual syndrome and osteoporosis.	Funding is provided under Outcome 1 – Population Health and Outcome 10 – Health System Capacity and Quality.	Regular progress reports.
	The Foundation has been funded to provide leadership for the National Polycystic Ovarian Syndrome Alliance to: develop the evidence-based guideline for the assessment and management of Polycystic Ovary Syndrome (PCOS); to improve the lives of women with PCOS through education, research and evidence based health care; and to facilitate cross-sector collaboration, community partnerships and interactions with government and policy makers to assist in the prevention and management of PCOS within Australia.		Regular needs assessment reports and a final report.
Men's health and wellbeing	The Australian Government Shed Development Program financially assists Men's Sheds across Australia to provide meeting places where men can find social support and camaraderie. Men's sheds have demonstrated success in reaching marginalised and isolated males, and in contributing to improvements in male health and wellbeing. The program gives priority to sheds working with key groups such as Aboriginal and Torres Strait Islander males, males living in rural and remote areas, males with a disability, including a mental illness, migrant males, and males who are socially disadvantaged.	Funding is provided under Outcome 10 – Health System Capacity and Quality.	• Quarterly progress reports. • Business Plan. • Audited financial reports. • Marketing plan. • Final Project Report.
	The program is administered by the Australian Men's Shed's Association (AMSA). Funding is also provided to assist AMSA to build its capacity to provide professional advice and assistance to all sheds.		

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Children's health and wellbeing	The Asthma Child and Adolescent Program targets children and adolescents and emphasises asthma information and emergency training for staff in preschools and schools. It also focuses on parents, and on self-management for adolescents. The program includes messages about chronic respiratory conditions linked to asthma, such as allergy and rhinitis. The program is delivered by Asthma Australia under the Asthma Management Program.	Funding is provided under Outcome 1 – Population Health.	Financial and service activity reports every four months, submitted in the context of an agreed reporting framework.
	The Healthy Families for Healthy Futures program provides workshops for children who are overweight, and their families, with a focus on encouraging positive lifestyle behaviours. The program is conducted by the Osborne General Practice network in Perth, Western Australia.	Funding is provided under Outcome 1 – Population Health.	Financial and activity reports submitted regularly in line with funding arrangements.
	The Stephanie Alexander Kitchen Garden National Program teaches primary school students to learn how to grow, harvest, prepare and share fresh food in the belief that this approach will provide a better chance of positively influencing children's food choices.	Funding is provided under Outcome 1 – Population Health.	Financial and activity reports submitted regularly in line with funding arrangements.
	The Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes budget measure supports activities to improve the eye and ear health of Indigenous children. Activities funded under the measure include: training health workers to undertake ear health assessments (including diagnosis of otitis media, or middle ear infection), and providing medical equipment for the assessments;	Funding for the measure is provided under Outcome 8 – Indigenous Health; Outcome 3 – Access to Medical Services; and Outcome 12 – Health Workforce Capacity.	Regular financial and service activity reports for projects funded under the measure.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Children's health and wellbeing continued	funding for additional ear surgery, particularly for remote Indigenous children with ear damage as a result of infections; a social marketing campaign promoting hearing health; the expansion of trachoma control activities in areas where trachoma is endemic (WA, SA and the NT); and expansion of the Visiting Optometrist Scheme, with 17 additional optometrists engaged to provide services to 224 priority Indigenous locations.		
Immunisation	The Immunise Australia Program is an Australian and State and Territory governments initiative which aims to increase national immunisation rates by funding free vaccination programs for eligible Australians. It provides for the National Immunisation Program and its Schedule and the Australian Childhood Immunisation Register, as well as communicating information about immunisation to the general public and health professionals.	Funding is provided under Outcome 1 – Population Health.	National Partnership Agreement on Essential Vaccines. Annual Report. National Healthcare Agreement.
	The Practice Incentives Program General Practice Immunisation Incentive provides payments to encourage practices to monitor, promote and provide immunisation services to children under the age of seven years in accordance to the National Immunisation Program Schedule. The incentive payments aim to encourage at least 90 per cent of practices to fully immunise at least 90 per cent of children under the age of seven years attending their practices.	Funding is provided under Outcome 5 – Primary Care.	Annual Report.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Screening	The National Bowel Cancer Screening Program aims to reduce the incidence of, and mortality from, bowel cancer through early detection of abnormalities, and where bowel cancer has developed. The program involves screening people of 50, 55 and 65 years of age who have no noticeable symptoms with a Faecal Occult Blood Test (FOBT), which detects small amounts of blood in the bowel motion. Participants with a positive FOBT result are advised to discuss the result with their doctor, who will generally refer them for further investigation; usually a colonoscopy.	Funding is provided under Outcome 1 – Population Health.	Annual Report. Australian Institute of Health and Welfare annual monitoring report of the performance of the NBCSP. Reviews and research projects including the NBCSP pilot program evaluation; NBCSP economic evaluation; and NBCSP Phase 1 evaluation.
Chronic Disease Management	Under the Asthma Management Program, the Community Support Program aims to target people with asthma, their family, and community carers, to increase awareness of best practice asthma management, and to empower people to take a more proactive role in the self-management of their asthma. The program includes messages about other linked respiratory conditions, such as allergy, rhinitis and chronic obstructive pulmonary disease. In addition, the program has a strong focus on prevention, especially in lower socio-economic areas; and innovative ways to communicate best practice messages to priority groups, in particular older Australians, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people and rural and remote communities. The program is delivered by Asthma Australia.	Funding is provided under Outcome 1 – Population Health.	Financial and service activity reports submitted every four months in the context of an agreed reporting framework.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Closing the Gap – NT – Indigenous health and related services – Dental follow-up program	The Closing the Gap – Northern Territory – Indigenous health and related services measure provides support for dental follow-up services. Under the NT Closing the Gap National Partnership Agreement, the NT Department of Health is funded for dental follow-up services. A limited number of grants are provided to Aboriginal Community Controlled Health Organisations to provide follow-up dental services. These services are targeted to children living in the prescribed areas of the Northern Territory with a referral from a child health check or from a subsequent follow-up service (for example, a primary health care consultation). Services are also provided to children less than 16 years of age living in the prescribed areas with an identified need such as a referral from a source other than an NTER Child Health Check.	Funding is provided under Outcome 8 – Indigenous Health.	Service activity and financial reports provided in the context of an agreed reporting framework.
Healthy Living	The Healthy Communities Initiative aims to empower local governments to engage in the healthy living agenda by delivering projects that target disadvantaged adults. Local Government Area (LGA) Grants are a key feature, and will benefit up to 92 LGAs across Australia. Forty-five LGAs have already been funded and up to a further 47 LGAs will be announced before the end of the year. LGA Grant recipients are supported by six funded National Grant Programs to deliver proven and effective healthy lifestyles programs in every state and territory, including a majority of grant recipients, and a quality framework registration system.	Funding is provided under Outcome 1 – Population Health.	Financial and activity reports submitted regularly in line with funding arrangements.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Injury Prevention	The Australian Government coordinates a range of injury prevention activities, including the publication of Don't Fall For It – A guide to preventing falls for older people.	Funding is provided under Outcome 1 – Population Health.	Financial and activity reports submitted in line with program requirements.
Prevention of type 2 diabetes	The lifestyle modification program component of the Prevention of Type 2 Diabetes Program targets people aged 40 to 49 years, and Aboriginal and Torres Strait Islander people aged 15 to 54 years, who are assessed as being at 'high risk' of developing type 2 diabetes, with the aim to reduce or delay their progression to type 2 diabetes.	Funding is provided under Outcome 1 – Population Health.	Financial and service activity reports submitted regularly in the context of an agreed reporting framework.
Primary Care Education	Under the Asthma Management Program, the GP and Allied Health Professional Asthma and Respiratory Education Program provides best-practice asthma management education nationally to general practitioners and allied health professionals including practice nurses, Aboriginal and Torres Strait Islander health workers, pharmacists and asthma educators. The National Asthma Council Australia is funded to deliver this program. Opportunities for training and support are provided through the Divisions of General Practice nationally. Training is conducted in major cities and in regional and rural areas through workshops incorporating a range of interactive learning activities.	Funding is provided under Outcome 1 – Population Health.	Financial and service activity reports submitted every four months in the context of an agreed reporting framework.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Blood Borne Viruses and Sexually Transmissible Disease Control Program	The Blood Borne Virus and Sexually Transmissible Disease Control Program supports community organisations by funding activities that provide education programs on prevention, detection and treatment of viral hepatitis and blood borne viruses.	Funding is provided under Outcome 1 – Population Health.	Performance and financial reporting as per individual contractual arrangements and via reporting against the indicators contained within the National Blood Borne Viruses (BBVs) and Sexually Transmissible Infections (STIs) Strategies 2010-13 via annual National BBV and STI Surveillance and Monitoring Reports.
Objective: Providing timely and high quality healthcare that meets individual needs throughout the lifespan — directly, and/or by facilitating access to appropriate service(s); and			
Objective: 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.			
PIP Indigenous Health Incentive	The PIP Indigenous Health Incentive supports general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease.	Funding is provided under Outcome 5 – Primary Care.	Annual Report and other reporting under the Indigenous Chronic Disease Package.
PIP Diabetes Incentive	Provides financial incentives aimed at encouraging general practitioners to provide early diagnosis and effective management of people with established diabetes mellitus (type 2 diabetes).	Funding is provided under Outcome 5 – Primary Care.	Annual Report.
PIP Asthma Incentive	Encourages general practices to better manage the clinical care of people with moderate to severe asthma.	Funding is provided under Outcome 5 – Primary Care.	Annual Report.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
PIP Quality Prescribing Incentive	Encourages practices to keep up to date with information on the quality use of medicines, by rewarding participation in a range of educational activities recognised or provided by the National Prescribing Service.	Funding is provided under Outcome 5 – Primary Care.	Annual Report.
Closing the Gap in Indigenous Health Outcomes – Indigenous Chronic Disease Package	The Indigenous Chronic Disease Package (ICDP) aims to close the gap in life expectancy between Indigenous and non-Indigenous peoples by funding measures that tackle chronic disease risk factors, improve chronic disease management and follow up care, and expand the primary care workforce. The types of measures being implemented are outlined in the Australian Government's Implementation Plan to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. Measures include:	Funding is provided under Outcome 8 – Indigenous Health, through the Aboriginal and Torres Strait Islander Chronic Disease Fund, with the exception of funding for the Practice Incentives Program – Indigenous Health Incentive (Outcome 5) and the Higher	Indigenous Chronic Disease Package Annual Report. Annual Progress Report on the Australian Government's contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.
	- funding for Regional Tackling Smoking and Healthy Lifestyle Teams to work with Aboriginal and Torres Strait Islander individuals, families and communities to reduce the major risk factors for chronic disease such as smoking, poor nutrition and lack of physical activity. A total of 57 teams are being rolled out across Australia over a three year period from 2010-11. Twenty two teams have been established; 19 teams are being established in 2011-12; and the final 17 will be rolled out in 2012-13; and	Utilisation Costs for MBS and PBS measure (Outcomes 2 and 3).	The ICDP final evaluation report to be completed at the end of 2012-13.
	- funding to all Quitlines to enhance their capacity to be more culturally sensitive and to provide accessible and appropriate services for Aboriginal and Torres Strait Islander peoples.		

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Closing the Gap – Care Coordination and Supplementary Services	The Care Coordination and Supplementary Services Program improves health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care. Care coordination is provided by qualified health workers (for example specialist nurses and Aboriginal Health Workers) to patients with a chronic disease who have been enrolled and referred by practices (mainstream or Aboriginal Medical Service) participating in the Practice Incentives Program Indigenous Health Incentive.	Commonwealth contribution to National Partnership Agreement – Closing the Gap.	Quarterly data and six monthly financial and activity reports.
	A flexible funding pool is also available for use by care coordinators to expedite a patient's access to urgent and essential allied health or specialist care, where this is not publicly available. This program is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 8 – Indigenous Health.	Sentinel Sites Evaluation.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Expanding Health Service Delivery	The Expanding Health Service Delivery Initiative supports the expansion and reform of primary health care services for Aboriginal and Torres Strait Islander people living in remote communities across the Northern Territory. Funding has enabled the establishment of 273 new positions in the Northern Territory Aboriginal primary health care sector; as well as the provision of additional audiology and chronic disease self management services delivered through regional hubs. Funding has also supported the implementation of a system-wide approach to the Continuous Quality Improvement (CQI) of Northern Territory primary health care services, with two CQI Coordinators supporting 13 regionally based CQI Facilitators to implement service improvement activities.	Funding is provided under Outcome 8 – Indigenous Health.	Regular service activity and financial reports provided in line with an agreed reporting framework.
Rural Primary Health Services – Preventative Health Initiative	The Preventative Health Initiative, a component of the Rural Primary Health Services program, provides funding for preventative health activities. The community capacity building approach being used enables communities with high health needs and limited access to health services to develop sustainable local solutions to address key social and environmental determinants of health. Projects vary, with some focusing on specific groups in the community such as children, youth or men; while others take a whole-of-community approach. This program is administered by Rural and Regional Health Australia.	Funding is provided under Outcome 5 –Primary Care.	Six and 12 month financial and activity reports required for each project.

Table 11A.81 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Family Planning	The Family Planning Grants Program supports evidence based family planning activities that have, or potentially have, a national focus. The program aims to coordinate national family planning efforts which allow individuals and couples to anticipate and attain their desired number of children through the use of contraceptive methods and the prevention and treatment of involuntary infertility. It also encourages national family planning activities which complement and work alongside the variety of Australian Government initiatives that focus on sexual health, men's and women's health, and pregnancy and parenting support.	Funding is provided under Outcome 1 – Population Health.	Financial and activity reports required from each project on a quarterly basis.

Source : Australian Government unpublished.

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation therapy, social work and counseling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services. The Personal Health Record (PHR) (also known as 'the Blue Book') is distributed to all families with a newborn in NSW; 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 for 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 service(s) to a Non-admitted Patient is reported by the LHDs to the Department of Health (DoH) on a quarterly basis.

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Health Services	Covering services such as health information and education, counselling, pre and post natal programs, early childhood health nursing/child and family health services, health promotion programs and specialised child sexual assault counselling services (primarily in rural and remote locations).	A range of funding via grants to non-government organisations and Australian Government Funding.	These services are measured as Non Admitted Patient Occasions of Service. Quarterly reporting by LHDs to DoH on the number of occasions on which one or more health care professional provides service(s) to a Non-admitted Patient. Half yearly reports on specialist Aboriginal child sexual assault counselling positions are provided for the Interagency Plan to Tackle Child Sexual Assault in Aboriginal communities.
New Street	The program provides a coordinated, consistent, quality response to children and young people aged 10-17 years who sexually abuse and their families, through an expanded network of specialised NSW Health New Street services. New Street Services for Children and Young people have been enhanced through the establishment of an additional site in Newcastle (Hunter New England LHD), a new service in Dubbo (Western NSW LHD) and an additional clinical position at the Sydney and Central Coast New Street Service. A Clinical Advisor for New Street Services and the Pre-Trial Diversion of Offenders Program position has been created and filled.	LHD funding and Keep Them Safe funding	Milestone reporting to Department of Premier and Cabinet Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under Keep Them Safe, NSW Health has committed to expanding services for children aged under 10 years who display problematic or harmful sexualised behaviour, including Aboriginal children. To increase service delivery, DoH has allocated KTS funding to enhance the Sparks program in the Hunter New England LHD — the only NSW Health specialist service responding to this client group. DoH also determined that 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. These are currently in development with oversight from a specialist working group which regularly reports to the Department's Child Protection and Wellbeing Advisory Group.	LHD funding and Keep Them Safe 'protected item' funding	As above
Child health, development and wellbeing	Services and programs cover universal and targeted postnatal maternal, child and family health services and early childhood health services: - Universal Services include Universal Health Home Visiting and SAFESTART. - Targeted Services include the Aboriginal maternal and Infant Health Service. 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.	A mix of LHD and Australian Government funding.	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require regular reports on recruitment and expenditure.

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Child health, development and wellbeing continued	Indigenous Early Childhood Development National Partnership. Department of Family and Community Services is now the lead on Indigenous child and family centres (element 1) and NSW Health is now the lead on sexual health and antenatal care (element 2).		
	Targeted programs: - Building Strong Foundations for Aboriginal Children, Families and Communities (BSF) – This program for Aboriginal children 0–5 years and their families is provided by Child and Family Nurses and Aboriginal Health workers teams working together to support parents to provide a healthy and safe environment for optimal growth, development and wellbeing. This aims to enable children to commence school with the necessary skills and capacities ready to engage fully with life and learning.	LHD funding	BSF – requires both state and national reporting (National Partnership Agreement – Indigenous Early Childhood Development Element 3)
	Sustaining NSW Families is a program of nurse led structured sustained health home visiting provided to vulnerable children at risk of poor developmental outcomes and their families. The program actively supports parents' aspirational goals for themselves and their child and builds parenting capacity and secure parent child relationships. It is a prevention and early intervention strategy which commences in the antenatal period and continues until child is 2 years of age.	State government 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

Table 11A.82 New South Wales, community health services programs

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Child health, development and wellbeing continued	**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. NSW Ministry of Health procures these services from non-government organisations on behalf of the whole of government.	Milestone reporting to Department of Premier and Cabinet. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget
	Family Referral Services (FRS) are intended to assist children and young people who do not meet the statutory threshold for child protection intervention and their families and would benefit from accessing support to address current problems and prevent escalation. FRS provide information and link vulnerable children young people and their families to a broad range of support services in their local areas. They were piloted in three locations from May 2010 to April 2011 and are now being rolled out state-wide.	Keep Them Safe 'protected item' funding	As above
	Getting on Track on Time – Got It: a new school based mental health early intervention program	As above	As above
	Whole Family Teams – an intensive mental health and drug and alcohol intervention for whole families whose children and young people have been referred for statutory child protection intervention.	As above	As above
	Health care needs of children in Out Of Home Care - Provision and coordination of health assessments, interventions and reviews of the health, development and wellbeing of children and young people in Out Of Home Care.	As above	As above

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Screening	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. - 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.	A mix of LHD and Australian Government funding.	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
Child Abuse and Sexual Assault Forensic and Medical services	This program area aims to improve forensic and medical services for victims of sexual assault and child abuse and ensure these services are culturally competent. Particular focus on improving access in rural and remote communities.	Combination of Department of Health allocation, LHD block funding and Commonwealth funding (Indigenous Health — National Partnership Agreement)	LHD report on service provision via a payment determinations for a fee to be payable to non-salaried medical practitioners in designated rural LHDs conducting forensic and medical examinations for sexual assault victims.

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Sexual Assault Services	Providing crisis and ongoing counselling and support, including court preparation and support, for victims of assault sexual assault and their non-offending family members; and advocacy, community education programs; and professional training and consultation.	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. Quarterly reporting by LHDs to DoH on the number of occasions on which one or more health care professional provides service(s) to a Non-admitted Patient.
Child Protection Counselling Services (also known as Physical Abuse and Neglect of Children Services)	Providing long-term and intensive counselling for families and a range of interventions where physical abuse or neglect of a child is occurring.	LHD 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. Quarterly reporting by LHDs to DoH on the number of occasions on which one or more health care professional provides service(s) to a Non-admitted Patient.
Maternal health	Maternity services include programs and initiatives directed toward: - workforce expansion and education to enhance access to locally provided clinical maternity education to improve the strength and capacity of the workforce. The increase in birth rate across NSW is up to 30 per cent in some LHDs. - maternity service model of care reform, risk assessment, tiered networks and collaborative working arrangements that will allow women to easily transition from one level to another as required	LHD block funding and some Department of Health funds allocated.	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require regular reports on recruitment and expenditure.

Table 11A.82 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal health continued	- strategies to promote normal birth in NSW, reduce unnecessary caesarean sections - enhanced services to improve early pregnancy care, including early pregnancy resources. - Aboriginal Maternal and Infant Health Service (AMIHS) provides antenatal and postnatal care up to 8 weeks, to Aboriginal mothers and babies.		
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 or over are screened in mental health and alcohol and other drugs services. Screening is an early identification and education strategy.	Screening is implemented within LHD resources. The Education Centre Against Violence (ECAV) is funded from the National Women's Health Program for training and resources to support the Program.	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.
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. Quarterly reporting by LHDs to DoH on the number of occasions on which one or more health care professional provides service(s) to a Non-admitted Patient.

Source: NSW Government unpublished.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Primary Care Partnerships (PCPs) strategy	Cross government funded voluntary alliances of heath and human services provider organisations are known as Primary Care Partnerships (PCPs). There are 30 PCPs in Victoria which engage over 1000 organisations. The PCPs deliver local service system reforms to: • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated • improve the management of chronic disease. The strategy to improve the coordination of services is supported by a statewide policy and operational framework and includes: • statewide practice standards and a continuous improvement manual • tools for screening, referral and coordinated care planning • data standards for sharing client health and care information embedded in agency client management software applications • e-referral systems to securely share client information with client consent.	Core funding provided by the Victorian Department of Health (DoH). Additional funding provided by other Victorian government departments including the Department of Justice and the Department of Planning and Community Development.	Suite of reports as part of the 2009–2012 PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the PCP program logic.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
PCPs continued.	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. They may include: • tools to overcome cultural/language barriers, including consumer information available in over 40 languages • tools to overcome geographical barriers, including place-based initiatives.		
Refugee Health Nurse Program	The Refugee Health Nurse Program (RHNP) supports the provision of care coordination, linkage and nursing care to newly arrived refugees. The RHNP has three aims: • to increase refugee access to primary health services • to improve the response of health services to refugees' needs • to enable refugee individuals, families and communities to improve their health and wellbeing.	The Victorian Government funds the RHNP through the Department of Health. The Integrated Care Branch of the department is responsible for program development and resource allocation.	Community health services funded under the RHNP report hours of service on a quarterly basis. This information is provided to the Integrated Care Branch of the Department of Health.
	Funding is provided to community health services in areas that have high numbers of newly arrived refugees, to employ community health nurses specialising in refugee and migrant health issues. These nurses work directly with refugee communities to improve their health and wellbeing, as well as with local service providers to develop a responsive and effective service response for refugee clients. The RHNP also funds a workforce support training program and a Refugee Health Nurse Facilitator who works with the funded agencies to build capacity and provide secondary consultations.	Community health services are funded to deliver the RHNP. The department's regional offices monitor program delivery and performance.	

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Dental Health Program	All health care and pensioner concession care holders and their dependants are eligible for public dental services in Victoria. Services are provided to eligible Victorians through community dental clinics in community health services, rural hospitals and the Royal Dental Hospital of Melbourne. There are waiting lists for public dental care at all clinics; however, eligible people with urgent needs are given priority and are assessed within 24 hours of contacting a clinic. Urgent dentures are provided within 3 months. In addition to people with urgent dental needs, people who have priority access are offered the next available appointment for care and are not placed on a wait list. Priority access to public dental care is provided to: • Children up to the age of 12 • Young people aged 13–17 years who are dependants of holders of health care or pensioner concession cards • Registered clients of mental health and disability services, supported by a letter of recommendation from a case manager or staff of special development schools • Refugees and Asylum Seekers • Aboriginal and Torres Strait Islanders, including via targeted initiatives dental clinics at the Victorian Aboriginal Health Service and Rumbalara Aboriginal Cooperative. • Pregnant women Fees for public dental services apply to people aged 18 years and over, and to children aged 0–12 years.	State funded public dental services are output funded and supported by an activity based funding model, where the activity measure is a completed course of care. There are three courses of care types: emergency, general and denture care. The funding unit is a Dental Unit of Value (DuV)	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 DuV targets based on their total service delivery funding. For performance monitoring, courses of care are converted to DuVs.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Dental Health Program continued	Exemption from fees applies to: • Aboriginal and Torres Strait Islanders • Homeless people and people at risk of homelessness • Refugees and Asylum Seekers • Children & young people aged 0–17 years who are health care or pensioner concession card holders or dependants of concession card holders • All children and young people up to 18 years of age, who are in Residential Care provided by the Children Youth and Families Division of DHS • 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		
NURSE-ON-CALL	NURSE-ON-CALL (NOC) is a statewide telephone-based health line that provides residents of Victoria with timely access to health information, assistance and advice for the cost of a local phone call. The service operates 24 hours, 7 days a week and takes about 1,000 calls per day. NURSE-ON-CALL nurses provide callers with one or a combination of: • triage • health information • information or advice about local health providers.	NOC is contracted to Medibank Health Solutions or MHS (formerly McKesson Asia-Pacific Pty Ltd). The costs paid for the contract are based on call volume.	MHS provide the department with a number of monthly reports. These provide data about call volumes, call arrival patterns, call outcome and caller demographics.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
IHSHY program	The Innovative Health Services for Homeless Youth (IHSHY) program is a Commonwealth/State program that promotes health care for homeless and at risk young people. Funding is provided to community health services to deliver innovative and flexible health services for homeless and otherwise at-risk young people. Services are aimed at responding to their complex health needs and improve their access to mainstream health services. IHSHY provides a means of engaging young people who are homeless or marginalised and who may not otherwise access health services.	IHSHY is provided under the National Healthcare Agreement with state and territory governments matching the Commonwealth's contribution.	Quantitative performance targets are set by the department and monitored quarterly.
Objective: Promoting health and preventing illness, early detection			
Maternal and child health	The Healthy Mothers, Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. Services are provided in areas that have high numbers of births and higher rates of relative socioeconomic disadvantage. The objectives of the program are to: • improve women's access and attendance at antenatal and post natal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours.	The Victorian Government funds the program through the Department of Health. The Integrated Care Branch of the department is responsible for program development and resource allocation. Department of Health regional offices monitor the performance of the program.	Quantitative performance targets are set by the Department of Health and monitored quarterly. The performance of the program has been monitored through a formal evaluation, the final report of which will be available by October 2011.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and child health continued	Women eligible for the program are those not able to access antenatal care services or who require additional support because of their: • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services.		
Women's health and wellbeing	The Victorian Women's Health Program aims to improve the health and wellbeing of all Victorian women (with an emphasis on those most at risk), through the development and implementation of targeted health promotion interventions. The dual strategy of delivering gender-specific health promotion interventions while working to improve mainstream services' responses to women is a key aspect of the women's health program.	Funding for this program is on-going. The Prevention and Population Health Branch of the Victorian Department of Health administers the funding for the program through regional offices, and works with the North and West Regional Office to monitor program delivery by the 3 state-wide women's health services. Department of Health regional offices monitor program delivery by the 9 regional women's health services.	Women's health services are required to develop 3 year health promotion plans and report on those plans on an annual basis.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Youth health and wellbeing	The Innovative Health Services for Homeless Youth (IHSHY) program is a Commonwealth/State program that promotes health care for homeless and at risk young people. Funding is provided to community health services to deliver innovative and flexible health services for homeless and otherwise at-risk young people. Services are aimed at responding to their complex health needs and improve their access to mainstream health services. IHSHY provides a means of engaging young people who are homeless or marginalised and who may not otherwise access health services.	IHSHY is provided under the National Healthcare Agreement with state and territory governments matching the Commonwealth's contribution.	Quantitative performance targets are set by the Department of Health and monitored quarterly.
Children's health and wellbeing	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. 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. The child health teams also support families to access additional services they may require in the community.	The Victorian Government funds the program through the Department of Health. The Integrated Care Branch of the department is responsible for program development and resource allocation. Department of Health regional offices monitor the performance of the program.	Quantitative performance targets are set by the department and monitored quarterly.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Children's health and wellbeing continued	Multidisciplinary child health teams based in community health services respond to developmental delays and other child health conditions. The Kids Life! program aims to improve the health behaviours of families with an overweight primary school aged child/children and to reduce the degree of excess weight of participating children.	The Victorian Government funds the program under the Primary Health Funding Approach which includes two components: (1) direct care and (2) health promotion.	Performance targets are set by the Department of Health and monitored quarterly. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Immunisation	Immunisation policy is a shared responsibility between the Commonwealth and State and Territory Governments. The Commonwealth sets the national immunisation agenda by developing, recommending and directing policy, research and evaluation activities on the advice of expert committees and research centres. States are responsible for program implementation which includes vaccine purchase and distribution, and ensuring adequate service provision, monitoring and evaluation. Under the new National Partnerships Agreement on Essential Vaccines (NPA) the Commonwealth continues to provide funding to State and Territory governments for the purchase of vaccines listed on the National Immunisation Program (NIP). States currently conduct their own procurement process to purchase vaccines and provide them free of charge to eligible persons.	The Commonwealth provides funding for the purchase of vaccines as well as some funding for service delivery. Victoria provides subsidies and incentive programs to local government. Health Protection Branch in WICA Division has responsibility for the Immunisation Program.	Under the NPA, Victoria reports against a range of performance measures such as coverage in a range of cohorts, and wastage and leakage.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Screening	The Screening and Cancer Prevention Unit oversees and delivers population based screening programs and cancer prevention initiatives in Victoria. The screening programs include the national cervical, breast and bowel cancer screening programs, newborn screening and prenatal screening. The Unit has a strong focus on improving participation and addressing health disparities in under-screened and non-screened communities. The Unit delivers: leadership and expert advice on screening issues to the Department of Health Victoria and relevant stakeholders; strategic policy development and planning; performance monitoring and trend analysis of programs; improvements in the evidence-based approach to screening policy and programs; capacity building initiatives in health services and screening providers; and supports recruitment and social marketing initiatives. The Maternity and Newborn Unit funds the Royal Children's Hospital to coordinate the Victorian Infant Hearing Screening Program (VIHSP). This program will achieve statewide coverage in 2011-12.	Funding for cancer screening programs is provided by the Victorian and Commonwealth Governments. Funding for newborn, prenatal and infant hearing screening is provided by the Victorian Government.	Annual cancer screening data is reported to the Australian Institute of Health and Welfare and the Productivity Commission, reports against targets agreed in Victorian-Commonwealth funding agreements are provided to Department of Health and Ageing as required, and all screening programs report measures such as throughput and/or participation rate to a range of Victorian Government and Department of Health Victoria reports.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Other	The Family and Reproductive Rights Education Program works with communities that traditionally practice female genital mutilation to eradicate the practice through behavioural and cultural change. The program also works with health service providers and other relevant stakeholders to raise awareness about the practice.	Funding for this program is ongoing. The Prevention and Population Health Branch administers the funding for the program through regional offices. This is with the exception of the FARREP Facilitator role which is allocated to Family Planning Victoria directly through the Prevention and Population Health Branch.	Agencies funded for FARREP are currently required to contribute to a three year statewide FARREP health promotion plan and report against that plan on an annual basis.
Objective: Providing timely and high quality healthcare that meets individual needs throughout the lifespan — directly, and/or by facilitating access to appropriate service(s); and			
Objective: Coordinating service provision to ensure continuity of care where more than one service type and/or ongoing service provision is required to meet individuals' healthcare needs.			
Community Health Program	The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 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.	These services are funded under the two components of the Primary Health Funding Approach: (1) direct care (funding administered by the Department's Integrated Care Branch) and (2) health promotion (funding administered by the Prevention and Population Health Branch).	Quantitative performance targets are set by the department and monitored quarterly. Agencies funded for health promotion are required to develop 3 year health promotion plans and report on those plans on an annual basis.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Community Health Program continued	CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with, complex conditions and chronic illnesses. Funding is provided for the provision of direct care, and for health promotion. CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.		Performance targets are set by the Victorian Department of Health and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
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 advocacy and reducing the risk factors for sexual ill-health.	Prior to 2009-10, funding was provided through the Public Health Funding Outcomes Agreement. From 2009-10, funding is provided under the National Healthcare Agreement.	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.
	Funding for family planning services is provided to community health services, and to a statewide service, Family Planning Victoria (FPV). FPV provides sexual and reproductive health education and training to health professionals, community groups, schools and the general public. FPV provides broad based sexual and reproductive health advice and services, including pre-pregnancy and fertility advice and information, contraception services, and blood borne virus education and training, to a range of clients with a particular emphasis on young people.	The Prevention and Population Health Branch of the department administers the funding for the program in relation to health promotion. The Integrated Care Branch of the department administers funding in relation to direct care service provision.	Agencies funded for family planning health promotion are required to develop 3 year health promotion plans and report on those plans on an annual basis.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Health	Aboriginal community health services are provided through a range of Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services funded by the Victorian Department of Health (department), including community health centres, hospitals and non-government organisations. The Victorian Aboriginal Health Service and other Aboriginal Cooperatives provide a range of medical services. The department is implementing the Closing the Health Gap initiative around two key targets — Close the gap in life expectancy within a generation and Halve the gap in mortality rates for Aboriginal children under five by 2018. The department is focusing in five key areas of: • Tackling smoking • Delivering primary health care services • Fixing the gaps and improving the patient journey • Healthy transition to adulthood • Making Indigenous health everyone's business.	The department has reviewed its funding processes and has reduced activities to five, with the intention to reduce the administrative burden on Aboriginal organisations. The department funds ACCHOs to provide direct service delivery and budgets are managed using three year service agreements. Funding can be provided either at the program level or via the eight regions. Specific funding for Aboriginal programs has been allocated through the COAG Closing the Health Gap strategy.	Performance targets are negotiated between the department and ACCHOs and are monitored through various reporting mechanisms which are being reviewed to support the reduced administrative functions for ACCHOs.
	The department has developed a statewide implementation plan, outlining how it will respond to the five priority reform areas addressing 17 key health priority areas. The Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership supports community health services and ACCHOs to work collaboratively to improve health outcomes for Aboriginal people in Victoria with, or at risk of developing, chronic disease through health promotion, prevention, early intervention, and ongoing care.	AHPACC Strategic Project Grants funding aims to support the local implementation of the new strategic directions 11 partnerships between Community Health Centres and ACCHOs have been funded.	The reporting approach for the AHPACC Strategic project grants has been designed to align with the Department of Health's 'Integrated Health Promotion Evaluation Planning Framework 2010-2011 to 2011-12'. The framework is applicable to both health promotion and chronic care programs being pursued through AHPACC.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Family and Reproductive Rights Education program (FARREP)	Family and Reproductive Rights Education Program works with communities that traditionally practice female genital mutilation to eradicate the practice through behavioural and cultural change. The program also works with health service providers and other relevant stakeholders to raise awareness about the practice.	Prior to 2009-10, funding was provided through the Public Health Funding Outcomes Agreement. From 2009-10, funding is provided under the National Healthcare Agreement. The Prevention and Population Health Branch of the Victorian Department of Health administers the funding for the program.	Agencies funded for FARREP are required to contribute to a three year statewide FARREP health promotion plan and report against that plan on an annual basis.
Early Intervention in Chronic Disease	EIiCD 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.

Table 11A.83 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Sexual health	Sexual Health & Viral Hepatitis develops and oversees a range of sexual health programs across Victoria. These programs seek to reduce the transmission of blood borne viruses and sexually transmissible infections and to promote safe, respectful and positive sexual relationships. Activities emphasize prevention, with a strong focus on those communities most affected by poor sexual health, including young people, gay men and Aboriginal and Torres Strait Islanders. Activities include: provision of expert advice to the Department of Health; research to ensure evidence-based practice; sector and policy development through strategic commissioning; and, performance management of service providers.	Sexual health services are funded through a combination of Commonwealth and Victorian Government funding.	Activity and narrative reports are provided regularly to both the Victorian Department of Health and the Department of Health and Ageing. Progress reports against the national blood borne viruses and sexually transmissible infections' strategies are reported to the Commonwealth.

Source : Victorian Government unpublished.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Offender Health Services	Offender Health Services (OHS) provide primary care services to prisoners incarcerated in the eleven publically run correctional centres across Queensland. The care provided aims to be of a standard comparable to that available to the general community provided through the Queensland public health care system. Offender Health Services supports prisoners to stay healthy and when they are sick and need care, to provide or facilitate access to high quality and safe services provided by Queensland Health.	State Output Revenue	No specific reports are produced. Information is provided to the Australian Institute of Health and Welfare (AIHW) for the production of The Health of Australia's Prisoners.
Multicultural Services	Queensland Health implemented a range of initiatives to: • Provide qualified interpreters for clients who are not proficient in English • Conduct an initial health assessment for newly arrived humanitarian entrants including referral to community based general practitioners for ongoing health care • Improve the availability of data on the health of culturally and linguistically diverse populations • Build the cultural capability of health care staff by providing cross cultural training and developing resources on diverse communities' health care beliefs and practices • Recruit and retain a culturally diverse workforce • Engage with culturally and linguistically diverse communities in the development of policies and services • Build the health literacy of culturally and linguistically diverse groups	State Output Revenue This program is coordinate by Multicultural Services. All work is guided by the Queensland Health Strategic Plan for Multicultural Health 2007-12.	A report on 2010-11 achievements under the *Queensland Health Strategic Plan for Multicultural Health 2007-12* is required to be provided to Multicultural Affairs Queensland for consideration in a report to the Queensland Government.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Mobile Women's Health Service	The Mobile Women's Health Service (MWHS) provides an important outreach health service to women in rural and remote communities, including Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds, who may be geographically and/or socially isolated. The service is based in 15 locations across Queensland and consists of a specially trained clinical nurse consultant who works as a sole practitioner to provide services that assist in the prevention, early detection and management of women's health issues. In some locations an Indigenous Women's Health Worker works with the nurse to assist in meeting the needs of local Indigenous women.	Funding for the MWHS is provided through the National Healthcare Agreement and State Output Revenue.	Mobile Women's Health Nurses provide activity data each six months which is reviewed at a program level.
Cancer Screening	The three cancer screening programs have specific strategies in place to address: • language and cultural barriers both for the Aboriginal and Torres Strait Islander peoples and consumers from Culturally and Linguistically Diverse (CALD) backgrounds • geographical barriers. Queensland Health are piloting a cancer screening module for the existing Ethnic Communities Council Queensland (ECCQ) "Living Well Multicultural Program" for communities from CALD backgrounds. In addition Queensland Health is working with Southbank TAFE English Language and Literacy Services to introduce cancer screening segment in the health section for newly arrived migrants and refugees. This work will facilitate an understanding and knowledge of CALD communities about the importance and availability of cancer screening services in Queensland.	Funding for the three Cancer Screening Services Branch Programs is provided through the National Healthcare Agreement and State Output Revenue.	Statistical reports are produced biennially for BSQ, QCSP and QBCSP. Aboriginal and Torres Strait Islander strategies are reported in "Making Tracks" reports and CALD activity outcomes are reported to Multicultural Health Queensland and in cancer screening program evaluation reports.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Cancer Screening continued	The BreastScreen Queensland (BSQ) Program Under development: • an Aboriginal and Torres Strait Islander Health Worker Community Engagement Kit to provide information, training and strategies for Health Workers to help promote regular breast cancer screening to women in their communities • mass media strategies (television and radio community service announcements) to encourage Aboriginal and Torres Strait Islander women to use mobile services when visiting Aboriginal and Torres Strait Islander communities. BSQ's statewide network of 11 Screening and Assessment Services includes 6 mobiles, 2 relocatable and 19 satellite services. The mobile service covers the whole State including out to the borders with NSW, SA and NT. These areas include a significant number of Indigenous communities. The BSQ Service covers over 200 locations on a 2 yearly schedule. Each screening episode is linked to an assessment centre for timely follow up. One 4-wheel drive mobile is specifically designed for rural and remote areas to provide access to women in these areas. It services Cape York, the Torres Strait and other remote areas.		Data on the BSQ Program including participation, cancer detection and other National Accreditation Standards are collected and reported Nationally and Statewide via Australian Institute of Health and Welfare (AIHW) monitoring reports, Report on Government Services (ROGS report), Service Delivery Statements (SDS), Chief Health Officer reports. Statistical reports are produced biennially for BSQ Services Statewide.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Cancer Screening continued	The Queensland Cervical Screening Program (QCSP) QCSP develops specific resources that target Aboriginal and Torres Strait Islander women's increased participation in the Queensland Cervical Screening Program and the School Based Vaccination Program (HPV vaccination). The Program also undertakes regular analysis of cervical screening participation in selected rural and remote Aboriginal and Torres Strait Islander communities in Queensland. An expert consultative committee to provide information and advice to the relevant projects undertaken by Cancer Screening Services Branch will be established in 2011-12. The Queensland Bowel Cancer Screening Program (QBCSP) The QBCSP continues to advocate to the Australian Government for a policy decision to implement an alternative service delivery model for distribution of FOBT kits through the National Bowel Cancer Screening Program (NBCSP) through local health services in remote Indigenous communities. This is the key recommendation from the pilot project undertaken in Queensland in 2008. The Program is developing resources that target Aboriginal and Torres Strait Islander people's increased participation in the Queensland Bowel Cancer Screening Program.		

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
The Patient Transport Reform Unit & Contract and Aeromedical Services	This program provides leadership for the patient transport reform agenda which aims to improve access to and the quality of available transport resources for patients ranging from acute, urgent, high dependency care to non-urgent, low dependency care. These services are under contract to non-government organisations including Royal Flying Doctor Service (RFDS), community helicopter providers and Careflight Medical Services working in partnership with Emergency Management Queensland, Department of Community Safety.	These services are funded through State Output Revenue. In the three rural RFDS bases the delivery of primary health care services provided by the RFDS are funded through the Commonwealth.	No reports are provided externally. Internally, activity reports are provided to the District Health Services to assist in the monitoring of utilisation of road ambulance and fixed-and rotary wing
Oral health services	Oral health services - including general and specialist dental care, health promotion and disease prevention - are provided to eligible children and adults via community and school based, mobile and fixed oral health clinics.	These services are funded from Queensland Health Corporate and Health Service District funds.	Performance targets and overall financial reporting are published in Queensland Health's annual report and Service Delivery Statement.
Objective: Promoting health and preventing illness, early detection			
Women's health and wellbeing	The Healthy Women's Initiative (HWI) is a network of 16 designated Aboriginal and Torres Strait Islander women's health workers whose role is to guide and support Aboriginal and Torres Strait Islander women to access women's health services in their local community. The HWI aims to improve health outcomes for Aboriginal and Torres Strait Islander women by implementing an integrated healthy women's initiative focusing on cervical screening and women's health.	Funding for the HWI is provided through State Output Revenue and the Australian Government through the National Healthcare Agreement (NHA) and Indigenous Early Childhood Development National Partnership Agreement (IECDNPA).	Healthy Women's Initiative health workers provide activity data each six months which is reviewed at a program level. Reporting also occurs for the IECDNPA through Maternal and Child Health Branch.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Men's health and wellbeing	The Pit Stop Men's Health Program was developed by Western Australia's Gascoyne Population Health Unit to address the disparity in men's health issues and reduce the incidence of preventable illness among men. Pit Stop uses a masculine concept, being the car, attached to a series of men's health tests. The purpose of the Program is to improve access to relevant health information, address chronic disease risk factors and promote local preventative health services. The Queensland Bowel Cancer Screening Program (QBCSP) piloted the delivery of Pit Stop in workplaces targeting outdoor workers, partnering with Queensland Transport and Main Roads and a small number of regional councils. The pilot was completed at the end of 2010 and a final evaluation report was produced, The QBCSP continues to implement Pit Stop in workplaces and community settings.	Funding for the QBCSP Pit Stop was through State Output Revenue.	Evaluation data is generated from each QBCSP Pit Stop and is collated as part of a broader evaluation of Pit Stops.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Youth health and wellbeing	The School Based Youth Health Nurse (SBYHN) Program enables the health and education sectors to work collaboratively with state secondary school communities to promote health and support schools to implement health promotion initiatives that meet the school's specific requirements. It also provides an opportunity for students, parents and members of the school community to access a health professional for matters relating to youth health within the school setting. The SBYHN role encompasses: whole of school health promotion across a number of population health priority areas (including healthy eating, physical activity, mental health, sun safety, drug education and sexual health education); individual consultations with young people, assessment and referral to appropriate services; and advocacy.	The Program is funded through State Output Revenue.	School Based Youth Health Nurses provide activity data each school term which is reviewed at a program level.
Immunisation	The Queensland Health Immunisation Program is responsible for implementing the National Immunisation Program Schedule in Queensland to reduce the incidence of vaccine preventable disease in the community. This includes: strategy and policy development; coordination and planning; procurement and distribution of funded vaccines; funding and coordination of the School Based Vaccination Program; provision of information and advice to service providers; quality assurance; monitoring of adverse events following immunisation; communication and education; resource development and dissemination; enhancement of the state immunisation database and monitoring, evaluation and research.	Funding for the immunisation program is provided through State Output Revenue and the National Partnership Agreement on Essential Vaccines	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement. Annual performance targets are also reported directly to the Australian Government according to set benchmarks in the National Partnership Agreement. The data source for the childhood program is the Australian Childhood Immunisation Register.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol, Tobacco and Other Drug Services	These services include a range of prevention, health promotion, assessment, counselling, early identification and intervention, treatment and educational services to minimise alcohol, tobacco and other drug related harm.	These services are funded through a range of programs or health services from State Output Revenue and Commonwealth funds.	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement.
Aboriginal and Torres Strait Islander Health	Queensland Health provides a range of primary and community health care services and activities, spanning the prevention, management and maintenance continuum that address particular needs of Indigenous communities. These include prevention, education and health promotion services for programs such as: men's and women's health programs including the Healthy Women's Initiative which focuses on increasing participation in cervical screening; child and adolescent health services; alcohol, tobacco and other drug services; sexual health services; allied health services; and patient transport provided to increase access to health care.	State Output Revenue	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement.

Table 11A.84 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Other programs			
HIV/AIDS, Hepatitis C and Sexual Health (HAHCSH)	The program implements the whole of government *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011* (the Strategy) in the strategic priority areas of • enabling environment • education and prevention • early detection, care management and treatment; • training and professional development; and • research and surveillance. Programs are delivered through public, non-government and private organisations including 16 Queensland Health Sexual Health Clinics providing sexual health and blood-borne virus services. A range of Queensland Health prevention/education initiatives, coordinated across Queensland by six regional HAHCSH Coordinators, target groups most at risk of sexually transmissible infections and blood-borne viruses.	Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.	Six monthly reports on activities provided by the HAHCSH Coordinators and funded NGOs. Other government departments involved in the Strategy provide annual activity reports to QH. HAHCSH Coordinator reports, NGO reports and government department reports inform an annual progress report on strategy implementation, Qld notifications data for sexually transmissible infections and blood-borne viruses are provided as required for the NHA performance indicators report.

Source : Queensland Government unpublished.

Table 11A.85 **Western Australia, community health services programs**

Programs funded by the WA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
'At-Risk' Children and Youth	**WA Community Health 'at-risk youth' Services** (statewide) 'At-risk' services specifically focus on young people and their families who are socially, economically or otherwise disadvantaged and who are likely to experience poor health outcomes because of their circumstances and their disinclination to access mainstream health services. Focus groups include Aboriginal people, homeless youth and those with psychological/mental health problems. Services include: health surveillance; universal and targeted prevention; early identification and intervention; health promotion and education to improve health outcomes; disease control and immunisation; health care advice; and specific family health programs.	Community health services are funded by the Department of Health and funding is provided directly to individual area health services or regions.	The program measure for all non-admitted patient services in Occasions of Service, reported via 6 monthly service reports.
	Community health services and the Innovative Health Services for Homeless Youth (IHSHY) program are the major service delivery vehicles for 'at-risk' children and young people. Services for 'at-risk' populations have a strong focus on collaboration and coordination between other parts of the health system, other government and non government agencies to improve access to services and address the social determinants of health.	IHSHY program funds are allocated through service agreements with individual service providers.	Annual reporting on IHSHY service delivery and annual financial acquittals.

Table 11A.85 **Western Australia, community health services programs**

Programs funded by the WA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Maternal and child health	**WA Community Child Health Services** (statewide) Child health services aim to promote improved health outcomes for babies, young children and their families across Western Australia through the provision of a range of universal and targeted programs. Services are delivered in: • child health centres, • community based centres and • the home environment. Child health and community health staff offer information and support regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breast feeding and nutrition. They offer: • A universal child health service beginning with a child health nurse visiting all mothers of new babies and a series of scheduled contacts for critical points in the child's development throughout the first four years. The service presents a unique opportunity to identify families experiencing difficulty in caring for their children and the early identification of children with developmental delay. • Support in the transition to parenting and to foster peer support amongst community members with new babies. Other group services include Triple P and targeted parenting groups (teenage parents, yarning groups for Aboriginal caregivers).	The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions.	The program measure for all non-admitted patient services is Occasions of Service.

Table 11A.85 **Western Australia, community health services programs**

Programs funded by the WA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and child health continued	• At-risk groups are offered targeted services, such as: - Aboriginal and Torres Strait Islander people where services are offered by an Aboriginal Health Team, and - newly arrived refugees. • These groups are offered an extended child health schedule delivered as a home visiting service. The Best Beginnings service is also offered to vulnerable families through home visiting models.		
Children's health and wellbeing	**WA Community School Health Services** (statewide) School Health Services aim to promote healthy development and wellbeing so students may reach their full potential. Services are delivered by community health nurses, and have a strong prevention focus, with roles that can be categorised into three integrated areas: health promotion; early detection; and specialist health expertise. School Health Services use surveillance activities and assessments to identify and monitor the health status of school-aged children throughout their school life. This system of early detection aims to ensure that children who may be at risk of developing health problems are detected as early as possible. Surveillance activities and screening programs are delivered at a population (universal), group or individual level (targeted).	Agreement between the Department of Education and Department of Health underpins the delivery of School Health Services. The Department of Education part funds WA School Health Services as agreed in the MOU between the Departments. The Department of Health negotiates with area/regional health services utilising service specifications. Funding is provided directly to individual area health services or regions.	HCARe reporting on occasions of service. School Level Agreement reporting.
Youth health and wellbeing	School Health Services have a strong presence in public secondary schools to provide primary health care for adolescents; health care planning for students with special issues; support for health-related curriculum; and other school health promotion. Mental health and resilience and sexual health are key focus issues in this service.		

Table 11A.85 **Western Australia, community health services programs**

Programs funded by the WA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Providing timely and high quality healthcare that meets individual needs throughout the lifespan — directly, and/or by facilitating access to appropriate service(s); and ***Objective: 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.***			
Child Development Service	**WA Community Health Child Development Services (CDS)** (statewide) Provides a range of assessment, early intervention and therapy services to children with, or at risk of, developmental disorders and delay.	The Department of Health negotiates with area/regional health services utilising service specifications.	Child Development Information System (metropolitan) and HCARe (regional) enable routine management and performance reporting.
	Services are delivered across the metropolitan area and within Western Australia Country Health Service in a range of settings including community based child development centres, day-care centres, schools and the in the home environment.	Funding is provided directly to individual area health services or regions.	Regular reporting to the Minister for Health via Briefing Notes for Information.
	Services are provided by multidisciplinary teams which may include speech pathologists, physiotherapists, occupational therapists, clinical psychologists, social workers, nurses, podiatrists, child care assistants, therapy assistants, audiologists, paediatricians and medical officers, along with administrative staff. Children often present with complex developmental concerns, requiring that services are provided by a multidisciplinary team.	Commencing 2010-2011 the State Government committed $49.7 million to improve access to child development services statewide.	

Table 11A.85 **Western Australia, community health services programs**

Programs funded by the WA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Child Development Service continued	CDS play a key role in health prevention and promotion through the delivery of community education, professional development and programs aimed at preventing the occurrence of a delay/disorder, minimising the impact of a disorder/delay and/or preventing the progression of a disorder/delay. WA Health currently provides the majority of child development however, there is increasingly engagement with the not-for-profit sector for the provision of a range of services in line with requirements highlighted by the Economic Audit Committee and associated with the 2010/2011 budget allocation for child development services statewide.		
School Dental Service	The School Dental Service provides free dental care to school children throughout the state ranging from pre-primary through to Year 11 and to Year 12 in remote localities. Care is provided by dental therapists under the supervision of dental officers from fixed and mobile dental clinics located at schools throughout WA. The program incorporates preventive strategies, which include oral health education for school children. Non-general and specialist services are referred. Costs may apply for this treatment.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: • Number of children enrolled and under care. • Dental health status i.e. number of decayed / missing / filled teeth. • Average cost of service per child.

Table 11A.85 **Western Australia, community health services programs**

Programs funded by the WA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
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: • Public Dental Clinics Metropolitan and Country. • Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Scheme. • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people. • Aged Care Dental Program. This program provides dental care to residents of Registered Aged Care Facilities. Residents are eligible to receive free annual screening dental examinations and a care plan. Further treatment needs are advised and the patient is referred to an appropriate provider. Ongoing treatment is through one of the Government programs for eligible residents.	The Department of Health WA negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measures include: • Access to dental treatment for eligible people. • Average waiting times. • Average cost of completed courses of adult dental care.

Source : WA Government unpublished.

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
GP Plus Health Care Centres (Centres) and GP Plus Super Clinics (Clinics)	Centres and Clinics provide a focal point within the community where a range of primary health care service providers work together to enable improved coordination and delivery of care. There are currently eight centres / clinics in operation. They operate in collaboration with local general practitioners and make it easier for the local community to access a broader range of allied health, mental health, drug and alcohol, nurse practitioner, counselling and other support services closer to home.	Recurrent and Capital State Government funding (Centres) Joint Australian and State Government capital funding under the GP Plus Super Clinics Program (Clinics)	Monthly activity and financial data reporting
GP Plus Services	In Metropolitan and Country Health Regions a range of programs aim to reduce growth in demand on acute services by preventing admissions to hospital and providing appropriate discharge to services closer to where people live in the home or the community.	Ongoing State Government Project Funding (GP Plus Services Fund)	Quarterly activity and financial data reporting
Allied Health Services	In metropolitan and country areas a range of allied health services provided by the Metropolitan and Country Local Health Networks (including speech pathology, occupational therapy, physiotherapy, social work, dietetic/nutrition, psychology and podiatry) aim specifically to reduce demand on acute services by preventing admissions to hospital and providing appropriate discharge to services closer to where people live in the home or the community.	Recurrent State Government funding	Quarterly and annual client activity reports
Hospital Avoidance and Early Discharge packages	The GP Plus Services Fund funds flexible packages of care to clients in metropolitan and country areas in their place of residence (including residential care facilities). There are two types of care packages: home supported discharge; and hospital avoidance.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Hospital Avoidance and Early Discharge packages continued	Health Care at Home (formerly Metro-Home link), is delivered under contract via a large non-government organisation to provide short term flexible, rapid response service for clients, including: • Avoiding immediate presentation to a public hospital Emergency Department • Avoiding an admission to a public hospital and / or • Requiring short term post acute services. This program operates 24 hours, seven days a week to clients in their homes/community or residential care facilities. Services include: neonatal, baby, child, postnatal and antenatal care, general, sub and post acute care, end of life care, rehabilitation; wound care, medication management, mental health, and specialist nursing services. All referrals go through the Metropolitan Referral Unit. Country Home Link and the Rapid Intensive Brokerage Support (RIBS) provide access to flexible services and equipment for country consumers to avoid the need for admission to metropolitan hospitals (Country Home Link) and country hospitals (RIBS). These programs also support early discharge from hospital. Examples of services provided include: showering and personal care, transportation, medication management/supervision, client observation in their own home, and linkages to ongoing longer term services, allied health, acute wound care, allied health services, intravenous therapy, tracheostomy care and PEG care.		

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Children's Centres	Children's Centres for Early Childhood Development and Parenting are an across Government initiative providing service hubs throughout the State where a range of education, care, health, community development and family support services are available for families with young children aged up to eight years. Children's Centres are primarily based in educational settings where families attending education and care programs can access a range of services that support parenting and promote early childhood development.	Funding for staffing and facilities is managed by Department of Education and Children's Services, with SA Health and Department of Families and Communities as primary partner agencies. Direct health and community services to be provided from these Centres (from existing budgets)	Publicly available annual progress report detailing outcomes achieved over the 12 month period
Closing the Gap on Indigenous Health Outcomes National Partnership Agreement	A range of primary prevention, health promotion, environmental health and primary health care programs for Aboriginal and Torres Strait Islander people across the State. Examples include: • Aboriginal Well Health Checks diagnostic and support services • Aboriginal Family Wellness Groups • A statewide audit program for Chronic Disease Management practice (ABCD) • Country Metro Liaison Officers • Aboriginal Environmental Health Workers • Making Indigenous Health Everyone's Business Children's Services • Social marketing campaigns, Quit Smoking Initiatives, evaluation of smoking Initiatives and Tackling Smoking Enforcement Activities.	State and Australian Government (COAG) funding until end 2012-13	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Indigenous Early Childhood Development National Partnership (IECD NP) Agreement	Element 1 – Aboriginal Children and Family Centres Elements 2 and 3 – various sexual, reproductive and child/maternal health services across the state.	State and Australian Government funding (including capital and ongoing) until end 2013-14	Monthly activity and financial data reporting
Aboriginal Dental Liaison Project	Aims to increase attendance of Aboriginal and Torres Strait Islander people in mainstream dental services.	Recurrent State Government funding	Monthly activity and financial data reporting
Aboriginal Population Health Programs	Statewide programs that identify, develop and evaluate strategies that effectively respond to the needs of Aboriginal people and communities affected by substance misuse, including tobacco, alcohol, illicit drugs, pharmaceuticals and volatile substances.	Recurrent State Government funding	Monthly activity and financial data reporting
Substance Misuse	The Aboriginal Substance Misuse Connection Program is a dedicated drug and alcohol treatment service for Aboriginal people.	State Government funding until December 2013	Monthly activity and financial data reporting
APY Lands Substance Misuse Service	APY Lands Substance Misuse Service aims to provide a range of alcohol and other drugs residential and non residential treatment, diversionary programs and information services for the APY Lands people.	Recurrent State Government funding	Quarterly and annual client activity reports
Aboriginal Primary Health Care Access Program	This program provides a range of primary and secondary health care services (including: transport, parenting programs, clinical services and child health checks) via general practice and allied health teams.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Primary Health Care Services and Aboriginal Health	A range of primary and secondary health care services are provided through Aboriginal specific primary health care services including transport, wellbeing programs, clinical services and adult and child health checks.	Commonwealth funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation
	Indigenous health services provided across country areas are managed through community health or community controlled Aboriginal Health Services. Programs have been implemented in line with the National Framework for Improving the Health and Well-being of Aboriginal and Torres Strait Islanders, the SA Aboriginal Health Policy 2007 and Cultural Respect Framework for Aboriginal and Torres Strait Islanders.	In country SA, recurrent Australian and State Government funding	Reporting requirements as per the National Strategic and SA Health's monthly activity and financial data reporting
Kanggawodli	Kanggawodli provides short term pre and post acute clinical support in the metropolitan area for rural and remote Aboriginal people in Adelaide to receive certain acute hospital services.	Recurrent State Government funding	Monthly activity and financial data reporting
New Arrival Refugees Program	A specialist service operating in Central and Northern Adelaide providing a range of early intervention, prevention and community capacity building initiatives to improve access to health services for new arrival refugees. Services provided by multi-disciplinary teams from specialist service and other primary health care centres. Services include: medical and nursing clinics, health information/education, immunisation, counselling and capacity building for other health providers.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Universal Contact Visit	Offered to families following the birth of a baby and involves a visiting child and family health nurse. The service enables family, child development and health issues to be identified early and to promote optimal development through early access to child health services, parenting information and support pathways for families.	Recurrent State Government funding	Monthly activity and financial data reporting
Family Home Visiting Program	A nurse led preventative parenting home visiting program for up to two years that focuses on ensuring the health and safety of infants, providing child development, enhancing the parent-infant relationship and connecting families to community supports.	Recurrent State Government funding	Monthly activity and financial data reporting
The Vulnerable Infants Support Service	Provided throughout the metropolitan area, this service provides additional service responses to highly vulnerable infants and parents experiencing active adversity.	State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013	Monthly, quarterly and annual activity and financial data reporting
Community Dental Service	Emergency and general dental care (including dentures) for adult holders of a concession card (and their dependents) in public dental clinics and contracted through private providers.	Recurrent State Government funding	Monthly activity, waiting list and financial data reporting
Specialist Dental Service	Specialist dental services for concession card holders provided in association with students of the University of Adelaide.	Recurrent State Government funding	Monthly activity, waiting list and financial data reporting
Street to Home Program	A primary health care service for people sleeping rough.	Funded by SA Health and DFC under a three year agreement. Current agreement runs 2009—2012	State – monthly Commonwealth – via Supported Accommodation Assistance Program (SAAP) National Data Collection Agency

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Supported Residential Facilities Allied Health Program	Provision of allied health and nursing services to residents in Supported Residential Facilities who have disability, mental illness and complex chronic health conditions.	Tri annual State Government funding	Quarterly activity data reporting and yearly funding acquittal
Palliative Care Services	Statewide provision of 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.	COAG funding and GPS matched funding	KPIs set by DH
Parents of Children with Disabilities Support Group	Parents of Children with Disabilities Support Group – My Time provides parent support groups for parents of children with disabilities. These support groups are held in local community venues.	Commonwealth funding provided to a non-government organisation	The non-government organisation reports to the Commonwealth
Objective: Promoting health and preventing illness, early detection			
Health Promotion, Prevention and Early Detection	Statewide, Health Promotion is of significant focus. A number of services and programs provide the coordination of activities to build capacity to integrate health promotion approaches into service delivery and the community and deliver statewide health promotion programs to promote health in areas including (but not limited to) chronic disease, parenting, male and female health. Examples of specific initiatives include:		
	• The Healthy for Life program provides services including chronic disease, and child and maternal health programs for Aboriginal people.	Recurrent Australian Government funding provided to a non-government organisation	Quarterly activity and financial data reporting to non-government organisation
	• The Lifestyle and Behavioural Modification Program targets individuals identified at high risk of developing a preventable chronic disease.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Health Promotion, Prevention and Early Detection continued	• Do it for Life, a statewide lifestyle modification program aimed at high risk adults with SNAPS risk factors (Smoking, Nutrition, Alcohol, Physical Inactivity and Stress). Specifically trained lifestyle workers assist clients to change behaviours to reduce the risk of developing chronic disease. Adults who score 12 or more on the AUSDRISK scale are eligible and people from vulnerable and disadvantaged populations are prioritised for service.	State Government funding over five years	Six-monthly activity and financial data reporting
	• A multi-strategy community-based Childhood Obesity Prevention Program involving community groups, schools and preschools, sporting clubs, retailers and others.	Recurrent State Government Funding	
	• The Eat Well Be Active initiative, developed to increase children's level of physical activity, consumption of fruit, vegetables and water, decrease screen based leisure activities (for example television, computer game usage) and the consumption of soft drink, juice beverages and energy dense, nutrient poor foods.	Recurrent State Government funding subject to outcomes review	Quarterly activity and financial data reporting
	• OPAL (Obesity Prevention and Lifestyle), a significant new childhood obesity prevention initiative. Local councils support communities by coordinating activities and making changes to local services to make sure healthy choices are easy for community members. OPAL has commenced in six SA communities and this will grow to 20 communities by 2012.	Non-recurrent State Government funding	
The Regional Falls Prevention Program	The Regional Falls Prevention Program is run through metropolitan areas and provides a regional approach to falls prevention and support for complex fallers with the aim of reducing disability and hospital presentations.	One off State Government Funding	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and Child Health	Primary health care services across the state provide a number of programs in the area of maternal and child health, including;		
	• A Community Midwifery Program, which provides antenatal, birthing (including home births) and postnatal services to vulnerable women in metropolitan and country areas.	Recurrent State Government funding.	Monthly activity and financial data reporting
	• Pregnancy to Parenting Programs in the metropolitan area to offer support and education to families where there are vulnerable infant risk factors, in the early pregnancy to early parenting period, including counselling; antenatal education classes; postnatal reunion; young and pregnant; birth and babies; breastfeeding education; and postnatal support group.	Recurrent State Government funding	Monthly activity and financial data reporting
	• Aboriginal Family Birthing Program provides a culturally respectful and clinically safe program providing continuity of care for Aboriginal women during their pregnancy, birthing and for up to six weeks postnatal. Pregnant women and their families are supported by a partnership team comprising midwives and an Aboriginal maternal and infant care worker. These workers are part of a broader team who ensure that pregnant Aboriginal women receive the level of care they require (a holistic approach) and that this care is provided close to or in the woman's home.	Recurrent State and Federal Government funding	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and Child Health continued	• The Maternal Health Program in country SA includes community health and primary health care programs for maternal health which are provided through community health services to meet the needs relating to maternal issues. Aboriginal family birthing initiatives are established provided across country sites. Health SA has established a Maternity Services Steering Committee with the intention of determining the most appropriate models of maternity service provision for country hospitals and health services.	Commonwealth funding provided to a non-government organisation	The non-government organisation reports to the Commonwealth
Women's health and wellbeing	Specific women's health centres / services in the metropolitan area provide a range of primary health care services and programs for women. Services are provided by multidisciplinary teams from community settings that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the most vulnerable in the community. Women's Health Statewide (as a health agency) focuses on mental health and those affected by violence, as well as specific cultural groups (e.g. Aboriginal and Torres Strait Islander, culturally and linguistically diverse and rural and remote).	Recurrent State Government funding	Monthly activity and financial data reporting
Men's health and wellbeing	Across metropolitan and country SA, there are a range of primary health care services and programs provided for men by multidisciplinary teams from community settings that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community. Examples of specific men's health programs are:		

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Men's health and wellbeing continued	• Strong Fathers, Strong Families Project is an initiative to promote the role of Aboriginal fathers, partners, grandfathers and uncles, and encourage them to actively participate in their children's and families' lives, particularly in the antenatal period and early childhood development years.	Commonwealth Funding	Quarterly and annual activity and financial data reporting
	• In country SA programs / initiatives include the Men's Shed Program, and the Men in Communities Program which provides support for men's psychological health and wellbeing in coping with stress associated with the impact of drought.	Recurrent State Government funding	Monthly activity and financial data reporting (metro); six monthly activity and financial data reporting (Country)
Youth health and wellbeing	Youth health and wellbeing is a key focus across the metropolitan and country areas. Initiatives include mental health services, Aboriginal health, chronic disease and sexual health. Additionally, there are number of youth health specific primary health care services / programs across the state. Examples include:		
	• Youth Primary Health Care Services (e.g. Second Story Youth Health Service Salisbury Shopfront, Marion Youth Services and Shine SA) which are a primary health care and sexual health service for youth and are provided through primary health care services.	Recurrent State Government funding	Monthly activity and financial data reporting
	• Child, Adolescent Mental Health Services (CAMHS) via a network of community based teams provides mental health services to children and young people up to 18 years and their families who are experiencing emotional, behavioural or psychiatric problems. This includes: a therapeutic service; child and family specialists, individual or family counselling; and information, training and consultation to GPs, schools and other agencies.	Recurrent State Government funding and budget variations	Monthly activity and financial data reporting; quarterly performance reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Youth health and wellbeing continued	• CAMHS in APY Lands involves the expansion of CAMHS to include a team permanently located on the APY Lands. • Journey Home is a statewide program focused on the mental health and wellbeing supports for young people exiting the juvenile justice system that will aim to provide a culturally relevant, family inclusive and effective transition program for young offenders. • Aboriginal focus schools, investing in aboriginal youth initiative looks at existing programs that provide relationship education, health literacy education and the promotion of health-protective behaviours for Indigenous youth.	State Government funding under the COAG national Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013	Monthly, quarterly and annual activity and financial data reporting
Children's health and wellbeing	Child development, rehabilitation and early intervention programs are provided from primary health care centres across the State. Examples include: • Child and Development Program, which provides specialist paediatricians and allied health staff to assess children in community and country locations with specific behavioural and cognitive issues which are impacting on the child's development. Referrals are made to appropriate specialists. • Multidisciplinary interventions for children 0–4 years of age with or at risk of developmental delays. Service models are 1:1; group and supported playgroup options for families. Children are prioritised according to levels of active adversity. Guardianship of the Minister and Aboriginal children are of the highest priority.	Recurrent State Government funding	Monthly activity and financial data reporting Country Health SA only provides Financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Children's health and wellbeing continued	• Early Intervention programs provide for early childhood intervention consultants to work within their local community assisting parents to access support services for children 0–8 years with a disability and/or developmental delay. • Child protection and advocacy services assess and treat children from birth to 18 years and their families where there are suspicions of child abuse and neglect. Provides telephone consultations with Families SA, police and health workers; undertakes interagency strategy discussions, provides forensic medical assessment and crisis psychosocial response; psychological and parenting assessments; therapy for children and families. • Child and Development Program is provided within country areas providing specialist paediatricians and allied health staff to assess children in community and country locations with specific behavioural and cognitive issues which are impacting on the child's development. Referrals are made to appropriate specialists. • Early Childhood Development Services across Southern Adelaide and Country SA provide Multi-disciplinary interventions for children 0–4 years of age with or at risk of developmental delays. • The Child and Family Health Service is provided from over 120 sites across the State and provides a range of child wellbeing, development and parenting supports for families of children 0–5 years of age, in a variety of settings, from groups to 1:1 consultations, a residential feeding and settling service, and access to information via the telephone and internet. Where appropriate, families are linked in with other services.		

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation	Vaccinations offered as part of the National Immunisation Program.	Commonwealth and State Government funding.	Immunisation providers enter data onto the Australian Childhood Immunisation Register
Screening	• Breast cancer screening for women over the age of 40 years with the primary target age group being women aged 50 to 69 through screening mammography.	Recurrent Commonwealth and State Government funding	Monthly activity and financial data reporting to State Government, and annual reporting to BreastScreen Australia
	• The Child Health Record, commonly known as the 'blue book' is an initiative of the Child and Family Health Division of the Women's and Children's Health Network. The book is an important place to record child health and development and features sections dedicated to each year of a child's life. Health checks are important for a child's development and are included in this record.	State Government funding	Nil
	• Newborn Hearing Screening Program aims to screen all babies born in SA for significant hearing loss. Once diagnosed, the infant can be assessed for various treatments and interventions that will enable appropriate cognitive development.	Recurrent State Government funding	Monthly activity and financial data reporting
Other	The Yarrow Place Rape and Sexual Assault *Service* provides 24 hour crisis response for recent sexual assault (age 16 or above) which can include crisis counselling; ongoing counselling and support; medical care and follow up medical care; collection of forensic evidence; group programmes; education, training and consultation for workers.	Recurrent State Government funding	Monthly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Providing timely and high quality healthcare that meets individual needs throughout the lifespan — directly, and/or by facilitating access to appropriate service(s); and			
Objective: Coordinating service provision to ensure continuity of care where more than one service type and/or ongoing service provision is required to meet individuals' healthcare needs			
Community and Primary Health Care Nursing	A range of Community and Primary Health Care Nursing Services are provided across metropolitan and country areas via home care nursing, palliative care, continence nursing, Diabetes Nurse Educators, breast care and domiciliary care services. These initiatives / programs include:		
	• In the country community primary health care services / centers often have Primary Health Care / Community Nursing Services via home care nursing, palliative care, continence nursing, Diabetes Nurse Educators, breast care and domiciliary care services	Recurrent State Government funding	Quarterly activity and financial data reporting
	• GP Plus Practice Nurse Initiative involves practice nurses placed in general practice to support general practitioners in the improved management of chronic conditions from early detection to complex co-morbidities. This initiative aims to reduce workforce pressure on general practice in areas of high demand or other areas. This program is delivered in both Metropolitan and Country Heath Regions.	Recurrent State Government funding (pending review)	Monthly financial and activity data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Disease Community Program	• The Chronic Disease Community Program aims to improve the quality of life for people living with chronic diseases. It provides targeted and tailored care packages with self-managed support to assist people to better manage their health and well being, and integrated management plans are developed for all participants. The program has a demonstrated impact on decreasing acute exacerbations of chronic illness and reducing episodes of unplanned hospitalisation.	Recurrent State Government funding	Quarterly activity and financial data reporting
Rehabilitation	Rehabilitation services, provided across the state, include:		
	• Day rehabilitation services which provides a multidisciplinary allied health and rehabilitation service for people in the community on discharge from hospital.	Recurrent State Government funding	Monthly activity and financial data reporting
	• Paediatric Rehabilitation Program, which provides rehabilitation consultant services to community clinics to provide specialist medical assessment and intervention.	Combination of State Government and Federal Government Funding	Monthly activity and financial data reporting
Facilitated Discharge	A statewide lead program titled "*non post acute care"* is undertaken under the provision of longer term specialised nursing care, education, management and monitoring of clients in the following target groups. The program is based on post hospital discharge. Services can be provided in places such as residential care facilities or a person's home. Key target areas include: • Extended community care • Palliative care • Homeless clients • HIV clients • Direct Observational Therapy. All referrals go through the Metropolitan Referral Unit.	Recurrent State Government funding	Monthly activity and financial data

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Healthy Ageing Services	Programs provided for older people to support them to live independently in the community. Services focus on physical and mental health, and assisting people to access appropriate services and navigate the health.	Recurrent State Government funding	Monthly activity and financial data reporting
Transition from Hospital to Community	A number of transition programs exist in both metropolitan and country areas. These include;		
	• The Transition Care Program provides case management and slow stream restorative care for older people on exit from hospital. The package transitions hospital patients from an acute service back to the community resulting in decreased hospital length of stay and improved patient outcomes.	Recurrent State and Commonwealth Government Funding. Commonwealth & State Government funding based on activity levels (CHLHN)	Quarterly activity and financial data reporting; annual Financial statements; monthly reporting (CHLHN)
	• Transition to Residential Aged Care is an initiative run in the northern metropolitan area and provides care for clients who are seeking long term aged care following a hospital stay. Offers care in a residential facility and case management to assist with finding a permanent placement.	Annual State Government funding	Monthly activity and financial data reporting
	• Disability Transition to Community (DTC) is a statewide initiative providing a wide range of care supports, including care hours and home modifications, for medically stable patients with complex care needs who require additional support to achieve a transition from hospital to the community. Assessment, allocation and review of funded patients are managed by SA Health.	Recurrent State Government Funding	Monthly activity and financial data reporting
Other			
Oral Health	A significant number of oral health programs are undertaken statewide. These include initiatives such as:	Recurrent State Government funding	Monthly activity and financial data reporting
	• Community Dental Service and Specialist Dental Service.		

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Oral Health continued	• The School Dental Service is a regular preventively focused general dental care for pre-school aged, primary and secondary school children under 18 years of age. • Oral care for people with special needs provides identification and referral to dental services for people living in Supported Residential Facilities. • Aged Care Oral Health Projects which are various projects to improve the oral health of certain aged care populations, both in residential care and community living. • The Population Oral Health Program provides the development and implementation of a Lift the Lip referral tool for general practitioners, nurses and childcare workers.		
Alcohol and other drugs	There is a number of alcohol and other drug programs across the State aimed at responding to the needs of communities affected by alcohol and substance misuse. Examples include:		
	• The Woolshed, a therapeutic community for men and women aged 16 years or over with significant alcohol and/or other drug-related problems.	Recurrent State Government funding	Monthly activity reporting
	• The City Watch House Community Nursing Service, providing assessment, treatment, management and referral of people held in police custody at the City Watch House.	Recurrent State Government funding	Quarterly data and activity reports and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol and other drugs continued	• The Driver Assessment Clinic, a state-wide initiative that assesses drivers for alcohol and/or other drug dependency who have been referred by the Courts Administration Authority and the Registrar of Motor Vehicles.	Recurrent State Government funding	Annual activity report Annual attendance / non-attendance reports to Courts Administration Authority and the Registrar of Motor Vehicles
	• Both Country Health SA and the Metropolitan Health Region provide the Police Drug Diversion Initiative.	Annual Australian Government funding	Quarterly client activity and annual financial reports to the Australian Government
	• The Clean Needle Program.	Recurrent Commonwealth and State Government funding	Annual activity reporting to the Commonwealth
	• Alcohol and Drug Information Service is a 24-hour telephone information, counselling, and referral service for the general public, concerned family and friends, students and health professionals.	Recurrent Commonwealth and State Government funding	Monthly activity and financial data reporting
	• Community Service Centres provide a free, confidential service at a number of locations across Adelaide and in regional centres.	Recurrent Commonwealth and State Government funding	Monthly activity reporting
	• The Court Assessment and Referral Drug Scheme (CARDS) program provides drug assessment and treatment services to clients who are defendants appearing before a Magistrates Court or Youth Court.	Funded under the National Health Care Agreement	Quarterly and annual client activity reporting to the Commonwealth
	• Tobacco Cessation Service provided through the Tobacco Program, QuitSA is funded to provide Quitline telephone support for smokers wishing to stop smoking. Quit SA trains health professionals in brief intervention.	Funded through contract with SA Health	Quarterly activity and financial data reporting

Table 11A.86 South Australia, community health services programs

Programs funded by the SA Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol and other drugs continued	• The Early Intervention Pilot Program is undertaken in partnership with SA Police and the Office of Crime Statistics and Research. It is a diversion program targeting young people aged 10 to 17 who have been detected for offences related to alcohol involving possession, consumption and intoxication.	Three year Commonwealth Government funding	Six-monthly progress reports
	• Withdrawal Management Services offer assessment and inpatient medical detoxification in a supportive environment for people withdrawing from alcohol and a range of other drugs.	Recurrent State Government funding	Monthly activity reporting
	• Day centres at Ceduna and Port Augusta provide a range of diversionary activities and non-residential rehabilitation and support services for people living in these communities to augment their sobering-up centres and mobile assistance patrols.	Commonwealth Government funding reviewed annually	Six monthly activity and annual financial data reporting
Sexual Health	Shine SA is a large non-government organisation which receives government funding towards providing a broad range of sexual and reproductive health services within a primary / public health framework. It provides comprehensive and confidential sexual health care, education and information, STI services and reproductive health.	Recurrent State Government funding	Quarterly activity and financial reporting data

Source: South Australian Government unpublished.

Table 11A.87 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2010-11

Program area	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Primary Health	**Primary Health** brings together a wide range of community and rural health services to meet the needs of both individuals and local communities. 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.	The majority of funding is allocated from the State budget. Area Health Services (North, South, North West) are responsible for area spending and overseeing program delivery.	Performance Information is collected and reported at the State level through Budget Papers, Annual Report, Key Activity and Performance Information reports and Tasmania Together.
	Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers. The size of sites also varies: small sites provide a limited range of services generally based around community nursing. Rural Health Facilities provide core primary health and community care services within a local community in addition to some inpatient sub acute beds. In addition, some rural sites provide residential aged care and/or emergency services.	Services are provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the Department of Health and Human Services (DHHS) budget.	As required performance reporting is provided nationally through: National Minimum Data Sets, Report on Government Services (RoGS), Australian Institute of Health and Welfare (AIHW), National Healthcare Agreement (NHA), Australian Council of Healthcare Standards.
	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.		
	Youth Health Services offer young people aged 12–24 years a flexible and confidential service including information, education, support, referral and counselling.		

Table 11A.87 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2010-11

Program area	*Description*	*Budgetary context*	*Reporting*
	Other Primary Health services include Aged Care Assessment Teams, Community Equipment Scheme, Community Rehabilitation Services, Community Therapy Services, (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry) Continence Services, Day Centres, and Health Promotion Activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.		Reporting in accordance with program specific requirements
	Regional Health Services – the Australian Government Rural Primary Health Program funds a number of rural health and wellbeing programs in a number of rural communities. Programs include Multipurpose Services/Centres, Rural Health Services, More Allied Health Services (MAHS) and Medical Specialist Outreach Assistance Program (MSOAP).	Australian Government funds	
Interpreter Services	Tasmanian Department of Health and Human Services (DHHS) provides access to Interpreter Services for CALD clients in all health settings as required.	Services are purchased on an 'as needs' basis	
	Tasmania's Health Plan is based on explicit principles for sustainable service design. If services can be provided safely, effectively and efficiently then they should be delivered locally. Where centralization of services is necessary because of quality, cost and sustainability considerations access will be facilitated through patient and care support and service accountability arrangements.	As for Primary Health above	As for Primary Health above
Rural Health Facility Emergency Response	Emergency services provided at some rural sites and three sites also operate an ambulance service.	As above	As above

Table 11A.87 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2010-11

Program area	*Description*	*Budgetary context*	*Reporting*
Primary Health Services	A range of services are provided on an outreach bases to rural communities from an urban hub such as Allied Health services, Aged Care Assessment Teams, Continence Services, MAHS, MSOAP.	As above	As above
Telehealth Services	Telehealth available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs and external organizations.	As above	As above
Transport Services	A range of transport services to access health care is available to people who are transport disadvantaged either because of socio-economic circumstances or because health and disability preclude use or their own or public transport.	As above	As above
Primary Health Services	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.	As above	As above
Day Centres	Providing social support and activities for the frail, aged and people with a disability at DHHS Day Centres around the State.	As above	As above
Community Recovery Coordination	Community Health provides coordination of the Agency's community recovery responsibilities covering the human and social elements of disaster recovery.	As above	As above

Table 11A.87 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2010-11

Program area	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Youth health and wellbeing	Youth Health Services work with young people 12–24 yrs providing individual services targeted to young people who are vulnerable or 'at risk' and through group and community programs for young people.	State and Australian government funding. Services delivered and managed within an Area Health Service framework.	
Chronic Disease Demonstration Service (Diabetes type 2)	Chronic Disease Demonstration Service (Type 2 Diabetes) provides multi-disciplinary care for individuals referred by GPs in Northern Tasmania.		
Health Promotion Framework	Working in Health Promoting Ways: A Strategic Framework for DHHS establishes DHHS commitment to promoting safe, healthy individuals, workplaces and communities.		
Objective: Providing timely and high quality healthcare that meets individual needs throughout the lifespan — directly, and/or by facilitating access to appropriate service(s); and			
Objective: 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.			
Palliative Care	Provides comprehensive assessment of the person seeking palliative care including pain and symptom management, emotional, social, spiritual, psychological and practical support.	As for Primary Health above	As for Primary Health above
Continence Services	Specialist assessment and prescribing of continence aids and appliances for clients over the age of 6 years.	As above	As above
Orthotics & Prosthetics Service (OPST)	OPST provides inpatient and outpatient prosthetic and orthotic services for clients across hospital and community settings.	As above	As above

Table 11A.87 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2010-11

Program area	*Description*	*Budgetary context*	*Reporting*
Community Equipment Scheme, Spinal Account and Continence Aids	The CES and Spinal Account provides standard and non-standard equipment and continence aids for clients to assist mobility and activities of daily living, surgical footwear, communication devices and minor home modifications for clients assessed and referred by an authorised clinician as part of their clinical management.	As above	As above
General Practice (GPs)	Provides funding to General Practice Workforce Tasmania to assist recruitment and retention of rural general practitioners. Provide support and contracts rural medical practitioners to provide services to rural health facilities around Tasmania.	As above	As above
Other			
Disability, Child, Youth and Family Services	Disability, Child, Youth and Family Services provides a range of services including Disability, Child Protection, Out-of-Home Care, Adoptions, Child Health and Parenting, Youth Justice, Targeted Youth Support, Gambling Support, and Family, Violence and Counselling Services. The newly implemented Gateway and Integrated Family Support Services and other reform initiatives have directed a greater focus on intervening earlier, and better integration of the delivery of child protection and family support services. Recent engagement of Gateway Services for people with a disability, their families and carers will provide a single point of access and thereby aid system navigation and coordination for this client group.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance information reported at State level through Tasmania Together, Budget Papers, Departmental Annual Reports and Activity and Performance Information reports. Performance reporting at national level through National Minimum Data Sets, the RoGS, the AIHW, and the National Disability Agreement.

Table 11A.87 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2010-11

Program area	*Description*	*Budgetary context*	*Reporting*
Oral health	Oral Health Services Tasmania provides emergency, general dental care, and dentures to eligible adults (holders of a Health Care or Pensioner Concession Card). Services are also provided to all children up to, but not including the age of 18. Oral Health Services Tasmania also engages in health promotion and prevention activities to promote oral health on a population basis.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance reported at state level through Budget Papers, the Annual Report, and Tasmania Together. Performance reporting nationally through the RoGS, the AIHW (via the Australian Research Centre for Population Oral Health), and to the Australian Health Ministers' Conference via the National Oral Health Plan Monitoring Group.
Alcohol and other drugs	Alcohol and Drug Services provide a range of specialist alcohol and other drug interventions and treatments at both individual and population levels.	As above	Performance Information reported at state level through Budget Papers, Annual Report and Key Activity and Performance Information reports. As required performance reporting nationally through National Minimum Data Sets, the RoGS, Tasmania Together, the AIHW, NHA and Australian Council of Healthcare Standards.
Population and Health Priorities	Population and Health Priorities focuses on population groups (including Indigenous health and women's and men's health) and implements programs aimed at preventing or reducing risk factors that lead to chronic conditions.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	As above
Public and Environmental Health Services	Public and Environmental Health Services monitors the health of the Tasmanian population, and implements programs to protect and promote health.	As above	As above

Source: Tasmanian Government unpublished.

Table 11A.88 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Improving access to services			
Corrections Health	Provides Primary Health Care services and coordinates clinical services at secondary and tertiary level to adult and youth detention services through the Alexander Maconochie Centre and Bimberi Youth Justice Centre respectively.	Through a designated budget	Monthly/Annual reports against output targets and budget
Community Care, Division of Rehabilitation, Aged and Community Care	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition, social work) - acute, post acute and rapid response services; specialist nursing assessments and self management of chronic conditions program.	Through a designated budget: • Some services HACC funded • Remainder ACT Government funding.	Monthly/Annual reports against a range of indicators including output targets, budget and quality indicators. Health Directorate's Annual Report includes Accountability Indicators related to achievement of occasions of service targets for nursing and allied health services. HACC outputs data reported quarterly and submitted 6 monthly.

Table 11A.88 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Child, Youth & Women's Health Program	Provides Maternal and Child Health nursing services including universal first home visit, child health checks, parenting education and support and vulnerable families program. Child Health Medical Officers and Community Paediatricians; early childhood immunisation and school based immunisation programs; kindergarten health checks, asthma education, nurse audiometrists and orthoptic screening; school youth health nurses; specialised services for children dependent on respiratory technology, nursing in special schools, physiotherapy, social work and nutrition services. Women's Health Service provides nursing, medical and counselling services, including cervical screening, for women who experience significant barriers to accessing health services. Child at Risk Health Unit. Provides specialist health services to children and young people and their families or carers who have been affected by abuse and neglect.	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 11A.88 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation	• The Health Protection Service (HPS) implements the National Immunisation Program (NIP) in the ACT. Vaccine is ordered and distributed to immunisation providers. Vaccine use is monitored and policies implemented to ensure high immunisation coverage in eligible groups in the ACT.	Through a designated budget (program coordination and vaccine delivery).	HPS reports RIG usage to Communicable Disease Network Australia (CDNA). Immunisation coverage in children – quarterly and annual reporting against targets and budgets.
	Within the Health Protection Service, the Vaccine Management Unit (VMU) delivers National Immunisation Program (NIP) vaccine to ACT Maternal Child Health clinics, general practices, hospitals and other immunisation providers. The VMU staff monitor storage conditions of vaccine to ensure cold chain standards are maintained as per national guidelines.	NIP vaccines are funded or provided by the Department of Health and Ageing (DoHA) as part of the National Partnership Agreement on Essential Vaccines	NIP vaccine usage levels are reported to DoHA quarterly as part of the National Partnership Agreement on Essential Vaccines.
	• HPS 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 small quantities of Hepatitis A vaccine for use in post exposure treatment of people exposed to Hepatitis A. Stocks of Normal Human Immunoglobulin and Zoster Immunoglobulin are also held by HPS measles and varicella post exposure treatment.		
	• To improve vaccination rates of refugees (mostly ineligible for vaccines on the NIP), HPS provides small quantities of Inactivated Polio (IPOL) and Adult Diptheria, Tetanus (ADT) vaccine.		

Table 11A.88 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Immunisation continued	• Since April 2009 the ACT Government has funded an adult pertussis vaccination program as a temporary disease control strategy in response to an increase in ACT pertussis (Whooping Cough) notifications in late 2008 and early 2009. The objectives of the program were to increase vaccination coverage and reduce disease incidence in parents and grandparents of infants aged less than 12 months of age, and to subsequently reduce the number of cases of pertussis in infants less than 12 months of age. Infants are most at risk of serious complications resulting from the disease. Since the program began over 29 000 doses of vaccine have been distributed to immunisation providers.		
Oral health	The Dental Health Program provides adult and child & youth dental services to eligible clients; oral health promotion activities; oral health information and advice; assessments and restorative dental treatment; oral surgery in community based clinics and under general anaesthetic; dentures and dental appliances; oral hygiene; domiciliary dental services and dental emergency services.	Through a designated budget	Monthly/Annual reports against output targets and budget
Alcohol and other drugs	The Alcohol and Drug Program provides consultation and liaison and withdrawal services; liaison and clinical advice to health professionals; services to women on the program who are pregnant or have babies; education and information to community groups and organizations.	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 11A.88 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Objective: Promoting health and preventing illness, early detection			
Dental Screening	The Dental Health Program conducts screening and health promotion activities targeting early childhood and primary school aged children, Koori pre-schools and alcohol and drug programs. The Dental Health Program has various Memorandum's of Understandings with external stakeholders to facilitate timely and appropriate access. The targeted client groups include refugees, homeless people, clients with disabilities, mental illness and alcohol and drug programs, Winnunga Nimmityjah Aboriginal Health Services and some specified medical conditions. In collaboration with Adelaide University, the Dental Health Program hosts dentistry student placements. With the combination of student placements and a recruitment strategy, the public dental workforce capacity is positive with no dentist vacancies.		
Cervical Screening	The Cervical screening program ACT register is part of the National Screening Program. It targets women who have been sexually active in any stage of their lives to have a Pap smear every two years until the age of 70 years. The Program seeks to reduce morbidity and mortality from cervical cancer by: maximising participation by eligible women in routine 2 yearly screening; encouraging practitioners to collect cervical smears containing adequate samples of cervical cells; instituting a uniform and reliable reporting system; developing appropriate evaluation and management protocols for women with screen-detected abnormalities; and promoting effective treatment and follow-up for women with screen-detected abnormalities.	Through a designated budget	Monthly/6 monthly/Annual reports against internal and national key activity indicators 6 monthly against key laboratory accreditation indicators Annual submission of data to the Australian Social Health Atlas

Source: ACT Government unpublished.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Remote Health	The role of Remote Health is to ensure that evidence-based, best practice primary health care services are delivered to the remote population throughout the Northern Territory. Services are delivered through Departmental Health Centres (54), non-government organisations (some funded by the Department), and independent community-controlled organisations. Services include the provision of 24-hour emergency care, primary clinical care, population health programs, referral and access to retrieval, medical and allied health specialist services, provision of essential medications, and management of chronic illness. Services are delivered by multi-disciplinary health teams at remote Health Centres throughout the Northern Territory. Around 90 per cent of all consultations and health contacts at remote Health Centres are with Aboriginal people. However, services are also accessible to non-Aboriginal residents and non-residents, for example tourists.	Remote Health services are funded through an identified program within the NT Department of Health (DoH) budget. External funding is provided by the Department of Health & Ageing (DoHA) through the Office of Aboriginal & Torres Strait Islander Health (OATSIH) under the Enhanced Health Services Delivery Initiative (EHSDI).	Reporting - performance targets against 6 agreed Priority Action Areas: (1) Promoting and Protecting Health & Wellbeing & Preventing Injury, (2) Health, Children & Young People in Safe & Strong Families, (3) Targeting Smoking, Alcohol & Substance Abuse, (4) Connecting Care, (5) Safety, Quality & Accountability (6) Attract, Develop & Retain a Workforce for the Future. A suite of core Primary Health Care indicators have been developed in conjunction with OATSIH, and reported against by Department of Health and non-Government remote primary health care providers across the NT. Financial reports are published in the Department of Health Annual Report.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Maternal Health Services	The role of Maternity Services is to provide contemporary, evidence-based, culturally appropriate models of care for Aboriginal women during pregnancy and the early postnatal period up to six weeks after birth. Remote Outreach Midwives provide clinical expertise, share knowledge and information through education and orientation to staff and have a role in provision of clinical services in communities where there is no midwife and/or where complex cases require expert input. Remote Area Midwives, based in some remote communities, provide pregnancy care and education, referring women into Midwifery Group Practices (MGP) and child health services. The MGP in Darwin and Alice Springs are urban-based services staffed by midwives who provide continuity of care to Aboriginal women residing in remote communities when they travel to Darwin or Alice Springs to give birth. Care and education is provided in the later part of pregnancy, through labour and birth and the early postnatal period. Community-based Strong Women Workers are employed in some communities, in collaboration with remote staff, to provide bi-cultural education and advice to promote healthier lifestyles and improve outcomes.	These services are funded through an identified program within the NT Department of Health budget and Northern Territory Closing The Gap funds. Some funding is also provided through the Council of Australian Government Indigenous Early Childhood Development National Partnership Agreement.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. Performance milestones against the Indigenous Early Childhood Development National Partnership Agreement Implementation Plan.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Child/Youth Health Services	The role of Child and Youth Health is to promote and support delivery of current, evidence-based, universal child health programs in remote Aboriginal communities, including coverage and compliance. Universal programs, like Healthy Under Five Kids, provide a platform for; screening, monitoring for growth and development, vaccination and health promotion, including the opportunity to work in partnership with parents to share information and advice. Urban based Child Health Nurses and Aboriginal Health Workers provide a visiting service to Remote Area staff. They share clinical expertise, evidence based information — including education and orientation — and work collaboratively to assist with school based health and screening programs. Community-based Child Health Workers reside in some communities, working in partnership with remote Health Centre staff, visiting staff and community members to promote evidence-based child health messages, activities and programs. Current work is underway to employ remote area Child Health Nurses in two Top End remote communities to ensure coverage and compliance of evidence-based child health programs, focusing on 0–8 year olds.	These services are funded through an identified program within the NT Department of Health budget and Northern Territory Closing The Gap funds. Some funding is also provided through the Council of Australian Government Indigenous Early Childhood Development National Partnership Agreement and the Office of Aboriginal and Torres Strait Islander Health New Directions- Mothers and Babies Wave 4.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. Performance milestones against the Indigenous Early Childhood Development National Partnership Agreement Implementation Plan and New Directions- Mothers and Babies Proposal.
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 Concession Card or Pensioner Concession Card. Services are provided from community and school based clinics in urban areas and in clinics in health centres as well as mobile trucks in remote communities. Community level and individual oral health promotion activities are also conducted.	These services are funded through an identified program within the NT Department of Health budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. Additional reporting associated with National Partnership Agreements provided to the Australian Government.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Condition Services (previously preventable chronic disease)	The Chronic Conditions Strategy Unit (CCSU) provides leadership and evidence-based advice to support implementation of effective actions for prevention and management of chronic conditions. CCSU works closely with policy makers, senior managers, health professionals, researchers and educators in government and non-government services across the NT. The NT Chronic Conditions Prevention and Management Strategy 2010–2020 is the key document that guides NT health services — all are committed to joint implementation. Priority areas include addressing social determinants and an increased focus on primary prevention. A working group is further developing policy and practice in two Key Action Areas of Early detection and management of chronic conditions, as well as developing a NT self-management framework. The CCSU has a key role in providing leadership in relation to promoting and protecting good health and preventing injury. CCSU also provides jurisdictional leadership in relation to the chronic conditions, including the Screening Subcommittee.	The CCSU is funded through an identified program within the NT Department of Health. Chronic Condition services in the NT have expanded through a combination of NT Government and Australian Government funding in primary care, hospital and Closing the Gap partnership agreements.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. Chronic disease indicators are included in the NT Aboriginal Health KPIs. The 2010 annual monitoring report will be released in October 2011.
Public Health Nutrition and Physical Activity services	Public health nutritionists provide training and support to primary health care teams to assist in the promotion of good nutrition and physical activity to the community, and in management of people with nutrition related conditions. In urban areas, they offer individual and group consultations through community care centres, while in remote communities they provide group education through health centres, women's centres, etc. They also work with agencies outside the health sector to promote regular participation in physical activity and improved nutrition and better food supply, for example in remote community stores.	These services are funded through an identified program within the NT Department of Health.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. There is reporting against the Preventative Health National Partnership Agreement.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Health Promotion Strategy Unit	The Health Promotion Strategy Unit (HPSU) is tasked with strengthening the capacity for effective health promotion across the Department of Health (DoH). This involves facilitating a uniform understanding of health promotion across the DoH; providing strategic and policy support to key staff; and a commitment to planning for health promotion through investment in research, program planning, and evaluation; social marketing; healthy workplaces; and developing sustainable education and training pathways. A key focus has been to build relationships with educational institutions and research bodies. HPSU has a key role in providing leadership in relation to promoting and protecting good health and preventing injury. HPSU also provides jurisdictional leadership in relation to the national preventative health agenda.	These Strategy Unit services are funded through an identified program within the NT DoH. The social marketing and healthy workplace initiatives are funded by the Australian Government. Primary health care services also provide health promotion activities.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. There are quarterly and annual reports related to Australian Government funding. There is reporting against the Preventative Health National Partnership Agreement and the NT Government's Territory 2030 strategic plan goals.
Women's Health	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 Department of Health responses to this work; project manages key strategic pieces of work to progress priority women's health issues such as those for Aboriginal and Torres Strait Islander Women, Migrant and Refugee Women and Domestic and Family Violence; manages the work of the Women's Information Service in Alice Springs, and acts as a source of information and leadership across the Department in regard to all aspects of women's health. The WHSU has also begun strategic planning with the Men's Health Strategy Unit regarding Aboriginal men's and women's health as well as examining possible strategies for promoting gender as a determinant of health across the Department.	These services are funded through an identified program within the NT Department of Health budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
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 is tasked with leading the development of a men's health strategy and the strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. The MHSU works to develop partnerships with key stakeholders from DoH, other government and non-government organisations, peak men's health agencies and Aboriginal community-controlled organisations. Improving men's knowledge, access and use of preventative health services by working with Departmental and other service providers is a high priority. The MHSU will also encourage and promote the development of a research effort around gender and health and improve access and use of gendered data to inform program development. The MHSU also supports Territory-wide planning, implementation and evaluation of health promotion programs which adopt a life course approach specific to men.	These services are funded through an identified program within the NT Department of Health budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in the Department of Health Annual Report.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Urban Community Health Services	The Community Health Branch provides services in mainly urban centres throughout the NT including Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs. Services include Child, Youth and Family Health Services, Community and Primary Care Services (including social work, palliative care, specialist nursing services and a community resource team), Hearing Services, School Health Services and Home Birth Services (Darwin and Alice Springs). The Branch participates in regional and national primary health care reforms and seeks to improve access and equity to services for urban communities. The Branch also funds a number of non-government organisations to provide services to achieve outcomes within the areas of Child and Family Health, and Community and Primary Care.	These services are funded through an identified program within the NT Department of Health budget. Additionally, federal funding is provided for Home And Community Care services delivered through the Specialist Nursing program.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report.
School Health Services	The aim of the school health service is to ensure school aged youth engage in their health and wellbeing to make informed choices that promote optimal future health and life outcomes. Health Promoting School Nurses support delivery of health education in: • smoking, alcohol and other drugs • nutrition • physical activity • health and well being • sexual health. They also work with the school community to plan, develop, implement and evaluate school identified health promoting programs, policies and strategies.	These services are funded through an identified program within the NT Department of Health budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Well Women's Cancer Screening	Well Women's Cancer Screening incorporates two national programs, both of which aim to detect cancers at an early stage to prevent mortality and morbidity: 1. BreastScreen NT, which is a free breast x-ray screening program targeted at women with no breast symptoms aged 50 to 69. Clinics are provided in Alice Springs, Katherine, Tennant Creek, Darwin, Palmerston and Nhulunbuy. 2. The NT Cervical Screening Program encourages women between the ages of 20 and 69 who have been sexually active to have a Pap smear every two years. The NT Pap Smear Register is a backup reminder system, sending women and their doctors a letter if they are overdue for their next Pap smear. Unless they choose not to be, women are automatically placed on the register when they have a Pap smear. It also funds a network of women's health educators across the NT.	These services are funded through an identified program within the Australian Health Care Agreement.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. WWCS prepares reports for National Aboriginal Health Performance Indicators, and annually the Productivity Commission, Safety Monitoring of the National Cervical Screening Guidelines, National accreditation standards, Australian Government National Public Health Expenditure Reports, the Australian Institute of Health and Welfare (AIHW) National Monitoring report for cervical and breastscreen.
Hearing Services	Hearing Services are provided in remote communities and urban centres and include professional and clinical leadership support to health, education and community personnel in identifying, managing and promoting ear health and hearing loss. Additional services include comprehensive diagnostic audiological evaluations of adults and children, including those referred for or receiving ENT services, provision of outreach teleotology to remote communities and care coordination for complex clients. A Universal Neonatal Hearing Screening Program for permanent hearing loss is provided through all urban birthing hospitals.	Services are funded as an identified program within the NT Department of Health and additional funding to support audiological and ENT services has been provided through the DoHA and EHSDI funding.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report. Service event ENT and Audiology data for consenting children provided with care under DoHA funded programs is provided to the AIHW and published annually.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
Mental Health	The Mental Health Program, through public specialist services and non-government organisations, provides: • mental health promotion, prevention and early intervention • specialist mental health assessment, treatment and case management for adult, child and youth and forensic populations • specialist acute inpatient services in Darwin and Alice Springs • consultation liaison services to acute and primary health care services and other relevant service providers • consumer and carer support and rehabilitation to the population of the Northern Territory. Community-based mental health teams are located in Darwin, Alice Springs, Katherine, East Arnhem and Barkly regions. Remote community mental health teams are supported by urban-based specialists from the hubs in Darwin and Alice Springs on an outreach basis with dedicated rural/remote mental health teams working closely to support consumers and primary care providers in very remote localities.	Services are funded through an identified program within the NT Department of Health budget. Additionally, Federal funding for a number of incentive or start-up programs may be provided through DoHA or other federal agencies.	Performance Indicators and targets against key activity areas are reported to the NT Treasury and Parliament under the Budget process as part of Department of Health Annual and quarterly reporting requirements. National reporting obligations are met under several different requirements including, COAG Mental Health Report, NHA Performance Indicators, Community Mental Health Care NMDS, Mental Health Establishment NMDS, Residential Mental Health Care NMDS and RoGS - Health Management Chapter.
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.	The post exposure program is funded through an identified budget within the Department of Health. DoHA refunds 50 per cent of the cost of rabies immunoglobulin administered to people who are bitten or scratched by bats only.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report.

Table 11A.89 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2010-11

Program	*Description*	*Budgetary context*	*Reporting*
TB Control Unit	The TB Control Unit covers screening of high risk groups (contacts, refugees, prisoners, health workers, fisherpersons); monitoring and administration of directly observed treatment for active TB and leprosy; remote community visits to implement preventive and early diagnostic strategies (treatment of latent TB infection, community screening); and provision of information to the public, service providers and governments.	These services are funded through an identified program within the NT Department of Health budget. Some external funding is provided via Customs and DIAC for the Illegal Foreign Fisherman (IFF).	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report.
Rheumatic Heart Disease	NT wide program to reduce the burden of rheumatic heart disease amongst the Indigenous population by reducing the occurrence of acute rheumatic fever. Provides health professionals and community members with best practice support, education, resource development and supply and patient care.	These services are funded through an identified program within the NT Department of Health budget. External funding is also provided via DoHA.	Performance measures against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health Annual Report.
Alcohol & Other Drugs	The Alcohol and Other Drugs Program (AODP) develops policies, strategies and programs to prevent and respond to the misuse of alcohol, tobacco and other drugs. The AODP includes policy development and legislative compliance, community development, accredited training, services development and treatment and care services and programs.	These services are funded through an identified program within the NT Department of Health budget. Some external funding is provided by DoHA through OATSIH.	Performance targets against key functions of Health Protection and Public Health Services. Financial reports are published in Department of Health Annual Report.
Sexual Health and Blood Borne Viruses Program	NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections and blood borne viruses such as HIV/AIDS and Hepatitis C. The program operates five sexual health clinics — known as Clinic 34 — in the major towns and provides support for rural and remote areas. The program funds community based organisations supporting sexual health work. Other community based organisations are funded to operate needle and syringe programs and provide harm reduction initiatives, community and peer support and education.	The program is funded through an identified budget within the Department of Health. Some external funding is provided via OATSIH and an NPA.	Reporting is against the business plan of the NT Sexual Health Advisory Group and the more detailed Sexual Health and Blood Borne Virus Unit business plan.

Source : NT Government unpublished.

Data quality information — Primary and community health, chapter 11

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.

Where RoGS indicators align with National Agreement indicators, DQI has been sourced from the Steering Committee's reports on National Agreements to the COAG Reform Council.

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 are available for the following performance indicators and measures:

Availability of female GPs 5
Early detection and early treatment for Indigenous people 7
Proportion of children receiving a fourth year developmental health check 10
People deferring visits to GPs due to financial barriers 13
GP Waiting times 16
Selected potentially avoidable GP-type presentations to emergency departments 20
People deferring purchase of medicines due to financial barriers 23
Management of upper respiratory tract infections 26
Management of diabetes 28
Management of asthma 32
Patient satisfaction 35
Health assessments for older people 39
Child immunisation coverage (at 5 years of age) 42
Participation rates for women in cervical screening 45
Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions 49
Selected potentially preventable hospitalisations for diabetes 53

Potentially preventable hospitalisations of older people for falls 56

Availability of GPs by region

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measures (computation)	Availability of general practitioners (GPs) by region. Definition 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 × (Numerator ÷ Denominator).
Data source/s	Numerator: Australian Government Department of Health and Ageing (DoHA) Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2011.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of Medicare Australia's Medicare fee-for-service payment systems. Medicare Australia, part of the Department of Human Services (DHS), collects MBS data under the *Human Services (Medicare) Act 1973* (previously *Medicare Australia Act 1973*) and regularly provides the data to DoHA.
Relevance	Region 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. DoHA is in the process of phasing in the widely used and regularly updated Australian Standard Geographical Classification – Remoteness Areas classification system. GP headcount and FWE figures include vocationally recognised as well as non-vocationally recognised general practitioners. GP headcount is a count of all GPs who have provided at least one Medicare service during the reference period and have had at least one claim for a Medicare service processed during the same reference period. GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing 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.

	FWE is calculated by dividing each doctor's 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. 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 Medicare services during the reference period. FWE allocates activity based on the practice location at which services were rendered within the reference period. 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.
Timeliness	GP headcount and FWE figures are available 10 weeks after the close of the reference period.
Accuracy	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 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. Since the commencement of Medicare, practitioners have provided demographic information to Medicare Australia including date of birth and gender. Demographic details are updated when practitioners review, renew or change their registration details with Medicare Australia. 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 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	From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons.
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1
Accessibility	Information is available for MBS Claims data from www.mbsonline.gov.au and www.medicareaustralia.gov.au/.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • The classification system used to allocate GPs to regions has not been updated since 1994, and does not reflect population changes that have since occurred. Data are reported only for two broad regional categories; reporting at a more detailed level using a more accurate classification system is a priority.

Availability of female GPs

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measures (computation)	Availability of female general practitioners (GPs) Definition The number of Full-time Workload Equivalent (FWE) female GPs per 100 000 females. Numerator: Number of FWE female GPs. Denominator: Estimated Resident Population (ERP) of females. Computation: 100 000 × (Numerator ÷ Denominator).
Data source/s	Numerator: Australian Government Department of Health and Ageing (DoHA) Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2011.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of Medicare Australia's Medicare fee-for-service payment systems. Medicare Australia, part of the Department of Human Services (DHS), collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA.
Relevance	Female FWE GP figures include vocationally recognised as well as non-vocationally recognised female 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 Medicare billing by the average billing of full-time doctors for the reference period. Example 1: A busy GP billing 50% 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 Medicare, demographic information has been provided by practitioners to Medicare Australia including date of birth and gender. The demographic details are updated when practitioners review, renew or change their registration details with Medicare Australia. 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	From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons.
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1
Accessibility	Information is available for MBS Claims data from www.mbsonline.gov.au and www.medicareaustralia.gov.au/

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following: • Data are of acceptable accuracy.

Early detection and early treatment for Indigenous people

Data quality information has been developed by the Health Working Group for three measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Early detection and early treatment for Indigenous people
Measures (computation)	Definition 1. The proportion of older people who received a health assessment by Indigenous status 2. The proportion of older Indigenous people who received a health assessment, time series 3. The proportion of Indigenous people who received a health assessment, by age group Numerators: The number of persons aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of persons 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. The number of persons 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. The number of persons 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. Denominators: The population of non-Indigenous people aged 75 years or over and the population of Indigenous people aged 55 years or over in the reference period. The population of Indigenous people aged 55 years or over in the reference period. The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period. Computation: 1.–3. 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerators: Australian Government Department of Health and Ageing (DoHA) Medicare data. Denominators: Denominators computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS). Total population: ABS 2009, *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0. For data by Indigenous status: ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of Medicare Australia's Medicare fee-for-service payment systems. Medicare Australia, part of the Department of Human Services (DHS), collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.
Relevance	These measures relate to specific Medicare services for which claims data are available. 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. Allocation of clients to state or territory is based on client postcode of residence as recorded by Medicare Australia 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. For services provided from 1 May 2010, disaggregation by age is based on client date of birth in Medicare Australia records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to each age group. Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.
Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	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. 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 Medicare in the reference period or a change of address after receiving the service was reported to Medicare in the reference period. Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data. Clients are counted once only in the reference period. Data do not include: • 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 • Child Health Checks received under the NT Emergency Response. Data have not been adjusted to account for known under-identification of Indigenous status in MBS data.
Coherence	The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis. As of 1 May 2010: • 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 Medicare Australia 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.
Interpretability	Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 and www.medicareaustralia.gov.au/statistics/mbs_item.shtml.
Accessibility	Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • No adjustment was made to this indicator to account for under-identification of Indigenous people in Medicare data.

Proportion of children receiving a fourth year developmental health check

Data quality information for this indicator has been sourced from the Steering Committee's 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 (computation)	Proportion of children who have received a 4 year old development health check. Numerator: The number of persons aged 3–5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10986 (Healthy Kids Check) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period. Denominator: The population aged 4 years, estimated by the AIHW using ERP data from the ABS. It was calculated by multiplying the 0-4 years ERP in each disaggregation (Indigenous status and remoteness) by the percentage of children aged 4 in this age group nationally. Calculation: 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerator: Australian Government Department of Health and Ageing (DoHA) Medicare Statistics data. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period. For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June in the year preceding the reference period. For data by remoteness: ABS ERP as at 30 June in the year preceding the reference period, by remoteness area, as specified in the Australian Standard Geographical Classification.

Data Quality Framework Dimensions

Institutional environment	Medicare Australia processes claims made through the MBS under the *Human Services (Medicare) Act 1973*. These data are then regularly provided to DoHA. The indicator was calculated by DoHA, using a denominator supplied by the AIHW. DoHA 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 DoHA. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator. For further information see the AIHW website.
Relevance	The measure relates to specific identified Medicare services for which Medicare Australia has processed a claim. 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.

The figures for the Northern Territory exclude children receiving Northern Territory Emergency Response Child Health Checks.

The analyses by state/territory and remoteness are based on postcode of residence of the client as recorded by Medicare Australia at the date the last service was received in the reference period. As clients may receive services in locations other than where they live, the data do not necessarily reflect the location in which services were received.

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

As with any administrative system a small degree of error may be present in the data captured.

MBS data used for statistical purposes is based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to Medicare Australia. Data are based on the date on which a Medicare claim was processed by Medicare Australia, not when 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 persons included in the numerator for the reference period.

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.

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).

Coherence

Claims for historical MBS items (708, 709 and 711) may still be processed by Medicare Australia and extracted for this indicator but are unlikely to impact on the time series. Details of the changes to MBS items are set out below.

As of 1 May 2010, the Healthy Kids Check Item 709 was replaced with four new MBS health assessment items (based on time and complexity) that cover all ages — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

Under these new reporting arrangements it is 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) has been retained under a new MBS item number — 10986. 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) has been 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.
Interpretability	Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 and www.medicareaustralia.gov.au/statistics/mbs_item.shtml.
Accessibility	Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1. Disaggregation of MBS data by remoteness area are not publicly available elsewhere.

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 Medicare data.

People deferring visits to GPs due to financial barriers

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	People deferring access to GPs due to cost.
Measure (computation)	Definition Proportion of people that required GP treatment but deferred that treatment due to cost. Numerator: People reporting deferring access to a GP in the last 12 months due to cost. Denominator: People aged 15 years and over who saw or needed to see a GP in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey, 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 on the ABS website at www.abs.gov.au. Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. Data Compiler(s): Data is compiled by the Health and Disability section of the Australian Bureau of Statistics (ABS). Statistical confidentiality is guaranteed under the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. 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.
Relevance	Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: There are no indigenous data able to be published for this indicator. Numerator/Denominator Source: Same data source. Data for this indicator were collected for all persons in Australia, excluding persons in very remote communities, as well as the following people: • 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.

The exclusion of persons usually resident in very remote communities only has a small impact on estimates, except for the Northern Territory, where such persons represent 24 per cent of the population. Patient Experience data are weighted to account for non-response.

As data are 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.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2010-11 data used for this indicator became available in November 2011.

The 2009 data used for this indicator became available in July 2010. Referenced Period: July 2010 to June 2011 for the 2010-11 survey; July to December 2009 for the 2009 survey.

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: the sample for the 2010-11 patient experience data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2010-11 survey was 81.4 per cent; response rate for the 2009 survey was 88 per cent.

Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable state and territory data.

Known Issues: Data were self-reported.

Year to year change: As the sample for 2010-11 and future patient experience surveys is around 27 000, the data should be sensitive to small year to year changes.

The data are self-reported but not attitudinal as people are reporting instances where they did not see a GP at any time in the past 12 months due to cost. Explanatory footnotes are provided with the data.

Coherence

Consistency over time: 2009 was the first year data were collected for this indicator. Data from 2009 and 2010-11 have shown some small changes.

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 very remote communities in the sample will affect the NT more than it affects other jurisdictions as people usually resident in very remote areas account for about 24 percent of people in NT.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data are collected the same way across all jurisdictions.

The 2009 and 2010-11 patient experience data are the only data available for this indicator. At this stage, there are no other directly comparable data sources, although the ABS Aboriginal and Torres Strait Islander Health Survey asks a multi-response question about whether respondents did not see a GP or specialist when they needed to, with cost being one of the possible responses. This question is matched in the patient experience survey for non-Indigenous comparisons.

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 ABS 2010-11 Patient Experience data are published in ABS 2011 *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the ABS 2011 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0.

An overview of results for the 2009 Patient Experience Survey is published in *ABS 2010 Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001 and *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. The data are shown by SEIFA, country of birth, self-assessed health status and remoteness, but not by jurisdiction.

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 Health and Disability section of the ABS on (02) 6252 5000.

Spreadsheets can be downloaded from the ABS website and a confidentialised unit record file will be available in 2012. Data must be confidentialised for privacy reasons.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The Patient Experience Survey excludes very remote areas which affects the comparability of NT data.
- Disaggregation of this indicator by Indigenous status is a priority.
- The sample size has increased from 7124 to 26 423 this year. The increased sample size has strengthened the reliability of the population-level estimates.

GP Waiting times

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	GP Waiting Times
Measure (computation)	Definition Length of time a patient needs to wait to see a GP for an urgent appointment. Numerator Number of people who reported seeing a GP for urgent medical care (for their own health) within specified waiting time categories (within 4 hours, more than 4 hours but within 24 hours, more than 24 hours). Denominator Number of persons aged 15 years or over who saw a GP for urgent medical care (for their own health) in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Patient Experience Survey, ABS.

Data Quality Framework Dimensions

Institutional environment	The Patient Experience Survey is a topic on the Multipurpose Household Survey, 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 on the ABS website at www.abs.gov.au. Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. Data Compiler(s): Data is compiled by the Health and Disability section of the Australian Bureau of Statistics (ABS). Statistical confidentiality is guaranteed under the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. 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.
Relevance	Data Completeness: All data is available for this indicator from this source. Indigenous Statistics: There are no Indigenous data able to be published for this indicator. Numerator and denominator are from the same data source.

Data for this indicator were collected for all persons in Australia, excluding persons in very remote communities, as well as the following people:

- 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.

The exclusion of persons usually resident in very remote communities only has a small impact on estimates, except for the Northern Territory, where such persons represent 24% of the population. Patient Experience data are weighted to account for non-response.

As data are 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% and 50% should be used with caution, and estimates with a relative standard error over 50% are considered too unreliable for general use.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was that going to the GP for a medical certificate for work for a cold would not be considered urgent.

Timeliness

Patient Experience data is collected annually. The 2009 data used for this indicator became available in July 2010, and the 2010-11 data became available in November 2011. The reference period for the 2009 survey was July to December 2009. The reference period for the 2010-11 survey was July 2010 to June 2011.

There are not likely to be revisions to this data after its release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: the sample for the 2010-11 patient experience data was 26,423 fully-responding households (sample size was 7124 for the 2009 survey).

Response rate: Response rate for the survey was 81.4 per cent (for the 2009 survey, the response rate was 88 per cent).

Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable state and territory data.

Known Issues: Data was self-reported and interpretation of urgent medical care was left up the respondent.

Year to year change: As the sample for 2010-11 and future patient experience surveys is around 27 000 the data should be sensitive to small year to year changes.

The data are 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).

Coherence

Consistency over time: 2009 was the first year data was collected for this indicator. Data from 2009 and 2010-11 have shown some small changes.

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 very remote communities in the sample will affect the NT more than it affects other jurisdictions as people usually resident in very remote areas account for about 24 per cent of persons 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 2009 and 2010-11 PEx provide the only national data available for this indicator. At this stage, there are no other comparable data sources.

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.

Other Supporting information: The ABS 2010-11 Patient Experience data is published in ABS 2011 *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the ABS 2011 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0.

An overview of results for the 2009 Patient Experience Survey is published in ABS 2010 *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001.

Accessibility

Data are publicly available. Tables showing waiting times for GPs are available in *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001 and *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. Waiting times are expressed differently, however, as they are shown within 4 hours, after 4 hours but same day, next day, and two or more days. The data are shown by SEIFA, country of birth, self-assessed health status and remoteness, but not by jurisdiction. 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 Health and Disability section of the ABS on (02) 6252 5000.

Spreadsheets can be downloaded from the ABS website and a confidentialised unit record file will be available in 2012. Data must be confidentialised for privacy reasons.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The Patient Experience Survey excludes very remote areas which affects the comparability of NT data.
- Data are based on waiting times for self-defined urgent medical care.
- Disaggregation of this indicator by Indigenous status is a priority.
- The Patient Experience Survey sample size increased from 7124 in

2009 to 26 423 in 2010-11. The increased sample size has strengthened the reliability of the population-level estimates.

Selected potentially avoidable GP-type presentations to emergency departments

Data quality information for this indicator has been sourced from the Steering Committee's 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	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 (computation)	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: • there was a type of visit of *Emergency presentation* (or *Emergency presentation* or *Not reported* for South Australia for 2008-09 and 2009-10) • 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 NNAPEDCD, based on the national minimum data set (NMDS) for Non-admitted patient emergency department care (NAPEDC). For data by remoteness: each presentation is allocated an ABS remoteness area, as specified in the Australian Standard Geographical Classification, based on the Statistical Local Area of usual residence of the patient.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health and Ageing. For further information see the AIHW website. The data were supplied to the AIHW 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 administrative arrangements, contractual requirements or legislation. States and territories supplied these data under the terms of the National Health Information Agreement (see link below). www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807 &libID=6442472788
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 2009–10, hospitals in peer groups A and B provided approximately 70 per cent of all public hospital emergency occasions of service.

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 definition of potentially avoidable GP type presentations is an interim measure, pending development of new methodology to more closely approximate the population that should be receiving service in the primary care sector.

The indicator includes only peer group A (Principal referral and Specialist women's and children's hospitals) and peer group B (Large hospitals).

The analyses by state/territory and remoteness are based on the statistical local area (SLA) of usual residence of the patient. Hence, data represent the number of presentations for patients living in each state/territory or remoteness area (regardless of the jurisdiction of the hospital where they presented).

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Timeliness

The reference periods for this performance indicator are 2008-09, 2009-10 and 2010-11**.**

Accuracy

For 2009–10, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B.

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 New South Wales' and Victoria's data.

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 (including waiting time outliers) 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.

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

As this indicator is limited to public hospitals classified in peer groups A and B, most of the data relates to hospitals within major cities. Consequently, the data may not cover areas where the proportion of Indigenous Australians (compared with other Australians) is higher than average. Similarly, disaggregation by socioeconomic status and remoteness should be interpreted with caution.

Area of usual residence was not reported, or not mappable to a remoteness area or SEIFA population group, for approximately 70 000 records.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in *Australian Hospital Statistics 2010-11: emergency department care and elective surgery waiting times* and the *National healthcare agreement: performance report 2009-10*.

For 2010-11, hospitals classified as peer groups A and B were based on 2009-10, rather than 2010-11 peer groups.

The 2009-10 data reported here differ from the equivalent data published previously in these publications because the hospitals classified as peer groups A and B were previously based on 2008-09, rather than 2009-10 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 data. Published products available on the AIHW website include *Australian hospital statistics*, and associated Excel tables.

Some data are also included on the MyHospitals website.

Interpretability Supporting information on the quality and use of the NNAPEDCD are published annually in *Australian hospital statistics* (Chapter 5 and 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 that might affect interpretation of the published data. Metadata information for the NAPEDC NMDS 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:

- 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 2009–10, the coverage of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) collection is complete for public hospitals in peer groups A and B.
- The definition of potentially avoidable GP type presentations is an interim measure, pending development of new methodology to more closely approximate the population that should be receiving service in the primary care sector.
- The quality of Indigenous status data in the NNAPEDCD has not been formally assessed for completeness; therefore caution should be exercised when interpreting these data.
- 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

People deferring purchase of medicines due to financial barriers

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	People deferring purchase of prescribed medicines due to cost.
Measure (computation)	Definition Proportion of people that deferred purchase of prescribed medicines due to cost. Numerator: Number of persons who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost. Denominator: Total number of persons aged 15 years or over who received a prescription for medication from a GP in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey, 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 on the ABS website at www.abs.gov.au. Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. Data Compiler(s): Data is compiled by the Health and Disability section of the Australian Bureau of Statistics (ABS). Statistical confidentiality is guaranteed under the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. 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.
Relevance	Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: There are no indigenous data able to be published for this indicator. Numerator/Denominator Source: Same data source. Data for this indicator were collected for all persons in Australia, excluding persons in very remote communities, as well as the following people: • 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.

The exclusion of persons usually resident in very remote communities only has a small impact on estimates, except for the Northern Territory, where such persons represent 24 per cent of the population. Patient Experience data are weighted to account for non-response.

As data are 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.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2010-11 data used for this indicator became available in November 2011.

The 2009 data used for this indicator became available in July 2010. Referenced Period: July 2010 to June 2011 for the 2010-11 survey; July to December 2009 for the 2009 survey.

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: the sample for the 2010-11 patient experience data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2010-11 survey was 81.4 per cent; response rate for the 2009 survey was 88 per cent.

Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable state and territory data.

Known Issues: Data were self-reported.

Year to year change: As the sample for 2010-11 and future patient experience surveys is around 27 000, the data should be sensitive to small year to year changes.

The data are self-reported but not attitudinal as people are reporting instances where they did not see a GP at any time in the past 12 months due to cost. Explanatory footnotes are provided with the data.

Coherence

Consistency over time: 2009 was the first year data were collected for this indicator. Data from 2009 and 2010-11 have shown some small changes.

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 very remote communities in the sample will affect the NT more than it affects other jurisdictions as people usually resident in very remote areas account for about 24 percent of people in NT.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data are collected the same way across all jurisdictions.

The 2009 and 2010-11 patient experience data are the only data available for this indicator. At this stage, there are no other directly comparable data sources, although the ABS Aboriginal and Torres Strait Islander Health Survey asks a multi-response question about whether respondents did not see a GP or specialist when they needed to, with cost being one of the possible responses. This question is matched in the patient experience survey for non-Indigenous comparisons.

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 ABS 2010-11 Patient Experience data are published in ABS 2011 *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the ABS 2011 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. An overview of results for the 2009 Patient Experience Survey is published in *ABS 2010 Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001 and *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. The data are shown by SEIFA, country of birth, self-assessed health status and remoteness, but not by jurisdiction. 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 Health and Disability section of the ABS on (02) 6252 5000.

Spreadsheets can be downloaded from the ABS website and a confidentialised unit record file will be available in 2012. Data must be confidentialised for privacy reasons.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The Patient Experience Survey excludes very remote areas which affects the comparability of NT data.
- Disaggregation of this indicator by Indigenous status is a priority.
- The sample size has increased from 7124 to 26 423 this year. The increased sample size has strengthened the reliability of the population-level estimates.

Management of upper respiratory tract infections

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Management of upper respiratory tract infections
Measures (computation)	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. Numerator: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed to patients, for all people and for concession card holders. Denominator: Estimated residential population and number of concession card holders. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.
Data source/s	Numerator: Australian Government Department of Health and Ageing (DoHA) Pharmaceutical Benefits Scheme (PBS) Statistics data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December. Number of concession card holders: obtained by DoHA from the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

Data Quality Framework Dimensions

Institutional environment	PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by DoHA and administered by Medicare Australia, part of the Department of Human Services. Provisions governing the operation of the PBS are contained in the *National Health Act 1953*. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and the denominator data sourced from FaHCSIA (and supplied by DoHA) and from the ABS.
Relevance	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. 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.

	Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.
Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	As PBS data for general patients is only available for items priced above $34.20, the majority of script data for these patients is missing. Thus comparison of script rate for the total population and concessional patients is potentially misleading. From 1 April 2012, PBS undercopayment data will be available for general patients. Until this happens caution should be used in interpreting the results.
Coherence	Prior to the 2011 Report, data included all prescriptions for the selected antibiotics. For the 2011 and subsequent reports, data include only prescriptions provided by GPs and OMPs. Prior to the 2011 Report, data were reported only for concession card holders. For the 2011 and subsequent reports, data are also reported for the general population.
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.
Accessibility	PBS Claims data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • URTI is one of a range of conditions for which these antibiotics are prescribed. Data are not able to be disaggregated by condition. • The use of antibiotics for URTI in the general population is underestimated because data exclude those priced at or below the PBS subsidy. The availability of complete data from April 2012 will significantly improve data quality.

Management of diabetes

Data quality information for this indicator has been sourced from the Steering Committee's 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	Effectiveness — appropriateness
Indicator	Proportion of people with diabetes mellitus who have received a Medicare Benefits Schedule (MBS) annual cycle of care.
Measure (computation)	Definition Proportion of people with diabetes mellitus who have received a MBS annual cycle of care. Numerator Number of people with a completed MBS diabetes annual cycle of care processed by Medicare Australia within the reference period. Denominator Number of people diagnosed with Type 1 and Type 2 diabetes in the community. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Numerator Australian Government Department of Health and Ageing (DoHA) MBS Statistics. 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 The National Diabetes Services Scheme (NDSS), an administrative database that provides counts of people known to have diabetes (through certification of diagnosis by a doctor or diabetes educator) who access NDSS services. ABS ERP by remoteness area, as specified in the Australian Standard Geographical Classification, as at 30 June in the year preceding the reference period.

Data Quality Framework Dimensions

Institutional environment	MBS Medicare Australia (now Department of Human Services – Medicare) processes claims made through the MBS under the *Human Services (Medicare) Act 1973*. These data are then regularly provided to DoHA. Medicare Australia also processes claims for DVA Treatment Card holders, also made through the MBS, under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Human Services (Medicare) Act 1973*. All claims data are regularly provided to DVA as per the Memorandum of Understanding between Medicare Australia and DVA. NDSS The NDSS is a subsidy scheme administered by Diabetes Australia Ltd, since its establishment in 1987, on behalf of DoHA.

At the point of registration with the Scheme, people provide demographic data, details of the type of diabetes they have and how it is treated. This information is held on a central database by Diabetes Australia Ltd and is uploaded monthly.

Diabetes Australia Ltd is a national federated body supporting people with diabetes and professional and research bodies concerned with the treatment and prevention of diabetes; see www.diabetesaustralia.com.au/en/About-Diabetes-Australia/.

The tables for this indicator were prepared by DoHA and the DVA and quality-assessed by the AIHW. DoHA 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 DoHA and the DVA. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator. For further information see the AIHW website.

Relevance

DoHA MBS Statistics and DVA TAS data

The measure relates to specific identified MBS services for which Medicare Australia has processed a claim.

For 2010-11, DVA clients comprised less than 4 per cent of people who received a GP annual cycle of care.

The analyses by state/territory and remoteness are based on postcode of residence of the client as recorded by Medicare Australia at the date of last service received in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received. There were a small number of DoHA MBS records with a postcode that was invalid or did not map to a remoteness area (59 records). These records were excluded from the analysis.

NDSS

The number of registrants on the NDSS can be counted to estimate diabetes prevalence. However, registration is voluntary and therefore it is likely that a proportion of people with diagnosed diabetes are not registered with the Scheme. Diabetes Australia estimates that the NDSS covers 80 per cent to 90 per cent of people with diagnosed diabetes.

NDSS data allow for disaggregation by area (based on postcode). As with the MBS data, there was a small number of records with a postcode that was invalid or did not concord to a remoteness area (310 records).

The indicator aggregates people with Type 1 and Type 2 diabetes (as using data linkage to disaggregate the data would raise Privacy Act concerns). However, while people with type 1 diabetes are significantly more likely to require a care plan, type 2 diabetes comprises around 85 per cent of all records. Consequently, aggregating data does not give an accurate proportion of persons with each type of diabetes who have an MBS annual cycle of care.

The denominator includes only Type 1 and Type 2 diabetes. Therefore, people diagnosed with 'other diabetes' were excluded (5,043 people in the 2010-11 data; 4434 in the 2009-10 data and 5235 people in the 2008-09 data).

Timeliness

DoHA MBS Statistics and DVA TAS data

The MBS data used in this indicator relate to all claims processed in the financial reference year.

NDSS

NDSS data are updated continuously. Data are available on a monthly basis from Diabetes Australia Ltd. The NDSS data used for this indicator relate to all registrants as at 30 June.

Accuracy

DoHA MBS Statistics and DVA TAS data

As with any administrative system a small degree of error may be present in the data captured.

Medicare claims data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to Medicare Australia.

Data are based on the date on which the MBS claim was processed by Medicare Australia, not when 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 persons included in the numerator term for the reference period.

NDSS

The AIHW estimates the number of duplicate records in the NDSS to be small (only 0.4 per cent of records from a subset of NDSS data as at June 2009). A small number of people who no longer have diabetes or who have died are likely to still be in the database.

The NDSS requires certification of a diagnosis of diabetes before an individual can register. This eliminates any self-report bias, but excludes those people with undiagnosed diabetes.

The NDSS may underestimate the prevalence of diabetes in remote areas due to a shortage of doctors/diabetes educators needed to approve registration application.

Postcodes (used for disaggregation by remoteness area) relate to the registrant's place of residence as recorded at the point of registration. This is likely to be accurate, as registrants have an incentive to update this information if and when they move so as to ensure products supplied to them under the NDSS are delivered to their correct place of residence.

Cells have been suppressed where the numerator is less than 10 to protect confidentiality.

Coherence

The reference period is not consistent across the data sources — the MBS data relate to all claims processed over the financial year, while the NDSS data include all registrants on the database at a point in time (30 June).

Interpretation of rates over time should not be undertaken as the prevalence estimate (denominator) increases each year with the increased coverage of the NDSS.

Accessibility

MBS

Medicare claims statistics are available at:

www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1;

https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

Disaggregation by remoteness area is not publicly available elsewhere.

NDSS data are not publicly accessible.

Interpretability

Information about services subsidised through Medicare is available from MBS online at www.health.gov.au/internet/mbsonline/publishing.nsf/content/ medicare-benefits-schedule-mbs-1.

Further information on the NDSS is available at www.ndss.com.au.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- This indicator appears reliable at a national level. However comparisons between jurisdictions and population groups may be problematic due to different population structures (including relative prevalence of Type 1 and Type 2 diabetes) which have not been accounted for in the calculation of this indicator.
- Compared with other jurisdictions, results for the ACT and the NT appear to be less reliable, perhaps due to their smaller population and, in the NT, lower coverage of services.
- The NDSS gives the best available approximation of people with diagnosed diabetes in Australia in 2009-10 but it does not cover all people with diabetes and its uptake is lower in remote areas.
- Disaggregation of this indicator by Indigenous status is a priority. Indigenous identification in MBS data is voluntary and the data significantly underestimate Indigenous utilisation.
- Requirements for the MBS annual cycle of care item are based on but not identical to RACGP clinical guidelines for the management of type 2 diabetes.
- It would be useful to report this indicator separately for type 1 and type 2 diabetes.

Management of asthma

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Chronic disease management
Measure (computation)	Management of asthma Definition Proportion of people with asthma who have a written asthma action plan. Numerator Estimated number of persons with asthma with a written asthma action plan. Denominator Estimated number of persons with asthma. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	The denominator and numerator for this indicator use ABS National Health Survey (NHS) data, which is weighted to benchmarks for the total NHS in-scope population derived from the Estimated Resident Population (ERP). For information on NHS scope and coverage, see the ABS *National Health Survey Users Guide* (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. Estimates for Indigenous persons are drawn from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), which was benchmarked to the estimated Indigenous population (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 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 persons 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 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 2007-08 NHS were released in May 2009.

The NATSIHS is conducted every six years. Results from the 2004-05 survey were released in April 2006.

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 persons usually resident in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up a relatively large proportion of the population. The 2007-08 NHS response rate was 91 per cent. NHS data are weighted to account for non-response.

The NATSIHS is conducted in all States and Territories and includes remote and non-remote areas. The 2004-05 sample was 10,000 persons/5200 households, with a response rate of 81 per cent of households.

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.

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 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). Changes to the NHS since 2004-05 to better align questions and concepts with the ACAM recommendations mean that data for this indicator is not comparable over time.

	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 *National Health Survey, Summary of Results* (ABS Cat. no. 4364.0) for an overview of results from the NHS, and *National Health Survey: State tables* (ABS Cat. no. 4362.0) for State and Territory specific tables. See the *National Aboriginal and Torres Strait Islander Health Survey* (Cat. no. 4715) for an overview of results from the NATSIHS. Other information from these surveys is also available on request.
Interpretability	Information to aid interpretation of the data is available from the *National Health Survey User Guide*, and the *National Aboriginal and Torres Strait Islander Health Survey User 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. • Data are not comparable between Indigenous and non-Indigenous people because of different years of the data collections and different interpretations of what is a 'written' plan.

Patient satisfaction

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by 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 (computation)	Measure a: Definition Proportion of people satisfied with selected aspects of GP care. Numerator Persons 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. Denominator Persons who saw a GP for their own health in the last 12 months, excluding persons who were interviewed by proxy. Measure b: Definition Proportion of people satisfied with selected aspects of dental professional care. Numerator persons who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them. Denominator persons who saw a dental professional in the last 12 months, excluding persons who were interviewed by proxy. Computation (a and b): 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey, 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 on the ABS website at www.abs.gov.au. Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. Data Compiler(s): Data is compiled by the Health and Disability section of the Australian Bureau of Statistics (ABS). Statistical confidentiality is guaranteed under the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975.

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.

Relevance

Data Completeness: All data are available for this indicator from this source.

Indigenous Statistics: There are no indigenous data able to be published for this indicator.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all persons in Australia, excluding persons in very remote communities, as well as the following people:

- 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.

The exclusion of persons usually resident in very remote communities only has a small impact on estimates, except for the Northern Territory, where such persons represent 24 per cent of the population. Patient Experience data are weighted to account for non-response.

As data are 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.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2010-11 data used for this indicator became available in November 2011.

Referenced Period: July 2010 to June 2011.

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: the sample for the 2010-11 patient experience data was 26 423 fully-responding households.

Response rate: Response rate for the 2010-11 survey was 81.4 per cent.

Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable state and territory data.Known Issues: Data were self-reported.

Year to year change: As the sample for 2010-11 and future patient experience surveys is around 27 000, the data should be sensitive to small year to year changes.

The data are self-reported but not attitudinal as people are reporting instances where they did not see a GP at any time in the past 12 months due to cost. Explanatory footnotes are provided with the data.

Coherence

Consistency over time: 2010-11 was the first year data were collected for this indicator.

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 very remote communities in the sample will affect the NT more than it affects other jurisdictions as people usually resident in very remote areas account for about 24 percent of people in NT.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data are collected the same way across all jurisdictions.

The 2010-11 patient experience data are the only data available for this indicator. At this stage, there are no other directly comparable data sources.

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 ABS 2010-11 Patient Experience data are published in ABS 2011 *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the ABS 2011 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0.

Accessibility

Data are publicly available in *Patient Experiences in Australia: Summary of Findings, 2010-11*, Cat. no. 4839.0. The data are shown by age, sex, remoteness and disadvantage.

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 Health and Disability section of the ABS on (02) 6252 5000.

Spreadsheets can be downloaded from the ABS website and a confidentialised unit record file will be available in 2012. Data must be confidentialised for privacy reasons.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The Patient Experience Survey excludes very remote areas which affects the comparability of NT data.
- Disaggregation of this indicator by Indigenous status is a priority.

- The sample size has increased from 7124 to 26 423 this year. The increased sample size has strengthened the reliability of the population-level estimates.

Health assessments for older people

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Health assessments for older people
Measures (computation)	Definition The proportion of older people who received a health assessment. 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. Denominator: The population of non-Indigenous people aged 75 years or over and the population of Indigenous people aged 55 years or over in the reference period. Computation: 1.–3. 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerator: Australian Government Department of Health and Ageing (DoHA) Medicare data. Denominator: Denominator computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS). Total population: ABS 2009, *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0. For data by Indigenous status: ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of Medicare Australia's Medicare fee-for-service payment systems. Medicare Australia, part of the Department of Human Services (DHS), collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.
Relevance	These measures relate to specific Medicare services for which claims data are available. 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.

	Allocation of clients to state or territory is based on client postcode of residence as recorded by Medicare Australia 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. For services provided from 1 May 2010, age is based on client date of birth in Medicare Australia 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. Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.
Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	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. 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 Medicare in the reference period or a change of address after receiving the service was reported to Medicare in the reference period. Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data. Clients are counted once only in the reference period. Data do not include: • 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.
Coherence	The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis. As of 1 May 2010: • 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). For services provided from 1 May 2010, disaggregation by age is based on client date of birth in Medicare Australia 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.
Interpretability	Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 and www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

Accessibility	Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issue: • No adjustment was made to this indicator to account for under-identification of Indigenous people in Medicare data.

Child immunisation coverage (at 5 years of age)

Data quality information for this indicator has been sourced from the Steering Committee's 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	Outcome
Indicator	Child immunisation coverage.
Measure (computation)	Proportion of children aged 60 months to less than 63 months who are fully vaccinated. Definition Proportion of children aged 5 years who are fully vaccinated. Numerator number of children who turned five between 1 January 2006 and 31 March 2006 who have been recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) as at 30 June 2011. Denominator number of children who turned five between 1 January 2011 and 31 March 2011 registered on ACIR as at 30 June 2011. Computation: 100 × (Numerator ÷ Denominator), presented as a rate per 100 children aged 5 years.
Data source/s	The Australian Childhood Immunisation Register (ACIR). For data by remoteness: ABS ERP, by remoteness areas, as specified in the Australian Standard Geographical Classification.

Data Quality Framework Dimensions

Institutional environment	The ACIR is administered and operated by Medicare Australia for the Australian Government Department of Health and Ageing (DoHA). Medicare Australia provides DoHA with quarterly coverage reports at the national and state level. Immunisations are notified to Medicare Australia by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments. 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.medicareaustralia.gov.au/public/services/acir/index.jsp. The tables for this indicator were prepared by Medicare Australia and quality-assessed by DoHA and the AIHW. DoHA 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 DoHA. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator. For further information see the AIHW website.
Relevance	The ACIR records details of vaccinations given to children under seven years of age who live in Australia, however reporting for the Australian Healthcare Agreement is only for those children aged five years, which for this report, are those children born between 1 January 2006 and 31 March 2006. A child is assessed as fully immunised at five years of age if they have received age appropriate immunisations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.

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.

The analyses by State/Territory remoteness and socioeconomic status are based on postcode of residence of the child as recorded on ACIR. As children may receive vaccinations in locations other than where they live, this data does not necessarily reflect the location in which services were received.

Indigenous status in the ACIR can be notified in three ways:

- When the child is registered with Medicare if the parent/guardian had marked the Medicare enrolment form.
- The immunisation provider can provide this information through the Record Encounter screen on the ACIR secure site or on the Immunisation encounter form.
- A parent/guardian can submit a Voluntary Indigenous Identifier to update their child's Medicare record which will then update their ACIR record.

Timeliness

ACIR data are reported quarterly. The data presented are for children born between 1 January 2006 and 31 March 2006. Data were processed on 30 June 2011 as a minimum 3-month lag period is allowed for late notification of immunisations to ACIR.

Accuracy

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.

Programs, such as the General Practice Immunisation Incentive (GPII), and provider incentive payments have helped minimise under-reporting by providing a financial incentive to report clean and accurate data.

The data contains minimal if any duplication of immunisations, as children are identified via their Medicare number. Approximately 99 per cent of children are registered with Medicare by 12 months of age.

The ACIR covers virtually all children, particularly because participation in the ACIR is via an 'opt-out' arrangement.

ACIR is considered to have high levels of Indigenous identification (estimated to be 95 per cent in 2005).

Medicare Australia used tables and concordance files prepared by the AIHW to construct rates by remoteness and socioeconomic status.

Coherence

The definitions of numerators and denominators have been consistent since the inception of the ACIR in 1996.

Accessibility

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 Medicare Australia's web site.

Medicare Australia publishes current immunisation coverage from the ACIR on its website, www.medicareaustralia.gov.au. Authorised immunisation providers can access detailed reports via a secured area of the Medicare Australia web site.

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.

Interpretability Further information on the ACIR can be found at www.medicareaustralia.gov.au/public/services/acir/index.jsp.

Information on the National Immunisation Program and vaccinations can be found at www.immunise.health.gov.au.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- 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 Medicare enrolment register, and approximately 99 per cent of children are registered with Medicare by 12 months of age.
- Data has been reported using the ACIR definition of fully-immunised children; that is, children who have received all age appropriate immunisations.

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 (computation)	Definition 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. 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. Numerator Total number of women aged 20–69 years who were screened in the 2 year period. 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. Computation/s: 100 × (Numerator ÷ Denominator) and age-standardised to the Australian population at 30 June 2001.
Data source/s	Numerator State and territory cervical cytology registers. Denominator For total population: For data by remoteness: ABS estimated resident population (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. For data by remoteness: ABS ERP by remoteness area, as specified in the Australian Standard Geographical Classification.

Data Quality Framework Dimensions

Institutional environment	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. 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. 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. 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 further information see the AIHW website (www.aihw.gov.au).
Relevance	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.

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 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.

For participation by remoteness, the numerator is the number of women screened in 2009 and 2010 aged 20–69 years who reside in each of the remoteness categories. A postal area (POA) to remoteness concordance was used to allocate women screened to remoteness categories based on their postcode. Aggregated postcode data are supplied from each State and Territory, and summed to generate the number of women screened by remoteness at the national level. The denominator is the average of the ABS ERP in the reference period for women aged 20–69 years in each remoteness category, generated by applying a POA to remoteness concordance and adjusted to exclude the estimated number of women who have had a hysterectomy, using national hysterectomy fractions.

Caution is required when examining differences across remoteness categories for several reasons. First, while the postcode of women screened is interpreted as postcode of residence, some women may supply an address other than where they reside, or their postcode may be invalid or missing. Second, because the concordances are based on the 2006 Census, the accuracy of ASGC areas diminish due to subsequent changes in demographics within some postcode boundaries, and some boundaries themselves may have changed over time.

Breakdown of remoteness and socioeconomic status categories by State and Territory introduces an additional source of inaccuracy because of the potential for some women to be allocated to a state or territory different to the one in which they reside. State and territory totals for SA, WA and the NT are affected by cross-border issues that make it impossible to allocate State or Territory of residence with absolute accuracy. Therefore rates for these jurisdictions should be treated as estimates only.

Timeliness

The most recent data available for the 2012 RoGS report are based on the two-year calendar period 1 January 2009 to 31 December 2010. 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. However, States and Territories are unable to check or verify participation by State and Territory of residence. States and Territories are also unable to check or verify participation by remoteness, since their data, once supplied to the AIHW, are nationalised and thereby lose their state or territory identity.

Concordances to allocate women screened to a remoteness area by their postcode are based on 2006 boundaries and classifications, while the current data for this indicator are for 2009 and 2010. Overall, some postcodes may not have valid POA-based remoteness data available, and some may have changed classification group since 2006 and no longer be accurate. This may affect some remoteness areas more than others.

Further, there may not be a postcode for all women screened, or the postcode supplied may not be valid.

The number of women screened in 2009 and 2010 that are unable to be allocated to a remoteness area are as follows (based on state or territory of postcode): 1138 women excluded (NSW: 97 excluded; Vic: 564 excluded; Qld: 256 excluded; WA: 2 excluded; SA: 8 excluded; Tas: 11 excluded; ACT: 11 excluded; NT: 189 excluded). No adjustments have been made to account for excluded women in the data.

Women residing in postcodes that cross boundaries are allocated to the state or territory according to ABS classifications. Women are counted only once in the two-year period 1 January 2009 to 31 December 2010, even if they were screened more than once during this period. All women screened in each State and Territory are included in order to present the most accurate national picture of cervical screening. This may lead to a small amount of double-counting, since one woman could be screened, and therefore counted, in two different jurisdictions over this two-year period, or a woman's screening record may appear on two cervical cytology registers.

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.

Cell suppression was required for some data due to denominators less than 1000 or due to rates that were unable to be sensibly estimated.

ERP data are provided by the ABS.

Coherence

Some of these data are published annually in Program monitoring reports prepared by the AIHW.

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 2008- 2009*.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following 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 for vaccine-preventable, acute and chronic conditions

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations
Measure (computation)	Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions. The *numerator* is the number of separations for selected potentially preventable hospitalisations, divided into three groups: • Vaccine-preventable conditions - Influenza and Pneumonia - Other vaccine preventable conditions (e.g. tetanus, measles, mumps, rubella - Total. • Acute conditions - Appendicitis with generalised peritonitis - Cellulitis - Convulsions and epilepsy - Dehydration and gastroenteritis - Dental conditions - Ear, nose and throat infections - Gangrene - Pelvic inflammatory disease - Perforated/bleeding ulcer - Pyelonephritis - Total - Total (excluding dehydration and gastroenteritis) • Chronic conditions - Angina - Asthma - Chronic obstructive pulmonary disease - Congestive heart failure - Diabetes complications (principal diagnosis only) - Hypertension - Iron deficiency anaemia - Nutritional deficiencies - Rheumatic heart disease - Total - Total (excluding diabetes complications). • Total selected potentially preventable hospitalisations • Total selected potentially preventable hospitalisations (excluding dehydration and gastroenteritis and excluding diabetes complications). The *denominator* is the Estimated Resident Population. 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 ICD-10-AM diagnosis codes and/or ACHI procedure codes in scope for each category of potentially preventable hospitalisations (see Appendix 5, *Australian hospital statistics 2009-10*).

Calculation is 1000 × (Numerator ÷ 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.

Denominator:

For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2009.

For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June 2009.

For data by remoteness: ABS ERP as at 30 June 2009, by remoteness areas, as specified in the Australian Standard Geographical Classification.

Computation:

1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

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 further information see the AIHW website.

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.

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

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 number of overnight separations is considered to be more comparable than the total number of separations among jurisdictions and between the public and private sectors. This is because variation in admission practices and policies mainly lead to variation in the number of same-day admissions among providers.

'Non-Indigenous' includes hospitalisations of non-Indigenous people and those for whom Indigenous status was not stated.

Analysis by state and territory and remoteness is based on the usual residence of the patient, not the location of the hospital.

Timeliness

The reference period for this data set is 2009-10.

Accuracy

For 2009-10, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory 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.

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.

The Indigenous status data are of sufficient quality for statistical reporting purposes for the following jurisdictions: NSW, Vic, Qld, SA, WA, NT (public hospitals only). National totals include these six jurisdictions only. Indigenous status data reported for Tasmania and ACT (public and private hospitals) should be interpreted with caution until further assessment of Indigenous identification is completed.

Variation in hospitalisation rates data for Indigenous people is affected by variation across states and territories in the completeness of Indigenous identification in hospital admitted patient data. Care must be taken in comparing hospital separations data for Indigenous people. Data reported for Indigenous people are not necessarily representative of other jurisdictions. 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 eHealth 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 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.

Data for the chronic diseases category diabetes complications exclude separations with an additional diagnosis of diabetes complications. Variations in both admission and administration practices 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.

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).

Coherence

The information presented for this indicator is calculated using the same methodology as data published in the *National healthcare agreement: performance report 2009-10* and *Australian hospital statistics 2009-10*. However, Australian hospital statistics does not exclude separations with an additional diagnosis of diabetes complications (for chronic conditions) and separations with dehydration and gastroenteritis (for acute conditions)

Caution should be used in comparing 2007-08 data with future years as changes between ICD-10-AM 5th edition and ICD-10-AM 6th edition and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes, and increased reporting of gastroenteritis (chronic and acute categories, respectively, 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.

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.

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 cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data on Indigenous status reported for Tasmania and the ACT should be interpreted with caution until an assessment of Indigenous identification is completed. Data for these jurisdictions are not included in the national total.
- 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.

Selected potentially preventable hospitalisations for diabetes

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations
Measure	Selected potentially preventable hospitalisations for diabetes.
(computation)	The *numerator* is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups: • Circulatory complications (E11.5x) • Coronary heart disease (I20-I25) • Stroke (I60-I69) • Disease of arteries (I70-I79) • Other circulatory • Total circulatory diseases (I00-I99) • 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. The *denominator* is the Estimated Resident Population. 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 for diabetes are defined by ICD-10-AM diagnosis codes. Calculation is 100 000 × (Numerator ÷ 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 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. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2009. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. 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 further information see the AIHW website. 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. 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
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.
Timeliness	The reference period for this data set is 2009-10.
Accuracy	For 2009-10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory 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. 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. Variations in both admission and administration practices 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. The number of overnight separations is considered to be more comparable than the total number of separations among jurisdictions and between the public and private sectors. This is because variation in admission practices and policies, mainly lead to variation in the number of same-day admissions among providers.

	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.
Coherence	The information presented for this indicator is calculated using the same methodology as other potentially preventable hospitalisations data published in *Australian hospital statistics 2009-10* and the *National healthcare agreement: performance report 2009-10*. Changes between the ICD-10-AM 5th edition (used in 2007-08) and ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparing 2007-08 data with data for subsequent periods.
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.
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 cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

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.

Potentially preventable hospitalisations of older people for falls

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations
Measure (computation)	Potentially preventable hospitalisations of older people for falls. The number of hospitalisations for persons aged 65 years and over with a reported external cause of falls, per 1000 persons. The *numerator* is the number of hospitalisations for persons aged 65 years and over with a reported external cause of falls. The *denominator* is the Estimated Resident Population. 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 for falls are defined by ICD-10-AM external cause codes (W00–W19). Calculation is 1 000 × (Numerator ÷ Denominator), presented as a number per 1 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 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. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. 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 further information see the AIHW website. 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. 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

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 number of overnight separations is considered to be more comparable than the total number of separations among jurisdictions and between the public and private sectors. This is because variation in admission practices and policies mainly lead to variation in the number of same-day admissions among providers.

Timeliness

The reference periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10.

Accuracy

For 2005-06 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT and five small hospitals in New South Wales. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT and the single private free-standing day hospital facility in the NT.

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.

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.

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.

For 2009-10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory 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.

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.

	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.
Coherence	Data for this indicator are comparable over time.
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.
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