
10 Primary and community health interpretative material

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The Primary and community health interpretative material is supporting material and includes explanations of why indicators have been chosen, and wherever possible, a link to the stated objectives of the service. It includes indicator definitions, technical details defining how the indicator is measured and guidance on how the indicator is to be interpreted, including caveats and the indicator's completeness and comparability status.

Further information on the Report on Government Services including other reported service areas, the glossary and list of abbreviations is available at <https://www.pc.gov.au/research/ongoing/report-on-government-services>.

10.1 Indicators

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

The comparability of performance indicator results is shaded in indicator interpretation boxes, figures and data tables as follows:

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are either not comparable (subject to caveats) within jurisdictions over time or are not comparable across jurisdictions or both.

The completeness of performance indicator results is shaded in indicator interpretation boxes, figures and data tables as follows:

- Data are complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions.
- Data are incomplete for the current reporting period. At least some data were not available.

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Equity

Access — Availability of primary healthcare services

'Availability of primary healthcare services' is an indicator of governments' objective to

provide access to primary healthcare services in an equitable manner (box 10.1).

Box 10.1 **Availability of primary healthcare services**

'Availability of primary healthcare services' is defined by four measures:

- PBS medicines by region, defined as the ABS census population divided by the number of approved providers of PBS medicines, by urban/rural location and Pharmacy Access/Remoteness Index of Australia (PhARIA) area
- General Practitioners (GPs) by region, defined as the number of FTE GPs per 100 000 people, by region
- GPs by sex, defined as the number of FTE GPs per 100 000 population, by sex
- Public dentists by region, defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region, based on clinical hours worked in the public sector.

PBS medicines by region

Similar rates across regions indicates equity of access by location.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions as at 30 June 2020.

GPs by region and sex

Similar rates across regions indicates equity of access by location. Similar rates by sex means it is more likely that patients who prefer to visit GPs of their own sex will have their preference met. Low availability of GPs of each sex can be associated with increased waiting times to see a GP, for patients who prefer to visit GPs of their own sex.

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

Data reported for these measures are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2019 data are available for all jurisdictions.

Public dentists by region

Similar rates across regions indicates equity of access by location.

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

- comparable (subject to caveats) across jurisdictions and over time from 2014 onwards
- complete (subject to caveats) for the current reporting period. All required 2019 data are available for all jurisdictions.

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

‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is an indicator of governments’ objective to provide access to primary and community healthcare in an equitable manner (box 10.2).

Box 10.2 **Early detection and early treatment for Aboriginal and Torres Strait Islander people**

‘Early detection and early treatment for Aboriginal and Torres Strait Islander people’ is defined as the proportion of older people who received a health assessment under Medicare by Indigenous status.

Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding hospital inpatients and people living in aged care facilities. Health assessments are Medicare Benefits Schedule (MBS) items that allow comprehensive examinations of patient health, including physical, psychological and social functioning.

A small or narrowing gap between the proportion of Aboriginal and Torres Strait Islander people and non-Indigenous people who received a health assessment can indicate more equitable access to early detection and early treatment services for Aboriginal and Torres Strait Islander people. An increase over time in the proportion of older Aboriginal and Torres Strait Islander people who received a health assessment is desirable as it indicates improved access to these services.

This indicator provides no information about health assessments provided outside Medicare (predominantly used by Aboriginal and Torres Strait Islander people in remote and very remote areas). Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander people who received early detection and early treatment services.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2019-20 data are available for all jurisdictions.

Effectiveness

Access — Affordability of primary healthcare services

‘Affordability of primary healthcare services’ is an indicator of governments’ objective to provide primary healthcare services that are affordable (box 10.3).

Box 10.3 **Affordability of primary healthcare**

'Affordability of primary healthcare' is defined by two measures:

- People delaying or not seeing GPs due to cost, defined as the proportion of people who delayed seeing or did not see a GP at any time in the previous 12 months due to cost.
- People delaying or not filling prescriptions due to cost, defined as the proportion of people who delayed filling or did not fill a prescription at any time in the previous 12 months due to cost.

A low or decreasing proportion of people deferring visits to GPs or filling prescriptions due to cost indicates more widely affordable access to GPs and medicines.

Data reported for these measures are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2019-20 data are available for all jurisdictions.

Data are sourced from the ABS Patient Experience Survey (PEXS) of people aged 15 years and over. The PEXS does not include people living in discrete Indigenous communities, which affects the representativeness of the NT results for both measures. Approximately 20 per cent of the estimated resident population of the NT live in discrete Indigenous communities.

Contextual data covering bulk billing of general practice attendances and specialist attendances, by region, are available in tables 10A.27-30).

Access — Timeliness of primary healthcare services

'Timeliness of primary healthcare services' is an indicator of governments' objective to ensure primary healthcare services are provided in a timely manner (box 10.4).

Box 10.4 Timeliness of primary healthcare services

'Timeliness of primary healthcare services' is defined by two measures:

- Public dentistry waiting times, defined as the number of days waited at the 50th (median) and 90th percentiles between being placed on a selected public dentistry waiting list and either being offered dental care or receiving dental care
- GP waiting times for urgent medical care, defined as the proportion of people who, in the previous 12 months, saw a GP for urgent medical care within specified times from making the appointment. Specified waiting times are: less than 4 hours; 4 to less than 24 hours; 24 hours or more.

A shorter time waited to see a dental professional indicates more timely access to public dental services. A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

Public dental waiting times only include records on persons eligible for public dental services who were aged 18 years or over. It excludes those on jurisdictional priority client schemes and those who access the service but pay full price. Data are reported by Aboriginal and Torres Strait Islander status, remoteness area of residence, and Socio-Economic Indexes for Areas (SEIFA) of residence.

Data reported for the public dentistry waiting times measure are:

- not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time
- incomplete for the current reporting period. All required 2019-20 data are not available for NSW.

Data reported for the GP waiting times measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2019-20 data are available for all jurisdictions.

The ABS Patient Experience Survey of people aged 15 years and over does not include people living in discrete Indigenous communities, which affects the representativeness of the NT results for the GP waiting times measure. Approximately 20 per cent of the estimated resident population of the NT live in discrete Indigenous communities.

Access — Potentially avoidable presentations to emergency departments

'Potentially avoidable presentations to emergency departments' (also known as 'GP-type presentations') is an indicator of governments' objective for primary and community healthcare to be accessible (box 10.5).

Box 10.5 Potentially avoidable presentations to emergency departments

Potentially avoidable presentations to emergency departments (interim measure) are defined as the number of selected 'GP-type presentations' to emergency departments, where selected GP-type presentations are emergency presentations:

- allocated to triage category 4 (semi-urgent) or 5 (non-urgent); and
- not arriving by ambulance, with police or corrections; and
- not admitted or referred to another hospital; and
- who did not die.

Potentially avoidable presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. Factors contributing to GP-type presentations at emergency departments include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff.

Once a suitable denominator for this measure is agreed, a low or decreasing rate/proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care. Currently, the *number* of potentially avoidable presentations to emergency departments are reported for this indicator. In future, this indicator will be reported as a *proportion* (for example, the number of potentially avoidable GP-type presentations to emergency departments, as a proportion of all presentations to emergency departments), subject to the identification of a suitable denominator.

Data reported for this measure are:

- not comparable across jurisdictions or within some jurisdictions over time, but are comparable within other jurisdictions over time (see caveats in data tables)
- complete (subject to caveats) for the current reporting period. All required data for 2019-20 are available for all jurisdictions.

Appropriateness — Developmental health checks

'Developmental health checks' is an indicator of governments' objective to ensure that services are appropriate and responsive to the needs of children (box 10.6).

Box 10.6 Developmental health checks

'Developmental health checks' are defined as the proportion of preschool-aged children who received a developmental health assessment.

A high or increasing proportion of preschool-aged children receiving developmental health checks is desirable.

Data are not yet available for reporting against this indicator.

Appropriateness — Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure that primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan (box 10.7).

Box 10.7 **Chronic disease management**

‘Chronic disease management’ is defined by two measures:

- Management of diabetes, defined as the proportion of people with diabetes with HbA1c (glycosylated haemoglobin) levels less than or equal to 7 per cent
- Management of asthma, defined as the proportion of people with asthma who have a written asthma action plan.

A high or increasing proportion for each measure is desirable. HbA1c provides a measure of the average blood glucose level for the preceding three months, and a HbA1c level less than or equal to 7 per cent indicates appropriate management. HbA1c data are for people aged 18-69 years.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for management of diabetes (2011-12) and management of asthma (2017-18).

The ABS National Health Survey does not include people living in very remote areas and discrete Indigenous communities, which affects the representativeness of the NT results for the asthma measure. Approximately 20 per cent of the estimated resident population of the NT live in very remote areas and discrete Indigenous communities.

Appropriateness — Immunisation coverage

‘Immunisation coverage’ is an indicator of governments’ objective to ensure primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan and communities (box 10.8).

Box 10.8 Immunisation coverage

‘Immunisation coverage’ is defined by four measures:

- Proportion of children aged 12<15 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b, *Haemophilus influenzae* type b and pneumococcal)
- Proportion of children aged 24<27 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b, hepatitis B, measles, mumps and rubella (MMR), meningococcal C and varicella)
- Proportion of children aged 60<63 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, and to the quarter ending 31 December 2017, including measles, mumps and rubella (MMR))Influenza vaccination
- Coverage for older people, defined as the proportion of people aged 65 years and over who have been vaccinated against seasonal influenza. Due to provider underreporting of influenza vaccinations for older people to the Australian Immunisation Register (AIR), 2019-20 data are reported as numbers rather than population coverage rates. This is an interim approach to be reviewed annually as provider reporting to the AIR improves. Data reported are:
 - the number of vaccines administered and reported to the AIR for people aged 65 years and over
 - the number of vaccines distributed for people aged 65 years and over.

A high or increasing proportion or number of people immunised is desirable.

Data reported for the three measures concerning childhood immunisations are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2019-20 data are available for all jurisdictions.

Data reported for the influenza vaccination coverage for older people measure are:

- comparable (subject to caveats) across jurisdictions
- incomplete for the current reporting period. Due to provider underreporting of influenza vaccinations for older people to the AIR, data are reported as numbers rather than population coverage rates.

Appropriateness — Cancer screening

‘Cancer screening’ is an indicator of governments’ objective to ensure primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan and communities (box 10.9).

Box 10.9 Cancer screening

‘Cancer screening’ is defined by three measures:

- Participation for women in breast cancer screening, defined as the proportion of women aged 50–74 years who are screened in the BreastScreen Australia Program over a 24-month period, reported as a rate
- Participation for women in cervical screening, defined as the proportion of the estimated eligible population of women (not had a hysterectomy) aged 25–74 years who are screened over a 5-year period, reported as a rate
- Participation of persons in bowel cancer screening, defined as persons aged 50–74 years who were invited to participate in the National Bowel Cancer Screening Program over a 24-month period and returned a completed test kit within 6 months of the end of that period, divided by the number of invitations issued minus those people who opted out or suspended without completing their screening test.

High or increasing participation rates are desirable.

Data reported for the breast and bowel cancer screening measures are:

- comparable (subject to caveats) across jurisdictions and over time. A break in series with the change of target age group for breast cancer screening from 50–69 years to 50–74 years means that data from 2014–2015 onwards are not comparable to earlier time periods
- complete (subject to caveats) for the current reporting period. All required data for the 24-month period 2018–2019 are available for all jurisdictions for both breast and bowel cancer screening programs.

Data reported for the cervical cancer screening measure are:

- comparable (subject to caveats) across jurisdictions, but not over time due to a change in the national cervical cancer screening program from December 2017. Data for 2018–2019 onwards are not comparable with data for earlier years.
- incomplete for the current reporting period. Due to a change in the national cervical cancer screening program from December 2017, participation data are only available for 2018–2019.

A new National Cervical Screening Program commenced in December 2017, at which time cervical screening changed from 2-yearly pap tests to 5-yearly cervical screening tests. As such, national reporting on cervical screening participation rates is in a period of transition. Under the new National Cervical Screening Program, program participation rates cannot be calculated until 5 years of data are available from program commencement.

Quality — Safety — General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure primary and community health services are high quality and safe (box 10.10).

Box 10.10 **General practices with accreditation**

‘General practices with accreditation’ is defined as the number of general practices in Australia that are accredited as a rate per 100 general practices. Accreditation is a voluntary process of independent third-party peer review that assesses general practices against a set of standards developed by the Royal Australasian College of General Practitioners.

A high or increasing rate 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.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
- incomplete for the current reporting period (2020). All required data for the number of general practices (denominator) are not available and therefore an accreditation rate cannot be calculated.

Quality — Responsiveness — Patient satisfaction

‘Patient satisfaction’ is an indicator of governments’ objective that primary and community health services are high quality (box 10.11).

Box 10.11 Patient satisfaction

‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of aspects of care that are key factors in patient outcomes and can be readily modified. Six measures of patient experience of communication with health professionals — a key aspect of care — are reported:

- the proportion of people who saw a GP in the previous 12 months who reported the GP always or often:
 - listened carefully to them
 - showed respect
 - spent enough time with them
- the proportion of people who saw a dental professional in the previous 12 months who reported the dental professional always or often:
 - listened carefully to them
 - showed respect
 - spent enough time with them.

High or increasing proportions can indicate improved satisfaction from the patient’s perspective with the quality of care.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2019-20 data are available for all jurisdictions.

Data are sourced from the ABS Patient Experience Survey (PEXS) of people aged 15 years and over. The PEXS does not include people living in discrete Aboriginal and Torres Strait Islander communities. This affects the representativeness of the NT results. Approximately 20 per cent of the estimated resident population of the NT live in discrete Indigenous communities.

Quality — Continuity — Continuity of care

‘Continuity of care’ is an indicator of governments’ objective to ensure that services are well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required (box 10.12).

Box 10.12 Continuity of care

‘Continuity of care’ is defined by three measures:

- the proportion of GP management plans and team care assessment plans that have been reviewed in the past 12 months
- the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent
- the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that issues were caused by a lack of communication between the health professionals.

For the first measure, proportions are calculated by dividing the number of MBS subsidised GP management plans and team care assessment plans reviewed (Medicare item no. 732), by the total number of MBS subsidised GP management plans (Medicare item no. 721) and team care assessment plans (Medicare item no. 723), multiplied by 100.

A high or increasing proportion of GP management and team care assessment plans reviewed is desirable.

The second and third measures are enumerated using data from the ABS Patient Experience Survey (PExS) of people aged 15 years and over. The PExS does not include people living in discrete Indigenous communities, which affects the representativeness of the NT results for both measures. Approximately 20 per cent of the estimated resident population of the NT live in discrete Indigenous communities.

For the second measure, a high or increasing proportion of patients who saw three or more different health professionals in the past 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent is desirable.

For the third measure a low or decreasing proportion of patients who saw three or more different health professionals in the past 12 months for the same condition and who reported that issues were caused by a lack of communication or coordination among the health professionals is desirable.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2019-20 data are available for all jurisdictions.

Sustainability — Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable primary and community healthcare services (box 10.13).

Box 10.13 **Workforce sustainability**

‘Workforce sustainability’ is defined by two measures:

- the proportion of full time equivalent (FTE) GPs in ten year age brackets
- the attrition rate of FTE GPs who exit the workforce as a proportion of the number of FTE GPs by age bracket.

A high or increasing percentage of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement is desirable. A low or decreasing rate of workforce attrition is desirable.

These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for GPs.

Data reported for the proportion of FTE GPs in ten-year age brackets are:

- not comparable over time (data for 2018 and 2019 are not comparable to earlier years), but are comparable across jurisdictions (subject to caveats)
- complete (subject to caveats) for the current reporting period. All required 2019 data are available for all jurisdictions.

For the measure ‘attrition rate of FTE GPs who exit the workforce as a proportion of the number of FTE GPs by age bracket’, only national data for the 2019 period are available for publication for the first time in this Report. It is expected that state and territory data will be available for future Reports.

The national attrition rate was measured as the proportion of GPs who were in scope in 2018, but not in scope in 2019. In scope is defined as Primary Care GPs, being GPs working in the treatment of non-admitted patients in the community. GPs who ‘exited’ (i.e., were no longer in-scope) in 2019 might still be in the medical workforce and practicing as a GP but are classified as an exit as they are no longer Primary Care GPs.

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 and community health services in an efficient manner (box 10.14).

Box 10.14 **Cost to government of general practice per person**

‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.

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

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

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions, and over time from 2012-13
- complete (subject to caveats) for the current reporting period. All required 2019-20 data are available for all jurisdictions.

Outcomes

Outcomes are the impact of services on the status of an individual or group (see section 1).

Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective for primary and community health services to promote health and prevent illness (box 10.15).

Box 10.15 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 by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective.

Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases, and notification to the relevant State or Territory authority is required on diagnosis.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2019-20 data are available for all jurisdictions.

Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective for primary and community health services to promote health, prevent illness and to support people to manage their health issues in the community (box 10.16).

Box 10.16 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. Two measures of selected potentially preventable hospitalisations are reported by jurisdiction of residence:

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

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2018-19 data are available for all jurisdictions.

- Potentially preventable hospitalisations for diabetes (Type 2 diabetes mellitus as principal diagnosis).

Data reported for this measure:

- Data are not comparable across jurisdictions or within some jurisdictions over time (see footnotes for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2018-19 data are available for all jurisdictions.

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate more effective management of selected conditions in the primary and community healthcare sector and/or more effective preventative programs. Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions. For example, the underlying prevalence of conditions, patient compliance with management and older people's access to aged care services and other support.

10.2 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	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma Action Plan	An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional. Source: National Asthma Council Australia, 2019 <i>Australian Asthma Handbook</i> , Version 2.0. National Asthma Council Australia, Melbourne, accessed 18 October 2019: https://www.nationalasthma.org.au/health-professionals/asthma-action-plans

Cervical Screening Test	A Cervical Screening Test consists of a human papillomavirus (HPV) test with partial genotyping and, if the HPV test detects oncogenic HPV, liquid based cytology (LBC).
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 3 months or more. Clients may have more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Comparability	Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data are considered complete if all required data are available for all jurisdictions that provide the service.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Full time equivalent (FTE)	FTE (Full Time Equivalent) is a workforce specific method to estimate the workload of GPs. The method calculates a GP's workload based on the MBS services claimed as well as patient and doctor factors that affect the duration of a consultation. One GPFTE represents a 40 hour week per week for 46 weeks of the year. For each Medicare provider, the measure attributes an estimate of the amount of time they have spent on their claims compared to what would be worked by a full-time GP, including billable time, non-billable time, and non-clinical time.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander health.
General practitioner (GP)	Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.
GP-type services	Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.
<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2018).
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 Services Australia Medicare reimbursement.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (Department of Health 2013). On diagnosis of these diseases, there is a requirement to

	notify the relevant State or Territory health authority.
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 Services Australia Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Services Australia Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure used to detect pre-cancerous abnormalities of the cervix.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under Services Australia 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.
Primary Health Networks	Primary Health Networks (PHNs) are a national network of independent primary health care organisations (replacing Medicare Locals from 1 July 2015) designed to improve the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and improve care coordination, particularly for those with chronic and complex conditions.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence).
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A general practitioner or an individual, or body, endorsed by the Commonwealth, a State or Territory to administer vaccines in Australia.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the Services Australia 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.
Socio-Economic Indexes for Areas (SEIFA)	Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Each SEIFA quintile represents approximately 20 per cent of the national population, but does not necessarily represent 20 per cent of the population in each state or territory.
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).

10.3 References

Department of Health 2018, Questions about vaccination. <https://beta.health.gov.au/resources/publications/questions-about-vaccination> (accessed 16 November 2018).

— 2013, Australian national notifiable diseases list and case definitions, www.health.gov.au/internet/main/publishing.nsf/Content/cda_surveil-nndss-dislist.htm (accessed 8 January 2014).