
11 Primary and community health

CONTENTS

11.1 Profile of primary and community health	11.2
11.2 Framework of performance indicators	11.14
11.3 Key performance indicator results	11.17
11.4 Future directions in performance reporting	11.88
11.5 Definitions of key terms	11.90
11.6 List of attachment tables	11.94
11.7 References	11.98

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 Australians, public dental services, drug and alcohol treatment and the PBS. The scope of this chapter does not extend to:

- public hospital emergency departments and outpatient services (reported in chapter 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' and chapter 14, 'Services for people with a disability').

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 in this edition include:

- data are available for the first time for reporting against ‘public dentistry waiting times’
- improved data for reporting of ‘management of acute upper respiratory tract infection’
- reporting time series for the first time for some indicators, and extending time series for several others
- data quality information (DQI) available for the first time for the indicators ‘use of pathology tests and diagnostic imaging’ and ‘cost to government of general practice per person’.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by governments include general practice, community health services, the PBS and public dental services. The Australian Government provides some funding for private dental and allied health services through the private health insurance rebate and, through the Department of Human Services, Medicare (DHS, Medicare), for people with long-term health conditions and/or mental health problems. Funding of private dental services for people with long-term health conditions through DHS, Medicare ceased 1 December 2012.

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 practitioners must be registered with the Medical Board of Australia. General practice data reported in this chapter relate mainly to services provided by those general practitioners who are recognised for Medicare as defined below:

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

Services provided in general practice include:

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

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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (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 2012 was \$5.80 for concession card holders and up to \$35.40 for general consumers (DoHA 2012a). The Australian Government pays the

remaining cost of medicines eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year. (DoHA 2012a).

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 2012 safety net threshold was \$1363.30 for general consumers and \$348.00 for concession card holders (DoHA 2012a).

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 Australians. 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 allied health services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with 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, through DHS, Medicare, for a limited range of oral surgical procedures. Private dental services were also funded through DHS, Medicare for people with chronic conditions and complex care needs until 1 December 2012. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force and has a role in the provision of dental services through 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 DHS, Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual *Bettering the Evaluation and Care of Health* (BEACH) survey of general practice activity in Australia found that 95.0 per cent of all general practice encounters in 2011-12 were for services at least partly funded by DHS, Medicare or the DVA (Britt *et al.* 2012) (table 11.1).

Table 11.1 General practice encounters and funding sources, April 2011 to March 2012^{a, b}

	Number ^c	Per cent of all encounters ^d	95% LCL	95% UCL
Total encounters for which BEACH data were recorded ^e	91 956	100.0	..	..
Direct encounters	90 429	98.3	98.1	98.6
No charge	450	0.5	0.3	0.7
DHS, Medicare or DVA paid	87 264	94.9	94.4	95.4
Workers compensation paid	1 853	2.0	1.8	2.2
Other paid (for example, hospital, State)	862	0.9	0.7	1.2
Indirect encounters ^f	1 522	1.7	1.4	1.9

LCL = lower confidence limit. UCL = upper confidence limit. DHS = Department of Human Services. DVA = Department of Veterans' Affairs. ^a An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals). ^b Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. ^c Number of encounters after post stratification weighting for GP activity and GP age and sex. ^d Missing data removed from analysis ($n = 7074$). ^e Includes 5 encounters for which direct/indirect was not specified. ^f For indirect encounters, the patient is not seen but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al.* (2012) *General practice activity in Australia 2011-12*, 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 (GPPII)
- the Divisions of General Practice Program (DGPP) — from 30 June 2012, Medicare Locals assumed responsibility for general practice support initiatives previously funded under the DGPP.

Australian Government expenditure on general practice in 2011-12 was \$6.7 billion, or \$299 per person (figure 11.36, 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 Australians and people living in rural and remote areas.

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues such as diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around \$8.0 billion in 2011-12. Expenditure on the PBS was around \$7.5 billion — or \$335 per person — in 2011-12, of which 77.8 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health sector overview.

Table 11.2 PBS and RPBS expenditure, 2011-12 (\$ million)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^b	538.6	400.3	322.0	200.3	118.9	37.5	34.3	10.0	1 661.9
PBS concessional ^c	2 040.2	1 450.3	1 127.5	499.7	503.4	170.8	57.4	17.0	5 866.3
PBS doctor's bag	4.3	3.3	2.8	1.0	1.0	0.3	0.2	0.1	13.0
PBS total^d	2 583.1	1 853.9	1 452.3	701.0	623.3	208.6	91.9	27.0	7 541.2
RPBS total ^e	156.3	88.7	108.3	35.8	33.5	13.6	6.8	0.9	444.0
PBS and RPBS Total	2 739.4	1 942.6	1 560.7	736.8	656.8	222.3	98.7	27.9	7 985.1
PBS \$ per person ^f	355.8	332.0	321.2	293.2	378.3	407.1	247.5	116.1	334.8

^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 Funding for supplies to prescribers for use in a medical emergency. ^e Includes RPBS general ordinary and safety net. ^f Excludes PBS doctor's bag.

Source: DoHA (unpublished) PBS Statistics; tables 11A.3 and 11A.4.

Community health services

Overall government expenditure data relating only to the services covered in this chapter are not available. Expenditure data reported here also cover services such as

food safety regulation and media campaigns to promote health awareness, as well as private dental services (funded by health insurance premium rebates and non-government expenditure) (table 11.3).

In 2010-11, government expenditure on community and public health was \$7.9 billion, of which State, Territory and local governments provided 73.8 per cent, and the Australian Government 26.2 per cent (table 11.3). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the DVA and DoHA, was \$908 million. State, Territory and local government expenditure on dental services was \$699 million in 2010-11. 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, 2010-11 (\$ million)

	<i>Australian Government</i>				<i>State, Territory and local government</i>	<i>Total government^c</i>	<i>Total Non-govern ment</i>	<i>Total government and non-govern ment^c</i>
	<i>DVA</i>	<i>DoHA and other^a</i>	<i>Insurance premium rebates^b</i>	<i>Total^c</i>				
Community and public health ^d	1	2 066	–	2 068	5 822	7 890	351	8 242
Dental services	105	803	528	1 437	699	2 136	5 721	7 857

^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. – Nil or rounded to zero.

Source: AIHW (2012) *Health Expenditure Australia 2010-11*, Cat. no. HWE 56.

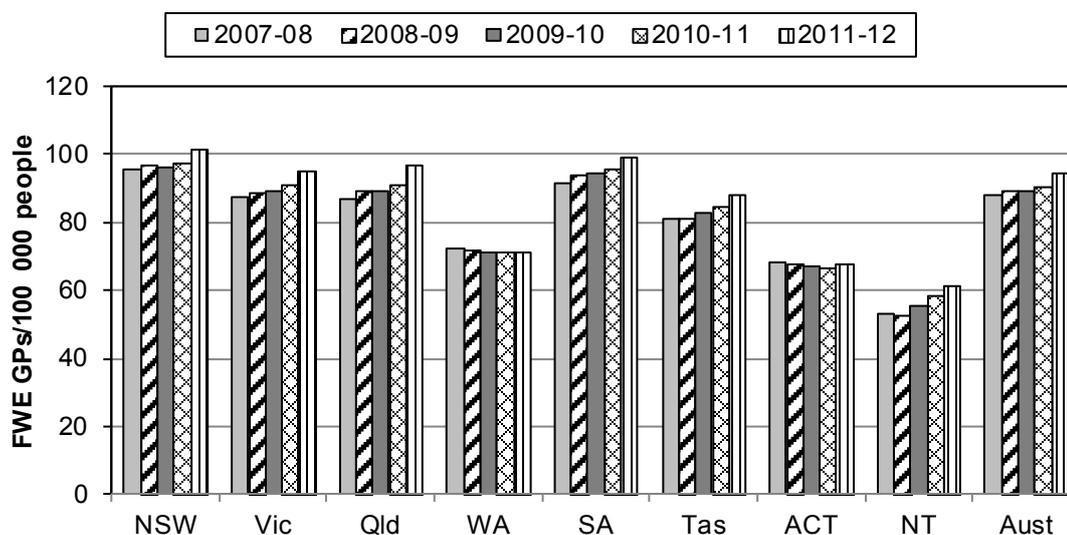
Size and scope

General practice

There were 29 011 vocationally registered GPs and OMPs billing Medicare Australia, based on MBS claims data, in 2011-12. On a full time workload equivalent (FWE) basis, there were 21 119 vocationally registered GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 93.9 FWE registered GPs and OMPs per 100 000 people (table 11A.5). These data exclude services

provided by GPs working in Indigenous primary healthcare services, public hospitals and the Royal Flying Doctor Service. In addition, for some GPs — particularly in rural areas — MBS claims provide income for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through DHS, Medicare. The numbers of FWE vocationally registered 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, b}**

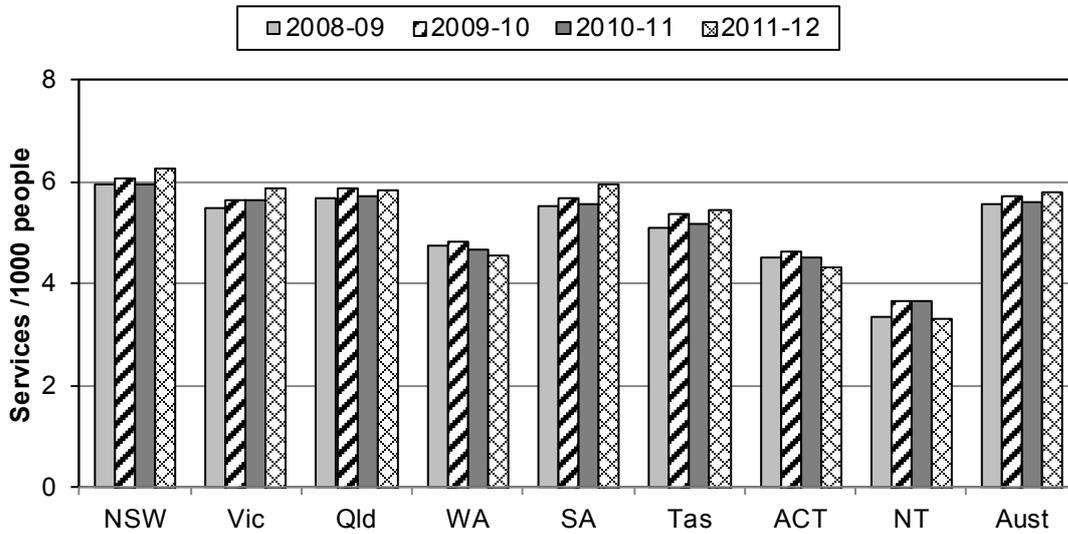


^a Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice. ^b Historical data may differ from data in previous reports due to a change in the methodology used to derive population estimates.

Source: DoHA (unpublished) MBS Statistics; table 11A.5.

Nationally, around 5763 general practitioner-type services were provided per 1000 population under DHS, Medicare in 2011-12 (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 for 2010-11 and previous years. Data for 2011-12 are preliminary and are not directly comparable with data for previous years. ^b Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.

Source: DoHA (unpublished) MBS Statistics; DVA (unpublished) ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.6.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 195 million services — 86.5 per cent of them concessional — were provided under the PBS in 2011-12 (table 11.4). This amounted to 8.7 filled prescriptions per person. A further 13 million services were provided under the RPBS in the same period.

Table 11.4 PBS and RPBS services, 2011-12 (million services)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^a	8.5	6.3	5.2	2.9	1.9	0.6	0.6	0.2	26.1
PBS concessional ^b	57.2	42.8	32.7	14.2	14.6	5.0	1.6	0.5	168.5
PBS doctor's bag ^c	0.1	0.1	0.1	–	–	–	–	–	0.3
PBS total	65.9	49.2	37.9	17.1	16.4	5.6	2.1	0.6	194.9
RPBS total ^d	4.4	2.8	3.1	1.0	1.0	0.4	0.2	–	13.0
Total	70.3	52.0	41.0	18.1	17.5	6.0	2.3	0.7	207.8
PBS services per person ^e	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7

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

Source: DoHA (unpublished) PBS Statistics; tables 11A.7 and 11A.8.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.88–11A.96 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.88–11A.96).

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 2011-12 targeted at disadvantaged people (tables 11A.88–11A.96). As updated data were not available for use of public dental services for the 2013 Report, data for 2010 are reported again.

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}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Emergency services ^e	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4

^a Rates are age standardised to the Australian population at 30 June 2001. ^b Limited to dentate people aged 5 years or over. ^c Data are for the number of people who used a public dental service at least once in the preceding 12 months, not for the number of services provided. ^d Type of service at the most recent visit. ^e Emergency visit is a visit for relief of pain.

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished), *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.9.

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 (AODTS–NMDS) — a collection of data from publicly funded government and non-government treatment services (AIHW 2012a). Treatment activities excluded from that collection 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 Australians 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 666 alcohol and other drug treatment agencies reported 2010-11 data to the AODTS–NMDS. Of these, 309 (46.4 per cent) identified as government providers and 357 (53.6 per cent) as non-government providers (table 11A.10). There were 150 488 reported closed treatment episodes in 2010-11 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.9 per cent of whom were male, accounted for 144 002 closed treatment episodes (AIHW 2012a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (47.3 per cent). Cannabis was the next most common drug of concern (22.1 per cent), followed by heroin (9.3 per cent) and amphetamines (8.7 per cent) (AIHW 2012a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.88–11A.96.

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 2011-12, 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.88–11A.96).

From the 2008-09 reporting period, data on Indigenous primary healthcare services that receive funding from the Australian Government have been collected through the Online Services Report (OSR) (previously the OATSIH Services Report)

questionnaire. 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 2010-11, OSR data are reported for 235 Indigenous primary healthcare services (table 11A.11). Of these services, 90 (38.3 per cent) were located in remote or very remote areas (table 11A.12). 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.13). 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 2.5 million episodes of healthcare were provided by participating services in 2010-11 (table 11.6). Of these, around 1.2 million (47.6 per cent) were in remote or very remote areas (table 11A.12).

Table 11.6 Estimated episodes of healthcare for Indigenous Australians by services for which OSR data are reported ('000)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	452.1	160.2	335.7	305.7	191.3	34.7	23.2	593.0	2 095.9
2009-10	542.4	184.8	378.8	408.8	191.6	36.2	25.7	614.6	2 382.9
2010-11	521.8	200.5	309.7	473.1	221.8	37.7	29.7	703.8	2 498.1

^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 (2012 and previous issues) *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results*, Cat. no.s IHW 31, 56 and 79; table 11A.11.

The services included in the OSR data collection employed around 3644 full time equivalent health staff (as at 30 June 2011). Of these, 1934 were Indigenous Australians (53.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous Australians were relatively low (7.2 per cent and 9.1 per cent, respectively) (table 11A.14).

11.2 Framework of performance indicators

The performance indicator framework is based on 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 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. The NHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

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.

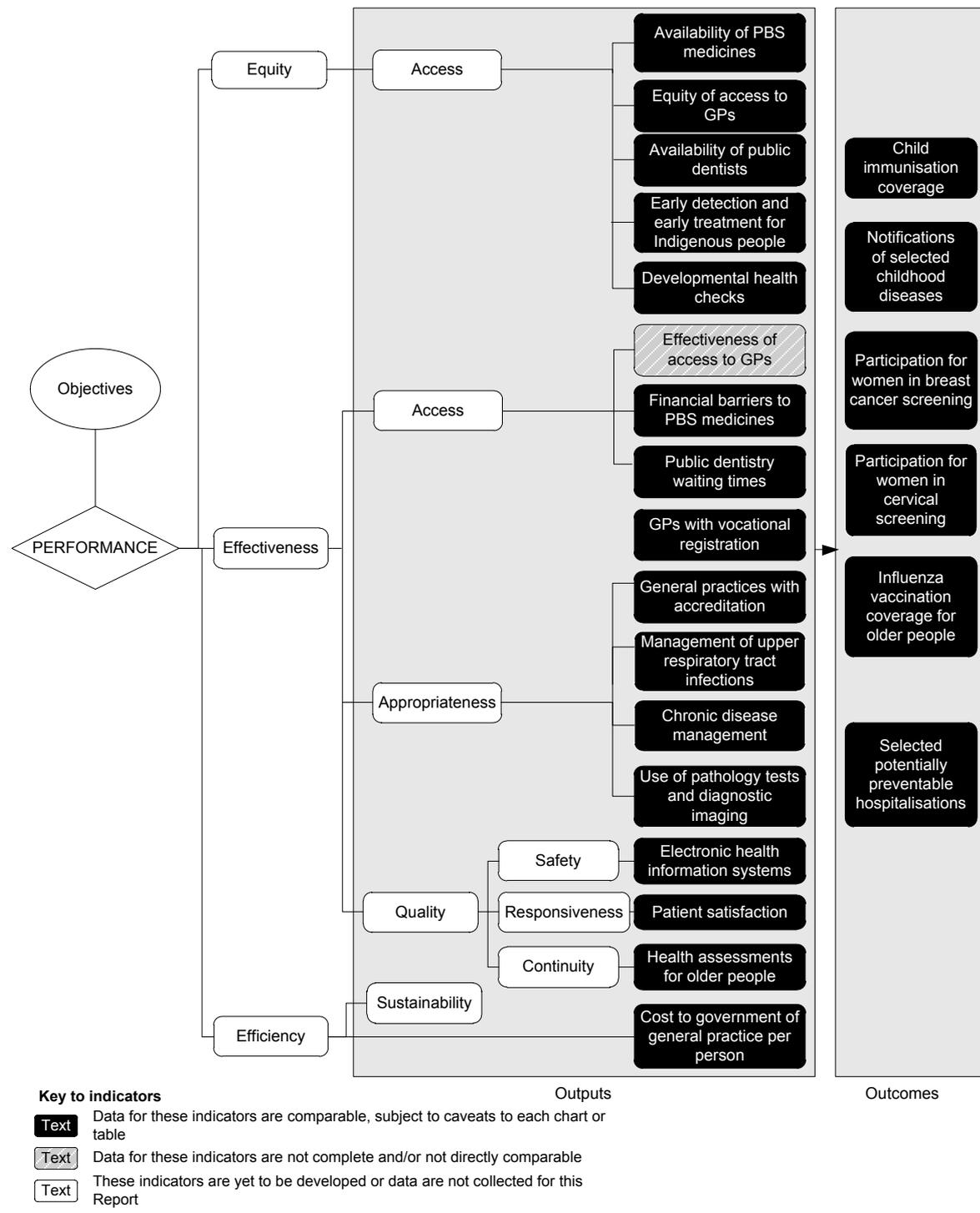
In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

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 2013 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 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



Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS' data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.

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 Australians 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.

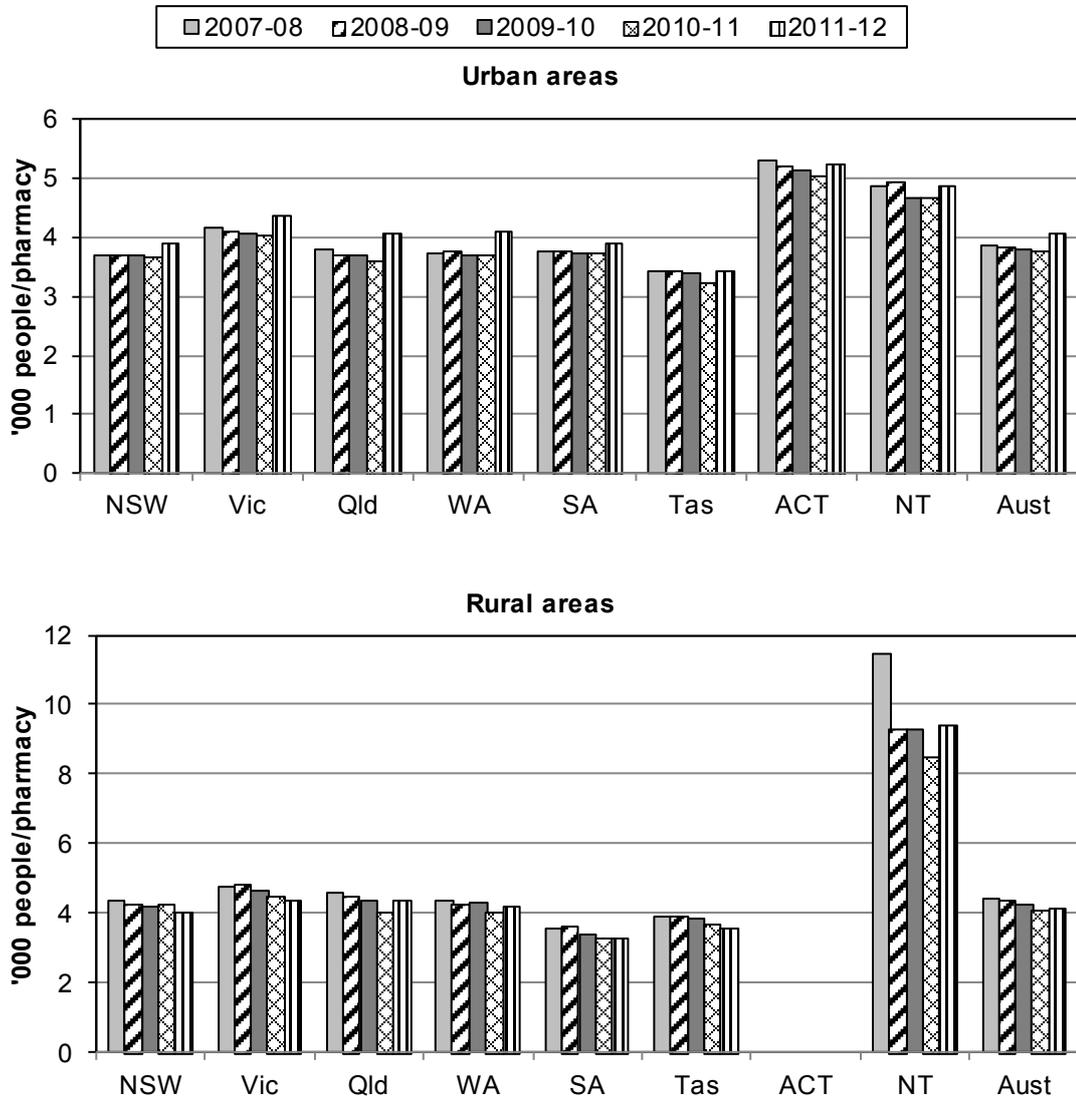
Data quality information for this indicator is under development.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 4082 people per pharmacy in urban areas and 4148 in rural areas in 2011-12. 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.15).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 41 medical practitioners and 246 hospitals — 91 private and 155 public¹ — approved to supply PBS medicines to the community in 2011-12. The approved medical practitioners and 51 of the approved public hospitals were located in rural areas (table 11A.15).

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^{a, b}

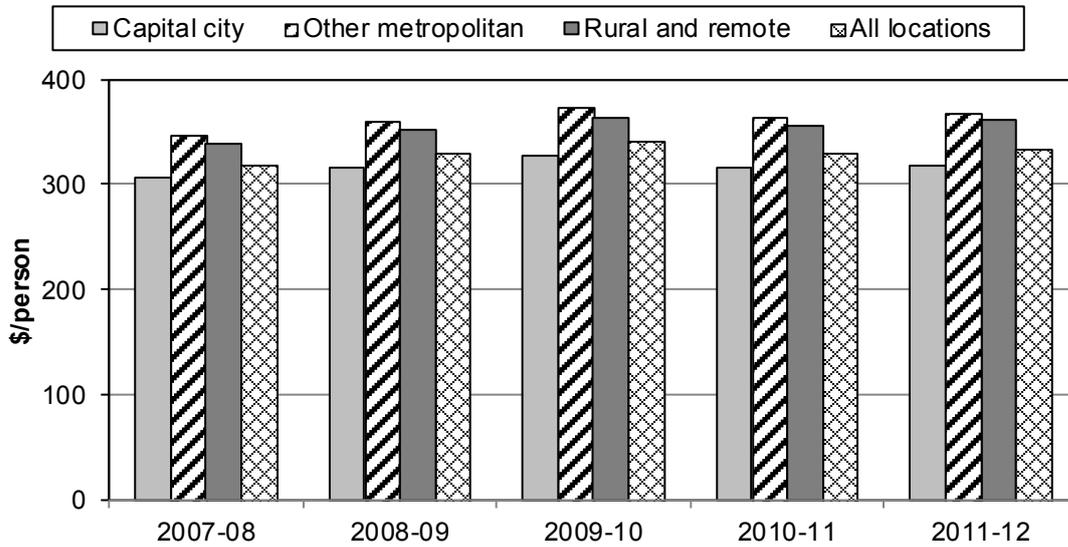


^a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. ^b Excludes RPBS and doctor's bag.

Source: DoHA (unpublished) derived from DHS, Medicare, ABS 2006 Census of Population and Housing and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems; table 11A.15.

Nationally, PBS expenditure per person increased from \$319 in 2007-08 to \$335 in 2011-12 (in 2011-12 dollars) (figure 11.5). PBS expenditure per person was lower in capital cities than in other metropolitan, rural and remote areas for the period.

Figure 11.5 PBS expenditure per person (2011-12 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.16.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.7. These data are not available by regional location. Nationally, 86.5 per cent of prescriptions subsidised under the PBS were concessional in 2011-12.

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.

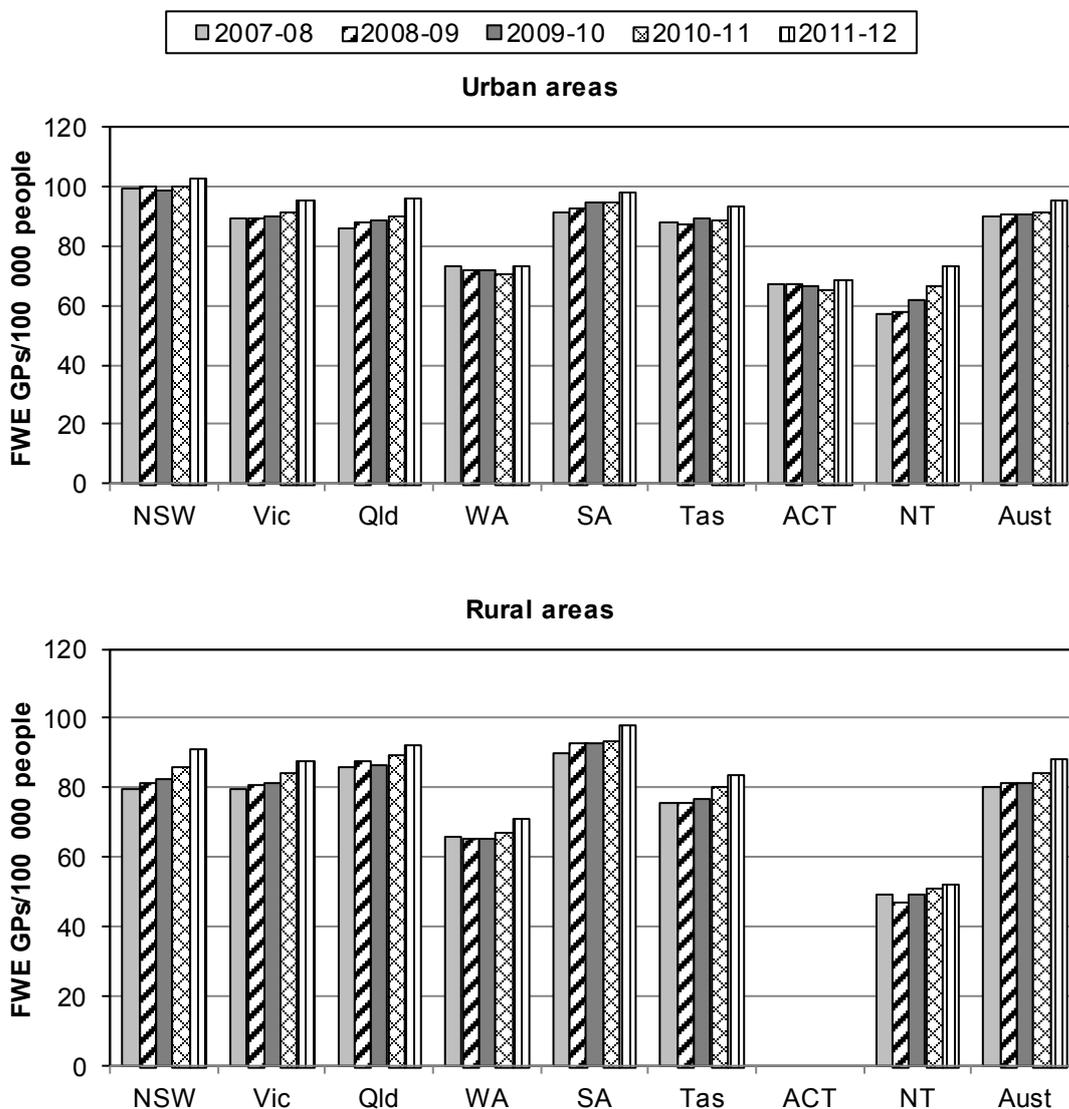
Data for this indicator are comparable.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

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 almost all states and territories in 2011-12 (figure 11.6). The bulk billed proportion of non-referred attendances was lower in remote centres and, to a lesser extent, rural areas than in capital cities, other metropolitan centres and 'other remote' areas (table 11A.26).

Figure 11.6 Availability of GPs (full time workload equivalent), 2011-12^{a, b, c}



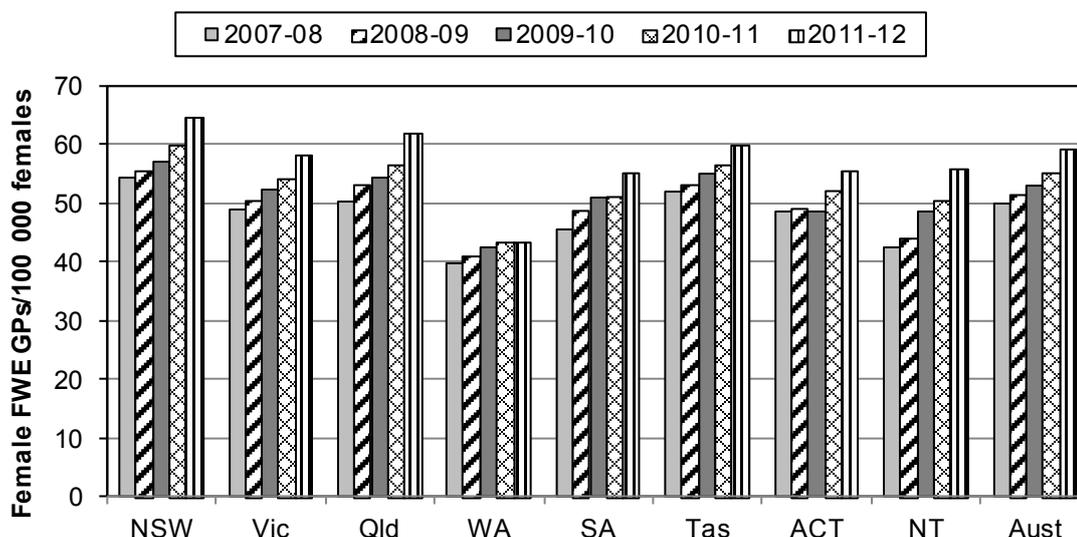
^a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas. ^b FWE GP numbers include vocationally registered GPs and OMPs billing DHS, 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.17.

Equity of access to GPs — availability of female GPs

In 2011-12, 41.7 per cent of Australia's GPs — 31.7 per cent of FWE GPs — were female (tables 11A.5 and 11A.18). The number of FWE GPs per 100 000 females increased from 49.8 to 59.3 in the period 2007-08 to 2011-12 (figure 11.7).

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



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

Source: DoHA (unpublished) MBS Statistics; table 11A.18.

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.

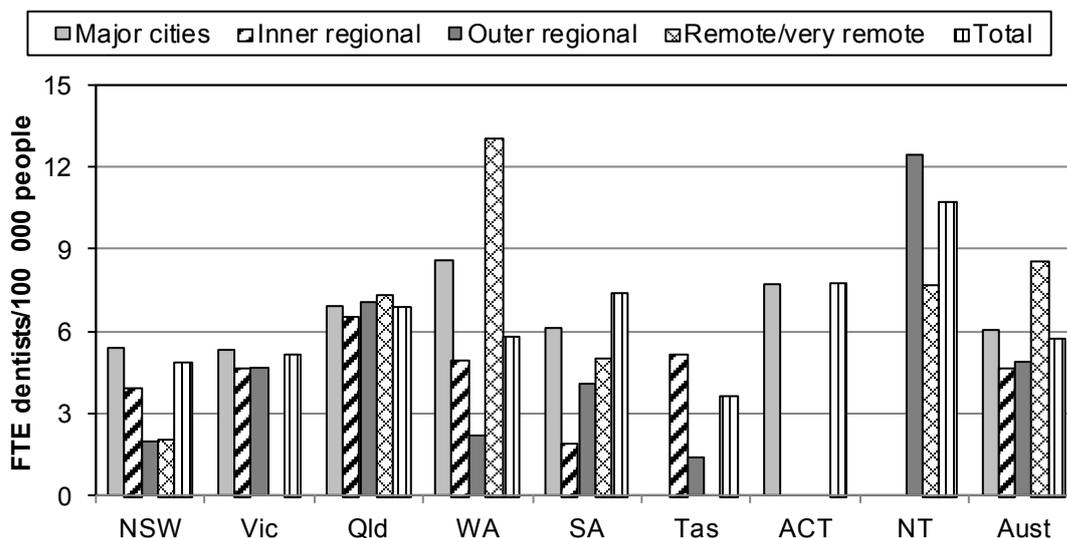
Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Nationally, there were more FTE public dentists per 100 000 people in remote and very remote areas combined than in major cities or regional areas in

2011 (figure 11.8, table 11A.19). Data for FTE dental therapists are presented in table 11A.20.

Figure 11.8 **Availability of public dentists, 2011^{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 Health Workforce Data Set; table 11A.19.

Early detection and early treatment for Indigenous Australians

'Early detection and early treatment for Indigenous Australians' is an indicator of governments' objective to provide equitable access to primary and community healthcare services for Indigenous Australians (box 11.5).

Box 11.5 Early detection and early treatment for Indigenous Australians

'Early detection and early treatment for Indigenous Australians' is defined as:

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

(Continued next page)

Box 11.5 (Continued)

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

- The proportion of older people who received a health assessment by Indigenous status, where
 - older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous Australians become eligible for ‘older’ people’s services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector overview)
 - health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing.
- The proportion of older Indigenous Australians who received a health assessment in successive years of a five year period.
- The proportion of Indigenous Australians 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 Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Indigenous Australians. An increase over time in the proportion of older Indigenous Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Indigenous Australians 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.

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.

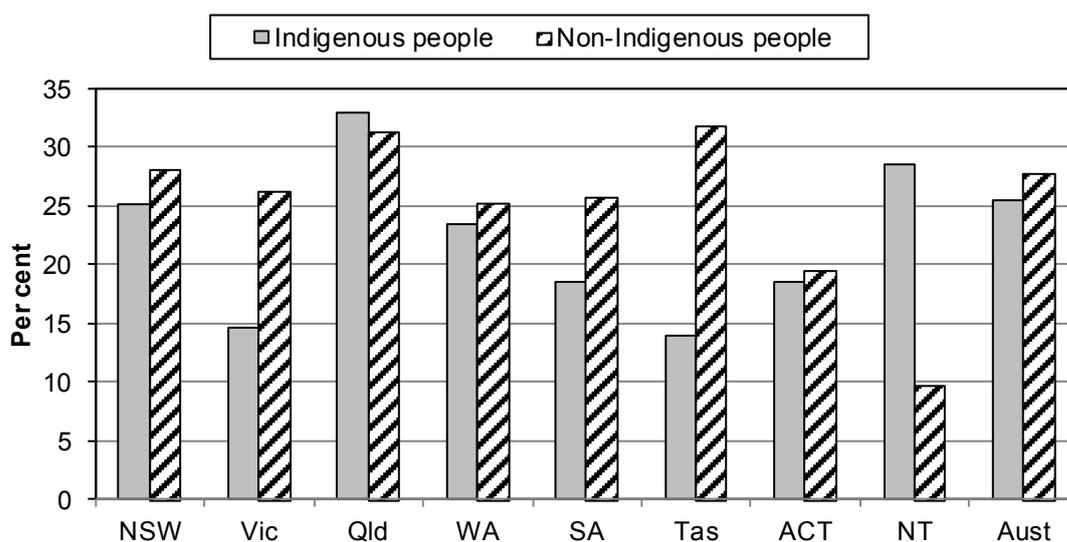
Data for this indicator are comparable.

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 Australians (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 2011-12, the proportion of Indigenous older Australians who received an annual health assessment was lower than the proportion of non-Indigenous older Australians who received an annual health assessment in all jurisdictions except the NT and Queensland (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, 2011-12^{a, b}

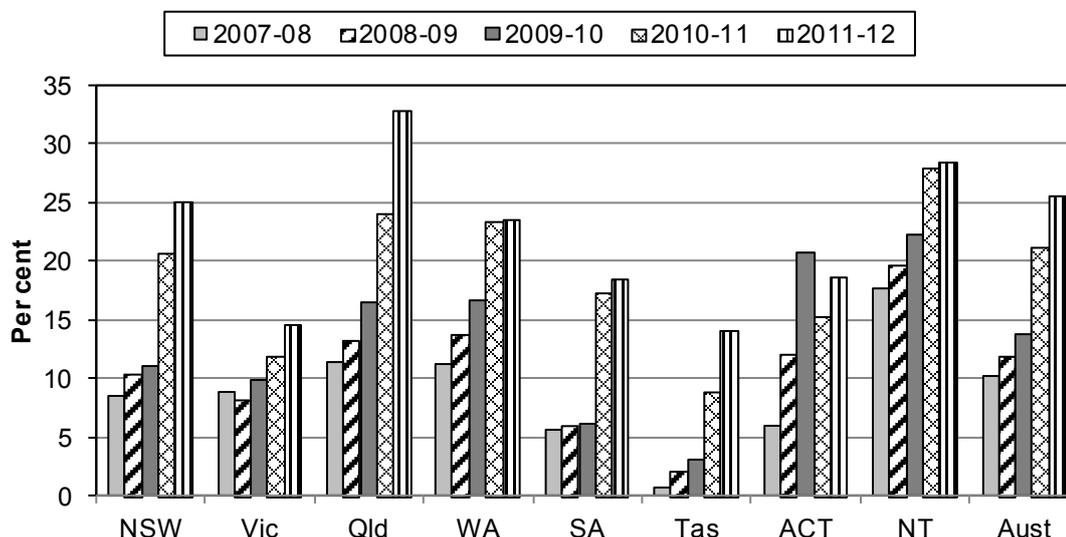


^a Older people are defined as Indigenous Australians aged 55 years or over and non-Indigenous Australians aged 75 years or over. ^b Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive a health assessment under the 'all older people' MBS items.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

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 (2011) *Australian demographic statistics June quarter 2011*, Cat. no. 3101.0; table 11A.21.

The proportion of older Indigenous Australians who received an annual health assessment increased in nearly all jurisdictions between 2007-08 and 2011-12 (figure 11.10).

Figure 11.10 Older Indigenous Australians who received an annual health assessment^a



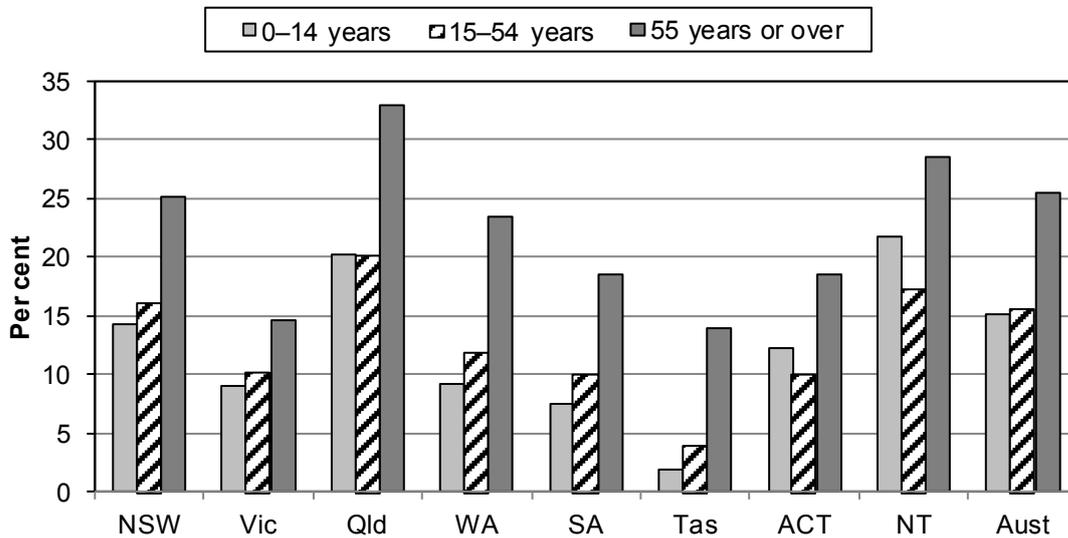
^a Older people are defined as Indigenous Australians aged 55 years or over. Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect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

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.22.

Health check MBS items were introduced for Indigenous Australians 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 Australians who received a health check or assessment by age, 2011-12^a

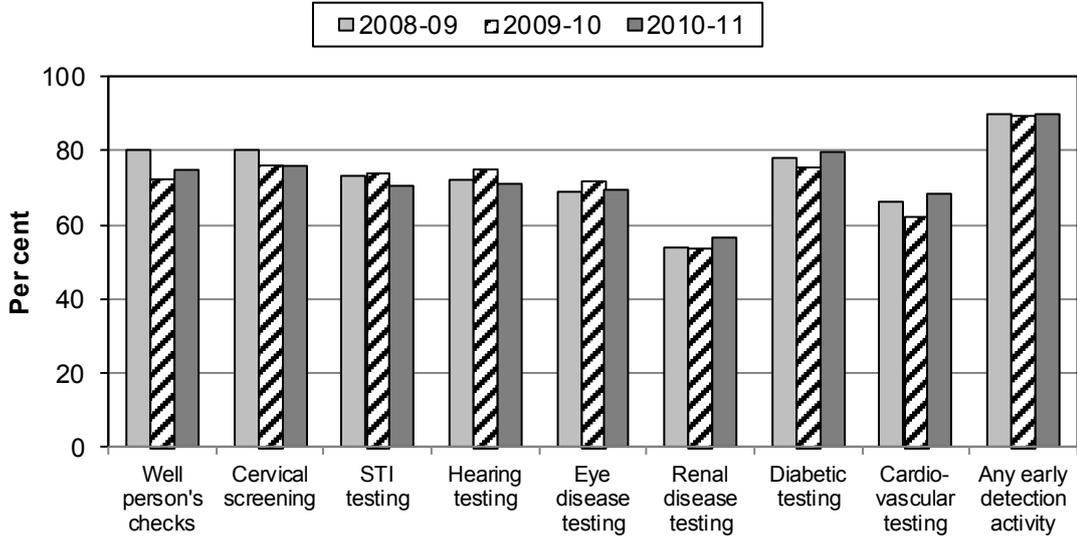


^a Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy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

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.23.

Nationally, the proportion of Indigenous primary healthcare services providing early detection services varied little in the period 2008-09 to 2010-11 (figure 11.12).

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 (2012 and previous issues) *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results, 2008-09, 2009-10 and 2010-11*, Cat. no.s IHW 31, 56 and 79; table 11A.24.

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 DHS, 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 or 4 years, while the 'Aboriginal and Torres Strait Islander Peoples Health Assessment' item is available to Indigenous Australians.

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 or 4 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.

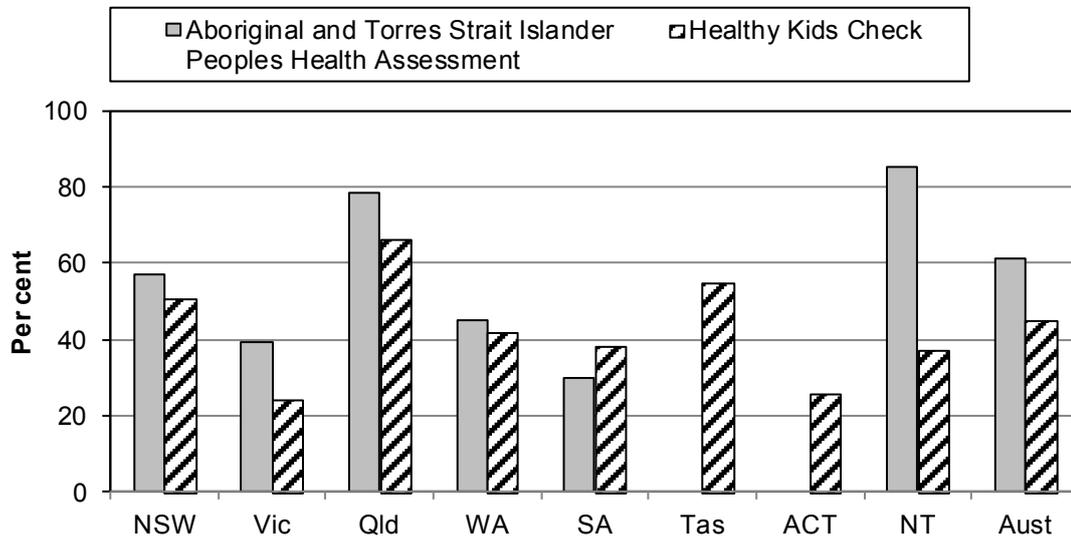
This indicator provides no information about developmental health checks for children that are provided outside DHS, Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community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

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Nationally, 45.8 per cent of children received a fourth year developmental health check under DHS, Medicare in 2011-12. The proportion of Indigenous children who received an Aboriginal and Torres Strait Islander Peoples Health Assessment in their fourth year 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, 2011-12^{a, b, c, d, e, f}**



^a Limited to health checks available under DHS, Medicare. ^b Aboriginal and Torres Strait Islander Peoples Health Assessment data include claims for MBS Item 715 for children aged 3–5 years. ^c Healthy Kids Check data include claims for MBS Items 701, 703, 705, 707 and 10 986 for children aged 3–5 years. ^d Children are counted once only; 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. ^f Aboriginal and Torres Strait Islander Peoples Health assessment data for Tasmania and the ACT are not published due to small numbers, but are included in the data for Australia.

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.25.

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.

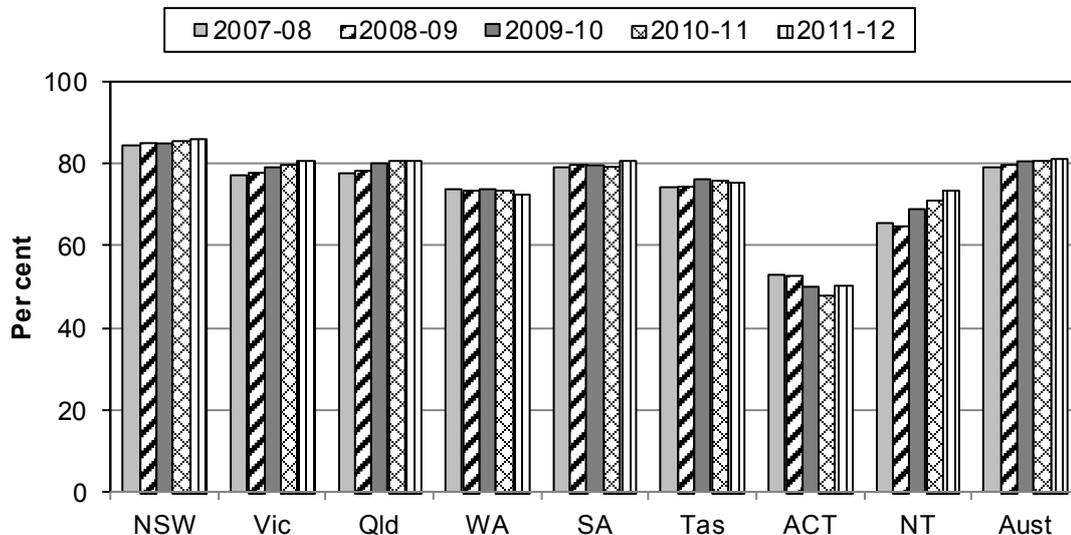
Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Effectiveness of access to GPs — bulk billing rates

Patient visits to GPs are either bulk billed, or the patient is required to pay part of the cost of the visit. GP visits are classed as non-referred attendances under DHS, Medicare. Where a patient is bulk billed they make no out-of-pocket contribution; the GP bills DHS, Medicare directly and, since 1 January 2005, receives 100 per cent of the Schedule fee (the patient rebate) as full payment for the service. The 100 per cent DHS, Medicare rebate applies to most GP services.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 81.5 per cent in 2011-12. For most jurisdictions, this proportion increased in the period 2007-08 to 2011-12 (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.26). 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.27).

Figure 11.14 GP visits that were bulk billed^{a, b}



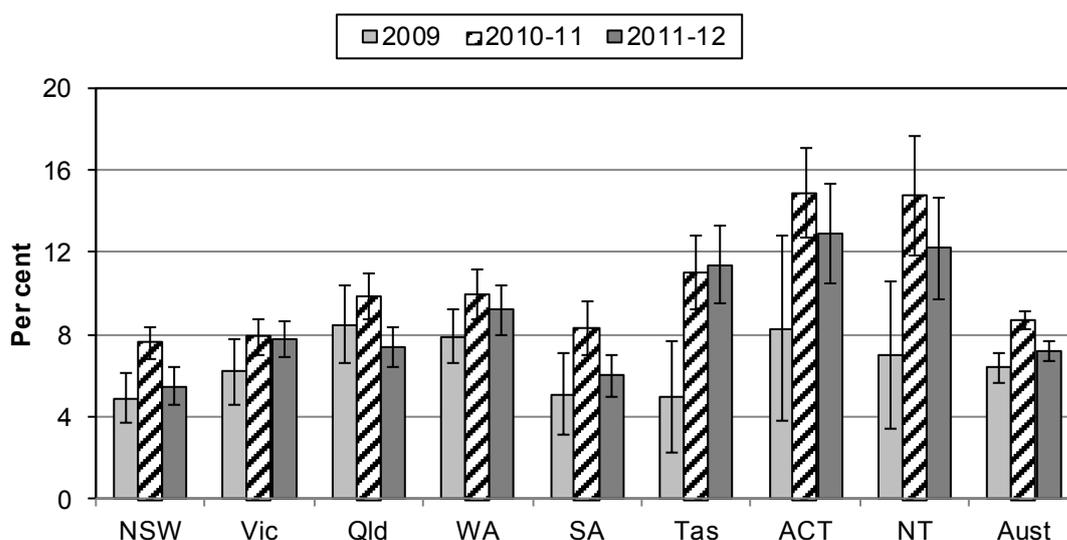
^a Includes attendances by practice nurses. ^b Allocation to State/Territory based on patients' DHS, Medicare enrolment postcode.

Source: DoHA (unpublished) MBS Statistics; table 11A.27.

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 2011-12, 7.2 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}



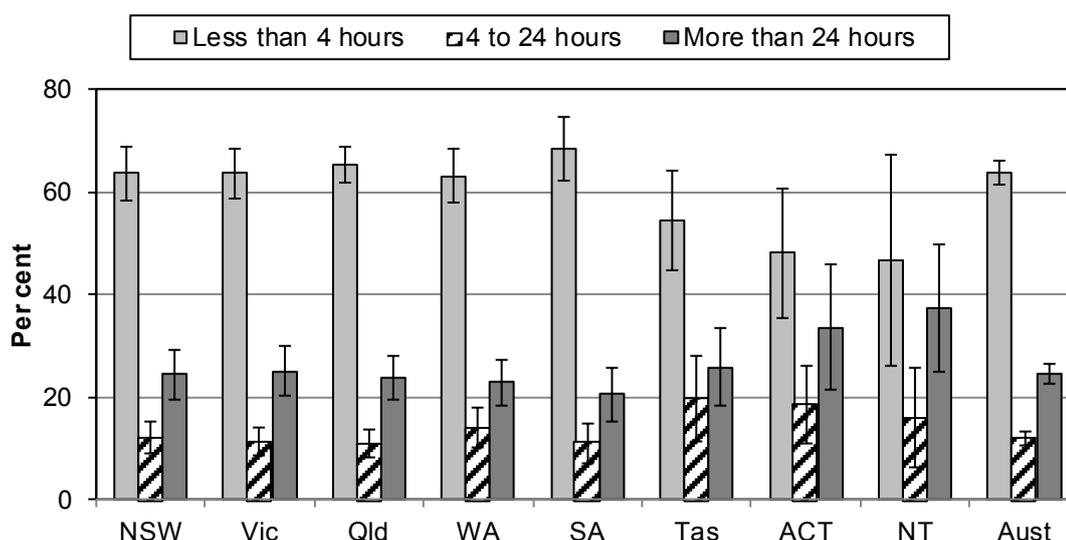
^a People aged 15 years or over. ^b Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. ^c Rates are age standardised to the Australian population at 30 June 2001. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2009, 2010-11, 2011-12*, Cat. no. 4839.0; table 11A.28.

Effectiveness of access to GPs — GP waiting times

Nationally, 63.6 per cent of people who saw a GP for urgent care waited less than 4 hours in 2011-12 (figure 11.16). Around 12.0 per cent waited from 4 to less than 24 hours, and 24.4 per cent waited for 24 hours or more. For visits to GPs not requiring urgent care, 27.4 per cent of people waited longer than they felt was acceptable to get an appointment (table 11A.30).

Figure 11.16 Hours waited for urgent treatment by GP, 2011-12^{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 2011-12*, Cat. no. 4839.0; table 11A.29.

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 2011-12 (table 11.7). Data are presented by Indigenous status and remoteness in table 11A.31.

Table 11.7 GP-type presentations to emergency departments ('000)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12	684.9	545.1	378.0	283.1	103.9	59.8	47.8	40.9	2 143.6

^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.32.

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.

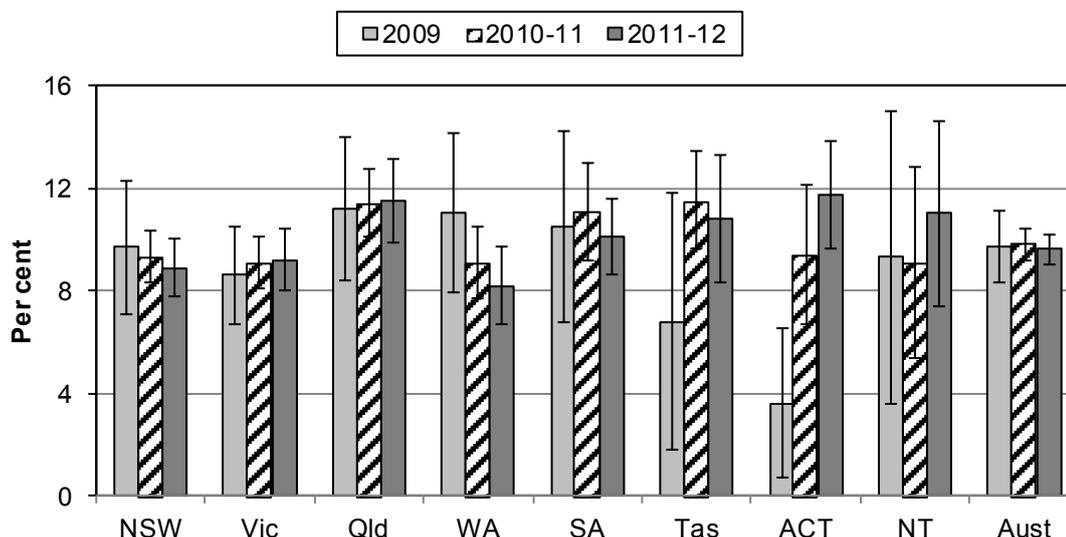
A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.

Data for this indicator are comparable.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Nationally, in 2011-12, 9.6 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}**



^a People 15 years or over who, in the last 12 months, were prescribed medication and delayed getting or did not get the medication due to cost. ^b Rates are age standardised to the Australian population at 30 June 2001. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2009, 2010-11, 2011-12*, Cat. no. 4839.0; table 11A.34.

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 time waited between being placed on a public dentistry waiting list and being seen by a dental professional. It is measured as the proportion of people on a public dental waiting list who saw a dental professional at a government dental clinic for non-urgent treatment, within specified waiting time categories.

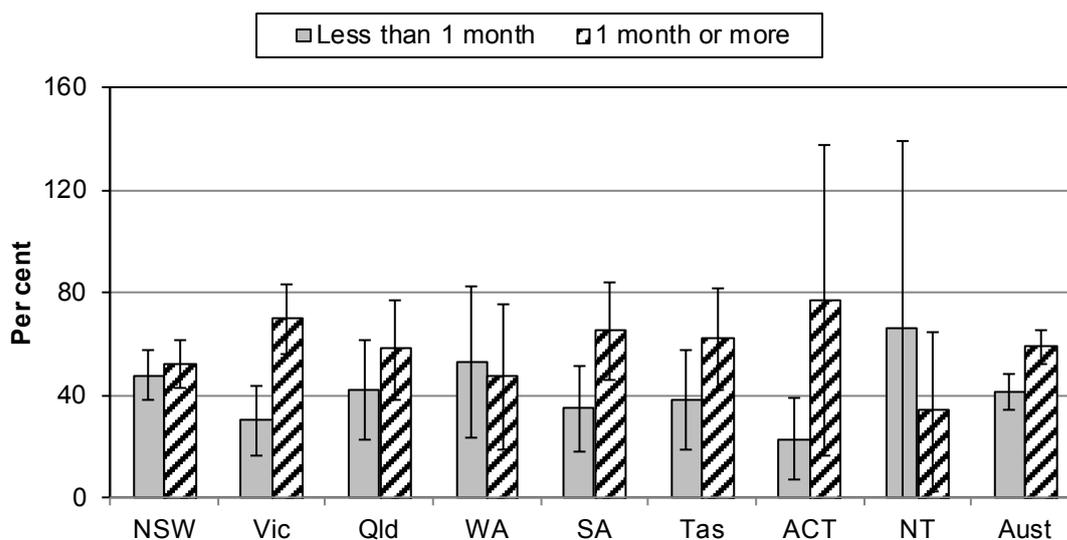
A high or increasing proportion of people waiting shorter periods to see a dental professional indicates more timely access to public dental services.

Data for this indicator are comparable.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Nationally, 24.3 per cent of people who were on a public dental waiting list for non-urgent treatment waited less than 2 weeks to see a dental professional at a government dental clinic in 2011-12 (table 11A.35). Around 41.3 per cent waited less than one month for treatment (figure 11.18).

Figure 11.18 Time waited for public dentistry services, 2011-12^{a, b, c, d, e}



^a Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months. Excludes treatment for urgent dental care. ^b Rates are age standardised to the Australian population at 30 June 2001. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2011-12*; tables 11A.35, 11A.36.

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. GPs without vocational registration may deliver services of equally high quality, however, their access to DHS Medicare rebates for the general practice services they provide is limited compared to vocationally registered GPs.

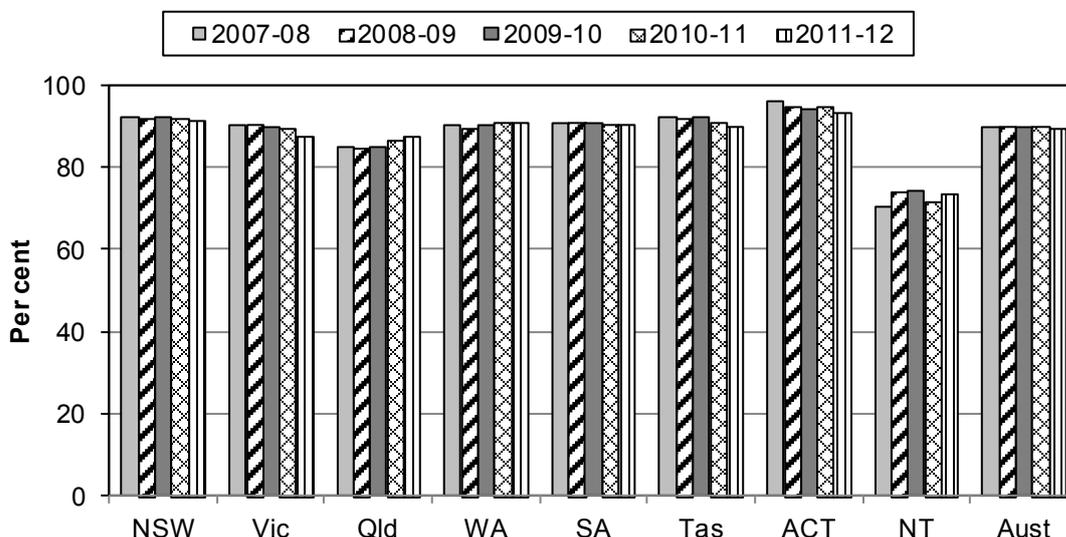
Data for this indicator are comparable.

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 (from April 2007) the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the 'practice eligible' route. Once vocational registration is achieved, GPs must meet mandated registration standards which include Continuing Professional Development (CPD) in order to maintain registration.

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2011-12 (figure 11.19). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in remote areas, in 2011-12 (table 11A.37).

Figure 11.19 GPs (full time workload equivalent) with vocational registration^a



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

Source: DoHA (unpublished) MBS Statistics; table 11A.38.

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.

(Continued next page)

Box 11.11 (Continued)

A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

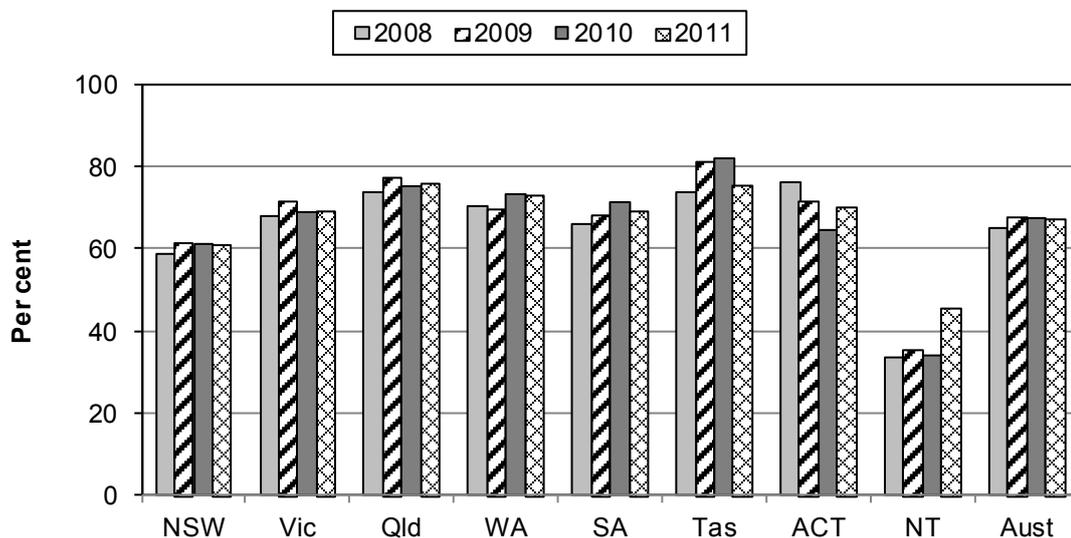
Data for this indicator are comparable.

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 Quality Practice Accreditation Pty Ltd.

Updated data for the number of general practices were not available for the 2013 Report. In June 2011, 4783 general practices — representing 67.4 per cent of general practices — were accredited nationally (figure 11.20).

Figure 11.20 General practices with accreditation, at 30 June

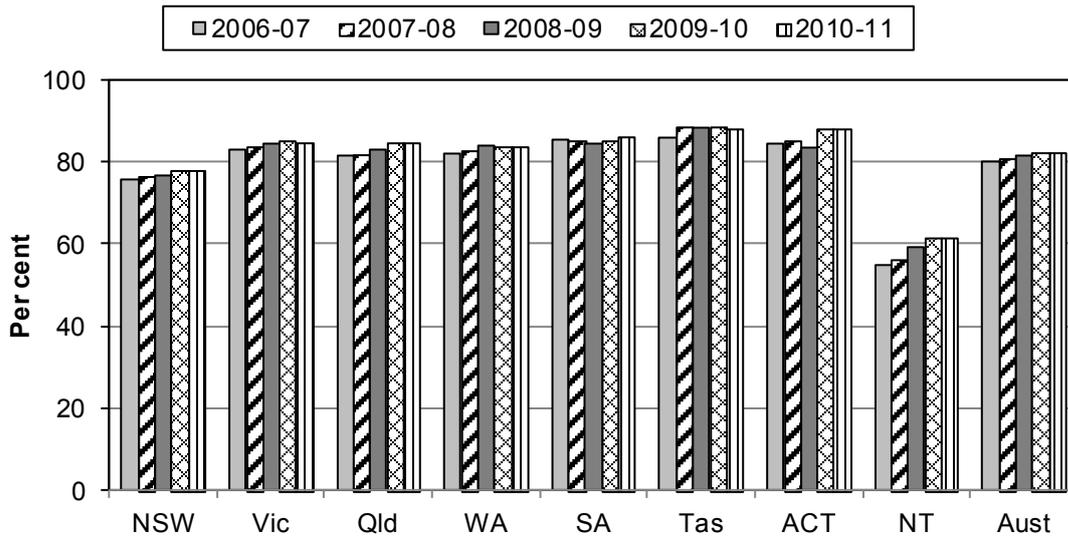


Source: AGPAL (unpublished); Quality Practice Accreditation Pty Ltd (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice 2010-11*; table 11A.39.

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 2006-07 to 2010-11 (figure 11.21).

Figure 11.21 **Proportion of general practice patient care provided by PIP practices^a**



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

Source: DoHA (unpublished) PIP and MBS data collections; table 11A.40.

Management of upper respiratory tract infection

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

Box 11.12 Management of upper respiratory tract infection

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

- number of prescriptions by GPs for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided to PBS concession card holders, per 1000 PBS concession card holders
- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.

A low or decreasing rate of prescriptions for the selected antibiotics and of the proportion of GP visits where systemic antibiotics are prescribed to treat acute URTI, can indicate that GPs' management of URTI more closely follows guidelines. Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

A low or decreasing proportion of GP visits where systemic antibiotics are prescribed to treat acute URTI can indicate that GPs' management of URTI more closely follows guidelines. Data quality information for this indicator is under development.

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

Data for this indicator are comparable.

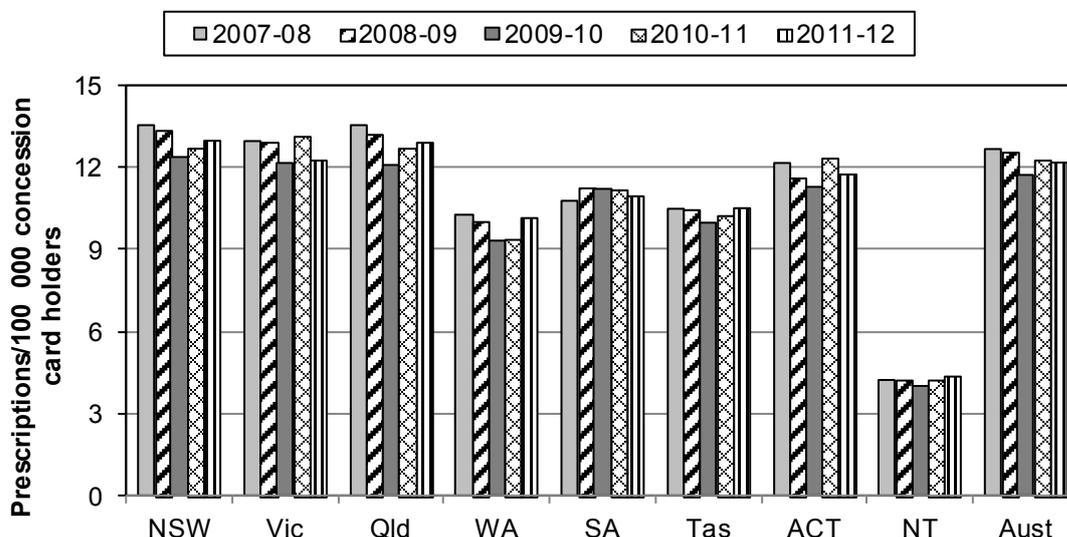
Reporting against this indicator has improved for the 2013 Report with the availability for the first time at State/Territory level of data for the additional measure proportion of GP visits for acute URTI where antibiotics are prescribed.

Rate of prescription of selected antibiotics

Caution should be used in the interpretation of this measure as the oral antibiotics most commonly prescribed to treat acute URTI are also prescribed for other illnesses. Information about the condition for which the antibiotics are prescribed is not available. Data are reported for PBS concession card holders because complete data are not available for prescriptions provided to non-holders of PBS concession cards. Caution should be used in interpretation of the measure over time, as the 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 acute URTI was 1220 per 1000 PBS concession card holders in 2011-12 (figure 11.22).

Figure 11.22 **Rate of prescription of the oral antibiotics used most commonly to treat acute upper respiratory tract infection^{a, b}**



^a Prescriptions ordered by vocationally registered 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.41.

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

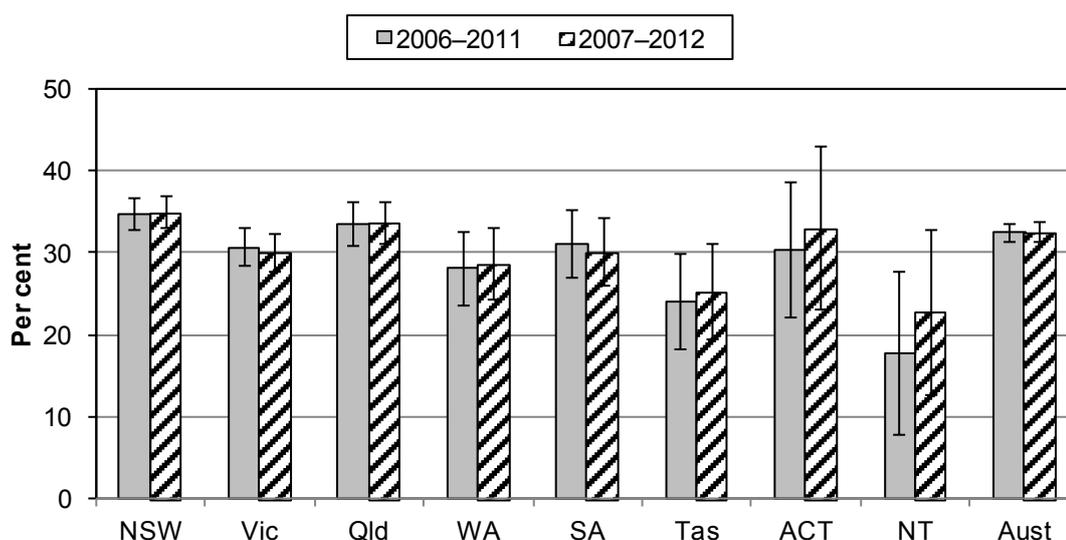
Data for the proportion of GP visits for acute URTI where systemic antibiotics are prescribed are for the first time available at State/Territory level, from the annual BEACH survey of general practice activity in Australia.

The BEACH survey collects information on the reason for the GP visit as well as the treatment prescribed or provided. This allows derivation of the proportion of visits to GPs for acute URTI for which systemic antibiotics were prescribed or supplied. Each year, the national BEACH sample comprises around 1000 GPs, each providing data for around 100 patient visits. Aggregation of data for a period of 5 years allows publication of data for all States and Territories (figure 11.23). This has some limitations — short-term change will be reflected only if substantive when averaged over a 5 year period, and proximate causes of change will not be directly identifiable. These limitations are to a degree mitigated by the reporting of data for each year in the reference period at the national level. This will assist in interpreting whether change reflected over rolling 5 year periods is due to substantive short-term change or to incremental change over several years.

Nationally, for the 5 years April 2007 to March 2012, the proportion of people presenting to GPs for acute URTI where the GP prescribed systemic antibiotics for

its treatment was 32.5 per cent (figure 11.23). This proportion was 32.8 per cent for the period April 2011 to March 2012 (figure 11.24). The higher proportion for the 5 year reference period reflects an increase in use of systemic antibiotics for treatment of acute URTI associated with the swine flu outbreak in 2009 (figure 11.24).

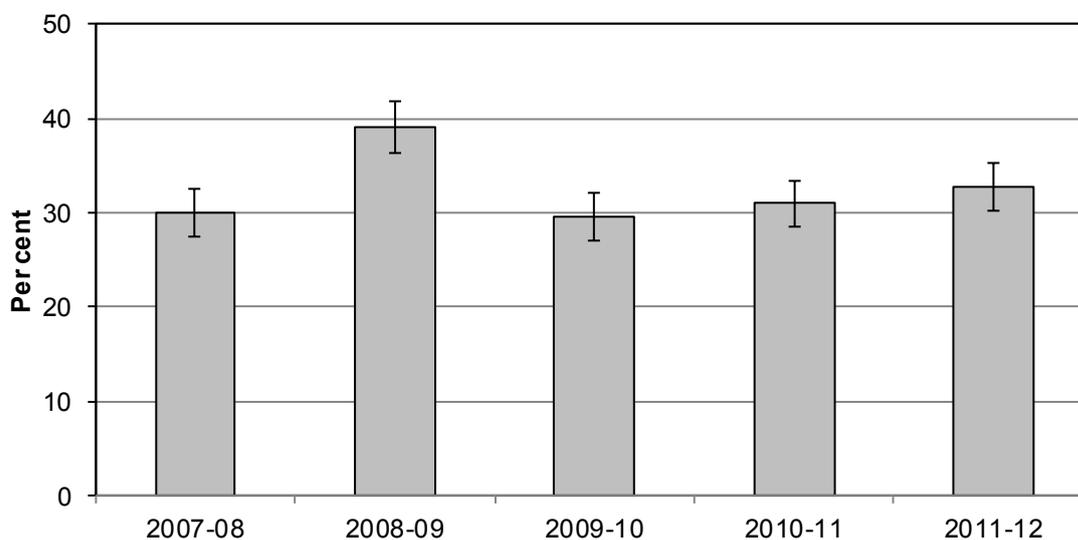
Figure 11.23 Proportion of acute URTI managements where systemic antibiotics were prescribed^{a, b}



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

Source: Britt et al (unpublished) BEACH Statistics; table 11A.42.

Figure 11.24 **Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia^{a, b}**



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

Source: Britt et al (unpublished) BEACH Statistics; table 11A.43.

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. Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

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 2013 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). Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

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 quality information for this indicator is under development.

Data reported against this indicator are comparable.

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

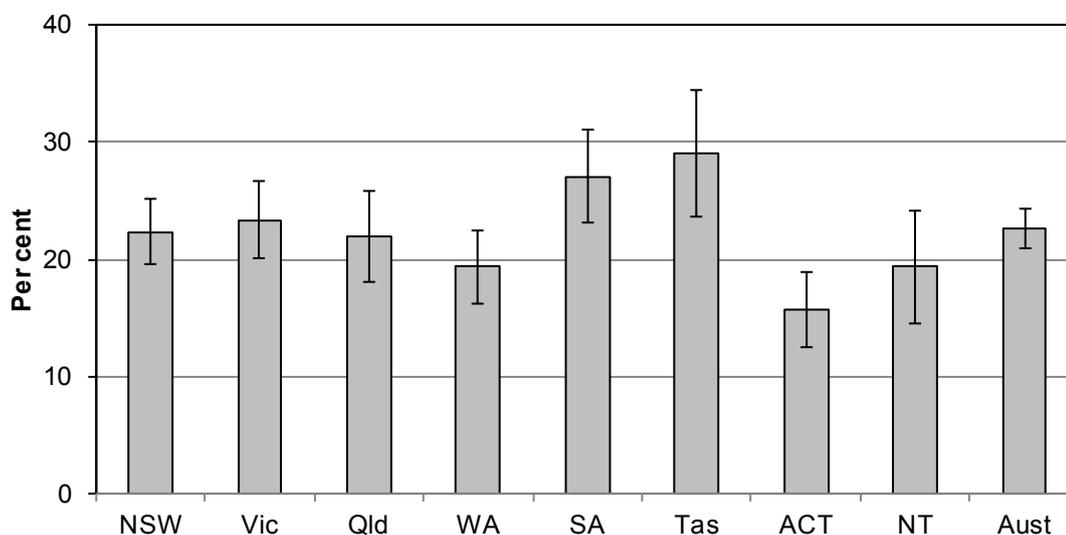
Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this Report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, 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, 22.7 per cent of people with diabetes received the annual cycle of care in 2011-12 (figure 11.25). Data for historical years are reported by geographical region in table 11A.45.

Figure 11.25 **People with diabetes mellitus who have received an annual cycle of care within general practice, 2011-12^{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 Error bars represent the 95 per cent confidence interval associated with each point estimate.

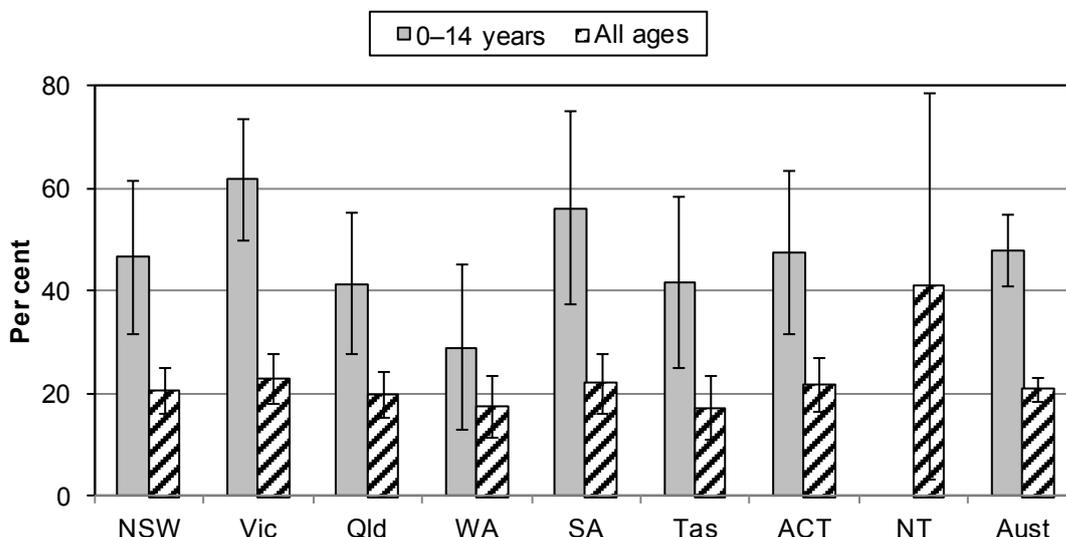
Source: DoHA (unpublished) MBS Statistics; ABS (2012) *Australian Health Survey: First Results, 2011-12*, Cat. no. 4364.0.55.001; table 11A.44.

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.

Updated data were not available for the 2013 Report for the proportion of people with current asthma reporting that they have a written asthma action plan. Nationally, this proportion was 20.8 per cent for all ages and 47.8 per cent for children aged 0–14 years in 2007-08 (figure 11.26). Data are reported by geographical region in table 11A.47. Data for 2004-05 are reported by Indigenous status in table 11A.48.

Figure 11.26 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.46.

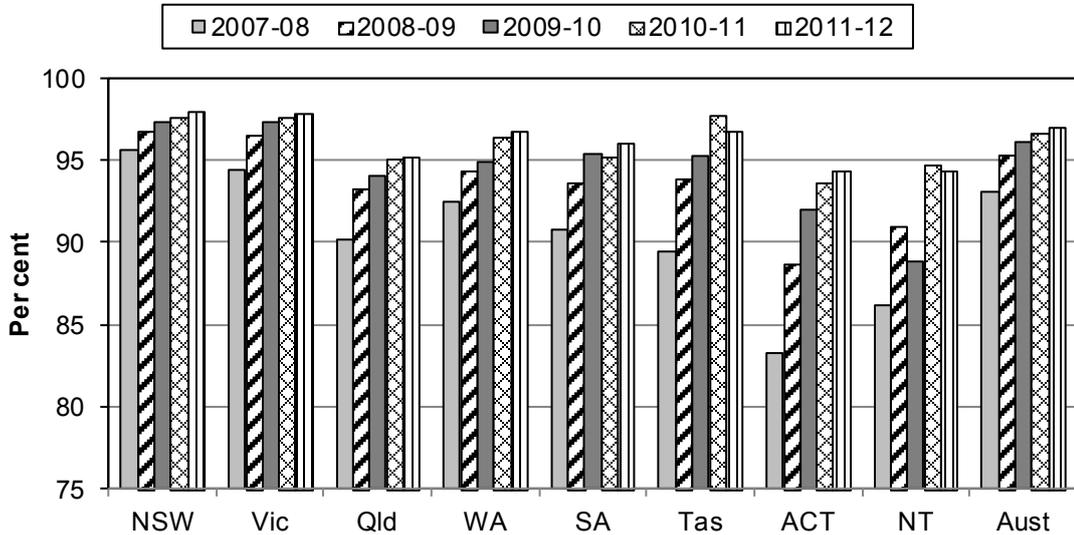
Chronic disease management — care planning and case conferencing

Individuals with chronic or terminal medical conditions commonly have complex, multidisciplinary care needs. Coordination of service provision to provide continuity of care and meet the changing needs of individuals over time is important in the effective management of such conditions. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care planning and case conferencing.

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

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing increased from 93.1 in 2007-08 to 97.0 per cent in 2011-12 (figure 11.27). The proportion increased steadily in almost all jurisdictions in the period 2007-08 to 2011-12.

Figure 11.27 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.49.

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

This indicator 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.

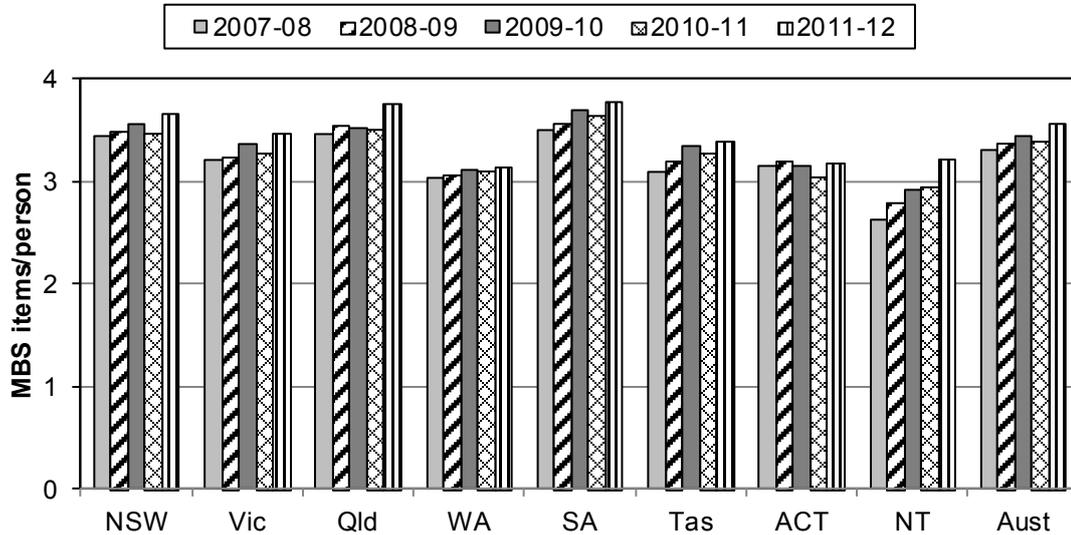
Data for this indicator are comparable.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS, Medicare is used as a proxy in reporting against this indicator. 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. DHS, Medicare data reflect only those services provided and rebated.

Nationally, the number of rebated MBS items for pathology tests requested by GPs ranged from 3.3 to 3.6 per person in the period 2007-08 to 2011-12 (figure 11.28).

Figure 11.28 **MBS items rebated through DHS, Medicare for pathology tests requested by GPs^a**

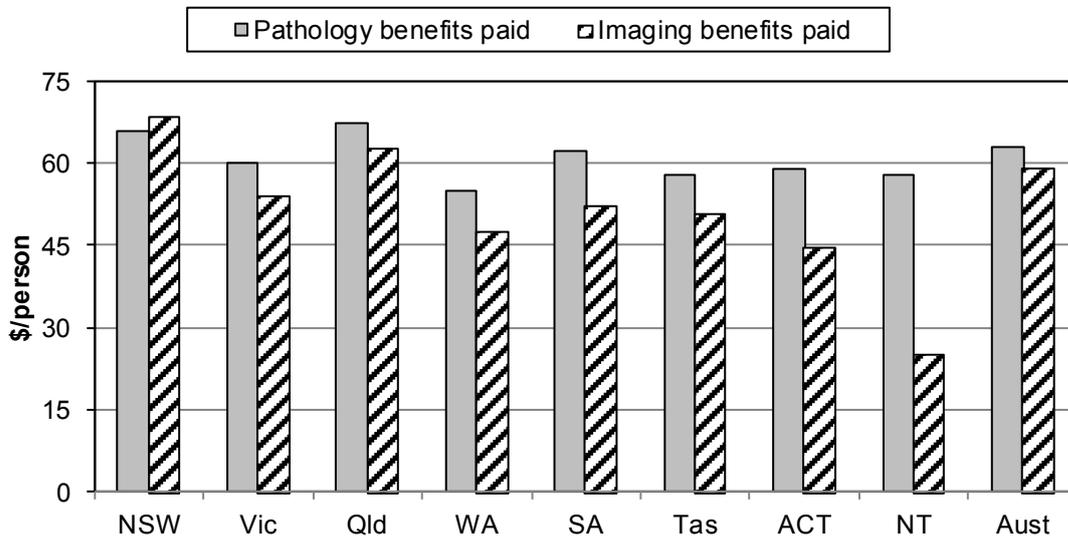


^a Data include tests requested by vocationally registered GPs and OMPs. Data include patient episode initiated items.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.50.

Australian Government expenditure under DHS, Medicare for pathology tests requested by vocationally registered GPs and OMPs amounted to \$1.4 billion, or around \$63 per person, in 2011-12. Nationally, Medicare benefits worth \$1.3 billion — around \$59 per person — were paid for diagnostic imaging services provided on referral from vocationally registered GPs and OMPs, in 2011-12 (figure 11.29).

Figure 11.29 Benefits paid for pathology tests and diagnostic imaging, 2011-12^a

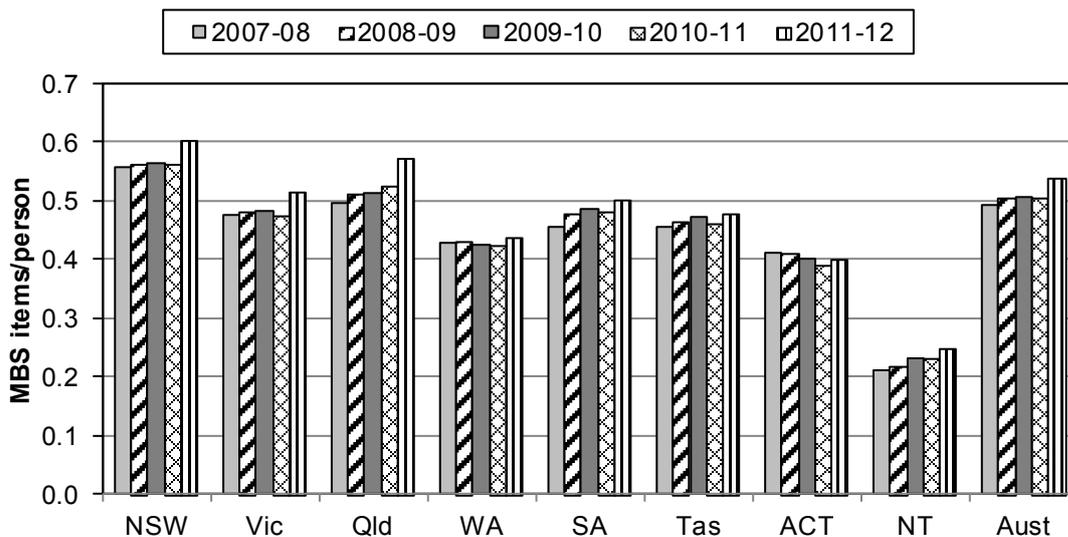


^a Includes benefits paid through DHS, Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally registered GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; tables 11A.50 and 11A.51.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs ranged from 0.49 to 0.54 per person in the period 2007-08 to 2011-12 (figure 11.30).

Figure 11.30 Diagnostic imaging services referred by GPs and rebated through DHS, Medicare^a



^a GPs include vocationally registered GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.51.

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 83.0 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (DoHA unpublished; table 11A.40).

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.

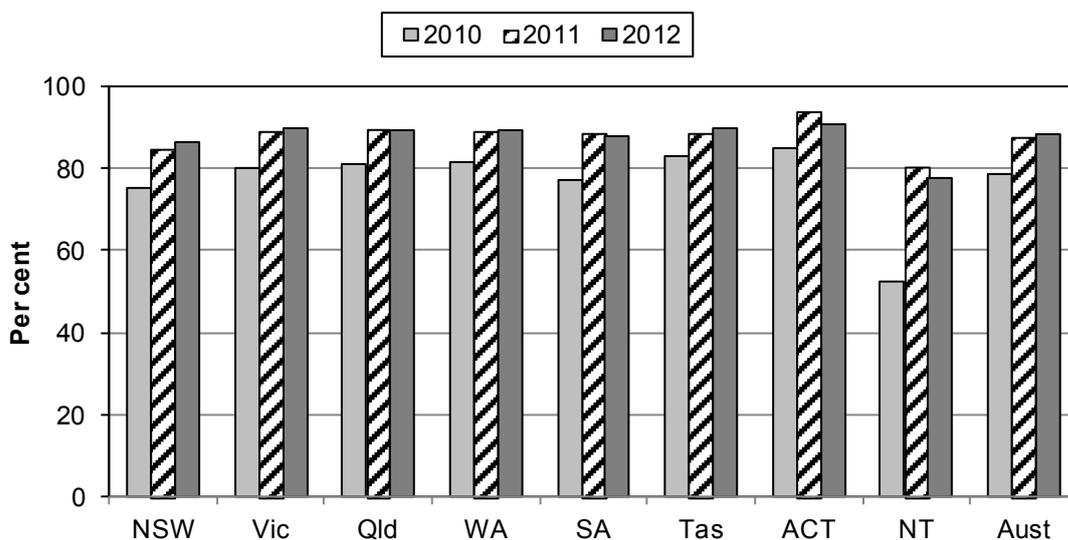
The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. It replaced, in August 2009, the PIP Information Management, Information Technology Incentive that had commenced in November 2006.

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, 88.3 per cent of PIP practices used electronic health systems in May 2012, an increase from 78.5 per cent in May 2010 (figure 11.31).

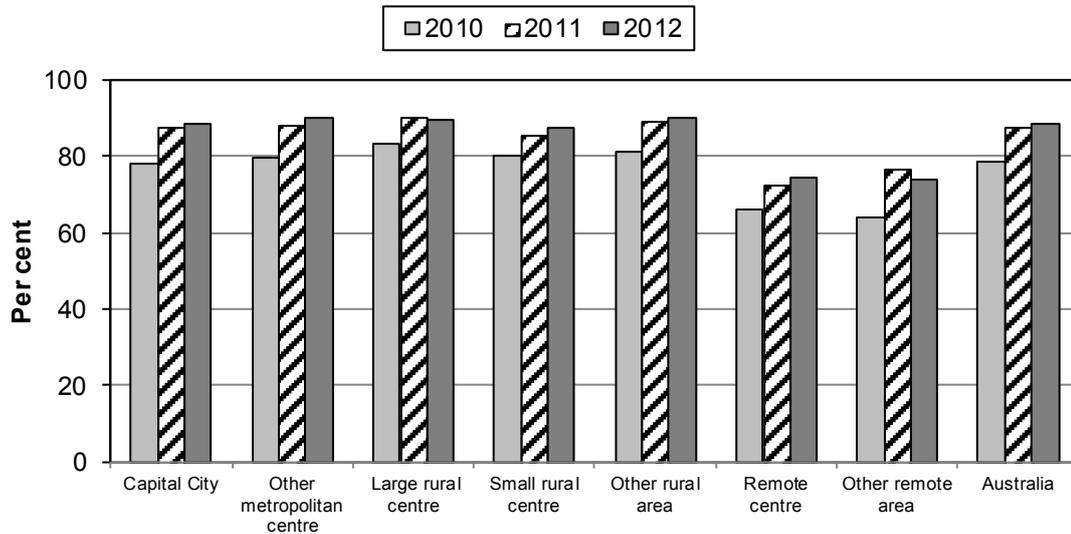
Figure 11.31 PIP practices using electronic health systems



Source: DoHA (unpublished) MBS and PIP data collections; table 11A.52.

The proportion of PIP practices using electronic health systems in remote areas was lower than in urban and rural areas in May 2012 (figure 11.32).

Figure 11.32 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.53.

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.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

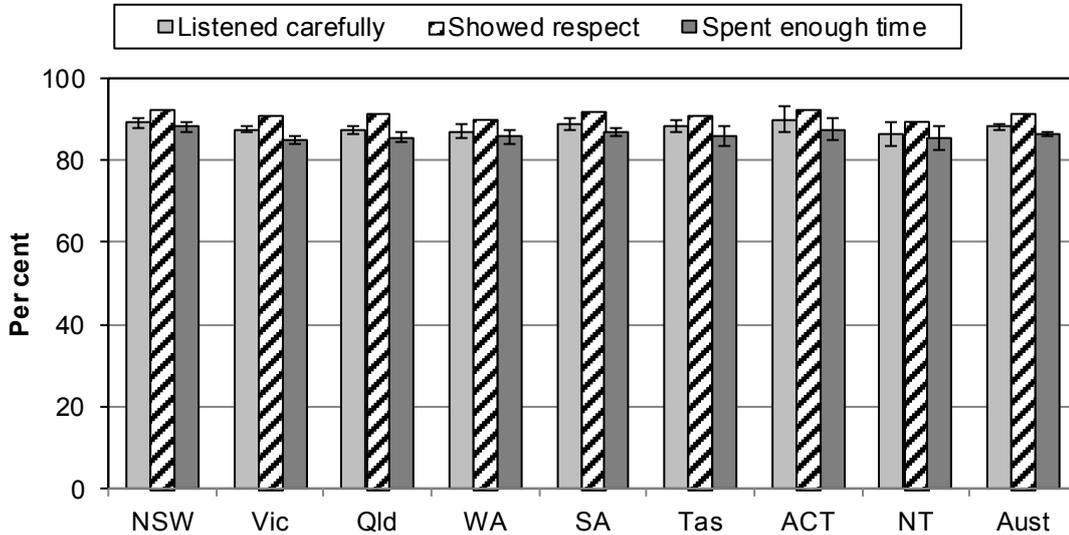
Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that the GP always or often (figure 11.33):

- listened carefully to them (88.1 per cent)
- showed respect (91.5 per cent)
- spent enough time with them (86.4 per cent).

Data are presented by remoteness area in tables 11A.54 and 11A.55.

Figure 11.33 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2011-12^{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 (unpublished) *Patient Experience Survey 2011-12*, Cat. no. 4839.0; tables 11A.54, 11A.55.

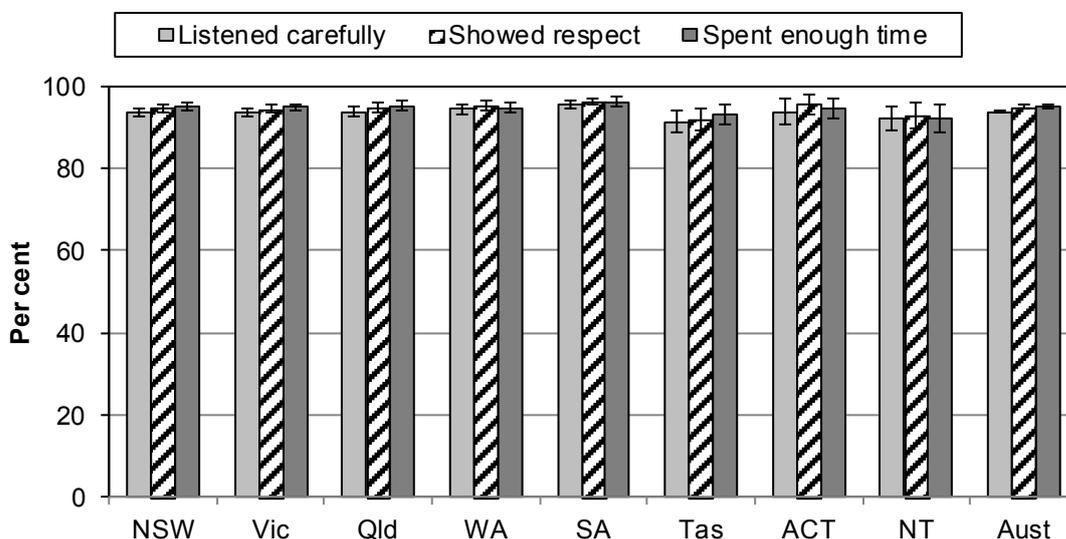
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that the dental professional always or often (figure 11.34):

- listened carefully to them (93.9 per cent)
- showed respect (94.9 per cent)
- spent enough time with them (95.0 per cent).

Data are presented by remoteness area in tables 11A.56 and 11A.57.

Figure 11.34 Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2011-12^{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 (unpublished) *Patient Experience Survey 2011-12*, Cat. no. 4839.0; tables 11A.56, 11A.57.

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 Australians aged 75 years or over and Indigenous Australians 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).

(Continued next page)

Box 11.17 (Continued)

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.

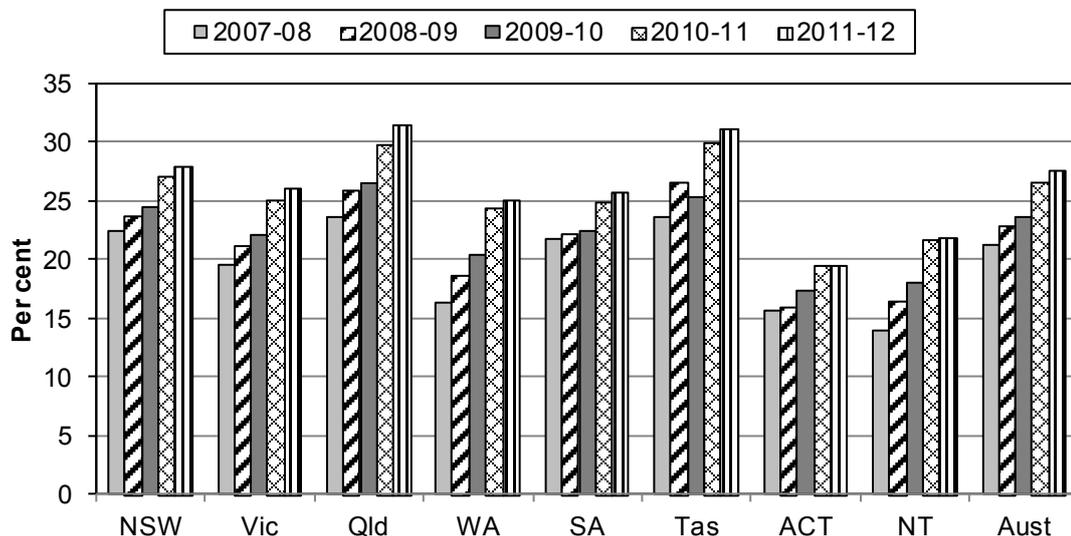
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The targeted age range for Indigenous Australians of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector overview). Results for Indigenous Australians 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 2007-08 to 2011-12. Nationally, this proportion increased from 21.3 per cent in 2007-08 to 27.6 per cent in 2011-12 (figure 11.35).

Figure 11.35 Older people who received a health assessment^a



^a Older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians 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 various years, *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.58.

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

This indicator needs to be interpreted with care. A low or decreasing 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.

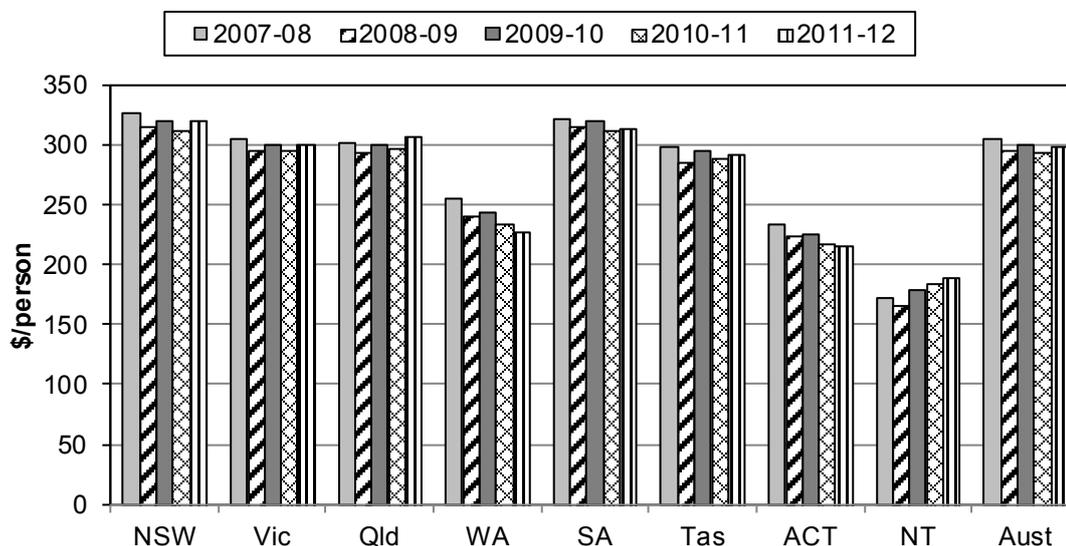
Data for this indicator are comparable.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

Nationally, the recurrent cost to the Australian Government of general practice was \$299 per person in 2011-12 (figure 11.36).

This page has changed since the Report release in January 2013. See errata at www.pc.gov.au/gsp/reports/rogs/2013/errata.

Figure 11.36 **Australian Government real expenditure per person on GPs (2011-12 dollars)^a**



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

Source: DoHA (unpublished) MBS, PIP, GPPII, 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
 - data quality information for this measure is under development
- 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
 - data quality information for this measure is under development
- the proportion of children aged 60 months to less than 63 months who are fully immunised, where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella
 - information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

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.

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 7 years of age.

Table 11.8 Valid vaccinations supplied to children under 7 years of age, by provider type, 2007–2012 (per cent)^{a, b, c}

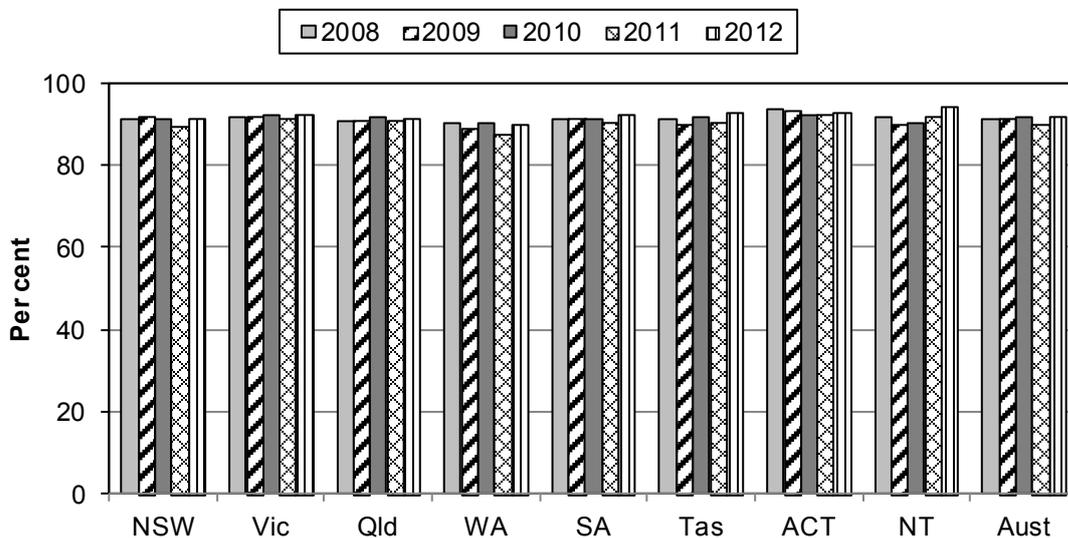
<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	84.4	53.4	82.8	64.4	69.2	87.1	42.4	4.4	71.3
Council	5.6	45.3	7.0	6.4	18.4	12.1	–	–	16.8
State or Territory health department	–	–	–	6.1	0.1	0.1	19.1	0.3	0.9
Public hospital	2.0	0.5	3.0	4.4	2.6	0.2	0.8	7.5	2.1
Private hospital	0.1	–	–	–	–	–	–	0.9	–
Indigenous health service	0.5	–	1.1	0.6	0.5	–	0.2	10.8	0.7
Community health centre	7.3	0.7	5.7	18.1	9.1	0.5	37.5	76.0	8.0
Other ^d	–	–	0.3	–	0.1	–	–	–	0.1
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 2007 to 30 June 2012. ^b Data are based on State/Territory in which the immunisation provider was located. ^c A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. ^d Other includes Divisions of GP, Flying Doctors Services, Indigenous Health Workers, Community nurses and unknown. – Nil or rounded to zero.

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.59.

Around 91.9 per cent of Australian children aged 12 months to less than 15 months at 30 June 2012 were assessed as fully immunised (figure 11.37).

Figure 11.37 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c, d}

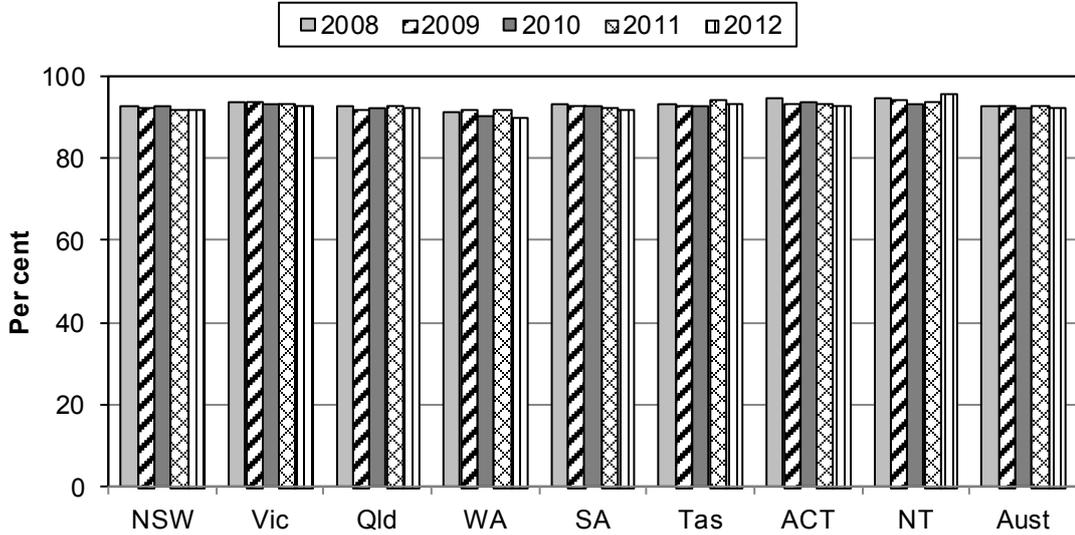


^a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child resided. ^b The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with DHS, Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS, Medicare. ^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.60.

Nationally, 92.3 per cent of children aged 24 months to less than 27 months at 30 June 2012 were assessed as being fully immunised (figure 11.38).

Figure 11.38 Children aged 24 months to less than 27 months who were fully immunised^{a, b, c}

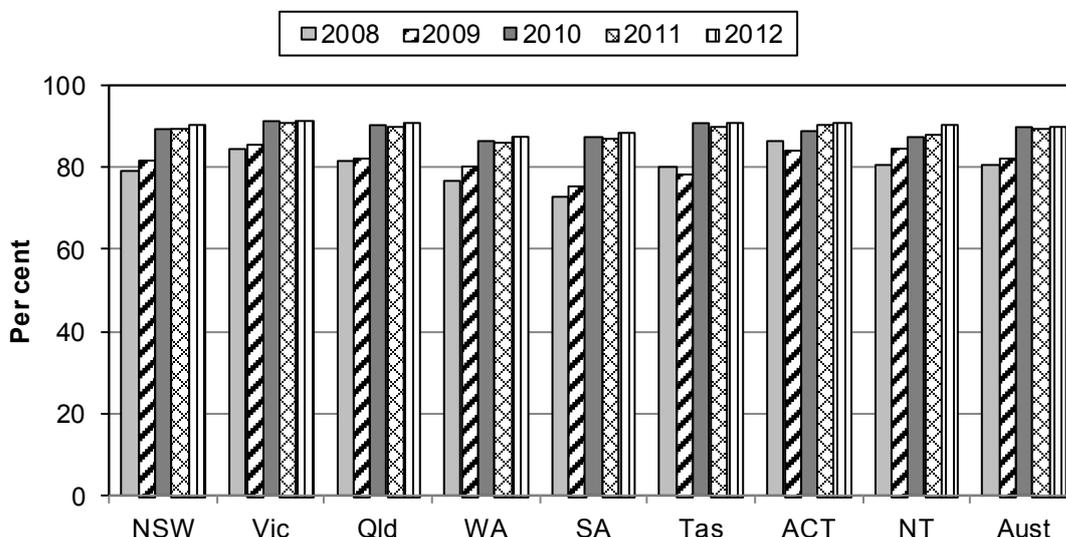


^a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child resided. ^b The ACIR includes all children under 7 years of age who are registered with DHS, Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS, Medicare (NCIRS 2000). ^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.61.

Nationally, 90.2 per cent of Australian children aged 60 months to less than 63 months at 30 June 2012 were assessed as fully immunised (figure 11.39).

Figure 11.39 Children aged 60 months to less than 63 months who were fully immunised^{a, b, c}



^a Coverage measured at 30 June for children turning 60 months of age by 31 March, by State or Territory in which the child resided. ^b The ACIR includes all children under 7 years of age who are registered with DHS, Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS, Medicare (NCIRS 2000). ^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.62.

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 invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

(Continued next page)

Box 11.20 (Continued)

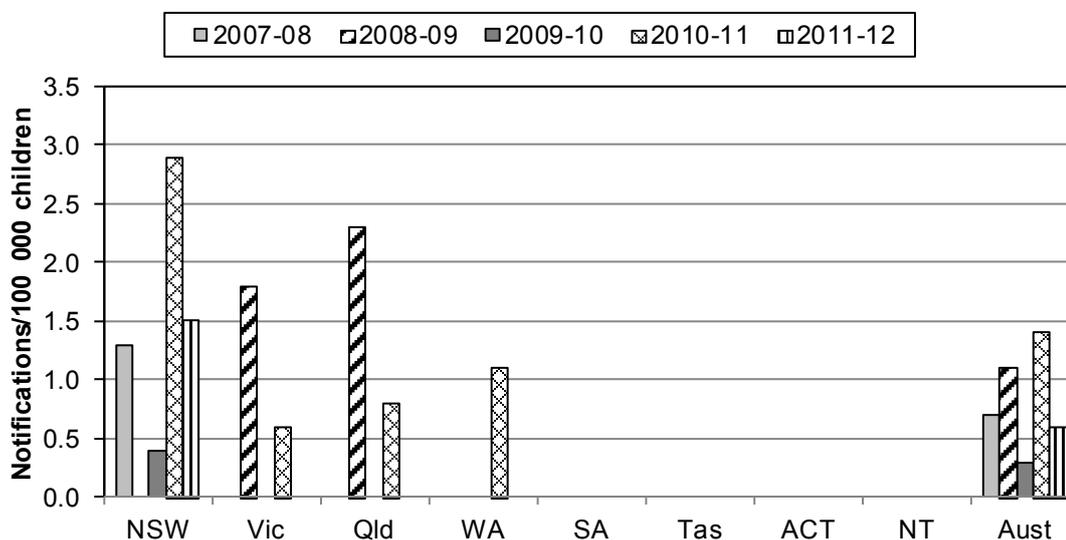
A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in 1 in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases through immunisation (and consequently the notification rates).

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In 2011-12 the national notification rate for measles was 0.6 per 100 000 children aged 0–14 years (figure 11.40). There were 27 notifications for this age group in 2011-12, lower than the 61 notifications for the previous year (table 11A.63).

Figure 11.40 Notifications of measles per 100 000 children aged 0–14 years^{a, b}

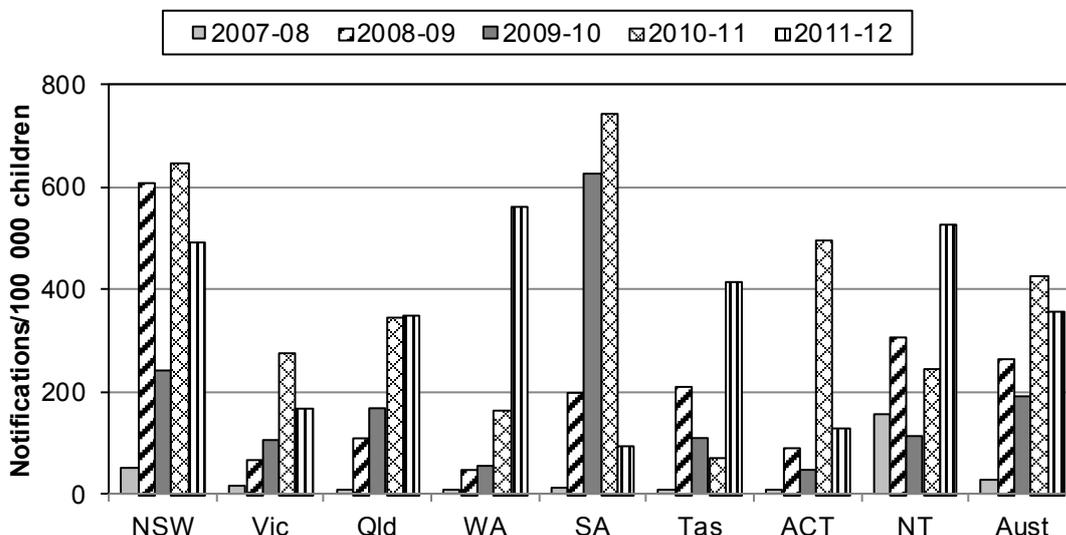


^a Data are suppressed where there are fewer than 5 notifications. ^b Data have been revised and differ from data published in the 2012 Report.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.63.

Nationally, there were over 15 000 notifications for pertussis (whooping cough) for children aged 0–14 years in 2011-12 — a rate of 356 notifications per 100 000 children in this age group (figure 11.41).

Figure 11.41 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years^a

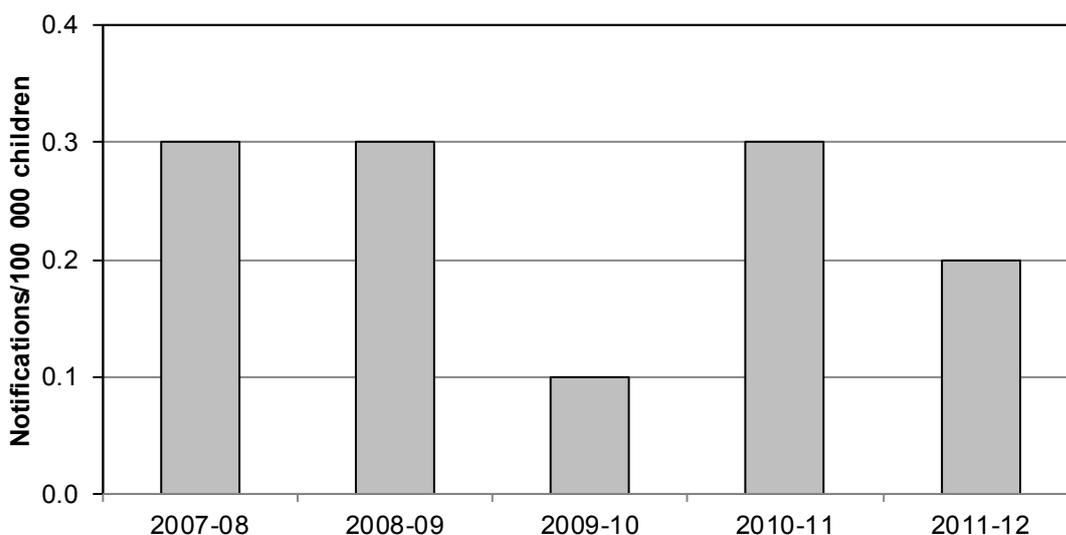


^a Data are suppressed where there are fewer than 5 notifications. ^b Data have been revised and differ from data published in the 2012 Report.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.64.

In 2011-12, the national notification rate for invasive *Haemophilus influenzae* type b — 0.2 per 100 000 children aged 0–14 years — remained low, consistent with recent years (figure 11.42).

Figure 11.42 Notifications of invasive *Haemophilus influenzae* type b per 100 000 children aged 0–14 years, Australia^a



^a Data have been revised and differ from data published in the 2012 Report.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.65.

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.

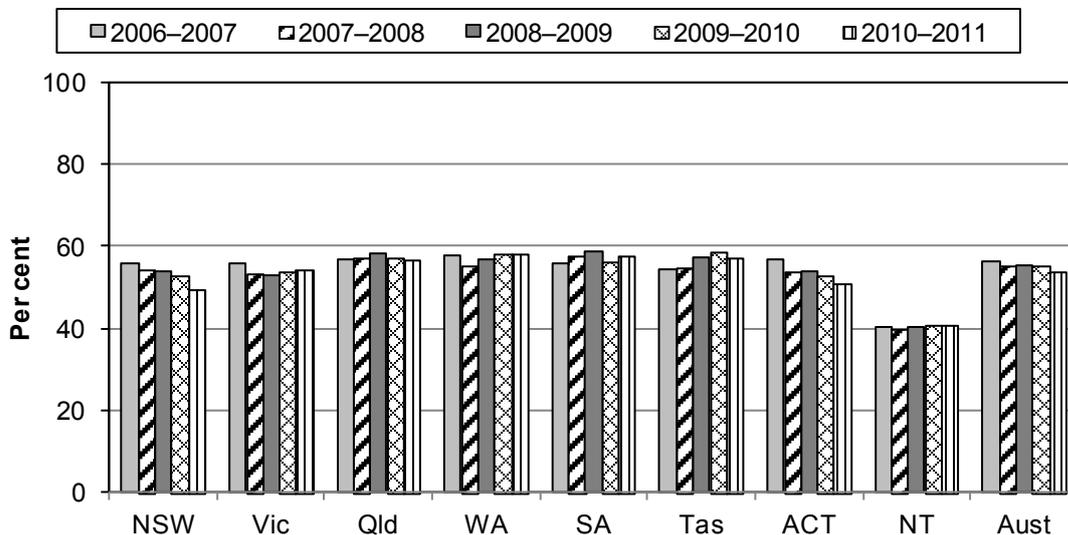
Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

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 decreased from 56.1 per cent in the 24 month period 2006 and 2007 to 53.9 per cent in the 24 month period 2010 and 2011 (figure 11.43). These rates remain below the National Accreditation Standards aim of participation by 70 per cent women in this age group.

Figure 11.43 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 In general, women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction, except for the ACT (where residents accounted for 91.3 per cent of those screened in the 2010–2011 reference period). ^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, 2011) *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0; tables 11A.66, 11A.67.

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 2010 and 2011, the national age standardised participation rate for Indigenous women aged 50–69 years (36.1 per cent) was below the total participation rate in that age group (53.9 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records (table 11A.68). For NESB women for the same 24 month period and age group, the national participation rate of 51.1 per cent was also lower than that of the national total female population (table 11A.69). 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. Updated State and Territory data for participation rate by

remoteness area were not available for the 2013 Report — data for previous years as well as national data for 2010–2011 are reported in table 11A.70.

Table 11.9 Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2010 and 2011 (24 month period) (per cent)^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT ^d	NT	Aust
Indigenous ^e	34.5	29.8	46.4	33.4	33.3	46.1	47.5	24.8	36.1
NESB ^f	52.5	43.6	67.8	67.1	51.3	45.0	14.7	38.7	51.1
All women aged 50–69 years	49.6	54.3	56.4	58.2	57.4	57.0	51.1	40.7	53.9

^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 (91.3 per cent in 2010–2011). ^e Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. ^f NESB is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2011) *Population by Age and Sex, Australian States and Territories*, June 2011, 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; tables 11A.66–11A.69.

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.

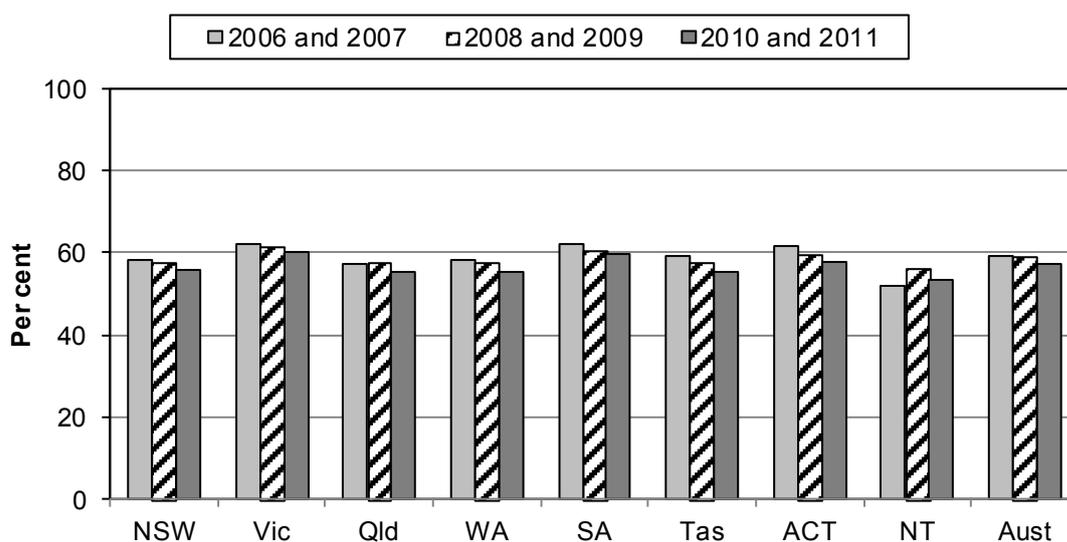
Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

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 2012b; 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 dropped from 59.4 per cent for the 24 month period 1 January 2006 to 31 December 2007 to 57.2 per cent for the 24 months 1 January 2010 to 31 December 2011 (figure 11.44). For most jurisdictions, participation rates have dropped slightly since the screening period of 2006 and 2007. Data for Indigenous women for 2004-05 are presented in table 11A.72.

Figure 11.44 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 (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.71.

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.

Updated data were not available for the 2013 Report. Nationally, 74.6 per cent of eligible people were fully vaccinated against influenza in 2009 (table 11A.73).

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 2009 for older adults fully vaccinated against both influenza and pneumococcal disease are presented by remoteness in table 11A.74. Data for Indigenous Australians fully vaccinated against influenza and pneumococcal disease in 2004-05 are presented in table 11A.75.

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 2012b; DHS 2002)
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

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

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2008b, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people’s access to aged care services and other support.

Data for this indicator are comparable.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013.

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

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

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

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

Data 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 the selected vaccine preventable, acute and chronic conditions reported here was 23.3 per 1000 people in 2010-11 (table 11.10). Of these, 47.7 per cent were for chronic and 49.4 per cent for acute conditions (table 11A.76). Data are presented disaggregated by Indigenous status in table 11A.77 and remoteness in table 11A.78. National data by Indigenous status and remoteness are presented in table 11A.79.

Table 11.10 Separations for selected potentially preventable hospitalisations per 1000 people, 2010-11^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Vaccine preventable conditions	0.6	0.8	0.8	0.6	1.0	0.4	0.5	3.0	0.8
Selected acute conditions ^d	10.6	11.6	12.3	12.6	12.4	8.4	9.0	18.0	11.5
Selected chronic conditions ^e	10.1	11.9	12.0	10.6	11.5	9.1	8.5	22.0	11.1
Total^{f, g}	21.2	24.2	25.0	23.7	24.7	17.7	17.9	42.5	23.3

^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 Selected acute conditions *excluding dehydration and gastroenteritis*. ^e Selected chronic conditions *excluding diabetes complications (additional diagnoses only)*. ^f Total is all potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)*. ^g Totals may not add as more than one condition may be reported for a separation.

Source: AIHW (2012b) *Australian Hospital Statistics 2010-11*, Cat. no. HSE 117; table 11A.76.

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2010-11 (table 11.11). Nationally, influenza and pneumonia accounted for 73.8 per cent of hospital separations for vaccine preventable conditions in 2010-11 (AIHW 2012).

Table 11.11 Separations for vaccine preventable conditions per 1000 people, 2010-11^{a, b}

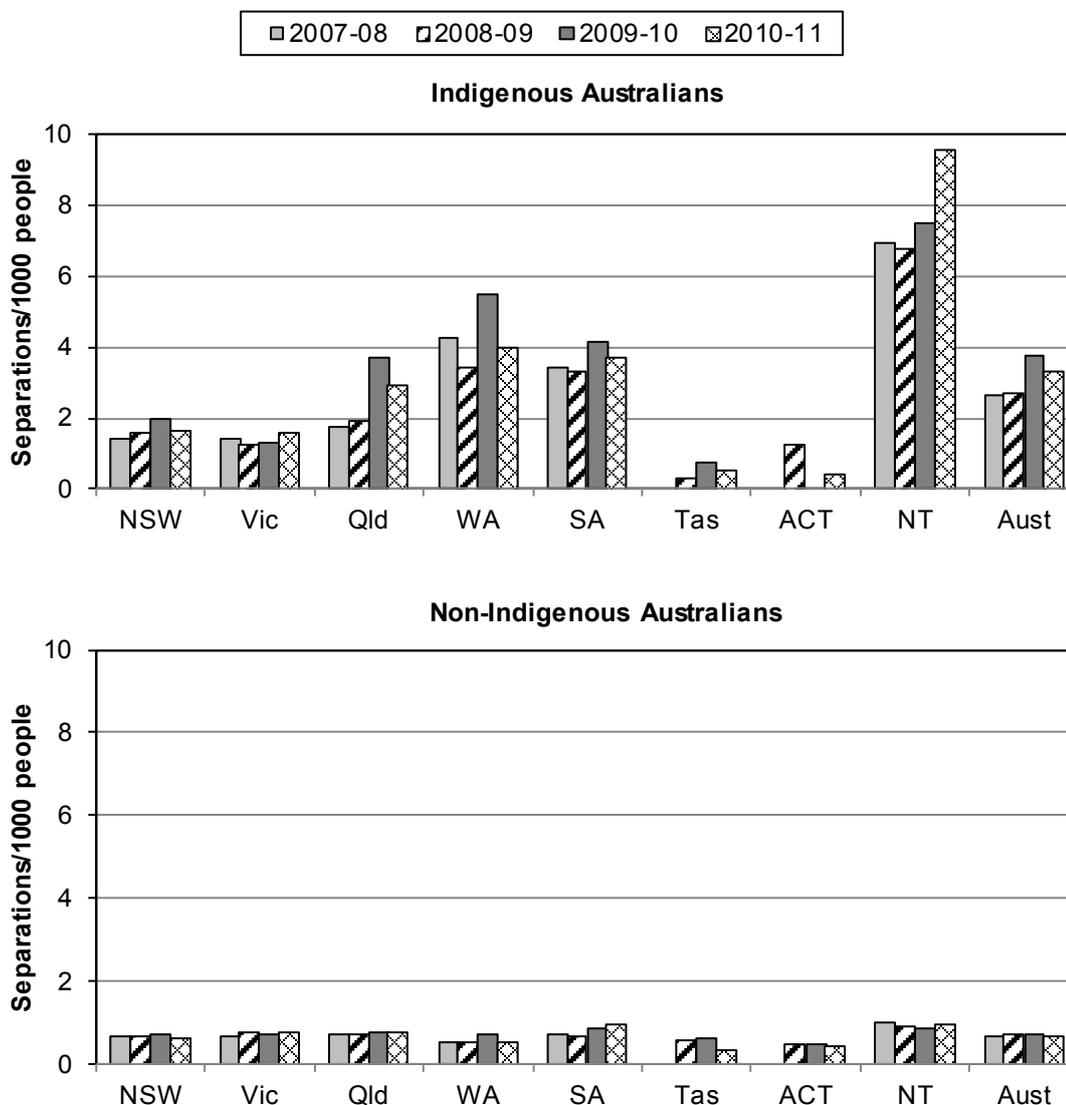
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Influenza and pneumonia	0.5	0.5	0.6	0.5	0.7	0.3	0.4	2.5	0.6
Other conditions	0.1	0.3	0.2	0.1	0.2	0.1	0.1	0.5	0.2
Total^d	0.6	0.8	0.8	0.6	1.0	0.4	0.5	3.0	0.8

^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 (2012b) *Australian Hospital Statistics 2010-11*, Cat. no. HSE 117; table 11A.80.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous Australians than for non-Indigenous Australians in 2010-11, in most jurisdictions (figure 11.45).

Figure 11.45 **Separations for vaccine preventable conditions by Indigenous status^{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 Australians 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.77.

Of the selected acute conditions, dental conditions, dehydration and gastroenteritis, and pyelonephritis recorded the highest rates of hospitalisation nationally in 2010-11 (table 11.12).

Table 11.12 Separations for selected acute conditions per 1000 people, 2010-11^{a, b}

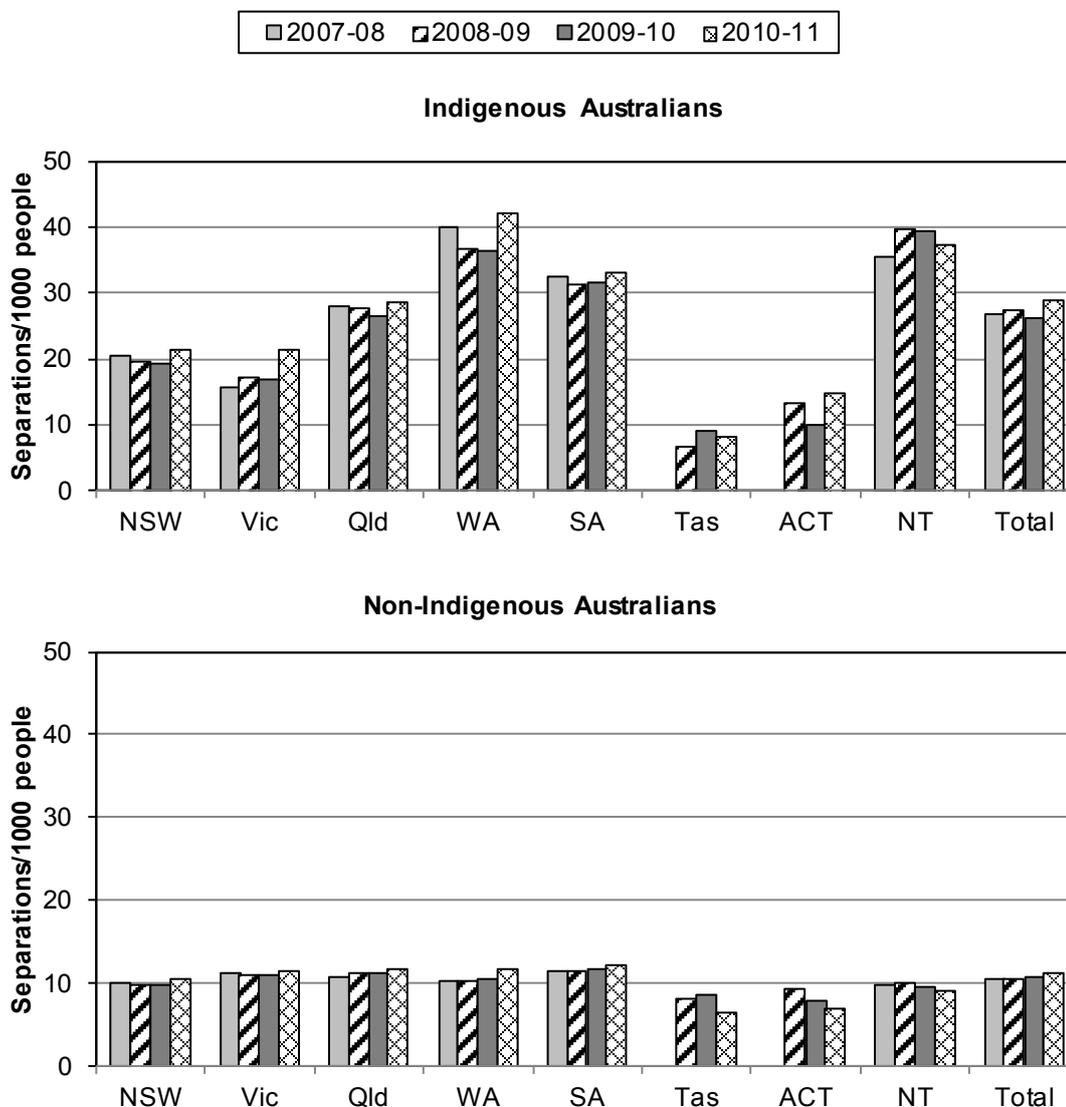
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Appendicitis	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Cellulitis	1.8	1.8	2.3	1.7	1.7	1.3	1.4	3.9	1.9
Convulsions and epilepsy	1.5	1.5	1.6	1.5	1.6	1.1	1.3	3.2	1.5
Dehydration and gastroenteritis	2.7	3.5	2.8	2.8	2.8	2.1	1.7	2.4	2.9
Dental conditions	2.3	2.9	2.7	3.7	3.3	2.3	2.1	2.9	2.8
Ear, nose and throat infections	1.6	1.6	1.9	1.9	2.3	1.1	1.0	2.3	1.7
Gangrene	0.2	0.3	0.3	0.3	0.2	0.3	0.1	0.9	0.3
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.1	0.6	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2
Pyelonephritis ^d	2.5	2.7	2.8	2.7	2.4	1.6	2.3	3.7	2.6
Total^e	13.0	14.9	14.8	15.1	14.9	10.2	10.4	20.3	14.2
<i>Total excluding dehydration and gastroenteritis^e</i>	10.6	11.6	12.3	12.6	12.4	8.4	9.0	18.0	11.5

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

Source: AIHW (2012b) *Australian Hospital Statistics 2010-11*, Cat. no. HSE 117; table 11A.81.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous Australians than for non-Indigenous Australians in all jurisdictions in 2010-11 (figure 11.46).

Figure 11.46 Separations for selected acute conditions by Indigenous status^{a, b, c, d, e, f}



^a Excludes separations for dehydration and gastroenteritis. ^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 NT data for Indigenous Australians are for public hospitals only. ^f 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.77.

Of the selected chronic conditions, diabetes complications, chronic obstructive pulmonary disease, congestive cardiac failure and asthma recorded the highest rates of hospitalisation nationally in 2010-11 (table 11.13).

Table 11.13 Separations for selected chronic conditions per 1000 people, 2010-11^{a, b}

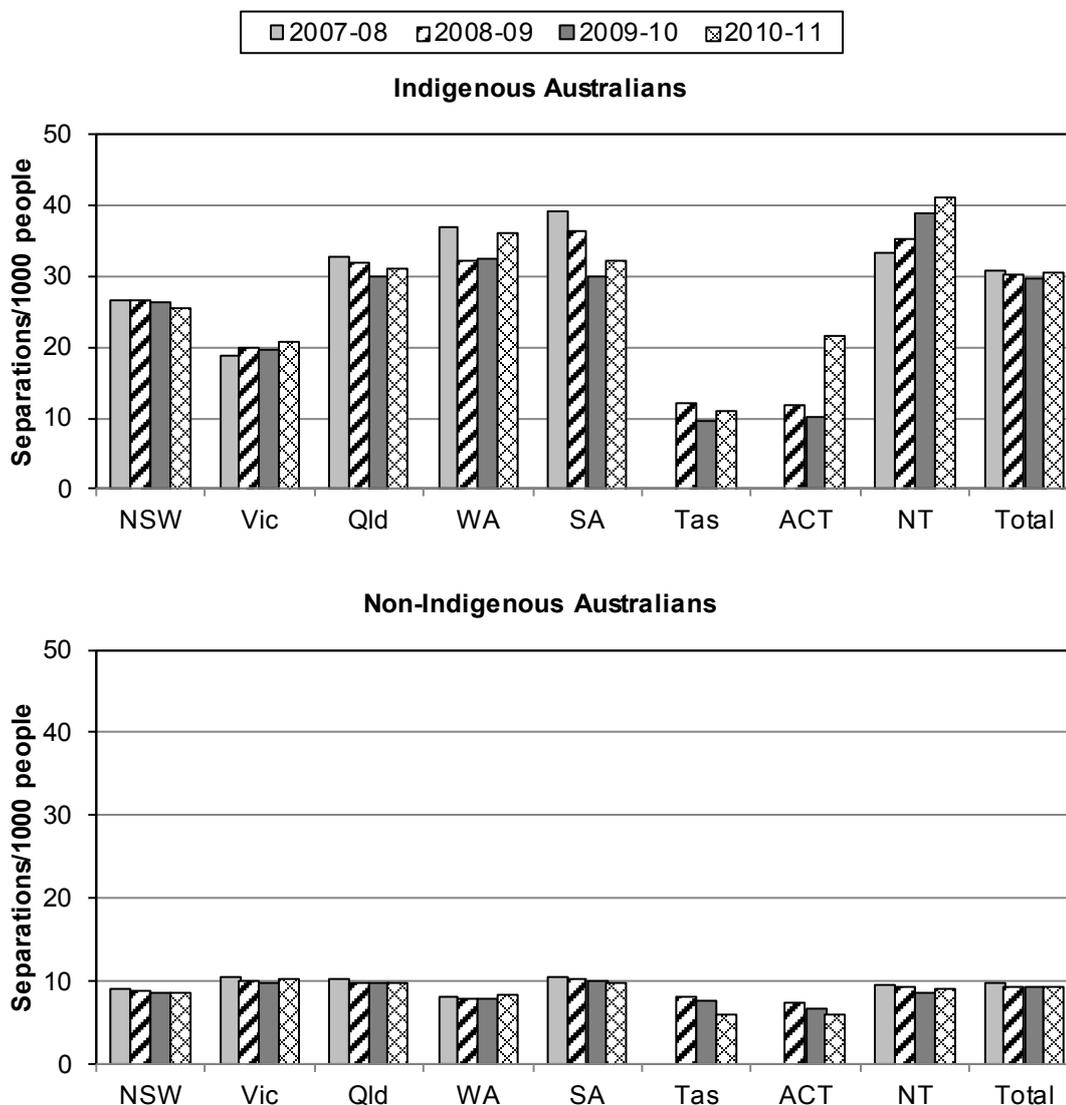
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Angina	1.1	1.3	1.8	1.5	1.3	0.9	0.7	2.5	1.3
Asthma	1.7	2.0	1.6	1.3	2.1	1.0	1.2	2.0	1.7
Chronic obstructive pulmonary disease	2.6	2.6	3.1	2.4	2.8	2.5	2.0	7.1	2.7
Congestive cardiac failure	1.9	2.2	2.0	2.0	1.9	1.5	2.0	3.7	2.0
Diabetes complications	2.5	3.1	4.2	8.7	3.0	2.4	2.3	7.5	3.7
Diabetes complications (<i>except as additional diagnosis</i>) ^d	1.4	1.7	1.7	1.5	1.7	1.4	1.4	4.2	1.6
Hypertension	0.3	0.3	0.4	0.2	0.3	0.2	0.1	0.3	0.3
Iron deficiency anaemia	1.1	1.7	1.1	1.6	1.3	1.5	1.0	1.3	1.4
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	–
Rheumatic heart disease ^e	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8	0.1
Total^f	11.0	13.0	14.1	17.4	12.5	9.7	9.1	24.3	12.9
Total <i>excluding diabetes complications as additional diagnosis</i> ^f	10.1	11.9	12.0	10.6	11.5	9.1	8.5	22.0	11.1
Total <i>excluding diabetes complications (all diagnoses)</i> ^f	8.7	10.3	10.2	9.1	9.8	7.6	7.1	17.7	9.5

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

Source: AIHW (2012b) *Australian Hospital Statistics 2010-11*, Cat. no. HSE 117; table 11A.82.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous Australians than for non-Indigenous Australians in all jurisdictions in 2010-11 (figure 11.47).

Figure 11.47 Separations for selected chronic conditions by Indigenous status^{a, b, c, d, e, f}



^a Excludes separations for diabetes complications (all diagnoses). ^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.77.

Potentially preventable hospitalisations for diabetes

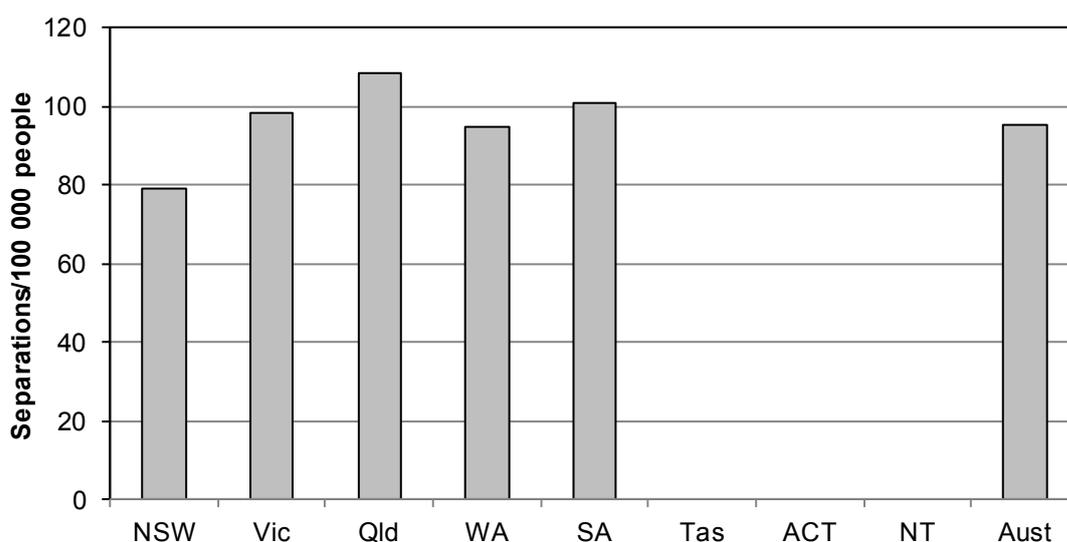
Diabetes is a chronic disease of increasing prevalence, and is an identified National Health Priority Area for Australia. People with diabetes are at high risk of serious

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 95.5 separations per 100 000 people in 2010-11 (figure 11.48).

Figure 11.48 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2010-11^{a, b, c}**

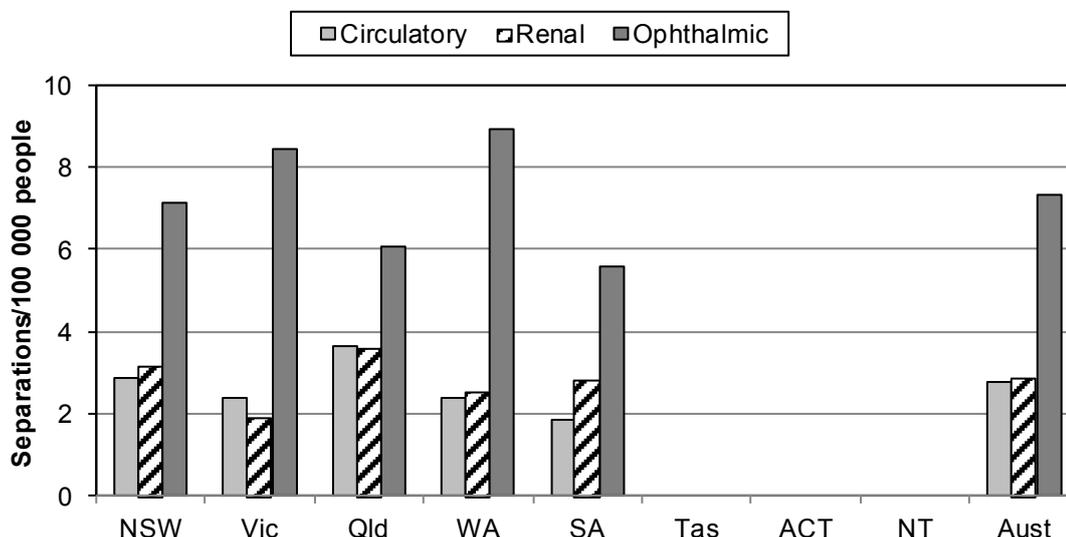


^a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^b Morbidity data are coded under coding 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.84.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2010-11 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.49).

Figure 11.49 Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2010-11^{a, b, c, d, e}



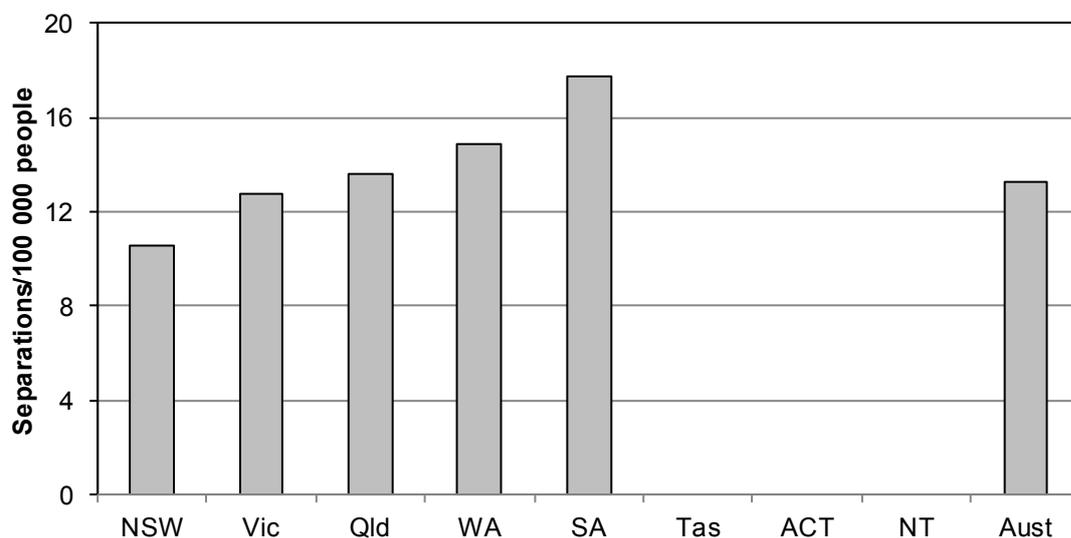
^a Results for individual complications can be affected by small numbers, and need to be interpreted with care. ^b Patients can have one or more complication(s) for each separation. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient 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.84.

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, 21.9 per cent of separations for Type 2 diabetes were same day separations in 2010-11 (table 11A.85).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2010-11, there were 13.3 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.50).

Figure 11.50 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11^{a, b, c}**



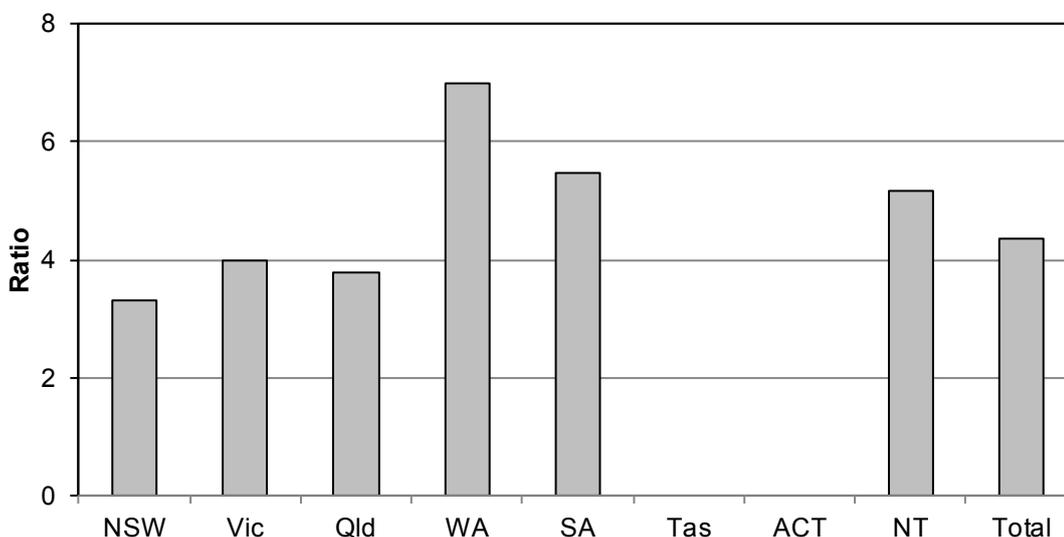
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 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.86.

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

There was a marked difference in 2010-11 between the separation rates for Indigenous Australians 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 Australians was 4.4 times as high as the separation rate for all Australian people (figure 11.51).

Figure 11.51 **Ratio of separation rates of Indigenous Australians to all people for diabetes, 2010-11^{a, b, c, d, e, f, g}**



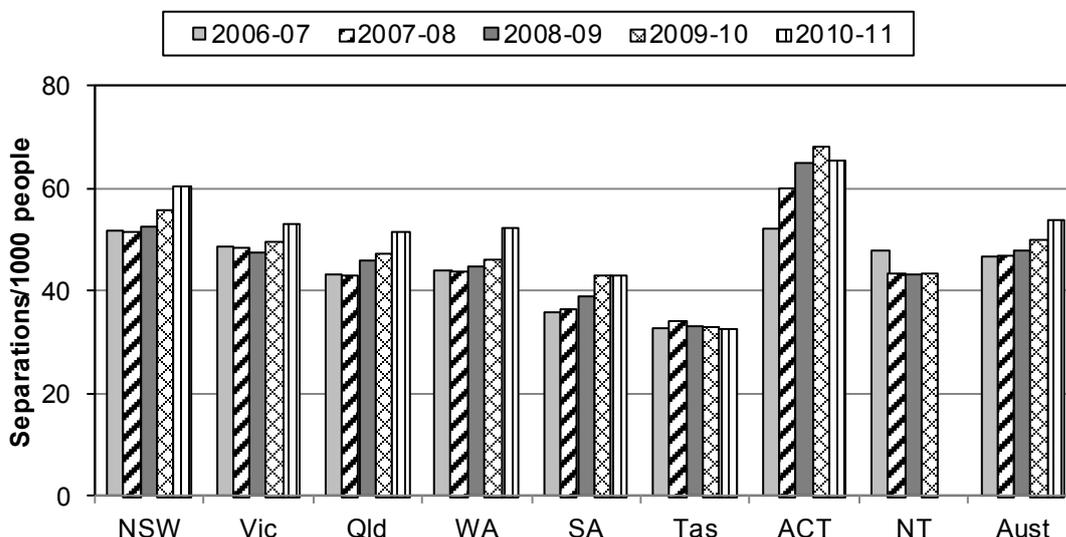
^a Excludes separations with diabetes complications as an additional diagnosis. ^b Ratios are directly age standardised to the Australian population at 30 June 2001. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. ^d Patients 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; table 11A.83.

Potentially preventable hospitalisations of older people for falls

For people over 65 years, injurious falls accounted for one in ten days spent in hospital in 2008-09 (AIHW 2012c). 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 2006-07 to 2010-11 in most jurisdictions (figure 11.52).

Figure 11.52 **Separations for older people with a reported external cause of falls^{a, b, c}**



^a Older people are defined as people aged 65 years or over. ^b Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. ^c Excludes separations records for hospital boarders and posthumous organ procurement. ^d Data are not published for the NT for 2010-11.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.87.

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. Allied health professional workforce data are anticipated to be available for the 2015 Report from the new National Registration and Accreditation Scheme. Priorities for future reporting on primary and community health services include:

- further improving the reporting of public dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items

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

Indigenous health

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

Continued efforts to improve the quality of Indigenous data, particularly Indigenous identification and completeness, 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. 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.

11.5 Definitions of key terms

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	<p>The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice based on RACGP guidelines.</p> <p>MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.</p>
Asthma Action Plan	<p>An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.</p> <p><i>Source:</i> ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra.</p>
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	<p>Geographically-based networks of GPs active until end June 2012. There were 109 Divisions of General Practice (DGP), 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN).</p> <p>The DGPP's aims were to contribute to improved health outcomes for communities by working with GPs and other health service providers to improve the quality and accessibility of healthcare at the local level. From 30 June 2012, Medicare Locals assumed responsibility for general practice support initiatives previously funded under the DGPP.</p>
Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by DHS, Medicare in a given period, calculated by dividing the practitioner's DHS, 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 polio vaccine, three doses of Hepatitis B vaccine and three doses of <i>Haemophilus influenzae</i> type B vaccine.
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, four doses of <i>Haemophilus influenzae</i> type B and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, 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 registered GPs — medical practitioners who are vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.
GP-type services	Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.
<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (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.
Medicare Locals	Medicare Locals (MLs) are not-for profit regional primary health care organisations with responsibility for supporting improved co-ordination of primary health care service delivery, as well as identifying and addressing gaps in primary health care services, across their region (http://www.amlalliance.com.au/about-us , accessed 27 November 2012). Established as part of the National Health Reform agenda, a national network comprising 61 MLs and a national body, the Australian Medicare Local Alliance (AML Alliance), were operational at 1 July 2012.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive DHS, Medicare reimbursement.

Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and <i>Haemophilus influenzae</i> type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 DHS, Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under DHS, Medicare for pathology tests requested by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: <ul style="list-style-type: none"> • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally registered, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and Quality Practice Accreditation Pty Ltd), divided by the total number of practices 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 DHS, Medicare as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS, Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Triage category	The urgency of the patient's need for medical and nursing care: <ul style="list-style-type: none"> • category 1 — resuscitation (immediate within seconds) • category 2 — emergency (within 10 minutes) • category 3 — urgent (within 30 minutes) • category 4 — semi-urgent (within 60 minutes) • category 5 — non-urgent (within 120 minutes).
Vocationally registered general practitioner	A medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (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 DHS, 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, 2011-12
Table 11A.2	Australian Government real expenditure on GPs (\$ million) (2011-12 dollars)
Table 11A.3	Australian government expenditure on the Pharmaceutical Benefits Scheme
Table 11A.4	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service
Table 11A.5	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 11A.6	Number of GP-type services used per 1000 people
Table 11A.7	PBS services
Table 11A.8	PBS services, by service type ('000)
Table 11A.9	Use of public dental services, by service type, 2010
Table 11A.10	Alcohol and other drug treatment agencies, by sector, 2010-11 (number)
Table 11A.11	Indigenous primary healthcare services and episodes of healthcare (number)
Table 11A.12	Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 11A.13	Proportion of Indigenous primary healthcare services that undertook selected health related activities (per cent)
Table 11A.14	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 2011 (number)
Table 11A.15	Approved providers of PBS medicines, by urban and rural location
Table 11A.16	PBS expenditure per person, by urban and rural location (2011-12 dollars)
Table 11A.17	Availability of GPs by region
Table 11A.18	Availability of female GPs
Table 11A.19	Availability of public dentists (per 100 000 people)
Table 11A.20	Availability of public dental therapists (per 100 000 people)
Table 11A.21	Annual health assessments for older people by Indigenous status (per cent)
Table 11A.22	Older Indigenous people who received an annual health assessment (per cent)
Table 11A.23	Indigenous people who received a health check or assessment, by age (per cent)
Table 11A.24	Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported
Table 11A.25	Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)

Table 11A.26	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 11A.27	Non-referred attendances that were bulk billed by age (per cent)
Table 11A.28	People deferring access to GPs due to cost (per cent)
Table 11A.29	Waiting time for GPs for an urgent appointment (per cent)
Table 11A.30	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 11A.31	Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2011-12 (number)
Table 11A.32	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 11A.33	Emergency department presentations, 2011-12 (number)
Table 11A.34	People deferring access to prescribed medication due to cost (per cent)
Table 11A.35	Waiting time for public dentistry (per cent) by remoteness, by State and Territory, 2011-12
Table 11A.36	Waiting time for public dentistry (per cent) by remoteness, Australia, 2011-12
Table 11A.37	Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent)
Table 11A.38	Number and proportion of full time workload equivalent (FWE) GPs with vocational registration
Table 11A.39	General practices that are accredited at 30 June
Table 11A.40	General practice activity in PIP practices (per cent)
Table 11A.41	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
Table 11A.42	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 11A.43	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia
Table 11A.44	Proportion of people with diabetes who had a GP annual cycle of care, 2011-12 (per cent)
Table 11A.45	Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent)
Table 11A.46	Proportion of people with asthma with a written asthma action plan, by age (per cent)
Table 11A.47	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 11A.48	Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05
Table 11A.49	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 11A.50	Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2011-12 dollars) and number of rebated MBS pathology items

Table 11A.51	Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2011-12 dollars) and number of rebated MBS imaging items
Table 11A.52	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 11A.53	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 11A.54	Client experience of GPs by remoteness, by State and Territory area
Table 11A.55	Client experience of GPs by remoteness area
Table 11A.56	Client experience of dental professionals by remoteness area, by State and Territory
Table 11A.57	Client experience of dental professionals by remoteness area
Table 11A.58	Annual health assessments for older people
Table 11A.59	Valid vaccinations supplied to children under seven years of age, by type of provider, 2007–2012
Table 11A.60	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 11A.61	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 11A.62	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 11A.63	Notifications of measles, children aged 0–14 years
Table 11A.64	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 11A.65	Notifications of Haemophilus influenzae type b, children aged 0–14 years
Table 11A.66	Participation rates for women in BreastScreen Australia (24 month period)
Table 11A.67	Participation rates for women in BreastScreen Australia by residential status, 2010 and 2011 (24 month period)
Table 11A.68	Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 11A.69	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 11A.70	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 11A.71	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
Table 11A.72	Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004-05 (per cent)
Table 11A.73	Influenza vaccination coverage, people aged 65 years or over
Table 11A.74	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
Table 11A.75	Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05

Table 11A.76	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 11A.77	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 11A.78	Separations for selected potentially preventable hospitalisations by remoteness, 2010-11 (per 1000 people)
Table 11A.79	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people)
Table 11A.80	Separations for selected vaccine preventable conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.81	Separations for selected acute conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.82	Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.83	Ratio of separations for Indigenous Australians to all Australians, diabetes, 2010-11
Table 11A.84	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2010-11 (per 100 000 people)
Table 11A.85	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2010-11 (per cent)
Table 11A.86	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11
Table 11A.84	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2010-11 (per 100 000 people)

Community health programs

Table 11A.88	Australian Government, community health services programs
Table 11A.89	New South Wales, community health services programs
Table 11A.90	Victoria, community health services programs
Table 11A.91	Queensland, community health services programs
Table 11A.92	Western Australia, community health services programs
Table 11A.93	South Australia, community health services programs
Table 11A.94	Tasmania, community health services programs
Table 11A.95	Australian Capital Territory, community health services programs
Table 11A.96	Northern Territory, community health services programs

11.7 References

- ACAM (Australian Centre for Asthma Monitoring) 2008, *Asthma in Australia 2008*, Cat. no. ACM 14, AIHW Asthma Series 3, Canberra.
- Australian Government 2010, *Building a 21st Century Primary Health Care System — Australia's First National Primary Health Care Strategy*, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2007, *National indicators for monitoring diabetes: report of the Diabetes Indicators Review Subcommittee of the National Diabetes Data Working Group*, Cat. no. CVD 38, Diabetes series no. 6, Canberra.
- 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses*, AIHW Cat. no. IHW 22, Canberra.
- 2008b, *Australia's health 2008*, Cat. no. AUS 99, Canberra.
- 2008c, *Diabetes: Australian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.
- 2012a, *Alcohol and other drug treatment services in Australia 2010-11: report on the National Minimum Data Set*, Cat. no. HSE 128, Drug treatment series no. 18, Canberra.
- 2012b, *Australian hospital statistics 2010-11*, Cat. no. HSE 117, Canberra.
- 2012c, *Hospitalisations due to falls in older people, Australia 2008-09*, Cat. no. INJCAT 138, Injury research and statistics series no. 62, Canberra.
- AIHW and NBCC (National Breast Cancer Centre) 2007, *Breast cancer survival by size and nodal status in Australia*, Cat. no. CAN 34, Cancer series no. 39, AIHW, Canberra.
- Britt, H., Miller, G.C, Henderson, J., Charles, J., Valenti, L., Harrison, C., Bayram, C., Zhang, C., Pollack, A.J., O'Halloran, J., Pan, Y. 2012, *General practice activity in Australia 2011-12*, General practice series no. 31, Sydney University Press, Sydney.
- DoHA (Australian Government Department of Health and Ageing) 2004, *Australian national notifiable diseases list and case definitions*, www.health.gov.au/internet/wcms/publishing.nsf/Content/cda_surveil-nndss-dislist.htm#pagetop (accessed 12 September 2007).
- 2008, *Immunisation Myths and Realities: responding to arguments against immunisation*, 4th edn, Canberra.
- 2009, *Evaluation of the BreastScreen Australia Program – Evaluation Final Report*, Australian Government, Canberra.

-
- 2010, *About the PBS*, www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-aboutus.htm-copy2 (accessed 24 September 2010).
- 2012a, *About the PBS*, <http://www.pbs.gov.au/info/about-the-pbs> (accessed 7 September 2012).
- 2012b, *The Pap smear*, <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/papsmear> (accessed 7 September 2012).
- DoHA and NHMRC (National Health and Medical Research Council) 2008, *The Australian Immunisation Handbook*, 9th edn, Canberra.
- DHS (Department of Human Services) 2002, *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*, Victorian Government, Melbourne.
- Hofmarcher, M., Oxley, H. and Rusticelli, E. 2007, *Improved Health System Performance through Better Care Coordination*, OECD Health Working Paper No. 30, OECD, Paris.
- Mitchell, H., Hocking, J. and Saville, M. 2003, 'Improvement in protection of adenocarcinoma of the cervix resulting from participation in cervical screening', *Cancer Cytopathology*, vol. 99, no. 6, pp. 336–341.
- National Advisory Committee on Oral Health 2004, *Healthy mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013*, Report endorsed by the Australian Health Ministers' Conference, Government of South Australia, Adelaide.
- NCIRS (National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases) 2000, *Vaccine Preventable Diseases and Vaccination Coverage in Australia, 1993–1998*, University of Sydney, Royal Alexandra Hospital for Children and Australian Government Department of Health and Aged Care, Canberra.
- NHPAC (National Health Priority Action Council) 2006, *National Chronic Disease Strategy*, Australian Government Department of Health and Ageing, Canberra.
- Quality Improvement Council 1998, *Australian Health and Community Service Standards: Community and Primary Health Care Services Module*, Melbourne.
- RACGP (Royal Australian College of General Practitioners) 2007, *Vocational Training*, www.racgp.org.au/vocationaltraining (accessed 12 October 2009 – no longer on the webpage 11/8/11).
- 2011, *RACGP Definition of general practice* www.racgp.org.au/whatisgeneralpractice (accessed 11 August 2011).

SCRGSP (Steering Committee for the Review of Government Service Provision) 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra.

Van Konkelenberg, R. Esterman, A. Van Konkelenberg, J. 2003, *Literature Reviews: Factors Influencing use of Emergency Departments and Characteristics of Patients Admitted Through Emergency Departments*, www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1002&context=ecc (accessed 11 August 2011).

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.

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

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

Attachment contents

Table 11A.1	Types of encounter, 2011-12
Table 11A.2	Australian Government real expenditure on GPs (\$ million) (2011-12 dollars)
Table 11A.3	Australian government expenditure on the Pharmaceutical Benefits Scheme (2011-12 dollars)
Table 11A.4	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2011-12 dollars)
Table 11A.5	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 11A.6	Number of GP-type services used per 1000 people
Table 11A.7	PBS services
Table 11A.8	PBS services, by service type ('000)
Table 11A.9	Use of public dental services, by service type, 2010
Table 11A.10	Alcohol and other drug treatment agencies, by sector, 2010-11 (number)
Table 11A.11	Indigenous primary healthcare services and episodes of healthcare (number)
Table 11A.12	Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 11A.13	Proportion of Indigenous primary healthcare services that undertook selected health related activities (per cent)
Table 11A.14	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 2011 (number)
Table 11A.15	Approved providers of PBS medicines, by urban and rural location
Table 11A.16	PBS expenditure per person, by urban and rural location (2011-12 dollars)
Table 11A.17	Availability of GPs by region
Table 11A.18	Availability of female GPs
Table 11A.19	Availability of public dentists (per 100 000 people)
Table 11A.20	Availability of public dental therapists (per 100 000 people)
Table 11A.21	Annual health assessments for older people by Indigenous status (per cent)
Table 11A.22	Older Indigenous people who received an annual health assessment (per cent)
Table 11A.23	Indigenous people who received a health check or assessment, by age (per cent)
Table 11A.24	Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported
Table 11A.25	Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
Table 11A.26	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 11A.27	Non-referred attendances that were bulk billed by age (per cent)
Table 11A.28	People deferring access to GPs due to cost (per cent)
Table 11A.29	Waiting time for GPs for an urgent appointment (per cent)
Table 11A.30	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 11A.31	Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2011-12 (number)
Table 11A.32	Selected potentially avoidable GP-type presentations to emergency departments (number)

Attachment contents

Table 11A.33	Emergency department presentations, 2011-12 (number)
Table 11A.34	People deferring access to prescribed medication due to cost (per cent)
Table 11A.35	Waiting time for public dentistry (per cent)
Table 11A.36	Waiting time for public dentistry by remoteness, Australia (per cent)
Table 11A.37	Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent)
Table 11A.38	Number and proportion of full time workload equivalent (FWE) GPs with vocational registration
Table 11A.39	General practices that are accredited at 30 June
Table 11A.40	General practice activity in PIP practices (per cent)
Table 11A.41	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
Table 11A.42	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 11A.43	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia
Table 11A.44	Proportion of people with diabetes who had a GP annual cycle of care, 2011-12 (per cent)
Table 11A.45	Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent)
Table 11A.46	Proportion of people with asthma with a written asthma action plan, by age (per cent)
Table 11A.47	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 11A.48	Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05
Table 11A.49	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 11A.50	Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2011-12 dollars) and number of rebated MBS pathology items
Table 11A.51	Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2011-12 dollars) and number of rebated MBS imaging items
Table 11A.52	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 11A.53	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 11A.54	Client experience of GPs by remoteness, States and Territories
Table 11A.55	Client experience of GPs by remoteness, Australia
Table 11A.56	Client experience of dental professionals by remoteness, States and Territories
Table 11A.57	Client experience of dental professionals by remoteness, Australia
Table 11A.58	Annual health assessments for older people
Table 11A.59	Valid vaccinations supplied to children under seven years of age, by type of provider, 2007–2012

Attachment contents

Table 11A.60	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 11A.61	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 11A.62	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 11A.63	Notifications of measles, children aged 0–14 years
Table 11A.64	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 11A.65	Notifications of invasive Haemophilus influenzae type b, children aged 0–14 years
Table 11A.66	Participation rates for women in BreastScreen Australia (24 month period)
Table 11A.67	Participation rates for women in BreastScreen Australia by residential status, 2010 and 2011 (24 month period)
Table 11A.68	Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 11A.69	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 11A.70	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 11A.71	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
Table 11A.72	Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004-05 (per cent)
Table 11A.73	Influenza vaccination coverage, people aged 65 years or over
Table 11A.74	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
Table 11A.75	Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05
Table 11A.76	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 11A.77	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 11A.78	Separations for selected potentially preventable hospitalisations by remoteness, 2010-11 (per 1000 people)
Table 11A.79	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people)
Table 11A.80	Separations for selected vaccine preventable conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.81	Separations for selected acute conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.82	Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.83	Ratio of separations for Indigenous Australians to all Australians, diabetes, 2010-11
Table 11A.84	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2010-11 (per 100 000 people)
Table 11A.85	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2010-11 (per cent)

Attachment contents

Table 11A.86 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11

Table 11A.87 Separation rates of older people for injuries due to falls

Community health programs

Table 11A.88 Australian Government, community health services programs

Table 11A.89 New South Wales, community health services programs

Table 11A.90 Victoria, community health services programs

Table 11A.91 Queensland, community health services programs

Table 11A.92 Western Australia, community health services programs

Table 11A.93 South Australia, community health services programs

Table 11A.94 Tasmania, community health services programs

Table 11A.95 Australian Capital Territory, community health services programs

Table 11A.96 Northern Territory, community health services programs

TABLE 11A.1

Table 11A.1 **Types of encounter, 2011-12 (a), (b)**

	<i>Number</i>	<i>Per cent of encounters (c) (n = 91 956)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Per cent of direct encounters (n = 90 429)</i>	<i>Per cent of Medicare/DVA-paid GP items (n = 87 243)</i>
	no.	%	%	%	%	%
Direct encounters	90 429	98.3	98.1	98.6	100.0	..
No charge	450	0.5	0.3	0.7	0.5	..
MBS/DVA items of service (direct encounters only) (d)	87 264	94.9	94.4	95.4	96.5	..
MBS/DVA items of service (GPs only)	87 243	94.9	94.4	95.3	96.5	100.0
Short surgery consultations	1 619	1.8	1.4	2.1	1.8	1.9
Standard surgery consultations	71 386	77.6	76.5	78.8	78.9	81.8
Long surgery consultations	7 403	8.1	7.5	8.6	8.2	8.5
Prolonged surgery consultations	479	0.5	0.4	0.6	0.5	0.5
Home or institution visits (excluding RACF)	637	0.7	0.5	0.9	0.7	0.7
Residential aged care facility	1 624	1.8	1.1	2.4	1.8	1.9
Health assessments	387	0.4	0.3	0.5	0.4	0.4
Chronic disease management items	1 137	1.2	1.1	1.4	1.3	1.3
Case conferences	5	–	–	–	–	–
GP mental health care items	1 221	1.3	1.2	1.5	1.4	1.4
Attendances associated with practice incentive payments	153	0.2	0.1	0.2	0.2	0.2
Other items	1 193	1.3	0.9	1.7	1.3	1.4
Workers compensation	1 853	2.0	1.8	2.2	2.0	..
Other paid (hospital, State, etc.)	862	0.9	0.7	1.2	1.0	..

TABLE 11A.1

Table 11A.1 **Types of encounter, 2011-12 (a), (b)**

	<i>Number</i>	<i>Per cent of encounters (c) (n = 91 956)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Per cent of direct encounters (n = 90 429)</i>	<i>Per cent of Medicare/DVA-paid GP items (n = 87 243)</i>
Indirect encounters (e)	1 522	1.7	1.4	1.9	..	..
Direct/indirect encounter unspecified	5	–	–	–	..	..
Total encounters	91 956	100.0	..	..	..	..
MBS/DVA items of service (all encounters)	87 323	95.0	94.5	95.4	..	..

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

- (a) An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals).
- (b) One Medicare item number counted per encounter (where applicable).
- (c) Missing data removed from analysis ($n=7074$).
- (d) Direct encounters are encounters where the patient is seen by the health professional. Includes direct encounters at which either a GP or other health professional item (or both) was recorded.
- (e) Indirect encounters are encounters where the patient is not seen but a service is provided (for example, a prescription or referral). Includes indirect encounters involving a GP or other health professional (or both). Includes five encounters involving chronic disease management or case conference items.
- .. Not applicable. – Nil or rounded to zero.

Source: Britt, H., Miller, G.C, Henderson, J., Charles, J., Valenti, L., Harrison, C., Bayram, C., Zhang, C., Pollack, A.J., O'Halloran, J., Pan, Y. 2012, *General practice activity in Australia 2011–12*, General practice series no. 31, Sydney University Press, Sydney.

TABLE 11A.2

**Table 11A.2 Australian Government real expenditure on GPs (\$ million)
(2011-12 dollars) (a), (b), (c), (d)**

This page has changed since the Report was released in January 2013. See errata at <http://www.pc.gov.au/gsp/reports/rogs/2013/errata>

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Expenditure										
2006-07	\$m	2 194.3	1 521.4	1 218.1	520.7	492.5	142.1	76.4	34.1	6 199.6
2007-08	\$m	2 261.4	1 596.5	1 276.8	541.8	510.9	147.8	79.7	37.3	6 452.2
2008-09	\$m	2 231.0	1 585.0	1 282.3	531.5	508.3	143.3	78.1	37.1	6 396.6
2009-10	\$m	2 294.1	1 651.2	1 343.7	550.6	523.0	149.3	79.7	40.7	6 632.3
2010-11	\$m	2 277.7	1 656.8	1 354.5	544.8	515.4	147.7	78.9	42.5	6 618.3
2011-12	\$m	2 322.6	1 682.0	1 391.1	545.8	517.4	149.6	80.4	44.1	6 733.1
Expenditure per person										
2006-07	\$	320.1	294.5	294.8	250.2	312.6	289.0	227.1	160.4	297.3
2007-08	\$	326.5	304.3	302.0	254.3	320.9	298.1	233.8	171.4	304.6
2008-09	\$	316.8	295.4	294.8	241.1	315.3	286.4	224.5	167.4	295.5
2009-10	\$	319.0	300.4	300.4	242.5	320.1	295.4	224.6	178.7	299.4
2010-11	\$	313.2	296.6	297.8	235.1	312.3	290.0	218.0	184.9	294.4
2011-12	\$	320.5	301.7	308.2	228.6	314.5	292.3	216.9	189.8	299.4

- (a) Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 dollars), table AA.51. Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.
- (b) Data include expenditure on Department of Human Services—Medicare (formerly Medicare Australia), the Practice Incentives Program (PIP), the Department of Veterans' Affairs (DVA), Divisions of General Practice Program (DGPP) and the General Practice Immunisation Incentive Scheme (GPPII).
- (c) DVA data for 2010-11 and 2011-12 include expenditure only on specialist GPs. DVA data for 2009-10 and previous years include expenditure on all local medical officers (LMO). Other data include expenditure on vocationally registered GPs and other medical practitioners (OMPs).
- (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, GPPII, DGPP and DVA data collections; table AA.51.

TABLE 11A.3

Table 11A.3 Australian government expenditure on the Pharmaceutical Benefits Scheme (2011-12 dollars) (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Total (b)										
2003-04	\$m	2 384.0	1 718.1	1 249.6	596.2	575.0	186.2	86.7	23.5	6 832.1
2004-05	\$m	2 423.4	1 749.7	1 311.3	603.1	585.7	185.0	88.4	24.8	6 971.8
2005-06	\$m	2 339.6	1 704.0	1 268.8	583.7	579.3	183.4	84.9	24.6	6 768.4
2006-07	\$m	2 263.7	1 636.2	1 244.8	569.8	556.2	175.5	81.3	23.3	6 550.8
2007-08	\$m	2 334.9	1 690.1	1 285.2	591.3	579.1	183.5	83.3	24.6	6 772.2
2008-09	\$m	2 476.3	1 774.4	1 365.5	630.9	603.8	193.4	87.6	25.8	7 157.7
2009-10	\$m	2 620.8	1 880.9	1 455.3	660.0	634.9	205.9	93.5	26.8	7 578.1
2010-11	\$m	2 583.8	1 842.2	1 428.5	662.7	614.8	205.4	92.0	27.3	7 456.7
2011-12	\$m	2 583.1	1 853.9	1 452.3	701.0	623.3	208.6	91.9	27.0	7 541.2
RPBS Total										
2004-05	\$m	217.7	135.1	136.8	46.9	47.0	18.6	8.8	1.1	612.0
2005-06	\$m	201.7	126.3	127.0	44.0	44.7	17.8	8.4	1.2	571.1
2006-07	\$m	184.7	115.5	118.7	41.1	41.0	15.8	7.7	1.0	525.4
2007-08	\$m	179.5	109.9	115.7	40.5	39.4	15.5	7.8	1.0	509.3
2008-09	\$m	178.6	106.6	115.4	40.1	38.9	15.1	7.8	1.0	503.5
2009-10	\$m	179.9	106.2	118.0	39.1	39.7	15.2	7.8	1.0	506.9
2010-11	\$m	164.9	95.5	110.9	36.5	34.8	14.0	7.3	0.9	464.7
2011-12	\$m	156.3	88.7	108.3	35.8	33.5	13.6	6.8	0.9	444.0
PBS and RPBS TOTAL										
2004-05	\$m	2 641.1	1 884.8	1 448.1	650.0	632.7	203.7	97.2	26.0	7 583.8
2005-06	\$m	2 541.3	1 830.3	1 395.8	627.8	624.0	201.2	93.3	25.7	7 339.4
2006-07	\$m	2 448.4	1 751.6	1 363.5	610.9	597.2	191.3	89.0	24.3	7 076.2
2007-08	\$m	2 514.4	1 800.0	1 400.9	631.8	618.5	199.0	91.1	25.6	7 281.4
2008-09	\$m	2 655.0	1 881.0	1 480.9	671.0	642.6	208.5	95.3	26.8	7 661.2
2009-10	\$m	2 800.7	1 987.0	1 573.3	699.1	674.7	221.1	101.3	27.8	8 085.0
2010-11	\$m	2 748.7	1 937.7	1 539.4	699.3	649.6	219.4	99.2	28.2	7 921.4
2011-12	\$m	2 739.4	1 942.6	1 560.7	736.8	656.8	222.3	98.7	27.9	7 985.1

TABLE 11A.3

Table 11A.3 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2011-12 dollars) (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS total expenditure per person (b)										
2003-04	\$	353.4	345.2	321.7	300.5	374.6	385.7	268.2	118.0	338.8
2004-05	\$	356.4	347.2	330.5	298.9	379.4	380.4	271.6	122.6	341.9
2005-06	\$	343.9	334.2	312.6	286.0	370.9	374.8	254.9	117.4	328.6
2006-07	\$	329.6	316.1	300.6	273.4	352.4	356.4	241.2	109.5	313.5
2007-08	\$	336.3	321.5	303.2	277.0	363.1	369.5	243.9	112.8	319.0
2008-09	\$	350.9	330.0	313.1	285.7	373.8	385.8	251.2	116.2	330.0
2009-10	\$	363.7	341.5	324.6	290.2	387.9	406.8	262.9	117.5	341.4
2010-11	\$	354.6	329.2	313.3	285.6	371.9	402.6	253.6	118.6	331.1
2011-12	\$	355.8	332.0	321.2	293.2	378.3	407.1	247.5	116.1	334.8
Proportion of PBS expenditure that is concessional (b)										
2003-04	%	79.9	79.7	79.7	77.9	81.6	84.7	65.8	65.4	79.5
2004-05	%	79.8	79.8	79.4	77.8	81.4	84.6	66.0	66.8	79.6
2005-06	%	80.3	80.3	79.6	77.9	82.3	85.0	66.7	67.1	80.0
2006-07	%	80.8	80.8	80.0	77.2	82.4	84.9	66.8	68.6	80.4
2007-08	%	79.9	80.1	78.6	75.0	81.8	84.7	65.5	66.8	79.3
2008-09	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9
2009-10	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
2010-11	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
2011-12	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8

(a) Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 dollars), table AA.51. Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.

(b) PBS expenditure data exclude RPBS and doctor's bag.

Source: DoHA (unpublished) PBS Statistics; table AA.51.

TABLE 11A.4

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service
(2011-12 dollars) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2007-08</i>										
PBS General Ordinary	\$m	395.5	283.7	233.7	127.7	90.8	24.6	24.6	7.4	1 187.9
PBS General Safety Net	\$m	69.1	49.3	37.9	18.9	13.7	3.1	3.9	0.7	196.7
PBS General total	\$m	464.6	333.0	271.6	146.6	104.5	27.7	28.6	8.1	1 384.6
PBS Concessional Ordinary	\$m	1 400.5	1 029.3	760.9	344.7	362.1	116.7	43.2	14.2	4 071.6
PBS Concessional Free Safety Net	\$m	464.3	324.1	249.4	98.8	111.4	38.8	11.4	2.2	1 300.5
PBS Concessional total (a)	\$m	1 864.9	1 353.4	1 010.3	443.6	473.5	155.5	54.6	16.4	5 372.1
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	5.5	3.7	3.4	1.1	1.1	0.3	0.2	0.1	15.4
PBS Unknown free safety net plus Doctors bag	\$m	5.5	3.7	3.4	1.1	1.1	0.3	0.2	0.1	15.4
PBS Total	\$m	2 334.9	1 690.1	1 285.2	591.3	579.1	183.5	83.3	24.6	6 772.2
RPBS Total (c)	\$m	179.5	109.9	115.7	40.5	39.4	15.5	7.8	1.0	509.3
PBS and RPBS TOTAL	\$m	2 514.4	1 800.0	1 400.9	631.8	618.5	199.0	91.1	25.6	7 281.4
PBS total expenditure per person (no.) (d)	\$	336.3	321.5	303.2	277.0	363.1	369.5	243.9	112.8	319.0
Proportion of PBS expenditure that is concessional (%)	%	79.9	80.1	78.6	75.0	81.8	84.7	65.5	66.8	79.3
<i>2008-09</i>										
PBS General Ordinary	\$m	437.4	314.6	266.6	146.0	99.1	28.9	26.8	8.4	1 327.8
PBS General Safety Net	\$m	84.3	57.3	46.6	22.8	15.7	4.5	4.8	0.8	236.7
PBS General total	\$m	521.6	371.8	313.2	168.9	114.8	33.4	31.6	9.2	1 564.5
PBS Concessional Ordinary	\$m	1 477.6	1 067.2	794.0	360.4	375.5	120.7	44.3	14.5	4 254.2

TABLE 11A.4

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service
(2011-12 dollars) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Concessional Free Safety Net	\$m	471.6	331.6	254.7	100.5	112.3	38.9	11.5	2.1	1 323.2
PBS Concessional total (a)	\$m	1 949.2	1 398.8	1 048.8	460.9	487.8	159.6	55.7	16.6	5 577.4
PBS Unknown Free Safety Net	\$m	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	\$m	5.5	3.8	3.5	1.2	1.2	0.4	0.2	0.1	15.8
PBS Unknown free safety net plus Doctors bag	\$m	5.5	3.8	3.5	1.2	1.2	0.4	0.2	0.1	15.8
PBS Total	\$m	2 476.3	1 774.4	1 365.5	630.9	603.8	193.4	87.6	25.8	7 157.7
RPBS Total (c)	\$m	178.6	106.6	115.4	40.1	38.9	15.1	7.8	1.0	503.5
PBS and RPBS TOTAL	\$m	2 655.0	1 881.0	1 480.9	671.0	642.6	208.5	95.3	26.8	7 661.2
PBS total expenditure per person (no.) (d)	\$	350.9	330.0	313.1	285.7	373.8	385.8	251.2	116.2	330.0
Proportion of PBS expenditure that is concessional (%)	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9
<i>2009-10</i>										
PBS General Ordinary	\$m	473.0	343.7	291.0	158.0	105.3	32.6	30.4	9.0	1 443.1
PBS General Safety Net	\$m	75.3	52.0	43.1	21.5	14.0	4.2	4.3	0.6	215.1
PBS General total	\$m	548.3	395.8	334.1	179.5	119.3	36.8	34.7	9.7	1 658.2
PBS Concessional Ordinary	\$m	1 584.9	1 140.7	854.7	377.5	398.7	129.2	47.0	15.0	4 547.8
PBS Concessional Free Safety Net	\$m	482.5	340.8	263.3	101.9	115.8	39.6	11.5	2.1	1 357.5
PBS Concessional total (a)	\$m	2 067.5	1 481.5	1 118.0	479.4	514.5	168.8	58.6	17.1	5 905.3
PBS Unknown Free Safety Net	\$m	—	—	—	—	—	—	—	—	—

TABLE 11A.4

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service
(2011-12 dollars) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Doctors Bag	\$m	5.0	3.6	3.2	1.1	1.1	0.3	0.2	0.1	14.6
PBS Unknown free safety net plus Doctors bag	\$m	5.0	3.6	3.2	1.1	1.1	0.3	0.2	0.1	14.6
PBS Total	\$m	2 620.8	1 880.9	1 455.3	660.0	634.9	205.9	93.5	26.8	7 578.1
RPBS Total (c)	\$m	179.9	106.2	118.0	39.1	39.7	15.2	7.8	1.0	506.9
PBS and RPBS TOTAL	\$m	2 800.7	1 987.0	1 573.3	699.1	674.7	221.1	101.3	27.8	8 085.0
PBS total expenditure per person (no.) (d)	\$	363.7	341.5	324.6	290.2	387.9	406.8	262.9	117.5	341.4
Proportion of PBS expenditure that is concessional (%)	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
<i>2010-11</i>										
PBS General Ordinary	\$m	470.3	342.0	282.9	163.8	104.1	33.0	30.0	9.6	1 435.8
PBS General Safety Net	\$m	74.4	51.9	43.1	22.5	14.4	3.9	4.5	0.7	215.4
PBS General total	\$m	544.7	393.9	326.0	186.3	118.5	36.9	34.5	10.3	1 651.1
PBS Concessional Ordinary	\$m	1 554.7	1 105.0	836.5	372.4	379.9	129.5	45.9	14.8	4 438.8
PBS Concessional Free Safety Net	\$m	479.6	339.7	262.6	102.9	115.4	38.6	11.3	2.1	1 352.3
PBS Concessional total (a)	\$m	2 034.3	1 444.7	1 099.2	475.3	495.3	168.1	57.3	17.0	5 791.1
PBS Unknown Free Safety Net	\$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	\$m	4.8	3.6	3.4	1.1	1.1	0.3	0.2	0.1	14.5
PBS Unknown free safety net plus Doctors bag	\$m	4.8	3.6	3.4	1.1	1.1	0.3	0.2	0.1	14.5
PBS Total	\$m	2 583.8	1 842.2	1 428.5	662.7	614.8	205.4	92.0	27.3	7 456.7
RPBS Total (c)	\$m	164.9	95.5	110.9	36.5	34.8	14.0	7.3	0.9	464.7

TABLE 11A.4

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service
(2011-12 dollars) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS and RPBS TOTAL	\$m	2 748.7	1 937.7	1 539.4	699.3	649.6	219.4	99.2	28.2	7 921.4
PBS total expenditure per person (no.) (d)	\$	354.6	329.2	313.3	285.6	371.9	402.6	253.6	118.6	331.1
Proportion of PBS expenditure that is concessional (%)	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
<i>2011-12</i>										
PBS General Ordinary	\$m	468.9	349.1	280.7	177.9	104.4	33.6	29.7	9.4	1 453.8
PBS General Safety Net	\$m	69.7	51.2	41.2	22.4	14.4	4.0	4.6	0.6	208.2
PBS General total	\$m	538.6	400.3	322.0	200.3	118.9	37.5	34.3	10.0	1 661.9
PBS Concessional Ordinary	\$m	1 550.7	1 102.1	856.1	393.0	383.1	130.7	45.6	14.8	4 476.1
PBS Concessional Free Safety Net	\$m	489.5	348.2	271.5	106.6	120.3	40.1	11.8	2.1	1 390.2
PBS Concessional total (a)	\$m	2 040.2	1 450.3	1 127.5	499.7	503.4	170.8	57.4	17.0	5 866.3
PBS Unknown Free Safety Net	\$m	—	—	—	—	—	—	—	—	—
PBS Doctors Bag	\$m	4.3	3.3	2.8	1.0	1.0	0.3	0.2	0.1	13.0
PBS Unknown free safety net plus Doctors bag	\$m	4.3	3.3	2.8	1.0	1.0	0.3	0.2	0.1	13.0
PBS Total	\$m	2 583.1	1 853.9	1 452.3	701.0	623.3	208.6	91.9	27.0	7 541.2
RPBS Total (c)	\$m	156.3	88.7	108.3	35.8	33.5	13.6	6.8	0.9	444.0
PBS and RPBS TOTAL	\$m	2 739.4	1 942.6	1 560.7	736.8	656.8	222.3	98.7	27.9	7 985.1
PBS total expenditure per person (no.) (d)	\$	355.8	332.0	321.2	293.2	378.3	407.1	247.5	116.1	334.8
Proportion of PBS expenditure that is concessional (%)	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8

TABLE 11A.4

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2011-12 dollars) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 dollars), table AA.51. Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.									
(b)	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 <i>National Health Act 1953</i> [Cwlth]).									
(c)	Includes RPBS ordinary and RPBS safety net.									
(d)	PBS expenditure per person excludes RPBS and PBS doctor's bag. – Nil or rounded to zero.									

Source: DoHA (unpublished) PBS Statistics; table AA.51.

TABLE 11A.5

Table 11A.5 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP numbers										
2002-03	no.	7 888	5 878	4 760	2 365	1 983	653	407	326	24 260
2003-04	no.	7 910	5 596	4 486	2 153	1 915	605	374	300	22 949
2004-05	no.	7 590	5 721	4 644	2 175	1 944	609	375	320	23 378
2005-06	no.	7 708	5 802	4 793	2 240	1 980	625	381	305	23 834
2006-07	no.	7 855	5 914	4 864	2 310	1 990	642	373	324	24 272
2007-08	no.	7 934	6 062	5 052	2 357	2 099	661	383	355	24 903
2008-09	no.	8 105	6 240	5 340	2 458	2 141	679	385	378	25 726
2009-10	no.	8 389	6 449	5 564	2 492	2 201	704	398	416	26 613
2010-11	no.	8 654	6 710	5 810	2 614	2 253	719	416	463	27 639
2011-12	no.	8 998	7 033	6 199	2 744	2 348	770	440	479	29 011
FWE GPs										
2002-03	no.	5 959	4 144	3 181	1 458	1 354	376	203	97	16 772
2003-04	no.	6 021	4 110	3 260	1 451	1 360	374	198	98	16 872
2004-05	no.	6 222	4 167	3 389	1 457	1 364	378	200	95	17 273
2005-06	no.	6 310	4 283	3 489	1 473	1 404	386	208	97	17 649
2006-07	no.	6 483	4 407	3 564	1 500	1 416	391	226	104	18 091
2007-08	no.	6 600	4 584	3 683	1 542	1 455	401	232	116	18 613
2008-09	no.	6 792	4 738	3 861	1 574	1 511	404	235	116	19 231
2009-10	no.	6 893	4 901	3 993	1 615	1 546	417	238	127	19 729
2010-11	no.	7 067	5 063	4 126	1 640	1 570	429	239	134	20 267
2011-12	no.	7 338	5 270	4 343	1 698	1 628	449	250	142	21 119
FWE GPs per 100 000 people (e)										
2002-03	per 100 000 people	89.6	84.7	84.5	75.2	88.7	79.2	62.6	48.7	84.8
2003-04	per 100 000 people	90.0	83.0	84.5	73.7	88.5	77.8	60.7	48.9	84.3
2004-05	per 100 000 people	92.5	83.1	85.9	72.9	88.2	78.1	60.9	46.8	85.3

TABLE 11A.5

Table 11A.5 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2005-06	per 100 000 people	93.0	84.2	86.3	72.3	90.0	79.1	62.4	46.3	85.9
2006-07	per 100 000 people	94.6	85.3	86.3	72.1	89.9	79.5	67.2	48.7	86.8
2007-08	per 100 000 people	95.3	87.4	87.1	72.3	91.4	81.0	68.2	53.1	87.9
2008-09	per 100 000 people	96.5	88.3	88.8	71.4	93.7	80.7	67.6	52.2	88.8
2009-10	per 100 000 people	95.8	89.2	89.3	71.1	94.6	82.5	67.2	55.6	89.1
2010-11	per 100 000 people	97.2	90.6	90.7	70.8	95.1	84.3	66.0	58.2	90.2
2011-12	per 100 000 people	101.2	94.5	96.2	71.1	99.0	87.8	67.6	61.0	93.9

- (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 and FWE data include vocationally registered GPs and other medical practitioners (OMPs).
- (c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.
- (e) Historical data may differ from data in previous reports due to a change in the methodology used to derive population estimates.

Source: DoHA unpublished, MBS Statistics.

TABLE 11A.6

Table 11A.6 **Number of GP-type services used per 1000 people (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	5 951.8	5 491.1	5 656.2	4 740.2	5 519.4	5 072.6	4 494.6	3 363.1	5 552.9
2009-10	6 043.5	5 612.1	5 845.4	4 808.3	5 666.4	5 341.4	4 621.9	3 633.1	5 678.9
2010-11	5 956.6	5 631.5	5 705.4	4 676.2	5 554.2	5 154.3	4 520.8	3 670.6	5 598.9
2011-12 (c), (e)	6 230.6	5 851.9	5 796.8	4 521.5	5 914.3	5 406.2	4 308.9	3 287.8	5 763.4

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

(b) Rates are directly age standardised to the Australian population as at 30 June 2001 for the 2010-11 and previous reference years.

(c) Denominator for 2011-12 is the estimated resident population at 31 December 2011. For historical years, the denominator is the estimated resident population at 30 June preceding the reference year.

(d) DVA data are included.

(e) Data for 2011-12 are preliminary and are not age-standardised. These data are not directly comparable with data for previous years.

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

TABLE 11A.7

Table 11A.7

PBS services

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Total (a)										
2003-04	'000	57 522.0	41 578.0	30 517.0	14 544.0	14 028.0	4 745.0	1 940.0	560.0	165 861.0
2004-05	'000	58 751.2	42 867.3	32 156.7	14 851.4	14 314.0	4 777.0	1 971.1	589.8	170 278.5
2005-06	'000	57 822.1	42 716.2	31 508.1	14 609.4	14 319.8	4 838.5	1 918.6	590.0	168 322.6
2006-07	'000	58 050.4	42 583.8	32 008.2	14 571.3	14 144.5	4 723.0	1 881.9	572.6	168 535.5
2007-08	'000	58 467.4	43 649.9	32 693.8	14 593.3	14 537.4	4 864.0	1 897.3	592.9	171 296.0
2008-09	'000	62 123.6	46 221.7	34 874.5	15 602.7	15 319.6	5 089.4	1 990.4	614.1	181 836.1
2009-10	'000	62 716.4	46 882.6	35 292.2	15 531.6	15 727.3	5 115.7	2 024.2	621.5	183 911.5
2010-11	'000	64 112.6	47 935.7	36 242.5	15 976.2	15 837.6	5 296.6	2 106.1	635.0	188 142.3
2011-12	'000	65 896.3	49 189.6	37 910.2	17 107.8	16 445.8	5 563.3	2 112.7	647.4	194 873.1
RPBS Total										
2004-05	'000	5 547.3	3 517.0	3 491.2	1 215.7	1 213.1	524.6	197.3	28.5	15 734.7
2005-06	'000	5 311.9	3 415.1	3 336.3	1 183.1	1 187.0	510.3	195.7	28.4	15 167.8
2006-07	'000	5 172.0	3 321.8	3 312.7	1 168.2	1 143.4	479.5	197.6	27.6	14 822.8
2007-08	'000	4 915.7	3 177.8	3 234.6	1 123.5	1 116.8	461.9	197.2	28.6	14 256.1
2008-09	'000	4 936.2	3 160.3	3 298.2	1 136.7	1 122.3	454.3	199.2	28.9	14 336.1
2009-10	'000	4 768.4	3 047.3	3 213.5	1 073.9	1 097.4	438.0	197.5	27.8	13 863.9
2010-11	'000	4 572.5	2 900.6	3 111.1	1 032.3	1 020.5	419.1	194.2	26.3	13 276.7
2011-12	'000	4 403.5	2 784.2	3 108.2	1 036.7	1 004.3	410.1	186.5	27.1	12 960.6
PBS and RPBS TOTAL										
2004-05	'000	64 298.5	46 384.2	35 647.9	16 067.1	15 527.2	5 301.5	2 168.4	618.3	186 013.1
2005-06	'000	63 134.0	46 131.3	34 844.4	15 792.5	15 506.8	5 348.8	2 114.3	618.4	183 490.5
2006-07	'000	63 222.3	45 905.6	35 320.9	15 739.5	15 287.9	5 202.5	2 079.4	600.2	183 358.3
2007-08	'000	63 383.1	46 827.7	35 928.4	15 716.9	15 654.2	5 325.9	2 094.5	621.5	185 552.2
2008-09	'000	67 059.8	49 382.0	38 172.8	16 739.4	16 441.9	5 543.7	2 189.6	643.0	196 172.2
2009-10	'000	67 484.8	49 929.9	38 505.8	16 605.6	16 824.6	5 553.8	2 221.7	649.3	197 775.4
2010-11	'000	68 685.0	50 836.3	39 353.6	17 008.5	16 858.1	5 715.8	2 300.3	661.3	201 418.9

TABLE 11A.7

Table 11A.7

PBS services

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12	'000	70 299.8	51 973.8	41 018.4	18 144.4	17 450.1	5 973.4	2 299.3	674.5	207 833.7
PBS total services per person (a)										
2003-04	no.	8.6	8.5	8.1	7.0	9.0	9.8	6.0	2.0	8.3
2004-05	no.	8.6	8.5	8.1	7.4	9.3	9.8	6.0	2.9	8.3
2005-06	no.	8.5	8.4	7.8	7.2	9.2	9.9	5.8	2.8	8.2
2006-07	no.	8.5	8.2	7.7	7.0	9.0	9.6	5.6	2.7	8.1
2007-08	no.	8.4	8.3	7.7	6.8	9.1	9.8	5.6	2.7	8.1
2008-09	no.	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
2009-10	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
2010-11	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
2011-12	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
Proportion of PBS services that are concessional (a)										
2003-04	%	82.8	83.4	83.3	81.8	85.3	87.2	67.9	69.8	82.9
2004-05	%	83.0	83.3	83.1	81.6	85.3	87.2	68.6	70.0	83.1
2005-06	%	83.9	84.1	83.7	82.1	86.0	87.7	70.3	71.6	83.8
2006-07	%	85.4	85.6	84.8	83.0	87.2	88.8	72.5	74.4	85.2
2007-08	%	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7
2008-09	%	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
2009-10	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
2010-11	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
2011-12	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5

(a) PBS services exclude RPBS and doctor's bag.

Source: DoHA (unpublished) PBS Statistics.

TABLE 11A.8

Table 11A.8

PBS services, by service type ('000)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>2007-08</i>									
PBS General Ordinary	6 469	4 782	3 922	2 039	1 429	422	417	127	19 607
PBS General Safety Net	1 623	1 131	843	418	326	78	88	17	4 524
PBS General total	8 091	5 913	4 765	2 458	1 755	500	505	144	24 132
PBS Concessional Ordinary	38 349	29 104	21 397	9 571	9 898	3 327	1 111	391	113 147
PBS Concessional Free Safety Net	11 913	8 548	6 457	2 541	2 859	1 030	277	57	33 681
PBS Concessional total (a)	50 262	37 652	27 854	12 112	12 756	4 356	1 388	448	146 828
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	114	85	74	24	26	7	4	2	336
PBS Unknown free safety net plus Doctors bag	114	85	74	24	26	7	4	2	336
PBS Total	58 467	43 650	32 694	14 593	14 537	4 864	1 897	593	171 296
RPBS Total (b)	4 916	3 178	3 235	1 124	1 117	462	197	29	14 256
PBS and RPBS TOTAL	63 383	46 828	35 928	15 717	15 654	5 326	2 094	622	185 552
PBS total services per person (no.) (c)	8.4	8.3	7.7	6.8	9.1	9.8	5.6	2.7	8.1
Proportion of PBS services that are concessional (%)	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7
<i>2008-09</i>									
PBS General Ordinary	6 825	4 993	4 197	2 229	1 484	443	441	135	20 747
PBS General Safety Net	2 018	1 354	1 071	513	385	112	109	20	5 581
PBS General total	8 842	6 348	5 267	2 742	1 869	555	550	155	26 327
PBS Concessional Ordinary	40 723	30 797	22 727	10 191	10 443	3 473	1 151	401	119 906

TABLE 11A.8

Table 11A.8 **PBS services, by service type ('000)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Concessional Free Safety Net	12 437	8 986	6 796	2 642	2 979	1 053	285	56	35 234
PBS Concessional total (a)	53 160	39 783	29 524	12 833	13 422	4 526	1 436	457	155 141
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	122	91	84	28	29	9	4	2	368
PBS Unknown free safety net plus Doctors bag	122	91	84	28	29	9	4	2	368
PBS Total	62 124	46 222	34 875	15 603	15 320	5 089	1 990	614	181 836
RPBS Total (b)	4 936	3 160	3 298	1 137	1 122	454	199	29	14 336
PBS and RPBS TOTAL	67 060	49 382	38 173	16 739	16 442	5 544	2 190	643	196 172
PBS total services per person (no.) (c)	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
Proportion of PBS services that are concessional (%)	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
<i>2009-10</i>									
PBS General Ordinary	6 927	5 130	4 289	2 281	1 543	457	462	138	21 227
PBS General Safety Net	1 714	1 148	914	449	330	96	95	15	4 763
PBS General total	8 641	6 279	5 203	2 730	1 873	554	557	153	25 990
PBS Concessional Ordinary	41 698	31 666	23 283	10 197	10 864	3 525	1 188	413	122 832
PBS Concessional Free Safety Net	12 266	8 856	6 732	2 580	2 964	1 030	276	54	34 757
PBS Concessional total (a)	53 963	40 521	30 015	12 777	13 828	4 555	1 463	467	157 589
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	112	83	74	25	26	7	3	2	332

TABLE 11A.8

Table 11A.8 **PBS services, by service type ('000)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS Unknown free safety net plus Doctors bag	112	83	74	25	26	7	3	2	332
PBS Total	62 716	46 883	35 292	15 532	15 727	5 116	2 024	621	183 912
RPBS Total (b)	4 768	3 047	3 214	1 074	1 097	438	198	28	13 864
PBS and RPBS TOTAL	67 485	49 930	38 506	16 606	16 825	5 554	2 222	649	197 775
PBS total services per person (no.) (c)	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
Proportion of PBS services that are concessional (%)	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
<i>2010-11</i>									
PBS General Ordinary	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

TABLE 11A.8

Table 11A.8 **PBS services, by service type ('000)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS total 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
<i>2011-12</i>									
PBS General Ordinary	6 867	5 130	4 232	2 445	1 514	465	447	139	21 239
PBS General Safety Net	1 682	1 175	926	484	341	94	104	15	4 821
PBS General total	8 549	6 305	5 158	2 929	1 855	559	550	155	26 060
PBS Concessional Ordinary	43 912	33 102	25 259	11 300	11 296	3 885	1 256	433	130 442
PBS Concessional Free Safety Net	13 329	9 700	7 421	2 853	3 270	1 112	303	58	38 047
PBS Concessional total (a)	57 240	42 802	32 681	14 153	14 565	4 997	1 559	491	168 489
PBS Unknown Free Safety Net	na	na	na	na	na	na	na	na	na
PBS Doctors Bag	107	83	72	26	25	7	3	1	324
PBS Unknown free safety net plus Doctors bag	107	83	72	26	25	7	3	1	324
PBS Total	65 896	49 190	37 910	17 108	16 446	5 563	2 113	647	194 873
RPBS Total (b)	4 404	2 784	3 108	1 037	1 004	410	187	27	12 961
PBS and RPBS TOTAL	70 300	51 974	41 018	18 144	17 450	5 973	2 299	674	207 834
PBS total services per person (no.) (c)	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
Proportion of PBS services that are concessional (%)	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5

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

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

TABLE 11A.8

Table 11A.8 **PBS services, by service type ('000)**

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

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

na Not available. – Nil or rounded to zero.

Source: DoHA (unpublished) PBS Statistics.

TABLE 11A.9

Table 11A.9 Use of public dental services, by service type, 2010 (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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% CI									
Emergency services	± 4.6	± 5.9	± 11.0	± 7.4	± 7.8	± 14.9	± 14.3	± 14.3	± 3.2
General services	± 9.2	± 10.6	± 16.6	± 19.9	± 16.8	± 16.9	± 28.0	± 28.7	± 5.9
All services	± 10.2	± 12.0	± 19.2	± 20.9	± 17.8	± 22.0	± 31.0	± 30.8	± 6.5

ASR = Age standardised rate. **CI** = confidence interval. **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), *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 11A.10

Table 11A.10 **Alcohol and other drug treatment agencies, by sector, 2010-11 (number)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (a)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Government	196	—	51	12	40	4	1	5	309
Non-government (b), (c)	66	136	58	44	19	12	9	13	357
Total	262	136	109	56	59	16	10	18	666

(a) 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.

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

(c) Includes only agencies that receive public funding.

– Nil or rounded to zero.

Source: AIHW 2012, *Alcohol and Other Drug Treatment Services in Australia 2010-11: report on the National Minimum Data Set*, Cat. no. HSE 128, Drug Treatment Series no. 18, Canberra.

TABLE 11A.11

Table 11A.11 **Indigenous primary healthcare services and episodes of healthcare (number) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Indigenous primary healthcare services									
2008-09	39	24	31	28	14	10	2	57	205
2009-10	50	26	33	37	13	10	1	53	223
2010-11	56	25	37	35	15	11	1	55	235
Episodes of healthcare provided									
2008-09	452 147	160 177	335 664	305 712	191 269	34 695	23 216	593 035	2 095 915
2009-10	542 377	184 778	378 805	408 819	191 615	36 159	25 703	614 631	2 382 887
2010-11	521 753	200 535	309 689	473 132	221 809	37 667	29 732	703 750	2 498 067

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

Source: AIHW 2012 and previous issues, *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results*, 2008-09, 2009-10 and 2010-11, Cat. no.s IHW 31,56,79, Canberra.

TABLE 11A.12

Table 11A.12 **Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number) (a), (b), (c), (d), (e)**

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Total</i>
Indigenous primary healthcare services						
2008-09	26	40	50	29	60	205
2009-10	29	48	55	33	58	223
2010-11	34	52	59	29	61	235
Episodes of healthcare provided						
2008-09	289 955	312 960	539 318	499 835	453 847	2 095 915
2009-10	363 823	395 027	583 324	550 907	489 806	2 382 887
2010-11	399 003	413 332	495 653	532 361	657 718	2 498 067

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

Source: AIHW 2012 and previous issues, *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results*, 2008-09, 2009-10 and 2010-11, Cat. no.s IHW 31,56,79, Canberra.

TABLE 11A.13

Table 11A.13 Proportion of Indigenous primary healthcare services that undertook selected health related activities (per cent) (a), (b), (c), (d)

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

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

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

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

(d) The 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.

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

Source: AIHW 2012 and previous issues, *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results*, 2008-09, 2009-10 and 2010-11, Cat. no.s IHW 31,56,79, Canberra.

TABLE 11A.14

Table 11A.14 **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 2011 (number) (a), (b), (c), (d)**

	2010	2011
<i>Indigenous staff</i>		
Aboriginal health workers	836.6	899.4
Doctors	16.1	26.0
Nurses	72.2	72.9
Specialists	1.2	0.2
Counsellors/social workers	52.3	59.2
Other social and emotional wellbeing staff (e)	242.3	220.8
Allied health professionals (f)	49.7	31.8
Dentists	4.4	7.4
Dental assistants	47.9	43.9
Traditional healers	8.1	10.8
Sexual health workers	44.5	38.7
Substance misuse workers	77.5	101.2
Environmental health workers	24.0	23.8
Driver/field officers	218.1	255.6
Other health staff	6.0	142.3
Total Indigenous staff (g)	1 700.9	1 933.9
<i>Non-Indigenous staff</i>		
Aboriginal health workers	30.7	14.0
Doctors	319.3	335.4
Nurses	615.3	710.7
Specialists	7.4	13.0
Counsellors/social workers	84.6	89.1
Other social and emotional wellbeing staff (e)	66.2	97.6
Allied health professionals (f)	108.2	144.2
Dentists	39.8	48.7
Dental assistants	27.8	35.1
Traditional healers	0.0	3.1
Sexual health workers	20.0	16.6
Substance misuse workers	43.4	50.7
Environmental health workers	6.0	10.3
Driver/field officers	40.1	39.4
Other health staff	–	67.5
Total non-Indigenous staff (g)	1 408.7	1 675.2
<i>Total health staff (g), (h)</i>		
Aboriginal health workers	867.4	916.3
Doctors	335.4	361.6
Nurses	691.5	789.1

TABLE 11A.14

Table 11A.14 **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 2011 (number) (a), (b), (c), (d)**

	2010	2011
Specialists	8.8	13.2
Counsellors/social workers	136.9	148.3
Other social and emotional wellbeing staff (e)	309.4	318.9
Allied health professionals (f)	157.8	176.0
Dentists	44.2	56.1
Dental assistants	75.7	79.1
Traditional healers	8.2	13.9
Sexual health workers	64.5	55.3
Substance misuse workers	120.9	154.9
Environmental health workers	30.0	34.1
Driver/field officers	258.2	296.9
Other health staff	6.0	230.3
Total health staff (g), (h)	3 114.7	3 643.8

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

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

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

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

(e) 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.

(f) 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.

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

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

– Nil or rounded to zero.

Source: AIHW 2011 and 2012, *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results*, 2009-10 and 2010-11, Cat. No.s IHW 56,79, Canberra.

TABLE 11A.15

Table 11A.15 **Approved providers of PBS medicines, by urban and rural location (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
Number of people per pharmacy									
Urban									
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
2011-12	3 891	4 363	4 059	4 116	3 921	3 445	5 243	4 861	4 082
Rural									
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
2011-12	4 051	4 344	4 381	4 202	3 287	3 593	..	9 374	4 148
Number of pharmacies									
Urban									
2007-08	1 454	1 005	814	424	315	81	61	18	4 172
2008-09	1 451	1 013	829	421	314	80	62	18	4 188
2009-10	1 447	1 022	832	430	318	81	63	19	4 212
2010-11	1 456	1 035	852	429	318	85	64	19	4 258
2011-12	1 462	1 047	844	441	320	84	68	20	4 286
Rural									
2007-08	268	156	173	84	92	51	..	9	833
2008-09	280	157	182	86	90	51	..	11	857
2009-10	284	162	185	85	96	52	..	11	876
2010-11	280	169	201	91	100	54	..	12	908
2011-12	300	179	204	99	103	57	..	12	955
Number of approved GPs — Rural (c)									
2007-08	22	3	16	18	4	7	..	1	71
2008-09	16	3	10	21	2	7	..	1	60
2009-10	11	3	8	23	2	5	..	1	53
2010-11	9	1	6	17	2	3	..	1	39
2011-12	11	9	5	11	1	4	..	—	41
Number of approved hospitals — urban (d)									
Public									
2007-08	—	51	21	6	—	—	—	1	79
2008-09	—	53	26	6	6	—	—	1	92
2009-10	—	53	27	8	8	—	—	1	97
2010-11	—	53	27	10	8	3	—	1	102
2011-12	—	53	27	12	8	3	—	1	104

TABLE 11A.15

Table 11A.15 **Approved providers of PBS medicines, by urban and rural location (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (b)</i>
Private									
2007-08	21	23	16	3	3	1	3	1	71
2008-09	23	25	19	4	4	1	3	1	80
2009-10	23	26	21	5	4	1	3	1	84
2010-11	22	28	24	5	4	1	4	1	89
2011-12	22	29	25	5	4	1	4	1	91
Number of approved hospitals — rural (d) (e)									
Public									
2007-08	–	12	59	–	–	–	..	3	74
2008-09	–	12	62	–	–	–	..	4	78
2009-10	–	13	63	–	–	–	..	4	80
2010-11	–	16	20	6	–	1	..	4	47
2011-12	–	18	22	6	–	1	..	4	51

(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) GPs in urban areas are not able to demonstrate that they are practising in an area where there is no pharmacist approved and therefore the category 'Number of approved GPs — Urban' is not applicable.

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

(e) There were no PBS approved private hospitals in rural areas in the years 2007-08 to 2011-12.

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.16 **PBS expenditure per person, by urban and rural location (2011-12 dollars) (a), (b), (c)**

	2007-08	2008-09	2009-10	2010-11	2011-12
Capital city	306.8	316.8	327.2	315.8	318.7
Other metropolitan	348.6	360.6	373.8	364.8	368.0
Rural and remote	338.2	351.0	364.1	355.9	361.8
All locations	319.0	330.0	341.4	331.1	334.8

- (a) Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 dollars), table AA.51. Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.
- (b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.
- (c) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the 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.51.

TABLE 11A.17

Table 11A.17 **Availability of GPs by region (a), (b), (c), (d)**

	<i>NSW (e)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
Number of GPs									
Urban									
2002-03	6 513	4 531	2 804	1 720	1 477	335	np	141	17 521
2003-04	6 231	4 310	2 678	1 604	1 436	316	np	121	16 696
2004-05	6 266	4 413	2 794	1 620	1 443	308	np	127	16 971
2005-06	6 327	4 437	2 846	1 651	1 469	317	np	113	17 160
2006-07	6 412	4 508	2 884	1 698	1 463	313	np	116	17 394
2007-08	6 047	4 598	2 978	1 717	1 503	328	383	121	17 675
2008-09	6 184	4 738	3 142	1 797	1 550	340	385	139	18 275
2009-10	6 349	4 896	3 272	1 803	1 568	349	398	142	18 777
2010-11	6 530	5 043	3 340	1 826	1 592	346	416	160	19 253
2011-12	6 725	5 305	3 544	1 895	1 644	362	440	153	20 068
Rural									
2002-03	1 782	1 347	1 956	645	506	318	..	185	6 739
2003-04	1 663	1 286	1 808	549	479	289	..	179	6 253
2004-05	1 699	1 308	1 850	555	501	301	..	193	6 407
2005-06	1 762	1 365	1 947	589	511	308	..	192	6 674
2006-07	1 816	1 406	1 980	612	527	329	..	208	6 878
2007-08	1 887	1 464	2 074	640	596	333	..	234	7 228
2008-09	1 921	1 502	2 198	661	591	339	..	239	7 451
2009-10	2 040	1 553	2 292	689	633	355	..	274	7 836
2010-11	2 124	1 667	2 464	788	661	373	..	303	8 380
2011-12	2 273	1 728	2 655	849	704	408	..	326	8 943
Number of full time workload equivalent GPs									
Urban									
2002-03	5 051	3 269	1 941	1 140	1 032	171	np	51	12 654
2003-04	5 065	3 212	1 961	1 123	1 029	170	np	49	12 608
2004-05	5 227	3 242	2 026	1 121	1 027	166	np	47	12 856
2005-06	5 283	3 335	2 105	1 132	1 060	171	np	48	13 135
2006-07	5 427	3 426	2 171	1 142	1 071	173	np	50	13 459
2007-08	5 274	3 551	2 241	1 166	1 080	179	232	54	13 778
2008-09	5 411	3 662	2 357	1 186	1 118	179	235	56	14 204
2009-10	5 461	3 788	2 459	1 216	1 149	185	238	62	14 558
2010-11	5 567	3 897	2 518	1 222	1 166	186	239	66	14 861
2011-12	5 748	4 059	2 686	1 259	1 204	195	250	73	15 474
Rural									
2002-03	1 111	875	1 240	319	322	205	..	46	4 118
2003-04	1 154	898	1 299	328	331	204	..	49	4 263
2004-05	1 195	925	1 363	336	337	212	..	49	4 416
2005-06	1 234	948	1 384	341	343	215	..	48	4 514
2006-07	1 283	981	1 393	358	345	218	..	54	4 632

TABLE 11A.17

Table 11A.17 **Availability of GPs by region (a), (b), (c), (d)**

	NSW (e)	Vic	Qld	WA	SA	Tas	ACT (e)	NT	Aust
2007-08	1 327	1 033	1 441	376	375	222	..	61	4 835
2008-09	1 381	1 076	1 504	388	393	225	..	60	5 027
2009-10	1 431	1 113	1 534	399	397	232	..	65	5 171
2010-11	1 500	1 166	1 599	417	404	243	..	67	5 397
2011-12	1 590	1 211	1 658	439	424	254	..	69	5 645
Number of full time workload equivalent GPs per 100 000 people									
Urban									
2002-03	93.6	88.3	84.3	79.4	91.6	88.2	np	58.4	88.9
2003-04	93.2	85.7	83.2	76.9	91.0	86.7	np	55.2	87.4
2004-05	95.2	85.4	84.0	75.7	90.1	83.7	np	53.6	88.0
2005-06	95.6	87.0	85.5	75.3	92.5	86.0	np	54.4	89.0
2006-07	97.2	87.3	85.4	73.9	91.5	86.0	np	53.7	89.4
2007-08	99.6	89.0	86.0	73.6	91.2	88.3	67.5	57.1	90.0
2008-09	100.4	89.6	87.9	72.2	93.2	87.3	67.2	58.0	90.7
2009-10	99.0	90.3	89.0	71.7	94.5	89.4	66.7	61.8	90.7
2010-11	99.9	91.7	90.1	71.0	95.0	89.0	65.6	66.4	91.5
2011-12	103.2	95.5	96.1	73.2	98.1	93.6	68.8	73.1	95.3
Rural									
2002-03	69.1	72.2	82.7	61.6	80.9	72.4	..	40.8	73.1
2003-04	71.4	73.2	85.2	62.7	82.6	71.1	..	43.4	74.9
2004-05	73.6	74.8	88.1	63.0	83.9	73.9	..	42.4	76.9
2005-06	75.5	76.0	87.6	62.9	85.0	74.4	..	41.0	77.7
2006-07	77.8	76.8	85.4	64.3	83.7	74.6	..	44.3	78.0
2007-08	79.7	79.6	86.2	65.8	89.9	75.5	..	49.1	80.0
2008-09	81.6	80.9	87.5	65.5	93.1	75.6	..	46.9	81.3
2009-10	82.6	81.5	86.5	65.2	92.8	77.1	..	49.5	81.5
2010-11	85.7	84.3	89.1	67.3	93.4	80.4	..	51.1	84.1
2011-12	90.9	87.6	92.4	70.9	98.1	83.8	..	52.1	88.0

- (a) Geographical locations are based on the 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 registered 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.

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

Source: DoHA unpublished, MBS Statistics.

TABLE 11A.18

Table 11A.18 **Availability of female GPs (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Female GPs										
2002-03	no.	2 782	2 079	1 682	843	679	250	184	152	8 651
2003-04	no.	2 707	2 008	1 663	793	659	233	173	136	8 372
2004-05	no.	2 751	2 116	1 717	801	671	243	180	151	8 630
2005-06	no.	2 853	2 168	1 799	828	703	254	183	132	8 920
2006-07	no.	2 958	2 247	1 850	877	718	270	181	151	9 252
2007-08	no.	3 010	2 359	1 955	898	775	277	191	171	9 636
2008-09	no.	3 142	2 446	2 117	987	809	294	192	184	10 171
2009-10	no.	3 323	2 569	2 230	1 016	828	306	192	193	10 657
2010-11	no.	3 520	2 720	2 327	1 089	872	318	216	220	11 282
2011-12	no.	3 736	2 925	2 553	1 134	925	357	230	235	12 095
Female FWEs GPs										
2002-03	no.	1 542	1 052	829	381	319	108	70	37	4 338
2003-04	no.	1 583	1 058	869	380	320	112	69	39	4 430
2004-05	no.	1 679	1 096	923	382	329	114	73	38	4 633
2005-06	no.	1 729	1 158	968	394	335	122	76	34	4 815
2006-07	no.	1 822	1 232	1 010	410	348	125	82	37	5 065
2007-08	no.	1 916	1 312	1 083	426	371	131	85	45	5 369
2008-09	no.	2 003	1 389	1 178	455	401	136	87	48	5 697
2009-10	no.	2 087	1 468	1 232	482	423	142	87	54	5 976
2010-11	no.	2 219	1 538	1 299	499	430	147	96	56	6 285
2011-12	no.	2 362	1 643	1 406	512	459	154	104	62	6 702
Female FWEs GPs as a proportion of all FWE GPs										
2002-03	%	25.9	25.4	26.0	26.2	23.6	28.7	34.4	37.9	25.9
2003-04	%	26.3	25.7	26.7	26.2	23.5	30.0	34.9	40.2	26.3
2004-05	%	27.0	26.3	27.2	26.2	24.1	30.2	36.3	40.3	26.8

TABLE 11A.18

Table 11A.18 **Availability of female GPs (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2005-06	%	27.4	27.0	27.7	26.8	23.8	31.5	36.5	34.8	27.3
2006-07	%	28.1	28.0	28.3	27.3	24.6	31.9	36.1	35.4	28.0
2007-08	%	29.0	28.6	29.4	27.6	25.5	32.7	36.4	38.8	28.8
2008-09	%	29.5	29.3	30.5	28.9	26.5	33.7	37.0	41.3	29.6
2009-10	%	30.3	30.0	30.8	29.9	27.4	34.1	36.6	42.7	30.3
2010-11	%	31.4	30.4	31.5	30.5	27.4	34.3	40.1	42.2	31.0
2011-12	%	32.2	31.2	32.4	30.2	28.2	34.3	41.3	43.7	31.7
Female FWE GPs										
2002-03	per 100 000 females	45.9	42.3	43.5	39.2	41.4	44.7	42.6	39.1	43.4
2003-04	per 100 000 females	46.8	42.0	44.7	38.4	41.3	45.8	42.1	41.5	43.8
2004-05	per 100 000 females	49.2	43.0	46.5	38.0	42.3	46.4	44.2	40.1	45.3
2005-06	per 100 000 females	50.3	44.7	47.2	38.6	42.1	49.0	44.9	33.2	46.2
2006-07	per 100 000 females	52.3	46.7	48.1	39.2	43.3	49.9	47.4	35.4	47.8
2007-08	per 100 000 females	54.4	48.9	50.4	39.7	45.7	52.1	48.6	42.4	49.8
2008-09	per 100 000 females	55.7	50.6	53.2	41.1	48.8	53.3	49.2	44.0	51.7
2009-10	per 100 000 females	57.1	52.4	54.3	42.5	50.9	55.2	48.5	48.7	53.2
2010-11	per 100 000 females	60.1	54.2	56.6	43.3	51.2	56.8	52.3	50.6	55.2
2011-12	per 100 000 females	64.7	58.3	62.1	43.2	55.2	60.0	55.5	56.1	59.3

- (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 numbers include vocationally registered 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.19

Table 11A.19 Availability of public dentists (per 100 000 people) (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (g)</i>	<i>Aust</i>
FTE dentists per 100 000 population (h)									
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/very remote	3.1	–	9.7	11.5	2.0	–	..	6.2	7.7
Total (i)	6.8	6.9	9.9	7.2	9.5	5.5	9.6	12.0	7.7
2010									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total (i)	na	na	na	na	na	na	na	na	na
2011									
Major cities	5.4	5.3	6.9	8.6	6.1	..	7.8	..	6.0
Inner regional	3.9	4.6	6.6	5.0	1.9	5.1	–	..	4.7
Outer regional	2.0	4.6	7.1	2.2	4.1	1.4	..	12.4	4.9
Remote/very remote	2.0	–	7.4	13.0	5.0	–	..	7.7	8.6
Total (i)	4.9	5.1	6.9	5.8	7.4	3.6	7.7	10.7	5.7

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

(b) Data are not available for 2007, 2008 or 2010.

(c) Allocation to State or Territory is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, State/Territory is coded 'unstated'.

(d) Remote/very remote includes Migratory areas.

(e) There are no major cities in Tasmania.

TABLE 11A.19

Table 11A.19 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d)**

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

(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) FTE based on a 40-hour week.

(i) Total includes remoteness area 'unstated'.

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

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 11A.20

Table 11A.20 **Availability of public dental therapists (per 100 000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g)</i>	<i>ACT (h)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
FTE dental therapists per 100 000 population (k)									
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/very remote	5.4	na	4.1	4.0	3.3	3.5	..	8.9	5.0
Total (l)	2.7	na	7.1	6.4	5.6	8.0	3.5	7.4	3.7
2010									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total (l)	na	na	na	na	na	na	na	na	na
2011									
Major cities	1.9	1.3	5.0	8.1	2.7	..	2.7	..	2.9
Inner regional	3.1	3.6	7.3	9.6	5.8	6.6	–	..	4.9
Outer regional	2.3	2.1	6.0	8.6	7.8	9.5	..	9.1	5.7
Remote/very remote	–	–	4.5	8.3	7.7	–	..	4.6	5.6
Total (l)	2.1	1.8	5.6	6.2	5.1	7.4	2.7	7.1	3.6

- (a) Data include dual registered practitioners (practitioners registered as both dental therapists and dental hygienists).
- (b) Data include professionals working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and “other public” areas.
- (c) Allocation to State or Territory is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, State/Territory is coded 'unstated'.
- (d) Remote/very remote includes Migratory areas.
- (e) Data are not available for 2007, 2008 or 2010.

TABLE 11A.20

Table 11A.20 **Availability of public dental therapists (per 100 000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g)</i>	<i>ACT (h)</i>	<i>NT (i)</i>	<i>Aust (j)</i>
(f)		Data are not available for Victoria for 2009 due to changes in Victoria's data collection form.							
(g)		There are no major cities in Tasmania.							
(h)		There are no outer regional, remote or very remote areas in the ACT.							
(i)		There are no major cities or inner regional areas in the NT.							
(j)		2009 data for Australia exclude data for Victoria.							
(k)		FTE based on a 40-hour week.							
(l)		Total includes remoteness area 'unstated'.							
		na Not available. .. Not applicable. – Nil or rounded to zero.							

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 11A.21

Table 11A.21 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
2008-09										
Indigenous older people										
Number of people assessed (h)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (i)	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 (j)	no.	111 344	73 138	62 716	21 998	27 423	9 486	2 430	283	308 818
Target population (k)	no.	460 531	344 073	236 932	116 213	122 218	34 614	15 201	2 720	1 332 334
Proportion of target population assessed	%	24.2	21.3	26.5	18.9	22.4	27.4	16.0	10.4	23.2
2009-10										
Indigenous older people										
Number of people assessed (h)	no.	1 652	337	2 053	1 021	153	36	46	1 185	6 483
Target population (i)	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 (j)	no.	116 753	77 945	65 082	24 451	28 048	9 151	2 724	292	324 446
Target population (k)	no.	468 520	350 827	241 647	118 873	123 651	35 221	15 695	2 854	1 357 123
Proportion of target population assessed	%	24.9	22.2	26.9	20.6	22.7	26.0	17.4	10.2	23.9
2010-11 (l)										
Indigenous older people										
Number of people assessed (h)	no.	3 216	422	3 151	1 508	451	109	36	1 572	10 465
Target population (i)	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271

TABLE 11A.21

Table 11A.21 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
Proportion of target population assessed	%	20.6	11.8	24.0	23.4	17.4	8.8	15.3	27.9	21.2
Non-Indigenous older people										
Number of people assessed (j)	no.	130 102	90 480	74 565	29 862	31 393	10 974	3 168	302	370 846
Target population (k)	no.	476 109	358 361	247 555	122 034	124 871	35 632	16 146	3 018	1 383 553
Proportion of target population assessed	%	27.3	25.2	30.1	24.5	25.1	30.8	19.6	10.0	26.8
2011-12 (m)										
Indigenous older people										
Number of people assessed (h)	no.	4 142	552	4 570	1 611	506	183	48	1 717	13 329
Target population (i)	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216
Proportion of target population assessed	%	25.1	14.6	32.9	23.5	18.5	14.0	18.6	28.6	25.5
Non-Indigenous older people										
Number of people assessed (j)	no.	136 813	95 883	79 697	31 734	32 706	11 470	3 261	310	391 874
Target population (k)	no.	486 234	365 335	253 931	125 917	126 579	36 074	16 664	3 223	1 413 773
Proportion of target population assessed	%	28.1	26.2	31.4	25.2	25.8	31.8	19.6	9.6	27.7

- (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.

TABLE 11A.21

Table 11A.21 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (f)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
(f)	Historical data for WA for target population of non-Indigenous older people have been revised and may differ from previous reports. WA data for proportion of non-Indigenous older people assessed are affected by the revisions.									
(g)	Includes Other Territories.									
(h)	Includes claims for MBS items 704, 706 and 715, for Indigenous people aged 55 years or over.									
(i)	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.									
(j)	Includes claims for MBS items 700, 702, 701, 703, 705 and 707, for people aged 75 years or over.									
(k)	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. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. Data for WA have been revised and may differ from previous reports.									
(l)	2010-11 data have been revised to include claims made up to 12 months after the assessment was received.									
(m)	2011-12 data are preliminary data.									

Source: DoHA unpublished, MBS Statistics; ABS 2008, 2009, 2010, 2011 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 Australians 1991 to 2021*, Cat. no. 3238.0, Canberra.

TABLE 11A.22

Table 11A.22 **Older Indigenous people who received an annual health assessment (per cent)**
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	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.	3 216	422	3 151	1 508	451	109	36	1 572	10 465
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	%	20.6	11.8	24.0	23.4	17.4	8.8	15.3	27.9	21.2
2011-12 (i)										
Number of people assessed	no.	4 142	552	4 570	1 611	506	183	48	1 717	13 329
Target population	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216
Proportion of target population assessed	%	25.1	14.6	32.9	23.5	18.5	14.0	18.6	28.6	25.5

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

TABLE 11A.22

Table 11A.22 **Older Indigenous people who received an annual health assessment (per cent)**
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
(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 data may differ slightly from data in previous reports due to a change in the methodology used to derive population estimates.									
(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 have been revised to include claims made up to 12 months after the assessment was received.									
(i)	2011-12 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.23

Table 11A.23 Indigenous people who received a health check or assessment, by age (per cent) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust (e)</i>
2010-11 (f)										
Children 0–14 years										
Children assessed	no.	6 045	801	8 349	2 371	476	112	68	3 933	22 155
Target population	no.	58 907	12 610	58 815	26 023	10 496	6 794	1 601	22 979	198 298
Proportion assessed	%	10.3	6.4	14.2	9.1	4.5	1.6	4.2	17.1	11.2
Adults 15–54 years										
People assessed	no.	11 074	1 614	11 845	5 021	1 324	315	150	6 601	37 944
Target population	no.	90 790	20 574	88 688	43 805	17 308	11 387	2 785	40 057	315 532
Proportion assessed	%	12.2	7.8	13.4	11.5	7.6	2.8	5.4	16.5	12.0
Adults 55 years or over										
People assessed	no.	3 216	422	3 151	1 508	451	109	36	1 572	10 465
Target population	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271
Proportion assessed	%	20.6	11.8	24.0	23.4	17.4	8.8	15.3	27.9	21.2
2011-12 (g)										
Children 0–14 years										
Children assessed	no.	8 488	1 147	12 048	2 416	797	136	197	5 020	30 249
Target population	no.	59 395	12 765	59 649	26 112	10 591	6 893	1 614	23 149	200 245
Proportion assessed	%	14.3	9.0	20.2	9.3	7.5	2.0	12.2	21.7	15.1
Adults 15–54 years										
People assessed	no.	14 899	2 141	18 401	5 310	1 755	449	286	7 012	50 253
Target population	no.	92 886	21 092	91 333	44 733	17 709	11 654	2 854	40 692	323 091
Proportion assessed	%	16.0	10.2	20.1	11.9	9.9	3.9	10.0	17.2	15.6
Adults 55 years or over										
People assessed	no.	4 142	552	4 570	1 611	506	183	48	1 717	13 329
Target population	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216

TABLE 11A.23

Table 11A.23 **Indigenous people who received a health check or assessment, by age (per cent) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust (e)</i>
Proportion assessed	%	25.1	14.6	32.9	23.5	18.5	14.0	18.6	28.6	25.5

- (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) 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.
- (d) Child health checks provided under the Northern Territory Intervention are excluded.
- (e) Includes Other Territories.
- (f) 2010-11 data have been revised to include claims made up to 12 months after the assessment was received.
- (g) 2011-12 data are preliminary data.

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.24

Table 11A.24 **Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported (a), (b), (c), (d)**

	<i>Unit</i>	<i>2008-09 (e)</i>	<i>2009-10</i>	<i>2010-11</i>
Early detection activities provided				
Well person's checks	%	80.0	72.7	74.8
PAP smears/cervical screening	%	80.0	76.2	75.6
STI testing	%	73.0	74.0	70.5
Hearing testing	%	72.0	74.9	70.9
Eye disease testing	%	69.0	71.8	69.7
Renal disease testing	%	54.0	53.4	56.4
Diabetic testing	%	78.0	75.3	79.5
Cardiovascular testing	%	66.0	62.3	68.4
Any early detection activity	%	90.0	89.7	89.7

- (a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) The OSR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).
- (c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.
- (d) The 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.
- (e) In 2008-09, 4 of 205 services reporting to the OSR collection did not provide valid data for this question. The denominator for 2008-09 is the number of services that provided valid data for this question (201).

Source: AIHW 2010–2012, *Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results*, Cat. numbers IHW 31,56,79, Canberra.

TABLE 11A.25

Table 11A.25 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f), (g)</i>	<i>ACT (f), (g)</i>	<i>NT</i>	<i>Aust</i>
2009-10										
Aboriginal and Torres Strait Islander Child Health Check (f), (h)	%	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (i)	%	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Total	%	20.6	6.9	28.5	16.3	10.5	19.2	12.3	29.2	17.8
2010-11 (j)										
Aboriginal and Torres Strait Islander Child Health Check (h)	%	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (i)	%	25.7	7.1	34.4	16.3	12.5	22.8	12.8	31.2	20.7
Total	%	26.3	7.3	35.2	17.5	12.7	21.5	12.8	44.6	21.7
2011-12 (a), (j)										
Aboriginal and Torres Strait Islander Child Health Check (f), (h)	no.	2 313	335	3 155	765	205	np	np	1 288	8 245
Target population (e)	no.	4 071	847	4 026	1 691	690	477	113	1 507	13 427
Proportion of target population assessed	%	56.8	39.6	78.4	45.2	29.7	np	np	85.5	61.4
Healthy Kids Check (i)	no.	45 123	16 249	36 891	12 160	7 029	3 166	1 176	769	122 563
Target population (e)	no.	88 617	68 125	55 505	28 911	18 391	5 752	4 608	2 071	272 003
Proportion of target population assessed	%	50.9	23.9	66.5	42.1	38.2	55.0	25.5	37.1	45.1
Total (g)	no.	47 436	16 584	40 046	12 925	7 234	3 166	1 176	2 057	130 808
Target population	no.	92 359	68 824	59 740	30 819	19 183	6 350	4 530	3 598	285 430
Proportion of target population assessed (g)	%	51.4	24.1	67.0	41.9	37.7	49.9	26.0	57.2	45.8

a) Computed by the Secretariat for the 2011-12 reference period. Historical data were sourced from the National Healthcare Agreement and do not include underlying data. The considerable increase in proportion of target population assessed compared to previous years is associated with a considerable increase in the number of children receiving fourth year developmental health checks (DoHA, pers. comm, 25 October 2012).

Table 11A.25 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f), (g)</i>	<i>ACT (f), (g)</i>	<i>NT</i>	<i>Aust</i>
(b)	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.									
(c)	Children are counted only once in the numerator.									
(d)	From the 2010-11 reference period, children who received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period were counted against the Aboriginal and Torres Strait Islander health assessment.									
(e)	Rates are computed using as denominator the population of children aged 4 years, derived from ABS ERP data. It was derived by multiplying the ERP for 0–4 years, disaggregated by Indigenous status, by the proportion of children aged 4 years in this age group nationally. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.									
(f)	Data for Aboriginal and Torres Strait Islander Child Health Checks are not published for Tasmania or the ACT for 2009-10 or for 2011-12 due to small numbers, but are included in the total for Australia.									
(g)	For 2011-12, 'total' developmental health checks data for the ACT and Tasmania are limited to 'Health Assessments'.									
(h)	Includes claims for Medicare Benefits Schedule (MBS) Item 708 (Aboriginal and Torres Strait Islander Child Health Check, available to 30 April 2010) and Item 715 (Aboriginal and Torres Strait Islander People's Health Assessment, available from 1 May 2010) for children aged three to five years.									
(i)	Includes claims for MBS items 709 and 711 (Healthy Kids Check, available to 30 April 2010) and items 701, 703, 705, 707 and 10986 (Health Assessment, available from 1 May 2010) for children aged 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. This is known to be a particular issue for Victoria, where the Victorian Maternal and Child Health Service provided a 3.5 year old Key Ages and Stages consultation to 45 923 children in the 2010-11 financial year. Data include Indigenous children who received a Healthy Kids Check and did not also receive a health check under MBS items 708 or 715.									
(j)	For 2010-11 and 2011-12, data are suppressed where fewer than 10 children received health checks.									
	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.26

Table 11A.26 **Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)**

	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
2005-06								
0-15 years	85.4	79.3	76.0	79.1	79.7	76.2	86.3	83.4
16-64 years	72.5	68.3	61.2	63.0	62.8	60.9	73.0	69.8
65 years or over	88.6	84.6	81.3	83.8	83.5	86.0	87.8	86.7
All ages	78.3	74.4	68.9	71.6	71.4	67.5	78.4	76.2
2006-07								
0-15 years	86.9	82.1	79.1	82.2	82.4	80.3	87.8	85.4
16-64 years	74.3	71.0	63.9	66.1	65.5	63.0	74.5	71.9
65 years or over	89.4	86.2	83.1	85.6	85.3	87.7	89.4	87.8
All ages	79.8	76.9	71.5	74.3	73.8	70.1	79.9	78.0
2007-08								
0-15 years	87.6	83.3	80.8	84.8	84.6	81.4	89.2	86.4
16-64 years	75.4	72.7	66.1	68.9	67.9	65.0	76.8	73.4
65 years or over	89.7	87.3	84.6	87.3	86.7	87.8	90.9	88.6
All ages	80.7	78.3	73.4	76.7	76.0	71.6	82.0	79.2
2008-09								
0-15 years	88.2	84.7	83.2	87.3	86.1	81.7	89.8	87.3
16-64 years	75.7	73.8	67.1	71.2	68.6	63.8	77.4	73.9
65 years or over	90.2	88.0	85.9	88.6	87.8	87.9	91.8	89.2
All ages	81.1	79.4	74.7	78.8	77.0	70.9	82.6	79.9
2009-10								
0-15 years	88.8	86.4	85.1	88.7	87.0	84.0	91.3	88.2
16-64 years	75.5	75.5	67.8	73.1	69.8	65.5	78.9	74.3
65 years or over	90.4	89.3	87.2	89.7	88.8	88.0	92.1	89.8
All ages	81.3	81.1	76.0	80.5	78.3	72.5	83.9	80.5
2010-11								
0-15 years	88.8	86.4	85.7	88.8	86.9	84.6	91.8	88.2
16-64 years	76.2	76.1	68.8	73.3	69.9	65.4	79.4	74.9
65 years or over	90.4	89.5	87.6	89.9	88.8	87.9	92.5	89.9
All ages	81.7	81.5	76.7	80.8	78.3	72.5	84.4	80.9
2011-12								
0-15 years	89.2	87.1	86.8	89.6	87.8	84.8	92.5	88.8
16-64 years	77.2	76.8	71.1	74.0	70.8	64.9	80.2	75.8
65 years or over	90.3	89.6	87.8	90.3	88.8	86.7	93.1	89.9
All ages	82.3	82.0	78.1	81.4	78.9	71.9	85.2	81.5

Table 11A.26 **Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)**

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

(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 =

(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.27

Table 11A.27 **Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c)**

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

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

(b) Patient age at date of service.

TABLE 11A.27

Table 11A.27 **Non-referred attendances that were bulk billed by age
(per cent) (a), (b), (c)**

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

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

Source: DoHA unpublished, MBS Statistics.

TABLE 11A.28

Table 11A.28 **People deferring access to GPs due to cost (per cent)**
(a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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
2011-12 (d)										
Proportion	%	5.5	7.8	7.4	9.2	6.0	11.4	12.9	12.2	7.2
RSE	%	8.5	6.0	7.2	6.8	8.6	8.5	9.6	10.5	3.4
95 per cent confidence interval	%	± 0.9	± 0.9	± 1.0	± 1.2	± 1.0	± 1.9	± 2.4	± 2.5	± 0.5

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. For 2011-12, data exclude people who delayed seeing a GP due to cost in the last 12 months if they did not visit a GP in that period.
- (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.
- (d) Data for 2011-12 exclude people who delayed seeing a GP due to cost in the last 12 months if they did not see a GP in that period.

Source: ABS unpublished, *Patient Experience Survey 2009, 2010-11, 2011-12*, Cat. No. 4839.0.

TABLE 11A.29

Table 11A.29 **Waiting time for GPs for an urgent appointment (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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 less than 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
24 hours or more										
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 less than 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
24 hours or more										
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
2011-12										
Within four hours										
Proportion	%	63.5	63.5	65.2	63.1	68.4	54.3	48.0	46.6	63.6
RSE	%	4.2	4.0	2.8	4.3	4.7	9.0	13.3	22.6	1.9
95 per cent confidence interval	%	± 5.2	± 5.0	± 3.6	± 5.3	± 6.3	± 9.6	± 12.5	± 20.6	± 2.3

TABLE 11A.29

Table 11A.29 **Waiting time for GPs for an urgent appointment (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Four to less than 24 hours										
Proportion	%	12.1	11.3	11.0	14.0	11.1	19.8	18.5	16.0	12.0
RSE	%	13.0	11.6	13.0	14.1	17.3	21.8	21.4	30.9	6.1
95 per cent confidence interval	%	± 3.1	± 2.6	± 2.8	± 3.9	± 3.8	± 8.4	± 7.7	± 9.7	± 1.4
24 hours or more										
Proportion	%	24.4	25.1	23.8	22.9	20.5	25.9	33.6	37.3	24.4
RSE	%	9.9	9.5	8.7	9.7	12.9	15.0	18.7	16.8	4.0
95 per cent confidence interval	%	± 4.7	± 4.7	± 4.1	± 4.4	± 5.2	± 7.6	± 12.3	± 12.3	± 1.9

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.
- (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*, Cat. No. 4839.0.

TABLE 11A.30

Table 11A.30 **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)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009										
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
2011-12										
Proportion	%	27.6	28.6	24.5	29.5	25.6	30.0	28.3	31.1	27.4
RSE	%	3.0	2.9	3.6	2.9	4.2	4.6	5.4	6.9	1.5
95 per cent confidence interval	%	± 1.6	± 1.6	± 1.8	± 1.7	± 2.1	± 2.7	± 3.0	± 4.2	± 0.8

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, 2011-12*, Cat. No. 4839.0.

TABLE 11A.31

Table 11A.31 **Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2011-12 (number) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12									
Indigenous status (e)									
Indigenous	27 528	7 174	23 498	15 265	3 612	2 852	1 136	12 471	93 536
Other Australians	657 371	537 933	354 545	267 838	100 287	56 978	46 657	28 429	2 050 038
Remoteness of residence (f)									
Major cities	492 160	375 696	213 261	187 331	96 619	..	47 724	..	1 412 791
Inner regional	175 704	146 754	103 193	48 513	4 267	37 880	48	..	516 359
Outer regional	14 210	22 403	43 735	42 432	1 574	21 576	..	23 846	169 776
Remote	1 063	217	16 464	2 866	341	302	..	12 449	33 702
Very remote	100	..	1 382	1 659	864	72	..	4 585	8 662
Total (g)	684 899	545 107	378 043	283 103	103 899	59 830	47 793	40 900	2 143 574

- (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 and remoteness area of usual residence of the patient, not by location of the hospital.
- (c) Limited to peer group A and B public hospitals.
- (d) The Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B) for these data.
- (e) The quality of Indigenous status data in the National Non-admitted Emergency Department Care Database (NNAPEDCD) has not been formally assessed for completeness; therefore caution should be exercised when interpreting these data. Other Australians includes non-Indigenous patients and those for whom Indigenous status was not stated.
- (f) 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 very remote areas in Victoria; 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. However, interstate visitors residing in these remoteness areas may be treated in those states and territories and rates cannot be calculated for those cases.

TABLE 11A.31

Table 11A.31 **Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2011-12 (number) (a), (b), (c)**

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

(g) 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.32

Table 11A.32 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	NSW (d)	Vic (d)	Qld	WA	SA (e)	Tas (f) (g)	ACT (g)	NT	Aust
2008-09	648 937	542 164	380 947	193 353	112 517	55 644	44 535	34 703	2 012 800
2009-10	706 134	550 887	371 539	207 545	117 056	62 534	46 217	37 717	2 099 629
2010-11 (h)	692 778	555 140	375 169	263 845	117 525	60 182	48 485	42 303	2 155 427
2011-12 (i)	684 899	545 107	378 043	283 103	103 899	59 830	47 793	40 900	2 143 574

- (a) GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not: admitted to the hospital, referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector.
- (b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.
- (c) Limited to peer group A and B public hospitals.
- (d) From 2009-10, data for the Albury Base Hospital (previously reported in NSW hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for NSW and Victoria.
- (e) For SA for 2008-09 and 2009-10, data include presentations for which the type of visit was not reported.
- (f) The Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B) for these data.
- (g) Historical data for Tasmania and the ACT have been revised and may differ from data published in previous reports.
- (h) Data for 2010-11 have been revised using hospital classification into peer groups A and B based on 2010-11 peer groups and differ from data published in the 2012 Report which utilised hospital classification into peer groups A and B based on 2009-10 peer groups.
- (i) Data for 2011-12 are preliminary. Hospital classification into peer groups A and B is based on 2010-11 peer groups.

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

TABLE 11A.33

Table 11A.33 **Emergency department presentations, 2011-12 (number) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Peer group A									
Triage category 4	544 721	476 735	364 528	178 611	108 419	38 950	47 283	52 028	1 811 275
Triage category 5	159 404	88 636	43 124	17 384	17 968	9 051	11 488	4 225	351 280
Peer group B									
Triage category 4	203 633	152 030	63 691	131 494	12 171	25 020	354	265	588 658
Triage category 5	45 323	34 436	11 313	19 924	3 142	4 026	95	63	118 322
Total	953 081	751 837	482 656	347 413	141 700	77 047	59 220	56 581	2 869 535

(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.

(d) The Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B) for these data.

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

TABLE 11A.34

Table 11A.34 **People deferring access to prescribed medication due to cost (per cent) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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
2011-12										
Proportion	%	8.9	9.2	11.5	8.2	10.1	10.8	11.7	11.0	9.6
RSE	%	6.3	6.5	7.1	9.5	7.6	11.7	9.1	16.4	3.2
95 per cent confidence interval	%	± 1.1	± 1.2	± 1.6	± 1.5	± 1.5	± 2.5	± 2.1	± 3.6	± 0.6

RSE = Relative standard error.

(a) People 15 years or over who, in the last 12 months, were prescribed medication and delayed getting or did not get the medication due to cost.

(b) 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, 2010-11*, Cat. No. 4839.0.

TABLE 11A.35

Table 11A.35 **Waiting time for public dentistry (per cent) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Less than 2 weeks										
Proportion	%	25.9	19.3	22.8	32.6	27.1	20.2	18.8	18.8	24.3
RSE	%	18.4	29.0	21.9	48.9	34.6	41.4	53.6	36.7	11.6
95% CI	±%	9.3	11.0	9.8	31.2	18.4	16.4	19.8	13.5	5.5
2 weeks to less than 1 month										
Proportion	%	21.9	11.1	19.4	20.5	7.9	18.1	np	np	17.0
RSE	%	15.5	30.0	47.0	48.7	45.0	35.3	np	np	10.7
95% CI	±%	6.6	6.6	17.9	19.5	7.0	12.5	np	np	3.6
Less than 1 month										
Proportion	%	47.8	30.4	42.2	53.1	35.0	38.3	23.0	66.3	41.3
RSE	%	10.2	22.8	23.3	28.2	24.2	26.2	34.9	55.7	8.4
95% CI	±%	9.5	13.6	19.3	29.3	16.6	19.7	15.7	72.4	6.8
1 month to less than 6 months										
Proportion	%	38.2	31.5	26.2	19.1	27.9	29.7	45.3	16.1	31.9
RSE	%	12.6	20.4	29.8	50.5	22.3	24.7	62.1	63.1	6.6
95% CI	±%	9.5	12.6	15.3	19.0	12.2	14.4	55.1	19.9	4.1
6 months to less than 1 year										
Proportion	%	9.3	13.4	4.9	12.6	8.3	8.3	21.0	–	9.2
RSE	%	35.7	39.7	52.8	70.9	35.3	57.6	31.8	–	17.2
95% CI	±%	6.5	10.4	5.1	17.6	5.7	9.3	13.1	–	3.1
One or more years										
Proportion	%	4.8	24.6	26.7	15.2	28.8	23.8	10.7	17.6	17.6
RSE	%	37.3	24.1	32.5	49.8	28.4	19.2	77.9	68.6	13.1
95% CI	±%	3.5	11.6	17.0	14.8	16.1	8.9	16.4	23.6	4.5
1 month or more										
Proportion	%	52.2	69.6	57.8	46.9	65.0	61.7	77.0	33.7	58.7
RSE	%	9.3	10.0	17.0	30.6	14.9	16.3	40.0	46.9	5.9
95% CI	±%	9.5	13.6	19.3	28.2	19.0	19.7	60.4	30.9	6.8

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

- (a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months. Excludes treatment for urgent dental care.
- (b) Rates are age-standardised to the 2001 estimated resident population (5 year ranges).
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

– Nil or rounded to zero. **np** Not published.

Source: ABS (unpublished) *Patient Experience Survey 2011-12*, Cat. No. 4839.0.

Table 11A.36 **Waiting time for public dentistry by remoteness, Australia
(per cent) (a), (b), (c)**

		<i>Unit</i>	<i>2011-12</i>
Less than 2 weeks			
Major cities			
Proportion	%		23.8
RSE	%		12.3
95% CI	± %		5.7
Other remoteness areas (d)			
Proportion	%		24.4
RSE	%		20.6
95% CI	± %		9.8
Inner regional			
Proportion	%		26.8
RSE	%		24.0
95% CI	± %		12.6
Outer regional, remote and very remote			
Proportion	%		29.9
RSE	%		39.5
95% CI	± %		23.2
Total			
Proportion	%		24.3
RSE	%		11.6
95% CI	± %		5.5
Between 2 weeks and 1 month			
Major cities			
Proportion	%		19.2
RSE	%		16.2
95% CI	± %		6.1
Other remoteness areas (d)			
Proportion	%		14.3
RSE	%		22.7
95% CI	± %		6.3
Inner regional			
Proportion	%		15.2
RSE	%		27.5
95% CI	± %		8.2
Outer regional, remote and very remote			
Proportion	%		13.0
RSE	%		62.1
95% CI	± %		15.8
Total			
Proportion	%		17.0
RSE	%		10.7
95% CI	± %		3.6

Table 11A.36 **Waiting time for public dentistry by remoteness, Australia
(per cent) (a), (b), (c)**

<i>Unit</i>		<i>2011-12</i>
Between 1 month and 6 months		
Major cities		
Proportion	%	33.9
RSE	%	9.8
95% CI	± %	6.5
Other remoteness areas (d)		
Proportion	%	31.0
RSE	%	12.9
95% CI	± %	7.8
Inner regional		
Proportion	%	29.2
RSE	%	18.1
95% CI	± %	10.4
Outer regional, remote and very remote		
Proportion	%	29.1
RSE	%	13.1
95% CI	± %	7.5
Total		
Proportion	%	31.9
RSE	%	6.6
95% CI	± %	4.1
Between 6 months and 1 year		
Major cities		
Proportion	%	10.4
RSE	%	24.9
95% CI	± %	5.1
Other remoteness areas (d)		
Proportion	%	7.5
RSE	%	22.8
95% CI	± %	3.4
Inner regional		
Proportion	%	8.7
RSE	%	31.7
95% CI	± %	5.4
Outer regional, remote and very remote		
Proportion	%	3.7
RSE	%	65.5
95% CI	± %	4.7
Total		
Proportion	%	9.2
RSE	%	17.2
95% CI	± %	3.1

Table 11A.36 **Waiting time for public dentistry by remoteness, Australia (per cent) (a), (b), (c)**

		<i>Unit</i>	<i>2011-12</i>
One or more years			
Major cities			
Proportion	%		12.6
RSE	%		19.6
95% CI	± %		4.8
Other remoteness areas (d)			
Proportion	%		22.8
RSE	%		18.7
95% CI	± %		8.4
Inner regional			
Proportion	%		20.1
RSE	%		20.6
95% CI	± %		8.1
Outer regional, remote and very remote			
Proportion	%		24.2
RSE	%		22.1
95% CI	± %		10.5
Total			
Proportion	%		17.6
RSE	%		13.1
95% CI	± %		4.5

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

- (a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months. Excludes treatment for urgent dental care.
- (b) Rates are age-standardised to the 2001 estimated resident population.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Other remoteness areas include inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) *Patient Experience Survey 2011-12*, Cat. No. 4839.0.

TABLE 11A.37

Table 11A.37 **Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent) (a), (b), (c), (d)**

	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural area</i>	<i>Remote centre</i>	<i>Other remote area</i>	<i>Aust</i>
2002-03	93.0	93.9	90.0	86.1	82.6	76.1	64.9	91.0
2003-04	93.7	93.0	90.0	86.7	83.8	71.2	68.3	91.4
2004-05	93.4	91.7	89.7	85.3	83.4	71.4	67.2	91.0
2005-06	93.1	90.3	90.7	84.2	83.1	68.2	72.9	90.6
2006-07	92.9	90.0	90.3	83.5	83.3	71.3	68.8	90.4
2007-08	92.7	89.9	87.6	82.2	83.1	71.0	65.5	90.0
2008-09	92.6	89.6	87.5	81.8	83.4	70.4	67.3	89.9
2009-10	92.6	89.6	87.1	80.2	83.3	68.9	69.6	89.7
2010-11	93.2	90.6	87.0	80.5	81.5	67.2	72.6	89.9
2011-12	92.8	90.9	86.6	80.3	80.8	67.6	73.5	89.6

- (a) 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.38

Table 11A.38 Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
FWE GPs with vocational registration										
2002-03	no.	5 532	3 719	2 815	1 336	1 244	337	193	80	15 257
2003-04	no.	5 595	3 738	2 882	1 338	1 261	344	189	81	15 428
2004-05	no.	5 774	3 789	2 933	1 335	1 262	348	191	81	15 714
2005-06	no.	5 858	3 870	3 004	1 346	1 289	353	199	79	15 997
2006-07	no.	6 007	3 987	3 051	1 362	1 301	356	215	80	16 359
2007-08	no.	6 098	4 131	3 125	1 395	1 322	370	223	82	16 745
2008-09	no.	6 260	4 284	3 265	1 414	1 376	372	223	86	17 279
2009-10	no.	6 346	4 402	3 389	1 455	1 403	385	224	94	17 699
2010-11	no.	6 490	4 528	3 574	1 494	1 418	390	227	96	18 216
2011-12	no.	6 725	4 630	3 810	1 542	1 474	405	234	104	18 924
Proportion of FWE GPs with vocational registration										
2002-03	%	92.8	89.8	88.5	91.6	91.9	89.6	95.4	82.8	91.0
2003-04	%	92.9	91.0	88.4	92.2	92.7	92.2	95.5	82.7	91.4
2004-05	%	92.8	90.9	86.6	91.7	92.6	92.1	95.5	84.4	91.0
2005-06	%	92.8	90.4	86.1	91.4	91.8	91.4	95.9	81.8	90.6
2006-07	%	92.7	90.5	85.6	90.8	91.8	91.0	95.2	76.9	90.4
2007-08	%	92.4	90.1	84.9	90.5	90.9	92.1	95.9	70.5	90.0
2008-09	%	92.2	90.4	84.6	89.8	91.1	92.0	95.0	74.2	89.9
2009-10	%	92.1	89.8	84.9	90.1	90.7	92.2	94.2	74.1	89.7
2010-11	%	91.8	89.4	86.6	91.1	90.3	90.9	94.8	71.8	89.9
2011-12	%	91.6	87.9	87.7	90.8	90.5	90.1	93.4	73.5	89.6

- (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.39

Table 11A.39 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007										
Accredited										
AGPAL	no.	1425	993	820	344	365	125	52	36	4160
Quality Practice Accreditation	no.	256	191	118	62	28	5	14	1	675
Total	no.	1681	1184	938	406	393	130	66	37	4835
General practices	no.	2829	1707	1278	591	564	172	94	126	7361
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.	1533	1029	883	372	384	130	54	43	4428
Quality Practice Accreditation	no.	274	210	135	82	35	6	15	3	760
2008										
Accredited										
AGPAL	no.	1372	936	795	329	339	113	47	37	3968
Quality Practice Accreditation	no.	267	212	148	73	36	10	23	3	772
Total	no.	1639	1148	943	402	375	123	70	40	4740
General practices	no.	2782	1687	1278	569	567	167	92	119	7261
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.	1471	972	858	356	357	121	49	47	4231
Quality Practice Accreditation	no.	278	228	163	77	37	10	23	3	819
2009										
Accredited										
AGPAL	no.	1364	915	782	311	338	115	43	37	3905
Quality Practice Accreditation	no.	315	262	182	86	42	15	22	5	930

TABLE 11A.39

Table 11A.39 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total	no.	1679	1177	964	397	380	130	65	42	4835
General practices	no.	2726	1641	1247	570	556	160	91	119	7110
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.	1450	959	833	331	359	118	46	46	4142
Quality Practice Accreditation	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1346	883	753	330	330	98	40	38	3818
Quality Practice Accreditation	no.	329	284	197	86	44	32	19	3	994
Total	no.	1675	1167	950	416	374	130	59	41	4812
General practices	no.	2731	1691	1266	569	525	158	91	120	7151
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.	1431	942	818	358	346	103	44	58	4100
Quality Practice Accreditation	no.	343	291	214	89	44	32	19	4	1036
2011										
Accredited										
AGPAL	no.	1318	871	735	327	323	86	38	41	3739
Quality Practice Accreditation	no.	340	296	206	93	48	33	21	7	1044
Total	no.	1658	1167	941	420	371	119	59	48	4783
General practices	no.	2712	1687	1241	573	537	158	84	105	7097
Proportion accredited	%	61.1	69.2	75.8	73.3	69.1	75.3	70.2	45.7	67.4
Registered for accreditation (b)										
AGPAL	no.	1399	926	784	350	339	92	40	57	3987

TABLE 11A.39

Table 11A.39 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Quality Practice Accreditation	no.	373	334	241	102	49	38	23	9	1169
2012 (c)										
Accredited										
AGPAL	no.	1308	865	719	323	323	85	39	52	3714
Quality Practice Accreditation	no.	439	344	280	109	65	42	23	10	1312
Total	no.	1747	1209	999	432	388	127	62	62	5026
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1403	932	781	345	337	87	41	58	3984
Quality Practice Accreditation	no.	476	362	311	120	71	46	25	11	1422

(a) Includes practices accredited by either of Australia's two accrediting bodies. Quality Practice Accreditation manages the General Practice Australia ACCREDITATION *plus* accreditation program.

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

(c) Data for the total number of practices were not available for 2011-12. Historical data were collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June". Data were provided by all Divisions of General Practice as required under contractual agreements with DoHA.

Source: AGPAL (Australian General Practice Accreditation Limited) unpublished; Quality Practice Accreditation Pty Ltd unpublished; PHCRIS, DoHA unpublished, ASD (various years).

TABLE 11A.40

Table 11A.40 **General practice activity in PIP practices (per cent)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of SWPEs that are in PIP practices (a)										
2001-02	%	72.0	80.9	79.7	83.7	79.5	86.4	49.9	76.0	77.6
2002-03	%	74.0	82.0	80.3	83.7	81.0	86.3	50.3	76.0	78.8
2003-04	%	75.8	83.3	79.8	80.3	84.8	88.3	76.4	51.3	79.7
2004-05	%	76.6	83.9	79.9	80.7	84.3	86.9	80.7	56.5	80.2
2005-06	%	77.2	84.3	80.1	82.2	85.2	88.5	83.4	55.1	80.9
2006-07	%	77.4	84.4	81.3	82.2	85.4	86.0	84.6	53.6	81.2
2007-08	%	77.9	85.0	81.4	82.6	85.1	88.7	86.1	54.9	81.6
2008-09	%	78.5	85.3	82.6	83.7	84.4	88.7	83.4	56.9	82.1
2009-10	%	79.1	85.9	84.0	83.6	84.8	88.4	88.1	59.8	82.9
2010-11	%	79.1	85.8	84.3	83.6	86.0	88.1	88.2	60.5	83.0
Proportion of services provided by PIP practices (b)										
2001-02	%	69.1	78.4	79.1	82.5	78.6	85.2	49.0	74.5	75.5
2002-03	%	71.0	79.4	79.7	82.4	79.7	85.3	51.2	74.8	76.7
2003-04	%	73.3	81.2	79.3	79.5	83.9	87.4	75.3	51.7	78.0
2004-05	%	74.2	82.0	80.0	80.1	83.4	86.5	79.6	58.0	78.7
2005-06	%	75.2	82.7	80.2	81.7	84.8	88.4	82.7	56.6	79.6
2006-07	%	75.6	83.0	81.6	82.0	85.2	86.0	84.4	55.0	80.1
2007-08	%	76.3	83.9	81.8	82.9	85.3	88.8	85.4	56.2	80.8
2008-09	%	76.9	84.3	83.0	84.0	84.6	88.4	83.5	59.5	81.4
2009-10	%	77.9	85.0	84.7	84.0	85.3	88.5	88.1	61.7	82.4
2010-11	%	77.8	84.8	84.6	84.0	86.1	88.2	88.2	61.7	82.4

(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.41

Table 11A.41 **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)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08										
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
Rate	per 1000 holders	1 271.7	1 314.0	1 267.9	940.2	1 119.8	1 022.4	1 232.6	422.9	1 223.9
2011-12										
Scripts	no.	2 349 145	1 761 703	1 400 017	471 336	515 907	171 723	63 802	20 031	6 753 664
Concession card holders	no.	1 810 065	1 434 628	1 082 274	463 942	471 039	163 012	54 111	46 017	5 535 884
Rate	per 1000 holders	1 297.8	1 228.0	1 293.6	1 015.9	1 095.3	1 053.4	1 179.1	435.3	1 220.0

TABLE 11A.41

Table 11A.41 **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)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.								
(b)	These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.								
(c)	Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.								
(d)	Number of concession card holders data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs.								
<i>Source:</i> DoHA unpublished, PBS Statistics.									

TABLE 11A.42

Table 11A.42 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2006 to 2011										
Systemic antibiotic prescribed	%	34.7	30.7	33.5	28.1	31.1	24.0	30.3	17.8	32.4
95 per cent confidence interval	± %	2.0	2.3	2.6	4.5	4.2	5.9	8.2	9.9	1.2
Encounters for acute URTI management (c)	no.	9 761	6 145	4 388	1 970	1 882	562	641	180	26 025
2007 to 2012										
Systemic antibiotic prescribed	%	35.0	30.1	33.7	28.7	30.1	25.3	33.0	22.8	32.5
95 per cent confidence interval	± %	1.9	2.3	2.6	4.3	4.1	5.9	9.9	10.0	1.2
Encounters for acute URTI management (c)	no.	10 384	6 215	4 473	1 979	1 852	542	527	149	26 619

URTI = Upper respiratory tract infection.

(a) Data are from April of the first year to March of the final year of each 5 year period.

(b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.

(c) An encounter is a professional interchange between a patient and a GP.

Source: Britt et al unpublished, BEACH Statistics.

TABLE 11A.43

Table 11A.43 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia (a), (b)**

	<i>Unit</i>	<i>2006-07</i>	<i>2007-08</i>	<i>2008-09</i>	<i>2009-10</i>	<i>2010-11</i>	<i>2011-12</i>
Encounters for acute URTI management (c)	per 100 GP encounters	5.2	5.6	5.5	5.5	4.9	5.6
95 per cent confidence interval	± %	0.3	0.3	0.3	0.3	0.3	0.3
Systemic antibiotic prescribed for URTI management	%	32.2	29.9	39.0	29.6	31.0	32.8
95 per cent confidence interval	± %	2.7	2.5	2.7	2.5	2.4	2.6

URTI = Upper respiratory tract infection.

(a) Data are for the period April to the following March.

(b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.

(c) An encounter is a professional interchange between a patient and a GP.

Source: Britt et al unpublished, BEACH Statistics.

TABLE 11A.44

Table 11A.44 **Proportion of people with diabetes who had a GP annual cycle of care, 2011-12 (per cent) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Cycles of care	'000	67.6	49.3	34.0	17.4	20.7	6.6	2.0	1.3	198.8
People with diabetes (d), (e)	'000	302.3	210.7	154.6	89.6	76.2	22.8	12.7	6.5	875.4
Relative standard error	%	7.2	8.2	10.7	9.6	8.4	11.3	13.0	16.5	4.1
95 per cent confidence interval	± '000	43.5	34.6	33.1	17.2	12.8	5.2	3.3	2.1	71.8
Received cycle of care	%	22.4	23.4	22.0	19.4	27.1	29.0	15.7	19.4	22.7
95 per cent confidence interval	± %	2.8	3.3	3.9	3.1	3.9	5.4	3.2	4.8	1.7

- (a) Data are preliminary. Annual cycles of care provided under the DVA are excluded.
- (b) Data do not account for GPs who provide the annual cycle of care but do not claim the MBS item.
- (c) 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 hemoglobin (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.
- (d) Data for the number of people with diabetes are preliminary estimates based on self-report data collected in the 2011-12 Australian Health Survey (AHS). Data exclude respondents who reported they had diabetes but that it was not current at the time of interview. This differs to the source of the denominator used for the historical data reported in table 11A.45 and 2011-12 data reported here should not be compared with those data.
- (e) Includes diabetes mellitus Types 1 and 2 and Type unknown.

Source: DoHA unpublished, MBS Statistics; ABS *Australian Health Survey: First Results, 2011-12*.

TABLE 11A.45

Table 11A.45 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09									
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. Data reported here are not necessarily comparable with data in previous Reports.
- (g) Data have been suppressed where the numerator is less than 10.

Table 11A.45 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(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.46

Table 11A.46 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2001										
0–14 years										
Proportion	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np	24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np	7.7
95 per cent confidence interval	%	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	np	± 3.7
15–64 years										
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	np	15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	np	6.5
95 per cent confidence interval	%	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	np	± 1.9
65 years or over										
Proportion	%	14.6	7.7	11.8	np	19.0	np	23.8	np	12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	np	22.1
95 per cent confidence interval	%	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	np	± 5.2
All ages (crude rates)										
Proportion	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	np	17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	np	5.3
95 per cent confidence interval	%	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	np	± 1.8
2004-05										
0–14 years										
Proportion	%	33.6	52.5	29.9	np	39.2	21.9	np	np	36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	np	9.6
95 per cent confidence interval	%	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	np	± 6.9
15–64 years										
Proportion	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	np	19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	np	6.9
95 per cent confidence interval	%	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	np	± 2.7
65 years or over										
Proportion	%	17.1	7.6	18.5	np	20.6	19.7	np	np	14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	np	17.5
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.46

Table 11A.46 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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.46 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

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

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.47

Table 11A.47 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
95 per cent confidence interval	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
95 per cent confidence interval	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
95 per cent confidence interval	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
95 per cent confidence interval	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (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.47 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

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

(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.48

Table 11A.48 **Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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.49

Table 11A.49 GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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
2011-12										
GPs using CDM items	no.	6 939	5 420	4 170	1 900	1 691	514	301	135	21 070
Total GPs	no.	7 084	5 538	4 378	1 963	1 761	531	319	143	21 717
GPs using CDM items	%	98.0	97.9	95.2	96.8	96.0	96.8	94.4	94.4	97.0

- (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.50

Table 11A.50 **Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2011-12 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08										
Benefits paid										
Benefits paid	\$m	510.9	361.1	338.6	140.1	108.8	31.3	24.4	12.3	1 515.2
Per person	\$	73.4	68.3	79.1	65.0	68.0	62.9	70.9	56.3	71.0
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	507.7	358.6	338.3	139.5	106.8	31.5	24.4	12.8	1 519.6
Per person	\$	71.7	66.2	76.9	62.4	65.9	62.7	69.4	57.2	69.6
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	497.2	355.3	313.4	135.7	109.3	31.4	22.7	13.0	1 477.9
Per person	\$	68.6	63.9	69.1	58.8	66.5	61.8	63.5	56.3	66.0
MBS pathology items rebated										
Number	'000	25 774	18 690	15 935	7 164	6 055	1 693	1 128	671	77 110
Per person	no.	3.56	3.36	3.51	3.10	3.68	3.33	3.15	2.91	3.44
2010-11										
Benefits paid										
Benefits paid	\$m	452.7	320.4	285.3	125.7	99.3	28.6	20.6	12.1	1344.5

TABLE 11A.50

Table 11A.50 **Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2011-12 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Per person	\$	62.2	57.4	62.7	54.2	60.1	56.1	56.8	52.5	59.8
MBS pathology items rebated										
Number	'000	25 250	18 318	15 961	7 191	6 017	1 663	1 102	676	76 176
Per person	no.	3.47	3.28	3.51	3.10	3.65	3.26	3.04	2.94	3.39
2011-12 (c)										
Benefits paid										
Benefits paid	\$m	476.4	335.4	303.9	131.1	102.2	29.7	21.9	13.5	1414.1
Per person	\$	65.7	60.2	67.3	54.9	62.1	58.0	59.1	58.1	62.9
MBS pathology items rebated										
Number	'000	26 524	19 297	16 967	7 498	6 229	1 739	1 181	748	80 183
Per person	no.	3.66	3.46	3.76	3.14	3.79	3.40	3.18	3.22	3.57

- (a) Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 dollars), table AA.51. Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.
- (b) DVA data are included for number of referrals and benefits paid on diagnostic imaging items.
- (c) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.
- (d) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.
- (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.51.

TABLE 11A.51

Table 11A.51 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2011-12 dollars) and number of rebated MBS imaging items (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08										
Benefits paid										
Benefits paid	\$m	459.0	289.0	242.9	105.4	80.3	25.4	17.5	5.0	1219.6
Per person	\$	65.9	54.7	56.8	48.9	50.2	51.1	50.6	22.9	57.1
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	457.5	285.4	248.9	105.6	82.8	25.3	16.9	5.0	1227.5
Per person	\$	64.6	52.7	56.6	47.2	51.0	50.4	48.1	22.4	56.2
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	488.2	303.8	269.1	112.2	88.2	27.1	17.0	5.7	1311.5
Per person	\$	67.4	54.6	59.3	48.6	53.6	53.4	47.6	24.8	58.6
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										

TABLE 11A.51

Table 11A.51 Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2011-12 dollars) and number of rebated MBS imaging items (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Benefits paid	\$m	464.8	281.4	260.5	106.7	82.8	25.0	15.4	5.3	1241.8
Per person	\$	63.9	50.4	57.3	46.0	50.2	49.1	42.7	23.1	55.2
MBS diagnostic imaging items rebated										
Number	'000	4 091	2 657	2 383	980	795	235	140	53	11 335
Per person	no.	0.56	0.48	0.52	0.42	0.48	0.46	0.39	0.23	0.50
2011-12 (c)										
Benefits paid										
Benefits paid	\$m	497.6	302.4	283.5	113.7	85.9	25.9	16.6	5.8	1331.5
Per person	\$	68.7	54.3	62.8	47.6	52.2	50.7	44.7	25.2	59.2
MBS diagnostic imaging items rebated										
Number	'000	4 379	2 870	2 585	1 044	825	245	148	58	12 153
Per person	no.	0.60	0.51	0.57	0.44	0.50	0.48	0.40	0.25	0.54

(a) Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 dollars), table AA.51. Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.

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

(c) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.

Source: DoHA unpublished, MBS and DVA data collections; table AA.51.

TABLE 11A.52

Table 11A.52 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP practices (May 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
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 (d)	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

TABLE 11A.52

Table 11A.52 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP practices (May 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 (d)	no.	1 412	1 050	856	364	299	109	62	37	4 189
Share of PIP practices	%	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6
PIP practices (May 2012)	no.	1 710	1 211	1 005	424	353	126	66	54	4 949
SWPE (c)	no.	4 948 168	4 213 416	3 260 160	1 562 809	1 276 083	402 315	279 439	90 413	16 032 803
PIP eHealth Incentive — uptake (d)	no.	1 481	1 087	897	378	310	113	60	42	4 368
Share of PIP practices	%	86.6	89.8	89.3	89.2	87.8	89.7	90.9	77.8	88.3

(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.

(d) The PIP eHealth incentive commenced in August 2009, replacing the two-part PIP information management / information technology (IM/IT) incentive. The incentive is 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 listed with the National E-Health Transition Authority (NEHTA); have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch; make sure that each of the practice GPs has (or has applied for) an individual PKI certificate; and, provide all GPs at the practice with access to the current editions of key electronic clinical resources as detailed in the eHealth Incentive Guidelines.

Source: DoHA unpublished, MBS and PIP data collections.

TABLE 11A.53

Table 11A.53 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b)**

	<i>Unit</i>	<i>Capital city</i>	<i>Other metro centre</i>	<i>Large rural centre</i>	<i>Small rural centre</i>	<i>Other rural</i>	<i>Remote centre</i>	<i>Other remote</i>	<i>Aust</i>
PIP practices (May 2012)	no.	3 002	378	318	364	701	63	123	4 949
SWPE (c)	no.	10 057 467	1 358 563	1 145 718	1 315 196	1 890 771	147 831	117 257	16 032 803
PIP eHealth Incentive — uptake (d)	%								
Share of PIP practices (May 2010)	%	77.8	79.7	83.1	80.2	81.0	66.1	63.9	78.5
Share of PIP practices (May 2011)	%	87.7	88.5	90.6	85.7	89.5	72.9	76.7	87.6
Share of PIP practices (May 2012)	%	88.4	90.0	89.6	87.6	90.3	74.6	74.0	88.3
Maintain secure electronic patient records									
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
Use mainly secure electronic patient records									
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.

(d) The PIP eHealth incentive commenced in August 2009, replacing the two-part PIP information management / information technology (IM/IT) incentive. The incentive is 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 listed with the National E-Health Transition Authority (NEHTA); have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch; make sure that each of the practice GPs has (or has applied for) an individual PKI certificate; and, provide all GPs at the practice with access to the current editions of key electronic clinical resources as detailed in the eHealth Incentive Guidelines.

Source: DoHA unpublished, MBS and PIP data collections.

TABLE 11A.54

Table 11A.54 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
2010-11										
GP always or often listened carefully										
Major cities										
Proportion	%	90.5	90.1	88.6	89.5	88.8	na	na	na	89.8
RSE	%	0.9	0.8	1.0	0.9	1.1	na	na	na	0.3
95% CI	± %	1.5	1.4	1.7	1.5	1.8	na	na	na	0.6
Other (c), (d)										
Proportion	%	88.1	87.3	87.2	88.9	84.7	na	na	na	na
RSE	%	1.1	1.2	1.0	1.5	2.1	na	na	na	na
95% CI	± %	2.0	2.1	1.7	2.6	3.5	na	na	na	na
Total										
Proportion	%	89.8	89.4	88.0	89.3	88.0	88.6	87.6	83.3	89.1
RSE	%	0.7	0.7	0.8	0.7	0.9	1.2	1.8	2.3	0.3
95% CI	± %	1.2	1.2	1.4	1.3	1.5	2.1	3.1	3.7	0.5
GP always or often showed respect										
Major cities										
Proportion	%	93.9	92.5	91.4	92.2	92.1	na	na	na	92.7
RSE	%	0.5	0.6	0.8	0.8	0.7	na	na	na	0.3
95% CI	± %	1.0	1.1	1.4	1.5	1.2	na	na	na	0.6
Other (c), (d)										
Proportion	%	92.2	90.6	90.2	92.2	88.8	na	na	na	na
RSE	%	0.8	1.2	1.2	1.3	1.8	na	na	na	na
95% CI	± %	1.5	2.1	2.1	2.4	3.1	na	na	na	na
Total										
Proportion	%	93.4	92.1	91.0	92.2	91.4	91.2	91.6	86.1	92.2
RSE	%	0.5	0.5	0.6	0.7	0.5	1.0	1.4	2.1	0.3
95% CI	± %	0.8	1.0	1.2	1.2	0.9	1.8	2.5	3.5	0.6
GP always or often spent enough time										
Major cities										
Proportion	%	88.6	86.9	87.8	86.7	85.7	na	na	na	87.5
RSE	%	0.8	1.0	0.9	0.9	1.2	na	na	na	0.4
95% CI	± %	1.3	1.6	1.5	1.5	2.0	na	na	na	0.7
Other (c), (d)										
Proportion	%	86.8	87.8	85.2	88.7	84.4	na	na	na	na
RSE	%	1.2	1.3	1.4	1.4	2.4	na	na	na	na
95% CI	± %	2.1	2.3	2.3	2.4	4.0	na	na	na	na

TABLE 11A.54

Table 11A.54 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Total										
Proportion	%	88.0	87.2	86.8	87.2	85.4	85.7	85.1	82.9	87.2
RSE	%	0.7	0.7	0.8	0.8	1.0	1.3	1.9	2.5	0.3
95% CI	± %	1.2	1.2	1.4	1.3	1.7	2.2	3.2	4.1	0.5
2011-12										
GP always or often listened carefully										
Major cities										
Proportion	%	89.1	88.1	88.6	87.5	89.1	..	90.0	..	88.6
RSE	%	0.8	0.7	0.8	1.0	0.8	..	1.7	..	0.4
95% CI	± %	1.4	1.2	1.3	1.8	1.3	..	3.0	..	0.7
Other (e)										
Proportion	%	88.9	86.4	85.7	85.7	88.3	88.3	–	86.5	87.1
RSE	%	1.0	1.5	1.1	2.2	1.8	0.9	–	1.7	0.6
95% CI	± %	1.7	2.6	1.9	3.6	3.1	1.5	–	2.9	1.0
Total										
Proportion	%	89.1	87.6	87.5	87.0	88.9	88.3	90.0	86.5	88.1
RSE	%	0.6	0.5	0.6	1.0	0.8	0.9	1.7	1.7	0.3
95% CI	± %	1.1	0.9	1.0	1.7	1.5	1.5	3.0	2.9	0.5
GP always or often showed respect										
Major cities										
Proportion	%	92.5	91.0	91.8	90.5	92.4	..	92.7	..	91.7
RSE	%	0.5	0.7	0.7	1.0	0.6	..	1.6	..	0.3
95% CI	± %	0.9	1.2	1.2	1.8	1.0	..	3.0	..	0.6
Other (e)										
Proportion	%	91.8	91.7	90.7	89.3	91.4	91.0	–	89.6	91.1
RSE	%	1.0	1.2	0.9	1.7	1.2	0.8	–	1.3	0.5
95% CI	± %	1.8	2.1	1.6	3.0	2.1	1.4	–	2.4	0.9
Total										
Proportion	%	92.3	91.1	91.3	90.2	92.2	91.0	92.7	89.6	91.5
RSE	%	0.4	0.6	0.5	0.9	0.5	0.8	1.6	1.3	0.3
95% CI	± %	0.8	1.1	0.8	1.6	1.0	1.4	3.0	2.4	0.5
GP always or often spent enough time										
Major cities										
Proportion	%	88.6	85.2	86.2	86.2	87.0	..	87.6	..	86.8
RSE	%	0.6	0.7	1.0	1.0	0.7	..	1.7	..	0.4
95% CI	± %	1.0	1.1	1.6	1.6	1.2	..	2.8	..	0.6

TABLE 11A.54

Table 11A.54 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Other (e)										
Proportion	%	86.9	84.7	84.9	84.4	86.1	86.0	–	85.4	85.6
RSE	%	1.5	1.6	1.1	2.4	1.9	1.4	–	1.7	0.6
95% CI	± %	2.5	2.6	1.9	4.0	3.3	2.4	–	2.8	1.1
Total										
Proportion	%	88.1	85.1	85.6	85.8	86.8	86.0	87.6	85.4	86.4
RSE	%	0.6	0.6	0.8	0.9	0.6	1.4	1.7	1.7	0.3
95% CI	± %	1.0	1.0	1.3	1.6	1.1	2.4	2.8	2.8	0.5

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

- (a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Rates are age standardised to the 2001 estimated resident population.
- (c) National data for 2010-11 were not published for inner regional, outer regional and remote areas combined. National data for 2010-11 for each remoteness area are reported in table 11A.55.
- (d) Very remote data were not collected in the 2010-11 Patient Experience Survey. For 2010-11, 'other' includes inner regional, outer regional and remote areas.
- (e) Data were collected for all remoteness areas in the 2011-12 survey. For 2011-12, 'other' includes inner and outer regional, remote and very remote areas.

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

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

TABLE 11A.55

Table 11A.55 Client experience of GPs by remoteness, Australia (a), (b)

	Unit	Major cities	Inner regional	Outer regional	Remote/Very remote (c), (d)	Total
2010-11 (c)						
GP always or often listened carefully						
Proportion	%	89.8	87.7	86.8	87.8	89.1
RSE	%	0.3	0.7	0.9	1.9	0.3
95% CI	± %	0.6	1.2	1.6	3.2	0.5
GP always or often showed respect						
Proportion	%	92.7	91.6	89.5	91.8	92.2
RSE	%	0.3	0.6	1.0	1.6	0.3
95% CI	± %	0.6	1.0	1.7	2.9	0.6
GP always or often spent enough time						
Proportion	%	87.5	87.0	84.9	87.2	87.2
RSE	%	0.4	0.8	1.2	1.9	0.3
95% CI	± %	0.7	1.4	2.0	3.3	0.5
2011-12 (d)						
GP always or often listened carefully						
Proportion	%	88.6	87.5	85.8	87.5	88.1
RSE	%	0.4	0.8	1.2	1.9	0.3
95% CI	± %	0.7	1.3	2.1	3.3	0.5
GP always or often showed respect						
Proportion	%	91.7	91.7	89.7	89.5	91.5
RSE	%	0.3	0.7	1.2	1.8	0.3
95% CI	± %	0.6	1.2	2.2	3.1	0.5
GP always or often spent enough time						
Proportion	%	86.8	86.2	84.2	84.4	86.4
RSE	%	0.4	0.9	1.3	2.3	0.3
95% CI	± %	0.6	1.5	2.1	3.8	0.5

(a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.

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

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

(d) Data were collected for all remoteness areas in the 2011-12 survey. For 2011-12, data for remote and very remote areas are combined.

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

TABLE 11A.56

Table 11A.56 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
2010-11										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.1	95.0	95.4	93.8	95.0	na	na	na	94.7
RSE	%	0.6	0.5	0.6	1.0	0.7	na	na	na	0.3
95% CI	± %	1.1	1.0	1.1	1.8	1.4	na	na	na	0.6
Other (c), (d)										
Proportion	%	91.6	92.3	93.4	94.2	95.0	na	na	na	na
RSE	%	1.5	1.3	0.9	1.3	1.8	na	na	na	na
95% CI	± %	2.7	2.4	1.7	2.5	3.3	na	na	na	na
Total										
Proportion	%	93.6	94.5	94.7	93.8	94.9	93.3	94.8	93.1	94.2
RSE	%	0.5	0.5	0.5	0.8	0.8	1.3	1.2	1.4	0.3
95% CI	± %	1.0	1.0	0.9	1.5	1.5	2.4	2.2	2.6	0.5
Dental professional always or often showed respect										
Major cities										
Proportion	%	95.2	96.1	96.1	94.4	95.4	na	na	na	95.6
RSE	%	0.6	0.5	0.5	0.9	0.7	na	na	na	0.3
95% CI	± %	1.1	0.9	0.9	1.6	1.4	na	na	na	0.6
Other (c), (d)										
Proportion	%	93.9	94.2	94.0	95.7	94.6	na	na	na	na
RSE	%	1.1	1.3	0.9	1.1	1.8	na	na	na	na
95% CI	± %	2.1	2.4	1.7	2.1	3.3	na	na	na	na
Total										
Proportion	%	95.0	95.7	95.3	94.6	95.1	94.0	95.9	94.5	95.2
RSE	%	0.5	0.5	0.5	0.7	0.8	1.2	0.9	1.2	0.2
95% CI	± %	1.0	0.9	0.9	1.3	1.4	2.2	1.6	2.3	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	94.9	96.0	95.8	94.5	96.4	na	na	na	95.5
RSE	%	0.6	0.5	0.8	0.8	0.7	na	na	na	0.3
95% CI	± %	1.1	1.0	1.6	1.4	1.2	na	na	na	0.6
Other (c), (d)										
Proportion	%	94.0	93.7	93.5	95.8	94.6	na	na	na	na
RSE	%	0.9	1.3	1.1	1.2	2.1	na	na	na	na
95% CI	± %	1.7	2.5	1.9	2.2	3.9	na	na	na	na

TABLE 11A.56

Table 11A.56 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Total										
Proportion	%	94.7	95.5	95.1	94.8	95.9	92.5	95.0	94.6	95.1
RSE	%	0.4	0.5	0.6	0.7	0.8	1.4	1.5	1.6	0.3
95% CI	± %	0.8	1.0	1.2	1.2	1.5	2.5	2.9	3.0	0.5
2011-12										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.2	93.8	94.0	95.0	95.4	..	93.9	..	94.2
RSE	%	0.6	0.7	0.8	0.8	0.6	..	1.7	..	0.2
95% CI	± %	1.1	1.2	1.4	1.6	1.2	..	3.1	..	0.4
Other (e)										
Proportion	%	92.2	93.3	93.5	92.9	96.8	91.4	–	92.3	93.0
RSE	%	1.3	1.2	1.1	2.0	1.3	1.5	–	1.6	0.6
95% CI	± %	2.4	2.3	2.1	3.7	2.4	2.7	–	2.8	1.1
Total										
Proportion	%	93.8	93.6	93.8	94.4	95.8	91.4	93.9	92.3	93.9
RSE	%	0.5	0.6	0.6	0.7	0.5	1.5	1.7	1.6	0.2
95% CI	± %	0.9	1.0	1.1	1.4	1.0	2.7	3.1	2.8	0.4
Dental professional always or often showed respect										
Major cities										
Proportion	%	95.5	94.7	94.9	96.1	96.2	..	95.7	..	95.3
RSE	%	0.5	0.7	0.6	0.6	0.5	..	1.2	..	0.3
95% CI	± %	1.0	1.3	1.2	1.2	0.9	..	2.3	..	0.5
Other (e)										
Proportion	%	92.7	93.9	94.8	92.5	96.9	91.8	–	93.0	93.7
RSE	%	1.4	1.2	1.2	2.0	1.4	1.4	–	1.7	0.5
95% CI	± %	2.5	2.2	2.2	3.6	2.6	2.6	–	3.1	1.0
Total										
Proportion	%	94.8	94.5	94.9	95.2	96.3	91.8	95.7	93.0	94.9
RSE	%	0.5	0.5	0.6	0.6	0.4	1.4	1.2	1.7	0.2
95% CI	± %	1.0	0.9	1.2	1.2	0.8	2.6	2.3	3.1	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	95.4	95.0	95.0	95.8	96.2	..	94.5	..	95.3
RSE	%	0.6	0.6	0.7	0.5	0.6	..	1.4	..	0.3
95% CI	± %	1.0	1.1	1.3	0.9	1.0	..	2.5	..	0.6

TABLE 11A.56

Table 11A.56 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Other (e)										
Proportion	%	94.2	94.4	95.5	91.5	96.7	93.0	–	92.3	94.3
RSE	%	1.2	1.4	1.1	2.3	1.4	1.3	–	1.8	0.4
95% CI	± %	2.1	2.5	2.1	4.1	2.7	2.4	–	3.3	0.7
Total										
Proportion	%	95.1	94.9	95.2	94.8	96.3	93.0	94.5	92.3	95.0
RSE	%	0.5	0.5	0.6	0.6	0.6	1.3	1.4	1.8	0.3
95% CI	± %	0.9	0.9	1.2	1.2	1.1	2.4	2.5	3.3	0.5

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

- (a) Proportion of people who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).
- (c) National data for 2010-11 were not published for inner regional, outer regional and remote areas combined. National data for 2010-11 for each remoteness area are reported in table 11A.57.
- (d) Very remote data were not collected in the 2010-11 Patient Experience Survey. For 2010-11, 'other' includes inner regional, outer regional and remote areas.
- (e) Data were collected for all remoteness areas in the 2011-12 survey. For 2011-12, 'other' includes inner and outer regional, remote and very remote areas.

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

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

TABLE 11A.57

Table 11A.57 **Client experience of dental professionals by remoteness, Australia (a), (b)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote (c), (d)</i>	<i>Total</i>
2010-11 (c)						
Dental professional always or often listened carefully						
Proportion	%	94.7	92.9	92.2	96.6	94.2
RSE	%	0.3	0.6	1.2	1.7	0.3
95% CI	± %	0.6	1.0	2.1	3.2	0.5
Dental professional always or often showed respect						
Proportion	%	95.6	94.4	93.7	97.2	95.2
RSE	%	0.3	0.5	1.0	1.6	0.2
95% CI	± %	0.6	0.9	1.8	3.0	0.5
Dental professional always or often spent enough time						
Proportion	%	95.5	94.1	93.3	96.8	95.1
RSE	%	0.3	0.6	1.1	1.5	0.3
95% CI	± %	0.6	1.1	2.1	2.8	0.5
2011-12 (d)						
Dental professional always or often listened carefully						
Proportion	%	94.2	93.6	91.9	92.7	93.9
RSE	%	0.2	0.7	1.1	2.0	0.2
95% CI	± %	0.4	1.3	2.0	3.6	0.4
Dental professional always or often showed respect						
Proportion	%	95.3	94.1	93.1	92.4	94.9
RSE	%	0.3	0.7	1.0	2.0	0.2
95% CI	± %	0.5	1.3	1.8	3.7	0.5
Dental professional always or often spent enough time						
Proportion	%	95.3	94.9	94.1	88.0	95.0
RSE	%	0.3	0.6	1.0	3.5	0.3
95% 95% CI	± %	0.6	1.1	1.9	6.1	0.5

RSE = Relative standard error. 95% CI = confidence interval.

- (a) Proportion of persons who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.
- (b) 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.
- (d) Data were collected for all remoteness areas in the 2011-12 survey. For 2011-12, data for remote and very remote areas are combined.

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

TABLE 11A.58

Table 11A.58 Annual health assessments for older people (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (e)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	453 905	332 645	235 780	109 442	120 452	34 516	14 366	7 051	1 313 687
Proportion assessed	%	21.55	19.51	22.14	16.69	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.	464 922	340 348	242 764	118 201	122 533	35 231	14 656	7 411	1 346 876
Proportion assessed	%	22.54	19.53	23.65	16.40	21.82	23.56	15.95	14.02	21.27
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	122 034	124 579	35 713	15 401	7 786	1 376 687
Proportion assessed	%	23.77	21.13	25.84	18.68	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	125 007	126 130	36 385	15 916	8 193	1 403 864
Proportion assessed	%	24.50	22.10	26.43	20.38	22.36	25.25	17.40	18.03	23.57
2010-11 (f)										
Older people assessed	no.	133 318	90 902	77 716	31 370	31 844	11 083	3 204	1 874	381 311
Older people	no.	491 718	361 938	260 684	128 477	127 470	36 871	16 381	8 643	1 432 824
Proportion assessed	%	27.11	25.12	29.81	24.42	24.98	30.06	19.56	21.68	26.61
2011-12 (g)										
Older people assessed	no.	140 955	96 435	84 267	33 345	33 212	11 653	3 309	2 027	405 203
Older people	no.	502 726	369 125	267 832	132 766	129 319	37 383	16 922	9 237	1 465 989
Proportion assessed	%	28.04	26.13	31.46	25.12	25.68	31.17	19.55	21.94	27.64

(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.

TABLE 11A.58

Table 11A.58 **Annual health assessments for older people (a), (b), (c), (d)**

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

(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) Historical data for WA for the number of older people have been revised and may differ from previous reports. WA data for the proportion of older people assessed are affected by the revisions.

(f) 2010-11 data have been revised to include claims made up to 12 months after the assessment was received.

(g) 2011-12 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 1991 to 2021*, Cat. no. 3238.0, Canberra.

TABLE 11A.59

Table 11A.59 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2007–2012 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Unknown</i>	<i>Aust</i>
Valid vaccinations provided											
GPs	no.	5 826 374	3 079 451	3 968 940	1 619 274	1 081 894	409 525	198 876	38 165	–	16 222 499
Council	no.	248 649	2 224 229	281 508	90 553	292 822	32 639	–	–	–	3 170 400
State or territory health department	no.	–	–	817	166 365	648	–	3 835	1 536	–	173 200
Public hospital	no.	63 846	53 054	129 481	1 300	9 147	1 525	1 272	25 611	1 128	286 364
Private hospital	no.	21	18	887	7	–	–	2	2 589	–	3 524
Aboriginal health service	no.	36 453	8 826	32 984	9 070	8 420	35	–	63 459	–	159 247
Community health centre	no.	471 838	14 237	299 494	470 644	96 815	162	142 708	212 751	487	1 709 136
Other (d)	no.	758	3 092	7 454	1 314	714	–	–	–	–	13 332
Total	no.	6 647 939	5 382 907	4 721 565	2 358 527	1 490 460	443 886	346 693	344 111	1 615	21 737 702
Proportion of total valid vaccinations											
GPs	%	84.4	53.4	82.8	64.4	69.2	87.1	42.4	4.4	–	71.3
Council	%	5.6	45.3	7.0	6.4	18.4	12.1	–	–	–	16.8
State or territory health department	%	–	–	–	6.1	0.1	0.1	19.1	0.3	–	0.9
Public hospital	%	2.0	0.5	3.0	4.4	2.6	0.2	0.8	7.5	65.9	2.1
Private hospital	%	0.1	–	–	–	–	–	–	0.9	–	–
Aboriginal health service	%	0.5	–	1.1	0.6	0.5	–	0.2	10.8	–	0.7
Community health centre	%	7.3	0.7	5.7	18.1	9.1	0.5	37.5	76.0	34.1	8.0
Other (d)	%	–	–	0.3	–	0.1	–	–	–	–	0.1
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 11A.59

Table 11A.59 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2007–2012 (a), (b), (c)**

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

(a) 1 July 2007 to 30 June 2012.

(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.60

Table 11A.60 **Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT NT (d)</i>	<i>Aust</i>	
Fully immunised (e)									
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
30 June 2012	91.7	92.7	91.7	90.1	92.6	93.1	93.1	94.2	91.9
Immunised against (at 30 June 2012)									
Diphtheria, tetanus and pertussis	92.1	93.3	92.0	90.7	92.9	93.4	93.6	94.3	92.4
Polio	92.1	93.2	92.0	90.7	92.9	93.3	93.6	94.3	92.3
<i>Haemophilus influenzae</i> type b	92.0	93.1	91.9	90.6	92.7	93.2	93.7	94.4	92.2

- (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 resided.
- (b) The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (d) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (e) Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b 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.61

Table 11A.61 **Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT NT</i> (d)	<i>Aust</i>	
Fully immunised (e)									
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
30 June 2012	92.1	93.0	92.6	90.1	92.2	93.6	92.8	95.7	92.3
Immunised against (at 30 June 2012)									
Diphtheria, tetanus and pertussis	94.5	95.1	94.3	93.0	94.1	95.1	95.1	97.3	94.5
Polio	94.4	95.0	94.3	92.9	94.1	95.0	95.0	97.3	94.4
<i>Haemophilus influenzae</i> type b	94.9	95.2	94.4	93.4	94.4	95.7	95.2	97.3	94.7
Measles, mumps and rubella	93.7	94.4	93.9	92.4	93.7	95.0	94.3	96.2	93.9

- (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, pertussis (whooping cough), polio, *Haemophilus influenzae* type b, hepatitis B and measles, mumps and rubella.

Source: DoHA unpublished, ACIR data collection.

TABLE 11A.62

Table 11A.62 **Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT NT (d)</i>	<i>Aust</i>	
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
30 June 2012	90.6	91.6	91.0	87.6	88.8	90.8	90.9	90.4	90.2
Immunised against (at 30 June 2012)									
Diphtheria, tetanus and pertussis	91.1	92.1	91.5	88.0	89.4	91.1	92.1	90.5	91.0
Polio	91.1	92.0	91.4	88.0	89.4	91.1	91.8	90.6	90.9
Measles, mumps and rubella	91.0	92.0	91.4	88.1	89.0	91.3	91.2	90.4	90.9

- (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, pertussis (whooping cough), polio and measles, mumps and rubella.

Source: DoHA unpublished, ACIR data collection.

TABLE 11A.63

Table 11A.63 **Notifications of measles, children aged 0–14 years (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	np	–	np	np	–	–	–	–	4
2007-08	no.	18	np	4	np	np	–	–	np	27
2008-09	no.	3	18	20	np	–	np	–	–	44
2009-10	no.	5	np	np	np	np	–	–	–	12
2010-11	no.	40	6	7	5	–	–	np	np	61
2011-12	no.	20	np	–	np	–	–	4	–	27
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	0.1
2007-08	per 100 000 children	1.3	np	np	np	np	–	–	np	0.7
2008-09	per 100 000 children	np	1.8	2.3	np	–	np	–	–	1.1
2009-10	per 100 000 children	0.4	np	np	np	np	–	–	–	0.3
2010-11	per 100 000 children	2.9	0.6	0.8	1.1	–	–	np	np	1.4
2011-12	per 100 000 children	1.5	np	–	np	–	–	np	–	0.6

- (a) While notified cases generally represent only a proportion of the total cases that occurred, the notified fraction for measles is expected to be high. The notified fraction may vary between states and territories and with time.
- (b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Notification rates for all years differ from those in the 2012 Report in which incorrect denominators were used. Rates have been recalculated for the 2013 Report using the estimated population of children aged 0–14 years as the denominator.
- 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.64

Table 11A.64 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	677	181	95	36	41	9	5	82	1 126
2008-09	no.	8 172	646	955	205	574	205	59	162	10 978
2009-10	no.	3 281	1 068	1 497	241	1 834	108	32	61	8 122
2010-11	no.	8 767	2 830	3 146	746	2 180	69	335	129	18 202
2011-12	no.	6 684	1 711	3 178	2 554	275	404	87	279	15 172
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	22.7	9.4	13.2	7.9	13.5	7.2	12.6	np	14.6
2007-08	per 100 000 children	50.6	18.2	11.0	8.4	14.2	9.3	7.8	156.5	27.3
2008-09	per 100 000 children	607.5	64.1	107.7	46.7	197.1	209.8	90.8	305.7	262.3
2009-10	per 100 000 children	242.7	105.2	166.9	54.1	626.6	110.8	48.5	114.9	192.5
2010-11	per 100 000 children	645.2	275.5	345.9	164.3	743.4	70.6	496.9	244.0	427.2
2011-12	per 100 000 children	491.9	166.5	349.4	562.5	93.8	413.6	129.0	527.8	356.0

- (a) 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.
- (b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Notification rates for all years differ from those in the 2012 Report in which incorrect denominators were used. Rates have been recalculated for the 2013 Report using the estimated population of children aged 0–14 years as the denominator.

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.65

Table 11A.65 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	4	3	8	np	–	–	–	–	17
2007-08	no.	7	–	np	–	np	np	–	np	12
2008-09	no.	3	np	3	np	–	–	–	np	11
2009-10	no.	np	–	np	np	np	–	–	np	6
2010-11	no.	6	np	np	np	–	–	–	–	12
2011-12	no.	–	–	np	np	np	–	–	np	7
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	np	np	0.9	np	–	–	–	–	0.4
2007-08	per 100 000 children	0.5	–	np	–	np	np	–	np	0.3
2008-09	per 100 000 children	np	np	np	np	–	–	–	np	0.3
2009-10	per 100 000 children	np	–	np	np	np	–	–	np	0.1
2010-11	per 100 000 children	0.4	np	np	np	–	–	–	–	0.3
2011-12	per 100 000 children	–	–	np	np	np	–	–	np	0.2

- (a) While notified cases generally represent only a proportion of the total cases that occurred, the notified fraction for invasive *Haemophilus influenzae* type b is expected to be high. The notified fraction may vary between states and territories and with time.
- (b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.
- (d) Notification rates for all years differ from those in the 2012 Report in which incorrect denominators were used. Rates have been recalculated for the 2013 Report using the estimated population of children aged 0–14 years as the denominator.
- 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.66

Table 11A.66 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (e)</i>	<i>Aust</i>
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	50.9	35.3	52.4
55–59 years	57.0	55.8	57.7	58.4	56.8	57.3	60.1	43.2	56.9
60–64 years	58.9	59.1	59.7	59.7	59.9	57.8	61.6	43.1	59.2
65–69 years	57.7	57.9	59.6	60.3	58.7	57.2	58.9	41.4	58.3
70–74 years	13.4	45.4	52.8	19.3	23.9	48.9	18.7	9.0	31.2
75–79 years	7.2	16.9	18.5	10.6	13.0	11.6	8.6	6.1	12.7
80–84 years	2.8	2.9	4.7	4.1	4.4	4.3	2.7	2.1	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	34.1	33.1	38.3	29.5	22.5	33.8
Ages 50–69									
ASR	56.1	56.0	56.6	57.6	55.9	54.2	57.1	40.1	56.1
2007–2008									
40–44 years	6.3	5.3	25.2	11.1	10.2	22.0	3.8	4.1	10.9
45–49 years	11.6	10.2	37.3	21.5	20.0	34.0	9.7	13.1	18.6
50–54 years	50.1	48.0	53.6	52.1	53.2	47.6	45.8	34.2	50.6
55–59 years	55.4	54.1	57.8	55.3	57.7	56.6	57.0	41.8	55.9
60–64 years	58.0	57.7	60.1	58.0	61.6	59.3	59.1	44.9	58.9
65–69 years	56.6	56.3	59.3	58.1	60.3	58.6	58.3	40.7	57.7
70–74 years	13.6	33.3	52.9	19.7	25.2	34.0	18.3	8.4	28.0
75–79 years	6.7	13.2	19.4	10.8	13.5	11.2	8.7	4.8	11.8
80–84 years	2.6	2.9	5.0	4.1	5.0	3.9	2.7	2.7	3.5
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	41.9	32.9	34.1	37.5	28.7	21.9	32.9
Ages 50–69									
ASR	54.4	53.2	57.1	55.3	57.4	54.5	53.9	39.7	55.1
2008–2009									
40–44 years	6.5	5.1	24.8	11.1	9.9	22.9	6.7	3.3	10.9
45–49 years	11.4	9.7	38.1	21.9	19.8	35.6	10.9	12.3	18.7
50–54 years	48.9	47.8	54.8	53.2	55.4	50.6	44.9	36.1	50.8
55–59 years	55.4	53.5	59.1	57.1	57.9	58.4	56.5	41.2	56.2
60–64 years	58.1	57.8	61.6	59.8	62.8	62.9	61.0	45.6	59.6
65–69 years	56.6	56.1	60.6	59.1	60.9	62.0	58.3	42.1	58.1
70–74 years	15.1	23.8	54.3	20.5	25.0	21.2	22.1	9.3	26.2
75–79 years	7.0	8.5	20.5	11.4	13.6	9.9	9.9	5.0	10.9
80–84 years	2.8	2.9	5.5	4.3	5.2	3.6	3.1	2.0	3.7

TABLE 11A.66

Table 11A.66 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (e)</i>	<i>Aust</i>
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	38.2	29.8	22.1	32.9
Ages 50–69									
ASR	54.0	53.0	58.4	56.7	58.6	57.4	53.8	40.6	55.4
2009–2010									
40–44 years	6.2	4.9	23.3	10.6	9.0	22.7	7.2	3.0	10.4
45–49 years	10.7	9.7	37.0	21.8	18.9	37.0	11.5	11.2	18.2
50–54 years	46.7	49.4	53.6	54.4	52.5	51.9	43.8	35.5	50.1
55–59 years	54.3	54.0	57.7	57.8	56.2	59.4	54.7	41.9	55.6
60–64 years	57.7	58.8	60.6	61.7	60.4	64.3	59.7	45.5	59.5
65–69 years	56.4	56.5	59.8	60.2	59.3	62.1	58.2	43.4	58.0
70–74 years	16.0	19.2	53.6	20.8	24.6	18.4	23.4	9.0	25.2
75–79 years	7.0	8.2	19.8	11.9	13.9	9.4	10.1	4.2	10.8
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	38.6	29.6	21.9	32.5
Ages 50–69									
ASR	52.8	53.9	57.3	57.9	56.4	58.4	52.7	40.8	55.0
2010–2011									
40–44 years	5.6	5.0	21.4	10.3	8.5	22.3	7.5	2.7	9.8
45–49 years	9.7	10.4	35.7	21.6	18.3	36.6	12.0	10.1	17.8
50–54 years	42.8	50.6	52.7	54.4	52.6	50.0	41.7	34.8	48.9
55–59 years	50.8	53.8	56.5	58.2	57.2	58.0	52.6	43.0	54.3
60–64 years	54.9	58.2	59.8	62.1	61.9	63.7	58.8	46.5	58.4
65–69 years	54.5	57.4	59.4	60.8	61.5	60.6	57.3	41.9	57.7
70–74 years	15.4	17.0	53.0	21.0	24.9	16.5	20.4	8.5	24.3
75–79 years	6.8	8.0	19.6	12.4	14.0	9.1	9.5	4.4	10.7
80–84 years	2.7	2.9	5.5	4.9	6.0	3.6	3.2	2.8	3.8
85+ years	0.5	0.6	1.3	1.1	1.1	0.7	0.7	0.6	0.8
40+ years									
ASR	26.8	29.1	40.6	34.3	33.5	37.7	28.7	21.7	31.8
Ages 50–69									
ASR	49.6	54.3	56.4	58.2	57.4	57.0	51.1	40.7	53.9

ASR = age standardised rate.

- (a) The participation rate is the number of women screened during the reference period as a percentage of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) ERP in each of the calendar years in the reference period. Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Participation rates for women 40 years or over and 50–69 years are age standardised to the 2001 Australian population standard.

**Table 11A.66 Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT (e)</i>	<i>Aust</i>
(c)	Data include only women who were residents of the jurisdiction in which they were screened, with the exception of NSW (and Tasmania and the NT for the 2006–2007 reference period) where data include all women screened, whether or not they were residents of the jurisdiction. Data may differ from participation rates data published elsewhere that allocate women to jurisdictions based on the jurisdiction in which screening took place.								
(d)	Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.								
(e)	Data for Tasmania and the NT include only participants resident in the jurisdiction in which screening took place (with the exception of the 2006–2007 reference period). Data differ from previous reports that included data for all women screened in Tasmania and in the NT, whether or not they were residents of the jurisdiction.								
(f)	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 7–9 per cent of women screened are not ACT residents (8.7 per cent in the 2010–2011 reference period (table 11A.64)).								

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

TABLE 11A.67

Table 11A.67

Participation rates for women in BreastScreen Australia by residential status, 2010 and 2011 (24 month period)

	<i>Unit</i>	<i>NSW (a)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (a)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
40+ years									
Residents screened	no.	478 869	393 531	426 301	184 315	144 622	50 969	24 010	9 307
Non-residents screened	no.	na	2014	2 036	na	157	60	2 302	95
Non-residents screened (proportion)	%	na	0.5	0.5	na	0.1	0.1	8.7	1.0
Ages 50–69									
Residents screened	no.	410 984	338 598	284 064	146 137	115 911	37 665	20 088	8 107
Non-residents screened	no.	na	1 649	1 463	na	121	46	1 915	80
Non-residents screened (proportion)	%	na	0.5	0.5	na	0.1	0.1	8.7	1.0

(a) Data for the number of women screened by jurisdiction of residence are not available for NSW or WA. 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.68

Table 11A.68 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b)**

	<i>NSW</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
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	23.1	33.8
Aged 60–69 years	40.8	33.3	48.3	36.5	32.8	55.6	76.0	25.8	39.1
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	0.1	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	13.6	23.1
Age 50–69 years (ASR)	37.0	27.6	46.4	30.8	31.6	39.5	44.2	24.2	35.9
2008–2009									
Aged 40–49 years	7.2	3.7	24.6	12.0	10.1	16.3	6.8	3.8	12.5
Aged 50–59 years	34.3	23.9	47.1	26.6	31.9	36.2	25.3	23.2	34.5
Aged 60–69 years	41.1	32.8	50.6	31.1	34.1	75.6	85.7	26.5	39.7
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	13.2	23.4
Age 50–69 years (ASR)	37.0	27.4	48.5	28.4	32.8	51.7	49.1	24.5	36.6
2009–2010									
Aged 40–49 years	7.4	4.1	22.9	12.8	8.9	17.8	7.3	3.1	12.1
Aged 50–59 years	32.5	24.4	44.8	29.0	31.5	37.5	26.9	23.2	33.8
Aged 60–69 years	40.8	32.9	50.5	32.8	35.8	77.4	84.4	25.3	39.9
Aged 70–79 years	10.4	12.9	33.2	14.1	17.7	np	np	4.7	16.6
Aged 80+ years	3.0	3.7	5.2	3.8	3.0	np	–	2.1	3.9
Age 40+ years (ASR)	20.4	16.0	34.0	20.4	20.7	np	np	12.7	23.1
Age 50–69 years (ASR)	35.8	27.7	47.0	30.5	33.2	53.2	49.6	24.0	36.2
2010–2011									
Aged 40–49 years	7.3	5.8	22.3	13.9	8.2	16.7	7.0	3.1	12.1
Aged 50–59 years	31.4	27.4	43.8	31.7	32.9	31.4	27.4	24.3	33.7
Aged 60–69 years	39.3	33.4	50.5	36.0	33.9	68.5	78.4	25.5	39.7
Aged 70–79 years	10.1	10.3	34.7	13.8	15.6	np	np	5.3	16.6
Aged 80+ years	2.2	4.9	4.1	6.3	1.0	np	–	3.0	3.6
Age 40+ years (ASR)	19.7	17.2	33.7	22.2	20.1	np	np	13.2	23.0
Age 50–69 years (ASR)	34.5	29.8	46.4	33.4	33.3	46.1	47.5	24.8	36.1

TABLE 11A.68

Table 11A.68 **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 periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Indigenous women are women who 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 7–9 per cent of women screened are not ACT residents (8.7 per cent in the 2010–2011 reference period (table 11A.64)).

– 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.69

Table 11A.69 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
2006–2007									
Aged 40–49 years	9.2	4.2	34.0	17.7	13.5	8.3	2.5	8.7	10.9
Aged 50–59 years	54.5	33.2	63.2	63.1	51.9	18.2	34.0	36.0	48.3
Aged 60–69 years	55.1	41.5	67.9	67.8	57.3	28.3	36.6	38.5	51.8
Aged 70–79 years	8.5	23.2	40.1	13.2	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	65.1	65.0	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	31.6	66.1	60.9	53.5	18.5	16.8	37.0	47.1
Aged 60–69 years	53.3	39.3	67.6	65.3	57.5	27.8	18.1	40.9	49.8
Aged 70–79 years	8.4	18.6	42.2	13.4	14.4	12.5	2.7	7.9	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	36.2	31.9	14.5	8.9	21.4	27.7
Aged 50–69 years (ASR)	53.1	34.6	66.7	62.6	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	6.7	10.8
Aged 50–59 years	52.2	30.0	69.0	63.3	54.6	32.0	15.2	36.3	46.9
Aged 60–69 years	53.4	36.7	68.8	67.9	56.6	39.0	16.6	42.4	49.1
Aged 70–79 years	8.7	12.4	43.6	13.8	15.0	8.4	3.9	6.5	13.7
Aged 80+ years	1.3	0.9	3.4	2.3	2.2	1.9	0.5	1.4	1.5
Aged 40+ years (ASR)	28.0	17.7	49.9	37.5	32.4	22.6	8.4	20.8	27.3
Aged 50–69 years (ASR)	52.7	32.6	68.9	65.1	55.4	34.8	15.7	38.7	47.8
2009–2010									
Aged 40–49 years	7.8	3.7	35.8	17.4	13.9	23.7	2.1	5.6	10.4
Aged 50–59 years	51.9	31.6	69.2	65.5	52.4	42.8	14.4	36.1	47.4
Aged 60–69 years	53.9	37.2	68.1	69.9	52.6	47.7	16.7	41.4	49.3
Aged 70–79 years	8.7	9.7	44.2	14.4	14.9	9.9	3.8	5.1	12.9
Aged 80+ years	1.2	0.8	3.5	2.3	2.1	2.3	0.5	2.0	1.5
Aged 40+ years (ASR)	27.8	18.0	49.7	38.5	30.7	29.8	8.2	20.1	27.3
Aged 50–69 years (ASR)	52.7	33.8	68.8	67.2	52.4	44.7	15.3	38.2	48.2
2010–2011									
Aged 40–49 years	8.4	5.5	34.8	17.4	13.6	26.0	2.4	5.1	11.1
Aged 50–59 years	51.4	42.8	68.5	65.0	51.4	43.1	14.0	37.5	50.6
Aged 60–69 years	54.1	44.8	66.8	70.5	51.0	48.0	15.8	40.5	51.9
Aged 70–79 years	8.6	9.5	44.0	14.6	14.7	10.7	3.2	5.6	12.8
Aged 80+ years	1.2	1.0	2.9	2.4	2.1	2.0	0.5	2.5	1.5
Aged 40+ years (ASR)	27.9	23.0	48.8	38.5	30.0	30.8	8.0	20.2	28.8
Aged 50–69 years (ASR)	52.5	43.6	67.8	67.1	51.3	45.0	14.7	38.7	51.1

Table 11A.69 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 periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (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 effect on 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 7–9 per cent of women screened are not ACT residents (8.7 per cent in the 2010–2011 reference period (table 11A.64)).

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.70

Table 11A.70 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2008–2009									
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
Aged 70–79 years	np	..	38.3	np	np	np	..	np	27.2
Aged 80+ years	np	..	np	np	np	np	..	np	5.4

TABLE 11A.70

Table 11A.70 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Age 40+ years (ASR)	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 (i)									
Major Cities									
Aged 40–49 years	7.8	7.0	29.7	16.3	13.5	..	9.2	..	12.8
Aged 50–59 years	49.0	50.9	54.4	57.2	53.5	..	48.8	..	51.7
Aged 60–69 years	55.3	57.1	59.3	61.9	58.3	..	59.6	..	57.5
Aged 70–79 years	10.7	13.2	37.7	15.5	17.7	..	18.0	..	17.0
Aged 80+ years	1.5	1.5	3.3	2.3	2.7	..	1.8	..	2.0
Age 40+ years (ASR)	27.5	28.4	40.9	34.5	32.3	..	29.6	..	31.2
Age 50–69 years (ASR)	51.3	53.2	56.2	59.0	55.3	..	52.8	..	53.9
Inner Regional									
Aged 40–49 years	9.1	7.9	27.3	14.2	13.7	29.6	np	..	15.0
Aged 50–59 years	52.4	55.1	55.1	53.2	55.5	56.3	np	..	54.2
Aged 60–69 years	60.1	61.5	61.8	61.9	65.5	64.0	np	..	61.5
Aged 70–79 years	13.4	16.6	39.5	20.7	23.6	13.3	np	..	20.5
Aged 80+ years	1.7	2.2	3.5	3.8	3.6	1.8	np	..	2.4
Age 40+ years (ASR)	30.0	31.2	40.8	33.4	35.0	38.6	np	..	33.8
Age 50–69 years (ASR)	55.2	57.5	57.6	56.4	59.3	59.1	np	..	56.9
Outer Regional									
Aged 40–49 years	13.2	10.2	34.5	13.7	17.2	31.0	..	6.6	21.4
Aged 50–59 years	52.7	55.7	61.5	51.8	59.2	54.4	..	42.4	55.8
Aged 60–69 years	60.3	61.6	65.3	59.6	65.0	62.6	..	50.6	62.1
Aged 70–79 years	16.7	18.9	43.1	22.6	25.7	16.0	..	6.5	24.7
Aged 80+ years	3.0	3.5	4.1	5.0	5.7	2.8	..	np	3.8
Age 40+ years (ASR)	32.1	32.5	46.2	32.8	37.4	38.6	..	23.8	37.1
Age 50–69 years (ASR)	55.5	58.0	62.9	54.7	61.3	57.4	..	45.6	58.2
Remote									
Aged 40–49 years	23.7	np	34.5	20.5	14.6	np	..	9.6	22.2
Aged 50–59 years	53.5	np	55.3	51.9	48.7	np	..	38.0	50.3
Aged 60–69 years	65.7	np	63.7	62.5	55.9	np	..	42.1	59.5
Aged 70–79 years	23.9	np	41.7	24.1	26.0	np	..	np	28.1
Aged 80+ years	np	np	6.3	np	6.1	np	..	np	6.1
Age 40+ years (ASR)	38.1	37.5	44.1	36.1	32.2	36.3	..	22.8	36.1
Age 50–69 years (ASR)	58.2	np	58.5	56.1	51.5	51.0	..	39.5	53.9
Very remote									
Aged 40–49 years	np	..	32.5	20.5	np	np	..	5.7	21.3
Aged 50–59 years	np	..	54.9	46.6	np	np	..	28.4	46.3
Aged 60–69 years	np	..	57.1	44.5	np	np	..	30.4	48.6

TABLE 11A.70

Table 11A.70 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Aged 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 2006. The accuracy of remoteness classifications decreases over time since the census year due to demographic changes within postcode boundaries. Sources of inaccuracy particularly affect rates based on small numbers and these should be interpreted with caution. Areas where rates are based on small numbers include very remote areas in NSW, SA and Tasmania, remote areas in Victoria and Tasmania, and inner regional areas in the ACT. Minor differences can result in apparently large variations where numerators are small numbers.
- (e) Women were allocated to a remoteness area based on postcode of usual residence. Some women's postcodes could not be matched to a remoteness area; these women were excluded from the state and territory calculations, but included in the state and territory and Australia totals. Some postcodes supplied by women may not accurately reflect their usual residence.
- (f) Data are not available for the 24 month periods 2006 and 2007, and 2007 and 2008. Data are not available for states and territories for the 24 month period 2010 and 2011.
- (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 7–9 per cent of women screened are not ACT residents (8.7 per cent in the 2010–2011 reference period (table 11A.64)).

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.71

Table 11A.71 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

<i>Age group (years)</i>	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2006 and 2007									
20–24	44.7	47.3	50.3	51.7	50.5	54.4	50.6	50.7	48.0
25–29	56.0	58.0	57.7	59.0	60.4	60.1	58.7	53.9	57.5
30–34	62.3	63.8	60.6	62.0	64.6	62.4	63.8	54.4	62.4
35–39	63.6	66.1	61.2	62.7	65.8	62.7	65.2	55.1	63.7
40–44	63.3	66.9	61.0	62.3	66.1	62.7	64.9	54.5	63.8
45–49	64.3	68.7	61.9	62.5	66.6	62.5	64.5	55.0	64.7
50–54	61.4	66.7	58.7	58.9	64.7	60.3	64.1	51.3	62.1
55–59	58.2	64.3	55.5	56.0	61.7	56.8	63.7	49.7	59.2
60–64	54.4	61.1	51.9	51.0	58.7	53.0	60.6	44.9	55.6
65–69	46.4	54.8	45.5	45.6	53.5	46.9	54.8	40.2	49.0
20–69 years	58.3	62.0	57.4	58.4	61.8	59.1	61.1	52.7	59.3
20–69 years (ASR)	58.4	62.3	57.4	58.3	61.9	59.2	61.5	52.0	59.4
2007 and 2008									
20–24	44.1	46.1	50.6	51.0	49.0	53.4	49.8	52.4	47.4
25–29	55.4	56.5	57.4	57.3	58.9	57.9	58.0	56.2	56.6
30–34	62.1	62.6	60.9	60.1	63.2	60.8	62.2	56.8	61.8
35–39	64.0	65.5	61.5	61.7	64.5	61.8	64.8	58.8	63.6
40–44	63.7	66.5	61.5	61.2	65.2	60.6	63.5	57.3	63.7
45–49	64.5	68.1	62.7	61.5	66.3	60.9	64.4	57.4	64.7
50–54	62.2	66.5	60.2	58.8	64.8	57.8	63.6	55.7	62.6
55–59	59.2	64.5	56.9	55.5	62.0	55.5	64.5	53.3	59.8
60–64	55.4	61.3	53.3	51.8	58.7	51.5	59.4	48.2	56.2
65–69	46.9	54.4	46.8	45.1	53.6	44.5	52.8	41.1	49.1
20–69 years	58.4	61.3	58.0	57.4	61.0	57.4	60.4	55.4	59.1
20–69 years (ASR)	58.6	61.6	58.1	57.4	61.2	57.5	60.7	54.8	59.3
2008 and 2009									
20–24	41.8	43.9	48.3	49.9	47.2	51.6	46.8	52.2	45.3
25–29	53.1	55.0	55.5	56.5	57.4	56.1	55.3	56.3	54.8
30–34	60.7	62.9	60.1	60.3	62.4	60.4	61.0	58.2	61.2
35–39	62.9	65.8	61.1	61.9	64.6	61.2	62.9	59.2	63.2
40–44	62.8	66.8	61.4	62.1	65.0	60.5	63.6	60.8	63.5
45–49	63.6	68.4	62.3	61.9	65.9	61.4	63.9	59.7	64.4
50–54	61.7	67.5	60.7	60.0	65.0	59.1	63.0	58.8	62.9
55–59	59.3	65.5	57.5	56.2	62.2	56.7	63.8	53.5	60.3
60–64	55.6	62.6	53.9	53.2	59.3	52.8	61.1	50.0	57.0
65–69	47.7	55.3	47.4	45.3	53.4	45.9	53.2	43.3	49.8
20–69 years	57.3	61.2	57.4	57.6	60.5	57.3	59.1	56.7	58.6
20–69 years (ASR)	57.6	61.7	57.6	57.7	60.7	57.4	59.7	56.3	58.9

TABLE 11A.71

Table 11A.71 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

<i>Age group (years)</i>	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2009 and 2010									
20–24	39.7	42.7	46.0	48.4	45.9	50.6	43.6	50.1	43.5
25–29	50.8	53.6	53.3	55.0	55.7	55.4	53.8	53.5	52.9
30–34	58.5	61.9	57.6	59.0	61.0	59.9	60.2	56.0	59.4
35–39	60.9	65.0	58.9	60.5	64.0	60.5	60.6	57.1	61.6
40–44	61.4	66.7	59.8	60.9	64.1	60.7	62.7	58.6	62.5
45–49	62.4	68.7	60.9	61.6	65.3	61.3	62.1	58.5	63.7
50–54	61.1	68.2	60.1	59.7	64.2	59.4	62.6	57.0	62.7
55–59	58.9	65.8	57.2	56.6	62.3	57.5	63.0	53.8	60.3
60–64	55.8	63.3	54.1	53.3	59.7	53.9	61.4	50.4	57.4
65–69	48.2	55.7	47.2	45.5	53.1	46.9	54.4	43.4	50.0
20–69 years	55.9	60.8	55.8	56.7	59.6	57.2	57.7	54.9	57.5
20–69 years (ASR)	56.3	61.4	56.1	56.9	59.9	57.4	58.5	54.7	57.9
2010 and 2011									
20–24	39.3	41.7	44.8	46.9	45.0	49.9	41.0	49.1	42.6
25–29	50.3	52.2	52.0	53.1	55.1	54.7	52.9	52.3	51.9
30–34	57.8	59.7	56.2	57.0	61.1	57.6	57.8	54.5	58.1
35–39	60.1	63.3	57.6	58.5	63.0	58.3	60.1	56.0	60.3
40–44	61.2	65.5	58.6	59.2	64.1	59.1	60.4	55.8	61.6
45–49	62.0	67.7	60.3	60.3	65.2	58.4	61.3	57.4	63.0
50–54	61.8	67.6	59.9	58.8	64.1	57.0	63.9	55.3	62.6
55–59	59.2	65.7	57.3	56.3	62.9	56.2	62.3	54.6	60.3
60–64	56.5	63.5	54.7	53.2	60.2	52.2	62.0	50.2	57.7
65–69	49.0	55.8	47.5	45.8	53.4	44.9	55.5	42.8	50.4
20–69 years	55.7	59.7	55.0	55.4	59.4	55.3	56.6	53.6	56.8
20–69 years (ASR)	56.1	60.3	55.3	55.6	59.7	55.6	57.6	53.5	57.2

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population in each of the calendar years in the reference period. Historical data may differ from previous reports as rates have been rebased on the 2011 Census. Rates for women aged 20–69 years 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) Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.

Table 11A.71 Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)

<i>Age group (years)</i>	<i>NSW</i>	<i>Vic (f)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
--------------------------	------------	----------------	------------	-----------	-----------	------------	----------------	-----------	-------------

(e) Number of women screened includes all women screened in each jurisdiction, except for Victoria and the ACT. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.

(f) Data for Victoria include only residents of Victoria and, from the the period 2008 and 2009, immediate border residents.

(g) Data for the ACT include only residents of the ACT and, from the the period 2008 and 2009, immediate border residents.

Source: AIHW 2012, *Cervical screening in Australia 2009–2010*, Cat. no. CAN 63, AIHW, Canberra; AIHW unpublished, State and Territory Cervical Cytology Registry data.

TABLE 11A.72

Table 11A.72 **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)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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.73

Table 11A.73 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2003										
People vaccinated	'000	663	499	328	172	186	52	23	5	1 928
Target population	'000	869	642	448	219	225	67	29	8	2 508
People vaccinated	%	76.3	77.7	73.1	78.4	82.8	76.7	80.7	68.1	76.9
2004										
People vaccinated	'000	716	541	353	181	188	53	24	6	2 062
Target population	'000	907	664	465	230	231	69	30	9	2 605
People vaccinated	%	78.9	81.6	75.8	78.7	81.4	77.3	80.0	67.5	79.1
2006										
People vaccinated	'000	710	565	364	194	200	57	25	6	2 121
Target population	'000	945	693	498	246	238	72	32	10	2 735
People vaccinated	%	75.1	81.4	73.1	78.7	83.9	79.2	77.8	63.3	77.5
2009										
People vaccinated	'000	720	550	410	200	200	60	28	8*	2,200
Target population	'000	990	740	550	270	250	77	36	12	2 900
People vaccinated	%	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3*	74.6

(a) A '*' indicates a relative standard error (RSE) of more than 25 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) The Adult Vaccination Survey was not conducted in 2005, 2007, 2008 or 2010.

Source: AIHW 2004, 2005, 2011, *Adult Vaccination Survey: Summary Results*, Cat. no. PHE 51, PHE 56, PHE 135, Canberra; DoHA unpublished, 2006 Adult Vaccination Survey. DoHA (unpublished) 2006 Adult Vaccination Survey.

TABLE 11A.74

Table 11A.74 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major city										
Proportion	%	48.9	50.6	52.0	46.2	55.0	..	50.4	..	50.2
RSE	%	4.4	4.5	4.8	7.2	5.2	..	6.0	..	2.4
95 per cent confidence interval	%	± 4.2	± 4.5	± 4.9	± 6.5	± 5.6	..	± 5.9	..	± 2.3
Inner regional										
Proportion	%	48.9	51.7	50.4	57.6	64.3	56.0	np	..	51.6
RSE	%	5.7	6.9	7.8	10.1	9.7	6.4	233.2	..	3.3
95 per cent confidence interval	%	± 5.4	± 7.0	± 7.7	± 11.5	± 12.2	± 7.0	np	..	± 3.4
Outer regional										
Proportion	%	49.9	53.5	46.2	51.5	39.8	47.9	..	41.7	48.9
RSE	%	9.0	13.5	11.5	17.7	17.5	9.9	..	7.3	4.2
95 per cent confidence interval	%	± 8.8	± 14.1	± 10.4	± 17.9	± 13.6	± 9.3	..	± 6.0	± 4.0
Remote, very remote (e)										
Proportion	%	56.3	np	66.4	np	46.3	40.8	..	58.3	57.3
RSE	%	35.7	124.6	17.3	53.0	36.0	44.9	..	16.0	10.9
95 per cent confidence interval	%	± 39.3	np	± 22.5	np	± 32.6	± 35.9	..	± 18.2	± 12.2
Total (f)										
Proportion	%	49.1	51.3	51.5	48.5	54.7	52.9	50.4	43.1	50.6
RSE	%	3.3	3.7	3.9	5.7	4.5	6.0	6.0	6.7	1.7
95 per cent confidence interval	%	± 3.2	± 3.7	± 3.9	± 5.4	± 4.8	± 6.2	± 5.9	± 5.7	± 1.7

TABLE 11A.74

Table 11A.74 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

RSE = Relative standard error.

- (a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.
- (b) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 *Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.
- (c) Rates are age-standardised to the Australian population at 30 June 2001.
- (d) Estimates with relative standard errors (RSEs) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.
- (e) Remote and very remote categories have been aggregated due to small numbers.
- (f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.
- .. Not applicable. **np** Not published.

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

TABLE 11A.75

Table 11A.75 **Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05 (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2

- (a) Vaccinations against influenza and pneumococcal disease have been available free to Indigenous people aged 50 years or over since 1999.
- (b) Estimates with relative standard error (RSE) between 25 per cent and 50 per cent should be used with caution. Estimates with RSE 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.76

Table 11A.76 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Vaccine-preventable conditions</i>									
2007-08	0.7	0.7	0.8	0.7	0.8	0.4	0.8	2.4	0.7
2008-09	0.7	0.8	0.8	0.6	0.7	0.6	0.5	2.4	0.7
2009-10	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8
2010-11	0.6	0.8	0.8	0.6	1.0	0.4	0.5	3.0	0.8
<i>Acute conditions excluding dehydration and gastroenteritis</i>									
2007-08	10.3	11.2	11.3	11.1	11.8	8.8	8.9	16.9	10.9
2008-09	10.0	11.0	11.7	11.1	11.7	8.1	9.5	18.7	10.9
2009-10	10.0	11.0	11.8	11.2	11.8	8.6	7.9	18.0	10.9
2010-11	10.6	11.6	12.3	12.6	12.4	8.4	9.0	18.0	11.5
<i>Chronic conditions excluding diabetes complications (additional diagnoses only)</i>									
2007-08	12.4	14.3	14.9	12.7	14.4	13.4	9.1	23.8	13.6
2008-09	12.2	13.8	14.2	12.8	14.2	11.9	10.8	23.3	13.3
2009-10	12.1	13.8	14.1	12.8	13.3	11.3	9.6	22.5	13.1
2010-11	10.1	11.9	12.0	10.6	11.5	9.1	8.5	22.0	11.1
<i>Chronic conditions excluding diabetes complications (all diagnoses)</i>									
2007-08	9.2	10.3	10.7	8.7	10.6	9.1	6.5	15.0	9.8
2008-09	8.9	9.9	10.3	8.4	10.3	8.2	7.6	15.7	9.5
2009-10	8.8	9.8	10.1	8.3	10.0	7.7	6.9	15.7	9.3
2010-11	8.7	10.3	10.2	9.1	9.8	7.6	7.1	17.7	9.5
<i>All potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only) (e)</i>									
2007-08	23.3	26.2	26.8	24.4	26.8	22.5	18.7	42.6	25.2
2008-09	22.8	25.5	26.5	24.4	26.5	20.6	20.8	44.0	24.8
2009-10	22.7	25.5	26.6	24.7	25.8	20.4	17.9	42.5	24.7

TABLE 11A.76

Table 11A.76 **Separations for selected potentially preventable hospitalisations, by State and Territory
(per 1000 people) (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (d)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11	21.2	24.2	25.0	23.7	24.7	17.7	17.9	42.5	23.3
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (all diagnoses) (e)</i>									
2007-08	20.1	22.2	22.7	20.4	23.1	18.3	16.2	34.1	21.4
2008-09	19.6	21.6	22.6	20.1	22.7	16.9	17.6	36.6	21.1
2009-10	19.5	21.5	22.7	20.3	22.6	16.9	15.3	35.8	21.0
2010-11	19.9	22.6	23.3	22.3	23.0	16.3	16.5	38.5	21.8

- (a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.
- (b) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (c) Caution should be used in comparing data over time due to changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11).
- (d) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for 2007-08, 2009-10 and 2010-11 include these hospitals.
- (e) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period.

TABLE 11A.77

Table 11A.77 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas (f)	ACT	NT	Aust
Vaccine preventable conditions									
Indigenous Australians									
2007-08	1.4	1.4	1.8	4.2	3.4	np	np	6.9	2.7
2008-09	1.6	1.3	1.9	3.4	3.3	0.3	np	6.8	2.7
2009-10	2.0	1.3	3.7	5.5	4.2	0.8	np	7.5	3.7
2010-11	1.7	1.6	2.9	4.0	3.7	0.5	0.4	9.6	3.4
Non-Indigenous Australians (g)									
2007-08	0.7	0.7	0.8	0.6	0.7	np	np	1.0	0.7
2008-09	0.7	0.8	0.8	0.5	0.7	0.6	0.5	0.9	0.7
2009-10	0.7	0.7	0.8	0.7	0.9	0.7	0.5	0.9	0.8
2010-11	0.6	0.8	0.8	0.5	0.9	0.4	0.5	1.0	0.7
Acute conditions <i>excluding dehydration and gastroenteritis</i>									
Indigenous Australians									
2007-08	20.3	15.7	28.0	39.9	32.5	np	np	35.5	26.7
2008-09	19.7	17.2	27.7	36.7	31.1	6.6	13.2	39.7	27.5
2009-10	19.2	16.9	26.6	36.5	31.6	9.1	10.1	39.4	26.1
2010-11	21.3	21.5	28.5	42.0	33.1	8.3	14.9	37.3	29.0
Non-Indigenous Australians (g)									
2007-08	10.2	11.3	10.9	10.3	11.6	np	np	10.0	10.7
2008-09	9.9	11.0	11.3	10.3	11.5	8.2	9.5	10.1	10.6
2009-10	9.9	11.1	11.4	10.5	11.7	8.6	7.9	9.6	10.7
2010-11	10.5	11.6	11.8	11.8	12.2	6.6	7.0	9.1	11.3
Chronic conditions <i>excluding diabetes complications (additional diagnoses only)</i>									
Indigenous Australians									
2007-08	36.3	25.2	49.0	59.1	60.8	np	np	51.6	44.2
2008-09	36.0	27.0	49.7	55.6	55.8	16.6	23.6	53.4	45.4

TABLE 11A.77

Table 11A.77 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas (f)	ACT	NT	Aust
2009-10	34.7	29.1	46.1	53.1	47.3	13.1	16.3	56.3	43.7
2010-11	30.4	26.4	38.3	45.9	41.7	12.9	27.3	52.5	38.0
Non-Indigenous Australians (g)									
2007-08	12.3	14.5	14.3	11.9	14.3	np	np	15.9	13.3
2008-09	12.1	14.0	13.6	11.9	14.1	11.9	10.7	14.9	13.0
2009-10	11.9	13.9	13.5	12.0	13.2	11.2	9.4	12.8	12.8
2010-11	10.0	12.1	11.5	9.9	11.5	7.3	7.2	11.3	10.9
Chronic conditions <i>excluding diabetes complications (all diagnoses)</i>									
Indigenous Australians									
2007-08	26.6	18.8	32.8	36.9	39.1	np	np	33.3	30.8
2008-09	26.7	19.9	32.1	32.4	36.4	12.3	11.8	35.4	30.3
2009-10	26.4	19.6	30.1	32.4	29.9	9.5	10.3	39.0	29.7
2010-11	25.6	20.9	31.1	36.3	32.3	11.1	21.6	41.3	30.7
Non-Indigenous Australians (g)									
2007-08	9.2	10.5	10.4	8.2	10.6	np	np	9.5	9.8
2008-09	8.9	10.1	9.9	7.9	10.4	8.2	7.6	9.5	9.4
2009-10	8.7	9.9	9.8	7.9	10.1	7.7	6.8	8.6	9.3
2010-11	8.7	10.4	9.9	8.5	9.8	6.1	5.9	9.0	9.4
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only) (h)</i>									
Indigenous Australians									
2007-08	57.8	42.2	78.1	101.6	96.0	np	np	92.3	72.8
2008-09	57.1	45.3	78.3	94.3	89.6	23.3	38.1	98.2	74.7
2009-10	55.6	47.0	75.6	93.9	82.6	22.4	26.8	101.5	73.6
2010-11	53.2	49.2	69.2	91.1	78.0	21.6	42.6	97.5	69.8
Non-Indigenous Australians (g)									
2007-08	23.0	26.4	25.8	22.7	26.5	np	np	26.7	24.6
2008-09	22.6	25.7	25.5	22.7	26.2	20.6	20.6	25.8	24.3

TABLE 11A.77

Table 11A.77 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas (f)	ACT	NT	Aust
2009-10	22.5	25.7	25.5	23.0	25.6	20.4	17.8	23.1	24.2
2010-11	21.0	24.5	24.0	22.1	24.4	14.2	14.7	21.3	22.9
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (all diagnoses)</i> (h)									
Indigenous Australians									
2007-08	48.2	35.8	62.3	80.5	74.7	np	np	75.1	59.0
2008-09	47.9	38.3	61.4	72.2	70.5	19.2	26.2	81.3	60.2
2009-10	47.3	37.7	60.0	73.8	65.6	19.0	20.8	84.9	60.0
2010-11	48.4	43.9	62.2	82.0	68.8	19.7	36.9	87.0	61.1
Non-Indigenous Australians (g)									
2007-08	20.0	22.4	21.9	19.0	22.9	np	np	20.4	21.0
2008-09	19.5	21.8	21.9	18.8	22.5	17.0	17.5	20.4	20.7
2009-10	19.3	21.7	21.8	19.0	22.6	16.9	15.2	18.9	20.6
2010-11	19.7	22.8	22.4	20.8	22.8	13.1	13.4	19.0	21.1

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

(b) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.

(c) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.

(d) The Indigenous status data are of sufficient quality for statistical reporting for NSW, Victoria, Queensland, SA and WA (public and private hospitals) and the NT (public hospitals only). National totals include these six jurisdictions only. Indigenous status data reported for Tasmania and the ACT (public and private hospitals) are excluded from national totals (as are data for private hospitals in the NT) and should be interpreted with caution until further assessment of Indigenous identification in hospital data is completed.

(e) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11).

(f) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for 2007-08, 2009-10 and 2010-11 include these hospitals.

(g) 'Non-Indigenous Australians' includes separations where Indigenous status was not stated.

(h) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Table 11A.77

**Separations for selected potentially preventable hospitalisations by Indigenous status
(per 1000 people) (a), (b), (c), (d), (e)**

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

np Not published.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period. ABS (2009) Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, 30 June 2009, Series B, Cat. no. 3238.0.

TABLE 11A.78

Table 11A.78 **Separations for selected potentially preventable hospitalisations by remoteness, 2010-11 (per 1000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Vaccine preventable conditions</i>									
Major cities	0.6	0.8	0.8	0.5	1.0	..	0.5	..	0.7
Inner regional	0.7	0.7	0.8	0.6	0.9	0.4	np	..	0.7
Outer regional	0.9	0.8	0.8	0.8	0.9	0.4	..	1.5	0.8
Remote	0.6	np	1.4	1.3	0.9	np	..	4.5	1.6
Very remote	np	..	2.2	2.5	1.9	–	..	5.9	3.1
<i>Acute conditions excluding dehydration and gastroenteritis</i>									
Major cities	9.9	11.1	11.2	11.8	11.6	..	9.0	..	10.8
Inner regional	12.1	13.0	12.9	12.0	12.6	8.2	np	..	12.2
Outer regional	13.5	13.5	13.7	14.3	15.6	8.7	..	11.0	13.1
Remote	20.2	9.9	21.7	17.7	14.2	11.3	..	28.1	19.8
Very remote	18.3	..	24.0	26.5	25.3	12.6	..	25.3	24.9
<i>Chronic conditions excluding diabetes complications (additional diagnoses only)</i>									
Major cities	9.1	11.8	11.2	9.5	10.8	..	8.5	..	10.4
Inner regional	11.3	12.2	12.2	11.0	11.2	9.0	np	..	11.5
Outer regional	14.4	12.8	13.2	13.3	15.0	9.1	..	14.6	13.3
Remote	20.8	15.4	18.3	16.0	12.1	13.0	..	31.5	18.4
Very remote	19.5	..	23.5	21.6	19.8	11.3	..	33.3	24.6
<i>Chronic conditions excluding diabetes complications (all diagnoses)</i>									
Major cities	7.9	10.1	9.7	8.2	9.3	..	7.1	..	8.9
Inner regional	9.9	10.5	10.4	9.4	9.6	7.3	np	..	9.9
Outer regional	12.3	10.8	11.1	11.4	12.3	8.1	..	11.4	11.2
Remote	17.7	13.9	15.2	13.2	9.9	8.8	..	26.4	15.3
Very remote	16.3	–	18.2	18.0	16.7	8.9	..	26.9	20.0

TABLE 11A.78

Table 11A.78 **Separations for selected potentially preventable hospitalisations by remoteness, 2010-11 (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)</i> (f)									
Major cities	19.6	23.7	23.1	21.8	23.4	..	17.9	..	21.8
Inner regional	24.1	25.8	25.8	23.5	24.6	17.4	12.1	..	24.4
Outer regional	28.7	27.0	27.5	28.2	31.4	18.2	..	26.8	27.1
Remote	41.5	25.6	41.2	34.8	27.0	24.4	..	63.4	39.5
Very remote	38.3	..	49.0	50.1	46.8	23.9	..	63.4	52.0
All potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (all diagnoses)</i> (f)									
Major cities	18.3	22.0	21.6	20.5	21.9	..	16.5	..	20.4
Inner regional	22.7	24.2	23.9	21.9	23.0	15.8	12.1	..	22.7
Outer regional	26.6	25.1	25.5	26.5	28.8	17.2	..	23.6	25.1
Remote	38.4	24.1	38.2	32.1	24.9	20.3	..	58.5	36.5
Very remote	35.1	..	44.1	46.8	43.8	21.5	..	57.5	47.7

- (a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.
- (b) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.
- (c) 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.
- (d) Separation rates are based on state or territory and remoteness area of usual residence, not hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (e) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11).
- (f) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.
- .. Not applicable. **np** Not published.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period.

TABLE 11A.79

Table 11A.79 **Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people) (a), (b), (c), (d), (e)**

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>
Potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and additional diagnoses of diabetes complications</i>					
Indigenous Australians					
2007-08	0.433	0.594	0.953	1.957	1.524
2008-09	0.492	0.595	0.967	1.849	1.589
2009-10	0.466	0.609	0.980	1.831	1.532
2010-11	0.445	0.569	0.898	1.841	1.463
Non-Indigenous Australians (f)					
2007-08	0.227	0.260	0.299	0.325	0.335
2008-09	0.229	0.259	0.299	0.311	0.340
2009-10	0.229	0.259	0.293	0.315	0.338
2010-11	0.217	0.248	0.280	0.307	0.333
Potentially preventable hospitalisations <i>excluding dehydration and gastroenteritis and diabetes complications (all diagnoses)</i>					
Indigenous Australians					
2007-08	0.358	0.479	0.761	1.630	1.220
2008-09	0.400	0.477	0.779	1.520	1.259
2009-10	0.385	0.497	0.787	1.548	1.229
2010-11	0.406	0.511	0.797	1.672	1.315
Non-Indigenous Australians (f)					
2007-08	0.194	0.223	0.257	0.281	0.296
2008-09	0.195	0.222	0.257	0.273	0.298
2009-10	0.195	0.223	0.252	0.276	0.308
2010-11	0.203	0.233	0.260	0.285	0.311

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

(b) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.

(c) Separations for patients usually resident overseas are excluded.

(d) Separation rates are based on patient's usual residence (not hospital location).

(e) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11).

(f) 'Non-Indigenous Australians' includes separations where Indigenous status was not stated.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period. ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, 30 June 2009, Series B, Cat. no. 3238.0.

TABLE 11A.80

Table 11A.80 **Separations for selected vaccine preventable conditions by Indigenous status, 2010-11 (per 1000 people)**
(a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (f)</i>	<i>Total (g)</i>	<i>Aust</i>
Vaccine preventable conditions per 1000 Indigenous Australians (g)										
Influenza and Pneumonia	1.4	1.3	2.0	3.5	3.2	0.5	0.3	8.2	2.8	np
Other vaccine preventable conditions	0.3	0.3	0.9	0.5	0.6	0.1	0.1	1.4	0.6	np
Total	1.7	1.6	2.9	4.0	3.7	0.5	0.4	9.6	3.5	np
Vaccine preventable conditions per 1000 non-Indigenous Australians (g), (h)										
Influenza and Pneumonia	0.5	0.5	0.6	0.4	0.7	0.3	0.4	0.8	0.5	np
Other vaccine preventable conditions	0.1	0.3	0.2	0.1	0.2	0.1	0.1	0.2	0.2	np
Total	0.6	0.8	0.8	0.5	0.9	0.4	0.5	1.0	0.7	np
Vaccine preventable conditions per 1000 people (all people) (i)										
Influenza and Pneumonia	0.5	0.5	0.6	0.5	0.7	0.3	0.4	2.5	0.6	0.6
Other vaccine preventable conditions	0.1	0.3	0.2	0.1	0.2	0.1	0.1	0.5	0.2	0.2
Total	0.6	0.8	0.8	0.6	1.0	0.4	0.5	3.0	0.8	0.8

(a) Conditions defined by ICD-10-AM codes as in AIHW 2012 *Australian hospital statistics 2010-11*.

(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. Totals include Australian residents of external Territories.

(e) Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification in hospital data is complete — these data are not included in totals.

(f) NT data for Indigenous and non-Indigenous Australians are for public hospitals only.

(g) Total for Indigenous and non-Indigenous Australians 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) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

TABLE 11A.80

Table 11A.80 **Separations for selected vaccine preventable conditions by Indigenous status, 2010-11 (per 1000 people)**
(a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (f)</i>	<i>Total (g)</i>	<i>Aust</i>
(i) The rates presented for Indigenous people and non-Indigenous Australians 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.										

np Not published.

Source: AIHW 2012, *Australian hospital statistics 2010-11*, Cat. no. HSE 117, Canberra; AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.81

Table 11A.81 Separations for selected acute conditions by Indigenous status, 2010-11 (per 1000 people) (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (f)</i>	<i>Total (g)</i>	<i>Aust</i>
Acute conditions per 1000 Indigenous Australians (g)										
Appendicitis with generalised peritonitis	0.5	0.2	0.3	0.6	0.6	0.1	0.8	0.6	0.4	np
Cellulitis	3.8	3.4	6.2	7.5	3.6	1.7	3.6	6.7	5.3	np
Convulsions and epilepsy	5.4	4.0	6.1	10.4	11.8	1.0	3.1	9.7	7.1	np
Dehydration and gastroenteritis	3.9	5.4	3.7	5.3	4.1	0.7	1.0	4.2	4.2	np
Dental conditions	3.2	5.1	3.5	5.0	5.2	2.3	3.9	5.2	4.0	np
Ear, nose and throat infections	2.9	2.2	3.6	5.6	4.2	1.6	0.6	3.9	3.6	np
Gangrene	0.3	1.2	1.2	2.4	0.6	0.2	–	2.3	1.2	np
Pelvic inflammatory disease	0.4	0.3	0.7	0.8	0.6	0.2	0.2	1.3	0.6	np
Perforated/bleeding ulcer	0.3	0.1	0.3	0.2	0.4	0.2	–	0.3	0.3	np
Pyelonephritis (h)	4.7	5.1	6.7	9.6	6.1	1.0	2.6	7.5	6.4	np
Total	25.2	26.9	32.2	47.2	37.2	9.0	15.8	41.5	33.2	np
Total — excluding dehydration and gastroenteritis	21.3	21.5	28.5	42.0	33.1	8.3	14.9	37.3	29.0	np
Acute conditions per 1000 non-Indigenous Australians (g), (i)										
Appendicitis with generalised peritonitis	0.3	0.3	0.3	0.4	0.3	0.3	0.2	0.3	0.3	np
Cellulitis	1.8	1.8	2.2	1.6	1.6	1.1	1.3	2.3	1.8	np
Convulsions and epilepsy	1.5	1.5	1.4	1.2	1.5	1.0	1.2	1.2	1.4	np

TABLE 11A.81

Table 11A.81 Separations for selected acute conditions by Indigenous status, 2010-11 (per 1000 people) (a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (f)</i>	<i>Total (g)</i>	<i>Aust</i>
Dehydration and gastroenteritis	2.7	3.5	2.8	2.7	2.8	1.2	1.2	1.2	2.9	np
Dental conditions	2.2	2.9	2.7	3.7	3.3	1.6	0.8	1.2	2.7	np
Ear, nose and throat infections	1.6	1.6	1.8	1.7	2.3	0.9	0.9	1.4	1.7	np
Gangrene	0.2	0.3	0.3	0.2	0.2	0.2	0.1	0.4	0.2	np
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	np
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.2	np
Pyelonephritis (h)	2.5	2.8	2.7	2.5	2.5	1.2	2.1	2.0	2.6	np
Total	13.2	15.1	14.6	14.5	14.9	7.8	8.3	10.3	14.2	np
Total — excluding dehydration and gastroenteritis	10.5	11.6	11.8	11.8	12.2	6.6	7.0	9.1	11.3	np
Acute conditions per 1000 people (all people) (j)										
Appendicitis with generalised peritonitis	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Cellulitis	1.8	1.8	2.3	1.7	1.7	1.3	1.4	3.9	1.9	1.9
Convulsions and epilepsy	1.5	1.5	1.6	1.5	1.6	1.1	1.3	3.2	1.5	1.5
Dehydration and gastroenteritis	2.7	3.5	2.8	2.8	2.8	2.1	1.7	2.4	2.9	np
Dental conditions	2.3	2.9	2.7	3.7	3.3	2.3	2.1	2.9	2.8	2.8
Ear, nose and throat infections	1.6	1.6	1.9	1.9	2.3	1.1	1.0	2.3	1.7	1.7
Gangrene	0.2	0.3	0.3	0.3	0.2	0.3	0.1	0.9	0.3	0.3

TABLE 11A.81

Table 11A.81 Separations for selected acute conditions by Indigenous status, 2010-11 (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	0.3	0.2	0.2	0.2	0.1	0.6	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.2
Pyelonephritis (h)	2.5	2.7	2.8	2.7	2.4	1.6	2.3	3.7	2.6	2.6
Total	13.0	14.9	14.8	15.1	14.9	10.2	10.4	20.3	14.2	14.2
Total — excluding dehydration and gastroenteritis	10.6	11.6	12.3	12.6	12.4	8.4	9.0	18.0	11.5	11.5

(a) Conditions defined by ICD-10-AM codes as in AIHW 2012 *Australian hospital statistics 2010-11*.

(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. Totals include Australian residents of external Territories.

(e) Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification in hospital data is complete — these data are not included in totals.

(f) NT data for Indigenous and non-Indigenous Australians are for public hospitals only.

(g) Total for Indigenous and non-Indigenous Australians 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) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(j) The rates presented for Indigenous people and non-Indigenous Australians 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 2012, *Australian hospital statistics 2010-11*, Cat. no. HSE 117, Canberra; AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.82

Table 11A.82 **Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people)**
(a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (f)</i>	<i>Total (g)</i>	<i>Aust</i>
Chronic conditions per 1000 Indigenous Australians (g)										
Angina	3.3	2.8	5.3	5.5	3.8	2.2	3.0	4.1	4.3	np
Asthma	3.6	2.9	3.5	4.7	3.9	0.7	3.7	4.1	3.8	np
Chronic obstructive pulmonary disease	12.6	8.8	12.7	12.9	16.2	5.3	1.9	19.0	13.4	np
Congestive heart failure	3.4	2.6	5.8	7.8	4.6	1.2	9.6	8.5	5.4	np
Diabetes complications (h)	4.9	5.5	7.2	9.6	9.3	1.8	5.7	11.2	7.2	np
Hypertension	0.7	0.4	1.2	1.1	0.6	–	–	0.9	0.9	np
Iron deficiency anaemia	1.7	3.2	2.1	3.3	2.2	1.7	2.8	2.2	2.2	np
Nutritional deficiencies	–	0.1	0.1	0.1	–	–	0.2	0.1	0.1	np
Rheumatic heart disease (i)	0.2	0.1	0.6	0.8	1.0	–	0.3	2.4	0.7	np
Total (h), (j)	30.4	26.4	38.3	45.9	41.7	12.9	27.3	52.5	38.0	np
Total — excluding diabetes complications (all diagnoses) (j)	25.6	20.9	31.1	36.3	32.3	11.1	21.6	41.3	30.7	np
Chronic conditions per 1000 non-Indigenous Australians (g), (k)										
Angina	1.1	1.3	1.8	1.4	1.3	0.8	0.6	1.9	1.3	np
Asthma	1.7	2.0	1.5	1.2	2.1	1.0	1.1	1.3	1.7	np
Chronic obstructive pulmonary disease	2.5	2.6	2.9	2.2	2.7	2.1	1.8	3.3	2.6	np
Congestive heart failure	1.9	2.4	2.0	1.9	2.0	1.2	1.6	1.7	2.1	np
Diabetes complications (h)	1.3	1.7	1.6	1.4	1.6	1.2	1.3	2.3	1.5	np
Hypertension	0.3	0.3	0.4	0.2	0.3	0.1	0.1	0.2	0.3	np
Iron deficiency anaemia	1.1	1.8	1.1	1.5	1.3	0.8	0.6	0.6	1.3	np

TABLE 11A.82

Table 11A.82 **Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people)**
(a), (b), (c), (d)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (e)</i>	<i>NT (f)</i>	<i>Total (g)</i>	<i>Aust</i>
Nutritional deficiencies	–	–	–	–	–	–	–	–	–	np
Rheumatic heart disease (i)	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.1	np
Total (h), (j)	10.0	12.1	11.5	9.9	11.5	7.3	7.2	11.3	10.9	np
Total — excluding diabetes complications (all diagnoses) (j)	8.7	10.4	9.9	8.5	9.8	6.1	5.9	9.0	9.4	np
Chronic conditions per 1000 people (all people) (l)										
Angina	1.1	1.3	1.8	1.5	1.3	0.9	0.7	2.5	1.3	1.3
Asthma	1.7	2.0	1.6	1.3	2.1	1.0	1.2	2.0	1.7	1.7
Chronic obstructive pulmonary disease	2.6	2.6	3.1	2.4	2.8	2.5	2.0	7.1	2.7	2.7
Congestive heart failure	1.9	2.2	2.0	2.0	1.9	1.5	2.0	3.7	2.0	2.0
Diabetes complications	2.5	3.1	4.2	8.7	3.0	2.4	2.3	7.5	3.7	3.7
Diabetes complications (h)	1.4	1.7	1.7	1.5	1.7	1.4	1.4	4.2	1.6	1.6
Hypertension	0.3	0.3	0.4	0.2	0.3	0.2	0.1	0.3	0.3	0.3
Iron deficiency anaemia	1.1	1.7	1.1	1.6	1.3	1.5	1.0	1.3	1.4	1.4
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	–	–
Rheumatic heart disease (i)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8	0.1	0.1
Total (j)	11.0	13.0	14.1	17.4	12.5	9.7	9.1	24.3	12.9	12.9
Total (h), (j)	10.1	11.9	12.0	10.6	11.5	9.1	8.5	22.0	11.1	11.1
Total — excluding diabetes complications (all diagnoses) (j)	8.7	10.3	10.2	9.1	9.8	7.6	7.1	17.7	9.5	9.5

(a) Conditions defined by ICD-10-AM codes as in AIHW 2012 *Australian hospital statistics 2010-11*. Changes to the Australian Coding Standards for diabetes mellitus and impaired glucose regulation between 2009-10 and 2010-11 resulted in marked decreases in the reporting of these conditions. Therefore caution should be used in comparisons of these data with earlier periods.

TABLE 11A.82

Table 11A.82 **Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people)**
(a), (b), (c), (d)

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

(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. Totals include Australian residents of external Territories.

(e) Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification in hospital data is complete — these data are not included in totals.

(f) NT data for Indigenous and non-Indigenous Australians are for public hospitals only.

(g) Total for Indigenous and non-Indigenous Australians 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 *excluding 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) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(l) The rates presented for Indigenous and non-Indigenous Australians 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 2012, *Australian hospital statistics 2010-11*, Cat. no. HSE 117, Canberra; AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.83

Table 11A.83 **Ratio of separations for Indigenous Australians to all Australians, diabetes, 2010-11**
(a), (b), (c), (d), (e), (f), (g)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total (b)</i>
Diabetes as a primary diagnosis (h)	no.	558	166	955	473	221	np	np	613	2 986
	SHSR	3.65	3.33	4.93	7.00	5.65	np	np	5.11	5.09
	95% CI	3.34 to 3.95	2.82 to 3.83	4.62 to 5.24	6.37 to 7.63	4.91 to 6.40	np	np	4.70 to 5.51	4.91 to 5.27
All diabetes — excluding diabetes complications as an additional diagnosis (i)	no.	853	278	1 208	730	282	np	np	749	4 100
	SHSR	3.32	3.98	3.78	7.01	5.49	np	np	5.16	4.37
	95% CI	3.09 to 3.54	3.51 to 4.45	3.57 to 3.99	6.50 to 7.52	4.85 to 6.13	np	np	4.79 to 5.53	4.24 to 4.51
All diabetes (j)	no.	2 319	653	4 452	11 073	1 170	np	np	3 375	23 042
	SHSR	3.70	3.26	5.55	30.33	8.84	np	np	8.30	9.47
	95% CI	3.55 to 3.85	3.01 to 3.51	5.38 to 5.71	29.77 to 30.90	8.33 to 9.34	np	np	8.02 to 8.58	9.35 to 9.59

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) Changes to the Australian Coding Standards for diabetes mellitus and impaired glucose regulation between 2009-10 and 2010-11 resulted in marked decreases in the reporting of these conditions. See Australian hospital statistics 2010-11 (Appendix 2).
- (h) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24'.
- (i) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24' or Additional diagnosis in 'E109', 'E119', 'E139' or 'E149'.
- (j) All diabetes refers to separations with either a principal or additional diagnosis of diabetes. Includes ICD-10-AM codes in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

TABLE 11A.83

Table 11A.83 **Ratio of separations for Indigenous Australians to all Australians, diabetes, 2010-11**
(a), (b), (c), (d), (e), (f), (g)

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

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.84

Table 11A.84 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2010-11 (per 100 000 people)**
(a), (b), (c), (d), (e), (f), (g), (h)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Circulatory	2.9	2.4	3.7	2.4	1.9	np	np	np	2.8
Renal	3.1	1.9	3.6	2.5	2.8	np	np	np	2.9
Ophthalmic	7.1	8.4	6.1	8.9	5.6	np	np	np	7.3
Other specified	38.3	42.2	52.1	43.2	52.4	np	np	np	44.1
Multiple	23.3	38.4	39.4	34.0	33.2	np	np	np	34.2
No complications	4.4	4.9	3.4	3.5	4.9	np	np	np	4.2
Total	79.3	98.2	108.3	94.6	100.8	np	np	np	95.5

- (a) Rates are age standardised to the Australian resident population at 30 June 2001.
- (b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.
- (c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.
- (d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.
- (e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.
- (f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (g) Totals may not add as a result of rounding.
- (h) Changes to the Australian Coding Standards for diabetes mellitus and impaired glucose regulation between 2009-10 and 2010-11 resulted in marked decreases in the reporting of these conditions. See AIHW (2012) *Australian hospital statistics 2010-11* (Appendix 2).

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.85

Table 11A.85 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2010-11 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
Circulatory	9.0	12.4	43.1	10.9	13.9	np	np	np	18.9
Renal	14.3	14.4	12.2	16.7	14.0	np	np	np	13.8
Ophthalmic	91.4	80.2	88.7	85.4	88.1	np	np	np	86.6
Other specified	9.5	15.6	23.4	11.7	13.6	np	np	np	14.9
Multiple	10.9	21.8	15.3	4.2	8.8	np	np	np	15.7
No complications	41.0	51.6	32.3	16.5	50.5	np	np	np	40.7
Total	19.1	25.1	24.7	16.4	17.9	np	np	np	21.9

- (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 for diabetes mellitus and impaired glucose regulation between 2009-10 and 2010-11 resulted in marked decreases in the reporting of these conditions. See AIHW (2012) *Australian hospital statistics 2010-11* (Appendix 2).

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.86

Table 11A.86 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
ASR	per 100 000 people	10.6	12.7	13.6	14.9	17.8	np	np	np	13.3
Crude	per 100 000 people	11.8	13.9	14.0	15.3	21.4	np	np	np	14.4
Separations	no.	854	773	630	350	352	np	np	np	3 212

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 for diabetes mellitus and impaired glucose regulation between 2009-10 and 2010-11 resulted in marked decreases in the reporting of these conditions. See AIHW (2012) *Australian hospital statistics 2010-11* (Appendix 2).

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 11A.87

Table 11A.87 Separation rates of older people for injuries due to falls (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	46 425	32 911	20 058	10 409	8 780	2 348	1 516	340	122 787
2006-07									
Separations per 1000 older people	51.6	48.5	43.0	43.8	35.8	32.7	52.2	47.8	46.7
Number of separations	50 938	35 649	22 078	10 954	9 358	2 455	1 697	375	133 504
2007-08									
Separations per 1000 older people	51.6	48.6	42.9	43.7	36.4	34.1	60.1	43.2	46.8
Number of separations	52 463	36 855	22 851	11 319	9 762	2 616	2 051	366	138 283
2008-09									
Separations per 1000 older people	52.4	47.6	45.7	44.6	39.0	32.9	65.0	43.2	47.7
Number	54 998	37 337	25 092	12 009	10 759	2 580	2 318	383	145 476
2009-10									
Separations per 1000 older people	55.9	49.5	47.1	46.2	43.0	32.8	68.2	43.3	50.1
Number of separations	60 117	39 885	26 759	12 877	12 059	2 638	2 546	408	157 289
2010-11 (d)									
Separations per 1000 older people	60.4	53.0	51.7	52.1	43.0	32.7	65.6	np	54.0
Number of separations	np	np	np	np	np	np	np	np	np

(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.

(d) The Australian total for 2010-11 does not include NT data.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
Closing the Gap – Urban Specialist Outreach Assistance Program	<p>The Closing the Gap – Urban Specialist Outreach Assistance Program facilitates access to medical specialist outreach services that focus on the management and treatment of chronic disease for Aboriginal and Torres Strait Islander peoples living in urban areas (Australian Standard Geographical Classification Remoteness Areas 1 and 2).</p> <p>The program is currently available in New South Wales, Queensland, Victoria, Western Australia and South Australia. It is anticipated that the program will commence in Tasmania and the Australian Capital Territory in 2012-13. (The Northern Territory is not eligible under the program as it has no Remoteness Areas 1 or 2.)</p>	<p>Commonwealth contribution to the National Partnership Agreement – Closing the Gap.</p> <p>Funding is provided under Outcome 8 – Indigenous Health.</p>	<p>Six monthly financial and activity reports.</p> <p>Sentinel Sites evaluation.</p> <p>National evaluation.</p>
General Practice After Hours Program	<p>The General Practice After Hours Program aims to improve access to effective and appropriate after hours primary care services for all Australians, regardless of where they live. Two major components of the program are the After Hours GP Helpline and Medicare Locals.</p> <p>The <i>After Hours GP Helpline</i> is a general practice medical advice and diagnostic service for people who need after hours assistance, cannot access their usual general practitioner, and are not sure what to do. The helpline is available nationally through healthdirect Australia, 13Health, NURSE-ON-CALL and, in Tasmania, through GP Assist.</p>	<p>Funding is provided under Outcome 5 – Primary Care.</p>	<p>Six-monthly financial and activity reports from each Medicare Local.</p> <p>Service activity reports submitted regularly in the context of an agreed reporting framework.</p>

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p><i>Medicare Locals</i> are responsible for the planning and funding of local face-to-face after hours primary care services. Their role is to improve the coordination and integration of after hours primary health care services, in order to best meet the needs of local communities. Medicare Locals achieve this by working closely with health professionals and other key stakeholders to bridge service gaps, and by making it easier for consumers to navigate their local health care system.</p>		
Practice Incentives Program	<p>The Practice Incentives Program (PIP) supports general practice activities that encourage continuing improvements, quality care, enhanced capacity, and improved access and health outcomes for patients. Financial incentives available under the program include:</p> <ul style="list-style-type: none"> - the PIP After Hours Incentive – encourages general practitioners to provide quality after hours services; - the PIP Asthma Incentive – encourages general practices to better manage the clinical care of people with moderate to severe asthma; - the PIP Diabetes Incentive – encourages general practitioners to provide early diagnosis and effective management of people with established diabetes mellitus (type 2 diabetes); - the 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.

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<ul style="list-style-type: none"> - 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. The PIP Indigenous Health Incentive is a key part of the Closing the Gap - Indigenous Chronic Disease Package (discussed below). 		
Primary Health Care base funding program	<p>The Primary Health Care base funding program supports Indigenous health organisations to improve community access to a broad range of clinical and population health services. These services include population health activities, clinical services such as the treatment of acute illness, emergency care, the management of chronic conditions, crisis intervention and referral. Organisations funded under this program must deliver primary health care services and/or advocacy services tailored to the needs of the community.</p> <p>The program is delivered by a range of Aboriginal Community Controlled Health Services, non-government organisations and some state and territory health departments.</p>	Funding is provided under Outcome 8 – Indigenous Health.	<p>Quarterly verbal progress reviews of services against agreed plans.</p> <p>Organisations' annual reports of service activity.</p> <p>Biannual reports against agreed national key performance indicators from services providing clinical primary health care.</p>
Closing the Gap – Improving Indigenous Access to Mainstream Primary Care Program	<p>The Closing the Gap – Improving Indigenous Access to Mainstream Primary Care Program facilitates access to culturally sensitive mainstream primary care for Aboriginal and Torres Strait Islander peoples, by funding Indigenous Health Project Officer and Aboriginal and Torres Strait Islander Outreach Worker positions in the Medicare Locals network.</p>	<p>Commonwealth contribution to the National Partnership Agreement – Closing the Gap.</p> <p>Funding is provided under Outcome 8 – Indigenous Health.</p>	<p>Six monthly financial and activity reports.</p> <p>Sentinel Sites evaluation.</p> <p>National evaluation.</p>

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples Program	The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples Program aims to improve the health outcomes of Aboriginal and Torres Strait Islander peoples who attend participating Aboriginal Community Controlled Health Services in rural and urban Australia, by funding activities that improve the quality use of medicines and medication compliance. The program also supports access by these clients to medicines under the Pharmaceutical Benefits Scheme by addressing cultural, transport and other barriers to access.	Funding is provided under Outcome 2 – Access to Pharmaceutical Services.	Regular service activity and financial reports provided in line with an agreed reporting framework.
Medical Specialist Outreach Assistance Program (MSOAP)	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.
MSOAP Indigenous Chronic Disease	MSOAP Indigenous Chronic Disease provides outreach services by multidisciplinary health teams, which include medical specialists, general practitioners and allied health professionals, to Aboriginal and Torres Strait Islander peoples living in rural and remote Australia.	Funding for MSOAP Indigenous Chronic Disease is provided under Outcome 8 – Indigenous Health.	Sentinel Sites evaluation.
Practice Incentives Program Procedural General Practitioner Payment	The Practice Incentives Program Procedural 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.

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Remote Area Aboriginal Health Service Program	The Remote Area Aboriginal Health Service Program is administered under Section 100 of the <i>National Health Act 1953</i> and allows for the supply of Pharmaceutical Benefit Scheme medicines to clients of eligible remote area Aboriginal Health Services at the time of medical consultation, without the need for a normal prescription form, and without charge.	Funding is provided under Outcome 2 – Access to Pharmaceutical Services.	Monthly program expenditure reported through the Department of Human Services.
Remote Area Health Corps	The Remote Area Health Corps assists remote Northern Territory Aboriginal Health Services to provide enhanced care services to clients by recruiting and deploying urban-based health professionals for short-term work placements in remote Northern Territory Aboriginal communities.	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.	Funding is provided under Outcome 6 – Rural Health.	Financial and service activity reports submitted regularly in the context of a National Reporting Framework.
Rural Primary Health Services Program	The Rural Primary Health Services Program funds a range of organisations such as state health entities, local governments, Indigenous health services, Medicare Locals and other non-government organisations, to provide supplementary primary and allied health care services in rural and remote communities. Services include mental health, social work, community nursing, Aboriginal health, family health and community health education, promotion and prevention. The actual services delivered depend on the needs of the target communities.	Funding is provided under Outcome 5 – Primary Care.	Six and twelve month financial and activity reports required for each project. Annual survey completed by Divisions of General Practice for Primary Health Care Research Information Service reporting.

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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 have little or no access to a female general practitioner, by facilitating the travel of female general practitioners to these communities.	Funding is provided under Outcome 6 – Rural Health.	Financial and service activity reports submitted regularly in the context of an agreed reporting framework.
Section 100 Pharmacy Support Allowance.	The Section 100 Pharmacy Support Allowance (Fifth Community Pharmacy Agreement) financially supports visits by pharmacists to provide a range of targeted quality use of medicines and medication management support services to remote area Aboriginal Health Services. The Aboriginal Health Service must participate in the special supply arrangements approved under Section 100 of the <i>National Health Act 1953</i> .	Funding is provided under Outcome 2 – Access to Pharmaceutical Services.	Regular service activity and financial reports provided in line with an agreed reporting framework.
Visiting Optometrists Scheme (VOS)	The Visiting Optometrists Scheme supports optometrists to deliver outreach optometric services to regional, remote and very remote locations, which would not otherwise have ready access to primary eye care. The scheme addresses some of the financial disincentives incurred by optometrists delivering outreach services, with funding provided for travel, accommodation, meals, facility fees, administrative support at the outreach location, external locum support at the home practice, lease and transport of equipment.	Funding is provided under Outcome 3 – Access to Medical Services and Outcome 8 – Indigenous Health.	Six monthly financial and activity reports.
VOS Expansion for Indigenous Australians	The VOS Expansion for Indigenous Australians specifically aims to attract optometrists to deliver new and expanded services to people living and working in identified national priority rural and remote Aboriginal and Torres Strait Islander communities across Australia.		

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Closing the Gap – PBS Co-payment Measure	The Closing the Gap – PBS Co-payment Measure under the Indigenous Chronic Disease Package improves access to Pharmaceutical Benefits Scheme medicines for eligible Aboriginal and Torres Strait Islander peoples living with, or at risk of, chronic disease. Eligible Practice Incentive Program accredited general practices and non-remote Indigenous Health Services may participate in the measure.	Commonwealth contribution to the National Partnership Agreement – Closing the Gap. Funding is provided under Outcome 8 – Indigenous Health.	Monthly expenditure reporting through the Department of Human Services.
Objective: Promoting health and preventing illness, early detection			
Maternal and child health	The <u>Asthma Child and Adolescent Program</u> provides information and emergency training for asthma and chronic respiratory conditions linked to asthma such as allergy and rhinitis. The program targets children and adolescents, staff in preschools and schools, and parents. The program is delivered by Asthma Australia under the Asthma Management Program. The <u>Australian Nurse Family Partnership Program</u> is an intensive home visiting program that aims to improve health outcomes for women pregnant with an Aboriginal and/or Torres Strait Islander child, 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 1 – Population Health. Funding is provided under Outcome 8 – Indigenous Health.	Financial and service activity reports every four months, submitted in the context of an agreed reporting framework. Quarterly Action Plan and Fidelity Reports. Six monthly financial reporting.

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The <u>New Directions Mothers and Babies Services Program</u> aims to increase access to child and maternal health care for Aboriginal and Torres Strait Islander families. It provides Aboriginal and Torres Strait Islander children and their mothers with access to antenatal care; standard information about baby care; practical advice and assistance with breastfeeding, nutrition and parenting; monitoring of developmental milestones, immunisation status and infections; and health checks for Indigenous children before starting school.	Indigenous Early Childhood Development National Partnership. Funding is provided under Outcome 8 – Indigenous Health.	Financial and activity reports required from each organisation twice a year.
Women's health and wellbeing	The Australian Government supports the <u>Jean Hailes Foundation for Women's Health</u> to promote 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. The Foundation also provides leadership for the National Polycystic Ovarian Syndrome Alliance which aims to improve the lives of women with Polycystic Ovary Syndrome through education, research and evidence based health care.	Funding is provided under Outcome 1 – Population Health.	Regular progress reports.
Men's health and wellbeing	The Australian Government <u>Shed Development Program</u> financially assists Men's Sheds across Australia to provide small grants for tools and the capital development of men's sheds. Priority is given to sheds working with males living in rural and remote areas, migrant males, males who are socially disadvantaged, males with a disability, including a mental illness, and, in 2012, Aboriginal and Torres Strait Islander males. The program is administered by the Australian Men's Shed's Association.	Funding is provided under Outcome 10 – Health System Capacity and Quality.	Regular progress reports. Final Project Report. Audited financial reports. Business Plan.

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The <u>Strong Fathers Strong Families Program</u> aims to provide access for Indigenous fathers, grandfathers and other male relatives to culturally appropriate, more male-inclusive or separate antenatal and other health-related services and messages that assist them to be more involved in the early development of their children's and family's lives.	Funding is provided under Outcome 8 – Indigenous Health.	Financial and activity reports are required from each jurisdiction twice a year.
Children's health and wellbeing	<p>The <u>Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes</u> measure supports activities to improve the eye and ear health of Indigenous children, by funding:</p> <ul style="list-style-type: none"> - the training of health workers to undertake ear health assessments (including diagnosis of otitis media, or middle ear infection), and the provision of medical equipment for these assessments; - additional ear surgery, particularly for remote Indigenous children with ear damage as a result of infections; - a social marketing campaign promoting hearing health; and - the expansion of trachoma control activities in areas where trachoma is endemic (Western Australia, South Australia and the Northern Territory), and to determine whether trachoma is a problem in New South Wales and Queensland. 	Funding 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.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Immunisation	The <u>General Practice Immunisation Incentive Scheme</u> supports 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 scheme aims 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.
	The <u>Immunise Australia Program</u> funds free vaccines to eligible Australians (consultation fees may be charged), with the aim of increasing national immunisation rates.	Funding is provided under Outcome 1 – Population Health.	National Partnership Agreement on Essential Vaccines. Annual Report. COAG reporting.
	The program administers the Australian Childhood Immunisation Register and the National HPV Vaccination Program Register, and communicates information about immunisation to the general public and health professionals.		Quarterly Australian Childhood Immunisation Register reports. National Healthcare Agreement.
Screening	The <u>BreastScreen Australia Program</u> aims to reduce mortality and morbidity from breast cancer by actively inviting women in the target age group of 50 to 69 years to undergo free biennial screening mammograms. Women aged 40 years and over are also eligible to attend this free service.	BreastScreen Australia is jointly funded by the Australian and state and territory governments.	Annual Report.
		Funding is provided under Outcome 1 – Population Health.	Australian Institute of Health and Welfare annual monitoring report.
		Funding is provided to the states and territories through the National Health Reform Agreement.	

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs***Programs funded by the Australian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The <u>National Bowel Cancer Screening Program</u> 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 aged 50, 55 and 65 years of age who have no noticeable symptoms with a Faecal Occult Blood Test, which detects small amounts of blood in the bowel motion. Participants with a positive test 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. Reviews and research projects including a pilot program evaluation, and an economic evaluation. Australian Institute of Health and Welfare annual monitoring report.
	The <u>Practice Incentives Program Cervical Screening Incentive</u> provides financial assistance to general practices to help increase cervical screening rates, targeting under-screened women 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.	Funding is provided under Outcome 5 – Primary Care.	Annual Report.
Other	The <u>Community Support Program</u> under the <u>Asthma Management Program</u> aims to increase awareness of best practice asthma management and empower people to be more proactive in self-managing their asthma. The program includes messages about other linked respiratory conditions, such as allergy, rhinitis and chronic obstructive pulmonary disease. It focuses strongly on prevention, especially in lower socio-economic areas; and innovative ways to communicate best practice messages to priority groups such as 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.88

Table 11A.88 Australian Government, community health services programs
Programs funded by the Australian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>The <u>Closing the Gap in Indigenous Health Outcomes</u> – <u>Indigenous Chronic Disease Package</u> aims to reduce key risk factors for chronic disease in the Indigenous community, improve chronic disease management and follow up, and increase the capacity of the primary care workforce to deliver effective care to Indigenous Australians with chronic diseases.</p> <p>This is achieved by delivering healthy lifestyle programs; providing financial incentives for Indigenous health services and general practices; removing barriers to essential follow-up services and Pharmaceutical Benefits Scheme medicines; and growing the number and skills of the Indigenous health workforce.</p>	<p>Funding is provided under Outcome 8 – Indigenous Health, Outcome 2 – Access to Pharmaceutical Services, Outcome 3 – Access to Medical Services and Outcome 5 – Primary Care.</p>	<p>Indigenous Chronic Disease Package Annual Report.</p>
	<p>The <u>Healthy Communities Initiative</u>, under the National Partnership Agreement on Preventive Health, supports local governments to engage in the healthy living agenda by delivering projects that target disadvantaged adults. Local Government Area grants are a key feature, supporting the delivery of proven and effective healthy lifestyles programs in every state and territory.</p>	<p>Funding is provided under Outcome 1 – Population Health.</p>	<p>Financial and activity reports submitted regularly in line with the funding agreement.</p>

TABLE 11A.88

Table 11A.88 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	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.		
	<p>The <u>Closing the Gap – Care Coordination and Supplementary Services Program</u> improves health outcomes for Aboriginal and Torres Strait Islander peoples with chronic health conditions through better access to coordinated and multidisciplinary care. Care coordination is provided by qualified health workers such as specialist nurses and Aboriginal Health Workers, to patients with a chronic disease who have been enrolled and referred by mainstream or Aboriginal Medical Service practices participating in the Practice Incentives Program Indigenous Health Incentive.</p> <p>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. The funds may also be used to assist with the cost of local transport to health care appointments.</p> <p>This program is administered by Rural and Regional Health Australia.</p>	<p>Commonwealth contribution to the National Partnership Agreement – Closing the Gap.</p> <p>Funding is provided under Outcome 8 – Indigenous Health.</p>	<p>Quarterly data and six monthly financial and activity reports.</p> <p>National evaluation.</p> <p>Sentinel Sites evaluation.</p>

TABLE 11A.88

Table 11A.88 Australian Government, community health services programs
Programs funded by the Australian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Other programs:			
Family Planning Grants Program	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.	Quarterly financial and activity reports required from each project.

Source: Australian Government unpublished.

TABLE 11A.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
Sexual Assault Services	NSW Health's 55 Sexual Assault Services provide holistic specialist assistance to adult and child victims of sexual assault including supporting their psycho-social, emotional and cultural wellbeing. Free counselling, court support, medical and forensic examinations and medical treatment are available to anyone who has recently been sexually assaulted in NSW.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Sexual Assault Service funding is implemented within service agreement allocations.	Sexual Assault Services are included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.
Joint Investigation Response Teams (JIRT)	JIRT is collaborative arrangement between NSW Community Services, NSW Police and NSW Health. The primary aim of JIRT is to minimise the number of investigative interviews child victims of sexual abuse, physical abuse and extreme neglect have to undertake and to provide seamless service delivery to child victims and their non-offending family members. NSW Health became an equal partner in JIRT in 2009. As the 2012 JIRT Secretariat, NSW Health is responsible for leading the review of the JIRT Policy and Procedures Manual (2001), the Memorandum of Understanding between the three partner agencies and the Statewide Management Group's Terms of Reference. NSW Health is also in the final stages of recruiting and placing 24 Senior Health Clinicians in every JIRT office across the state.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. JIRT funding is implemented within service agreement allocations.	<i>Keep Them Safe (KTS)</i> requires an audit of the JIRT Program every three years. An annual JIRT CEO Report Card is collated each year to meet the KTS audit requirements.

TABLE 11A.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Medical and forensic services for victims of sexual assault	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. The program has a particular focus on improving access in rural and remote communities.	Combination of Ministry of Health allocation, LHD block funding and Commonwealth funding (Indigenous Health-National Partnership Agreement)	LHDs report on service provision via a payment determination for a fee to be payable to non-salaried medical practitioners in designated rural LHDs conducting forensic and medical examinations for sexual assault victims.
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under <i>Keep Them Safe</i> (KTS) NSW Health committed to expanding services for children aged under 10 years who display problematic or harmful sexualised behaviour, including Aboriginal children. To increase service delivery, the Ministry of Health allocated KTS funding to enhance the Sparks program in the Hunter New England LHD, which is the only NSW Health specialist service responding to this client group. The Ministry is also developing a statewide policy directive and guidelines on best practice service delivery, including training requirements for staff, were necessary to resolve current issues and assist LHDs in their local responses to the target group.	LHD funding and Keep Them Safe 'protected item' funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.

TABLE 11A.89

Table 11A.89 New South Wales, community health services programs
Programs funded by the NSW Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
New Street	New Street 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 position for New Street Services and the Pre-Trial Diversion of Offenders Program 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.
Health Child Wellbeing Units	Health Child Wellbeing Units provide support and assistance to health mandatory reporters to assist them to identify and provide appropriate responses for children and young people at risk of significant harm and to determine what other supports should be put in place for vulnerable children and young people below this statutory reporting threshold.	Keep Them Safe 'protected item' funding.	Milestone reporting to Department of Premier and Cabinet. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget
Family Referral Services	Family Referral Services (FRS) are intended to link vulnerable children, young people, and families with appropriate available support services in their local area. FRS refer clients to a range of local support services such as case management, housing, childcare, supported playgroup, drug and alcohol/mental health services, youth services, home visiting, family support, parenting education and respite care.	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 Family and Community Services. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget

TABLE 11A.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Protection Counselling Services	<p>The target group is vulnerable children and young people who are below the threshold for statutory child protection intervention, and their families. Government agencies, non-government organisations, and the private sector (e.g., general practitioners, childcare workers) can refer families to Family Referral Services. Families may also self-refer.</p> <p>There are 8 Family referral Services currently operating in NSW covering the following regional areas: Western NSW, Hunter Central Coast, Western Sydney (2), Illawarra, New England North West, Mid North Coast and Far North Coast.</p> <p>CPCS are located in each NSW Local Health District and provide specialist, tertiary-level counselling and casework services to children and young people and their families, where abuse or neglect has been substantiated by Community Services. This usually involves a medium- to long-term intervention (between 3 months and 18 months). Interventions are child-focussed and family-centred, and aim to address and stop the effects of abuse and neglect and exposure to domestic violence on children and young people. The aim is to work toward maintaining the child or young person living with their family wherever this is possible.</p>	LHD receive block funding from the Ministry 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 a services to a Non-admitted Patient and reported by the LHDs to the Ministry of Health on a quarterly basis.
Maternal and child health	<p>Objective: Promoting health and preventing illness, early detection</p> <p>Maternity services are part of the core services provided by LHDs to their population. Community antenatal and postnatal care is provided including through shared care arrangements with GPs.</p>	LHD block funding and some IECD NP funds (Commonwealth)	Varies by program. Some services measured as Non Admitted Patient Occasions of Service.

TABLE 11A.89

Table 11A.89 New South Wales, community health services programs
Programs funded by the NSW Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Targeted programs for vulnerable populations include:</p> <ul style="list-style-type: none"> - Aboriginal Maternal and Infant Health Service (AMIHS) provides culturally appropriate antenatal and postnatal care up to 8 weeks, to Aboriginal mothers and babies. Mental health and drug and alcohol secondary services are being delivered in selected AMIHS sites across the state as part of the Indigenous Early Childhood Development National Partnership Agreement (IECD NP). Quit for new life, a smoking cessation intervention specifically for Aboriginal pregnant women is also being rolled out across AMIHS programs. 		Regular reports on activity, outcomes against indicators
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 (IHSY).	<p>These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the LHDs to the Department of Health on a quarterly basis.</p> <p>IHSY program reports annually to MCYPH branch</p>

TABLE 11A.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services. <i>Personal Health Record (PHR)</i> - The NSW PHR (also known as 'the Blue Book') is distributed to all families with a newborn in NSW and provides a schedule of nine recommended child health checks from birth to four years of age. The PHR uses a joint parental-professional approach to detect or anticipate problems. <i>Early Childhood Health Services</i> provide a range of services to support good health outcomes of children, including parenting support and education, breastfeeding support, universal health home visiting, screening for postnatal depression and referral if necessary, and health and development advice for families with young children.	Local Health Districts (LHDs) receive block funding from the Department of Health to provide health services to their population. Each LHD determines how much money is allocated to this program. NSW Health	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides services to a Non-admitted Patient is reported by LHDs to the Department of Health (DoH) on a quarterly basis.
Children's health and wellbeing	Children's Health and Wellbeing services include universal services provided to the whole population and targeted services. Universal services including Postnatal child and family health services such as early childhood health services and Universal Home Health Visiting.		Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.

TABLE 11A.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>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.</p>	LHD funds	
	<p>Sustaining NSW Families is a program of nurse led structured evidenced based sustained health home visiting provided to vulnerable children at risk of poor developmental outcomes and their families in selected low socio-economic areas. The program actively supports parents' aspirational goals for themselves and their child and builds parenting capacity and secure parent/ child relationships. It is prevention and early intervention strategy which commences in the antenatal period and continues until child is 2 years of age with the aim of optimising child health and development outcomes. In 2011-12 two further sites were implemented including one site that includes some bi-lingual nurses (English/Arabic and English/Mandarin) and the other is in a rural area with a focus on engaging vulnerable Aboriginal families.</p>	Most funding is Keep Them Safe dedicated 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.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Health care needs of children in Out Of Home Care - coordination and provision of health development and wellbeing assessments, reviews and interventions of children and young people in OOHC. This state-wide project is being implemented in phases commencing with children/young people entering Statutory Out of Home care who are expected to remain in care for more than 90 days.</p>	Keep Them Safe funding	Quarterly data reporting to Ministry of Health. Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
	<p>Building Strong Foundations for Aboriginal Children Families and Communities is a culturally safe early childhood health service for Aboriginal children birth to school entry age and their families. It aims to support parents and communities to provide an environment that will optimise the health, development and wellbeing of their child so that children are ready able to engage fully in life and learning. It has close links to Aboriginal maternity services including NSW Aboriginal Mothers and Infants Health Services and New Directions as well as mains team services. Teams comprising Aboriginal Health Workers and Child and Family Health nurses provide the main frontline service. Seven new sites were funded late 2011/12 bringing total to 15 across NSW.</p>	State program funding to selected sites.	Annual Reporting and six monthly financial acquittal

TABLE 11A.89

Table 11A.89 **New South Wales, community health services programs***Programs funded by the NSW Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Screening	<p>Domestic Violence Routine Screening - Women are routinely screened for recent or current domestic violence in antenatal and early childhood health services, and women aged 16 and over are screened in mental health and alcohol and other drugs services. Screening is an early identification and education strategy</p> <p>Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program includes the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies.</p> <p>- StEPS is a free vision screening program for all four year old children in NSW. The program is designed to identify childhood vision problems early which cannot be detected by observation, behaviour, family history or vision surveillance. By identifying and treating vision problems during the critical visual development period, treatment outcomes can be maximised.</p>	<p>LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Domestic Violence Routine Screening funding is implemented within service agreement allocations.</p> <p>A mix of LHD and Australian Government funding.</p>	<p>A one-month data collection snapshot from all LHDs is conducted in November of each year. This provides information on outcomes such as screening and identification rates, and referrals. Domestic Violence Routine Screening is also included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.</p> <p>Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.</p>

Source: NSW Government unpublished.

TABLE 11A.90

Table 11A.90 **Victoria, community health services programs***Programs funded by the Victorian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
Primary Care Partnerships (PCPs) strategy	<p>Primary Care Partnerships (PCPs) are cross government funded voluntary alliances of health and human services provider organisations. The 30 PCPs in Victoria which engage over 1000 organisations. PCPs deliver local service system reforms to:</p> <ul style="list-style-type: none"> • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated; and • improve the management of chronic disease. <p>The strategy to improve the coordination of services is supported by a statewide policy and operational framework and includes:</p> <ul style="list-style-type: none"> • 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; and • e-referral systems to securely share client information with client consent. <p>PCPs identify local health and well being priorities and ways to address these priorities. 'Place based' partnership approaches are used to assess and engage with communities that experience significant disadvantage. Interventions may be targeted to particular population groups, for example, farmers, people with a refugee background and ethnic communities. They may include:</p> <ul style="list-style-type: none"> • tools to overcome cultural/language barriers, including consumer information available in over 40 community languages; and • tools to overcome geographical barriers including place-based initiatives. 	Core funding provided by the Victorian Department of Health. 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.90

Table 11A.90 **Victoria, community health services programs***Programs funded by the Victorian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Refugee Health Nurse Program	<p>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:</p> <ul style="list-style-type: none"> • to increase refugee access to primary health services • to improve the response of health services to refugees' needs; and • to enable refugee individuals, families and communities to improve their health and wellbeing. <p>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 local service providers to develop a responsive and effective service response for refugee clients.</p> <p>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.</p>	<p>The Victorian Government funds the RHNP through the Department of Health.</p> <p>The Integrated Care Branch of the department is responsible for program development and resource allocation.</p> <p>The department's regional offices monitor program delivery and performance.</p> <p>Community health services are funded to deliver the RHNP.</p>	<p>Community health services funded under the RHNP report hours of service on a quarterly basis.</p> <p>This information is provided to the Integrated Care Branch of the Department of Health.</p>

TABLE 11A.90

Table 11A.90 **Victoria, community health services programs***Programs funded by the Victorian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Dental Health Program	<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • Children up to the age of 12 • Young people aged 13 – 17 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 their case manager or staff of special development schools • Refugees and Asylum Seekers • Aboriginal and Torres Strait Islanders • Pregnant women 	<p>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.</p> <p>There are three course of care types: emergency, general and denture care. The funding unit is a Dental Unit of Value (DuV)</p>	<p>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.</p> <p>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</p>

TABLE 11A.90

Table 11A.90 Victoria, community health services programs
Programs funded by the Victorian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Fees for public dental services apply to people aged 18 years and over, who are health care or pensioner concession card holders or dependants of concession card holders and children aged 0–12 years who are not health care or pensioner concession card holders or not dependants of concession card holders. An inability to pay fees cannot be used as a basis for refusing a dental service to an eligible person. Exemption from fees for public dental services applies to the following people:</p> <ul style="list-style-type: none"> • 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 & Families Division of DHS • All youth justice clients up to 18 years of age in custodial care • Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special developmental schools • Those receiving care from undergraduate students • Those experiencing financial hardship 		

TABLE 11A.90

Table 11A.90 Victoria, community health services programs
Programs funded by the Victorian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
NURSE-ON-CALL	<p>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:</p> <ul style="list-style-type: none"> • triage • health information • information or advice about local health providers. 	<p>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.</p>	<p>MHS provide the department with a number of monthly reports. These provide data about call volumes, call arrival patterns, call outcome and caller demographics.</p>
IHSY program	<p>The Innovative Health Services for Homeless Youth (IHSY) 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. IHSY provides a means of engaging young people who are homeless or marginalised and who may not otherwise access health services.</p>	<p>IHSY is provided under the National Healthcare Agreement with state and territory governments matching the Commonwealth's contribution.</p>	<p>Quantitative performance targets are set by the department and monitored quarterly.</p>

TABLE 11A.90

Table 11A.90 **Victoria, community health services programs***Programs funded by the Victorian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Promoting health and preventing illness, early detection			
Maternal and child health	<p>The Healthy Mothers, Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. The program is delivered by community health services in areas that have high numbers of births and higher rates of relative socioeconomic disadvantage. The objectives of the program are to:</p> <ul style="list-style-type: none"> • improve women's access and attendance at antenatal and postnatal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. <p>Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their:</p> <ul style="list-style-type: none"> • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services. 	<p>The Victorian Government funds the program through the Department of Health.</p> <p>The Integrated Care Branch of the department is responsible for program development and resource allocation.</p> <p>Department of Health regional offices monitor the performance of the program.</p> <p>Funding of this program continues until June 2012. Extension of funding for this program beyond 30 June 2012 is subject to budget outcomes.</p>	<p>Quantitative performance targets are set by the Department of Health and monitored quarterly.</p> <p>The performance of the program has been monitored through a formal evaluation completed in August 2011.</p>

TABLE 11A.90

Table 11A.90 **Victoria, community health services programs***Programs funded by the Victorian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Children's health and wellbeing	<p>Services for children and families within community health are based on evidence which identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services respond to the needs of young children and their families.</p> <p>Child health teams provide multidisciplinary care through a mix of group and individual interventions. Services promote positive health, growth and functioning within the community. Their focus is the provision of early interventions as well as to improve the capacity of parents and families to understand and manage the health and development needs of their child. The child health teams also support families to access additional services they may require in the community.</p>	<p>The Victorian Government funds the program through the Department of Health.</p> <p>The Integrated Care Branch of the department is responsible for program development and resource allocation.</p> <p>Department of Health regional offices monitor the performance of the program.</p>	Quantitative performance targets are set by the department and monitored quarterly.
Screening	The Screening and Cancer Prevention team 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 and newborn screening program. The team has a strong focus on improving participation and addressing health disparities in under screened and non-screened communities.	Funding for cancer screening programs is provided by the Victorian and Commonwealth Governments. Funding for the newborn and infant hearing screening programs 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.90

Table 11A.90 Victoria, community health services programs
Programs funded by the Victorian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>The team 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.</p> <p>The Maternity and Newborn Unit funds the Royal Children's Hospital to coordinate the Victorian Infant Hearing Screening Program (VIHSP) now being implemented state-wide.</p>		
	<p>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</p> <p>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.</p>		
Community Health Program	<p>The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 350 sites across Victoria. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers.</p>	<p>These services are funded under the Primary Health Funding Approach. The Approach includes two components (1) direct care and (2) health promotion.</p>	<p>Quantitative performance targets are set by the department and monitored quarterly.</p> <p>Agencies funded for health promotion are required to develop 3 year health promotion plans and report on those plans on an annual basis.</p>

TABLE 11A.90

Table 11A.90 **Victoria, community health services programs***Programs funded by the Victorian Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Program (contd)	<p>CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses.</p> <p>Funding is provided for the provision of direct care, and for health promotion.</p> <p>CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.</p>	<p>The Integrated Care Branch of the department administers funding in relation to direct care service provision.</p> <p>The Prevention and Population Health Branch of the department administers funding for the program in relation to health promotion.</p>	
Family Planning (with input from Prevention and Population Health Branch)	<p>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.</p> <p>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.</p>	<p>Prior to 2009-10, funding was provided through the Public Health Funding Outcomes Agreement.</p> <p>From 2009-10, funding is provided under the National Healthcare Agreement.</p> <p>The Prevention and Population Health Branch of the department administers the funding for the program in relation to health promotion.</p> <p>The Integrated Care Branch of the department administers funding in relation to direct care service provision.</p>	<p>Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.</p> <p>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.</p>

TABLE 11A.90

Table 11A.90 Victoria, community health services programs
Programs funded by the Victorian Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Early Intervention in Chronic Disease	<p>EliCD focuses upon community based early intervention services for people with chronic diseases.</p> <p>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.</p>	These services are funded under the Primary Health Funding Approach	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.

Source: Victorian Government unpublished.

TABLE 11A.91

Table 11A.91 Queensland, community health services programs
Programs funded by the Queensland Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
Multicultural Services	<p>Queensland Health continued to implement initiatives to:</p> <ul style="list-style-type: none"> • 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; and • build the health literacy of culturally and linguistically diverse groups. 	<p>State Output Revenue</p> <p>This program was coordinated by Multicultural Services.</p>	<p>Queensland Health is required to report on the 10 key performance indicators of the Queensland Multicultural Policy 2011, in the Department's annual report.</p>

TABLE 11A.91

Table 11A.91 Queensland, community health services programs
Programs funded by the Queensland Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Cancer Screening	<p>The three cancer screening programs have specific strategies in place to address:</p> <ul style="list-style-type: none"> - language and cultural barriers both for the Aboriginal and Torres Strait Islander peoples and consumers from Culturally and Linguistically Diverse (CALD) backgrounds; and - geographical barriers <p>Queensland Health is piloting the addition of a cancer screening module to the Ethnic Communities Council Queensland "Living Well Multicultural Program" and has worked in collaboration with Southbank TAFE English Language and Literacy Services to develop a reader and workbook for newly arrived migrants and refugees to promote the importance and availability of cancer screening services in Queensland in CALD communities.</p> <p><i>Queensland Bowel Cancer Screening Program (QBCSP)</i> The QBCSP is supported by a network of 12 Gastroenterology Nurse Coordinators (GENCs) and 11 Health Promotion Officers across the state. Health Promotion Officers actively promote participation in the Program by eligible people and educate the general public about bowel cancer awareness and healthy lifestyles.</p> <p>The QBCSP continues to implement an alternative service delivery model for distribution of FOBT kits through the National Bowel Cancer Screening Program (NBCSP) through local Indigenous health services in Indigenous communities. This is currently occurring in an ad-hoc way whilst the Australian Government considers recommendations from the Queensland and other jurisdictional pilots that occurred between 2009-2011.</p>	<p>Funding for the three Cancer Screening Services Branch Programs is provided through the National Healthcare Agreement and State Output Revenue.</p> <p>The QBCSP GENCs and HPOs are funded through state funds from the Queensland Government</p>	<p>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.</p> <p>Staff record activity and quality assurance data and report back every 12 months.</p>

TABLE 11A.91

Table 11A.91 Queensland, community health services programs
Programs funded by the Queensland Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p><i>BreastScreen Queensland (BSQ)</i></p> <p>In 2010, the BSQ Program piloted and developed, in consultation with its Statewide Aboriginal and Torres Strait Islander Health Worker Reference Group, an Aboriginal and Torres Strait Islander Health Worker Community Engagement Kit. This Kit provides Health Workers with information, training about breast cancer, screening and health promotion to assist them in promoting and educating women in their communities about having a regular breast screen.</p> <p>The BSQ Program promotes and supports Aboriginal and Torres Strait Islander women's participation in breast cancer screening through a network of Health Promotion Officers based at each of the 11 BSQ Services across Queensland.</p> <p>Aboriginal and Torres Strait Islander women have access to seven mobiles including one four-wheel drive, which provides free breast cancer screening services at over 200 locations throughout Queensland, on a two-yearly screening schedule. The four-wheel drive mobile has been specifically designed for rural and remote areas, servicing Cape York, the Torres Strait and other remote areas and Indigenous communities such as Camooweal, Dajarra and Boulia.</p>		

TABLE 11A.91

Table 11A.91 Queensland, community health services programs
Programs funded by the Queensland Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p><i>The Queensland Cervical Screening Program (QCSP)</i></p> <p>The QCSP promotes and supports remote Aboriginal and Torres Strait Islander women's participation in cervical screening through the Healthy Women's Initiative (HWI) which is a network of 16 designated Aboriginal and Torres Strait Islander women's health workers.</p> <p>The Mobile Women's Health Service (MWHS) provides an important outreach health service to women in rural and remote communities who may be geographically and/or socially isolated. The service is a network of 15 clinical nurse consultants and 2 Indigenous Women's Health Workers who provide cervical screening and women's health clinics in over 200 communities across Queensland.</p>		HWI and MWHS staff record activity data each six months.
The Patient Transport Team	<p>The Patient Transport Team manages the statewide patient transport service provider agreements, to assist with improving access to, and the quality of available transport resources for patients ranging from acute, urgent, high dependency care to non-urgent, low dependency care.</p> <p>Service providers are 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.</p> <p>In addition, this team also manages the implementation of the Patient Travel Subsidy Scheme (PTSS) election commitment.</p>	<p>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.</p>	<p>No reports are provided externally. Internally, activity reports are provided to the District Health Services to assist in the monitoring of usage of road ambulance and fixed-and rotary wing aeromedical transport at a district and facility level. (from July 2012 reports will be provided to the Hospital and Health Services (HHS))</p>

TABLE 11A.91

Table 11A.91 **Queensland, community health services programs***Programs funded by the Queensland Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Promoting health and preventing illness, early detection			
Men's health and wellbeing	<p>Minimal Pit Stop activity was conducted by the Queensland Bowel Cancer Screening Program in 2011-2012 with funding for this program ceasing in 2010-2011. A limited number of Pit Stops continued to be delivered by other community health and health promotion units within Queensland Health particularly in regional and rural areas.</p> <p>In 2011-2012, the QBCSP continued to implement health promotion strategies targeting improved men's health and well-being in the area of cancer prevention and early detection. One strategy included development of a cancer screening and prevention brief intervention tool which was implemented in workplaces and community settings statewide. An evaluation of the brief intervention tool's effectiveness is underway.</p>	QBCSP Pit Stops are funded through Hospital and Health Service QBCSP Health Promotion budgets.	Evaluation data is generated from each QBCSP Pit Stop and is collated as part of a broader evaluation of Pit Stops.
Youth health and wellbeing	<p>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.</p>	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.

TABLE 11A.91

Table 11A.91 **Queensland, community health services programs***Programs funded by the Queensland Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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 of, and support for the delivery 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.
<p>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</p> <p>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.</p>			
Oral health services	Oral health services are provided to eligible children and adults via community- and school-based mobile and fixed public dental clinics. Services include general and specialist dental care, and health promotion and disease prevention activities.	Services are 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.
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.	Funded through State Output Revenue and Commonwealth funds.	Performance targets and overall financial reporting are published in Queensland Health's Annual Report and Service Delivery Statement.

TABLE 11A.91

Table 11A.91 Queensland, community health services programs
Programs funded by the Queensland Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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 in Queensland Health's Annual Report and Service Delivery Statement.
HIV/AIDS, Hepatitis C and Sexual Health (HAHCSH)	<p>The program implements five national strategies:</p> <ol style="list-style-type: none"> 1. The Sixth National HIV Strategy 2010-2013; 2. The Third National Hepatitis C Strategy 2010-2013; 3. The Second National Sexually Transmissible Infections Strategy 2010-2013; 4. The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013; and 5. The National Hepatitis B Strategy 2010-2013. <p>Services and public health 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.</p> <p>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.</p>	Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.	<p>Six monthly reports on activities by HAHCSH Coordinators and funded NGOs.</p> <p>Notification data for sexually transmissible infections and blood-borne viruses provided for the NHA report.</p>

Source: Queensland Government unpublished.

TABLE 11A.92

Table 11A.92 Western Australia, community health services programs
Programs funded by the WA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
Aboriginal Health Promotion	Provision of health promotion initiatives that include community wide education and community development activities.	Funding is provided directly to individual Aboriginal Health Service providers by means of a Service Level Agreement with the Department of Health WA.	Regular reporting is required. Various output measures are specified.
Aboriginal Primary Health Services	A range of primary health care services and programs are provided using a multidisciplinary approach in community settings focused on Aboriginal and Torres Strait Islander people. Aboriginal health teams provide a strong linkage point with other mainstream providers for an integrated approach.	Funding is provided directly to individual Aboriginal Health Service providers by means of a Service Level Agreement with the Department of Health WA.	Regular reporting is required. Various output measures are specified.
Aboriginal Child Health Interim Schedule	A comprehensive schedule of maternal and child contacts for Aboriginal and Torres Strait Islander families with young children (0-5 years) in the Perth metropolitan area and some country regions. The approach builds on and strengthens the existing universal child health schedule by offering additional visits to families who do not wish to access mainstream child health services or those families who need additional support. A total of 20 contacts are offered during the first five years of life.	State funding is provided directly to individual area health services or regions. Area health services or regions are responsible for delivering Aboriginal child health services.	Services are reported as Occasions of Service for non-admitted patients Reports are produced for service planning and reviews.

TABLE 11A.92

Table 11A.92 **Western Australia, community health services programs***Programs funded by the WA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health 'at risk' Services (statewide)	<p>Community health provides services for "at risk" populations that 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.</p> <p>"At-risk" services specifically focus on children, adolescents, young people and their families who are socially and economically disadvantaged and who are more likely to experience poor health outcomes because of their circumstances. Target groups include Aboriginal people, migrants, refugees and culturally and linguistically diverse groups. 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.</p> <p>An example of 'at risk' services include the Child and Adolescent Community Health Refugee and Migrant Health Team, who provide specialised services to meets the health and developmental needs of refugee children, adolescents and their families in the Perth metropolitan area.</p>	<p>State funding is provided directly to individual area health services or regions.</p> <p>Area health services or regions are responsible for delivering 'at risk' services.</p>	<p>Services are reported as Occasions of Service for non-admitted patients. Reports are produced for service planning and reviews.</p>

TABLE 11A.92

Table 11A.92 Western Australia, community health services programs
Programs funded by the WA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
WA Country Health Service (WACHS) Health Promotion Program	Health Promotion practitioners are based within regional public and/or primary health units coordinate health promotion programs. These practitioners work with internal and external stakeholders with a focus on enabling and building the capacity of individuals, communities and select populations to promote health. Key areas for programs include: - Tobacco; - Mental health; - Alcohol; - Nutrition; and - Physical activity.	Funding for these services is mainly via core state health funding to Area Health Services.	The state program measure for all non-admitted patient services is Occasions of Service.
<i>Objective: Promoting health and preventing illness, early detection</i>			
WA Country Health Service (WACHS) programs	Pit Stop Men's Health program encourages men to have regular health checkups through attaching the concept of mechanical tune-ups for their cars to their own health. WACHS delivers the program.	State funding was provided to set up the program.	Reporting provided on an annual basis.
Child and Adolescent Community Health (CACH) – Health Promotion and Community Development	Health promotion and community development aims to facilitate community engagement and action to create healthy and sustainable environments and communities for children and their families. Health promotion practitioners work in partnership with community nursing staff, the community and local agencies to deliver health promotion initiatives in response to community needs.	State funding is provided to CACH which is responsible for delivering community health services.	Reports are produced for service planning and reviews. Annual reported to CACH Management.

TABLE 11A.92

Table 11A.92 Western Australia, community health services programs
Programs funded by the WA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child and Adolescent Community Health - Child Health Services (statewide)	<p>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 prevention, early identification and intervention community health services. Services are delivered in child health centres, community based centres and in the home environment. Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breast feeding and nutrition.</p> <p>WA offers a universal community child health service that begins with a child health nurse contacting all mothers of new babies and additional contacts at the critical points in the child's development throughout the first four years. It is a vital entry point for families with young children into health and social services and a unique opportunity to improve outcomes for families experiencing difficulty in caring for their children.</p>	State funding is provided. Health services are responsible for delivering child health services.	Services are reported as Occasions of Service for non-admitted patients. Reports are produced as required for service planning and reviews

TABLE 11A.92

Table 11A.92 **Western Australia, community health services programs***Programs funded by the WA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
BreastScreen WA	<p>Responsible for the leadership, strategic planning, management, coordination and service delivery of the state-wide breast cancer screening program.</p> <p>BreastScreen WA provides free mammograms to asymptomatic women over 40 years of age. The primary target group for the service is women aged 50 to 69 years.</p> <p>BreastScreen WA provides free mammograms to asymptomatic women over 40 years of age. The primary target group for the service is women aged 50 to 69 years.</p>	Funding for cancer screening services is provided through state funds and the joint State/Australian Government funding arrangements.	Annual data reporting to the Australian Institute of Health and Welfare for BreastScreen Australia, six monthly to Department of Health WA and regular published statistical reports.
Subsidised Dental Care	<p>Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of benefit / allowance from Centrelink or Department of Veteran Affairs) via:</p> <ul style="list-style-type: none"> - Public Dental Clinics Metropolitan and Country; - Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Schemes and the Private Orthodontic Subsidy scheme; - In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people; and - Aged Care Dental Program. This program provides dental care to residents of Registered Aged Care Facilities. Residents are eligible to receive free annual 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 to provide funding directly to maintain the program.	<p>Program measures include:</p> <ul style="list-style-type: none"> • Access to dental treatment for eligible people; • Average waiting times; and • Average cost of completed courses of adult dental care.

TABLE 11A.92

Table 11A.92 Western Australia, community health services programs
Programs funded by the WA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
School Health Services (statewide)	School health services aim to promote improved health outcomes for school aged children and young people through universal and targeted prevention, health promotion, early identification and intervention. Services are provided on site and in collaboration with public and private schools. The Department of Education is a joint funder of the program. Universal health assessments at school entry, support to children in school with particular health needs, access to health care for adolescents and health promotion for all students are key elements of the program.	<p>State funded program.</p> <p>Agreement between the Department of Education and Department of Health which underpins the delivery of School Health Services. The Department of Education part funds School Health Services in WA, as agreed in the MOU between the Departments.</p> <p>Area health services or regions are responsible for delivering child health services.</p>	<p>Services are reported as Occasions of Service for non-admitted patients.</p> <p>Reports are produced as required for service planning and reviews.</p>
School Dental	<p>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.</p> <p>The program incorporates preventive strategies, which include oral health education for school children. Non-general and specialist services are referred to the private sector or, where a child is eligible to attend, a Government clinic for subsidised care.</p>	The Department of Health WA negotiates with Dental Health Services to provide funding directly to maintain the program.	<p>Program measures include:</p> <ul style="list-style-type: none"> • Number of children enrolled and under care; • Dental Health status i.e. number of decayed / missing / filled teeth; and • Average cost of service per child.

TABLE 11A.92

Table 11A.92 **Western Australia, community health services programs***Programs funded by the WA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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.			
Chronic Disease Management	<p>A range of non-hospital care is provided across the spectrum of chronic disease management including diabetes management and asthma management. The South Metropolitan and North Metropolitan Health Services also run condition specific programs for patients with Chronic Pulmonary Disease (COPD), diabetes and Congestive Heart Failure (CHF) at high risk of hospitalisation. The program is multi-disciplinary and educates patients on symptom monitoring, action planning and self efficacy as well as supporting access to health and social care services in a timely manner to prevent deterioration of their condition and ultimately reduce hospitalisation. The multidisciplinary teams include nursing, dietetics, occupational therapy, physiotherapy, podiatry and social work. Aboriginal Health Liaison Officers facilitate and improve access to services and programs for the Aboriginal population.</p> <p>The service provides care co-ordination and planning, individual and group education and physical rehabilitation, and action planning. Extensive collaboration and linkage with government community health services, non-government providers, Divisions of General Practice and GPs enables the team to integrate services to support ongoing patient self-management.</p>	Funding for these services is mainly via core WA Health funding to Health Services.	<p>The State program measure for all non-admitted patient services is Occasions of Service. In some areas quantitative and qualitative data is collected including client questionnaires and clinical outcome measures. Program measures include numbers of clients and referrals.</p>

Source: WA Government unpublished.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
Aboriginal Primary Health Care Services	The Northern Adelaide Local Health Network (NALHN) provides primary and secondary health care services (including transport, wellbeing programs, clinical services and adult and child health checks) through the Kokotinna Tappangga and Purrunga Waiingga through the Aboriginal Primary Health Care Access Program.	Mixture of recurrent State and Council of Australian Governments (COAG)* funding.	Quarterly activity and financial data reporting to non-government organisation.
	The Watto Purrunga Aboriginal Primary Health Care Service provides a range of primary health care services and programs provided by multidisciplinary teams from community settings. These services are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	The Southern Adelaide Local Health Network (SALHN) provides an Aboriginal Family Clinic that holds sessions at two primary health care sites, and provides medical care, including health care checks.	Mix of recurrent State Government and COAG funding.	Monthly activity and financial data reporting
Fixing The Gaps And Improving The Patient Journey	The pilot metropolitan, rural, remote area specialist service support program aims to streamline and improve processes for Indigenous Australians from metropolitan, rural and remote areas accessing a range of specialty services.	State Government funding under COAG until June 2013.	Monthly, quarterly and annual activity and financial data reporting.
Aboriginal Patient Journey Program	The Aboriginal Patient Journey Program is provided by the Country Health South Australia Local Health Network (CHSALHN) and aims to improve the journey of Aboriginal people accessing specialist and hospital services that are external to their home community locations.	State Government and COAG funding.	Quarterly activity and financial reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health Care	<p>All health networks provide a Primary Health Care Program that includes:</p> <ul style="list-style-type: none"> • Aboriginal Family Wellness program which aims to promote early intervention, prevention and detection of chronic disease • Developing genuine relationships with Aboriginal families and communities • The Audit of Chronic Disease Program which aims to improve the quality of chronic disease management and best practice in Aboriginal Primary Health Care • Aboriginal Well Health Checks program which aims to increase access by Aboriginal people to health assessments to detect chronic disease. 	State Government and COAG funding.	Quarterly activity and financial reporting.
New Arrival Refugees Program	Statewide specialist primary health care service providing a range of early intervention, prevention and community capacity building initiatives to improve access to health services for new arrival refugees. Services include: medical and nursing clinics, health information/education, immunisation, counselling, and capacity building for other health providers.	Recurrent State Government funding.	Quarterly activity and monthly financial data reporting.
Healthy Ageing Services	The SALHN provides programs 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 their health.	Recurrent State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Supported Residential Facilities (SRFs) Allied Health Program	The Central Adelaide Local Health Network (CALHN) provide allied health and nursing services to residents in SRFs who have a disability, mental illness and complex chronic health conditions.	Tri annual State Government funding from DSCI.	Quarterly activity data reporting and yearly funding acquittal.
Rehabilitation Service	Rehabilitation Services involve the maintenance of an individual's independence, function and ability through the provision of inpatient, rehabilitation in the home, day rehabilitation, in reach therapy and outpatient rehabilitation services.	COAG funding and GPS matched funding. Core funding (casemix).	KPI's set by DHA. Monthly reporting to COAG and Department of Health and Ageing (DHA). Annual reporting to COAG and DHA. Daily activity for bed capacity. Monthly activity and financial reporting.
GP Plus Services and Hospital Avoidance	Statewide, there are a range of programs aimed at reducing 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. Further initiatives include: The GP Plus Services Funding, funds a range of programs aimed at reducing 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. Services include: Primary prevention, Health Promotion, Chronic Disease Management, Community Nursing and Allied Health.	Non-recurrent State Government Project Funding (GP Plus Services Fund) and recurrent State Government funds.	Quarterly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	GP Plus Centres and Super Clinics are a statewide network of integrated primary care centres comprising: allied health, mental health, drug and alcohol, nurse practitioner, counselling, other support services closer to home and General Practices.	Non-recurrent State Government Project Funding	
	Specialist Nursing Services include nurse-led services for clients with chronic and complex diseases living in SA. Nurses have a key role in providing a link between GPs and tertiary services and assess and manage clients as they navigate the pathway through treatment.	Recurrent and non-recurrent State Government funding.	
	Health Call Centre – <i>Healthdirect</i> provides health advice and information to all South Australians via a free call service, available 24 hours a day, seven days per week. Experienced, specially trained Registered Nurses provide: triage, information and advice. Nurses use a computerised decision support system that is based on clinical guidelines to advise callers on the best action to take, and when to take it. Callers are also able to find out about their local health services. In the after hours period, when there is generally limited access to GP services, the registered nurse may transfer the caller to a telephone based GP for a further consultation. Patients requiring face-to-face after hours care will be directed to local services.	Commonwealth and State Government funding.	
Kanggawodli	Kanggawodli is managed through the NALHN and provides short term pre and post acute clinical support for rural and remote Aboriginal people.	Recurrent State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Indigenous Health (Rural)	Aboriginal Primary Health Care, encompassing The Aboriginal Primary Health Care Access Program and the Healthy for Life Program is provided through the CHSALHN and provides a range of primary and secondary health care services that contributes to the Closing the Gap in life expectancy and having the gap in mortality rates for Aboriginal children decreased by improving access for Aboriginal children to effective health care services. Services include: clinical service, parenting programs, well health checks, transport to primary health care programs and allied health services. The programs are delivered from CHSALHN Aboriginal Health teams in those areas of Country SA where currently there are no Aboriginal Community Controlled Health Services.	Commonwealth OATSIH funding.	Six monthly activity and financial data reporting.
	A statewide initiative called Making Indigenous Health Everyone's Business - Aboriginal Environmental Health Workers aims at improving environmental conditions through the development of Indigenous Environmental Health Workers, particularly in remote locations.	State Government funding under COAG until June 2013.	Monthly, quarterly and annual activity and financial data reporting.
	The Aboriginal Health Services Program is provided by the CHSALHN and it funds a number of Aboriginal Community controlled health services to provide a range of Primary Health care services. These include: Traditional Healer programs, dental, unique centre of learning, Kinship, Primary health care, Men's health and Environmental health programs.	State Government funding.	Six monthly activity and financial reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Street to Home Program	<p>A primary health care service for people rough sleeping provided through the CALHN.</p> <p>The homeless nursing program provides specialised nursing care in the Adelaide CBD for people experiencing homelessness in a walk in clinic setting that works collaboratively with other stakeholders to provide multidisciplinary care. This program aims to prevent unplanned public hospital presentations and/or admissions.</p>	Funded by SA Health and DCSI under a three year agreement. Current agreement runs 2012 – 2013.	<p>State – monthly.</p> <p>Commonwealth – via Supported Accommodation Assistance Program (SAAP) National Data Collection Agency.</p>
Transition Services	<p>There are a number of Transition programs accessible within the Metro and Country regions in South Australia, including:</p> <p>The <i>Transition Care Program</i> (TCP) is a statewide initiative that provides short term restorative residential aged care or community place for patients aged 65+ or 50 years for Indigenous patients. The focus of TCP is providing care and support, linked to goals for patients that enable recovery and reduce functional decline after an acute hospital stay. The TCP aims to support the patient's transition to their own homes and/or to lower level residential aged care. In metro areas, Local Health Networks (LHNs) manage admissions and monitor performance via local TCP teams that report to DHA.</p> <p>In CHSALHN, the TCP provides residential and community based care packages to assist older people with the transition from an acute service episode back to home with the emphasis on restorative care.</p>	<p>Recurrent State and Commonwealth Government Funding contribution.</p> <p>Commonwealth and State Government funding based on activity levels.</p>	<p>Quarterly activity and financial data reporting.</p> <p>Monthly activity and financial data reporting.</p>

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	Transition to Residential Aged Care (TRAC) is an initiative that provides care for clients who are seeking long term aged care following a hospital stay. The program 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.
	The Disability Transition to Community (DTC) is a statewide initiative providing a wide range of care supports, including care hours and/or accommodation for medically stable patients with complex care needs that require additional support to achieve a transition from hospital to the community. DTC funding contributes to the ongoing care costs for Disability SA patients with complex needs that have had a significant length of stay in acute care, or would otherwise likely experience an extended length of stay in the absence of this intervention. All metro referrals go through the Metropolitan Referral Unit and a similar process occurs in country. Assessment, allocation and review of funded patients are managed by DHA.	Recurrent State Government Funding.	Monthly activity and financial data reporting.
Palliative Care Services	Palliative care services are a statewide initiative that provides a suite of services involving integrated care across in-hospital, - hospice and home. This program provides links with other primary care providers for people on an end of life care pathway, with a focus on supporting people to die in their place of choice.	COAG funding and GPS matched funding.	KPI's set by DHA.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Promoting health and preventing illness, early detection			
Maternal and Child Health	<p>There are a number of Maternal and Child Health Services provided across Country and Metropolitan areas, which have an aim of promoting health and preventing illness and early detection, including:</p> <p>The <i>Child and Family Health Service - Universal Contact Visit</i>, which is a service, offered to all families in South Australia by a community Child and Family Health Nurse following the birth of a baby. The service enables family and child development issues to be identified early and to promote optimal development through early access to children services, parenting information and support pathways for families. This is provided through the Women's and Children's Health Network (W&CHN).</p> <p>W&CHN provide access to the <i>Child and Family Health Service - Family Home Visiting Program</i>, which is a nurse-led preventative parenting, home visiting program undertaken over a period of up to two years that focuses on supporting positive child development, enhancing the parent-infant relationship and connecting families to wider community supports.</p> <p>The <i>Newborn and Children's Hearing Screening Program</i> is provided through the W&CHN. It is a statewide population based hearing screening program for infants aged 0-6 months. The program aims to ensure all infants who are identified with moderate or greater hearing loss are actively engaged in family focused medical interventions and are referred to early intervention services.</p>	<p>Recurrent State Government funding.</p> <p>Recurrent State Government funding.</p> <p>Recurrent State Government funding.</p>	<p>Monthly activity and financial data reporting.</p> <p>Monthly activity and financial data reporting.</p> <p>Monthly activity and financial data reporting.</p>

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<i>Parents of Children with Disabilities Support Group – MyTime</i> provides 28 parent support groups in South Australia for parents and grandparents of children with disabilities. These support groups are held in local community venues. This initiative is coordinated by the W&CHN.	Commonwealth funding provided to a non-government organisation.	The non-government organisation reports to the Commonwealth.
	The <i>Aboriginal Family Birthing Program</i> 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 post-natal. Pregnant women and their families are supported by a partnership team comprising midwives and an Aboriginal Maternal and Infant Care Worker. Much of the care is provided close to or in the woman's home. A key element is addressing the social determinants of health and referring families into community support services. These services are provided at multiple locations through the metropolitan and country areas.	Combination of State Government and COAG funding.	Monthly activity and financial data reporting.
	<i>Community Midwifery Program</i> provides antenatal, birthing and postnatal services to women across the CHSALHN.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	The SALHN offers support and education to families in the early pregnancy to early parenting period through <i>Pregnancy to Parenting Programs</i> . Families are particularly targeted where there are vulnerable infant risk factors. One-to-one counselling and support, particularly in relation to antenatal care, emotional well-being, psychosocial issues, and early parenting and child development services are provided. Services/activities provided include: antenatal education classes, postnatal reunion, young and pregnant, birth & babies, breastfeeding education, and postnatal support group.	Recurrent State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The <i>Child and Family Health Service – Early Childhood Intervention Program</i> is provided by the W&CHN where early intervention childhood consultants work within their local community to assist parent's access support services for their children aged 0-8 years with a disability and/or developmental delay.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	The <i>Child and Family Health Service – Early Child Parent Services Program</i> provides allied health led community based services to support families of children aged 0-3 years to improve infant well being when: <ul style="list-style-type: none"> - There are psychosocial issues in families that will detract from their ability to provide care if not addressed by increasing parental capacity, problem solving ability and improving understanding of where to seek assistance in the future. - Where there are difficulties in the relationship between the infant and the caregiver. Intervention is focussed on the difficulties in this relationship. Teams have a range of allied health staff including Aboriginal Cultural Consultants, Psychologists, Social Workers and Family Workers. Services may be provided on an individual or group basis. Consultation and facilitation of case reviews are provided to Child and Family Health Service staff.	Recurrent State Government funding.	Monthly activity and financial data reporting.
Primary Health Care Services That Can Deliver - Vulnerable Infants Support Services	The Vulnerable Infants Support Service is provided throughout the metro area. It provides additional service responses to highly vulnerable infants and parents experiencing active adversity.	State Government funding under COAG until June 2013.	Monthly, quarterly and annual activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Port Pirie Lead Implementation Program (Environmental Health Centre)	This program monitors lead levels in blood of the Port Pirie community with a particular focus on pregnant women and children aged 0-5 years. This program provides intervention to reduce blood lead levels in children and pregnant women and provides ongoing community education around safe lead practices. This program is provided via the CHSALHN.	Recurrent State Government funding.	Quarterly lead in blood data used as the basis of the technical paper produced by the Public Health Department of DHA.
Women's health and wellbeing	<p>The provision of Women's health and wellbeing programs are provided statewide. This includes:</p> <p><i>Community Midwifery Program</i>, provided via the NALHN includes the provision of antenatal, birthing (including home births) and postnatal services to vulnerable women in the northern Adelaide region.</p> <p>The <i>Women's Health Statewide Service</i>, provided through the W&CHN, focuses on mental health and the effects of violence and abuse. This includes: referral, counselling in the areas of anxiety and depression related to interpersonal trauma, disordered eating, health information and resource development, projects including a specific Aboriginal Women's health project. Key populations include Aboriginal and Torres Strait Islander, culturally and linguistically diverse and rural and remote. A community development project targeting women of newly arrived communities from countries which practice female genital mutilation. Support to HIV positive and affected women is provided via the <i>Women's Health Statewide Service</i>.</p>	<p>Recurrent State Government funding.</p> <p>Recurrent State Government funding and budget variations.</p> <p>Commonwealth PHOFA HIV funding.</p>	<p>Monthly activity and financial data reporting provided by hospital auspicing program.</p> <p>Monthly activity and financial data reporting.</p> <p>Quarterly performance reporting.</p>

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The <i>Women's Primary Health Care Service</i> is a service provided through the SALHN, NALHN and CHSALHN. This program provides a range of primary health care services from a multidisciplinary team aimed at prevention and early intervention to promote the health and wellbeing of vulnerable populations. Services include: health education/promotion, sexual health clinics, well women clinics, nursing and medical clinics, therapeutic and lifestyle counselling and group interventions.	Recurrent State Government funding.	Monthly activity and financial data reporting (metro). Six monthly activity and financial data reporting (Country).
Men's health and wellbeing	Men's Health and Wellbeing initiatives are provided across most LHN's. Such initiatives included: <i>Strong Fathers, Strong Families Project</i> . This 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. This project is provided through the NALHN. <i>Men's Primary Health Care Services</i> include a range of primary health care services and programs provided by multidisciplinary teams from community settings aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community. The program includes support of some men's shed programs.	Commonwealth Funding. Recurrent State Government funding.	Quarterly and annual activity and financial data reporting. Monthly activity and financial data reporting (metro). Six monthly activity and financial data reporting (Country).
Youth health and wellbeing	Youth health and wellbeing is of focus across metro and country areas. Initiatives range from mental health services, Aboriginal health, chronic disease and sexual health. Programs include:		

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<i>Youth Primary Health Care Services</i> , which is a primary health care and sexual health services for young people and is provided through primary health care services. This includes Shopfront, Marion Youth Services and country programs.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	Via the W&CHN, The <i>Second Story Youth Health Service</i> provides primary health services to young people aged 12 – 25 years from key population groups, including Aboriginal and Torres Strait Islander; young people under Guardianship of the Minister, in care, or involved in the justice system, young parents, newly arrived, at risk of harm, same-sex attracted, or at risk of developing chronic disease. Services include: health information, assessment and referral, sexual health, medical and nursing clinics, counselling and group programs, and funded projects.	Recurrent State Government funding and budget variations. Commonwealth PHOFA HIV funding.	Monthly activity and financial data reporting. Quarterly performance reporting.
	Additionally, there a number of youth Aboriginal services provided metro wide, including: <i>Healthy Transition to Adulthood</i> : CAMHS in APY Lands provided through Anangu Pitjantjatjara Yankunytjatjara Lands, northern South Australia. This program involves the expansion of Child and Adolescent Mental Health Services to include a team permanently located in the APY Lands. The <i>Healthy Transition to Adulthood: Journey Home</i> is a statewide program focused on the mental health and wellbeing support for young people exiting the juvenile justice system that aims to provide a culturally relevant, family inclusive and effective transition program for young offenders.	State Government funding under COAG until June 2013.	Monthly, quarterly and annual activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The third Healthy Transition to Adulthood program is the <i>Aboriginal focus schools and investing in Aboriginal youth initiative</i> . This is a statewide expansion of existing programs that provide relationship education, health literacy education and the promotion of health-protective behaviours for Indigenous youth (See also SHine SA).		
Children's Health And Wellbeing	<p>There is a significant focus on children's health and wellbeing across the state. Initiatives include:</p> <p>Child and Adolescent Mental Health Services which operates, through the W&CHN, provides a network of community based teams together with tertiary inpatient and group programs. This program provides mental health services to children, adolescents and young people up to 18 years who are experiencing emotional, behavioural or psychiatric problems. This includes: therapeutic services, child, adolescent and family specialists (e.g. clinical psychologists, psychiatrists, social workers and mental health nurses), individual therapy, and mental health information, training and consultation to general practitioners, schools and other government and non-government agencies.</p>	Recurrent State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The Child Development Unit Program provides specialist paediatricians and allied health staff (psychologists, speech pathologists, occupational therapists, physiotherapists, an education consultant and social worker) undertake comprehensive assessments of children with complex developmental/behavioural issues which are impacting on the child's functioning. Reports are completed and recommendations are made for appropriate follow-up services. Assessments are completed in the metropolitan Child Development Unit located at the Women's and Children's Hospital and also via outreach services at country and regional locations. This is managed through the W&CHN.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	The <i>Children and Families Allied Health Services Program</i> is provided via the CALHN and involves a range of allied health services (including speech pathology, occupational therapy, physiotherapy, social work, dietetic/nutrition and podiatry). This program is provided in primary healthcare and DECD Children's Centres including individual therapy, health information, education, group work and advocacy.	Recurrent State Government funding.	Quarterly and annual client activity reports.
	W&CHN provides access to the <i>Child and Family Health Service</i> . This 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 aged 0-5 years. These are provided in a variety of settings, from groups to 1:1 consultations, and include a residential feeding and settling service, and access to information via the telephone and internet. Where appropriate, families are linked in with other services.	Recurrent State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The <i>Child Protection and Advocacy Services</i> involve assessing and treating children from birth to 18 years and their families where there are suspicions of child abuse and neglect. This program provides telephone consultations with Families SA, Police and health workers, undertakes interagency strategy discussions, and provides forensic medical assessment and crisis psychosocial response, psychological and parenting assessments, and therapy for children and families.	Recurrent State Government funding.	Financial data reporting only.
	<i>Early Childhood Development Services</i> are provided across the state. These services provide multi-disciplinary interventions for children aged 0-4 years with, or at risk of developmental delays.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	CHSALHN lead the <i>Child Development Program</i> , 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.	Recurrent State Government funding.	Monthly activity and financial data reporting.
	<i>Making Indigenous Health Everyone's Business - Children's Services</i> is a statewide initiative and increases access for Indigenous children and families to health promotion and intensive intervention services through children's services.	State Government funding under COAG until June 2013.	Monthly activity and financial data reporting.
Immunisation	The W&CHN provide Vaccinations through the Vaccination Programs as part of the National Immunisation Program.	Commonwealth and State Government funding.	Registered) Immunisation providers enter data onto the Australian Childhood Immunisation Register.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Screening	Breast cancer screening is provided via BreastScreen SA for women over the age of 40 years with the primary target age group being women aged 50 to 69 through screening mammography. Services are provided across six metropolitan clinics and three mobile units. This is a statewide service.	Recurrent Commonwealth and State Government funding.	Monthly activity and financial data reporting to State Government, and annual reporting to BreastScreen Australia.
Health Promotion and Risk Reduction	The <i>Do-it-for-life program</i> is a lifestyle modification program and is aimed at high risk adults with SNAPS risk factors (Smoking, Nutrition, Alcohol, Physical Inactivity and Stress). Eligible clients are from vulnerable and disadvantaged populations who are assessed at risk of developing chronic disease.	State Government funding.	Six monthly activity and financial data reporting.
	<i>Health Promotion Officers – Eat Well Be Active Program</i> is based on the SA Eat Well Be Active Strategy 2011-2016 and is provided across SA. Regional coordinators are based in a number of regions to assist addressing, coordinating and advocating for programs and solutions that support healthy eating and physical activity. The target group is children and their parents and families.	Recurrent State Government funding.	Six monthly activity and financial reporting.
	The <i>OPAL (Obesity Prevention and Lifestyle) program</i> is a community based, childhood obesity prevention initiative based on the French EPODE program. OPAL is a \$40m, 10 year (2009-2018), joint Federal, State and Local Government initiative that is located in 20 communities (with 19 local Councils) across South Australia	Shared State and Federal Government funding.	Quarterly activity and financial reporting – from SA Health staff stationed in Councils.
	The <i>Regional Falls Prevention Program</i> is run through the CALHN and NALHN and provides a regional approach to falls prevention and support for complex fallers with the aim of reducing disability and hospital presentations.	Non-recurrent State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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.			
Paediatric Rehabilitation Program	The Paediatric Rehabilitation Program, via the W&CHN, provides Rehabilitation Consultant services to community clinics to provide specialist medical assessment and intervention. The program provides both inpatient and ambulatory intensive rehabilitation programs. Teams are medically led and are comprised of multidisciplinary allied health professionals. A Movement Disorders Program is run through the Paediatric Rehabilitation Department located in the Women's and Children's Hospital.	Recurrent State Government funding. Combination of State Government and Federal Government Funding.	Monthly activity and financial data reporting.
Community Nursing Services	A range of Community Nursing Services are provided statewide via home care nursing and can include post acute care, pre and post natal care and midwifery in select locations, palliative care, chronic disease management/support, wound management, burns management, domiciliary oxygen management, continence nursing (including stomal therapy), diabetes nurse educators, breast care and domiciliary care services. Community nurses also deliver Primary Health Care initiatives and support or lead Health Promotion programs and deliver Department of Veteran Affairs Community Nursing Programs. Referrals in the metropolitan area go through the Metropolitan Referral unit with the aim of reducing unplanned public hospital presentations and/or admissions.	Recurrent Commonwealth and State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health Nurses	Primary Health Nurses work in a range of settings, such as chronic disease and risk factor programs, mental health, cancer care, healthy ageing, pregnancy and antenatal care.	Recurrent State Government funding.	Monthly activity and financial data reporting.
Allied Health	A range of allied health services (including speech pathology, occupational therapy, physiotherapy, social work, dietetics and podiatry) provided through community health with in reach into acute. Services include individual therapy, health promotion, group work and advocacy. Such services are provided in a range of settings including: GP Plus centres and Community Health Centres.	Recurrent State Government funding. (Funding for AH services comes from a range of sources including State funds).	Quarterly and annual client activity reports.
O'Brien Street Medical Practice specialising in Gay Men's Health	This service includes a range of General Practice and primary health care services provided by multidisciplinary services, including: chronic disease, HIV and Hepatitis C management education/promotion, sexual health clinics, allied health, therapeutic and lifestyle counselling within the CALHN.	Recurrent State Government funding.	Monthly activity and financial data reporting.
Country Home Link and the Rapid Intensive Brokerage Support (RIBS) program	CHSALHN provide 2 key hospital avoidance programs including Country Home Link and the Rapid Intensive Brokerage Support (RIBS) program. These programs provide access to flexible services and equipment for country consumers to avoid the need for hospital admission to metropolitan hospital (Country Home Link) and country hospitals (RIBS). These programs also support early discharge from hospitals. 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.	Recurrent State Government funding.	Not Provided.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Health Care at Home	<p>This statewide initiative, Health Care at Home (formerly Metro-Home link), is a program led via a large non-government organisation and receives Government funding towards providing a short term flexible, rapid response service for clients:</p> <ul style="list-style-type: none"> - Avoiding an immediate presentation to a public hospital Emergency Department - Avoiding an admission to a public hospital and / or - Requiring short term post acute services. <p>This program operates 24 hours, seven days a week to clients in their homes/community or residential care facilities. The services provided include: neonatal, babies, children, 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.</p>	State Government funding until 2016.	Monthly activity and financial data reporting.
Aboriginal Health	<p>Primary health care services include:</p> <ul style="list-style-type: none"> - Health Checks / Assessments which aims to detect chronic conditions early, with timely referral to appropriate diagnostic and support services. - Family Wellness is a statewide initiative aimed at improving the engagement, trust and participation between Indigenous Australians and health service providers to promote early intervention, prevention and early detection of chronic disease. - Health Promotion - The Chronic Disease Management program investigates the impact on existing primary health care and hospital services demand and improve the quality of disease through audits of services against best practice standards. 	Some recurrent State and additional COAG funding for specific initiatives.	Monthly, quarterly and annual activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral health	<p>A significant number of oral health programs are undertaken statewide covering numerous aspects of the community. Such initiatives include:</p> <ul style="list-style-type: none"> • Aboriginal Oral Health Program, which aims to increase the attendance of Aboriginal children and adults in mainstream dental services by increasing culturally appropriate resources. • 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. • Community Dental Service, providing 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. • Oral care for people with special needs provides identification and referral to dental services for people living in Supported Residential Facilities and those experiencing homelessness in the Adelaide CBD. • The Population Oral Health Program provides the development and implementation of a Lift the Lip referral tool for general practitioners, nurses and childcare workers. • The School Dental Service provides a regular, preventive focused general dental care for pre-school aged, primary and secondary school children less than 18 years of age. • The Clinical Placements Program provides general & emergency dental services for concession card holders, provided in association with students of the University of Adelaide. 	Recurrent State Government funding and additional COAG funding for specific initiatives.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 **South Australia, community health services programs***Programs funded by the SA Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<ul style="list-style-type: none"> The Newly Arrived Migrants with a Refugee Background program provides a clinical need assessment in the first year of residency in South Australia and priority access for one course of general dental care. The aim is to reduce multiple emergency presentations. 	Recurrent State Government funding.	New program implemented early 2012 and will be evaluated in September 2012.
Alcohol and other drugs	<p>The Drug and Alcohol Service South Australia (DASSA) lead a number of alcohol and other drug related initiatives across the state with a focus on the Aboriginal and non-aboriginal population, including:</p> <ul style="list-style-type: none"> Aboriginal Population Health Programs, which identifies, develops and evaluates 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. This work is undertaken in partnership with Aboriginal organisations and communities, and includes the provision of advice at the national, state and regional levels. The Aboriginal Connection Program (formerly known as the Aboriginal Substance Misuse Connection Program) is a dedicated drug and alcohol treatment service for Aboriginal people. The focus area of this service is primarily based on the inner city of Adelaide, and also extends to the metropolitan regions of Adelaide. Clients of this service have complex needs and are homeless or at risk of homelessness. APY Lands Substance Misuse Service aims to provide a range of specialist treatment interventions for Anangu with problematic alcohol and other drug use through direct service provision, collaboration with other agencies and primary health care services. The service also provides advice and support to family members of people affected by problematic substance misuse. 	Recurrent State Government funding.	Monthly activity and financial data reporting.
		State Government funding until December 2013.	Monthly activity and financial data reporting.
		Recurrent Commonwealth and State Government funding.	Monthly activity and financial data reporting.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<ul style="list-style-type: none"> 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 State Government funding.	Quarterly and annual client activity reports.
	<ul style="list-style-type: none"> The City Watch House Community Nursing Service is a program that provides assessment, treatment, management and referral of people held in police custody at the City Watch House. It is recognised that it is within the first 24 hours in custody that people are at the most risk for impulsive behaviours due to situational crisis, intoxication, mental health issues and withdrawal from substances. The program assists SAPOL in managing physical and mental health issues of detainees held in custody. The program provides consultation, liaison and referral to community services for detainees which includes DASSA services, Mental Health services, Street to Home, general practitioners, Aboriginal Prisoners & Offenders Support Services and other government and non-government services while detained and in custody at the City Watch House. 	Recurrent State Government funding.	Quarterly data, activity reports and financial data reporting.
	<ul style="list-style-type: none"> The Clean Needle Program is an important public health initiative aimed at reducing the spread of blood borne viruses, including Hepatitis B, Hepatitis C and HIV. Access to sterile injecting equipment through this program is vital to reduce the spread of blood borne viruses amongst injecting drug users and to reduce the risk of blood borne virus transmission to the broader community. 	Recurrent Commonwealth and State Government funding.	Annual activity reporting to the Commonwealth.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<ul style="list-style-type: none"> The Community Service Centres provide a free, confidential service at a number of locations across Adelaide (4 clinics) and regional centres (13 clinics) of South Australia, including counselling, assessment and referral for people from any age group with alcohol and other drug related problems, counselling and support for family members and friends, information sessions for community groups and consultation, education and training for other professionals on alcohol and other drug issues. The Adelaide based clinics also provide maintenance pharmacotherapy services (e.g. methadone and buprenorphine) as well as outpatient counselling for opioid-dependent clinics. This service is also the point of referral, liaison and support for private prescribers and community pharmacists. 	Recurrent Commonwealth and State Government funding.	Monthly activity reporting.
	<ul style="list-style-type: none"> The Courts Administration Authority Six-Month Drug Treatment Program and Youth Court Assessment and Referral Drug Scheme programs provide drug assessment and treatment services to clients who defendants are appearing before a Magistrates Court or Youth Court, who's offending, may be drug-related, and are referred to the program by the Court. 	Funded under the National Health Care Agreement until 30 September 2012.	Quarterly and annual client activity reporting.
	<ul style="list-style-type: none"> The Driver Assessment Clinic is a statewide 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.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<ul style="list-style-type: none"> The Woolshed is a therapeutic community for men and women aged 18 years and over with significant alcohol and/or other drug-related problems. The community operates as a drug-free environment and assists residents to develop living, work and interpersonal skills through a highly structured program involving group and individual counselling sessions, education, craft and recreation activities. 	Recurrent State Government funding.	Monthly activity reporting.
	<ul style="list-style-type: none"> The Cancer Council SA is funded to deliver The Tobacco Cessation Service to provide the Quit SA service. This delivers smoking cessation support for South Australians through telephone counselling, text messaging and internet based information, and through projects targeting specific high prevalence populations. 	Funded through contract with SA Health.	Quarterly activity and financial data reporting.
	<ul style="list-style-type: none"> The Early Intervention Pilot Program is undertaken in partnership with South Australia Police and the Office of Crime Statistics and Research. It is a diversion program targeting young people aged 10 to 17 years who have been detected by the police for a range of issues related to alcohol and diverted through to the health system. The program was operational from 1 August 2010 to 30 June 2013. Activity to June 2013 will be focussed on considering the outcomes of the evaluation and developing a policy position and strategies to guide future responses to young people and alcohol. 	Four year Commonwealth Government funding.	Six-monthly progress reports.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<ul style="list-style-type: none"> Withdrawal Management Services offer assessment and inpatient medical detoxification in a supportive environment for people withdrawing from alcohol and a range of other drugs. This is a free and confidential service where no referral is required. Withdrawal Services are currently working with the SA Health major projects office and Mental Health services on the transition plan to a new purpose built facility co-located with Adult Mental Health Services, Country Mental Health Services, and peri-natal Mental Health Services. Relocation of Withdrawal Services to the new Glenside facilities is proposed for May 2013. 	Recurrent State Government funding.	Monthly activity reporting.
	The Drug and Alcohol Support for the Community Protection Panel (commencing Sept 2011) is a Case Management Team that provides assertive case management to repeat young offenders (12 -20 years) and their families with the aim of reducing re-offending and promote integration, functionality and participation in their communities. The DASSA service includes providing expert drug and alcohol assessment and intervention to clients and their families, as well as ongoing support, mentoring and clinical supervision in relation to alcohol, tobacco and other drug issues to the other team members.	Recurrent State Government funding until 30 June 2013.	Six-monthly progress reports.
	Within the CHSALHN, 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.
	In CHSALHN, the <i>Police Drug Diversion Initiative</i> provides for people apprehended by police for minor drug offences to be diverted from the criminal justice system into education, assessment and treatment.	Funded under the National Health Care Agreement.	Quarterly client activity reports. Annual statistical overview report.

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>The <i>Drug and Alcohol Support for the Reunification Initiative</i> is a Department for Education and Child Development initiative which provides a multidisciplinary approach to working families, including responses to alcohol and other drug issues affecting parenting capacity.</p>	State Government funding until 13 March 2014.	Ad-hoc reports as required. Expenditure report at end of financial year.
	<p>DASSA is funded to provide services which will reduce the alcohol and other drug intake of parents involved in the program thereby contributing to a reduction in the numbers of children entering alternative care, and/or increasing the number of children reunified with their birth families by providing a coordinated, multidisciplinary service response to families.</p>	State Government funding under COAG until June 2013.	Monthly, quarterly and annual activity and financial data reporting.
	<p>Under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, South Australia is committing \$5.76 million over four years to address smoking among Aboriginal people. This funds the Tackling Smoking initiative until June 2013. The aim of the Tackling Smoking initiative is to reduce smoking rates and the consequent burden of tobacco related disease for Aboriginal people by delivering effective marketing campaigns and quit smoking services. Initiatives include:</p> <ul style="list-style-type: none"> - Social Marketing Campaigns. This initiative aims to increase awareness of the harms associated with tobacco use and encourage quit attempts. - Quit Smoking initiatives to reduce tobacco smoking among Indigenous Australians in South Australia with a component specific to pregnant Aboriginal women. - Evaluation of Smoking Initiatives is a program to assist with the collection of qualitative and quantitative data for all 'Tackling Smoking' initiatives under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. 		

TABLE 11A.93

Table 11A.93 South Australia, community health services programs
Programs funded by the SA Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	- Tackling Smoking Enforcement Activities is a program aimed at increasing legislative and regulatory compliance of the sale, supply and use of tobacco products in regional and remote Aboriginal communities in South Australia.		
Sexual health	<i>SHine SA</i> is a Non-Government Organisation that provides sexual health services including: Sexually transmitted infection screening, counselling and community education. Priority groups include youth, Aboriginal community, same sex attracted and the culturally and linguistically diverse.	Recurrent State Government and COAG funding.	Quarterly activity and financial data reporting.
	The Yarrow Place Rape and Sexual Assault Service is provided via the W&CHN and provides a 24 hour crisis response for recent sexual assault (age 16 and above) which can include crisis counselling, ongoing counselling and support, medical care and follow up medical care, collection of forensic evidence, group programs, education, training and consultation for workers.	Recurrent State Government funding.	Monthly activity and financial data reporting.

* COAG funding includes a variety of initiatives including National Partnerships such as Closing the Gap.

Source: SA Government unpublished.

TABLE 11A.94

Table 11A.94 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2011-12*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Improving access to services			
General	<p>Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities.</p> <p><i>Community Health Centres</i> offer a variety of services including counselling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability, and family and child health services.</p> <p>Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers.</p> <p>The size of sites also varies: small sites provide a limited range of services generally based around community nursing.</p> <p><i>Rural Health Facilities</i> provide core primary health and community care services within a local community in addition to some inpatient sub acute beds. In addition, some rural sites provide residential aged care and/or emergency services.</p> <p><i>Palliative Care Services</i> – specialist palliative care clinicians work within a consultancy framework across the health sector to support primary health service providers in urban and rural areas to provide quality palliative care.</p>	<p>The majority of funding is allocated from the State budget.</p> <p>During 2010-2012 Area Health Services (North, South, North West) were responsible for area spending and overseeing program delivery. From 2012-2013 these will be replaced by Tasmanian Health Organisations under the national health reforms.</p> <p>Services are provided in accordance with the Tasmanian Government's Output Budgeting framework.</p> <p>Services are funded through identified outputs within the Department of Health and Human Services (DHHS) budget.</p> <p>Australian Government funds</p>	<p>Performance Information is collected and reported at the State level through Budget Papers, Annual Report, Key Activity and Performance Information reports and Tasmania Together.</p> <p>National reporting through: National Minimum Data Sets, Reports on Government Services, Australian Institute of Health and Welfare (AIHW), National Healthcare Agreement (NHA), Australian Council of Healthcare Standards.</p> <p>Reporting in accordance with specific program requirements.</p>

TABLE 11A.94

Table 11A.94 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2011-12*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p><i>Other Primary Health services</i> 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.</p> <p><i>Regional Health Services</i> – 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).</p>		
Overcoming cultural/language barriers	<p>Interpreter services</p> <p>Tasmanian Department of Health and Human Services (DHHS) provides access to Interpreter Services for CALD clients in all health settings as required.</p>	Services are purchased on an 'as needs' basis	As above
Overcoming geographical barriers	<p>Rural Health Facility Emergency Response. Emergency services provided at some rural sites and three sites also operate an ambulance service.</p> <p>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 and MSOAP.</p>	As for Primary Health above	As for Primary Health above

TABLE 11A.94

Table 11A.94 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2011-12*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	Telehealth available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs and external organizations		
	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.		
Overcoming socioeconomic barriers	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 of their own or public transport. 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
Overcoming social isolation barriers	Day centres. Providing social support and activities for the frail, aged and people with a disability at DHHS Day Centres around the State. Community Health provides coordination of the Agency's community recovery responsibilities covering the human and social elements of disaster recovery.	As above	As above
Objective: Promoting health and preventing illness, early detection			
Maternal and child health	The Child Health and Parenting Service provides child health, growth and developmental assessments, parent support and information and early intervention services.	State funded	As above

TABLE 11A.94

Table 11A.94 **Tasmania, community health services programs***Programs funded by the Tasmanian Government during 2011-12*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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.	As above	As above
Children's health and wellbeing	The Child Health and Parenting Service provides child health, growth and developmental assessments, parent support and information and early intervention services.	As above	As above
Screening	BreastScreen Tasmania provides free screening mammograms for the women of Tasmania through clinics in Hobart, Launceston and a Mobile Unit.	As above	As above
Other program areas	<p>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.</p> <p>Alcohol and Drug Services provide a range of specialist alcohol and other drug interventions and treatments at both individual and population levels.</p> <p>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.</p> <p>Public and Environmental Health Services monitors the health of the Tasmanian population, and implements programs to protect and promote health.</p>	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	<p>Performance Information collected and reported at state level through Budget Papers, Annual Report and Key Activity and Performance Information reports.</p> <p>As required performance reporting is provided nationally through National Minimum Data Sets, RoGS, Tasmania Together, the AIHW, NHA and Australian Council of Healthcare Standards.</p>

Source: Tasmanian Government unpublished.

TABLE 11A.95

Table 11A.95 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Objective: Promoting health and preventing illness, early detection			
Child, Youth & Women's Health Program	<p>Provides:</p> <ul style="list-style-type: none"> • Maternal and Child Health nursing services including universal first home visit, child health checks, early childhood immunisation, parenting education and support and vulnerable families program. • Child Health Targeted Support services including Child Health Medical Officers and Community Paediatricians; the 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; and the IMPACT Program which supports families who are pregnant or have children less than 2yrs and are clients of Mental Health and or are receiving Opioid Replacement Therapy. • School based programs including immunisation programs; kindergarten health checks, school youth health nurses; nursing in special schools and support for children with complex health issues in schools. • Asthma education, nurse audiometrists and orthoptic screening, social work physiotherapy, and nutrition services. • Specialised services for children dependent on respiratory technology in homes and schools. • Women's Health Service provides nursing, medical and counselling services, including cervical screening, for women who experience significant barriers to accessing health services. • Child Protection Training 	Through a designated budget	Monthly/Annual reports against output targets and budget

TABLE 11A.95

Table 11A.95 Australian Capital Territory, community health services programs
Programs funded by the ACT Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
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.	<p>Monthly/Annual reports against a range of indicators including output targets, budget and quality indicators.</p> <p>Health Directorate's Annual Report include Accountability Indicators related to achievement of occasions of service targets for nursing and allied health services.</p> <p>HACC outputs data reported quarterly and submitted 6 monthly.</p>

TABLE 11A.95

Table 11A.95 Australian Capital Territory, community health services programs
Programs funded by the ACT Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Alcohol and Drug Services	<p>The Alcohol and Drug Services provides:</p> <ol style="list-style-type: none"> 1. Consultation and Liaison Services including co – morbidity service, IMPACT program, health promotion and harm minimisation education, withdrawal management, information and referral for health professionals, clients and families for those clients admitted to Canberra Hospital; 2. Withdrawal Services including supervised inpatient and outpatient withdrawal, education and support groups, counselling, liaison and referral to other specialist services; 3. Co- morbidity services to support clients who have mental health conditions and/or other drug issues; 4. Opioid Treatment Services including provision of opioid substitution pharmacotherapy treatment and key worker support to improve the health of clients; 5. Counselling and Treatment Services for adults, young people, family members and carers, therapeutic groups, 24 hr help line, Intake Telephone Service; 6. Diversion Services following referrals from the AFP or ACT courts, case management, referrals to appropriate treatment services; 7. Specialists Medical Services including comprehensive drug and alcohol management, induction and ongoing care for clients with complex needs who are prescribed opiate replacement, liaison and provision of medical advice and care to inpatients, GP's and health practitioner ; 8. Services for women's health, sexual health and health promotion. 	Through a designated budget and commonwealth initiatives	Monthly/Quarterly/Annual reports against output targets and budgets

TABLE 11A.95

Table 11A.95 Australian Capital Territory, community health services programs
Programs funded by the ACT Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
BreastScreen ACT, Capital Region Cancer Service (CRCS).	<p>The BreastScreen ACT Program commenced in the ACT in 1991. The Program was established as part of the National BreastScreen Australia Program and provides a screening service for the early detection of breast cancer. It is targeted specifically to well women who are resident in the ACT, without symptoms and in the age bracket of 50-69 years, although women 40 -49 years and 70 years and older are eligible to attend. As this is a population screening program, the main aim is to reduce the incidence of morbidity and mortality by achieving a participation rate of 70% among women aged 50-69 years.</p> <p>BreastScreen ACT is jointly funded by the ACT Government and The Commonwealth. There are two components of the Program. The screening and assessment services provide all services from the initial mammogram to any follow-up diagnostic procedures needed. In the ACT services are provided through two clinics.</p> <p>The ACT Government is responsible for the implementation of the Program at a local level and the Australian Government provides overall coordination of policy formulation, national data collection, quality control, monitoring and evaluation.</p> <p>The collection of data in BreastScreen ACT is a high priority, as it enables the monitoring of the program's efficiency and performance and provides a means to ensure that high quality is maintained. A National Standardised Data Set, definitions and common performance measures have been developed. All states and territories have agreed to collect data in accordance with the Standardised Data Set.</p>	Designated budget. The program is jointly funded by the ACT Government and the Commonwealth Government.	Monthly and annual reporting of key accountability indicators to ACT Government. Annual reporting against key components of the National data set to DoHA via the Australian Institute of Health and Welfare (AIHW) and the Review of Government Services (ROGS).

TABLE 11A.95

Table 11A.95 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Immunisation	<p>The Health Protection Service (HPS) coordinates and implements the National Immunisation Program (NIP) and ACT vaccination programs across both public and private sectors in the ACT. HPS develops strategic and operational immunisation policies for the ACT; provides clinical advice about vaccinations and immunisations to members of the public, immunisation providers and health care professionals; and provides education to health care professionals and immunisation providers.</p> <p>Vaccine is ordered and distributed to immunisation providers. Within the HPS, the Vaccine Management Unit (VMU) delivers NIP and ACT funded vaccine to Child Health clinics, general practices, hospitals and other immunisation providers. The VMU staff monitor storage conditions of vaccine to ensure cold chain standards are maintained as per national guidelines. Vaccine use is monitored and policies implemented to ensure high immunisation coverage in eligible groups in the ACT.</p> <p>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 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 for measles and varicella post exposure treatment .</p> <p>To improve vaccination rates of refugees (mostly ineligible for vaccines on the NIP), HPS provides Inactivated Polio (IPOL) and Adult Diphtheria, Tetanus (ADT) vaccine.</p>	<p>Through a designated budget (program coordination and vaccine delivery).</p> <p>NIP vaccines are funded or provided by the Department of Health and Ageing (DoHA) as part of the National Partnership Agreement on Essential Vaccines</p>	<p>Immunisation coverage in children – quarterly and annual reporting against targets and budgets. NIP vaccine usage levels are reported to the Department of Health and Ageing (DoHA) quarterly as part of the National Partnership Agreement on Essential Vaccines.</p> <p>HPS reports RIG usage to Communicable Disease Network Australia (CDNA).</p>

TABLE 11A.95

Table 11A.95 Australian Capital Territory, community health services programs
Programs funded by the ACT Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Dental Screening	<p>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.</p> <p>Through the 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.</p>	Through a designated budget	Monthly reporting through scorecard
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.	Through a designated budget	Monthly/6 monthly/Annual reports against internal and national key activity indicators 6 monthly against key laboratory accreditation indicators

TABLE 11A.95

Table 11A.95 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	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.		Annual submission of data to the Australian Social Health Atlas
<i>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</i>			
<i>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.</i>			
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.95

Table 11A.95 **Australian Capital Territory, community health services programs***Programs funded by the ACT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Sexual Health and Blood Borne Virus Policy (SH&BBV Program)	<p>The Sexual Health and Blood Borne Virus (SH&BBV) Program implements the HIV/AIDS, Hepatitis C, Sexually Transmissible Infections: A Strategic Framework for the ACT 2007-2012 whose goals include the following:</p> <ol style="list-style-type: none"> 1. Reduce the transmission in the ACT of HIV, hepatitis C (HCV), and sexually transmissible infections (STI); 2. Increase access for ACT residents to testing and treatment for HIV, HCV and STIs; and, 3. Improve the health and wellbeing of ACT residents living with HIV/AIDS and HCV and reduce the morbidity associated with undiagnosed and untreated STIs. <p>To achieve these goals, the SH&BBV Program works in collaboration with Government agencies and supports ACT community-based non-governmental organisations to deliver community health, sexual health and blood borne virus screening, prevention, care and treatment programs to priority populations. The SH&BBV Program works in partnership with the Canberra Sexual Health Centre at the Canberra Hospital on a range of initiatives to provide outreach screening and treatment services to at-risk populations.</p> <p>In addition, education and prevention campaigns to raise awareness of HIV, Hepatitis C and Sexually Transmitted Infections (STIs), including school-based and needs-based education are delivered to the general community as well as being tailored to priority populations.</p>	The SH&BBV Program is funded through the ACT Government and a combination of other Commonwealth funding initiatives.	Annual reports against output targets and budget.

TABLE 11A.95

Table 11A.95 Australian Capital Territory, community health services programs
Programs funded by the ACT Government during 2011-12

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Primary health care is provided for people living with HIV and Hepatitis C, those receiving treatment for STIs and those who may have been exposed to infection. These services are undertaken in general practice, the Canberra Sexual Health Centre, Sexual Health and Family Planning ACT, the ACT Medicare Local's HIV Program and other health care services / outreach programs.</p> <p>Support for people living with HIV/AIDS and Hepatitis C is provided through a diverse range of government and non-government organisations, and peer support groups including but not limited to the AIDS Action Council of the ACT and the ACT Hepatitis Resource Centre. These and other organisations such as schools also provide HIV/AIDS, Hepatitis C and STI awareness programs relevant to their client groups.</p>		

Source: ACT Government unpublished.

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Remote Health	<p>The role of Remote Health is the delivery of evidence based, best practice primary health care services to Aboriginal and non-Aboriginal people in remote areas from a network of 54 Department of Health managed community health centres, and to collaborate with health services managed by non-government organisations and independent Aboriginal community controlled health services.</p> <p>Remote Health workforce consists of rural medical practitioners, remote area nurses, Aboriginal health practitioners, Aboriginal community workers and allied health professionals providing direct care to clients as a collaborative multidisciplinary team. Services include primary health care, 24 hour emergency care, medical evacuations, care and treatment for chronic disease and public health programs. In the remote setting, primary health care professionals work collaboratively with other departmental program professionals to deliver integrated and coordinated care to clients, targeting Preventable Chronic Disease, Maternal Child and Youth Health, Oral and Ear Health, Sexual Health, Mental Health, Alcohol and Other Drugs and Aged and Disability Services.</p> <p>Remote Health manages the relationships between the Northern Territory and Australian Government agencies and non-government organisations involved in primary health care, and for developing sustainable systems for effective and efficient service delivery. Consultation also occurs with the community to foster and develop community capacity, facilitate community decision making, promote and support the employment of local people and establish effective governance systems so that health services can successfully and confidently make the full transition to community controlled entities.</p>	<p>Remote Health services are funded through an identified program within the NT Department of Health budget. External funding is provided by Department of Health and Ageing through the Office for Aboriginal & Torres Strait Islander Health (OATSIH) under Stronger Futures NT.</p>	<p>Reporting – Performance targets against six Priority Action Areas. A suite of core Primary Health Care indicators (Aboriginal Health Key Performance Indicators) developed in conjunction with OATSIH) are reported against by all Government and non-Government remote primary health care service providers across the NT.</p> <p>Financial reports are published in the Department of Health Annual Report.</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Maternal Health Services	<p>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.</p> <p>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.</p>	<p>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.</p>	<p>Performance targets against key functions of Community Health and Public Health Services and financial reports in Department of Health Annual Report.</p> <p>Performance milestones against the Indigenous Early Childhood Development National Partnership Agreement (NPA) Implementation Plan.</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child / Youth Health Services	<p>Child and Youth Health supports service providers delivering preventive health programs for children across the Northern Territory. Acknowledging the role of social determinants as drivers of poor child and adult health outcomes, and that these determinants do not sit solely within a health context, there is coordination between governmental and non-governmental services supporting children's and families' health and well-being in the Territory.</p> <p>This strategic approach supports frontline staff who work directly with children and families, to deliver evidence-based programs, focus on client outcomes and program evaluation.</p> <p>Work is progressing to deliver the Healthy Under 5 Kids program as the universal child health program for all children across the Northern Territory, regardless of geography or service agency. Supporting this, is development a child health information management system that provides a clearer of the picture of children's health in the Territory, as well as indicating areas of high need and providing appropriate program monitoring and workforce planning.</p> <p>Work has commenced in partnership with Menzies School of Health Research to get clearer understanding of the health issues confronting young people in the Northern Territory, as well as the principal drivers of those young people's health, to identify effective programs. Work is also underway to develop a specific Youth Health Strategy for the Territory. Council of Australian Government Indigenous Early Childhood Development NPA provides funding for programs supporting young people in respect of pregnancy and parenting.</p>	<p>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.</p>	<p>Performance targets against key functions of Community Health and Public Health Services financial reports in Department of Health Annual Report.</p> <p>Performance milestones against the Indigenous Early Childhood Development NPA Implementation Plan.</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Oral Health Services	Oral Health Services provide free assessment and treatment to all children up to school-leaving age and to adults holding a current Healthcare 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 Northern Territory Department of Health budget Extra Children Services to prescribed Indigenous communities through Closing the Gap Commonwealth finding.	Performance targets against key functions of Community Health and Public Health Services and financial reports in Department of Health Annual Report. NPA reporting to the Australian Government. Final report to the Australian Government on Closing the Gap Program
Chronic Condition Services (previously Preventable chronic disease)	The Chronic Conditions Strategy Unit (CCSU) provides leadership and evidence-based advice to support the implementation of effective actions for prevention and management of chronic conditions. The CCSU works closely with policy makers, senior managers, health professionals, researchers and education providers in government and non-government services across the the Territory. The Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020 is the key document that guides Northern Territory health services, with all services committed to joint implementation. The priority areas include addressing social determinants and an increased focus on primary prevention.	The CCSU is funded through an identified program within the NT Department of Health. Chronic Condition services in the Northern Territory have expanded through a combination of NT Govt and Australian Govt 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 in Department of Health Annual Report. Chronic disease indicators in the Northern Territory Aboriginal Health KPIs. The 2011 annual monitoring report will be released in October 2012 Quarterly reporting is provided as per Closing the Gap NPA.

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Public Health Nutrition and Physical Activity	<p>Services are delivered both by public health nutritionists usually located within multi-disciplinary teams, and policy officers based in the Strategy Unit.</p> <p>Public health nutritionists (PHN) provide training and support to primary health care teams to promote healthy nutrition and regular physical activity to the community, and assist with the management of people with nutrition related conditions. In urban areas, they offer individual and group consultations through community care centres; in remote communities they provide group education through health centres and community centres (e.g. women's centres).</p> <p>PHNs also work with agencies outside the health sector to improve food supply and stimulate demand for healthy food in remote community stores - increasing food security.</p> <p>The strategy unit focuses on providing strategic direction, developing relevant Northern Territory policies and guidelines, or contributing to national developments (e.g. the update of the National Dietary Guidelines). At times, this work involves collaboration with other government agencies (e.g. the Northern Territory Department of Education, the Department of Families, Housing, Community Services and Indigenous Affairs, and research institutions (e.g. Menzies School of Health Research).</p> <p>A recent development includes a partnership with the South Australian Government and the City of Palmerston to pilot a multi-strategy, community-based obesity prevention initiative called Childhood Obesity Prevention and Lifestyle (COPAL) in Palmerston. COPAL was developed as part of the National Partnership Agreement (NPA) on Preventive Health under the Healthy Children Initiative. It aims to promote healthy eating and increase children's participation in physical activity, with the long term goal of reducing rates of childhood obesity.</p>	<p>These services are funded through an identified program within the Northern Territory Department of Health (Department of Health), as well as Australian Government funding under</p> <ul style="list-style-type: none"> - the Enhanced Health Service Delivery Initiative (EHSDI) and - the National Partnership Agreement on Preventive Health, under the Healthy Children Initiative 	<p>Performance targets against key functions of Community Health and Public Health Services. Financial reports in Department of Health Annual Report.</p> <p>Activity reports against EHSDI and Preventive Health NPA</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Health Promotion Strategy Unit	<p>The core function of the Health Promotion Strategy Unit (HPSU) is to build and strengthen capacity for effective health promotion and prevention in the Department of Health (Department of Health) and its partners across government and non-government sectors.</p> <p>This involves facilitating a uniform understanding of health promotion across Government and non-Government health and related sectors; providing strategic and policy support to key stakeholders, staff and organisations; and a commitment to planning for health promotion through investment in research, program planning, and evaluation; social marketing; healthy workplaces; and developing sustainable education and training pathways.</p> <p>The HPSU plays a key role in providing leadership in relation to Priority Area Action 1 in the Department of Health Corporate Plan, which relates to promoting and protecting good health and preventing injury. A key focus has been to develop and consult on a Northern Territory Health Promotion Framework, provide Health Promotion Training and Education options across the Territory health and community sector, establishing and supporting of healthy workers programs, providing health promotion information to professionals, communities and individuals in the NT and providing a planning and evaluation system for health promotion programs for Department of Health and its partners. The HPSU has continued its commitment to maintain the relationship with education institutions and research bodies. The HPSU also provides jurisdictional leadership in relation to the national preventative health agenda.</p>	<p>These Strategy Unit services are funded through an identified program within the NT Department of Health. The social marketing, healthy workplace initiatives and health promotion capacity building for the maternity workforce are funded by the Australian Government through NPAs. Primary health care services also provide health promotion activities, the HPSU provides guidance and professional development to the Primary Health Care Services.</p>	<p>Performance targets against key functions of Community Health and Public Health Services. Financial reports in Department of Health Annual Report. Quarterly and annual reports related to Australian Government funding. Reporting against the Preventative Health NPA and Indigenous Early Childhood Development NPA</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women's Health	<p>The Women's Health Strategy Unit (WHSU) engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders and coordinates and leads Department of Health responses to this work.</p> <p>WHSU project instigates leads and project manages key strategic pieces of work to progress priority women's health issues such as those for Aboriginal and Torres Strait Islander Women, Migrant and Refugee Women and Domestic and Family Violence.</p> <p>The Unit also manages the work of the Women's Information Service (WISe) in Alice Springs, and acts as a source of information and leadership across the Department in regard to all aspects of women's health.</p> <p>WHSU has instigated and leads a strategic approach to gender as a key determinant of health both in the Department of Health, with other key stakeholders and services providers and as the Department of Health representative on the Office of Women's Policy Gender Equity Panel.</p>	These services are funded through an identified program within the Northern Territory 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.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Men's Health	<p>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.</p> <p>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.</p> <p>The MHSU works to develop partnerships with key stakeholders from Department of Health, 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.</p> <p>The MHSU 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.</p> <p>The MHSU supports Territory-wide planning, implementation and evaluation of health promotion programs which adopt a life course approach specific to men.</p>	These services are funded through an identified program within the Department of Health budget.	Performance targets against key functions of Community Health and Public Health Services and financial reports are published in the Department of Health Annual Report.

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Urban Community Health	<p>The Community Health Branch provides a range of key primary health care services across the urban centres of Darwin, Palmerston, Alice Springs, Katherine, Tennant Creek and Nhulunbuy and to provide services in partnership with other health stakeholders in the urban environment.</p> <p>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 in Darwin.</p> <p>The Branch participates in regional and national primary health care reforms and seeks to improve access and equity to services for urban communities.</p> <p>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.</p>	<p>Services funded through identified program within the Department of Health budget.</p> <p>Additional Australian Government funding (as a non-output service for Minimum Data Set purposes) for Home And Community Care services delivered through the Specialist Nursing program.</p>	<p>Performance targets against key functions of Community Health and Public Health Services.</p> <p>Financial reports are published in Department of Health Annual Report.</p> <p>Basic reporting (client numbers) against the Specialist Nursing program.</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
School Health Services	<p>Community Health provides a School Health Service to 15 Northern Territory Government middle, secondary and special schools</p> <p>Health Promoting School Nurses work in partnership with school staff using a health promotion approach to integrate health education into the curriculum within an overarching Health Promoting Schools framework. The Key Outcome areas are:</p> <ol style="list-style-type: none"> 1. support delivery of <i>health education</i> in: <ul style="list-style-type: none"> • Smoking, alcohol and other drugs • Nutrition • Physical Activity • Health and Wellbeing • Sexual Health; 2. work with the school community to plan, develop, implement and evaluate school identified health promoting programs, policies and strategies; 3. contribute to health and wellbeing through early intervention efforts aimed at reducing the longitudinal incidence of chronic disease, and risk taking behaviours during youth/adolescence; and 4. establish networks to facilitate health and wellbeing information to the school community through partnerships. 	These services are funded through an identified program within the Department of Health budget.	Performance targets against key functions of Community Health and Public Health Services and financial reports are published in the Department of Health Annual Report.

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Well Women's Cancer Screening	<p>Well Women's Cancer Screening incorporates the two highly successful women's cancer screening programs, the BreastScreen Australia program and the National Cervical Screening Program. The service has adopted a holistic approach to women's screening into a well women's screening model. Both programs aim to detect cancers at an early stage to prevent mortality and morbidity. Key activities are as follows.</p> <ul style="list-style-type: none"> • BreastScreen NT provides free breast screening for asymptomatic women aged 50 to 69. Clinics are provided in Darwin and Alice Springs and a visiting service travels to Palmerston, Tennant Creek, Katherine and Nhulunbuy. • The Territory Pap Smear Register is co-ordinated by Well Women's Cancer Screening to aid in the prevention and early detection of cervical cancer. • A Remote Areas Well Women's Screening Program services remote area women and provides breast examinations, and pap smear screening in a culturally appropriate manner. 	These services are funded through an identified program within the Australian Health Care Agreement.	<p>Performance targets are measured against key functions of Community Health and Public Health Services and financial reports in the Annual Report.</p> <p>National Aboriginal Health performance indicator reports. Annual Reporting: RoGS, Safety Monitoring – national Cervical Screening Guidelines, BreastScreen Australia National Accreditation Standards, Australian Government National Public Health Expenditure, AIHW National Monitoring reports.</p>
Hearing Services	<p>Hearing Services are mostly provided in specialised hearing centres located in remote and urban community health centres, or hospital facilities.</p> <p>A multidisciplinary team of specialists provide; hearing loss prevention, otitis media care coordination, diagnostic hearing assessment and support ENT services including E-Teleotology. Hearing services are provided through integrated care pathways and support community based health, early childhood and education strategies for identifying, managing and promoting ear health and hearing.</p> <p>The Universal Neonatal Hearing Screening (UNHS) program for permanent hearing loss is provided through all urban birthing hospitals.</p>	Services are funded as identified programs within the Northern Territory Department of Health and additional funding to ear health and hearing services to Indigenous children has been provided through the Department of HealthA.	<p>Performance targets against key functions of Community Health and Public Health Services. Financial reports in Department of Health Annual Report. Performance targets for Department of HealthA funded programs and consented service event data shared with AIHW - published annually.</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Mental Health	<p>The Mental Health Program, through public specialist services and non-government organisations, provides:</p> <ul style="list-style-type: none"> • 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; • primary health services for mental health consumers; and • consumer and carer support and rehabilitation to the population of the Northern Territory. <p>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.</p>	<p>Services are funded through an identified program within the Northern Territory Department of Health budget.</p> <p>Additionally, Australian Government funding supports service development and reform under NPAs or for nationally funded projects.</p>	<p>Department of Health Annual and quarterly reporting of Performance Indicators and targets against key activity areas to Northern Territory Treasury and Parliament under the Budget process and in the Annual Report.</p> <p>National reporting including, COAG Mental Health Report, NHA Performance Indicators, Community Mental Health Care National Minimum Data Set (NMDS), Mental Health Establishment NMDS, Residential Mental Health Care NMDS and RoGS Health Management Chapter.</p>
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	<p>The Centre for Disease Control 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.</p>	<p>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.</p>	<p>Send letter every 6 months to DoHA for post-exposure rabies immunoglobulin reimbursement.</p>

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Illegal foreign fishers (IFF) and irregular maritime arrivals (IMA)	The Tuberculosis Unit provides specialist services for identified TB patients in unauthorised entrants to Australia. Illegal foreign fishers (IFF) and irregular maritime arrivals (IMA) are screened and managed in close association with the Department of Immigration and Citizenship (DIAC).	Funding through an identified program within Department of Health budget. Some external funding via DIAC for Illegal Foreign Fisherman (IFF) & IMAs. A memorandum of understanding is under negotiation.	TB notifications are included in the Northern Territory notifiable diseases system. Reported quarterly to the Department of Health and Ageing and the Department of Health.
Trachoma	The program aims to eliminate trachoma within a finite time-frame by implementing the Communicable Diseases Network Australia's Guidelines for the public health management of trachoma in Australia, across the Northern Territory, conducting training in trachoma for health service providers and building capacity in remote areas to effectively manage trachoma in their jurisdiction. Communities at risk will be identified and targeted.	NPA	Provides quarterly performance reports and a final project report.
Rheumatic Heart Disease Control Program	Territory wide program to reduce the burden of rheumatic heart disease amongst the Indigenous population by reducing the occurrence of acute rheumatic fever. The objectives of the project include: maintenance of a centralised register, development and implementation of on-going initiatives that utilise the register to improve program coordination, improve secondary prophylactic antibiotic use and effectiveness, and facilitate communication between health sectors and across levels of care; and the development and implementation of ongoing initiatives to improve patient self-management, primary care worker training, and community education.	External funding by Australian Government. NPA is under negotiation.	Provides progress reports to Australian Government DoHA against performance indicators in February and August each year. A financial statement each February.

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Essential Vaccines Service Delivery	The program aims to support the cost-effective delivery of immunisation programs under the National Immunisation Program (NIP). The outcomes are to: minimise the incidence of major vaccine preventable disease in Australia; maintain and where possible increase immunisation coverage rates for vulnerable groups and, in particular, minimise disparities between Indigenous and non-Indigenous Australians; enable all eligible Australians to access high quality and free essential vaccines through the NIP in a timely manner; and increase community understanding and support for the public health benefit of immunisation.	NPA	A quarterly report of vaccine purchase and utilisation.
Vaccine Preventable Disease Surveillance	The Commonwealth has developed the Vaccine Preventable Disease (VPD) Surveillance Program comprising the National Immunisation Program Support Activities (NIPSA), invasive pneumococcal disease (IPD) surveillance and varicella surveillance programs. The objective of the Program is to improve the national surveillance of VPD by providing resources to improve data collection in the National Notifiable Diseases Surveillance System (NNDSS) dataset, in particular to record detailed laboratory and vaccination data on vaccine-preventable diseases.	NPA	Quarterly summary of data. Annual progress report to the Australian Government.
National Public Health	Northern Territory 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.	National Public Health (previously known as PHOFA) funded across Department of Health with Health Protection Division receiving around 45%.	Health Gains Planning provides a public health expenditure report.

TABLE 11A.96

Table 11A.96 **Northern Territory, community health services programs***Programs funded by the NT Government during 2011-12*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	The program funds community based organisations supporting sexual health work. in the major towns and provides support for rural and remote areas. Other community based organisations are funded to operate needle and syringe programs and provide harm reduction initiatives, community and peer support and education. Also provides limited funding to fund a position with Immunisation Unit.		
COAG- Needle & Syringe Programs	Program aims to enhance the capacity of needle and syringe programs, to provide effective and accessible education, counselling and referral services, to increase the number of clients accessing treatment services and ultimately reduce the levels of injecting drug use and rates of transmission of blood borne virus.	External funding through Australian Health Care Agreement.	Nil
Combined Hep C & Illicit Drug Project	Hepatitis C Education and Prevention Initiative aims to reduce hepatitis C transmission and to improve care and support services for those affected.	External funding through Australian Health Care Agreement.	Nil
Adolescent Sexuality Education Program	To build the capacity of local schools and communities to deliver sexuality education to young people in and out of schools. This is a collaboration between the Department of Education and Training and the Department of Health.	External funding by DoHA through NPA on Indigenous Childhood Development.	6 monthly progress report to OATSIH.
Aedes aegypti	18-month program for the elimination of the dengue mosquito Aedes aegypti in Tennant Creek.	Jointly funded by Northern Territory Government and Australian Government for life of the project.	Provide the Office of Health Protection DoHA with informal Progress Reports and a Final Report on 30 June 2013. The final progress report contains the financial statement.

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 GPs by region	3
Availability of female GPs	6
Early detection and early treatment for Indigenous people	8
Proportion of children receiving a fourth year developmental health check	11
People deferring visits to GPs due to financial barriers	14
GP Waiting times	18
Selected potentially avoidable GP-type presentations to emergency departments	22
People deferring purchase of medicines due to financial barriers	26
Public dentistry waiting times	30
Management of upper respiratory tract infections	34
Management of diabetes	36
Management of asthma	42
Use of pathology tests and diagnostic imaging	45
Patient satisfaction	48
Health assessments for older people	52
Cost to government of general practice per person	55

Child immunisation coverage (at 5 years of age)	57
Participation rates for women in cervical screening	59
Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions	61
Selected potentially preventable hospitalisations for diabetes	66
Potentially preventable hospitalisations of older people for falls	69

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. <u>Definition</u> The number of Full-time Workload Equivalent (FWE) GPs per 100 000 people, by region. <u>Numerator:</u> Number of FWE GPs. <u>Denominator:</u> Estimated Resident Population (ERP) by region. <u>Computation:</u> $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	<u>Numerator:</u> Australian Government Department of Human Services (DHS), Medicare data. <u>Denominator:</u> Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December in the reference year.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to DoHA.
Relevance	<p>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'.</p> <p>The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991.</p> <p>DoHA is in the process of phasing in the new ABS Australian Statistical Geography Standard in order to improve regional classification of data.</p> <p>GP headcount and FWE figures include vocationally recognised as well as non-vocationally recognised general practitioners.</p> <p>GP headcount is a count of all GPs who have provided at least one DHS, Medicare service during the reference period and have had at least one claim for a DHS, Medicare service processed during the same reference period.</p> <p>GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing DHS, Medicare. FWE is a standardised measure adjusted for the partial contribution of casual and part-time doctors and is a more reliable estimate of the GP workforce.</p>

FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full-time doctors for the reference period.

Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure.

Example 2: A part-time GP billing half the services of the average for full-time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.

A GP can work at more than one location. Allocation of GP headcount to state or territory and region is based on the practice location at which the GP provided the most DHS, Medicare services during the reference period. FWE allocates activity based on the practice location at which services were rendered within the reference period.

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 DHS, Medicare claims data are processed, a small number of providers will become eligible for inclusion in the headcounts. Revision of headcount figures will result in very small differences to published figures each year. FWE figures are not revised each year.

Since the commencement of DHS, Medicare, practitioners have provided demographic information to DHS, Medicare including date of birth and gender. Demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare Australia. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data.

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

Estimates are compiled the same way across jurisdictions and over time.

Accessibility

Information is available for MBS Claims data from www.mbsonline.gov.au and www.medicareaustralia.gov.au/.

Interpretability

General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The classification system used to allocate 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) <u>Definition</u> The number of Full-time Workload Equivalent (FWE) female GPs per 100 000 females. <u>Numerator:</u> Number of FWE female GPs. <u>Denominator:</u> Estimated Resident Population (ERP) of females. <u>Computation:</u> $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	<u>Numerator:</u> Australian Government Department of Human Services (DHS), Medicare data. <u>Denominator:</u> Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to 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 DHS, Medicare billing by the average billing of full-time doctors for the reference period. Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure. Example 2: A part-time GP billing half the services of the average for full-time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.
Timeliness	FWE figures are available 10 weeks after the close of the reference period.
Accuracy	FWE figures are not revised each year. Since the commencement of DHS, Medicare, demographic information has been provided by practitioners to DHS, Medicare including date of birth and gender. The demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data.

	To overcome the problems and biases posed by missing data, similar practitioners were grouped based on the known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.
Coherence	<p>Estimates are compiled the same way across jurisdictions and over time, with the following exception that is not expected to significantly affect the data:</p> <ul style="list-style-type: none"> • per person data are computed using ERP as at 30 June for all reference periods prior to and including 2010-11; for 2011-12 the ERP at 31 December is used.
Accessibility	Information is available for MBS Claims data from www.mbsonline.gov.au and www.medicareaustralia.gov.au/
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1
<u>Data Gaps/Issues Analysis</u>	
Key data gaps /issues	<p>The Steering Committee notes the following:</p> <ul style="list-style-type: none"> • 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)	<p><u>Definition</u></p> <ol style="list-style-type: none">1. The proportion of older people who received a health assessment by Indigenous status2. The proportion of older Indigenous people who received a health assessment, time series3. The proportion of Indigenous people who received a health assessment, by age group <p><u>Numerators:</u></p> <p>The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>The number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>The number of people aged 0–14 years, 15–54 years, or 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p><u>Denominators:</u></p> <p>The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period.</p> <p>The population of Indigenous people aged 55 years or over in the reference period.</p> <p>The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period.</p> <p><u>Computation:</u></p> <p>1.–3. $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p><u>Numerators:</u> Australian Government Department of Human Services (DHS), Medicare data.</p> <p><u>Denominators:</u></p> <p>Denominators computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS).</p> <p><u>Total population:</u> ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.</p> <p>For data <u>by Indigenous status</u>: ABS 2009, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021</i>, Cat. No. 3238.0 (B Series).</p>

Data Quality Framework Dimensions

Institutional environment

MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA.

Relevance

The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.

These measures relate to specific DHS, 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 DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received, and might not be where the service was provided.

For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to each age group.

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 DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, 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.

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can

Coherence

be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

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 DHS, Medicare records at the date the service was received.

Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.

Accessibility

Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.

Interpretability

DHS, 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.

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 DHS, Medicare data.

Proportion of children receiving a fourth year developmental health check

Data quality information for this indicator has been prepared based on the Steering Committee's 2012 report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Developmental health checks.
Measures (computation)	<p>Proportion of children who have received a 4 year old development health check.</p> <p><u>Numerator</u>: The number of people aged 3–5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10 986 (Healthy Kids Check) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period.</p> <p><u>Denominator</u>: The population aged 4 years, estimated using ERP data from the ABS. It was calculated by multiplying the 0-4 years ERP disaggregated by Indigenous status by the percentage of children aged 4 years in this age group nationally.</p> <p><u>Calculation</u>: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p><u>Numerator</u>: Australian Government Department of Human Services (DHS), Medicare Statistics data.</p> <p><u>Denominator</u>: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period.</p> <p>For data <u>by Indigenous status</u>: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June in the year preceding the reference period.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes claims made through the MBS under the <i>Human Services (Medicare) Act 1973</i>. These data are then regularly provided to DoHA.</p> <p>Data for 2009-10 and 2010-11 were 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.</p> <p>Data for 2011-12 were calculated by the Secretariat using numerator data supplied by DoHA and denominator data sourced from the ABS.</p>
Relevance	<p>The measure relates to specific identified DHS, Medicare services for which DHS, Medicare has processed a claim.</p> <p>The MBS items included in this indicator do not cover all developmental health check activity such as that conducted through state and territory early childhood health assessments in preschools and community health centres.</p> <p>The figures for the NT exclude children receiving NT Emergency Response Child Health Checks.</p>

Timeliness

MBS claims data are available within 14 days of the end of a month. The indicator relates to all claims processed in the reference year.

Accuracy

As with any administrative system a small degree of error may be present in the data captured.

Analyses by state/territory are based on postcode of residence of the client as recorded by DHS, Medicare at the date the last service was received in the reference period. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.

Historical data are based on the date the claim was processed. From 2011-12, data are based on the date the service was rendered. Current year data are preliminary and subject to revision in subsequent reports.

Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.

Children who received more than one type of health check are counted once only in the calculations for this indicator. Where a child received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period, the child was counted once against the Aboriginal and Torres Strait Islander health assessment.

MBS data presented for Aboriginal and Torres Strait Islander Peoples Health Assessments have not been adjusted to account for known under-identification of Indigenous status.

Cells have been suppressed where the numerator is less than 10 for confidentiality reasons and where rates are highly volatile (for example, the denominator is very small) or data are known to be of insufficient quality (for example, where Indigenous identification rates are low).

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

As of 1 May 2010, the following changes to MBS items occurred:

- The Healthy Kids Check Item 709 was replaced with four MBS health assessment items (based on time and complexity) that cover all ages — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). This renders it possible that health assessments for refugees and humanitarian entrants and for people with an intellectual disability (previously claimed under items 714, 718 or 719 and now claimed under the new MBS health assessment items) have been counted. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low for children aged 3–5 years.
- A Healthy Kids Check provided by a practice nurse or a registered Aboriginal health worker on behalf of a medical practitioner (previously item 711) was replaced with MBS item number 10 986. The change to the MBS item number does not impact time series analysis.
- The Aboriginal and Torres Strait Islander Child Health Check (previously item 708) was replaced by the Aboriginal and Torres Strait Islander People's Health Assessment (715) that has no designated time or complexity requirements and covers all ages. The change to the MBS item number does not impact time series analysis.

Accessibility

Information is available for MBS Claims data from 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.

Interpretability

DHS, 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.

Data Gaps/Issues Analysis**Key data gaps /issues**

The Steering Committee notes the following issues:

- Data do not include developmental health check activity conducted outside the MBS, for example, in preschools and community health centres. Accordingly, the indicator understates developmental health check activity.
- No adjustment was made to this indicator to account for under-identification of Indigenous children in DHS, Medicare data.

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.
Measures (computation)	<p><u>Definition</u> Proportion of people that required GP treatment but deferred that treatment due to cost.</p> <p><u>Numerator</u>: People reporting deferring access to a GP in the last 12 months due to cost.</p> <p><u>Denominator</u>: People aged 15 years and over who needed to see a GP in the last 12 months.</p> <p><u>Computation</u>: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the Australian Bureau of Statistics (ABS).</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
----------------------------------	--

Relevance

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, for 2011-12, very remote Australia).

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 people in Australia, excluding the following:

- members of the Australian permanent defence forces

- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11 data, people living in remote communities (including discrete Indigenous communities)
- for 2011-12 data, people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT.

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 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 2011-12 data used for this indicator became available from 23 November 2012.

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 2011 to June 2012. (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 data).

Accuracy

There are not likely to be revisions to these data after their release.

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 size for the 2011-12 data was 26 437 fully-responding households; the sample size for the 2010-11 data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2011-12 survey was 79.6 per cent; 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 and, for 2011-12, remoteness breakdowns.

Known Issues: Data were self-reported.

The 2011-12 survey differed from the previous surveys in that people who did not see a GP in the last 12 months and delayed seeing a GP were not asked if the reason for delaying was due to cost. However, the numerator still includes those people who saw a GP in the last 12 months and either delayed or did not see a GP due to cost, and people who did not see a GP due to cost. It is expected that this will have minimal effect on the estimates. However, this issue may impact on time series comparisons between 2010-11 and 2011-12 for this indicator.

Coherence

Explanatory footnotes are provided with the data.

Consistency over time: 2009 was the first year data were collected for this indicator. Differences between 2010-11 and 2011-12 are likely to be impacted by the known data issues explained above.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 survey, and very remote communities in the previous surveys will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 24 per cent of people in the 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 Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other directly comparable data sources.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001, *Patient Experiences in Australia: Summary of Findings, 2010-11 and 2011-12* Cat. no. 4839.0. The data are shown by age, sex, remoteness and SEIFA. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

The 2011-12 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2011-12* (Cat. no. 4839.0). 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. These publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in these publications.

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.

Data Gaps/Issues Analysis**Key data gaps /issues**

The Steering Committee notes the following issues:

- The inclusion of very remote areas for the first time in the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Disaggregation of this indicator by Indigenous status is a priority.

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
Measures (computation)	<u>Definition</u> Length of time a patient needs to wait to see a GP for an urgent appointment. <u>Numerator</u> 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). <u>Denominator</u> Number of people aged 15 years or over who saw a GP for urgent medical care (for their own health) in the last 12 months. <u>Computation</u> : $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Patient Experience Survey, ABS.

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the Australian Bureau of Statistics (ABS).</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, for 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this indicator from this source.</p>

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 people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11 data, people living in remote communities (including discrete Indigenous communities)
- for 2011-12 data, people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory.

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 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. 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 would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2011-12 data used for this indicator became available from 23 November 2012.

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 2011 to June 2012. (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 data).

Accuracy

There are not likely to be revisions to these data after their release.

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 size for the 2011-12 data was 26 437 fully-responding households; the sample size for the 2010-11 data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2011-12 survey was 79.6 per cent; response rate for the 2010-11 survey was 81.4 per cent; response rate for the 2009 survey was 88 per cent.

Standard Errors: This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for remote/very remote breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use.

Known Issues: Data were self-reported and interpretation of urgent medical care was left up the respondent.

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. Questions relating to waiting times for GPs were asked in a different section of the questionnaire in the 2011-12 survey from where they were asked in 2010-11. This change in question ordering may impact on a person's response.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 survey, and very remote communities in the previous surveys will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 24 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001, *Patient Experiences in Australia: Summary of Findings, 2010-11 and 2011-12* Cat. no. 4839.0. The data are shown by age, sex, remoteness and SEIFA. Jurisdictional data are not currently publically available but may be made available in the future.

Waiting time categories are classified differently, however, as they are shown within 4 hours, more than 4 hours but same day, next day, and two or more days. The data are shown by SEIFA, remoteness, country of birth, self-assessed health status and whether has a long term health condition. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey is available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

The 2011-12 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2011-12* (Cat. no. 4839.0). 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. These publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in these publications.

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.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The inclusion of very remote areas for the first time in the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are based on waiting times for self-defined urgent medical care.
- Disaggregation of this indicator by Indigenous status is a priority.

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.
Measures (computation)	<p>The number of presentations to public hospital emergency departments in hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals), where:</p> <ul style="list-style-type: none">• there was a type of visit of Emergency presentation (or, for SA for 2008-09 and 2009-10, Emergency presentation or Not reported) where:• 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	<p>This indicator is calculated using data from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), based on the national minimum data set (NMDS) for Non-admitted patient emergency department care (NAPEDC).</p> <p>For data by remoteness: ABS ERP as at 30 June preceding the financial year by remoteness area, as specified in the Australian Standard Geographical Classification.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Minister for Health.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p>
----------------------------------	---

Relevance

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988* (Cwlth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website <www.aihw.gov.au>

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

<<http://www.aihw.gov.au/nhissc/>>

< <http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

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 2011-12, hospitals in peer groups A and B provided over 80 per cent of all public hospital emergency occasions of service.

From August 2011 the scope of the NNAPEDCD has expanded due to reporting for the National Health Reform Agreement (NPA IPHS), with hospital coverage including Peer Group A, B and Other. For the duration of the agreement, hospitals that have not previously reported to the NNAPEDCD NMDS can come into scope, subject to agreement between the jurisdiction and the Commonwealth.

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 Australians and those for whom Indigenous status was not stated.

Timeliness

The reference period for these data is 2008-09, 2009-10, 2010-11 and 2011-12.

Accuracy

For 2009-10 and 2010-11, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2011-12, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100 per cent for public hospitals in peer groups A and B.

In the baseline year (2007-08), the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008-09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania.

From 2009-10, the data for the Albury Base Hospital (previously reported in New South Wales hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for New South Wales and Victoria.

Backcasting of earlier years for this indicator is provided due to data resupply from Tasmania and the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

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.

Coherence

The data reported for 2011-12 are consistent with data reported for the NNAPEDCD for previous years for individual hospitals.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the National Hospital Establishments Database (NPHED) for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator is calculated using the same methodology as data published in *Australian Hospital Statistics: emergency department care and elective surgery waiting times* (report series) and the *National healthcare agreement: performance report 2010-11*.

However, 2010-11 data reported previously in these publications are different from the equivalent data published here because the hospitals classified as peer groups A and B were based on 2009-10, rather than 2010-11 peer groups.

Caution should be used in comparing these data with earlier years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Accessibility

The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are the *Australian hospital statistics* suite of products with associated Excel tables. These products may be accessed on the AIHW website at: <http://www.aihw.gov.au/hospitals/>

Interpretability

Metadata information for the NAPEDC NMDS and the NAPEDC DSS are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

METeOR and the National health data dictionary can be accessed on the AIHW website at:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>

<http://www.aihw.gov.au/publication-detail/?id=6442468385>

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 and Indigenous status should be interpreted with caution.
- For 2010-11, the coverage of the NNAPEDCD collection is complete for public hospitals in peer groups A and B. It is estimated that 2011-12 has similar coverage, although final coverage cannot be calculated until the 2011-12 NPHEd data are available.
- 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.
Measures (computation)	<p><u>Definition</u> Proportion of people that deferred purchase of prescribed medicines due to cost.</p> <p><u>Numerator</u>: Number of people who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost.</p> <p><u>Denominator</u>: Total number of people aged 15 years or over who received a prescription for medication from a GP in the last 12 months.</p> <p><u>Computation</u>: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
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. It is 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 are compiled by the Health 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

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, for 2011-12, very remote Australia).

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 people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11 data, people living in remote communities (including discrete Indigenous communities)
- for 2011-12 data, people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory.

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 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 2011-12 data used for this indicator became available from 23 November 2012.

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 2011 to June 2012. (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 data).

Accuracy

There are not likely to be revisions to these data after their release.

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 size for the 2011-12 data was 26 437 fully-responding households; the sample size for the 2010-11 data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2011-12 survey was 79.6 per cent; 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 and, for 2011-12, remoteness breakdowns.

Coherence

Known Issues: Data were self-reported.

Explanatory footnotes are provided with the data.

Consistency over time: 2009 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 discrete Indigenous communities in the 2011-12 survey, and very remote communities in the previous surveys will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 24 per cent 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 Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other directly comparable data sources.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001, *Patient Experiences in Australia: Summary of Findings, 2010-11 and 2011-12* Cat. no. 4839.0. The data are shown by age, sex, remoteness and SEIFA. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

The 2011-12 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2011-12* (Cat. no. 4839.0). 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. These publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in these publications.

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.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The inclusion of very remote areas for the first time in the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Disaggregation of this indicator by Indigenous status is a priority.

Public dentistry waiting times

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Public dentistry waiting times.
Measures (computation)	<p><u>Definition</u> Waiting time between being placed on a public dentistry waiting list and being seen by a dental professional.</p> <p><u>Numerator</u>: Number of people aged 15 years and over on a public dental waiting list who reported seeing a dental professional at a government dental clinic (for their own health) within specified waiting time categories (less than 2 weeks, 2 weeks to less than 1 month, 1 month to less than 6 months, 6 months to less than 1 year, more than 1 year). Additional categories: less than 1 month and 1 month or more.</p> <p><u>Denominator</u>: Number of people aged 15 years or over who were on a public dentistry waiting list (for their own health) in the last 12 months.</p> <p><u>Computation</u>: $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the 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.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975.</p> <p>Data Compiler(s): Data are compiled by the Health section of the Australian Bureau of Statistics (ABS).</p> <p>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.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and very remote Australia).</p> <p>Data Completeness: All data are available for this indicator from this source.</p> <p>Indigenous Statistics: There are no Indigenous data able to be published for this indicator.</p>

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory.

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 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. Respondents were instructed to exclude treatment for urgent dental care. The definition of 'urgent dental care' was left up to the respondent's interpretation.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2011-12 data used for this indicator became available from 23 November 2012.

Referenced Period: July 2011 to June 2012.

Accuracy

There are not likely to be revisions to this data after its release.

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 2011-12 patient experience data was 26 437 fully-responding households.

Response rate: Response rate for the survey was 79.6 per cent.

Standard Errors: The very low prevalence rate for this data item (2 per cent) resulted in many cells with RSEs too high to provide meaningful and reliable data for the time periods in the original specifications.

As such, some variables (such as waiting times and remoteness categories) had to be aggregated. RSEs are nevertheless often greater than 25 per cent and should either be used with caution or, where greater than 50 per cent, are considered too unreliable for general use.

Known Issues: Data were self-reported and interpretation of urgent dental care was left up to the respondent. Further, this indicator may not cover those who saw a public dental professional but were not placed on a public dental waiting list.

Coherence

Explanatory footnotes are provided with the data.

Consistency over time: This is the first time data have been available from the ABS Patient Experience survey.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Accessibility

Data publicly available. Tables showing waiting times for dental professionals are available in *Patient Experiences in Australia: Summary of Findings, 2011-12* (Cat. no. 4839.0). However, there are some notable differences in the data. The waiting times reported in the 4839.0 publication are for the length of time between making an appointment and seeing a dental professional for the most recent urgent dental care (ie., it is not restricted to public dentistry, and it includes urgent dental care). Further, the waiting time categories differ to those presented in this indicator.

The dental data available in 4839.0 are shown by SEIFA, remoteness, country of birth, self-assessed health status and whether has a long term health condition. Jurisdictional data is not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data is available. Additional data from the Patient Experience Survey is available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

Other Supporting information: The ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2011-12* (Cat. no. 4839.0). This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in that publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- People on public dental waiting lists who receive publicly funded treatment outside government dental clinics, for example from private dental professionals under voucher schemes.
- Disaggregation of this indicator by Indigenous status is a priority.

Management of upper respiratory tract infections

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Management of upper respiratory tract infections
Measures (computation)	<u>Definition</u> 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 concession card holders. <u>Numerator:</u> The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed to concession card holders. <u>Denominator:</u> Estimated number of concession card holders. <u>Computation:</u> $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.
Data source/s	<u>Numerator:</u> Australian Government Department of Health and Ageing (DoHA) Pharmaceutical Benefits Scheme (PBS) Statistics data. <u>Denominator:</u> 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	<p>PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by DoHA and administered by the Department of Human Services (DHS), Medicare. Provisions governing the operation of the PBS are contained in the <i>National Health Act 1953</i>.</p> <p>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).</p>
Relevance	<p>These measures relate to PBS subsidised oral antibiotics used most commonly in treating URTI: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names that were ordered by GPs and dispensed to patients were extracted for each reference period.</p> <p>These antibiotics are used to treat a range of conditions in addition to URTI. Data disaggregated by the condition being treated are not available. The proportion of these antibiotics prescribed for treatment of URTI is unknown.</p> <p>Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.</p>

Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	As PBS data for general patients has historically been available only for items priced above the PBS general co-payment (\$35.40 in 2012), 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 under-copayment data are 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.
Accessibility	PBS Claims data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp .
Interpretability	Information on PBS data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp at the PBS item reports and PBS group reports links.
<u>Data Gaps/Issues Analysis</u>	
Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • 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.
Measures (computation)	<p><u>Definition</u></p> <p>Proportion of people with diabetes mellitus who have received a MBS annual cycle of care.</p> <p><u>Numerator</u></p> <p>Number of people with a completed MBS diabetes annual cycle of care processed by the Australian Government Department of Human Services (DHS), Medicare within the reference period.</p> <p><u>Denominator</u></p> <p>Number of people diagnosed with Type 1 and Type 2 diabetes in the community.</p> <p><u>Computation:</u> $100 \times (\text{Numerator} \div \text{Denominator})$.</p>
Data source/s	<p><u>Numerator</u></p> <p>DHS, Medicare Statistics data.</p> <p>Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data.</p> <p><u>Denominator</u></p> <p>For 2011-12 data: the National Health Survey (NHS) component of the ABS Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope population derived from the Estimated Resident Population (ERP). For information on scope and coverage, see the ABS <i>Australian Health Survey Users Guide</i> (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.</p> <p>For data for 2008-09 to 2010-11: 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.</p> <p>ABS ERP by remoteness area, as specified in the Australian Standard Geographical Classification, as at 30 June in the year preceding the reference period.</p>

Data Quality Framework Dimensions

Institutional environment

MBS

DHS, Medicare Statistics data processes claims made through the MBS under the *Human Services (Medicare) Act 1973*. These data are then regularly provided to DoHA. DHS, Medicare 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 DHS, Medicare and DVA.

AHS

The AHS was 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.

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/.

Computations

Data for 2011-12 were calculated by the Secretariat using numerator data supplied by DoHA and denominator data sourced from the ABS.

Data for 2008-09 to 2010-11 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 DHS, Medicare has processed a claim.

Data for 2011-12 are preliminary and do not include DVA data.

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 DHS, Medicare 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.

AHS

The 2011-12 NHS component of the AHS collected self-reported data for people told by a doctor or nurse that they had diabetes and that it was current and long-term; that is, their diabetes was current at the time of interview and had lasted, or was expected to last, 6 months or more. Data exclude respondents who reported they had diabetes but that it was not current at the time of interview. More accurate information on the number of people with diabetes based on measured blood sugar levels will be available upon release of results from the National Health Measures Survey in 2013.

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 people with each type of diabetes who have an MBS annual cycle of care.

The NDSS-sourced denominator includes only Type 1 and Type 2 diabetes. Therefore, people diagnosed with 'other diabetes' were excluded (5043 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.

AHS

The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

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.

DHS, 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 DHS, Medicare.

Data are based on the date on which the MBS claim was processed by DHS, Medicare, 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 people included in the numerator term for the reference period.

AHS

The AHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of people usually residing in very remote areas has a small impact on estimates except for the NT, where they make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The data used in this indicator generally have acceptable levels of sampling error.

Self-reported data can introduce bias into the estimate of diagnosed diabetes prevalence. An estimation of self-reporting bias made from the 1999–2000 AusDiab study found that approximately 9 per cent of participants who self-reported having diabetes did not have blood glucose levels in the diabetes range (AIHW 2009, Diabetes prevalence in Australia: an assessment of national data sources, Cat. no. CVD 46, Diabetes series no. 14). More accurate information on the number of people with diabetes based on measured blood sugar levels will be available upon release of results from the National Health Measures Survey in 2013.

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 2011-12 denominator data source differs from the source for previous reference periods. The 2011-12 data are not comparable with data for the earlier reference periods. For 2008-09 to 2010-11, interpretation of rates over time should not be undertaken as the prevalence estimate (denominator) increases each year with the increased coverage of the NDSS.

The reference period is not consistent across the data sources — the MBS data relate to all claims processed over the financial year, while the AHS data relate to the previous 12 months and NDSS data include all registrants on the database at a point in time (30 June).

Accessibility

MBS

DHS, 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.

AHS

Data for the NHS component of the AHS are published in the ABS *Australian Health Survey: First Results, 2011–12*, available from the ABS website at www.abs.gov.au. Other information from this survey is also available on request.

NDSS data are not publicly accessible.

Interpretability

Information about services subsidised through DHS, Medicare is available from MBS online at www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.

The ABS 2010-11 AHS survey data are published in *Australian Health Survey: First Results, 2011–12* which includes explanatory and technical notes. Data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website.

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:

- Data for 2011-12 were computed using different methodology than was used in earlier years and should not be compared with those data.
- 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.
 - 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.

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
Measures (computation)	Management of asthma <u>Definition</u> Proportion of people with asthma who have a written asthma action plan. <u>Numerator</u> Estimated number of people with asthma with a written asthma action plan. <u>Denominator</u> Estimated number of people with asthma. <u>Computation</u> : $100 \times (\text{Numerator} \div \text{Denominator})$.

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 Australians are drawn from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), which was benchmarked to the estimated Indigenous Australians (adjusted for the scope of the survey).

Data Quality Framework Dimensions

Institutional environment The NHS and NATSIHS are collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.

Relevance The NHS 2007-08 asked all respondents whether they had ever been told by a doctor or nurse that they have asthma, whether symptoms were present or they had taken treatment in the 12 months prior to interview, and whether they still had asthma. Those who answered yes to these questions were asked whether they had "a written asthma action plan, that is, written instructions of what to do if your asthma is worse or out of control". A very small number of respondents who were sequenced around these questions may have reported current long-term asthma in response to later general questions about medical conditions. These people are included in and contribute to estimates of the prevalence of asthma, but information about written action plans was not collected from them.

In the 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 people usually resident in very remote areas has a small impact on estimates, except for the Northern Territory, where such people 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 people/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.

Accessibility

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.

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.

Use of pathology tests and diagnostic imaging

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	<p>DHS, Medicare processes and collects MBS data for: claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to DoHA.</p> <p>claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.</p> <p>MBS claims data are an administrative by-product of DHS, Medicare's fee-for-service payment systems.</p> <p>For reference periods to 2009-10, DoHA provided raw data and rates inclusive of DVA data.</p> <p>From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.</p>
Indicator	<p>The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:</p> <p>Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'.</p> <p>Diagnostic imaging services — all items in BTOS 'G'.</p> <p>Claims are allocated to state/territory based on location at which the service was rendered.</p> <p>Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.</p>
Measures (computation)	
Measure 1	<p>MBS items rebated through Department of Human Services (DHS), Medicare for pathology tests requested by general practitioners (GP), and Other Medical Practitioners (OMP), per person</p> <p><u>Definition</u></p> <p>The number of MBS items rebated through DHS, Medicare for pathology tests requested by specialist GPs and OMPs, per person</p> <p><u>Numerator:</u></p> <p>The number of MBS items rebated through DHS, Medicare for pathology tests requested by GPs and OMPs</p> <p><u>Denominator:</u></p> <p>Estimated Resident Population (ERP)</p> <p><u>Computation:</u></p> <p>Numerator ÷ Denominator</p>
Measure 2	<p>Diagnostic imaging services provided on referral from specialist GPs and OMPs and rebated through DHS, Medicare, per person</p> <p><u>Definition</u></p> <p>The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs, per person</p> <p><u>Numerator:</u></p> <p>The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs</p>

	<p><u>Denominator:</u> Estimated Resident Population (ERP)</p> <p><u>Computation:</u> Numerator ÷ Denominator</p>
Measure 3	<p>DHS, Medicare benefits paid per person for pathology tests requested by GPs and OMPs.</p> <p>Data for the four previous years are deflated using the GDP Price deflator to provide real expenditure, that can be compared with the current year.</p>
Measure 4	<p>DHS, Medicare benefits paid per person for diagnostic imaging referred by GPs and OMPs.</p> <p>Data for the four previous years are deflated using the GDP Price deflator to provide real expenditure, that can be compared with the current year.</p>
Data source/s	<p><u>Numerator:</u></p> <ul style="list-style-type: none"> • For MBS data: DHS, Medicare data. • For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <p><u>Denominator:</u> Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP). For reference periods prior to and including 2009-10 ERP as at 30 June. For the 2010-11 and 2011-12 reference periods ERP as at 31 December.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes and collects MBS data for:</p> <ul style="list-style-type: none"> • claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to DoHA. • claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA. <p>MBS claims data are an administrative by-product of DHS, Medicare's fee-for-service payment systems.</p> <p>For reference periods to 2009-10, DoHA provided raw data and rates inclusive of DVA data.</p> <p>From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.</p>
Relevance	<p>The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:</p> <ul style="list-style-type: none"> • Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'. • Diagnostic imaging services — all items in BTOS 'G'. <p>Claims are allocated to state/territory based on location at which the service was rendered.</p> <p>Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.</p>

Timeliness

Data include all claims processed in the reference period.

Accuracy

Data are limited to claims for services requested/referred by GPs and, for MBS data, OMPs (DVA data include only services requested/referred by specialist GPs). Data do not include claims for services requested/referred by other medical specialists.

Data include all claims processed in the reference period.

Pathology tests

The pathology episode cone applies to services requested by general practitioners for non-hospitalised patients:

when more than three MBS pathology items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for three items — those with the highest schedule fees (there are some items exempted from the episode cone). Where additional tests performed in a patient episode are not rebated through DHS, Medicare, they are not included in the data. This results in some underreporting of the number of pathology tests conducted on request by GPs and OMPs. Data include Patient Episode Initiated Items.

Diagnostic imaging

Diagnostic imaging services provided and rebated through DHS, Medicare can differ from the services requested by GPs and OMPs.

In certain circumstances, as defined by legislation, a radiologist can identify the need for, and perform, more or different diagnostic imaging services than are requested by a GP/OMP. The data reflect the services provided and rebated through DHS, Medicare, rather than the services requested by GPs/OMPs.

Coherence

Data were computed by DoHA for this indicator for the reference periods prior to and including 2009-10, using the ERP as at 30 June. From the 2010-11 reference period, data are computed by the Secretariat from numerator data obtained separately from DoHA and the DVA, using the ERP as at 31 December. These changes are expected to have negligible impact on the data.

Accessibility**MBS**

DHS, 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.

DVA data are not publically accessible.

Interpretability

General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis**Key data gaps /issues**

The Steering Committee notes the following issues:

- This is a proxy measure — data are limited to those services rebated through DHS, Medicare that were provided in response to request/referral by GPs/OMPs.
- Provides information about relative requests/referrals for pathology tests and diagnostic imaging across jurisdictions and over time, but not the appropriateness thereof.

Patient satisfaction

Data quality information for this 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.
Measures (computation)	<p><u>Measure a:</u></p> <p><u>Definition</u></p> <p>Proportion of people satisfied with selected aspects of GP care.</p> <p><u>Numerator</u> People who saw a GP in the last 12 months reporting the GP always or often: listened carefully; showed respect; spent enough time with them.</p> <p><u>Denominator</u> People who saw a GP for their own health in the last 12 months, excluding people who were interviewed by proxy.</p> <p><u>Measure b:</u></p> <p><u>Definition</u></p> <p>Proportion of people satisfied with selected aspects of dental professional care.</p> <p><u>Numerator</u> People who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully; showed respect; spent enough time with them.</p> <p><u>Denominator</u> People who saw a dental professional in the last 12 months, excluding people who were interviewed by proxy.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the Australian Bureau of Statistics (ABS).</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
----------------------------------	--

Relevance

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, for 2011-12 data only, very remote Australia).

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 people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11 data, people living in remote communities (including discrete indigenous communities)
- for 2011-12 data, people living in discrete indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. The exclusion of people usually resident in very remote communities in the 2010-11 iteration of the survey has a small impact on estimates, except for the NT, where people usually resident in very remote areas account for about 24 per cent of the population.

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 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. People who were interviewed by proxy were excluded.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2011-12 data used for this indicator became available from 23 November 2012. 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 Periods:

- July 2011 to June 2012 (2011-12 data)

July 2010 to June 2011 (2010-11 data).

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
- the sample for the 2011-12 patient experience data was 26 437 fully-responding households.

Response rate:

- the response rate for the 2010-11 survey was 81.4 per cent
- the response rate for the 2011-12 survey was 79.6 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.

These data are attitudinal, as the survey collects data for whether people felt the health professional in question spent enough time with them, listened carefully and showed them respect.

Data are used from personal interviews only — proxy interviews are excluded.

Explanatory footnotes are provided with the data.

Coherence

Consistency over time: 2009 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 2010-11 survey sample) and discrete indigenous communities (in the 2011-12 survey sample) will affect the NT more than it affects other jurisdictions. (People usually resident in very remote areas account for about 24 per cent 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 Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Accessibility

Data are publicly available in *Patient Experiences in Australia: Summary of Findings, 2010-11*, and *Patient Experiences in Australia: Summary of Findings, 2011-12*, Cat. no. 4839.0. The data are shown by age, sex, remoteness and disadvantage. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Interpretability

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.

Context: 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 Patient Experience data are published in ABS 2011 and ABS 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11 and 2011-12*, Cat. no. 4839.0. The publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the ABS 2011 and 2012 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11 and 2011-12*, Cat. no. 4839.0.

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)	<p><u>Definition</u></p> <p>The proportion of older people who received a health assessment.</p> <p><u>Numerator:</u></p> <p>The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of Indigenous people aged 55 years or over with an MBS claim for Items 704, 706 (Health assessment for older Aboriginal and Torres Strait Islander People) or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p><u>Denominator:</u></p> <p>The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period.</p> <p><u>Computation:</u></p> <p>$100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p><u>Numerator:</u> Australian Government Department of Human Services (DHS), Medicare data.</p> <p><u>Denominator:</u></p> <p>Denominator computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS).</p> <p><u>Total population:</u> ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.</p> <p>For data by <u>Indigenous status</u>: ABS 2009, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021</i>, Cat. No. 3238.0 (B Series).</p>

Data Quality Framework Dimensions

Institutional environment	<p>MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to DoHA.</p> <p>The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.</p>
Relevance	<p>These measures relate to specific DHS, Medicare services for which claims data are available.</p> <p>Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly because the life expectancy of Indigenous people is, on average, relatively low.</p>

Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received.

For services provided from 1 May 2010, age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to health assessments for older people and health assessments for older Indigenous people.

Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.

In the NT, MBS statistics do not necessarily fully reflect services supplied to Indigenous people as the claim rate is low due to a smaller number of GPs in remote areas.

Timeliness
Accuracy

MBS claims data are available within 14 days of the end of a month.

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 DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, 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.

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

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 DHS, Medicare records at the date the service was received.

Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.

Accessibility

Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.

Interpretability

DHS, 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.

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 DHS, Medicare data.

Cost to government of general practice per person

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost to government of general practice per person
Measures (computation)	Government Expenditure on GPs per person Definition Cost to government of general practice per person in the population <u>Numerator:</u> Nominal expenditure on services rendered by GPs and OMPs. <u>Denominator:</u> Estimated Resident Population (ERP). <u>Computation:</u> Numerator ÷ Denominator Data for years prior to 2011-12 are deflated using the GDP Price deflator to provide real expenditure, that can be compared with the current year.
Data source/s	<u>Numerator:</u> <ul style="list-style-type: none">• For MBS data: Department of Human Services (DHS), Medicare data and Practice incentive program (PIP) area data sourced by the Australian Government Department of Health and Ageing (DoHA)• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <u>Denominator:</u> Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December.

Data Quality Framework Dimensions

Institutional environment	DHS, Medicare processes and collects MBS data for: <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to DoHA.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA. MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems.
Relevance	The measure relates to: <ul style="list-style-type: none">• services provided by GPs and, for MBS data, OMPs (DVA data include only services provided by specialist GPs) for which DHS, Medicare has processed a claim.• services provided under PIP, the Divisions of General Practice Program (DGPP) and the General Practice Immunisation Incentive Scheme (GPPII). Claims allocated to state/territory based on location at which service rendered.

	Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.
Timeliness	Data include all claims processed in the reference period.
Accuracy	DHS, Medicare data include claimed services rendered under PIP, DGPP and GPIL by GPs and OMPs as well as by practice nurses or registered Aboriginal health workers for and on behalf of the GMP/OMP. DVA data are limited to claims for services provided by specialist GPs.
Coherence	Data include all claims processed in the reference period. Nominal State and Territory total expenditure data were computed by DoHA for the reference periods 2006-07 to 2009-10. For the 2010-11 and 2011-12 reference periods, DHS, Medicare and DVA nominal expenditure data were provided separately to and compiled by the Secretariat. These changes are expected to have negligible impact on the data. Expenditure per person data were computed by the Secretariat using the 2006 Census-based ERP as at 31 December for all reference periods. This differs from previous reports, where per person data were computed by DoHA using 30 June ERP for all reference periods except 2010-11. This change is expected to have negligible impact on the data.
Accessibility	<u>MBS</u> DHS, 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 . DVA data are not publically accessible.
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1
<u>Data Gaps/Issues Analysis</u>	
Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none"> • Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Child immunisation coverage (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 Department of Health and Ageing) with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Child immunisation coverage.
Measures (computation)	<p>Proportion of children aged 60 months to less than 63 months who are fully vaccinated.</p> <p><u>Definition</u></p> <p>Proportion of children aged 5 years who are fully vaccinated. <u>Numerator</u> number of children who turned five by 31 March in the reference year who have been recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) as at 30 June in the reference year.</p> <p><u>Denominator</u> number of children who turned five between 1 January and 31 March in the reference year registered on ACIR as at 30 June in the reference year.</p> <p><u>Computation</u>: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 children aged 5 years.</p>
Data source/s	The Australian Childhood Immunisation Register (ACIR).

Data Quality Framework Dimensions

Institutional environment	<p>The ACIR is administered and operated by Australian Government Department of Human Services (DHS), Medicare. DHS, Medicare provides DoHA with quarterly coverage reports at the national and state level.</p> <p>Immunisations are notified to DHS, Medicare by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments.</p> <p>For information on the institutional environment of the ACIR, including the legislative obligations of the ACIR, financing and governance arrangements, and mechanisms for scrutiny of ACIR operations, please see www.medicareaustralia.gov.au/public/services/acir/index.jsp.</p> <p>The tables for this indicator were prepared by DHS, Medicare and quality-assessed by DoHA. DoHA drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies).</p>
Relevance	<p>The ACIR records details of vaccinations given to children under seven years of age who live in Australia.</p> <p>A child is assessed as fully immunised at five years of age if they have received immunisations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.</p> <p>There are possible gaps in coverage due to unknown vaccination status of children less than 5 years migrating to Australia. The extent of this is not currently quantifiable.</p> <p>The analyses by State/Territory are based on postcode of residence of the child as recorded on ACIR.</p>

Timeliness

ACIR data are reported quarterly. Data are processed on 30 June in the reference year as a minimum 3-month lag period is allowed for late notification of immunisations to ACIR.

Accuracy

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 (GPPI) and provider incentive payments have helped minimise under-reporting by providing a financial incentive to vaccinate children and notify the ACIR.

The data contains minimal if any duplication of immunisations, as children are identified via their DHS, Medicare number. Approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.

The ACIR covers virtually all children, particularly because participation in the ACIR is via an 'opt-out' arrangement.

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 the DHS, Medicare web site.

DHS, Medicare 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 DHS, Medicare 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 DHS, Medicare enrolment register, and approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.
- Data have been reported using the program definition of fully-immunised for children aged 60 to 63 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.

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.
Measures (computation)	<p><u>Definition</u></p> <p>This indicator presents the number of women within the national target age group (20–69 years) screened in a 2 year period as a proportion of the eligible female population and age-standardised to the Australian standard population at 30 June 2001.</p> <p>The eligible female population is the average of the Australian Bureau of Statistics (ABS) estimated resident female population for the 2 year reporting period. This population is adjusted for the estimated proportion of women who have had a hysterectomy using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p> <p><u>Numerator</u> Total number of women aged 20–69 years who were screened in the 2 year period.</p> <p><u>Denominator</u> Average number of women aged 20–69 years in the same 2 year period, adjusted using national hysterectomy fractions to exclude the estimated number of women who have had a hysterectomy.</p> <p><u>Computation/s:</u> $100 \times (\text{Numerator} \div \text{Denominator})$ and age-standardised to the Australian population at 30 June 2001.</p>
Data source/s	<p><u>Numerator</u> State and territory cervical cytology registers.</p> <p><u>Denominator</u> For <u>total population</u>:</p> <p>ABS estimated resident population (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The National Cervical Screening Program (NCSP) is a joint program of the Australian Government and State and Territory governments. The target age group is women aged 20–69 years.</p> <p>Cervical cytology registries in each state and territory are maintained by jurisdictional Program managers. Data are supplied to the registries from pathology laboratories. Data from cervical cytology registers are provided to the Australian Institute of Health and Welfare (AIHW) annually in an aggregated format.</p> <p>The NCSP is monitored annually. Results are compiled and reported at the national level by the AIHW in an annual <i>Cervical screening in Australia</i> report.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio. It is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website (www.aihw.gov.au).</p>
Relevance	<p>The data used to calculate this indicator are accurate and of high quality. The cervical cytology registers collect information on all Pap tests undertaken in Australia except where women advise the clinician they do not wish to have their data collected. The use of ERP based on Census data for denominators provide the most comprehensive data coverage possible. The data are entirely appropriate for this indicator.</p>

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.

Timeliness

The most recent data available for the 2013 RoGS report are based on the two-year calendar period 1 January 2010 to 31 December 2011. Data are presented as a rate for the two-year period to reflect the recommended screening interval.

Accuracy

This indicator is calculated on data that have been supplied to the AIHW by individual state and territory registers. Prior to publication, the results of analyses are referred back to states and territories for checking and clearance. Any errors found by states and territories are corrected once confirmed. Thus participation by state and territory, based on the state or territory in which the woman was screened, is both robust and readily verified.

Women who opt off the cervical cytology register are not included in the participation data, but this is thought to only exclude around 1 per cent of all women screened.

Coherence

Some of these data are published annually in Program monitoring reports prepared by the AIHW. Denominator data for the 24 month periods 2005 and 2006 to 2009 and 2010 have been revised using population data re-based on the 2011 Census. Participation rates for these periods are therefore consistent with rates for the 24 month period 2010 and 2011 and with AIHW monitoring reports. However, participation rates for these periods may differ from those published in previous reports.

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
Measures (computation)	<p>Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions.</p> <p>The <i>numerator</i> is the number of separations for selected potentially preventable hospitalisations, divided into three groups:</p> <ul style="list-style-type: none">• Vaccine-preventable conditions<ul style="list-style-type: none">- Influenza and Pneumonia- Other vaccine preventable conditions (e.g. tetanus, measles, mumps, rubella)- Total.• Acute conditions<ul style="list-style-type: none">- 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<ul style="list-style-type: none">- 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 as additional diagnoses)
- Total (excluding diabetes complications — all diagnoses).
- Total selected potentially preventable hospitalisations
 - Total selected potentially preventable hospitalisations (excluding dehydration and gastroenteritis and excluding diabetes complications as additional diagnoses)
 - Total selected potentially preventable hospitalisations (excluding dehydration and gastroenteritis and excluding diabetes complications — all diagnoses).

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 2010-11*).

Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

Data source/s

Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.

Denominator:

For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2010.

For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June 2010.

For data by remoteness: ABS ERP as at 30 June 2010, by remoteness areas, as specified in the Australian Standard Geographical Classification.

Computation:

$1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

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.

Relevance

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.

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.

'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 Statistical Local Area of usual residence of the patient, not the location of the hospital.

Timeliness

The reference period for this data set is 2010-11.

Accuracy

For 2010-11, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory.

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.

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 for the following jurisdictions: NSW, Victoria, Queensland, SA and WA (public and private hospitals) and the NT (public hospitals only). National totals include these six jurisdictions only (and only public hospitals for the NT). Indigenous status data reported for Tasmania and the ACT (public and private hospitals) are excluded from national totals and should be interpreted with caution until further assessment of Indigenous identification is completed.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

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 service provider or where rates are likely to be highly volatile, for example where the denominator is very small. The following rule was applied:

- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in the *National healthcare agreement: performance report 2010-11* and *Australian hospital statistics 2010-11*. 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 later years as changes between ICD-10-AM 5th edition and ICD-10-AM 6th edition and the associated Australian Coding Standards that resulted in:

- decreased reporting of additional diagnoses for diabetes
- increased reporting of gastroenteritis.

Further, Tasmanian data are not comparable over time as 2008–09 data excludes two private hospitals that were included in 2007-08 and 2009–10 data reported in the National Healthcare Agreement performance reports.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- Australian hospital statistics with associated Excel tables.
- Interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Some data are also included on the MyHospitals website.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- 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 (and NT private hospitals) are not included in the national total.
- Caution should be used in comparing 2007–08 data with later years as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007–08), ICD-10-AM 6th edition (used in 2008–09 and 2009–10) and ICD-10-AM 7th edition (used in 2010–11) and the associated Australian Coding Standards resulted in decreased reporting of additional diagnoses for diabetes, and increased reporting of gastroenteritis (chronic and acute categories, respectively, affected). 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
Measures (computation)	<p>Selected potentially preventable hospitalisations for diabetes.</p> <p>The <i>numerator</i> is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups:</p> <ul style="list-style-type: none">• Circulatory complications (E11.5x)<ul style="list-style-type: none">- 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. <p>The <i>denominator</i> is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for diabetes are defined by ICD-10-AM diagnosis codes.</p> <p>Calculation is $100\,000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 100 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 years combined.</p>
Data source/s	<p><u>Numerator:</u> This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p><u>Denominator:</u></p> <p>For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2010.</p> <p><u>Computation:</u></p> <p>$1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

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 Health. 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 2010-11.

Accuracy

For 2010-11 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory. 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.

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 admission practices and policies lead to variation among providers in the number of admissions for some conditions. Variations in both admission and administration practices and policies mean that dialysis treatments may be counted as separations with diabetes complications by some hospitals and not others, reducing the comparability of the data at state and territory level. This is particularly significant for Indigenous people because of the high prevalence of diabetes in that population.

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 2010-11* and the *National healthcare agreement: performance report 2010-11*.

Changes between the ICD-10-AM 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11) and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes.

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).

Some data are also included on the MyHospitals website.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis**Key data gaps /issues**

The Steering Committee notes the following issues:

- Further work is required to improve the comparability of data due to changes across editions of the ICD-10-AM.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

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
Measures (computation)	<p>Potentially preventable hospitalisations of older people for falls.</p> <p>The number of hospitalisations for people aged 65 years or over with a reported external cause of falls, per 1000 people.</p> <p>The <i>numerator</i> is the number of hospitalisations for people aged 65 years or over with a reported external cause of falls.</p> <p>The <i>denominator</i> is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for falls are defined by ICD-10-AM external cause codes (W00–W19).</p> <p>Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined.</p>
Data source/s	<p><u>Numerator</u>: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p><u>Denominator</u>:</p> <p>For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period.</p> <p><u>Computation</u>:</p> <p>$1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at:</p> <p>www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
----------------------------------	---

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 periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11.

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.

For 2010-11 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. However, 2010-11 data were not available for the NT.

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

	<p>jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.</p> <p>Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.</p> <p>Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small).</p>
Coherence	<p>For 2010-11, NT data are not available and are excluded from the Australian total. With this exception, data for this indicator are comparable over time.</p>
Accessibility	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> • Australian hospital statistics with associated Excel tables. • Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).
Interpretability	<p>Some data are also included on the MyHospitals website.</p> <p>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.</p>
<u>Data Gaps/Issues Analysis</u>	
<ul style="list-style-type: none"> • Key data gaps /issues 	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • NT data were not available for 2010-11. • The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.