Report on Government Services 2014

Volume E: Health

Steering Committee for the Review of Government Service Provision

ISSN 1328 181X
ISBN 978-1-74037-473-6 (Volume E)
ISBN 978-1-74037-476-7 (set)

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An appropriate citation for this paper is:

SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, *Report on Government Services 2014*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, *Report on Government Services 2014*, vol. E, *Health*, Productivity Commission, Canberra.

Foreword

It gives me great pleasure, as one of my tasks as the newly appointed Chairman of the Productivity Commission, to write this foreword on behalf of the Steering Committee for the Review of Government Service Provision, which I have chaired over the past year.

The Report on Government Services was commissioned in 1993 by Heads of Government (now COAG), to help drive improvements to government services. This is the nineteenth report in the series. The previous 15 reports were overseen by Gary Banks. Over those years, the Report grew in scope and content, becoming a comprehensive repository of comparative information on the equity, effectiveness, efficiency and outcomes of a wide range of services.

Improving government services is important to us all: everyone relies on these services at different stages and the services are particularly important for disadvantaged members of our society. Improving government services is also important economically: governments spent over $184 billion on the services covered by this Report, representing about 68.6 per cent of general government final consumption expenditure in 2012-13 — equivalent to around 12.1 per cent of Australia's gross domestic product.

In a break from previous practice, the Report is being released in electronic form only. To improve accessibility, the Report is being released in seven separate volumes across four days. All information previously included in the Report is available in the new format.

On behalf of the Steering Committee, I would like to thank the members of the twelve working groups that provide advice and input for this Report, and the statistical bodies that provide invaluable technical advice and assistance. I would also like to thank the Review Secretariat within the Productivity Commission, which supports the Steering Committee and working groups, and produces the Report.

Peter Harris
Chairman

January 2014

Contents

This Report is in seven volumes: Volume A contains Part A (Approach to performance reporting and Statistical context), Volume B contains Part B (Child care, education and training), Volume C contains Part C (Justice), Volume D contains Part D (Emergency management), Volume E contains Part E (Health), Volume F contains Part F (Community Services) and Volume G contains Part G (Housing and Homelessness).

Steering Committee

This Report was produced under the direction of the Steering Committee for the Review of Government Service Provision (SCRGSP). The Steering Committee comprises the following current members:

Mr Peter Harris	Chairman	Productivity Commission
Ms Madonna Morton	Aust Govt	Department of Prime Minister and Cabinet
Mr Peter Robinson	Aust Govt	Department of the Treasury
Mr Mark Thomann	Aust Govt	Department of Finance and Deregulation
Ms Janet Schorer	NSW	Department of Premier and Cabinet
Mr Rick Sondalini	NSW	NSW Treasury
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Ms Janelle Thurlby	QLD	Queensland Treasury
Ms Marion Burchell	WA	Department of the Premier and Cabinet
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Mr Chris McGowan	SA	Department of the Premier and Cabinet
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Ms Rebekah Burton	TAS	Department of Premier and Cabinet
Mr Geoffrey Rutledge	ACT	Chief Minister's Department
Mr Leigh Eldridge	NT	Department of the Chief Minister
Mr Bruce Michael	NT	Department of Treasury and Finance
Mr Peter Harper		Australian Bureau of Statistics
Mr David Kalisch		Australian Institute of Health and Welfare

People who also served on the Steering Committee during the production of this Report include:

Mr Kevin Cosgriff	NSW	NSW Treasury
Dr Meg Montgomery	NSW	Department of Premier and Cabinet
Mr Simon Kent	VIC	Department of Premier and Cabinet
Mr Shane McWhinney	VIC	Department of Premier and Cabinet
Mr Paul Cantrall	QLD	Department of Premier and Cabinet
Mr Coan Harvey	WA	Department of Treasury
Ms Pam Davoren	ACT	Chief Minister's Department
Mr Craig Graham	NT	Department of Treasury and Finance
Ms Jenny Coccetti	NT	Department of the Chief Minister

Acronyms and abbreviations

Abbreviations

AACR	Australasian Association of Cancer Registries
AAGR	average annual growth rates
AAT	Administrative Appeals Tribunal
AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	aged care assessment team
ACARA	Australian Curriculum and Assessment Reporting Authority
ACE	adult community education
ACECQA	Australian Children's Education and Care Quality Authority
ACER	Australian Council for Educational Research
ACFI	aged care funding instrument
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACOSS	Australian Council of Social Services
ACSAA	Aged Care Standards and Accreditation Agency
ACSES	The Australian Council of State Emergency Services

ACSQHC	Australian Commission for Safety and Quality in Health Care
ACT	Australian Capital Territory
ADL	activities of daily living
ADR	Alternative Dispute Resolution
AEDI	Australian Early Development Index
AFAC	Australasian Fire and Emergency Services Authorities Council
AFP	Australian Federal Police
AGCCC	Australian Government Census of Child Care Services
AGCCPS	Australian Government Child Care Provider Survey
AGPAL	Australian General Practice Accreditation Limited
AGSRC	Average Government School Recurrent Costs
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHS	Australian Health Survey
AHV	Aboriginal Housing Victoria
AIC	Australian Institute of Criminology
AICTEC	Australian Information and Communications Technology Education Committee
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIJA	Australian Institute of Judicial Administration
AIPAR	Australian Institute for Population Ageing Research
AJJA	Australasian Juvenile Justice Administrators

ALLS	Adult Literacy and Life Skills
ANZEMC	Australia-New Zealand Emergency Management Committee
ANZPAA	Australia and New Zealand Police Advisory Agency
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industrial Classification
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
AQF	Australian Qualifications Framework
AQFC	Australian Qualifications Framework Council
AR-DRG v 5.1	Australian refined diagnosis related group, version 5.1
AR-DRGs	Australian refined diagnosis related groups
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ARO	Authorised Review Officer
ASCED	Australian Standard Classification of Education
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
ASM	Active Service Model
ASO	ambulance service organisation
ASOC	Australian Standard Offence Classification
ASR	Age-standardised rate
ASSNP	core activity need for assistance
ASQA	Australian Skills Quality Authority

ATC	Australian Transport Commission
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BBF	Building a Better Future
BEACH	Bettering the Evaluation and Care of Health
BMI	Body Mass Index
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package
CAD	computer aided dispatch
CAEPR	Centre for Aboriginal Economic Policy Research
CALD	culturally and linguistically diverse
CAP	conditional adjustment payment
CAP	Crisis Accommodation Program
Cat. no.	Catalogue number
CAWG	Court Administration Working Group
CCB	Child Care Benefit
CCET	Child care, education and training
CCMS	Child Care Management System
CCR	Child Care Rebate
CCTR	Child Care Tax Rebate
CDC	Community Directed Care
CDC	consumer directed care
CD-ROM	Compact Disc Read Only Memory

CDSMAC	Community and Disability Services Ministers' Advisory Council
CEaCS	Childhood Education and Care Survey
CFA	Country Fire Authority
CFCs	Child and Family Centres
CGC	Commonwealth Grants Commission
CGRIS	Coordinator-General for Remote Indigenous Services
CHDSMC	Community, Housing and Disability Services Ministers' Conference
CHIP	Community Housing and Infrastructure Program
CHOS	Canadian National Occupancy Standard
CI	confidence interval
CIS	Complaints Investigation Scheme
CMHC	Community Mental Health Care
COAG	Council of Australian Governments
CPG	Court Practitioners Group
CPI	Consumer Price Index
CRA	Commonwealth Rent Assistance
CRC	COAG Reform Council
CR	Crude rate
CRS	Commonwealth Rehabilitation Services
CRS	Complaints Resolution Scheme
CRYPAR	Coordinated Response to Young People at Risk
CSASAW	Commonwealth-State Agreement for Skilling Australia's Workforce

CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file
DDHCS	Department of Disability, Housing and Community Services
DEEWR	Department of Education, Employment and Workplace Relations
DET	Department of Education (NSW)
DHAC	Department of Health and Aged Care
DHS	Department of Human Services
DHSH	Department of Human Services and Health
DIISRTE	Department of Industry, Innovation, Science, Research and Tertiary Education
DiRCS	Differences in Recorded Crime Statistics
DoCS	Department of Community Services (NSW)
DoHA	Department of Health and Ageing
DPEM	Department of Police and Emergency Management (Tas)
DPIE	Department of Primary Industries and Energy
DQI	data quality information
DSE	Department of Sustainability and Environment
DSS	Department of Social Services
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	EACH Dementia

ECEC	Early Childhood Education and Care
ECEC NMDS	Early Childhood Education and Care National Minimum Data Set
EMA	Emergency Management Australia
EMS	emergency medical service
ERP	estimated resident population
ESO	emergency services organisation
FaCS	Department of Family and Community Services
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FDC	family day care
FFR	Federal Financial Relations
FLAG	Flexible Learning Advisory Group
FSO	fire services organisation
FTE	full time equivalent
FWE	full time workload equivalent
FYA	Foundation for Young Australians
GDP	gross domestic product
GFS	Government Finance Statistics
GGFCE	General Government Final Consumption Expenditure
GP	general practitioner
GPII	General Practice Immunisation Incentives Scheme
GSAIG	Green Skills Agreement Implementation Group
GSP	gross state product
GSS	General Social Survey

GST	goods and services tax
HACC	Home and Community Care
HAF	Housing Affordability Fund
HDSC	Health Data Standards Committee
HECS	Higher Education Contribution Scheme
HELP	Higher Education Loan Program
HHWR	Hospitals and Health Workforce Reform
HILDA	Household Income and Labour Dynamic Australia
HIP	Home Independence Project
HMAC	Housing Ministers' Advisory Council
HOIST	New South Wales Population Health Survey 2007
HoTS	Heads of Treasuries
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD	International Classification of Diseases
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10
ICH	Indigenous community housing
ICHO	Indigenous Community Housing Organisation
ICT	information and communication technologies
IER	Indigenous Expenditure Report
IGA	Intergovernmental Agreement
IMR	Infant mortality rate

IPD	Implicit Price Deflator
IRG	Independent Reference Group
IRSD	Index of Relative Socio-economic Disadvantage
ISO	International Organisation for Standardisation
ISS	Inclusion Support Subsidy
JCIE	Joint Committee on International Education
JJ NMDS	Juvenile Justice National Minimum Data Set
JJ RIG	Juvenile Justice Research and Information Group
K10	Kessler Psychological Distress Scale
KPIs	key performance indicators
LBOTE	Language background other than English
LCL	lower confidence limit
LDC	long day care
LFS	Labour Force Survey
LGCSA	Local Government Community Services Association of Australia
LMO	local medical officer
LOTE	Language other than English
LSOP	Long Stay Older Patients
LSAC	Longitudinal Study of Australian Children
LSAY	Longitudinal Surveys of Australian Youth
MBI	Modified Barthel Index
MBS	Medicare Benefits Schedule
MCATSIA	Ministerial Council on Aboriginal and Torres Strait Islander Affairs

MCEECDYA	Ministerial Council for Education, Early Childhood Development and Youth Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCFFR	Ministerial Council on Federal Financial Relations
MCTEE	Ministerial Council of Tertiary Education and Employment
MFS	Metropolitan Fire Service
MHE	Mental Health Establishments
MHS	mental health services
MPS	multi-purpose services
NA	National Agreement
na	not available
NAHA	National Affordable Housing Agreement
NAP	National Assessment Program
NAPLAN	National Assessment Program — Literacy and Numeracy
NASWD	National Agreement for Skills and Workforce Development
NATESE	National Advisory for Tertiary Education, Skills and Employment
NMVTRC	National Motor Vehicle Theft Reduction Council
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCAG	National Corrections Advisory Group
NCCH	National Centre for Classification in Health

NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NCJSF	National Criminal Justice Statistical Framework
NCPASS	National Child Protection and Support Services data working group
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDA	National Disability Agreement
NDIS	National Disability Insurance Scheme
NEA	National Education Agreement
NEAT	Department of Natural Resources Environment and the Arts
NESB	non-English speaking background
NGOs	non-government organisations
NHA	National Healthcare Agreement
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHPAC	National Health Priority Action Council
NHPC	National Health Performance Committee
NHS	National Health Survey
NIA ECEC	National Information Agreement on Early Childhood Education and Care
NIDP	National Information Development Plan
NIHEC	National Indigenous Health Equality Council
NIRA	National Indigenous Reform Agreement

NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NMS	National Minimum Standard
NNDSS	National Notifiable Diseases Surveillance System
no.	number
NOOSR	National Office of Overseas Skills Recognition
NP	National Partnership
np	not published
NPAs	National Partnership Agreements
NPC	National Preschool Census
NP ECE Education	National Partnership Agreement on Early Childhood
NPMC	Navigation Projects Management Committee
NQA ITS	National Quality Agenda IT System
NQF	National Quality Framework
NQS	National Quality Standard
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NRSS	National Road Safety Strategy
NSCSP	National Survey of Community Satisfaction with Policing
NSOC	National Senior Officials Committee
NSSC	National Schools Statistics Collection
NSSC	National Skills Standards Council

NSMHS	National Standards for Mental Health Services
NSW RFS	New South Wales Rural Fire Service
NSW	New South Wales
NSWFB	New South Wales Fire Brigade
NT	Northern Territory
NTCE	Northern Territory Certificate of Education
NTES	National Territory Emergency Services
NVEAC	National VET Equity Advisory Council
NYPR	National Youth Participation Requirement
OCYFS	Office for Children, Youth and Family Support (ACT)
OECD	Organisation for Economic Co-operation and Development
OID	Overcoming Indigenous Disadvantage
OMP	other medical practitioner
OSHC	outside school hours care
OSR	Online services report
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PDF	Portable Document Format
PDWG	Performance and Data Working Group
PEP	Personal Enablement Program
PES	Post Enumeration Survey
PhARIA	Pharmacy Access/Remoteness Index of Australia
PIF	performance indicator framework

PIP	Practice Incentives Program
PIRLS	Progress in International Reading Literacy Study
PISA	Programme for International Student Assessment
PKI	Public Key Infrastructure
PSM	ABS Population Survey Monitor
PWI	personal wellbeing index
QE	Qualification Equivalents
QFRS	Queensland Fire and Rescue Service
QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QMF	Quality Management Framework
RACGP	Royal Australian College of General Practitioners
RAV	Rural Ambulance Victoria
RCS	resident classification scale
RFDS	Royal Flying Doctor Service
RISS	Remote and Indigenous Service Support
RoGS	Report on Government Services
ROSC	return of spontaneous circulation
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
S/TES	State/Territory Emergency Service

SA	South Australia
SAAP CAD	SAAP Coordination and Development Committee
SAAP NDCA	SAAP National Data Collection Agency
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Service
SCCHDS	Standing Council on Community, Housing and Disability Services
SCDC	Strategic Cross Sectoral Data Committee
SCOTESE	Standing Council on Tertiary Education, Skills and Employment
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SCSEEC	Standing Council for School Education and Early Childhood
SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SEIFA	Socio Economic Indexes for Areas
SEM	standard error of the mean
SES	socioeconomic status
SES	State Emergency Services
SHSC	Specialist Homelessness Services collection
SIQ	standard Indigenous question
SLA	statistical local area
SMHWB	National Survey of Mental Health and Wellbeing

SMR	standardised mortality ratios
SOMIH	State-owned and managed Indigenous housing
SPP	specific purpose payment or special purpose payment
SPRC	Social Policy Research Centre
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAC	Training Accreditation Council
TAFE	technical and further education
Tas	Tasmania
TAS	Tasmanian Ambulance Service
TCP	Transition Care Program
TEQSA	Tertiary Education Quality Standards Agency
TFS	Tasmania Fire Service
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
UCC	user cost of capital
UCL	upper confidence limit
UK	United Kingdom
URTI	upper respiratory tract infection
USAR	Urban Search and Rescue
USA	United States of America
U-Turn	U-Turn diversionary program for young motor vehicle offenders
VCAT	Victorian Civil and Administrative Tribunal

VET	vocational education and training
VF	ventricular fibrillation
VHC	Veterans' Home Care
Vic	Victoria
VRQA	Victorian Registration Quality Authority
VT	ventricular tachycardia
WA	Western Australia
WGIR	Working Group on Indigenous Reform
WHO	World Health Organisation
YAT	Youth Attainment and Transitions
YPIRAC	Younger people in residential aged care

Glossary

Access	Measures how easily the community can obtain a delivered service (output).
Appropriateness	Measures how well services meet client needs and also seeks to identify the extent of any underservicing or overservicing.
Constant prices	See 'real dollars'.
Cost effectiveness	Measures how well inputs (such as employees, cars and computers) are converted into outcomes for individual clients or the community. Cost effectiveness is expressed as a ratio of inputs to outcomes. For example, cost per life year saved is a cost effectiveness indicator reflecting the ratio of expenditure on breast cancer detection and management services (including mammographic screening services, primary care, chemotherapy, surgery and other forms of care) to the number of women's lives that are saved.
Current prices	See 'nominal dollars'.
Descriptors	Descriptive statistics included in the Report that relate, for example, to the size of the service system, funding arrangements, client mix and the environment within which government services are delivered. These date are provided to highlight and make more transparent the differences among jurisdictions.
Effectiveness	Reflects how well the outputs of a service achieve the stated objectives of that service (also see program effectiveness).
Efficiency	Reflects how resources (inputs) are used to produce outputs and outcomes, expressed as a ratio of outputs to inputs (technical efficiency), or inputs to outcomes (cost effectiveness). (Also see 'cost effectiveness' and 'technical efficiency'.)

Equity	Measures the gap between service delivery outputs or outcomes for special needs groups and the general population. Equity of access relates to all Australians having adequate access to services, where the term adequate may mean different rates of access for different groups in the community (see chapter 1 for more detail).
Inputs	The resources (including land, labour and capital) used by a service area in providing the service.
Nominal dollars	Refers to financial data expressed 'in the price of the day' and which are not adjusted to remove the effects of inflation. Nominal dollars do not allow for inter-year comparisons because reported changes may reflect changes to financial levels (prices and/or expenditure) and adjustments to maintain purchasing power due to inflation.
Output	The service delivered by a service area, for example, a completed episode of care is an output of a public hospital.
Outcome	The impact of the service on the status of individuals or a group, and the success of the service area in achieving its objectives. A service provider can influence an outcome but external factors can also apply. A desirable outcome for a school, for example, would be to add to the ability of the students to participate in, and interact with, society throughout their lives. Similarly, a desirable outcome for a hospital would be to improve the health status of an individual receiving a hospital service.
Process	Refers to the way in which a service is produced or delivered (that is, how inputs are transformed into outputs).
Program effectiveness	Reflects how well the outcomes of a service achieve the stated objectives of that service (also see effectiveness).
Quality	Reflects the extent to which a service is suited to its purpose and conforms to specifications.

Real dollars	Refers to financial data measured in prices from a constant base year to adjust for the effects of inflation. Real dollars allow the inter-year comparison of financial levels (prices and/or expenditure) by holding the purchasing power constant.
Technical efficiency	A measure of how well inputs (such as employees, cars and computers) are converted into service outputs (such as hospital separations, education classes or residential aged care places). Technical efficiency reflects the ratio of outputs to inputs. It is affected by the size of operations and by managerial practices. There is scope to improve technical efficiency if there is potential to increase the quantity of outputs produced from given quantities of inputs, or if there is potential to reduce the quantities of inputs used in producing a certain quantity of outputs.
Unit costs	Measures average cost, expressed as the level of inputs per unit of output. This is an indicator of efficiency.

Terms of Reference

The Report on Government Services

Outputs and objectives

1. The Steering Committee will measure and publish annually data on the equity, efficiency and cost effectiveness of government services through the Report on Government Services (ROGS).
2. The ROGS facilitates improved service delivery, efficiency and performance, and accountability to governments and the public by providing a repository of meaningful, balanced, credible, comparative information on the provision of government services, capturing qualitative as well as quantitative change. The Steering Committee will seek to ensure that the performance indicators are administratively simple and cost effective.
3. The ROGS should include a robust set of performance indicators, consistent with the principles set out in the Intergovernmental Agreement on Federal Financial Relations; and an emphasis on longitudinal reporting, subject to a program of continual improvement in reporting.
4. To encourage improvements in service delivery and effectiveness, ROGS should also highlight improvements and innovation.

Steering Committee authority

5. The Steering Committee exercises overall authority within the ROGS reporting process, including determining the coverage of its reporting and the specific performance indicators that will be published, taking into account the scope of National Agreement reporting and avoiding unnecessary data provision burdens for jurisdictions.
6. The Steering Committee will implement a program of review and continuous improvement that will allow for changes to the scope of the ROGS over time, including reporting on new service areas and significant service delivery areas that are jurisdiction-specific.

Reporting to COAG

7. The Steering Committee will review the ROGS every three years and advise COAG on jurisdictions' compliance with data provision requirements and of potential improvements in data collection. It may also report on other matters, for example, ROGS's scope, relevance and usefulness; and other matters consistent with the Steering Committee's terms of reference and charter of operations.

E Health sector overview

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this sector overview by an 'EA' prefix (for example, table EA.1). A full list of attachment tables is provided at the end of this sector overview, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

E.1 Introduction

This sector overview provides an introduction to the Public hospitals (chapter 10), Primary and community health (chapter 11), and Mental health management (chapter 12) chapters of this Report. It provides an overview of the health sector, presenting both contextual information and high level performance information.

Major improvements in reporting in health this year are identified in each of the service-specific health chapters.

Health services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, the detection and

treatment of illness and injury, and the rehabilitation and palliative care of individuals who experience illness and injury. The health system also includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury.

Policy context

All levels of government in Australia fund, deliver and regulate health services, with most of the activity performed by the Australian, State and Territory governments. The Australian Government's health services activities include:

- funding State and Territory governments to assist with the cost of providing public hospital services in line with the National Health Reform Agreement and the National Healthcare Agreement (NHA)
- providing rebates to patients and regulating medical services provided by General Practitioners (GPs) and specialists, practice nurses, and some services provided by allied health professionals (such as Medicare), and delivering public health programs
- funding and regulating the Pharmaceutical Benefits Scheme (PBS)
- funding and regulating private health insurance rebates
- funding improved access to primary health care, including Indigenous-specific primary health, specialist services and infrastructure for rural and remote communities
- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
- funding hospital services and the provision of other services through the Department of Veterans' Affairs
- funding hearing services for eligible Australians through the Australian Government Hearing Services Program
- funding the Medicare Safety Net.

State and Territory governments contribute funding for, and deliver, a range of health care services (including services specifically for Indigenous Australians) such as:

- community health services
- mental health programs

- specialist palliative care
- public hospital services
- public dental services
- patient transport
- health policy research and policy development
- public health (such as health promotion programs and disease prevention)
- the regulation, inspection, licensing and monitoring of premises, institutions and personnel.

Local governments are generally involved in environmental control and a range of community-based and home care services, although the exact nature of their involvement varies across jurisdictions. The non-government sector plays a significant role in the health system, delivering general practice and specialist medical and surgical services, dental services, a range of other allied health services (such as optometry and physiotherapy) and private hospitals.

Sector scope

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings. This Report primarily concentrates on the performance of public hospitals (chapter 10), primary and community health services (including general practice) (chapter 11) and mental health management (chapter 12). These services are selected for reporting as they:

- make an important contribution to the health of the community
- reflect government priorities, for example, they fall within the National Health Priority Areas
- represent significant components of government expenditure on healthcare
- have common objectives across jurisdictions.

High level residential aged care services and patient transport (ambulance) services are not covered in the health chapters in this Report, but are reported separately in chapter 13 ('Aged care services') and chapter 9 ('Fire, road rescue and ambulance').

Other major areas of government involvement in health provision not covered in the health chapters, or elsewhere in the Report, include:

- public health programs, other than those for mental health
- funding for specialist medical practitioners.

Profile of health sector

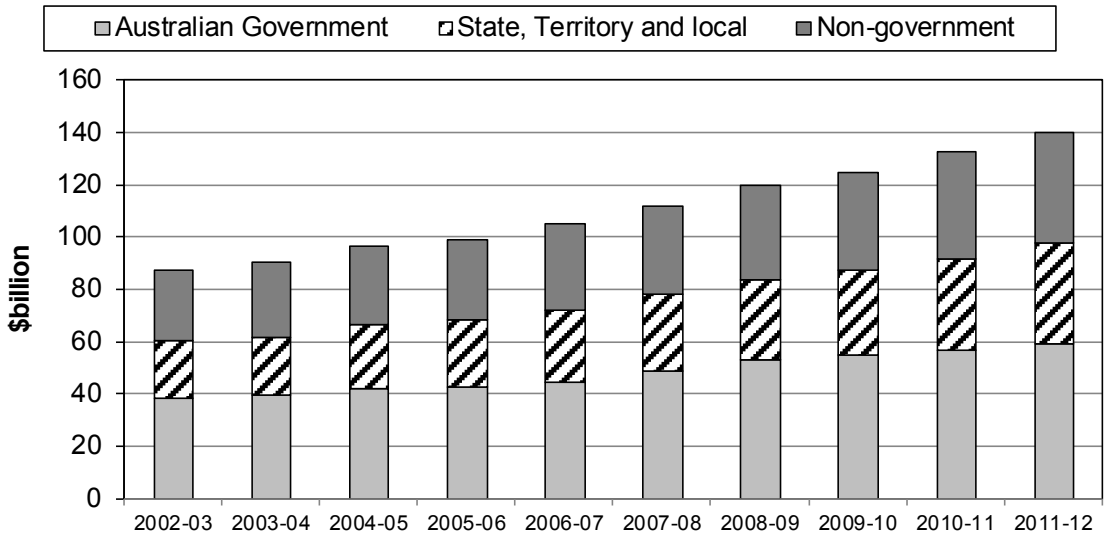
Detailed profiles for the services within the health sector are reported in chapters 10, 11 and 12, and cover health service funding and expenditure as well as the size and scope of the individual service types.

Descriptive statistics

Descriptive statistics for the health sector are included in this section. Additional descriptive data for each jurisdiction are presented in tables EA.5–EA.6.

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $140.2 billion in 2011-12 (figure E.1). This total was estimated to account for 9.5 per cent of gross domestic product in 2011-12, an increase of 1.7 percentage points from the 7.8 per cent of GDP in 2002-03 (AIHW 2013a).

Figure E.1 **Total health expenditure, by source of funds (2011-12 dollars)[a, b, c, d]**



[a] Includes recurrent and capital expenditure. [b] Includes expenditure on ambulance services (reported in chapter 9). [c] Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. [d] 'Non-government' includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers.

Source: AIHW 2013, *Health Expenditure Australia 2011-12*, Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59, Canberra; Table EA.1.

In 2011-12, the health expenditure of the Australian, State and Territory, and local governments was $97.8 billion, which represented 69.7 per cent of total health expenditure within Australia. The Australian Government accounted for the largest

proportion of health care expenditure — $59.5 billion or 42.4 per cent of the total in 2011-12. State and Territory, and local governments contributed $38.3 billion or 27.3 per cent of total health expenditure in that year (AIHW 2013a). The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers (tables EA.1 to EA.7).

Between 2002-03 and 2011-12, the average annual rate of growth in real expenditure was 4.9 per cent for the Australian Government, 6.8 per cent for State, Territory and local governments, and 5.0 per cent for non-government sources (table EA.1).[1]

The Health chapters (Part E) provide performance information on Australian, State and Territory, and local governments health services that account for $77.4 billion of total recurrent health expenditure (or 84.3 per cent of all government recurrent expenditure on health in 2011-12) (table EA.4). The services covered are:

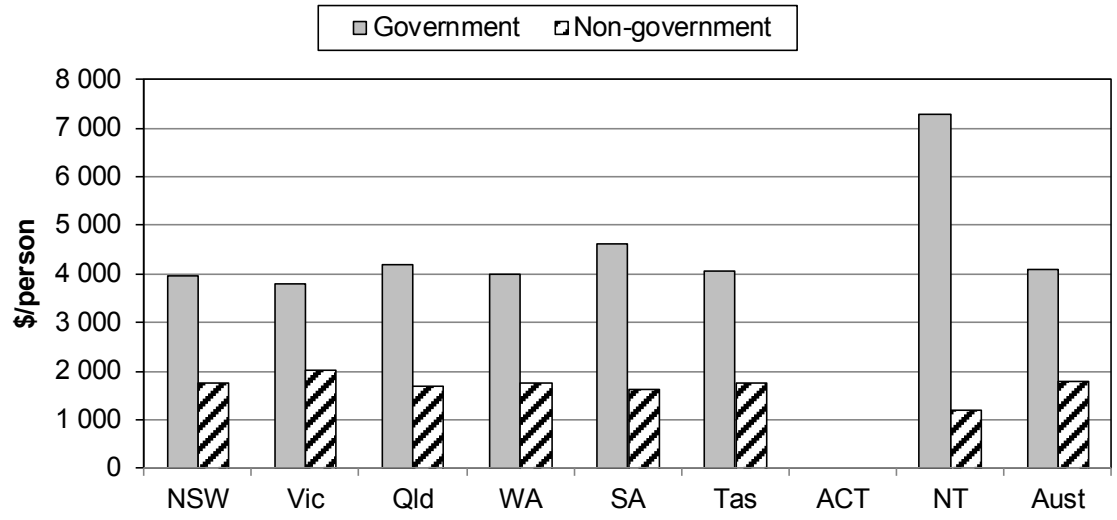
- public hospitals (chapter 10)
- primary and community health (chapter 11) — medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services
- specialist mental health services (chapter 12) — recurrent expenditure estimated to be around $7.0 billion in 2011-12 (table 12A.4).

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure per person in Australia increased from $4474 in 2002-03 to $6230 in 2011-12 (expressed in 2011-12 dollars) (table EA.5). Government real recurrent health expenditure per person in Australia increased from $2985 in 2002-03 to $4079 in 2011-12 (expressed in 2011-12 dollars). Non-government recurrent expenditure per person in Australia rose from $1259 in 2002-03 to $1802 in 2011-12 (expressed in 2011-12 dollars) (figure E.2 and table EA.6).

In 2010-11, Australian, State and Territory government total expenditure on health for Indigenous Australians was $4.2 billion (AIHW 2013b; table E.1). Health expenditure by area of expenditure in 2010-11 is presented for Indigenous and non-Indigenous Australians in table E.2.

[1] There was a break in series due to differences in definitions of public hospital and public hospital services between 2002-03 and 2003-04.

Figure E.2 **Recurrent health expenditure per person, by source of funds, 2011-12** [a, b, c]



[a] Includes expenditure on ambulance services (reported in chapter 9). [b] Government expenditure includes expenditure by the Australian, State, Territory and local governments. [c] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditure for NSW residents, and the ACT population is not the appropriate denominator. [d] Excludes expenditure on high level residential aged care.

Source: AIHW 2013, *Health Expenditure Australia 2011-12*, Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59, Canberra; Table EA.6.

Table E.1 **Health funding for Indigenous and non-Indigenous Australians by source of funding, 2010-11**

Source of funding	*Amount ($ million)*			
	Indigenous	*Non-Indigenous*	*Total*	*Indigenous share (%)*
State and Territory governments	2 119.2	28 172.0	30 291.2	7.0
Australian Government	2 040.7	52 967.2	55 007.8	3.7
Direct Australian Government	1 245.0	33 078.3	34 323.3	3.6
Indirect through Australian State/Territory governments	746.1	13 493.9	14 240.0	5.2
Indirect through non-government[a]	49.6	6 394.9	6 444.5	0.8
All governments	4 159.9	81 139.2	85 299.0	4.9
Non-government	392.1	37 964.9	38 357.1	1.0
Total health	**4 552.0**	**119 104.1**	**123 656.1**	**3.7**

[a] Includes private health insurance rebates for all Australians. Also includes Specific Purpose Payments covering highly specialised drugs in private hospitals and other payments.

Source: AIHW 2013, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010–11,* Health and Welfare Expenditure Series no. 48. Cat. no. HWE 57, Canberra.

Table E.2 **Expenditure on health services for Indigenous and non-Indigenous Australians, 2010-11**

	Expenditure ($ million)				*Expenditure per person ($)*		
Area of expenditure	*Indigenous*	*Non-Indigenous*	*Total*	*Indigenous share (%)*	*Indigenous*	*Non-Indigenous*	*Ratio*
Total hospital services	2 178.0	47 527.6	49 705.7	4.4	3 825.6	2 169.4	1.8
Public hospitals[a]	2 067.4	36 870.4	38 937.8	5.3	3 631.3	1 683.0	2.2
Admitted patients[b]	1 748.7	31 106.6	32 855.4	5.3	3 071.6	1 419.9	2.2
Non-admitted patients	333.0	5 749.4	6 082.4	5.5	584.9	262.4	2.2
Private hospitals[c]	110.7	10 657.3	10 767.9	1.0	194.4	486.5	0.4
Patient transport	183.4	2 601.4	2 784.7	6.6	322.1	118.7	2.7
Medical	376.3	22 148.2	22 524.5	1.7	660.9	1 011.0	0.7
Medicare	286.0	17 380.7	17 666.8	1.6	502.4	793.3	0.6
Other	90.2	4 767.5	4 857.7	1.9	158.5	217.6	0.7
Dental	84.8	7 780.8	7 865.5	1.1	148.9	355.2	0.4
Community health[d]	1 119.6	5 172.0	6 291.6	17.8	1 966.5	236.1	8.3
Other professional	43.8	4 053.4	4 097.2	1.1	77.0	185.0	0.4
Public health	185.7	1 810.3	1 996.1	9.3	326.2	82.6	4.0
Medications	209.9	18 215.2	18 425.0	1.1	368.7	831.4	0.4
Aids and appliances	15.2	3 616.6	3 631.8	0.4	26.7	165.1	0.2
Research	124.2	4 158.5	4 282.7	2.9	218.2	189.8	1.2
Health administration	31.1	2 020.1	2 051.2	1.5	54.6	92.2	0.6
Total health	**4 552.0**	**119 104.1**	**123 656.1**	**3.7**	**7 995.4**	**5 436.5**	**1.5**

[a] Excludes dental services, patient transport services, community health services, public health and health research undertaken by the hospital. [b] Admitted patient expenditure estimates are adjusted for Aboriginal and Torres Strait Islander under-identification. [c] Includes State/Territory governments' expenditure for services provided for public patients in private hospitals. The estimates are not comparable to previous estimates due to improved methodology. [d] Includes other recurrent expenditure on health not elsewhere classified, such as family planning previously reported under 'Other health services (n.e.c.)'. State and Territory expenditure on Closing the Gap initiatives have been allocated to this category for the first time.

Source: AIHW 2013, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11,* Health and Welfare Expenditure Series no. 48. Cat. no. HWE 57, Canberra.

Factors affecting demand for services

Health status is linked to demand for health services and is associated with a range of demographic and socioeconomic factors. Financial, educational, geographic and cultural barriers can reduce access to health services and contribute to poorer health outcomes.

Social and economic factors

It has been well documented that people who experience social and economic disadvantage are at risk of negative health outcomes. Compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives (AIHW 2012). Those who are disadvantaged tend to have greater health risks such as smoking more and higher rates of obesity (SCRGSP 2012). Burden-of-disease studies indicate greater burden among people who are relatively disadvantaged in society (Begg et al. 2007). Those who are disadvantaged are more likely to report their health as fair or poor than those that do not suffer the same disadvantage as measured by the Socio Economic Indexes for Areas (SEIFA).

Higher income and wealth are associated with better health. People with higher income are better able to access health services in a timely manner, and are also able to access goods and services that have health benefits such as better housing, food and other healthy pursuits (AIHW 2012). People with higher education levels, which are also associated with higher incomes and better access to health care, are likely to have better health (AIHW 2012).

Geographic location

Geographic distance to health services, particularly in remote and very remote areas, can contribute to poor health. People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities (AIHW 2012). Those in remote areas are more likely to report their health as fair or poor and less likely to report their health as excellent, very good or good than those in major cities.

Nationally, 2.3 per cent of the population lived in remote and very remote areas in 2012 (table 2A.12). Those living in remote and very remote areas made up less than 7 per cent of the population in each State and Territory except the NT, where the figure was 43.9 per cent — 20.8 per cent in remote and 23.1 per cent in very remote areas.

Indigenous status

Indigenous Australians are generally less healthy than other Australians, die at much younger ages, and have more disability and a lower quality of life (AIHW 2012; tables EA.35 and EA.37). Many Indigenous Australians live in conditions of social and economic disadvantage — a recent study found socioeconomic disadvantage to be the leading health risk for Indigenous Australians in the NT, accounting for 42 to 54 per cent of the life expectancy gap between Indigenous and non-Indigenous Australians (Zhao *et al*. 2013). Indigenous Australians have low employment and income levels when compared to non-Indigenous Australians (see chapter 2 Statistical context p. 2.2; tables 2A.23–2A.25; tables 2A.34–2A.36; SCRGSP 2011). Indigenous Australians have relatively high rates for many health risk factors and are more likely to smoke and to consume alcohol at risky levels (ABS 2013a; SCRGSP 2011; Zhao *et al*. 2013). Indigenous Australians are more likely to live in inadequate and overcrowded housing (SCRGSP 2011) and in remote areas with more limited access to health services. In 2006, 51 992 Indigenous Australians were living in discrete Indigenous communities that were 100 kilometres or more from the nearest hospital (ABS 2007).

Nationally, 3.0 per cent of the total population identified as Indigenous in 2011. Those identifying as Indigenous made up less than 5 per cent of the population in each State and Territory except the NT, where the figure was 29.8 per cent (tables 2A.1 and 2A.15).

Service-sector objectives

Government involvement in health services is predicated on the desire to improve the health of all Australians and to ensure equity of access and the sustainability of the Australian health system. Box E.1 presents the overall objectives of the health system as summarised for this Report, which are consistent with the objectives outlined in the National Healthcare Agreement (MCFFR 2012). Governments provide a variety of services in different settings to fulfil these objectives.

Box E.1 **Overall objectives of the health system**

Government involvement in the health system is aimed at efficiently and effectively improving health outcomes for all Australians and ensuring the sustainability of the Australian health system, achieving the following outcomes:

- Australians are born and remain healthy
- Australians receive appropriate high quality and affordable primary and community health services
- Australians receive appropriate high quality and affordable hospital and hospital related care
- Australians have positive health care experiences which take account of individual circumstances and care needs
- Australians have a health system that promotes social inclusion and reduces disadvantage, especially for Indigenous Australians
- Australians have a sustainable health system.

Measuring the equity, effectiveness and efficiency of Australia's health system is a complex task. It must account for the performance of a range of services (such as prevention and medical intervention) and service providers (such as community health centres, GPs and public hospitals), and account for the overall outcomes generated by the health system. The appropriate mix of services — including the prevention of illness and injury, and medical treatment (prevention versus medical intervention) — and the appropriate mix of service delivery mechanisms (community-based versus hospital-based) plays an important role in determining outcomes. Other relevant factors are external to the health system, such as the socioeconomic and demographic characteristics of the population, available infrastructure and the environment.

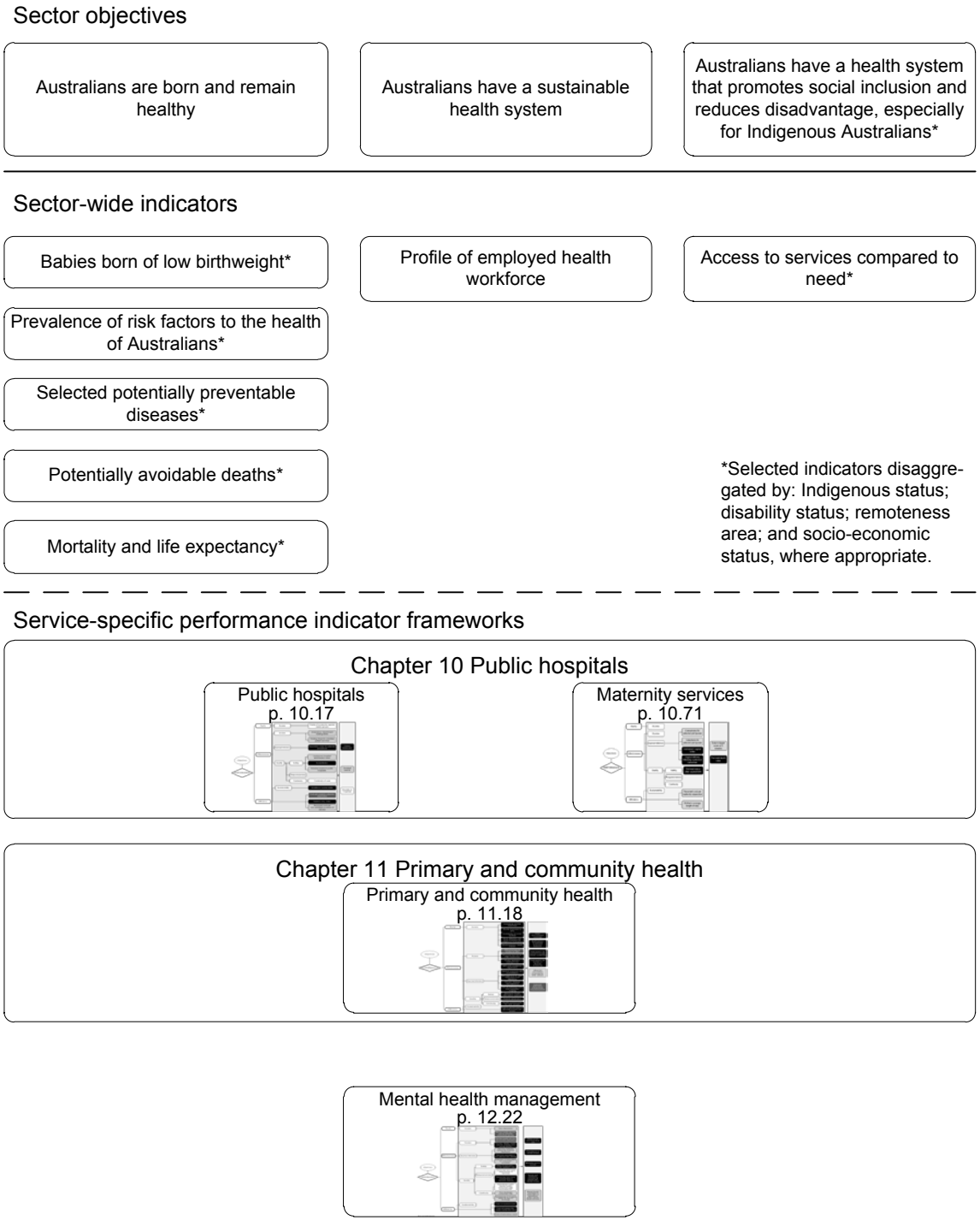
E.2 Sector performance indicator framework

This sector overview is based on a sector performance indicator framework (figure E.3). This framework is made up of the following elements:

- Sector objectives — three sector objectives are a précis of the key objectives of the health system and reflect the outcomes in the NHA (box E.1).
- Sector-wide indicators — seven sector-wide indicators relate to the overarching service sector objectives identified in the NHA.
- Information from the service-specific performance indicator frameworks that relate to health services. Discussed in more detail in chapters 10, 11 and 12, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

This sector overview provides an overview of relevant performance information. Chapters 10, 11 and 12 and their associated attachment tables provide more detailed information.

Figure E.3 **Health services sector 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 Australian Bureau of Statistics (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 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

Sector-wide performance indicators

This section includes high level indicators of health outcomes. Many factors are likely to influence outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and delivery of government services.

Babies born of low birth weight

'Babies born of low birth weight' is an indicator of governments' objective that Australians are born and remain healthy (box E.2). The birth weight of a baby is an important indicator of its health status and future wellbeing. Low birth weight babies have a greater risk of poor health and dying, require a longer period of hospitalisation after birth, and are more likely to develop significant disabilities (Goldenberg & Culhane 2007).

Box E.2 **Low birth weight of babies**

Babies' birth weight is defined as low if they weigh less than 2500 grams, very low if they weigh less than 1500 grams and extremely low if they weigh less than 1000 grams (AIHW and Li et al. 2013).

A low or decreasing number of low birth weight babies is desirable.

Factors external to the health system also have a strong influence on the birth weight of babies. Some factors contributing to low birth weight include socioeconomic status, size of parents, age of mother, number of babies previously born, mother's nutritional status, smoking and alcohol intake, and illness during pregnancy (Li et al. 2011).

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 2011 data are available for all jurisdictions.

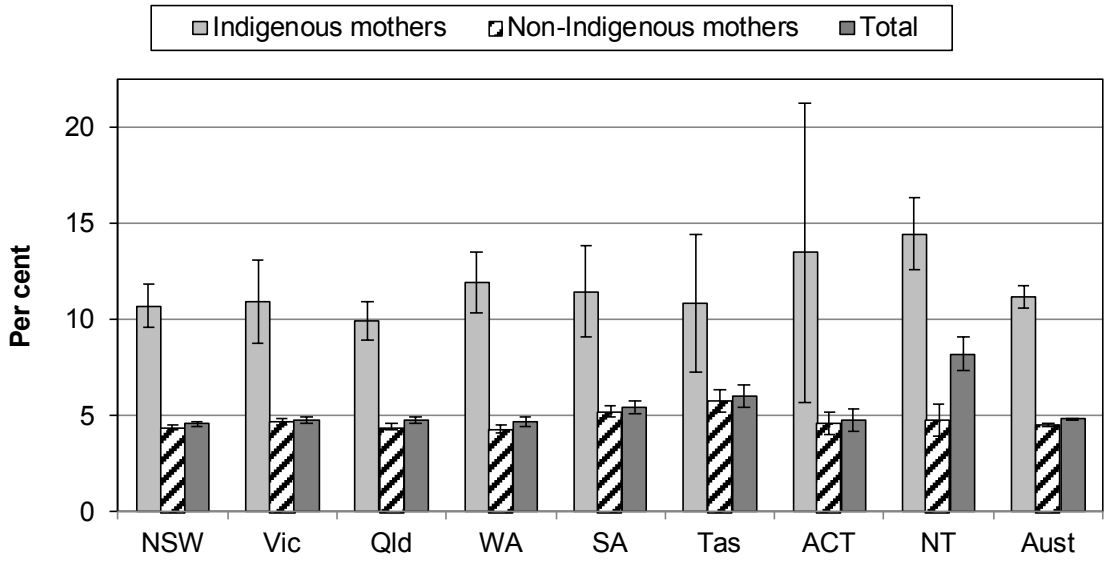
Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

In 2011, 93.7 per cent of liveborn babies in Australia weighed 2500 grams or over (AIHW and Li et al. 2013). The average birth weight for all live births was 3367 grams in 2011 (table EA.8). In 2011, 6.3 per cent of all liveborn babies in Australia weighed less than 2500 grams. This included 1.0 per cent of babies with a very low birth weight — less than 1500 grams (table EA.8).

Nationally, rates of low birth weight babies increased with remoteness, from 4.6 per cent in major cities, rising to 5.3 per cent in outer regional areas, and 9.3 per cent in very remote areas in 2011 (table EA.11).

Nationally, the average birth weight for liveborn babies of Indigenous mothers was 3187 grams in 2011 (table EA.9). Among live-born singleton babies born to Indigenous mothers in 2011, the proportion with low birth weight was twice that of those born to non-Indigenous mothers (figure E.4).

Figure E.4 **Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2011**[a, b, c, d, e]



[a] Low birth weight is defined as less than 2500 grams. [b] Disaggregation by State/Territory is by place of usual residence of the mother. [c] Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated. [d] Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birth weight. [e] Birth weight data on babies born to Indigenous mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.

Source: AIHW (unpublished) National Perinatal Data Collection; table EA.10.

Prevalence of risk factors to the health of Australians

'Prevalence of risk factors to the health of Australians' is an indicator of governments' objective that Australians are born and remain healthy (box E.3).

A number of behaviours create risks to health outcomes; for example, lack of exercise, smoking, excessive alcohol consumption, sun exposure and unhealthy dietary habits. Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is reducing health risk factors through activities that raise awareness of health issues to reduce the risk and onset of illness and injury.

Box E.3 **Prevalence of risk factors to the health of Australians**

'Prevalence of risk factors to the health of Australians' is defined by the following measures:

- Prevalence of overweight and obesity — the number of people with a Body Mass Index (BMI) in the categories of either overweight or obese, as a percentage of the population. BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to World Health Organization and National Health and Medical Research Council guidelines.

  Among adults, a BMI of 25 to less than 30 is considered overweight and a BMI of 30 and over is considered to be obese (WHO 2000; NHMRC 2013).

  Children are defined as people aged 5–17 years. For children, obesity is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.
- Rates of current daily smokers — number of people aged 18 years or over who smoke tobacco every day as a percentage of the population aged 18 years or over.
- Risk of alcohol related harm over a lifetime — people aged 18 years or over assessed as having an alcohol consumption pattern that puts them at risk of long-term alcohol related harm, as a percentage of the population aged 18 years or over.

  'Lifetime risk of alcohol related harm' is defined according to the 2009 National Health and Medical Research Council guidelines: for males and females, no more than two standard drinks on any day. This has been operationalised as: for both males and females, an average of more than 2 standard drinks per day in the last week.

Rates for all three measures are age standardised.

A low or decreasing rate is desirable for each health risk factor.

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 2011–2013 data are available for all jurisdictions.

Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

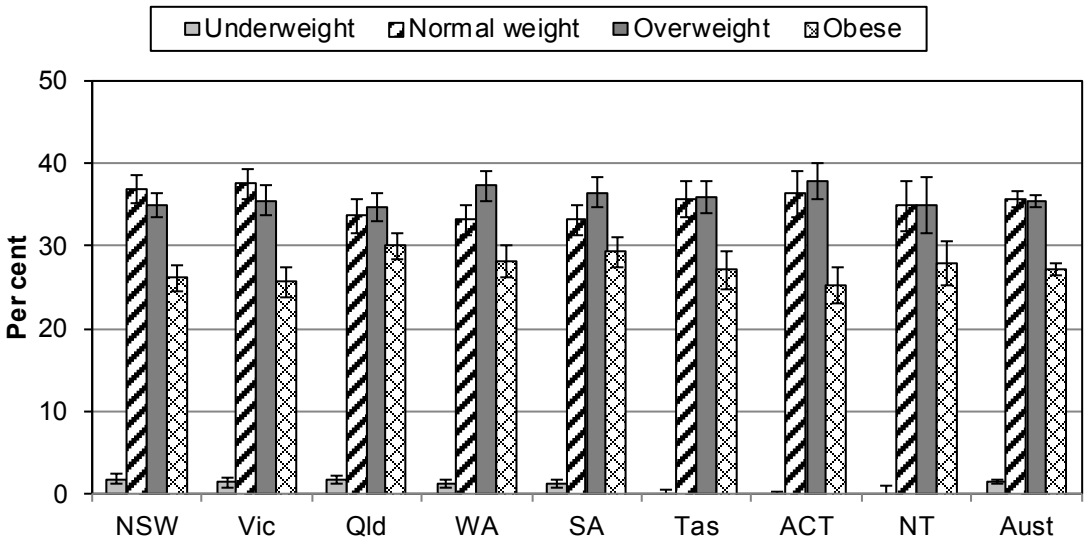
Prevalence of overweight and obesity

Being overweight or obese increases the risk of an individual developing, among other things, heart disease, stroke and Type 2 diabetes. In 2011-12, over a third of Australians' measured BMI was in the overweight range and over a quarter were obese (figure E.5; table EA.12).

The percentage of adults who were overweight or obese tended to be higher in remote (70.1 per cent) and outer regional areas (67.8 per cent), than in major cities

(60.9 per cent) in 2011-12 (table EA.13). The percentage of people who were overweight or obese increased from 2007-08 in all areas of Australia (table EA.13).

Figure E.5 **Proportion of adults in BMI categories, 2011-12[a, b, c, d, e, f]**



[a] Adults are defined as people aged 18 years and over. [b] Obesity for adults is defined as BMI equal to or greater than 30. [c] Measured people only. [d] Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population. [e] Data have been revised and may differ from data published in the 2013 Report. [f] Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished), *Australian Health Survey 2011–13* (2011-12 Core component); table EA.12.

The percentage of people who were overweight or obese tended to be higher in older age groups, peaking at age 70–74 for males and females (83.8 per cent and 74.0 per cent respectively) in 2011-12. Overall, the percentage of males and females that were overweight or obese increased from 2007-08 (by 2.1 percentage points for males and 0.9 percentage points for females) although the change varied by age category (table EA.15).

Nationally, the rate of overweight and obesity was higher for Indigenous adults (71.4 per cent) than for non-Indigenous adults (62.6 per cent) in 2011–13 (table EA.16). Data for the rate of overweight and obesity for children by Indigenous status are reported in table EA.18.

Rates of current daily smokers

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2011 (ABS 2013b). Smoking

is responsible for around 80 per cent of all lung cancer deaths and 20 per cent of all cancer deaths (HealthInsite 2011).

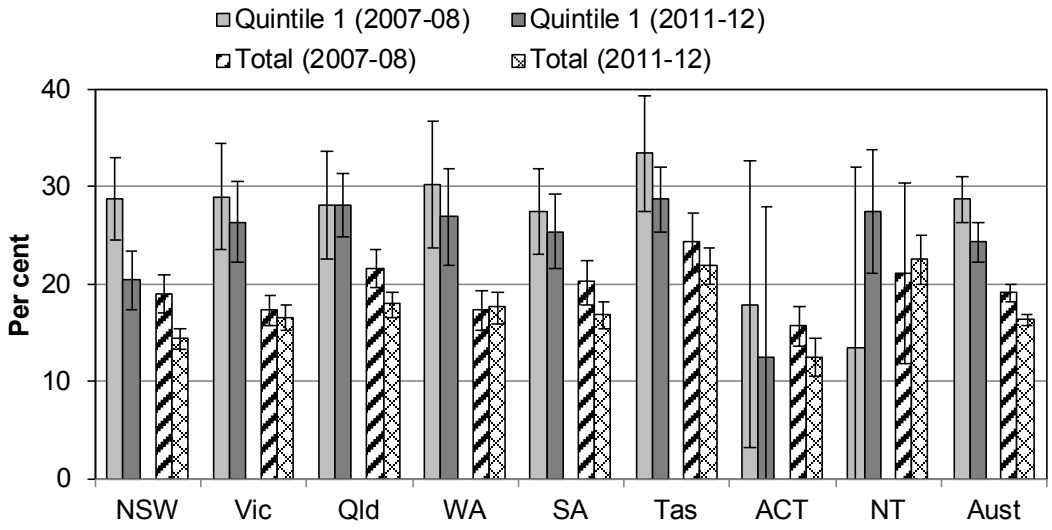
The proportion of adult daily smokers aged 18 years and over accounted for 16.3 per cent of the population in 2011-12, a decrease of 2.8 percentage points from 2007-08 (figure E.6 and table EA.19).

Nationally, people from more disadvantaged socioeconomic backgrounds have a higher propensity to smoke (age standardised). In 2011-12, 24.3 per cent of adults living in areas from the first quintile of the SEIFA — the areas of greatest relative disadvantage — were daily smokers, compared with 9.0 per cent from the fifth quintile — the areas of least relative disadvantage — (figure E.6 and table EA.20).

Adults from more remote locations also had a higher propensity to smoke (age standardised). In 2011-12, daily smokers accounted for 26.1 per cent of the population in remote geographical areas, gradually decreasing as remoteness of residence decreases, accounting for 22.6 per cent of the population in outer regional areas, 19.5 per cent in inner regional areas and 14.7 per cent in major cities (table EA.19).

Nationally, Indigenous Australians had higher age-standardised rates of daily smoking (41.2 per cent) than non-Indigenous Australians (16.0 per cent) in 2011–13 (table EA.21).

Figure E.6 **Proportion of adults who are daily smokers, by State and Territory[a, b, c, d, e, f]**



[a] Rates for total are age-standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). [b] A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general. [c] Total includes persons for whom an Index of disadvantage of residence score was not known. [d] 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. [e] Data for 2011-12 have been revised and differ from data published in the 2013 Report. [f] Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

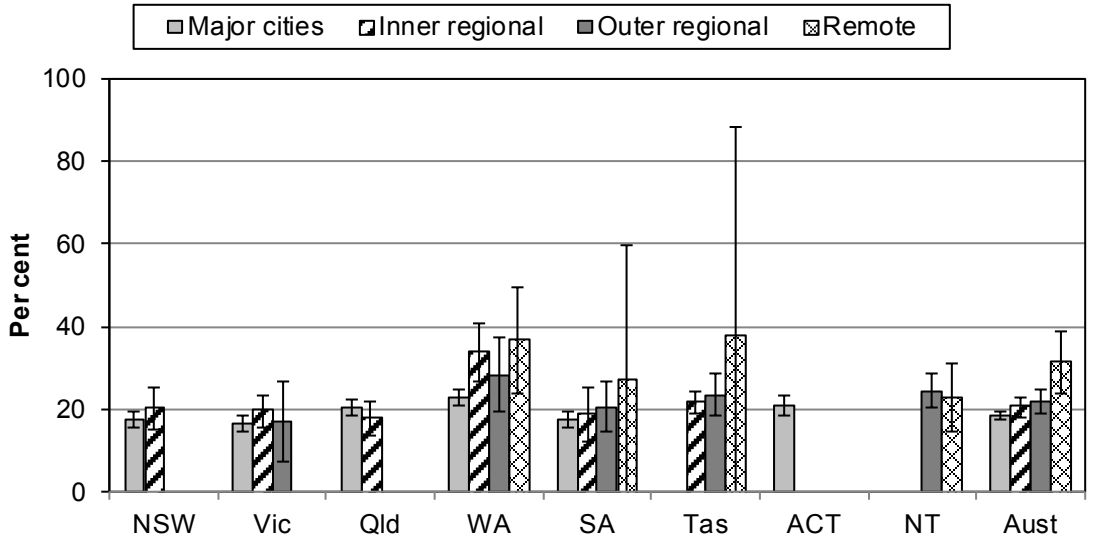
Source: ABS (unpublished), *Australian Health* Survey *2011-13* (2011-12 Core component)*;* ABS (unpublished) *National Health Survey 2007-08*; table EA.19.

Levels of risky alcohol consumption

The National Health and Medical Research Council (NHMRC) reports that excessive long term alcohol consumption increases the risk of heart disease, diabetes, liver cirrhosis and some types of cancers. It can contribute to injury and death through accidents, violence, suicide and homicide, and also to financial problems, family breakdown, and child abuse and neglect (NHMRC 2009).

Rates are based on the 2009 NHMRC guidelines for reducing risks from drinking alcohol (NHMRC 2009). Across Australia, 19.4 per cent of adults were at risk of alcohol related harm over a lifetime in 2011-12, although the age standardised rates varied among jurisdictions (table EA.22). Adults who are at risk of alcohol related harm over a lifetime gradually decreased as remoteness of residence decreased in 2011-12 (figure E.7). There is no statistically significant difference between socioeconomic categories of the proportion of Australians at risk of alcohol related harm over a lifetime (table EA.23).

Figure E.7 **Proportion of adults at risk of alcohol related harm over a lifetime, by remoteness, 2011-12[a, b, c, d, e]**



[a] Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time. [b] Rates are age standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). [c] There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. [d] Very remote data were not collected. [e] Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished*) Australian Health Survey 2011-13* (2011-12 (National Health Survey (NHS) component); ABS (unpublished) *National Health Survey 2007-08*; table EA.22.

Nationally, the age standardised proportion of adults at risk of alcohol related harm over a lifetime (2009 NHMRC guidelines) was similar for Indigenous Australians (19.2 per cent) and non-Indigenous Australians (19.5 per cent) in 2011–13, although results varied across jurisdictions (table EA.24).

Selected potentially preventable diseases

'Selected potentially preventable diseases' is an indicator of governments' objective that Australians are born and remain healthy (box E.4).

Selected potentially preventable diseases are diseases that can potentially be prevented through reducing health risk factors such as obesity, smoking and harmful drinking. Note that a similarly named indicator 'selected potentially preventable hospitalisations' is reported in chapter 11 Primary and community health. Selected potentially preventable *hospitalisations* are hospital admissions that could potentially be reduced by more effective management of illness and injury in the primary and community healthcare sector.

Box E.4 **Selected potentially preventable diseases**

'Selected potentially preventable diseases' is defined by the following measures:

- Incidence of selected cancers — incidence of selected cancers of public health importance.
  - For melanoma, lung and bowel cancer, the measure is defined as the number of new cases in the reported year expressed as a directly age standardised rate.
  - For breast and cervical cancer in females, the measure is defined as the number of new cases in women in the reported year expressed as a directly age standardised rate.
  - Data reported for this measure are:
    - comparable (subject to caveats) across jurisdictions and over time except for NSW and the ACT, for which 2010 data are estimated
    - incomplete for the current reporting period. Data for 2010 were not available for NSW or the ACT and estimates are reported for these jurisdictions.
- Incidence of heart attacks — the number of deaths recorded as acute coronary heart disease deaths plus the number of non-fatal hospitalisations for acute myocardial infarction or unstable angina not ending in a transfer to another acute hospital, expressed as a directly age-standardised rate.
  - Data reported for this measure are:
    - comparable (subject to caveats) over time at the national level
    - incomplete for the current reporting period. Data are not currently available by State and Territory.
- Prevalence of type 2 diabetes — the number of people recorded as having Type 2 diabetes as a percentage of the total population aged 18 years or over.
  - Data reported for this measure are:
    - comparable across jurisdictions except for the NT where people in very remote areas, for which data are not available, comprise around 23 per cent of the population (see caveats in attachment tables) but are not comparable over time
    - complete for the current reporting period except for the NT. All required 2011–13 data are reported for all jurisdictions except the NT.

A low or decreasing rate is desirable for each incidence/prevalence rate.

Incidence is defined as the number of new cases in the reported year and is expressed as a rate of the relevant population.

Prevalence is defined as the proportion of the population suffering from a disorder.

Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

As well as addressing health risk factors, well-planned disease prevention and early intervention programs help prevent a number of diseases (or more successfully treat diseases through early identification). A number of programs form an important

element of preventing disease and improving the health of Australians (NPHT 2009), such as:

- immunisation
- cancer screening and early treatment
- early detection and intervention
- individual disease risk assessments and early intervention for biomedical risk factors such as: high blood pressure, high blood cholesterol, or impaired glucose tolerance
- childhood infectious diseases control
- sexually transmitted infections control.

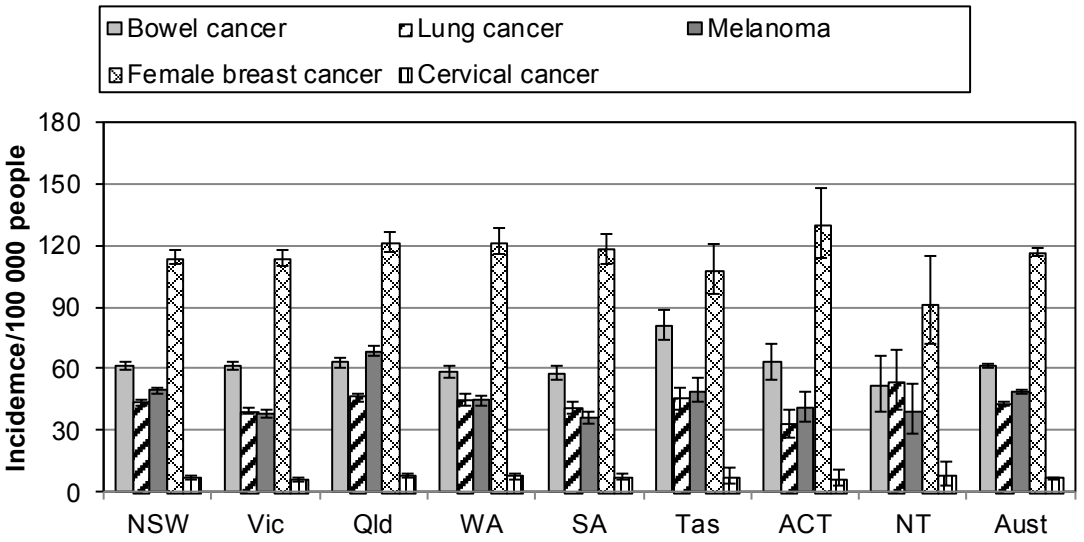
Incidence of selected cancers

Health service efforts to control cancer involve (AIHW 2013c):

- *public health programs* — programs to reduce the major risk factors; tobacco consumption, poor diet, insufficient physical activity, being overweight or obese, unsafe alcohol use, infectious diseases and exposure to ultraviolet radiation
- *early detection* — screening programs for cancers in Australia have contributed to substantial declines in associated mortality. Screening can also help prevent the development of cancer if changes can be found before they become cancer
- *research support* — such as provided through the National Health and Medical Research Council.

Nationally, the age standardised rate of lung cancer was 42.8 new cases per 100 000 people in 2010. Bowel cancer, which has been linked to diet, occurred at a rate of 61.8 new cases per 100 000 people in 2010 (table EA.24). Other cancers such as melanoma are also preventable. The incidence of these cancers for 2010, along with breast and cervical cancer, are reported in figure E.8. Tables EA.26–28 report the incidence of the selected cancers by remoteness, SEIFA IRSD quintiles and Indigenous status.

Figure E.8 **Incidence of selected cancers, per 100 000 people, 2010[a, b, c]**



a Age-standardised to the Australian population as at 30 June 2001 using five-year age groups to 84 years, and expressed per 100 000 persons (per 100 000 females for female breast cancer and cervical cancer). **b** Due to the low incidence of cancers in some jurisdictions, comparisons across time and between jurisdictions should be made with caution. **c** Data for NSW and the ACT are based on projections rather than actual cancer incidence and are not comparable with data for other jurisdictions.

Source: AIHW (unpublished) Australian Cancer Database; ABS (unpublished) Estimated Resident Population, 30 June 2010; table EA.25.

Incidence of heart attacks

Cardiovascular disease is the largest cause of premature death in Australia. Although death rates for cardiovascular disease have declined considerably in recent decades, it continues to be one of the biggest health problems requiring attention in Australia (AIHW 2013c).

The major, preventable risk factors for cardiovascular disease are: tobacco smoking; high blood pressure; high blood cholesterol; insufficient physical activity; overweight and obesity; poor nutrition; and diabetes.

Nationally, the rate of heart attacks was 427 new cases per 100 000 people in 2011 (table EA.30). The incidence of heart attacks was greater for Indigenous Australians (table EA.29). Caution should be taken in interpreting these data as they have been estimated using an algorithm that is under AIHW development. It should be considered an interim measure until current validation work is complete.

Prevalence of type 2 diabetes

Diabetes mellitus is a chronic condition in which the body makes too little of the hormone insulin or cannot use it properly. Type 2 diabetes is the most common form of diabetes, occurring mostly in people aged 50 years and over, and accounting for 85-90 per cent of all cases of diabetes mellitus (AIHW 2013c).

Diabetes mellitus and its complications contribute significantly to ill health, disability, poor quality of life and premature death. It also increases the risk of a variety of complications including end-stage kidney disease, coronary heart disease, stroke and other vascular diseases. Type 2 diabetes is more common in people who do insufficient physical activity and are overweight or obese. It is strongly associated with high blood pressure, high cholesterol and excess weight carried around the waist (Better Health Channel 2013). Thus, early intervention and treatment programs have the potential to reduce the cases and severity of the disease.

Prevalence of type 2 diabetes is derived using a combination of fasting blood glucose and self-reported information on diabetes diagnosis and medication use. Data include all newly diagnosed diabetes cases as the vast majority can be assumed to be type 2 diabetes. See DQI for further detail.

Nationally, an estimated 4.3 per cent of people aged 18 years or over had type 2 diabetes in 2011-12 (table EA.31).

Potentially avoidable deaths

'Potentially avoidable deaths' is an indicator of governments' objective that Australians are born and remain healthy (box E.5). Avoidable deaths reflect the effectiveness of current and past preventative health activities.

Box E.5 **Potentially avoidable deaths**

'Potentially avoidable deaths' is defined as potentially preventable deaths (deaths amenable to screening and primary prevention, such as immunisation) and deaths from potentially treatable conditions (deaths amenable to therapeutic interventions) for those aged less than 75 years per 100 000 people aged less than 75 years.

A low or decreasing potentially avoidable death rate is desirable.

Most components of the health system can influence potentially avoidable death rates, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on potentially avoidable death rates.

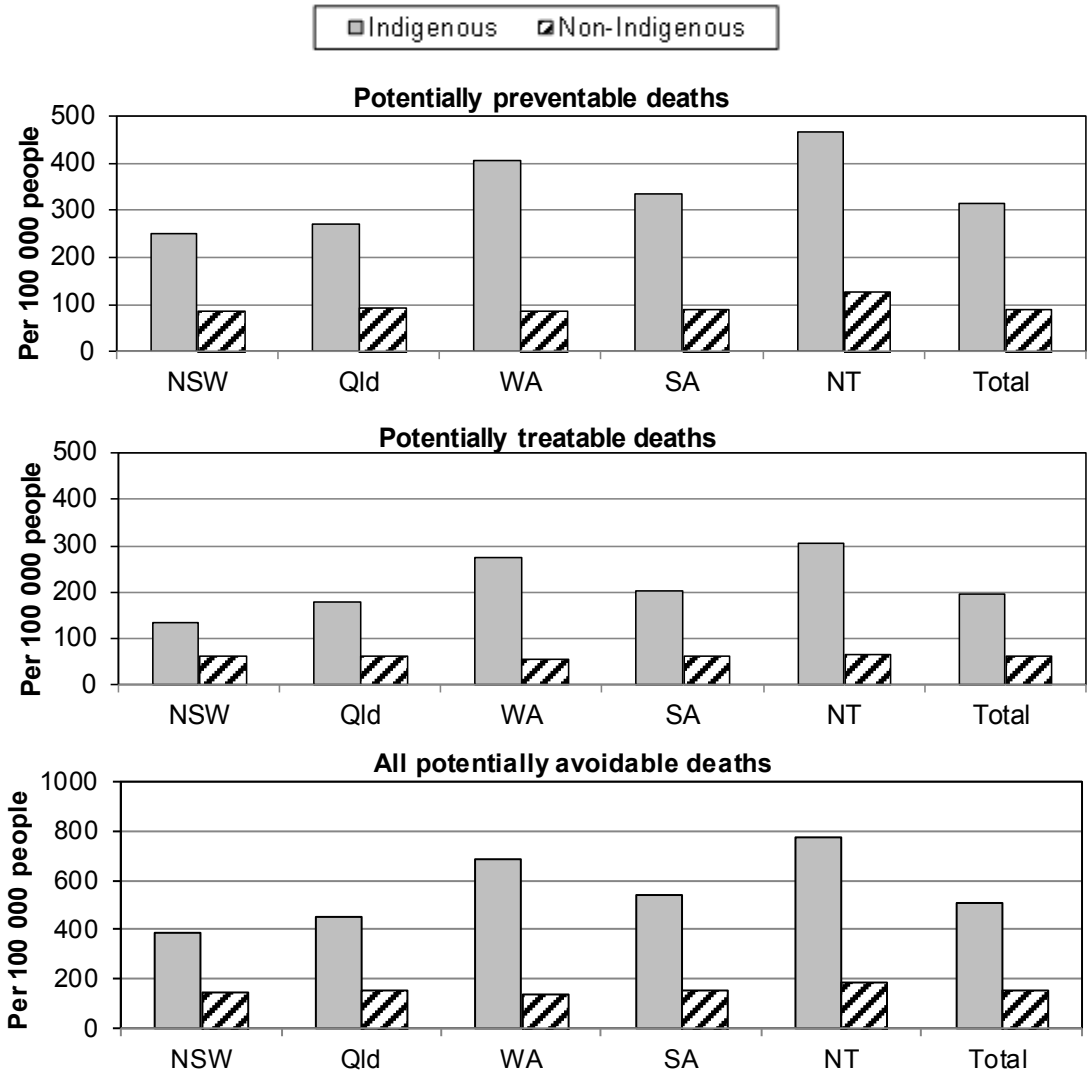
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2007–2011 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Indigenous Australians had significantly higher death rates from potentially avoidable deaths (preventable and treatable) over the period 2007–2011, comprising higher potentially preventable deaths per 100 000 people and higher treatable deaths per 100 000 people (figure E.9 and table EA.33). Single year data for all Australians are presented in table EA.32.

Figure E.9 **Age standardised mortality rates of potentially avoidable deaths, under 75 years, 2007–2011[a, b, c, d, e, f, g, h, i, j]**



[a] Standardised death rates calculated using the direct method, age-standardised by 5 year age groups to less than 75 years. [b] Excludes deaths where Indigenous status was not provided. [c] Avoidable mortality is defined as mortality before the age of 75 years, from conditions which are potentially avoidable within the existing health system. [d] Data based on year of registration. See DQI for more information. [e] Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. [f] Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for more information. [g] For WA, Indigenous deaths data for 2007, 2008 and 2009 have been revised. See DQI for more information. [h] Total includes data for NSW, Queensland, WA, SA and the NT only. [i] Preventable deaths are those which are amenable to screening and primary prevention such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector. [j] Deaths from potentially treatable conditions are those which are amenable to therapeutic interventions, and reflect the safety and quality of the current treatment system.

Source: ABS (unpublished) *Causes of Deaths, Australia, 2011*, Cat. no. 3303.0; table EA.33.

The mortality and life expectancy of Australians

'The mortality and life expectancy of Australians' is an indicator of governments' objective that Australians are born and remain healthy (box E.6).

Comparing mortality and life expectancy data across populations, including cause, age, sex, population group and geographical distribution, provide important insights into the overall health of Australians (AIHW 2013d). Trends over time in mortality and life expectancy data can signal changes in the health status of the population, as well as provide a baseline indicator for the effectiveness of the health system.

Box E.6 **The mortality and life expectancy of Australians**

'The mortality and life expectancy of Australians' is defined by the following measures:

- 'Life expectancy' — the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his/her lifetime.

  A high or increasing life expectancy is desirable.
- 'Median age at death' — the age at which exactly half the deaths registered (or occurring) in a given time period were deaths of people above that age and half were deaths below that age.

  A high or increasing median age at death is desirable.
- 'Mortality rates' — the number of registered deaths compared to the total population (expressed as a rate). Rates are provided for:
  - Australian mortality rate — age standardised mortality per 1000 people
  - infant and child mortality rates — the number of deaths of children under one year of age in a calendar year per 1000 live births in the same year (infant mortality rate) and the number of deaths of children between one and four years of age in a calendar year per 100 000 children (child mortality rate)
  - mortality rates by major cause of death — age standardised deaths, by cause of death compared to the total population (expressed as a rate).

  A low or decreasing mortality rate is desirable.

Most components of the health system can influence the mortality and life expectancy of Australians, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence.

Data reported for this indicator are:

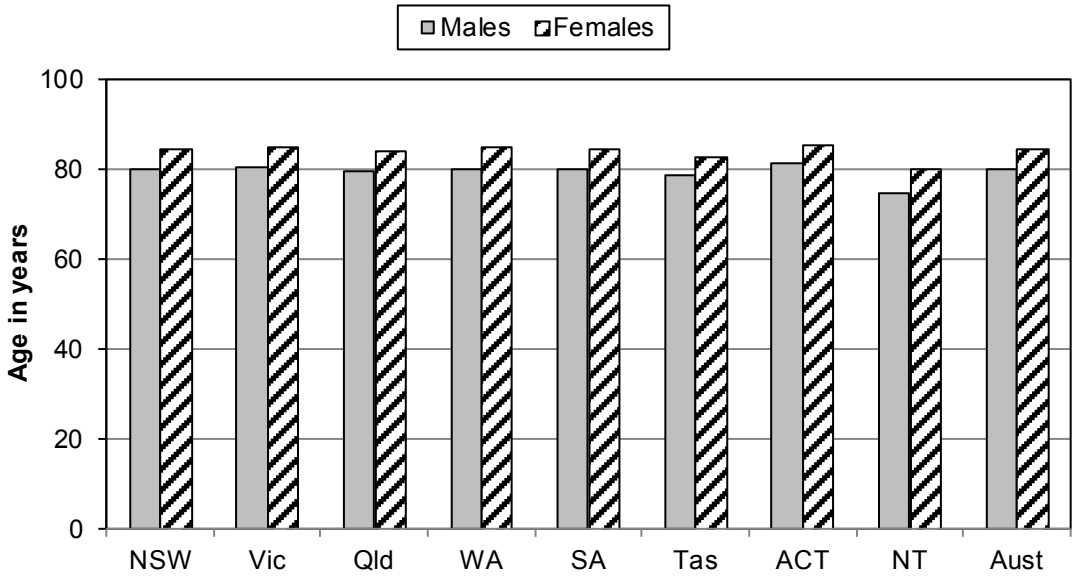
- comparable (subject to caveats) across jurisdictions and over time except for median age at death
- complete (subject to caveats) for the current reporting period. All required 2010–2012 data for life expectancy, 2012 data for median age at death and 2012 data for mortality rates are available for all jurisdictions.

Data quality Information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during the twenty-first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2013c). It has risen steadily in each decade since, reaching 79.9 years for males and 84.3 years for females in 2010–2012 (figure E.10).

Figure E.10 **All Australians average life expectancy at birth, 2010–2012[a]**

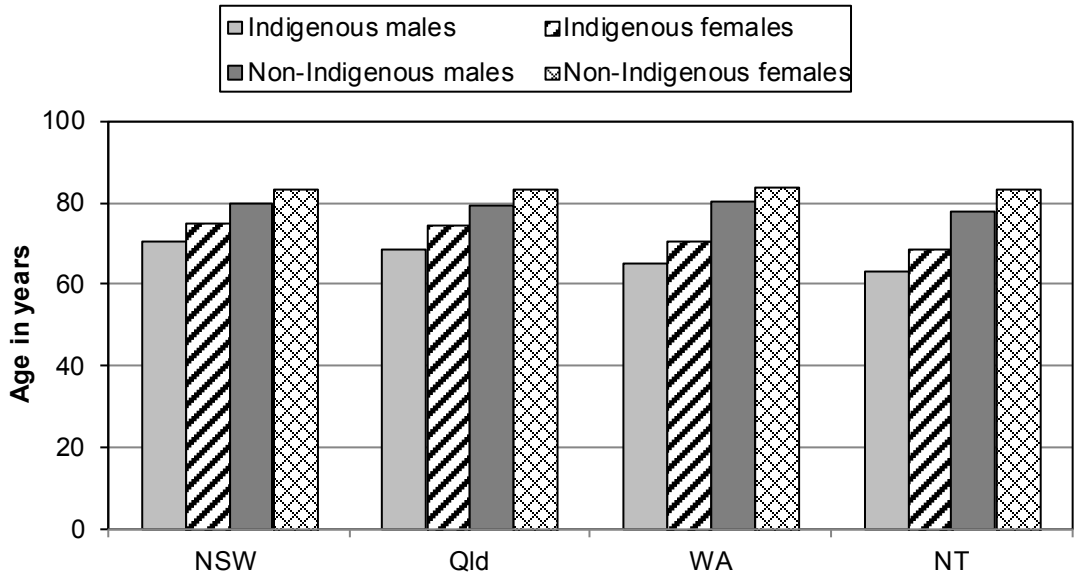


a Data for Australia include 'other territories'.

Source: ABS (2013) *Deaths, Australia,* 2010-2012, Cat. no. 3302, Canberra; table EA.34.

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS estimates indicate a life expectancy at birth of 69.1 years for Indigenous males and 73.7 years for Indigenous females born from 2010 to 2012. In the same time period, life expectancy at birth for non-Indigenous males was 79.7 years and for non-Indigenous females was 83.1 years (table EA.35). Life expectancy at birth by Indigenous status and sex for NSW, Queensland, WA and the NT are presented in figure E.11.

Figure E.11 **Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)[a, b]**



[a] Indigenous estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths in these jurisdictions. [b] Life tables are constructed separately for Males and Females.
Source: ABS (2013) *Life Tables for Aboriginal and Torres Strait Islander Australians 2010–2012*, Cat. no. 3302, Canberra; table EA.35.

Median age at death

The median age at death in 2012 was 78.9 years of age for Australian males and 84.7 years of age for Australian females (table EA.36).

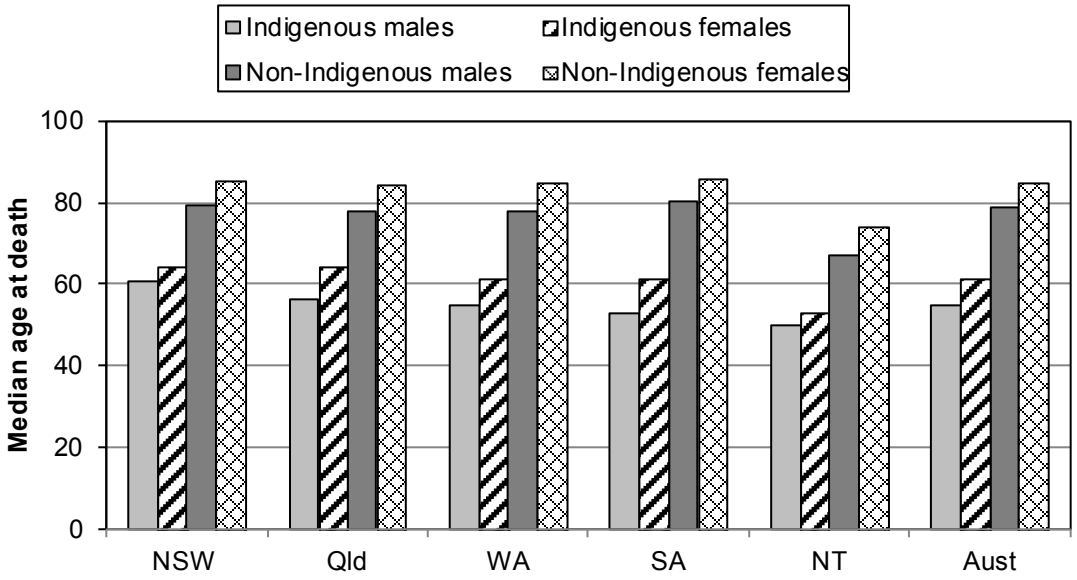
Comparisons of the median age at death for Indigenous and non-Indigenous Australians are affected by different age structures in the populations and by differences in the extent of identification of Indigenous deaths across jurisdictions and across age groups. Identification of Indigenous status for infant deaths is high, but falls significantly in older age groups. The median age of death for Indigenous Australians is, therefore, likely to be an underestimate.

Caution should be taken when comparing median age at death between Indigenous and non-Indigenous populations. Coory and Baade (2003) note that:

- the relationship between a change in median age at death and a change in death rate depends upon the baseline death rate. So comparison of trends in median age at death for Indigenous and non-Indigenous Australians is difficult to interpret
- changes in the median age at death of public health importance might be difficult to distinguish from statistical noise.

In the jurisdictions for which data were available for Indigenous Australians, the median age at death for male Indigenous Australians was 55.0 years of age. The median age at death for female Indigenous Australians was 61.3 years of age (figure E.12 and table EA.37).

Figure E.12 **Median age at death, by sex and Indigenous status, 2012[a, b]**



a Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths. **b** The accuracy of Indigenous mortality data is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data.

Source: ABS (2013) *Deaths, Australia, 2012*, Cat. no. 3302.0, Canberra; table EA.37.

Mortality rates

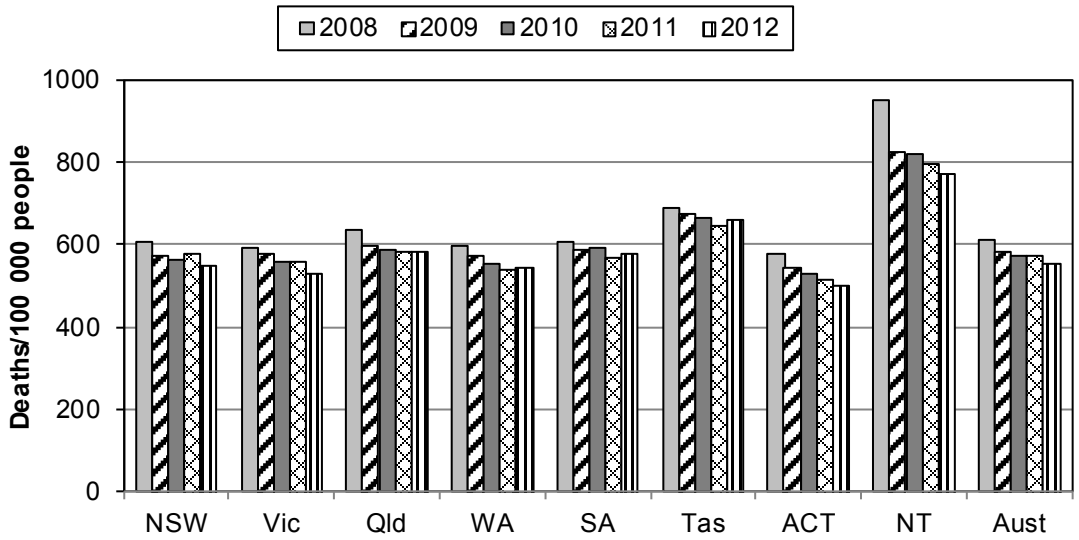
There were 147 098 deaths in Australia in 2012 (ABS 2013c), which translated into an age standardised mortality rate of 553.6 deaths per 100 000 people (figure E.13). Death rates over the last 20 years have declined for all states and territories (ABS 2013c).

Mortality rates — Infant and child

The annual infant mortality rate in Australia declined from an average of 4.8 deaths per 1000 live births in 2003 to 3.3 deaths per 1000 live births in 2012 (table EA.42 and figure E.14).

The Australian infant and child combined mortality rate was 91.5 deaths per 100 000 population in 2010–2012 (children aged 0 to 4 years). Of the total deaths for this age group, 84.5 per cent were infant deaths (table EA.43).

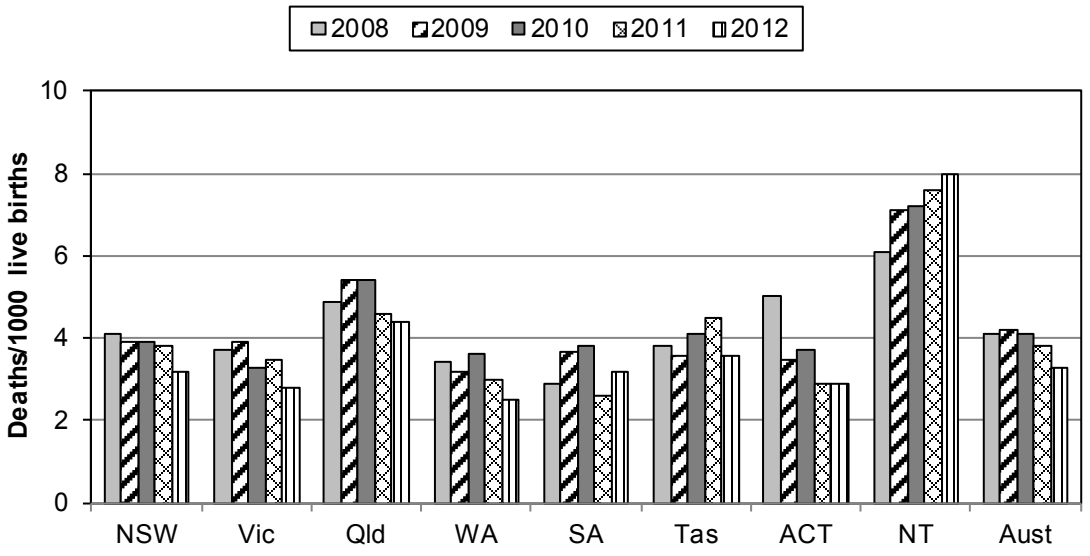
Figure E.13 **Mortality rates, age standardised[a, b, c, d]**



a Deaths are based on year of registration of death. **b** Deaths per 100 000 standard population. Standardised death rates use total people in the 2001 Australian population as the standard population. **c** Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census. Rates are not comparable with rates for Indigenous and non-Indigenous Australians which use ERPs based on the 2006 Census. **d** Australian totals includes all states and territories.

Source: ABS (2013) *Deaths, Australia, 2012*, Cat. no. 3302.0, AusInfo, Canberra; table EA.38.

Figure E.14 **Infant mortality rate[a, b]**



a Infant deaths per 1000 live births. **b** Data for Australia include all states and territories.

Source: ABS (2013) *Deaths, Australia, 2012,* Cat. no. 3302.0, Canberra; table EA.41.

Mortality rates — by remoteness

Mortality indicators showed that very remote areas of Australia have had consistently higher mortality rates than have other remoteness areas. In 2012, the age standardised mortality rates were highest in very remote areas (8.4 deaths per 1000 people), while major cities had the lowest mortality rates (5.5 deaths per 1000 people) (ABS 2013c).

Mortality rates — Indigenous Australians

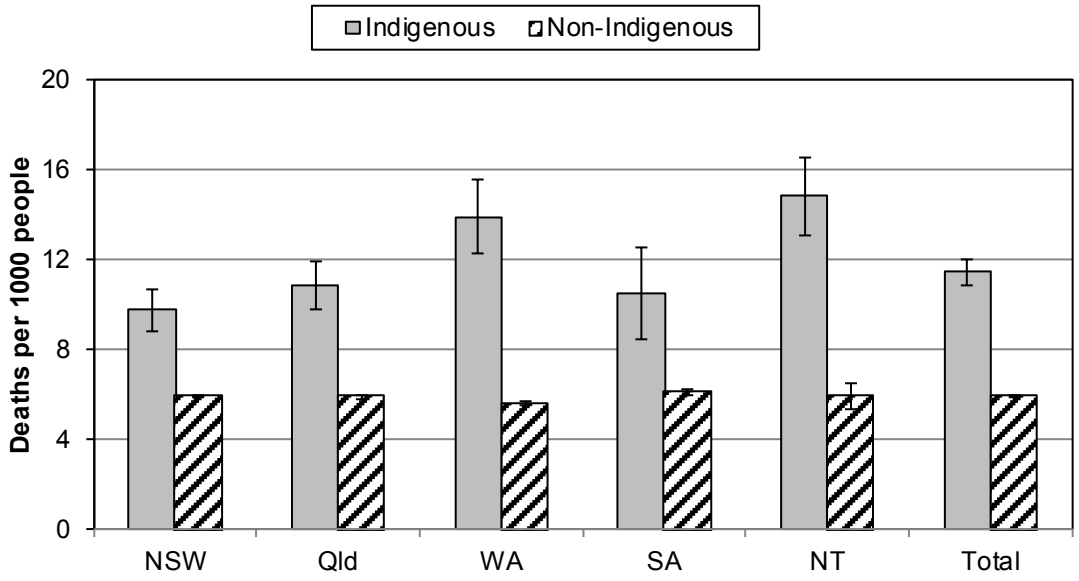
Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of identification of Indigenous Australians in these collections varies significantly across states and territories so care is required when making comparisons.

For the period 2008–2012, NSW, Queensland, WA, SA and the NT have been assessed as having adequate identification and number of Indigenous deaths for mortality analysis. For these five jurisdictions combined, the overall mortality rate for Indigenous Australians was 1143.4 per 100 000 people, nearly twice as high as for non-Indigenous Australians (589.7 per 100 000 people) (figure E.15 and table EA.39). Due to identification completeness issues, mortality rates presented here are likely to be underestimates of the true mortality of Indigenous Australians (ABS and AIHW 2008).

Data on longer-term trends for WA, SA and the NT suggest that the mortality rate for Indigenous infants decreased by 62 per cent between 1991 and 2010 (AHMAC 2012). While this is a significant improvement, infant mortality rates for Indigenous children are still markedly higher than for non-Indigenous children in Australia.

For the period 2008–2012, the average infant mortality rate for Indigenous infants (less than one year) was higher than for non-Indigenous infants in the jurisdictions (NSW, Queensland, WA, SA and the NT) for which there were data available (table EA.44). For the same period, the average child mortality rate for Indigenous children (1–4 years) was also higher for these jurisdictions (table EA.44). The combined infant and child average mortality rate for Indigenous infants and children (0–4 years) was 203.3 deaths per 100 000 of the infant and child population in NSW, Queensland, WA, SA and NT. This compared with 91.4 deaths per 100 000 of the infant and child population for non-Indigenous infants and children (table EA.44).

Figure E.15 **Mortality rates, age standardised, by Indigenous status, five year average, 2008–2012**[a, b, c, d, e]



[a] Deaths are based on year of registration. [b] Mortality rates are age-standardised to the 2001 Australian standard population. [c] Calculations of rates for the Indigenous population are based on *ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians 1991 to 2009* (ABS Cat. no. 3238.0, low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for comparison with the Indigenous population are derived by subtracting Indigenous population projections from total Estimated Resident Population (ERP) and should be used with care, as these data include deaths and population units for which Indigenous status were not stated. ERP used in calculations are final ERP based on 2006 Census. [d] Total includes NSW, Queensland, SA, WA, and NT combined, based on State or Territory of usual residence. Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths. [e] Error bars represent the 95 per cent variability band associated with each point estimate. See the DQI for more information.

Source: ABS (unpublished), *Deaths, Australia, 2012*; table EA.39.

Mortality rates — by major cause of death

The most common causes of death among Australians in 2011 were cancers, diseases of the circulatory system (including heart disease, heart attack and stroke), and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.3 and EA.45).

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT), death rates were significantly higher for Indigenous Australians than for non-Indigenous Australians in 2007–11. For these jurisdictions the leading age-standardised cause of death for Indigenous Australians was circulatory diseases followed by neoplasms (cancer) (tables E.4 and EA.46).

Table E.3 **Age standardised mortality rates by major cause of death (deaths per 100 000 people), 2011[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Certain infectious and parasitic diseases	11.6	8.5	8.5	6.3	8.9	6.8	8.5	np	9.4
Neoplasms	177.7	173.3	175.1	166.6	170.6	189.5	146.5	220.3	174.5
Diseases of the blood[c]	1.9	1.8	1.8	1.6	2.2	np	np	–	1.8
Endocrine, nutritional and metabolic diseases	20.9	24.8	23.7	23.4	24.8	34.1	20.0	60.1	23.5
Mental and behavioural disorders	27.9	27.3	27.3	23.7	30.4	40.6	26.5	51.6	27.9
Diseases of the:									
• nervous system	23.8	27.8	23.3	30.5	28.4	29.5	32.2	30.9	26.0
• eye and adnexa	np	np	np	np	–	–	–	–	np
• ear and mastoid process	np	np	np	np	np	–	–	–	np
• circulatory system	177.5	161.8	180.3	153.1	171.3	190.4	151.5	201.4	171.6
• respiratory system	49.5	46.3	49.9	42.1	45.9	53.3	42.8	83.5	48.0
• digestive system	20.2	19.9	20.3	19.8	19.5	21.9	19.4	37.0	20.2
• skin and subcutaneous tissue	2.1	1.4	1.4	1.3	1.6	np	np	np	1.6
• musculoskeletal system and connective tissue	4.7	4.4	4.8	3.7	3.3	5.4	np	np	4.4
• genitourinary system	12.9	14.1	12.1	11.2	13.2	13.1	14.5	np	13.0
Pregnancy, childbirth and the puerperium	np	np	np	–	np	–	–	–	np
Certain conditions originating in the perinatal period	3.0	2.5	3.3	2.0	1.9	np	np	np	2.8
Congenital conditions[d]	2.5	2.3	2.7	1.9	2.4	np	np	np	2.4
Abnormal findings nec[e]	5.9	3.3	3.7	4.2	4.3	np	7.7	np	4.6
External causes of morbidity and mortality	34.1	36.0	42.7	44.2	37.6	45.5	31.5	60.5	38.1
Total	**576.4**	**555.8**	**581.0**	**535.6**	**566.6**	**642.4**	**513.1**	**795.0**	**570.0**

[a] Age standardised to the Australian population as at 30 June 2001. [b] Australian total includes 'Other territories'. [c] Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. [d] Congenital malformations, deformations and chromosomal abnormalities. [e] Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. – Nil or rounded to zero. **np** Not published.

Source: ABS (unpublished) *Causes of Death Australia, 2011* Cat. no. 3301.0; table EA.45.

Compared to non-Indigenous Australians, Indigenous Australians died at higher rates from 'endocrine, metabolic and nutritional disorders', 'kidney diseases', 'digestive diseases', and 'respiratory diseases' (tables E.4 and EA.46).

Table E.4 **Age standardised Indigenous mortality rate (deaths per 100 000 people) compared to non-Indigenous rate, by major cause of death, 2007–2011**[a, b, c]

	Rate difference — Indigenous rate less non-Indigenous rate						*Rate ratio — Indigenous rate divided by non-Indigenous rate*					
	NSW	Qld	WA	SA	NT	Total	NSW	Qld	WA	SA	NT	Total
Circulatory diseases	130.0	122.7	238.3	128.3	192.9	147.0	1.6	1.6	2.4	1.6	2.2	1.7
Cancer	60.5	76.6	87.9	26.2	114.4	76.3	1.3	1.4	1.5	1.1	1.6	1.4
External causes	27.2	28.4	90.3	65.7	57.7	48.1	1.8	1.7	3.2	2.8	1.9	2.3
Endocrine and other disorders[d]	48.2	103.9	140.5	42.9	167.9	94.9	3.3	5.6	6.9	2.7	6.4	5.3
Respiratory diseases	59.0	48.9	71.0	62.9	98.5	64.0	2.2	2.0	2.6	2.3	2.8	2.3
Digestive diseases	19.9	33.8	56.3	38.3	57.6	36.5	2.0	2.7	3.8	2.9	3.2	2.8
Kidney Disease	11.7	20.6	39.9	np	57.6	24.8	2.0	3.0	4.9	np	6.5	3.2
Conditions originating in the perinatal period	2.0	2.9	3.3	np	6.6	3.2	1.7	2.0	3.1	np	3.3	2.2
Infectious and parasitic diseases	8.4	16.2	17.7	np	31.6	15.6	1.8	3.3	3.5	np	3.4	2.8
Nervous system diseases	- 1.3	- 2.7	16.2	5.7	3.8	2.1	0.9	0.9	1.5	1.2	1.2	1.1
Other causes	30.0	28.8	73.8	33.2	75.9	42.7	1.6	1.7	2.8	1.7	2.5	2.0
All causes	**395.7**	**480.2**	**835.1**	**439.1**	**864.6**	**555.5**	**1.7**	**1.8**	**2.5**	**1.7**	**2.4**	**1.9**

a All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2006 (final) 2007 (final), 2008 (final), 2009 (revised), 2010 (preliminary). See Cause of Death, Australia, 2010 (cat. no. 3303.0) Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009. **b** Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method. **c** Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. **d** Endocrine, metabolic and nutritional disorders. **np** not published

Source: ABS (unpublished) *Causes of Death Australia, 2011* Cat. no. 3301.0; table EA.46.

Profile of employed health workforce

'Profile of employed health workforce' is an indicator of governments' objective that Australians have a sustainable health system (box E.7).

Box E.7 **Profile of employed health workforce**

'Profile of employed health workforce' is defined by three measures:

- the full time equivalent employed health workforce divided by the population
- the proportion of the full time equivalent employed health workforce under the age of 45 years
- the net growth in the full time equivalent employed health workforce.

High or increasing rates in the health workforce measures can give an indication of the sustainability of the health system and its ability to respond and adapt to future needs.

Data reported for this indicator are:

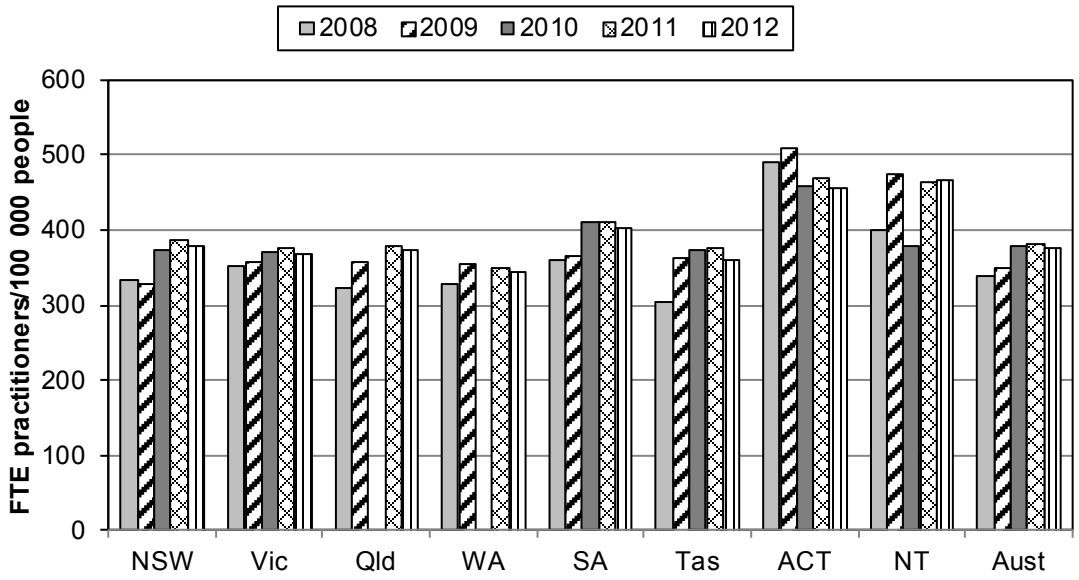
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Information about data quality for this indicator/measure is at www.pc.gov.au/gsp/reports/rogs/2014.

In 2012, the majority of employed medical practitioners (commonly referred to as doctors) that were employed in medicine were clinicians (94.5 per cent), of whom 34.5 per cent were general practitioners, 35.0 per cent were specialists, 15.3 per cent were specialists-in-training, 12.7 per cent were hospital non-specialists and 2.5 per cent were other clinicians. The proportion of women increased from 34.9 per cent in 2008 to 37.9 per cent in 2012 (AIHW 2014). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.16.

In 2012, the number of nurses and midwives registered in Australia was 334 078. In 2012, the number of nurses and midwives registered and employed in Australia was 290 144, or 1279 per 100 000 population (table EA.48). The majority of employed nurses and midwives were clinicians (80.1 per cent). The principal area of the main job of employed registered and enrolled nurses and midwives was aged care (14.2 per cent) followed by medical (9.0 per cent) and surgical (8.0) roles. The average age of employed nurses and midwives changed little between 2008 (44.1 years) and 2012 (44.6 years). The proportion of employed nurses and midwives aged 50 or older increased from 35.1 per cent to 39.1 per cent over this period (AIHW 2013e). The number of FTE nurses and midwives per 100 000 people by jurisdiction is illustrated in figure E.17.

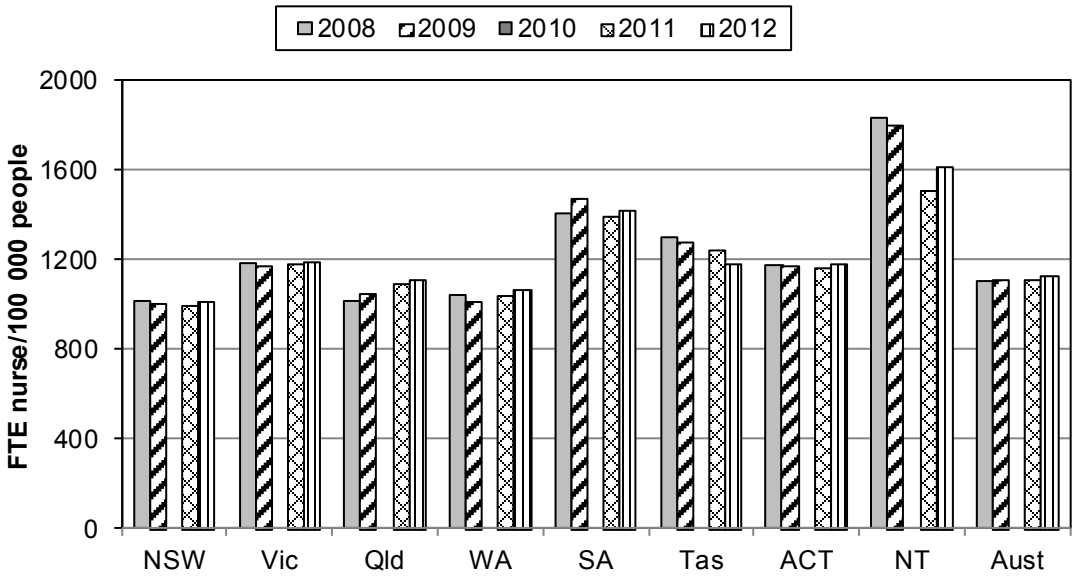
Figure E.16 **Full time equivalent employed medical practitioners**[a, b, c, d, e, f, g]



[a] FTE rate (FTE per 100 000 people) is based on a standard full-time working week of 40 hours. [b] Excludes employed medical practitioners on extended leave. [c] Care must be taken when interpreting the ACT's data as the ACT's medical practitioners provide a large number of services to NSW residents. This rate used the ACT resident population as the denominator, hence a high rate for the ACT. The rate will reduce if the NSW population within the catchment area of Southern NSW is included in the denominator. [d] From 2010, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction's health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details). [e] 2010 data exclude Queensland and WA due to closure of the registration period after the national registration deadline. [f] Caution should be used in comparing data for the NT with other jurisdictions from 2010 as this was the first year of changed doctors' registration requirements (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally). [g] From 2011, State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy. If principal practice details are also unavailable, State and Territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

Source: AIHW (unpublished) National Health Workforce Data Set: medical practitioners; AIHW (unpublished) Medical Labour Force Survey; ABS (unpublished) Estimated Resident Population (based on 2011 ABS Census of Population and Housing); table EA.47.

Figure E.17 **Full time equivalent employed nurses and midwives**[a, b, c, d, e]



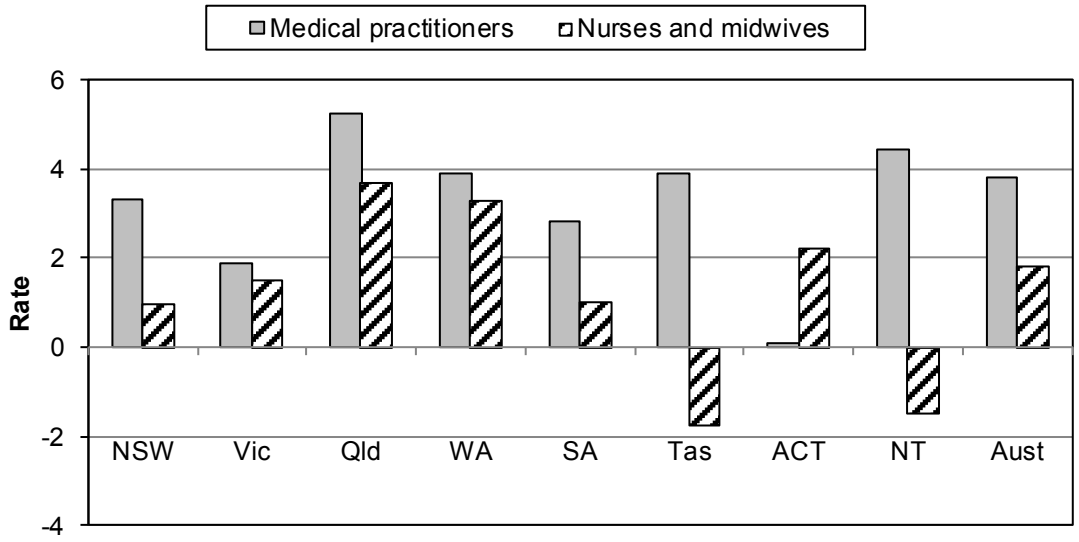
[a] FTE nurse rate (per 100 000 people) based on a 38-hour week. [b] Excludes nurses on extended leave. [c] Data are not available for 2010. [d] From 2011, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction's health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details). [e] From 2011, State and Territory is derived from State and Territory of main job where available; otherwise State and Territory of principal practice is used as a proxy. If principal practice details are also unavailable, State and Territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

Source: AIHW (unpublished) National Health Workforce Data Set and AIHW 2011; table EA.48.

At the national level, 50.9 per cent of employed medical practitioners were under the age of 45 in 2012 (table EA.47). The medical practitioner workforce grew at an average annual rate of 3.8 per cent from 2008 to 2012 (figure E.18). The nursing and midwifery workforce grew at an average rate of 1.8 per cent annually from 2008 to 2012 (figure E.18), and 47.0 per cent of employed nurses were under the age of 45 in 2011 (table EA.48).

Nationally, 0.8 per cent of the nursing and midwifery workforce were Indigenous in 2012 (table EA.50). Of people employed in health-related occupations in 2011, 1.6 per cent were Indigenous. Within health related occupations in 2011, the occupations with the highest percentage of Indigenous Australians were health and welfare support officers, which includes the occupation Indigenous Health Workers (tables EA.51–EA.53).

Figure E.18 **Annual average growth in selected workforces, 2008–2012**[a, b, c, d, e, f]



[a] Net growth measures the change in the FTE number in the workforce in the reference year compared to the year prior to the reference year. [b] FTEs calculated based on a 40-hour standard working week for medical practitioners and a 38-hour week for nurses/midwives. [c] From 2010, health workforce labour surveys are conducted at the national level and survey questions are consistent across jurisdictions. For 2009 and previous years, surveys were managed by each jurisdiction's health authority and there were some differences in survey questions between jurisdictions and within jurisdictions over time. This has little impact on the data reported here. However, caution should be used in comparing data between jurisdictions and over time (see DQI for further details) [d] From 2011, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'. [e] Data for 2007, 2008 and 2009 are for the workforce (i.e. including those employed, on extended leave and looking for work in the workforce). Data from 2010 are only for those employed in the workforce. [f] Caution should be used in comparing medical workforce data for the NT with other jurisdictions from 2010 as this was the first year of changed doctors' registration requirements (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally).

Source: AIHW (unpublished) National Health Workforce Data Set; ABS (unpublished) Estimated Resident Population (based on the 2011 ABS Census of Population and Housing); table EA.49.

Access to services compared to need by type of service

'Access to services compared to need by type of service' is an indicator of governments' objective that Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population (box E.8).

Results from the 2011-12 Australian Health Survey indicate that the majority of Australians (85.6 per cent) aged 15 years or over reported their health as either good, very good or excellent (ABS 2012). In the 2012-13 Australian Aboriginal and

Torres Strait Islander Health Survey, 75 per cent of Indigenous Australians reported their health as either good, very good or excellent (ABS 2013a).

Box E.8 **Access to services compared to need by type of service**

'Access to services compared to need by type of service' is defined as the number of people aged 15 years or over who accessed a particular health service in the past 12 months (for hospital admissions), 3 months (for dental services) or 2 weeks (for other health services) divided by the population aged 15 years or over, expressed as a percentage. Rates are age standardised and calculated separately for each type of service and by categories of self-assessed health status. Service types are: admitted hospitalisations, casualty/outpatients, GP and/or specialist doctor consultations, consultations with other health professional and dental consultation. Self-assessed health status is categorised as excellent/very good/good and fair/poor. Data are reported for all Australians by remoteness and by Socio Economic Indexes for Areas (SEIFA) and for Indigenous Australians.

High or increasing rates of 'access to services compared to need by type of service' are desirable, as are rates for those in disadvantaged groups being close to the rates for those who are not disadvantaged.

Data reported for this indicator are

- comparable (subject to caveats) across jurisdictions but not over time
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions

Data quality information for this indicator is under development.

The latest available data for self-assessed health status are from the 2012-13 National Aboriginal and Torres Strait Islander Health Survey for Indigenous Australians (ABS 2013a) and from the 2011-12 National Health Survey for non-Indigenous Australians (ABS 2012). Indigenous Australians were less likely than non-Indigenous Australians to report very good or excellent health. Taking into account differences in age structure between the populations, Indigenous Australians overall were more than twice as likely to report their health as fair or poor than non-Indigenous Australians in 2011–13 (ABS 2013a).

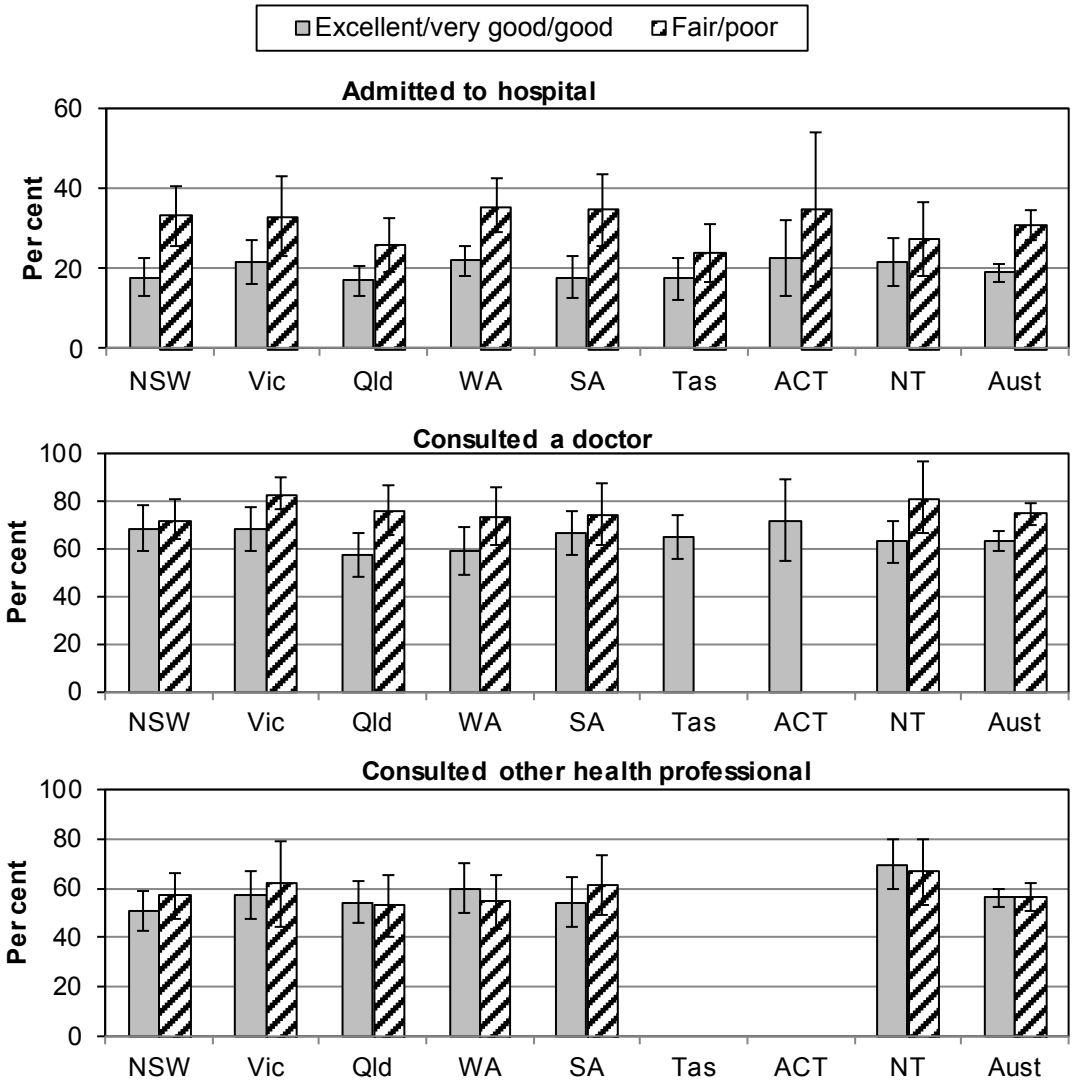
Data from the surveys show that 27.1 per cent of Australians who reported their health status as being excellent/very good/good accessed health services in 2011-12, while health services were accessed by 48.5 per cent of people who reported their health status as being fair/poor (table EA.54).

Data for Indigenous Australians are not comparable with data for non-Indigenous Australians due to a slightly different methodology. Nationally, the proportion of

Indigenous Australians who accessed services varied significantly by self-assessed health status for hospital admissions and doctor consultations, but not consultations with other health professionals (figure E.19). Data for people accessing health services by Indigenous status in 2004-05 are reported in table EA.57.

Data on the proportion of people who accessed health services by remoteness and SEIFA and data on the types of health services people accessed are reported for 2004-05 and 2011-12 in tables EA.58–EA.61.

Figure E.19 **Proportion of Indigenous Australians who accessed health services by health status, 2011-12[a, b, c, d, e, f, g]**



[a] Rates are age standardised by State/Territory to the 2001 estimated resident population. [b] Data are not comparable with data for all Australians due to differences in methodology. [c] People aged 15 years or over who consulted a doctor or another health professional in the last 2 weeks, or were admitted to hospital in the last 12 months. [d] Error bars represent the 95 per cent confidence intervals associated with each estimate.

Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.55.001; table EA.56.

Service-specific performance indicator frameworks

The health service specific frameworks in chapters 10, 11 and 12 reflect both the general Report framework and the National Health Performance Framework.[2] They differ from the general Report framework (see chapter 1) in two respects. First, they include three subdimensions of quality — safety, responsiveness and continuity — and, second, they include an extra dimension of efficiency — sustainability. These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Report framework:

- *safety*: the avoidance, or reduction to acceptable levels, of actual or potential harm from health care services, management or environments, and the prevention or minimisation of adverse events associated with health care delivery
- *responsiveness*: the provision of services that are client oriented and respectful of clients' dignity, autonomy, confidentiality, amenity, choices, and social and cultural needs
- *continuity*: the provision of uninterrupted, timely, coordinated healthcare interventions and actions across programs, practitioners and organisations
- *sustainability*: the capacity to provide infrastructure (such as workforce, facilities and equipment), be innovative and respond to emerging needs (NHPC 2009).

Other aspects of the Steering Committee's framework of performance indicators are defined in chapter 1.

This section summarises information from the following specific indicator frameworks:

- public hospitals (see chapter 10 for more detail)
- maternity services (see chapter 10 for more detail)
- primary and community health (see chapter 11 for more detail)
- mental health management (see chapter 12 for more detail).

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2 The former National Health Performance Committee developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. The National Health Performance Framework was reviewed by the National Health Performance Committee and a revised framework was agreed by the National Health Information Standards and Statistics Committee in 2009. A number of groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications.

Additional information is available to assist the interpretation of these results:

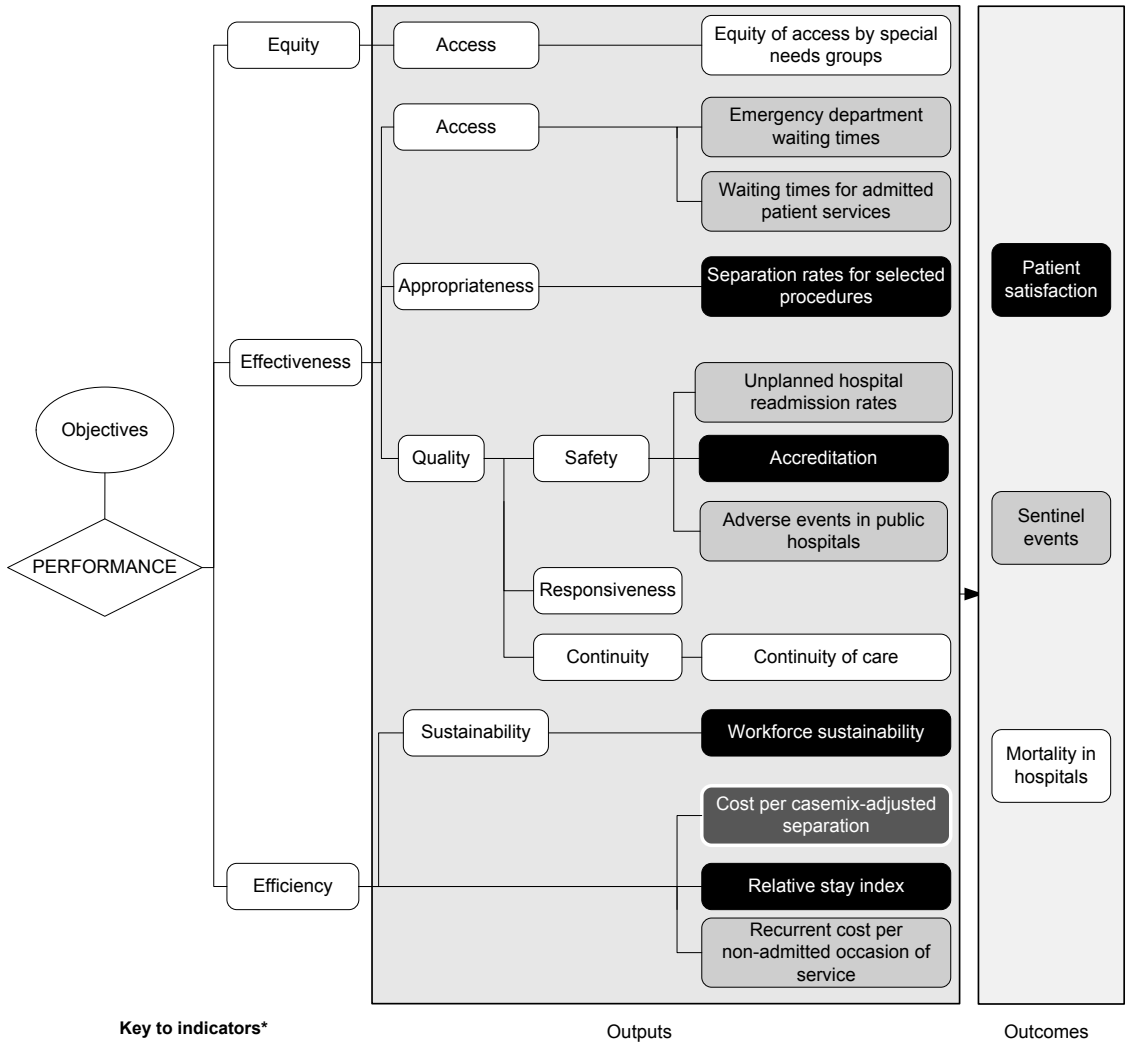
- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 10, 11 and 12)
- caveats and footnotes to the reported data (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
- additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability, language background, sex) (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
- data quality information for many indicators, based on the ABS Data Quality Framework (chapters 10, 11 and 12 Data quality information).

A full list of attachment tables and available data quality information is provided at the end of chapters 10, 11 and 12.

Public hospitals

The performance indicator framework for public hospitals is presented in figure E.20. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of public hospitals.

Figure E.20 **Public hospitals performance indicator framework**



An overview of the public hospital performance indicator results are presented in table E.5. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.5 **Performance indicators for public hospitals**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Effectiveness — Access indicators									
Emergency department waiting times, 2012-13									
Most recent data for this indicator are complete but not directly comparable (chapter 10)									
Proportion of patients seen on time (per cent)									
Resuscitation	100	100	100	100	100	100	100	100	100
Emergency	83	84	84	81	75	83	74	66	82
Urgent	73	72	68	52	66	65	43	52	68
Semi-urgent	77	68	74	67	78	70	46	52	72
Non-urgent	92	87	92	93	92	90	79	89	91
Total	78	73	74	66	75	71	51	57	73
Waiting times for admitted patient services									
Elective surgery waiting times: Number of days waited, 2012-13									
Most recent data for this measure are complete but not directly comparable (chapter 10)									
50th percentile	50	36	27	30	34	41	51	40	36
90th percentile	335	223	163	159	182	406	277	196	265
Elective surgery waiting times: Proportion who waited more than 365 days, 2012-13									
Most recent data for this measure are complete but not directly comparable (chapter 10)									
%	2.8	3.3	2.5	1.5	1.0	11.5	4.1	3.3	2.7
Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals (per cent), 2012-13									
Most recent data for this measure are complete but not directly comparable (chapter 10)									
Resuscitation	44	56	54	59	55	56	62	48	52
Emergency	32	44	40	52	41	32	40	23	39
Urgent	27	36	39	43	38	22	24	23	34
Semi-urgent	30	36	45	45	43	24	28	24	35
Non-urgent	53	53	62	55	61	47	40	50	54
Total	30	38	41	46	41	25	29	24	36

Source: tables 10A.17, 10A.22 and 10A.44.

Effectiveness — Appropriateness indicators									
Separation rates for selected procedures, public hospitals, per 1000 people (age-standardised), 2011-12									
Most recent data for this indicator are complete and comparable (chapter 10)									
Cataract extraction	2.6	3.1	1.6	4.3	3.5	1.3	3.5	5.1	2.7
Cholecystectomy	1.4	1.4	1.2	1.1	1.4	1.4	1.4	1.2	1.3
Coronary angioplasty	0.9	0.8	0.8	0.9	1.0	1.0	1.9	..	0.9
Coronary artery bypass graft	0.3	0.3	0.3	0.2	0.3	0.4	0.6	..	0.3
Cystoscopy	1.6	2.8	2.0	3.0	2.6	1.5	2.4	1.7	2.2
Haemorrhoidectomy	1.0	0.8	0.4	0.5	0.5	0.7	0.4	0.9	0.7
Hip replacement	0.7	0.7	0.5	0.8	0.7	0.6	1.0	0.6	0.6
Hysterectomy	1.0	1.1	1.0	1.1	1.3	1.1	0.7	0.8	1.0
Inguinal herniorrhaphy	1.0	1.0	0.8	0.9	1.0	1.1	0.9	0.9	1.0
Knee replacement	0.7	0.5	0.5	0.7	0.6	0.3	0.9	0.4	0.6
Myringotomy	0.5	0.8	0.7	0.7	1.3	0.6	0.8	0.6	0.7
Prostatectomy	0.9	1.1	0.8	0.8	1.0	0.8	0.9	1.0	0.9

(Continued next page)

Table E.5 **(continued)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Septoplasty	0.3	0.5	0.2	0.2	0.4	0.1	0.4	0.1	0.3
Tonsillectomy	0.9	1.2	0.9	1.0	1.3	0.8	1.0	0.7	1.0
Varicose veins, stripping and ligation	0.2	0.3	0.1	0.1	0.3	0.1	0.6	0.2	0.2

Source: table 10A.45.

Effectiveness — Quality — Safety indicators

Unplanned hospital readmissions within 28 days of selected surgical admissions, 2011-12

Most recent data for this indicator are complete but not directly comparable (chapter 10)

Surgical, procedure prior to separation, rate per 1000 separations									
Knee replacement	18.5	19.1	26.9	17.4	17.7	np	np	np	20.0
Hip replacement	17.7	17.4	14.2	22.5	23.7	np	np	np	17.7
Tonsillectomy and adenoidectomy	24.8	23.7	32.6	33.3	33.7	60.6	18.3	np	27.8
Hysterectomy	27.9	32.4	33.2	31.5	28.1	28.1	np	np	30.9
Prostatectomy	22.7	26.4	36.3	50.3	25.9	np	np	np	27.2
Cataract surgery	2.8	3.2	4.0	2.6	3.3	7.2	–	np	3.2
Appendicectomy	23.5	24.5	20.4	31.3	36.0	29.8	26.3	49.6	24.7

Accreditation, proportion of accredited beds, public hospitals 2011-12

Most recent data for this measure are complete and comparable (chapter 10)

%	97	100	100	100	100	87	100	100	99

Adverse events in public hospitals

Healthcare associated infections in acute care hospitals per 10 000 patient days, 2012-13									
Data for this measure not complete or not directly comparable (chapter 10)									
	1.0	0.9	1.0	0.8	0.8	1.0	1.3	0.7	0.9
Separations with an adverse event, public hospitals: Events per 100 separations, 2011-12									
Data for this indicator not complete or not directly comparable (chapter 10)									
Total	6.3	6.1	6.0	6.0	6.7	7.7	6.3	3.2	6.1

Source: tables 10A.47–10A.51.

Efficiency sustainability indicators

Workforce sustainability

Most recent data for this indicator are complete and comparable (chapter 10)

Nursing workforce by age group (per cent), 2012									
<30	13.8	17.0	14.7	16.0	14.1	12.0	15.4	17.9	na
30-39	20.1	21.3	20.7	20.1	18.9	15.5	21.7	25.6	na
40-49	24.5	25.9	27.8	26.7	26.7	27.7	25.6	22.8	na
50-59	30.3	26.3	26.7	26.8	31.0	34.2	28.3	25.3	na
60+	11.2	9.5	10.0	10.4	9.3	10.6	9.0	8.4	na
Medical practitioner workforce by age group (per cent), 2012									
<30	7.7	10.3	9.5	11.7	10.0	8.6	7.0	9.6	na
30-39	26.7	28.1	29.6	27.9	27.4	23.9	28.1	35.6	na
40-49	24.5	24.1	25.7	25.4	24.9	26.4	26.6	24.4	na
50-59	21.8	21.0	20.7	20.4	20.5	23.8	23.3	17.6	na
60+	19.3	16.4	14.4	14.6	17.2	17.3	14.9	12.7	na

Source: tables 10A.52–10A.55.

(Continued next page)

Table E.5 **(continued)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Medical practitioner workforce by age group, 2012									
<30	7.7	10.3	9.5	11.7	10.0	8.6	7.0	9.6	na
30-39	26.7	28.1	29.6	27.9	27.4	23.9	28.1	35.6	na
40-49	24.5	24.1	25.7	25.4	24.9	26.4	26.6	24.4	na
50-59	21.8	21.0	20.7	20.4	20.5	23.8	23.3	17.6	na
60+	19.3	16.4	14.4	14.6	17.2	17.3	14.9	12.7	na

Source: tables 10A.52–10A.55.

Efficiency indicators

Recurrent cost per casemix adjusted separation, dollars, 2011-12

Most recent data for this indicator are complete but not directly comparable (chapter 10)

Total recurrent	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Capital	475	804	424	542	395	427	556	693	493

Relative stay index, 2011-12

Most recent data for this indicator are complete and comparable (chapter 10)

Total	1.05	0.91	0.89	0.98	1.02	1.04	1.00	1.16	0.98

Recurrent cost per non-admitted occasion of service, 2011-12

Most recent data for this indicator not complete or not directly comparable (chapter 10). Data are available in tables 10A.61–10A.65.

Source: tables 10A.56–10A.68.

Outcome indicators

Patient satisfaction, 2012-13

Most recent data for this indicator are complete and comparable (chapter 10).

Proportion (%) of persons who went to an *emergency department* in the last 12 months reporting:									
ED doctors, specialists or nurses always or often listened carefully to them									
Doctors/specialists	85.0	83.4	84.0	84.7	83.4	81.3	82.5	87.6	84.2
Nurses	87.6	89.8	90.1	90.9	87.4	89.6	83.5	90.5	89.1
ED doctors, specialists or nurses always or often showed respect to them									
Doctors/specialists	86.4	84.7	85.5	87.2	84.8	83.3	82.6	88.4	85.7
Nurses	88.5	91.1	90.2	92.4	89.6	90.3	86.7	90.2	90.1
ED doctors, specialists or nurses always or often spent enough time with them									
Doctors/specialists	81.0	79.9	80.7	83.1	79.5	74.9	75.3	85.0	80.7
Nurses	85.2	85.6	87.5	90.4	86.6	84.3	80.8	89.5	86.4
Proportion (%) of persons who were admitted to hospital in the last 12 months reporting:									
Hospital doctors, specialists or nurses always or often listened carefully to them									
Doctors/specialists	91.3	89.5	87.1	90.8	89.5	85.9	89.3	81.5	89.5
Nurses	90.5	92.1	91.8	92.0	90.8	89.9	89.8	86.9	91.2
hospital doctors, specialists or nurses always or often showed respect to them									
Doctors/specialists	91.5	89.3	88.4	92.6	90.2	86.2	91.2	81.3	90.2
Nurses	92.2	91.1	91.4	93.0	91.7	88.4	90.6	87.6	91.5
hospital doctors, specialists or nurses always or often spent enough time with them									
Doctors/specialists	87.5	85.6	85.8	87.2	84.0	84.7	85.4	80.3	86.2
Nurses	88.5	89.0	89.2	91.8	87.7	86.5	85.3	85.8	88.9

Source: tables 10A.69–10A.76.

(Continued next page)

Table E.5 **(continued)**

Sentinel events, 2011-12

Most recent data for this indicator are complete but not directly comparable (chapter 10).

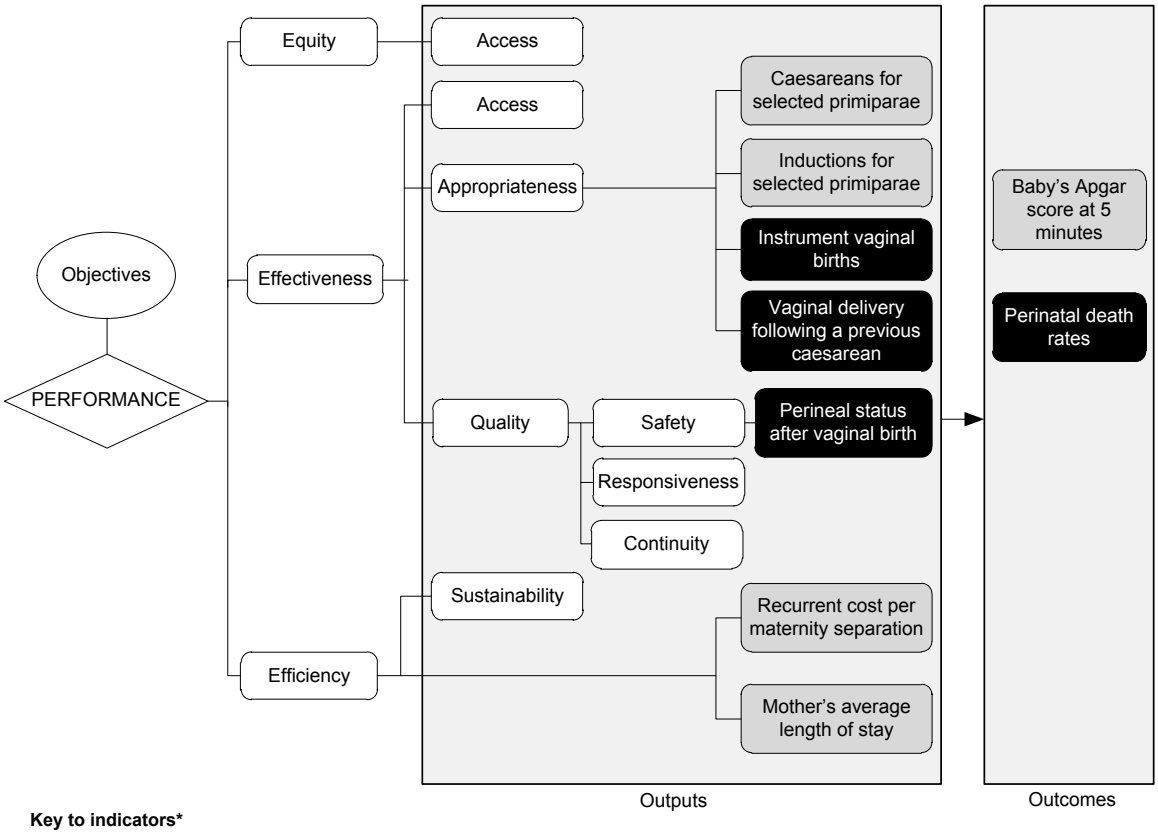
Data are available in tables 10A.77–10A.93.

a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available. **np** Not published.

Maternity services

The performance indicator framework for maternity services is presented in figure E.21. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of maternity services.

Figure E.21 **Maternity services performance indicator framework**



Key to indicators*

Text Most recent data for all measures are comparable and complete

Text Most recent data for at least one measure are comparable and complete

Text Most recent data for all measures are either not comparable and/or not complete

Text No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

An overview of the maternity services performance indicator results are presented in table E.6. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.6 **Performance indicators for maternity services[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Effectiveness — Appropriateness indicators									
Caesareans for selected primiparae — Proportion (%) of births that were caesareans, 2012									
Most recent data for this indicator not complete or not directly comparable (chapter 10)									
Public hospitals	23.8	23.2	22.9	24.7	20.2	na	21.3	28.6	23.3
Private hospitals	30.9	30.6	36.5	33.4	29.3	na	36.3	np	32.9
Inductions for selected primiparae — Proportion (%) of births that were induced, rate, 2012									
Most recent data for this indicator not complete or not directly comparable (chapter 10)									
Public hospitals	36.3	31.7	29.4	36.3	38.3	na	23.5	36.0	33.7
Private hospitals	35.5	34.5	33.8	42.3	44.3	na	25.9	np	36.4
Instrumental vaginal births, 2011									
Most recent data for this indicator not complete but are comparable (chapter 10)									
%	23.2	27.6	21.2	29.9	24.0	29.2	26.6	18.9	24.8
Vaginal birth following a previous caesarean, 2011									
Most recent data for this indicator are complete and comparable (chapter 10)									
Non-instrumental	12.9	12.3	12.2	9.5	13.1	13.9	11.5	18.3	12.3
Instrumental	3.6	3.9	2.6	3.7	4.2	4.0	4.8	3.0	3.5
Source: tables 10A.97–10A.107.									
Effectiveness — Quality — Safety indicators									
Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births, 2011									
Most recent data for this indicator are complete and comparable (chapter 10)									
%	2.0	1.9	1.8	2.1	2.2	1.7	3.6	2.9	2.0
Source: table 10A.108.									
Efficiency indicators									
Cost per maternity separation, without complications, dollars, 2010-11,									
Most recent data for this indicator are complete but not directly comparable (chapter 10)									
Vaginal delivery	5 304	4 359	5 096	5 669	4 495	5 829	6 919	5 137	4 998
Caesarean	8 689	8 947	–	13 196	9 917	12 010	12 328	11 257	9 681
Mother's average length of stay, days, 2011-12									
Most recent data for this indicator are complete and comparable (chapter 10)									
Vaginal delivery	1.8	1.8	1.6	1.9	1.8	2	1.4	2	1.8
Caesarean	3.9	3.8	3.4	3.8	4.1	3.8	3.9	4.6	3.8
Source: table 10A.109–10A.110.									

(Continued next page)

Table E.6 **(continued)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Outcome indicators									
Apgar score at 5 minutes, 2012									
Most recent data for this indicator are not complete and are not directly comparable (chapter 10)									
Percentage of live births with an Apgar score of 3 or lower by birthweight									
<1500g	17.7	17.5	17.0	4.1	12.7	na	12.4	np	na
1500g–1999g	1.3	1.1	2.2	1.3	0.8	na	–	np	na
2000g–2499g	0.7	0.6	0.6	0.5	0.1	na	0.5	np	na
2500g+	0.2	0.2	0.2	0.2	0.1	na	0.2	0.3	na
Perinatal death rates — deaths per '000 total births, 2011									
Most recent data for this indicator are not complete but are comparable (chapter 10)									
Fetal deaths	5.2	5.6	5.9	7.8	4.5	7.4	5.4	8.5	5.8
Neonatal deaths	3.0	2.6	3.1	2.0	1.5	2.7	1.8	4.3	2.7
Perinatal deaths	8.1	8.1	9.1	9.7	6.0	10.1	7.2	12.8	8.4

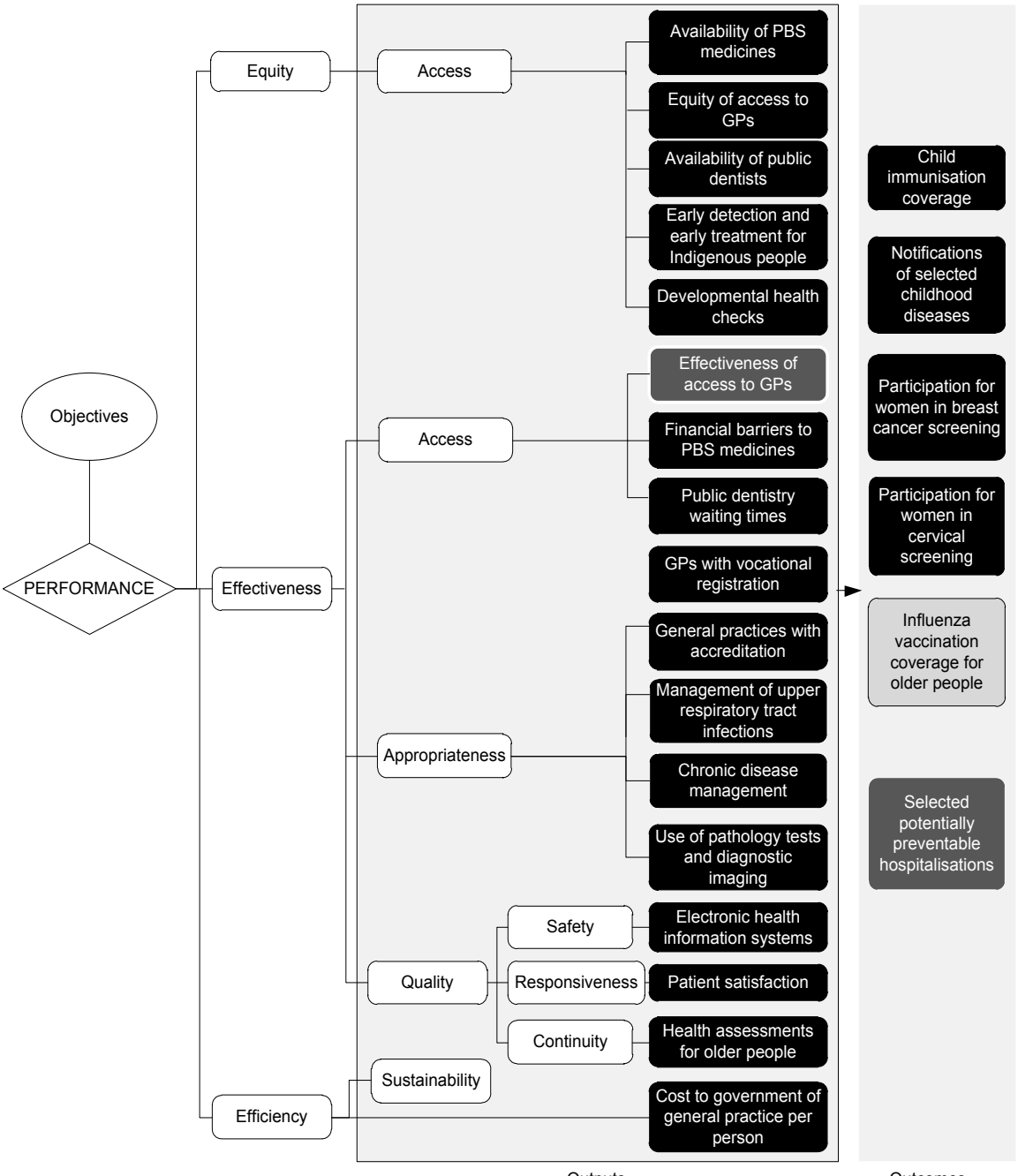
Source: tables 10A.111–10A.116.

a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available.

Primary and community health

The performance indicator framework for primary and community health is presented in figure E.22. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of primary and community health.

Figure E.22 **Primary and community health performance indicator framework**



Key to indicators*

Text Most recent data for all measures are comparable and complete

Text Most recent data for at least one measure are comparable and complete

Text Most recent data for all measures are either not comparable and/or not complete

Text No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

An overview of the primary and community health performance indicator results are presented in table E.7. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 11 and the footnotes in attachment 11A.

Table E.7 **Performance indicators for Primary and community health[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Availability of PBS medicines — PBS prescriptions filled at concessional rate (per cent), 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion of total	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
Equity of access to GPs, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Full time workload equivalent GPs by remoteness area per 100 000 people									
Major cities, rate	106.7	99.1	102.7	71.5	104.8	..	72.6	..	98.9
Outer regional, rate	79.2	93.5	93.8	83.9	87.5	76.1	..	74.4	86.5
Availability of female GPs per 100 000 females									
Rate	68.1	62.1	65.6	44.5	57.4	63.0	57.9	58.4	62.4
Availability of public dentists — per 100 000 people, 2012									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion of total	5.1	4.2	6.0	5.6	5.7	3.8	6.9	8.1	5.2
Early detection and early treatment for Indigenous Australians — Proportion of Older Indigenous Australians who received a health assessment, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3
Children receiving a fourth year developmental health check, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion	61.4	29.3	72.1	45.3	48.1	57.3	35.3	65.0	52.8

Source: tables 11A.11–11A.31.

Effectiveness — Access indicators

Effectiveness of access to GPs									
Most recent data for this indicator are comparable and complete (subject to caveats) for some but not all measures (chapter 11)									
Bulk billing rates for non-referred patients, 2012-13									
Proportion (%)	86.8	82.1	81.7	73.0	81.4	76.4	55.0	78.2	82.3
GP waiting times for urgent appointment, 2011-12 — less than 4 hours									
Proportion (%)	64.3	63.4	66.8	62.0	66.2	54.1	61.2	49.5	64.1
People deferring treatment due to cost, 2012-13 — deferring visits to GPs									
Proportion (%)	4.8	5.2	6.3	8.0	6.1	7.7	8.8	5.0	5.8
Selected potentially avoidable GP-type presentations to emergency departments, 2012-13									
'000	682.3	574.5	383.8	282.1	105.9	61.6	46.6	39.8	2176.6

(Continued next page)

Table E.7 **(continued)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Financial barriers to PBS medicines									
People deferring treatment due to cost, *2012-13* — deferring purchase of medicines									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	7.9	8.6	9.9	7.1	9.1	9.8	6.7	8.9	8.5
Public dentistry waiting times, 2012-13 — less than 1 month									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	34.2	28.5	28.3	37.4	15.1	32.5	36.3	40.4	30.5

Source: tables 11A.32–11A.45.

Effectiveness — Appropriateness indicators

GPs with vocational registration, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	91.3	86.9	88.4	90.7	90.7	92.2	93.0	72.1	89.4
General practices with accreditation, at 30 June 2011									
Most recent available data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	61.1	69.2	75.8	73.3	69.1	75.3	70.2	45.7	67.4
Management of upper respiratory tract infections									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Prescriptions for oral antibiotics used to treat upper respiratory tract infections per 1000 people, 2012-13									
Rate	318.5	311.4	311.1	191.1	320.2	331.6	176.8	88.0	297.1
Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, April 2008 to March 2013									
Proportion (%)	35.7	29.9	34.1	25.9	28.6	26.5	28.0	21.4	32.5
Management of chronic disease									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
People with diabetes mellitus who have received an annual cycle of care within general practice, *2012-13*									
Proportion (%)	25.1	26.2	25.5	20.5	29.1	31.9	15.4	19.2	25.0
People with asthma who have a written asthma action plan, *2011-12*									
Proportion (%)	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
Pathology tests and diagnostic imaging — Medicare benefits for pathology tests, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
$ per person	63.8	59.4	67.0	55.1	59.3	55.7	58.7	66.0	61.8

Source: tables 11A.46–11A.66.

Effectiveness — Quality — Safety indicators

Electronic health information systems — general practices using electronic systems, May 2013									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	69.4	76.2	74.2	68.4	72.7	75.6	80.0	48.2	72.2

Source: tables 11A.67–11A.69.

(Continued next page)

Table E.7 **(continued)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Effectiveness — Quality — Responsiveness indicators									
Patient satisfaction, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%) of people who saw a practitioner in the previous 12 months where the practitioner always or often: listened carefully to them									
GP	90.1	89.4	88.7	88.3	88.2	89.7	89.5	87.2	89.3
Dental practitioner	95.8	94.2	94.0	95.5	94.4	94.1	94.8	91.9	94.8
Source: tables 11A.70–11A.74.									
Effectiveness — Quality — Continuity indicators									
Health assessments for older people — proportion of older people assessed, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	29.4	27.1	33.4	27.5	27.2	34.3	22.0	26.5	29.2
Source: table 11A.75.									
Efficiency indicators									
Cost to government of general practice per person — fee-for-service expenditure, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
$ per person	303.1	288.0	299.9	224.7	285.0	265.1	225.1	223.1	286.1
Source: table 11A.2.									
Outcome indicators									
Child immunisation coverage — Children aged 60 to 63 months fully immunised, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Proportion (%)	91.6	92.6	91.5	89.4	90.9	92.9	92.3	90.7	91.5
Notifications of selected childhood diseases —notifications per 100 000 children, 2012-13									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Measles	6.1	np	np	0.6	np	–	–	np	2.2
Participation rates for women in breast cancer screening — Ages 50–69, 1 January 2011 to 31 December 2012									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Rate	50.4	54.3	57.1	57.8	58.8	57.8	53.5	41.6	54.5
Participation rates for women in cervical screening — Ages 20–69 (ASR), 1 January 2011 to 31 December 2012									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Rate	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
Influenza vaccination coverage for older people — 65 years or over, 2009									
Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 11)									
Rate	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3	74.6

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Table E.7 **(continued)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Separations for selected potentially preventable hospitalisations, 2011-12, per 1000 people									
Most recent data for the indicator are comparable and complete (subject to caveats) except for the measure potentially preventable hospitalisations for diabetes (chapter 11)									
Vaccine-preventable	0.8	0.8	0.9	0.8	0.9	0.5	0.7	3.1	0.8
Acute conditions *excluding dehydration and gastroenteritis*	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0
Chronic conditions *excluding additional diagnoses of diabetes complications*	10.4	11.9	12.5	10.7	11.4	9.1	8.5	21.0	11.3

Source: tables 11A.76–11A.93.

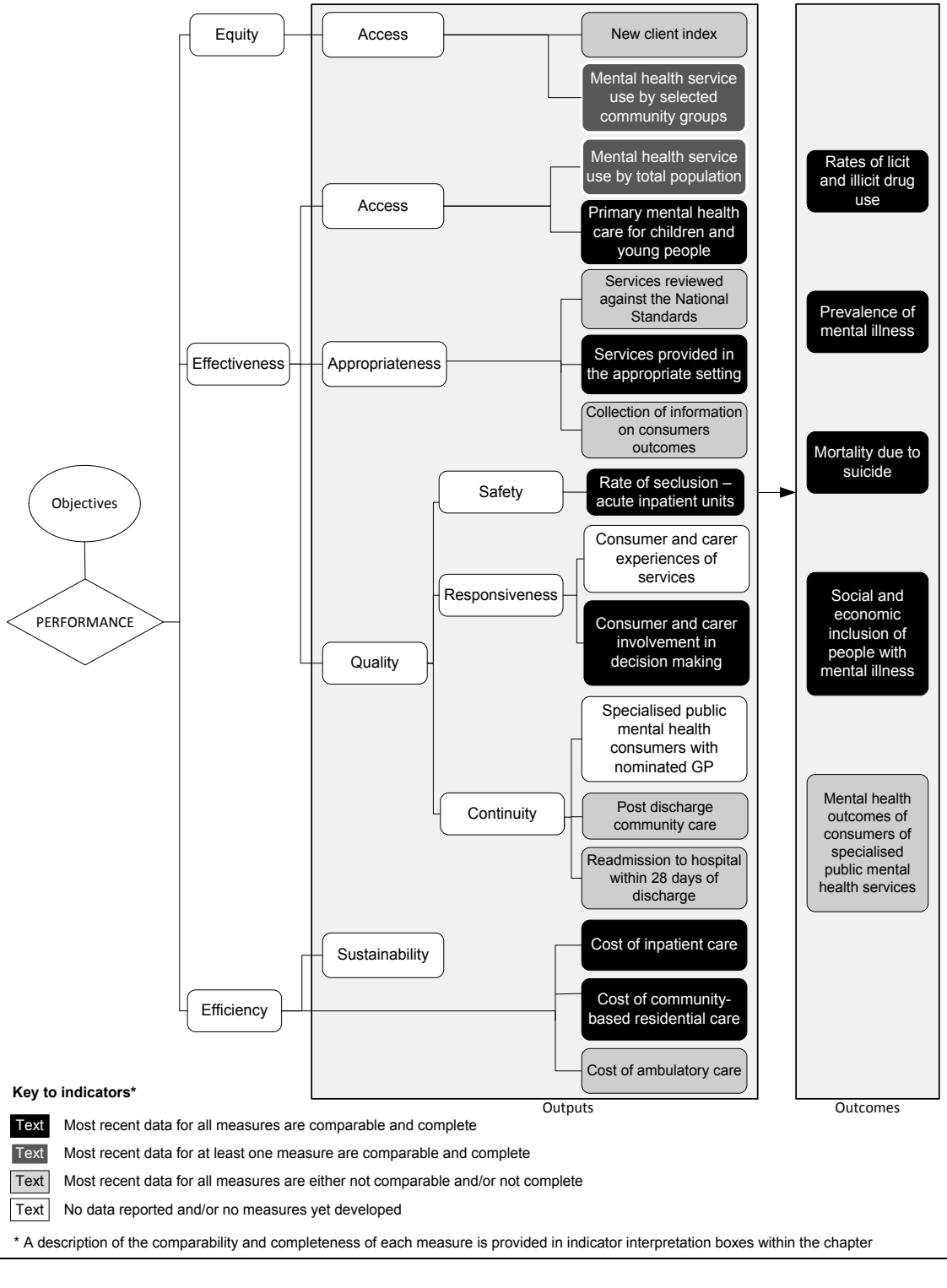
a Caveats for these data are available in Chapter 11 and Attachment 11A. Refer to the indicator interpretation boxes in chapter 11 for information to assist with the interpretation of data presented in this table. **b** Some data are derived from detailed data in Chapter 11 and Attachment 11A. – Nil or rounded to zero. **na** Not available. **np** Not published.

Source: Chapter 11 and Attachment 11A.

Mental health management

The performance indicator framework for mental health management is presented in figure E.23. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of mental health management.

Figure E.23 **Mental health management performance indicator framework**



* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

An overview of the mental health management performance indicator results are presented in table E.8. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 12 and the footnotes in attachment 12A.

Table E.8 **Performance indicators for Mental health management**[a]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Equity — Access indicators									
New client index									
Most recent data for this measure are not directly comparable nor complete (chapter 12)									
Proportion of clients under the care of State or Territory specialised public mental health services who were new clients, 2011-12									
Proportion (%)	39.8	na	45.5	41.6	42.7	21.9	42.2	49.6	41.5
Mental health service use by selected community groups									
Proportion (%) of the Indigenous population using State and Territory mental health services, compared with the proportion for non-Indigenous population, 2011-12									
Most recent data for this measure are comparable (subject to caveats), but not complete (chapter 12)									
Indigenous	5.4	na	4.8	5.4	6.9	1.2	7.9	3.8	na
Non-Indigenous	1.2	na	1.7	1.8	1.7	0.8	1.9	2.3	na
Proportion (%) of the Indigenous population using MBS and DVA funded mental health services, compared with the proportion for non-Indigenous population, 2011-12									
Most recent data for this measure are comparable and complete (chapter 12)									
Indigenous	10.7	12.5	6.7	4.0	8.2	8.4	12.5	1.5	7.4
Non-Indigenous	7.0	7.8	6.7	5.5	7.0	6.2	5.6	3.6	6.9
Source: tables 12A.25–26.									
Effectiveness — Access indicators									
Mental health service use by total population									
Most recent data for this indicator are comparable, but not complete (chapter 12)									
Proportion (%) of the population in a State and Territory using a specialised public mental health service or a MBS-subsidised service, 2011-12									
Specialised public mental health	1.6	na	1.8	2.0	2.1	1.6	2.2	2.7	1.4
MBS and DVA subsidised service	7.3	8.0	7.0	5.5	7.2	6.3	5.7	3.0	7.1
Primary mental health care for children and young people									
Most recent data for this indicator are comparable, but not complete (chapter 12)									
Proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS, 2012-13									
Proportion (%)	5.3	6.1	5.0	3.9	5.5	5.2	4.6	1.8	5.2
Source: tables 12A.30 and 12A.33.									
Effectiveness — Appropriateness indicators									
Services reviewed against national standards									
Most recent data for this indicator are complete, but not complete (chapter 12)									
Proportion of specialised public mental health services that had completed an external review against national standards and were assessed as meeting 'all Standards' (level 1), June 2012									
Proportion (%)	72.9	63.4	99.7	62.9	41.7	–	100.0	100.0	71.5
Services provided in the appropriate setting									
Most recent data for this measure are comparable and complete (chapter 12)									
Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services, 2011-12									
Proportion (%)	43.5	64.2	56.3	53.4	58.8	56.8	74.4	63.9	54.2

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Table E.9 **(Continued)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Collection of information on consumers outcomes									
Most recent data for this measure are comparable, but not complete (chapter 12)									
Proportion of episodes with completed consumer outcomes measures collected for people in specialised public mental health services — ongoing community care, 2011-12									
Proportion (%)	21.1	na	34.1	29.1	34.8	23.3	7.8	19.7	26.5

Source: tables 12A.34–36.

Effectiveness — Quality — Safety indicators

Rate of seclusion — acute inpatient units

Most recent data for this indicator are comparable and complete (chapter 12)

Number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units, 2012-13									
no.	8.5	10.9	12.7	6.0	9.1	19.7	0.9	15.8	9.6

Source: table 12A.37.

Effectiveness — Quality — Responsiveness indicators

Consumer and carer involvement in decision making

Most recent data for this measure are comparable and complete (chapter 12)

Paid consumer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE), 2011-12									
no.	3.0	3.2	3.9	0.7	4.0	2.3	–	–	2.9

Source: table 12A.38.

Effectiveness — Quality — Continuity indicators

Community follow up for people within the first 7 days of discharge from hospital

Most recent data for this indicator are not comparable nor complete (chapter 12)

Proportion of overnight separations from psychiatric inpatient acute services with a community mental health service contact recorded in the 7 days following separation, 2011-12									
Proportion (%)	52.4	na	64.4	50.7	50.5	27.4	77.7	44.1	54.6

Readmissions to hospital within 28 days of discharge

Most recent data for this indicator are complete, but not comparable (chapter 12)

Proportion of overnight separations from psychiatric inpatient acute services that were followed by a readmission to a psychiatric inpatient service within 28 days of discharge, 2011-12									
Proportion (%)	15.7	14.3	15.1	13.7	9.3	14.1	12.6	9.8	14.4

Source: tables 12A.39 and 12A.41.

Efficiency indicators

Cost of inpatient care

Most recent data for this indicator are comparable and complete (chapter 12)

Cost per inpatient bed day, 2011-12									
General mental health services (acute units)									
$ per bed day	949	800	859	1 123	865	931	910	1 526	921
Public acute hospital with a psychiatric unit or ward (acute units)									
$ per bed day	944	802	891	1 104	871	1 036	839	1 526	918

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Table E.10 **(Continued)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Average recurrent cost per patient day for community residential services									
Most recent data for this indicator are comparable and complete (chapter 12)									
General adult units — 24-hour staffed units, 2011-12									
$ per patient day	225	488	..	368	484	490	650	308	447
Average cost of ambulatory care									
Most recent data for this indicator are comparable, but not complete (chapter 12)									
Average cost per treatment day of ambulatory care, 2011-12									
$ per episode	245	na	424	431	324	467	249	543	326

Source: tables 12A.43, 12A.45–47.

Outcome indicators

Rates of licit and illicit drug use									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people aged 14 years or over who used any illicit drug in the preceding 12 months, 2010									
Proportion (%)	11.4	11.0	12.3	15.4	12.7	9.6	11.4	18.8	12.0
Prevalence of mental illness									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people with a lifetime mental disorders among adults aged 16–85 years, 2007									
Proportion (%)	20.1 ± 2.2	20.7 ± 2.3	19.2 ± 2.6	21.4 ± 4.1	19.1 ± 3.4	14.1 ± 5.4	np	np	20.0 ± 1.1
Mortality due to suicide									
Most recent data for this indicator are comparable and complete (chapter 12)									
Suicide rate per 100 000 people, 2007–2011									
Rate	8.6	9.5	12.7	13.0	12.0	14.1	9.9	20.1	10.6
Social and economic inclusion of people with a mental illness									
Most recent data for this indicator are comparable and complete (chapter 12)									
Proportion of people aged 16–64 years with mental or behavioural problems who are employed, 2011-12									
Proportion (%)	65.2 ± 7.7	59.4 ± 6.4	57.7 ± 6.7	65.0 ± 5.9	61.2 ± 7.2	51.6 ± 8.7	72.5 ± 8.2	63.2 ± 10.3	61.7 ± 3.1
Mental health outcomes of consumers of specialised public mental health services									
Most recent data for this indicator are not comparable nor complete (chapter 12)									
Proportion of people discharged from a State or Territory public hospital psychiatric inpatient unit who had a significant improvement in their clinical mental health outcomes, 2011-12									
Proportion (%)	68.1	na	73.4	72.1	71.3	73.0	np	77.6	70.8

Source: tables 12A.49, 12A.56, 12A.61, 12A.65 and 12A.72.

a Caveats for these data are available in chapter 12 and attachment 12A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. .. Not applicable. **np** Not published.

E.3 Cross cutting and interface issues

Many determinants affect Australian's health (AIHW 2012). They include the delivery of an efficient, effective and equitable health service, but also factors such as individuals' and communities' social and economic conditions and background.

Major improvements in health outcomes therefore depend on strong partnerships between components of the health system and relationships between the health sector and other government services:

- *Early childhood, education and training services* play an important role in shaping a child's development, which has consequences for overall health and wellbeing in later life (AIHW 2011).

  Good health is critical to a child's educational development. Impaired hearing, malnutrition, poor general health, including poor eyesight, anaemia, skin diseases, and sleep deprivation have been identified as having adverse effects on the educational attainment of Indigenous children (AMA 2001).

- *Justice services* have a critical role in providing a safe and secure society, free from violence. They also enforce laws designed to improve public health such as to prevent road traffic accidents and the use of illicit drugs.

  A person's health can also be a critical factor in a person's interaction with the justice system. Research shows that prisoners have significantly worse health, with generally higher levels of diseases, mental illness and illicit drug use than Australians overall (AIHW 2012).

- *Emergency management services* have an important role in the preparation and response to emergency events providing emergency first aid, protection and shelter. Ambulance services are an integral part of a jurisdiction's health service providing emergency as well as non-emergency patient care and transport.

- *Community services* and health services interact at many levels. People with disability are more likely than others to have poor physical and mental health, and higher rates of risk factors such as smoking and obesity (AIHW 2012). Aged care services can keep people living independently and healthily, without undue call on the health sector. Child protection services act to protect children and ensure their good health (while medical professionals are the source of many child protection notifications).

- *Housing and homelessness services* play an important role in ensuring the health of Australians. Living conditions (particularly poor housing and infrastructure) are a major contributor to health and well being. People with unmet housing needs tend to experience higher death rates, poor health, and are more likely to have serious chronic illnesses (Garner 2006).

E.4 Future directions in performance reporting

This health sector overview will continue to be developed in future reports.

It is anticipated that work undertaken to achieve the COAG aspirations will lead to improvements in performance reporting for the health sector. There are several important national initiatives currently underway. COAG has agreed to the National Health Reform Agreement (COAG 2011). The Agreement includes a commitment to introduce clear and transparent performance reporting against the new Performance and Accountability Framework that will include:

- a subset of the national performance indicators already agreed by COAG through the NHA
- reference to national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Health Care
- design principles for the new Hospital Performance Reports and Healthy Communities Reports.

Performance reporting will be through the establishment of the National Health Performance Authority. The Authority will:

- provide clear and transparent quarterly public reporting of the performance of every Local Hospital Network, private hospital and Medicare Local
- monitor the performance of Local Hospital Networks, Medicare Locals and hospitals
- develop additional performance indicators as appropriate
- maintain the MyHospitals website.

The COAG Reform Council will continue its role of reviewing the national performance indicators at a State and Territory level. It will report on the performance of the Australian and State and Territory governments in achieving the jurisdictional level outcomes and performance benchmarks included in the NHA.

The Public hospitals, Primary and community health and Mental health management chapters contain a service-specific section on future directions in performance reporting.

E.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this sector overview.

New South Wales Government comments

"During 2012-13 significant progress was made on our reform journey.

Partnerships between NSW Health organisations continue to mature, and we can report strong achievements against the targets in NSW 2021- A Plan to Make NSW Number One.

NSW Health performed well against the key performance targets under Goals 11 and 12.

Key achievements in Keeping people healthy and out of hospital (Goal 11) include:

- Enrolled 4446 adults in the Get Healthy Information and Coaching Service
- Commenced the NSW Healthy Children's Initiative 2013–2017 and the Healthy Worker Initiative 2013–2017 to promote healthy weight, healthy eating and physical activity. The rate of overweight and obesity has stabilised for children and adults
- Implemented the NSW Tobacco Strategy 2012–17 to reduce smoking and decrease associated chronic diseases. The rate of smoking has declined since 2002 in both Indigenous and non-Indigenous adults aged 16 years or over
- Amended the Smoke-free Environment Act 2000 to reduce exposure to second hand smoke in a range of public places, with the first major changes taking effect in January 2013 with smoking restricted in outdoor public places which are most commonly visited by families and children
- Launched a range of evidence-based public education programs to reduce smoking and risky drinking, including two programs targeting people whose alcohol consumption poses a lifetime risk to health
- A significant decrease in Aboriginal infant mortality over the last 10 years. The gap between Aboriginal and non-Aboriginal infant mortality has also reduced significantly
- Significant effort has been made to promote the benefits of timely complete immunisation. The rate for children who are fully immunised at one year of age remains high.
- Key achievements in Providing world class clinical services with timely access and effective infrastructure (Goal 12) include:
- Meeting waiting time targets for booked surgery in all categories for the National Elective Surgery Targets (NEST) under the National Health Reform Agreement with the Federal Government
- Meeting or exceeding national performance targets in providing timely care for people presenting to our Emergency Departments in four out of five triage categories."

Victorian Government comments

“In 2012-13, healthcare services in Victoria have been navigating through the challenges of a slower Australian economy, a growing and ageing population, and more complex healthcare needs. National Health Reform has been challenging as new national agencies have become established. Against this backdrop, in partnership with a range of healthcare providers, the Victorian government continues to build and maintain high quality health, mental health and aged care services for Victorians.

Health spending in 2012-13 totalled $13.67 billion, which will increase to $14.34 billion in 2013-14. Increased investment in 2012-13 included $818 million over four years for growth in hospital services, including additional State funding for elective surgery in the context of lapsing Commonwealth funding for these services. A range of initiatives to support the rural maternity workforce and improve maternity service sustainability were also implemented in 2012-13. Investment in the Victorian health system is continuing in 2013-14 with an additional $1.47 billion committed over 4 years for growth in hospital services.

The Victorian Government is also committed to ensuring state-funded mental health services are a more integral and connected part of Victoria’s broader health and human services system, with community-based recovery-oriented treatment and care at the centre of reform. Investment of $1.14 billion was allocated in 2012-13, including additional funding for community-based mental health services, new and redeveloped acute and sub-acute mental health beds, and new specialist services. Funding for mental health services will increase to over $1.2 billion in 2013-14 with new funding for more hospital beds for people with a mental illness, improved access to services for vulnerable Victorians and more support for mental health and alcohol and drug sector workers.

Investment in State-funded primary health care in Victoria in 2012-13 included $61.8 million over four years to improve health outcomes for Aboriginal Victorians, including assistance to increase access to both Aboriginal community-controlled and mainstream health services. Further State funding has been allocated in 2013-14 to improve health outcomes associated with cardiovascular disease and stroke, with improved access initiatives for Victorians living in rural and regional areas.

Victoria’s clinical networks continue to provide leadership and support for collaboration between clinicians. Improved consumer information about the maternity and neonatal service system has also been published, including a statewide parenting kit for Victorian families that develops health literacy and facilitates better health outcomes for children.

The Victorian Government is confident that Victoria’s health system is well placed to address major challenges ahead, continues to perform to a high standard, and is sustainable and responsive to people’s needs.”

Queensland Government comments

“ The 2013-2014 Queensland State budget will see a record $12.3 billion invested in the Queensland healthcare system, an increase of 4.5 per cent on the 2012-2013 estimated actual budget. However, meeting healthcare needs sustainably also requires a continuing commitment to innovation and reform with a focus on measuring outputs and outcomes rather than just inputs.

In 2013-2014, 83.7 per cent of the total Queensland Health budget will be channelled directly to independent Hospital and Health Services (HHS), empowering local management and better responsiveness of healthcare services. The Queensland Government is committed to a robust performance management and reporting framework to hold HHSs accountable for their performance. Open hospital performance reporting allows healthcare consumers to more easily track and compare local health services. Services continue to be delivered within budget — an overall surplus that was recorded by the HHSs in 2012-2013 is being reinvested in additional health services, including extra elective surgery activity to reduce waiting times across the state.

The recently published Blueprint for better healthcare in Queensland outlines structural and cultural improvements that need to occur in coming years to establish Queensland as the leader in Australian healthcare. For instance, it sets a target for the cost of healthcare delivery to equal or better national benchmarks by mid 2014. Improvements have already been achieved since 2009-2010, with further significant improvements expected in 2013-2014.

Significant investment is being made to implement a range of clinical redesign projects. There are many positive indicators of performance with continued reductions in waiting times for emergency department and elective surgery, as well as decreasing average length of stay in our public hospitals. Increased partnerships with the private and not-for-profit sectors in providing innovative, effective and efficient public service delivery models are being explored.

Investment in Queensland’s healthcare infrastructure continued apace in 2013 with the opening of the Gold Coast University Hospital and further progress on the new Queensland Children’s Hospital and the Sunshine Coast Public University Hospital (SCPUH).

Queensland has the most decentralised population of any Australian jurisdiction. The recently announced expansion of the Rural Telehealth Service will help support equity of access to healthcare across the State. Improving Indigenous health toward ‘closing the gap’ is an ongoing priority with several initiatives this year including a new Brisbane-based Centre of Excellence in Indigenous Health.

The Queensland Mental Health Commission was also established from 1 July 2013 to drive and lead cultural change in the way mental health, drug and alcohol services are planned and delivered. Other important developments include the launch of a new Queensland HIV Strategy to reduce infection rates, increased funding to clear cochlear implant waiting lists and the ‘Mums and Bubs’ package of enhanced Maternal and Child Health Services. ”

Western Australian Government comments

“In 2012-13, WA Health continued to provide a high quality service for the Western Australian community, despite increasing demand for its services from the State’s growing population. The solid performance was underpinned by long-term planning, regular and ongoing monitoring and review, innovative reform and a professional workforce. The year began with restructuring public health system governance through appointing five high-level governing councils. In addition, health system efforts were focused through the four pillars of the WA Health Strategic Intent 2010–2015:

- Caring for individuals and the community
  The Western Australian community benefits from effective public health programs, responsive health services and hospitals which meet high standards of safety and quality. The commitment to safety and quality was strengthened in 2012-13 by adopting new national safety and quality service standards. A range of public health initiatives aimed at preventing chronic disease and injury were delivered, including those designed to better protect the community from vaccine-preventable diseases and ongoing initiatives to reduce smoking.
- Caring for those who need it most
  In 2012-13, WA Health hospitals performed strongly against the National Emergency Access Target, with measures implemented to ensure timely access to appropriate care. Community care initiatives were established to enhance services for people with a disability or chronic health condition. New subacute care programs commenced and existing ones were expanded. WA Health has made a significant contribution under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, including 98 Aboriginal specific programs delivered in country Western Australia that improved health outcomes for Aboriginal people.
- Making the best use of funds and resources
  Statewide capital programs have progressed well, with several health building projects completed in 2012-13. Construction continued on other major developments including the Fiona Stanley and new children’s hospitals. Of WA Health services, 76 per cent are now funded under the Activity-Based Funding model with an aim to improve efficiency in service delivery. Implementation of an Emergency Telehealth Service in selected rural areas has delivered significant benefits to areas in need.
- Supporting our team
  WA Health has seen more doctors and nurses recruited to meet challenging health workforce demands, particularly in the country areas. Recognised as key to improving the health of Aboriginal people, WA Health also embarked on a range of initiatives to increase the number of Aboriginal people working in the health system.”

South Australian Government comments

“In 2012-13, the Department for Health and Ageing experienced significant reform designed to support the department’s achievement of goals set out in the SA Health Care Plan 2007–16.

Significant legislative reform was achieved during 2012-13. The *Advance Care Directives Bill 2013*, which will simplify existing arrangements for advance care directives, passed both houses of the Parliament of South Australia and is likely to commence mid-2014. The *South Australian Public Health Act 2011* became fully operational, providing the basis for developing a state Public Health Plan and local planning by local councils.

SA Health continued to excel in the provision of Emergency Department and elective surgery services, bettering the national average in a number of key areas of hospital performance. By the end of 2012-13, there were no patients overdue for elective surgery in the South Australian public health system.

The department progressed work on major capital developments during 2012-13 and investment in medical research and innovation continued, with the opening of the $5 million Australian Cancer Research Foundation’s Cancer Genomics Facility at the SA Pathology site. Work on the new Royal Adelaide Hospital site reached several significant milestones and the $163 million Flinders Medical Centre redevelopment was opened. A new $12 million Rehabilitation and Allied Health Building at The Queen Elizabeth Hospital was opened and construction on the final phase of the $17.4 million Modbury Hospital Emergency Department redevelopment began. Young patients with chronic illnesses are now being treated in a new ward at the Women’s and Children’s Hospital, following the opening of the $5.4 million 20-bed Cassia Ward, and SA Ambulance Service launched its first MedSTAR Kids neonatal and paediatric ambulance.

Investment continued in major eHealth initiatives. The largest, the Enterprise Patient Administration System (EPAS), continued to progress during 2012-13. EPAS will provide the foundations for the delivery of an SA Health wide electronic health record and will help improve care by enabling clinicians to spend less time on paperwork and more time with patients at the bedside.

The Northern Community Mental Health Centre was opened, furthering SA Health’s efforts to provide high-quality mental health services. This is the third of six being built across Adelaide as part of a $34 million state government initiative.

Redevelopment works at Country Health SA sites progressed well in 2012-13, including the $39.2 million Port Lincoln and $36 million Riverland hospitals. Redevelopment and upgrade works of the Emergency Departments at Cummins Hospital and the South Coast District Hospital in Victor Harbor were completed.

SA Health’s efforts to reduce the prevalence of smoking continues to deliver good results. Data from the 2012 South Australian Health Omnibus Survey showed that the key target in the South Australian Tobacco Control Strategy 2011–16, to reduce the percentage of young smokers (15 to 29 years) to 16 per cent by 2016, is on track.”

Tasmanian Government comments

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During 2012-13 the Department of Health and Human Services has continued to deliver high quality health services to the population of Tasmania.

This year marked the first year of operation of the three Tasmanian Health Organisations, and the first year in which service agreements were required in accordance with the *Tasmanian Health Organisation Act 2011*.

In 2012-2013, Ambulance Tasmania reduced its statewide median emergency response times despite the number of call-outs increasing by more than 12 per cent, and BreastScreen Tasmania continued to out-perform the national target, with almost 93 per cent of clients assessed within the recommended timeframe.

Another significant milestone was the passing of the new *Mental Health Act 2013* through the Tasmanian Parliament, which comes into effect from 1 January 2014 to ensure there is a human rights approach taken to helping clients suffering from mental illness.

Preventative health remains a core focus and this year the five-yearly *State of Public Health Report* was released, accompanied by the *Health Indicators Tasmania Report*. It shows that the life-expectancy of Tasmanians is improving and self-reported health is generally good. However, Tasmania’s health challenges continue to be towards encouraging Tasmanians to maintain healthy lifestyles and to reduce the prevalence of smoking and chronic disease caused by obesity. Tasmania also has a generally older and more dispersed population than other states, creating particular challenges for our health system.

To meet these and other challenges, the Tasmanian Lead Clinicians Group (TLCG) is leading work to update Tasmania’s Health Plan. They are consulting widely with clinicians and stakeholders to ensure the vision for health services into the future remains flexible and relevant.

The TLCG released *Tasmania’s Health Planning Framework* in August 2013 as the first step in developing a new health plan. Following this, a discussion paper on Clinical Advisory Groups (CAGs) was released seeking feedback on the proposed strategy for implementing the planning framework through the development of CAGs.

Work is currently underway to establish a number of these high level CAGs. Each CAG will provide advice to the TLCG, and lead work in a range of specific areas, including access to and integration of services; quality and safety of care; clinical governance and engagement; efficient resource utilisation; and, statewide service planning.

The TLCG have also identified a number of priority areas for action over the next twelve months as we move forward in building an efficient, safe and sustainable health system for all Tasmanians.

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Australian Capital Territory Government comments

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The ACT Government, through ACT Health, plans, manages and delivers public sector health services to both ACT residents and residents in the NSW surrounding region. The total catchment population (the Australian Capital Region) was 617 071 persons as at June 2012. Canberra is the major health referral centre for the Greater Southern Region of NSW.

As a result of the requirements under the current national health reform agenda, the ACT has established a Local Hospital Network comprising of Canberra Hospital and Health Services, Calvary Hospital, Clare Holland House, and Queen Elizabeth II Family Centre. The network provides a comprehensive range of acute, sub- and non-acute, emergency, non-admitted, and community based health services in the ACT.

In 2012-13, the ACT exceeded its target for the number of people removed from the elective surgery waiting list — the highest on record for the ACT — and continues to reduce the quantum of patients waiting longer than clinically recommended times. The high quality of service that patients receive in ACT public hospitals was reflected in the quality of theatre and post operative care, the effective treatment of people who received hospital healthcare through our hospital and community based services, and the low number of people who acquired a bacteraemial infection during their hospital stay.

The ACT, through the Australian Council on Healthcare Standards, met all accreditation criteria — with 28 marked achievements, 18 extensive achievements, and one outstanding achievement — to retain its full accreditation status for another four years.

The needs of the Canberra community are changing and the ACT Government is embarking on a program of investment in health infrastructure to meet the challenges of a growing and ageing population in the ACT and surrounding region.

The Health Infrastructure Program began with a careful examination of the current health system and a comprehensive review of the future needs of the community. Since the program was first announced in 2008, it has delivered a range of community based projects and many enhancements to services and facilities at our hospitals.

New building projects completed in 2013 include the Belconnen Community Health Centre; the Centenary Hospital for Women and Children; and an extension to the emergency department/intensive care unit at Canberra Hospital, while an expansion and refurbishment of the Tuggeranong Community Health Centre and the Canberra Region Cancer Centre will be completed in 2014. Planning continues on further hospital and community health infrastructures and associated workforce and e-Health services.

The ACT continues to work with the Commonwealth and the health reform bodies on matters relating to the *National Health Reform Agreement*.

”

Northern Territory Government comments

“During 2012-13, Northern Territory Department of Health services provided care in a range of settings, including remote health centres and our five hospitals.

Northern Territory statistics reflect the challenges of geography and a population widely distributed across remote and very remote areas. This contributes to significant socioeconomic disadvantage for some sectors of the population which often results in limited life and health choices and poorer wellbeing. We continue to address these challenges through service delivery approaches that respond to local needs and conditions.

The Northern Territory Government's New Service Framework for Health and Hospital Services (the NSF) was announced in November 2012. The NSF's key objective is to redesign our organisation and health services in order to:

- deliver improved patient and client access to better integrated services
- increase local decision making across our services
- ensure a regional focus and regional input into service provision in communities
- provide a Territory-wide performance and accountability framework
- provide a Territory-wide safety and quality system.

The NSF also implements national health reforms. Operational services will be delivered by two organisations: the Top End and Central Australia Health Services. A more streamlined contemporary Department of Health will be established as the overall health system manager, with responsibility for: planning and managing the Northern Territory public health system; setting Territory-wide policy and frameworks, and monitoring the performance of health services. The Department will also continue to deliver a number of Territory-wide services and provide corporate services for the whole public health system.

Other major initiatives in 2012-13 included:

- improving performance against national targets for Emergency Departments and elective surgery waiting times
- implementing Alcohol Mandatory Treatment (on 1 July 2013)
- enhancing police watch house and prisoner health services
- reviewing the Patient Assistance Travel Scheme (PATS)
- commencing a scoping study for a Palmerston hospital
- opening the New Alice Springs Hospital Emergency Department and Medical Imaging Department
- enhancing cardiac and cardiac outreach services
- commencing secure care services in Alice Springs.”

Australian Government comments

“

Australia’s health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities.

Compared to similar countries, Australia has an efficient health system. The most recent Global Burden of Disease Study found that Australia achieves strong health outcomes with lower than average spending on health per capita.

Effective and efficient health policy takes into consideration the effects of an ageing population on demand for health care, increasing risks to the overall health of Australians through poor lifestyle choices and the impact of advancing technology and new drugs. Australia’s health system faces significant challenges from illness, poor health behaviours and health outcome disparities. About one-third of Australia’s burden of disease is due to ‘lifestyle’ health risks such as smoking, obesity, dietary risks, physical inactivity, and alcohol misuse. Significant gains have been made with lower smoking rates across the population. Obesity is being tackled through work to develop dietary guidelines and a front of pack labelling system to provide consumers with the information they need to make healthy eating choices.

Medicare provides all Australians with free treatment as a public patient in public hospitals. Over 80 per cent of general practitioner services are bulk billed at no cost to the patient. Medicare also provides subsidised access to specialists, optometrical services and certain allied health services. The Pharmaceutical Benefits Scheme (PBS) allows Australians to access medications at affordable prices. The PBS subsidises around 750 medicines available in more than 1970 forms.

Australia’s comprehensive immunisation program protects people against harmful diseases. Compared to most other countries, Australia provides a greater range of vaccines free to its citizens. In 2012-13, immunisation coverage for five year olds exceeded 90 per cent.

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E.6 List of attachment tables

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

E.7 References

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EA Health sector overview — attachment

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

Attachment contents

Table EA.1 **Total health expenditure, by broad source of funds (2011-12 dollars) (a), (b), (c)**

	Unit	*Australian Government* (d)	*State, Territory and local governments*	*Total government*	*Non -government* (d)	***Total***
Expenditure						
2002-03	$m	38 626	22 075	60 701	27 004	**87 705**
2003-04	$m	39 718	22 238	61 956	28 655	**90 611**
2004-05	$m	42 323	24 155	66 478	30 026	**96 503**
2005-06	$m	42 458	25 966	68 424	30 655	**99 079**
2006-07	$m	44 282	27 937	72 219	32 755	**104 974**
2007-08	$m	48 812	29 247	78 059	34 040	**112 099**
2008-09	$m	53 073	30 498	83 570	36 188	**119 758**
2009-10	$m	54 694	33 041	87 735	37 047	**124 782**
2010-11	$m	56 652	35 279	91 930	40 647	**132 578**
2011-12	$m	59 524	38 290	97 815	42 426	**140 241**
Shares (e)						
2002-03	%	44.0	25.2	69.2	30.8	**100.0**
2003-04	%	43.8	24.5	68.4	31.6	**100.0**
2004-05	%	43.9	25.0	68.9	31.1	**100.0**
2005-06	%	42.9	26.2	69.1	30.9	**100.0**
2006-07	%	42.2	26.6	68.8	31.2	**100.0**
2007-08	%	43.5	26.1	69.6	30.4	**100.0**
2008-09	%	44.3	25.5	69.8	30.2	**100.0**
2009-10	%	43.8	26.5	70.3	29.7	**100.0**
2010-11	%	42.7	26.6	69.3	30.7	**100.0**
2011-12	%	42.4	27.3	69.7	30.3	**100.0**

(a) Constant price health expenditure for 2002-03 to 2011-12 is expressed in terms of 2011-12 prices using Implicit Price Deflators, constructed by AIHW, presented in table EA.7.

(b) Components may not add to totals due to rounding.

(c) Data exclude expenditure on high level residential aged care.

(d) Funding of expenditure has been adjusted for medical expenses tax rebate.

(e) Data are derived.

Source : AIHW 2013, *Health Expenditure Australia 2011-12* , Health and Welfare Expenditure Series no. 50, Cat. no. HWE 59, Canberra.

Table EA.2 Government recurrent health expenditure, by area of expenditure (2011-12 dollars) (a), (b), (c), (d)

	Unit	*Public hospitals* (e)	*Private hospitals*	*Medical services*	*Dental services*	*Other health practitioners* (f)	*Medications*	*Other health* (f), (g)	***Total government recurrent expenditure***
Expenditure									
2002-03	$m	24 134	2 941	12 803	1 047	805	5 348	11 449	**58 526**
2003-04	$m	25 399	2 942	12 898	1 037	853	5 872	11 322	**60 321**
2004-05	$m	26 895	3 075	13 901	1 097	784	6 189	12 281	**64 222**
2005-06	$m	28 051	3 122	13 889	1 107	822	6 242	12 556	**65 789**
2006-07	$m	29 682	3 157	14 435	1 112	961	6 591	13 477	**69 414**
2007-08	$m	31 688	3 420	15 650	1 298	1 212	7 159	15 009	**75 435**
2008-09	$m	33 151	3 502	16 332	1 688	1 323	7 860	16 396	**80 252**
2009-10	$m	34 667	3 835	17 132	1 929	1 462	8 459	16 688	**84 172**
2010-11	$m	36 560	4 019	17 907	2 155	1 512	8 731	16 219	**87 103**
2011-12	$m	38 483	3 958	18 617	2 305	1 555	8 980	17 928	**91 826**
Shares (h)									
2002-03	%	41.2	5.0	21.9	1.8	1.4	9.1	19.6	**100.0**
2003-04	%	42.1	4.9	21.4	1.7	1.4	9.7	18.8	**100.0**
2004-05	%	41.9	4.8	21.6	1.7	1.2	9.6	19.1	**100.0**
2005-06	%	42.6	4.7	21.1	1.7	1.2	9.5	19.1	**100.0**
2006-07	%	42.8	4.5	20.8	1.6	1.4	9.5	19.4	**100.0**
2007-08	%	42.0	4.5	20.7	1.7	1.6	9.5	19.9	**100.0**
2008-09	%	41.3	4.4	20.4	2.1	1.6	9.8	20.4	**100.0**
2009-10	%	41.2	4.6	20.4	2.3	1.7	10.0	19.8	**100.0**
2010-11	%	42.0	4.6	20.6	2.5	1.7	10.0	18.6	**100.0**
2011-12	%	41.9	4.3	20.3	2.5	1.7	9.8	19.5	**100.0**

(a) Constant price health expenditure for 2002-03 to 2011-12 is expressed in terms of 2011-12 prices using Implicit Price Deflators, constructed by AIHW, presented in table EA.7.

(b) Tables show funding provided by the Australian Government, State and Territory governments and local government authorities.

(c) Components may not add to totals due to rounding.

(d) Data exclude expenditure on high level residential aged care.

(e) Public hospitals (2002-03) include any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Includes services provided off-site, such as hospital in the home, dialysis or other services. Public hospital services (2003-04 to 2011-12) excludes any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Can include services provided off the hospital site such as hospital in the home, dialysis or other services.

(f) Due to changes in methods, care must be taken comparing 2002-03 and 2003-04.

(g) Other health comprises patient transport services, community health, public health, aids and appliances, other non-institutional health nec., administration and research.

(h) Data are derived.

Source: AIHW (unpublished) Health expenditure database.

Table EA.3 Non-government recurrent health expenditure by area of expenditure (2011-12 dollars) (a), (b), (c), (d), (e)

	Unit	*Public hospitals* (f)	*Private hospitals*	*Medical services*	*Dental services*	*Other health practi-tioners* (g)	*Medica-tions*	*Other health* (g), (h)	***Total non-government recurrent expenditure***
Expenditure									
2002-03	$m	1 804	4 352	3 574	4 708	2 415	4 226	3 597	**24 677**
2003-04	$m	1 651	4 683	3 825	4 807	2 540	4 686	4 014	**26 205**
2004-05	$m	1 985	4 815	3 698	5 033	2 698	5 222	4 120	**27 571**
2005-06	$m	2 083	4 859	3 738	5 025	2 780	5 452	4 228	**28 165**
2006-07	$m	2 270	5 053	4 053	5 194	2 845	6 041	4 381	**29 837**
2007-08	$m	2 453	5 198	4 372	5 175	2 714	6 530	4 560	**31 001**
2008-09	$m	2 872	6 407	4 589	5 364	2 506	7 349	4 764	**33 851**
2009-10	$m	2 937	6 597	4 772	5 846	2 612	7 799	4 966	**35 529**
2010-11	$m	3 350	7 003	5 012	5 723	2 810	9 711	5 224	**38 834**
2011-12	$m	3 552	7 517	5 283	6 031	2 916	9 860	5 401	**40 560**
Shares (i)									
2002-03	%	7.3	17.6	14.5	19.1	9.8	17.1	14.6	**100.0**
2003-04	%	6.3	17.9	14.6	18.3	9.7	17.9	15.3	**100.0**
2004-05	%	7.2	17.5	13.4	18.3	9.8	18.9	14.9	**100.0**
2005-06	%	7.4	17.3	13.3	17.8	9.9	19.4	15.0	**100.0**
2006-07	%	7.6	16.9	13.6	17.4	9.5	20.2	14.7	**100.0**
2007-08	%	7.9	16.8	14.1	16.7	8.8	21.1	14.7	**100.0**
2008-09	%	8.5	18.9	13.6	15.8	7.4	21.7	14.1	**100.0**
2009-10	%	8.3	18.6	13.4	16.5	7.4	22.0	14.0	**100.0**
2010-11	%	8.6	18.0	12.9	14.7	7.2	25.0	13.5	**100.0**
2011-12	%	8.8	18.5	13.0	14.9	7.2	24.3	13.3	**100.0**

(a) Total health funding has not been adjusted to include medical expenses tax rebate as funding by the Australian Government.

(b) Constant price health expenditure for 2002-03 to 2011-12 is expressed in terms of 2011-12 prices using Implicit Price Deflators, constructed by AIHW, presented in table EA.7.

(c) Tables show funding by the major non-government sources of funding for health care.

(d) Data exclude expenditure on high level residential aged care.

(e) Components may not add to totals due to rounding.

(f) Public hospitals (2002-03) include any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Includes services provided off-site, such as hospital in the home, dialysis or other services. Public hospital services (2003-04 to 2011-12) excludes any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Can include services provided off the hospital site such as hospital in the home, dialysis or other services.

(g) Due to changes in methods, care must be taken comparing 2002-03 and 2003-04.

(h) Other health comprises patient transport services, community health, public health, aids and appliances, other non-institutional health nec., administration and research.

(i) Data are derived.

Source: AIHW (unpublished) Health expenditure database.

Table EA.4 **Recurrent health expenditure, by source of funds and area of expenditure, 2011-12 (a), (b), (c), (d)**

		Government					*Non-government*				*Total*
		Australian Government									
Area of expenditure	*Unit*	*Direct expenditure*	*Health insurance premium rebates* (e)	*Total*	*State, Territory and local*	*Total government*	*Private health insurance funds*	*Individuals*	*Other* (f)	*Total non-government*	
Expenditure											
Hospitals	$m	16 906	2 630	19 536	22 905	42 441	6 287	2 450	2 331	11 068	53 509
Public hospital services (g)	$m	15 736	337	16 072	22 411	38 483	805	1 117	1 630	3 552	42 034
Private hospitals	$m	1 171	2 293	3 464	494	3 958	5 483	1 334	701	7 517	11 475
Patient transport services	$m	206	75	281	2 084	2 365	179	351	96	626	2 991
Medical services	$m	18 115	502	18 617	–	18 617	1 200	2 955	1 128	5 283	23 900
Dental services	$m	1 060	528	1 587	718	2 305	1 261	4 736	34	6 031	8 336
State/territory provider	$m	..	–	–	718	718	–	20	22	42	760
Private provider	$m	1 060	528	1 587	–	1 587	1 261	4 716	12	5 989	7 576
Other health practitioners	$m	1 297	250	1 547	8	1 555	599	1 928	390	2 916	4 472
Community health and other (h)	$m	1 122	–	1 122	5 703	6 825	1	115	149	265	7 090
Public health	$m	1 503	–	1 503	663	2 166	–	20	47	66	2 232
Medications	$m	8 959	21	8 980	–	8 980	50	9 733	78	9 860	18 839
Benefit-paid medications	$m	8 430	–	8 430	–	8 430	–	1 665	–	1 665	10 096
All other medications	$m	528	21	549	–	549	50	8 067	78	8 195	8 744
Aids and appliances	$m	427	204	631	–	631	488	2 503	65	3 056	3 687
Administration	$m	528	460	988	300	1 288	1 100	–	2	1 102	2 390
Research	$m	3 856	–	3 855	798	4 653	–	5	281	286	4 939
Total recurrent	**$m**	**53 976**	**4 671**	**58 647**	**33 179**	**91 826**	**11 165**	**24 795**	**4 599**	**40 560**	**132 386**

Table EA.4 **Recurrent health expenditure, by source of funds and area of expenditure, 2011-12 (a), (b), (c), (d)**

		Government					*Non-government*				*Total*
		Australian Government									
Area of expenditure	*Unit*	*Direct expenditure*	*Health insurance premium rebates* (e)	*Total*	*State, Territory and local*	*Total government*	*Private health insurance funds*	*Individuals*	*Other* (f)	*Total non-government*	
Shares (i)											
Hospitals	%	31.6	4.9	36.5	42.8	79.3	11.7	4.6	4.4	20.7	100.0
Public hospital services	%	37.4	0.8	38.2	53.3	91.6	1.9	2.7	3.9	8.5	100.0
Private hospitals	%	10.2	20.0	30.2	4.3	34.5	47.8	11.6	6.1	65.5	100.0
Patient transport services	%	6.9	2.5	9.4	69.7	79.1	6.0	11.7	3.2	20.9	100.0
Medical services	%	75.8	2.1	77.9	–	77.9	5.0	12.4	4.7	22.1	100.0
Dental services	%	12.7	6.3	19.0	8.6	27.7	15.1	56.8	0.4	72.3	100.0
State/territory provider	%	..	–	–	94.5	94.5	–	2.6	2.9	5.5	100.0
Private provider	%	14.0	7.0	20.9	–	20.9	16.6	62.2	0.2	79.1	100.0
Other health practitioners	%	29.0	5.6	34.6	0.2	34.8	13.4	43.1	8.7	65.2	100.0
Community health and other	%	15.8	–	15.8	80.4	96.3	–	1.6	2.1	3.7	100.0
Public health	%	67.3	–	67.3	29.7	97.0	–	0.9	2.1	3.0	100.0
Medications	%	47.6	0.1	47.7	–	47.7	0.3	51.7	0.4	52.3	100.0
Benefit-paid medications	%	83.5	–	83.5	–	83.5	–	16.5	–	16.5	100.0
All other medications	%	6.0	0.2	6.3	–	6.3	0.6	92.3	0.9	93.7	100.0
Aids and appliances	%	11.6	5.5	17.1	–	17.1	13.2	67.9	1.8	82.9	100.0
Administration	%	22.1	19.2	41.3	12.6	53.9	46.0	–	0.1	46.1	100.0
Research	%	78.1	–	78.1	16.2	94.2	–	0.1	5.7	5.8	100.0
Total recurrent	**%**	**40.8**	**3.5**	**44.3**	**25.1**	**69.4**	**8.4**	**18.7**	**3.5**	**30.6**	**100.0**

(a) Total health funding has not been adjusted to include medical expenses tax rebate as funding by the Australian Government.

(b) Tables show funding provided by the Australian Government, State and Territory governments and local government authorities and by the major non-government sources of funding for health care. They do not show total expenditure on health goods and services.

Table EA.4 **Recurrent health expenditure, by source of funds and area of expenditure, 2011-12 (a), (b), (c), (d)**

		Government					*Non-government*				*Total*
		Australian Government									
Area of expenditure	*Unit*	*Direct expenditure*	*Health insurance premium rebates* (e)	*Total*	*State, Territory and local*	*Total government*	*Private health insurance funds*	*Individuals*	*Other* (f)	*Total non-government*	

(c) Data exclude expenditure on high level residential aged care.

(d) Components may not add to totals due to rounding.

(e) Includes the 30-40 per cent rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.

(f) Expenditure on health goods and services by workers compensation and compulsory third-party motor vehicle insurers, as well as other sources of income (for example, rent, interest earned) for service providers.

(g) Public hospital services exclude certain services undertaken in hospitals. Can include services provided off-site, such as hospital in the home, dialysis or other services.

(h) 'Other' denotes 'other recurrent health services nec'.

(i) Data are derived.

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

Source: AIHW 2013, *Health Expenditure Australia 2011-12* , Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59, Canberra.

Table EA.5 **Total health expenditure per person (2011-12 dollars) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (c)	*NT*	*Aust*
2002-03	4 364	4 713	4 327	4 437	4 421	4 244	5 206	5 169	4 474
2003-04	4 573	4 516	4 487	4 637	4 644	4 227	5 460	5 561	4 571
2004-05	4 842	4 739	4 582	5 001	5 053	4 458	5 801	5 818	4 815
2005-06	4 834	4 843	4 745	5 019	4 978	4 781	5 887	6 241	4 879
2006-07	5 017	5 012	5 126	5 214	5 140	4 788	5 945	6 326	5 090
2007-08	5 259	5 080	5 455	5 473	5 709	5 156	6 012	6 795	5 335
2008-09	5 473	5 363	5 714	5 624	6 018	5 345	6 259	7 165	5 577
2009-10	5 609	5 572	5 895	5 581	6 015	5 411	6 416	7 052	5 708
2010-11	5 769	5 902	6 103	6 056	6 246	6 036	6 927	7 818	5 980
2011-12	5 967	6 099	6 422	6 331	6 497	6 200	7 390	9 188	6 230

(a) Constant price health expenditure for 2002-03 to 2011-12 is expressed in terms of 2011-12 prices using Implicit Price Deflators, constructed by AIHW, presented in table EA.7.

(b) Data exclude expenditure on high level residential aged care.

(c) ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

np Not published.

Source: AIHW (unpublished) Health expenditure database.

Table EA.6 Recurrent health expenditure per person by source of funds (2011-12 dollars) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (d)	*NT*	*Aust*
Government recurrent health expenditure									
2002-03	2 925	2 969	2 952	2 988	3 110	2 882	np	4 106	2 985
2003-04	3 070	2 882	2 959	3 140	3 224	2 877	np	4 489	3 042
2004-05	3 290	2 987	3 054	3 288	3 499	3 011	np	4 675	3 204
2005-06	3 277	3 029	3 201	3 225	3 517	3 125	np	4 883	3 239
2006-07	3 366	3 110	3 403	3 399	3 663	3 272	np	5 066	3 365
2007-08	3 534	3 350	3 654	3 590	3 974	3 679	np	5 562	3 589
2008-09	3 677	3 489	3 827	3 627	4 223	3 786	np	5 892	3 737
2009-10	3 779	3 640	3 986	3 605	4 352	3 952	np	5 698	3 849
2010-11	3 816	3 737	4 012	3 775	4 434	4 133	np	6 348	3 928
2011-12	3 958	3 809	4 204	3 990	4 609	4 047	np	7 283	4 079
Non-government recurrent health expenditure									
2002-03	1 261	1 410	1 123	1 267	1 143	1 178	np	897	1 259
2003-04	1 332	1 469	1 168	1 332	1 242	1 174	np	904	1 322
2004-05	1 384	1 530	1 233	1 394	1 260	1 170	np	941	1 375
2005-06	1 361	1 552	1 269	1 428	1 294	1 214	np	1 046	1 387
2006-07	1 432	1 621	1 346	1 477	1 260	1 261	np	1 053	1 446
2007-08	1 471	1 580	1 380	1 589	1 349	1 332	np	1 108	1 475
2008-09	1 567	1 705	1 482	1 684	1 430	1 448	np	1 142	1 576
2009-10	1 626	1 801	1 521	1 682	1 455	1 331	np	1 086	1 625
2010-11	1 709	1 954	1 641	1 846	1 614	1 544	np	1 153	1 751
2011-12	1 753	2 040	1 713	1 768	1 647	1 776	np	1 218	1 802
Total recurrent health expenditure									
2002-03	4 185	4 380	4 075	4 256	4 253	4 061	np	5 005	4 244
2003-04	4 402	4 350	4 126	4 472	4 467	4 050	np	5 391	4 364
2004-05	4 674	4 517	4 287	4 683	4 760	4 181	np	5 618	4 579
2005-06	4 638	4 581	4 469	4 653	4 810	4 340	np	5 928	4 626
2006-07	4 798	4 731	4 749	4 875	4 923	4 533	np	6 118	4 811
2007-08	5 005	4 930	5 033	5 179	5 323	5 012	np	6 668	5 065
2008-09	5 244	5 193	5 309	5 311	5 653	5 233	np	7 036	5 313
2009-10	5 405	5 441	5 507	5 287	5 807	5 283	np	6 785	5 474
2010-11	5 525	5 691	5 652	5 621	6 048	5 678	np	7 500	5 680
2011-12	5 711	5 849	5 916	5 757	6 256	5 822	np	8 502	5 881

(a) Tables show funding provided by the Australian Government, State and Territory governments and local government authorities and by the major non-government sources of funding for health goods and services. They do not show total expenditure on health services by the different service provider sectors.

(b) Constant price health expenditure for 2002-03 to 2011-12 is expressed in terms of 2011-12 prices using Implicit Price Deflators, constructed by AIHW, presented in table EA.7.

(c) Data exclude expenditure on high level residential aged care.

(d) ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditure for NSW residents. Thus the ACT population is not the appropriate denominator.

np Not published.

Source: AIHW (unpublished) Health expenditure database.

Table EA.7 **Total health price index**

	2002–03	*2003–04*	*2004–05*	*2005–06*	*2006–07*	*2007–08*	*2008–09*	*2009–10*	*2010–11*	*2011–12*
Total health price index(a)	78.4	81.1	84.0	87.5	90.4	92.4	94.9	97.3	98.3	100.0
Government final consumption expenditure on hospitals and nursing homes	75.5	78.2	80.3	84.0	87.3	89.9	92.9	96.4	97.7	100.0
Medicare medical services fees charged(b)	73.3	77.2	83.2	87.9	90.6	93.1	94.5	96.8	98.4	100.0
Dental services(a)	75.0	79.8	83.0	87.6	91.2	94.3	96.7	99.1	100.0	100.0
Other health practitioners(a)	76.4	78.2	80.5	84.3	86.0	85.9	89.5	91.9	94.8	100.0
Professional health workers wage rates	70.7	74.0	76.7	80.2	83.8	86.9	90.2	93.8	97.2	100.0
PBS pharmaceuticals(a)	98.3	98.4	98.5	98.6	98.8	99.0	99.5	99.7	100.0	100.0
HFCE on chemist goods	98.2	96.8	97.8	99.1	101.5	102.0	100.6	101.0	99.9	100.0
Aids and appliances(a)	97.6	104.4	107.1	110.0	112.3	115.5	113.5	108.0	101.9	100.0
Australian Government gross fixed capital formation	95.6	94.0	95.7	96.5	98.1	98.0	100.2	99.5	99.9	100.0
State, territory and local government gross fixed capital formation	85.6	86.3	88.6	91.3	94.4	96.6	100.5	98.4	98.9	100.0
Private gross fixed capital formation	87.6	89.2	91.9	93.9	96.5	98.5	100.9	100.2	100.5	100.0
Gross domestic product	71.2	73.4	76.2	79.9	83.8	87.6	92.0	92.8	98.4	100.0

(a) Implicit Price Deflator, constructed by AIHW

(b) Chain price index, constructed by the AIHW

Source : AIHW 2013, *Health Expenditure Australia 2011-12* , Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59, Canberra.

Table EA.8 **Birthweights, live births, all mothers, 2011 (a)**

	Unit	*NSW*	*Vic* (b)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (c)	*NT*	*Aust*
Mean birthweight										
	grams	3 372	3 371	3 377	3 355	3 340	3 381	3 343	3 275	3 367
Number of babies by birthweight										
Less than 1000g	no.	400	370	305	125	104	29	35	26	1 394
1000–1499g	no.	503	392	381	165	106	51	48	40	1 686
1500–1999g	no.	1 059	919	825	363	267	98	115	75	3 721
2000–2499g	no.	3 648	2 927	2 459	1 279	924	300	259	232	12 028
2500–2999g	no.	14 727	11 188	9 202	5 115	3 308	889	844	709	45 982
3000–3499g	no.	35 311	26 159	21 642	11 728	7 253	2 120	1 950	1 376	107 539
3500–3999g	no.	29 896	22 377	19 293	9 749	6 015	1 974	1 744	1 017	92 065
4000–4499g	no.	9 509	7 470	6 545	3 015	1 926	684	560	363	30 072
4500g and over	no.	1 565	1 381	1 110	396	289	144	103	61	5 049
Not stated	no.	46	–	4	–	2	–	–	–	52
All births	**no.**	**96 664**	**73 183**	**61 766**	**31 935**	**20 194**	**6 289**	**5 658**	**3 899**	**299 588**
Less than 1500g	*no.*	903	762	686	290	210	80	83	66	3 080
Less than 2500g	*no.*	5 610	4 608	3 970	1 932	1 401	478	457	373	18 829
Proportion of babies by birthweight										
Less than 1000g	%	0.4	0.5	0.5	0.4	0.5	0.5	0.6	0.7	0.5
1000–1499g	%	0.5	0.5	0.6	0.5	0.5	0.8	0.8	1.0	0.6
1500–1999g	%	1.1	1.3	1.3	1.1	1.3	1.6	2.0	1.9	1.2
2000–2499g	%	3.8	4.0	4.0	4.0	4.6	4.8	4.6	6.0	4.0
2500–2999g	%	15.2	15.3	14.9	16.0	16.4	14.1	14.9	18.2	15.3
3000–3499g	%	36.5	35.7	35.0	36.7	35.9	33.7	34.5	35.3	35.9
3500–3999g	%	30.9	30.6	31.2	30.5	29.8	31.4	30.8	26.1	30.7
4000–4499g	%	9.8	10.2	10.6	9.4	9.5	10.9	9.9	9.3	10.0
4500g and over	%	1.6	1.9	1.8	1.2	1.4	2.3	1.8	1.6	1.7
Not stated	%	–	–	–	–	–		–	–	–
All births	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Less than 1500g (c	*%*	0.9	1.0	1.1	0.9	1.0	1.3	1.5	1.7	1.0
Less than 2500g (c	*%*	5.8	6.3	6.4	6.0	6.9	7.6	8.1	9.6	6.3

(a) This table cannot be compared with birthweight for all births in previous reports.

(b) Data for Victoria are provisional data.

(c) Non-ACT residents made up 14.6 per cent of women who gave birth in the ACT. Care must be taken when interpreting percentages. For example, the percentage of live births of ACT residents who gave birth in the ACT where the birthweight was less than 1,500 grams was 1.0 per cent and where the birthweight was less than 2,500 grams the percentage was 6.5 per cent.

– Nil or rounded to zero.

Source: Li Z, Zeki R, Hilder L & Sullivan EA 2013. *Australia's mothers and babies 2011*. Perinatal statistics series no. 28. Cat. no. PER 58. Sydney: AIHW National Perinatal Epidemiology and Statistics Unit.

Table EA.9 **Birthweights, live births, Indigenous mothers, 2011 (a)**

	Unit	*NSW*	*Vic* (b)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (c)	*NT*	*Aust*
Mean birthweight	grams	3 229	3 246	3 215	3 144	3 116	3 206	2 929	3 089	3 187
Number of babies by birthweight										
Less than 1500g	no.	36	np	74	30	26	np	np	37	237
1500–2499g	no.	310	100	336	187	79	np	np	184	1 245
2500–2999g	no.	611	166	764	420	160	54	18	357	2 550
3000–3499g	no.	973	294	1 251	540	216	98	26	489	3 887
3500–3999g	no.	764	249	881	368	157	84	23	233	2 759
4000–4499g	no.	240	85	300	105	45	18	8	91	892
4500g and over	no.	46	np	51	17	10	<5	–	25	166
Not stated	no.	1	–	–	–	–	–	–	–	1
All births	**no.**	2 981	924	3 657	1 667	693	np	np	1 416	11 737
Less than 2500g	*no.*	346	116	410	217	105	39	28	221	1 482
Proportion of babies by birthweight										
Less than 1500g	%	1.2	np	2.0	1.8	3.8	np	np	2.6	2.0
1500–2499g	%	10.4	10.8	9.2	11.2	11.4	np	np	13.0	10.6
2500–2999g	%	20.5	18.0	20.9	25.2	23.1	18.2	17.5	25.2	21.7
3000–3499g	%	32.6	31.8	34.2	32.4	31.2	33.1	25.2	34.5	33.1
3500–3999g	%	25.6	26.9	24.1	22.1	22.7	28.4	22.3	16.5	23.5
4000–4499g	%	8.1	9.2	8.2	6.3	6.5	6.1	7.8	6.4	7.6
4500g and over	%	1.5	np	1.4	1.0	1.4	np	–	1.8	1.4
Not stated	%	–	–	–	–	–	–	–	–	–
All births	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Less than 2500g	*%*	11.6	12.6	11.2	13.0	15.2	13.2	27.2	15.6	12.6

(a) This table cannot be compared with birthweight for all births to Indigenous mothers in previous reports.

(b) Data for Victoria are provisional data.

(c) Of Indigenous women who gave birth in the ACT, 28.2 per cent were non-ACT residents. Care must be taken when interpreting percentages. For example, the percentage of liveborn babies born in the ACT to ACT resident Indigenous women in 2011 where the birthweight was less than 2500 grams was 16.4 per cent.

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

Source: Li Z, Zeki R, Hilder L & Sullivan EA 2013. *Australia's mothers and babies 2011*. Perinatal statistics series no. 28. Cat. no. PER 58. Sydney: AIHW National Perinatal Epidemiology and Statistics Unit.

Table EA.10 **Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic* (f)	*Qld*	*WA*	*SA*	*Tas* (g)	*ACT* (g)	*NT*	*Aust*
2007										
Proportion low birthweight babies born to										
Indigenous mothers	%	10.3	10.6	10.0	14.4	13.8	np	np	12.3	11.2
Non-Indigenous mothers	%	4.3	4.7	4.3	4.4	4.7	np	np	4.1	4.5
Total (h)	**%**	**4.5**	**4.7**	**4.7**	**5.0**	**4.9**	**5.3**	**4.5**	**7.3**	**4.7**
Number of low birthweight babies born to										
Indigenous mothers	no.	298	65	308	249	81	np	np	169	1 186
Non-Indigenous mothers	no.	3 888	3 147	2 391	1 214	861	np	np	89	12 100
Total (h)	**no.**	**4 212**	**3 215**	**2 702**	**1 463**	**942**	**326**	**201**	**258**	**13 319**
Variability bands for rate										
Indigenous mothers	no.	1.1	2.4	1.1	1.7	2.8	np	np	1.7	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	np	np	0.8	0.1
Total (h)	**no.**	**0.1**	**0.2**	**0.2**	**0.3**	**0.3**	**0.6**	**0.6**	**0.9**	**0.1**
2008										
Proportion low birthweight babies born to										
Indigenous mothers	%	10.4	13.1	8.9	14.0	12.4	9.2	10.0	13.7	11.2
Non-Indigenous mothers	%	4.3	4.5	4.4	4.3	4.6	5.0	3.7	4.1	4.4
Total (h)	**%**	**4.5**	**4.6**	**4.6**	**4.9**	**4.8**	**5.2**	**3.8**	**7.6**	**4.7**
Number of low birthweight babies born to										
Indigenous mothers	no.	314	85	294	233	75	26	7	184	1 218
Non-Indigenous mothers	no.	3 947	3 067	2 445	1 213	849	298	166	98	12 083
Total (h)	**no.**	**4 280**	**3 155**	**2 742**	**1 446**	**924**	**324**	**174**	**282**	**13 327**
Variability bands for rate										
Indigenous mothers	no.	1.1	2.6	1.0	1.7	2.6	3.4	7.0	1.8	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.5	0.8	0.1
Total (h)	**no.**	**0.1**	**0.2**	**0.2**	**0.2**	**0.3**	**0.6**	**0.5**	**0.8**	**0.1**
2009										
Proportion low birthweight babies born to										
Indigenous mothers	%	10.0	12.2	9.8	13.0	10.4	8.3	13.9	12.5	10.9
Non-Indigenous mothers	%	4.2	4.6	4.7	4.3	5.0	5.0	3.7	5.0	4.5
Total (h)	**%**	**4.4**	**4.7**	**4.9**	**4.8**	**5.1**	**5.1**	**3.8**	**7.7**	**4.7**
Number of low birthweight babies born to										
Indigenous mothers	no.	294	91	320	223	63	23	11	174	1 199
Non-Indigenous mothers	no.	3 813	3 076	2 637	1 221	921	290	172	117	12 247
Total (h)	**no.**	**4 124**	**3 231**	**2 961**	**1 444**	**984**	**313**	**184**	**291**	**13 532**
Variability bands for rate										
Indigenous mothers	no.	1.1	2.4	1.0	1.6	2.4	3.3	7.6	1.7	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.5	0.9	0.1
Total (h)	**no.**	**0.1**	**0.2**	**0.2**	**0.2**	**0.3**	**0.6**	**0.5**	**0.9**	**0.1**

Table EA.10 **Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic* (f)	*Qld*	*WA*	*SA*	*Tas* (g)	*ACT* (g)	*NT*	*Aust*
2010										
Proportion low birthweight babies born to										
Indigenous mothers	%	10.0	10.0	10.1	12.3	12.7	6.6	12.7	12.4	10.7
Non-Indigenous mothers	%	4.2	4.8	4.6	4.3	4.8	5.5	4.3	4.4	4.5
Total (h)	**%**	**4.4**	**4.8**	**4.9**	**4.7**	**5.0**	**5.5**	**4.4**	**7.3**	**4.8**
Number of low birthweight babies born to										
Indigenous mothers	no.	312	78	344	204	81	15	8	163	1 205
Non-Indigenous mothers	no.	3 841	3 255	2 585	1 227	881	309	205	104	12 407
Total (h)	**no.**	**4 172**	**3 359**	**2 929**	**1 431**	**962**	**326**	**213**	**271**	**13 663**
Variability bands for rate										
Indigenous mothers	no.	1.0	2.1	1.0	1.6	2.6	3.2	8.2	1.8	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1
Total (h)	**no.**	**0.1**	**0.2**	**0.2**	**0.2**	**0.3**	**0.6**	**0.6**	**0.8**	**0.1**
2011										
Proportion low birthweight babies born to										
Indigenous mothers	%	10.7	10.9	10.0	11.9	11.5	10.8	13.5	14.5	11.2
Non-Indigenous mothers	%	4.4	4.7	4.4	4.3	5.2	5.8	4.6	4.8	4.6
Total (h)	**%**	**4.6**	**4.8**	**4.7**	**4.7**	**5.5**	**6.0**	**4.8**	**8.2**	**4.8**
Number of low birthweight babies born to										
Indigenous mothers	no.	322	89	354	198	78	31	10	193	1 275
Non-Indigenous mothers	no.	4 038	3 212	2 492	1 266	989	328	216	116	12 657
Total (h)	**no.**	**4 379**	**3 322**	**2 849**	**1 464**	**1 067**	**368**	**227**	**309**	**13 985**
Variability bands for rate										
Indigenous mothers	no.	1.1	2.1	1.0	1.6	2.4	3.6	7.8	1.9	0.6
Non-Indigenous mothers	no.	0.1	0.2	0.2	0.2	0.3	0.6	0.6	0.8	0.1
Total (h)	**no.**	**0.1**	**0.2**	**0.2**	**0.2**	**0.3**	**0.6**	**0.6**	**0.9**	**0.1**

Low birthweight is defined as less than 2500 grams.

(a) Data are sourced from the 2012-13 National Indigenous Reform Agreement Performance Report.

(b) Data do not include babies born to non-Indigenous mothers and Indigenous fathers. Therefore, the number of babies born to Indigenous mothers is not necessarily the total number of Indigenous babies born.

(c) Disaggregation by State/Territory are by place of usual residence of the mother.

(d) Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated.

(e) Data relate to live births. Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birthweight.

(f) Data for Victoria are provisional and subject to vary with data quality activities. Further minor changes to the data are not forseen to produce any detectable change to the indicator.

(g) Birthweight data on babies born to Indigenous mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.

(h) Includes births to mothers whose Indigenous status was not stated.

Source : AIHW unpublished, National Perinatal Data Collection.

Table EA.11 Proportion of live-born singleton babies of low birthweight, by remoteness and SEIFA quintiles, and SEIFA deciles, National, 2011 (a), (b), (c)

	Aust %	*Variability band ±*	*Aust no.*
Remoteness of residence (d)			
Major cities	4.6	0.1	9 457
Inner regional	5.0	0.2	2 475
Outer regional	5.3	0.3	1 367
Remote	6.1	0.7	298
Very remote	9.3	1.0	308
SEIFA of residence (e)			
Decile 1	6.2	0.3	2 102
Decile 2	5.6	0.3	1 619
Decile 3	5.3	0.3	1 559
Decile 4	4.8	0.2	1 415
Decile 5	4.9	0.2	1 407
Decile 6	4.4	0.2	1 329
Decile 7	4.3	0.2	1 220
Decile 8	4.6	0.2	1 286
Decile 9	4.1	0.2	1 081
Decile 10	3.6	0.2	887
Total (g)	4.8	0.1	**13 985**

(a) Low birthweight is defined as less than 2500 grams.

(b) Excludes multiple births, stillbirths and births with unknown birthweight. Births were included if they were at least 20 weeks gestation or if gestation was not known at least 400 grams birthweight.

(c) Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated.

(d) Disaggregation by remoteness area is by place of usual residence of the mother, not by place of birth.

(e) Socio-Economic Indexes for Areas (SEIFA) deciles are based on the ABS Index of Relative Socio-economic Disadvantage, with decile 1 being the most disadvantaged and decile 10 being the least disadvantaged. Disaggregation by SEIFA is based on the place of usual residence of the mother, not by place of birth.

(g) Total includes number of babies for which remoteness areas and/or SEIFA categories for the mothers could not be assigned.

Source: AIHW (unpublished) National Perinatal Data Collection.

Table EA.12 **Proportion of adults and children in BMI categories (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (g), (h)	*Aust*
Adults										
2011-12 (h)										
Underweight	%	1.9	1.5	1.8	1.3	1.3	1.0	0.6	2.3	1.6
Conf. Inter.	±	0.5	0.6	0.5	0.5	0.5	0.6	0.4	1.1	0.2
Normal weight	%	36.9	37.5	33.6	33.1	33.1	35.7	36.4	34.9	35.7
Conf. Inter.	±	1.6	1.8	2.0	1.8	1.8	2.1	2.8	3.0	0.9
Overweight	%	35.0	35.5	34.7	37.3	36.5	36.0	37.8	34.9	35.5
Conf. Inter.	±	1.5	1.8	1.7	1.9	1.8	1.9	2.2	3.4	0.7
Obese	%	26.2	25.6	30.0	28.2	29.2	27.2	25.2	27.9	27.2
Conf. Inter.	±	1.6	1.8	1.6	2.0	1.8	2.3	2.2	2.7	0.8
2007-08										
Underweight	%	1.8	1.5	3.1	1.4	2.3	2.1	1.1	–	2.0
Conf. Inter.	±	0.7	0.6	1.4	0.6	0.9	1.2	0.7	–	0.4
Normal weight	%	37.6	37.5	35.7	35.6	36.9	35.2	39.8	36.8	36.9
Conf. Inter.	±	2.4	2.6	2.5	3.2	2.5	3.3	3.0	19.4	1.2
Overweight	%	37.1	36.5	36.1	37.4	37.1	36.2	34.2	30.4	36.7
Conf. Inter.	±	2.4	2.3	2.5	3.0	2.6	3.1	2.8	11.2	1.2
Obese	%	23.4	24.5	25.0	25.6	23.7	26.5	24.8	32.8	24.4
Conf. Inter.	±	2.2	2.4	2.4	3.2	2.2	3.2	2.5	17.9	1.1
Children										
2011-12 (h)										
Underweight	%	4.2	4.6	6.9	5.5	4.4	5.0	4.6	9.9	5.1
Conf. Inter.	±	1.3	1.3	1.9	1.8	1.7	2.1	2.0	4.0	0.6
Normal weight	%	70.6	71.8	67.2	66.8	72.0	69.7	70.0	64.9	69.8
Conf. Inter.	±	3.6	3.2	3.5	3.4	4.2	5.0	4.4	6.1	1.7
Overweight	%	18.5	17.8	17.4	21.1	16.6	16.9	19.5	17.4	18.2
Conf. Inter.	±	2.8	3.1	2.6	2.8	3.5	3.5	4.1	4.5	1.3
Obese	%	6.7	5.8	8.5	6.6	7.0	8.5	5.9	7.8	6.9
Conf. Inter.	±	1.6	1.6	2.0	2.0	2.2	3.1	1.9	3.5	0.9
2007-08										
Underweight	%	7.8	6.3	10.2	6.9	6.2	4.1	3.3	np	7.5
Conf. Inter.	±	2.6	2.8	3.5	3.3	3.3	3.5	1.8	np	1.4
Normal weight	%	68.8	68.5	62.9	68.1	68.1	77.2	75.8	88.4	67.7
Conf. Inter.	±	4.7	5.1	6.4	6.1	8.2	7.1	5.1	52.1	2.9
Overweight	%	15.0	18.9	18.0	19.6	18.4	12.1	np	np	17.2
Conf. Inter.	±	3.7	4.4	5.3	5.4	6.4	5.4	np	np	2.1
Obese	%	8.5	6.3	8.9	5.4	7.3	6.6	np	np	7.5
Conf. Inter.	±	3.3	2.5	4.0	2.8	4.5	3.9	np	np	1.7
Relative standard error for adults										
2011-12 (h)										
Underweight	%	13.6	20.9	14.3	19.5	19.7	28.3	33.9	24.1	7.7
Normal weight	%	2.2	2.5	3.0	2.8	2.7	3.0	3.9	4.3	1.3

Table EA.12 **Proportion of adults and children in BMI categories (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (g), (h)	*Aust*
Overweight	%	2.2	2.6	2.5	2.5	2.5	2.7	3.0	5.0	1.0
Obese	%	3.0	3.5	2.7	3.6	3.2	4.3	4.5	4.9	1.6
2007-08										
Underweight	%	19.5	21.2	22.5	22.1	20.9	29.0	30.1	–	11.3
Normal weight	%	3.2	3.5	3.6	4.6	3.4	4.8	3.8	26.9	1.7
Overweight	%	3.3	3.3	3.5	4.1	3.6	4.4	4.2	18.9	1.6
Obese	%	4.8	5.0	4.9	6.3	4.8	6.2	5.1	27.8	2.3
Relative standard error for children										
2011-12 (h)										
Underweight	%	15.2	13.8	13.8	16.7	19.0	21.2	22.4	20.5	5.8
Normal weight	%	2.6	2.3	2.6	2.6	2.9	3.7	3.2	4.8	1.2
Overweight	%	7.7	8.7	7.5	6.8	10.6	10.6	10.6	13.1	3.6
Obese	%	12.4	14.0	12.1	15.4	16.2	19.0	16.2	22.7	6.4
2007-08										
Underweight	%	17.0	22.7	17.3	24.2	26.6	43.2	27.1	np	9.5
Normal weight	%	3.5	3.8	5.2	4.6	6.1	4.7	3.4	30.1	2.2
Overweight	%	12.5	11.9	14.9	14.2	17.9	22.7	np	np	6.2
Obese	%	19.7	20.7	22.9	26.0	31.2	29.8	np	np	11.5

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.

(a) Adults are defined as persons aged 18 years and over. Children are defined as persons aged 5–17 years.

(b) Data for 2011-12 have been revised and differ from the data published in the 2013 Report.

(c) Body mass index (BMI) categories for adults are defined as: Underweight (BMI less than 18.5); Normal weight (BMI 18.5–24.9); Overweight (BMI 25.0–29.9); Obese (BMI 30.0 or over).

(d) BMI catagories for children are defined as BMI (appropriate for age and sex) that is likely to be equal to the BMI for the same adult category at age 18 years.

(e) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.

(f) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 yr ranges from 18 for adults, selected ranges from 5–17 for children).

(g) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.

(h) Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size.

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

Source : ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 Core component); ABS (unpublished) *National Health Survey 2007-08* .

Table EA.13 **Rate of overweight and obesity for adults and children, by remoteness (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
Adults										
2011-12 (e), (g)										
Major cities	%	59.4	59.1	62.4	64.2	64.2	–	63.0	–	60.9
Conf. Inter. (f)	±	2.1	2.3	2.0	2.2	2.1	–	2.8	–	1.2
Inner regional	%	68.2	68.9	67.4	70.0	71.0	61.9	–	–	67.8
Conf. Inter. (f)	±	4.1	4.1	3.7	6.1	7.5	2.6	–	–	1.8
Outer regional	%	64.0	59.8	70.8	72.3	69.3	66.3	–	62.3	67.8
Conf. Inter. (f)	±	6.5	14.2	5.1	6.3	8.2	4.0	–	3.7	3.0
Remote	%	np	–	67.3	68.7	65.8	70.9	–	64.4	70.1
Conf. Inter. (f)	±	np	–	35.4	13.2	15.9	24.3	–	6.9	6.1
Very remote (e)	%	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	±	na	na	na	na	na	na	na	na	na
2007-08										
Major cities	%	58.4	58.7	57.5	59.6	61.6	..	59.1	..	58.8
Conf. Inter. (f)	±	2.7	3.0	3.9	3.8	2.8	..	3.0	..	1.4
Inner regional	%	64.4	66.8	66.4	72.7	51.1	60.8	..	..	66.2
Conf. Inter. (f)	±	5.3	5.6	4.6	8.4	9.2	4.6	..	..	2.3
Outer regional	%	69.2	77.1	60.5	65.1	59.6	66.3	..	53.8	65.0
Conf. Inter. (f)	±	10.0	14.5	8.1	13.4	22.8	6.2	..	17.6	4.5
Remote	%	53.0	..	64.2	73.3	61.7	81.3	..	52.9	64.0
Conf. Inter. (f)	±	55.3	..	27.7	12.7	18.3	48.5	..	38.2	12.2
Very remote (e)	%	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	±	na	na	na	na	na	na	na	na	na
Children										
2011-12 (e), (g)										
Major cities	%	24.2	24.8	25.3	26.9	21.1	–	25.4	–	24.6
Conf. Inter.	±	3.6	3.9	3.9	3.8	3.9	–	4.5	–	1.8
Inner regional	%	27.6	21.5	26.2	27.4	28.6	26.0	–	–	25.6
Conf. Inter.	±	8.7	7.7	6.3	13.8	14.1	5.3	–	–	4.3
Outer regional	%	30.1	12.4	28.0	32.6	32.0	25.3	–	22.6	27.4
Conf. Inter.	±	16.1	7.5	10.2	11.0	12.6	10.9	–	5.9	4.7
Remote	%	–	–	27.0	31.0	21.1	–	–	33.6	27.6
Conf. Inter.	±	–	–	43.8	42.3	29.5	–	–	10.8	14.7
Very remote (e)	%	na	na	na	na	na	na	na	na	na
Conf. Inter.	±	na	na	na	na	na	na	na	na	na
2007-08										
Major cities	%	21.5	23.6	24.6	23.0	23.5	..	20.9	..	22.8
Conf. Inter.	±	5.2	5.2	7.3	6.1	8.3	..	4.7	..	3.1
Inner regional	%	27.3	28.5	30.6	24.7	38.3	19.8	..	..	28.7
Conf. Inter.	±	11.5	11.3	11.2	12.4	28.5	9.1	..	..	5.3
Outer regional	%	28.4	np	22.8	24.3	np	16.8	..	np	25.5
Conf. Inter.	±	26.1	np	14.8	19.2	np	9.0	..	np	10.7

Table EA.13 **Rate of overweight and obesity for adults and children, by remoteness (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
Remote	%	..	..	35.4	30.6	np	..	..	np	21.3
Conf. Inter.	±	..	..	67.1	28.5	np	..	..	np	16.7
Very remote (e)	%	na	na	na	na	na	na	na	na	na
Conf. Inter.	±	na	na	na	na	na	na	na	na	na
Relative standard error for adults										
2011-12 (e), (g)										
Major cities	%	1.8	2.0	1.6	1.7	1.7	–	2.3	–	1.0
Inner regional	%	3.1	3.1	2.8	4.4	5.4	2.1	–	–	1.4
Outer regional	%	5.2	12.1	3.6	4.4	6.1	3.0	–	3.0	2.3
Remote	%	np	–	26.8	9.8	12.3	17.5	–	5.5	4.5
Very remote (e)	%	na	na	na	na	na	na	na	na	na
2007-08										
Major cities	%	2.4	2.6	3.4	3.2	2.4	..	2.6	..	1.3
Inner regional	%	4.2	4.3	3.5	5.9	9.2	3.8	..	..	1.8
Outer regional	%	7.4	9.6	6.9	10.5	19.5	4.8	..	16.7	3.6
Remote	%	53.3	..	22.0	8.9	15.1	30.5	..	36.9	9.7
Very remote (e)	%	na	na	na	na	na	na	na	na	na
Relative standard error for children										
2011-12 (e), (g)										
Major cities	%	7.7	8.1	7.8	7.1	9.4	–	9.0	–	3.7
Inner regional	%	16.1	18.3	12.4	25.7	25.1	10.5	–	–	8.5
Outer regional	%	27.2	30.9	18.6	17.1	20.1	22.0	–	13.3	8.8
Remote	%	–	–	82.6	69.7	71.4	–	–	16.5	27.2
Very remote (e)	%	na	na	na	na	na	na	na	na	na
2007-08										
Major cities	%	21.5	23.6	24.6	23.0	23.5	..	20.9	..	22.8
Inner regional	%	27.3	28.5	30.6	24.7	38.3	19.8	..	..	28.7
Outer regional	%	28.4	np	22.8	24.3	np	16.8	..	np	25.5
Remote	%	..	..	35.4	30.6	np	..	..	np	21.3
Very remote (e)	%	na	na	na	na	na	na	na	na	na

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. 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.

(a) Adults are defined as persons aged 18 years and over. Children are defined as persons aged 5–17 years.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Overweight for children is defined as BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for adults is defined as BMI equal to or greater than 30. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

(c) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.

Table EA.13 **Rate of overweight and obesity for adults and children, by remoteness (a), (b), (c), (d), (e)**

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

(d) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults, selected ranges from 5–17 for children).

(e) Data for 2011-12 have been revised and differ from data published in the 2013 Report.

(f) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.

(g) Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size.

Source : ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 Core component); ABS (unpublished) *National Health Survey 2007-08* .

Table EA.14 Rates of overweight and obesity for adults and children, by SEIFA IRSD quinitiles (a), (b), (c), (d), (e), (f)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (g), (h)	Aust
Adults										
2011-12 (f), (h)										
Quintile 1	%	63.4	65.6	68.0	71.7	69.3	65.3	61.7	67.2	65.8
Conf. Inter.	±	4.6	4.5	5.4	7.1	5.7	3.9	14.3	7.1	2.8
Quintile 2	%	65.7	66.9	65.1	67.5	67.3	65.7	52.5	66.0	66.2
Conf. Inter.	±	4.1	3.7	4.4	3.7	3.6	4.7	11.8	5.8	1.8
Quintile 3	%	60.9	61.3	64.2	64.4	65.5	61.1	63.6	68.8	62.8
Conf. Inter.	±	3.5	4.9	3.8	4.8	4.4	5.0	8.2	6.2	1.8
Quintile 4	%	58.3	60.5	64.0	67.3	61.4	64.7	65.8	59.5	61.6
Conf. Inter.	±	3.9	4.8	3.3	3.7	5.5	6.4	5.5	7.4	2.3
Quintile 5	%	57.7	52.3	61.9	60.6	60.2	52.2	61.8	55.7	57.5
Conf. Inter.	±	3.4	4.6	4.7	5.4	6.1	11.0	4.0	10.1	2.3
2007-08										
Quintile 1	%	66.0	67.4	63.5	72.7	67.3	69.1	55.3	55.9	65.9
Conf. Inter.	±	6.0	7.3	5.8	5.2	6.0	6.2	7.1	37.4	3.2
Quintile 2	%	59.7	60.5	65.9	63.5	55.1	63.5	65.0	80.1	61.9
Conf. Inter.	±	3.9	6.4	5.9	6.8	6.6	7.7	35.7	38.8	2.7
Quintile 3	%	63.6	63.2	63.9	63.5	64.0	59.5	60.7	40.5	63.3
Conf. Inter.	±	5.7	6.7	6.1	6.0	5.4	9.1	11.2	32.8	2.3
Quintile 4	%	62.6	60.7	53.4	64.3	63.6	59.1	56.7	45.0	60.5
Conf. Inter.	±	6.0	5.0	6.6	7.9	5.6	7.6	5.7	43.7	2.4
Quintile 5	%	54.7	56.7	55.5	53.9	59.5	58.4	59.8	60.4	55.3
Conf. Inter.	±	4.6	5.7	8.5	7.4	7.8	24.2	3.4	8.5	2.7
Children										
2011-12 (f), (h)										
Quintile 1	%	35.4	26.9	28.0	29.7	35.2	29.9	21.2	35.8	31.4
Conf. Inter.	±	7.9	8.8	9.3	11.5	10.3	9.9	27.3	16.8	4.1
Quintile 2	%	32.5	34.0	27.9	35.9	23.5	17.6	44.4	34.3	31.0
Conf. Inter.	±	10.2	7.4	7.5	6.6	7.2	6.9	41.1	7.9	4.4
Quintile 3	%	17.6	20.5	31.1	23.0	22.0	35.7	18.9	22.8	23.3
Conf. Inter.	±	7.4	6.8	7.2	7.8	9.8	13.2	10.0	12.1	2.8
Quintile 4	%	22.0	18.3	21.0	28.7	20.2	17.1	26.7	17.0	21.3
Conf. Inter.	±	7.4	7.4	6.9	6.7	7.0	11.1	10.1	8.5	3.1
Quintile 5	%	20.5	21.0	20.4	23.4	14.3	15.7	26.1	16.4	20.7
Conf. Inter.	±	5.5	6.6	7.1	7.2	6.6	16.8	6.0	15.5	2.8
2007-08										
Quintile 1	%	31.9	41.7	44.1	44.6	35.9	26.3	np	np	36.2
Conf. Inter.	±	5.5	4.6	7.8	6.3	5.1	4.1	34.4	9.3	2.2
Quintile 2	%	23.8	29.5	31.8	37.1	24.3	10.6	np	np	28.3
Conf. Inter.	±	5.1	4.6	5.2	6.2	4.4	4.8	17.6	8.7	2.5
Quintile 3	%	28.8	23.8	22.7	14.9	23.9	np	11.3	np	23.9
Conf. Inter.	±	5.7	5.7	5.9	6.0	6.1	7.5	9.0	10.8	2.8

Table EA.14 **Rates of overweight and obesity for adults and children, by SEIFA IRSD quinitiles (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (g), (h)	*Aust*
Quintile 4	%	24.1	19.9	22.4	16.9	19.3	28.0	16.7	np	21.0
Conf. Inter.	±	3.5	4.6	4.5	5.7	6.2	7.1	6.3	9.6	2.0
Quintile 5	%	10.5	21.9	11.5	22.4	24.2	np	25.6	np	17.2
Conf. Inter.	±	4.8	5.6	5.2	5.5	8.5	21.1	5.8	17.1	2.4
Relative standard error for adults										
2011-12 (f), (h)										
Quintile 1	%	3.7	3.5	4.0	5.1	4.2	3.1	11.8	5.4	2.2
Quintile 2	%	3.2	2.8	3.4	2.8	2.8	3.6	11.5	4.5	1.4
Quintile 3	%	2.9	4.1	3.0	3.8	3.5	4.2	6.5	4.6	1.5
Quintile 4	%	3.4	4.0	2.7	2.8	4.6	5.1	4.3	6.4	1.9
Quintile 5	%	3.0	4.5	3.8	4.6	5.2	10.8	3.3	9.3	2.1
2007-08										
Quintile 1	%	4.6	5.5	4.6	3.6	4.5	4.6	6.5	34.1	2.5
Quintile 2	%	3.4	5.4	4.5	5.4	6.1	6.2	28.1	24.7	2.2
Quintile 3	%	4.6	5.4	4.8	4.8	4.3	7.8	9.4	41.3	1.8
Quintile 4	%	4.9	4.2	6.3	6.3	4.5	6.6	5.2	49.6	2.0
Quintile 5	%	4.3	5.1	7.8	7.0	6.7	21.2	2.9	7.1	2.5
Relative standard error for children										
2011-12 (f), (h)										
Quintile 1	%	11.4	16.7	16.9	19.8	14.9	16.9	65.8	23.9	6.6
Quintile 2	%	15.9	11.1	13.7	9.4	15.6	19.9	47.2	11.8	7.3
Quintile 3	%	21.3	16.9	11.8	17.3	22.7	18.8	27.0	27.2	6.2
Quintile 4	%	17.2	20.6	16.7	11.9	17.6	33.0	19.4	25.3	7.4
Quintile 5	%	13.7	16.0	17.6	15.7	23.5	54.6	11.8	48.2	6.8
2007-08										
Quintile 1	%	21.2	21.2	17.8	39.4	37.0	20.8	np	np	10.7
Quintile 2	%	28.9	20.1	20.6	16.0	32.3	46.3	np	np	12.2
Quintile 3	%	23.4	22.2	22.1	30.4	32.0	np	96.0	np	12.6
Quintile 4	%	21.9	29.7	29.3	33.0	36.2	38.8	20.7	np	12.5
Quintile 5	%	36.1	19.4	47.5	22.1	33.0	np	12.0	np	11.8

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. 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.

(a) Adults are defined as persons aged 18 years and over. Children are defined as persons aged 5–17 years.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Overweight for children is defined as BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for adults is defined as BMI equal to or greater than 30. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

(c) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.

Table EA.14 **Rates of overweight and obesity for adults and children, by SEIFA IRSD quinitiles (a), (b), (c), (d), (e), (f)**

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

(d) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults, selected ranges from 5–17 for children).

(e) A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general.

(f) Data for 2011-12 have been revised and differ from data published in the 2013 Report.

(g) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.

(h) Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size.

Source : ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 Core component); ABS (unpublished) *National Health Survey 2007-08* .

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
Overweight and obese adults										
Males										
2011-12 (e), (f)										
18–24	%	41.2	37.8	39.4	46.8	40.8	39.3	51.5	50.4	40.8
25–34	%	62.2	64.4	67.2	67.0	68.6	65.0	57.6	59.6	64.6
35–44	%	75.9	72.1	76.7	78.8	71.4	66.2	75.1	72.6	74.9
45–54	%	76.9	78.4	80.8	77.0	81.4	75.2	84.7	78.6	78.5
55–64	%	74.5	77.8	84.2	78.8	80.8	85.6	74.6	71.8	78.5
65–69	%	75.1	78.0	83.2	76.1	85.4	78.0	72.0	74.3	78.3
70–74	%	82.8	78.8	89.3	90.0	83.0	83.1	77.2	85.8	83.8
75 and over	%	68.2	63.4	77.8	71.0	78.6	78.1	81.3	74.5	70.3
Total males	**%**	**68.5**	**68.0**	**72.7**	**72.0**	**71.6**	**68.7**	**70.7**	**69.3**	**69.9**
Total males	000	1 665.6	1 182.2	1 059.1	560.3	386.0	114.3	83.1	35.4	5 086.2
2007-08										
18–24	%	40.5	36.8	42.2	42.2	34.9	41.4	np	np	39.8
25–34	%	69.9	52.3	62.9	64.2	56.7	43.1	54.4	40.3	62.0
35–44	%	68.8	69.7	71.7	77.0	71.5	78.2	72.1	47.9	70.7
45–54	%	74.9	77.9	74.7	83.7	78.7	66.8	76.0	81.5	76.7
55–64	%	72.8	76.2	75.1	72.4	79.3	77.6	np	np	74.9
65–69	%	74.2	82.1	85.1	79.8	78.6	91.8	np	np	79.4
70–74	%	79.0	89.2	75.7	64.2	63.8	78.9	np	np	78.3
75 and over	%	80.4	70.1	77.7	71.4	58.7	65.1	np	np	74.3
Total males	**%**	**68.6**	**66.1**	**68.5**	**70.0**	**65.7**	**64.1**	**66.8**	**73.1**	**67.8**
Total males	000	1 332.5	925.4	726.6	417.8	252.2	79.6	61.6	32.9	3 828.6
Females										
2011-12 (e), (f)										
18–24	%	31.6	21.6	36.4	38.9	41.7	42.8	29.1	37.2	31.8
25–34	%	37.3	43.8	44.7	52.0	49.8	51.8	47.7	45.5	43.2
35–44	%	51.7	53.4	57.3	59.2	58.4	57.1	52.0	55.0	54.7
45–54	%	64.5	62.7	61.8	63.6	69.7	59.5	58.9	69.6	63.6
55–64	%	70.4	68.6	70.4	63.2	69.4	72.2	68.8	66.0	69.1
65–69	%	63.3	65.8	67.0	66.1	68.5	73.0	61.8	78.4	65.7
70–74	%	75.6	73.5	70.3	75.4	74.9	74.2	86.5	57.4	74.0
75 and over	%	61.3	69.9	68.3	70.7	62.7	58.2	69.9	np	65.7
Total female	**%**	**53.3**	**53.8**	**56.5**	**58.6**	**59.6**	**58.1**	**54.9**	**56.0**	**55.2**
Total female	000	1 259.0	929.8	812.9	426.5	317.8	97.8	62.2	27.1	3 933.3
2007-08										
18–24	%	35.7	36.1	33.2	37.8	26.1	43.8	np	np	34.8
25–34	%	43.2	40.8	49.0	48.1	39.4	52.6	48.5	45.8	44.4
35–44	%	48.4	59.7	57.1	59.8	59.8	58.1	52.0	51.3	55.1
45–54	%	55.1	62.3	56.2	61.2	67.7	70.0	47.8	53.6	58.7
55–64	%	65.0	78.2	63.8	64.9	64.3	69.0	np	np	67.9

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
65–69	%	65.8	67.4	84.9	65.9	87.0	81.2	np	np	71.9
70–74	%	77.3	67.2	67.7	59.9	72.5	72.7	np	np	70.6
75 and over	%	60.7	50.2	53.5	58.1	61.1	68.5	np	np	56.9
Total female	**%**	**52.1**	**55.8**	**54.5**	**55.9**	**55.5**	**61.5**	**51.3**	**39.4**	**54.3**
Total female	000	982.2	762.7	626.9	328.7	206.1	79.5	46.1	22.2	3 054.3
All adults										
2011-12 (e), (f)										
18–24	%	36.4	30.1	38.0	42.9	41.2	41.0	40.9	44.4	36.4
25–34	%	50.4	54.7	56.5	60.2	59.7	58.2	53.1	52.3	54.5
35–44	%	64.1	62.7	67.1	69.3	65.1	61.7	63.9	64.0	64.9
45–54	%	70.9	70.5	71.2	70.5	75.6	67.2	71.9	74.3	71.1
55–64	%	72.5	73.1	77.2	71.4	75.4	79.1	71.5	69.0	73.9
65–69	%	69.3	72.1	75.3	71.2	76.5	75.5	67.0	76.2	72.1
70–74	%	79.1	76.2	79.4	82.7	78.5	78.9	81.8	74.6	78.8
75 and over	%	64.5	66.9	72.9	70.8	69.9	66.5	75.2	62.9	67.8
Total adults	**%**	**61.1**	**61.0**	**64.7**	**65.6**	**65.7**	**63.3**	**63.0**	**62.9**	**62.7**
Total adults	000	2 924.7	2 112.0	1 872.1	986.8	703.8	212.2	145.3	62.5	9 019.4
2007-08										
18–24	%	38.1	36.5	37.4	40.1	31.0	42.6	np	np	37.3
25–34	%	57.6	46.9	56.1	56.5	48.1	48.0	51.7	43.8	53.6
35–44	%	58.4	64.9	64.2	68.3	65.9	67.4	61.7	50.1	62.9
45–54	%	65.3	70.4	65.1	72.9	73.5	68.4	61.6	65.4	67.9
55–64	%	70.0	75.0	85.0	72.5	83.5	86.8	np	np	75.7
65–69	%	69.1	77.2	69.3	68.7	72.4	73.2	71.8	88.8	71.5
70–74	%	78.2	77.6	71.4	61.9	68.1	76.1	np	np	74.3
75 and over	%	69.6	59.6	63.3	64.1	60.0	67.0	np	np	64.8
Total adults	**%**	**60.6**	**61.0**	**61.2**	**62.9**	**60.9**	**62.8**	**59.0**	**63.2**	**61.1**
Total adults	**000**	2 314.8	1 688.0	1 353.5	746.5	458.2	159.1	107.7	55.1	6 882.9
Relative standard errors										
Males										
2011-12 (e), (f)										
18–24	%	10.8	10.9	11.8	8.7	14.8	14.0	9.6	14.2	4.6
25–34	%	5.1	4.2	3.7	5.2	5.1	6.4	6.4	8.4	2.1
35–44	%	3.1	3.7	3.4	3.7	4.7	5.4	4.9	5.3	1.7
45–54	%	3.3	3.4	3.7	3.5	3.6	4.7	4.2	5.4	1.6
55–64	%	4.3	4.1	2.9	3.4	3.7	3.3	5.8	7.2	1.8
65–69	%	6.1	4.9	3.8	6.0	4.7	5.3	11.3	10.9	2.5
70–74	%	4.9	6.3	3.3	4.5	6.1	7.2	9.2	9.6	2.3
75 and over	%	5.4	8.5	5.5	6.3	4.9	5.8	8.9	15.1	2.9
2007-08										
18–24	%	15.1	16.4	14.7	15.2	24.1	19.0	np	np	6.1

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
25–34	%	4.9	9.0	7.4	7.1	8.4	17.1	7.6	58.6	3.6
35–44	%	5.6	5.5	6.7	4.7	6.4	7.6	5.6	70.0	2.7
45–54	%	5.2	5.1	5.4	4.4	5.0	8.1	5.5	30.2	2.2
55–64	%	5.6	7.8	5.7	6.8	5.4	5.9	np	np	3.0
65–69	%	7.8	9.0	7.0	9.3	9.4	4.8	np	np	3.9
70–74	%	6.5	6.6	9.5	19.5	16.2	13.3	np	np	3.9
75 and over	%	6.0	8.3	8.5	8.8	13.0	8.5	np	np	3.5
Total males	**%**	**2.5**	**2.6**	**3.0**	**2.7**	**2.8**	**3.8**	**2.8**	**23.8**	**1.3**
Females										
2011-12 (e), (f)										
18–24	%	10.6	20.5	11.9	11.0	13.4	13.2	22.0	17.7	5.7
25–34	%	7.6	8.3	7.8	5.9	8.2	8.1	6.9	7.9	3.5
35–44	%	5.4	5.6	5.0	5.2	5.7	6.1	9.0	8.8	2.6
45–54	%	3.9	5.1	5.1	5.6	5.9	6.2	7.5	6.9	2.2
55–64	%	4.2	5.4	4.1	4.6	5.2	4.9	5.3	7.1	2.3
65–69	%	7.2	7.3	6.6	8.1	6.7	6.9	9.5	7.3	3.6
70–74	%	6.0	8.0	8.1	6.6	5.6	7.5	7.2	21.9	3.4
75 and over	%	6.6	4.5	5.6	6.1	6.9	8.3	8.8	np	2.9
Total females	**%**	**2.3**	**2.7**	**2.6**	**2.7**	**2.6**	**2.8**	**3.5**	**4.4**	**1.2**
2007-08										
18–24	%	18.1	18.2	16.2	19.6	25.9	23.4	np	np	7.0
25–34	%	7.9	9.8	9.3	10.1	11.0	11.4	9.8	30.9	4.1
35–44	%	7.0	6.6	7.0	7.9	9.2	11.3	8.4	49.2	2.9
45–54	%	7.3	8.1	8.7	10.2	8.5	8.0	11.0	37.5	3.7
55–64	%	6.8	5.0	6.7	8.9	7.9	8.8	np	np	3.2
65–69	%	8.9	12.5	6.2	11.7	5.2	11.6	np	np	3.7
70–74	%	6.5	12.0	10.5	16.2	10.3	10.2	np	np	4.7
75 and over	%	10.1	13.4	11.7	13.3	9.4	8.6	np	np	5.0
Total females	**%**	**3.2**	**3.4**	**2.9**	**4.4**	**3.7**	**4.1**	**4.4**	**20.4**	**1.5**
All adults										
2011-12 (e), (f)										
18–24	%	7.4	11.3	7.5	7.6	9.1	8.8	8.9	10.8	3.4
25–34	%	4.5	3.9	3.8	3.6	4.4	4.8	4.9	6.1	2.0
35–44	%	3.1	3.0	3.1	3.3	3.5	3.3	4.9	4.7	1.5
45–54	%	2.4	3.2	3.2	2.6	3.3	3.9	4.4	4.2	1.3
55–64	%	3.0	3.6	2.7	2.7	3.1	3.0	4.0	5.0	1.5
65–69	%	4.3	4.5	3.7	4.2	4.0	4.2	7.2	6.5	2.1
70–74	%	4.1	4.5	3.4	4.2	4.7	4.8	6.1	10.0	1.9
75 and over	%	4.0	4.3	4.0	3.9	4.4	4.7	6.3	14.3	2.0
Total adults	**%**	**1.5**	**1.6**	**1.5**	**1.4**	**1.3**	**1.6**	**2.3**	**2.7**	**0.8**
2007-08										
18–24	%	10.1	12.1	11.8	11.6	17.1	13.9	np	np	4.3

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
25–34	%	4.5	6.5	6.2	5.9	7.2	9.9	6.1	30.3	3.0
35–44	%	4.3	4.7	4.5	4.4	5.0	6.9	4.4	40.6	1.8
45–54	%	4.2	4.8	5.2	5.5	4.6	5.9	5.9	29.7	2.2
55–64	%	4.3	4.4	4.6	4.9	4.4	4.8	4.9	11.3	2.1
65–69	%	5.9	7.4	4.4	6.8	5.0	5.7	np	np	2.6
70–74	%	4.9	7.8	6.8	12.6	9.6	8.2	np	np	3.5
75 and over	%	5.8	8.0	6.6	8.0	8.5	5.9	np	np	2.9
Total adults	**%**	**2.0**	**2.2**	**2.2**	**2.6**	**2.0**	**2.7**	**2.6**	**17.2**	**1.0**
95 per cent confidence intervals										
Males										
2011-12 (e), (f)										
18–24	±	8.7	8.1	9.1	8.0	11.8	10.8	9.7	14.0	3.7
25–34	±	6.2	5.3	4.9	6.8	6.9	8.2	7.2	9.8	2.7
35–44	**±**	4.6	5.2	5.1	5.8	6.6	7.0	7.2	7.5	2.6
45–54	±	5.0	5.2	5.9	5.3	5.8	6.9	6.9	8.3	2.4
55–64	±	6.3	6.3	4.7	5.3	5.9	5.6	8.5	10.1	2.7
65–69	±	9.0	7.4	6.3	9.0	7.9	8.1	16.0	15.9	3.9
70–74	±	7.9	9.7	5.8	8.0	10.0	11.7	14.0	16.1	3.8
75 and over	±	7.2	10.6	8.4	8.8	7.5	8.8	14.1	22.0	3.9
Total males	**±**	**2.2**	**2.5**	**2.2**	**2.3**	**2.4**	**3.1**	**3.6**	**4.5**	**1.2**
2007-08										
18–24	±	11.9	11.8	12.2	12.6	16.5	15.4	np	np	4.8
25–34	±	6.8	9.2	9.1	8.9	9.4	14.5	8.1	46.3	4.3
35–44	**±**	7.6	7.5	9.4	7.1	8.9	11.7	8.0	65.7	3.7
45–54	±	7.6	7.8	7.9	7.2	7.7	10.6	8.2	48.2	3.2
55–64	±	8.0	11.7	8.3	9.6	8.4	9.0	np	np	4.4
65–69	±	11.3	14.5	11.7	14.6	14.5	8.7	np	np	6.1
70–74	±	10.0	11.6	14.1	24.5	20.3	20.5	np	np	6.0
75 and over	±	9.4	11.3	13.0	12.3	14.9	10.8	np	np	5.2
Total males	**±**	**3.3**	**3.4**	**4.0**	**3.8**	**3.6**	**4.8**	**3.7**	**34.0**	**1.7**
Females										
2011-12 (e), (f)										
18–24	±	6.5	8.7	8.5	8.4	10.9	11.1	12.5	12.9	3.5
25–34	±	5.6	7.1	6.9	6.0	8.0	8.2	6.5	7.1	2.9
35–44	**±**	5.4	5.9	5.7	6.0	6.5	6.8	9.2	9.5	2.8
45–54	±	4.9	6.2	6.2	7.0	8.1	7.3	8.6	9.4	2.7
55–64	±	5.7	7.3	5.7	5.7	7.1	7.0	7.2	9.2	3.1
65–69	±	9.0	9.5	8.6	10.5	9.0	9.9	11.5	11.2	4.6
70–74	±	8.9	11.5	11.1	9.7	8.2	10.9	12.2	24.6	4.9
75 and over	±	7.9	6.2	7.5	8.5	8.4	9.4	12.1	np	3.8
Total females	**±**	**2.4**	**2.8**	**2.9**	**3.1**	**3.0**	**3.2**	**3.8**	**4.8**	**1.3**
2007-08										

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f), (g)	*Aust*
18–24	±	12.6	12.9	10.6	14.5	13.3	20.1	np	np	4.8
25–34	±	6.7	7.8	9.0	9.6	8.5	11.7	9.3	27.8	3.5
35–44	±	6.7	7.8	7.8	9.2	10.7	12.8	8.5	49.4	3.1
45–54	±	7.9	9.9	9.6	12.3	11.3	11.0	10.3	39.3	4.3
55–64	±	8.7	7.6	8.3	11.3	10.0	11.9	np	np	4.2
65–69	±	11.5	16.5	10.2	15.1	9.0	18.5	np	np	5.2
70–74	±	9.9	15.8	13.9	19.0	14.7	14.5	np	np	6.6
75 and over	±	12.0	13.2	12.2	15.1	11.2	11.5	np	np	5.6
Total females	**±**	**3.3**	**3.7**	**3.1**	**4.8**	**4.0**	**5.0**	**4.4**	**15.7**	**1.6**
All adults										
2011-12 (e), (f)										
18–24	±	5.3	6.7	5.6	6.4	7.4	7.1	7.2	9.4	2.5
25–34	±	4.4	4.1	4.2	4.3	5.2	5.4	5.1	6.3	2.1
35–44	**±**	3.9	3.6	4.1	4.5	4.5	4.0	6.1	5.9	2.0
45–54	±	3.4	4.4	4.4	3.6	4.9	5.1	6.2	6.0	1.9
55–64	±	4.3	5.1	4.1	3.8	4.6	4.6	5.6	6.7	2.2
65–69	±	5.9	6.3	5.5	5.9	6.0	6.2	9.5	9.7	3.0
70–74	±	6.4	6.7	5.3	6.8	7.2	7.4	9.7	14.7	2.9
75 and over	±	5.0	5.7	5.7	5.4	6.0	6.1	9.3	17.6	2.7
Total adults	**±**	**1.8**	**1.9**	**1.9**	**1.9**	**1.7**	**2.0**	**2.8**	**3.3**	**0.9**
2007-08										
18–24	±	7.6	8.6	8.7	9.1	10.4	11.6	np	np	3.2
25–34	±	5.1	6.0	6.8	6.5	6.8	9.4	6.2	26.0	3.1
35–44	**±**	5.0	6.0	5.7	5.8	6.5	9.1	5.4	39.8	2.2
45–54	±	5.4	6.6	6.7	7.8	6.7	7.9	7.1	38.1	3.0
55–64	±	5.8	6.7	6.3	6.6	6.2	6.8	6.9	19.6	2.9
65–69	±	8.1	10.9	7.4	9.7	8.1	9.8	np	np	3.8
70–74	±	7.5	11.8	9.5	15.3	12.8	12.3	np	np	5.0
75 and over	±	7.9	9.3	8.2	10.1	10.0	7.8	np	np	3.7
Total adults	**±**	**2.3**	**2.6**	**2.6**	**3.2**	**2.4**	**3.3**	**3.0**	**21.4**	**1.2**

RSE = Relative Standard Error. 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.

(a) Adults are defined as persons aged 18 years and over.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Obesity for adults is defined as BMI equal to or greater than 30.

(c) Data are calculated from measured height and weight. Data exclude those for whom measured height and weight were not available. Data are not comparable with data for 2004-05 that are based on self-reported height and weight.

(d) Rates for total are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(e) Data for 2011-12 have been revised and differ from data published in the 2013 Report.

Table EA.15 **Rates of overweight and obesity for adults, by sex and age (a), (b), (c), (d), (e)**

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

(f) Data for the NT should be used with care as very remote areas were excluded from the Australian Health Survey, which translates to exclusion of around 23 per cent of the NT population.

(g) Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size.

np Not published.

Source : ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 Core component); ABS (unpublished) *National Health Survey 2007-08* .

Table EA.16 **Rates of overweight and obesity for adults, by Indigenous status, 2011–13 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Rates										
Indigenous	%	75.9	69.8	71.3	73.4	69.4	68.9	69.6	59.8	71.4
Conf. Inter.	±	4.3	5.8	4.8	4.3	5.7	5.8	10.8	7.1	2.3
Non-Indigenous	%	61.0	61.1	64.5	65.3	65.5	63.8	62.5	62.1	62.6
Conf. Inter.	±	1.8	1.9	1.8	2.0	1.7	2.0	2.9	2.9	1.0
Relative standard errors										
Indigenous	%	2.9	4.2	3.4	3.0	4.2	4.3	7.9	6.1	1.6
Non-Indigenous	%	1.5	1.6	1.4	1.5	1.4	1.6	2.4	2.4	0.8
Rate ratio (g)	no.	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1.0	1.1

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. 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.

(a) Adults are defined as persons aged 18 years and over.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Obesity for adults is defined as BMI equal to or greater than 30.

(c) BMI calculated from measured height and weight. Data are not comparable with 2004-05 data that are calculated from self-reported height and weight.

(d) Rates are age standardised to the 2001 Australian population (10 year age ranges from 18 years).

(e) Data for non-Indigenous people for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(f) 95 per cent confidence interval.

(g) Rate ratio is the rate of Indigenous people overweight or obese divided by the rate of non-Indigenous people overweight or obese.

Source : ABS (unpublished) *Australian Health Survey 2011–13* (2011-12 Core component); ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (2012-13 NATSIHS component).

Table EA.17 **Rates of overweight and obesity for adults, by Indigenous status, 2004-05 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Rates										
Indigenous	%	66.9	55.7	66.1	65.4	71.9	60.1	63.7	53.9	64.1
Conf. Inter.	±	6.4	13.1	6.8	6.8	8.5	9.5	10.6	9.1	3.3
Non-Indigenous	%	53.6	53.3	52.5	52.2	54.5	54.7	53.2	51.2	53.2
Conf. Inter.	±	1.8	1.7	2.2	2.8	1.6	2.6	3.4	11.5	0.9
Relative standard errors										
Indigenous	%	4.9	12.0	5.3	5.3	6.0	8.0	8.5	8.6	2.6
Non-Indigenous	%	1.7	1.6	2.1	2.7	1.5	2.4	3.3	11.5	0.9

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. 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.

(a) Adults are defined as persons aged 18 years and over.

(b) Overweight for adults is defined as BMI equal to 25 but less than 30. Obesity for adults is defined as BMI equal to or greater than 30.

(c) BMI calculated from self-reported height and weight. Data excludes persons for whom height or weight was not reported. Data are not comparable with data for 2007-08 and 2011-12 that are based on measured height and weight.

(d) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (10 year age ranges from 18 years).

(e) Data for non-Indigenous people have been revised and differ from previous reports.

(f) Data for non-Indigenous people for the NT should be used with care as exclusion of very remote areas from the National Health Survey translates to exclusion of around 23 per cent of the NT population.

(g) 95 per cent confidence interval.

na Not available.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05;* ABS unpublished, *National Health Survey, 2004-05* .

Table EA.18 **Rate of overweight and obesity for children by Indigenous status, 2011–13 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Rate										
Indigenous	%	37.7	36.3	30.7	35.3	37.4	34.1	42.0	23.9	33.7
Conf. Inter.	±	6.1	8.4	6.8	7.4	8.8	9.2	16.0	7.0	3.1
Non-Indigenous	%	24.5	23.9	25.5	27.8	23.0	24.8	24.7	23.8	24.8
Conf. Inter.	±	3.3	3.3	3.5	3.3	3.4	4.5	4.3	5.3	1.6
Relative standard errors										
Indigenous	%	8.2	11.8	11.4	10.8	12.0	13.7	19.4	14.9	4.7
Non-Indigenous	%	6.9	7.0	6.9	6.1	7.6	9.2	8.8	11.3	3.2

Conf. Inter. = 95 per cent confidence interval. **RSE** = Relative Standard Error. 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.

(a) Children are defined as persons aged 5-17 years.

(b) Overweight for children is defined as BMI (appropriate for age and sex) that is likely to be equal to 25 but less than 30 at age 18 years. Obesity for children is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

(c) BMI calculated from measured height and weight.

(d) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (selected age ranges from 5-17 years).

(e) Data for non-Indigenous people for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(f) 95 per cent confidence interval.

Source: ABS (unpublished) *Australian Health Survey 2011–13* (2011-12 Core component)*;* ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (2012-13 NATSIHS component).

Table EA.19 **Proportion of adults who are daily smokers, by remoteness (a), (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c), (d)	Aust
Remoteness of residence (age standardised rate)										
2011-12 (d), (e)										
Major cities	%	13.5	14.8	15.9	16.4	15.6	0.0	12.5	0.0	14.7
Conf. Inter. (f)	±	1.4	1.6	1.6	1.6	1.6	0.0	1.9	0.0	0.7
Inner regional	%	17.2	22.2	20.6	21.2	14.5	18.8	0.0	0.0	19.5
Conf. Inter. (f)	±	3.3	3.9	4.3	5.7	5.4	2.2	0.0	0.0	1.8
Outer regional	%	21.6	24.1	20.6	24.2	26.4	28.4	0.0	21.5	22.6
Conf. Inter. (f)	±	7.4	18.6	4.1	6.8	5.5	3.7	0.0	2.9	2.2
Remote	%	31.1	0.0	48.6	20.1	23.4	42.1	0.0	25.2	26.1
Conf. Inter. (f)	±	43.6	0.0	40.8	10.1	20.3	26.5	0.0	4.2	7.2
Very remote (b)	%	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	±	na	na	na	na	na	na	na	na	na
Total	**%**	**14.4**	**16.5**	**17.9**	**17.6**	**16.8**	**21.9**	**12.5**	**22.5**	**16.3**
Conf. Inter. (f)	**±**	**1.1**	**1.3**	**1.3**	**1.6**	**1.4**	**1.9**	**1.9**	**2.5**	**0.6**
Daily smokers	'000	807.8	702.9	601.6	308.4	203.3	78.7	35.0	29.4	2 751.4
2007-08										
Major cities	%	17.9	17.0	18.5	16.7	18.1	..	15.8	..	17.6
Conf. Inter. (f)	±	2.1	1.7	2.6	2.3	2.1	..	2.0	..	1.0
Inner regional	%	20.8	17.5	22.0	13.2	25.5	23.2	0.0	..	20.1
Conf. Inter. (f)	±	4.6	3.5	4.0	5.1	10.2	4.2	0.0	..	2.1
Outer regional	%	23.7	21.3	28.4	23.9	28.5	27.4	..	21.7	25.7
Conf. Inter. (f)	±	6.1	14.5	5.3	5.6	7.0	5.2	..	12.1	3.1
Remote	%	27.9	0.0	33.4	32.8	21.7	11.3	..	19.6	27.3
Conf. Inter. (f)	±	32.2	0.0	16.1	17.0	10.5	6.4	..	11.7	7.3
Very remote (b)	%	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	±	na	na	na	na	na	na	na	na	na
Total	**%**	**19.0**	**17.3**	**21.6**	**17.3**	**20.2**	**24.3**	**15.7**	**21.1**	**19.1**
Conf. Inter. (f)	**±**	**1.9**	**1.6**	**2.0**	**2.1**	**2.3**	**3.0**	**2.0**	**10.5**	**0.9**
Daily smokers	'000	975.4	682.5	665.2	268.6	232.9	85.1	41.9	28.8	2 980.3
Relative standard error										
2011-12 (d), (e)										
Major cities	%	5.3	5.4	5.0	5.0	5.3	–	7.6	–	2.5
Inner regional	%	9.8	8.9	10.7	13.8	18.9	5.9	–	–	4.8
Outer regional	%	17.4	39.4	10.2	14.4	10.7	6.6	–	6.8	5.0
Remote	%	71.4	–	42.9	25.6	44.4	32.1	–	8.5	14.2
Very remote (b)	%	na	na	na	na	na	na	na	na	na
Total	%	**4.0**	**4.1**	**3.8**	**4.6**	**4.2**	**4.5**	**7.6**	**5.8**	**2.0**
2007-08										
Major cities	%	6.1	5.2	7.2	7.1	5.8	..	6.4	..	2.9
Inner regional	%	11.3	10.1	9.2	19.7	20.5	9.3	–	..	5.3
Outer regional	%	13.2	34.7	9.6	12.0	12.6	9.7	..	28.5	6.1
Remote	%	58.7	–	24.6	26.5	24.8	29.1	..	30.5	13.7

Table EA.19 **Proportion of adults who are daily smokers, by remoteness (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c), (d)	*Aust*
Very remote (b)	%	na	na	na	na	na	na	na	na	na
Total	%	**5.2**	**4.6**	**4.7**	**6.3**	**5.7**	**6.2**	**6.4**	**25.4**	**2.4**

RSE = Relative standard error. 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.

(a) Rates for total are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 years).

(b) Very remote data was not collected.

(c) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(d) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.

(e) Data for 2011-12 have been revised and differ from data published in the 2013 Report.

(f) 95 per cent confidence interval.

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

Source : ABS (unpublished) Australian Health Survey 2011-13 (2011-12 Core component); ABS (unpublished) National Health Survey 2007-08.

Table EA.20 **Proportion of adults who are daily smokers, by SEIFA IRSD quintiles (a), (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c), (d)	Aust
SEIFA IRSD quintile (age standardised)										
2011-12 (d), (e)										
Quintile 1	%	20.4	26.4	28.1	26.9	25.4	28.7	12.5	27.5	24.3
Conf. Inter. (f)	±	3.0	4.2	3.3	5.0	3.8	3.3	15.5	6.3	2.0
Quintile 2	%	16.4	22.7	21.5	21.5	17.6	22.7	14.5	29.3	19.9
Conf. Inter. (f)	±	2.4	3.1	3.6	3.1	2.7	4.0	9.6	8.0	1.5
Quintile 3	%	15.4	15.6	17.9	22.4	16.8	17.9	19.8	25.6	17.0
Conf. Inter. (f)	±	2.3	2.9	2.4	3.2	4.0	5.1	5.7	5.0	1.1
Quintile 4	%	11.1	12.1	14.5	15.2	13.5	15.4	15.3	18.7	12.9
Conf. Inter. (f)	±	1.8	2.8	2.9	2.6	3.2	3.7	2.6	4.2	1.1
Quintile 5	%	9.7	7.4	9.5	8.6	9.2	15.9	8.8	12.2	9.0
Conf. Inter. (f)	±	2.4	2.7	2.4	2.2	2.9	5.6	2.2	6.5	1.2
Total (g)	**%**	**14.4**	**16.5**	**17.9**	**17.6**	**16.8**	**21.9**	**12.5**	**22.5**	**16.3**
Conf. Inter. (f)	**±**	**1.1**	**1.3**	**1.3**	**1.6**	**1.4**	**1.9**	**1.9**	**2.5**	**0.6**
Daily smokers	'000	792.1	702.9	601.6	308.4	203.3	78.7	35.0	29.4	2 751.4
2007-08										
Quintile 1	%	28.8	29.0	28.1	30.2	27.4	33.4	17.9	13.5	28.7
Conf. Inter. (f)	±	4.2	5.4	5.5	6.5	4.4	6.0	14.7	18.5	2.4
Quintile 2	%	19.3	17.8	28.0	23.1	24.2	24.4	26.7	18.7	21.6
Conf. Inter. (f)	±	4.6	4.0	5.2	4.8	4.4	6.5	17.0	12.9	2.1
Quintile 3	%	19.3	16.7	23.8	19.1	18.3	17.1	18.5	26.5	19.6
Conf. Inter. (f)	±	4.4	3.2	4.2	4.0	4.8	4.6	5.4	20.8	1.8
Quintile 4	%	15.6	17.4	16.2	16.2	14.1	18.9	16.6	13.7	16.2
Conf. Inter. (f)	±	3.2	4.0	3.5	5.1	3.5	8.2	4.4	36.6	1.7
Quintile 5	%	12.3	10.0	11.7	8.2	13.5	18.1	np	np	11.2
Conf. Inter. (f)	±	3.0	2.7	3.4	2.7	4.8	13.3	np	np	1.6
Total (g)	**%**	**19.0**	**17.3**	**21.6**	**17.3**	**20.2**	**24.3**	**15.7**	**21.1**	**19.1**
Conf. Inter. (f)	**±**	**1.9**	**1.6**	**2.0**	**2.1**	**2.3**	**3.0**	**2.0**	**9.3**	**0.9**
Daily smokers	'000	975.4	682.5	665.2	268.6	232.9	85.1	41.9	28.8	2 980.3
Relative standard error										
2011-12 (d), (e)										
Quintile 1	%	7.6	8.2	6.0	9.5	7.7	5.9	63.0	11.7	4.3
Quintile 2	%	7.4	6.9	8.5	7.4	7.7	9.0	33.9	14.0	3.9
Quintile 3	%	7.5	9.6	6.9	7.4	12.0	14.6	14.8	9.9	3.3
Quintile 4	%	8.2	11.8	10.3	8.8	11.9	12.2	8.7	11.3	4.5
Quintile 5	%	12.8	18.5	12.9	12.8	15.9	18.1	12.8	27.3	7.0
Total (g)	%	**4.0**	**4.1**	**3.8**	**4.6**	**4.2**	**4.5**	**7.6**	**5.8**	**2.0**
2007-08										
Quintile 1	%	7.4	9.6	10.0	11.1	8.2	9.2	41.9	69.9	4.2
Quintile 2	%	12.3	11.4	9.4	10.6	9.2	13.6	32.5	35.2	4.9
Quintile 3	%	11.7	9.9	9.0	10.8	13.3	13.9	14.8	40.2	4.8
Quintile 4	%	10.6	11.7	11.1	16.0	12.5	22.3	13.5	136.5	5.5

Table EA.20 Proportion of adults who are daily smokers, by SEIFA IRSD quintiles (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c), (d)	*Aust*
Quintile 5	%	12.4	13.9	14.7	16.6	18.2	37.6	np	np	7.3
Total (g)	%	**5.2**	**4.6**	**4.7**	**6.3**	**5.7**	**6.2**	**6.4**	**22.4**	**2.4**

RSE = Relative standard error. 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.

(a) Rates for total are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 years).

(b) A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general.

(c) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(d) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.

(e) Data for 2011-12 have been revised and differ from data published in the 2013 Report.

(f) 95 per cent confidence interval.

(g) Total includes those who could not be allocated to a SEIFA quintile.

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

Source : ABS (unpublished) *Australian Health Survey 2011-13* (2011-12 Core component); ABS (unpublished) *National Health Survey 2007-08* .

Table EA.21 Proportion of adults who are daily smokers, by Indigenous status (a), (b)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c), (d)	Aust
2011–13 (d)										
Rate of adult daily smokers (age standardised)										
Indigenous	%	39.5	41.0	41.8	39.5	42.2	39.1	28.1	48.0	41.2
Conf. Inter. (e)	±	4.9	5.7	4.4	4.4	5.6	6.0	9.4	5.1	2.1
Non-Indigenous	%	14.0	16.5	17.1	17.4	16.3	21.2	12.6	22.1	16.0
Conf. Inter. (e)	±	1.1	1.3	1.2	1.5	1.4	1.9	1.9	2.7	0.7
Relative standard errors — Rate of adult daily smokers (age standardised)										
Indigenous	%	6.3	7.1	5.4	5.7	6.8	7.8	17.1	5.5	2.6
Non-Indigenous	%	4.2	4.1	3.7	4.5	4.4	4.5	7.8	6.3	2.1
Rate ratio (f)		2.8	2.5	2.4	2.3	2.6	1.8	2.2	2.2	2.6
2007-08 (g)										
Rate of adult daily smokers (age standardised)										
Indigenous	%	47.6	46.6	42.8	39.6	47.0	44.2	29.8	46.6	44.8
Conf. Inter. (e)	±	4.6	3.8	4.2	4.4	5.4	5.9	6.5	4.9	2.0
Non-Indigenous (g	%	18.8	17.3	21.5	16.9	20.0	23.5	16.0	22.2	18.9
Conf. Inter. (e)	±	1.9	1.6	2.0	2.0	2.3	3.1	2.0	12.3	0.9
Relative standard errors — Rate of adult daily smokers (age standardised)										
Indigenous	%	5.0	4.1	5.0	5.7	5.9	6.8	11.2	5.4	2.3
Non-Indigenous (g	%	5.1	4.8	4.6	6.2	5.8	6.7	6.4	28.2	2.4
Rate ratio (f)		2.5	2.7	2.0	2.3	2.4	1.9	1.9	2.1	2.4

RSE = Relative standard error. 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.

(a) Adults are defined as persons aged 18 years and over.

(b) Rates are age standardised to the 2001 Australian population (10 year age ranges from 18 years to 55 years or over).

(c) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey in 2011-12 and the National Health Survey in 2007-08 translates to exclusion of around 23 per cent of the NT population.

(d) Data for 2011–13 for non-Indigenous people for the NT are not comparable to data for previous years due to the increased sample size.

(e) 95 per cent confidence interval.

(f) Rate ratio is the rate for Indigenous Australians divided by the rate for non-Indigenous Australians.

Source : ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey 2012-13* (2012-13 NATSIHS component); ABS unpublished, *National Aboriginal and Torres Strait Islander Social Survey, 2008* ; ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component); ABS unpublished, *National Health Survey, 2007-08* .

Table EA.22 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d), (e)	Aust
Remoteness of residence (age standardised rate)										
2011-12 (e)										
Major cities	%	17.5	16.7	20.5	22.9	17.6	..	21.0	..	18.5
Conf. Inter. (f)	±	1.9	1.9	2.1	2.1	2.0	..	2.4	..	1.0
Inner regional	%	20.4	19.7	17.8	33.7	18.8	21.7	–	..	20.6
Conf. Inter. (f)	±	5.2	3.9	4.3	7.0	6.7	2.7	–	..	2.4
Outer regional	%	np	17.0	np	28.5	20.7	23.6	..	24.5	22.1
Conf. Inter. (f)	±	np	9.8	np	8.8	5.9	5.2	..	4.2	2.9
Remote	%	np	..	np	36.7	27.3	37.6	..	22.9	31.4
Conf. Inter. (f)	±	np	..	np	12.7	32.6	50.6	..	8.1	7.4
Very remote (c)	%	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	±	na	na	na	na	na	na	na	na	na
Total	**%**	**18.5**	**17.5**	**19.9**	**25.3**	**18.2**	**22.8**	**21.0**	**24.2**	**19.4**
Conf. Inter. (f)	**±**	**1.5**	**1.6**	**1.8**	**2.1**	**1.8**	**2.4**	**2.4**	**3.5**	**0.8**
Adults at risk	'000	1 027.5	760.4	682.8	443.1	228.3	86.9	58.5	30.7	3 318.2
2007-08										
Major cities	%	18.9	17.7	20.3	22.9	18.6	..	21.3	..	19.2
Conf. Inter. (f)	±	1.8	1.9	2.2	2.7	2.1	..	2.1	..	0.8
Inner regional	%	25.5	23.5	23.3	28.4	20.9	21.3	–	..	24.3
Conf. Inter. (f)	±	4.0	5.0	4.2	6.5	10.9	3.6	–	..	2.5
Outer regional	%	np	21.7	25.6	40.8	12.2	np	..	23.8	24.2
Conf. Inter. (f)	±	np	14.3	4.0	11.2	5.5	np	..	16.8	2.9
Remote	%	np	..	39.5	23.8	24.6	np	..	52.1	32.1
Conf. Inter. (f)	±	np	..	24.8	20.3	12.8	np	..	30.9	11.1
Very remote (c)	%	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	±	na	na	na	na	na	na	na	na	na
Total	**%**	na	na	na	na	na	na	na	na	na
Conf. Inter. (f)	**±**	**1.7**	**1.8**	**2.0**	**2.5**	**1.8**	**2.9**	**2.1**	**14.6**	**0.9**
Adults at risk	'000	1 063.2	749.3	694.6	395.4	220.0	77.8	55.2	38.5	3 294.0
Relative standard error										
2011-12 (e)										
Major cities	%	5.4	5.8	5.3	4.6	5.7	..	5.8	..	2.9
Inner regional	%	13.0	10.1	12.2	10.6	18.1	6.4	–	..	5.9
Outer regional	%	np	29.3	np	15.7	14.5	11.3	..	8.8	6.8
Remote	%	np	..	np	17.6	60.8	68.7	..	18.1	12.1
Very remote (c)	%	na	na	na	na	na	na	na	na	na
Total	%	**4.2**	**4.7**	**4.7**	**4.3**	**4.9**	**5.5**	**5.8**	**7.4**	**2.2**
2007-08										
Major cities	%	4.8	5.6	5.5	5.9	5.6	..	5.0	..	2.1
Inner regional	%	8.0	10.9	9.3	11.7	26.7	8.7	–	..	5.3
Outer regional	%	np	33.5	8.0	14.0	22.8	np	..	35.9	6.0
Remote	%	np	..	32.1	43.5	26.5	np	..	30.2	17.7

Table EA.22 Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d), (e)	*Aust*
Very remote (c)	%	na	na	na	na	na	na	na	na	na
Total	%	**4.2**	**5.0**	**4.5**	**5.0**	**5.1**	**7.0**	**5.0**	**22.3**	**2.1**

RSE = Relative standard error. 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.

(a) Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time.

(b) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 years).

(c) Very remote data was not collected.

(d) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(e) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.

(f) 95 per cent confidence interval.

Source : ABS (unpublished) Australian Health Survey 2011-13 (2011-12 NHS component); ABS (unpublished) National Health Survey 2007-08.

Table EA.23 Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d), (e)	Aust
SEIFA IRSD quintile (age standardised)										
2011-12 (e)										
Quintile 1	%	14.1	16.7	20.2	22.7	14.4	21.0	10.4	22.1	16.7
Conf. Inter. (f)	±	3.6	3.5	5.0	6.7	3.9	4.3	10.2	8.1	1.9
Quintile 2	%	18.3	15.5	18.5	25.5	16.7	22.6	20.3	23.8	18.3
Conf. Inter. (f)	±	3.8	4.0	4.0	5.8	3.3	6.4	10.9	6.9	1.8
Quintile 3	%	19.1	15.1	21.5	24.9	18.1	20.7	21.1	21.5	19.2
Conf. Inter. (f)	±	3.8	3.8	3.7	4.6	5.9	6.1	6.8	6.6	2.0
Quintile 4	%	19.6	20.0	21.3	21.1	20.1	26.5	17.0	26.7	20.2
Conf. Inter. (f)	±	3.2	4.6	4.1	5.0	5.7	7.3	4.6	7.2	2.1
Quintile 5	%	20.6	21.2	18.3	29.8	21.2	23.7	23.6	31.9	21.7
Conf. Inter. (f)	±	4.7	3.4	4.2	4.6	4.5	8.3	4.1	13.7	2.1
Total (g)	**%**	**18.5**	**17.5**	**19.9**	**25.3**	**18.2**	**22.8**	**21.0**	**24.2**	**19.4**
Conf. Inter. (f)	**±**	**1.5**	**1.6**	**1.8**	**2.1**	**1.8**	**2.4**	**2.4**	**3.5**	**0.8**
Adults at risk	'000	1 027.5	760.4	682.8	443.1	228.3	86.9	58.5	30.7	3 318.2
2007-08										
Quintile 1	%	11.7	16.2	26.1	19.8	14.3	23.3	23.9	22.7	17.3
Conf. Inter. (f)	±	2.8	5.3	5.2	6.1	3.0	6.0	12.4	36.9	1.8
Quintile 2	%	19.4	16.1	23.0	27.4	19.0	20.3	24.0	35.7	20.7
Conf. Inter. (f)	±	4.3	4.2	3.6	5.3	4.4	7.6	20.0	22.9	1.7
Quintile 3	%	23.9	24.3	24.0	23.4	20.5	17.9	27.5	27.9	23.6
Conf. Inter. (f)	±	4.8	4.9	4.2	6.5	5.8	4.7	11.3	24.1	2.2
Quintile 4	%	22.3	16.6	17.6	26.8	16.1	22.3	18.7	23.2	19.8
Conf. Inter. (f)	±	4.2	3.8	4.3	5.9	3.9	6.8	3.9	26.6	1.9
Quintile 5	%	24.2	20.9	20.0	26.5	22.8	21.5	21.3	28.1	22.6
Conf. Inter. (f)	±	3.5	4.0	5.4	5.5	5.9	8.5	2.5	17.0	1.9
Total (g)	**%**	**20.4**	**18.8**	**22.3**	**25.3**	**18.5**	**21.5**	**21.3**	**33.4**	**20.9**
Conf. Inter. (f)	**±**	**1.7**	**1.8**	**2.0**	**2.5**	**1.8**	**2.9**	**2.1**	**14.6**	**0.9**
Adults at risk	'000	1 063.2	749.3	694.6	395.4	220.0	77.8	55.2	38.5	3 294.0
Relative standard error										
2011-12 (e)										
Quintile 1	%	13.1	10.6	12.7	15.1	13.8	10.5	50.3	18.6	5.7
Quintile 2	%	10.7	13.1	11.2	11.7	10.2	14.4	27.4	14.8	5.0
Quintile 3	%	10.1	12.7	8.8	9.5	16.5	15.1	16.4	15.7	5.2
Quintile 4	%	8.4	11.7	9.8	12.0	14.5	14.1	13.8	13.7	5.3
Quintile 5	%	11.5	8.2	11.8	7.8	10.7	17.8	8.9	22.0	4.8
Total (g)	%	**4.2**	**5.0**	**4.5**	**5.0**	**5.1**	**7.0**	**5.0**	**22.3**	**2.1**
2007-08										
Quintile 1	%	12.2	16.6	10.1	15.7	10.6	13.2	26.4	83.1	5.4
Quintile 2	%	11.4	13.4	8.0	9.8	11.9	19.2	42.6	32.8	4.2
Quintile 3	%	10.3	10.4	9.0	14.1	14.4	13.4	20.9	44.0	4.7
Quintile 4	%	9.6	11.7	12.6	11.2	12.3	15.7	10.6	58.5	4.8

Table EA.23 Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d), (e)	*Aust*
Quintile 5	%	7.3	9.7	13.7	10.7	13.2	20.1	6.0	30.9	4.2
Total (g)	%	**4.2**	**5.0**	**4.5**	**5.0**	**5.1**	**7.0**	**5.0**	**22.3**	**2.1**

RSE = Relative standard error. 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.

(a) Rates are based on the 2009 NHMRC guidelines and can be used for the purposes of comparisons over time.

(b) Rates for total are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 years).

(c) A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general.

(d) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(e) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.

(f) 95 per cent confidence interval.

(g) Total includes those who could not be allocated to a SEIFA quintile.

Source : ABS (unpublished) Australian Health Survey 2011-13 (2011-12 NHS component); ABS (unpublished) National Health Survey 2007-08.

Table EA.24 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d), (e)	*Aust*
2011–13 (e)										
Number of adults at risk										
Indigenous	'000	22.1	5.6	19.5	11.3	4.7	2.6	0.6	5.8	72.3
Non-Indigenous	'000	1 003.9	757.3	663.8	434.2	227.1	83.8	57.6	28.3	3 256.0
Rate of adults at risk of long term harm from alcohol (age standardised)										
Indigenous	%	19.7	19.9	18.2	23.0	22.1	18.1	15.5	14.2	19.2
Conf. Inter. (f)	±	3.3	4.1	3.7	3.8	5.1	4.2	6.2	4.0	1.6
Non-Indigenous	%	18.4	17.7	20.1	25.4	18.5	23.0	20.9	24.9	19.5
Conf. Inter. (f)	±	1.5	1.7	1.9	2.1	1.8	2.4	2.3	3.9	0.9
Relative standard errors										
Indigenous	%	8.4	10.5	10.4	8.3	11.7	11.9	20.3	14.5	4.3
Non-Indigenous	%	4.3	4.8	4.8	4.3	4.9	5.4	5.7	7.9	2.3
Rate ratio (f)		1.1	1.1	0.9	0.9	1.2	0.8	0.7	0.6	1.0
2004-05 (g)										
Number of adults at risk										
Indigenous	'000	16.6	3.8	17.4	8.6	3.4	1.9	0.5	3.8	56.0
Non-Indigenous	'000	1 085.9	764.0	623.8	349.1	257.5	65.8	52.3	28.2	3 226.6
Rate of adults at risk of long term harm from alcohol (age standardised)										
Indigenous	%	21.4	22.1	23.0	20.4	21.2	19.1	21.0	10.3	20.3
Conf. Inter. (f)	±	3.9	7.7	4.4	3.9	7.1	4.3	7.2	3.1	1.9
Non-Indigenous	%	21.9	20.4	22.4	24.6	23.0	19.2	21.6	29.6	21.9
Conf. Inter. (f)	±	1.3	1.6	1.5	2.3	1.6	2.0	2.5	11.7	0.7
Relative standard errors										
Indigenous	%	9.3	17.8	9.7	9.8	17.0	11.4	17.4	15.5	4.9
Non-Indigenous	%	3.1	3.9	3.4	4.8	3.6	5.2	5.8	20.1	1.6
Rate ratio (f)		1.0	1.1	1.0	0.8	0.9	1.0	1.0	0.3	0.9

RSE = Relative standard error. 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.

(a) Adults are defined as persons aged 18 years or over.

(b) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (10 year age ranges from 18 years to 55 years or over).

(c) Long term harm measured as per the 2009 NHMRC alcohol guidelines. Rates are based on the 2009 NHMRC guidelines.

(d) Data for non-Indigenous people for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey in 2011-12 and the National Health Survey in 2004-05 translates to exclusion of around 23 per cent of the NT population.

(e) Data for 2011–13 for non-Indigenous people for the NT are not comparable to data for previous years due to the increased sample size.

(f) 95 per cent confidence interval.

(g) Rate ratio is the age standardised Indigenous proportion divided by the age standardised non-Indigenous proportion.

Table EA.24 **Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status (a), (b), (c)**

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

(h) Data for 2004-05 are based on the 2009 NHMRC alcohol guidelines and differ from previously reported data that were based on 2001 NHMRC guidelines.

Source : ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey 2012-13* (2012-13 NATSIHS component); ABS unpublished, *Australian Health Survey 2011–13* (2011-12 Core component); ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05* ; ABS unpublished, *National Health Survey, 2004-05* .

Table EA.25 **Incidence of selected cancers (a)**

	Unit	NSW (b), (c)	Vic	Qld	WA	SA	Tas	ACT (b), (d)	NT	Aust
Incidence of selected cancers					*Age standardised rate per 100 000 population*					
2010 (b)										
Bowel cancer (e)	rate	61.5	61.7	63.2	58.5	57.6	80.7	62.9	52.0	61.8
Variability band (g)		59.8–63.3	59.7–63.8	60.9–65.6	55.4–61.8	54.3–61.0	73.7–88.1	54.3–72.2	39.5–66.7	60.8–62.8
Lung cancer (e)	rate	43.5	39.2	46.3	45.1	40.7	45.6	33.2	53.1	42.8
Variability band (g)		42.0–44.9	37.7–40.9	44.3–48.3	42.3–48.0	37.9–43.6	40.5–51.2	26.9–40.1	39.9–68.9	42.0–43.7
Melanoma (e)	rate	49.5	38.2	68.2	44.5	36.0	49.3	41.3	39.3	48.5
Variability band (g)		47.9–51.1	36.6–39.8	65.8–70.7	41.8–47.3	33.3–38.9	43.7–55.4	34.5–48.6	28.3–52.7	47.6–49.4
Female breast cancer (f)	rate	113.9	114.0	121.6	121.5	118.1	108.2	129.8	91.7	116.4
Variability band (g)		110.6–117.3	110.2–117.9	117.1–126.1	115.3–127.9	111.3–125.3	96.7–120.7	113.5–147.5	72.4–114.3	114.5–118.4
Cervical cancer (f)	rate	7.0	6.3	7.9	7.6	7.4	7.3	6.1	7.8	7.1
Variability band (g)		6.1–7.9	5.4–7.3	6.8–9.2	6.1–9.4	5.7–9.5	4.3–11.5	3.0–10.7	3.6–14.9	6.6–7.6
2009 (c), (d), (b)										
Bowel cancer (e)	rate	59.5	60.8	63.6	58.4	60.6	71.6	62.9	54.7	60.9
Variability band (g)		57.8–61.3	58.8–62.8	61.2–66.0	55.3–61.7	57.2–64.1	65.0–78.7	54.2–72.4	40.5–71.6	59.9–61.9
Lung cancer (e)	rate	43.6	41.5	47.2	45.9	43.6	39.5	31.3	57.7	43.8
Variability band (g)		42.2–45.1	39.9–43.2	45.2–49.3	43.0–48.8	40.7–46.7	34.7–44.8	25.2–38.3	42.2–76.2	42.9–44.6
Melanoma (e)	rate	48.2	41.4	69.3	46.0	36.3	47.7	34.9	37.0	49.1
Variability band (g)		46.7–49.8	39.8–43.1	66.8–71.8	43.2–48.9	33.6–39.2	42.2–53.8	28.8–41.9	26.1–50.5	48.2–50.0
Female breast cancer (f)	rate	116.7	109.4	120.8	113.5	112.7	117.0	149.0	83.0	115.2
Variability band (g)		113.4–120.2	105.6–113.2	116.3–125.4	107.4–119.8	105.9–119.7	104.9–130.0	131.4–168.3	62.5–107.5	113.3–117.2
Cervical cancer (f)	rate	6.8	5.7	7.6	8.4	5.1	6.0	6.5	14.1	6.7
Variability band (g)		6.0–7.7	4.8–6.6	6.5–8.8	6.7–10.2	3.7–6.8	3.3–9.9	3.4–11.4	5.7–27.4	6.2–7.2
2008										
Bowel cancer (e)	rate	60.6	62.1	66.4	58.1	66.1	77.4	63.2	49.3	62.7
Variability band (g)		58.8–62.4	60.0–64.2	64.0–68.9	54.9–61.5	62.5–69.9	70.5–84.8	54.4–73.0	35.8–65.6	61.7–63.7
Lung cancer (e)	rate	43.4	42.6	47.9	44.3	44.0	47.9	35.4	79.2	44.4
Variability band (g)		41.9–44.9	40.9–44.3	45.9–50.1	41.5–47.2	41.1–47.1	42.5–53.8	28.9–42.9	60.7–100.8	43.5–45.2

Table EA.25 **Incidence of selected cancers (a)**

	Unit	*NSW* (b), (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b), (d)	*NT*	*Aust*
Melanoma (e)	rate	48.1	39.7	68.9	49.5	39.9	49.1	44.6	35.3	49.3
Variability band (g)		46.6–49.7	38.0–41.4	66.4–71.4	46.6–52.5	37.0–42.9	43.4–55.4	37.5–52.6	24.3–48.8	48.4–50.3
Female breast cancer (f)	rate	114.0	116.7	123.1	118.8	119.0	103.1	117.6	97.4	116.9
Variability band (g)		110.6–117.4	112.8–120.7	118.5–127.8	112.5–125.3	112.0–126.3	91.7–115.5	102.0–134.9	74.2–125.0	114.9–118.9
Cervical cancer (f)	rate	6.7	6.6	7.1	8.7	8.1	6.9	3.8	14.1	7.1
Variability band (g)		5.9–7.6	5.7–7.6	6.0–8.3	7.1–10.7	6.2–10.3	3.9–11.1	1.5–7.9	6.1–26.5	6.6–7.6
2007										
Bowel cancer (e)	rate	63.8	64.3	66.6	57.3	65.7	81.8	60.6	69.7	64.5
Variability band (g)		62.0–65.6	62.2–66.4	64.1–69.1	54.1–60.6	62.1–69.5	74.6–89.5	51.9–70.4	53.1–89.3	63.4–65.5
Lung cancer (e)	rate	43.6	45.6	46.5	42.9	41.1	49.8	38.0	56.0	44.6
Variability band (g)		42.2–45.2	43.8–47.4	44.4–48.6	40.1–45.9	38.2–44.1	44.2–56.0	31.1–45.9	41.8–73.0	43.7–45.4
Melanoma (e)	rate	48.3	39.6	64.7	46.2	34.6	42.0	32.7	25.4	47.5
Variability band (g)		46.7–49.9	37.9–41.3	62.3–67.2	43.3–49.2	31.9–37.5	36.7–47.7	26.6–39.7	18.5–34.0	46.6–48.4
Female breast cancer (f)	rate	111.0	112.3	113.2	102.5	117.4	97.4	115.1	82.8	110.9
Variability band (g)		107.6–114.4	108.4–116.3	108.7–117.8	96.6–108.7	110.5–124.7	86.3–109.5	99.5–132.3	60.1–110.2	109.0–112.9
Cervical cancer (f)	rate	7.7	6.0	6.9	7.8	5.0	7.9	4.4	10.4	6.9
Variability band (g)		6.8–8.7	5.1–7.0	5.8–8.1	6.2–9.7	3.5–6.8	4.9–12.1	1.9–8.7	4.8–19.4	6.4–7.4
Number of new cases						*Number*				
2010										
Bowel cancer	no.	4 976	3 728	2 862	1 345	1 158	506	204	80	14 860
Lung cancer	no.	3 506	2 375	2 108	1 022	821	287	105	71	10 296
Melanoma	no.	3 861	2 245	3 089	1 031	684	291	141	63	11 405
Female breast cancer	no.	4 582	3 475	2 848	1 463	1 155	334	236	88	14 181
Cervical cancer	no.	265	182	177	90	65	19	11	9	818
2009 (c), (d), (h)										
Bowel cancer	no.	4 668	3 565	2 780	1 294	1 202	440	195	70	14 214

Table EA.25 **Incidence of selected cancers (a)**

	Unit	*NSW* (b), (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b), (d)	*NT*	*Aust*
Lung cancer	no.	3 438	2 441	2 086	1 008	860	247	96	65	10 241
Melanoma	no.	3 695	2 376	3 041	1 036	671	274	117	54	11 264
Female breast cancer	no.	4 609	3 266	2 766	1 324	1 086	355	265	71	13 742
Cervical cancer	no.	251	164	165	93	45	15	12	11	756
2008										
Bowel cancer	no.	4 656	3 545	2 844	1 254	1 273	467	191	61	14 291
Lung cancer	no.	3 319	2 441	2 053	948	855	289	107	89	10 101
Melanoma	no.	3 617	2 216	2 951	1 080	734	276	144	50	11 068
Female breast cancer	no.	4 392	3 413	2 739	1 343	1 121	306	207	75	13 596
Cervical cancer	no.	248	182	149	96	66	17	7	12	777
2007										
Bowel cancer	no.	4785	3584	2774	1200	1240	481	178	80	14322
Lung cancer	no.	3 279	2 548	1 925	887	777	288	110	70	9 884
Melanoma	no.	3 542	2 163	2 698	977	619	237	104	50	10 390
Female breast cancer	no.	4 203	3 199	2 449	1 127	1 108	286	200	61	12 633
Cervical cancer	no.	278	164	145	82	40	21	8	10	748

(a) Due to the low incidence of cancers in some jurisdictions, comparisons across time and between jurisdictions should be made with caution.

(b) NSW and ACT data for 2010 are estimated as actual incidence data were not available. See the data quality statement for more details.

(c) 2009 incidence data for NSW include an extra 1.2% imputed cases for currently missing 'death certificate only' notifications. See the data quality statement for more details.

(d) 2009 incidence data for the ACT include an extra 1.4% imputed cases for currently missing 'death certificate only' notifications. See the data quality statement for more details.

(e) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 84 years, and expressed per 100 000 persons.

(f) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 84 years, and expressed per 100 000 females.

(g) Variability band (± rate per 100 000 population)

(h) 2009 data have been revised and may differ from data published in the 2013 Report.

Source: AIHW unpublished, Australian Cancer Database 2010; ABS unpublished, Estimated Resident Population, 30 June.

Table EA.26 **Incidence of selected cancers, by remoteness area, 2010 (a)**

	NSW (b)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT* (c)	*Total excluding NSW/ACT* (d)	*Total excluding NSW/ACT* (d)
					Age standardised rate per 100 000 population					*no.*
Bowel cancer (e)										
Major cities	na	58.5	60.8	57.3	56.3	..	na	..	58.5	5,904
Variability band (g)	na	56.2–60.8	57.8–63.8	53.6–61.1	52.4–60.4	..	na	..	57.0–60.1	
Inner regional	na	65.5	65.2	63.8	52.9	80.6	na	..	65.9	2,282
Variability band (g)	na	61.2–70.1	60.5–70.2	55.3–72.8	44.1–62.5	71.8–89.9	na	..	63.2–68.7	
Outer regional	na	76.5	69.6	59.8	63.7	81.7	na	61.1	70.0	1,215
Variability band (g)	na	67.2–86.4	63.1–76.4	49.6–71.2	53.8–74.4	69.7–94.7	na	43.4–82.9	66.1–74.1	
Remote	na	47.9	68.8	55.0	83.0	74.5	na	48.3	68.4	179
Variability band (g)	na	9.3–121.2	50.9–90.3	39.3–74.5	60.4–109.5	28.2–151.6	na	28.5–75.7	58.4–79.4	
Very remote	na	..	41.6	57.3	67.1	69.9	na	16.2	49.1	51
Variability band (g)	na	..	22.1–68.4	30.7–94.3	25.3–130.8	13.7–206.0	na	4.6–34.6	35.2–65.8	
Lung cancer (e)										
Major cities	na	36.7	44.7	44.5	42.4	..	na	..	40.8	4,106
Variability band (g)	na	34.9–38.5	42.2–47.3	41.2–47.9	39.0–45.9	..	na	..	39.6–42.1	
Inner regional	na	41.7	45.6	47.0	36.0	42.9	na	..	43.2	1,506
Variability band (g)	na	38.3–45.3	41.7–49.7	39.8–55.0	29.1–44.0	36.6–49.8	na	..	41.0–45.4	
Outer regional	na	43.5	48.4	46.5	37.4	48.5	na	51.2	45.7	801
Variability band (g)	na	36.7–50.9	43.0–54.1	37.5–56.5	29.9–45.8	39.6–58.7	na	34.6–71.1	42.5–49.0	
Remote	na	43.5	58.6	49.1	31.1	61.5	na	32.9	46.5	115
Variability band (g)	na	5.4–119.7	41.4–79.2	32.9–68.5	17.9–49.1	22.1–129.6	na	13.1–63.2	38.0–56.0	
Very remote	na	..	75.5	32.1	52.6	114.3	na	91.1	62.1	74
Variability band (g)	na	..	50.5–108.1	11.7–62.0	20.2–100.9	27.0–301.7	na	45.4–148.8	47.3–79.1	

Table EA.26 **Incidence of selected cancers, by remoteness area, 2010 (a)**

	NSW (b)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT* (c)	*Total excluding NSW/ACT* (d)	*Total excluding NSW/ACT* (d)
					Age standardised rate per 100 000 population					*no.*
Melanoma (e)										
Major cities	na	34.8	70.8	40.0	33.4	..	na	..	45.2	4,520
Variability band (g)	na	33.1–36.6	67.6–74.0	37.0–43.2	30.3–36.6	..	na	..	43.8–46.5	
Inner regional	na	46.7	65.1	64.4	40.5	49.3	na	..	54.3	1,774
Variability band (g)	na	43.0–50.7	60.2–70.2	55.8–73.6	32.5–49.6	42.3–57.0	na	..	51.8–57.0	
Outer regional	na	43.2	66.7	44.8	45.7	49.1	na	49.0	53.6	908
Variability band (g)	na	36.0–51.3	60.4–73.4	36.1–54.8	36.7–55.8	39.6–59.9	na	32.6–68.7	50.1–57.2	
Remote	na	48.4	44.2	49.7	49.8	43.6	na	38.0	46.5	126
Variability band (g)	na	1.9–162.7	30.3–62.0	35.0–67.5	32.0–73.0	8.3–107.1	na	20.0–63.1	38.5–55.6	
Very remote	na	..	37.4	49.1	16.3	62.3	na	np	31.7	46
Variability band (g)	na	..	21.0–60.0	25.4–79.9	1.6–49.1	7.4–225.7	na	np	22.3–42.8	
Female breast cancer (f)										
Major cities	na	113.8	122.1	122.9	122.8	..	na	..	118.7	6,170
Variability band (g)	na	109.4–118.4	116.3–128.1	115.5–130.6	114.6–131.4	..	na	..	115.7–121.7	
Inner regional	na	111.2	124.0	120.6	134.1	109.9	na	..	117.9	2,009
Variability band (g)	na	103.1–119.8	114.8–133.7	104.6–138.3	114.1–156.2	95.4–125.8	na	..	112.7–123.2	
Outer regional	na	121.9	117.4	124.9	69.8	107.4	na	100.9	111.5	970
Variability band (g)	na	104.9–140.7	105.8–129.7	104.3–147.5	54.3–87.4	88.1–129.6	na	74.8–132.6	104.5–118.8	
Remote	na	99.2	74.1	100.7	131.0	104.4	na	81.1	99.4	131
Variability band (g)	na	16.7–283.8	49.1–107.2	69.5–137.4	89.9–179.7	29.5–231.8	na	47.6–128.7	82.5–117.9	
Very remote	na	..	130.7	110.3	92.0	–	na	77.8	104.0	63
Variability band (g)	na	..	83.9–189.5	57.8–177.7	29.5–200.1	..	na	36.9–140.9	78.5–134.7	

Table EA.26 **Incidence of selected cancers, by remoteness area, 2010 (a)**

	NSW (b)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT* (c)	*Total excluding NSW/ACT* (d)	*Total excluding NSW/ACT* (d)
					Age standardised rate per 100 000 population					*no.*
Cervical cancer (f)										
Major cities	na	6.1	7.0	7.1	7.9	..	na	..	6.7	342
Variability band (g)	na	5.1–7.2	5.6–8.5	5.3–9.0	5.8–10.4	..	na	..	6.0–7.5	
Inner regional	na	7.9	8.3	6.4	6.1	6.6	na	..	7.6	108
Variability band (g)	na	5.5–10.7	5.8–11.3	3.0–11.7	2.2–12.3	3.1–11.7	na	..	6.2–9.2	
Outer regional	na	5.0	9.9	9.1	5.3	8.0	na	np	8.1	64
Variability band (g)	na	1.6–11.5	6.7–14.0	4.0–16.9	1.5–12.5	2.8–16.0	na	np	6.2–10.3	
Remote	na	–	10.3	13.6	9.1	13.7	na	np	11.4	16
Variability band (g)	na	..	2.2–25.9	4.6–27.4	0.5–31.1	0.0–82.5	na	np	6.2–18.1	
Very remote	na	..	21.2	24.5	–	–	na	–	13.1	8
Variability band (g)	na	..	5.2–49.5	2.5–67.5	..	..	na	..	4.9–26.0	

(a) Remoteness areas are classified according to the Australian Standard Geographical classification (ASGC) Remoteness Area. Disaggregation by remoteness area is based on postcode of usual residence. There are no very remote areas in Victoria; no major cities in Tasmania; and no major cities or inner regional areas in the NT.

(b) 2010 incidence data for NSW and ACT were not available. Estimates were made for the jurisdictions as a whole (see table EA.24) but not by remoteness area.

(c) For the NT, incidence rates based on counts of between 1 and 4 persons are not published due to statistical unreliability, consistent with NT Health Department policy.

(d) Totals do not include NSW or ACT as disaggregation by remoteness area was not available. Therefore totals should not be compared to previous years.

(e) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 84 years, and expressed per 100 000 persons.

(f) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 84 years, and expressed per 100 000 females.

(g) Variability band (± rate per 100 000 population)

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

Source: AIHW (unpublished) Australian Cancer Database 2010; ABS (unpublished) concordances from Postal Area to Remoteness Area; ABS (unpublished) Estimated Resident Population, 30 June 2010.

Table EA.27 **Incidence of selected cancers, by SEIFA IRSD quintiles, 2010 (a)**

	NSW (b)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT* (c)	*Total excluding NSW/ACT* (d)	*Total excluding NSW/ACT* (d)
	Age standardised rate per 100 000 population									*no.*
Bowel cancer (e)										
Quintile 1	na	66.0	63.8	62.8	64.8	84.8	na	32.1	66.6	2181
Variability band (g)	na	61.0–71.3	59.1–68.7	49.5–78.5	58.5–71.6	75.5–95.0	na	16.2–55.1	63.8–69.5	
Quintile 2	na	65.8	74.8	66.9	53.5	67.3	na	79.9	66.4	1886
Variability band (g)	na	61.2–70.7	68.6–81.4	59.5–75.0	46.9–60.7	45.8–95.3	na	34.7–152.	63.4–69.5	
Quintile 3	na	62.5	63.3	56.3	59.9	80.8	na	66.4	61.7	2073
Variability band (g)	na	58.0–67.1	58.3–68.7	51.1–61.9	51.2–69.7	65.6–98.5	na	37.6–106.	59.1–64.5	
Quintile 4	na	57.1	57.9	56.2	55.5	71.7	na	61.9	57.8	1868
Variability band (g)	na	53.0–61.5	53.4–62.8	49.0–64.1	48.1–63.8	55.3–91.3	na	37.9–93.8	55.2–60.5	
Quintile 5	na	55.7	56.8	55.4	49.4	..	na	np	55.2	1622
Variability band (g)	na	51.8–59.8	51.2–62.9	49.2–62.1	41.3–58.6	..	na	np	52.5–57.9	
Lung cancer (e)										
Quintile 1	na	45.3	54.2	50.3	52.5	48.3	na	81.1	50.6	1676
Variability band (g)	na	41.2–49.7	49.9–58.6	38.3–64.8	46.9–58.6	41.5–56.0	na	53.4–116.	48.2–53.1	
Quintile 2	na	40.7	52.1	51.7	43.7	44.4	na	56.2	45.9	1312
Variability band (g)	na	37.1–44.6	47.0–57.7	45.2–58.9	37.9–50.2	27.0–68.8	na	23.3–112.	43.4–48.5	
Quintile 3	na	42.1	49.3	48.8	34.9	42.5	na	51.6	45.1	1515
Variability band (g)	na	38.5–46.0	44.9–54.0	44.0–54.0	28.3–42.6	31.7–55.8	na	24.7–92.4	42.8–47.4	
Quintile 4	na	31.5	38.0	39.3	36.9	40.7	na	30.8	35.4	1137
Variability band (g)	na	28.5–34.8	34.4–42.0	33.2–46.1	30.9–43.8	28.4–56.5	na	13.0–58.8	33.4–37.6	
Quintile 5	na	33.5	34.2	36.9	21.5	..	na	np	33.1	961
Variability band (g)	na	30.5–36.7	29.8–39.1	31.9–42.4	16.2–27.8	..	na	np	31.0–35.3	

Table EA.27 **Incidence of selected cancers, by SEIFA IRSD quintiles, 2010 (a)**

	NSW (b)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT* (c)	*Total excluding NSW/ACT* (d)	*Total excluding NSW/ACT* (d)
				Age standardised rate per 100 000 population						*no.*
Melanoma (e)										
Quintile 1	na	25.0	58.8	47.6	37.8	48.0	na	15.6	42.2	1321
Variability band (g)	na	21.9–28.4	54.2–63.7	36.4–61.1	32.9–43.3	40.8–56.1	na	5.8–31.3	39.9–44.5	
Quintile 2	na	40.0	68.0	48.7	37.3	55.6	na	45.6	48.5	1322
Variability band (g)	na	36.3–44.0	62.1–74.5	42.4–55.6	31.6–43.7	35.4–82.9	na	14.3–103.	45.9–51.2	
Quintile 3	na	35.4	70.3	39.5	33.7	60.2	na	66.5	46.9	1570
Variability band (g)	na	32.1–39.0	65.0–75.9	35.2–44.2	27.1–41.5	46.3–76.8	na	34.8–111.	44.6–49.3	
Quintile 4	na	41.1	67.1	46.9	36.1	39.4	na	52.3	50.0	1628
Variability band (g)	na	37.6–44.9	62.3–72.2	40.6–54.0	30.0–43.1	27.4–54.8	na	29.6–83.0	47.6–52.5	
Quintile 5	na	44.0	79.2	45.3	32.7	..	na	23.4	52.2	1531
Variability band (g)	na	40.6–47.7	72.8–86.0	39.7–51.4	26.1–40.5	..	na	7.6–54.6	49.6–54.9	
Female breast cancer (f)										
Quintile 1	na	103.6	112.3	116.2	104.5	109.7	na	37.7	106.9	1701
Variability band (g)	na	94.6–113.2	103.4–121.8	91.1–146.0	93.0–117.1	94.5–126.6	na	20.6–63.4	101.8–112.2	
Quintile 2	na	110.4	119.1	120.5	121.9	107.5	na	202.1	116.4	1638
Variability band (g)	na	101.7–119.7	108.2–130.9	106.6–135.6	107.3–137.9	67.7–161.9	na	108.1–34	110.8–122.3	
Quintile 3	na	115.1	124.6	113.4	115.7	96.3	na	126.5	117.1	2020
Variability band (g)	na	106.8–123.9	114.8–135.1	103.2–124.4	97.9–135.7	72.9–124.7	na	79.5–190.	112.0–122.3	
Quintile 4	na	113.8	121.2	126.6	131.7	120.4	na	97.5	119.8	2039
Variability band (g)	na	105.7–122.2	112.2–130.7	112.1–142.4	115.3–149.8	90.7–156.6	na	63.3–142.	114.6–125.2	
Quintile 5	na	121.5	132.1	130.8	123.3	..	na	101.7	125.8	1945
Variability band (g)	na	113.5–129.9	120.6–144.4	117.8–144.9	105.7–142.8	..	na	25.9–236.	120.2–131.6	

Table EA.27 **Incidence of selected cancers, by SEIFA IRSD quintiles, 2010 (a)**

	NSW (b)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT* (c)	*Total excluding NSW/ACT* (d)	*Total excluding NSW/ACT* (d)
				Age standardised rate per 100 000 population						*no.*
Cervical cancer (f)										
Quintile 1	na	7.0	11.2	14.8	8.8	7.2	na	np	9.0	131
Variability band (g)	na	4.7–10.0	8.4–14.7	6.7–28.1	5.6–13.0	3.5–13.0	na	np	7.5–10.7	
Quintile 2	na	7.0	9.2	6.9	9.6	4.4	na	np	7.9	99
Variability band (g)	na	4.8–9.9	6.2–13.0	3.9–11.4	5.6–15.2	0.1–24.5	na	np	6.4–9.6	
Quintile 3	na	6.4	5.9	8.5	6.9	10.3	na	np	7.0	116
Variability band (g)	na	4.6–8.8	3.9–8.5	5.9–11.9	3.0–13.6	3.1–24.5	na	np	5.8–8.4	
Quintile 4	na	5.8	6.7	6.4	7.0	5.3	na	np	6.3	105
Variability band (g)	na	4.1–8.1	4.7–9.2	3.5–10.7	3.4–12.8	0.6–19.1	na	np	5.2–7.7	
Quintile 5	na	5.8	6.7	6.6	3.0	..	na	–	5.8	87
Variability band (g)	na	4.1–7.9	4.4–9.8	3.9–10.5	0.5–8.8	..	na	..	4.7–7.2	

(a) 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. The SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each State or Territory. Disaggregation by SEIFA is based on Statistical Local Area (SLA) of usual residence at time of diagnosis. Not all quintiles are represented in every jurisdiction. Socio-Economic Indexes for Areas quintiles are based on 2006 classifications. The accuracy of these classifications decreases over time due to changes in demographics within SLA boundaries since 2006.

(b) 2010 incidence data for NSW and ACT were not available. Estimates were made for the jurisdictions as a whole (see table EA.24) but not by SEIFA quintile.

(c) For the NT, incidence rates based on counts of between 1 and 4 persons are not published due to statistical unreliability, consistent with NT Health Department policy.

(d) Totals do not include NSW or ACT as disaggregation by SEIFA quintile was not available. Therefore totals should not be compared to previous years.

(e) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 84 years, and expressed per 100 000 persons.

(f) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 84 years, and expressed per 100 000 females.

(g) Variability band (± rate per 100 000 population)

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

Source: AIHW (unpublished) Australian Cancer Database 2010; ABS (unpublished) concordances from Postal Area to ABS Index of Relative Socio-economic Disadvantage (IRSD); ABS (unpublished) Estimated Resident Population, 30 June 2010.

Table EA.28 **Incidence of selected cancers, by Indigenous status (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Total* (g)	*Total*
				Age standardised rate per 100 000 population						*(no.)*
2010 (f), (g)										
Bowel cancer										
Indigenous	na	102.0	58.4	41.8	28.2	62.2	na	13.6	43.9	52
Variability band (h), (i)	na	54.9–171.5	38.4–84.4	20.9–73.1	5.9–76.1	14.9–163.6	na	4.3–32.0	31.7–59.0	
Other Australians (j)	na	61.4	61.4	58.2	57.9	81.0	na	59.2	60.4	4 235
Variability band (h), (i)	na	59.4–63.4	59.1–63.7	55.1–61.4	54.6–61.4	74.0–88.4	na	45.5–75.4	58.6–62.2	
Lung cancer										
Indigenous	na	69.5	91.7	44.4	81.9	98.8	na	97.3	80.8	90
Variability band (h), (i)	na	34.0–124.3	66.7–122.4	21.4–80.0	36.1–155.7	34.3–218.5	na	59.9–147.8	63.6–100.9	
Other Australians (j)	na	38.9	44.2	44.3	40.1	44.8	na	42.4	44.2	3 111
Variability band (h), (i)	na	37.3–40.5	42.3–46.2	41.6–47.2	37.4–43.0	39.7–50.4	na	30.3–57.4	42.6–45.8	
Melanoma of the skin										
Indigenous	na	20.9	7.6	2.0	17.2	7.3	na	np	5.8	7
Variability band (h), (i)	na	3.5–63.1	1.6–19.3	0.1–11.4	3.5–50.3	0.2–40.8	na	np	1.9–12.8	
Other Australians (j)	na	37.9	67.6	45.0	36.5	50.4	na	42.3	59.7	4 176
Variability band (h), (i)	na	36.3–39.5	65.2–70.1	42.3–47.8	33.8–39.4	44.7–56.7	na	31.7–55.1	57.9–61.6	
Female breast cancer										
Indigenous	na	98.4	88.2	86.5	44.5	–	na	88.2	87.2	69
Variability band (h), (i)	na	44.2–185.7	57.8–127.6	47.5–142.2	12.1–114.2	na	na	50.0–142.6	65.9–112.7	
Other Australians (j)	na	113.0	119.6	122.6	116.3	110.4	na	93.6	120.3	4 330
Variability band (h), (i)	na	109.2–116.8	115.2–124.1	116.3–129.1	109.6–123.3	98.6–123.1	na	71.7–119.8	116.7–123.9	
Cervical cancer										
Indigenous	na	28.2	26.4	19.1	–	–	na	np	20.1	17
Variability band (h), (i)	na	7.6–72.4	10.3–53.1	7.0–41.5	na	na	na	np	10.6–33.8	
Other Australians (j)	na	6.2	7.5	7.4	7.5	7.5	na	8.0	7.5	259
Variability band (h), (i)	na	5.3–7.1	6.4–8.7	5.9–9.2	5.8–9.6	4.4–11.8	na	3.2–16.4	6.6–8.5	

Table EA.28 **Incidence of selected cancers, by Indigenous status (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Total* (g)	*Total*
	Age standardised rate per 100 000 population									*(no.)*
2009										
Bowel cancer										
Indigenous	44.1	44.9	69.8	51.0	23.9	73.2	–	40.0	52.3	100
Variability band (h), (i)	29.8–62.5	19.5–87.0	47.2–98.7	25.9–88.4	3.5–73.2	20.1–178.0	na	18.1–73.9	41.5–64.8	
Other Australians (j)	59.4	60.4	61.6	57.9	61.3	72.1	62.2	53.7	59.8	8 712
Variability band (h), (i)	57.7–61.1	58.4–62.4	59.3–64.0	54.8–61.2	57.8–64.9	65.5–79.3	53.6–71.6	39.8–70.6	58.5–61.1	
Lung cancer										
Indigenous	87.9	71.5	88.2	85.3	47.1	92.8	–	67.8	84.8	138
Variability band (h), (i)	64.8–116.0	34.7–128.4	62.9–119.6	49.1–137.5	13.0–114.4	30.5–208.7	na	36.6–112.8	70.2–101.3	
Other Australians (j)	43.0	41.1	45.4	44.9	43.4	39.1	30.3	46.8	44.0	6 459
Variability band (h), (i)	41.6–44.5	39.5–42.7	43.5–47.5	42.2–47.8	40.5–46.4	34.3–44.3	24.4–37.0	33.7–63.1	43.0–45.1	
Melanoma of the skin										
Indigenous	5.4	7.3	6.0	11.5	–	–	–	np	7.0	16
Variability band (h), (i)	1.3–13.6	0.7–27.1	1.1–15.6	2.1–31.6	na	na	na	np	3.6–12.0	
Other Australians (j)	48.5	41.1	68.7	46.3	36.4	49.0	35.8	40.5	54.3	7 810
Variability band (h), (i)	46.9–50.1	39.5–42.8	66.2–71.2	43.5–49.2	33.7–39.3	43.3–55.2	29.5–42.9	29.4–54.3	53.1–55.6	
Female breast cancer										
Indigenous	98.5	81.2	72.0	104.1	10.4	115.6	np	100.6	91.2	108
Variability band (h), (i)	70.5–133.2	32.4–164.6	45.2–107.8	57.3–170.8	0.3–57.8	28.3–287.9	np	53.2–169.7	73.3–111.8	
Other Australians (j)	115.6	108.2	119.2	114.5	111.5	117.3	148.6	73.2	116.3	8 662
Variability band (h), (i)	112.2–119.	104.5–112.0	114.8–123.8	108.3–120.9	104.8–118.4	105.1–130.4	131.0–167.8	54.1–96.6	113.8–118.8	
Cervical cancer										
Indigenous	12.2	9.0	20.6	8.1	–	–	np	np	15.0	20
Variability band (h), (i)	2.9–30.4	0.2–50.1	7.6–42.2	1.5–24.0	na	na	np	np	8.2–24.4	
Other Australians (j)	6.7	5.7	7.2	8.2	5.1	6.1	6.1	11.2	7.1	500
Variability band (h), (i)	5.9–7.6	4.9–6.7	6.1–8.4	6.6–10.1	3.7–6.8	3.4–10.1	3.0–10.9	4.3–23.0	6.5–7.8	

Table EA.28 **Incidence of selected cancers, by Indigenous status (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Total* (g)	*Total*
	Age standardised rate per 100 000 population									*(no.)*
2008										
Bowel cancer										
Indigenous	68.2	109.5	34.2	30.2	np	–	np	np	47.7	94
Variability band (h), (i)	47.6–94.2	58.0–186.6	20.5–53.0	11.3–62.6	np	–	np	np	37.8–59.3	
Other Australians (j)	60.5	60.7	64.8	58.1	66.4	79.0	62.6	56.2	62.1	14 131
Variability band (h), (i)	58.8–62.3	58.7–62.7	62.4–67.2	54.9–61.4	62.7–70.1	72.0–86.6	53.9–72.3	41.5–74.1	61.1–63.1	
Lung cancer										
Indigenous	77.5	np	54.6	96.0	57.6	np	np	124.3	73.6	149
Variability band (h), (i)	55.6–104.6	np	35.4–79.7	60.2–144.2	17.7–136.3	np	np	80.7–181.5	61.4–87.5	
Other Australians (j)	42.4	41.1	45.8	43.2	43.7	44.7	34.7	52.6	42.9	9 805
Variability band (h), (i)	40.9–43.9	39.5–42.8	43.8–47.9	40.4–46.1	40.8–46.8	39.5–50.4	28.3–42.2	38.5–70.0	42.1–43.8	
Melanoma of the skin										
Indigenous	np	28.5	np	np	–	–	np	–	6.2	14
Variability band (h), (i)	np	8.2–68.5	np	np	–	–	np	–	3.0–10.9	
Other Australians (j)	48.5	39.1	68.6	49.9	40.4	50.8	44.6	40.1	49.5	11 043
Variability band (h), (i)	47.0–50.1	37.5–40.8	66.2–71.2	47.0–53.0	37.5–43.5	44.9–57.3	37.5–52.6	28.8–54.1	48.5–50.4	
Female breast cancer										
Indigenous	100.5	157.8	94.0	99.9	np	np	np	64.3	92.0	123
Variability band (h), (i)	71.2–137.1	85.2–264.9	62.7–134.2	50.3–175.1	np	np	np	28.5–120.6	75.1–111.2	
Other Australians (j)	112.9	115.3	121.0	119.4	117.0	104.0	119.4	111.4	115.8	13 444
Variability band (h), (i)	109.5–116.3	111.4–119.2	116.5–125.7	113.1–126.1	110.1–124.2	92.5–116.6	103.6–137.0	83.1–145.5	113.8–117.7	
Cervical cancer										
Indigenous	np	np	20.4	22.2	–	np	–	np	14.2	26
Variability band (h), (i)	np	np	8.3–40.4	7.8–48.9	–	np	–	np	8.8–21.4	
Other Australians (j)	6.6	6.5	6.7	8.6	8.3	6.6	3.9	np	6.9	752
Variability band (h), (i)	5.8–7.5	5.5–7.5	5.6–7.9	7.0–10.6	6.4–10.5	3.7–10.9	1.6–8.0	np	6.4–7.4	

Table EA.28 **Incidence of selected cancers, by Indigenous status (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (f)	*NT*	*Total* (g)	*Total*
	Age standardised rate per 100 000 population									*(no.)*

(a) Age-standardised to the Australian population as at 30 June 2001, using five-year age groups to 64 years, and expressed per 100 000 persons.

(b) Other includes non-Indigenous people and those for whom Indigenous status was not stated.

(c) Populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(d) Some jurisdictions may use an imputation method to impute missing Indigenous status for reporting purposes. This may lead to an underreporting of rates in this Indicator compared to those shown in jurisdictional cancer incidence reports.

(e) The incidence rate for Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.

(f) 2010 incidence data were not available for NSW or the ACT. Estimates were made for the jurisdictions as a whole but not by Indigenous status.

(g) For 2010, the total includes only Queensland, WA and the NT, for whom the quality of Indigenous status data is considered acceptable for statistical analysis. Totals for previous years also include NSW. This constitutes a break in time series and totals data for 2010 are not comparable with data for previous years.

(h) A 95 per cent variability band (confidence interval) for an estimate is a range of values which is very likely (95 times out of 100) to contain the true unknown value. Rates derived from administrative data counts are not subject to sampling error but may still be subject to natural random variation, especially for small counts. To quantify this variation variability bands are calculated to provide a confidence interval for the estimate.

(i) Variability bands should be used for the purposes of comparisons over time. They should not be used for comparing rates between jurisdictions at a single point in time as the variability bands and rates do not take into account differences in Indigenous under-identification between jurisdictions.

(j) 'Other' includes non-Indigenous people and those for whom Indigenous status was not stated.

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

Source : AIHW unpublished, Australian Cancer Database 2010; ABS unpublished, Estimated Resident Population, 30 June 2009; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021,* Series B, Cat. no. 3238.0, Canberra.

Table EA.29 Age standardised rate of heart attacks (new cases), people 25 years or over, by Indigenous status, 2007 to 2011 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
Rate of heart attacks										
2007										
Indigenous	rate	na	na	na	na	na	na	na	na	1 208.2
Non-Indigenous (f)	rate	na	na	na	na	na	na	na	na	521.1
2008										
Indigenous	rate	na	na	na	na	na	na	na	na	1 197.8
Non-Indigenous (f)	rate	na	na	na	na	na	na	na	na	485.6
2009										
Indigenous	rate	na	na	na	na	na	na	na	na	1 183.5
Non-Indigenous (f)	rate	na	na	na	na	na	na	na	na	450.7
2010										
Indigenous	rate	na	na	na	na	na	na	na	na	1 104.3
Non-Indigenous (f)	rate	na	na	na	na	na	na	na	na	435.2
2011										
Indigenous	rate	na	na	na	na	na	na	na	na	1 076.9
Non-Indigenous (f)	rate	na	na	na	na	na	na	na	na	420.8

(a) Data should be interpreted with caution. These data are estimated from national hospital and deaths data, using an algorithm developed by the AIHW which has not yet been validated. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information for further detail.

(b) The estimated number of heart attacks in a given year is derived from hospitalisations with a principal diagnoses of acute myocardial infarction or unstable angina that did not end in a transfer to another acute hospital or death in hospital, plus deaths from acute coronary heart disease. Rates are calculated as the estimated number of heart attacks divided by the relevant Australian estimated resident population.

(c) Rates are directly age-standardised to the 2001 Australian standard population.

(d) The populations used to derive rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive rates for all Australians.

(e) Estimates are based on data from the five jurisdictions where the quality of identification of Indigenous status is considered to be reasonable in both the NHMD and the NMD (NSW, QLD, WA, SA and the NT).

(f) Non-Indigenous includes cases where Indigenous status was not stated or was inadequately described.

Source : AIHW (unpublished) National Hospital Morbidity Database; AIHW (unpublished) National Mortality Database; ABS (2012) *Australian Demographic Statistics, September 2011* , Cat. no. 3101.0; ABS (unpublished) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* , Series B, Cat.no. 3238.0.

Table EA.30 **Rate of heart attacks, by age and sex, people aged 25 years and over, 2007 to 2011 (a), (b), (c)**

	Unit	*<25*	*25-34*	*35-44*	*45-54*	*55-64*	*65-74*	*75-84*	*85+*	*Aust* (d)
Rate per 100 000 population										
2007										
Males	rate	na	22.3	149.3	492.7	979.0	1 650.8	2 710.5	4 586.1	729.0
Females	rate	na	6.4	44.1	148.1	350.7	785.8	1 683.5	3 475.5	358.2
Total	**rate**	**na**	**14.4**	**96.3**	**319.0**	**664.7**	**1 209.3**	**2 135.1**	**3 840.9**	**534.2**
2008										
Males	rate	na	18.8	142.0	457.1	907.6	1 556.2	2 519.7	4 408.5	682.7
Females	rate	na	5.3	40.9	144.0	314.1	721.0	1 599.7	3 402.9	337.4
Total	**rate**	**na**	**12.1**	**91.1**	**299.2**	**610.4**	**1 130.7**	**2 006.3**	**3 737.6**	**501.7**
2009										
Males	rate	na	18.4	140.4	438.5	882.3	1 399.8	2 334.5	4 104.6	639.9
Females	rate	na	5.1	46.3	139.6	296.9	641.1	1 442.7	3 102.1	310.2
Total	**rate**	**na**	**11.8**	**93.0**	**287.8**	**588.7**	**1 014.1**	**1 838.7**	**3 439.7**	**467.2**
2010										
Males	rate	na	17.3	131.5	437.3	823.6	1 325.5	2 225.0	3 980.0	611.4
Females	rate	na	5.2	43.3	139.9	283.6	620.5	1 395.3	2 943.8	299.2
Total	**rate**	**na**	**11.3**	**87.0**	**287.3**	**552.4**	**968.0**	**1 765.3**	**3 296.5**	**447.8**
2011										
Males	rate	na	15.8	125.7	416.8	784.4	1 264.7	2 127.3	3 834.8	584.0
Females	rate	na	6.4	40.6	134.3	274.0	578.3	1 287.7	2 900.5	283.8
Total	**rate**	**na**	**11.1**	**82.8**	**274.2**	**527.7**	**917.7**	**1 663.8**	**3 222.4**	**427.0**

(a) Data should be interpreted with caution. These data are estimated from national hospital and deaths data, using an algorithm developed by the AIHW which has not yet been validated. The accuracy of the estimates rely on the accuracy of coding of principal diagnosis, transfers and deaths in hospital in the National Hospital Morbidity Database (NHMD) and the underlying cause of death in the National Mortality Database (NMD). See data quality information for further detail.

(b) The estimated number of heart attacks in a given year is derived from hospitalisations with a principal diagnoses of acute myocardial infarction or unstable angina that did not end in a transfer to another acute hospital or death in hospital, plus deaths from acute coronary heart disease. Rates are calculated as the estimated number of heart attacks divided by the relevant Australian estimate resident population.

(c) The populations used to derive rates are based on the 2011 Census and are not comparable with the 2006 based populations used to derive rates for Indigenous and non-Indigenous Australians.

(d) The Australian total is directly age-standardised to the 2001 Australian standard population.

Source : AIHW (unpublished) National Hospital Morbidity Database; AIHW (unpublished) National Mortality Database; ABS (2012) *Australian Demographic Statistics, September 2011* , Cat. no. 3101.0; ABS (2013) *Australian Demographic Statistics, December 2012* , Cat. no. 3101.0.

Table EA.31 **Proportion of people with type 2 diabetes (based on fasting blood glucose test), by State and Territory, by sex, 2011-12 (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
People aged 18 years or over										
Proportion										
Males	%	5.4	5.1	5.8	5.4	6.4	5.1	4.4	8.6	5.5
95 per cent confidence interval	±	1.9	2.4	1.9	1.7	2.2	1.6	2.3	5.1	0.9
Females	%	3.1	2.3	3.3	3.9	4.4	3.0	4.8	6.3	3.2
95 per cent confidence interval	±	1.1	1.7	1.3	1.7	1.7	1.2	2.2	5.0	0.7
Total (f)	%	**4.2**	**3.6**	**4.6**	**4.6**	**5.4**	**4.0**	**4.6**	**7.4**	**4.3**
95 per cent confidence interval	±	1.1	1.3	1.1	1.2	1.3	1.0	1.8	3.1	0.5
Relative standard error										
Males	%	17.6	24.0	16.4	16.3	17.8	16.4	27.3	30.4	8.5
Females	%	18.9	37.4	20.1	22.0	19.2	20.0	24.1	40.7	10.7
Total (f)	%	**13.0**	**18.4**	**12.8**	**13.6**	**12.3**	**13.0**	**19.3**	**21.8**	**6.4**
People aged 25 years or over										
Proportion										
Males	%	6.2	5.8	6.7	6.2	7.4	5.9	5.0	9.9	6.3
95 per cent confidence interval	±	2.1	2.7	2.1	2.0	2.6	1.9	2.7	5.9	1.0
Females	%	3.5	2.7	3.7	4.4	5.1	3.5	5.5	4.0	3.6
95 per cent confidence interval	±	1.3	2.0	1.5	1.9	1.9	1.4	2.6	3.9	0.8
Total (f)	%	**4.8**	**4.1**	**5.2**	**5.2**	**6.1**	**4.6**	**5.3**	**7.0**	**4.9**
95 per cent confidence interval	±	1.2	1.5	1.3	1.4	1.5	1.2	2.0	2.9	0.6

Table EA.31 **Proportion of people with type 2 diabetes (based on fasting blood glucose test), by State and Territory, by sex, 2011-12 (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Relative standard error										
Males	%	17.6	24.0	16.4	16.3	17.8	16.4	27.3	30.4	8.5
Females	%	18.9	37.4	20.1	22.0	19.2	20.0	24.1	49.4	10.7
Total (f)	%	**13.0**	**18.4**	**12.8**	**13.6**	**12.3**	**13.0**	**19.3**	**21.2**	**6.4**

RSE = Relative Standard Error. Estimates with RSEs between 25 percent and 50 per cent should be used with caution.

(a) Data include pregnant women.

(b) Data include those with known type 2 diabetes and all persons with newly diagnosed diabetes. Diabetes prevalence is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. The type of diabetes for newly diagnosed cases cannot be determined from a fasting plasma glucose test alone. However, as it is assumed that the vast majority of newly diagnosed cases would be Type 2, all newly diagnosed cases of diabetes have been included in this measure. See DQI for more information.

(c) Fasting plasma glucose is a fasting blood test. Data include only people who fasted for 8 hours or more prior to their blood test. For Australia in 2011-12, approximately 79% of people aged 18 years or over and people aged 25 years or over who participated in the National Health Measures Survey had fasted.

(d) Rates are age standardised to the 2001 Australian standard population using 5 year ranges from 18 years.

(e) Data for the NT should be used with care as the exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(f) Denominator includes a small number of persons for whom test results were not reported.

Source: ABS unpublished, *Australian Health Survey 2011-13*, (2011-12 National Health Measures Survey component).

Table EA.32 **Age-standardised mortality rates of potentially avoidable deaths, under 75 years (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g), (h)
Potentially preventable deaths (i)									
2007									
Number of deaths	6 362	4 461	3 959	2 044	1 623	637	240	382	19 708
Rate per 100 000 persons	94.5	88.7	100.5	102.1	101.2	123.4	77.8	225.8	97.2
variability band (±)	2.3	2.6	3.2	4.5	5.0	9.7	10.0	24.8	1.4
2008									
Number of deaths	6 373	4 719	4 303	2 100	1 551	611	247	374	20 277
Rate per 100 000 persons	92.6	91.5	105.9	101.3	94.8	116.0	78.7	217.2	97.5
variability band (±)	2.3	2.6	3.2	4.4	4.8	9.3	10.0	23.9	1.3
2009									
Number of deaths	6 436	4 880	4 261	2 068	1 607	666	247	336	20 502
Rate per 100 000 persons	91.2	92.1	101.4	96.7	96.6	122.9	76.1	189.0	95.8
variability band (±)	2.2	2.6	3.1	4.2	4.8	9.5	9.6	21.8	1.3
2010									
Number of deaths	6 534	4 473	4 396	2 102	1 644	597	240	337	20 322
Rate per 100 000 persons	90.1	82.4	101.3	95.3	96.4	106.9	72.9	180.0	92.4
variability band (±)	2.2	2.4	3.0	4.1	4.7	8.7	9.4	20.6	1.3
2011									
Number of deaths	6 576	4 681	4 358	2 019	1 537	614	242	341	20 368
Rate per 100 000 persons	88.4	83.8	97.3	88.4	89.0	105.8	71.3	182.7	90.1
variability band (±)	2.2	2.4	2.9	3.9	4.5	8.6	9.1	20.6	1.3
Potentially treatable deaths (j)									
2007									
Number of deaths	4 310	2 888	2 630	1 203	1 075	352	175	209	12 841
Rate per 100 000 persons	63.7	57.4	66.8	60.2	66.3	66.2	58.5	138.0	63.1
variability band (±)	1.9	2.1	2.6	3.4	4.0	7.0	8.8	21.0	1.1
2008									
Number of deaths	4 328	2 973	2 739	1 208	1 019	389	170	185	13 011
Rate per 100 000 persons	62.6	56.9	67.2	58.5	61.0	71.1	56.3	110.2	62.2
variability band (±)	1.9	2.1	2.5	3.3	3.8	7.1	8.6	17.3	1.1
2009									
Number of deaths	4 213	3 026	2 708	1 211	1 071	384	156	190	12 959
Rate per 100 000 persons	59.1	57.1	63.9	56.4	63.1	69.3	49.4	116.2	60.2
variability band (±)	1.8	2.0	2.4	3.2	3.8	7.0	7.9	18.0	1.0
2010									
Number of deaths	4 150	2 950	2 615	1 214	1 050	365	166	181	12 691
Rate per 100 000 persons	56.8	54.0	59.9	54.9	60.6	63.6	51.3	102.3	57.3
variability band (±)	1.7	2.0	2.3	3.1	3.7	6.6	7.9	16.1	1.0
2011									
Number of deaths	4 382	2 972	2 621	1 184	1 026	339	137	175	12 835
Rate per 100 000 persons	58.3	53.0	58.0	51.8	57.4	58.3	40.6	94.7	56.3
variability band (±)	1.7	1.9	2.2	3.0	3.5	6.3	6.9	15.0	1.0

Table EA.32 **Age-standardised mortality rates of potentially avoidable deaths, under 75 years (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g), (h)
All potentially avoidable deaths (b)									
2007									
Number of deaths	10 672	7 348	6 589	3 247	2 697	989	414	590	32 548
Rate per 100 000 persons	158.1	146.1	167.3	162.3	167.5	189.6	136.3	363.8	160.3
variability band (±)	3.0	3.4	4.1	5.6	6.4	12.0	13.3	32.5	1.7
2008									
Number of deaths	10 700	7 691	7 042	3 307	2 570	999	417	558	33 287
Rate per 100 000 persons	155.2	149.0	173.1	159.8	155.8	187.1	135.0	327.4	159.7
variability band (±)	3.0	3.3	4.1	5.5	6.1	11.8	13.2	29.5	1.7
2009									
Number of deaths	10 648	7 905	6 969	3 279	2 678	1 050	403	525	33 461
Rate per 100 000 persons	150.3	149.2	165.3	153.2	159.7	192.2	125.4	305.3	156.0
variability band (±)	2.9	3.3	3.9	5.3	6.1	11.8	12.4	28.3	1.7
2010									
Number of deaths	10 684	7 422	7 011	3 315	2 694	961	406	517	33 012
Rate per 100 000 persons	146.9	136.4	161.3	150.2	157.0	170.5	124.2	282.2	149.7
variability band (±)	2.8	3.1	3.8	5.1	6.0	11.0	12.3	26.1	1.6
2011									
Number of deaths	10 958	7 653	6 978	3 202	2 562	953	378	515	33 202
Rate per 100 000 persons	146.6	136.9	155.4	140.2	146.3	164.1	111.9	277.4	146.4
variability band (±)	2.8	3.1	3.7	4.9	5.7	10.6	11.4	25.5	1.6

(a) Age-standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 1000 or 100 000 persons. SDRs in this table have been calculated using the direct method, age-standardised by 5 year age groups to less than 75 years.

(b) Data based on reference year. See data quality information (DQI) for a more detailed explanation.

(c) Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census.

(d) Avoidable mortality has been defined in the Public Health Information Development Unit's report, *Australian and New Zealand Atlas of Avoidable Mortality* (2006), and in reports by NSW Health and Victorian Department of Human Services as mortality before the age of 75 years, from conditions which are potentially avoidable within the present health system.

(e) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised) and 2011 (preliminary). See Explanatory Notes 29-33 and Causes of Death Revisions 2009 and 2010 (Technical Note) in *Causes of Death, Australia, 2011* (cat. no. 3303.0).

(f) Some totals and figures may not compute due to the effects of rounding.

(g) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for a more detailed explanation.

(h) All states and territories including other territories.

Table EA.32 **Age-standardised mortality rates of potentially avoidable deaths, under 75 years (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g), (h)

(i) Preventable deaths are those which are amenable to screening and primary prevention, such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector.

(j) Treatable deaths are those which are amenable to therapeutic interventions, and reflecting the safety and quality of the current treatment system.

Source: ABS (unpublished) *Causes of Death, Australia* , Cat. no. 3303.0.

Table EA.33 Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT, 2007–2011 (a), (b), (c), (d), (e), (f), (g), (h), (i)

	Unit	*NSW*	*Qld* (j)	*WA* (k)	*SA*	*NT*	*Total* (j), (k), (l)
Potentially preventable deaths (m)							
Indigenous							
Number of deaths	no.	1 115	1 115	908	303	915	4 355
Rate (a)	per 100 000	250.0	271.5	407.4	336.4	467.0	315.5
Non-Indigenous							
Number of deaths	no.	30 816	19 615	9 184	7 566	846	68 026
Rate (a)	per 100 000	87.7	93.2	87.2	90.5	125.4	89.8
Deaths from potentially treatable conditions (n)							
Indigenous							
Number of deaths	no.	592	711	548	168	557	2 575
Rate (a)	per 100 000	135.2	178.8	273.7	202.2	306.9	196.5
Non-Indigenous							
Number of deaths	no.	20 619	12 254	5 405	5 040	380	43 697
Rate (a)	per 100 000	58.4	58.0	51.3	59.2	61.5	57.4
All potentially avoidable deaths (b)							
Indigenous							
Number of deaths	no.	1 707	1 825	1 455	471	1 471	6 929
Rate (a)	per 100 000	385.2	450.4	681.2	538.6	773.9	512.0
Non-Indigenous							
Number of deaths	no.	51 434	31 869	14 588	12 606	1 225	111 722
Rate (a)	per 100 000	146.1	151.2	138.5	149.8	186.9	147.2

(a) Age-standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 1000 or 100 000 persons. SDRs in this table have been calculated using the direct method, age-standardised by 5 year age groups to less than 75 years.

(b) Avoidable mortality has been defined in the Public Health Information Development Unit's report, Australian and New Zealand Atlas of Avoidable Mortality (2006), and in reports by NSW Health and Victorian Department of Human Services as mortality before the age of 75 years, from conditions which are potentially avoidable within the present health system.

(c) Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. 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.

(d) Data based on year of registration. See data quality information (DQI) for a more detailed explanation.

(e) Some totals and figures may not compute due to the effects of rounding.

(f) Data are presented in five-year groupings due to the volitatlity of small numbers each year.

(g) Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis.

Table EA.33 **Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT, 2007–2011 (a), (b), (c), (d), (e), (f), (g), (h), (i)**

	Unit	*NSW*	*Qld* (j)	*WA* (k)	*SA*	*NT*	*Total* (j), (k), (l)

(h) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised) and 2011 (preliminary). See Explanatory Notes 29-33 and Causes of Death Revisions 2009 and 2010 (Technical Note) in *Causes of Death, Australia, 2011* (cat. no. 3303.0).

(i) Deaths where the Indigenous status of the deceased was not stated are excluded from analysis.

(j) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for a more detailed explanation.

(k) For WA, Indigenous deaths data for 2007, 2008 and 2009 have been corrected. The data differ from previous reports in which they were over-reported. Please see DQI for more information.

(l) Total includes data for NSW, Queensland, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(m) Preventable deaths are those which are amenable to screening and primary prevention such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector.

(n) Deaths from potentially treatable conditions are those which are amenable to therapeutic interventions, and reflect the safety and quality of the current treatment system.

Source : ABS (unpublished), Causes of Death, Australia, 2011; ABS (unpublished) Estimated Resident Population; ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* , 2006–2010, Series B, Cat. no. 3238.0.

Table EA.34 **All Australians average life expectancy at birth (years) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
Males									
2002–2004	78.0	78.5	77.8	78.6	78.0	76.7	79.7	72.3	78.1
2003–2005	76.3	76.8	75.6	75.6	77.5	75.8	74.3	57.1	76.3
2004–2006	76.9	77.3	75.9	75.6	77.4	76.6	74.9	55.0	76.6
2005–2007	77.0	77.4	76.0	76.0	77.7	76.3	76.0	56.8	76.8
2006–2008	77.7	77.9	76.4	76.4	78.2	76.9	75.9	57.1	77.3
2007–2009	77.9	78.2	76.7	76.2	78.6	76.6	76.7	59.2	77.5
2008–2010	78.3	78.5	77.0	76.4	78.9	78.2	78.3	61.4	77.9
2009–2011	79.8	80.3	79.5	80.1	79.7	78.3	81.0	74.9	79.7
2010–2012	79.9	80.5	79.5	80.1	79.8	78.7	81.2	74.7	79.9
Females									
2004–2006	83.3	83.3	82.9	83.3	83.1	81.8	83.9	78.0	83.0
2004–2006	83.3	83.6	83.2	83.8	83.4	82.1	84.0	78.2	83.3
2004–2006	83.4	83.7	83.4	83.8	83.6	82.3	83.9	78.1	83.5
2005–2007	83.8	83.8	83.6	84.0	83.9	82.4	84.0	78.4	83.7
2006–2008	83.9	83.9	83.7	84.0	83.8	82.3	84.0	78.4	83.7
2007–2009	84.3	84.1	83.8	84.1	83.9	82.2	84.3	79.0	83.9
2008–2010	84.1	84.3	83.9	84.3	83.8	82.3	84.7	79.2	84.0
2009–2011	84.2	84.4	84.1	84.6	84.0	82.5	84.8	80.5	84.2
2010–2012	84.2	84.5	84.0	84.8	84.2	82.6	85.1	80.0	84.3
Difference between male and female life expectancies at birth (c)									
2004–2006	7.0	6.5	7.3	7.7	5.6	6.0	9.6	20.9	6.7
2004–2006	6.5	6.4	7.5	8.2	6.2	5.7	9.0	23.1	6.9
2005–2007	6.8	6.4	7.6	8.0	6.2	6.1	8.0	21.6	6.9
2006–2008	6.2	6.0	7.3	7.6	5.6	5.4	8.1	21.3	6.4
2007–2009	6.4	5.9	7.1	7.9	5.3	5.6	7.6	19.8	6.4
2008–2010	5.8	5.8	6.9	7.9	4.9	4.1	6.4	17.8	6.1
2009–2011	4.4	4.1	4.6	4.5	4.3	4.2	3.8	5.6	4.5
2010–2012	4.3	4.0	4.5	4.7	4.4	3.9	3.9	5.3	4.4

(a) Life expectancy is calculated using three years of data.

(b) Figures for Australia include Other territories.

(c) Differences are based on unrounded estimates.

Source: ABS 2013, *Life Tables, Australia, States and Territories, 2010-2012* (Cat. no. 3302.0.55.001).

Table EA.35 **Estimated life expectancies at birth, by Indigenous status and sex (years) (a), (b), (c)**

	NSW	*Qld*	*WA*	*NT*	*Australia — for comparison* (d), (e)	*Australia — Headline estimates* (d), (f)
2010–2012						
Indigenous						
Life expectancy at birth						
Males	70.5	68.7	65.0	63.4	67.4	69.1
Females	74.6	74.4	70.2	68.7	72.3	73.7
Persons (c)	72.5	71.5	67.5	66.0	69.8	71.3
Upper and lower 95 per cent confidence intervals						
Males	69.0–72.0	67.3–70.1	63.4–66.6	61.3–65.5	66.1–68.7	67.8–70.4
Females	73.3–75.9	73.2–75.6	68.8–71.6	66.8–70.6	71.2–73.4	72.5–74.9
Persons	na	na	na	na	na	na
Non-Indigenous						
Life expectancy at birth						
Males	79.8	79.4	80.1	77.8	79.8	79.7
Females	83.1	83.0	83.7	83.1	83.2	83.1
Persons (c)	81.4	81.2	81.9	80.4	81.5	81.4
Difference between Indigenous and non-Indigenous life expectancies at birth (g)						
Males	9.3	10.8	15.1	14.4	12.4	10.6
Females	8.5	8.6	13.5	14.4	10.9	9.5
Persons (c)	8.9	9.7	14.3	14.4	11.7	10.1
2005–2007						
Indigenous						
Life expectancy at birth						
Males	68.3	67.1	64.5	61.5	65.7	67.5
Females	74.0	72.7	70.0	69.4	71.7	73.1
Persons (c)	71.1	69.8	67.2	65.3	68.6	70.2
Upper and lower 95 per cent confidence intervals						
Males	66.3–70.3	65.6–68.6	62.9–66.1	60.1–62.9	64.3–67.1	66.1–68.9
Females	72.3–75.7	71.4–74.0	68.5–71.5	68.1–70.7	70.5–72.9	71.9–74.3
Persons	na	na	na	na	na	na
Non-Indigenous						
Life expectancy at birth						
Males	78.8	78.8	79.2	75.5	78.9	78.9
Females	82.6	82.7	82.9	81.0	82.7	82.6
Persons (c)	80.7	80.7	81.0	78.1	80.7	80.7
Difference between Indigenous and non-Indigenous life expectancies at birth (g)						
Males	10.5	11.8	14.7	14.0	13.2	11.4
Females	8.6	10.0	12.9	11.6	11.0	9.6
Persons (c)	9.6	10.9	13.8	12.8	12.1	10.5

(a) Indigenous estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths in these jurisdictions.

(b) Care should be taken in comparing life expectancy data by Indigenous status over time as Indigenous status is determined by self-identification and can vary from one Census to another.

Table EA.35 **Estimated life expectancies at birth, by Indigenous status and sex (years) (a), (b), (c)**

	NSW	*Qld*	*WA*	*NT*	*Australia — for comparison* (d), (e)	*Australia — Headline estimates* (d), (f)

(c) Life tables are constructed separately for males and females. Life expectancy estimates for Persons are a weighted combination of male and female life expectancies.

(d) Australian totals include all states and territories.

(e) These estimates, calculated without an age-adjustment, are not the headline estimates for Australia but are provided to enable effective comparison with the state and territory estimates.

(f) Headline estimates for Australia for 2010–2012 are calculated using an improved methodology (taking into account age-specific identification rates) that could not be applied at state/territory level. Therefore, these data should not be compared with data for any State or Territory. The statistical impact of the improved methodology as well as the improved collection of Indigenous status in the 2011 Post Enumeration Survey were also applied to provide 'Headline estimates' for Australia for 2005--2007 data, to enable comparison over time.

(g) Differences are based on unrounded estimates.

na Not available.

Source: ABS 2013, *Life Tables for Aboriginal and Torres Strait Islander Australians, 2010–2012* , Cat. no. 3302.0.55.003; ABS unpublished, Estimated Resident Population, Cat. no. 3101.0.

Table EA.36 **Median age at death (years) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
All Australians									
Males									
2003	76.3	76.8	75.6	75.6	77.5	75.8	74.3	57.1	76.3
2004	76.9	77.3	75.9	75.6	77.4	76.6	74.9	55.0	76.6
2005	77.0	77.4	76.0	76.0	77.7	76.3	76.0	56.8	76.8
2006	77.7	77.9	76.4	76.4	78.2	76.9	75.9	57.1	77.3
2007	77.9	78.2	76.7	76.2	78.6	76.6	76.7	59.2	77.5
2008	78.3	78.5	77.0	76.4	78.9	78.2	78.3	61.4	77.9
2009	78.2	78.5	76.7	76.5	79.1	77.3	76.7	59.3	77.8
2010	78.5	79.1	77.0	77.0	79.5	78.0	77.4	61.3	78.2
2011 (d)	78.9	79.4	77.0	76.8	79.4	78.1	77.9	60.2	78.4
2012 (e)	79.2	79.9	77.4	77.2	80.2	78.0	78.4	59.8	78.9
Females									
2003	82.6	82.7	81.9	82.2	83.0	82.1	81.4	62.8	82.4
2004	82.7	82.9	82.1	82.0	83.2	82.6	81.0	61.4	82.6
2005	83.1	83.2	82.4	82.8	83.7	82.7	82.4	57.1	83.0
2006	83.4	83.6	82.8	82.6	84.0	83.1	82.6	65.0	83.3
2007	83.6	83.9	83.1	83.1	84.2	83.6	82.5	60.3	83.5
2008	84.0	84.2	83.4	83.7	84.5	83.4	83.0	61.8	83.9
2009	84.0	84.5	83.2	83.2	84.4	83.4	83.1	64.5	83.9
2010	84.2	84.7	83.6	83.7	84.8	83.5	84.4	64.1	84.2
2011 (d)	84.6	84.9	83.9	84.1	85.3	83.8	84.3	62.1	84.5
2012 (e)	84.8	85.3	84.0	84.0	85.6	83.8	84.8	63.6	84.7

(a) Median age at death does not adjust for the age structure of the populations involved.

(b) Based on year of registration of death.

(c) Figures for Australia include ‘Other Territories’.

(d) Data for 2011 have been revised and may differ from previous reports.

(e) Data for 2012 are preliminary due to the delay between the registration of a death and the Australian Bureau of Statistics being notified of the registration.

Source: ABS 2013, *Deaths Australia, 2012* , Cat. no. 3302.0, Canberra.

Table EA.37 **Median age at death, by Indigenous status (years) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT*	*Aust* (e), (f)
Indigenous (c), (d)									
Males									
2003	56.8	np	51.2	50.2	48.8	np	np	46.3	51.1
2004	55.8	np	53.7	50.0	49.5	np	np	43.8	51.2
2005	54.3	np	51.1	52.8	42.4	np	np	45.8	50.4
2006	59.3	np	55.6	47.9	50.4	np	np	45.4	52.4
2007	58.1	np	54.7	51.3	50.5	np	np	45.9	52.7
2008	59.9	np	53.2	48.7	49.0	np	np	52.1	53.1
2009	57.2	np	53.2	50.2	48.0	np	np	48.3	52.3
2010	58.3	np	55.0	52.0	54.0	np	np	50.8	54.3
2011 (g)	58.5	np	57.3	52.2	50.3	np	np	51.8	55.4
2012 (h)	60.6	np	56.1	54.8	53.0	np	np	49.9	55.0
Females									
2003	58.9	np	62.1	55.0	50.0	np	np	52.8	57.3
2004	62.7	np	57.9	63.6	53.5	np	np	54.0	60.1
2005	65.8	np	59.5	57.8	47.5	np	np	50.4	57.9
2006	64.8	np	57.0	57.0	59.3	np	np	55.3	59.0
2007	63.0	np	59.5	58.1	58.3	np	np	55.7	59.2
2008	63.8	np	62.3	57.7	53.5	np	np	56.0	59.3
2009	65.9	np	62.6	56.8	53.0	np	np	55.4	61.0
2010	67.1	np	59.5	56.3	59.3	np	np	55.4	60.7
2011 (g)	66.2	np	59.0	54.2	50.3	np	np	55.0	58.5
2012 (h)	63.9	np	63.9	61.1	61.3	np	np	52.8	61.3
Non-Indigenous (c), (d)									
Males									
2003	76.5	np	75.9	76.1	77.7	np	np	65.9	76.4
2004	77.0	np	76.2	76.3	77.6	np	np	63.0	76.8
2005	77.2	np	76.4	76.6	77.9	np	np	63.7	76.9
2006	77.8	np	76.7	76.9	78.3	np	np	64.7	77.4
2007	78.1	np	77.1	76.9	78.7	np	np	64.6	77.7
2008	78.5	np	77.3	77.0	79.2	np	np	66.3	78.0
2009	78.4	np	77.2	77.3	79.3	np	np	66.6	78.0
2010	78.6	np	77.5	77.8	79.6	np	np	64.9	78.3
2011 (g)	79.1	np	77.5	77.4	79.7	np	np	66.6	78.5
2012 (h)	79.3	np	77.6	77.9	80.2	np	np	67.1	78.7
Females									
2003	82.7	np	82.2	82.4	83.2	np	np	74.5	82.6
2004	82.8	np	82.5	82.3	83.3	np	np	71.3	82.7
2005	83.1	np	82.6	83.2	83.7	np	np	70.5	83.1
2006	83.5	np	83.1	83.1	84.1	np	np	75.0	83.4
2007	83.7	np	83.3	83.4	84.3	np	np	69.3	83.6
2008	84.2	np	83.7	84.1	84.6	np	np	75.7	84.1
2009	84.1	np	83.4	83.6	84.6	np	np	71.8	83.9

Table EA.37 **Median age at death, by Indigenous status (years) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT*	*Aust* (e), (f)
2010	84.3	np	83.9	84.2	84.9	np	np	75.2	84.3
2011 (g)	84.7	np	84.2	84.4	85.3	np	np	73.5	84.6
2012 (h)	84.9	np	84.2	84.4	85.6	np	np	74.0	84.7

(a) Median age at death does not adjust for the age structure of the populations involved.

(b) Based on year of registration of death.

(c) Excludes deaths for whom the Indigenous status was not specified. As a result, Indigenous and non-Indigenous deaths may be underestimated.

(d) Care should be exercised when comparing median age at death of Indigenous Australians and non-Indigenous Australians. For example, higher coverage of Indigenous infant deaths compared with older age groups may result in the median age at death being underestimated.

(e) Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths.

(f) Figures for Australia include 'Other Territories'.

(g) Data for 2011 have been revised and may differ from previous reports.

(h) Data for 2012 are preliminary due to the delay between the registration of a death and the Australian Bureau of Statistics being notified of the registration.

np Not published.

Source : ABS 2013, *Deaths Australia, 2012* , Cat. no. 3302.0, Canberra.

Table EA.38 Age standardised mortality rate (all causes), by State and Territory (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld* (d)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d) (e)
2012										
Rate	per 100 000 persons	545.9	526.1	581.4	539.9	574.0	660.4	498.0	768.8	553.6
	variability band ±	4.9	5.5	6.8	9.2	10.0	19.7	23.9	56.6	2.9
2011										
Rate	per 100 000 persons	576.4	555.8	581.0	535.6	566.6	642.4	513.1	795.0	570.0
	variability band ±	5.1	5.8	6.9	9.4	10.1	19.6	24.7	62.1	2.9
2010										
Rate	per 100 000 persons	562.6	557.8	589.8	556.0	593.9	664.6	528.8	818.4	572.5
	variability band ±	5.1	5.8	7.1	9.7	10.4	20.2	25.6	63.2	3.0
2009										
Rate	per 100 000 persons	569.7	577.4	595.9	568.9	587.9	671.0	540.2	824.6	582.0
	variability band ±	5.2	6.0	7.2	10.0	10.5	20.5	26.4	64.3	3.1
2008										
Rate	per 100 000 persons	607.9	592.6	638.0	596.8	606.8	688.5	578.0	950.3	612.4
	variability band ±	5.4	6.2	7.6	10.4	10.8	21.0	27.8	70.5	3.2
2007										
Rate	per 100 000 persons	600.4	583.4	621.2	594.7	611.5	693.2	560.1	902.2	604.4
	variability band ±	5.5	6.2	7.6	10.6	10.9	21.3	27.8	68.5	3.2

(a) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 standard population. SDRs in this table have been calculated using the direct method, age standardised by 5 year age groups to 95 years or over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.

(b) Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census. Rates are not comparable with rates for Indigenous and non-Indigenous Australians which use ERPs based on the 2006 Census.

(c) Data based on year of registration. See data quality information (DQI) for more detail.

(d) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for more information.

(e) Includes Other Territories.

Source : ABS unpublished, Deaths, Australia, Cat. No. 3302.0; ABS 2013, *Australian Demographic Statistics* , Cat. no. 3101.0.

Table EA.39 Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, five year aggregate, 2008–2012 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)

	Unit	*NSW*	*Qld* (i)	*WA*	*SA*	*NT*	*Total* (j)
Indigenous							
Rate per 100 000 persons	rate	976.0	1 086.0	1 390.6	1 049.8	1 480.1	1 143.4
Variability bands (k)	±	90.9	106.3	161.9	205.5	170.0	57.5
Non-Indigenous							
Rate per 100 000 persons	rate	591.4	590.2	561.1	610.7	592.0	589.7
Variability bands (k)	±	5.3	7.2	10.0	10.8	57.6	3.7
Rate ratio (l)	no.	1.7	1.8	2.5	1.7	2.5	1.9

(a) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age groups to 75 years or over.

(b) Although most deaths of Indigenous people are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these data are likely to underestimate the Indigenous all causes mortality rate.

(c) Data are reported individually by jurisdiction of usual residence for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(d) Data are based on year of registration. Note that the terms 'registration year' in the Deaths collection and 'reference year' in the Causes of Death collection have the same meaning.

(e) Data are presented in five-year groupings due to volatility of the small numbers involved.

(f) Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. In the present table, non-Indigenous population estimates have been derived by subtracting the 2006-census-based Indigenous population projections from the 2006-census based total persons estimated resident population (ERP). 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.

(g) A derived Estimated Resident Population (ERP) based on the 2006 Census is used in the calculation of total population rates. Non-Indigenous ERP was derived by subtracting Aboriginal and Torres Strait Islander projections based on the 2006 Census (3238.0) from the total population ERP. Population figures from Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (cat. no. 3238.0) (based on the 2006 Census) are used to calculate Aboriginal and Torres Strait Islander rates.

Table EA.39 **Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, five year aggregate, 2008–2012 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

	Unit	*NSW*	*Qld* (i)	*WA*	*SA*	*NT*	*Total* (j)

(h) Some totals and figures may not compute due to the effects of using different denominators and of rounding.

(i) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality statements for more information.

(j) Total includes data for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(k) Variability bands can be be used for comparisons within jurisdictions (for cause of death or over time), but not between jursidictions or between jurisdictions and totals. See data quality statement for details.

(l) Rate ratio is the age standardised Indigenous rate divided by the non-Indigenous rate.

Source : ABS unpublished, *Deaths, Australia, 2012* , Cat. No. 3302.0.

Table EA.40 **Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, single year, 2006 to 2012 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Qld* (h)	*WA*	*SA*	*NT*	*Total* (h), (i)
2006							
Indigenous rate	rate	920.0	1 087.1	1 528.9	964.0	1 605.4	1 160.9
Variability bands (j)	±	93.9	109.7	175.4	197.6	189.5	60.6
Non-Indigenous rate	rate	606.6	593.8	570.9	607.9	634.1	599.2
Variability bands (j)	±	5.6	7.6	10.6	11.1	66.1	3.9
Rate ratio (k)	no.	1.5	1.8	2.7	1.6	2.5	1.9
2007							
Indigenous rate	rate	999.5	1 098.0	1 502.0	1 067.3	1 575.3	1 187.3
Variability bands (j)	±	96.3	108.5	169.6	212.8	181.9	60.2
Non-Indigenous rate	rate	604.4	604.9	586.7	618.6	679.0	604.5
Variability bands (j)	±	5.5	7.6	10.6	11.1	66.5	3.9
Rate ratio (k)	no.	1.7	1.8	2.6	1.7	2.3	2.0
2008							
Indigenous rate	rate	952.4	1 035.3	1 491.2	1 031.2	1 639.5	1 155.8
Variability bands (j)	±	94.8	106.5	166.1	202.2	187.0	59.4
Non-Indigenous rate	rate	615.5	626.7	590.5	620.7	718.2	616.5
Variability bands (j)	±	5.5	7.6	10.5	11.0	67.8	3.8
Rate ratio (k)	no.	1.5	1.7	2.5	1.7	2.3	1.9
2009							
Indigenous rate	rate	949.3	1 128.5	1 329.2	1 044.3	1 425.6	1 129.0
Variability bands (j)	±	91.3	110.1	159.1	194.7	170.3	57.8
Non-Indigenous rate	rate	583.1	579.4	567.0	605.8	602.7	583.1
Variability bands (j)	±	5.3	7.2	10.2	10.8	59.6	3.7
Rate ratio (k)	no.	1.6	1.9	2.3	1.7	2.4	1.9

Table EA.40 **Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, single year, 2006 to 2012 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Qld* (h)	*WA*	*SA*	*NT*	*Total* (h), (i)
2010							
Indigenous rate	rate	956.4	1 095.6	1 324.9	1 181.3	1 432.6	1 133.2
Variability bands (j)	±	89.1	105.4	156.2	231.4	166.8	56.9
Non-Indigenous rate	rate	583.0	580.5	557.3	619.7	587.1	583.7
Variability bands (j)	±	5.3	7.1	9.9	10.8	57.2	3.7
Rate ratio (k)	no.	1.6	1.9	2.4	1.9	2.4	1.9
2011 (n)							
Indigenous rate	rate	1 082.7	1 015.9	1 322.1	909.6	1 330.3	1 122.4
Variability bands (j)	+	93.0	100.5	153.9	181.9	156.2	55.6
Non-Indigenous rate	rate	601.3	582.0	537.6	596.7	556.9	587.4
Variability bands (j)	+	5.3	7.0	9.6	10.5	53.9	3.6
Rate ratio (k)	no.	1.8	1.7	2.5	1.5	2.4	1.9
2012							
Indigenous rate	rate	900.6	1 104.4	1 411.8	1 042.9	1 524.3	1 128.3
Variability bands (j)	±	82.2	102.5	158.8	199.7	162.2	54.3
Non-Indigenous rate	rate	571.4	577.1	545.3	608.9	508.3	573.9
Variability bands (j)	±	5.1	6.9	9.5	10.6	50.1	3.5
Rate ratio (k)	no.	1.6	1.9	2.6	1.7	3.0	2.0

(a) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 standard population. SDRs in this table have been calculated using the direct method, age standardised by 5 year age groups to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.

(b) Although most deaths of Indigenous people are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these data are likely to underestimate the Indigenous all causes mortality rate.

Table EA.40 **Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, single year, 2006 to 2012 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Qld* (h)	*WA*	*SA*	*NT*	*Total* (h), (i)

(c) Data are reported individually by jurisdiction of usual residence for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(d) Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. 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. 2006 Census year non-Indigenous and Indigenous population estimates are sourced from ABS *Experimental Estimates of Aboriginal and Torres Strait Islander Australians* (Cat. no. 3238.0.55.001).

(e) A derived Estimated Resident Population (ERP) based on the 2006 Census is used in the calculation of total population rates. Non-Indigenous ERP was derived by subtracting Aboriginal and Torres Strait Islander projections based on the 2006 Census (3238.0) from the total population ERP. Population figures from Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (cat. no. 3238.0) (based on the 2006 Census) are used to calculate Aboriginal and Torres Strait Islander rates.

(f) Data are based on year of registration. Note that the terms 'registration year' in the Deaths collection and 'reference year' in the Causes of Death collection have the same meaning.

(g) Some totals and figures may not compute due to the effects of rounding.

(h) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality information (DQI) for more information.

(i) Total includes data for NSW, Qld, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(j) Variability bands can be used for comparisons within jurisdictions (for cause of death or over time), but not between jurisdictions or between jurisdictions and totals. See DQI for more information.

(k) Rate ratio is the age standardised Indigenous rate divided by the non-Indigenous rate.

Source : ABS unpublished, *Deaths, Australia* , various years, Cat. No. 3302.0.

Table EA.41 **Infant mortality (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	ACT	*NT*	*Aust*
2003									
Number of deaths	398	309	230	100	65	40	24	32	1 199
Rate per 1000 live births	4.6	5.1	4.8	4.1	3.7	7.0	5.8	8.4	4.8
2004									
Number of deaths	399	282	262	99	54	21	29	38	1 184
Rate per 1000 live births	4.6	4.5	5.2	3.9	3.2	3.6	6.9	10.7	4.7
2005									
Number of deaths	425	321	264	120	91	22	24	35	1 302
Rate per 1000 live births	4.7	5.1	5.1	4.6	5.1	3.5	5.7	9.6	4.9
2006									
Number of deaths	424	283	279	136	59	25	23	33	1 262
Rate per 1000 live births	4.6	4.3	5.3	4.9	3.2	3.9	5.1	8.9	4.7
2007									
Number of deaths	387	270	308	71	88	28	18	33	1 203
Rate per 1000 live births	4.0	3.8	5.0	2.4	4.5	4.2	3.8	8.5	4.1
2008									
Number of deaths	412	264	308	108	59	26	24	24	1 226
Rate per 1000 live births	4.1	3.7	4.9	3.4	2.9	3.8	5.0	6.1	4.1
2009									
Number of deaths	387	278	356	99	73	24	17	27	1 261
Rate per 1000 live births	3.9	3.9	5.4	3.2	3.7	3.6	3.5	7.1	4.2
2010									
Number of deaths	390	230	347	113	76	26	19	28	1 229
Rate per 1000 live births	3.9	3.3	5.4	3.6	3.8	4.1	3.7	7.2	4.1
2011									
Number of deaths	372	251	294	96	52	30	15	30	1 140
Rate per 1000 live births	3.8	3.5	4.6	3.0	2.6	4.5	2.9	7.6	3.8
2012									
Number of deaths	312	219	281	83	65	22	16	33	1 031
Rate per 1000 live births	3.2	2.8	4.4	2.5	3.2	3.6	2.9	8.0	3.3

(a) Includes all deaths within the first year of life.

(b) Data are based on year of registration. Note that the terms 'registration year' in the Deaths collection and 'reference year' in the Causes of Death collection have the same meaning.

(c) Some totals and figures may not compute due to rounding.

(d) Small numbers of registered deaths can lead to volatility in death rates.

(e) NSW data include previously unprocessed NSW Birth Registrations for the period 2005 to 2010.

(f) Includes other territories.

Source : ABS 2013, *Deaths, Australia, 2012* , Cat. no. 3302.0, Canberra.

Table EA.42 **Infant mortality rate by Indigenous status, three year average (per 1000 live births) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas*	ACT	*NT*	*Aust*
Indigenous									
2004–2006	6.6	na	11.1	11.9	6.7	na	na	16.7	na
2005–2007	7.2	na	9.1	10.2	8.9	na	na	15.7	na
2006–2008	6.2	na	7.9	9.5	6.4	na	na	13.6	na
2007–2009	5.3	na	7.6	7.1	6.7	na	na	12.2	na
2008–2010	4.1	na	8.8	7.7	4.6	na	na	11.4	na
2009–2011	3.9	na	8.4	7.0	5.4	na	na	13.0	na
2010–2012	3.8	na	6.9	6.5	6.5	na	na	13.7	na
Non-Indigenous									
2004–2006	4.5	na	4.7	3.9	3.6	na	na	4.7	na
2005–2007	4.2	na	4.8	3.4	4.0	na	na	4.2	na
2006–2008	4.1	na	4.7	3.1	3.4	na	na	3.8	na
2007–2009	3.9	na	4.7	2.8	3.5	na	na	3.9	na
2008–2010	3.9	na	4.7	3.1	3.4	na	na	3.7	na
2009–2011	3.8	na	4.7	2.9	3.3	na	na	3.6	na
2010–2012	3.5	na	4.4	2.6	3.0	na	na	3.7	na

(a) Includes deaths within the first year of life.

(b) Deaths where Indigenous status was not stated are excluded. As a result, infant death rates by Indigenous status may be underestimated.

(c) Data are based on year of registration. Note that the terms 'registration year' in the Deaths collection and 'reference year' in the Causes of Death collection have the same meaning.

(d) Data are presented in three-year groupings to reduce volatility stemming from the small numbers of registered Indigenous infant deaths.

(e) Data are not available for Victoria, Tasmania or the ACT due to small numbers of registered Indigenous infant deaths.

(f) NSW data have been revised to include previously unprocessed NSW Birth Registrations for the period 2005 to 2010.

(g) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registrations of deaths on mortality indicators. See data quality statements for more information.

na Not available.

Source : ABS 2013, *Deaths Australia, 2012* , Cat. no. 3302.0, Canberra.

Table EA.43 **All causes infant and child mortality, by age group (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld* (e)	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e), (f), (g)
Infants (<1 year) (h)										
2007–2009										
Number of deaths	no.	1 186	812	972	278	220	78	59	84	3 690
Rate per 1000 live births		4.3	3.8	5.1	3.0	3.7	3.9	4.1	7.2	4.2
2008–2010										
Number of deaths		1 189	772	1 011	320	208	76	60	79	3 716
Rate per 1000 live births		4.0	3.6	5.1	3.5	3.5	3.8	4.1	6.9	4.1
2009–2011										
Number of deaths		1 149	759	997	308	201	80	51	85	3 630
Rate per 1000 live births		3.8	3.6	5.2	3.3	3.3	4.2	3.3	7.3	4.0
2010–2012										
Number of deaths	no.	1074	700	903	292	193	78	50	91	3381
Rate per 1000 live births		3.6	3.3	4.8	3.0	3.2	3.9	3.3	7.7	3.7
Child (0–4 years) (i)										
2007–2009										
Number of deaths	no.	204	955	1 146	346	271	94	71	104	4 378
Rate per 100 000 population		104.1	95.0	132.1	80.9	96.3	97.7	105.9	191.9	105.9
2008–2010										
Number of deaths	no.	1 386	919	1 150	398	258	94	71	100	4 377
Rate per 100 000 population		101.9	88.7	126.2	88.9	89.4	94.4	102.8	180.5	102.6
2009–2011										
Number of deaths	no.	1 346	901	1 124	383	249	96	58	103	4 260
Rate per 100 000 population		97.7	85.4	120.8	82.9	84.3	95.6	80.6	184.0	97.9
2010–2012										
Number of deaths	no.	1254	834	1046	370	238	91	60	110	4003
Rate per 100 000 population		88.3	79.0	114.6	78.9	81.4	95.3	82.9	198.3	91.5

(a) State or Territory of usual residence.

(b) Data are presented in three-year groupings due to volatility of the small numbers involved.

(c) Data based on reference year. Note that the terms 'registration year' in the Deaths collection and 'reference year' in the Causes of Death collection have the same meaning.

(d) Some totals and figures may not compute due to the effects of using different denominators and of rounding.

(e) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been

(f) Due to potential over-reporting of WA Indigenous deaths for 2007, 2008 and 2009, WA mortality data were not previously supplied in 2011. Corrected WA Indigenous mortality data for these years are now available. See data quality statements for more information.

(g) All states and territories including other territories.

(h) Includes all deaths within the first year of life. Historical data have been revised and differ from previous reports. Rates represent the number of deaths per 1000 live births.

(i) For child deaths (0–4 years), the rates represent the number of deaths per 100 000 ERP (0–4 years) at 30 June of the mid point year of the reference period. Rates are derived using ERPs based on the 2006 Census.

Source : ABS unpublished, *Deaths, Australia* , Cat. no. 3302.0; ABS unpublished *Births, Australia* Cat. no. 3301.0; ABS unpublished, Estimated Resident Population.

Table EA.44 **All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Qld* (h)	*WA* (i)	*SA*	*NT*	*Total* (j)
2008–2012							
Infants (<1 year) (k)							
Number of deaths							
Indigenous	no.	103	182	85	26	97	493
Non-Indigenous	no.	1 745	1 320	396	290	45	3 796
Rate							
Indigenous	per 1000 live births	3.6	6.9	7.3	5.5	12.5	6.2
Non-Indigenous	per 1000 live births	3.7	4.5	2.8	3.1	3.8	3.7
Rate ratio (l)		1.0	1.5	2.6	1.8	3.2	1.7
Child (1–4 years) (m)							
Number of deaths							
Indigenous	no.	27	35	25	5	25	123
Non-Indigenous	no.	274	217	95	74	10	673
Rate							
Indigenous	per 100 000 population	32.8	43.1	71.6	35.8	80.4	50.5
Non-Indigenous	per 100 000 population	15.7	18.7	16.4	19.5	23.1	17.2
Rate ratio (l)		2.1	2.3	4.4	1.8	3.5	2.9
Child (0–4 years) (n)							
Number of deaths							
Indigenous	no.	130	217	110	31	122	627
Non-Indigenous	no.	2 019	1 537	491	364	55	4 475
Rate							
Indigenous	per 100 000 population	124.3	210.8	249.7	175.3	311.0	203.3
Non-Indigenous	per 100 000 population	92.1	106.1	109.5	48.4	101.7	91.4
Rate ratio (l)		1.4	2.0	2.3	3.6	3.1	2.2
2007–2011							
Infants (<1 year) (k)							
Number of deaths							
Indigenous	no.	128	182	89	28	99	526
Non-Indigenous	no.	1 795	1 355	386	311	43	3 890
Rate							
Indigenous	per 1000 live births	6.2	7.0	7.4	6.3	13.0	7.4
Non-Indigenous	per 1000 live births	4.1	4.5	2.8	3.4	3.8	3.9
Rate ratio (l)		1.5	1.6	2.6	1.9	3.4	1.9
Child (1–4 years) (m)							
Number of deaths							
Indigenous	no.	30	36	19	6	21	112
Non-Indigenous	no.	302	213	96	73	10	694
Rate							
Indigenous	per 100 000 population	37.6	45.2	55.4	44.0	68.9	47.1
Non-Indigenous	per 100 000 population	17.6	19.1	17.2	19.8	23.6	18.3
Rate ratio (l)		2.1	2.4	3.2	2.2	2.9	2.6

Table EA.44 **All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Qld* (h)	*WA* (i)	*SA*	*NT*	*Total* (j)
Child (0–4 years) (n)							
Number of deaths							
Indigenous	no.	158	218	108	34	120	638
Non-Indigenous	no.	2 097	1 568	482	384	53	4 584
Rate							
Indigenous	per 100 000 population	155.8	216.4	249.7	197.1	311.9	211.9
Non-Indigenous	per 100 000 population	96.9	110.6	68.5	82.8	98.5	95.4
Rate ratio (l)		1.6	2.0	3.6	2.4	3.2	2.2

(a) Although most deaths of Indigenous people are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these data are likely to underestimate the Indigenous all causes mortality rate.

(b) Data are reported individually by jurisdiction of residence for NSW, Queensland, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(c) Data are presented in five-year groupings due to volatility of the small numbers involved.

(d) A derived Estimated Resident Population (ERP) based on the 2006 Census is used in the calculation of total population rates. Non-Indigenous ERP was derived by subtracting Aboriginal and Torres Strait Islander projections based on the 2006 Census (3238.0) from the total population ERP. Population estimates from *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* (Cat. no. 3238.0) (based on the 2006 Census) are used to calculate Aboriginal and Torres Strait Islander rates.

(e) Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. 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 are based on year of registration. See data quality statements for a more detailed explanation.

(g) Some totals and figures may not compute due to the effects of using different denominators and of rounding.

(h) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and deaths registrationns. Queensland deaths data for 2010 have been adjusted to minimise the the impact of late registration of deaths on mortality indicators. See data quality statements for more information.

(i) Due to potential over-reporting of WA Indigenous deaths for 2007, 2008 and 2009, WA mortality data were not previously supplied in 2011. Corrected WA Indigenous mortality data for these years are now available. See data quality statements for more information.

(j) Total includes data for NSW, Queenland, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(k) For infant deaths (less than one year) rates are per 1000 live births. Includes all deaths within the first year of life. The volatility in infant mortality rates is partially due to the relatively small number of infant deaths registered.

(l) Rate ratio is the Indigenous mortality rate divided by the non-Indigenous mortality rate.

(m) For child deaths (1–4 years), the rates represent the number of deaths per 100 000 Estimated Resident Population (1-4 years) at 30 June of the mid point year of the reference period. Includes deaths of all children aged 0–4 years.

Table EA.44 **All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT (a), (b), (c), (d), (e), (f), (g)**

Unit	*NSW*	*Qld* (h)	*WA* (i)	*SA*	*NT*	*Total* (j)

(n) For child deaths (0–4 years), the rates represent the number of deaths per 100 000 Estimated Resident Population (0–4 years) at 30 June of the mid point year of the reference period. Data include all deaths of children aged 0–4 years.

Source : ABS unpublished *Deaths, Australia* , Cat. no. 3302.0, various years.

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
2011									
Cause of death				*Rate (per 100 000 persons)*					
Certain infectious and parasitic diseases (A00-B99)	11.6	8.5	8.5	6.3	8.9	6.8	8.5	np	9.4
Neoplasms (C00-D48)	177.7	173.3	175.1	166.6	170.6	189.5	146.5	220.3	174.5
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	1.9	1.8	1.8	1.6	2.2	np	np	–	1.8
Endocrine, nutritional and metabolic diseases (E00-E90)	20.9	24.8	23.7	23.4	24.8	34.1	20.0	60.1	23.5
Mental and behavioural disorders (F00-F99)	27.9	27.3	27.3	23.7	30.4	40.6	26.5	51.6	27.9
Diseases of the nervous system (G00-G99)	23.8	27.8	23.3	30.5	28.4	29.5	32.2	30.9	26.0
Diseases of the eye and adnexa (H00-H59)	np	np	np	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	np	np	np	np	np	–	–	–	np
Diseases of the circulatory system (I00-I99)	177.5	161.8	180.3	153.1	171.3	190.4	151.5	201.4	171.6
Diseases of the respiratory system (J00-J99)	49.5	46.3	49.9	42.1	45.9	53.3	42.8	83.5	48.0
Diseases of the digestive system (K00-K93)	20.2	19.9	20.3	19.8	19.5	21.9	19.4	37.0	20.2
Diseases of the skin and subcutaneous tissue (L00-L99)	2.1	1.4	1.4	1.3	1.6	np	np	np	1.6
Diseases of the musculoskeletal system and connective tissue (M00-M99)	4.7	4.4	4.8	3.7	3.3	5.4	np	np	4.4
Diseases of the genitourinary system (N00-N99)	12.9	14.1	12.1	11.2	13.2	13.1	14.5	np	13.0
Pregnancy, childbirth and the puerperium (O00-O99)	np	np	np	–	np	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)	3.0	2.5	3.3	2.0	1.9	np	np	np	2.8
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.5	2.3	2.7	1.9	2.4	np	np	np	2.4
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	5.9	3.3	3.7	4.2	4.3	np	7.7	np	4.6

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
External causes of morbidity and mortality (V01-Y98)		34.1	36.0	42.7	44.2	37.6	45.5	31.5	60.5	38.1
Total		**576.4**	**555.8**	**581.0**	**535.6**	**566.6**	**642.4**	**513.1**	**795.0**	**570.0**
Cause of Death					*variability band* ± (g) (h)					
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.8	1.0	1.3	2.0	3.2	np	0.4
Neoplasms (C00-D48)	±	2.9	3.3	3.8	5.2	5.7	10.7	13.3	31.4	1.6
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.3	0.4	0.5	0.6	np	np	–	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.2	1.4	2.0	2.1	4.5	4.9	17.9	0.6
Mental and behavioural disorders (F00-F99)	±	1.0	1.2	1.4	2.2	2.1	4.5	6.2	18.6	0.6
Diseases of the nervous system (G00-G99)	±	1.0	1.3	1.5	2.2	2.3	4.2	5.8	16.2	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	–	np	–	–	np	–	np
Diseases of the ear and mastoid process (H60-H95)	±	np	–	np	np	np	–	–	–	np
Diseases of the circulatory system (I00-I99)	±	2.9	3.3	4.1	5.5	5.8	11.3	15.6	33.4	1.7
Diseases of the respiratory system (J00-J99)	±	1.5	1.7	2.1	2.7	2.8	5.8	6.4	20.3	0.9
Diseases of the digestive system (K00-K93)	±	1.0	1.2	1.3	1.9	2.0	3.6	5.0	13.1	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	0.5	0.5	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.5	0.5	0.6	0.8	0.8	1.7	np	np	0.3
Diseases of the genitourinary system (N00-N99)	±	0.7	0.9	1.0	1.4	1.5	2.8	4.2	np	0.4
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	–	np	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)	±	0.4	0.4	0.5	0.6	0.7	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.4	0.5	0.6	0.8	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.5	0.5	0.6	0.8	0.9	np	2.9	np	0.3

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.5	1.9	2.7	2.9	5.7	5.9	12.0	0.8
Total	±	**5.1**	**5.8**	**6.9**	**9.4**	**10.1**	**19.6**	**24.7**	**62.1**	**2.9**
2010										
Cause of death					*Rate (per 100 000 persons)*					
Certain infectious and parasitic diseases (A00-B99)		9.9	7.4	6.7	8.8	10.1	7.7	7.5	np	8.6
Neoplasms (C00-D48)		175.6	175.5	185.6	172.1	178.3	194.9	157.6	217.1	177.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		1.6	1.6	1.6	1.8	1.6	np	np	np	1.6
Endocrine, nutritional and metabolic diseases (E00-E90)		19.2	23.8	22.6	24.1	25.0	35.2	20.0	53.7	22.6
Mental and behavioural disorders (F00-F99)		25.8	26.8	24.6	25.9	29.8	37.4	26.9	48.4	26.6
Diseases of the nervous system (G00-G99)		22.5	26.4	22.8	28.1	28.6	24.8	24.0	33.5	24.7
Diseases of the eye and adnexa (H00-H59)		np	–	–	np	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)		–	np	np	–	–	np	–	–	np
Diseases of the circulatory system (I00-I99)		176.5	166.9	187.0	161.8	186.1	213.2	168.7	198.5	176.6
Diseases of the respiratory system (J00-J99)		48.6	45.1	48.1	41.6	49.1	53.9	41.1	76.5	47.2
Diseases of the digestive system (K00-K93)		19.8	21.0	21.1	20.3	18.8	23.1	16.2	41.4	20.5
Diseases of the skin and subcutaneous tissue (L00-L99)		1.9	1.5	1.3	1.0	1.5	np	np	np	1.5
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.3	4.9	5.0	4.1	3.6	7.9	np	np	4.6
Diseases of the genitourinary system (N00-N99)		12.4	14.0	12.2	12.5	14.5	13.3	12.9	26.8	13.1
Pregnancy, childbirth and the puerperium (O00-O99)		np	np	np	np	np	–	–	np	np
Certain conditions originating in the perinatal period (P00-P96)		2.9	2.2	3.3	2.1	2.6	np	np	np	2.8

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.7	2.7	2.9	2.2	2.2	np	np	np	2.7
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		4.4	1.7	3.4	2.9	3.1	np	np	np	3.2
External causes of morbidity and mortality (V01-Y98)		34.3	36.2	41.4	46.5	38.8	40.8	40.3	78.9	38.4
Total		**562.6**	**557.8**	**589.8**	**556.0**	**593.9**	**664.6**	**528.8**	**818.4**	**572.5**
Cause of Death					*variability band* ± (g) (h)					
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.8	1.2	1.4	2.2	3.0	np	0.4
Neoplasms (C00-D48)	±	2.9	3.3	4.0	5.4	5.8	11.0	14.1	31.9	1.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.3	0.4	0.5	0.5	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	0.9	1.2	1.4	2.0	2.1	4.6	5.0	15.5	0.6
Mental and behavioural disorders (F00-F99)	±	1.1	1.2	1.4	2.1	2.2	4.6	5.7	17.7	0.6
Diseases of the nervous system (G00-G99)	±	1.0	1.3	1.4	2.2	2.3	4.0	5.5	13.7	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	–	–	np	–	–	–	–	–
Diseases of the ear and mastoid process (H60-H95)	±	–	np	np	–	–	np	–	–	–
Diseases of the circulatory system (I00-I99)	±	2.8	3.1	4.0	5.2	5.7	11.2	14.5	32.9	1.6
Diseases of the respiratory system (J00-J99)	±	1.5	1.6	2.0	2.7	3.0	5.7	7.2	20.6	0.9
Diseases of the digestive system (K00-K93)	±	1.0	1.1	1.3	1.9	1.9	3.8	4.4	14.2	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	0.4	0.5	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.4	0.5	0.7	0.8	0.8	2.2	np	np	0.3
Diseases of the genitourinary system (N00-N99)	±	0.7	0.9	1.0	1.5	1.6	2.8	4.0	12.1	0.4
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	np	np	–	–	np	–
P96)		0.4	0.4	0.5	0.6	0.8	np	np	np	0.2

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.4	0.5	0.6	0.7	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.5	0.3	0.5	0.7	0.8	np	np	np	0.2
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.5	1.9	2.8	3.0	5.5	6.7	14.1	0.8
Total	±	**5.1**	**5.8**	**7.1**	**9.7**	**10.4**	**20.2**	**25.6**	**63.2**	**3.0**
2009										
Cause of death					*Rate (per 100 000 persons)*					
Certain infectious and parasitic diseases (A00-B99)		8.2	7.2	6.6	8.0	8.0	6.9	6.6	np	7.6
Neoplasms (C00-D48)		173.7	176.3	184.0	177.2	176.3	197.6	155.9	218.9	177.4
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		1.7	1.6	1.4	2.4	2.4	np	np	np	1.8
Endocrine, nutritional and metabolic diseases (E00-E90)		21.4	26.4	25.0	24.6	23.4	33.2	25.7	67.3	24.4
Mental and behavioural disorders (F00-F99)		24.9	26.0	23.6	26.7	25.9	34.8	29.5	49.3	25.6
Diseases of the nervous system (G00-G99)		21.6	25.0	24.3	26.8	29.2	28.1	25.7	39.2	24.3
Diseases of the eye and adnexa (H00-H59)		np	np	–	np	–	–	np	–	np
Diseases of the ear and mastoid process (H60-H95)		np	–	np	np	np	–	–	–	np
Diseases of the circulatory system (I00-I99)		187.1	180.0	192.1	173.3	190.2	212.7	185.9	200.6	186.2
Diseases of the respiratory system (J00-J99)		46.3	44.1	47.6	40.0	44.0	54.4	30.2	73.9	45.3
Diseases of the digestive system (K00-K93)		21.0	21.0	19.6	19.7	21.0	20.9	19.8	41.6	20.7
Diseases of the skin and subcutaneous tissue (L00-L99)		2.0	1.1	1.5	1.8	np	np	np	np	1.5
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.2	4.2	5.0	4.8	3.5	6.9	np	np	4.4
Diseases of the genitourinary system (N00-N99)		13.5	15.5	11.4	12.3	14.6	11.6	12.9	20.2	13.7

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Pregnancy, childbirth and the puerperium (O00-O99)		np	np	np	np	–	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)		3.1	2.8	3.8	2.0	2.4	np	np	np	3.0
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.4	3.1	3.6	2.2	3.2	np	np	np	2.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		3.6	2.3	3.3	3.7	2.7	np	np	np	3.1
External causes of morbidity and mortality (V01-Y98)		34.9	40.7	43.0	43.4	40.0	52.8	36.9	74.9	39.9
Total		**569.7**	**577.4**	**595.9**	**568.9**	**587.9**	**671.0**	**540.2**	**824.6**	**582.0**
Cause of Death					*variability band* ± (g) (h)					
Certain infectious and parasitic diseases (A00-B99)	±	0.6	0.7	0.8	1.2	1.2	2.1	2.9	np	0.4
Neoplasms (C00-D48)	±	2.9	3.4	4.0	5.6	5.8	11.2	14.2	32.4	1.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.3	0.4	0.7	0.7	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.3	1.5	2.1	2.1	4.6	5.8	18.0	0.6
Mental and behavioural disorders (F00-F99)	±	1.0	1.2	1.4	2.2	2.1	4.5	6.2	18.6	0.6
Diseases of the nervous system (G00-G99)	±	1.0	1.3	1.5	2.2	2.3	4.2	5.8	16.2	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	–	np	–	–	np	–	np
Diseases of the ear and mastoid process (H60-H95)	±	np	–	np	np	np	–	–	–	np
Diseases of the circulatory system (I00-I99)	±	2.9	3.3	4.1	5.5	5.8	11.3	15.6	33.4	1.7
Diseases of the respiratory system (J00-J99)	±	1.5	1.7	2.1	2.7	2.8	5.8	6.4	20.3	0.9
Diseases of the digestive system (K00-K93)	±	1.0	1.2	1.3	1.9	2.0	3.6	5.0	13.1	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.4	0.6	np	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.4	0.5	0.7	0.9	0.8	2.0	np	np	0.3
Diseases of the genitourinary system (N00-N99)	±	0.8	1.0	1.0	1.5	1.6	2.6	4.1	10.1	0.5

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	np	np	np	–	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)	±	0.4	0.5	0.6	0.6	0.8	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.5	0.6	0.6	0.9	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.4	0.4	0.5	0.8	0.8	np	np	np	0.2
External causes of morbidity and mortality (V01-Y98)	±	1.3	1.7	2.0	2.7	3.0	6.3	6.5	15.0	0.8
Total	±	**5.2**	**6.0**	**7.2**	**10.0**	**10.5**	**20.5**	**26.4**	**64.3**	**3.1**
2008										
Cause of death					*Rate (per 100 000 persons)*					
Certain infectious and parasitic diseases (A00-B99)		10.6	6.5	7.2	6.7	8.9	6.3	8.5	29.2	8.4
Neoplasms (C00-D48)		179.5	184.2	192.7	176.8	186.2	205.0	168.6	235.0	184.2
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		np	2.3	1.8	2.9	2.8	np	np	np	2.1
Endocrine, nutritional and metabolic diseases (E00-E90)		21.6	26.2	26.9	26.7	24.6	32.3	22.4	86.6	25.1
Mental and behavioural disorders (F00-F99)		25.9	27.2	22.7	25.6	26.6	33.1	28.5	44.7	26.0
Diseases of the nervous system (G00-G99)		22.6	25.7	25.1	30.4	28.2	26.9	34.9	24.5	25.3
Diseases of the eye and adnexa (H00-H59)		np	np	np	np	np	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)		–	–	np	–	np	–	–	–	np
Diseases of the circulatory system (I00-I99)		209.3	188.3	218.1	187.2	194.2	222.5	186.3	222.5	202.5
Diseases of the respiratory system (J00-J99)		48.8	45.8	49.0	43.8	46.1	57.5	35.5	93.1	47.7
Diseases of the digestive system (K00-K93)		20.9	20.9	21.1	21.6	20.3	24.7	19.6	43.1	21.1
Diseases of the skin and subcutaneous tissue (L00-L99)		2.2	1.4	1.3	np	1.3	np	np	np	1.6

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.9	4.4	4.7	5.2	4.3	8.0	9.8	np	4.9
Diseases of the genitourinary system (N00-N99)		14.1	12.9	13.9	12.1	15.4	12.4	14.4	39.4	13.8
Pregnancy, childbirth and the puerperium (O00-O99)		–	np	np	–	–	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)		3.1	2.6	3.2	1.8	2.1	np	np	np	2.8
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.8	2.8	3.8	2.2	2.6	np	np	np	2.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		4.0	3.1	3.4	5.0	2.9	np	np	np	3.7
External causes of morbidity and mortality (V01-Y98)		35.7	38.2	42.9	47.0	40.1	49.7	36.4	101.6	40.1
Total		**607.9**	**592.6**	**638.0**	**596.8**	**606.8**	**688.5**	**578.0**	**950.3**	**612.4**
Cause of Death					*variability band* ± (g) (h)					
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.8	1.1	1.3	2.0	3.4	12.1	0.4
Neoplasms (C00-D48)	±	3.0	3.5	4.2	5.7	6.1	11.5	15.0	34.9	1.8
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	np	0.4	0.4	0.7	0.7	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.3	1.6	2.2	2.1	4.5	5.5	22.0	0.6
Mental and behavioural disorders (F00-F99)	±	1.1	1.3	1.4	2.2	2.1	4.5	6.2	17.3	0.6
Diseases of the nervous system (G00-G99)	±	1.0	1.3	1.5	2.4	2.3	4.1	6.9	11.2	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	np	np	np	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	±	–	–	np	–	np	–	–	–	np
Diseases of the circulatory system (I00-I99)	±	3.1	3.4	4.4	5.8	5.9	11.7	15.9	35.8	1.8
Diseases of the respiratory system (J00-J99)	±	1.5	1.7	2.1	2.8	2.9	6.0	7.0	22.8	0.9
Diseases of the digestive system (K00-K93)	±	1.0	1.2	1.4	2.0	2.0	4.0	5.1	15.1	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	0.3	np	0.5	np	np	np	0.2

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.5	0.5	0.6	1.0	0.9	2.2	3.6	np	0.3
Diseases of the genitourinary system (N00-N99)	±	0.8	0.9	1.1	1.5	1.6	2.8	4.4	14.9	0.5
Pregnancy, childbirth and the puerperium (O00-O99)	±	–	np	np	–	–	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)	±	0.4	0.4	0.5	0.6	0.8	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.5	0.6	0.6	0.8	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.4	0.5	0.6	1.0	0.8	np	np	np	0.3
External causes of morbidity and mortality (V01-Y98)	±	1.4	1.6	2.0	2.9	3.0	6.2	6.6	18.2	0.8
Total	±	**5.4**	**6.2**	**7.6**	**10.4**	**10.8**	**21.0**	**27.8**	**70.5**	**3.2**
2007										
Cause of death					*Rate (per 100 000 persons)*					
Certain infectious and parasitic diseases (A00-B99)		10.2	6.9	7.7	6.2	7.9	3.7	np	25.1	8.2
Neoplasms (C00-D48)		179.8	180.9	173.2	181.3	181.8	202.5	172.5	229.0	179.9
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)		2.2	2.0	2.3	1.8	2.1	np	np	np	2.1
Endocrine, nutritional and metabolic diseases (E00-E90)		20.3	25.9	21.8	26.1	24.6	36.4	24.5	63.8	23.6
Mental and behavioural disorders (F00-F99)		25.4	24.8	19.3	21.2	25.5	27.3	31.1	41.3	24.0
Diseases of the nervous system (G00-G99)		22.0	24.9	22.2	29.8	25.9	25.6	29.8	17.0	24.0
Diseases of the eye and adnexa (H00-H59)		np	np	–	–	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)		–	np	–	–	–	np	–	np	np
Diseases of the circulatory system (I00-I99)		205.4	188.7	213.0	188.0	207.5	230.4	177.7	255.4	202.0
Diseases of the respiratory system (J00-J99)		49.6	47.4	60.1	46.2	45.9	58.8	38.0	69.6	50.6

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Diseases of the digestive system (K00-K93)		20.1	20.1	22.5	23.0	20.6	22.3	18.0	39.2	21.1
Diseases of the skin and subcutaneous tissue (L00-L99)		1.8	1.2	np	np	1.9	np	np	np	1.6
Diseases of the musculoskeletal system and connective tissue (M00-M99)		4.4	5.1	3.8	5.5	4.9	7.8	np	np	4.8
Diseases of the genitourinary system (N00-N99)		13.9	13.9	14.9	13.7	14.6	17.2	9.5	34.6	14.3
Pregnancy, childbirth and the puerperium (O00-O99)		np	–	np	np	np	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)		3.0	2.8	3.4	1.3	np	np	np	np	2.9
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)		2.6	2.9	3.5	2.2	2.8	np	np	np	2.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)		4.6	3.2	8.7	2.4	2.8	np	np	np	4.5
External causes of morbidity and mortality (V01-Y98)		34.9	32.5	43.2	45.0	39.8	48.2	36.9	92.9	38.1
Total		**600.4**	**583.4**	**621.2**	**594.7**	**611.5**	**693.2**	**560.1**	**902.2**	**604.4**
Cause of Death					*variability band* ± (g) (h)					
Certain infectious and parasitic diseases (A00-B99)	±	0.7	0.7	0.8	1.1	1.2	1.5	np	11.6	0.4
Neoplasms (C00-D48)	±	3.0	3.5	4.0	5.8	6.1	11.5	15.3	34.2	1.8
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	±	0.3	0.4	0.5	0.6	0.6	np	np	np	0.2
Endocrine, nutritional and metabolic diseases (E00-E90)	±	1.0	1.3	1.4	2.2	2.2	4.9	5.9	17.9	0.6
Mental and behavioural disorders (F00-F99)	±	1.1	1.3	1.3	2.0	2.1	4.1	6.6	17.6	0.6
Diseases of the nervous system (G00-G99)	±	1.0	1.3	1.4	2.4	2.2	4.1	6.5	8.8	0.6
Diseases of the eye and adnexa (H00-H59)	±	np	np	–	–	–	–	–	–	np
Diseases of the ear and mastoid process (H60-H95)	±	–	np	–	–	–	np	–	np	np
Diseases of the circulatory system (I00-I99)	±	3.2	3.5	4.4	5.9	6.2	12.1	15.8	38.4	1.8

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

		NSW	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Diseases of the respiratory system (J00-J99)	±	1.6	1.8	2.4	3.0	3.0	6.2	7.4	19.7	0.9
Diseases of the digestive system (K00-K93)	±	1.0	1.2	1.4	2.1	2.0	3.8	4.9	13.3	0.6
Diseases of the skin and subcutaneous tissue (L00-L99)	±	0.3	0.3	np	np	0.6	np	np	np	0.2
Diseases of the musculoskeletal system and connective tissue (M00-M99)	±	0.5	0.6	0.6	1.0	1.0	2.2	np	np	0.3
Diseases of the genitourinary system (N00-N99)	±	0.8	0.9	1.2	1.6	1.6	3.3	3.7	14.3	0.5
Pregnancy, childbirth and the puerperium (O00-O99)	±	np	–	np	np	np	–	–	–	np
Certain conditions originating in the perinatal period (P00-P96)	±	0.4	0.5	0.6	0.5	np	np	np	np	0.2
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	±	0.4	0.5	0.6	0.6	0.9	np	np	np	0.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	±	0.5	0.5	0.9	0.7	0.8	np	np	np	0.3
External causes of morbidity and mortality (V01-Y98)	±	1.4	1.5	2.0	2.9	3.0	6.1	6.8	16.3	0.8
Total	±	**5.5**	**6.2**	**7.6**	**10.6**	**10.9**	**21.3**	**27.8**	**68.5**	**3.2**

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised) and 2011 (preliminary). See Explanatory Notes 29-33 and Causes of Death Revisions 2009 and 2010 (Technical Note) in *Causes of Death, Australia, 2011* (Cat. no. 3303.0).

(b) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100,000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 95 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.

(c) Data based on reference year. See data quality statements for a more detailed explanation.

(d) Some totals and figures may not compute due to the effects of rounding.

(e) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality statements for more information.

(f) All states and territories including other territories.

Table EA.45 **Age standardised mortality rates by cause of death (with variability bands), by State and Territory (a), (b), (c), (d), (e)**

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

– Nil or rounded to zero.

np not available for publication but included in totals where applicable, unless otherwise indicated.

Source : ABS unpublished, *Causes of Death, Australia, 2011* , Cat. no. 3303.0.

Table EA.46 Age standardised mortality rates by major cause of death, by Indigenous status, 2007–2011 (a), (b), (c), (d), (e), (f), (g), (h), (i)

	NSW	*Qld* (j)	*WA* (k)	*SA*	*NT*	*Total* (j), (k), (l)
Cause of death — Rate (per 100 000 population)						
Indigenous Australians						
Circulatory diseases (I00-I99)	330.1	321.7	413.5	329.3	351.2	343.6
Neoplasms (cancer) (C00-D48)	238.3	253.7	262.4	206.0	309.1	253.7
External causes of morbidity and mortality (V01-Y98)	61.4	68.5	131.2	103.3	119.8	85.5
Endocrine, metabolic and nutritional disorders (E00-E90)	69.2	126.5	164.3	68.1	198.9	117.2
Respiratory diseases (J00-J99)	109.1	99.3	114.0	111.1	154.0	113.0
Digestive diseases (K00-K93)	40.7	54.0	76.6	58.5	84.4	57.0
Kidney Diseases (N00-N29)	23.3	31.0	50.0	np	68.1	36.2
Conditions originating in the perinatal period (P00-P96)	4.9	5.9	4.9	np	9.4	5.9
Infectious and parasitic diseases (A00-B99)	18.8	23.2	24.7	np	44.6	24.5
Nervous system diseases (G00-G99)	22.0	20.9	46.0	35.0	28.8	27.1
Other causes (m)	76.4	70.9	115.6	79.8	126.4	87.5
All causes	**994.2**	**1 075.5**	**1 403.3**	**1 051.6**	**1 494.6**	**1 151.3**
Non-Indigenous persons						
Circulatory diseases (I00-I99)	200.0	199.0	175.2	201.0	158.4	196.6
Neoplasms (cancer) (C00-D48)	177.8	177.0	174.5	179.8	194.6	177.4
External causes of morbidity and mortality (V01-Y98)	34.2	40.0	40.9	37.5	62.1	37.3
Endocrine, metabolic and nutritional disorders (E00-E90)	20.9	22.6	23.8	25.2	31.0	22.3
Respiratory diseases (J00-J99)	50.0	50.4	43.1	48.2	55.5	49.0
Digestive diseases (K00-K93)	20.8	20.2	20.3	20.3	26.7	20.5
Kidney Diseases (N00-N29)	11.6	10.3	10.1	13.5	10.5	11.4
Conditions originating in the perinatal period (P00-P96)	3.0	3.0	1.6	2.1	2.8	2.7
Infectious and parasitic diseases (A00-B99)	10.4	7.0	7.0	9.1	13.0	8.9
Nervous system diseases (G00-G99)	23.3	23.6	29.8	29.3	25.0	24.9
Other causes (m)	46.4	42.1	41.8	46.5	50.5	44.8
All causes	**598.5**	**595.3**	**568.2**	**612.5**	**630.0**	**595.8**
Cause of death — Rate difference (Indigenous less non-Indigenous)						
Circulatory diseases (I00-I99)	130.0	122.7	238.3	128.3	192.9	147.0
Neoplasms (cancer) (C00-D48)	60.5	76.6	87.9	26.2	114.4	76.3
External causes of morbidity and mortality (V01-Y98)	27.2	28.4	90.3	65.7	57.7	48.1
Endocrine, metabolic and nutritional disorders (E00-E90)	48.2	103.9	140.5	42.9	167.9	94.9
Respiratory diseases (J00-J99)	59.0	48.9	71.0	62.9	98.5	64.0
Digestive diseases (K00-K93)	19.9	33.8	56.3	38.3	57.6	36.5

Table EA.46 Age standardised mortality rates by major cause of death, by Indigenous status, 2007–2011 (a), (b), (c), (d), (e), (f), (g), (h), (i)

	NSW	*Qld* (j)	*WA* (k)	*SA*	*NT*	*Total* (j), (k), (l)
Kidney Diseases (N00-N29)	11.7	20.6	39.9	np	57.6	24.8
Conditions originating in the perinatal period (P00-P96)	2.0	2.9	3.3	np	6.6	3.2
Infectious and parasitic diseases (A00-B99)	8.4	16.2	17.7	np	31.6	15.6
Nervous system diseases (G00-G99)	- 1.3	- 2.7	16.2	5.7	3.8	2.1
Other causes (m)	30.0	28.8	73.8	33.2	75.9	42.7
All causes	**395.7**	**480.2**	**835.1**	**439.1**	**864.6**	**555.5**
Cause of death — Rate ratio (Indigenous divided by non-Indigenous)						
Circulatory diseases (I00-I99)	1.6	1.6	2.4	1.6	2.2	1.7
Neoplasms (cancer) (C00-D48)	1.3	1.4	1.5	1.1	1.6	1.4
External causes of morbidity and mortality (V01-Y98)	1.8	1.7	3.2	2.8	1.9	2.3
Endocrine, metabolic and nutritional disorders (E00-E90)	3.3	5.6	6.9	2.7	6.4	5.3
Respiratory diseases (J00-J99)	2.2	2.0	2.6	2.3	2.8	2.3
Digestive diseases (K00-K93)	2.0	2.7	3.8	2.9	3.2	2.8
Kidney Diseases (N00-N29)	2.0	3.0	4.9	np	6.5	3.2
Conditions originating in the perinatal period (P00-P96)	1.7	2.0	3.1	np	3.3	2.2
Infectious and parasitic diseases (A00-B99)	1.8	3.3	3.5	np	3.4	2.8
Nervous system diseases (G00-G99)	0.9	0.9	1.5	1.2	1.2	1.1
Other causes (m)	1.6	1.7	2.8	1.7	2.5	2.0
All causes	**1.7**	**1.8**	**2.5**	**1.7**	**2.4**	**1.9**

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised) and 2011 (preliminary). See Explanatory Notes 29-33 and Causes of Death Revisions 2009 and 2010 (Technical Note) in *Causes of Death, Australia, 2011* (Cat. no. 3303.0).

(b) Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method.

(c) Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. 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.

(d) Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis.

(e) Deaths where the Indigenous status of the deceased was not stated are excluded from analysis.

(f) Data are presented in five-year groupings due to the volatility of small numbers each year.

(g) Data based on reference year. See data quality information (DQI) for a more detailed explanation.

Table EA.46 **Age standardised mortality rates by major cause of death, by Indigenous status, 2007–2011 (a), (b), (c), (d), (e), (f), (g), (h), (i)**

	NSW	*Qld* (j)	*WA* (k)	*SA*	*NT*	*Total* (j), (k), (l)

(h) A derived Estimated Resident Population (ERP) based on the 2006 Census is used in the calculation of total population rates. Non-Indigenous ERP was derived by subtracting Aboriginal and Torres Strait Islander projections based on the 2006 Census (3238.0) from the total population ERP. Population estimates from *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* (Cat. no. 3238.0) (based on the 2006 Census) are used to calculate Aboriginal and Torres Strait

(i) Some totals and figures may not compute due to the effects of rounding.

(j) Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See DQI for a more detailed explanation.

(k) For WA, Indigenous deaths data for 2007, 2008 and 2009 have been corrected. The data differ from previous reports in which they were over-reported. Please see DQI for more information.

(l) Total includes data for NSW, Queensland, WA, SA and the NT only. These 5 states and territories have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support mortality analysis.

(m) Other causes consist of all conditions excluding the selected causes displayed in the table.

np Not published.

Source : ABS unpublished, *Causes of Death, Australia, 2010* , Cat. no. 3303.0.

Table EA.47 **Employed medical practitioners (a), (b), (c), (d)**

	NSW (e)	*Vic* (f)	*Qld* (g), (h)	WA(g), (i)	*SA*	*Tas* (j)	*ACT* (k)	*NT* (l)	*Aust*
Practitioner rate (per 100 000 people)									
2003	287.6	300.2	240.8	241.1	321.8	280.1	369.7	442.9	282.5
2004	315.2	311.4	221.3	242.8	321.0	288.3	391.8	241.0	289.2
2005	321.6	313.6	234.1	242.0	318.1	295.7	412.8	348.4	295.4
2006	310.8	321.6	238.9	306.7	325.9	275.5	401.1	411.2	301.6
2007	304.5	325.9	290.8	365.1	338.7	312.2	422.8	418.1	318.9
2008	307.5	324.8	308.7	315.0	345.1	301.3	450.2	377.3	318.4
2009	308.6	332.6	334.6	336.7	353.9	366.4	474.0	443.0	331.4
2010 (d), (m), (n)	337.5	340.4	na	na	376.4	350.5	423.5	352.2	345.4
2011	352.4	350.8	349.3	325.9	386.3	354.7	423.4	420.2	353.1
2012 (o)	350.7	348.9	348.6	325.3	380.5	347.1	418.8	429.2	351.1
FTE practitioner rate (per 100 000 people) based on 40-hour week									
2003	324.2	334.8	264.9	260.4	350.8	290.6	407.6	503.5	313.6
2004	352.3	343.3	242.9	258.0	347.5	301.2	426.0	263.5	318.1
2011	359.4	342.6	256.4	250.5	340.3	301.5	441.6	379.9	322.8
2006	337.2	355.4	259.8	320.5	347.9	283.1	413.1	452.3	326.5
2007	331.1	353.6	314.1	383.3	355.6	316.9	453.4	451.6	343.7
2008	333.6	352.4	321.8	329.1	359.7	305.0	489.6	400.1	339.9
2009	326.3	355.1	355.6	352.7	363.6	362.7	508.6	472.7	349.6
2010 (d), (m), (n)	373.7	371.4	na	na	409.4	372.4	458.0	378.6	378.8
2011	385.5	375.3	378.4	349.0	409.0	374.9	468.1	462.8	381.4
2012 (o)	378.0	366.5	373.2	343.6	401.1	359.2	454.1	466.1	373.9
FTE employed medical practitioner rate (per 100 000 people), by age group, 2012 (a), (o)									
< 25 years	0.7	1.5	0.7	0.7	0.3	1.5	0.3	1.0	0.9
25–34	84.2	95.6	90.9	92.5	98.3	77.6	102.3	146.2	91.1
35–44	98.2	92.5	104.5	92.5	105.3	87.2	126.0	129.2	98.5
45–54	89.9	86.6	95.4	81.1	94.9	96.7	117.3	94.7	90.3
55–64	70.6	63.3	59.3	55.9	72.1	73.6	83.7	63.4	65.3
65 years or over	34.5	27.0	22.5	20.8	30.2	22.6	24.2	31.2	28.0

FTE = Full time equivalent.

(a) FTE rate (FTE per 100 000 people) is based on standard full-time working week of 40 hours.

(b) Includes medical practitioners who are employed in medicine. Excludes medical practitioners on extended leave.

(c) Due to rounding of average hours worked, the sum of states and territories' FTE rates may not add up to total FTE rate for Australia and the sum of age groups FTE rates may not add up to total FTE rate for each state. The Australian total includes employed practitioners who did not state or adequately describe their state or territory of principal practice and employed practitioners who are overseas.

(d) Jurisdictional differences between the previous survey questions prior to 2010, as well as the introduction of the new collection tool in 2010, have resulted in a slight change in the pattern of responses to the employment-related questions. As such, comparing data over time should be done with caution. (See Data Quality Information for further information.)

(e) Prior to 2010, NSW data are based on responses to the AIHW Medical Labour Force Survey weighted to financial registrants holding general, conditional specialist, limited prescribing and referring or non-practising registration.

Table EA.47 **Employed medical practitioners (a), (b), (c), (d)**

	NSW (e)	*Vic* (f)	*Qld* (g), (h)	WA(g), (i)	*SA*	*Tas* (j)	*ACT* (k)	*NT* (l)	*Aust*

(f) In 2009, Victoria surveyed only general, specific and provisional registered medical practitioners in the Medical Labour Force Survey but responses are weighted to all registered medical practitioners.

(g) 2010 data exclude Qld and WA due to their registration period closing after the national registration deadline of 30 September 2010.

(h) In 2009, Queensland data are based on responses to the Medical Labour Force Survey weighted to all registrants excluding some conditional registration types. In 2005, responses to annual Medical Labour Force Surveys were weighted to general registrants and conditionally registered specialists only.

(i) For WA, in 2009, the scope was consistent, that is, the survey population and the benchmark figures are based on general and conditional registrants. In 2005, the survey was administered to both general and conditional registrants but benchmark figures were for general registrants only. For WA in 2009, the benchmark data includes a significant number of registered medical practitioners that are no longer active in the workforce. This inflates the perception of the medical labour force in WA. It is also unknown how significantly past years have been affected. Care should be taken when interpreting these

(j) Prior to 2010, Tasmania data are based on responses to the AIHW Medical Labour Force Survey weighted to general registrants, conditionally registered specialists and non-practising registrants only.

(k) Care must be taken when interpreting ACT's data as the ACT supplies a large number of services to the Greater Southern Area NSW. Inclusion of population from this catchment area would significantly reduce the ratio of practitioners per 100 000 population.

(l) Comparisons with NT data should be made with caution. From 2010, doctors' registration requirements have changed (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally).

(m) From 2010, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

(n) 2010 data exclude Queensland and WA due to closure of their registration period after the national registration deadline of 30 September 2010.

(o) From 2012, data exclude provisional registrants.

np Not published. **na** Not available.

Source : AIHW unpublished, National Health Workforce Data Set; ABS (unpublished) Estimated Resident Population (based on the 2011 ABS Census of Population and Housing).

Table EA.48 **Employed nurses (a), (b), (c), (d), (e)**

	NSW	*Vic* (f)	*Qld* (g)	*WA* (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)	*Aust*
Practitioner rate (per 100 000 people)									
2003	1 116	1 351	1 036	1 074	1 429	1 330	1 173	1 563	1 189
2004	1 130	1 369	1 058	1 167	1 500	1 281	1 192	1 162	1 212
2005	1 083	1 367	1 036	1 136	1 523	1 366	1 244	3 468	1 198
2006	na	na	na	na	na	na	na	na	na
2007	1 116	1 438	1 171	1 134	1 508	1 428	1 229	1 385	1 250
2008	1 117	1 391	1 140	1 215	1 625	1 472	1 285	1 827	1 255
2009	1 110	1 386	1 170	1 186	1 712	1 465	1 275	1 814	1 261
2010 (k)	na	na	na	na	na	na	na	na	na
2011	1 111	1 429	1 248	1 218	1 670	1 451	1 276	1 514	1 284
2012 (l)	1 113	1 413	1 241	1 223	1 666	1 393	1 264	1 596	1 279
FTE nurses rate (per 100 000 people) based on a 38-hour week									
2003	975	1 134	897	888	1 181	1 141	1 037	1 575	1 017
2004	1 014	1 146	916	983	1 259	1 115	1 069	1 149	1 046
2005	975	1 144	913	950	1 279	1 190	1 126	3 468	1 040
2006	na	na	na	na	na	na	na	na	na
2007	1 007	1 224	1 032	972	1 287	1 254	1 106	1 431	1 095
2008	1 014	1 183	1 014	1 042	1 403	1 301	1 170	1 827	1 103
2009	1 005	1 167	1 043	1 008	1 469	1 280	1 168	1 800	1 105
2010 (k)	na	na	na	na	na	na	na	na	na
2011	993	1 182	1 091	1 037	1 388	1 239	1 164	1 504	1 107
2012 (l)	1 014	1 189	1 107	1 064	1 416	1 179	1 183	1 615	1 123
FTE employed nurses and midwives, rate per 100 000 people based on 38-hour weeks, by age, 2012 (l)									
< 25 years	48.1	68.4	61.1	67.5	70.6	51.3	58.4	78.9	60.0
25–34	189.2	254.7	198.3	205.1	239.6	169.7	242.9	414.2	215.4
35–44	222.0	267.9	266.9	234.9	310.8	227.9	288.3	354.8	252.8
45–54	305.0	341.2	342.3	323.5	468.7	424.5	343.2	430.9	340.0
55–64	221.4	229.5	210.6	206.5	299.3	275.7	229.0	307.0	227.5
65 years or over	28.4	27.4	28.1	26.4	27.0	29.4	21.2	28.8	27.7

FTE = Full time equivalent.

(a) Includes registered and enrolled nurses who are employed in nursing.

(b) FTE rate (FTE per 100 000 people) is based on standard full-time working week of 38 hours.

(c) Data for 2002, 2006 and 2010 are not available.

(d) Due to rounding of average hours worked, the sum of states and territories' FTE rates may not add up to total FTE rate for Australia and the sum of age groups FTE rates may not add up to total FTE rate for each state. The Australian total includes employed practitioners who did not state or adequately describe their state or territory of principal practice and employed practitioners who are overseas.

(e) Jurisdictional differences between the previous survey questions prior to 2010, as well as the introduction of the new collection tool in 2010, have resulted in a slight change in the pattern of responses to the employment-related questions. As such, comparing data over time should be done with caution. (See Data Quality Information for further information.)

Table EA.48 **Employed nurses (a), (b), (c), (d), (e)**

	NSW	*Vic* (f)	*Qld* (g)	*WA* (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)	*Aust*

(f) Because survey data for Victoria were not available in 2005, the 2006 Victorian survey responses were weighted to 2005 benchmarks. Therefore, care should be taken when comparing these data for Victoria with earlier years and in making comparisons with other states and territories in 2005. In 2008 Victorian data was affected by large numbers of online survey records not being able to be used for technical reasons. Estimates for Victoria for 2008 and 2009 should be treated with caution due to low response rate (33.3 per cent and 31.7 per cent respectively).

(g) Queensland estimates for 2007, 2008 and 2009 should be treated with caution due to low response rates (33.9 per cent, 32.9 per cent and 28.2 respectively). Benchmark data for Queensland in 2009 was estimated by using the total from a summary table provided to AIHW by Queensland Health prorated to the age distribution of 2008.

(h) Estimates for WA for 2005, 2007, 2008 and 2009 should be treated with caution due to low response rates (26.9 per cent, 36.7 per cent, 34.4 per cent and 35.4 per cent respectively). Benchmark data for Western Australia in 2009 was estimated by using the total from the Nursing board annual report prorated to the age distribution of 2008.

(i) Estimates for Tasmania for 2009 should be treated with caution due to low response rate (33.2 per cent). Differences between 2008 and 2009 for Tasmanian data in particular may be caused by the large decline in the response rate for that jurisdiction (from 56.9% to 33.2%).

(j) Estimates for the NT for 2004, 2007, 2008 and 2009 should be treated with caution due to low response rates (35.1 per cent, 28.7 per cent, 34.9 per cent and 32.8 per cent respectively). Data for NT for 2005 are not published. Benchmark data for the Northern Territory in 2009 was estimated by using the total from the Nursing board quarterly bulletin report prorated to the age distribution of 2008. Data for the NT is affected by the transient nature of the nursing labour force in that jurisdiction. According to the Nursing Board Annual Report, approximately one-third of all nurses do not re-register each year, primarily because they no longer practise in the jurisdiction. There has been some variation across years in the degree to which nurses who are interstate have been removed from the renewal process and hence the survey.

(k) From 2010, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

(l) From 2012, data exclude provisional registrants.

np Not published. **na** Not available.

Source : AIHW unpublished, National Health Workforce Data Set; ABS (unpublished) Estimated Resident Population (based on the 2011 ABS Census of Population and Housing).

Table EA.49 Net growth in health workforce, selected professions (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
FTE Medical practitioners in the workforce (d), (e)										
2008	no.	23 404	18 773	13 865	7 165	5 770	1 518	1 695	882	73 076
2009	no.	23 257	19 341	15 733	7 916	5 907	1 826	1 792	1 069	76 740
2010	no.	26 694	20 302	na	na	6 655	1 895	1 657	870	na
2011	no.	27 827	20 723	16 878	8 204	6 708	1 926	1 728	1 072	85 140
2012	no.	27 560	20 607	17 018	8 349	6 637	1 839	1 701	1 095	84 820
Growth in medical workforce from 2008 to 2012 (g)										
Net growth	**%**	**17.8**	**9.8**	**22.7**	**16.5**	**15.0**	**21.1**	**0.3**	**24.1**	**16.1**
Annual average	**%**	**4.2**	**2.4**	**5.3**	**3.9**	**3.6**	**4.9**	**0.1**	**5.5**	**3.8**
FTE Nurses and midwives in the workforce (f)										
2008	no.	71 129	63 001	43 691	22 694	22 502	6 479	4 050	4 028	237 236
2009	no.	71 631	63 559	46 166	22 624	23 860	6 441	4 114	4 072	242 521
2010	no.	na	na	na	na	na	na	na	na	na
2011	no.	71 657	65 439	48 858	24 390	22 755	6 340	4 283	3 479	247 246
2012	no.	73 948	66 866	50 485	25 850	23 436	6 033	4 425	3 789	254 842
Growth in the nursing and midwifery workforce from 2008 to 2012 (g)										
Net growth	**%**	**4.0**	**6.1**	**15.5**	**13.9**	**4.1**	**- 6.9**	**9.3**	**- 5.9**	**7.4**
Annual average	**%**	**1.0**	**1.5**	**3.7**	**3.3**	**1.0**	**-1.8**	**2.2**	**-1.5**	**1.8**

(a) Net growth measures the change in the full time equivalent (FTE) number in the workforce in the reference year compared to the year prior to the reference year.

(b) FTEs calculated based on a 40 hour standard working week for medical practitioners and a 38 hour week for nurses and midwives.

(c) Due to rounding of average hours worked, the total FTE for Australia may not add up to the sum of states and territories.

(d) 2008 and 2009 data for NSW, Queensland and Tasmania are underestimates, as the benchmark figures did not include all registered medical practitioners. For WA the 2008 benchmark used was the total number of registered practitioners in 2008 using 2007 age by sex proportions. For WA 2008 and 2009, the benchmark data were inflated by a significant number of registered medical practitioners that are no longer active in the workforce.

(e) For the NT, benchmarks for 2007 and 2009 were based on the medical board newsletter relating to medical practioners who had been registered during any part of the year, while the 2008 benchmarks were based on data analysis by the NT health department which was restricted to practitioners registered at a point in time (but included the only source for data by age group). The difference between these two sources for 2008 was concentrated in conditionally registered medical practitioners (i.e. short term registrations). The small decline in the survey data for 2008 and subsequent apparent large increase in the 2009 data is attributable to this difference in the benchmark data source. In contrast, AIHW calculations show that the increase in FTE between 2007 and 2009 was a more reasonable 10.3 per cent over two years.

(f) For 2009, state and territory estimates should be treated with caution due to low response rates in some jurisdictions, particularly Victoria, Queensland, WA, Tasmania and the NT. In 2008 Victorian data was affected by large numbers of online survey records not being able to be used for technical reasons.

(g) Jurisdictional differences between the previous survey questions prior to 2010, as well as the introduction of the new collection tool in 2010, have resulted in a slight change in the pattern of responses to the employment-related questions. As such, comparing data over time should be done with caution. (See Data Quality Information for further information.)

Table EA.49 **Net growth in health workforce, selected professions (a), (b)**

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

(h) In 2010, state and territory is derived from state and territory of otherwise, state and territory of residence is used as a proxy. If residence details are unavailable, state and territory of main job is used. Records with no information on all three locations are coded to 'Not stated'.

(i) Data for 2007, 2008 and 2009 are for the workforce (i.e. include employed, those on extended leave and those looking for work in the workforce) — this was National Healthcare Agreement indicator 65.1 which is no longer reported on. Data for 2010 and 2011 are only for those employed in the workforce. Therefore, comparisons should be made with caution.

(j) For medical practitioners, 2010 data for Queensland and WA are not available.

(k) For nurses and midwives, data not available for 2010.

na Not available.

Source : AIHW unpublished, National Health Workforce Data Set; AIHW unpublished, Medical Labour Force Survey; AIHW unpublished, Nursing and Midwifery Labour Force Survey; ABS unpublished, Estimated Resident Population (based on the 2011 ABS Census of Population and Housing).

Table EA.50 Employed health workforce, by Indigenous status and state and territory of principal practice (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
Medical practitioners employed in medicine (c)									
2010 (d)									
Number									
Indigenous (c)	60	23	na	na	9	3	7	14	117
Non-Indigenous	24 284	18 790	na	na	6 158	1 770	1 508	794	53 330
Not stated	90	73	na	na	24	6	5	1	199
Total	24 434	18 886	na	na	6 191	1 779	1 520	809	53 646
Percentage of employed medical practitioners who are Indigenous (e)	0.2	0.1	na	na	0.1	0.2	0.5	1.7	0.2
2011									
Number									
Indigenous (c)	93	22	59	32	17	4	7	16	249
Non-Indigenous	25 232	19 308	15 509	7 609	6 292	1 795	1 545	950	78 282
Not stated	89	83	61	27	19	14	4	5	302
Total	25 413	19 413	15 628	7 667	6 328	1 813	1 557	972	78 833
Percentage of employed medical practitioners who are Indigenous (e)	0.4	0.1	0.4	0.4	0.3	0.2	0.5	1.7	0.3
2012 (f)									
Number									
Indigenous (c)	na	na	na	na	na	na	na	na	na
Non-Indigenous	na	na	na	na	na	na	na	na	na
Not stated	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
Percentage of employed medical practitioners who are Indigenous (e)	na	na	na	na	na	na	na	na	na
Employed nurses and midwives (g)									
2010 (h)									
Number									
Indigenous	na	na	na	na	na	na	na	na	na
Non-Indigenous	na	na	na	na	na	na	na	na	na
Not stated	na	na	na	na	na	na		na	na
Total	na	na	na	na	na	na	na	na	na
Percentage of employed nurses and midwives who are Indigenous (e)	na	na	na	na	na	na	na	na	na
2011 (i)									
Number									
Indigenous	850	310	545	164	167	103	25	47	2 212

Table EA.50 Employed health workforce, by Indigenous status and state and territory of principal practice (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
Non-Indigenous	78 160	77 555	54 368	28 127	26 653	7 228	4 652	3 404	280 199
Not stated	341	294	215	139	101	33	24	19	1 166
Total	79 351	78 159	55 128	28 430	26 921	7 364	4 701	3 470	283 577
Percentage of employed nurses and midwives who are Indigenous (e)	1.1	0.4	1.0	0.6	0.6	1.4	0.5	1.4	0.8
2012									
Number									
Indigenous	865	313	587	159	182	101	38	56	2 301
Non-Indigenous	80 057	78 957	55 870	29 472	27 297	7 014	4 677	3 683	287 046
Not stated	254	184	150	82	82	17	19	10	797
Total	81 176	79 455	56 607	29 712	27 561	7 132	4 734	3 749	290 144
Percentage of employed nurses and midwives who are Indigenous (e)	1.1	0.4	1.0	0.5	0.7	1.4	0.8	1.5	0.8

(a) State and territory is derived from state and territory of main job where available. Otherwise, state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

(b) Includes employed practitioners who did not state or adequately describe their state or territory and employed practitioners who live overseas. Therefore, state and territory totals may not sum to the national total.

(c) Due to the small population size, the overall response rate and unexplained variation between years, data for Indigenous medical practitioners should be treated with caution.

(d) For medical practitioners, 2010 data for Queensland and Western Australia are not available.

(e) Excludes the response category 'Indigenous status—Not stated'.

(f) For medical practitioners, 2012 data are not available.

(g) Includes people registered as midwives only.

(h) For nurses and midwives, data are not available for 2010.

(i) Nurses and midwives data for 2011 have been revised and may differ from previous reports.

na Not available.

Source: AIHW various years, *Medical workforce* (various years), *Nursing and midwifery workforce* (various years).

Table EA.51 **Indigenous health workforce, by State/Territory, 2011 (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous Australians										
Employed in health related occupation										
15-24 years	no.	260	76	214	94	61	18	8	105	836
25-34 years	no.	670	172	573	199	143	51	13	257	2 078
35-44 years	no.	862	214	782	279	200	60	21	286	2 704
45-54 years	no.	778	180	654	248	186	71	23	245	2 385
55-64 years	no.	336	76	305	141	69	30	7	117	1 084
65 years & over	no.	25	12	39	26	12	4	–	17	135
Total	**no.**	**2 931**	**730**	**2 567**	**987**	**671**	**234**	**72**	**1 027**	**9 222**
Census population	'000	173	38	156	70	30	20	5	57	548
All people										
Employed in health related occupation										
15-24 years	no.	9 610	9 301	6 952	3 677	2 623	647	514	393	33 717
25-34 years	no.	38 545	35 679	26 165	13 372	10 722	2 482	2 146	1 931	131 045
35-44 years	no.	43 155	36 658	29 776	14 314	11 959	3 208	2 173	1 585	142 838
45-54 years	no.	47 276	37 069	30 493	15 002	13 974	4 181	2 331	1 540	151 877
55-64 years	no.	30 772	23 604	17 786	9 361	8 522	2 658	1 480	940	95 140
65 years & over	no.	6 555	4 655	3 313	1 801	1 353	410	251	146	18 484
Total	**no.**	**175 913**	**146 966**	**114 485**	**57 527**	**49 153**	**13 586**	**8 895**	**6 535**	**573 101**
Census population	'000	6 918	5 354	4 333	2 239	1 597	495	357	212	21 508
Indigenous health workforce as a proportion of total health workforce										
15-24 years	%	2.7	0.8	3.1	2.6	2.3	2.8	1.6	26.7	2.5
25-34 years	%	1.7	0.5	2.2	1.5	1.3	2.1	0.6	13.3	1.6
35-44 years	%	2.0	0.6	2.6	1.9	1.7	1.9	1.0	18.0	1.9
45-54 years	%	1.6	0.5	2.1	1.7	1.3	1.7	1.0	15.9	1.6
55-64 years	%	1.1	0.3	1.7	1.5	0.8	1.1	0.5	12.4	1.1
65 years & over	%	0.4	0.3	1.2	1.4	0.9	1.0	–	11.6	0.7
Total	**%**	**1.7**	**0.5**	**2.2**	**1.7**	**1.4**		**0.8**	**15.7**	**1.6**
Indigenous Australians as a proportion of total census population										
Total	%	2.5	0.7	3.6	3.1	1.9	4.0	1.5	26.8	2.5

(a) Aged 15 years and over.

(b) Coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition, Revision 1. The Occupation code assigned to a response is based on the occupation title and tasks of the main job held during the week prior to Census Night.

(c) No reliance should be placed on small cells

(d) Components may not add to total due to perturbation of component data.

Source : ABS 2012, *2011 Census of Population and Housing* , Canberra.

Table EA.52 **Indigenous health workforce, by sex, 2011 (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous Australians										
Employed in health related occupation										
Male	no.	783	207	718	308	215	45	25	433	2 734
Female	no.	2 146	523	1 849	679	456	189	46	596	6 487
Total	**no.**	**2 931**	**730**	**2 567**	**987**	**671**	**234**	**72**	**1 027**	**9 222**
All people										
Employed in health related occupation										
Male	no.	47 025	36 440	31 245	15 021	12 359	3 498	2 368	1 942	149 912
Female	no.	**128 885**	**110 527**	**83 240**	**42 506**	**36 793**	**10 090**	**6 527**	**4 593**	**423 189**
Total	**no.**	175 913	146 966	114 485	57 527	49 153	13 586	8 895	6 535	573 101
Indigenous health workforce as a proportion of total health workforce										
Male	%	1.7	0.6	2.3	2.1	1.7	1.3	1.1	22.3	1.8
Female	%	1.7	0.5	2.2	1.6	1.2	1.9	0.7	13.0	1.5
Total	**%**	**1.7**	**0.5**	**2.2**	**1.7**	**1.4**	**1.7**	**0.8**	**15.7**	**1.6**

(a) Aged 15 years and over.

(b) Coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition, Revision 1. The Occupation code assigned to a response is based on the occupation title and tasks of the main job held during the week prior to Census Night.

(c) No reliance should be placed on small cells.

(d) Components may not add to total due to perturbation of component data.

Source : ABS 2012, *2011 Census of Population and Housing* , Canberra.

Table EA.53 Indigenous persons employed in selected health-related occupations, 2011 (a), (b), (c), (d)

	Indigenous Australians	*All people*	*Per cent of Indigenous people employed in a health-related occupation*
Health and welfare services managers	**351**	**17 387**	**2.0**
Health professionals			
Health Professionals nfd	55	2 113	2.6
Health diagnostic and promotion professionals			
Health Diagnostic and Promotion Professionals nfd	7	157	4.5
Dietitians	24	3 705	0.6
Medical Imaging Professionals	22	13 243	0.2
Occupational and Environmental Health Professional	298	18 924	1.6
Optometrists and Orthoptists	6	4 303	0.1
Pharmacists	28	19 936	0.1
Other Health Diagnostic and Promotion Professionals	572	5 595	10.2
Total	**954**	**68 862**	**1.4**
Health therapy professionals			
Health Therapy Professionals nfd	–	171	–
Chiropractors and Osteopaths	11	4 347	0.3
Complementary Health Therapists	19	5 949	0.3
Dental Practitioners	21	10 991	0.2
Occupational Therapists	22	9 251	0.2
Physiotherapists	73	15 928	0.5
Podiatrists	5	2 803	0.2
Speech Professionals and Audiologists	17	6 799	0.3
Total	**168**	**56 231**	**0.3**
Medical practitioners			
Medical Practitioners nfd	4	1 431	0.3
Generalist Medical Practitioners	129	43 429	0.3
Anaesthetists	6	3 765	0.2
Specialist Physicians	–	5 468	–
Psychiatrists	6	2 586	0.2
Surgeons	11	4 926	0.2
Other Medical Practitioners	17	8 619	0.2
Total	**173**	**70 229**	**0.2**
Midwifery and nursing professionals			
Midwifery and Nursing Professionals nfd	3	354	0.8
Midwives	70	14 105	0.5
Nurse Educators and Researchers	21	5 288	0.4
Nurse Managers	81	12 631	0.6
Registered Nurses	1 710	206 916	0.8
Total	**1 890**	**239 292**	**0.8**
Total Health professionals	**3 240**	**433 726**	**0.7**

Table EA.53 Indigenous persons employed in selected health-related occupations, 2011 (a), (b), (c), (d)

	Indigenous Australians	*All people*	*Per cent of Indigenous people employed in a health-related occupation*
Health and welfare support workers			
Health and Welfare Support Workers nfd	65	777	8.4
Ambulance Officers and Paramedics	215	11 939	1.8
Dental Hygienists, Technicians and Therapists	32	6 333	0.5
Diversional Therapists	42	4 256	1.0
Enrolled and Mothercraft Nurses	285	17 891	1.6
Indigenous Health Workers	1 257	1 373	91.6
Massage Therapists	73	10 604	0.7
Welfare Support Workers	3 572	50 205	7.1
Total	**5 548**	**103 383**	**5.4**
Psychologists	**81**	**18 522**	**0.4**
Total aged 15 years and over (n)	**9 221**	**573 101**	**1.6**

(a) Aged 15 years and over.

(b) Coded using the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition, Revision 1. The Occupation code assigned to a response is based on the occupation title and tasks of the main job held during the week prior to Census Night.

(c) No reliance should be placed on small cells

(d) Components may not add to total due to perturbation of component data.

Source : ABS 2012, *2011 Census of Population and Housing* , Canberra.

Table EA.54 Proportion of people who accessed health services by health status, 2011-12 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
					Health status (excellent/very good/good)					
Admitted to hospital	%	10.9	11.2	11.0	12.2	12.0	10.8	12.4	12.9	11.3
Casualty/outpatients/day clinic	%	1.7	2.1	2.5	2.8	2.9	1.5	2.1	2.7	2.2
Doctor consultation (GP and/or specialist)	%	22.5	21.6	24.4	21.2	21.2	21.9	21.0	22.9	22.3
Dental consultation (e)	%	16.7	18.9	17.5	18.4	20.3	15.7	17.7	15.0	17.8
Consultation with other health professional	%	6.6	8.2	6.6	5.7	8.5	5.1	8.5	5.3	7.0
Total accessing health care (f)	%	**26.9**	**27.0**	**28.6**	**25.4**	**26.9**	**25.1**	**26.9**	**26.5**	**27.1**
					Health status (fair/poor)					
Admitted to hospital	%	21.7	21.9	26.1	24.5	26.3	22.9	21.5	25.0	23.3
Casualty/outpatients/day clinic	%	2.3	7.3	8.6	5.9	9.1	6.3	8.0	10.1	6.1
Doctor consultation (GP and/or specialist)	%	40.5	52.8	43.3	36.7	40.7	40.1	37.7	36.0	43.4
Dental consultation (e)	%	19.5	15.6	16.2	14.8	18.3	13.8	13.4	22.1	17.4
Consultation with other health professional	%	11.9	14.7	11.9	15.9	12.0	11.3	23.1	8.8	13.2
Total accessing health care (f)	**%**	**43.8**	**55.8**	**50.2**	**44.8**	**48.3**	**44.4**	**47.7**	**42.4**	**48.5**
					95 per cent confidence interval for Health status (excellent/very good/good)					
Admitted to hospital	± %	1.4	1.2	1.6	1.6	1.7	1.9	2.2	3.1	0.6
Casualty/outpatients/day clinic	± %	0.5	0.7	0.7	0.8	0.9	0.8	0.9	1.2	0.3
Doctor consultation (GP and/or specialist)	± %	1.8	1.7	1.9	2.0	2.2	2.6	2.4	2.9	0.8
Dental consultation (e)	± %	1.9	1.8	1.8	2.1	2.4	2.3	2.1	2.8	0.8
Consultation with other health professional	± %	1.1	1.1	1.0	1.0	1.9	1.4	2.0	1.9	0.5
Total accessing health care (f)	**± %**	**2.1**	**2.0**	**2.0**	**2.2**	**2.3**	**2.6**	**3.0**	**3.3**	**0.9**
					95 per cent confidence interval for Health status (fair/poor)					
Admitted to hospital	± %	4.8	5.6	6.1	5.4	6.8	5.8	7.4	7.2	2.5
Casualty/outpatients/day clinic	± %	1.3	3.3	3.2	2.7	4.8	2.9	6.2	4.5	1.2
Doctor consultation (GP and/or specialist)	± %	6.9	8.3	6.2	7.5	6.4	6.8	9.4	9.6	3.6
Dental consultation (e)	± %	5.0	4.6	5.2	4.4	5.3	4.9	7.0	8.4	2.5
Consultation with other health professional	± %	3.1	5.1	3.7	5.3	3.8	4.1	7.5	5.7	1.8
Total accessing health care (f)	**± %**	**6.9**	**8.0**	**6.0**	**8.0**	**5.9**	**6.3**	**10.1**	**8.3**	**3.5**

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).

(b) People aged 15 years and over who were admitted to hospital in the last 12 months, consulted a dentist in the last 3 months or who visited casualty, an outpatient clinic, day clinic or consulted a GP, specialist or other health professional in the last 2 weeks.

Table EA.54 **Proportion of people who accessed health services by health status, 2011-12 (a), (b), (c)**

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

(c) Data for 2011-12 are not comparable to data for 2004-05 due to changes to question methodology. In 2004-05, respondents were asked individual questions on actions they had taken for their health in a specified time period (for example, consulting a general practitioner in the last 2 weeks) while in 2011-12 respondents were asked to identify actions they had undertaken in the last 12 months from a prompt card. In 2011-12, if the respondent answered yes to an action they were then asked whether they had done so in the specified time frame.

(d) Data for the NT should be used with care as very remote areas are excluded from the Australian Health Survey, which translates to the exclusion of around 23 per cent of the NT population.

(e) Data presented for 2011-12 for ‘Dental consultation’ relate to 'in the last 3 months', and are not comparable with 2004-05 data.

(f) Total persons accessing casualty/outpatients/day clinic or consulting a doctor (GP and/or specialist) or other health professional in the last 2 weeks. Data for 2011-12 are not comparable with data for 2004-05.

np Not published.

Source: ABS unpublished *Australian Health Survey, 2011-13* (National Health Survey 2011-12 component), Cat. No. 4640.0

Table EA.55 Proportion of people who accessed health services by health status, 2004-05 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
					Health status (excellent/very good/good)					
Admitted to hospital	%	14.2	13.5	13.5	15.8	13.5	13.5	13.4	13.7	14.0
Casualty/outpatients/day clinic	%	3.4	5.5	3.7	4.8	4.5	4.7	np	np	4.2
Doctor consultation (GP and/or specialist)	%	21.1	21.5	20.5	22.4	21.8	21.6	19.9	21.5	21.3
Dental consultation (e)	%	5.5	5.9	5.2	6.3	6.4	5.6	5.8	4.4	5.7
Consultation with other health professional	%	11.8	14.3	14.0	13.5	14.2	11.9	12.5	12.6	13.2
Total accessing health care (f)	%	**41.8**	**41.7**	**41.1**	**43.4**	**42.9**	**40.5**	**37.7**	**38.8**	**41.8**
					Health status (fair/poor)					
Admitted to hospital	%	27.6	24.6	25.8	28.1	26.5	27.0	23.8	37.2	26.5
Casualty/outpatients/day clinic	%	7.9	10.0	10.3	12.5	11.4	11.9	5.5	13.0	9.7
Doctor consultation (GP and/or specialist)	%	41.8	44.1	42.3	39.7	41.1	44.1	30.4	38.7	42.0
Dental consultation (e)	%	5.8	6.8	5.8	5.6	9.0	3.5	np	np	6.3
Consultation with other health professional	%	19.7	22.1	24.2	23.9	23.8	19.4	27.4	30.3	22.0
Total accessing health care (f)	**%**	**60.6**	**65.2**	**63.3**	**63.0**	**64.2**	**58.6**	**58.5**	**66.5**	**62.6**
					95 per cent confidence interval for Health status (excellent/very good/good)					
Admitted to hospital	± %	1.2	1.5	1.3	1.4	1.1	1.9	2.1	10.7	0.6
Casualty/outpatients/day clinic	± %	0.7	1.0	0.7	1.2	0.8	1.0	np	np	0.4
Doctor consultation (GP and/or specialist)	± %	1.3	1.6	1.6	2.1	1.8	2.2	3.0	15.0	0.8
Dental consultation (e)	± %	0.8	1.0	0.7	1.2	1.0	1.1	1.4	4.1	0.5
Consultation with other health professional	± %	1.3	1.6	1.5	1.6	1.3	1.7	1.7	13.6	0.7
Total accessing health care (f)	**± %**	**1.9**	**2.3**	**2.0**	**2.2**	**2.2**	**2.7**	**16.7**	**3.3**	**1.1**
					95 per cent confidence interval for Health status (fair/poor)					
Admitted to hospital	± %	4.7	4.0	3.7	5.9	4.4	6.0	7.3	34.1	2.2
Casualty/outpatients/day clinic	± %	2.8	2.8	3.5	4.1	3.6	4.4	2.6	16.9	1.3
Doctor consultation (GP and/or specialist)	± %	5.4	5.1	5.4	6.1	5.9	7.5	7.1	26.6	2.7
Dental consultation (e)	± %	2.9	3.2	2.3	3.0	3.9	2.5	np	np	1.3
Consultation with other health professional	± %	3.8	4.6	4.2	6.0	4.3	5.4	7.9	20.1	2.1
Total accessing health care (f)	**± %**	**5.7**	**5.5**	**5.5**	**6.9**	**5.0**	**7.6**	**8.2**	**32.1**	**3.0**

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15 years).

(b) Persons who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

(c) Limited to people aged 15 years or over.

Table EA.55 **Proportion of people who accessed health services by health status, 2004-05 (a), (b), (c)**

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

(d) Data for the NT should be used with care as very remote areas are excluded from the Australian Health Survey, which translates to the exclusion of around 23 per cent of the NT population.

(e) Data presented for 2004-05 for ‘Dental consultation’ relate to 'in the last 2 weeks', and are not comparable with 2011-12 data.

(f) Total persons accessing any of the selected health services above. Components may not add to total because persons may have accessed more than one type of health service. Data for 2004-05 are not comparable with data for 2011-12.

np Not published.

Source : ABS (unpublished) *National Health Survey, 2004-05* .

Table EA.56 **Proportion of Indigenous Australians who accessed health services by health status, 2012-13 (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Health status (excellent/very good/good)					
Admitted to hospital (d)	%	17.3	21.6	17.5	22.4	18.6	17.7	23.9	22.1	19.0
Casualty/outpatients/day clinic (e)	%	5.6	5.2	6.1	5.2	6.7	3.1	10.5	4.4	5.5
Doctor consultation (GP and/or specialist) (e)	%	22.3	28.6	19.8	22.0	29.6	23.4	37.1	24.1	22.8
Dental consultation (f)	%	12.6	13.5	11.2	13.6	17.4	10.6	21.0	18.1	13.3
Consultation with other health professional (e)	%	16.9	23.4	18.5	22.2	23.2	20.6	32.2	26.0	20.1
Total accessing health care (g)	**%**	**33.0**	**42.0**	**34.1**	**37.2**	**43.4**	**35.6**	**50.3**	**37.7**	**35.8**
					Health status (fair/poor)					
Admitted to hospital (d)	%	33.6	31.5	27.2	36.8	34.4	23.1	34.0	27.1	31.2
Casualty/outpatients/day clinic (e)	%	7.8	18.0	12.4	16.9	7.5	10.2	9.7	7.5	11.1
Doctor consultation (GP and/or specialist) (e)	%	38.8	43.6	40.4	41.8	42.9	43.1	48.7	36.3	40.1
Dental consultation (f)	%	15.6	14.0	11.2	13.5	20.2	16.6	19.3	15.5	14.5
Consultation with other health professional (e)	%	31.3	35.9	26.8	31.4	36.7	22.7	25.2	29.6	30.6
Total accessing health care (g)	**%**	**54.5**	**55.4**	**52.4**	**56.9**	**58.2**	**51.6**	**55.5**	**45.2**	**53.9**
					95 per cent confidence interval for Health status (excellent/very good/good)					
Admitted to hospital (d)	± %	4.5	5.5	3.7	3.8	5.5	5.1	9.8	5.8	2.0
Casualty/outpatients/day clinic (e)	± %	2.6	2.6	2.2	1.6	3.9	1.7	9.1	3.4	1.2
Doctor consultation (GP and/or specialist) (e)	± %	4.8	5.6	4.2	4.7	6.4	4.8	9.7	5.4	2.0
Dental consultation (f)	± %	3.5	4.5	3.0	3.8	5.7	4.6	9.7	4.8	1.6
Consultation with other health professional (e)	± %	4.1	5.3	4.1	4.9	5.2	5.0	11.5	6.1	1.9
Total accessing health care (g)	**± %**	**5.6**	**6.1**	**4.6**	**5.2**	**6.2**	**5.1**	**8.6**	**5.9**	**2.2**
					95 per cent confidence interval for Health status (fair/poor)					
Admitted to hospital (d)	± %	7.5	9.4	6.7	6.7	8.8	7.1	17.2	8.9	3.4
Casualty/outpatients/day clinic (e)	± %	4.1	7.3	6.2	6.1	4.5	5.8	9.7	4.3	2.5
Doctor consultation (GP and/or specialist) (e)	± %	7.3	9.4	8.3	9.6	7.9	9.0	20.2	10.3	3.8
Dental consultation (f)	± %	6.0	7.0	4.7	6.0	8.4	7.3	18.0	8.5	2.7
Consultation with other health professional (e)	± %	7.1	10.0	6.8	7.3	10.9	7.6	20.4	7.7	3.4
Total accessing health care (g)	**± %**	**8.8**	**9.4**	**8.3**	**8.7**	**9.5**	**8.2**	**17.5**	**8.7**	**4.1**

Table EA.56 **Proportion of Indigenous Australians who accessed health services by health status, 2012-13 (a), (b), (c)**

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

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).

(b) Limited to people aged 15 years or over.

(c) Data are not comparable to 2011-12 data for all Australians (table EA.54) due to differences in survey methodology.

(d) People who were admitted to hospital in the last 12 months.

(e) People who accessed the specified health service in the last two weeks.

(f) People who visited the dentist in the last 3 months. Data are not comparable to data for 2004-05 (table EA.57, people who visited the dentist in the last 2 weeks).

(g) Total accessing casualty/outpatients/day clinic, or consulting a doctor or other health professional, in the last 2 weeks. Components may not add to total because people may have accessed more than one type of health service. Data are not comparable to data for 2004-05 (table EA.57) or to 2011-12 data for all Australians (table EA.54) due to differences in survey methodology.

np Not published.

Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.55.001.

Table EA.57 Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d)	Aust
					Health status (excellent/very good/good)					
Indigenous										
Admitted to hospital	%	14.7	17.1	16.0	19.1	19.2	10.7	9.9	23.3	17.0
Casualty/outpatients/ day clinic	%	3.0	1.7	5.0	5.0	6.7	3.3	np	4.4	4.0
Doctor consultation (GP and/or specialist)	%	20.9	24.0	21.2	23.1	25.4	18.4	12.9	23.8	21.9
Dental consultation	%	3.3	np	3.4	np	np	np	np	2.6	3.3
Consultation with other health professional	%	14.5	15.6	18.7	20.7	20.5	9.0	14.1	37.2	19.7
Total accessing health care (e)	**%**	**40.4**	**47.9**	**43.4**	**47.1**	**46.1**	**34.3**	**30.0**	**55.3**	**44.3**
Non-Indigenous										
Admitted to hospital	%	14.2	13.4	13.2	15.6	13.4	13.3	13.1	10.8	13.8
Casualty/outpatients/ day clinic	%	1.6	2.5	1.5	2.0	2.8	2.1	1.8	–	1.9
Doctor consultation (GP and/or specialist)	%	21.0	21.3	20.3	21.9	21.5	21.0	19.4	12.4	21.0
Dental consultation	%	5.5	5.9	5.2	6.4	6.6	5.8	5.6	8.2	5.7
Consultation with other health professional	%	11.6	14.4	14.0	13.3	14.2	12.1	12.1	12.5	13.2
Total accessing health care (e)	**%**	**41.1**	**41.2**	**40.4**	**42.0**	**43.1**	**39.9**	**37.5**	**35.9**	**41.1**
					Health status (fair/poor)					
Indigenous										
Admitted to hospital	%	29.9	34.8	26.1	28.3	27.7	31.9	20.5	39.2	29.7
Casualty/outpatients/ day clinic	%	5.0	10.9	14.6	16.3	10.7	7.2	np	10.9	10.8
Doctor consultation (GP and/or specialist)	%	40.6	45.4	34.6	41.1	39.4	52.2	27.4	43.0	39.8
Dental consultation	%	3.0	np	7.0	np	np	np	np	4.6	4.3
Consultation with other health professional	%	24.6	33.7	28.1	21.3	24.1	24.9	30.5	47.5	27.8
Total accessing health care (e)	**%**	**61.3**	**71.7**	**65.8**	**59.1**	**61.7**	**66.6**	**48.2**	**70.6**	**64.1**
Non-Indigenous										
Admitted to hospital	%	28.6	25.1	26.3	28.6	26.1	26.5	23.1	49.4	27.1
Casualty/outpatients/ day clinic	%	4.9	4.9	5.4	6.4	9.3	6.8	np	np	5.5
Doctor consultation (GP and/or specialist)	%	41.7	44.2	42.7	40.5	41.2	44.0	30.9	20.8	42.1
Dental consultation	%	5.7	6.9	5.7	5.5	8.8	3.6	6.9	–	6.1
Consultation with other health professional	%	19.2	22.2	24.2	23.7	23.7	18.9	27.8	18.0	21.7
Total accessing health care (e)	**%**	**60.7**	**64.8**	**62.5**	**62.2**	**64.3**	**58.3**	**58.5**	**58.9**	**62.3**

Table EA.57 Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d)	Aust
		95 per cent confidence interval for Health status (excellent/very good/good)								
Indigenous										
Admitted to hospital	± %	4.6	6.2	4.4	4.6	6.2	5.7	6.8	6.8	2.2
Casualty/outpatients/ day clinic	± %	1.5	1.9	2.9	3.5	4.4	2.5	3.4	2.9	1.1
Doctor consultation (GP and/or specialist)	± %	5.2	9.2	5.9	7.3	7.4	5.9	8.2	8.5	2.8
Dental consultation	± %	2.1	4.6	2.1	2.5	3.4	3.3	2.8	1.7	0.9
Consultation with other health professional	± %	5.8	6.5	6.1	8.5	7.4	5.3	6.3	7.5	2.9
Total accessing health care (e)	**± %**	**6.9**	**11.2**	**6.6**	**8.5**	**8.5**	**6.7**	**12.4**	**7.7**	**3.3**
Non-Indigenous										
Admitted to hospital	± %	1.2	1.5	1.3	1.4	1.1	1.8	2.0	9.4	0.7
Casualty/outpatients/ day clinic	± %	0.4	0.7	0.5	0.7	0.7	0.8	0.8	–	0.3
Doctor consultation (GP and/or specialist)	± %	1.3	1.6	1.7	2.1	1.8	2.1	2.9	7.4	0.8
Dental consultation	± %	0.8	1.0	0.8	1.2	1.0	1.2	1.4	7.2	0.5
Consultation with other health professional	± %	1.3	1.6	1.5	1.6	1.3	1.7	1.7	13.8	0.7
Total accessing health care (e)	**± %**	**1.8**	**2.3**	**2.0**	**2.3**	**2.2**	**2.6**	**3.2**	**13.1**	**1.1**
		95 per cent confidence interval for Health status (fair/poor)								
Indigenous										
Admitted to hospital	± %	7.9	12.9	7.7	7.5	10.1	10.2	11.9	9.1	3.5
Casualty/outpatients/ day clinic	± %	2.5	8.2	6.9	7.8	9.8	4.6	2.5	6.3	2.5
Doctor consultation (GP and/or specialist)	± %	8.1	14.0	8.2	8.0	11.0	11.7	15.2	9.6	3.8
Dental consultation	± %	2.6	3.0	6.8	1.1	6.3	6.8	9.9	4.1	2.2
Consultation with other health professional	± %	7.6	13.7	7.7	6.0	8.0	8.9	15.3	10.6	3.4
Total accessing health care (e)	**± %**	**10.1**	**9.8**	**7.6**	**8.2**	**11.7**	**10.6**	**18.8**	**8.7**	**4.1**
Non-Indigenous										
Admitted to hospital	± %	4.9	4.0	3.7	6.2	4.2	5.6	7.0	39.7	2.1
Casualty/outpatients/ day clinic	± %	2.1	1.9	2.3	2.9	4.1	2.9	np	np	1.0
Doctor consultation (GP and/or specialist)	± %	5.1	5.1	5.2	6.3	6.1	7.6	7.3	30.0	2.5
Dental consultation	± %	2.6	3.1	2.3	2.9	4.4	2.5	3.7	–	1.2
Consultation with other health professional	± %	3.8	4.5	4.5	6.0	4.4	5.2	7.9	14.9	2.1
Total accessing health care (e)	**± %**	**5.7**	**6.1**	**5.5**	**6.9**	**5.2**	**7.9**	**8.2**	**41.1**	**2.9**

Table EA.57 **Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 (a), (b), (c)**

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

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15 years).

(b) People who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

(c) Limited to people aged 15 years or over.

(d) Data for non-Indigenous people for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(e) Total people accessing any of the selected health services above. Components may not add to total because persons may have accessed more than one type of health service. Data for 2004-05 are not comparable with data for 2011-12.

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

Source : ABS (unpublished) *National Health Survey, 2004-05* ; ABS (unpublished) *National Aboriginal and Torres Strait Islander Health Survey, 2004-05* .

Table EA.58 Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Health status (excellent/very good/good)					
Major cities										
Admitted to hospital	%	10.7	10.4	11.1	12.0	13.3	..	12.4	..	11.1
Casualty/outpatients/day clinic	%	1.6	2.0	2.5	2.6	2.9	..	2.1	..	2.1
Doctor consultation (GP and/or specialist)	%	23.3	21.5	24.4	21.2	22.5	..	21.0	..	22.7
Dental consultation (e)	%	17.5	20.0	18.6	19.9	20.5	..	17.7	..	18.8
Consultation with other health professional	%	6.6	7.8	6.8	5.5	8.8	..	8.5	..	7.1
Total accessing health care (f)	**%**	**27.4**	**26.4**	**28.6**	**25.3**	**28.2**	**..**	**26.9**	**..**	**27.2**
Inner regional										
Admitted to hospital	%	12.3	13.9	13.3	11.4	7.2	11.4	..	..	12.7
Casualty/outpatients/day clinic	%	np	1.8	1.8	np	np	1.2	..	..	1.8
Doctor consultation (GP and/or specialist)	%	19.6	20.2	24.1	22.3	14.7	21.2	..	..	20.8
Dental consultation (e)	%	15.1	17.7	14.3	10.2	24.6	17.8	..	..	16.1
Consultation with other health professional	%	7.2	9.3	6.1	np	9.0	6.3	..	..	7.7
Total accessing health care (f)	**%**	**25.3**	**27.6**	**28.1**	**29.4**	**23.3**	**24.9**	**..**	**..**	**26.6**
Outer regional										
Admitted to hospital	%	11.1	15.2	7.7	15.2	9.2	8.2	..	11.4	10.3
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	..	2.4	3.3
Doctor consultation (GP and/or specialist)	%	24.3	26.7	25.6	20.7	19.6	22.7	..	24.0	23.7
Dental consultation (e)	%	13.5	np	16.8	16.4	17.7	11.9	..	15.4	14.7
Consultation with other health professional	%	np	np	5.3	5.9	7.2	2.4	..	5.3	5.5
Total accessing health care (f)	**%**	**30.8**	**34.5**	**30.0**	**24.4**	**24.1**	**25.8**	**..**	**27.5**	**28.4**
Remote										
Admitted to hospital	%	np	..	np	13.0	np	np	..	18.9	13.0
Casualty/outpatients/day clinic	%	–	..	np	np	np	–	..	np	3.8
Doctor consultation (GP and/or specialist)	%	–	..	np	21.7	np	np	..	18.5	20.3
Dental consultation (e)	%	np	..	np	10.4	np	–	..	14.7	11.9
Consultation with other health professional	%	–	..	np	np	np	np	..	np	5.6
Total accessing health care (f)	**%**	**–**	**..**	**34.3**	**27.6**	**23.6**	**np**	**..**	**22.4**	**25.8**
					Health status (fair/poor)					
Major cities										
Admitted to hospital	%	19.1	19.5	30.2	21.2	29.4	..	21.5	..	22.2
Casualty/outpatients/day clinic	%	2.0	7.1	7.3	4.1	7.8	..	8.0	..	5.3

Table EA.58 **Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Doctor consultation (GP and/or specialist)	%	41.2	53.3	43.9	38.9	44.0	..	37.7	..	44.3
Dental consultation (e)	%	21.6	18.9	18.9	14.4	19.8	..	13.4	..	19.9
Consultation with other health professional	%	11.0	17.3	12.2	14.0	10.8	..	23.1	..	13.5
Total accessing health care (f)	**%**	**44.6**	**56.2**	**50.9**	**45.4**	**50.8**	**..**	**47.7**	**..**	**49.4**
Inner regional										
Admitted to hospital	%	29.7	26.5	28.2	29.9	np	20.3	..	..	26.3
Casualty/outpatients/day clinic	%	np	np	np	np	np	5.7	..	..	5.3
Doctor consultation (GP and/or specialist)	%	44.6	50.6	41.3	37.5	np	45.5	..	..	44.8
Dental consultation (e)	%	19.5	7.7	12.3	np	np	10.9	..	..	13.4
Consultation with other health professional	%	16.3	7.2	13.3	np	np	13.7	..	..	13.0
Total accessing health care (f)	**%**	**47.7**	**54.7**	**49.4**	**43.8**	**np**	**48.4**	**..**	**..**	**49.7**
Outer regional										
Admitted to hospital	%	np	np	17.9	37.6	26.5	33.6	..	23.0	25.7
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	..	5.3	11.9
Doctor consultation (GP and/or specialist)	%	np	35.5	42.2	np	37.8	35.3	..	34.0	34.4
Dental consultation (e)	%	–	np	np	np	np	22.4	..	20.0	8.5
Consultation with other health professional	%	np	np	np	np	np	12.7	..	4.8	11.2
Total accessing health care (f)	**%**	**np**	**35.5**	**55.0**	**35.3**	**46.9**	**45.2**	**..**	**38.7**	**40.2**
Remote										
Admitted to hospital	%	–	..	np	np	np	–	..	24.9	16.6
Casualty/outpatients/day clinic	%	–	..	np	np	np	–	..	np	21.0
Doctor consultation (GP and/or specialist)	%	–	..	np	np	np	np	..	42.5	46.0
Dental consultation (e)	%	–	..	np	np	np	np	..	np	35.4
Consultation with other health professional	%	–	..	–	np	np	–	..	np	16.6
Total accessing health care (f)	**%**	**–**	**..**	**np**	**np**	**np**	**np**	**..**	**56.4**	**58.2**
	95 per cent confidence interval for Health status (excellent/very good/good)									
Major cities										
Admitted to hospital	± %	1.7	1.4	1.8	1.9	1.8	..	2.2	..	0.8
Casualty/outpatients/day clinic	± %	0.7	0.8	0.9	0.9	1.0	..	0.9	..	0.4
Doctor consultation (GP and/or specialist)	± %	2.2	2.2	2.3	2.6	2.4	..	2.4	..	1.0
Dental consultation (e)	± %	2.4	1.9	2.2	2.3	2.5	..	2.1	..	1.0
Consultation with other health professional	± %	1.2	1.3	1.3	1.1	2.1	..	2.0	..	0.6
Total accessing health care (f)	**± %**	**2.4**	**2.3**	**2.4**	**2.6**	**2.4**	**..**	**3.0**	**..**	**1.1**

Table EA.58 Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Inner regional										
Admitted to hospital	± %	2.9	3.0	3.9	7.1	5.0	2.2	..	..	1.4
Casualty/outpatients/day clinic	± %	np	1.1	1.2	np	np	0.9	..	..	0.7
Doctor consultation (GP and/or specialist)	± %	3.9	3.2	4.7	10.1	5.5	2.9	..	..	1.8
Dental consultation (e)	± %	3.2	3.9	3.7	4.5	7.9	2.6	..	..	1.8
Consultation with other health professional	± %	2.7	3.3	2.3	np	7.9	1.9	..	..	1.3
Total accessing health care (f)	**± %**	**5.3**	**5.0**	**4.6**	**10.8**	**9.9**	**3.1**	**..**	**..**	**2.3**
Outer regional										
Admitted to hospital	± %	9.5	9.2	2.9	6.1	5.6	3.1	..	3.3	2.2
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	..	1.4	1.2
Doctor consultation (GP and/or specialist)	± %	9.9	9.3	5.4	6.1	6.8	5.2	..	3.3	3.1
Dental consultation (e)	± %	7.5	np	4.8	5.7	7.6	4.4	..	3.3	2.2
Consultation with other health professional	± %	np	np	2.3	5.1	5.0	1.9	..	2.0	1.8
Total accessing health care (f)	**± %**	**9.9**	**8.6**	**5.6**	**6.2**	**7.1**	**4.9**	**..**	**3.6**	**2.9**
Remote										
Admitted to hospital	± %	np	..	np	6.5	np	np	..	11.7	3.9
Casualty/outpatients/day clinic	± %	–	..	np	np	np	–	..	np	2.4
Doctor consultation (GP and/or specialist)	± %	–	..	np	8.6	np	np	..	5.6	5.8
Dental consultation (e)	± %	np	..	np	7.0	np	–	..	8.2	3.9
Consultation with other health professional	± %	–	..	np	np	np	np	..	np	3.3
Total accessing health care (f)	**± %**	**–**	**..**	**20.4**	**8.3**	**25.9**	**np**	**..**	**7.1**	**6.7**
		95 per cent confidence interval for Health status (fair/poor)								
Major cities										
Admitted to hospital	± %	5.3	7.7	9.1	5.0	8.6	..	7.4	..	3.0
Casualty/outpatients/day clinic	± %	1.5	4.2	3.7	2.3	4.0	..	6.2	..	1.4
Doctor consultation (GP and/or specialist)	± %	7.5	8.5	8.9	8.7	7.7	..	9.4	..	4.1
Dental consultation (e)	± %	5.7	5.9	6.4	4.8	6.2	..	7.0	..	2.7
Consultation with other health professional	± %	3.4	6.5	4.4	5.9	3.8	..	7.5	..	2.1
Total accessing health care (f)	**± %**	**7.4**	**8.2**	**8.5**	**9.0**	**7.5**	**..**	**10.1**	**..**	**4.0**
Inner regional										
Admitted to hospital	± %	13.7	9.4	14.9	23.3	17.9	np	..	..	5.7
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	..	..	2.2
Doctor consultation (GP and/or specialist)	± %	13.7	15.8	14.2	16.6	15.7	np	..	..	6.5

Table EA.58 Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Dental consultation (e)	± %	13.3	6.7	10.3	16.9	np	np	..	..	5.2
Consultation with other health professional	± %	8.0	5.1	8.7	19.9	np	np	..	..	4.1
Total accessing health care (f)	**± %**	**13.9**	**15.9**	**13.1**	**17.3**	**np**	**10.1**	**..**	**..**	**6.0**
Outer regional										
Admitted to hospital	± %	np	np	10.9	24.4	26.0	19.6	..	8.1	6.7
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	..	2.6	5.8
Doctor consultation (GP and/or specialist)	± %	np	21.3	32.8	np	25.2	10.3	..	9.5	8.7
Dental consultation (e)	± %	–	np	np	np	np	15.1	..	8.3	4.1
Consultation with other health professional	± %	np	np	np	np	np	7.6	..	3.8	4.7
Total accessing health care (f)	**± %**	**19.3**	**21.3**	**16.1**	**31.2**	**33.9**	**18.3**	**..**	**9.2**	**9.0**
Remote										
Admitted to hospital	± %	–	..	np	np	np	–	..	21.7	10.4
Casualty/outpatients/day clinic	± %	–	..	np	np	np	–	..	np	22.4
Doctor consultation (GP and/or specialist)	± %	–	..	np	np	np	np	..	31.0	22.6
Dental consultation (e)	± %	–	..	np	np	np	np	..	np	38.7
Consultation with other health professional	± %	–	..	–	np	np	–	..	np	20.1
Total accessing health care (f)	**± %**	**–**	**..**	**np**	**np**	**np**	**np**	**..**	**12.0**	**13.1**

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).

(b) People aged 15 years or over who were admitted to hospital in the last 12 months, consulted a dentist in the last 3 months or who visited casualty, an outpatient clinic, day clinic or consulted a GP, specialist or other health professional in the last 2 weeks.

(c) Data for 2011-12 are not comparable to data for 2004-05 due to changes to question methodology. In 2004-05, respondents were asked individual questions on actions they had taken for their health in a specified time period (for example, consulting a general practitioner in the last 2 weeks) while in 2011-12 respondents were asked to identify actions they had undertaken in the last 12 months from a prompt card. In 2011-12, if the respondent answered yes to an action they were then asked whether they had done so in the specified time frame.

(d) Very remote areas are excluded from the Australian Health Survey

(e) Data presented for 2011-12 for 'Dental consultation' relate to 'in the last 3 months', and are not comparable with 2004-05 data.

(f) Total people accessing casualty/outpatients/day clinic or consulting a doctor (GP and/or specialist) or other health professional in the last 2 weeks. Data for 2004-05 and 2011-12 are not comparable.

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

Source : ABS unpublished *Australian Health Survey, 2011-13* (National Health Survey 2011-12 component)

Table EA.59 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Health status (excellent/very good/good)					
Major cities										
Admitted to hospital	%	13.7	13.2	14.3	14.3	12.8	..	13.4	..	13.6
Casualty/outpatients/ day clinic	%	3.4	5.5	3.7	4.9	4.3	..	3.8	..	4.3
Doctor consultation (GP and/or specialist)	%	22.3	22.9	21.0	24.1	22.1	..	19.9	..	22.4
Dental consultation (d)	%	5.7	5.7	5.3	6.8	6.5	..	5.8	..	5.8
Consultation with other health professional	%	12.1	13.6	13.8	13.2	14.4	..	12.5	..	13.1
Total accessing health care (e)	**%**	**42.8**	**42.5**	**42.0**	**42.8**	**44.0**	**..**	**38.8**	**..**	**42.6**
Inner regional										
Admitted to hospital	%	16.6	15.0	11.5	19.2	14.9	14.5	..	..	14.8
Casualty/outpatients/ day clinic	%	3.1	4.9	3.2	3.4	3.3	4.7	..	..	3.8
Doctor consultation (GP and/or specialist)	%	18.4	16.1	20.9	18.3	18.4	21.3	..	..	18.6
Dental consultation (d)	%	5.2	6.5	6.2	5.9	7.8	5.7	..	..	6.0
Consultation with other health professional	%	11.1	14.4	15.1	15.0	14.4	12.1	..	..	13.4
Total accessing health care (e)	**%**	**39.3**	**38.2**	**40.5**	**44.0**	**42.1**	**41.4**	**..**	**..**	**39.9**
Outer regional										
Admitted to hospital	%	13.9	10.9	14.4	18.7	16.1	12.1	..	13.8	14.2
Casualty/outpatients/ day clinic	%	4.3	8.8	4.1	3.8	7.3	np	..	np	4.8
Doctor consultation (GP and/or specialist)	%	15.4	22.7	18.3	18.0	22.3	21.9	..	26.2	19.1
Dental consultation (d)	%	5.1	4.9	3.9	3.1	4.6	5.9	..	2.1	4.4
Consultation with other health professional	%	10.9	25.5	13.2	14.5	11.9	12.2	..	13.2	14.1
Total accessing health care (e)	**%**	**37.5**	**45.4**	**39.4**	**44.1**	**40.8**	**39.7**	**..**	**39.4**	**40.3**
Remote										
Admitted to hospital	%	np	..	8.0	26.3	16.9	5.7	..	np	16.2
Casualty/outpatients/ day clinic	%	np	..	6.5	9.6	3.8	np	..	np	5.9
Doctor consultation (GP and/or specialist)	%	36.3	..	22.6	15.5	24.9	np	..	np	20.0
Dental consultation (d)	%	–	..	np	5.4	4.7	np	..	12.3	4.5
Consultation with other health professional	%	–	..	12.4	11.5	17.3	4.9	..	10.3	11.4
Total accessing health care (e)	**%**	**47.3**	**..**	**37.4**	**40.2**	**45.8**	**28.8**	**..**	**32.0**	**39.4**

Table EA.59 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Health status (fair/poor)					
Major cities										
Admitted to hospital	%	27.3	22.2	25.8	30.6	28.4	..	23.8	..	26.2
Casualty/outpatients/ day clinic	%	7.9	9.6	10.7	13.9	10.9	..	5.5	..	9.6
Doctor consultation (GP and/or specialist)	%	42.2	43.8	42.6	40.9	45.9	..	30.4	..	42.6
Dental consultation (d)	%	7.1	8.2	7.2	6.0	9.7	..	7.0	..	7.5
Consultation with other health professional	%	17.0	19.0	24.5	25.1	24.1	..	27.4	..	20.3
Total accessing health care (e)	**%**	**61.2**	**63.4**	**64.0**	**63.8**	**67.4**	**..**	**58.5**	**..**	**62.9**
Inner regional										
Admitted to hospital	%	27.8	28.0	23.4	20.0	20.8	32.1	..	..	26.2
Casualty/outpatients/ day clinic	%	10.4	10.5	12.4	9.6	17.5	15.2	..	..	11.7
Doctor consultation (GP and/or specialist)	%	42.3	44.9	43.7	35.7	25.8	53.1	..	..	43.0
Dental consultation (d)	%	2.3	4.2	5.4	np	np	4.6	..	..	4.1
Consultation with other health professional	%	30.5	29.1	20.8	24.4	13.9	22.9	..	..	25.7
Total accessing health care (e)	**%**	**61.5**	**71.4**	**63.8**	**65.1**	**53.6**	**67.9**	**..**	**..**	**64.9**
Outer regional										
Admitted to hospital	%	30.0	36.3	30.3	30.0	20.1	21.5	..	53.9	30.2
Casualty/outpatients/ day clinic	%	4.0	12.4	6.0	np	10.3	8.2	..	np	6.8
Doctor consultation (GP and/or specialist)	%	38.3	44.1	40.0	36.2	34.5	32.8	..	34.1	38.4
Dental consultation (d)	%	3.7	np	2.5	4.1	8.8	2.4	..	np	3.7
Consultation with other health professional	%	19.0	27.8	30.1	np	26.1	14.0	..	np	23.4
Total accessing health care (e)	**%**	**56.0**	**59.9**	**60.2**	**55.9**	**56.0**	**45.4**	**..**	**53.9**	**56.7**
Remote										
Admitted to hospital	%	np	..	20.6	np	np	10.9	..	np	16.1
Casualty/outpatients/ day clinic	%	np	..	np	np	np	np	..	np	10.5
Doctor consultation (GP and/or specialist)	%	np	..	29.6	38.1	12.8	25.9	..	44.3	32.8
Dental consultation (d)	%	–	..	np	np	np	–	..	np	6.6
Consultation with other health professional	%	np	..	np	–	52.2	19.4	..	57.7	27.3
Total accessing health care (e)	**%**	**43.7**	**..**	**71.8**	**61.1**	**65.0**	**49.5**	**..**	**82.3**	**66.4**

Table EA.59 Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	95 per cent confidence interval for Health status (excellent/very good/good)									
Major cities										
Admitted to hospital	± %	1.4	1.8	1.8	1.8	1.3	..	2.1	..	0.8
Casualty/outpatients/ day clinic	± %	0.8	1.1	1.1	1.3	1.0	..	1.3	..	0.5
Doctor consultation (GP and/or specialist)	± %	1.7	1.8	2.8	2.6	2.2	..	3.0	..	1.0
Dental consultation (d)	± %	0.9	1.2	1.1	1.4	1.1	..	1.4	..	0.5
Consultation with other health professional	± %	1.4	1.5	2.3	2.0	1.6	..	1.7	..	0.8
Total accessing health care (e)	**± %**	**2.1**	**2.3**	**3.0**	**2.8**	**2.7**	**..**	**3.3**	**..**	**1.2**
Inner regional										
Admitted to hospital	± %	3.3	3.1	2.7	5.8	3.4	2.2	..	..	1.4
Casualty/outpatients/ day clinic	± %	1.7	1.7	1.4	1.9	2.3	1.1	..	..	0.8
Doctor consultation (GP and/or specialist)	± %	3.1	3.4	3.0	5.7	5.2	2.4	..	..	1.4
Dental consultation (d)	± %	1.9	2.4	2.2	3.5	3.2	1.3	..	..	1.0
Consultation with other health professional	± %	2.6	3.3	2.8	4.3	4.6	2.0	..	..	1.5
Total accessing health care (e)	**± %**	**4.6**	**5.5**	**4.0**	**8.4**	**6.5**	**3.1**	**..**	**..**	**2.2**
Outer regional										
Admitted to hospital	± %	4.6	4.9	3.4	6.0	4.9	3.4	..	12.0	2.0
Casualty/outpatients/ day clinic	± %	2.7	5.2	1.7	2.0	3.1	np	..	np	1.2
Doctor consultation (GP and/or specialist)	± %	5.4	7.6	3.1	6.6	5.5	3.9	..	18.3	2.4
Dental consultation (d)	± %	2.9	3.4	1.6	2.0	2.5	2.4	..	3.4	1.1
Consultation with other health professional	± %	3.9	11.0	3.4	4.3	3.9	3.6	..	17.3	2.4
Total accessing health care (e)	**± %**	**6.8**	**10.3**	**4.2**	**7.7**	**7.2**	**5.3**	**..**	**19.6**	**3.4**
Remote										
Admitted to hospital	± %	np	..	6.4	11.4	8.5	8.4	..	np	4.4
Casualty/outpatients/ day clinic	± %	np	..	7.1	10.6	4.0	np	..	np	3.7
Doctor consultation (GP and/or specialist)	± %	54.9	..	11.7	9.9	8.4	np	..	np	6.5
Dental consultation (d)	± %	–	..	np	7.2	4.4	np	..	8.8	2.6
Consultation with other health professional	± %	–	..	9.6	8.2	4.9	5.0	..	12.2	3.7
Total accessing health care (e)	**± %**	**39.6**	**..**	**11.9**	**13.6**	**11.3**	**23.6**	**..**	**34.2**	**7.4**

Table EA.59 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
		95 per cent confidence interval for Health status (fair/poor)								
Major cities										
Admitted to hospital	± %	6.2	4.3	6.0	7.9	5.8	..	7.3	..	2.8
Casualty/outpatients/ day clinic	± %	3.4	3.3	5.4	5.2	3.4	..	2.6	..	1.6
Doctor consultation (GP and/or specialist)	± %	6.3	6.1	8.6	7.3	7.5	..	7.1	..	3.0
Dental consultation (d)	± %	4.0	4.2	3.4	4.0	5.4	..	3.7	..	2.0
Consultation with other health professional	± %	3.9	5.2	7.3	7.4	5.3	..	7.9	..	2.3
Total accessing health care (e)	**± %**	**7.2**	**7.0**	**8.5**	**8.7**	**6.3**	**..**	**8.2**	**..**	**3.6**
Inner regional										
Admitted to hospital	± %	8.0	11.6	6.6	12.5	11.3	6.7	..	..	4.0
Casualty/outpatients/ day clinic	± %	6.7	7.1	6.8	8.7	17.0	6.2	..	..	3.0
Doctor consultation (GP and/or specialist)	± %	10.7	13.0	9.3	16.0	11.8	9.7	..	..	4.7
Dental consultation (d)	± %	3.1	4.9	4.4	np	np	3.6	..	..	1.9
Consultation with other health professional	± %	13.6	14.6	6.6	21.3	11.1	7.0	..	..	6.1
Total accessing health care (e)	**± %**	**10.6**	**9.9**	**9.2**	**16.7**	**12.7**	**8.1**	**..**	**..**	**4.8**
Outer regional										
Admitted to hospital	± %	12.3	16.5	9.3	17.5	10.1	10.0	..	59.1	6.2
Casualty/outpatients/ day clinic	± %	3.5	5.8	5.1	np	7.3	7.0	..	np	2.5
Doctor consultation (GP and/or specialist)	± %	12.5	15.1	11.6	23.1	16.0	12.4	..	44.7	6.1
Dental consultation (d)	± %	3.1	np	3.1	5.2	9.6	2.7	..	np	1.8
Consultation with other health professional	± %	10.5	16.1	11.0	np	14.2	8.3	..	np	6.8
Total accessing health care (e)	**± %**	**12.7**	**17.0**	**11.1**	**21.2**	**17.2**	**15.1**	**..**	**59.1**	**6.6**
Remote										
Admitted to hospital	± %	np	..	23.3	np	np	12.3	..	np	12.0
Casualty/outpatients/ day clinic	± %	np	..	np	np	np	np	..	np	9.7
Doctor consultation (GP and/or specialist)	± %	np	..	38.0	21.5	13.0	18.2	..	49.7	16.3
Dental consultation (d)	± %	–	..	np	np	np	–	..	np	8.1
Consultation with other health professional	± %	np	..	np	–	56.7	26.9	..	29.4	16.8
Total accessing health care (e)	**± %**	**118.5**	**..**	**30.2**	**55.6**	**45.8**	**22.4**	**..**	**25.2**	**16.8**

Table EA.59 **Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 (a), (b), (c)**

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

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15 years).

(b) Persons who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

(c) Limited to people aged 15 years or over.

(d) Data presented for 2004-05 for ‘Dental consultation’ relate to 'in the last 2 weeks', and are not comparable with 2011-12 data.

(e) Total persons accessing any of the selected health services above. Components may not add to total because persons may have accessed more than one type of health service. Data for 2004-05 are not comparable with data for 2011-12.

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

Source : ABS (unpublished) *National Health Survey, 2004-05* .

Table EA.60 Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d)	Aust
					Health status (excellent/very good/good)					
Quintile 1										
Admitted to hospital	%	12.7	13.0	8.4	16.3	8.3	14.6	np	16.5	12.0
Casualty/outpatients/day clinic	%	2.3	3.7	np	4.0	3.5	np	np	–	2.8
Doctor consultation (GP and/or specialist)	%	26.4	20.2	22.4	22.4	26.1	23.1	np	17.4	23.6
Dental consultation	%	15.3	13.0	12.2	11.6	15.3	12.6	np	16.0	14.0
Consultation with other health professional	%	6.3	4.2	5.2	5.1	7.6	3.2	np	np	5.6
Total accessing health care (d)	**%**	**31.8**	**23.8**	**26.8**	**25.0**	**30.2**	**26.3**	**18.7**	**18.8**	**28.1**
Quintile 2										
Admitted to hospital	%	11.9	13.3	9.3	11.4	12.0	7.5	np	12.3	11.6
Casualty/outpatients/day clinic	%	3.4	2.3	2.5	3.4	3.1	np	–	np	2.8
Doctor consultation (GP and/or specialist)	%	23.9	21.6	25.6	22.0	21.5	16.5	25.0	22.6	23.1
Dental consultation	%	15.3	16.5	15.7	14.7	19.3	18.4	19.8	10.3	16.1
Consultation with other health professional	%	5.6	6.9	5.9	4.6	8.7	5.4	np	np	6.2
Total accessing health care (d)	**%**	**27.0**	**25.7**	**30.6**	**26.8**	**26.7**	**20.1**	**26.8**	**26.0**	**27.4**
Quintile 3										
Admitted to hospital	%	7.5	11.3	10.4	9.9	13.8	7.9	10.9	12.1	10.0
Casualty/outpatients/day clinic	%	np	2.0	3.1	np	np	np	np	np	2.1
Doctor consultation (GP and/or specialist)	%	21.1	25.9	21.9	19.9	16.9	24.0	23.6	24.2	22.4
Dental consultation	%	14.8	19.2	17.2	16.8	21.3	12.6	13.4	13.6	16.9
Consultation with other health professional	%	4.8	9.9	5.9	5.4	5.9	4.2	4.3	3.9	6.5
Total accessing health care (d)	**%**	**24.5**	**32.4**	**25.6**	**24.2**	**22.3**	**26.4**	**26.1**	**27.3**	**26.9**
Quintile 4										
Admitted to hospital	%	10.2	10.2	12.2	12.4	10.7	13.6	15.1	15.6	11.2
Casualty/outpatients/day clinic	%	np	np	2.4	3.9	2.7	–	np	np	2.0
Doctor consultation (GP and/or specialist)	%	22.8	21.7	25.8	19.8	19.4	26.3	21.9	27.8	22.5
Dental consultation	%	18.2	21.1	16.9	19.9	24.3	20.9	16.3	17.6	19.2
Consultation with other health professional	%	8.8	11.2	8.7	6.7	7.3	8.4	12.7	11.3	9.0
Total accessing health care (d)	**%**	**28.4**	**28.2**	**29.9**	**25.4**	**24.8**	**29.7**	**29.5**	**34.0**	**27.9**
Quintile 5										
Admitted to hospital	%	12.1	9.1	14.6	13.4	13.9	np	11.9	np	11.9
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	3.2	np	1.3
Doctor consultation (GP and/or specialist)	%	19.3	18.6	26.1	21.4	23.3	13.2	20.5	19.5	20.6
Dental consultation	%	19.3	23.4	23.8	23.0	20.5	17.9	19.9	19.0	21.6

Table EA.60 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
Consultation with other health professional	%	7.1	8.1	6.5	6.5	13.6	np	8.4	np	7.5
Total accessing health care (d)	**%**	**23.5**	**25.0**	**30.2**	**25.3**	**33.1**	**19.3**	**26.9**	**21.3**	**25.6**
					Health status (fair/poor)					
Quintile 1										
Admitted to hospital	%	24.7	29.4	23.5	33.3	22.7	18.7	np	np	25.6
Casualty/outpatients/day clinic	%	np	13.9	10.8	np	18.5	6.5	np	np	8.2
Doctor consultation (GP and/or specialist)	%	39.5	55.5	48.8	42.8	32.3	35.4	np	37.2	44.4
Dental consultation	%	18.8	7.5	13.3	np	13.5	15.0	np	np	13.5
Consultation with other health professional	%	6.4	13.9	10.4	np	11.6	11.3	np	np	10.4
Total accessing health care (d)	**%**	**40.4**	**56.5**	**59.8**	**47.4**	**49.3**	**39.5**	**47.1**	**42.6**	**48.9**
Quintile 2										
Admitted to hospital	%	27.0	15.2	25.3	16.4	23.5	32.0	np	np	23.1
Casualty/outpatients/day clinic	%	np	np	11.0	np	6.0	np	np	np	6.8
Doctor consultation (GP and/or specialist)	%	45.7	53.4	50.6	41.2	42.0	38.6	np	27.3	47.6
Dental consultation	%	23.9	20.9	22.4	np	18.1	18.2	np	np	20.9
Consultation with other health professional	%	12.9	14.0	13.5	np	12.1	10.4	np	np	13.1
Total accessing health care (d)	**%**	**50.0**	**56.1**	**58.2**	**45.5**	**46.9**	**47.2**	**np**	**37.4**	**52.4**
Quintile 3										
Admitted to hospital	%	18.9	22.8	32.8	24.2	11.6	18.7	np	31.8	24.1
Casualty/outpatients/day clinic	%	np	np	np	np	np	np	np	np	4.2
Doctor consultation (GP and/or specialist)	%	40.0	50.9	37.7	34.0	38.8	53.4	37.8	np	42.6
Dental consultation	%	19.6	15.6	6.4	17.5	21.9	np	np	31.0	15.5
Consultation with other health professional	%	13.8	np	12.8	14.1	np	np	np	np	13.3
Total accessing health care (d)	**%**	**43.9**	**57.2**	**44.4**	**35.7**	**40.3**	**55.0**	**45.2**	**37.7**	**47.2**
Quintile 4										
Admitted to hospital	%	13.2	15.5	37.6	27.1	38.4	np	24.9	31.3	20.2
Casualty/outpatients/day clinic	%	–	np	np	np	np	np	np	np	5.5
Doctor consultation (GP and/or specialist)	%	36.1	55.5	31.1	29.1	43.8	35.5	32.7	42.2	40.0
Dental consultation	%	np	np	22.3	18.4	17.8	np	np	np	15.5
Consultation with other health professional	%	14.2	np	np	21.5	np	np	21.8	np	14.6
Total accessing health care (d)	**%**	**39.5**	**57.3**	**33.1**	**50.9**	**46.0**	**35.5**	**45.2**	**48.5**	**46.6**
Quintile 5										
Admitted to hospital	%	15.0	24.7	np	17.6	33.8	np	20.9	34.7	20.6
Casualty/outpatients/day clinic	%	np	np	np	–	np	np	np	np	6.1

Table EA.60 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d)	Aust
Doctor consultation (GP and/or specialist)	%	37.6	44.2	29.7	32.0	38.9	np	34.0	54.4	40.0
Dental consultation	%	25.0	25.0	np	22.6	23.9	np	15.1	np	25.2
Consultation with other health professional	%	np	30.0	np	np	np	np	22.9	np	18.2
Total accessing health care (d)	**%**	**44.8**	**48.0**	**32.5**	**37.6**	**56.9**	**np**	**43.4**	**57.8**	**46.0**
95 per cent confidence interval for Health status (excellent/very good/good)										
Quintile 1										
Admitted to hospital	± %	2.9	3.4	3.6	7.0	3.3	4.2	np	11.5	1.6
Casualty/outpatients/day clinic	± %	1.3	2.0	np	2.4	2.3	np	np	–	0.8
Doctor consultation (GP and/or specialist)	± %	4.3	3.8	5.4	5.1	4.6	4.5	np	9.1	2.4
Dental consultation	± %	3.5	3.8	4.7	5.1	4.2	3.9	np	7.2	1.8
Consultation with other health professional	± %	2.3	2.5	2.9	3.0	3.7	1.8	np	np	1.1
Total accessing health care (d)	**± %**	**4.5**	**4.1**	**6.4**	**4.8**	**4.6**	**4.3**	**8.4**	**8.4**	**2.6**
Quintile 2										
Admitted to hospital	± %	3.8	3.5	2.5	3.7	3.2	3.0	np	7.4	1.8
Casualty/outpatients/day clinic	± %	1.9	1.5	1.7	2.0	1.6	np	–	np	0.7
Doctor consultation (GP and/or specialist)	± %	4.8	5.1	3.7	4.8	3.7	4.4	12.3	13.0	2.2
Dental consultation	± %	3.4	4.2	3.2	4.2	4.6	5.3	14.9	6.1	1.5
Consultation with other health professional	± %	2.4	2.8	2.1	1.9	3.0	3.3	np	np	1.2
Total accessing health care (d)	**± %**	**4.8**	**4.8**	**4.1**	**4.9**	**4.5**	**4.9**	**14.3**	**12.8**	**2.3**
Quintile 3										
Admitted to hospital	± %	2.7	2.7	2.8	3.5	4.6	3.7	4.6	4.8	1.5
Casualty/outpatients/day clinic	± %	np	1.4	1.8	np	np	np	np	np	0.6
Doctor consultation (GP and/or specialist)	± %	4.6	4.1	4.3	4.1	4.7	5.5	6.6	7.8	2.1
Dental consultation	± %	3.7	4.2	4.1	3.9	6.0	3.7	6.1	4.6	2.2
Consultation with other health professional	± %	1.6	2.9	1.8	3.1	3.1	2.5	2.9	2.1	1.1
Total accessing health care (d)	**± %**	**4.6**	**4.5**	**4.2**	**5.0**	**4.6**	**5.4**	**6.6**	**7.8**	**2.2**
Quintile 4										
Admitted to hospital	± %	3.5	2.5	3.4	2.9	3.4	5.1	4.3	8.7	1.3
Casualty/outpatients/day clinic	± %	np	np	1.3	2.4	1.8	–	np	np	0.9
Doctor consultation (GP and/or specialist)	± %	4.3	4.1	4.6	4.3	5.2	8.7	4.5	7.5	1.9
Dental consultation	± %	4.7	4.8	4.0	4.6	5.3	7.4	5.8	6.7	2.4
Consultation with other health professional	± %	2.2	3.7	2.8	2.5	3.1	5.1	4.6	5.3	1.3
Total accessing health care (d)	**± %**	**3.9**	**4.7**	**4.7**	**5.3**	**5.5**	**9.8**	**5.6**	**7.9**	**1.9**

Table EA.60 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (d)	Aust
Quintile 5										
Admitted to hospital	± %	3.5	2.8	4.4	3.3	5.8	np	3.2	np	1.7
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	1.3	np	0.7
Doctor consultation (GP and/or specialist)	± %	3.5	3.5	4.9	4.3	5.7	7.5	2.9	10.2	1.9
Dental consultation	± %	3.2	3.9	4.5	5.3	6.4	8.0	2.8	8.5	1.6
Consultation with other health professional	± %	2.2	2.2	3.0	2.5	6.4	np	2.5	np	1.2
Total accessing health care (d)	**± %**	**3.9**	**3.7**	**5.4**	**5.0**	**7.4**	**11.3**	**3.4**	**10.5**	**2.0**
		95 per cent confidence interval for Health status (fair/poor)								
Quintile 1										
Admitted to hospital	± %	10.6	19.7	11.9	17.4	9.9	6.4	np	np	6.0
Casualty/outpatients/day clinic	± %	np	17.9	6.7	np	21.8	6.0	np	np	2.6
Doctor consultation (GP and/or specialist)	± %	9.5	19.0	12.8	20.4	10.2	10.5	np	13.4	5.0
Dental consultation	± %	8.6	5.1	7.8	np	9.8	9.8	np	np	3.9
Consultation with other health professional	± %	3.8	17.6	6.1	np	8.3	5.9	np	np	3.0
Total accessing health care (d)	**± %**	**9.4**	**18.9**	**12.6**	**15.9**	**20.8**	**9.6**	**23.0**	**12.2**	**5.2**
Quintile 2										
Admitted to hospital	± %	12.4	8.4	9.7	14.3	8.7	18.0	np	np	5.1
Casualty/outpatients/day clinic	± %	np	np	8.1	np	4.5	np	np	np	2.3
Doctor consultation (GP and/or specialist)	± %	21.0	13.6	11.9	18.8	10.8	16.1	np	25.6	6.7
Dental consultation	± %	17.5	11.8	14.7	np	8.3	14.1	np	np	5.3
Consultation with other health professional	± %	7.8	8.0	9.3	np	5.9	7.4	np	np	4.2
Total accessing health care (d)	**± %**	**21.2**	**13.8**	**10.7**	**17.0**	**10.7**	**18.1**	**np**	**36.5**	**6.7**
Quintile 3										
Admitted to hospital	± %	7.1	12.1	9.0	9.0	12.7	11.9	np	24.0	4.5
Casualty/outpatients/day clinic	± %	np	np	np	np	np	np	np	np	2.2
Doctor consultation (GP and/or specialist)	± %	12.5	17.6	11.7	14.0	23.4	17.4	21.9	np	7.4
Dental consultation	± %	9.5	11.9	4.8	12.3	19.3	np	np	24.6	4.1
Consultation with other health professional	± %	7.5	np	7.9	10.5	np	np	np	np	4.1
Total accessing health care (d)	**± %**	**12.6**	**16.0**	**8.6**	**13.9**	**23.4**	**17.4**	**15.5**	**33.6**	**6.9**
Quintile 4										
Admitted to hospital	± %	7.5	14.2	35.6	12.9	27.3	np	15.5	34.2	5.0
Casualty/outpatients/day clinic	± %	–	np	np	np	np	np	np	np	3.4
Doctor consultation (GP and/or specialist)	± %	18.7	37.2	9.2	12.4	19.2	29.4	24.0	29.6	7.8
Dental consultation	± %	np	np	11.8	13.2	12.8	np	np	np	5.6

Table EA.60 **Proportion of people who accessed health services by health status, by SEIFA, 2011-12 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
Consultation with other health professional	± %	15.4	np	np	13.1	np	np	20.0	np	5.1
Total accessing health care (d)	**± %**	**19.0**	**36.7**	**8.3**	**18.2**	**20.8**	**29.4**	**24.9**	**29.6**	**7.9**
Quintile 5										
Admitted to hospital	± %	9.5	24.2	np	10.6	28.7	np	13.6	25.4	6.7
Casualty/outpatients/day clinic	± %	np	np	np	–	np	np	np	np	4.9
Doctor consultation (GP and/or specialist)	± %	17.7	23.3	19.4	17.8	40.8	np	13.1	30.4	8.4
Dental consultation	± %	19.1	17.6	np	19.4	27.0	np	12.0	np	7.2
Consultation with other health professional	± %	np	26.8	np	np	np	np	11.7	np	7.0
Total accessing health care (d)	**± %**	**20.9**	**24.9**	**19.2**	**15.8**	**20.4**	**np**	**14.8**	**36.0**	**8.5**

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (10 year age ranges from 15 years).

(b) Persons aged 15 years or over who were admitted to hospital in the last 12 months, consulted a dentist in the last 3 months or who visited casualty, an outpatient clinic, day clinic or consulted a GP, specialist or other health professional in the last 2 weeks.

(c) Changes to question methodology mean that data items for 2011-12 are not comparable with 2004-05. In 2004-05 respondents were asked individual questions on actions they had taken for their health (for example, consulting a general practitioner in the last 2 weeks) while in 2011-12 respondents were asked to identify from a prompt card which actions they had undertaken in the last 12 months. If the respondent answered yes to any of these actions they were then asked separate questions about whether they had done so in the last 2 weeks. Changes in data between 2004-05 and 2011-12 may therefore be due to changes in question methodology rather than changes in the proportion of people undertaking particular actions.

(d) Data for the NT should be used with care as very remote areas are excluded from the Australian Health Survey, which translates to the exclusion of around 23 per cent of the NT population.

(e) Data presented for 2011-12 for ‘Dental consultation’ relate to 'in the last 3 months', and are not comparable with 2004-05 data.

(f) Total persons accessing casualty/outpatients/day clinic or consulting a doctor (GP and/or specialist) or other health professional in the last 2 weeks. Data for 2004-05 and 2011-12 are not comparable.

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

Source : ABS unpublished *Australian Health Survey, 2011-13* (National Health Survey 2011-12 component)

Table EA.61 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Health status (excellent/very good/good)					
Quintile 1										
Admitted to hospital	%	14.5	12.5	14.5	15.7	13.7	13.7	np	np	14.0
Casualty/outpatients/day clinic	%	3.6	5.6	3.2	4.1	4.6	4.3	–	–	4.1
Doctor consultation (GP and/or specialist)	%	25.2	25.2	21.6	15.6	23.7	21.8	np	np	23.5
Dental consultation (d)	%	4.4	2.6	3.7	7.8	3.4	4.5	–	–	4.0
Consultation with other health professional	%	9.6	8.3	10.5	12.0	11.2	9.2	–	–	9.7
Total accessing health care (e)	**%**	**42.5**	**39.1**	**39.1**	**34.9**	**42.3**	**38.3**	**np**	**np**	**40.3**
Quintile 2										
Admitted to hospital	%	15.0	15.5	12.3	16.1	13.6	8.6	np	np	14.3
Casualty/outpatients/day clinic	%	4.0	7.9	3.1	6.5	6.0	np	6.8	np	4.8
Doctor consultation (GP and/or specialist)	%	20.7	20.2	21.5	23.4	23.4	20.3	np	np	21.4
Dental consultation (d)	%	4.2	4.2	4.1	4.4	6.4	8.4	np	np	4.4
Consultation with other health professional	%	11.7	14.9	12.8	13.7	14.1	12.8	10.5	–	12.9
Total accessing health care (e)	**%**	**41.5**	**39.5**	**38.4**	**42.7**	**44.7**	**37.8**	**np**	**np**	**40.7**
Quintile 3										
Admitted to hospital	%	13.1	12.4	12.4	17.4	16.5	12.7	np	np	13.5
Casualty/outpatients/day clinic	%	3.0	5.4	3.7	3.3	5.2	np	np	np	3.9
Doctor consultation (GP and/or specialist)	%	19.8	18.7	20.1	20.4	27.3	22.8	12.6	51.8	20.4
Dental consultation (d)	%	6.4	6.0	5.6	6.4	7.0	3.2	np	np	6.1
Consultation with other health professional	%	12.3	14.2	15.6	13.7	14.1	12.9	9.6	32.6	13.9
Total accessing health care (e)	**%**	**41.0**	**39.8**	**43.3**	**44.0**	**48.3**	**41.1**	**16.5**	**66.2**	**42.0**
Quintile 4										
Admitted to hospital	%	13.2	12.9	14.0	11.1	13.1	14.5	15.0	8.1	13.1
Casualty/outpatients/day clinic	%	3.1	5.7	4.4	3.5	3.6	6.0	2.1	–	4.3
Doctor consultation (GP and/or specialist)	%	21.8	22.2	18.6	22.0	19.8	23.8	np	np	20.8
Dental consultation (d)	%	5.7	6.3	6.1	5.8	7.6	9.2	5.7	5.5	6.2
Consultation with other health professional	%	11.0	14.6	13.0	12.5	15.8	13.2	np	np	13.3
Total accessing health care (e)	**%**	**42.5**	**41.3**	**40.6**	**39.7**	**43.8**	**44.8**	**37.8**	**19.9**	**41.3**
Quintile 5										
Admitted to hospital	%	15.0	14.9	14.8	17.7	11.9	14.7	12.9	28.1	14.9
Casualty/outpatients/day clinic	%	3.3	4.5	3.9	5.9	3.6	5.1	np	np	4.1
Doctor consultation (GP and/or specialist)	%	18.8	21.4	20.9	27.4	17.4	17.1	20.3	30.4	20.6
Dental consultation (d)	%	6.8	7.8	7.3	8.2	7.0	8.4	np	np	7.3

Table EA.61 Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Consultation with other health professional	%	13.7	17.4	20.2	14.4	14.7	20.4	np	np	15.8
Total accessing health care (e)	**%**	**41.7**	**46.2**	**46.2**	**49.2**	**39.1**	**45.6**	**39.8**	**64.3**	**44.1**
					Health status (fair/poor)					
Quintile 1										
Admitted to hospital	%	25.7	25.0	26.0	30.5	20.5	26.0	–	–	25.4
Casualty/outpatients/day clinic	%	11.2	9.6	12.1	6.4	13.7	10.6	np	np	11.0
Doctor consultation (GP and/or specialist)	%	45.9	49.2	51.1	28.9	38.1	45.0	np	np	46.0
Dental consultation (d)	%	4.5	5.3	np	np	7.6	3.1	–	–	4.4
Consultation with other health professional	%	15.0	15.5	25.3	10.4	13.4	16.4	–	–	17.0
Total accessing health care (e)	**%**	**64.7**	**66.5**	**73.7**	**60.6**	**61.4**	**58.2**	**np**	**np**	**66.0**
Quintile 2										
Admitted to hospital	%	33.6	30.4	30.0	27.0	27.2	18.2	np	np	30.8
Casualty/outpatients/day clinic	%	3.1	11.6	11.8	13.1	5.8	4.5	np	np	7.5
Doctor consultation (GP and/or specialist)	%	36.0	48.0	47.5	56.1	36.8	46.1	44.7	–	42.3
Dental consultation (d)	%	6.9	5.7	4.2	np	10.3	np	–	–	6.3
Consultation with other health professional	%	18.7	25.3	30.2	34.2	23.5	18.3	np	np	24.3
Total accessing health care (e)	**%**	**62.1**	**71.2**	**70.9**	**70.4**	**64.6**	**54.9**	**np**	**np**	**66.0**
Quintile 3										
Admitted to hospital	%	23.1	24.6	28.6	28.4	20.8	34.9	–	34.6	25.4
Casualty/outpatients/day clinic	%	11.5	13.8	8.6	9.8	12.2	12.6	np	np	11.6
Doctor consultation (GP and/or specialist)	%	47.4	49.0	36.3	29.7	52.4	42.7	np	np	44.2
Dental consultation (d)	%	3.2	2.6	9.0	4.8	9.4	np	–	np	4.7
Consultation with other health professional	%	29.0	22.1	23.8	14.4	35.3	30.5	np	np	24.6
Total accessing health care (e)	**%**	**59.1**	**65.1**	**54.6**	**52.5**	**68.1**	**60.8**	**np**	**np**	**59.7**
Quintile 4										
Admitted to hospital	%	22.0	25.7	19.6	29.1	34.0	29.8	26.2	34.1	24.6
Casualty/outpatients/day clinic	%	8.2	8.8	8.1	25.1	13.4	19.2	3.9	–	10.0
Doctor consultation (GP and/or specialist)	%	37.0	40.1	30.8	38.3	45.7	36.9	27.5	35.6	37.2
Dental consultation (d)	%	11.3	4.3	np	np	9.9	np	3.8	np	7.3
Consultation with other health professional	%	18.0	22.0	18.0	33.9	29.8	22.3	np	np	22.0
Total accessing health care (e)	**%**	**52.5**	**61.8**	**52.0**	**70.2**	**63.1**	**59.3**	**61.0**	**80.6**	**57.9**
Quintile 5										
Admitted to hospital	%	32.1	18.8	22.1	26.6	26.4	26.2	np	np	25.7
Casualty/outpatients/day clinic	%	6.5	5.7	10.2	9.2	14.0	15.2	np	np	7.8

Table EA.61 Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Doctor consultation (GP and/or specialist)	%	43.4	34.0	43.0	32.2	37.6	48.3	np	np	38.3
Dental consultation (d)	%	3.7	18.9	14.0	8.7	6.7	14.1	10.1	–	10.8
Consultation with other health professional	%	18.5	27.9	19.3	21.4	22.8	20.1	np	np	23.1
Total accessing health care (e)	**%**	**60.6**	**64.9**	**57.3**	**60.8**	**67.5**	**60.1**	**59.1**	**100.0**	**62.4**
95 per cent confidence interval for Health status (excellent/very good/good)										
Quintile 1										
Admitted to hospital	± %	2.7	3.4	3.2	6.2	3.2	2.7	np	np	1.7
Casualty/outpatients/day clinic	± %	1.5	2.6	1.5	2.5	1.8	1.4	–	–	0.9
Doctor consultation (GP and/or specialist)	± %	4.0	4.7	3.1	5.9	4.6	3.3	np	np	2.2
Dental consultation (d)	± %	1.8	1.5	1.7	3.6	1.6	1.5	–	–	0.9
Consultation with other health professional	± %	2.8	3.0	3.6	5.4	3.2	2.1	–	–	1.4
Total accessing health care (e)	**± %**	**4.3**	**4.8**	**3.9**	**6.8**	**4.7**	**3.9**	**np**	**np**	**2.4**
Quintile 2										
Admitted to hospital	± %	3.4	4.6	2.5	3.2	3.5	6.2	np	np	1.7
Casualty/outpatients/day clinic	± %	1.7	3.9	1.2	2.5	1.8	np	5.7	np	1.0
Doctor consultation (GP and/or specialist)	± %	3.1	6.5	2.9	3.6	4.2	7.8	np	np	1.7
Dental consultation (d)	± %	1.4	2.2	1.5	1.7	2.0	5.5	np	np	0.7
Consultation with other health professional	± %	2.1	4.6	2.8	3.2	3.2	5.5	19.6	–	1.4
Total accessing health care (e)	**± %**	**4.6**	**7.2**	**3.2**	**4.4**	**4.8**	**8.7**	**np**	**np**	**2.3**
Quintile 3										
Admitted to hospital	± %	2.4	2.5	3.8	3.9	3.4	3.9	np	np	1.3
Casualty/outpatients/day clinic	± %	1.3	2.2	2.1	1.8	2.6	np	np	np	0.7
Doctor consultation (GP and/or specialist)	± %	3.8	3.3	4.1	5.1	5.0	7.1	34.5	42.1	1.8
Dental consultation (d)	± %	1.9	2.1	2.0	2.3	2.4	2.5	np	np	1.0
Consultation with other health professional	± %	2.7	2.9	3.3	4.2	3.6	5.4	13.0	46.2	1.4
Total accessing health care (e)	**± %**	**4.5**	**4.4**	**5.5**	**5.9**	**6.0**	**7.5**	**26.3**	**32.1**	**2.2**
Quintile 4										
Admitted to hospital	± %	3.8	2.8	2.7	3.8	2.7	6.0	4.3	5.9	1.5
Casualty/outpatients/day clinic	± %	1.9	1.6	1.9	1.8	1.3	4.5	1.5	–	0.8
Doctor consultation (GP and/or specialist)	± %	4.6	2.7	2.6	5.5	2.3	4.8	np	np	1.6
Dental consultation (d)	± %	1.7	2.1	1.9	3.0	2.0	4.6	3.3	8.9	0.9
Consultation with other health professional	± %	2.9	2.8	2.7	4.5	2.6	6.3	np	np	1.5
Total accessing health care (e)	**± %**	**5.8**	**3.4**	**3.6**	**7.2**	**3.8**	**7.8**	**6.1**	**18.3**	**2.4**

Table EA.61 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Quintile 5										
Admitted to hospital	± %	2.7	3.3	4.1	4.8	2.9	6.0	2.5	43.9	1.5
Casualty/outpatients/day clinic	± %	1.5	1.5	1.9	2.6	2.2	3.1	np	np	0.9
Doctor consultation (GP and/or specialist)	± %	2.2	2.6	3.7	4.7	3.0	5.1	3.9	36.7	1.3
Dental consultation (d)	± %	1.8	2.4	2.2	3.0	2.6	3.9	np	np	1.1
Consultation with other health professional	± %	2.6	3.5	5.1	3.7	2.9	6.8	np	np	1.8
Total accessing health care (e)	**± %**	**3.5**	**3.6**	**5.7**	**5.4**	**4.6**	**6.9**	**4.0**	**30.6**	**2.0**
		95 per cent confidence interval for Health status (fair/poor)								
Quintile 1										
Admitted to hospital	± %	9.1	9.5	7.5	16.7	11.5	9.2	–	–	4.8
Casualty/outpatients/day clinic	± %	7.9	5.0	7.2	8.4	9.3	5.9	np	np	3.3
Doctor consultation (GP and/or specialist)	± %	8.2	12.1	12.1	13.7	12.4	10.1	np	np	5.1
Dental consultation (d)	± %	4.1	5.5	np	np	7.6	3.7	–	–	2.2
Consultation with other health professional	± %	6.6	8.1	8.8	10.6	7.8	6.3	–	–	3.9
Total accessing health care (e)	**± %**	**8.9**	**11.4**	**9.0**	**18.7**	**12.0**	**12.3**	**np**	**np**	**4.6**
Quintile 2										
Admitted to hospital	± %	10.4	12.6	7.8	11.6	8.3	16.7	np	np	5.8
Casualty/outpatients/day clinic	± %	2.0	6.6	7.2	8.7	3.6	6.9	np	np	2.2
Doctor consultation (GP and/or specialist)	± %	9.0	13.5	10.9	10.9	11.0	15.9	57.8	–	4.6
Dental consultation (d)	± %	8.3	7.4	2.8	np	10.4	np	–	–	4.0
Consultation with other health professional	± %	7.6	12.1	8.3	11.7	9.0	18.6	np	np	4.8
Total accessing health care (e)	**± %**	**11.4**	**16.8**	**7.4**	**12.1**	**11.8**	**17.7**	**np**	**np**	**5.8**
Quintile 3										
Admitted to hospital	± %	9.6	9.8	9.0	12.6	8.2	16.7	–	78.5	5.0
Casualty/outpatients/day clinic	± %	6.1	7.7	6.1	8.0	8.3	12.3	np	np	3.5
Doctor consultation (GP and/or specialist)	± %	11.3	15.7	13.6	10.7	16.7	16.6	np	np	6.7
Dental consultation (d)	± %	2.7	3.2	6.0	5.1	9.1	np	–	np	1.9
Consultation with other health professional	± %	12.7	9.8	10.2	9.7	16.2	15.9	np	np	5.9
Total accessing health care (e)	**± %**	**12.7**	**13.4**	**13.0**	**13.9**	**17.3**	**16.5**	**np**	**np**	**6.4**
Quintile 4										
Admitted to hospital	± %	8.7	9.4	7.6	14.8	9.4	16.5	15.5	34.4	4.3
Casualty/outpatients/day clinic	± %	8.7	5.4	4.9	15.0	7.0	20.2	4.2	–	3.2
Doctor consultation (GP and/or specialist)	± %	12.6	9.4	10.8	17.0	9.4	28.8	13.2	30.6	5.3
Dental consultation (d)	± %	8.4	3.8	np	np	9.6	np	4.6	np	3.3

Table EA.61 **Proportion of people who accessed health services by health status, by SEIFA, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Consultation with other health professional	± %	9.3	11.0	7.0	18.4	7.6	19.9	np	np	4.2
Total accessing health care (e)	**± %**	**13.8**	**11.5**	**10.2**	**15.1**	**9.0**	**25.4**	**16.8**	**41.1**	**6.1**
Quintile 5										
Admitted to hospital	± %	12.1	10.0	16.6	17.4	10.7	13.2	np	np	5.2
Casualty/outpatients/day clinic	± %	4.7	4.6	13.6	6.6	12.5	16.8	np	np	3.0
Doctor consultation (GP and/or specialist)	± %	11.8	13.6	19.0	15.3	16.1	18.7	np	np	6.0
Dental consultation (d)	± %	3.7	13.4	10.8	12.0	6.0	12.8	6.2	–	4.5
Consultation with other health professional	± %	8.9	12.7	13.6	14.8	13.1	17.9	np	np	5.0
Total accessing health care (e)	**± %**	**11.8**	**14.1**	**23.6**	**24.8**	**13.3**	**20.0**	**9.8**	**–**	**6.9**

(a) Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year age ranges from 15 years).

(b) Persons who accessed at least one of the health services noted in the table in the last two weeks or were admitted to hospital in the last 12 months.

(c) Limited to people aged 15 years or over.

(d) Data presented for 2004-05 for ‘Dental consultation’ relate to 'in the last 2 weeks', and are not comparable with 2011-12 data.

(e) Total persons accessing any of the selected health services above. Components may not add to total because persons may have accessed more than one type of health service. Data for 2004-05 are not comparable with data for 2011-12.

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

Source : ABS (unpublished), *National Health Survey, 2004-05* .

Data quality information — Health sector overview E

Data quality information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of measures from performance indicators in the Health sector summary. 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 measures:

Babies born of low birthweight

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator

The incidence of low birthweight among liveborn babies of Aboriginal and Torres Strait Islander mothers and other mothers as a proportion of liveborn infants.

Measure (computation)

Numerator: Number of low birthweight live-born singleton infants born in a calendar year.

Low birthweight is defined as less than 2500 grams.

Denominator: Number of live-born singleton infants born in a calendar year.

Calculation: 100 × (Numerator ÷ Denominator)

Variability band: to be calculated using the standard method for estimating 95% confidence intervals as follows:

Crude rate

$$CI\ (CR)95\% = CR\ \pm 1.96\ \times CR/\sum_{\alpha}^{l} d$$

Where n=number of live-born singleton infants.

CI = confidence interval

CR = crude rate (expressed as a percentage)

Data source/s

This indicator is calculated using data from the AIHW National Perinatal Data Collection (NPDC).

For data by socioeconomic status: calculated by AIHW using the ABS' Socioeconomic Index for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSD). Each Statistical Local Area in Australia is ranked and divided into quintiles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

For data by remoteness: ABS' Australian Standard Geographical Classification.

Data Quality Framework Dimensions

Institutional environment

The National Perinatal Epidemiology and Statistics Unit (NPESU) calculated this indictor on behalf of the Australian Institute of Health and Welfare (AIHW).

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health and Ageing. For further information see the AIHW website.

The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.

Relevance

The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and

territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s).

The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation, except in WA, where births are included if gestational age is 20 weeks or more, or if gestation unknown, if birthweight is at least 400 grams, and in Victoria where livebirths are included or any gestational age and stillbirths if gestational age is 20 weeks or more, or if gestation unknown, if birthweight is at least 400 grams. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.

The NPDC includes all relevant data elements of interest for this indicator. Birthweight is a Perinatal NMDS item. In 2011, very few (0.02 per cent) records for live-born singleton babies were missing the data for birthweight.

While each jurisdiction has a unique perinatal form for collecting data on which the format of the Indigenous status question and recording categories varies slightly, all systems include the NMDS item on Indigenous status of mother.

No formal national assessment has been undertaken to determine completeness of the coverage of Indigenous mothers in the Perinatal NMDS. However, the proportion of Indigenous mothers for the period 2002–2011 has been consistent, at 3.6–3.9 per cent of women who gave birth. For maternal records where Indigenous status was not stated (0.2 per cent), data were excluded from Indigenous and non-Indigenous analyses.

The indicator is presented by Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD). The data supplied to the NPDC include a code for SLA from all states and territories. Reporting by remoteness is in accordance with the Australian Statistical Geography Standard (ASGS).

Timeliness

The reference period for the data is 2007 to 2011. Collection of data for the NPDC is annual.

Accuracy

Inaccurate responses may occur in all data provided to the AIHW. The AIHW does not have direct access to perinatal records to determine the accuracy of the data provided. However, the NPESU undertakes validation on receipt of data by the AIHW. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The NPESU does not adjust data to account for possible data errors.

Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the NPESU. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The NPESU does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers

reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.

The data supplied for the 2011 Perinatal NMDS by Victoria to prepare this indicator was provisional and subject to vary with data quality activities. Further minor changes to the data are not forseen to produce any detectable change to the indicator.

The geographical location code for the area of usual residence of the mother is included in the Perinatal NMDS. Only 0.1 per cent of records were non-residents or could not be assigned to a state or territory of residence. There is no scope in the data element Area of usual residence of mother to discriminate temporary residence of mother for the purposes of accessing birthing services from usual residence. The former may differentially impact populations from remote and very remote areas, where services are not available locally.

Birthweight is nearly universally reported. Less than 0.05 per cent of records were missing overall. Data presented by Indigenous status are influenced by the quality and completeness of Indigenous identification of mothers which is likely to differ among jurisdictions. Approximately 0.2 per cent of mothers who gave birth in the reference period had missing Indigenous status information. No adjustments have been made for under-identification or missing Indigenous status information and thus jurisdictional comparisons of Indigenous data should not be made.

Disaggregated data by Indigenous status is reported by single year for time series and by three-year combined data for the current reporting period. Single year data by Indigenous status should be used with caution due to the small number of low birthweight infants born to Indigenous mothers each year.

Coherence

Data for this indicator are published annually in *Australia's mothers and babies*; and biennially in reports such as the *Aboriginal and Torres Strait Islander Health Performance Framework* report, the *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, and the *Overcoming Indigenous Disadvantage* report. The numbers presented in these publications will differ slightly from those presented here as this measure excludes multiple births and stillbirths.

Changing levels of Indigenous identification over time and across jurisdictions may also affect the accuracy of compiling a consistent time series in future years.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing.

The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2007 through to 2010 reported by remoteness are reported for RA 2006. Data for 2011 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2010 and previous

years are not comparable to remoteness data for 2011 and subsequent years.

Data for 2007 through to 2010 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011 are reported using SEIFA 2011 at the SLA level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011 to be a series break when applied to data supplied for this indicator, therefore SEIFA data for 2011 are not directly comparable with SEIFA data from previous years.

Accessibility

The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are:

- *Australia's mothers and babies annual report*
- *Indigenous mothers and their babies, Australia 2001–2004*
- *METeOR – online metadata repository*
- *National health data dictionary*.

Ad-hoc data are also available on request (charges apply to recover costs).

Interpretability

Supporting information on the use and quality of the Perinatal NMDS are published annually in *Australia's mothers and babies* (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in *Perinatal National Minimum Data Set compliance evaluation: 2006-2009*. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in *Indigenous mothers and their babies, Australia 2001–2004* (Chapter 1 and Chapter 5).

Metadata information for this indicator has been published in the AIHW's online metadata repository, METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and in the *National health data dictionary*.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Birthweight is included in the Perinatal National Minimum Data Set (NMDS) and data are complete for over 99.9 per cent of babies.
- This measure only includes births of at least 20 weeks gestation or 400 grams birthweight. It excludes multiple births and stillbirths and the measure may therefore differ slightly from information presented in other publications on low birthweight.
- The National Perinatal Data Collection (NPDC) includes information on the Indigenous status of the mother only. Since 2005, all jurisdictions have collected information on Indigenous status of the mother in accordance with the Perinatal NMDS.
- No formal national assessment has been undertaken to determine completeness of the coverage or identification of Indigenous mothers in the NPDC. The current data have not been adjusted for under-identification of Indigenous status of the mother and thus jurisdictional comparisons of Indigenous data should not be made.
- Remoteness data for 2010 and previous years are not directly comparable to remoteness data for 2011 and subsequent years.
- SEIFA data for 2011 are not directly comparable with SEIFA data from previous years.

Prevalence of risk factors to the health of Australians

Prevalence of overweight and obesity

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	Prevalence of risk factors to the health of Australians — Proportion of adults and children who are overweight or obese.
Measure (computation)	Numerator: Number of people aged 18 years and over with a Body Mass Index (BMI) greater than or equal to 25, and number of children aged 5–17 years exceeding age and sex specific BMI values for overweight and obesity. Denominator: Number of people aged 18 years and over and number of children aged 5–17 years, for whom height and weight measurements were taken.
Data source/s	For the 2014 reporting cycle, the denominator and numerator for this indicator, for the general and non-indigenous population, use data from the full sample or Core component of the general population component of the ABS Australian Health Survey (AHS) from approximately 32 000 people, which is weighted to benchmarks for the total AHS in-scope estimated resident population (ERP) at 31 October 2011. This information replaces data supplied for the 2013 reporting cycle which was based on the National Health Survey (NHS) subset (20 500 people) of the full sample (32 000 people). The larger sample size (the full sample or core) supplied for the 2014 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AHS, see *Structure of the Australian Health Survey*. For the 2014 reporting cycle, the denominator and numerator for the Aboriginal and Torres Strait Islander population use data from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) component of the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) from approximately 9300 people, which is weighted to benchmarks for the Aboriginal and Torres Strait Islander ERP at 30 June 2011. For the 2015 reporting cycle, data from the full sample or Core component of the AATSIHS of approximately 13 000 people will be used. For more information on the structure of the AATSIHS, see *Structure of the Australian Aboriginal and Torres Strait Islander Health Survey*. Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS.

Data Quality Framework Dimensions

Institutional environment	The AHS and NATSIHS were 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, www.abs.gov.au.

Relevance

The 2011–13 AHS and 2011-12 NATSIHS collected measured height and weight from persons aged 2 years and over. For the purposes of this indicator, Body Mass Index (BMI) values are derived from measured height and weight information using the formula: weight (kg) / height $(m)^2$.

Despite some limitations, BMI is widely used internationally as a relatively straightforward way of measuring overweight and obesity.

Timeliness

The AHS is conducted every three years over a 12 month period. Results from the Core component of the AHS were released in June 2013.

The AATSIHS is conducted over a 12 month period, approximately every 6 years. Results from the NATSIHS component of the AATSIHS were released in November 2013. The previous NATSIHS was conducted in 2004-05.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up approximately 23 per cent of the population. The response rate for the 2011-12 Core component was 82 per cent. Results are weighted to account for non-response.

The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The final response rate for the 2012-13 NATSIHS component was 80 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for the indicator 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 following comments apply to data for the general and non-Indigenous populations only.

- Data for overweight and obesity are not directly comparable to the 2004-05 NHS due to the difference in collection methodology and possible erroneous estimation of respondent self-reported measurements in 2004-05
- Data for the NT for 2011-12 are not comparable to previous years due to the increase in sample size. Data for the NT for 2007-08 should be used with caution due to large RSEs resulting from the small sample size.
- RSEs for adult overweight and obesity rates by State/Territory and Remoteness Areas are generally within acceptable limits, except for remote areas in all jurisdictions and outer regional areas in Victoria where rates are considered too unreliable for general use.

- The breakdown by State/Territory and SEIFA quintiles for adults in general has sampling error within acceptable limits, except quintile 5 in the NT which should be used with caution. For children, remoteness and SEIFA disaggregations by State/Territory should generally be used with caution.
- Adult overweight and obesity rates by age and sex generally have acceptable levels of sampling error at the State/Territory level, though some of the rates for females in the NT should be used with caution.
- Sampling errors for BMI data for adults by State/Territory are generally within acceptable limits, though rates of underweight for most States/Territories for both adults and children should be used with caution.

The following comments apply to data from the NATSIHS for the Aboriginal and Torres Strait Islander population only:

- Data for overweight and obesity are not directly comparable to the 2004-05 NATSIHS due to the difference in collection methodology and possible erroneous estimation of respondent self-reported measurements in 2004-05.
- Data collected on measured height, weight and waist circumference in the 2012-13 NATSIHS used the same methodology and equipment as the 2011-12 NHS. Neither survey collected self-reported measurements so the two are directly comparable.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Most surveys, including Computer-Assisted Telephone Interviewing (CATI) health surveys conducted by the States and Territories, collect only self-reported height and weight. There is a general tendency across the population for people to overestimate height and underestimate weight, which results in BMI scores based on self-reported height and weight to be lower than BMI scores based on measured height and weight. Therefore, NHS and NATSIHS data for 2004-05 are not comparable with 2011–13 data which are based on measured height and weight.

The age- and sex-specific cutoff points for BMI categories for children are from the work of Cole TJ, Bellizzi MC, Flegal KM & Dietz WH 2000, "Establishing a standard definition for child overweight and obesity worldwide: international survey", BMJ 320:1240.

The AHS collected a range of other health-related information that can be analysed in conjunction with BMI.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. See: *Australian Health Survey: Updated Results* (Cat. no. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). Other information from the survey is available on request.

Interpretability

Information to aid interpretation of the data is available on the ABS website from the *Australian Health Survey: User Guide, 2011-13* (Cat. no. 4363.0.55.001) and the *Australian Aboriginal and Torres Strait Islander*

Health Survey: Users' Guide, 2012-13 (Cat. no. 4727.0.55.002).

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. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

For information on how the results compare between the two samples, see Comparison of Results in Australian Health Survey: Updated Results (cat. No. 4364.0.55.003).

Rates of current daily smokers

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	Prevalence of risk factors to the health of Australians — Rates of current daily smokers.
Measure (computation)	Numerator: Number of persons aged 18 years or over who smoke tobacco every day. Denominator: Population aged 18 years or over.
Data source/s	For the 2014 reporting cycle, the denominator and numerator for this indicator, for the general and non-indigenous population, use data from the full sample or Core component of the general population component of the ABS Australian Health Survey (AHS) from approximately 32 000 people, which is weighted to benchmarks for the total AHS in-scope estimated resident population (ERP) at 31 October 2011. This information replaces data supplied for the 2013 reporting cycle which was based on the National Health Survey (NHS) subset (20 500 people) of the full sample (32 000 people). The larger sample size (the full sample or core) supplied for the 2014 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AHS, see *Structure of the Australian Health Survey*. For the 2014 reporting cycle, the denominator and numerator for the Aboriginal and Torres Strait Islander population use data from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) component of the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) from approximately 9300 people, which is weighted to benchmarks for the Aboriginal and Torres Strait Islander ERP at 30 June 2011. For the 2015 reporting cycle, data from the full sample or Core component of the AATSIHS of approximately 13 000 people will be used. For more information on the structure of the AATSIHS, see *Structure of the Australian Aboriginal and Torres Strait Islander Health Survey*. Data reported for 2007-08 are from the ABS 2007-08 NHS and the ABS 2008 National Aboriginal and Torres Strait Islander Social Survey.

Data Quality Framework Dimensions

Institutional environment	The AHS and NATSIHS were 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 AHS and NATSIHS collected self-reported information on smoker status from persons aged 15 years and over. This refers to the smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes, but excluding chewing tobacco and smoking of non-tobacco

products. The 'current daily smoker' category includes respondents who reported at the time of interview that they regularly smoked one or more cigarettes, cigars or pipes per day.

Timeliness

The AHS is conducted every three years over a 12 month period. Results from the 2011-12 Updated Results (Core) component of the AHS were released in June 2013.

The AATSIHS is conducted over a 12 month period, approximately every 6 years. Results from the NATSIHS component of the AATSIHS were released in November 2013.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up approximately 23 per cent of the population. The response rate for the 2011-12 Core component was 82 per cent. Results are weighted to account for non-response.

The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The final response rate for the 2012-13 NATSIHS component was 80 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for the indicator 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 following comments apply to data for the general and non-Indigenous populations only.

- Data for Northern Territory in 2011-12 is not comparable to previous years due to the increase in sample size. Data for the NT for 2007-08 should be used with caution due to large RSEs resulting from the small sample size.
- This indicator generally has acceptable levels of sampling error for State/Territory by sex and age breakdown, for persons under the age of 65 years. For persons aged 65 years or over, rates for the ACT and the NT should be used with caution.
- RSEs for adult smoking rates by State/Territory and remote areas are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use.
- Adult smoking rates generally have acceptable levels of sampling error for State/Territory and SEIFA quintiles, though some rates for Victoria, Queensland, South Australia, Tasmania, Australian Capital Territory and Northern Territory should either be used with caution or are considered too unreliable for general use.

The following comments apply to data from the NATSIHS for the Indigenous population only:

- Smoking questions were changed in the 2012-13 NATSIHS to add

questions about specific tobacco products (chewing tobacco, cigars, pipes, other), in order to account for potential high levels of chewing tobacco use among Aboriginal and Torres Strait islander people, which would elevate nicotine levels observed in biomedical data. This change in the questionnaire is minor and the data are considered to be comparable to the 2011-12 AHS data.

- Overall, this indicator has an RSE of less than 25 per cent for all states and territories. Finer levels of disaggregation (e.g. by the inclusion of other cross- classifying variables) may result in higher levels of sampling error.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practice. The AHS collected a range of other health-related information that can be analysed in conjunction with smoker status.

Other non-ABS collections, such as the National Drug Strategy Household Survey (NDSHS), report estimates of smoker status. Results from the recent NDSHS in 2010 show slightly lower estimates for current daily smoking than in the 2011-13 AHS. These differences may be due to the greater potential for non-response bias in the NDSHS and the differences in collection methodology.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. See: *Australian Health Survey: Updated Results* (Cat. no. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). Other information from the survey is available on request.

Interpretability

Information to aid interpretation of the data is available on the ABS website from the *Australian Health Survey: User Guide, 2011-13* (Cat. no. 4363.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

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. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Levels of risky alcohol consumption

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	Prevalence of risk factors to the health of Australians — Levels of risky alcohol consumption.
Measure (computation)	Numerator: Number of persons aged 18 years and over who reported an average of more than 2 standard drinks per day in the last week. Denominator: Number of persons aged 18 years and over.
Data source/s	The denominator and numerator for this indicator, for the general and non-indigenous population, use data from the National Health Survey (NHS) component of the general population component of the ABS Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope estimated resident population (ERP) at 31 October 2011. For information on scope and coverage, see the *Australian Health Survey: Users' Guide* (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. For the 2014 reporting cycle, the denominator and numerator for the Aboriginal and Torres Strait Islander population use data from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) component of the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) from approximately 9300 people, which is weighted to benchmarks for the Aboriginal and Torres Strait Islander ERP at 30 June 2011. For more information on the structure of the AATSIHS, see *Structure of the Australian Aboriginal and Torres Strait Islander Health Survey*. Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS.

Data Quality Framework Dimensions

Institutional environment	The AHS and NATSIHS were 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 2011-12 NHS and 2012-13 NATSIHS collected self-reported information on alcohol consumption from persons aged 15 years and over. Respondents were asked to report the number of drinks of each type they had consumed, the size of the drinks, and, where possible, the brand name(s) of the drink(s) consumed on each of the most recent three days in the last week on which they had consumed alcohol. Intake of alcohol refers to the quantity of alcohol contained in any drinks consumed, not the quantity of the drinks. According to average daily alcohol intake over the 7 days of the reference week, persons who consumed more than 2 standard drinks on any day were

at risk of long term health problems.

To measure against the 2009 guidelines, reported quantities of alcoholic drinks consumed were converted to millilitres (mls) of alcohol present in those drinks, using the formula:

- alcohol content of the type of drink consumed (%) x number of drinks (of that type) consumed x vessel size (in millilitres).

An average daily amount of alcohol consumed was calculated (i.e. an average over the 7 days of the reference week), using the formula:

- average consumption over the 3 days for which consumption details were recorded x number of days consumed alcohol / 7.

According to average daily alcohol intake over the 7 days of the reference week, persons who consumed more than 2 standard drinks on any day were at risk of long term health problems.

Timeliness

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.

The AATSIHS is conducted over a 12 month period, approximately every 6 years. Results from the NATSIHS component of the AATSIHS were released in November 2013. The previous NATSIHS was conducted in 2004-05.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.

The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The final response rate for the 2012-13 NATSIHS component was 80 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for the indicator 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 collection of accurate data on quantity of alcohol consumed is difficult, particularly where recall is concerned, given the nature and possible circumstances of consumption. The use of the one week reference period (with collection of data for the most recent three days in the last week on which the person drank) is considered to be short enough to minimise recall bias but long enough to obtain a reasonable indication of drinking behaviour. While the last week exact recall method may not always reflect the usual drinking behaviour of the respondent at the individual level, at the population level this is expected to largely average out.

The collection and coding of individual brands and container size ensures

that no mental calculation is required of the respondent in reporting standard drinks, and is considered to eliminate potential for the underestimation bias which is known to occur when people convert drinks into standard drinks.

The following comments apply to data for the general and non-Indigenous populations only.

- Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size in 2011-12. Data for the NT for 2007-08 should be used with caution due to large RSEs resulting from the small sample size
- This indicator generally has acceptable levels of sampling error for State/Territory and Remoteness Areas, except for remote areas where some rates are considered too unreliable for general use. The breakdown by State/Territory and SEIFA quintiles in general has sampling error within acceptable limits, except for the two lowest quintiles in the ACT which should either be used with caution or are considered too unreliable for general use.

Coherence

The AHS and AATSIHS collected a range of other health-related information that can be analysed in conjunction with alcohol risk level. For more detailed information see the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide*, available on the ABS website.

Aggregate levels of alcohol consumption implied by the AHS are somewhat less than the estimates of apparent consumption of alcohol based on the availability of alcoholic beverages in Australia from taxation and customs data, see *Apparent Consumption of Alcohol, 2010-11* (Cat. no. 4307.0.55.001). This suggests a tendency towards under-reporting of alcohol consumption in self-report surveys.

Other collections, such as the National Drug Strategy Household Survey (NDSHS), report against the same NHMRC guidelines. Results from the most recent NDSHS in 2010 show slightly lower estimates for long-term harm from alcohol than in the 2011-13 AHS. These differences may be due to the greater potential for non-response bias in the NDSHS and the differences in collection methodology.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. See: *Australian Health Survey: Updated Results* (Cat. no. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). Other information from the survey is available on request.

Interpretability

Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' 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. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Selected potentially preventable diseases

Incidence of selected cancers

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	Selected potentially preventable diseases — Incidence of selected cancers
Measure (computation)	The selected cancers of public health importance are bowel cancer, lung cancer, melanoma of the skin, breast cancer in females and cervical cancer. For bowel cancer, lung cancer and melanoma, the numerator is the number of new cases occurring in the Australian population in the reported year. The denominator is the total Australian population for the same year. For breast and cervical cancer the numerator is the number of new cases occurring in the Australian female population in the reported year. The denominator is the total Australian female population for the same year. Calculation is 100 000 × (Numerator ÷ Denominator), calculated separately for each type of cancer, presented as a rate per 100 000 and age-standardised to the Australian population as at 30 June 2001.
Data source/s	*Numerator:* Australian Cancer Database (ACD) *Denominators:* For bowel cancer, lung cancer and melanoma: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP). For breast and cervical cancer: ABS ERP for female population. For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous population) Series B. For data by Remoteness area: ABS ERPs for Australian Standard Geographical Classifications (ASGC) Remoteness Areas. For data by socioeconomic status: calculated by AIHW using the ABS' 2006 Index of Relative Socio-economic Disadvantage (IRSD) and ERPs by Statistical Local Area (SLA). Each SLA in Australia is ranked by IRSD score and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

Data Quality Framework Dimensions

Institutional environment	The National Cancer Statistics Clearing House (NCSCH), housed at the AIHW, is a collaborative partnership between the AIHW and the Australasian Association of Cancer Registries (AACR). Cancer incidence data are supplied to the AIHW by state and territory cancer registries. These data are compiled by AIHW to form the Australian Cancer Database (ACD). All jurisdictions have legislation requiring mandatory reporting of all cancer cases with the exception of basal cell carcinoma of the skin and squamous cell carcinoma of the skin.
Relevance	The data used to calculate this indicator are accurate and of high quality.

The mandatory reporting of cancers and the use of Estimated Resident Populations (ERPs) based on Census data for denominators provides the most comprehensive data coverage possible. The data are appropriate for this indicator.

Timeliness

Data available for the 2014 Report are based on cancers diagnosed in 2010, noting that cancers for NSW and ACT are based on estimates.

Accuracy

2010 incidence data for NSW and ACT were not available for inclusion in the 2010 version of the ACD. The development of the new NSW Cancer Registries system has resulted in a delay in processing incidence data for 2010 onwards. Details of the expected time-line for processing of 2010 cancer incidence data for NSW and ACT are available at www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data#incidence-when-2009. Therefore 2010 incidence data for NSW and ACT were estimated by the AIHW. Although the estimation procedure has been shown to be reasonably accurate for estimating overall cancer incidence, its accuracy with respect to individual cancers will vary.

As NSW and ACT make up about a third of Australia's population, the national incidence data for 2010 is likely to be somewhat inaccurate for some individual cancers; which cancers these are is not predictable. Until the actual 2010 cancer data are available from these jurisdictions caution should be exercised when comparing the 2010 NSW, ACT and Australian data with data from previous years. The estimates of 2010 incidence in NSW and ACT cannot be disaggregated by Indigenous status, remoteness area or socioeconomic status. The Australian totals for these tables do not include NSW and ACT.

It is anticipated that the 2011 version of the ACD will include the real 2010 incidence data for NSW and ACT.

2009 incidence data for NSW and ACT include estimates of so-called 'death certificate only' (DCO) cases. An extended delay in the provision of 2009 mortality data from the Council of Australian Registrars has meant that NSW and ACT have not been able to register cases of cancer that are recorded on a death certificate but which were not notified to the cancer registry by any other means. The number of such cases in 2009 for each cancer, sex and age group has been estimated by the AIHW based on the numbers observed for 2004–2008. Overall for the five cancers covered in the Indicator, about 1.2 per cent of NSW cases and 1.4 per cent of ACT cases are estimated DCO cases. The percentage varies by cancer type.

For Indigenous status, the numerator for 'Indigenous' is the number of people who self-reported that they were Indigenous at the time of diagnosis. 'Other' includes those who self-reported that they were not Indigenous at the time of diagnosis and those who chose not to identify as either Indigenous or non-Indigenous.

Caution is required when examining differences across Indigenous status as Vic, SA, Tas and ACT do not have adequate data quality for this indicator. NSW, Qld, WA and NT have indicated that their Indigenous data quality is sufficient for reporting; however, 2010 incidence data for NSW is estimated and Indigenous status for these estimates is not available. Therefore, in 2010, Qld, WA and NT are the only jurisdictions with adequate Indigenous data quality.

Socioeconomic status rankings (by Index of Relative Socio-Economic

Disadvantage (IRSD) score) are calculated by SLA using a population-based method at the Australia-wide level. That is, the quintiles are national quintiles, not state and territory quintiles.

An SLA-to-remoteness-area concordance and SLA-to-socioeconomic-status concordance were used to allocate remoteness area and socioeconomic status to each record on the ACD based on the person's SLA of residence at time of diagnosis.

Caution is required when examining differences across remoteness area and socioeconomic status categories. The SLA of a person is computed by the cancer registry based on the address provided by the person. Some people may supply an address other than that where they normally reside or the details the person provides may not correspond to a valid address meaning that their cancer record cannot be allocated to a remoteness area or socioeconomic status category at all. Such records are excluded from the tables and this may affect some remoteness area and socioeconomic categories more than others. Also, because the concordances are based on the 2006 census, SLA boundaries may have changed over time which creates inaccuracies.

Due to the very small number of diagnoses involved, disaggregation by Indigenous status, or remoteness area, or socioeconomic status by state and territory is not necessarily robust. For example, some SLAs cover a large and heterogeneous geographical area including towns and very remote areas, yet all people in a given SLA are assigned the same socioeconomic status.

Variability bands have been provided to indicate the extent to which conclusions can be drawn about differences in incidence rates between population subgroups. The bands are calculated as 95 per cent confidence intervals around the age-standardised rate, based on the assumption that the number of cancers diagnosed within each category is a Poisson random variable. Although this is a standard assumption in cancer incidence calculations around the world it is important to note that it is not possible to prove or disprove this assumption.

This indicator only counts one year of incidence data. For jurisdictions that record relatively small numbers of cancers, rates may fluctuate widely from year to year; these changes should be interpreted with caution.

Due to Health Department policy in the ACT and NT, incidence rates based on counts of between 1 and 4 persons have been suppressed because of statistical unreliability.

This indicator is calculated on data that have been supplied to the AIHW and undergone extensive checks at both the source cancer registry and the AIHW. The state and territory cancer registries have checked the tables and given their approval for the AIHW to supply them to the Productivity Commission.

Coherence

These data are published annually by the AIHW. While there are sometimes changes to coding for particular cancers, it is possible to map coding changes to make meaningful comparisons over time.

Not all Australian State and Territory cancer registries use the same ICD-10 code groupings to classify certain cancers. Further, the national cancer data presented here may use different code groupings to some jurisdictions. This may mean that data presented here are different to that reported by

individual jurisdictional cancer registries, for certain cancers.

The AIHW define the PI4 cancers by the following ICD 10 codes:

• Cancer	ICD10 codes
• Bowel	C18–C20
• Lung	C34
• Melanoma	C43
• Female breast	C50
• Cervical	C53

Some State and Territory jurisdictions may use different methodologies for particular subgroups (for example, some may use an imputation method for determining Indigenous cancers). This may lead to differences in rates between this Indicator and those shown in jurisdictional cancer incidence reports.

The incidence rate in Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.

Accessibility

The NCSCH provides summary cancer incidence and mortality data annually via the AIHW website where they can be downloaded free of charge. A biennial report, *Cancer in Australia*, is published and is also available on the AIHW website where it can be downloaded without charge. More specialised data can be requested via the AIHW website.

Interpretability

While numbers of new cancers are easy to interpret, calculation of age-standardised rates is more complex and the concept may be confusing to some readers. Information on how and why age-standardised rates have been calculated and how to interpret them is available in all AIHW cancer publications presenting data in this format, for example, *Cancer in Australia: an overview, 2012*. Information about the Australian Cancer Database is available on the AIHW website.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- 2010 incidence data for NSW and ACT were not available for inclusion in the 2010 version of the Australian Cancer Database (ACD). The development of the new NSW Cancer Registries system has resulted in a delay in processing incidence data for 2010 onwards. Details of the expected time-line for processing of 2010 cancer incidence data for NSW and ACT are available at: www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data#incidence-when-2009. Therefore 2010 incidence data for NSW and ACT were estimated by the Australian Institute of Health and Welfare (AIHW). Although the estimation procedure has been shown to be reasonably accurate for estimating overall cancer incidence, its accuracy with respect to individual cancers will vary. Until the actual 2010 cancer data are available from these jurisdictions caution should be exercised when comparing the 2010 NSW, ACT and Australian data with data from previous years. The estimates of 2010 incidence in NSW and ACT cannot be disaggregated by Indigenous status, remoteness area or socioeconomic status. The Australian totals for these tables do not include NSW and ACT.
- This indicator only counts one year of incidence data. For jurisdictions that record relatively small numbers of cancers, rates may fluctuate widely from year to year; these changes should be interpreted with caution.

- The quality of Indigenous identification in cancer registry data varies between jurisdictions. National disaggregation by Indigenous status is based on jurisdictions with adequate data quality (NSW, Qld, WA and NT). Indigenous data for other jurisdictions should be interpreted with caution. Even with adequate data quality, the small numbers behind many disaggregations means certain Indigenous data are not robust enough for meaningful comparisons. Information on adequacy of Indigenous identification in cancer registry data is provided to AIHW by each jurisdictional cancer registry.
- Some jurisdictions may use an imputation method to impute missing Indigenous status for reporting purposes. This may lead to an underreporting of rates in this Indicator compared to those shown in jurisdictional cancer incidence reports.
- The incidence rate in Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.
- Remoteness area and socioeconomic status are based on Statistical Local Area (SLA) of residential address at the time of diagnosis.
- Due to Health Department policy in the ACT and NT, incidence rates based on counts of between 1 and 4 persons have been suppressed because of statistical unreliability.

Incidence of heart attacks

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Indicator	Selected potentially preventable diseases — Incidence of heart attacks
Measure (computation)	Count (a) number of deaths where 'acute coronary heart disease' (ICD-10 codes I20–I24) is the underlying cause of death in each calendar year (based on year of registration of death). For ages 25 years or over. Count (b) number of non-fatal hospitalisations where 'acute myocardial infarction' (ICD-10-AM I21) or 'unstable angina' (ICD-10-AM I20.0) are the principal diagnosis, and separation mode is not equal to 'died' or 'transferred to another acute hospital', and care type is not equal to 'newborn-unqualified days only' or 'organ procurement – posthumous' or 'hospital border' in each calendar year (based on discharge date from hospital). For ages 25 years or over. The number of acute coronary events is estimated by: (a) + (b): *Numerator* Number of deaths recorded with an underlying cause of acute coronary heart disease (a) plus the number of non-fatal hospitalisations with a principal diagnosis of acute myocardial infarction or unstable angina that do not end in a transfer to another acute hospital (b). For ages 25 years or over. *Denominator* Total population aged 25 years or over for year in question. *Rates* 100,000 x (numerator ÷ denominator). Age specific rates are presented for each 10 year age group from 25 years, by sex. Total rates are directly age-standardised to the 2001 Australian population using 10 year age groups. *Indigenous* National incidence estimates for Indigenous and Other Australians are calculated based on data from NSW, Qld, SA, WA and NT only. Indigenous rates are directly age-standardised to the 2001 Australian population using 10 year age groups capped at 75 years or over. The estimates for Indigenous and Other Australians are derived using only data from the five jurisdictions where the quality of identification is considered reasonable in both the NHMD and the NMD (NSW, Qld, WA, SA and NT).
Data source/s	*Numerator* Australian Institute of Health and Welfare (AIHW) National Hospital Morbidity Database (NHMD), AIHW National Mortality Database (NMD) *Denominator* For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June (2007 to 2011). For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous population) Series B.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator using data extracted from the AIHW NHMD, the NMD and Australian Bureau of Statistics (ABS) population data.

The AIHW is a national agency set up by the Australian Government under the Australian *Institute of Health and Welfare Act 1987* 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 Health portfolio.

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.

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.

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 (Commonwealth),* 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.

Relevance

The data provide an estimate of the incidence of acute coronary events in Australia, based on administrative data currently available. Non-fatal events are estimated from the National Hospital Morbidity Database (NHMD) and fatal events from the National Mortality Database (NMD).

It is an estimate of 'events', not individuals. It should be noted that an individual may have multiple events in the one year or in different years. Each would be counted.

The method of estimation has been developed based on an analysis of current hospital and deaths data (AIHW 2011, *Monitoring acute coronary syndrome using national hospital data: an information paper on trends and issues*. Cat. no. CVD 57. Canberra). This method has not yet been validated and should therefore be considered interim. The AIHW is currently undertaking work to validate the algorithm.

The accuracy of the estimates rely on the accuracy of coding of the principal diagnosis (as either AMI or UA) in the NHMD and of the underlying cause of death (as acute coronary heart disease) in the NMD. It also relies on the accuracy of coding of transfers to another acute hospital and of death in hospital.

One acute coronary event may involve multiple hospitalisations, due to

transfers for treatment and on-going care. In the NHMD these are recorded as multiple unlinked hospital episodes. Therefore, to estimate the number of non-fatal events only those episodes that did not end in a transfer to another acute hospital or end in a death in hospital are counted.

The coding of principal diagnosis and the coding of death in hospital in the NHMD are likely to be of reasonable quality. However, the coding of transfers may vary across hospitals and jurisdictions.

It is possible that the method underestimates the number of fatal acute coronary deaths by only counting those deaths coded as ICD-10 I20-I24. This excludes chronic coronary heart disease (I25). It is possible that some deaths from heart attacks are coded as chronic heart disease, especially in older people. However, the extent of this is unknown until validation is undertaken.

The year in which the event occurred is determined from the separation date for hospitalisations, and from the year of registration of death.

Data are reported by the state or territory of residence of the person at the time of hospitalisation or death.

Variations in key variables (particularly in transfer rates) across jurisdictions indicate that the method of estimation may lead to an under-estimate of incidence in some jurisdictions and an over-estimate in others. This variation may be due to differences in treatment patterns but could also be due to differences in coding practices. As the extent of this cannot be measured until the algorithm is validated estimates are not reported at a jurisdictional level.

Estimates for Indigenous and Other Australians, are based on data from those jurisdictions where the quality of identification is considered reasonable in both the NHMD and the NMD. Only NSW, Qld, WA, SA and the NT are included in the national estimates reported by Indigenous status. Estimates for Other Australians are calculated by subtracting Indigenous estimates from total estimates for the five jurisdictions and divided by the population of Other Australians in those jurisdictions. Other Australians therefore includes non-Indigenous people and people whose Indigenous status was not stated or inadequately described.

Timeliness

This indicator reports the latest information available (for years 2007 to 2011).

Accuracy

The method of estimation has not yet been validated and possible errors are not able to be calculated at this time. Estimates should be treated with caution until the method is validated. This work will inform future reporting of data at a jurisdictional level.

The accuracy of the estimates will depend on the accuracy of coding in the NHMD and the NMD (see data sources for DQS for each data source). In particular the accuracy of coding of principal diagnosis, hospital transfers, deaths in hospital and underlying cause of death are central to the accuracy of the estimates.

The accuracy of Indigenous estimates is also reliant on the appropriate identification of Indigenous people in the NHMD and the NMD. Only five jurisdictions are considered to have reasonable quality Indigenous identification in both datasets required to estimate this indicator (the NHMD and the NMD). The five jurisdictions are NSW, QLD, WA, SA and the NT. Indigenous counts for the NT exclude acute coronary events treated in the

private hospital in the NT. All non-fatal events treated in the private hospital in the NT are therefore included in the incidence counts for Other Australians.

The computation method for age-standardisation of data reported by Indigenous status has been refined since the previous reporting cycle.

Deaths occurring between 1992 and 2006 but registered in 2010 by the Queensland Registry of Births, Deaths and Marriages are excluded from the estimates for Indigenous and Other Australians.

NMD data for 2009 and 2010 has been revised since the previous reporting cycle. NMD data for 2010 and 2011 may be subject to further revisions.

Coherence

This is the second year in which this indicator has been reported. The method should be considered as interim until validation is complete.

Accessibility

The AIHW provide a variety of products that draw upon the NMD and NHMD including online data cubes and reports.

These products may be accessed on the AIHW website:

www.aihw.gov.au/hospitals-data/

www.aihw.gov.au/deaths/.

Interpretability

NHMD

The NHMD data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from public and private hospitals. States and territories use these data for service planning, monitoring, and internal and public reporting. Hospitals may be required to provide data to states and territories through administrative arrangements, contractual requirements or legislation.

The scope of the NHMD 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.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

States and territories supplied these data to the AIHW under the terms of the *National Health Information Agreement*.

The data quality statement for the AIHW National Hospital Morbidity Database can be found in Appendix 1 of *Australian hospital statistics 2011-12* or at www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543822

Year specific data quality statements for the National Hospital Morbidity Database 2010-11 and 2011-12 can be found at: meteor.aihw.gov.au/content/index.phtml/itemId/511338 and meteor.aihw.gov.au/content/index.phtml/itemId/529483

NMD

The AIHW NMD contains cause of death information for all deaths registered in Australia. Information is provided to the AIHW by the Registrars of Births, Deaths and Marriages and coded nationally by the Australian Bureau of Statistics (ABS).

The data quality statements for the AIHW National Mortality Database can be found in the following ABS publications:

ABS Quality declaration summary for Causes of death, Australia, 2011 (Cat. no. 3303.0) www.abs.gov.au/Ausstats/abs@.nsf/0/D4A300EE1E04AA43CA2576E800156A24?OpenDocument and

ABS Quality declaration summary for Deaths, Australia, 2011 (Cat. no. 3302.0) www.abs.gov.au/Ausstats/abs@.nsf/0/9FD0E6AAA0BB3388CA25750B000E3CF5?OpenDocument

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- This indicator estimates the incidence of acute coronary events from the National Hospital Morbidity Database (NHMD) and the National Mortality Database (NMD).
- It is an interim indicator while validation work is underway.
- The accuracy of the estimates is reliant on the accuracy and consistency of coding of the principal diagnosis and underlying cause of death in each jurisdiction. It also relies on the accuracy of coding of transfers to another acute hospital and of death in hospital.
- Variations in key variables (particularly in transfer rates in hospitals) across jurisdictions indicate that the method of estimation may lead to an under-estimate of incidence in some jurisdictions and an over-estimate in others. The extent of this cannot be measured until the algorithm is validated. As a result, State and Territory estimates are not presented.
- The estimates shown in Table EA.29 for Indigenous and Other Australians are derived using only data from the five jurisdictions where the quality of identification is considered reasonable in both the NHMD and the NMD (NSW, Qld, WA, SA and NT). The estimates provided in table EA.30, by sex, are derived using data from all jurisdictions.

Prevalence of type 2 diabetes

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Selected potentially preventable diseases — Prevalence of type 2 diabetes
Measure (computation)	Numerator: Number of persons aged 18 years or over with known diabetes (type 2) or newly diagnosed diabetes as determined by a fasting plasma glucose test. For the supplementary measure: number of persons aged 25 years and over with known diabetes (Type 2) or newly diagnosed diabetes as determined by a fasting plasma glucose test. Denominator: Number of persons aged 18 years and over. For the supplementary measure: number of persons aged 25 years and over.
Data source/s	For the 2014 reporting cycle, the denominator and numerator for this indicator for the general population uses data from the 2011-12 National Health Measures Survey (NHMS) component of the Australian Bureau Statistics (ABS) Australian Health Survey (AHS) (approximately 9500 people aged 18 years or over), 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 Australian Health Survey: Users' Guide (cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. For the 2015 reporting cycle, the denominator and numerator for this indicator for the Aboriginal and Torres Strait Islander population will use data from the National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS) component of the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Data Quality Framework Dimensions

Institutional environment	The 2011-12 NHMS 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. The interview components of the AHS were conducted under the Census and Statistics Act 1905. Ethics approval was sought and gained (for the NHMS component only) from the Australian Government Department of Health and Ageing's Departmental Ethics Committee. 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, www.abs.gov.au.
Relevance	The 2011-12 NHMS uses a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of Type 2 diabetes. A respondent to the survey is considered to have known diabetes (type 2) if they had ever been told by a doctor or nurse that they have Type 2 diabetes

and:

- They were taking diabetes medication (either insulin or tablets); **or**
- Their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L.

A respondent to the survey is considered to have newly diagnosed diabetes if they reported no prior diagnosis of diabetes, but had a fasting plasma glucose value greater than or equal to 7.0 mmol/L.

Note: The type of diabetes for newly diagnosed cases cannot be determined from a fasting plasma glucose test alone. However, as it is assumed that the vast majority of newly diagnosed cases would be Type 2, all newly diagnosed cases of diabetes have been included in this measure.

The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.

The same definition for diabetes will be used in the NATSIHMS.

Timeliness

The NHMS was conducted for the first time in 2011–13. Results from the 2011-12 NHMS were released in August 2013. Results from the NATSIHMS will be released in 2014.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.

All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 38 per cent went on to complete the biomedical component.

Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in *Australian Health Survey: Biomedical Results for Chronic Disease* (Cat. no. 4364.0.55.005).

In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.

As they are drawn from a sample survey, data for the indicator 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.

	This indicator, and the supplementary indicator, generally have acceptable levels of sampling error for State/Territory by sex breakdown. However, rates by sex for the Northern Territory should be used with caution. Likewise, the RSEs for Remote Australia are both greater than 25 per cent and should be used with caution.
Coherence	The methods used to construct the indicator are consistent and comparable with other collections. The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes status. Other non-ABS collections, such as the 1999–2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab) and the 2009-10 Victorian Health Monitor (VHM) have reported estimates of diabetes prevalence based on biomedical measures and self-reported diagnosis and medication use . Results from the recent VHM were very similar to those from the NHMS. Results from AusDiab showed higher estimates of diabetes than the NHMS, however this difference is most likely due to the difference in test used to measure diabetes (AusDiab used an Oral Glucose Tolerance test, which is a more comprehensive test for diabetes than fasting plasma glucose). For information on how these studies compare, see *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005).
Accessibility	See *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005). Other information from this survey is also available on request.
Interpretability	Information to aid interpretation of the data is available from the Australian Health Survey: Users' 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. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Potentially avoidable deaths

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Potentially avoidable deaths
Measure (computation)	Numerator: death registrations for 2007–2011 (5 year aggregate), and 2007 to 2011 (single years) provided by state and territory Registrars of Births, Deaths and Marriages which have an ICD-10 code which has been further classified as preventable or treatable as per the NHA Technical Manual. Denominator: Estimated Resident Population, Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, Population Projections, Australia
Data source/s	Numerator – ABS Causes of Death collection (3303.0) Denominator - ABS Estimated Resident Population (3101.0); Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, August 2009 (cat. no. 3238), Series B. For the non-Indigenous population, the projected Indigenous population (3238.0, Series B) is subtracted from the 2006-Census-based Estimated Resident Population.

Data Quality Framework Dimensions

Institutional environment	These collections are conducted under the Census and Statistics Act 1905. For 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, see ABS Institutional Environment.
Relevance	The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics. Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Statistical Classification of Diseases and Related health Problems (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used by the ABS to code cause of death since 1997. For further information on the ABS Causes of Death collection, see the relevant Data Quality Statement.
Timeliness	Causes of death data is published on an annual basis. Death records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis. One dimension of timeliness in death registrations data is the interval

between the occurrence and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.

Preliminary ERP data is compiled and published quarterly and is generally made available five to six months after the end of each reference quarter. Every year, the 30 June ERP is further disaggregated by sex and single year of age, and is made available five to six months after the end of the reference quarter. Commencing with data for September quarter 2006, revised estimates are released annually and made available 21 months after the end of the reference period for the previous financial year, once more accurate births, deaths and net overseas migration data becomes available. In the case of births and deaths, the revised data is compiled on a date of occurrence basis. In the case of net overseas migration, final data is based on actual traveller behaviour. Generally ERP data is not changed once it has been finalised unless there are compelling reasons to do so, as in June 2013 when data from September 1991 to June 2006 was revised (for more information on this recasting process, please see the feature article titled Recasting 20 years of ERP in the December quarter 2012 issue of Australian Demographic Statistics (cat. no. 3101.0).

For further information on ABS Estimated Resident Population, see the relevant Data Quality Statement.

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period and is not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

All coroner certified deaths registered after 1 January 2006 are now subject to a revisions process. In this round of COAG reporting, 2007, 2008 and 2009 data is final, 2010 data is revised and 2011 data is preliminary. Data for 2010 and 2011 is subject to further revisions. Prior to 2006 all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (e.g. a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths, as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

Revisions will only impact on coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See Technical Note: Causes of Death Revisions 2009 and 2010 in Causes of Death, Australia, 2011 (cat.no. 3303.0).

In November 2010, the Queensland Registrar of Births, Deaths and Marriages advised the ABS of an outstanding deaths registration initiative

undertaken by the Registry. This initiative resulted in the November 2010 registration of 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). Of these, around three-quarters (284) were deaths of Aboriginal and Torres Strait Islander Australians.

The ABS discussed different methods of adjustment of Queensland death registrations data for 2010 with key stakeholders. Following the discussion, a decision was made by the ABS and key stakeholders to use an adjustment method that added together deaths registered in 2010 for usual residents of Queensland which occurred in 2007, 2008, 2009 and 2010. This method minimises the impact on mortality indicators used in various government reports. However, care should still be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010. Please note that there are differences between data output in the Causes of Death, Australia, 2010 publication (cat. no. 3303.0) and 2010 data reported for COAG, as this adjustment was not applied in the publication. For further details see Technical Note: Registration of outstanding deaths, Queensland 2010, from the Deaths, Australia, 2010 publication (cat. no, 3302.0) and Explanatory Note 103 in the Causes of Death, Australia, 2010 publication (cat. no. 3303.0).

Investigation conducted by the WA Registrar of Births, Deaths and Marriages indicated that some deaths of non-Indigenous people were wrongly identified as deaths of Indigenous people in WA for 2007, 2008 and 2009. The ABS discussed this issue with a range of key stakeholders and users of Aboriginal and Torres Strait Islander deaths statistics. Following this discussion, the ABS did not release WA Aboriginal and Torres Strait Islander deaths data for the years 2007, 2008 and 2009 in the 2010 issue of *Deaths, Australia* publication, or in the 2011 COAG data supply. The WA Registry corrected the data and resupplied the corrected data to the ABS. These corrected data were then released by the ABS in spreadsheets attached to *Deaths, Australia, 2010* (cat. no. 3302.0) publication on 24 May 2012, and are included in this round of COAG reporting.

All ERP data sources are subject to non-sampling error. Non-sampling error can arise from inaccuracies in collecting, recording and processing the data. In the case of Census and Post Enumeration Survey (PES) data, every effort is made to minimise reporting error by the careful design of questionnaires, intensive training and supervision of interviewers, and efficient data processing procedures. The ABS does not have control over any non-sampling error associated with births, deaths and migration data. For more information see the *Demography Working Paper 1998/2 - Quarterly birth and death estimates, 1998 (cat. no. 3114.0)*. and Australian Demographic Statistics (cat. no. 3101.0).

Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population projections are based on assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the projected Indigenous population from the total population. For the current round of COAG reporting, in the absence of 2011 Census-based Indigenous population projections, the non-Indigenous population denominator has been calculated by subtracting the 2006 Census-based Indigenous projections (see Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, August 2009, cat. no.

	3238.0) from the 2006 Census-based Estimated Resident Population (3101.0). 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. Non-Indigenous data from the Causes of Death collection do not include death registrations with a 'not stated' Indigenous status. Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading, for example, where the non-Indigenous mortality rate is higher than the indigenous mortality rate. Age-standardised death rates based on a very low death count have been deemed unpublishable. Some cells have also not been published to prevent back-calculation of these suppressed cells. Caution should be used when interpreting rates for this indicator.
Coherence	The methods used to construct the indicator are consistent and comparable with other collections and with international practice.
Accessibility	Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. ERP data is available in a variety of formats on the ABS website under the 3101.0 and 3201.0 product families. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the Census and Statistics Act (1905). This may restrict access to data at a very detailed level.
Interpretability	Data for this indicator have been age-standardised, using the direct method, to 'under 75 years' of age. Direct age-standardisation to the 2001 total Australian population was used (see Data Cube: Standard Population for Use in Age-Standardisation Table in Australian Demographic Statistics, Dec 2012 (cat. no. 3101.0)). Age-standardised results provide a measure of relative difference only between populations.

Mortality and life expectancy

Life expectancy

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mortality and life expectancy — Life expectancy
Measure (computation)	Direct estimation of life tables for Indigenous and non-Indigenous Australians, from which life expectancy at birth is obtained. Age/sex-specific death rates used in the construction of the life tables are calculated as: Numerator: death registrations for 2010–2012 provided by State and Territory Registrars of Births, Deaths and Marriages. For Indigenous Australians, deaths registrations were adjusted using factors obtained from the 2011 Census Data Enhancement Indigenous Mortality Study to account for under-identification of Indigenous deaths. Denominator: 30 June 2011 estimated resident Australian Indigenous and non-Indigenous populations.
Data source/s	*Life Tables, States, Territories and Australia, 2010-2012* (Cat. no. 3302.0.55.001); *Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012* (Cat. no. 3302.0.55.003).

Data Quality Framework Dimensions

Institutional environment	For 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. Death statistics are sourced from death registrations systems administered by the various State and Territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each State and Territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a Medical Certificate of Cause of Death, or supplied as a result of a coronial investigation.
Relevance	Life tables based on assumed improvements in mortality are produced by the ABS using assumptions on future life expectancy at birth, based on recent trends in life expectancy. These life tables are not published by the ABS, they are used as inputs into ABS population projections. The life tables are current or period life tables, based on death rates for a short period of time during which mortality has remained much the same. Mortality rates for the Australian and state and territory life tables are based on death registrations and estimated resident population for the period 2010–2012. The life tables do not take into account future assumed

improvements in mortality.

Life tables are presented separately for males and females. The life table depicts the mortality experience of a hypothetical group of newborn babies throughout their entire lifetime. It is based on the assumption that this group is subject to the age-specific mortality rates of the reference period. Typically this hypothetical group is 100 000 in size.

Life tables for Indigenous Australians from which life expectancy at birth estimates were sourced were produced to enable the compilation of ABS estimates and projections of the Indigenous population of Australia for the period 2001 to 2026.

Estimates of life expectancy at birth for Indigenous Australians are commonly used as a measure for assessing Indigenous population health and disadvantage.

Timeliness

ABS estimates of all Australian life expectancy at birth are calculated for a 3-year period and published on an annual basis.

ABS estimates of life expectancy for Indigenous Australians are calculated for a 3-year period and reported every 5 years, with 2010–2012 estimates released in November 2013. Comparable 2005-2007 life expectancy estimates for Indigenous Australians were also released in November 2013.

Accuracy

Compilation of life tables requires complete and accurate data on deaths that occur in a period, and reliable estimates of the population exposed to the risk of dying during that period. These data are required by age and sex so as to calculate age-sex specific death rates.

Information on deaths is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Sources of non-sample error include:

- completeness of an individual record at a given point in time;
- completeness of the dataset (eg impact of registration lags, processing lags and duplicate records);
- extent of coverage of the population (whilst all deaths are legally required to be registered, some cases may not be registered for an extended time, if at all); and
- lack of consistency in the application of questions or forms used by data providers, both through time and between different jurisdictions.

In November 2010, the Queensland Registry of Births, Deaths and Marriages registered 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). The ABS life tables are based on deaths by year of occurrence, and are therefore unaffected by this late registration of deaths.

Every effort is made to minimise error by working closely with data providers, the careful design of forms, training of processing staff, and efficient data processing procedures.

ERP is based on Census counts by place of usual residence, adjusted for net Census undercount and the number of Australian residents temporarily overseas on Census night, and backdated from the Census date to 30 June. For post-censal years, ERP is obtained by adding postcensal births, deaths and migrations to the Census ERP.

In the case of life tables for the Indigenous population, registrations of Indigenous deaths and Indigenous population estimates present particular methodological challenges. For example, there are a number of factors which may contribute to under-identification of Indigenous deaths in death registrations records. In addition, there are quality issues associated with Indigenous population estimates, such as undercount of the Indigenous population in the Census, and non-response to the Indigenous status question on the Census form. Due to the inherent uncertainties in these data, care should be exercised when interpreting Aboriginal and Torres Strait Islander life expectancy estimates.

An improvement has been made to the method of calculating Indigenous life tables at the Australia level for the period 2010-2012 (these data are labelled 'headline estimates for Australia'). The method now takes age-specific identification rates into account when calculating the under-identification adjustment.

Comparable 2005-2007 'headline life expectancy estimates for Australia', specifically factoring in the statistical impact of this methodological refinement and the improved collection of Indigenous status in the Post Enumeration Survey, were also computed for Indigenous Australians.

This method could not be used for state and territory life tables due to insufficient sample from the Post Enumeration Survey to accurately calculate age-specific identification rates. The estimates for New South Wales, Queensland, Western Australia and the Northern Territory were therefore calculated without an age-specific adjustment, and followed the same methodology that was used for the 2005–2007 life tables. Due to the different methodologies, life expectancy estimates for these states and one territory are not comparable with the headline estimates for Australia, which used an age-specific adjustment. Comparable, non age-adjusted Australia level life tables are provided to enable national and state and territory comparisons (labelled 'Australia — for comparison').

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practice.

Due to the improvements made to the method of compiling the 2010-2012 Indigenous life tables at the Australia level, a comparable set of 2005-2007 life tables was released by the ABS in Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012 (cat. no. 3302.0.55.003).

Accessibility

ABS life expectancy estimates are published on the ABS website www.abs.gov.au (see *Life Tables, States, Territories and Australia, 2010–2012* (Cat. no. 3302.0.55.001).

Indigenous life expectancy estimates are also published on the ABS website, (see *Life Tables for Aboriginal and Torres Strait Islander Australians, Australia, 2010–2012* (Cat. no. 3302.0.55.003).

Interpretability

Please view Explanatory Notes and Glossary that provide information on the data sources, terminology, classifications and other technical aspects associated with these statistics.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- A large number of unregistered deaths in Queensland dating back to 1992 were identified and registered in 2010. Care should be taken when interpreting Indigenous death data for Queensland for 2010.
- An improved method for calculating Indigenous life tables at the Australia

level, which takes age-specific Indigenous identification rates into account for calculating under-identification adjustment, was used to provide additional stand-alone Australian total data for both 2010–2012 and 2005–2007. The method could not be applied at state/territory level as robust age-specific identification rates were not available. State and Territory life expectancy estimates for 2010–2012 were produced using a similar methodology to that used for the 2005–2007 estimates.

- Data by Indigenous status are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths reported in these jurisdictions (although data are included in national totals). Further work is required to improve the quality of data by Indigenous status, to enable reporting for all states and territories. However, for some jurisdictions, it may not be possible to derive life expectancy estimates due to the small number of Indigenous deaths.
- Data by Indigenous status are available every five years. The most recent available data are for 2012 and were published in November 2013.
- Data are not available by socioeconomic status (SES). Disaggregation of this indicator by SES is a priority.
- The measure for this indicator is based on a three year average. Multiple year averages may not be able to determine trends over time as each reporting year incorporates the two previous years. Further work is required to determine what level of disaggregation is reliable for single year data.

Mortality rates — Infant and child

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Mortality rates — Infant and child
Measure (computation)	Numerator: death registrations for the period 2007-2012 (single years) provided by state and territory Registrars of Births, Deaths and Marriages. • Infant: Number of deaths among children aged under 1 year • Child 0-4: Number of deaths among children aged 0 to 4 years • Child 1-4: Number of deaths among children aged 1 to 4 years Denominator: • Infant: Number of live births in the period • Child 0-4: Population aged 0 to 4 years • Child 1-4: Population aged 1 to 4 years
Data source/s	Numerator – ABS Deaths Collection (3302.0) Denominator - ABS Births Collection, ABS Estimated Residential Population (3101.0) Infant: ABS Births Collection (3301.0) Child 0-4: ABS Population Projections (2006 Census based), (3222.0) Child 1-4: ABS Population Projections (2006 Census based), (3222.0) Indigenous: ABS Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians (2006 Census based), (3238.0)

Data Quality Framework Dimensions

Institutional environment	These collections are conducted under the Census and Statistics Act 1905. For 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, see ABS Institutional Environment.
Relevance	Deaths data are published on an annual basis. The ABS Deaths collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics. The ABS Births collection includes all births that are live born and have not been previously registered, births to temporary visitors to Australia, births occurring within Australian Territorial waters, births occurring in Australian Antarctic Territories and other external territories, births occurring in transit (i.e. on ships or planes) if registered in the state or territory of "next port of call", births to Australian nationals employed overseas at Australian legations and consular offices and births that occurred in earlier years that

have not been previously registered (late registrations). Births data exclude fetal deaths, adoptions, sex changes, legitimations and corrections, and births to foreign diplomatic staff, and births occurring on Norfolk Island.

For further information on the ABS Deaths and Births collections, see the relevant Data Quality Statements.

Timeliness

Death records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis. One dimension of timeliness in death registrations data is the interval between the occurrence and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.

Births records are provided electronically to the ABS by individual Registrars on a monthly basis for compilation into aggregate statistics on a quarterly and annual basis. One dimension of timeliness in birth registrations data is the interval between the occurrence and registration of a birth. As a result, some births occurring in one year are not registered until the following year or even later. This can be caused by either a delay by the parent(s) in submitting a completed form to the registry, or a delay by the registry in processing the birth (for example, due to follow up activity due to missing information on the form, or resource limitations).

Preliminary ERP data is compiled and published quarterly and is generally made available five to six months after the end of each reference quarter. Every year, the 30 June ERP is further disaggregated by sex and single year of age, and is made available five to six months after end of the reference quarter. Commencing with data for September quarter 2006, revised estimates are released annually and made available 21 months after the end of the reference period for the previous financial year, once more accurate births, deaths and net overseas migration data becomes available. In the case of births and deaths, the revised data is compiled on a date of occurrence basis. In the case of net overseas migration, final data is based on actual traveller behaviour. Final estimates are made available every 5 years after a census and revisions are made to the previous inter-censal period. Generally ERP data is not changed once it has been finalised unless there are compelling reasons to do so, as in June 2013 when data from September 1991 to June 2006 was revised (for more information on this recasting process, please see the feature article titled Recasting 20 years of ERP in the December quarter 2012 issue of Australian Demographic Statistics (cat. no. 3101.0).

For further information on ABS Estimated Resident Population, see the relevant Data Quality Statement.

Accuracy

Information on births and deaths is obtained from a complete enumeration of births and deaths registered during a specified period and are not subject to sampling error. However, births and deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data.

Concerns have been raised with the accuracy of the NSW births counts in recent years. In response to these concerns the ABS, in conjunction with the NSW Registry of Births, Deaths and Marriages, has undertaken an investigation which has led to the identification of an ABS systems processing error. The ABS acknowledges that this has resulted in previous undercounts of births in NSW. Data for NSW and Australia have been revised to include previously unprocessed NSW birth registrations for the

period 2005 to 2011.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

In November 2010, the Queensland Registrar of Births, Deaths and Marriages advised the ABS of an outstanding deaths registration initiative undertaken by the Registry. This initiative resulted in the November 2010 registration of 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). Of these, around three-quarters (284) were deaths of Aboriginal and Torres Strait Islander Australians.

The ABS discussed different methods of adjustment of Queensland death registrations data for 2010 with key stakeholders. Following the discussion, a decision was made by the ABS and key stakeholders to use an adjustment method that added together deaths registered in 2010 for usual residents of Queensland which occurred in 2007, 2008, 2009 and 2010. This method minimises the impact on mortality indicators used in various government reports. However, care should still be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010.

Investigation conducted by the WA Registrar of Births, Deaths and Marriages indicated that some deaths of non-Indigenous people were wrongly recorded as deaths of Indigenous people in WA for 2007, 2008 and 2009. The ABS discussed this issue with a range of key stakeholders and users of Aboriginal and Torres Strait Islander deaths statistics. Following this discussion, the ABS did not release WA Aboriginal and Torres Strait Islander deaths data for the years 2007, 2008 and 2009 in the 2010 issue of *Deaths, Australia* publication, or in the 2011 COAG data supply. The WA Registry corrected the data and resupplied the corrected data to the ABS. These corrected data were then released by the ABS in spreadsheets attached to *Deaths, Australia, 2010* (cat. no. 3302.0) publication on 24 May 2012, and are included in this round of COAG reporting.

All ERP data sources are subject to non-sampling error. Non-sampling error can arise from inaccuracies in collecting, recording and processing the data. In the case of Census and Post Enumeration Survey (PES) data every effort is made to minimise reporting error by the careful design of questionnaires, intensive training and supervision of interviewers, and efficient data processing procedures. The ABS does not have control over any non-sampling error associated with births, deaths and migration data. For more information see the *Demography Working Paper 1998/2 - Quarterly birth and death estimates, 1998 (cat. no. 3114.0)* and Australian Demographic Statistics (cat. no. 3101.0).

Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population projections are based on assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by

	subtracting the projected Indigenous population from the total population. For the current round of COAG reporting, in the absence of 2011 Census-based Indigenous population projections, the non-Indigenous population denominator has been calculated by subtracting the 2006 Census-based Indigenous projections (see Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, August 2009, cat. no. 3238.0) from the 2006 Census-based ERP for total population (3101.0). 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. Non-Indigenous data from the Deaths collection do not include death registrations with a 'not stated' Indigenous status. Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading for example where the non-Indigenous mortality rate is higher than the indigenous mortality rate. All rates in this indicator must be used with caution.
Coherence	The methods used to construct the indicator are consistent and comparable with other collections and with international practice.
Accessibility	Deaths data are available in a variety of formats on the ABS website under the 3302.0 product family. Births data are available in a variety of formats on the ABS website under the 3301.0 product family. ERP data is available in a variety of formats on the ABS website under the 3101.0 product family. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act* (1905). This may restrict access to data at a very detailed level.
Interpretability	Data for this indicator have been presented as crude rates, either per 1,000 live births or 1000 estimated resident population.

Mortality rates by major cause of death

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Age standardised mortality by major cause of death
Measure (computation)	Numerator: death registrations by major cause of death. Denominator: Estimated Resident Population, Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, Population Projections, Australia
Data source/s	Numerator – ABS Causes of death statistics are sourced from death registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory, that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred. As part of the registration process, information on the causes of death is either supplied by the medical practitioner certifying the death on a *Medical Certificate of Cause of Death*, or supplied as a result of a coronial investigation. Death records are provided electronically to the ABS by individual Registrars, on a monthly basis. Each death record contains both demographic data and medical information from the *Medical Certificate of Cause of Death*, where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS) Denominator - ABS Estimated Resident Population (3101.0); Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, August 2009 (cat. no. 3238), Series B. For the non-Indigenous population, the projected Indigenous population (3238.0, Series B) is subtracted from the 2006-Census-based Estimated Resident Population.

Data Quality Framework Dimensions

Institutional environment	These collections are conducted under the Census and Statistics Act 1905. For 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, see ABS Institutional Environment.
Relevance	The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics. From the 2006 reference year, the scope of the collection is: • all deaths registered in Australia for the reference year and which are received by the ABS by the end of the March quarter of the subsequent

year; and

- deaths registered prior to the reference year but not previously received from the Registrar, nor included in any statistics reported for an earlier period.

For example, records received by the ABS during the March quarter of 2011 which were initially registered in 2010 or prior (but not forwarded to the ABS until 2011) are assigned to the 2010 reference year. Any registrations relating to 2010 which are received by the ABS after the end of the March quarter are assigned to the 2011 reference year.

Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Statistical Classification of Diseases and Related Health Problems (ICD). The ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used by the ABS to code cause of death since 1997.

See Causes of Death, Australia, 2011 (cat.no. 3303.0) for further detail on scope and coverage of the collection.

Timeliness

Death records are provided electronically to the ABS by individual Registrars and the National Coroners Information System (NCIS) on a monthly basis, for compilation into aggregate statistics on an annual basis. One dimension of timeliness in causes of death registrations data is the interval between the occurrence and registration of a death. As a result, a small number of deaths occurring in one year are not registered until the following year or later.

Causes of Death data are published annually, following the publication of Deaths, Australia (ABS cat 3302.0) in November of each year.

There is a focus on fitness for purpose when causes of death statistics are released. To meet user requirements for accurate causes of death data, it is necessary to obtain information from other administrative sources before all information for the reference period is available (e.g. information from finalisation of coronial proceedings to code an accurate cause of death). A balance therefore needs to be maintained between accuracy (completeness) of data and timeliness. The ABS provides the data in a timely manner, ensuring that all coding possible can be undertaken with accuracy prior to publication.

In addition, to address the issues which arise through the publication of causes of death data for open coroners' cases, these data are now subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing. For further information on the revisions process see Causes of Death, Australia, 2011 (cat.no. 3303.0) Explanatory Notes and Causes of Death Revisions 2009 and 2010 (Technical Note). See also Causes of Death Revisions 2006 (Technical Note) in Causes of Death, Australia, 2010 (cat. No. 3303.0).

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period, so is not subject to sampling

error. However, causes of death data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data. The most significant of these errors are: mis-reporting of data items; deficiencies in coverage; incomplete records; and processing errors. Every effort is made to minimise non-sample error by working closely with data providers, running quality checks throughout the data processing cycle, training of processing staff, and efficient data processing procedures.

Although it is considered likely that most deaths of Aboriginal and Torres Strait Islander (Indigenous) Australians are registered, a proportion of these deaths are not registered as Indigenous. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred and may differ from the self-identified Indigenous origin of the deceased. Forms are often not subject to the same best practice design principles as statistical questionnaires, and respondent and/or interviewer understanding is rarely tested. Over-precise analysis of Indigenous deaths and mortality should be avoided.

Causes of death statistics are released with a view to ensuring that they are fit for purpose when released. Supporting documentation for causes of death statistics are published and should be considered when interpreting the data to enable the user to make informed decisions on the relevance and accuracy of the data for the purpose the user is going to use those statistics. To meet user requirements for timely data it is often necessary to obtain information from the administrative source before all information for the reference period is available (e.g. finalisation of coronial proceedings). A balance needs to be maintained between accuracy (completeness) of data and timeliness, taking account of the different needs of users.

All coroner certified deaths registered after 1 January 2006 are now subject to a revisions process. In this round of COAG reporting, 2007, 2008 and 2009 data is final, 2010 data is revised and 2011 data is preliminary. Data for 2010 and 2011 is subject to further revisions. Prior to 2006 all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (e.g. a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths, as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

Revisions will only impact on coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See Technical Note: Causes of Death Revisions 2009 and 2010 and in Causes of Death, Australia, 2011 (cat.no. 3303.0).

In November 2010, the Queensland Registrar of Births, Deaths and Marriages advised the ABS of an outstanding deaths registration initiative undertaken by the Registry. This initiative resulted in the November 2010 registration of 374 previously unregistered deaths which occurred between 1992 and 2006 (including a few for which a date of death was unknown). Of these, around three-quarters (284) were deaths of Aboriginal and Torres Strait Islander Australians.

The ABS discussed different methods of adjustment of Queensland death

registrations data for 2010 with key stakeholders. Following the discussion, a decision was made by the ABS and key stakeholders to use an adjustment method that added together deaths registered in 2010 for usual residents of Queensland which occurred in 2007, 2008, 2009 and 2010. This method minimises the impact on mortality indicators used in various government reports. However, care should still be taken when interpreting Aboriginal and Torres Strait Islander death data for Queensland for 2010. Please note that there are differences between data output in the Causes of Death, Australia, 2010 publication (cat. No. 3303.0) and 2010 data reported for COAG, as this adjustment was not applied in the publication. For further details see Technical Note: Registration of outstanding deaths, Queensland 2010, from the Deaths, Australia, 2010 publication (cat. no. 3302.0) and Explanatory Note 103 in the Causes of Death, Australia, 2010 publication (cat. no. 3303.0).

Investigation conducted by the WA Registrar of Births, Deaths and Marriages indicated that some deaths of non-Indigenous people were wrongly recorded as deaths of Indigenous people in WA for 2007, 2008 and 2009. The ABS discussed this issue with a range of key stakeholders and users of Aboriginal and Torres Strait Islander deaths statistics. Following this discussion, the ABS did not release WA Aboriginal and Torres Strait Islander deaths data for the years 2007, 2008 and 2009 in the 2010 issue of *Deaths, Australia* publication, or in the 2011 COAG data supply. The WA Registry corrected the data and resupplied the corrected data to the ABS. These corrected data were then released by the ABS in spreadsheets attached to *Deaths, Australia, 2010* (ABS, 2011) publication on 24 May 2012, and are included in this round of COAG reporting.

Coherence

The international standards and recommendations for the definition and scope of causes of deaths statistic in a vital statistics system are set out in the **Principles and Recommendations for a Vital Statistics System Revision 2,** published by the United Nations Statistical Division (UNSD). Consistent with the UNSD recommendations, the ABS defines a death as the permanent disappearance of all evidence of life at any time after live birth has taken place. In addition, the UNSD recommends that the deaths to be counted include all deaths "occurring in every geographic area and in every population group comprising the national area". For the purposes of Australia, this includes all deaths occurring within Australia as defined by the **Australian Statistical Geography Standard (ASGS)** that applies at the time.

Registration of deaths is compulsory in Australia under relevant state/territory legislation. However, each state/territory Registrar has its own death registration form. Most data items are collected in all states and territories and therefore statistics at a national level are available for most characteristics. In some cases, different wording of questions asked on the registration form may result in different answers, which may affect final figures.

Use of the supporting documentation released with the statistics is important for assessing coherence within the dataset and when comparing the statistics with data from other sources. Changing business rules over time and/or across data sources can affect consistency and hence interpretability of statistical output. The Explanatory Notes in each issue contains information pertinent to this particular release which may impact on comparison over time

Accessibility	Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the **Census and Statistics Act** (1905). This may restrict access to data at a very detailed level.
Interpretability	Information on data sources, terminology, classifications and other technical aspects associated with death statistics can be found in Causes of Death, Australia, (cat.no 3303.0) in the Explanatory Notes, Appendices and Glossary on the ABS website.

Profile of employed health workforce

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Health Agreement (data supplied by ABS) with additional Steering Committee comments.

Indicator definition and description

Indicator	Profile of employed health workforce
Measure (computation)	Full time equivalent employed health practitioners per 1000 population (by age group). Workforce sustainability reports aged profiles for nurse and midwife, medical practitioner, dental practitioner and allied health practitioner workforces. It shows the numbers of each of these registered professions in ten year age brackets, both by jurisdiction and by region.
Data source/s	National Health Workforce Data Set: medical practitioners 2010, 2011 and 2012. National Health Workforce Data Set: nurses and midwives 2011 and 2012.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator using estimates derived from the National Health Workforce Data Set (NHWDS). The NHWDS is developed through the collaboration of three agencies. The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme (NRAS) across Australia, including collecting registration data and administering the workforce surveys. Health Workforce Australia is responsible for the development of the health workforce surveys. The AIHW receives registration and survey data from the AHPRA. The registration and workforce survey data are combined, cleansed and adjusted for non-response to form NHWDS, and the findings reported by profession. AIHW is the data custodian of the NHWDS. These data are used for workforce planning, monitoring and reporting. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister. For further information see the AIHW website.
Relevance	Medical practitioners, dental practitioners, nurses/midwives and allied health practitioners are required by law to be registered with their relevant national board to practise in Australia. All medical practitioners, dental practitioners, nurses/midwives and nominated allied health practitioners must complete the formal registration renewal form(s) to practise in Australia. This is the compulsory component of the renewal process. The exception is Aboriginal and Torres Strait Islander health practitioners in the allied health workforce; where those who are not required by their employer to use the title 'Aboriginal and Torres Strait Islander health practitioner', 'Aboriginal health practitioner' or 'Torres Strait Islander health practitioner'

are not required to be registered, and can continue to work using their current titles (e.g. 'Aboriginal health worker', 'drug and alcohol worker' and 'mental health worker').

The health workforce surveys for each of these professions is voluntary and only practitioners who renew their registration receive a questionnaire for completion. New registrants will not receive a survey form until they renew their registration the following year, during the registration renewal period. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

National Health Workforce Data Set: medical practitioners 2010, 2011 and 2012

The NHWDS: medical practitioners 2010, 2011 and 2012 contain registration details of all registered medical practitioners in Australia, at 30 September on the annual renewal date. Data were extracted from the AHPRA database at the end of November of the same year. The NHWDS also contains workforce data of respondents whose principal state of practice was not Queensland or Western Australia, obtained from the Medical Workforce Survey 2010. These states were excluded from the survey because not all registrations in these states expired prior to the national registration deadline. In 2011 and 2012, the NHWDS contains workforce data obtained from the Medical Workforce Survey for all states and territories.

National Health Workforce Data Set: dental practitioners 2011 and 2012

The NHWDS: dental practitioners 2011 and 2012 contain registration details of all registered dental practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database at the end of January the following year. In 2011 and 2012, the NHWDS contains workforce data obtained from the Dental Workforce Survey.

National Health Workforce Data Set: nurses and midwives 2011 and 2012

The NHWDS: nurses and midwives 2011 and 2012 contain registration details of all registered nurses/midwives in Australia at 31 May on the annual renewal date. Data were extracted from the AHPRA database at the end of November of the same year. In 2011 and 2012, the NHWDS contains workforce data obtained from the Nursing and Midwifery Workforce Survey.

National Health Workforce Data Set: allied health practitioners 2011 and 2012.

The NHWDS: allied health practitioners 2011 and 2012 contain registration details of all registered allied health practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database at the end of January the following year. The NHWDS also contains workforce data obtained from each profession-specific health workforce survey.

Indicator data for allied health practitioners are not comparable between 2011 and 2012 due to four additional professions joining the NRAS in 2012. For 2011, data was collected for seven professions: chiropractors, optometrists, osteopaths, pharmacists, physiotherapists, psychologists and podiatrists. For 2012, in addition to the seven in 2011, data was collected

for Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.

Due to transitional arrangements with the migration of data from state and territory-based systems to NRAS, in 2012, many medical radiation practitioners in Queensland, Western Australia and Tasmania were not required to renew their registrations and, as a result did not complete a workforce survey. As a consequence, data for Queensland, Western Australia and Tasmania for this profession are excluded from the indicator data for allied health practitioners.

For the same reason, occupational therapists in Queensland, Western Australia and South Australia are excluded from the indicator data for allied health practitioners in 2012.

Timeliness

National Health Workforce Data Set:

The NHWDS for each of the registered professions will be produced annually during the national registration renewal process. Each profession will also be administered a Workforce Survey as part of the registration renewal process.

—*Medical practitioners 2010, 2011 and 2012*

The NHWDS: medical practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 July and 30 September each year, including the collection of the Medical Workforce Survey. The period for the 2010 renewal process was extended to the end of January 2011. Despite this extension, there were still Queensland and Western Australia registrants with expiry dates after January. Therefore data from these states were not included in the 2010 data set.

—*Nurses and midwives 2011 and 2012*

The NHWDS: nurses and midwives is produced annually from information collected by the national registration renewal process, conducted between 1 April and 31 May each year, including the collection of the Nursing and Midwifery Workforce Survey. The period for the 2011 renewal process was extended to the end of June 2011 for Queensland and end of December 2011 for Western Australia registrants.

Accuracy

Data manipulation and estimation processes

The registration and workforce survey data for each health profession are combined, cleansed and adjusted for non-response to form the National Health Workforce Data Set (NHWDS). The cleaning and editing procedures included range and logic checks, clerical scrutiny at unit record level, and validation of unit record and aggregate data.

The data have undergone imputation for item non response and are weighted to the total number of registered practitioners to adjust for population non response. It should be noted that both of these kinds of non-response is likely to introduce some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of records. Care should be taken when drawing conclusions about the size of the differences between estimates.

As a result of the estimation method to adjust for non-response, numbers of medical practitioners, dental practitioners, nurses/midwives or allied health practitioners may have been in fractions, but have been rounded to whole numbers for this indicator. The full-time equivalent (FTE) rate calculations are based on rounded numbers.

Registration data from the National Registration and Accreditation Scheme (NRAS)

Registration details were migrated from the respective state and territory professional board (or council) for practitioners with registrations expiring after the official AHPRA closing date for their profession.

Some data items previously collected by the AIHW Labour Force Surveys are now collected by the NRAS. However, some data quality issues due to migrated data items from the respective state and territory health profession boards may have affected the weighting method.

Medical practitioners, dental practitioners, nurses/midwives and allied health practitioners who reside overseas have been included with practitioners whose state or territory of principal practice and state or territory of main job, respectively, could not be determined.

Health Workforce Survey

The online survey questionnaire does not include electronic sequencing of questions to automatically guide the respondent to the next appropriate question based on previous responses to questions. This resulted in a number of inconsistent responses.

The order of the response categories for some questions may have also impacted on the accuracy of the information captured. In addition, there was variation in some responses between the online and paper surveys.

NHWDS data by profession

The following should be noted when comparing state and territory indicator data:

- The data include employed professionals who did not state or adequately describe their state of principal practice and employed professionals who reside overseas. The national estimates include this group.

National Health Workforce Data Set: medical practitioners 2010, 2011 and 2012

- The overall response rate for 2010 (excluding Queensland and Western Australia) was 76.6 per cent.
- The overall response rate for 2011 was 85.3 per cent.
- The overall response rate for 2012 was 90.1 per cent.

National Health Workforce Data Set: nurses and midwives 2011 and 2012

- The overall response rate for 2011 was 85.1 per cent.

The overall response rate for 2012 was 93.3 per cent.

Coherence

Health Workforce Survey—coherence with previous surveys

Labour force data published by the AIHW before the NRAS was established in July 2010, were the result of collated jurisdiction-level occupation-specific surveys. The current Health Workforce Survey gathers similar information from each professional group through a separate questionnaire, tailored slightly to take account of profession-specific responses to certain questions, e.g. work setting of main job.

For this indicator, the workforce surveys for medical practitioners, dental practitioners, nurses/midwives and allied health practitioners collect similar data items, but the methodology differs from previous years. The AHPRA is now the single source of registered practitioner data instead of eight state and territories bodies for each profession, and there is greater consistency between jurisdictions and years in the scope of registration information.

The scope and coverage of the Health Workforce Survey is also different from that of the previous series of AIHW Labour Force Surveys as not all jurisdictions surveyed all types of registered health practitioners.

If the location of principal practice recorded in the registration data was different from the corresponding details of their main job self-reported by practitioners in the survey, the location was derived hierarchically based on main job information and then on principal practice location then place of residence.

Date of birth is one of many data items previously collected by the AIHW Labour Force Surveys, which is now collected by the NRAS.

The three employment-related questions in the new survey are now nationally consistent, but vary from the previous AIHW Labour Force Survey. Due to the differences in data collection (including survey design and questionnaire), processing and estimation methods, it is recommended that comparisons between workforce data from the NHWDS and the previous AIHW Labour Force Survey be made with caution.

AIHW Published Numbers

For this indicator, the rates are based on practitioners employed in the medical, allied health and nursing and midwifery workforces, which is consistent with data published in AIHW's workforce reports. Except dental practitioner data are restricted to persons employed in the public sector and are thus not comparable to figures published elsewhere by the AIHW.

Registration data from the NRAS—coherence with published AHPRA/Board data

The NHWDS comprises the registration data extracted at a point in time from the NRAS, while the AHPRA/Board numbers include people registered in the previous 12 months, thereby including registrants whose registration terminated during that period (including short term registrants).

For 2011, the only source of published statistics about registered health professionals is the 2010–11 AHPRA annual report. From March 2012, each Board publishes the data on a quarterly basis.

Medical practitioners in 2010, 2011 and 2012.

The NHWDS numbers of registered medical practitioners for 2010 and 2011 are similar to data reported in the 2010–11 AHPRA annual report. For 2010, there were 84,516 registered practitioners for 2010, compared with 88,293 registered practitioners at 30 June 2011 in the AHPRA annual report.

For 2011, there were 87,790 registered medical practitioners in the NHWDS. Furthermore, the Medical Board of Australia in their quarterly data tables reported 91,354 for March 2012 and 91,645 for June 2012.

For 2012, there were 91,504 registered medical practitioners in the NHWDS, compared with 91,745 reported at December 2012 in the AHPRA quarterly data tables.

Nurses/midwives in 2011 and 2012

The NHWDS number of registered nurses and midwives for 2011 is similar to data reported in the 2010–11 AHPRA annual report, with 330,680 registered nurses and midwives in the NHWDS, compared with 332,185 registered nurses and midwives at 30 June 2011 in the AHPRA annual report. The Nursing and Midwifery Board of Australia in their quarterly data

tables reported 341,189 for March 2012.

For 2012, there were 334,078 registered nurses and midwives in the NHWDS, compared with 343,703 reported at June 2012 in the 2011–12 AHPRA annual report.

Accessibility Published products available on the AIHW website include workforce reports, survey questionnaires, user guides to the data sets and supplementary detailed tables.

Interpretability Explanatory information for the Medical Workforce Survey, Dental Workforce Survey and the Nursing and Midwifery Workforce Survey is contained in the published reports, supplementary detailed tables and data quality statements to the data set for each. For individual allied health professions, information about their workforce surveys is available in the *Allied health workforce 2012* report and data quality statement. This includes collection method, scope and coverage, survey response, imputation and weighting procedures, and assessment of data quality (including comparison with other data sources).

These are available via the AIHW website and readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator.

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- The rates have been calculated per 100,000 population for this indicator to assist with interpretation.
- Due to the differences in data collection, processing and estimation methods, including survey design and questionnaire, it is recommended that comparisons between workforce data from the National Health Workforce Data Set (NHWDS) and the previous Australian Institute of Health and Welfare (AIHW) Labour Force Survey be made with caution.
- Results for the indicator are estimates because the survey data have undergone imputation and weighting to adjust for non-response. It should be noted that any of these adjustments may have introduced some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of survey records. Care should be taken when drawing conclusions about the size of the differences between estimates.
- The 2011 and 2012 allied health workforce indicator data exclude provisional registrants.
- The 2012 dental, medical and nursing and midwifery workforce indicator data exclude provisional registrants.
- Data have been revised since the publication of *Medical workforce 2010*, *Medical workforce 2011* and *Nursing and midwifery workforce 2011*, so these data will not match data previously published.
- The 2011 data for osteopaths in the allied health workforce has been revised since the publication of *Allied health workforce 2012*, so the data will not match data previously published.

10 Public hospitals

CONTENTS

Attachment tables

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

Public hospitals are important providers of government funded health services in Australia. This chapter reports on the performance of State and Territory public hospitals, focusing on acute care services. It also reports separately on a significant component of the services provided by public hospitals — maternity services.

Major improvements in reporting on public hospitals in this edition include:

- 'Emergency department waiting times' and 'Elective surgery waiting times' data are reported by socioeconomic status

- a new measure 'Presentations to emergency departments with a length of stay of 4 hours or less ending in admission' is reported under the 'Waiting times for admitted patient services' indicator
- 'Selected hospital procedures' are reported by Indigenous status, remoteness and socioeconomic status
- a new maternity services indicator 'Instrumental vaginal births' is reported
- improved data are reported for the maternity services indicator 'Mother's average length of stay'
- data quality information (DQI) is available for the first time for the indicators 'Recurrent cost per non-admitted occasion of service', 'Caesareans for selected primiparae', 'Inductions for selected primiparae' and 'Instrumental vaginal births'.

10.1 Profile of public hospitals

Definition

A key objective of Australian governments is to provide public hospital services to ensure the population has access to cost-effective health services, based on clinical need and within clinically appropriate times, irrespective of geographic location. Public hospitals provide a range of services, including:

- acute care services to admitted patients
- subacute and non-acute services to admitted patients (for example, rehabilitation, palliative care, and long stay maintenance care)
- emergency, outpatient and other services to non-admitted patients
- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
- public health services
- teaching and research activities.

This chapter focuses on services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity and, in the case of services to admitted patients, have the most reliable data relative to other hospitals data. Data in the chapter include subacute and non-acute care services.

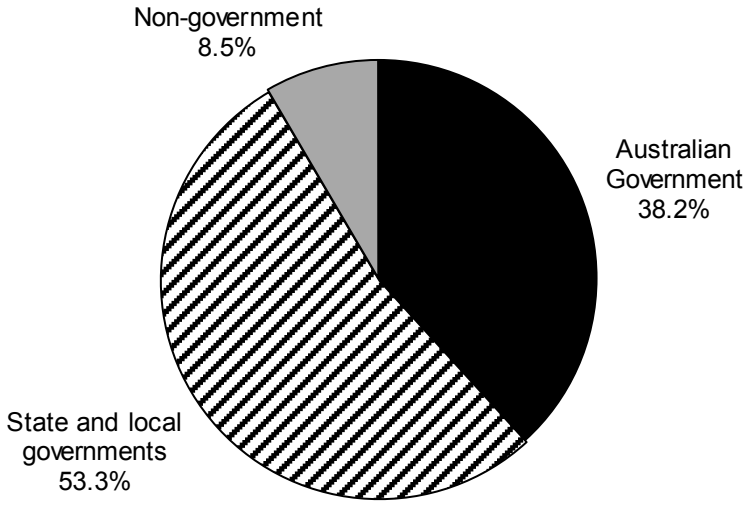
In some instances, data for stand-alone psychiatric hospitals are included in this chapter. However, under the National Mental Health Strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the 'Mental health management' chapter of this Report (chapter 12).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $40.4 billion in 2011-12 (table 10A.1). The majority of public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2011-12, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) was around 70 per cent across Australia (AIHW 2013a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments contributed 91.5 per cent of funding for public hospital services in 2011-12 (figure 10.1). Public hospital services accounted for 41.9 per cent of government recurrent expenditure on health services in 2011-12 (AIHW 2013b).

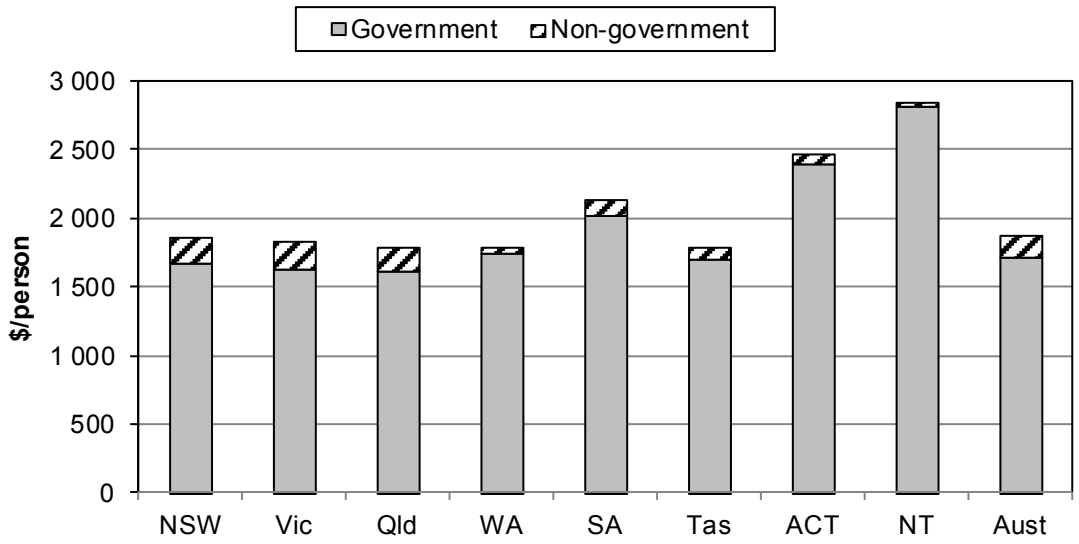
Figure 10.1 **Recurrent expenditure, public hospital services, by source of funds, 2011-12**



Source: AIHW (2013), *Health expenditure Australia 2011–12*, Health and Welfare Expenditure Series No. 50, Cat. no. HWE 59. Canberra.

Non-government sources contributed 8.5 per cent of all recurrent expenditure on public hospital services in 2011-12 (including depreciation) (figure 10.2 and table 10A.2). Non-government expenditure comprised revenue from health insurance funds, individuals, workers' compensation and compulsory third-party motor vehicle insurers and other sources. The proportion of hospitals' revenue per person funded from non-government sources varied across jurisdictions in 2011-12 (figure 10.2).

Figure 10.2 **Source of public hospital recurrent expenditure, 2011-12**[a, b, c]



a Depreciation is included in recurrent expenditure. **b** Non-government expenditure includes expenditure by health insurance funds, individuals, workers' compensation, compulsory third-party motor vehicle insurers and other sources. **c** The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

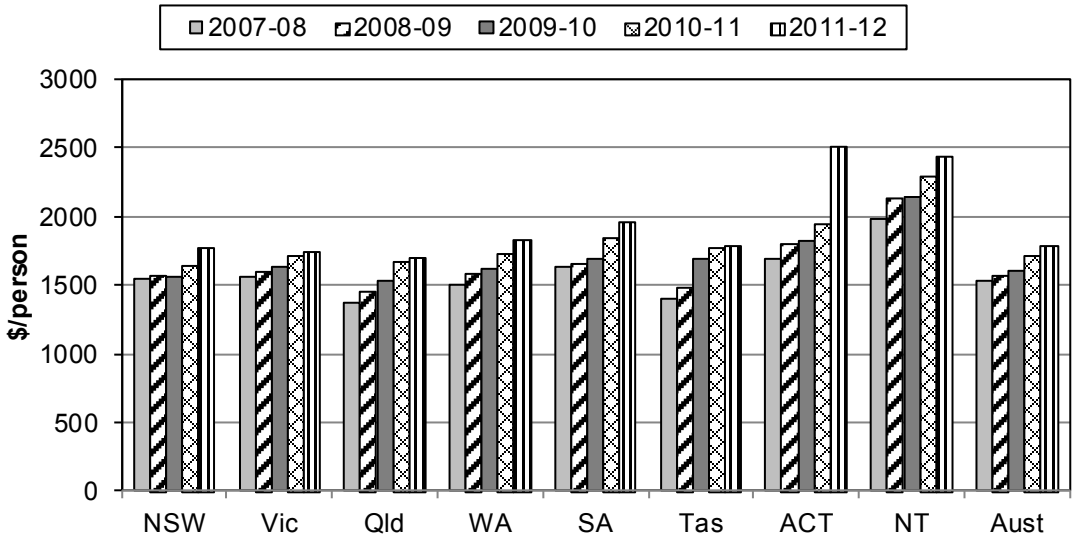
Source: AIHW (2013), *Health expenditure Australia 2011–12*, Health and Welfare Expenditure Series No. 50, Cat. no. HWE 59. Canberra; table 10A.2.

Expenditure data in figures 10.1 and 10.2 are sourced from unpublished data from the AIHW Health Expenditure Australia database, and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2011-12* (AIHW 2013a). The AIHW publication *Health Expenditure Australia 2011-12* provides information about the differences in the expenditure data between the two sources (AIHW 2013b).

In 2011-12, government real recurrent expenditure on public hospitals was $1792 per person nationally, up from $1525 in 2007-08 (in 2011-12 dollars) (figure 10.3). It is difficult to make comparisons across jurisdictions based on these recurrent expenditure data, due to differences in the data coverage. The main differences are:

- the inclusion, by some jurisdictions, of expenditure on community health services as well as public hospital services
- the exclusion, by some jurisdictions, of expenditure on privately owned or privately operated hospitals that have been contracted to provide public hospital services.

Figure 10.3 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2011-12 dollars)[a, b, c, d, e]**



a Expenditure data exclude depreciation and interest payments. **b** Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. **c** Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2013b). **d** Queensland pathology services were purchased from a Statewide pathology service rather than being provided by hospital employees. **e** The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 71, 84, 107, 117 and 134; AIHW (2013), *Health expenditure Australia 2011–12*, Health and Welfare Expenditure Series No. 50, Cat. no. HWE 59. Canberra, AIHW; table 10A.3.

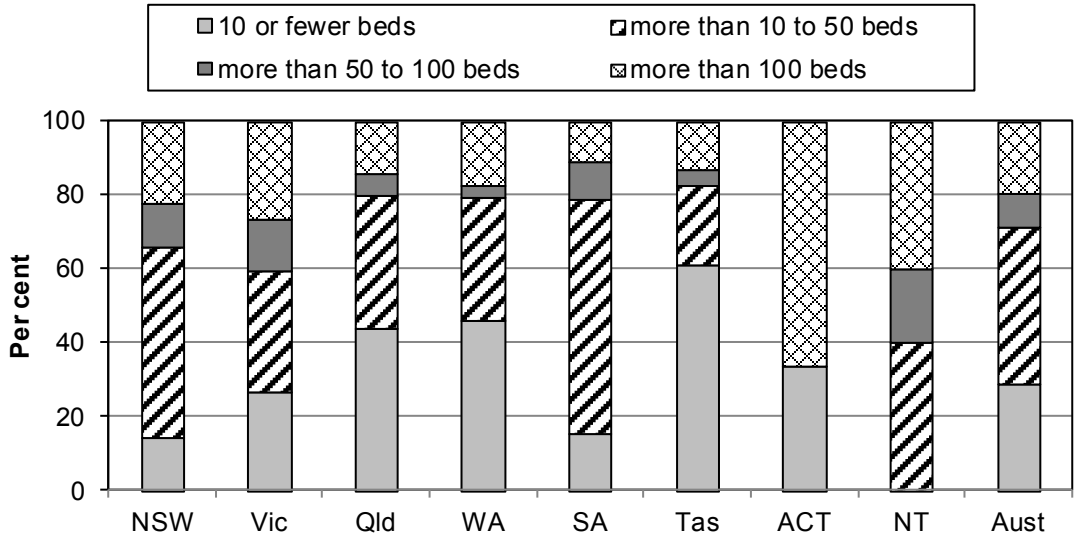
Size and scope of sector

There are several ways to measure the size and scope of Australia's public hospital sector. This chapter reports on: the number and size of hospitals; the number and location of public hospital beds; the number and type of public hospital separations; the proportion of separations by age group of the patient; the number of separations and incidence of treatment, by procedure and Indigenous status of the patient; the number of hospital staff; and types of public hospital activity.

Hospitals

In 2011-12, Australia had 753 public hospitals (including 17 psychiatric hospitals) (table 10A.4 and AIHW 2013a). Although 71 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 15 per cent of total available beds (figure 10.4 and table 10A.4).

Figure 10.4 **Public hospitals, by size, 2011-12**[a, b, c, d, e]



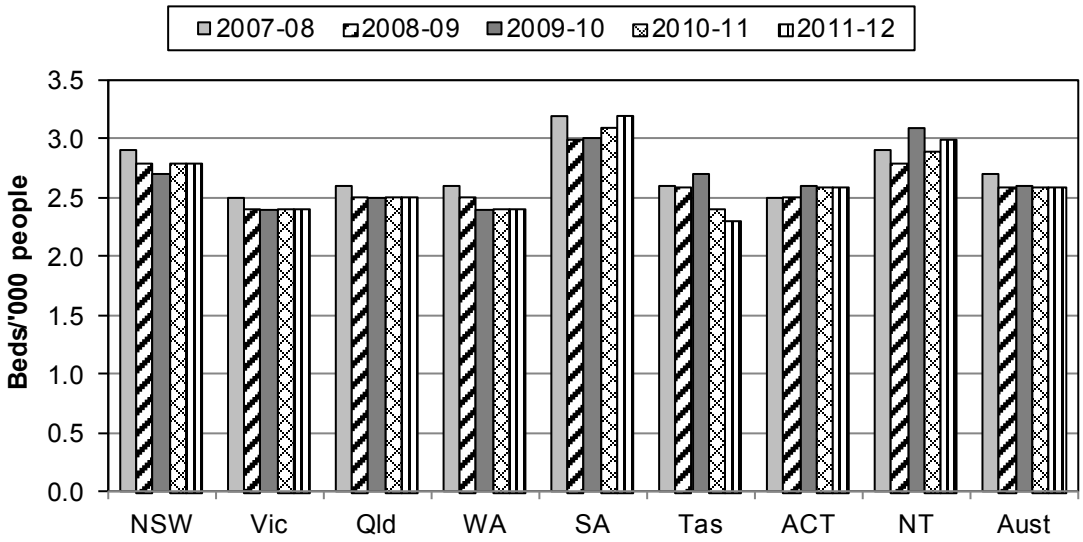
[a] The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of hospital buildings or campuses. [b] Size is based on the average number of available beds. [c] The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services. [d] The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database. [e] The ACT did not have hospitals with more than 10 to 50 beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.4.

Hospital beds

There were 58 420 available beds for admitted patients in public hospitals in 2011-12, equivalent to 2.6 beds per 1000 people (figures 10.5 and table 10A.4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the increasing significance of same day hospitalisations and hospital-in-the-home care (AIHW 2011a). Nationally, about 88 per cent of beds in public acute hospitals were available for overnight-stay patients in 2011-12 (AIHW 2013a).

Figure 10.5 **Available beds, public hospitals[a]**



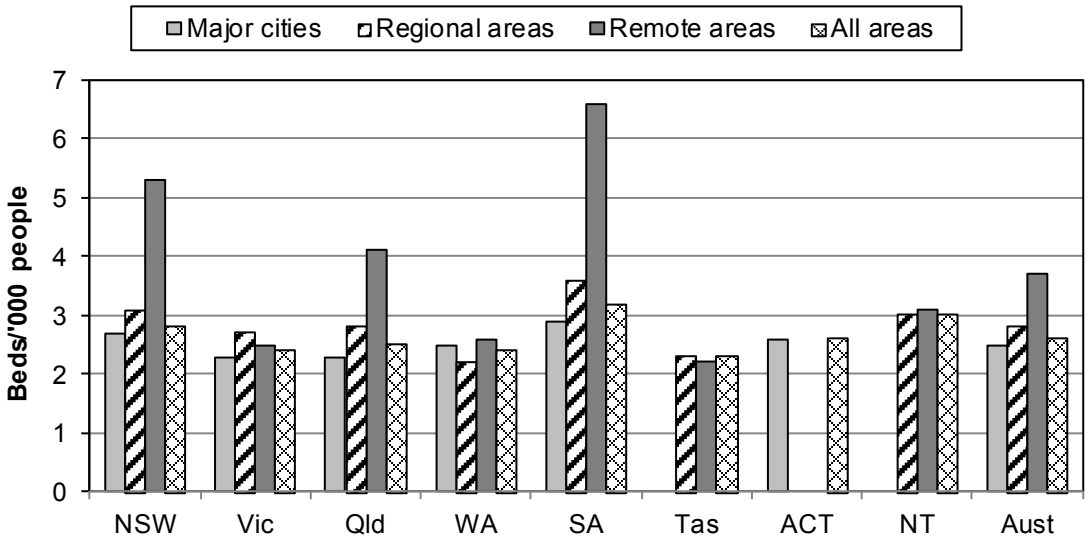
[a] Available beds includes both average available beds for overnight and same day accommodation. Average available overnight beds is the number of beds available to provide overnight accommodation for patients (other than neonatal cots (nonspecial-care) and beds occupied by hospital-in-the-home patients), averaged over the counting period. Average available same day beds is the number of beds, chairs or trolleys available to provide accommodation for same-day patients, averaged over the counting period (HDSC 2012).

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 71, 84, 107, 117 and 134; table 10A.5.

The comparability of bed numbers can be affected by the casemix of hospitals, including the extent to which hospitals provide same day admitted services and other specialised services. There are also differences in admission practices and how available beds are counted, both across jurisdictions and over time.

Nationally, more beds were available per 1000 people in remote areas (figure 10.6). The patterns of bed availability can reflect a number of factors, including patterns of availability of other healthcare services, patterns of disease and injury and the relatively poor health of Indigenous Australians, who have higher population concentrations in remote areas. These data also need to be viewed in the context of the age and sex structure (reported in chapter 2) and the morbidity and mortality (reported in the 'Health sector overview') of the population in each State and Territory.

Figure 10.6 **Available beds, public hospitals, by location, 2011-12**[a, b, c]



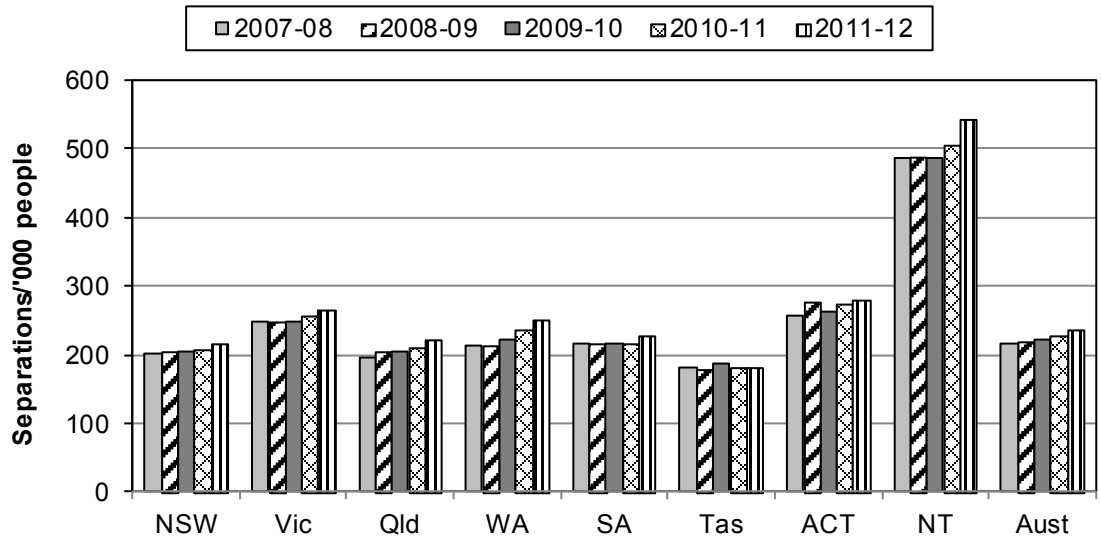
a Available beds includes both average available beds for overnight and same day accommodation. Average available overnight beds is the number of beds available to provide overnight accommodation for patients (other than neonatal cots (nonspecial-care) and beds occupied by hospital-in-the-home patients), averaged over the counting period. Average available same day beds is the number of beds, chairs or trolleys available to provide accommodation for same-day patients, averaged over the counting period (HDSC 2012). **b** Analysis by remoteness area is of less relevance to geographically smaller jurisdictions and those jurisdictions with small populations residing in remote areas (such as Victoria) (AIHW 2013a). **c** Tasmania and the NT do not have major cities and the ACT does not have regional and remote areas.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.5.

Admitted patient care

There were approximately 5.5 million separations from public (non-psychiatric) hospitals in 2011-12 (table 10A.6). Nationally, this translates into 236.0 separations per 1000 people (figure 10.7). Acute separations accounted for 95.3 per cent of separations from public hospitals, newborns who required acute care accounted for 1.3 per cent and rehabilitation care accounted for 1.7 per cent (table 10A.13). Palliative care, geriatric evaluation and management and maintenance care constitute the remainder. Of the total number of separations in public (non-psychiatric) hospitals, 51.0 per cent were for same day patients. Public psychiatric hospitals accounted for around 0.2 per cent of total separations in public hospitals in 2011-12 (table 10A.6).

Figure 10.7 **Separation rates in public (non-psychiatric) hospitals**[a, b, c]



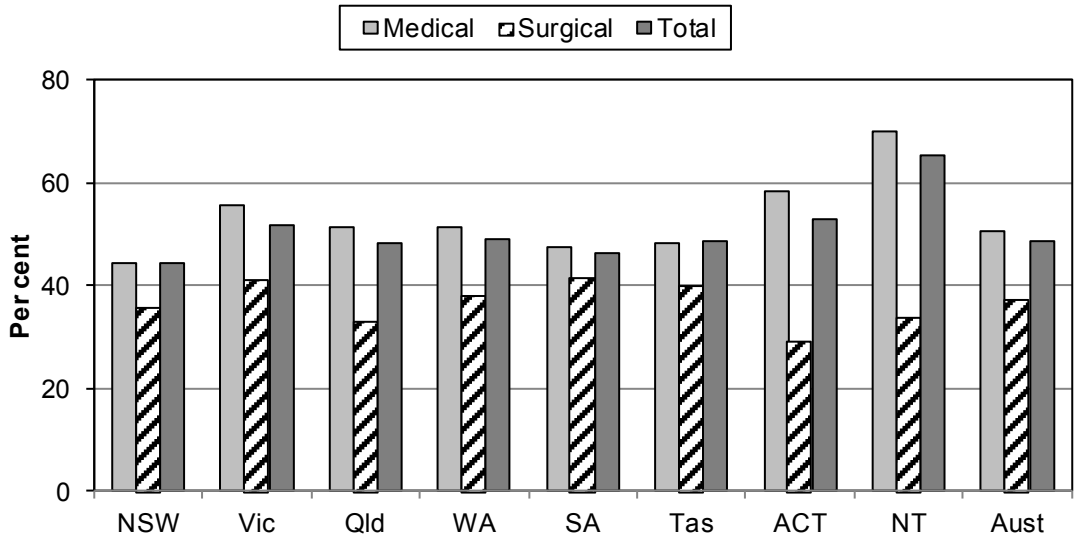
[a] Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders (hospital boarder is defined in section 10.8) and posthumous organ procurement. [b] Rates are directly age standardised to the Australian population at 30 June 2001. [c] The NT has a high percentage of the population that is Indigenous which contributes to the high level of separations in the NT.

Source: AIHW (various years), *Australian Hospital Statistics,* Health Services Series, Cat. nos HSE 71, 84, 107, 117 and 134; table 10A.7.

Differences across jurisdictions in separation rates reflect variations in the health profiles of the people living in each State and Territory, the decisions made by medical staff about the type of care required and people's access to services other than public hospitals (for example, primary care and private hospitals).

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. For example in SA, chemotherapy and scope procedures are treated as an outpatient rather than same day service. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2011-12 (figure 10.8). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 10.8 **Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2011-12[a]**



a 'Total' includes medical, surgical, chemotherapy, radiotherapy, renal dialysis and 'other' separations based on AR-DRG version 6.0x categories.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.8.

People aged 55 years and over accounted for half of the separations in public hospitals (52.1 per cent) in 2011-12, even though they accounted for only 25.2 per cent of the estimated resident population at 30 June 2011 (table 10A.9 and AIHW 2013a).

The 10 AR-DRGs that accounted for the most overnight acute separations in public hospitals (18.0 per cent of all overnight acute separations recorded) in 2011-12 are shown in table 10A.14. 'Giving birth by vaginal delivery without catastrophic or severe complications or comorbidities' accounted for the most overnight acute separations (3.9 per cent) followed by 'Chest pain' (2.3 per cent).

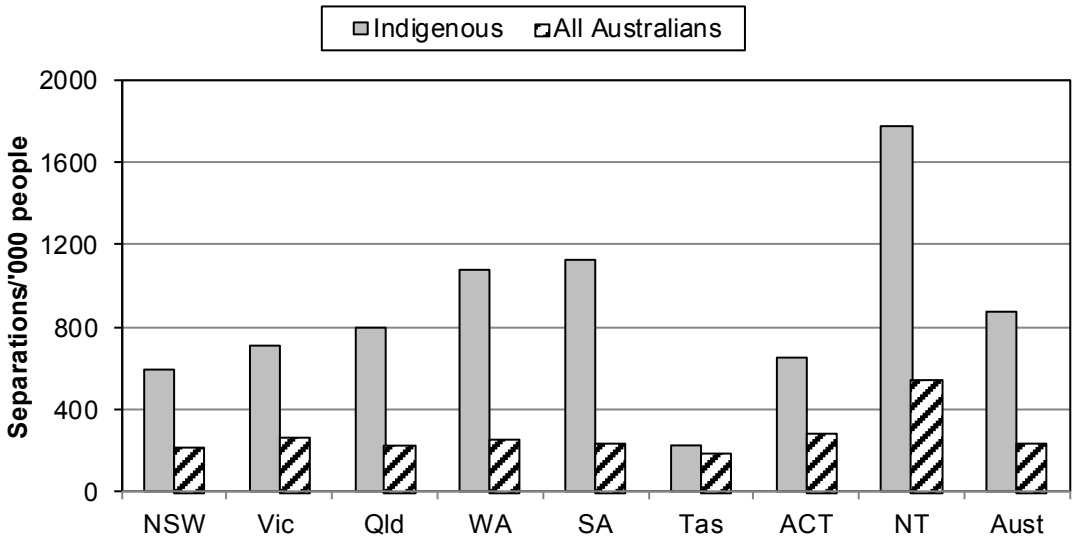
The 10 AR-DRGs that accounted for the most patient days (16.6 per cent of all patient days recorded) in 2011-12 are shown in table 10A.15. 'Schizophrenia disorders with mental health legal status' accounted for the largest number of patient days (3.1 per cent), followed by 'Major affective disorders for those aged less than 70 years without catastrophic or severe complications or comorbidities' (2.1 per cent) (table 10A.15).

Admitted patient care for Indigenous Australians

The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. Efforts to improve Indigenous identification are

ongoing. In 2011-12, on an age standardised basis, 877.4 public hospital separations (including same day separations) for Indigenous Australians were reported per 1000 Indigenous Australians. This rate was markedly higher than the corresponding rate of 236.4 per 1000 for all Australians (figure 10.9).

Figure 10.9 **Estimates of public hospital separations, by Indigenous status of patient, 2011-12[a, b]**



a The rates are directly age standardised to the Australian population at 30 June 2001. **b** Identification of Indigenous Australians is incomplete and completeness varies across jurisdictions.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.11.

Hospital episodes of care involving dialysis accounted for a large portion of same day separations, particularly for Indigenous Australians. The hospitalisation rate for Indigenous Australians for dialysis was 12 times as high as the rate for non-Indigenous Australians. When dialysis is excluded, the hospitalisation rate for Indigenous Australians in 2011-12 (138.9 per 1000 of the population) was less than that for non-Indigenous Australians (168.6 per 1000 of the population) (AIHW 2013a).

In 2011-12, separations for Indigenous Australians accounted for around 4.0 per cent of total separations and 6.1 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10A.10). Indigenous Australians made up only around 3 per cent of the population nationally, although this rate varied significantly from 0.8 per cent in Victoria to 29.1 per cent in the NT (tables 2A.2 and 2A.15). Most separations involving Indigenous Australians (92.0 per cent) in these jurisdictions occurred in public hospitals (table 10A.10).

Non-admitted patient services

A total of 53.1 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2011-12 (table 10.1). In addition, public hospitals delivered 303 931 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 10A.16). In public acute hospitals in 2011-12, accident and emergency services comprised 14.7 per cent of all individual occasions of service to non-admitted patients. 'Other medical, surgical and obstetric services' (23.1 per cent), 'pathology services' (19.3 per cent) and 'pharmacy' (10.6 per cent) were other common types of non-admitted patient care (table 10.1).

Table 10.1 **Non-admitted patient occasions of service, by type of non-admitted patient care, public acute hospitals, 2011-12[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[b]	*Aust*
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	10.5	23.5	15.3	16.0	24.4	30.7	7.2	25.3	14.7
Pathology	16.5	12.9	36.1	11.3	..	..	32.9	21.8	19.3
Radiology and organ imaging	3.7	9.6	9.3	7.9	10.8	..	3.7	16.0	6.5
Pharmacy[c]	17.5	6.8	5.5	4.3	..	..	2.4	6.2	10.6
Other medical/surgical/ obstetric	22.1	25.3	24.2	15.4	44.1	44.2	12.6	28.3	23.1
Mental health	4.2	na	0.3	1.4	0.8	0.5	15.8	..	2.7
Dental	1.7	0.3	..	0.2	0.3	–	..	..	0.9
Allied health	2.7	16.3	5.5	22.4	7.7	20.5	1.2	2.3	7.6
Other non-admitted									
Community health	6.8	0.2	1.1	16.3	0.1	4.1	24.0	..	5.9
District nursing[d]	6.5	3.6	1.1	2.5	0.3	..	..	..	4.0
Most common occasions of service (%)	**92.3**	**98.5**	**98.4**	**97.9**	**88.6**	**100.0**	**99.8**	**100.0**	**95.3**
Total occasions of service ('000)	**24 062**	**7 061**	**11 188**	**5 895**	**2 199**	**504**	**1 643**	**572**	**53 125**

[a] Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements vary significantly across jurisdictions. [b] Radiology data for the NT are underestimated and pathology data relate to only three of the five hospitals. [c] Justice Health in NSW reported a large number of occasions of service that may not be typical of pharmacy. [d] Justice Health in NSW reported a large number of occasions of service that may not be typical of district nursing. – Nil or rounded to zero. **..** Not applicable. **na** Not available.

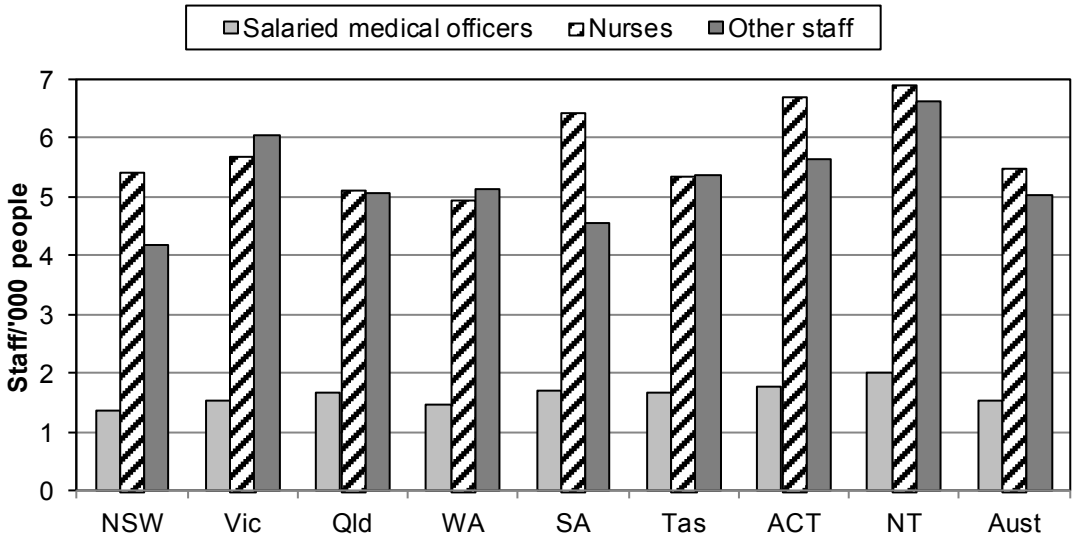
Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.16.

There is considerable variation among states and territories and across reporting years in the way in which non-admitted patient occasions of service are collected. Differing admission practices across states and territories also lead to variation among jurisdictions in the services reported (AIHW 2013a).

Staff

In 2011-12, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.5 per 1000 people) (figure 10.10). Comparing data on FTE staff across jurisdictions should be undertaken with care, because these data are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures and can explain some of the differences in FTE staff in some staffing categories across jurisdictions (AIHW 2011).

Figure 10.10 **Average FTE staff per 1000 people, public hospitals, 2011-12**[a, b, c, d, e]



[a] 'Other staff' include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. [b] Staff per 1000 people are calculated from ABS population data at 31 December 2011 (table 2A.2). Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (tables 2A.1-2) for details. [c] For Victoria, FTEs can be slightly understated. [d] Queensland pathology services staff employed by the State pathology service are not included. [e] Data for two small Tasmanian hospitals are not included.

Source AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; ABS (unpublished), Australian Demographic Statistics, December Quarter 2011, Cat. no. 3101.0; tables 10A.12 and 2A.2.

10.2 Framework of performance indicators for public hospitals

Performance is reported against objectives that are common to public hospitals in all jurisdictions (box 10.1). The Health sector overview explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

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 area of health and aged care, and health indicators in the National Indigenous Reform Agreement (NIRA) 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 the health performance indicators in the NHA. The NHA was reviewed in 2011, 2012 and 2013, resulting in changes that have been reflected in this Report, as relevant.

Box 10.1 **Objectives for public hospitals**

The common government objectives for public hospitals are to provide acute and specialist services that are:

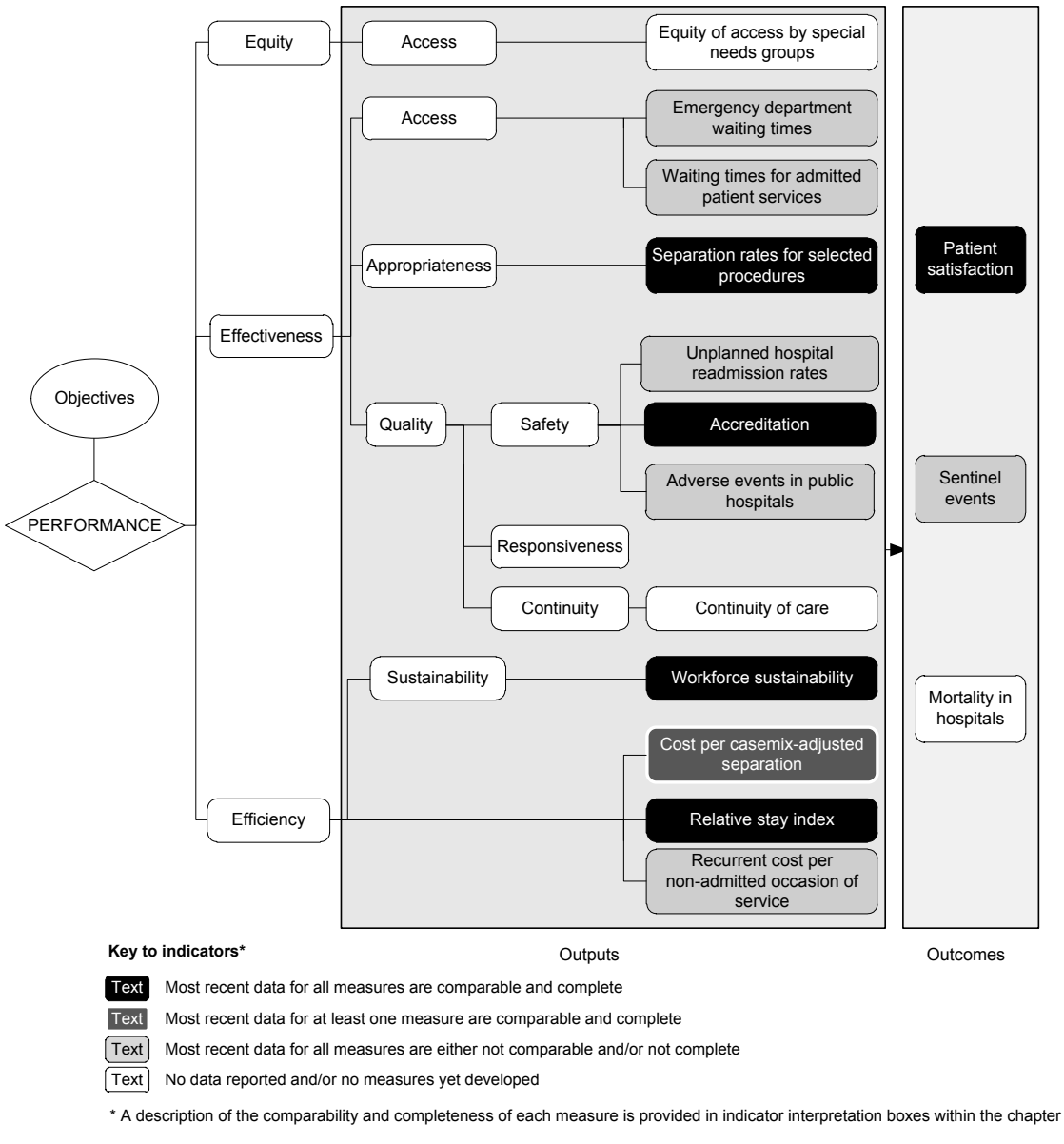
- safe and of high quality
- appropriate and responsive to individual needs
- affordable, timely and accessible
- equitably and efficiently delivered.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospital services (figure 10.11). The performance indicator framework shows which data are comparable in the 2014 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 context chapter 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) (chapter 2).

Figure 10.11 **Public hospitals 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 key data gaps and issues identified by the

Steering Committee. All DQI for the 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

10.3 Key performance indicator results for public hospitals

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

As discussed in section 10.1, public hospitals provide a range of services to admitted patients, including some subacute and nonacute services such as rehabilitation and palliative care. The extent to which these subacute and nonacute treatments can be identified and excluded from the data differs across jurisdictions. Similarly, psychiatric treatments are provided in public (non-psychiatric) hospitals at different rates across jurisdictions.

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 — access

Equity indicators measure how well a service is meeting the needs of certain groups in society (see chapter 1). Public hospitals have a significant influence on the equity of the overall healthcare system. While access to public hospital services is important to the community in general, it is particularly important for people of low socioeconomic status (and others) who can have difficulty in accessing alternative services, such as those provided by private hospitals.

Equity of access by special needs groups

'Equity of access by special needs groups' is an indicator of governments' objective to provide accessible services (box 10.2).

Box 10.2 **Equity of access by special needs groups**

'Equity of access by special needs groups' measures the performance of agencies providing services for three identified special needs groups: Indigenous Australians; people living in communities outside the capital cities (that is, people living in other metropolitan areas, or rural and remote communities); and people from a culturally and linguistically diverse group.

Equity of access by special needs groups has been identified as a key area for development in future Reports. Data for the emergency department waiting times and waiting times for admitted patient services indicators are reported by Indigenous status and remoteness.

Effectiveness — access

Emergency department waiting times

'Emergency department waiting times' is an indicator of governments' objective to provide accessible services (box 10.3).

Box 10.3 **Emergency department waiting times**

'Emergency department waiting times' is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand.

These waiting times are measured using the nationally agreed method of calculation to subtract the time at which the patient presents at the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who do not wait for care after being triaged or clerically registered are excluded from the data.

The benchmarks, set according to triage category, are as follows:

- triage category 1: need for resuscitation — patients seen immediately
- triage category 2: emergency — patients seen within 10 minutes
- triage category 3: urgent — patients seen within 30 minutes
- triage category 4: semi-urgent — patients seen within 60 minutes
- triage category 5: non-urgent — patients seen within 120 minutes (HDSC 2008).

(Continued next page)

Box 10.3 **(Continued)**

A high or increasing proportion of patients seen within the benchmarks set for each triage category is desirable.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (table 10.2) and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 10A.17).

Nationally, in 2012-13, 100 per cent of patients in triage category 1 were seen within the clinically appropriate timeframe, and 82 per cent of patients in triage category 2 were seen within the clinically appropriate timeframe. For all triage categories combined, 73 per cent of patients were seen within triage category timeframes (table 10.2). Emergency department waiting times for peer group A and B hospitals are reported in table 10A.18.

Emergency department waiting times by Indigenous status, remoteness and socioeconomic status, for peer group A and B hospitals are reported in the attachment (tables 10A.19–10A.21). Nationally, there was little difference between Indigenous and non-Indigenous Australians in the percentages of patients treated within national benchmarks across the triage categories, although there were variations across states and territories for some triage categories (table 10A.19). At the national level, there was variation in waiting times across triage categories by remoteness, although there was less variation for the most serious category, resuscitation (table 10A.20). There was little difference in waiting times across triage categories by socioeconomic status on a national basis (table 10A.21).

Under the National Partnership Agreement on Improving Public Health Services (NPA), an Expert Panel reviewed the implementation of emergency department and elective surgery targets. Fifteen recommendations were made, which were approved by COAG and are incorporated into the revised NPA signed by all jurisdictions in

August 2011. Recommendations included the adoption of a new National Emergency Access Target (NEAT) that replaced the concept of 'clinically appropriate' with a revised target of 90 per cent of patients leaving the emergency department within four hours of presentation — either by admission, transfer to another hospital, or discharge.

Reporting against interim targets for the new National Emergency Access Target (NEAT) commenced on 1 January 2012. This target must be met by 1 January 2015.

Table 10.2 **Emergency department patients seen within triage category timeframes, public hospitals (per cent)[a]**

Triage category	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12									
1 — Resuscitation[b]	100	100	100	99	100	100	100	100	100
2 — Emergency	82	83	82	76	79	77	76	64	80
3 — Urgent	71	72	63	52	70	64	50	49	66
4 — Semi-urgent	74	67	69	67	77	71	47	49	70
5 — Non-urgent	89	87	90	94	92	88	81	89	89
Total	**76**	**72**	**69**	**65**	**76**	**71**	**55**	**54**	**72**
Data coverage[c]	88	91	72	78	80	92	100	100	84
2012-13									
1 — Resuscitation[b]	100	100	100	100	100	100	100	100	100
2 — Emergency	83	84	84	81	75	83	74	66	82
3 — Urgent	73	72	68	52	66	65	43	52	68
4 — Semi-urgent	77	68	74	67	78	70	46	52	72
5 — Non-urgent	92	87	92	93	92	90	79	89	91
Total	**78**	**73**	**74**	**66**	**75**	**71**	**51**	**57**	**73**
Data coverage[c]	na	na	na	na	na	na	na	na	na

a Percentages are derived from all hospitals that reported to the Non-admitted Patient Emergency Department Care Database, including all principal referral and specialist women's and children's hospitals, large hospitals and public hospitals that were classified to other peer groups. **b** Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time. **c** Data coverage is estimated as the number of occasions of service with waiting times data divided by the number of emergency department occasions of service. This can underestimate coverage because some occasions of service are for other than emergency presentations. For some jurisdictions, the number of emergency department occasions of service reported to the Non-admitted Patient Emergency Department Care Database exceeded the number of accident and emergency occasions of service reported to the National Public Hospital Establishments Database. For these jurisdictions the coverage has been estimated as 100 per cent. **na** Not available.

Source: AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra; AIHW (2012), *Australian hospital statistics 2011-12: emergency department care*, Health services series no. 45. Cat. no. HSE 126. Canberra; table 10A.17.

Waiting times for admitted patient services

'Waiting times for admitted patient services' is an indicator of governments' objective to provide accessible services (box 10.4). Elective surgery patients who wait longer are likely to suffer discomfort and inconvenience, and more urgent patients can experience poor health outcomes as a result of extended waits.

Box 10.4 **Waiting times for admitted patient services**

'Waiting times for admitted patient services' is defined by the following three measures:

- Overall elective surgery waiting times
- Elective surgery waiting times by clinical urgency category
- Waiting times for admission following emergency department care.

Overall elective surgery waiting times

'Overall elective surgery waiting times' are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. 'Overall waiting times' are presented as the number of days within which 50 per cent of patients are admitted and the number of days within which 90 per cent of patients are admitted. The proportion of patients who waited more than 12 months is also shown.

For overall elective surgery waiting times, a low or decreasing number of days waited at the 50th and 90th percentiles, and a low or decreasing proportion of people waiting more than 365 days are desirable.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2014.

Elective surgery waiting times by clinical urgency category

'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:

- category 1 — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it may become an emergency

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Box 10.4 **(Continued)**

- category 2 — admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
- category 3 — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. The desirable timeframe for this category is admission within 365 days.

The term 'extended wait' is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting more than the agreed desirable waiting times of 30 days and 90 days respectively.

For elective surgery waiting times by clinical urgency category, a low or decreasing proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories (table 10.3).

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2014.

Presentations to emergency departments with a length of stay of 4 hours or less ending in admission

'Presentations to emergency departments with a length of stay of 4 hours or less ending in admission' reports the Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission. Length of stay is calculated as the length of time between presentation to the emergency department and physical departure.

A high or increasing proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission is desirable.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2014.

Overall elective surgery waiting times

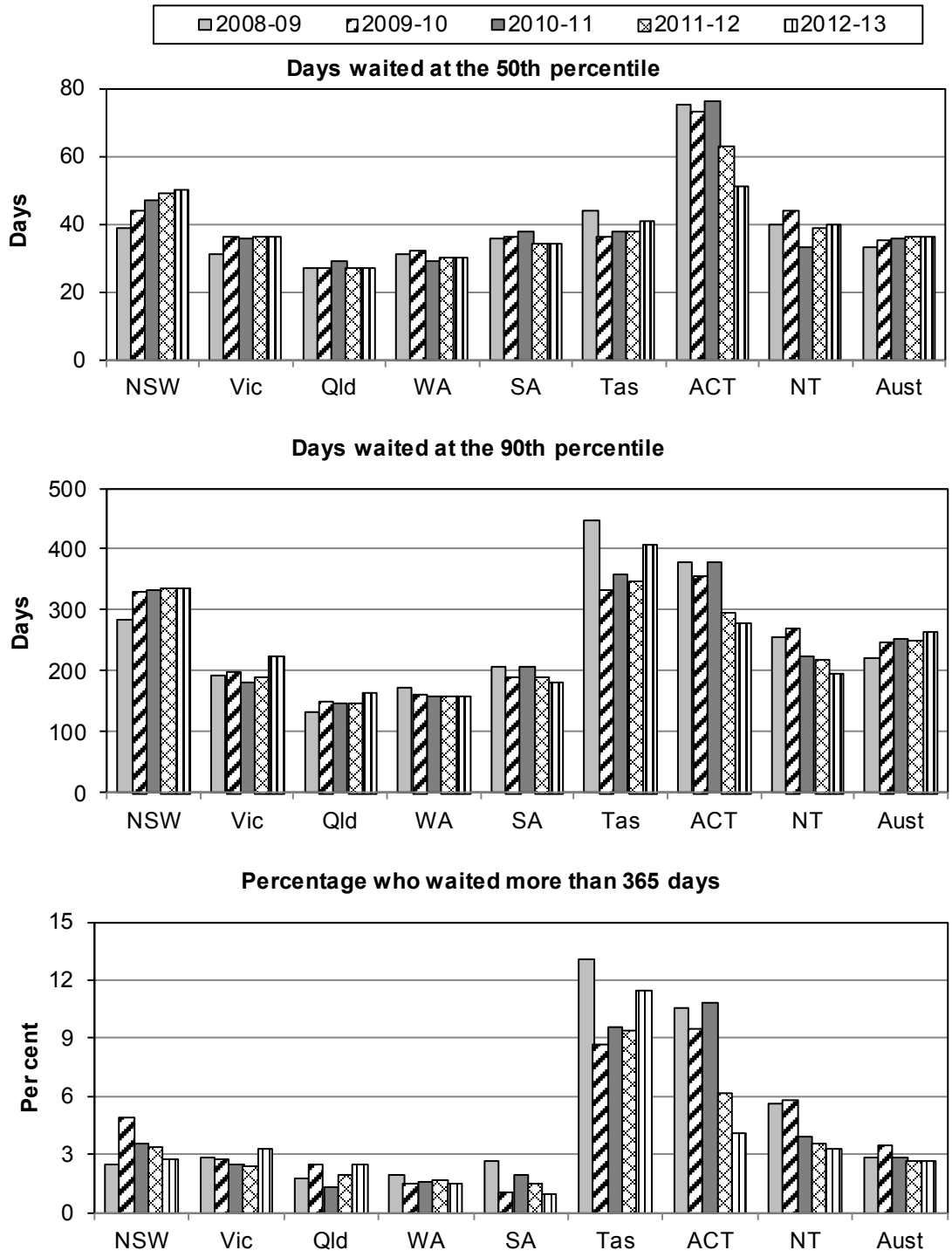
Elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery, and in 2012-13 covered 93 per cent of separations for elective surgery in public acute hospitals (table 10A.22).

Patients on waiting lists who were not subsequently admitted to hospital are excluded. Patients can be removed from waiting lists because they no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the hospital (AIHW 2013c). In 2012-13, 13.3 per cent of patients who were removed from waiting lists were removed for reasons other than elective or emergency admission (AIHW 2013c).

Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by another hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported in NSW, SA and the NT. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions (AIHW 2013c).

Nationally in 2012-13, 50 per cent of patients were admitted within 36 days and 90 per cent of patients were admitted within 265 days. The proportion of patients who waited more than a year was 2.7 per cent. Nationally, waiting times at the 50th percentile increased by three days between 2008-09 and 2012-13, from 33 to 36 days. However, there were different trends for different jurisdictions and for different sized hospitals over that period (figure 10.12 and table 10A.22).

Figure 10.12 **Waiting times for elective surgery, public hospitals**



Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat nos. HSE 71, 84, 107, 117 and 134; AIHW (2013), *Australian hospital statistics 2012–13*: *elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140; table 10A.22.

Attachment 10A includes data on elective surgery waiting times by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times

by Indigenous status, remoteness and socioeconomic status (tables 10A.22–10A.27). Nationally, Indigenous Australians had longer waiting times for elective surgery than non-Indigenous Australians at the 50th percentile and 90th percentile (table 10A.24). Those living in regional areas had longer waiting times than those in major cities at the 50th and 90th percentiles at the national level (table 10A.25). Elective surgery waiting times tended to increase with social disadvantage at the 50th and 90th percentiles on a national basis (table 10A.26).

Elective surgery waiting times by clinical urgency category

Elective surgery waiting times by urgency category data not only provide an indication of the extent to which patients are seen within a clinically desirable time, but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2011-12 are shown in table 10.3. The states and territories with lower proportions of patients in category 1 tended to have smaller proportions of patients in this category who were 'not seen on time'. NSW, Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had low proportions of patients in category 1 who had extended waits (tables 10.3, 10A.28, 10A.30 and 10A.40).

The system of urgency categorisation for elective surgery in public hospitals is important to ensure that priority is given to patients according to their needs. While elective surgery waiting times by urgency category are not comparable across jurisdictions, this measure has the advantage of providing an indication of the extent to which patients are seen within a clinically desirable time period according to the urgency category to which they have been assigned.

Under the National Partnership Agreement on Improving Public Health Services (NPA), an Expert Panel reviewed the implementation of emergency department and elective surgery targets. Fifteen recommendations were made, which were approved by COAG and are incorporated into the revised NPA signed by all jurisdictions in August 2011.

Reporting against interim targets for the new National Elective Surgery Target (NEST) commenced on 1 January 2012. The NEST requires that at its conclusion, 100 per cent of patients be treated within clinically recommended time across all urgency categories through two complementary strategies (NEST Part 1 and NEST Part 2) containing three targets. NEST Part 1 is a stepped improvement in patients seen within the clinically recommended time. NEST Part 2 is a stepped reduction in patients who have already waited longer than the clinically recommended time, and

additionally requires that each year the 10 per cent of patients who have waited the longest in each jurisdiction must have their surgery.

The AIHW, with the Royal Australasian College of Surgeons, submitted a proposal to Health Ministers in December 2012 for nationally agreed elective surgery urgency category definitions, including consistent treatment of patients 'not ready for care'. This was endorsed by Health Ministers, and NSW is now leading work on nation-wide implementation of the recommendations outlined in the proposal.

Table 10.3 **Classification of elective surgery patients, by clinical urgency category, 2011-12 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Patients on waiting lists								
Category 1	2.8	3.5	8.9	5.5	5.0	6.2	3.5	4.7
Category 2	16.4	46.6	47.1	31.0	23.0	52.5	47.2	42.9
Category 3	80.8	49.9	44.0	63.5	72.0	41.3	49.3	52.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	25.5	30.3	40.0	23.4	27.1	39.0	30.2	38.8
Category 2	33.2	46.9	44.6	34.8	33.3	44.0	48.6	41.4
Category 3	41.3	22.8	15.4	41.8	39.6	17.0	21.2	19.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: State and Territory governments (unpublished).

Reporting of elective surgery waiting times by clinical urgency category includes the proportions of patients with extended waits at admission. The proportions of patients on waiting lists who already had an extended wait are reported in tables 10A.28, 10A.30, 10A.32, 10A.34, 10A.36, 10A.38, 10A.40 and 10A.42. The proportion of patients on waiting lists who already had an extended wait at the date of the census does not represent the completed waiting times of patients. This is represented by the proportion of patients with extended waits at admission.

Of patients admitted from waiting lists in NSW in 2011-12:

- 25.5 per cent were classified to category 1, of whom 6.3 per cent had an extended wait
- 33.2 per cent were classified to category 2, of whom 9.8 per cent had an extended wait
- 41.3 per cent were classified to category 3, of whom 8.4 per cent had an extended wait.

Overall in NSW, 8.3 per cent of all patients experienced extended waits (table 10.3 and table 10A.28).

Of patients admitted from waiting lists in Victoria in 2011-12:

- 30.3 per cent were classified to category 1, of whom zero per cent had an extended wait
- 46.9 per cent were classified to category 2, of whom 27.7 per cent had an extended wait
- 22.8 per cent were classified to category 3, of whom 8.5 per cent had an extended wait.

Overall in Victoria, 14.9 per cent of all patients experienced extended waits (table 10.3 and table 10A.30).

Of patients admitted from waiting lists in Queensland in 2011-12:

- 40.0 per cent were classified to category 1, of whom 12.3 per cent had an extended wait
- 44.6 per cent were classified to category 2, of whom 22.5 per cent had an extended wait
- 15.4 per cent were classified to category 3, of whom 10.2 per cent had an extended wait.

Overall in Queensland, 16.5 per cent of all patients experienced extended waits (table 10.3 and table 10A.32).

Of patients admitted from waiting lists in WA in 2011-12:

- 23.4 per cent were classified to category 1, of whom 15.4 per cent had an extended wait
- 34.8 per cent were classified to category 2, of whom 17.4 per cent had an extended wait
- 41.8 per cent were classified to category 3, of whom 3.5 per cent had an extended wait.

Overall in WA, 11.1 per cent of all patients experienced extended waits (table 10.3 and table 10A.34).

Of patients admitted from waiting lists in SA in 2011-12:

- 27.1 per cent were classified to category 1, of whom 9.9 per cent had an extended wait
- 33.3 per cent were classified to category 2, of whom 16.8 per cent had an extended wait

- 39.6 per cent were classified to category 3, of whom 3.9 per cent had an extended wait.

Overall in SA, 7.8 per cent of all patients experienced extended waits (table 10.3 and table 10A.36).

Of patients admitted from waiting lists in Tasmania in 2011-12:

- 39.0 per cent were classified to category 1, of whom 24.0 per cent had an extended wait
- 44.0 per cent were classified to category 2, of whom 40.0 per cent had an extended wait
- 17.0 per cent were classified to category 3, of whom 28.0 per cent had an extended wait.

Overall in Tasmania, 32.0 per cent of all patients experienced extended waits (table 10.3 and table 10A.38).

Of patients admitted from waiting lists in the ACT in 2011-12:

- 30.2 per cent were classified to category 1, of whom 2.5 per cent had an extended wait
- 48.6 per cent were classified to category 2, of whom 49.3 per cent had an extended wait
- 21.2 per cent were classified to category 3, of whom 14.7 per cent had an extended wait.

Overall in the ACT, 27.9 per cent of all patients experienced extended waits (table 10.3 and table 10A.40).

Of patients admitted from waiting lists in NT in 2011-12:

- 38.8 per cent were classified to category 1, of whom 16.1 per cent had an extended wait
- 41.4 per cent were classified to category 2, of whom 32.8 per cent had an extended wait
- 19.8 per cent were classified to category 3, of whom 16.3 per cent had an extended wait.

Overall in the NT, 23.0 per cent of all patients experienced extended waits (table 10.3 and table 10A.42).

All jurisdictions also provided data on urgency category waiting times by clinical specialty (tables 10A.29, 10A.31, 10A.33, 10A.35, 10A.37, 10A.39, 10A.41 and 10A.43).

Presentations to emergency departments with a length of stay of 4 hours or less ending in admission

This measure is reported for the first time this year. Nationally in 2012-13, 36 per cent of those who presented to an emergency department waited 4 hours or less to be admitted to hospital. Nationally the percentage waiting 4 hours or less to be admitted was 52 per cent of patients requiring resuscitation, 39 per cent of emergency patients and 34 per cent of urgent patients. Waiting times improved for all triage categories from 2011-12 to 2012-13 on a national basis (table 10.4).

Table 10.4 **Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals[a, b, c, d]**

Triage category	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12									
1 — Resuscitation	44	53	43	61	53	62	61	53	49
2 — Emergency	25	35	24	54	36	30	41	28	32
3 — Urgent	21	29	20	50	33	21	28	28	27
4 — Semi-urgent	23	30	25	51	37	24	27	29	29
5 — Non-urgent	43	53	46	62	52	43	44	60	48
Total[d]	**24**	**31**	**23**	**52**	**36**	**25**	**32**	**29**	**29**
2012-13									
1 — Resuscitation	44	56	54	59	55	56	62	48	52
2 — Emergency	32	44	40	52	41	32	40	23	39
3 — Urgent	27	36	39	43	38	22	24	23	34
4 — Semi-urgent	30	36	45	45	43	24	28	24	35
5 — Non-urgent	53	53	62	55	61	47	40	50	54
Total[d]	**30**	**38**	**41**	**46**	**41**	**25**	**29**	**24**	**36**

a Includes presentations for all types of visit. **b** Length of stay is calculated as the length of time between presentation to the emergency department and physical departure. **c** Data are for all hospitals. **d** Total includes presentations for which the triage category was not reported.

Source: AIHW (2013), *Australian hospital statistics 2012–13: emergency department care*, Health services series no. 52. Cat. no. HSE 142. Canberra; AIHW (2012), *Australian hospital statistics 2011–12: emergency department care*, Health services series no. 45. Cat. no. HSE 126. Canberra; table 10A.44.

Data on emergency department presentations for non-admitted patients may be affected by variations in reporting practices across states and territories and over time. The comparability of emergency department waiting times data across

jurisdictions can be influenced by differences in data coverage (table 10.2) and clinical practices — in particular, the allocation of cases to urgency categories.

Data in table 10.4 are for all hospitals. Data for 'Principal referral and specialist women's and children's' hospitals and 'Large hospitals' are presented in table 10A.44. Nationally in 2012-13 a higher proportion of patients were admitted within 4 hours or less in large hospitals than in principal referral and specialist women's and children's hospitals for all triage categories, except resuscitation, which had broadly similar admission rates (table 10A.44).

Effectiveness — appropriateness

Separation rates for selected procedures

'Separation rates for selected procedures' is an indicator of the appropriateness of hospital services (box 10.5).

Box 10.5 **Separation rates for selected procedures**

'Separation rates for selected procedures' is defined as separations per 1000 people for certain procedures in public hospitals. The procedures are selected for their frequency, for sometimes being elective and discretionary, and because alternative treatments are sometimes available.

Higher/lower or increasing/decreasing rates are not necessarily associated with inappropriate care. However, large jurisdictional variations in rates for particular procedures can require investigation to determine whether service levels are appropriate.

Care needs to be taken when interpreting the differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

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Box 10.5 **(Continued)**

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 2011-12 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The separation rates for selected procedures reported here reflect the activities of the public health system. For all procedures, separation rates varied across jurisdictions (table 10.5).

Table 10.5 **Separations for selected procedures per 1000 people, public hospitals, 2011-12[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Procedure									
Cataract extraction	2.6	3.1	1.6	4.3	3.5	1.3	3.5	5.1	2.7
Cholecystectomy	1.4	1.4	1.2	1.1	1.4	1.4	1.4	1.2	1.3
Coronary angioplasty	0.9	0.8	0.8	0.9	1.0	1.0	1.9	..	0.9
Coronary artery bypass graft	0.3	0.3	0.3	0.2	0.3	0.4	0.6	..	0.3
Cystoscopy	1.6	2.8	2.0	3.0	2.6	1.5	2.4	1.7	2.2
Haemorrhoidectomy	1.0	0.8	0.4	0.5	0.5	0.7	0.4	0.9	0.7
Hip replacement	0.7	0.7	0.5	0.8	0.7	0.6	1.0	0.6	0.6
Hysterectomy, females aged 15–69 years	1.0	1.1	1.0	1.1	1.3	1.1	0.7	0.8	1.0
Inguinal herniorrhaphy	1.0	1.0	0.8	0.9	1.0	1.1	0.9	0.9	1.0
Knee replacement	0.7	0.5	0.5	0.7	0.6	0.3	0.9	0.4	0.6
Myringotomy (with insertion of tube)	0.5	0.8	0.7	0.7	1.3	0.6	0.8	0.6	0.7
Prostatectomy	0.9	1.1	0.8	0.8	1.0	0.8	0.9	1.0	0.9
Septoplasty	0.3	0.5	0.2	0.2	0.4	0.1	0.4	0.1	0.3
Tonsillectomy	0.9	1.2	0.9	1.0	1.3	0.8	1.0	0.7	1.0
Varicose veins, stripping and ligation	0.2	0.3	0.1	0.1	0.3	0.1	0.6	0.2	0.2

a Rates are standardised to the Australian population as at 30 June 2001 and are calculated for the total population for all procedures except prostatectomy (rates calculated for the male population only) and hysterectomy (rates calculated for females aged 15–69 years). **..** Not applicable.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.45.

Data for private hospitals are reported in table 10A.45. Table 10A.45 also reports selected separations for all hospitals by Indigenous status, remoteness and socioeconomic status. Table 10A.46 reports additional information for the selected

separations for all hospitals such as numbers of separations and the standardised separation rate ratio.

Effectiveness — quality

There is no single definition of quality in healthcare, but the Australian Commission on Safety and Quality in Health Care (ACSQHC) has defined quality as 'the extent to which the properties of a service or product produce a desired outcome' (Runciman 2006). No single indicator can measure quality across all providers. An alternative approach is to identify and report on aspects of quality of care. The aspects of quality recognised in the performance indicator framework are safety, responsiveness and continuity. This Report includes indicators of safety, but no indicators have yet been developed for responsiveness or continuity.

Various governments publicly report performance indicators for service quality of public hospitals. Some have adopted the same indicators reported in this chapter. For example:

- The Australian Government's MyHospitals website, which is managed by the National Health Performance Authority, reports *staphylococcus aureus* bacteraemia (SAB) infections as counts and rates per 10 000 occupied bed days for most public hospitals and a number of private hospitals.
- In NSW, reporting of surgical site infection rates for hip and knee surgery is mandatory for public hospitals.
- Victorian hospitals are required to publish annual quality of care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, pressure wound monitoring and prevention, patient satisfaction and consumer participation in health care decision making.
- Queensland Health publishes regular online public hospitals performance, which among other measures, includes patient experience results.
- Both the WA and Tasmanian health departments' annual reports include information on unplanned re-admission rates and WA also includes a section on patient evaluation of health services.
- SA Health publishes an annual patient safety report, which provides a summary of the types of incidents that occurred in public hospitals and a comprehensive overview of the major patient safety programs being conducted by SA Health. It links the programs to the safety issues identified by analysis of data from the incident management system (Safety Learning System), Coronial recommendations and other sources, to help explain what actions are being taken to address these safety issues. A Measuring Consumer Experience SA Public

Hospital Inpatient Annual Report, which details the key findings from the SA Consumer Experience Surveillance System, is also published.

- ACT Health publishes quarterly reports that include data on unplanned readmissions, unplanned returns to operating theatre and hospital acquired infection rates. Information about quality and safety activities and consumer feedback management is also included in an annual report.
- The NT Health Department Annual Report publishes information on unplanned re-admission rates after discharge for acute mental health episodes.

Safety

Improving patient safety is an important issue for all hospitals. Studies on medical errors have indicated that adverse healthcare related events occur in public hospitals in Australia and internationally, and that their incidence is potentially high (for example Eshani *et al*. 2006). These adverse events can result in serious consequences for individual patients, and the associated costs to individuals and the health care system can be considerable (Van den Bos et al. 2011).

Safety — unplanned hospital readmission rates

'Unplanned hospital readmission rates' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.6). Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post discharge planning was inadequate, or for reasons outside the control of the hospital (for example poor post-discharge care).

Box 10.6 **Unplanned hospital readmission rates**

'Unplanned hospital readmission rates' is defined as the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition. It is calculated as the number of separations that were unplanned or unexpected readmissions to the same hospital following a separation in which a selected surgical procedure was performed and which occurred within 28 days of the previous date of separation, expressed per 1000 separations in which one of the selected surgical procedures was performed. Selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.

(Continued on next page)

Box 10.6 **(Continued)**

Low or decreasing rates for this indicator are desirable. Conversely, high rates for this indicator suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Unplanned readmission rates are not adjusted for casemix or patient risk factors, which can vary across hospitals and across jurisdictions. Unplanned hospital readmission rates in public hospitals in 2011-12 are reported in table 10.6. Unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 10A.48.

Table 10.6 **Unplanned hospital readmission rates, per 1000 separations, 2011-12**

	NSW	*Vic*	*Qld*	*WA*[a]	*SA*	*Tas*	*ACT*	*NT*	*Total*[a]
Surgical procedure prior to separation									
Knee replacement	18.5	19.1	26.9	17.4	17.7	np	np	np	20.0
Hip replacement	17.7	17.4	14.2	22.5	23.7	np	np	np	17.7
Tonsillectomy and Adenoidectomy	24.8	23.7	32.6	33.3	33.7	60.6	18.3	np	27.8
Hysterectomy	27.9	32.4	33.2	31.5	28.1	28.1	np	np	30.9
Prostatectomy	22.7	26.4	36.3	50.3	25.9	np	np	np	27.2
Cataract surgery	2.8	3.2	4.0	2.6	3.3	7.2	–	np	3.2
Appendicectomy	23.5	24.5	20.4	31.3	36.0	29.8	26.3	49.6	24.7

[a] Total rates for Australia do not include WA. For all jurisdictions except WA, this indicator is calculated by the AIHW using data from the National Hospital Morbidity Database, based on the national minimum data set for Admitted patient care. For WA, the indicator was calculated and supplied by WA Health and was not independently verified by the AIHW. **np** Not published. – Nil or rounder to zero.

Source: AIHW (unpublished) Admitted Patient Care National Minimum Data Set; WA Health (unpublished); table 10A.47.

There are some difficulties in identifying re-admissions that were unplanned. The indicator is likely to be an under-estimate because:

- it identifies only those patients re-admitted to the same hospital, so does not include patients who go to another hospital

- episodes of non-admitted patient care provided in outpatient clinics or emergency departments which may have been related to a previous admission are not included
- the unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event. This does not include all possible unplanned/unexpected readmissions.

Safety — hospital accreditation

'Accreditation' is an indicator of governments' objective to provide public hospital services that are of high quality (box 10.7).

Box 10.7 **Accreditation**

'Accreditation' is defined as the number of beds in accredited hospitals as a percentage of total beds. 'Accreditation' signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through a number of agencies. These agencies are accredited through the Joint Accreditation System of Australia and New Zealand or the International Society for Quality in Healthcare. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.

A high or increasing rate of accreditation is desirable. However, it is not possible to draw conclusions about the quality of care in those hospitals that do not have accreditation. Until 1 January 2013 public hospital accreditation was voluntary in all jurisdictions except Victoria and Queensland, where it is mandatory for all public hospitals (excluding those that provide only dental or mothercraft services).

Data reported for this indicator are:

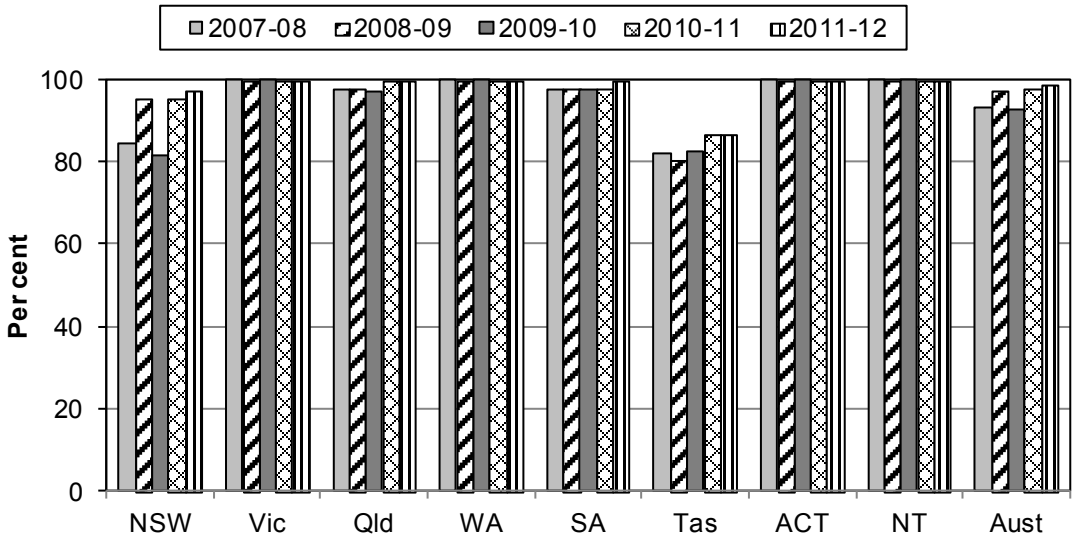
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data for this indicator are shown in figure 10.13. Australian Health Ministers have mandated accreditation in all public and private hospitals and day procedure services in Australia. From 1 January 2013, health services will be assessed to the National Safety and Quality Health Service (NSQHS) Standards by accrediting agencies approved by the ACSQHC. There are currently 10 accrediting agencies

with approval listed on the ACSQHC website. By 2016 it is anticipated all Australian hospitals will have been accredited to all 10 NSQHS Standards.

Figure 10.13 **Proportion of accredited beds, public hospitals**[a, b]



[a] Where average available beds for the year were not available, bed numbers at 30 June were used. [b] Includes psychiatric hospitals.

Source: AIHW (various years), *Australian Hospital Statistics,* Health Services Series, Cat nos. HSE 71, 84, 107, 117 and 134; table 10A.49.

Safety — adverse events in public hospitals

'Adverse events in public hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.8). Adverse events in public hospitals can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures. Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported separately in this chapter as an outcome indicator.

Box 10.8 **Adverse events in public hospitals**

'Adverse events in public hospitals' is defined by the following two measures:

- healthcare-associated infections
- adverse events treated in hospitals.

Healthcare-associated infections

Healthcare-associated infections is the number of *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals, expressed as a rate per 10 000 patient days for public hospitals reporting for the SAB indicator.

A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.

SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient-episode of SAB:

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- an invasive instrumentation or incision related to the SAB was performed within 48 hours
- SAB is associated with neutropenia ($<1x10^9$/L) contributed to by cytotoxic therapy.

Cases where a known previous blood culture has been obtained within the last 14 days are excluded. Patient days for unqualified newborns are included. Patient days for hospital boarders and posthumous organ procurement are excluded.

A low or decreasing healthcare-associated infections rate is desirable.

Data reported for this measure are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2014.

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Box 10.8 **(Continued)**

Adverse events treated in hospitals

Adverse events treated in hospitals are incidents in which harm resulted to a person during hospitalisation. They are measured by separations that had an adverse event including infections, falls resulting in injuries and problems with medication and medical devices that occurred during a hospitalisation. Hospitalisation is identified by diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation.

Low or decreasing adverse events treated in hospitals is desirable.

Data reported for this measure are:

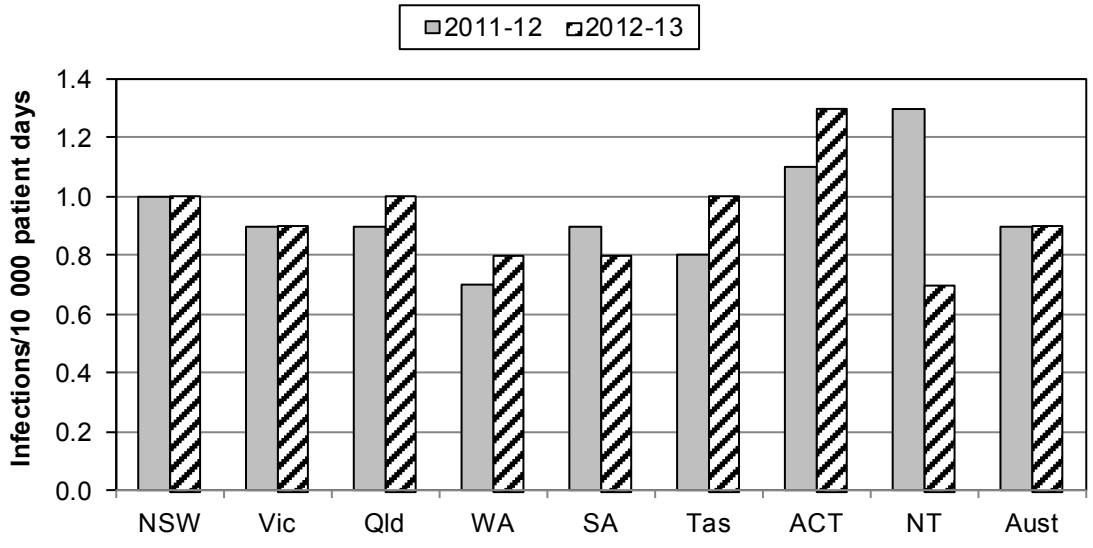
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Data quality information for this measure is under development.

Safety — healthcare-associated infections

Healthcare-associated infections in public hospitals per 10 000 patient days is reported in figure 10.14.

Figure 10.14 **Healthcare-associated infections, public hospitals[a, b]**



a Comprises both Methicillin resistant *Staphylococcus aureus* and Methicillin sensitive *Staphylococcus aureus*. **b** The SAB patient episodes were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). The comparability of the SAB rates across jurisdictions and over time is limited, because of coverage differences and because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity.

Source: AIHW unpublished; table 10A.50.

Safety — adverse events treated in hospitals

In 2011-12, 6.1 per cent of separations in public hospitals reported an ICD-10-AM code indicating an adverse event (table 10.7). Around 55.3 per cent of separations with an adverse event reported procedures causing abnormal reactions/complications, and 37.6 per cent reported adverse effects of drugs, medicaments and biological substances (table 10A.51). Data for 2010-11 are reported in table 10A.51.

Table 10.7 **Separations with an adverse event, per 100 separations, public hospitals, 2011-12[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
External cause of injury and poisoning									
Adverse effects of drugs, medicaments and biological substances	2.4	2.1	2.1	2.3	2.5	2.4	2.2	0.9	2.2
Misadventures to patients during surgical and medical care	0.2	0.3	0.3	0.3	0.2	0.4	0.3	0.1	0.3
Procedures causing abnormal reactions/complications	3.2	3.3	3.3	3.2	3.5	4.5	3.5	2.0	3.3
Other external causes of adverse events	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.1	0.1
Place of occurrence of injury and poisoning: Health service area	6.1	5.9	5.9	5.9	6.5	7.6	6.1	3.0	6.0
Diagnoses									
Selected post-procedural disorders	0.9	0.7	0.8	0.8	1.1	1.2	1.1	0.4	0.8
Haemorrhage and haematoma complicating a procedure	0.5	0.5	0.4	0.5	0.4	0.5	0.5	0.3	0.5
Infection following a procedure	0.5	0.4	0.5	0.4	0.4	0.5	0.4	0.4	0.4
Complications of internal prosthetic devices	1.2	1.3	1.3	1.1	1.2	1.2	1.4	0.8	1.2
Other diagnoses of complications of medical and surgical care	0.7	1.1	0.8	0.8	0.8	1.1	0.7	0.6	0.8
Total (any of the above)[c]	**6.3**	**6.1**	**6.0**	**6.0**	**6.7**	**7.7**	**6.3**	**3.2**	**6.1**
Adverse events for overnight separations	**10.1**	**11.8**	**10.1**	**10.7**	**10.7**	**12.0**	**11.9**	**7.9**	**10.7**

[a] Separations that included ICD-10-AM diagnosis and/or external cause codes that indicated an adverse event was treated and/or occurred during the hospitalisation. [b] Age standardised rate. [c] Categories do not sum to the totals because multiple diagnoses and external causes can be recorded for each separation and external cause codes and diagnosis codes can be used together to describe an adverse event.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.51.

A separation may be recorded against more than one category in table 10.7, as some adverse events are reported as diagnoses and others as external causes or places of occurrence (of the injury or poisoning).

These data can be interpreted as representing selected adverse events in health care that have resulted in, or have affected, hospital admissions, rather than all adverse events that occurred in hospitals. Some of the adverse events included in these tables may represent events that occurred before admission.

Some adverse events are not identifiable using the codes for an adverse event or a place of occurrence of hospital. Some other diagnosis codes may suggest that an adverse event has occurred when it has not.

Responsiveness

The Steering Committee has identified the responsiveness of public hospitals as an area for development in future Reports.

Continuity — continuity of care

'Continuity of care' is an indicator of governments' objective to provide public hospital services that are of high quality (box 10.9).

Box 10.9 **Continuity of care**

'Continuity of care' measures the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations.

Continuity of care has been identified as a key area for development in future Reports.

Sustainability

Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide sustainable public hospital services (box 10.10). Labour, particularly nurses and medical practitioners, is the most significant and costly resource used in providing public hospital services (figure 10.21), and the sustainability of the workforce helps determine whether sustainability problems might arise in the future delivery of public hospital services.

The sustainability of the public hospital workforce is affected by a number of factors; in particular, whether the number of new entrants are sufficient to maintain the existing workforce, and the proportion of the workforce that is close to retirement.

Box 10.10 **Workforce sustainability**

'Workforce sustainability' reports age profiles for nurse and medical practitioner workforces. It shows the proportions of registered nurses and medical practitioners in ten year age brackets, by jurisdiction and by region.

A high or increasing proportion of the workforce that are new entrants and/or a low or decreasing proportion of the workforce that is close to retirement is desirable.

All nurses (including midwives) and medical practitioners in the workforce are included in these measures as crude indicators of the potential respective workforces for public hospitals.

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 public hospitals.

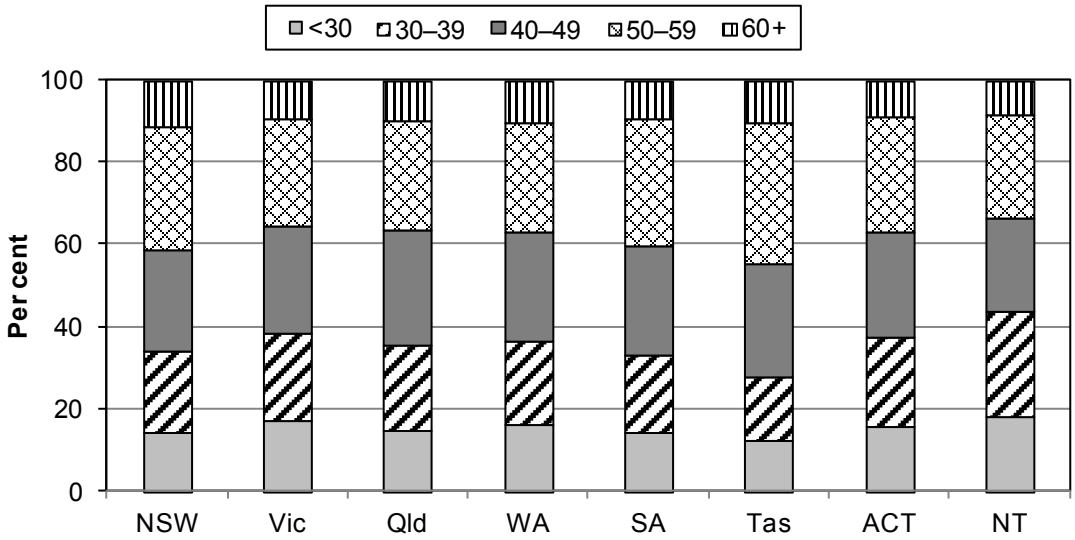
Data reported for this indicator are:

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

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The age profile of the nursing workforce (which includes midwives) for 2012 for each jurisdiction is shown in figure 10.15. Nursing workforce data by remoteness area for 2012 are shown in figure 10.16.

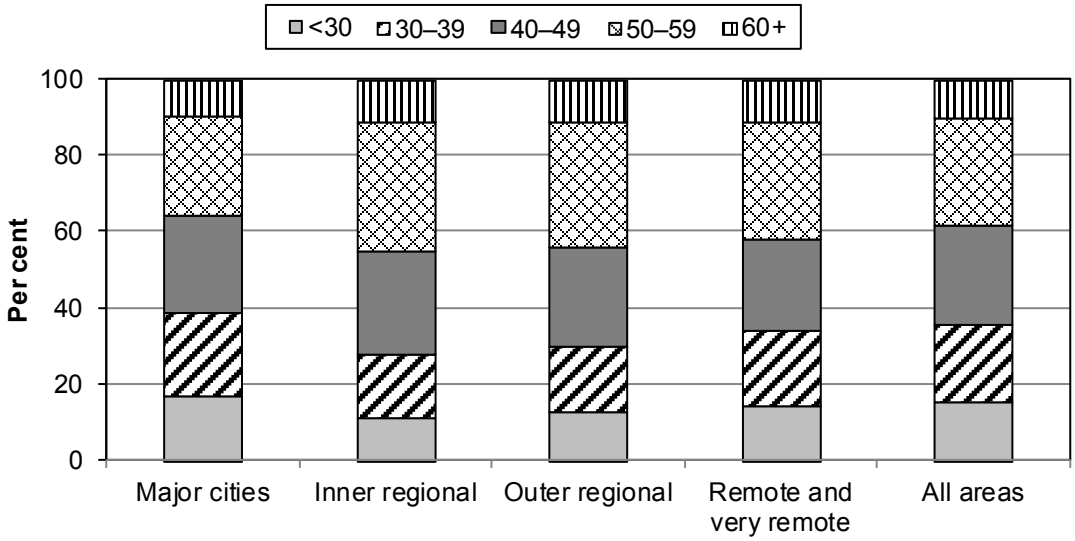
Figure 10.15 **Nursing workforce, by age group, 2012**[a, b]



[a] Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses who are registered but on extended leave and nurses who are registered and looking for work in nursing. [b] State and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.53.

Figure 10.16 **Nursing workforce, by age group and remoteness area, 2012**[a, b]

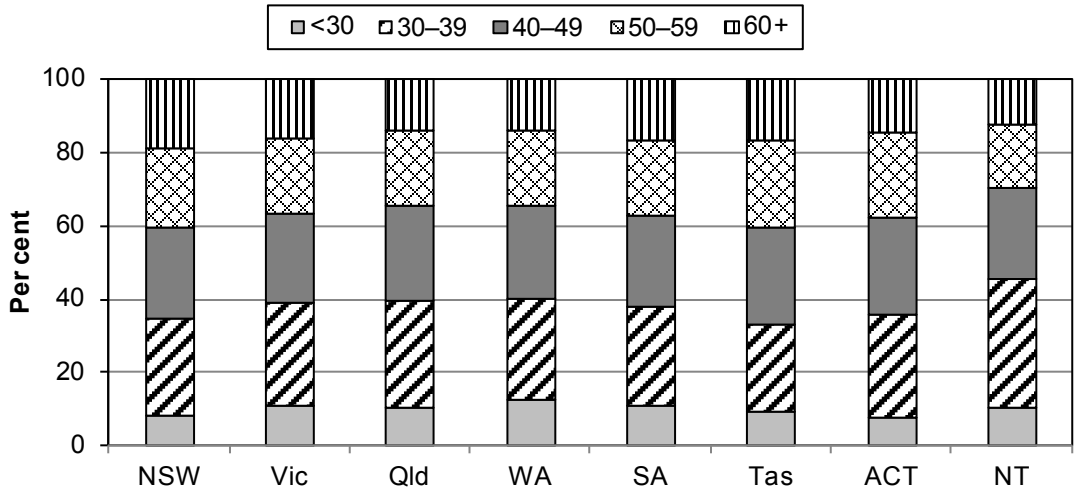


[a] Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses who are registered but on extended leave and nurses who are registered and looking for work in nursing. [b] Remote and very remote areas include migratory areas.

Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.52.

The age profile of the medical practitioner workforce in 2012 for each jurisdiction is shown in figure 10.17. Medical practitioner workforce data for 2012 by remoteness area are shown in figure 10.18.

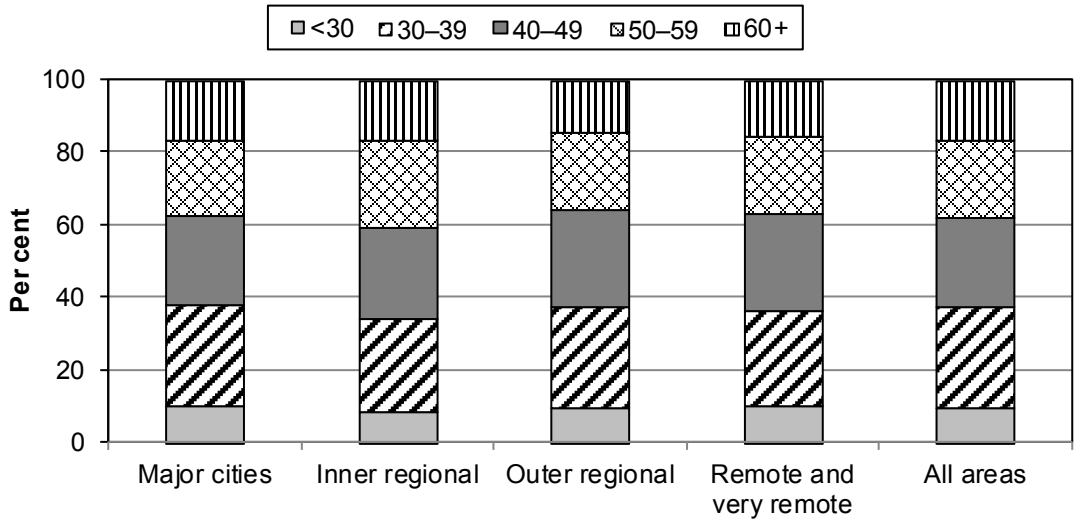
Figure 10.17 **Medical practitioner workforce, by age group, 2012[a, b]**



a Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine. **b** State and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.55.

Figure 10.18 **Medical practitioner workforce, by age group and remoteness area, 2012[a, b]**



a Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine. **b** Remote and very remote areas include migratory areas.

Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.54.

Efficiency

Two approaches to measuring the efficiency of public hospital services are included in this Report: the 'cost per casemix-adjusted unit of output' (the unit cost) and the 'casemix-adjusted relative length of stay index'. Length of stay is correlated with costs at aggregate levels of reporting.

The Steering Committee's approach is to report the full costs of a service where they are available. Where the full costs of a service cannot be accurately measured, the Steering Committee seeks to report estimated costs that are comparable. Where differences in comparability remain, the differences are documented. The Steering Committee has identified financial reporting issues that have affected the accuracy and comparability of unit costs for acute care services. These include the treatment of payroll tax, superannuation, depreciation and the user cost of capital associated with buildings and equipment. A number of issues remain to further improve the quality of these estimates.

Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) can reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study, reported in *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The study examined the extent to which differences in asset measurement techniques applied by participating agencies can affect the comparability of reported unit costs.

The results reported in the study for public hospitals indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. However, considered in the context of total unit costs, the differences created by these asset measurement effects were relatively small, because capital costs represent a small proportion of total cost (although the differences can affect cost rankings across jurisdictions). A key message from the study was that the adoption of nationally uniform accounting standards across all service areas would be a desirable outcome.

Care needs to be taken, therefore, in comparing unit costs across jurisdictions. Differences in counting rules, the treatment of various expenditure items (for example, superannuation) and the allocation of overhead costs have the potential to affect such comparisons. In addition, differences in the use of salary packaging can allow hospitals to lower their wage bills (and thus State or Territory government expenditure) while maintaining the after-tax income of their staff. No data were

available for reporting on the effect of salary packaging and any variation in its use across jurisdictions.

Cost per casemix-adjusted separation

'Cost per casemix-adjusted separation' is an indicator of governments' objective to deliver services in a cost effective manner (box 10.11).

Box 10.11 **Cost per casemix-adjusted separation**

'Cost per casemix-adjusted separation' is defined by the following two measures:

- Recurrent cost per casemix-adjusted separation is the average cost of providing care for an admitted patient (overnight stay or same day) adjusted with AR-DRG cost weights for the relative complexity of the patient's clinical condition and of the hospital services provided (AIHW 2000).
  - This measure includes overnight stays, same day separations, private patient separations in public hospitals and private patient recurrent costs. It excludes non-acute hospitals, mothercraft hospitals, multipurpose hospitals, multipurpose services, hospices, rehabilitation hospitals, psychiatric hospitals and hospitals in the 'unpeered and other' peer groups. The data exclude expenditure on non-admitted patient care, the user cost of capital and depreciation, and research costs.
  - All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (4.7 per cent of total separations in 2011-12 (table 10A.13)), so the acute care cost weights are applied to non-acute separations. The admitted patient cost proportion is an estimate only.
  - Some jurisdictions have developed experimental cost estimates for acute, non-psychiatric patients, which are reported here. Separations for non-acute patients and psychiatric acute care patients are excluded from these estimates because AR-DRG cost weights are a poor predictor of these separations.
  - Data reported for this measure are:
    - comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
    - complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

(Continued on next page)

Box 10.11 **(Continued)**

- Total cost per casemix-adjusted separation is the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. This measure allows the full cost of hospital services to be considered. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation.
  - Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.
  - Data reported for this measure are:
    - comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
    - complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

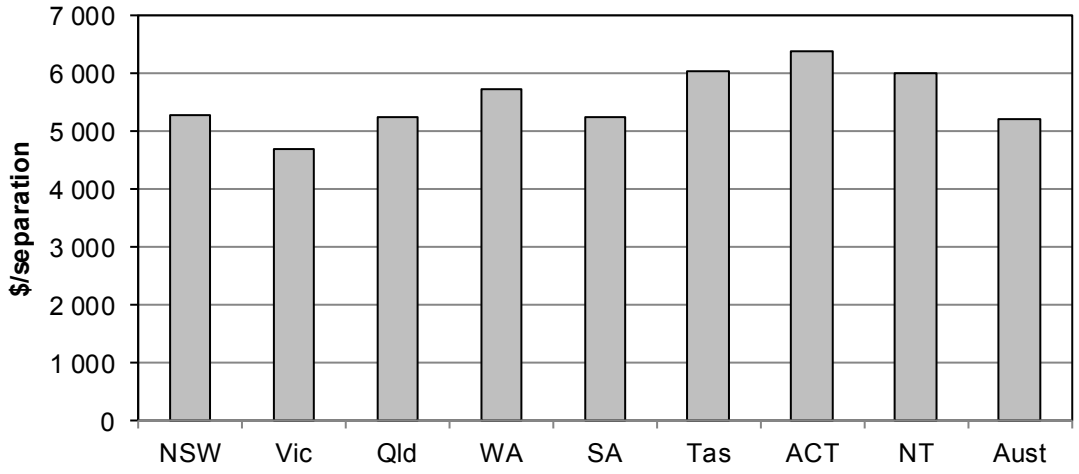
A low or decreasing cost per casemix-adjusted separation can reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Recurrent cost per casemix-adjusted separation

'Recurrent cost per casemix-adjusted separation' data are presented in figure 10.19.

Figure 10.19 **Recurrent cost per casemix-adjusted separation, 2011-12**[a, b, c, d]

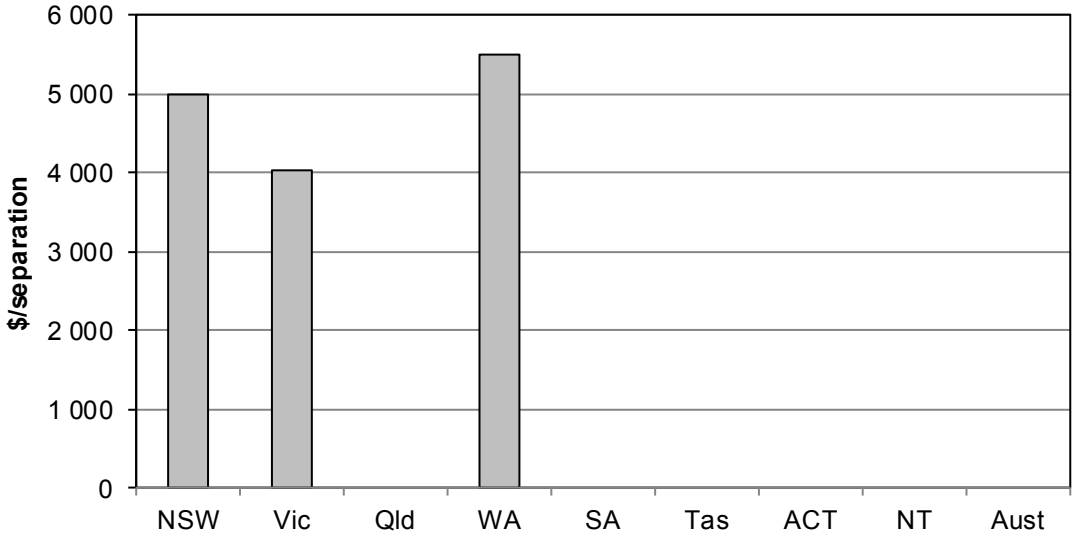


[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Cost Data Collection, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2008-09 AR-DRG v 5.2 cost weights. [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.56.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.20). (These estimates relate to a subset of the selected public hospitals reported in figure 10.19 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 10.11). The effect of restricting the analysis to acute, non-psychiatric admitted patients was to decrease the estimated recurrent cost per casemix adjusted separation for the subset of hospitals by 5.6 per cent for NSW, 14.0 per cent for Victoria and 4.1 per cent for WA (AIHW 2013a).

Figure 10.20 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2011-12**[a, b, c, d]



[a] Excludes psychiatric hospitals, subacute, non-acute and unpeered hospitals. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded $1000 per day and more than $1 million of apparent expenditure on non-acute patients days was reported. [b] Separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. [c] Average cost weight from the National Hospital Cost Data Collection, based on acute, newborn with at least one qualified day, or not reported, using the 2008-09 AR-DRG version 5.2 cost weights. [d] These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.56.

Recurrent cost per casemix-adjusted separation is affected by differences in the mix of admitted patient services produced by hospitals in each jurisdiction. Hospitals have been categorised by 'peer groups' to enable those with similar activities to be compared. The public hospital peer groups include 'Principal referral and Specialist women's and children's hospitals', 'Large hospitals', 'Medium hospitals' and 'Small acute hospitals'.

The dominant peer classification is the 'Principal referral and Specialist women's and children's' category. The 90 hospitals in this group had an average of 45 440 separations each at an average cost of $5222 per separation (table 10A.57 and table 10.8). Data for each of the hospital peer groups are presented in table 10.8. Detailed data for all peer groups are presented in table 10A.57.

Table 10.8 **Recurrent cost per casemix-adjusted separation, by hospital peer group, 2011-12**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Hospital peer group									
Principal referral and Specialist women's and children's	5 337	4 670	5 355	5 738	5 287	5 777	6 384	5 967	5 222
Large	5 003	4 593	3 973	5 149	5 051	7 390	..	..	4 912
Medium	4 964	4 945	4 645	5 399	5 208	6 406	..	..	5 025
Small acute	5 931	5 947	5 065	8 259	4 884	7 514	..	6 424	6 171
All hospitals[d]	**5 280**	**4 693**	**5 246**	**5 733**	**5 251**	**6 033**	**6 384**	**6 017**	**5 204**

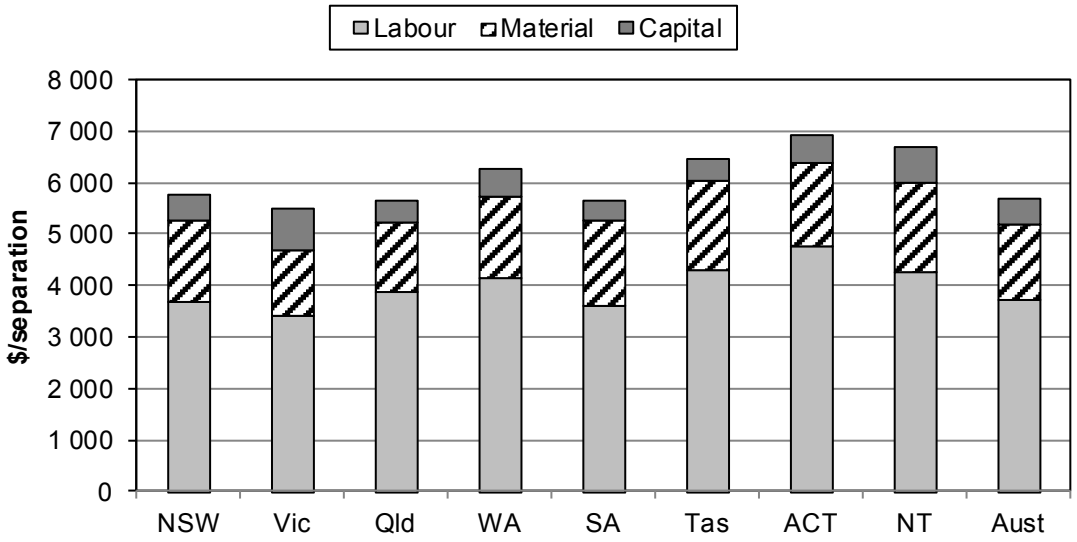
[a] Data exclude depreciation and the user cost of capital, spending on non-admitted patient care and research costs. [b] The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. [c] Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded. [d] Includes all hospitals in this cost per casemix-adjusted analysis. .. Not applicable.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.57.

Total cost per casemix-adjusted separation

Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospital services. Results for this measure in 2011-12 are reported in figure 10.21. Labour costs accounted for the majority of costs in most jurisdictions. The user cost of capital for land is not included in figure 10.21 but is reported in table 10A.58.

Figure 10.21 **Total cost per casemix-adjusted separation, public hospitals, 2011-12**[a, b, c]



[a] Labour includes medical and non-medical labour costs. Material includes other non-labour recurrent costs, such as repairs and maintenance (table 10A.56). [b] Capital cost includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. Capital cost excludes the user cost of capital associated with land (reported in table 10A.58). [c] Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; State and Territory governments (unpublished); tables 10A.56 and 10A.58.

Relative stay index

'Relative stay index' is an indicator of governments' objective to deliver services efficiently (box 10.12). Data for this indicator are reported in figure 10.22. The relative stay index is reported by funding source and by medical, surgical and other AR DRGs in tables 10A.59 and 10A.60 respectively.

Box 10.12 **Relative stay index**

'Relative stay index' is defined as the actual number of acute care patient days divided by the expected number of acute care patient days, adjusted for casemix. Casemix adjustment allows comparisons to take account of variation in types of service provided but not other influences on length of stay, such as the Indigenous status of the patient. Acute care separations only are included. Section 10.8 contains a more detailed definition outlining exclusions from the index.

(Continued on next page)

Box 10.12 **(Continued)**

The relative stay index for Australia for all hospitals (public and private) is one. A relative stay index greater than one indicates that average length of patient stay is higher than expected given the jurisdiction's casemix distribution. A relative stay index of less than one indicates that the number of bed days used was less than expected. A low or decreasing relative stay index is desirable if it is not associated with poorer health outcomes or significant extra costs outside the hospital systems (for example, in-home care).

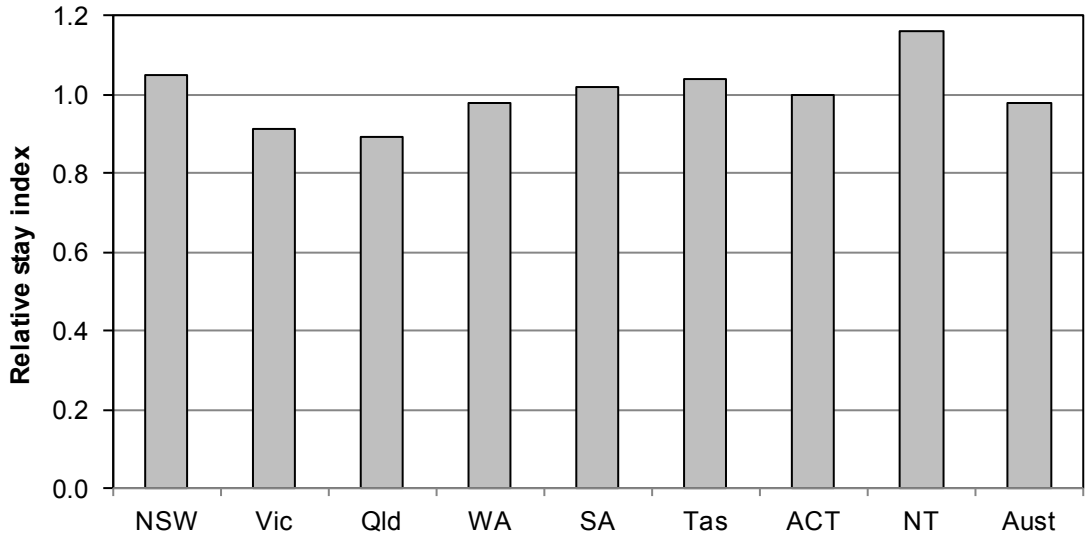
States and territories vary in their thresholds for classifying patients as either same day admitted patients or outpatients. These variations affect the relative stay index.

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 2011-12 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Figure 10.22 **Relative stay index, public hospitals, 2011-12[a, b]**



a Separations exclude newborns with unqualified days, organ procurement posthumous and hospital boarders. **b** The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 6.0x. The indirectly standardised relative stay index is not strictly comparable between jurisdictions but is a comparison of the jurisdiction with the national average based on the casemix of the jurisdiction.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; table 10A.59.

Recurrent cost per non-admitted occasion of service

'Recurrent cost per non-admitted occasion of service' is an indicator of governments' objective to deliver services in a cost effective manner (box 10.13).

Box 10.13 **Recurrent cost per non-admitted occasion of service**

'Recurrent cost per non-admitted occasion of service' is defined as the proportion of recurrent expenditure allocated to patients who were not admitted, divided by the total number of non-admitted patient occasions of service in public hospitals. Occasions of service include examinations, consultations, treatments or other services provided to patients in each functional unit of a hospital. Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.

A low or decreasing recurrent cost per non-admitted occasion of service can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness. This indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2000).

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- incomplete for the current reporting period. All required data were not available for Victoria, Queensland and the NT.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2011-12 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was $265 for 2.4 million occasions, the outpatient cost per occasion of service was $102 for 17.3 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $120 for 22.8 million occasions (table 10A.61).
- In WA, the emergency department cost per occasion of service was $535 for 976 000 occasions, the outpatient cost per occasion of service was $283 for

1.6 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $379 for 2.6 million occasions (table 10A.62).

- In SA, the emergency department cost per occasion of service was $455 for 608 000 occasions, the outpatient cost per occasion of service was $314 for 1.6 million occasions and the overall cost per occasion of service (emergency plus outpatient) was $353 for 2.2 million occasions (table 10A.63).
- In Tasmania, the emergency department cost per occasion of service was $451 for 125 000 occasions. The outpatient cost per occasion of service was $268 for 481 000 occasions. An overall cost per occasion of service was not available (table 10A.64).
- In the ACT, the emergency department cost per occasion of service was $839 for 119 000 occasions, the outpatient cost per occasion of service was $338 for 340 000 occasions and the overall cost per occasion of service (emergency plus outpatient) was $463 for 459 000 occasions (table 10A.65).

Given the lack of a nationally consistent non-admitted patient classification system, this Report includes national data from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection (NHCDC). The NHCDC collects data across a sample of hospitals that is expanding over time. The sample for each jurisdiction is not necessarily representative, because hospitals contribute data on a voluntary basis. The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals. Therefore, an estimation process has been carried out to create representative national activity figures from the sample data. In addition, the purpose of the NHCDC is to calculate between-DRG cost weights, not to compare the efficiency of hospitals.

Emergency department data were contributed by 228 public hospitals. These data suggest that the cost per emergency department presentation for the public hospitals sector in 2010-11 was $498 per presentation for 5.5 million presentations (table 10A.66). The cost per presentation for emergency departments by triage class are shown in table 10A.67. Cost per non-admitted clinic occasion of service data were provided by 203 public hospitals with an average cost of $340 per occasion of service for 8.1 million occasions of service (table 10A.68).

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).

Patient satisfaction

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are high quality and responsive to individual patient needs (box 10.14). Patient satisfaction surveys are different from other sources of hospital quality data, because they provide information on hospital quality from the patient's perspective. Surveys can be useful for obtaining information on patient views of both clinical and non-clinical hospital care (such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment).

Box 10.14 **Patient satisfaction**

'Patient satisfaction' is defined by the following six measures for the purposes of this report:

- Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often listened carefully to them
- Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often showed respect to them
- Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often spent enough time with them
- Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them
- Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them
- Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, because it suggests the hospital care received was of high quality and better met the expectations and needs of patients.

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 2012-13 data are available for all jurisdictions.

Descriptive information on patient surveys undertaken by states and territories is also reported. The descriptive information includes the survey time period, method, sample size, response rate and a selection of results where available. Information on how jurisdictions have used patient satisfaction surveys to improve public hospital quality in recent years is also reported. If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients' needs. As State and Territory based surveys differ in content, timing and scope across jurisdictions, it is not possible to compare their results nationally.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Patient satisfaction data for emergency department and admitted hospital patients are reported in table 10.9. Relative standard errors and confidence intervals are reported in attachment tables 10A.69—10A.76. These tables also report patient satisfaction by remoteness.

Table 10.9 **Patient satisfaction, hospitals, 2012-13[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Emergency department patients									
Proportion of people who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often listened carefully to them									
Doctors or specialists	85.0	83.4	84.0	84.7	83.4	81.3	82.5	87.6	84.2
Nurses	87.6	89.8	90.1	90.9	87.4	89.6	83.5	90.5	89.1
Proportion of people who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often showed respect to them									
Doctors or specialists	86.4	84.7	85.5	87.2	84.8	83.3	82.6	88.4	85.7
Nurses	88.5	91.1	90.2	92.4	89.6	90.3	86.7	90.2	90.1
Proportion of people who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often spent enough time with them									
Doctors or specialists	81.0	79.9	80.7	83.1	79.5	74.9	75.3	85.0	80.7
Nurses	85.2	85.6	87.5	90.4	86.6	84.3	80.8	89.5	86.4
Admitted hospital patients									
Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them									
Doctors or specialists	91.3	89.5	87.1	90.8	89.5	85.9	89.3	81.5	89.5
Nurses	90.5	92.1	91.8	92.0	90.8	89.9	89.8	86.9	91.2
Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them									
Doctors or specialists	91.5	89.3	88.4	92.6	90.2	86.2	91.2	81.3	90.2
Nurses	92.2	91.1	91.4	93.0	91.7	88.4	90.6	87.6	91.5
Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them									
Doctors or specialists	87.5	85.6	85.8	87.2	84.0	84.7	85.4	80.3	86.2
Nurses	88.5	89.0	89.2	91.8	87.7	86.5	85.3	85.8	88.9

a Rates are age standardised to the 2001 estimated resident population (5 year ranges). ED=Emergency department.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, tables 10A.69–10A.76.

State and territory based survey data

State and Territory survey approaches differed markedly across jurisdictions, so it is not possible to compare results:

- All jurisdictions provided details of surveys conducted in 2012 and/or 2013, with the exception of Tasmania and the NT, which did not update survey details for this Report.
- The length of time that surveys were conducted varied from a 12 month period to a two month period.

- Queensland, WA and SA, used Computer Assisted Telephone Interviewing, while other jurisdictions used a combination of mail and internet surveys.
- Most jurisdictions surveyed admitted and non-admitted patients. One jurisdiction surveyed emergency departments only.
- Sample sizes varied from 26 800 to around 500 patients.

More information on the survey methods and results are in tables 10A.77–10A.84.

All jurisdictions reported that they use survey results in some way to improve services. All jurisdictions provide survey results or feedback to hospitals. Most jurisdictions have a formalised approach to prioritising the areas in need of improvement identified by the surveys and then implementing quality improvements. More information on how survey results are used to improve services are in tables 10A.77–10A.84.

Sentinel events

'Sentinel events' is an indicator of governments' objective to deliver public hospital services that are safe and of high quality (box 10.15). Sentinel events can indicate hospital system and process deficiencies that compromise quality and safety. Sentinel events are a subset of adverse events that result in death or very serious harm to the patient. Adverse events are reported elsewhere in this chapter as an output indicator.

Box 10.15 **Sentinel events**

'Sentinel events' is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition. Sentinel events have the potential to seriously undermine public confidence in the healthcare system.

Australian health ministers have agreed on a national core set of sentinel events for which all public hospitals are required to provide data. The eight nationally agreed core sentinel events are:

1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
2. Suicide of a patient in an inpatient unit.
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
4. Intravascular gas embolism resulting in death or neurological damage.
5. Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
7. Maternal death or serious morbidity associated with labour or delivery.
8. Infant discharged to the wrong family.

A low or decreasing number of sentinel events is desirable.

Over time, an increase in the number of sentinel events reported might reflect improvements in incident reporting mechanisms and organisational cultural change, rather than an increase in the frequency of such events. However, trends need to be monitored to establish whether this is the underlying reason.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete (subject to caveats) for the current reporting period. All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Sentinel event programs have been implemented by all State and Territory governments. The purpose of these programs is to facilitate a safe environment for patients by reducing the frequency of these events. The programs are not punitive, and are designed to facilitate self reporting of errors so that the underlying causes of the events can be examined, and action taken to reduce the risk of these events re-occurring.

In 2007 the AIHW, in conjunction with the ACSQHC, published a report that included national sentinel events data for 2004-05 (AIHW and ACSQHC 2007). The report identified that reporting practices differ across jurisdictions and, as a result, the data are not comparable across jurisdictions.

Numbers of sentinel events for 2011-12 are reported below. Data for 2007-08 to 2010-11 are reported in tables 10A.85 to 10A.92. Australian totals are reported in table 10A.93. As larger states and territories will tend to have more sentinel events than smaller jurisdictions, the numbers of separations and individual occasions of service are also presented to provide context.

In NSW public hospitals in 2011-12, there was a total of 38 sentinel events (table 10A.85) compared to around 1.7 million separations (table 10A.6) and around 24.0 million individual occasions of service (table 10A.16). The sentinel events comprised:

- one procedure involving the wrong patient or body part resulting in death or major permanent loss of function
- 20 suicides of a patient in an inpatient unit
- 14 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- one haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility
- one medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
- one maternal death or serious morbidity associated with labour or delivery (table 10A.85).

In Victorian public hospitals in 2011-12, there was a total of 20 sentinel events (table 10A.86) compared to around 1.5 million separations (table 10A.6) and around 7.0 million individual occasions of service (table 10A.16). The sentinel events comprised:

- one procedure involving the wrong patient or body part resulting in death or major permanent loss of function
- 8 suicides of a patient in an inpatient unit
- 7 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- 4 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs (table 10A.86).

In Queensland public hospitals in 2011-12, there was a total of 11 sentinel events (table 10A.87) compared to around 1.0 million separations (table 10A.6) and around 11.2 million individual occasions of service (table 10A.16). The sentinel events comprised:

- one procedure involving the wrong patient or body part resulting in death or major permanent loss of function
- one suicide of a patient in an inpatient unit
- 5 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- four maternal deaths or serious morbidity associated with labour or delivery (table 10A87).

In WA public hospitals in 2011-12, there was a total of 11 sentinel events (table 10A.88) compared to around 588 000 separations (table 10A.6) and around 5.9 million individual occasions of service (table 10A.16). The sentinel events comprised:

- one procedure involving the wrong patient or body part resulting in death or major permanent loss of function
- 5 suicides of a patient in an inpatient unit
- 3 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- two maternal deaths or serious morbidity associated with labour or delivery (table 10A.88).

In SA public hospitals in 2011-12, there was a total of 23 sentinel events (table 10A.89) compared to around 407 000 separations (table 10A.6) and around 2.2 million individual occasions of service (table 10A.16). The sentinel events comprised:

- 5 retained instruments or other material after surgery requiring re-operation or further surgical procedure
- one medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
- 17 maternal deaths or serious morbidity associated with labour or delivery (table 10A.89)[1].

[1] In the category of maternal death or serious morbidity associated with labour or delivery, 14 related to post-partum haemorrhage >1500mls, three to fourth degree tear's and three to other classifications of serious morbidity.

In Tasmanian public hospitals in 2011-12, there was one sentinel event (table 10A.90) compared to around 100 000 separations (table 10A.6) and around 504 000 individual occasions of service (table 10A.16). The sentinel event was a retained instrument or other material after surgery requiring re-operation or further surgical procedure (table 10A.90).

In ACT public hospitals in 2011-12, there was a total of three sentinel events (table 10A.91) compared to around 97 000 separations (table 10A.6) and around 1.6 million individual occasions of service (table 10A.16). ACT sentinel events were not reported by category due to confidentiality concerns.

In the NT public hospitals in 2011-12, there were no reported sentinel events (table 10A.92) compared to around 113 000 separations (table 10A.6) and around 572 000 individual occasions of service (table 10A.16).

Mortality in hospitals

'Mortality in hospitals' is an indicator of governments' objective to deliver public hospital services that are safe and of high quality (box 10.16).

Box 10.16 **Mortality in hospitals**

'Mortality in hospitals' is defined by the following three measures:

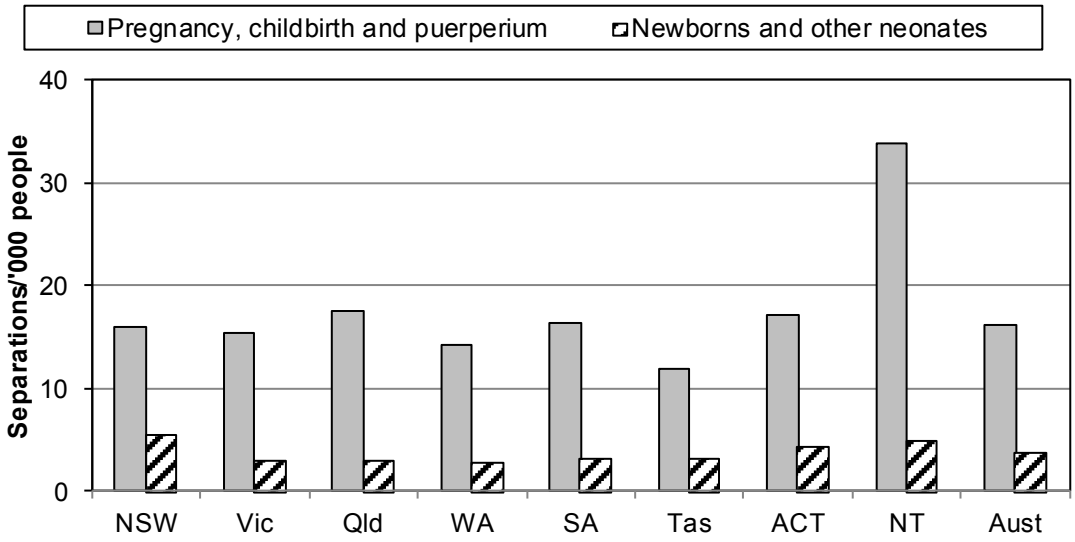
- Hospital standardised mortality ratio
- Death in low-mortality diagnostic related groups
- In-hospital mortality rates.

Mortality in hospitals has been identified as a key area for development in future Reports.

10.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 8.4 per cent of total acute separations in public hospitals (table 10A.95) and around 10.7 per cent of the total cost of all acute separations in public hospitals in 2011-12 (table 10A.94). Figure 10.23 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2011-12.

Figure 10.23 **Separation rates for maternity services, public hospitals, 2011-12**[a, b, c, d]



[a] The puerperium refers to the period of confinement immediately after labour (around six weeks). [b] Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight of less than 2500 grams. [c] Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days'. [d] Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (tables 2A.1-2) for details.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134; ABS (unpublished), Australian Demographic Statistics, December Quarter 2011, Cat. no. 3101.0; tables 2A.2 and 10A.95.

In Australian public hospitals in 2011-12, 41.4 per cent of the separations for pregnancy, childbirth and the puerperium had a DRG of vaginal delivery (tables 10A.95 and 10A.96). In the context of all AR-DRGs in public hospitals, vaginal deliveries comprised the largest number of overnight acute separations (3.9 per cent of all separations) (table 10A.14). The cost of vaginal deliveries was $753.2 million in 2011-12 (table 10A.96).

The complexity of maternity services is partly related to the mother's age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions (table 10.10).

Table 10.10 **Mean age of mothers at time of giving birth, public hospitals**

	NSW	*Vic*[a]	*Qld*	*WA*[b]	*SA*[c]	*Tas*	*ACT*[d]	*NT*
2008								
First birth	27.9	27.7	25.5	26.0	26.9	27.0	28.0	24.5
Second birth	30.2	30.0	28.1	28.6	29.5	29.6	30.2	26.4
Third birth	31.5	31.5	29.7	30.1	31.0	31.7	31.9	28.5
All births	29.8	29.6	27.9	28.2	29.1	29.2	29.8	26.8
2009								
First birth	27.9	28.2	25.6	26.2	27.0	24.9	28.0	24.2
Second birth	30.4	30.7	28.3	28.6	29.6	27.7	30.5	26.8
Third birth	31.6	32.0	29.8	30.1	31.1	29.0	31.4	28.6
All births	29.9	30.1	28.0	28.3	29.1	27.3	29.8	26.9
2010								
First birth	28.2	28.2	25.6	26.3	27.1	26.3	28.0	24.6
Second birth	30.3	30.7	28.2	28.8	29.6	28.6	30.4	27.1
Third birth	31.6	32.0	29.8	30.3	31.3	29.9	31.9	28.9
All births	29.9	30.1	28.0	28.4	29.2	28.8	29.9	27.0
2011								
First birth	28.2	27.9	25.9	26.5	27.3	26.9	28.4	24.7
Second birth	30.4	30.2	28.2	28.8	29.8	29.4	30.6	27.2
Third birth	31.6	31.7	30.1	30.4	31.3	30.4	32.2	28.7
All births	29.9	29.7	28.1	28.5	29.3	28.9	30.0	27.1
2012								
First birth	27.8	28.2	26.0	26.6	27.3	na	28.5	24.8
Second birth	30.3	30.1	28.4	28.9	29.8	na	30.9	27.4
Third birth	31.5	31.4	29.9	30.3	31.3	na	32.0	28.8
All births	29.5	29.6	28.2	28.5	29.3	na	30.1	27.2

a Data for Victoria for 2012 are preliminary. **b** Data for WA for 2012 are preliminary. **c** Data for SA for 2012 are preliminary. **d** ACT 2012 data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. **na** Not available.

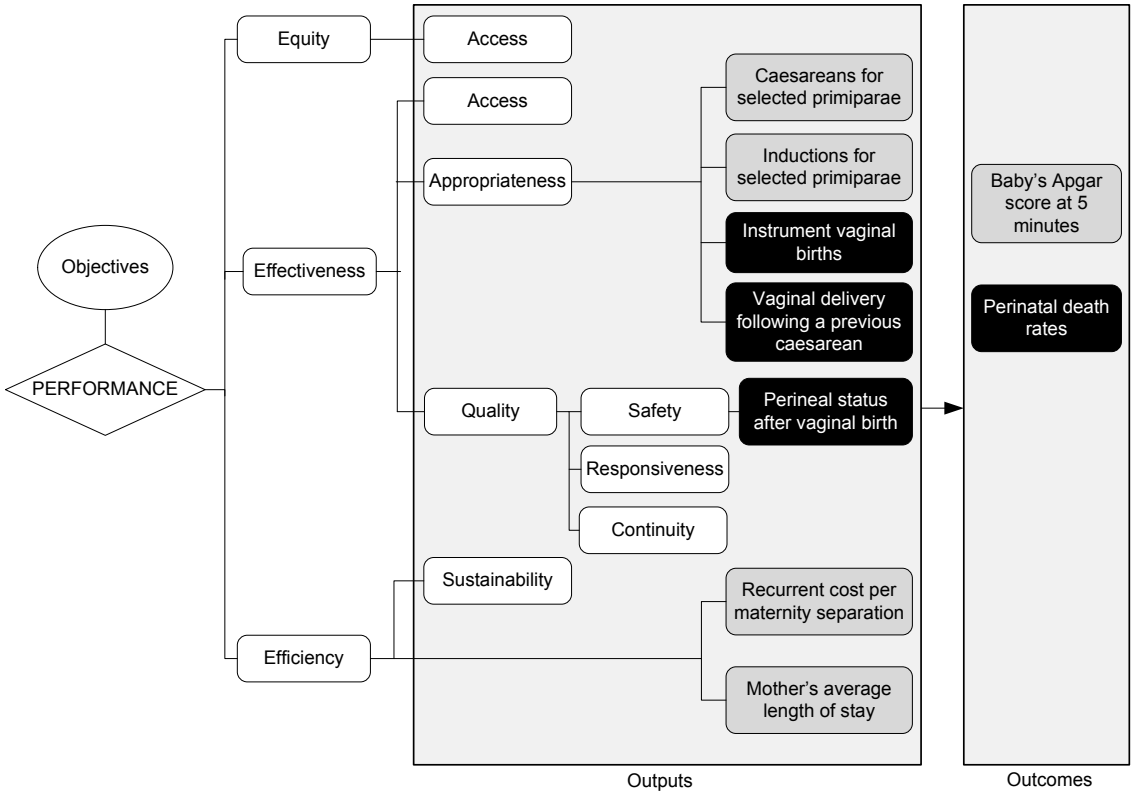
Source: State and Territory governments (unpublished).

10.5 Framework of performance indicators for maternity services

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of maternity services (figure 10.24). The performance indicator framework shows which data are comparable in the 2014 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 Health sector overview explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

The Report's statistical context chapter 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) (chapter 2).

Figure 10.24 **Maternity services 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 key data gaps and issues identified by the Steering Committee. All DQI for the 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

10.6 Key performance indicator results for maternity 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 — access

The Steering Committee has identified equity of access as an area for development in future Reports. Equity of access indicators will measure access to maternity services by special needs groups such as Indigenous Australians or people in rural and remote areas.

Effectiveness — access

The Steering Committee has identified the effectiveness of access to maternity services as an area for development in future Reports. Effectiveness of access indicators will measure access to appropriate services for the population as a whole, particularly in terms of affordability and/or timeliness.

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

'Caesareans for selected primiparae' and 'Inductions for selected primiparae' are indicators of the appropriateness of maternity services in public hospitals (box 10.17).

Box 10.17 **Caesareans and inductions for selected primiparae[a]**

'Caesareans and inductions for selected primiparae' are defined as the number of inductions or caesareans for the selected primiparae[a] divided respectively by the number of the selected primiparae who gave birth.

High intervention rates can indicate a need for investigation, although labour inductions and birth by caesarean section are interventions that are appropriate in some circumstances, depending on the health and wellbeing of mothers and babies.

Rates are reported for women aged between 25 and 29 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks. This group is considered to be low risk parturients[b], so caesarean or induction rates should be low in their population.

Data reported for this indicator are:

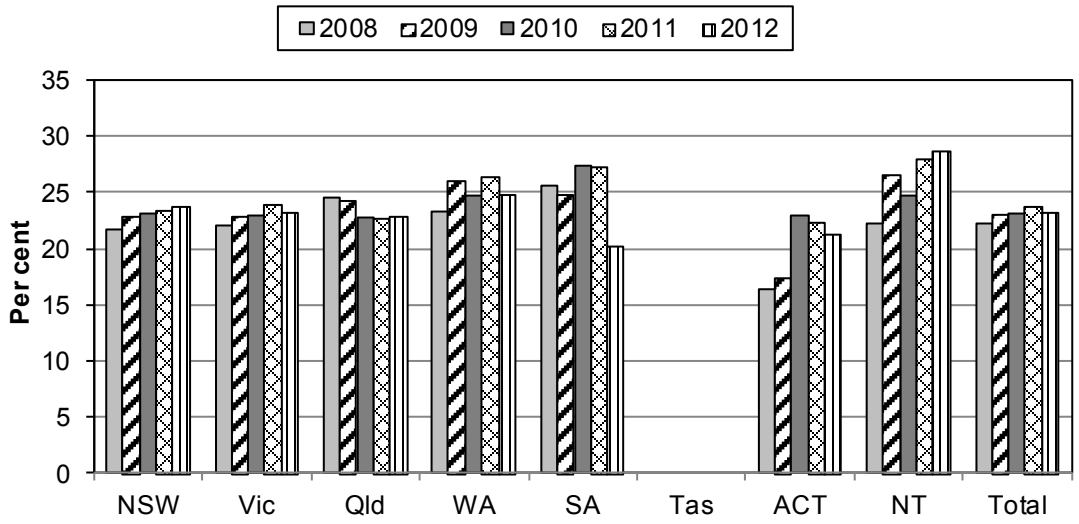
- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- incomplete for the current reporting period. All required data were not available for Tasmania.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

[a] Primiparae refers to a woman who has given birth to a liveborn or stillborn infant for the first time. [b] Parturient means 'about to give birth'.

Caesarean rates for selected primiparae in public hospitals are reported in figure 10.25. Induction rates for selected primiparae in public hospitals are reported in figure 10.26. Caesarean and induction rates for private hospitals are shown in table 10A.97 for comparison. They are higher than the rate for public hospitals in almost all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 10A.98–10A.105.

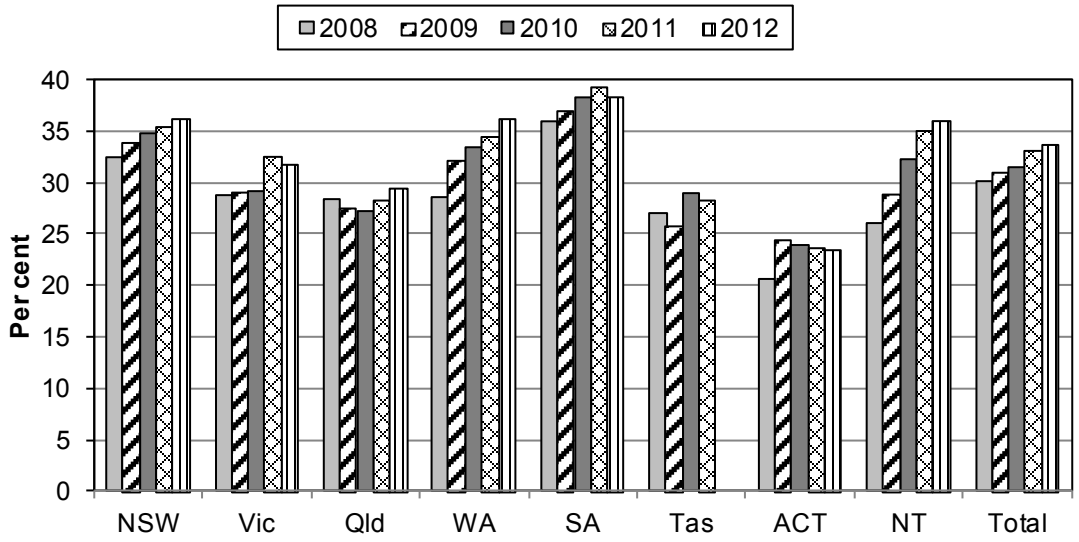
Figure 10.25 **Caesareans for selected primiparae, public hospitals**[a, b, c, d, e, f]



[a] Data for 2012 for Victoria are preliminary. [b] Data for WA for 2012 are preliminary. [c] Data for SA for 2012 are preliminary. [d] Data for Tasmania are not available. [e] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. [f] Total includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); tables 10A.98–10A.105.

Figure 10.26 **Inductions for selected primiparae, public hospitals**[a, b, c, d, e, f]



[a] Data for 2012 for Victoria are preliminary. [b] Data for WA for 2012 are preliminary. [c] Data for SA for 2012 are preliminary. [d] Data for 2012 for Tasmania are not available. [e] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. [f] Total includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); tables 10A.98–10A.105.

Instrumental vaginal births

'Instrumental vaginal births' is an indicator of the appropriateness of maternity services (box 10.18). This indicator is reported for the first time this year.

Box 10.18 **Instrumental vaginal births**

'Instrumental vaginal births' is defined as the number of instrumental vaginal births as a percentage of total births. Instrumental vaginal births includes forceps and vacuum extraction. The indicator is calculated for women aged 20 to 34 years, with a singleton baby positioned with the head towards the cervix at the onset of labour born between 37 and 41 weeks gestation.

While low or decreasing instrumental vaginal births can be desirable, a high rate does not necessarily indicate inappropriate care. Reasons for instrumental vaginal births often include:

- the first baby/birth of the mother
- the baby was becoming distressed during birth
- the baby was not moving down through the birth canal
- there was a medical reason why the mother should or could not push.

In these cases the use of instruments is often necessary and appropriate and can often have a better outcome for mother and baby than a caesarean section. A low or decreasing rate of instrumental vaginal births could be undesirable in situations such as this if there is a corresponding increase in the rate of caesarean sections.

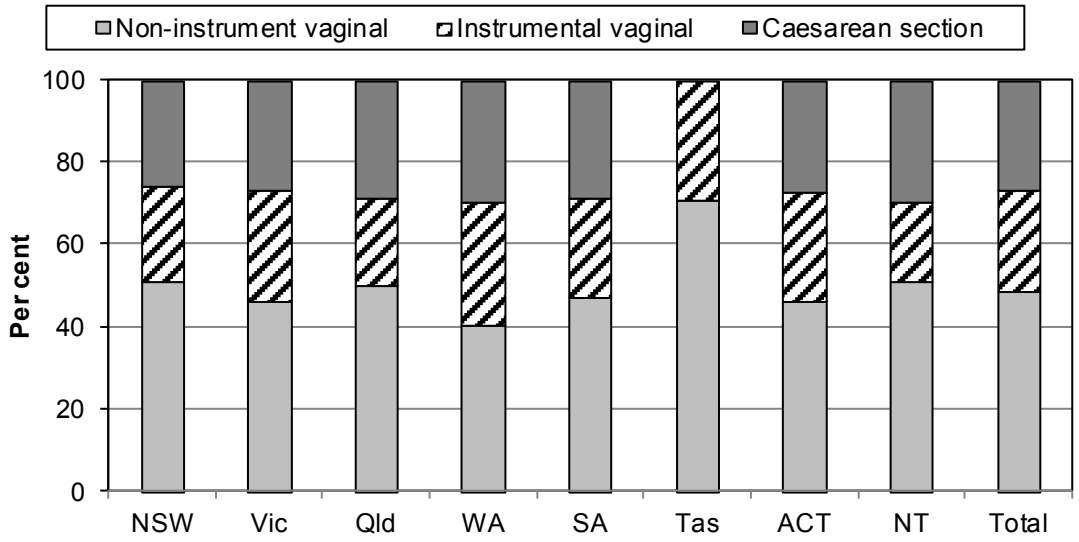
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period. All required data were not available for Tasmania.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

In 2011 across Australia, close to a quarter of women giving birth for the first time gave birth with the assistance of instruments. In contrast 48.2 per cent gave birth without the use of instruments and 27.0 per cent had a caesarean section. There was significant variation between states and territories (figure 10.27).

Figure 10.27 **Method of birth for selected women giving birth for the first time, 2011**[a, b, c]



[a] 'Selection criteria: women aged 20 to 34 years, with a singleton baby positioned with head towards the cervix at the onset of labour born between 37 and 41 weeks gestation. [b] 'Provisional data were provided by Victoria for this table. [c] Caesarean section data for Tasmania not published as presentations were only recorded for vaginal births.

Data source: AIHW (unpublished) National Perinatal Data Collection; table 10A.106.

Vaginal delivery following previous caesarean

'Vaginal delivery following a previous caesarean' is an indicator of the appropriateness of maternity services in public hospitals (box 10.19).

Box 10.19 **Vaginal delivery following a previous caesarean**

'Vaginal delivery following a previous caesarean' is defined as the percentage of multiparous[a] mothers who have had a previous caesarean, whose current method of birth was either an instrumental or non-instrumental vaginal delivery.

Interpretation of this indicator is ambiguous. There is ongoing debate about the relative risk to both mother and baby of a repeat caesarean section compared with a vaginal birth following a previous caesarean. Low rates of vaginal birth following a previous caesarean may warrant investigation, or on the other hand, they can indicate appropriate clinical caution. When interpreting this indicator, emphasis needs to be given to the potential for improvement.

[a] Multiparous means woman who has given birth from at least two pregnancies that each resulted in a live birth or stillbirth.

(Continued on next page)

Box 10.19 **(Continued)**

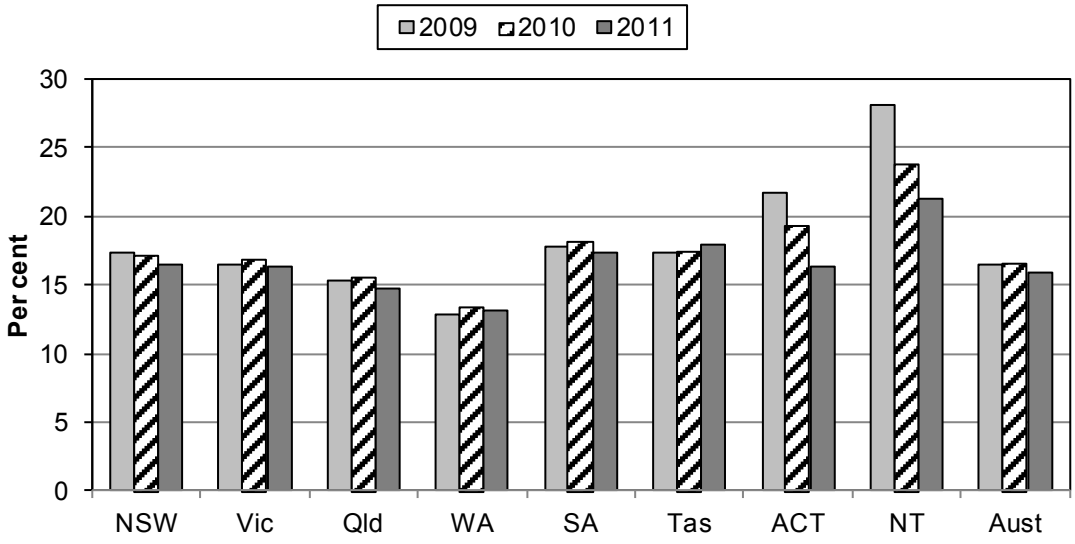
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2011 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally in 2011, of women that had a previous caesarean section, 15.9 per cent had either an instrumental or non-instrumental vaginal delivery as their current method of birth, while 84.1 per cent had another caesarean section (figure 10.28 and table 10A.107).

Figure 10.28 **Women who had a vaginal birth after previous caesarean section[a, b, c, d, e]**



[a] Vaginal birth comprises both instrumental and non-instrumental vaginal births. [b] For multiple births, the method of birth of the first born baby was used. [c] For NSW, Victoria, WA and the NT non-instrumental vaginal birth includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. [d] Instrumental vaginal birth includes forceps and vacuum extraction. [e] Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2007 and 2011, around 15 per cent of women who gave birth in the ACT were non-residents of the ACT.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA. (various years), *Australia's mothers and babies,* Perinatal statistics series Cat nos. PER 50, 52 and 56; table 10A.107.

Effectiveness — quality

The performance indicator framework for maternity services identifies three subdimensions of quality for health services: safety; responsiveness and continuity. For maternity services in this Report, data are reported against the subdimension of safety only. Other subdimensions of quality have been identified by the Steering Committee for future development.

Safety — perineal status after vaginal birth

'Perineal status after vaginal birth' is an indicator of governments' objective to provide safe and high quality services (box 10.20). Perineal lacerations caused by childbirth are painful, take time to heal and can result in ongoing discomfort and debilitating conditions such as faecal incontinence.

Box 10.20 **Perineal status after vaginal birth**

'Perineal status after vaginal birth' is defined as the state of the perineum following a vaginal birth (HDSC 2008). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 10.8 for definitions) (NCCH 2008). It is measured by the proportion of women giving birth with third or fourth degree lacerations to their perineum following vaginal birth.

A low or decreasing rate of women giving birth with third or fourth degree lacerations after vaginal birth is desirable. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices. Severe lacerations (third and fourth degree laceration) of the perineum are not avoidable in all cases and so safe labour management is associated with a low (rather than zero) proportion of third or fourth degree lacerations.

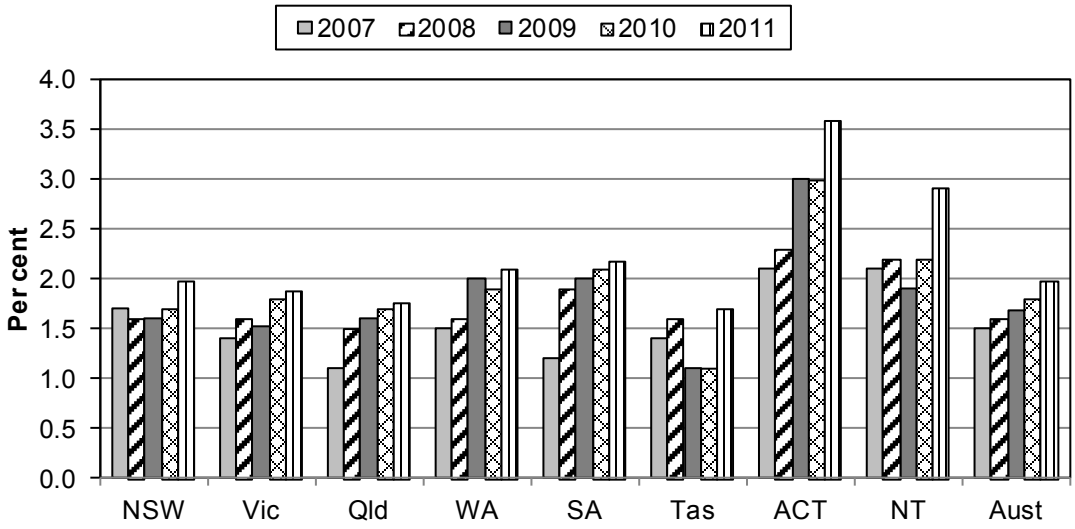
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2011 data are available for all jurisdictions.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The proportion of mothers with third or fourth degree lacerations to their perineum following vaginal births is shown in figure 10.29. More information on perineal status after vaginal birth (including the proportion of mothers with intact perineum following vaginal births) is contained in table 10A.108.

Figure 10.29 **Perineal status — mothers with third or fourth degree lacerations after vaginal births[a, b, c]**



a For multiple births, the perineal status after birth of the first child was used. **b** Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.**c** Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2007 and 2011, around 15 per cent of women who gave birth in the ACT were non-residents of the ACT.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA. (various years), *Australia's mothers and babies,* Perinatal statistics series Cat nos. PER 22, 48, 50, 52 and 56; table 10A.108.

Responsiveness, continuity

The Steering Committee has identified the responsiveness and continuity of care of maternity services as an area for development in future Reports.

Efficiency — sustainability

The Steering Committee has identified the sustainability of maternity services as an area for development in future Reports.

Efficiency

Recurrent cost per maternity separation

'Recurrent cost per maternity separation' is an indicator of governments' objective to deliver cost effective services (box 10.21).

Box 10.21 **Recurrent cost per maternity separation**

'Recurrent cost per maternity separation' is presented for the two AR-DRGs that account for the largest number of maternity patient days: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities.

Low or decreasing recurrent costs per maternity separation can reflect high or increasing efficiency in providing maternity services to admitted patients. However, this is only likely to be the case where the low cost maternity services are provided at equal or superior effectiveness.

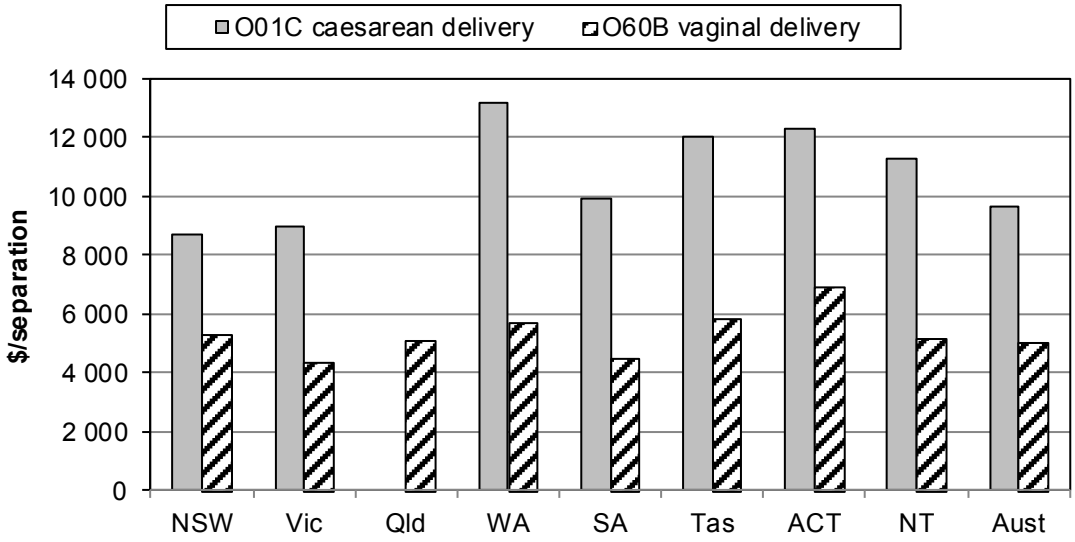
Data reported for this indicator are:

- comparable (subject to caveats) within some jurisdictions over time but are not comparable across jurisdictions or over time for other jurisdictions (see caveats in attachment tables for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2010-11 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.30). Data for a number of other maternity related AR-DRGs are shown in table 10A.109. Data are sourced from the NHCDC. The NHCDC is a voluntary annual collection, the purpose of which is to calculate DRG cost weights. The samples are not necessarily representative of the set of hospitals in each jurisdiction. An estimation process has been carried out to create representative national activity figures from the sample data.

Figure 10.30 **Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2010-11**[a, b, c]



[a] Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and comorbidities. [b] Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Caution must be used in making direct comparisons between jurisdictions, because of differences in hospital costing systems. [c] Average cost for Queensland for O01C caesarean delivery was zero.

Source: IHPA (unpublished), *National Hospital Cost Data Collection*; table 10A.109.

Mother's average length of stay

'Mother's average length of stay' is an indicator of governments' objective to deliver services efficiently (box 10.22).

Box 10.22 **Mother's average length of stay**

'Mother's average length of stay' is defined as the total number of patient days for the selected maternity AR-DRG, divided by the number of separations for that AR-DRG.

Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care and potential readmissions. The indicator is not adjusted for multiple births born vaginally and without complications but requiring a longer stay to manage breastfeeding.

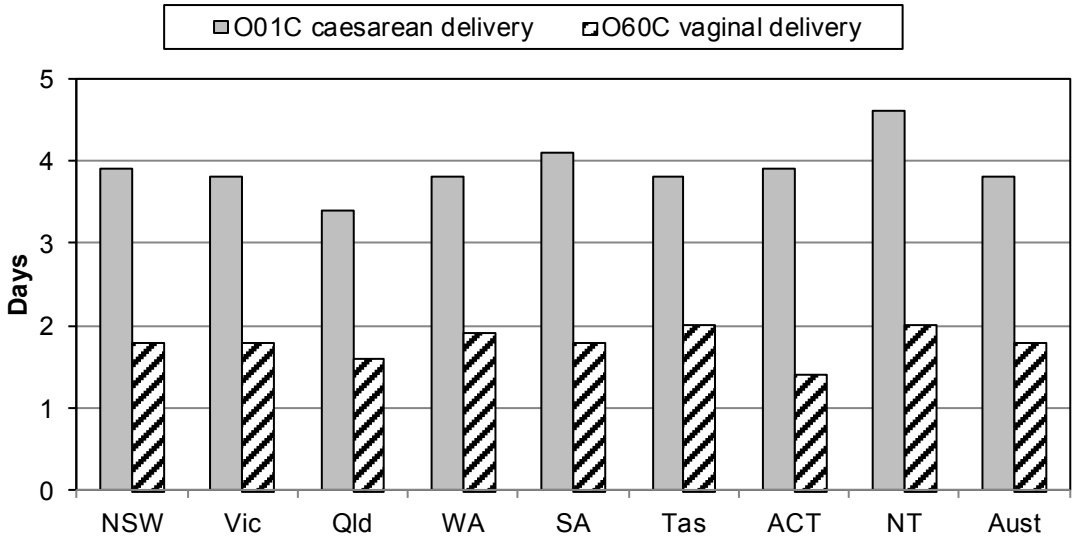
Data reported for this indicator are:

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

Data quality information for this indicator is under development.

Data are reported for two selected maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery single uncomplicated. Data are sourced from the AIHW Admitted patient collection for the first time this year for this indicator. In previous reports, data for this indicator were sourced from the NHCDC, hence data this year are not comparable with previous reports (figure 10.31).

Figure 10.31 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2011-12**[a]



[a] Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60C vaginal delivery single uncomplicated.

Source: AIHW (2013), *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134; table 10A.110.

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).

Baby's Apgar score

'Baby's Apgar score at five minutes' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.23). The future health of babies with lower Apgar scores is often poorer than those with higher scores.

Box 10.23 **Baby's Apgar score at five minutes**

Baby's Apgar score at five minutes is defined as the number of live births with an Apgar score of less than 4, at 5 minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories. The Apgar score is a numerical score that indicates a baby's condition shortly after birth. Apgar scores are based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability. Between 0 and 2 points are given for each of these five characteristics and the total score is between 0 and 10. The Apgar score is routinely assessed at 1 and 5 minutes after birth, and subsequently at 5 minute intervals if it is still low at 5 minutes (Day *et al*. 1999).

A high or increasing Apgar score is desirable.

Low Apgar scores (defined as less than 4) are strongly associated with babies' birthweights being low. The management of labour in hospitals does not usually affect birthweights, but can affect the prevalence of low Apgar scores for babies with similar birthweights. Apgar scores can therefore indicate relative performance within birthweight categories, although factors other than hospital maternity services can influence Apgar scores within birthweight categories — for example antenatal care, multiple births and socioeconomic factors.

Data reported for this indicator are:

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

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

'Low' (less than 4) Apgar scores for babies by birthweight category are contained in table 10.11. The full range of Apgar scores for 2003 to 2012 are reported in table 10A.111.

Table 10.11 **Live births with an Apgar score of less than 4, 5 minutes post-delivery, public hospitals, 2012**

Birthweight (grams)	*Unit*	*NSW*	*Vic*[a]	*Qld*	*WA*[b]	*SA*[c]	*Tas*	*ACT*[d]	*NT*
Less than 1500	no.	913	658	588	295	227	na	81	44
Low Apgar	%	17.7	17.5	17.0	4.1	12.7	na	12.4	np
1500-1999	no.	1 364	754	638	311	281	na	80	47
Low Apgar	%	1.3	1.1	2.2	1.3	0.8	na	–	np
2000-2499	no.	3 630	2 253	1 884	873	742	na	212	188
Low Apgar	%	0.7	0.6	0.6	0.5	0.1	na	0.5	np
2500 and over	no.	73 524	52 201	41 475	18 090	14 239	na	4 206	2 896
Low Apgar	%	0.2	0.2	0.2	0.2	0.1	na	0.2	0.3

a Data for Victoria are preliminary. **b** Data for WA are preliminary. **c** Data for SA are preliminary. **d** ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. **na** Not available. – Nil or rounded to zero. **np** Not published.

Source: State and Territory governments (unpublished); table 10A.111.

Perinatal death rate

'Perinatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.24).

Box 10.24 **Perinatal death rate**

'Perinatal death rate' is defined by the following three measures:

- Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks. The fetal death rate is calculated as the number of fetal deaths divided by the total number of births (live births and fetal deaths combined). The rate of fetal deaths is expressed per 1000 total births, by State or Territory of usual residence of the mother
- Neonatal death is the death of a live born infant within 28 days of birth (see section 10.8 for a definition of a live birth). The neonatal death rate is calculated as the number of neonatal deaths divided by the number of live births registered. The rate of neonatal deaths is expressed per 1000 live births, by State or Territory of usual residence of the mother.
- A perinatal death is a fetal or neonatal death. The perinatal death rate is calculated as the number of perinatal deaths divided by the total number of births (live births registered and fetal deaths combined). It is expressed per 1000 total births, by State or Territory of usual residence of the mother.

Low or decreasing death rates are desirable and can indicate high quality maternity services. The neonatal death rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.

Differences in the fetal death rate between jurisdictions are likely to be due to factors outside the control of admitted patient maternity services (such as the health of mothers and the progress of pregnancy before hospital admission). To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

Data reported for this indicator are:

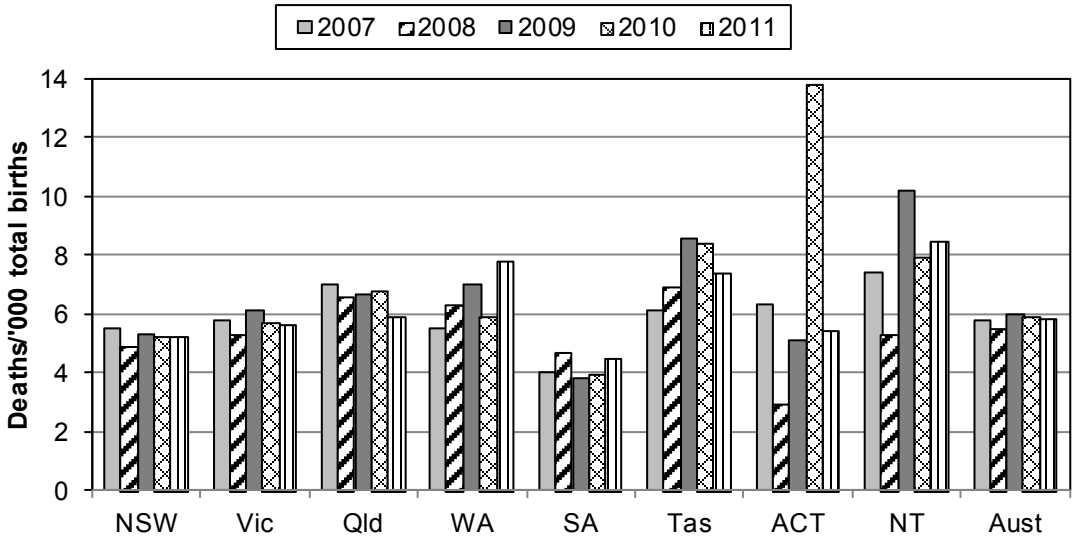
- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period. All required Indigenous data were not available for Victoria, Tasmania and the ACT.

Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Fetal death rate

Fetal death rates are reported in figure 10.32. Nationally, fetal death rates have generally been steady over the period 2007–2011. National time series for fetal death rates for the period 1999 to 2011 are included in table 10A.114.

Figure 10.32 **Fetal death rate**[a, b, c]

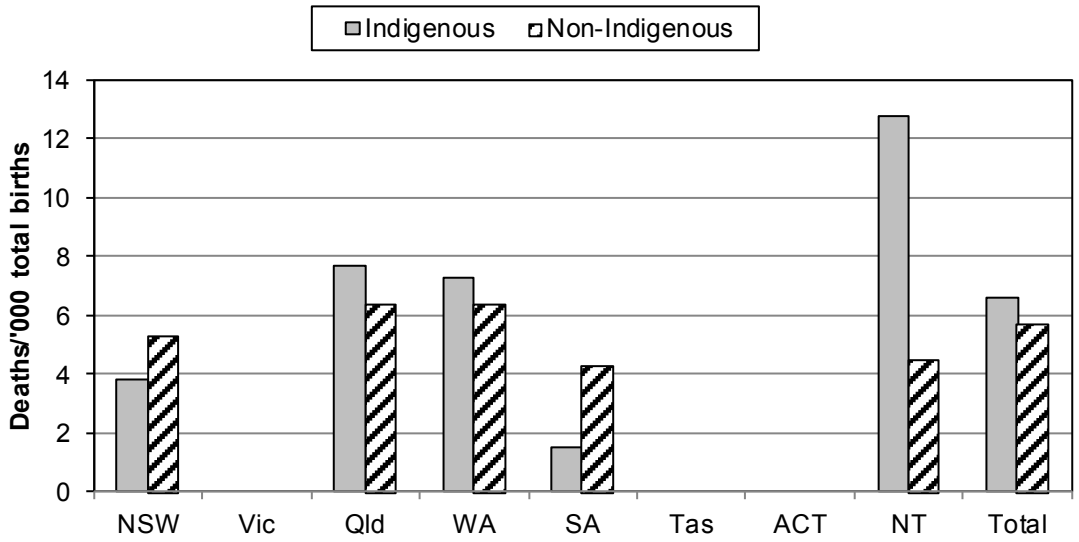


[a] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of fetal deaths and small populations. [b] Some fetal deaths occurring in WA could be the result of termination of pregnancy at 20 weeks gestation or more. [c] The ACT and Australian total exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data were included in the 2010 reference year. The data therefore shows a decline in 2008 and an increase in 2010 which is not related to any actual significant change in fetal death rates.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.112.

Fetal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of Indigenous identification in mortality data (ABS 2004). For three of the five jurisdictions for which data are available, the fetal death rates for Indigenous Australians are higher than those for non-Indigenous Australians (figure 10.33).

Figure 10.33 **Fetal death rate by Indigenous status of mother 2007–2011**[a]



[a] Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

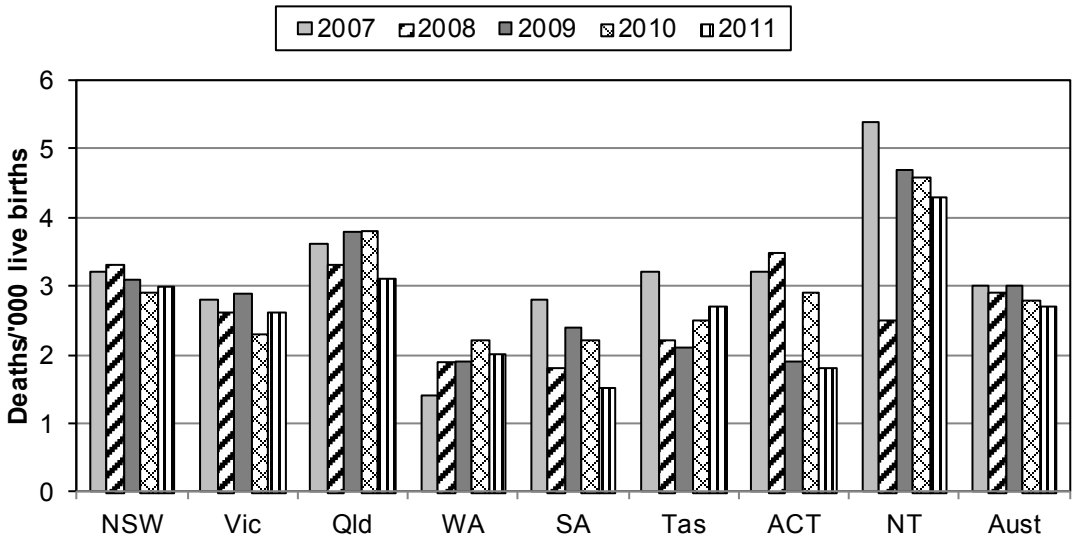
Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.116.

Neonatal death rate

Neonatal death rates are reported in figure 10.34. Nationally, neonatal death rates have declined slightly over the period 2007–2011. National time series for neonatal death rates for the period 1999 to 2011 are included in table 10A.114.

Neonatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of Indigenous identification in mortality data (ABS 2004). In the jurisdictions for which data are available, the neonatal death rates for Indigenous Australians are higher than those for non-Indigenous Australians (figure 10.35).

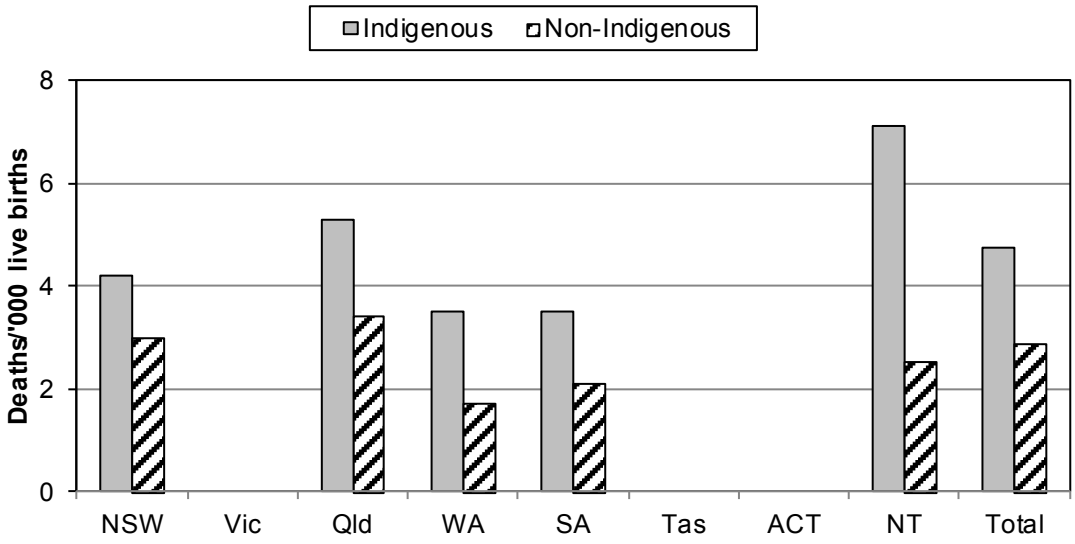
Figure 10.34 **Neonatal death rate**[a]



[a] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of neonatal deaths and small populations.

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.113.

Figure 10.35 **Neonatal death rate by Indigenous status of mother 2007–2011**[a]



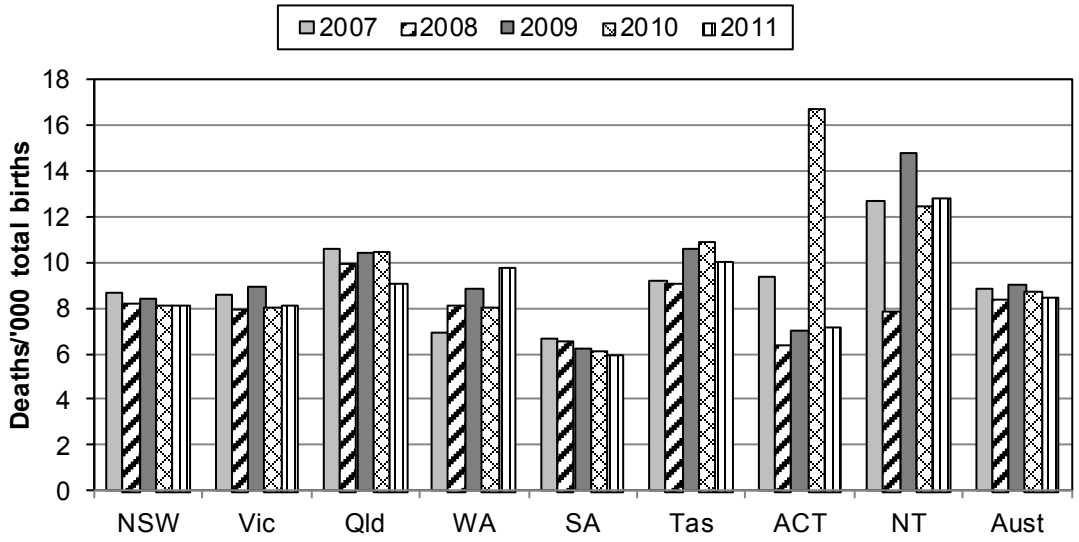
[a] Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.116.

Perinatal death rate

Perinatal death rates are shown in figure 10.36. National time series for perinatal death rates for the period 1999 to 2011 are included in table 10A.114.

Figure 10.36 **Perinatal death rate**[a, b]

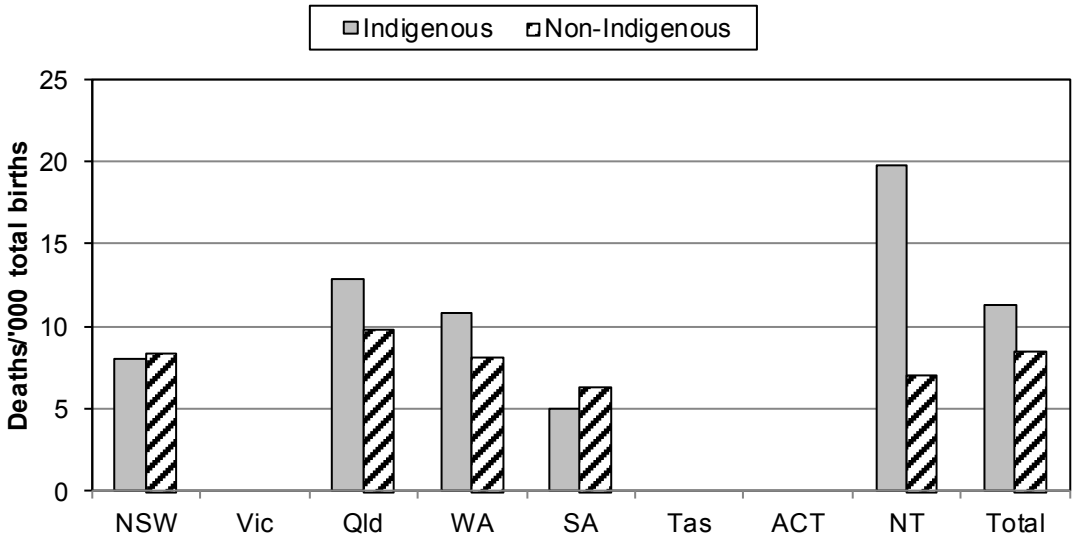


[a] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths. [b] The ACT and Australian total may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data were included in the 2010 reference year. The data therefore shows a decline in 2008 and an increase in 2010 which is not related to any actual significant change in fetal death rates.

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.115.

Perinatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of Indigenous identification in mortality data (ABS 2004). In three of the jurisdictions for which data are available, perinatal death rates for Indigenous Australians are higher than those for non-Indigenous Australians (figure 10.37).

Figure 10.37 **Perinatal death rate by Indigenous status of mother 2007–2011**[a]



[a] Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.116.

10.7 Future directions in performance reporting

Priorities for future reporting on public hospitals and maternity services include the following:

- Improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups, and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, two aspects of quality — responsiveness and continuity — and the efficiency subdimension of sustainability.
- Improving currently reported indicators for public hospitals and maternity services where data are not complete or not directly comparable. There is scope to improve reporting of the quality and access dimensions of the public hospitals framework, and the output indicators for maternity services.
- Improving the reporting of elective surgery waiting times by urgency category to achieve greater comparability across jurisdictions and improving timeliness of the data.

- Improving the reporting of quality and safety indicators in both the public hospitals' and maternity services' frameworks.
- Improving the quality of data on Indigenous Australians. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing.

10.8 Definitions of key terms

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can receive acute, subacute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 6.0x is based on the ICD-10-AM classification.
Australian Classification of Health Interventions (ACHI)	ACHI is the Australian classification of health interventions.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an incision into abdomen and uterus.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.

Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment can be radical and is frequently costly.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Cost of capital	The return foregone on the next best investment, estimated at a rate of 8 per cent of the depreciated replacement value of buildings, equipment and land. Also called the 'opportunity cost' of capital.
Cost per casemix adjusted separation	Recurrent expenditure multiplied by the inpatient fraction and divided by the total number of casemix-adjusted separations plus estimated private patient medical costs.
Cost per non-admitted occasion of service	Recurrent expenditure divided by the inpatient fraction and divided by the total number of non-admitted occasions of service.
Elective surgery waiting times	Elective surgery waiting times are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted for the awaited procedure. Days on which the patient was not ready for care are excluded.
Emergency department waiting time to commencement of clinical care	The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse.
Emergency department waiting times to admission	The time elapsed for each patient from presentation to the emergency department to admission to hospital.
Episiotomy	A surgical incision into the perineum and vagina that attempts to control trauma while widening the vaginal opening to expedite birth of the infant or provide better access for application of forceps or vacuum cup to the fetus.
Fetal death	Delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Excludes infants that weigh less than 400 grams or that are of a gestational age of less than 20 weeks.
Fetal death rate	The number of fetal deaths divided by the total number of births (that is, by live births registered and fetal deaths combined).
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 can include services for specific populations, such as women's health or Indigenous health.
ICD-10-AM	The Australian modification of the International Standard Classification of Diseases and Related Health Conditions. This is the current classification of diagnoses in Australia.
Hospital boarder	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Inpatient fraction	The ratio of admitted patient costs to total hospital costs, also known as the admitted patient cost proportion.
Labour cost per casemix-adjusted	Salary and wages plus visiting medical officer payments, multiplied by the inpatient fraction, divided by the number of casemix-adjusted

separation	separations.
Length of stay	The period from admission to separation less any days spent away from the hospital (leave days).
Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Newborn qualification status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is qualified if the infant meets at least one of the following criteria: • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient, • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care, • is admitted to, or remains in hospital without its mother. A newborn patient day is unqualified if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.
Nursing workforce	Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing.
Medical practitioner workforce	Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner.
Multiparous	A woman who has given birth from at least two pregnancies that each resulted in a live birth or stillbirth.
Non-acute care	Includes maintenance care and newborn care (where the newborn does not require acute care).
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded

	consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 2008).
Perineal status	The state of the perineum following a birth.
Primary care	Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.
Primipara	A woman who has given birth to a liveborn or stillborn infant for the first time.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge can be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The time in the woman's perinatal period between the birth and up to 42 days after the birth.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of patient days for acute care separations in selected AR–DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR DRGs which have a length of stay component in the definition, and error AR-DRGs.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, from acute to rehabilitation). Includes admitted patients who receive same day procedures (for example, renal dialysis).
Separation rate	Hospital separations per 1000 people or 100 000 people.

Selected primiparae	Primiparae with no previous deliveries, aged 25–29 years, singleton, vertex presentation and gestation of 37–41 weeks (inclusive).
Subacute care	Specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care.
Triage category	The urgency of the patient's need for medical and nursing care: category 1 — resuscitation (immediate within seconds) category 2 — emergency (within 10 minutes) category 3 — urgent (within 30 minutes) category 4 — semi-urgent (within 60 minutes) category 5 — non-urgent (within 120 minutes).
Urgency category for elective surgery	Category 1 patients — admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it can become an emergency. Category 2 patients — admission within 90 days is desirable for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

10.9 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). Attachment tables are available from the Review website (www.pc.gov.au/gsp).

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10A Public hospitals — attachment

Definitions for the indicators and descriptors in this attachment are in section 10.8 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).

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Table 10A.1 **Recurrent expenditure, public hospitals (including psychiatric hospitals), (2011-12 dollars, million) (a), (b)**

	NSW (c)	*Vic*	*Qld* (d)	*WA* (e)	*SA*	*Tas* (f)	*ACT*	*NT* (g)	*Aust*
2002-03									
Salary and wages	5 163	4 245	2 330	1 461	1 071	279	235	206	14 989
Non-salary	3 353	2 383	1 333	854	817	211	208	111	9 271
Total	**8 516**	**6 628**	**3 663**	**2 315**	**1 888**	**490**	**444**	**316**	**24 260**
2003-04									
Salary and wages	5 644	4 325	2 403	1 498	1 177	291	244	192	15 773
Non-salary	3 626	2 542	1 429	864	813	223	204	118	9 820
Total	**9 270**	**6 867**	**3 832**	**2 362**	**1 990**	**513**	**449**	**310**	**25 592**
2004-05									
Salary and wages	5 949	4 555	2 484	1 617	1 271	338	284	226	16 723
Non-salary	3 827	2 636	1 593	909	847	234	201	126	10 373
Total	**9 776**	**7 190**	**4 077**	**2 527**	**2 118**	**572**	**485**	**352**	**27 096**
2005-06									
Salary and wages	6 303	4 624	2 831	1 679	1 350	377	303	258	17 724
Non-salary	3 909	2 786	1 725	931	870	281	201	135	10 837
Total	**10 212**	**7 410**	**4 556**	**2 610**	**2 220**	**657**	**504**	**392**	**28 561**
2006-07									
Salary and wages	6 418	4 850	3 244	1 894	1 411	400	310	272	18 798
Non-salary	4 044	2 843	1 841	1 067	861	294	222	144	11 316
Total	**10 461**	**7 693**	**5 085**	**2 961**	**2 272**	**694**	**532**	**416**	**30 114**
2007-08									
Salary and wages	6 470	5 156	3 690	2 090	1 531	387	346	279	19 950
Non-salary	4 297	2 985	2 032	1 139	1 057	311	234	150	12 206
Total	**10 767**	**8 142**	**5 722**	**3 229**	**2 588**	**697**	**581**	**430**	**32 156**
2008-09									
Salary and wages	6 731	5 397	4 022	2 298	1 622	439	382	310	21 201
Non-salary	4 258	3 120	2 172	1 210	1 033	308	249	166	12 516
Total	**10 989**	**8 517**	**6 194**	**3 507**	**2 655**	**746**	**631**	**477**	**33 717**
2009-10									
Salary and wages	6 624	5 610	4 384	2 326	1 691	528	390	335	21 887
Non-salary	4 418	3 228	2 314	1 329	1 046	325	265	154	13 078
Total	**11 041**	**8 838**	**6 699**	**3 654**	**2 737**	**853**	**655**	**489**	**34 965**
2010-11									
Salary and wages	6 927	6 001	4 951	2 507	1 773	557	423	360	23 500
Non-salary	4 899	3 441	2 482	1 503	1 231	343	289	167	14 356
Total	**11 826**	**9 442**	**7 433**	**4 010**	**3 004**	**900**	**713**	**527**	**37 855**
2011-12									
Salary and wages	7 532	6 256	5 128	2 775	1 923	569	572	392	25 146
Non-salary	5 374	3 490	2 578	1 606	1 306	347	361	176	15 238
Total	**12 906**	**9 746**	**7 706**	**4 381**	**3 230**	**916**	**933**	**568**	**40 384**

(a) Expenditure data exclude depreciation.

(b) Recurrent expenditure on the purchase of public hospitals services at the State, or area health service-level, from privately owned and/or operated hospitals is excluded.

(c) NSW hospital expenditure recorded against special purposes and trust funds is excluded.

(d) Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees.

(e) In WA, expenditure on public patients at Joondalup and Peel Health Campuses is included from 2006-07 figures but not in those for previous years.

(f) For 2005-06 data for one hospital are not included.

(g) Interest payments for the NT were not reported

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2013), *Health expenditure Australia 2011–12*, Health and Welfare Expenditure Series No. 50, Cat. no. HWE 59. Canberra, AIHW.

Table 10A.2 **Recurrent expenditure, public hospital services, by source of funding, (2011-12 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (d)	*NT*	*Aust (e)*
2002-03										
Total expenditure										
Government	$'000	6 874 172	5 402 649	3 274 172	1 974 834	1 642 384	431 788	376 159	286 093	20 262 252
Non-government	$'000	762 914	651 656	140 397	117 881	62 252	56 954	34 437	18 543	1 845 033
Expenditure per person										
Government	$ per person	1 041.7	1 115.1	884.7	1 018.5	1 083.4	907.1	1 153.9	1 416.3	1 033.5
Non-government	$ per person	115.6	134.5	37.9	60.8	41.1	119.7	105.6	91.8	94.1
2003-04										
Total expenditure										
Government	$'000	7 368 286	5 982 097	3 608 696	2 090 793	1 675 192	419 437	402 813	297 954	21 845 269
Non-government	$'000	771 100	511 509	144 501	120 205	71 611	61 381	34 527	12 788	1 727 621
Expenditure per person										
Government	$ per person	1 110.5	1 220.8	952.4	1 063.5	1 098.5	872.0	1 228.1	1 475.0	1 101.8
Non-government	$ per person	116.2	104.4	38.1	61.1	47.0	127.6	105.3	63.3	87.1
2004-05										
Total expenditure										
Government	$'000	8 769 614	6 466 999	3 692 403	2 367 372	2 072 229	499 377	na	372 354	24 705 750
Non-government	$'000	946 451	679 950	89 664	236 613	69 738	32 379	na	6 227	2 099 626
Expenditure per person										
Government	$ per person	1 315.0	1 304.6	953.6	1 187.2	1 351.7	1 029.6	na	1 825.3	1 232.5
Non-government	$ per person	141.9	137.2	23.2	118.7	45.5	66.8	na	30.5	104.7
2005-06										
Total expenditure										
Government	$'000	9 611 905	6 391 667	4 630 952	2 504 762	2 167 857	541 667	469 048	390 476	26 760 714
Non-government	$'000	983 333	664 286	167 857	166 667	78 571	41 667	71 429	5 952	2 190 476
Expenditure per person										

Table 10A.2 **Recurrent expenditure, public hospital services, by source of funding, (2011-12 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (d)	*NT*	*Aust (e)*
Government	$ per person	1 430.8	1 272.5	1 168.3	1 233.9	1 403.1	1 110.0	1 404.3	1 886.4	1 317.5
Non-government	$ per person	146.4	132.2	42.3	82.1	50.9	85.4	213.9	28.8	107.8
2006-07										
Total expenditure										
Government	$'000	10 139 748	6 465 063	5 356 243	2 754 868	2 344 788	641 466	560 137	485 682	28 747 995
Non-government	$'000	844 215	718 213	199 313	163 803	91 638	44 674	68 729	9 164	2 138 603
Expenditure per person										
Government	$ per person	1 494.2	1 266.7	1 320.6	1 326.4	1 502.1	1 303.8	1 657.2	2 301.8	1 393.6
Non-government	$ per person	124.4	140.7	49.1	78.9	58.7	90.8	203.3	43.4	103.7
2007-08										
Total expenditure										
Government	$'000	10 620 690	7 286 986	6 193 548	3 111 235	2 672 970	741 935	659 622	525 028	31 812 013
Non-government	$'000	989 989	704 116	303 671	181 313	151 279	51 168	71 190	15 573	2 468 298
Expenditure per person										
Government	$ per person	1 542.8	1 401.3	1 488.8	1 457.3	1 693.9	1 495.8	1 917.5	2 419.5	1 513.7
Non-government	$ per person	143.8	135.4	73.0	84.9	95.9	103.2	206.9	71.8	117.4
2008-09										
Total expenditure										
Government	$'000	10 938 525	7 489 435	6 589 209	3 368 571	2 743 432	763 781	730 174	504 278	33 127 404
Non-government	$'000	1 111 216	877 598	380 394	243 364	140 298	64 870	16 957	14 614	2 849 311
Expenditure per person										
Government	$ per person	1 562.2	1 409.6	1 541.0	1 524.9	1 716.8	1 521.5	2 080.3	2 261.3	1 542.5
Non-government	$ per person	158.7	165.2	89.0	110.2	87.8	129.2	48.3	65.5	132.7
2009-10										
Total expenditure										
Government	$'000	11 315 353	8 117 220	6 939 834	3 353 734	2 852 697	795 643	769 710	503 112	34 647 303

Table 10A.2 **Recurrent expenditure, public hospital services, by source of funding, (2011-12 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (d)	*NT*	*Aust (e)*
Non-government	$'000	1 176 349	872 407	460 581	220 954	159 751	24 896	16 598	13 485	2 943 983
Expenditure per person										
Government	$ per person	1 593.3	1 497.9	1 589.2	1 481.3	1 762.0	1 572.4	2 150.0	2 206.6	1 584.5
Non-government	$ per person	165.6	161.0	105.5	97.6	98.7	49.2	46.4	59.1	134.6
2010-11										
Total expenditure										
Government	$'000	11 677 584	8 988 741	6 932 446	3 632 549	2 967 247	879 222	832 139	589 560	36 499 488
Non-government	$'000	1 249 744	985 670	600 819	288 639	163 767	33 777	19 447	12 282	3 354 145
Expenditure per person										
Government	$ per person	1 626.4	1 635.5	1 562.4	1 566.4	1 818.2	1 724.0	2 279.8	2 563.3	1 646.2
Non-government	$ per person	174.1	179.3	135.4	124.5	100.3	66.2	53.3	53.4	151.3
2011-12										
Total expenditure										
Government	$'000	12 164 000	9 097 000	7 295 000	4 175 000	3 332 000	873 000	891 000	655 000	38 482 000
Non-government	$'000	1 324 000	1 078 000	787 000	110 000	180 000	41 000	23 000	9 000	3 552 000
Expenditure per person										
Government	$ per person	1 675.9	1 630.3	1 614.7	1 746.9	2 023.1	1 705.1	2 401.6	2 811.2	1 709.4
Non-government	$ per person	182.4	193.2	174.2	46.0	109.3	80.1	62.0	38.6	157.8

(a) Depreciation is included in recurrent expenditure.

(b) Non-government expenditure includes expenditure by health insurance funds, individuals, workers' compensation and compulsory third-party motor vehicle insurers as well as other sources.

(c) Up to 2002–03, patient transport, dental, community health and public health services that were delivered in public hospitals were included as expenditure on public hospitals. From 2003–04, they are included under their own classifications and are not included in expenditure on public hospital services. Care must be taken when comparing 2002–03 with 2003–04 (see AIHW (2013), *Health expenditure Australia 2011–12,* Health and Welfare Expenditure Series No. 50, Cat. no. HWE 59. Canberra, AIHW 'Chapter 5 Technical notes' for further information).

(d) The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

(e) Components may not add to totals due to rounding.

Table 10A.2 **Recurrent expenditure, public hospital services, by source of funding, (2011-12 dollars) (a), (b), (c)**

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

na Not available.

Source: AIHW various years, Health Expenditure Australia, Health and Welfare Expenditure Series, AIHW, Canberra.

Table 10A.3 **Recurrent expenditure per person, public hospitals (including psychiatric) (2011-12 dollars) (a), (b)**

	NSW	*Vic*	*Qld* (c)	*WA* (d)	*SA*	*Tas* (e)	*ACT* (f)	*NT*	*Aust*
2002-03	1 290.3	1 367.9	989.7	1 184.1	1 245.4	1 029.8	1 360.5	1 566.0	1 236.4
2003-04	1 396.5	1 401.5	1 011.2	1 192.9	1 303.1	1 067.5	1 367.4	1 535.5	1 289.6
2004-05	1 465.3	1 450.5	1 052.9	1 259.4	1 380.3	1 179.2	1 473.1	1 723.9	1 350.6
2005-06	1 519.0	1 475.2	1 149.4	1 278.9	1 435.4	1 347.3	1 508.0	1 894.4	1 405.0
2006-07	1 540.5	1 507.3	1 253.6	1 420.4	1 454.2	1 410.9	1 572.4	1 973.2	1 458.9
2007-08	1 550.1	1 565.7	1 375.5	1 508.7	1 639.9	1 406.2	1 687.7	1 981.2	1 524.9
2008-09	1 568.2	1 603.0	1 448.7	1 582.6	1 661.7	1 486.3	1 797.1	2 137.3	1 569.0
2009-10	1 553.5	1 631.0	1 533.9	1 611.8	1 690.3	1 685.2	1 827.9	2 143.7	1 598.4
2010-11	1 646.2	1 718.0	1 675.2	1 727.5	1 837.7	1 765.3	1 952.9	2 291.7	1 706.7
2011-12	1 772.4	1 746.7	1 705.6	1 831.8	1 958.1	1 788.2	2 514.3	2 435.7	1 791.7

(a) Expenditure data exclude depreciation and interest payments.

(b) Recurrent expenditure on the purchase of public hospitals services at the State, or area health service-level, from privately owned and/or operated hospitals is not included.

(c) Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees.

(d) In WA, recurrent expenditure per person from 2006-07 includes expenditure on public patients at Joondalup and Peel Health Campuses. Expenditure for these patients is not included in previous years.

(e) In Tasmania, for 2005-06, data for one hospital are not included.

(f) The expenditure numbers for the ACT include substantial expenditures for NSW residents, and so the ACT expenditure is overstated.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2013), *Health expenditure Australia 2011–12*, Health and Welfare Expenditure Series No. 50, Cat. no. HWE 59. Canberra, AIHW.

Table 10A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08									
No. of hospitals									
10 or fewer beds	23	42	79	40	7	17	1	–	209
more than 10 to 50 beds	126	48	63	33	58	7	–	2	337
more than 50 to 100 beds	29	21	11	5	6	–	–	1	73
more than 100 to 200 beds	23	19	10	8	2	1	–	1	64
more than 200 to 500 beds	20	14	9	6	5	1	1	1	57
more than 500 beds	7	4	5	2	2	1	1	–	22
Total	**228**	**148**	**177**	**94**	**80**	**27**	**3**	**5**	**762**
Proportion of total hospitals (%)									
10 or fewer beds	10.1	28.4	44.6	42.6	8.8	63.0	33.3	0.0	27.4
more than 10 to 50 beds	55.3	32.4	35.6	35.1	72.5	25.9	0.0	40.0	44.2
more than 50 to 100 beds	12.7	14.2	6.2	5.3	7.5	0.0	0.0	20.0	9.6
more than 100 beds	21.9	25.0	13.6	17.0	11.3	11.1	66.7	40.0	18.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of available beds									
10 or fewer beds	94	217	283	267	45	104	10	..	1 020
more than 10 to 50 beds	3 335	1 194	1 444	787	1 543	164	..	50	8 517
more than 50 to 100 beds	2 170	1 544	726	338	468	..	..	60	5 306
more than 100 to 200 beds	3 614	2 843	1 612	1 147	329	134	..	171	9 850
more than 200 to 500 beds	6 168	4 407	2 612	1 632	1 380	266	222	335	17 023
more than 500 beds	4 625	2 477	3 974	1 234	1 216	607	619	..	14 752
Total	**20 006**	**12 682**	**10 651**	**5 405**	**4 981**	**1 275**	**851**	**616**	**56 467**
Proportion of total beds (%)									
10 or fewer beds	0.5	1.7	2.7	4.9	0.9	8.2	1.2	..	1.8
more than 10 to 50 beds	16.7	9.4	13.6	14.6	31.0	12.9	..	8.1	15.1
more than 50 to 100 beds	10.8	12.2	6.8	6.3	9.4	..	..	9.7	9.4
more than 100 beds	72.0	76.7	77.0	74.2	58.7	79.0	98.8	82.1	73.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2008-09									
No. of hospitals									
10 or fewer beds	27	41	72	42	7	18	1	–	208
more than 10 to 50 beds	122	46	64	31	58	7	–	2	330
more than 50 to 100 beds	28	24	10	5	6	–	–	1	74
more than 100 to 200 beds	23	19	10	9	2	1	–	1	65
more than 200 to 500 beds	19	15	9	5	5	1	1	1	56
more than 500 beds	8	4	5	2	2	1	1	–	23
Total	**227**	**149**	**170**	**94**	**80**	**28**	**3**	**5**	**756**
Proportion of total hospitals (%)									
10 or fewer beds	11.9	27.5	42.4	44.7	8.8	64.3	33.3	0.0	27.5

Table 10A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
more than 10 to 50 beds	53.7	30.9	37.6	33.0	72.5	25.0	0.0	40.0	43.7
more than 50 to 100 beds	12.3	16.1	5.9	5.3	7.5	0.0	0.0	20.0	9.8
more than 100 beds	22.0	25.5	14.1	17.0	11.3	10.7	66.7	40.0	19.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of available beds									
10 or fewer beds	99	197	270	235	41	99	10	..	951
more than 10 to 50 beds	3 186	1 071	1 466	738	1 468	150	..	40	8 119
more than 50 to 100 beds	2 023	1 724	690	330	460	..	..	60	5 288
more than 100 to 200 beds	3 464	2 795	1 634	1 345	316	130	..	171	9 855
more than 200 to 500 beds	5 752	4 727	2 688	1 435	1 387	330	223	335	16 876
more than 500 beds	5 281	2 354	4 057	1 286	1 201	566	642	..	15 388
Total	**19 805**	**12 869**	**10 805**	**5 369**	**4 874**	**1 275**	**875**	**606**	**56 478**
Proportion of total beds (%)									
10 or fewer beds	0.5	1.5	2.5	4.4	0.8	7.8	1.1	..	1.7
more than 10 to 50 beds	16.1	8.3	13.6	13.7	30.1	11.8	..	6.6	14.4
more than 50 to 100 beds	10.2	13.4	6.4	6.1	9.4	..	..	9.9	9.4
more than 100 beds	73.2	76.7	77.5	75.7	59.6	80.5	98.9	83.5	74.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2009-10									
No. of hospitals									
10 or fewer beds	31	41	74	44	10	14	1	–	215
more than 10 to 50 beds	119	48	62	31	55	5	–	2	322
more than 50 to 100 beds	27	22	10	4	6	2	–	1	72
more than 100 to 200 beds	23	18	10	9	2	1	–	1	64
more than 200 to 500 beds	18	17	9	5	5	1	1	1	57
more than 500 beds	8	4	5	2	2	1	1	–	23
Total	**226**	**150**	**170**	**95**	**80**	**24**	**3**	**5**	**753**
Proportion of total hospitals (%)									
10 or fewer beds	13.7	27.3	43.5	46.3	12.5	58.3	33.3	0.0	28.6
more than 10 to 50 beds	52.7	32.0	36.5	32.6	68.8	20.8	0.0	40.0	42.8
more than 50 to 100 beds	11.9	14.7	5.9	4.2	7.5	8.3	0.0	20.0	9.6
more than 100 beds	21.7	26.0	14.1	16.8	11.3	12.5	66.7	40.0	19.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of available beds									
10 or fewer beds	130	225	241	245	74	76	10	..	1 001
more than 10 to 50 beds	3 128	1 204	1 415	751	1 378	81	..	52	8 009
more than 50 to 100 beds	1 976	1 613	709	307	462	166	..	60	5 293
more than 100 to 200 beds	3 475	2 562	1 659	1 342	309	130	..	189	9 667
more than 200 to 500 beds	5 612	5 206	2 779	1 432	1 422	330	227	393	17 400
more than 500 beds	5 287	2 376	4 108	1 299	1 214	576	670	..	15 530

Table 10A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	**19 608**	**13 186**	**10 911**	**5 376**	**4 859**	**1 359**	**907**	**694**	**56 900**
Proportion of total beds (%)									
10 or fewer beds	0.7	1.7	2.2	4.6	1.5	5.6	1.1	..	1.8
more than 10 to 50 beds	16.0	9.1	13.0	14.0	28.4	6.0	..	7.5	14.1
more than 50 to 100 beds	10.1	12.2	6.5	5.7	9.5	12.2	..	8.6	9.3
more than 100 beds	73.3	76.9	78.3	75.8	60.6	76.2	98.9	83.9	74.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2010-11									
No. of hospitals									
10 or fewer beds	29	40	74	43	11	14	1	–	212
more than 10 to 50 beds	118	50	62	31	54	5	–	2	322
more than 50 to 100 beds	30	22	10	3	6	1	–	1	73
more than 100 to 200 beds	22	19	9	10	3	1	–	1	65
more than 200 to 500 beds	18	16	10	5	4	1	1	1	56
more than 500 beds	9	4	5	2	2	1	1	–	24
Total	**226**	**151**	**170**	**94**	**80**	**23**	**3**	**5**	**752**
Proportion of total hospitals (%)									
10 or fewer beds	12.8	26.5	43.5	45.7	13.8	60.9	33.3	–	28.2
more than 10 to 50 beds	52.2	33.1	36.5	33.0	67.5	21.7	–	40.0	42.8
more than 50 to 100 beds	13.3	14.6	5.9	3.2	7.5	4.3	–	20.0	9.7
more than 100 beds	21.7	25.8	14.1	18.1	11.3	13.0	66.7	40.0	19.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of available beds									
10 or fewer beds	122	209	224	239	51	76	10	–	930
more than 10 to 50 beds	3 026	1 220	1 394	761	1 328	81	–	52	7 862
more than 50 to 100 beds	2 146	1 596	697	226	452	87	–	60	5 263
more than 100 to 200 beds	3 278	2 839	1 505	1 496	519	116	–	183	9 936
more than 200 to 500 beds	5 473	5 065	3 111	1 469	1 262	333	223	367	17 303
more than 500 beds	5 887	2 480	4 186	1 302	1 428	503	693	–	16 478
Total	**19 931**	**13 408**	**11 117**	**5 492**	**5 040**	**1 196**	**926**	**662**	**57 772**
Proportion of total beds (%)									
10 or fewer beds	0.6	1.6	2.0	4.4	1.0	6.4	1.1	0.0	1.6
more than 10 to 50 beds	15.2	9.1	12.5	13.9	26.3	6.8	0.0	7.9	13.6
more than 50 to 100 beds	10.8	11.9	6.3	4.1	9.0	7.3	0.0	9.1	9.1
more than 100 beds	73.4	77.4	79.2	77.7	63.7	79.6	98.9	83.1	75.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2011-12									
No. of hospitals									
10 or fewer beds	32	40	74	44	12	14	1	–	217
more than 10 to 50 beds	116	50	62	32	51	5	–	2	318

Table 10A.4 **Public hospitals (including psychiatric hospitals) by hospital size (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
more than 50 to 100 beds	27	21	10	3	8	1	–	1	71
more than 100 to 200 beds	22	20	8	10	3	1	–	1	65
more than 200 to 500 beds	19	16	10	5	4	1	1	1	57
more than 500 beds	9	4	6	2	2	1	1	–	25
Total	**225**	**151**	**170**	**96**	**80**	**23**	**3**	**5**	**753**
Proportion of total hospitals (%)									
10 or fewer beds	14.2	26.5	43.5	45.8	15.0	60.9	33.3	–	28.8
more than 10 to 50 beds	51.6	33.1	36.5	33.3	63.8	21.7	–	40.0	42.2
more than 50 to 100 beds	12.0	13.9	5.9	3.1	10.0	4.3	–	20.0	9.4
more than 100 beds	22.2	26.5	14.1	17.7	11.3	13.0	66.7	40.0	19.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of available beds									
10 or fewer beds	125	192	223	243	89	76	10	–	958
more than 10 to 50 beds	2 970	1 192	1 415	785	1 279	81	–	54	7 776
more than 50 to 100 beds	1 915	1 480	720	227	639	89	–	60	5 130
more than 100 to 200 beds	3 198	2 840	1 300	1 579	482	115	–	195	9 709
more than 200 to 500 beds	5 868	5 126	2 853	1 521	1 280	324	225	387	17 584
more than 500 beds	5 996	2 540	4 734	1 321	1 464	503	704	–	17 261
Total	**20 073**	**13 370**	**11 245**	**5 677**	**5 232**	**1 188**	**939**	**696**	**58 420**
Proportion of total beds (%)									
10 or fewer beds	0.6	1.4	2.0	4.3	1.7	6.4	1.1	–	1.6
more than 10 to 50 beds	14.8	8.9	12.6	13.8	24.4	6.8	–	7.8	13.3
more than 50 to 100 beds	9.5	11.1	6.4	4.0	12.2	7.5	–	8.6	8.8
more than 100 beds	75.0	78.6	79.0	77.9	61.7	79.3	98.9	83.6	76.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses.

(b) Size is based on the average number of available beds.

(c) The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services.

(d) A change in definition of average available beds may affect comparison over time.

(e) The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database.

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

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.5 **Available beds per 1000 people, by region, public hospitals (including psychiatric) (number) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA* (d)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2002-03									
Metropolitan	2.6	2.3	2.4	2.4	2.7	..	2.1	..	2.5
Rural	3.0	2.8	2.6	2.6	3.9	2.4	..	2.7	2.8
Remote	5.4	0.3	6.3	4.3	7.9	3.1	..	3.0	5.1
Total	**2.7**	**2.5**	**2.7**	**2.6**	**3.2**	**2.4**	**2.1**	**2.9**	**2.7**
2003-04									
Major cities	2.7	2.3	2.4	2.4	2.7	..	2.1	..	2.5
Regional	3.4	2.7	2.5	2.5	3.7	2.4	..	2.7	2.9
Remote	6.7	2.4	6.3	4.5	7.8	2.6	..	3.0	5.3
Total	**2.9**	**2.4**	**2.6**	**2.5**	**3.2**	**2.4**	**2.1**	**2.9**	**2.7**
2004-05									
Major cities	2.9	2.3	2.4	2.5	2.9	..	2.1	..	2.6
Regional	3.6	2.7	2.5	2.5	3.7	2.7	–	2.7	3.0
Remote	7.3	2.4	6.3	4.5	7.7	2.6	..	3.0	5.3
Total	**3.1**	**2.4**	**2.6**	**2.6**	**3.3**	**2.7**	**2.1**	**2.9**	**2.8**
2005-06									
Major cities	2.7	2.4	2.4	2.4	2.8	..	2.2	..	2.5
Regional	3.3	2.6	2.5	2.4	3.6	2.7	–	2.7	2.8
Remote	6.5	2.4	5.7	3.9	7.6	2.5	..	2.9	4.9
Total	**2.9**	**2.4**	**2.5**	**2.5**	**3.2**	**2.7**	**2.2**	**2.8**	**2.7**
2006-07									
Major cities	2.7	2.3	2.1	2.5	2.7	..	2.4	..	2.5
Regional	3.4	2.7	2.9	2.9	3.6	2.8	–	2.8	3.0
Remote	7.5	2.1	5.6	3.8	7.8	3.0	..	2.9	4.9
Total	**2.9**	**2.4**	**2.5**	**2.7**	**3.1**	**2.8**	**2.3**	**2.8**	**2.7**
2007-08									
Metropolitan	2.7	2.4	2.3	2.6	2.8	..	2.6	..	2.5
Rural	3.4	2.7	2.9	2.5	3.7	2.6	–	2.9	3.0
Remote	7.7	2.9	4.9	3.2	7.7	3.0	..	2.9	4.5
Total	**2.9**	**2.5**	**2.6**	**2.6**	**3.2**	**2.6**	**2.5**	**2.9**	**2.7**
2008-09									
Major cities	2.6	2.3	2.2	2.5	2.7	..	2.5	..	2.5
Regional	3.3	2.7	2.8	2.3	3.4	2.6	..	2.8	2.9
Remote	6.9	3.0	4.9	2.9	7.3	2.1	..	2.8	4.3
Total	**2.8**	**2.4**	**2.5**	**2.5**	**3.0**	**2.6**	**2.5**	**2.8**	**2.6**
2009-10									
Major cities	2.6	2.3	2.3	2.4	2.7	..	2.6	..	2.5
Regional	3.1	2.7	2.6	2.2	3.3	2.7	..	3.1	2.8
Remote	5.7	3.0	4.4	2.9	7.0	2.1	..	3.0	4.0
Total	**2.7**	**2.4**	**2.5**	**2.4**	**3.0**	**2.7**	**2.6**	**3.1**	**2.6**

Table 10A.5 **Available beds per 1000 people, by region, public hospitals (including psychiatric) (number) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA* (d)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11									
Major cities	2.6	2.3	2.3	2.4	2.8	..	2.6	..	2.5
Regional	3.1	2.7	2.6	2.2	3.3	2.4	..	2.9	2.8
Remote	5.6	3.0	4.2	2.8	6.7	2.1	..	2.9	3.9
Total	**2.8**	**2.4**	**2.5**	**2.4**	**3.1**	**2.4**	**2.6**	**2.9**	**2.6**
2011-12									
Major cities	2.7	2.3	2.3	2.5	2.9	..	2.6	..	2.5
Regional	3.1	2.7	2.8	2.2	3.6	2.3	..	3.0	2.8
Remote	5.3	2.5	4.1	2.6	6.6	2.2	..	3.1	3.7
Total	**2.8**	**2.4**	**2.5**	**2.4**	**3.2**	**2.3**	**2.6**	**3.0**	**2.6**

(a) Population calculated based on a crude rate. Data need to be viewed in the context of the age and sex structure and morbidity and mortality of the population in each jurisdiction. The age and sex structure of the population in each jurisdiction is provided in the 'Statistical appendix' and mortality rates in the 'Health sector summary'.

(b) An ‘available bed’ is one that is immediately available for exclusive or predominate use by admitted patients. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekends only) are also excluded (National Health Data Dictionary, Version 14).

(c) The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services.

(d) In WA, beds available for public patients at Joondalup and Peel Health Campuses are included from 2006-07 figures but not in those for previous years.

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

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.6 **Summary of separations, public hospitals (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT (b)*	*NT*	*Aust*
2007-08										
Separations										
Public hospitals	no.	1 466 737	1 351 172	831 965	458 202	368 330	96 270	81 127	90 258	4 744 061
Public acute hospitals	no.	1 457 131	1 350 768	831 548	456 639	366 224	95 616	81 127	90 258	4 729 311
Public psychiatric hospitals	no.	9 606	404	417	1 563	2 106	654	..	..	14 750
Overnight separations										
Public hospitals	no.	827 520	584 094	424 194	222 762	204 515	45 758	37 341	34 276	2 380 460
Public acute hospitals	no.	819 222	583 691	423 779	221 333	202 762	45 113	37 341	34 276	2 367 517
Public psychiatric hospitals	no.	8 298	403	415	1 429	1 753	645	..	..	12 943
Same day separations										
Public hospitals	no.	639 217	767 078	407 771	235 440	163 815	50 512	43 786	55 982	2 363 601
Public acute hospitals	no.	637 909	767 077	407 769	235 306	163 462	50 503	43 786	55 982	2 361 794
Public psychiatric hospitals	no.	1 308	1	2	134	353	9	..	..	1 807
Same day separations (per cent of total)										
Public hospitals	%	43.6	56.8	49.0	51.4	44.5	52.5	54.0	62.0	49.8
Public acute hospitals	%	43.8	56.8	49.0	51.5	44.6	52.8	54.0	62.0	49.9
Public psychiatric hospitals	%	13.6	0.2	0.5	8.6	16.8	1.4	..	..	12.3
Separations per 1000 population (c)										
Public hospitals	no.	202.8	247.8	195.7	215.1	216.4	184.0	256.1	486.4	217.6
Public acute hospitals	no.	201.4	247.7	195.6	214.3	215.1	182.7	256.1	486.4	216.9
Public psychiatric hospitals	no.	1.4	0.1	0.1	0.7	1.3	1.3	..	..	0.7
2008-09										
Separations										
Public hospitals	no.	1 505 969	1 379 624	883 340	467 433	374 540	94 892	89 869	95 356	4 891 023
Public acute hospitals	no.	1 500 020	1 379 132	882 933	465 971	372 401	94 226	89 869	95 356	4 879 908
Public psychiatric hospitals	no.	5 949	492	407	1 462	2 139	666	..	..	11 115

Table 10A.6 **Summary of separations, public hospitals (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT (b)*	*NT*	*Aust*
Overnight separations										
Public hospitals	no.	844 105	590 087	440 246	227 217	206 420	45 360	41 176	35 533	2 430 144
Public acute hospitals	no.	838 343	589 596	439 839	225 833	204 644	44 700	41 176	35 533	2 419 664
Public psychiatric hospitals	no.	5 762	491	407	1 384	1 776	660	..	..	10 480
Same day separations										
Public hospitals	no.	661 864	789 537	443 094	240 216	168 120	49 532	48 693	59 823	2 460 879
Public acute hospitals	no.	661 677	789 536	443 094	240 138	167 757	49 526	48 693	59 823	2 460 244
Public psychiatric hospitals	no.	187	1	–	78	363	6	..	..	635
Same day separations (per cent of total)										
Public hospitals	%	43.9	57.2	50.2	51.4	44.9	52.2	54.2	62.7	50.3
Public acute hospitals	%	44.1	57.2	50.2	51.5	45.0	52.6	54.2	62.7	50.4
Public psychiatric hospitals	%	3.1	0.2	0.0	5.3	17.0	0.9	..	..	5.7
Separations per 1000 population (c)										
Public hospitals	no.	204.2	247.3	202.1	212.6	216.3	179.0	275.4	487.9	219.3
Public acute hospitals	no.	203.4	247.2	202.0	212.0	215.1	177.7	275.4	487.9	218.8
Public psychiatric hospitals	no.	0.9	0.1	0.1	0.7	1.3	1.3	..	..	0.5
2009-10										
Separations										
Public hospitals	no.	1 542 968	1 424 663	922 970	505 909	383 055	101 673	88 356	99 694	5 069 288
Public acute hospitals	no.	1 536 690	1 424 134	922 581	504 381	381 202	101 038	88 356	99 694	5 058 076
Public psychiatric hospitals	no.	6 278	529	389	1 528	1 853	635	..	..	11 212
Overnight separations										
Public hospitals	no.	852 671	615 183	453 538	236 231	209 695	50 445	40 729	36 737	2 495 229
Public acute hospitals	no.	846 630	614 655	453 155	234 792	208 195	49 826	40 729	36 737	2 484 719
Public psychiatric hospitals	no.	6 041	528	383	1 439	1 500	619	..	..	10 510
Same day separations										

Table 10A.6 **Summary of separations, public hospitals (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT (b)*	*NT*	*Aust*
Public hospitals	no.	690 297	809 480	469 432	269 678	173 360	51 228	47 627	62 957	2 574 059
Public acute hospitals	no.	690 060	809 479	469 426	269 589	173 007	51 212	47 627	62 957	2 573 357
Public psychiatric hospitals	no.	237	1	6	89	353	16	..	..	702
Same day separations (per cent of total)										
Public hospitals	%	44.7	56.8	50.9	53.3	45.3	50.4	53.9	63.2	50.8
Public acute hospitals	%	44.9	56.8	50.9	53.4	45.4	50.7	53.9	63.2	50.9
Public psychiatric hospitals	%	3.8	0.2	1.5	5.8	19.1	2.5	..	..	6.3
Separations per 1000 population (c)										
Public hospitals	no.	204.3	248.8	204.8	222.8	217.3	188.0	263.6	486.8	221.4
Public acute hospitals	no.	203.4	248.7	204.7	222.1	216.2	186.7	263.6	486.8	220.9
Public psychiatric hospitals	no.	0.9	0.1	0.1	0.7	1.1	1.2	..	..	0.5
2010-11										
Separations										
Public hospitals	no.	1 582 804	1 496 041	964 349	548 272	390 154	99 333	93 745	104 434	5 279 132
Public acute hospitals	no.	1 576 866	1 495 555	964 025	546 785	388 483	99 118	93 745	104 434	5 269 011
Public psychiatric hospitals	no.	5 938	486	324	1 487	1 671	215	..	..	10 121
Overnight separations										
Public hospitals	no.	875 005	645 995	472 812	255 849	212 421	49 703	43 849	38 350	2 593 984
Public acute hospitals	no.	869 273	645 515	472 492	254 433	211 101	49 496	43 849	38 350	2 584 509
Public psychiatric hospitals	no.	5 732	480	320	1 416	1 320	207	..	..	9 475
Same day separations										
Public hospitals	no.	707 799	850 046	491 537	292 423	177 733	49 630	49 896	66 084	2 685 148
Public acute hospitals	no.	707 593	850 040	491 533	292 352	177 382	49 622	49 896	66 084	2 684 502
Public psychiatric hospitals	no.	206	6	4	71	351	8	..	..	646
Same day separations (per cent of total)										
Public hospitals	%	44.7	56.8	51.0	53.3	45.6	50.0	53.2	63.3	50.9

Table 10A.6 **Summary of separations, public hospitals (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT (b)	NT	Aust
Public acute hospitals	%	44.9	56.8	51.0	53.5	45.7	50.1	53.2	63.3	50.9
Public psychiatric hospitals	%	3.5	1.2	1.2	4.8	21.0	3.7	..	..	6.4
Separations per 1000 population (c)										
Public hospitals	no.	205.7	255.7	209.4	235.2	217.2	181.4	272.3	504.5	225.9
Public acute hospitals	no.	204.8	255.6	209.3	234.6	216.2	180.9	272.3	504.5	225.5
Public psychiatric hospitals	no.	0.8	0.1	0.1	0.6	1.0	0.5	0.0	0.0	0.5
2011-12										
Separations										
Public hospitals	no.	1 660 602	1 543 773	1 001 215	588 143	407 315	99 632	97 455	113 357	5 511 492
Public acute hospitals	no.	1 655 276	1 543 310	1 000 832	586 745	405 462	99 276	97 455	113 357	5 501 713
Public psychiatric hospitals	no.	5 326	463	383	1 398	1 853	356	..	..	9 779
Overnight separations										
Public hospitals	no.	924 308	660 844	496 615	270 866	218 944	49 120	45 138	38 864	2 704 699
Public acute hospitals	no.	919 191	660 387	496 235	269 498	217 482	48 772	45 138	38 864	2 695 567
Public psychiatric hospitals	no.	5 117	457	380	1 368	1 462	348	–	–	9 132
Same day separations										
Public hospitals	no.	736 294	882 929	504 600	317 277	188 371	50 512	52 317	74 493	2 806 793
Public acute hospitals	no.	736 085	882 923	504 597	317 247	187 980	50 504	52 317	74 493	2 806 146
Public psychiatric hospitals	no.	209	6	3	30	391	8	..	..	647
Same day separations (per cent of total)										
Public hospitals	%	44.3	57.2	50.4	53.9	46.2	50.7	53.7	65.7	50.9
Public acute hospitals	%	44.5	57.2	50.4	54.1	46.4	50.9	53.7	65.7	51.0
Public psychiatric hospitals	%	3.9	1.3	0.8	2.1	21.1	2.2	..	..	6.6
Separations per 1000 population (c)										
Public hospitals	no.	216.1	264.9	220.3	248.8	227.6	179.9	278.8	544.7	236.4
Public acute hospitals	no.	215.3	264.8	220.2	248.2	226.5	179.2	278.8	544.7	236.0

Table 10A.6 **Summary of separations, public hospitals (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT (b)*	*NT*	*Aust*
Public psychiatric hospitals	no.	0.8	0.1	0.1	0.6	1.1	0.7	0.0	0.0	0.4

(a) Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded.

(b) Data on state of hospitalisation should be interpreted with caution because of cross-border flows of patients. This is particularly the case for the ACT. In 2009–10, about 23 per cent of separations for ACT hospitals were for patients who resided in NSW.

(c) Figures are directly age-standardised to the June 2001 Australian population.

.. Not applicable.

Source: AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.7 **Separations, public (non-psychiatric) hospitals (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (b)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total separations (no.)										
2002-03	'000	1 280	1 149	702	366	365	80	64	68	4 074
2003-04	'000	1 314	1 187	721	366	377	81	69	70	4 183
2004-05	'000	1 333	1 223	733	382	363	86	64	76	4 261
2005-06	'000	1 409	1 272	750	393	376	94	72	83	4 451
2006-07	'000	1 451	1 314	784	449	389	97	76	86	4 646
2007-08	'000	1 457	1 351	832	457	366	96	81	90	4 729
2008-09	'000	1 500	1 379	883	466	372	94	90	95	4 880
2009-10	'000	1 537	1 424	923	504	381	101	88	100	5 058
2010-11	'000	1 577	1 496	964	547	388	99	94	104	5 269
2011-12	'000	1 655	1 543	1 001	587	405	99	97	113	5 502
Overnight separations (no.)										
2002-03	'000	728	525	358	185	183	41	28	29	2 077
2003-04	'000	751	535	370	184	189	40	30	29	2 129
2004-05	'000	756	545	377	188	191	45	30	31	2 164
2005-06	'000	792	561	383	194	192	48	33	34	2 237
2006-07	'000	814	577	398	213	197	48	35	34	2 315
2007-08	'000	819	584	424	221	203	45	37	34	2 368
2008-09	'000	838	590	440	226	205	45	41	36	2 420
2009-10	'000	847	615	453	235	208	50	41	37	2 485
2010-11	'000	869	646	472	254	211	49	44	38	2 585
2011-12	'000	919	660	496	269	217	49	45	39	2 696
Same day separations (no.)										
2002-03	'000	552	624	343	181	182	39	36	39	1 997
2003-04	'000	562	652	351	181	187	40	39	41	2 054
2004-05	'000	577	678	356	193	172	42	34	45	2 097
2005-06	'000	617	711	367	200	184	46	39	50	2 214
2006-07	'000	637	737	386	236	192	49	41	52	2 331
2007-08	'000	638	767	408	235	163	51	44	56	2 362
2008-09	'000	662	790	443	240	168	50	49	60	2 460
2009-10	'000	690	809	469	270	173	51	48	63	2 573
2010-11	'000	708	850	492	292	177	50	50	66	2 685
2011-12	'000	736	883	505	317	188	51	52	74	2 806
Same day separations as a percentage of total separations (%)										
2002-03	%	43.1	54.3	48.9	49.4	49.9	49.1	56.7	56.9	49.0
2003-04	%	42.8	55.0	48.7	49.6	49.8	49.9	56.5	58.2	49.1
2004-05	%	43.3	55.4	48.6	50.6	47.4	48.3	53.1	59.2	49.2
2005-06	%	43.8	55.9	48.9	50.8	48.9	49.0	54.7	59.6	49.7
2006-07	%	43.9	56.1	49.2	52.6	49.4	50.5	54.4	60.6	50.2
2007-08	%	43.8	56.8	49.0	51.5	44.6	52.8	54.0	62.0	49.9
2008-09	%	44.1	57.2	50.2	51.5	45.0	52.6	54.2	62.7	50.4

Table 10A.7 **Separations, public (non-psychiatric) hospitals (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (b)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009-10	%	44.9	56.8	50.9	53.4	45.4	50.7	53.9	63.2	50.9
2010-11	%	44.9	56.8	51.0	53.5	45.7	50.1	53.2	63.3	50.9
2011-12	%	44.5	57.2	50.4	54.1	46.4	50.9	53.7	65.7	51.0
Total separations (rate per 1000) (c)										
2002-03	no.	188.6	231.2	189.3	194.4	229.2	163.9	219.7	422.5	204.8
2003-04	no.	191.1	235.0	189.2	190.2	234.2	162.4	235.6	428.9	206.8
2004-05	no.	191.6	238.2	187.9	194.4	224.0	172.2	214.4	456.2	207.3
2005-06	no.	199.8	243.7	187.9	195.7	228.4	185.8	238.4	483.0	212.8
2006-07	no.	204.4	246.6	190.1	217.7	231.5	187.5	244.8	480.1	218.0
2007-08	no.	201.4	247.7	195.6	214.3	215.1	182.7	256.1	486.4	216.9
2008-09	no.	203.4	247.2	202.0	212.0	215.1	177.7	275.4	487.9	218.8
2009-10	no.	203.4	248.7	204.7	222.1	216.2	186.7	263.6	486.8	220.9
2010-11	no.	204.8	255.6	209.3	234.6	216.2	180.9	272.3	504.5	225.5
2011-12	no.	215.3	264.8	220.2	248.2	226.5	179.2	278.8	544.7	236.0

(a) Excludes separations for which the care type was reported as ‘newborn with no qualified days’ and records for hospital boarders and posthumous organ procurement.

(b) In WA, separations for public patients at Joondalup and Peel Health Campuses are included from 2006-07 figures but not in those for previous years.

(c) Rates per 1000 people are directly age standardised to the Australian population at June 2001.

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.8 **Separations, public (non-psychiatric) hospitals (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08									
Total separations (no.)									
Medical (b)	1 075 744	935 574	609 430	303 039	265 814	69 367	60 730	75 748	3 395 446
Surgical (c)	289 603	256 652	153 636	92 101	84 261	17 573	15 695	10 591	920 112
Chemotherapy and radiotherapy (d)	2 989	69 312	23 261	22 417	67	2 724	579	1 340	122 689
Other (e)	88 795	89 230	45 221	39 082	16 082	5 952	4 123	2 579	291 064
Total	**1 457 131**	**1 350 768**	**831 548**	**456 639**	**366 224**	**95 616**	**81 127**	**90 258**	**4 729 311**
Overnight separations (no.)									
Medical (b)	610 722	416 390	311 986	157 430	146 984	32 417	25 465	26 637	1 728 031
Surgical (c)	184 869	148 401	100 736	58 060	49 357	11 316	10 811	6 745	570 295
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	23 600	18 870	11 057	5 833	6 419	1 364	1 065	894	69 102
Total	**819 191**	**583 661**	**423 779**	**221 323**	**202 760**	**45 097**	**37 341**	**34 276**	**2 367 428**
Same day separations (no.)									
Medical (b)	465 022	519 184	297 444	145 609	118 830	36 950	35 265	49 111	1 667 415
Surgical (c)	104 734	108 251	52 900	34 041	34 904	6 257	4 884	3 846	349 817
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	65 195	70 360	34 164	33 249	9 663	4 588	3 058	1 685	221 962
Total	**634 951**	**697 795**	**384 508**	**212 899**	**163 397**	**47 795**	**43 207**	**54 642**	**2 239 194**
Same day separations (% of total separations)									
Medical (b)	43.2	55.5	48.8	48.0	44.7	53.3	58.1	64.8	49.1
Surgical (c)	36.2	42.2	34.4	37.0	41.4	35.6	31.1	36.3	38.0

Table 10A.8 **Separations, public (non-psychiatric) hospitals (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Chemotherapy and radiotherapy (d)	..	..	..	..	..	..	..	..	..
Other (e)	73.4	78.9	75.5	85.1	60.1	77.1	74.2	65.3	76.3
Total	**43.6**	**51.7**	**46.2**	**46.6**	**44.6**	**50.0**	**53.3**	**60.5**	**47.3**
2008-09									
Total separations (no.)									
Medical (b)	1 114 220	941 849	650 276	303 707	269 050	67 615	67 949	81 164	3 495 830
Surgical (c)	292 302	267 369	158 618	96 761	87 099	18 641	16 582	10 947	948 319
Chemotherapy and radiotherapy (d)	2 975	73 029	25 039	23 597	68	1 703	985	332	127 728
Other (e)	90 523	96 885	49 000	41 906	16 184	6 267	4 353	2 913	308 031
Total	**1 500 020**	**1 379 132**	**882 933**	**465 971**	**372 401**	**94 226**	**89 869**	**95 356**	**4 879 908**
Overnight separations (no.)									
Medical (b)	625 263	417 652	323 042	160 155	146 209	31 261	28 569	27 193	1 759 344
Surgical (c)	188 074	153 753	105 047	59 576	51 484	11 987	11 511	7 067	588 499
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	24 976	18 162	11 750	6 094	6 950	1 451	1 092	1 271	71 746
Total	**838 313**	**589 567**	**439 839**	**225 825**	**204 643**	**44 699**	**41 172**	**35 531**	**2 419 589**
Same day separations (no.)									
Medical (b)	488 957	524 197	327 234	143 552	122 841	36 354	39 380	53 971	1 736 486
Surgical (c)	104 228	113 616	53 571	37 185	35 615	6 654	5 071	3 880	359 820
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	65 547	78 723	37 250	35 812	9 234	4 816	3 261	1 642	236 285
Total	**658 732**	**716 536**	**418 055**	**216 549**	**167 690**	**47 824**	**47 712**	**59 493**	**2 332 591**
Same day separations (% of total separations)									

Table 10A.8 **Separations, public (non-psychiatric) hospitals (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Medical (b)	43.9	55.7	50.3	47.3	45.7	53.8	58.0	66.5	49.7
Surgical (c)	35.7	42.5	33.8	38.4	40.9	35.7	30.6	35.4	37.9
Chemotherapy and radiotherapy (d)	..	..	..	..	..	..	..	..	..
Other (e)	72.4	81.3	76.0	85.5	57.1	76.8	74.9	56.4	76.7
Total	**43.9**	**52.0**	**47.3**	**46.5**	**45.0**	**50.8**	**53.1**	**62.4**	**47.8**
2009-10									
Total separations (no.)									
Medical (b)	1 148 104	966 954	679 688	336 424	278 661	69 129	66 350	85 690	3 631 000
Surgical (c)	294 260	276 242	163 807	98 150	86 804	21 693	16 768	11 295	969 019
Chemotherapy and radiotherapy (d)	3 056	78 910	29 121	25 609	80	1 546	869	296	139 487
Other (e)	91 270	102 028	49 965	44 198	15 657	8 670	4 369	2 413	318 570
Total	**1 536 690**	**1 424 134**	**922 581**	**504 381**	**381 202**	**101 038**	**88 356**	**99 694**	**5 058 076**
Overnight separations (no.)									
Medical (b)	631 054	434 916	332 471	167 675	150 506	34 859	27 865	28 263	1 807 609
Surgical (c)	190 038	160 840	108 579	60 625	50 770	13 338	11 746	7 368	603 304
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	25 501	18 887	12 105	6 488	6 919	1 616	1 116	1 104	73 736
Total	**846 593**	**614 643**	**453 155**	**234 788**	**208 195**	**49 813**	**40 727**	**36 735**	**2 484 649**
Same day separations (no.)									
Medical (b)	517 050	532 038	347 217	168 749	128 155	34 270	38 485	57 427	1 823 391
Surgical (c)	104 222	115 402	55 228	37 525	36 034	8 355	5 022	3 927	365 715
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	65 769	83 141	37 860	37 710	8 738	7 054	3 253	1 309	244 834

Table 10A.8 **Separations, public (non-psychiatric) hospitals (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	**687 041**	**730 581**	**440 305**	**243 984**	**172 927**	**49 679**	**46 760**	**62 663**	**2 433 940**
Same day separations (% of total separations)									
Medical (b)	45.0	55.0	51.1	50.2	46.0	49.6	58.0	67.0	50.2
Surgical (c)	35.4	41.8	33.7	38.2	41.5	38.5	29.9	34.8	37.7
Chemotherapy and radiotherapy (d)	..	..	..	..	..	..	..	..	..
Other (e)	72.1	81.5	75.8	85.3	55.8	81.4	74.5	54.2	76.9
Total	**44.7**	**51.3**	**47.7**	**48.4**	**45.4**	**49.2**	**52.9**	**62.9**	**48.1**
2010-11									
Total separations (no.)									
Medical (b)	1 172 721	1 024 494	711 461	367 113	283 517	66 200	69 676	89 360	3 784 542
Surgical (c)	302 063	280 610	169 395	104 667	89 010	21 492	18 078	11 886	997 201
Chemotherapy and radiotherapy (d)	3 463	80 043	30 289	27 237	92	1 701	953	564	144 342
Other (e)	98 619	110 408	52 880	47 768	15 864	9 725	5 038	2 624	342 926
Total	**1 576 866**	**1 495 555**	**964 025**	**546 785**	**388 483**	**99 118**	**93 745**	**104 434**	**5 269 011**
Overnight separations (no.)									
Medical (b)	648 161	461 437	346 968	182 427	151 823	34 024	29 902	29 409	1 884 151
Surgical (c)	194 776	165 036	112 384	64 887	52 347	13 666	12 732	7 832	623 660
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	26 295	19 004	13 140	7 098	6 931	1 790	1 212	1 105	76 575
Total	**869 232**	**645 477**	**472 492**	**254 412**	**211 101**	**49 480**	**43 846**	**38 346**	**2 584 386**
Same day separations (no.)									
Medical (b)	524 560	563 057	364 493	184 686	131 694	32 176	39 774	59 951	1 900 391
Surgical (c)	107 287	115 574	57 011	39 780	36 663	7 826	5 346	4 054	373 541

Table 10A.8 **Separations, public (non-psychiatric) hospitals (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	72 324	91 404	39 740	40 670	8 933	7 935	3 826	1 519	266 351
Total	**704 171**	**770 035**	**461 244**	**265 136**	**177 290**	**47 937**	**48 946**	**65 524**	**2 540 283**
Same day separations (% of total separations)									
Medical (b)	44.7	55.0	51.2	50.3	46.5	48.6	57.1	67.1	50.2
Surgical (c)	35.5	41.2	33.7	38.0	41.2	36.4	29.6	34.1	37.5
Chemotherapy and radiotherapy (d)	..	..	..	..	..	..	..	..	..
Other (e)	73.3	82.8	75.2	85.1	56.3	81.6	75.9	57.9	77.7
Total	**44.7**	**51.5**	**47.8**	**48.5**	**45.6**	**48.4**	**52.2**	**62.7**	**48.2**
2011-12									
Total separations (no.)									
Medical (b)	1 240 166	1 068 642	752 652	400 416	296 701	65 897	73 171	97 348	3 994 993
Surgical (c)	313 010	281 589	174 426	107 869	91 971	21 694	18 563	12 329	1 021 451
Chemotherapy and radiotherapy (d)	3 064	83 459	23 696	29 464	106	2 105	657	453	143 004
Other (e)	99 036	109 620	50 058	48 996	16 684	9 580	5 064	3 227	342 265
Total	**1 655 276**	**1 543 310**	**1 000 832**	**586 745**	**405 462**	**99 276**	**97 455**	**113 357**	**5 501 713**
Overnight separations (no.)									
Medical (b)	690 188	475 195	365 343	195 236	156 320	34 057	30 628	29 480	1 976 447
Surgical (c)	202 065	166 174	116 786	66 859	53 968	13 043	13 206	8 180	640 281
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	26 927	19 003	14 106	7 379	7 194	1 658	1 304	1 202	78 773
Total	**919 180**	**660 372**	**496 235**	**269 474**	**217 482**	**48 758**	**45 138**	**38 862**	**2 695 501**
Same day separations (no.)									

Table 10A.8 **Separations, public (non-psychiatric) hospitals (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Medical (b)	549 978	593 447	387 309	205 180	140 381	31 840	42 543	67 868	2 018 546
Surgical (c)	110 945	115 415	57 640	41 010	38 003	8 651	5 357	4 149	381 170
Chemotherapy and radiotherapy (d)	np	np	np	np	np	np	np	np	np
Other (e)	72 109	90 617	35 952	41 617	9 490	7 922	3 760	2 025	263 492
Total	**733 032**	**799 479**	**480 901**	**287 807**	**187 874**	**48 413**	**51 660**	**74 042**	**2 663 208**
Same day separations (% of total separations)									
Medical (b)	44.3	55.5	51.5	51.2	47.3	48.3	58.1	69.7	50.5
Surgical (c)	35.4	41.0	33.0	38.0	41.3	39.9	28.9	33.7	37.3
Chemotherapy and radiotherapy (d)	..	..	..	..	..	..	..	..	..
Other (e)	72.8	82.7	71.8	84.9	56.9	82.7	74.2	62.8	77.0
Total	**44.3**	**51.8**	**48.1**	**49.1**	**46.3**	**48.8**	**53.0**	**65.3**	**48.4**

(a) Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarder or Posthumous organ procurement have been excluded.

(b) Separations where the second character of the AR-DRG was equal to 6, 7 or 8.

(c) Separations where the second character of the AR-DRG was equal to 0, 1, 2 or 3.

(d) Separations where the first three characters of the AR-DRG was equal to R63 or R64.

(e) Separations where the second character of the AR-DRG was equal to 4.

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

Source: AIHW (unpublished), National Hospital Morbidity Database.

Table 10A.9 **Separations in public hospitals, by age group (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08										
Age group										
Under 1	'000	39.4	35.5	22.6	10.0	9.3	2.1	1.8	2.5	123.1
1 to 4	'000	46.7	33.6	27.4	13.5	12.5	1.9	1.8	2.7	140.3
5 to 14	'000	59.5	44.5	37.3	18.0	14.0	3.4	2.9	3.0	182.6
15 to 24	'000	104.6	90.9	77.9	36.6	29.2	8.0	5.9	7.3	360.4
25 to 34	'000	156.5	142.1	99.0	48.3	37.4	10.0	9.1	9.9	512.3
35 to 44	'000	144.2	145.5	90.8	51.2	39.2	10.3	9.4	15.3	505.9
45 to 54	'000	152.8	154.8	100.8	57.8	41.3	12.3	8.5	18.4	546.7
55 to 64	'000	186.3	195.8	119.3	66.7	47.1	15.3	12.2	18.5	661.1
65 to 74	'000	231.2	223.7	120.3	69.2	55.0	15.5	13.5	9.2	737.6
75 to 84	'000	246.7	212.7	101.3	63.8	59.3	12.3	12.1	3.0	711.3
85 and over	'000	99.0	72.0	35.1	23.1	23.9	5.2	3.9	0.5	262.7
Total	'000	1 466.7	1 351.2	832.0	458.2	368.3	96.3	81.1	90.3	4 744.1
Proportion of total separations										
Under 1	%	2.7	2.6	2.7	2.2	2.5	2.2	2.2	2.8	2.6
1 to 4	%	3.2	2.5	3.3	2.9	3.4	2.0	2.3	3.0	3.0
5 to 14	%	4.1	3.3	4.5	3.9	3.8	3.5	3.5	3.3	3.8
15 to 24	%	7.1	6.7	9.4	8.0	7.9	8.3	7.2	8.1	7.6
25 to 34	%	10.7	10.5	11.9	10.5	10.2	10.4	11.3	11.0	10.8
35 to 44	%	9.8	10.8	10.9	11.2	10.6	10.7	11.6	17.0	10.7
45 to 54	%	10.4	11.5	12.1	12.6	11.2	12.7	10.5	20.4	11.5
55 to 64	%	12.7	14.5	14.3	14.6	12.8	15.9	15.1	20.5	13.9
65 to 74	%	15.8	16.6	14.5	15.1	14.9	16.1	16.6	10.2	15.5
75 to 84	%	16.8	15.7	12.2	13.9	16.1	12.8	14.9	3.3	15.0
85 and over	%	6.7	5.3	4.2	5.0	6.5	5.4	4.8	0.6	5.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2008-09										
Age group										
Under 1	'000	47.4	29.4	23.5	10.3	9.2	2.1	2.2	2.5	126.5
1 to 4	'000	46.3	32.7	29.1	13.6	12.1	2.0	2.0	3.1	141.0
5 to 14	'000	57.3	44.8	39.4	18.6	13.3	3.3	3.0	3.3	182.9
15 to 24	'000	105.1	93.5	80.7	37.6	29.0	7.7	6.4	7.7	367.7
25 to 34	'000	154.3	142.3	102.5	49.7	37.6	9.5	9.6	10.5	515.9
35 to 44	'000	144.2	144.8	94.2	51.8	40.1	10.0	10.1	16.4	511.7
45 to 54	'000	159.2	161.8	108.3	59.2	42.4	12.9	9.6	20.7	574.1
55 to 64	'000	194.3	203.4	128.5	68.0	48.5	14.3	14.5	18.6	690.0
65 to 74	'000	237.9	231.1	128.7	71.1	54.8	15.1	14.0	9.5	762.3
75 to 84	'000	252.6	219.3	109.1	63.9	62.2	12.9	13.5	2.5	735.8

Table 10A.9 Separations in public hospitals, by age group (a)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
85 and over	'000	107.4	76.5	39.4	23.7	25.4	5.1	5.0	0.5	283.0
Total	'000	1 506.0	1 379.6	883.3	467.4	374.5	94.9	89.9	95.4	4 891.0
Proportion of total separations										
Under 1	%	3.1	2.1	2.7	2.2	2.4	2.2	2.4	2.6	2.6
1 to 4	%	3.1	2.4	3.3	2.9	3.2	2.1	2.2	3.3	2.9
5 to 14	%	3.8	3.3	4.5	4.0	3.5	3.5	3.3	3.4	3.7
15 to 24	%	7.0	6.8	9.1	8.1	7.7	8.1	7.2	8.1	7.5
25 to 34	%	10.2	10.3	11.6	10.6	10.0	10.0	10.7	11.0	10.5
35 to 44	%	9.6	10.5	10.7	11.1	10.7	10.5	11.3	17.2	10.5
45 to 54	%	10.6	11.7	12.3	12.7	11.3	13.6	10.7	21.8	11.7
55 to 64	%	12.9	14.7	14.5	14.5	12.9	15.1	16.1	19.5	14.1
65 to 74	%	15.8	16.8	14.6	15.2	14.6	15.9	15.5	10.0	15.6
75 to 84	%	16.8	15.9	12.4	13.7	16.6	13.6	15.0	2.6	15.0
85 and over	%	7.1	5.5	4.5	5.1	6.8	5.3	5.6	0.5	5.8
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10										
Age group										
Under 1	'000	46.9	27.3	23.5	10.7	9.2	2.9	2.2	2.8	125.4
1 to 4	'000	47.0	33.1	30.6	14.6	12.2	2.3	1.9	2.9	144.6
5 to 14	'000	58.2	45.2	39.0	18.3	14.0	3.4	3.1	3.2	184.4
15 to 24	'000	104.8	95.5	80.6	39.1	29.5	7.5	6.2	7.5	370.8
25 to 34	'000	154.8	142.5	104.3	52.4	37.7	9.2	9.6	10.7	521.1
35 to 44	'000	145.8	147.0	97.9	54.4	39.3	10.3	9.5	17.4	521.6
45 to 54	'000	161.3	171.2	114.1	64.8	43.0	13.7	9.5	22.3	599.9
55 to 64	'000	203.5	211.9	135.8	75.8	49.9	15.4	14.0	20.9	727.2
65 to 74	'000	247.6	242.5	138.2	77.7	56.9	16.8	14.2	9.1	802.9
75 to 84	'000	259.9	227.3	116.8	71.3	64.2	14.6	12.9	2.2	769.2
85 and over	'000	113.3	81.2	42.3	26.8	27.3	5.4	5.4	0.5	302.2
Total	'000	1 543.0	1 424.7	923.0	505.9	383.1	101.7	88.4	99.7	5 069.3
Proportion of total separations										
Under 1	%	3.0	1.9	2.5	2.1	2.4	2.9	2.5	2.8	2.5
1 to 4	%	3.0	2.3	3.3	2.9	3.2	2.3	2.2	2.9	2.9
5 to 14	%	3.8	3.2	4.2	3.6	3.7	3.4	3.5	3.2	3.6
15 to 24	%	6.8	6.7	8.7	7.7	7.7	7.4	7.0	7.6	7.3
25 to 34	%	10.0	10.0	11.3	10.4	9.8	9.0	10.9	10.7	10.3
35 to 44	%	9.5	10.3	10.6	10.7	10.3	10.2	10.7	17.4	10.3
45 to 54	%	10.5	12.0	12.4	12.8	11.2	13.5	10.7	22.4	11.8
55 to 64	%	13.2	14.9	14.7	15.0	13.0	15.2	15.8	21.0	14.3
65 to 74	%	16.0	17.0	15.0	15.4	14.9	16.5	16.1	9.2	15.8

Table 10A.9 **Separations in public hospitals, by age group (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
75 to 84	%	16.8	16.0	12.7	14.1	16.8	14.4	14.5	2.3	15.2
85 and over	%	7.3	5.7	4.6	5.3	7.1	5.3	6.2	0.5	6.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11										
Age group										
Under 1	'000	40.8	28.4	23.5	12.2	9.1	2.3	2.3	2.6	121.3
1 to 4	'000	47.3	34.6	29.5	16.3	11.7	2.2	2.1	2.9	146.5
5 to 14	'000	59.2	47.2	38.4	20.9	13.4	3.2	3.4	3.3	189.0
15 to 24	'000	106.0	101.7	81.8	42.8	28.8	7.0	7.0	8.1	383.1
25 to 34	'000	157.5	150.8	105.7	56.3	38.3	9.2	10.0	11.9	539.7
35 to 44	'000	146.5	153.5	101.6	58.5	37.5	10.0	10.4	17.3	535.3
45 to 54	'000	166.1	176.1	119.0	68.9	44.0	13.2	10.0	23.2	620.5
55 to 64	'000	209.2	224.1	143.8	82.1	52.6	15.0	14.1	21.8	762.5
65 to 74	'000	256.6	251.1	150.4	83.8	58.3	17.0	15.4	10.1	842.8
75 to 84	'000	269.4	239.5	124.0	75.6	66.3	14.9	12.8	2.8	805.2
85 and over	'000	124.3	89.0	46.5	30.9	30.1	5.4	6.3	0.5	333.1
Total	'000	1 582.7	1 496.0	964.3	548.3	390.2	99.3	93.7	104.4	5 279.0
Proportion of total separations										
Under 1	%	2.5	1.8	2.4	2.1	2.2	2.3	2.4	2.3	2.2
1 to 4	%	2.8	2.2	3.0	2.8	2.9	2.2	2.2	2.5	2.7
5 to 14	%	3.6	3.1	3.8	3.5	3.3	3.2	3.5	2.9	3.4
15 to 24	%	6.4	6.6	8.2	7.3	7.1	7.0	7.1	7.1	7.0
25 to 34	%	9.5	9.8	10.6	9.6	9.4	9.2	10.3	10.5	9.8
35 to 44	%	8.8	9.9	10.1	10.0	9.2	10.0	10.7	15.3	9.7
45 to 54	%	10.0	11.4	11.9	11.7	10.8	13.3	10.2	20.4	11.3
55 to 64	%	12.6	14.5	14.4	14.0	12.9	15.0	14.4	19.2	13.8
65 to 74	%	15.5	16.3	15.0	14.3	14.3	17.1	15.8	8.9	15.3
75 to 84	%	16.2	15.5	12.4	12.8	16.3	14.9	13.1	2.5	14.6
85 and over	%	7.5	5.8	4.6	5.2	7.4	5.4	6.5	0.5	6.0
Total	%	95.3	96.9	96.3	93.2	95.8	99.7	96.2	92.1	95.8
2011-12										
Age group										
Under 1	'000	61.9	29.8	24.8	13.2	9.2	2.5	2.4	2.6	146.5
1 to 4	'000	46.9	34.5	29.9	16.6	11.7	2.1	2.3	3.0	147.0
5 to 14	'000	61.0	47.9	40.3	21.9	14.0	3.2	3.2	3.6	195.1
15 to 24	'000	108.4	105.9	86.2	43.9	29.7	6.7	7.1	8.7	396.5
25 to 34	'000	160.8	157.4	113.4	61.5	39.8	8.9	10.7	12.7	565.1
35 to 44	'000	150.1	155.9	104.1	62.3	38.5	10.1	10.9	19.0	550.9
45 to 54	'000	168.4	178.9	123.3	74.0	47.4	12.8	10.9	24.5	640.2
55 to 64	'000	219.3	228.4	145.0	87.5	55.1	15.2	14.0	24.9	789.4

Table 10A.9 **Separations in public hospitals, by age group (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
65 to 74	'000	270.6	265.2	154.0	89.0	60.1	17.2	16.1	10.7	883.0
75 to 84	'000	280.9	245.0	130.2	82.5	69.9	15.6	12.9	3.0	839.9
85 and over	'000	132.3	94.9	50.1	35.8	31.9	5.3	7.0	0.6	357.9
Total	'000	1 660.6	1 543.8	1 001.2	588.1	407.3	99.6	97.5	113.4	5 511.5
Proportion of total separations										
Under 1	%	3.7	1.9	2.5	2.2	2.3	2.5	2.5	2.3	2.7
1 to 4	%	2.8	2.2	3.0	2.8	2.9	2.1	2.4	2.6	2.7
5 to 14	%	3.7	3.1	4.0	3.7	3.4	3.3	3.3	3.2	3.5
15 to 24	%	6.5	6.9	8.6	7.5	7.3	6.7	7.2	7.7	7.2
25 to 34	%	9.7	10.2	11.3	10.5	9.8	8.9	11.0	11.2	10.3
35 to 44	%	9.0	10.1	10.4	10.6	9.5	10.1	11.2	16.8	10.0
45 to 54	%	10.1	11.6	12.3	12.6	11.6	12.9	11.1	21.6	11.6
55 to 64	%	13.2	14.8	14.5	14.9	13.5	15.2	14.3	22.0	14.3
65 to 74	%	16.3	17.2	15.4	15.1	14.8	17.3	16.5	9.5	16.0
75 to 84	%	16.9	15.9	13.0	14.0	17.2	15.6	13.3	2.7	15.2
85 and over	%	8.0	6.1	5.0	6.1	7.8	5.4	7.2	0.5	6.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement.

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.10 **Separations by hospital sector and Indigenous status of patient (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (c)
2007-08										
Public hospitals										
Indigenous people	no.	53 136	12 351	64 885	42 686	17 332	2 611	1 861	61 563	251 953
Non-Indigenous people	no.	1 399 247	1 327 050	749 576	415 516	339 248	91 216	77 705	28 687	4 259 324
Not reported	no.	14 354	11 771	17 504	–	11 750	2 443	1 561	8	55 387
Total	**no.**	**1 466 737**	**1 351 172**	**831 965**	**458 202**	**368 330**	**96 270**	**81 127**	**90 258**	**4 566 664**
Private hospitals										
Indigenous people	no.	1 053	619	4 420	12 131	1 114	np	np	np	19 337
Non-Indigenous people	no.	843 085	791 528	701 790	313 287	228 226	np	np	np	2 877 916
Not reported	no.	13 782	10 144	74 089	–	14 257	np	np	np	112 272
Total	**no.**	**857 920**	**802 291**	**780 299**	**325 418**	**243 597**	**np**	**np**	**np**	**3 009 525**
Indigenous separations (% of total separations)										
Public hospitals	%	3.6	0.9	7.8	9.3	4.7	2.7	2.3	68.2	5.5
Private hospitals	%	0.1	0.1	0.6	3.7	0.5	np	np	np	0.6
All hospitals	%	2.3	0.6	4.3	7.0	3.0	np	np	np	3.6
Separations in public hospitals (% of total separations)										
Indigenous people	%	98.1	95.2	93.6	77.9	94.0	np	np	np	92.9
Non-Indigenous people	%	62.4	62.6	51.6	57.0	59.8	np	np	np	59.7
2008-09										
Public hospitals										
Indigenous people	no.	56 753	12 680	68 708	40 978	18 453	2 452	1 987	66 189	263 761
Non-Indigenous people	no.	1 434 823	1 357 081	797 701	426 455	339 592	89 994	86 244	29 165	4 384 817
Not reported	no.	14 393	9 863	16 931	–	16 495	2 446	1 638	2	57 684
Total	**no.**	**1 505 969**	**1 379 624**	**883 340**	**467 433**	**374 540**	**94 892**	**89 869**	**95 356**	**4 706 262**
Private hospitals										
Indigenous people	no.	1 459	710	4 426	14 443	1 018	np	np	np	22 056

Table 10A.10 **Separations by hospital sector and Indigenous status of patient (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (c)
Non-Indigenous people	no.	885 960	800 180	733 180	347 719	240 286	np	np	np	3 007 325
Not reported	no.	19 795	10 130	76 335	–	14 196	np	np	np	120 456
Total	**no.**	**907 214**	**811 020**	**813 941**	**362 162**	**255 500**	**np**	**np**	**np**	**3 149 837**
Indigenous separations (% of total separations)										
Public hospitals	%	3.8	0.9	7.8	8.8	4.9	2.6	2.2	69.4	5.6
Private hospitals	%	0.2	0.1	0.5	4.0	0.4	np	np	np	0.7
All hospitals	%	2.4	0.6	4.3	6.7	3.1	np	np	np	3.6
Separations in public hospitals (% of total separations)										
Indigenous people	%	97.5	94.7	93.9	73.9	94.8	np	np	np	92.3
Non-Indigenous people	%	61.8	62.9	52.1	55.1	58.6	np	np	np	59.3
2009-10										
Public hospitals										
Indigenous people	no.	59 468	14 034	73 598	45 197	19 702	3 018	1 893	69 431	281 430
Non-Indigenous people	no.	1 469 511	1 401 247	834 350	460 712	344 117	96 445	84 771	30 259	4 540 196
Not reported	no.	13 989	9 382	15 022	–	19 236	2 210	1 692	4	57 633
Total	**no.**	**1 542 968**	**1 424 663**	**922 970**	**505 909**	**383 055**	**101 673**	**88 356**	**99 694**	**4 879 259**
Private hospitals										
Indigenous people	no.	1 535	1 142	3 699	16 405	771	np	np	np	23 552
Non-Indigenous people	no.	936 936	871 026	764 773	364 895	239 686	np	np	np	3 177 316
Not reported	no.	22 235	13 608	76 481	–	29 558	np	np	np	141 882
Total	**no.**	**960 706**	**885 776**	**844 953**	**381 300**	**270 015**	**np**	**np**	**np**	**3 342 750**
Indigenous separations (% of total separations)										
Public hospitals	%	3.9	1.0	8.0	8.9	5.1	3.0	2.1	69.6	5.8
Private hospitals	%	0.2	0.1	0.4	4.3	0.3	np	np	np	0.7
All hospitals	%	2.4	0.7	4.4	6.9	3.1	np	np	np	3.7
Separations in public hospitals (% of total separations)										

Table 10A.10 **Separations by hospital sector and Indigenous status of patient (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (c)
Indigenous people	%	97.5	92.5	95.2	73.4	96.2	np	np	np	92.3
Non-Indigenous people	%	61.1	61.7	52.2	55.8	58.9	np	np	np	58.8
2010-11										
Public hospitals										
Indigenous people	no.	62 385	16 416	78 263	50 135	20 826	2 837	2 128	72 920	300 945
Non-Indigenous people	no.	1 507 520	1 468 985	872 535	498 137	351 331	94 652	90 172	31 513	4 730 021
Not reported	no.	12 899	10 640	13 551	–	17 997	1 844	1 445	1	55 088
Total	**no.**	**1 582 804**	**1 496 041**	**964 349**	**548 272**	**390 154**	**99 333**	**93 745**	**104 434**	**5 086 054**
Private hospitals										
Indigenous people	no.	1 885	2 696	3 491	17 809	609	np	np	np	26 490
Non-Indigenous people	no.	980 483	862 310	790 644	399 952	244 411	np	np	np	3 277 800
Not reported	no.	29 519	10 464	65 067	–	38 261	np	np	np	143 311
Total	**no.**	**1 011 887**	**875 470**	**859 202**	**417 761**	**283 281**	**np**	**np**	**np**	**3 447 601**
Indigenous separations (% of total separations)										
Public hospitals	%	3.9	1.1	8.1	9.1	5.3	2.9	2.3	69.8	5.9
Private hospitals	%	0.2	0.3	0.4	4.3	0.2	np	np	np	0.8
All hospitals	%	2.5	0.8	4.5	7.0	3.2	np	np	np	3.8
Separations in public hospitals (% of total separations)										
Indigenous people	%	97.1	85.9	95.7	73.8	97.2	np	np	np	91.9
Non-Indigenous people	%	60.6	63.0	52.5	55.5	59.0	np	np	np	59.1
2011-12										
Public hospitals										
Indigenous people	no.	69 850	18 741	84 708	55 720	22 831	3 258	2 191	79 649	336 948
Non-Indigenous people	no.	1 579 067	1 511 411	905 093	532 423	366 676	94 973	94 151	33 707	5 117 501
Not reported	no.	11 685	13 621	11 414	–	17 808	1 401	1 113	1	57 043
Total	**no.**	**1 660 602**	**1 543 773**	**1 001 215**	**588 143**	**407 315**	**99 632**	**97 455**	**113 357**	**5 511 492**

Table 10A.10 **Separations by hospital sector and Indigenous status of patient (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (c)
Private hospitals										
Indigenous people	no.	2 639	1 718	3 959	19 586	535	np	np	np	29 170
Non-Indigenous people	no.	1 032 182	909 183	832 185	416 733	265 931	np	np	np	3 557 459
Not reported	no.	35 319	6 909	65 044	–	23 514	np	np	np	158 048
Total	**no.**	**1 070 140**	**917 810**	**901 188**	**436 319**	**289 980**	**np**	**np**	**np**	**3 744 677**
Indigenous separations (% of total separations)										
Public hospitals	%	4.2	1.2	8.5	9.5	5.6	3.3	2.2	70.3	6.1
Private hospitals	%	0.2	0.2	0.4	4.5	0.2	np	np	np	0.8
All hospitals	%	2.7	0.8	4.7	7.4	3.4	np	np	np	4.0
Separations in public hospitals (% of total separations)										
Indigenous people	%	96.4	91.6	95.5	74.0	97.7	np	np	np	92.0
Non-Indigenous people	%	60.5	62.4	52.1	56.1	58.0	np	np	np	59.0

(a) Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded.

(b) Identification of Indigenous patients is not considered to be complete and completeness varies among the jurisdictions.

(c) Total includes data only for NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions.

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

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.11 **Separations per 1000 people, by Indigenous status of patient (number) (a), (b)**

	NSW	*Vic*	*Qld*	*WA* (c)	*SA*	*Tas* (d)	*ACT* (d)	*NT* (d)	*Total* (e)
2002-03									
Public hospitals									
Indigenous people	np	np	685.2	809.4	788.1	np	np	1 223.3	np
Total population	np	np	189.4	195.4	231.0	np	np	422.5	np
Private Hospitals									
Indigenous people	np	np	64.1	109.7	16.2	np	np	np	np
Total population	np	np	162.8	148.1	130.0	np	np	np	np
2003-04									
Public hospitals									
Indigenous people	np	np	710.9	789.3	853.9	np	np	1 286.2	np
Total population	np	np	189.3	191.0	235.9	np	np	428.9	np
Private Hospitals									
Indigenous people	np	np	70.7	198.3	51.2	np	np	np	np
Total population	np	np	167.8	149.8	124.8	np	np	np	np
2004-05									
Public hospitals									
Indigenous people	np	np	733.6	821.5	822.2	np	np	1 441.0	907.0
Total population	193.3	238.3	188.1	195.2	225.3	np	np	456.2	208.1
Private Hospitals									
Indigenous people	np	np	np	np	np	np	np	np	np
Total population	106.6	136.1	172.4	155.7	126.5	np	np	np	133.9
2005-06									
Public hospitals									
Indigenous people	495.6	np	745.4	845.2	875.0	np	np	1 548.0	792.1
Total population	203.2	243.4	186.2	196.4	228.4	np	np	479.1	213.6
Private Hospitals									
Indigenous people	np	np	np	np	np	np	np	np	np
Total population	108.6	136.4	175.2	157.2	129.2	np	np	np	np
2006-07									
Public hospitals									
Indigenous people	528.0	624.3	756.7	876.5	929.3	np	np	1 584.8	787.5
Total population	206.0	246.7	190.2	218.4	232.6	np	np	480.1	218.8
Private Hospitals									
Indigenous people	np	np	np	np	np	np	np	np	np
Total population	112.9	141.3	177.9	138.4	132.5	np	np	np	141.4
2007-08									
Public hospitals									
Indigenous people	550.5	629.8	785.7	869.4	908.9	np	np	1 670.7	807.7
Total population	202.8	247.8	195.7	215.1	216.4	np	np	486.4	217.6
Private Hospitals									

Table 10A.11 Separations per 1000 people, by Indigenous status of patient (number) (a), (b)

	NSW	*Vic*	*Qld*	*WA* (c)	*SA*	*Tas* (d)	*ACT* (d)	*NT* (d)	*Total* (e)
Indigenous people	15.0	53.7	82.0	315.3	91.3	np	np	np	95.1
Total population	117.6	145.5	181.5	150.9	138.3	np	np	np	147.0
2008-09									
Public hospitals									
Indigenous people	511.5	535.8	732.5	817.3	950.5	np	np	1 656.0	763.3
Total population	205.6	249.5	204.4	215.8	217.7	np	np	495.5	221.3
Private Hospitals									
Indigenous people	17.3	44.1	64.6	373.1	67.4	np	np	np	81.7
Total population	122.9	145.3	186.6	165.3	143.4	np	np	np	145.6
2009-10									
Public hospitals									
Indigenous people	522.5	558.1	752.8	901.8	1 005.2	np	np	1 663.8	813.4
Total population	207.1	251.4	206.7	225.4	219.9	np	np	500.2	224.3
Private Hospitals									
Indigenous people	15.4	62.5	47.4	411.8	52.0	np	np	np	84.0
Total population	127.7	155.4	188.0	168.8	149.0	np	np	np	152.6
2010-11									
Public hospitals									
Indigenous people	540.7	636.4	765.2	986.6	1 059.5	np	np	1 704.3	848.0
Total population	207.3	258.0	211.5	238.3	218.2	np	np	510.6	227.9
Private Hospitals									
Indigenous people	18.5	135.5	40.5	453.0	37.7	np	np	np	93.2
Total population	131.3	149.6	186.5	180.4	152.8	np	np	np	152.3
2011-12									
Public hospitals									
Indigenous people	589.5	715.3	794.9	1 074.5	1 129.1	223.5	652.5	1 778.7	877.4
Total population	216.1	264.9	220.3	248.8	227.6	179.9	278.8	544.7	236.4
Private Hospitals									
Indigenous people	24.6	91.9	43.7	488.0	33.2	np	np	np	95.5
Total population	137.7	155.9	195.2	183.1	155.5	np	np	np	158.2

(a) Directly age standardised to the Australian population at 30 June 2001.

(b) Identification of Aboriginal and Torres Strait Islander patients has varied among jurisdictions and over time. From 2011-12 Indigenous data are of acceptable quality for all states and territories in public hospitals. From 2006-07 data for NSW, Victoria, Queensland, SA, WA and the NT (public only) were of acceptable quality. For 2005-06 NSW, Queensland, SA, WA and the NT (public only) were of acceptable quality. Prior to this Queensland, SA, WA and the NT (public only) were of acceptable quality. Data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality and changes in hospitalisation rates for Indigenous people over time may include a component due to improved identification. Indigenous status should therefore be interpreted cautiously.

(c) In WA, separations for public patients at Joondalup and Peel Health Campuses are included from 2006-07 public hospitals figures but not in those for previous years.

Table 10A.11 **Separations per 1000 people, by Indigenous status of patient (number) (a), (b)**

	NSW	*Vic*	*Qld*	*WA* (c)	*SA*	*Tas* (d)	*ACT* (d)	*NT* (d)	*Total* (e)

(d) Private hospital data are supressed for confidentiality reasons.

(e) The totals include data only for the states and teritories that had acceptable data quality. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

np Not published.

Source: AIHW (unpublished), National Hospital Morbidity Database.

Table 10A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	NSW (b)	*Vic* (c)	*Qld* (d)	*WA* (e)	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*
2002-03									
Salaried medical officers	1.0	1.0	0.9	0.9	1.1	0.7	0.9	1.2	1.0
Nurses	4.5	4.5	3.9	4.1	5.0	3.7	4.4	4.4	4.4
Registered nurses	na	4.0	3.3	3.7	3.9	3.3	3.8	2.2	na
Other nurses	na	0.5	0.6	0.4	1.1	0.4	0.6	2.1	na
Other personal care staff	na	na	0.2	0.0	na	na	0.4	0.1	na
Diagnostic and allied health	1.4	2.0	0.9	1.1	1.3	0.7	1.0	1.3	1.4
Administrative and clerical	1.7	1.8	1.3	1.6	1.8	1.0	1.6	1.8	1.6
Domestic and other staff	1.8	1.3	1.7	1.9	1.3	2.0	0.6	2.2	1.6
Total staff	10.4	10.6	8.9	9.6	10.4	8.2	8.9	10.9	10.0
2003-04									
Salaried medical officers	1.0	1.1	1.0	1.0	1.1	0.8	1.0	1.2	1.0
Nurses	4.8	4.9	3.9	4.1	5.1	3.8	4.5	4.7	4.6
Registered nurses	na	na	3.3	3.7	4.0	3.3	3.8	4.5	na
Other nurses	na	na	0.6	0.4	1.1	0.4	0.7	0.2	na
Other personal care staff	na	na	0.2	0.0	na	na	0.4	0.1	na
Diagnostic and allied health	1.5	2.2	0.9	1.1	1.3	0.7	1.1	1.3	1.5
Administrative and clerical	1.7	1.8	1.2	1.6	1.8	1.0	1.6	1.8	1.6
Domestic and other staff	1.8	1.3	1.6	1.9	1.4	2.0	0.6	2.4	1.6
Total staff	10.8	11.4	8.7	9.7	10.7	8.3	9.1	11.5	10.4
2004-05									
Salaried medical officers	1.1	1.1	1.0	1.0	1.1	0.9	1.1	1.3	1.1
Nurses	5.0	4.9	3.9	4.2	5.2	4.5	4.6	5.1	4.7
Registered nurses	na	na	3.3	3.8	4.0	3.9	3.9	4.9	na
Other nurses	na	na	0.6	0.5	1.1	0.5	0.7	0.2	na
Other personal care staff	na	na	0.2	na	na	0.4	0.5	0.1	na
Diagnostic and allied health	1.5	2.3	0.9	1.2	1.3	0.9	1.2	1.4	1.5
Administrative and clerical	1.8	1.8	1.1	1.7	1.8	1.2	1.9	1.9	1.6
Domestic and other staff	1.7	1.4	1.6	1.9	1.3	1.8	0.6	2.6	1.6
Total staff	11.1	11.6	8.6	9.9	10.7	9.7	10.0	12.3	10.6
2005-06									
Salaried medical officers	1.2	1.1	1.0	1.0	1.3	1.0	1.2	1.5	1.1
Nurses	5.3	5.0	4.0	4.3	5.7	4.7	5.0	5.7	4.9
Registered nurses	na	na	3.4	4.0	4.4	4.2	4.3	5.0	na
Other nurses	na	na	0.6	0.3	1.2	0.5	0.8	0.7	na
Other personal care staff	na	na	0.2	na	na	0.2	0.5	0.1	na
Diagnostic and allied health	1.6	2.4	0.9	1.2	1.4	0.9	1.3	1.4	1.6
Administrative and clerical	1.8	1.9	1.2	1.6	1.9	1.3	1.8	2.0	1.7
Domestic and other staff	1.7	1.4	1.6	1.9	1.5	2.1	0.5	2.6	1.6
Total staff	11.5	11.8	8.9	10.1	11.7	10.2	10.4	13.2	10.9

Table 10A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	NSW (b)	*Vic* (c)	*Qld* (d)	*WA* (e)	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*
2006-07									
Salaried medical officers	1.1	1.2	1.2	1.2	1.4	1.1	1.3	1.6	1.2
Nurses	5.4	5.2	4.3	4.6	5.6	4.6	5.2	5.7	5.0
Registered nurses	na	na	3.7	4.4	4.4	4.1	4.3	5.1	na
Other nurses	na	na	0.6	0.2	1.2	0.5	0.9	0.7	na
Other personal care staff	na	na	0.2	0.0	0.5	0.2	0.5	0.1	na
Diagnostic and allied health	1.7	2.4	1.1	1.3	1.2	0.9	1.3	1.4	1.7
Administrative and clerical	1.8	2.0	1.4	1.9	2.0	1.5	1.7	2.1	1.8
Domestic and other staff	1.7	1.3	1.8	2.0	1.3	2.0	0.5	2.6	1.6
Total staff	11.7	12.0	10.0	11.0	12.0	10.2	10.5	13.5	11.4
2007-08									
Salaried medical officers	1.2	1.3	1.4	1.2	1.4	1.0	1.5	1.6	1.3
Nurses	5.3	5.2	4.6	4.5	5.8	4.5	5.7	5.6	5.1
Registered nurses	na	na	4.0	4.3	4.6	4.0	4.7	5.0	na
Other nurses	na	na	0.6	0.2	1.2	0.5	1.0	0.6	na
Other personal care staff	na	na	0.2	na	0.5	na	0.5	0.1	na
Diagnostic and allied health	1.8	2.4	1.2	1.4	1.3	1.1	1.4	1.5	1.7
Administrative and clerical	1.6	2.1	1.5	1.9	1.9	1.3	1.8	2.0	1.8
Domestic and other staff	1.4	1.3	1.8	2.0	1.2	2.0	0.5	2.6	1.5
Total staff	11.4	12.2	10.6	11.0	12.1	9.9	11.4	13.3	11.4
2008-09									
Salaried medical officers	1.2	1.4	1.4	1.3	1.5	1.5	1.8	1.7	1.4
Nurses	5.4	5.4	4.6	4.7	6.1	4.9	5.8	6.1	5.2
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.2	na	0.5	na	0.5	0.1	na
Diagnostic and allied health	1.7	2.4	1.1	1.4	1.2	1.0	1.5	1.5	1.7
Administrative and clerical	1.6	2.1	1.5	1.9	1.9	1.6	2.0	2.0	1.8
Domestic and other staff	1.3	1.2	1.7	1.9	1.2	2.2	0.5	2.6	1.4
Total staff	11.1	12.5	10.5	11.2	12.3	11.2	12.2	14.0	11.5
2009-10									
Salaried medical officers	1.3	1.4	1.4	1.4	1.6	1.8	1.7	1.7	1.4
Nurses	5.2	5.5	4.6	4.7	6.3	5.3	5.8	6.7	5.2
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.2	na	0.5	na	0.5	0.0	0.1
Diagnostic and allied health	1.6	2.5	1.1	1.2	1.2	1.0	1.5	1.6	1.6
Administrative and clerical	1.6	2.1	1.5	1.9	1.8	2.0	2.0	2.1	1.7
Domestic and other staff	1.3	1.3	1.7	1.8	1.1	2.1	0.5	2.7	1.4
Total staff	**10.9**	**12.7**	**10.5**	**11.0**	**12.6**	**12.3**	**12.0**	**14.9**	**11.5**

Table 10A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	NSW (b)	*Vic* (c)	*Qld* (d)	*WA* (e)	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*
2010-11									
Salaried medical officers	1.3	1.5	1.6	1.4	1.6	1.9	1.8	1.9	1.5
Nurses	5.2	5.7	5.1	4.8	6.4	5.5	5.9	6.7	5.4
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.3	na	0.6	na	0.6	0.0	0.1
Diagnostic and allied health	1.5	2.6	1.2	1.2	1.2	1.1	1.6	1.6	1.7
Administrative and clerical	1.6	2.1	1.7	2.0	2.1	2.1	2.1	2.0	1.9
Domestic and other staff	1.1	1.3	1.8	1.9	1.1	2.1	0.5	2.7	1.4
Total staff	**10.8**	**13.2**	**11.6**	**11.2**	**12.9**	**12.7**	**12.4**	**15.0**	**11.9**
2011-12									
Salaried medical officers	1.4	1.5	1.7	1.5	1.7	1.7	1.8	2.0	1.5
Nurses	5.4	5.7	5.1	4.9	6.5	5.3	6.7	6.9	5.5
Registered nurses	na	na	na	na	na	na	na	na	na
Other nurses	na	na	na	na	na	na	na	na	na
Other personal care staff	na	na	0.3	na	0.5	na	0.6	0.0	0.1
Diagnostic and allied health	1.4	2.6	1.2	1.3	1.1	1.1	2.5	1.7	1.7
Administrative and clerical	1.6	2.2	1.7	2.0	2.0	2.2	2.6	2.1	1.9
Domestic and other staff	1.1	1.3	1.8	1.8	1.0	2.1	0.0	2.8	1.4
Total staff	**11.0**	**13.3**	**11.9**	**11.5**	**12.7**	**12.4**	**14.2**	**15.6**	**12.0**

(a) Where average FTE staff numbers are not available for a financial year, staff numbers on the last day of the financial year are used (for example, 30 June 2009, for 2008-09). Staff contracted to provide products (rather than labour) are not included. Numbers per 1000 people are calculated from population estimates for each financial year (table AA.2).

(b) For NSW, 'other personal care staff' are included in 'diagnostic and allied health' and 'domestic and other staff'.

(c) For Victoria, FTEs may be slightly understated. 'Other personal care staff' are included in 'domestic and other staff'.

(d) Queensland pathology services staff employed by the state pathology service are not included.

(e) Many WA hospitals were unable to provide a split between nurse categories and these have been reported as registered nurses.

Table 10A.12 **Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) (a)**

	NSW (b)	*Vic* (c)	*Qld* (d)	*WA* (e)	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*

(f) In Tasmania in 2006-07 data for two small hospitals are not included. Tasmanian 'other personal care' staff are included in 'domestic and other staff'.

na Not available.

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra; ABS (unpublished), Australian Demographic Statistics, December Quarter 2010, Cat. no. 3101.0; table AA.2.

Table 10A.13 **Separations, by type of episode of care, public hospitals (including psychiatric), 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08										
Number of separations										
Acute care	no.	1 409 636	1 305 676	794 041	441 410	353 543	93 197	75 465	88 197	4 561 165
Rehabilitation care	no.	25 954	13 400	16 853	8 496	6 884	1 141	2 249	469	75 446
Palliative care	no.	8 273	5 128	4 266	1 392	1 388	268	572	311	21 598
Geriatric evaluation and management	no.	1 806	11 017	537	617	201	24	540	71	14 813
Psychogeriatric care	no.	1 007	2 016	500	656	259	29	21	6	4 494
Maintenance care	no.	6 065	870	5 448	2 211	2 341	589	1 283	404	19 211
Newborn total	no.	77 326	55 476	44 600	22 023	15 014	3 933	3 955	3 341	225 668
Newborn — unqualified days only	no.	63 340	42 411	34 763	18 603	11 300	2 911	2 960	2 555	178 843
Other admitted care	no.	–	–	483	–	–	–	2	13	498
Not reported	no.	10	–	–	–	–	–	–	1	11
Total (b)	no.	**1 530 077**	**1 393 583**	**866 728**	**476 805**	**379 630**	**99 181**	**84 087**	**92 813**	**4 922 904**
Total (c)	no.	**1 466 737**	**1 351 172**	**831 965**	**458 202**	**368 330**	**96 270**	**81 127**	**90 258**	**4 744 061**
Proportion of total separations										
Acute care	%	96.1	96.6	95.4	96.3	96.0	96.8	93.0	97.7	96.1
Rehabilitation care	%	1.8	1.0	2.0	1.9	1.9	1.2	2.8	0.5	1.6
Palliative care	%	0.6	0.4	0.5	0.3	0.4	0.3	0.7	0.3	0.5
Geriatric evaluation and management	%	0.1	0.8	0.1	0.1	0.1	–	0.7	0.1	0.3
Psychogeriatric care	%	0.1	0.1	0.1	0.1	0.1	–	–	–	0.1
Maintenance care	%	0.4	0.1	0.7	0.5	0.6	0.6	1.6	0.4	0.4
Newborn excluding unqualified days	%	1.0	1.0	1.2	0.7	1.0	1.1	1.2	0.9	1.0

Table 10A.13 **Separations, by type of episode of care, public hospitals (including psychiatric), 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other admitted care	%	–	–	0.1	–	–	–	–	–	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (c)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2008-09										
Number of separations										
Acute care	no.	1 437 796	1 332 252	842 765	450 300	359 088	91 658	82 785	93 271	4 689 915
Rehabilitation care	no.	26 400	13 821	17 574	8 923	6 907	1 168	2 681	401	77 875
Palliative care	no.	9 345	5 652	5 457	1 245	1 298	304	609	352	24 262
Geriatric evaluation and management	no.	2 348	12 250	1 336	708	377	44	1 244	–	18 307
Psychogeriatric care	no.	669	2 001	525	716	265	165	53	–	4 394
Maintenance care	no.	6 391	802	5 547	1 895	2 767	464	1 369	402	19 637
Newborn total	no.	77 150	54 476	45 160	22 143	15 450	3 934	4 136	3 478	225 927
Newborn — unqualified days only	no.	54 139	41 630	35 353	18 497	11 612	2 845	3 009	2 566	169 651
Other admitted care	no.	–	–	329	–	–	–	1	18	348
Not reported	no.	9	–	–	–	–	–	–	–	9
Total (b)	no.	**1 560 108**	**1 421 254**	**918 693**	**485 930**	**386 152**	**97 737**	**92 878**	**97 922**	**5 060 674**
Total (c)	no.	**1 505 969**	**1 379 624**	**883 340**	**467 433**	**374 540**	**94 892**	**89 869**	**95 356**	**4 891 023**
Proportion of total separations										
Acute care	%	95.5	96.6	95.4	96.3	95.9	96.6	92.1	97.8	95.9
Rehabilitation care	%	1.8	1.0	2.0	1.9	1.8	1.2	3.0	0.4	1.6
Palliative care	%	0.6	0.4	0.6	0.3	0.3	0.3	0.7	0.4	0.5
Geriatric evaluation and management	%	0.2	0.9	0.2	0.2	0.1	–	1.4	–	0.4
Psychogeriatric care	%	–	0.1	0.1	0.2	0.1	0.2	0.1	–	0.1

Table 10A.13 **Separations, by type of episode of care, public hospitals (including psychiatric), 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Maintenance care	%	0.4	0.1	0.6	0.4	0.7	0.5	1.5	0.4	0.4
Newborn excluding unqualified days	%	1.5	0.9	1.1	0.8	1.0	1.1	1.3	1.0	1.2
Other admitted care	%	–	–	–	–	–	–	–	–	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (c)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2009-10										
Number of separations										
Acute care	no.	1 468 941	1 377 417	880 728	489 249	366 576	97 527	81 422	97 365	4 859 225
Rehabilitation care	no.	29 312	14 796	18 786	8 511	6 510	1 358	2 788	614	82 675
Palliative care	no.	10 279	6 208	5 953	1 284	1 627	310	651	321	26 633
Geriatric evaluation and management	no.	3 689	13 250	1 671	668	1 327	35	639	31	21 310
Psychogeriatric care	no.	744	–	544	708	260	48	31	1	2 336
Maintenance care	no.	6 936	811	5 150	1 430	2 794	479	1 640	384	19 624
Newborn total	no.	76 982	55 875	45 393	22 467	15 454	4 364	4 453	3 487	228 475
Newborn — unqualified days only	no.	53 920	43 694	35 515	18 408	11 493	2 533	3 268	2 544	171 375
Other admitted care	no.	–	–	260	–	–	85	–	35	380
Not reported	no.	5	–	–	–	–	–	–	–	5
Total (b)	no.	**1 596 888**	**1 468 357**	**958 485**	**524 317**	**394 548**	**104 206**	**91 624**	**102 238**	**5 240 663**
Total (c)	no.	**1 542 968**	**1 424 663**	**922 970**	**505 909**	**383 055**	**101 673**	**88 356**	**99 694**	**5 069 288**
Proportion of total separations										
Acute care	%	95.2	96.7	95.4	96.7	95.7	95.9	92.2	97.7	95.9
Rehabilitation care	%	1.9	1.0	2.0	1.7	1.7	1.3	3.2	0.6	1.6
Palliative care	%	0.7	0.4	0.6	0.3	0.4	0.3	0.7	0.3	0.5

Table 10A.13 **Separations, by type of episode of care, public hospitals (including psychiatric), 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Geriatric evaluation and management	%	0.2	0.9	0.2	0.1	0.3	–	0.7	–	0.4
Psychogeriatric care	%	–	–	0.1	0.1	0.1	–	–	–	–
Maintenance care	%	0.4	0.1	0.6	0.3	0.7	0.5	1.9	0.4	0.4
Newborn excluding unqualified days	%	1.5	0.9	1.1	0.8	1.0	1.8	1.3	0.9	1.1
Other admitted care	%	–	–	–	–	–	0.1	–	–	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (c)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2010-11										
Number of separations										
Acute care	no.	1 510 980	1 446 301	919 598	529 774	371 880	96 124	86 828	102 340	5 063 825
Rehabilitation care	no.	30 832	14 776	19 385	9 496	7 664	1 114	2 718	441	86 426
Palliative care	no.	10 919	6 659	6 599	1 234	1 678	217	629	320	28 255
Geriatric evaluation and management	no.	5 624	15 293	2 172	804	1 701	141	707	42	26 484
Psychogeriatric care	no.	808	–	596	730	288	1	21	1	2 445
Maintenance care	no.	7 919	621	5 863	1 384	2 803	437	1 570	292	20 889
Newborn total	no.	77 737	56 535	45 530	23 273	15 693	4 548	4 557	3 545	231 418
Newborn — unqualified days only	no.	62 019	44 278	35 563	18 423	11 553	3 267	3 286	2 623	181 012
Other admitted care	no.	–	–	169	–	–	14	1	76	260
Not reported	no.	4	134	–	–	–	4	–	–	142
Total (b)	no.	**1 644 823**	**1 540 319**	**999 912**	**566 695**	**401 707**	**102 600**	**97 031**	**107 057**	**5 460 144**
Total (c)	no.	**1 582 804**	**1 496 041**	**964 349**	**548 272**	**390 154**	**99 333**	**93 745**	**104 434**	**5 279 132**
Proportion of total separations										

Table 10A.13 **Separations, by type of episode of care, public hospitals (including psychiatric), 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Acute care	%	95.5	96.7	95.4	96.6	95.3	96.8	92.6	98.0	95.9
Rehabilitation care	%	1.9	1.0	2.0	1.7	2.0	1.1	2.9	0.4	1.6
Palliative care	%	0.7	0.4	0.7	0.2	0.4	0.2	0.7	0.3	0.5
Geriatric evaluation and management	%	0.4	1.0	0.2	0.1	0.4	0.1	0.8	–	0.5
Psychogeriatric care	%	0.1	–	0.1	0.1	0.1	–	–	–	–
Maintenance care	%	0.5	–	0.6	0.3	0.7	0.4	1.7	0.3	0.4
Newborn excluding unqualified days	%	1.0	0.8	1.0	0.9	1.1	1.3	1.4	0.9	1.0
Other admitted care	%	–	–	–	–	–	–	–	0.1	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (c)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2011-12										
Number of separations										
Acute care	no.	1 564 100	1 490 776	947 980	566 072	387 421	95 999	91 177	111 520	5 255 045
Rehabilitation care	no.	31 964	14 954	24 068	11 511	9 205	910	2 603	347	95 562
Palliative care	no.	12 371	7 191	7 333	1 456	1 492	476	648	293	31 260
Geriatric evaluation and management	no.	5 907	16 963	3 712	1 554	1 597	324	374	20	30 451
Psychogeriatric care	no.	827	–	472	732	255	54	42	–	2 382
Maintenance care	no.	8 671	553	6 859	1 411	3 037	384	1 210	146	22 271
Newborn total	no.	78 731	58 981	46 498	24 112	16 258	4 132	4 862	3 704	237 278
Newborn — unqualified days only	no.	42 116	45 672	35 804	18 705	11 950	2 670	3 483	2 806	163 206
Other admitted care	no.	135	–	97	–	–	13	22	133	400
Not reported	no.	12	27	–	–	–	10	–	–	49

Table 10A.13 **Separations, by type of episode of care, public hospitals (including psychiatric), 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total (b)	no.	**1 702 718**	**1 589 445**	**1 037 019**	**606 848**	**419 265**	**102 302**	**100 938**	**116 163**	**5 674 698**
Total (c)	no.	**1 660 602**	**1 543 773**	**1 001 215**	**588 143**	**407 315**	**99 632**	**97 455**	**113 357**	**5 511 492**
Proportion of total separations										
Acute care	%	94.2	96.6	94.7	96.2	95.1	96.4	93.6	98.4	95.3
Rehabilitation care	%	1.9	1.0	2.4	2.0	2.3	0.9	2.7	0.3	1.7
Palliative care	%	0.7	0.5	0.7	0.2	0.4	0.5	0.7	0.3	0.6
Geriatric evaluation and management	%	0.4	1.1	0.4	0.3	0.4	0.3	0.4	–	0.6
Psychogeriatric care	%	–	–	–	0.1	0.1	0.1	–	–	–
Maintenance care	%	0.5	–	0.7	0.2	0.7	0.4	1.2	0.1	0.4
Newborn excluding unqualified days	%	2.2	0.9	1.1	0.9	1.1	1.5	1.4	0.8	1.3
Other admitted care	%	–	–	–	–	–	–	–	0.1	–
Not reported	%	–	–	–	–	–	–	–	–	–
Total (c)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Excludes records for hospital boarders or posthumous organ procurement.

(b) Total separations include 'newborn unqualified days only', which are not normally included as admitted patient care.

(c) Total separations exclude 'newborn unqualified days only', which are not normally included as admitted patient care.

– Nil or rounded to zero.

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra.

Table 10A.14 **Australian refined diagnosis related groups (AR-DRGs) version 6.0x with the highest number of overnight acute separations, public hospitals, 2011-12 (a), (b), (c)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations (no.)										
O60B	Vaginal delivery without catastrophic or severe CC	33 825	26 190	19 521	9 982	6 391	1 598	1 895	1 286	100 688
F74Z	Chest pain	19 488	12 982	12 396	5 021	6 165	572	588	644	57 856
O01C	Caesarean delivery without catastrophic or severe CC	15 316	11 510	9 085	4 473	3 498	800	893	666	46 241
G70B	Other digestive system diagnoses without catastrophic or severe CC	13 917	9 599	7 835	4 863	3 376	657	557	467	41 271
J64B	Cellulitis without catastrophic or severe CC	13 827	7 855	8 499	5 016	2 802	596	544	1 568	40 707
E65B	Chronic obstructive airways disease without catastrophic CC	14 594	7 599	7 259	3 465	3 296	870	479	892	38 454
G66Z	Abdominal pain or mesenteric adenitis	12 139	9 917	5 442	3 172	2 750	484	512	391	34 807
P67D	Neonate, admWt >2499 g without significant OR procedure without problem	22 703	3 641	2 979	1 697	1 255	767	390	282	33 714
O66A	Antenatal and other obstetric admission	11 362	6 301	6 842	3 507	2 144	629	557	904	32 246
G67B	Oesophagitis and gastroenteritis without catastrophic/severe CC	12 015	6 614	6 181	2 987	2 933	456	387	463	32 036
Total acute separations (excluding same day)		**874 131**	**621 389**	**466 372**	**254 787**	**208 699**	**47 008**	**41 050**	**38 094**	**2 551 530**
Separations (per cent)										
O60B	Vaginal delivery without catastrophic or severe CC	3.9	4.2	4.2	3.9	3.1	3.4	4.6	3.4	3.9
F74Z	Chest pain	2.2	2.1	2.7	2.0	3.0	1.2	1.4	1.7	2.3

Table 10A.14 **Australian refined diagnosis related groups (AR-DRGs) version 6.0x with the highest number of overnight acute separations, public hospitals, 2011-12 (a), (b), (c)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
O01C	Caesarean delivery without catastrophic or severe CC	1.8	1.9	1.9	1.8	1.7	1.7	2.2	1.7	1.8
G70B	Other digestive system diagnoses without catastrophic or severe CC	1.6	1.5	1.7	1.9	1.6	1.4	1.4	1.2	1.6
J64B	Cellulitis without catastrophic or severe CC	1.6	1.3	1.8	2.0	1.3	1.3	1.3	4.1	1.6
E65B	Chronic obstructive airways disease without catastrophic CC	1.7	1.2	1.6	1.4	1.6	1.9	1.2	2.3	1.5
G66Z	Abdominal pain or mesenteric adenitis	1.4	1.6	1.2	1.2	1.3	1.0	1.2	1.0	1.4
P67D	Neonate, admWt >2499 g without significant OR procedure without problem	2.6	0.6	0.6	0.7	0.6	1.6	1.0	0.7	1.3
O66A	Antenatal and other obstetric admission	1.3	1.0	1.5	1.4	1.0	1.3	1.4	2.4	1.3
G67B	Oesophagitis and gastroenteritis without catastrophic/severe CC	1.4	1.1	1.3	1.2	1.4	1.0	0.9	1.2	1.3
10 AR-DRGs with most acute separations		**19.4**	**16.4**	**18.4**	**17.3**	**16.6**	**15.8**	**16.6**	**19.9**	**18.0**

(a) Includes separations for which the care type was reported as ‘acute’ or ‘newborn with qualified days’, or was not reported.

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

(c) Excludes same day separations and separations where patients stayed over 365 days.

CC=complications or comorbidities, admWt=admission weight.

Source: AIHW (unpublished), National Hospital Morbidity Database.

Table 10A.15 **Top 10 AR-DRGs (version 6.0x) with the most patient days, excluding same day separations, public hospitals, 2011-12 (a), (b)**

AR-DRG		*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient days (no.)										
U61A	Schizophrenia disorders with mental health legal status	139 886	92 152	85 870	41 152	22 947	–	5 606	5 346	392 959
U63B	Major affective disorders age<70/ without catastrophic or severe CC	93 957	58 758	38 009	27 818	28 011	6 140	4 937	1 662	259 292
O60B	Vaginal delivery without catastrophic or severe CC	89 678	64 953	44 247	26 197	17 301	4 582	4 473	3 901	255 332
U61B	Schizophrenia disorders without mental health legal status	90 425	47 014	15 847	23 205	25 338	11 291	2 628	512	216 260
E65B	Chronic obstructive airways disease without catastrophic CC	77 592	35 710	31 857	15 677	15 926	4 946	2 788	4 441	188 937
O01C	Caesarean delivery without catastrophic or severe CC	59 237	43 375	30 989	16 971	14 457	3 088	3 496	3 056	174 669
A06B	Tracheostomy with ventilation >95 hours without catastrophic CC or Tracheostomy/Ventilation >95 hours with catastrophic CC	65 525	40 050	30 711	11 871	14 627	3 809	3 846	2 922	173 361
E62A	Respiratory infections/Inflammations with catastrophic CC	59 699	41 042	24 239	8 965	15 599	2 547	2 684	2 526	157 301
J64B	Cellulitis without catastrophic or severe CC	56 304	31 725	25 504	18 220	11 164	2 439	2 320	5 109	152 785
U67Z	Personality disorders and acute Reactions	37 026	25 383	16 461	24 854	13 584	3 002	1 552	606	122 468
Total (days)		**4 572 839**	**3 044 640**	**2 062 280**	**1 205 221**	**1 077 055**	**256 616**	**217 758**	**203 002**	**12 639 411**
Patient days (per cent)										
U61A	Schizophrenia disorders with mental health legal status	3.1	3.0	4.2	3.4	2.1	–	2.6	2.6	3.1

Table 10A.15 **Top 10 AR-DRGs (version 6.0x) with the most patient days, excluding same day separations, public hospitals, 2011-12 (a), (b)**

AR-DRG		*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
U63B	Major affective disorders age<70/ without catastrophic or severe CC	2.1	1.9	1.8	2.3	2.6	2.4	2.3	0.8	2.1
O60B	Vaginal delivery without catastrophic or severe CC	2.0	2.1	2.1	2.2	1.6	1.8	2.1	1.9	2.0
U61B	Schizophrenia disorders without mental health legal status	2.0	1.5	0.8	1.9	2.4	4.4	1.2	0.3	1.7
E65B	Chronic obstructive airways disease without catastrophic CC	1.7	1.2	1.5	1.3	1.5	1.9	1.3	2.2	1.5
O01C	Caesarean delivery without catastrophic or severe CC	1.3	1.4	1.5	1.4	1.3	1.2	1.6	1.5	1.4
A06B	Tracheostomy with ventilation >95 hours without catastrophic CC or Tracheostomy/Ventilation >95 hours with catastrophic CC	1.4	1.3	1.5	1.0	1.4	1.5	1.8	1.4	1.4
E62A	Respiratory infections/Inflammations with catastrophic CC	1.3	1.3	1.2	0.7	1.4	1.0	1.2	1.2	1.2
J64B	Cellulitis without catastrophic or severe CC	1.2	1.0	1.2	1.5	1.0	1.0	1.1	2.5	1.2
U67Z	Personality disorders and acute Reactions	0.8	0.8	0.8	2.1	1.3	1.2	0.7	0.3	1.0
Per cent of patient days accounted for by ten AR-DRGs with the most patient days		**16.8**	**15.8**	**16.7**	**17.8**	**16.6**	**16.3**	**15.8**	**14.8**	**16.6**

(a) Excludes same day separations and separations where patients stayed over 365 days.

(b) Includes separations for which the care type was reported as ‘acute’ or ‘newborn with qualified days’, or was not reported.

CC=complications or comorbidities.

na Not availaible.

Source: AIHW (unpublished), National Hospital Morbidity Database.

Table 10A.16 **Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas (b)*	*ACT*	*NT* (c)	*Aust* (d)
Public acute hospitals										
Individual occasions of service										
Accident and emergency	no.	2 537 681	1 659 550	1 711 873	944 759	537 115	154 731	118 767	144 859	7 809 335
Dialysis	no.	19 471	..	..	..	–	..	..	..	19 471
Pathology	no.	3 965 916	912 193	4 041 412	667 367	..	..	540 400	124 567	10 251 855
Radiology and organ imaging	no.	891 658	677 531	1 041 237	466 017	238 331	..	60 502	91 730	3 467 006
Endoscopy and related procedures	no.	19 625	..	12 145	..	24 909	..	2 828	..	59 507
Other medical/surgical/obstetric (e)	no.	5 320 869	1 785 512	2 702 089	906 898	970 285	222 847	206 898	161 842	12 277 240
Mental health	no.	1 014 067	na	33 010	82 930	16 877	2 681	259 257	..	1 408 822
Alcohol and drug	no.	1 256 848	99 356	32 997	..	..	..	..	..	1 389 201
Dental	no.	407 418	23 278	..	13 513	7 637	–	..	..	451 846
Pharmacy (f)	no.	4 199 079	481 973	618 792	255 820	..	..	39 428	35 550	5 630 642
Allied health	no.	661 364	1 153 840	615 174	1 323 002	169 619	103 166	20 042	13 320	4 059 527
Other non-admitted services										
Community health	no.	1 646 019	10 643	125 390	959 942	1 920	20 627	394 483	..	3 159 024
District nursing (g)	no.	1 575 712	253 560	122 512	150 314	5 858	..	..	..	2 107 956
Other outreach	no.	546 165	3 940	131 792	124 583	226 649	–	–	–	1 033 129
Total (individual)	no.	**24 061 892**	**7 061 376**	**11 188 423**	**5 895 145**	**2 199 200**	**504 052**	**1 642 605**	**571 868**	**53 124 561**
Group sessions										
Outpatient care										
Allied health	no.	14 039	25 445	15 383	22 647	7 403	..	307	..	85 224
Dental	no.	67	..	..	6	..	..	..	..	73
Other medical/surgical/obstetric (e)	no.	37 749	1 528	5 767	502	11 026	..	12	3	56 587

Table 10A.16 **Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas (b)*	*ACT*	*NT* (c)	*Aust* (d)
Mental health	no.	29 808	..	..	4 352	475	..	6 025	..	40 660
Alcohol & drug	no.	704	..	255	na	–	..	–	..	959
Community health	no.	29 702	..	926	30 015	–	..	33	..	60 676
District nursing	no.	3 089	..	7	1 678	–	..	–	..	4 774
Other outreach	no.	8 724	..	86	2 184	43 788	..	..	..	54 782
Other	no.	74	–	–	101	–	..	..	..	196
Total (group sessions)	no.	**123 977**	**26 973**	**22 424**	**61 485**	**62 692**	**..**	**6 377**	**3**	**303 931**
Public acute hospitals										
Accident and emergency	%	10.5	23.5	15.3	16.0	24.4	30.7	7.2	25.3	14.7
Outpatient services										
Dialysis	%	0.1	..	..	..	–	..	..	..	–
Pathology	%	16.5	12.9	36.1	11.3	..	..	32.9	21.8	19.3
Radiology and organ imaging	%	3.7	9.6	9.3	7.9	10.8	..	3.7	16.0	6.5
Endoscopy and related procedures	%	0.1	..	0.1	..	1.1	..	0.2	..	0.1
Other medical/surgical/obstetric (e)	%	22.1	25.3	24.2	15.4	44.1	44.2	12.6	28.3	23.1
Mental health	%	4.2	na	0.3	1.4	0.8	0.5	15.8	..	2.7
Alcohol and drug	%	5.2	1.4	0.3	..	..	..	..	..	2.6
Dental	%	1.7	0.3	..	0.2	0.3	–	..	..	0.9
Pharmacy (f)	%	17.5	6.8	5.5	4.3	..	..	2.4	6.2	10.6
Allied health	%	2.7	16.3	5.5	22.4	7.7	20.5	1.2	2.3	7.6
Other non-admitted services										
Community health	%	6.8	0.2	1.1	16.3	0.1	4.1	24.0	..	5.9
District nursing (g)	%	6.5	3.6	1.1	2.5	0.3	..	..	..	4.0
Other outreach	%	2.3	0.1	1.2	2.1	10.3	–	–	–	1.9

Table 10A.16 Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2011-12 (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas (b)*	*ACT*	*NT* (c)	*Aust* (d)
Total (individual)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Group sessions										
Allied health	%	11.3	94.3	68.6	36.8	11.8	..	4.8	..	28.0
Dental	%	0.1	..	..	–	..	..	..	..	–
Other medical/surgical/obstetric (e)	%	30.4	5.7	25.7	0.8	17.6	..	0.2	100.0	18.6
Mental health	%	24.0	..	..	7.1	0.8	..	94.5	..	13.4
Alcohol & drug	%	0.6	..	1.1	na	–	..	–	..	0.3
Community health	%	24.0	..	4.1	48.8	–	..	0.5	..	20.0
District nursing	%	2.5	..	–	2.7	–	..	–	..	1.6
Other outreach	%	7.0	..	0.4	3.6	69.8	..	..	..	18.0
Other	%	0.1	–	–	0.2	–	..	..	..	0.1
Total (group sessions)	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**..**	**100.0**	**100.0**	**100.0**

(a) Reporting arrangements have varied significantly across years and across jurisdictions.

(b) Includes data for the Mersey Community Hospital.

(c) Radiology figures for the NT are underestimated and pathology figures relate only to three of the five hospitals.

(d) Includes only those states and territories for which data are available.

(e) Other includes the outpatient services of Gynaecology, Obstetrics, Cardiology, Endocrinology, Oncology, Respiratory, Gastroenterology, Medical, General practice primary care, Paediatric, Plastic surgery, Urology, Orthopaedic surgery, Ophthalmology, Ear, nose and throat, Chemotherapy, Paediatric surgery and Renal medical.

(f) Justice Health (formerly known as Corrections Health) in New South Wales reported a large number of occasions of service that may not be typical of Pharmacy.

(g) Justice Health (formerly known as Corrections Health) in New South Wales reported a large number of occasions of service that may not be typical of District nursing.

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

Source : AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
2003-04										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	100	99	99	96	100	100	99
2 – Emergency	%	76	88	76	74	62	67	69	57	76
3 – Urgent	%	58	83	55	72	41	61	64	63	62
4 – Semi-urgent	%	65	75	56	75	49	61	58	59	61
5 – Non-urgent	%	86	90	84	97	87	92	77	86	82
Total	%	**66**	**80**	**60**	**80**	**50**	**64**	**65**	**64**	**72**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	81	88	68	58	82	93	70	59	78
2 – Emergency	%	68	73	57	42	66	65	43	62	63
3 – Urgent	%	47	51	33	27	45	42	36	41	43
4 – Semi-urgent	%	19	22	11	8	16	14	15	15	16
5 – Non-urgent	%	6	5	3	2	5	3	3	7	4
Total	%	**31**	**32**	**21**	**13**	**32**	**28**	**19**	**24**	**27**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	7	7	6	11	9	7	6	8
3 – Urgent	%	33	28	35	22	34	36	24	27	30
4 – Semi-urgent	%	45	48	48	45	48	47	42	53	46
5 – Non-urgent	%	14	16	10	26	6	7	25	13	15
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	72	81	61	100	66	80	94	92	75
Hospitals reporting emergency department episode-level data	no.	53	37	20	81	12	3	2	5	213
2004-05										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	100	98	99	96	100	100	100
2 – Emergency	%	75	86	71	75	72	76	70	61	76
3 – Urgent	%	60	81	54	67	58	67	50	61	64
4 – Semi-urgent	%	66	73	57	65	62	64	52	55	65
5 – Non-urgent	%	87	89	85	91	89	91	83	86	88
Total	%	**68**	**79**	**59**	**70**	**63**	**68**	**58**	**62**	**69**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	82	90	72	66	77	85	70	57	79
2 – Emergency	%	67	73	58	47	57	64	43	62	63

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	NSW	Vic	Qld	WA	SA (a)	Tas (b)	ACT	NT	Aust
3 – Urgent	%	46	53	34	33	39	41	37	42	43
4 – Semi-urgent	%	19	22	11	12	13	14	12	14	17
5 – Non-urgent	%	6	5	3	2	6	3	2	6	5
Total	%	**30**	**33**	**22**	**21**	**28**	**26**	**21**	**24**	**28**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	8	10	11	7	8	6	8
3 – Urgent	%	33	28	35	29	35	33	29	27	32
4 – Semi-urgent	%	44	48	48	49	48	51	47	52	47
5 – Non-urgent	%	14	15	9	11	5	7	16	14	12
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	76	88	64	68	68	84	100	100	76
Hospitals reporting emergency department episode-level data	no.	57	38	21	13	8	4	2	5	148
2005-06										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	100	98	99	95	100	100	99
2 – Emergency	%	81	83	66	77	69	68	71	59	77
3 – Urgent	%	61	79	55	69	56	57	44	59	64
4 – Semi-urgent	%	66	71	58	67	62	59	47	53	65
5 – Non-urgent	%	87	89	86	90	85	89	84	87	87
Total	%	**69**	**77**	**60**	**71**	**62**	**62**	**52**	**60**	**69**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	82	91	73	68	75	84	81	52	80
2 – Emergency	%	66	74	57	51	59	61	57	67	64
3 – Urgent	%	44	53	33	37	40	40	43	44	43
4 – Semi-urgent	%	18	22	10	13	13	13	13	16	17
5 – Non-urgent	%	5	5	3	5	6	3	3	6	5
Total	%	**30**	**32**	**22**	**23**	**28**	**26**	**25**	**25**	**28**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	8	10	11	8	6	6	8
3 – Urgent	%	33	29	36	28	34	34	32	27	32
4 – Semi-urgent	%	44	48	47	50	48	49	49	51	47
5 – Non-urgent	%	14	15	9	11	5	7	12	15	12
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	81	89	65	68	68	86	100	100	78
Hospitals reporting emergency department episode-level data	no.	62	38	21	14	8	3	2	5	153
2006-07										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	98	98	99	96	100	100	99
2 – Emergency	%	87	82	67	71	72	72	77	56	78
3 – Urgent	%	71	73	57	59	56	62	47	54	65
4 – Semi-urgent	%	74	67	60	61	63	61	49	48	66
5 – Non-urgent	%	89	88	87	87	87	87	81	87	88
Total	%	**76**	**74**	**61**	**64**	**63**	**64**	**54**	**55**	**70**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	81	92	71	67	71	82	73	70	79
2 – Emergency	%	64	74	56	46	58	57	58	64	62
3 – Urgent	%	43	53	31	33	40	38	42	43	42
4 – Semi-urgent	%	18	22	10	11	13	13	14	14	16
5 – Non-urgent	%	5	5	3	4	6	3	4	7	5
Total	%	**28**	**33**	**22**	**21**	**32**	**25**	**25**	**25**	**27**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	9	10	12	8	7	6	8
3 – Urgent	%	32	29	37	29	36	34	33	29	32
4 – Semi-urgent	%	45	48	46	51	47	50	48	52	47
5 – Non-urgent	%	15	15	8	9	4	7	11	12	12
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	81	89	64	72	69	96	100	100	78
Hospitals reporting emergency department episode-level data	no.	71	38	21	16	8	3	2	5	164
2007-08										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	98	99	100	99	100	100	100
2 – Emergency	%	81	79	69	69	72	74	81	59	76

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
3 – Urgent	%	69	71	56	56	54	54	52	47	63
4 – Semi-urgent	%	75	65	61	59	60	58	51	47	66
5 – Non-urgent	%	90	86	87	86	80	86	78	86	87
Total	%	**76**	**71**	**63**	**61**	**61**	**60**	**58**	**52**	**69**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	80	92	71	65	73	84	73	67	78
2 – Emergency	%	61	75	55	45	60	58	60	64	61
3 – Urgent	%	40	53	32	33	42	38	42	42	41
4 – Semi-urgent	%	16	21	10	11	14	13	13	13	16
5 – Non-urgent	%	5	4	3	4	6	5	3	5	4
Total	%	**26**	**33**	**22**	**20**	**29**	**25**	**25**	**24**	**27**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	8	9	10	11	8	8	6	9
3 – Urgent	%	31	30	37	29	35	35	32	30	32
4 – Semi-urgent	%	45	47	44	52	46	50	45	53	46
5 – Non-urgent	%	15	14	9	8	6	7	14	10	12
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	81	89	64	72	67	88	100	100	78
Hospitals reporting emergency department episode-level data	no.	71	38	22	16	8	3	2	5	165
2008-09										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	99	99	100	99	100	100	100
2 – Emergency	%	80	82	72	69	75	76	86	62	77
3 – Urgent	%	68	74	59	53	59	54	53	48	64
4 – Semi-urgent	%	73	68	65	62	62	61	53	49	67
5 – Non-urgent	%	90	86	88	89	83	87	78	89	88
Total	%	**75**	**73**	**66**	**62**	**64**	**62**	**60**	**54**	**70**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	81	92	69	67	78	82	77	72	79
2 – Emergency	%	62	74	53	48	58	58	63	61	61
3 – Urgent	%	41	52	30	34	42	38	44	43	40
4 – Semi-urgent	%	17	21	10	12	15	13	15	14	16
5 – Non-urgent	%	5	4	3	4	5	5	3	4	5
Total	%	**26**	**33**	**22**	**22**	**30**	**25**	**27**	**25**	**27**
Proportion of occasions of service (d)										

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
1 – Resuscitation	%	1	1	1	1	1	1	1	1	1
2 – Emergency	%	8	9	10	11	12	7	9	7	9
3 – Urgent	%	31	30	39	30	35	34	31	30	32
4 – Semi-urgent	%	44	47	43	51	44	50	44	53	46
5 – Non-urgent	%	16	13	8	8	8	8	15	10	12
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	83	88	72	72	67	89	100	100	80
Hospitals reporting emergency department episode-level data	no.	85	38	26	16	8	4	2	5	184
2009-10										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	99	99	100	99	100	100	100
2 – Emergency	%	82	80	77	71	78	71	83	63	78
3 – Urgent	%	70	71	60	55	63	52	57	49	65
4 – Semi-urgent	%	73	67	66	64	63	63	56	51	68
5 – Non-urgent	%	89	85	89	92	85	88	77	91	88
Total	%	**75**	**72**	**66**	**64**	**67**	**63**	**62**	**56**	**70**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	81	90	69	68	78	79	72	72	78
2 – Emergency	%	62	73	54	49	59	54	55	61	61
3 – Urgent	%	41	51	32	35	41	32	38	44	40
4 – Semi-urgent	%	17	21	10	11	16	10	13	14	16
5 – Non-urgent	%	5	4	3	4	7	4	3	6	5
Total	%	**27**	**33**	**23**	**23**	**30**	**21**	**24**	**26**	**27**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	1	0	1	1
2 – Emergency	%	8	9	10	11	12	8	9	7	9
3 – Urgent	%	30	31	40	31	36	35	31	28	33
4 – Semi-urgent	%	45	47	42	50	44	46	46	53	45
5 – Non-urgent	%	16	13	7	7	7	11	13	10	12
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	83	90	72	73	67	89	100	100	81

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
Hospitals reporting emergency department episode-level data	no.	84	39	26	16	8	4	2	5	184
2010-11										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	100	99	100	100	100	100	100
2 – Emergency	%	83	81	78	71	78	72	78	65	79
3 – Urgent	%	71	70	60	50	66	55	48	53	65
4 – Semi-urgent	%	73	65	67	65	70	63	48	54	68
5 – Non-urgent	%	88	86	90	92	88	83	75	90	88
Total	%	**76**	**71**	**67**	**63**	**71**	**62**	**55**	**58**	**70**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	81	87	67	72	76	77	75	76	77
2 – Emergency	%	62	69	52	54	58	53	54	62	60
3 – Urgent	%	41	49	32	38	40	32	37	46	40
4 – Semi-urgent	%	18	21	10	13	16	11	14	15	16
5 – Non-urgent	%	6	5	3	4	8	4	4	5	5
Total	%	**27**	**33**	**24**	**26**	**30**	**21**	**24**	**26**	**28**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	1	1	1	1	0	0	1	1
2 – Emergency	%	9	9	11	11	13	7	10	6	10
3 – Urgent	%	30	32	41	32	37	35	31	26	33
4 – Semi-urgent	%	45	47	41	49	42	48	46	56	45
5 – Non-urgent	%	15	11	6	7	7	9	13	10	11
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	83	90	72	74	68	93	100	100	81
Hospitals reporting emergency department episode-level data	no.	86	39	26	16	8	4	2	5	186
2011-12										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	100	99	100	100	100	100	100
2 – Emergency	%	82	83	82	76	79	77	76	64	80
3 – Urgent	%	71	72	63	52	70	64	50	49	66
4 – Semi-urgent	%	74	67	69	67	77	71	47	49	70
5 – Non-urgent	%	89	87	90	94	92	88	81	89	89
Total	%	**76**	**72**	**69**	**65**	**76**	**71**	**55**	**54**	**72**

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	88	93	69	69	78	83	77	71	80
2 – Emergency	%	64	75	50	53	59	51	56	58	61
3 – Urgent	%	42	54	30	36	40	33	38	44	41
4 – Semi-urgent	%	18	23	9	13	15	11	15	16	17
5 – Non-urgent	%	6	6	3	4	6	4	3	5	5
Total	%	**29**	**36**	**23**	**25**	**29**	**21**	**26**	**26**	**29**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	0	1	1	1	1	0	1	1
2 – Emergency	%	9	9	11	11	12	8	11	7	10
3 – Urgent	%	32	33	42	32	36	34	33	29	34
4 – Semi-urgent	%	44	48	40	48	43	48	44	54	45
5 – Non-urgent	%	14	10	6	7	7	10	11	9	10
Total	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	88	91	72	78	80	92	100	100	84
Hospitals reporting emergency department episode-level data	no.	95	40	26	17	14	4	2	5	203
2012-13										
Proportion of patients seen on time (c) (d)										
1 – Resuscitation	%	100	100	100	100	100	100	100	100	100
2 – Emergency	%	83	84	84	81	75	83	74	66	82
3 – Urgent	%	73	72	68	52	66	65	43	52	68
4 – Semi-urgent	%	77	68	74	67	78	70	46	52	72
5 – Non-urgent	%	92	87	92	93	92	90	79	89	91
Total	%	**78**	**73**	**74**	**66**	**75**	**71**	**51**	**57**	**73**
Estimated proportion of occasions of service ending in admission (d) (e)										
1 – Resuscitation	%	80	74	72	69	79	80	81	72	76
2 – Emergency	%	63	58	52	50	59	52	56	57	58
3 – Urgent	%	42	41	32	35	41	33	36	44	38
4 – Semi-urgent	%	18	17	10	13	15	11	16	16	15
5 – Non-urgent	%	6	4	3	4	6	4	4	5	5
Total	**%**	**29**	**28**	**25**	**24**	**30**	**21**	**26**	**26**	**27**
Proportion of occasions of service (d)										
1 – Resuscitation	%	1	0	1	1	1	1	0	1	1
2 – Emergency	%	11	10	12	12	13	8	11	9	11
3 – Urgent	%	32	34	42	33	36	35	34	28	35

Table 10A.17 **Emergency department waiting times, by triage category, public hospitals**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA* (a)	*Tas* (b)	*ACT*	*NT*	*Aust*
4 – Semi-urgent	%	44	47	40	47	42	48	45	53	44
5 – Non-urgent	%	12	9	5	7	7	9	10	9	9
Total	**%**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Data coverage										
Estimated proportion of presentations with episode-level data (f)	%	na	na	na	na	na	na	na	na	na
Hospitals reporting emergency department episode-level data	no.	95	40	27	17	14	4	2	5	204

(a) The estimated proportion of occasions of service ending in admission in SA excludes data for large hospitals. Includes records for which the Type of visit was reported as Emergency presentation or was not reported

(b) Includes data for the Mersey Community Hospital.

(c) The proportion of occasions of service for which the waiting time to service delivery was within the time specified in the definition of the triage category. For the triage category Resuscitation, an occasion of service was classified as 'seen on time' if the waiting time to service was reported as less than or equal to 2 minutes.

(d) Values are derived from all hospitals that reported to the non-admitted patient emergency department care database, including all principal referral and specialist women's and children's hospitals, large hospitals and public hospitals that were classified to other peer groups.

(e) The proportion of occasions of service for which the emergency department departure status was reported as 'admitted to this hospital'.

(f) The number of presentations reported to the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) divided by the number of emergency occasions of service reported to the National Public Hospital Establishments Database (NPHED) as a percentage.

Source : AIHW various years, *Australian hospital statistics* , Health Services Series, AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: emergency department care,* Health services series no. 52. Cat. no. HSE 142. Canberra: AIHW, Canberra; AIHW (2012), Australian hospital statistics 2011–12: emergency department care, Health services series no. 45. Cat. no. HSE 126. Canberra: AIHW, (2010), *Australian hospital statistics 2009–10: emergency department care and elective surgery waiting times* . Health services series no. 38. Cat. no. HSE 93. Canberra: AIHW

Table 10A.18 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*	*Aust (total number)*
2010-11											*no.*
Peer group A hospitals											
Triage category 1	*%*	100	100	100	100	100	100	100	100	100	36 426
Triage category 2	*%*	83	81	77	68	77	67	78	65	79	453 165
Triage category 3	*%*	68	68	58	46	63	41	48	50	62	1 455 076
Triage category 4	*%*	70	65	65	63	68	49	48	48	65	1 652 580
Triage category 5	*%*	84	87	89	91	87	76	75	83	85	318 925
Total (d)	***%***	73	70	65	60	69	50	55	52	67	3 916 284
Total number (d), (e)	*no.*	1 172 976	974 641	859 878	356 158	276 139	81 910	100 989	93 593	3 916 284	
Peer group B hospitals											
Triage category 1	*%*	100	100	97	95	100	100	..	..	98	4 133
Triage category 2	*%*	83	78	88	73	80	86	..	..	80	86 771
Triage category 3	*%*	76	74	71	52	76	82	..	..	70	353 537
Triage category 4	*%*	74	64	77	64	79	82	..	..	70	545 735
Triage category 5	*%*	89	82	93	91	97	94	..	..	88	112 954
Total (d)	***%***	77	70	77	63	80	84	..	..	72	1 103 156
Total number (d), (e)	*no.*	341 772	289 132	144 541	238 044	41 977	47 690	..	..	1 103 156	
Total (Peer group A and B hospitals)											
Triage category 1	*%*	100	100	100	99	100	100	100	100	100	40 559
Triage category 2	*%*	83	81	78	70	77	72	78	65	79	539 936
Triage category 3	*%*	70	69	59	49	65	55	48	50	63	1 808 613

Table 10A.18 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 4	%	71	64	67	63	70	63	48	48	66	2 198 315
Triage category 5	%	85	85	90	91	88	83	75	83	86	431 879
Total (d)	**%**	74	70	66	61	71	62	55	52	68	5 019 440
Total number (d), (e)	*no.*	1 514 748	1 263 773	1 004 419	594 202	318 116	129 600	100 989	93 593	5 019 440	
2011-12											
Peer group A hospitals											
Triage category 1	%	100	100	100	100	100	100	100	100	100	35 924
Triage category 2	%	82	82	81	75	77	73	76	62	80	498 947
Triage category 3	%	69	69	62	47	65	54	50	45	64	1 565 049
Triage category 4	%	72	66	68	65	72	61	47	40	67	1 724 027
Triage category 5	%	86	87	90	93	88	86	81	78	87	313 518
Total (d)	**%**	74	71	68	62	71	63	55	46	69	4 137 593
Total number (d), (e)	*no.*	1 253 722	1 003 224	939 721	385 412	266 275	83 890	109 724	95 625	4 137 593	
Peer group B hospitals											
Triage category 1	%	100	100	100	96	100	99	–	–	99	4 200
Triage category 2	%	81	83	89	76	82	89	–	–	81	89 750
Triage category 3	%	74	77	65	54	74	84	–	–	69	355 354
Triage category 4	%	74	67	70	66	75	84	–	–	70	531 070
Triage category 5	%	89	86	91	93	94	94	–	–	89	98 670
Total (d)	**%**	76	73	71	65	77	85	–	–	72	1 079 077
Total number (d), (e)	*no.*	321 640	303 713	110 690	262 245	34 560	46 229	–	–	1 079 077	

Table 10A.18 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Total (Peer group A and B hospitals)											
Triage category 1	*%*	100	100	100	99	100	100	100	100	100	40 124
Triage category 2	*%*	82	82	82	75	78	77	76	62	80	588 697
Triage category 3	*%*	70	71	62	50	66	64	50	45	65	1 920 403
Triage category 4	*%*	72	66	69	65	72	71	47	40	68	2 255 097
Triage category 5	*%*	87	86	90	93	89	88	81	78	88	412 188
Total (d)	***%***	74	71	69	63	72	71	55	46	70	5 216 670
Total number (d), (e)	*no.*	1 575 362	1 306 937	1 050 411	647 657	300 835	130 119	109 724	95 625	5 216 670	
2012-13											
Peer group A hospitals											
Triage category 1		100	100	100	100	100	100	100	100	100	38 227
Triage category 2		83	84	84	80	74	83	74	64	82	539 908
Triage category 3		70	70	68	47	62	58	43	48	66	1 616 513
Triage category 4		74	67	75	62	73	64	46	44	69	1 767 809
Triage category 5		90	87	93	90	88	88	79	80	89	290 798
Total (d)		76	72	74	61	70	66	51	50	71	4 253 397
Total number (d), (e)		1 306 601	1 033 286	949 223	387 085	281 965	88 764	109 697	96 776	4 253 397	
Peer group B hospitals											
Triage category 1		100	100	100	99	100	100	–	–	100	4 372
Triage category 2		84	84	88	80	68	84	–	–	83	108 790

Table 10A.18 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 3	76	77	61	54	59	79	–	–	68	402 604
Triage category 4	78	68	69	70	69	79	–	–	72	546 542
Triage category 5	92	85	89	94	92	95	–	–	90	95 914
Total (d)	79	74	69	67	66	81	–	–	73	1 158 261
Total number (d), (e)	334 494	302 281	166 455	272 314	35 173	47 544	–	–	1 158 261	
Total (Peer group A and B hospitals)										
Triage category 1	100	100	100	100	100	100	100	100	100	42 599
Triage category 2	83	84	84	80	74	83	74	64	82	648 698
Triage category 3	72	71	67	50	61	65	43	48	66	2 019 117
Triage category 4	75	67	74	65	72	70	46	44	70	2 314 351
Triage category 5	91	86	92	92	89	90	79	80	89	386 712
Total (d)	76	72	73	64	70	71	51	50	72	5 411 658
Total number (d), (e)	1 641 095	1 335 567	1 115 678	659 399	317 138	136 308	109 697	96 776	5 411 658	

(a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.

(b) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.

(c) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

(d) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.

(e) The totals include records for which the triage category was not assigned or not reported.

.. Not applicable.

Table 10A.18 **Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*	*Aust (total number)*

Source : AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

Table 10A.19 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (d)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
2010-11											
Total (Peer group A and B hospitals)											
Indigenous											*no.*
Triage category 1	*%*	100	100	100	98	100	100	100	100	100	1 756
Triage category 2	*%*	78	78	82	73	76	69	78	66	76	18 995
Triage category 3	*%*	66	72	66	60	64	52	43	53	62	73 151
Triage category 4	*%*	68	68	70	69	67	62	46	46	64	95 079
Triage category 5	*%*	84	87	91	92	85	84	75	78	86	17 759
Total (e)	***%***	71	72	71	68	69	61	52	52	67	206 745
Total number (e), (f)	*no.*	48 288	15 779	56 129	32 709	9 458	5 022	2 484	36 876	206 745	
Other Australians											
Triage category 1	*%*	100	100	100	99	100	100	100	100	100	38 803
Triage category 2	*%*	83	81	78	70	77	72	78	64	79	520 941
Triage category 3	*%*	70	69	59	48	65	55	48	48	63	1 735 462
Triage category 4	*%*	71	64	66	63	70	63	48	49	66	2 103 236
Triage category 5	*%*	85	85	90	91	88	83	75	86	86	414 120
Total (e)	***%***	74	70	66	61	71	62	55	52	69	4 812 695
Total number (e), (f)	no.	1 466 460	1 247 994	948 290	561 493	308 658	124 578	98 505	56 717	4 812 695	

Table 10A.19 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (d)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
2011-12											
Total (Peer group A and B hospitals)											
Indigenous											
Triage category 1	*%*	100	100	100	98	100	100	n.p.	100	100	1 816
Triage category 2	*%*	81	77	83	76	78	81	74	63	78	22 148
Triage category 3	*%*	67	74	67	58	65	62	49	50	63	82 090
Triage category 4	*%*	70	70	70	70	69	70	47	43	65	100 151
Triage category 5	*%*	86	89	88	93	88	87	80	76	87	17 267
Total (e)	***%***	72	74	71	69	71	70	54	49	67	223 473
Total number (e), (f)	*no.*	53 731	17 161	62 162	35 140	9 361	5 543	2 592	37 783	223 473	
Other Australians											
Triage category 1	*%*	100	100	100	99	100	100	100	100	100	38 308
Triage category 2	*%*	82	83	82	75	78	77	76	62	81	566 549
Triage category 3	*%*	70	71	62	49	66	64	50	41	65	1 838 313
Triage category 4	*%*	72	66	69	65	73	71	47	39	68	2 154 946
Triage category 5	*%*	87	86	90	93	89	89	81	80	88	394 921
Total (e)	***%***	74	71	68	63	72	71	55	44	70	4 993 197
Total number (e), (f)	*no.*	1 521 631	1 289 776	988 249	612 517	291 474	124 576	107 132	57 842	4 993 197	
2012-13											
Total (Peer group A and B hospitals)											
Indigenous											

Table 10A.19 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (d)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 1	%	100	100	100	100	100	100	n.p.	100	100	2 070
Triage category 2	%	81	81	85	83	72	84	73	65	80	25 846
Triage category 3	%	70	72	72	61	61	63	41	53	66	88 735
Triage category 4	%	74	70	74	73	68	69	44	45	68	105 092
Triage category 5	%	89	88	90	92	86	90	73	77	88	17 570
Total (e)	**%**	**75**	**73**	**76**	**72**	**67**	**70**	**49**	**52**	**70**	**239 319**
Total number (e), (f)	no.	61 385	18 291	68 010	35 056	10 012	6 114	2 697	37 754	239 319	
Other Australians											
Triage category 1	%	100	100	100	100	100	100	100	100	100	40 529
Triage category 2	%	83	84	84	80	74	83	74	64	82	622 852
Triage category 3	%	72	71	67	49	61	65	43	44	66	1 930 382
Triage category 4	%	75	67	74	65	72	70	46	43	70	2 209 259
Triage category 5	%	91	86	92	92	89	90	79	82	89	369 142
Total (e)	**%**	**76**	**72**	**73**	**63**	**70**	**71**	**51**	**48**	**72**	**5 172 339**
Total number (e), (f)	no.	1 579 710	1 317 276	1 047 668	624 343	307 126	130 194	107 000	59 022	5 172 339	

(a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.

(b) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.

(c) The quality of the identification of Indigenous patients in National Non-admitted Patient Emergency Department Care Database has not been assessed. Identification of Indigenous patients is not considered to be complete, and completeness may vary among the states and territories.

(d) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

Table 10A.19 **Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (d)*	*ACT*	*NT*	*Aust*	*Aust (total number)*

(e) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.

(f) The totals include records for which the triage category was not assigned or not reported.

Source : AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
2010-11											
Total (Peer group A and B hospitals)											
Major cities											*no.*
Triage category 1	*%*	100	100	100	100	100	100	99	100	100	28 183
Triage category 2	*%*	85	82	76	70	77	75	77	65	79	394 923
Triage category 3	*%*	71	68	55	43	64	52	48	49	63	1 253 345
Triage category 4	*%*	72	62	65	59	69	60	48	50	65	1 446 773
Triage category 5	*%*	85	83	89	89	88	84	75	85	85	277 763
Total (f)	***%***	75	68	63	57	70	62	55	53	68	3 401 080
Total number (f), (g), (h)	*no.*	1 123 089	879 272	606 274	405 232	289 040	2 106	93 140	2 927	3 401 080	
Inner regional											
Triage category 1	*%*	100	100	99	96	100	100	100	100	99	6 930
Triage category 2	*%*	78	79	83	63	77	69	81	64	77	94 766
Triage category 3	*%*	66	72	66	49	65	46	48	50	65	364 134
Triage category 4	*%*	68	69	70	63	72	54	50	48	67	502 391
Triage category 5	*%*	85	89	90	92	89	79	80	90	87	110 213
Total (f)	***%***	71	73	71	61	72	55	57	53	69	1 078 473
Total number (f), (g), (h)	*no.*	332 026	319 572	230 655	94 289	16 934	77 781	5 871	1 345	1 078 473	
Outer regional											
Triage category 1	*%*	100	100	100	93	100	99	100	100	99	3 366
Triage category 2	*%*	78	73	84	80	78	78	84	61	79	36 492

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 3	%	65	75	65	79	66	69	49	42	67	135 753
Triage category 4	%	66	71	65	83	73	76	47	47	68	176 138
Triage category 5	%	84	90	89	96	89	91	75	81	90	28 208
Total (f)	**%**	70	75	68	83	72	75	57	48	71	379 960
Total number (f), (g), (h)	*no.*	36 254	53 100	116 708	73 002	7 485	46 829	1 592	44 990	379 960	
Remote											
Triage category 1	%	100	100	100	100	100	100	–	100	100	462
Triage category 2	%	75	74	92	76	79	75	np	70	78	5 205
Triage category 3	%	64	71	84	69	68	69	50	56	70	24 946
Triage category 4	%	70	70	83	75	74	68	57	52	69	32 569
Triage category 5	%	86	94	92	94	88	89	73	86	91	6 273
Total (f)	**%**	70	74	85	74	74	71	56	57	72	69 455
Total number (f), (g), (h)	*no.*	3 339	1 072	29 548	6 188	1 983	1 075	54	26 196	69 455	
Very remote											
Triage category 1	%	np	–	100	100	100	np	–	100	100	311
Triage category 2	%	72	92	86	73	73	73	np	67	72	2 496
Triage category 3	%	72	78	71	63	63	63	np	56	61	10 440
Triage category 4	%	65	71	74	73	71	61	55	47	56	12 331
Triage category 5	%	96	95	93	93	86	79	np	82	88	1 547
Total (f)	**%**	72	78	76	72	71	64	44	54	62	27 125
Total number (f), (g), (h)	*no.*	377	139	5 169	3 469	928	278	18	16 747	27 125	

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
2011-12											
Total (Peer group A and B hospitals)											
Major cities											
Triage category 1	*%*	100	100	100	100	100	100	100	100	100	27 327
Triage category 2	*%*	83	83	81	75	78	78	76	59	81	426 000
Triage category 3	*%*	70	70	59	44	65	65	49	44	64	1 327 802
Triage category 4	*%*	73	64	67	61	72	71	47	38	67	1 487 047
Triage category 5	*%*	87	84	90	91	89	89	81	86	87	263 221
Total (f)	***%***	74	70	66	59	72	73	55	45	69	3 531 540
Total number (f), (g), (h)	*no.*	1 173 784	904 482	628 280	446 191	272 792	1 955	101 278	2 778	3 531 540	
Inner regional											
Triage category 1	*%*	100	100	100	95	100	100	100	np	100	7 070
Triage category 2	*%*	81	82	83	71	78	75	78	61	80	103 608
Triage category 3	*%*	69	73	66	54	67	58	51	46	67	381 954
Triage category 4	*%*	71	70	70	68	76	65	48	40	70	510 172
Triage category 5	*%*	87	89	90	94	92	87	81	79	88	104 868
Total (f)	***%***	74	74	71	66	74	66	57	46	72	1 107 684
Total number (f), (g), (h)	*no.*	339 496	324 064	240 162	100 100	16 554	79 543	6 426	1 339	1 107 684	
Outer regional											
Triage category 1	*%*	100	100	100	97	100	99	100	100	100	3 583

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 2	%	79	81	84	80	81	81	80	59	79	43 286
Triage category 3	%	68	77	68	76	70	74	51	31	68	150 297
Triage category 4	%	70	75	71	81	79	79	47	31	69	183 028
Triage category 5	%	87	92	90	95	91	92	83	68	91	30 067
Total (f)	**%**	72	79	73	81	77	79	57	36	72	410 261
Total number (f), (g), (h)	*no.*	37 728	67 017	127 871	77 337	7 096	45 841	1 641	45 730	410 261	
Remote											
Triage category 1	%	100	np	100	97	100	100	–	100	100	477
Triage category 2	%	80	84	93	78	79	90	np	70	82	6 066
Triage category 3	%	62	79	81	64	73	75	57	59	70	27 180
Triage category 4	%	68	75	72	74	79	81	45	55	65	33 692
Triage category 5	%	87	90	87	95	95	88	64	89	88	4 907
Total (f)	**%**	69	80	78	73	78	80	52	59	70	72 322
Total number (f), (g), (h)	*no.*	3 475	1 321	30 872	6 905	1 786	1 036	61	26 866	72 322	
Very remote											
Triage category 1	%	np	np	100	100	100	np	np	100	100	274
Triage category 2	%	79	82	84	77	80	68	np	65	72	2 903
Triage category 3	%	66	77	72	62	73	66	np	54	60	11 520
Triage category 4	%	70	67	73	73	77	88	np	46	56	12 561
Triage category 5	%	82	95	92	94	91	100	np	77	86	1 520
Total (f)	**%**	71	75	76	72	77	78	50	53	61	28 778

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
Total number (f), (g), (h)	*no.*	439	154	5 440	4 068	823	233	16	17 605	28 778	
2012-13											
Total (Peer group A and B hospitals)											
Major cities											
Triage category 1	**%**	100	100	100	100	100	100	99	100	100	29 730
Triage category 2	**%**	83	84	83	79	74	82	73	60	81	474 727
Triage category 3	**%**	71	71	63	42	61	64	43	45	64	1 422 362
Triage category 4	**%**	75	66	72	59	72	71	46	42	69	1 561 853
Triage category 5	**%**	91	85	92	90	89	92	78	84	89	249 075
Total (f)	**%**	**76**	**71**	**70**	**58**	**69**	**73**	**51**	**48**	**70**	**3 737 883**
Total number (f), (g), (h)	no.	1 230 281	934 209	686 307	492 991	287 501	2 201	101 601	2 792	3 737 883	
Inner regional											
Triage category 1	**%**	100	100	100	100	100	100	100	np	100	6 785
Triage category 2	**%**	83	83	86	86	74	83	75	62	84	105 335
Triage category 3	**%**	73	73	75	66	63	59	44	44	72	369 623
Triage category 4	**%**	75	70	78	74	75	66	48	44	73	471 443
Triage category 5	**%**	90	88	92	94	92	88	83	86	90	90 144
Total (f)	%	**77**	**74**	**78**	**74**	**71**	**67**	**54**	**49**	**75**	**1 043 361**
Total number (f), (g), (h)	no.	327 436	320 113	235 634	51 921	17 289	83 505	6 191	1 272	1 043 361	
Outer regional											

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 1	**%**	100	100	100	100	100	100	100	100	100	3 784
Triage category 2	**%**	82	81	87	91	76	82	79	62	82	49 813
Triage category 3	**%**	73	76	73	86	67	74	42	36	72	162 743
Triage category 4	**%**	76	76	75	93	75	76	48	37	74	198 814
Triage category 5	**%**	91	93	94	99	92	92	74	70	93	32 643
Total (f)	**%**	**78**	**78**	**77**	**91**	**73**	**77**	**54**	**41**	**76**	**447 807**
Total number (f), (g), (h)	no.	56 906	69 730	137 615	80 268	7 468	46 987	1 452	47 381	447 807	
Remote											
Triage category 1	**%**	100	np	100	98	100	100	–	100	100	435
Triage category 2	**%**	80	85	90	81	78	88	np	71	80	5 639
Triage category 3	**%**	68	78	79	65	70	78	56	61	69	21 900
Triage category 4	**%**	79	73	67	76	79	74	35	57	64	27 772
Triage category 5	**%**	90	94	86	95	93	93	np	90	90	3 887
Total (f)	**%**	**76**	**78**	**75**	**74**	**77**	**78**	**52**	**61**	**69**	**59 634**
Total number (f), (g), (h)	no.	3 157	1 340	19 800	6 358	1 699	1 213	44	26 023	59 634	
Very remote											
Triage category 1	**%**	np	np	100	100	100	np	–	100	100	389
Triage category 2	**%**	81	80	91	86	75	80	np	67	78	4 003
Triage category 3	**%**	68	75	81	74	67	76	np	56	68	14 943
Triage category 4	**%**	74	70	68	85	82	66	np	47	61	18 552
Triage category 5	**%**	91	95	86	95	84	80	np	77	85	2 498

Table 10A.20 **Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory (a), (b), (c), (d)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT*	*NT*	*Aust*	*Aust (total number)*
Total (f)	**%**	**75**	**75**	**76**	**83**	**75**	**73**	**63**	**54**	**67**	**40 385**
Total number (f), (g), (h)	no.	819	216	15 314	5 084	793	200	16	17 943	40 385	

(a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.

(b) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.

(c) Area of usual residence was not reported or not mappable to remoteness areas for approximately 80 000 records.

(d) Remoteness areas are based on the usual residential address of the patient. Not all remoteness areas are represented in each State or Territory. The remoteness area 'Major city' does not exist within Tasmania or the NT, 'Inner regional' does not exist within the NT, 'Outer regional' does not exist in the ACT, 'Remote' does not exist in the ACT and 'Very remote' does not exist in Victoria or the ACT. However, data are reported for the state/territory where the hospital was located. This means, for example, that although there is no ‘major city’ classification in Tasmania, Tasmanian hospitals may treat some patients whose usual residence is a major city in another jurisdiction.

(e) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

(f) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.

(g) The totals include records for which the triage category was not assigned or not reported.

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

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

Source: AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*	*Aust (total number)*
2010-11											
Total (Peer group A and B hospitals)											*no.*
Quintile 1											
Triage category 1	**%**	100	100	99	96	100	100	100	100	100	9 349
Triage category 2	**%**	83	78	80	84	79	74	81	65	80	113 956
Triage category 3	**%**	70	67	60	81	61	60	48	51	65	405 639
Triage category 4	**%**	70	61	65	84	64	67	47	46	66	458 109
Triage category 5	**%**	85	84	88	96	86	86	75	81	86	88 369
Total (f)	**%**	**73**	**67**	**66**	**84**	**67**	**66**	**57**	**51**	**69**	1 075 442
Total number (f), (g), (h)	*no.*	316 203	225 603	272 034	41 219	107 740	82 010	1 358	29 275	1 075 442	
Quintile 2											
Triage category 1	**%**	100	100	100	99	100	100	100	100	100	7 954
Triage category 2	**%**	79	82	80	71	77	69	82	63	78	110 475
Triage category 3	**%**	66	75	65	46	66	58	52	50	65	368 031
Triage category 4	**%**	67	69	71	59	71	67	52	47	67	467 575
Triage category 5	**%**	83	87	90	89	90	87	81	85	85	115 825
Total (f)	**%**	**71**	**74**	**71**	**58**	**71**	**66**	**60**	**51**	**70**	1 069 911
Total number (f), (g), (h)	*no.*	445 116	233 443	172 406	121 030	72 148	13 797	4 595	7 376	1 069 911	
Quintile 3											
Triage category 1		100	100	100	98	100	100	100	100	99	8 100
Triage category 2		83	81	78	70	76	68	76	68	78	113 383

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 3		69	71	60	47	65	44	53	54	63	391 949
Triage category 4		71	65	67	63	70	52	51	51	66	525 335
Triage category 5		86	85	90	91	88	78	78	86	87	89 561
Total (f)		**73**	**70**	**66**	**61**	**71**	**53**	**58**	**55**	**68**	1 128 354
Total number (f), (g), (h)		282 092	335 353	198 759	210 377	44 476	19 912	5 460	31 925	1 128 354	
Quintile 4											
Triage category 1		100	100	100	99	100	100	99	100	100	7 686
Triage category 2		83	81	75	69	78	73	77	60	78	107 432
Triage category 3		68	67	55	47	68	35	47	43	60	345 739
Triage category 4		70	63	64	61	74	40	46	47	64	389 607
Triage category 5		84	84	90	91	91	75	74	81	85	65 696
Total (f)		**72**	**68**	**63**	**59**	**73**	**47**	**53**	**49**	**66**	916 182
Total number (f), (g), (h)		200 410	263 773	219 051	115 755	55 678	11 645	32 449	17 421	916 182	
Quintile 5											
Triage category 1		100	100	100	100	100	100	100	100	100	6 182
Triage category 2		91	83	79	67	75	75	78	59	81	88 770
Triage category 3		77	68	60	43	66	47	48	42	65	277 584
Triage category 4		79	63	68	61	77	61	48	46	68	329 879
Triage category 5		90	84	93	92	90	87	76	81	87	64 554
Total (f)		**81**	**69**	**68**	**57**	**73**	**62**	**55**	**48**	**70**	766 985
Total number (f), (g), (h)		251 252	194 979	126 098	95 110	36 324	704	56 320	6 198	766 985	

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*	*Aust (total number)*
2011-12											
Total (Peer group A and B hospitals)											
Quintile 1											
Triage category 1	**%**	100	100	100	97	100	100	100	100	100	9 470
Triage category 2	**%**	82	80	82	81	79	78	74	63	81	127 348
Triage category 3	**%**	69	69	61	77	61	67	51	48	66	435 268
Triage category 4	**%**	71	65	66	82	67	73	48	40	68	473 740
Triage category 5	**%**	87	87	88	96	87	90	76	75	88	93 801
Total (f)	**%**	**73**	**70**	**67**	**81**	**68**	**73**	**56**	**47**	**70**	**1 139 640**
Total number (f), (g), (h)	*no.*	389 477	236 612	276 336	44 429	80 340	81 375	2 341	28 730	1 139 640	
Quintile 2											
Triage category 1	**%**	100	100	100	95	100	97	100	100	100	8 494
Triage category 2	**%**	81	81	82	71	78	72	80	63	80	123 149
Triage category 3	**%**	67	74	64	55	66	65	52	46	67	400 215
Triage category 4	**%**	70	69	69	68	72	73	48	41	69	496 351
Triage category 5	**%**	85	87	89	94	90	90	83	83	87	104 751
Total (f)	**%**	**72**	**73**	**69**	**67**	**72**	**71**	**58**	**47**	**71**	**1 132 992**
Total number (f), (g), (h)	*no.*	436 117	302 859	177 427	91 095	97 018	15 796	3 542	9 138	1 132 992	
Quintile 3											
Triage category 1	**%**	100	100	100	100	100	100	100	100	100	7 808

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 2	*%*	83	82	83	77	79	73	76	67	81	123 312
Triage category 3	*%*	72	71	64	47	71	54	50	54	64	406 582
Triage category 4	*%*	73	64	71	62	74	62	47	50	67	512 527
Triage category 5	*%*	87	85	91	91	88	86	81	87	88	80 461
Total (f)	*%*	**75**	**70**	**70**	**61**	**75**	**63**	**56**	**54**	**69**	**1 130 726**
Total number (f), (g), (h)	*no.*	311 312	260 021	240 178	240 481	30 253	18 656	2 493	27 332	1 130 726	
Quintile 4											
Triage category 1	*%*	100	100	100	99	100	100	100	100	100	7 013
Triage category 2	*%*	84	84	80	75	78	88	75	59	81	110 537
Triage category 3	*%*	71	69	58	46	68	57	51	32	62	360 456
Triage category 4	*%*	73	65	67	64	76	63	47	33	66	396 981
Triage category 5	*%*	88	86	90	93	91	86	80	71	88	62 232
Total (f)	*%*	**75**	**70**	**66**	**61**	**74**	**67**	**55**	**37**	**68**	**937 248**
Total number (f), (g), (h)	*no.*	161 357	313 800	208 897	141 563	57 854	12 122	27 379	14 276	937 248	
Quintile 5											
Triage category 1	*%*	100	100	100	100	100	np	100	100	100	5 943
Triage category 2	*%*	82	85	82	73	76	86	76	58	80	97 474
Triage category 3	*%*	72	72	64	44	69	68	49	31	64	296 107
Triage category 4	*%*	76	66	72	64	79	69	48	31	68	346 779
Triage category 5	*%*	89	87	93	93	93	91	81	66	88	63 317
Total (f)	*%*	**77**	**72**	**71**	**60**	**76**	**74**	**55**	**36**	**70**	**809 665**

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Total number (f), (g), (h)	*no.*	256 640	183 744	129 781	117 033	33 586	654	73 390	14 837	809 665	
2012-13											
Total (Peer group A and B hospitals)											
Quintile 1											
Triage category 1	**%**	100	100	100	100	100	100	100	100	100	9 977
Triage category 2	**%**	82	83	84	81	76	83	72	66	82	147 711
Triage category 3	**%**	70	70	70	53	58	67	42	52	68	481 904
Triage category 4	**%**	73	67	73	66	67	71	45	45	70	543 959
Triage category 5	**%**	90	85	90	92	86	90	77	77	88	93 805
Total (f)	**%**	**75**	**72**	**74**	**65**	**67**	**72**	**52**	**52**	**72**	**1 277 384**
Total number (f), (g), (h)	*no.*	410 259	268 828	324 123	88 870	85 100	73 748	1 851	24 605	1 277 384	
Quintile 2											
Triage category 1	**%**	100	100	100	100	100	100	100	100	100	9 040
Triage category 2	**%**	83	82	85	83	74	83	76	62	82	132 908
Triage category 3	**%**	72	74	66	59	62	66	47	46	68	415 685
Triage category 4	**%**	76	68	73	70	72	70	49	43	71	471 934
Triage category 5	**%**	90	88	92	93	89	89	78	80	90	81 755
Total (f)	**%**	**77**	**73**	**73**	**69**	**70**	**72**	**55**	**48**	**73**	**1 111 356**
Total number (f), (g), (h)	*no.*	346 824	298 385	196 355	132 092	98 325	20 738	3 864	14 773	1 111 356	
Quintile 3											
Triage category 1	**%**	100	100	100	100	100	100	100	100	100	8 034

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust*	*Aust (total number)*
Triage category 2	**%**	82	84	84	79	74	79	72	68	82	130 148
Triage category 3	**%**	70	71	64	49	63	61	40	56	65	403 516
Triage category 4	**%**	74	66	74	67	74	67	45	53	70	466 938
Triage category 5	**%**	90	86	92	93	90	90	80	89	89	74 837
Total (f)	**%**	**75**	**72**	**72**	**64**	**71**	**68**	**50**	**58**	**71**	**1 083 518**
Total number (f), (g), (h)	*no.*	309 124	288 427	229 339	160 116	40 521	22 509	7 507	25 975	1 083 518	
Quintile 4											
Triage category 1	**%**	100	100	100	100	100	100	99	100	100	7 533
Triage category 2	**%**	85	85	84	80	72	88	73	62	82	121 929
Triage category 3	**%**	73	71	65	47	62	57	43	36	65	378 667
Triage category 4	**%**	77	67	73	63	76	66	46	37	69	427 242
Triage category 5	**%**	92	86	93	91	92	88	77	69	89	65 763
Total (f)	**%**	**78**	**72**	**72**	**61**	**71**	**68**	**51**	**42**	**71**	**1 001 157**
Total number (f), (g), (h)	*no.*	229 217	300 823	216 864	118 868	65 761	15 159	34 556	19 909	1 001 157	
Quintile 5											
Triage category 1	**%**	100	100	100	99	100	100	100	100	100	6 282
Triage category 2	**%**	83	84	85	79	72	88	74	63	82	102 841
Triage category 3	**%**	73	71	70	43	65	63	43	36	65	300 295
Triage category 4	**%**	77	68	77	60	78	71	46	37	69	354 998
Triage category 5	**%**	92	87	95	89	94	90	79	71	90	59 749
Total (f)	**%**	**78**	**73**	**76**	**58**	**73**	**73**	**52**	**41**	**71**	**824 210**
Total number (f), (g), (h)	*no.*	292 938	169 071	127 696	136 471	24 995	1 951	60 942	10 146	824 210	

Table 10A.21 **Patients treated within national benchmarks for emergency department waiting time, by State and Territory, by SEIFA IRSD quintiles (a), (b), (c), (d)**

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

(a) The proportion of presentations for which the waiting time to commencement of clinical care was within the time specified in the definition of the triage category. Records were excluded from the calculation of waiting time statistics if the triage category was unknown, if the patient did not wait or was dead on arrival, or if the waiting time was missing or otherwise invalid.

(b) SEIFA quintiles are based on the SEIFA IRSD, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. The SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by SEIFA is based on the patient's usual residence, not the location of the hospital.

(c) It should be noted that the data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Peer group A and B hospitals provided over 80 per cent of Emergency Department services.

(d) Area of usual residence was not reported or not mappable to SEIFA categories for approximately 80 000 records.

(e) For National Healthcare agreement purposes, the Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B).

(f) The totals exclude records for which the waiting time to service was invalid, and records for which the episode end status was either 'Did not wait to be attended by a health care professional' or 'Dead on arrival, not treated in emergency department'.

(g) The totals include records for which the triage category was not assigned or not reported.

(h) Total includes separations for which a SEIFA category could not be assigned as the place of residence was unknown or not stated.

Source : AIHW (unpublished) National Non-admitted Patient Emergency Department Care Database.

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
2003-04									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	20	19	15	4	5	2	1	2	68
Est coverage of surgical separations (e)	100	100	97	100	100	100	100	100	99
Number of admissions (f)	92 850	84 822	89 308	26 695	30 267	10 304	4 686	4 498	343 430
Days waited at 50th percentile	27	28	21	26	36	44	np	29	27
Days waited at 90th percentile	188	200	116	181	197	348	np	236	182
% waited more than 365 days	3.7	4.2	3.0	3.9	3.6	9.5	np	5.2	3.9
Large hospitals									
Number of reporting hospitals (d)	22	8	7	1	2	1	1	..	42
Est coverage of surgical separations (e)	100	73	100	31	100	100	100	..	85
Number of admissions (f)	46 249	31 649	16 560	3 474	6 382	2 109	3 861	..	110 284
Days waited at 50th percentile	36	22	23	np	48	np	np	..	30
Days waited at 90th percentile	270	127	106	np	214	np	np	..	206
% waited more than 365 days	5.4	1.8	2.3	np	4.5	np	np	..	4.2
Medium hospitals									
Number of reporting hospitals (d)	40	4	9	5	–	..	..	..	58
Est coverage of surgical separations (e)	100	30	81	80	–	..	..	..	59
Number of admissions (f)	39 666	10 166	5 325	13 633	na	..	..	..	68 790
Days waited at 50th percentile	41	29	27	27	na	..	..	..	34
Days waited at 90th percentile	242	122	140	216	na	..	..	..	215
% waited more than 365 days	4.0	1.5	1.4	3.3	na	..	..	..	3.3
Total (g)									
Number of reporting hospitals (d)	**105**	**31**	**31**	**12**	**7**	**3**	**2**	**5**	**196**
Est coverage of surgical separations (e)	**100**	**78**	**96**	**76**	**64**	**100**	**100**	**100**	**87**

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Number of admissions (f)	**182 400**	**126 637**	**111 193**	**46 056**	**36 649**	**12 413**	**8 547**	**5 054**	**528 949**
Admissions per 1000 population (h)	**27.2**	**25.6**	**28.9**	**23.4**	**23.9**	**25.9**	**26.5**	**25.4**	**26.5**
Days waited at 50th percentile	**32**	**27**	**22**	**27**	**37**	**42**	**46**	**34**	**28**
Days waited at 90th percentile	**222**	**175**	**115**	**200**	**201**	**372**	**373**	**245**	**193**
% waited more than 365 days	**4.1**	**3.3**	**2.8**	**4.0**	**3.8**	**10.3**	**10.4**	**5.3**	**3.9**
2004-05									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	26	19	16	4	5	2	1	2	75
Est coverage of surgical separations (e)	100	100	97	100	100	100	100	100	99
Number of admissions (f)	117 762	84 230	90 171	29 258	30 193	10 451	4 994	5 026	372 085
Days waited at 50th percentile	29	28	22	26	36	41	np	25	28
Days waited at 90th percentile	274	216	105	184	203	373	np	252	203
% waited more than 365 days	6.7	4.3	1.9	3.4	3.9	10.3	np	5.5	4.6
Large hospitals									
Number of reporting hospitals (d)	16	8	6	2	2	1	1	..	36
Est coverage of surgical separations (e)	100	73	100	48	100	66	100	..	82
Number of admissions (f)	34 153	32 307	13 272	7 696	6 511	3 354	3 623	..	100 916
Days waited at 50th percentile	41	23	22	np	30	np	np	..	29
Days waited at 90th percentile	330	159	95	np	179	np	np	..	227
% waited more than 365 days	7.6	2.3	1.5	np	4.5	np	np	..	4.8
Medium hospitals									
Number of reporting hospitals (d)	41	5	9	4	–	..	..	..	59
Est coverage of surgical separations (e)	100	37	83	75	–	..	..	..	62
Number of admissions (f)	41 509	12 668	5 433	10 220	na	..	..	..	69 830
Days waited at 50th percentile	47	34	28	23	na	..	..	..	37

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	316	213	137	182	na	..	..	..	272
% waited more than 365 days	7.3	6.0	1.5	4.0	na	..	..	..	6.1
Total (g)									
Number of reporting hospitals (d)	**104**	**32**	**31**	**11**	**7**	**3**	**2**	**5**	**195**
Est coverage of surgical separations (e)	**100**	**79**	**96**	**72**	**62**	**90**	**100**	**100**	**87**
Number of admissions (f)	**197 600**	**129 205**	**108 876**	**49 295**	**36 704**	**13 805**	**8 617**	**5 644**	**549 746**
Admissions per 1000 population (h)	**29.3**	**25.9**	**27.7**	**24.7**	**23.9**	**28.5**	**26.6**	**28.1**	**27.2**
Days waited at 50th percentile	**34**	**28**	**22**	**27**	**35**	**34**	**45**	**29**	**29**
Days waited at 90th percentile	**294**	**200**	**105**	**197**	**201**	**352**	**368**	**266**	**217**
% waited more than 365 days	**6.9**	**4.0**	**1.8**	**3.8**	**4.0**	**9.5**	**10.1**	**5.9**	**4.8**
2005-06									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	28	19	16	4	5	3	1	2	78
Est coverage of surgical separations (e)	100	100	97	100	100	100	100	100	99
Number of admissions (f)	127 298	85 425	89 393	28 512	30 352	15 041	5 106	5 076	386 203
Days waited at 50th percentile	31	32	24	30	38	34	np	26	30
Days waited at 90th percentile	278	238	132	208	213	332	np	298	228
% waited more than 365 days	5.6	5.0	2.3	4.5	3.9	8.7	np	7.2	4.7
Large hospitals									
Number of reporting hospitals (d)	14	9	6	2	2	..	1	..	34
Est coverage of surgical separations (e)	100	72	100	52	100	..	100	..	81
Number of admissions (f)	29 741	37 473	12 435	8 630	5 567	..	3 970	..	97 816
Days waited at 50th percentile	43	32	26	22	40	..	np	..	35
Days waited at 90th percentile	312	222	105	224	199	..	np	..	251
% waited more than 365 days	5.4	3.9	1.4	4.5	6.1	..	np	..	4.6

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Medium hospitals									
Number of reporting hospitals (d)	36	4	7	4	–	..	..	..	51
Est coverage of surgical separations (e)	100	36	86	78	–	..	..	..	62
Number of admissions (f)	38 306	11 626	4 034	9 675	na	..	..	..	63 641
Days waited at 50th percentile	48	32	28	23	na	..	..	..	38
Days waited at 90th percentile	304	136	112	145	na	..	..	..	257
% waited more than 365 days	4.8	2.1	1.1	2.7	na	..	..	..	3.8
Total (g)									
Number of reporting hospitals (d)	**100**	**32**	**31**	**11**	**7**	**3**	**2**	**5**	**191**
Est coverage of surgical separations (e)	**100**	**79**	**96**	**76**	**63**	**100**	**100**	**100**	**87**
Number of admissions (f)	**201 438**	**134 524**	**106 323**	**48 935**	**35 919**	**15 041**	**9 076**	**5 695**	**556 951**
Admissions per 1000 population (h)	**29.6**	**26.6**	**26.6**	**24.1**	**23.2**	**30.9**	**27.8**	**27.9**	**27.2**
Days waited at 50th percentile	**36**	**32**	**25**	**28**	**38**	**34**	**61**	**30**	**32**
Days waited at 90th percentile	**291**	**224**	**127**	**205**	**212**	**332**	**372**	**313**	**237**
% waited more than 365 days	**5.4**	**4.5**	**2.1**	**4.3**	**4.2**	**8.7**	**10.3**	**7.7**	**4.6**
2006-07									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	17	5	5	3	1	2	82
Est coverage of surgical separations (e)	100	100	97	84	100	100	100	100	98
Number of admissions (f)	134 093	86 679	91 827	26 002	31 705	14 181	5 129	5 215	394 831
Days waited at 50th percentile	31	29	26	29	39	38	np	31	30
Days waited at 90th percentile	259	224	149	223	207	343	np	363	225
% waited more than 365 days	2.3	4.0	2.6	5.0	3.8	9.2	np	9.8	3.4
Large hospitals									
Number of reporting hospitals (d)	12	8	5	2	2	..	1	..	30

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Est coverage of surgical separations (e)	100	70	100	42	100	..	100	..	77
Number of admissions (f)	24 825	33 713	11 658	8 571	5 489	..	4 177	..	88 433
Days waited at 50th percentile	39	33	22	23	43	..	np	..	33
Days waited at 90th percentile	266	195	96	233	201	..	np	..	224
% waited more than 365 days	1.3	2.3	1.9	3.8	4.5	..	np	..	2.7
Medium hospitals									
Number of reporting hospitals (d)	37	4	7	4	–	..	..	..	52
Est coverage of surgical separations (e)	100	35	81	80	–	..	..	..	63
Number of admissions (f)	36 573	11 277	4 090	11 718	na	..	..	..	63 658
Days waited at 50th percentile	50	28	27	28	na	..	..	..	39
Days waited at 90th percentile	271	137	125	209	na	..	..	..	231
% waited more than 365 days	1.1	1.2	1.1	4.2	na	..	..	..	1.7
Total (g)									
Number of reporting hospitals (d)	**99**	**32**	**31**	**13**	**7**	**3**	**2**	**5**	**192**
Est coverage of surgical separations (e)	**100**	**79**	**96**	**67**	**64**	**100**	**100**	**100**	**87**
Number of admissions (f)	**201 630**	**131 669**	**107 893**	**48 986**	**37 194**	**14 181**	**9 306**	**5 911**	**556 770**
Admissions per 1000 population (h)	**29.4**	**25.5**	**26.1**	**23.5**	**23.6**	**28.8**	**27.7**	**27.8**	**26.7**
Days waited at 50th percentile	**35**	**30**	**25**	**29**	**40**	**38**	**63**	**35**	**32**
Days waited at 90th percentile	**260**	**208**	**142**	**225**	**206**	**343**	**364**	**370**	**226**
% waited more than 365 days	**1.9**	**3.3**	**2.5**	**4.6**	**3.9**	**9.2**	**9.9**	**10.2**	**3.1**
2007-08									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	18	6	5	2	1	2	83
Est coverage of surgical separations (e)	100	100	100	100	100	100	100	100	100
Number of admissions (f)	133 191	90 392	92 935	30 354	33 402	10 516	5 322	5 406	401 518

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Days waited at 50th percentile	33	30	27	29	42	39	np	39	31
Days waited at 90th percentile	275	232	143	225	203	400	np	329	233
% waited more than 365 days	2.2	4.3	2.6	4.1	3.5	11.1	np	8.0	3.4
Large hospitals									
Number of reporting hospitals (d)	15	8	5	3	2	1	1	..	35
Est coverage of surgical separations (e)	100	68	100	57	100	100	100	..	80
Number of admissions (f)	28 980	32 028	10 515	11 778	6 286	3 633	4 255	..	97 475
Days waited at 50th percentile	42	40	27	27	53	np	np	..	39
Days waited at 90th percentile	281	211	112	189	276	np	np	..	237
% waited more than 365 days	0.9	2.3	0.9	1.2	6.6	np	np	..	2.4
Medium hospitals									
Number of reporting hospitals (d)	36	3	7	4	1	..	..	..	51
Est coverage of surgical separations (e)	100	32	85	81	22	..	..	..	64
Number of admissions (f)	32 030	7 886	3 993	12 809	1 358	..	..	..	58 076
Days waited at 50th percentile	60	29	34	31	np	..	..	..	42
Days waited at 90th percentile	290	124	117	177	np	..	..	..	238
% waited more than 365 days	1.3	0.6	0.4	2.2	np	..	..	..	1.4
Total (g)									
Number of reporting hospitals (d)	**98**	**31**	**31**	**14**	**8**	**3**	**2**	**5**	**192**
Est coverage of surgical separations (e)	**100**	**80**	**98**	**79**	**70**	**100**	**100**	**100**	**91**
Number of admissions (f)	**199 578**	**130 306**	**107 623**	**57 122**	**41 046**	**14 149**	**9 577**	**6 100**	**565 501**
Admissions per 1000 population (h)	**28.7**	**24.8**	**25.4**	**26.7**	**25.8**	**28.6**	**28.0**	**28.1**	**26.6**
Days waited at 50th percentile	**39**	**33**	**27**	**30**	**42**	**36**	**72**	**43**	**34**
Days waited at 90th percentile	**278**	**221**	**137**	**206**	**208**	**369**	**372**	**337**	**235**
% waited more than 365 days	**1.8**	**3.6**	**2.3**	**3.0**	**3.9**	**10.1**	**10.3**	**8.6**	**3.0**

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
2008-09									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	19	6	5	2	2	2	85
Est coverage of surgical separations (e)	100	100	100	100	100	100	100	100	100
Number of admissions (f)	134 856	104 532	98 135	31 125	34 827	12 450	10 104	5 646	431 675
Days waited at 50th percentile	33	28	26	29	39	49	75	38	31
Days waited at 90th percentile	273	201	133	181	208	460	378	243	216
% waited more than 365 days	2.8	3.3	1.9	2.6	2.4	13.6	11.0	5.0	3.2
Large hospitals									
Number of reporting hospitals (d)	15	8	4	4	2	1	..	..	34
Est coverage of surgical separations (e)	100	70	100	87	100	100	..	..	84
Number of admissions (f)	28 391	35 342	7 158	12 485	6 033	2 357	..	..	91 766
Days waited at 50th percentile	45	39	37	28	41	np	..	..	40
Days waited at 90th percentile	293	188	146	178	263	np	..	..	227
% waited more than 365 days	2.1	1.9	1.1	1.4	4.8	np	..	..	2.5
Medium hospitals									
Number of reporting hospitals (d)	35	3	8	4	1	1	..	..	52
Est coverage of surgical separations (e)	100	26	89	78	21	100	..	..	60
Number of admissions (f)	30 299	7 816	4 634	14 650	na	2 124	..	..	62 815
Days waited at 50th percentile	59	42	29	32	na	np	..	..	42
Days waited at 90th percentile	300	132	123	152	na	np	..	..	230
% waited more than 365 days	1.6	1.5	0.9	1.4	na	np	..	..	1.5
Total (g)									
Number of reporting hospitals (d)	**98**	**31**	**32**	**15**	**8**	**4**	**2**	**5**	**195**
Est coverage of surgical separations (e)	**100**	**78**	**98**	**85**	**70**	**100**	**100**	**100**	**91**

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Number of admissions (f)	**199 384**	**147 690**	**109 940**	**60 398**	**44 152**	**16 931**	**10 104**	**6 410**	**595 009**
Admissions per 1000 population (h)	**28.3**	**27.5**	**25.3**	**27.4**	**27.4**	**33.8**	**29.0**	**28.9**	**27.5**
Days waited at 50th percentile	**39**	**31**	**27**	**31**	**36**	**44**	**75**	**40**	**33**
Days waited at 90th percentile	**283**	**194**	**133**	**174**	**207**	**448**	**378**	**256**	**220**
% waited more than 365 days	**2.5**	**2.9**	**1.8**	**2.0**	**2.7**	**13.1**	**10.6**	**5.6**	**2.9**
2009-10									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	29	20	19	5	5	2	2	2	84
Est coverage of surgical separations (e)	100	98	100	100	96	100	97	100	100
Number of admissions (f)	135 790	109 398	100 846	29 888	34 660	12 443	9 778	5 500	438 303
Days waited at 50th percentile	37	32	27	30	36	36	73	42	33
Days waited at 90th percentile	319	193	150	176	197	363	357	256	234
% waited more than 365 days	5.0	3.2	2.5	2.1	1.2	9.9	9.6	5.3	3.7
Large hospitals									
Number of reporting hospitals (d)	14	9	4	3	2	1	–	–	33
Est coverage of surgical separations (e)	100	76	100	74	100	100	..	..	88
Number of admissions (f)	27 099	38 927	8 219	12 919	6 443	2 093	..	..	95 700
Days waited at 50th percentile	57	44	29	27	43	np	..	..	42
Days waited at 90th percentile	342	215	174	142	181	np	..	..	259
% waited more than 365 days	5.9	2.1	2.5	0.6	0.7	np	..	..	3.0
Medium hospitals									
Number of reporting hospitals (d)	34	3	8	4	1	1	–	–	51
Est coverage of surgical separations (e)	100	24	96	77	19	100	..	..	61
Number of admissions (f)	30 130	7 436	4 750	14 063	3 124	2 074	..	..	61 577
Days waited at 50th percentile	65	48	30	34	np	np	..	..	45

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	342	165	125	143	np	np	..	..	296
% waited more than 365 days	4.6	2.3	2.1	1.1	np	np	..	..	3.1
Total (g)									
Number of reporting hospitals (d)	**96**	**32**	**32**	**14**	**8**	**4**	**2**	**5**	**193**
Est coverage of surgical separations (e)	**100**	**78**	**100**	**79**	**68**	**100**	**97**	**100**	**91**
Number of admissions (f)	**198 503**	**155 761**	**113 834**	**61 298**	**44 227**	**16 610**	**9 778**	**6 244**	**606 255**
Admissions per 1000 population (h)	**27.6**	**28.3**	**25.4**	**27.0**	**27.1**	**32.9**	**27.6**	**27.4**	**27.4**
Days waited at 50th percentile	**44**	**36**	**27**	**32**	**36**	**36**	**73**	**44**	**35**
Days waited at 90th percentile	**330**	**197**	**150**	**161**	**189**	**332**	**357**	**271**	**246**
% waited more than 365 days	**4.9**	**2.8**	**2.5**	**1.5**	**1.1**	**8.7**	**9.5**	**5.8**	**3.5**
2010-11									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	30	20	19	6	5	2	1	2	85
Est coverage of surgical separations (e)	100	99	100	100	99	100	100	100	100
Number of admissions (f)	142 084	112 381	100 808	34 286	35 970	12 334	6 245	5 783	449 891
Days waited at 50th percentile	39	34	29	29	38	38	np	30	34
Days waited at 90th percentile	332	188	151	171	214	332	np	211	242
% waited more than 365 days	4.0	3.0	1.4	1.8	2.1	10.8	np	3.4	3.1
Large hospitals									
Number of reporting hospitals (d)	16	9	4	3	2	1	1	–	36
Est coverage of surgical separations (e)	100	71	100	94	100	100	100	..	92
Number of admissions (f)	30 158	36 090	8 568	13 179	7 044	2 082	5 093	..	102 214
Days waited at 50th percentile	63	40	28	26	48	np	np	..	42
Days waited at 90th percentile	335	167	125	132	236	np	np	..	263
% waited more than 365 days	3.3	1.1	1.0	1.0	1.8	np	np	..	2.4

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Medium hospitals									
Number of reporting hospitals (d)	30	4	8	4	1	1	–	–	48
Est coverage of surgical separations (e)	100	27	85	85	19	100	..	..	61
Number of admissions (f)	26 045	8 520	4 373	15 111	3 067	2 081	..	..	59 197
Days waited at 50th percentile	63	56	29	33	np	np	..	..	46
Days waited at 90th percentile	331	165	139	148	np	np	..	..	273
% waited more than 365 days	1.7	1.0	0.7	1.2	np	np	..	..	1.6
Total (g)									
Number of reporting hospitals (d)	**96**	**34**	**32**	**14**	**8**	**4**	**2**	**5**	**195**
Est coverage of surgical separations (e)	**100**	**78**	**98**	**92**	**71**	**100**	**100**	**100**	**93**
Number of admissions (f)	**204 820**	**157 073**	**113 760**	**64 785**	**46 081**	**16 497**	**11 338**	**6 429**	**620 783**
Admissions per 1000 population (h)	**28.2**	**28.1**	**25.0**	**28.0**	**27.9**	**32.4**	**31.3**	**28.0**	**27.6**
Days waited at 50th percentile	**47**	**36**	**29**	**29**	**38**	**38**	**76**	**33**	**36**
Days waited at 90th percentile	**333**	**182**	**148**	**159**	**208**	**359**	**378**	**223**	**252**
% waited more than 365 days	**3.6**	**2.5**	**1.3**	**1.6**	**2.0**	**9.6**	**10.8**	**3.9**	**2.9**
2011-12									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	30	21	16	7	5	2	2	2	85
Est coverage of surgical separations (e)	100	98	89	100	100	100	100	100	97
Number of admissions (f)	146 951	114 380	98 950	37 685	37 176	11 970	11 362	6 572	465 046
Days waited at 50th percentile	43	34	26	31	35	39	63	36	35
Days waited at 90th percentile	339	193	150	173	195	418	296	212	253
% waited more than 365 days	3.9	2.7	2.1	2.2	2.0	11.9	6.2	3.1	3.2
Large hospitals									
Number of reporting hospitals (d)	14	8	4	7	2	1	..	..	36

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Est coverage of surgical separations (e)	100	74	100	100	100	100	..	..	89
Number of admissions (f)	27 461	32 461	8 961	23 195	7 490	1 934	..	..	101 502
Days waited at 50th percentile	63	38	29	28	49	np	..	..	40
Days waited at 90th percentile	322	166	154	141	235	np	..	..	236
% waited more than 365 days	2.8	1.6	2.1	1.2	1.4	np	..	..	1.9
Medium hospitals									
Number of reporting hospitals (d)	33	3	8	5	13	1	..	..	63
Est coverage of surgical separations (e)	100	26	86	100	100	100	..	..	78
Number of admissions (f)	31 849	7 238	4 523	14 584	16 796	1 898	..	..	76 888
Days waited at 50th percentile	64	58	29	33	30	np	..	..	44
Days waited at 90th percentile	330	207	119	160	174	np	..	..	260
% waited more than 365 days	2.1	1.9	0.1	1.4	0.7	np	..	..	1.5
Total (g)									
Number of reporting hospitals (d)	**96**	**32**	**29**	**36**	**40**	**4**	**2**	**5**	**244**
Est coverage of surgical separations (e)	**100**	**80**	**89**	**100**	**96**	**100**	**100**	**100**	**92**
Number of admissions (f)	**211 452**	**154 079**	**114 328**	**82 248**	**65 186**	**15 802**	**11 362**	**7 250**	**661 707**
Admissions per 1000 population (h)	**29.6**	**28.2**	**25.8**	**35.6**	**40.0**	**31.1**	**31.5**	**31.5**	**30.0**
Days waited at 50th percentile	**49**	**36**	**27**	**30**	**34**	**38**	**63**	**39**	**36**
Days waited at 90th percentile	**335**	**189**	**147**	**159**	**191**	**348**	**296**	**219**	**251**
% waited more than 365 days	**3.4**	**2.4**	**2.0**	**1.7**	**1.5**	**9.4**	**6.2**	**3.5**	**2.7**
2012-13									
Principal referral and women's and children's hospitals									
Number of reporting hospitals (d)	31	21	20	7	5	2	2	2	90
Est coverage of surgical separations (e)	100	98	100	100	100	100	100	100	99
Number of admissions (f)	151 744	115 578	102 656	40 325	35 664	11 654	11 628	7 119	476 368

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
Days waited at 50th percentile	43	35	26	30	36	45	51	37	35
Days waited at 90th percentile	340	222	168	175	175	462	277	193	269
% waited more than 365 days	3.4	3.5	2.6	2.2	1.4	12.9	4.1	3.3	3.3
Large hospitals									
Number of reporting hospitals (d)	13	8	4	7	2	1	..	..	35
Est coverage of surgical separations (e)	100	70	100	100	100	100	..	..	87
Number of admissions (f)	25 784	31 223	10 661	23 359	7 639	1 816	..	..	100 482
Days waited at 50th percentile	63	32	28	30	43	np	..	..	38
Days waited at 90th percentile	323	176	140	149	227	np	..	..	238
% waited more than 365 days	1.5	2.3	2.5	0.4	1.0	np	..	..	1.6
Medium hospitals									
Number of reporting hospitals (d)	30	3	8	5	12	1	..	..	59
Est coverage of surgical separations (e)	100	26	84	100	100	100	..	..	78
Number of admissions (f)	31 177	6 614	4 255	14 673	16 922	2 005	..	..	75 646
Days waited at 50th percentile	63	80	28	32	28	np	..	..	45
Days waited at 90th percentile	326	320	115	140	188	np	..	..	287
% waited more than 365 days	1.1	3.8	0.2	1.3	0.2	np	..	..	1.3
Total (g)									
Number of reporting hospitals (d)	**96**	**32**	**33**	**35**	**39**	**4**	**2**	**5**	**246**
Est coverage of surgical separations (e)	**100**	**80**	**98**	**100**	**97**	**100**	**100**	**100**	**93**
Number of admissions (f)	**216 106**	**153 415**	**119 767**	**84 981**	**64 136**	**15 475**	**11 628**	**7 808**	**673 316**
Admissions per 1000 population (h)	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
Days waited at 50th percentile	**50**	**36**	**27**	**30**	**34**	**41**	**51**	**40**	**36**
Days waited at 90th percentile	**335**	**223**	**163**	**159**	**182**	**406**	**277**	**196**	**265**

Table 10A.22 **Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals (a)**

	NSW	*Vic*	*Qld* (b)	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust*
% waited more than 365 days	**2.8**	**3.3**	**2.5**	**1.5**	**1.0**	**11.5**	**4.1**	**3.3**	**2.7**

(a) Public hospitals only. Principal referral hospitals and women's and children's hospitals include major cities hospitals with > 20 000 acute casemix adjusted separations a year and regional hospitals with > 16 000 acute casemix adjusted separations a year, as well as specialised acute women's and children's hospitals with > 10 000 acute casemix adjusted separations a year. Large hospitals include major cities acute hospitals treating > 10 000 acute casemix adjusted separations a year, regional acute hospitals treating > 8000 acute casemix adjusted separations a year and remote hospitals with > 5000 acute casemix adjusted separations a year. Medium hospitals include medium acute hospitals in regional and major city areas treating between 5000 and 10 000 acute casemix adjusted separations a year and medium acute hospitals in regional and major city areas treating between 2000 and 5000 acute casemix adjusted separations per year, plus acute hospitals treating < 2000 acute casemix adjusted separations a year but with > 2000 separations a year.

(b) For Queensland, the number of admissions includes admissions that were removed from the waiting list for elective admission before the start of the collection period or separated before the end of the collection period. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods.

(c) Includes data for the Mersey Community Hospital.

(d) Number of hospitals reporting to the National Elective Surgery Waiting Times Data Collection.

(e) The number of separations with urgency of admission reported as 'elective' and a surgical procedure for public hospitals reporting to the National Elective Surgery Waiting Times Data Collection as a proportion of the number of separations with urgency of admission of 'elective' and a surgical procedure for all public hospitals.

(f) Number of admissions for elective surgery reported to the National Elective Surgery Waiting Times Data Collection.

(g) Includes data for hospitals not included in the specified hospital peer groups.

(h) Crude rate based on the Australian estimated resident population as at 31 December.

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

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140. Canberra: AIHW

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
2003-04									
Cardio-thoracic									
Days waited at 50th percentile	14	6	11	9	20	24	29	..	11
Days waited at 90th percentile	76	49	103	36	89	84	106	..	72
% waited more than 365 days	0.1	0.1	0.2	–	–	1.0	0.4	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	55	29	13	57	48	62	85	67	35
Days waited at 90th percentile	352	174	110	379	341	267	656	381	274
% waited more than 365 days	9.3	4.0	3.7	10.5	8.7	5.8	21.3	11.1	6.8
General surgery									
Days waited at 50th percentile	26	26	23	21	30	33	27	56	26
Days waited at 90th percentile	134	159	102	131	151	246	275	296	139
% waited more than 365 days	1.9	2.7	1.9	1.5	1.9	5.7	6.0	6.5	2.2
Gynaecology									
Days waited at 50th percentile	27	25	21	22	29	46	31	6	25
Days waited at 90th percentile	127	110	90	73	144	166	166	57	113
% waited more than 365 days	1.4	1.2	1.4	0.3	0.9	1.4	1.4	0.4	1.2
Neurosurgery									
Days waited at 50th percentile	18	18	11	29	25	50	28	..	19
Days waited at 90th percentile	99	140	84	125	160	337	287	..	127
% waited more than 365 days	0.8	1.4	0.9	1.8	2.4	8.2	2.8	..	1.4
Ophthalmology									
Days waited at 50th percentile	105	31	33	82	62	234	198	134	60
Days waited at 90th percentile	392	162	396	292	212	639	693	375	343
% waited more than 365 days	12.1	2.7	10.8	4.8	2.7	43.3	31.3	10.8	8.7
Orthopaedic surgery									
Days waited at 50th percentile	52	62	21	67	75	176	98	52	46
Days waited at 90th percentile	328	335	138	414	366	689	392	283	316
% waited more than 365 days	8.0	8.6	3.3	11.5	10.0	32.3	13.0	6.1	7.8
Plastic surgery									
Days waited at 50th percentile	27	22	27	32	32	31	52	28	27
Days waited at 90th percentile	132	152	102	279	182	201	444	374	151
% waited more than 365 days	1.5	2.2	1.2	7.5	4.0	3.7	13.1	12.5	2.7
Urology									
Days waited at 50th percentile	31	24	24	22	42	36	28	28	28
Days waited at 90th percentile	146	177	102	118	180	158	136	232	148
% waited more than 365 days	1.6	3.3	1.8	2.2	2.6	1.5	0.6	5.6	2.2
Vascular surgery									
Days waited at 50th percentile	15	20	16	15	8	45	18	..	16
Days waited at 90th percentile	88	228	108	87	47	371	327	..	119
% waited more than 365 days	1.0	6.8	4.8	3.0	0.2	10.3	9.2	..	3.7

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Other									
Days waited at 50th percentile	8	23	26	10	29	5	28	21	15
Days waited at 90th percentile	55	86	126	42	105	27	224	219	99
% waited more than 365 days	0.1	0.3	2.0	0.4	–	0.4	6.5	4.9	1.1
Total									
Days waited at 50th percentile	**32**	**27**	**22**	**27**	**37**	**42**	**46**	**34**	**28**
Days waited at 90th percentile	**222**	**175**	**115**	**200**	**201**	**372**	**373**	**245**	**193**
% waited more than 365 days	**4.1**	**3.3**	**2.8**	**4.0**	**3.8**	**10.3**	**10.4**	**5.3**	**3.9**
2004-05									
Cardio-thoracic									
Days waited at 50th percentile	14	5	8	13	12	24	17	..	11
Days waited at 90th percentile	69	66	69	42	70	86	35	..	62
% waited more than 365 days	0.2	–	0.3	–	0.2	–	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	60	29	15	83	50	39	116	55	37
Days waited at 90th percentile	446	192	105	351	314	448	689	384	322
% waited more than 365 days	14.1	4.9	2.9	9.6	8.6	13.0	17.3	10.7	8.4
General surgery									
Days waited at 50th percentile	27	26	25	20	31	28	28	51	27
Days waited at 90th percentile	163	194	99	120	142	199	201	315	155
% waited more than 365 days	3.1	3.7	1.6	1.5	1.9	3.3	2.8	8.1	2.8
Gynaecology									
Days waited at 50th percentile	27	28	21	19	28	29	30	6	25
Days waited at 90th percentile	133	139	87	68	128	141	160	66	113
% waited more than 365 days	2.2	1.7	0.9	0.5	0.6	0.8	0.8	1.2	1.5
Neurosurgery									
Days waited at 50th percentile	21	21	11	34	21	42	70	..	22
Days waited at 90th percentile	129	149	78	134	153	436	337	..	141
% waited more than 365 days	1.9	1.2	0.4	1.2	2.0	13.7	9.0	..	1.7
Ophthalmology									
Days waited at 50th percentile	140	34	28	78	71	115	209	145	66
Days waited at 90th percentile	450	179	189	314	255	554	531	356	364
% waited more than 365 days	18.2	1.7	2.8	6.1	2.9	35.0	28.4	9.1	9.8
Orthopaedic surgery									
Days waited at 50th percentile	61	64	22	81	69	160	112	36	48
Days waited at 90th percentile	410	358	123	396	363	648	404	289	356
% waited more than 365 days	12.7	9.6	2.3	11.2	9.8	30.8	13.0	7.9	9.6
Plastic surgery									
Days waited at 50th percentile	28	24	25	25	31	22	35	39	27
Days waited at 90th percentile	140	187	97	245	213	192	463	294	162
% waited more than 365 days	2.0	3.8	1.7	5.4	7.2	5.6	13.3	8.3	3.6

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Urology									
Days waited at 50th percentile	28	23	26	21	28	37	33	50	26
Days waited at 90th percentile	163	182	109	126	119	174	191	188	155
% waited more than 365 days	3.4	4.0	1.4	2.2	2.7	3.1	2.6	5.7	3.0
Vascular surgery									
Days waited at 50th percentile	18	23	16	16	8	40	23	..	18
Days waited at 90th percentile	101	298	92	66	39	203	534	..	121
% waited more than 365 days	2.4	8.4	2.3	1.2	0.6	5.2	14.2	..	3.9
Other									
Days waited at 50th percentile	7	21	26	9	22	6	35	13	14
Days waited at 90th percentile	66	81	116	43	90	32	332	98	96
% waited more than 365 days	0.4	0.9	3.1	0.1	0.5	0.2	7.4	0.9	1.5
Total									
Days waited at 50th percentile	**34**	**28**	**22**	**27**	**35**	**34**	**45**	**29**	**29**
Days waited at 90th percentile	**294**	**200**	**105**	**197**	**201**	**352**	**368**	**266**	**217**
% waited more than 365 days	**6.9**	**4.0**	**1.8**	**3.8**	**4.0**	**9.5**	**10.1**	**5.9**	**4.8**
2005-06									
Cardio-thoracic									
Days waited at 50th percentile	13	7	7	14	18	36	27	..	12
Days waited at 90th percentile	73	92	78	46	72	135	100	..	73
% waited more than 365 days	–	0.2	0.1	0.2	–	–	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	70	45	20	82	46	45	140	75	47
Days waited at 90th percentile	404	229	143	320	296	491	828	623	331
% waited more than 365 days	13.0	4.9	3.7	8.2	7.8	15.4	23.0	18.4	8.3
General surgery									
Days waited at 50th percentile	29	29	26	21	31	23	27	51	28
Days waited at 90th percentile	175	203	112	132	141	193	159	324	166
% waited more than 365 days	2.3	3.7	1.7	2.5	1.5	3.9	4.2	8.4	2.6
Gynaecology									
Days waited at 50th percentile	28	29	25	16	31	32	36	6	27
Days waited at 90th percentile	126	148	94	77	113	170	186	63	119
% waited more than 365 days	1.6	1.9	0.6	0.2	0.6	1.2	2.2	1.6	1.3
Neurosurgery									
Days waited at 50th percentile	20	26	12	44	18	74	52	..	26
Days waited at 90th percentile	103	177	108	147	121	427	372	..	152
% waited more than 365 days	2.1	2.0	1.0	1.1	1.6	14.1	10.4	..	2.1
Ophthalmology									
Days waited at 50th percentile	132	38	34	71	68	41	180	189	69
Days waited at 90th percentile	362	210	247	291	291	545	504	455	326
% waited more than 365 days	9.4	1.0	3.8	6.0	4.2	30.2	22.5	19.1	6.5

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Orthopaedic surgery									
Days waited at 50th percentile	66	69	23	70	77	146	137	36	54
Days waited at 90th percentile	390	392	168	370	404	538	450	340	364
% waited more than 365 days	12.0	11.2	2.9	10.2	12.3	22.4	15.3	8.4	9.9
Plastic surgery									
Days waited at 50th percentile	29	24	29	31	37	25	52	46	29
Days waited at 90th percentile	185	223	134	310	217	146	392	357	197
% waited more than 365 days	3.9	5.3	2.3	8.8	5.0	3.3	12.9	8.9	4.7
Urology									
Days waited at 50th percentile	28	20	28	21	38	36	49	25	26
Days waited at 90th percentile	168	176	118	147	160	184	215	174	162
% waited more than 365 days	2.6	3.9	1.7	3.2	4.0	3.4	3.1	7.2	3.0
Vascular surgery									
Days waited at 50th percentile	19	33	21	17	12	42	22	..	20
Days waited at 90th percentile	122	507	84	76	47	284	552	..	175
% waited more than 365 days	2.0	14.2	2.0	0.8	0.3	4.3	13.6	..	5.0
Other									
Days waited at 50th percentile	8	23	24	14	33	12	33	11	16
Days waited at 90th percentile	64	78	111	48	110	133	199	85	91
% waited more than 365 days	0.7	0.5	2.7	–	–	–	1.9	1.2	1.0
Total									
Days waited at 50th percentile	**36**	**32**	**25**	**28**	**38**	**34**	**61**	**30**	**32**
Days waited at 90th percentile	**291**	**224**	**127**	**205**	**212**	**332**	**372**	**313**	**237**
% waited more than 365 days	**5.4**	**4.5**	**2.1**	**4.3**	**4.2**	**8.7**	**10.3**	**7.7**	**4.6**
2006-07									
Cardio-thoracic									
Days waited at 50th percentile	12	7	12	13	18	27	24	..	12
Days waited at 90th percentile	62	63	82	40	74	173	87	..	66
% waited more than 365 days	–	0.1	0.2	–	0.1	0.5	–	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	69	39	23	90	54	57	105	50	46
Days waited at 90th percentile	335	204	159	431	312	521	803	546	308
% waited more than 365 days	4.1	3.5	3.6	13.5	7.4	12.9	23.1	14.8	5.5
General surgery									
Days waited at 50th percentile	28	29	26	25	33	29	29	53	28
Days waited at 90th percentile	158	183	124	177	158	268	164	326	162
% waited more than 365 days	0.7	2.8	2.1	3.5	2.4	6.9	1.5	7.8	2.0
Gynaecology									
Days waited at 50th percentile	29	36	24	21	32	38	39	7	28
Days waited at 90th percentile	145	143	97	94	119	238	209	81	130
% waited more than 365 days	0.7	1.2	0.8	0.2	0.3	3.7	1.8	1.2	0.9

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Neurosurgery									
Days waited at 50th percentile	23	21	15	42	21	38	29	..	26
Days waited at 90th percentile	130	162	158	169	89	505	296	..	154
% waited more than 365 days	0.9	1.7	4.0	1.1	0.2	11.9	7.7	..	1.9
Ophthalmology									
Days waited at 50th percentile	123	36	34	77	68	54	173	255	71
Days waited at 90th percentile	339	228	268	304	278	528	510	643	318
% waited more than 365 days	3.5	1.1	4.8	6.7	4.6	23.6	27.7	36.3	4.6
Orthopaedic surgery									
Days waited at 50th percentile	65	63	25	52	69	123	123	49	50
Days waited at 90th percentile	330	340	175	301	345	561	403	399	318
% waited more than 365 days	4.2	8.6	3.5	6.6	9.2	22.5	12.3	11.9	6.0
Plastic surgery									
Days waited at 50th percentile	28	23	29	29	37	22	62	42	28
Days waited at 90th percentile	167	213	135	312	182	166	371	315	193
% waited more than 365 days	1.3	4.5	2.0	8.2	4.1	3.7	10.1	8.1	3.6
Urology									
Days waited at 50th percentile	28	21	27	19	44	33	52	50	26
Days waited at 90th percentile	167	151	127	133	177	148	237	407	158
% waited more than 365 days	1.4	2.7	2.3	3.1	4.1	2.1	3.4	11.8	2.3
Vascular surgery									
Days waited at 50th percentile	17	25	20	20	12	43	27	..	20
Days waited at 90th percentile	89	273	84	103	71	242	482	..	133
% waited more than 365 days	0.5	6.3	1.6	1.1	1.5	4.2	11.4	..	2.4
Other									
Days waited at 50th percentile	6	23	29	13	21	12	36	20	15
Days waited at 90th percentile	46	86	122	42	82	54	151	251	90
% waited more than 365 days	0.1	0.4	0.6	0.3	0.4	0.6	2.0	5.4	0.6
Total									
Days waited at 50th percentile	**35**	**30**	**25**	**29**	**40**	**38**	**63**	**35**	**32**
Days waited at 90th percentile	**260**	**208**	**142**	**225**	**206**	**343**	**364**	**370**	**226**
% waited more than 365 days	**1.9**	**3.3**	**2.5**	**4.6**	**3.9**	**9.2**	**9.9**	**10.2**	**3.1**
2007-08									
Cardio-thoracic									
Days waited at 50th percentile	14	6	10	19	14	21	18	..	12
Days waited at 90th percentile	74	85	69	55	101	131	103	..	78
% waited more than 365 days	0.1	0.1	0.3	–	–	0.5	0.4	..	0.1
Ear, nose and throat surgery									
Days waited at 50th percentile	87	48	28	106	63	50	135	73	57
Days waited at 90th percentile	346	276	161	416	350	406	610	530	335
% waited more than 365 days	4.4	3.4	3.4	14.0	9.1	11.3	30.4	18.1	6.2

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
General surgery									
Days waited at 50th percentile	29	34	26	27	37	25	35	44	29
Days waited at 90th percentile	165	204	109	152	180	344	218	244	170
% waited more than 365 days	0.6	2.8	1.1	1.7	2.6	9.0	1.3	5.5	1.7
Gynaecology									
Days waited at 50th percentile	32	45	25	30	29	37	53	10	31
Days waited at 90th percentile	168	158	95	138	121	195	226	110	145
% waited more than 365 days	0.9	1.4	0.9	1.1	0.4	3.3	2.3	2.3	1.1
Neurosurgery									
Days waited at 50th percentile	25	24	21	35	21	35	39	..	25
Days waited at 90th percentile	148	185	134	187	95	343	276	..	166
% waited more than 365 days	0.7	1.5	4.3	1.8	0.2	9.9	7.6	..	1.9
Ophthalmology									
Days waited at 50th percentile	134	36	42	55	61	104	169	149	68
Days waited at 90th percentile	335	217	296	267	230	670	484	524	315
% waited more than 365 days	2.6	1.9	5.5	3.5	2.5	30.7	18.4	18.9	3.8
Orthopaedic surgery									
Days waited at 50th percentile	70	61	27	58	77	125	121	53	54
Days waited at 90th percentile	343	335	175	254	379	548	427	414	323
% waited more than 365 days	4.5	8.4	3.3	3.3	10.5	20.2	13.6	11.6	5.8
Plastic surgery									
Days waited at 50th percentile	25	22	28	18	40	13	45	42	26
Days waited at 90th percentile	147	235	148	144	187	134	347	376	186
% waited more than 365 days	0.5	5.6	2.8	1.7	3.5	2.4	9.5	10.5	3.2
Urology									
Days waited at 50th percentile	28	20	31	21	44	41	50	59	27
Days waited at 90th percentile	166	170	122	127	185	185	267	210	162
% waited more than 365 days	1.1	2.7	2.4	2.4	2.8	3.2	4.5	2.9	2.1
Vascular surgery									
Days waited at 50th percentile	18	25	22	27	14	25	25	..	21
Days waited at 90th percentile	108	364	82	145	57	242	705	..	161
% waited more than 365 days	0.5	9.9	1.3	2.6	0.9	5.6	19.6	..	3.8
Other									
Days waited at 50th percentile	7	24	27	18	21	50	35	63	19
Days waited at 90th percentile	63	88	96	72	76	795	157	383	89
% waited more than 365 days	–	1.0	0.4	0.4	–	37.1	1.5	10.2	1.4
Total									
Days waited at 50th percentile	**39**	**33**	**27**	**30**	**42**	**36**	**72**	**43**	**34**
Days waited at 90th percentile	**278**	**221**	**137**	**206**	**208**	**369**	**372**	**337**	**235**
% waited more than 365 days	**1.8**	**3.6**	**2.3**	**3.0**	**3.9**	**10.1**	**10.3**	**8.6**	**3.0**

2008-09

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Cardio-thoracic									
Days waited at 50th percentile	13	9	11	13	11	15	19	7	12
Days waited at 90th percentile	62	107	74	38	117	107	69	15	76
% waited more than 365 days	0.1	0.7	0.2	–	0.3	–	–	–	0.3
Ear, nose and throat surgery									
Days waited at 50th percentile	84	56	31	73	51	56	204	36	58
Days waited at 90th percentile	353	267	158	294	252	268	627	385	318
% waited more than 365 days	6.3	3.2	3.3	5.7	3.4	7.3	33.6	10.8	5.2
General surgery									
Days waited at 50th percentile	30	32	26	27	34	58	41	47	30
Days waited at 90th percentile	149	176	114	154	175	564	193	225	165
% waited more than 365 days	1.1	2.5	1.1	2.0	1.8	19.6	2.8	4.6	2.4
Gynaecology									
Days waited at 50th percentile	30	35	25	29	22	30	56	13	28
Days waited at 90th percentile	139	137	96	117	112	175	211	99	126
% waited more than 365 days	0.7	1.0	0.4	0.7	0.7	4.5	3.6	1.0	0.9
Neurosurgery									
Days waited at 50th percentile	26	22	18	40	26	35	43	..	24
Days waited at 90th percentile	168	165	107	167	84	265	217	..	157
% waited more than 365 days	1.5	1.5	0.8	2.5	0.1	6.2	1.6	..	1.5
Ophthalmology									
Days waited at 50th percentile	135	48	35	49	49	109	115	118	65
Days waited at 90th percentile	344	181	205	200	252	571	318	350	306
% waited more than 365 days	3.5	1.1	1.9	1.2	2.0	26.9	8.1	8.7	3.0
Orthopaedic surgery									
Days waited at 50th percentile	76	51	28	51	68	..	125	36	53
Days waited at 90th percentile	355	301	172	224	334	..	506	315	323
% waited more than 365 days	6.5	6.7	3.0	3.1	7.0	..	18.5	8.0	5.6
Plastic surgery									
Days waited at 50th percentile	22	17	26	24	31	17	48	69	22
Days waited at 90th percentile	135	193	147	147	186	126	338	520	168
% waited more than 365 days	0.7	3.7	3.4	1.9	4.4	3.1	9.1	11.7	3.0
Urology									
Days waited at 50th percentile	29	20	32	24	43	43	63	81	27
Days waited at 90th percentile	126	140	116	121	151	181	388	234	137
% waited more than 365 days	1.1	1.9	1.4	1.5	2.2	3.6	11.2	5.2	1.8
Vascular surgery									
Days waited at 50th percentile	17	27	19	28	11	44	25	208	20
Days waited at 90th percentile	104	320	79	222	47	535	382	565	175
% waited more than 365 days	0.3	8.4	1.0	4.2	0.7	12.7	11.9	32.0	3.5

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Other									
Days waited at 50th percentile	10	26	14	19	26	156	42	30	21
Days waited at 90th percentile	104	82	96	79	75	475	159	137	105
% waited more than 365 days	0.1	0.2	0.6	0.5	–	20.0	1.3	2.9	1.5
Total									
Days waited at 50th percentile	**39**	**31**	**27**	**31**	**36**	**44**	**75**	**40**	**33**
Days waited at 90th percentile	**283**	**194**	**133**	**174**	**207**	**448**	**378**	**256**	**220**
% waited more than 365 days	**2.5**	**2.9**	**1.8**	**2.0**	**2.7**	**13.1**	**10.6**	**5.6**	**2.9**
2009-10									
Cardio-thoracic									
Days waited at 50th percentile	14	20	7	16	10	11	20	0	14
Days waited at 90th percentile	62	104	52	62	104	72	77	0	71
% waited more than 365 days	–	1.3	–	0.1	0.1	–	–	–	0.4
Ear, nose and throat surgery									
Days waited at 50th percentile	117	61	32	62	55	49	200	59	63
Days waited at 90th percentile	378	289	164	196	263	239	477	389	340
% waited more than 365 days	12.8	4.8	3.1	2.3	2.3	6.4	29.9	10.8	6.8
General surgery									
Days waited at 50th percentile	33	35	26	27	34	33	36	49	31
Days waited at 90th percentile	191	160	134	163	148	385	213	291	172
% waited more than 365 days	1.9	2.1	1.6	1.6	0.7	10.4	4.2	6.6	2.1
Gynaecology									
Days waited at 50th percentile	31	35	27	38	25	34	45	10	30
Days waited at 90th percentile	181	129	103	119	105	191	223	121	135
% waited more than 365 days	2.0	0.4	0.6	0.1	0.2	1.8	2.9	0.7	1.0
Neurosurgery									
Days waited at 50th percentile	32	30	24	39	28	55	33	6	30
Days waited at 90th percentile	235	195	139	209	87	432	211	6	197
% waited more than 365 days	2.7	2.3	1.0	3.2	–	10.3	0.9	–	2.3
Ophthalmology									
Days waited at 50th percentile	168	53	35	42	54	75	143	112	69
Days waited at 90th percentile	361	212	216	189	302	292	326	340	329
% waited more than 365 days	7.6	1.8	2.5	1.1	2.7	5.4	8.9	8.3	4.1
Orthopaedic surgery									
Days waited at 50th percentile	98	61	31	54	67	156	140	56	62
Days waited at 90th percentile	371	308	229	210	286	645	503	295	352
% waited more than 365 days	11.6	6.6	4.9	2.8	0.8	28.2	19.0	6.8	7.9

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Plastic surgery									
Days waited at 50th percentile	22	19	23	24	27	16	30	59	22
Days waited at 90th percentile	163	175	133	159	146	131	311	291	164
% waited more than 365 days	1.4	3.2	3.3	2.0	1.8	3.1	7.1	8.5	2.7
Urology									
Days waited at 50th percentile	29	24	29	29	36	30	84	88	28
Days waited at 90th percentile	144	122	115	140	118	143	306	338	134
% waited more than 365 days	1.8	1.2	2.2	1.7	0.5	2.6	7.0	3.1	1.7
Vascular surgery									
Days waited at 50th percentile	17	36	18	25	9	32	22	597	20
Days waited at 90th percentile	103	374	86	170	33	529	301	948	183
% waited more than 365 days	0.7	10.4	2.3	1.6	–	14.8	6.7	64.3	3.9
Other									
Days waited at 50th percentile	11	32	25	20	9	26	42	21	22
Days waited at 90th percentile	107	114	103	76	49	182	232	111	102
% waited more than 365 days	3.6	1.2	0.9	0.2	–	0.6	3.2	–	1.1
Total									
Days waited at 50th percentile	**44**	**36**	**27**	**32**	**36**	**36**	**73**	**44**	**35**
Days waited at 90th percentile	**330**	**197**	**150**	**161**	**189**	**332**	**357**	**271**	**246**
% waited more than 365 days	**4.9**	**2.8**	**2.5**	**1.5**	**1.1**	**8.7**	**9.5**	**5.8**	**3.5**
2010-11									
Cardio-thoracic									
Days waited at 50th percentile	15	21	10	16	21	25	17	..	16
Days waited at 90th percentile	65	99	57	63	110	82	51	..	77
% waited more than 365 days	0.2	0.1	0.2	–	0.4	0.2	–	..	0.2
Ear, nose and throat surgery									
Days waited at 50th percentile	100	68	32	58	50	82	255	42	64
Days waited at 90th percentile	364	316	148	215	243	280	655	415	340
% waited more than 365 days	9.0	5.3	0.8	3.3	0.9	5.5	33.4	12.1	5.6
General surgery									
Days waited at 50th percentile	34	36	29	26	34	28	46	34	32
Days waited at 90th percentile	207	158	129	142	141	273	233	200	164
% waited more than 365 days	1.7	2.2	0.6	1.8	1.7	7.9	2.9	4.1	1.8
Gynaecology									
Days waited at 50th percentile	33	36	28	34	23	29	44	11	30
Days waited at 90th percentile	189	120	104	128	109	125	199	99	133
% waited more than 365 days	1.6	0.4	0.5	0.1	0.1	0.8	2.6	0.6	0.8

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Neurosurgery									
Days waited at 50th percentile	34	39	29	32	34	74	26	np	34
Days waited at 90th percentile	288	195	207	151	110	436	132	np	221
% waited more than 365 days	4.2	2.4	3.0	1.7	0.2	14.0	2.1	np	3.3
Ophthalmology									
Days waited at 50th percentile	178	49	37	35	77	168	121	98	71
Days waited at 90th percentile	358	188	298	171	349	422	294	278	335
% waited more than 365 days	5.6	0.7	2.9	0.7	6.5	20.8	4.5	3.0	3.6
Orthopaedic surgery									
Days waited at 50th percentile	97	61	34	53	73	147	179	49	64
Days waited at 90th percentile	360	293	214	237	315	622	491	273	345
% waited more than 365 days	7.4	6.1	2.9	3.5	4.0	29.2	21.5	6.1	6.2
Plastic surgery									
Days waited at 50th percentile	29	21	26	23	29	22	10	18	24
Days waited at 90th percentile	211	154	119	161	132	223	260	101	156
% waited more than 365 days	2.4	2.3	0.9	1.6	1.8	5.6	6.4	1.6	2.1
Urology									
Days waited at 50th percentile	29	24	28	27	37	30	70	50	28
Days waited at 90th percentile	116	110	120	156	106	153	423	154	122
% waited more than 365 days	1.5	1.1	0.8	1.8	0.6	2.4	13.3	–	1.6
Vascular surgery									
Days waited at 50th percentile	17	31	18	26	12	25	24	..	21
Days waited at 90th percentile	108	305	76	145	41	315	369	..	149
% waited more than 365 days	0.8	7.5	0.3	0.7	0.1	8.1	10.4	..	2.6
Other									
Days waited at 50th percentile	11	28	37	22	21	11	42	15	23
Days waited at 90th percentile	86	82	120	82	80	29	253	303	98
% waited more than 365 days	1.3	0.2	0.8	0.3	–	–	3.2	3.4	0.6
Total									
Days waited at 50th percentile	**47**	**36**	**29**	**29**	**38**	**38**	**76**	**33**	**36**
Days waited at 90th percentile	**333**	**182**	**148**	**159**	**208**	**359**	**378**	**223**	**252**
% waited more than 365 days	**3.6**	**2.5**	**1.3**	**1.6**	**2.0**	**9.6**	**10.8**	**3.9**	**2.9**
2011-12									
Cardio-thoracic									
Days waited at 50th percentile	19	19	11	19	18	20	23	..	16
Days waited at 90th percentile	78	109	58	77	98	73	72	..	81
% waited more than 365 days	0.1	0.2	0.1	–	0.1	–	–	..	0.1

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Ear, nose and throat surgery									
Days waited at 50th percentile	111	68	28	60	47	62	160	56	66
Days waited at 90th percentile	365	317	178	253	213	311	481	293	344
% waited more than 365 days	9.7	5.2	2.0	3.8	1.2	5.5	15.7	7.0	5.6
General surgery									
Days waited at 50th percentile	35	38	26	26	28	35	35	39	31
Days waited at 90th percentile	223	170	119	118	110	356	150	211	164
% waited more than 365 days	1.8	1.7	0.9	1.8	1.1	9.7	0.8	4.1	1.8
Gynaecology									
Days waited at 50th percentile	35	41	32	24	20	28	35	15	31
Days waited at 90th percentile	174	142	124	98	95	133	159	123	133
% waited more than 365 days	1.2	1.2	0.8	0.1	0.1	0.9	1.0	1.3	0.9
Neurosurgery									
Days waited at 50th percentile	34	38	16	40	32	66	19	..	31
Days waited at 90th percentile	286	171	110	175	104	506	104	..	191
% waited more than 365 days	3.8	1.7	1.8	0.9	0.6	13.9	0.6	..	2.7
Ophthalmology									
Days waited at 50th percentile	181	49	40	36	70	113	131	133	74
Days waited at 90th percentile	357	188	303	190	314	531	287	274	335
% waited more than 365 days	4.8	0.7	7.3	1.2	2.4	25.3	1.2	2.9	3.6
Orthopaedic surgery									
Days waited at 50th percentile	100	66	28	48	70	121	145	42	63
Days waited at 90th percentile	359	273	211	222	294	602	428	192	338
% waited more than 365 days	7.0	5.0	3.0	2.9	4.1	22.0	15.9	3.4	5.4
Plastic surgery									
Days waited at 50th percentile	32	20	23	26	28	24	6	29	24
Days waited at 90th percentile	254	196	140	151	146	205	168	128	182
% waited more than 365 days	1.8	4.3	1.0	1.6	2.2	4.7	4.9	2.8	2.7
Urology									
Days waited at 50th percentile	28	23	26	28	35	28	46	54	27
Days waited at 90th percentile	110	111	100	157	106	151	224	210	116
% waited more than 365 days	1.0	0.9	0.8	2.2	0.6	3.1	2.6	4.9	1.2
Vascular surgery									
Days waited at 50th percentile	19	29	13	22	14	22	28	63	20
Days waited at 90th percentile	120	247	70	166	50	101	505	296	147
% waited more than 365 days	0.9	5.5	0.4	2.5	0.4	4.9	14.3	7.9	2.5

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Other (c)									
Days waited at 50th percentile	17	27	25	26	21	10	59	14	25
Days waited at 90th percentile	96	88	112	90	81	40	266	66	100
% waited more than 365 days	0.8	0.2	1.0	0.2	0.2	–	5.8	–	0.6
Total									
Days waited at 50th percentile	**49**	**36**	**27**	**30**	**34**	**38**	**63**	**39**	**36**
Days waited at 90th percentile	**335**	**189**	**147**	**159**	**191**	**348**	**296**	**219**	**251**
% waited more than 365 days	**3.4**	**2.4**	**2.0**	**1.7**	**1.5**	**9.4**	**6.2**	**3.5**	**2.7**
2012-13									
Cardio-thoracic									
Days waited at 50th percentile	21	18	11	14	15	37	10	..	17
Days waited at 90th percentile	75	103	75	64	69	137	54	..	80
% waited more than 365 days	0.1	0.7	0.1	–	0.2	–	–	..	0.3
Ear, nose and throat surgery									
Days waited at 50th percentile	127	69	28	68	50	59	95	75	68
Days waited at 90th percentile	364	335	174	259	244	383	429	323	349
% waited more than 365 days	8.4	7.4	3.0	4.4	1.3	10.3	15.8	7.3	5.9
General surgery									
Days waited at 50th percentile	34	43	26	26	24	35	43	34	30
Days waited at 90th percentile	230	213	131	111	99	340	184	157	178
% waited more than 365 days	1.5	2.9	1.5	0.9	0.5	9.3	0.2	2.5	1.9
Gynaecology									
Days waited at 50th percentile	35	39	33	26	23	29	33	18	31
Days waited at 90th percentile	192	187	144	98	89	139	132	99	157
% waited more than 365 days	1.1	2.1	1.5	0.1	0.2	1.4	0.5	1.3	1.2
Neurosurgery									
Days waited at 50th percentile	33	44	14	34	28	86	20	..	30
Days waited at 90th percentile	256	217	127	182	92	429	95	..	210
% waited more than 365 days	2.7	2.1	2.2	2.9	0.6	12.2	0.9	..	2.6
Ophthalmology									
Days waited at 50th percentile	196	44	39	43	72	178	134	138	76
Days waited at 90th percentile	353	253	211	213	295	739	302	307	335
% waited more than 365 days	3.3	1.9	3.1	1.5	2.3	34.5	0.7	6.4	3.2
Orthopaedic surgery									
Days waited at 50th percentile	106	69	29	55	58	113	126	45	65
Days waited at 90th percentile	358	301	280	223	275	720	435	189	342
% waited more than 365 days	6.1	5.8	5.5	2.6	1.4	24.5	15.2	2.2	5.5

Table 10A.23 **Elective surgery waiting times, by specialty of surgeon**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas* (b)	*ACT*	*NT*	*Aust*
Plastic surgery									
Days waited at 50th percentile	33	20	23	24	28	22	7	43	24
Days waited at 90th percentile	277	226	127	148	137	147	79	149	187
% waited more than 365 days	1.8	5.0	1.3	1.6	1.4	2.9	0.5	3.0	2.8
Urology									
Days waited at 50th percentile	27	22	25	23	33	34	31	70	25
Days waited at 90th percentile	107	112	108	130	101	217	160	180	113
% waited more than 365 days	0.7	1.0	1.4	1.6	0.5	4.3	0.9	2.6	1.1
Vascular surgery									
Days waited at 50th percentile	20	29	15	21	13	14	21	37	20
Days waited at 90th percentile	118	284	82	151	44	92	267	197	153
% waited more than 365 days	1.0	5.1	0.5	1.8	–	2.3	5.5	4.8	2.0
Other (c)									
Days waited at 50th percentile	15	42	21	23	22	43	36	9	25
Days waited at 90th percentile	86	114	148	103	77	403	164	79	110
% waited more than 365 days	0.6	0.4	0.7	0.3	–	11.4	1.3	1.1	0.5
Total									
Days waited at 50th percentile	**50**	**36**	**27**	**30**	**34**	**41**	**51**	**40**	**36**
Days waited at 90th percentile	**335**	**223**	**163**	**159**	**182**	**406**	**277**	**196**	**265**
% waited more than 365 days	**2.8**	**3.3**	**2.5**	**1.5**	**1.0**	**11.5**	**4.1**	**3.3**	**2.7**

(a) The total number of admissions for Queensland include 644 admissions that were removed from the waiting list for elective admission before 30 June 2005 and separated before 30 June 2006. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods. The total number of admissions for Queensland includes 507 patients who were removed from the waiting list for elective admission before 30 June 2007 and separated before 30 June 2008. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods.

(b) Includes data for the Mersey Community Hospital. For Tasmania in 2008-09, admissions for Orthopaedic surgery were included under the category General Surgery.

(c) Includes specialty of surgeon 'not reported'

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

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140. Canberra: AIHW

Table 10A.24 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	Indigenous (b)									*Non-Indigenous (c)*								
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11																		
All hospitals																		
50th percentile																		
Cataract extraction	265	41	68	43	70	np	np	133	125	226	56	47	34	87	239	141	148	86
Cholecystectomy	56	41	62	42	58	79	np	99	58	61	49	51	28	49	68	68	56	52
Coronary artery bypass graft	13	np	20	26	19	np	np	–	20	15	22	7	14	22	25	12	–	16
Cystoscopy	28	24	31	26	46	24	np	110	29	23	23	28	27	35	28	70	74	25
Haemorrhoidectomy	48	np	37	np	np	–	–	133	65	65	62	61	35	55	33	120	62	59
Hysterectomy	59	np	37	21	74	72	np	82	51	55	48	41	44	54	46	58	60	48
Inguinal herniorrhaphy	50	35	51	32	np	33	np	76	49	70	54	58	33	43	57	78	55	57
Myringoplasty	332	np	76	85	186	np	43	154	120	317	83	67	92	179	180	351	112	105
Myringotomy	70	38	48	44	np	108	np	21	48	67	49	33	43	47	123	148	22	44
Prostatectomy	67	np	76	np	–	np	np	np	59	62	28	45	33	48	78	82	60	46
Septoplasty	311	np	92	np	143	np	–	np	189	312	105	56	92	137	222	393	np	146
Tonsillectomy	176	110	81	87	74	154	352	59	98	190	96	54	78	71	112	334	65	90
Total hip replacement	153	np	60	np	np	np	np	np	134	146	107	78	77	117	197	253	141	105
Total knee replacement	310	np	110	np	np	np	np	np	227	294	144	109	94	136	399	326	220	169
Varicose veins stripping & ligation	128	np	np	np	–	np	np	np	108	100	103	63	67	204	85	333	94	94
Total (d)	**50**	**35**	**34**	**31**	**33**	**40**	**67**	**43**	**39**	**47**	**36**	**29**	**29**	**38**	**36**	**75**	**30**	**36**
90th percentile																		
Cataract extraction	362	83	309	193	301	np	np	364	354	361	179	333	158	349	425	301	282	342
Cholecystectomy	218	168	151	206	132	400	np	300	171	232	131	139	160	99	457	250	223	156
Coronary artery bypass graft	79	np	75	63	92	np	np	–	76	77	87	56	63	83	83	49	–	72

Table 10A.24 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	Indigenous (b)									*Non-Indigenous (c)*								
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cystoscopy	114	78	136	203	141	44	np	223	124	105	99	126	177	97	112	368	224	111
Haemorrhoidectomy	362	np	129	np	np	–	–	250	250	301	240	155	212	220	366	279	239	247
Hysterectomy	267	np	135	82	274	342	np	182	225	302	135	141	127	168	212	202	224	196
Inguinal herniorrhaphy	296	296	130	139	np	401	np	313	252	326	155	161	164	140	591	289	197	246
Myringoplasty	370	np	166	282	321	np	43	551	441	384	354	192	233	354	694	672	469	365
Myringotomy	177	99	118	97	np	187	np	138	119	300	138	105	115	109	197	364	105	129
Prostatectomy	114	np	442	np	–	np	np	np	173	230	158	168	120	91	195	749	135	161
Septoplasty	374	np	431	np	245	np	–	np	380	381	378	262	345	301	694	691	np	371
Tonsillectomy	366	324	190	213	290	317	564	348	354	366	330	181	210	263	293	612	396	343
Total hip replacement	358	np	447	np	np	np	np	np	357	362	335	272	236	316	629	595	261	351
Total knee replacement	366	np	374	np	np	np	np	np	370	371	392	350	306	350	717	573	404	368
Varicose veins stripping & ligation	300	np	np	np	–	np	np	np	358	350	422	302	267	409	421	597	462	359
Total (d)	**337**	**204**	**155**	**188**	**167**	**353**	**363**	**283**	**260**	**331**	**176**	**148**	**158**	**210**	**349**	**368**	**212**	**243**
2011-12																		
All hospitals																		
50th percentile																		
Cataract extraction	272	60	67	87	84	198	162	168	126	231	60	49	35	78	244	162	176	89
Cholecystectomy	64	63	63	43	31	111	np	86	60	60	55	45	27	42	89	57	52	51
Coronary artery bypass graft	24	21	20	65	32	np	np	–	24	23	18	5	22	18	21	21	–	15
Cystoscopy	36	23	33	44	31	29	83	71	35	26	22	25	28	32	28	52	47	25
Haemorrhoidectomy	31	np	40	46	np	np	np	121	46	71	63	57	33	38	65	83	135	58
Hysterectomy	66	59	50	35	48	109	np	47	54	57	57	53	40	40	51	60	92	52

Table 10A.24 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	Indigenous (b)									*Non-Indigenous (c)*								
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Inguinal herniorrhaphy	47	76	57	16	33	80	np	53	43	73	60	51	29	34	57	73	79	56
Myringoplasty	314	np	86	92	8	np	–	90	91	315	106	78	77	74	114	393	92	109
Myringotomy	86	48	55	57	34	92	99	43	57	76	49	29	47	43	90	113	40	48
Prostatectomy	98	np	45	54	np	np	–	np	56	57	33	39	34	36	43	45	63	42
Septoplasty	262	np	178	np	np	np	np	np	135	322	98	56	100	137	200	321	110	154
Tonsillectomy	150	95	83	118	78	169	133	62	95	230	97	57	78	63	98	168	74	91
Total hip replacement	292	101	188	np	np	np	–	np	182	195	109	88	96	133	224	196	107	120
Total knee replacement	334	np	134	87	np	np	np	np	256	300	135	118	118	172	495	226	121	185
Varicose veins stripping & ligation	136	np	np	np	np	np	np	np	144	99	106	77	65	123	64	230	223	99
Total (d)	**57**	**42**	**32**	**34**	**30**	**44**	**71**	**49**	**41**	**50**	**36**	**28**	**30**	**34**	**37**	**59**	**40**	**36**
90th percentile																		
Cataract extraction	362	232	394	217	261	480	292	295	355	360	173	368	193	324	554	291	268	346
Cholecystectomy	239	204	164	147	112	645	np	274	201	248	161	126	139	103	525	169	267	172
Coronary artery bypass graft	86	36	75	181	131	np	np	–	104	85	84	55	61	78	73	71	–	75
Cystoscopy	101	120	97	188	83	134	138	194	131	102	100	96	158	93	135	224	157	107
Haemorrhoidectomy	174	np	127	112	np	np	np	234	195	304	262	163	182	122	797	314	227	246
Hysterectomy	283	184	138	93	98	217	np	145	175	306	171	167	123	176	198	229	162	205
Inguinal herniorrhaphy	325	448	208	148	359	331	np	156	265	338	173	147	151	141	524	198	330	270
Myringoplasty	376	np	323	263	296	np	–	400	349	376	352	286	238	302	565	529	381	365
Myringotomy	331	112	137	172	163	180	280	131	161	322	141	102	113	98	197	270	105	135
Prostatectomy	191	np	169	77	np	np	–	np	169	183	185	139	139	88	106	188	129	160
Septoplasty	365	np	326	np	np	np	np	np	360	372	367	296	358	316	601	543	413	369
Tonsillectomy	363	328	290	336	327	373	267	280	354	370	327	223	238	254	331	330	320	355

Table 10A.24 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	Indigenous (b)									*Non-Indigenous (c)*								
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total hip replacement	372	281	289	np	np	np	–	np	378	364	300	301	266	335	660	441	239	356
Total knee replacement	378	np	328	328	np	np	np	np	377	370	352	361	342	362	868	488	477	370
Varicose veins stripping & ligation	352	np	np	np	np	np	np	np	358	342	384	349	379	363	667	627	562	361
Total (d)	**339**	**232**	**177**	**169**	**162**	**352**	**286**	**248**	**260**	**336**	**186**	**150**	**157**	**194**	**348**	**285**	**219**	**247**
2012-13																		
All hospitals																		
50th percentile																		
Cataract extraction	265	64	80	76	92	251	121	174	140	231	52	43	44	81	277	157	150	90
Cholecystectomy	52	36	39	40	28	99	26	64	48	56	60	46	29	30	70	65	56	50
Coronary artery bypass graft	19	np	12	16	15	np	np	–	15	27	19	8	13	15	43	8	–	16
Cystoscopy	30	21	27	30	42	36	32	67	29	25	21	24	22	30	34	34	48	23
Haemorrhoidectomy	58	np	np	51	np	np	np	58	54	67	79	56	35	19	68	84	86	59
Hysterectomy	73	151	57	23	28	84	np	65	59	59	59	55	35	43	69	55	56	53
Inguinal herniorrhaphy	49	51	45	28	20	74	np	37	42	71	71	65	34	29	104	85	54	61
Myringoplasty	162	np	90	97	12	np	–	150	121	311	132	82	83	89	77	np	83	124
Myringotomy	68	64	53	39	65	95	np	98	54	68	50	35	54	41	71	64	45	49
Prostatectomy	43	np	36	24	np	np	–	np	41	53	28	36	31	36	51	65	53	39
Septoplasty	304	np	143	115	np	301	np	np	238	328	129	75	124	99	269	346	115	196
Tonsillectomy	237	100	79	70	103	81	154	77	105	259	105	51	89	68	98	176	74	98
Total hip replacement	117	157	208	np	np	np	–	np	158	196	105	78	92	108	380	136	108	115
Total knee replacement	333	np	208	88	np	np	np	np	297	296	141	152	105	153	616	179	113	195
Varicose veins stripping & ligation	62	np	214	np	np	–	np	np	88	97	145	56	70	87	39	157	98	97

Table 10A.24 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	Indigenous (b)									*Non-Indigenous (c)*								
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total (d)	**56**	**44**	**28**	**34**	**28**	**47**	**38**	**52**	**40**	**49**	**36**	**27**	**30**	**34**	**41**	**51**	**35**	**36**
90th percentile																		
Cataract extraction	359	323	334	214	318	677	304	399	357	355	248	217	208	301	755	305	239	338
Cholecystectomy	303	165	167	105	76	338	178	155	197	234	188	139	112	90	399	217	190	181
Coronary artery bypass graft	97	np	92	43	61	np	np	–	88	85	85	68	44	54	127	56	–	76
Cystoscopy	104	83	108	99	112	295	189	180	126	104	96	100	137	97	179	168	146	107
Haemorrhoidectomy	195	np	np	104	np	np	np	331	261	310	284	211	121	90	750	248	222	257
Hysterectomy	335	272	168	98	148	256	np	254	240	315	213	172	120	130	237	189	444	217
Inguinal herniorrhaphy	284	191	173	138	110	262	np	130	225	338	232	181	120	119	636	235	145	286
Myringoplasty	363	np	308	279	362	np	–	400	348	383	375	330	279	364	434	np	286	367
Myringotomy	317	178	106	165	167	400	np	258	177	333	170	102	128	95	251	211	126	139
Prostatectomy	107	np	168	172	np	np	–	np	168	211	179	170	146	107	121	139	130	167
Septoplasty	362	np	461	271	np	547	np	np	399	378	571	377	390	330	584	572	471	389
Tonsillectomy	362	336	246	205	343	445	487	351	358	366	355	212	261	271	455	377	371	359
Total hip replacement	367	312	426	np	np	np	–	np	372	362	308	346	271	317	831	373	281	357
Total knee replacement	379	np	462	166	np	np	np	np	406	368	365	462	312	343	964	445	353	373
Varicose veins stripping & ligation	356	np	377	np	np	–	np	np	356	353	403	308	342	339	273	545	387	356
Total (d)	**342**	**247**	**173**	**174**	**167**	**328**	**218**	**259**	**278**	**335**	**223**	**162**	**158**	**182**	**408**	**278**	**174**	**265**

(a) Data are suppressed where there are fewer than 10 elective surgery admissions in the category.

(b) The quality of the data reported for Indigenous status in the National Elective Surgery Waiting Times Data Collection (NESWTDC) has not been formally assessed; therefore, caution should be exercised when interpreting these data. Data for Tasmania and the Australian Capital Territory should be interpreted with caution until further assessment of Indigenous identification is completed. The Australian totals for Indigenous and Other Australians do not include data for Tasmania and the Australian Capital Territory for 2010-11 and 2011-12.

(c) Other Australians includes records for which the Indigenous status was Not reported.

Table 10A.24 **Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) (a)**

	Indigenous (b)									*Non-Indigenous (c)*								
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(d) Total includes all removals for elective surgery procedures, including but not limited to the procedures listed above.

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

Source : AIHW (unpublished) linked National Hospital Morbidity Database; AIHW (unpublished) National Elective Surgery Waiting Times Data Collection.

Table 10A.25 **Waiting times for elective surgery in public hospitals, by State and Territory, by remoteness area (days) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All hospitals									
2010-11									
50th percentile									
Major cities	42	37	28	31	41	48	77	4	36
Inner regional	56	32	29	27	33	35	63	np	38
Outer regional	61	28	34	29	29	38	np	29	39
Remote	43	36	28	32	28	38	np	33	32
Very remote	27	32	35	27	26	55	np	50	35
90th percentile									
Major cities	316	176	140	162	221	222	367	50	229
Inner regional	345	177	157	138	162	353	370	np	289
Outer regional	349	189	166	165	156	342	np	236	303
Remote	338	195	157	182	150	350	np	173	223
Very remote	233	182	185	156	151	425	np	278	221
2011-12									
50th percentile									
Major cities	46	37	28	30	38	np	59	8	36
Inner regional	58	35	28	28	32	37	66	np	38
Outer regional	65	29	32	31	30	39	46	40	36
Remote	38	35	27	29	26	31	np	39	29
Very remote	46	29.5	28	33	21	47.5	0	56	34.5
90th percentile									
Major cities	322	188	147	161	210	np	283	320	232
Inner regional	349	182	143	152	215	384	291	np	287
Outer regional	350	179	182	160	147	304	290	236	267
Remote	341	216	166	137	119	269	np	174	166
Very remote	315	207	161	165	127	296	0	247	186

(a) The data presented for this indicator are sourced from linked records in the National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection. The linked records represent about 97 per cent of all records in the National Elective Surgery Waiting Times Data Collection for 2010-11 and 2011-12.

(b) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. Data are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, the data represent the waiting times for patients living in each remoteness area (regardless of their jurisdiction of residence) in the reporting jurisdiction.

(c) Data are suppressed where there are fewer than 10 elective surgery admissions in the category.

np Not published.

Source: AIHW (unpublished) linked National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection.

Table 10A.26 **Waiting times for elective surgery in public hospitals, by State and Territory, by SEIFA IRSD quintiles (days) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All hospitals									
2010-11									
50th percentile									
Quintile 1	52	41	30	29	40	37	61	42	41
Quintile 2	56	35	28	30	40	37	75	39	41
Quintile 3	42	38	29	29	37	34	72	29	35
Quintile 4	43	35	29	31	35	32	78	30	35
Quintile 5	28	30	25	29	35	np	73	34	30
90th percentile									
Quintile 1	338	196	159	170	225	353	370	278	286
Quintile 2	343	180	153	163	211	336	379	237	297
Quintile 3	322	176	146	147	207	352	388	150	209
Quintile 4	319	175	145	168	173	323	367	235	214
Quintile 5	207	150	129	164	183	np	364	223	184
2011-12									
50th percentile									
Quintile 1	56	41	28	34	32	39	64.5	50	40
Quintile 2	59	37	28	29	36	35	52	45	41
Quintile 3	43	38	29	30	31	38	64	38	34
Quintile 4	45	34	28	30	34	36	65	36	34
Quintile 5	32	32	25	30	35	np	57	40	31
90th percentile									
Quintile 1	343	200	154	178	192	322	283	254	285
Quintile 2	346	195	158	150	207	304	298	223	290
Quintile 3	321	185	151	155	176	430	305	186	210
Quintile 4	318	183	145	159	182	462	289	225	204
Quintile 5	215	156	142	161	170	np	277	229	184

(a) The data presented for this indicator are sourced from linked records in the National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection. The linked records represent about 97 per cent of all records in the National Elective Surgery Waiting Times Data Collection for 2010-11 and 2011-12.

(b) 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. Disaggregation by SEIFA is by the patient's usual residence, not the location of the hospital. Data are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, the data represent the waiting times for patients in each SEIFA quintile (regardless of their jurisdiction of residence) in the reporting jurisdiction.

(c) Data are suppressed where there are fewer than 10 elective surgery admissions in the category.

Table 10A.26 **Waiting times for elective surgery in public hospitals, by State and Territory, by SEIFA IRSD quintiles (days) (a), (b), (c)**

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

np Not published.

Source: AIHW (unpublished) linked National Hospital Morbidity Database and National Elective Surgery Waiting Times Data Collection.

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
2003-04									
Cataract extraction									
Days waited at 50th percentile	154	42	40	96	83	393	234	149	83
Days waited at 90th percentile	415	180	502	295	238	745	707	378	379
% waited more than 365 days	14.6	3.0	13.9	4.5	3.7	58.2	33.5	11.3	10.9
Cholecystectomy									
Days waited at 50th percentile	44	43	38	29	43	92	65	91	42
Days waited at 90th percentile	216	181	107	149	164	396	400	359	188
% waited more than 365 days	4.0	2.9	1.9	1.3	1.1	11.1	12.9	9.3	3.4
Coronary artery bypass graft									
Days waited at 50th percentile	21	8	20	16	27	33	26	..	18
Days waited at 90th percentile	102	68	119	74	93	91	112	..	100
% waited more than 365 days	0.1	0.2	0.2	–	–	1.0	0.6	..	0.2
Cystoscopy									
Days waited at 50th percentile	32	26	27	24	53	35	35	41	29
Days waited at 90th percentile	138	176	119	155	191	146	156	218	156
% waited more than 365 days	1.0	2.7	1.8	3.6	3.1	0.2	0.6	3.6	2.0
Haemorrhoidectomy									
Days waited at 50th percentile	38	51	34	37	29	101	123	104	39
Days waited at 90th percentile	209	274	152	229	134	933	714	256	223
% waited more than 365 days	4.6	7.3	3.4	3.9	0.8	17.1	21.3	7.1	5.0
Hysterectomy									
Days waited at 50th percentile	40	30	34	29	62	79	69	40	37
Days waited at 90th percentile	183	145	105	83	212	213	260	91	156
% waited more than 365 days	2.6	1.6	1.4	0.2	1.5	4.4	2.9	–	1.9
Inguinal herniorrhaphy									
Days waited at 50th percentile	42	41	35	29	44	70	58	84	40
Days waited at 90th percentile	200	190	126	149	185	394	377	457	189
% waited more than 365 days	2.9	3.4	2.3	1.2	0.9	11.0	10.8	18.3	3.1
Myringoplasty									
Days waited at 50th percentile	122	69	43	125	124	167	327	168	89
Days waited at 90th percentile	498	382	692	720	461	691	1 061	1 163	516
% waited more than 365 days	16.8	11.0	16.1	18.2	23.7	31.3	47.6	23.1	16.4
Myringotomy									
Days waited at 50th percentile	42	23	21	34	34	40	62	45	27
Days waited at 90th percentile	224	74	94	156	98	124	319	135	105
% waited more than 365 days	3.5	0.4	1.0	1.2	0.1	1.4	6.9	–	0.9
Prostatectomy									
Days waited at 50th percentile	40	25	25	23	34	41	21	28	29
Days waited at 90th percentile	194	286	99	119	210	75	97	272	193
% waited more than 365 days	4.5	7.6	2.3	1.5	4.4	–	2.2	3.7	4.7

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Septoplasty									
Days waited at 50th percentile	138	70	36	241	170	204	506	253	98
Days waited at 90th percentile	518	553	819	882	640	847	1 045	465	609
% waited more than 365 days	18.0	15.8	18.5	33.6	28.1	31.6	70.1	34.4	19.8
Tonsillectomy									
Days waited at 50th percentile	99	36	27	91	78	134	148	132	50
Days waited at 90th percentile	445	164	158	404	385	574	646	412	327
% waited more than 365 days	14.6	2.0	4.2	13.1	10.6	17.4	28.6	16.2	8.4
Total hip replacement									
Days waited at 50th percentile	91	127	52	98	132	233	154	121	92
Days waited at 90th percentile	392	402	188	396	378	714	427	472	378
% waited more than 365 days	11.9	12.4	3.8	10.8	12.0	35.2	18.6	16.7	11.1
Total knee replacement									
Days waited at 50th percentile	168	152	68	135	160	434	204	157	134
Days waited at 90th percentile	497	448	388	557	441	964	526	314	484
% waited more than 365 days	24.6	16.2	10.7	20.2	16.0	55.0	25.1	6.3	19.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	63	81	74	44	151	106	346	210	75
Days waited at 90th percentile	322	920	827	882	695	1 062	925	686	690
% waited more than 365 days	7.9	23.6	24.0	20.9	26.3	35.7	47.6	45.0	18.5
Not available/Not stated									
Days waited at 50th percentile	24	23	19	21	30	34	28	24	22
Days waited at 90th percentile	144	149	98	159	168	248	241	188	141
% waited more than 365 days	2.1	2.6	1.8	3.4	3.0	6.3	5.0	3.4	2.5
Total									
Days waited at 50th percentile	**32**	**27**	**22**	**27**	**37**	**42**	**46**	**34**	**28**
Days waited at 90th percentile	**222**	**175**	**115**	**200**	**201**	**372**	**373**	**245**	**193**
% waited more than 365 days	**4.1**	**3.3**	**2.8**	**4.0**	**3.8**	**10.3**	**10.4**	**5.3**	**3.9**
2004-05									
Cataract extraction									
Days waited at 50th percentile	182	44	33	94	99	368	240	167	92
Days waited at 90th percentile	475	187	209	317	272	595	531	365	388
% waited more than 365 days	21.2	1.9	2.6	6.1	2.9	51.1	29.9	9.7	12.1
Cholecystectomy									
Days waited at 50th percentile	50	49	40	28	40	64	57	92	46
Days waited at 90th percentile	274	236	104	165	132	217	334	367	217
% waited more than 365 days	6.1	4.4	1.2	2.2	0.8	3.5	6.6	10.6	4.2
Coronary artery bypass graft									
Days waited at 50th percentile	17	7	11	20	20	28	12	..	14
Days waited at 90th percentile	94	129	84	53	78	86	33	..	89
% waited more than 365 days	0.1	0.1	0.4	–	–	–	–	..	0.2

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Cystoscopy									
Days waited at 50th percentile	27	23	29	23	22	37	44	47	27
Days waited at 90th percentile	146	174	160	187	100	179	197	182	158
% waited more than 365 days	2.2	3.6	1.4	3.5	1.6	3.0	2.5	3.4	2.6
Haemorrhoidectomy									
Days waited at 50th percentile	49	58	40	33	35	104	105	np	45
Days waited at 90th percentile	338	308	201	170	92	638	370	np	294
% waited more than 365 days	8.7	7.6	6.3	4.3	0.8	27.8	12.1	np	7.4
Hysterectomy									
Days waited at 50th percentile	40	35	34	25	53	45	44	43	36
Days waited at 90th percentile	189	173	105	78	168	161	186	389	153
% waited more than 365 days	3.7	2.2	0.8	0.8	1.1	1.6	2.0	11.5	2.4
Inguinal herniorrhaphy									
Days waited at 50th percentile	47	48	38	25	45	72	77	84	43
Days waited at 90th percentile	246	255	111	151	153	273	311	379	216
% waited more than 365 days	4.7	5.3	1.5	2.6	1.1	5.6	3.5	11.3	4.0
Myringoplasty									
Days waited at 50th percentile	210	64	46	123	115	38	96	49	88
Days waited at 90th percentile	629	434	489	419	544	489	1 093	730	550
% waited more than 365 days	32.5	12.4	12.6	14.1	26.1	15.0	30.0	23.8	19.9
Myringotomy									
Days waited at 50th percentile	34	23	21	77	43	46	127	65	29
Days waited at 90th percentile	200	80	103	168	111	157	241	263	119
% waited more than 365 days	3.3	0.6	1.0	0.9	–	–	3.9	4.8	0.9
Prostatectomy									
Days waited at 50th percentile	40	25	28	28	39	36	30	53	32
Days waited at 90th percentile	265	267	98	123	155	52	162	188	216
% waited more than 365 days	6.9	6.5	1.9	1.1	3.1	–	3.7	3.2	5.2
Septoplasty									
Days waited at 50th percentile	179	63	46	176	173	np	354	149	96
Days waited at 90th percentile	662	565	1 031	649	614	np	952	433	642
% waited more than 365 days	30.4	19.0	20.4	29.0	24.7	np	50.0	13.0	24.2
Tonsillectomy									
Days waited at 50th percentile	110	39	28	127	73	75	173	76	62
Days waited at 90th percentile	516	205	128	406	306	402	734	369	360
% waited more than 365 days	19.1	3.1	2.0	14.0	7.0	15.0	22.4	10.5	9.8
Total hip replacement									
Days waited at 50th percentile	106	141	50	114	125	355	173	96	102
Days waited at 90th percentile	481	400	179	377	375	668	427	402	433
% waited more than 365 days	18.9	12.8	4.0	10.5	10.9	48.5	15.1	16.7	14.4
Total knee replacement									

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 50th percentile	218	176	60	165	140	411	207	217	152
Days waited at 90th percentile	604	463	267	450	418	747	587	503	542
% waited more than 365 days	33.1	17.6	7.2	17.8	14.2	57.9	28.7	33.3	23.5
Varicose veins stripping and ligation									
Days waited at 50th percentile	68	90	68	29	169	96	519	243	78
Days waited at 90th percentile	483	1,145	808	147	668	510	1,087	876	775
% waited more than 365 days	13.8	27.9	20.0	4.8	26.1	22.2	67.1	47.6	21.1
Not available/Not stated									
Days waited at 50th percentile	25	23	19	21	29	27	29	21	23
Days waited at 90th percentile	173	174	93	150	163	245	262	212	154
% waited more than 365 days	3.6	3.3	1.4	3.0	3.8	6.4	5.6	4.7	3.1
Total									
Days waited at 50th percentile	**34**	**28**	**22**	**27**	**35**	**34**	**45**	**29**	**29**
Days waited at 90th percentile	**294**	**200**	**105**	**197**	**201**	**352**	**368**	**266**	**217**
% waited more than 365 days	**6.9**	**4.0**	**1.8**	**3.8**	**4.0**	**9.5**	**10.1**	**5.9**	**4.8**
2005-06									
Cataract extraction									
Days waited at 50th percentile	161	49	41	83	96	389	182	246	93
Days waited at 90th percentile	368	225	272	293	314	566	496	464	342
% waited more than 365 days	10.5	0.8	4.2	5.9	4.5	50.8	22.7	21.6	7.5
Cholecystectomy									
Days waited at 50th percentile	50	48	41	31	29	47	48	71	45
Days waited at 90th percentile	261	210	138	175	96	264	169	568	211
% waited more than 365 days	4.4	3.3	1.5	3.3	–	4.9	6.4	15.0	3.4
Coronary artery bypass graft									
Days waited at 50th percentile	16	10	8	20	25	45	22	..	15
Days waited at 90th percentile	90	159	93	62	79	138	98	..	100
% waited more than 365 days	–	0.2	0.1	–	–	–	–	..	0.1
Cystoscopy									
Days waited at 50th percentile	24	21	32	23	35	38	55	51	25
Days waited at 90th percentile	141	159	140	198	137	180	216	211	155
% waited more than 365 days	1.8	2.8	1.7	4.8	3.5	2.7	2.9	5.0	2.5
Haemorrhoidectomy									
Days waited at 50th percentile	54	70	42	32	47	53	70	np	51
Days waited at 90th percentile	292	366	171	322	105	353	379	np	286
% waited more than 365 days	5.3	10.0	3.3	8.3	–	8.5	12.5	np	6.3
Hysterectomy									
Days waited at 50th percentile	41	40	39	26	54	48	49	47	40
Days waited at 90th percentile	209	161	110	90	138	184	276	372	157
% waited more than 365 days	3.4	1.9	0.7	0.2	0.2	1.3	4.2	11.6	2.1
Inguinal herniorrhaphy									

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 50th percentile	51	56	41	24	44	41	47	71	48
Days waited at 90th percentile	259	257	133	148	142	308	202	517	233
% waited more than 365 days	3.5	5.6	2.1	3.1	0.8	5.3	3.3	17.9	3.8
Myringoplasty									
Days waited at 50th percentile	190	83	60	99	72	69	631	364	98
Days waited at 90th percentile	574	361	376	440	367	1 903	1 000	1 144	463
% waited more than 365 days	26.7	9.4	10.2	10.4	10.0	38.9	61.1	45.7	16.3
Myringotomy									
Days waited at 50th percentile	40	34	29	75	38	23	144	30	37
Days waited at 90th percentile	210	107	118	220	117	153	329	187	139
% waited more than 365 days	1.8	0.2	2.7	0.3	0.2	–	6.5	–	1.1
Prostatectomy									
Days waited at 50th percentile	48	21	28	25	50	41	52	62	35
Days waited at 90th percentile	281	278	126	116	324	70	239	250	246
% waited more than 365 days	6.0	7.8	3.0	1.5	7.5	–	3.9	9.1	5.9
Septoplasty									
Days waited at 50th percentile	266	96	66	147	130	np	312	130	128
Days waited at 90th percentile	613	430	945	503	522	np	847	468	542
% waited more than 365 days	32.9	14.7	19.0	16.2	20.1	np	41.8	19.4	22.4
Tonsillectomy									
Days waited at 50th percentile	129	56	40	119	74	57	203	118	72
Days waited at 90th percentile	406	215	182	390	231	648	894	389	336
% waited more than 365 days	13.6	3.9	3.9	11.3	2.0	26.5	30.3	13.3	8.1
Total hip replacement									
Days waited at 50th percentile	119	154	61	99	106	238	149	120	111
Days waited at 90th percentile	418	408	187	359	418	552	477	345	406
% waited more than 365 days	16.0	13.0	3.3	9.2	14.9	32.2	16.8	8.3	13.3
Total knee replacement									
Days waited at 50th percentile	242	188	74	138	193	326	219	137	178
Days waited at 90th percentile	519	463	287	498	505	639	633	1,060	492
% waited more than 365 days	29.1	18.6	6.4	20.0	26.0	41.0	29.6	22.2	23.1
Varicose veins stripping and ligation									
Days waited at 50th percentile	70	182	71	33	203	52	241	352	98
Days waited at 90th percentile	358	726	699	416	504	252	927	635	596
% waited more than 365 days	9.5	29.1	19.9	10.3	29.4	3.9	46.3	47.6	19.6
Not available/Not stated									
Days waited at 50th percentile	27	26	21	23	32	28	36	22	25
Days waited at 90th percentile	191	195	109	167	176	253	290	237	174
% waited more than 365 days	3.3	4.1	1.6	3.6	3.7	5.7	6.7	5.6	3.3
Total									
Days waited at 50th percentile	**36**	**32**	**25**	**28**	**38**	**34**	**61**	**30**	**32**

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	**291**	**224**	**127**	**205**	**212**	**332**	**372**	**313**	**237**
% waited more than 365 days	**5.4**	**4.5**	**2.1**	**4.3**	**4.2**	**8.7**	**10.3**	**7.7**	**4.6**
2006-07									
Cataract extraction									
Days waited at 50th percentile	152	50	40	85	96	111	177	320	93
Days waited at 90th percentile	343	237	292	297	288	625	516	641	330
% waited more than 365 days	3.9	0.8	5.8	6.3	3.9	35.7	29.3	40.3	5.0
Cholecystectomy									
Days waited at 50th percentile	47	45	38	32	36	61	71	111	43
Days waited at 90th percentile	202	170	133	279	107	258	239	503	182
% waited more than 365 days	1.2	1.8	1.1	5.2	–	6.4	2.9	14.1	1.7
Coronary artery bypass graft									
Days waited at 50th percentile	15	9	15	26	24	43	19	..	17
Days waited at 90th percentile	76	80	91	67	83	196	77	..	88
% waited more than 365 days	0.1	0.2	0.1	–	–	0.4	–	..	0.1
Cystoscopy									
Days waited at 50th percentile	25	21	29	16	42	35	66	48	25
Days waited at 90th percentile	151	141	168	167	195	146	257	260	157
% waited more than 365 days	1.0	2.0	3.1	3.4	5.1	0.9	4.0	7.5	2.1
Haemorrhoidectomy									
Days waited at 50th percentile	44	53	42	36	32	94	81	np	44
Days waited at 90th percentile	237	265	201	359	158	298	160	np	241
% waited more than 365 days	2.1	3.7	4.8	8.2	0.7	8.8	–	np	3.3
Hysterectomy									
Days waited at 50th percentile	45	43	36	32	52	62	53	32	43
Days waited at 90th percentile	204	146	116	118	154	241	252	129	165
% waited more than 365 days	1.0	1.1	1.2	0.4	0.4	3.2	4.4	4.8	1.1
Inguinal herniorrhaphy									
Days waited at 50th percentile	48	45	40	32	47	77	79	77	45
Days waited at 90th percentile	231	198	168	232	141	424	224	362	217
% waited more than 365 days	1.2	2.4	2.4	5.0	1.5	13.6	1.4	9.5	2.4
Myringoplasty									
Days waited at 50th percentile	125	62	62	143	186	154	252	440	93
Days waited at 90th percentile	354	278	379	485	434	1 106	952	863	378
% waited more than 365 days	6.5	6.2	11.0	14.8	22.6	28.6	35.7	58.3	11.4
Myringotomy									
Days waited at 50th percentile	42	28	38	68	49	37	61	13	39
Days waited at 90th percentile	232	92	150	301	133	114	321	116	152
% waited more than 365 days	1.1	0.2	1.1	5.5	0.6	–	6.1	5.0	1.3
Prostatectomy									
Days waited at 50th percentile	44	23	28	23	55	51	30	45	35

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	223	225	128	122	232	83	218	441	206
% waited more than 365 days	2.6	5.2	1.9	1.9	4.3	–	5.1	15.4	3.4
Septoplasty									
Days waited at 50th percentile	203	75	56	159	129	np	167	205	113
Days waited at 90th percentile	370	376	545	561	354	np	851	1 814	405
% waited more than 365 days	11.4	10.7	16.9	19.1	9.5	np	29.4	42.9	13.6
Tonsillectomy									
Days waited at 50th percentile	123	53	42	112	80	117	194	154	75
Days waited at 90th percentile	345	199	183	461	364	1 278	943	683	332
% waited more than 365 days	4.3	2.0	3.8	17.5	9.8	35.5	35.8	20.2	6.1
Total hip replacement									
Days waited at 50th percentile	134	132	62	83	111	244	140	164	106
Days waited at 90th percentile	356	361	245	326	468	617	330	413	358
% waited more than 365 days	5.9	9.4	5.3	7.1	16.5	38.3	8.1	27.3	8.6
Total knee replacement									
Days waited at 50th percentile	221	170	74	115	171	392	233	203	162
Days waited at 90th percentile	365	437	343	399	559	654	527	434	390
% waited more than 365 days	9.9	15.6	9.0	12.0	28.5	54.0	24.1	36.4	13.4
Varicose veins stripping and ligation									
Days waited at 50th percentile	59	109	77	51	284	39	218	305	83
Days waited at 90th percentile	230	431	770	336	747	254	957	1,269	426
% waited more than 365 days	1.9	14.0	22.6	8.9	35.5	3.3	41.3	46.7	12.8
Not available/Not stated									
Days waited at 50th percentile	26	26	21	24	33	32	38	26	26
Days waited at 90th percentile	184	189	114	183	163	280	239	246	174
% waited more than 365 days	1.2	3.3	1.8	3.8	2.7	6.9	5.1	5.9	2.4
Total									
Days waited at 50th percentile	**35**	**30**	**25**	**29**	**40**	**38**	**63**	**35**	**32**
Days waited at 90th percentile	**260**	**208**	**142**	**225**	**206**	**343**	**364**	**370**	**226**
% waited more than 365 days	**1.9**	**3.3**	**2.5**	**4.6**	**3.9**	**9.2**	**9.9**	**10.2**	**3.1**
2007-08									
Cataract extraction									
Days waited at 50th percentile	168	43	48	59	73	417	175	184	87
Days waited at 90th percentile	340	231	317	265	225	737	484	498	326
% waited more than 365 days	2.9	1.7	6.0	3.3	1.2	51.5	18.5	20.1	4.3
Cholecystectomy									
Days waited at 50th percentile	53	50	37	33	50	78	83	76	47
Days waited at 90th percentile	202	194	117	194	154	420	227	384	188
% waited more than 365 days	0.7	1.4	0.7	1.8	0.6	13.8	1.8	10.5	1.4
Coronary artery bypass graft									
Days waited at 50th percentile	14	11	9	24	20	31	13	..	14

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	102	151	67	56	113	140	84	..	97
% waited more than 365 days	0.1	0.2	0.2	–	–	0.8	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	26	21	33	20	35	49	51	52	26
Days waited at 90th percentile	156	163	137	146	119	174	279	181	157
% waited more than 365 days	0.9	2.0	3.0	3.1	1.1	2.4	4.0	3.5	1.8
Haemorrhoidectomy									
Days waited at 50th percentile	50	65	37	39	48	68	72	79	50
Days waited at 90th percentile	249	260	167	245	168	440	168	307	245
% waited more than 365 days	1.9	4.2	2.5	2.9	1.7	12.5	–	6.1	2.8
Hysterectomy									
Days waited at 50th percentile	52	52	36	42	54	66	85	78	49
Days waited at 90th percentile	239	161	121	161	167	221	308	158	192
% waited more than 365 days	1.8	1.2	0.7	1.1	0.8	3.5	4.1	3.4	1.4
Inguinal herniorrhaphy									
Days waited at 50th percentile	56	52	40	35	51	98	90	74	50
Days waited at 90th percentile	231	232	145	196	201	424	237	461	225
% waited more than 365 days	0.8	4.1	0.9	1.5	2.4	15.5	1.8	11.5	2.2
Myringoplasty									
Days waited at 50th percentile	177	63	62	166	200	441	417	406	104
Days waited at 90th percentile	365	322	358	408	551	1 432	860	1 043	411
% waited more than 365 days	9.8	5.9	9.9	15.8	32.2	60.0	64.0	55.6	14.5
Myringotomy									
Days waited at 50th percentile	63	39	36	73	57	44	94	44	48
Days waited at 90th percentile	315	113	168	355	159	150	418	106	182
% waited more than 365 days	2.4	0.5	0.9	9.4	0.7	–	13.8	3.6	2.4
Prostatectomy									
Days waited at 50th percentile	47	22	36	28	58	39	45	50	36
Days waited at 90th percentile	232	234	155	105	217	135	178	160	203
% waited more than 365 days	1.7	5.6	3.0	0.9	2.5	–	3.0	–	3.0
Septoplasty									
Days waited at 50th percentile	224	105	68	156	148	507	196	153	141
Days waited at 90th percentile	369	364	625	382	459	1 557	645	1 913	389
% waited more than 365 days	11.3	9.7	14.5	12.3	18.6	60.4	32.4	21.1	13.1
Tonsillectomy									
Days waited at 50th percentile	148	67	40	146	109	96	289	95	88
Days waited at 90th percentile	350	271	188	443	399	539	677	385	349
% waited more than 365 days	4.1	2.9	3.8	18.0	14.3	15.7	43.2	11.2	7.1
Total hip replacement									
Days waited at 50th percentile	134	121	62	84	114	294	185	129	107
Days waited at 90th percentile	357	405	230	246	484	679	478	928	359

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
% waited more than 365 days	6.3	12.7	3.3	3.1	16.4	39.6	21.3	21.7	8.9
Total knee replacement									
Days waited at 50th percentile	235	166	77	118	207	381	226	292	160
Days waited at 90th percentile	367	505	294	307	656	762	496	618	386
% waited more than 365 days	10.5	18.7	6.9	5.7	34.9	53.9	25.2	37.5	13.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	71	140	57	66	258	46	401	123	91
Days waited at 90th percentile	290	480	353	397	603	331	867	987	430
% waited more than 365 days	2.7	20.3	9.4	12.9	34.3	9.1	53.6	27.1	13.8
Not available/Not stated									
Days waited at 50th percentile	27	27	22	25	35	28	42	28	27
Days waited at 90th percentile	200	203	113	160	175	263	261	229	181
% waited more than 365 days	1.2	3.4	1.8	2.2	2.7	6.2	6.1	5.6	2.3
Total									
Days waited at 50th percentile	**39**	**33**	**27**	**30**	**42**	**36**	**72**	**43**	**34**
Days waited at 90th percentile	**278**	**221**	**137**	**206**	**208**	**369**	**372**	**337**	**235**
% waited more than 365 days	**1.8**	**3.6**	**2.3**	**3.0**	**3.9**	**10.1**	**10.3**	**8.6**	**3.0**
2008-09									
Cataract extraction									
Days waited at 50th percentile	168	56	42	49	59	197	121	146	84
Days waited at 90th percentile	348	190	224	190	259	570	339	372	320
% waited more than 365 days	3.8	1.0	2.2	0.8	1.3	30.4	8.8	10.2	3.6
Cholecystectomy									
Days waited at 50th percentile	53	47	40	32	44	59	85	82	47
Days waited at 90th percentile	189	175	117	149	148	426	226	253	170
% waited more than 365 days	1.8	1.5	0.7	0.9	0.5	14.1	3.5	4.9	1.8
Coronary artery bypass graft									
Days waited at 50th percentile	15	15	10	15	17	29	11	..	14
Days waited at 90th percentile	80	184	74	35	119	142	51	..	93
% waited more than 365 days	–	1.3	0.1	–	0.2	–	–	..	0.4
Cystoscopy									
Days waited at 50th percentile	26	19	33	22	35	36	80	49	25
Days waited at 90th percentile	118	126	145	161	100	158	394	213	133
% waited more than 365 days	0.8	1.2	1.4	2.5	1.1	1.2	12.1	3.0	1.5
Haemorrhoidectomy									
Days waited at 50th percentile	51	68	42	30	38	204	84	73	51
Days waited at 90th percentile	191	248	166	178	179	591	164	318	216
% waited more than 365 days	1.6	5.0	2.1	1.4	3.4	30.8	–	8.0	3.3
Hysterectomy									
Days waited at 50th percentile	50	48	41	56	50	55	77	56	48
Days waited at 90th percentile	215	141	119	160	184	280	235	208	171

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
% waited more than 365 days	1.6	0.6	0.5	1.1	1.0	4.3	3.5	1.1	1.2
Inguinal herniorrhaphy									
Days waited at 50th percentile	58	52	47	32	48	68	87	80	52
Days waited at 90th percentile	241	214	145	156	217	622	272	206	218
% waited more than 365 days	2.3	3.4	1.2	0.9	1.1	22.7	5.7	1.5	3.0
Myringoplasty									
Days waited at 50th percentile	190	82	70	101	153	71	273	82	92
Days waited at 90th percentile	366	316	328	381	451	450	689	593	370
% waited more than 365 days	10.9	6.9	8.1	11.4	16.3	15.0	40.0	16.2	10.8
Myringotomy									
Days waited at 50th percentile	45	43	33	58	48	49	119	35	44
Days waited at 90th percentile	195	120	119	212	109	154	353	128	141
% waited more than 365 days	1.1	0.3	1.2	2.5	0.4	1.0	8.9	2.5	1.2
Prostatectomy									
Days waited at 50th percentile	55	23	40	28	56	51	42	108	41
Days waited at 90th percentile	182	227	121	72	136	109	467	216	172
% waited more than 365 days	2.2	4.8	1.7	0.1	2.4	–	13.3	–	2.8
Septoplasty									
Days waited at 50th percentile	237	86	69	110	106	136	420	105	128
Days waited at 90th percentile	369	353	413	336	337	909	728	1 203	378
% waited more than 365 days	12.3	8.5	12.6	8.6	7.7	29.0	58.5	30.3	12.6
Tonsillectomy									
Days waited at 50th percentile	145	80	48	101	74	113	346	66	85
Days waited at 90th percentile	361	281	168	301	277	244	560	413	335
% waited more than 365 days	8.2	2.6	3.5	5.8	1.8	7.4	46.1	11.2	5.7
Total hip replacement									
Days waited at 50th percentile	125	107	68	68	102	370	170	59	100
Days waited at 90th percentile	364	348	242	218	374	757	489	391	364
% waited more than 365 days	8.9	9.2	4.0	1.8	11.0	50.5	22.0	12.5	9.6
Total knee replacement									
Days waited at 50th percentile	223	143	86	83	182	493	249	172	147
Days waited at 90th percentile	376	463	343	271	429	825	589	409	393
% waited more than 365 days	14.0	17.1	7.9	4.2	19.0	69.9	37.3	11.1	14.9
Varicose veins stripping and ligation									
Days waited at 50th percentile	69	110	55	91	116	104	298	118	87
Days waited at 90th percentile	270	486	275	393	344	584	749	524	373
% waited more than 365 days	2.2	17.0	5.9	12.4	7.9	13.9	35.4	21.1	10.6
Not available/Not stated									
Days waited at 50th percentile	28	25	22	26	29	32	44	25	26
Days waited at 90th percentile	194	172	113	149	172	315	256	181	168
% waited more than 365 days	1.7	2.6	1.5	1.9	2.4	8.4	6.3	3.9	2.3

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Total									
Days waited at 50th percentile	**39**	**31**	**27**	**31**	**36**	**44**	**75**	**40**	**33**
Days waited at 90th percentile	**283**	**194**	**133**	**174**	**207**	**448**	**378**	**256**	**220**
% waited more than 365 days	**2.5**	**2.9**	**1.8**	**2.0**	**2.7**	**13.1**	**10.6**	**5.6**	**2.9**
2009-10									
Cataract extraction									
Days waited at 50th percentile	211	63	37	41	61	100	162	123	86
Days waited at 90th percentile	363	228	224	183	313	297	371	341	336
% waited more than 365 days	8.4	1.4	2.2	0.5	1.6	4.6	10.9	8.7	4.3
Cholecystectomy									
Days waited at 50th percentile	62	50	40	31	47	76	72	65	51
Days waited at 90th percentile	233	156	138	171	117	562	273	259	186
% waited more than 365 days	2.5	1.2	0.8	1.6	0.5	16.5	6.6	–	2.2
Coronary artery bypass graft									
Days waited at 50th percentile	19	23	5	20	12	16	16	..	15
Days waited at 90th percentile	69	122	53	70	132	75	55	..	80
% waited more than 365 days	–	2.7	–	–	0.3	–	–	..	0.7
Cystoscopy									
Days waited at 50th percentile	25	22	30	28	30	26	85	88	25
Days waited at 90th percentile	130	108	117	162	90	103	274	247	126
% waited more than 365 days	1.3	0.7	1.5	2.5	0.2	0.4	5.4	6.5	1.3
Haemorrhoidectomy									
Days waited at 50th percentile	68	77	60	33	46	51	111	69	66
Days waited at 90th percentile	284	245	190	220	189	931	320	315	260
% waited more than 365 days	2.0	4.3	3.7	2.9	0.5	21.3	8.3	6.8	3.5
Hysterectomy									
Days waited at 50th percentile	52	52	39	49	56	59	70	89	50
Days waited at 90th percentile	284	149	134	150	176	259	275	263	196
% waited more than 365 days	3.6	0.4	1.1	0.1	0.2	4.3	4.3	2.6	1.9
Inguinal herniorrhaphy									
Days waited at 50th percentile	72	52	47	37	50	63	88	75	57
Days waited at 90th percentile	319	170	155	198	162	461	270	265	250
% waited more than 365 days	4.3	1.9	1.6	0.8	0.3	13.3	3.9	5.0	3.1
Myringoplasty									
Days waited at 50th percentile	291	85	66	100	132	56	372	78	103
Days waited at 90th percentile	418	294	280	350	386	907	708	597	382
% waited more than 365 days	20.9	5.1	5.5	7.8	15.7	17.1	57.1	22.1	12.5
Myringotomy									
Days waited at 50th percentile	71	48	34	59	50	50	148	31	48
Days waited at 90th percentile	319	147	120	149	108	137	376	134	151
% waited more than 365 days	5.0	0.6	0.9	0.6	0.3	–	11.0	–	1.2

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Prostatectomy									
Days waited at 50th percentile	61	31	40	41	56	55	71	109	47
Days waited at 90th percentile	227	198	179	111	114	127	672	462	188
% waited more than 365 days	3.7	2.2	4.6	0.1	0.6	–	14.0	13.9	2.9
Septoplasty									
Days waited at 50th percentile	311	104	56	81	98	153	373	173	144
Days waited at 90th percentile	460	381	368	317	342	931	676	403	413
% waited more than 365 days	28.4	11.0	10.3	7.0	3.9	25.6	52.8	10.3	16.3
Tonsillectomy									
Days waited at 50th percentile	220	86	53	76	77	73	331	143	91
Days waited at 90th percentile	387	318	213	181	331	247	498	474	357
% waited more than 365 days	15.7	6.0	4.0	1.3	3.9	3.8	43.0	12.7	8.4
Total hip replacement									
Days waited at 50th percentile	167	119	69	78	120	291	222	134	116
Days waited at 90th percentile	391	352	269	209	327	740	505	360	373
% waited more than 365 days	16.2	8.9	5.2	1.7	1.3	40.2	28.1	6.9	11.1
Total knee replacement									
Days waited at 50th percentile	301	155	93	100	162	431	366	172	180
Days waited at 90th percentile	415	417	368	277	337	896	568	494	414
% waited more than 365 days	24.6	14.5	10.3	5.9	1.2	59.6	50.0	15.0	18.1
Varicose veins stripping and ligation									
Days waited at 50th percentile	77	119	70	70	144	113	254	119	96
Days waited at 90th percentile	338	474	386	308	343	680	435	471	389
% waited more than 365 days	5.6	19.9	13.4	6.1	5.3	20.9	30.7	11.4	12.8
Not available/Not stated									
Days waited at 50th percentile	29	28	23	27	29	29	42	30	28
Days waited at 90th percentile	258	169	128	144	147	283	275	223	184
% waited more than 365 days	3.2	2.5	2.2	1.4	0.9	7.2	6.1	4.5	2.7
Total									
Days waited at 50th percentile	**44**	**36**	**27**	**32**	**36**	**36**	**73**	**44**	**35**
Days waited at 90th percentile	**330**	**197**	**150**	**161**	**189**	**332**	**357**	**271**	**246**
% waited more than 365 days	**4.9**	**2.8**	**2.5**	**1.5**	**1.1**	**8.7**	**9.5**	**5.8**	**3.5**
2010-11									
Cataract extraction									
Days waited at 50th percentile	227	57	48	35	87	246	140	126	90
Days waited at 90th percentile	361	196	333	159	349	435	300	285	343
% waited more than 365 days	6.3	0.6	3.7	0.4	6.1	27.3	5.1	3.3	4.1
Cholecystectomy									
Days waited at 50th percentile	61	50	52	28	49	68	70	68	54
Days waited at 90th percentile	240	137	141	163	99	454	261	234	171
% waited more than 365 days	2.1	0.9	0.4	1.9	0.2	14.7	3.4	3.3	1.8

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Coronary artery bypass graft									
Days waited at 50th percentile	16	22	7	14	23	28	13	..	17
Days waited at 90th percentile	77	87	58	63	88	86	49	..	75
% waited more than 365 days	0.2	0.2	–	–	0.5	0.5	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	23	23	28	27	35	28	73	83	25
Days waited at 90th percentile	105	99	126	176	98	112	380	224	115
% waited more than 365 days	1.2	0.6	0.7	2.6	0.4	0.6	11.1	4.4	1.3
Haemorrhoidectomy									
Days waited at 50th percentile	66	63	61	34	55	33	126	60	60
Days waited at 90th percentile	310	248	155	212	220	366	286	250	255
% waited more than 365 days	3.8	4.0	1.0	3.6	2.2	11.1	–	–	3.4
Hysterectomy									
Days waited at 50th percentile	55	49	40	43	54	48	55	71	49
Days waited at 90th percentile	300	137	141	127	169	210	218	224	201
% waited more than 365 days	3.6	0.4	1.1	0.1	0.2	1.4	3.3	–	1.7
Inguinal herniorrhaphy									
Days waited at 50th percentile	70	54	58	33	43	54	82	58	57
Days waited at 90th percentile	329	161	159	168	136	587	290	241	259
% waited more than 365 days	3.3	1.3	0.7	2.3	1.0	15.7	5.2	5.0	2.6
Myringoplasty									
Days waited at 50th percentile	316	84	68	90	182	180	317	147	108
Days waited at 90th percentile	383	356	190	246	354	694	672	539	369
% waited more than 365 days	19.0	9.7	1.1	4.9	7.3	21.7	46.7	23.2	10.7
Myringotomy									
Days waited at 50th percentile	68	49	35	43	48	119	164	22	47
Days waited at 90th percentile	297	139	108	114	110	197	384	106	139
% waited more than 365 days	2.9	0.6	0.2	1.0	–	1.6	11.6	–	0.9
Prostatectomy									
Days waited at 50th percentile	62	29	45	33	49	82	82	56	47
Days waited at 90th percentile	222	174	169	119	91	191	749	154	170
% waited more than 365 days	3.1	2.9	1.4	0.3	0.8	–	23.4	2.0	2.5
Septoplasty									
Days waited at 50th percentile	312	110	58	94	137	231	404	277	159
Days waited at 90th percentile	385	384	263	349	301	721	894	489	382
% waited more than 365 days	18.7	12.2	2.8	9.4	2.5	31.9	55.0	36.4	13.7
Tonsillectomy									
Days waited at 50th percentile	192	97	56	78	71	120	336	64	94
Days waited at 90th percentile	370	330	183	210	263	302	637	385	351
% waited more than 365 days	11.6	5.3	0.9	1.7	0.9	3.3	42.4	13.1	6.5
Total hip replacement									

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 50th percentile	149	98	78	80	118	194	253	148	108
Days waited at 90th percentile	363	323	273	237	312	635	581	273	357
% waited more than 365 days	8.0	6.9	4.2	2.9	3.3	33.2	28.6	–	7.6
Total knee replacement									
Days waited at 50th percentile	295	133	109	94	136	377	328	213	173
Days waited at 90th percentile	372	382	350	306	351	717	585	404	376
% waited more than 365 days	13.8	11.7	7.7	5.1	5.7	51.0	42.7	28.8	12.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	101	104	63	68	204	85	319	94	100
Days waited at 90th percentile	350	434	305	274	411	421	584	462	368
% waited more than 365 days	5.3	13.8	4.1	4.8	18.9	19.4	33.8	11.1	10.2
Not available/Not stated									
Days waited at 50th percentile	31	29	25	27	29	29	41	24	28
Days waited at 90th percentile	276	164	126	143	153	272	305	165	184
% waited more than 365 days	2.6	2.4	1.0	1.5	1.6	7.1	7.0	2.9	2.2
Total									
Days waited at 50th percentile	**47**	**36**	**29**	**29**	**38**	**38**	**76**	**33**	**36**
Days waited at 90th percentile	**333**	**182**	**148**	**159**	**208**	**359**	**378**	**223**	**252**
% waited more than 365 days	**3.6**	**2.5**	**1.3**	**1.6**	**2.0**	**9.6**	**10.8**	**3.9**	**2.9**
2011-12									
Cataract extraction									
Days waited at 50th percentile	225	61	51	38	78	244	162	170	91
Days waited at 90th percentile	359	192	363	191	323	551	291	280	344
% waited more than 365 days	5.0	0.5	9.7	0.8	2.3	35.2	1.1	3.1	4.0
Cholecystectomy									
Days waited at 50th percentile	60	54	44	28	42	89	57	63	51
Days waited at 90th percentile	252	161	127	148	104	521	167	267	176
% waited more than 365 days	2.2	1.4	0.4	2.3	0.6	18.0	0.7	3.2	2.0
Coronary artery bypass graft									
Days waited at 50th percentile	23	18	8	25	18	21	20	..	16
Days waited at 90th percentile	85	83	56	78	84	72	70	..	76
% waited more than 365 days	0.1	–	–	–	–	–	–	..	0.1
Cystoscopy									
Days waited at 50th percentile	25	21	24	29	32	27	55	48	25
Days waited at 90th percentile	101	97	93	176	93	132	230	166	108
% waited more than 365 days	0.6	0.5	1.1	2.9	0.4	1.6	2.2	2.6	1.0
Haemorrhoidectomy									
Days waited at 50th percentile	70	63	52	34	36	52	83	131	57
Days waited at 90th percentile	304	263	154	181	120	781	306	228	245
% waited more than 365 days	3.3	4.1	1.3	2.8	0.5	25.4	2.3	0.5	3.2
Hysterectomy									

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 50th percentile	58	57	55	39	40	53	60	74	53
Days waited at 90th percentile	307	171	167	120	174	200	217	158	207
% waited more than 365 days	3.2	1.6	1.2	0.2	0.2	1.4	1.5	1.8	1.8
Inguinal herniorrhaphy									
Days waited at 50th percentile	73	60	54	29	33	58	73	73	57
Days waited at 90th percentile	342	175	152	151	142	516	198	283	277
% waited more than 365 days	4.1	1.3	1.1	2.7	1.4	14.9	1.6	7.4	3.1
Myringoplasty									
Days waited at 50th percentile	314	108	82	84	63	130	399	92	106
Days waited at 90th percentile	376	355	290	259	295	702	588	399	364
% waited more than 365 days	18.8	8.7	4.1	2.0	2.6	23.5	56.3	12.5	9.5
Myringotomy									
Days waited at 50th percentile	76	49	31	48	43	91	116	43	49
Days waited at 90th percentile	322	144	110	123	98	194	270	122	145
% waited more than 365 days	2.6	1.6	1.1	0.2	0.5	–	2.0	1.4	1.1
Prostatectomy									
Days waited at 50th percentile	56	33	38	34	36	46	45	55	42
Days waited at 90th percentile	178	187	139	135	90	97	188	106	160
% waited more than 365 days	1.7	2.3	1.4	1.9	0.8	–	3.6	–	1.7
Septoplasty									
Days waited at 50th percentile	320	101	60	99	133	200	323	110	160
Days waited at 90th percentile	372	370	298	358	316	601	552	414	370
% waited more than 365 days	16.0	11.0	4.7	9.0	2.9	22.9	39.6	18.5	11.8
Tonsillectomy									
Days waited at 50th percentile	221	98	61	78	64	103	177	73	97
Days waited at 90th percentile	370	333	253	243	254	336	335	301	358
% waited more than 365 days	13.5	6.3	3.5	3.3	1.7	5.1	5.4	4.3	7.2
Total hip replacement									
Days waited at 50th percentile	193	99	81	95	130	229	193	98	116
Days waited at 90th percentile	365	288	285	266	337	669	434	233	357
% waited more than 365 days	9.6	4.8	4.6	3.4	6.1	30.7	18.6	3.0	7.2
Total knee replacement									
Days waited at 50th percentile	303	123	120	119	173	476	216	123	184
Days waited at 90th percentile	372	343	362	342	362	833	444	490	371
% waited more than 365 days	13.7	8.0	9.2	8.7	8.9	52.2	20.7	14.3	11.6
Varicose veins stripping and ligation									
Days waited at 50th percentile	100	112	77	66	119	66	256	236	103
Days waited at 90th percentile	343	417	356	379	363	667	660	562	365
% waited more than 365 days	3.7	13.3	6.9	11.5	8.2	23.1	33.2	35.9	10.0
Not available/Not stated									
Days waited at 50th percentile	33	29	23	27	28	30	33	27	28

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	280	175	122	129	137	264	265	158	181
% waited more than 365 days	2.4	2.4	1.2	1.3	1.2	6.7	5.8	3.0	2.1
Total									
Days waited at 50th percentile	**49**	**36**	**27**	**30**	**34**	**38**	**63**	**39**	**36**
Days waited at 90th percentile	**335**	**189**	**147**	**159**	**191**	**348**	**296**	**219**	**251**
% waited more than 365 days	**3.4**	**2.4**	**2.0**	**1.7**	**1.5**	**9.4**	**6.2**	**3.5**	**2.7**
2012-13									
Cataract extraction									
Days waited at 50th percentile	232	52	44	45	82	275	157	156	91
Days waited at 90th percentile	355	249	219	208	302	753	305	308	338
% waited more than 365 days	3.2	0.8	3.3	1.1	2.5	40.3	0.6	6.6	3.1
Cholecystectomy									
Days waited at 50th percentile	56	60	46	29	30	71	63	58	50
Days waited at 90th percentile	235	188	141	112	90	399	217	170	181
% waited more than 365 days	1.7	1.8	0.9	0.6	0.1	13.0	–	3.4	1.7
Coronary artery bypass graft									
Days waited at 50th percentile	27	20	8	13	15	45	7	..	16
Days waited at 90th percentile	85	85	69	43	55	134	56	..	77
% waited more than 365 days	0.2	0.3	0.2	–	–	–	–	..	0.2
Cystoscopy									
Days waited at 50th percentile	25	21	24	22	30	34	34	50	23
Days waited at 90th percentile	104	96	100	136	97	182	168	158	108
% waited more than 365 days	0.6	0.5	1.5	2.2	0.5	1.8	0.5	3.2	0.9
Haemorrhoidectomy									
Days waited at 50th percentile	67	79	56	36	19	68	86	75	58
Days waited at 90th percentile	310	284	210	121	90	754	235	226	257
% waited more than 365 days	3.0	4.4	3.6	0.2	0.2	22.8	–	6.6	3.5
Hysterectomy									
Days waited at 50th percentile	60	60	55	35	42	70	55	60	53
Days waited at 90th percentile	316	213	171	120	131	237	189	254	218
% waited more than 365 days	2.3	2.6	1.8	–	–	4.1	0.7	6.6	1.9
Inguinal herniorrhaphy									
Days waited at 50th percentile	71	71	65	34	29	99	81	52	60
Days waited at 90th percentile	337	232	181	120	119	633	232	133	284
% waited more than 365 days	3.4	2.7	2.2	0.8	0.2	25.9	0.7	0.7	3.1
Myringoplasty									
Days waited at 50th percentile	303	131	84	87	68	80	399	143	123
Days waited at 90th percentile	383	374	322	279	364	553	525	386	365
% waited more than 365 days	15.3	11.3	6.2	3.4	9.2	16.7	62.5	10.3	9.7
Myringotomy									
Days waited at 50th percentile	68	51	36	51	42	71	59	73	49

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

	NSW	*Vic*	*Qld* (a)	*WA*	*SA*	*Tas (b)*	*ACT*	*NT*	*Aust*
Days waited at 90th percentile	329	171	103	133	96	266	296	177	141
% waited more than 365 days	2.3	2.0	0.9	0.2	0.2	4.7	4.7	2.3	1.3
Prostatectomy									
Days waited at 50th percentile	53	27	36	31	36	52	65	63	39
Days waited at 90th percentile	198	179	168	147	107	121	139	157	167
% waited more than 365 days	1.8	1.8	2.3	1.0	0.5	–	1.9	–	1.7
Septoplasty									
Days waited at 50th percentile	327	129	76	124	100	272	340	117	197
Days waited at 90th percentile	377	569	379	390	331	584	572	443	389
% waited more than 365 days	16.6	18.7	12.2	13.6	2.3	31.9	31.8	22.9	15.7
Tonsillectomy									
Days waited at 50th percentile	258	105	56	88	69	96	170	75	98
Days waited at 90th percentile	366	354	216	259	279	448	377	363	359
% waited more than 365 days	10.1	8.4	4.3	4.6	1.5	16.4	13.4	9.6	7.3
Total hip replacement									
Days waited at 50th percentile	195	105	78	92	108	372	136	107	115
Days waited at 90th percentile	362	309	347	271	317	831	373	281	357
% waited more than 365 days	7.4	5.8	7.8	4.2	3.0	50.8	10.7	2.2	7.5
Total knee replacement									
Days waited at 50th percentile	297	141	153	105	153	615	177	121	196
Days waited at 90th percentile	368	368	462	312	342	962	448	366	374
% waited more than 365 days	11.3	10.1	18.2	5.6	3.3	66.7	19.0	11.1	12.1
Varicose veins stripping and ligation									
Days waited at 50th percentile	97	144	56	70	88	39	157	98	96
Days waited at 90th percentile	353	403	317	342	339	273	545	387	356
% waited more than 365 days	4.7	12.5	4.9	7.3	3.4	3.6	14.7	11.1	7.7
Not available/Not stated									
Days waited at 50th percentile	32	29	23	26	28	29	29	26	28
Days waited at 90th percentile	283	209	139	132	129	225	211	139	195
% waited more than 365 days	2.1	3.3	1.9	1.2	0.7	5.8	3.9	1.9	2.2
Total									
Days waited at 50th percentile	**50**	**36**	**27**	**30**	**34**	**41**	**51**	**40**	**36**
Days waited at 90th percentile	**335**	**223**	**163**	**159**	**182**	**406**	**277**	**196**	**265**
% waited more than 365 days	**2.8**	**3.3**	**2.5**	**1.5**	**1.0**	**11.5**	**4.1**	**3.3**	**2.7**

(a) The total number of admissions for Queensland includes 644 admissions that were removed from the waiting list for elective admission before 30 June 2005 and separated before 30 June 2006. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods. The total number of admissions for Queensland includes 507 patients who were removed from the waiting list for elective admission before 30 June 2007 and separated before 30 June 2008. It is expected that these admissions would be counterbalanced overall by the number of admissions occurring in a similar way in future reporting periods.

(b) Includes data for the Mersey Community Hospital.

Table 10A.27 **Elective surgery waiting times, by indicator procedure**

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

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

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra; AIHW (2013), *Australian hospital statistics 2012–13: elective surgery waiting times*. Health services series no. 51. Cat. no. HSE 140. Canberra: AIHW

Table 10A.28 **NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent) (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	na	na	38.9	15.7	5.1	1.5	3.3	0.1	0.3	1.2
Category 2 (over 90 days)	na	na	40.2	38.7	28.9	16.2	7.4	1.2	0.4	0.9
Category 3 (over 12 months)	na	na	10.6	0.1	0.2	0.1	1.3	2.0	0.2	0.3
All patients	na	na	22.7	13.7	8.5	3.7	2.5	1.8	0.2	0.4
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	na	na	21.7	22.8	12.9	7.9	7.2	7.9	7.4	6.3
Category 2 (over 90 days)	na	na	28.8	29.5	25.5	24.3	14.5	15.9	10.3	9.8
Category 3 (over 12 months)	na	na	20.8	15.8	4.4	4.6	6.4	12.1	8.8	8.4
All patients	na	na	23.6	22.9	14.2	12.5	9.2	12.1	8.9	8.3
Waiting time data coverage										
Per cent of elective surgery separations	na	na	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

na Not available.

Source: NSW Government (unpublished).

Table 10A.29 **NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	95	99	692	243	44	74	116	71	349	143	27
No. of extended wait patients	11	1	5	1	–	–	–	1	1	4	–
% overdue	11.6	1.0	0.7	0.4	–	–	–	1.4	0.3	2.8	–
Category 2											
No. patients on waiting list	145	904	3 584	1 860	236	699	1 069	482	2 054	224	94
No. of extended wait patients	–	9	46	5	6	–	12	1	22	1	1
% overdue	–	1.0	1.3	0.3	2.5	–	1.1	0.2	1.1	0.4	1.1
Category 3											
No. patients on waiting list	42	8 055	8 206	3 960	837	14 795	16 003	1 581	1 791	551	154
No. of extended wait patients	–	35	35	22	12	8	58	3	1	3	–
% overdue	–	0.4	0.4	0.6	1.4	0.1	0.4	0.2	0.1	0.5	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	1 813	2 507	17 619	7 038	1 297	1 793	5 312	2 779	6 533	3 092	932
No. of extended wait patients	162	142	1 006	394	57	35	168	88	919	182	41
% overdue	8.9	5.7	5.7	5.6	4.4	2.0	3.2	3.2	14.1	5.9	4.4
Category 2											
No. patients admitted from waiting list	1 340	4 102	20 631	12 118	1 303	4 835	6 001	2 650	10 845	1 335	696
No. of extended wait patients	105	755	1 981	790	123	249	628	251	1 422	67	59
% overdue	7.8	18.4	9.6	6.5	9.4	5.1	10.5	9.5	13.1	5.0	8.5

Table 10A.29 **NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 3											
No. patients admitted from waiting list	262	8 917	14 778	7 553	1 269	20 228	19 259	2 824	5 483	1 106	323
No. of extended wait patients	2	1 507	968	323	151	1 288	2 176	150	245	44	18
% overdue	0.8	16.9	6.6	4.3	11.9	6.4	11.3	5.3	4.5	4.0	5.6

– Nil or rounded to zero.

Source: NSW Government (unpublished).

Table 10A.30 **Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent) (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	–	0.1	0.7	–	–	–	–	–	–	–
Category 2 (over 90 days)	39.1	43.3	42.3	36.8	34.0	35.1	32.9	29.9	28.0	34.0
Category 3 (over 12 months)	27.1	24.8	20.8	14.2	10.5	9.3	9.3	6.8	6.8	9.4
All patients	31.1	31.8	29.7	23.8	20.5	21.3	20.3	17.4	16.3	20.6
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	–	–	0.0	–	–	–	–	–	–	–
Category 2 (over 90 days)	20.5	20.4	23.6	27.7	25.3	29.9	27.0	27.0	25.4	27.7
Category 3 (over 12 months)	8.8	7.5	8.7	10.3	8.5	9.7	7.9	8.0	7.4	8.5
All patients	12.4	11.9	13.7	16.2	14.5	16.5	14.6	15.1	13.9	14.9
Waiting time data coverage										
Per cent of elective surgery separations	70.1	76.3	77.0	77.9	77.9	78.1	79.2	79.6	78.0	77.0

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

– Nil or rounded to zero.

Source: Victorian Government (unpublished).

Table 10A.31 **Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	71	58	380	206	32	66	48	202	457	41	28
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Category 2											
No. patients on waiting list	259	1 906	5 216	2 618	588	583	4 769	2 143	2 556	378	366
No. of extended wait patients	73	687	1 629	660	219	10	2 077	1 009	761	140	14
% overdue	28.2	36.0	31.2	25.2	37.2	1.7	43.6	47.1	29.8	37.0	3.8
Category 3											
No. patients on waiting list	74	4 003	4 043	1 679	205	4 320	3 918	2 623	913	924	243
No. of extended wait patients	3	611	400	48	10	76	312	482	67	142	8
% overdue	4.1	15.3	9.9	2.9	4.9	1.8	8.0	18.4	7.3	15.4	3.3
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	1 484	2 061	10 067	5 867	851	2 135	3 664	8 083	10 218	1 101	876
No. of extended wait patients	–	–	–	–	–	–	–	–	1	–	–
% overdue	–	–	–	–	–	–	–	–	0.0	–	–
Category 2											
No. patients admitted from waiting list	1 229	6 182	16 481	9 751	1 745	4 864	11 782	5 999	10 654	1 176	2 159
No. of extended wait patients	276	2 092	4 843	2 095	633	230	4 957	1 796	2 527	319	158
% overdue	22.5	33.8	29.4	21.5	36.3	4.7	42.1	29.9	23.7	27.1	7.3

Table 10A.31 **Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 3											
No. patients admitted from waiting list	203	4 540	5 803	2 311	224	11 198	4 404	2 428	2 677	694	437
No. of extended wait patients	3	624	471	211	11	128	720	545	94	159	5
% overdue	1.5	13.7	8.1	9.1	4.9	1.1	16.3	22.4	3.5	22.9	1.1

– Nil or rounded to zero.

Source: Victorian Government (unpublished).

Table 10A.32 **Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent) (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	2.3	1.1	5.4	11.0	6.4	8.0	6.4	8.4	10.4	7.8
Category 2 (over 90 days)	5.3	2.3	11.3	20.5	20.5	21.4	22.1	28.2	21.1	26.6
Category 3 (over 12 months)	38.2	34.1	30.5	32.8	32.5	24.4	15.5	1.1	3.4	8.0
All patients	26.0	21.8	22.2	26.5	25.6	21.6	17.8	16.3	12.6	16.8
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	9.3	9.5	10.4	14.3	13.2	14.7	13.0	12.8	13.5	12.3
Category 2 (over 90 days)	11.8	10.1	9.4	15.6	17.7	16.9	18.4	21.3	24.9	22.5
Category 3 (over 12 months)	13.0	12.7	8.5	10.2	11.7	11.2	8.7	11.3	6.2	10.2
All patients	11.1	10.5	9.6	14.1	14.9	15.0	14.7	16.3	17.6	16.5
Waiting time data coverage										
Per cent of elective surgery separations	95.0	95.0	95.0	95.0	95.0	98.0	98.0	98.0	98.0	98.0

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

Source: Queensland Government (unpublished).

Table 10A.33 **Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	120	181	821	484	78	190	302	320	715	86	57
No. of extended wait patients	7	3	3	16	13	–	25	40	96	3	1
% overdue	5.8	1.7	0.4	3.3	16.7	–	8.3	12.5	13.4	3.5	1.8
Category 2											
No. patients on waiting list	239	1 860	4 390	2 189	448	905	4 835	1 234	1 373	219	127
No. of extended wait patients	11	326	893	320	235	93	2 045	342	438	30	9
% overdue	4.6	17.5	20.3	14.6	52.5	10.3	42.3	27.7	31.9	13.7	7.1
Category 3											
No. patients on waiting list	58	1 785	2 540	1 691	100	3 153	5 375	995	667	122	165
No. of extended wait patients	2	110	181	55	17	184	588	101	81	8	11
% overdue	3.4	6.2	7.1	3.3	17.0	5.8	10.9	10.2	12.1	6.6	6.7
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	2 070	3 256	13 349	6 222	1 051	1 364	8 562	4 203	5 511	1 762	769
No. of extended wait patients	238	269	1 481	662	91	130	455	903	1 472	141	66
% overdue	11.5	8.3	11.1	10.6	8.7	9.5	5.3	21.5	26.7	8.0	8.6
Category 2											
No. patients admitted from waiting list	839	6 327	13 425	8 443	665	4 982	9 904	3 366	3 685	775	1 228
No. of extended wait patients	82	1 373	2 887	1 659	176	577	3 295	975	747	86	187
% overdue	9.8	21.7	21.5	19.6	26.5	11.6	33.3	29.0	20.3	11.1	15.2

Table 10A.33 **Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Category 3											
No. patients admitted from waiting list	100	1 877	2 923	2 243	113	4 117	5 158	961	576	154	343
No. of extended wait patients	1	180	227	108	16	780	456	49	46	11	23
% overdue	1.0	9.6	7.8	4.8	14.2	18.9	8.8	5.1	8.0	7.1	6.7

– Nil or rounded to zero.

Source: Queensland Government (unpublished).

Table 10A.34 **WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent) (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	39.2	37.5	40.9	27.4	26.2	13.9	21.1	11.7	16.4	14.5
Category 2 (over 90 days)	48.0	47.2	52.4	53.0	46.2	40.1	30.1	28.8	25.2	23.8
Category 3 (over 12 months)	29.7	23.5	24.9	19.7	6.5	4.1	3.1	2.6	3.5	4.1
All patients	34.8	31.1	34.2	31.8	21.9	17.0	14.2	12.1	11.0	10.8
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	15.3	16.4	17.8	18.9	28.8	12.3	14.1	14.5	12.7	15.4
Category 2 (over 90 days)	23.5	28.7	31.8	32.1	44.0	30.2	24.7	24.1	19.3	17.4
Category 3 (over 12 months)	6.4	7.4	7.6	8.3	24.3	5.4	4.5	3.1	3.2	3.5
All patients	13.6	15.8	17.3	18.4	31.6	16.0	14.3	13.8	11.3	11.1
Waiting time data coverage										
Per cent of elective surgery separations	77.0	76.0	72.0	76.0	67.0	79.0	78.0	79.0	92.0	100.0

(a) Waiting times are counted as the time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

Source: WA Government (unpublished).

Table 10A.35 **WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	38	47	128	41	16	38	59	159	199	24	190
No. of extended wait patients	8	6	15	4	1	2	8	20	46	2	24
% overdue	21.1	12.8	11.7	9.8	6.3	5.3	13.6	12.6	23.1	8.3	12.6
Category 2											
No. patients on waiting list	27	568	990	366	99	395	1 239	364	667	161	467
No. of extended wait patients	–	160	229	21	38	82	303	122	194	49	74
% overdue	–	28.2	23.1	5.7	38.4	20.8	24.5	33.5	29.1	30.4	15.8
Category 3											
No. patients on waiting list	23	1 581	1 440	739	133	3 024	2 116	361	536	210	785
No. of extended wait patients	–	90	92	2	7	75	116	27	16	19	6
% overdue	–	5.7	6.4	0.3	5.3	2.5	5.5	7.5	3.0	9.0	0.8
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	572	810	3 776	1 590	253	711	1 810	2 391	2 571	491	3 919
No. of extended wait patients	–	101	416	70	45	75	162	509	587	49	768
% overdue	–	12.5	11.0	4.4	17.8	10.5	9.0	21.3	22.8	10.0	19.6
Category 2											
No. patients admitted from waiting list	169	2 138	7 203	2 212	369	1 901	4 898	1 412	4 140	627	3 057
No. of extended wait patients	27	458	752	100	112	329	1 418	410	845	83	346
% overdue	16.0	21.4	10.4	4.5	30.4	17.3	29.0	29.0	20.4	13.2	11.3

Table 10A.35 **WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Category 3											
No. patients admitted from waiting list	76	3 265	5 403	3 548	166	9 589	4 375	654	2 776	316	3 665
No. of extended wait patients	–	210	273	9	5	148	298	62	127	37	17
% overdue	–	6.4	5.1	0.3	3.0	1.5	6.8	9.5	4.6	11.7	0.5

– Nil or rounded to zero.

Source: WA Government (unpublished).

Table 10A.36 **SA elective surgery waiting times, by clinical urgency category, public hospitals (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	17.0	27.1	19.8	22.9	21.6	26.0	0.8	2.5	0.1	–
Category 2 (over 90 days)	22.1	26.0	27.9	20.8	16.8	11.2	1.1	1.1	0.1	–
Category 3 (over 12 months)	18.3	20.7	13.5	12.2	11.3	6.5	0.1	0.1	–	–
All patients	18.8	22.2	17.1	15.1	13.5	9.3	0.3	0.5	–	–
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	13.5	17.6	20.0	22.4	22.5	21.5	17.4	11.2	13.2	9.9
Category 2 (over 90 days)	15.6	18.6	24.9	22.9	22.1	27.1	15.6	10.9	12.7	16.8
Category 3 (over 12 months)	4.9	6.2	9.4	10.5	9.5	11.4	7.2	3.1	6.1	3.9
All patients	10.1	13.0	16.9	18.0	17.4	19.2	13.2	8.4	10.7	7.8
Waiting time data coverage										
Per cent of elective surgery separations	62.3	62.5	62.2	60.4	61.6	67.7	70.6	70.7	70.7	100.0

(a) For 2004-05, waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1. In previous periods, SA counted the waiting time in all urgency categories.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

– Nil or rounded to zero.

Source : SA Government (unpublished).

Table 10A.37 **SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	21	46	176	98	13	27	27	127	100	35	4
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Category 2											
No. patients on waiting list	29	377	791	428	71	246	257	381	497	21	16
No. of extended wait patients	–	–	–	–	1	–	–	–	–	–	–
% overdue	–	–	–	–	1.4	–	–	–	–	–	–
Category 3											
No. patients on waiting list	9	1 264	1 142	715	48	2 831	2 687	673	341	14	33
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	749	1 254	3 926	4 019	279	808	1 279	2 268	2 145	823	121
No. of extended wait patients	169	81	322	118	24	76	37	237	629	64	–
% overdue	22.6	6.5	8.2	2.9	8.6	9.4	2.9	10.4	29.3	7.8	–
Category 2											
No. patients admitted from waiting list	266	2 802	6 060	3 438	319	1 319	1 745	2 373	3 054	167	185
No. of extended wait patients	98	222	615	154	53	205	231	247	510	6	3
% overdue	36.8	7.9	10.1	4.5	16.6	15.5	13.2	10.4	16.7	3.6	1.6

Table 10A.37 **SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Category 3											
No. patients admitted from waiting list	26	2 482	4 265	3 170	88	6 882	5 858	1 156	1 624	95	153
No. of extended wait patients	1	79	155	12	4	215	359	125	40	4	1
% overdue	3.8	3.2	3.6	0.4	4.5	3.1	6.1	10.8	2.5	4.2	0.7

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

Source: SA Government (unpublished).

Table 10A.38 **Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	na	na	na	52.0	39.7	46.4	48.0	55.3	55.6	39.0
Category 2 (over 90 days)	na	na	na	66.0	64.8	68.5	68.6	66.7	66.7	70.0
Category 3 (over 12 months)	na	na	na	31.0	32.0	40.3	27.2	22.7	25.6	34.0
All patients	na	na	na	49.0	48.8	54.4	51.3	49.4	51.1	53.0
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	na	na	na	28.0	25.0	23.4	27.1	23.3	28.0	24.0
Category 2 (over 90 days)	na	na	na	43.0	46.1	51.2	48.2	45.3	39.0	40.0
Category 3 (over 12 months)	na	na	na	23.0	22.6	28.8	28.5	19.8	28.0	28.0
All patients	na	na	na	32.0	32.4	34.4	35.1	31.6	33.0	32.0
Waiting time data coverage										
Per cent of elective surgery separations	na	na	na	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

na Not available.

Source: Tasmanian Government (unpublished).

Table 10A.39 **Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	48	20	145	42	39	14	30	49	95	6	–
No. of extended wait patients	22	10	59	6	19	5	13	8	46	1	–
% overdue	45.8	50.0	40.7	14.3	48.7	35.7	43.3	16.3	48.4	16.7	..
Category 2											
No. patients on waiting list	–	232	876	173	151	853	1 260	185	367	14	–
No. of extended wait patients	–	139	531	26	116	737	995	114	213	9	–
% overdue	..	59.9	60.6	15.0	76.8	86.4	79.0	61.6	58.0	64.3	..
Category 3											
No. patients on waiting list	–	168	803	229	7	784	637	211	385	14	–
No. of extended wait patients	–	38	520	8	–	115	199	79	142	4	–
% overdue	..	22.6	64.8	3.5	–	14.7	31.2	37.4	36.9	28.6	..
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	411	397	1 797	808	176	229	420	1 064	794	85	1
No. of extended wait patients	152	180	431	69	93	31	105	232	176	12	–
% overdue	37.0	45.3	24.0	8.5	52.8	13.5	25.0	21.8	22.2	14.1	–
Category 2											
No. patients admitted from waiting list	–	470	2 009	1 145	109	474	1 318	515	849	89	–
No. of extended wait patients	–	216	716	211	83	258	824	246	205	10	–
% overdue	..	46.0	35.6	18.4	76.1	54.4	62.5	47.8	24.1	11.2	..

Table 10A.39 **Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Category 3											
No. patients admitted from waiting list	–	235	506	392	2	556	546	91	335	28	–
No. of extended wait patients	–	25	177	20	–	236	230	25	44	6	–
% overdue	..	10.6	35.0	5.1	–	42.4	42.1	27.5	13.1	21.4	..

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

Source: Tasmanian Government (unpublished).

Table 10A.40 **ACT elective surgery waiting times, by clinical urgency category, public hospitals (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	6.6	–	0.8	0.9	6.8	6.6	0.8	6.6	1.1	–
Category 2 (over 90 days)	55.8	52.1	60.9	54.2	54.0	54.5	51.2	58.3	50.1	41.1
Category 3 (over 12 months)	32.5	30.2	34.2	34.1	24.3	20.9	15.4	20.2	14.6	5.7
All patients	41.5	38.6	45.3	42.8	38.7	38.5	34.4	40.2	33.5	22.2
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	8.8	2.2	9.2	3.7	7.2	4.1	5.9	6.4	9.8	2.5
Category 2 (over 90 days)	47.1	47.5	55.6	48.3	49.1	53.4	54.9	56.3	55.1	49.3
Category 3 (over 12 months)	18.1	28.2	30.2	27.0	30.4	29.0	24.8	22.0	23.6	14.7
All patients	26.6	27.3	32.5	29.9	32.4	34.0	34.5	34.4	34.9	27.9
Waiting time data coverage										
Per cent of elective surgery separations	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

– Nil or rounded to zero.

Source: ACT Government (unpublished).

Table 10A.41 **ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	1	2	20	9	6	18	10	13	51	4	8
No. of extended wait patients	–	–	–	–	–	–	–	–	–	–	–
% overdue	–	–	–	–	–	–	–	–	–	–	–
Category 2											
No. patients on waiting list	9	129	271	114	16	78	707	43	330	18	185
No. of extended wait patients	1	30	61	10	6	17	450	14	124	4	63
% overdue	11.1	23.3	22.5	8.8	37.5	21.8	63.6	32.6	37.6	22.2	34.1
Category 3											
No. patients on waiting list	–	474	93	79	2	716	313	27	118	87	74
No. of extended wait patients	–	43	1	1	–	–	39	7	3	11	8
% overdue	..	9.1	1.1	1.3	–	–	12.5	25.9	2.5	12.6	10.8
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	91	141	679	406	86	166	249	482	475	266	375
No. of extended wait patients	12	–	13	7	–	5	1	2	27	8	12
% overdue	13.2	–	1.9	1.7	–	3.0	0.4	0.4	5.7	3.0	3.2
Category 2											
No. patients admitted from waiting list	86	602	1 062	555	88	268	1 186	203	836	116	490
No. of extended wait patients	7	428	363	119	20	96	852	103	363	53	306
% overdue	8.1	71.1	34.2	21.4	22.7	35.8	71.8	50.7	43.4	45.7	62.4

Table 10A.41 **ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Category 3											
No. patients admitted from waiting list	1.0	373	136	217	4	909	264	26	167	170	125
No. of extended wait patients	–	133	7	11	–	16	68	15	13	69	20
% overdue	–	35.7	5.1	5.1	–	1.8	25.8	57.7	7.8	40.6	16.0

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

Source: ACT Government (unpublished).

Table 10A.42 **NT elective surgery waiting times, by clinical urgency category, public hospitals (a), (b)**

	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Per cent of patients on waiting lists with extended waits (c)										
Category 1 (over 30 days)	57.8	41.9	61.4	53.6	53.7	57.0	49.7	37.2	23.7	15.6
Category 2 (over 90 days)	52.0	55.8	64.2	57.0	51.7	52.4	50.0	42.9	38.4	30.4
Category 3 (over 12 months)	26.5	34.7	42.2	42.6	39.3	35.8	24.2	15.0	16.7	6.1
All patients	35.8	42.6	55.9	49.0	45.9	44.9	39.1	27.7	25.6	17.0
Per cent of patients admitted from waiting lists with extended waits										
Category 1 (over 30 days)	14.5	19.0	17.2	16.7	19.2	19.6	24.3	23.5	18.6	16.1
Category 2 (over 90 days)	24.0	30.5	30.5	31.0	43.0	37.9	41.6	47.8	41.2	32.8
Category 3 (over 12 months)	14.6	14.8	14.9	22.7	39.9	29.1	19.7	19.1	17.9	16.3
All patients	17.9	22.1	21.5	22.5	31.1	28.6	29.8	32.2	27.1	23.0
Waiting time data coverage (d)										
Per cent of elective surgery separations	70.6	68.3	71.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Waiting times are counted as time waited in the most recent urgency category plus any time waited in more urgent categories, for example time in category 2, plus time spent previously in category 1.

(b) Extended waits include those patients overdue in any category, that is, it is not restricted to patients waiting greater than 365 days**.** There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for category 3 patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting longer than the agreed desirable waits of 30 and 90 days respectively.

(c) Data show patients on the waiting list at 30 June.

(d) In previous reports, waiting times coverage data were derived including scopes. Data from 2004-05 exclude these scopes.

Source: NT Government (unpublished).

Table 10A.43 **NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 1											
No. patients on waiting list	na	8	54	17	na	3	17	8	4	2	9
No. of extended wait patients	na	–	7	–	na	–	7	1	1	–	3
% overdue	na	–	13.0	–	na	–	41.2	12.5	25.0	–	33.3
Category 2											
No. patients on waiting list	na	157	350	130	na	234	172	30	27	11	7
No. of extended wait patients	na	40	87	23	na	143	37	4	3	2	1
% overdue	na	25.5	24.9	17.7	na	61.1	21.5	13.3	11.1	18.2	14.3
Category 3											
No. patients on waiting list	na	251	360	95	na	424	117	61	35	14	10
No. of extended wait patients	na	12	27	13	na	13	12	1	4	1	–
% overdue	na	4.8	7.5	13.7	na	3.1	10.3	1.6	11.4	7.1	–
Waiting time at admission											
Category 1											
No. patients admitted from waiting list	na	144	1 066	974	na	53	301	107	64	24	73
No. of extended wait patients	na	26	218	83	na	4	68	16	25	5	7
% overdue	na	18.1	20.5	8.5	na	7.5	22.6	15.0	39.1	20.8	9.6
Category 2											
No. patients admitted from waiting list	na	376	1 248	434	na	340	372	90	68	35	27
No. of extended wait patients	na	94	451	108	na	153	116	25	17	13	3
% overdue	na	25.0	36.1	24.9	na	45.0	31.2	27.8	25.0	37.1	11.1

Table 10A.43 **NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2011-12**

	Cardio-thoracic	*Ear, Nose & Throat*	*General*	*Gynae-cology*	*Neuro-surgery*	*Opthal-mology*	*Ortho-paedic*	*Plastic*	*Urology*	*Vascular*	*Other*
Waiting time at Census date											
Category 3											
No. patients admitted from waiting list	na	190	396	164	na	449	144	18	31	17	25
No. of extended wait patients	na	48	106	19	na	16	24	6	8	6	–
% overdue	na	25.3	26.8	11.6	na	3.6	16.7	33.3	25.8	35.3	–

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

Source : NT Government (unpublished).

Table 10A.44 **Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12									
Principal referral and specialist women's and children's hospitals									
Resuscitation	43	53	42	61	52	59	61	53	48
Emergency	21	34	22	53	30	29	41	23	29
Urgent	16	27	19	49	24	18	28	21	24
Semi-urgent	19	29	22	51	28	20	27	19	26
Non-urgent	36	48	42	60	42	33	44	35	41
Total (c)	19	30	21	51	28	22	32	22	26
Large hospitals									
Resuscitation	42	56	47	59	40	81	..	..	49
Emergency	28	35	23	57	57	42	..	..	36
Urgent	21	32	21	51	52	36	..	..	30
Semi-urgent	21	34	29	48	51	44	..	..	30
Non-urgent	51	66	49	66	61	86	..	..	58
Total (c)	23	34	23	52	53	41	..	..	32
All hospitals (d)									
Resuscitation	44	53	43	61	53	62	61	53	49
Emergency	25	35	24	54	36	30	41	28	32
Urgent	21	29	20	50	33	21	28	28	27
Semi-urgent	23	30	25	51	37	24	27	29	29
Non-urgent	43	53	46	62	52	43	44	60	48
Total (c)	24	31	23	52	36	25	32	29	29
2012-13									
Principal referral and specialist women's and children's hospitals									
Resuscitation	43	57	54	59	53	56	62	49	51
Emergency	28	44	37	49	35	31	40	20	36
Urgent	23	36	36	42	29	18	24	19	31
Semi-urgent	27	35	43	44	32	19	28	16	33
Non-urgent	46	50	60	52	51	36	40	33	49
Total (c)	26	38	38	45	32	22	29	19	33
Large hospitals									
Resuscitation	44	44	54	54	39	69	..	..	48
Emergency	36	40	55	56	52	37	..	..	45
Urgent	29	31	51	42	44	34	..	..	37
Semi-urgent	31	33	57	41	44	42	..	..	36
Non-urgent	64	58	66	53	61	77	..	..	62
Total (c)	32	34	53	46	46	38	..	..	39
All hospitals (d)									

Table 10A.44 **Proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, public hospitals (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Resuscitation	44	56	54	59	55	56	62	48	52
Emergency	32	44	40	52	41	32	40	23	39
Urgent	27	36	39	43	38	22	24	23	34
Semi-urgent	30	36	45	45	43	24	28	24	35
Non-urgent	53	53	62	55	61	47	40	50	54
Total (c)	30	38	41	46	41	25	29	24	36

(a) Includes presentations for all Types of visit.

(b) Length of stay is calculated as the length of time between presentation to the emergency department and physical departure.

(c) The total includes presentations for which the triage category was not reported.

(d) All hospitals includes hospitals in peer groups other than Principal referral and specialist women's and children's hospitals and Large hospitals.

.. Not applicable.

Source: AIHW (2012), *Australian hospital statistics 2011–1*2: emergency department care, Health services series no. 45. Cat. no. HSE 126. Canberra: AIHW (2013), *Australian hospital statistics 2012–13: emergency department care* , Health services series no. 52. Cat. no. HSE 142. Canberra.

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cataract extraction									
Hospital sector									
Public	2.6	3.1	1.6	4.3	3.5	1.3	3.5	5.1	2.7
Private	6.2	5.3	7.4	6.2	4.9	9.0	2.9	3.0	6.1
Indigenous status (d)									
Indigenous	7.0	7.7	5.8	9.3	9.6	5.9	12.4	6.9	7.2
Other Australians	8.6	8.3	8.7	10.2	8.4	10.1	6.1	7.7	8.7
Remoteness of residence (e)									
Major cities	8.4	8.2	8.7	10.6	8.1	..	5.3	..	8.5
Inner regional	9.6	9.0	9.4	11.3	9.3	7.2	np	..	9.4
Outer regional	8.5	8.5	9.5	9.5	9.7	8.0	..	9.2	9.0
Remote	7.9	10.6	8.3	9.0	8.2	6.3	..	5.6	8.1
Very remote	9.2	..	7.7	7.5	5.0	7.2	..	6.7	7.4
Socioeconomic status of area of residence (f)									
1–Lowest	8.4	8.0	8.9	10.5	9.2	7.5	28.2	7.0	8.5
2	8.6	8.7	9.6	10.6	8.3	11.7	26.6	9.4	8.9
3	9.6	8.7	8.8	10.1	7.6	7.9	12.7	9.5	9.1
4	7.8	8.1	9.1	10.9	8.6	4.6	7.4	7.3	8.5
5–Highest	9.0	8.4	8.6	10.8	7.4	..	5.0	11.5	8.7
Total	8.7	8.4	9.0	10.5	8.4	10.3	6.4	8.1	8.8
Cholecystectomy									
Hospital sector									
Public	1.4	1.4	1.2	1.1	1.4	1.4	1.4	1.2	1.3
Private	0.8	0.8	1.1	0.9	0.9	1.0	1.1	0.5	0.9
Indigenous status (d)									
Indigenous	3.2	3.5	2.8	3.2	3.2	2.9	4.4	2.6	3.0
Other Australians	2.2	2.2	2.4	2.0	2.3	2.4	2.5	1.5	2.2
Remoteness of residence (e)									
Major cities	2.1	2.1	2.3	1.9	2.2	..	2.1	..	2.2
Inner regional	2.4	2.6	2.6	2.5	2.4	2.4	np	..	2.5
Outer regional	2.4	2.8	2.2	2.2	2.7	2.4	..	1.3	2.3
Remote	2.8	4.6	2.6	2.1	2.4	2.7	..	2.2	2.4
Very remote	2.7	..	2.0	1.7	2.0	np	..	2.2	1.9
Socioeconomic status of area of residence (f)									
1–Lowest	2.6	2.4	2.7	2.5	2.8	2.4	11.8	1.8	2.6
2	2.2	2.6	2.5	2.3	2.3	3.0	11.4	2.3	2.4
3	2.4	2.3	2.4	2.0	2.2	2.7	3.3	2.8	2.3
4	2.1	2.2	2.3	2.0	1.9	1.7	2.8	0.8	2.1
5–Highest	1.8	1.8	2.1	1.7	1.7	..	2.1	1.4	1.8

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	2.2	2.2	2.4	2.0	2.3	2.4	2.5	1.7	2.2
Coronary angioplasty									
Hospital sector									
Public	0.9	0.8	0.8	0.9	1.0	1.0	1.9	..	0.9
Private	0.6	0.8	0.7	0.7	0.5	0.2	0.9	..	0.7
Indigenous status (d)									
Indigenous	2.1	2.5	2.0	2.8	6.3	1.2	7.1	..	2.2
Other Australians	1.5	1.6	1.5	1.6	1.5	1.2	2.7	..	1.5
Remoteness of residence (e)									
Major cities	1.6	1.6	1.4	1.6	1.4	..	1.8	..	1.5
Inner regional	1.2	1.6	1.6	1.6	1.4	1.2	np	..	1.5
Outer regional	1.1	1.6	1.5	1.4	2.1	1.1	..	..	1.4
Remote	1.7	1.8	1.3	1.3	2.3	1.2	..	..	1.4
Very remote	1.9	..	1.5	1.2	4.1	np	..	..	1.4
Socioeconomic status of area of residence (f)									
1–Lowest	1.3	1.5	1.6	1.7	1.7	1.1	45.8	..	1.4
2	1.4	1.8	1.7	1.7	1.5	1.9	43.3	..	1.6
3	1.6	1.8	1.5	1.6	1.4	1.2	4.2	..	1.6
4	1.6	1.5	1.4	1.6	1.6	0.9	2.4	..	1.5
5–Highest	1.7	1.4	1.2	1.4	1.2	..	1.7	..	1.5
Total	1.5	1.6	1.5	1.6	1.5	1.2	2.8	..	1.5
Coronary artery bypass graft									
Hospital sector									
Public	0.3	0.3	0.3	0.2	0.3	0.4	0.6	..	0.3
Private	0.2	0.2	0.3	0.1	0.2	np	0.1	..	0.2
Indigenous status (d)									
Indigenous	0.8	1.3	1.3	1.2	4.3	np	np	..	1.1
Other Australians	0.5	0.5	0.6	0.3	0.5	0.4	0.7	..	0.5
Remoteness of residence (e)									
Major cities	0.5	0.5	0.5	0.3	0.5	..	0.4	..	0.5
Inner regional	0.4	0.6	0.6	0.5	0.5	0.4	np	..	0.5
Outer regional	0.3	0.6	0.7	0.4	0.9	0.3	..	..	0.5
Remote	0.7	np	0.7	0.3	1.0	np	..	..	0.6
Very remote	1.0	..	0.8	0.5	2.8	np	..	..	0.8
Socioeconomic status of area of residence (f)									
1–Lowest	0.5	0.5	0.6	0.5	0.7	0.4	20.9	..	0.5
2	0.4	0.6	0.7	0.4	0.6	0.5	12.3	..	0.5
3	0.5	0.6	0.6	0.4	0.5	0.4	0.9	..	0.5
4	0.5	0.5	0.5	0.3	0.5	0.4	0.5	..	0.5
5–Highest	0.4	0.4	0.4	0.3	0.4	..	0.4	..	0.4

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	0.5	0.5	0.6	0.3	0.6	0.4	0.7	..	0.5
Cystoscopy									
Hospital sector									
Public	1.6	2.8	2.0	3.0	2.6	1.5	2.4	1.7	2.2
Private	2.5	2.9	3.4	4.2	3.4	4.0	3.0	1.3	3.0
Indigenous status (d)									
Indigenous	2.5	4.8	3.0	3.3	2.9	4.0	8.4	1.5	2.8
Other Australians	4.1	5.7	5.4	7.2	6.0	5.6	5.3	3.1	5.2
Remoteness of residence (e)									
Major cities	4.1	5.8	5.5	7.3	6.2	..	4.4	..	5.3
Inner regional	4.1	5.7	5.3	7.8	5.4	5.9	np	..	5.2
Outer regional	3.8	4.7	5.3	6.4	5.4	4.9	..	3.3	4.9
Remote	3.9	4.8	4.2	5.7	5.4	3.6	..	2.2	4.5
Very remote	3.3	..	3.4	3.7	5.3	6.0	..	1.9	3.6
Socioeconomic status of area of residence (f)									
1–Lowest	3.6	5.2	5.3	6.6	5.9	4.8	47.8	2.5	4.7
2	3.8	5.8	5.5	6.7	5.8	6.8	30.3	4.2	5.0
3	5.2	5.8	5.3	7.2	6.0	6.7	7.8	3.1	5.8
4	3.9	5.8	5.6	6.9	6.2	6.3	5.8	2.7	5.4
5–Highest	4.3	5.8	5.4	7.9	6.2	..	4.3	4.2	5.4
Total	4.1	5.7	5.4	7.2	6.0	5.6	5.4	2.9	5.3
Haemorrhoidectomy									
Hospital sector									
Public	1.0	0.8	0.4	0.5	0.5	0.7	0.4	0.9	0.7
Private	1.9	0.9	1.2	0.6	0.9	1.3	0.9	1.7	1.3
Indigenous status (d)									
Indigenous	1.9	1.6	0.7	0.6	0.4	0.9	np	0.5	1.1
Other Australians	2.9	1.7	1.7	1.1	1.4	2.0	1.3	3.2	2.0
Remoteness of residence (e)									
Major cities	2.9	1.3	1.6	0.9	1.4	..	1.2	..	1.9
Inner regional	2.9	2.6	2.3	1.8	1.5	1.9	np	..	2.5
Outer regional	3.0	2.6	1.2	1.7	2.0	2.1	..	3.4	2.1
Remote	2.2	3.5	0.9	1.0	1.2	1.2	..	1.4	1.2
Very remote	1.9	..	0.5	0.7	1.0	np	..	1.1	0.8
Socioeconomic status of area of residence (f)									
1–Lowest	2.9	1.8	1.7	1.4	1.4	1.8	np	1.8	2.1
2	2.7	2.2	1.6	1.3	1.4	3.0	3.8	2.8	2.2
3	3.3	1.7	1.8	1.1	1.3	2.3	1.3	3.7	2.0
4	3.0	1.3	1.6	1.2	1.5	1.5	1.6	2.7	1.8
5–Highest	2.7	1.4	1.6	0.9	1.6	..	1.1	3.6	1.8

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	2.9	1.7	1.7	1.1	1.4	2.0	1.3	2.6	2.0
Hip replacement									
Hospital sector									
Public	0.7	0.7	0.5	0.8	0.7	0.6	1.0	0.6	0.6
Private	0.8	0.9	0.8	1.0	1.1	1.1	1.3	0.2	0.9
Indigenous status (d)									
Indigenous	1.1	1.5	0.7	0.7	0.5	1.5	np	0.2	0.8
Other Australians	1.4	1.6	1.3	1.7	1.8	1.7	2.3	0.8	1.5
Remoteness of residence (e)									
Major cities	1.4	1.5	1.3	1.6	1.6	..	1.8	..	1.4
Inner regional	1.5	2.0	1.4	2.1	1.8	1.7	np	..	1.7
Outer regional	1.4	1.9	1.3	2.4	2.6	1.6	..	0.9	1.7
Remote	1.3	1.9	0.9	1.8	2.0	1.8	..	0.6	1.4
Very remote	1.6	..	0.9	1.0	1.7	np	..	0.3	1.0
Socioeconomic status of area of residence (f)									
1–Lowest	1.2	1.3	1.3	2.4	1.8	1.4	37.4	0.5	1.4
2	1.4	1.8	1.5	1.7	1.8	2.1	24.3	1.5	1.6
3	1.5	1.7	1.3	1.6	1.8	1.9	3.4	0.9	1.6
4	1.5	1.6	1.3	1.7	1.6	1.9	2.5	0.9	1.6
5–Highest	1.6	1.6	1.3	1.8	1.7	..	1.6	np	1.5
Total	1.4	1.6	1.3	1.7	1.8	1.7	2.4	0.8	1.5
Hysterectomy, females aged 15–69 (g)									
Hospital sector									
Public	1.0	1.1	1.0	1.1	1.3	1.1	0.7	0.8	1.0
Private	1.1	1.0	1.5	1.6	1.3	1.4	1.5	0.9	1.2
Indigenous status (d)									
Indigenous	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Australians	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Remoteness of residence (e)									
Major cities	2.0	1.9	2.4	2.3	2.5	..	1.9	..	2.1
Inner regional	2.5	3.1	2.9	3.0	2.6	2.5	np	..	2.8
Outer regional	2.5	2.9	2.5	2.8	3.2	2.6	..	1.9	2.6
Remote	2.6	3.4	2.5	2.5	3.4	2.1	..	1.5	2.5
Very remote	2.8	..	2.6	2.3	2.8	np	..	1.2	2.1
Socioeconomic status of area of residence (f)									
1–Lowest	2.0	2.2	2.7	2.6	2.8	2.5	23.2	1.5	2.3
2	2.3	2.7	2.8	2.3	2.5	2.9	8.6	0.9	2.5
3	2.6	2.4	2.4	2.5	2.7	2.6	3.8	1.9	2.5
4	2.0	2.0	2.5	2.5	2.6	2.4	2.7	1.9	2.2
5–Highest	1.8	1.7	2.3	2.3	2.1	..	1.8	1.8	1.9

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	2.1	2.1	2.5	2.6	2.6	2.5	2.3	1.7	2.3
Inguinal herniorrhaphy									
Hospital sector									
Public	1.0	1.0	0.8	0.9	1.0	1.1	0.9	0.9	1.0
Private	1.1	1.1	1.4	1.3	1.0	1.3	1.6	0.8	1.2
Indigenous status (d)									
Indigenous	1.5	1.8	1.1	0.9	1.3	1.9	3.0	0.6	1.2
Other Australians	2.1	2.1	2.3	2.2	2.0	2.4	2.5	2.0	2.1
Remoteness of residence (e)									
Major cities	2.1	2.1	2.2	2.2	2.0	..	2.1	..	2.1
Inner regional	2.1	2.3	2.4	2.2	2.0	2.4	np	..	2.3
Outer regional	2.0	2.4	2.3	2.2	2.1	2.2	..	2.0	2.2
Remote	2.1	2.3	1.9	1.7	2.2	1.5	..	1.6	1.9
Very remote	2.5	..	1.8	1.3	1.6	1.9	..	1.0	1.6
Socioeconomic status of area of residence (f)									
1–Lowest	2.1	2.0	2.1	2.2	2.0	2.2	32.6	1.3	2.1
2	1.9	2.3	2.2	2.2	1.9	3.1	9.5	1.5	2.1
3	2.4	2.1	2.4	2.0	2.0	2.5	4.5	2.5	2.2
4	2.2	2.1	2.4	2.3	2.1	2.3	2.7	1.8	2.2
5–Highest	2.2	2.1	2.1	2.3	2.1	..	2.1	1.8	2.2
Total	2.1	2.1	2.2	2.2	2.0	2.3	2.5	1.7	2.2
Knee replacement									
Hospital sector									
Public	0.7	0.5	0.5	0.7	0.6	0.3	0.9	0.4	0.6
Private	1.2	1.1	1.3	1.5	1.4	1.2	2.0	0.3	1.2
Indigenous status (d)									
Indigenous	1.5	0.7	0.7	0.7	np	0.9	4.5	0.2	0.9
Other Australians	1.8	1.6	1.8	2.1	2.0	1.5	2.8	0.9	1.8
Remoteness of residence (e)									
Major cities	1.8	1.5	1.6	2.0	1.8	..	2.0	..	1.7
Inner regional	2.0	2.1	2.1	2.6	2.1	1.5	np	..	2.1
Outer regional	1.9	2.0	2.2	2.9	2.9	1.4	..	0.8	2.1
Remote	1.9	1.7	1.7	2.5	2.4	1.7	..	0.8	1.9
Very remote	2.5	..	1.6	1.8	0.9	1.5	..	0.2	1.4
Socioeconomic status of area of residence (f)									
1–Lowest	1.8	1.5	1.9	3.1	2.3	1.3	47.4	0.5	1.8
2	1.9	1.9	2.1	2.3	2.0	2.3	27.3	0.9	2.0
3	2.1	1.7	1.9	2.2	1.8	1.8	5.4	1.1	1.9
4	1.9	1.7	1.8	2.1	2.0	1.5	2.5	0.8	1.8
5–Highest	1.8	1.4	1.6	1.9	1.7	..	2.0	0.4	1.7

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	1.9	1.6	1.8	2.2	2.0	1.5	2.8	0.8	1.8
Myringotomy									
Hospital sector									
Public	0.5	0.8	0.7	0.7	1.3	0.6	0.8	0.6	0.7
Private	1.1	1.1	1.1	1.3	1.9	1.1	1.9	0.4	1.2
Indigenous status (d)									
Indigenous	1.6	1.7	1.6	2.1	1.7	0.7	2.7	0.6	1.6
Other Australians	1.6	1.9	1.7	2.1	3.3	1.7	2.7	1.3	1.8
Remoteness of residence (e)									
Major cities	1.6	1.7	1.7	2.1	3.3	..	2.3	..	1.8
Inner regional	1.6	2.3	2.0	2.3	3.4	1.5	np	..	2.0
Outer regional	1.3	2.3	1.4	1.6	2.5	1.4	..	1.2	1.6
Remote	1.5	3.2	2.1	1.8	2.3	0.8	..	1.0	1.8
Very remote	1.0	..	2.1	2.2	1.7	np	..	0.5	1.6
Socioeconomic status of area of residence (f)									
1–Lowest	1.1	1.4	1.7	2.4	2.8	1.5	76.0	0.7	1.5
2	1.4	2.0	1.7	2.0	3.3	2.2	9.5	1.4	1.8
3	1.7	1.9	1.9	1.9	2.9	1.5	3.6	1.5	1.9
4	1.6	1.9	1.7	2.0	3.8	1.1	3.0	1.0	1.9
5–Highest	2.2	2.0	1.7	2.5	3.6	..	2.2	1.2	2.1
Total	1.6	1.9	1.7	2.1	3.2	1.7	2.7	1.0	1.8
Prostatectomy (h)									
Hospital sector									
Public	0.9	1.1	0.8	0.8	1.0	0.8	0.9	1.0	0.9
Private	1.8	2.0	1.9	1.7	1.5	2.2	2.7	0.5	1.8
Indigenous status (d)									
Indigenous	0.0	0.0	0.0	0.0	0.0	0.0	np	0.0	0.0
Other Australians	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Remoteness of residence (e)									
Major cities	2.7	3.2	2.6	2.5	2.5	..	2.8	..	2.8
Inner regional	2.7	2.9	3.1	2.8	2.3	3.2	np	..	2.9
Outer regional	2.5	2.8	2.6	2.3	2.8	2.6	..	1.7	2.6
Remote	2.8	4.9	2.0	1.9	2.5	2.4	..	0.7	2.1
Very remote	1.9	..	1.6	1.6	1.8	4.6	..	1.2	1.7
Socioeconomic status of area of residence (f)									
1–Lowest	2.5	2.7	2.6	2.7	2.4	2.5	22.8	1.3	2.6
2	2.4	3.1	3.0	2.2	2.6	4.7	27.6	2.1	2.7
3	2.9	2.9	2.8	2.5	2.5	3.4	7.4	2.4	2.8
4	2.7	3.3	2.6	2.2	2.7	3.5	3.6	0.9	2.8
5–Highest	3.0	3.6	2.6	2.8	2.6	..	2.8	np	3.1

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	2.7	3.1	2.7	2.5	2.5	3.0	3.6	1.4	2.8
Septoplasty									
Hospital sector									
Public	0.3	0.5	0.2	0.2	0.4	0.1	0.4	0.1	0.3
Private	0.8	0.9	0.7	0.7	0.9	0.4	0.7	0.4	0.8
Indigenous status (d)									
Indigenous	0.5	0.9	0.3	0.2	0.3	np	np	np	0.4
Other Australians	1.1	1.4	0.9	1.0	1.3	0.5	1.1	0.7	1.1
Remoteness of residence (e)									
Major cities	1.2	1.3	0.9	1.0	1.4	..	0.9	..	1.1
Inner regional	1.0	1.5	0.8	0.9	1.2	0.5	np	..	1.0
Outer regional	0.6	1.4	1.1	0.9	1.0	0.5	..	0.7	0.9
Remote	0.8	3.6	0.6	0.9	0.8	np	..	0.4	0.7
Very remote	np	..	0.6	0.4	1.0	np	..	0.2	0.5
Socioeconomic status of area of residence (f)									
1–Lowest	0.9	1.3	0.7	0.8	1.1	0.5	9.2	0.3	0.9
2	0.9	1.3	1.0	0.9	1.3	0.6	5.3	1.0	1.0
3	1.2	1.4	0.9	0.8	1.5	0.4	1.5	0.7	1.1
4	1.2	1.2	1.0	0.9	1.4	0.5	1.3	0.5	1.1
5–Highest	1.5	1.5	0.9	1.2	1.4	..	0.9	0.5	1.3
Total	1.1	1.4	0.9	0.9	1.3	0.5	1.1	0.5	1.1
Tonsillectomy									
Hospital sector									
Public	0.9	1.2	0.9	1.0	1.3	0.8	1.0	0.7	1.0
Private	1.4	1.1	1.5	1.6	1.4	1.1	2.6	0.4	1.4
Indigenous status (d)									
Indigenous	1.8	2.5	1.1	1.1	1.8	1.3	4.9	0.4	1.4
Other Australians	2.3	2.3	2.5	2.7	2.8	1.9	3.6	1.5	2.4
Remoteness of residence (e)									
Major cities	2.2	1.9	2.2	2.7	2.7	..	3.1	..	2.2
Inner regional	2.7	3.4	3.0	3.0	2.8	1.9	np	..	2.9
Outer regional	2.5	3.9	2.3	2.5	3.0	1.7	..	1.3	2.5
Remote	2.6	3.0	2.5	1.9	3.0	1.8	..	1.2	2.2
Very remote	2.0	..	1.6	1.6	2.5	np	..	0.4	1.3
Socioeconomic status of area of residence (f)									
1–Lowest	2.1	2.2	2.2	2.2	2.8	1.8	110.1	0.6	2.2
2	2.2	2.8	2.5	2.6	2.6	2.7	12.1	1.5	2.5
3	2.7	2.5	2.5	2.7	2.8	2.0	5.3	1.9	2.6
4	2.1	2.2	2.4	2.7	3.0	1.4	4.2	1.0	2.3
5–Highest	2.5	1.9	2.2	2.7	2.6	..	3.0	1.7	2.3

Table 10A.45 **Separation statistics for selected hospital procedures per 1000 people, all hospitals 2011-12 (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	2.3	2.3	2.4	2.6	2.8	1.9	3.7	1.0	2.4
Varicose veins, stripping and ligation									
Hospital sector									
Public	0.2	0.3	0.1	0.1	0.3	0.1	0.6	0.2	0.2
Private	0.3	0.4	0.4	0.4	0.3	0.3	0.8	0.2	0.4
Indigenous status (d)									
Indigenous	0.4	0.6	0.1	0.1	0.3	np	1.6	np	0.2
Other Australians	0.5	0.8	0.5	0.6	0.7	0.4	1.4	0.6	0.6
Remoteness of residence (e)									
Major cities	0.5	0.7	0.6	0.6	0.7	..	1.1	..	0.6
Inner regional	0.6	0.8	0.5	0.7	0.7	0.4	np	..	0.6
Outer regional	0.4	0.9	0.4	0.6	0.8	0.3	..	0.6	0.5
Remote	0.4	np	0.4	0.4	0.5	np	..	0.3	0.4
Very remote	np	..	0.2	0.3	0.3	np	..	0.2	0.3
Socioeconomic status of area of residence (f)									
1–Lowest	0.5	0.6	0.5	0.6	0.6	0.4	16.3	0.2	0.5
2	0.4	0.8	0.5	0.5	0.6	0.4	8.7	0.9	0.6
3	0.6	0.8	0.5	0.5	0.7	0.5	2.8	0.6	0.6
4	0.6	0.7	0.5	0.6	0.8	0.3	1.4	0.5	0.6
5–Highest	0.6	0.7	0.6	0.8	0.8	..	1.1	0.3	0.7
Total	0.5	0.8	0.5	0.6	0.7	0.4	1.4	0.4	0.6

(a) Separations for which the care type was reported as Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement were excluded.

(b) Rates per 1000 population were directly age-standardised.

(c) The procedures and diagnoses are defined using ICD-10-AM codes.

(d) Other Australians includes records for which the Indigenous status was Not reported.

(e) Disaggregation by remoteness area is by usual residence, not remoteness of hospital. However, state/territory data are reported by jurisdiction of the hospital, regardless of the jurisdiction of residence.

(f) Socioeconomic status of area of residence is 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. These socioeconomic groups represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by socioeconomic group is based on the patient's usual residence, not the location of the hospital.

(g) For Hysterectomy, the rate per 1000 population was calculated for the estimated resident female population aged 15 to 69 years.

(h) For Prostatectomy, the rate per 1000 population was calculated for the estimated resident male population.

Source: AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.46 **Separation statistics for selected hospital procedures, all hospitals, 2011-12**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cataract extraction										
Separations	no.	71 382	51 497	41 176	24 050	17 357	6 637	1 963	971	215 033
Separations not within state of residence	%	1.7	1.9	2.5	0.2	2.3	28.1	22.8	0.7	2.8
Proportion of separations public patients (a)	%	28.7	28.5	12.1	39.3	36.7	10.7	53.5	56.0	27.1
Separation rate (b)	per 1000	8.7	8.4	9.0	10.5	8.4	10.3	6.4	8.1	8.8
Standardised separation rate ratio	Ratio	1.0	0.9	1.0	1.2	1.0	1.2	0.7	0.9	
Cholecystectomy										
Separations	no.	16 571	12 897	10 810	4 864	3 970	1 295	913	375	51 695
Separations not within state of residence	%	1.6	2.3	2.2	0.7	1.9	1.4	21.0	4.0	2.2
Proportion of separations public patients (a)	%	61.6	62.2	51.5	56.3	61.4	58.5	54.3	74.9	59.0
Separation rate (b)	per 1000	2.2	2.2	2.4	2.0	2.3	2.4	2.5	1.7	2.2
Standardised separation rate ratio	Ratio	1.0	1.0	1.1	0.9	1.0	1.1	1.1	0.8	
Coronary angioplasty										
Separations	no.	12 171	9 681	7 051	3 851	3 012	738	921	–	37 425
Separations not within state of residence	%	1.5	3.8	9.4	1.2	9.9	2.7	43.2	np	5.3
Proportion of separations public patients (a)	%	46.2	44.3	44.7	44.6	54.2	55.7	51.9	np	46.2
Separation rate (b)	per 1000	1.5	1.6	1.5	1.6	1.5	1.2	2.8	np	1.5
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	1.0	1.0	0.8	1.8	np	
Coronary artery bypass graft										
Separations	no.	3 864	3 206	2 720	829	1 117	238	224	–	12 198
Separations not within state of residence	%	3.4	3.4	7.2	0.4	14.2	2.5	46.4	..	5.8
Proportion of separations public patients (a)	%	51.2	50.0	50.5	52.2	53.5	52.9	62.5	..	51.3
Separation rate (b)	per 1000	0.5	0.5	0.6	0.3	0.6	0.4	0.7	..	0.5
Standardised separation rate ratio	Ratio	1.0	1.1	1.2	0.7	1.1	0.7	1.4	..	
Cystoscopy										

Table 10A.46 **Separation statistics for selected hospital procedures, all hospitals, 2011-12**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations	no.	32 977	34 462	25 156	16 967	11 599	3 498	1 827	451	126 937
Separations not within state of residence	%	2.3	2.0	3.0	0.2	1.5	0.7	26.3	2.2	2.3
Proportion of separations public patients (a)	%	36.7	45.6	34.1	39.1	39.3	25.5	42.0	52.3	39.0
Separation rate (b)	per 1000	4.1	5.7	5.4	7.2	6.0	5.6	5.4	2.9	5.3
Standardised separation rate ratio	Ratio	0.8	1.1	1.0	1.4	1.1	1.1	1.0	0.6	
Haemorrhoidectomy										
Separations	no.	21 821	9 557	7 658	2 696	2 556	1 109	478	520	46 395
Separations not within state of residence	%	1.3	2.2	1.5	0.3	0.6	0.8	18.8	1.9	1.6
Proportion of separations public patients (a)	%	31.2	41.7	23.2	40.4	30.2	32.6	29.1	35.2	32.6
Separation rate (b)	per 1000	2.9	1.7	1.7	1.1	1.4	2.0	1.3	2.6	2.0
Standardised separation rate ratio	Ratio	1.4	0.8	0.8	0.6	0.7	1.0	0.7	1.3	
Hip replacement										
Separations	no.	11 764	9 950	6 292	4 153	3 608	1 079	773	86	37 705
Separations not within state of residence	%	1.9	2.7	5.4	0.3	4.1	0.9	33.4	7.0	3.4
Proportion of separations public patients (a)	%	36.6	35.6	32.2	38.7	35.5	29.7	40.0	66.3	35.7
Separation rate (b)	per 1000	1.4	1.6	1.3	1.7	1.8	1.7	2.4	0.8	1.5
Standardised separation rate ratio	Ratio	0.9	1.1	0.9	1.1	1.2	1.1	1.6	0.5	
Hysterectomy, females aged 15–69										
Separations	no.	7 850	6 153	5 793	2 898	2 197	661	421	186	26 159
Separations not within state of residence	%	2.0	2.4	3.3	0.2	1.9	0.8	24.9	1.1	2.5
Proportion of separations public patients (a)	%	39.8	46.3	36.9	36.7	46.8	42.1	30.2	45.2	40.9
Separation rate (b)	per 1000	2.1	2.1	2.5	2.6	2.6	2.5	2.3	1.7	2.3
Standardised separation rate ratio	Ratio	0.9	0.9	1.1	1.2	1.1	1.1	1.0	0.7	
Inguinal herniorrhaphy										
Separations	no.	16 451	12 410	10 339	5 225	3 679	1 353	890	338	50 685

Table 10A.46 **Separation statistics for selected hospital procedures, all hospitals, 2011-12**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations not within state of residence	%	1.5	1.8	2.8	0.5	1.1	0.7	22.4	1.2	2.1
Proportion of separations public patients (a)	%	39.4	42.0	33.2	38.3	43.0	40.8	36.0	45.3	38.9
Separation rate (b)	per 1000	2.1	2.1	2.2	2.2	2.0	2.3	2.5	1.7	2.2
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	1.0	0.9	1.1	1.2	0.8	
Knee replacement										
Separations	no.	15 452	10 077	8 677	5 162	4 061	1 001	955	106	45 491
Separations not within state of residence	%	1.5	2.7	5.4	0.2	5.1	0.4	34.5	1.9	3.4
Proportion of separations public patients (a)	%	34.6	31.2	22.5	32.4	28.3	21.1	30.4	55.7	30.4
Separation rate (b)	per 1000	1.9	1.6	1.8	2.2	2.0	1.5	2.8	0.8	1.8
Standardised separation rate ratio	Ratio	1.0	0.9	1.0	1.2	1.1	0.8	1.5	0.4	
Myringotomy (with insertion of tube)										
Separations	no.	10 817	9 649	7 708	4 778	4 719	790	914	262	39 637
Separations not within state of residence	%	1.8	2.4	3.0	0.2	1.5	10.1	21.8	0.4	2.6
Proportion of separations public patients (a)	%	28.4	35.9	28.4	33.5	34.1	34.4	29.2	58.8	31.9
Separation rate (b)	per 1000	1.6	1.9	1.7	2.1	3.2	1.7	2.7	1.0	1.8
Standardised separation rate ratio	Ratio	0.8	1.0	0.9	1.1	1.7	0.9	1.4	0.5	
Prostatectomy										
Separations	no.	10 535	9 013	6 222	2 840	2 404	942	564	87	32 607
Separations not within state of residence	%	2.4	2.3	4.2	0.2	2.2	0.3	28.9	2.3	2.9
Proportion of separations public patients (a)	%	31.1	31.8	26.9	29.8	32.0	22.3	23.9	57.5	30.1
Separation rate (b)	per 1000	2.7	3.1	2.7	2.5	2.5	3.0	3.6	1.4	2.8
Standardised separation rate ratio	Ratio	1.0	1.1	1.0	0.9	0.9	1.1	1.3	0.5	
Septoplasty										
Separations	no.	7 955	7 563	4 017	2 234	2 187	251	434	119	24 760
Separations not within state of residence	%	3.0	2.2	4.2	0.2	3.2	0.8	23.7	0.8	3.1

Table 10A.46 **Separation statistics for selected hospital procedures, all hospitals, 2011-12**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of separations public patients (a)	%	22.4	30.6	14.4	24.0	30.3	21.5	35.3	21.8	24.6
Separation rate (b)	per 1000	1.1	1.4	0.9	0.9	1.3	0.5	1.1	0.5	1.1
Standardised separation rate ratio	Ratio	1.0	1.2	0.8	0.8	1.2	0.4	1.0	0.5	
Tonsillectomy										
Separations	no.	15 517	11 829	10 462	5 941	4 040	871	1 291	262	50 213
Separations not within state of residence	%	2.0	3.4	2.3	0.1	1.5	0.7	25.0	–	2.7
Proportion of separations public patients (a)	%	34.7	45.1	26.7	36.3	38.4	41.8	27.9	60.7	36.1
Separation rate (b)	per 1000	2.3	2.3	2.4	2.6	2.8	1.9	3.7	1.0	2.4
Standardised separation rate ratio	Ratio	1.0	1.0	1.0	1.1	1.2	0.8	1.5	0.4	
Varicose veins, stripping and ligation										
Separations	no.	4 006	4 367	2 325	1 395	1 180	210	501	93	14 077
Separations not within state of residence	%	1.3	0.8	2.7	0.3	1.2	–	29.5	–	2.2
Proportion of separations public patients (a)	%	33.8	35.8	23.4	22.8	41.6	15.7	40.9	43.0	32.3
Separation rate (b)	per 1000	0.5	0.8	0.5	0.6	0.7	0.4	1.4	0.4	0.6
Standardised separation rate ratio	Ratio	0.9	1.2	0.8	1.0	1.1	0.6	2.3	0.7	

(a) Ophthalmological services purchased from the private sector rather than being provided by public hospitals will result in a understating of Cataract extraction separation rates in the public sector.

(b) Separations per 1000 population was directly age-standardised.

.. Not applicable. **np** Not published. — Nil or rounded to Zero

Source: AIHW 2013, *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.47 **Unplanned hospital readmissions rates (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)	Aust (c)
				rate per 1000 separations						*no.*
2009-10										
Surgical procedure prior to separation										
Knee replacement	24.5	26.0	37.1	15.0	16.1	27.6	np	np	26.2	240
Hip replacement	16.0	18.0	21.9	14.6	np	26.1	np	np	16.4	118
Tonsillectomy and Adenoidectomy	20.1	26.0	30.4	30.7	33.3	52.5	np	np	26.5	525
Hysterectomy	30.8	31.5	36.4	30.8	23.2	65.7	np	np	31.3	307
Prostatectomy	33.1	23.5	33.6	44.3	34.4	np	np	np	30.9	217
Cataract surgery	4.0	3.3	4.1	4.1	4.4	7.8	np	10.9	3.8	179
Appendicectomy	21.6	25.8	24.9	29.5	36.4	20.0	25.9	50.6	25.1	519
2010-11										
Surgical procedure prior to separation										
Knee replacement	21.7	22.0	37.5	31.1	19.6	31.7	np	np	24.4	242
Hip replacement	16.5	20.8	14.2	14.7	10.3	np	np	np	16.5	119
Tonsillectomy and Adenoidectomy	22.9	23.9	31.0	34.4	31.3	37.6	19.3	np	26.3	516
Hysterectomy	29.1	28.9	34.7	33.5	28.1	40.1	np	np	30.5	284
Prostatectomy	27.2	20.9	25.8	38.0	21.9	np	np	np	25.1	174
Cataract surgery	3.2	3.9	4.0	4.3	4.0	–	–	np	3.5	166
Appendicectomy	24.8	25.6	19.6	30.8	22.8	19.9	37.7	40.2	24.2	548
2011-12										
Surgical procedure prior to separation										
Knee replacement	18.5	19.1	26.9	17.4	17.7	np	np	np	20.0	204
Hip replacement	17.7	17.4	14.2	22.5	23.7	np	np	np	17.7	129
Tonsillectomy and Adenoidectomy	24.8	23.7	32.6	33.3	33.7	60.6	18.3	np	27.8	557
Hysterectomy	27.9	32.4	33.2	31.5	28.1	28.1	np	np	30.9	281

Table 10A.47 **Unplanned hospital readmissions rates (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)	Aust (c)
Prostatectomy	22.7	26.4	36.3	50.3	25.9	np	np	np	27.2	181
Cataract surgery	2.8	3.2	4.0	2.6	3.3	7.2	–	np	3.2	156
Appendicectomy	23.5	24.5	20.4	31.3	36.0	29.8	26.3	49.6	24.7	623

(a) The reported rate is the number of unplanned/unexpected readmissions per 1000 separations.

(b) This indicator is limited to public hospitals.

(c) Total rates and numbers for 2009-10 for Australia do not include WA and Tasmania. Total rates and numbers for 2010-11 and 2011-12 for Australia do not include WA.

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

Source: AIHW (unpublished) National Hospital Morbidity Database; WA Health (unpublished).

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (c)*	*Aust (c)*
					rate per 1000 separations					*no.*
Knee replacement										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	23.5	165
Peer group B	na	na	na	na	na	na	na	na	12.9	21
Other peer groups	na	na	na	na	na	na	na	na	11.6	18
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	np.	np.
Other Australians	na	na	na	na	na	na	na	na	20.1	203
Remoteness of residence (e)										
Major cities	na	na	na	na	na	na	na	na	18.7	109
Inner regional	na	na	na	na	na	na	na	na	19.6	56
Outer regional	na	na	na	na	na	na	na	na	25.6	35
Remote & Very remote	na	na	na	na	na	na	na	na	np	np
SEIFA of residence (f)										
Quintile 1	na	na	na	na	na	na	na	na	18.7	61
Quintile 2	na	na	na	na	na	na	na	na	21.9	64
Quintile 3	na	na	na	na	na	na	na	na	20.6	35
Quintile 4	na	na	na	na	na	na	na	na	21.6	30
Quintile 5	na	na	na	na	na	na	na	na	14.4	13
Hip replacement										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	19.9	104
Peer group B	na	na	na	na	na	na	na	na	17.7	19

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (c)*	*Aust (c)*
Other peer groups	na	na	na	na	na	na	na	na	6.2	6
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	np	np.
Other Australians	na	na	na	na	na	na	na	na	17.7	127
Remoteness of residence (e)										
Major cities	na	na	na	na	na	na	na	na	17.7	74
Inner regional	na	na	na	na	na	na	na	na	15.9	32
Outer regional	na	na	na	na	na	na	na	na	22.5	22
Remote & Very remote	na	na	na	na	na	na	na	na	np.	np.
SEIFA of residence (f)										
Quintile 1	na	na	na	na	na	na	na	na	19.5	41
Quintile 2	na	na	na	na	na	na	na	na	14.8	30
Quintile 3	na	na	na	na	na	na	na	na	22.9	29
Quintile 4	na	na	na	na	na	na	na	na	14.8	16
Quintile 5	na	na	na	na	na	na	na	na	16.7	13
Tonsillectomy and Adenoidectomy										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	32.1	450
Peer group B	na	na	na	na	na	na	na	na	24.9	72
Other peer groups	na	na	na	na	na	na	na	na	11.2	35
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	30.7	37
Other Australians	na	na	na	na	na	na	na	na	27.6	520
Remoteness of residence (e)										

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (c)*	*Aust (c)*
Major cities	na	na	na	na	na	na	na	na	30.3	352
Inner regional	na	na	na	na	na	na	na	na	26.8	150
Outer regional	na	na	na	na	na	na	na	na	19.4	45
Remote & Very remote	na	na	na	na	na	na	na	na	18.9	9
SEIFA of residence (f)										
Quintile 1	na	na	na	na	na	na	na	na	24.3	148
Quintile 2	na	na	na	na	na	na	na	na	27.6	149
Quintile 3	na	na	na	na	na	na	na	na	29.6	104
Quintile 4	na	na	na	na	na	na	na	na	32.9	107
Quintile 5	na	na	na	na	na	na	na	na	27.2	48
Hysterectomy										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	34.8	230
Peer group B	na	na	na	na	na	na	na	na	21.8	32
Other peer groups	na	na	na	na	na	na	na	na	18.6	19
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	37.7	11
Other Australians	na	na	na	na	na	na	na	na	30.7	270
Remoteness of residence (e)										
Major cities	na	na	na	na	na	na	na	na	32.8	172
Inner regional	na	na	na	na	na	na	na	na	29.0	72
Outer regional	na	na	na	na	na	na	na	na	24.3	28
Remote & Very remote	na	na	na	na	na	na	na	na	43.9	9
SEIFA of residence (f)										

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (c)*	*Aust (c)*
Quintile 1	na	na	na	na	na	na	na	na	28.4	77
Quintile 2	na	na	na	na	na	na	na	na	34.3	82
Quintile 3	na	na	na	na	na	na	na	na	34.6	58
Quintile 4	na	na	na	na	na	na	na	na	30.3	44
Quintile 5	na	na	na	na	na	na	na	na	23.4	20
Prostatectomy										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	29.8	145
Peer group B	na	na	na	na	na	na	na	na	26.9	24
Other peer groups	na	na	na	na	na	na	na	na	13.2	12
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	np	np
Other Australians	na	na	na	na	na	na	na	na	26.7	176
Remoteness of residence (e)										
Major cities	na	na	na	na	na	na	na	na	29.6	114
Inner regional	na	na	na	na	na	na	na	na	23.7	44
Outer regional	na	na	na	na	na	na	na	na	23.9	20
Remote & Very remote	na	na	na	na	na	na	na	na	np	np
SEIFA of residence (f)										
Quintile 1	na	na	na	na	na	na	na	na	24.6	52
Quintile 2	na	na	na	na	na	na	na	na	27.5	49
Quintile 3	na	na	na	na	na	na	na	na	29.4	35
Quintile 4	na	na	na	na	na	na	na	na	28.4	28
Quintile 5	na	na	na	na	na	na	na	na	29.4	17

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (c)*	*Aust (c)*
Cataract surgery										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	4.0	87
Peer group B	na	na	na	na	na	na	na	na	4.5	39
Other peer groups	na	na	na	na	na	na	na	na	1.7	30
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	5.5	5
Other Australians	na	na	na	na	na	na	na	na	3.2	151
Remoteness of residence (e)										
Major cities	na	na	na	na	na	na	na	na	4.0	108
Inner regional	na	na	na	na	na	na	na	na	2.2	29
Outer regional	na	na	na	na	na	na	na	na	2.3	16
Remote & Very remote	na	na	na	na	na	na	na	na	2.8	3
SEIFA of residence (f)										
Quintile 1	na	na	na	na	na	na	na	na	3.4	51
Quintile 2	na	na	na	na	na	na	na	na	2.4	33
Quintile 3	na	na	na	na	na	na	na	na	2.2	17
Quintile 4	na	na	na	na	na	na	na	na	4.1	31
Quintile 5	na	na	na	na	na	na	na	na	5.4	24
Appendicectomy										
Hospital peer group										
Peer group A	na	na	na	na	na	na	na	na	25.0	515
Peer group B	na	na	na	na	na	na	na	na	24.8	80
Other peer groups	na	na	na	na	na	na	na	na	20.0	28

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (c)*	*Aust (c)*
Indigenous status (d)										
Indigenous	na	na	na	na	na	na	na	na	37.9	33
Other Australians	na	na	na	na	na	na	na	na	24.2	590
Remoteness of residence (e)										
Major cities	na	na	na	na	na	na	na	na	24.3	396
Inner regional	na	na	na	na	na	na	na	na	25.3	143
Outer regional	na	na	na	na	na	na	na	na	25.2	62
Remote & Very remote	na	na	na	na	na	na	na	na	40.6	20
SEIFA of residence (f)										
Quintile 1	na	na	na	na	na	na	na	na	23.4	139
Quintile 2	na	na	na	na	na	na	na	na	28.1	158
Quintile 3	na	na	na	na	na	na	na	na	27.8	131
Quintile 4	na	na	na	na	na	na	na	na	22.4	103
Quintile 5	na	na	na	na	na	na	na	na	22.6	90

(a) This indicator is limited to public hospitals.

(b) Cells have been suppressed to protect confidentiality where the presentation could identify a patient or service provider or where rates are likely to be highly volatile, for example, where the denominator is very small. See the Data Quality Statement for further details.

(c) Total rates and numbers for Australia do not include WA.

(d) Other Australians' includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

(e) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. Hence, rates represent the number of separations for patients living in each remoteness area divided by the total number of separations for people living in that remoteness area and hospitalised in the reporting jurisdiction.

Table 10A.48 **Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2011-12 (a), (b)**

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

(f) 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. Disaggregation by SEIFA is by the patient's usual residence, not the location of the hospital. Hence, rates represent the number of separations for patients in each SEIFA quintile divided by the total number of separations for people living in that SEIFA quintile and hospitalised in the reporting jurisdiction.

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

Table 10A.49 **Proportion of accredited beds in public hospitals (per cent) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total beds accredited by ACHS or other agency									
2002-03	93	98	93	91	96	79	100	96	94
2003-04	91	99	97	76	97	82	100	96	93
2004-05	95	100	97	93	98	83	100	100	96
2005-06	93	100	97	96	98	83	100	100	96
2006-07	85	100	94	100	97	83	100	100	93
2007-08	85	100	97	100	98	82	100	100	93
2008-09	95	100	98	100	98	80	100	100	97
2009-10	82	100	97	100	98	83	100	100	93
2010-11	95	100	100	100	98	87	100	100	98
2011-12	97	100	100	100	100	87	100	100	99

(a) Accreditation status at 30 June. Where average available beds for various years were not available, bed numbers at 30 June were used.

Source: AIHW various years, *Australian hospital statistics*, Health Services Series, AIHW, Canberra.

Table 10A.50 **Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA (a)**

	unit	NSW	Vic	Qld (b)	WA (c)	SA	Tas	ACT	NT	Aust (d)
2010-11										
Infection rates										
Methicillin resistant Staphylococcus aureus	*rate per 10 000 patient days*	0.4	0.2	0.3	0.2	0.2	0.2	0.2	0.5	0.3
Methicillin sensitive Staphylococcus aureus	*rate per 10 000 patient days*	0.9	0.7	0.9	0.8	0.7	1.1	0.7	0.9	0.8
Total (e)	***rate per 10 000 patient days***	**1.3**	**0.9**	**1.2**	**1.0**	**0.9**	**1.2**	**0.9**	**1.5**	**1.1**
Number of infections										
Methicillin resistant Staphylococcus aureus	*no.*	233	118	72	23	31	6	6	16	505
Methicillin sensitive Staphylococcus aureus	*no.*	536	322	218	117	91	36	23	27	1370
Total	*no.*	**769**	**440**	**290**	**140**	**122**	**42**	**29**	**43**	**1875**
Coverage (f), (g)	*%*	94	99	77	84	81	91	98	100	90
2011-12										
Infection rates										
Methicillin resistant *Staphylococcus aureus*	*rate per 10 000 patient days*	0.3	0.2	0.2	0.2	0.3	0.1	0.2	0.5	0.2
Methicillin sensitive *Staphylococcus aureus*	*rate per 10 000 patient days*	0.7	0.8	0.7	0.6	0.6	0.7	0.9	0.8	0.7
Total (e)	***rate per 10 000 patient days***	**1.0**	**0.9**	**0.9**	**0.7**	**0.9**	**0.8**	**1.1**	**1.3**	**0.9**
Number of infections										
Methicillin resistant *Staphylococcus aureus*	no.	201	82	51	23	42	4	6	15	424
Methicillin sensitive *Staphylococcus aureus*	no.	473	379	220	81	85	23	31	24	1316

Table 10A.50 **Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA (a)**

	unit	*NSW*	*Vic*	*Qld (b)*	*WA (c)*	*SA*	*Tas*	*ACT*	*NT*	*Aust (d)*
Total	**no.**	**674**	**461**	**271**	**104**	**127**	**27**	**37**	**39**	**1740**
Coverage (f), (g)	%	97	99	98	83	80	90	98	100	95
2012-13										
Infection rates										
Methicillin resistant *Staphylococcus aureus*	*rate per 10 000 patient days*	0.3	0.2	0.1	0.1	0.2	0.1	0.2	0.2	0.2
Methicillin sensitive *Staphylococcus aureus*	*rate per 10 000 patient days*	0.7	0.7	0.8	0.6	0.6	0.9	1.1	0.5	0.7
Total (e)	***rate per 10 000 patient days***	**1.0**	**0.9**	**1.0**	**0.8**	**0.8**	**1.0**	**1.3**	**0.7**	**0.9**
Number of infections										
Methicillin resistant *Staphylococcus aureus*	no.	206	81	47	22	23	2	7	7	395
Methicillin sensitive *Staphylococcus aureus*	no.	447	344	260	106	91	29	37	15	1329
Total	**no.**	**653**	**425**	**307**	**128**	**114**	**31**	**44**	**22**	**1724**
Coverage (f), (g)	%	98	99	96	93	93	86	98	100	97

(a) The SAB patient episodes were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). The comparability of the SAB rates among jurisdictions and over time is limited because of coverage differences and because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity.

(b) For 2010-11 only includes patients 14 years of age and over.

(c) For 2010-11 and 2011-12, data do not comply with the agreed specification, therefore WA data are not comparable with data from other jurisdictions. Refer to the Data Quality Statement for further details.

(d) For 2012-13 Australian totals include WA.

(e) Total may not equal sum of components due to rounding.

(f) Coverage estimates may be preliminary.

(g) Coverage is the number of patient days for hospitals included in the SAB surveillance arrangements as a proportion of total patient days for all public hospitals.

Table 10A.50 **Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by MRSA and MSSA (a)**

	unit	*NSW*	*Vic*	*Qld (b)*	*WA (c)*	*SA*	*Tas*	*ACT*	*NT*	*Aust (d)*

Source: AIHW (unpublished) sourced from State and Territory healthcare-associated infection surveillance data.

Table 10A.51 **Separations with an adverse event, public hospitals (a),(b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11										
Number of events										
External cause of injury and poisoning										
Adverse effects of drugs, medicaments and biological substances	*no.*	na	na	na	na	na	na	na	na	na
Misadventures to patients during surgical and medical care	*no.*	na	na	na	na	na	na	na	na	na
Procedures causing abnormal reactions/complications	*no.*	na	na	na	na	na	na	na	na	na
Other external causes of adverse events	*no.*	na	na	na	na	na	na	na	na	na
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	*no.*	na	na	na	na	na	na	na	na	na
Diagnoses										
Selected post-procedural disorders	*no.*	na	na	na	na	na	na	na	na	na
Haemorrhage and haematoma complicating a procedure	*no.*	na	na	na	na	na	na	na	na	na
Infection following a procedure	*no.*	na	na	na	na	na	na	na	na	na
Complications of internal prosthetic devices	*no.*	na	na	na	na	na	na	na	na	na
Other diagnoses of complications of medical and surgical care	*no.*	na	na	na	na	na	na	na	na	na
Total (any of the above) (c)	*no.*	na	na	na	na	na	na	na	na	na
Events per 100 separations (d)										
External cause of injury and poisoning										
Adverse effects of drugs, medicaments and biological substances	*Rate*	2.3	2.1	1.9	2.2	2.4	2.2	1.8	np	2.1
Misadventures to patients during surgical and medical care	*Rate*	0.2	0.3	0.3	0.3	0.3	0.3	0.3	np	0.3
Procedures causing abnormal reactions/complications	*Rate*	3.1	3.1	3.2	3.2	3.6	4.1	3.5	np	3.2
Other external causes of adverse events	*Rate*	0.1	0.1	0.1	0.1	0.2	0.1	0.2	np	0.1
Place of occurrence of injury and poisoning										

Table 10A.51 **Separations with an adverse event, public hospitals (a),(b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Place of occurrence: Health service area	Rate	5.9	5.7	5.5	5.8	6.3	7.0	5.8	np	5.7
Diagnoses										
Selected post-procedural disorders	Rate	0.9	0.6	0.7	0.9	1.1	1.1	1.1	np	0.8
Haemorrhage and haematoma complicating a procedure	Rate	0.4	0.5	0.4	0.5	0.4	0.5	0.5	np	0.5
Infection following a procedure	Rate	0.5	0.4	0.4	0.4	0.4	0.5	0.5	np	0.4
Complications of internal prosthetic devices	Rate	1.2	1.2	1.3	1.2	1.2	1.2	1.3	np	1.2
Other diagnoses of complications of medical and surgical care	Rate	0.7	1.0	0.8	0.8	0.8	0.9	0.8	np	0.8
Total (any of the above) (c)	Rate	6.1	5.8	5.7	6.0	6.6	7.1	6.0	np	5.9
2011-12										
Number of events										
External cause of injury and poisoning										
Adverse effects of drugs, medicaments and biological substances	no.	39 674	32 632	21 282	13 369	10 061	2 393	2 159	973	122 543
Misadventures to patients during surgical and medical care	no.	3 864	5 188	3 257	1 482	1 012	422	285	159	15 669
Procedures causing abnormal reactions/complications	no.	52 902	51 360	32 805	18 641	14 405	4 444	3 458	2 257	180 272
Other external causes of adverse events	no.	2 093	2 633	1 261	412	953	128	194	90	7 764
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	no.	101 761	91 565	59 278	34 598	26 368	7 544	5 968	3 444	330 526
Diagnoses										
Selected post-procedural disorders	no.	15 433	10 457	7 673	4 719	4 435	1 233	1 073	401	45 424
Haemorrhage and haematoma complicating a procedure	no.	7 731	8 025	4 419	2 746	1 797	487	502	326	26 033
Infection following a procedure	no.	8 185	5 709	4 514	2 369	1 578	488	351	437	23 631
Complications of internal prosthetic devices	no.	19 505	20 253	12 774	6 571	4 825	1 237	1 410	893	67 468
Other diagnoses of complications of medical and surgical care	no.	11 387	16 630	8 262	4 474	3 344	1 065	721	704	46 587

Table 10A.51 **Separations with an adverse event, public hospitals (a),(b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total (any of the above) (c)	*no.*	103 896	94 060	60 429	35 373	27 435	7 652	6 142	3 592	338 579
Events per 100 separations (d)										
External cause of injury and poisoning										
Adverse effects of drugs, medicaments and biological substances	*Rate*	2.4	2.1	2.1	2.3	2.5	2.4	2.2	0.9	2.2
Misadventures to patients during surgical and medical care	*Rate*	0.2	0.3	0.3	0.3	0.2	0.4	0.3	0.1	0.3
Procedures causing abnormal reactions/complications	*Rate*	3.2	3.3	3.3	3.2	3.5	4.5	3.5	2.0	3.3
Other external causes of adverse events	*Rate*	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.1	0.1
Place of occurrence of injury and poisoning										
Place of occurrence: Health service area	*Rate*	6.1	5.9	5.9	5.9	6.5	7.6	6.1	3.0	6.0
Diagnoses										
Selected post-procedural disorders	*Rate*	0.9	0.7	0.8	0.8	1.1	1.2	1.1	0.4	0.8
Haemorrhage and haematoma complicating a procedure	*Rate*	0.5	0.5	0.4	0.5	0.4	0.5	0.5	0.3	0.5
Infection following a procedure	*Rate*	0.5	0.4	0.5	0.4	0.4	0.5	0.4	0.4	0.4
Complications of internal prosthetic devices	*Rate*	1.2	1.3	1.3	1.1	1.2	1.2	1.4	0.8	1.2
Other diagnoses of complications of medical and surgical care	*Rate*	0.7	1.1	0.8	0.8	0.8	1.1	0.7	0.6	0.8
Total (any of the above) (c)	*Rate*	6.3	6.1	6.0	6.0	6.7	7.7	6.3	3.2	6.1
Adverse events for overnight separations	*Rate*	10.1	11.8	10.1	10.7	10.7	12.0	11.9	7.9	10.7

(a) Public hospitals include public acute and public psychiatric hospitals.

(b) Separations that included ICD-10-AM diagnosis and/or external cause codes that indicated an adverse event was treated and/or occurred during the hospitalisation.

(c) Categories do not sum to the totals because multiple diagnoses and external causes can be recorded for each separation and external cause codes and diagnosis codes can be used together to describe an adverse event.

(d) Age standardised rate.

Source: AIHW (unpublished) National Hospital Morbidity Database.

Table 10A.52 **Nursing workforce (includes midwives), by age group and remoteness area (a), (b), (c), (d), (e)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Nurses (registered and enrolled) in workforce											
Major cities	**no.**	**150 435**	**159 662**	**159 880**	**na**	**174 214**	**176 797**	**176 286**	**na**	**213 669**	**220 210**
Inner regional	**no.**	**49 289**	**50 080**	**51 726**	**na**	**55 701**	**56 742**	**59 076**	**na**	**59 342**	**56 716**
Outer regional	**no.**	**23 222**	**22 287**	**23 699**	**na**	**24 479**	**25 342**	**26 404**	**na**	**26 115**	**26 657**
Remote and very remote	**no.**	**5 985**	**5 460**	**5 504**	**na**	**5 867**	**6 680**	**6 579**	**na**	**7 064**	**7 334**
Total	**no.**	**245 531**	**253 592**	**254 956**	**na**	**277 297**	**282 968**	**291 246**	**na**	**306 414**	**311 176**
Proportion of Nurses aged under 30											
Major cities	%	14.1	13.4	10.2	na	15.0	15.0	14.7	na	16.5	16.6
Inner regional	%	8.2	8.6	6.7	na	10.2	9.9	10.6	na	10.9	10.9
Outer regional	%	8.4	8.4	6.4	na	10.2	10.5	11.0	na	11.7	12.2
Remote and very remote	%	8.2	10.2	8.6	na	11.3	12.5	12.0	na	13.4	13.7
Total	%	12.1	11.8	9.0	na	13.6	13.6	13.5	na	15.0	15.1
Proportion of Nurses aged 30 to 39											
Major cities	%	25.3	25.1	22.6	na	24.6	23.5	23.4	na	22.0	21.8
Inner regional	%	22.5	21.3	18.5	na	21.1	19.0	19.7	na	16.7	16.5
Outer regional	%	23.0	21.9	19.2	na	20.6	19.3	20.4	na	17.4	17.3
Remote and very remote	%	24.7	23.7	20.6	na	24.8	23.0	21.5	na	20.5	19.8
Total	%	24.5	24.0	21.4	na	23.6	22.3	22.1	na	20.5	20.4
Proportion of Nurses aged 40 to 49											
Major cities	%	33.6	33.1	32.9	na	29.3	28.6	28.0	na	26.5	25.8
Inner regional	%	40.4	39.3	37.4	na	33.6	32.6	30.6	na	28.4	27.1
Outer regional	%	38.4	38.2	37.4	na	33.5	32.8	31.0	na	27.3	26.5
Remote and very remote	%	35.9	34.4	34.9	na	30.6	29.2	29.8	na	24.5	24.4
Total	%	35.5	34.8	34.3	na	30.4	29.7	28.8	na	26.9	26.1
Proportion of Nurses aged 50 to 59											
Major cities	%	21.8	22.8	26.9	na	24.1	25.4	25.9	na	25.8	26.0
Inner regional	%	23.7	25.0	30.0	na	28.1	30.5	30.8	na	33.8	34.4
Outer regional	%	24.0	24.9	29.5	na	27.5	29.2	29.3	na	33.0	32.6

Table 10A.52 **Nursing workforce (includes midwives), by age group and remoteness area (a), (b), (c), (d), (e)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Remote and very remote	%	24.4	25.3	28.2	na	26.7	27.4	28.8	na	31.5	30.9
Total	%	22.5	23.5	27.8	na	25.2	26.8	27.3	na	28.1	28.2
Proportion of Nurses aged 60+											
Major cities	%	5.2	5.6	7.4	na	7.0	7.4	7.9	na	9.2	9.8
Inner regional	%	5.3	5.8	7.3	na	7.0	7.9	8.4	na	10.3	11.1
Outer regional	%	6.1	6.6	7.7	na	8.2	8.1	8.3	na	10.7	11.3
Remote and very remote	%	6.8	6.3	7.7	na	6.7	7.9	8.0	na	10.2	11.1
Total	%	5.4	5.9	7.5	na	7.2	7.7	8.2	na	9.5	10.2

(a) No data collected for 2010. The 2012 data exclude provisional registrants.

(b) In 2008, 2009 , 2011 and 2012, total include 'Not Stated' for ASGC Remoteness areas. Numbers of 'Not Stated' are significantly higher in 2008 and 2009 than in 2011 and 2012.

(c) In 2008, 2009, 2011 and 2012, nurses are allocated to a region based on postcode of main job. In 2008, 2009 and 2011, region is based on 2006 version Australian Standard Geographical Classification (ASGC) — Remoteness Areas. In 2012, region is based on 2011 version Australian Statistical Geography Standard(ASGS) — Remoteness Areas. Previous versions of these data were supplied using a mix of 2001 and 2006 versions of the classification so these data may not match earlier supplies.

(d) In 2008, 2009, 2011 and 2012, data include registered and enrolled nurses in the workforce: those who are employed in nursing, on extended leave and looking for work in nursing.

(e) 2008 data has been revised due to the correction of an error in processing Victoria data.

na Not available.

Source : AIHW National Health Workforce Data Set (unpublished).

Table 10A.53 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	Unit	*NSW*	*Vic* (e)	*Qld* (f)	*WA* (f)	*SA*	*Tas* (f)	*ACT*	*NT* (g)
2003									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	13.2	14.6	9.5	8.0	11.8	6.8	7.7	8.9
Nurses aged 30 to 39	%	24.4	26.2	24.6	21.0	24.7	20.0	21.6	26.3
Nurses aged 40 to 49	%	36.3	33.7	34.6	35.2	38.8	37.8	39.0	35.3
Nurses aged 50 to 59	%	20.8	20.8	24.4	28.3	21.1	28.3	26.7	24.5
Nurses aged 60+	%	5.2	4.6	6.9	7.5	3.7	7.1	5.0	5.0
Total nurses in workforce	**no.**	**77 463**	**68 900**	**40 839**	**21 858**	**22 687**	**6 499**	**3 963**	**3 323**
2004									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	12.6	14.3	9.4	8.1	11.4	6.9	8.0	14.6
Nurses aged 30 to 39	%	24.0	25.5	24.1	21.2	23.7	19.5	20.2	27.5
Nurses aged 40 to 49	%	35.4	33.1	33.8	35.8	38.2	38.0	36.7	30.6
Nurses aged 50 to 59	%	22.4	22.1	25.0	27.0	22.5	28.4	28.9	23.6
Nurses aged 60+	%	5.6	5.0	7.7	7.9	4.2	7.3	6.2	3.7
Total nurses in workforce	**no.**	**79 293**	**70 986**	**42 690**	**23 895**	**23 836**	**6 347**	**4 048**	**2 496**
2005									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	12.7	7.4	5.9	6.1	10.1	8.7	8.5	na
Nurses aged 30 to 39	%	23.9	21.1	18.9	18.2	22.1	19.1	20.2	na
Nurses aged 40 to 49	%	33.9	33.2	35.1	34.5	37.0	36.1	34.6	na
Nurses aged 50 to 59	%	23.8	29.6	30.7	31.9	25.5	29.2	30.2	na

Table 10A.53 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	Unit	*NSW*	*Vic* (e)	*Qld* (f)	*WA* (f)	*SA*	*Tas* (f)	*ACT*	*NT* (g)
Nurses aged 60+	%	5.7	8.6	9.5	9.2	5.2	6.9	6.5	na
Total nurses in workforce	**no.**	**77 075**	**72 153**	**42 973**	**23 839**	**24 279**	**6 823**	**4 284**	**na**
2006									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	na	na	na	na	na	na	na	na
Nurses aged 30 to 39	%	na	na	na	na	na	na	na	na
Nurses aged 40 to 49	%	na	na	na	na	na	na	na	na
Nurses aged 50 to 59	%	na	na	na	na	na	na	na	na
Nurses aged 60+	%	na	na	na	na	na	na	na	na
Total nurses in workforce	**no.**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2007									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	14.6	15.5	13.3	9.8	8.8	10.8	12.8	17.6
Nurses aged 30 to 39	%	25.5	24.0	23.6	21.0	20.6	17.5	23.5	23.5
Nurses aged 40 to 49	%	28.6	29.2	31.5	33.0	34.3	34.1	32.6	27.8
Nurses aged 50 to 59	%	24.5	24.2	24.2	27.8	28.9	29.1	26.1	25.0
Nurses aged 60+	%	6.8	7.1	7.4	8.5	7.4	8.4	4.9	6.2
Total nurses in workforce	**no.**	**81 606**	**79 279**	**51 436**	**25 047**	**24 952**	**7 329**	**4 413**	**3 234**
2008									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	14.1	14.6	13.4	12.4	11.8	10.2	11.7	16.9
Nurses aged 30 to 39	%	22.2	23.0	23.0	21.3	21.3	16.9	22.4	24.2
Nurses aged 40 to 49	%	28.5	28.5	31.3	30.4	32.4	32.8	30.1	28.0

Table 10A.53 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	Unit	*NSW*	*Vic* (e)	*Qld* (f)	*WA* (f)	*SA*	*Tas* (f)	*ACT*	*NT* (g)
Nurses aged 50 to 59	%	27.8	26.1	24.8	27.3	27.8	30.6	28.7	24.8
Nurses aged 60+	%	7.5	7.8	7.5	8.6	6.7	9.5	7.1	6.1
Total nurses in workforce	**no.**	**82 450**	**77 839**	**51 249**	**27 858**	**27 017**	**7 570**	**4 632**	**4 353**
2009									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	14.1	13.9	13.4	12.1	12.4	10.3	12.6	16.7
Nurses aged 30 to 39	%	21.4	23.3	23.0	21.2	21.7	16.0	21.2	26.7
Nurses aged 40 to 49	%	26.8	28.0	31.4	30.1	30.4	31.2	28.7	27.4
Nurses aged 50 to 59	%	29.2	26.3	24.7	27.8	28.4	31.8	29.7	22.8
Nurses aged 60+	%	8.4	8.5	7.5	8.7	7.1	10.8	7.8	6.4
Total nurses in workforce	**no.**	**83 516**	**79 844**	**54 180**	**28 092**	**28 889**	**7 650**	**4 720**	**4 355**
2010									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	na	na	na	na	na	na	na	na
Nurses aged 30 to 39	%	na	na	na	na	na	na	na	na
Nurses aged 40 to 49	%	na	na	na	na	na	na	na	na
Nurses aged 50 to 59	%	na	na	na	na	na	na	na	na
Nurses aged 60+	%	na	na	na	na	na	na	na	na
Total nurses in workforce	**no.**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2011									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	13.3	17.0	14.7	15.9	13.8	12.7	14.0	16.9
Nurses aged 30 to 39	%	20.3	21.4	21.0	19.6	19.3	15.2	21.4	25.1
Nurses aged 40 to 49	%	25.4	26.6	28.6	27.6	27.8	28.2	26.1	23.6
Nurses aged 50 to 59	%	30.5	26.1	26.3	26.7	30.7	33.7	29.6	26.1

Table 10A.53 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	Unit	*NSW*	*Vic* (e)	*Qld* (f)	*WA* (f)	*SA*	*Tas* (f)	*ACT*	*NT* (g)
Nurses aged 60+	%	10.5	8.9	9.3	10.3	8.4	10.2	8.8	8.4
Total nurses in workforce	**no.**	85 196.0	84 714.9	59 851.2	30 842.4	29 055.6	7 836.8	5 003.8	3 773.0
2012									
Nurses (registered and enrolled) in workforce									
Nurses aged under 30	%	13.8	17.0	14.7	16.0	14.1	12.0	15.4	17.9
Nurses aged 30 to 39	%	20.1	21.3	20.7	20.1	18.9	15.5	21.7	25.6
Nurses aged 40 to 49	%	24.5	25.9	27.8	26.7	26.7	27.7	25.6	22.8
Nurses aged 50 to 59	%	30.3	26.3	26.7	26.8	31.0	34.2	28.3	25.3
Nurses aged 60+	%	11.2	9.5	10.0	10.4	9.3	10.6	9.0	8.4
Total nurses in workforce	**no.**	86 451.9	85 472.1	60 995.4	32 109.0	29 327.0	7 630.9	5 073.6	4 036.0

(a) In 2008, 2009, 2011 and 2012, data include registered and enrolled nurses in the workforce: those who are employed in nursing, on extended leave and looking for work in nursing.

(b) 2011 and 2012 data is by derived state, derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details unavailable, state and territory of residence is used. For records with no information on all three locations, they are coded to 'Not stated'. Northern Territory is the jurisdiction most affected - see Data quality statement.

(c) 2012 data exclude provisional registrants

(d) No data collected for 2010

(e) In 2008 and 2009 Victorian data was affected by large numbers of online survey records not being able to be used for technical reasons. Estimates for Victoria for 2008 and 2009 should be treated with caution due to low response rate (39.9 per cent, 33.3 per cent and 31.6 per cent respectively). Estimates for Victoria for 2005 are derived from responses to the 2006 AIHW Nursing and Midwifery Labour Force Census, weighted to 2005 registration and enrolment benchmark figures. Nurse labour force data for 2008 has been revised due to the correction of an error in processing Victorian data.

(f) Estimates for Queensland for 2008 and 2009 should be treated with caution due to low response rate (32.9 per cent and 28.2 per cent respectively). Estimates for WA for 2008 and 2009 should be treated with caution due to low response rates (34.4 per cent and 35.4 per cent respectively). Estimates for Tasmania for 2009 should be treated with caution due to a low response rate 33.2 per cent.

Table 10A.53 **Nursing workforce (includes midwives), by age group (a), (b). (c), (d)**

	Unit	*NSW*	*Vic* (e)	*Qld* (f)	*WA* (f)	*SA*	*Tas* (f)	*ACT*	*NT* (g)

(g) Estimates for the NT for 2008 and 2009 should be treated with caution due to low response rates (34.9 per cent and 32.8 per cent respectively). Data for the NT is affected by the transient nature of the nursing labour force in that jurisdiction. According to the Nursing Board Annual Report, approximately one-third of all nurses do not re-register each year, primarily because they no longer practise in the jurisdiction. There has been some variation across years in the degree to which nurses who are interstate have been removed from the renewal process and hence the survey.

na Not available.

Source : AIHW National Health Workforce Data Set (unpublished).

Table 10A.54 **Medical practitioner workforce, by age group and remoteness area (a), (b), (c), (d), (e)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Medical practitioners in workforce											
Major cities	**no.**	**43 358**	**45 994**	**47 632**	**49 835**	**50 981**	**52 639**	**56 655**	**42 427**	**64 433**	**64 641**
Inner regional	**no.**	**7 485**	**7 471**	**7 577**	**7 816**	**8 141**	**8 686**	**9 258**	**7 621**	**11 098**	**11 029**
Outer regional	**no.**	**3 198**	**2 710**	**2 993**	**3 061**	**3 258**	**3 516**	**3 924**	**2 092**	**4 656**	**4 964**
Remote and very remote	**no.**	**745**	**582**	**711**	**886**	**1 001**	**867**	**1 095**	**514**	**1 218**	**1 197**
Total	**no.**	**57 043**	**59 004**	**61 165**	**63 688**	**68 812**	**70 193**	**74 260**	**55 424**	**81 751**	**81 910**
Medical practitioners under 30											
Major cties	%	9.9	11.0	12.4	10.2	10.2	10.8	10.6	10.3	10.7	9.6
Inner regional	%	7.7	9.3	8.8	7.4	8.2	8.1	8.8	8.9	9.2	7.8
Outer regional	%	10.7	7.5	7.9	8.8	7.1	8.0	10.3	8.9	11.1	9.1
Remote and very remote	%	7.0	5.8	8.4	13.0	9.6	5.9	15.5	10.7	9.0	9.6
Total	%	9.6	10.6	11.6	9.8	9.7	10.2	10.6	10.1	10.5	9.3
Medical practitioners aged 30 to 39											
Major cties	%	25.9	26.3	26.4	25.7	27.1	27.2	27.1	27.7	29.1	28.2
Inner regional	%	20.9	21.0	21.1	21.1	22.3	22.2	22.7	24.7	25.8	26.1
Outer regional	%	25.5	24.1	24.6	22.6	24.7	26.8	24.4	27.2	27.7	28.2
Remote and very remote	%	33.3	29.7	29.7	30.1	29.9	30.0	30.5	26.1	29.1	26.3
Total	%	25.4	25.7	25.8	25.0	26.3	26.5	26.7	27.5	28.6	27.9
Medical practitioners aged 40 to 49											
Major cties	%	27.7	27.5	27.0	27.0	26.2	26.0	26.0	24.2	23.9	24.6
Inner regional	%	33.3	32.4	31.7	29.8	29.0	27.7	27.1	25.9	25.4	25.4
Outer regional	%	31.6	30.9	30.7	30.3	30.0	28.1	28.0	24.6	25.9	26.9
Remote and very remote	%	29.8	28.7	29.0	27.2	28.8	32.4	27.9	27.8	25.8	27.0
Total	%	28.4	28.0	27.6	27.4	26.7	26.3	26.1	24.4	24.3	24.9
Medical practitioners aged 50 to 59											

Table 10A.54 **Medical practitioner workforce, by age group and remoteness area (a), (b), (c), (d), (e)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Major cties	%	21.6	20.8	20.3	21.1	20.4	20.5	20.5	20.7	20.1	20.7
Inner regional	%	24.0	24.0	25.4	26.9	25.6	26.7	25.6	24.6	23.7	23.9
Outer regional	%	18.6	22.5	22.2	23.6	24.0	22.5	23.2	24.1	21.1	21.1
Remote and very remote	%	18.5	20.8	19.7	16.3	18.7	19.4	14.2	18.1	20.3	21.4
Total	%	21.4	21.1	20.9	21.7	21.0	21.3	21.0	21.1	20.6	21.1
Medical practitioners aged 60+											
Major cties	%	14.8	14.4	13.8	16.0	16.1	15.5	15.8	17.0	16.2	16.9
Inner regional	%	14.0	13.3	13.1	14.8	14.8	15.2	15.9	15.8	15.9	16.9
Outer regional	%	13.6	14.9	14.7	14.7	14.3	14.6	14.0	15.1	14.1	14.6
Remote and very remote	%	11.5	15.1	13.1	13.4	13.1	12.3	11.8	17.1	15.8	15.7
Total	%	15.1	14.7	14.0	16.0	16.2	15.8	15.7	16.8	16.0	16.8

(a) No 2010 data collected for Queensland and WA. 2012 data excludes provisional registrants.

(b) In 2008, 2009 , 2011 and 2012, total include 'Not Stated' for ASGC Remoteness areas. Numbers of 'Not Stated' are significantly higher in 2008 and 2009 than in 2011 and 2012.

(c) In 2008, 2009, 2010, 2011 and 2012, data include employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.

(d) In 2008, 2009, 2010, 2011 and 2012, Remote and very remote areas include Migratory areas. Estimates for remote and very remote areas should be treated with caution due to the relatively small number of medical practitioners used to produce these estimates.

(e) In 2008, 2009, 2010, 2011 and 2012, medical practitioners are allocated to a region based on postcode of main job. In 2008, 2009, 2010 and 2011, region is based on 2006 version Australian Standard Geographical Classification (ASGC) — Remoteness Areas. In 2012, region is based on 2011 version Australian Statistical Geography Standard(ASGS) — Remoteness Areas. Previous versions of these data were supplied using a mix of 2001 and 2006 versions of the classification so these data may not match earlier supplies.

Source : AIHW National Health Workforce Data Set (unpublished).

Table 10A.55 **Medical practitioner workforce, by age group (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (g), (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)
2003									
Medical practitioners in workforce									
Medical practitioners under 30	%	9.3	10.9	8.7	8.3	10.0	6.0	7.4	20.3
Medical practitioners aged 30 to 39	%	25.6	25.6	24.6	24.1	28.0	18.7	21.4	34.9
Medical practitioners aged 40 to 49	%	27.4	28.3	29.7	28.6	27.8	33.5	34.3	27.3
Medical practitioners aged 50 to 59	%	21.7	20.9	21.2	22.4	21.8	25.4	24.2	10.9
Medical practitioners aged 60+	%	16.1	14.3	15.7	16.6	12.4	16.5	12.8	6.7
Total Medical practitioners in workforce	**no.**	**19 465**	**14 993**	**9 284**	**4 791**	**4 990**	**1 373**	**1 231**	**916**
2004									
Medical practitioners in workforce									
Medical practitioners under 30	%	11.3	13.1	7.8	8.0	9.2	5.6	6.8	13.1
Medical practitioners aged 30 to 39	%	26.7	25.9	24.4	23.5	27.6	17.6	21.7	32.8
Medical practitioners aged 40 to 49	%	26.3	27.5	30.7	29.2	28.5	32.1	33.3	27.5
Medical practitioners aged 50 to 59	%	20.3	20.2	22.3	21.8	21.6	27.6	25.5	17.8
Medical practitioners aged 60+	%	15.4	13.4	14.8	17.5	13.0	17.2	12.6	8.8
Total Medical practitioners in workforce	**no.**	**21 406**	**15 757**	**8 718**	**4 895**	**5 011**	**1 416**	**1 302**	**497**
2005									
Medical practitioners in workforce									
Medical practitioners under 30	%	13.6	14.4	6.5	8.8	8.7	4.5	6.7	19.9
Medical practitioners aged 30 to 39	%	26.7	26.5	24.4	23.2	27.8	17.4	21.1	34.0
Medical practitioners aged 40 to 49	%	26.0	27.3	30.5	28.4	27.6	32.6	33.2	22.6
Medical practitioners aged 50 to 59	%	19.9	19.4	22.8	22.3	21.8	28.5	26.1	15.6

Table 10A.55 **Medical practitioner workforce, by age group (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (g), (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)
Medical practitioners aged 60+	%	13.8	12.4	15.8	17.3	14.1	17.0	13.0	7.9
Total Medical practitioners in workforce	**no.**	**22 015**	**16 085**	**9 474**	**4 990**	**5 006**	**1 481**	**1 381**	**732**
2006									
Medical practitioners in workforce									
Medical practitioners under 30	%	9.1	13.3	7.1	9.5	8.3	4.2	6.7	18.5
Medical practitioners aged 30 to 39	%	25.1	26.0	23.5	23.6	26.7	18.9	25.1	33.1
Medical practitioners aged 40 to 49	%	26.4	26.1	29.9	28.3	28.3	30.4	28.8	26.9
Medical practitioners aged 50 to 59	%	22.0	20.2	23.6	21.3	21.4	28.4	23.6	14.7
Medical practitioners aged 60+	%	17.4	14.3	15.8	17.3	15.3	18.0	15.8	6.9
Total Medical practitioners in workforce	**no.**	**21 656**	**16 900**	**9 937**	**6 378**	**5 178**	**1 384**	**1 364**	**891**
2007									
Medical practitioners in workforce									
Medical practitioners under 30	%	9.2	11.9	7.6	12.0	8.8	4.2	4.7	13.9
Medical practitioners aged 30 to 39	%	24.4	26.2	28.0	27.4	27.5	19.4	37.1	28.9
Medical practitioners aged 40 to 49	%	26.4	25.6	28.5	26.3	26.7	28.0	28.2	29.1
Medical practitioners aged 50 to 59	%	22.4	19.7	21.0	19.9	21.1	28.7	16.4	16.4
Medical practitioners aged 60+	%	17.5	16.6	14.9	14.3	16.1	19.7	13.6	11.7
Total Medical practitioners in workforce	**no.**	**21 530**	**17 515**	**12 436**	**7 758**	**5 526**	**1 638**	**1 486**	**924**
2008									
Medical practitioners in workforce									
Medical practitioners under 30	%	11.2	11.9	5.1	13.3	9.6	4.1	12.0	14.0

Table 10A.55 **Medical practitioner workforce, by age group (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (g), (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)
Medical practitioners aged 30 to 39	%	24.2	26.7	28.6	28.1	27.6	18.5	28.9	32.8
Medical practitioners aged 40 to 49	%	26.0	25.7	27.8	26.4	25.2	27.6	26.2	25.6
Medical practitioners aged 50 to 59	%	21.9	20.5	22.3	19.0	20.6	29.3	21.3	16.8
Medical practitioners aged 60+	%	16.6	15.1	16.2	13.2	17.1	20.6	11.6	10.8
Total Medical practitioners in workforce	**no.**	**21 958**	**17 813**	**13 571**	**6 995**	**5 791**	**1 607**	**1 592**	**865**
2009									
Medical practitioners in workforce									
Medical practitioners under 30	%	10.2	12.0	8.0	16.0	8.0	3.6	10.8	14.8
Medical practitioners aged 30 to 39	%	24.4	27.2	28.8	27.8	28.4	17.9	31.4	29.4
Medical practitioners aged 40 to 49	%	25.1	25.2	28.8	24.9	25.9	30.7	24.4	27.7
Medical practitioners aged 50 to 59	%	22.3	20.2	20.2	18.9	21.2	27.9	21.5	17.2
Medical practitioners aged 60+	%	17.9	15.3	14.3	12.4	16.5	20.0	11.9	10.9
Total Medical practitioners in workforce	**no.**	**22 442**	**18 620**	**15 026**	**7 708**	**5 827**	**1 884**	**1 708**	**1 045**
2010									
Medical practitioners in workforce									
Medical practitioners under 30	%	8.6	11.8	na	na	11.1	9.3	9.3	11.9
Medical practitioners aged 30 to 39	%	26.8	28.3	na	na	27.8	25.9	25.4	32.8
Medical practitioners aged 40 to 49	%	24.5	24.0	na	na	24.4	25.5	26.5	27.1
Medical practitioners aged 50 to 59	%	21.6	20.5	na	na	20.5	23.7	24.1	18.0
Medical practitioners aged 60+	%	18.5	15.4	na	na	16.3	15.5	14.6	10.3
Total Medical practitioners in workforce	**no.**	**25 134**	**19 528**	**na**	**na**	**6 361**	**1 849**	**1 566**	**836**

Table 10A.55 **Medical practitioner workforce, by age group (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (g), (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)
2011									
Medical practitioners in workforce									
Medical practitioners under 30	%	8.9	11.9	10.4	12.3	11.6	9.0	8.0	12.1
Medical practitioners aged 30 to 39	%	27.3	28.4	30.6	29.0	27.7	26.4	28.3	37.2
Medical practitioners aged 40 to 49	%	24.0	23.6	25.3	24.8	23.7	24.8	26.0	22.8
Medical practitioners aged 50 to 59	%	21.1	20.6	20.0	19.9	20.3	23.8	23.4	15.9
Medical practitioners aged 60+	%	18.7	15.6	13.6	14.0	16.7	15.9	14.4	11.9
Total Medical practitioners in workforce	**no.**	**26 286**	**20 116**	**16 177**	**7 914**	**6 524**	**1 884**	**1 607**	**1 022**
2012									
Medical practitioners in workforce									
Medical practitioners under 30	%	7.7	10.3	9.5	11.7	10.0	8.6	7.0	9.6
Medical practitioners aged 30 to 39	%	26.7	28.1	29.6	27.9	27.4	23.9	28.1	35.6
Medical practitioners aged 40 to 49	%	24.5	24.1	25.7	25.4	24.9	26.4	26.6	24.4
Medical practitioners aged 50 to 59	%	21.8	21.0	20.7	20.4	20.5	23.8	23.3	17.6
Medical practitioners aged 60+	%	19.3	16.4	14.4	14.6	17.2	17.3	14.9	12.7
Total Medical practitioners in workforce	**no.**	**26 277**	**20 166**	**16 330**	**8 149**	**6 467**	**1 840**	**1 611**	**1 039**

(a) In 2008, 2009, 2010, 2011 and 2012, data include employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.

(b) 2011 and 2012 data is by derived state, derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details unavailable, state and territory of residence is used. For records with no information on all three locations, they are coded to 'Not stated'. NT is the jurisdiction most affected - see Data quality statement.

(c) 2012 data exclude provisional registrants.

Table 10A.55 **Medical practitioner workforce, by age group (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (g), (h)	*SA*	*Tas* (i)	*ACT*	*NT* (j)

(d) In 2008 and 2009, NSW data are based on responses to the Medical Labour Force Survey weighted to financial registrants holding general, conditional specialist, limited prescribing and referring or non-practising registration.

(e) In 2008 and 2009, Victoria surveyed only general, specific and provisional registered medical practitioners in the Medical Labour Force Survey but responses are weighted to all registered medical practitioners.

(f) In 2008 and 2009, Queensland data are based on responses to the Medical Labour Force Survey weighted to all registrants excluding some conditional registration types. The Queensland benchmarks for 2009 were taken from the Queensland medical board annual report which included an age breakdown in 10 year increments whilst the estimates for previous years was done using 5 year increments. Given that the response rates have fallen between 2008 and 2009 and that the response rates for some age groups are particularly small, (notably the response rate for 25-34 year olds was only 7.8 per cent for males and 11.4 per cent for females), Queensland data should be treated with caution, particularly for the younger groups.

(g) In 2010 no data collected for Queensland and WA.

(h) In 2008 and 2009, for WA data, the scope has been consistent, that is, the survey population and the benchmark figures are based on general and conditional registrants. For 2005, survey was administered to both general and conditional registrants but benchmark figures were for general registrants only. For 2008 the benchmark used was the total number of registered practitioners in 2008 using 2007 age by sex proportions. For WA in 2007, 2008 and 2009, the benchmark data includes a significant number of registered medical practitioners that are no longer active in the workforce. This inflates the perception of the medical labour force in WA. It is also unknown how significantly past years have been affected. Care should be taken when interpreting these figures.

(i) In 2008 and 2009, Tasmania data are based on responses to the annual Medical Labour Force Survey weighted to general registrants, conditionally registered specialists and non-practising practitioners only.

(j) 2010 data is by state of principal practice while 2011 and 2012 data is by derived state, derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details unavailable, state and territory of residence is used. For records with no information on all three locations, they are coded to 'Not stated'. NT is the jurisdiction most affected - see Data quality statement.

na Not available.

Source : AIHW National Health Workforce Data Set (unpublished).

Table 10A.56 **Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	Tas	*ACT*	*NT* (b)	*Aust*
Total separations (c)	'000	1 593	1 511	977	565	384	98	97	113	5 339
Acute separations (d)	'000	1 559	1 473	937	552	372	96	93	112	5 193
Proportion of separations not acute	%	2.1	2.5	4.1	2.3	3.1	2.0	4.1	0.9	2.7
Average cost weight (e)	no.	1.04	0.96	1.15	0.91	1.07	1.06	1.00	0.67	0.99
Casemix-adjusted separations (f)	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Total admitted patient days (c)	'000	5 583	4 587	2 985	1 611	1 349	334	327	294	17 070
Admitted patient days for acute patients	'000	5 100	3 813	102	1 423	1 181	293	270	278	14 865
Proportion of bed days not acute	%	8.7	16.9	96.6	11.7	12.5	12.3	17.4	5.4	12.9
Total recurrent expenditure	$m	12 906	9 746	7 706	4 381	3 230	916	933	568	40 384
Admitted patient cost proportion (g)		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Total admitted patient recurrent expenditure	$m	8 905	6 823	5 240	3 154	2 261	632	644	454	28 269
Relative stay index (h)		1.09	0.92	0.90	1.01	1.06	1.09	1.02	1.18	1.00
Average cost data for selected included hospitals										
Non-medical labour costs per casemix-adjusted separation										
Nursing	$	1 320	1 271	1 338	1 323	1 396	1 460	1 857	1 788	1 336
Diagnostic/allied health (i)	$	347	412	373	353	285	314	392	380	366
Administrative	$	361	284	356	438	292	450	526	364	346
Other staff	$	215	229	343	326	151	324	100	437	251
Superannuation	$	247	247	296	289	249	443	453	na	265
Total non-medical labour costs	$	2 490	2 443	2 707	2 729	2 373	2 990	3 328	2 969	2 564

Table 10A.56 **Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	Tas	*ACT*	*NT* (b)	*Aust*
Other recurrent costs per casemix-adjusted separation										
Domestic services	$	117	100	108	139	93	99	224	158	113
Repairs/maintenance	$	113	87	97	202	104	65	75	153	109
Medical supplies (i)	$	574	400	572	380	349	746	518	435	491
Drug supplies	$	235	243	243	286	244	326	156	247	245
Food supplies	$	92	46	36	34	32	50	44	49	49
Administration	$	360	278	286	233	150	281	452	199	294
Other	$	113	121	21	323	671	180	170	507	168
Total other recurrent costs	$	1 604	1 275	1 362	1 596	1 642	1 747	1 639	1 749	1 477
Total excluding medical labour costs	$	4 094	3 718	4 068	4 326	4 015	4 738	4 967	4 718	4 041
Medical labour costs per casemix-adjusted separation										
Public patients										
Salaried/sessional staff	$	630	731	961	1 054	856	1 006	902	1 150	797
Visiting medical officer payments	$	248	70	63	172	185	2	301	97	147
Private patients (estimated) (j)	$	307	174	153	181	195	288	214	51	218
Total medical labour costs	$	1 185	975	1 177	1 407	1 237	1 295	1 417	1 299	1 163
Total labour costs (medical + non-medical)	$	3 675	3 418	3 884	4 136	3 609	4 285	4 745	4 267	3 727
Total recurrent cost per casemix-adjusted separation	**$**	**5 280**	**4 693**	**5 246**	**5 733**	**5 251**	**6 033**	**6 384**	**6 017**	**5 204**
Experimental estimates of recurrent cost per casemix-adjusted acute non-psychiatric separations (k)	**$**	**4 983**	**4 038**	**na**	**5 497**	**na**	**na**	**na**	**na**	**na**

(a) Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from this table. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. Expenditure data exclude depreciation.

(b) These figures should be interpreted in conjunction with the consideration of cost disabilities associated with hospital service delivery in the NT.

Table 10A.56 **Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2011-12 (a)**

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

(c) Excludes separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement.

(d) Separations for which the care type was reported as acute and unspecified and newborn episodes of care with qualified days.

(e) Average cost weight from the National Hospital Cost Data Collection, using the 2008–09 AR-DRG version 5.2 cost weights for separations for which the care type was reported as acute, newborn with at least one qualified day or was not reported.

(f) Casemix-adjusted separations are the product of total separations and average cost weight.

(g) Of the selected hospitals, three small hospitals had their admitted patient cost proportion estimated by the Health and Allied Services Advisory Council ratio. Admitted patient cost proportion was previously called the inpatient fraction.

(h) Relative stay index based on public hospitals using the indirect method. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average of public hospitals based on the casemix of that group. Relative stay index based on AR-DRG version 5.2.

(i) Queensland pathology services are purchased from the statewide pathology service rather than being provided by each hospital's employees resulting in higher medical supplies costs and lower diagnostic staff costs.

(j) Estimated private patient medical costs calculated as the sum of salary/sessional and visiting medical officer payments divided by the number of public patient days multiplied by the number of private patient days. This is a notional estimate of the medical costs for all non-public patients, including those self funded and those funded by private health insurance, compensation and the Department of Veterans' Affairs.

(k) Estimates relate to a subset of the selected public hospitals only. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded $1000 per day and more than $1 000 000 of apparent expenditure on non-acute patients days was reported. These data are provided by states and territories on a voluntary basis.

na Not available.

Source: AIHW 2013, *Australian Hospital Statistics 2011-12,* Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Principal referral: major cities (>20 000 acute weighted separations) and regional (>16 000 acute weighted separations)										
Number of hospitals	no.	28	19	17	5	4	2	2	2	79
Separations per hospital (c)	no.	39 613	61 896	44 533	62 586	55 057	39 107	48 728	48 507	48 710
AR-DRGs (5+) per hospital (d)	no.	438	525	422	463	504	474	454	401	461
Average cost weight (e)		1.10	0.99	1.05	0.96	1.20	1.07	1.00	0.70	1.04
Relative stay index (f)		1.12	0.89	0.92	1.02	1.07	1.03	1.02	1.21	1.00
Cost per casemix adjusted separation	$	5 291	4 586	5 285	5 659	5 223	5 777	6 384	5 967	5 158
Specialist women's and children's (>10 000 acute weighted separations)										
Number of hospitals	no.	3	2	3	2	1	–	–	–	11
Separations per hospital (c)	no.	19 877	30 046	16 046	21 096	31 472	..	..	..	21 956
AR-DRGs (5+) per hospital (d)	no.	237	247	202	202	321	..	..	..	231
Average cost weight (e)		1.22	1.30	1.20	1.26	1.15	..	..	..	1.24
Relative stay index (f)		1.08	0.99	0.96	1.10	1.13	..	..	..	1.05
Cost per casemix adjusted separation	$	6 200	5 990	6 345	6 200	5 749	..	..	..	6 107
Total principal referral and specialist women's and children's										
Number of hospitals	no.	31	21	20	7	5	2	2	2	90
Separations per hospital (c)	no.	37 703	58 863	40 260	50 732	50 340	39 107	48 728	48 507	45 440
AR-DRGs (5+) per hospital (d)	no.	418	499	389	389	467	474	454	401	433
Average cost weight (e)		1.10	1.00	1.06	1.00	1.19	1.07	1.00	0.70	1.05
Relative stay index (f)		1.12	0.90	0.92	1.03	1.08	1.03	1.02	1.21	1.00
Cost per casemix adjusted separation	$	5 337	4 670	5 355	5 738	5 287	5 777	6 384	5 967	5 222
Large major cities (>10 000 acute weighted separations)										
Number of hospitals	no.	10	2	2	3	2	–	–	–	19
Separations per hospital (c)	no.	16 001	17 446	22 138	23 381	18 172	..	..	..	18 193
AR-DRGs (5+) per hospital (d)	no.	259	125	280	284	275	..	..	..	253
Average cost weight (e)		1.00	1.00	1.00	1.00	1.00	..	..	..	1.00

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Relative stay index (f)		1.08	0.96	0.83	0.92	0.95	..	..	..	1.00
Cost per casemix adjusted separation	$	4 839	5 347	3 965	4 851	5 051	..	..	..	4 832
Large regional (>8 000 acute weighted separations) and remote (>5 000 acute weighted separations)										
Number of hospitals	no.	3	8	1	4	–	1	–	–	17
Separations per hospital (c)	no.	11 613	17 491	6 857	15 803	..	7 736	..	..	14 857
AR-DRGs (5+) per hospital (d)	no.	236	322	206	240	..	243	..	..	276
Average cost weight (e)		1.00	1.00	1.00	1.00	..	1.00	..	..	1.00
Relative stay index (f)		1.02	0.95	0.97	0.97	..	1.11	..	..	0.97
Cost per casemix adjusted separation	$	5 933	4 442	4 029	5 539	..	7 390	..	..	5 025
Total large hospitals										
Number of hospitals	no.	13	10	3	7	2	1	–	–	36
Separations per hospital (c)	no.	14 988	17 482	17 044	19 051	18 172	7 736	..	..	16 618
AR-DRGs (5+) per hospital (d)	no.	253	283	255	259	275	243	..	..	264
Average cost weight (e)		1.00	1.00	1.00	1.00	1.00	1.00	..	..	1.00
Relative stay index (f)		1.07	0.95	0.86	0.94	0.95	1.11	..	..	0.99
Cost per casemix adjusted separation	$	5 003	4 593	3 973	5 149	5 051	7 390	..	..	4 912
Medium (5000 to 10 000 acute weighted separations)										
Number of hospitals	no.	11	3	4	3	4	1	–	–	26
Separations per hospital (c)	no.	8 567	8 329	10 617	10 624	10 253	8 872	..	..	9 363
AR-DRGs (5+) per hospital (d)	no.	175	194	190	113	195	195	..	..	176
Average cost weight (e)		0.87	0.73	0.64	0.87	0.72	0.77	..	..	0.79
Relative stay index (f)		1.02	0.97	0.56	0.99	0.96	1.10	..	..	0.93
Cost per casemix adjusted separation	$	5 051	5 057	4 397	5 291	5 423	6 406	..	..	5 100
Medium (2000 to 5000 acute weighted separations)										
Number of hospitals	no.	20	10	9	2	8	–	–	–	49
Separations per hospital (c)	no.	4 185	4 623	4 103	4 072	4 353	..	..	..	4 282

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
AR-DRGs (5+) per hospital (d)	no.	116	125	124	119	128	..	..	..	122
Average cost weight (e)		0.75	0.70	0.73	0.74	0.77	..	..	..	0.74
Relative stay index (f)		1.01	1.04	0.80	0.90	0.92	..	..	..	0.96
Cost per casemix adjusted separation	$	4 858	4 885	4 911	5 879	4 946	..	..	..	4 929
Total medium										
Number of hospitals	no.	31	13	13	5	12	1	–	–	75
Separations per hospital (c)	no.	5 740	5 478	6 107	8 003	6 319	8 872	..	..	6 043
AR-DRGs (5+) per hospital (d)	no.	137	141	144	115	150	195	..	..	141
Average cost weight (e)		0.81	0.71	0.68	0.84	0.74	0.77	..	..	0.76
Relative stay index (f)		1.01	1.02	0.68	0.97	0.94	1.10	..	..	0.94
Cost per casemix adjusted separation	$	4 964	4 945	4 645	5 399	5 208	6 406	..	..	5 025
Small regional acute (<2000 acute weighted separations and less than 40 per cent not acute or outlier bed days)										
Number of hospitals	no.	40	22	26	3	14	5	–	–	110
Separations per hospital (c)	no.	1 186	1 311	1 108	1 348	1 018	518	..	..	1 145
AR-DRGs (5+) per hospital (d)	no.	49	44	49	61	47	25	..	..	47
Average cost weight (e)		0.76	0.68	0.76	0.78	0.79	0.87	..	..	0.75
Relative stay index (f)		1.02	1.32	0.90	1.12	1.03	1.71	..	..	1.07
Cost per casemix adjusted separation	$	5 694	5 947	4 931	5 565	4 744	7 580	..	..	5 505
Remote acute (<5000 acute weighted separations)										
Number of hospitals	no.	5	–	16	12	4	1	–	3	41
Separations per hospital (c)	no.	803	..	785	2 679	1 557	303	..	5 448	1 746
AR-DRGs (5+) per hospital (d)	no.	32	..	36	87	47	14	..	110	56
Average cost weight (e)		0.60	..	0.74	0.74	0.75	0.70	..	0.52	0.68
Relative stay index (f)		0.91	..	1.00	0.85	1.00	1.06	..	0.93	0.91
Cost per casemix adjusted separation	$	9 318	..	5 372	8 596	5 211	6 799	..	6 424	7 322
Total small acute										

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of hospitals	no.	45	22	42	15	18	6	–	3	151
Separations per hospital (c)	no.	1 143	1 311	985	2 413	1 138	482	..	5 448	1 308
AR-DRGs (5+) per hospital (d)	no.	47	44	44	82	47	24	..	110	49
Average cost weight (e)		0.75	0.68	0.75	0.75	0.78	0.85	..	0.52	0.72
Relative stay index (f)		1.01	1.32	0.93	0.88	1.02	1.65	..	0.93	1.02
Cost per casemix adjusted separation	$	5 931	5 947	5 065	8 259	4 884	7 514	..	6 424	6 171
Total hospitals in cost per casemix adjusted separation analysis										
Number of hospitals	**no.**	**120**	**66**	**78**	**34**	**37**	**10**	**2**	**5**	**352**
Separations per hospital (c)	**no.**	**13 275**	**22 894**	**12 527**	**16 608**	**10 388**	**9 772**	**48 728**	**22 671**	**15 167**
AR-DRGs (5+) per hospital (d)	**no.**	**188**	**244**	**157**	**186**	**150**	**153**	**454**	**226**	**189**
Average cost weight (e)		**1.04**	**0.96**	**1.01**	**0.91**	**1.07**	**1.06**	**1.00**	**0.67**	**0.99**
Relative stay index (f)		**1.10**	**0.91**	**0.91**	**1.00**	**1.04**	**1.07**	**1.02**	**1.18**	**1.00**
Cost per casemix adjusted separation	**$**	**5 280**	**4 693**	**5 246**	**5 733**	**5 251**	**6 033**	**6 384**	**6 017**	**5 204**
Small non-acute (<2000 acute weighted separations more than 40 per cent not acute or outlier bed days)										
Number of hospitals	no.	17	3	14	4	18	1	–	–	57
Separations per hospital (c)	no.	1 097	1 241	837	1 494	627	304	–	–	906
Total expenditure	$'000	140 250	33 114	71 049	42 058	65 098	2 450	–	–	354 018
Cost per casemix adjusted separation	$	7548.0	8222.0	6309.0	9094.0	6752.0	5227.0	0.0	0.0	7371.0
Multi-purpose service										
Number of hospitals	no.	18	9	9	40	2	–	–	–	78
Separations per hospital (c)	no.	235	689	663	221	973	–	–	–	349
Total expenditure	$'000	69 399	58 697	46 054	92 322	9 786	–	–	–	276 259
Cost per casemix adjusted separation	$	15952.0	10293.0	5756.0	6550.0	6404.0	0.0	0.0	0.0	8613.0
Rehabilitation										
Number of hospitals	no.	5	–	–	1	2	–	–	–	8
Separations per hospital (c)	no.	458	–	–	4 597	1 234	–	–	–	1 170

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total expenditure	$'000	110 634	–	–	87 916	58 119	–	–	–	256 670
Cost per casemix adjusted separation	$	21214.0	0.0	0.0	9617.0	21519.0	0.0	–	0.0	12734.0
Mothercraft										
Number of hospitals	no.	3	2	1	–	–	–	1	–	7
Separations per hospital (c)	no.	2 318	1 914	2 224	–	–	–	–	–	1 858
Total expenditure	$'000	17 289	11 204	4 674	–	–	–	3 154	–	36 321
Cost per casemix adjusted separation	$	1338.0	2200.0	2190.0	0.0	0.0	0.0	0.0	0.0	1694.0
Other non-acute										
Number of hospitals	no.	12	–	–	–	–	–	–	–	12
Separations per hospital (c)	no.	916	–	–	–	–	–	–	–	916
Total expenditure	$'000	162 761	–	–	–	–	–	–	–	162 761
Cost per casemix adjusted separation	$	7333.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7333.0
Total non-acute										
Number of hospitals	no.	105	38	92	62	43	13	1	–	354
Separations per hospital	no.	587	863	262	378	513	147	na	..	469
AR-DRGs (5+) per hospital	no.	10	12	9	10	15	5	na	..	11
Average cost weight		1	1	1	1	1	1	na	..	1
Relative stay index		1	1	1	1	1	2	na	..	1
Cost per casemix adjusted separation	$	9 526	9 156	9 898	11 489	12 058	13 878	na	..	10 534
Psychiatric (g)										
Number of hospitals	no.	7	2	4	2	2	1	–	–	18
Separations per hospital (c)	no.	756	232	96	699	927	356	–	–	541
Total expenditure	$'000	245 061	49 417	137 584	88 033	78 950	18 101	–	–	617 146
Cost per casemix adjusted separation	$	11593.0	41040.0	53649.0	15863.0	19115.0	29609.0	0.0	0.0	17270.0
Unpeered and other acute (includes hospitals with fewer than 200 separations)										
Number of hospitals	no.	43	22	64	15	19	11	–	–	174

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Separations per hospital (c)	no.	307	844	60	176	237	114	–	–	253
Total expenditure	$'000	274 457	247 556	97 636	93 092	40 394	27 421	–	–	780 556
Cost per casemix adjusted separation	$	10 920	7 628	13 428	26 432	8 815	10 971	–	–	12 327
Total										
Number of hospitals used in this analysis	**no.**	**225**	**104**	**170**	**96**	**80**	**23**	**3**	**5**	**706**
Average beds per hospital (h)	**no.**	**89**	**89**	**66**	**59**	**65**	**52**	**313**	**139**	**78**
Number of hospitals	**no.**	**225**	**151**	**170**	**96**	**80**	**23**	**3**	**5**	**753**
Separations per hospital	**no.**	**7 354**	**14 844**	**5 890**	**6 126**	**5 080**	**4 332**	**32 485**	**22 671**	**7 797**
Total expenditure	**$'000**	**12 905 606**	**9 746 466**	**7 705 940**	**4 380 674**	**3 229 556**	**915 578**	**932 981**	**567 521**	**40 384 321**
Teaching (excluding psychiatric)										
Number of hospitals	no.	20	16	22	6	7	3	2	2	78
Separations per hospital (c)	no.	43 876	49 937	35 600	50 107	41 149	28 650	48 728	48 507	42 677
AR-DRGs (5+) per hospital (d)	no.	425	402	349	349	412	397	454	401	391
Average cost weight (e)		1.14	1.15	1.08	1.03	1.18	1.10	1.00	0.70	1.10
Relative stay index (f)		1.14	0.92	0.93	1.05	1.06	1.04	1.02	1.21	1.02
Cost per casemix adjusted separation	$	5 321	5 896	5 396	6 004	5 257	5 961	6 384	5 967	5 591

(a) The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included.

(b) Expenditure and cost per casemix adjusted separation data exclude depreciation.

(c) Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded.

(d) The number of different version 5.2 AR-DRGs provided by a hospital for which there were at least five acute separations.

(e) Average cost weight from the National Hospital Cost Data Collection, based on acute and unspecified separations and Newborn episodes of care with qualified days, using the 2008–09 AR-DRG version 5.2 cost weights.

Table 10A.57 **Costs and utilisation by hospital peer group, public hospitals, 2011-12 (a), (b)**

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

(f) Relative stay index based on observed vs expected length of stay based on age and AR-DRG Version 5.2, public hospitals using the indirect method. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average of public hospitals based on the casemix of that group.

(g) Psychiatric hospitals consist of a mix of short-term acute, long-term, psychogeriatric and forensic psychiatric hospitals.

(h) Calculated by dividing total number of available beds across all hospitals by total number of hospitals.

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

Source : AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.58 **Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2011-12 (a), (b), (c)**

	Unit	*NSW*	*Vic* (d)	*Qld*	*WA* (d)	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Land										
Asset value at 30 June	$m	1 664	na	685	428	229	38	28	20	3 093
User cost of capital	$m	133	na	55	34	18	3	2	2	247
Casemix-adjusted separations	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Inpatient fraction		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Cost per casemix-adj. separation	$	55	na	33	67	31	20	16	17	33
Buildings										
Asset value at 30 June	$m	7 682	5 197	4 886	2 270	1 520	403	580	534	23 072
User cost of capital	$m	615	416	391	182	122	32	46	43	1846
Annual depreciation	$m	329	398	147	55	73	15	15	17	1049
Casemix-adjusted separations	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Inpatient fraction		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Cost per casemix-adj. separation	$	393	561	326	459	332	316	434	633	383
Equipment										
Asset value at 30 June	$m	870	1 862	975	181	118	110	58	17	4 191
User cost of capital	$m	70	149	78	15	9	9	5	1	335
Annual depreciation	$m	170	203	84	31	32	8	13	4	544
Casemix-adjusted separations	'000	1 657	1 451	1 124	514	411	104	97	76	5 286
Inpatient fraction		0.69	0.70	0.68	0.72	0.70	0.69	0.69	0.80	0.70
Cost per casemix-adj. separation	$	100	243	98	88	70	111	124	60	116
Interest payments	$m	41.6	–	–	2.8	4.5	–	0.2	–	49.1
Interest payments per separation	$	17.3	–	–	5.4	7.7	–	1.2	–	6.5
Total capital cost (excl. land) per casemix-adj. separation	**$**	**475**	**804**	**424**	**542**	**395**	**427**	**556**	**693**	**493**

Table 10A.58 **Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2011-12 (a), (b), (c)**

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

(a) Capital cost is defined as the user cost of capital (calculated at 8 per cent of the current value of non-current physical assets) plus the depreciation amount. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

(b) Where possible, data relate to inpatients in public acute hospitals, with the scope the same as that for recurrent cost per casemix adjusted separations calculated by the AIHW, that is - psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other, hospices, rehabilitation facilities and small non-acute and multi-purpose services are excluded.

(c) Inpatient fractions sourced from AIHW's Australian Hospital Statistics for all jurisdictions.

(d) The asset values and depreciation amounts for Victoria and WA relate to inpatients only and so have not been adjusted by the inpatient fraction.

(e) Interest payments are not reported.

na Not available. – Nil or rounded to zero.

Source : State and Territory governments (unpublished); AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.59 **Relative stay index for patients in public hospitals, by funding source, 2011-12 (a), (b)**

Accommodation status	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Public patients (c)	1.04	0.91	0.89	0.97	1.01	1.03	1.00	1.16	0.97
Private health insurance	1.07	0.96	0.96	1.10	1.10	1.05	1.03	1.01	1.03
Self-funded	1.06	0.92	0.84	0.91	0.90	0.93	0.89	1.08	1.01
Workers compensation	1.14	1.02	1.08	1.21	1.18	1.04	1.09	1.49	1.11
Motor vehicle 3rd party personal claim	1.24	0.91	1.05	1.20	1.24	1.28	1.00	1.34	1.09
Department of Veterans' Affairs	0.99	0.90	0.83	0.94	1.06	1.07	0.88	1.28	0.96
Other (d)	1.80	0.93	0.90	1.08	1.09	0.99	1.08	1.24	1.22
Total	**1.05**	**0.91**	**0.89**	**0.98**	**1.02**	**1.04**	**1.00**	**1.16**	**0.98**

(a) Separations for which the care type was reported as acute or newborn with qualified days, or was not reported.

(b) Relative stay index based on all hospitals using the indirect method using AR-DRG version 6.0x. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average based on the casemix of that group.

(c) Public patients includes separations with a funding source of Australian Health Care Agreements, Reciprocal health care agreements, Other hospital or public authority (with a public patient election status) and No charge raised (in public hospitals).

(d) Includes patients whose funding source was reported as other compensation, Department of Defence, Correctional facilities, other hospital or public authority, other and unknown.

– Nil or rounded to zero.

Source : AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.60 **Relative stay index, indirectly standardised, patients in public hospitals, by medical, surgical and other type of diagnosis related group 2011-12 (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Medical	1.03	0.90	0.86	0.95	1.01	1.06	0.99	1.10	0.95
Surgical	1.08	0.95	0.97	1.05	1.06	1.00	1.01	1.34	1.02
Other	1.16	0.95	0.96	1.00	1.04	1.00	1.04	1.32	1.04
All public hospitals	**1.05**	**0.91**	**0.89**	**0.98**	**1.02**	**1.04**	**1.00**	**1.16**	**0.98**

(a) Separations for which the care type was reported as acute or newborn with qualified days, or was not reported. Relative stay index based on all hospitals using AR-DRG version 6.0x.

(b) The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average based on the casemix of that group.

Source : AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.61 **NSW recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Occassions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	870 579	882 510	906 689	916 314	952 499
Large hospitals	no.	686 050	689 374	683 249	693 313	718 201
Medium hospitals	no.	568 564	559 006	570 768	590 426	590 153
Small hositals	no.	141 569	141 249	139 356	139 172	131 678
Unpeered and other acute hospitals	no.	29 640	26 353	26 662	27 044	25 519
Total public acute	no.	2 296 402	2 298 492	2 326 724	2 366 269	2 418 050
Outpatient						
Principal referral and Women's and children's hospitals	no.	8 084 029	8 428 689	8 024 141	8 057 030	9 159 883
Large hospitals	no.	2 449 095	2 694 304	2 646 680	2 692 358	3 014 713
Medium hospitals	no.	1 201 479	1 154 536	1 184 590	1 261 467	1 358 327
Small hositals	no.	109 868	110 675	116 213	125 779	124 305
Unpeered and other acute hospitals	no.	3 443 706	3 621 901	3 504 152	3 476 754	3 685 381
Total public acute	no.	15 288 177	16 010 105	15 475 776	15 613 388	17 342 609
Other						
Principal referral and Women's and children's hospitals	no.	1 059 433	1 164 306	1 043 412	879 446	1 212 795
Large hospitals	no.	681 171	690 388	567 511	612 388	619 867
Medium hospitals	no.	419 714	440 748	421 894	386 468	554 453
Small hositals	no.	110 401	108 954	106 655	116 928	164 585
Unpeered and other acute hospitals	no.	643 240	503 100	501 099	468 942	503 515
Total public acute	no.	2 913 959	2 907 496	2 640 571	2 464 172	3 055 215
Total						
Principal referral and Women's and children's hospitals	no.	10 014 041	10 475 505	9 974 242	9 852 790	11 325 177
Large hospitals	no.	3 816 316	4 074 066	3 897 440	3 998 059	4 352 781
Medium hospitals	no.	2 189 757	2 154 290	2 177 252	2 238 361	2 502 933
Small hositals	no.	361 838	360 878	362 224	381 879	420 568

Table 10A.61 **NSW recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	no.	4 116 586	4 151 354	4 031 913	3 972 740	4 214 415
Total public acute	no.	20 498 538	21 216 093	20 443 071	20 443 829	22 815 874
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	64 966	46 561	43 263	57 306	60 501
Other	no.	na	na	na	na	na
Total	no.	64 966	46 561	43 263	57 306	60 501
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	$	209	216	226	281	277
Large hospitals	$	203	151	204	252	267
Medium hospitals	$	194	164	220	221	256
Small hositals	$	120	98	117	106	234
Unpeered and other acute hospitals	$	90	96	105	116	129
Total public acute	$	197	175	210	245	265
Outpatient						
Principal referral and Women's and children's hospitals	$	119	139	154	164	124
Large hospitals	$	99	103	114	119	104
Medium hospitals	$	66	73	94	92	93
Small hositals	$	136	111	133	125	177
Unpeered and other acute hospitals	$	32	9	38	40	47
Total public acute	$	92	99	116	122	102
Other						
Principal referral and Women's and children's hospitals	$	101	101	106	129	138
Large hospitals	$	87	80	103	94	144
Medium hospitals	$	118	124	122	141	90
Small hositals	$	119	103	120	113	98

Table 10A.61 **NSW recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	$	69	84	85	101	12
Total public acute	$	94	96	105	116	108
Total						
Principal referral and Women's and children's hospitals	$	125	142	155	172	138
Large hospitals	$	116	107	128	138	136
Medium hospitals	$	109	107	133	135	131
Small hositals	$	125	103	123	115	164
Unpeered and other acute hospitals	$	38	19	44	48	44
Total public acute	$	104	107	125	136	120
Public psychiatric						
Emergency department	$	na	na	na	na	na
Outpatient	$	1 500	894	1 123	862	736
Other	$	na	na	na	na	na
Total	$	1 513	907	1 137	872	771

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

na Not available.

Source: NSW Government (unpublished).

Table 10A.62 **WA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Occassions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	223 113	229 705	280 942	377 377	408 829
Large hospitals	no.	150 840	133 032	106 722	255 184	283 874
Medium hospitals	no.	84 020	105 399	110 235	24 967	26 855
Small hositals	no.	143 639	131 683	147 031	160 324	173 961
Unpeered and other acute hospitals	no.	72 893	85 514	81 393	83 831	81 990
Total public acute	no.	674 505	685 333	726 323	901 683	975 509
Outpatient						
Principal referral and Women's and children's hospitals	no.	1 577 667	1 611 707	1 662 696	1 317 725	1 023 297
Large hospitals	no.	360 576	290 118	317 121	363 001	258 069
Medium hospitals	no.	448 024	515 736	565 286	128 633	89 716
Small hositals	no.	394 937	367 379	388 176	180 793	120 151
Unpeered and other acute hospitals	no.	198 272	241 705	242 553	160 312	97 307
Total public acute	no.	2 976 476	3 026 645	3 175 832	2 150 464	1 588 540
Other						
Principal referral and Women's and children's hospitals	no.	235 087	10 857	136 365	na	na
Large hospitals	no.	152 895	30 934	15 201	na	na
Medium hospitals	no.	127 464	40 991	44 293	na	na
Small hositals	no.	129 136	72 764	92 460	na	na
Unpeered and other acute hospitals	no.	32 133	80 629	30 249	na	na
Total public acute	no.	676 715	236 175	318 568	na	na
Total						
Principal referral and Women's and children's hospitals	no.	2 035 867	1 852 269	2 080 003	1 695 102	1 432 126
Large hospitals	no.	664 311	454 084	439 044	618 185	541 943
Medium hospitals	no.	659 508	662 126	719 814	153 600	116 571
Small hositals	no.	524 073	440 143	480 636	341 117	294 112

Table 10A.62 **WA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	no.	230 405	322 334	272 802	244 143	179 297
Total public acute	no.	4 114 164	3 730 956	3 992 299	3 052 147	2 564 049
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department (b)						
Principal referral and Women's and children's hospitals	$	490	530	505	465	603
Large hospitals	$	369	411	635	585	534
Medium hospitals	$	187	214	643	370	481
Small hositals	$	na	na	na	433	437
Unpeered and other acute hospitals	$	na	na	na	311	424
Total public acute	$	na	na	na	476	535
Outpatient						
Principal referral and Women's and children's hospitals	$	231	244	267	246	306
Large hospitals	$	118	119	157	87	248
Medium hospitals	$	99	126	121	62	213
Small hositals	$	176	213	245	141	237
Unpeered and other acute hospitals	$	173	180	201	125	254
Total public acute	$	186	203	222	190	283
Other						
Principal referral and Women's and children's hospitals	$	72	78	81	na	na
Large hospitals	$	72	78	81	na	na
Medium hospitals	$	72	78	81	na	na
Small hositals	$	72	78	81	na	na

Table 10A.62 **WA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	$	72	78	81	na	na
Total public acute	$	72	78	81	na	na
Total						
Principal referral and Women's and children's hospitals	$	241	278	287	295	391
Large hospitals	$	122	152	271	292	398
Medium hospitals	$	93	117	198	112	275
Small hositals	$	151	191	213	278	355
Unpeered and other acute hospitals	$	159	154	188	189	332
Total public acute	$	182	213	253	275	379
Public psychiatric						
Emergency department	$	na	na	na	na	na
Outpatient	$	na	na	na	na	na
Other	$	na	na	na	na	na
Total	$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

(b) Total cost per emergency department calculated using data for metropolitan hospitals only.

na Not available.

Source : WA Government (unpublished).

Table 10A.63 SA recurrent cost per non-admitted patient occasion of service, public hospitals (a)

		2007-08	2008-09	2009-10	2010-11	2011-12
Occassions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	262 490	257 999	272 164	280 184	286 285
Large hospitals	no.	37 864	38 518	39 971	42 569	40 564
Medium hospitals	no.	148 915	142 719	147 775	148 348	201 743
Small hositals	no.	67 566	62 979	65 586	61 869	68 473
Unpeered and other acute hospitals	no.	9 876	9 055	8 760	11 018	10 817
Total public acute	no.	526 711	511 270	534 256	543 988	607 882
Outpatient						
Principal referral and Women's and children's hospitals	no.	941 700	990 999	1 012 893	1 026 225	1 109 261
Large hospitals	no.	149 367	139 747	170 186	170 025	164 271
Medium hospitals	no.	174 605	196 281	205 610	191 881	187 799
Small hositals	no.	85 741	88 939	87 954	84 746	80 649
Unpeered and other acute hospitals	no.	17 643	21 995	21 542	17 542	20 651
Total public acute	no.	1 369 056	1 437 961	1 498 185	1 490 389	1 562 631
Other						
Principal referral and Women's and children's hospitals	no.	na	na	na	na	na
Large hospitals	no.	na	na	na	na	na
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	no.	1 204 190	1 248 998	1 285 057	1 306 409	1 395 546
Large hospitals	no.	187 231	178 265	210 157	212 594	204 835
Medium hospitals	no.	323 520	339 000	353 385	340 229	389 542
Small hositals	no.	153 307	151 918	153 540	146 585	149 122

Table 10A.63 **SA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	no.	27 519	31 050	30 302	28 560	31 468
Total public acute	no.	1 895 767	1 949 231	2 032 441	2 034 377	2 170 513
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	$	426	529	556	658	691
Large hospitals	$	336	333	244	402	502
Medium hospitals	$	189	213	232	256	215
Small hositals	$	54	60	64	94	67
Unpeered and other acute hospitals	$	–	–	–	–	–
Total public acute	$	302	365	380	460	455
Outpatient						
Principal referral and Women's and children's hospitals	$	319	355	370	410	365
Large hospitals	$	207	287	216	220	267
Medium hospitals	$	96	85	82	115	108
Small hositals	$	52	34	39	133	65
Unpeered and other acute hospitals	$	–	–	–	–	–
Total public acute	$	261	291	292	334	314
Other						
Principal referral and Women's and children's hospitals	$	na	na	na	na	na
Large hospitals	$	na	na	na	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na

Table 10A.63 **SA recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	$	342	391	409	463	432
Large hospitals	$	233	297	221	256	314
Medium hospitals	$	138	139	145	178	164
Small hositals	$	53	45	50	117	66
Unpeered and other acute hospitals	$	–	–	–	–	–
Total public acute	$	272	310	315	368	353
Public psychiatric						
Emergency department	$	na	na	na	na	na
Outpatient	$	na	na	na	na	na
Other	$	na	na	na	na	na
Total	$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

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

Source: SA Government (unpublished).

Table 10A.64 **Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Occassions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	77 243	80 151	62 340	68 687	68 418
Large hospitals	no.	47 414	49 957	44 871	44 328	43 194
Medium hospitals	no.	..	..	..	..	..
Small hositals	no.	..	..	..	..	..
Unpeered and other acute hospitals	no.	17 966	12 234	6 822	10 324	12 987
Total public acute	no.	142 623	142 342	114 033	123 339	124 599
Outpatient						
Principal referral and Women's and children's hospitals	no.	364 955	389 290	218 617	395 067	390 313
Large hospitals	no.	88 054	89 672	81 085	84 057	76 266
Medium hospitals	no.	..	..	..	..	..
Small hositals	no.	..	..	..	..	..
Unpeered and other acute hospitals	no.	7 212	6 582	2 234	4 539	14 896
Total public acute	no.	460 221	485 544	301 936	483 663	481 475
Other						
Principal referral and Women's and children's hospitals	no.	na	na	60 464	na	na
Large hospitals	no.	na	na	1 460	na	na
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	no.	na	na	na	na	na
Large hospitals	no.	na	na	na	na	na
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na

Table 10A.64 **Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	2008-09	2009-10	2010-11	2011-12
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	$	494	575	469	391	483
Large hospitals	$	252	353	340	338	360
Medium hospitals	$	..	..	..	..	..
Small hositals	$	..	..	..	..	..
Unpeered and other acute hospitals	$	151	44	169	184	140
Total public acute	$	..	451	400	355	451
Outpatient						
Principal referral and Women's and children's hospitals	$	163	213	302	248	260
Large hospitals	$	178	185	182	272	281
Medium hospitals	$	..	..	..	..	..
Small hositals	$	..	..	..	..	..
Unpeered and other acute hospitals	$	94	78	59	65	412
Total public acute	$	164	206	268	250	268
Other						
Principal referral and Women's and children's hospitals	$	na	na	133	na	na
Large hospitals	$	na	na	166	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na

Table 10A.64 **Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	$	na	na	na	na	na
Large hospitals	$	na	na	na	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	na	na	na	na	na
Public psychiatric						
Emergency department	$	na	na	na	na	na
Outpatient	$	na	na	na	na	na
Other	$	na	na	na	na	na
Total	$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

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

Source : Tasmania Government (unpublished).

Table 10A.65 **ACT recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Occassions of service						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	no.	51 756	54 117	57 487	60 572	64 928
Large hospitals	no.	46 685	47 781	49 327	51 355	53 839
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	98 441	101 898	106 814	112 197	118 767
Outpatient						
Principal referral and Women's and children's hospitals	no.	201 380	230 384	256 195	240 336	285 636
Large hospitals	no.	53 924	57 435	60 653	74 157	71 812
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	255 304	287 819	316 848	314 493	340 455
Other						
Principal referral and Women's and children's hospitals	no.	na	na	na	na	na
Large hospitals	no.	na	na	na	na	na
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	no.	253 136	284 501	313 682	300 908	350 564
Large hospitals	no.	100 609	105 216	109 980	125 512	125 651
Medium hospitals	no.	na	na	na	na	na
Small hositals	no.	na	na	na	na	na

Table 10A.65 **ACT recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	no.	na	na	na	na	na
Total public acute	no.	353 745	389 717	423 662	426 420	459 222
Public psychiatric						
Emergency department	no.	na	na	na	na	na
Outpatient	no.	na	na	na	na	na
Other	no.	na	na	na	na	na
Total	no.	na	na	na	na	na
Cost per occasion						
Public acute						
Emergency department						
Principal referral and Women's and children's hospitals	$	na	na	na	na	na
Large hospitals	$	na	na	na	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	600	637	665	723	839
Outpatient						
Principal referral and Women's and children's hospitals	$	na	na	na	na	na
Large hospitals	$	na	na	na	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	253	268	330	255	338
Other						
Principal referral and Women's and children's hospitals	$	na	na	na	na	na
Large hospitals	$	na	na	na	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na

Table 10A.65 **ACT recurrent cost per non-admitted patient occasion of service, public hospitals (a)**

		2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	na	na	na	na	na
Total						
Principal referral and Women's and children's hospitals	$	na	na	na	na	na
Large hospitals	$	na	na	na	na	na
Medium hospitals	$	na	na	na	na	na
Small hositals	$	na	na	na	na	na
Unpeered and other acute hospitals	$	na	na	na	na	na
Total public acute	$	349	368	371	340	463
Public psychiatric						
Emergency department	$	na	na	na	na	na
Outpatient	$	na	na	na	na	na
Other	$	na	na	na	na	na
Total	$	na	na	na	na	na

(a) These data are based on the hospitals that participated in the National Hospital Cost Data Collection.

na Not available.

Source: ACT Government (unpublished).

Table 10A.66 **Emergency department number of presentations and actual average cost per presentation (a), (b), (c), (d)**

	Presentations	*Average cost/presentation*
	no.	$
2009-10	5 250 307	479
2010-11	5 448 339	498

(a) Not all hospitals that submit data to the NHCDC submit Urgency Related Group data (ED classification). This data is a combination of all NHCDC hospitals ED data.

(b) Depreciation costs are not included by all jurisdictions for 2009-10. Depreciation costs are included for all jurisdictions in 2010-11. Victoria has provided depreciation costs for the first time in Round 15.

(c) 2009-10 and 2010-11 data are based on 228 public sector hospitals.

(d) Estimated data are not available

Source: IHPA, *NHCDC Round 14* (2009-10) and *Round 15* (2010-11).

Table 10A.67 **Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b), (c), (d), (e)**

Urgency related grouping		*Actual presentations*	*Actual average cost per presentation*
		no.	$
2009-10			
Admitted triage 1			
1	Injury, multiple sites	2 919	1 300
2	Illness of other or unknown systems	10	1 066
3	Injury, single site	1 710	1 396
4	Poisoning, comatose; poisoning, conscious	1 287	1 204
5	Respiratory system illness	2 946	1 286
6	Circulatory system illness	4 625	981
7	All other MDC groups	5 916	1 273
Admitted triage 2			
8	Injury, multiple sites	9 204	919
9	Poisoning, comatose	712	1 101
10	Injury, single site*major	8 887	825
11	Digestive system illness; Hepatobilary system illness	13 635	978
12	Respiratory system illness	29 297	909
13	Injury, single site*minor	3 460	951
14	Neurological illness	14 589	997
15	Poisoning, conscious; drug reaction; alcohol/drug abuse	5 672	977
16	Circulatory system illness	86 085	890
17	All other MDC groups	29 497	931
Admitted triage 3			
18	Injury, multiple sites	22 093	765
19	Blood/Immune system illness	10 705	803
20	Injury, single site*major	21 778	701
21	Neurological illness	45 891	868
22	Obstetric illness; Gynaecological illness	16 242	545
23	Digestive system illness; Hepatobilary system illness	99 644	818
24	Circulatory system illness	74 634	809
25	Poisoning, conscious; drug reaction; alcohol/drug abuse	9 944	870
26	Urological illness	29 502	815
27	Respiratory system illness	66 371	799
28	Injury, single site*minor	10 854	747
29	All other MDC groups	70 320	859
Admitted triage 4			
30	Poisoning, comatose; poisoning, conscious; drug reaction; alcohol/drug abuse; circulatory system illness	16 215	656

Table 10A.67 **Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b), (c), (d), (e)**

Urgency related grouping		*Actual presentations*	*Actual average cost per presentation*
31	Respiratory system illness	21 067	714
32	Digestive system illness; Hepatobilary system illness	61 238	716
33	All other MDC groups	121 710	693
34	Injury, single site	29 020	601
35	Psychiatric illness; social problem; other presentation	21 316	766
Admitted triage 5			
36	Psychiatric illness; social problem; other presentation	3 230	518
37	All other MDC groups	17 134	532
38	Dead on Arrival	2 532	240
Non-admitted triage 1			
39	All MDC groups	4 158	1 197
Non-admitted triage 2			
40	Alcohol/drug abuse	1 818	836
41	Illness of other or unknown systems	29	905
42	Musculoskeletal/connective tissue illness	2 352	665
43	Circulatory system illness; Respiratory system illness	44 052	747
44	Injury, single site	21 817	786
45	Poisoning, comatose	2 398	739
46	All other MDC groups	37 947	675
Non-admitted triage 3			
47	Injury, multiple sites	19 577	487
48	Circulatory system illness	52 077	602
49	Illness of other or unknown systems	256	727
50	Injury, single site*major	50 609	516
51	Alcohol/drug abuse; Obstetric illness; Gynaecological illness; Male reproductive illness	43 767	589
52	Digestive system illness; Hepatobilary system illness	90 575	565
53	Neurological illness	45 628	594
54	Injury, single site*minor	57 051	550
55	Respiratory system illness	75 478	462
56	Musculoskeletal/connective tissue illness	10 825	511
57	All other MDC groups	161 645	472
Non-admitted triage 4			
58	Injury, single site*major	136 706	320
59	Injury, multiple sites	47 803	287

Table 10A.67 **Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b), (c), (d), (e)**

Urgency related grouping		*Actual presentations*	*Actual average cost per presentation*
60	Alcohol/drug abuse; Obstetric illness; Gynaecological illness; Male reproductive illness	74 566	361
61	Circulatory system illness; Respiratory system illness	112 793	333
62	Digestive system; Hepatobiliary system illness	117 673	381
63	Musculoskeletal/connective tissue illness	37 657	358
64	Injury, single site*minor	182 042	333
65	Illness of the ENT	49 809	269
66	Illness of the eyes	34 115	248
67	Other presentation except DNW	94 256	300
68	All other MDC groups	197 298	343
Non-admitted triage 5			
69	Poisoning, comatose; Poisoning, conscious	2 700	257
70	Injury, multiple sites; Injury, single site	83 738	227
71	Other presentation except DNW	89 279	183
72	All other MDC groups	137 695	209
73	DNW/ Left before treatment completed	225 731	200
AE2	Adm - Triage not (1, 2, 3, 4 or 5)	61	529
AE3	Adm - Blank Diagnosis Code	2 101	660
AE4	Adm - Invalid Diagnosis Code	59 973	812
AE5	Adm - Unacceptable Diagnosis Code – No MDB map	1 731	844
NE1	NonAdm - Episode End Status not (1, 2, 3, 4, 5, 6 or 7).	25 728	419
NE2	NonAdm - Triage not (1, 2, 3, 4 or 5)	182	376
NE3	NonAdm - Blank Diagnosis Code	38 552	319
NE4	NonAdm - Invalid Diagnosis Code	122 893	412
NE5	NonAdm - Unacceptable Diagnosis Code – No MDB map	6 468	428
Total		**3 595 500**	**499**
2010-11			
Admitted triage 1			
A03	Injury	5 404	1 950
A04	Poisoning	1 265	1 396
A05	Respiratory system illness	3 668	1 461
A06	Circulatory system illness	6 021	1 217
A07	All other MDB groups	7 137	1 499
Admitted triage 2			
A09	Poisoning	4 545	1 060

Table 10A.67 **Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b), (c), (d), (e)**

Urgency related grouping		*Actual presentations*	*Actual average cost per presentation*
A10	Injury	22 053	1 140
A11	Gastrointestinal system illness	15 295	1 136
A12	Respiratory system illness	35 081	1 014
A14	Neurological illness	16 770	1 138
A15	Toxic effects of drugs	1 242	1 057
A16	Circulatory system illness	95 704	953
A17	All other MDB groups	33 858	970
Admitted triage 3			
A19	Blood / Immune system illness	12 419	890
A20	Injury	57 266	819
A21	Neurological illness	48 898	934
A22	Obstetric/Gynaecological illness	16 881	538
A23	Gastrointestinal system illness	106 829	914
A24	Circulatory system illness	80 261	875
A25	Poisoning/Toxic effects of drugs	10 066	870
A26	Urological illness	30 212	905
A27	Respiratory system illness	75 864	863
A29	All other MDB groups	84 635	834
Admitted triage 4			
A30	Poisoning/Toxic effects of drugs	3 075	700
A31	Respiratory system illness	22 110	732
A32	Gastrointestinal system illness	59 537	775
A33	All other MDB groups	128 539	707
A34	Injury	42 858	643
A35	Psychiatric/Social problem/Other presentation	23 228	784
Admitted triage 5			
A36	Psychiatric/Social problem/Other presentation	3 988	528
A37	All other MDB groups	19 717	596
N38	Dead on Arrival w any Triage w any MDB	3 986	169
Non-admitted triage 1			
N39	All MDB groups	6 366	1 469
Non-admitted triage 2			
N40	Alcohol/drug abuse	2 866	879
N42	Musculoskeletal/connective tissue illness	3 078	707

Table 10A.67 **Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b), (c), (d), (e)**

Urgency related grouping		*Actual presentations*	*Actual average cost per presentation*
N43	Circulatory system / Respiratory system illness	71 623	840
N44	Injury	29 432	834
N45	Poisoning	3 945	820
N46	All other MDB groups	55 693	753
Non-admitted triage 3			
N48	Circulatory system illness	82 193	649
N50	Injury	159 828	553
N51	Genitourinary illness	62 606	626
N52	Gastrointestinal system illness	128 172	607
N53	Neurological illness	66 256	629
N55	Respiratory system illness	100 247	510
N56	Musculoskeletal/connective tissue illness	15 026	543
N57	All other MDB groups	224 866	493
Non-admitted triage 4			
N58	Injury	434 911	343
N60	Genitourinary illness	90 982	407
N61	Circulatory system / Respiratory system illness	149 082	369
N62	Gastrointestinal system illness	160 501	422
N63	Musculoskeletal/connective tissue illness	53 036	383
N65	Illness of the ENT	68 375	286
N66	Illness of the eyes	51 543	250
N67	Other presentation block	109 494	338
N68	All other MDB groups	286 707	353
Non-admitted triage 5			
N69	Poisoning/Toxic effects of drugs	3 812	257
N70	Injury	110 355	236
N71	Other presentation block	102 520	206
N72	All other MDB groups	172 661	237
N73	Did Not Wait	258 865	155
AE2	Error - Triage not=1,2,3,4 or 5	33	543
AE3	Error - Blank Diagnosis Code	16 999	794
AE4	Error - Invalid Diagnosis Code	43 642	848
AE5	Error - Diagnosis Code – No MDB map	1 622	964
NE1	Error - Episode End Status not=1,2,3,4,5,6 or 7	22 356	346
NE2	Error - Triage not=1,2,3,4 or 5	156	699
NE3	Error - Blank Diagnosis Code	200 902	293

Table 10A.67 Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation (a), (b), (c), (d), (e)

Urgency related grouping		*Actual presentations*	*Actual average cost per presentation*
NE4	Error - Invalid Diagnosis Code	189 587	396
NE5	Error - Diagnosis Code – No MDB map	14 383	453
Total		**4 633 133**	**513**

(a) Not all hospitals that submit data to the National Hospital Cost Data Collection submit emergency department data. The emergency department national database contains only acute hospitals with emergency department cost and activity.

(b) Emergency department urgency related grouping data reported by 180 hospitals in 2009-10 and 167 hospitals in 2010-11.

(c) Costing and admission practices vary between jurisdictions and hospitals.

(d) Depreciation costs are not included for all jurisdictions for 2009-10. Depreciation costs are included for all jurisdictions in 2010-11. Victoria has provided depreciation costs for the first time in Round 15.

(e) Estimated data are not available

Source: IHPA, *NHCDC Round 14* (2009-10) and *Round 15* (2010-11).

Table 10A.68 **Non-admitted clinic number of occassions of service and actual average cost per occasion of service (a), (b), (c)**

	Occasions of service	*Average cost per occasion of service*
	no.	$
2009-10	12 153 528	284
2010-11	8 117 889	340

(a) Tier 0 figures stated here represent the total of all non-admitted activity reported regardless of reporting level or classification.

(b) Depreciation costs are not included by all jurisdictions in 2009-10. Depreciation costs are included by all jurisdictions in 2010-11.

(c) 2009-10 data is based on 225 public sector hospitals. 2010-11 data is based on 203 public sector hospitals.

Source: IHPA, *NHCDC Round 14* (2009-10) and *Round 15* (2010-11).

Table 10A.69 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often listened carefully to them										
					proportion					
Major cities	%	84.3	83.7	82.8	86.0	82.3	..	82.5	..	83.9
Other (c)	%	86.6	81.9	85.5	82.7	84.4	81.3	-	87.6	84.5
Total	**%**	**85.0**	**83.4**	**84.0**	**84.7**	**83.4**	**81.3**	**82.5**	**87.6**	**84.2**
					relative standard error					
Major cities	%	2.3	2.1	2.0	2.3	4.1	..	3.4	..	1.0
Other (c)	%	2.2	3.5	3.4	2.9	3.8	2.2	-	7.2	1.4
Total	**%**	**1.7**	**1.9**	**1.9**	**2.0**	**2.8**	**2.2**	**3.4**	**7.2**	**0.8**
					95 per cent confidence interval					
Major cities	±	3.9	3.5	3.3	3.9	6.7	..	5.5	..	1.6
Other (c)	±	3.8	5.6	5.7	4.6	6.4	3.5	-	12.3	2.2
Total	±	**2.9**	**3.1**	**3.2**	**3.4**	**4.5**	**3.5**	**5.5**	**12.3**	**1.3**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often showed respect to them										
					proportion					
Major cities	%	86.3	85.4	83.5	88.6	84.5	..	82.6	..	85.7
Other (c)	%	86.9	82.3	87.7	84.1	85.3	83.3	-	88.4	85.5
Total	**%**	**86.4**	**84.7**	**85.5**	**87.2**	**84.8**	**83.3**	**82.6**	**88.4**	**85.7**
					relative standard error					
Major cities	%	2.1	2.4	2.1	1.8	3.3	..	3.7	..	0.9
Other (c)	%	2.3	3.6	3.1	2.8	3.4	2.2	-	7.8	1.3

Table 10A.69 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	**%**	**1.5**	**2.1**	**1.7**	**1.8**	**2.5**	**2.2**	**3.7**	**7.8**	**0.7**
					95 per cent confidence interval					
Major cities	±	3.6	3.9	3.4	3.2	5.5	..	6.0	..	1.6
Other (c)	±	3.8	5.9	5.3	4.7	5.6	3.6	-	13.5	2.2
Total	±	**2.6**	**3.4**	**2.8**	**3.0**	**4.1**	**3.6**	**6.0**	**13.5**	**1.2**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often spent enough time with them										
					proportion					
Major cities	%	80.9	79.8	80.7	84.6	81.2	..	75.3	..	81.0
Other (c)	%	81.7	79.4	81.0	80.6	78.5	74.9	-	85.0	80.3
Total	**%**	**81.0**	**79.9**	**80.7**	**83.1**	**79.5**	**74.9**	**75.3**	**85.0**	**80.7**
					relative standard error					
Major cities	%	3.1	2.7	2.5	2.6	3.0	..	3.7	..	1.3
Other (c)	%	3.3	3.6	3.8	3.4	5.0	3.5	-	8.2	1.4
Total	**%**	**2.4**	**2.4**	**2.1**	**2.2**	**2.4**	**3.5**	**3.7**	**8.2**	**0.9**
					95 per cent confidence interval					
Major cities	±	5.0	4.2	4.0	4.3	4.8	..	5.5	..	2.0
Other (c)	±	5.3	5.6	6.0	5.3	7.7	5.1	-	13.7	2.2
Total	±	**3.8**	**3.7**	**3.3**	**3.6**	**3.8**	**5.1**	**5.5**	**13.7**	**1.4**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who went to an emergency department for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

Table 10A.69 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2012-13 (a), (b)**

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

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

(c) Includes inner and outer regional, remote and very remote areas.

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

Source: ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.70 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2012-13 (a), (b)**

	Proportion (%)	*relative standard error (%)*	*95 per cent confidence interval (±)*
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often listened carefully to them			
Major cities	83.9	1.0	1.6
Other (c)	84.5	1.4	2.2
Inner regional	84.9	1.9	3.2
Outer regional	83.4	2.3	3.7
Remote/very remote	87.0	8.8	15.0
Total	**84.2**	**0.8**	**1.3**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often showed respect to them			
Major cities	85.7	0.9	1.6
Other (c)	85.5	1.3	2.2
Inner regional	86.3	1.6	2.7
Outer regional	83.6	2.6	4.2
Remote/very remote	88.8	8.1	14.1
Total	**85.7**	**0.7**	**1.2**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often spent enough time with them			
Major cities	81.0	1.3	2.0
Other (c)	80.3	1.4	2.2
Inner regional	81.3	1.9	3.1
Outer regional	77.6	2.6	3.9
Remote/very remote	84.9	9.4	15.6
Total	**80.7**	**0.9**	**1.4**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who went to an emergency department for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

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

(c) Includes inner and outer regional, remote and very remote areas.

Source : ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.71 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often listened carefully to them										
					proportion					
Major cities	%	86.6	90.5	89.3	91.1	86.8	..	83.5	..	88.8
Other (c)	%	90.4	86.7	90.9	90.5	88.0	89.6	-	90.5	89.4
Total	**%**	**87.6**	**89.8**	**90.1**	**90.9**	**87.4**	**89.6**	**83.5**	**90.5**	**89.1**
					relative standard error					
Major cities	%	2.4	1.6	1.6	1.7	2.5	..	3.0	..	1.1
Other (c)	%	1.9	3.4	2.7	2.9	2.8	1.7	-	7.6	1.1
Total	**%**	**1.8**	**1.4**	**1.5**	**1.3**	**1.8**	**1.7**	**3.0**	**7.6**	**0.8**
					95 per cent confidence interval					
Major cities	±	4.1	2.9	2.7	3.1	4.3	..	4.8	..	1.9
Other (c)	±	3.4	5.8	4.8	5.2	4.9	3.1	-	13.5	1.9
Total	±	**3.1**	**2.4**	**2.6**	**2.4**	**3.1**	**3.1**	**4.8**	**13.5**	**1.4**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often showed respect to them										
					proportion					
Major cities	%	87.3	92.0	89.5	92.0	89.2	..	86.7	..	89.8
Other (c)	%	90.9	88.4	90.5	93.3	90.5	90.3	-	90.2	90.4
Total	**%**	**88.5**	**91.1**	**90.2**	**92.4**	**89.6**	**90.3**	**86.7**	**90.2**	**90.1**
					relative standard error					
Major cities	%	2.5	1.6	1.8	1.6	1.7	..	2.8	..	1.0
Other (c)	%	1.9	3.3	2.6	2.8	2.8	1.6	-	7.6	1.1

Table 10A.71 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	**%**	**1.7**	**1.2**	**1.5**	**1.1**	**1.8**	**1.6**	**2.8**	**7.6**	**0.7**
					95 per cent confidence interval					
Major cities	±	4.2	2.8	3.1	3.0	3.0	..	4.8	..	1.8
Other (c)	±	3.4	5.7	4.6	5.1	4.9	2.7	-	13.4	1.9
Total	±	**3.0**	**2.2**	**2.6**	**2.0**	**3.1**	**2.7**	**4.8**	**13.4**	**1.3**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often spent enough time with them										
					proportion					
Major cities	%	83.6	85.6	86.5	90.4	87.1	..	80.8	..	85.8
Other (c)	%	88.2	84.6	88.7	90.0	86.6	84.3	-	89.5	87.2
Total	**%**	**85.2**	**85.6**	**87.5**	**90.4**	**86.6**	**84.3**	**80.8**	**89.5**	**86.4**
					relative standard error					
Major cities	%	2.8	2.1	2.0	2.1	2.1	..	2.9	..	1.1
Other (c)	%	2.1	3.4	2.7	2.8	3.9	2.5	-	7.7	1.0
Total	**%**	**1.9**	**1.7**	**1.7**	**1.4**	**2.3**	**2.5**	**2.9**	**7.7**	**0.7**
					95 per cent confidence interval					
Major cities	±	4.6	3.6	3.4	3.8	3.5	..	4.6	..	1.8
Other (c)	±	3.7	5.6	4.6	4.9	6.6	4.1	-	13.6	1.7
Total	±	**3.2**	**2.9**	**3.0**	**2.5**	**3.9**	**4.1**	**4.6**	**13.6**	**1.2**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who went to an emergency department for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

Table 10A.71 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2012-13 (a), (b)**

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

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

(c) Includes inner and outer regional, remote and very remote areas.

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

Source : ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.72 **Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2012-13 (a), (b)**

	Proportion (%)	*relative standard error (%)*	*95 per cent confidence interval (±)*
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often listened carefully to them			
Major cities	88.8	1.1	1.9
Other (c)	89.4	1.1	1.9
Inner regional	89.3	1.6	2.8
Outer regional	88.8	2.0	3.4
Remote/very remote	94.3	7.8	14.5
Total	**89.1**	**0.8**	**1.4**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often showed respect to them			
Major cities	89.8	1.0	1.8
Other (c)	90.4	1.1	1.9
Inner regional	90.5	1.5	2.6
Outer regional	89.7	1.7	2.9
Remote/very remote	94.9	8.2	15.2
Total	**90.1**	**0.7**	**1.3**
Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often spent enough time with them			
Major cities	85.8	1.1	1.8
Other (c)	87.2	1.0	1.7
Inner regional	87.4	1.6	2.7
Outer regional	85.7	1.7	2.9
Remote/very remote	93.7	8.6	15.8
Total	**86.4**	**0.7**	**1.2**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who visited an emergency department for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

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

(c) Includes inner and outer regional, remote and very remote areas.

Source : ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.73 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often listened carefully to them										
					proportion					
Major cities	%	91.5	90.0	85.1	91.9	90.8	..	89.3	..	89.8
Other (c)	%	90.6	89.0	89.6	87.4	85.9	85.9	-	81.5	88.8
Total	**%**	**91.3**	**89.5**	**87.1**	**90.8**	**89.5**	**85.9**	**89.3**	**81.5**	**89.5**
					relative standard error					
Major cities	%	1.5	2.2	3.1	1.7	2.1	..	4.6	..	1.0
Other (c)	%	3.0	2.9	1.9	3.9	5.3	3.2	-	3.2	1.3
Total	**%**	**1.5**	**1.8**	**1.7**	**1.6**	**1.7**	**3.2**	**4.6**	**3.2**	**0.8**
					95 per cent confidence interval					
Major cities	±	2.7	3.9	5.1	3.1	3.8	..	8.0	..	1.8
Other (c)	±	5.4	5.0	3.4	6.7	8.9	5.5	-	5.2	2.2
Total	**±**	**2.6**	**3.2**	**2.8**	**2.8**	**3.0**	**5.5**	**8.0**	**5.2**	**1.3**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often showed respect to them										
					proportion					
Major cities	%	91.7	90.3	86.9	92.9	90.4	..	91.2	..	90.4
Other (c)	%	89.7	85.7	90.1	91.1	89.1	86.2	-	81.3	89.5
Total	**%**	**91.5**	**89.3**	**88.4**	**92.6**	**90.2**	**86.2**	**91.2**	**81.3**	**90.2**
					relative standard error					
Major cities	%	1.5	2.4	3.2	1.5	2.0	..	3.2	..	1.1
Other (c)	%	4.8	6.5	2.0	4.3	4.7	3.6	-	3.9	1.6

Table 10A.73 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	**%**	**1.2**	**2.3**	**1.8**	**1.3**	**1.6**	**3.6**	**3.2**	**3.9**	**0.9**
					95 per cent confidence interval					
Major cities	±	2.7	4.2	5.5	2.7	3.6	..	5.8	..	2.0
Other (c)	±	8.5	11.0	3.6	7.6	8.3	6.0	-	6.3	2.7
Total	**±**	**2.2**	**4.1**	**3.2**	**2.3**	**2.9**	**6.0**	**5.8**	**6.3**	**1.7**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often spent enough time with them										
					proportion					
Major cities	%	87.4	86.2	85.3	88.5	85.4	..	85.4	..	86.6
Other (c)	%	87.6	83.3	85.9	82.4	81.9	84.7	-	80.3	85.1
Total	**%**	**87.5**	**85.6**	**85.8**	**87.2**	**84.0**	**84.7**	**85.4**	**80.3**	**86.2**
					relative standard error					
Major cities	%	2.2	2.7	3.3	2.0	2.1	..	6.7	..	1.3
Other (c)	%	3.2	10.2	3.0	4.4	7.1	2.7	-	3.8	1.9
Total	**%**	**2.0**	**2.5**	**2.3**	**1.9**	**2.0**	**2.7**	**6.7**	**3.8**	**1.2**
					95 per cent confidence interval					
Major cities	±	3.7	4.6	5.5	3.5	3.5	..	11.2	..	2.1
Other (c)	±	5.5	16.6	5.1	7.0	11.4	4.6	-	6.0	3.1
Total	**±**	**3.5**	**4.3**	**3.9**	**3.3**	**3.3**	**4.6**	**11.2**	**6.0**	**2.0**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

Table 10A.73 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2012-13 (a), (b)**

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

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

(c) Includes inner and outer regional, remote and very remote areas.

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

Source : ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.74 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2012-13 (a), (b)**

	Proportion (%)	*relative standard error (%)*	*95 per cent confidence interval (±)*
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often listened carefully to them			
Major cities	89.8	1.0	1.8
Other (c)	88.8	1.3	2.2
Inner regional	88.4	2.0	3.5
Outer regional	89.5	1.5	2.6
Remote/very remote	90.3	5.3	9.3
Total	**89.5**	**0.8**	**1.3**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often showed respect to them			
Major cities	90.4	1.1	2.0
Other (c)	89.5	1.6	2.7
Inner regional	88.7	2.5	4.3
Outer regional	91.3	1.3	2.3
Remote/very remote	90.3	5.5	9.7
Total	**90.2**	**0.9**	**1.7**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often spent enough time with them			
Major cities	86.6	1.3	2.1
Other (c)	85.1	1.9	3.1
Inner regional	84.4	3.1	5.2
Outer regional	86.5	2.2	3.8
Remote/very remote	86.5	5.4	9.2
Total	**86.2**	**1.2**	**2.0**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges) except for remote/very remote (10 year ranges).

(c) Includes inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.75 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often listened carefully to them										
					proportion					
Major cities	%	90.1	91.4	90.7	92.8	93.5	..	89.8	..	91.1
Other (c)	%	90.3	94.5	93.2	90.3	83.7	89.9	-	86.9	91.3
Total	**%**	**90.5**	**92.1**	**91.8**	**92.0**	**90.8**	**89.9**	**89.8**	**86.9**	**91.2**
					relative standard error					
Major cities	%	1.4	1.3	1.9	1.8	1.7	..	3.5	..	0.7
Other (c)	%	4.6	1.5	2.1	2.7	3.6	3.2	-	4.9	0.9
Total	**%**	**1.3**	**1.0**	**1.5**	**1.5**	**1.8**	**3.2**	**3.5**	**4.9**	**0.6**
					95 per cent confidence interval					
Major cities	±	2.5	2.4	3.4	3.3	3.2	..	6.2	..	1.3
Other (c)	±	8.1	2.7	3.8	4.7	5.9	5.7	-	8.4	1.7
Total	**±**	**2.3**	**1.8**	**2.8**	**2.8**	**3.2**	**5.7**	**6.2**	**8.4**	**1.1**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often showed respect to them										
					proportion					
Major cities	%	91.7	91.2	90.1	94.2	94.0	..	90.6	..	91.8
Other (c)	%	93.2	89.0	93.0	90.3	85.4	88.4	-	87.6	91.0
Total	**%**	**92.2**	**91.1**	**91.4**	**93.0**	**91.7**	**88.4**	**90.6**	**87.6**	**91.5**
					relative standard error					
Major cities	%	1.7	1.6	2.0	1.6	1.7	..	3.5	..	0.9
Other (c)	%	1.8	10.4	2.0	2.7	3.4	4.6	-	5.0	1.4
Total	**%**	**1.4**	**1.7**	**1.5**	**1.5**	**1.8**	**4.6**	**3.5**	**5.0**	**0.8**

Table 10A.75 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2012-13 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					95 per cent confidence interval					
Major cities	±	3.0	2.8	3.5	3.0	3.1	..	6.2	..	1.6
Other (c)	±	3.3	18.1	3.7	4.7	5.6	8.0	-	8.5	2.5
Total	**±**	**2.5**	**3.0**	**2.6**	**2.7**	**3.3**	**8.0**	**6.2**	**8.5**	**1.5**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often spent enough time with them										
					proportion					
Major cities	%	87.7	88.5	88.4	93.1	89.7	..	85.3	..	88.8
Other (c)	%	90.4	88.8	90.1	88.1	82.6	86.5	-	85.8	89.0
Total	**%**	**88.5**	**89.0**	**89.2**	**91.8**	**87.7**	**86.5**	**85.3**	**85.8**	**88.9**
					relative standard error					
Major cities	%	2.0	1.8	2.2	1.7	2.1	..	5.4	..	0.8
Other (c)	%	2.5	5.6	2.8	3.2	3.8	4.1	-	5.2	1.6
Total	**%**	**1.6**	**1.7**	**1.8**	**1.5**	**1.8**	**4.1**	**5.4**	**5.2**	**0.8**
					95 per cent confidence interval					
Major cities	±	3.4	3.1	3.8	3.0	3.6	..	9.0	..	1.4
Other (c)	±	4.4	9.8	5.0	5.5	6.1	6.9	-	8.7	2.8
Total	**±**	**2.9**	**2.9**	**3.2**	**2.6**	**3.1**	**6.9**	**9.0**	**8.7**	**1.4**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges) except for NT (10 year ranges).

Table 10A.75 **Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2012-13 (a), (b)**

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

(c) Includes inner and outer regional, remote and very remote areas.

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

Source : ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.76 Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2012-13 (a), (b)

	Proportion (%)	*relative standard error (%)*	*95 per cent confidence interval (±)*
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often listened carefully to them			
Major cities	91.1	0.7	1.3
Other (c)	91.3	0.9	1.7
Inner regional	91.8	1.4	2.5
Outer regional	90.9	1.8	3.1
Remote/very remote	86.8	5.7	9.6
Total	**91.2**	**0.6**	**1.1**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often showed respect to them			
Major cities	91.8	0.9	1.6
Other (c)	91.0	1.4	2.5
Inner regional	91.0	2.2	3.9
Outer regional	91.0	1.8	3.2
Remote/very remote	88.9	5.4	9.4
Total	**91.5**	**0.8**	**1.5**
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often spent enough time with them			
Major cities	88.8	0.8	1.4
Other (c)	89.0	1.6	2.8
Inner regional	88.8	2.6	4.5
Outer regional	89.1	2.1	3.6
Remote/very remote	86.0	6.2	10.4
Total	**88.9**	**0.8**	**1.4**

Rates with RSEs greater than 25 per cent should be used with caution. Rates with an RSE greater than 50 per cent are considered too unreliable for general use.

(a) Persons 15 years and over who were admitted to hospital for their own health in the last 12 months, excluding interviews by proxy. Excludes those who responded don't know.

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges) except for remote/very remote (10 year ranges).

(c) Includes inner and outer regional, remote and very remote areas.

Source: ABS (unpublished) Patient Experience Survey 2012-13.

Table 10A.77 NSW patient evaluation of hospital services

When the survey was conducted

Year(s):

Not conducted in 2012

Time period (eg. July to Sept):

na

Survey method (eg. telephone, mailout etc):

Survey Recommenced January 2013 - to be reported in ROGS 2015

Respondents (eg. Admitted patients in public acute care hospitals):

na

Sample size:

na

Response rate:

na

Size of underlying population:

na

Organisation conducting the survey:

na

Organisation funding the survey:

na

Table 10A.77 NSW patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

na

Survey results:

na

na Not available.

Source: NSW Government (unpublished).

Table 10A.78 Victorian patient evaluation of hospital services

When the survey was conducted

Year(s):

2012

Time period (eg. July to Sept):

January to December

Survey method (eg. telephone, mailout etc):

Paper survey mailout with options to return paper survey or to respond online

Respondents (eg. Admitted patients in public acute care hospitals):

Admitted adult (18 and over) patients in public hospitals (acute and subacute); Non-admitted adults (18 and over) attending public Emergency Departments

Sample size:

Victorian Patient Satisfaction Monitor (VPSM) Sent out 75,792 Returned 26,812
Emergency Department -Victorian Patient Satisfaction Monitor (ED-VPSM) Sent out 21,829 Returned 4,580

Response rate:

VPSM 35.4 per cent
ED-VPSM 21 per cent

Size of underlying population:

VPSM Eligible adult inpatients of Victorian public hospitals (acute and sub-acute)
ED-VPSM Adult non-admitted emrgency department attendees

Organisation conducting the survey:

Table 10A.78 Victorian patient evaluation of hospital services

UltraFeedback Pty Ltd

Organisation funding the survey:

Department of Health, Victoria

How was information from the survey used to help improve public hospital quality:

Health services are provided six monthly campus level reports. These reports provide results and offer benchmarking with state and peer group results. Health services use these results to determine where to direct improvement activity and to establish if previous interventions have been effective.

Survey results:

The results for the VPSM are provided for the Overall Care Index (OCI) and the Consumer Participation Indicator (CPI). These scores are provided as a number between 20 (poor) and 100 (excellent). The results for the ED-VPSM are provided as a number between one (poor) and five (excellent).
January to June 2012 VPSM: OCI = 79.9; CPI = 81.9; ED-VPSM = 3.77
June to December 2012 VPSM: OCI = 79.6; CPI 81.4; ED-VPSM = 3.77

Source : Victorian Government (unpublished).

Table 10A.79 Queensland patient evaluation of hospital services

When the survey was conducted

Year(s):

2013

Time period (eg. July to Sept):

August to September

Survey method (eg. telephone, mailout etc):

Telephone (CATI - Computer Assisted Telephone Interviews)

Respondents (eg. Admitted patients in public acute care hospitals):

Patients of public hospital emergency departments (only those hospitals with electronic emergency department information system)
Patients were excluded if it was determined they:
• did not wait for treatment;
• left after treatment had commenced;
• were admitted to a mental health unit or ward;
• were discharged to a nursing home or institution;
• were transferred to another health care facility, other than a hospital;
• were deceased in the Emergency Department or subsequently;
• presented for a mental health issue (except drug or alcohol related);
• presented with self-harm;
• were in a known or suspected domestic violence situation;
• had a miscarriage, stillbirth, live birth where the neonate subsequently died before discharge, intrauterine death, hydatidiform mole, or complications following miscarriage or termination;
• had requested an interpreter in the hospital;
• usually resided outside Australia; or
• had refused consent to be contacted to provide feedback.
Responses for patients under the age of 16 were provided by their parent or guardian, or by the adult who accompanied them at the Emergency Department.

Sample size:

Table 10A.79 Queensland patient evaluation of hospital services

approx. 10 000

Response rate:

unknown

Size of underlying population:

232 324

Organisation conducting the survey:

Government Statistician, Queensland Treasury and Trade (formerly Office of Economic and Statistical Research, Queensland Treasury)

Organisation funding the survey:

Queensland Health

How was information from the survey used to help improve public hospital quality:

Individualised hospital reports will be produced, presenting the hospital's results and the 34 other hospital results. Comparison to the 2011 Emergency Department Patient Experience Survey will be undertaken where possible. Reports will be disseminated to Hospital and Health Service (HHS) Chief Executives, Executive Directors of Medical Services (EDMSs) and Executive Directors of Nursing Services (EDONs) in December 2013. Hospitals are encouraged to review the results to identify areas in need of improvement and subsequently design and implement improvement initiatives. Some hospitals will contact high performing hospitals to learn from their processes. Subsequent to hospitals receiving their hospital reports, presentations will be undertaken to statewide groups such as the Statewide Emergency Department Clinical Network, Directors of Medical Services Advisory Committee (DOMSAC), Directors of Nursing and Midwifery Advisory Committee, etc. to present the results and discuss quality improvement initiatives.

Survey results:

Unknown

Source: Queensland Government (unpublished).

Table 10A.80 WA patient evaluation of hospital services

When the survey was conducted

Year(s):

2012-13

Time period (eg. July to Sept):

July 2012- June 2013

Survey method (eg. telephone, mailout etc):

Computer Assisted Telephone Interview (CATI). Self report adults (16+ years) and parent/guardian reports on behalf of child (<16 years).

Respondents (eg. Admitted patients in public acute care hospitals):

Survey conducted on admitted patients (including a subset of older adult patients), emergency department patients and outpatients. The scope was all public patients in Western Australian hospitals. The groups reported on in this document include adult admitted, child admitted, older adult admitted, adult outpatients and adult emergency department patients. Child outpatients and child emergency department patients are not reported as this would result in hospital level identification.

Sample size:

7440 admitted patients 1397 outpatients and 1586 emergency patients

Response rate:

The eligible contacted response rate for emergency patients was 91.84 per cent, the eligible contacted response rate for child admitted patients was 94.52 per cent, the eligible contacted response rate for adult admitted patients was 91.22 per cent, the eligible contacted response rate for outpatients was 91.8 per cent and the eligible contacted response rate for older adults is 84.43 per cent.

Size of underlying population:

For the admitted population the underlying population are those people who have been admitted to hospital and meet the same criteria as survey participants. For admitted patients this is ~ 419 000 admissions in 2012/2013. The criteria are public acute patients, residents of WA, not requiring an interpreter, discharged home, no psychiatric care days.

Table 10A.80 WA patient evaluation of hospital services

Organisation conducting the survey:

Edith Cowen University, Survey Research Centre

Organisation funding the survey:

WA Department of Health

How was information from the survey used to help improve public hospital quality:

Each participating hospital receives detailed information from the survey that is used to inform service improvement. Hospitals can also request a workshop to assist in the interpretation of the survey results so that the best use can be made of them. In WA, many hospitals use patient satisfaction as a performance indicator and the use made of the results is hospital-based. Some examples of how hospitals have used the survey to improve public hospital quality include the implementation of a process to record and cross reference for food allergies, employment of a Customer Liaison Officer to improve communication with patients on rights and services, storage of patient care plans in the wall desk of all rooms to increase patient involvement, improved discharge coordination procedures, and the introduction of brochures to inform patients on how the ED works.

Survey results:

Admitted Adults

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	4576	69.19	0.3	68.63	69.75
Consistency Scale: Continuity of care	4539	71.16	0.4	70.43	71.88
Informed Scale: Information and communication	4576	83.55	0.3	83.01	84.09
Involvement Scale: Involved in decisions about your care and treatment	4578	74.15	0.3	73.57	74.73
Needs Scale: Meeting personal needs	4575	90.70	0.2	90.23	91.17
Time and Care Scale: Time and attention paid to patient care	4576	87.69	0.2	87.26	88.12
Residential Scale: Residential aspects of the hospital	4568	62.74	0.3	62.16	63.33

Table 10A.80 WA patient evaluation of hospital services

Outcome Scale: Patient rated outcome of hospital stay	4579	86.86	0.3	86.34	87.39
Overall indicator of satisfaction weighted by ranked issues of importance	4578	79.20	0.2	78.78	79.62

Admitted Children

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	2068	65.69	0.4	64.86	66.51
Consistency Scale: Continuity of care	2058	70.79	0.6	69.68	71.90
Informed Scale: Information and communication	2068	84.23	0.4	83.46	85.00
Involvement Scale: Involved in decisions about your care and treatment	2069	75.52	0.4	74.74	76.30
Needs Scale: Meeting personal needs	2068	90.62	0.3	89.95	91.28
Time and Care Scale: Time and attention paid to patient care	2069	86.49	0.3	85.84	87.14
Residential Scale: Residential aspects of the hospital	2065	61.40	0.5	60.49	62.31
Outcome Scale: Patient rated outcome of hospital stay	2069	89.82	0.3	89.15	90.50
Overall indicator of satisfaction weighted by ranked issues of importance	2069	78.94	0.3	78.33	79.56

Admitted Older Adults

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	792	74.07	0.6	72.94	75.19
Consistency Scale: Continuity of care	788	80.09	0.6	78.84	81.34
Informed Scale: Information and communication	791	83.51	0.6	82.28	84.74
Involvement Scale: Involved in decisions about your care and treatment	792	67.57	0.8	65.97	69.17
Needs Scale: Meeting personal needs	788	92.91	0.5	91.98	93.85
Time and Care Scale: Time and attention paid to patient care	791	92.84	0.4	92.01	93.68
Residential Scale: Residential aspects of the hospital	788	65.25	0.7	63.91	66.59

Table 10A.80 **WA patient evaluation of hospital services**

Outcome Scale: Patient rated outcome of hospital stay	792	88.31	0.6	87.18	89.43
Overall indicator of satisfaction weighted by ranked issues of importance	792	81.67	0.4	80.81	82.54

Outpatient Adults

Scales	Sample Size	Mean Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	1137	61.16	0.5	60.27	62.06
Consistency Scale: Continuity of care	1126	77.05	0.6	75.83	78.27
Informed Scale: Information and communication	1136	80.43	0.6	79.26	81.60
Involvement Scale: Involved in decisions about your care and treatment	1137	67.41	0.8	65.78	69.03
Needs Scale: Meeting personal needs	1133	90.23	0.5	89.22	91.24
Time and Care Scale: Time and attention paid to patient care	1136	78.92	0.6	77.72	80.11
Residential Scale: Residential aspects of the hospital	1129	59.33	0.6	58.12	60.53
Outcome Scale: Patient rated outcome of hospital stay	1137	80.08	0.6	78.90	81.25
Overall indicator of satisfaction weighted by ranked issues of importance	1137	75.54	0.4	74.71	76.37

Emergency Department Adults

Scales	Sample Size	Scale Score	SE	Lower 95% CI	Upper 95% CI
Access Scale: Getting into hospital	1434	69.92	0.5	69.02	70.82
Consistency Scale: Continuity of care	1427	76.86	0.6	75.71	78.00
Informed Scale: Information and communication	1429	82.97	0.6	81.88	84.07
Involvement Scale: Involved in decisions about your care and treatment	1434	59.90	0.8	58.34	61.47
Needs Scale: Meeting personal needs	1433	83.09	0.4	82.29	83.90
Time and Care Scale: Time and attention paid to patient care	1432	87.67	0.5	86.63	88.72
Residential Scale: Residential aspects of the hospital	1423	60.87	0.6	59.75	61.99
Outcome Scale: Patient rated outcome of hospital stay	1434	86.62	0.6	85.49	87.76

Table 10A.80 **WA patient evaluation of hospital services**

	Overall indicator of satisfaction weighted by ranked issues of importance	1434	76.86	0.4	76.06	77.66

Source : WA Government (unpublished).

Table 10A.81 SA patient evaluation of hospital services

When the survey was conducted

Year(s):

2011-12

Time period (eg. July to Sept):

July 2011 to June 2012. The 2012-13 Measuring Consumer Experience Report is due in late 2013.

Survey method (eg. telephone, mailout etc):

Computer Assisted Telephone Interviewing (CATI) of a random sample.

Respondents (eg. Admitted patients in public acute care hospitals):

South Australian adults aged 16 years or more who have been in hospital care at least overnight in a metropolitan or country hospital.

Sample size:

2438 consumers were interviewed.

Response rate:

The response rate is 76%.

Size of underlying population:

A sample of 3593 was drawn from all consumers who met the SA Consumer Experience Survey System (SACESS) eligibility criteria.

Organisation conducting the survey:

Population Research and Outcomes Studies (PROS) - University of Adelaide

Organisation funding the survey:

SA Health

Table 10A.81 SA patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

The first Measuring Consumer Experience SA Public Hospital Inpatient Annual Report for 2010-11 was released in 2012. The second Measuring Consumer Experience report 2011-12 will be released in 2013. Six monthly reports have been established to report by Local Health Networks and Hospitals. Ongoing monitoring of consumers' experience requires LHNs to review and implement strategies to improve their results to 85 by 2013/14.

Survey results:

Questions about each domain were coded to generate scores ranging from zero (a negative response) to 100 (a positive response). The average of the responses to items from domains was used to derive a mean score. The results show the average score for core domains of care relating to consumer experiences of overnight care at a South Australian metropolitan or country hospital.

- 77.1 for involvement in care and treatment (KPI)
- 76.9 for consistent and co-ordinated care
- 93.0 for treated with respect and dignity
- 78.3 for involved in decision making
- 88.3 for doctors
- 90.7 for nursing
- 88.4 for cleanliness
- 91.0 for pain control
- 90.5 for privacy

The lowest mean score (76.9) was recorded for the domain consistent and co-ordinated care and the highest (93.0) for the domain treated with respect and dignity.

A score of 85 or less is considered to represent an area where improvement is required. SA Health performed above the benchmark score of 85 for six of these domains. Scores for the four domains 'treated with respect and dignity', 'nursing', 'pain control' and 'privacy' were above 90. There was no significant difference between scores for 2010-11 and 2011-12 for six domains. SA Health continues to score highly in the domains 'pain control' and 'privacy' despite mean scores being statistically significantly lower ($p<0.05$) than those reported in 2010-2011.

Table 10A.81 SA patient evaluation of hospital services

Two domains of care remain below the SA Health benchmark. These are 'involvement in decision-making', and the lowest scoring 'consistent and coordinated care'. Low scoring in 'consistent and coordinated care' reflects patients' perceptions that there was not always good consistency and teamwork between clinical teams. The domain 'involvement in decision-making' includes two questions, one about information provided to the patient, and a second question about finding a staff member to discuss worries and fears. Patients scored their involvement with decisions about their care and treatment during their stay more highly than their involvement with decision about their discharge plans.

The domain 'involvement in care and treatment' is a key performance indicator (KPI) for health services. Results from 2011-12 have been compared with the previous reporting period in 2010-11 to allow monitoring of performance over time. The results from questions in one domain 'involvement in care and treatment' were able to be compared with results from previous survey in 2008 as a KPI.

Source: SA Government (unpublished).

Table 10A.82 Tasmanian patient evaluation of hospital services

When the survey was conducted

Year(s):

na

Time period (eg. July to Sept):

na

Survey method (eg. telephone, mailout etc):

na

Respondents (eg. Admitted patients in public acute care hospitals):

na

Sample size:

na

Response rate:

na

Size of underlying population:

na

Organisation conducting the survey:

na

Organisation funding the survey:

na

Table 10A.82 Tasmanian patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

na

Survey results:

na

na Not available.

Source: Tasmanian Government (unpublished).

Table 10A.83 ACT patient evaluation of hospital services

When the survey was conducted

Year(s):

First hospital in 2013; Second hospital in 2012

Time period (eg. July to Sept):

March to May 2013 in first hospital; July - Dec 2012 in second one.

Survey method (eg. telephone, mailout etc):

Mailout for both hospitals.

Respondents (eg. Admitted patients in public acute care hospitals):

Admitted inpatients in public hospital acute and sub-acute care; In second hospital, surveys conducted with both inpatient and outpatient services.

Sample size:

526 in first hospital; 3924 in second hospital.

Response rate:

32.5 per cent (171 patient responses); 34.4 per cent in second hosp.

Size of underlying population:

617 071 (this is the ACT Capital Region population as of June 2012; includes ACT and surrounding areas of NSW).

Organisation conducting the survey:

Press Garney for first hosp.; ACT Health for second hospital.

Organisation funding the survey:

Calvary Health Care ACT; ACT Health

Table 10A.83 ACT patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

Survey provides patient rating of their experience against 90 survey questions which serves as feedback highlighting areas requiring further work. In second hospital, the survey is used to highlight the top 5 areas for improvement both as an organisational wide priority and also Divisional Top 5 priorities.

Survey results:

Overall mean score was 75.6 which was in the ninth percentile group of public hospitals of 151-300 bed capacity. The survey identified a number of priority issues for attention with communication within the treating team and with patients as priority items. In the second hosp., overall satisfaction of 4.37 out of a possible 5.00. 84.7 per cent were "satisfied" or "very satisfied" with "all aspects of their experience with the hospital/health service".

Source : ACT Government (unpublished).

Table 10A.84 NT patient evaluation of hospital services

When the survey was conducted

Year(s):

No valid survey results available

Time period (eg. July to Sept):

na

Survey method (eg. telephone, mailout etc):

na

Respondents (eg. Admitted patients in public acute care hospitals):

na

Sample size:

na

Response rate:

na

Size of underlying population:

na

Organisation conducting the survey:

na

Organisation funding the survey:

na

Table 10A.84 NT patient evaluation of hospital services

How was information from the survey used to help improve public hospital quality:

na

Survey results:

na

na Not available.
Source: NT Government (unpublished).

Table 10A.85 **NSW selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	4	6	3	1	1
Suicide of a patient in an inpatient unit.	5	2	18	12	20
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	14	16	16	10	14
Intravascular gas embolism resulting in death or neurological damage.	–	2	–	1	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	1	1	–	1
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	6	1	4	2	1
Maternal death or serious morbidity associated with labour or delivery.	–	–	2	3	1
Infant discharged to the wrong family.	–	–	–	–	–
Total	**29**	**28**	**44**	**29**	**38**

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source : NSW government (unpublished).

Table 10A.86 **Victoria selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	1	–	–	1	1
Suicide of a patient in an inpatient unit.	7	7	6	9	8
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	11	3	9	5	7
Intravascular gas embolism resulting in death or neurological damage.	–	–	1	1	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	2	1	2	1	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	2	1	1	2	4
Maternal death or serious morbidity associated with labour or delivery.	6	3	2	2	–
Infant discharged to the wrong family.	–	–	–	–	–
Total	**29**	**15**	**21**	**21**	**20**

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source : Victorian government (unpublished).

Table 10A.87 **Queensland selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	8	2	1	–	1
Suicide of a patient in an inpatient unit.	5	2	4	1	1
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	–	1	1	5	5
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	5	6	2	4	–
Maternal death or serious morbidity associated with labour or delivery.	1	2	2	1	4
Infant discharged to the wrong family.	–	–	–	–	–
Total	**19**	**13**	**10**	**11**	**11**

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source: Queensland government (unpublished).

Table 10A.88 **WA selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	1	–	1	1	1
Suicide of a patient in an inpatient unit.	9	3	3	5	5
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	3	3	1	1	3
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	2	2	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	4	2	1	2	–
Maternal death or serious morbidity associated with labour or delivery.	5	1	1	3	2
Infant discharged to the wrong family.	2	–	–	–	–
Total	**26**	**11**	**7**	**12**	**11**

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source : WA government (unpublished).

Table 10A.89 **SA selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	1	–	–	–	–
Suicide of a patient in an inpatient unit.	5	6	5	2	–
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	3	7	3	3	5
Intravascular gas embolism resulting in death or neurological damage.	1	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	–	1	1	1
Maternal death or serious morbidity associated with labour or delivery (b).	2	2	5	4	17
Infant discharged to the wrong family.	–	–	–	–	–
Total	**12**	**15**	**14**	**10**	**23**

(a) Sentinel events definitions can vary across jurisdictions.

(b) In the category of maternal death or serious morbidity associated with labour or delivery, 14 related to post-partum haemorrhage >1500mls, three (3) to fourth degree tear's and three (3) to other classifications of serious morbidity.

– Nil or rounded to zero.

Table 10A.90 **Tasmania selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	–	–	–
Suicide of a patient in an inpatient unit.	1	–	–	–	–
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	1	–	–	–	1
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	1	–	–	–	–
Maternal death or serious morbidity associated with labour or delivery.	–	–	–	–	–
Infant discharged to the wrong family.	–	–	–	–	–
Total	**3**	**–**	**–**	**–**	**1**

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source: Tasmanian government (unpublished).

Table 10A.91 **ACT selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	np	np	np
Suicide of a patient in an inpatient unit.	–	–	np	np	np
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	np	–	np	np	np
Intravascular gas embolism resulting in death or neurological damage.	–	–	np	np	np
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	np	np	np
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	–	np	np	np
Maternal death or serious morbidity associated with labour or delivery.	–	–	np	np	np
Infant discharged to the wrong family.	–	–	np	np	np
Total	**np**	**–**	**7**	**2**	**3**

(a) Sentinel events definitions can vary across jurisdictions.

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

Source : ACT government (unpublished).

Table 10A.92 **NT selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	–	–	–	–	–
Suicide of a patient in an inpatient unit.	–	–	–	–	–
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	–	–	–	2	–
Intravascular gas embolism resulting in death or neurological damage.	–	–	–	–	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	–	–	–	–	–
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	–	–	–	–	–
Maternal death or serious morbidity associated with labour or delivery.	1	–	1	–	–
Infant discharged to the wrong family.	–	–	–	–	–
Total	**1**	**–**	**1**	**2**	**–**

(a) Sentinel events definitions can vary across jurisdictions.

– Nil or rounded to zero.

Source : NT government (unpublished).

Table 10A.93 **Australia selected sentinel events (number) (a)**

	2007-08	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.	15	8	5	3	4
Suicide of a patient in an inpatient unit.	32	20	36	29	34
Retained instruments or other material after surgery requiring re-operation or further surgical procedure.	32	30	30	26	35
Intravascular gas embolism resulting in death or neurological damage.	1	2	1	2	–
Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.	4	4	3	1	1
Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.	18	10	9	11	6
Maternal death or serious morbidity associated with labour or delivery.	15	8	13	13	24
Infant discharged to the wrong family.	2	–	–	–	–
Total (b)	**119**	**82**	**104**	**87**	**107**

(a) Sentinel events definitions can vary across jurisdictions.

(b) The total for 2009-10 includes 7 sentinel events for the ACT which are not reported in the 8 sub categories of sentinel events due to confidentiality issues.

– Nil or rounded to zero.

Source : State and Territory governments (unpublished).

Table 10A.94 **Separations, same day separations, patient days, average length of stay and costs for MDC 14 and MDC 15, public hospitals, Australia, 2011-12**

		AR-DRG		
	Unit	*Pregnancy, childbirth and the puerperium (MDC14)*	*Newborns and other neonates (MDC15)*	*Total (all acute separations in public hospitals)* (a)
Separations	no.	362 244	84 259	5 329 166
Separations per 10 000 population (b)	no.	161.1	37.5	2 370.1
Patient days	no.	904 575	574 678	15 644 476
Patient days per 10 000 population	no.	402.3	255.6	6 957.6
Average length of stay (ALOS)	days	2.5	6.8	2.9
ALOS (days) excluding same day	days	3.0	7.3	5.0
Cost by volume (c)	$'000	1 716 537	832 037	23 729 749
Cost by proportion	%	7.2	3.5	100.0

(a) Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days', or was not reported.

(b) Crude rate based on the Australian population as at 31 December 2010.

(c) Based on AR–DRG version 6.0 estimated public cost estimates.

ALOS—average length of stay, MDC—Major Diagnostic Category, DRG—Diagnosis Related Group.

Source: AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.95 **Separations by major diagnostic category (AR-DRGs) version 6.0, public hospitals, 2011-12**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations										
Pregnancy, childbirth and puerperium	no.	115 832	86 188	79 136	33 886	26 928	6 067	6 330	7 877	362 244
Newborns and other neonates	no.	39 936	15 723	12 734	6 635	4 977	1 601	1 550	1 103	84 259
Total acute (a) separations	no.	1 600 727	1 504 112	958 674	571 479	391 729	97 471	92 556	112 418	5 329 166
Proportion of all separations										
Pregnancy, childbirth and puerperium	%	7.2	5.7	8.3	5.9	6.9	6.2	6.8	7.0	6.8
Newborns and other neonates	%	2.5	1.0	1.3	1.2	1.3	1.6	1.7	1.0	1.6
Separations per 1000 population										
Pregnancy, childbirth and puerperium	no.	16.0	15.5	17.5	14.2	16.4	11.9	17.1	33.9	16.1
Newborns and other neonates	no.	5.5	2.8	2.8	2.8	3.0	3.1	4.2	4.7	3.7

(a) Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days', or was not reported.

Source: AIHW 2013, *Australian Hospital Statistics 2011-12*, Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra; AIHW; ABS (unpublished), Australian Demographic Statistics, December Quarter 2010, Cat. no. 3101.0; table AA.2.

Table 10A.96 **10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2011-12 (a)**

AR-DRG	*Separations*	*Same day separations*	*Same day separations*	*Separations per 10 000 population* (b)	*Patient days*	*Patient days per 10 000 population* (b)	*ALOS (days)*	*ALOS (days), excluding same day*	*Cost by volume*
	no.	no.	%	per 10 000	no.	per 10 000	no.	no.	$'000
O60A Vaginal Delivery W Catastrophic or Severe CC	16 485	187	1.1	7.4	67 447	30.2	4.0	4.1	123 835
O60B Vaginal Delivery W/O Catastrophic or Severe CC	104 675	3 986	3.8	46.9	259 685	116.2	2.0	2.5	509 977
O60C Vaginal Delivery Single uncomplicated	28 653	3 611	12.6	12.8	50 797	22.7	2.0	1.9	119 368
A06B Trach W Vent >95 hours W/O Cat CC or Trach/Vent >95 hours W Cat CC	6 864	4	0.1	3.1	176 806	79.1	26.0	25.8	597 690
L61Z Haemodialysis	1018 295	1016 708	99.8	455.8	1 020 000	455.9	1.0	1.1	600 794
U61A Schizophrenia Disorders W MHLS	15 003	–	0.0	6.7	482 628	216.0	32.0	32.2	335 452
U61B Schizophrenia Disorders W/O MHLS	13 422	–	0.0	6.0	241 600	108.1	18.0	18.0	185 170
A06A Tracheostomy W Ventilation >95 hours W Catastrophic CC	2 187	–	0.0	1.0	109 302	48.9	50.0	50.0	416 101
O01A Caesarean Delivery W Catastrophic CC	4 320	30	0.7	1.9	40 845	18.3	9.0	9.5	75 012
O01B Caesarean Delivery W Severe CC	11677	47	0.4	5.2	61 792	27.7	5.0	5.3	134 017
O01C Caesarean Delivery W/O Catastrophic or Severe CC	46363	121	0.3	20.8	175 887	78.7	4.0	3.8	434 607
U63A Major Affective Disorders, Age >69 or W Catastrophic or Severe CC	3068	0	0.0	1.4	86 897	38.9	28.0	28.3	77 111
U63B Major Affective Disorders, Age<70 or W/O Catastrophic or Severe CC	18047	0	0.0	8.1	261 277	117.0	14.0	14.5	246 053

Table 10A.96 **10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2011-12 (a)**

AR-DRG	*Separations*	*Same day separations*	*Same day separations*	*Separations per 10 000 population* (b)	*Patient days*	*Patient days per 10 000 population* (b)	*ALOS (days)*	*ALOS (days), excluding same day*	*Cost by volume*
E65B Chronic Obstructive Airways Disease W/O Catastrophic CC	43055	4601	10.7	19.3	193 538	86.6	4.0	4.9	226 943
R63Z Chemotherapy	141928	141876	100.0	63.5	142 017	63.6	1.0	2.7	209 060
I03B Hip Replacement W/O Catastrophic CC	10 722	10	0.1	4.8	69 071	30.9	6.0	6.4	209 712

(a) Based on AR–DRG version 6.0x estimated public cost estimates.

(b) Crude rate based on Australian population as at 31 December 2010.

ALOS = Average Length of Stay. CC = complication or comorbidity. W = with. W/O = without.

– Nil or rounded to zero.

Source: AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.97 **Intervention rates for selected primiparae, 2012 (a)**

	Unit	*NSW*	*Vic* (b)	*Qld*	*WA* (b)	*SA*	*Tas*	*ACT* (c), (d)	*NT*	*Aust* (e)
Proportion of inductions for selected primiparae										
Public hospitals										
Selected primiparae who gave birth	no.	9 342	5 890	3 816	2 264	1 973	na	1 223	283	24 791
Selected primiparae inductions	no.	3 391	1 869	1 122	821	755	na	287	102	8 347
Rate	%	36.3	31.7	29.4	36.3	38.3	na	23.5	36.0	33.7
Private hospitals										
Selected primiparae who gave birth	no.	2 572	1 390	2 222	1 700	569	na	375	np	8 828
Selected primiparae inductions	no.	912	479	751	719	252	na	97	np	3 210
Rate	%	35.5	34.5	33.8	42.3	44.3	na	25.9	np	36.4
Proportion of caesareans for selected primiparae										
Public hospitals										
Selected primiparae who gave birth	no.	9 342	5 890	3 816	2 264	1 973	na	1 223	283	24 791
Selected primiparae caesareans	no.	2 223	1 369	873	560	399	na	260	81	5 765
Rate	%	23.8	23.2	22.9	24.7	20.2	na	21.3	28.6	23.3
Private hospitals										
Selected primiparae who gave birth	no.	2 572	1 390	2 222	1 700	569	na	375	np	8 828
Selected primiparae caesareans	no.	796	425	811	567	167	na	136	np	2 902
Rate	%	30.9	30.6	36.5	33.4	29.3	na	36.3	np	32.9

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Data for Victoria and WA are preliminary.

(c) ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT.

(d) ACT Selected Primiparae data has been derived using a different methodology from 2010-11 and is therefore not directly comparable with data from previous years.

(e) Totals for Australia include only jurisdictions for which data are available.

na Not available.

Table 10A.97 **Intervention rates for selected primiparae, 2012 (a)**

	Unit	*NSW*	*Vic* (b)	*Qld*	*WA* (b)	*SA*	*Tas*	*ACT* (c), (d)	*NT*	*Aust* (e)

Source: State and Territory governments.

Table 10A.98 **Intervention rates for selected primiparae, NSW (a)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	6 957	6 882	6 946	6 930	7 641	7 897	8 311	8 402	8 961	9 342
Selected primiparae inductions	no.	1 845	1 848	1 988	1 968	2 484	2 564	2 815	2 920	3 169	3 391
Rate	%	26.5	26.9	28.6	28.4	32.5	32.5	33.9	34.8	35.4	36.3
Private hospitals											
Selected primiparae who gave birth	no.	2 618	2 479	2 520	2 195	2 570	2 634	2 814	2 787	2 619	2 572
Selected primiparae inductions	no.	988	866	935	778	916	900	1 001	1 024	934	912
Rate	%	37.7	34.9	37.1	35.4	35.6	34.2	35.6	36.7	35.7	35.5
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	6 957	6 882	6 946	6 930	7 641	7 897	8 311	8 402	8 961	9 342
Selected primiparae caesareans	no.	1 385	1 399	1 471	1 432	1 652	1 714	1 907	1 935	2 092	2 223
Rate	%	19.9	20.3	21.2	20.7	21.6	21.7	22.9	23.0	23.3	23.8
Private hospitals											
Selected primiparae who gave birth	no.	2 618	2 479	2 520	2 195	2 570	2 634	2 814	2 787	2 619	2 572
Selected primiparae caesareans	no.	675	641	699	659	751	748	866	864	811	796
Rate	%	25.8	25.9	27.7	30.0	29.2	28.4	30.8	31.0	31.0	30.9

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

Source: NSW Government (unpublished).

Table 10A.99 **Intervention rates for selected primiparae, Victoria (a)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	5 122	4 841	5 230	5 622	6 101	6 022	6 509	6 509	7 128	5 890
Selected primiparae inductions	no.	1 689	1 577	1 609	1 734	1 885	1 731	1 890	1 890	2 321	1 869
Rate	%	33.0	32.6	30.8	30.8	30.9	28.7	29.0	29.0	32.6	31.7
Private hospitals											
Selected primiparae who gave birth	no.	1 965	1 635	1 802	1 818	1 849	2 067	1 973	1 973	1 495	1 390
Selected primiparae inductions	no.	743	565	656	676	659	709	674	674	530	479
Rate	%	37.8	34.6	36.4	37.2	35.6	34.3	34.2	34.2	35.5	34.5
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	5 122	4 841	5 230	5 622	6 101	6 022	6 509	6 509	7 128	5 890
Selected primiparae caesareans	no.	1 187	1 022	1 173	1 312	1 380	1 325	1 487	1 487	1 701	1 369
` Rate	%	23.2	21.1	22.4	23.3	22.6	22.0	22.8	22.8	23.9	23.2
Private hospitals											
Selected primiparae who gave birth	no.	1 965	1 635	1 802	1 818	1 849	2 067	1 973	1 973	1 495	1 390
Selected primiparae caesareans	no.	514	420	488	500	530	555	595	595	463	425
Rate	%	26.2	25.7	27.1	27.5	28.7	26.9	30.2	30.2	31.0	30.6

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

Source : Victorian Government (unpublished).

Table 10A.100 **Intervention rates for selected primiparae, Queensland (a)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	3 135	3 255	3 389	3 453	3 777	3 937	4 078	4 049	3 844	3 816
Selected primiparae inductions	no.	943	916	936	1 028	1 075	1 120	1 123	1 102	1 090	1 122
Rate	%	30.1	28.1	27.6	29.8	28.5	28.4	27.5	27.2	28.4	29.4
Private hospitals											
Selected primiparae who gave birth	no.	1 987	1 949	2 000	2 034	2 175	2 237	2 252	2 288	2 343	2 222
Selected primiparae inductions	no.	694	663	713	678	718	738	734	739	801	751
Rate	%	34.9	34.0	35.7	33.3	33.0	33.0	32.6	32.3	34.2	33.8
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	3 135	3 255	3 389	3 453	3 777	3 937	4 078	4 049	3 844	3 816
Selected primiparae caesareans	no.	763	728	810	846	900	967	990	924	871	873
Rate	%	24.3	22.4	23.9	24.5	23.8	24.6	24.3	22.8	22.7	22.9
Private hospitals											
Selected primiparae who gave birth	no.	1 987	1 949	2 000	2 034	2 175	2 237	2 252	2 288	2 343	2 222
Selected primiparae caesareans	no.	682	698	736	796	854	809	837	840	848	811
Rate	%	34.3	35.8	36.8	39.1	39.3	36.2	37.2	36.7	36.2	36.5

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

Source: Queensland Government (unpublished).

Table 10A.101 **Intervention rates for selected primiparae, WA (a)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012 (b)*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	1 413	1 459	1 474	1 606	1 782	1 764	1 810	1 985	2 141	2 264
Selected primiparae inductions	no.	476	449	496	504	576	505	583	664	737	821
Rate	%	33.7	30.8	33.6	31.4	32.3	28.6	32.2	33.5	34.4	36.3
Private hospitals											
Selected primiparae who gave birth	no.	1 199	1 182	1 215	1 280	1 457	1 456	1 592	1 603	1 575	1 700
Selected primiparae inductions	no.	468	472	475	501	576	547	624	629	637	719
Rate	%	39.0	39.9	39.1	39.1	39.5	37.6	39.2	39.2	40.4	42.3
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	1 413	1 459	1 474	1 606	1 782	1 764	1 810	1 985	2 141	2 264
Selected primiparae caesareans	no.	287	340	364	372	420	410	470	490	564	560
Rate	%	20.3	23.3	24.7	23.2	23.6	23.2	26.0	24.7	26.3	24.7
Private hospitals											
Selected primiparae who gave birth	no.	1 199	1 182	1 215	1 280	1 457	1 456	1 592	1 603	1 575	1 700
Selected primiparae caesareans	no.	400	435	464	479	463	439	545	556	525	567
Rate	%	33.4	36.8	38.2	37.4	31.8	30.2	34.2	34.7	33.3	33.4

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Data for 2012 are preliminary.

Table 10A.102 **Intervention rates for selected primiparae, SA (a), (b)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	1 332	1 344	1 393	1 338	1 534	1 579	1 669	1 786	1 923	1 973
Selected primiparae inductions	no.	478	446	483	487	554	567	619	682	756	755
Rate	%	35.9	33.2	34.7	36.4	36.1	35.9	37.1	38.2	39.3	38.3
Private hospitals											
Selected primiparae who gave birth	no.	643	591	586	634	632	632	644	667	600	569
Selected primiparae inductions	no.	250	225	233	246	275	250	264	263	249	252
Rate	%	38.9	38.1	39.8	38.8	43.5	39.6	41.0	39.4	41.5	44.3
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	1 332	1 344	1 393	1 338	1 534	1 579	1 669	1 786	1 923	1 973
Selected primiparae caesareans	no.	312	333	357	341	394	405	414	489	526	399
Rate	%	23.4	24.8	25.6	25.5	25.7	25.6	24.8	27.4	27.4	20.2
Private hospitals											
Selected primiparae who gave birth	no.	643	591	586	634	632	632	644	667	600	569
Selected primiparae caesareans	no.	220	221	222	197	208	209	197	190	191	167
Rate	%	34.2	37.4	37.9	31.1	32.9	33.1	30.6	28.5	31.8	29.3

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Data for 2012 are preliminary.

Source: SA Government (unpublished).

Table 10A.103 **Intervention rates for selected primiparae, Tasmania (a)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	270	296	268	386	206	233	214	224	259	na
Selected primiparae inductions	no.	93	93	74	137	55	63	55	65	73	na
Rate	%	34.4	31.4	27.6	35.5	26.7	27.0	25.7	29.0	28.2	na
Private hospitals											
Selected primiparae who gave birth	no.	238	237	215	239	123	124	145	152	55	na
Selected primiparae inductions	no.	87	86	95	94	43	40	46	49	20	na
Rate	%	36.6	36.3	44.2	39.3	35.0	32.3	31.7	32.2	36.4	na
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	270	296	268	386	206	233	214	224	259	na
Selected primiparae caesareans	no.	24	34	10	114	na	na	na	na	na	na
Rate	%	8.9	11.5	3.7	29.5	na	na	na	na	na	na
Private hospitals											
Selected primiparae who gave birth	no.	238	237	215	239	123	124	145	152	55	na
Selected primiparae caesareans	no.	25	22	17	61	na	na	na	na	na	na
Rate	%	10.5	9.3	7.9	25.5	na	na	na	na	na	na

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

na Not available.

Source: Tasmanian Government (unpublished).

Table 10A.104 **Intervention rates for selected primiparae, ACT (a), (b), (c)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012 (c)*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	936	887	865	948	1 085	1 076	1 135	1 215	1 065	1 223
Selected primiparae inductions	no.	215	162	193	190	215	222	278	291	252	287
Rate	%	23.0	18.3	22.3	20.0	19.8	20.6	24.5	24.0	23.7	23.5
Private hospitals											
Selected primiparae who gave birth	no.	557	550	582	613	521	564	574	471	434	375
Selected primiparae inductions	no.	156	141	169	185	160	195	160	137	139	97
Rate	%	28.0	25.6	29.0	30.2	30.7	34.6	27.9	29.1	32.0	25.9
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	936	887	865	948	1 085	1 076	1 135	1 215	1 065	1 223
Selected primiparae caesareans	no.	158	164	157	187	195	176	198	278	238	260
Rate	%	16.9	18.5	18.2	19.7	18.0	16.4	17.4	22.9	22.3	21.3
Private hospitals											
Selected primiparae who gave birth	no.	557	550	582	613	521	564	574	471	434	375
Selected primiparae caesareans	no.	138	148	162	174	172	181	184	154	159	136
Rate	%	24.8	26.9	27.8	28.4	33.0	32.1	32.1	32.7	36.6	36.3

(a) Data are calculated according to ACHS Obstetric Clinical Indicator 1 denominator, Clinical Indicator 1.2 and Clinical Indicator 1.4. Selected primiparae: mothers with no previous deliveries, 20–34 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

(b) Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Across 2003 to 2011, the proportion of non-ACT resident selected primiparae who gave birth in the ACT ranges between 12 to 15 per cent.

(c) Data are preliminary.

Source : ACT Government (unpublished).

Table 10A.105 **Intervention rates for selected primiparae, NT (a)**

	Unit	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Proportion of inductions for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	163	155	189	178	180	234	211	230	243	283
Selected primiparae inductions	no.	57	39	49	48	41	61	61	74	85	102
Rate	%	35.0	25.2	25.9	27.0	22.8	26.1	28.9	32.2	35.0	36.0
Private hospitals											
Selected primiparae who gave birth	no.	96	74	80	54	83	na	100	81	np	np
Selected primiparae inductions	no.	30	27	34	43	57	na	33	26	np	np
Rate	%	31.3	36.5	42.5	79.6	68.7	na	33.0	32.1	np	np
Proportion of caesareans for selected primiparae											
Public hospitals											
Selected primiparae who gave birth	no.	163	155	189	178	180	234	211	230	243	283
Selected primiparae caesareans	no.	48	36	50	53	49	52	56	57	68	81
Rate	%	29.4	23.2	26.5	29.8	27.2	22.2	26.5	24.8	28.0	28.6
Private hospitals											
Selected primiparae who gave birth	no.	96	74	80	54	83	na	100	81	np	np
Selected primiparae caesareans	no.	29	22	38	22	22	na	32	24	np	np
Rate	%	30.2	29.7	47.5	40.7	26.5	na	32.0	29.6	np	np

(a) Selected primiparae: mothers with no previous deliveries, 25–29 years of age (inclusive), singleton pregnancy, gestation 37 to 41 weeks (inclusive), and vertex presentation.

na Not available. **np** Not published.

Source: NT Government (unpublished).

Table 10A.106 **Method of birth for selected women giving birth for the first time, 2011 (a), (b)**

	Unit	*NSW*	*Vic (c)*	*Qld*	*WA*	*SA*	*Tas (d)*	*ACT*	*NT*	*Aust*
Number										
Non-instrument vaginal	no.	14 510	9 910	8 396	3 673	2 776	817	777	480	41 339
Instrumental vaginal	no.	6 617	5 963	3 553	2 721	1 411	337	450	178	21 230
Caesarean section	no.	7 420	5 767	4 822	2 701	1 699	np	466	282	23 157
Not stated	no.	8	1	–	–	–	–	–	–	9
Total	no.	28 555	21 641	16 771	9 095	5 886	1 154	1 693	940	85 735
Per cent										
Non-instrument vaginal	%	50.8	45.8	50.1	40.4	47.2	70.8	45.9	51.1	48.2
Instrumental vaginal	%	23.2	27.6	21.2	29.9	24.0	29.2	26.6	18.9	24.8
Caesarean section	%	26.0	26.6	28.8	29.7	28.9	np	27.5	30.0	27.0
Not stated	%	0.0	0.0	–	–	–	–	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Selection criteria: women aged 20 to 34 years, with a singleton baby positioned with head towards the cervix at the onset of labour born between 37 and 41 weeks gestation.

(b) This indicator is not for women who gave birth in public hospital only. Data includes women who met the selection criteria and gave birth in private hospitals and outside of hospital.

(c) Provisional data were provided by Victoria for this table.

(d) Caesarean section data for Tas not published as presentations were only recorded for vaginal births.

– Nil or rounded to zero.

Source: AIHW (unpublished) National Perinatal Data Collection.

Table 10A.107 **Multiparous mothers who have had a previous caesarean section by current method of birth (a), (b)**

	Unit	NSW (c)	Vic (c)	Qld	WA (c)	SA	Tas	ACT (d)	NT (c)	Aust
2007										
Number										
Non-instrumental vaginal	no.	1 961	1 421	1 380	475	490	135	114	132	6 108
Instrumental vaginal (e)	no.	414	466	225	151	131	24	33	18	1 462
Caesarean section	no.	11 110	9 442	8 494	4 317	2 672	759	532	464	37 790
Not stated	no.	3	–	–	–	–	–	–	–	3
Total	no.	13 488	11 329	10 099	4 943	3 293	918	679	614	45 363
Per cent										
Non-instrumental vaginal	%	14.5	12.5	13.7	9.6	14.9	14.7	16.8	21.5	13.5
Instrumental vaginal (e)	%	3.1	4.1	2.2	3.1	4.0	2.6	4.9	2.9	3.2
Caesarean section	%	82.4	83.3	84.1	87.3	81.1	82.7	78.4	75.6	83.3
Not stated	%	–	–	–	–	–	–	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2008										
Number										
Non-instrumental vaginal	no.	2 053	1 395	1 441	483	497	134	140	136	6 279
Instrumental vaginal (e)	no.	506	447	275	172	141	23	31	15	1 610
Caesarean section	no.	11 539	9 371	9 014	4 635	2 800	767	614	450	39 190
Not stated	no.	1	–	–	–	–	–	–	–	1
Total	no.	14 099	11 213	10 730	5 290	3 438	924	785	601	47 080
Per cent										
Non-instrumental vaginal	%	14.6	12.4	13.4	9.1	14.5	14.5	17.8	22.6	13.3
Instrumental vaginal (e)	%	3.6	4.0	2.6	3.3	4.1	2.5	3.9	2.5	3.4
Caesarean section	%	81.8	83.6	84.0	87.6	81.4	83.0	78.2	74.9	83.2
Not stated	%	–	–	–	–	–	–	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 10A.107 **Multiparous mothers who have had a previous caesarean section by current method of birth (a), (b)**

	Unit	*NSW (c)*	*Vic (c)*	*Qld*	*WA (c)*	*SA*	*Tas*	*ACT (d)*	*NT (c)*	*Aust*
2009										
Number										
Non-instrumental vaginal	no.	2 001	1 380	1 405	498	476	142	116	164	6 182
Instrumental vaginal (e)	no.	510	488	249	159	144	19	30	19	1 618
Caesarean section	no.	11 956	9 477	9 174	4 438	2 850	766	528	467	39 656
Not stated	no.	–	23	–	–	–	–	–	–	23
Total	no.	14 467	11 363	10 828	5 095	3 470	927	674	650	47 474
Per cent										
Non-instrumental vaginal	%	13.8	12.1	13.0	9.8	13.7	15.3	17.2	25.2	13.0
Instrumental vaginal (e)	%	3.5	4.3	2.3	3.1	4.1	2.0	4.5	2.9	3.4
Caesarean section	%	82.6	83.4	84.7	87.1	82.1	82.6	78.3	71.8	83.5
Not stated	%	–	0.2	–	–	–	–	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010										
Number										
Non-instrumental vaginal	no.	1 925	1 470	1 443	507	477	135	122	135	6 214
Instrumental vaginal (e)	no.	537	454	261	180	149	25	28	21	1 655
Caesarean section	no.	11 851	9 512	9 225	4 481	2 809	761	627	499	39 765
Not stated	no.	3	3	–	–	–	–	–	–	6
Total	no.	14 316	11 439	10 929	5 168	3 435	921	777	655	47 640
Per cent										
Non-instrumental vaginal	%	13.4	12.9	13.2	9.8	13.9	14.7	15.7	20.6	13.0
Instrumental vaginal (e)	%	3.8	4.0	2.4	3.5	4.3	2.7	3.6	3.2	3.5
Caesarean section	%	82.8	83.2	84.4	86.7	81.8	82.6	80.7	76.2	83.5
Not stated	%	–	–	–	–	–	–	–	–	–
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 10A.107 **Multiparous mothers who have had a previous caesarean section by current method of birth (a), (b)**

	Unit	*NSW (c)*	*Vic (c)*	*Qld*	*WA (c)*	*SA*	*Tas*	*ACT (d)*	*NT (c)*	*Aust*
2011										
Number										
Non-instrumental vaginal	no.	1 952	1 429	1 306	508	458	136	91	124	6 004
Instrumental vaginal (e)	no.	546	456	277	196	145	39	38	20	1 717
Caesarean section	no.	12 617	9 703	9 128	4 645	2 880	802	664	532	40 971
Not stated	no.	1	1	–	–	–	–	–	–	2
Total	no.	15 116	11 589	10 711	5 349	3 483	977	793	676	48 694
Per cent										
Non-instrumental vaginal	%	12.9	12.3	12.2	9.5	13.1	13.9	11.5	18.3	12.3
Instrumental vaginal (e)	%	3.6	3.9	2.6	3.7	4.2	4.0	4.8	3.0	3.5
Caesarean section	%	83.5	83.7	85.2	86.8	82.7	82.1	83.7	78.7	84.1
Not stated	%	0.0	0.0	–	–	–	–	–	–	0.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) For multiple births, the method of birth of the first born baby was used.

(b) Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.

(c) In 2010 and 2011, for NSW and WA, 'Non-instrumental vaginal' includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. In 2006 to 2009, for NSW, Victoria, WA and the NT, 'Non-instrumental vaginal' includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used.

(d) Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2007 and 2011, around 15.0 per cent of women who gave birth in the ACT were non-residents of the ACT.

(e) Instrumental vaginal birth includes forceps and vacuum extraction.

– Nil or rounded to zero.

Source : AIHW (various years), ***Australia's mothers and babies*** , Perinatal statistics series, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit.

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
2002										
Number										
Intact	no.	18 130	18 866	13 537	7 073	3 900	na	1 250	1 549	64 367
1st degree laceration	no.	17 961	7 084	7 298	2 912	1 773	na	621	304	37 860
2nd degree laceration	no.	14 630	8 594	6 777	3 192	3 996	na	1 029	471	38 575
3rd/4th degree laceration	no.	877	329	342	148	120	na	34	44	1 914
Episiotomy	no.	9 674	9 905	3 922	3 291	2 387	na	554	301	30 049
Combined laceration and episiotomy	no.	716	893	1 515	444	300	na	88	113	3 994
Other (g)	no.	2 492	8	2 118	668	115	na	–	38	5 439
Not stated	no.	6	6	–	–	–	na	–	32	44
Total	no.	**64 486**	**45 685**	**35 509**	**17 728**	**12 591**	**na**	**3 576**	**2 852**	**182 242**
Proportion of perineal										
Intact	%	28.1	41.3	38.1	39.9	31.0	na	35.0	54.3	35.3
1st degree laceration	%	27.9	15.5	20.6	16.4	14.1	na	17.4	10.7	20.8
2nd degree laceration	%	22.7	18.8	19.1	18.0	31.7	na	28.8	16.5	21.2
3rd/4th degree laceration	%	1.4	0.7	1.0	0.8	1.0	na	1.0	1.5	1.1
Episiotomy	%	15.0	21.7	11.0	18.6	19.0	na	15.5	10.6	16.5
Combined laceration and episiotomy	%	1.1	2.0	4.3	2.5	2.4	na	2.5	4.0	2.2
Other (g)	%	3.9	–	6.0	3.8	0.9	na	–	1.3	3.0
Not stated	%	0.0	0.0	–	–	–	na	–	1.1	0.0
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**	**100.0**	**100.0**
2003										
Number										
Intact	no.	17 657	18 688	13 368	6 779	3 761	na	1 176	1 455	62 956
1st degree laceration	no.	17 923	6 993	6 955	2 808	1 924	na	613	370	37 594
2nd degree laceration	no.	14 404	8 718	6 855	3 350	3 950	na	1 103	466	38 772

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
3rd/4th degree laceration	no.	958	343	340	172	176	na	33	42	2 065
Episiotomy	no.	9 284	9 425	4 032	3 181	2 227	na	551	272	28 976
Combined laceration and episiotomy	no.	616	878	767	390	299	na	96	94	3 132
Other (g)	no.	2 659	–	1 724	550	2	na	1	35	4 970
Not stated	no.	12	–	1	–	–	na	5	2	15
Total	no.	**63 513**	**45 045**	**34 042**	**17 230**	**12 339**	**na**	**3 578**	**2 736**	**178 480**
Proportion of perineal										
Intact	%	27.8	41.5	39.3	39.3	30.5	na	32.9	53.2	35.3
1st degree laceration	%	28.2	15.5	20.4	16.3	15.6	na	17.1	13.5	21.1
2nd degree laceration	%	22.7	19.4	20.1	19.4	32.0	na	30.8	17.0	21.7
3rd/4th degree laceration	%	1.5	0.8	1.0	1.0	1.4	na	0.9	1.5	1.2
Episiotomy	%	14.6	20.9	11.8	18.5	18.0	na	15.4	9.9	16.2
Combined laceration and episiotomy	%	1.0	1.9	2.3	2.3	2.4	na	2.7	3.4	1.8
Other (g)	%	4.2	–	5.1	3.2	0.0	na	–	1.3	2.8
Not stated	%	0.0	–	0.0	–	–	na	0.1	0.1	0.0
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**	**100.0**	**100.0**
2004										
Number										
Intact	no.	16 840	18 426	13 352	6 530	3 753	na	1 153	1 223	61 301
1st degree laceration	no.	17 838	6 486	7 173	2 840	1 842	na	577	543	37 335
2nd degree laceration	no.	14 263	9 013	7 148	3 502	4 194	na	1 161	475	39 698
3rd/4th degree laceration	no.	1 053	368	346	202	113	na	66	42	2 157
Episiotomy	no.	9 082	9 459	4 191	2 744	2 064	na	438	246	28 337
Combined laceration and episiotomy	no.	537	790	385	340	286	na	108	28	2 462
Other (g)	no.	2 837	–	1 703	616	–	na	–	35	5 191
Not stated	no.	8	–	1	–	2	na	1	21	37

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
Total	no.	**62 458**	**44 542**	**34 299**	**16 774**	**12 254**	**na**	**3 504**	**2 613**	**176 518**
Proportion of perineal										
Intact	%	27.0	41.4	38.9	38.9	30.6	na	32.9	46.8	34.7
1st degree laceration	%	28.6	14.6	20.9	16.9	15.0	na	16.5	20.8	21.2
2nd degree laceration	%	22.8	20.2	20.8	20.9	34.2	na	33.1	18.2	22.5
3rd/4th degree laceration	%	1.7	0.8	1.0	1.2	0.9	na	1.9	1.6	1.2
Episiotomy	%	14.5	21.2	12.2	16.4	16.8	na	12.5	9.4	16.1
Combined laceration and episiotomy	%	0.9	1.8	1.1	2.0	2.3	na	3.1	1.1	1.4
Other (g)	%	4.5	–	5.0	3.7	–	na	–	1.3	2.9
Not stated	%	–	–	–	–	–	na	–	0.8	–
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**	**100.0**	**100.0**
2005										
Number										
Intact	no.	16 172	18 231	13 137	6 570	3 594	na	1 223	1 095	59 952
1st degree laceration	no.	17 427	6 116	7 044	2 815	1 733	na	593	593	36 305
2nd degree laceration	no.	14 952	9 241	7 309	3 636	4 000	na	1 146	491	40 791
3rd/4th degree laceration	no.	1 027	472	378	206	147	na	65	31	2 327
Episiotomy	no.	8 487	9 174	4 248	2 739	2 024	na	441	213	27 323
Combined laceration and episiotomy	no.	515	883	356	430	294	na	85	26	2 612
Other (g)	no.	2 786	–	1 862	587	–	na	–	–	5 235
Not stated	no.	12	4	–	–	1	na	–	–	18
Total	no.	**61 378**	**44 121**	**34 334**	**16 983**	**11 793**	**na**	**3 553**	**2 449**	**174 563**
Proportion of perineal										
Intact	%	26.3	41.3	38.3	38.7	30.5	na	34.4	44.7	34.3
1st degree laceration	%	28.4	13.9	20.5	16.6	14.7	na	16.7	24.2	20.8
2nd degree laceration	%	24.4	20.9	21.3	21.4	33.9	na	32.3	20.0	23.4

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
3rd/4th degree laceration	%	1.7	1.1	1.1	1.2	1.2	na	1.8	1.3	1.3
Episiotomy	%	13.8	20.8	12.4	16.1	17.2	na	12.4	8.7	15.7
Combined laceration and episiotomy	%	0.8	2.0	1.0	2.5	2.5	na	2.4	1.1	1.5
Other (g)	%	4.5	–	5.4	3.5	–	na	–	–	3.0
Not stated	%	–	–	–	–	–	na	–	–	–
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**	**100.0**	**100.0**
2006										
Number										
Intact	no.	17 100	19 017	14 623	6 819	3 753	2 221	1 238	1 161	65 917
1st degree laceration	no.	17 154	6 059	7 416	2 848	2 936	646	643	682	38 334
2nd degree laceration	no.	16 020	9 945	7 761	3 900	2 975	779	1 258	449	42 975
3rd/4th degree laceration	no.	1 190	483	395	207	159	58	82	38	2 595
Episiotomy	no.	8 482	9 361	4 273	2 775	1 950	578	429	226	28 086
Combined laceration and episiotomy	no.	582	756	444	343	330	–	96	32	2 572
Other (g)	no.	3 516	–	1 982	649	18	–	–	–	6 165
Not stated	no.	19	1	–	–	1	–	–	–	21
Total	no.	**64 063**	**45 622**	**36 894**	**17 541**	**12 122**	**4 282**	**3 746**	**2 588**	**186 665**
Proportion of perineal										
Intact	%	26.7	41.7	39.6	38.9	31.0	51.9	33.0	44.9	35.3
1st degree laceration	%	26.8	13.3	20.1	16.2	24.2	15.1	17.2	26.4	20.5
2nd degree laceration	%	25.0	21.8	21.0	22.2	24.5	18.2	33.6	17.3	23.0
3rd/4th degree laceration	%	1.9	1.1	1.1	1.2	1.3	1.4	2.2	1.5	1.4
Episiotomy	%	13.2	20.5	11.6	15.8	16.1	13.5	11.5	8.7	15.0
Combined laceration and episiotomy	%	0.9	1.7	1.2	2.0	2.7	–	2.6	1.2	1.4
Other (g)	%	5.5	–	5.4	3.7	0.1	–	–	–	3.3
Not stated	%	0.0	0.0	–	–	0.0	–	–	–	0.0

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2007										
Number										
Intact	no.	17 326	19 664	14 361	7 543	3 836	2 224	1 358	1 190	67 383
1st degree laceration	no.	16 622	6 124	7 440	3 102	3 010	688	636	644	38 273
2nd degree laceration	no.	16 428	10 693	8 208	4 139	3 227	856	1 282	487	45 296
3rd/4th degree laceration	no.	1 125	647	401	277	153	62	80	56	2 803
Episiotomy	no.	8 539	9 752	4 351	2 938	1 805	593	396	218	28 625
Combined laceration and episiotomy	no.	1 058	760	474	367	370	–	97	14	3 139
Other (g)	no.	3 526	–	1 966	651	19	–	–	13	6 175
Not stated	no.	127	1	2	–	1	–	3	4	135
Total	no.	**64 751**	**47 641**	**37 203**	**19 017**	**12 421**	**4 423**	**3 852**	**2 626**	**191 829**
Proportion of perineal										
Intact	%	26.8	41.3	38.6	39.7	30.9	50.3	35.3	45.3	35.1
1st degree laceration	%	25.7	12.9	20.0	16.3	24.2	15.6	16.5	24.5	20.0
2nd degree laceration	%	25.4	22.4	22.1	21.8	26.0	19.4	33.3	18.5	23.6
3rd/4th degree laceration	%	1.7	1.4	1.1	1.5	1.2	1.4	2.1	2.1	1.5
Episiotomy	%	13.2	20.5	11.7	15.4	14.5	13.4	10.3	8.3	14.9
Combined laceration and episiotomy	%	1.6	1.6	1.3	1.9	3.0	–	2.5	0.5	1.6
Other (g)	%	5.4	–	5.3	3.4	0.2	–	–	0.5	3.2
Not stated	%	0.2	–	–	–	–	–	0.1	0.2	0.1
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2008										
Number										
Intact	no.	16 994	20 209	12 876	7 863	3 809	2 246	1 276	1 401	66 672
1st degree laceration	no.	19 072	6 019	6 811	3 175	3 400	726	628	426	40 257

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
2nd degree laceration	no.	17 382	11 714	9 461	4 599	3 603	921	1 509	566	49 755
3rd/4th degree laceration	no.	1 056	778	623	317	250	71	92	60	3 247
Episiotomy	no.	9 063	10 103	4 685	2 470	1 609	560	363	235	29 088
Combined laceration and episiotomy	no.	1 855	743	587	979	620	–	68	41	4 893
Other (g)	no.	1 433	–	5 173	767	44	–	3	23	7 443
Not stated	no.	14	–	3	–	2	–	–	2	21
Total	no.	**66 869**	**49 566**	**40 219**	**20 170**	**13 337**	**4 524**	**3 939**	**2 754**	**201 376**
Proportion of perineal										
Intact	%	25.4	40.8	32.0	39.0	28.6	49.6	32.4	50.9	33.1
1st degree laceration	%	28.5	12.1	16.9	15.7	25.5	16.0	15.9	15.5	20.0
2nd degree laceration	%	26.0	23.6	23.5	22.8	27.0	20.4	38.3	20.6	24.7
3rd/4th degree laceration	%	1.6	1.6	1.5	1.6	1.9	1.6	2.3	2.2	1.6
Episiotomy	%	13.6	20.4	11.6	12.2	12.1	12.4	9.2	8.5	14.4
Combined laceration and episiotomy	%	2.8	1.5	1.5	4.9	4.6	–	1.7	1.5	2.4
Other (g)	%	2.1	–	12.9	3.8	0.3	–	0.1	0.8	3.7
Not stated	%	–	–	–	–	–	–	–	0.1	–
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2009										
Number										
Intact	no.	16 297	14 541	12 325	7 799	3 723	2 216	1 352	1 191	59 442
1st degree laceration	no.	18 857	8 663	6 907	3 242	3 318	700	685	620	42 992
2nd degree laceration	no.	17 528	11 536	10 014	4 759	3 665	940	1 546	520	50 508
3rd/4th degree laceration	no.	1 074	754	666	413	269	49	125	53	3 403
Episiotomy	no.	9 134	9 382	4 778	2 595	1 608	566	380	297	28 740
Combined laceration and episiotomy	no.	2 040	904	563	1 060	631	–	47	38	5 283
Other (g)	no.	1 391	3 543	5 431	651	31	–	–	34	11 081

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
Not stated	no.	3	152	1	–	–	–	–	1	157
Total	no.	**66 324**	**49 475**	**40 685**	**20 519**	**13 245**	**4 471**	**4 135**	**2 754**	**201 606**
Proportion of perineal										
Intact	%	24.6	29.4	30.3	38.0	28.1	49.6	32.7	43.2	29.5
1st degree laceration	%	28.4	17.5	17.0	15.8	25.1	15.7	16.6	22.5	21.3
2nd degree laceration	%	26.4	23.3	24.6	23.2	27.7	21.0	37.4	18.9	25.1
3rd/4th degree laceration	%	1.6	1.5	1.6	2.0	2.0	1.1	3.0	1.9	1.7
Episiotomy	%	13.8	19.0	11.7	12.6	12.1	12.7	9.2	10.8	14.3
Combined laceration and episiotomy	%	3.1	1.8	1.4	5.2	4.8	–	1.1	1.4	2.6
Other (g)	%	2.1	7.2	13.3	3.2	0.2	–	–	1.2	5.5
Not stated	%	–	0.3	–	–	–	–	–	–	0.1
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2010										
Number										
Intact	no.	15 340	16 124	11 998	7 768	3 551	1 831	1 391	1 082	59 085
1st degree laceration	no.	18 909	8 904	7 580	3 146	3 377	781	614	567	43 878
2nd degree laceration	no.	17 874	12 025	10 465	4 980	3 645	912	1 395	619	51 915
3rd/4th degree laceration	no.	1 129	908	693	382	282	46	120	61	3 621
Episiotomy	no.	9 488	10 283	5 047	2 626	1 816	549	436	326	30 571
Combined laceration and episiotomy	no.	2 065	1 441	433	1 133	659	27	47	44	5 849
Other (g), (h), (i)	no.	1 205	–	4 747	448	13	97	–	22	4 879
Not stated	no.	10	439	–	–	–	–	–	–	449
Total	no.	**66 020**	**50 124**	**40 963**	**20 483**	**13 343**	**4 243**	**4 003**	**2 721**	**201 900**
Proportion of perineal										
Intact	%	23.2	32.2	29.3	37.9	26.6	43.2	34.7	39.8	29.3
1st degree laceration	%	28.6	17.8	18.5	15.4	25.3	18.4	15.3	20.8	21.7

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
2nd degree laceration	%	27.1	24.0	25.5	24.3	27.3	21.5	34.8	22.7	25.7
3rd/4th degree laceration	%	1.7	1.8	1.7	1.9	2.1	1.1	3.0	2.2	1.8
Episiotomy	%	14.4	20.5	12.3	12.8	13.6	12.9	10.9	12.0	15.1
Combined laceration and episiotomy	%	3.1	2.9	1.1	5.5	4.9	0.6	1.2	1.6	2.9
Other (g), (h), (i)	%	1.8	–	11.6	2.2	0.1	2.3	–	0.8	2.4
Not stated	%	–	0.9	–	–	–	–	–	–	0.2
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
2011										
Number										
Intact	no.	14 789	12 182	11 997	7 643	3 628	1 363	1 228	1 003	53 986
1st degree laceration	no.	19 065	8 405	8 119	3 274	3 313	1 098	531	557	44 362
2nd degree laceration	no.	17 584	12 198	10 331	5 016	3 702	985	1 368	608	51 812
3rd/4th degree laceration	no.	1 304	928	720	439	290	73	134	77	3 980
Episiotomy	no.	9 603	10 405	5 047	2 947	2 085	442	426	332	31 134
Combined laceration and episiotomy	no.	2 269	1 490	410	1 267	370	97	56	30	5 954
Other (g), (h), (i)	no.	1 120	3 529	4 190	393	6	227	–	31	9 496
Not stated	no.	25	428	4	–	1	–	–	–	458
Total	no.	**65 759**	**49 565**	**40 818**	**20 979**	**13 395**	**4 285**	**3 743**	**2 638**	**201 182**
Proportion of perineal										
Intact	%	22.5	24.6	29.4	36.4	27.1	31.8	32.8	38.0	26.8
1st degree laceration	%	29.0	17.0	19.9	15.6	24.7	25.6	14.2	21.1	22.1
2nd degree laceration	%	26.7	24.6	25.3	23.9	27.6	23.0	36.5	23.0	25.8
3rd/4th degree laceration	%	2.0	1.9	1.8	2.1	2.2	1.7	3.6	2.9	2.0
Episiotomy	%	14.6	21.0	12.4	14.0	15.6	10.3	11.4	12.6	15.5
Combined laceration and episiotomy	%	3.5	3.0	1.0	6.0	2.8	2.3	1.5	1.1	3.0
Other (g), (h), (i)	%	1.7	7.1	10.3	1.9	0.0	5.3	–	1.2	4.7

Table 10A.108 **Perineal status after vaginal births (a), (b), (c)**

	Unit	*NSW*	*Vic (d)*	*Qld*	*WA*	*SA*	*Tas (e)*	*ACT (f)*	*NT*	*Aust*
Not stated	%	0.0	0.9	0.0	–	0.0	–	–	–	0.2
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) 1st degree laceration: perineal laceration, rupture or tear during delivery involving fourchette, labia, skin, slight, vagina, vulva; 2nd degree laceration: perineal laceration, rupture or tear during delivery as with 1st degree also involving pelvic floor, perineal muscles, vaginal muscles; 3rd degree laceration: perineal laceration, rupture or tear during delivery as with 2nd degree also involving anal sphincter, rectovaginal septum, sphincter NOS; 4th degree laceration: perineal laceration, rupture or tear during delivery as with 3rd degree also involving anal mucosa, rectal mucosa. Because of differences in definitions and methods used for data collection, care must be taken when comparing across jurisdictions.

(b) For multiple births, the perineal status after delivery of the first born was used.

(c) Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.

(d) Include mothers reported with a labial, clitorial, vaginal and/or cervical laceration.

(e) In 2010 and 2011, for Tasmania, cases where both a laceration and episiotomy occurred were coded as ‘Combined laceration and episiotomy’ in the electronic systems. In the paper-based form they were recorded as ‘Episiotomy’. Care must be taken when interpreting these numbers. Before 2010, for Tasmania, cases where both a laceration and episiotomy occured were coded as episiotomy. Care must be taken when interpreting these numbers.

(f) Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2006 and 2011, around 15.0 per cent of women who gave birth in the ACT were non-residents of the ACT.

(g) For NSW, includes unspecified perineal tear and vulval or perineal haematoma.

(h) In 2010 and 2011, for Queensland, other includes genital grazes such as clitoral or labial.

(i) In 2010 and 2011, for WA, 'other' includes unspecified perineal tear and vulval or perineal haematoma.

– Nil or rounded to zero.

Source : AIHW (various years), ***Australia’s mothers and babies*** , Perinatal statistics series, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit.

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
2009-10										
O01A — Caesarean Delivery W Ccc										
Separations	no.	1 198	844	667	499	349	45	73	78	3 752
Patient days	no.	11 679	7 753	5 363	4 672	3 859	441	470	869	35 107
ALOS	days	9.75	9.19	8.04	9.36	11.07	9.80	6.00	11.14	9.36
Sample size (f)	no. hospitals	41	28	19	17	12	3	2	3	125
Average cost (g)	$/DRG	13 595	17 648	15 484	20 750	18 386	24 436	17 336	57 945	17 364
Direct	$/DRG	9 965	13 467	12 716	18 045	14 776	18 819	12 141	41 651	13 570
Overhead	$/DRG	3 630	4 181	2 768	2 705	3 610	5 617	5 195	16 294	3 793
O01B — Caesarean Delivery W Scc										
Separations	no.	3 433	2 809	1 729	1 140	870	182	191	178	10 533
Patient days	no.	20 095	15 420	8 720	6 229	5 134	1 096	942	1 296	58 931
ALOS	days	5.85	5.49	5.04	5.46	5.90	6.02	5.00	7.28	5.60
Sample size (f)	no. hospitals	47	34	23	23	24	3	2	4	160
Average cost (g)	$/DRG	9 789	11 228	10 760	14 952	11 719	16 483	12 380	25 386	11 477
Direct	$/DRG	7 176	8 697	8 805	12 176	9 153	12 530	8 595	17 986	8 855
Overhead	$/DRG	2 614	2 531	1 954	2 776	2 565	3 953	3 785	7 400	2 622
O01C — Caesarean Delivery W/O Cscc										
Separations	no.	15 825	10 981	8 282	4 508	3 544	900	776	564	45 379
Patient days	no.	63 370	43 447	29 479	18 182	14 884	3 625	3 010	2 665	178 663
ALOS	days	4.00	3.96	3.56	4.03	4.20	4.03	4.00	4.73	3.94
Sample size (f)	no. hospitals	50	36	24	25	25	3	2	4	169
Average cost (g)	$/DRG	8 441	8 767	8 697	13 226	10 224	12 057	9 604	16 608	9 374
Direct	$/DRG	6 167	6 860	7 126	10 028	7 821	9 094	6 673	11 275	7 153
Overhead	$/DRG	2 274	1 907	1 571	3 199	2 403	2 963	2 931	5 333	2 222

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
O02A — Vaginal Delivery W Or Pr W Cscc										
Separations	no.	464	394	270	186	137	18	26	37	1 532
Patient days	no.	2 220	1 594	1 076	860	665	79	99	189	6 783
ALOS	days	4.78	4.05	3.99	4.63	4.87	4.39	4.00	5.11	4.43
Sample size (f)	no. hospitals	41	31	20	19	13	3	2	3	132
Average cost (g)	$/DRG	9 983	8 933	10 095	12 821	9 369	11 174	11 934	18 382	10 272
Direct	$/DRG	7 443	6 979	8 258	10 562	7 389	8 438	8 823	12 620	8 001
Overhead	$/DRG	2 540	1 955	1 837	2 259	1 980	2 737	3 112	5 762	2 271
O02B — Vaginal Delivery W Or Pr W/O Cscc										
Separations	no.	1 525	1 056	854	433	380	48	109	70	4 476
Patient days	no.	5 747	3 126	2 639	1 472	1 319	176	364	275	15 119
ALOS	days	3.77	2.96	3.09	3.40	3.47	3.67	3.00	3.93	3.38
Sample size (f)	no. hospitals	48	32	23	21	18	3	2	5	152
Average cost (g)	$/DRG	6 745	6 365	7 011	8 940	6 560	10 849	6 886	13 184	7 051
Direct	$/DRG	4 959	4 987	5 734	7 148	5 156	8 136	4 797	8 702	5 431
Overhead	$/DRG	1 786	1 378	1 277	1 792	1 403	2 713	2 089	4 482	1 620
O03A — Ectopic Pregnancy (h)										
Separations	no.	155	138	84	68	29	7	np	10	494
Patient days	no.	426	376	204	180	69	25	14	28	1 322
ALOS	days	2.75	2.72	2.43	2.66	2.42	3.57	4.00	2.80	2.67
Sample size (f)	no. hospitals	36	24	17	8	7	3	2	3	100
Average cost (g)	$/DRG	7 161	6 466	8 496	9 532	7 049	8 980	10 188	9 713	7 613
Direct	$/DRG	5 580	5 228	7 020	7 657	5 659	6 836	7 087	6 976	6 073
Overhead	$/DRG	1 581	1 238	1 476	1 875	1 390	2 144	3 101	2 737	1 540
O03B — Ectopic Pregnancy (h)										

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
Separations	no.	849	661	517	262	185	45	64	41	2 623
Patient days	no.	1 619	1 067	893	455	328	72	118	85	4 638
ALOS	days	2	2	2	2	2	2	2	2	2
Sample size (f)	no. hospitals	45	28	21	16	12	3	2	3	130
Average cost (g)	$/DRG	4 656	4 132	6 473	6 001	5 769	5 450	6 214	7 523	5 187
Direct	$/DRG	3 621	3 355	5 407	4 981	4 622	4 070	4 481	5 324	4 164
Overhead	$/DRG	1 035	777	1 067	1 019	1 147	1 380	1 733	2 199	1 023
O04A — Postpartum & Post Abortn W Or Pr (h)										
Separations	no.	76	58	60	39	27	5	6	2	273
Patient days	no.	406	228	318	199	267	33	21	21	1 494
ALOS	days	5.32	3.94	5.30	5.13	10.01	6.60	4.00	10.50	5.47
Sample size (f)	no. hospitals	27	22	16	9	7	3	2	1	87
Average cost (g)	$/DRG	9 167	7 009	13 677	15 721	14 791	5 219	12 233	18 854	11 357
Direct	$/DRG	6 877	5 587	11 581	13 261	11 976	3 891	9 056	13 928	9 176
Overhead	$/DRG	2 289	1 422	2 097	2 460	2 815	1 328	3 176	4 926	2 181
O04B — Postpartum & Post Abortn W Or Pr (h)										
Separations	no.	429	361	241	198	101	51	19	15	1,415
Patient days	no.	811	600	479	332	235	87	31	55	2,631
ALOS	days	2	2	2	2	2	2	2	4	2
Sample size (f)	no. hospitals	46	34	24	22	16	3	2	3	150
Average cost (g)	$/DRG	3,609	2,859	4,340	4,508	4,609	11,070	3,920	7,501	3,812
Direct	$/DRG	2,732	2,267	3,610	3,517	3,458	8,596	2,698	5,072	2,967
Overhead	$/DRG	877	592	731	991	1,151	2,474	1,222	2,430	844
O05Z — Abortion W Or Pr										
Separations	no.	7 386	8 295	3 152	2 273	5 438	474	242	1 089	28 349

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
Patient days	no.	8 099	8 625	3 450	2 443	5 576	519	284	1 180	30 175
ALOS	days	1.10	1.04	1.09	1.07	1.03	1.09	1.00	1.08	1.06
Sample size (f)	no. hospitals	57	40	27	24	28	3	2	4	185
Average cost (g)	$/DRG	1 809	1 736	2 823	3 109	1 479	4 359	3 370	1 803	1 971
Direct	$/DRG	1 340	1 381	2 359	2 344	1 222	3 244	2 384	1 264	1 542
Overhead	$/DRG	469	355	464	765	257	1 115	985	539	429
O60A — Vaginal Delivery W Cscc										
Separations	no.	4 744	3 687	2 343	1 769	1 282	277	270	299	14 671
Patient days	no.	21 037	14 471	9 097	7 858	5 833	1 206	986	1 408	61 895
ALOS	days	4.43	3.92	3.88	4.44	4.55	4.35	4.00	4.71	4.22
Sample size (f)	no. hospitals	51	37	26	25	21	4	2	4	170
Average cost (g)	$/DRG	7 351	6 455	7 102	9 561	7 177	9 451	6 663	14 590	7 512
Direct	$/DRG	5 398	4 993	5 765	8 148	5 572	7 292	4 600	10 173	5 820
Overhead	$/DRG	1 953	1 462	1 337	1 413	1 606	2 159	2 063	4 417	1 692
O60B — Vaginal delivery W/O Cscc										
Separations	no.	37 037	29 760	24 670	11 521	8 143	1 812	2 006	1 226	116 175
Patient days	no.	100 682	75 514	54 130	31 991	21 791	5 058	4 621	3 538	297 325
ALOS	days	2.72	2.54	2.19	2.78	2.68	2.79	2.00	2.89	2.56
Sample size (f)	no. hospitals	53	37	46	27	26	4	2	5	196
Average cost (g)	$/DRG	5 312	4 153	4 490	5 956	4 483	6 162	4 170	8 323	4 872
Direct	$/DRG	3 833	3 192	3 639	4 743	3 426	4 710	2 882	5 562	3 705
Overhead	$/DRG	1 480	961	851	1 213	1 058	1 452	1 288	2 761	1 167
O60C — Vaginal Delivery Single Uncomplicated										
Separations	no.	9 766	4 535	764	2 625	1 803	700	592	535	21 319
Patient days	no.	19 209	8 933	1 258	5 411	3 374	1 509	953	1 176	41 823

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
ALOS	days	1.97	1.97	1.65	2.06	1.87	2.16	2.00	2.20	1.96
Sample size (f)	no. hospitals	54	37	3	25	25	8	2	5	159
Average cost (g)	$/DRG	4 669	3 298	3 043	4 624	3 178	4 659	2 662	6 038	4 166
Direct	$/DRG	3 301	2 545	2 405	3 512	2 360	3 524	1 846	3 877	3 036
Overhead	$/DRG	1 368	753	638	1 112	818	1 136	817	2 161	1 130
2010-11										
O01A - Caesarean Delivery +Ccc										
Separations	no.	1 227	910	774	442	310	67	76	71	3 877
Patient days	no.	11 558	9 522	6 191	4 288	3 121	581	486	806	36 554
ALOS	days	9	10	8	10	10	9	6	11	9
Sample size (f)	no. hospitals	42	28	24	19	12	3	2	4	134
Average cost (g)	$/DRG	15 639	19 089	15 760	20 571	17 615	20 871	21 464	24 365	17 558
Direct	$/DRG	11 405	14 230	13 207	17 789	13 970	16 557	12 314	15 838	13 548
Overhead	$/DRG	4 234	4 859	2 553	2 782	3 645	4 315	9 150	8 527	4 009
O01B - Caesarean Delivery +Scc										
Separations	no.	3 403	2 949	1 844	1 236	826	193	226	163	10 839
Patient days	no.	19 468	15 538	9 100	6 480	4 861	1 030	1 061	1 280	58 818
ALOS	days	5.72	5.27	4.93	5.24	5.89	5.35	4.69	7.85	5.43
Sample size (f)	no. hospitals	56	33	27	23	21	3	2	4	169
Average cost (g)	$/DRG	10 911	11 365	11 729	14 715	11 940	15 134	15 663	16 012	11 937
Direct	$/DRG	7 982	8 623	9 756	11 744	9 247	12 038	8 960	10 045	9 107
Overhead	$/DRG	2 929	2 741	1 973	2 971	2 692	3 096	6 703	5 967	2 829
O01C - Caesarean Delivery -Cscc										
Separations	no.	15 100	10 770	–	4 838	3 295	877	798	614	36 292

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
Patient days	no.	58 120	42 121	–	18 790	13 720	3 475	2 976	2 959	142 160
ALOS	days	3.85	3.91	–	3.88	4.16	3.96	3.73	4.82	3.92
Sample size (f)	no. hospitals	57	34	–	24	25	3	2	4	149
Average cost (g)	$/DRG	8 689	8 947	–	13 196	9 917	12 010	12 328	11 257	9 681
Direct	$/DRG	6 408	6 841	–	9 955	7 581	9 611	7 404	6 664	7 220
Overhead	$/DRG	2 280	2 106	–	3 240	2 337	2 399	4 923	4 593	2 462
O02A - Vaginal Delivery +Or Pr +Cscc										
Separations	no.	451	371	301	240	130	20	36	39	1 589
Patient days	no.	2 082	1 506	1 217	1 001	691	72	137	243	6 948
ALOS	days	4.61	4.06	4.05	4.17	5.29	3.54	3.81	6.23	4.37
Sample size (f)	no. hospitals	46	26	25	22	15	3	2	4	143
Average cost (g)	$/DRG	10 544	9 373	10 980	13 854	10 200	11 385	15 355	14 047	11 030
Direct	$/DRG	7 888	7 200	9 177	10 650	7 874	9 039	9 231	8 910	8 457
Overhead	$/DRG	2 656	2 173	1 803	3 204	2 327	2 346	6 124	5 137	2 573
O02B - Vaginal Delivery +Or Pr -Cscc										
Separations	no.	1 707	1 124	934	438	359	75	135	76	4 849
Patient days	no.	5 754	3 302	2 807	1 572	1 248	235	427	259	15 604
ALOS	days	3.37	2.94	3.00	3.58	3.47	3.15	3.16	3.41	3.22
Sample size (f)	no. hospitals	54	29	31	23	18	3	2	4	164
Average cost (g)	$/DRG	6 974	6 546	7 767	9 078	6 487	8 300	8 733	6 734	7 247
Direct	$/DRG	5 163	5 020	6 477	7 132	5 043	6 605	5 249	3 969	5 558
Overhead	$/DRG	1 811	1 526	1 290	1 946	1 444	1 695	3 484	2 765	1 689
O03A - Ectopic Pregnancy (h)										
Separations	no.	134	136	76	66	38	11	12	14	487
Patient days	no.	412	386	237	164	96	35	28	46	1 404

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
ALOS	days	3.07	2.85	3.13	2.49	2.50	3.14	2.33	3.29	2.89
Sample size (f)	no. hospitals	38	23	19	13	9	3	2	3	110
Average cost (g)	$/DRG	7 911	6 543	10 358	9 708	8 491	8 955	14 054	9 339	8 416
Direct	$/DRG	6 295	5 267	8 806	7 201	6 616	7 198	7 660	6 074	6 595
Overhead	$/DRG	1 616	1 276	1 552	2 507	1 874	1 757	6 393	3 265	1 821
O03B - Ectopic Pregnancy (h)										
Separations	no.	797	633	520	229	160	41	46	42	2 469
Patient days	no.	1 461	1 068	819	369	282	71	89	81	4 239
ALOS	days	1.83	1.69	1.57	1.61	1.76	1.73	1.93	1.93	1.72
Sample size (f)	no. hospitals	47	29	22	14	12	3	2	3	132
Average cost (g)	$/DRG	4 587	4 086	6 231	6 185	5 748	7 454	7 978	6 507	5 172
Direct	$/DRG	3 613	3 259	5 267	4 837	4 598	6 073	4 877	4 279	4 124
Overhead	$/DRG	974	827	963	1 348	1 150	1 381	3 102	2 228	1 048
O04A - Postpartum & Post Abortn+Or Pr (h)										
Separations	no.	65	64	63	36	14	6	9	4	260
Patient days	no.	328	383	248	185	124	15	33	27	1 344
ALOS	days	5.05	5.98	3.96	5.21	8.80	2.45	3.67	6.75	5.16
Sample size (f)	no. hospitals	29	23	16	10	7	3	2	1	91
Average cost (g)	$/DRG	9 721	11 787	9 912	13 567	13 351	4 710	15 897	19 483	11 240
Direct	$/DRG	7 560	9 537	8 322	10 818	10 833	3 831	10 646	13 427	8 959
Overhead	$/DRG	2 162	2 249	1 590	2 749	2 518	880	5 251	6 055	2 281
O04B - Postpartum & Post Abortn+Or Pr (h)										
Separations	no.	396	369	260	158	99	56	24	17	1 381
Patient days	no.	741	664	487	268	327	74	54	79	2 694
ALOS	days	1.87	1.80	1.87	1.70	3.28	1.33	2.25	4.65	1.95

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
Sample size (f)	no. hospitals	52	34	25	22	19	3	2	4	161
Average cost (g)	$/DRG	3 770	3 239	4 500	5 085	4 834	3 664	7 493	10 356	4 135
Direct	$/DRG	2 934	2 512	3 823	3 853	3 536	2 935	4 556	5 569	3 198
Overhead	$/DRG	837	726	677	1 232	1 298	730	2 937	4 787	936
O05Z - Abortion+ Or Proc										
Separations	no.	6 565	7 473	2 884	2 102	5 431	489	274	1 099	26 318
Patient days	no.	7 170	7 780	23 213	2 298	5 572	534	313	1 167	48 047
ALOS	days	1.09	1.04	8.05	1.09	1.03	1.09	1.14	1.06	1.83
Sample size (f)	no. hospitals	65	38	32	21	29	3	2	4	194
Average cost (g)	$/DRG	1 879	1 850	2 977	3 330	1 686	2 465	4 768	1 709	2 101
Direct	$/DRG	1 407	1 410	2 546	2 417	1 355	1 989	2 968	1 122	1 618
Overhead	$/DRG	472	440	432	913	331	476	1 800	587	483
O60A - Vaginal Delivery +Cscc										
Separations	no.	4 432	3 652	2 628	1 596	1 367	283	127	279	14 364
Patient days	no.	20 436	13 953	19 771	6 795	6 064	1 132	513	1 443	70 109
ALOS	days	4.61	3.82	7.52	4.26	4.44	4.01	4.04	5.17	4.88
Sample size (f)	no. hospitals	60	36	33	23	24	3	2	5	186
Average cost (g)	$/DRG	8 233	6 739	7 867	9 243	7 597	9 525	10 167	9 508	7 905
Direct	$/DRG	6 053	5 119	6 532	7 893	5 799	7 426	6 353	5 854	6 109
Overhead	$/DRG	2 180	1 620	1 335	1 350	1 797	2 099	3 814	3 653	1 796
O60B - Vaginal Delivery -Cscc										
Separations	no.	31 013	26 184	19 741	9 156	6 934	1 833	485	1 277	96 623
Patient days	no.	84 279	64 685	56 022	23 785	18 823	5 126	1 366	3 807	257 894
ALOS	days	2.72	2.47	2.84	2.60	2.71	2.80	2.82	2.98	2.67
Sample size (f)	no. hospitals	61	37	48	25	26	3	2	5	207

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*
Average cost (g)	$/DRG	5 304	4 359	5 096	5 669	4 495	5 829	6 919	5 137	4 998
Direct	$/DRG	3 863	3 307	4 223	4 660	3 408	4 584	4 347	2 975	3 834
Overhead	$/DRG	1 440	1 051	872	1 009	1 087	1 245	2 571	2 162	1 164
O60C - Vaginal Delivery + Mod Comp Dx										
Separations	no.	16 085	5 854	6 824	4 901	1 664	706	2 213	481	38 729
Patient days	no.	34 429	11 474	10 948	11 874	3 021	1 428	4 538	1 040	78 752
ALOS	days	2.14	1.96	1.60	2.42	1.82	2.02	2.05	2.16	2.03
Sample size (f)	no. hospitals	61	34	48	26	25	3	2	4	203
Average cost (g)	$/DRG	4 278	3 484	3 838	7 356	2 977	4 541	4 296	3 737	4 413
Direct	$/DRG	3 167	2 646	3 215	5 103	2 213	3 599	2 764	2 094	3 272
Overhead	$/DRG	1 111	838	622	2 252	764	942	1 532	1 642	1 141

(a) Cells with fewer than five separations have been marked 'np' for privacy concerns.

(b) Estimated population costs are obtained by weighting the sample results according to the known charactistics of the population.

(c) DRGs with few separations depict an average cost per patients that is significantly different to that reported nationally. Results for smaller jurisdictions such as Tasmania, NT and the ACT are affected by diseconomies of scale and the requirement to provide comprehensive health care to their populations. Caution should be used when interpreting this information. Due to the relatively few observations within these DRGs, smaller State/Territories (Tasmania, NT and ACT) average cost per patient is not a suitable measure if intended for comparative purposes.

(d) The effects of the interaction and relation betwee Public and Private sectors in the provision of Tasmanian health service should be considered when interpreting the data. An example of this is the Public Sector is the only provider of Intensive Care Services to the North and North West of the State.

(e) The admitted patient results from the NT will be affected by many factors distinguishing them from the average for the nation. Including, issues of remoteness, poor health status of the population, measurable high instance of chronic disease not reflected in DRG assignment, low numbers of primary care facilities and lack of community based opportunities to aid in discharge planning strategies. NT ALOS is consistently greater or equal to the national average. The reasons for this will vary from DRG to DRG, but typically it is a function of large distances travelled by the patient and there may be language issues and additional supervision prior top surgery (many Indigenous Australians do not speak English as a first language), interruption of the process due to emergency procedures, (only having a single hospital in each location), and few opportunities for those individuals suffering from chronic poverty, and a lack or responsiveness of the DRGs to the high levels of chronic illness many of the Indigenous patients suffer.

Table 10A.109 **Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0x) in selected public hospitals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c), (d)	*ACT* (c)	*NT* (c),(e)	*Aust*

(f) The sample size is the number of hospitals contributing to the cost and activity data for each AR-DRG.

(g) Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the type of hospitals contributing to the collection. Direct comparison between jurisdictions is difficult as there are differences in hospital costing systems. In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which did not include depreciation cost in 2009-10 but did in 2010-11 (Round 15).

(h) Instead of O03Z, O04Z (which are DRGs in ARDRG version 5.2), figures are according to DRGs (O03A, O03B, O04A, O04B) in AR-DRG version 6.0x)

ALOS = patient's Average Length of Stay. c = catastrophic. cc = complications and co-morbidities. Or Pr = operating room procedure. s = severe. w/o = without. w = with.

np Not published. – Nil or rounded to zero.

Source: IHPA, *NHCDC Round 14* (2009-10) v6.0x and *Round 15* (2010-11) v6.0x.

Table 10A.110 Average length of stay for selected maternity AR-DRG (version 6.0x) 2011-12 (a)

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
O01C	Caesarean delivery without catastrophic or severe CC									
	ALOS (days)									
	Public	3.9	3.8	3.4	3.8	4.1	3.8	3.9	4.6	3.8
	Private	5.2	5	4.6	5.3	5.2	np	np	np	5
	Total	4.3	4.2	3.9	4.5	4.5	np	np	np	4.2
	Separations									
	Public	15 347	11 515	9 111	4 490	3 512	803	913	671	46 362
	Private	8 446	7 007	6 959	4 028	1 615	np	np	np	29 487
	Total	23 793	18 522	16 070	8 518	5 127	np	np	np	75 849
O60C	Vaginal delivery single uncomplicated									
	ALOS (days)									
	Public	1.8	1.8	1.6	1.9	1.8	2	1.4	2	1.8
	Private	3.8	3.9	3.4	3.5	3.9	np	np	np	3.6
	Total	2.1	2.2	1.9	2.2	2.1	np	np	np	2.1
	Separations									
	Public	9 770	6 008	6 833	2 438	1 892	695	568	449	28 653
	Private	1 469	1 301	1 300	626	301	np	np	np	5 536
	Total	11 239	7 309	8 133	3 064	2 193	np	np	np	34 189

(a) Separations for which the care type was reported as Acute, Newborn (with qualified days) or was not reported. Excludes separations where the length of stay was greater than 120 days. Average length of stay suppressed for private hospitals in Tasmania, the ACT and the NT, or if fewer than 50 separations were reported.

np Not published.

CC=complications and comorbidities

Source: AIHW 2013, *Australian Hospital Statistics 2011-12* , Health Services Series No. 50, Cat no. HSE 134, AIHW, Canberra.

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
2003										
Birthweight less than 1500g	no. of live births	787	539	488	208	191	52	57	38	2 360
Apgar score 0	% of live births	1.8	3.2	3.3	2.4	2.1	1.9	3.5	5.3	2.6
Apgar score 1-3	% of live births	11.7	16.1	7.8	5.3	9.9	3.9	15.8	7.9	11.0
Apgar score 4-6	% of live births	12.1	11.5	10.7	12.0	6.8	5.8	24.6	13.2	11.4
Apgar score 7-10	% of live births	73.3	68.5	77.7	79.3	81.2	88.5	56.1	73.7	74.2
Birthweight 1500-1999g	no. of live births	913	627	492	251	204	66	69	47	2 669
Apgar score 0	% of live births	0.1	0.2	0.2	–	–	–	–	–	0.1
Apgar score 1-3	% of live births	0.8	1.6	1.4	1.6	–	1.5	–	2.1	1.1
Apgar score 4-6	% of live births	5.0	3.0	3.1	2.8	2.0	4.6	4.4	8.5	3.8
Apgar score 7-10	% of live births	93.4	95.1	94.9	95.6	98.0	93.9	95.7	89.4	94.7
Birthweight 2000-2499g	no. of live births	2 596	1 878	1 445	713	534	133	140	198	7 637
Apgar score 0	% of live births	–	0.1	–	0.1	0.4	–	–	–	0.1
Apgar score 1-3	% of live births	0.5	0.3	0.3	0.6	0.7	0.8	0.7	–	0.4
Apgar score 4-6	% of live births	2.3	1.8	2.0	1.5	2.1	1.5	0.7	5.6	2.1
Apgar score 7-10	% of live births	96.8	97.5	97.7	97.5	96.8	97.8	98.6	94.4	97.2
Birthweight 2500g and over	no. of live births	60 606	40 478	31 674	13 295	11 715	2 901	2 842	2 529	166 040
Apgar score 0	% of live births	–	–	–	–	–	–	–	–	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.2	0.1
Apgar score 4-6	% of live births	1.1	0.9	0.8	0.8	0.9	1.0	0.8	1.2	0.9
Apgar score 7-10	% of live births	98.6	98.8	99.0	99.0	98.9	98.8	99.0	98.5	98.8
2004										
Birthweight less than 1500g	no. of live births	813	544	483	270	190	49	60	51	2 460
Apgar score 0	% of live births	1.6	2.0	5.0	2.2	2.1	–	–	3.9	2.4
Apgar score 1-3	% of live births	12.2	13.6	12.4	5.6	13.7	4.1	10.0	17.7	11.8
Apgar score 4-6	% of live births	12.9	7.4	9.3	10.4	6.3	8.2	13.3	11.8	10.1

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Apgar score 7-10	% of live births	72.1	75.7	72.7	81.1	77.9	87.8	76.7	66.7	74.7
Birthweight 1500-1999g	no. of live births	910	575	512	280	213	50	89	34	2 663
Apgar score 0	% of live births	0.1	–	–	–	–	–	–	–	–
Apgar score 1-3	% of live births	0.9	0.9	0.8	0.7	–	–	1.1	–	0.8
Apgar score 4-6	% of live births	5.0	2.6	2.9	1.4	2.8	6.0	5.6	–	3.5
Apgar score 7-10	% of live births	93.9	96.3	96.3	97.1	97.2	94.0	93.3	100.0	95.5
Birthweight 2000-2499g	no. of live births	2 593	1 926	1 488	690	558	159	166	175	7 755
Apgar score 0	% of live births	–	0.1	0.1	–	–	–	–	–	0.1
Apgar score 1-3	% of live births	0.5	0.3	0.5	0.1	0.5	–	0.6	0.6	0.4
Apgar score 4-6	% of live births	1.9	2.2	2.0	2.5	3.4	1.3	1.2	4.0	2.2
Apgar score 7-10	% of live births	97.1	97.1	97.2	97.1	96.1	98.8	98.2	95.4	97.1
Birthweight 2500g and over	no. of live births	60 011	40 353	31 948	13 662	11 601	2 949	2 777	2 451	165 752
Apgar score 0	% of live births	–	–	–	–	–	–	0.1	–	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.1
Apgar score 4-6	% of live births	1.0	0.9	0.9	0.7	0.8	1.4	1.0	1.9	0.9
Apgar score 7-10	% of live births	98.6	98.8	98.9	99.1	99.1	98.5	98.7	97.8	98.8
2005										
Birthweight less than 1500g	no. of live births	767	620	484	267	240	44	69	46	2 537
Apgar score 0	% of live births	3.3	2.3	3.7	1.5	2.1	2.3	2.9	4.4	2.8
Apgar score 1-3	% of live births	15.1	16.9	11.4	8.6	13.3	6.8	7.3	19.6	13.7
Apgar score 4-6	% of live births	12.8	10.8	8.1	10.9	7.9	11.4	11.6	10.9	10.6
Apgar score 7-10	% of live births	67.4	68.9	76.5	78.3	76.7	79.5	78.3	65.2	72.0
Birthweight 1500-1999g	no. of live births	910	586	565	282	224	52	66	59	2 744
Apgar score 0	% of live births	–	0.2	–	0.4	–	–	–	–	0.1
Apgar score 1-3	% of live births	1.4	0.7	0.7	1.1	–	–	1.5	–	0.9
Apgar score 4-6	% of live births	4.2	3.9	2.8	3.9	4.5	1.9	3.0	3.4	3.7

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Apgar score 7-10	% of live births	93.5	94.7	96.5	94.7	95.5	98.1	95.5	96.6	94.9
Birthweight 2000-2499g	no. of live births	2 701	1 953	1 650	741	621	174	159	169	8 168
Apgar score 0	% of live births	0.1	0.1	–	–	–	0.5	–	–	0.1
Apgar score 1-3	% of live births	0.4	0.5	0.4	0.3	0.3	–	1.3	1.2	0.4
Apgar score 4-6	% of live births	2.5	2.4	1.6	1.6	2.1	1.7	0.6	2.4	2.1
Apgar score 7-10	% of live births	96.4	96.9	97.7	97.8	97.6	97.1	98.1	96.5	97.0
Birthweight 2500g and over	no. of live births	62 819	42 376	34 917	14 659	12 078	3 652	2 811	2 607	175 919
Apgar score 0	% of live births	–	–	–	–	–	–	–	0.1	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1
Apgar score 4-6	% of live births	1.0	0.9	0.7	0.8	1.3	1.0	0.6	2.1	0.9
Apgar score 7-10	% of live births	98.7	98.9	99.1	99.1	98.6	98.9	99.3	97.6	98.8
2006										
Birthweight less than 1500g	no. of live births	1 014	455	585	299	196	40	75	52	2 716
Apgar score 0	% of live births	3.7	2.4	3.2	2.3	2.0	2.5	–	–	2.9
Apgar score 1-3	% of live births	10.6	12.6	13.2	7.4	4.6	7.5	18.7	17.3	11.0
Apgar score 4-6	% of live births	12.5	12.6	9.2	13.0	9.7	20.0	5.3	7.7	11.5
Apgar score 7-10	% of live births	71.4	71.4	73.7	76.3	83.7	70.0	76.0	75.0	73.5
Birthweight 1500-1999g	no. of live births	1 012	641	590	308	193	54	73	56	2 927
Apgar score 0	% of live births	0.2	0.1	–	–	–	1.9	–	5.4	0.2
Apgar score 1-3	% of live births	1.1	1.2	1.0	0.3	–	1.9	–	–	0.9
Apgar score 4-6	% of live births	5.1	4.7	3.7	4.9	3.1	3.7	5.5	–	4.5
Apgar score 7-10	% of live births	93.2	93.7	95.1	94.8	96.9	92.6	94.5	94.6	94.1
Birthweight 2000-2499g	no. of live births	2 872	2 042	1 673	798	616	194	172	187	8 554
Apgar score 0	% of live births	–	0.1	0.1	–	–	–	–	–	0.1
Apgar score 1-3	% of live births	0.5	0.4	0.3	0.6	0.5	0.5	1.7	–	0.4
Apgar score 4-6	% of live births	1.9	2.1	1.4	2.8	2.1	1.0	3.5	1.6	2.0

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Apgar score 7-10	% of live births	97.0	97.1	97.5	96.6	97.4	98.5	94.8	98.4	97.2
Birthweight 2500g and over	no. of live births	64 305	44 192	35 847	15 735	12 538	3 845	3 145	2 637	182 244
Apgar score 0	% of live births	–	–	–	–	–	0.1	–	0.1	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1
Apgar score 4-6	% of live births	1.0	0.9	0.7	0.8	1.0	0.9	1.1	1.7	0.9
Apgar score 7-10	% of live births	98.6	98.8	99.1	99.0	98.9	99.0	98.7	98.1	98.8
2007										
Birthweight less than 1500g	no. of live births	774	658	543	289	215	71	64	57	2 671
Apgar score 0	% of live births	2.1	3.0	2.6	1.4	1.4	9.9	1.6	–	2
Apgar score 1-3	% of live births	13.8	14.3	10.3	8.0	11.2	5.6	21.9	14.0	12
Apgar score 4-6	% of live births	14.3	15.5	12.0	15.9	9.3	9.9	18.8	22.8	14
Apgar score 7-10	% of live births	69.8	66.1	74.4	74.7	78.1	74.7	57.8	59.6	71
Birthweight 1500-1999g	no. of live births	942	712	610	344	195	88	89	45	3 025
Apgar score 0	% of live births	0.1	0.1	–	–	–	–	–	–	0
Apgar score 1-3	% of live births	1.7	1.1	1.1	1.2	0.5	1.1	–	–	1
Apgar score 4-6	% of live births	5.4	5.1	5.2	5.2	7.2	–	6.7	8.8	5
Apgar score 7-10	% of live births	92.8	93.4	93.1	93.0	92.3	98.9	93.3	88.9	93
Birthweight 2000-2499g	no. of live births	2 827	2 067	1 667	858	653	261	165	166	8 664
Apgar score 0	% of live births	–	–	0.1	0.1	0.2	–	–	–	0
Apgar score 1-3	% of live births	0.6	0.5	0.5	0.2	0.5	–	–	1.8	0
Apgar score 4-6	% of live births	2.9	3.1	1.6	2.2	1.5	1.2	–	3.0	2
Apgar score 7-10	% of live births	96.4	96.1	97.7	97.2	97.9	98.9	97.6	95.8	97
Birthweight 2500g and over	no. of live births	66 970	46 496	38 689	16 110	13 194	5 849	3 304	2 721	193 333
Apgar score 0	% of live births	–	–	–	–	–	0.2	–	–	0
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0
Apgar score 4-6	% of live births	1.0	1.2	0.7	1.0	1.1	0.9	1.2	1.8	1

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Apgar score 7-10	% of live births	98.9	98.6	99.0	98.8	98.7	98.9	98.5	97.8	98.8
2008										
Birthweight less than 1500g	no. of live births	849	628	564	298	204	53	65	47	2 708
Apgar score 0	% of live births	3.1	3.0	2.1	1.3	1.5	9.4	–	6.4	2.7
Apgar score 1-3	% of live births	17.1	13.5	14.2	7.4	14.2	9.4	15.4	14.9	14.1
Apgar score 4-6	% of live births	14.6	19.9	12.8	17.8	9.3	7.6	30.8	23.4	15.8
Apgar score 7-10	% of live births	64.2	63.5	70.4	73.5	75.0	73.6	53.9	53.2	66.9
Birthweight 1500-1999g	no. of live births	1 052	628	602	332	240	98	74	43	3 069
Apgar score 0	% of live births	0.3	3.0	–	0.3	–	–	1.4	–	0.8
Apgar score 1-3	% of live births	0.8	13.5	1.5	0.6	0.8	2.0	4.1	2.3	3.6
Apgar score 4-6	% of live births	5.6	19.9	5.3	6.6	3.3	4.1	16.2	4.7	8.6
Apgar score 7-10	% of live births	93.3	63.5	92.9	92.5	95.8	93.9	78.4	93.0	86.9
Birthweight 2000-2499g	no. of live births	2 880	1 985	1 706	817	605	290	159	185	8 627
Apgar score 0	% of live births	0.1	0.1	0.1	–	–	0.3	–	–	0.1
Apgar score 1-3	% of live births	0.6	0.4	0.5	0.6	0.3	0.3	–	–	0.5
Apgar score 4-6	% of live births	2.4	3.2	1.8	1.7	2.8	1.7	1.3	1.1	2.4
Apgar score 7-10	% of live births	96.2	96.3	97.5	97.4	96.9	97.6	98.7	98.4	96.8
Birthweight 2500g and over	no. of live births	67 810	46 453	39 344	16 439	13 402	5 959	3 367	2 742	195 516
Apgar score 0	% of live births	–	–	–	–	–	0.2	–	0.1	–
Apgar score 1-3	% of live births	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.1	0.1
Apgar score 4-6	% of live births	1.0	1.3	0.8	1.0	0.9	0.8	1.6	1.6	1.0
Apgar score 7-10	% of live births	98.5	98.6	99.0	98.9	99.0	99.0	98.0	98.1	98.7
2009										
Birthweight less than 1500g	no. of live births	829	668	537	327	222	52	68	52	2 755
Apgar score 0	% of live births	2.1	1.5	3.7	2.1	2.3	1.9	1.5	1.9	2.3

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Apgar score 1-3	% of live births	17.0	15.1	12.7	7.3	7.2	23.1	8.8	21.2	13.8
Apgar score 4-6	% of live births	11.8	13.9	14.3	17.1	8.6	9.6	27.9	9.6	13.5
Apgar score 7-10	% of live births	67.4	65.6	66.7	72.8	82.0	65.4	61.8	67.3	68.5
Birthweight 1500-1999g	no. of live births	933	792	618	325	260	89	67	61	3 145
Apgar score 0	% of live births	0.3	0.4	–	0.6	–	1.1	–	–	0.3
Apgar score 1-3	% of live births	0.9	1.3	0.8	1.2	1.5	–	4.5	1.6	1.1
Apgar score 4-6	% of live births	4.5	7.2	4.5	9.2	5.0	4.5	10.5	13.1	6.0
Apgar score 7-10	% of live births	93.9	90.7	94.3	88.6	93.5	94.4	85.1	83.4	92.2
Birthweight 2000-2499g	no. of live births	2 847	2 051	1 843	837	669	256	184	204	8 891
Apgar score 0	% of live births	–	0.1	–	–	–	–	–	–	0.0
Apgar score 1-3	% of live births	0.6	0.5	0.8	0.4	0.1	–	1.1	–	0.5
Apgar score 4-6	% of live births	2.9	3.1	2.3	3.1	4.2	2.0	3.8	3.4	2.9
Apgar score 7-10	% of live births	96.0	96.2	96.7	96.3	98.8	98.1	95.1	96.6	96.5
Birthweight 2500g and over	no. of live births	67 545	47 142	39 765	16 591	13 345	5 920	3 540	2 749	196 597
Apgar score 0	% of live births	–	0.0	–	–	–	0.2	0.1	–	–
Apgar score 1-3	% of live births	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Apgar score 4-6	% of live births	1.1	1.3	1.0	1.1	1.1	0.8	1.8	1.7	1.2
Apgar score 7-10	% of live births	98.4	98.3	98.7	98.7	98.8	98.9	98.1	98.2	98.5
2010										
Birthweight less than 1500g	no. of live births	841	668	585	277	214	90	74	54	2 803
Apgar score 0	% of live births	2.0	1.5	3.2	1.4	0.9	4.4	1.4	–	2.0
Apgar score 1-3	% of live births	14.9	15.1	15.7	6.9	10.3	7.8	16.2	18.5	13.8
Apgar score 4-6	% of live births	15.1	13.9	16.1	16.3	9.3	13.3	12.2	24.1	14.7
Apgar score 7-10	% of live births	67.3	65.6	63.9	75.5	79.4	74.5	70.3	57.4	68.0

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Birthweight 1500-1999g	no. of live births	964	792	603	300	261	93	73	55	3 141
Apgar score 0	% of live births	–	0.4	0.2	–	0.4	1.1	1.4	–	0.2
Apgar score 1-3	% of live births	1.5	1.3	1.5	1.3	0.8	–	–	1.8	1.3
Apgar score 4-6	% of live births	5.0	7.2	5.6	8.3	5.0	2.2	5.5	9.1	6.0
Apgar score 7-10	% of live births	93.0	90.7	92.2	90.3	93.9	96.8	93.2	89.1	92.1
Birthweight 2000-2499g	no. of live births	2 852	2 051	1 796	800	659	269	179	163	8 769
Apgar score 0	% of live births	–	0.1	0.1	0.1	–	–	0.6	–	0.1
Apgar score 1-3	% of live births	0.6	0.5	0.5	0.1	0.2	–	0.6	1.2	0.5
Apgar score 4-6	% of live births	2.9	3.1	3.2	3.8	2.0	1.9	2.2	3.7	3.0
Apgar score 7-10	% of live births	96.1	96.2	96.0	95.6	97.9	98.1	96.7	95.1	96.3
Birthweight 2500g and over	no. of live births	66 894	47 142	39 878	16 727	13 462	5 643	3 726	2 758	196 230
Apgar score 0	% of live births	–	–	–	–	–	0.2	0.1	–	–
Apgar score 1-3	% of live births	0.2	0.2	0.2	0.1	0.1	0.1	0.3	0.2	0.2
Apgar score 4-6	% of live births	1.1	1.3	1.0	1.3	1.2	1.2	1.1	1.7	1.2
Apgar score 7-10	% of live births	98.4	98.3	98.8	98.6	98.7	98.5	98.6	98.1	98.5
2011										
Birthweight less than 1500g	no. of live births	884	601	563	283	204	79	81	55	2 750
Apgar score 0	% of live births	3.5	3.5	2.7	1.8	2.9	–	–	np	na
Apgar score 1-3	% of live births	14.5	13.0	13.5	6.0	3.9	7.6	17.3	9.1	12.1
Apgar score 4-6	% of live births	13.1	13.5	16.7	17.7	14.2	17.7	17.3	9.1	14.7
Apgar score 7-10	% of live births	68.0	65.1	66.1	74.2	78.9	74.7	65.4	78.2	68.7
Birthweight 1500-1999g	no. of live births	941	730	635	290	242	98	104	64	3 104
Apgar score 0	% of live births	0.4	0.1	0.2	–	–	–	–	–	0.2
Apgar score 1-3	% of live births	1.1	1.2	0.9	0.3	0.8	3.1	2.9	np	na
Apgar score 4-6	% of live births	7.0	9.3	5.8	5.9	4.5	3.1	7.7	7.8	6.9
Apgar score 7-10	% of live births	91.0	89.3	92.9	93.5	94.6	93.9	89.4	90.6	91.5

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Birthweight 2000-2499g	no. of live births	2 955	2 148	1 728	849	752	300	204	196	9 132
Apgar score 0	% of live births	0.1	0.1	–	–	–	–	–	np	na
Apgar score 1-3	% of live births	0.8	0.7	1.1	0.5	0.1	0.3	–	–	0.7
Apgar score 4-6	% of live births	2.4	3.2	3.0	4.1	3.6	2.3	6.4	3.1	3.1
Apgar score 7-10	% of live births	96.2	95.9	95.7	95.5	96.3	97.3	93.6	96.4	96.0
Birthweight 2500g and over	no. of live births	68 594	48 033	40 503	17 398	13 958	5 812	3 676	2 748	200 722
Apgar score 0	% of live births	–	–	–	–	–	–	–	–	–
Apgar score 1-3	% of live births	0.2	0.2	0.2	0.1	0.1	0.1	0.2	np	na
Apgar score 4-6	% of live births	1.2	1.4	1.0	1.2	1.4	1.1	1.6	1.6	1.2
Apgar score 7-10	% of live births	98.3	98.4	98.7	98.6	98.5	98.7	98.1	98.3	98.5
2012										
Birthweight less than 1500g	no. of live births	913	658	588	295	227	na	81	44	2 806
Apgar score 0	% of live births	3.1	2.1	2.6	1.0	2.6	na	2.5	np	na
Apgar score 1-3	% of live births	14.6	15.4	14.5	3.1	10.1	na	9.9	np	na
Apgar score 4-6	% of live births	14.1	17.5	14.5	16.6	10.6	na	17.3	20.5	na
Apgar score 7-10	% of live births	67.5	63.8	67.0	79.0	76.7	na	70.4	70.5	na
Birthweight 1500-1999g	no. of live births	1 364	754	638	311	281	na	80	47	3 475
Apgar score 0	% of live births	0.3	0.1	–	–	0.4	na	–	–	na
Apgar score 1-3	% of live births	1.0	0.9	2.2	1.3	0.4	na	–	np	na
Apgar score 4-6	% of live births	5.5	6.9	4.9	6.8	3.9	na	10.0	np	na
Apgar score 7-10	% of live births	92.6	91.6	92.8	92.0	95.4	na	90.0	95.7	na
Birthweight 2000-2499g	no. of live births	3 630	2 253	1 884	873	742	na	212	188	9 782
Apgar score 0	% of live births	–	0.1	–	–	–	na	–	–	na
Apgar score 1-3	% of live births	0.6	0.5	0.6	0.5	0.1	na	0.5	np	na
Apgar score 4-6	% of live births	2.6	3.3	3.0	4.2	3.0	na	3.8	3.2	na
Apgar score 7-10	% of live births	96.3	96.0	96.4	95.2	96.9	na	95.8	96.3	na

Table 10A.111 **Baby's Apgar scores at five minutes, by birthweight, public hospitals**

	Unit	*NSW*	*Vic* (a)	*Qld*	*WA* (b)	*SA* (c)	*Tas*	*ACT* (d)	*NT* (e)	*Aust*
Birthweight 2500g and over	no. of live births	73 524	52 201	41 475	18 090	14 239	na	4 206	2 896	206 631
Apgar score 0	% of live births	–	–	–	–	–	na	–	np	na
Apgar score 1-3	% of live births	0.2	0.2	0.2	0.1	0.1	na	0.2	0.3	na
Apgar score 4-6	% of live births	1.1	1.5	1.2	1.4	1.4	na	2.1	1.5	na
Apgar score 7-10	% of live births	98.3	98.2	98.5	98.4	98.5	na	97.7	98.1	na

(a) Data for 2012 for Victoria are preliminary.

(b) Data for WA for 2012 are preliminary. The low Apgar rate for 2012 would seem to indicate that babies belonging in the numerator were not available for reporting at the time of extract.

(c) SA data exclude live births if Apgar scores are not recorded. Data for 2012 are preliminary.

(d) Data for 2012 are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2006 and 2009, 15.0 per cent of women who gave birth in the ACT were non-residents of the ACT.

(e) 2005 data exclude one baby with birthweight 0–1499g with unknown Apgar score.

na Not available. – Nil or rounded to zero.

Source : State and Territory governments (unpublished).

Table 10A.112 **Fetal deaths (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT (b)	NT	Aust (b) (c)
2002										
Total all births (d)	no.	85 537	62 691	47 963	23 729	17 760	6 038	4 789	3 695	252 202
Fetal deaths (e), (f)	no.	350	352	245	108	96	49	21	19	1 240
Fetal death rate	per 1000 total relevant births	4.1	5.6	5.1	4.6	5.4	8.1	4.4	5.1	4.9
2003										
Total all births (d)	no.	86 772	61 498	48 644	24 465	17 584	5 808	4 159	3 838	252 799
Fetal deaths (e), (f)	no.	428	440	302	192	141	56	31	48	1 638
Fetal death rate	per 1000 total relevant births	4.9	7.2	6.2	7.8	8.0	9.6	7.5	12.5	6.5
2004										
Total all births (d)	no.	86 367	62 919	50 275	25 492	17 263	5 853	4 199	3 577	255 971
Fetal deaths (e), (f)	no.	473	502	335	197	123	44	25	26	1 725
Fetal death rate	per 1000 total relevant births	5.5	8.0	6.7	7.7	7.1	7.5	6.0	7.3	6.7
2005										
Total all births (d)	no.	87 083	63 811	52 048	26 444	17 910	6 361	4 242	3 701	261 628
Fetal deaths (e), (f)	no.	494	524	387	191	110	53	36	42	1 837
Fetal death rate	per 1000 total relevant births	5.7	8.2	7.4	7.2	6.1	8.3	8.5	11.3	7.0
2006										
Total all births (d)	no.	87 856	65 583	53 024	27 940	18 342	6 518	4 520	3 735	267 544
Fetal deaths (e), (f)	no.	520	347	359	164	82	43	41	39	1 595
Fetal death rate	per 1000 total relevant births	5.9	5.3	6.8	5.9	4.5	6.6	9.1	10.4	6.0
2007										
Total all births (d)	no.	89 991	70 720	61 683	29 325	19 740	6 703	4 783	3 923	286 889
Fetal deaths (e), (f)	no.	496	407	434	161	78	41	30	29	1 676
Fetal death rate	per 1000 total relevant births	5.5	5.8	7.0	5.5	4.0	6.1	6.3	7.4	5.8
2008										
Total all births (d)	no.	95 152	71 555	63 554	32 051	20 324	6 822	4 818	3 963	298 269

Table 10A.112 **Fetal deaths (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT (b)	NT	Aust (b) (c)
Fetal deaths (e), (f)	no.	468	380	422	201	95	47	14	21	1 648
Fetal death rate	per 1000 total relevant births	4.9	5.3	6.6	6.3	4.7	6.9	2.9	5.3	5.5
2009										
Total all births (d)	no.	93 278	71 352	66 538	31 093	19 809	6 683	4 883	3 858	297 518
Fetal deaths (e), (f)	no.	495	432	441	215	75	57	25	39	1 780
Fetal death rate	per 1000 total relevant births	5.3	6.1	6.7	7.0	3.8	8.6	5.1	10.2	6.0
2010										
Total all births (d)	no.	96 417	70 975	64 908	31 609	20 154	6 439	5 221	3 930	299 670
Fetal deaths (e), (f)	no.	499	407	441	185	78	54	72	31	1 767
Fetal death rate	per 1000 total relevant births	5.2	5.7	6.8	5.9	3.9	8.4	13.8	7.9	5.9
2011										
Total all births (d)	no.	99 567	71 844	63 630	32 513	19 981	6 657	5 149	3 988	303 365
Fetal deaths (e), (f)	no.	513	400	377	254	89	49	28	34	1 748
Fetal death rate	per 1000 total relevant births	5.2	5.6	5.9	7.8	4.5	7.4	5.4	8.5	5.8

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table is 2010 (preliminary). See ABS Causes of Death (cat. no. 3303.0) 2010 Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.

(b) Data may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data will be included in the 2010 reference year.

(c) All states and territories, including other territories

(d) All births is the number of live births and fetal deaths combined. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

(e) Perinatal deaths (including fetal deaths) for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(f) Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

Source : ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Table 10A.113 **Neonatal deaths (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (b)*
2002										
Total live births (c)	no.	86 575	61 478	47 771	23 600	17 656	6 002	4 112	3 717	250 962
Neonatal deaths (d), (e)	no.	232	202	179	52	50	24	21	19	779
Neonatal death rate	per 1000 live births	2.7	3.3	3.7	2.2	2.8	4.0	5.1	5.1	3.1
2003										
Total live births (c)	no.	86 344	61 058	48 342	24 273	17 443	5 752	4 128	3 790	251 161
Neonatal deaths (d), (e)	no.	272	250	153	62	40	27	16	21	841
Neonatal death rate	per 1000 live births	3.2	4.1	3.2	2.6	2.3	4.7	3.9	5.5	3.3
2004										
Total live births (c)	no.	85 894	62 417	49 940	25 295	17 140	5 809	4 174	3 551	254 246
Neonatal deaths (d), (e)	no.	272	206	186	55	36	15	25	21	816
Neonatal death rate	per 1000 live births	3.2	3.3	3.7	2.2	2.1	2.6	6.0	5.9	3.2
2005										
Total live births (c)	no.	86 589	63 287	51 661	26 253	17 800	6 308	4 206	3 659	259 791
Neonatal deaths (d), (e)	no.	309	242	192	76	59	13	20	21	932
Neonatal death rate	per 1000 live births	3.6	3.8	3.7	2.9	3.3	2.1	4.8	5.7	3.6
2006										
Total live births (c)	no.	87 336	65 236	52 665	27 776	18 260	6 475	4 479	3 696	265 949
Neonatal deaths (d), (e)	no.	301	201	185	93	33	16	15	20	864
Neonatal death rate	per 1000 live births	3.4	3.1	3.5	3.3	1.8	2.5	3.3	5.4	3.2
2007										
Total live births (c)	no.	89 495	70 313	61 249	29 164	19 662	6 662	4 753	3 894	285 213
Neonatal deaths (d), (e)	no.	286	200	218	40	55	21	15	21	856
Neonatal death rate	per 1000 live births	3.2	2.8	3.6	1.4	2.8	3.2	3.2	5.4	3.0
2008										
Total live births (c)	no.	94 684	71 175	63 132	31 850	20 229	6 775	4 804	3 942	296 621

Table 10A.113 **Neonatal deaths (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust (b)*
Neonatal deaths (d), (e)	no.	317	187	209	60	37	15	17	10	853
Neonatal death rate	per 1000 live births	3.3	2.6	3.3	1.9	1.8	2.2	3.5	2.5	2.9
2009										
Total live births (c)	no.	92 783	70 920	66 097	30 878	19 734	6 626	4 858	3 819	295 738
Neonatal deaths (d), (e)	no.	287	204	253	58	48	14	9	18	891
Neonatal death rate	per 1000 live births	3.1	2.9	3.8	1.9	2.4	2.1	1.9	4.7	3.0
2010										
Total live births (c)	no.	95 918	70 568	64 467	31 424	20 076	6 385	5 149	3 899	297 903
Neonatal deaths (d), (e)	no.	279	159	243	68	44	16	15	18	842
Neonatal death rate	per 1000 live births	2.9	2.3	3.8	2.2	2.2	2.5	2.9	4.6	2.8
2011										
Total live births (c)	no.	99 054	71 444	63 253	32 259	19 892	6 608	5 121	3 954	301 617
Neonatal deaths (d), (e)	no.	293	185	199	63	30	18	9	17	814
Neonatal death rate	per 1000 live births	3.0	2.6	3.1	2.0	1.5	2.7	1.8	4.3	2.7

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table is 2010 (preliminary). See ABS Causes of Death (cat. no. 3303.0) 2010 Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.

(b) All states and territories, including other territories

(c) Total live births are all live births registered in the calendar year.

(d) Perinatal deaths (including neonatal deaths) for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(e) A neonatal death is the death within 28 days of birth of a child who after delivery, breathes or shows any evidence of life such as a heartbeat.

Source : ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Table 10A.114 **Neonatal, fetal and perinatal death rates, Australia (a)**

	Fetal death rate (b)	*Neonatal death rate* (c)	*Perinatal death rate* (d)
1999	5.1	3.4	8.5
2000	5.2	3.1	8.3
2001	5.2	3.3	8.4
2002	4.9	3.1	8.0
2003	6.5	3.3	9.8
2004	6.7	3.2	9.9
2005	7.0	3.6	10.6
2006	6.0	3.2	9.2
2007	5.8	3.0	8.8
2008	5.5	2.9	8.4
2009	6.0	3.0	9.0
2010	5.9	2.8	8.7
2011	5.8	2.7	8.4

(a) Perinatal deaths (including fetal and neonatal deaths) for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(b) Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

(c) A neonatal death is the death within 28 days of birth of a child who after delivery, breathes or shows any evidence of life such as a heartbeat.

(d) Perinatal deaths are fetal and neonatal deaths combined. Fetal deaths exclude those records where gestational age was less than 20 weeks or birthweight was known to be less than 400 grams.

Source : ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Table 10A.115 **Perinatal deaths (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT (b)	NT	Aust (b) (c)
2002										
Total all births (d)	no.	85 537	62 691	47 963	23 729	17 760	6 038	4 789	3 695	252 202
Perinatal deaths (e), (f)	no.	582	554	424	160	146	73	42	38	2 019
Perinatal death rate	per 1000 total births	6.8	8.8	8.8	6.7	8.2	12.1	8.8	10.3	8.0
2003										
Total all births (d)	no.	86 772	61 498	48 644	24 465	17 584	5 808	4 159	3 838	252 799
Perinatal deaths (e), (f)	no.	700	690	455	254	181	83	47	69	2 479
Perinatal death rate	per 1000 total births	8.1	11.2	9.4	10.4	10.3	14.3	11.3	18.0	9.8
2004										
Total all births (d)	no.	86 367	62 919	50 275	25 492	17 263	5 853	4 199	3 577	255 971
Perinatal deaths (e), (f)	no.	745	708	521	252	159	59	50	47	2 541
Perinatal death rate	per 1000 total births	8.6	11.3	10.4	9.9	9.2	10.1	11.9	13.1	9.9
2005										
Total all births (d)	no.	87 083	63 811	52 048	26 444	17 910	6 361	4 242	3 701	261 628
Perinatal deaths (e), (f)	no.	803	766	579	267	169	66	56	63	2 769
Perinatal death rate	per 1000 total births	9.2	12.0	11.1	10.1	9.4	10.4	13.2	17.0	10.6
2006										
Total all births (d)	no.	87 856	65 583	53 024	27 940	18 342	6 518	4 520	3 735	267 544
Perinatal deaths (e), (f)	no.	821	548	544	257	115	59	56	59	2 459
Perinatal death rate	per 1000 total births	9.3	8.4	10.3	9.2	6.3	9.1	12.4	15.8	9.2
2007										
Total all births (d)	no.	89 991	70 720	61 683	29 325	19 740	6 703	4 783	3 923	286 889
Perinatal deaths (e), (f)	no.	782	607	652	201	133	62	45	50	2 532
Perinatal death rate	per 1000 total births	8.7	8.6	10.6	6.9	6.7	9.2	9.4	12.7	8.8
2008										
Total all births (d)	no.	95 152	71 555	63 554	32 051	20 324	6 822	4 818	3 963	298 269

Table 10A.115 **Perinatal deaths (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT (b)	NT	Aust (b) (c)
Perinatal deaths (e), (f)	no.	785	567	631	261	132	62	31	31	2 501
Perinatal death rate	per 1000 total births	8.2	7.9	9.9	8.1	6.5	9.1	6.4	7.8	8.4
2009										
Total all births (d)	no.	93 278	71 352	66 538	31 093	19 809	6 683	4 883	3 858	297 518
Perinatal deaths (e), (f)	no.	782	636	694	273	123	71	34	57	2 671
Perinatal death rate	per 1000 total births	8.4	8.9	10.4	8.8	6.2	10.6	7.0	14.8	9.0
2010										
Total all births (d)	no.	96 417	70 975	64 908	31 609	20 154	6 439	5 221	3 930	299 670
Perinatal deaths (e), (f)	no.	778	566	684	253	122	70	87	49	2 609
Perinatal death rate	per 1000 total births	8.1	8.0	10.5	8.0	6.1	10.9	16.7	12.5	8.7
2011										
Total all births (d)	no.	99 567	71 844	63 630	32 513	19 981	6 657	5 149	3 988	303 365
Perinatal deaths (e), (f)	no.	806	585	576	317	119	67	37	51	2 562
Perinatal death rate	per 1000 total births	8.1	8.1	9.1	9.7	6.0	10.1	7.2	12.8	8.4

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table is 2010 (preliminary). See ABS Causes of Death (cat. no. 3303.0) 2010 Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.

(b) Data may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data will be included in the 2010 reference year.

(c) All states and territories, including other territories

(d) Total all births is the number live births and fetal deaths combined. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

(e) Perinatal deaths for years 2003-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(f) Perinatal deaths are fetal and neonatal deaths combined. Fetal deaths exclude those records where gestational age was less than 20 weeks or birthweight was known to be less than 400 grams.

Table 10A.115 **Perinatal deaths (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT (b)*	*NT*	*Aust (b) (c)*

Source : ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total (d)*
2003–2007										
Fetal deaths (e)										
Indigenous										
Total all births (f)	no.	17 251	na	18 593	9 279	3 515	na	na	7 892	56 530
Fetal deaths	no.	89	na	155	79	25	na	na	108	456
Fetal death rate	per 1000 total births	5.2	na	8.3	8.5	7.1	na	na	13.7	8.1
Non-Indigenous (g)										
Total all births (f)	no.	420 818	na	247 081	124 387	87 324	na	na	10 882	890 492
Fetal deaths	no.	2 322	na	1 662	826	509	na	na	76	5 395
Fetal death rate	per 1000 total births	5.5	na	6.7	6.6	5.8	na	na	7.0	6.1
Neonatal deaths (h)										
Indigenous										
Total live births (i)	no.	17 162	na	18 438	9 200	3 490	na	na	7 784	56 074
Neonatal deaths	no.	82	na	111	47	16	na	na	74	330
Neonatal death rate	per 1000 live births	4.8	na	6.0	5.1	4.6	na	na	9.5	5.9
Non-Indigenous (g)										
Total live births (i)	no.	418 496	na	245 419	123 561	86 815	na	na	10 806	885 097
Neonatal deaths	no.	1 358	na	823	279	207	na	na	30	2 697
Neonatal death rate	per 1000 live births	3.2	na	3.4	2.3	2.4	na	na	2.8	3.0
Perinatal deaths (j)										
Indigenous										
Total all births (f)	no.	17 251	na	18 593	9 279	3 515	na	na	7 892	56 530
Perinatal deaths	no.	171	na	266	126	41	na	na	182	786
Perinatal death rate	per 1000 total births	9.9	na	14.3	13.6	11.7	na	na	23.1	13.9
Non-Indigenous (g)										
Total all births (f)	no.	420 818	na	247 081	124 387	87 324	na	na	10 882	890 492

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total (d)*
Perinatal deaths	no.	3 680	na	2 485	1 105	716	na	na	106	8 092
Perinatal death rate	per 1000 total births	8.7	na	10.1	8.9	8.2	na	na	9.7	9.1
2004–2008										
Fetal deaths (e)										
Indigenous										
Total all births (f)	no.	18 000	na	19 592	10 065	3 911	na	na	7 811	59 379
Fetal deaths	no.	89	na	160	79	23	na	na	97	448
Fetal death rate	per 1000 total births	4.9	na	8.2	7.8	5.9	na	na	12.4	7.5
Non-Indigenous (g)										
Total all births (f)	no.	428 449	na	260 992	131 187	89 668	na	na	11 088	921 384
Fetal deaths	no.	2 362	na	1 777	835	465	na	na	60	5 499
Fetal death rate	per 1000 total births	5.5	na	6.8	6.4	5.2	na	na	5.4	6.0
Neonatal deaths (h)										
Indigenous										
Total live births (i)	no.	17 911	na	19 432	9 986	3 888	na	na	7 714	58 931
Neonatal deaths	no.	84	na	116	49	15	na	na	65	329
Neonatal death rate	per 1000 live births	4.7	na	6.0	4.9	3.9	na	na	8.4	5.6
Non-Indigenous (g)										
Total live births (i)	no.	426 087	na	259 215	130 352	89 203	na	na	11 028	915 885
Neonatal deaths	no.	1 401	na	874	275	205	na	na	28	2 783
Neonatal death rate	per 1000 live births	3.3	na	3.4	2.1	2.3	na	na	2.5	3.0
Perinatal deaths (j)										
Indigenous										
Total all births (f)	no.	18 000	na	19 592	10 065	3 911	na	na	7 811	59 379
Perinatal deaths	no.	173	na	276	128	38	na	na	162	777
Perinatal death rate	per 1000 total births	9.6	na	14.1	12.7	9.7	na	na	20.7	13.1

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total (d)*
Non-Indigenous (g)										
Total all births (f)	no.	428 449	na	260 992	131 187	89 668	na	na	11 088	921 384
Perinatal deaths	no.	3 763	na	2 651	1 110	670	na	na	88	8 282
Perinatal death rate	per 1000 total births	8.8	na	10.2	8.5	7.5	na	na	7.9	9.0
2005–2009										
Fetal deaths (e)										
Indigenous										
Total all births (f)	no.	18 595	na	21 389	10 700	4 211	na	na	7 835	62 730
Fetal deaths	no.	89	na	176	17	87	na	na	107	476
Fetal death rate	per 1000 total births	4.8	na	8.2	4.1	8.1	na	na	13.7	7.6
Non-Indigenous (g)										
Total all births (f)	no.	434 765	na	275 458	135 661	92 406	na	na	11 345	949 635
Fetal deaths	no.	2 384	na	1 867	423	845	na	na	63	5 582
Fetal death rate	per 1000 total births	5.5	na	6.8	4.6	6.2	na	na	5.6	5.9
Neonatal deaths (h)										
Indigenous										
Total live births (i)	no.	18 506	na	21 213	10 683	4 124	na	na	7 728	62 254
Neonatal deaths	no.	80	na	128	15	47	na	na	62	332
Neonatal death rate	per 1000 live births	4.3	na	6.0	3.6	4.4	na	na	8.0	5.3
Non-Indigenous (g)										
Total live births (i)	no.	432 381	na	273 591	135 238	91 561	na	na	11 282	944 053
Neonatal deaths	no.	1 420	na	929	217	280	na	na	28	2 874
Neonatal death rate	per 1000 live births	3.3	na	3.4	2.4	2.1	na	na	2.5	3.0
Perinatal deaths (j)										
Indigenous										
Total all births (f)	no.	18 595	na	21 389	10 700	4 211	na	na	7 835	62 730

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total (d)
Perinatal deaths	no.	169	na	304	32	134	na	na	169	808
Perinatal death rate	per 1000 total births	9.1	na	14.2	7.7	12.4	na	na	21.6	12.9
Non-Indigenous (g)										
Total all births (f)	no.	434 765	na	275 458	135 661	92 406	na	na	11 345	949 635
Perinatal deaths	no.	3 804	na	2 796	640	1 125	na	na	91	8 456
Perinatal death rate	per 1000 total births	8.7	na	10.2	7.0	8.3	na	na	8.0	8.9
2006–2010										
Fetal deaths (e)										
Indigenous										
Total all births (f)	no.	19 870	na	23 042	11 336	4 358	na	na	7 906	66 512
Fetal deaths	no.	88	na	195	75	9	na	na	105	472
Fetal death rate	per 1000 total births	4.4	na	8.5	6.6	2.1	na	na	13.3	7.1
Non-Indigenous (g)										
Total all births (f)	no.	442 824	na	286 640	140 682	94 011	na	na	11 503	975 660
Fetal deaths	no.	2 390	na	1 877	851	399	na	na	54	5 571
Fetal death rate	per 1000 total births	5.4	na	6.6	6.1	4.3	na	na	4.7	5.7
Neonatal deaths (h)										
Indigenous										
Total live births (i)	no.	19 782	na	22 847	11 261	4 349	na	na	7 801	66 040
Neonatal deaths	no.	86	na	129	47	14	na	na	62	338
Neonatal death rate	per 1000 live births	4.3	na	5.6	4.2	3.2	na	na	7.9	5.1
Non-Indigenous (g)										
Total live births (i)	no.	440 434	na	284 763	139 831	93 612	na	na	11 449	970 089
Neonatal deaths	no.	1 384	na	979	272	202	na	na	25	2 862
Neonatal death rate	per 1000 live births	3.1	na	3.4	1.9	2.2	na	na	2.2	3.0
Perinatal deaths (j)										

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total (d)
Indigenous										
Total all births (f)	no.	19 870	na	23 042	11 336	4 358	na	na	7 906	66 512
Perinatal deaths	no.	174	na	324	122	23	na	na	167	810
Perinatal death rate	per 1000 total births	8.8	na	14.1	10.8	5.3	na	na	21.1	12.2
Non-Indigenous (g)										
Total all births (f)	no.	442 824	na	286 640	140 682	94 011	na	na	11 503	975 660
Perinatal deaths	no.	3 774	na	2 856	1 123	601	na	na	79	8 433
Perinatal death rate	per 1000 total births	8.6	na	10.0	8.0	6.4	na	na	6.9	8.6
2007–2011										
Fetal deaths (e)										
Indigenous										
Total all births (f)	no.	21 964	na	24 830	11 944	4 567	na	na	7 881	71 186
Fetal deaths	no.	84	na	190	87	7	na	na	101	469
Fetal death rate	per 1000 total births	3.8	na	7.7	7.3	1.5	na	na	12.8	6.6
Non-Indigenous (g)										
Total all births (f)	no.	452 441	na	295 458	144 647	95 441	na	na	11 781	999 768
Fetal deaths	no.	2 387	na	1 900	929	408	na	na	53	5 677
Fetal death rate	per 1000 total births	5.3	na	6.4	6.4	4.3	na	na	4.5	5.7
Neonatal deaths (h)										
Indigenous										
Total live births (i)	no.	21 880	na	24 640	11 857	4 560	na	na	7 780	70 717
Neonatal deaths	no.	91	na	131	42	16	na	na	55	335
Neonatal death rate	per 1000 live births	4.2	na	5.3	3.5	3.5	na	na	7.1	4.7
Non-Indigenous (g)										
Total live births (i)	no.	450 054	na	293 558	143 718	95 033	na	na	11 728	994 091
Neonatal deaths	no.	1 371	na	991	247	198	na	na	29	2 836

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total (d)
Neonatal death rate	per 1000 live births	3.0	na	3.4	1.7	2.1	na	na	2.5	2.9
Perinatal deaths (j)										
Indigenous										
Total all births (f)	no.	21 964	na	24 830	11 944	4 567	na	na	7 881	71 186
Perinatal deaths	no.	175	na	321	129	23	na	na	156	804
Perinatal death rate	per 1000 total births	8.0	na	12.9	10.8	5.0	na	na	19.8	11.3
Non-Indigenous (g)										
Total all births (f)	no.	452 441	na	295 458	144 647	95 441	na	na	11 781	999 768
Perinatal deaths	no.	3 758	na	2 891	1 176	606	na	na	82	8 513
Perinatal death rate	per 1000 total births	8.3	na	9.8	8.1	6.3	na	na	7.0	8.5

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2006 (final) 2007 (final), 2008 (final), 2009 (revised), 2010 (preliminary). See Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009.

(b) Perinatal deaths (including fetal and neonatal deaths) for years 1999-2007 have been subject to a revision of scope rules. See ABS Perinatal Deaths, Australia, 2007 (cat.no. 3304.0) Explanatory Notes 18-20 for further information.

(c) Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These 5 states have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths.

(d) Total includes data for NSW, Queensland, WA, SA and the NT only.

(e) Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams.

(f) Total all births is the number of live births and fetal deaths combined. Fetal deaths by definition include only infants of a gestational age of at least 20 weeks or weighing at least 400 grams

(g) Non-Indigenous includes Indigenous status not stated.

(h) A neonatal death is the death within 28 days of birth of a child who after delivery, breathes or shows any evidence of life such as a heartbeat.

(i) Total live births are all live births registered in the calendar year.

(j) Perinatal deaths are fetal and neonatal deaths combined. Fetal deaths exclude those records where gestational age was less than 20 weeks or birthweight was known to be less than 400 grams.

Table 10A.116 **Perinatal, neonatal and fetal deaths (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total (d)*

na Not available.

Source: ABS Perinatal deaths, Australia, Cat. no. 3304.0, Canberra (unpublished).

Data quality information — Public hospitals, chapter 10

Data quality information

DQI provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Public hospitals 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:

Emergency department waiting times

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Emergency department waiting times
Measure (computation)	The national benchmark waiting times are: • Triage category 1: seen within seconds, calculated as less than or equal to 2 minutes • Triage category 2: seen within 10 minutes • Triage category 3: seen within 30 minutes • Triage category 4: seen within 60 minutes • Triage category 5: seen within 120 minutes The proportion of patients seen on time is calculated as: Numerator—Number of patients seen within the cut-off point, by triage category. Denominator—Number of patients by triage category. Inclusions: records with a type of visit of Emergency presentation. Restricted to hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospital) or peer group B (Large hospitals). Exclusions: records with an episode end status of Did not wait to be attended by a health care professional or Dead on arrival, not treated in emergency department. Records are also excluded if the waiting time was missing or otherwise invalid.
Data source/s	This indicator is calculated using data from the AIHW's NNAPEDCD, based on the National Minimum Data Set (NMDS) for Non-admitted patient emergency department care (NAPEDC). For data by socioeconomic status: calculated by AIHW using the Australian Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Local Area (SLA) as at 30 June 2011 (2011–12) or 30 June 2012 (2012–13). Each SLA in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population. For data by remoteness: ABS ERP as at 30 June 2011 (2011–12) or 30 June 2012 (2012–13), by remoteness areas, as specified in the Australian Standard Geographical Classification.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio. 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.

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.

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 NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):

www.aihw.gov.au/nhissc/

www.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.

Relevance

The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or B (Large hospitals). In 2012–13, hospitals in peer groups A and B provided over 86 per cent of all public hospital emergency presentations.

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 analyses by remoteness and socioeconomic status are based on the statistical local area (SLA) of usual residence of the patient. However, data are reported by jurisdiction of presentation, regardless of the jurisdiction of usual residence. Hence, data represent the proportion of patients living in each remoteness area or Socio-Economic Indexes for Areas (SEIFA) population group (regardless of their jurisdiction of residence) seen within the benchmark time in the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). For 2011–12, the SEIFA scores for each SLA are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011. For 2012–13, the SEIFA scores for each Statistical Area level 2 (SA2) are derived from 2011 Census data and represent the attributes of the population in that SA2 in 2011.

	Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.
Timeliness	The reference period for these data is 2011–12 and 2012–13.
Accuracy	For 2011–12, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2012–13, 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 NSW hospital statistics) was reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for NSW and Victoria. States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors (including waiting time outliers) are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. The quality of Indigenous status data 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. Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.
Coherence	The data reported for 2011–12 and 2012–13 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 are calculated using the same

	methodology as data published in Australian hospital statistics 2011–12, Australian hospital statistics: emergency department care (report series) and the National Healthcare Agreement: performance report 2011–12. However, 2011–12 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 2010–11, rather than 2011–12 peer groups. Caution should be used in comparing data across reference years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time. Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles. National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years. In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007-08 through to 2011-12 reported by remoteness are reported for RA 2006. Data for 2012-13 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2011-12 and previous years are not directly comparable to remoteness data for 2012-13 and subsequent years. Data for 2007-08 through to 2010-11 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. Data for 2012-13 are reported using SEIFA 2011 at the Statistical Area (SA) 2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.
Accessibility	The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: Australian hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at: www.aihw.gov.au/hospitals/.
Interpretability	Metadata information for the Non-Admitted Patient Emergency Department Care (NAPEDC) National Minimum Data Set (NMDS) and the NAPEDC Data Set Specification (DSS) are published in the AIHW's online metadata

repository, METeOR, and the National health data dictionary.

The National health data dictionary can be accessed online at:

www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the 2011–12 NNAPEDCD can be accessed on the AIHW website at:

www.meteor.aihw.gov.au/content/index.phtml/itemId/529471

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data.

For 2011-12, the coverage of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) collection is complete for public hospitals in peer groups A and B. It is estimated that 2012-13 has similar coverage, although final coverage cannot be calculated until the 2012-13 National Public Hospital Establishments Database (NPHED) data are available.

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 groups A or B, and the peer group for a hospital, may vary over time.

Remoteness data for 2011-12 and previous years are not directly comparable to remoteness data for 2012-13 and subsequent years.

SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Elective surgery waiting times

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element Effectiveness — access

Indicator Elective surgery waiting times

Measure (computation) Median and 90th percentile waiting times for elective surgery

The number of days' waiting time is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was not ready for care and minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.

The 50th percentile (median) represents the number of days within which 50 per cent of patients were admitted; half the waiting times will be shorter than the median and half the waiting times longer. The 90th percentile data represent the number of days within which 90 per cent of patients were admitted.

Elective surgery waiting times by clinical urgency category

Elective surgery waiting times by clinical urgency category reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:

- category 1 — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- category 2 — admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.
- category 3 — admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. Desirable timeframe for this category is admission within 365 days.

Data source/s

Median and 90th percentile waiting times for elective surgery

For 2011–12 and 2012–13, this indicator is calculated using data from the NESWTDC, based on the National Minimum Data Set (NMDS) for Elective surgery waiting times (removals data).

For 2011–12, the NESWTDC was linked to the NHMD, based on the NMDS for Admitted patient care, to allow disaggregation by remoteness of area of usual residence and SEIFA of usual residence (all jurisdictions).

For data by socioeconomic status: calculated by AIHW using the Australian Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Local Area (SLA) as at 30 June 2011 (2011–12). Each SLA in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

For data by remoteness: ABS ERP as at 30 June 2011 (2011–12), by remoteness areas, as specified in the Australian Standard Geographical Classification.

Elective surgery waiting times by clinical urgency category

Elective surgery waiting times by clinical urgency category are sourced from state and territory health departments as part of the annual Report on Government Services data collection.

Data Quality Framework Dimensions

Institutional environment

Median and 90th percentile waiting times for elective surgery

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio.

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.

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.

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):

www.aihw.gov.au/nhissc/

www.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.

Elective surgery waiting times by clinical urgency category

The Secretariat for the Review of Government Service Provision has calculated the Elective surgery waiting times by clinical urgency category.

The data were supplied 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.

Relevance

Median and 90th percentile waiting times for elective surgery

The purpose of the NMDS for Elective surgery waiting times (removals data) is to collect information about patients waiting for elective surgery in public hospitals. The scope of this NMDS is patients removed from waiting lists for elective surgery which are managed by public acute hospitals. This includes private patients treated in public hospitals and may include public patients treated in private hospitals.

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.

Analyses by remoteness and socioeconomic status are based on the Statistical Local Area of usual residence of the patient.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SLA are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011.

Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, data represent the waiting time for patients living in each remoteness area or SEIFA population group (regardless of their jurisdiction of residence) for the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Elective surgery waiting times by clinical urgency category

'Elective surgery waiting times by urgency category' data provide an indication of the extent to which patients are seen within a clinically desirable time and also draw attention to the variation in the way in which patients are classified across jurisdictions.

The system of urgency categorisation for elective surgery in public hospitals is important to ensure that priority is given to patients according to their needs. While elective surgery waiting times by urgency category are not comparable across jurisdictions, this measure has the advantage over other measures in that it provides an indication of the extent to which patients are seen within a clinically desirable time period according to the urgency category to which they have been assigned.

Timeliness

The reference period for these data is 2011–20121 and 2012–13.

Accuracy

Median and 90th percentile waiting times for elective surgery

For 2011–12 and 2012–13:

- Coverage of the NESWTDC was over 90 per cent. Coverage was 100 per cent for the Principal referral and Specialist women's and children's hospitals peer group (peer group A) and was progressively lower for the large hospitals group (peer group B) and the medium hospitals group (peer group C). In 2011–12, coverage also varied by jurisdiction, ranging from 100 per cent in NSW, WA, Tasmania, the ACT and the NT, to 77 per cent in Victoria. For 2012–13, the preliminary estimate of the proportion of public elective surgery that was also reported to the NESWTDC was 93 per cent
- Almost all public hospitals provided data for the NHMD in 2011–12, with the exception of all separations for a mothercraft hospital in the ACT.
- Records from the NESWTDC and the NHMD were linked to assign remoteness areas and SEIFA categories from the admitted patient record to the corresponding elective surgery waiting times record. In 2011–12 approximately 97 per cent of NESWTDC records for removals were linked to the NHMD.
- There is apparent variation in the assignment of clinical urgency categories, both among and within jurisdictions, and for individual surgical specialties and indicator procedures, as well as overall. Interpretation of waiting times for jurisdictions should take into consideration these differences.
- The Indigenous status data were sourced from the NESWTDC for all jurisdictions.
- For 2009–10, the data for Albury Base Hospital (previously reported in NSW hospital statistics) was reported by the Victorian Department of Health as part of the Albury Wodonga Health Service. From 2010–11, the data for Albury Base Hospital have not been available.
- For 2011–12, SA and WA provided data for a large number of smaller hospitals (32 and 22 respectively) that were not included in the data for previous years.
- For 2011–12, Queensland was not able to provide data for 3 hospitals that had reported almost 10,000 admissions in 2010–11.
- The increase in admissions for the NT between 2010–11 and 2011–12 was, in part, due to the inclusion of certain surgical procedures from 2011–12

that had previously been incorrectly excluded from the NESWTDC by the NT.

Interpretation of waiting times for jurisdictions should take into consideration cross-border flows, particularly for 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 datasets are checked against data from other datasets. 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.

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 rules were applied:

- Cells based on fewer than 10 elective surgery admissions were suppressed.
- Cells based on data from one public hospital only were suppressed

Elective surgery waiting times by clinical urgency category

Caution should be used when interpreting data as they as they have not been subjected to the usual level of confirmation with patient-level data in the NHMD.

There is apparent variation in the assignment of clinical urgency categories, both among and within jurisdictions, and for individual surgical specialties and indicator procedures, as well as overall. Interpretation of waiting times for jurisdictions should take into consideration these differences.

Coherence

Median and 90th percentile waiting times for elective surgery

Caution should be exercised when comparing waiting times data between jurisdictions due to differences in the assignment of clinical urgency categories (see Australian hospital statistics 2012–13: elective surgery waiting times, Appendix A p 40 www.aihw.gov.au/publication-detail/?id=60129544692

The data can be meaningfully compared across reference periods, except for the Indigenous disaggregation. Caution should be used in comparing data by peer groups across reference years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

The information presented for this indicator is based on the same data as published in, Australian hospital statistics 2011–12, Australian hospital statistics: elective surgery waiting times (report series) and the National Healthcare Agreement: performance report 2011–12.

The data reported for the 2011–12 and 2012–13 NEWSTDC are consistent with data reported for previous years for individual hospitals.

In addition, some 2011–12 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 2010–11, rather than 2011–12 peer groups. Caution should be exercised when interpreting the 2012–13 data as potential revisions to the 2012–13 NESWTDC data could occur following linking to the 2012–13 NHMD.

Analyses presented in Australian hospital statistics and previous National Healthcare Agreement performance reports may also differ slightly depending

	on whether the NESWTDC or linked NESWTDC/NHMD was used. National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years. When comparing data over time, linked data should not be compared with unlinked data. For example, the 2011–12 linked data supplied cannot be directly compared to the 2012–13 unlinked data supplied in this reporting cycle. In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007-08 through to 2010-11 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. The AIHW consider the change from SEIFA 2006 to SEIFA 2011 to be a series break when applied to data supplied for this indicator, therefore SEIFA data for 2011-12 are not directly comparable with SEIFA data from previous reporting cycles. Elective surgery waiting times by clinical urgency category Caution should be exercised when comparing waiting times data between jurisdictions due to differences in the assignment of clinical urgency categories (see *Australian hospital statistics 2011–12: elective surgery waiting times*, Box 3.1 pp 10–11 Text Box 3.1 www.aihw.gov.au/publication-detail/?id=10737423188).
Accessibility	Median and 90th percentile waiting times for elective surgery The AIHW provides a variety of products that draw upon the NESWTDC. 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 www.aihw.gov.au/hospitals/ Elective surgery waiting times by clinical urgency category The COAG Reform Council reported Elective surgery waiting times by clinical urgency category as part of reporting on the National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan.
Interpretability	Median and 90th percentile waiting times for elective surgery Metadata information for the Elective Surgery Waiting Times (ESWT) National Minimum Data Set (NMDS) and ESWT Data Set Specification (DSS) are published in the AIHW's online metadata repository, METeOR, and the National health data dictionary. The National health data dictionary can be accessed online at: www.aihw.gov.au/publication-detail/?id=10737422826 The Data Quality Statement for the NNAPEDCD can be accessed on the AIHW website at: www.meteor.aihw.gov.au/content/index.phtml/itemId/543809 Elective surgery waiting times by clinical urgency category Variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of

patients assigned to each of the three urgency categories.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following key data gaps/issues: Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by another hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported in NSW, SA and the NT. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. There is apparent variation in the assignment of clinical urgency categories, both among and within jurisdictions, for individual surgical specialties and indicator procedures, influencing the overall total. For example, the proportion of patients admitted from waiting lists who were assigned to Category 3 treatment clinically recommended within 365 days) was 44 per cent for NSW and 16 per cent for Queensland (Table A.1 from Australian hospital statistics 2012–13: elective surgery waiting times, Appendix A p 40 www.aihw.gov.au/publication-detail/?id=60129544692 Interpretation of waiting times for jurisdictions should take into consideration these differences. For example, a state could report relatively long median waiting times in association with a relatively high proportion of patients assessed by clinicians in the state as being in Category 3. Conversely, a state in which a relatively high proportion of patients are assessed by clinicians as being in Category 1 or 2 (treatment clinically recommended within 30 days and 90 days, respectively) could have relatively short median waiting times. Analyses for remoteness and socioeconomic status are based on the reported area of usual residence of the patient, regardless of the jurisdiction of the hospital. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction. The quality of Indigenous status data in the NESWTDC has not been formally assessed for completeness: caution should be exercised when interpreting these data. Interpretation of waiting times for jurisdictions should take into consideration cross-border flows, particularly for the ACT. SEIFA data for 2011-12 are not directly comparable with SEIFA data from previous reporting cycles.

Separation rates for selected procedures

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness—appropriateness
Indicator	Separation rates for selected procedures
Measure (computation)	The *numerator* is the number of hospital separations involving the procedures: cataract extraction, cholecystectomy, coronary artery bypass graft, coronary angioplasty, cystoscopy, haemorrhoidectomy, hip

replacement, inguinal herniorrhaphy, knee replacement, myringotomy, tonsillectomy, varicose veins stripping and ligation, septoplasty, prostatectomy and hysterectomy.

The *denominator* is the Estimated Resident Population (ERP), with the exception of prostatectomy, where only the male ERP is used, and hysterectomy, where only the female ERP aged 15–69 years is used.

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).

Calculation is 1000 × (numerator ÷ denominator), presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

For hysterectomy only: Total population data were age-standardised using 5 year age groups between 15–69 years. Indigenous disaggregation for the ACT and Tasmania was age-standardised using 5-year age groups from 15–64, with ages over 64 combined. Indigenous disaggregation for all other jurisdictions was standardised using 5-year age groups between 15–69 years as data on the Indigenous population aged 65–69 years were available for these jurisdictions.

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) ERP as at 30 June 2011.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio.

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.

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.

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): www.aihw.gov.au/nhissc/ www.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.
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. Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction. Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated. Indigenous and Other Australians' rates of hysterectomy in Tasmania and the ACT may underestimate rates of hysterectomy for women aged 15–69 years due to the age-standardisation method used (see above).
Timeliness	The reference period for these data is 2011–12.

Accuracy	For 2011–12 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private free-standing day hospitals in the ACT and the NT. Coronary artery bypass graft and coronary angioplasty are not performed in NT hospitals. Residents of the NT requiring these procedures receive treatment interstate. 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. Data on procedures are recorded uniformly using the Australian Classification of Health Interventions. Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. 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 rules were applied: • Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000. • Data for private hospitals in Tasmania, the ACT and the NT were suppressed. • Rates which appear misleading (for example, because of cross border flows) were also suppressed.
Coherence	The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2010–11* and the *National healthcare agreement: performance report 2010–11*. The data can be meaningfully compared across reference periods for all jurisdictions except Tasmania. 2008–09 data for Tasmania does not include two private hospitals that were included in 2007–08 and 2009–10 data reported in National Healthcare Agreement performance reports. In 2009-10, WA was missing 2400 separations for one public hospital and was not able to provide about 10 600 separations for one private hospital.
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). • 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 note 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 is 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 key data gaps/issues: Higher/lower rates are not necessarily associated with inappropriate care. However, large jurisdictional variations in rates for particular procedures can require investigation to determine whether service levels are appropriate. Care needs to be taken when interpreting the differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

Unplanned hospital readmission rates

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 — quality/safety
Indicator	Unplanned/unexpected readmissions within 28 days of selected surgical admissions. For the 2013 report, the National Health Information Standards and Statistics Committee (NHISSC), on behalf of Australian Health Ministers' Conference, amended the title of this indicator in the NHISSC specifications to: Unplanned hospital readmission rates to better reflect how the indicator is calculated. Readmissions for this indicator are defined within 28 days from the end of the patient's surgical episode of care.
Measure (computation)	Numerator: the number of separations for public hospitals which meet all of the following criteria: • the separation is a readmission to the same hospital following a separation in which one of the following procedures was performed: knee replacement; hip replacement; tonsillectomy and adenoidectomy; hysterectomy; prostatectomy; cataract surgery; appendicectomy • the readmission occurs within 28 days of the previous date of separation • the principal diagnosis for the readmission is a post-operative complication. Denominator: the number of separations in which one of the following surgical procedures was undertaken: knee replacement; hip replacement; tonsillectomy and adenoidectomy; hysterectomy; prostatectomy; cataract surgery; appendicectomy. The denominator is limited to separations with a separation date between 1 July and 19 May in the reference year.
Data source/s	For all jurisdictions except WA, this indicator is calculated by the Australian Institute of Health and Welfare (AIHW) using data from the NHMD, based on the national minimum data set (NMDS) for Admitted patient care. For WA, the indicator was calculated and supplied by WA Health and was not independently verified by the AIHW. For data by socioeconomic status: calculated by AIHW using the Australian

Bureau of Statistics (ABS) Socio-Economic Indexes For Areas (SEIFA), Index of Relative Socio-Economic Disadvantage (IRSD) 2011 and Estimated Resident Population (ERP) by Statistical Local Area (SLA) as at 30 June 2011. Each SLA in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

For data by remoteness: each separation is allocated an ABS remoteness area, as specified in the Australian Standard Geographical Classification, based on the SLA of usual residence of the patient.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio.

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.

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.

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):

www.aihw.gov.au/nhissc/

www.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.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence

	Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included. The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. The analyses by remoteness and socioeconomic status are based on the Statistical Local Area (SLA) of usual residence of the patient. The Socio-Economic Indexes for Areas (SEIFA) categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SLA are derived from 2011 Census data and represent the attributes of the population in that SLA in 2011. Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, rates represent the number of separations for patients living in each remoteness area or SEIFA population group (regardless of their jurisdiction of residence) divided by the total number of separations for people living in that remoteness area or SEIFA population group and hospitalised in the reporting jurisdiction. This is relevant if significant numbers of one jurisdiction's residents are treated in another jurisdiction. The unplanned and/or unexpected readmissions counted in the computation for this indicator have been limited to those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned. Unplanned and/or unexpected readmissions attributable to other causes have not been included. With regard to hysterectomy, there are three related procedures that are not defined for the indicator, and therefore have not been included in any National Healthcare Agreement (NHA) reporting (all years). These are (in ICD-10-AM 7th edition), 35750-00—Laparoscopically assisted vaginal hysterectomy; 35753-02—Laprascopically assisted vaginal hysterectomy with removal of adnexa; and 35653-00—Subtotal abdominal hysterectomy. For public hospitals, there were 1743 separations in 2011–12 and 1627 separations in 2010–11 that involved one of these procedures. The calculation of the indicator is limited to public hospitals and to readmissions to the same hospital. Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.
Timeliness	The reference period for this data set is 2011–12.
Accuracy	The exception was a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT and the NT. States and territories are primarily responsible for the quality of the data they provide. However, the AIHW 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 against 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 AIHW report Indigenous identification in hospital separations data: quality report (AIHW 2013) found that nationally, about 88 per cent of Indigenous Australians were identified correctly in hospital admissions data in the 2011–12 study period, and the 'true' number of separations for

Indigenous Australians was about 9 per cent higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

For this indicator, the linkage of separations records is based on the patient identifiers which are reported for public hospitals. As a consequence, only readmissions to the same public hospital are in scope; and readmissions to different public hospitals and readmissions involving private hospitals are not included.

For WA the indicator was calculated and supplied by WA Health.

To calculate this indicator, readmissions within the 2011–12 financial year had to be linked to an initial separation (which involved the specified surgery) that occurred within the 2011–12 financial year. The 19 May was specified as the cut-off date for the initial separation to exclude initial separations from the denominator for which a readmission may occur in the following financial year. The use of the cut-off date ensures that the numerator and denominator for this indicator are consistent.

Data on procedures are recorded uniformly using the Australian Classification of Health Interventions. Data on diagnoses are recorded uniformly using the ICD-10-AM.

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 rules were applied:

- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 200.
- Rates were suppressed where the numerator was zero and the denominator was less than 200.
- Counts were suppressed when the number was less than 5.
- Data for private hospitals in Tasmania, ACT and the NT were suppressed.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in Australian hospital statistics 2011–12 and the National healthcare agreement: performance report 2011–12.

The data can be meaningfully compared across reference periods for all jurisdictions.

However, caution is required when analysing SEIFA over time for the reasons outlined above (see Relevance section). Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Queensland, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA),

	based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007-08 through to 2010-11 reported for SEIFA quintiles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. The AIHW consider the change from SEIFA 2006 to SEIFA 2011 to be a series break when applied to data supplied for this indicator, therefore SEIFA data for 2011-12 are not directly comparable with SEIFA data from previous reporting cycles.
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). These products may be accessed on the AIHW website at: www.aihw.gov.au/hospitals/
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 note 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 National Minimum Data Set (NMDS) for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the National health data dictionary. The National health data dictionary can be accessed online at: • www.aihw.gov.au/publication-detail/?id=10737422826 • The Data Quality Statement for the National Hospital Morbidity Database can be accessed on the AIHW website at: • www.meteor.aihw.gov.au/content/index.phtml/itemId/529483

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: The National Hospital Morbidity Database (NHMD) is a comprehensive data set that has records for all separations of admitted patients from essentially all public and private hospitals in Australia. The indicator is an underestimate of all possible unplanned/unexpected readmissions because: • it could only be calculated for public hospitals and for readmissions to the same hospital. • episodes of non-admitted patient care provided in outpatient clinics or emergency departments which may have been related to a previous admission are not included. • the unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event for which a specified International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) diagnosis code has been assigned. This does not include all possible unplanned/unexpected readmissions. Calculation of the indicator for WA was not possible using data from the NHMD. Data for WA were supplied by WA Health. The Australian rates and numbers do not include WA. Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. SEIFA data for 2011-12 are not directly comparable with SEIFA data from previous reporting cycles.

Accreditation

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Accreditation
Measure (computation)	Accreditation' is defined as the number of beds in accredited hospitals as a percentage of total beds. Accreditation is awarded to a hospital based on meeting a defined set of standards. Public hospitals can seek accreditation through a number of agencies. These agencies are accredited through the Joint Accreditation System of Australia and New Zealand or the International Society for Quality in Healthcare. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.
Data source/s	This indicator is calculated using data from the NPHED. The NPHED contains information on public hospital expenditure and estimates of the proportion of recurrent expenditure attributed to admitted patient care. The NPHED is based on the National Minimum Data Set (NMDS) for Public hospital establishments.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio. 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. 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. 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): www.aihw.gov.au/nhissc/ www.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.
Relevance	The purpose of the NMDS for Public hospital establishments is to collect information on the characteristics of public hospitals and summary information on non-admitted services provided by them. The scope is public hospitals in Australia, including public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans Affairs, and drug and alcohol treatment centres. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The collection covers hospitals within the jurisdiction of the State and Territory health authorities. Hence, public hospitals not administered by the State and Territory health authorities (hospitals operated by correctional authorities or the Australian Defence Force for example, and hospitals located in offshore territories) are not included. The collection does not include data for private hospitals.
Timeliness	The reference period for this data set is 2011-12.
Accuracy	For 2011-12, coverage of the NPHED was essentially complete. States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation 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. Although there are national standards for public hospital establishments data, differences in financial accounting, counting and classification practices across jurisdictions may affect the comparability of these data. The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses. There was variation between states and territories in the reporting of expenditure, depreciation, available beds, staffing categories and outpatient occasions of service. Comparability of bed numbers can be affected by the range and types of patients treated by a hospital (casemix), with, for example, different proportions of beds being available for special and more general purposes. States and territories may differ in the extent to which non-admitted services are provided in non-hospital settings that are beyond the scope of the NPHED. The comparability of accreditation data among states and territories is limited because of the voluntary nature of participation in award schemes for hospitals in some jurisdictions. As accreditation for public hospitals was counted as at 30 June 2011, hospitals that were accredited for the majority of the financial year, but had their accreditation status lapse shortly before this date, would have been counted as non-accredited.
Coherence	The NPHED includes data for each year from 1993–94 to 2011–12. The data reported for 2011–12 are consistent with data reported for the NPHED for previous years for individual hospitals. Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in admission practices. Changes in administrative and/or reporting practices for hospitals, changes in accounting practices for financial data, and changes in counting practices can affect comparisons over time.
Accessibility	The AIHW provides a variety of products that draw upon the NHMD and the NPHED. Published products available on the AIHW website include: • Australian hospital statistics with associated Excel tables • Interactive data cubes for Public hospital establishments.
Interpretability	Supporting information on the quality and use of the NPHED 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, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and 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 key data gaps/issues: The comparability of accreditation data among states and territories is limited because of the voluntary nature of participation in award schemes for hospitals in some jurisdictions. As accreditation for public hospitals was counted as at 30 June 2011, hospitals that were accredited for the majority of the financial year, but had their accreditation status lapse shortly before this date, would have

	been counted as non-accredited. It is not possible to draw conclusions about the quality of care in those hospitals that do not have 'accreditation'. Public hospital accreditation is voluntary in all jurisdictions except Victoria, where it is mandatory for all public hospitals (excluding those that provide only dental or mothercraft services).

Healthcare associated infections

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 — quality/safety
Indicator	Healthcare-associated *infections*.
Measure (computation)	SAB patient episodes (as defined below) associated with acute care public hospitals. Patient episodes associated with care provided by private hospitals and non-hospital healthcare are excluded. The definition of an acute public hospital is 'all public hospitals including those hospitals defined as public psychiatric hospitals in the Public Hospital Establishments NMDS'. All types of public hospitals are included, both those focusing on acute care, and those focusing on non-acute or sub-acute care, including psychiatric, rehabilitation and palliative care. Unqualified newborns are included in the indicator. Hospital boarders and posthumous organ procurement are excluded from the indicator. A patient episode of SAB is defined as a positive blood culture for *Staphylococcus aureus*. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded. A *Staphylococcus aureus* bacteraemia will be considered to be healthcare-associated if: the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, OR, if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient-episode of SAB: 1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter) 2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site 3. An invasive instrumentation or incision related to the SAB was performed within 48 hours 4. SAB is associated with neutropenia (<1 x 109) contributed to by cytotoxic therapy This definition of a patient episode of SAB was agreed by all states and territories and used by all states and territories for reporting for the 2010-11 and subsequent years.

	The *denominator* is number of patient days for public acute care hospitals (only for hospitals included in the surveillance arrangements).Calculation is 10 000 × (Numerator ÷ Denominator), presented as a number per 10 000 and number only. Coverage: Denominator ÷ Number of patient days for all public hospitals in the State or Territory.
Data source/s	*Numerator*: State and Territory healthcare-associated infection surveillance data. *Denominator*: State and Territory admitted patient data.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio. 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. 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. 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): www.aihw.gov.au/nhissc/ www.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.
Relevance	This indicator is for patient episodes of SAB acquired, diagnosed and treated in public acute care hospitals. The definition of a public acute care hospital is 'all public hospitals including those hospitals defined as public psychiatric hospitals in the Public Hospital Establishments NMDS'. All types of public

	hospitals are included, both those focusing on acute care, and those focusing on non-acute or sub-acute care, including psychiatric, rehabilitation and palliative care. The provision of 'acute' services varies among jurisdictions, so it is not possible to exclude 'non-acute' hospitals from the indicator in a way that would be uniform among the states and territories. Therefore all public hospitals have been included in the scope of the indicator so that the same approach is taken for each State and Territory, except for WA where mental health beds are not included in 2010-11 or 2011-12 data. The SAB patient episodes reported were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). No denominator is available to describe the total admitted and non-admitted patient activity of public hospitals. However, the number of patient days for admitted patient activity is used as the denominator to take into account the large differences between the sizes of the public hospital sectors among the jurisdictions. The accuracy and comparability of the SAB rates among jurisdictions and over time is limited because the count of patient days reflects the amount of admitted patient activity, but does not reflect the amount of non-admitted patient activity. The amount of hospital activity that patient days reflect varies among jurisdictions and over time because of variation in admission practices. In 2012, the scope of the indicator was revised to include unqualified newborns. Data reported for 2010-11 and subsequent years include unqualified newborns, except for WA where unqualified newborns are not included in 2010-11 or 2011-12 data. It is not possible to backcast the data for earlier years. Only patient episodes associated with public acute care hospitals in each jurisdiction are counted. If a case is associated with care provided in another jurisdiction then it may be reported (where known) by the jurisdiction where the care associated with the SAB occurred. Almost all patient episodes of SAB will be diagnosed when the patient is an admitted patient. However, the intention is that patient episodes are reported whether they were determined to be associated with admitted patient care or non-admitted patient care in public acute care hospitals. The data presented have not been adjusted for any differences in case-mix between the states and territories. Analysis by state/territory is based on the location of the hospital.
Timeliness	The reference period for this data is 2012-13, with revised data provided for 2011-12.
Accuracy	For some states and territories there is less than 100 per cent coverage of public hospitals. For those jurisdictions with incomplete coverage of public hospitals (in the numerator), only patient days for those hospitals (or parts of hospitals) that contribute data are included (in the denominator). Differences in the types of hospitals not included may impact on the accuracy and comparability of rates. For 2010-11 and previous years, data for Queensland include only patients aged 14 years and over. Sometimes it is difficult to determine if a case of SAB is associated with care provided by a particular hospital. Counts therefore may not be precise where cases are incorrectly included or excluded. However, it is likely that the number of cases incorrectly included or excluded would be small. It is possible that there will be less risk of SAB in hospitals not included in the SAB surveillance arrangements, especially if such hospitals undertake fewer

	invasive procedures than those hospitals which are included. There may be imprecise exclusion of private hospital and non-hospital patient episodes due to the inherent difficulties in determining the origins of SAB episodes. For 2010-11 and subsequent years, all states and territories used the definition of SAB patient episodes associated with acute care public hospitals as defined above. The patient day data may be preliminary for some hospitals/jurisdictions. Some states and territories have provided revised data for 2011-12, thus a revised table for 2011-12 is provided.
Coherence	National data for this indicator were first presented in the 2010 COAG Reform Council report. Since that report further work has been undertaken on data development for this indicator, including the definition of an episode of SAB and a suitable denominator, as well as the coverage of public hospitals. The most recent work in 2012 was to revise the scope of the indicator to include unqualified newborns. Data reported for 2010-11 and subsequent years include unqualified newborns, except for WA where unqualified newborns are not included in 2010-11 and 2011-12 data. It is not possible to backcast the data for earlier years. Data for 2012-13, 2011-12 and 2010-11 are therefore not comparable with data for previous years. Data for 2010-11 and 2011-12 are comparable, except for Queensland, where the 2010-11 data do not include patients aged 13 years and under, whereas the 2011-12 data include patients of all ages. Furthermore, for 2010-11 and 2011-12, WA data do not include unqualified newborns or mental health beds, therefore WA data are not comparable with data from other jurisdictions for these two years. Data for 2011-12 and 2012-13 are comparable, except for WA, where data for 2011-12 do not include unqualified newborns or mental health beds, whereas WA data for 2012-13 include both unqualified newborns and mental health beds. WA data for 2012-13 are comparable with 2012-13 data from other jurisdictions. WA data is included in Australian totals for 2010-11 and 2011-12. Technically, the differing scope for 2010-11 and 2011-12 WA data result in Australian totals for 2010-11 and 2011-12 data which are not comparable with 2012-13 data, however, AIHW investigations indicate that the effect is minimal, and thus consider that Australian data are comparable over 2010-11, 2011-12 and 2012-13. As 2008-09 data were provided prior to the development of agreed national definitions, by only five jurisdictions, and was limited to principal referral and large hospitals, these data are not comparable with 2009-10 data, except for Tasmania. Some jurisdictions have previously published related data (see Accessibility above).
Accessibility	The following states and territories publish data relating to healthcare-associated SAB in various report formats on their websites: NSW: Your Health Service public website reports SAB by individual hospital. www.health.nsw.gov.au/hospitals/search.asp NSW: Healthcare associated infections reporting for 8 infection indicators by state. www.health.nsw.gov.au/quality/hai/index.asp

	Queensland: Queensland Health Hospital Performance website: www.health.Queensland.gov.au/performance/default.asp WA: Healthcare Associated Infection Unit - Annual Report and aggregate reports. www.public.health.wa.gov.au/3/455/3/reports__healthcare_associated_infection_unit.pm SA: Healthcare Associated Bloodstream Infection Report. www.health.sa.gov.au/INFECTIONCONTROL/Default.aspx?PageContentID=18&tabid=147 Tasmania: Acute public hospitals healthcare associated infection surveillance report. www.dhhs.tas.gov.au/peh/tasmanian_infection_prevention_and_control_unit/publications_and_guidelines
Interpretability	Jurisdictional manuals should be referred to for full details of the definitions used in healthcare-associated infection surveillance. Definitions for this indicator are published in the performance indicator specifications.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: • There may be imprecise exclusion of private hospital and non-hospital patient episodes due to the inherent difficulties in determining the origins of SAB episodes. • For some states and territories there is less than 100 per cent coverage of public hospitals. For those jurisdictions with incomplete coverage of public hospitals (in the numerator), only patient days for those hospitals that contribute data are included (in the denominator). Differences in the types of hospitals not included may impact on the accuracy and comparability of rates. • The accuracy and comparability of the rates of SAB among jurisdictions and over time is also limited because the count of patient days (denominator) reflects the amount of admitted patient activity, but does not reflect the amount of non-admitted patient activity. • The data for 2012-13 are comparable with those from 2011-12 except for WA. • The data for 2011-12 are comparable with those from 2010-11 except for Queensland. • WA data for 2010-11 and 2011-12 are not comparable with data from other jurisdictions. • The patient day data may be preliminary for some hospitals/jurisdictions.

Workforce sustainability

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency — sustainability
Indicator	Workforce sustainability

Measure (computation)	Workforce sustainability reports aged profiles for nurse and midwife, medical practitioner, dental practitioner and allied health practitioner workforces. It shows the numbers of each of these registered professions in ten year age brackets, both by jurisdiction and by region.
Data source/s	National Health Workforce Data Set: medical practitioners 2010, 2011 and 2012; National Health Workforce Data Set: nurses and midwives 2011 and 2012; National Health Workforce Data Set: dental practitioners 2011 and 2012; National Health Workforce Data Set: allied health practitioners 2012.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator using estimates derived from the National Health Workforce Data Set (NHWDS). The NHWDS is developed through the collaboration of three agencies. The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme (NRAS) across Australia, including collecting registration data and administering the workforce surveys. Health Workforce Australia is responsible for the development of the health workforce surveys. The AIHW receives registration and survey data from the AHPRA. The registration and workforce survey data are combined, cleansed and adjusted for non-response to form NHWDS, and the findings reported by profession. AIHW is the data custodian of the NHWDS. These data are used for workforce planning, monitoring and reporting. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister. For further information see the AIHW website.
Relevance	Medical practitioners, dental practitioners, nurses/midwives and allied health practitioners are required by law to be registered with their relevant national board to practise in Australia. All medical practitioners, dental practitioners, nurses/midwives and nominated allied health practitioners must complete the formal registration renewal form(s) to practise in Australia. This is the compulsory component of the renewal process. The exception is Aboriginal and Torres Strait Islander health practitioners in the allied health workforce; where those who are not required by their employer to use the title 'Aboriginal and Torres Strait Islander health practitioner', 'Aboriginal health practitioner' or 'Torres Strait Islander health practitioner' are not required to be registered, and can continue to work using their current titles (e.g. 'Aboriginal health worker'. 'drug and alcohol worker' and 'mental health worker'). The health workforce surveys for each of these professions is voluntary and only practitioners who renew their registration receive a questionnaire for completion. New registrants will not receive a survey form until they renew their registration the following year, during the registration renewal period. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year. <u>National Health Workforce Data Set: medical practitioners 2010, 2011 and 2012</u> The NHWDS: medical practitioners 2010, 2011 and 2012 contain registration details of all registered medical practitioners in Australia, at 30 September on the annual renewal date. Data were extracted from the AHPRA database at

the end of November of the same year. The NHWDS also contains workforce data of respondents whose principal state of practice was not Queensland or WA, obtained from the Medical Workforce Survey 2010. These states were excluded from the survey because not all registrations in these states expired prior to the national registration deadline. In 2011, the NHWDS contains workforce data obtained from the Medical Workforce Survey 2011 for all states and territories.

National Health Workforce Data Set: dental practitioners 2011 and 2012

The NHWDS: dental practitioners 2011 contains registration details of all registered dental practitioners in Australia, at 30 November 2011 renewal date. Data were extracted from the AHPRA database at the end of January 2012. It also contains workforce data obtained from the Dental Workforce Survey 2011.

National Health Workforce Data Set: nurses and midwives 2011 and 2012

The NHWDS: nurses and midwives 2011 contains registration details of all registered nurses/midwives in Australia at 31 May 2011 renewal date. Data were extracted from the AHPRA database at the end of November 2011. The NHWDS also contains workforce data obtained from the Nursing and Midwifery Workforce Survey 2011.

National Health Workforce Data Set: allied health practitioners 2011 and 2012.

The NHWDS: allied health practitioners 2011 and 2012 contains registration details of all registered allied health practitioners in Australia, at 30 November on the annual renewal date. Data were extracted from the AHPRA database as at the end of January the following year. The NHWDS also contains workforce data obtained from each profession-specific health workforce survey.

Indicator data for allied health practitioners are not comparable between 2011 and 2012 due to four additional professions joining the NRAS in 2012. For 2011, data was collected for seven professions: chiropractors, optometrists, osteopaths, pharmacists, physiotherapists, psychologists and podiatrists. For 2012, in addition to the seven in 2011, data was collected for Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists.

Due to transitional arrangements with the migration of data from state and territory-based systems to NRAS, in 2012, many medical radiation practitioners in Queensland, WA and Tasmania were not required to renew their registrations and, as a result did not complete a workforce survey. As a consequence, data for Queensland, WA and Tasmania for this profession are excluded from the indicator data for allied health practitioners.

Similarly, occupational therapists in Queensland, WA and SA are excluded from the indicator data for allied health practitioners in 2012.

Timeliness

National Health Workforce Data Set:

The NHWDS for each of the registered professions will be produced annually during the national registration renewal process. Each profession will also be administered a Workforce Survey as part of the registration renewal process.

—Medical practitioners 2010, 2011 and 2012

The NHWDS: medical practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 July and 30 September each year, including the collection of the Medical Workforce Survey. The period for the 2010 renewal process was extended to the end of January 2011. Despite this extension, there were still Queensland and WA registrants with expiry dates after January. Therefore data from these states were not included in the 2010 data set.

—Nurses and midwives 2011 and 2012

The NHWDS: nurses and midwives is produced annually from information collected by the national registration renewal process, conducted between 1 April and 31 May each year, including the collection of the Nursing and Midwifery Workforce Survey. The period for the 2011 renewal process was extended to the end of June 2011 for Queensland and end of December 2011 for WA registrants.

—*Dental practitioners 2011 and 2012*

The NHWDS: dental practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 September and 30 November each year, including the collection of the Dental Workforce Survey. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

—*Allied health practitioners 2011 and 2012*

The NHWDS: allied health practitioners is produced annually from information collected by the national registration renewal process, conducted between 1 September and 30 November each year, including the collection of the profession-specific workforce surveys. Practitioners with limited registration are due for renewal on the anniversary of their first registration and can thus renew and complete a survey at any time through the year.

Accuracy

Data manipulation and estimation processes

The registration and workforce survey data for each health profession are combined, cleansed and adjusted for non-response to form the National Health Workforce Data Set (NHWDS). The cleaning and editing procedures included range and logic checks, clerical scrutiny at unit record level, and validation of unit record and aggregate data.

The data have undergone imputation for item non response and are weighted to the total number of registered practitioners to adjust for population non response. It should be noted that both of these kinds of non-response is likely to introduce some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of records. Care should be taken when drawing conclusions about the size of the differences between estimates.

As a result of the estimation method to adjust for non-response, numbers of medical practitioners, dental practitioners, nurses/midwives or allied health practitioners may have been in fractions, but have been rounded to whole numbers for this indicator. The full-time equivalent (FTE) rate calculations are based on rounded numbers.

Registration data from the National Registration and Accreditation Scheme (NRAS)

Registration details were migrated from the respective state and territory professional board (or council) for practitioners with registrations expiring after the official AHPRA closing date for their profession.

Some data items previously collected by the AIHW Labour Force Surveys are now collected by the NRAS. However, some data quality issues due to migrated data items from the respective state and territory health profession boards may have affected the weighting method.

Medical practitioners, dental practitioners, nurses/midwives and allied health practitioners who reside overseas have been included with practitioners whose state or territory of principal practice and state or territory of main job, respectively, could not be determined.

Health Workforce Survey

The online survey questionnaire does not include electronic sequencing of

questions to automatically guide the respondent to the next appropriate question based on previous responses to questions. This resulted in a number of inconsistent responses.

The order of the response categories for some questions may have also impacted on the accuracy of the information captured. In addition, there was variation in some responses between the online and paper surveys.

NHWDS data by profession

The following should be noted when comparing state and territory indicator data:

- The data include employed professionals who did not state or adequately describe their state of principal practice and employed professionals who reside overseas. The national estimates include this group.

National Health Workforce Data Set: medical practitioners 2010 and 2011

- The overall response rate for 2010 (excluding Queensland and WA) was 76.6 per cent. Of these respondents, 65.4 per cent completed the survey online and 34.6 per cent used the paper form.
- The overall response rate for 2011 was 85.3 per cent. Of these respondents, 84.7 per cent completed the survey online and 15.3 per cent used paper.

National Health Workforce Data Set: nurses and midwives 2011

- The overall response rate was 85.1 per cent. Of these respondents, 86.7 per cent completed the survey online and 13.3 per cent used paper.

National Health Workforce Data Set: dental practitioners 2011

- The overall response rate was 80.3 per cent. Of these respondents, 84.5 per cent completed the survey online and 15.5 per cent used paper.

National Health Workforce Data Set: allied health practitioners 2011 and 2012

- The overall response rate for 2011 was 61.4 per cent. Of these respondents, 91.5 per cent completed the survey online and 8.5 per cent used paper.
- The overall response rate for 2012 was 68.7 per cent. Of these respondents, 92.8 per cent completed the survey online and 7.2 per cent used paper.

Coherence

Health Workforce Survey—coherence with previous surveys

Labour force data published by the AIHW before the NRAS was established in July 2010, were the result of collated jurisdiction-level occupation-specific surveys. The current Health Workforce Survey gathers similar information from each professional group through a separate questionnaire, tailored slightly to take account of profession-specific responses to certain questions, e.g. work setting of main job.

For this indicator, the workforce surveys for medical practitioners, dental practitioners, nurses/midwives and allied health practitioners collect similar data items, but the methodology differs from previous years. The AHPRA is now the single source of registered practitioner data instead of eight state and territories bodies for each profession, and there is greater consistency between jurisdictions and years in the scope of registration information.

The scope and coverage of the Health Workforce Survey is also different from that of the previous series of AIHW Labour Force Surveys as not all jurisdictions surveyed all types of registered health practitioners.

If the location of principal practice recorded in the registration data was different from the corresponding details of their main job self-reported by practitioners in the survey, the location was derived hierarchically based on main job information and then on principal practice location then place of residence.

	Date of birth is one of many data items previously collected by the AIHW Labour Force Surveys, which is now collected by the NRAS. The three employment-related questions in the new survey are now nationally consistent, but vary from the previous AIHW Labour Force Survey. Due to the differences in data collection (including survey design and questionnaire), processing and estimation methods, it is recommended that comparisons between workforce data from the NHWDS and the previous AIHW Labour Force Survey be made with caution. AIHW Published Numbers For this indicator, the rates are based on practitioners employed in the medical, allied health and nursing and midwifery workforces, which is consistent with data published in AIHW's workforce reports. Except dental practitioner data are restricted to persons employed in the public sector and are thus not comparable to figures published elsewhere by the AIHW. Registration data from the NRAS—coherence with published AHPRA/Board data The NHWDS comprises the registration data extracted at a point in time from the NRAS, while the AHPRA/Board numbers include people registered in the previous 12 months, thereby including registrants whose registration terminated during that period (including short term registrants). For 2011, the only source of published statistics about registered health professionals is the 2010–11 AHPRA annual report. From March 2012, each Board publishes the data on a quarterly basis. *Medical practitioners in 2010 and 2011.* The NHWDS numbers of registered medical practitioners for 2010 and 2011 are similar to data reported in the 2010–11 AHPRA annual report. For 2010, there were 84 516 registered practitioners for 2010, compared with 88,293 registered practitioners at 30 June 2011 in the AHPRA annual report. For 2011, there were 87 790 practitioners in the NHWDS. Furthermore, the Medical Board of Australia in their quarterly data tables reported 91,354 for March 2012 and 91 645 for June 2012. *Nurses/midwives in 2011* The NHWDS number of registered nurses and midwives for 2011 is similar to data reported in the 2010–11 AHPRA annual report, with 330,680 registered nurses and midwives in the NHWDS, compared with 332,185 registered nurses and midwives at 30 June 2011 in the AHPRA annual report. The Nursing and Midwifery Board of Australia in their quarterly data tables reported 341 189 for March 2012 and 343 703 for June 2012. *Dental practitioners in 2011* The NHWDS number of registered dental practitioners for 2011 is similar to data reported in the 2010–11 AHPRA annual report, with 18 803 registered practitioners in the NHWDS, compared with 18 319 registered dental practitioners at 30 June 2011 in the AHPRA annual report. The Dental Board of Australia in their quarterly data tables reported 18 902 for March 2012 and 19 087 for June 2012. *Allied health practitioners in 2011 and 2012* The NHWDS number of registered allied health practitioners for 2011 and 2012 are similar to data reported in the 2010–11 AHPRA annual report. For 2011, there were 91 587 registered practitioners in the NHWDS, compared with 91 318 registrations at 30 June 2011 in the AHPRA annual report. For 2012, there were 126 788 registered practitioners in the NHWDS, compared with 128 408 reported at December 2012 in the AHPRA quarterly data tables.
Accessibility	Published products available on the AIHW website include workforce reports, survey questionnaires, user guides to the data sets and supplementary

	detailed tables.
Interpretability	Explanatory information for the Medical Workforce Survey, Dental Workforce Survey and the Nursing and Midwifery Workforce Survey is contained in the published reports, supplementary detailed tables and data quality statements to the data set for each. For individual allied health professions, information about their workforce surveys is available in the *Allied health workforce 2012* report and data quality statement. This includes collection method, scope and coverage, survey response, imputation and weighting procedures, and assessment of data quality (including comparison with other data sources). These are available via the AIHW website and readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. The indicator does not provide information on those currently in training and the intentions of those in the medical workforce to leave the workforce in the near future. Due to the differences in data collection, processing and estimation methods, including survey design and questionnaire, it is recommended that comparisons between workforce data from the National Health Workforce Data Set (NHWDS) and the previous Australian Institute of Health and Welfare (AIHW) Labour Force Survey be made with caution. Results for the indicator are estimates because the survey data have undergone imputation and weighting to adjust for non-response. It should be noted that any of these adjustments may have introduced some bias in the estimates and any bias is likely to become more pronounced when response rates are low or when estimates are based on a small number of survey records. Care should be taken when drawing conclusions about the size of the differences between estimates. Data have been revised since the publication of Medical workforce 2010, Medical workforce 2011 and Nursing and midwifery workforce 2011 so these data will not match data previously published.

Cost per casemix-adjusted separation

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost per casemix-adjusted separation
Measure (computation)	Recurrent cost per casemix-adjusted separation The average cost per case mix-adjusted separation in public hospitals. The formula used to calculate the cost per casemix-adjusted separation is: (Recurrent expenditure × IFRAC) ÷ (Total separations × Average cost weight) Where: • Recurrent expenditure is as defined by the recurrent expenditure data elements in the National Minimum Data Set for Public Hospital Establishments.

- IFRAC (admitted patient cost proportion) is the estimated proportion of total hospital expenditure that relates to admitted patient care.
- Average cost weight is calculated from the National Hospital Morbidity Database, using the 2009-10 Australian Refined Diagnosis Related Group (AR-DRG) version 6.0x cost weights published by the Department of Health.

Total cost per casemix-adjusted separation

'Total cost per casemix-adjusted separation' is defined as the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. The indicator is included because it allows the full cost of hospital services to be considered in a single measure. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation.

Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other government services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs in all jurisdictions to avoid double counting.

Data source/s

Recurrent cost per casemix-adjusted separation

This indicator is calculated using data from the NPHED and the NHMD. The NPHED contains information on public hospital expenditure and estimates of the proportion of recurrent expenditure attributed to admitted patient care. The NPHED is based on the National Minimum Data Set (NMDS) for Public hospital establishments.

The NHMD is the source of data on casemix-adjusted separations for public hospitals. The NHMD is based on the NMDS for Admitted patient care.

Casemix-adjusted separations are calculated by the application of cost weights sourced from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection for each separation's recorded AR-DRG.

Total cost per casemix-adjusted separation

Capital costs are sourced from state and territory health departments as part of the annual Report on Government Services data collection.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 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 Health portfolio.

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.

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.

	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): www.aihw.gov.au/nhissc/ www.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.
Relevance	The purpose of the NMDS for Public hospital establishments is to collect information on the characteristics of public hospitals and summary information on non-admitted services provided by them. The scope is public hospitals in Australia, including public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans Affairs, and drug and alcohol treatment centres. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The collection covers hospitals within the jurisdiction of the State and Territory health authorities. Hence, public hospitals not administered by the State and Territory health authorities (hospitals operated by correctional authorities or the Australian Defence Force for example, and hospitals located in offshore territories) are not included. The collection does not include data for private hospitals. 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 all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. The scope of the analysis includes public hospitals that provide mainly acute care. These are the hospitals in the public hospital peer groups of Principal referral and specialist women's and children's hospitals, Large hospitals, Medium hospitals, and Small acute hospitals. Excluded are Small non-acute hospitals, Multi-purpose services, Hospices, Rehabilitation hospitals, Mothercraft hospitals, Other non-acute hospitals, Psychiatric hospitals, and hospitals in the Unpeered and other hospitals peer group. Also excluded are hospitals for which expenditure or admitted patient care data were incomplete, although most of these were excluded for other reasons (for example they are small non-acute hospitals). This indicator is an efficiency indicator, in which the numerator represents the amount of resources used (expenditure) to generate outputs (measured in a standardised way, that is, as cost-weighted separations).
Timeliness	The reference period for this data set is 2011-12.

Accuracy

For 2011-12, coverage of the NPHED was essentially complete. Almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation 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 data are defined in the NMDSs detailed above.

However, the comparability of the cost per casemix-adjusted separation in any one year is sensitive to a number of deficiencies in available data:

- the proportion of recurrent expenditure that relates to admitted patient care is estimated in different ways in different hospitals and is not always comparable
- capital costs are not included in the numerator. While depreciation information is provided by most jurisdictions, this may vary across states and territories
- only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. The proportions of separations that are not acute vary across states and territories.
- the proportions of patients other than public patients vary across states and territories, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error.

Cells have been suppressed to protect confidentiality (where the numerator would identify a single service provider).

Coherence

The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2011-12.*

The denominator for the indicator is based on the reported admitted patient activity, adjusted using cost-weights to derive a 'standard' unit of output as an artificial construct. The estimated number of cost-weighted separations (particularly using constant AR-DRGs and AR-DRG cost weights over time) is for comparison purposes only.

Time series analysis of this indicator is not recommended.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD and the NPHED. Published products available on the AIHW website include:

- *Australian hospital statistics* with associated Excel tables
- Interactive data cubes for Public hospital establishments.

Interpretability

Supporting information on the quality and use of the NPHED and 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, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and 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 key data gaps/issues: • the proportion of recurrent expenditure that relates to admitted patient care is estimated in different ways in different hospitals and is not always comparable • only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. • the proportion of patients other than public patients can vary, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error. • Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Relative stay index

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Relative Stay Index
Measure (computation)	Relative stay indexes (RSIs) are calculated as the number of observed patient days' for separations in selected AR-DRGs, divided by the number of expected patient days', standardised for casemix (based on national figures). An RSI greater than 1.0 indicates that an average patient's length of stay is higher than expected given the casemix for the group of separations of interest. An RSI of less than 1.0 indicates that the length of stay was less than expected. The standardisation for casemix (based on AR-DRG version 6.0x and the age of the patient for each separation) allows comparisons to be made that take into account variation in types of services provided; however, it does not take into account other influences on length of stay, such as Indigenous status. The RSI method includes acute care separations only, and excludes separations for patients who died or were transferred within 2 days of admission, or with a length of stay greater than 120 days. Excluded from the analysis were: • AR-DRGs for rehabilitation (such as Z60A *Rehabilitation with catastrophic/severe complications or comorbidities*) • predominantly same-day AR-DRGs (such as R63Z *Chemotherapy* and L61Z *Admit for renal dialysis*) • AR-DRGs with a length of stay component in the definition • *Error* AR-DRGs
Data source/s	The NHMD is the source of data on casemix adjusted separations for public hospitals. The NHMD is based on the NMDS for Admitted patient care. Casemix adjusted separations are calculated by the application of cost weights sourced from the Independent Hospital Pricing Authority's National Hospital Cost Data Collection for each separation's recorded AR-DRG.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of

	Health and Welfare Act 1987 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 Health portfolio. 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. 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. 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): www.aihw.gov.au/nhissc/ www.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.
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 all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. The scope of the analysis includes public hospitals that provide mainly acute care. These are the hospitals in the public hospital peer groups of Principal referral and specialist women's and children's hospitals, Large hospitals, Medium hospitals, and Small acute hospitals. Excluded are Small non-acute hospitals, Multi-purpose services, Hospices, Rehabilitation hospitals, Mothercraft hospitals, Other non-acute hospitals, Psychiatric hospitals, and hospitals in the Unpeered and other hospitals peer group. Also excluded are hospitals for which expenditure or admitted patient care data were incomplete, although most of these were excluded for other reasons (for example they are Small non-acute hospitals).

Timeliness	The reference period for this data set is 2011-12.
Accuracy	Almost all public hospitals provided data for the NHMD, with the exception of a Mothercraft hospital in the ACT. States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validation 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 comparability of the RSI in any one year is sensitive to a number of deficiencies in available data: • only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. The proportions of separations that are not acute vary across states and territories. • the proportions of patients other than public patients vary across states and territories, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error. Cells have been suppressed to protect confidentiality (where the numerator would identify a single service provider).
Coherence	The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2011-12*. The denominator for the indicator is based on the reported admitted patient activity, adjusted using cost-weights to derive a 'standard' unit of output as an artificial construct. The estimated number of cost-weighted separations (particularly using constant AR-DRGs and AR-DRG cost weights over time) is for comparison purposes only. Comparisons with RSIs presented in *Australian hospital statistics 2003–04* (AIHW 2005) and earlier reports should be made with caution, because the indexes for earlier years were calculated using AR-DRG version 4, for reports from 2004–05 to 2009–10, the RSIs were calculated using AR-DRG versions 5.0/5.1/5.2 and for 2010-11 and 2011-12, the RSIs were calculated using AR-DRG versions 6.0/6.0x. Time series analysis of this indicator is not recommended.
Accessibility	The AIHW provides a variety of products that draw upon the NHMD and the NPHED. Published products available on the AIHW website include: • Australian hospital statistics with associated Excel tables • Interactive data cubes for Public hospital establishments.
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, changes in accounting methods and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Public hospital establishments and 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	The Steering Committee notes the following issues:

gaps/issues	• only cost weights applicable to acute care separations are available, so these have been applied to all separations, including the 3 per cent that were not acute. • the proportion of patients other than public patients can vary, and the estimation of medical costs for these patients (undertaken to adjust expenditure to resemble what it would be if all patients had been public patients) is subject to error. • Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Recurrent cost per non-admitted occasion of service

Data quality information for this indicator has been sourced from the Review with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Recurrent cost per non-admitted occasion of service
Measure (computation)	Recurrent cost per non-admitted occasion of service' is defined as the proportion of recurrent expenditure allocated to patients who were not admitted, divided by the total number of non-admitted patient occasions of service in public hospitals. Occasions of service include examinations, consultations, treatments or other services provided to patients in each functional unit of a hospital. Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.
Data source/s	This indicator is calculated using data from states and territories collected by the Review.

Data Quality Framework Dimensions

Institutional environment	Data were supplied by State and Territory health authorities. The State and Territory health authorities receive these data from patient administrative and clinical records. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	This indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids.
Timeliness	The reference period for this data set is 2011-12.
Accuracy	Inaccurate responses may occur in all data provided to the Review. The Review does not have direct access to records to determine the accuracy of the data provided. However, the Review undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The Review does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the Review. Processing errors prior to data supply may be found through the validation checks applied by the Review. This indicator is calculated on data that has been reported to the Review. Prior to publication, these data are referred back to jurisdictions for checking and review. The Review does not adjust the data to correct for missing values.
Coherence	Data are not available for two jurisdictions, Victoria and the NT.

These data are not comparable across jurisdictions. There is considerable variation among states and territories and between reporting years in the way in which non-admitted patient occasions of service data are collected.

- There are differing admission practices between the states and territories.
- There is variation in the types of services provided for non-admitted patients and the type of facility providing these services, for example, states and territories may differ in the extent to which outpatient services are provided in non-hospital settings (such as community health services).
- Reporting categories vary across jurisdictions.
- Inconsistencies arising from differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service.

Statistics on emergency department presentations for non-admitted patients may be affected by variations in reporting practices across states and territories. Although there are national standards for data on non-admitted patient emergency department services there are some variations in how those services are defined and counted across states and territories and over time. For example, there is variation in:

- the point at which the commencement of clinical care is reported
- the point at which the emergency department presentation is reported as completed for those patients subsequently admitted within the emergency department and/or elsewhere in the hospital.

For some jurisdictions, the reporting of outpatient clinic care varied over the periods 2010–11 and 2011–12, in order to align with the reporting requirements for Activity Based Funding. These changes included: the discontinuation of reporting for some activity; the commencement of reporting for some activity; and the re-categorisation of some clinics according to the Tier 2 clinics structure. Therefore, these data may not be comparable with data reported for previous years.

Accessibility

Cost per occasion of service data are not widely published elsewhere due to data quality issues. No nationally data collection currently exists which can produce comparable data. Data collection and reporting practices differ greatly across jurisdictions.

Interpretability

Supporting information on the quality and use of the data are not publicly available. Metadata such as concepts, classifications and counting rules are not published and are not consistent across jurisdictions.

Definitions are not well developed and could be ambiguous or confusing to the user.

There is little other information available to assist the user such as glossaries, standards, explanatory material, methodological information, user guides or classifications.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- the of recurrent expenditure that relates to occasions of service is estimated in different ways in different hospitals and is not always comparable
- This indicator does not adjust for the complexity of service, it is desirable for data to be casemix adjusted
- Variations in admission practices and policies lead to variation among

providers in the number of admissions for some conditions

- Data are not available for two jurisdictions, Victoria and the NT.

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 Outcome

Indicator Patient satisfaction

Measure (computation) Patient Experience Survey

Nationally comparable information that indicates levels of patient satisfaction around key aspects of care they received.

Numerators:

- persons who had been to a hospital emergency department in the last 12 months reporting doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them
- persons who had been to a hospital emergency department in the last 12 months reporting nurses always or often: listened carefully, showed respect, and spent enough time with them
- persons who had been admitted to a hospital in the last 12 months reporting doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them
- persons who have been admitted to a hospital in the last 12 months reporting nurses always or often: listened carefully, showed respect, and spent enough time with them

Denominators:

- persons who had been to a hospital emergency department in the last 12 months, excluding persons who were interviewed by proxy
- persons who had been to a hospital emergency department in the last 12 months, excluding persons who were interviewed by proxy
- persons who had been admitted to a hospital in the last 12 months, excluding persons who were interviewed by proxy
- persons who have been admitted to a hospital in the last 12 months, excluding persons who were interviewed by proxy

State and territory based survey data

This indicator also reports information on patient surveys undertaken by states and territories. The descriptive information includes the survey time period, method, sample size, response rate and a selection of results where available. This indicator also provides information on how jurisdictions have used patient satisfaction surveys to improve public hospital quality in recent years.

Data source/s ABS Patient Experience Survey, 2012-13.
State and territory based survey data are sourced from state and territory governments.

Data Quality Framework Dimensions

Institutional Patient Experience Survey

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 Collection authority: The Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. Data Compiler(s): Data is compiled by the Health 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 is withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible. State and territory based survey data The Secretariat for the Review of Government Service Provision has collated the State and territory based survey data. The data were supplied by State and Territory health authorities. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	Level of Geography: Data is available by State/Territory, 2011 SEIFA and 2011 Remoteness (major cities, inner and outer regional, remote and very remote Australia). Data Completeness: All data is available for this indicator from this source. Indigenous Statistics: Indigenous data and associated data quality statements will be provided in a separate data supply. Due to differences in survey design and collection methodology, ABS advises that data from the Patient Experience survey is not comparable to data from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). As such, comparisons between Indigenous and the general population are not available for this indicator. Socioeconomic status data: Data is available by the 2011 SEIFA index of disadvantage. There has been no significant impact from transitioning from 2006 SEIFA to 2011 SEIFA. Similarly, there has been no significant impact from transitioning from the 2006 remoteness classification to the 2011 remoteness classification. Numerator/Denominator Source: Same data source. Data for this indicator was collected for all persons in Australia, excluding the following people: • members of the Australian permanent defence forces • diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts • overseas residents in Australia • members of non-Australian defence forces (and their dependents) • people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons • 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 2012-13 iteration continues to include data from very remote areas. The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas. Data was self-reported for this indicator. Persons who were interviewed by proxy were excluded.
Timeliness	Patient Experience Survey Collection interval/s: Patient Experience data is collected annually. Data available: The 2012-13 data used for this indicator became available from 22 November 2013. Referenced Period: July 2012 to June 2013. There are not likely to be revisions to this data after its release. State and territory based survey data Timeliness varies between jurisdictions, although most jurisdictions have undertaken some type of survey in 2010 and/or 2011.
Accuracy	Patient Experience Survey Method of Collection: The data was collected by computer assisted telephone interview. Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Sample/Collection size: The sample for the 2012-13 patient experience survey was 30,749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26,437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation. Response rate: Response rate for the survey was 78.9 per cent As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 per cent and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use. 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. Similarly, data for the “other” remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data. The data for this indicator is attitudinal, as it collects whether people felt they waited too long to get an appointment with a GP or specialist, and whether the person felt the health professional in question spent enough time with them, listened carefully and showed them respect (the ‘patient satisfaction’ questions). Data is used from personal interviews only (i.e. excluding proxy interviews). Explanatory footnotes are provided for each table. State and territory based survey data Accuracy varies between jurisdictions depending on the survey method and factors such as response rates and sample sizes.
Coherence	Patient Experience Survey Consistency over time: 2009 was the first year data was collected for this

	indicator. Questions relating to acceptable waiting times for GPs were asked in 2009, 2010-11, 2011-12 and 2012-13. While the question wording itself did not change, the position in the survey (ie where the question was asked) changed in 2011-12 and again in 2012-13. There has been a noticeable contextual effect with this change in question ordering, and ABS recommends that this data item is not comparable over time. This has been footnoted in the relevant tables. Similarly, questions relating to acceptable waiting times for Medical Specialists were asked in 2009, 2010-11, 2011-12 and 2012-13. While the question wording itself did not change, the position in the survey (ie where the question was asked) changed in 2011-12. There has been a noticeable contextual effect with this change in question ordering. As such, ABS recommends that 2012-13 data is comparable to 2011-12, but not before this (ie not comparable to 2010-11 or 2009). As a result, a time series can be started from 2011-12 onwards. This has been footnoted in the relevant tables. 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. <u>State and territory based survey data</u> State and territory based surveys differ in method, content, timing and scope across jurisdictions, so it is not possible to compare the results nationally.
Accessibility	<u>Patient Experience Survey</u> Data publicly available. Tables showing patients experiences with health professionals are available in Health Services: Patient Experiences in Australia, 2009 (cat. no. 4839.0.55.001), Patient Experiences in Australia: Summary of Findings, 2010-11, Patient Experiences in Australia: Summary of Findings, 2011-12 and Patient Experiences in Australia: Summary of Findings, 2012-13 (cat. no. 4839.0). Data for this indicator is shown by age, sex, SEIFA and remoteness. Jurisdictional data is not currently publicly available but may be made available in the future. Data is 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. <u>State and territory based survey data</u> Approaches to making survey results available to the public vary between States and territories.
Interpretability	Context: This data was collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data was collected over a twelve month period and therefore

should minimise any seasonality effects in the data.

Other Supporting information: The ABS Patient Experience data is published in Patient Experiences in Australia: Summary of Findings, 2012-13 (cat. no. 4839.0). This publication includes explanatory and technical notes.

Socioeconomic status definition: The SEIFA Index of Relative Socio-economic Disadvantage uses a broad definition of relative socio-economic disadvantage in terms of people's access to material and social resources, and their ability to participate in society. While SEIFA represents an average of all people living in an area, it does not represent the individual situation of each person. Larger areas are more likely to have greater diversity of people and households.

Socioeconomic status derivation: The 2011 SEIFA index of relative socio-economic disadvantage is derived from Census variables related to disadvantage, such as low income, low educational attainment, unemployment, and dwellings without motor vehicles.

Socioeconomic status deciles derivation: Deciles are based on an equal number of areas. A score for a collection district (CD) is created by adding together the weighted characteristics of that CD. The scores for all CDs are then standardised to a distribution where the average equals 1000 and roughly two-thirds of the scores lie between 900 and 1100. The CDs are ranked in order of their score, from lowest to highest. Decile 1 contains the bottom 10 per cent of CDs, Decile 2 contains the next 10 per cent of CDs and so on. Further information on SEIFA can be found in the ABS Technical paper Socio-Economic Indexes for Areas 2011 (cat. No. 2033.0.55.001).

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2012-13 (cat. no. 4839.0).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The Patient Experience Survey does not include people living in very remote areas, which affects the comparability of the NT results.
- State and Territory disaggregation of this indicator by Indigenous status and SES is a priority.
- Due to the requirement for sufficient data in specific age groups for the age standardisation process, remoteness disaggregation of age-standardised data by State and Territory is only available by major cities (with the other remoteness categories combined), with no State and Territory disaggregation available for SES.
- State and territory based surveys differ in method, content, timing and scope across jurisdictions, so it is not possible to compare the results nationally.

Caesareans and inductions for selected primiparae

Data quality information for this indicator has been sourced from states and territories with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Caesareans and inductions for selected primiparae
Measure	Caesareans and inductions for selected primiparae' are defined as the number of inductions or caesareans for the selected primiparae divided

(computation)	respectively by the number of the selected primiparae who gave birth. Rates are reported for women aged between 25 and 29 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks. This group is considered to be low risk parturients, so caesarean or induction rates should be low in their population. Primiparae refers to a woman who has given birth to a liveborn or stillborn infant for the first time. Parturient means 'about to give birth'
Data source/s	This indicator is calculated using data from states and territories.

Data Quality Framework Dimensions

Institutional environment	Data were supplied by State and Territory health authorities. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	High intervention rates can indicate a need for investigation, although labour inductions and birth by caesarean section are interventions that are appropriate in some circumstances, depending on the health and wellbeing of mothers and babies.
Timeliness	The reference period for the data is 2012. Collection of data is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Review. The Review does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Review undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The Review does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the Review. Processing errors prior to data supply may be found through the validation checks applied by the Review. This indicator is calculated on data that has been reported to the Review. Prior to publication, these data are referred back to jurisdictions for checking and review. The Review does not adjust the data to correct for missing values.
Coherence	Note that because of data editing and subsequent updates of State/Territory databases, numbers reported for this indicator can differ from those in reports published by the states and territories. Changing levels of Indigenous identification over time and across jurisdictions may also affect the accuracy of compiling a consistent time series in future years.
Accessibility	Data are published by states and territories and are also collected by the AIHW as part of the National Perinatal Data Collection. Note that the AIHW data are available to the Review one year later than that available to the Review by collecting data direct from states and territories. The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are: • Australia's mothers and babies annual report • Indigenous mothers and their babies, Australia 2001–2004 • METeOR – online metadata repository • National health data dictionary. Ad-hoc data are also available on request (charges apply to recover costs).
Interpretability	Supporting information on the use and quality of the Perinatal NMDS are

	published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2001 to 2005. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in Indigenous mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5). Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.
Data Gaps/Issues Analysis	
Key data gaps/issues	The Steering Committee notes the following issues: • Data are collected direct from states and territories and are not reliable as they are not collected under a NMDS and have had minimal validation. The AIHW data, however, are less timely and are available to the Review one year later than that available to the Review by collecting data direct from states and territories. • Disaggregation of this indicator for Indigenous status and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Instrument vaginal births

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description	
Element	Effectiveness—appropriateness
Indicator	Instrument vaginal births
Measure (computation)	'Instrument vaginal births' is defined as the number of instrument vaginal births as a percentage of total births. Instrument vaginal births includes forceps and vacuum extraction. The indicator is calculated for women aged 20 to 34 years, with a singleton baby positioned with head towards the cervix at the onset of labour born between 37 and 41 weeks gestation.
Data source/s	This indicator is calculated using data from the AIHW National Perinatal Data Collection (NPDC).
Data Quality Framework Dimensions	
Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. Data were supplied by State and Territory health authorities to the National Perinatal Epidemiology and Statistics Unit (NPESU), a collaborating unit of the Institute. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at

	birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s). The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.
Timeliness	The reference period for the data is 2011. Collection of data for the NPDC is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.
Coherence	Data for this indicator are published in the AIHW National Perinatal Epidemiology and Statistics Unit report *National core maternity indicators*.
Accessibility	The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are: • Australia's mothers and babies annual report • Indigenous mothers and their babies, Australia 2001–2004 • National core maternity indicators • METeOR – online metadata repository • National health data dictionary. Ad-hoc data are also available on request (charges apply to recover costs).
Interpretability	Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2006 to 2009. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in Indigenous mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5). Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: • Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data. • Disaggregation of this indicator for Indigenous status and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Vaginal delivery following a previous caesarean

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness—appropriateness
Indicator	Vaginal delivery following a previous caesarean
Measure (computation)	'Vaginal delivery following a previous caesarean' is defined as the percentage of multiparous mothers who have had a previous caesarean, whose current method of birth was either an instrumental or non-instrumental vaginal delivery. Multiparous means a pregnant woman who had at least one previous pregnancy resulting in a live birth or stillbirth. For multiple births, the method of birth of the first born baby was used.
Data source/s	This indicator is calculated using data from the AIHW National Perinatal Data Collection (NPDC).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. Data were supplied by State and Territory health authorities to the National Perinatal Epidemiology and Statistics Unit (NPESU), a collaborating unit of the Institute. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s). The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.
Timeliness	The reference period for the data is 2011. Collection of data for the NPDC is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Institute. The

	Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.
Coherence	Data for this indicator are published in the annual report Australia's mothers and babies.
Accessibility	The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are: • Australia's mothers and babies annual report • Indigenous mothers and their babies, Australia 2001–2004 • METeOR – online metadata repository • National health data dictionary. Ad-hoc data are also available on request (charges apply to recover costs).
Interpretability	Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2006 to 2009. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in Indigenous mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5). Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issues:

- Interpretation of this indicator is ambiguous. There is ongoing debate about the relative risk to both mother and baby of a repeat caesarean section compared with a vaginal birth following a previous caesarean. Low rates of vaginal birth following a previous caesarean may warrant investigation, or on the other hand, they can indicate appropriate clinical caution. When interpreting this indicator, emphasis needs to be given to the potential for improvement.
- Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data.
- A formal assessment of the extent of under-identification of Indigenous status in the NPDC is required. This will identify whether the data require adjustment, and contribute to improved time series reporting.
- Disaggregation of this indicator for SES and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Perineal status after vaginal birth

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — quality/safety
Indicator	Perineal status after vaginal birth
Measure (computation)	'Perineal status after vaginal birth' is the percentage of mothers with third or fourth degree lacerations to their perineum after a vaginal birth. A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa. For multiple births, the perineal status after birth of the first child was used.
Data source/s	This indicator is calculated using data from the AIHW National Perinatal Data Collection (NPDC).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. Data were supplied by State and Territory health authorities to the National Perinatal Epidemiology and Statistics Unit (NPESU), a collaborating unit of the Institute. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the

	mother and baby(s). The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and neonatal length of stay.
Timeliness	The reference period for the data is 2011. Collection of data for the NPDC is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded.
Coherence	Data for this indicator are published in the annual report Australia's mothers and babies.
Accessibility	The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are: • Australia's mothers and babies annual report • Indigenous mothers and their babies, Australia 2001–2004 • METeOR – online metadata repository • National health data dictionary. Ad-hoc data are also available on request (charges apply to recover costs).
Interpretability	Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2006 to 2009. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in Indigenous mothers and their babies, Australia 2001–2004 (Chapter 1 and Chapter 5). Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data	The Steering Committee notes the following issues:

gaps/issues	• Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths. • Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data. • A formal assessment of the extent of under-identification of Indigenous status in the NPDC is required. This will identify whether the data require adjustment, and contribute to improved time series reporting. • Disaggregation of this indicator for SES and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Apgar score at five minutes

Data quality information for this indicator has been sourced from states and territories with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Apgar score at five minutes
Measure (computation)	This indicator is defined as the number of live births with an Apgar score of 3 or less, at five minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories. The Apgar score is a numerical score that indicates a baby's condition shortly after birth. Apgar scores are based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability. Between 0 and 2 points are given for each of these five characteristics and the total score is between 0 and 10. The Apgar score is routinely assessed at one and five minutes after birth, and subsequently at five minute intervals if it is still low at five minutes.
Data source/s	This indicator is calculated using data from states and territories.

Data Quality Framework Dimensions

Institutional environment	Data were supplied by State and Territory health authorities. The State and Territory health authorities receive these data from patient administrative and clinical records. This information is usually collected by midwives or other birth attendants. States and territories use these data for service planning, monitoring and internal and public reporting.
Relevance	The National Perinatal Data Collection comprises data items as specified in the Perinatal NMDS plus additional items collected by the states and territories. The purpose of the Perinatal NMDS is to collect information at birth for monitoring pregnancy, childbirth and the neonatal period for both the mother and baby(s). The Perinatal NMDS is a specification for data collected on all births in Australia in hospitals, birth centres and the community. It includes information for all live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth; and data items relating to the baby, including birth status (live or stillbirth), sex, gestational age at birth, birth weight, Apgar score and

	neonatal length of stay.
Timeliness	The reference period for the data is 2011. Collection of data is annual.
Accuracy	Inaccurate responses may occur in all data provided to the Institute. The Institute does not have direct access to perinatal records to determine the accuracy of the data provided. However, the Institute undertakes validation on receipt of data. Data received from states and territories are checked for completeness, validity and logical errors. Potential errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors. Errors may occur during the processing of data by the states and territories or at the AIHW. Processing errors prior to data supply may be found through the validation checks applied by the Institute. This indicator is calculated on data that has been reported to the AIHW. Prior to publication, these data are referred back to jurisdictions for checking and review. The Institute does not adjust the data to correct for missing values. Note that because of data editing and subsequent updates of State/Territory databases, and because data are being reported by place of residence rather than place of birth the numbers reported for this indicator differ from those in reports published by the states and territories. The data are not rounded. The geographical location code for the area of usual residence of the mother is included in the Perinatal NMDS. Only 0.2 per cent of records were non-residents or could not be assigned to a state or territory of residence. There is no scope in the data element Area of usual residence of mother to discriminate temporary residence of mother for the purposes of accessing birthing services from usual residence. The former may differentially impact populations from remote and very remote areas, where services are not available locally.
Coherence	Data for this indicator are published in the annual report Australia's mothers and babies; and biennially in reports such as the Aboriginal and Torres Strait Islander Health Performance Framework report, the Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, and the Overcoming Indigenous Disadvantage report. The numbers presented in these publications will differ slightly from those presented here as this measure excludes multiple births and stillbirths. Changing levels of Indigenous identification over time and across jurisdictions may also affect the accuracy of compiling a consistent time series in future years.
Accessibility	The AIHW provides a variety of products that draw upon the NPDC. Published products available on the AIHW website are: • Australia's mothers and babies annual report • Indigenous mothers and their babies, Australia 2001–2004 • METeOR – online metadata repository • National health data dictionary. Ad-hoc data are also available on request (charges apply to recover costs).
Interpretability	Supporting information on the use and quality of the Perinatal NMDS are published annually in Australia's mothers and babies (Chapter 1), available in hard copy or on the AIHW website. Comprehensive information on the quality of Perinatal NMDS elements are published in Perinatal National Minimum Data Set compliance evaluation 2001 to 2005. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. More detailed information on the quality of Indigenous data that might affect interpretation of the indicator was published in Indigenous mothers and their babies, Australia 2001–2004

	(Chapter 1 and Chapter 5). Metadata information for this indicator has been published in the AIHW's online metadata repository — METeOR. Metadata information for the Perinatal NMDS are also published in METeOR, and the National health data dictionary.
Data Gaps/Issues Analysis	
Key data gaps/issues	The Steering Committee notes the following issues: • Data are relatively old and may not be representative of current outcomes. Further work is required to ensure availability of more timely data. • Disaggregation of this indicator for Indigenous status and remoteness by State and Territory is a priority. Further development work on the current data source is required.

Fetal, neonatal and perinatal deaths

Data quality information for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description	
Element	Outcome
Indicator	Fetal, neonatal and perinatal deaths
Measure (computation)	Fetal deaths *Numerator:* Fetal deaths (stillbirth). The birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks. *Denominator:* Total number of births (live births and fetal deaths combined). *Computation:* The 'fetal death rate' is calculated as the number of fetal deaths divided by the total number of births expressed per 1000 total births, by State or Territory of usual residence of the mother. Neonatal deaths *Numerator:* Neonatal deaths. The death of a live born infant within 28 days of birth. *Denominator:* The number of live births registered. *Computation:* The 'neonatal death rate' is calculated as the number of neonatal deaths divided by the number of live births expressed per 1000 live births, by state or territory of usual residence of the mother Perinatal death *Numerator:* A perinatal death is a fetal or neonatal death. *Denominator:* The total number of births (live births and fetal deaths combined). *Computation:* The 'perinatal death rate' is calculated as the number of perinatal deaths divided by the total number of births expressed per 1000 total births, by State or Territory of usual residence of the mother.
Data source/s	ABS *Perinatal deaths, Australia*, Cat. no. 3304.0 sourced from death registrations administered by the various state and territory Registrars of Births, Deaths and Marriages.

Data Quality Framework Dimensions

Institutional environment

Statistics presented in *Perinatal Deaths, Australia, 2010* (cat. no. 3304.0) are sourced from death registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all neonatal deaths and those fetal deaths of at least 20 weeks gestation or 400 grams birth weight are registered. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a Certificate of Cause of Perinatal Death, or supplied as a result of a coronial investigation.

Death records are provided electronically and/or in paper form to the ABS by individual Registrars on a monthly basis. Each death record contains both demographic data and medical information from the Certificate of Cause of Perinatal Death where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS).

For further information on the institutional environment of the Australian Bureau of Statistics (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

Perinatal statistics provide valuable information for the analysis of fetal, neonatal and perinatal deaths in Australia. This electronic product presents data at the national and state level on registered perinatal deaths by sex, state of usual residence, main condition in fetus/infant, main condition in mother and Indigenous status. Fetal, neonatal and perinatal death rates are also provided.

The ABS Perinatal Deaths collection includes all perinatal deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or perinatal deaths statistics.

From the 2006 reference year, the scope of the perinatal death statistics includes all fetal deaths of at least 20 weeks gestation or at least 400 grams birth weight, and all neonatal deaths (all live born babies who die within 28 days of birth, regardless of gestation or weight) which are:

- registered in Australia for the reference year and are received by the ABS by the end of the March quarter of the subsequent year; and
- registered prior to the reference year but not previously received from the Registrar nor included in any statistics reported for an earlier period.

Data for the 1999 to 2006 reference years based on the revised scope definition of at least 20 weeks gestation or at least 400 grams birth weight was republished in Perinatal Deaths, Australia, 2007(cat. no. 3304.0).

Data in the Perinatal Deaths collection include demographic items, as well as causes of death information, which is coded according to the International Classification of Diseases (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of cause of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) is used for the 2009 data.

Timeliness

Perinatal deaths data are published annually and released approximately

15 months after the end of the reference period. Prior to 2006, perinatal death statistics were included in the annual Causes of Death, Australia (cat. no. 3303.0) collection.

Causes of death statistics are released with a view to ensuring that they are fit for purpose when released. To meet user requirements for timely data it is often necessary to obtain information from the administrative source before all information for the reference period is available (e.g. finalisation of coronial proceedings). A balance needs to be maintained between accuracy (completeness) of data and timeliness, taking account of the different needs of users. To address the issues which arise through the publication of causes of death data for open coroners cases, these data are now subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing. See Explanatory Notes 28-32 for further information on the revisions process.

Accuracy

Non-sample errors are the main influence on accuracy in datasets such as this which are a complete census of the population rather than a sample. Non-sample error arises from inaccuracies in collecting, recording and processing the data. The most significant of these errors are: mis-reporting of data items; deficiencies in coverage; non-response to particular questions; and processing errors. Every effort is made to minimise non-sample error by working closely with data providers, running quality checks throughout the data processing cycle, training of processing staff, and efficient data processing.

The main sources of non-sample error for perinatal deaths data are:

- completeness of an individual record at a given point in time (e.g. incomplete causes of death information due to non-finalisation of coronial proceedings)
- completeness of the dataset e.g. impact of registration lags, processing lags and duplicate records
- extent of coverage of the population (whilst all deaths are legally required to be registered some cases may not be registered for an extended time, if at all)
- particular data items which would be useful for statistical purposes may not be collected by jurisdictions where that item is not essential for administration purposes
- question and 'interviewer' biases given that information for death registrations are supplied about the person by someone else. For example, Indigenous origin as reported by a third party can be different from self reported responses on a form
- level of specificity and completeness in coronial reports or doctor's findings on the Certificate of Cause of Perinatal Death will impact on the accuracy of coding

The ABS has implemented a new revisions process that applies to all coroner certified perinatal deaths registered after 1 January 2007. The revisions process enables the use of additional information relating to coroner certified perinatal deaths as it becomes available over time, resulting in increased specificity of the assigned ICD-10 codes. See Explanatory Notes 28-32 for further information on the revision process.

Coherence

Use of the supporting documentation released with the statistics is important for assessing coherence within the dataset and when comparing the statistics with data from other sources. Changing business rules over time and/or across data sources can affect consistency and hence interpretability of statistical output. The Explanatory Notes in each issue contains information pertinent to the particular release which may impact

	on comparison over time.
Accessibility	Prior to the 2006 reference year, perinatal causes of death statistics were published in Causes of Death, Australia (cat. no. 3303.0). In addition to the information provided in the commentary, a series of data cubes are also available providing detailed breakdowns by cause of death. The ABS observes strict confidentiality protocols as required by the Census and Statistics Act (1905). This may restrict access to data at a very detailed level which is sought by some users. If the information you require is not available from the commentary or the data cubes, then the ABS may also have other relevant data available on request. Inquiries should be made to the National Information and Referral Service on 1300 135 070 or by sending an email to client.services@abs.gov.au.
Interpretability	Information on some aspects of statistical quality may be hard to obtain as information on the source data has not been kept over time. This is related to the issue of the administrative rather than statistical purpose of the collection of the source data. Perinatal Deaths, Australia contains detailed Explanatory Notes, an Appendix and Glossary that provide information on the data sources, terminology, classifications and other technical aspects associated with these statistics.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: 'Fetal death rate' is reported as an indicator because maternity services for admitted patients have some potential to reduce the likelihood of fetal deaths. However, this potential is limited and other factors (such as the health of mothers and the progress of pregnancy before hospital admission) are also important. Hence, differences in the 'fetal death rate' between jurisdictions are likely to be due to factors outside the control of maternity services for admitted patients. To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and maternity services. As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

11 Primary and community health

CONTENTS

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 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:

- PBS expenditure on medicines supplied under s.100 of the *National Health Act 1953* [Cwlth] to remote Aboriginal Medical Services are reported for the first time
- government expenditure on dental services by state and territory are reported for the first time
- reporting on episodes of treatment for alcohol and other drugs
- Australian Goverment expenditure on Indigenous primary healthcare services is reported for the first time
- data for the availability of public dental hygienists are reported for the first time, alongside existing reporting for public dentists and dental therapists
- an updated Australian geographical location classification system for reporting Department of Human Services (DHS) — Medicare data is used, improving reporting for the following measures
  - PBS expenditure per person by region
  - availability of general practitioners (GPs) by region
  - GP bulk billing rates by region
  - GPs with vocational registration by region
  - proportion of practices registered for the Practice Incentives Program (PIP) using electronic health systems by region
- age-standardised data are reported for the first time for the indicators 'use of pathology tests and diagnostic imaging' and 'cost to government of general practice per person'
- data are available for all people for the measure number of filled prescriptions by GPs for selected antibiotics (previously concession card holders only)
- data for the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent are reported for the first time
- extending time series for reporting on some indicators

- data quality information (DQI) available for the first time for the indicators 'availability of PBS medicines' and 'notifications of selected childhood diseases', as well as for additional measures under the 'child immunisation coverage' indicator.

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 also provides some funding through DHS Medicare for private dental and allied health services — for the general community, through the private health rebate, and for people with specific conditions or needs (for example, 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.

The Australian Government also funds a national network of 61 Medicare Locals, established under the National Health Reform agenda. These independent primary health care organisations have responsibility to coordinate primary health care delivery and address health care needs and service gaps within their boundaries. Established progressively from 1 July 2011, all 61 Medicare Locals have been operating across the country since 1 July 2012 with the support of a national body, the Australian Medicare Local Alliance. Medicare Locals evolved from the Divisions of General Practice Program (DGPP) which, over a 20 year period, aimed to support networks of general practices within defined geographical boundaries to improve health service delivery and respond to health service challenges at the local level.

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 (Department of Health 2010). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2013 was $5.90 for concession card holders and up to $36.10 for general consumers (Department of Health 2013a). 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 (Department of Health 2013a).

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 2013 safety net threshold was $1390.60 for general consumers and $354.00 for concession card holders (Department of Health 2013a).

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 particular needs — for example, people with chronic conditions and complex care needs — and improves access to allied health services in rural and remote areas.

Dental services

State and Territory governments and the Australian Government 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. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

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. 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.

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 95.8 per cent of all general practice encounters in 2012-13 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2013) (table 11.1).

Table 11.1 **General practice encounters and funding sources, April 2012 to March 2013[a, b]**

	Number[c]	*Per cent of all encounters*[d]	*95% LCL*	*95% UCL*
Total encounters for which BEACH data were recorded[e]	90 077	100	..	..
Direct encounters	88 568	98.3	98.1	98.6
No charge	334	0.4	0.3	0.4
DHS Medicare or DVA paid	85 870	95.3	94.9	95.8
Workers compensation paid	1580	1.8	1.6	1.9
Other paid (for example, hospital, State)	785	0.9	0.6	1.2
Indirect encounters[f]	1506	1.7	1.4	1.9

LCL = lower confidence limit. UCL = upper confidence limit. 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* = 8487). [e] Includes 2 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*. (2013) *General practice activity in Australia 2012-13*, Sydney University; table 11A.1.

The Australian Government also provides funding for general practice services under initiatives such as the PIP, the General Practice Immunisation Incentives Scheme (GPII) (effective to 30 June 2013) and Medicare Locals.

Australian Government total expenditure on general practice in 2012-13 was $7.4 billion (table 11A.2). This includes fee-for-service expenditure ($6.8 billion, or 92 per cent of the total expenditure) through DHS Medicare and the Department of Veteran's Affairs (DVA), as well as expenditure on the PIP, GPII and Medicare Locals ($0.6 billion, or 8 per cent of the total expenditure).

Age standardisation can be applied to fee-for-service expenditure on general practice to adjust for the effect of variations in age profiles on rates (see chapter 2 for details). The age-standardised expenditure on general practice per person was $286 in 2012-13.

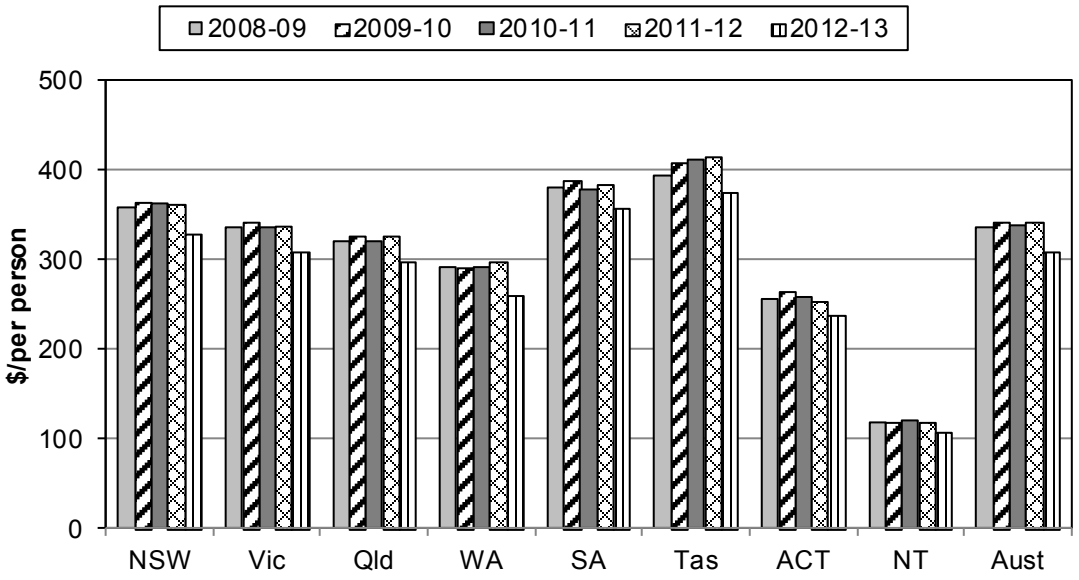
Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas, for example, in hospital emergency departments, Indigenous primary healthcare and other 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 $7.5 billion in 2012-13 (tables 11A.4 and 11A.5). Expenditure on the PBS was $7.1 billion — $309 per person — in 2012-13, lower than in the preceding four years in which expenditure was relatively stable, fluctuating between $336 and $342 per person (in 2012-13 dollars) (figure 11.1). Over the same period, the proportion of PBS expenditure that is concessional rose from 77.9 to 78.5 per cent (tables 11A.3 and 11A.5).

Figure 11.1 **PBS expenditure per person (2012-13 dollars)[a, b, c, d, e, f, g]**



[a] Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). [b] Rates are derived using the Australian Bureau of Statistics (ABS) ERP for 31 December 2012 and are not comparable with rates in figure 11.6 that are derived using the 30 June 2012 ERP. [c] 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 the Department of Health's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications supplied to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 11A.6]). [d] Includes PBS general ordinary and safety net. [e] Includes PBS concessional ordinary and concessional free safety net. [f] Includes RPBS general ordinary and safety net. [g] Excludes PBS doctor's bag.

Source: Department of Health (unpublished) PBS Statistics; tables 11A.4 and 11A.5.

Community health services

Overall government expenditure data relating only to the primary and community health services covered in this chapter are not available. Expenditure data reported here also cover public health 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 11.2).

In 2011-12, government expenditure on community and public health was $9.3 billion, of which State, Territory and local governments provided 70.8 per cent, and the Australian Government 29.2 per cent (table 11.2). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the DVA and the Department of Health, was $1.1 billion. State, Territory and local government expenditure on dental services was $718 million in 2011-12. Additional expenditure is incurred by some states and territories through schemes that fund the

provision of dental services to eligible people by private practitioners. Dental expenditure by state and territory is provided in table 11A.7.

Australian Government expenditure on Aboriginal medical services was $531 million in 2012-13 (table 11A.8).

Table 11.2 **Estimated funding on community and public health, and dental services, 2011-12 ($ million)**

	Australian Government				*State, Territory and local government*	*Total government*[c]	*Non-government*	*Total government and non-government*[c]
	DVA	*Department of Health and other*[a]	*Insurance premium rebates*[b]	*Total*[c]				
Community and public health[d]	1	2 624	–	2 625	6 366	8 991	331	9 322
Dental services	104	956	528	1 587	718	2 305	6 031	8 336

[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 Department of Health. [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.

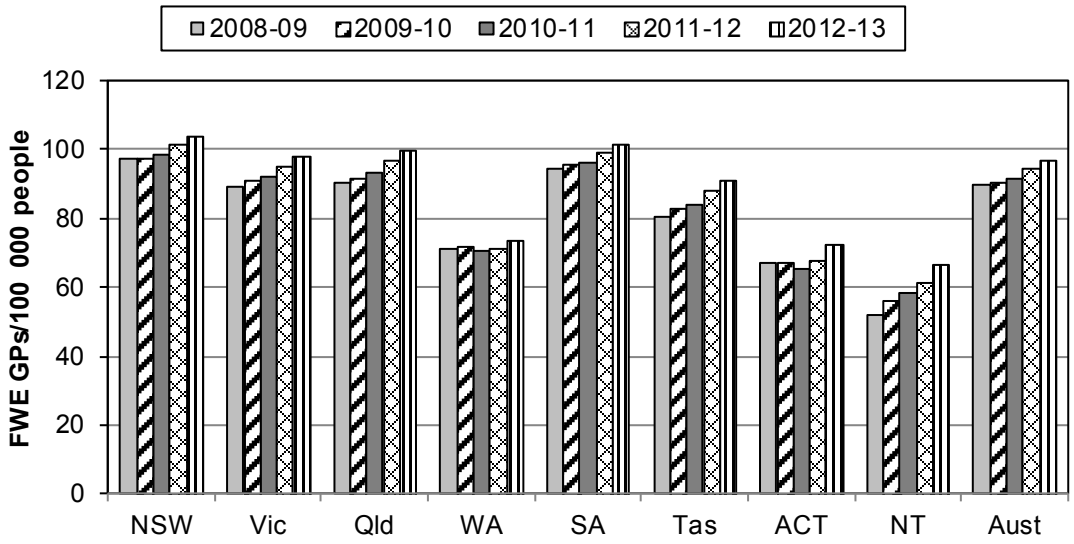
Source: AIHW (2013) *Health Expenditure Australia 2011-12*, Cat. no. HWE 56.

Size and scope

General practice

There were 30 681 vocationally registered GPs and OMPs billing Medicare Australia, based on MBS claims data, in 2012-13. On a full time workload equivalent (FWE) basis, there were 22 087 vocationally registered GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 96.4 FWE registered GPs and OMPs per 100 000 people (table 11A.9). 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 11.2.

Figure 11.2 **Availability of GPs (full time workload equivalent)[a, b]**

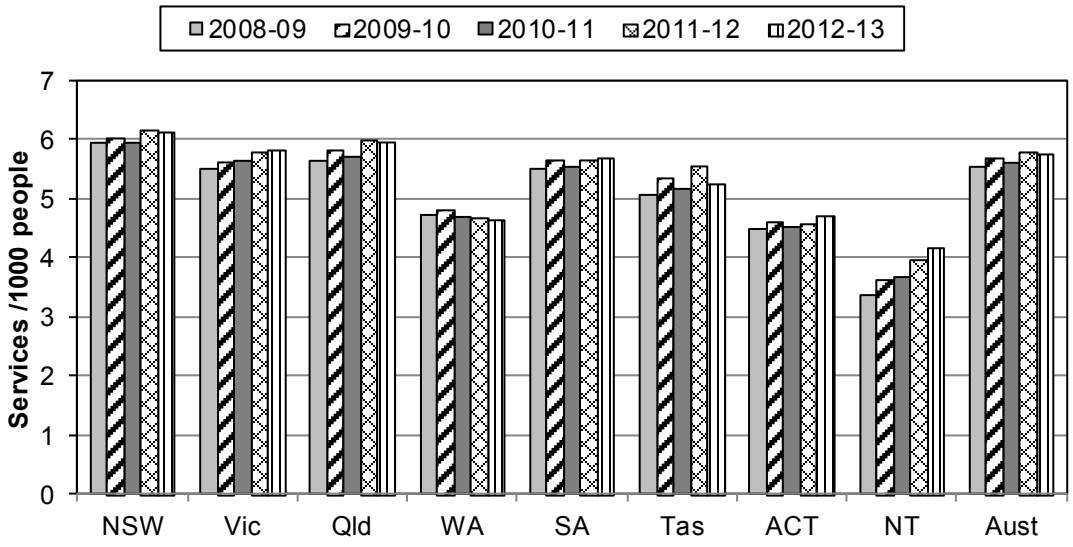


a Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice. **b** The ABS ERPs used to derive rates for 2010-11 and previous years are revised to the ABS' final 2011 Census rebased ERPs and data may differ from previous reports. ERP data used to derive rates from 2011-12 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.2) for details.

Source: Department of Health (unpublished) MBS Statistics; table 11A.9.

Nationally, around 5768 general practitioner-type services were provided per 1000 population under DHS Medicare in 2012-13 (figure 11.3).

Figure 11.3 **GP type service use[a, b]**



a Rates are age standardised to the Australian population at 30 June 2001. Data for 2011-12 have been revised. **b** Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished) ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.10.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 197 million services — 87.8 per cent of them concessional — were provided under the PBS in 2012-13 (table 11.3). This amounted to 9.2 filled prescriptions per person. A further 12 million services were provided under the RPBS in the same period.

Table 11.3 **PBS and RPBS services, 2012-13 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	7.8	5.6	4.8	2.7	1.7	0.5	0.5	0.1	23.7
PBS concessional[b]	58.8	44.1	34.1	14.0	15.1	5.0	1.6	0.5	173.3
PBS doctor's bag[c]	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	66.6	49.9	38.9	16.7	16.8	5.5	2.2	0.7	197.3
RPBS total[d]	4.2	2.7	3.0	1.0	0.9	0.4	0.2	–	12.4
Total	70.8	52.5	42.0	17.7	17.8	5.9	2.3	0.7	209.7
PBS services per person[e]	9.6	9.2	9.1	7.2	10.7	11.5	6.2	2.9	9.2

[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: Department of Health (unpublished) PBS Statistics; tables 11A.11 and 11A.12.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.105–11A.113 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), 13 (Aged care services) and 14 (Services for people with disability).

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 preschool and secondary school students (tables 11A.105–11A.113).

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 2012-13 targeted at disadvantaged people (tables 11A.105–11A.113). As current data are not available for use of public dental services for the 2014 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 11.4).

Table 11.4 **Use of public dental services by service type, per 1000 people, 2010[a, b, c, d]**

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

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

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished), *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.13.

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. 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 2013a). 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 659 alcohol and other drug treatment agencies reported 2011-12 data to the AODTS–NMDS. Of these, 317 (48.1 per cent) identified as government providers and 342 (51.9 per cent) as non-government providers (table 11A.14). There were 153 668 reported closed treatment episodes in 2011-12 (table 11A.14) (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.5 per cent of whom were male, accounted for 146 948 closed treatment episodes (table 11A.14) (AIHW 2013a).

Alcohol was the most commonly reported principal drug of concern (45.8 per cent), followed by cannabis (22.0 per cent), amphetamines (11.5 per cent) and heroin (8.8 per cent), in closed treatment episodes for clients seeking treatment for their own substance abuse. Additional drugs of concern were reported in over 80 per cent of the episodes (AIHW 2013a).

Alcohol was the most common principal drug of concern in all states and territories. Cannabis was the second most common principal drug in all states and territories except South Australia, where amphetamines were more common (AIHW 2013a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.105–11A.113.

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, planned and governed by local Indigenous communities with the aim of delivering 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 2012-13, 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.105–11A.113).

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) 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 2011-12, OSR data are reported for 224 Indigenous primary healthcare services (table 11A.15). Of these services, 90 (40.2 per cent) were located in remote or very remote areas (table 11A.16). 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.17). 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 2.6 million episodes of healthcare were provided by participating services in 2011-12 (table 11.5). Of these, around 1.2 million (47.0 per cent) were in remote or very remote areas (table 11A.16).

Table 11.5 **Estimated episodes of healthcare for Indigenous Australians by services for which OSR data are reported ('000)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	452	160	336	306	191	35	23	586	2 089
2009-10	542	185	379	409	192	36	26	622	2 391
2010-11	522	201	310	473	222	38	30	704	2 498
2011-12	516	234	475	462	216	44	34	641	2 621

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 (2013 and previous issues) *Aboriginal and Torres Strait Islander health services report*: *online services report - key results*, Cat. no.s IHW 31, 56, 79 and 104; table 11A.15.

The services included in the OSR data collection employed around 3469 full time equivalent healthcare staff (as at 30 June 2012). Of these, 1946 were Indigenous Australians (56.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous Australians were relatively low (5.9 per cent and 12.9 per cent, respectively) (table 11A.18).

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, 2012 and 2013 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.

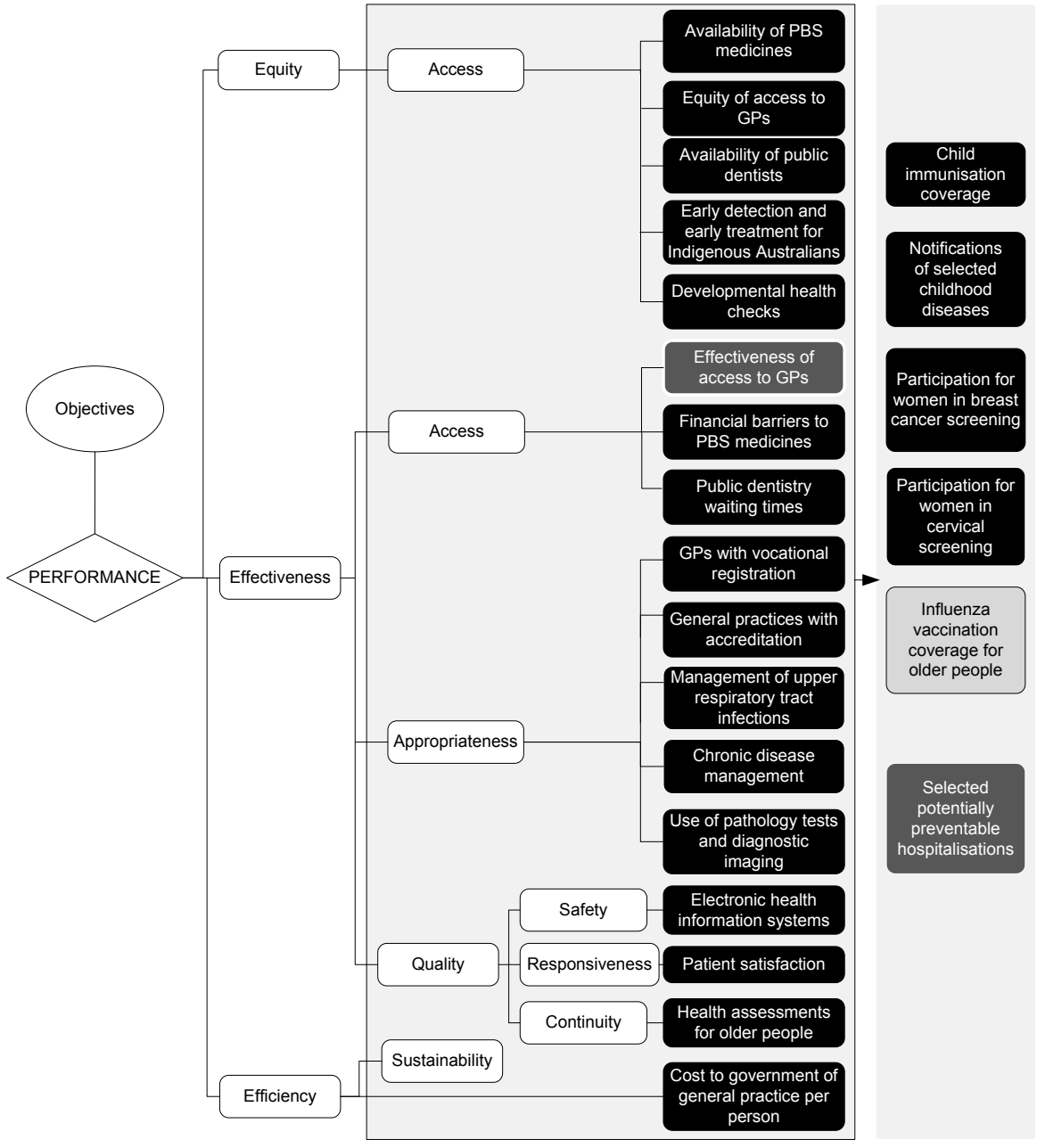
In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 11.4). The performance indicator framework shows which data are comparable in the 2014 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 context chapter 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) (chapter 2).

Figure 11.4 **Primary and community health performance indicator framework**



Key to indicators*

Text Most recent data for all measures are comparable and complete

Text Most recent data for at least one measure are comparable and complete

Text Most recent data for all measures are either not comparable and/or not complete

Text No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

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 Australian Bureau of Statistics (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 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

11.3 Key performance indicator results

Different delivery contexts, locations and client factors may affect the equity, effectiveness and efficiency of primary and community 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 by region in these measures.

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 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 2013 data are available for all jurisdictions.

Data quality information for this indicator is under development.

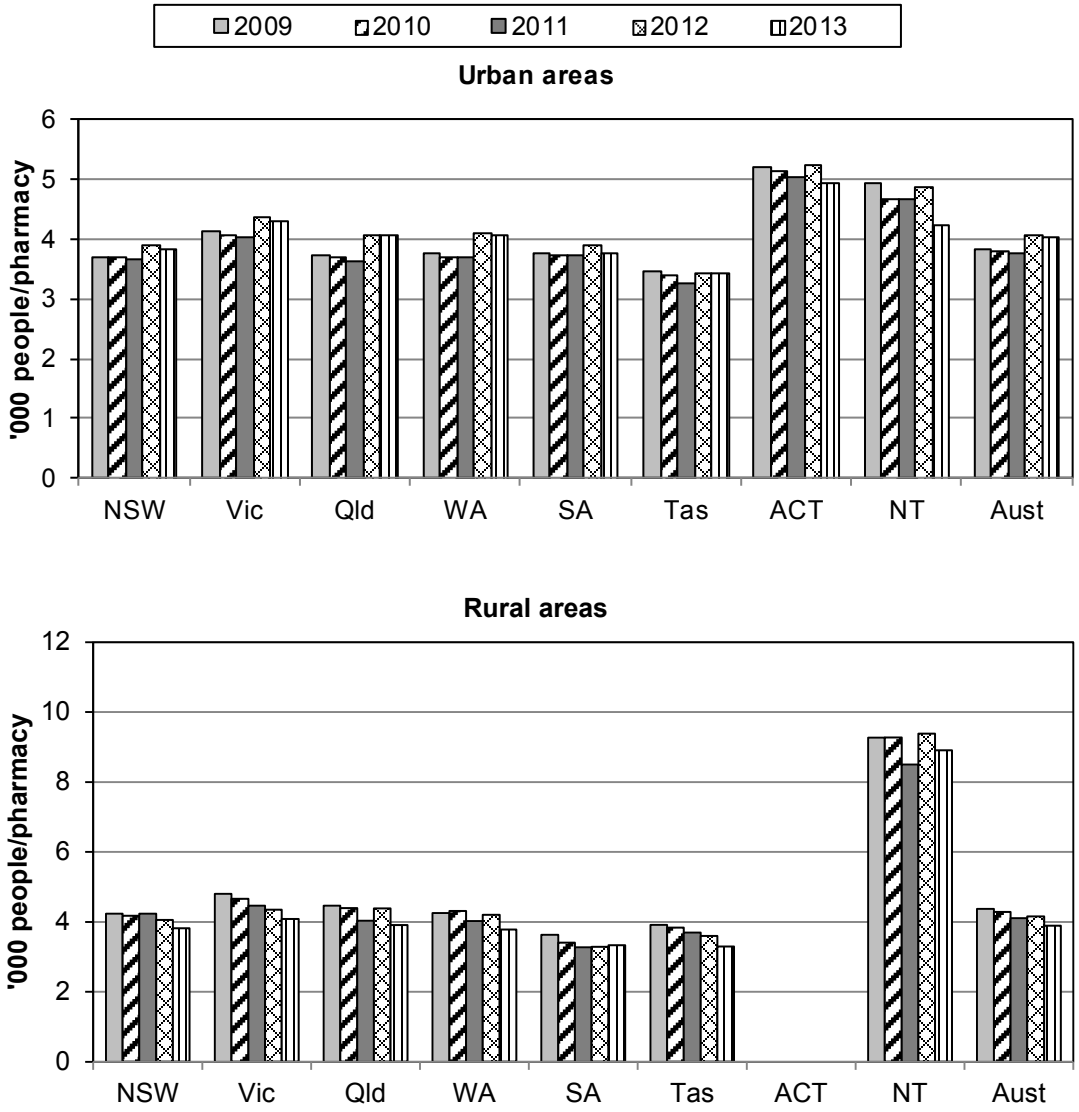
Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 4034 people per pharmacy in urban areas and 3887 people per pharmacy in rural areas at 30 June 2013. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.5, table 11A.19).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 33 medical practitioners and 254 hospitals — 95 private and 159 public[1] — approved to supply PBS medicines to the community at 30 June 2013. The

[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.

approved medical practitioners and 49 of the approved public hospitals were located in rural areas (table 11A.19).

Figure 11.5 **People per pharmacy**[a, b]

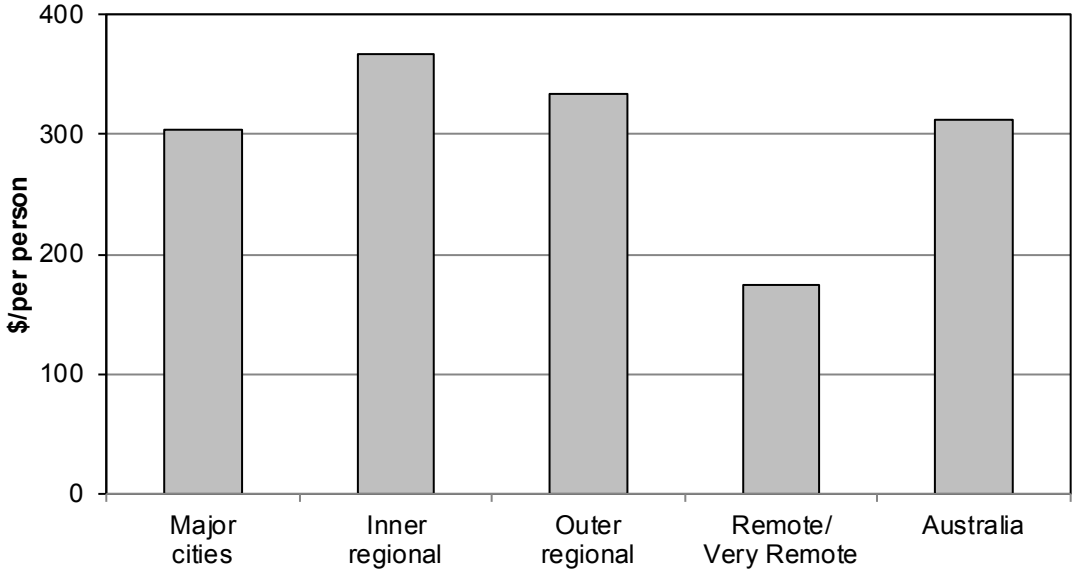


a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. **b** Excludes RPBS and doctor's bag. **c** Care should be taken in using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).

Source: Department of Health (unpublished) derived from DHS Medicare, ABS *2006/2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre; table 11A.19.

Nationally, PBS expenditure per person was around $312 in 2012-13 (figure 11.6). PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 11.6).

Figure 11.6 **PBS expenditure per person, 2012-13[a, b, c]**



[a] Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. [b] Rates are derived using the ABS ERP for 30 June 2012 and are not comparable with rates in figure 11.1 that are derived using the 31 December 2012 ERP. [c] Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million in 2012-13 [table 11A.6]).

Source: Department of Health (unpublished) PBS Statistics; table 11A.20.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.11. These data are not available by regional location. Nationally, 87.7 per cent of prescriptions subsidised under the PBS were concessional in 2012-13.

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 reported for this indicator are:

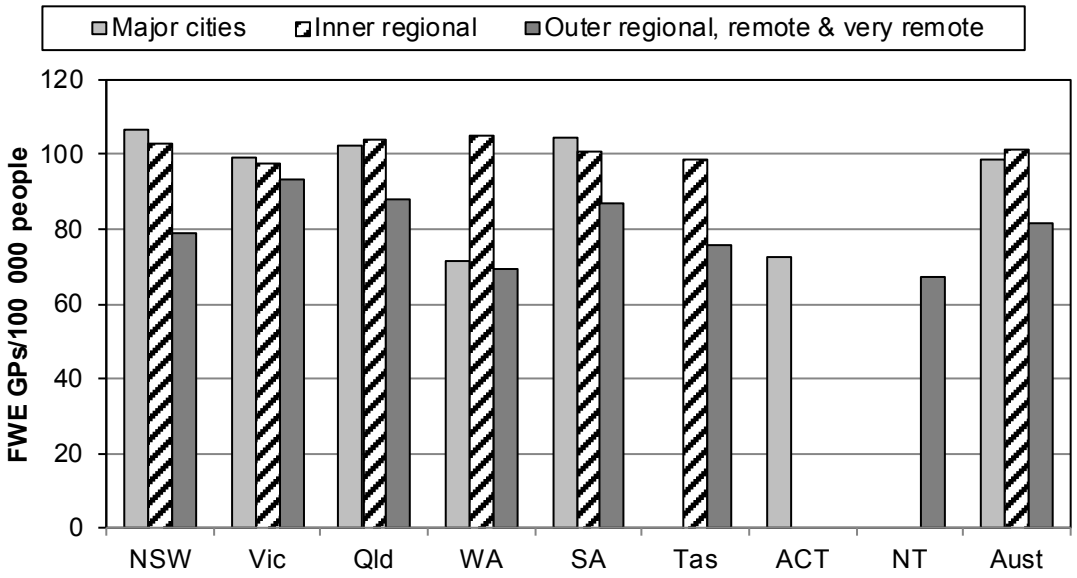
- comparable (subject to caveats) across jurisdictions for 2012-13 but not comparable to data for previous years for the measure availability of GPs by region
- comparable (subject to caveats) across jurisdictions and over time for the measure availability of female GPs
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

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 major cities and inner regional areas than in outer regional, remote and very remote areas in all jurisdictions in 2012-13 (figure 11.7). The bulk billed proportion of non-referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 11A.32).

Figure 11.7 **Availability of GPs (full time workload equivalent), 2012-13[a, b, c]**



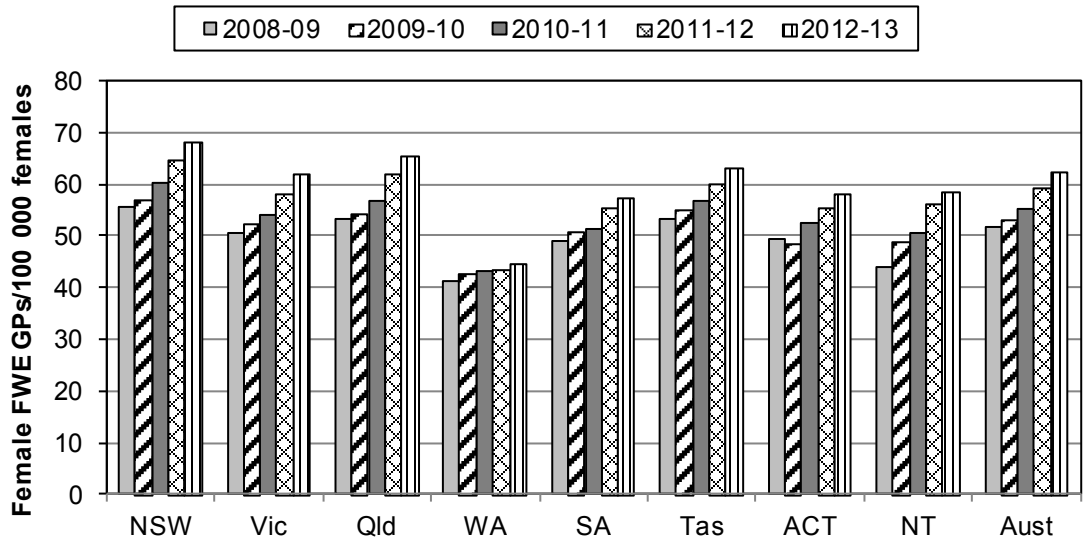
[a] Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. [b] FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. [c] There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. For the ACT, major cities includes inner regional areas.

Source: Department of Health (unpublished) MBS Statistics; table 11A.22.

Equity of access to GPs — availability of female GPs

In 2012-13, 42.4 per cent of Australia's GPs — 32.5 per cent of FWE GPs — were female (tables 11A.9 and 11A.24). The number of FWE GPs per 100 000 females increased from 51.7 to 62.4 in the period 2008-09 to 2012-13 (figure 11.8).

Figure 11.8 **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: Department of Health (unpublished) MBS Statistics; table 11A.24.

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.

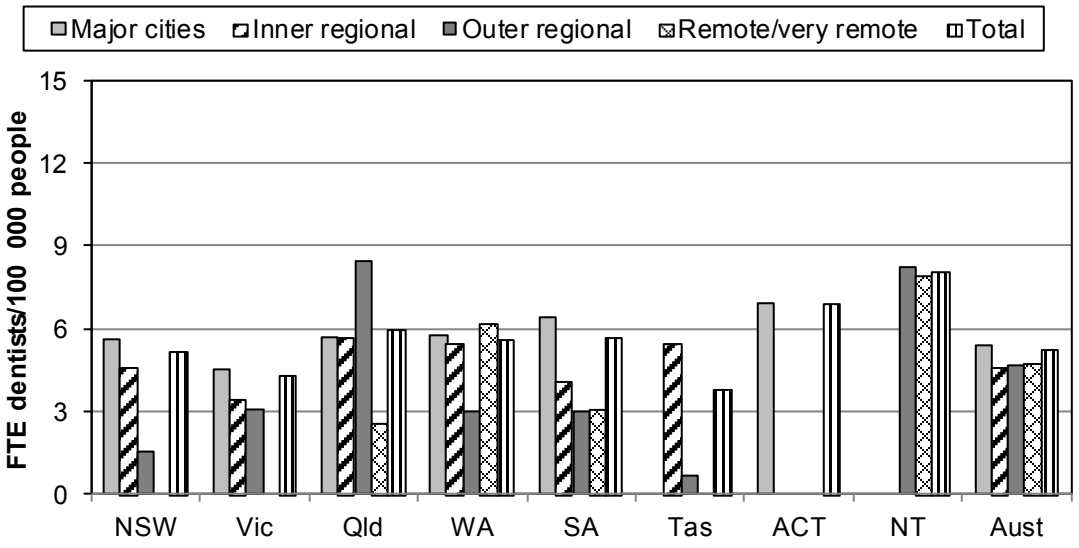
Data reported for this indicator are:

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

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, there were 5.4 FTE public dentists per 100 000 people in major cities — more than in regional and remote/very remote areas — in 2012 (figure 11.9, table 11A.25). Nationally, the number of FTE public dental therapists per 100 000 people was highest in outer regional areas (5.2), followed by inner regional (4.6) and remote/very remote (4.5) areas and lowest in major cities (2.7) (table 11A.26). Data for FTE dental hygienists and dental therapists are presented in table 11A.26.

Figure 11.9 **Availability of public dentists, 2012**[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 NSW, 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.25.

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 and timely prevention and intervention measures (early treatment).

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. A high or increasing proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

(Continued next page)

Box 11.5 **(Continued)**

This indicator provides no information about health assessments provided outside DHS Medicare. Such services are provided under service delivery models used, for example, in remote and very remote areas and therefore accessed predominantly by Indigenous Australians. Accordingly, this indicator understates the proportion of Indigenous Australians who received early detection and early treatment services.

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 data are available for all jurisdictions for 2012-13 for the three health assessment measures, and for 2011-12 for the measure primary healthcare services providing early detection services.

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 2012-13, the proportion of Indigenous older Australians who received an annual health assessment was higher than the proportion of non-Indigenous older Australians who received an annual health assessment in all jurisdictions except Victoria, SA and Tasmania (figure 11.10).

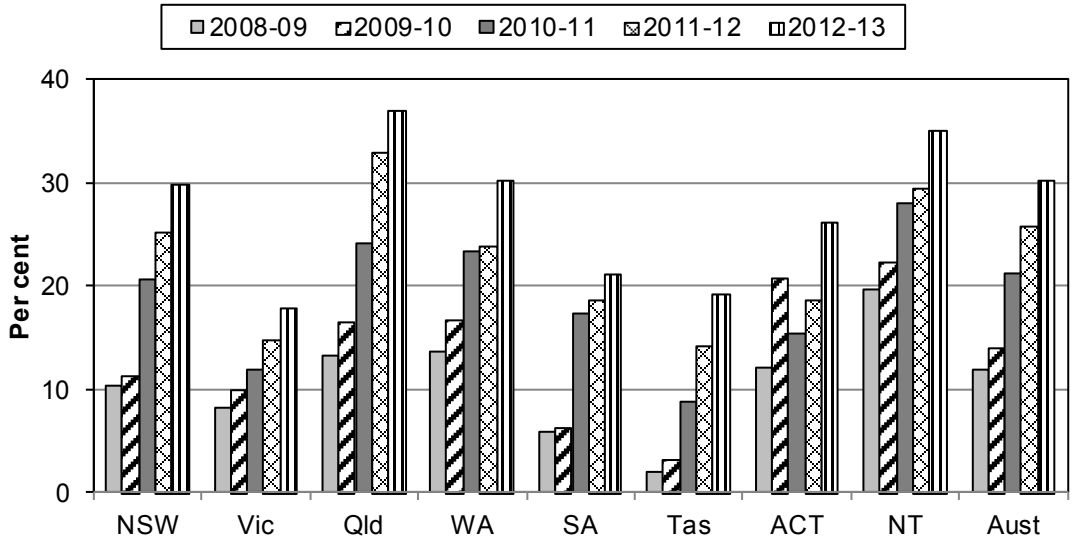
Figure 11.10 **Older people who received an annual health assessment by Indigenous status, 2012-13**[a, b, c, d]

[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 the mainstream MBS Health Assessment for people aged 75 years or over. This is unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous Australians. [c] Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments. [d] The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census.

Source: Derived from Department of Health (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.27.

The proportion of older Indigenous Australians who received an annual health assessment increased in all jurisdictions between 2008-09 and 2012-13 (figure 11.11).

Figure 11.11 **Older Indigenous Australians who received an annual health assessment[a, b]**



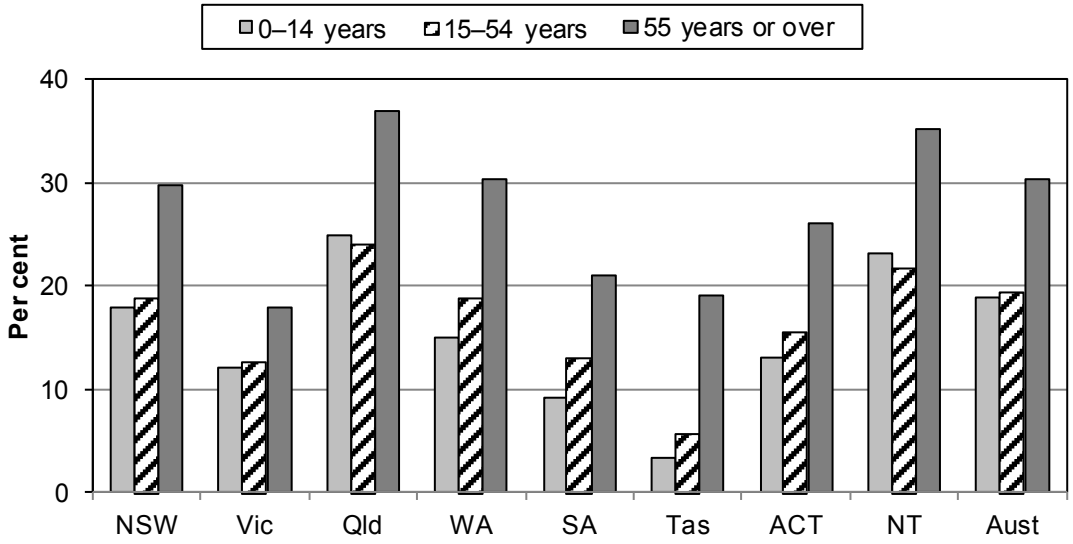
[a] Older people are defined as Indigenous Australians aged 55 years or over. Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians. [b] Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data are therefore likely to understate the proportion who access health assessments.

Source: Derived from Department of Health (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.28.

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 11.12). 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 11.12 **Indigenous Australians who received a health assessment by age, 2012-13[a, b]**

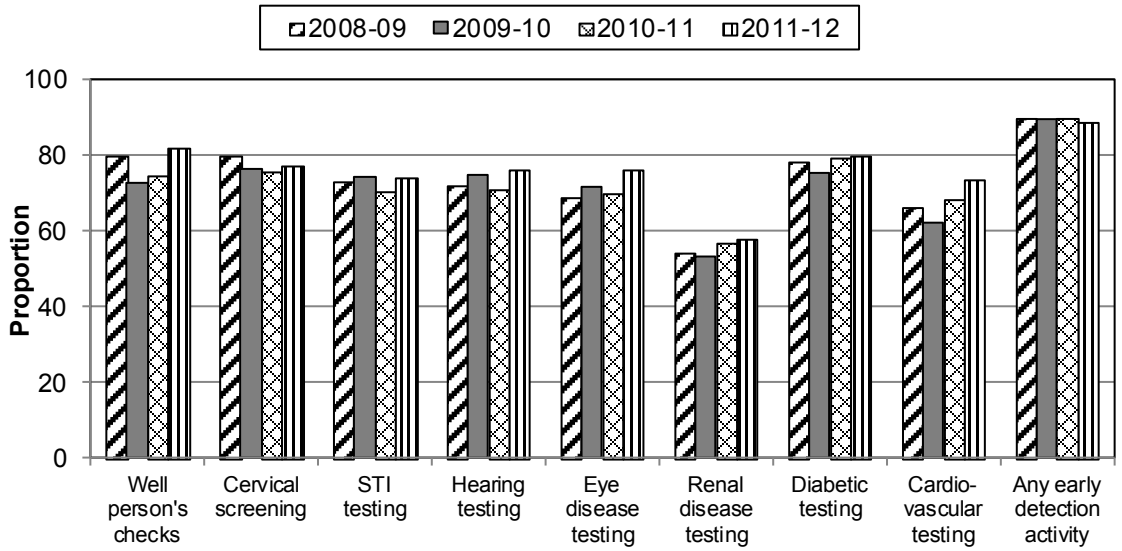


a Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians. **b** Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data are therefore likely to understate the proportion who access health assessments.

Source: Derived from Department of Health (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.29.

Nationally, the proportion of Indigenous primary healthcare services providing early detection services varied little in the period 2008-09 to 2011-12 (figure 11.13).

Figure 11.13 **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: online services report - key results, 2008-09, 2009-10 and 2010-11*, Cat. no.s IHW 31, 56 and 79; table 11A.30.

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 assessment under DHS Medicare, by health assessment type. 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 assessment is desirable as it suggests improved access to these services.

The proportion of Indigenous children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Indigenous children who received a fourth year developmental health assessment. The proportion of non-Indigenous children who received a Healthy Kids Check or, for those who did not receive a Healthy Kids Check, received a Health assessment at the age of 5 years, is reported as a proxy for the proportion of non-Indigenous children who received a fourth year developmental health assessment.

Fourth year developmental health assessment 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.

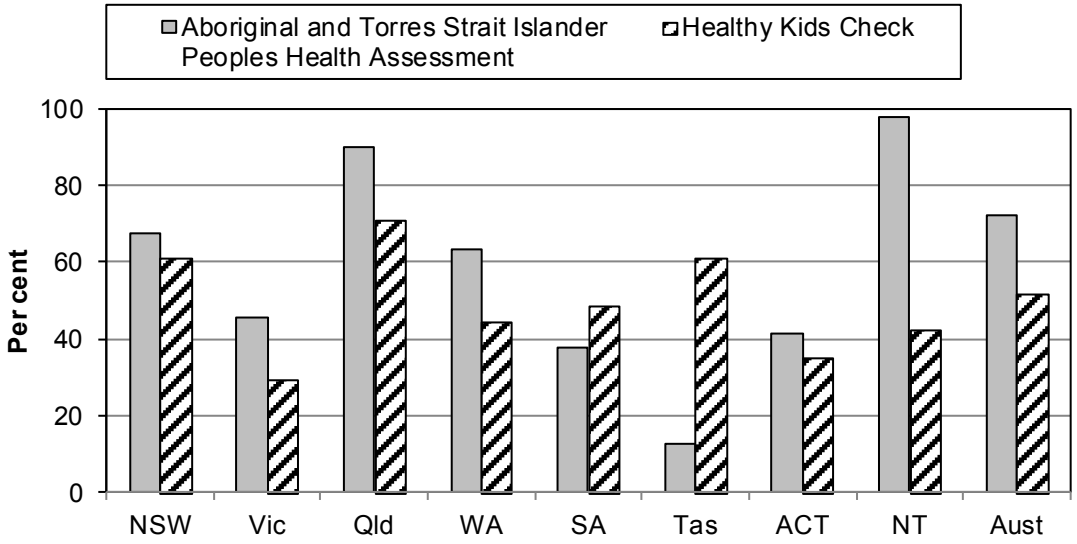
This indicator provides no information about developmental health checks for children that are provided outside DHS Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community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

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2012-13 are not comparable to historical data
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, 52.8 per cent of children received a fourth year developmental health check under DHS Medicare in 2012-13. 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 11.14).

Figure 11.14 **Children who received a fourth year developmental health check, by health check type, 2012-13[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 same or a previous reference period. [f] The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census.

Source: Department of Health (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.31.

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 less than 24 hours
  - 24 hours or more
- potentially avoidable presentations to emergency departments — two measures, defined as:
  - the proportion of people who visited a hospital emergency department for care they thought at the time could have been provided by a GP
  - the number of selected 'GP-type presentations' to emergency departments, where selected 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.

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 2012-13 data are available for all jurisdictions.

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

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions but not comparable over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

(Continued next page)

Box 11.7 **(Continued)**

A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and comparable over time for 2011-12 and 2012-13 but not for previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.

Data reported for this measure are:

- comparable (subject to caveats) within some jurisdictions over time but are not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

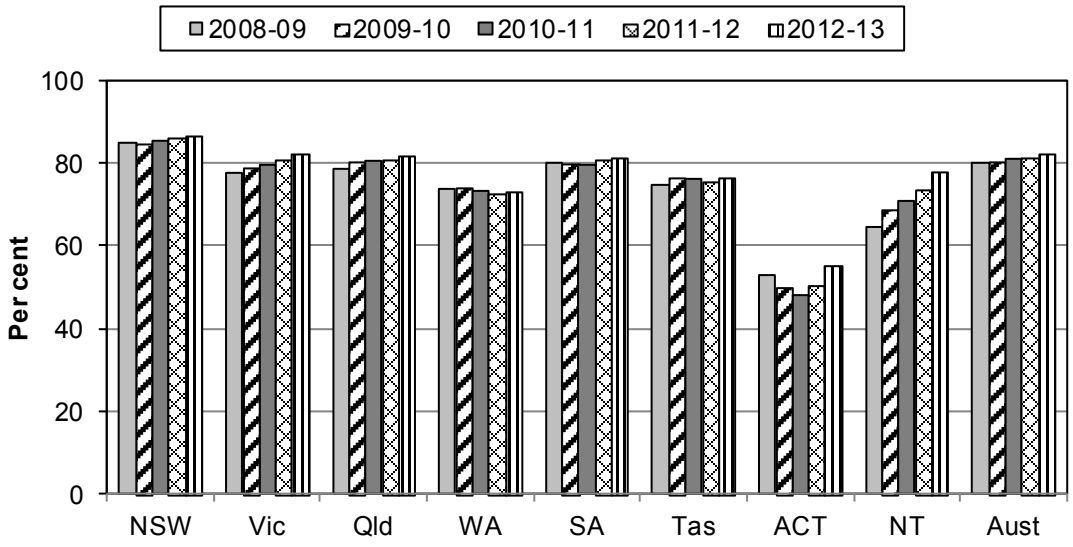
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

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 82.3 per cent in 2012-13. For most jurisdictions, this proportion increased in the period 2008-09 to 2012-13 (figure 11.15). The bulk billed proportion of non-referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 11A.32). 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.34).

Figure 11.15 **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.

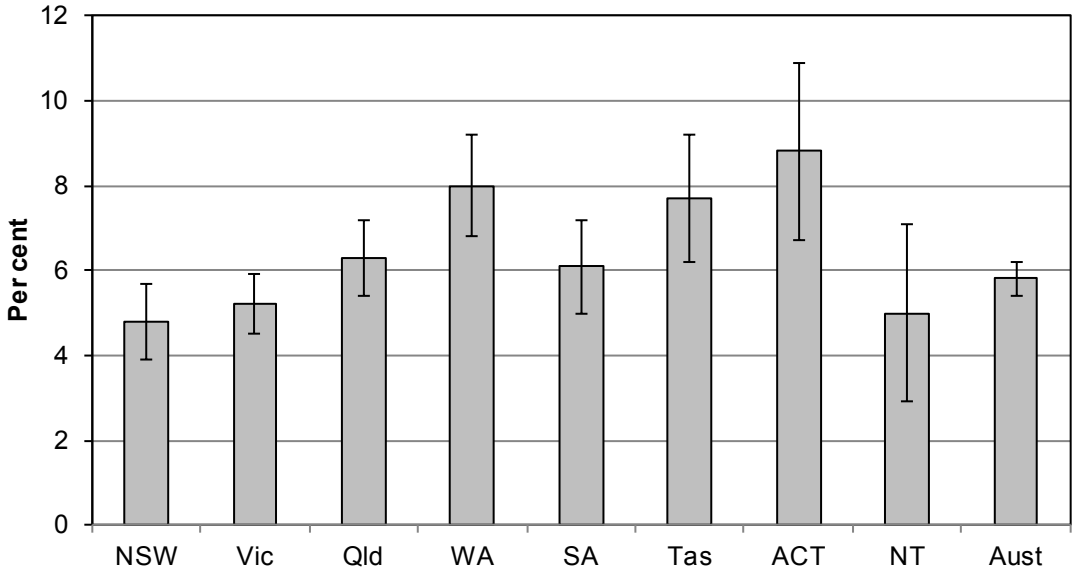
Source: Department of Health (unpublished) MBS Statistics; table 11A.34.

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 2012-13, 5.8 per cent of ABS Patient experience survey respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 11.16).

Data for Indigenous Australians deferring access to GPs due to cost, available for the first time from the ABS 2011-12 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS), are presented in table 11A.36. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 11.16 **People deferring visits to GPs due to cost, 2012-13**[a, b, c, d, e, f]



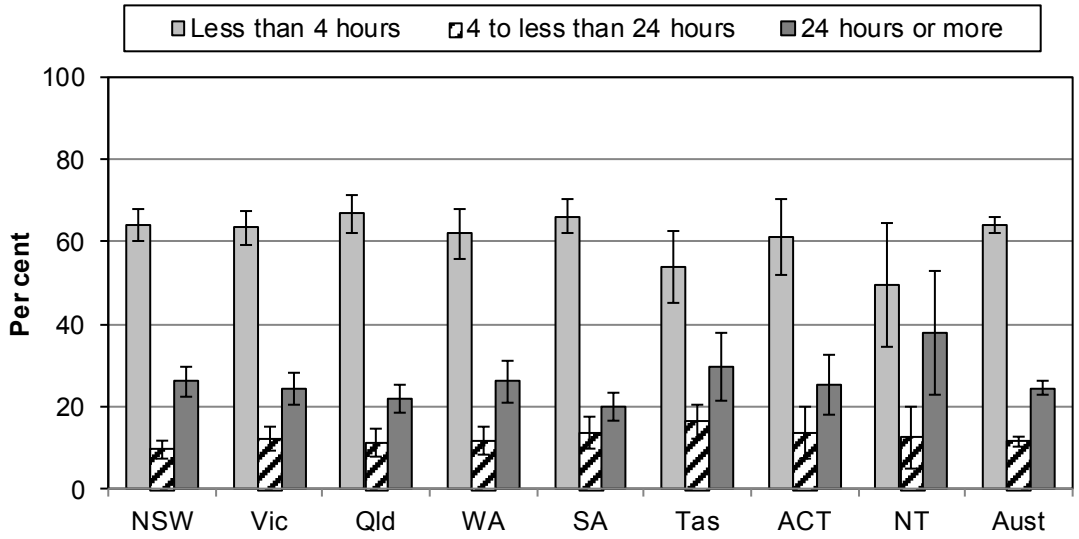
[a] People aged 15 years or over. [b] Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Data are not comparable to data for previous years due to a change in survey question wording and sequencing. [e] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions. [f] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; table 11A.35.

Effectiveness of access to GPs — GP waiting times

Nationally, 64.1 per cent of people who saw a GP for urgent care waited less than 4 hours in 2012-13 (figure 11.17). Around 11.4 per cent waited from 4 to less than 24 hours, and 24.6 per cent waited for 24 hours or more. Overall, 20.9 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 11A.38).

Figure 11.17 **Hours waited for urgent treatment by a GP, 2012-13**[a, b, c, d, e, f]



[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] Data are comparable with data for 2011-12 but not with data for previous years due to a changed survey question. [d] Rates are age standardised to the Australian population at 30 June 2001. [e] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions. [f] Error bars represent the 95 per cent confidence interval associated with each point estimate.

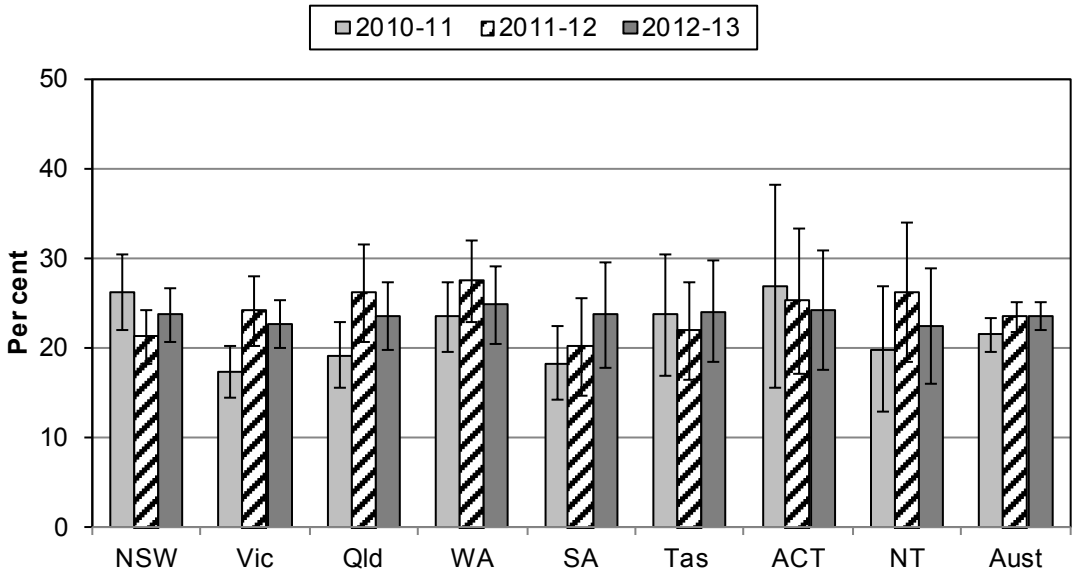
Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; table 11A.37.

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, 23.6 per cent of people who went to a hospital emergency department for their own health thought at the time that care could have been provided at a general practice (figure 11.18).

Figure 11.18 **People visiting a hospital emergency department for care they thought could have been provided at a general practice[a, b, c, d]**



a Proportion of people aged 15 years or over who went to a hospital emergency department for their own health and at the time, thought the care could have been provided at a general practice. **b** Rates are age-standardised to the 2001 Australian standard population. **c** Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. **d** Data for 2011-12 and 2012-13 include very remote areas but not discrete Indigenous communities, which will affect the NT more than other jurisdictions.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0; table 11A.40.

Nationally, there were around 2.2 million GP-type presentations to public hospital emergency departments in 2012-13 (table 11.6).

Table 11.6 **GP-type presentations to emergency departments, ('000)[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2012-13	682.3	574.5	383.8	282.1	105.9	61.6	46.6	39.8	2 176.6

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.39.

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.

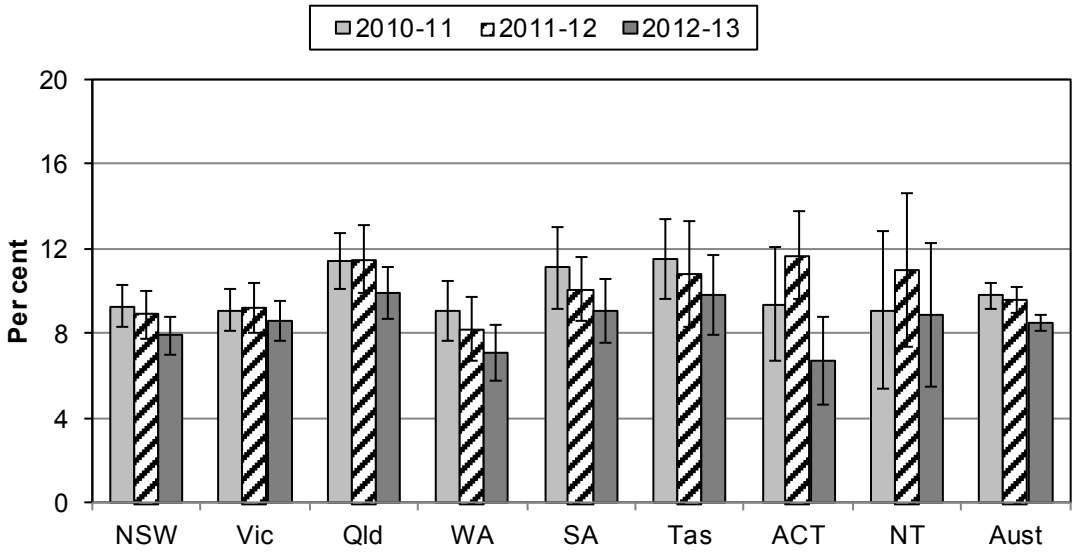
Data reported for this indicator are:

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

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, in 2012-13, 8.5 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 11.19). National data by remoteness are reported in table 11A.44. Data for Indigenous Australians are available for the first time from the ABS 2011-12 AATSIHS and are presented in table 11A.42. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 11.19 **People deferring purchase of prescribed medicines due to cost**[a, b, c, d, e]



[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] Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. [d] Data for 2011-12 and 2012-13 include very remote areas but not discrete Indigenous communities, which will affect the NT more than other jurisdictions. [e] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey, 2010-11, 2011-12*, *2012-13*, Cat. no. 4839.0; table 11A.41.

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, 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.

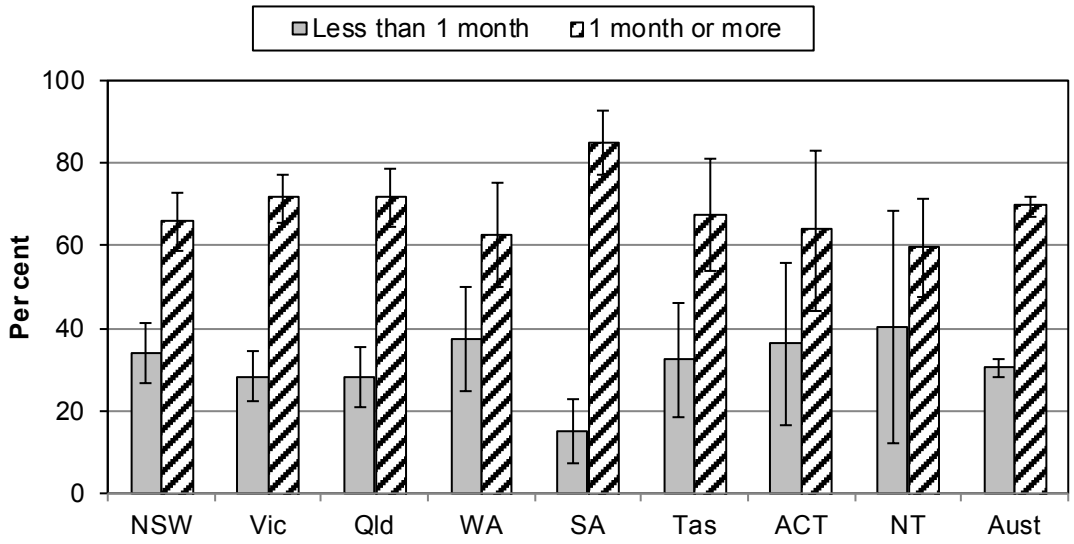
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but not over time. Data for 2012-13 are not comparable with data for 2011-12 and previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, 30.5 per cent of people who were on a public dental waiting list for waited less than 1 month to see a dental professional at a government dental clinic in 2012-13 (figure 11.20). Data are presented by remoteness in table 11A.44. Data for Indigenous Australians that are reported in table 11A.45 are not comparable to data for all Australians (see DQI for details).

Figure 11.20 **Time waited for public dentistry services, 2012-13**[a, b, c, d]



[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] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*; table 11A.43.

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 reported for this indicator are:

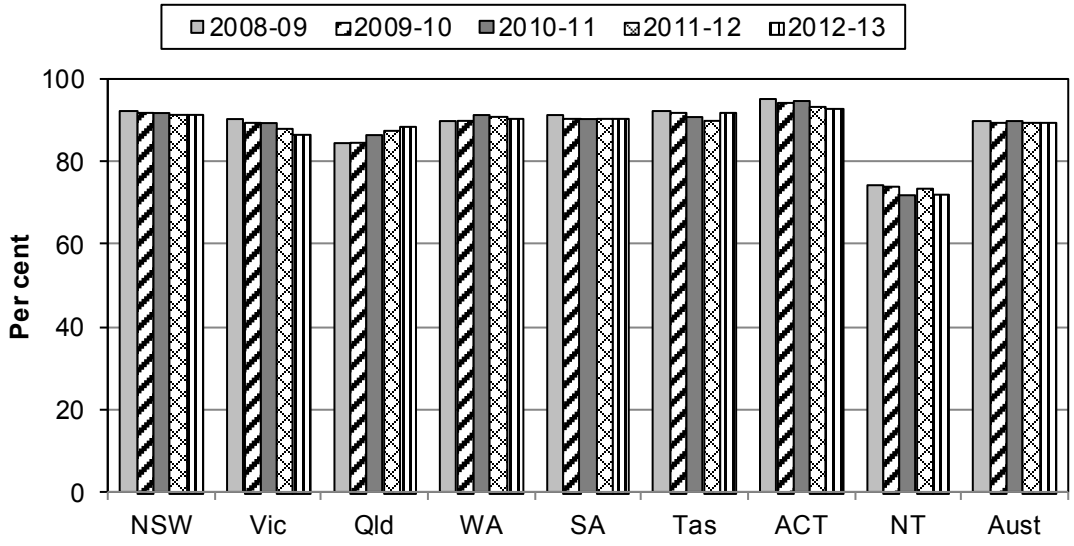
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

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 in order to maintain registration.

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2012-13 (figure 11.21). The proportion of FWE GPs with vocational registration was highest in major cities and lowest in remote areas in 2012-13 (table 11A.46).

Figure 11.21 **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: Department of Health (unpublished) MBS Statistics; table 11A.48.

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 independent third-party 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 reported for this indicator are:

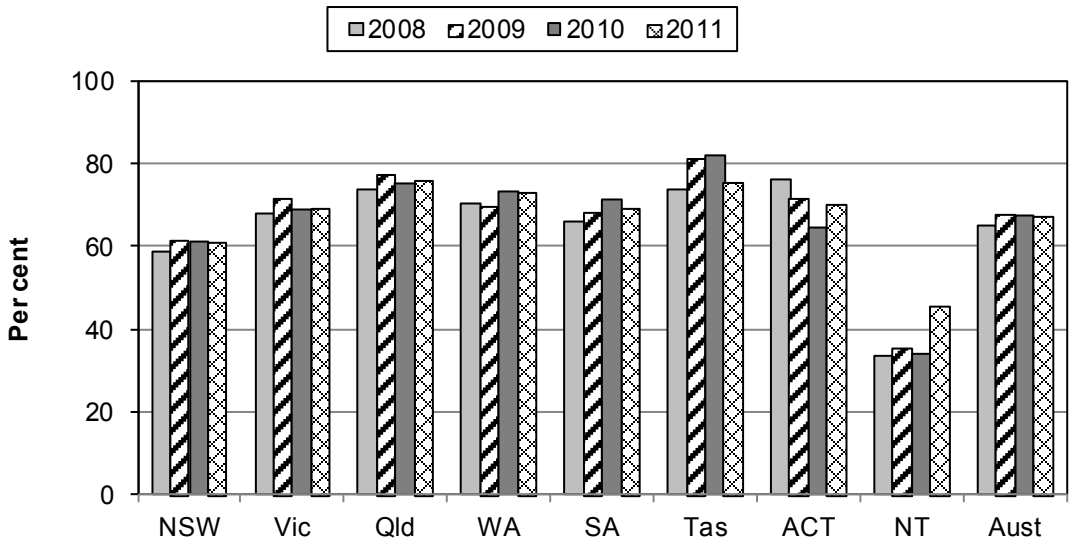
- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

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.

Current data for the number of general practices remained unavailable for the 2014 Report. In June 2011, 4783 general practices — representing 67.4 per cent of general practices — were accredited nationally (figure 11.22).

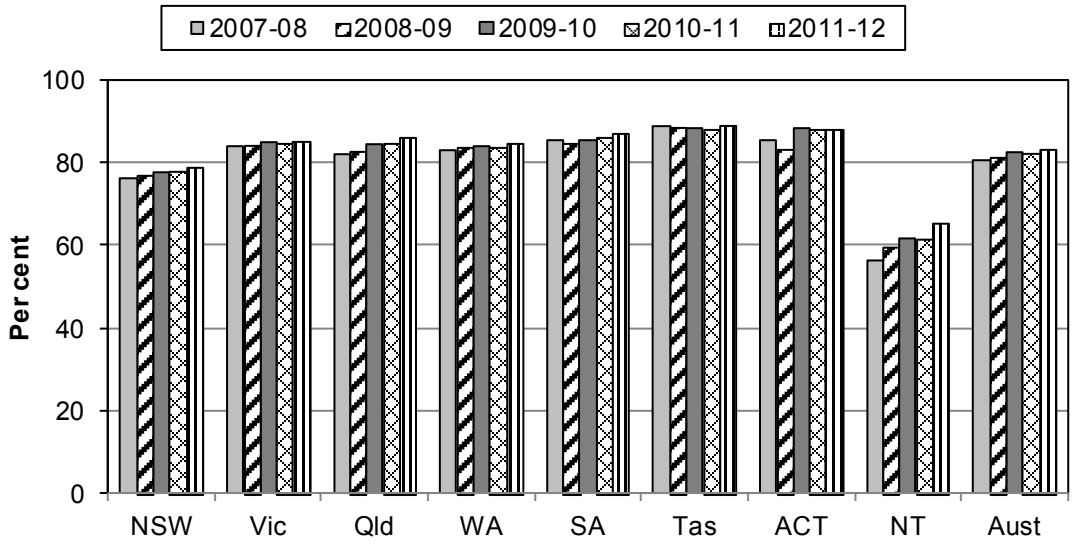
Figure 11.22 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); Quality Practice Accreditation Pty Ltd (unpublished); Primary Health Care Research and Information Service and Department of Health (unpublished) *Annual Survey of Divisions of General Practice 2010-11*; table 11A.49.

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 increased slightly in the period from 2007-08 to 2011-12 (figure 11.23).

Figure 11.23 **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: Department of Health (unpublished) PIP and MBS data collections; table 11A.50.

Management of acute 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:

- filled GP prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) per 1000 people
- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.

Low or decreasing rates of prescription of the selected antibiotics and acute URTI GP visits where systemic antibiotics are prescribed can indicate that GPs' management of acute URTI more closely follows guidelines.

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 both pharmaceutical costs and antibiotic resistance in the community.

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 2012-13 data are available for all jurisdictions.

Data quality information for the measure filled GP prescriptions for selected antibiotics is at www.pc.gov.au/gsp/reports/rogs/2014. Data quality information for the measure acute URTI GP visits where systemic antibiotics are prescribed is under development.

Rate of prescription of selected antibiotics

Caution should be used in interpreting the rate of prescription of the selected antibiotics 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.

Complete data are available for the first time, for 2012-13, for all prescriptions for the selected antibiotics that are filled. Complete historical data were available only for prescriptions provided to holders of PBS concession cards (see table 11A.52).

Nationally, the prescription rate for the oral antibiotics most commonly used to treat acute URTI was 297 per 1000 people in 2012-13 (figure 11.24).

Figure 11.24 **Rate of filled prescriptions of the oral antibiotics used most commonly to treat acute upper respiratory tract infection, per 1000 people, 2012-13[a, b]**

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

Source: Department of Health (unpublished) PBS Statistics; table 11A.51.

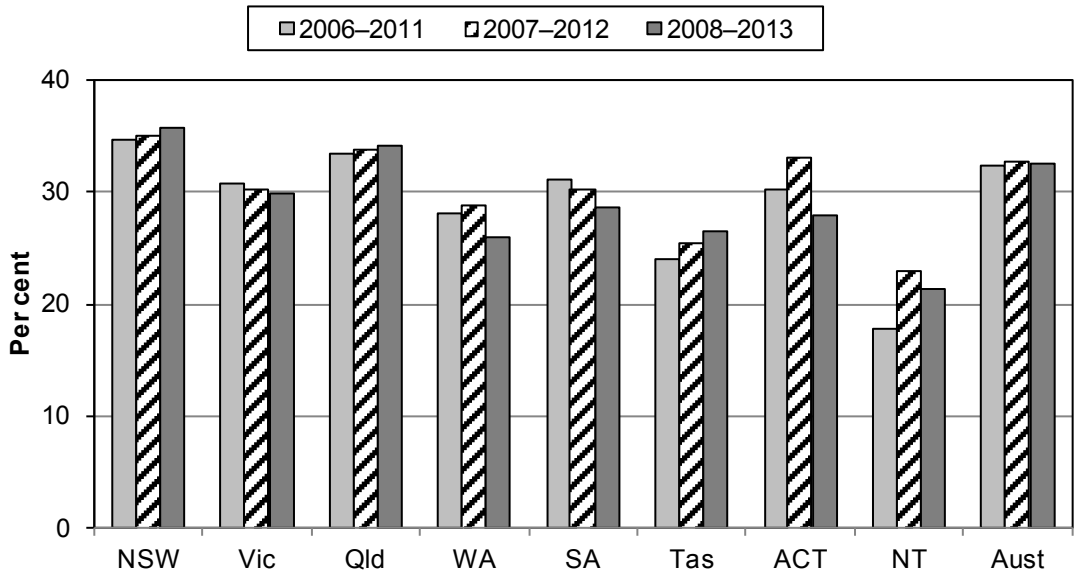
Proportion of GP visits for acute URTI where systemic antibiotics are prescribed

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 11.25). 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 2008 to March 2013, 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 11.25). This proportion was 29.9 per cent for the period April 2012 to March 2013 (figure 11.25). 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 11.26).

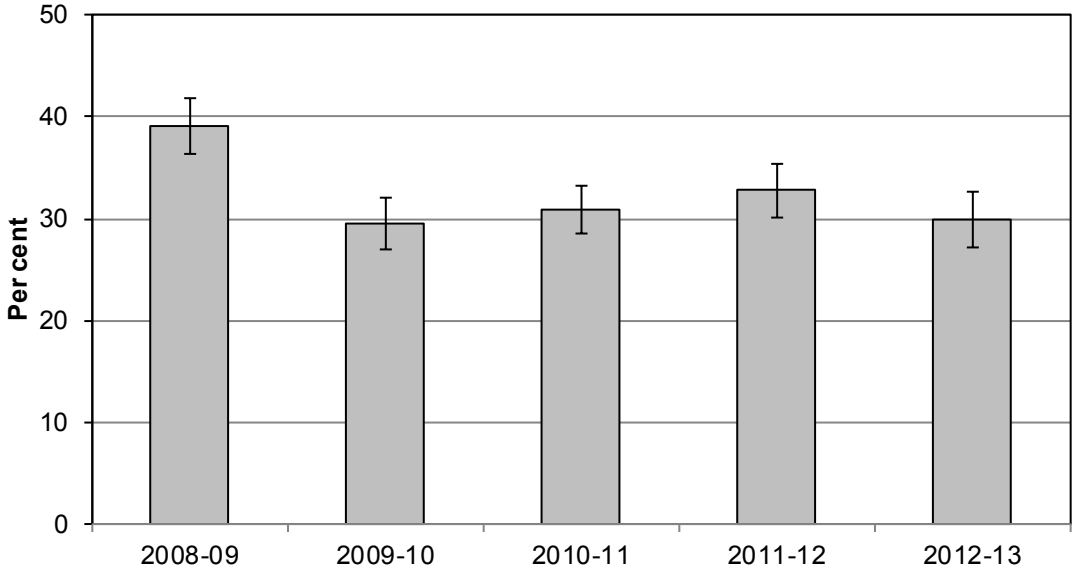
Figure 11.25 **Proportion of acute URTI managements where systemic antibiotics were prescribed[a, b]**



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.53.

Figure 11.26 **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.54.

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 four measures:

- management of diabetes — annual cycle of care, defined as the proportion of people with diabetes who 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, divided by the estimated number of people with diabetes)
- management of diabetes — HbA1c, defined as the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes with HbA1c below 7 per cent, divided by the estimated number of people with diabetes)
- 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 who received an annual cycle of care within general practice, people with diabetes with HbA1c below 7 per cent, people with asthma who have a written asthma action plan, and GPs who use chronic disease management items, 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 rebate is not captured.

HbA1c measures the level of glucose in the blood averaged over the preceding three months. HbA1c levels below 7 per cent are indicative of appropriate management of diabetes in that period.

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).

(Continued next page)

Box 11.13 **(Continued)**

A high or increasing proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions for management of diabetes — annual cycle of care and care planning/case conferencing. All required 2011-12 data are available for all jurisdictions for management of diabetes — HbA1c and management of asthma.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014, except for the measure proportion of GPs who use chronic disease management items, which is under development.

Reporting against this indicator has improved as data are for the first time available for reporting against the measure proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent.

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

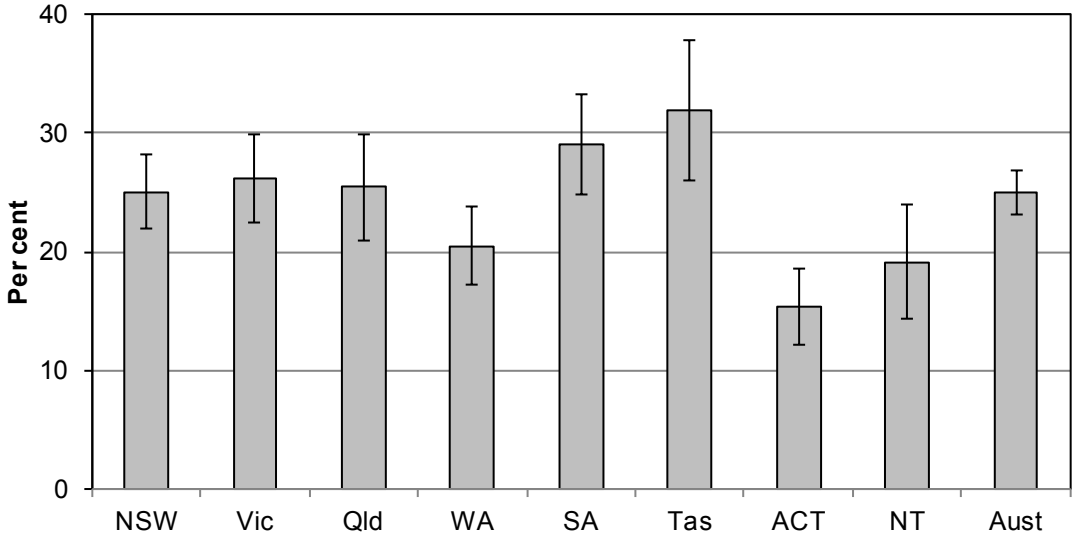
Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this Report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, 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, 25.0 per cent of people with diabetes received the annual cycle of care in 2012-13 (figure 11.27). Data for historical years are reported by geographical region in table 11A.56.

Figure 11.27 **People with diabetes mellitus who have received an annual cycle of care within general practice, 2012-13[a, b]**



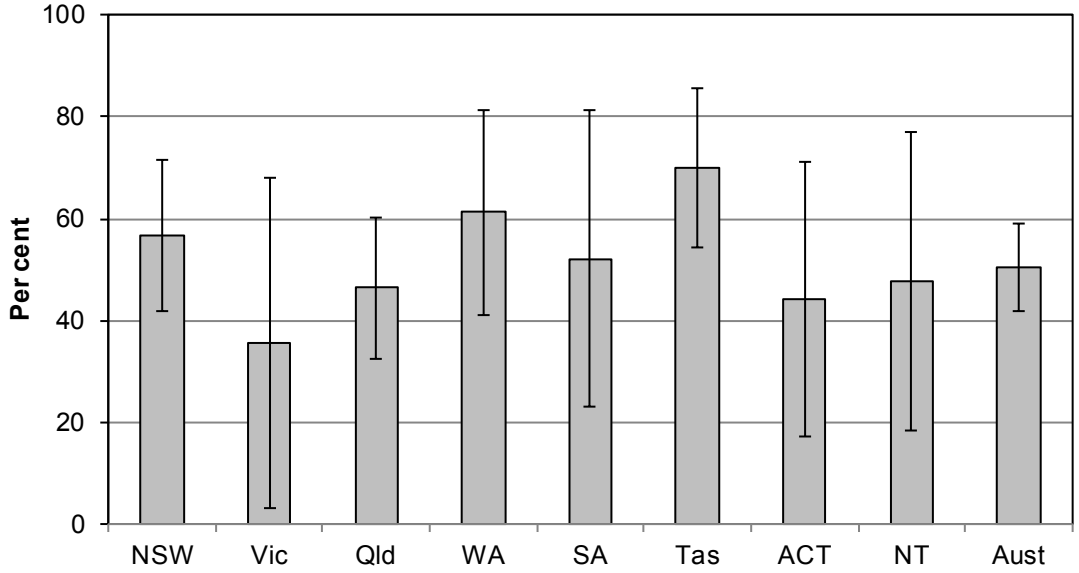
a Excludes annual cycles of care provided by GPs where a standard MBS rebate is claimed. GPs who are not registered for the PIP diabetes incentive are unlikely to claim against the annual cycle of care MBS item. **b** Denominator data are derived from self-reported estimates of diabetes prevalence. **c** Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: Department of Health (unpublished) MBS Statistics and DVA data collections; ABS (unpublished) *Australian Health Survey 2011–13* (National Health Survey (NHS) component 2011-12), Cat. no. 4364.0; table 11A.55.

HbA1c (glycosolated haemoglobin) provides a measure of the average blood glucose level for the preceding three months. RACGP guidelines for management of diabetes indicate that HbA1c levels should be tested at least every 6 months. Nationally, 77.5 per cent of people with known diabetes had a HbA1c test in the previous 12 months (table 11A.57).

An outcome of appropriate management of diabetes, by the primary and community health care sector in conjunction with the patient, is a HbA1c level at or below 7 per cent. Nationally, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (figure 11.28).

Figure 11.28 **People with known diabetes with HbA1c level 7.0 per cent or less**



a People aged 18 years to 69 years with known diabetes. Includes pregnant women. **b** Known diabetes based on fasting plasma glucose test results and self-reported information on diagnosis/medication use. **c** Rates are not age-standardised. **d** Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

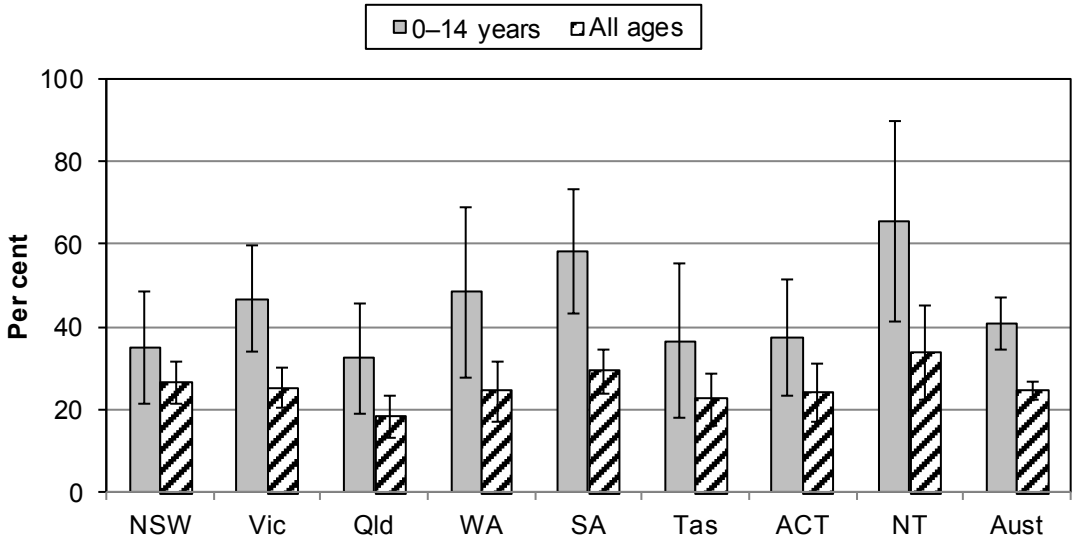
Source: ABS (unpublished) *Australian Health Survey, 2011-13*, (National Health Measures 2011-12 component) Cat. No. 4364.0; table 11A.58.

Chronic disease management — asthma

Asthma, an identified National Health Priority Area for Australia, is a common chronic disease among Australians — particularly children — and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity.

Nationally, the proportion of people with current asthma reporting that they have a written asthma action plan was 24.6 per cent for all ages and 40.9 per cent for children aged 0–14 years in 2011-12 (figure 11.29). Data for 2007-08 are reported by geographical region in table 11A.60. Data for 2004-05 are reported by Indigenous status in table 11A.61.

Figure 11.29 **Proportion of people with asthma who have a written asthma action plan, 2011-12[a, b, c]**



[a] Rates for 'all ages' are age standardised to the Australian population at 30 June 2001. [b] Error bars represent the 95 per cent confidence interval associated with each point estimate. [c] Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Health Survey, 2011-13*, (NHS component) Cat. No. 4364.0; table 11A.59.

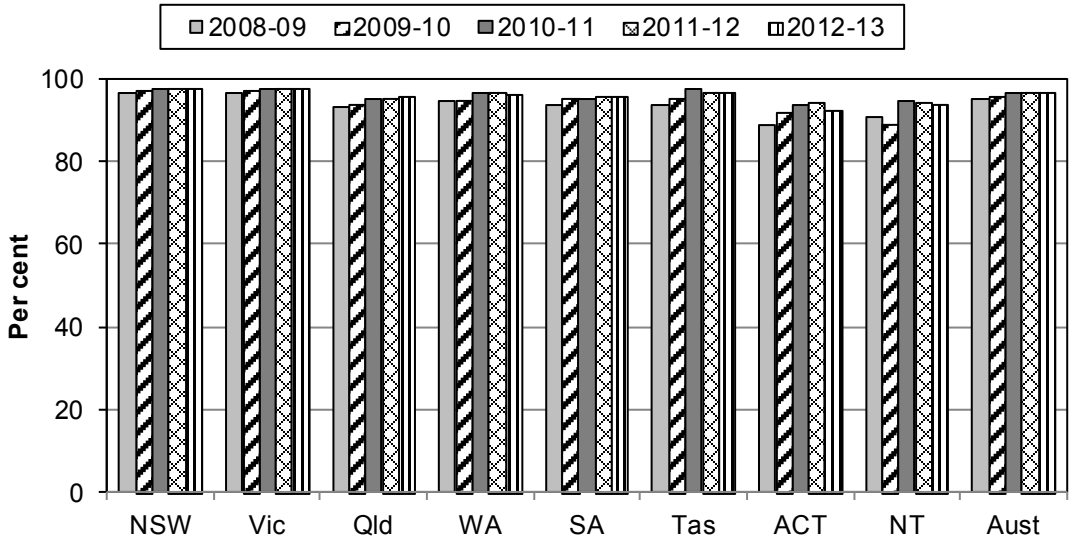
Chronic disease management — care planning and case conferencing

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 95.3 in 2008-09 to 97.0 per cent in 2011-12 and 2012-13 (figure 11.30).

Figure 11.30 **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 become available on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Source: Department of Health (unpublished) MBS Statistics; table 11A.62.

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 needs to be interpreted with care 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. 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.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions for 2012-13 but not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

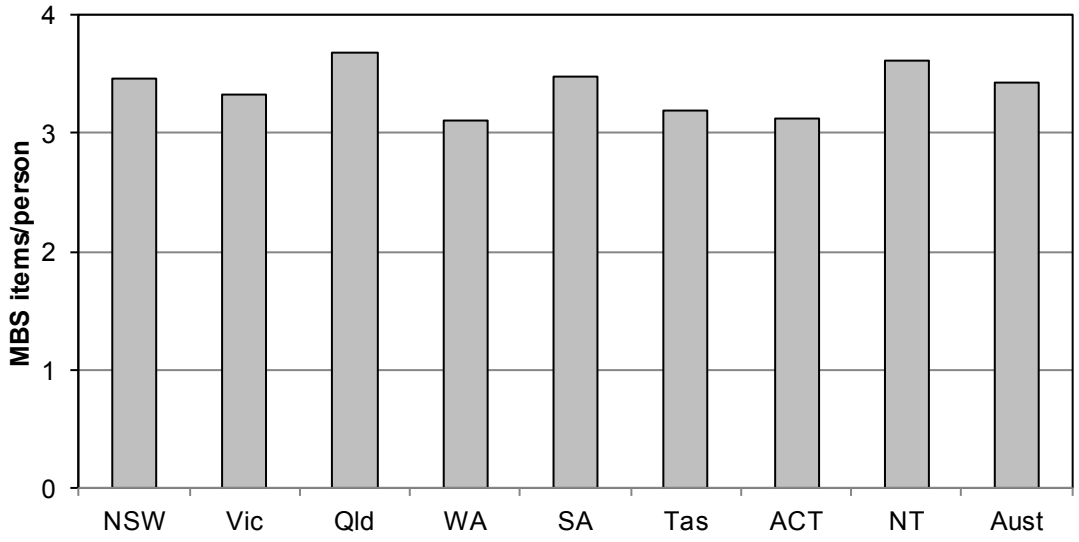
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

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.

Data for this indicator are improved with the introduction of age-standardisation of rates for 2012-13. Historical data are provided in tables 11A.64 for pathology tests and 11A.66 for diagnostic imaging.

Nationally, the number of rebated MBS items for pathology tests requested by GPs was 3.4 per person in 2012-13 (figure 11.31).

Figure 11.31 **MBS items rebated through DHS Medicare for pathology tests requested by GPs, 2012-13[a, b]**

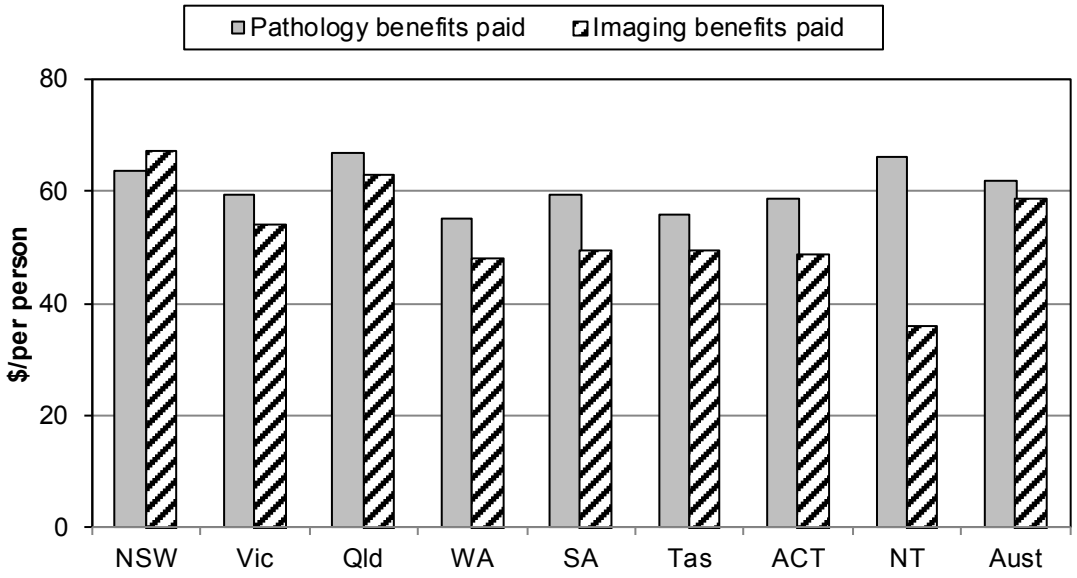


a Data are age standardised to the 2001 Australian standard population. **b** Data include tests requested by vocationally registered GPs and OMPs. Data include patient episode initiated items.

Source: Department of Health (unpublished) MBS and DVA data collections; table 11A.63.

Australian Government expenditure under DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs amounted to $1.5 billion, or around $62 per person, in 2012-13. Nationally, Medicare benefits worth $1.4 billion — around $59 per person — were paid for diagnostic imaging services provided on referral from vocationally registered GPs and OMPs, in 2012-13 (figure 11.32).

Figure 11.32 **Benefits paid for pathology tests and diagnostic imaging, 2012-13[a]**

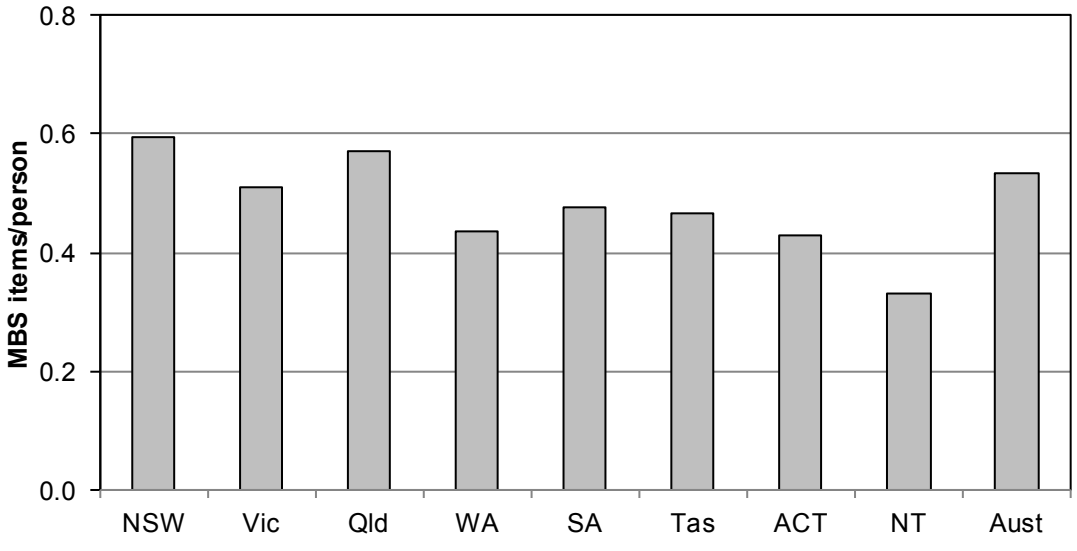


[a] Includes benefits paid through DHS Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally registered GPs and OMPs.

Source: Department of Health (unpublished) MBS and DVA data collections; tables 11A.63 and 11A.65.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs was 0.54 per person in 2012-13 (figure 11.33).

Figure 11.33 **Diagnostic imaging services referred by GPs and rebated through DHS Medicare, 2012-13[a]**



[a] GPs include vocationally registered GPs and OMPs.

Source: Department of Health (unpublished) MBS and DVA data collections; table 11A.65.

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 (Department of Health unpublished; table 11A.51).

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 2012-13 data are available for all jurisdictions.

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:

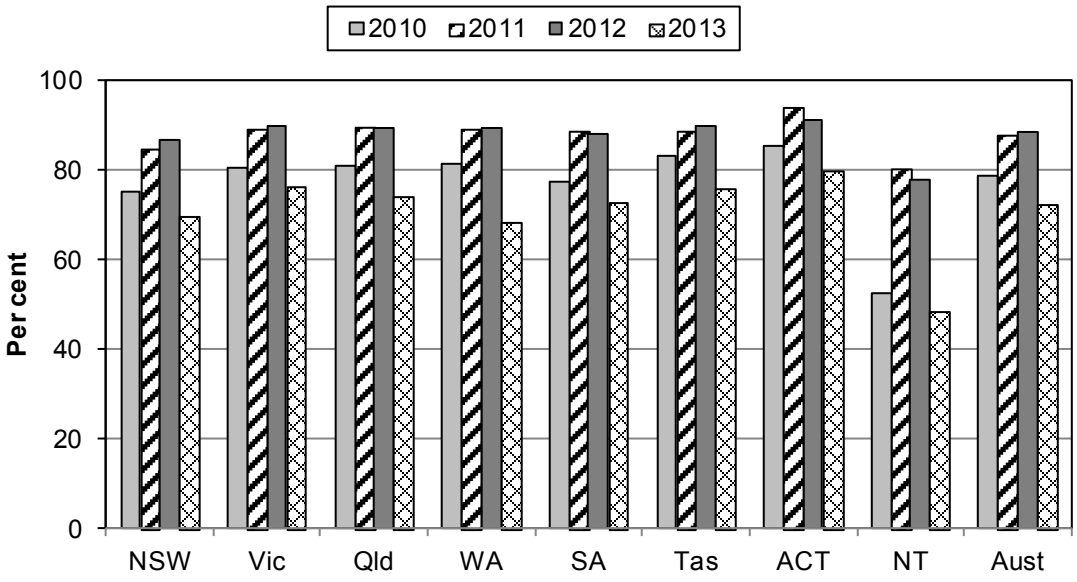
- use of electronic health information systems
- teaching medical students
- improving management for patients with diabetes and/or asthma.

The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Accordingly, new eligibility requirements were introduced from 1 February 2013, requiring practices to:

- integrate healthcare identifiers into electronic practice records
- have a secure messaging capability
- use data records and clinical coding of diagnoses
- send prescriptions electronically to a prescription exchange service
- participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software.

Nationally, the increase in the proportion of PIP practices using electronic health systems from 78.5 per cent in 2010 to 88.3 per cent in 2012 was followed by a decrease to 72.2 per cent in 2013, as implementation of the new requirements was not yet completed in a number of practices (figure 11.34).

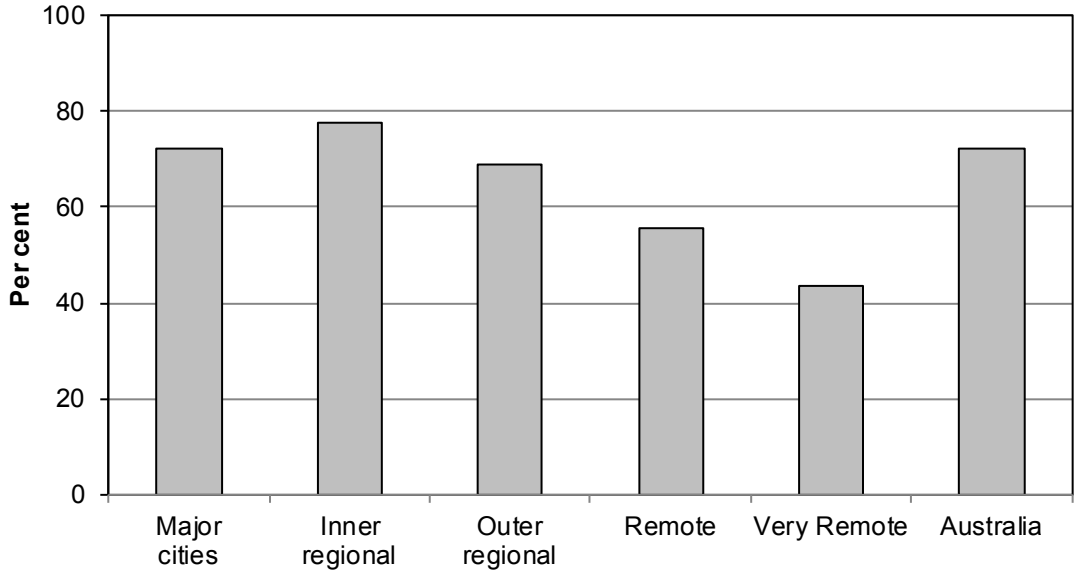
Figure 11.34 **PIP practices using electronic health systems**



Source: Department of Health (unpublished) MBS and PIP data collections; table 11A.67.

The proportion of PIP practices using electronic health systems in remote and very remote areas was lower than in major cities and regional areas in May 2013 (figure 11.35).

Figure 11.35 **PIP practices using electronic health systems by area, 2013[a]**



a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.

Source: Department of Health (unpublished) MBS and PIP data collections; table 11A.68.

Quality — responsiveness

Patient satisfaction

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

Box 11.16 **Patient satisfaction**

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

- experience with selected key aspects of GP care, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months
- experience with selected key aspects of dental professional care, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.

High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.

Data 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 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

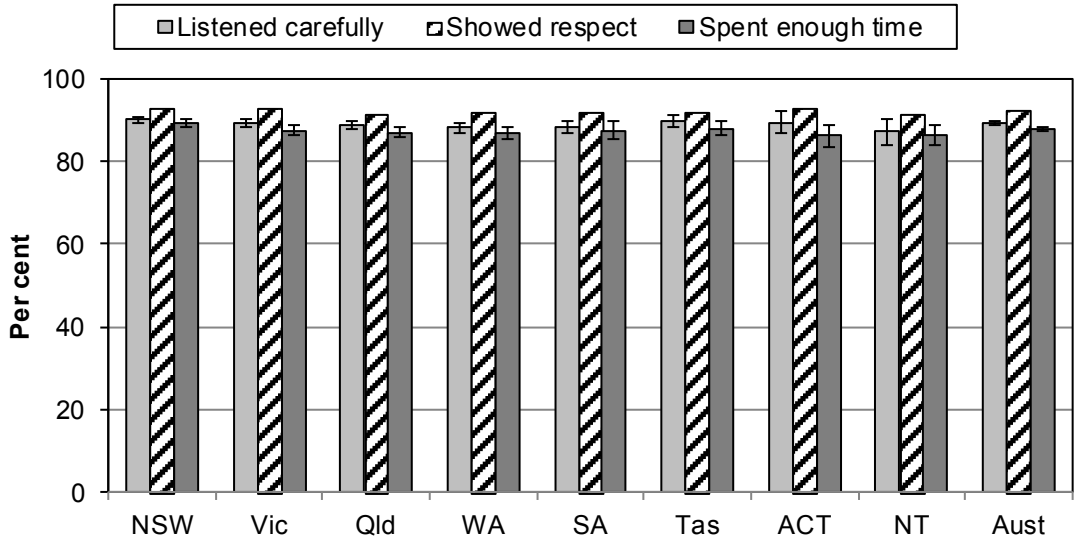
Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2012-13, the GP always or often (figure 11.36):

- listened carefully to them (89.3 per cent)
- showed respect (92.5 per cent)
- spent enough time with them (88.0 per cent).

Data are presented by remoteness area in tables 11A.70 and 11A.71. Data for Indigenous Australians that are reported in table 11A.72 are not comparable to the data presented here (see DQI for details).

Figure 11.36 **Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2012-13**[a, b, c]



[a] People aged 15 years or over who saw a GP in the last 12 months. [b] Rates are age-standardised to the Australian population at 30 June 2001. [c] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; tables 11A.70, 11A.71.

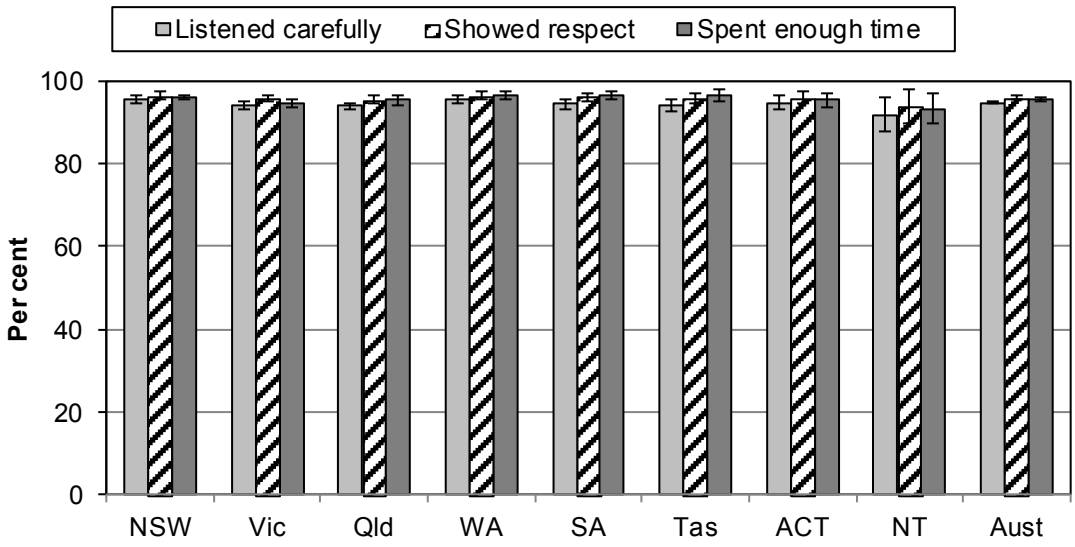
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that, in 2012-13, the dental professional always or often (figure 11.37):

- listened carefully to them (94.8 per cent)
- showed respect (96.1 per cent)
- spent enough time with them (95.6 per cent).

Data are presented by remoteness area in tables 11A.73 and 11A.74.

Figure 11.37 **Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2012-13** [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. [c] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; tables 11A.73, 11A.74.

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).

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 reported against this indicator are:

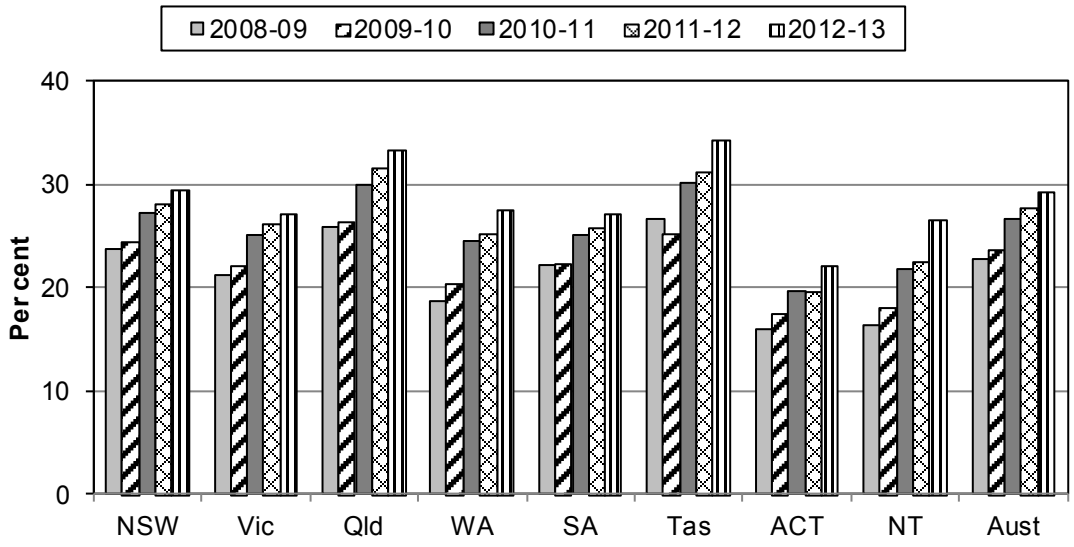
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

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 2008-09 to 2012-13. Nationally, this proportion increased from 22.8 per cent in 2008-09 to 29.2 per cent in 2012-13 (figure 11.38).

Figure 11.38 **Older people who received a health assessment[a, b]**



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. **b** Populations used to derive the rates are based on the 2006 Census.

Source: Department of Health (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.75.

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.

This indicator needs to 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 and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Indigenous primary healthcare services. Consequently, costs for primary care are understated for jurisdictions where a large proportion of the population live in rural and remote areas.

Data reported for this indicator are:

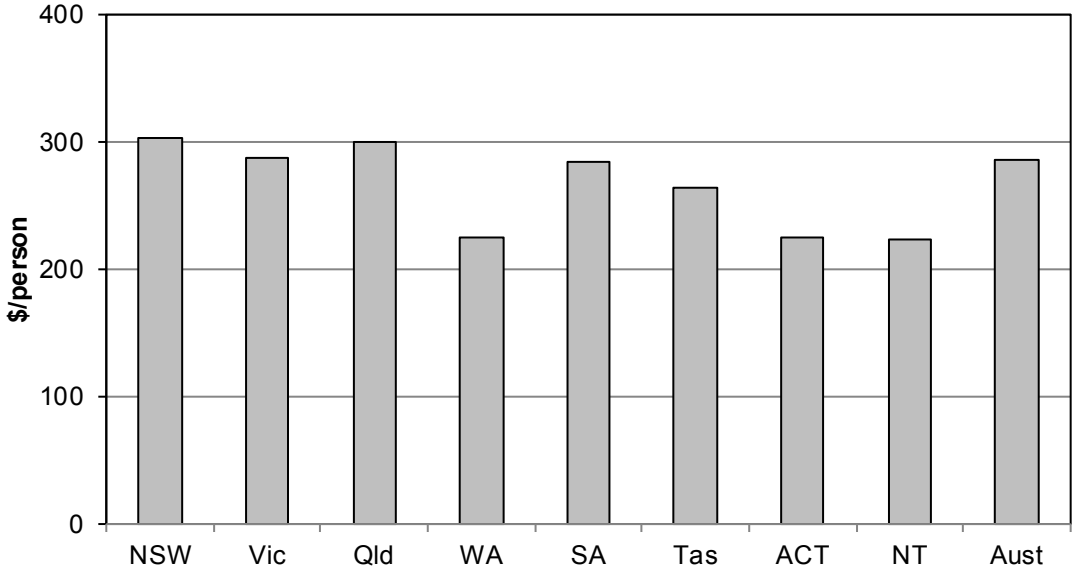
- comparable (subject to caveats) across jurisdictions for 2012-13, but not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data for this indicator have improved with the introduction of age-standardisation for 2012-13 data. These data are not comparable with data for previous years that are not age-standardised. Historical data are provided in table 11A.3.

Nationally, the recurrent cost to the Australian Government of general practice was $286 per person in 2012-13 (figure 11.39).

Figure 11.39 **Australian Government expenditure per person on GPs, 2012-13[a]**



[a] Data are directly age-standardised to the 2001 Australian standard population. [b] Data include DHS Medicare and DVA payments.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished); table 11A.2.

Outcomes

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

Child immunisation coverage

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

Box 11.19 **Child immunisation coverage**

'Child immunisation coverage' is defined by three measures:

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

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

Data 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 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Many providers deliver child immunisation services (table 11.7). High immunisation coverage levels have been encouraged under the General Practice Immunisation Incentives Scheme, which provided incentives for the immunisation of children under 7 years of age to 30 June 2013.

Table 11.7 **Valid vaccinations supplied to children under 7 years of age, by provider type, 2008–2013 (per cent)[a, b, c]**

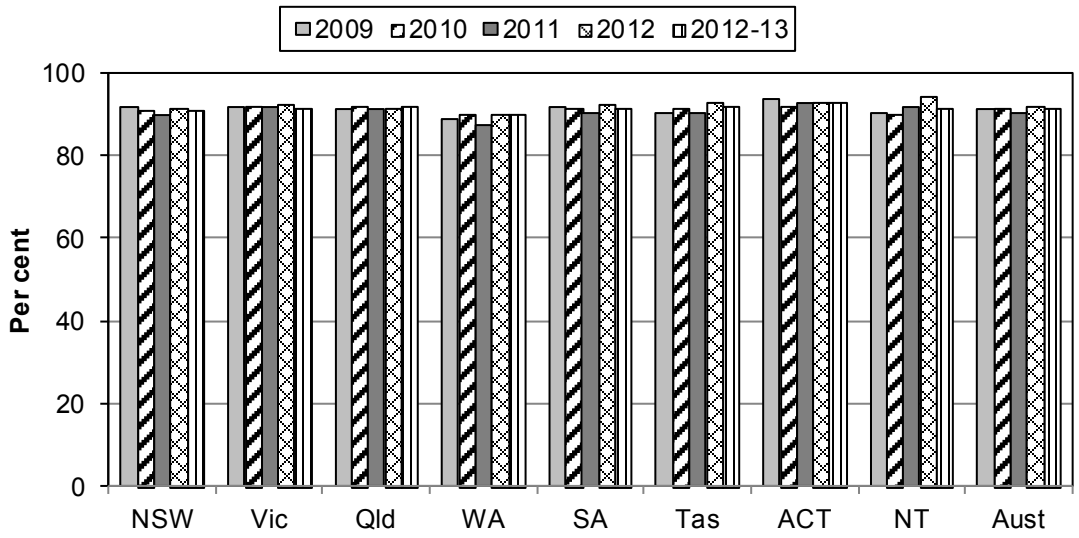
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	89.1	59.2	86.7	68.7	74.2	92.9	58.2	13.2	76.3
Council	3.5	40.3	6.1	3.7	18.5	7.1	–	–	14.2
State or Territory health department	–	–	–	6.4	–	–	1.2	0.5	0.8
Public hospital	np	np	np	np	np	np	np	np	np
Private hospital	–	–	–	–	–	–	–	0.8	–
Indigenous health service	0.6	0.2	0.7	0.4	0.6	–	–	21.9	0.8
Community health centre	6.8	0.3	6.4	20.8	6.6	–	40.6	63.5	7.9
Other[d]	–	0.1	0.1	0.1	0.1	–	–	–	0.1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

[a] Data are for the period 1 July 2008 to 30 June 2013. [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. **np** Not published.

Source: Department of Health (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.76.

Nationally, 91.3 per cent of Australian children aged 12 months to less than 15 months were assessed as fully immunised in 2012-13 (figure 11.40).

Figure 11.40 **Children aged 12 months to less than 15 months who were fully immunised**[a, b, c, d]

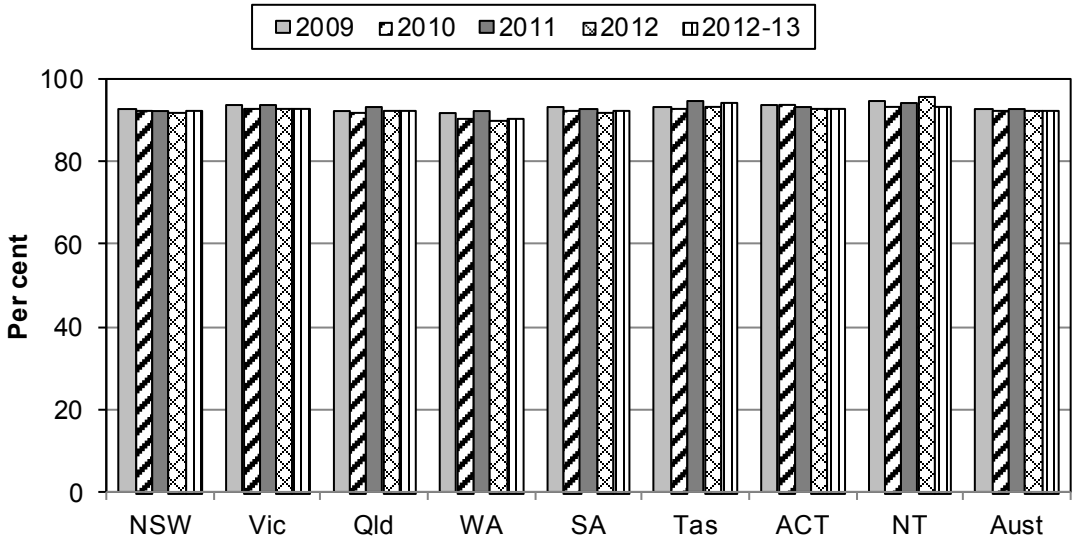


[a] Coverage for years to 2012 measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child resided. For 2013, data include all children aged 12 to 15 months of age fully vaccinated in the 2012-13 financial year. [b] The Australian Childhood Immunisation 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: Department of Health (unpublished) ACIR data collection; table 11A.77.

Nationally, 92.4 per cent of children aged 24 months to less than 27 months were assessed as fully immunised in 2012-13 (figure 11.41).

Figure 11.41 **Children aged 24 months to less than 27 months who were fully immunised[a, b, c]**

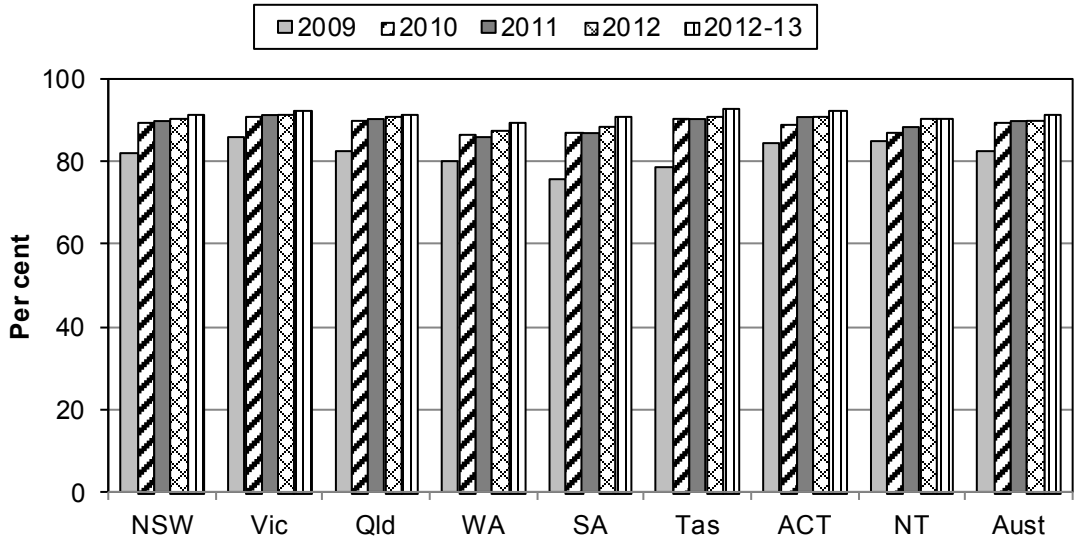


a Coverage for years to 2012 measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child resided. For 2013, data include all children aged 24 to 27 months of age fully vaccinated in the 2012-13 financial year. **b** The ACIR includes all children under 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: Department of Health (unpublished) ACIR data collection; table 11A.78.

Nationally, 91.5 per cent of Australian children aged 60 months to less than 63 months were assessed as fully immunised in 2012-13 (figure 11.42).

Figure 11.42 **Children aged 60 months to less than 63 months who were fully immunised[a, b, c]**



a Coverage for years to 2012 measured at 30 June for children turning 60 months of age by 31 March, by State or Territory in which the child resided. For 2013, data include all children aged 60 to 63 months of age fully vaccinated in the 2012-13 financial year. **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: Department of Health (unpublished) ACIR data collection; table 11A.79.

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 (and consequently the notification rates) through immunisation.

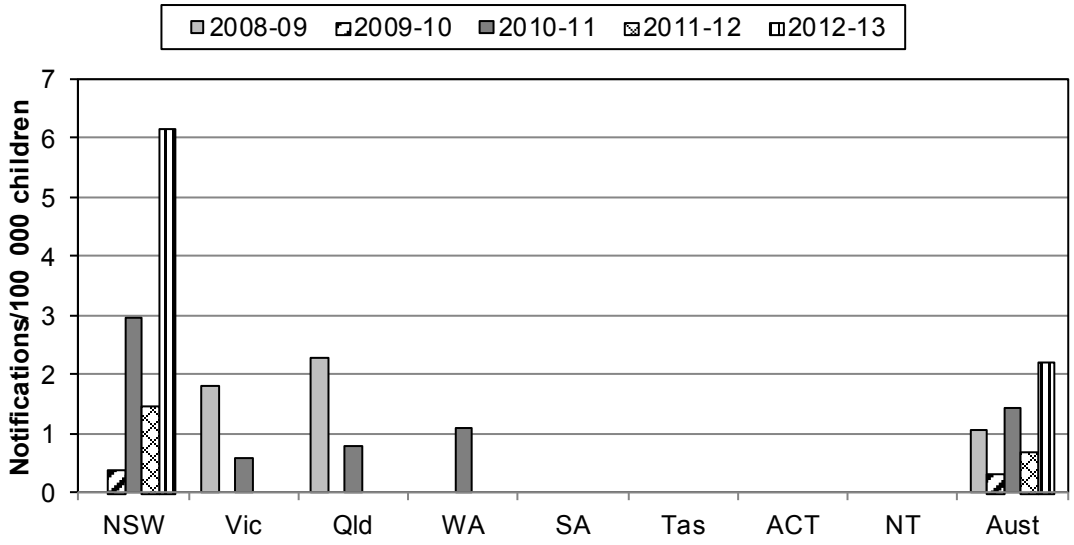
Data reported against this indicator are:

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

Data quality information for this indicator is under development.

Nationally, there were 94 notifications for measles for children aged 0–14 years in 2012-13 — a rate of 2.2 notifications per 100 000 children aged 0–14 years (figure 11.43). This was the higher than for any other year in the period 2008-09 to 2012-13 (table 11A.80).

Figure 11.43 **Notifications of measles per 100 000 children aged 0–14 years**[a]

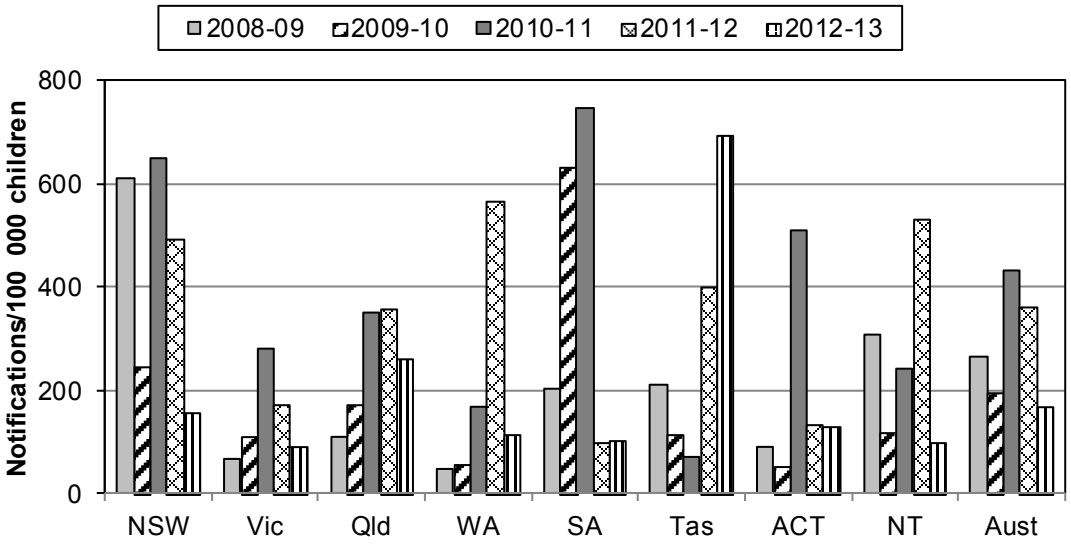


[a] Data are suppressed where the number of notifications reported for a jurisdiction is fewer than 5.

Source: Department of Health (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.80.

Nationally, there were over 7000 notifications for pertussis (whooping cough) for children aged 0–14 years in 2012-13 — a rate of 163 notifications per 100 000 children in this age group (figure 11.44).

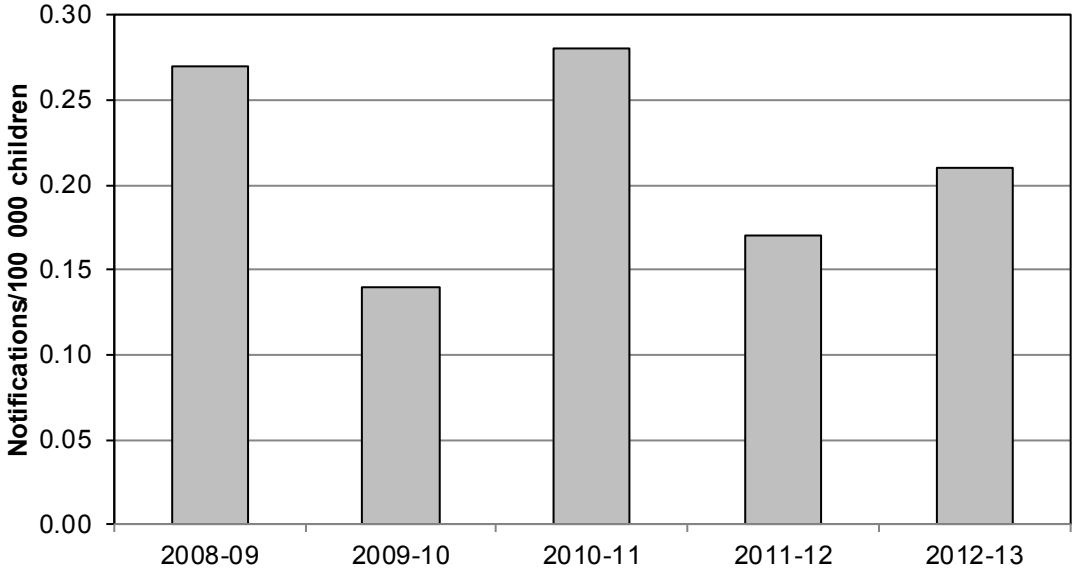
Figure 11.44 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**



Source: Department of Health (unpublished) NNDSS, ABS *Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.81.

In 2012-13, 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 11.45).

Figure 11.45 **Notifications of invasive *Haemophilus influenzae* type b per 100 000 children aged 0–14 years, Australia**



Source: Department of Health (unpublished) NNDSS, *ABS Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.82.

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 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 for the 24 month period 2011 and 2012 are available for all jurisdictions.

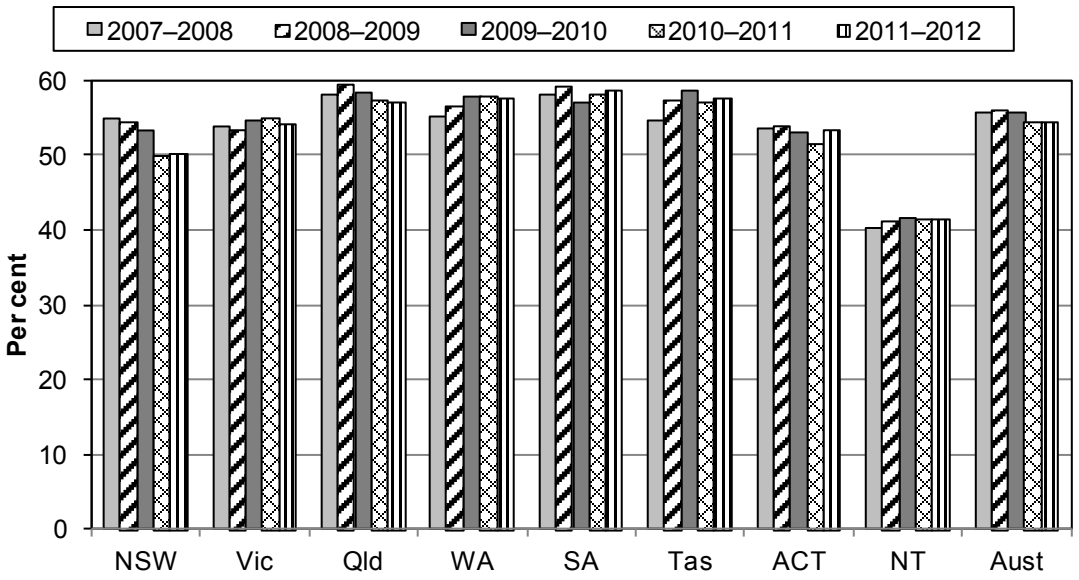
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

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 (Department of Health 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 55.6 per cent in the 24 month period 2007 and 2008 to 54.5 per cent in the 24 month period 2011 and 2012 (figure 11.46). These rates remain below the National Accreditation Standards aim of participation by 70 per cent women in this age group.

Figure 11.46 **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. ERPs to June 2011 are revised to the ABS' final 2011 Census rebased ERPs. The final ERPs replace the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data for June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details. [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.83, 11A.84.

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. 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 unavailable for the 2014 Report — data for 2009–2010 and previous years, as well as national data for 2010–2011 are reported in table 11A.87.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.8. In the 24 month period 2011 and 2012, the national age standardised participation rate for Indigenous women aged 50–69

years was 37.7 per cent (table 11A.85). A low participation rate can in part reflect under-reporting of Indigenous status in screening program records. Rates for Indigenous women are derived using projected populations based on the 2006 Census and are not comparable with rates for all women or NESB women which are derived using ERPs based on the 2011 Census.

In the 24 month period 2011 and 2012, the national age standardised participation rate for NESB women aged 50–69 years was 50.6 per cent, lower than the total participation rate in that age group (54.5 per cent) (table 11A.86).

Table 11.8 **Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2011 and 2012 (24 month period) (per cent)[a, b, c, d, e, f]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[d]	*NT*	*Aust*
Indigenous[e]	36.4	30.5	47.7	36.9	34.0	47.5	50.1	24.6	37.7
NESB[f]	46.8	50.7	62.2	64.2	52.1	44.1	19.0	37.8	50.6
All women aged 50–69 years	50.4	54.3	57.1	57.8	58.8	57.8	53.5	41.6	54.5

[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.83–11A.86.

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 reported against this indicator are:

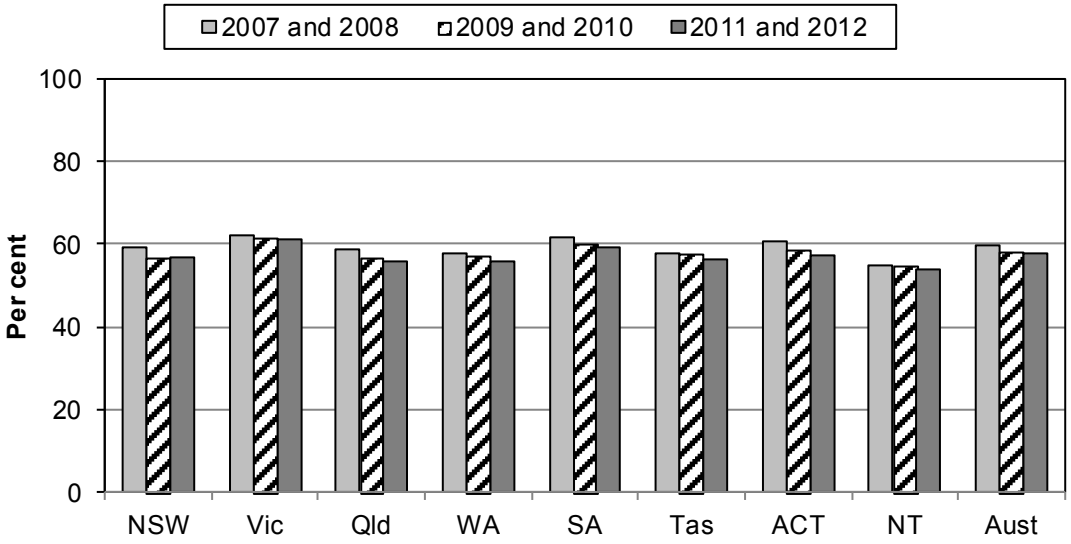
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2011 and 2012 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

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 (Department of Health 2012; 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 59.8 per cent for the 24 month period 1 January 2007 to 31 December 2008 to 57.7 per cent for the 24 months 1 January 2011 to 31 December 2012 (figure 11.47). For most jurisdictions, participation rates have decreased since the screening period of 2007 and 2008. Data for Indigenous women for 2004-05 are presented in table 11A.89.

Figure 11.47 **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 (based on the 2011 Census) in each calendar year in the reference period and age standardised to the 2001 Australian population. **b** Eligible female population adjusted for the 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.88.

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.

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 reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

Data quality information for this indicator is under development.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (Department of Health 2013b). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the Immunisation Program. GPs provide the majority of these vaccinations.

Updated data were not available for the 2014 Report. Nationally, 74.6 per cent of eligible people were fully vaccinated against influenza in 2009 (table 11A.90).

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.91. Data for Indigenous Australians fully vaccinated against influenza and pneumococcal disease in 2004-05 are presented in table 11A.92

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 (the first measure is reported against the indicator of the same name in the NHA):

- 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 reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time except for the measure potentially preventable hospitalisations for diabetes
- complete (subject to caveats) for the current reporting period except for the measure potentially preventable hospitalisations for diabetes, for which data are not published for Tasmania, the ACT and the NT. All other required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

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

This measure has improved for the 2014 Report with data for all states and territories included in Australian totals for the first time. Indigenous identification in 2011-12 hospital administrative data is considered acceptable for analysis in all states and territories from the 2011-12 reporting period.

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 are age-standardised to account for differences in the age structures of the populations across states and territories.

Nationally, the age-standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 24.0 per 1000 people in 2011-12 (table 11.9). Of these, 47.1 per cent were for chronic and 49.9 per cent for acute conditions (table 11A.93). Data are presented disaggregated by Indigenous status in table 11A.94 and remoteness in table 11A.95. National data by Indigenous status and remoteness are presented in table 11A.96.

Table 11.9 **Separations for selected potentially preventable hospitalisations per 1000 people, 2011-12[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Vaccine preventable conditions	0.8	0.8	0.9	0.8	0.9	0.5	0.7	3.1	0.8
Selected acute conditions[d]	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0
Selected chronic conditions[e]	10.4	11.9	12.5	10.7	11.4	9.1	8.5	21.0	11.3
Total[f, g]	**22.0**	**24.6**	**26.0**	**24.9**	**25.0**	**18.0**	**18.7**	**43.5**	**24.0**

[a] Separation rates are directly age-standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories. Excludes overseas residents and unknown state of residence. [d] 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 (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; AIHW (unpublished); table 11A.93.

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2011-12 (table 11.10). Nationally, influenza and pneumonia accounted for 79.0 per cent of hospital separations for vaccine preventable conditions in 2011-12 (AIHW 2013b).

Table 11.10 **Separations for vaccine preventable conditions per 1000 people, 2011-12[a, b]**

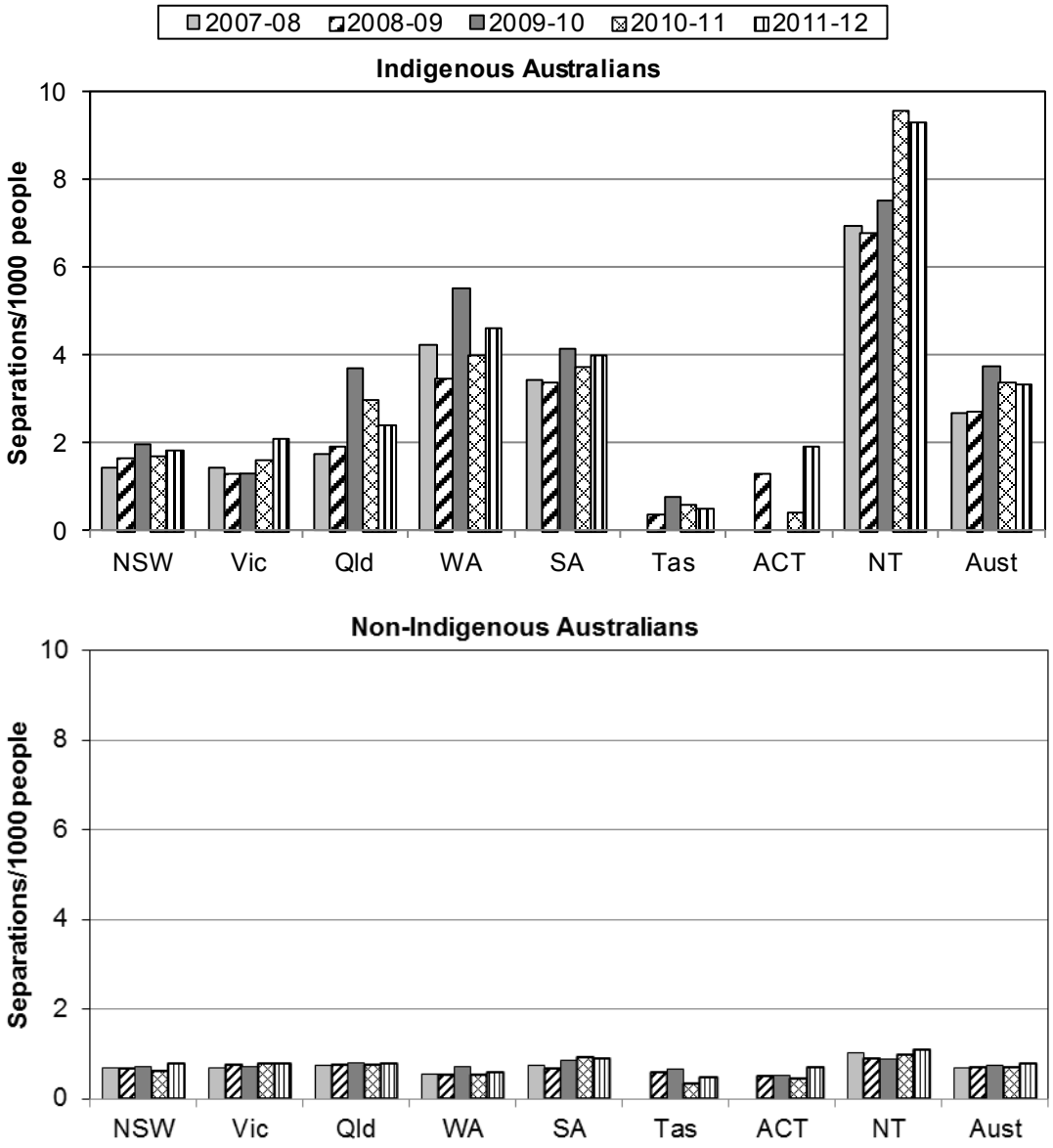
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.6	0.5	0.7	0.6	0.8	0.4	0.6	2.5	0.6
Other conditions	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.6	0.2
Total[d]	**0.8**	**0.8**	**0.9**	**0.8**	**0.9**	**0.5**	**0.7**	**3.1**	**0.8**

[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 (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; table 11A.97.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous Australians than for non-Indigenous Australians in 2011-12, in most jurisdictions (figure 11.48).

Figure 11.48 **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 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. [e] For 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.97.

Of the selected acute conditions, dental conditions, dehydration and gastroenteritis, and pyelonephritis recorded the highest rates of hospitalisation nationally in 2011-12 (table 11.11).

Table 11.11 **Separations for selected acute conditions per 1000 people, 2011-12[a, b]**

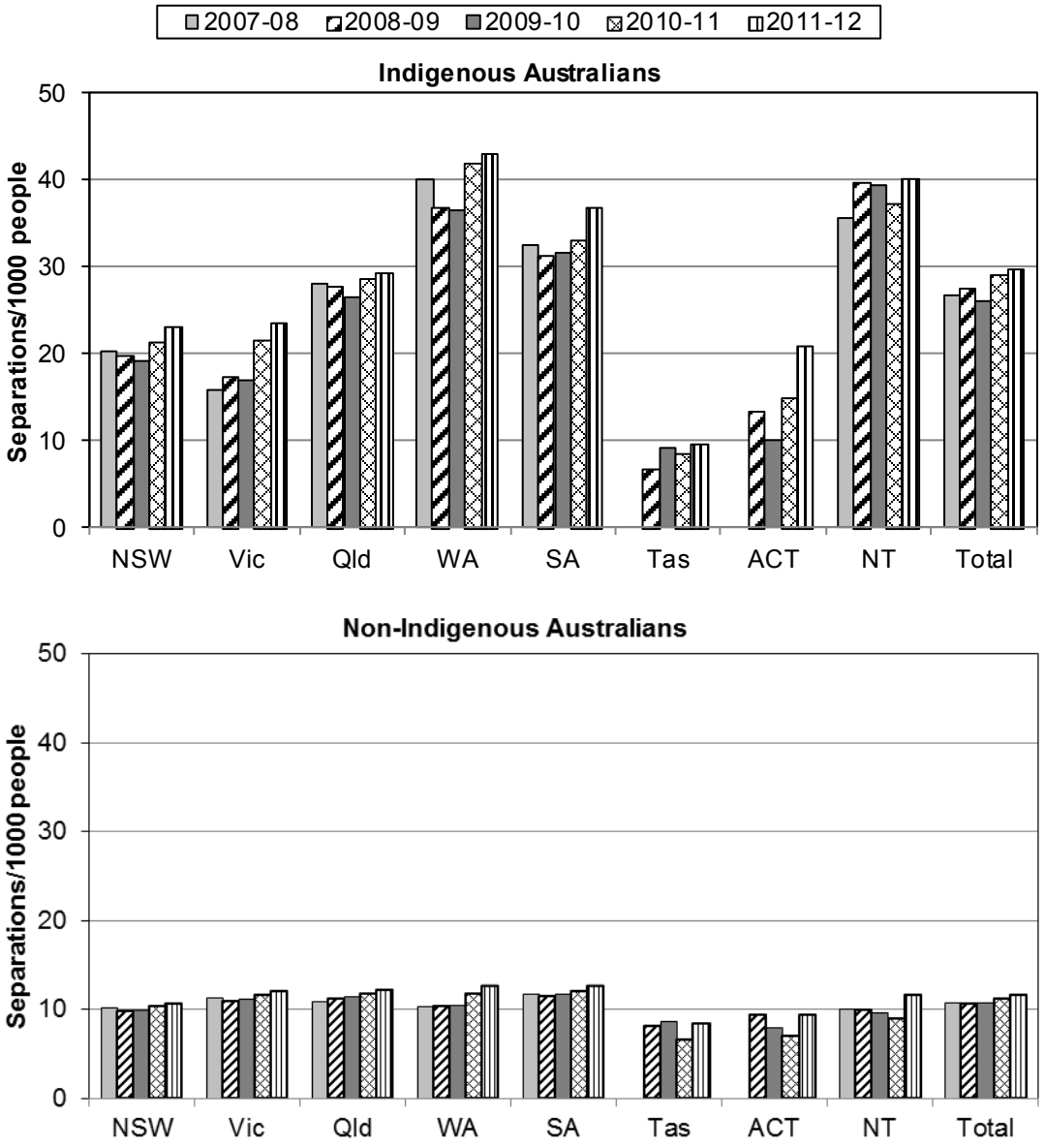
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.4	0.3	0.4	0.4	0.4	0.3	0.2	0.5	0.4
Cellulitis	1.9	1.8	2.1	1.9	1.7	1.3	1.4	4.1	1.9
Convulsions and epilepsy	1.6	1.5	1.7	1.5	1.7	1.2	1.4	3.4	1.6
Dehydration and gastroenteritis[d]	2.6	3.5	3.1	2.7	2.7	2.0	1.8	3.2	2.9
Dental conditions	2.3	3.1	2.9	3.9	3.6	2.3	2.2	3.1	2.9
Ear, nose and throat infections	1.6	1.8	1.9	2.1	2.3	1.1	1.1	2.8	1.8
Gangrene	0.2	0.4	0.3	0.4	0.2	0.2	0.1	0.8	0.3
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.6	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis[e]	2.6	2.8	3.0	3.0	2.5	1.6	2.6	4.4	2.7
Total[d, f]	**13.5**	**15.6**	**15.8**	**16.2**	**15.6**	**10.4**	**11.3**	**23.0**	**14.9**
Total excluding dehydration and gastroenteritis[f]	**10.9**	**12.0**	**12.7**	**13.6**	**12.8**	**8.5**	**9.5**	**19.8**	**12.0**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories and excludes overseas residents and unknown State of residence. [d] Data for dehydration and gastroenteritis, and therefore for total selected acute conditions, are not comparable across jurisdictions due to differences in clinical coding and admission protocols. [e] Kidney inflammation caused by bacterial infection. [f] Totals may not add as more than one acute condition may be reported for a separation.

Source: AIHW (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; AIHW (unpublished) National Hospital Morbidity Database; table 11A.98.

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 2011-12 (figure 11.49).

Figure 11.49 **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 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. [f] For 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.98.

Of the selected chronic conditions, chronic obstructive pulmonary disease, congestive cardiac failure, asthma and diabetes complications (as well as diabetes complications as principal diagnosis only), recorded the highest rates of hospitalisation nationally in 2011-12 (table 11.12).

Table 11.12 **Separations for selected chronic conditions per 1000 people, 2011-12[a, b]**

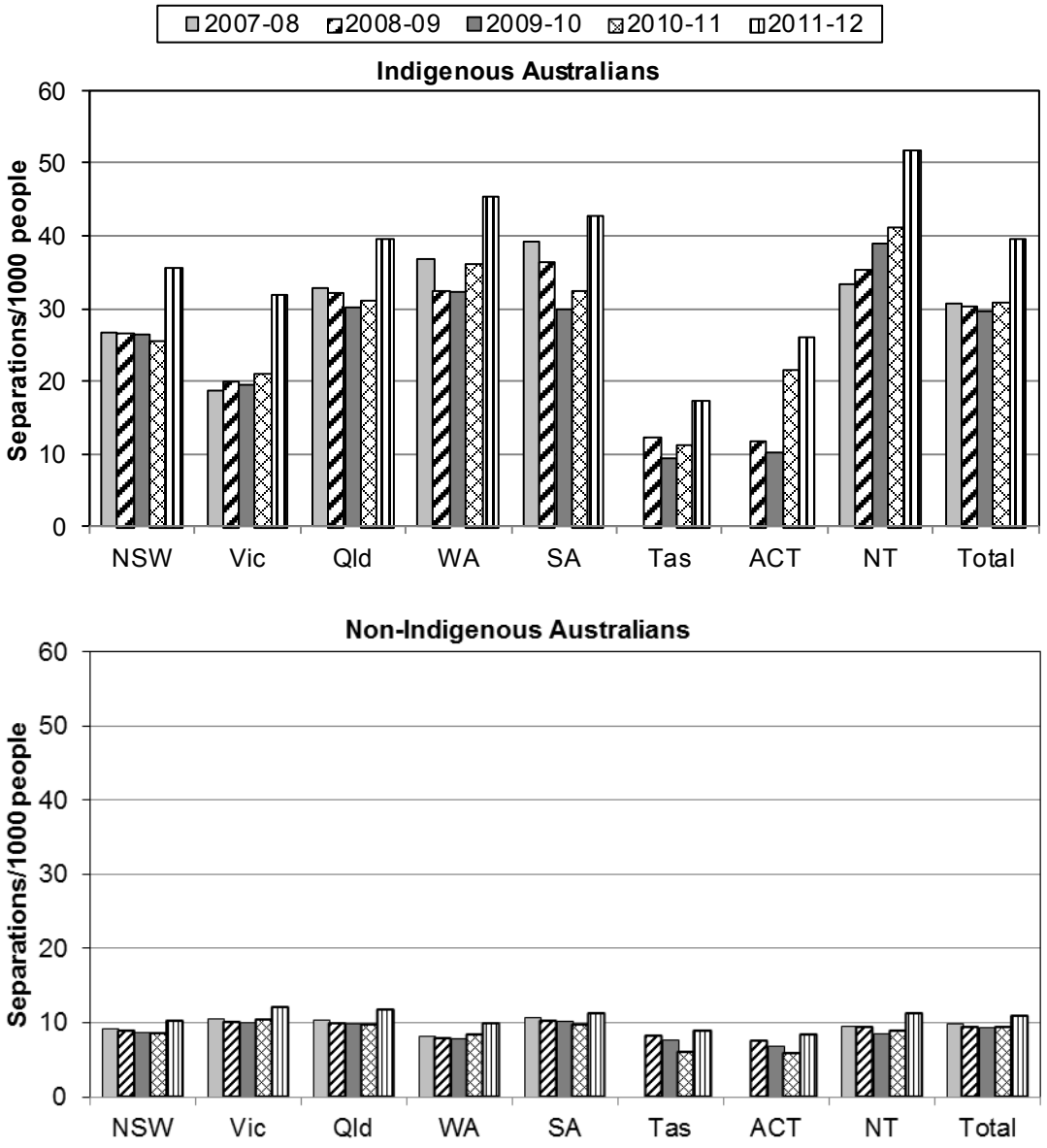
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.0	1.2	1.9	1.3	1.3	0.9	0.7	2.4	1.3
Asthma	1.8	2.0	1.7	1.4	1.9	1.0	1.2	1.9	1.8
Chronic obstructive pulmonary disease	2.7	2.6	3.1	2.4	2.7	2.1	2.4	7.1	2.8
Congestive cardiac failure	1.9	2.2	2.1	1.9	1.8	1.4	1.6	3.5	2.0
Diabetes complications (as principal or additional diagnosis)[d]	2.5	3.1	4.3	8.0	3.1	2.9	2.0	6.8	3.6
Diabetes complications (as principal diagnosis only)	1.4	1.7	1.8	1.6	1.9	1.8	1.2	3.3	1.6
Hypertension	0.3	0.3	0.5	0.3	0.3	0.2	0.2	0.2	0.3
Iron deficiency anaemia	1.1	1.9	1.3	1.6	1.4	1.6	1.1	1.5	1.4
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	–	<0.1	0.1	<0.1
Rheumatic heart disease [e]	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.9	0.1
Total[d, f]	**11.3**	**13.0**	**14.5**	**16.8**	**12.3**	**9.9**	**9.1**	**23.4**	**13.0**
Total excluding diabetes complications as additional diagnosis[f]	**10.4**	**11.9**	**12.5**	**10.7**	**11.4**	**9.1**	**8.5**	**21.0**	**11.3**

[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] Data for diabetes complications, and therefore for total selected chronic conditions, are not comparable across jurisdictions due to differences in clinical coding and admission protocols. [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. – Nil or rounded to zero.

Source: AIHW (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; AIHW (unpublished) National Hospital Morbidity Database; table 11A.99.

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 2011-12 (figure 11.50).

Figure 11.50 **Separations for selected chronic conditions by Indigenous status**[a, b, c, d, e, f]



[a] Excludes separations for diabetes complications as additional diagnosis. [b] Separation rates are directly age standardised to the Australian population at 30 June 2001. [c] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [d] Separation rates are based on State/Territory of usual residence. [e] NT data for 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. [f] From 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.99.

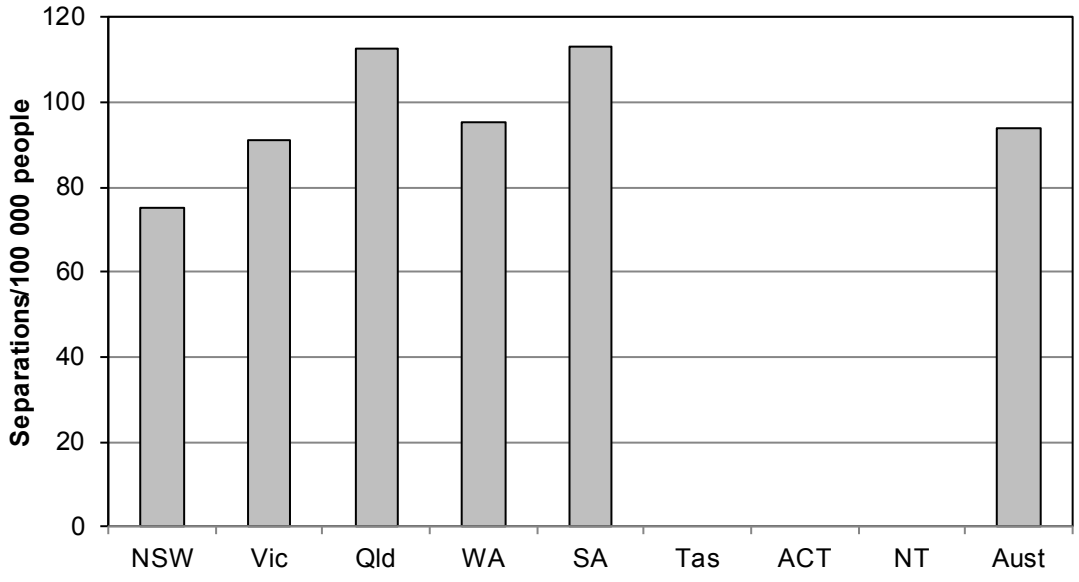
Potentially preventable hospitalisations for diabetes

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 93.8 separations per 100 000 people in 2011-12 (figure 11.51).

Figure 11.51 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2011-12[a, b, c]**



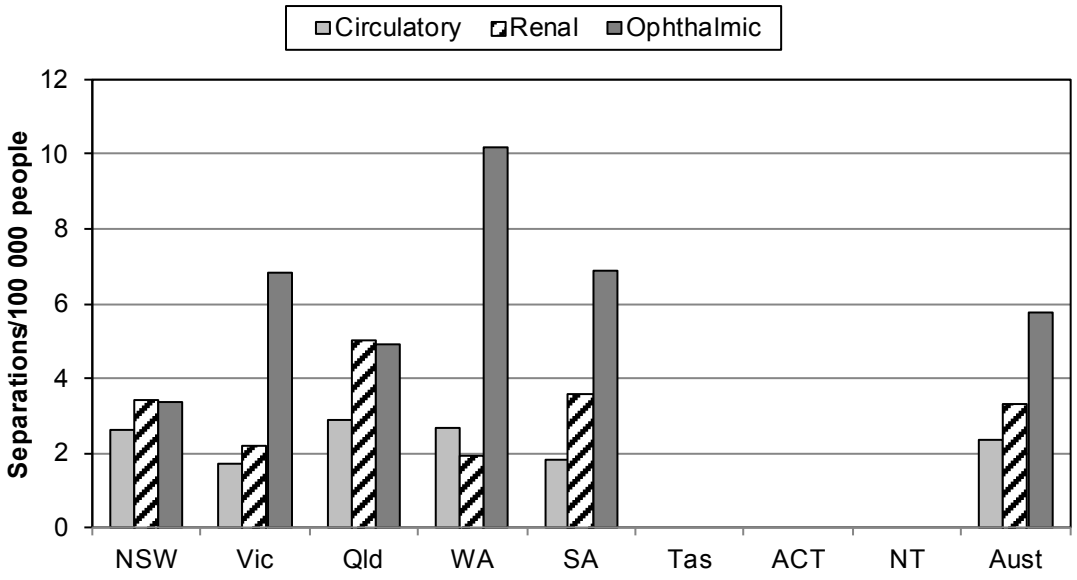
a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. **b** Morbidity data are coded under coding 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.101.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2011-12 were ophthalmic, renal and circulatory complications.

Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.52).

Figure 11.52 **Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2011-12[a, b, c, d, e]**



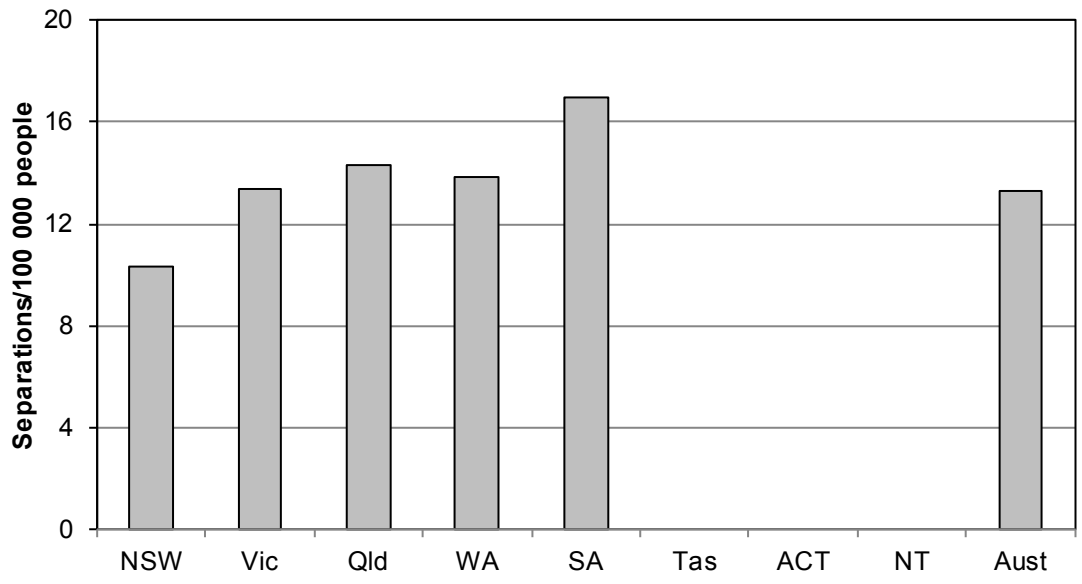
[a] Results for individual complications can be affected by small numbers, and need to be interpreted with care. [b] Patients can have one or more complication(s) for each separation. [c] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of 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.101.

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, 22.4 per cent of separations for Type 2 diabetes were same day separations in 2011-12 (table 11A.102).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2011-12, 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 11.53).

Figure 11.53 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2011-12[a, b, c]**



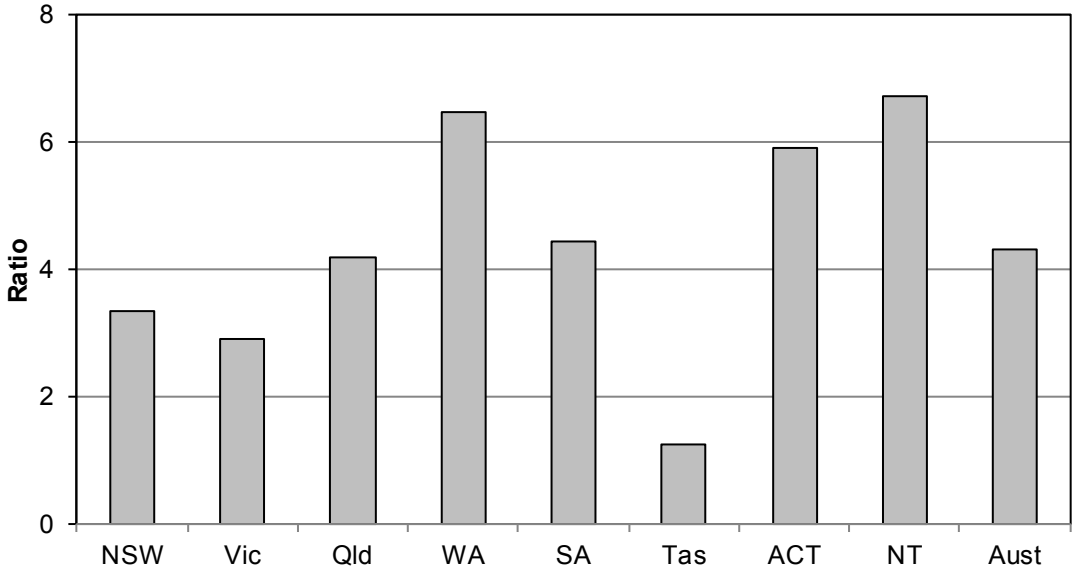
a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes unspecified diabetes. Data are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 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.103.

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 2011-12 between the separation rates for Indigenous Australians and those for the total population for diabetes diagnoses (figure 11.54).

Figure 11.54 **Ratio of separation rates of Indigenous Australians to all people for diabetes, 2011-12**[a, b, c, d, e, f]



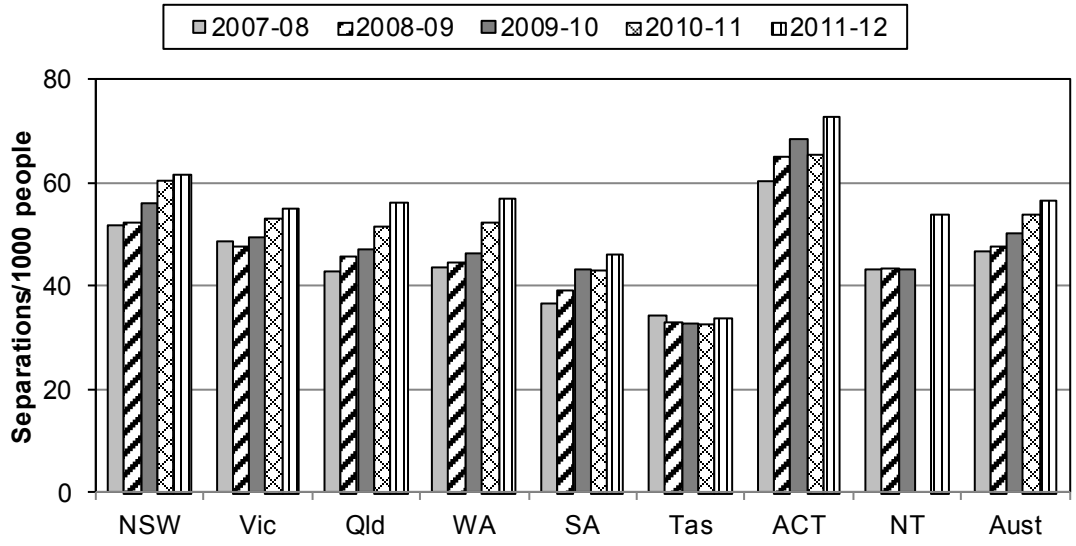
[a] Excludes separations with diabetes complications as an additional diagnosis. [b] Ratios are directly age standardised to the Australian population at 30 June 2001. [c] Separation rates are based on state of usual residence. [d] Patients aged 75 years or over are excluded. [e] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [f] NT data are for public hospitals only.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.100.

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 2009-10 (Bradley 2013). 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 2007-08 to 2011-12 in most jurisdictions (figure 11.55).

Figure 11.55 **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 available for the NT for 2010-11.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.104.

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.

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	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma Action Plan	An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional. *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra.
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs were active until end June 2012. There were 109 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The Divisions of General Practice Program (DGPP) 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 2011, Medicare Locals progressively assumed responsibility for general practice support initiatives previously funded under the DGPP. The DGPP ceased on 30 June 2012.
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 *Haemophilus influenzae* type B vaccine.
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, four doses of *Haemophilus influenzae* type B and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, 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 *Health Insurance Act 1973* (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.
Haemophilus influenzae type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013c).
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 independent 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 regions (www.amlalliance.com.au/about-us, accessed 25 November 2013). Established progressively from 1 July 2011 under the National Health Reform agenda, the national network of 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 (Department of Health 2013d). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally 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: • 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.
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: • 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 *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her 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).

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11A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 11.5 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

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

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Table 11A.1 **Types of encounter, 2012-13 (a), (b)**

	Number	*Per cent of encounters* (c) *(n = 90 077)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n = 88 586)*	*Medicare/DVA-paid GP items (n = 85 881)*
	no.	%	%	%	%	%
Direct encounters	88 568	98.3	98.1	98.6	100.0	..
No charge	334	0.4	0.3	0.4	0.4	..
MBS/DVA items of service (direct encounters only) (d)	85 870	95.3	94.9	95.8	96.9	..
MBS/DVA items of service (GPs only)	85 881	95.3	94.9	95.8	97.0	100.0
Short surgery consultations	1 502	1.7	1.4	1.9	0.0	1.7
Standard surgery consultations	69 260	76.9	75.8	78.0	0.8	80.6
Long surgery consultations	8 071	9.0	8.4	9.6	0.1	9.4
Prolonged surgery consultations	491	0.6	0.4	0.6	0.0	0.6
Home or institution visits (excluding RACF)	829	0.9	0.7	1.1	0.0	1.0
Residential aged care facility	1 490	1.7	1.2	2.1	0.0	1.7
Health assessments	346	0.4	0.3	0.4	0.0	0.4
Chronic disease management items	1 232	1.4	1.2	1.5	0.0	1.4
Case conferences	11	<0.05	–	–	0.0	–
GP mental health care items	1 258	1.4	1.2	1.5	0.0	1.5
Attendances associated with practice incentive payments	187	0.2	0.2	0.3	0.0	0.2
Other items	1 203	1.3	1.1	1.6	0.0	1.4
Workers compensation	1 580	1.8	1.6	1.9	1.8	..
Other paid (hospital, State, etc.)	785	0.9	0.6	1.2	0.9	..

Table 11A.1 **Types of encounter, 2012-13 (a), (b)**

	Number	*Per cent of encounters* (c) *(n = 90 077)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n = 88 586)*	*Medicare/DVA-paid GP items (n = 85 881)*
Indirect encounters (e)	1 506	1.7	1.4	1.9	–	..
Direct/indirect encounter unspecified	2	<0.05	–	–	..	..
Total encounters	**90 077**	**100.0**	..	..	..	..
MBS/DVA items of service (all encounters)	85 885	95.3	94.9	95.8	..	..

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* =8487).

(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., Bayram, C., Valenti, L., Harrison, C., Charles, J., Pan, Y., Zhang, C., Pollack, A.J., O'Halloran, J. 2013, *General practice activity in Australia 2012–13* , General practice series no. 33, Sydney University Press, Sydney.

Table 11A.2 **Australian Government real expenditure on GPs — fee-for-service expenditure ($ million) (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
Expenditure through DHS Medicare fee for service — total										
2012-13	$m	2 355.6	1 714.2	1 413.7	557.7	515.1	149.2	83.5	46.6	6 835.5
Expenditure through DHS Medicare fee for service — per person (ASR) (e), (f)										
2012-13	$	303.1	288.0	299.9	224.7	285.0	265.1	225.1	223.1	286.1

ASR = age standardised rate.

(a) Age standardised expenditure per person data are available for the first time for the 2012-13 reference year. Data for previous years are provided in table 11A.3.

(b) 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.

(c) Data include expenditure on Department of Human Services—Medicare (DHS Medicare) and the Department of Veteran's Affairs (DVA). Data exclude expenditure on the Practice Incentives Program (PIP), the General Practice Immunisation Incentive Scheme (GPII) and Medicare Locals (ML). Data are not comparable with data in table 11A.3 that include this expenditure.

(d) Data for Australia includes expenditure on patients of unknown age.

(e) Expenditure per person is directly age standardised to the 2001 Australian standard population. Expenditure on Medicare Locals, GPII and PIP is excluded as these are not related to age and cannot be age-standardised. Data are not comparable to previous years for which crude rates are reported (see table 11A.3).

(f) Rates are derived using the ABS first preliminary estimated resident population based on the 2011 Census.

Source : Department of Health unpublished, MBS statistics; DVA unpublished; table 2A.51.

Table 11A.3 **Australian Government real expenditure on GPs ($ million) (2012-13 dollars) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Expenditure (c)										
2006-07	$m	2 202.2	1 526.9	1 222.4	522.6	494.3	142.7	76.6	34.2	6 221.9
2007-08	$m	2 277.0	1 607.5	1 285.7	545.6	514.5	148.8	80.2	37.6	6 496.8
2008-09	$m	2 273.1	1 614.9	1 306.4	541.5	517.8	146.0	79.6	37.8	6 517.1
2009-10	$m	2 299.0	1 654.8	1 346.6	551.8	524.1	149.6	79.9	40.8	6 646.6
2010-11	$m	2 321.0	1 687.0	1 376.2	555.3	525.4	150.5	80.1	43.2	6 738.8
2011-12	$m	2 361.5	1 709.9	1 415.6	554.3	525.5	152.0	81.8	44.8	6 845.4
2012-13 (e)	$m	2 532.2	1 858.5	1 531.6	619.3	568.1	167.2	89.8	59.3	7 426.0
Expenditure per person (crude rates) (f)										
2006-07	$	324.5	299.2	301.4	251.6	316.6	290.3	226.4	162.1	301.6
2007-08	$	330.8	309.2	309.1	255.5	325.9	300.1	233.0	173.6	309.1
2008-09	$	324.6	303.9	305.6	245.1	324.1	291.0	226.7	169.9	303.5
2009-10	$	323.7	305.4	308.3	243.8	323.8	295.4	223.3	179.1	304.0
2010-11	$	323.3	307.0	310.2	239.5	321.8	295.0	219.6	187.6	303.9
2011-12	$	325.8	306.7	313.7	232.2	319.4	297.0	220.6	192.8	304.4

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Rates are derived using the ABS final 2011 Census rebased estimated resident population (ERP).

(c) Data include expenditure on Department of Human Services—Medicare, the Practice Incentives Program (PIP), the Department of Veterans' Affairs (DVA) and the General Practice Immunisation Incentive Scheme (GPII). Data include expenditure on the Divisions of General Practice Program (DGPP) for 2011-12 and previous years. From 2012-13, total expenditure data include core operational expenditure on Medicare Locals (ML).

(d) From 2010-11, DVA data 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).

(e) 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.

(f) Expenditure data for 2011-12 and previous years are crude rates and are not comparable with data for 2012-13, which are age-standardised. See table 11A.2 for age-standardised expenditure per person data for 2012-13.

Source : Department of Health unpublished, MBS, PIP, GPII, DGPP, ML and DVA data collections; table 2A.51.

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS Total (d)										
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	2 404.4	1 736.1	1 301.0	598.4	581.1	183.6	87.7	24.6	6 917.2
2005-06	$m	2 327.9	1 695.5	1 262.5	580.8	576.4	182.5	84.5	24.5	6 734.6
2006-07	$m	2 271.8	1 642.0	1 249.3	571.9	558.2	176.1	81.6	23.4	6 574.4
2007-08	$m	2 351.1	1 701.7	1 294.1	595.4	583.1	184.8	83.9	24.8	6 818.9
2008-09	$m	2 523.0	1 807.8	1 391.2	642.8	615.1	197.0	89.2	26.3	7 292.6
2009-10	$m	2 626.4	1 884.9	1 458.5	661.4	636.3	206.4	93.7	26.9	7 594.5
2010-11	$m	2 631.9	1 876.5	1 455.1	675.1	626.3	209.2	93.7	27.9	7 595.6
2011-12	$m	2 625.1	1 884.0	1 475.9	712.4	633.4	212.0	93.4	27.5	7 663.8
2012-13	$m	2 423.2	1 748.7	1 370.9	640.9	592.7	192.6	89.8	25.5	7 084.2
RPBS Total (e)										
2004-05	$m	216.0	134.0	135.7	46.5	46.6	18.5	8.7	1.1	607.2
2005-06	$m	200.7	125.7	126.3	43.8	44.5	17.7	8.4	1.2	568.2
2006-07	$m	185.4	115.9	119.1	41.3	41.2	15.9	7.7	1.0	527.3
2007-08	$m	180.7	110.7	116.5	40.8	39.6	15.6	7.8	1.0	512.8
2008-09	$m	182.0	108.6	117.6	40.8	39.6	15.4	7.9	1.0	513.0
2009-10	$m	180.3	106.4	118.2	39.2	39.8	15.3	7.9	1.0	508.0
2010-11	$m	168.0	97.3	113.0	37.2	35.4	14.2	7.4	0.9	473.4
2011-12	$m	158.8	90.2	110.1	36.4	34.1	13.9	6.9	0.9	451.2
2012-13	$m	139.5	77.5	97.9	30.9	28.6	12.0	6.5	0.8	393.7
PBS and RPBS TOTAL										
2004-05	$m	2 620.4	1 870.1	1 436.7	644.9	627.7	202.1	96.4	25.8	7 524.5
2005-06	$m	2 528.6	1 821.2	1 388.8	624.6	620.9	200.2	92.9	25.6	7 302.8

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07	$m	2 457.2	1 757.9	1 368.4	613.1	599.4	192.0	89.3	24.4	7 101.7
2007-08	$m	2 531.8	1 812.4	1 410.6	636.2	622.8	200.4	91.7	25.8	7 331.7
2008-09	$m	2 705.0	1 916.4	1 508.8	683.6	654.7	212.4	97.1	27.3	7 805.6
2009-10	$m	2 806.7	1 991.3	1 576.7	700.6	676.1	221.6	101.5	27.8	8 102.4
2010-11	$m	2 799.9	1 973.8	1 568.1	712.3	661.7	223.5	101.1	28.7	8 069.0
2011-12	$m	2 783.9	1 974.2	1 586.0	748.7	667.5	225.9	100.3	28.4	8 115.0
2012-13	$m	2 562.7	1 826.1	1 468.8	671.8	621.4	204.6	96.3	26.3	7 477.9
PBS total expenditure per person (f)										
2004-05	$	353.6	344.5	327.9	296.6	376.4	377.4	269.5	121.6	339.2
2005-06	$	342.2	332.6	311.1	284.6	369.0	372.9	253.7	116.9	327.0
2006-07	$	330.7	317.3	301.7	274.4	353.6	357.7	242.0	109.9	314.7
2007-08	$	338.6	323.7	305.3	278.9	365.6	372.1	245.6	113.6	321.2
2008-09	$	357.5	336.3	319.0	291.1	380.9	393.1	255.9	118.4	336.2
2009-10	$	364.5	342.3	325.3	290.9	388.7	407.7	263.4	117.7	342.1
2010-11	$	361.2	335.3	319.1	290.9	378.8	410.1	258.4	120.8	337.3
2011-12	$	361.6	337.4	326.4	298.0	384.4	413.8	251.5	118.0	340.2
2012-13	$	329.1	307.2	296.6	258.8	355.9	375.2	236.1	107.1	308.6
Proportion of PBS expenditure that is concessional										
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

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
2012-13	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Rates for 2012-13 are derived using the preliminary ABS 2011 Census based estimated resident populations (ERP) for 31 December 2012. The national rate differs from that reported in table 11A.21, which reports rates derived from the final ABS 2011 Census based ERP for 30 June 2011.

(c) 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 Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 11A.6]).

(d) PBS total includes PBS general ordinary, general safety net, concessional ordinary, concessional safety net and doctor's bag.

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

(f) PBS expenditure per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
PBS General Ordinary	$m	445.6	320.5	271.7	148.8	101.0	29.4	27.4	8.6	1 352.9
PBS General Safety Net	$m	85.9	58.3	47.4	23.3	16.0	4.6	4.9	0.8	241.1
PBS General total	$m	531.5	378.8	319.1	172.0	116.9	34.0	32.2	9.4	1 594.0
PBS Concessional Ordinary	$m	1 505.5	1 087.3	809.0	367.2	382.6	123.0	45.1	14.8	4 334.4
PBS Concessional Free Safety Net	$m	480.5	337.9	259.5	102.4	114.5	39.6	11.7	2.1	1 348.2
PBS Concessional total (a)	$m	1 986.0	1 425.1	1 068.5	469.6	497.0	162.6	56.8	16.9	5 682.5
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	5.6	3.9	3.6	1.2	1.2	0.4	0.2	0.1	16.1
PBS Unknown free safety net plus Doctors bag	$m	5.6	3.9	3.6	1.2	1.2	0.4	0.2	0.1	16.1
PBS Total	**$m**	**2 523.0**	**1 807.8**	**1 391.2**	**642.8**	**615.1**	**197.0**	**89.2**	**26.3**	**7 292.6**
RPBS Total (d)	$m	182.0	108.6	117.6	40.8	39.6	15.4	7.9	1.0	513.0
PBS and RPBS TOTAL	**$m**	**2 705.0**	**1 916.4**	**1 508.8**	**683.6**	**654.7**	**212.4**	**97.1**	**27.3**	**7 805.6**
PBS total expenditure per person (no.) (e)	$	357.5	336.3	319.0	291.1	380.9	393.1	255.9	118.4	336.2
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
2009-10										
PBS General Ordinary	$m	474.1	344.5	291.6	158.4	105.5	32.7	30.5	9.1	1 446.2
PBS General Safety Net	$m	75.5	52.1	43.2	21.5	14.0	4.2	4.3	0.6	215.5
PBS General total	$m	549.5	396.6	334.8	179.9	119.5	36.8	34.8	9.7	1 661.8
PBS Concessional Ordinary	$m	1 588.4	1 143.2	856.6	378.3	399.5	129.5	47.1	15.0	4 557.7

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS Concessional Free Safety Net	$m	483.6	341.5	263.8	102.1	116.1	39.7	11.6	2.1	1 360.4
PBS Concessional total (a)	$m	2 071.9	1 484.7	1 120.4	480.4	515.6	169.2	58.7	17.1	5 918.0
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	5.0	3.6	3.2	1.1	1.1	0.3	0.2	0.1	14.7
PBS Unknown free safety net plus Doctors bag	$m	5.0	3.6	3.2	1.1	1.1	0.3	0.2	0.1	14.7
PBS Total	**$m**	**2 626.4**	**1 884.9**	**1 458.5**	**661.4**	**636.3**	**206.4**	**93.7**	**26.9**	**7 594.5**
RPBS Total (d)	$m	180.3	106.4	118.2	39.2	39.8	15.3	7.9	1.0	508.0
PBS and RPBS TOTAL	**$m**	**2 806.7**	**1 991.3**	**1 576.7**	**700.6**	**676.1**	**221.6**	**101.5**	**27.8**	**8 102.4**
PBS total expenditure per person (no.) (e)	$	364.5	342.3	325.3	290.9	388.7	407.7	263.4	117.7	342.1
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
2010-11										
PBS General Ordinary	$m	479.0	348.4	288.2	166.9	106.0	33.6	30.6	9.8	1 462.5
PBS General Safety Net	$m	75.8	52.9	43.9	22.9	14.7	4.0	4.6	0.7	219.4
PBS General total	$m	554.8	401.2	332.1	189.8	120.7	37.6	35.2	10.5	1 681.9
PBS Concessional Ordinary	$m	1 583.6	1 125.6	852.1	379.3	386.9	131.9	46.8	15.1	4 521.5
PBS Concessional Free Safety Net	$m	488.6	346.0	267.5	104.8	117.6	39.3	11.5	2.2	1 377.5
PBS Concessional total (a)	$m	2 072.2	1 471.6	1 119.6	484.2	504.5	171.2	58.3	17.3	5 899.0
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS Doctors Bag	$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.7
PBS Unknown free safety net plus Doctors bag	$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.7
PBS Total	**$m**	**2 631.9**	**1 876.5**	**1 455.1**	**675.1**	**626.3**	**209.2**	**93.7**	**27.9**	**7 595.6**
RPBS Total (d)	$m	168.0	97.3	113.0	37.2	35.4	14.2	7.4	0.9	473.4
PBS and RPBS TOTAL	**$m**	**2 799.9**	**1 973.8**	**1 568.1**	**712.3**	**661.7**	**223.5**	**101.1**	**28.7**	**8 069.0**
PBS total expenditure per person (no.) (e)	$	361.2	335.3	319.1	290.9	378.8	410.1	258.4	120.8	337.3
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
2011-12										
PBS General Ordinary	$m	476.5	354.8	285.3	180.8	106.1	34.1	30.2	9.5	1 477.4
PBS General Safety Net	$m	70.9	52.0	41.9	22.7	14.7	4.0	4.7	0.6	211.6
PBS General total	$m	547.4	406.8	327.2	203.5	120.8	38.2	34.9	10.2	1 689.0
PBS Concessional Ordinary	$m	1 575.9	1 120.0	870.0	399.4	389.3	132.8	46.4	15.1	4 548.9
PBS Concessional Free Safety Net	$m	497.5	353.9	275.9	108.4	122.3	40.7	12.0	2.2	1 412.8
PBS Concessional total (a)	$m	2 073.3	1 473.9	1 145.9	507.8	511.6	173.6	58.3	17.2	5 961.7
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	4.4	3.3	2.8	1.1	1.0	0.3	0.2	0.1	13.2
PBS Unknown free safety net plus Doctors bag	$m	4.4	3.3	2.8	1.1	1.0	0.3	0.2	0.1	13.2
PBS Total	**$m**	**2 625.1**	**1 884.0**	**1 475.9**	**712.4**	**633.4**	**212.0**	**93.4**	**27.5**	**7 663.8**
RPBS Total (d)	$m	158.8	90.2	110.1	36.4	34.1	13.9	6.9	0.9	451.2

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS and RPBS TOTAL	**$m**	**2 783.9**	**1 974.2**	**1 586.0**	**748.7**	**667.5**	**225.9**	**100.3**	**28.4**	**8 115.0**
PBS total expenditure per person (no.) (e)	$	361.6	337.4	326.4	298.0	384.4	413.8	251.5	118.0	340.2
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
2012-13										
PBS General Ordinary	$m	428.3	327.8	254.4	164.9	97.9	28.9	28.9	8.6	1 339.7
PBS General Safety Net	$m	58.8	39.8	32.6	18.0	12.4	3.1	3.9	0.5	169.2
PBS General total	$m	487.1	367.6	287.0	182.9	110.3	32.0	32.9	9.1	1 508.9
PBS Concessional Ordinary	$m	1 454.0	1 041.7	815.3	355.0	362.7	121.1	45.1	14.2	4 209.1
PBS Concessional Free Safety Net	$m	477.1	335.6	265.4	101.9	118.7	39.1	11.7	2.1	1 351.5
PBS Concessional total (a)	$m	1 931.1	1 377.3	1 080.7	456.9	481.3	160.2	56.8	16.3	5 560.6
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	4.9	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
PBS Unknown free safety net plus Doctors bag	$m	4.9	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
PBS Total	**$m**	**2 423.2**	**1 748.7**	**1 370.9**	**640.9**	**592.7**	**192.6**	**89.8**	**25.5**	**7 084.2**
RPBS Total (d)	$m	139.5	77.5	97.9	30.9	28.6	12.0	6.5	0.8	393.7
PBS and RPBS TOTAL	**$m**	**2 562.7**	**1 826.1**	**1 468.8**	**671.8**	**621.4**	**204.6**	**96.3**	**26.3**	**7 477.9**
PBS total expenditure per person (no.) (c), (e)	$	329.1	307.2	296.6	258.8	355.9	375.2	236.1	107.1	308.6
Proportion of PBS expenditure that is concessional (%)	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

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

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Rates for 2012-13 are derived using the ABS 2011 Census based estimated resident populations (ERP) for 31 December 2012. The national rate differs from that reported in table 11A.21, which reports rates derived from the final ABS 2011 Census based ERP for 30 June 2011.

(c) 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 Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 11A.6]).

(d) Includes RPBS ordinary and RPBS safety net.

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

– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.6 **Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas, 2012-13 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
	$m	0.1	–	6.6	10.4	0.8	0.1	–	18.8	36.9

(a) Includes expenditure on PBS medicines supplied in bulk under s.100 of the *National Health Act 1953* (Cwlth) to Aboriginal Health Services in remote and very remote areas.

(b) This program seeks to address identified barriers to accessing essential medicines experienced by Indigenous people living in remote areas (see www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-faq accessed 8 November 2013).

(c) Allocation to state and territory is based on location of the Aboriginal Health Service. Clients are not necessarily resident in the same state or territory.

– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.7 **Expenditure on dental services, 2011-12 ($ million)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Government									
Australian Government									
DVA	32	17	29	10	8	2	6	–	104
Department of Health and other (a)	462	219	175	14	73	6	6	2	956
Insurance premium rebates (b)	166	106	108	78	47	10	9	3	528
Total	660	342	311	101	129	18	21	5	1 587
State, Territory and Local Government	190	153	188	73	66	25	11	12	718
Total government	**850**	**495**	**500**	**175**	**195**	**43**	**32**	**17**	**2 305**
Non-government	1 708	2 035	801	931	256	102	125	73	6 031
Total government and non-government	2 558	2 530	1 300	1 106	451	144	157	89	8 336

DVA=Department of Veterans' Affairs

(a) 'Department of Health and other' comprises Department of Health funded expenditure such as on MBS and PBS, and other Australian Government expenditure such as for the SPP associated with the National Healthcare Agreement and health–related NP payments, capital consumption, estimates of the medical expenses tax offset, and health research not funded by Department of Health.

(b) Includes the 30–40% rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.

– Nil or rounded to zero.

Source: AIHW 2013 *Health Expenditure Australia 2011-12* , Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59.

Table 11A.8 **Australian Government funding of Aboriginal Medical Services (a), (b), (c), (d)**

	Unit	*NSW/ACT*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	$m	84.6	37.5	93.3	74.4	41.8	7.6	np	131.7	470.9
2009-10	$m	94.0	38.8	105.4	80.5	41.0	8.3	np	143.7	511.6
2010-11	$m	97.4	42.1	98.9	90.7	45.0	8.8	np	134.7	517.6
2011-12	$m	105.1	41.2	101.9	93.3	42.3	10.0	np	144.0	537.7
2012-13	$m	108.4	43.1	94.3	90.2	45.1	9.7	np	140.2	531.0

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Data reflect funding provided to all organisations for which primary function is primary health care and/or substance use and/or mental health services (excludes GST). Excludes funding to Peak bodies.

(c) Funding for Capital Works is not included.

(d) Data for NSW and the ACT have been combined in order to avoid the identification of individual services.

np = Not published.

Source: Department of Health unpublished, table 2A.51.

Table 11A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP numbers										
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
2012-13	no.	9 427	7 344	6 629	2 973	2 448	810	470	580	30 681
FWE GPs										
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
2012-13	no.	7 593	5 544	4 573	1 803	1 681	464	272	158	22 087
FWE GPs per 100 000 people (e)										
2003-04	per 100 000 people	90.8	83.9	86.0	73.8	89.2	77.7	60.4	48.6	85.1
2004-05	per 100 000 people	93.3	84.1	87.5	73.1	89.0	78.0	60.7	46.8	86.2
2005-06	per 100 000 people	93.9	85.3	88.0	72.6	90.9	79.2	62.2	46.6	86.9

Table 11A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07	per 100 000 people	95.5	86.3	87.9	72.2	90.7	79.6	66.9	49.1	87.7
2007-08	per 100 000 people	95.9	88.2	88.5	72.2	92.2	81.0	67.5	53.4	88.6
2008-09	per 100 000 people	97.0	89.2	90.3	71.3	94.6	80.5	67.0	52.0	89.5
2009-10	per 100 000 people	97.1	90.4	91.4	71.3	95.5	82.4	66.6	55.6	90.2
2010-11	per 100 000 people	98.4	92.1	93.0	70.7	96.2	84.1	65.5	58.1	91.4
2011-12	per 100 000 people	101.2	94.5	96.2	71.1	99.0	87.8	67.6	61.0	93.9
2012-13	per 100 000 people	103.3	97.6	99.2	72.9	101.1	90.5	71.8	66.5	96.4

(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) The ABS Estimated Resident Populations (ERPs) used to derive rates for 2006-07 to 2010-11 are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data used to derive rates from 2011-12 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.2) for details.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.10 **Number of GP-type services used per 1000 people (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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 (e)	$	6 161.8	5 809.9	6 000.2	4 663.8	5 651.8	5 574.4	4 560.2	3 955.0	5 783.1
2012-13	$	6 125.6	5 839.5	5 968.5	4 626.3	5 690.2	5 268.3	4 705.6	4 156.1	5 767.6

(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.

(c) From 2011-12, rates are derived using the ABS estimated resident population (ERP) at 31 December, based on the 2011 Census. For previous years, rates are derived using the ABS ERP at 30 June preceding the reference year, based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

(d) DVA data are included.

(e) Data for 2011-12 are age-standardised and may differ from the crude rates published in the 2013 Report.

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection.

Table 11A.11 **PBS services**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS Total (b)										
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
2012-13	'000	66 639.3	49 861.2	38 932.6	16 735.9	16 821.3	5 494.5	2 156.6	664.1	197 305.4
RPBS Total (c)										
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
2012-13	'000	4 177.1	2 655.0	3 030.2	975.2	942.7	374.7	189.3	27.0	12 371.3
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

Table 11A.11 **PBS services**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
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
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
2012-13	'000	70 816.4	52 516.1	41 962.8	17 711.1	17 764.1	5 869.2	2 345.9	691.1	209 676.6
PBS total services per person (d)										
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
2012-13	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional										
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
2012-13	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8

Table 11A.11 **PBS services**

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

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwlth).

(b) Includes PBS general ordinary, general free safety net, concessional ordinary, concessional free safety net and doctor's bag.

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

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

Source: Department of Health unpublished, PBS Statistics.

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
2008-09									
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
PBS Concessional Free Safety Net	12 437	8 986	6 796	2 642	2 979	1 053	285	56	35 234
PBS Concessional total (b)	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 (c)	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.) (d)	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
2009-10									
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

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS Concessional Free Safety Net	12 266	8 856	6 732	2 580	2 964	1 030	276	54	34 757
PBS Concessional total (b)	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
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 (c)	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.) (d)	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
2010-11									
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 (b)	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

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
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 (c)	4 572	2 901	3 111	1 032	1 020	419	194	26	13 277
PBS and RPBS TOTAL	68 685	50 836	39 354	17 009	16 858	5 716	2 300	661	201 419
PBS total services per person (no.) (d)	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
2011-12									
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 (b)	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 (c)	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

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS total services per person (no.) (d)	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
2012-13									
PBS General Ordinary	6 229	4 608	3 902	2 223	1 415	405	410	133	19 324
PBS General Safety Net	1 535	1 037	849	442	317	81	97	14	4 371
PBS General total	7 763	5 645	4 750	2 664	1 732	486	506	146	23 695
PBS Concessional Ordinary	44 882	34 074	26 304	11 119	11 629	3 858	1 326	454	133 647
PBS Concessional Free Safety Net	13 880	10 051	7 798	2 925	3 432	1 142	321	62	39 612
PBS Concessional total (b)	58 762	44 125	34 102	14 045	15 061	5 001	1 647	516	173 259
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	114	91	80	26	28	8	4	2	352
PBS Unknown free safety net plus Doctors bag	114	91	80	26	28	8	4	2	352
PBS Total	66 639	49 861	38 933	16 736	16 821	5 495	2 157	664	197 305
RPBS Total (c)	4 177	2 655	3 030	975	943	375	189	27	12 371
PBS and RPBS TOTAL	70 816	52 516	41 963	17 711	17 764	5 869	2 346	691	209 677
PBS total services per person (no.) (d)	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional (%)	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwlth).

Table 11A.12 **PBS services, by service type ('000)**

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

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

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

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

na Not available. – Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.13 **Use of public dental services, by service type, 2010 (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Dental services per 1000 population (ASR)									
Emergency services	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	**43.7**	**55.4**	**97.9**	**126.0**	**97.3**	**135.4**	**96.3**	**183.3**	**74.4**
RSE (per cent)									
Emergency services	24.6	28.8	20.9	30.4	29.9	25.9	50.0	28.5	11.3
General services	13.8	12.0	11.9	9.0	10.2	8.1	17.5	9.3	5.0
All services	**11.9**	**11.1**	**10.0**	**8.4**	**9.3**	**8.3**	**16.4**	**8.6**	**4.5**
95 per cent 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. **RSE** = relative standard error. **CI** = confidence interval.

(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.14 **Alcohol and other drug treatment services, 2011-12 (number) (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (a)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Treatment services by sector										
Government	no.	195	–	53	14	42	7	1	5	317
Non-government (b), (c)	no.	68	136	44	49	14	9	8	14	342
Total	**no.**	**263**	**136**	**97**	**63**	**56**	**16**	**9**	**19**	**659**
Closed treatment episodes by sector										
Government	no.	30 002	–	18 442	2 352	6 970	1 081	2 414	1 056	62 317
Non-government (b), (c)	no.	8 319	53 574	6 842	16 149	1 741	591	1 666	2 469	91 351
Total	**no.**	**38 321**	**53 574**	**25 284**	**18 501**	**8 711**	**1 672**	**4 080**	**3 525**	**153 668**
Closed treatment episodes for client's own drug use by sex										
Male	no.	25 603	32 910	17 216	11 442	6 063	1 117	2 635	2 257	99 243
Female	no.	11 879	16 999	7 478	5 961	2 548	437	1 375	905	47 582
Total (d)	**no.**	**37 494**	**50 004**	**24 705**	**17 403**	**8 613**	**1 554**	**4 010**	**3 165**	**146 948**

(a) Includes only services that receive public funding.

(b) WA has a number of integrated services that include both government and non-government providers.

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

(d) Totals include episodes for people of unknown sex

– Nil or rounded to zero.

Source: AIHW 2013, *Alcohol and Other Drug Treatment Services in Australia 2011-12,* Cat. no. HSE 139, Drug Treatment Series no. 21, Canberra.

Table 11A.15 **Indigenous primary healthcare services and episodes of healthcare (number) (a), (b), (c), (d), (e)**

	Units	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous primary healthcare services										
2008-09	no.	39	24	31	28	14	10	2	57	205
2009-10	no.	50	26	33	37	13	10	1	53	223
2010-11	no.	56	25	37	35	15	11	1	55	235
2011-12	no.	52	25	37	35	13	9	1	52	224
Episodes of healthcare provided										
2008-09	'000	452	160	336	306	191	35	23	586	2 089
2009-10	'000	542	185	379	409	192	36	26	622	2 391
2010-11	'000	522	201	310	473	222	38	30	704	2 498
2011-12	'000	516	234	475	462	216	44	34	641	2 621

(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 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31, 56, 79, 104, Canberra.

Table 11A.16 **Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number) (a), (b), (c), (d), (e)**

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Total*
Indigenous primary healthcare services							
2008-09	no.	26	40	50	29	60	205
2009-10	no.	29	48	55	33	58	223
2010-11	no.	34	52	59	29	61	235
2011-12	no.	33	48	53	28	62	224
Episodes of healthcare provided							
2008-09	'000	290	313	539	503	444	2 089
2009-10	'000	364	395	583	557	491	2 391
2010-11	'000	399	413	496	532	658	2 498
2011-12	'000	436	460	493	560	671	2 621

(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.

(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.

Source : AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31,56,79,104, Canberra.

Table 11A.17 **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*	*2011-12*
Diagnosis and treatment of illness/disease	85.0	82.1	81.2	80.4
Management of chronic illness	89.0	87.0	85.0	86.2
Transportation to medical appointments	86.0	87.0	88.5	90.2
Outreach clinic services	55.0	55.6	52.6	60.7
24 hour emergency care	31.0	27.8	23.5	28.1
Monitoring child growth	64.0	76.2	71.8	79.0
School-based activities	68.0	70.4	74.4	79.0
Hearing screening	72.0	74.9	70.9	76.3
Pneumococcal immunisation	76.0	74.9	70.9	69.6
Influenza immunisation	82.0	81.6	78.2	81.3
Child immunisation	81.0	81.6	76.9	80.8
Women's health group	77.0	76.2	78.2	78.1
Support for public housing issues	58.0	67.7	59.0	71.0
Community development work	60.0	66.8	65.4	75.0
Legal/police/prison/advocacy services	42.0	43.1	44.9	46.0
Dental services	52.0	48.9	45.3	53.1
Involvement in steering groups on health	77.0	81.2	79.5	86.2
Participation in regional planning forums	57.0	57.9	59.0	67.0
Dialysis services	4.0	6.3	4.7	3.6

(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 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31,56,79,104, Canberra.

Table 11A.18 **Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services which provide data for Online Services Reporting (OSR) (number) (a), (b), (c)**

	2010	*2011*	*2012*
Indigenous staff			
Aboriginal health workers	836.6	899.4	896.5
Doctors	16.1	26.0	20.7
Nurses	72.2	72.9	101.3
Specialists	1.2	0.2	0.3
Counsellors/social workers	52.3	59.2	33.4
Other social and emotional wellbeing staff (d)	242.3	220.8	203.7
Allied health professionals (e)	49.7	31.8	58.1
Dentists	4.4	7.4	4.6
Dental assistants	47.9	43.9	46.2
Traditional healers	8.1	10.8	4.7
Sexual health workers	44.5	38.7	43.3
Substance misuse workers	77.5	101.2	104.7
Environmental health workers	24.0	23.8	32.7
Driver/field officers	218.1	255.6	250.0
Other health staff (f)	6.0	142.3	145.8
Total Indigenous staff (g)	**1 700.9**	**1 933.9**	**1 946.0**
Non-Indigenous staff			
Aboriginal health workers	30.7	14.0	34.3
Doctors	319.3	335.4	331.8
Nurses	615.3	710.7	681.8
Specialists	7.4	13.0	12.1
Counsellors/social workers	84.6	89.1	40.6
Other social and emotional wellbeing staff (d)	66.2	97.6	82.5
Allied health professionals (e)	108.2	144.2	115.9
Dentists	39.8	48.7	55.8
Dental assistants	27.8	35.1	31.0
Traditional healers	0.0	3.1	0.5
Sexual health workers	20.0	16.6	11.7
Substance misuse workers	43.4	50.7	54.3
Environmental health workers	6.0	10.3	8.5
Driver/field officers	40.1	39.4	36.7
Other health staff (f)	–	67.5	25.4
Total non-Indigenous staff (g)	**1 408.7**	**1 675.2**	**1 522.9**
Total health staff (d), (e)			
Aboriginal health workers	867.4	913.4	930.8
Doctors	335.4	361.4	352.5
Nurses	691.5	787.6	783.1
Specialists	8.7	13.2	12.3

Table 11A.18 **Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services which provide data for Online Services Reporting (OSR) (number) (a), (b), (c)**

	2010	*2011*	*2012*
Counsellors/social workers	136.8	148.3	74.0
Other social and emotional wellbeing staff (d)	309.5	319.4	286.2
Allied health professionals (e)	157.9	176.0	174.0
Dentists	44.2	56.1	60.5
Dental assistants	75.7	79.1	77.2
Traditional healers	8.2	13.9	5.2
Sexual health workers	64.5	55.3	55.0
Substance misuse workers	120.9	151.9	159.0
Environmental health workers	30.0	34.1	41.2
Driver/field officers	258.2	294.9	286.7
Other health staff (f)	6.0	209.7	171.2
Total health staff (g), (h)	**3 114.9**	**3 614.4**	**3 468.9**

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

(d) 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.

(e) 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.

(f) Other health staff' include: outreach workers, special program support workers, patient liasion officers, and other health-related positions.

(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 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results*, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 56,79,104, Canberra.

Table 11A.19 **Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)**

	NSW (c)	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust* (e)
Number of people per pharmacy									
Urban									
2009	3 690	4 118	3 715	3 770	3 773	3 451	5 214	4 941	3 836
2010	3 700	4 082	3 701	3 691	3 725	3 409	5 131	4 681	3 814
2011	3 677	4 031	3 615	3 699	3 725	3 248	5 051	4 681	3 777
2012	3 891	4 363	4 059	4 116	3 921	3 445	5 243	4 861	4 082
2013 (f)	3 855	4 319	4 065	4 066	3 775	3 440	4 952	4 254	4 034
Rural									
2009	4 232	4 803	4 459	4 255	3 632	3 911	..	9 272	4 367
2010	4 172	4 655	4 386	4 305	3 405	3 836	..	9 272	4 277
2011	4 232	4 462	4 037	4 021	3 269	3 694	..	8 500	4 108
2012	4 051	4 344	4 381	4 202	3 287	3 593	..	9 374	4 148
2013 (f)	3 811	4 077	3 904	3 776	3 332	3 288	..	8 898	3 887
Number of pharmacies									
Urban									
2009	1 451	1 013	829	421	314	80	62	18	4 188
2010	1 447	1 022	832	430	318	81	63	19	4 212
2011	1 456	1 035	852	429	318	85	64	19	4 258
2012	1 462	1 047	844	441	320	84	68	20	4 286
2013	1 546	1 082	887	455	347	93	72	18	4 500
Rural									
2009	280	157	182	86	90	51	..	11	857
2010	284	162	185	85	96	52	..	11	876
2011	280	169	201	91	100	54	..	12	908
2012	300	179	204	99	103	57	..	12	955
2013	248	165	183	101	85	53	–	15	851
Number of approved GPs — Rural (g)									
2009	16	3	10	21	2	7	..	1	60
2010	11	3	8	23	2	5	..	1	53
2011	9	1	6	17	2	3	..	1	39
2012	11	9	5	11	1	4	..	–	41
2013	10	1	5	11	1	5	..	..	33
Number of approved hospitals — urban (h)									
Public									
2009	–	53	26	6	6	–	–	1	92
2010	–	53	27	8	8	–	–	1	97
2011	–	53	27	10	8	3	–	1	102
2012	–	53	27	12	8	3	–	1	104
2013	1	52	30	12	10	4	..	1	110

Table 11A.19 Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)

	NSW (c)	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust* (e)
Private									
2009	23	25	19	4	4	1	3	1	80
2010	23	26	21	5	4	1	3	1	84
2011	22	28	24	5	4	1	4	1	89
2012	22	29	25	5	4	1	4	1	91
2013	26	29	25	4	6	1	3	1	95
Number of approved hospitals — rural (h) (i)									
Public									
2009	–	12	62	–	–	–	..	4	78
2010	–	13	63	–	–	–	..	4	80
2011	–	16	20	6	–	1	..	4	47
2012	–	18	22	6	–	1	..	4	51
2013	..	16	20	6	3	..	..	4	49

(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) The ABS Census population counts used to derived these rates differ across years. For data up to 2012, rates are derived using 2006 Census based counts. From 2013, rates are derived using 2011 Census based counts. Rates derived using counts based on different Censuses are not comparable.

(c) For 2013, one public hospital in NSW is a campus of a Victorian hospital participating in the Pharmaceutical Reforms.

(d) Care should be taken using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).

(e) Includes other territories

(f) 118 pharmacies were reclassified as urban at 30 June 2013. Those pharmacies were classified as rural at 30 June 2012.

(g) 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.

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

(i) There were no PBS approved private hospitals in rural areas in the years 2009 to 2013.

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

Source: Department of Health unpublished, derived from Department of Human Services, ABS 2006/2011 Census of Population and Housing and the University of Adelaide's Australian Population and Migration Research Centre.

Table 11A.20 PBS expenditure per person, by remoteness area (2012-13 dollars) (a), (b), (c), (d)

	Unit	*2012-13*
Total expenditure		
Major cities	$m	4 768.7
Inner regional	$m	1 524.5
Outer regional	$m	681.8
Remote	$m	67.7
Very remote	$m	24.5
Australia	$m	7 069.5
Expenditure per person		
Major cities	$	303.7
Inner regional	$	367.3
Outer regional	$	333.2
Remote	$	211.7
Very remote	$	117.0
Australia	$	311.7

(a) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.

(b) 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 Department of Health 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 medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth].) Expenditure on medications dispensed to remote and very remote areas under s.100 was $36.9 million in 2012-13.

(c) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.

(d) Rates are derived using the final ABS 2011 Census based estimated resident populations (ERP) for 30 June 2012. The national rate differs from that reported in tables 11A.4 and 11A.5, which are derived from the final ABS 2011 Census based ERP for December 31 2011.

Source: Department of Health unpublished, PBS Statistics; ABS 2013, *Regional Population Growth, Australia, 2012* , Cat. no. 3218.0.

Table 11A.21 **PBS expenditure per person, by urban and rural location, 2008-09 to 2011-12 (2012-13 dollars) (a), (b), (c), (d)**

	2008-09	*2009-10*	*2010-11*	*2011-12*
Capital city	322.7	327.9	321.7	323.9
Other metropolitan	367.4	374.6	371.6	374.0
Rural and remote	357.6	364.9	362.6	367.6
All locations	336.2	342.1	337.3	340.2

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 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 Department of Health 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 medicines supplied in bulk under s.100 of the *National Health Act 1953* [Cwlth]).

(d) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.22 **Availability of GPs by remoteness area, 2012-13 (a), (b), (c), (d), (e), (f)**

	NSW (f)	*Vic* (g)	*Qld*	*WA*	*SA* (h)	*Tas* (h)	*ACT* (e)	*NT* (h)	*Aust*
Number of GPs									
Year									
Major cities	6 620	5 355	3 725	1 967	1 709	..	470	..	19 846
Inner regional	2 201	1 639	1 346	337	312	585	np	..	6 420
Outer regional	606	350	1 169	339	313	195	..	215	3 109
Remote	np	np	237	191	114	30	..	365	746
Very remote	np	..	152	139	np	np	..	np	560
Total	**9 427**	**7 344**	**6 629**	**2 973**	**2 448**	**810**	**470**	**580**	**30 681**
Number of full time workload equivalent GPs									
Major cities	5 754	4 254	2 899	1 330	1 271	..	272	..	15 780
Inner regional	1 456	1 055	960	229	181	330	np	..	4 211
Outer regional	383	234	631	155	177	126	..	98	1 771
Remote	np	np	54	60	52	8	..	60	223
Very remote	np	..	29	29	np	np	..	np	102
Total	**7 593**	**5 544**	**4 573**	**1 803**	**1 681**	**464**	**272.0**	**158**	**22 087**
Number of full time workload equivalent GPs per 100 000 people									
Major cities	106.7	99.1	102.7	71.5	104.8	..	72.6	..	98.9
Inner regional	103.2	97.6	103.9	105.4	101.0	98.3	np	..	101.5
Outer regional	79.2	93.5	93.8	83.9	87.5	76.1	..	74.4	86.5
Remote	np	np	67.6	59.0	85.8	74.2	..	122.8	69.7
Very remote	np	..	48.7	43.8	np	np	..	np	48.8
Total	**104.2**	**98.6**	**100.3**	**74.2**	**101.6**	**90.6**	**72.6**	**67.3**	**97.4**

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which are based on a different classification.

(b) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.

(c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).

(d) 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.

(e) 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.

(f) For NSW, remote and very remote area data are not reported for confidentiality reasons, but are included in outer regional area data.

(g) For Victoria, remote area data are not reported for confidentiality reasons, but are included in outer regional data.

Table 11A.22 **Availability of GPs by remoteness area, 2012-13 (a), (b), (c), (d), (e), (f)**

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

(h) For SA, Tasmania and the NT, very remote area data are not reported for confidentiality reasons, but are included in remote area data.

(i) For the ACT, inner regional area data are not reported for confidentiality reasons, but are included in major cities data.

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

Source : Department of Health unpublished, MBS Statistics.

Table 11A.23 Availability of GPs by region, 2003-04 to 2011-12 (a), (b), (c), (d)

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*
Number of GPs									
Urban									
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									
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									
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									
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
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

Table 11A.23 **Availability of GPs by region, 2003-04 to 2011-12 (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*
Number of full time workload equivalent GPs per 100 000 people									
Urban									
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									
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 1994 Rural, Remote and Metropolitan Areas 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) Data are not comparable with data for 2012-13, for which geographical location is based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

(c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).

(d) 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.

(e) 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.

(f) 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: Department of Health unpublished, MBS Statistics.

Table 11A.24 **Availability of female GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs										
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
2012-13	no.	4 014	3 071	2 797	1 241	985	368	238	287	13 001
Female FWEs GPs										
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
2012-13	no.	2 519	1 781	1 516	544	481	162	110	66	7 180
Female FWEs GPs as a proportion of all FWE GPs										
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
2005-06	%	27.4	27.0	27.7	26.8	23.8	31.5	36.5	34.8	27.3

Table 11A.24 **Availability of female GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
2012-13	%	33.2	32.1	33.2	30.2	28.6	34.9	40.5	41.7	32.5
Female FWE GPs										
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
2012-13	per 100 000 females	68.1	62.1	65.6	44.5	57.4	63.0	57.9	58.4	62.4

(a) From 2011-12, rates are computed by the Secretariat using first preliminary December 31 female ERP based on the 2011 Census. Rates for previous years are derived using ERPs based on the 2001 and 2006 Censuses. Rates derived using ERPs based on different Censuses are not comparable.

(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 and FWE numbers include vocationally registered GPs and OMPs.

(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.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.25 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (g)	*Aust*
FTE dentists per 100 000 population (h)									
2008									
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 and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2009									
Major cities	7.7	7.6	11.1	7.5	11.8	..	9.5	..	8.6
Inner regional	4.9	4.9	8.6	6.1	5.4	7.6	–	..	6.0
Outer regional	3.9	4.7	8.3	4.0	2.1	1.8	..	16.6	5.9
Remote and very remote	3.2	–	9.9	10.9	2.0	–	..	6.2	7.7
Total	**6.9**	**6.9**	**10.1**	**7.2**	**9.5**	**5.5**	**9.5**	**12.0**	**7.8**
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	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2011									
Major cities	4.8	4.8	6.4	5.7	8.7	..	7.1	..	5.6
Inner regional	3.6	4.8	6.6	5.4	4.1	5.4	–	..	4.8
Outer regional	2.0	4.2	7.5	3.5	4.9	0.5	..	13.2	5.1
Remote/very remote	1.9	–	1.5	10.1	5.0	–	..	9.1	6.1
Total	**4.4**	**4.7**	**6.5**	**5.8**	**7.6**	**3.7**	**7.1**	**11.3**	**5.4**
2012									

Table 11A.25 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (g)	*Aust*
Major cities	5.6	4.5	5.7	5.7	6.4	..	6.9	..	5.4
Inner regional	4.5	3.4	5.7	5.5	4.0	5.4	–	..	4.6
Outer regional	1.5	3.1	8.4	3.0	3.0	0.7	..	8.2	4.7
Remote/very remote	–	–	2.6	6.2	3.0	–	..	7.9	4.7
Total	**5.1**	**4.2**	**6.0**	**5.6**	**5.7**	**3.8**	**6.9**	**8.1**	**5.2**

(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 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 include Migratory areas.

(e) There are no major cities in Tasmania.

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

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

(h) 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.26 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (h)	*Aust* (i)
2009									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	0.2	–	0.2	0.6	0.7	..	0.5	..	0.2
Inner regional	0.0	–	–	–	–	–	–	..	–
Outer regional	0.1	–	0.5	–	–	–	..	1.4	0.2
Remote/very remote	0.8	–	–	–	–	–	..	–	–
Total (l)	**0.1**	**–**	**0.2**	**0.4**	**0.5**	**–**	**0.5**	**0.8**	**0.2**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	2.0	–	6.4	6.5	5.5	..	3.4	..	3.0
Inner regional	5.3	–	9.3	7.3	6.4	6.6	–	..	5.1
Outer regional	3.2	–	8.8	6.6	7.1	11.1	..	6.1	6.1
Remote/very remote	5.6	–	4.1	3.7	3.4	–	..	8.9	5.0
Total (l)	**2.8**	**–**	**7.3**	**6.4**	**5.7**	**8.0**	**3.4**	**7.4**	**3.8**
2010									
FTE dental hygienists per 100 000 population (j), (k)									
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**
FTE dental therapists per 100 000 population (j), (k)									
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 and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**

Table 11A.26 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (h)	*Aust* (i)
2011									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	0.1	0.0	0.1	0.6	0.6	..	0.3	..	0.2
Inner regional	–	–	–	–	–	–	–	..	–
Outer regional	–	0.2	0.1	–	–	–	..	–	0.1
Remote and very remote	–	–	–	–	–	–	..	–	–
Total (l)	**0.1**	**0.0**	**0.1**	**0.5**	**0.5**	**–**	**0.3**	**–**	**0.1**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	1.7	1.3	5.2	4.9	3.8	..	2.5	..	2.8
Inner regional	3.4	2.3	6.8	7.9	8.8	6.6	–	..	4.6
Outer regional	2.5	1.6	6.0	8.4	6.1	9.1	..	9.4	5.4
Remote/very remote	2.6	–	4.0	7.0	6.5	–	..	4.5	5.1
Total (l)	**2.1**	**1.5**	**5.6**	**5.6**	**4.8**	**7.2**	**2.5**	**7.6**	**3.4**
2012									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	0.2	0.1	0.1	0.4	0.8	..	0.2	..	0.2
Inner regional	0.1	0.0	–	–	–	–	–	..	0.1
Outer regional	–	0.3	0.1	–	–	–	..	–	0.1
Remote/very remote	–	–	–	–	–	–	..	1.3	0.3
Total (l)	**0.1**	**0.1**	**0.1**	**0.3**	**0.6**	**–**	**0.2**	**0.6**	**0.2**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	1.6	1.4	5.1	4.8	4.0	..	2.9	..	2.7
Inner regional	4.1	2.3	6.1	8.4	7.8	5.9	–	..	4.6
Outer regional	2.4	0.9	6.3	8.9	6.2	6.5	..	8.9	5.2
Remote/very remote	1.5	–	4.0	4.0	5.8	7.0	..	5.6	4.5
Total (l)	**2.1**	**1.5**	**5.4**	**5.4**	**4.7**	**6.1**	**2.9**	**7.5**	**3.3**

Table 11A.26 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (h)	*Aust* (i)

(a) Dual registered practitioners (practitioners registered as both dental therapists and dental hygienists) are included in dental therapists data and not in dental hygienists data.

(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 include Migratory areas.

(e) Data are not available for 2008 or 2010.

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

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
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										
Indigenous older people										
Number of people assessed (h)	no.	3 216	422	3 151	1 508	451	109	36	1 572	10 465

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Target population (i)	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
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 (l)										
Indigenous older people										
Number of people assessed (h)	no.	4 156	558	4 589	1 632	508	185	48	1 765	13 441
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	%	25.2	14.7	33.0	23.8	18.5	14.1	18.6	29.3	25.7
Non-Indigenous older people										
Number of people assessed (j)	no.	137 439	96 169	79 926	31 878	32 887	11 500	3 270	314	393 383
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	%	28.3	26.3	31.5	25.3	26.0	31.9	19.6	9.7	27.8
2012-13 (m)										
Indigenous older people										
Number of people assessed (h)	no.	5 156	713	5 427	2 186	604	261	73	2 232	16 652
Target population (i)	no.	17 314	3 983	14 679	7 236	2 874	1 368	280	6 359	55 027
Proportion of target population assessed	%	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3
Non-Indigenous older people										

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Number of people assessed (j)	no.	145 691	101 547	86 998	35 660	35 200	12 834	3 788	371	422 089
Target population (k)	no.	495 999	374 032	262 013	130 142	128 746	36 755	17 245	3 453	1 448 184
Proportion of target population assessed	%	29.4	27.1	33.2	27.4	27.3	34.9	22.0	10.7	29.1

(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) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

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

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

(f) Data for WA for non-Indigenous people have been revised and may differ from previous reports.

(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) 2011-12 data have been revised to include claims made up to 12 months after the assessment was received.

(m) 2012-13 data are preliminary data.

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

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

Source : Department of Health unpublished, MBS data collection; ABS 2008, 2009, 2010, 2011 and unpublished, *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.28 **Older Indigenous Australians who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
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										
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 (h)										
Number of people assessed	no.	4 156	558	4 589	1 632	508	185	48	1 765	13 441
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	%	25.2	14.7	33.0	23.8	18.5	14.1	18.6	29.3	25.7
2012-13 (i)										
Number of people assessed	no.	5 156	713	5 427	2 186	604	261	73	2 232	16 652
Target population	no.	17 314	3 983	14 679	7 236	2 874	1 368	280	6 359	55 027

Table 11A.28 **Older Indigenous Australians who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Proportion of target population assessed	%	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3

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

(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) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

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

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

(f) 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) 2011-12 data have been revised to include claims made up to 12 months after the assessment was received.

(i) 2012-13 data are preliminary data.

Source: Department of Health 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.29 **Indigenous Australians who received a health check or assessment, by age (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
2010-11										
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.	11 073	1 614	11 844	5 020	1 325	315	150	6 599	37 940
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	7.7	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 (f)										
Children 0–14 years										
Children assessed	no.	8 520	1 150	12 133	2 436	800	137	197	5 270	30 643
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	20.3	9.3	7.6	2.0	12.2	22.8	15.3
Adults 15–54 years										
People assessed	no.	14 933	2 148	18 474	5 355	1 768	449	286	7 228	50 641
Target population	no.	92 886	21 092	91 333	44 733	17 709	11 654	2 854	40 692	323 091
Proportion assessed	%	16.1	10.2	20.2	12.0	10.0	3.9	10.0	17.8	15.7
Adults 55 years or over										
People assessed	no.	4 156	558	4 589	1 632	508	185	48	1 765	13 441
Target population	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216

Table 11A.29 **Indigenous Australians who received a health check or assessment, by age (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
Proportion assessed	%	25.2	14.7	33.0	23.8	18.5	14.1	18.6	29.3	25.7
2012-13 (g)										
Children 0–14 years										
Children assessed	no.	10 710	1 561	15 077	3 939	994	234	214	5 429	38 158
Target population	no.	60 104	12 950	60 620	26 295	10 726	6 990	1 648	23 415	202 827
Proportion assessed	%	17.8	12.1	24.9	15.0	9.3	3.3	13.0	23.2	18.8
Adults 15–54 years										
People assessed	no.	17 743	2 709	22 496	8 565	2 332	661	448	8 977	63 931
Target population	no.	94 956	21 632	93 981	45 622	18 096	11 937	2 905	41 280	330 547
Proportion assessed	%	18.7	12.5	23.9	18.8	12.9	5.5	15.4	21.7	19.3
Adults 55 years or over										
People assessed	no.	5 156	713	5 427	2 186	604	261	73	2 232	16 652
Target population	no.	17 314	3 983	14 679	7 236	2 874	1 368	280	6 359	55 027
Proportion assessed	%	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3

(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) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

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

(e) Includes Other Territories.

(f) 2011-12 data have been revised to include claims made up to 12 months after the assessment was received.

(g) 2012-13 data are preliminary data.

Source: Department of Health 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.30 Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported (a), (b), (c), (d)

	Unit	*2008-09* (e)	*2009-10*	*2010-11*	*2011-12*
Early detection activities provided					
Well person's checks	%	80	72.7	74.8	81.7
PAP smears/cervical screening	%	80	76.2	75.6	77.2
STI testing	%	73	74.0	70.5	74.1
Hearing testing	%	72	74.9	70.9	76.3
Eye disease testing	%	69	71.8	69.7	76.3
Renal disease testing	%	54	53.4	56.4	57.6
Diabetic testing	%	78	75.3	79.5	79.9
Cardiovascular testing	%	66	62.3	68.4	73.2
Any early detection activity	%	90	89.7	89.7	88.8

(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 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31,56,79,104, Canberra.

Table 11A.31 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT*	*Aust*
2009-10										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	%	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (h)	%	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										
Aboriginal and Torres Strait Islander Child Health Check (g)	%	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (h)	%	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 (i)										
Aboriginal and Torres Strait Islander Child Health Check (g)	no.	2 326	338	3 185	774	204	47	61	1 365	8 300
Target population (e)	no.	4 071	847	4 026	1 691	690	477	113	1 507	13 427
Proportion of target population assessed	%	57.1	39.9	79.1	45.8	29.6	9.9	54.0	90.6	61.8
Healthy Kids Check (h)	no.	46 370	16 878	37 594	12 480	7 201	3 219	1 218	805	125 765
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	%	52.3	24.8	67.7	43.2	39.2	56.0	26.4	38.9	46.2
Total	no.	48 696	17 216	40 779	13 254	7 405	3 166	1 176	2 170	134 065
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	**%**	**52.7**	**25.0**	**68.3**	**43.0**	**38.6**	**49.9**	**26.0**	**60.3**	**47.0**
2012-13 (a), (i)										
Aboriginal and Torres Strait Islander Child Health Check (g)	no.	2 864	403	3 791	1 106	271	64	48	1 489	10 036

Table 11A.31 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT*	*Aust*
Target population (e)	no.	4 242	886	4 205	1 743	717	505	116	1 524	13 944
Proportion of target population assessed	%	67.5	45.5	90.2	63.4	37.8	12.7	41.5	97.7	72.0
Healthy Kids Check (h)	no.	56 161	21 191	42 935	14 014	9 498	3 666	1 821	932	150 218
Target population (e)	no.	91 948	72 693	60 619	31 657	19 613	6 007	5 176	2 197	289 805
Proportion of target population assessed	%	61.1	29.2	70.8	44.3	48.4	61.0	35.2	42.4	51.8
Total	no.	59 025	21 594	46 726	15 120	9 769	3 730	1 869	2 421	160 254
Target population	no.	96 190	73 579	64 824	33 400	20 330	6 512	5 292	3 722	303 749
Proportion of target population assessed	**%**	**61.4**	**29.3**	**72.1**	**45.3**	**48.1**	**57.3**	**35.3**	**65.0**	**52.8**

a) Computed by the Secretariat from 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 (Department of Health, pers. comm, 25 October 2012).

(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 based on the 2006 Census. 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 due to small numbers, but are included in the total for Australia.

Table 11A.31 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)**

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

(g) 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 3, 4 or 5 years for the 2012-13 reference period, and 3 or 4 years for the 2011-12 reference period. Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

(h) 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 3, 4 or 5 years from 2011-12, and 3 or 4 years for data to 2010-11. 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 several jurisdictions. For example, in Victoria, the Victorian Maternal and Child Health Service provided a 3.5 year old Key Ages and Stages consultation to 47 638 children in the 2011-12 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.

(i) From 2011-12, data include Indigenous and non-Indigenous children aged 3, 4 or 5 years who received a health assessment under the specified MBS items, provided they had not received such a check in a previous reference period. This constitutes a break in time series for the data. Data for 2011-12 and 2012-13 should not be compared with data for previous years, which are limited to children aged 3 or 4 years.

np Not published.

Source: Department of Health 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.32 **Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)**

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Aust* (e)
2012-13						
0–15 years	89.4	88.3	88.7	91.6	92.5	89.2
16–64 years	78.6	72.3	73.7	74.4	83.1	77.0
65 years or over	90.5	88.8	89.7	92.0	94.0	90.1
All ages (f)	83.3	79.6	80.5	81.3	86.6	82.3

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

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

(c) Patient age at date of service.

(d) Allocation to remoteness area based on patients' Medicare enrolment postcode.

(e) Australia includes attendances where patient postcodes could not be allocated to a remoteness area.

(f) All ages includes attendances where patient age is unknown.

Source : Department of Health unpublished, MBS Statistics.

Table 11A.33 **Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
2006-07								
0–15 years	86.9	82.1	79.1	82.2	82.4	80.3	87.8	85.4
16–64 years	74.3	71.0	63.9	66.1	65.5	63.0	74.5	71.9
65 years or over	89.4	86.2	83.1	85.6	85.3	87.7	89.4	87.8
All ages	79.8	76.9	71.5	74.3	73.8	70.1	79.9	78.0
2007-08								
0–15 years	87.6	83.3	80.8	84.8	84.6	81.4	89.2	86.4
16–64 years	75.4	72.7	66.1	68.9	67.9	65.0	76.8	73.4
65 years or over	89.7	87.3	84.6	87.3	86.7	87.8	90.9	88.6
All ages	80.7	78.3	73.4	76.7	76.0	71.6	82.0	79.2
2008-09								
0–15 years	88.2	84.7	83.2	87.3	86.1	81.7	89.8	87.3
16–64 years	75.7	73.8	67.1	71.2	68.6	63.8	77.4	73.9
65 years or over	90.2	88.0	85.9	88.6	87.8	87.9	91.8	89.2
All ages	81.1	79.4	74.7	78.8	77.0	70.9	82.6	79.9
2009-10								
0–15 years	88.8	86.4	85.1	88.7	87.0	84.0	91.3	88.2
16–64 years	75.5	75.5	67.8	73.1	69.8	65.5	78.9	74.3
65 years or over	90.4	89.3	87.2	89.7	88.8	88.0	92.1	89.8
All ages	81.3	81.1	76.0	80.5	78.3	72.5	83.9	80.5
2010-11								
0–15 years	88.8	86.4	85.7	88.8	86.9	84.6	91.8	88.2
16–64 years	76.2	76.1	68.8	73.3	69.9	65.4	79.4	74.9
65 years or over	90.4	89.5	87.6	89.9	88.8	87.9	92.5	89.9
All ages	81.7	81.5	76.7	80.8	78.3	72.5	84.4	80.9
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

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Data are not comparable to data for 2012-13 which are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

Table 11A.33 **Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)**

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

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

(d) Patient age at date of service.

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

Source: Department of Health unpublished, MBS Statistics.

Table 11A.34 **Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
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
2012-13									
0–15 years	91.0	86.8	89.5	90.2	92.1	86.9	68.1	85.5	89.2

Table 11A.34 **Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
16–64 years	83.7	77.7	75.7	61.0	73.9	67.4	47.9	73.9	77.0
65 years or over	91.3	89.2	90.4	89.7	90.6	88.3	66.5	91.2	90.1
All ages	86.8	82.1	81.7	73.0	81.4	76.4	55.0	78.2	82.3

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

(b) Patient age at date of service.

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

(d) All ages includes attendances where patient age is unknown.

(e) Australia includes attendances where patient postcodes could not be allocated to a State/Territory.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.35 **People deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Proportion	%	4.8	5.2	6.3	8.0	6.1	7.7	8.8	5.0	5.8
RSE	%	9.2	6.4	7.2	7.7	9.5	10.1	12.3	21.5	3.4
95 per cent confidence interval	%	± 0.9	± 0.7	± 0.9	± 1.2	± 1.1	± 1.5	± 2.1	± 2.1	± 0.4

RSE = Relative standard error.

(a) People aged 15 years or over who delayed or did not visit a GP at any time in the last 12 months due to cost.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges except for Queensland, for which 10 year ranges are used.

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

(d) Data for 2012-13 are not comparable to data for previous years due to a change in question sequencing/wording. See data quality information for further detail.

(e) Data are not comparable to data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

(f) Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions, but include very remote areas.

Source : ABS unpublished, *Patient Experience Survey 2012-13* , Cat. no. 4839.0.

Table 11A.36 **Indigenous Australians deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	11.1	12.3	13.0	13.8	7.7	16.3	20.7	11.0	12.2
RSE (c)	%	24.5	28.4	26.9	20.7	43.8	23.9	24.3	40.2	10.2
95 per cent confidence interval	± %	5.3	6.9	6.8	5.6	6.6	7.6	9.9	8.7	2.4

RSE = Relative standard error.

(a) Indigenous people aged 15 years or over who reported needing to see a GP in the last 12 months but did not because of cost, divided by the number of Indigenous people aged 15 years or over who reported needing to see a GP in the last 12 months.

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

(d) Data are not comparable with data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.

(e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source : ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13,* Cat. no. 4727.0.

Table 11A.37 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12 (d)										
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
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
2012-13 (d)										
Within four hours										
Proportion	%	64.3	63.4	66.8	62.0	66.2	54.1	61.2	49.5	64.1
RSE	%	3.1	3.2	3.4	5.0	3.2	8.2	7.5	15.3	1.4
95 per cent confidence interval	±	3.9	4.0	4.4	6.1	4.2	8.7	9.0	14.9	1.8
Four to less than 24 hours										
Proportion	%	9.6	12.3	11.2	11.8	13.7	16.4	13.6	12.5	11.4
RSE	%	11.4	12.7	15.5	15.7	14.2	12.8	24.0	31.0	5.6
95 per cent confidence interval	±	2.1	3.1	3.4	3.6	3.8	4.1	6.4	7.6	1.2
24 hours or more										
Proportion	%	26.1	24.2	22.1	26.2	20.1	29.6	25.2	38.0	24.6
RSE	%	6.9	8.3	8.0	9.9	8.8	14.2	14.7	20.2	3.5
95 per cent confidence interval	±	3.5	3.9	3.5	5.1	3.5	8.2	7.2	15.0	1.7

RSE = relative standard error.

(a) Time waited between making an appointment and seeing the GP for urgent medical care.

(b) People aged 15 years or over who saw a GP for urgent medical care for their own health in the last 12 months. 'Urgent' as defined by respondent. Discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash).

(c) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges except for WA, for which 10 year ranges are used.

Table 11A.37 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f)**

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

(d) Data for 2012-13 are comparable with data for 2011-12 but are not comparable with data for previous years, due to a change to the question wording in 2011-12. See data quality information for further details.

(e) 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.

(f) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

Source : ABS unpublished, *Patient Experience Survey 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.38 **Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment, 2012-13 (per cent) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion		20.8	21.6	17.8	24.8	21.1	23.6	22.0	21.0	20.9
RSE		3.4	3.3	4.8	4.5	4.9	5.9	7.8	11.9	2.0
95 per cent confidence interval		± 1.4	± 1.4	± 1.7	± 2.2	± 2.0	± 2.7	± 3.4	± 4.9	± 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 using 5 year ranges.

(c) Data for 2012-13 are not comparable to data for previous years due to a change in question sequencing. See data quality information for further details.

Source: ABS unpublished, *Patient Experience Survey 2012-13* , Cat. no. 4839.0.

Table 11A.39 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	NSW (d)	*Vic* (d)	*Qld*	*WA*	*SA* (e)	*Tas* (f)	*ACT*	*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	692 778	555 140	375 169	263 845	117 525	60 182	48 485	42 303	2 155 427
2011-12 (g)	684 991	554 124	378 087	286 820	103 928	59 840	47 807	40 903	2 156 500
2012-13 (h)	682342	574470	383829	282121	105880	61603	46617	39750	2176612

(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) Data for 2011-12 have been revised using hospital classification into peer groups A and B based on 2011-12 peer groups and differ from data published in the 2013 Report which utilised hospital classification into peer groups A and B based on 2010-11 peer groups.

(h) Data for 2012-13 are preliminary. Hospital classification into peer groups A and B is based on 2011-12 peer groups.

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

Table 11A.40 **People attending a hospital emergency department who thought the care could have been provided at a general practice (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
2010-11										
Proportion	%	26.3	17.3	19.2	23.5	18.3	23.7	26.9	19.9	21.5
RSE	%	8.2	8.5	9.5	8.4	11.5	14.4	21.5	17.8	4.6
95% confidence interval	±	4.2	2.9	3.6	3.9	4.1	6.7	11.3	7.0	1.9
2011-12										
Proportion	%	21.2	24.1	26.1	27.4	20.2	21.9	25.3	26.2	23.5
RSE	%	7.3	8.2	10.7	8.3	13.5	12.7	16.4	15.2	3.4
95% confidence interval	±	3.0	3.9	5.5	4.5	5.4	5.5	8.1	7.8	1.6
2012-13										
Proportion	%	23.7	22.7	23.6	24.8	23.7	24.1	24.2	22.5	23.6
RSE	%	6.5	6.1	8.0	8.9	12.7	11.8	14.0	14.7	3.5
95% confidence interval	±	3.0	2.7	3.7	4.3	5.9	5.6	6.6	6.5	1.6

RSE = Relative standard error.

(a) People aged 15 years or over who reported attending a hospital emergency department and thought at the time that the care received could have been provided at a general practice.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges except for ACT and NT, for which 15 year age ranges are used.

(c) Excludes persons who responded "Don't know" whether care could have been provided at a GP

(d) Data from 2011-12 exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions, but include very remote areas. Data for previous years exclude very remote areas which translates into the exclusion of around 23 per cent of the NT population — NT data for 2010-11 should therefore be used with care.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12* , *2012-13* , Cat. no. 4839.0.

Table 11A.41 **People deferring access to prescribed medication due to cost (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
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
2012-13 (e)										
Proportion	%	7.9	8.6	9.9	7.1	9.1	9.8	6.7	8.9	8.5
RSE	%	5.6	5.5	6.4	9.4	8.3	10.1	15.7	19.2	2.6
95 per cent confidence interval	%	± 0.9	± 0.9	± 1.2	± 1.3	± 1.5	± 1.9	± 2.1	± 3.4	± 0.4

RSE = Relative standard error.

(a) People aged 15 years and over who received a prescription for medication from a GP in the last 12 months and delayed using or did not get medication at any time in the last 12 months due to the cost.

(b) Rates are age standardised to the 2001 estimated resident population using 5 year age ranges except for WA and SA, for which 10 year age ranges were used.

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

(d) Data for 2010-11 and subsequent reference years are comparable over time, but are not comparable with data for 2009 due to a change in the sequencing and wording of the survey question.

(e) Data from 2011-12 exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions, but include very remote areas. Data for previous years exclude very remote areas which translates into the exclusion of around 23 per cent of the NT population — NT data for 2009 and 2010-11 should therefore be used with care.

(f) Data are not comparable to data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

Source : ABS unpublished, *Patient Experience Survey 2010-11* , *2011-12, 2012-13* Cat. no. 4839.0.

Table 11A.42 **Indigenous people deferring access to prescribed medication due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	24.4	36.3	47.0	45.2	35.3	46.5	24.1	22.8	34.6
RSE (c)	%	19.7	14.8	15.0	19.3	26.0	14.9	37.2	34.1	8.4
95 per cent confidence interval	± %	9.4	10.5	13.8	17.1	18.0	13.5	17.6	15.2	5.7

RSE = Relative standard error.

(a) Indigenous people aged 15 years and over who received a prescription for medication in the last 12 months and did not get the medication due to the cost, divided by the number of Indigenous people who received a prescription for medication in the last 12 months.

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

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

(d) Data are not comparable to data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.

(e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table 11A.43 **Waiting time for public dentistry, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Less than 1 month										
Proportion	%	34.2	28.5	28.3	37.4	15.1	32.5	36.3	40.4	30.5
RSE (c)	%	10.7	10.5	12.9	17.1	25.8	21.6	27.5	35.8	3.9
95% CI	±%	7.2	5.9	7.1	12.6	7.6	13.8	19.5	28.3	2.3
1 month or more										
Proportion	%	65.8	71.5	71.7	62.6	84.9	67.5	63.7	59.6	69.5
RSE	%	5.6	4.2	5.1	10.2	4.6	10.4	15.6	10.3	1.7
95% CI	±%	7.2	5.9	7.1	12.6	7.6	13.8	19.5	12.0	2.3

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.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges except for the ACT, for which 10 year age ranges were used.

(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) Data for 2012-13 are not comparable with data for 2011-12 that excluded treatment for urgent dental care (no longer excluded).

(e) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

Source ABS (unpublished) *Patient Experience Survey 2012-13,* Cat. no. 4839.0.

Table 11A.44 **Waiting time for public dentistry by remoteness, Australia, 2012-13 (a), (b), (c), (d), (e)**

	Unit	*Major CIties*	*Other* (f)	*Inner regional*	*Outer regional/*	***Total***
Less than 1 month						
Proportion	%	31.8	27.9	28.4	27.7	**30.5**
RSE	%	6.5	9.8	11.5	17.6	**3.9**
95% CI	± %	4.0	5.4	6.4	9.5	**2.3**
1 month or more						
Proportion	%	68.2	72.1	71.6	72.3	**69.5**
RSE	%	3.0	3.8	4.6	6.7	**1.7**
95% CI	± %	4.0	5.4	6.4	9.5	**2.3**

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 for their own health.

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

(d) Data for 2012-13 are not comparable with data for previous years which excluded treatment for urgent dental care (no longer excluded).

(e) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

(f) 'Other' includes inner and outer regional, remote and very remote areas.

Source : ABS unpublished, *Patient Experience Survey 2012-13* , Cat. no. 4839.0.

Table 11A.45 Waiting times for public dentistry, Indigenous Australians, by remoteness, Australia, 2012-13 (per cent) (a), (b), (c), (d), (e)

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Aust* (c)
Less than 1 month					
Proportion	%	57.8	56.6	63.2	59.0
RSE	%	6.5	8.0	8.1	4.5
95% CI	± %	7.4	8.9	10.0	5.2
1 month or more					
Proportion	%	29.5	33.8	21.2	28.0
RSE	%	14.2	13.7	19.8	9.1
95% CI	± %	8.2	9.1	8.2	5.0

CI = confidence interval. RSE = relative standard error. Estimates with RSEs between 25 percent and 50 percent should be used with caution.

(a) Indigenous people aged 15 years or over who reported seeing a dental professional at a government dental clinic within specified waiting time categories for non-urgent treatment in the last 12 months, divided by the number of Indigenous people aged 15 years or over who reported seeing a a dental professional at a government dental clinic in the last 12 months.

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

(c) Includes persons in non-remote areas only, as the survey questions were not asked of people in remote areas.

(d) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.

(e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table 11A.46 **Proportion of full time workload equivalent (FWE) GPs with vocational registration by region, 2012-13 (per cent) (a), (b), (c), (d)**

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Aust*
2012-13	92.6	82.8	78.8	75.5	83.4	89.4

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

(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 : Department of Health unpublished, MBS Statistics.

Table 11A.47 **Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent) (a), (b), (c), (d)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
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) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. 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: Department of Health unpublished, MBS Statistics.

Table 11A.48 **Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
FWE GPs with vocational registration										
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
2012-13	no.	6 928	4 819	4 040	1 636	1 524	428	253	114	19 742
Proportion of FWE GPs with vocational registration										
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
2012-13	%	91.3	86.9	88.4	90.7	90.7	92.2	93.0	72.1	89.4

(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 : Department of Health unpublished, MBS Statistics.

Table 11A.49 **General practices that are accredited at 30 June (a)**

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

Table 11A.49 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	no.	1 679	1 177	964	397	380	130	65	42	4 835
General practices	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (b)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
Quality Practice Accreditation	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
Quality Practice Accreditation	no.	329	284	197	86	44	32	19	3	994
Total	no.	1 675	1 167	950	416	374	130	59	41	4 812
General practices	no.	2 731	1 691	1 266	569	525	158	91	120	7 151
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
Quality Practice Accreditation	no.	343	291	214	89	44	32	19	4	1 036
2011										
Accredited										
AGPAL	no.	1 318	871	735	327	323	86	38	41	3 739
Quality Practice Accreditation	no.	340	296	206	93	48	33	21	7	1 044
Total	no.	1 658	1 167	941	420	371	119	59	48	4 783
General practices	no.	2 712	1 687	1 241	573	537	158	84	105	7 097
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.	1 399	926	784	350	339	92	40	57	3 987

Table 11A.49 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Quality Practice Accreditation	no.	373	334	241	102	49	38	23	9	1 169
2012 (c)										
Accredited										
AGPAL	no.	1 308	865	719	323	323	85	39	52	3 714
Quality Practice Accreditation	no.	439	344	280	109	65	42	23	10	1 312
Total	no.	1 747	1 209	999	432	388	127	62	62	5 026
General practices	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.	1 403	932	781	345	337	87	41	58	3 984
Quality Practice Accreditation	no.	476	362	311	120	71	46	25	11	1 422
2013 (c)										
Accredited										
AGPAL	no.	1 284	892	742	333	331	85	38	52	3 757
Quality Practice Accreditation	no.	625	462	382	160	91	59	34	15	1 828
Total	no.	1 909	1 354	1 124	493	422	144	72	67	5 585
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.	1 352	941	784	347	332	86	46	55	3 943
Quality Practice Accreditation	no.	659	485	407	168	98	62	36	19	1 934

(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.

Table 11A.49 **General practices that are accredited at 30 June (a)**

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

(c) Data for the total number of practices are not available for 2011-12 or 2012-13. 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 Department of Health.

na Not available.

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

Table 11A.50 General practice activity in PIP practices (per cent)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of SWPEs that are in PIP practices (a)										
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
2011-12	%	80.6	86.4	85.8	84.8	87.3	89.3	88.3	64.1	84.2
Proportion of services provided by PIP practices (b)										
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
2011-12	%	79.1	85.4	86.0	84.5	87.3	89.3	88.3	65.6	83.4

(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: Department of Health unpublished, MBS and PIP data collections.

Table 11A.51 **Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections, 2012-13 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All people										
Scripts	no.	2 340 481	1 768 423	1 434 337	472 595	532 288	169 921	67 108	20 855	6 806 008
Population (e)	no.	7 348 899	5 679 633	4 610 932	2 472 717	1 662 169	512 422	379 554	236 869	22 906 352
Rate	per 1000 people	318.5	311.4	311.1	191.1	320.2	331.6	176.8	88.0	297.1

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

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally 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.

(e) Estimated resident population at 31 December based on the ABS 2011 Census, first preliminary estimates.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.52 **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, 2007-08 to 2011-12 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
Concession card holders										
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
Concession card holders										
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
Concession card holders										
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.52 **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, 2007-08 to 2011-12 (a), (b), (c), (d)**

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

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

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally 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.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.53 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
2008 to 2013										
Systemic antibiotic prescribed	%	35.7	29.9	34.1	25.9	28.6	26.5	28.0	21.4	32.5
95 per cent confidence interval	± %	2.0	2.3	2.6	3.7	3.7	6.1	8.3	8.8	1.2
Encounters for acute URTI management (c)	no.	10 330	6 003	4 643	2 163	1 673	502	510	140	26 454

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) A GP encounter is a professional interchange between a patient and a GP.

Source : Britt et al unpublished, BEACH Statistics.

Table 11A.54 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia (a) (b)**

	Unit	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*	*2012-13*
Encounters for acute URTI management (c)	per 100 GP encounters	5.2	5.6	5.5	5.5	4.9	5.6	5.3
95 per cent confidence interval	± %	0.3	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	29.9
95 per cent confidence interval	± %	2.7	2.5	2.7	2.5	2.4	2.6	2.7

URTI = Upper respiratory tract infection.

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

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

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

Source: Britt et al unpublished, BEACH Statistics.

Table 11A.55 **Proportion of people with self-reported diabetes who had a GP annual cycle of care (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
2011-12 (f)										
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
2012-13 (g)										
Cycles of care	'000	77.5	56.6	41.1	19.7	22.7	7.5	2.1	1.8	229.1
People with diabetes (d), (e)	'000	308.7	215.8	161.4	96.4	78.1	23.6	13.3	9.2	916.3
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	44.4	35.4	34.5	18.5	13.1	5.3	3.5	3.0	75.1
Received cycle of care	**%**	**25.1**	**26.2**	**25.5**	**20.5**	**29.1**	**31.9**	**15.4**	**19.2**	**25.0**
95 per cent confidence interval	± %	3.2	3.7	4.5	3.3	4.2	5.9	3.2	4.8	1.9

(a) Data do not account for GPs who provide the annual cycle of care but do not use the MBS 'annual cycle of care' item. A standard MBS consultation item rebate is more likely to be used by GPs not registered for the PIP Diabetes incentive.

(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.

Table 11A.55 **Proportion of people with self-reported diabetes who had a GP annual cycle of care (per cent) (a), (b), (c), (d)**

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

(c) Data for the number of people with diabetes are derived from estimates based on self-report data collected in the 2011-12 National Health Survey (NHS) component of the Australian Health Survey (AHS). Data exclude respondents who reported they had diabetes but that it was not current at the time of interview. Data should not be compared with historical data (table 11A.54) or with data for the proportion of people with known diabetes who had a HbA1c test in the last 12 months (table 11A.55) which use different estimates for the number of people with diabetes.

(d) Includes diabetes mellitus Types 1 and 2 and Type unknown.

(e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(f) Data for 2011-12 exclude annual cycles of care provided under the DVA.

(g) Data for 2012-13 are preliminary. Data for 2012-13 include annual cycles of care provided under the DVA.

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

Table 11A.56 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

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

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

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

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

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

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

(f) Historical data may differ from previous reports as data include services provided under the DVA. 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.56 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

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

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

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

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection; Department of Health unpublished, NDSS database.

Table 11A.57 **Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Proportion of people with known diabetes who had a HbA1c test in last 12 months										
Males	%	86.4	72.1	74.7	81.6	84.8	88.2	73.3	84.7	80.4
Females	%	66.9	91.1	58.9	82.6	100.0	85.0	83.2	94.8	73.0
Persons	%	78.4	79.9	69.2	82.1	88.2	86.8	79.1	91.1	77.5
Relative Standard Error (RSE)										
Males	%	12.1	31.7	11.6	15.9	13.2	15.1	42.5	26.7	5.9
Females	%	39.2	13.6	26.0	22.5	0.0	19.5	22.5	7.8	13.4
Persons	%	15.1	14.0	12.5	12.4	9.9	11.1	18.9	8.8	6.3
95% confidence interval										
Males	± %	20.6	44.8	17.0	25.4	22.0	26.1	61.1	44.2	9.2
Females	± %	51.4	24.2	30.0	36.3	0.0	32.6	36.7	14.5	19.1
Persons	± %	23.2	21.9	16.9	19.9	17.1	19.0	29.2	15.7	9.5

Estimates with RSEs between 25 percent and 50 percent should be used with caution.

(a) Persons aged 18 years to 69 years. Includes pregnant women.

(b) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. See data quality information for further detail.

(c) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79% of people aged 18 years and over who participated in the National Health Measures Survey had fasted.

(d) Rates are non-age standardised.

(e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS unpublished, *Australian Health Survey 2011–13* (National Health Measures component 2011-12).

Table 11A.58 **Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent , by State and Territory, by sex, 2011-12 (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (g)	*Aust*
						Proportion				
Males	%	66.2	41.2	48.5	65.3	41.6	67.4	73.9	23.2	53.8
Females	%	44.9	19.1	43.0	55.6	84.6	72.2	26.5	71.9	45.0
Total	%	56.7	35.5	46.4	61.3	52.1	69.9	44.3	47.7	50.5
						Relative standard error				
Males	%	14.1	*51.5*	22.1	19.5	39.5	19.3	27.9	*61.8*	11.1
Females	%	31.6	*88.0*	18.5	30.8	13.9	15.6	*63.2*	27.6	15.8
Total	%	13.4	46.5	15.3	16.7	28.5	11.4	31.0	31.4	8.8
						95 per cent confidence interval				
Males	±	18.3	41.7	21.0	24.9	32.2	25.5	40.3	28.1	11.8
Females	±	27.8	32.9	15.6	33.6	23.1	22.1	32.8	38.8	13.9
Total	±	14.9	32.4	13.9	20.1	29.1	15.7	26.9	29.3	8.7

(a) Estimates with a relative standard error (RSE) 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.

(b) People aged 18 years to 69 years. Includes pregnant women.

(c) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use.

(d) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the National Health Measures Survey had fasted.

(e) Rates are non-age standardised.

(f) Denominator includes a small number of persons for whom test results were not reported.

(g) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source : ABS (unpublished) *Australian Health Survey 2011-13* , (2011-12 National Health Measures Survey component).

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

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

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c), (d), (e)	*Aust*
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
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) (f)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c), (d), (e)	*Aust*
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
2011-12										
0–14 years										
Proportion	%	35.1	46.9	32.6	48.4	58.3	36.6	37.4	65.5	40.9
RSE	%	20.0	14.0	20.8	21.6	13.2	26.1	18.9	18.9	7.8
95 per cent confidence interval	%	± 13.7	± 12.9	± 13.3	± 20.5	± 15.1	± 18.7	± 13.9	± 24.2	± 6.2
15–24 years										
Proportion	%	15.5	20.4	np	31.0	27.2	np	np	np	18.6
RSE	%	47.3	35.9	np	32.4	38.7	np	np	np	18.8
95 per cent confidence interval	%	± 14.3	± 14.3	np	± 19.7	± 20.6	np	np	np	± 6.9
25–44 years										
Proportion	%	24.4	11.8	11.8	15.7	19.0	23.1	17.5	26.1	16.8
RSE	%	22.7	25.6	30.9	34.4	29.0	25.2	31.9	29.9	12.6
95 per cent confidence interval	%	± 10.8	± 5.9	± 7.2	± 10.6	± 10.8	± 11.4	± 10.9	± 15.3	± 4.1
45–64 years										
Proportion	%	22.6	27.9	21.9	15.7	20.5	15.7	19.0	16.5	22.6
RSE	%	23.9	20.8	23.1	33.4	26.7	32.9	30.9	40.6	10.8
95 per cent confidence interval	%	± 10.6	± 11.4	± 9.9	± 10.3	± 10.7	± 10.1	± 11.5	± 13.1	± 4.8
65 years or over										
Proportion	%	37.0	23.2	16.0	16.7	21.9	20.1	33.1	42.2	26.4
RSE	%	20.3	22.5	30.3	38.3	32.9	34.9	39.6	43.0	12.5
95 per cent confidence interval	%	± 14.7	± 10.2	± 9.5	± 12.6	± 14.1	± 13.7	± 25.6	± 35.6	± 6.5
All ages (ASR) (f)										
Proportion	%	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
RSE	%	9.7	9.9	13.8	15.2	9.5	14.2	14.6	17.0	4.5
95 per cent confidence interval	%	± 5.1	± 4.9	± 5	± 7.3	± 5.5	± 6.3	± 7	± 11.3	± 2.2

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

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c), (d), (e)	Aust

(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) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(d) Data for the NT are not published for 2001 or 2004-05 as sample sizes were insufficient to provide reliable estimates, but are included in the Australian total. For the same reason, 2007-08 data for the NT are published only for all ages, although data by age are included in the Australian total.

(e) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.

(f) For 'all ages', 2007-08 and 2011-12 data are age standardised to the Australian population at 30 June 2001. These data differ from previous reports which reported crude rates.

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* , ABS unpublished, *Australian Health Survey 2011–13* (NHS component 2011-12).

Table 11A.60 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
95 per cent confidence interval	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
95 per cent confidence interval	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
95 per cent confidence interval	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
95 per cent confidence interval	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (f)										
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	± 6.0	± 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.60 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

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

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

(e) Data for the NT should be used with care as exclusion of very remote areas translates to exclusion of around 23 per cent of the NT population.

(f) 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.61 **Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
95 per cent confidence interval	%	± 9.2	± 19.1	± 9.8	± 4.9	± 9.6	± 17.8	± 16.0	± 3.1	± 3.9
Non-Indigenous people										
Proportion	%	23.6	26.3	20.5	15.8	21.9	17.5	28.3	–	22.5
RSE	%	11.8	9.2	10.7	15.8	10.2	12.6	15.6	–	5.4
95 per cent confidence interval	%	± 5.5	± 4.8	± 4.3	± 4.9	± 4.4	± 4.3	± 8.6	–	± 2.4

RSE = relative standard error.

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

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

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

– Nil or rounded to zero.

Source : ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey* , 2004-05; ABS unpublished, *National Health Survey* , 2004-05.

Table 11A.62 **GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
2012-13										
GPs using CDM items	no.	7 208	5 682	4 413	1 977	1 718	525	323	139	21 985
Total GPs	no.	7 354	5 818	4 601	2 055	1 794	543	349	148	22 662
GPs using CDM items	%	98.0	97.7	95.9	96.2	95.8	96.7	92.6	93.9	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 : Department of Health unpublished, MBS Statistics.

Table 11A.63 Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2012-13 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
Benefits paid per person (ASR)										
2012-13	$	63.8	59.4	67.0	55.1	59.3	55.7	58.7	66.0	61.8
MBS pathology items per person (ASR)										
2012-13	no.	3.47	3.33	3.68	3.10	3.48	3.20	3.13	3.62	3.43

ASR = age standardised rate.

(a) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 11A.64).

(b) DVA data are included.

(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.

(f) Data exclude tests ordered by eligible midwives and nurse practitioners.

Source : Department of Health unpublished, MBS and DVA data collections.

Table 11A.64 **Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
Benefits paid										
Benefits paid	$m	517.3	365.3	344.7	142.1	108.8	32.1	24.8	13.0	1 548.2
Per person	$	73.0	67.4	78.3	63.6	67.1	63.9	70.7	58.2	70.9
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	498.3	356.0	314.1	135.9	109.5	31.5	22.8	13.0	1 481.1
Per person	$	68.7	64.0	69.2	58.9	66.6	61.9	63.6	56.4	66.1
MBS pathology items rebated										
Number	'000	25 774	18 690	15 935	7 164	6 055	1 693	1 128	671	77 110
Per person	no.	3.56	3.36	3.51	3.10	3.68	3.33	3.15	2.91	3.44
2010-11										
Benefits paid										
Benefits paid	$m	463.1	327.3	290.0	128.2	101.3	29.2	20.9	12.3	1372.2
Per person	$	64.5	59.5	65.4	55.3	62.0	57.3	57.2	53.4	61.9
MBS pathology items rebated										
Number	'000	25 364	18 372	15 940	7 201	6 026	1 669	1 098	676	76 347
Per person	no.	3.53	3.34	3.59	3.11	3.69	3.27	3.01	2.94	3.44
2011-12										
Benefits paid										
Benefits paid	$m	484.3	339.8	307.7	133.1	103.6	30.1	22.1	13.7	1434.5

Table 11A.64 **Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Per person	$	66.8	61.0	68.2	55.8	63.0	58.8	59.7	59.0	63.8
MBS pathology items rebated										
Number	'000	26 520	19 235	16 900	7 487	6 217	1 733	1 172	748	80 012
Per person	no.	3.66	3.45	3.74	3.14	3.78	3.39	3.16	3.22	3.56
2012-13										
Benefits paid (e)										
Benefits paid	$m	495.9	355.7	317.1	138.3	107.8	31.4	22.2	14.4	1482.9
MBS pathology items rebated										
Number	'000	27 177	20 092	17 469	7 788	6 431	1 829	1 176	774	82 737

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Per person data for 2011-12 and previous years are crude rates and are not comparable to 2012-13 data which are age standardised (see table 11A.61).

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

(d) 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.

(e) 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.

(f) 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.

(g) Estimated Resident Populations (ERPs) used to derive rates for 2010-11 are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details. For data up to 2009-10 the rates are derived using the ERPs based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

(h) Data exclude tests ordered by eligible midwives and nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

Table 11A.65 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2012-13 dollars) and number of rebated MBS imaging items (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
Benefits paid per person (ASR)										
2012-13	$	67.2	53.9	62.9	48.0	49.2	49.2	48.5	35.8	58.6
MBS diagnostic imaging items per person (ASR)										
2012-13	no.	0.59	0.51	0.57	0.44	0.48	0.47	0.43	0.33	0.54

ASR = age standardised rate.

(a) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 11A.66).

(b) DVA data are included.

(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) Data exclude tests ordered by eligible midwives and nurse practitioners.

Source : Department of Health unpublished, MBS and DVA data collections.

Table 11A.66 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
Benefits paid										
Benefits paid	$m	466.2	290.8	253.6	107.6	84.3	25.8	17.2	5.1	1250.7
Per person	$	65.8	53.7	57.6	48.1	52.0	51.4	49.0	22.8	57.3
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	489.3	304.5	269.7	112.4	88.4	27.2	17.1	5.7	1314.3
Per person	$	67.5	54.8	59.4	48.7	53.8	53.5	47.7	24.9	58.7
MBS diagnostic imaging items rebated										
Number	'000	4 087	2 691	2 324	982	798	240	143	53	11 320
Per person	no.	0.56	0.48	0.51	0.43	0.49	0.47	0.40	0.23	0.51
2010-11										
Benefits paid										
Benefits paid	$m	474.1	286.9	265.3	108.7	84.4	25.4	15.6	5.4	1265.9
Per person	$	66.0	52.2	59.8	46.9	51.7	49.8	42.7	23.5	57.1
MBS diagnostic imaging items rebated										
Number	'000	4 096	2 660	2 384	981	796	235	140	53	11 344
Per person	no.	0.57	0.48	0.54	0.42	0.49	0.46	0.38	0.23	0.51
2011-12										
Benefits paid										

Table 11A.66 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Benefits paid	$m	505.4	307.0	287.8	115.5	87.2	26.4	16.8	5.9	1352.1
Per person	$	69.7	55.1	63.8	48.4	53.0	51.6	45.4	25.6	60.1
MBS diagnostic imaging items rebated										
Number	'000	4 377	2 867	2 583	1 044	824	245	149	58	12 145
Per person	no.	0.60	0.51	0.57	0.44	0.50	0.48	0.40	0.25	0.54
2012-13										
Benefits paid										
Benefits paid	$m	528.5	323.5	297.7	119.8	90.2	28.2	17.8	7.1	1412.8
MBS diagnostic imaging items rebated										
Number	'000	4 613	3 037	2 692	1 095	860	263	160	69	12 789

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Per person data for 2011-12 and previous years are crude rates and are not comparable to 2012-13 data which are age standardised (see table 11A.65).

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

(d) 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.

(e) Data exclude imaging referred by eligible midwives and nurse practitioners.

(f) Estimated Resident Populations (ERPs) used to derive rates for 2010-11 are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details. For data up to 2009-10 the rates are derived using the ERPs based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

Table 11A.67 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2010)	no.	1 700	1 209	981	409	354	123	67	38	4 881
SWPE (c)	no.	4 765 033	4 063 295	3 060 662	1 500 216	1 225 101	389 553	269 970	79 148	15 352 978
PIP eHealth Incentive — uptake	no.	1 280	971	793	333	274	102	57	20	3 830
Share of PIP practices	%	75.3	80.3	80.8	81.4	77.4	82.9	85.1	52.6	78.5
PIP practices (May 2011)	no.	1 664	1 178	957	409	338	123	66	46	4 781
SWPE (c)	no.	4 792 245	4 100 376	3 129 970	1 508 314	1 239 216	396 459	277 984	86 021	15 530 585
PIP eHealth Incentive — uptake	no.	1 412	1 050	856	364	299	109	62	37	4 189
Share of PIP practices	%	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6
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	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
PIP practices (May 2013) (b)	no.	1 798	1 229	1 046	433	363	127	65	56	5 117
SWPE (c)	no.	5 129 251	4 207 334	3 319 305	1 619 421	1 300 886	399 791	270 671	90 909	16 337 568
PIP eHealth Incentive — uptake	no.	1 247	937	776	296	264	96	52	27	3 695
Share of PIP practices	%	69.4	76.2	74.2	68.4	72.7	75.6	80.0	48.2	72.2

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

Table 11A.67 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

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

(b) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013.
Under the previous requirements, practices were required to: 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.

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

Source : Department of Health unpublished, MBS and PIP data collections.

Table 11A.68 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2013 (a), (b), (c)**

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Australia*
PIP practices (May 2013)	no.	3 425	981	536	104	71	5 117
SWPE (d)	no.	11 535 057	3 200 427	1 399 214	157 697	45 173	16 337 568
PIP eHealth Incentive — uptake (c), (e)							
Share of PIP practices (May 2013)	%	72.3	77.5	68.8	55.8	43.7	72.2

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

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

(c) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 compared to historical data under previous requirements (see table 11A.69).
Previously, practices were required to: 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.

(d) 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.

(e) Uptake refers to the number of practices that received a PIP eHealth Incentive payment for the May quarter, this may be different from the total number of eligible practices and does not include practices that did not receive a payment due to having a zero SWPE for the May quarter.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 11A.69 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012 (a), (b)**

	Unit	*Capital city*	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural*	*Remote centre*	*Other remote*	*Aust*
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), (e)									
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

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. 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) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 (see tables 11A.67 and 11A.68).
Under the previous requirements, practices were required to: 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.

(e) Uptake refers to the number of practices that received a PIP eHealth Incentive payment for the May quarter, this may be different from the total number of eligible practices and does not include practices that did not receive a payment due to having a zero SWPE for the May quarter.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 11A.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c) (d)	*Aust* (e)
2010-11 (c), (e)										
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.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c) (d)	Aust (e)
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 (d)										
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 (d)										
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 (d)										
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.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c) (d)	*Aust* (e)
Other (d)										
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**
2012-13 (d)										
GP always or often listened carefully										
Major cities										
Proportion	%	90.7	89.3	89.6	89.0	89.0	..	89.5	..	89.8
RSE	%	0.5	0.7	0.7	0.8	0.9	..	1.4	..	0.3
95% CI	± %	1.0	1.3	1.2	1.5	1.6	..	2.5	..	0.5
Other (d)										
Proportion	%	88.6	89.7	87.1	86.1	85.5	89.7	–	87.2	88.1
RSE	%	1.4	1.0	1.1	1.6	1.9	0.9	–	1.9	0.5
95% CI	± %	2.5	1.7	1.9	2.6	3.1	1.6	–	3.3	0.9
Total										
Proportion	**%**	**90.1**	**89.4**	**88.7**	**88.3**	**88.2**	**89.7**	**89.5**	**87.2**	**89.3**
RSE	**%**	**0.5**	**0.6**	**0.6**	**0.7**	**0.9**	**0.9**	**1.4**	**1.9**	**0.2**
95% CI	**± %**	**0.8**	**1.1**	**1.0**	**1.2**	**1.5**	**1.6**	**2.5**	**3.3**	**0.4**
GP always or often showed respect										
Major cities										
Proportion	%	93.6	93.1	92.3	92.5	92.6	..	93.1	..	93.0
RSE	%	0.5	0.6	0.5	0.7	0.6	..	1.1	..	0.3
95% CI	± %	0.9	1.0	0.9	1.2	1.2	..	2.0	..	0.5
Other (d)										
Proportion	%	92.4	91.7	91.0	90.9	89.4	92.2	–	91.4	91.5
RSE	%	0.9	0.9	1.0	1.5	1.6	0.9	–	1.2	0.4
95% CI	± %	1.6	1.5	1.8	2.6	2.8	1.5	–	2.1	0.7
Total										
Proportion	**%**	**93.2**	**92.8**	**91.7**	**92.1**	**91.8**	**92.2**	**93.1**	**91.4**	**92.5**
RSE	**%**	**0.4**	**0.5**	**0.5**	**0.6**	**0.6**	**0.9**	**1.1**	**1.2**	**0.2**
95% CI	**± %**	**0.7**	**0.9**	**0.9**	**1.1**	**1.1**	**1.5**	**2.0**	**2.1**	**0.4**
GP always or often spent enough time										
Major cities										

Table 11A.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c) (d)	*Aust* (e)
Proportion	%	89.7	87.6	88.2	87.2	87.6	..	86.2	..	88.3
RSE	%	0.7	0.8	0.7	0.9	1.3	..	1.6	..	0.4
95% CI	± %	1.3	1.4	1.3	1.5	2.3	..	2.6	..	0.6
Other (d)										
Proportion	%	88.7	87.3	85.3	86.1	87.4	87.9	–	86.3	87.0
RSE	%	1.2	1.4	1.5	2.3	1.7	1.0	–	1.5	0.6
95% CI	± %	2.1	2.5	2.5	3.9	2.9	1.7	–	2.5	1.1
Total										
Proportion	**%**	**89.4**	**87.6**	**87.1**	**87.0**	**87.6**	**87.9**	**86.2**	**86.3**	**88.0**
RSE	**%**	**0.5**	**0.6**	**0.7**	**0.8**	**1.2**	**1.0**	**1.6**	**1.5**	**0.3**
95% CI	**± %**	**1.0**	**1.1**	**1.1**	**1.4**	**2.1**	**1.7**	**2.6**	**2.5**	**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) Very remote data were not collected in the 2010-11 Patient Experience Survey. NT data should be used with care as around 23 per cent of the NT population usually resides in very remote areas. For 2010-11, 'other' Includes inner regional, outer regional and remote areas.

(d) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys, although discrete Indigenous communities are excluded, which will impact the NT more than other jurisdictions. For 2011-12 and 2012-13, 'other' includes inner and outer regional, remote and very remote areas.

(e) 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.69.

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

Source : ABS unpublished, *Patient Experience Survey 2010-11, 2011-12* , *2012-13* , Cat. no. 4839.0.

Table 11A.71 **Client experience of GPs by remoteness, Australia (a), (b), (c)**

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Remote/Very remote* (d), (e)	***Total***
2010-11 (d)						
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 (e)						
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**
2012-13 (e)						
GP always or often listened carefully						
Proportion	%	89.8	88.4	87.8	84.2	**89.3**
RSE	%	0.3	0.6	0.9	4.4	**0.2**
95% CI	± %	0.5	1.1	1.6	7.3	**0.4**
GP always or often showed respect						
Proportion	%	93.0	92.2	90.5	89.0	**92.5**
RSE	%	0.3	0.5	0.7	1.6	**0.2**
95% CI	± %	0.5	1.0	1.2	2.8	**0.4**
GP always or often spent enough time						
Proportion	%	88.3	87.4	86.7	84.2	**88.0**
RSE	%	0.4	0.7	1.1	2.6	**0.3**
95% CI	± %	0.6	1.3	1.9	4.3	**0.5**

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

Table 11A.71 **Client experience of GPs by remoteness, Australia (a), (b), (c)**

	Unit	Major cities	Inner regional	Outer regional	Remote/Very remote (d), (e)	**Total**

(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) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

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

(e) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys. Data for remote and very remote areas are combined.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.72 Client experience of GPs by remoteness, Indigenous people, Australia, 2012-13 (a), (b), (c), (d)

	Unit	*Major cities*	*Inner regional*	*Outer regional*	***Total* (e)**
2012-13 (e)					
GP always or often listened carefully					
Proportion	%	89.8	88.8	86.4	**88.5**
RSE	%	1.4	1.9	2.3	**1.0**
95% CI	± %	2.5	3.3	3.9	**1.8**
GP always or often showed respect					
Proportion	%	90.5	88.0	87.5	**89.0**
RSE	%	1.7	1.9	1.4	**1.0**
95% CI	± %	3.0	3.3	2.4	**1.7**
GP always or often spent enough time					
Proportion	%	86.2	85.0	83.2	**85.0**
RSE	%	1.8	2.1	2.3	**1.1**
95% CI	± %	3.0	3.4	3.7	**1.9**

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

(a) Persons 15 years and 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 (5 year ranges).

(c) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.

(d) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

(e) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
2010-11 (c), (d)										
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.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
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 (e)										
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	0	92.3	93
RSE	%	1.3	1.2	1.1	2.0	1.3	1.5	0	1.6	0.6
95% CI	± %	2.4	2.3	2.1	3.7	2.4	2.7	0	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	0	93	93.7
RSE	%	1.4	1.2	1.2	2.0	1.4	1.4	0	1.7	0.5
95% CI	± %	2.5	2.2	2.2	3.6	2.6	2.6	0	3.1	1
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
Other (e)										

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
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	0	1.8	0.4
95% CI	± %	2.1	2.5	2.1	4.1	2.7	2.4	0	3.3	0.7
Total										
Proportion	%	**95.1**	**94.9**	**95.2**	**94.8**	**96.3**	**93.0**	**94.5**	**92.3**	**95**
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**
2012-13 (e)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	96.4	94.7	94.5	95.6	95.2	..	94.8	..	95.4
RSE	%	0.5	0.6	0.5	0.6	0.6	..	1.0	..	0.3
95% CI	± %	0.9	1.2	1.0	1.1	1.1	..	1.8	..	0.5
Other (e)										
Proportion	%	92.9	92.0	93.0	95.5	92.0	94.1	–	91.9	93.0
RSE	%	1.3	1.4	1.0	1.3	2.6	0.8	–	2.3	0.5
95% CI	± %	2.4	2.6	1.8	2.4	4.6	1.5	–	4.2	1.0
Total										
Proportion	**%**	**95.8**	**94.2**	**94.0**	**95.5**	**94.4**	**94.1**	**94.8**	**91.9**	**94.8**
RSE	**%**	**0.5**	**0.5**	**0.4**	**0.5**	**0.7**	**0.8**	**1.0**	**2.3**	**0.2**
95% CI	**± %**	**1.0**	**1.0**	**0.8**	**1.0**	**1.4**	**1.5**	**1.8**	**4.2**	**0.4**
Dental professional always or often showed respect										
Major cities										
Proportion	%	97.0	96.4	95.7	96.6	96.6	..	95.9	..	96.5
RSE	%	0.4	0.5	0.6	0.5	0.6	..	0.8	..	0.3
95% CI	± %	0.8	0.9	1.2	0.9	1.1	..	1.5	..	0.6
Other (e)										
Proportion	%	94.5	92.8	95.2	97.0	94.8	95.8	–	93.9	94.8
RSE	%	1.0	1.3	0.9	1.2	1.5	0.6	–	2.1	0.4
95% CI	± %	1.8	2.5	1.7	2.2	2.8	1.2	–	3.9	0.8
Total										
Proportion	**%**	**96.6**	**95.7**	**95.5**	**96.6**	**96.2**	**95.8**	**95.9**	**93.9**	**96.1**
RSE	**%**	**0.4**	**0.5**	**0.5**	**0.4**	**0.6**	**0.6**	**0.8**	**2.1**	**0.3**
95% CI	**± %**	**0.8**	**0.8**	**0.9**	**0.8**	**1.0**	**1.2**	**1.5**	**3.9**	**0.5**
Dental professional always or often spent enough time										
Major cities										
Proportion	%	96.7	95.1	94.9	96.3	96.3	..	95.4	..	95.8

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
RSE	%	0.4	0.5	0.7	0.7	0.7	..	0.9	..	0.2
95% CI	± %	0.7	1.0	1.3	1.3	1.2	..	1.7	..	0.4
Other (e)										
Proportion	%	93.4	92.9	96.5	97.8	96.6	96.6	–	93.4	95.0
RSE	%	1.3	1.7	0.7	0.6	1.1	0.8	–	2.0	0.6
95% CI	± %	2.5	3.1	1.4	1.2	2.0	1.5	–	3.6	1.0
Total										
Proportion	**%**	**96.1**	**94.7**	**95.4**	**96.6**	**96.4**	**96.6**	**95.4**	**93.4**	**95.6**
RSE	**%**	**0.4**	**0.5**	**0.6**	**0.6**	**0.5**	**0.8**	**0.9**	**2.0**	**0.2**
95% CI	**± %**	**0.7**	**1.0**	**1.1**	**1.1**	**1.0**	**1.5**	**1.7**	**3.6**	**0.4**

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) Very remote data were not collected in the 2010-11 Patient Experience Survey. NT data should be used with care as around 23 per cent of the NT population usually resides in very remote areas. For 2010-11, 'other' Includes inner regional, outer regional and remote areas.

(d) 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.71.

(e) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys, although discrete Indigenous communities are excluded, which will impact the NT more than other jurisdictions. For 2011-12 and 2012-13, '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, 2012-13* , Cat. no. 4839.0.

Table 11A.74 Client experience of dental professionals by remoteness, Australia (a), (b), (c)

	Unit	Major CIties	Inner regional	Outer regional	Remote/Very remote (c), (d)	**Total**
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**
2012-13 (d)						
Dental professional always or often listened carefully						
Proportion	%	95.4	92.6	93.4	92.9	**94.8**
RSE	%	0.3	0.8	1.2	3.5	**0.2**
95% CI	± %	0.5	1.4	2.2	6.4	**0.4**
Dental professional always or often showed respect						
Proportion	%	96.5	94.2	95.9	97.1	**96.1**
RSE	%	0.3	0.6	0.7	1.1	**0.3**
95% CI	± %	0.6	1.2	1.2	2.2	**0.5**
Dental professional always or often spent enough time						
Proportion	%	95.8	94.5	96.0	96.2	**95.6**
RSE	%	0.2	0.7	0.8	1.3	**0.2**
95% 95% CI	± %	0.4	1.3	1.5	2.4	**0.4**

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

Table 11A.74 **Client experience of dental professionals by remoteness, Australia (a), (b), (c)**

	Unit	Major CIties	Inner regional	Outer regional	Remote/Very remote (c), (d)	**Total**

(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 and 2012-13 surveys. For 2011-12 and 2012-13, data for remote and very remote areas are combined.

Source : ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.75 **Annual health assessments for older people (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	453 905	332 645	235 780	109 442	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										
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 (d)										
Older people assessed	no.	141 595	96 727	84 515	33 510	33 395	11 685	3 318	2 079	406 824
Older people	no.	502 726	369 125	267 832	132 766	129 319	37 383	16 922	9 237	1 465 989
Proportion assessed	%	28.17	26.20	31.56	25.24	25.82	31.26	19.61	22.51	27.75
2012-13 (e)										
Older people assessed	no.	150 847	102 260	92 425	37 846	35 804	13 095	3 861	2 603	438 741
Older people	no.	513 313	378 015	276 692	137 378	131 620	38 123	17 525	9 812	1 503 211

Table 11A.75 **Annual health assessments for older people (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion assessed	%	29.39	27.05	33.40	27.55	27.20	34.35	22.03	26.53	29.19

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

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

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

(d) 2011-12 data have been revised to include assessments for which rebates were claimed in 2012-13.

(e) 2012-13 data are preliminary data.

Source : Department of Health unpublished, MBS data collection; ABS 2008, 2009, 2010, 2011 and unpublished, *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.76 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2008–2013 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
Valid vaccinations provided										
GPs	no.	5 961 186	3 169 975	3 974 396	1 684 717	1 098 617	410 369	208 187	41 521	16 547 160
Council	no.	236 940	2 160 911	279 374	90 716	274 053	31 230	–	–	3 073 224
State or territory health department	no.	–	–	620	156 231	403	–	4 331	1 642	163 227
Public hospital (e)	no.	na	na	na	na	na	na	na	na	na
Private hospital	no.	22	10	969	7	–	–	2	2 487	3 497
Aboriginal health service	no.	37 566	9 009	30 583	9 832	9 422	46	–	68 836	165 294
Community health centre	no.	457 424	14 732	291 583	508 938	97 325	195	144 957	199 469	1 715 150
Other (f)	no.	832	3 203	5 020	1 681	697	–	–	–	11 433
Total	**no.**	**6 693 970**	**5 357 840**	**4 582 545**	**2 452 122**	**1 480 517**	**441 840**	**357 477**	**313 955**	**21 678 985**
Proportion of total valid vaccinations										
GPs	%	89.05	59.17	86.73	68.70	74.20	92.88	58.24	13.23	76.33
Council	%	3.54	40.33	6.10	3.70	18.51	7.07	–	–	14.18
State or territory health department	%	–	–	0.01	6.37	0.03	–	1.21	0.52	0.75
Public hospital (e)	%	na	na	na	na	na	na	na	na	na
Private hospital	%	–	–	0.02	–	–	–	–	0.79	0.02
Aboriginal health service	%	0.56	0.17	0.67	0.40	0.64	0.01	–	21.93	0.76
Community health centre	%	6.83	0.27	6.36	20.76	6.57	0.04	40.55	63.53	7.91
Other (f)	%	0.01	0.06	0.11	0.07	0.05	–	–	–	0.05
Total	**%**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Table 11A.76 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2008–2013 (a), (b), (c)**

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

(a) 1 July 2008 to 30 June 2013.

(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) Includes data for unknown State or Territory.

(e) Data for 2008–2013 for vaccinations provided at public hospitals are not available.

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

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

Source: Department of Health unpublished, Australian Childhood Immunisation Register (ACIR) data collection.

Table 11A.77 **Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Fully immunised (a), (b)									
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 (g)	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
2012-13 (b)	90.8	91.7	92.0	90.2	91.3	92.2	92.8	91.5	91.3
Immunised against (2012-13) (f)									
Diphtheria, tetanus and pertussis	91.4	92.4	92.4	91.0	91.8	92.5	93.6	91.7	91.9
Polio	91.3	92.3	92.4	90.9	91.8	92.4	93.6	91.7	91.8
Haemophilus influenzae type b	91.1	92.2	92.3	90.7	91.6	92.3	93.4	91.6	91.7

(a) Coverage for the years 2008 to 2012 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) Coverage for 2012-13 includes all children vaccinated against the specified diseases, at 12 months to less than 15 months of age, in the 2012-13 financial year, by the State or Territory in which the child resided. These data may differ from data reported elsewhere which are measured at 30 June 2013, for children turning 12 months of age by 31 March 2013, by the State or Territory in which the child resided.

(c) 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).

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

(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) 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.

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

Source: Department of Health unpublished, ACIR data collection.

Table 11A.78 **Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Fully immunised (a), (b), (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
2012-13 (b)	92.3	93.1	92.6	90.6	92.5	94.2	93.2	93.4	92.4
Immunised against (at 30 June 2013)									
Diphtheria, tetanus and pertussis	94.7	95.5	94.5	93.4	94.7	95.8	95.8	95.3	94.8
Polio	94.7	95.5	94.5	93.4	94.7	95.8	95.8	95.4	94.7
Haemophilus influenzae type b	94.7	95.2	94.3	93.3	94.4	95.8	95.5	95.3	94.6
Measles, mumps and rubella	93.7	94.5	93.9	92.5	93.8	95.2	94.5	94.7	93.9

(a) Coverage for the years 2008 to 2012 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) Coverage for 2012-13 includes all children vaccinated against the specified diseases, at 24 months to less than 27 months of age, in the 2012-13 financial year, by the State or Territory in which the child resided. These data may differ from data reported elsewhere which are measured at 30 June 2013, for children turning 24 months of age by 31 March 2013, by the State or Territory in which the child resided.

(c) 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).

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

(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.

(f) 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.

Source: Department of Health unpublished, ACIR data collection.

Table 11A.79 **Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Fully immunised (a), (b), (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
2012-13 (b)	91.6	92.6	91.5	89.4	90.9	92.9	92.3	90.7	91.5
Immunised against (at 30 June 2013)									
Diphtheria, tetanus and pertussis	92.1	93.1	92.0	90.0	91.4	93.2	92.9	91.0	92.1
Polio	92.0	93.0	92.0	90.0	91.3	93.1	92.8	91.1	92.0
Measles, mumps and rubella	91.9	92.9	91.9	89.9	91.2	93.5	92.7	91.2	91.9

(a) Coverage for 2008 to 2012 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) Coverage for 2012-13 includes all children vaccinated against the specified diseases, at 60 months to less than 63 months of age, in the 2012-13 financial year, by the State or Territory in which the child resided. These data may differ from data reported elsewhere which are measured at 30 June 2013, for children turning 60 months of age by 31 March 2013, by the State or Territory in which the child resided.

(c) 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).

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

(e) Children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio and measles, mumps and rubella.

(f) 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.

Source: Department of Health unpublished, ACIR data collection.

Table 11A.80 Notifications of measles, children aged 0–14 years (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	np	–	np	np	–	–	–	–	4
2007-08	no.	18	np	4	np	np	–	–	np	27
2008-09	no.	3	18	20	np	–	np	–	–	44
2009-10	no.	5	3	np	np	np	–	–	–	12
2010-11	no.	40	6	7	5	–	–	np	np	61
2011-12	no.	20	np	–	np	np	–	4	–	28
2012-13	no.	85	np	np	3	np	–	–	np	94
Notifications per 100 000 children (0–14 years)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	0.1
2007-08	per 100 000 children	1.4	np	0.5	np	np	–	–	np	0.7
2008-09	per 100 000 children	0.2	1.8	2.3	np	–	np	–	–	1.1
2009-10	per 100 000 children	0.4	0.3	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	–	5.9	–	0.7
2012-13	per 100 000 children	6.1	np	np	0.6	np	–	–	np	2.2

(a) Notification of the relevant State/Territory authority is required when measles is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for measles — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over 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) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

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

Source : Department of Health unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS (unpublished), *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 11A.81 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	677	181	95	36	41	9	5	82	1 126
2008-09	no.	8 161	681	955	205	586	205	59	162	11 014
2009-10	no.	3 282	1 095	1 497	240	1 836	108	32	61	8 151
2010-11	no.	8 771	2 834	3 146	746	2 180	69	335	129	18 210
2011-12	no.	6 709	1 715	3 179	2 564	278	384	87	279	15 195
2012-13	no.	2 138	927	2 370	527	300	660	88	52	7 062
Notifications per 100 000 children (0–14 years) (c)										
2006-07	per 100 000 children	22.9	9.5	13.6	8.0	13.7	7.3	12.6	np	14.8
2007-08	per 100 000 children	50.8	18.5	11.3	8.6	14.3	9.3	7.8	158.2	27.7
2008-09	per 100 000 children	607.1	68.8	110.6	47.4	203.4	211.2	91.3	309.7	266.6
2009-10	per 100 000 children	242.1	109.4	170.7	54.5	633.9	111.4	48.8	115.8	195.1
2010-11	per 100 000 children	643.2	280.7	355.2	166.7	750.6	71.6	504.9	245.8	432.3
2011-12	per 100 000 children	489.4	168.0	353.4	558.2	95.3	401.4	128.5	529.6	356.8
2012-13	per 100 000 children	154.7	89.1	259.0	111.1	102.0	694.9	126.1	97.7	163.3

(a) Notification of the relevant State/Territory authority is required when whooping cough is diagnosed. Diagnosis cannot always be confirmed using available tools. Therefore, the 'notified fraction' is likely to be only a proportion of the total number of cases. The notified fraction may vary between states and territories and over time.

(b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.

(c) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

Source : Department of Health unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS (unpublished), *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 11A.82 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	4	3	8	np	–	–	–	–	17
2007-08	no.	7	–	np	–	np	np	–	np	12
2008-09	no.	3	np	3	np	–	–	–	np	11
2009-10	no.	np	–	np	np	np	–	–	np	6
2010-11	no.	6	np	np	np	–	–	–	–	12
2011-12	no.	–	–	np	np	np	–	–	np	7
2012-13	no.	3	3	3	–	–	–	–	–	9
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	0.3	0.3	1.0	np	–	–	–	–	0.4
2007-08	per 100 000 children	0.5	–	np	–	np	np	–	np	0.3
2008-09	per 100 000 children	0.2	np	0.3	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
2012-13	per 100 000 children	0.2	0.3	0.3	–	–	–	–	–	0.2

(a) Notification of the relevant State/Territory authority is required when invasive *Haemophilus influenzae* type b (Hib) is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for Hib — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over 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) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

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

Source: Department of Health unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS (unpublished), *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 11A.83 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
2007–2008									
40–44 years	6.3	5.4	25.6	11.1	10.3	22.0	3.8	4.1	11.0
45–49 years	11.7	10.3	37.9	21.4	20.1	34.0	9.6	13.1	18.8
50–54 years	50.5	48.5	54.5	52.0	53.7	47.6	45.6	34.4	51.1
55–59 years	56.0	54.8	59.0	55.3	58.4	56.9	57.0	42.5	56.6
60–64 years	58.4	58.3	61.1	57.9	62.1	59.4	58.7	45.8	59.3
65–69 years	56.9	56.8	60.2	58.1	60.8	58.7	58.1	41.6	58.2
70–74 years	13.6	33.6	53.8	19.7	25.4	34.0	18.2	8.7	28.3
75–79 years	6.7	13.2	19.6	10.8	13.5	11.2	8.5	4.9	11.8
80–84 years	2.6	3.0	5.1	4.1	5.0	3.9	2.7	2.8	3.5
85+ years	0.6	0.6	1.4	0.9	0.9	0.6	0.4	0.3	0.8
40+ years (ASR)	29.4	30.5	42.6	32.8	34.4	37.6	28.6	22.2	33.2
Ages 50–69 (ASR)	54.8	53.8	58.2	55.2	58.0	54.6	53.7	40.3	55.6
2008–2009									
40–44 years	6.5	5.1	25.2	11.0	10.0	22.9	6.7	3.3	11.0
45–49 years	11.5	9.8	38.7	21.7	20.0	35.7	10.9	12.3	18.8
50–54 years	49.1	48.3	55.7	52.8	55.9	50.5	44.9	36.0	51.1
55–59 years	56.1	54.4	60.5	57.2	58.8	58.9	56.9	42.0	57.1
60–64 years	58.6	58.5	62.8	60.0	63.5	63.3	60.9	46.4	60.3
65–69 years	56.9	56.6	61.4	59.2	61.5	62.2	58.5	43.5	58.6
70–74 years	15.2	24.1	55.4	20.6	25.3	21.3	22.2	9.6	26.5
75–79 years	7.0	8.5	20.7	11.4	13.6	9.8	9.8	5.2	10.9
80–84 years	2.8	2.9	5.5	4.3	5.2	3.6	3.1	2.1	3.7
85+ years	0.6	0.6	1.6	0.9	1.1	0.7	0.7	0.5	0.8
40+ years (ASR)	29.4	29.3	43.4	33.6	34.9	38.3	29.8	22.4	33.3
Ages 50–69 (ASR)	54.4	53.6	59.5	56.6	59.3	57.6	53.9	41.2	56.0
2009–2010									
40–44 years	6.2	4.9	23.7	10.5	9.0	22.7	7.1	3.0	10.4
45–49 years	10.8	9.8	37.8	21.6	19.1	37.2	11.5	11.3	18.4
50–54 years	46.9	49.9	54.5	53.9	53.0	51.9	44.0	35.5	50.5
55–59 years	55.0	54.9	59.1	57.8	57.1	59.9	55.4	42.5	56.5
60–64 years	58.4	59.8	62.1	61.8	61.4	65.0	60.0	46.9	60.4
65–69 years	56.7	56.8	60.5	60.1	59.9	62.1	58.4	45.0	58.3
70–74 years	16.1	19.5	54.9	20.9	25.0	18.6	23.6	9.6	25.6
75–79 years	7.0	8.1	20.0	11.8	13.9	9.3	10.0	4.3	10.8
80–84 years	2.8	2.9	5.4	4.5	5.5	3.6	2.9	2.6	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)	28.8	29.4	42.5	34.1	33.6	38.8	29.7	22.3	32.8
Ages 50–69 (ASR)	53.3	54.6	58.4	57.8	57.1	58.6	53.1	41.5	55.6

Table 11A.83 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
2010–2011									
40–44 years	5.7	5.0	21.7	10.1	8.6	22.3	7.4	2.7	9.8
45–49 years	9.8	10.6	36.6	21.5	18.6	36.8	12.1	10.2	18.0
50–54 years	43.1	51.1	53.5	53.8	53.2	50.0	42.1	34.8	49.3
55–59 years	51.5	54.6	57.9	57.9	58.3	58.5	53.4	43.5	55.1
60–64 years	55.9	59.6	61.5	62.3	63.3	64.7	59.7	48.3	59.6
65–69 years	54.6	57.6	59.9	60.4	61.9	60.5	57.2	43.9	57.9
70–74 years	15.6	17.3	54.3	21.1	25.4	16.7	20.7	9.1	24.8
75–79 years	6.8	8.0	19.7	12.2	14.1	9.0	9.4	4.6	10.7
80–84 years	2.7	2.9	5.5	4.8	6.0	3.6	3.1	2.9	3.8
85+ years	0.5	0.6	1.3	1.1	1.1	0.7	0.7	0.7	0.8
40+ years (ASR)	27.0	29.5	41.4	34.1	34.0	37.9	28.9	22.1	32.1
Ages 50–69 (ASR)	50.1	55.0	57.5	57.9	58.3	57.3	51.6	41.6	54.6
2011–2012									
40–44 years	6.0	6.2	21.1	10.3	9.0	22.4	8.7	2.5	10.2
45–49 years	10.0	12.9	36.1	22.1	18.7	37.3	14.0	9.9	18.7
50–54 years	42.7	50.4	52.5	53.8	54.3	50.5	43.2	35.8	48.9
55–59 years	51.7	53.6	57.8	57.6	58.4	58.3	55.8	41.7	54.9
60–64 years	56.6	58.9	61.3	62.2	63.4	64.5	63.0	47.1	59.6
65–69 years	55.8	57.0	59.9	60.6	62.4	62.7	58.0	45.8	58.2
70–74 years	16.2	20.0	54.2	21.7	26.2	17.2	21.1	10.2	25.8
75–79 years	7.5	9.0	20.2	13.1	15.8	9.1	10.5	5.4	11.5
80–84 years	2.9	3.4	5.6	5.3	6.8	3.6	3.2	2.0	4.1
85+ years	0.6	0.7	1.4	1.3	1.3	0.6	0.9	0.9	0.9
40+ years (ASR)	27.4	30.0	41.1	34.3	34.5	38.2	30.5	22.1	32.4
Ages 50–69 (ASR)	50.4	54.3	57.1	57.8	58.8	57.8	53.5	41.6	54.5

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) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

(c) Participation rates for women 40 years or over and 50–69 years are age standardised to the 2001 Australian population standard.

Table 11A.83 Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)

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

(d) Data include only women who were residents of the jurisdiction in which they were screened, with the exception of NSW for reference periods up to and including 2010–2011 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.

(e) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.

(f) Data for WA may include some Indigenous women usually resident in the NT in in WA catchment areas.

(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, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

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

Table 11A.84 **Participation rates for women in BreastScreen Australia by residential status, 2011 and 2012 (24 month period)**

	Unit	*NSW* (a)	*Vic*	*Qld*	*WA* (a)	*SA*	*Tas*	*ACT*	*NT*
40+ years									
Residents screened	no.	496 874	409 907	434 523	191 393	149 625	52 250	25 850	9 570
Non-residents screened	no.	na	2105	2120	132	162	49	1771	83
Non-residents screened (proportion)	%	na	0.5	0.5	0.1	0.1	0.1	6.4	0.9
Ages 50–69									
Residents screened	no.	425 013	343 340	290 911	151 117	119 567	38 856	21 353	8 372
Non-residents screened	no.	na	1684	1492	114	127	37	1436	72
Non-residents screened (proportion)	%	na	0.5	0.5	0.1	0.1	0.1	6.3	0.9

(a) Data for NSW exclude women who are not residents of NSW. However, data are not available for non-residents of NSW screened in NSW.

Source: State and Territory governments unpublished.

Table 11A.85 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA* (e)	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
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	0.6	5.4	7.8	3.1	np	–	1.6	3.6
Age 40+ years (ASR)	20.5	15.8	34.0	21.9	19.8	np	np	13.6	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	0.2	6.7	3.8	4.1	np	–	1.6	4.1
Age 40+ years (ASR)	20.9	15.4	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
2011–2012									
Aged 40–49 years	8.1	7.4	22.9	15.4	8.6	18.4	6.8	3.6	13.0
Aged 50–59 years	33.0	27.3	45.0	35.8	33.5	31.9	32.8	23.1	35.1
Aged 60–69 years	41.7	35.4	51.8	38.4	34.6	71.4	76.7	26.8	41.6
Aged 70–79 years	10.8	9.5	35.8	16.2	20.0	np	np	4.3	17.7
Aged 80+ years	3.2	3.1	4.9	7.1	1.0	–	–	2.5	3.8
Age 40+ years (ASR)	21.0	17.9	34.7	24.7	21.1	np	np	13.1	24.2
Age 50–69 years (ASR)	36.4	30.5	47.7	36.9	34.0	47.5	50.1	24.6	37.7

Table 11A.85 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

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

ASR = age standardised rate.

(a) The populations used to derive rates for Indigenous Australians are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians and for women who speak a language other than English at home.

(b) 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.

(c) Indigenous women are women who self-identified as being of Aboriginal and/or Torres Strait Islander descent.

(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 WA may include some Indigenous women usually resident in the NT in in WA catchment areas.

(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, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

– 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.86 **Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT*	*Aust*
2007–2008									
Aged 40–49 years	7.9	3.5	28.9	14.1	12.0	5.8	1.5	6.5	9.4
Aged 50–59 years	47.7	30.0	57.2	56.1	50.1	16.3	14.4	34.3	43.1
Aged 60–69 years	51.9	42.6	66.2	64.5	67.6	29.3	18.8	42.6	51.4
Aged 70–79 years	7.4	16.9	39.3	13.6	13.7	12.8	2.6	9.0	14.4
Aged 80+ years	1.1	0.8	3.0	1.9	1.5	1.6	0.5	1.9	1.3
Aged 40+ years (ASR)	26.2	19.4	42.9	33.7	31.9	13.5	8.2	20.6	26.3
Aged 50–69 years (ASR)	49.4	35.0	60.7	59.4	57.0	21.4	16.2	37.6	46.4
2008–2009									
Aged 40–49 years	7.6	3.1	30.6	14.3	12.6	12.3	1.7	5.4	9.5
Aged 50–59 years	47.1	28.5	59.7	58.2	51.2	28.1	13.1	33.6	42.9
Aged 60–69 years	52.0	39.8	67.5	67.3	66.8	41.2	17.3	44.2	50.8
Aged 70–79 years	7.7	11.2	40.6	13.9	14.3	8.6	3.7	7.4	12.6
Aged 80+ years	1.1	0.8	3.3	2.2	1.9	1.6	0.5	1.5	1.3
Aged 40+ years (ASR)	26.0	17.6	44.7	34.9	32.4	20.5	7.8	20.1	25.9
Aged 50–69 years (ASR)	49.0	33.0	62.8	61.8	57.3	33.3	14.7	37.8	46.0
2009–2010									
Aged 40–49 years	7.1	3.3	29.9	14.3	11.8	17.9	1.7	4.5	9.2
Aged 50–59 years	46.9	30.1	60.0	60.1	49.1	37.6	12.5	33.4	43.5
Aged 60–69 years	52.6	40.5	66.9	69.2	62.2	50.4	17.5	43.6	51.1
Aged 70–79 years	7.7	8.9	41.3	14.5	14.3	10.2	3.6	5.9	11.9
Aged 80+ years	1.1	0.7	3.3	2.1	1.8	1.9	0.5	2.1	1.3
Aged 40+ years (ASR)	25.8	17.9	44.5	35.9	30.7	26.9	7.7	19.5	25.9
Aged 50–69 years (ASR)	49.1	34.2	62.7	63.7	54.3	42.7	14.4	37.4	46.5
2010–2011									
Aged 40–49 years	7.6	4.9	29.0	14.3	11.6	19.7	2.0	4.1	9.8
Aged 50–59 years	46.4	40.7	59.3	59.4	48.3	37.9	12.1	34.6	46.4
Aged 60–69 years	52.9	48.9	65.7	69.7	60.4	50.9	16.7	43.0	53.8
Aged 70–79 years	7.6	8.7	41.1	14.7	14.2	11.0	3.1	6.6	11.8
Aged 80+ years	1.1	0.9	2.8	2.2	1.8	1.7	0.5	2.7	1.3
Aged 40+ years (ASR)	25.9	22.8	43.7	35.8	30.1	27.8	7.5	19.7	27.4
Aged 50–69 years (ASR)	49.0	43.9	61.8	63.4	53.1	43.0	13.9	38.0	49.3
2011–2012									
Aged 40–49 years	6.9	7.3	29.4	15.2	12.2	19.2	2.9	4.6	10.5
Aged 50–59 years	43.3	47.8	59.6	59.2	48.2	39.3	16.6	34.7	47.3
Aged 60–69 years	52.1	55.2	66.2	71.8	58.0	51.4	22.5	42.4	55.7
Aged 70–79 years	7.3	10.6	40.3	15.2	13.6	9.8	3.1	6.2	12.2
Aged 80+ years	0.9	1.2	3.2	2.5	2.2	2.1	0.9	1.6	1.5
Aged 40+ years (ASR)	24.6	27.0	43.9	36.5	29.8	28.0	10.1	19.7	28.3
Aged 50–69 years (ASR)	46.8	50.7	62.2	64.2	52.1	44.1	19.0	37.8	50.6

Table 11A.86 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

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

ASR = age standardised rate. **NESB** = Non English speaking background.

(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 2011 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) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs and rates may differ from those published in previous reports. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1) for details. Data are not comparable with data for Indigenous Australians as rates for Indigenous Australians remain based on the 2006 Census.

(c) NESB is defined as persons who speak a language other than English at home.

(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) An apparent drop in participation of NESB women in Tasmania occurred from the 2005–2006 screening period and coincided with a significant reduction in self-reporting of NESB status that followed a change in the client registration form in 2006. Since revision of the form in May 2009, both self-reporting of NESB status and participation rates are returning to earlier levels. The observed drop in participation, therefore, appears to reflect the drop in self reporting of NESB status rather than reduced participation.

(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, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

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

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
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.87 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Age 40+ years (ASR)	52.3	..	43.8	29.1	34.4	np	..	16.7	33.5
Age 50–69 years (ASR)	np	..	58.0	42.5	51.6	np	..	29.2	48.0
2009–2010									
Major Cities									
Aged 40–49 years	7.8	7.0	29.7	16.3	13.5	..	9.2	..	12.8
Aged 50–59 years	49.0	50.9	54.4	57.2	53.5	..	48.8	..	51.7
Aged 60–69 years	55.3	57.1	59.3	61.9	58.3	..	59.6	..	57.5
Aged 70–79 years	10.7	13.2	37.7	15.5	17.7	..	18.0	..	17.0
Aged 80+ years	1.5	1.5	3.3	2.3	2.7	..	1.8	..	2.0
Age 40+ years (ASR)	27.5	28.4	40.9	34.5	32.3	..	29.6	..	31.2
Age 50–69 years (ASR)	51.3	53.2	56.2	59.0	55.3	..	52.8	..	53.9
Inner Regional									
Aged 40–49 years	9.1	7.9	27.3	14.2	13.7	29.6	np	..	15.0
Aged 50–59 years	52.4	55.1	55.1	53.2	55.5	56.3	np	..	54.2
Aged 60–69 years	60.1	61.5	61.8	61.9	65.5	64.0	np	..	61.5
Aged 70–79 years	13.4	16.6	39.5	20.7	23.6	13.3	np	..	20.5
Aged 80+ years	1.7	2.2	3.5	3.8	3.6	1.8	np	..	2.4
Age 40+ years (ASR)	30.0	31.2	40.8	33.4	35.0	38.6	np	..	33.8
Age 50–69 years (ASR)	55.2	57.5	57.6	56.4	59.3	59.1	np	..	56.9
Outer Regional									
Aged 40–49 years	13.2	10.2	34.5	13.7	17.2	31.0	..	6.6	21.4
Aged 50–59 years	52.7	55.7	61.5	51.8	59.2	54.4	..	42.4	55.8
Aged 60–69 years	60.3	61.6	65.3	59.6	65.0	62.6	..	50.6	62.1
Aged 70–79 years	16.7	18.9	43.1	22.6	25.7	16.0	..	6.5	24.7
Aged 80+ years	3.0	3.5	4.1	5.0	5.7	2.8	..	np	3.8
Age 40+ years (ASR)	32.1	32.5	46.2	32.8	37.4	38.6	..	23.8	37.1
Age 50–69 years (ASR)	55.5	58.0	62.9	54.7	61.3	57.4	..	45.6	58.2
Remote									
Aged 40–49 years	23.7	np	34.5	20.5	14.6	np	..	9.6	22.2
Aged 50–59 years	53.5	np	55.3	51.9	48.7	np	..	38.0	50.3
Aged 60–69 years	65.7	np	63.7	62.5	55.9	np	..	42.1	59.5
Aged 70–79 years	23.9	np	41.7	24.1	26.0	np	..	np	28.1
Aged 80+ years	np	np	6.3	np	6.1	np	..	np	6.1
Age 40+ years (ASR)	38.1	37.5	44.1	36.1	32.2	36.3	..	22.8	36.1
Age 50–69 years (ASR)	58.2	np	58.5	56.1	51.5	51.0	..	39.5	53.9
Very remote									
Aged 40–49 years	np	..	32.5	20.5	np	np	..	5.7	21.3
Aged 50–59 years	np	..	54.9	46.6	np	np	..	28.4	46.3

Table 11A.87 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Aged 60–69 years	np	..	57.1	44.5	np	np	..	30.4	48.6
Aged 70–79 years	np	..	36.7	na	np	np	..	np	25.4
Aged 80+ years	np	..	np	np	np	np	..	np	5.0
Age 40+ years (ASR)	49.0	..	41.6	30.5	30.5	np	..	16.1	32.4
Age 50–69 years (ASR)	np	..	55.7	45.8	45.6	np	..	29.0	47.2
2010–2011 (i)									
Major Cities									
Aged 40–49 years	na	na	na	na	na	na	na	na	12.3
Aged 50–59 years	na	na	na	na	na	na	na	na	50.8
Aged 60–69 years	na	na	na	na	na	na	na	na	57.0
Aged 70–79 years	na	na	na	na	na	na	na	na	16.7
Aged 80+ years	na	na	na	na	na	na	na	na	2.0
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	30.7
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	53.1
Inner Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	14.9
Aged 50–59 years	na	na	na	na	na	na	na	na	53.6
Aged 60–69 years	na	na	na	na	na	na	na	na	61.3
Aged 70–79 years	na	na	na	na	na	na	na	na	20.2
Aged 80+ years	na	na	na	na	na	na	na	na	2.4
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	33.5
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	56.5
Outer Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	20.7
Aged 50–59 years	na	na	na	na	na	na	na	na	55.0
Aged 60–69 years	na	na	na	na	na	na	na	na	61.4
Aged 70–79 years	na	na	na	na	na	na	na	na	24.9
Aged 80+ years	na	na	na	na	na	na	na	na	4.1
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	36.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	57.4
Remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	21.7
Aged 50–59 years	na	na	na	na	na	na	na	na	52.2
Aged 60–69 years	na	na	na	na	na	na	na	na	59.9
Aged 70–79 years	na	na	na	na	na	na	na	na	30.7
Aged 80+ years	na	na	na	na	na	na	na	na	6.9
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	37.0
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	55.2
Very remote									

Table 11A.87 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Aged 40–49 years	na	na	na	na	na	na	na	na	19.3
Aged 50–59 years	na	na	na	na	na	na	na	na	43.3
Aged 60–69 years	na	na	na	na	na	na	na	na	49.5
Aged 70–79 years	na	na	na	na	na	na	na	na	28.0
Aged 80+ years	na	na	na	na	na	na	na	na	7.7
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	31.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	45.8

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 2007 and 2008, and 2011 and 2012. 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, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

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

Age group (years)	*NSW*	*Vic* (e), (f)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e), (g)	*NT*	*Aust*
2007 and 2008									
20–24	44.5	46.6	51.5	51.3	49.4	53.5	49.7	52.7	47.9
25–29	56.0	57.1	58.4	57.7	59.5	58.0	58.0	56.5	57.2
30–34	62.6	63.2	61.8	60.3	63.7	60.9	62.0	57.1	62.3
35–39	64.3	66.1	62.3	61.8	64.8	61.8	64.6	59.0	64.0
40–44	64.2	67.1	62.5	61.5	65.7	60.6	63.4	57.7	64.2
45–49	65.0	68.7	63.6	61.6	66.8	61.0	64.3	57.7	65.2
50–54	62.6	67.0	61.0	59.0	65.1	57.8	63.4	56.0	63.0
55–59	59.8	65.3	58.0	55.9	62.6	55.7	64.4	53.7	60.5
60–64	55.8	61.8	54.1	52.0	59.1	51.5	59.2	48.5	56.7
65–69	47.1	54.8	47.4	45.2	53.8	44.5	52.5	41.2	49.4
20–69 years	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
20–69 years (ASR)	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009									
20–24	42.1	44.2	48.8	50.2	47.4	51.6	46.6	52.4	45.6
25–29	53.5	55.5	56.2	56.8	57.8	56.2	55.3	56.5	55.3
30–34	61.1	63.3	60.9	60.6	62.8	60.5	60.8	58.6	61.6
35–39	63.2	66.2	61.7	62.1	64.9	61.2	62.7	59.3	63.6
40–44	63.2	67.3	62.1	62.3	65.4	60.5	63.5	61.2	64.0
45–49	64.0	69.0	63.1	62.1	66.3	61.5	64.0	60.0	64.9
50–54	61.9	67.8	61.2	60.1	65.2	59.1	62.8	59.1	63.2
55–59	59.9	66.3	58.4	56.7	62.8	57.0	63.9	53.8	61.0
60–64	56.1	63.2	54.7	53.5	59.8	53.0	61.1	50.4	57.6
65–69	47.9	55.5	47.8	45.4	53.5	45.7	52.8	43.3	50.0
20–69 years	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
20–69 years (ASR)	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010									
20–24	39.8	42.8	46.3	48.4	45.9	50.5	43.4	50.2	43.6
25–29	51.0	53.9	53.8	55.2	56.0	55.3	53.8	53.5	53.2
30–34	58.8	62.2	58.1	59.3	61.3	59.9	60.0	56.4	59.8
35–39	61.0	65.2	59.4	60.6	64.2	60.5	60.4	57.3	61.9
40–44	61.7	67.0	60.3	61.1	64.4	60.7	62.6	58.8	62.8
45–49	62.8	69.2	61.6	61.9	65.7	61.5	62.4	58.8	64.1
50–54	61.1	68.4	60.4	59.7	64.4	59.5	62.6	57.2	62.8
55–59	59.4	66.3	57.8	57.0	62.7	57.7	63.1	54.0	60.7
60–64	56.4	64.1	54.9	53.9	60.4	54.3	61.7	50.9	58.1
65–69	48.2	55.8	47.3	45.5	53.1	46.8	54.0	43.4	50.0
20–69 years	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
20–69 years (ASR)	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2

Table 11A.88 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

Age group (years)	*NSW*	*Vic* (e), (f)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e), (g)	*NT*	*Aust*
2010 and 2011									
20–24	39.3	41.7	44.9	46.9	45.0	49.8	40.9	49.0	42.6
25–29	50.4	52.3	52.1	53.2	55.1	54.6	52.9	52.2	52.0
30–34	57.9	59.8	56.3	57.1	61.3	57.6	57.7	54.6	58.2
35–39	60.1	63.4	57.8	58.6	63.1	58.4	60.0	56.3	60.4
40–44	61.2	65.6	58.8	59.2	64.1	59.1	60.4	55.9	61.7
45–49	62.3	68.2	60.8	60.7	65.6	58.6	61.8	57.6	63.4
50–54	61.8	67.7	60.0	58.8	64.2	57.0	63.9	55.4	62.6
55–59	59.4	65.8	57.6	56.5	63.1	56.4	62.4	54.8	60.5
60–64	57.3	64.4	55.6	54.0	61.1	52.9	62.5	50.9	58.6
65–69	48.9	55.7	47.5	45.8	53.3	44.7	55.2	42.7	50.3
20–69 years	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
20–69 years (ASR)	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012									
20–24	39.7	42.1	44.8	46.7	45.2	49.6	40.5	50.6	42.8
25–29	50.6	52.6	52.4	53.2	55.0	56.1	52.3	52.4	52.2
30–34	58.1	59.7	56.6	56.9	60.5	57.3	57.0	54.9	58.2
35–39	60.4	63.7	58.1	58.4	62.1	59.4	59.8	55.0	60.6
40–44	61.5	66.1	58.8	59.2	63.0	59.7	60.6	56.2	61.9
45–49	63.0	68.8	61.1	61.1	65.2	60.8	62.1	58.4	63.9
50–54	62.8	68.7	60.2	59.7	63.5	58.3	62.4	55.9	63.3
55–59	60.2	66.8	58.2	56.7	62.8	57.4	61.6	54.1	61.2
60–64	58.4	65.9	55.8	55.1	61.1	54.0	62.5	50.7	59.5
65–69	50.6	57.1	48.0	47.0	53.2	46.4	54.7	43.5	51.5
20–69 years	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
20–69 years (ASR)	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7

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 based on the 2011 Census in each of the calendar years in the reference period. 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.

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

Table 11A.88 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

Age group (years)	*NSW*	*Vic* (e), (f)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e), (g)	*NT*	*Aust*

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

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

Source : AIHW 2013, *Cervical screening in Australia 2010–2011* , Cat. no. CAN 63, AIHW, Canberra; AIHW unpublished, State and Territory Cervical Cytology Registry data.

Table 11A.89 **Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004-05 (per cent)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source : ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey* , 2004-05; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* , 30 June 2004, Series B, Cat. no. 3238.0.

Table 11A.90 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

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

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

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

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

Table 11A.91 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

Table 11A.91 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

RSE = Relative standard error.

(a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.

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

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

(d) Estimates with relative standard errors (RSEs) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

(e) Remote and very remote categories have been aggregated due to small numbers.

(f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.

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

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

Table 11A.92 **Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05 (a)**

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

(a) Vaccinations against influenza and pneumococcal disease have been available free to Indigenous people aged 50 years or over since 1999.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*.

Table 11A.93 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust* (c)
Vaccine-preventable conditions									
2007-08	0.7	0.7	0.8	0.6	0.8	0.4	0.8	2.3	0.7
2008-09	0.7	0.8	0.8	0.6	0.7	0.6	0.5	2.3	0.7
2009-10	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.5	0.8
2010-11	0.6	0.8	0.8	0.6	1.0	0.4	0.5	3.0	0.8
2011-12	0.8	0.8	0.9	0.8	0.9	0.5	0.7	3.1	0.8
Acute conditions *excluding dehydration and gastroenteritis*									
2007-08	10.2	11.1	11.2	10.8	11.8	8.7	8.7	16.5	10.8
2008-09	9.9	10.9	11.6	10.8	11.7	8.0	9.3	18.3	10.7
2009-10	10.6	11.7	12.6	12.7	12.5	8.4	8.9	18.2	11.7
2010-11	10.6	11.8	12.6	12.7	12.5	8.4	8.9	18.2	11.7
2011-12	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0
Chronic conditions *excluding diabetes complications (additional diagnoses only)*									
2007-08	12.2	14.2	14.8	12.4	14.3	13.1	8.8	23.1	13.5
2008-09	12.0	13.7	14.1	12.4	14.1	11.7	10.5	22.8	13.1
2009-10	12.1	14.0	14.4	12.8	13.4	11.2	9.6	22.9	13.2
2010-11	10.1	12.1	12.3	10.6	11.6	9.0	8.5	22.6	11.2
2011-12	10.4	11.9	12.5	10.7	11.4	9.1	8.5	21.0	11.3
All potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)* (f)									
2007-08	23.0	25.9	26.6	23.8	26.7	22.1	18.2	41.5	24.9
2008-09	22.5	25.2	26.3	23.7	26.3	20.2	20.2	43.0	24.5
2009-10	22.8	25.8	27.1	24.8	26.1	20.4	17.9	43.1	24.9
2010-11	21.3	24.6	25.6	23.8	25.0	17.7	17.9	43.4	23.6
2011-12	22.0	24.6	26.0	24.9	25.0	18.0	18.7	43.5	24.0

Table 11A.93 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

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

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

(b) Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census.

(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) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), the ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards.

(e) 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 subsequent reference years include these hospitals.

(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.

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

Table 11A.94 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f), (g)	*ACT* (f)	*NT*	*Aust* (d)
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
2011-12	1.8	2.1	2.4	4.6	4.0	0.5	1.9	9.3	3.3
Non-Indigenous Australians (h)									
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
2011-12	0.8	0.8	0.8	0.6	0.9	0.5	0.7	1.1	0.8
Acute conditions *excluding dehydration and gastroenteritis*									
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
2011-12	23.1	23.5	29.3	43.0	36.9	9.5	20.9	40.2	29.8
Non-Indigenous Australians (h)									
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
2011-12	10.7	12.1	12.2	12.7	12.6	8.4	9.4	11.6	11.6

Table 11A.94 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f), (g)	*ACT* (f)	*NT*	*Aust* (d)
Chronic conditions excluding diabetes complications *(additional diagnoses only)*									
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
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
2011-12	35.7	31.9	39.5	45.5	42.9	17.3	26.0	52.0	39.5
Non-Indigenous Australians (h)									
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
2011-12	10.3	12.1	11.9	10.0	11.4	9.0	8.4	11.4	11.0
All potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)* (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
2011-12	60.3	57.2	70.5	92.4	82.8	27.2	48.8	99.7	72.0
Non-Indigenous Australians (h)									
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
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
2011-12	21.7	24.8	24.8	23.2	24.7	17.8	18.4	24.0	23.3

Table 11A.94 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f), (g)	*ACT* (f)	*NT*	*Aust* (d)

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

(b) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(c) 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.

(d) 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.

(e) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), the ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards.

(f) From 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

(g) 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 subsequent reference years include these hospitals.

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

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

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* , Series B, Cat. no. 3238.0.

Table 11A.95 **Separations for selected potentially preventable hospitalisations by remoteness, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
Vaccine preventable conditions									
Major cities	0.8	0.8	0.9	0.7	0.9	..	0.7	..	0.8
Inner regional	0.8	0.6	0.8	0.6	0.9	0.5	np	..	0.7
Outer regional	1.0	0.8	0.8	1.1	0.9	0.9	..	1.4	0.9
Remote	1.0	np	1.4	1.5	1.0	0.3	..	4.5	1.7
Very remote	1.7	..	1.5	2.2	2.9	np	..	6.9	3.0
Acute conditions *excluding dehydration and gastroenteritis*									
Major cities	10.2	11.4	11.4	12.8	12.1	..	9.5	..	11.2
Inner regional	12.5	14.2	13.6	12.7	12.8	8.1	14.4	..	12.8
Outer regional	13.6	15.0	14.9	15.2	16.3	16.0	..	13.1	13.8
Remote	21.3	12.1	21.4	19.1	14.5	10.9	..	25.3	20.0
Very remote	24.6	..	25.8	24.3	26.0	15.9	..	31.8	26.6
Chronic conditions *excluding diabetes complications (additional diagnoses only)*									
Major cities	9.4	11.7	11.5	9.6	10.8	..	8.5	..	10.5
Inner regional	12.0	12.4	13.0	11.0	11.2	9.2	10.9	..	12.0
Outer regional	14.7	13.6	14.3	13.7	15.0	9.1	..	13.6	12.9
Remote	–	–	–	–	–	–	–	–	–
Very remote	30.4	..	24.6	20.8	23.7	22.0	..	38.0	26.6
All potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)* (g)									
Major cities	20.3	23.8	23.6	23.0	23.7	..	18.6	..	22.3
Inner regional	25.1	27.1	27.3	24.2	24.8	17.8	27.3	..	25.4
Outer regional	29.2	29.3	29.9	29.8	32.1	25.9	..	27.9	27.5
Remote	46.6	23.6	41.4	35.7	25.8	20.4	..	56.1	39.4
Very remote	56.4	..	51.6	46.9	52.2	38.1	..	75.4	55.7

Table 11A.95 **Separations for selected potentially preventable hospitalisations by remoteness, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

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

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

(b) Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census.

(c) 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.

(d) 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.

(e) 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.

(f) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), the ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards.

(g) 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.96 Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people) (a), (b), (c), (d), (e), (f)

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*
Potentially preventable hospitalisations *excluding dehydration and gastroenteritis and additional diagnoses of diabetes complications*					
Indigenous Australians					
2007-08	43.3	59.4	95.3	195.7	152.4
2008-09	49.2	59.5	96.7	184.9	158.9
2009-10	46.6	60.9	98.0	183.1	153.2
2010-11	44.5	56.9	89.8	184.1	146.3
2011-12	49.2	64.8	98.2	175.7	161.5
Non-Indigenous Australians (g)					
2007-08	22.7	26.0	29.9	32.5	33.5
2008-09	22.9	25.9	29.9	31.1	34.0
2009-10	22.9	25.9	29.3	31.5	33.8
2010-11	21.7	24.8	28.0	30.7	33.3
2011-12	22.5	26.9	30.4	31.1	35.0

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

The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(b) Historical data have been revised and differ from previous reports.

(c) 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.

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

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

(f) 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).

(g) '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*, Series B, Cat. no. 3238.0.

Table 11A.97 **Separations for selected vaccine preventable conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Vaccine preventable conditions per 1000 Indigenous Australians									
Influenza and Pneumonia	1.4	1.5	2.0	3.8	3.7	0.5	1.6	7.3	2.7
Other vaccine preventable conditions	0.4	0.6	0.4	0.9	0.3	–	0.2	2.0	0.6
Total	**1.8**	**2.1**	**2.4**	**4.6**	**4.0**	**0.5**	**1.9**	**9.3**	**3.3**
Vaccine preventable conditions per 1000 non-Indigenous Australians (i)									
Influenza and Pneumonia	0.6	0.5	0.7	0.5	0.8	0.4	0.6	0.8	0.6
Other vaccine preventable conditions	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.3	0.2
Total	**0.8**	**0.8**	**0.8**	**0.6**	**0.9**	**0.5**	**0.7**	**1.1**	**0.8**
Vaccine preventable conditions per 1000 people (all people) (j)									
Influenza and Pneumonia	0.6	0.5	0.7	0.6	0.8	0.4	0.6	2.5	0.6
Other vaccine preventable conditions	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.6	0.2
Total	**0.8**	**0.8**	**0.9**	**0.8**	**0.9**	**0.5**	**0.7**	**3.1**	**0.8**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2013 *Australian hospital statistics 2011-12* .

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(f) Indigenous status data reported for Tasmania and the ACT are included in the Australian total for the first time. Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

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

Table 11A.97 **Separations for selected vaccine preventable conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)

(h) Data for Australia include Australian residents of external Territories.

(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.

Source : AIHW 2013, *Australian hospital statistics 2011-12* , Cat. no. HSE 134; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.98 **Separations for selected acute conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Acute conditions per 1000 Indigenous Australians									
Appendicitis with generalised peritonitis	0.3	0.3	0.5	0.5	0.4	0.4	0.1	0.8	0.5
Cellulitis	4.3	3.2	6.3	7.8	4.8	1.2	1.5	7.2	5.5
Convulsions and epilepsy	6.2	5.1	6.0	10.0	14.0	1.0	5.5	10.6	7.4
Dehydration and gastroenteritis	4.1	4.7	3.8	4.8	5.2	1.3	1.2	5.0	4.2
Dental conditions	3.5	4.8	3.9	4.9	5.5	2.3	5.9	5.7	4.2
Ear, nose and throat infections	2.8	3.3	3.1	6.1	4.3	1.3	1.6	4.7	3.6
Gangrene	0.4	1.2	1.1	2.5	0.7	0.6	0.3	1.8	1.1
Pelvic inflammatory disease	0.4	0.3	0.6	1.5	0.7	0.4	0.3	1.2	0.7
Perforated/bleeding ulcer	0.4	0.3	0.6	0.3	0.3	0.2	–	0.2	0.4
Pyelonephritis (i)	4.8	5.0	7.2	9.5	6.2	2.1	5.5	8.1	6.5
Total	**27.2**	**28.2**	**33.1**	**47.7**	**42.1**	**10.7**	**22.1**	**45.2**	**34.0**
Total — excluding dehydration and gastroenteritis	23.1	23.5	29.3	43.0	36.9	9.5	20.9	40.2	29.8
Acute conditions per 1000 non-Indigenous Australians (j)									
Appendicitis with generalised peritonitis	0.4	0.3	0.4	0.4	0.4	0.3	0.2	0.4	0.4
Cellulitis	1.9	1.8	2.0	1.7	1.6	1.3	1.4	2.7	1.8
Convulsions and epilepsy	1.5	1.5	1.5	1.3	1.5	1.2	1.4	1.1	1.5

Table 11A.98 **Separations for selected acute conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Dehydration and gastroenteritis	2.6	3.5	3.0	2.6	2.7	2.0	1.8	2.2	2.9
Dental conditions	2.3	3.1	2.8	3.8	3.6	2.3	2.2	1.7	2.8
Ear, nose and throat infections	1.5	1.7	1.8	1.9	2.2	1.2	1.1	1.9	1.7
Gangrene	0.2	0.4	0.3	0.3	0.2	0.2	0.1	0.5	0.3
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis (i)	2.6	2.9	2.9	2.9	2.6	1.6	2.6	2.8	2.7
Total	**13.4**	**15.6**	**15.3**	**15.3**	**15.3**	**10.4**	**11.2**	**13.9**	**14.6**
Total — excluding dehydration and gastroenteritis	10.7	12.1	12.2	12.7	12.6	8.4	9.4	11.6	11.6
Acute conditions per 1000 people (all people) (k)									
Appendicitis with generalised peritonitis	0.4	0.3	0.4	0.4	0.4	0.3	0.2	0.5	0.4
Cellulitis	1.9	1.8	2.1	1.9	1.7	1.3	1.4	4.1	1.9
Convulsions and epilepsy	1.6	1.5	1.7	1.5	1.7	1.2	1.4	3.4	1.6
Dehydration and gastroenteritis	2.6	3.5	3.1	2.7	2.7	2.0	1.8	3.2	2.9
Dental conditions	2.3	3.1	2.9	3.9	3.6	2.3	2.2	3.1	2.9
Ear, nose and throat infections	1.6	1.8	1.9	2.1	2.3	1.1	1.1	2.8	1.8
Gangrene	0.2	0.4	0.3	0.4	0.2	0.2	0.1	0.8	0.3

Table 11A.98 **Separations for selected acute conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.6	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis (i)	2.6	2.8	3.0	3.0	2.5	1.6	2.6	4.4	2.7
Total	**13.5**	**15.6**	**15.8**	**16.2**	**15.6**	**10.4**	**11.3**	**23.0**	**14.9**
Total — excluding dehydration and gastroenteritis	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0

(a) Conditions defined by ICD-10-AM codes as in AIHW 2013 *Australian hospital statistics 2011-12* .

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(f) Indigenous status data reported for Tasmania and the ACT are included in the Australian total for the first time. Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

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

(h) Data for Australia include Australian residents of external Territories.

(i) Kidney inflammation caused by bacterial infection.

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

(k) 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.

Source : AIHW 2013, *Australian hospital statistics 2011-12* , Cat. no. HSE 134; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.99 **Separations for selected chronic conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Chronic conditions per 1000 Indigenous Australians									
Angina	4.1	3.6	5.2	4.5	3.5	1.7	–	2.8	4.1
Asthma	3.5	3.5	3.2	5.2	4.5	0.8	2.0	4.0	3.7
Chronic obstructive pulmonary disease	14.9	12.5	12.0	12.3	17.8	6.2	6.1	20.4	14.1
Congestive heart failure	4.5	2.9	6.2	8.6	5.8	3.1	4.6	8.9	5.9
Diabetes complications (i)	5.6	6.5	8.6	10.0	8.7	2.5	10.0	9.8	7.6
Hypertension	0.9	0.4	0.8	1.0	0.7	0.5	0.3	0.7	0.8
Iron deficiency anaemia	1.9	1.8	2.5	2.9	1.5	2.4	2.0	3.1	2.4
Nutritional deficiencies	0.1	0.2	0.1	–	–	–	–	0.1	0.1
Rheumatic heart disease (j)	0.2	0.3	0.7	0.9	0.4	–	1.1	2.2	0.7
Total (i), (k)	**35.7**	**31.9**	**39.5**	**45.5**	**42.9**	**17.3**	**26.0**	**52.0**	**39.5**
Chronic conditions per 1000 non-Indigenous Australians (l)									
Angina	1.0	1.2	1.8	1.3	1.3	0.9	0.7	2.1	1.3
Asthma	1.8	2.0	1.6	1.3	1.8	1.1	1.2	1.3	1.7
Chronic obstructive pulmonary disease	2.6	2.6	2.9	2.2	2.6	2.0	2.3	3.2	2.6
Congestive heart failure	1.9	2.3	2.0	1.9	2.0	1.4	1.7	1.8	2.0
Diabetes complications (i)	1.3	1.7	1.7	1.4	1.8	1.8	1.1	1.7	1.5
Hypertension	0.3	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.3
Iron deficiency anaemia	1.1	1.9	1.2	1.5	1.4	1.6	1.1	0.9	1.4
Nutritional deficiencies	–	–	–	–	–	–	–	–	0.0
Rheumatic heart disease (j)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1

Table 11A.99 **Separations for selected chronic conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Total (i), (k), (l)	**10.3**	**12.1**	**11.9**	**10.0**	**11.4**	**9.0**	**8.4**	**11.4**	**11.0**
Chronic conditions per 1000 people (all people) (m)									
Angina	1.0	1.2	1.9	1.3	1.3	0.9	0.7	2.4	1.3
Asthma	1.8	2.0	1.7	1.4	1.9	1.0	1.2	1.9	1.8
Chronic obstructive pulmonary disease	2.7	2.6	3.1	2.4	2.7	2.1	2.4	7.1	2.8
Congestive heart failure	1.9	2.2	2.1	1.9	1.8	1.4	1.6	3.5	2.0
Diabetes complications	2.5	3.1	4.3	8.0	3.1	2.9	2.0	6.8	3.6
Diabetes complications (i)	1.4	1.7	1.8	1.6	1.9	1.8	1.2	3.3	1.6
Hypertension	0.3	0.3	0.5	0.3	0.3	0.2	0.2	0.2	0.3
Iron deficiency anaemia	1.1	1.9	1.3	1.6	1.4	1.6	1.1	1.5	1.4
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	..	<0.1	0.1	<0.1
Rheumatic heart disease (j)	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.9	0.1
Total (k)	**11.3**	**13.0**	**14.5**	**16.8**	**12.3**	**9.9**	**9.1**	**23.4**	**13.0**
Total (i), (k)	**10.4**	**11.9**	**12.5**	**10.7**	**11.4**	**9.1**	**8.5**	**21.0**	**11.3**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2013 *Australian hospital statistics 2011-12* . Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

Table 11A.99 **Separations for selected chronic conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)

(e) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(f) Indigenous status data reported for Tasmania and the ACT are included in the Australian total for the first time. Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

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

(h) Data for Australia include Australian residents of external Territories.

(i) Excludes separations with an additional diagnosis of diabetes complications.

(j) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.

(k) Total may not sum to the individual categories as more than one chronic condition can be reported for a separation.

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

(m) 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.

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

Source : AIHW 2013, *Australian hospital statistics 2011-12* , Cat. no. HSE 134; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.100 **Ratio of separations for Indigenous Australians to all Australians, diabetes, 2011-12 (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (b)	*ACT* (b)	*NT* (b)	*Total*
Diabetes as a primary diagnosis (h)	no.	632	173	1 203	494	181	37	27	645	3 392
	SHSR	4.18	3.91	5.93	6.59	4.32	1.38	7.06	6.86	5.40
All diabetes — excluding diabetes complications as an additional diagnosis (i)	no.	876	219	1 487	781	251	50	33	834	4 531
	SHSR	3.36	2.91	4.20	6.48	4.45	1.27	5.92	6.71	4.32
All diabetes (j)	no.	2 528	670	4 947	10 424	1 062	141	71	3 556	23 399
	SHSR	3.66	3.07	5.20	26.42	7.51	1.72	4.04	9.03	8.24

SHSR = Standardised Hospital Separation Ratio

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) Data are available for Tasmania and the ACT for the first time. NT data are for public hospitals only.

(c) Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

(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) Separation rates are based on state of usual residence.

(g) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

(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'.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.101 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2011-12 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Circulatory	2.6	1.7	2.9	2.7	1.8	np	np	np	2.3
Renal	3.4	2.2	5.0	1.9	3.6	np	np	np	3.3
Ophthalmic	3.4	6.8	4.9	10.2	6.9	np	np	np	5.7
Other specified	36.6	41.5	52.1	40.8	54.9	np	np	np	43.5
Multiple	25.4	33.5	43.4	35.6	41.1	np	np	np	34.5
No complications	4.0	5.4	4.1	4.1	4.6	np	np	np	4.4
Total (g)	**75.3**	**91.1**	**112.4**	**95.3**	**112.9**	**np**	**np**	**np**	**93.8**

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

(b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.

(c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.

(e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

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

(h) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.102 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2011-12 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Circulatory	9.2	7.3	16.5	–	18.4	np	np	np	10.0
Renal	13.6	16.4	12.8	17.8	24.3	np	np	np	15.1
Ophthalmic	76.2	82.7	89.4	87.9	97.1	np	np	np	85.2
Other specified	12.2	17.6	24.0	12.7	24.0	np	np	np	18.0
Multiple	16.4	14.1	16.9	14.1	23.7	np	np	np	16.8
No complications	35.9	55.4	29.9	24.5	48.8	np	np	np	40.0
Total	**17.6**	**23.1**	**23.7**	**21.7**	**29.2**	**np**	**np**	**np**	**22.4**

(a) Data are for the number of same day separations with the specified principal diagnosis, as a per cent of all separations with the specified principal diagnosis.

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

(c) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.

(d) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(e) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.

(f) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(g) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

(h) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

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

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.103 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2011-12 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
ASR	per 100 000 people	10.3	13.4	14.3	13.8	17.0	np	np	np	13.3
Crude	per 100 000 people	11.8	14.9	15.3	14.0	20.9	np	np	np	14.6
Separations	no.	852	823	685	329	342	np	np	np	3 268

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 *Australian hospital statistics 2010-11* (Appendix 2).

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.104 **Separation rates of older people for injuries due to falls (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
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
2011-12									
Separations per 1000 older people	61.6	55.2	56.2	56.8	46.0	33.7	73.0	54.0	56.5
Number of separations	68 833	45 953	32 782	16 539	13 297	2 845	2 858	513	183 620

(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.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Asthma Australia – Adolescent and Child Asthma Program	The Adolescent and Child Asthma Program is a national health promotion and prevention program delivered by Asthma Australia. The program aims to provide information and training about asthma and linked chronic respiratory conditions across schools and educational settings with a focus on social inclusion and includes tools and training for better self-management of these conditions among children, young people, parents, care givers and school staff in schools and community settings.	Funding is provided through the Department of Health's Chronic Disease Prevention and Service Improvement Fund. The program is administered by Asthma Australia.	Financial and program performance reports are submitted biannually for assessment against an agreed reporting framework and funding agreement.
Asthma Australia – Community Support Program	The Community Support Program is a national health promotion and prevention program delivered by Asthma Australia. The program aims to provide information, support and training within community settings to improve the self-management of asthma and linked chronic respiratory conditions. Target groups for the program are older Australians, culturally and linguistically diverse Australians, Aboriginal and Torres Strait Islander peoples, rural and remote communities, people residing in lower socio-economic areas and those with limited literacy skills. Delivery of the program takes place within primary health care and other community settings to increase the capacity of people with asthma and linked chronic respiratory conditions to access medical support and assistance.	Funding is provided through the Department of Health's Chronic Disease Prevention and Service Improvement Fund. The program is administered by Asthma Australia.	Financial and program performance reports are submitted biannually for assessment against an agreed reporting framework and funding agreement.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Healthy Communities initiative under the National Partnership Agreement on Preventive Health	The Healthy Communities initiative provides grant funding to Local Government Areas (LGAs) to implement a range of community-based healthy lifestyle programs that facilitate increased access to physical activity, healthy eating and healthy weight programs and activities. This preventive health initiative seeks to address the rising prevalence of lifestyle related chronic disease by laying the foundations for healthy behaviours in the daily lives of Australians through the community setting. The initiative targets disadvantaged populations and adults predominantly not in the workforce. Grants to LGAs support the delivery of proven and effective healthy lifestyle programs in every state and territory.	Funding for the Healthy Communities initiative is under the National Partnership Agreement on Preventive Health. The Department of Health is responsible for administering funding agreements with 92 LGAs to deliver programs in their local area.	Financial and activity reports submitted regularly to the Department in line with funding agreements between the Commonwealth and individual LGAs. Progress and financial reporting is not publicly available. Evaluation of the initiative is being undertaken by a consultancy under contract with the Department.
Medical Specialist Outreach Assistance Program	The Medical Specialist Outreach Assistance Program (MSOAP) improves access to medical specialist services for people living in rural and remote locations, by removing the financial disincentives incurred by specialists who provide outreach services. This is achieved by meeting costs associated with delivering outreach services such as travel, accommodation, and venue hire.	Funding for MSOAP is provided by the Department of Health. The program is administered by Rural and Regional Health Australia.	Quarterly financial and service activity reports.
	The MSOAP-Indigenous Chronic Disease (MSOAP-ICD) is an expansion of the MSOAP, focusing on chronic disease in Aboriginal and Torres Strait Islander communities. The MSOAP-ICD supports specialists, allied health professionals and general practitioners as part of a multidisciplinary team.	Funding for MSOAP-ICD is provided by the Department of Health by Rural and Regional Health Australia.	Quarterly financial and service activity reports, as well as Sentinel Sites Evaluation.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Rural Primary Health Services Program (RPHS)	The aim of the RPHS program is to improve the health and wellbeing of people in rural and remote Australia. The 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 included mental health, social work, community nursing, Aboriginal health, family health, and community health education, promotion and prevention.The type of services delivered depends on the identified needs of the target communities.	Funding for the RPHS program is provided by the Department of Health.	Non-Medicare Local funded organisations provide six and twelve month financial and activity reports, as well as final reports. Medicare Locals provide six and twelve month financial and activity reports.
Royal Flying Doctor Service of Australia (RFDS)	The Royal Flying Doctor Service of Australia (RFDS) is funded to provide 'traditional services'; these are, emergency primary aero-medical transfers, primary health (GP and nursing), medical chests and remote (telehealth) consultations in rural and remote Australia (NSW, QLD, SA, WA and NT from Tennant Creek to the SA border). The services are provided for people, living, working and travelling in rural and remote Australia who are beyond the normal medical infrastructure.	Funding for the delivery of RFDS 'traditional services' is provided by the Department of Health.	Quarterly activity and financial reporting as well as annual activity and financial reports.
Rural Women's GP Service Program (RWGPS)	The Royal Flying Doctor Service of Australia (RFDS) is funded to provide the Rural Women's GP Service Program (RWGPS). The RWGPS aims to improve access to primary health care services for women in rural and remote Australia who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities. The RWGPS is open to all members of the community, including men and children.	Funding for the delivery of the RWGPS is provided by the Department of Health.	Brief quarterly reports and six and twelve month reports.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Medicare Locals Program	Medicare Locals operate as health system planners at the regional level. They are working with service providers and the community to identify the health needs and service gaps of their local area populations, including for disadvantaged or underserviced populations (e.g. Aboriginal or Torres Strait Islander people and people from culturally and linguistically diverse backgrounds). Medicare Locals deliver a variety of health services to address service gaps and barriers (e.g. cultural, language, financial, service availability, geographical) to accessing services. The range of services delivered by Medicare Locals varies according to the health needs of the local community and includes after hours services, psychological services, Aboriginal and Torres Strait Islander health, care coordination and supplementary services, community health promotion and self-management, eHealth change and adoption, nursing, pharmacy support, asthma and diabetes education. Primary and community health objectives targeted by the program include: - Reorientating the health system from acute to primary health care; - Health promotion/prevention; - Early detection/intervention; - Improving access to services; - Improving timeliness and quality of services; - Ensuring locally focused and responsive services; - Improving coordination and integration of primary health care services; - Reducing health inequalities; and - Supporting delivery of best practice services.	The Department of Health provides approximately $327.5 million in 2012-13 (Note: Some Medicare Locals also receive State funding). The Department of Health is responsible for program spending, oversight and delivery.	Medicare Locals are required to provide an Annual Plan and Annual Budget (including Needs Assessment Report), Strategic Plan (Annual), Six Month Report and Twelve Month Report as a part of the reporting requirements under the Medicare Locals Deed for Funding. Components of the Six and Twelve Month Reports are available to the public. As Medicare Locals also receive additional funding from State Health Departments and other departmental program areas for specific service delivery there are additional reporting requirements as dictated by the respective program areas. An independent program evaluation is being undertaken.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Practice Incentives Program (PIP)	The PIP is aimed at supporting general practice activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients. There are 10 separate incentives under PIP that focus on topics including eHealth, diabetes, asthma, cervical screening, Indigenous health, quality prescribing, aged care access, GP procedural services, teaching and rural services.	Funding for PIP is provided by the Department of Health. PIP is administered by the Department of Human Services.	Quarterly reporting by the Department of Human Services, via the Medicare Australia Statistics web portal.
Life Saving Drugs Program	The Life Saving Drugs Program provides patients with very rare and life threatening conditions with financial assistance to access expensive and 'life-saving' drugs not available on the Pharmaceutical Benefits Scheme (PBS). In 2012-13, the Life Saving Drugs Program provided 228 eligible patients with free access to expensive lifesaving medicines for very rare life-threatening conditions at a cost of $79 million. During 2012-13, ten medicines were funded through the program for the treatment of seven separate disorders including: • imiglucerase (Cerezyme®), velaglucerase (VPRIV®) and miglustat (Zavesca®) to treat Gaucher's disease; • agalsidase alfa (Replagal®) and agalsidase beta (Fabrazyme®) for Fabry disease; • laronidase (Aldurazyme®) for Mucopolysaccharidosis Type I; • idursulfase (Elaprase®) for Mucopolysaccharidosis Type II; • galsulfase (Naglazyme®) for Mucopolysaccharidosis Type VI; • alglucosidase alfa (Myozyme®) for infantile-onset Pompe disease; and • eculizumab (Soliris®) for Paroxysmal Nocturnal Haemoglobinuria. Each condition has separate eligibility guidelines, developed and administered with the advice of an expert disease advisory committee.	Funding for the Life Saving Drugs program is provided by the Department of Health.	Annual Report and the Portfolio Budget Statements (under Program 2.3: Targeted assistance – pharmaceuticals) Further information about the Life Saving Drugs Program can be found on the Department of Health's website at www.health.gov.au/lsdp

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The Pharmaceutical Benefits Advisory Committee is an independent, expert advisory body comprising doctors, other health professionals and a consumer representative, which makes recommendations to the Australian Government about medicines funded through the PBS. In order for a medicine to be made available for the treatment of patients through the Life Saving Drugs Program, the medicine must first be rejected for PBS listing because it fails to meet the required cost effectiveness criteria. The Life Saving Drugs Program Criteria and Conditions for Funding must be satisfied, which include that there is acceptable evidence to predict that a patient's life-span will be substantially extended as a direct consequence of the use of the medicine, and that the medicine is clinically effective.		
Fifth Community Pharmacy Agreement (5CPA)	5CPA provides $15.4 billion for the dispensing of PBS medicine and to ensure vital medicines are accessible to the Australian community. The 5CPA includes $663.4m over the life of the Agreement for Professional Services and Programs which promote access to services that assist patient medication management and support the quality use of medicine and through this, improve consumer health outcomes. A number of these programs target particular population groups (such as the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people) and geographical settings (such as the Rural Pharmacy Workforce Program).	· $13.7b over five years for the dispensing of PBS medicines. · $952m for the Community Service Obligation funding pool, which supports the timely supply of medicines to all Australians. · $663.4m for a range of Programs and Services that increase patient health outcomes.	· Data via PBS · Department of Human Services report data on a number of 5CPA Programs · Reporting data or activity for 5CPA programs by funding recipients

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Section 100 Programs	In addition to the drugs and medicinal preparations available under normal PBS arrangements, a number of drugs are also available as pharmaceutical benefits but are distributed under alternative arrangements provided for under section 100 of the *National Health Act 1953*. These programs include the Highly Specialised Drugs Program, Efficient Funding of Chemotherapy, Botulinum Toxin Program, Human Growth Hormone Program, InVitro Fertilisation/Gamete Intra Fallopian Transfer (IVF/GIFT) Program, and Opiate Dependence Program.	· The PBS is an uncapped special appropriation.	· Regular service activity and financial reports provided in line with an agreed reporting framework.
Closing the Gap – PBS Co-payment Measure	The Closing the Gap (CTG) Pharmaceutical Benefits Scheme Co-Payment Measure, is one of 14 measures under the Indigenous Chronic Disease Package. The CTG lowers or removes the patient co-payment for PBS medicines. The CTG improves access to Pharmaceutical Benefits Scheme medicines for eligible Aboriginal and Torres Strait Islanders living with, or at risk of, chronic disease. Eligible Practice Incentive Program (PIP) accredited general practices and non-remote Indigenous Health Services (IHS) may participate in the measure which commenced on 1 July 2010.	· Commonwealth contribution to the National Partnership Agreement – Closing the Gap. · Funding is provided by the Department of Health.	· Department of Human Services records registration of PIP accredited GP practices and non-remote IHS, as well as eligible registered patients. · Measure expenditure data is reported monthly through DHS.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Primary Health Care (Office for Aboriginal and Torres Strait Islander Health)	The program supports Community Controlled Organisations to improve community access to a broad range of clinical and population health services. Organisations funded under this program must deliver primary health care services and/or advocacy services tailored to the needs of the community. These services include population health activities; and clinical services including the treatment of acute illness, emergency care, management of chronic conditions, crisis intervention and referral.	Funding is provided by the Department of Health. The program is delivered by a range of Aboriginal Community Controlled Health Services, Non-Government Organisations and some State and Territory health departments.	· Services are required to undertake a quarterly review of progress against agreed plans. · Organisations provide an annual report of service activity. Services providing clinical primary health care also report biannually against agreed national key performance indicators.
Closing the Gap in Indigenous Health Outcomes - Indigenous Chronic Disease Package	The Indigenous Chronic Disease Package (ICDP) aims to improve the prevention, detection and management of chronic disease in Aboriginal and Torres Strait Islander peoples to close the gap in life expectancy. The ICDP is helping to build a health system that meets the needs of Aboriginal and Torres Strait Islander people, providing support to both Aboriginal community controlled health organisations and mainstream general practices. The package provides funding for prevention programs and community education initiatives to reduce the key risk factors that contribute to chronic disease; improved access to best practice chronic disease management and follow up care; and an expanded Indigenous health workforce to increase the use of health services by Aboriginal and Torres Strait Islander people with, or at risk of developing, chronic disease.	Funding for the ICDP is provided through the Aboriginal and Torres Strait Islander Chronic Disease Fund, and the Practice Incentives Program – Indigenous Health Incentive.	· The Department of Health reports annually on implementation and progress of the Indigenous Chronic Disease Package to the Standing Council on Health.

Source : Australian Government unpublished.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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. Personal Health Record (PHR) - 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. Early Childhood Health Services 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.	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.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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. **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.	LHD funds	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
	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. Services include bi-lingual nurses (English/Arabic and English/Mandarin) and services in a rural area with a focus on engaging vulnerable Aboriginal families.	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.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	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.	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.
	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.	State program funding to selected sites.	Annual Reporting and six monthly financial acquittal.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Screening	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. Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program includes the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies. - Statewide Eyesight Preschooler Screening (StEPS) - is a free vision screening program for all four year old children in NSW. The program is designed to identify childhood vision problems early which cannot be detected by observation, behaviour, family history or vision surveillance. By identifying and treating vision problems during the critical visual development period, treatment outcomes can be maximised.	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. A mix of LHD and Australian Government funding.	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. Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
Youth health and wellbeing	Provides education and health promotion programs, clinical services and planning of youth friendly services. Also provides specific health services for homeless and at risk young people.	A mix of LHD and Australian Government funding is allocated for Innovative Health Services for Homeless Youth (IHSHY).	These services are measured as Non Admitted Patient Occasions of Service. 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. ISHSY program reports annually to MCYPH branch.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and child health	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. Targeted programs for vulnerable populations include: - 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.	LHD block funding and some IECD NP funds (Commonwealth)	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Regular reports on activity, outcomes against indicators
Child Protection Counselling Services	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.	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.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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, hoe visiting, family support, parenting education and respite care. 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. 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.	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
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under Keep Them Safe (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.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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
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.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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.	Keep Them Safe (KTS) 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.
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.

Source : NSW Government unpublished.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Primary Care Partnerships (PCPs) Strategy	Primary Care Partnerships (PCPs) are cross government funded voluntary alliances of heath and human services provider organisations. There are 29 PCPs in Victoria which engage over 1000 organisations. PCPs deliver local service system reforms to: • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated; and • improve the management of chronic disease. The strategy to improve the coordination of services is supported by a state-wide policy and operational framework and includes: state-wide 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. 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.	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 Transport, Planning and Local Infrastructure.	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. A new PCP Program Logic for 2013-17, with changed reporting requirements for PCPs, will be implemented in 2013-14.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Refugee Health Nurse Program	The Refugee Health Nurse Program (RHNP) seeks to optimise the long-term health of asylum seekers/ refugees by promoting accessible and culturally appropriate health care services that are innovative and responsive to the unique needs of asylum seekers/refugees. The program supports a coordinated model of care, and acknowledges the importance of early identification and intervention in health issues in the early stages of settlement. The RHNP has three aims: • 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. The RHNP builds the capacity of individuals, families and refugee communities to improve their health through: disease management and prevention; the development of referral networks and collaborative relationships with general practitioners and other health providers; connection with social support and orientation programs.	• The Victorian Government funds the RHNP through the Department of Health. • Community health services are funded to deliver the RHNP.	• Community health services funded under the RHNP report hours of service on a quarterly basis.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Dental Health Program	All health care and pensioner concession care holders and their dependants are eligible for public dental services in Victoria. Services are provided to eligible Victorians through community dental clinics in community health services, rural hospitals and the Royal Dental Hospital of Melbourne. There are waiting lists for public dental care at all clinics, however eligible people with urgent needs are given priority and are assessed within 24 hours of contacting a clinic. Urgent dentures are provided within 3 months. In addition to people with urgent dental needs, people who have priority access are offered the next available appointment for care and are not placed on a wait list. Priority access to public dental care is provided to: • Children up to the age of 12 • Young people aged 13 – 17 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	• State funded public dental services are output funded and supported by an activity based funding model. • From 1 July 2013, with the implementation of the National Partnership Agreement on Treating More Public Dental Patients, the funding unit is a Dental Weighted Activity Unit (DWAU), calculated using the Australian Dental Association (ADA) three digit item codes and a weighting.	• Performance targets are set by the department and monitored through various reporting mechanisms to demonstrate program delivery. Examples of targets are people treated, waiting times and quality measures. • Funded agencies delivering dental services are set DWAU targets based on their total service delivery funding. For performance monitoring, all activity (treatment items) are converted to DWAUs.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	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: • 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 out-of-home 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.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Nurse on Call	NURSE-ON-CALL 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 uses registered nurses to triage callers' symptoms and health issues so as to advise on health care needs. NURSE-ON-CALL also provides callers with health information; and information about local health providers.	NURSE-ON-CALL is delivered by Medibank Health Solutions under contract to the Department of Health.	Medibank Health Solutions provides the department with a number of monthly reports.
IHSHY Program	The Innovative Health Services for Homeless Youth (IHSHY) program is a Commonwealth/State funded initiative that promotes health care for young people who are homeless or at risk of homelessness. Funding is provided to community health services to deliver innovative and flexible health services for the target population. The services respond to the complex health needs and improve their access to mainstream health services. IHSHY provides a means of engaging young people who may not otherwise access health services.	Joint state/Commonwealth funded. IHSHY is provided under the National Healthcare Agreement.	Quantitative performance targets are set by the department and monitored quarterly.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Maternal & Child Health	The Healthy Mothers, Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. 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: • improve women's access and attendance at antenatal and post natal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their: • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services.	The Victorian Government funds the program through the Department of Health. Funding of this program continues until June 2014. Extension of funding for this program beyond 30 June 2014 is subject to budget outcomes.	Quantitative performance targets are set by the Department of Health and monitored quarterly. The performance of the program was monitored through a formal evaluation completed in August 2011.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Children's Health & Wellbeing	Services for children and families within community health are based on evidence which identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services respond to the needs of young children and their families. Child health teams provide multidisciplinary care through a mix of group and individual interventions. Services promote positive health, growth and functioning within the community. Their focus is the provision of early interventions as well as to improve the capacity of parents and families to understand and manage the health and development needs of their child. Community health practitioners also support families to access additional services they may require in the community.	The Victorian Government funds the program through the Department of Health.	Quantitative performance targets are set by the department and monitored quarterly.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Community Health Program	The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 350 sites across Victoria. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers. CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses. In addition, community health prioritises services to population groups that are known to have poor health status, are subject to disadvantage or are at risk. These include people who are homeless or at risk of homelessness, refugees, aboriginal people, people with an intellectual disability or a serious mental illness. Funding is provided for the provision of direct care, and for health promotion. CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.	These services are funded under the Primary Health Funding Approach. The Approach includes two components (1) direct care and (2) health promotion.	Quantitative performance targets are set by the department and monitored quarterly. CHSs report annually to their consumers, carers, community and other stakeholders through the Quality of Care report. Agencies funded for health promotion are required to develop four year health promotion plans and report on those plans on an annual basis.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Family Planning	Family planning services assist Victorians to make individual choices on sexual and reproductive health matters by providing services that are accessible, culturally relevant and responsive to people who experience difficulty accessing mainstream services. Family planning health promotion focuses on promoting the sexual and reproductive health of Victorians, with a focus on groups at higher risk of ill-health. Funding for family planning services is provided to community health services, and to a statewide service, Family Planning Victoria (FPV).	From 2009-10, funding is provided under the National Healthcare Agreement.	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly. In line with broader Integrated Health Promotion Program requirements, agencies funded for family planning health promotion are required to submit a health promotion plan every four years and report on this plan annually.
Early Intervention in Chronic Disease (EIiCD)	EIiCD focuses upon community based early intervention services for people with chronic diseases. The aim of the initiative is to enhance existing capacity of community health services in supporting people with chronic disease in managing the impact of their condition including the physical, emotional and psychological impact of having a chronic disease. Services aim to reduce the impacts of chronic disease, slow disease progression and reduce potential/future hospitalisation. Models of care are multidisciplinary and provide self management support, care coordination, education, allied health and nursing.	These services are funded under the Primary Health Funding Approach	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.

Source : Victorian Government unpublished.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol, Tobacco and Other Drug Services	Alcohol, Tobacco and Other Drug Services in Queensland are delivered through approximately 97 public and non-government organisations. Services include a range of prevention and health promotion activities; screening and assessment; care coordination and support; counselling; early and brief intervention; referral and aftercare. Services are provided to a broad population (including men, women and Indigenous Australians) who are referred from a range of sources including self, family and friends, community and health services, GPs and, law and justice agencies. Alcohol and other drug services are delivered within a harm minimisation framework, consistent with the National Drug Strategy 2010-2015.	Funded through State Output Revenue and Commonwealth funds.	National reporting through National Minimum Data Set (NMDS) processes - national publication is prepared from the NMDS.
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 primarily funded by the Queensland Department of Health, with some Commonwealth funding. Services are delivered by Hospital and Health Services.	Performance targets and overall financial reporting are published in Queensland Health's annual report and Service Delivery Statement.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Retrieval Services and Counter Disaster (RSCD)	The emergency retrieval and aeromedical transport of critically ill or injured patients across Queensland and the north coast of New South Wales is coordinated by RSCD to improve access to, and the quality of available transport resources to support patients ranging from acute, urgent, high dependency care to non-urgent, low dependency care. These transport services are provided under statewide service agreements in partnership with non-government organisations including: Royal Flying Doctor Service (RFDS), community helicopter providers and CareFlight Medical Services; and with Emergency Management Queensland and the Queensland Ambulance Service, Department of Community Safety and Australian Helicopters Pty Ltd. For patients who can travel by themselves and are required to travel away from their home to access specialist medical services, financial assistance is provided to eligible patients through the Patient Travel Subsidy Scheme (PTSS).	Funding source - State Output Revenue (except for the RFDS aeromedical services provided from the Cairns, Mt Isa and Charleville bases which are partially funded by the Commonwealth. RFDS also provides primary health care services funded by the Commonwealth.) Budget oversight - RSCD Governance oversight - RSCD Delivered - RSCD	No patient transport reports are provided externally. Internally, activity reports are provided to the Hospital and Health Services (HHSs) to assist in the monitoring of usage of road ambulance, fixed-and rotary wing aeromedical transport at HHS and facility level. PTSS activity and expenditure reports are provided monthly to HHSs and will be provided to CBRC in the mid-year financial review 2013-14

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Blood Borne Viruses and Sexually Transmissible Infections (BBVs and STIs)	The program implements five national strategies: 1. The Sixth National HIV Strategy 2010-2013; 2. The National Hepatitis B Strategy 2010-2013. 3. The Third National Hepatitis C Strategy 2010-2013; 4. The Second National Sexually Transmissible Infections Strategy 2010-2013; 5. The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013. Services and public health programs are delivered through public, non-government and private organisations including 16 Hospital and Health Service (HHS) Sexual Health Clinics providing preventative and clinical BBV and STI services. Clinical and funded non-government programs target groups most at risk of BBVs and STIs. (e.g. gay men, injecting drug users, culturally and linguistically diverse, Aboriginal and Torres Strait Islanders and young people). The Queensland HIV Strategy 2012-2015 outlines the strategic direction for HIV prevention and management in Queensland.	Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.	Six monthly performance reports on activities by funded NGO programs Quarterly report provided to the BBV and STI Standing Committee (BBVSS) Commonwealth Indigenous funding reports Notification data for BBVs and STIs provided for the NHA report.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Get Healthy Services	Under an agreement with New South Wales Ministry of Health, Queensland has implemented the Get Healthy Information and Coaching Service (GHS) available to Queensland adults through 13Health (13 432584) or via www.gethealthy.qld.gov.au. Since commencement on the 8 February 2013 to the 30 June 2013, over 1300 contacts were received resulting in 452 participants enrolling in the Get Health Coaching program. The Service has been promoted through a range of channels to the broader community, community organisations, health service providers, workplaces and state and local government.	Funding for the Get Health Information and Coaching Service is provided through the National Partnership Agreement on Preventive Health, Healthy Workers initiative.	Reports are received as per contractual requirements between Queensland Department of Health and New South Wales Ministry of Health.
Women's health	Queensland Health supports remote Aboriginal and Torres Strait Islander women's participation in cervical screening through the Healthy Women's Initiative (HWI). The HWI is a network of 16 designated Aboriginal and Torres Strait Islander women's health workers who focus on cervical screening and women's health issues to improve the health outcomes for Aboriginal and Torres Strait Islander women. The Department of Health funds the Mobile Women's Health Service (MWHS) to provide an 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.	Funding for the HWI and MWHS are provided through the National Healthcare Agreement and State Output Revenue.	Delivery of the HWI and MWHS is the responsibility of Hospital and Health Services in accordance with Service Level Agreements.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Enhanced Maternal and Child Health Service	Queensland Health is implementing the Enhanced Maternal and Child Health Service to ensure all families have access to two home visits in the first month following birth and community clinics at key stages during the first year of a child's life.	State government Delivered by state government, may be delivered in partnership with other providers	Quarterly reporting
Child health services	A range of child health services are provided to children and young people aged 0-18 years and their families in the community. These services may include interventions such as child development checks, lactation support, parent information sessions; as well secondary and/or tertiary health services such as parenting and behaviour support, nutrition support, or referrals to other service providers. Services are available to all children and young people aged 0-18 years and their families as well as targeted services to particular or 'at risk' populations such as young parents, Aboriginal and Torres Strait Islander families, and refugee families.	State and Commonwealth government funding. Delivered by state government, may be delivered in partnership with other providers	Local Hospital and Health Service reporting arrangements are in place.

Source : Queensland Government unpublished.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
National Partnership Agreement (NPA) - Closing the Gap in Indigenous Health Outcomes	The Closing the Gap NPA is centred on five priority areas through the delivery of services to Indigenous communities throughout WA: Area 1 – Tackling Smoking • Outcomes – Reduction in smoking prevalence and in the burden of tobacco related disease for Aboriginal communities. • Outputs - 11 State funded Tackling Smoking programs were successfully implemented throughout the State and all are delivering a range of strategies and activities for smoking cessation and/or prevention. Interventions include education, social marketing, brief intervention and smoking cessation quit groups. Area 2 – Healthy Transition to Adulthood • Outcomes – Increased sense of social and emotional wellbeing; Reductions in uptake of alcohol, tobacco and illicit drugs, rates of sexually transmissible infections, hospitalisations for violence and injury and morbidity and mortality amongst Aboriginal men. • Outputs - 24 programs continue to increase the access and uptake of services supporting social and emotional well being among young Aboriginal people. Initiatives include self-esteem, sexual health and drugs and alcohol education, social marketing, training, counselling and peer mentorship and leadership strategies.	• Area 1 – Commonwealth and State funded • Area 2 – State funded • Area 3 – State funded • Area 4 Commonwealth and State • Area 5 – Commonwealth and State • Programs delivered by both WA Health and non-government organisations (Aboriginal Community Controlled Health Organisations)	• WA requires biannual reporting from all COAG Closing the Gap programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WA reports annually through AHMAC for Closing the Gap funded programs.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	Area 3 – Making Indigenous Health Everyone's business • Outcomes - Increase health outcomes for Indigenous people in prison settings and Aboriginal men's health. • Outputs - 14 programs continue to increase health outcomes for Aboriginal men and Aboriginal people in the prison settings and post-release. Ten of these are Aboriginal Health Community Re-Entry programs. Area 4 – Primary Health Care Services that can deliver • Outcomes - Improved access to quality primary health care; increased uptake of MBS-funded services; Implementation of best practice standards and accreditation and increased cultural competence of primary care services. • Outputs – A suite of 26 State funded primary health care services continue to be delivered through culturally secure community health care settings with a focus on the prevention, early detection, treatment and self management of chronic disease. Area 5 – Fixing the gaps and improving the patient journey • Outcomes - Reduced average length of stay; Improved level of engagement to deliver better follow up and referrals; Improved patient satisfaction and health journey and reduced admissions and incomplete treatments. • Outputs - 24 State funded programs continue to support access to patient transport services and improvements in continuum of care particularly for Aboriginal people living in rural and remote WA.		

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
NPA Indigenous Early Childhood Development (IECD)	The IECD NPA is centred on the following element: Element 3: Increase access to, and use of, maternal and child health services by Indigenous families • Outputs - A further 14 programs continue to provide postnatal services and outreach programs with a focus on adolescent mothers. These programs provide clinical policies, guidelines and standards of practice, and work force support and development to maternal and child health services delivering care to Aboriginal women. These services also include the provision of child health checks and immunisation services.	• Element 3 – State funded • Programs delivered by both WA Health and non-government organisations (Aboriginal Community Controlled Health Organisations)	• WA requires biannual reporting from all COAG IECD programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WA reports annually to Australian Government Department of Health for the programs.
Primary health/chronic disease programs for Aboriginal communities	WA has carriage of approximately 18 contracted primary health/chronic disease programs across the State in a community health care setting with a focus on the prevention, early detection, treatment and self management of chronic disease. • Outcomes – the majority of these services aim to increase access to culturally appropriate primary health care services for Aboriginal people in WA. • Outputs – provision of 24-hour accident and emergency services, outpatient services, management of chronic conditions, immunisation, health promotion, screening and associated treatment, maternal and child health and integration of service delivery.	• State funding is provided • Programs delivered through Aboriginal Community Controlled Health Organisations (non-government).	• WA requires biannual reporting from all COAG IECD programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Child Health Interim Schedule	A comprehensive schedule of maternal and child contacts for Aboriginal families with young children (0-5 years) is provided in Country WA. 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.	• State funding is provided directly to individual health services or regions. • 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.
WA Country Health Service 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. WA delivers the program and provides resources to other service providers.	• State funding was provided to set up the program. State funding is used to administer the program.	• Reporting provided on an annual basis.
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of a benefit/allowance from Centrelink or Department of Veterans' Affairs) via: • Public dental clinics in the metropolitan and country areas • Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Scheme • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people • Aged Care Dental Program provides dental care to residents of registered aged care facilities. Residents are eligible to receive free annual screening dental examinations and a care plan. Further treatment needs are advised and the patient is referred to an appropriate provider. Ongoing treatment is through one of the Government programs for eligible residents.	State funding is provided.	Program measures include: • Access to dental treatment for eligible people • Average waiting times • Average cost of completed courses of adult dental care.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child and Adolescent Community Health - Child Health Services (statewide)	• Child health services aim to promote improved health outcomes for babies, young children and their families across Western Australia through the provision of a range of universal and targeted prevention, early identification and intervention community health services. • WA offers a universal Birth to School Entry community child health service that begins with a child health nurse contacting all mothers of new babies within 10 days of birth and the offer of an additional 6 contacts at the critical points in the child's development throughout the first four years of life. More intensive services are offered and provided to individual families and groups according to need. • The Enhanced Aboriginal Child Health Schedule provides a modified and expanded version of the Universal Child Health Contact Schedule, offering to families 15 scheduled contacts from pregnancy to five years of age. These are offered in a consistent and culturally appropriate manner. The object is to proactively engage with Aboriginal families who do not access mainstream services and are known to have higher health needs. • Services are delivered in child health centres, community based centres and in homes. Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breast feeding and nutrition.	• State funding is provided. • WA 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. • Quarterly reports against key performance indicators are provided to the Government.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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 by the WA Department of Health on school sites in collaboration with education providers. • Key elements of the program are universal health assessments at school entry to all students in government and non government schools, support to children in schools with particular health needs, access to health care for adolescents and health promotion for all students. In secondary government schools the focus is more on health promotion and providing to students the opportunity for access to a health professional who can advise, assess and refer according to the presenting health issue.	• The program is State funded. • Agreement is between the WA Department of Education and WA Department of Health which underpins the delivery of School Health Services. • The WA Department of Education partly funds School Health Services in WA	• Services are reported as Occasions of Service for non-admitted patients. • Reports are produced as required for service planning and reviews. • Service delivery reports are not accessible to the public.
Child and Adolescent Community Health - Child Development Services (Statewide)	• Community child development services in Western Australia provide a range of assessment, early intervention, and treatment (therapy) services to children with or at risk of developmental delay and disorders. The intention is to assess and intervene early to address developmental issues to maximise a child's potential and reduce the likelihood of conditions becoming consolidated and requiring more intensive and expensive therapeutic services later in life. • Child development services work with mental health, education and disability service providers to maximise opportunities for a child as part of a holistic and family centred approach. • The child development service workforce comprises: speech	• State funding is provided. • WA Health Services are responsible for delivering child development services.	• Services are reported as occasions of service (for non-admitted patients). • Additional reports are produced as required for service planning and review, including for example number of new referrals and wait times.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Disease Management	A range of non-hospital care is provided across the spectrum of chronic disease management including cardiovascular, diabetes, musculoskeletal conditions, respiratory and renal disease. Programs are delivered through the Better Health Improvement Projects (BeHIP) in line with the WA Chronic Health Conditions Framework (2011) and Chronic Conditions Self-Management (CCSM) Strategic Framework, including: • Metropolitan Healthy Lifestyles • Chronic Condition Self-Management (CCSM) • Familial Hypercholesterolemia • Multidisciplinary Diabetes Services • Chronic condition Service Coordination (CCSC) The CCSM programs are multi-disciplinary and often inter-agency, and educate consumers 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, psychology, dietetics, occupational therapy, physiotherapy, podiatry and social work. Aboriginal Health Liaison Officers facilitate and improve access to services and programs for the Aboriginal population. The CCSC is integrated into other National Partnership Agreement programs and provide multi-agency care co-ordination, planning and case management, individual and group education and physical rehabilitation. Extensive stakeholder engagement, consultation and collaboration with government community health services, government and non-government providers, consumers, carers, and Medicare Locals enables the team to integrate services to support ongoing consumer self-management.	• Funding for these services is mainly via core WA Department of Health funding to Health Services and Medicare Locals.	• 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 programs and services delivered; clients and referrals; referral sources; service providers trained.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol and other drug treatment services	The WA Drug and Alcohol Office (DAO) provides or contracts a statewide network of services relating to prevention, treatment, professional education and training, and research activities to prevent and reduce the adverse impacts of alcohol and other drugs in the Western Australian community. DAO clinical services are integrated with key non-government agencies to provide counselling and treatment services to youth, adults and families and also support local communities to prevent alcohol and other drug problems. DAO supports a comprehensive range of outpatient counselling and residential rehabilitation services, including specialist youth, women's and family services, provided primarily by non-government agencies. Most of these agencies are members of the Western Australian Network of Alcohol and other Drug Agencies (WANADA). Treatment includes: • outpatient and inpatient withdrawal; • assessment and counselling; • rehabilitation; • community-based pharmacotherapy; • supported accommodation; and • treatment for people engaged in a range of diversion programs.	• Funding to DAO is allocated from the Western Australian State Government through the Mental Health Commission. • Funds are allocated within DAO to direct government treatment services; and non-government funded service providers.	• As a statutory authority, DAO reports to the Board of the Western Australian Drug and Alcohol Authority. • DAO reports financial, performance indicators and information on activity and outcomes related to State Government goals in its Annual Report to Parliament. • Performance reporting at State level is through the Treasury budget statements. • At a National level, performance reporting is provided against the Intergovernmental Committee on Drugs (IGCD) (through the Australian Government Department of Health).

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	DAO's Next Step Drug and Alcohol Services comprise: • a specialist clinic in East Perth providing outpatient clinical programs for youth and adults • a residential withdrawal service, including dedicated beds for Aboriginal people • clinical services throughout the metropolitan area that are integrated with Community Drug Service Teams (CDST) • support for a state-wide network of general practitioners providing pharmacotherapy. The Drug and Alcohol Youth Service (DAYS) is an integrated outpatient service, operated as a partnership between Mission Australia and Next Step, for young people between the ages of 12 to 18 and their families. DAYS provides a comprehensive range of alcohol and other drug assessment and treatment services. The service provides comprehensive multidisciplinary assessment and treatment both on-site and on an outreach basis. The WA Diversion Program aims to reduce crime by diverting offenders with drug use problems away from the criminal justice system and into treatment to break the cycle of offending and address their drug use. The Alcohol and Drug Information Service (ADIS) is a 24-hour, state-wide, confidential telephone service providing information, advice, counselling and referral to anyone concerned about their own or another person's alcohol and other drug use. ADIS also encompasses the Parent Drug Information Service (PDIS), a specific support service for parents, and the Quitline telephone counselling service and the Quitline Aboriginal Liaison Team for tobacco users.		

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The Alcohol and Drug Information Service (ADIS) is a 24-hour, state-wide, confidential telephone service providing information, advice, counselling and referral to anyone concerned about their own or another person's alcohol and other drug use. ADIS also encompasses the Parent Drug Information Service (PDIS), a specific support service for parents, and the Quitline telephone counselling service and the Quitline Aboriginal Liaison Team for tobacco users. PDIS works in partnership with other programs within DAO and relevant agencies to provide support for parents and families in WA who may be experiencing alcohol and other drug problems. Callers have the option of talking to a professional counsellor, a volunteer parent or both.		

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Prevention and community action	DAO conducts a range of prevention and early intervention programs and services to: • prevent and delay the onset of alcohol and other drug use • support environments that discourage risky use • enhance healthy community attitudes and skills to avoid risky use • support and enhance the community's capacity to address alcohol and other drug problems • support initiatives that discourage inappropriate supply of alcohol and other drugs. Prevention includes a range of activities: • prevention and early intervention programs and services; • community based education programs; and • public health prevention campaigns and support for regional prevention networks. DAO delivers public health campaigns and initiatives to reduce risky alcohol use and prevent illicit drug use including: • The Alcohol.Think Again campaign encourages and supports communities to achieve a safer drinking culture in WA. • The Drug Aware program focuses on reducing the harm from illicit drugs by encouraging sensible informed decisions about illicit drug use, through providing credible, factual information and delivering comprehensive strategies to address drug-related issues. DAO supports a state-wide network of local drug action groups that deliver preventative activities and education for youth and support for families. DAO also supports school drug education through the state, Catholic and independent school sectors.	State funding is provided	• As a statutory authority, DAO reports to the Board of the Western Australian Drug and Alcohol Authority. • DAO reports financial, performance indicators and information on activity and outcomes related to State Government goals in its Annual Report to Parliament. • Performance reporting at State level is through the Treasury budget statements. • At a National level, performance reporting is provided against the Intergovernmental Committee on Drugs (IGCD) (through the Australian Government Department of Health+D23).

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Programs	DAO provides culturally secure workforce and organisational development programs for human service agencies and staff to respond effectively to Aboriginal people affected by alcohol and other drug use. This involves policy advice and professional education and training, as well as strategic support and planning for treatment and prevention programs. DAO is a Registered Training Organisation offering nationally recognised training that complies with the Australian Quality Training Framework.	State funding is provided, with additional funding from: • WA Department of Families, Housing, Community Services and Indigenous Affairs - Breaking The Cycle of Alcohol and Drug Abuse in Indigenous Communities • COAG, Closing the Gap, Healthy Transition to Adulthood, National Partnership Agreement.	As above. Additional reporting to WA Department of Families, Housing, Community Services and Indigenous Affairs and COAG.
Workforce Development	Workforce development initiatives include: • education and training for a range of human service professionals in health, justice, child protection, community services and for specialist alcohol and drug workers; • clinical placements; and • Indigenous workforce development including nationally recognised certificate III programs for Aboriginal alcohol and drug workers.	Drug and Alcohol Office recurrent State Appropriation	• As a statutory authority, DAO reports to the Board of the Western Australian Drug and Alcohol Authority. • DAO reports financial, performance indicators and information on activity and outcomes related to State Government goals in its Annual Report to Parliament. • Performance reporting at State level is through the Treasury budget statements. • At a National level, performance reporting is provided against the Intergovernmental Committee on Drugs (IGCD) (through the Australian Government Department of Health).

Source : WA Government unpublished.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Health Services	A number of primary health services are accessible across South Australia aimed at providing health care checks and improving the health outcomes of the Aboriginal community across metropolitan, regional and rural areas of SA. Services provided include: • Aboriginal Family Clinic • Aboriginal Primary Health Care Access Program • Watto Purrunna Aboriginal Primary Health Care Service • Aboriginal Well Health Checks Programs • Aboriginal Family Wellness Groups Further targeted services include: • The Strong Fathers, Strong Families Project, encouraging the role and participation of Aboriginal fathers, partners, grandfathers and uncles in their children's and families' lives • Metropolitan Aboriginal Family Birthing Program, providing a culturally respectful and clinically safe program providing continuity of care for Aboriginal women during their pregnancy, birthing, and up to six weeks post natal • Aboriginal Step Down Services, aiming to improve accommodation option, access to appropriate health services and support transition of care • Country Metro Liaison Officers, enhancing the quality, safety and continuum of care for individual Indigenous patients referred to metropolitan and country general hospitals. Additionally, a number of services are provided under the COAG National Partnership on Closing the Gap in Indigenous Health Outcomes, with a specific focus on children, including:	Funding is provided through a mix of: • Commonwealth Government funding • Recurrent State Government and COAG funding • Commonwealth Government funding to a NGO • Commonwealth COAG Indigenous Nation Partnership funding • State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013.	• Monthly, quarterly and annual activity and financial data reporting. • Quarterly activity and financial data reporting to non-government organisation.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	• Aboriginal focus schools and Investing in Aboriginal Youth, providing relationship education, health literacy education and the promotion of health-protective behaviours for Indigenous youth • Children's Services as part of the Making Indigenous Health Everyone's Business initiative, aiming to increase access for Indigenous children and families to health promotion and intensive intervention services through children's services • The Early childhood services including the Aboriginal Family Birthing Program, Aboriginal Step Down Units and initial funding for support for three Aboriginal Patient Pathways Officers • The Aboriginal Health Promotion program. Further information on the above services can be found at www.sahealth.sa.gov.au/wps/wcm/connect/public+content/SA+Health+Internet/Health+services/Aboriginal+health+services/		
Allied Health Services	Non hospital based allied health services (including: speech pathology; occupational therapy; social work; psychology; dietetic/nutrition; and podiatry) are provided through CALHN, CHSALHN and NALHN. Within these services are programs specifically targets at children's health and development, including the Allied Health Services in Children's Centres Program. Allied health services are also provided through the Supported Residential Facilities (SRFs) Allied Health Program, providing assessment and care co-ordination to residents in SRFs who have disability, mental illness and complex chronic health conditions.	Funding provided through: • CALHN Intermediate Care funding • CHSALHN and NALHN funding through recurrent State Government Funding • State Government funding through the Department of Education and Child Development and delivered by CHSALHN.	Quarterly and annual client activity reports.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child Development Services	A number of services aimed at child development services are offered across South Australia, which include: Early Childhood Development Services, providing multidisciplinary interventions for children 0-4 years of age with, or at risk of, developmental delays. Service models are 1:1; group and supported playgroups options for families; and provided from primary health care centres. Children are prioritised according to levels of active adversity with Guardianship of the Minister and Aboriginal children are of the highest priority. The Child Development Unit Program, delivered through WCHN and CHSALHN, providing specialist paediatricians and allied health staff undertake comprehensive assessments of children with complex developmental/ behavioural issues which are impacting on the child's functioning and development.	Funding provided through recurrent State Government funding. The programs are delivered by CALHN, WCHN, and CHSALHN respectively.	Monthly activity and financial data reporting.
	Early Childhood Development and Disability Services, providing multi-disciplinary therapy and health interventions for children 0-5years of age (to school entry) with or at risk of developmental delays or with a disability. Some sites provide services above this age for specific needs.		Financial data reporting only.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Early Childhood Health Services	Under the Child and Family Health Service specific programs are available targeted at support in the early childhood years, including: • The Early Childhood Intervention Program which provides consultants to work within the local community to assist parent access to support services for children aged 0-8 years with a disability and/or developmental delay. • The Early Child Parent Services, providing therapeutic and family support services to families of children aged 0-3 years to improve infant wellbeing, enhance parental capacity and problem solving ability. Teams of Allied Health staff include Aboriginal and culturally specific staff, Psychologists, Social Workers and Family Workers. Services may be provided on an individual or group basis.	Funding is provided through recurrent State Government funding. The service is provided by WCHN staff and delivered under the policy direction of The Department for Education and Child Development (DECD).	Monthly activity and financial data reporting.
Child and Family Health Service	The Child and Family Health Service provides a range of child wellbeing, development and parenting supports for families of children 0-5 years of age, over 120 sites across the state. These are provided in a variety of settings, and include early parenting groups, 1:1 consultations, a residential feeding and settling service, and access to information via the telephone and internet. Where appropriate, families are linked in with other services. Parenting SA is provided through the Child and Family Health Service, offering a population strategy providing information on quality parenting practices for parents and carers of children aged 0-18 years, through free printed Parent Easy Guides for mainstream, Aboriginal and migrant families, free public seminars, and grants to local parent groups.	Funding is provided through recurrent State Government funding. The service is provided by WCHN staff and delivered under the policy direction of The Department for Education and Child Development (DECD).	Monthly activity and financial data reporting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child Health Screening Services `	Newborn and child screening services are available across the state to assist in the early identification of health issues. Such services include: • Universal Contact Visit service providing a visit from a community Child and Family Health Nurse following the birth of a baby • Newborn and Children's Hearing Service providing Universal Neonatal Hearing Screening and the Hearing Assessment service • Autism Diagnostic Service providing specialist paediatricians and allied health staff to undertake comprehensive assessments of children an Autism Spectrum Disorder. The Family Home Visiting Program, under the Child and Family Health provides a nurse led preventative home visiting program over a period of up to two years with a focus on child development and developing family and community relationships.	Funding is provided through recurrent State Government funding and serviced by WCHN staff and delivered under the policy direction of The Department for Education and Child Development (DECD). Autism diagnostic service is State Government funded for 4 years from 1 July 2010 to 30 June 2014.	Monthly activity and financial data reporting.
Community Nursing	A number of community nursing services are provided across the State, which include:		Monthly activity and financial data reporting.
	The CHSALHN Community Nursing Services, providing a broad range of community nursing services across country areas via home care nursing, including post-acute care, pre and post natal care and midwifery in select locations, palliative care, chronic disease management/ support i.e. end stage vascular disease, diabetes, respiratory disease. Provide wound management, burns management, domiciliary oxygen management, continence nursing (including stomal therapy), Diabetes Nurse Educators, breast care nursing and domiciliary care services.	Funding is provided through recurrent State Government funding. The program is delivered by CHSALHN.	

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	Additionally the Community Nursing Service is delivered through RDNS, providing longer term specialised nursing care, education, management and monitoring of clients in the extended community care and palliative care target groups. All referrals go through the Metropolitan Referral Unit.	Funding is provided by the State Government until December 2016. The program is delivered by RDNS.	
	The Health Care at Home program, aiming to provide a short term flexible, rapid response service for clients avoiding an immediate presentation to a metropolitan public hospital or Emergency Department or requiring short term post-acute services. This program operates 24 hours, seven days a week to clients in their homes/community or residential care facilities. 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.	Funding is provided by the State Government until December 2016. The program is delivered by RDNS.	
Criminal Justice Services	The Journey Home service offers mental health and wellbeing support for young people exiting the juvenile justice system, aiming to provide a culturally relevant, family inclusive and effective transition program for young offenders.	Funding is provided by the State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013 and delivered by RDNS.	Monthly, quarterly and annual activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol Services	The Drug and Alcohol Service South Australia (DASSA) deliver a number of drug and alcohol related initiatives statewide aimed at providing support for those suffering from alcohol and substance abuse and related health issues. Services include: • Drug and alcohol support for the Reunification Initiative providing services which aim to 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 • Withdrawal Management Service, offering assessment and inpatient medical detoxification for people withdrawing from alcohol and a range of other drugs • Drug and Alcohol Services Program providing funding to non-government organisations to deliver counselling, residential and non-residential rehabilitation, sobering up services, Mobile Assistance Patrol services and training and sector development. Similarly community based drug and alcohol services provided include: • Alcohol and drug information service, providing a 24 hour telephone information line • Community service centres, providing counselling, assessment and referral services across Adelaide (4 clinics) and regional centres (13 clinics) • The Woolshed, a therapeutic community for 18 years and over with alcohol and drug related problems • Day centres at Ceduna and Port Augusta provide diversionary activities and non-residential rehabilitation and support • The Clean Needle Program, a public health initiative aimed at reducing the spread of blood borne viruses Further information about the above services can be found at www.dassa.sa.gov.au/site/page.cfm?u=455	Funding is provided by: • State Government funding until March 2014 • recurrent State Government funding • funding under the National Health Care Agreement • Commonwealth Government funding and reviewed annually. All programs are delivered by DASSA.	• Ad-hoc reports as required. • Expenditure report at end of financial year. • Monthly activity reports. • Quarterly service activity and financial reports. Annual activity report. National Minimum Data Set – Alcohol and Other Drug Treatment Services (NMDS-AODTS). • Quarterly and annual client activity reports. • Monthly activity reporting. • Six monthly activity and annual

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol Services – Criminal Justice	Drug and alcohol services with a specific focus on the interaction with the criminal justice system include: • The Illicit Drug Diversion Initiative, a service for people apprehended by police for minor drug offences to be diverted from the criminal justice system into education, assessment and treatment • The Community Protection Panel Assertive Case Management (CPPACM) Team, providing 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 Driver Assessment Clinic, assessing drivers for alcohol and/or other drug dependency who have been referred by the Courts Administration Authority and the Registrar of Motor Vehicles • The City Watch House Community Nursing Service (CWHCNS), providing assessment, treatment, management and referral of people held in police custody at the City Watch House.	Funding is provided through: • Annual State Government funding and administered by DASSA • Funding is provided under the National Health Care Agreement • Funding is provided by the State Government until 30 June 2013 • Funding is provided through recurrent State Government funding. Programs delivered by DASSA.	• Quarterly client activity and annual financial reports to DASSA. • Quarterly service activity and financial reports. Appointment summary data. Monthly statistical reports. Annual activity report. Six-monthly progress reports. • Quarterly activity report. Annual attendance / non-attendance reports to Courts Administration Authority and the Registrar of Motor Vehicles.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol services - Aboriginal Health	Services with a focus on drug and alcohol issues within the Aboriginal Community include: • The Aboriginal Population Health Programs, which identify, develop and evaluate strategies that effectively respond to the needs of Aboriginal people and communities affected by substance misuse • The Aboriginal Connection Program, a dedicated drug and alcohol treatment service for Aboriginal clients with complex needs and who are at risk of homelessness, primarily based in metropolitan Adelaide • The APY Lands Substance Misuse Services provide a range of specialist treatment interventions for Anangu with problematic alcohol and other drug use.	Funding is provided through: • Recurrent State Government funding. • State Government funding until December 2013 • Recurrent State and Commonwealth Government funding. Programs delivered by DASSA.	Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Health Promotion	A number of primary and community services and programs with a focus on health promotion including obesity prevention, smoking prevention and active lifestyle promotion. Such services include: • The Eat Well Be Active program, addressing and advocating for programs that support healthy eating and physical activity with children and their families • The Centre for Health Promotion, statewide programs promoting parenting, breastfeeding, youth health and safe sleeping for infants • The Do it for Life Program, a lifestyle modification program 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 • The Tackling Smoking initiative, including: o Specific initiatives aimed at the Aboriginal Community o Quit Smoking initiatives and social marketing campaigns, increasing awareness of the harms associated with tobacco use and encouraging quit attempts o The Quit SA service, smoking cessation support for South Australians through telephone counselling, and internet based information.	Funding is provided through a mix of: • Recurrent State Government and GPS funding, with programs delivered by the relevant LHNs • State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013 • Funding is provided through a contract with SA Health until 30 June 2014. Governance is provided by DASSA and the program is delivered by Cancer Council SA.	• Quarterly activity and financial data reporting. • Quarterly performance and monthly financial data reporting. • Final report completed. • Monthly, quarterly and annual activity and financial data reporting. • Quarterly activity and financial data reporting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Maternal Health Services	A number of programs are accessible across South Australia aimed at providing support and services to pregnant women and their families, these include: • The Pregnancy to Parenting Programs, offering support and education to families in the early pregnancy to early parenting period. 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, psycho social issues, early parenting and child development. Services/activities provided include: antenatal education classes; postnatal reunion; young and pregnant; birth & babies; breastfeeding education; and postnatal support group • The Maternal Health Program, within CHSALHN, has a Country Maternity Services Committee to advise on models of maternity service provision for country communities. Additionally, through this program the Aboriginal Family Birthing Program provides maternal and family services to high risk pregnant Aboriginal women and families at Port Augusta, Whyalla, Ceduna, and Murray Bridge • The Community Midwifery Program, providing antenatal, birthing and postnatal services to women across Country Health South Australia.	Funding is provided through a mix of: • Recurrent State Government funding and delivered by SALHN and CHSALHN • State and Commonwealth Government funding.	Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Oral Health Services	A significant number of oral health programs are undertaken statewide by the South Australian Dental Service (SADS) with such initiatives including: • The Community Dental Service, Specialist Dental Service and Clinical Placements Program, providing emergency and general dental care (including dentures) for adult holders of a concession card and their dependents in public dental clinics • The Population Oral Health Program, undertaking the development and implementation of a Lift the Lip referral tool for general practitioners, nurses and childcare workers. • The School Dental Service, general dental care for pre-school aged, primary and secondary school children under 18 years of age. Additionally, oral health services are provided with a particular focus on vulnerable groups, including: • Oral Health Care for People with Special Needs, identification and referral to dental services of people living in Supported Residential Facilities and those experiencing homelessness • Aged Care Oral Health Projects, improving oral health of certain aged care populations, both in residential care and community living • Aboriginal Oral Health program, aiming to increase attendance of Aboriginal children and adults in mainstream dental services • Services for newly arrived migrants with a refugee background.	Funding is provided through recurrent State Government and SAIP funding. All programs are delivered by SADS.	Monthly activity, waiting list and financial data reporting. Monthly activity and financial data reporting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Palliative Care Services	Palliative care services are delivered across two Local Health Networks, which include: • The provision of palliative care services delivered through CALHN, involving integrated care across in-hospital, hospice and home. Providing 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 • NALHN palliative care services involving integrated care across in-hospital and out-of -hospital settings, linking with other primary care providers for people on an end of life care pathway.	Funding is provided through COAG and GPS matched funding. The programs are delivered by CALHN and NALHN.	KPI's set by the Australian Government Department of Health. Monthly activity and financial reporting.
Primary Health Nursing Programs	Multiple primary health nursing programs are delivered across various areas of metropolitan South Australia, with such programs including: • Primary health nurses work in a range of settings, such as chronic disease and risk factor programs, mental health, cancer care, health ageing, pregnancy and antenatal care • The Virtual Nursing Service, providing specialist nursing care to assist patients with Tuberculosis who have complex medication management and compliance issues to prevent a prolonged public hospital admission • Additionally offered 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.	Funding is provided through: • Recurrent State Government funding and delivered by NALHN • Recurrent State Government funding and delivered by RDNS • Non-recurrent State Government project funding and delivered by NALHN.	Monthly activity and financial data reporting. Quarterly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Refugee and Migrant Health Services	The New Arrival Refugees program is a state wide specialist General Practice service providing a range of health assessment, coordination of health care planning for new arrivals with no known medical history, complex needs and high risk indicators relevant to country or camp of origin. Services include: medical and nursing clinics; health information/ education; immunisation; counselling; and capacity building for other health providers, mainstream GPS etc.	Funding is provided through CALHN Intermediate Care funding. The program is delivered by CALHN.	Quarterly activity and monthly financial data reporting.
Rehabilitation Services	Multiple rehabilitation services are delivered within the metropolitan area, being: The Paediatric Rehabilitation Program, providing rehabilitation consultant services to community clinics to provide specialist medical assessment and intervention. It provides both inpatient and ambulatory intensive rehabilitation programs. Teams are medically led and are comprised of multi-disciplinary Allied Health Professionals. A Movement Disorders Program and Hip Surveillance Service are run through the Paediatric Rehabilitation Department located in the Women's and Children's Hospital The Northern Rehabilitation Service, which provides the maintenance of an individual's independence, function and ability through the provision of inpatient, Rehabilitation in the Home, and outpatient rehabilitation services.	The funding is provided through a combination of recurrent State Government and Federal Government Funding. The program is delivered by WCHN. The funding is provided through a mix of COAG and GPS matched funding and core funding (Casemix). The program is delivered by NALHN.	Monthly activity and financial data reporting. KPI's set by the Australian Government Department of Health. Monthly reporting to COAG and DHA. Annual reporting to COAG and DHA. Daily activity regarding bed capacity. Monthly activity and financial re+D31porting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Rural and Remote Services	Country Health South Australia Local Health Network (CHSALHN) provide a range of primary and community health services in rural and remote areas of South Australia, including: • The GP Plus Services Better Care in the Community Chronic Disease program, servicing 13 sites in country SA, which aims to provide more coordinated and targeted care for people with chronic disease (i.e. respiratory, cardiac and diabetes related conditions) living in country SA thereby avoiding the need for hospitalisation or an extended stay in hospital • The GP Plus Services Country Nurse Initiative, aiming to increase the capacity of primary health care nursing and other service providers to provide quality health services for people with chronic disease in country SA. A key component of this initiative is to enhance the capacity of general practice through targeted support for practice nurses enabling greater involvement in nurse-led chronic disease services. Identified opportunities include direct clinical care and service coordination, maintaining good health through screening, health promotion and education for individuals and the community • The Hep C Nursing Services, establishing nurse-led services for clients with Hepatitis C living in country South Australia. Nurses will have a key role in providing a link between GPs and tertiary services, and will assess and manage Hep C clients as they navigate the pathway through treatment • The Country Home Link and Rapid Intensive Brokerage Support (RIBS) Hospital Avoidance Programs, which 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.	Funding is provided through recurrent State Government funding and programs are delivered by CHSALHN.	Monthly activity and financial data reporting Quarterly reporting to DH about estimated admissions avoided. Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Screening Services	The Port Pirie Lead Implementation Program (Environmental Health Centre) monitors blood in lead levels of the Port Pirie community with a particular focus on pregnant women and children 0-5 years, provides intervention to reduce blood lead levels in children and pregnant women and provides ongoing community education around lead safe practices.	The funding is provided through recurrent State Government funding. The program is delivered by CHSALHN.	Quarterly lead in blood data used as the basis of the Technical Paper produced by the Public Health Department within the Australian Government Department of Health.
Sexual Health Services	The Yarrow Place Rape and Sexual Assault Service provides 24 hour crisis response for recent sexual assault (age 16 years 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.	The funding is provided through recurrent State Government funding. The program is delivered by CALHN.	Monthly activity and financial data reporting.
Men's Primary Health Care Services	The O'Brien Street Medical Practice specialising in Gay Men's Health offers a range of targeted General Practice and primary health care services provided to HIV positive Men in partnership with GP's that are independent contractors. The practice also engages its own multidisciplinary Services: for chronic disease, HIV and HEP C management education/promotion; sexual health clinics; Allied Health, therapeutic and lifestyle counselling within CALHN.	Funding is provided through recurrent State Government funding. The program is delivered by CALHN.	Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Women's Health Services	The provision of numerous women's health services across metropolitan and country South Australia includes: Women's Primary Health Care Services, offering a range of services provided by a multidisciplinary team from 3 community settings 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 The Women's Health Statewide Service, focusing on mental health and the effects of violence and abuse, including referral, counselling in the areas of anxiety and depression related to interpersonal trauma, disordered eating; health information and resource development. Projects include a specific Aboriginal Women's health project. Key populations include Aboriginal and Torres Strait Islander, culturally and linguistically diverse and rural and remote clients. A community development project targeting women of newly arrived communities from countries which practice female genital mutilation. Support to HIV positive and affected women via Women's Health Statewide Service The Southern Women's Health Service, offering programs that focus on domestic violence, mental health and well-being, health information, support for some specific groups of women (e.g. older women, same sex attracted women and Indigenous women), and risk factor and chronic disease management.	Funding is provided through recurrent State Government funding. The service is delivered by WCHN. Funding is provided through recurrent State Government funding and budget variations and Commonwealth Public Health Outcome Funding Agreements – HIV. Governance and delivery are provided by WCHN. Funding is provided through recurrent State Government funding. The service is delivered by SALHN.	Monthly activity and financial data reporting. Quarterly performance reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Youth Health Services	Youth health and wellbeing is serviced across metro and country areas through a range of Youth Primary Health Care Services offered to the community which include: • Healthy lifestyle and counselling primary health care services for young people 18-25 years • Primary health care, sexual health, mental health and drug and alcohol services for young people are provided through community health services and at a youth health service that will become part of GP Plus Health Care Centre, Marion • The Second Story Youth Health Service, providing 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.	Funding is provided through recurrent State Government funding. The service is delivered by NALHN. Funding is provided through recurrent State Government funding. The service is delivered by SALHN. Funding is provided through Commonwealth Public Health Outcome Funding Agreements –HIV. Governance and delivery are provided by WCHN.	Monthly activity and financial data reporting. Monthly activity and financial data reporting. Monthly activity and financial data reporting. Quarterly performance reporting.

Source : SA Government unpublished.

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
Primary Health	Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities. Community Health Centres offer a variety of services including counselling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability and family and child health services.	The majority of funding is allocated from the State budget. During 2012-13 Tasmanian Health Organisations (North, South and North West) were responsible for area spending and overseeing program delivery.	Performance information is collected and reported at the State level through Budget Papers, Annual Report, Key Activity and Performance Information reports
	Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers. The size of sites also varies: small sites provide a limited range of services generally based around community nursing. Rural Health Facilities provide core primary health and community care services within a local community in addition to some inpatient sub-acute beds. In addition, some rural sites provide residential aged care and/or emergency services.	Services are provided in accordance with the Tasmanian Government's Output Budgeting Framework. Services are funded through identified outputs within the DHHS budget. `	National reporting through: National Minimum Data Sets; Report on Government Services; Australian Institute of Health and Welfare (AIHW); Australian Council of Healthcare Standards.
	Palliative Care Services - specialist palliative care clinicians work within a consultancy framework across the health sector to support primary health service providers in urban and rural areas to provide quality palliative care.	Australian Government funds.	Reporting in accordance with specific program requirements.

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
	Other Primary Health services include Aged Care Assessment Teams; Community Equipment Scheme; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Continence Services; Day Centres and Health Promotion activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.	Australian Government funding.	Reporting in accordance with specific program requirements.
	The Australian Government funds the Rural Health Outreach Fund (RHOF) and the Medical Outreach – Indigenous Chronic Disease Program (MO-ICDP) to provide a broad range of outreach medical, nursing and allied health services to rural and remote areas of Tasmania.	Australian Government and State funding	
	Overcoming cultural/language barriers – The Tasmanian DHHS provides access to Interpreter Services for CALD clients in all health settings as required. Overcoming geographical barriers – emergency services are provided at some rural sites and three sites also operate an ambulance service.	Services purchased on an 'as needs' basis	As above
	A range of services are provided on an outreach basis to rural communities from an urban hub – allied health services, Aged Care Assessment Teams, Continence Services, RHOF and MO-ICDP.	Australian Government and State funding	As above

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
	Telehealth is available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs ad external organisations. In addition to Australian Government contributions, the State provides funding to Health Recruitment Plus to assist recruitment and retention of rural general practitioners and to support rural medical practitioners to provide services to rural health facilities around Tasmania.		
Maternal and child health	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.	The service is provided in accordance with the Tasmanian Government's Output Budgeting Framework. Services are funded through identified outputs within the DHHS budget.	Performance Information collected and reported at State level through Budget Papers, Annual Report and the Your Health and Human Services Progress Chart.
Oral Health Services	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.	As above	As above
Alcohol and drug services	Alcohol and drug services provide a range of specialist alcohol and other drug interventions and both individual and population levels.	As above	As above

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
Population and Health Priorities	Population and Health Priorities focuses on population groups (including Indigenous health and women's and men's health) and implements programs aimed at preventing or reducing risk factors that lead to chronic conditions.	As above	As above
Public and Environmental Health Services	Public and Environmental Health Services monitors the health of the Tasmanian population, and implements programs to protect and promote health.	As above	As above
	Overcoming socioeconomic barriers- a range of transport services to access health care is available to people who are transport disadvantaged either because of socioeconomic 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 around the state provide social support and activities for the frail, aged and people with a disability. Community Health provides coordination of community recovery responsibilities covering the human and social elements of disaster recovery.	As above	As above

Source : Tasmanian Government unpublished.

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Community Care, Division of Rehabilitation, Aged and Community Care	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition and social work), acute, post acute and rapid response services, specialist nursing assessments, self management of chronic conditions program, and Falls & Falls Injury Prevention Program.	Through a designated budget: • Some services HACC funded • Remainder ACT Government funded	Monthly and annual reports against a range of indicators including output targets, budget and quality indicators. The ACT Government Health Directorate's Annual Report includes Accountability Indicators related to the achievement of occasions of service targets for nursing and allied health services. HACC outputs data reported quarterly, submitted biannually.
Health Call Centre	The ACT is one of the Australian jurisdictions which jointly funds Healthdirect Australia. Healthdirect Australia procures and contract manages third party providers to deliver telehealth services free of charge to the Australian public. These services include: - 24/7 nurse-based telephone triage - Health advice and information - After Hours GP Line - A Pregnancy, Birth & Babies Helpline and Website - Mental health information portal - HealthInsite - a health and wellbeing information website - National Health Service Directory Healthdirect ensures patients access the right health advice at the right time and identifies other health service providers for improved connection of care.	Jointly funded by the ACT Government and the Australian Government.	Reporting is conducted by Healthdirect

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Community Health Intake	Community Health Intake facilitates access to community health services by providing a single point of entry to services. The public can phone Community Health Intake for information about health services or to arrange appointments with health professionals in community settings. Health professionals can fax referral forms to Community Health Intake for processing. Community Health Intake also has a dedicated GP phone line which provides information about community health services, provides information about clients with existing referrals, and transfers GP calls to other services and programs.	Funded by the ACT Government.	Monthly reporting to operational management
Primary Health Care (afterhours)	• Canberra Afterhours Locum Medical Service (CALMS) is an accredited, primary medical care service available to all ACT residents based on clinical need. The service is operated by General Practitioners and nurses. • CALMS provides high quality accredited, afterhours primary medical care to residents of the ACT, including Residential Aged Care Facilities (RACFs) through clinics at Calvary Public Hospital, the Canberra Hospital and Tuggeranong Health centre and the visitation to patient's place of residence. • The service operates throughout the entire afterhours period i.e., from 6:00pm to 8:30am Monday through Friday, and 24-hours a day on weekends and public holidays. The services is open 365 days per year.	• In 2012-2013 CALMS operated under a Service Funding Agreement (SFA) with ACT Health. • ACT Health funds CALMS based on their operational activity in the previous quarter. • CALMS operates under the policy goals of the ACT Primary Health Care Strategy 2011-2014 that take a broad view of comprehensive and inclusive approach in primary health care.	• The current requirements for ACT Health funded SFAs, require NGOs to provide ACT Health with − 6-monthly financial and performance reports; and − annual audited financial reports and performance requirements reports.

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Justice Health Services	The Justice Health Service provides: 1. The Justice Health Service represents a combination of the Primary Health Team and Forensic Mental Health Services delivered at the Alexander Maconochie Centre (Adults), the Bimberi Youth Justice Centre (Adolescents and Youth) and the Periodic Detention Centre (Adults). The Forensic Mental Health Services also delivers services to the Courts and in the general Community. 2. The Primary Health Team provides and coordinates clinical services at secondary and tertiary level to people in the Alexander Maconochie Centre (AMC) and Bimberi Youth Justice Centre (BYJC) respectively. 3. The Forensic Mental Health Services (FMHS) provides specialist forensic mental health services within the AMC and BYJC for people with moderate and severe mental illness. FMHS also provides Mental Health services at the Courts and to high risk and complex consumers in the Community via their Forensic Community Outreach Service (FCOS).	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Women, Youth and Children Community Health Program	Provides: • 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.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Dental Screening	The Dental Health Program conducts screening and health promotion activities targeting early childhood and primary school aged children, Koori pre-schools and alcohol and drug programs. The Dental Health Program has various Memorandum's of Understandings with external stakeholders to facilitate timely and appropriate access. The targeted client groups include refugees, homeless people, clients with disabilities, mental illness and alcohol and drug programs, Winnunga Nimmityjah Aboriginal Health Services and some specified medical conditions. 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.	Through a designated budget	Monthly reporting through scorecard

Source : ACT Government unpublished.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
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 delivered from community and school based clinics in urban areas and clinics in health centres as well as mobile trucks in remote communities. Services are also provided to eligible clients through the Special Needs clinic and treatment under general anaesthetic is provided in both urban and regional centres. Community level and individual oral health promotion activities are also conducted. Primary and community health objectives targeted: • 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). Population groups served: • children up to school-leaving age and • adults holding a current Healthcare Concession Card or Pensioner Concession Card.	Funding sources: • NT Department of Health • Australian Government via National Partnership Agreements (NPAs) Budget management/oversight by Director Health Development Branch. Governance oversight by Executive Director Territory-wide Services Program delivery via services managed by Health Development Branch.	Routine reporting: • Executive Monthly Performance Reports (internal) and • Department of Health Annual Report, Health Development and Promotion Output report (public). • Quarterly (internal) and bi-annual (public) against both NPAs Implementation reports, (internal/public).

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Men's Health	The Men's Health Strategy Unit (MHSU) provides expert advice, leadership and strategic directions in men's health with a particular focus on Aboriginal male health. The MSHU leads the development of a men's health strategy and strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. The MHSU plays a support role for Aboriginal Male Health Coordinators working in remote communities to engage men and undertake health promotion activities. It coordinates the delivery of urban based male health awareness activities through the 'Pitstop' program. It is involved in staff training on male health aimed at improving service capability for males. The MHSU also encourages and promotes the development of a research effort around gender and health to improve access and use of gendered data to inform program development. Primary and community health objectives targeted: • promoting health and preventing illness Population groups served: • men, with a particular focus on Aboriginal men.	Funding source: Northern Territory Government via Department of Health budget Budget spending / oversight by Director Health Development Branch. Governance oversight by Executive Director Territory-wide Services. Program delivery (limited direct funding) by NT Department of Health and NGO service providers	Routine reporting: Department of Health Annual Report, Health Development and Promotion Output report (public).

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Remote Health	Remote Health delivers 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 collaborates with non-government Aboriginal community controlled health services. 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, 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.	Funding sources: 1. Northern Territory Government via Department of Health budget 2. Australian Government Department of Health through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) • Primary Health Care base • Stronger Futures Remote Services Primary Health Care • Child and Maternal Health • Substance use 3. Medicare Local Northern Territory (MLNT) Primary Health Care Initiative	Routine Reporting: Bi-annual • Financial report to OATSIH • Written report on Child and Maternal Health to OATSIH • Written report on CQI to OATSIH • Written report to MLNT on PHC initiative Annual • Department of Health Annual Report (public). • Financial report to OATSIH
	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.	Budget spending/oversight by Director Remote Health Branch. Governance oversight by Executive Director Territory-wide Services. Program delivered by -Remote Health services and -Remote Health grant funded non-government Aboriginal community controlled organisations.	

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child / Youth Health Services	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. This strategic approach supports frontline staff working directly with children and families, to deliver evidence-based programs, with a focus on client outcomes and program evaluation. There has been significant work in progression of 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 of a child health information management system that allows appropriate program monitoring and workforce planning, indicates areas of high need and that provides a clearer of the picture of children's health in the Territory. Development of a number of high-level discussion papers looking at the drivers of youth (12-24 y.o.) morbidity and mortality in the NT provide the evidence-base for the ongoing development 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.	Funding sources: -Northern Territory Government Department of Health budget, Remote Health Services Output. -Northern Territory Government Closing The Gap funds. -Australian Government Indigenous Early Childhood Development NPA.	Routine reporting: - Department of Health Annual Report, Health Development and Promotion D7Output report (public). Quarterly (internal) and annual external reports against Australian Government Indigenous Early Childhood Development NPA Implementation Plan.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Public Health Nutrition and Physical Activity	Services are delivered both by public health nutritionists usually located within multi-disciplinary teams, and policy officers based in the Strategy Unit. Public health nutritionists (PHNs) 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. They also offer individual and group dietetic consultations through community care centres and health clinics in both urban and remote area. PHNs also work with agencies outside the health sector (e.g. the Department of Families, Housing, Community Services and Indigenous Affairs Stores Licensing Unit and Outback Stores) to increase food security by improving food supply and stimulating demand for healthy food in remote community stores. PHNs also work with the education sector to ensure meals and food provided at schools, are in line with the Australian Dietary Guidelines for Children. The strategy unit focuses on providing strategic direction, developing relevant Northern Territory policies and guidelines, or contributing to national developments (e.g. the development of a new National Nutrition Strategy). At times, this work involves collaboration with other government agencies (e.g. the Northern Territory Department of Education, and research institutions (e.g. Menzies School of Health Research).	Funding sources 1. Northern Territory Government via Department of Health budget 2. Australian Government Department of Health via • the Stronger Futures NT NPA (previously Enhanced Health Services Delivery Initiative) • the NPA on Preventive Health, under the Healthy Children Initiative 3. NT Medicare Local (under Medical Outreach Indigenous Chronic Disease Program) – provision of clinical dietetic services in remote communities. Budget spending/oversight by Health Development Branch Directorate. Governance oversight by Executive Director Territory-wide Services. Program delivered by NT Department of Health with NGO partnerships.	-Department of Health Annual Report, Urban and Remote Health Services Output reports (public). -Quarterly (internal) and annual (public) reports to Australian Government -Monthly activity reporting to NT Medicare Local (internal/public)

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The strategy unit, in partnership with the South Australian Government and the City of Palmerston, are currently piloting 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.		
Health Promotion Strategy Unit	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. 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.	Funding sources -NT Department of Health. -Australian Government via NPAs	-Performance targets against key functions of Community Health and Public Health Services. -Financial reports in Department of Health Annual Report. -Six monthly and annual reports related to Australian Government funding. -Reporting against the Preventative Health NPA and Indigenous Early Childhood Development NPA

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	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 implementing 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, supporting health promotion settings approaches such as health promoting health services and hospitals, providing health promotion information to professionals, communities and individuals in the NT, working with research organisations on identifying affective strategies and enablers to develop a health literate system, 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.		

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Hearing Services	Hearing Services are mostly provided in specialised hearing centres located in remote and urban community health centres, or hospital facilities. 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. The Universal Neonatal Hearing Screening (UNHS) program for permanent hearing loss is provided through all urban birthing hospitals.	Funding sources - NT Department of Health, and -Australian Government for additional ear health and hearing services for Indigenous children. Budget spending/oversight by Directors of Health Development (remote areas) and Community Health Branches (urban areas) Governance oversight by Executive Director Territory-wide Services. Service delivery by Department of Health NT Hearing Program (Community Health) and Hearing Health Program (Health Development).	Routine reporting: Annually Department of Health Annual Report public. Performance targets for Australian Government-funded programs and consented service event data shared with AIHW are published annually.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Condition Services (previously Preventable chronic disease)	The Chronic Conditions Strategy Unit (CCSU) provides leadership and evidence-based advice to support 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 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. Major work completed in 2012-13 including development and trialling of a visual culturally appropriate self management assessment tool, as a collaboration between Flinders University, Menzies school of Health research and NT Department of Health. The Diabetes in Pregnancy NHMRC partnership project has had significant progress with the establishment of a NT clinical register, development of referral pathways for each region, implementation of formal early screening and enrolment in the research project. Commitments of funding from NTG and AG for expanded cardiac services has seen work done on introducing low risk angioplasty, establishment of networked EGCs to enable a centralised database and expansion of cardiac nurse coordinators.	Funding sources Northern Territory Department of Health. Australian Government and NT Government via -Closing the Gap Partnership Agreements to expand services for people with chronic conditions and -NPA / other Health Department funding for chronic conditions prevention related activities.	Routine reporting: Department of Health Annual Report, annual, public. Chronic disease indicators in the Northern Territory Aboriginal Health KPIs. (not public) Quarterly reporting per Closing the Gap NPA.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
School Health Services	Community Health provides a School Health Service to 15 Northern Territory Government middle, secondary and special schools 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: 1. support delivery of health education in: • 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 4. establish networks to facilitate health and wellbeing information to the school community through *partnerships.*	Funding Source Northern Territory Department of Health Budget spending/oversight by Director Community Health. Governance oversight by Executive Director Territory-wide Services Program delivered by Community Health Branch via School Health Service.	Routine reporting: Quarterly internal. Reported in Community Health section of Department of Health Annual Report, annual, public.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Urban Community Health	The Community Health Branch provides a range of key primary health care services directly and in partnership with other health stakeholders across the urban centres of Darwin, Palmerston, Alice Springs, Katherine, Tennant Creek and Nhulunbuy. 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, Sexual Assault Referral Centres and Home Birth Services in Darwin. The Branch participates in regional and national primary health care reforms and seeks to improve access and equity to services for urban communities. The Branch also funds a number of non-government organisations to provide services to achieve outcomes within the areas of Child and Family Health, and Community and Primary Care.	Funding sources -NT Department of Health. -Australian Government funding (for Home And Community Care services via Specialist Nursing program) Budget spending/oversight by Director Community Health Branch. Governance oversight by Executive Director Territory-wide Services. Program delivered by Community Health plus small number of non-government organisations in some regional centres.	Routine Reporting: Department of Health Annual Report, annual, public. -Service events, training and client numbers per the Specialist Nursing program supplied biannually to the Australian Government.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Women's Health	The Women's Health Strategy Unit (WHSU) engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders and coordinates and leads Department of Health responses to this work. 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. 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. 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. Collaborative work has occurred with Branches across the Department to promote screening for family violence and consistent recording in clinical systems to enable better monitoring.	Funding source Northern Territory Government via an identified program within the Department of Health budget. Budget spending/oversight by Director Health Development Branch. Governance oversight by Executive Director Territory-wide Services Program delivery via strong collaboration with NGO partners..	Routine reporting: Department of Health Annual Report, annual public

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Sexual Health and Blood Borne Viruses Program	NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections and blood borne viruses such as HIV/AIDS and Hepatitis C. The program operates five sexual health clinics, known as Clinic 34, in the major towns that aim to improve access to early testing and treatment for STIs and BBVs for member of the priority populations identified in the National STI and BBV strategies. The program provides technical and financial support to primary care services in rural and remote areas. The program funds community based organisations to develop and implement STI and BBV prevention programs, including an NT wide Needle and Syringe Program. Clinical education programs are provided both directly and through supporting the other training organisation. Several research programs are supported, involving both local and national partnerships. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) The Adolescent Sexuality Education Project (ASEP) is a collaboration between the Northern Territory (NT) Department of Education and Children's Services (DECS) and the Department of Health (DoH) in association with the Central Australian Aboriginal Congress (CAAC) and is a component of the National Partnership Agreement on Indigenous Early Childhood Development. The partnership is funded for 5 years by the Office of Aboriginal and Torres Strait Islander Health to provide targeted sexual and reproductive health education to Indigenous adolescents in schools and community settings • promoting health and preventing illness.	Funding source: NT Department of Health. OATSIH and an NPA. • Budget/spending oversight: • NT Department of Health and OATSIH • Delivery oversight: • NT Department of Health • Program delivery: • NT Department of Health, NT AIDS and Hepatitis C Council, Family Planning NT • ASEP: Funding Source: Australian Government NPA • Budget/spending oversight: • NT Department of Health and OATSIH • Delivery oversight: • NT Department of Health • Program delivery: NT Department of Health, NT AIDS and Hepatitis C Council, Family Planning NT	Routine Reporting: Annually and Quarterly reporting against business plan of Sexual Health and Blood Borne Virus Unit, (internal). ASEP Routine Reporting: Quarterly (internal), Quarterly (external) reporting against NPA

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Rheumatic Heart Disease	NT wide program aims to reduce the burden of rheumatic heart disease amongst the Indigenous population by reducing the occurrence of acute rheumatic fever. The program provides health professionals and community members with best practice support, education, resource development and supply and patient care. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) • promoting health and preventing illness	Funding Source: Australian Government NPA • Budget/spending oversight: • CDC – NT DoH • Delivery oversight: • CDC – NT DoH • Program delivery: • CDC – NTDoH	Routine reporting: 6 monthly reporting against NPA
TB Control Unit	The TB Control Unit covers screening of high risk groups (contacts, refugees, prisoners, health workers, Irregular Maritime Arrivals (IMAs) and fisherpersons); monitoring and administration of directly observed treatment for active TB and leprosy; remote community visits to implement preventive and early diagnostic strategies (treatment of latent TB infection, community screening); and provision of information to the public, service providers and governments. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) • promoting health and preventing illness	Funding Sources: • NT Department of Health • DIAC for the Illegal Foreign Fisherman (IFF) and IMAs. • Budget/spending oversight: • CDC - NTDoH • Delivery oversight: • CDC- NTDoH • Program delivery: • CDC - NTDoH	Routine reporting: • Estimates data reports, annually, public • NT Department of Health Annual Report, annual, public.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	CDC provides education and (privately purchased) rabies vaccine for pre-exposure prophylaxis against Australian Bat Lyssavirus (ABL) to persons at risk of occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and some regional centres to those potentially exposed to both rabies virus and ABL. Education programs are provided to the community and to occupational groups. • promoting health and preventing illness	Funding sources: 1) NT Department of Health. 2) Australian Government Department of Health refunds 50% of the cost of rabies immunoglobulin administered to people who are bitten or scratched by bats only. • Budget/spending oversight: • NTDoH • Delivery oversight: • NTDoH • Program delivery: • NTDoH	Routine reporting: • NT Department of Health Annual Report, annual, public.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
NT Trachoma Service	The trachoma service is a public health program that is working towards the global elimination of blinding trachoma. Chlamydia trachomatis is an infectious disease that is the most common cause of preventable blindness and blindness resulting from infection. Australia is the only first world nation that still has blinding trachoma. The Surgery; Antibiotics; Facial cleanliness; Environmental control (SAFE) strategy for the elimination of trachoma underpins service provision. This manifests as: • establishing pathways of referral to ophthalmology services; • training the health workforce to identify Trichiasis (eye lashes abrading the cornea); • conducting screening on high risk populations, and determining the prevalence for a predetermined subset of the at risk population, • coordinating the appropriate pharmacological intervention based upon the prevalence of the trachoma in the population. • training the health workforce to identify Trachoma and how to provide appropriate individual and population controls. • developing and implementing health promotion strategies to enhance the frequency of “clean faces”, which is a key intervention in interrupting the transmission of the infection. • identifying and advocating for the presence of suitable health hardware such as taps and basins, which facilitates hand and facial cleanliness.	Funding source: DoHA – OATSIH via NT Department of Health Budget oversight: program section head Centre for Disease Control (CDC) and the territory program coordinator. Governance oversight: OATSIH, the Director of Centre for Disease Control, the program section head (CDC) and the territory program coordinator Program delivered by: NT Department of Health: CDC, Remote Health, Health Development Unit; NGOs including Sunshine Health Board, Katherine West Health Board, CAAC, Indigenous Eye Health Unit – University of Melbourne, and the Kirby Institute. `	Routine: • Quarterly to OATSIH; Annually in Department’s Annual Report (public)

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The primary goals of the service are: • to reduce the prevalence of trachoma infection to less than 5%. This is evident when high risk populations have demonstrated continuous and sustained prevalence below 5% for at least five years as per the WHO guidelines. • to demonstrate the continuous and sustained reduction of the frequency of Trichiasis to below 1 in 1000 for at least five years in at risk populations. The target population for the service is those at risk of blinding trichiasis / trachoma. This is comprised of indigenous people living in remote locations. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) • promoting health and preventing illness		

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 PBS medicines

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Measure 1: People per pharmacy by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure (computation)	People per pharmacy by region *Definition* The estimated resident population (ERP) divided by the number of pharmacies, in urban areas and in rural areas *Numerator* ERP for urban areas and for rural areas *Denominator* Number of pharmacies in urban and in rural areas *Computation* Numerator ÷ Denominator
Data source/s	University of Adelaide's National Centre for Social Applications of Geographic Information Systems, using Department of Human Services, Medicare pharmacies data and ABS ERP data.

Data Quality Framework Dimensions

Institutional environment	Australian Government Department of Health, PBS data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are presented by State/Territory by urban and rural location. Urban and rural location for ERP is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year from 2012-13. For previous years, geographical location is based on the ABS Australian Standard Geographical Classification 2006 as at 30 June preceding the reference year. 'Urban' constitutes ASGS 'Major cities'. Rural constitutes inner regional, outer regional, remote and very remote areas combined. Urban and rural location for pharmacies is based on the Pharmacy Access/Remoteness Index of Australia (PhARIA) classification. PhARIA is a composite index that incorporates measurements of general remoteness based on the ASGS and previously the ASGC with a professional isolation component represented by the road distance to the five closest pharmacies. 'Urban' is equivalent to the ASGS 'Major cities'. Rural constitutes the remaining PhARIA categories (2 to 6) combined.
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	

Coherence	Estimates are compiled the same way across regions and over time. The ERPs used to derive rates differ across years. For data up to 2010-11 rates are derived using preliminary ERPs based on the 2006 Census. For data from 2011-12 rates are derived using ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data do not include Aboriginal Medical Services that can supply medications to people in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] for the purpose of improving access to medicines for people in those areas. This has particular relevance for the NT, as 43.9 per cent of the population live in remote and very remote areas.
- Disaggregation of data by region is limited to 'Urban' (equivalent to major cities) and 'Rural' (all other areas). Further disaggregation of rural data would be of value.

Measure 2: PBS expenditure per person by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure (computation)	PBS expenditure per person by region *Definition* Expenditure on Pharmaceutical Benefits Scheme (PBS) medicines divided by the ERP, by remoteness area *Numerator* Expenditure on PBS medicines *Denominator* ERP *Computation* Numerator ÷ Denominator
Data source/s	*Numerator* Australian Government Department of Health, PBS Statistics *Denominator* ABS ERP as at 30 June preceding the reference year for 2012-13.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Expenditure data are reported on a cash basis and are available by region only for general and concessional categories. Therefore, data exclude expenditure on doctor's bag and other categories administered under special arrangements, such as, medications dispensed to Aboriginal Medical Services in remote and very remote areas under s.100 of the *National Health Act 1953* (Cwlth) for the purpose of improving access to PBS medicines for Indigenous people and others located in those areas. This expenditure, $36.9 million in 2012-13, is not suitable for computation of expenditure per person as 'catchment' areas for Aboriginal Medical Services cross regional boundaries. Geographical location is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification from 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification. This constitutes a break in time series; data for 2012-13 are not comparable with data for previous years.
Timeliness	Reliable PBS date of supply data are available 16 weeks after the close of the reference period.
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across regions. The change to ASGS based geographical location for 2012-13 from RRMA based geographical location for previous years constitutes a break in time series. Data for 2012-13 are not comparable with data for previous years. Data are not directly comparable to data published in the DoHA annual

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

Accessibility	Information is available for PBS expenditure data from www.pbs.gov.au/info/browse/statistics.
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data are reported only at the national level; reporting by State/Territory is a priority
- Data exclude medications supplied to Aboriginal Medical Services in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] for the purpose of improving access for Indigenous people and others located in those areas.
- Geographical location is based on the ASGS 2011 classification system from 2012-13, a key improvement over the classification system used for previous years that was developed in 1994.

Measure 3: Equity of access to PBS medicines

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure (computation)	Proportion of PBS prescriptions filled at a concessional rate *Definition* The number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. *Numerator* The number of PBS prescriptions filled at a concessional rate *Denominator* The total number of prescriptions filled.
Data source/s	Australian Government Department of Health, PBS Statistics.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are reported by State/Territory.
Timeliness	Reliable PBS supply data are available 16 weeks after the close of the reference period
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across jurisdictions and over time.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Data do not capture medicines supplied by Aboriginal Medical Services in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] for the purpose of improving access to medicines for Indigenous people and others located in these areas. This has particular relevance for the NT as around 43 per cent of the population live in these areas.

Availability of GPs by region

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measures (computation)	Availability of general practitioners (GPs) by region. Definition The number of Full-time Workload Equivalent (FWE) GPs per 100 000 people, by region. Numerator: Number of FWE GPs. Denominator: Estimated Resident Population (ERP) by region. Computation: 100 000 × (Numerator ÷ Denominator).
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: 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 *Human Services (Medicare) Act 1973* (previously *Medicare Australia Act 1973*) and regularly provides the data to DoHA.
Relevance	Geographical location based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year for 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification — urban includes 'Capital city' and 'Other metropolitan area'; rural includes 'Large rural centres', 'Small rural centres', 'Other rural areas', 'Remote centres' and 'Other remote areas'. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991. GP headcount and FWE figures include vocationally recognised as well as non-vocationally recognised general practitioners. GP headcount is a count of all GPs who have provided at least one 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. 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.

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 to 2011-12 under the RRMA based geographical classification, data are reported separately for NSW and the ACT. Data for previous years a 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

The change in geographical location classification constitutes a break in time series. Data for 2012-13 are not comparable with data for previous years.

Estimates are compiled the same way across jurisdictions.

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 for the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994
- Data are reported for 5 regional categories for 2012-13, compared to only 2 broad regional categories for previous years.

Availability of female GPs

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measures (computation)	Availability of female general practitioners (GPs) Definition The number of Full-time Workload Equivalent (FWE) female GPs per 100 000 females. Numerator: Number of FWE female GPs. Denominator: Estimated Resident Population (ERP) of females. Computation: 100 000 × (Numerator ÷ Denominator).
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: 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 *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA.
Relevance	Female FWE GP figures include vocationally recognised as well as non-vocationally recognised female general practitioners. FWE is a standardised measure used to estimate the workforce activity of GPs, adjusting for the partial contribution of casual and part-time doctors. FWE is calculated by dividing each doctor's 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	Estimates are compiled the same way across jurisdictions and over time.
	For data to 2010-11, rates are derived using the ABS 2006 Census based ERP as at 30 June preceding the reference year. From 2011-12, rates are derived using the preliminary ABS 2011 Census based ERP as at 31 Decmber in the reference year.
	Rates derived using ERPs based on different Censuses are not comparable.
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: • Data are of acceptable accuracy.

Early detection and early treatment for Indigenous people

Data quality information has been developed by the Health Working Group for three measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Early detection and early treatment for Indigenous people
Measures (computation)	Definition 1. The proportion of older people who received a health assessment by Indigenous status 2. The proportion of older Indigenous people who received a health assessment, time series 3. The proportion of Indigenous people who received a health assessment, by age group Numerators: The number of 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. 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. 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. Denominators: 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. The population of Indigenous people aged 55 years or over in the reference period. The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period. Computation: 1.–3. 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerators: Australian Government Department of Human Services (DHS), Medicare data. Denominators: Denominators computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS). Total population: ABS various years, *Australian demographic statistics*, Cat. no. 3101.0. For data by Indigenous status: ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment

MBS claims data are an administrative by-product of 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.

The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.

Relevance

These measures relate to specific 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

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, 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.auinternet/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)	Proportion of children who have received a 4 year old development health check. Numerator: The number of people aged 3, 4 or 5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10 986 (Healthy Kids Check or Health Assessment) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period. Denominator: 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. Calculation: 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare Statistics data. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period. For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June in the year preceding the reference period.
Data Quality Framework Dimensions	
Institutional environment	DHS, Medicare processes claims made through the MBS under the *Human Services (Medicare) Act 1973*. These data are then regularly provided to DoHA. 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. Data from 2011-12 are calculated by the Secretariat using numerator data supplied by DoHA and denominator data sourced from the ABS.
Relevance	The measure relates to specific identified DHS, Medicare services for which DHS, Medicare has processed a claim. The MBS items included in this indicator do not cover all developmental health check activity such as that conducted through state and territory early childhood health assessments in preschools and community health centres.
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.

Data to 2010-11 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.

From 2011-12, children are counted only if they have not received a fourth year developmental health check in a previous reference period.

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)	Definition Proportion of people that required GP treatment but deferred that treatment due to cost. Numerator: People reporting deferring access to a GP in the last 12 months due to cost. Denominator: People aged 15 years and over who needed to see a GP in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. 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, from 2011-12, very remote Australia). Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: Data are not available by Indigenous status for this indicator. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on people deferring the purchase of prescribed medicines due to cost but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

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, people living in very remote communities (including discrete Indigenous communities)
- from 2011-12, 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. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

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 2012-13 data used for this measure became available 22 November 2013.

The 2010-11 and 2011-12 data used for this indicator became available in November of 2011 and 2012, respectively.

The 2009 data used for this measure became available in July 2010. Referenced Period: July 2012 to June 2013 (2012-13 data), July 2011 to June 2012 (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 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: sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase will

	improve the reliability of the data, particularly at finer levels of disaggregation. 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 2012-13 survey was 78.9 per cent; 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, from 2011-12, remoteness breakdowns. An exception to this would be State data for Tasmania, ACT and NT, where RSEs are consistently higher than other States. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data. Known Issues: Data were self-reported.
Coherence	Consistency over time: Data are not comparable over time, due to changes in question wording and sequencing in 2011-12, and a further change in sequencing in 2012-13. Data were first collected for this measure in 2009. 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 and 2012-13 surveys, and of 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 23 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*, *2011*-12, and 2012-13 (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 2012-13 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2012-13* (Cat. no. 4839.0). The ABS 2010-11 and 2011-12 Patient Experience data are published in ABS 2011 and 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11* and *2011-12* (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 from 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 for the first time available for the Indigenous population, from the 2012-13 NATSIHS. Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- Data are not comparable over time due to changes in question wording and sequencing. Comparable time series data 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)	Definition Length of time a patient needs to wait to see a GP for an urgent appointment. Numerator Number of people who reported seeing a GP for urgent medical care (for their own health) within specified waiting time categories (less than 4 hours, 4 to less than 24 hours, 24 hours or more). Denominator 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. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Patient Experience Survey, ABS.

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 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, from 2011-12, very remote Australia). Data Completeness: All data are available for this measure from this source.

Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

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 2009, people living in remote communities
- for 2010-11, people living in very remote communities (including discrete Indigenous communities)
- from 2011-12, people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2012-13 data used for this indicator became available 22 November 2013.

The 2010-11 and 2011-12 data used for this indicator became available in November of 2011 and 2012, respectively.

The 2009 data used for this indicator became available in July 2010. Referenced Period: July 2012 to June 2013 (2012-13 data), July 2011 to June 2012 (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 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 size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation. 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 2012-13 survey was 78.9 per cent; 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.

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 RSE between 25 and 50 per cent should be used with caution, and estimates with a RSE over 50 per cent are considered too unreliable for general use.

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: Data for 2012-13 are comparable to data for 2011-12 but are not comparable to data for previous years, due to a significant change in question wording and coding methodology in the 2011-12 survey. Data were first collected for this measure in 2009.

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 and 2012-13 surveys, and of 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 23 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*, *2011-12*, and *2012-13* (Cat. no. 4839.0).

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 data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2012-13 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2012-13* (Cat. no. 4839.0). The ABS 2010-11 and 2011-12 Patient Experience data are published in ABS 2011 and 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11* and *2011-12* (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:

- Data for 2011-12 and 2012-13 are comparable. A significant change in the question wording and coding method for the 2011-12 survey means that data from 2011-12 onwards are not comparable with data for prior years. Comparable time series data is a priority.
- The inclusion of very remote areas from 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 measure 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)	The number of presentations to public hospital emergency departments in hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals), where: • there was a type of visit of Emergency presentation (or, for SA for 2008-09 and 2009-10, Emergency presentation or Not reported) • a triage category of 4 or 5 was allocated • the patient did not arrive by ambulance or police or correctional vehicle; and • the patient was not admitted to the hospital, was not referred to another hospital, and did not die.
Data source/s	This indicator is calculated using data from the 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).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* 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. 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. 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. 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 web pages):

www.aihw.gov.au/nhissc/
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.

Relevance

The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or B (Large hospitals). In 2012–13, hospitals in peer groups A and B provided about 86 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, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council, to be completed by the end of 2013.

The indicator includes only peer group A (Principal referral and Specialist women's and children's hospitals) and peer group B (Large hospitals).

Analyses by state/territory 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 (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, 2011-12 and 2012-13**.**

Accuracy

For 2009-10 to 2011–12, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2012–13, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100% for public

hospitals in peer groups A and B (for review).

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.

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.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence

The data reported for 2012-13 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 2011-12*.

However, 2011-12 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 2010-11, rather than 2011-12, 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: 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:

meteor.aihw.gov.au/content/index.phtml/itemId/181162

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).
- For 2011-12, the coverage of the NNAPEDCD collection is complete for public hospitals in peer groups A and B. It is estimated that 2012-13 has similar coverage, although final coverage cannot be calculated until the 2012-13 NPHED data are available.
- The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council, to be completed by the end of 2013.
- 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)	Definition Proportion of people that deferred purchase of prescribed medicines due to cost. Numerator: Number of people who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost. Denominator: Total number of people aged 15 years or over who received a prescription for medication from a GP in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. 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, from 2011-12, very remote Australia). Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: Data are not available by Indigenous status for this indicator. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on people deferring the purchase of prescribed medicines due to cost but differences in survey design and collection methodology between the Patient Experience survey and the

NATSIHS mean the data are not comparable.

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, people living in very remote communities (including discrete Indigenous communities)
- from 2011-12, 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. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

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 2012-13 data used for this indicator became available 22 November 2013.

The 2010-11 and 2011-12 data used for this indicator became available in November of 2011 and 2012, respectively.

The 2009 data used for this indicator became available in July 2010. Referenced Period: July 2012 to June 2013 (2012-13 data), July 2011 to June 2012 (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 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: sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial

increase from the 2011-12 sample size of 26 437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation. 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 2012-13 survey was 78.9 per cent; 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, from 2011-12, remoteness breakdowns. An exception to this would be State data for Tasmania, ACT and NT, where RSEs are consistently higher than other States. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Known Issues: Data were self-reported.

Coherence

Consistency over time: Data for 2010-11, 2011-12 and 2012-13 are comparable over time but are not comparable to data for 2009, due to a change in question wording and sequencing. Data were first collected for this measure in 2009.

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 and 2012-13 surveys, and of 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 23 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*, *2011*-12, and *2012-13* (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 2012-13 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2012-13* (Cat. no. 4839.0). The ABS 2010-11 and 2011-12 Patient Experience data are published in ABS 2011 and 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11* and *2011-12* (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:

- Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from 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.
- The sample size increase from 26 423 in 2011-12 to 30 749 in 2012-13 strengthens reliability of the population-level estimates.
- 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)	Definition Waiting time between being placed on a public dentistry waiting list and being seen by a dental professional. Numerator: Number of people aged 15 years or 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 1 month, 1 month or more). Denominator: 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. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. 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 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 very remote Australia). Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on public dentistry waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not

comparable.

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.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2012-13 data used for this indicator became available 22 November 2013.

Referenced Period: July 2012 to June 2013.

There are not likely to be revisions to this data after its release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: The sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent.

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 RSE between 25 and 50 per cent should be used with caution, and estimates with a RSE over 50 per cent are considered too unreliable for general use.

Standard Errors: RSEs are greater than 25 per cent for waiting times less than 1 month for SA, the ACT and the NT and should therefore be used with caution.

Known Issues: 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: Data are not comparable over time, due to a significant change in question wording and sequencing in the 2012-13 survey. In 2011-12, respondents were instructed to exclude treatment for urgent dental care and were limited to those whose most recent dental visit was to a government clinic. In contrast, in 2012-13 respondents were not instructed to exclude treatment for urgent dental care and included all people who needed to see a dental professional.

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.

Accessibility

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Data publicly available. Tables showing waiting times for dental professionals are available in *Patient Experiences in Australia: Summary of Findings, 2011-12* and *2012-13* (Cat. no. 4839.0).

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 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 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. The data were collected over a twelve month period and therefore should minimise any seasonality effects in the data.

Other Supporting information: The ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings,*

2011-12 and *2012-13* (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:

- Data for 2012-13 are not comparable with data for prior years due to changes in question wording and sequencing in the 2012-13 survey. Comparable time series data is a priority.
- The inclusion of very remote areas from 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 for the first time available for the Indigenous population, from the 2012-13 NATSIHS. Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The sample size increase from 26 423 in 2011-12 to 30 749 in 2012-13 strengthens reliability of the population-level estimates.

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)	Definition The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided per 1000 people. Numerator: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed. Denominator: ERP. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.
Data source/s	Numerator: Australian Government Department of Health Pharmaceutical Benefits Scheme (PBS) Statistics data. Denominator: ABS preliminary ERP based on the 2011 Census at 31 December in the reference year.

Data Quality Framework Dimensions

Institutional environment	PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by DoHA and administered by the Department of Human Services (DHS), Medicare. Provisions governing the operation of the PBS are contained in the *National Health Act 1953*. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and ABS ERP.
Relevance	These measures relate to PBS subsidised oral antibiotics used most commonly in treating URTI: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names that were ordered by GPs and dispensed to patients were extracted for each reference period. These antibiotics are used to treat a range of conditions in addition to URTI. Data disaggregated by the condition being treated are not available. The proportion of these antibiotics prescribed for treatment of URTI is unknown. Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.
Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	PBS data for 2012-13 are complete. For previous years, PBS data for general patients was available only for items priced above the PBS general

	co-payment ($35.40 in 2012) and therefore, the majority of script data for these patients was missing.
	Data include only prescriptions provided by GPs and OMPs.
Coherence	Data for 2012-13 are not comparable to data for previous years which were available only for concession card holders.
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.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • URTI is one of a range of conditions for which these antibiotics are prescribed. Data are not able to be disaggregated by condition. • The availability of complete data on the selected antibiotics dispensed in the general population significantly improves data quality for 2012-13.

Management of diabetes — annual cycle of care

Data quality information for this measure 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	Chronic disease management.
Measure (computation)	Management of diabetes — annual cycle of care. Definition Proportion of people with diabetes mellitus who have received a Medicare Benefits Schedule (MBS) annual cycle of care Numerator 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. Denominator Number of people diagnosed with Type 1 and Type 2 diabetes in the community. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Numerator DHS, Medicare Statistics 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. Denominator For 2011-12 and 2012-13 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 *Australian Health Survey Users Guide* (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. 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. ABS ERP by remoteness area, as specified in the Australian Standard Geographical Classification, as at 30 June in the year preceding the reference period.

Data Quality Framework Dimensions

Institutional environment

MBS

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;
- 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 2012-13 and 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 diabetes — HbA1c level

Data quality information for this measure has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Chronic disease management
Measure (computation)	Management of diabetes — HbA1c Definition Proportion of people with known diabetes mellitus who have an HbA1c level of less than or equal to 7.0 per cent. Numerator Number of people aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test, who have an HbA1c level of less than or equal to 7.0 per cent. Denominator Number of persons aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	For the 2014 reporting cycle, the denominator and numerator for this indicator use data from the 2011–12 National Health Measures Survey (NHMS) component of the Australian Bureau Statistics (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 *Australian Health Survey: Users' Guide* (cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.

Data Quality Framework Dimensions

Institutional environment	The 2011–12 NHMS 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.
Relevance	For this measure, the fasting plasma glucose test is used in the determination of people with known diabetes and the HbA1c test is used in the determination of effective management of diabetes. The 2011-12 NHMS uses a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of known diabetes. A respondent to the survey is considered to have known diabetes if they had ever been told by a doctor or nurse that they have diabetes and: • they were taking diabetes medication (either insulin or tablets) **or**

- their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L.

Persons with known diabetes who have an HbA1c result of less than or equal to 7.0 per cent are considered to be managing their diabetes effectively.

The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.

Timeliness

The NHMS was conducted for the first time in 2011–13. Results from the 2011-12 NHMS were released in August 2013. Results from the NATSIHMS will be released in 2014.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.

All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 38 per cent went on to complete the biomedical component.

Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005).

In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.

As they are drawn from a sample survey, data for the indicator 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.

This indicator produces high levels of sampling error for some States and Territories when split by sex. Estimates for males and females in Victoria have RSEs greater than 50 per cent and should be considered unreliable for general use. Likewise, estimates for males in the Northern Territory and females in the Australian Capital Territory also have RSEs greater than 50 per cent.

Data for several State and Territories also have RSEs greater than 25 per cent, including the total for Victoria, South Australia, the Australian Capital Territory and the Northern Territory, and these estimates should be used with caution.

Coherence	The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes management. The 2009-10 Victorian Health Monitor (VHM) reported estimates of diabetes management based on the proportion of people with known diabetes meeting the HbA1c management target of less than or equal to 7.0 nmol/L. The VHM age-standardised rate (39 per cent) was similar to the NHMS rate for Victoria (36 per cent).
Accessibility	See *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005). Other information from this survey is also available on request.
Interpretability	Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website. Many health-related issues, including diabetes, are closely associated with age. However, numbers across age ranges were too few to do any meaningful age standardisation at the State/Territory level for this measure. Therefore the data presented are based on crude rates.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- State and Territory data by Indigenous status are anticipated to be available for the 2013-14 report.
- The 2011-12 National Health Measures Survey (NHMS) was conducted for the first time as part of the 2011–13 Australian Health Survey (AHS), with participation voluntary in the NHMS. Of those who took part in the AHS, 38 per cent took part in the NHMS. The NHMS sample was found to be representative of the AHS population.
- The NHMS does not include people living in very remote areas, which affects the comparability of the NT results.

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 Definition Proportion of people with asthma who have a written asthma action plan. Numerator Estimated number of people with asthma with a written asthma action plan. Denominator Estimated number of people with asthma. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Data reported for 2011-12 are from the National Health Survey (NHS) component of the ABS Australian Health Survey (AHS). Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS. The denominator and numerator 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 *Australian Health Survey: Users' Guide* (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. Estimates for 2004-05 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 2011-12 and 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 2011-12 NHS component of the AHS were released in October 2012.

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 approximately 23 per cent of the population. Results are weighted to account for non-response.

The response rate for the 2011-12 NHS was 85 per cent and for the 2007-08 NHS was 91 per cent.

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.

Coherence

Questions used in the 2011-12 and 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). Data for 2011-12 and 2007-08 are comparable over time (except for the Northern Territory) but are not comparable to data from the 2004-05 survey due to better alignment of questions and concepts with the ACAM recommendations since 2004-05.

Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size in 2011-12.

The NHS and NATSIHS collect a range of other health-related information (for example, information on smoking) that can be analysed in conjunction with data on asthma and asthma plans.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

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 *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' 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

DHS, Medicare processes and collects MBS data for:

- claims made through the MBS under the *Health Insurance Act 1973*. These data are regularly provided to DoHA.
- 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.

MBS claims data are an administrative by-product of DHS, Medicare's fee-for-service payment systems.

For reference periods to 2009-10, DoHA provided raw data and rates inclusive of DVA data.

From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.

Indicator

The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:

Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'.

Diagnostic imaging services — all items in BTOS 'G'.

Claims are allocated to state/territory based on location at which the service was rendered.

Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.

Measures (computation)

Measure 1

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 (age-standardised)

Definition

The number of MBS items rebated through DHS, Medicare for pathology tests requested by specialist GPs and OMPs, per person (age-standardised)

Numerator:

The number of MBS items rebated through DHS, Medicare for pathology tests requested by GPs and OMPs

Denominator:

Estimated Resident Population (ERP)

Computation:

Numerator ÷ Denominator, age-standardised

Measure 2

Diagnostic imaging services provided on referral from specialist GPs and OMPs and rebated through DHS, Medicare, per person (age-standardised)

Definition

The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs, per person (age-standardised)

Numerator:

The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs

Denominator:

Estimated Resident Population (ERP)

Computation:

Numerator ÷ Denominator, age-standardised

Measure 3

DHS, Medicare benefits paid per person for pathology tests requested by GPs and OMPs (age-standardised).

Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) to provide real expenditure, comparable over time.

Measure 4

DHS, Medicare benefits paid per person for diagnostic imaging referred by GPs and OMP (age-standardised)s.

Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) to provide real expenditure, comparable over time.

Data source/s

Numerator:

- 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.

Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP). For reference periods prior to and including 2009-10 ERP as at 30 June, based on the 2006 Census. From the 2010-11 reference year ABS ERP as at 31 December, based on the 2011 Census.

Data Quality Framework Dimensions

Institutional environment

DHS, Medicare processes and collects MBS data for:

- claims made through the MBS under the *Health Insurance Act 1973*. These data are regularly provided to DoHA.
- 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.

MBS claims data are an administrative by-product of DHS, Medicare's fee-for-service payment systems.

For reference periods to 2009-10, DoHA provided raw data and rates inclusive of DVA data.

From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.

Relevance

The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:

- Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'.
- Diagnostic imaging services — all items in BTOS 'G'.

Claims are allocated to state/territory based on location at which the service was rendered.

Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.

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

Rates for 2012-13 are age-standardised to the 2001 Australian Standard Population. These data are not comparable to crude rates reported for previous years.

Data were computed by DoHA for this indicator for reference years prior to and including 2009-10, using the 2006 Census based ERP as at 30 June preceding the reference year.

From 2010-11, data are computed by the Secretariat from numerator data obtained separately from DoHA and the DVA, using the ERP as at 31 December based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility

MBS

DHS, Medicare claims statistics are available at www.health.gov.au/ nternet/main/ publishing.nsf/Content/Medicare+Statistics-1;

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: • Age-standardisation of rates for 2012-13 is a significant improvement. However, rates are not comparable with crude rates reported for previous years. • 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)	Measure a: Definition Proportion of people satisfied with selected aspects of GP care. Numerator 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. Denominator People who saw a GP for their own health in the last 12 months, excluding people who were interviewed by proxy. Measure b: Definition Proportion of people satisfied with selected aspects of dental professional care. Numerator 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. Denominator People who saw a dental professional in the last 12 months, excluding people who were interviewed by proxy.
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 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, from 2011-12, very remote Australia).

Data Completeness: All data are available for this indicator from this source.

Indigenous Statistics: Data are not available by Indigenous status for this indicator. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

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, people living in very remote communities (including discrete indigenous communities)
- from 2011-12, people living in discrete indigenous communities.

From 2011-12, the Patient Experience survey included 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 where people usually resident in very remote areas account for about 23 per cent of the population. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

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: data for 2012-13 became available 22 November 2013; 2011-12 data became available 23 November 2012; 2010-11 data became available November 2011.

Referenced Periods:

- July 2012 to June 2013.

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 size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase

will improve the reliability of the data, particularly at finer levels of disaggregation. The sample size for 2010-11 was 26 423 fully-responding households.

Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent; response rate for the 2010-11 survey was 81.4 per cent.

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.

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) and discrete indigenous communities (from the 2011-12 survey) will affect the NT more than it affects other jurisdictions. (People usually resident in very remote areas account for about 23 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*, *2011-12* and *2012-13* (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.

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: 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, ABS 2012 and ABS 2013 *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12* and *2012-13* (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, 2012 and 2013 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12* and *2012-13*, Cat. no. 4839.0.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data are for the first time available for the Indigenous population, from the 2012-13 NATSIHS. Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The sample size increase from 26 423 in 2011-12 to 30 749 in 2012-13 strengthens reliability of the population-level estimates.

Health assessments for older people

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Health assessments for older people
Measures (computation)	Definition The proportion of older people who received a health assessment. Numerator: The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of Indigenous people aged 55 years or over with an MBS claim for Items 704, 706 (Health assessment for older Aboriginal and Torres Strait Islander People) or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period. Denominator: The population of 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. Computation: 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Denominator computed by the Secretariat using Australian Bureau of Statistics (ABS) 2006 Census based ERP. Total population: ABS various years, *Australian demographic statistics*, Cat. no. 3101.0. For data by Indigenous status: ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of 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. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.
Relevance	These measures relate to specific 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.

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

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 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 Numerator: Nominal expenditure on services rendered by GPs and OMPs. Denominator: Estimated Resident Population (ERP). Computation: Numerator ÷ Denominator, directly age-standardised from 2012-13; crude rates for previous years. Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) to provide real expenditure, comparable over time.
Data source/s	Numerator: • For MBS data: Department of Human Services (DHS), Medicare data sourced by the Australian Government Department of Health • 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. Denominator: 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: • claims made through the MBS under the *Health Insurance Act 1973*. These data are regularly provided to DoHA. • 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. MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems.
Relevance	The measure relates to: • 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. 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. For 2012-13, data exclude expenditure on services provided under the Practice incentive program (PIP), Medicare Locals and the General Practice Immunisation Incentive Scheme (GPII) as these data cannot be subjected to age-standardisation.
Timeliness	Data include all claims processed in the reference period.
Accuracy	From 2012-13, DHS, Medicare data include claimed services by GPs and OMPs as well as by practice nurses or registered Aboriginal health workers for and on behalf of the GMP/OMP. For previous years, DHS, Medicare data also include services rendered under PIP, DGPP and GPII. DVA data are limited to claims for services provided by specialist GPs. Data include all claims processed in the reference period.
Coherence	Age-standardised rates reported for 2012-13 are not comparable with crude rates reported for previous years due to the effect of age standardisation and the exclusion of services rendered under PIP, DGPP and GPII from age-standardised rates. 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 2011 Census-based ERP as at 31 December for all reference periods..
Accessibility	MBS DHS, Medicare claims statistics are available at: www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1; 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: • 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

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) with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Child immunisation coverage.
Measures (computation)	Proportion of children who are fully vaccinated at the age of: - 12 months to less than 15 months - 24 months to less than 27 months - 60 months to less than 63 months. Definition Proportion of children who are fully vaccinated at the specified ages. Different methodology was applied to compute current year data to that used for historical data. *Current year data*: Numerator children who turned 1, 2 and 5 years of age in the reference year who were recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) in the 2012-13 reference year. Denominator number of children who turned 1, 2 and 5 years in the reference year registered on ACIR. *Historical data*: Numerator number of children who turned 1, 2 and 5 years of age 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. Denominator number of children who turned 1, 2 and 5 years between 1 January and 31 March in the reference year registered on ACIR as at 30 June in the reference year. Computation: 100 × (Numerator ÷ Denominator), presented as a rate per 100 children aged 1, 2 and 5 years.
Data source/s	The Australian Childhood Immunisation Register (ACIR).

Data Quality Framework Dimensions

Institutional environment

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.

Immunisations are notified to DHS, Medicare by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments.

For information on the institutional environment of the ACIR, including the legislative obligations of the ACIR, financing and governance arrangements, and mechanisms for scrutiny of ACIR operations, please see www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.

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).

Relevance

The ACIR records details of vaccinations given to children under seven years of age who live in Australia.

Children assessed as fully immunised at one year of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, *Haemophilus influenzae* type b and pneumococcal.

Children assessed as fully immunised at two years of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, *Haemophilus influenzae* type b and measles, mumps and rubella.

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.

There are possible gaps in coverage due to unknown vaccination status of children less than 5 years migrating to Australia. The extent of this is not currently quantifiable.

The analyses by state/territory are based on postcode of residence of the child as recorded on ACIR.

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.

Provider notification payments and links to family assistance payments for parents have helped minimise under-reporting by providing a financial incentive for parents to vaccinate their children and for providers to 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/provider/patients/acir/statistics.jsp. 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.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.

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 12 to 15 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and pneumococcal.
- Data have been reported using the program definition of fully immunised for children aged 24 to 27 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b, and measles, mumps, and rubella.
- 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.
- From 31 December 2013, reporting of vaccination coverage rates will be amended to include pneumococcal in the 12 to < 15 month cohort.
- From 31 December 2014, reporting of vaccination coverage will be amended to include meningococcal C and varicella in the 24 to < 27 month cohort.
- From 31 December 2017, reporting of vaccination coverage will be amended to remove the assessment of MMR in the 60 to < 63 month cohort.
- Given these changes, trends in vaccination coverage rates over time need to be interpreted carefully

Notifications of selected childhood diseases

Data quality information for this indicator has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Notifications of selected childhood diseases.
Measures (computation)	Notifications of measles for children aged 0–14 years Notifications of whooping cough (pertussis) for children aged 0–14 years Notifications of invasive *Haemophilus influenzae* type b (Hib) for children aged 0–14 years Definition Number of notifications reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years by date of diagnosis, per 100 000 children aged 0–14 years for: - measles - whooping cough (pertussis) - invasive *Haemophilus influenzae* type b (Hib). Numerator number of notifications reported to the NNDSS for children aged 0–14 years in the reference period. Denominator estimated resident population of children aged 0–14 years at 31 December in the reference period. Computation: 100 × (Numerator ÷ Denominator), presented as a rate per 100 000 children aged 0–14 years.
Data source/s	Numerator: The National Notifiable Diseases Surveillance System (NNDSS) Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 31 December in the reference period (ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0).

Data Quality Framework Dimensions

Institutional environment

The NNDSS is administered and operated by the Department of Health.

Notifiable diseases are notified to the relevant State/Territory government health departments by clinicians and laboratories under jurisdictional public health legislation. The Department of Health receives data for these notifiable diseases under the *National Health Security Act 2007*.

For information on the institutional environment of the NNDSS, including the legislative obligations of the NNDSS, financing and governance arrangements, and mechanisms for scrutiny of NNDSS operations, please see www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi2903q.htm.

Relevance

Nationally notifiable diseases require notification of the relevant State/Territory health authority upon diagnosis. Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions. State/Territory health authorities notify the NNDSS of notified cases.

Allocation to State/Territory is by postcode of residence of the case as provided by the notifying doctor or laboratory.

Timeliness

State/Territory health authorities notify data to the NNDSS on a daily basis. Data include all notifications for the selected diseases for each reference period (financial year).

Accuracy

Measles and invasive Hib

The 'notified fraction' represents the proportion of total cases for which notification is made. This is expected to be high for measles and invasive Hib as it is uncommon for either disease to go undiagnosed, due to the often severe presentations of the disease. Comprehensive follow up of the contacts of all cases also enables identification of cases.

Pertussis (whooping cough)

The notified fraction for whooping cough is likely to be only a proportion of the total number of cases that occur, as identification of pertussis is limited by patient and physician awareness, testing practices and in some cases, the united sensitivity of diagnostics tests. Pertussis is generally believed to be significantly under-diagnosed.

ERPs to 31 December 2010 are the ABS' final 2011 Census rebased ERPs. ERPs from 31 December 2011 are ABS first preliminary estimates based on the 2011 Census.

Data for the number of notifications are suppressed for confidentiality reasons where the number of notifications was less than 3.

Data for notification rates are suppressed where there were less than 5 notifications.

Coherence

Data are reported for each financial year in the period 2006-07 to 2012-13.

Changes in surveillance and testing methods over time and by jurisdiction may make comparisons both over time and across jurisdictions difficult. Changes in the national case definition criteria for establishing a case may

	affect the coherence of the data over time. The current NNDSS case definition, including historical edits, can be found at www.health.gov.au/casedefintions.
Accessibility	The Department of Health publishes aggregated levels of data from the NNDSS on its website www9.health.gov.au/cda/source/cda-index.cfm. Data are updated on a daily basis.
Interpretability	The current NNDSS case definitions, including edits, can be found at www.health.gov.au/internet/main/publishing.nsf/Content/cdna-casedefinitions.htm.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: Whooping cough notifications may undercount the actual number of cases that occur as diagnosis cannot always be confirmed using currently available diagnostic tools.

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)	Definition This indicator presents the number of women within the national target age group (20–69 years) screened in a 2 year period as a proportion of the eligible female population and age-standardised to the Australian standard population at 30 June 2001. The eligible female population is the average of the Australian Bureau of Statistics (ABS) estimated resident female population for the 2 year reporting period. This population is adjusted for the estimated proportion of women who have had a hysterectomy using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. Numerator Total number of women aged 20–69 years who were screened in the 2 year period. Denominator Average number of women aged 20–69 years in the same 2 year period, adjusted using national hysterectomy fractions to exclude the estimated number of women who have had a hysterectomy. Computation/s: 100 × (Numerator ÷ Denominator) and age-standardised to the Australian population at 30 June 2001.
Data source/s	Numerator State and territory cervical cytology registers. Denominator For total population: ABS estimated resident population 2011 Census based (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.

Data Quality Framework Dimensions

Institutional environment	The National Cervical Screening Program (NCSP) is a joint program of the Australian Government and State and Territory governments. The target age group is women aged 20–69 years. Cervical cytology registries in each state and territory are maintained by jurisdictional Program managers. Data are supplied to the registries from pathology laboratories. Data from cervical cytology registers are provided to the Australian Institute of Health and Welfare (AIHW) annually in an aggregated format. The NCSP is monitored annually. Results are compiled and reported at the national level by the AIHW in an annual *Cervical screening in Australia* report. The Institute is an independent statutory authority within the Health and Ageing portfolio. It is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website (www.aihw.gov.au).
Relevance	The data used to calculate this indicator are accurate and of high quality. The cervical cytology registers collect information on all Pap tests undertaken in Australia except where women advise the clinician they do not wish to have their data collected. The use of ERP based on Census data for denominators provide the most comprehensive data coverage possible. The data are entirely appropriate for this indicator.

	For participation by state and territory, the numerator is the number of women aged 20–69 years screened in each state and territory in the reference period, except for Victoria and the ACT where data are for residents (and some immediate border residents) of the jurisdiction only. Data are supplied as aggregated data by each state and territory. The denominator is the average of the ABS ERP for women aged 20–69 years in each State and Territory, adjusted to exclude the estimated number of women who have had a hysterectomy, using national hysterectomy fractions.
	Caution is required when examining differences across states and territories of Australia due to the substantial differences in population, area, geographic structure, policies and other factors.
Timeliness	The most recent data available for the 2014 RoGS report are based on the two-year calendar period 1 January 2011 to 31 December 2012. 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 and are consistent across reports published at similar times.
	Rates may differ from those presented in reports published in 2011 or previous years which are derived from ABS 2006 Census based ERPs.
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 2009–2010*.

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)	Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions. The *numerator* is the number of separations for selected potentially preventable hospitalisations, for each of the following three groups and their sub-categories: • Vaccine-preventable conditions - Influenza and Pneumonia - Other vaccine preventable conditions (e.g. tetanus, measles, mumps, rubella) - Total. • Acute conditions - Appendicitis with generalised peritonitis - Cellulitis - Convulsions and epilepsy - Dehydration and gastroenteritis - Dental conditions - Ear, nose and throat infections - Gangrene - Pelvic inflammatory disease - Perforated/bleeding ulcer - Pyelonephritis - Total acute conditions - Total acute conditions (excluding dehydration and gastroenteritis) • Chronic conditions - Angina - Asthma - Chronic obstructive pulmonary disease - Congestive heart failure - Diabetes complications (principal diagnosis only) - Hypertension - Iron deficiency anaemia - Nutritional deficiencies - Rheumatic heart disease

- Total

- Total (excluding diabetes complications as additional diagnoses).

- Total selected potentially preventable hospitalisations (excluding dehydration and gastroenteritis and excluding diabetes complications as additional 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 B, *Australian hospital statistics 2011-12*).

Calculation is 1000 × (Numerator ÷ Denominator), presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

Data source/s

Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.

Denominator:

For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2011.

For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June 2011.

For data by remoteness: ABS ERP as at 30 June 2011, by remoteness areas, as specified in the Australian Statistical Geography Standard 2011 (ASGS).

Computation:

1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for 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.

'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 2011-12.

Accuracy

For 2011-12, 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 AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88% of Indigenous Australians were identified correctly in hospital admissions data in the 2011–12 study period, and the 'true' number of separations for Indigenous Australians was about 9% higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

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 2011-12* and *Australian hospital statistics 2011-12*.

However, caution should be used when comparing 2007–08 with later years due to changes between the ICD-10-AM 5th edition (used in 2007–08), the ICD-10-AM 6th edition (used in 2008–09 and 2009–10) and ICD-10-AM 7th edition (used in 2010–11 and 2011–12) and the associated Australian Coding Standards that resulted in:

- decreased reporting of additional diagnoses for diabetes
- increased reporting of diagnoses for dehydration and gastroenteritis.

In light of these comparability issues, the data presented for 2011–12 exclude:

- Diabetes complications (additional diagnoses only) from the chronic conditions category, and
- Dehydration and gastroenteritis from the acute conditions category, and
- Diabetes complications (additional diagnoses only) and dehydration and gastroenteritis from the total.

However it should be acknowledged that these data are not consistent with the original intent of the indicator.

In addition, Tasmanian data are not comparable over time as 2008–09 data for Tasmania does not include two private hospitals that were included in 2007–08 and 2009–10 data reported in the National Healthcare Agreement performance reports.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

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, accessible at meteor.aihw.gov.au/content/index.phtml/itemId/529483 and the National health data dictionary, accessible atwww.aihw.gov.au/publication-detail/?id=10737422826.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- 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.
- National level data by Indigenous status for 2011-12 include all States and Territories for the first time and are not comparable with data for 2010-11 and prior years.
- Caution should be used in interpretation of data disaggregated by Indigenous status due to variation among jurisdictions in the quality of the Indigenous status data.

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)	Selected potentially preventable hospitalisations for diabetes. The *numerator* is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups: • Circulatory complications (E11.5x) • Renal complications (E11.2x) • Ophthalmic complications (E11.3x) • Other specified complications (E11.0x, E11.1x, E11.4x, E11.6x) • Multiple complications (E11.7x) • No complications (E11.9x) • Total. The *denominator* is the Estimated Resident Population. A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Potentially preventable hospitalisations for diabetes are defined by ICD-10-AM diagnosis codes. Calculation is 100 000 × (Numerator ÷ Denominator), presented as a number per 100 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 years 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 2011. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for 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 2011-12.

Accuracy

For 2011-12 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 2011-12* and the *National healthcare agreement: performance report 2011-12*. 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 2011-12) 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)	Potentially preventable hospitalisations of older people for falls. The number of hospitalisations for people aged 65 years or over with a reported external cause of falls, per 1000 people. The *numerator* is the number of hospitalisations for people aged 65 years or over with a reported external cause of falls. The *denominator* is the Estimated Resident Population. A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Potentially preventable hospitalisations for falls are defined by ICD-10-AM external cause codes (W00–W19). Calculation is 1000 × (Numerator ÷ Denominator), presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined.
Data source/s	Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for 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 periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12.

Accuracy

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 and 2011-12, 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 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.

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

NT data are not available for 2010-11, and are excluded from the Australian total for that year. With this exception, data for this indicator are comparable over time.

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:

- 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.

12 Mental health management

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.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.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the Australian, State and Territory governments' management of mental health and mental illnesses through a variety of service types and delivery settings.

The following improvements have been made to the chapter this year:

- a case study on how follow-up community care can influence psychiatric inpatient hospital readmission within 28 days has been included

- a new indicator on seclusion events has been added to the framework — this is the first mental health management safety indicator to be included
- 'average cost per community treatment day' has replaced the 'average cost per three month community care period' measure to provide a better measure of unit costs
- the 'services reviewed against the National Standards' indicator has been revised to weight the results for expenditure, to provide a better understanding of the share of activity covered by the different assessment levels
- time series data reporting in some attachment tables has been expanded, in particular, seven years are now reported for most data for State and Territory governments' specialised mental health services
- data quality information (DQI) is available for the first time for the indicators 'new client index', 'primary mental health care for children and young people', 'collection of outcomes information', 'readmissions to hospital within 28 days of discharge', 'rates of illicit and licit drug use' and 'mental health outcomes of consumers of specialised public mental health services'.

12.1 Framework for measuring health management performance

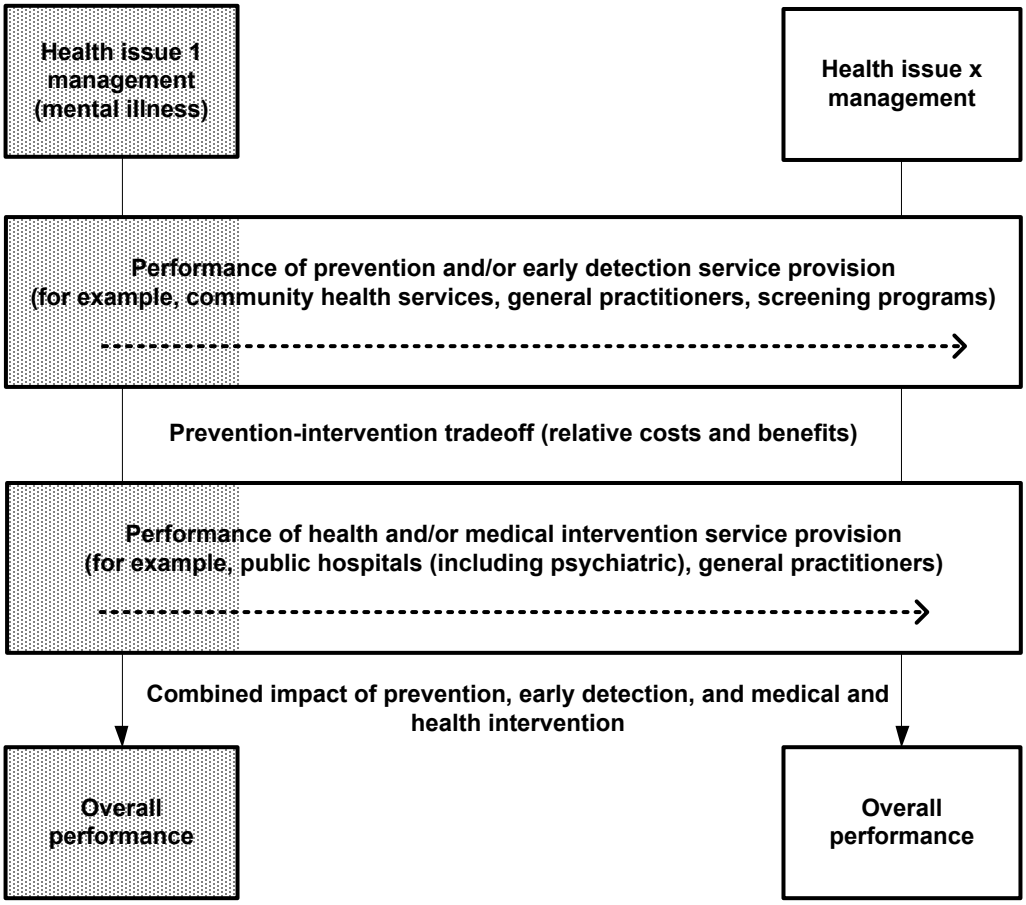
Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of service providers in specific settings, and the overall management of diseases, illnesses and injuries across a spectrum of services, including prevention, early detection and treatment programs. The measurement approach is summarised in figure 12.1.

The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue. The Health sector overview in this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular

service delivery mechanisms. The mental health management performance framework provides information on the interaction and integration arrangements between General Practitioners (GPs) (as the key providers of primary health), community-based and hospital-based providers in meeting the needs of people with a mental illness.

Figure 12.1 **The Australian health system — measurement approach**



12.2 Profile of mental health management

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

> … a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental health is identified by governments as a national health priority area as are cancer, asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions, and obesity. The national health priority areas represented over 70 per cent of the total burden of disease and injury in Australia in 2003 and mental illnesses contribute significantly to this total burden (13.3 per cent) (Begg et al. 2007). The total burden comprises the number of 'years' lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of 'healthy' life lost due to disability). Mental illness is the leading cause of 'healthy' life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg et al. 2007).

Mental illness is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments. The most common mental illnesses are anxiety, affective (mood) and substance use disorders. Mental illness also includes low prevalence conditions such as schizophrenia, bipolar disorder and other psychoses, and severe personality disorder (DoHA 2010). While of lower prevalence, these conditions can severely affect people's ability to function in their daily lives (Morgan et al. 2011).

Specialised mental health management services offered by a range of government and non-government service providers include promotion, prevention, treatment, management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Mental health is also the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health and other, services. The performance of public hospitals is reported in chapter 10 and the performance of primary and community health services is reported in chapter 11.

This chapter focuses on the performance of State and Territory specialised public mental health services that treat the mostly low prevalence, but severe, mental

illnesses. It also includes performance data on the mental health services provided by GPs, psychiatrists and other allied health professionals under the Medicare Benefits Schedule (MBS).

Other health and related services are also important for people with a mental illness, including alcohol and drug treatment services (chapter 11), public hospitals (chapter 10) and aged care services (chapter 13). This Report does not include specific performance information on these services' treatment of people with a mental illness. Mental health patients often have complex needs that can also affect other government services they receive, such as those covered in chapter 4 (School education), chapter 8 (Corrective services), chapter 9 (Fire and ambulance services), chapter 14 (Services for people with disability) and chapter 18 (Homelessness services).

Some key terms used in mental health management are outlined in section 12.6.

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of specialised public mental health services including admitted patient care in hospitals, community-based ambulatory care services and community-based residential care (for further details see the sector scope section later in this chapter). Some of these services are provided by non-government organisations, for example governments' can fund private and non-government entities to provide admitted patient hospital care. State and Territory governments also fund not-for-profit, non-government organisations (NGOs) to provide a range of support services for people with psychiatric disability arising from a mental illness.

The Australian Government is responsible for the funding of the following mental health services and related programs:

- MBS-subsidised services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers)
- Pharmaceutical Benefits Scheme (PBS) funded mental health-related medications
- other specific programs, including those provided by the non-government sector, designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health-related services through the Medicare Safety Net, the Department of Veterans' Affairs (DVA) and the Private Health Insurance Premium Rebates.

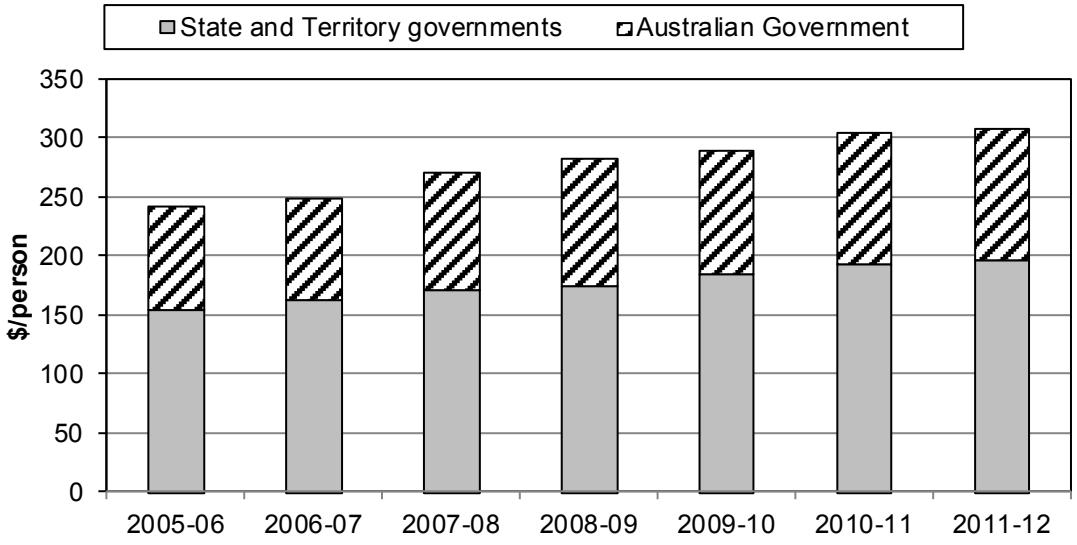
The Australian Government also provides a specific purpose payment (SPP) to State and Territory governments for health services under the National Healthcare Agreement (NHA). According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have budget flexibility to allocate funds within that sector as they deem appropriate. Consequently, specific mental health funding cannot be separately identified in the Australian Government funding provided to State and Territory governments under the NHA.

The Australian, State and Territory governments also fund and/or provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

Funding

Real government recurrent expenditure of around $7.0 billion was allocated to mental health services in 2011-12 (table 12A.4). State and Territory governments made the largest contribution ($4.4 billion, or 63.5 per cent), although this includes Australian Government funding under the NHA SPP. The Australian Government spent $2.5 billion or 36.5 per cent of total government recurrent expenditure on mental health services (table 12A.4). Real average governments' expenditure per person on specialised mental health services in 2011-12 was $309, an increase from $242 in 2005-06 (figure 12.2).

Figure 12.2 **Real recurrent governments' expenditure on mental health services, by funding source (2011-12 dollars)[a, b, c]**



[a] Real expenditure for all years (2011-12 dollars), using the implicit price deflators for general government final consumption expenditure on hospitals and nursing homes (tables 12A.73 and 12A.74). [b] State and Territory governments' expenditure includes expenditure sourced from 'other revenue' that includes patient fees and reimbursement by third party compensation insurers and from Australian Government funding provided under the Australian Health Care Agreement base grants/NHA SPP. [c] Australian Government expenditure includes funding provided for State and Territory governments' specialised mental health services, see table 12A.3 for details.

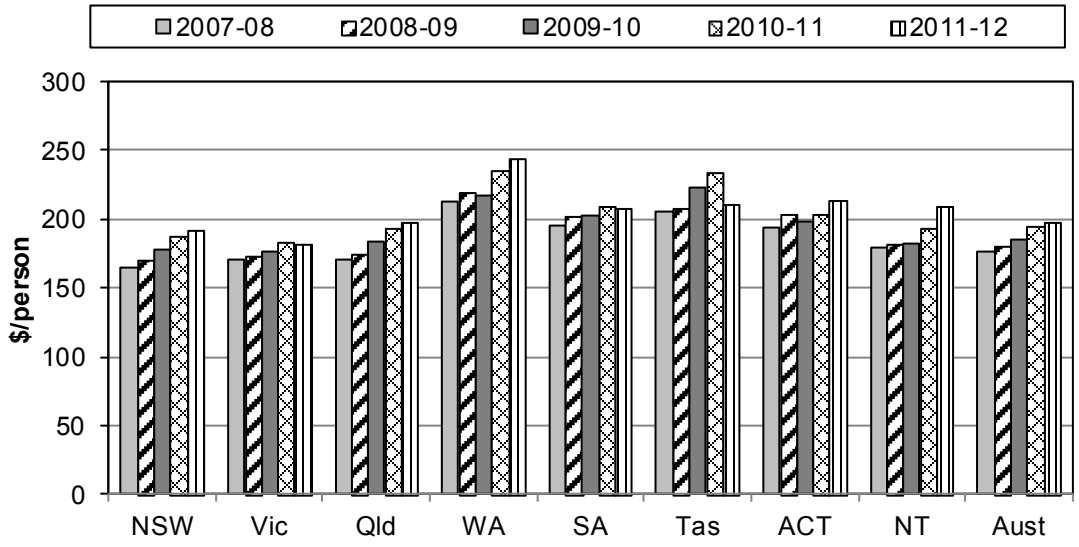
Source: Department of Health (unpublished); Australian Institute of Health and Welfare (AIHW) (unpublished) Mental Health Establishments (MHE) National Minimum Data Set (NMDS); table 12A.4.

One of the largest components of Australian Government expenditure on mental health services in 2011-12 was expenditure under the PBS for mental health-related medications ($830.4 million) (table 12A.1). Real expenditure on PBS mental health-related medications increased by an annual average rate of 1.5 per cent between 2005-06 and 2011-12. This average annual growth rate was lower than the overall Australian Government mental health services average annual expenditure growth rate of 6.2 per cent. Expenditure on PBS mental health-related medications decreased as a share of real expenditure from 43.0 per cent in 2005-06 to 32.8 per cent in 2011-12 (table 12A.1).

In 2011-12, another significant component of Australian Government expenditure for mental health services was MBS payments for psychologists and other allied health professionals (social workers and occupational therapists) (14.6 per cent). Consultant psychiatrists also accounted for a significant share of expenditure at 11.2 per cent (table 12A.1). For details on the remainder of the Australian Government's expenditure for mental health services see table 12A.1.

Real expenditure per person on State and Territory governments' specialised public mental health services has increased over time (figure 12.3). Recurrent expenditure on State and Territory governments' specialised public mental health services includes expenditure funded from all sources, including the Australian Government. Expenditure on State and Territory governments' specialised public mental health services by source of funding is in table 12A.3.

Figure 12.3 **Real recurrent expenditure on State and Territory governments' specialised public mental health services (2011-12 dollars)[a, b, c, d, e]**

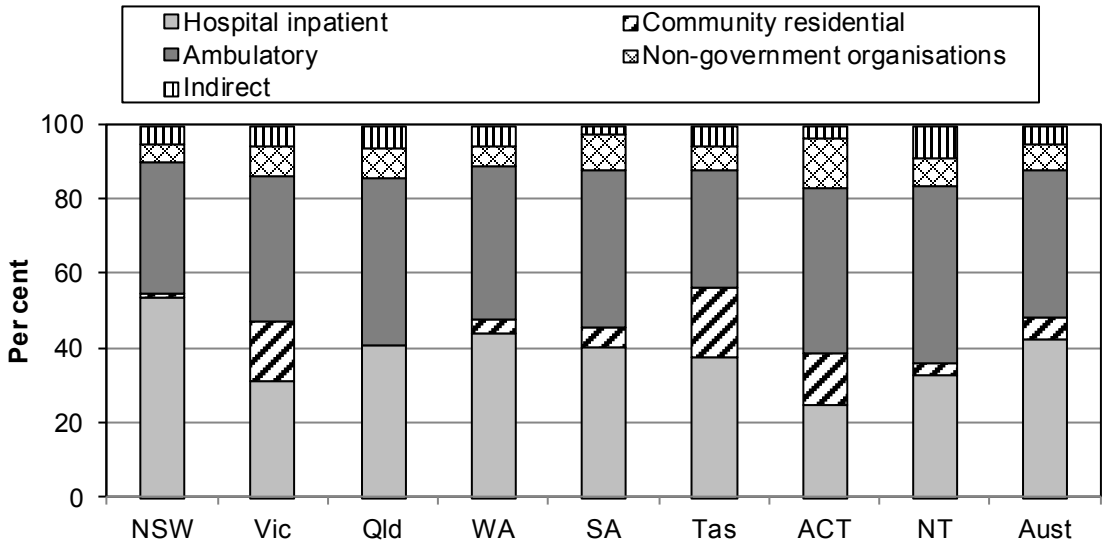


a Real expenditure (2011-12 dollars), using State and Territory implicit price deflators for general government final consumption on hospitals and nursing homes (table 12A.73). **b** Estimates of State and Territory governments' spending include funding from other revenue (including patient fees and reimbursement by third party compensation insurers) and Australian Government funds. **c** Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.5. **d** Expenditure data on State and Territory governments' specialised public mental health services by source of funding are presented in table 12A.3. **e** The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year.

Source: Department of Health (unpublished); State and Territory governments (unpublished); AIHW (unpublished) MHE NMDS; table 12A.2.

Figure 12.4 shows how recurrent expenditure on State and Territory governments' specialised public mental health services was distributed across the different service types in 2011-12.

Figure 12.4 **Recurrent expenditure on State and Territory governments' specialised public mental health services, by service category, 2011-12[a, b, c, d, e]**



[a] Includes all State and Territory governments' expenditure on specialised public mental health services, regardless of source of funds. [b] Depreciation is excluded. Depreciation estimates are reported in table 12A.5. [c] The differential reporting of clinical service providers and NGOs artificially segregates the mental health data. Given that the role of NGOs varies across states and territories, the level of expenditure on NGOs does not necessarily reflect the level of community support services available. [d] Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non-government entities. [e] Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services.

Source: AIHW (unpublished) MHE NMDS; table 12A.6.

Size and scope of sector

Prevalence of mental illness and high/very high levels of psychological distress

According to the National Survey of Mental Health and Wellbeing (SMHWB), in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey (table 12A.56). A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months (table 12A.56).

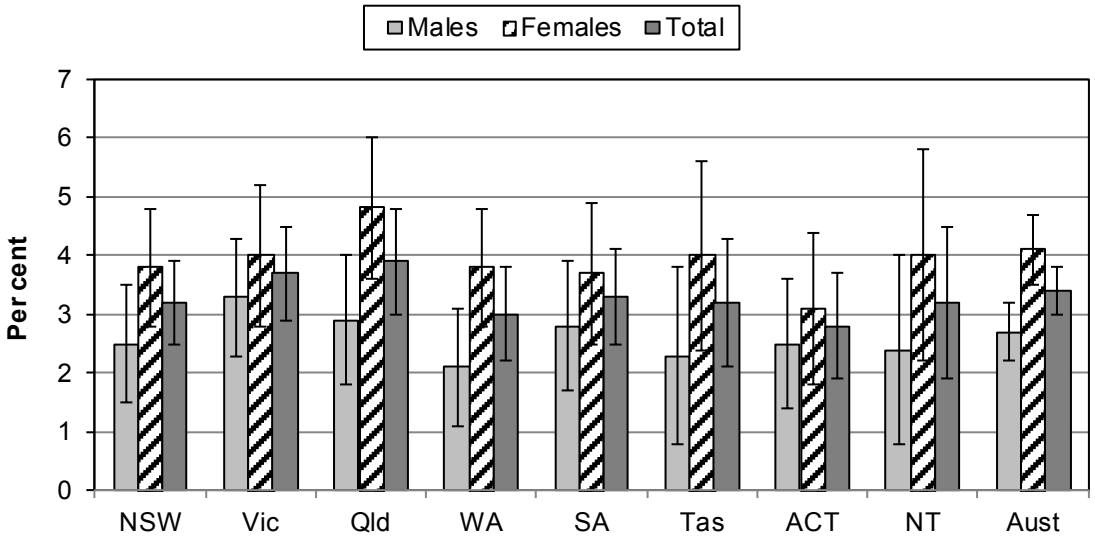
A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Data from the 2007 SMHWB show

that people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (table 12A.7). Analysis of the 1997 SMHWB showed a strong association between a high/very high K10 score and a current diagnosis of anxiety and affective disorders (ABS 2012). According to the ABS, which uses the K10 instrument in the SMHWB and National Health Surveys (NHS), the K10:

> … is a scale designed to measure non-specific psychological distress, based on questions about negative emotional states experienced in the past 30 days. … it is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may signify a need for professional help. It is also useful for estimating population need for mental health services (ABS 2012).

Females had higher proportions of very high levels of psychological distress than males in 2011-12 (figure 12.5). People with disability or restrictive long-term health condition and people in low socio-economic areas also reported higher proportions of very high levels of psychological distress than other community groups (table 12A.9). In 2012-13, 29.4 ± 2.1 per cent of Indigenous Australians aged 18 years or over reported high/very high levels of psychological distress (table 12A.15). After adjusting for age, this was 2.7 times the rate for non-Indigenous adults. Tables 12A.8–16 contain additional data on high/very high levels of psychological distress from NHSs conducted in 2004-05, 2007-08 and 2011-12.

Figure 12.5 **Adults with very high levels of psychological distress, by sex, 2011-12[a, b]**



a Adults are defined as people aged 18 years and over. **b** Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source: ABS (unpublished) *Australian Health Survey (AHS) 2011–13* (2011-12 NHS component); table 12A.8.

Mental health services

There are a range of government provided or funded mental health services; the key services are the following:

- MBS-subsidised mental health services — services provided by GPs, psychiatrists, psychologists or another allied health professionals on a fee-for-service basis that are partially or fully funded under Medicare.
- Admitted patient care in hospitals — services provided to admitted patients in stand-alone psychiatric hospitals or in specialised psychiatric units in acute hospitals.
- Community-based mental health services, comprising:
  - ambulatory care services provided by outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care
  - specialised residential services that provide beds in the community, staffed onsite (24 hour and non-24 hour) by mental health professionals
  - not-for-profit, non-government organisations' (NGO) services, funded by the Australian, State and Territory governments to provide community support for people with psychiatric disability, including accommodation, outreach to

people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy (DoHA 2010).

MBS-subsidised GP mental health services

GPs are often the first type of service accessed by people seeking help when suffering from a mental illness (AIHW 2012). GPs can diagnose, manage and treat mental illnesses and they also refer patients to more specialised service providers such as psychiatrists and psychologists (see other MBS-subsidised services below).

According to the *Bettering the Evaluation and Care of Health* (BEACH) (an annual survey collected from a sample of approximately 1000 GPs), 12.1 per cent of GP encounters (an estimated 15.0 million MBS-subsidised services) were mental health-related in 2011-12 (AIHW 2013). Under the BEACH, a mental health-related encounter is defined as one at which a mental health-related problem is managed. Problems managed reflect the GP's understanding of the health problem presented by the patient. These encounters comprise those billed as general surgery consultations and those billed under specific mental health MBS items.

A GP can manage more than one problem at a single encounter. In 2011-12, 13.0 mental health-related problems were managed per 100 encounters. Depression was the most frequently reported mental health-related problem managed (4.4 per 100 GP encounters) and of all problems was the fifth most frequently managed (Britt et al. 2012). Anxiety (1.9 per 100 GP encounters) and sleep disturbance (1.5 per 100 GP encounters) were the next most common mental health-related problems. The most common form of GP management for a mental health-related problem was the prescription, supply or recommendation of a medication (AIHW 2013).

Another measure of GP mental-health related activity is the number of services provided under specific mental health MBS items (GP Mental Health Treatment Plan, Focussed Psychological Strategies and Family Group Therapy). In 2011-12, 2.2 million MBS-subsidised specific mental health MBS items (97.6 per 1000 people) were provided by GPs and Other Medical Practitioners (OMPs) (table 12A.17).

Other MBS-subsidised services

In 2011-12, 5.7 million other MBS-subsidised mental health-related services were provided by psychiatrists, psychologists and other allied health professionals

(AIHW 2013). This comprised 3.4 million provided by psychologists, 2.1 million services provided by psychiatrists, and 231 182 services provided by other allied health professionals (table 12A.17). This was equivalent to 153.4 psychologist services, 91.6 psychiatrist services, and 10.3 other allied health services per 1000 people (table 12A.17).

Admitted patient care and community-based mental health services — service use, patient days, beds and staffing

Estimating activity across the publicly funded specialised mental health services sector, which comprises admitted patient care and community-based mental health services, is problematic as the way activity is measured differs across the service types. Service activity is reported by separations for admitted patient care, episodes for community-based residential care and contacts for community-based ambulatory care. Service use data for the NGO sector are not available.

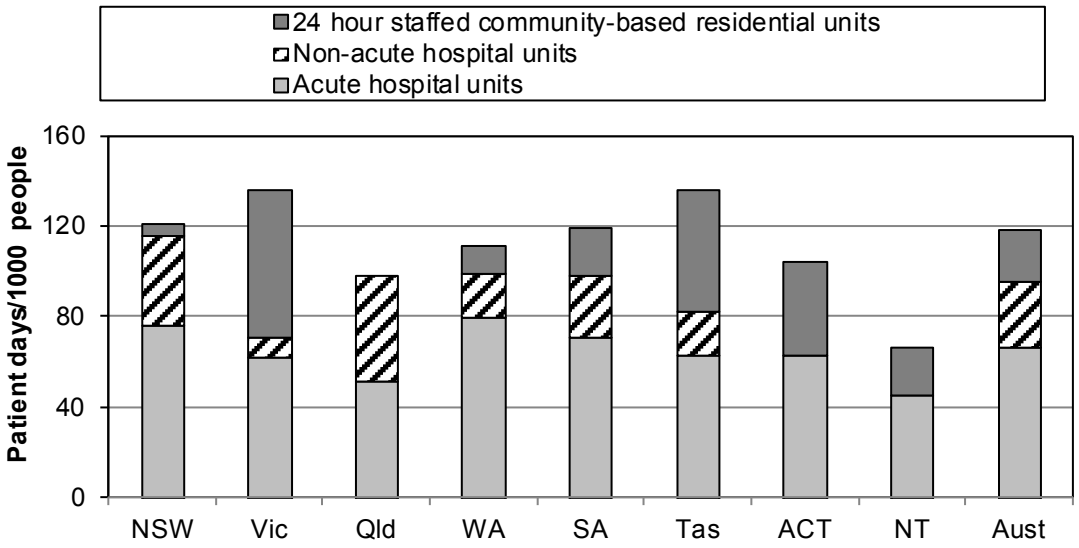
There were 86 669 separations with specialised psychiatric care in public acute hospitals and 9561 specialised psychiatric care separations in public psychiatric hospitals in 2010-11 (table 12A.19). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (21.0 per cent in public acute hospitals and 22.4 per cent in public psychiatric hospitals) (table 12A.19). Ambulatory equivalent specialised psychiatric care is also provided in public hospitals. In 2009-10, the latest year for which data are published, there were 5193 of these separations from public acute hospitals and 132 in public psychiatric hospitals (AIHW 2013).

There were 4234 episodes of community-based residential care in 2010-11 (table 12A.21). Schizophrenia, schizotypal and delusional disorders (F20-29) as a principal diagnosis accounted for the largest proportion of these episodes (61.5 per cent) (AIHW 2013). There were 7.2 million community-based ambulatory care patient contacts, equivalent to 326.8 contacts per 1000 people, in 2010-11 (table 12A.21). For those contacts, the largest proportion was for the principal diagnosis of schizophrenia (25.6 per cent) (AIHW 2013).

Data on service use by the Indigenous status of patients are available, but comparisons are not necessarily accurate because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous Australians, and differences in the complexity, incidence and prevalence of illnesses between Indigenous and non-Indigenous Australians. Table 12A.21 contains information on use of these services by Indigenous status.

Activity can also be measured across specialised public mental health services by accrued mental health patient days, mental health beds and full time equivalent (FTE) direct care staff. Admitted patient care and community-based residential (24 hour staffed) accrued patient days per 1000 people for 2011-12 are included in figure 12.6.

Figure 12.6 **Accrued mental health patient days, 2011-12[a, b, c]**



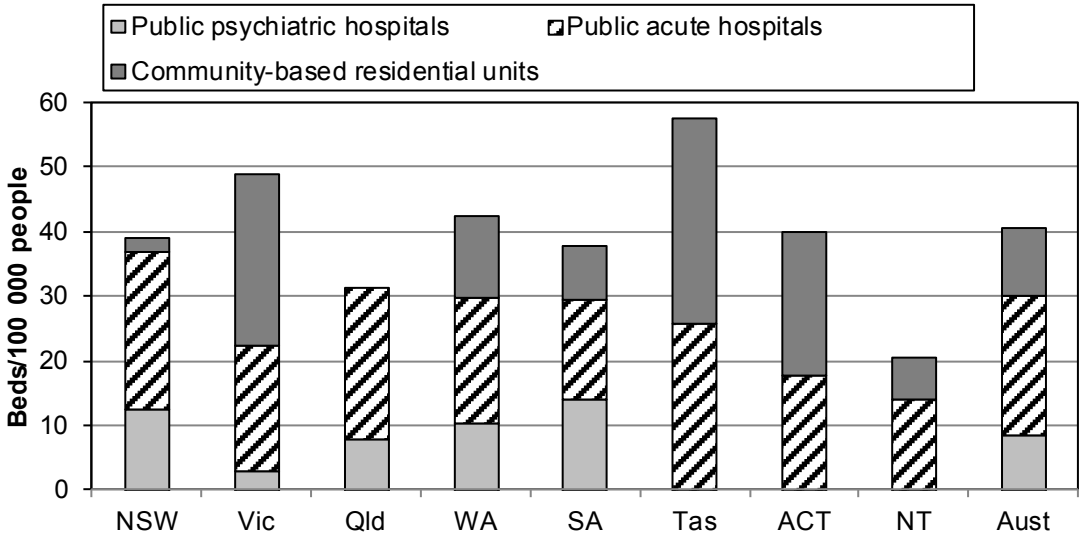
[a] Hospital patient days include those funded by government, but provided by services managed and operated by private and non-government entities. [b] Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. [c] The ACT and the NT do not have non-acute hospital units.

Source: AIHW (unpublished) MHE NMDS; table 12A.18.

Beds are counted as those that can provide overnight accommodation for patients admitted to hospital or residential services (see section 12.6 for more details). Figure 12.7 presents the number of beds per 100 000 people by service setting, in 2011-12. These data show the differences in service mix across states and territories.

Figure 12.8 reports FTE direct care staff per 100 000 people employed across the admitted patient and community-based services (ambulatory and residential). Nursing staff comprise the largest FTE component of direct care staff employed in specialised public mental health services. Across Australia in 2011-12, there were 68.2 nurses per 100 000 people, compared with 25.2 allied health care staff, 13.1 medical staff and 5.1 other personal care staff (table 12A.23). FTE direct care staff employed in specialised public mental health services, by service setting, are reported in table 12A.24.

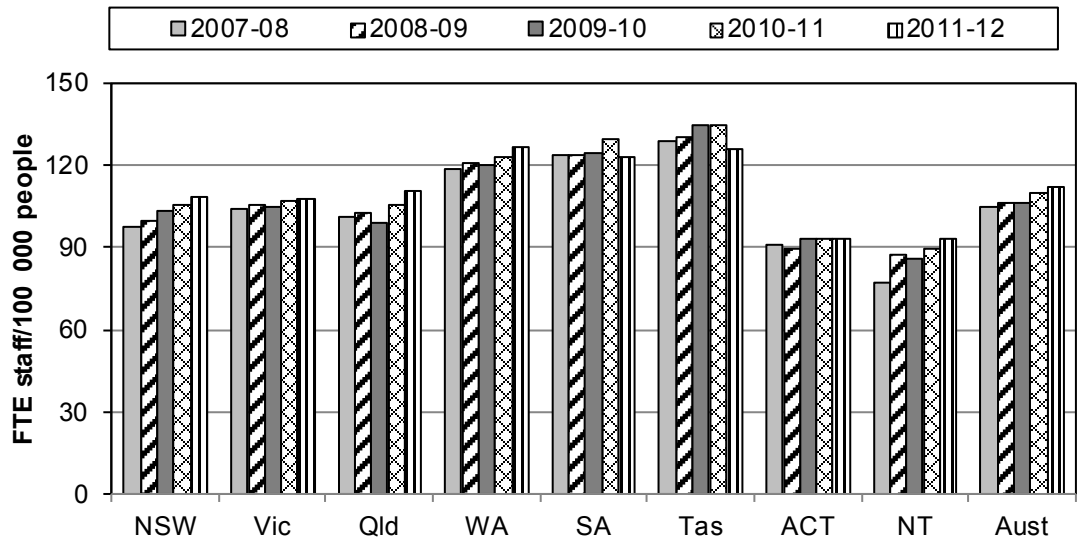
Figure 12.7 **Mental health beds in public hospitals and community-based residential units, 2011-12[a, b, c, d]**



a Includes beds in public hospitals and publicly funded community-based residential units. **b** Hospital beds can include government funded beds managed and operated by private and non-government entities. **c** Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. **d** Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished) MHE NMDS; table 12A.22.

Figure 12.8 **FTE health professional direct care staff[a, b]**



a Includes staff within the health professional categories of 'medical', 'nursing', 'allied health' and 'other personal care'. Section 12.6 provides detailed definitions for these staffing categories. **b** The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year.

Source: AIHW (unpublished) MHE NMDS; table 12A.23.

Case study

Box 12.1 contains a case study on the influence of community follow-up contact on reducing psychiatric inpatient hospital readmissions within 28 days.

Box 12.1 Reducing psychiatric inpatient hospital readmission within 28 days, influenced by seven day follow-up contact

Readmissions following a recent discharge from an acute psychiatric inpatient episode can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. The relationship between acute psychiatric inpatient readmission and contact with mental health services post-discharge (follow-up care) has been explored in the ACT. Results indicate that reduction in readmissions is influenced by the amount, the quality and the type of follow-up community contact including who, beyond the consumer, is involved.

The ACT provides a high level of follow-up care, including high frequency contact over a number of days to weeks — this is possible due, in part, to the size of the jurisdiction, service accessibility and system attributes.

- Mental health services in the ACT are provided by one central organisation.
- Public mental health service provision is captured in a centralised electronic system, covering both inpatient and community services — this enables service providers to coordinate and be aware of clinical care within inpatient services and across the community.

Follow-up community care that engages consumers' family and carers is another key factor in reducing the need for further inpatient care. Follow-up contact that includes direct face-to-face contact and involves significant others in the consumer's life appears to improve the likelihood of the consumer remaining in the community for longer and reduces the possibility of relapse to a degree requiring an inpatient readmission.

Community follow-up within seven days of discharge

In the ACT, rates of community follow-up within seven days of discharge have improved progressively over the period 2005-06 to 2012-13 and are relatively high compared to the national average. The ACT rate exceeded the *indicative* national target agreed under the *Measurement Strategy for the Fourth National Mental Health Plan* (75 per cent) from 2010-11.

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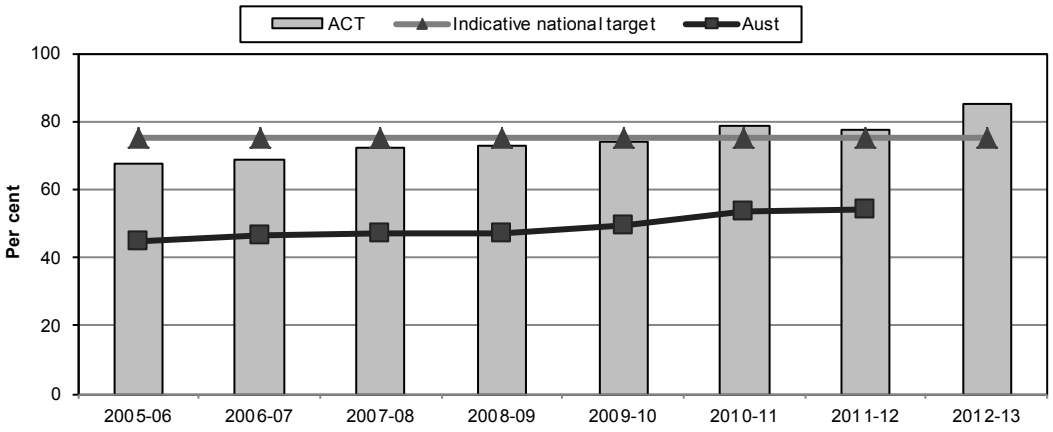
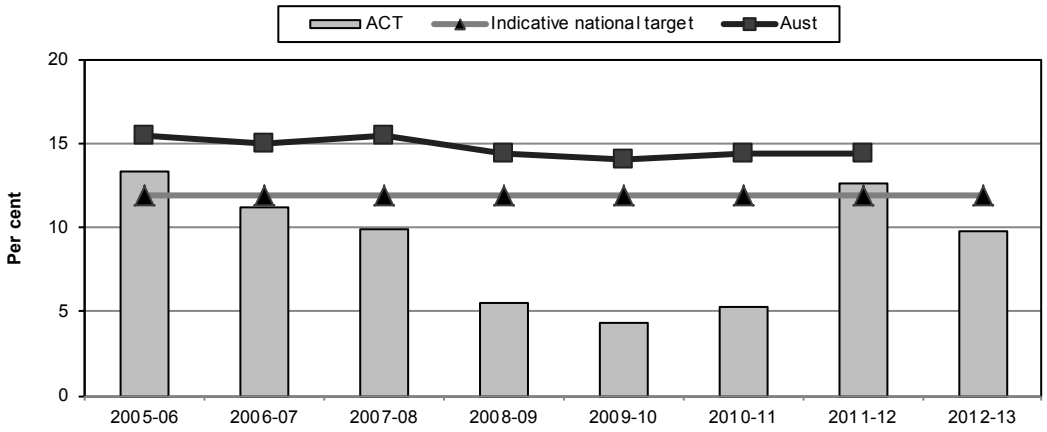
Box 12.1 **(continued)**



Readmission within 28 days of discharge from an initial inpatient episode

Rates of psychiatric inpatient hospital readmission within 28 days have decreased and are trending lower compared to the national average. The ACT rate has been below the indicative national target agreed under the Measurement Strategy for the Fourth National Mental Health Plan since 2006-07 until 2010-11. In 2011-12, the trend was reversed creating a spike in that year, but the rate decreased again in 2012-13.



The relationship between community follow-up and readmission is complex and influenced by a range of factors not directly related to the two indicators shown here. Between 2010 and 2012 a number of changes were introduced in the ACT, this included, an increase in the number of available beds for inpatient admissions (a new inpatient unit), implementation of a Mental Health Assessment Unit in the Emergency Department and the introduction of Step-Up-Step-Down community 'placements' pre- and post-admission (the reduction in the readmissions rate may be partly due to these additional services diverting the need for an inpatient admission, however their use is not included in the data provided for this indicator). These services continue to emphasise maintaining people in the community for longer, offering pre-admission inpatient assessment and early treatment, and offering alternative options to inpatient admission where appropriate.

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Box 12.1 **(continued)**

These changes have caused adjustments to the inpatient casemix. A greater share of consumers admitted to hospital are now more likely to require a subsequent hospital admission due to the complexity, co-morbidity and nature of their longer term mental illnesses and their longer more variable recovery phase due to the influence of substance use. An improved understanding of the interplay of these indicators would benefit from further analysis of case-mix — particularly co-morbidity, complexity of presentations and the effect of substance use/abuse.

Results for 2012-13 indicate a period of adjustment to the changes made to services available and management of those services for the types of case-mix consumers most in need of inpatient care and more intense community follow-up from 2011-12.

The consumer's engagement with other community support services and family and friends where possible, also influences their degree of acuity and coping ability and prolongs their functional capacity to minimise their need for further acute inpatient care.

Source: ACT Government (unpublished).

12.3 Framework of performance indicators for mental health management

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for mental health services draws on governments' broad objectives for national mental health policy, as encompassed in the *National Mental Health Policy 2008* (box 12.2). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS-subsidised, admitted patient and community-based services) and includes outcome indicators of system-wide performance.

Box 12.2 Broad objectives and policy directions of National Mental Health Policy

The *National Mental Health Policy 2008* has an emphasis on whole-of-government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. The key broad objectives are to:

- promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- promote recovery from mental health problems and mental illness
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The key policy directions are summarised as follows:

- Rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected.
- Mental health promotion will support destigmatisation and assist people to be emotionally resilient, cope with negative experiences and participate in the community.
- The proportion of people with mental health problems, mental illness and people at risk of suicide will be reduced.
- Emerging mental health problems or mental illnesses will receive early intervention to minimise the severity and duration of the condition and to reduce its broader impacts.
- People will receive timely access to high quality, coordinated care appropriate to their conditions and circumstances.
- People with mental health problems and mental illness will enjoy full social, political and economic participation in their communities.
- The crucial role of carers will be acknowledged and respected and they will be provided with appropriate support to enable them to fulfil their role.
- The mental health workforce will be appropriately trained and adequate in size and distribution to meet the need for care.
- Across all sectors, mental health services should be monitored and evaluated to ensure they are of high quality and achieving positive outcomes.
- Research and evaluation efforts will generate new knowledge about mental health problems and mental illness that can reduce the impact of these conditions.

National Mental Health Strategy

In 1991, Australian Health Ministers signed the *Mental Health Statement of Rights and Responsibilities*. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the National Mental Health Strategy (NMHS) endorsed by Australian, State and Territory governments in 1992 (AIHW 2008). During 2011-12, the Statement was updated to align with the *National Mental Health Policy 2008* and Australia's international obligations with respect to the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child.

The NMHS was established to guide the reform agenda for mental health in Australia across the whole-of-government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan. The National Mental Health Policy describes the broad aims and objectives of the NMHS. The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. The fourth plan aims to strengthen the accountability framework with Australian, State and Territory governments by developing targets and data sources for a set of indicators and to provide annual progress reports to Council of Australian Governments (COAG) (AHMC 2009). These indicators will be the primary vehicle for monitoring the progress of these governments in achieving national mental health reform under the fourth plan.

COAG National Healthcare Agreement

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 NHA covers the areas of health and aged care services. The NHA includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council. Performance indicators reported in this chapter are aligned with the mental health-related performance indicators in the NHA. The NHA was reviewed in 2011, 2012 and 2013 resulting in changes that have been reflected in this Report, as relevant.

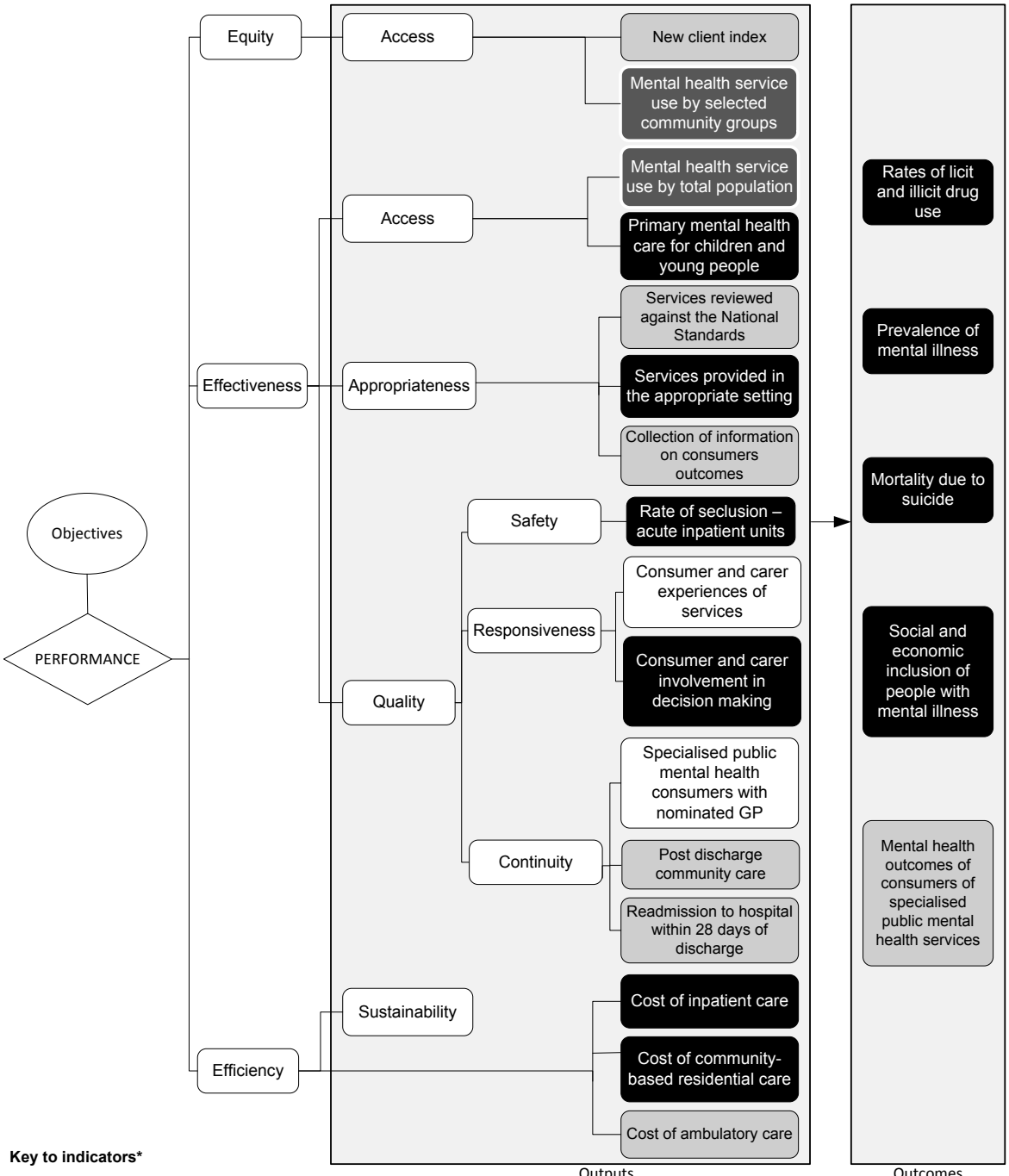
Performance indicator framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health management services (figure 12.9). The performance indicator framework shows which data are complete and comparable in the 2014 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 (section 1.6).

The Report's statistical context chapter 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) (chapter 2).

Data quality information 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 key data gaps and issues identified by the Steering Committee. All DQI for the 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

Figure 12.9 **Mental health management performance indicator framework**



Key to indicators*

Text Most recent data for all measures are comparable and complete

Text Most recent data for at least one measure are comparable and complete

Text Most recent data for all measures are either not comparable and/or not complete

Text No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

12.4 Key performance indicators for mental health management

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 — access — new client index

'New client index' is an indicator of governments' objective to provide mental health services in an equitable manner (box 12.3). Population treatment rates are relatively low and it might be difficult for a new client to access specialised public mental health services if resources are already utilised by existing clients.

Box 12.3 **New client index**

'New client index' is defined as the proportion of total clients under the care of State and Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period.

A high or increasing proportion of total clients who are new might be desirable, as it suggests it is easier for new clients to access specialised public mental health services. However, results are difficult to interpret. The appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown.

This indicator does not provide information on whether the services are appropriate or adequate for the needs of the people receiving them (new or existing clients), or correctly targeted to those clients who are most in need.

Data reported for this indicator are:

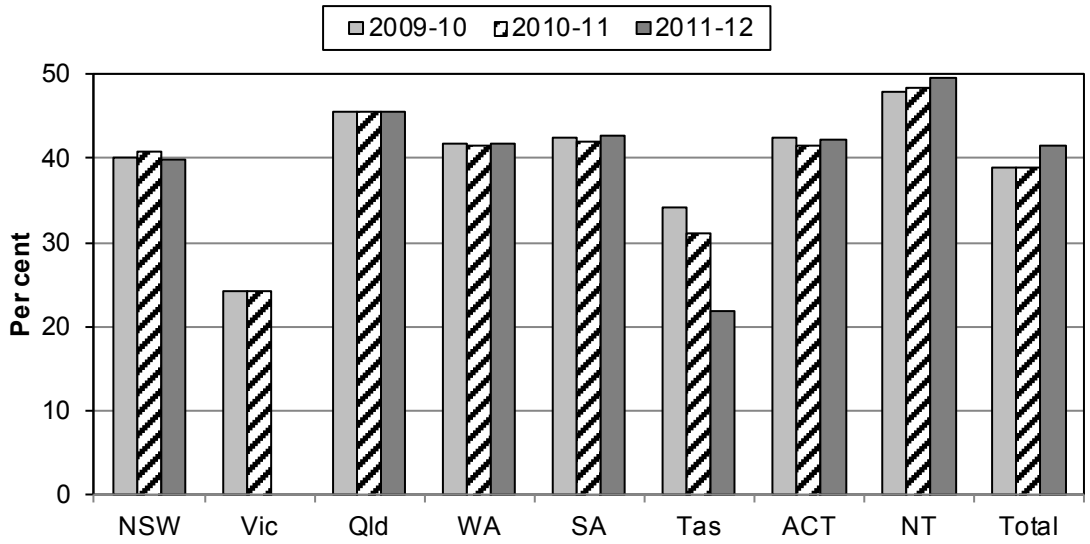
- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required 2011-12 data are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The proportions of total clients of specialised public mental health services who are new are reported in figure 12.10. Data for 2011-12 are not available for Victoria due to service level collection gaps resulting from protected industrial action during this

period. This affects all data collected in community-based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. Victoria has requested no substitute or proxy data be included at the jurisdictional level or to fill the gap in calculation of the national results. The total includes only those states and territories that have provided data.

Figure 12.10 **Proportion of total clients of State and Territory specialised public mental health services who are new[a, b, c, d, e]**



a Clients in receipt of services include all people who received one or more community-based ambulatory service contact or had one or more day of inpatient or community-based residential care in the data period. **b** A new client is a consumer who had not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service. **c** The approach to identifying unique clients differs across jurisdictions. Some have a State-wide unique patient identifier, others use a statistical linkage key. For SA, the client counts are not unique, but are an aggregation of three separate databases. **d** Victorian 2011-12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. **e** Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12.

Source: State and Territory governments (unpublished); table 12A.25.

Equity — access — mental health service use by selected community groups

'Mental health service use by selected community groups' is an indicator of governments' objective to provide mental health services in an equitable manner, including access to services by selected community groups such as Indigenous Australians (box 12.4).

Box 12.4 **Mental health service use by selected community groups**

'Mental health service use by selected community groups' is defined by two measures:

- proportion of the population in a selected community group using State and Territory specialised public mental health services, compared with the proportion of the population outside the selected community group using State and Territory specialised public mental health services
- proportion of the population in a selected community group using MBS-subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the selected community group using MBS-subsidised ambulatory mental health services.

The selected community groups reported are Indigenous Australians, people from outer regional, remote and very remote locations and people residing in low socio-economic areas. For MBS-subsidised ambulatory mental health services, data by socio-economic status are reported by decile at the national level only.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across the selected community group. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data reported for the 'proportion of the population in a selected community group using State and Territory specialised public mental health services' measure are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011-12 by geographic location and Socio Economic Indexes for Areas (SEIFA) are not comparable to previous years' data
- incomplete for the current reporting period (subject to caveats). All required 2011-12 data are not available for Victoria.

Data reported for the 'proportion of the population in a selected community group using MBS-subsidised ambulatory mental health services' measure are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011-12 by geographic location and SEIFA are not comparable to previous years' data
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The proportions of the population using State and Territory specialised public mental health services in 2011-12, by selected community groups are reported in figure 12.11. The results are not available for Victoria or at the national level.

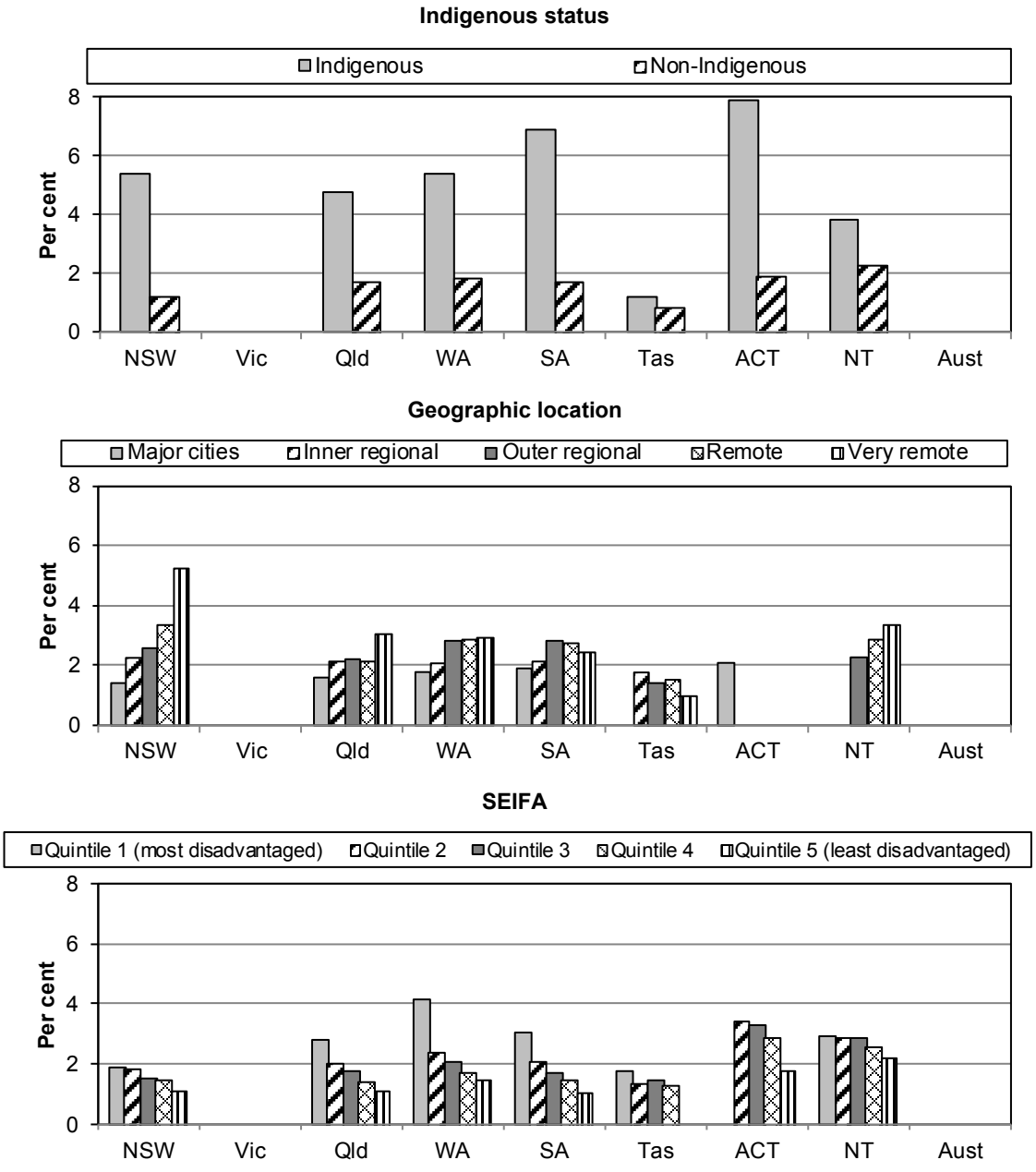
These results, which are derived using community-based ambulatory care data, should be interpreted with care, as:

- people receiving only admitted and/or community-based residential services are not included in the proportion of people accessing services or in rates of service use
- there is no identifier to distinguish 'treatment' versus 'non-treatment' service contacts in the community mental health care data set
- jurisdictions differ in their collection and reporting of community-based ambulatory care data — there are variations in local business rules and in the interpretation of the national definitions.

The proportions of the population using MBS-subsidised ambulatory mental health services, by selected community groups, are reported in figure 12.12. Data are not available at the State and Territory level for Socio Economic Indexes for Areas (SEIFA) quintiles.

Data on the use of State and Territory community-based specialised public mental health services and MBS-subsidised ambulatory mental health services by SEIFA deciles are in table 12A.29. Data on the use of private hospital mental health services are also contained in tables 12A.26–29.

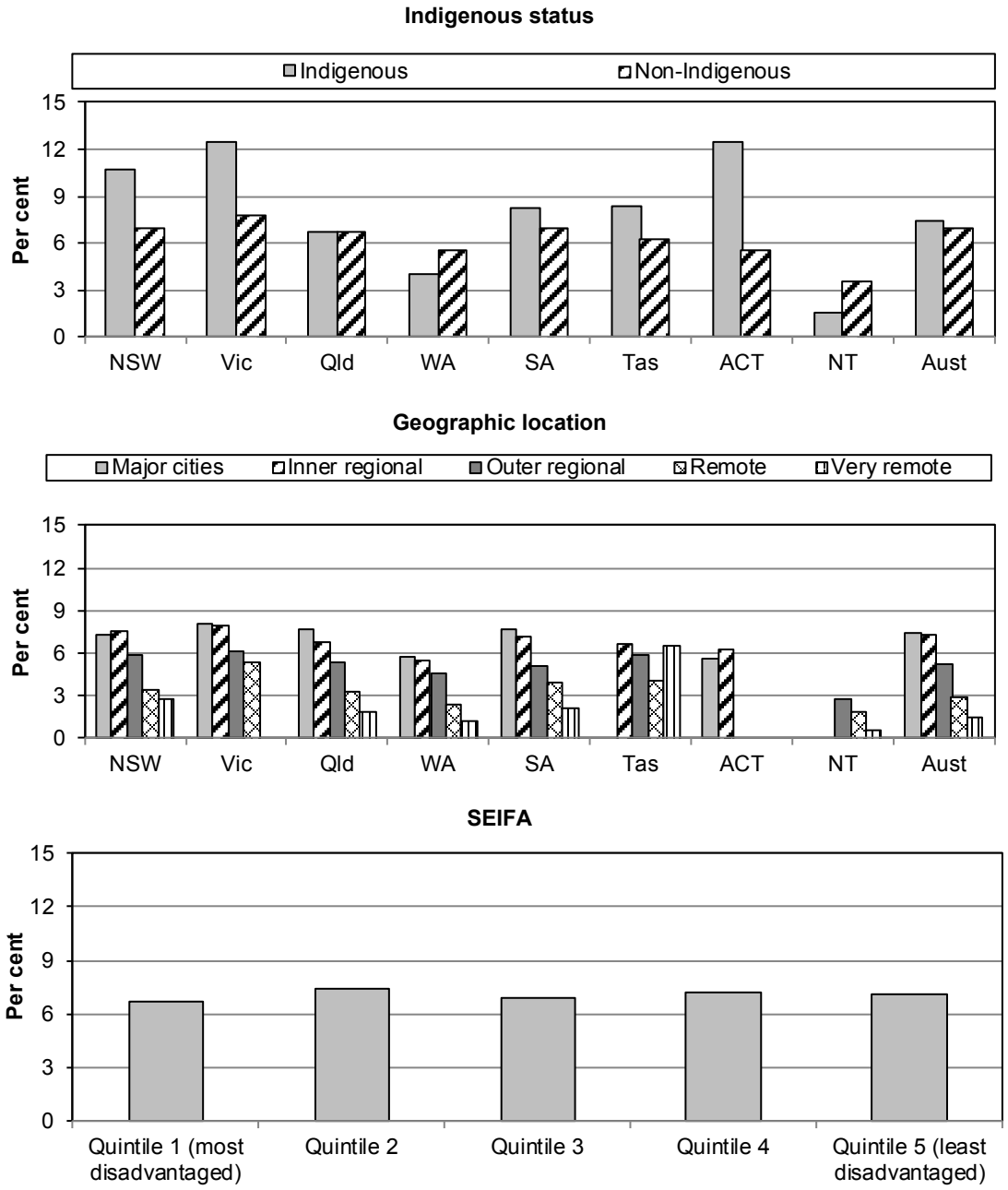
Figure 12.11 **Population using State and Territory specialised public mental health services, by selected community group, 2011-12[a, b, c, d, e, f, g, h]**



SEIFA = Socio-Economic Indexes for Areas. **a** Proportions are age-standardised to the Australian population as at 30 June 2001. **b** State and Territory specialised public mental health services are counts of people receiving one or more service contact provided by community-based ambulatory services. **c** Data are not available for Victoria or at the national level. **d** SA submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. **e** Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. **f** Tasmania does not have major cities. SEIFA Quintile 5 is not applicable for Tasmania. **g** The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for quintile 1 are not published for the ACT. **h** The NT does not have major cities or inner regional locations.

Source: State and Territory governments (unpublished) Community Mental Health Care (CMHC) data; tables 12A.26–28.

Figure 12.12 **Population using MBS-subsidised ambulatory mental health services, by selected community group, 2011-12[a, b, c, d, e]**



SEIFA = Socio-Economic Indexes for Areas. **a** Proportions are age-standardised to the Australian population as at 30 June 2001. **b** MBS-subsidised services are those mental health-specific services provided under the general MBS and by DVA. The specific Medicare items included are detailed in table 12A.30. **c** Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. **d** Victoria does not have very remote areas. Tasmania does not have major cities. The ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. **e** Data for SEIFA quintiles are not available by state or territory.

Source: Department of Health (unpublished) MBS Statistics data; DVA (unpublished); tables 12A.26–28.

Effectiveness — access — mental health service use by total population

'Mental health service use by total population' is an indicator of governments' objective to provide equitable access to mental health services for all people who need them (box 12.5). An estimate of the population who need mental health services is not available, so the indicator is reported as a proportion of the total population.

Box 12.5 **Mental health service use by total population**

'Mental health service use by total population' is defined as the proportion of the population using a State and Territory specialised public mental health service or a MBS-subsidised service. Data are reported separately for State and Territory specialised public mental health services and MBS-subsidised services. Data from the 2007 SMHWB on the proportion of people who had a lifetime mental disorder with symptoms in the 12 months before the survey who used any service for mental health are also reported in tables 12A.31–32.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. People with a mental illness can have low rates of service use due to them choosing not to access services, appropriate services are unavailable, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Data reported for the 'proportion of the population using State and Territory specialised public mental health services' measure are:

- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period (subject to caveats). All required 2011-12 data are not available for Victoria.

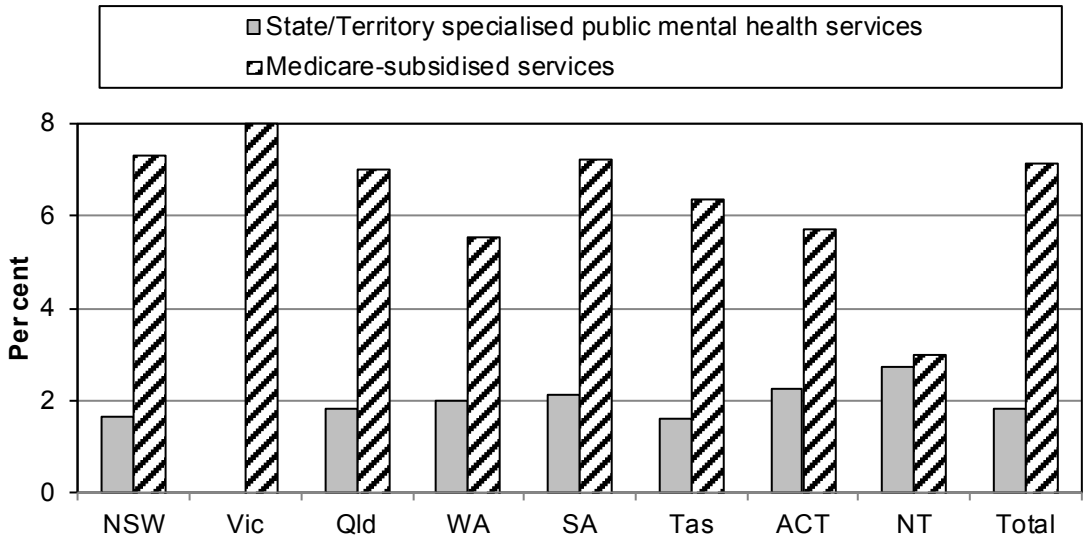
Data reported for the 'proportion of the population using MBS-subsidised ambulatory mental health services' measure are:

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

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

In 2011-12, 1.8 per cent and 7.1 per cent of the total population received State and Territory specialised public mental health services and MBS-subsidised (MBS general and DVA), respectively (figure 12.13).

Figure 12.13 **Population receiving mental health services, by service type, 2011-12[a, b, c, d]**



a Rates are age-standardised to the Australian population as at 30 June 2001. **b** Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community-based ambulatory services (most people who have received an inpatient service or residential care service have also received a service contact with a community-based ambulatory service). **c** MBS-subsidised services are those specific mental health services provided under the general MBS and DVA by psychiatrists, clinical psychologists, GPs and other allied health services. The specific MBS items included are detailed in table 12A.30. People seen by more than one provider type are counted only once. **d** Data for State and Territory specialised public mental health services are not available for Victoria for 2011-12 due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.

Source: State and Territory governments (unpublished) CMHC data; Department of Health (unpublished) MBS Statistics data; DVA (unpublished); table 12A.30.

Effectiveness — access — primary mental health care for children and young people

'Primary mental health care for children and young people' is an indicator of governments' objective to prevent, where possible, the development of mental health problems and mental illness and undertake early intervention for mental health problems and mental illness (box 12.6). Early identification of and intervention in mental illnesses for children and young people can result in better outcomes.

Box 12.6 **Primary mental health care for children and young people**

'Primary mental health care for children and young people' is defined as the proportion of young people aged under 25 years who received a primary mental health care service subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

High or increasing proportions of young people who had contact with primary mental health care services subsidised through the MBS is desirable.

This indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. It also does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

Data reported for this indicator are:

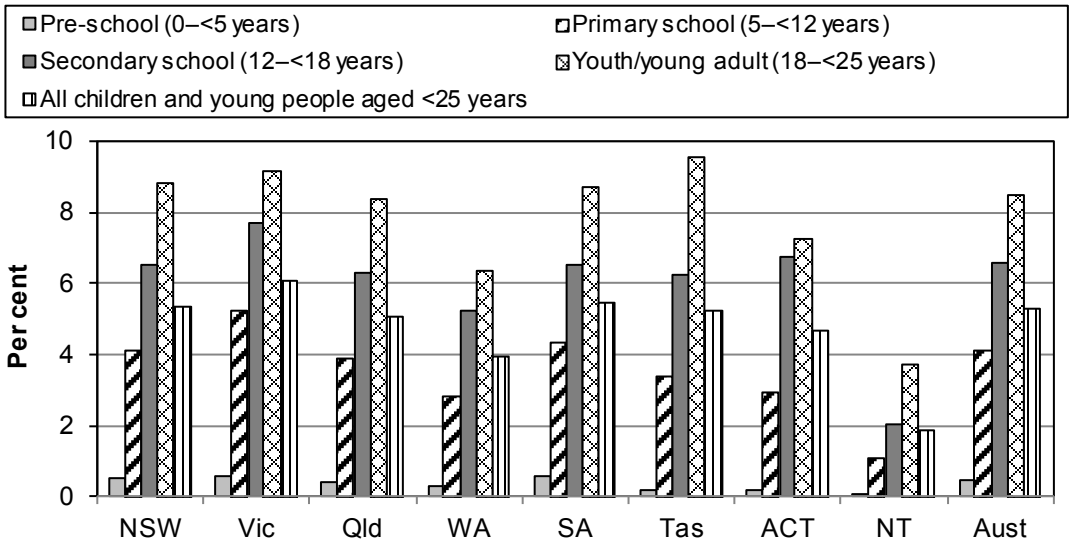
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Results for this indicator should be interpreted with caution. Primary mental health care for children and young people can be accessed from services other than those that are MBS subsidised. Other providers of primary mental health care to young people include community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses and university and Technical and Further Education counselling services. A component of the mental health care provided by State and Territory specialised public mental health services could also be considered primary mental health care for young people, but this cannot be reliably differentiated from other care types (NMHPSC 2011a).

In 2012-13, 5.2 per cent of all children and young people aged under 25 years had contact with MBS-subsidised primary mental health care services (figure 12.14).

Figure 12.14 **Children and young people who received MBS-subsidised primary mental health care, 2012-13**



Source: Department of Health (unpublished); table 12A.33.

Effectiveness — appropriateness — services reviewed against the National Standards

'Services reviewed against the National Standards' is an indicator of governments' objective to provide mental health services that are appropriate (box 12.7). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care (see box 12.8 for details on the relevant standards). This indicator has been revised for this year's Report to weight the results by expenditure. This provides a better understanding of the share of activity covered by the different assessment levels.

Box 12.7 **Services reviewed against the National Standards**

'Services reviewed against the National Standards' is defined as the proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the *National Standards for Mental Health Services* (NSMHS). Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — services reviewed by an external accreditation agency and judged to have met all National Standards.

(Continued next page)

Box 12.7 **(continued)**

- *Services at level 2* — services reviewed by an external accreditation agency and judged to have met some but not all National Standards.
- *Services at level 3* — services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — services that do not meet criteria detailed under levels 1 to 3.

A high or increasing proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Revised *National Standards for Mental Health Services* (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The standards have been broadened to include non-government community mental health services and private office-based services as well as specialised public mental health services. Implementation guidelines have also been released.

Box 12.8 outlines the 2010 NSMHS against which public mental health services are now assessed. External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Box 12.8 **The 2010 National Standards for Mental Health Services**

The first NSMHS were developed under the *First National Mental Health Plan 1993–1998*. Revised NSMHS were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The 2010 NSMHS comprise 10 overarching standards:

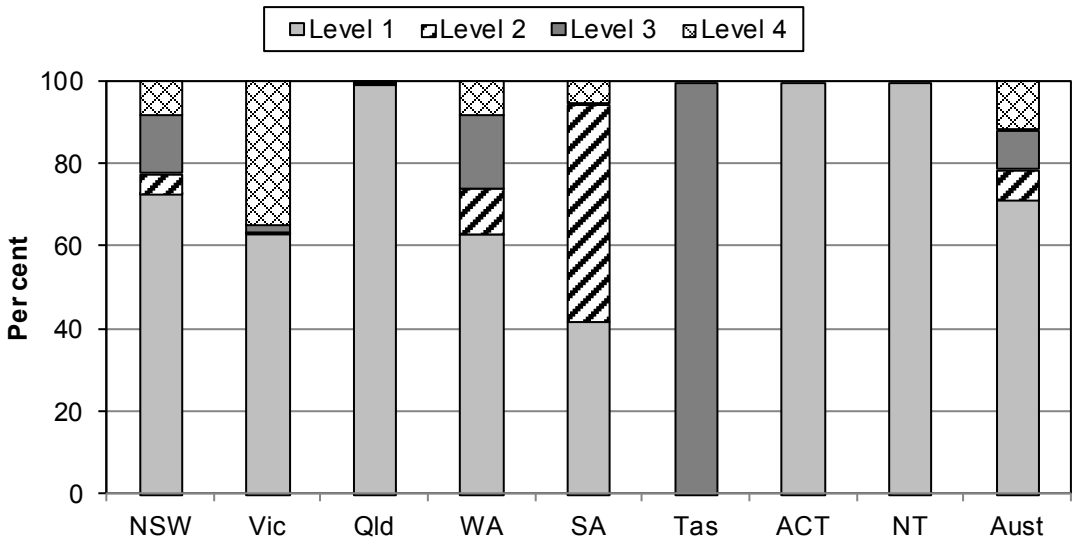
1. Rights and responsibilities
2. Safety
3. Consumer and carer participation
4. Diversity responsiveness
5. Promotion and prevention
6. Consumers
7. Carers
8. Governance, leadership and management
9. Integration
10. Delivery of care.

In future, services will be required to undergo accreditation against the ten new national safety and quality health service standards mandated by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the revised 2010 NSMHS. Reaccreditation against the 2010 NSMHS was to be undertaken by 2014. However, services indicated their preference to undertake NSMHS reaccreditation in conjunction with the accreditation against the ACSQHC standards which were implemented from January 2013 onwards.

Source: AHMC (2010) and Department of Health (unpublished).

Figure 12.15 shows the proportion of expenditure on specialised public mental health services that had completed an external review against the NSMHS and were assessed as meeting 'all standards' (level 1) or as meeting 'some but not all standards' (level 2). Figure 12.15 also shows the proportion of expenditure on specialised public mental health services that were either in the process of being reviewed by an external accreditation agency but the outcomes were not known, or that had booked for review by an external accreditation agency (level 3); and those that did not meet criteria detailed under levels 1 to 3 (level 4).

Figure 12.15 **Share of expenditure on specialised public mental health services reviewed against the NSMHS, by assessment level, 30 June 2012[a, b]**



a Data are based on expenditure on individual service units within mental health organisations, not at the whole organisation level. However, there is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to a service unit. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the organisation's units are 'counted' at that assessment level. In other jurisdictions, service units are 'counted' individually at assessment levels and assessment levels may or may not be consistent across the units within an organisation. The approach can also vary across organisations within a single jurisdiction. **b** Box 12.7 contains definitions of the assessment levels.

Source: AIHW (unpublished) MHE NMDS; table 12A.34.

Effectiveness — appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an indicator of governments' objective to provide mental health services in mainstream or community-based settings wherever possible (box 12.9).

Box 12.9 **Services provided in the appropriate setting**

'Services provided in the appropriate setting' is defined as the proportion of State and Territory governments' recurrent expenditure on specialised mental health services (excluding aged care community residential expenditure) that was on community-based services. Community-based services are defined as ambulatory care, adult residential services and non-government organisations. Aged residential care is excluded to improve comparability.

A high or increasing proportion of recurrent expenditure spent on community-based services is desirable, reflecting a greater reliance on services that are based in community settings.

Data reported for this indicator are:

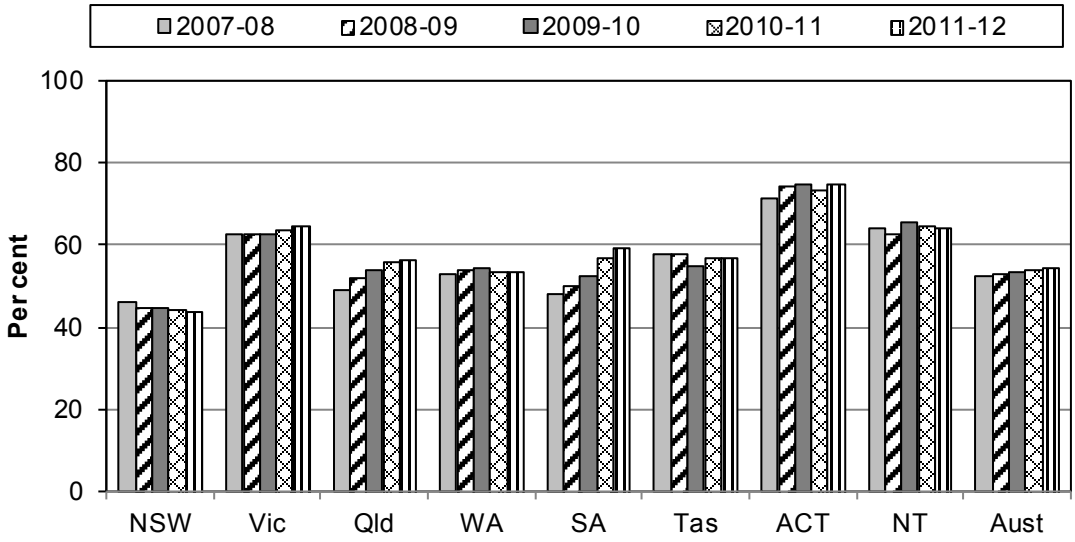
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. More appropriate mental health treatment options can be provided by encouraging the treatment of patients in community-based settings, rather than in stand-alone psychiatric hospitals and public (non-psychiatric) hospitals.

Figure 12.16 shows recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services.

Figure 12.16 **Recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services[a, b, c, d]**



a Community-based expenditure includes expenditure on ambulatory, NGO grants and adult residential services. Aged care residential expenditure is excluded to improve comparability. **b** Total expenditure on specialised public mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. **c** Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. **d** The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year.

Source: AIHW (unpublished) MHE NMDS; table 12A.35.

Effectiveness — appropriateness — collection of information on consumers' outcomes

'Collection of information on consumers' outcomes' is an indicator of governments' objective that consumer outcomes be monitored (box 12.10). It is a process indicator, reflecting the capability of services in establishing systems to collect information on consumers' mental health outcomes.

Box 12.10 **Collection of information on consumers' outcomes**

'Collection of information on consumers' outcomes' is defined as the proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by client type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital).

High or increasing proportions of episodes for which information on consumers' mental health outcomes is collected is desirable.

This indicator monitors the uptake of the routine National Outcomes Casemix Collection. It does not provide information on whether consumers had appropriate outcomes.

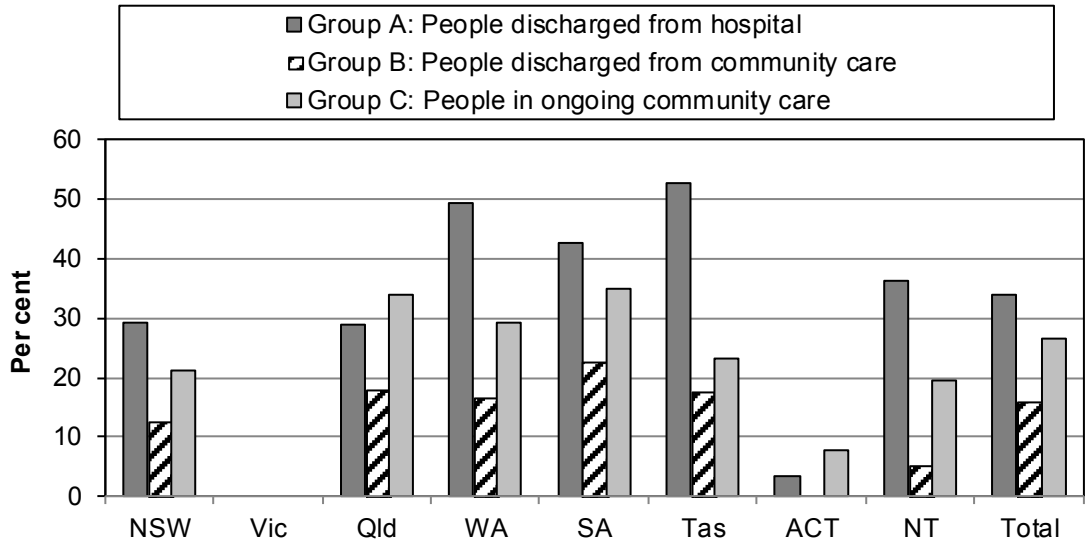
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period. All required data for 2011-12 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The estimated proportions of specialised public mental health service episodes for which information on consumers' mental health outcomes is collected are shown in figure 12.17.

Figure 12.17 **Estimated proportion of episodes for which 'complete' consumer outcome measures were collected, 2011-12[a, b, c, d]**



[a] These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government (Department of Health). To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a 'matching pair' — that is, a beginning and end rating are needed to enable an outcome score to be determined. [b] Victorian 2011-12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. [c] Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12. [d] For the ACT the proportion of matched pairs for people discharged from a community episode of care (Group B) was below the statistical threshold for a meaningful comparison.

Source: Australian Mental Health Outcomes and Classification Network (unpublished), authorised by the Australian Government Department of Health; table 12A.36.

Quality — safety — rate of seclusion — acute inpatient units

'Rate of seclusion — acute inpatient units' is an indicator of governments' objective that services are of a high quality and safe (box 12.11). The reduction, and where possible elimination of, seclusion and restraint in specialised public mental health services is a national safety priority for specialised public mental health services (NMHWG 2005).

Box 12.11 **Rate of seclusion — acute inpatient units**

'Rate of seclusion — acute inpatient units' is defined as the number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units. Seclusion involves a patient being confined at any time of the day or night alone in a room or area from which it is not within their control to leave (NMHWG 2005; NMHPSC 2011b). See section 12.6 for further details on seclusion and how 'seclusion events' are defined.

A low or decreasing number of seclusion events per 1000 patient days (or where possible none) in specialised public mental health inpatient units is desirable.

The indicator does not provide any information on the duration of seclusion events. Information on the duration of seclusion events if reported alongside this indicator would provide a better understanding of performance in relation to the use and management of seclusion in inpatient units.

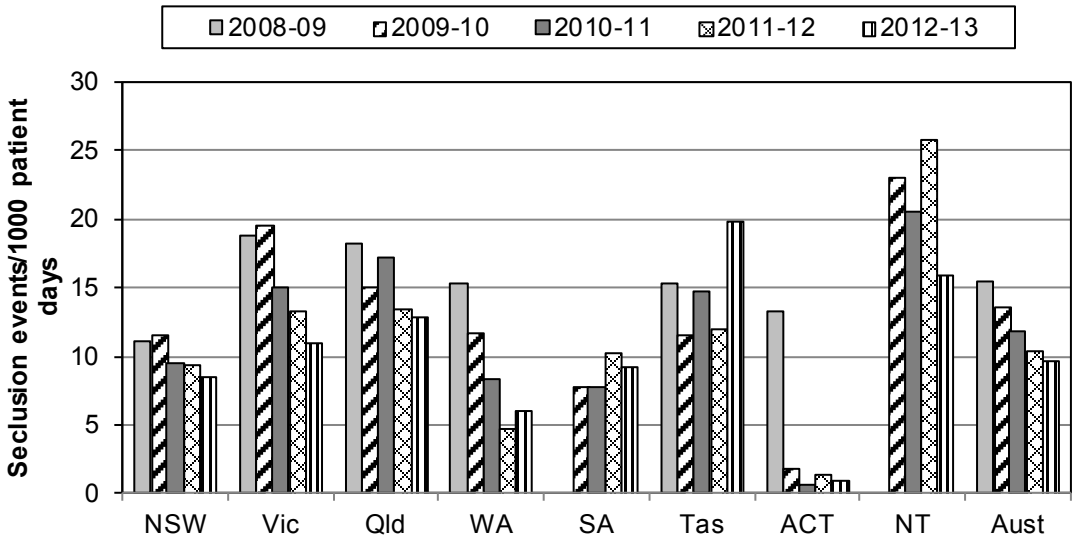
Data reported for this indicator are:

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

Data quality information for this indicator is under development.

Data on the number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units are shown in figure 12.18. Legislation (a Mental Health Act or equivalent) or mandatory policy governs the use of seclusion in each State and Territory and the definition of 'seclusion' can vary across jurisdictions (NMHPSC 2011b).

Figure 12.18 **Rate of seclusion[a, b, c, d]**



a Data are from a number of ad hoc seclusion data collections for specialised mental health public acute hospital services conducted by the Safety and Quality Partnership Standing Committee of the Mental Health, Drug and Alcohol Principal Committee, in partnership with the relevant state and territory authorities. **b** Variation in jurisdictional legislation may result in differences in the definition of a seclusion event. Data reported by jurisdictions may therefore vary and comparisons should be made with caution. **c** Detailed notes on jurisdictions' seclusion collections are in table 12A.37. **d** SA and the NT data for 2008-09 are not available.

Source: AIHW (2013); table 12A.37.

Quality — responsiveness — consumer and carer experiences of services

'Consumer and carer experiences of services' is an indicator of governments' objective that services are of a high quality and responsive to the needs of consumers and their carers (box 12.12). Consumers and their carers should have positive experiences in all mental health service areas with clinicians and services provided. Both are important aspects of the NMHS.

Box 12.12 **Consumer and carer experiences of services**

'Consumer and carer experiences of services' is yet to be defined.

Data for this indicator were not available for the 2014 Report.

Quality — responsiveness — consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective that consumers and carers are involved at the service delivery level, where they have the opportunity to influence the services they

receive (box 12.13). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.13 **Consumer and carer involvement in decision making**

'Consumer and carer involvement in decision making' is defined by two measures:

- the number of paid FTE consumer staff per 1000 FTE direct care, consumer and carer staff
- the number of paid FTE carer staff per 1000 FTE direct care, consumer and carer staff.

High or increasing proportions of paid FTE direct care, consumer and carer staff who are consumer/carer staff implies better opportunities for consumers and carers to be involved at the service delivery level, where they can influence the services received.

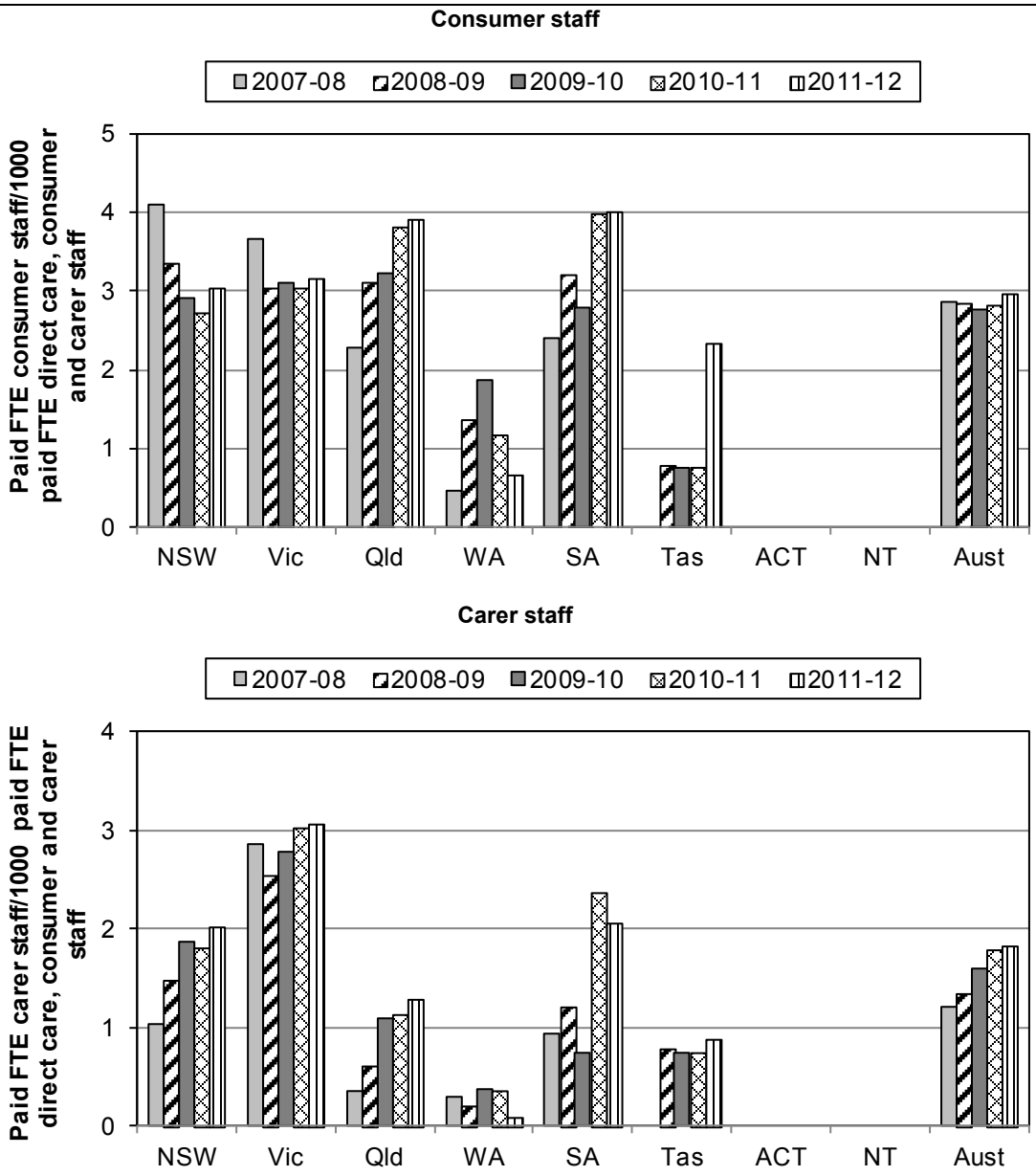
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data before 2010-11 are not comparable to data from that year
- complete for the current reporting period (subject to caveats). All required data for 2011-12 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Figure 12.19 reports the number of paid FTE consumer and carer staff per 1000 paid FTE direct care, consumer and carer staff.

Figure 12.19 **Paid FTE consumer or carer staff per 1000 paid FTE direct care, consumer and carer staff**[a, b, c, d, e]



[a] Data up to 2009-10 were restricted to consumer/carer consultants. From 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. Comparisons between data up to 2009-10 with data from 2010-11 should not be made [b] The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. [c] WA has advised that this information does not represent the full range of consumer and carer participation (see table 12A.38 for further details). [d] Tasmania did not employ consumer and carer staff in 2007-08. [e] The ACT and the NT do not employ consumer and carer staff.

Source: AIHW (unpublished) MHE NMDS; table 12A.38.

Quality — continuity — specialised public mental health service consumers with nominated GP

'Specialised public mental health service consumers with nominated GP' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services. GPs can be an important point of contact for those with a mental illness (box 12.14).

Box 12.14 **Specialised public mental health service consumers with nominated GP**

'Proportion of specialised public mental health service consumers with nominated GP' is yet to be defined.

Data for this indicator were not available for the 2014 Report.

Quality — continuity — post discharge community care

'Post discharge community care' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services (box 12.15).

Box 12.15 **Post discharge community care**

'Post discharge community care' is defined as the proportion of admitted patient overnight acute separations from psychiatric inpatient services for which a community-based ambulatory mental health care contact was recorded in the seven days following separation.

A high or increasing rate of community follow up within the first seven days of discharge from hospital is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts. Only community-based ambulatory contact made by State and Territory specialised public mental health services are included. Where clinical follow up is managed outside these services (for example, by private psychiatrists or GPs), these contacts are not included.

Data reported for this indicator are:

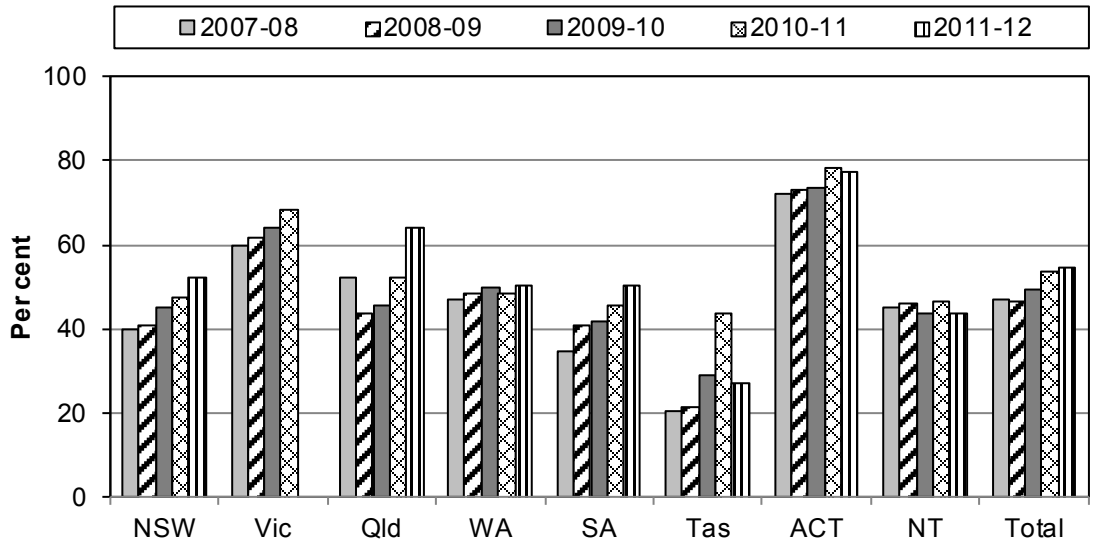
- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required 2011-12 data are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2012). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (NMHPSC 2011a).

Data on the rates of community follow up for people within the first seven days of discharge from an acute inpatient psychiatric unit are reported in figure 12.20.

Figure 12.20 **Community follow up for people within the first seven days of discharge from acute inpatient psychiatric units**[a, b, c, d, e]



[a] Community-based ambulatory mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the effect on the indicator is immaterial). Contacts made on the day of discharge are also excluded. [b] Due to data supply issues, totals for 2011-12 should be interpreted with caution.The total only includes those jurisdictions that have provided data. [c] Victorian data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. [d] Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12. [e] Data are not comparable across jurisdictions. States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers. Three jurisdictions — WA, SA and Tasmania — indicated that the data submitted were not based on unique patient identifiers. Results for these jurisdictions could appear 'lower' relative to jurisdictions that are able to track utilisation across services.

Source: State and Territory unpublished, admitted patient and community mental health care data; table 12A.39.

Quality — continuity — readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is an indicator of governments' objective to provide effective care and continuity of care in the delivery of mental health services (box 12.16).

Box 12.16 **Readmissions to hospital within 28 days of discharge**

'Readmissions to hospital within 28 days of discharge' is defined as the proportion of admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospital is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain people out of hospital (NMHPSC 2011a).

Readmission rates are affected by factors other than deficiencies in specialised public mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG Information Strategy Committee Performance Indicator Drafting Group 2005).

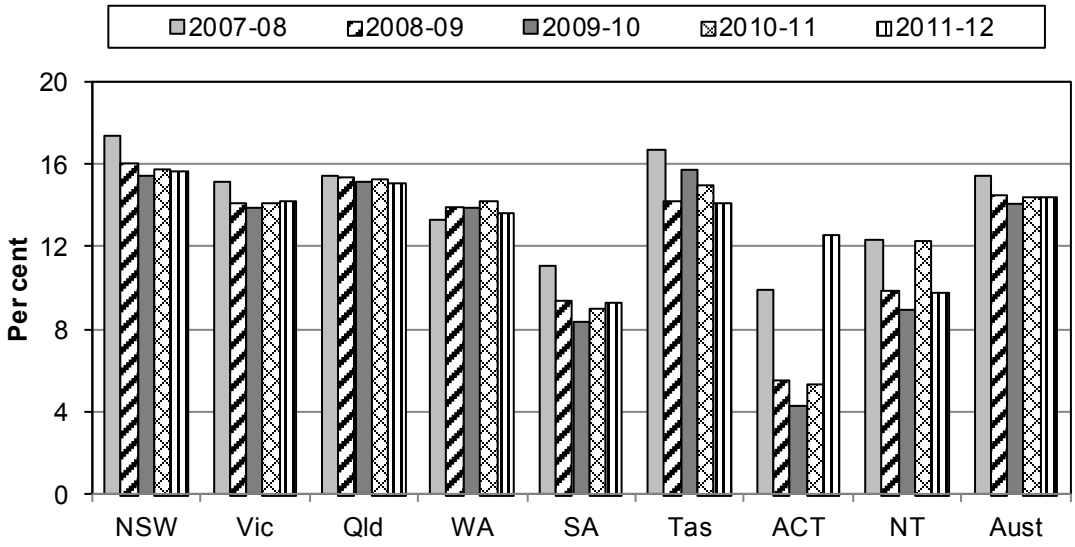
Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.21.

Figure 12.21 **Readmissions to hospital within 28 days of discharge from acute psychiatric units[a]**



a No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.

Source: Department of Health unpublished, from data provided by State and Territory governments' health authorities; table 12A.41.

Efficiency — Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency — cost of inpatient care

'Cost of inpatient care' is an indicator of governments' objective that specialised public mental health services are delivered in an efficient manner (box 12.17).

Box 12.17 **Cost of inpatient care**

'Cost of inpatient care' is defined by two measures:

- 'Cost per inpatient bed day' is defined as the cost of providing inpatient services per inpatient bed day — data are disaggregated by hospital and care type (psychiatric hospitals [acute units and non-acute units] and general hospitals [acute and non-acute units]) and by inpatient target population (acute units only).
- 'Average length of stay' is defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (acute units only). Patient days for clients who separated in the reference period (2011-12) that were during the previous period (2010-11) are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

These measures are considered together for the inpatient acute units by target population to provide a 'proxy' measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

A low or decreasing cost per inpatient bed day combined with similar or shorter average lengths of stay can indicate more efficient service delivery, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

This indicator does not account for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More suitable measures for mental health services would be cost per casemix adjusted separation, for which cost is adjusted to take into account the type and complexity of cases, and the relative stay index (that also adjusts for casemix) similar to those presented for public hospitals (chapter 10). Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Data reported for the two measures for this indicator are:

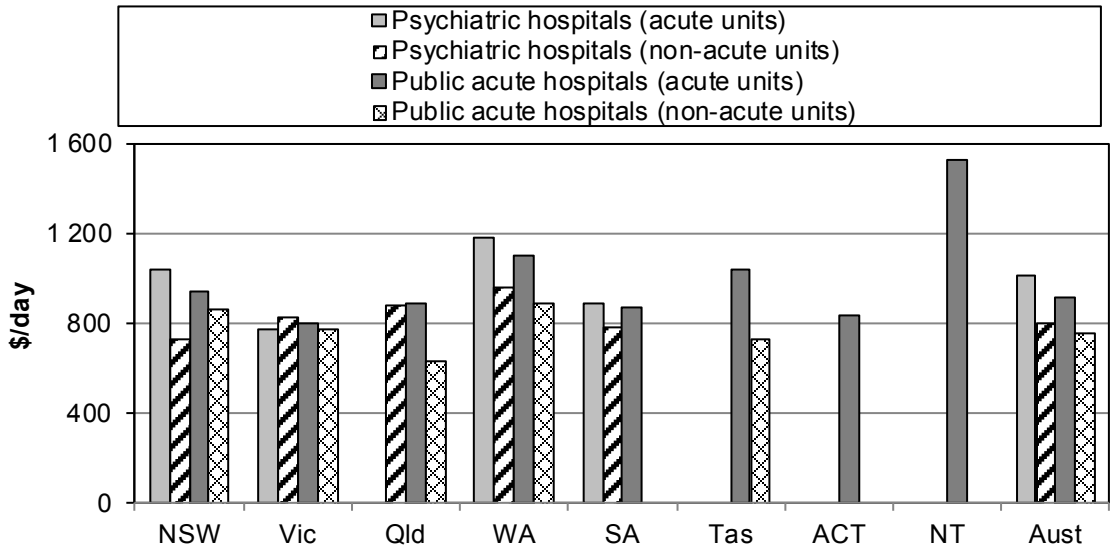
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions providing the services.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data on average recurrent cost per inpatient bed day by hospital (psychiatric and public acute) and care type (acute or non-acute) are reported in figure 12.22. Costs per inpatient bed day and average length of stay data for acute units by inpatient target population (for psychiatric and public acute hospitals combined) are presented in figure 12.23. Data for forensic services are included for costs per inpatient bed day only as the length of stay is dependent on factors outside the

control of the specialised public mental health services. Data for cost per inpatient bed day for all units by target population are included in table 12A.42.

Figure 12.22 **Average recurrent cost per inpatient bed day, public hospitals, by hospital and care type, 2011-12[a, b, c, d, e, f, g]**



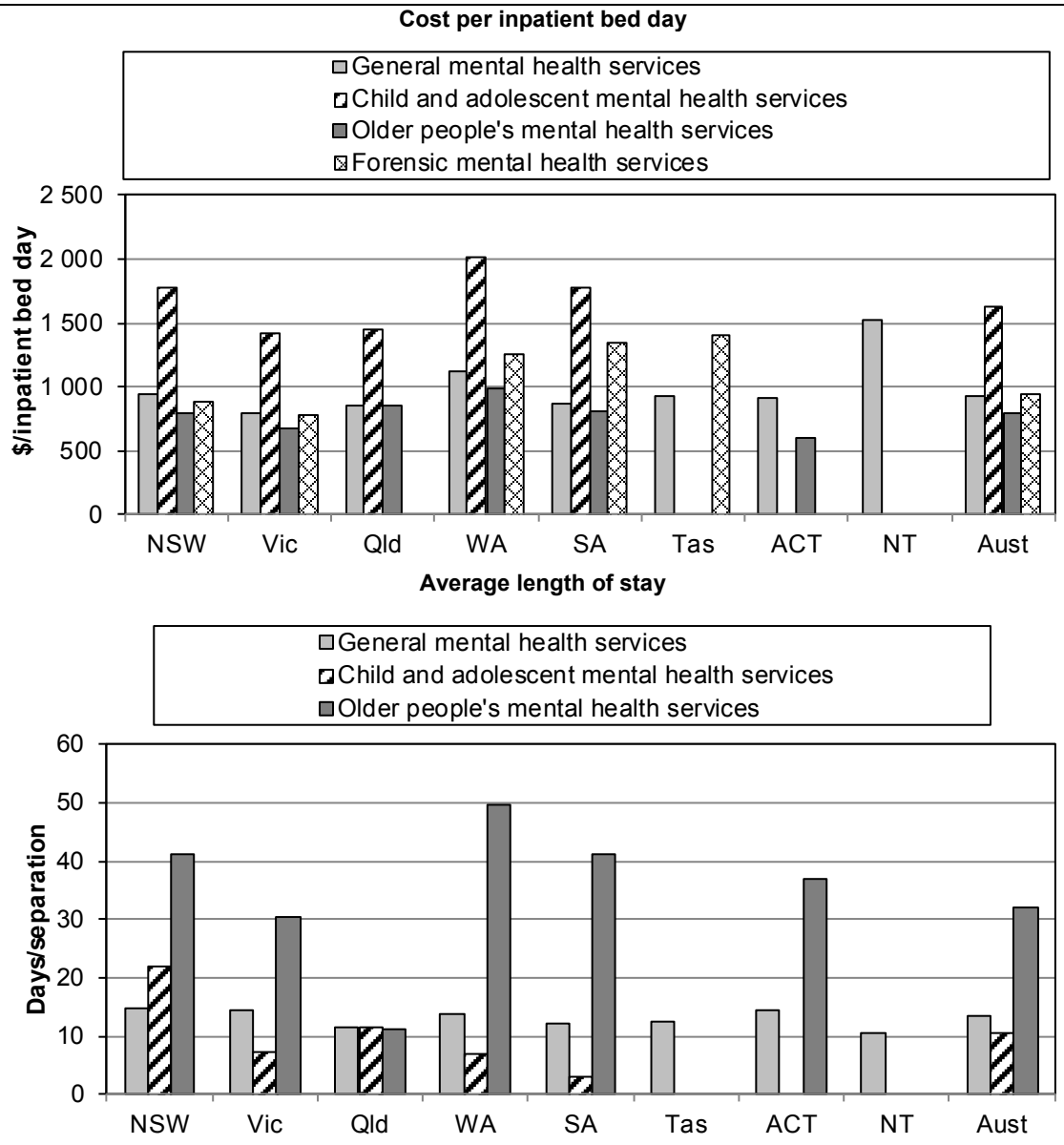
[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Mainstreaming has occurred at different rates across jurisdictions. Victorian data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. [d] Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non-government entities. [e] Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. [f] Tasmania, the ACT and the NT do not have psychiatric hospitals. [g] SA, the ACT and the NT do not have non-acute units in general hospitals.

Source: AIHW (unpublished) MHE NMDS; table 12A.45.

Data on 'average length of stay' should be considered with caution. The quality of the separations data used to derive them is variable across jurisdictions. Until recently, these separations data were not subject to in-depth scrutiny. It is expected that the quality of these data will improve over time.

The 'average length of stay' data reported here may not match data reported elsewhere (such as the AIHW's *Mental Health Services in Australia* publication) due to differences in scope, for example these data include separations and days within the reference period only.

Figure 12.23 **Costs for inpatient care in acute units of public hospitals, by target population, 2011-12[a, b, c, d, e, f, g]**



[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non-government entities. [d] Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Additionally, Queensland does not report any acute forensic services, however forensic patients can and do access acute care through general units, which may also impact on the comparability of both cost and length of stay data. [e] Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people's mental health services. [f] The ACT does not have separate forensic or child and adolescent mental health inpatient services. [g] The NT has general mental health services only.

Source: AIHW (unpublished) MHE NMDS; tables 12A.43-44.

Efficiency — cost of community-based residential care

'Cost of community-based residential care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.18).

Box 12.18 **Cost of community-based residential care**

'Cost of community-based residential care' is defined as the average cost per day for specialised public mental health services of providing community-based residential care.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based residential settings.

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 2011-12 data are available for all jurisdictions providing the services.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community-based residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost per patient day for community-based residential care services is presented in table 12.1. For general adult units in 2011-12, the average cost per patient day for 24 hour staffed community-based residential care was an estimated $447 nationally. For non-24 hour staffed community-based residential units, the average cost per patient day was $163 nationally. For State or Territory governments that had community-based older people's residential care units in 2011-12, the average recurrent cost per patient day for 24 hour staffed services was $358 nationally (table 12.1).

Table 12.1 **Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2011-12[a, b]**

	NSW[c]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*[e]	*Tas*	*ACT*[c]	*NT*[e]	*Aust*
General adult units									
24 hour staffed	225	488	..	368	484	490	650	308	447
Non-24 hour staffed	178	158	..	148	331	198	133	..	163
Older people's care units									
24 hour staffed	234	347	..	..	..	682	249	..	358

a Depreciation is excluded. **b** Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). **c** NSW, Victoria and the ACT do not have any community-based residential services that are non-24 hour older people's units. **d** Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services. **e** WA, SA and the NT do not have any community-based residential services that are older people's units. .. Not applicable.

Source: AIHW (unpublished) MHE NMDS; table 12A.46.

Efficiency — cost of ambulatory care

'Cost of ambulatory care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.19).

Box 12.19 **Cost of ambulatory care**

'Cost of ambulatory care' is defined by two measures:

- average cost per treatment day of ambulatory care provided by community-based specialised public mental health services
- average number of community treatment days per episode of ambulatory care provided by community-based specialised public mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in care costs. It is equivalent to the 'length of stay' efficiency measure for public hospitals.

(Continued next page)

Box 12.19 **(continued)**

An episode of ambulatory care is a three month period of ambulatory care for an individual registered consumer where the consumer was under 'active care' (one or more treatment days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

Low or decreasing average cost or fewer community treatment days can indicate greater efficiency although, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The measures do not account for differences in the consumer mix. The consumer mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of consumers with more complex conditions in community-based ambulatory settings.

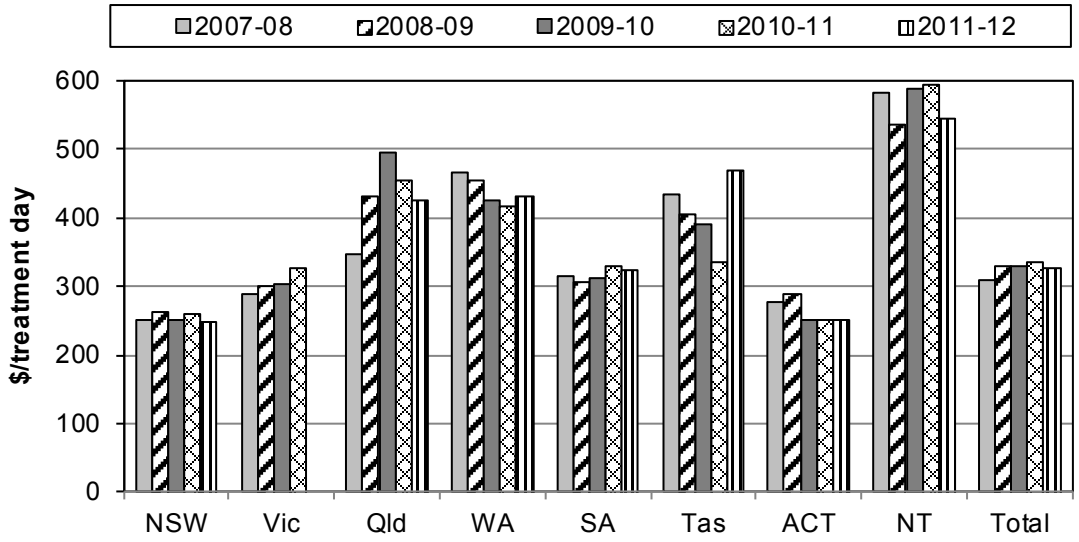
Data reported for the two measures are:

- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required data for 2011-12 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Average recurrent cost per treatment day of ambulatory care data are shown in figure 12.24 and average treatment days per episode of ambulatory care data are shown in figure 12.25.

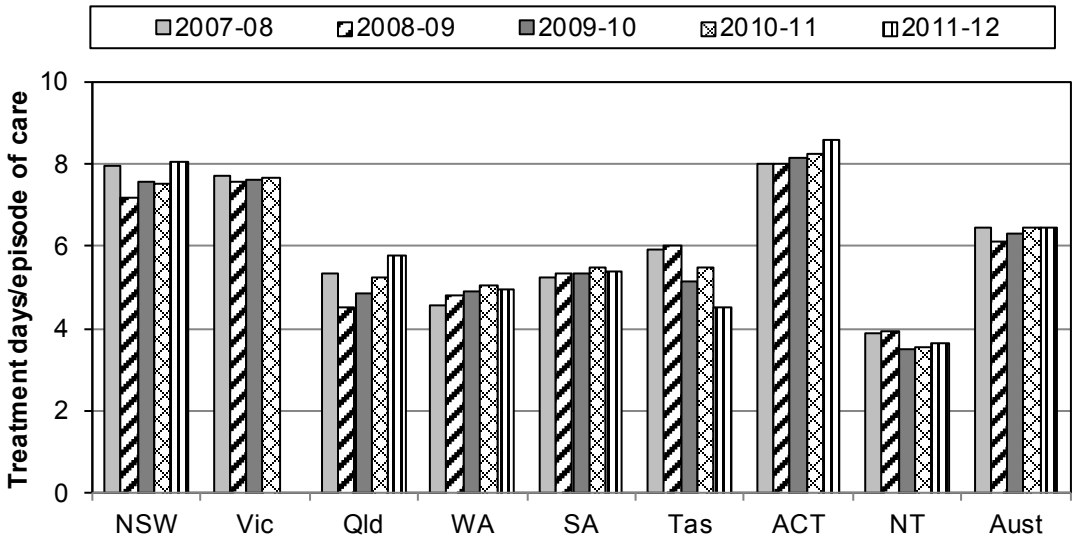
Figure 12.24 **Average recurrent cost per treatment day of ambulatory care (2011-12 dollars)[a, b, c, d, e, f]**



a Real expenditure (2011-12 dollars), using State and Territory implicit price deflators for general government final consumption on hospital and nursing home services (table 12A.73). **b** Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the CMHC NMDS that were defined as 'non-uniquely identifiable consumers'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. **c** 'Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care. **d** The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. **e** Victorian 2011-12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. **f** Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12.

Source: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.47.

Figure 12.25 **Average treatment days per episode of ambulatory care**[a, b, c, d]



[a] 'Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care and treatment days data. [b] The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. [c] Data are not available for Victoria for 2011-12 due to an industrial dispute leading to reduced collection rates. Victoria requested no substitute or proxy data be included to fill the gap at the jurisdiction level or in the calculation of the national results. The total only includes those jurisdictions that have provided data. [d] Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12.

Source: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.47.

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).

The output indicators reported above focus on specialised public mental health services provided by State and Territory governments (although the indicators 'mental health service use by selected community groups', 'mental health service use by total population' and 'primary mental health care for children and young people' include measures of access to MBS-subsidised services). The outcome indicators identified and/or reported here reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole-of-government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).

Rates of licit and illicit drug use

'Rates of licit and illicit drug use' is an indicator of governments' objective under the NMHS to prevent the development of mental health problems and mental illness where possible, by reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery (box 12.20). High rates of substance use and abuse in young people can contribute to the onset of, and poor recovery from, mental illness (NMHPSC 2011a).

Box 12.20 **Rates of licit and illicit drug use**

'Rates of licit and illicit drug use' is defined as the proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months. The specific drugs are: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin.

A low or decreasing proportion of people aged 14 years or over using specific licit and illicit drugs is desirable. It suggests a reduction in the risk factors that contribute to the onset of mental illness and prevent longer term recovery.

Many of the risk and protective factors that impact on a person's propensity to use licit or illicit drugs lie outside the ambit of the mental health system. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of substance abuse. A reduction in the prevalence of drugs use, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2010 are not comparable to data for 2007
- complete for the current reporting period (subject to caveats). All required 2010 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Alcohol is the substance most commonly used and abused, and is a major cause of death, injury and illness in Australia (AHMC 2012). In 2010, of people aged 14 years or over, 80.5 per cent drank alcohol over the last 12 months and 20.1 per cent drank alcohol at levels considered 'risky' for developing long-term health problems (table 12A.48). Data from the 2007 *National Drug Strategy Household Survey Report* on alcohol use and risk status are in table 12A.52.

Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (table 12A.49). Younger people's usage of cannabis and

meth/amphetamines is of particular concern for their associated mental health problems (AHMC 2012). Cannabis use can precipitate schizophrenia in people who have a family history, increase the risk of psychosis symptoms and also exacerbate the schizophrenia symptoms (AHMC 2012). Psychosis symptoms are also associated with meth/amphetamine use and dependent meth/amphetamine users can also suffer from a range of co-morbid mental health problems (AHMC 2012). Table 12A.50 shows the rates of use of cannabis and meth/amphetamines by young people.

Data on self-reported health conditions including mental illness and level of psychological distress by whether a person had used an illicit drug in the previous 12 months are included in table 12A.51. Data from the 2007 *National Drug Strategy Household Survey Report* on illicit drug use are in tables 12A.53–55.

Prevalence of mental illness

'Prevalence of mental illness' is an indicator of governments' objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.21).

Box 12.21 **Prevalence of mental illness**

'Prevalence of mental illness' is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.

A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

(Continued next page)

Box 12.21 **(continued)**

A reduction in the prevalence of mental illness can be brought about by preventative activities to stop an illness occurring, or by increasing access to effective treatments for those who have an illness (AHMC 2012). Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system, in sectors that affect the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2007 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Prevalence of mental illness data are from the 2007 SMHWB, the latest prevalence estimates available. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level; however, jurisdictional data are available in table 12A.56. National data on the prevalence of mental illness by disorder, age and sex are reported in tables 12A.57-58.

The SMHWB provided prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders, affective disorders and substance use disorders, but did not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder. The *National Survey of Psychotic Illness 2010* provides information on the one-month treated prevalence of these and other psychotic illnesses. In 2010, there were an estimated 3.1 cases of psychotic illness per 1000 adult population (aged 18–64 years), for which there was a contact with public specialised mental health services. Males had a higher treated prevalence rate than females (3.7 cases compared to 2.4 cases per 1000 adult population). Males aged 25–34 years had the highest rate at 5.2 cases per 1000 population (Morgan et al. 2011).

Mortality due to suicide

'Mortality due to suicide' is an indicator of governments' objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.22).

Box 12.22 **Mortality due to suicide**

'Mortality due to suicide' is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Indigenous and non-Indigenous Australians.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, non-government organisations and other special interest groups. Any effect on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.

Many factors outside the control of mental health services can influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data are not comparable across time periods for some dissagregations (see the attachment tables 12A.60–63 for details)
- complete for the current reporting period (subject to caveats). All required 2011 data are available for all jurisdictions.

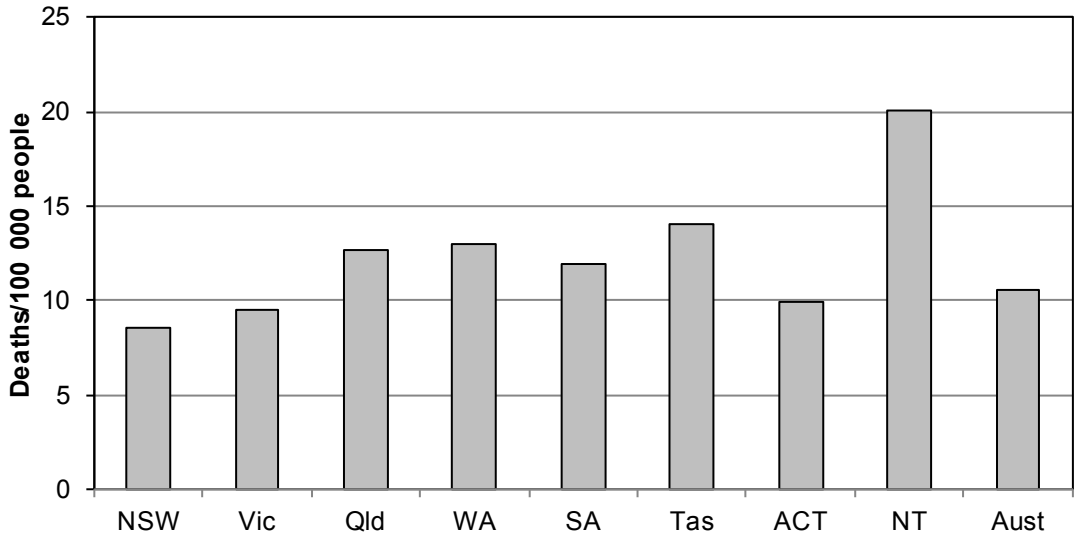
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

People with a mental illness are at a higher risk of suicide than are the general population. They are also at a higher risk of death from other causes, such as cardiovascular disease (Coghlan et al. 2001; Joukamaa et al. 2001; Sartorius 2007; Lawrence et al. 2013).

All Coroner certified deaths registered after 1 January 2006 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD-10 codes over time (ABS 2010). Each year of data is now released as preliminary, revised and final. For further information on this revisions process see the DQI for this indicator.

In the period 2007–2011, 11 600 deaths by suicide were recorded in Australia (table 12A.61) — equivalent to 10.6 deaths per 100 000 people (figure 12.26). The rate for males (16.5 per 100 000 males) was around three times that for females (4.9 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged 75–84 years and aged 85 years or over where the male suicide rate was around five or six times the female rate, respectively (figure 12.27). Table 12A.62 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

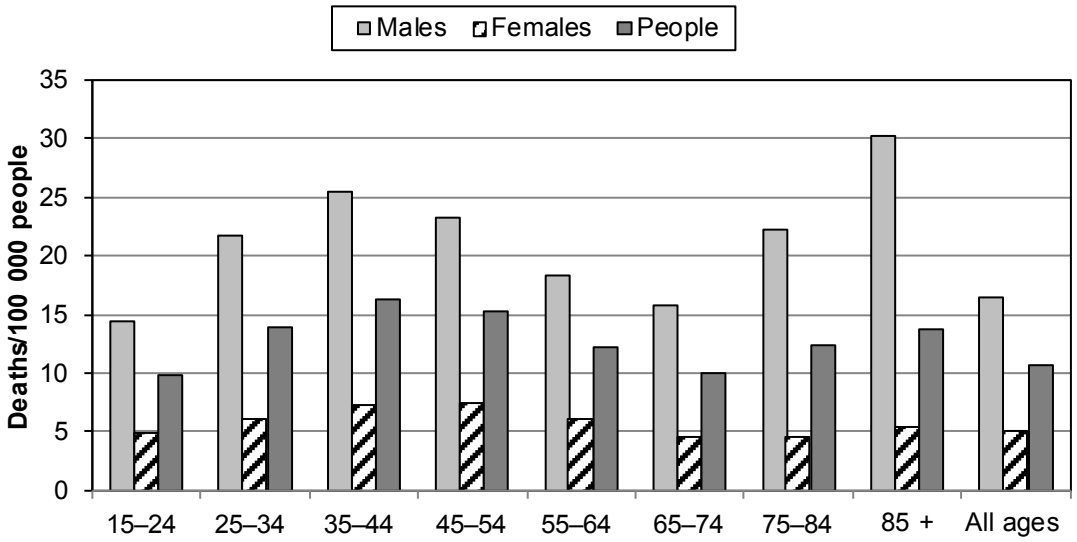
Figure 12.26 **Suicide rates, 5 year average, 2007–2011**[a, b, c]



[a] Suicide deaths include ICD-10 codes X60-X84 and Y87.0. [b] The death rate is age standardised to the mid-year 2001 population. [c] Causes of death data for 2007, 2008 and 2009 have undergone revision/s and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.61.

Figure 12.27 **Suicide rates, by age and sex, 2007–2011[a, b, c]**



[a] Suicide deaths include ICD-10 codes X60-X84 and Y87.0. [b] Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2007–2011. [c] Causes of death data for 2007, 2008 and 2009 have undergone revision/s and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process.

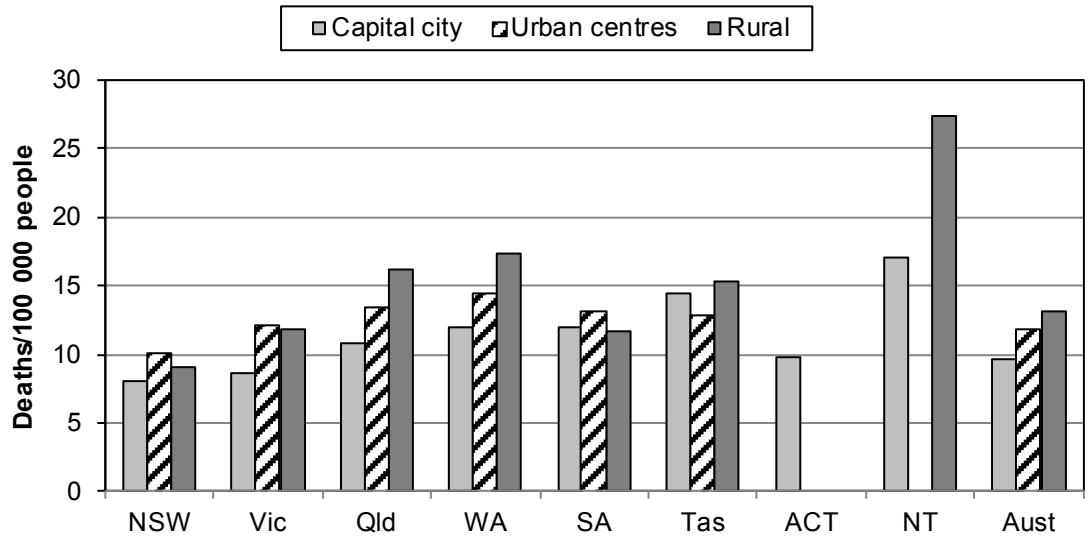
Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.60.

Nationally the suicide rate in the period 2007–2011 was higher in rural areas. There were 9.6 suicides per 100 000 people in capital cities and 11.8 suicides per 100 000 people in urban centres, compared with 13.1 suicides per 100 000 people in rural areas in Australia (figure 12.28).

Tables 12A.59 and 12A.61–63 contain time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.29). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous Australians during the period 2007–2011, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous Australians.

Figure 12.28 **Suicide rates, by area, 2007–2011**[a, b, c, d, e]

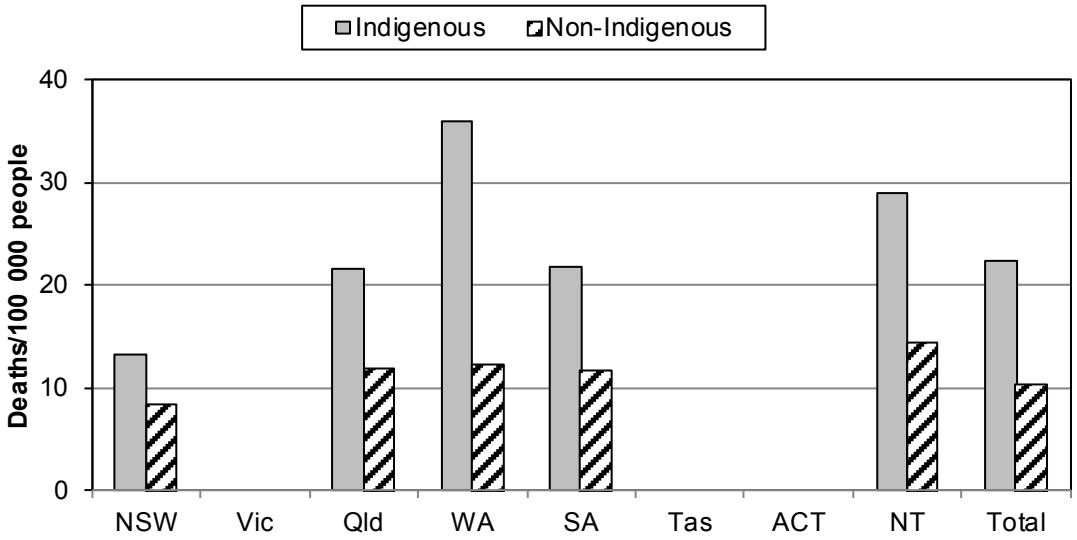


[a] The capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities comprise Statistical Area 2s classified as capital cities. Urban centres comprise all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10 000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. [b] The suicide rate is directly age standardised to the mid-year 2001 population. [c] Suicides are reported by year of registration of death. [d] Causes of death data for 2007, 2008 and 2009 have undergone revisions and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process. [e] The ACT did not have any 'urban centres'. Data for ACT 'rural' areas and NT 'urban centres' are not published.

Source: ABS (unpublished) *Causes of Deaths, Australia,* Cat. no. 3303.0; table 12A.63.

Care needs to be taken when interpreting these data because data for Indigenous Australians are incomplete and data for some jurisdictions are not published. Indigenous Australians are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions.

Figure 12.29 **Suicide rates, by Indigenous status, 2007–2011**[a, b, c, d, e, f]



[a] Deaths from suicides are deaths with ICD-10 codes X60–X84 and Y87.0. [b] Suicide rates are age-standardised. [c] Data on deaths of Indigenous Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. [d] Deaths with a 'not stated' Indigenous status are included in the data for non-Indigenous. [e] Causes of death data for 2007, 2008 and 2009 have undergone revisions and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process. [f] Total data are for NSW, Queensland, WA, SA, and the NT combined, based on the state or territory of usual residence. Data for the Indigenous mortality analysis are excluded for Victoria, Tasmania and the ACT due to insufficient levels of identification or numbers of deaths.

Source: ABS (unpublished) *Causes of Deaths, Australia,* Cat. no. 3303.0; table 12A.64.

Social and economic inclusion of people with a mental illness

'Social and economic inclusion of people with a mental illness' is an indicator of governments' objective to improve mental health and facilitate recovery from illness through encouraging meaningful participation in recreational, social, employment and other activities in the community (box 12.23).

Box 12.23 **Social and economic inclusion of people with a mental illness**

'Social and economic inclusion of people with a mental illness' is defined by two measures:

- proportion of people aged 16–64 years with a mental illness who are employed, compared with the equivalent proportion for people without a mental illness
- proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time), compared with the equivalent proportion for people without a mental illness.

A high or increasing proportion of people with a mental illness aged 16–64 years who are employed is desirable. A high or increasing proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study is also desirable.

This indicator measures employment participation relative to the total population aged 16–64 years, as distinct from the labour force (that is, people who are employed or unemployed, but actively looking for work). Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). Data on the proportion of people aged 16–64 years who are unemployed or not in the labour force (by mental illness status) are in table 12A.65. It also does not provide information on whether for those employed or enrolled for study, their jobs/studies are appropriate or meaningful.

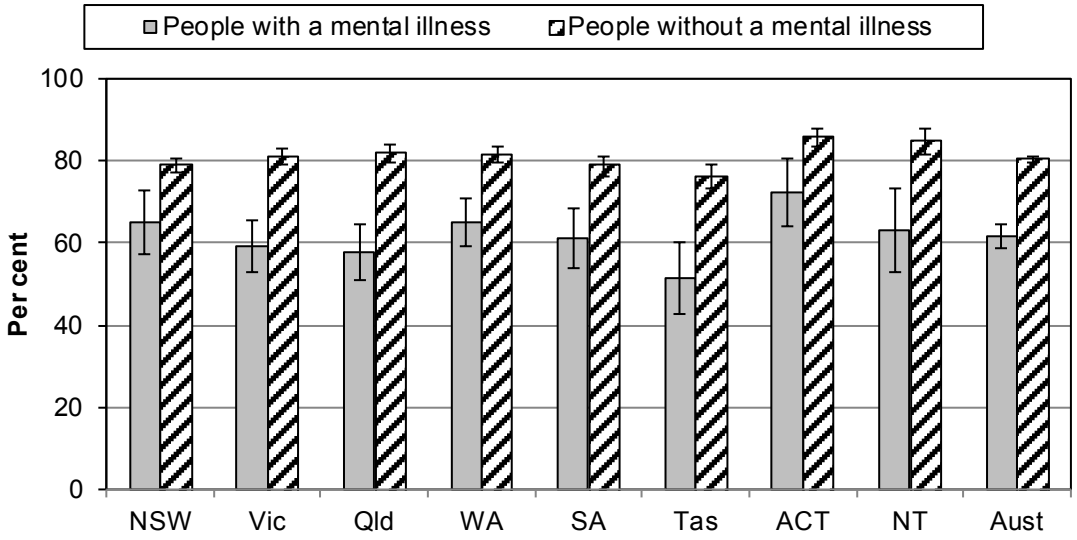
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and overtime depending on the source, that is 2011-12 NHS data are comparable to 2007-08 NHS data, but not to 2007 SMHWB data
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2012). Nationally, in 2011-12, the proportion of all Australians with a mental illness who were employed was 61.7 ± 3.1 per cent, compared to 80.3 ± 0.9 per cent for those without a mental illness (figure 12.30).

Figure 12.30 **People aged 16–64 years who are employed, by mental illness status, 2011-12[a, b]**



[a] People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. [b] Estimates have been age standardised to the 2001 estimated resident population.

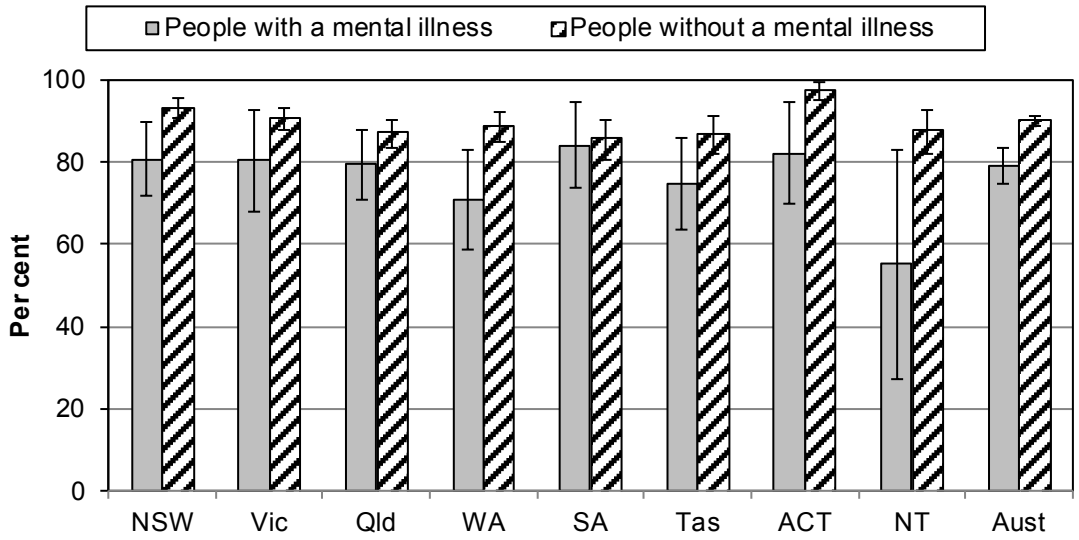
Source: ABS (unpublished) *AHS 2011–13* (2011-12 NHS component), Cat. no. 4364.0; table 12A.65.

Data from the 2007-08 National Health Survey and the 2007 SMHWB on the labour force and employment participation of people who had a mental illness/disorder are in tables 12A.69 and 12A.71.

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2012). The effect of these disruptions can be long term, restricting the person's ability to participate in a range of social and vocational activities over their lifetime (AHMC 2012).

Nationally, in 2011-12, the proportion of people aged 16–30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification was 79.2 ± 4.2 per cent, compared to 90.2 ± 1.2 per cent for those without a mental illness (figure 12.31). Data from the 2007-08 NHS and the 2007 SMHWB on the participation of people aged 16–30 years in the labour force and/or in education or training are in tables 12A.68 and 12A.70-71.

Figure 12.31 **People aged 16–30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification, by mental illness status, 2011-12[a, b]**



a People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. **b** Estimates have been age standardised to the 2001 estimated resident population.

Source: ABS (unpublished) *AHS 2011–13* (2011-12 NHS component), Cat. no. 4364.0; table 12A.66.

Mental health outcomes of consumers of specialised public mental health services

'Mental health outcomes of consumers of specialised public mental health services' is an indicator of governments' objective to improve the effectiveness and quality of service delivery and outcomes and promote recovery from mental health problems and mental illness (box 12.24).

Box 12.24 **Mental health outcomes of consumers of specialised public mental health services**

'Mental health outcomes of consumers of specialised public mental health services' is defined as the proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by three consumer types: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.

(Continued next page)

Box 12.24 **(continued)**

Results are difficult to interpret as there are a range of mental health clinical outcomes for people treated in specialised public mental health services and 'best practice' outcomes are unknown (AHMC 2012). A high or increasing proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

The assessment of a consumer's clinical mental health outcomes is based on the changes reported in a consumer's 'score' on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (AHMC 2012). Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre- and post- scores to the standard deviation of the pre-score (AHMC 2012). Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between -0.5 and zero; and 'significant deterioration' if the effect size index is less than or equal to -0.5 (AHMC 2012).

This indicator has many technical and conceptual issues. The outcome measurement tool is imprecise. A single 'average score' does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods (AHMC 2012). The approach separates a consumer's care into segments (hospital versus the community) rather than tracking the person's overall outcomes across treatment settings. In addition, consumers' outcomes are measured from the clinician's perspective and not as the 'lived experience' from the consumer's viewpoint (AHMC 2012).

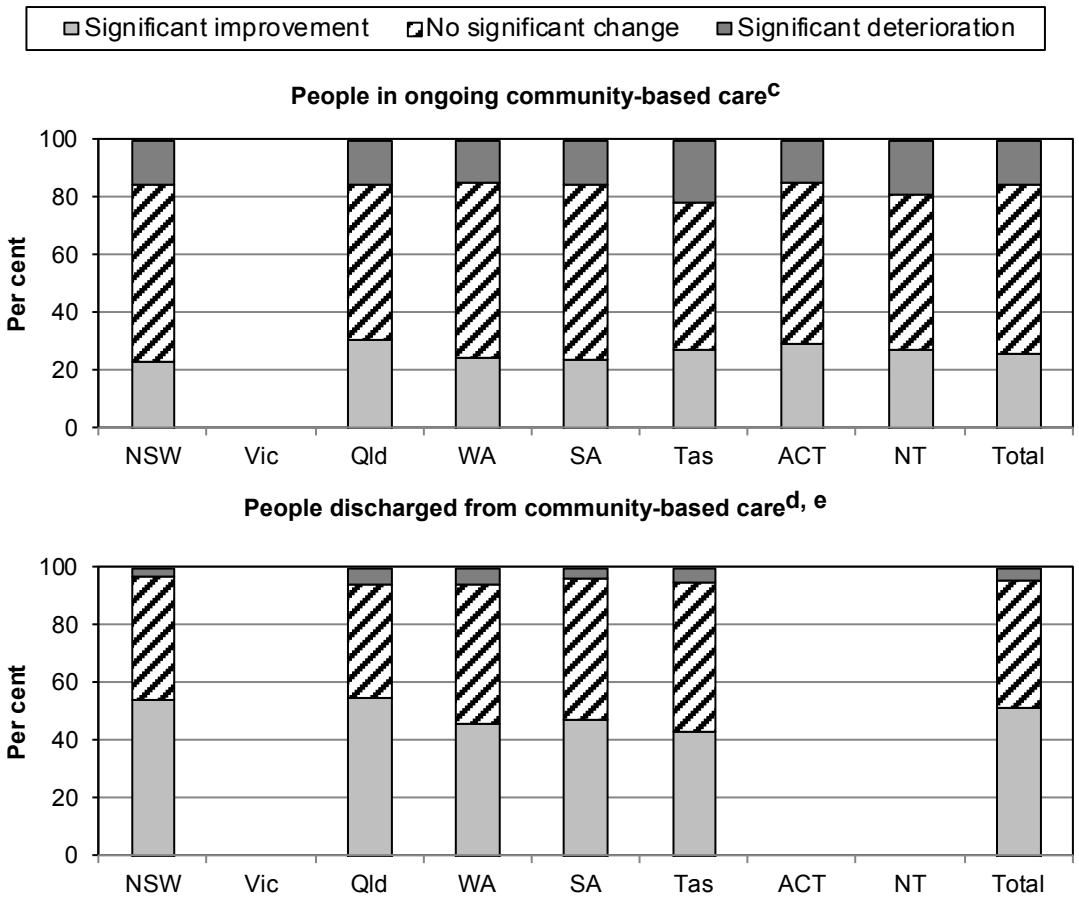
Data reported for this indicator are:

- not comparable across jurisdictions or over time due to differences in the quality of the data and the proportion of episodes for which completed outcomes data are available
- incomplete for the current reporting period. All required data for 2011-12 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, in 2011-12, 26.0 per cent of people in ongoing community-based care, 51.5 per cent of people discharged from community-based care and 70.8 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figures 12.32-33). Caution is required in interpreting results across states and territories. Data are of variable quality and there are different levels of coverage across states and territories (AHMC 2012).

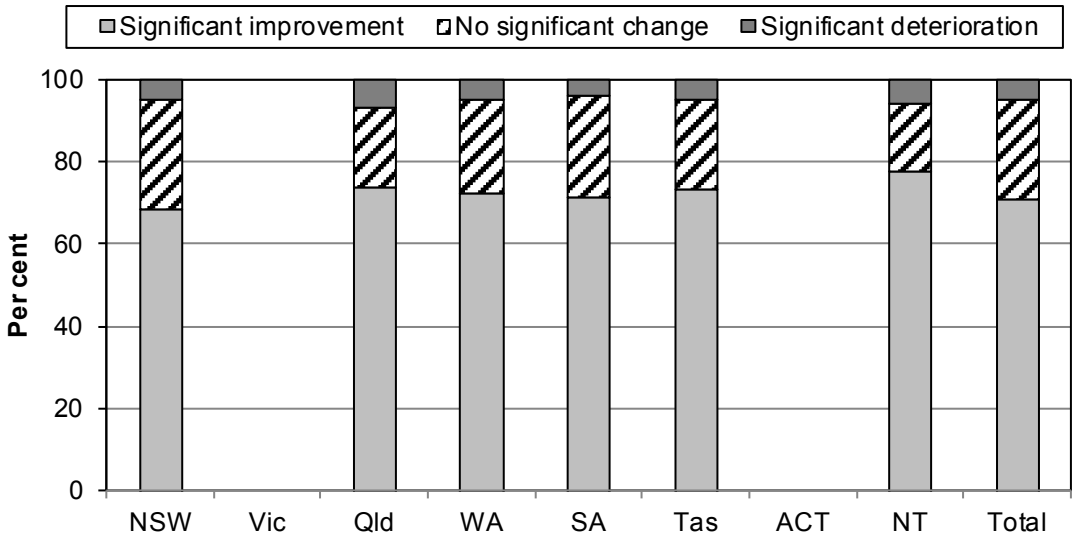
Figure 12.32 **Mental health outcomes of consumers of State and Territory community-based specialised public mental health services, 2011-12[a, b]**



a Victorian 2011-12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. **b** Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12. **c** Data comprise people receiving relatively long term community-based care. Data include people who were receiving care for the whole of 2011-12, and those who commenced community-based care sometime after 1 July 2011 who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June 2012). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year. **d** Data comprise people who received relatively short term community-based care. The defining characteristic of the group is that the episode of community-based care commenced, and was completed, within 2011-12. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge, from community-based care. People whose episode of community-based care was completed because they were admitted to hospital are not included. **e** The ACT and NT data are not published due to insufficient observations.

Source: Australian Mental Health Outcomes and Classification Network (unpublished), authorised by the Australian Government Department of Health; table 12A.72.

Figure 12.33 **Mental health outcomes of consumers discharged from State or Territory inpatient mental health services, 2011-12[a, b, c]**



a Data comprise people who received a discrete episode of inpatient care within a psychiatric unit. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where the length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes. **b** Victorian 2011-12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. **c** The ACT data are not published due to insufficient observations.

Source: Australian Mental Health Outcomes and Classification Network (unpublished), authorised by the Australian Government Department of Health; table 12A.72.

12.5 Future directions in performance reporting

Priorities for future reporting on mental health management include the following:

- improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups
- developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
- improving reporting on government funded non-government entities to include information on their activity and the outcomes of the consumers of these services
- identifying indicators that relate to the performance framework dimension of sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities

- further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

12.6 Definitions of key terms

General terms

General practice The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.

Health management The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.

Incidence rate Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).

Separation An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Mental health

Acute services Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can:

- focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms
- target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.

Accrued mental health patient days Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, that is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.

The key basic rules to calculate the number of accrued mental health care days are as follows:

	• For a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days. • Admission and discharge on the same day are equal to one patient day. • Leave days involving an overnight absence are not counted. • A patient day is recorded on the day of return from leave.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Average available beds	The number of beds available to provide overnight accommodation for patients admitted to hospital (other than neonatal cots [non-special-care] and beds occupied by hospital-in-the-home patients) or to specialised residential mental health care, averaged over the counting period. Beds are available only if they are suitably located and equipped to provide care and the necessary financial and human resources can be provided.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected.

Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, youth, older people's or forensic services. General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The proportion of the population who die as a result of suicide.
Non-acute services	Non-acute services are defined by two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of

	providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Older people's mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
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 health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Seclusion	Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement (NMHPSC 2011b). The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does

	not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition (AIHW 2013).
Seclusion event	An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions (NMHPSC 2011b).
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a non-24 or 24-hour basis.
Staffing categories (mental health)	Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis. Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry. Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation. Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses. Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states). Diagnostic and health professionals (allied health professionals): qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

	Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers. Psychologists: people who are registered as psychologists with the relevant State or Territory registration board. Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists. Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions. Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category. Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.
Stand-alone psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met: • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.
Substance use disorders	Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).
Youth mental health services	Services principally targeting children and young people generally aged 16-25 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

12.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 12A.1	Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000)
Table 12A.2	Real estimated recurrent expenditure on State and Territory governments' specialised mental health services (2011-12 dollars)
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12A Mental health management — attachment

Definitions for the indicators and descriptors in this attachment are in section 12.6 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

Attachment contents

Attachment contents

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Mental health specific payments to states and territories (d)	85 032	84 023	89 233	87 296	3 738	6 557	18 550
National programs and initiative (DOHA managed) (e)	113 607	127 400	247 401	232 183	229 205	270 592	311 737
National programs and initiative (FaHCSIA managed) (f)	–	9 935	92 537	154 211	145 463	144 906	151 238
National programs and initiative (DVA managed) (g)	149 589	161 222	160 676	169 751	163 416	160 839	157 482
National Suicide Prevention Program (h)	10 307	19 829	20 819	22 153	22 522	24 762	51 568
MBS — Psychiatrists (i)	262 908	264 324	266 916	268 158	268 944	276 689	282 976
MBS — General practitioners (j)	277 400	172 613	150 151	187 319	203 732	234 750	198 100
MBS — Psychologists/Allied Health (k)	2 858	63 976	196 628	263 557	313 334	361 400	369 570
Pharmaceutical Benefits Schedule (l)	757 454	760 443	779 721	798 931	801 106	828 666	830 424
Private Health Insurance Premium Rebates (m)	69 094	73 857	82 637	79 020	96 782	96 077	96 905
Research (n)	32 766	35 535	42 450	50 036	55 425	59 893	61 040
National Mental Health Commission (o)	..	..	..	..	..	..	2 661
TOTAL	**1 761 014**	**1 773 157**	**2 129 169**	**2 312 614**	**2 303 667**	**2 465 131**	**2 532 249**
Per cent							
Mental health specific payments to states and territories (d)	4.8	4.7	4.2	3.8	0.2	0.3	0.7
National programs and initiative (DOHA managed) (e)	6.5	7.2	11.6	10.0	9.9	11.0	12.3
National programs and initiative (FaHCSIA managed) (f)	0.0	0.6	4.3	6.7	6.3	5.9	6.0
National programs and initiative (DVA managed) (g)	8.5	9.1	7.5	7.3	7.1	6.5	6.2
National Suicide Prevention Program (h)	0.6	1.1	1.0	1.0	1.0	1.0	2.0
MBS — Psychiatrists (i)	14.9	14.9	12.5	11.6	11.7	11.2	11.2
MBS — General practitioners (j)	15.8	9.7	7.1	8.1	8.8	9.5	7.8
MBS — Psychologists/Allied Health (k)	0.2	3.6	9.2	11.4	13.6	14.7	14.6
Pharmaceutical Benefits Schedule (l)	43.0	42.9	36.6	34.5	34.8	33.6	32.8

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Private Health Insurance Premium Rebates (m)	3.9	4.2	3.9	3.4	4.2	3.9	3.8
Research (n)	1.9	2.0	2.0	2.2	2.4	2.4	2.4
National Mental Health Commission (o)	..	..	..	..	..	..	0.1
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Detailed notes on how estimates specific to Commonwealth mental health specific expenditure are derived are provided in the AIHW *Mental Health Services in Australia* on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/.

(b) Estimated Australian Government expenditure shown in the table covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, both directly and indirectly related to provision of support for people affected by mental illness, is not covered in the table.

(c) Constant price expenditure for all years expressed in 2011-12 prices using the general government final consumption expenditure on hospital and nursing home services. Details provided in table 12A.74.

(d) *Mental health specific payments to states and territories:* For years up to 2008-09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993–1998, and Australian Health Care Agreements 1998–2003 and 2008-09. From July 2009, the Australian Government provided special purpose payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA. From 2008-09 onwards, the amounts include: National Perinatal Depression Plan — Payments to States; and from 2011-12, National Partnership — Supporting Mental Health Reform. Note that the expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement – Improving Public Hospital Services, which will total $175 million over the period 2010-11 to 2013-14. Mental-health specific payments for 2010-11 cannot be separately identified from payments for other categories of subacute beds made to states and territories.

(e) *National programs and initiatives (Department of Health and Ageing [from September 2013 it is the Department of Health] managed):* This category of expenditure includes the expenditure groups described in the AIHW Mental Health Services in Australia on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/.

(f) *National programs and initiatives (Families, Housing, Community Services and Indigenous Affairs [FaHCSIA] [from September 2013 it is the Department of Social Services] managed)*: Expenditure on FaHCSIA-managed COAG Action Plan programs refers to funding outlays on three initatives funded by the Australian Government under the COAG Action Plan on Mental Health (Personal Helpers and Mentors, More Respite Care Places to Help Families and Carers, Community based programmes to help families coping with mental illness).

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*

(g) *National programs and initiatives (Department of Veterans' Affairs [DVA] managed)*: This category of expenditure includes the groups described in the AIHW *Mental Health Services in Australia* on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/

(h) *National Suicide Prevention Program*: Expenditure reported includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan and the 2010-11 and 2011-12 Federal Budgets.

(i) *Medicare Benefits Schedule – Psychiatrists*: Expenditure reported refers to benefits paid for services by consultant psychiatrists processed in each of the index years. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Medical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.

(j) *Medicare Benefits Schedule – General Practitioners (GP)*: Prior to 2006-07, General Practitioner mental health-related expenditure was based on a crude estimate of 6.1 per cent of total MBS benefits paid for GP attendances, and derived from data and assumptions as detailed in the National Mental Health Report 2007. This estimate was historical and aimed to recognise that, although few mental health specific items were available in the MBS to accurately monitor GP mental health service provision, GPs are a significant provider of services to people with mental illness. Commencing November 2006, new mental health specific GP items were introduced under the Better Access to Mental Health Care initiative. To incorporate these changes, GP expenditure reported for 2006-07 is based on total MBS benefits paid against these new mental health specific items, plus an additional 6.1 per cent of total GP Benefits paid in the period preceding the introduction of the new items (July and November 2006).
From 2007-08 onwards, expenditure on GP mental health care is based solely on benefits paid against MBS mental health specific GP items, which are predominantly the Better Access GP mental health items plus a small number of other items that were created in the years preceding the introduction of the Better Access initiative. This method provides a significantly lower expenditure figure than obtained using the 6.1 per cent estimate of previous years because it is conservative and does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific mental health item. Comparisons of GP mental health related expenditure reported pre- and post-2006-07 are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services.

(k) *Medicare Benefits Schedule – Psychologists/Allied Health*: Expenditure refers to MBS benefits paid for Clinical Psychologists, Psychologists, Social Workers and Occupational Therapists under the new items introduced through the Better Access to Mental Health Care initiative on 1 November 2006, plus a small number of Psychologist/Allied health items that were created under the Enhanced Primary Care program in the years preceding the introduction of the Better Access initiative.

(l) *Pharmaceutical Benefits Scheme*: Expenditure under the Pharmaceutical Benefits Scheme refers to all Australian Government benefits for psychiatric medication in each of the index years, defined as drugs included in the following classes of the Anatomical Therapeutic Chemical Drug Classification System: antipsychotics (except prochloperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. Expenditure on Clozapine, funded under the Highly Specialised Drugs Program, has been included for all years, including Clozapine dispensed through public hospitals. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Pharmaceutical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*

(m) *Private Health Insurance Premium Rebates*: Estimates of the 'mental health share' of Australian Government Private Health Insurance Rebates are derived from a combination of sources and based on the assumption that a proportion of Australian Government outlays designed to increase public take up of private health insurance have subsidised private psychiatric care in hospitals. The methodology undepinning these estimates is described in the AIHW Mental Health Services in Australia on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/

(n) *Research*: Research funding represents the value of mental health related grants administered by the National Health and Medical Research Council (NHMRC) during the relevant year. Data were sourced from the NHMRC website: www.nhmrc.gov.au/grants/research-funding-statistics-and-data/mental-health-1, accessed 15 September 2013.

(o) *National Mental Health Commission:* The Commission commenced operation in January 2012

.. Not applicable.

Source: Department of Health (Australian Government), unpublished.

Table 12A.2 **Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Real recurrent expenditure ($'000)									
2005-06	1 039 194.4	824 857.5	561 987.6	396 709.9	264 295.9	83 236.3	55 130.9	33 204.1	3 258 616.6
2006-07	1 084 168.0	852 054.0	627 022.5	416 401.4	293 222.2	94 789.3	64 048.7	36 348.1	3 468 054.1
2007-08	1 133 485.3	883 648.6	708 215.7	452 982.7	308 762.1	101 584.8	66 578.4	38 715.0	3 693 972.7
2008-09	1 189 574.4	915 938.5	748 092.4	483 604.9	322 794.5	103 885.0	71 371.7	40 541.8	3 875 803.3
2009-10	1 258 338.4	954 764.5	804 363.6	490 268.3	328 712.3	113 000.9	71 005.5	41 637.6	4 062 091.2
2010-11	1 344 068.2	1 002 421.7	857 340.2	544 567.5	340 799.2	119 267.5	74 380.2	44 493.5	4 327 338.1
2011-12	1 393 410.2	1 013 624.3	891 259.6	581 463.6	342 489.2	107 510.4	79 209.9	48 650.0	4 457 617.1
Real expenditure per person ($)									
2005-06	155	164	142	195	171	171	165	160	160
2006-07	160	167	155	200	188	193	189	172	168
2007-08	165	170	170	212	196	205	193	179	176
2008-09	170	172	175	219	202	207	203	182	180
2009-10	177	176	184	217	203	223	198	183	186
2010-11	187	182	193	235	209	234	204	193	195
2011-12	192	182	197	244	208	210	214	209	198

(a) Constant price expenditure expressed in 2011-12 prices using the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.73).

(b) Estimates of expenditure on State and Territory governments specialised mental health services include revenue from other sources (including patient fees and reimbursement by third party compensation insurers), Australian government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments (SPP), 'other Australian Government funds', Australian Government mental health specific payments to states and territories and funding provided through the Department of Veterans' Affairs.

(c) Depreciation is excluded for all years.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

Table 12A.2 **Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2011-12 dollars) (a), (b), (c), (d)**

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

Source: Australian Institute of Health and Welfare (AIHW) unpublished, Mental Health Establishments National Minimum Data Set (MHE NMDS); Australian Government unpublished; ABS (various issues), *Australian Demographic Statistics, December* (various years), Cat. no. 3101.0; table 12A.75.

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
2005-06									
State/Territory funds	974 115.3	774 987.1	531 711.5	382 072.6	249 163.4	77 609.4	52 368.2	31 415.5	3 073 443.0
Australian Government funds									
Mental health specific payments to states and territories (g)	25 926.0	20 551.7	16 934.3	8 820.7	6 581.3	2 554.4	1 844.9	1 724.9	84 938.1
Department of Veterans' Affairs (h)	10 280.9	9 850.5	1 103.5	2 013.9	3 741.3	184.3	179.9	–	27 354.3
Total Australian Government funds	36 206.8	30 402.2	18 037.8	10 834.6	10 322.6	2 738.7	2 024.8	1 724.9	112 292.4
Other revenue	28 872.2	19 468.2	12 238.3	3 802.7	4 809.9	2 888.3	737.9	63.6	72 881.2
Total funds	**1 039 194.4**	**824 857.5**	**561 987.6**	**396 709.9**	**264 295.9**	**83 236.3**	**55 130.9**	**33 204.1**	**3 258 616.6**
2006-07									
State/Territory funds	1 027 254.8	789 613.6	595 711.9	400 839.2	279 212.4	89 174.3	61 357.2	34 529.6	3 277 693.0
Australian Government funds									
Mental health specific payments to states and territories (g)	27 214.3	19 465.9	16 544.2	8 502.1	6 745.4	1 984.2	1 741.4	1 771.4	83 968.9
Department of Veterans' Affairs (h)	8 427.7	8 923.3	3 281.7	3 176.9	3 461.8	501.5	165.6	16.5	27 955.1
Total Australian Government funds	35 642.1	28 389.2	19 825.9	11 679.0	10 207.2	2 485.7	1 907.0	1 787.9	111 924.0
Other revenue	21 271.1	34 051.1	11 484.8	3 883.1	3 802.7	3 129.3	784.5	30.6	78 437.2
Total funds	**1 084 168.0**	**852 054.0**	**627 022.5**	**416 401.4**	**293 222.2**	**94 789.3**	**64 048.7**	**36 348.1**	**3 468 054.1**
2007-08									
State/Territory funds	1 077 417.1	829 545.6	677 800.5	437 834.3	293 292.4	95 192.7	63 380.4	36 161.1	3 510 624.0
Australian Government funds									
Mental health specific payments to states and territories (g)	27 928.4	21 108.7	17 598.1	9 005.1	6 646.1	2 433.2	2 415.1	2 092.0	89 226.7
Department of Veterans' Affairs (h)	8 346.5	6 890.9	2 546.0	2 669.6	4 010.7	333.9	247.4	36.7	25 081.7
Total Australian Government funds	36 274.8	27 999.6	20 144.1	11 674.7	10 656.8	2 767.1	2 662.6	2 128.7	114 308.4

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Other revenue	19 793.4	26 103.4	10 271.2	3 473.7	4 812.9	3 625.0	535.4	425.3	69 040.2
Total funds	**1 133 485.3**	**883 648.6**	**708 215.7**	**452 982.7**	**308 762.1**	**101 584.8**	**66 578.4**	**38 715.0**	**3 693 972.7**
2008-09									
State/Territory funds	1 137 966.6	855 329.8	715 536.1	468 206.3	303 853.7	95 767.6	68 433.7	38 750.8	3 683 844.6
Australian Government funds									
Mental health specific payments to states and territories (g)	27 594.5	20 690.9	17 645.2	8 977.5	6 419.8	2 125.2	2 059.1	1 783.9	87 296.0
Department of Veterans' Affairs (h)	8 477.1	10 604.6	3 853.2	3 934.0	4 873.3	603.3	55.5	2.6	32 403.7
Total Australian Government funds	36 071.6	31 295.5	21 498.5	12 911.4	11 293.1	2 728.5	2 114.7	1 786.5	119 699.7
Other revenue	15 536.2	29 313.2	11 057.8	2 487.2	7 647.7	5 389.0	823.3	4.5	72 259.0
Total funds	**1 189 574.4**	**915 938.5**	**748 092.4**	**483 604.9**	**322 794.5**	**103 885.0**	**71 371.7**	**40 541.8**	**3 875 803.3**
2009-10									
State/Territory funds	1 236 515.2	911 210.4	788 907.7	484 610.8	319 033.3	108 192.1	69 708.4	41 432.6	3 959 610.6
Australian Government funds									
Mental health specific payments to states and territories (g)	1 018.7	871.1	629.3	485.1	269.9	158.5	142.5	162.2	3 737.4
Department of Veterans' Affairs (h)	9 336.5	9 376.5	4 070.0	2 431.8	3 850.1	567.8	364.0	42.8	30 039.5
Total Australian Government funds	10 355.2	10 247.6	4 699.3	2 917.0	4 120.0	726.3	506.5	205.0	33 776.9
Other revenue	11 468.0	33 306.5	10 756.6	2 740.5	5 558.9	4 082.5	790.6	–	68 703.7
Total funds	**1 258 338.4**	**954 764.5**	**804 363.6**	**490 268.3**	**328 712.3**	**113 000.9**	**71 005.5**	**41 637.6**	**4 062 091.2**
2010-11									
State/Territory funds	1 305 947.5	952 397.8	840 139.0	539 317.2	332 827.5	116 286.4	72 750.7	44 214.6	4 203 880.6
Australian Government funds									
Mental health specific payments to states and territories (g)	1 845.8	1 525.9	1 301.5	816.1	456.5	211.1	181.5	217.6	6 556.0

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Department of Veterans' Affairs (h)	9 766.3	10 187.8	3 547.9	2 090.5	4 307.9	404.5	321.4	–	30 626.4
Total Australian Government funds	11 612.1	11 713.7	4 849.4	2 906.6	4 764.4	615.6	502.9	217.6	37 182.3
Other revenue	26 508.7	38 310.2	12 351.9	2 343.7	3 207.3	2 365.6	1 126.6	61.2	86 275.2
Total funds	**1 344 068.2**	**1 002 421.7**	**857 340.2**	**544 567.5**	**340 799.2**	**119 267.5**	**74 380.2**	**44 493.5**	**4 327 338.1**
2011-12									
State/Territory funds	1 361 630.0	956 499.6	868 857.5	570 698.7	332 477.3	104 104.7	77 551.8	48 105.3	4 319 924.8
Australian Government funds									
Mental health specific payments to states and territories (g)	6 082.8	3 997.1	3 252.8	2 601.6	1 326.5	340.6	552.6	395.7	18 549.6
Department of Veterans' Affairs (h)	9 506.2	9 010.6	2 859.2	1 719.6	3 849.0	461.9	275.2	43.3	27 725.1
Total Australian Government funds	15 589.0	13 007.7	6 112.0	4 321.2	5 175.5	802.4	827.8	439.0	46 274.7
Other revenue	16 191.2	44 116.9	16 290.1	6 443.6	4 836.4	2 603.3	830.3	105.7	91 417.6
Total funds	**1 393 410.2**	**1 013 624.3**	**891 259.6**	**581 463.6**	**342 489.2**	**107 510.4**	**79 209.9**	**48 650.0**	**4 457 617.1**

(a) Constant price expenditure expressed in 2011-12 prices using the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.73).

(b) Estimates of State and Territory government funds include Australian government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments (SPP).

(c) Depreciation excluded for all years.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) The Australian total for mental health specific payments to states and territories differ slightly to those in table 12A.1 as in that table the deflator for Australia is used, whereas in this table State or Territory specific deflators are used and the Australian total is the sum of states and territories.

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)**

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

(g) Mental health specific payments to states and territories: For years up to 2008-09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993-98, and Australian Health Care Agreements 1998-2003 and 2008-09. From July 2009 the Australian Government provided special purpose payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA. From 2008-09 onwards, the amounts include: National Perinatal Depression Plan – Payments to States; and from 2011-12, National Partnership — Supporting Mental Health Reform. Note that the expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement – Improving Public Hospital Services, which will total $175 million over the period 2010-11 to 2013-14. Mental-health specific payments for 2010-11 cannot be separately identified from payments for other categories of subacute beds made to states and territories.

(h) Department of Veterans' Affairs: refers to payments for mental health care provided in public hospitals for veterans. Non admitted costs are not included as relevant data sets are incomplete or unavailable. There were no mental health related public hospital services claimed in the Northern Territory in 2010-11 or 2005-06.

– Nil or rounded to zero.

Source : AIHW unpublished, MHE NMDS; Department of Health (Australian Government), unpublished.

Table 12A.4 **Real Australian, State and Territory governments expenditure on specialised mental health services (2011-12 dollars) ($000s), (a), (b), (c), (d)**

	Aust
Real expenditure ($'000)	
State and Territory governments	
2005-06	3 146 324.2
2006-07	3 356 130.2
2007-08	3 579 664.3
2008-09	3 756 103.6
2009-10	4 028 314.3
2010-11	4 290 155.8
2011-12	4 411 342.4
Australian Government	
2005-06	1 761 014.4
2006-07	1 773 157.2
2007-08	2 129 169.4
2008-09	2 312 614.0
2009-10	2 303 667.3
2010-11	2 465 130.8
2011-12	2 532 249.3
Total	
2005-06	**4 907 338.6**
2006-07	**5 129 287.4**
2007-08	**5 708 833.6**
2008-09	**6 068 717.7**
2009-10	**6 331 981.5**
2010-11	**6 755 286.6**
2011-12	**6 943 591.7**
Expenditure per person	
State and Territory governments	
2005-06	155
2006-07	163
2007-08	170
2008-09	175
2009-10	184
2010-11	193
2011-12	196
Australian Government	
2005-06	87
2006-07	86
2007-08	101
2008-09	108

Table 12A.4 **Real Australian, State and Territory governments expenditure on specialised mental health services (2011-12 dollars) ($000s), (a), (b), (c), (d)**

	Aust
2009-10	105
2010-11	111
2011-12	113
Total	
2005-06	**242**
2006-07	**249**
2007-08	**272**
2008-09	**283**
2009-10	**290**
2010-11	**305**
2011-12	**309**
Proportion of expenditure	
State and Territory governments	
2005-06	64.1
2006-07	65.4
2007-08	62.7
2008-09	61.9
2009-10	63.6
2010-11	63.5
2011-12	63.5
Australian Government	
2005-06	35.9
2006-07	34.6
2007-08	37.3
2008-09	38.1
2009-10	36.4
2010-11	36.5
2011-12	36.5

(a) Constant price expenditure expressed in 2011-12 prices using the State and Territory and Australian total implicit price deflators for general government final consumption expenditure on hospital and nursing home services (tables 12A.73 and 12A.74).

(b) Estimates of State and Territory government funds include other revenue and Australian government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments (SPP).

(c) Depreciation excluded for all years.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

Source: AIHW unpublished, MHE NMDS; Department of Health (Australian Government), unpublished; ABS (various issues), *Australian Demographic Statistics, December* (various years), Cat. no. 3101.0; table 12A.75.

Table 12A.5 **Depreciation (current prices) ($'000s) (a), (b)**

	NSW (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06	15 282	7 350	8 453	4 282	53	–	287	–	35 706
2006-07	12 392	7 234	9 656	4 059	46	–	–	–	33 387
2007-08	13 805	11 344	9 108	3 546	438	–	–	543	38 784
2008-09	8 993	12 888	8 214	4 126	3 245	–	–	–	37 466
2009-10	14 367	19 661	7 739	4 265	2 506	–	–	–	48 537
2010-11	13 425	29 586	9 248	4 341	1 493	–	–	–	58 093
2011-12	13 562	26 260	9 134	4 799	1 063	–	–	–	54 818

(a) See the *AIHW Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure estimates.

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) The quality of the NSW 2010-11 MHE NMDS data has been affected by the reconfiguration of the service system during the year.

– Nil or rounded to zero.

Source: AIHW unpublished, MHE NMDS.

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
2005-06									
Recurrent expenditure ($'000)									
Public psychiatric hospital	191 193	30 160	65 653	63 095	81 328	..	..	..	431 429
Public acute hospital	266 130	193 649	177 088	92 132	36 614	22 545	9 026	10 374	807 557
Total inpatient expenditure (i)	457 324	223 809	242 741	155 226	117 942	22 545	9 026	10 374	1 238 986
Community residential	24 448	121 861	..	4 913	2 815	16 039	5 941	268	176 285
Ambulatory	307 723	269 596	159 795	142 248	79 311	25 173	23 878	12 446	1 020 171
Non-government organisations	31 744	61 087	25 347	16 474	14 686	1 690	5 136	3 088	159 251
Indirect	64 155	32 200	26 764	7 234	5 140	4 971	2 219	2 048	144 731
Total expenditure	885 394	708 553	454 648	326 096	219 894	70 418	46 200	28 223	2 739 425
Per cent									
Public psychiatric hospital	21.6	4.3	14.4	19.3	37.0	..	..	..	15.7
Public acute hospital	30.1	27.3	39.0	28.3	16.7	32.0	19.5	36.8	29.5
Total inpatient expenditure (i)	51.7	31.6	53.4	47.6	53.6	32.0	19.5	36.8	45.2
Community residential	2.8	17.2	..	1.5	1.3	22.8	12.9	0.9	6.4
Ambulatory	34.8	38.0	35.1	43.6	36.1	35.7	51.7	44.1	37.2
Non-government organisations	3.6	8.6	5.6	5.1	6.7	2.4	11.1	10.9	5.8
Indirect	7.2	4.5	5.9	2.2	2.3	7.1	4.8	7.3	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2006-07									
Recurrent expenditure ($'000)									
Public psychiatric hospital	189 191	32 916	70 375	66 936	80 028	..	..	..	439 446
Public acute hospital	310 228	206 207	190 034	98 566	55 009	29 785	14 186	10 297	914 311
Total inpatient expenditure (i)	499 419	239 123	260 409	165 502	135 036	29 785	14 186	10 297	1 353 758
Community residential	27 812	124 657	..	6 485	2 985	18 475	6 906	349	187 669

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Ambulatory	332 867	283 885	208 876	154 482	88 466	27 721	27 418	15 240	1 138 956
Non-government organisations	40 539	64 265	32 539	18 025	21 803	3 266	5 283	4 093	189 812
Indirect	63 188	42 990	29 264	10 696	4 760	4 263	1 866	2 117	159 143
Total expenditure	963 825	754 920	531 088	355 190	253 051	83 509	55 658	32 095	3 029 337
Per cent									
Public psychiatric hospital	19.6	4.4	13.3	18.8	31.6	..	..	..	14.5
Public acute hospital	32.2	27.3	35.8	27.8	21.7	35.7	25.5	32.1	30.2
Total inpatient expenditure (i)	51.8	31.7	49.0	46.6	53.4	35.7	25.5	32.1	44.7
Community residential	2.9	16.5	..	1.8	1.2	22.1	12.4	1.1	6.2
Ambulatory	34.5	37.6	39.3	43.5	35.0	33.2	49.3	47.5	37.6
Non-government organisations	4.2	8.5	6.1	5.1	8.6	3.9	9.5	12.8	6.3
Indirect	6.6	5.7	5.5	3.0	1.9	5.1	3.4	6.6	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2007-08									
Recurrent expenditure ($'000)									
Public psychiatric hospital	181 465	39 731	77 752	67 508	80 601	..	..	..	447 057
Public acute hospital	340 701	221 090	221 511	113 050	60 245	34 203	16 006	11 663	1 018 467
Total inpatient expenditure (i)	522 166	260 821	299 262	180 558	140 846	34 203	16 006	11 663	1 465 524
Community residential	15 109	131 314	..	9 137	6 337	19 325	7 400	456	189 077
Ambulatory	372 671	303 441	249 240	174 580	98 702	29 171	27 051	16 399	1 271 255
Non-government organisations	60 362	65 625	39 436	21 079	24 487	4 690	6 117	3 843	225 639
Indirect	66 831	42 036	33 167	13 723	5 662	4 748	3 281	2 444	171 892
Total expenditure	1 037 139	803 237	621 105	399 078	276 033	92 137	59 854	34 805	3 323 388
Per cent									
Public psychiatric hospital	17.5	4.9	12.5	16.9	29.2	..	..	..	13.5

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Public acute hospital	32.9	27.5	35.7	28.3	21.8	37.1	26.7	33.5	30.6
Total inpatient expenditure (i)	50.3	32.5	48.2	45.2	51.0	37.1	26.7	33.5	44.1
Community residential	1.5	16.3	..	2.3	2.3	21.0	12.4	1.3	5.7
Ambulatory	35.9	37.8	40.1	43.7	35.8	31.7	45.2	47.1	38.3
Non-government organisations	5.8	8.2	6.3	5.3	8.9	5.1	10.2	11.0	6.8
Indirect	6.4	5.2	5.3	3.4	2.1	5.2	5.5	7.0	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2008-09									
Recurrent expenditure ($'000)									
Public psychiatric hospital	181 514	37 200	80 643	74 273	80 738	..	..	..	454 368
Public acute hospital	405 641	240 976	227 751	124 447	66 018	35 893	16 401	12 983	1 130 110
Total inpatient expenditure (i)	587 156	278 176	308 394	198 720	146 756	35 893	16 401	12 983	1 584 478
Community residential	13 905	142 206	..	12 876	9 146	19 079	9 867	877	207 956
Ambulatory	401 855	323 484	285 218	193 361	113 267	32 060	31 380	17 219	1 397 845
Non-government organisations	57 706	70 004	46 100	23 673	24 020	4 676	6 213	3 635	236 026
Indirect	54 010	45 281	41 801	14 352	6 686	5 320	2 656	3 192	173 299
Total expenditure	1 114 631	859 150	681 512	442 982	299 876	97 029	66 518	37 907	3 599 606
Per cent									
Public psychiatric hospital	16.3	4.3	11.8	16.8	26.9	..	..	..	12.6
Public acute hospital	36.4	28.0	33.4	28.1	22.0	37.0	24.7	34.2	31.4
Total inpatient expenditure (i)	52.7	32.4	45.3	44.9	48.9	37.0	24.7	34.2	44.0
Community residential	1.2	16.6	..	2.9	3.0	19.7	14.8	2.3	5.8
Ambulatory	36.1	37.7	41.9	43.6	37.8	33.0	47.2	45.4	38.8
Non-government organisations	5.2	8.1	6.8	5.3	8.0	4.8	9.3	9.6	6.6
Indirect	4.8	5.3	6.1	3.2	2.2	5.5	4.0	8.4	4.8

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10									
Recurrent expenditure ($'000)									
Public psychiatric hospital	221 217	43 821	86 884	75 391	72 841	..	..	..	500 154
Public acute hospital	416 798	252 140	244 112	131 455	74 835	43 090	16 636	12 931	1 191 998
Total inpatient expenditure (i)	638 015	295 961	330 997	206 846	147 676	43 090	16 636	12 931	1 692 152
Community residential	11 918	152 333	..	14 900	9 047	20 249	10 630	1 271	220 350
Ambulatory	434 303	344 622	338 363	206 557	123 367	34 007	30 945	19 395	1 531 558
Non-government organisations	68 310	74 657	50 254	25 777	30 192	5 495	7 908	3 748	266 340
Indirect	65 525	56 640	46 945	14 126	6 925	6 318	2 473	2 793	201 744
Total expenditure	1 218 072	924 212	766 558	468 206	317 207	109 159	68 591	40 139	3 912 145
Per cent									
Public psychiatric hospital	18.2	4.7	11.3	16.1	23.0	..	..	..	12.8
Public acute hospital	34.2	27.3	31.8	28.1	23.6	39.5	24.3	32.2	30.5
Total inpatient expenditure (i)	52.4	32.0	43.2	44.2	46.6	39.5	24.3	32.2	43.3
Community residential	1.0	16.5	..	3.2	2.9	18.6	15.5	3.2	5.6
Ambulatory	35.7	37.3	44.1	44.1	38.9	31.2	45.1	48.3	39.1
Non-government organisations	5.6	8.1	6.6	5.5	9.5	5.0	11.5	9.3	6.8
Indirect	5.4	6.1	6.1	3.0	2.2	5.8	3.6	7.0	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11									
Recurrent expenditure ($'000)									
Public psychiatric hospital	243 983	42 208	90 406	82 134	66 809	..	..	..	525 539
Public acute hospital	451 426	271 298	254 034	151 114	74 959	44 492	18 564	14 301	1 280 190
Total inpatient expenditure (i)	695 410	313 506	344 440	233 247	141 768	44 492	18 564	14 301	1 805 729

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Community residential	11 773	164 361	..	17 747	11 754	21 040	10 014	1 458	238 147
Ambulatory	465 525	368 771	364 375	221 445	135 670	36 229	32 348	20 929	1 645 293
Non-government organisations	72 596	80 406	65 576	28 472	36 494	7 677	8 633	3 382	303 238
Indirect	69 195	58 336	60 658	24 596	6 252	6 966	2 961	3 267	232 230
Total expenditure	1 314 499	985 381	835 049	525 508	331 938	116 405	72 521	43 337	4 224 637
Per cent									
Public psychiatric hospital	18.6	4.3	10.8	15.6	20.1	..	..	..	12.4
Public acute hospital	34.3	27.5	30.4	28.8	22.6	38.2	25.6	33.0	30.3
Total inpatient expenditure (i)	52.9	31.8	41.2	44.4	42.7	38.2	25.6	33.0	42.7
Community residential	0.9	16.7	..	3.4	3.5	18.1	13.8	3.4	5.6
Ambulatory	35.4	37.4	43.6	42.1	40.9	31.1	44.6	48.3	38.9
Non-government organisations	5.5	8.2	7.9	5.4	11.0	6.6	11.9	7.8	7.2
Indirect	5.3	5.9	7.3	4.7	1.9	6.0	4.1	7.5	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011-12									
Recurrent expenditure ($'000)									
Public psychiatric hospital	236 006	40 821	97 368	88 757	63 841	..	..	..	526 794
Public acute hospital	511 470	274 569	267 483	167 242	73 621	40 559	19 437	16 004	1 370 386
Total inpatient expenditure (i)	747 476	315 390	364 851	255 999	137 463	40 559	19 437	16 004	1 897 180
Community residential	11 664	164 144	..	21 556	18 442	19 837	11 014	1 486	248 143
Ambulatory	497 775	394 360	401 463	240 252	144 506	34 302	35 444	23 286	1 771 390
Non-government organisations	68 051	83 643	69 410	31 796	33 460	6 507	10 529	3 571	306 967
Indirect	68 445	56 086	55 536	31 860	8 618	6 304	2 785	4 302	233 937
Total expenditure	1 393 410	1 013 624	891 260	581 464	342 489	107 510	79 210	48 650	4 457 617

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Per cent									
Public psychiatric hospital	16.9	4.0	10.9	15.3	18.6	..	..	..	11.8
Public acute hospital	36.7	27.1	30.0	28.8	21.5	37.7	24.5	32.9	30.7
Total inpatient expenditure (i)	53.6	31.1	40.9	44.0	40.1	37.7	24.5	32.9	42.6
Community residential	0.8	16.2	..	3.7	5.4	18.5	13.9	3.1	5.6
Ambulatory	35.7	38.9	45.0	41.3	42.2	31.9	44.7	47.9	39.7
Non-government organisations	4.9	8.3	7.8	5.5	9.8	6.1	13.3	7.3	6.9
Indirect	4.9	5.5	6.2	5.5	2.5	5.9	3.5	8.8	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Expenditure is current prices for all years and includes all spending, regardless of source of funds.

(b) Depreciation is excluded for all years.

(c) See the AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure estimates.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(e) Totals may not add due to rounding

(f) The quality of the NSW 2010-11 *MHE NMDS* data has been affected by the reconfiguration of the service system during the year.

(g) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day seven days a week. In addition, Queensland have advised that funding to non-government services for psychiatric disability support services is administered either by Queensland Health or Disability Services Queensland (DSQ).

(h) For Tasmania, in 2005-06, non-government organisations (NGOs) providing residential services were included for the first time in the community residential category. As these NGOs are now categorised as residential services, NGO funding has decreased from previous years. Indirect/residual expenditure represents State indirect/residual expenditure. If organisational indirect expenditure were included this expenditure would have been $10 719 100.

(i) Includes expenditure on public hospital services managed and operated by private and non-government entities.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS; State and Territory governments unpublished.

Table 12A.7 **Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent) (a)**

	Any 12-month mental disorder (b)	*No 12-month mental disorder*	*Total*
Level of psychological distress (c)			
Low	10.9 ± 1.1	89.1 ± 1.0	100.0
Moderate	32.0 ± 2.6	68.0 ± 2.5	100.0
High	57.1 ± 5.1	42.9 ± 5.1	100.0
Very high	79.6 ± 7.2	20.4 ± 7.1	100.0
Disability status (d)			
Profound/severe	42.9 ± 8.2	57.1 ± 8.2	100.0
Moderate/mild	32.1 ± 5.5	67.9 ± 5.6	100.0
Schooling/employment restriction only	43.4 ± 7.1	56.6 ± 7.1	100.0
No disability/no specific limitations or restrictions	16.6 ± 1.1	83.4 ± 1.1	100.0
Days out of role (e)			
0 days	14.7 ± 1.3	85.3 ± 1.3	100.0
1 to 7 days	28.5 ± 2.5	71.5 ± 2.5	100.0
More than 7 days	42.0 ± 5.2	58.0 ± 5.2	100.0
Suicidal behaviour			
Ideation (f)	71.7 ± 8.7	28.3 ± 8.7	100.0
Plans	77.5 ± 12.6	22.5*± 12.6	100.0
Attempts	94.2 ± 9.0	5.8** ± 8.9	100.0
No suicidal behaviours	18.7 ± 1.1	81.3 ± 1.1	100.0
Total people aged 16–85 years	20.0 ± 1.1	80.0 ± 1.1	100.0

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) Level of psychological distress is measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; low scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50.

(d) Disability status relates to whether a person has disability, a core-activity limitation (mild, moderate, severe or profound), or a schooling or employment restriction.

(e) People who were unable to carry out or had to cut down on their usual activities in the 30 days prior to interview. Total includes 'not stated'.

(f) Suicidal ideation refers to the presence of serious thoughts about committing suicide.

Source: ABS 2008, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0.

Table 12A.8 **Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion					
Males	%	2.5	3.3	2.9	2.1	2.8	2.3*	2.5	2.4*	2.7
Females	%	3.8	4.0	4.8	3.8	3.7	4.0	3.1	4.0	4.1
Total	**%**	**3.2**	**3.7**	**3.9**	**3.0**	**3.3**	**3.2**	**2.8**	**3.2**	**3.4**
					Relative standard errors					
Males	%	20.2	15.5	18.6	23.9	20.3	32.2	22.1	34.5	9.5
Females	%	13.4	15.7	13.2	14.1	16.8	20.7	20.7	23.0	7.1
Total	**%**	**12.0**	**11.7**	**12.1**	**13.0**	**12.7**	**17.7**	**15.4**	**20.1**	**5.9**
					95 per cent confidence intervals					
Males	±	1.0	1.0	1.1	1.0	1.1	1.5	1.1	1.6	0.5
Females	±	1.0	1.2	1.2	1.0	1.2	1.6	1.3	1.8	0.6
Total	**±**	**0.7**	**0.8**	**0.9**	**0.8**	**0.8**	**1.1**	**0.9**	**1.3**	**0.4**

(a) Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined.

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

Source : ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component),* Cat. no. 4364.0.

Table 12A.9 **Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12 (a), (b), (c), (d)**

	Age standardised proportion (%)	*Relative standard error (%)*	*95 % confidence interval (±)*
Remoteness of residence			
Major cities	3.3	8.0	0.5
Inner regional	3.8	12.8	0.9
Outer regional	3.5	19.2	1.3
Remote	2.9*	42.1	2.4
Very remote (e)	..	..	..
SEIFA of residence (quintiles) (f)			
Quintile 1	5.4	12.6	1.3
Quintile 2	4.1	8.8	0.7
Quintile 3	3.5	12.7	0.9
Quintile 4	2.8	13.3	0.7
Quintile 5	1.9	17.2	0.6
SEIFA of residence (deciles) (f)			
Decile 1	5.7	15.9	1.8
Decile 2	5.2	17.4	1.8
Decile 3	3.9	14.8	1.1
Decile 4	4.2	14.5	1.2
Decile 5	4.1	17.5	1.4
Decile 6	2.9	15.8	0.9
Decile 7	3.0	18.8	1.1
Decile 8	2.7	21.5	1.1
Decile 9	2.0	23.8	1.0
Decile 10	1.7*	25.3	0.9
Disability status			
With disability or restrictive long-term health condition	8.2	6.7	1.1
No disability or restrictive long-term health condition	1.1	9.4	0.2

SEIFA = Socio-Economic Indexes for Areas

(a) Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data was not collected in the 2011-12 component of the 2011-13 AHS.

(f) Socioeconomic Index for Areas, Index of relative disadvantage. Quintile/decile 1 contains areas of most disadvantage

.. Not applicable.

Table 12A.9 **Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12 (a), (b), (c), (d)**

	Age standardised proportion (%)	*Relative standard error (%)*	*95 % confidence interval (±)*

Source: ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
						Age standardised proportion				
Remoteness of residence										
Major cities	%	10.6	10.7	10.6	10.3	10.5	..	9.1	..	10.6
Inner regional	%	9.9	13.1	11.9	13.3	11.0*	8.8	–	..	11.4
Outer regional/remote	%	8.3*	13.2*	9.9	9.8	16.8	10.4	..	9.0	10.8
Very remote (e)	%	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles) (f)										
Quintile 1	%	15.9	16.4	19.6	16.5	17.6	11.2	np	11.1	16.7
Quintile 2	%	14.0	13.0	11.9	13.4	12.5	9.3	11.4*	6.8*	12.9
Quintile 3	%	11.0	11.6	11.3	10.3	8.2	10.2	11.0*	10.0*	10.9
Quintile 4	%	8.3	9.6	7.7	6.7	5.9*	6.7*	10.6	9.1*	8.1
Quintile 5	%	5.7	7.8	8.1	8.3	10.1	5.9*	7.3	6.8*	7.4
Disability status										
With disability or restrictive long-term health condition	%	21.2	26.6	21.4	22.1	24.3	17.4	17.5	20.4	22.7
No disability or restrictive long-term health condition	%	5.2	4.8	5.1	4.7	5.1	3.8	4.4	3.8	5.0
Total	%	**10.4**	**11.4**	**10.8**	**10.6**	**11.4**	**9.1**	**9.1**	**9.0**	**10.8**
						Relative standard errors				
Remoteness of residence										
Major cities	%	6.5	6.9	8.4	8.0	8.5	–	9.7	..	3.4
Inner regional	%	16.9	13.4	13.7	22.4	29.3	10.5	–	..	7.3
Outer regional/remote	%	44.2	31.7	22.0	19.2	19.2	16.9	..	15.0	11.5
Very remote (e)	%	..	..	..	..	..	..	..	..	..

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
SEIFA of residence (quintiles) (f)										
Quintile 1	%	12.7	11.9	17.3	13.4	13.1	14.2	np	23.5	7.8
Quintile 2	%	12.2	12.6	11.9	15.2	11.9	17.4	34.7	36.8	5.2
Quintile 3	%	17.6	12.2	10.6	17.4	21.2	16.5	26.4	30.6	6.1
Quintile 4	%	17.1	15.9	16.1	16.5	29.7	28.7	15.9	25.6	9.6
Quintile 5	%	19.8	20.9	16.4	19.2	24.7	47.7	16.9	28.4	9.0
Disability status										
With disability or restrictive long-term health condition	%	9.5	7.1	7.7	8.1	8.5	11.5	13.1	15.3	3.7
No disability or restrictive long-term health condition	%	11.0	10.6	11.7	14.2	12.6	18.7	16.1	21.8	4.8
Total	**%**	**6.7**	**6.2**	**6.3**	**7.2**	**7.3**	**8.8**	**9.7**	**15.0**	**3.2**
					95 per cent confidence intervals					
Remoteness of residence										
Major cities	±	1.4	1.4	1.7	1.6	1.8	..	1.7	..	0.7
Inner regional	±	3.3	3.4	3.2	5.8	6.3	1.8	–	..	1.6
Outer regional/remote	±	7.2	8.2	4.3	3.7	6.3	3.5	..	2.7	2.4
Very remote (e)	±	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles) (f)										
Quintile 1	±	4.0	3.8	6.6	4.3	4.5	3.1	np	5.1	2.5
Quintile 2	±	3.3	3.2	2.8	4.0	2.9	3.2	7.7	4.9	1.3
Quintile 3	±	3.8	2.8	2.4	3.5	3.4	3.3	5.7	6.0	1.3
Quintile 4	±	2.8	3.0	2.4	2.1	3.4	3.8	3.3	4.5	1.5
Quintile 5	±	2.2	3.2	2.6	3.1	4.9	5.5	2.4	3.8	1.3

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Disability status										
With disability or restrictive long-term health condition	±	3.9	3.7	3.2	3.5	4.1	3.9	4.5	6.1	1.7
No disability or restrictive long-term health condition	±	1.1	1.0	1.2	1.3	1.3	1.4	1.4	1.6	0.5
Total	**±**	**1.4**	**1.4**	**1.3**	**1.5**	**1.6**	**1.6**	**1.7**	**2.7**	**0.7**

SEIFA = Socio-Economic Indexes for Areas

(a) Total includes a small number of persons for whom levels of psychological distress were unable to be determined

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data was not collected in the 2011-12 component of the 2011-13 AHS.

(f) Socioeconomic Index for Areas, Index of relative disadvantage. Quintile/decile 1 contains areas of most disadvantage

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

Source: ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)* , Cat. no. 4364.0.

Table 12A.11 **Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion (c), (d)					
Males	%	3.2	3.0	2.0	2.3	3.5	*2.5	np	np	2.8
Females	%	4.8	4.0	4.1	3.3	3.5	*4.0	np	np	4.1
Total	**%**	**4.0**	**3.5**	**3.1**	**2.8**	**3.5**	**3.3**	**3.4**	**np**	**3.5**
					Relative standard errors (d)					
Males	%	18.0	23.0	20.3	22.1	19.8	31.4	np	np	9.2
Females	%	16.1	16.0	15.5	17.8	18.6	26.0	np	np	9.3
Total	**%**	**11.9**	**13.3**	**13.5**	**13.6**	**13.8**	**20.0**	**17.6**	**np**	**6.7**
					95 per cent confidence intervals					
Males	±	1.1	1.3	0.8	1.0	1.4	1.5	np	np	0.5
Females	±	1.5	1.2	1.2	1.2	1.3	2.0	np	np	0.8
Total	**±**	**0.9**	**0.9**	**0.8**	**0.8**	**1.0**	**1.3**	**1.2**	**np**	**0.5**

(a) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(b) Adults are defined as people aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

np Not published.

Source : ABS unpublished, *2007-08 National Health Survey* , Cat. no. 4364.0.

Table 12A.12 **Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08 (a), (b)**

	Proportion (c), (d)	*Relative standard error (%)* (d)	*95 % confidence interval (±)*
Remoteness of residence			
Major cities	3.6	8.0	0.6
Inner regional	3.3	11.5	0.8
Outer regional	3.0	14.7	0.9
Remote	*3.2	32.5	2.0
Very remote (e)	..	..	..
SEIFA of residence (quintiles)			
Quintile 1	6.5	9.5	1.2
Quintile 2	3.7	12.7	0.9
Quintile 3	3.3	15.1	1.0
Quintile 4	2.1	16.1	0.7
Quintile 5	2.3	19.0	0.9
SEIFA of residence (deciles)			
Decile 1	8.1	12.2	1.9
Decile 2	5.1	12.3	1.2
Decile 3	4.1	16.1	1.3
Decile 4	3.2	19.3	1.2
Decile 5	3.7	23.7	1.7
Decile 6	2.7	17.0	0.9
Decile 7	2.1	22.6	0.9
Decile 8	2.2	22.1	1.0
Decile 9	*2.9	25.2	1.4
Decile 10	*1.5	27.0	0.8
Disability status			
With disability or restrictive long-term health condition	7.3	6.4	0.9
No disability or restrictive long-term health condition	1.0	16.4	0.3
Total	**3.5**	**6.7**	**0.5**

SEIFA = Socio-Economic Indexes for Areas

(a) Adults are defined as people aged 18 years and over.

(b) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimate with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data were not collected in the 2007-08 NHS.

Table 12A.12 **Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08 (a), (b)**

	Proportion (c), (d)	*Relative standard error (%)* (d)	*95 % confidence interval (±)*

.. Not applicable.

Source: ABS unpublished, *2007-08 National Health Survey*, Cat. no. 4364.0.

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion (c)					
Remoteness of residence										
Major cities	%	13.4	11.9	11.2	9.7	12.3	..	10.9	..	12.1
Inner regional	%	12.1	11.7	11.9	10.9	*13.3	11.6	–	..	11.9
Outer regional/remote	%	*12.2	8.5	13.0	*9.6	14.2	9.9	..	*13.4	11.8
Very remote (d)	%	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles)										
Quintile 1	%	20.1	18.6	15.8	19.3	20.4	15.9	np	np	18.6
Quintile 2	%	13.2	14.0	12.4	9.3	13.8	8.7	np	np	12.6
Quintile 3	%	11.4	11.5	11.4	14.3	13.1	9.0	*20.5	np	11.9
Quintile 4	%	9.8	8.5	*7.8	8.2	9.0	*6.7	12.4	np	8.9
Quintile 5	%	10.1	10.0	9.5	*3.9	9.9	*9.4	7.1	*23.4	9.2
Disability status										
With disability or restrictive long-term health condition	%	23.4	21.0	18.7	17.9	24.8	19.9	19.4	np	21.0
No disability or restrictive long-term health condition	%	6.3	5.3	6.8	5.1	5.2	4.8	4.6	np	5.9
Gender										
Males	%	10.2	8.5	9.0	8.6	12.2	9.0	9.8	np	9.6
Females	%	15.4	15.0	14.0	11.4	13.8	12.5	12.0	15.1	14.4
Total	**%**	**12.8**	**11.8**	**11.5**	**10.0**	**13.0**	**10.8**	**10.9**	***13.4**	**12.0**
					Relative standard errors (e)					
Remoteness of residence										
Major cities	%	6.6	7.9	10.1	8.7	8.3	..	9.3	..	3.6
Inner regional	%	14.9	15.8	14.1	22.3	26.3	12.6	–	..	7.0

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Outer regional/remote	%	26.4	24.4	12.2	27.4	19.8	14.0	..	36.8	7.3
Very remote (d)	%	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles)										
Quintile 1	%	8.2	12.6	11.3	13.7	12.9	12.6	np	np	5.1
Quintile 2	%	15.3	14.3	11.6	16.9	18.5	16.9	np	np	7.0
Quintile 3	%	15.5	13.7	12.0	16.3	17.0	24.2	29.9	np	6.9
Quintile 4	%	13.6	17.8	25.7	17.0	22.1	28.8	15.9	np	8.6
Quintile 5	%	15.2	17.6	21.5	29.8	16.6	32.4	16.1	44.5	7.8
Disability status										
With disability or restrictive long-term health condition	%	6.7	7.8	9.2	8.5	8.0	11.8	9.4	np	3.9
No disability or restrictive long-term health condition	%	9.4	12.5	14.5	14.0	15.5	19.6	17.4	np	5.5
Gender										
Males	%	9.6	11.3	12.9	10.8	12.1	14.3	14.3	np	4.5
Females	%	7.2	8.0	7.8	9.3	9.9	14.1	10.4	18.3	4.0
Total	**%**	**5.7**	**6.6**	**7.7**	**7.2**	**8.3**	**9.3**	**9.4**	**36.8**	**3.1**
					95 per cent confidence intervals					
Remoteness of residence										
Major cities	±	1.7	1.8	2.2	1.6	2.0	..	2.0	..	0.9
Inner regional	±	3.5	3.6	3.3	4.7	6.9	2.8	–	..	1.6
Outer regional/remote	±	6.3	4.1	3.1	5.2	5.5	2.7	..	9.7	1.7
Very remote (d)	±	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles)										
Quintile 1	±	3.2	4.6	3.5	5.2	5.2	3.9	np	np	1.8

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Quintile 2	±	4.0	3.9	2.8	3.1	5.0	2.9	np	np	1.7
Quintile 3	±	3.5	3.1	2.7	4.6	4.4	4.3	12.0	np	1.6
Quintile 4	±	2.6	3.0	3.9	2.7	3.9	3.8	3.9	np	1.5
Quintile 5	±	3.0	3.5	4.0	2.3	3.2	5.9	2.2	20.4	1.4
Disability status										
With disability or restrictive long-term health condition	±	3.1	3.2	3.4	3.0	3.9	4.6	3.6	np	1.6
No disability or restrictive long-term health condition	±	1.2	1.3	1.9	1.4	1.6	1.8	1.6	np	0.6
Gender										
Males	±	1.9	1.9	2.3	1.8	2.9	2.5	2.7	np	0.8
Females	±	2.2	2.4	2.1	2.1	2.7	3.4	2.4	5.4	1.1
Total	**±**	**1.4**	**1.5**	**1.7**	**1.4**	**2.1**	**2.0**	**2.0**	**9.7**	**0.7**

SEIFA = Socio-Economic Indexes for Areas

(a) Adults are defined as people aged 18 years and over.

(b) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Very remote data were not collected in the 2007-08 NHS.

(e) Estimate with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

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

Source: ABS unpublished, *2007-08 National Health Survey* , Cat. no. 4364.0.

Table 12A.14 **Level of psychological distress K10, 2007-08 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
Males									
18–64 years									
Low (10–15)	70.6 ± 3.4	72.4 ± 3.4	70.2 ± 4.2	68.3 ± 3.8	67.9 ± 4.4	75.2 ± 5.3	69.3 ± 3.6	np	70.5 ± 1.7
Moderate (16–21)	19.1 ± 2.7	18.7 ± 3.4	19.9 ± 3.5	22.8 ± 4.0	19.2 ± 2.4	15.7 ± 4.5	20.6 ± 3.2	np	19.6 ± 1.6
High (22–29) & Very high (30–50)	10.3 ± 2.1	8.9 ± 2.3	9.9 ± 2.5	8.9 ± 2.1	12.9 ± 3.5	9.1 ± 2.7	10.1 ± 2.8	np	9.9 ± 1.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years or over									
Low (10–15)	77.1 ± 5.2	83.7 ± 4.8	75.2 ± 6.7	82.8 ± 7.0	74.0 ± 6.4	73.1 ± 8.5	74.2 ± 10.8	np	78.7 ± 2.8
Moderate (16–21)	12.6 ± 4.2	9.5 ± 4.1	19.3 ± 6.0	10.7* ± 6.0	16.4 ± 5.9	15.6 ± 6.7	18.5* ± 12.3	np	13.3 ± 2.4
High (22–29) & Very high (30–50)	10.3 ± 4.1	6.8 ± 2.7	5.5*± 3.1	6.5* ± 4.5	9.6* ± 4.7	11.3* ± 6.8	7.4* ± 6.3	np	8.0 ± 1.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	71.7 ± 3.2	74.1 ± 2.8	71.0 ± 3.9	70.4 ± 3.3	69.0 ± 3.5	74.8 ± 4.8	69.8 ± 3.7	63.9 ± 17.1	71.8 ± 1.6
Moderate (16–21)	18.1 ± 2.4	17.3 ± 2.8	19.8 ± 3.2	21.1 ± 3.5	18.7 ± 2.0	15.7 ± 4.1	20.3 ± 3.6	23.9* ± 14.1	18.6 ± 1.4
High (22–29) & Very high (30–50)	10.3 ± 1.9	8.6 ± 1.9	9.2 ± 2.3	8.6 ± 1.8	12.3 ± 3.1	9.5 ± 2.7	9.8 ± 2.7	12.3* ± 12.2	9.6 ± 0.9
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Females									
18–64 years									
Low (10–15)	60.9 ± 3.0	61.4 ± 3.5	58.4 ± 3.9	68.1 ± 3.3	62.1 ± 4.0	65.0 ± 4.8	61.0 ± 3.7	np	61.4 ± 1.5
Moderate (16–21)	23.7 ± 2.9	22.7 ± 2.9	26.6 ± 3.8	19.7 ± 3.2	23.0 ± 3.1	21.3 ± 4.0	27.4 ± 3.5	np	23.6 ± 1.5
High (22–29) & Very high (30–50)	15.4 ± 2.4	15.8 ± 2.4	15.1 ± 2.5	12.2 ± 2.4	14.8 ± 3.1	13.7 ± 4.0	11.6 ± 2.5	np	15.0 ± 1.2
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years and over									
Low (10–15)	65.1 ± 5.1	70.7 ± 7.2	75.1 ± 6.2	75.4 ± 5.6	76.5 ± 5.2	70.4 ± 7.2	67.7 ± 8.4	np	70.5 ± 3.0
Moderate (16–21)	19.5 ± 5.1	18.1 ± 5.6	16.6 ± 5.2	16.5 ± 5.2	15.6 ± 4.3	22.4 ± 6.5	18.3 ± 7.4	np	18.1 ± 2.6

Table 12A.14 **Level of psychological distress K10, 2007-08 (per cent) (a), (b)**

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
	High (22–29) & Very high (30–50)	15.4 ± 3.7	11.2* ± 5.5	8.3 ± 3.8	8.1 ± 3.5	7.8 ± 3.4	7.2* ± 3.9	14.0 ± 6.7	np	11.5 ± 2.0
	Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total										
	Low (10–15)	61.7 ± 2.6	63.1 ± 3.3	61.0 ± 3.7	69.3 ± 2.8	65.0 ± 3.5	66.0 ± 3.9	61.9 ± 3.4	59.0 ± 19.6	63.0 ± 1.4
	Moderate (16–21)	23.0 ± 2.6	21.9 ± 2.5	25.0 ± 3.4	19.2 ± 2.6	21.6 ± 2.8	21.5 ± 3.6	26.2 ± 3.2	26.6 ± 14.5	22.7 ± 1.4
	High (22–29) & Very high (30–50)	15.4 ± 2.2	15.0 ± 2.4	14.0 ± 2.1	11.5 ± 2.2	13.4 ± 2.6	12.4 ± 3.2	11.9 ± 2.4	14.4* ± 9.7	14.4 ± 1.1
	Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
People										
18–64 years										
	Low (10–15)	65.8 ± 2.2	66.9 ± 2.2	64.2 ± 2.9	68.2 ± 2.8	65.0 ± 3.2	70.0 ± 3.4	65.1 ± 2.6	np	66.0 ± 1.1
	Moderate (16–21)	21.4 ± 1.9	20.7 ± 2.1	23.3 ± 2.6	21.3 ± 2.7	21.1 ± 1.9	18.5 ± 2.6	24.0 ± 2.4	np	21.6 ± 1.1
	High (22–29) & Very high (30–50)	12.8 ± 1.5	12.4 ± 1.7	12.5 ± 1.9	10.5 ± 1.7	13.8 ± 2.5	11.5 ± 2.2	10.9 ± 2.1	np	12.4 ± 0.8
	Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years and over										
	Low (10–15)	70.7 ± 3.7	76.7 ± 4.6	75.2 ± 4.9	78.9 ± 4.5	75.4 ± 4.0	71.6 ± 5.5	70.7 ± 6.1	np	74.3 ± 2.3
	Moderate (16–21)	16.3 ± 3.5	14.1 ± 3.3	17.9 ± 4.2	13.7 ± 4.1	16.0 ± 3.4	19.3 ± 4.4	18.4 ± 6.2	np	15.9 ± 1.9
	High (22–29) & Very high (30–50)	13.0 ± 3.0	9.2 ± 3.4	6.9 ± 2.7	7.3 ± 2.7	8.6 ± 3.0	9.1 ± 3.7	10.9 ± 4.8	np	9.9 ± 1.4
	Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total										
	Low (10–15)	66.6 ± 2.0	68.5 ± 2.0	65.9 ± 2.7	69.8 ± 2.4	67.0 ± 2.6	70.3 ± 3.0	65.8 ± 2.5	61.6 ± 15.4	67.3 ± 1.0
	Moderate (16–21)	20.5 ± 1.8	19.6 ± 1.8	22.4 ± 2.3	20.1 ± 2.3	20.2 ± 1.6	18.7 ± 2.2	23.3 ± 2.4	25.1 ± 12.0	20.7 ± 1.0
	High (22–29) & Very high (30–50)	12.9 ± 1.4	11.9 ± 1.5	11.6 ± 1.7	10.0 ± 1.4	12.9 ± 2.1	11.0 ± 1.9	10.9 ± 2.0	13.3* ± 8.1	12.0 ± 0.7
	Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 12A.14 **Level of psychological distress K10, 2007-08 (per cent) (a), (b)**

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

(a) Derived from the Kessler Psychological Distress Scale–10 items (K10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 4 weeks prior to interview. The K10 is scored from 10 to 50, with higher scores indicating a higher level of distress; low scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50.

(b) A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use. These estimates are not published.

(c) Separate estimates for the NT are not available for some estimates from this survey, but the NT contributes to national estimates.

(d) Totals include not stated.

np Not published.

Source : ABS unpublished, *2007-08 National Health Survey* , Cat. no. 4364.0.

Table 12A.15 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status, 2011-13 (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion (%)					
Indigenous	rate	30.5	31.5	30.3	28.5	32.8	26.3	30.9	21.6	29.4
Non-Indigenous	rate	9.9	11.3	11.5	10.9	12.2	9.9	8.9	8.2	10.8
					Relative standard errors					
Indigenous	%	8.2	7.8	7.0	5.9	7.4	10.4	16.8	8.8	3.6
Non-Indigenous	%	6.8	6.1	6.5	7.8	7.4	9.0	9.1	13.2	3.0
					95 per cent confidence intervals					
Indigenous	±	4.9	4.8	4.1	3.3	4.8	5.4	10.2	3.7	2.1
Non-Indigenous	±	1.3	1.3	1.5	1.7	1.8	1.8	1.6	2.1	0.6

(a) Levels of psychological distress are derived from the Kessler Psychological Distress Scale (K5). Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined.

(b) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (10 year ranges from 18 years).

(c) Adults are defined as persons aged 18 years and over.

(d) Totals for Indigenous persons exclude a small number of persons for whom responses were provided by proxy but who were not present at interview.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2012-13* and ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component), Cat. no. 4362.0.

Table 12A.16 **Level of psychological distress K10, 2004-05 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
2004-05									
Males									
18–64 years									
Low (10–15)	65.9	64.8	64.5	68.1	64.7	68.9	65.8	na	65.6
Moderate (16–21)	23.3	23.8	23.4	22.1	24.5	19.7	24.8	na	23.3
High (22–29) & Very high (30–50)	10.7	11.1	11.9	9.8	10.5	11.1	9.4	na	11.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	71.4	73.9	66.0	80.9	76.1	74.4	65.5	na	72.4
Moderate (16–21)	17.7	15.7	19.8	13.0	18.5	15.7	25.4	na	17.2
High (22–29) & Very high (30–50)	10.9*	9.8*	14.0*	6.0	5.3*	9.9*	9.1	na	10.2
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	66.8	66.2	64.7	69.9	66.7	69.8	65.8	na	66.6
Moderate (16–21)	22.4	22.6	22.9	20.9	23.5	19.0	24.8	na	22.4
High (22–29) & Very high (30–50)	10.8	10.9	12.2	9.2	9.6	10.9	9.4	na	10.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Females									
18–64 years									
Low (10–15)	58.6	55.0	58.1	63.3	58.4	63.8	55.5	na	58.1
Moderate (16–21)	26.6	28.2	25.1	21.2	26.1	21.0	29.2	na	26.0
High (22–29) & Very high (30–50)	14.6	16.5	16.8	15.4	15.5	15.3	15.3	na	15.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	65.0	63.8	61.9	75.1	69.5	68.3	60.9	na	65.4

Table 12A.16 **Level of psychological distress K10, 2004-05 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
Moderate (16–21)	21.8	26.4	23.8	16.7	19.3	21.5	29.0	na	22.8
High (22–29) & Very high (30–50)	13.1	9.3	14.1	8.1	11.2	10.2	10.1	na	11.6
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	59.8	56.6	58.7	65.2	60.6	64.6	56.2	na	59.4
Moderate (16–21)	25.8	27.9	24.9	20.5	24.7	21.1	29.2	na	25.5
High (22–29) & Very high (30–50)	14.4	15.2	16.4	14.3	14.6	14.3	14.6	na	15.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
People									
18–64 years									
Low (10–15)	62.3	59.9	61.3	65.7	61.6	66.3	60.6	na	61.8
Moderate (16–21)	25.0	26.0	24.3	21.7	25.3	20.4	27.0	na	24.7
High (22–29) & Very high (30–50)	12.7	13.8	14.4	12.6	13.0	13.2	12.4	na	13.4
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	67.9	68.4	63.8	77.8	72.5	71.1	63.0	na	68.6
Moderate (16–21)	20.0	21.6	21.9	15.0	18.9	18.9	27.3	na	20.2
High (22–29) & Very high (30–50)	12.1	9.5	14.1	7.2*	8.6	10.0*	9.7	na	11.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	63.2	61.3	61.6	67.5	63.6	67.2	60.9	na	62.9
Moderate (16–21)	24.1	25.3	23.9	20.7	24.1	20.1	27.0	na	24.0
High (22–29) & Very high (30–50)	12.6	13.1	14.3	11.8	12.2	12.6	12.1	na	13.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0

(a) Psychological distress as measured by the Kessler 10 scale.

Table 12A.16 **Level of psychological distress K10, 2004-05 (per cent) (a), (b)**

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

(b) A '*' indicates that an estimate has a relative standard error (RSE) of between 25 per cent and 50 per cent and should be used with caution.

(c) Separate estimates for the NT are not available for this survey, but the NT contributes to national estimates.

(d) Totals include not stated.

na Not available (small numbers not reported for privacy reasons).

Source : ABS 2006, *National Health Survey 2004-05* , Cat. no. 4362.0, Canberra.

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	28 805	23 009	16 671	7 022	7 423	1 513	1 182	317	85 942
Patient attendances (d)	546 004	585 193	327 045	114 737	162 878	36 725	18 471	3 547	1 794 600
Group psychotherapy	15 850	18 137	2 898	870	567	2 877	146	15	41 360
Interview with non-patient	1 982	1 987	1 601	439	433	126	48	18	6 634
Telepsychiatry	643	92	334	15	9	2	11	19	1 125
Case conferencing	80	763	41	42	47	38	4	–	1 015
Electroconvulsive therapy (e)	5 280	5 327	4 886	1 480	1 216	790	45	2	19 026
Total psychiatrist services	**598 644**	**634 508**	**353 476**	**124 605**	**172 573**	**42 071**	**19 907**	**3 918**	**1 949 702**
GP mental health specific services									
GP mental health care plans	407 865	335 835	209 549	106 349	80 756	23 307	14 934	5 095	1 183 690
Focussed psychological strategies	13 254	10 350	7 051	1 474	4 168	414	376	46	37 133
Total GP mental health specific services	**421 119**	**346 185**	**216 600**	**107 823**	**84 924**	**23 721**	**15 310**	**5 141**	**1 220 823**
Psychologist services									
Psychological therapy — clinical psychologists	208 032	174 404	69 774	114 269	49 556	20 361	11 577	1 404	649 377
Focussed psychological strategies — psychologists	402 284	431 801	237 281	54 998	48 985	22 620	19 001	3 699	1 220 669
Enhanced primary care — psychologists	3 056	2 213	1 731	263	356	127	28	14	7 788
Total psychologist services	**613 372**	**608 418**	**308 786**	**169 530**	**98 897**	**43 108**	**30 606**	**5 117**	**1 877 834**

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other allied health services									
Focussed psychological strategies — occupational therapist	5 830	3 826	1 999	1 563	1 642	494	3	82	15 439
Focussed psychological strategies — social worker	26 594	25 519	12 119	5 505	5 052	1 571	135	375	76 870
Enhanced Primary Care — mental health worker (f)	1 045	599	323	37	375	18	3	–	2 400
Total allied health services	**33 469**	**29 944**	**14 441**	**7 105**	**7 069**	**2 083**	**141**	**457**	**94 709**
Rate per 1000 people (g)									
Psychiatrist services	86.4	120.9	83.6	58.5	108.4	84.9	58.4	18.0	92.1
GP mental health specific services	60.8	66.0	51.2	50.6	53.3	47.8	44.9	23.6	57.6
Psychologist services	88.5	116.0	73.0	79.6	62.1	87.0	89.8	23.5	88.7
Other allied health services	4.8	5.7	3.4	3.3	4.4	4.2	0.4	2.1	4.5
2008-09									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	31 484	25 495	17 220	8 055	7 418	1 785	1 266	306	93 029
Patient attendances (d)	543 800	583 020	330 605	117 929	162 032	37 344	17 961	3 831	1 796 522
Group psychotherapy	20 082	17 924	2 479	678	574	3 106	201	30	45 074
Interview with non-patient	2 848	2 594	1 948	439	552	112	73	15	8 581
Telepsychiatry	752	78	447	26	8	1	15	29	1 356
Case conferencing	190	734	97	44	37	31	9	2	1 144
Electroconvulsive therapy (e)	5 425	6 326	5 462	1 852	1 628	589	103	6	21 391
Assessment and treatment of pervasive developmental disorder	32	65	22	5	–	–	–	1	125

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total psychiatrist services	**604 613**	**636 236**	**358 280**	**129 023**	**172 254**	**42 968**	**19 628**	**4 220**	**1 967 222**
GP mental health specific services									
GP mental health care	520 403	434 383	290 904	138 410	111 352	28 783	19 020	6 688	1 549 943
Focussed psychological strategies	13 238	10 693	6 037	1 115	3 261	249	345	226	35 164
Family group therapy	6 696	6 144	1 000	274	560	161	85	16	14 936
Total GP mental health specific services	**540 337**	**451 220**	**297 941**	**139 799**	**115 173**	**29 193**	**19 450**	**6 930**	**1 600 043**
Psychologist services									
Psychological therapy — clinical psychologists	298 137	226 729	111 728	145 385	77 824	28 968	14 297	1 767	904 835
Focussed psychological strategies — psychologists	517 849	550 951	315 067	76 491	59 519	23 591	25 367	4 963	1 573 798
Enhanced primary care — psychologists	2 705	1 858	1 413	267	178	88	68	14	6 591
Assessment and treatment of pervasive developmental disorder	1 180	2 196	399	348	244	101	87	20	4 575
Total psychologist services	**819 871**	**781 734**	**428 607**	**222 491**	**137 765**	**52 748**	**39 819**	**6 764**	**2 489 799**
Other allied health services									
Focussed psychological strategies — occupational therapist	9 207	7 689	3 373	1 951	2 956	519	182	10	25 887
Focussed psychological strategies — social worker	42 707	41 722	17 111	9 107	7 860	2 451	449	133	121 540
Enhanced Primary Care — mental health worker (f)	1 059	742	298	39	169	13	–	2	2 322
Total allied health services	**52 973**	**50 153**	**20 782**	**11 097**	**10 985**	**2 983**	**631**	**145**	**149 749**
Rate per 1000 people (g)									
Psychiatrist services	85.9	118.6	82.4	58.5	106.9	85.9	56.4	19.0	90.9

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP mental health specific services	76.7	84.1	68.5	63.4	71.4	58.4	55.9	31.3	73.9

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Psychologist services	116.4	145.7	98.5	100.9	85.5	105.4	114.5	30.5	115.0
Other allied health services	7.5	9.3	4.8	5.0	6.8	6.0	1.8	0.7	6.9
2009-10									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	34 265	26 289	17 780	8 249	7 264	1 902	1 385	366	97 511
Patient attendances (d)	543 765	577 090	338 197	124 506	160 934	36 999	17 554	3 822	1 802 867
Group psychotherapy	22 013	16 144	2 504	669	563	3 190	135	21	45 239
Interview with non-patient	4 238	3 093	2 613	428	593	131	59	18	11 173
Telepsychiatry	733	117	697	29	107	8	19	9	1 719
Case conferencing	302	884	93	93	36	21	5	–	1 434
Electroconvulsive therapy (e)	5 715	6 320	6 642	2 217	1 565	720	123	24	23 326
Assessment and treatment of pervasive developmental disorder	50	69	68	np	16	np	–	–	212
Total psychiatrist services	**611 081**	**630 006**	**368 594**	**136 206**	**171 078**	**42 976**	**19 280**	**4 260**	**1 983 481**
GP mental health specific services									
GP mental health care	581 755	343 420	492 773	154 864	127 135	32 634	8 789	20 543	1 761 913
Focussed psychological strategies	13 609	9 101	6 078	1 289	3 135	451	285	318	34 266
Family group therapy	6 080	895	5 833	244	516	92	13	97	13 770
Total GP mental health specific services	**601 444**	**353 416**	**504 684**	**156 397**	**130 786**	**33 177**	**9 087**	**20 958**	**1 809 949**
Psychologist services									
Psychological therapy — clinical psychologists	343 733	277 745	146 601	168 215	97 566	33 247	17 445	2 617	1 087 169

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Focussed psychological strategies — psychologists	614 418	640 812	390 393	93 016	68 990	27 300	28 131	6 143	1 869 203
Enhanced primary care — psychologists	2 968	1 834	1 322	358	239	95	58	28	6 902
Assessment and treatment of pervasive developmental disorder	1 863	3 323	1 170	555	441	93	117	155	7 717
Total psychologist services (h)	**962 998**	**923 714**	**539 486**	**262 144**	**167 236**	**60 735**	**45 751**	**8 959**	**2 971 023**
Other allied health services									
Focussed psychological strategies — occupational therapist	13 062	9 474	np	3 940	2 267	1 075	259	np	34 194
Focussed psychological strategies — social worker	51 896	58 436	24 164	11 255	10 964	4 001	1 073	292	162 081
Enhanced Primary Care — mental health worker (f)	np	np	680	120	78	8	np	7	2 669
Total allied health services (h)	**65 889**	**68 753**	**28 960**	**13 351**	**15 273**	**5 084**	**1 336**	**307**	**198 953**
Rate per 1000 people (g)									
Psychiatrist services	85.0	114.6	82.4	60.0	104.7	85.0	54.3	18.7	89.5
GP mental health specific services	83.6	64.3	112.8	68.9	80.0	65.6	25.6	92.0	81.7
Psychologist services	133.9	168.1	120.6	115.5	102.4	120.2	128.9	39.3	134.1
Other allied health services	9.2	12.5	6.5	5.9	9.3	10.1	3.8	1.3	9.0
2010-11									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	35 803	27 131	19 866	8 591	7 099	1 741	1 582	312	102 125

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient attendances (d)	557 867	576 962	344 504	124 555	154 924	35 592	18 856	3 945	1 817 205
Group psychotherapy	22 572	15 306	2 411	557	400	2 818	242	68	44 374
Interview with non-patient	5 953	3 915	4 219	475	668	152	173	16	15 571
Telepsychiatry	941	149	1 184	127	182	18	14	18	2 633
Case conferencing	517	956	209	145	160	22	10	7	2 026
Electroconvulsive therapy (e)	12 621	13 809	15 951	4 404	4 350	2 268	275	72	53 750
Assessment and treatment of pervasive developmental disorder	55	69	54	3	12	4	1	–	198
Total psychiatrist services	**636 329**	**638 297**	**388 398**	**138 857**	**167 795**	**42 615**	**21 153**	**4 438**	**2 037 882**
GP mental health specific services									
GP mental health care	676 154	579 248	397 898	175 073	147 956	38 433	24 211	8 728	2 047 701
Focussed psychological strategies	17 504	10 485	8 606	1 512	3 332	716	424	326	42 905
Family group therapy	5 626	4 755	769	212	603	147	95	15	12 222
Total GP mental health specific services	**699 284**	**594 488**	**407 273**	**176 797**	**151 891**	**39 296**	**24 730**	**9 069**	**2 102 828**
Psychologist services									
Psychological therapy — clinical psychologists	399 144	333 786	184 361	175 818	116 009	35 023	23 066	3 043	1 270 250
Focussed psychological strategies — psychologists	694 950	693 592	445 505	111 650	73 850	36 235	28 534	6 933	2 091 249
Enhanced primary care — psychologists	2 844	1 889	1 312	430	217	125	61	9	6 887
Assessment and treatment of pervasive developmental disorder	2 065	3 626	1 367	726	414	39	144	64	8 445
Total psychologist services (h)	**1 099 029**	**1 032 894**	**632 552**	**288 627**	**190 492**	**71 422**	**51 805**	**10 049**	**3 376 870**

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other allied health services									
Focussed psychological strategies — occupational therapist	18 101	10 304	3 672	2 584	5 407	939	350	9	41 366
Focussed psychological strategies — social worker	57 507	71 410	26 016	12 796	12 061	4 478	1 464	259	185 991
Enhanced Primary Care — mental health worker (f)	1 222	1 143	744	341	141	12	4	3	3 610
Total allied health services (h)	**76 832**	**82 857**	**30 434**	**15 721**	**17 609**	**5 429**	**1 818**	**272**	**230 972**
Rate per 1000 people (g)									
Psychiatrist services	87.5	114.3	85.4	59.9	101.7	83.7	58.4	19.3	90.7
GP mental health specific services	96.2	106.4	89.5	76.3	92.0	77.2	68.3	39.5	93.6
Psychologist services	151.1	184.9	139.1	124.6	115.4	140.2	143.1	43.7	150.2
Other allied health services	10.6	14.8	6.7	6.8	10.7	10.7	5.0	1.2	10.3
2011-12									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	37 346	29 634	21 864	9 406	7 124	1 651	1 536	290	108 877
Patient attendances (d)	561 520	590 523	368 265	124 548	154 032	33 233	17 079	3 465	1 852 665
Group psychotherapy	26 936	14 018	3 005	580	254	1 470	208	105	46 576
Interview with non-patient	6 079	5 614	5 411	374	895	150	174	24	18 721
Telepsychiatry	872	148	1 122	55	47	28	21	8	2 301

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Case conferencing	966	1 716	378	161	159	20	15	6	3 421
Electroconvulsive therapy (e)	5 350	7 020	8 094	2 366	2 004	980	139	33	25 986
Assessment and treatment of pervasive developmental disorder	68	78	61	16	np	np	np	np	230
Total psychiatrist services	**639 137**	**648 751**	**408 200**	**137 511**	**164 522**	**37 536**	**19 182**	**3 938**	**2 058 777**
GP mental health specific services									
GP mental health care	699 492	605 877	417 905	167 758	150 998	39 415	25 166	9 506	2 116 117
Focussed psychological strategies	15 866	10 090	7 387	1 428	2 709	817	266	129	38 692
Family group therapy	5 217	4 321	712	137	661	125	58	7	11 238
Electroconvulsive therapy (i)	6 964	6 987	8 406	2 753	2 094	1 084	163	32	28 483
Total GP mental health specific services	**727 541**	**627 275**	**434 410**	**172 076**	**156 462**	**41 441**	**25 653**	**9 674**	**2 194 532**
Clinical psychologist services									
Total clinical psychologist services	**428 948**	**365 900**	**214 421**	**174 908**	**127 577**	**35 887**	**27 315**	**3 133**	**1 378 089**
Other psychologist services									
Focussed psychological strategies — psychologists	677 689	673 360	442 712	111 347	76 946	36 903	24 859	7 086	2 050 902
Enhanced primary care — psychologists	4 119	2 770	1 920	578	410	104	85	42	10 028
Assessment and treatment of pervasive developmental disorder	2 642	4 659	1 660	789	509	90	132	113	10 594
Total other psychologist services (h)	**684 502**	**680 798**	**446 365**	**112 717**	**77 865**	**37 097**	**25 076**	**7 277**	**2 071 697**

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other allied health services									
Focussed psychological strategies — occupational therapist	17 266	10 666	4 116	2 354	6 168	770	275	32	41 647
Focussed psychological strategies — social worker	55 398	73 476	26 691	11 812	12 393	4 085	1 709	269	185 833
Enhanced Primary Care — mental health worker (f)	1 128	1 246	659	328	np	np	np	np	3 614
Total allied health services (h)	**73 801**	**85 465**	**31 466**	**14 495**	**18 800**	**4 863**	**1 991**	**301**	**231 182**
Rate per 1000 people (g)									
Psychiatrist services	88.2	116.4	90.4	57.6	100.0	73.4	51.7	16.9	91.6
GP mental health specific services	100.4	112.5	96.3	72.1	95.1	81.0	69.2	41.6	97.6
Clinical psychologist services	59.2	65.6	47.5	73.3	77.6	70.1	73.7	13.5	61.3
Other psychologist services	94.4	122.1	98.9	47.2	47.3	72.5	67.6	31.3	92.1
Other allied health services	10.2	15.3	7.0	6.1	11.4	9.5	5.4	1.3	10.3

(a) State and territory is based on the postcode of the mailing address of the patient as recorded by Medicare Australia. Provider type is based on the MBS item numbers claimed.

(b) A listing of the MBS items associated with each of the categories is available in the Medicare Benefits Schedule and General practice data source sections of the *Mental Health Services in Australia* (various issues), (mhsa.aihw.gov.au/home/).

(c) Includes consultations in consulting room, hospital and home visits.

(d) Includes attendances in consulting room, hospital and other locations.

(e) Data for electroconvulsive therapy may include services provided by medical practitioners other than psychiatrists.

(f) Mental health workers include psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.

(g) Crude rates based on the preliminary Australian estimated resident population as at 31 December mid-point of financial year.

(h) Totals for other psychologist and other allied health services include specific services for Indigenous Australians that were introduced on 1 November 2008.

(i) This item is for the initiation of management of anaesthesia for electroconvulsive therapy and includes data for services provided by medical practitioners other than GPs.

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

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

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

Source: AIHW various issues, *Mental Health Services in Australia* (various years) (available at mhsa.aihw.gov.au/home/).

Table 12A.18 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	*ACT* (h)	*NT* (h)	*Aust*
Patient days									
Acute units									
2005-06	468 925	325 855	216 029	167 257	117 148	30 681	15 342	11 266	1 352 503
2006-07	502 521	328 817	216 505	165 365	120 755	28 219	16 419	11 854	1 390 455
2007-08	501 388	322 087	222 006	183 741	119 808	30 924	18 539	10 990	1 409 483
2008-09	525 512	334 711	224 395	181 426	115 412	31 291	19 884	11 517	1 444 148
2009-10	531 649	332 677	226 762	182 647	114 605	29 615	21 484	10 877	1 450 316
2010-11	536 310	345 369	228 406	177 733	117 123	29 249	22 941	11 518	1 468 649
2011-12	547 250	343 809	230 274	188 644	115 761	32 148	23 163	10 489	1 491 538
Nonacute units									
2005-06	256 893	55 745	225 242	44 800	90 200	9 074	..	..	681 954
2006-07	252 391	56 837	222 783	50 751	84 637	9 482	..	..	676 881
2007-08	279 349	63 428	219 026	36 838	77 836	7 128	..	..	683 605
2008-09	265 820	54 667	215 715	38 357	65 509	9 125	..	..	649 193
2009-10	285 494	53 712	213 343	40 061	59 746	8 531	..	..	660 887
2010-11	287 011	54 293	216 365	51 600	56 073	9 779	..	..	675 121
2011-12	287 810	51 032	209 993	47 013	46 036	10 011	..	..	651 895
24-hour staffed community residential									
2005-06	73 112	321 675	..	11 380	8 635	34 155	13 981	..	462 938
2006-07	73 773	338 377	..	12 006	9 232	34 697	14 023	..	482 108
2007-08	42 051	352 741	..	14 888	15 277	27 194	13 599	1 737	467 487
2008-09	37 375	344 623	..	24 725	20 649	28 727	14 262	3 550	473 911
2009-10	35 355	351 719	..	33 008	20 187	30 172	15 416	3 841	489 698
2010-11	34 503	353 996	..	17 605	22 529	29 958	14 961	4 144	477 696
2011-12	40 567	363 985	..	30 073	34 397	27 333	15 367	4 828	516 550

Table 12A.18 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	*ACT* (h)	*NT* (h)	*Aust*
Patient days per 1000 people									
Acute units									
2005-06	69.8	64.9	54.5	82.4	75.8	62.9	46.0	54.3	66.6
2006-07	74.1	64.4	53.4	79.6	77.3	57.4	48.5	56.2	67.4
2007-08	72.8	61.9	53.4	86.1	75.9	62.4	53.9	50.7	67.1
2008-09	75.1	63.0	52.5	82.1	72.2	62.4	56.6	51.8	67.2
2009-10	74.9	61.4	51.9	80.7	70.8	58.5	60.0	47.8	66.3
2010-11	74.7	62.8	51.5	76.6	71.7	57.3	62.9	50.0	66.2
2011-12	75.5	61.7	51.0	79.0	70.4	62.8	62.5	45.1	66.3
Nonacute units									
2005-06	38.2	11.1	56.8	22.1	58.4	18.6	..	..	33.6
2006-07	37.2	11.1	54.9	24.4	54.2	19.3	..	..	32.8
2007-08	40.6	12.2	52.7	17.3	49.3	14.4	..	..	32.5
2008-09	38.0	10.3	50.5	17.4	41.0	18.2	..	..	30.2
2009-10	40.2	9.9	48.8	17.7	36.9	16.8	..	..	30.2
2010-11	40.0	9.9	48.8	22.3	34.3	19.2	..	..	30.4
2011-12	39.7	9.2	46.5	19.7	28.0	19.6	..	..	29.0
24-hour staffed community residential									
2005-06	10.9	64.0	..	5.6	5.6	70.0	41.9	..	22.8
2006-07	10.9	66.3	..	5.8	5.9	70.6	41.4	..	23.4
2007-08	6.1	67.8	..	7.0	9.7	54.8	39.5	8.0	22.2
2008-09	5.3	64.9	..	11.2	12.9	57.3	40.6	16.0	22.1
2009-10	5.0	64.9	..	14.6	12.5	59.6	43.1	16.9	22.4
2010-11	4.8	64.4	..	7.6	13.8	58.7	41.0	18.0	21.5
2011-12	5.6	65.3	..	12.6	20.9	53.4	41.5	20.8	23.0

Table 12A.18 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	*ACT* (h)	*NT* (h)	*Aust*

(a) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of patient day estimates.

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) Hospital patient days include those provided in services funded by government, but managed and operated by private and non-government entities.

(d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) Queensland does not fund community residential services; however, it funds a number of campus based and non-campus based extended treatment services. Data from these services are included as non-acute units.

(g) Caution is required when interpreting WA data. Several residential services that reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010–11. In addition, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010–11 collection, to more accurately reflect the function of these services.

(h) The ACT and the NT did not have non-acute hospital units.

.. Not applicable.

Source : AIHW unpublished, MHE NMDS; ABS (various issues), *Australian Demographic Statistics* , December (various years), Cat. no. 3101.0.

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
		no.	no.	no.	%
2005-06					
F00–F03	Dementia	609	188	797	0.9
F04–F09	Other organic mental disorders	599	146	745	0.8
F10	Mental and behavioural disorders due to use of alcohol	1 623	542	2 165	2.4
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 464	878	4 342	4.9
F20	Schizophrenia	17 402	3 231	20 633	23.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 505	260	1 765	2.0
F22	Persistent delusional disorders	787	163	950	1.1
F23	Acute and transient psychotic disorders	1 309	217	1 526	1.7
F25	Schizoaffective disorders	5 078	1 028	6 106	6.8
F30	Manic episode	449	71	520	0.6
F31	Bipolar affective disorders	7 331	1 157	8 488	9.5
F32	Depressive episode	10 844	1 068	11 912	13.3
F33	Recurrent depressive disorders	3 761	251	4 012	4.5
F34	Persistent mood (affective) disorders	910	109	1 019	1.1
F38, F39	Other and unspecified mood (affective) disorders	143	41	184	0.2
F40	Phobic anxiety disorders	62	14	76	0.1
F41	Other anxiety disorders	994	57	1 051	1.2

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F42	Obsessive-compulsive disorders	239	22	261	0.3
F43	Reaction to severe stress and adjustment disorders	7 232	1 402	8 634	9.7
F44	Dissociative (conversion) disorders	124	13	137	0.2
F45, F48	Somatoform and other neurotic disorders	79	10	89	0.1
F50	Eating disorders	604	15	619	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	169	24	193	0.2
F60	Specific personality disorders	3 642	542	4 184	4.7
F61–F69	Disorders of adult personality and behaviour	189	45	234	0.3
F70–F79	Mental retardation	139	53	192	0.2
F80–F89	Disorders of psychological development	168	31	199	0.2
F90	Hyperkinetic disorders	114	11	125	0.1
F91	Conduct disorders	291	53	344	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	170	61	231	0.3
F99	Mental disorder not otherwise specified	251	22	273	0.3
G30	Alzheimer's disease	509	134	643	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	224	357	581	0.7
	Other specified mental health-related principal diagnosis (c)	209	17	226	0.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Other (d)	4 796	1 022	5 818	6.5
	Total	**76 019**	**13 255**	**89 274**	**100.0**
2006-07					
F00–F03	Dementia	557	178	735	0.8
F04–F09	Other organic mental disorders	569	133	702	0.8
F10	Mental and behavioural disorders due to use of alcohol	1 980	621	2 601	2.8
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 606	981	4 587	5.0
F20	Schizophrenia	17 610	3 014	20 624	22.3
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 456	248	1 704	1.8
F22	Persistent delusional disorders	776	130	906	1.0
F23	Acute and transient psychotic disorders	1 395	211	1 606	1.7
F25	Schizoaffective disorders	5 359	1 021	6 380	6.9
F30	Manic episode	559	69	628	0.7
F31	Bipolar affective disorders	7 935	1 089	9 024	9.8
F32	Depressive episode	11 103	1 065	12 168	13.2
F33	Recurrent depressive disorders	3 701	314	4 015	4.3
F34	Persistent mood (affective) disorders	998	118	1 116	1.2
F38, F39	Other and unspecified mood (affective) disorders	133	30	163	0.2
F40	Phobic anxiety disorders	54	6	60	0.1
F41	Other anxiety disorders	1 160	102	1 262	1.4

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F42	Obsessive-compulsive disorders	226	24	250	0.3
F43	Reaction to severe stress and adjustment disorders	8 141	1 274	9 415	10.2
F44	Dissociative (conversion) disorders	116	8	124	0.1
F45, F48	Somatoform and other neurotic disorders	81	8	89	0.1
F50	Eating disorders	575	7	582	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	193	12	205	0.2
F60	Specific personality disorders	3 744	531	4 275	4.6
F61–F69	Disorders of adult personality and behaviour	163	33	196	0.2
F70–F79	Mental retardation	156	44	200	0.2
F80–F89	Disorders of psychological development	175	31	206	0.2
F90	Hyperkinetic disorders	112	9	121	0.1
F91	Conduct disorders	298	32	330	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	190	58	248	0.3
F99	Mental disorder not otherwise specified	267	86	353	0.4
G30	Alzheimer's disease	497	85	582	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	218	324	542	0.6
	Other specified mental health-related principal diagnosis (c)	235	36	271	0.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Other (d)	5 400	839	6 239	6.7
	Total	**79 738**	**12 771**	**92 509**	**100.0**
2007-08					
F00–F03	Dementia	592	221	813	0.9
F04–F09	Other organic mental disorders	596	172	768	0.8
F10	Mental and behavioural disorders due to use of alcohol	2 128	690	2 818	3.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 155	779	3 934	4.3
F20	Schizophrenia	17 250	2 834	20 084	21.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 609	260	1 869	2.0
F22	Persistent delusional disorders	817	136	953	1.0
F23	Acute and transient psychotic disorders	1 432	168	1 600	1.7
F25	Schizoaffective disorders	5 354	949	6 303	6.9
F30	Manic episode	532	60	592	0.6
F31	Bipolar affective disorders	7 628	1 157	8 785	9.6
F32	Depressive episode	11 051	1 121	12 172	13.3
F33	Recurrent depressive disorders	2 997	554	3 551	3.9
F34	Persistent mood (affective) disorders	938	116	1 054	1.2
F38, F39	Other and unspecified mood (affective) disorders	145	25	170	0.2
F40	Phobic anxiety disorders	79	11	90	0.1
F41	Other anxiety disorders	1 089	99	1 188	1.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F42	Obsessive-compulsive disorders	236	19	255	0.3
F43	Reaction to severe stress and adjustment disorders	8 501	1 098	9 599	10.5
F44	Dissociative (conversion) disorders	112	11	123	0.1
F45, F48	Somatoform and other neurotic disorders	106	8	114	0.1
F50	Eating disorders	523	6	529	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	155	9	164	0.2
F60	Specific personality disorders	3 834	614	4 448	4.9
F61–F69	Disorders of adult personality and behaviour	197	73	270	0.3
F70–F79	Mental retardation	147	56	203	0.2
F80–F89	Disorders of psychological development	199	42	241	0.3
F90	Hyperkinetic disorders	106	17	123	0.1
F91	Conduct disorders	262	29	291	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	172	58	230	0.3
F99	Mental disorder not otherwise specified	167	101	268	0.3
G30	Alzheimer's disease	491	150	641	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	191	247	438	0.5
	Other specified mental health-related principal diagnosis (c)	296	10	306	0.3
	Other (d)	5 832	823	6 655	7.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**78 919**	**12 723**	**91 642**	**100.0**
2008-09					
F00–F03	Dementia	565	163	728	0.7
F04–F09	Other organic mental disorders	600	101	701	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 365	572	2 937	3.0
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	2 827	558	3 385	3.4
F20	Schizophrenia	18 127	2 270	20 397	20.7
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 966	174	2 140	2.2
F22	Persistent delusional disorders	803	108	911	0.9
F23	Acute and transient psychotic disorders	1 338	137	1 475	1.5
F25	Schizoaffective disorders	6 239	733	6 972	7.1
F30	Manic episode	577	51	628	0.6
F31	Bipolar affective disorders	8 622	1 080	9 702	9.9
F32	Depressive episode	14 406	1 105	15 511	15.8
F33	Recurrent depressive disorders	3 433	342	3 775	3.8
F34	Persistent mood (affective) disorders	821	93	914	0.9
F38, F39	Other and unspecified mood (affective) disorders	117	24	141	0.1
F40	Phobic anxiety disorders	65	7	72	0.1
F41	Other anxiety disorders	1 386	107	1 493	1.5
F42	Obsessive-compulsive disorders	210	15	225	0.2

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F43	Reaction to severe stress and adjustment disorders	8 863	931	9 794	10.0
F44	Dissociative (conversion) disorders	108	7	115	0.1
F45, F48	Somatoform and other neurotic disorders	73	10	83	0.1
F50	Eating disorders	635	6	641	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	180	8	188	0.2
F60	Specific personality disorders	3 979	550	4 529	4.6
F61–F69	Disorders of adult personality and behaviour	211	58	269	0.3
F70–F79	Mental retardation	190	np	190	0.2
F80–F89	Disorders of psychological development	236	28	264	0.3
F90	Hyperkinetic disorders	85	–	85	0.1
F91	Conduct disorders	311	np	311	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	381	25	406	0.4
F99	Mental disorder not otherwise specified	189	64	253	0.3
G30	Alzheimer's disease	452	100	552	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	235	np	235	0.2
	Other specified mental health-related principal diagnosis (c)	349	11	360	0.4
	Other (d)	6 853	1 047	7 900	8.0

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**87 797**	**10 562**	**98 359**	**100.0**
2009-10					
F00–F03	Dementia	534	126	660	0.7
F04–F09	Other organic mental disorders	645	119	764	0.8
F10	Mental and behavioural disorders due to use of alcohol	2 235	560	2 795	3.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	2 626	530	3 156	3.4
F20	Schizophrenia	17 155	2 436	19 591	21.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 707	221	1 928	2.1
F22	Persistent delusional disorders	770	79	849	0.9
F23	Acute and transient psychotic disorders	1 303	145	1 448	1.6
F25	Schizoaffective disorders	5 376	750	6 126	6.7
F30	Manic episode	511	51	562	0.6
F31	Bipolar affective disorders	7 726	976	8 702	9.5
F32	Depressive episode	11 932	1 139	13 071	14.3
F33	Recurrent depressive disorders	2 631	348	2 979	3.3
F34	Persistent mood (affective) disorders	790	72	862	0.9
F38, F39	Other and unspecified mood (affective) disorders	131	20	151	0.2
F40	Phobic anxiety disorders	71	10	81	0.1
F41	Other anxiety disorders	1 442	131	1 573	1.7
F42	Obsessive-compulsive disorders	230	23	253	0.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F43	Reaction to severe stress and adjustment disorders	8 528	964	9 492	10.4
F44	Dissociative (conversion) disorders	128	13	141	0.2
F45, F48	Somatoform and other neurotic disorders	69	7	76	0.1
F50	Eating disorders	576	9	585	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	158	10	168	0.2
F60	Specific personality disorders	3 599	578	4 177	4.6
F61–F69	Disorders of adult personality and behaviour	171	31	202	0.2
F70–F79	Mental retardation	144	51	195	0.2
F80–F89	Disorders of psychological development	243	38	281	0.3
F90	Hyperkinetic disorders	80	19	99	0.1
F91	Conduct disorders	331	49	380	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	352	21	373	0.4
F99	Mental disorder not otherwise specified	199	81	280	0.3
G30	Alzheimer's disease	518	88	606	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	227	232	459	0.5
	Other specified mental health-related principal diagnosis (c)	364	7	371	0.4
	Other (d)	7 004	1 063	8 067	8.8

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**80 506**	**10 997**	**91 503**	**100.0**
2010-11					
F00–F03	Dementia	443	61	504	0.5
F04–F09	Other organic mental disorders	618	90	708	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 318	487	2 805	2.9
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 517	600	4 117	4.3
F20	Schizophrenia	18 164	2 137	20 301	21.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 978	202	2 180	2.3
F22	Persistent delusional disorders	802	97	899	0.9
F23	Acute and transient psychotic disorders	1 318	99	1 417	1.5
F25	Schizoaffective disorders	6 031	792	6 823	7.1
F30	Manic episode	625	47	672	0.7
F31	Bipolar affective disorders	8 147	896	9 043	9.4
F32	Depressive episode	11 874	917	12 791	13.3
F33	Recurrent depressive disorders	2 625	170	2 795	2.9
F34	Persistent mood (affective) disorders	752	69	821	0.9
F38, F39	Other and unspecified mood (affective) disorders	165	13	178	0.2
F40	Phobic anxiety disorders	72	9	81	0.1
F41	Other anxiety disorders	1 612	67	1 679	1.7
F42	Obsessive-compulsive disorders	249	10	259	0.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F43	Reaction to severe stress and adjustment disorders	9 446	928	10 374	10.8
F44	Dissociative (conversion) disorders	149	4	153	0.2
F45, F48	Somatoform and other neurotic disorders	96	2	98	0.1
F50	Eating disorders	616	11	627	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	174	16	190	0.2
F60	Specific personality disorders	4 146	420	4 566	4.7
F61–F69	Disorders of adult personality and behaviour	162	23	185	0.2
F70–F79	Mental retardation	177	30	207	0.2
F80–F89	Disorders of psychological development	243	23	266	0.3
F90	Hyperkinetic disorders	75	3	78	0.1
F91	Conduct disorders	396	10	406	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	393	8	401	0.4
F99	Mental disorder not otherwise specified	352	–	352	0.4
G30	Alzheimer's disease	511	51	562	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	199	70	269	0.3
	Other specified mental health-related principal diagnosis (c)	271	3	274	0.3
	Other (d)	7 953	1 196	9 149	9.5

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**86 669**	**9 561**	**96 230**	**100.0**

(a) Admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded.

(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis.

(d) Includes all other codes not included as a mental health principal diagnosis.

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

Source : AIHW various issues, *Mental Health Services in Australia* (various years), (available at mhsa.aihw.gov.au/home/).

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Number									
Males									
Less than 15 years	39 242	61 978	65 976	27 955	23 046	2 652	8 294	1 534	230 677
15–24	135 686	152 875	83 386	30 460	25 441	2 531	28 628	3 871	462 878
25–34	252 587	252 055	108 586	47 572	34 707	4 812	32 443	6 435	739 197
35–44	199 198	194 510	91 381	45 952	32 112	4 062	16 903	4 290	588 408
45–54	113 329	119 193	57 663	32 580	22 076	4 822	12 055	2 162	363 880
55–64	51 652	65 399	33 349	21 487	9 102	1 782	4 657	1 212	188 640
65 years and over	29 325	106 367	26 531	22 786	10 204	5 496	5 092	794	206 595
Total males (a)	821 019	952 377	466 872	228 792	156 688	26 157	108 072	20 298	2 780 275
Females									
Less than 15 years	30 780	38 115	45 103	18 043	13 925	2 195	9 272	649	158 082
15–24	112 548	150 119	79 990	38 489	19 770	4 416	30 477	3 038	438 847
25–34	129 122	153 943	80 377	44 052	21 971	4 023	19 210	4 221	456 919
35–44	121 075	160 153	77 948	44 759	25 206	3 916	14 329	3 616	451 002
45–54	92 416	129 707	64 160	45 469	19 741	4 136	11 232	2 817	369 678
55–64	57 219	74 678	36 751	24 617	12 383	3 048	6 025	1 228	215 949
65 years and over	46 767	174 060	41 180	48 247	22 129	9 058	11 660	488	353 589
Total females (a)	589 927	880 775	425 509	263 676	135 125	30 792	102 205	16 057	2 444 066
People									
Less than 15 years	70 129	100 093	111 085	45 998	37 020	4 864	17 599	2 184	388 972
15–24	248 456	303 005	163 378	68 949	45 224	6 949	59 160	6 909	902 030
25–34	382 257	405 998	188 965	91 624	56 678	8 847	51 733	10 656	1 196 758
35–44	320 939	354 663	169 330	90 711	57 321	7 989	31 307	7 906	1 040 166
45–54	206 402	248 900	121 823	78 049	41 817	8 993	23 311	4 979	734 274

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
55–64	109 218	140 079	70 101	46 103	21 487	4 831	10 691	2 440	404 950
65 years and over	75 010	271 201	67 638	70 777	32 275	14 672	14 202	1 268	547 043
Total (b)	**1 832 177**	**1 833 205**	**892 393**	**492 468**	**302 400**	**65 576**	**210 833**	**36 356**	**5 665 408**
Rate (per 1,000 population) (c)									
Males									
Less than 15 years	57.4	124.0	155.3	132.9	157.0	53.3	260.4	57.8	111.2
15–24	288.7	425.5	287.0	202.1	235.9	77.1	1 037.5	231.8	318.0
25–34	523.7	687.2	382.7	329.6	341.7	168.8	1 215.8	355.3	509.0
35–44	401.5	513.6	308.8	295.2	283.4	119.8	684.2	244.7	388.1
45–54	245.9	346.9	208.6	223.3	201.6	137.5	531.0	146.5	258.3
55–64	141.1	244.0	148.1	192.2	103.2	61.1	275.0	122.4	169.1
65 years and over	72.1	353.6	118.0	208.7	99.1	173.5	362.9	157.9	172.8
Total males (a)	246.3	378.9	232.4	223.8	208.2	111.2	624.3	185.0	274.1
Females									
Less than 15 years	47.4	80.5	111.9	91.6	99.2	46.7	301.5	26.1	80.4
15–24	249.6	435.0	286.1	273.5	192.8	138.9	1 164.8	196.3	315.1
25–34	265.5	417.6	283.4	314.7	222.2	135.6	713.6	238.6	314.7
35–44	241.3	414.3	258.0	292.1	222.7	111.5	565.2	222.3	294.1
45–54	197.9	370.4	230.1	315.2	176.1	115.5	463.4	207.5	259.2
55–64	157.2	274.2	167.9	231.8	136.3	104.2	348.1	156.3	195.1
65 years and over	92.6	463.9	157.3	373.8	168.4	232.0	675.5	110.4	241.7
Total females (a)	173.7	336.1	210.6	259.5	171.8	120.5	594.4	158.6	235.4
Total people									
Less than 15 years	52.6	102.8	134.1	113.0	128.9	50.3	281.1	42.4	96.3
15–24	269.8	430.2	286.5	236.6	215.0	107.5	1 100.5	214.7	316.7
25–34	394.6	552.1	333.1	322.2	282.7	152.1	965.1	297.7	412.1

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
35–44	321.7	463.4	283.1	293.7	253.1	115.8	625.4	233.9	341.1
45–54	222.5	358.8	219.4	269.0	188.7	126.9	496.6	175.7	259.0
55–64	149.6	259.2	157.9	211.5	120.0	82.7	312.2	137.4	182.2
65 years and over	82.3	401.2	139.0	297.1	137.7	207.5	453.8	134.2	205.8
Total (b)	**265.1**	**357.3**	**221.5**	**242.2**	**195.6**	**130.5**	**616.3**	**170.8**	**274.9**
2006-07									
Number									
Males									
Less than 15 years	52 850	65 142	68 238	29 023	26 869	6 118	8 058	1 715	258 013
15–24	157 769	146 075	99 033	35 453	26 836	4 085	26 355	3 735	499 341
25–34	293 437	255 661	136 745	52 831	48 005	6 654	31 352	6 857	831 542
35–44	242 766	200 969	110 867	50 402	44 058	6 020	18 745	5 352	679 179
45–54	147 155	125 412	68 829	35 713	29 942	6 840	11 414	1 893	427 198
55–64	70 202	69 302	37 575	23 399	12 528	2 566	4 170	1 148	220 890
65 years and over	38 374	88 736	31 958	22 163	9 776	6 580	3 974	679	202 240
Total males (a)	1 003 086	955 935	553 343	249 098	198 083	38 926	104 893	21 384	3 124 748
Females									
Less than 15 years	34 800	42 273	49 801	17 356	17 002	4 062	7 953	992	174 239
15–24	127 370	150 159	94 250	44 259	24 824	7 897	28 382	2 767	479 908
25–34	145 183	156 335	92 550	46 035	27 152	5 230	19 528	4 533	496 546
35–44	153 131	161 996	96 595	50 486	34 278	6 774	16 953	3 732	523 945
45–54	121 441	131 390	74 283	48 786	27 710	6 065	11 262	2 825	423 762
55–64	71 887	77 097	43 412	28 175	16 460	3 867	5 556	1 185	247 639
65 years and over	68 461	152 440	46 652	46 821	21 430	15 554	11 044	362	362 764
Total females (a)	722 696	874 196	497 571	282 028	168 894	49 474	102 205	16 401	2 713 465
People									

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Less than 15 years	87 685	107 415	118 065	46 379	43 871	10 183	16 055	2 707	432 360
15–24	285 537	296 287	193 287	79 712	51 660	12 014	54 772	6 502	979 771
25–34	439 120	412 062	229 296	98 868	75 157	11 886	50 910	11 390	1 328 689
35–44	396 346	362 993	207 463	100 888	78 348	12 830	35 718	9 084	1 203 670
45–54	269 194	256 802	143 112	84 499	57 653	12 973	22 694	4 718	851 645
55–64	142 214	146 399	80 987	51 574	28 989	6 485	9 726	2 333	468 707
65 years and over	106 985	241 176	78 610	68 984	31 206	22 166	15 018	1 041	565 186
Total (b)	**1 828 468**	**1 830 278**	**1 050 960**	**535 809**	**382 304**	**93 186**	**207 487**	**37 785**	**5 966 277**
Rate (per 1,000 population) (c)									
Males									
Less than 15 years	77.3	129.7	158.8	136.2	183.0	123.3	253.0	64.7	123.8
15–24	331.2	397.0	332.9	229.5	244.3	123.0	955.1	215.2	336.3
25–34	610.1	695.6	477.2	362.0	475.1	237.6	1 174.9	378.4	571.4
35–44	490.4	526.6	369.1	317.5	388.6	179.5	758.8	303.3	445.2
45–54	315.9	359.3	244.4	240.6	270.4	193.2	502.8	126.1	298.9
55–64	187.2	251.3	161.3	201.5	137.9	85.0	246.3	111.5	192.3
65 years and over	92.1	286.4	137.0	195.1	92.9	202.6	283.2	126.1	164.2
Total males (a)	299.2	375.2	271.2	238.1	262.6	165.0	605.3	188.8	304.5
Females									
Less than 15 years	53.5	88.7	122.2	86.9	121.2	87.0	258.6	39.6	88.1
15–24	277.5	424.8	328.1	306.8	237.4	246.6	1 084.7	174.6	337.3
25–34	300.0	426.1	325.5	328.1	276.3	179.2	725.5	254.5	343.0
35–44	304.8	414.6	315.0	325.5	302.9	194.3	668.7	226.5	339.1
45–54	255.9	368.4	259.7	331.3	244.5	166.7	464.6	202.4	291.7
55–64	191.4	272.9	190.4	253.8	174.7	127.6	321.0	142.6	215.7
65 years and over	133.2	398.1	172.9	351.7	160.4	391.0	639.8	76.5	242.5

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total females (a)	209.9	330.0	241.6	271.7	214.8	191.9	594.5	155.2	258.1
Total people									
Less than 15 years	65.7	109.8	141.1	112.3	152.8	105.7	256.4	52.5	106.4
15–24	305.3	410.7	330.6	266.8	240.9	184.2	1 018.9	195.8	337.0
25–34	455.1	561.0	401.7	345.4	377.1	207.8	949.8	317.0	457.7
35–44	397.4	470.0	341.8	321.4	345.9	187.5	713.6	266.3	392.0
45–54	286.3	363.9	252.1	285.8	257.3	180.7	483.5	162.9	295.5
55–64	189.5	262.2	175.7	227.0	156.7	107.2	284.0	125.4	204.1
65 years and over	114.9	348.1	156.3	279.6	130.7	306.8	479.9	102.9	207.2
Total (b)	**269.7**	**353.3**	**256.7**	**257.9**	**249.3**	**189.2**	**602.9**	**172.3**	**288.0**
2007-08									
Number									
Males									
Less than 15 years	54 762	54 125	76 331	29 163	29 505	9 447	8 265	1 640	263 238
15–24	184 734	137 121	108 312	36 359	29 943	7 412	24 591	3 215	531 687
25–34	355 111	236 320	153 452	56 300	56 261	11 232	27 680	7 053	903 409
35–44	292 683	197 867	127 742	51 256	51 794	10 167	17 279	4 889	753 677
45–54	183 155	126 146	81 201	37 727	37 971	10 928	10 690	2 409	490 227
55–64	83 938	67 908	42 359	25 594	15 663	4 931	4 259	909	245 561
65 years and over	45 786	82 281	35 607	24 218	11 745	8 410	5 444	528	214 019
Total males (a)	1 200 743	906 012	625 063	260 826	232 893	62 527	98 692	20 646	3 407 402
Females									
Less than 15 years	36 288	36 896	52 758	16 990	16 432	7 796	10 379	778	178 317
15–24	132 106	144 876	100 645	46 955	27 868	11 066	29 435	3 007	495 958
25–34	163 717	141 706	101 403	46 049	33 118	8 750	17 649	4 138	516 530
35–44	174 214	158 411	106 223	56 335	44 022	11 435	16 781	3 644	571 065

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
45–54	132 986	128 081	80 389	48 451	34 139	11 326	12 871	2 556	450 799
55–64	70 774	78 566	44 263	30 097	20 837	6 149	6 496	1 005	258 187
65 years and over	74 591	139 767	51 659	43 517	23 763	19 503	13 565	368	366 733
Total females (a)	785 095	830 400	537 415	288 596	200 195	76 035	108 200	15 500	2 841 436
People									
Less than 15 years	91 158	91 021	129 090	46 156	45 937	17 244	18 646	2 418	441 670
15–24	317 087	281 997	208 957	83 315	57 812	18 478	54 093	6 222	1 027 961
25–34	519 221	378 026	254 855	102 350	89 379	19 982	45 451	11 191	1 420 455
35–44	467 790	356 307	233 965	107 592	95 845	21 603	34 102	8 533	1 325 737
45–54	316 282	254 232	161 590	86 178	72 135	22 255	23 573	4 965	941 210
55–64	154 799	146 484	86 622	55 693	36 500	11 081	10 772	1 914	503 865
65 years and over	120 459	222 048	87 266	67 735	35 508	27 914	19 031	896	580 857
Total (b)	**2 072 440**	**1 736 456**	**1 162 557**	**554 558**	**456 942**	**147 701**	**207 467**	**36 146**	**6 374 267**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	80.1	106.5	173.4	134.1	199.9	189.5	255.5	61.2	125.0
15–24	378.3	361.5	353.3	228.7	269.3	222.5	879.9	181.2	349.0
25–34	730.6	631.2	520.6	370.7	553.2	403.9	1 002.3	377.2	609.2
35–44	590.4	513.6	415.7	315.2	457.8	307.7	683.8	276.6	489.3
45–54	387.5	355.1	281.8	248.4	339.2	305.8	465.1	157.3	337.1
55–64	217.7	238.9	176.0	212.4	167.7	158.2	236.9	84.8	207.3
65 years and over	107.0	258.1	147.5	205.9	109.2	251.8	357.1	91.3	168.8
Total males (a)	353.1	346.3	297.8	241.8	305.1	265.7	558.8	175.8	324.9
Females									
Less than 15 years	55.8	76.4	126.5	83.3	116.3	166.0	331.4	30.8	89.2
15–24	283.6	403.3	341.4	317.6	263.3	347.2	1 122.1	184.9	342.5

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
25–34	335.3	380.6	348.1	318.9	333.8	302.8	641.3	225.7	351.3
35–44	345.2	401.1	339.7	356.4	389.0	330.3	650.8	218.3	365.9
45–54	275.6	352.2	273.6	322.3	297.9	307.3	525.9	178.9	304.4
55–64	182.3	268.5	187.1	259.9	214.4	195.8	346.6	114.4	217.1
65 years and over	142.3	357.3	186.1	318.1	175.2	482.3	729.0	72.7	239.8
Total females (a)	225.8	307.3	255.0	270.5	252.1	293.6	619.6	141.3	265.6
Total people									
Less than 15 years	68.3	91.8	150.6	109.5	159.0	178.1	292.9	46.4	107.6
15–24	332.3	381.8	347.5	271.6	266.3	283.4	998.4	182.9	345.9
25–34	532.9	506.2	434.9	345.4	444.8	352.4	824.3	302.2	480.9
35–44	467.6	456.7	377.4	335.5	423.5	319.2	667.9	248.3	427.5
45–54	331.1	353.6	277.7	285.2	318.4	306.6	496.7	167.7	320.7
55–64	200.1	253.9	181.5	235.7	191.5	177.1	293.3	98.1	212.3
65 years and over	126.5	312.7	168.2	266.2	146.0	378.0	562.2	82.6	207.6
Total (b)	**289.8**	**327.1**	**276.7**	**256.6**	**279.4**	**280.9**	**591.8**	**158.6**	**295.7**
2008-09									
Number									
Males									
Less than 15 years	53 539	57 020	69 564	34 115	33 837	9 406	8 128	1 975	267 584
15–24	171 329	133 507	84 433	38 255	35 906	10 491	25 270	4 347	503 538
25–34	313 446	216 375	125 107	60 557	59 071	13 937	27 686	7 559	823 738
35–44	282 427	193 192	105 837	58 506	59 530	14 136	20 277	4 831	738 736
45–54	186 573	125 183	68 080	41 871	42 059	12 907	10 206	2 541	489 420
55–64	84 909	72 207	35 777	25 053	18 046	8 227	5 549	1 236	251 004
65 years and over	58 257	79 146	29 029	26 172	13 837	8 911	6 658	455	222 465
Total males (a)	1 156 291	876 648	517 871	285 039	262 412	78 015	103 779	22 955	3 303 010

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Females									
Less than 15 years	37 897	37 270	48 266	21 148	19 012	7 034	10 011	1 028	181 666
15–24	136 950	142 510	83 923	53 375	33 094	13 786	31 795	3 405	498 838
25–34	153 624	142 334	81 922	51 410	41 034	10 557	22 738	4 362	507 981
35–44	172 520	155 971	83 097	59 040	51 147	14 705	18 509	3 805	558 794
45–54	137 339	125 192	64 417	52 783	39 505	12 354	13 842	2 274	447 706
55–64	74 183	78 068	35 652	32 153	24 338	7 722	7 771	1 265	261 152
65 years and over	89 167	131 117	43 626	49 024	26 211	20 078	13 861	221	373 305
Total females (a)	805 354	812 501	441 009	319 368	234 382	86 247	118 527	16 371	2 833 759
People									
Less than 15 years	91 569	94 290	117 847	55 269	52 849	16 440	18 141	3 005	449 410
15–24	308 462	276 021	168 356	91 631	69 000	24 277	57 215	7 752	1 002 714
25–34	467 566	358 709	207 029	111 989	100 105	24 494	50 567	11 921	1 332 380
35–44	455 922	349 275	188 938	117 553	110 687	28 912	38 911	8 636	1 298 834
45–54	324 932	250 377	132 497	94 658	81 568	25 305	24 133	4 815	938 285
55–64	159 347	150 275	71 430	57 209	42 386	15 949	13 338	2 501	512 435
65 years and over	147 707	210 324	72 655	75 203	40 059	28 989	20 657	676	596 270
Total (b)	**2 051 579**	**1 689 328**	**958 921**	**609 276**	**525 217**	**173 788**	**223 328**	**39 328**	**6 270 765**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	77.9	110.8	154.6	152.6	227.7	187.8	247.3	72.9	125.3
15–24	345.0	344.6	268.3	234.2	320.5	312.7	901.8	240.7	324.1
25–34	633.6	563.0	411.2	376.7	568.7	497.8	969.5	395.6	540.6
35–44	569.4	496.7	337.7	350.9	528.3	432.5	792.8	271.2	475.3
45–54	389.5	346.4	231.3	268.6	372.2	358.5	439.3	163.3	331.0
55–64	215.0	246.9	144.6	200.9	188.7	257.7	299.3	111.0	206.3

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
65 years and over	132.3	241.1	116.1	214.4	125.6	258.4	419.9	73.8	170.2
Total males (a)	336.2	330.2	241.4	256.3	340.6	329.3	583.8	189.6	309.9
Females									
Less than 15 years	58.0	76.2	113.1	100.7	133.7	148.6	316.0	40.5	89.7
15–24	289.0	387.7	278.3	352.0	309.4	431.3	1 213.5	207.6	337.9
25–34	309.5	373.9	273.8	343.0	406.0	365.8	812.2	231.5	338.0
35–44	341.5	391.6	261.9	367.8	454.4	426.9	709.3	225.5	355.6
45–54	280.7	338.3	214.3	344.0	342.3	332.4	562.2	156.6	297.4
55–64	185.8	258.6	145.9	266.9	243.8	238.0	402.2	136.1	212.9
65 years and over	166.6	327.9	152.7	347.9	190.0	485.9	718.9	41.0	238.4
Total females (a)	227.9	296.4	205.1	292.4	293.9	333.1	673.0	144.4	260.7
Total people									
Less than 15 years	68.3	93.9	134.4	127.4	181.7	168.7	281.1	57.2	108.0
15–24	317.9	365.6	273.2	290.9	315.1	370.6	1 055.2	224.9	330.9
25–34	471.8	468.9	343.1	360.5	488.4	430.8	894.2	314.1	440.2
35–44	455.3	443.6	299.6	359.2	491.4	430.7	753.1	248.9	415.5
45–54	335.6	342.3	222.7	306.1	357.1	345.8	504.3	160.1	314.5
55–64	200.7	252.8	145.3	233.3	216.9	247.8	352.3	122.4	209.7
65 years and over	151.4	288.9	135.6	286.0	161.4	382.4	587.9	58.5	207.5
Total (b)	**294.8**	**313.6**	**223.5**	**277.1**	**335.5**	**351.5**	**632.5**	**167.4**	**291.9**
2009-10									
Number									
Males									
Less than 15 years	55 617	58 865	64 050	36 263	36 458	11 539	10 502	2 894	276 188
15–24	194 198	136 613	75 322	43 713	37 083	14 725	23 932	4 080	529 666
25–34	360 216	212 696	112 225	68 442	59 549	20 832	30 156	6 456	870 572

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
35–44	321 520	198 512	96 721	64 902	61 150	17 384	21 995	5 110	787 294
45–54	203 206	128 415	62 759	47 702	46 587	15 444	12 722	2 666	519 501
55–64	95 362	72 427	34 715	28 721	21 436	8 458	7 146	1 171	269 436
65 years and over	66 302	81 070	27 779	31 519	13 287	10 247	11 291	401	241 896
Total males (a)	1 300 584	888 610	473 593	321 343	275 600	98 681	117 749	22 779	3 498 939
Females									
Less than 15 years	42 034	38 740	43 742	25 000	18 535	9 827	11 446	1 187	190 511
15–24	138 723	153 599	78 342	58 934	32 183	16 731	36 918	3 382	518 812
25–34	156 345	146 349	73 952	55 207	44 709	14 281	25 806	4 465	521 114
35–44	183 051	160 410	76 764	63 702	52 955	19 542	20 050	3 716	580 190
45–54	144 038	134 412	59 620	59 271	41 185	16 258	14 457	1 984	471 225
55–64	88 349	80 891	34 718	35 638	25 366	10 308	10 017	1 131	286 418
65 years and over	95 084	132 732	42 704	53 999	25 146	19 118	20 162	336	389 281
Total females (a)	849 771	847 150	409 855	351 908	240 123	106 109	138 868	16 205	2 959 989
People									
Less than 15 years	97 709	97 605	107 792	61 263	54 993	21 423	21 948	4 081	466 814
15–24	333 043	290 216	153 672	102 649	69 267	31 571	60 938	7 462	1 048 818
25–34	516 863	359 201	186 179	123 674	104 258	35 213	56 025	10 921	1 392 334
35–44	505 271	358 974	173 485	128 624	114 176	37 026	42 091	8 826	1 368 473
45–54	347 565	262 865	122 379	106 975	87 781	31 772	27 213	4 650	991 200
55–64	184 322	153 318	69 433	64 362	46 803	18 801	17 163	2 302	556 504
65 years and over	161 548	213 802	70 483	85 522	38 453	29 400	31 453	737	631 398
Total (b)	**2 242 034**	**1 736 010**	**883 458**	**680 134**	**543 348**	**212 599**	**257 497**	**38 984**	**6 594 064**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	80.4	113.1	139.4	159.3	244.5	230.1	314.0	106.0	127.9

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
15–24	377.6	336.5	229.9	256.0	323.8	430.7	842.1	216.5	328.0
25–34	699.3	526.1	354.3	403.0	556.5	739.1	1 016.4	323.2	547.2
35–44	643.8	504.7	304.2	385.2	545.4	535.3	849.8	281.4	502.1
45–54	419.7	350.5	209.2	300.5	408.5	428.2	541.9	168.5	346.6
55–64	236.6	241.6	137.1	223.9	219.2	260.1	375.8	101.6	216.4
65 years and over	146.0	239.5	106.6	248.6	117.6	287.2	683.5	61.0	178.9
Total males (a)	369.9	325.7	215.1	281.2	352.6	419.0	661.2	182.1	320.5
Females									
Less than 15 years	63.9	78.5	100.5	116.7	129.7	206.9	357.5	46.3	93.0
15–24	285.5	404.7	250.8	375.6	295.9	518.1	1 394.4	201.1	341.5
25–34	303.9	367.5	236.6	349.7	429.4	488.6	886.7	226.9	332.9
35–44	358.6	397.8	238.3	389.8	471.3	569.1	759.8	214.6	364.9
45–54	290.4	357.3	194.1	378.0	354.1	434.8	584.1	134.3	308.1
55–64	215.8	260.4	138.1	285.7	248.8	311.1	504.8	115.3	227.1
65 years and over	173.5	323.7	144.2	372.0	178.6	452.6	1 008.8	58.8	242.1
Total females (a)	235.5	302.5	185.6	312.9	298.4	416.6	780.0	140.4	266.4
Total people									
Less than 15 years	72.4	96.3	120.5	138.6	188.3	219.4	335.3	77.1	110.9
15–24	333.0	369.5	240.1	313.3	310.2	474.9	1 110.0	209.2	334.7
25–34	502.0	447.6	295.8	377.4	493.8	613.4	953.3	275.4	441.1
35–44	500.3	450.6	271.1	387.6	508.6	554.2	805.2	248.8	433.4
45–54	354.6	354.0	201.6	339.0	381.1	432.5	564.3	152.0	327.3
55–64	226.9	251.2	137.6	254.4	234.3	286.4	441.7	107.9	222.0
65 years and over	161.2	285.6	126.6	314.5	151.5	377.3	861.6	60.0	213.3
Total (b)	**312.1**	**315.7**	**197.5**	**299.7**	**332.4**	**420.7**	**725.4**	**171.0**	**297.7**

2010-11

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number									
Males									
Less than 15 years	53 036	57 824	72 813	42 776	32 021	7 000	8 900	2 339	276 709
15–24	206 312	147 891	92 363	54 328	38 495	9 058	27 770	4 397	580 614
25–34	374 096	211 602	128 045	74 158	63 636	14 058	26 754	7 325	899 674
35–44	351 095	204 707	111 891	70 991	65 026	13 116	20 986	5 535	843 347
45–54	214 607	133 645	73 858	51 986	47 926	11 299	14 007	2 788	550 116
55–64	103 602	73 148	38 367	31 831	23 731	5 281	5 971	1 255	283 186
65 years and over	67 449	86 616	31 531	31 509	14 623	8 192	8 124	418	248 462
Total males (a)	1 378 280	915 441	548 876	357 783	285 478	68 048	112 834	24 061	3 690 801
Females									
Less than 15 years	42 780	35 815	51 300	28 703	20 137	6 107	10 502	827	196 171
15–24	161 084	169 999	96 151	70 234	34 661	11 384	39 911	3 040	586 464
25–34	173 977	149 064	82 701	60 239	45 294	9 033	21 600	5 224	547 132
35–44	202 688	171 229	88 749	67 465	54 097	12 340	21 573	4 208	622 349
45–54	158 044	136 234	68 181	65 891	41 782	12 316	13 965	2 163	498 576
55–64	93 863	84 995	41 885	38 616	26 114	8 260	10 058	1 291	305 082
65 years and over	101 540	138 036	45 582	54 456	28 308	15 615	11 783	404	395 724
Total females (a)	938 018	885 380	474 560	385 808	250 423	75 100	129 900	17 160	3 156 349
People									
Less than 15 years	95 881	93 665	124 113	71 479	52 158	13 132	19 402	3 166	472 996
15–24	367 518	317 934	188 540	124 570	73 160	20 501	67 706	7 437	1 167 366
25–34	548 366	360 809	210 754	134 403	108 930	23 157	48 373	12 549	1 447 341
35–44	554 048	376 073	200 640	138 490	119 130	25 645	42 569	9 743	1 466 338
45–54	373 577	269 912	142 067	117 887	89 718	23 660	27 974	4 951	1 049 746
55–64	197 940	158 143	80 256	70 453	49 849	13 570	16 029	2 546	588 786

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
65 years and over	169 546	224 652	77 113	85 985	42 937	23 838	19 907	822	644 800
Total (b)	**2 408 488**	**1 994 752**	**1 023 502**	**752 186**	**560 498**	**150 689**	**242 857**	**41 221**	**7 174 193**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	76.2	112.1	160.5	187.9	216.6	141.5	263.3	86.7	128.6
15–24	418.9	375.4	290.8	319.6	339.4	264.7	926.7	225.6	369.5
25–34	734.7	521.2	409.1	420.3	590.1	481.0	875.6	346.0	564.4
35–44	707.1	525.3	355.8	414.8	586.6	402.0	789.3	298.3	540.4
45–54	440.9	365.3	246.8	320.8	421.1	309.1	591.5	172.8	365.7
55–64	252.2	241.3	151.4	243.2	240.1	156.3	311.2	104.4	224.3
65 years and over	143.9	250.4	118.7	243.7	127.0	218.5	474.7	62.2	179.3
Total males (a)	395.2	337.3	252.2	307.8	366.3	283.1	611.8	186.5	339.1
Females									
Less than 15 years	65.0	73.2	119.3	131.6	142.3	132.0	327.5	32.8	96.1
15–24	342.8	454.1	313.4	440.8	322.3	354.9	1 403.9	184.0	392.3
25–34	342.9	371.5	266.4	363.7	430.9	305.1	717.6	266.3	348.7
35–44	398.7	425.5	276.8	403.0	488.5	362.0	801.5	242.0	391.9
45–54	319.0	361.3	223.0	410.8	361.1	330.3	559.4	145.9	325.5
55–64	225.1	269.1	165.1	295.7	254.3	244.6	501.0	128.0	237.6
65 years and over	181.4	329.9	150.9	361.1	199.0	360.7	567.1	70.0	240.8
Total females (a)	262.2	316.1	216.1	334.4	311.9	290.3	708.3	148.2	284.6
Total people									
Less than 15 years	70.8	93.2	140.4	160.3	180.3	137.2	294.6	60.6	112.8
15–24	381.9	413.8	301.9	378.3	331.1	309.2	1 159.5	206.5	380.7
25–34	539.5	447.0	338.1	392.9	511.6	393.6	797.5	307.7	457.6
35–44	551.3	474.7	316.0	409.1	537.6	384.4	795.6	271.1	465.7

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
45–54	380.4	363.3	234.8	365.6	390.9	320.4	575.0	159.9	345.8
55–64	239.1	255.5	158.3	269.4	247.4	200.9	408.3	115.2	231.2
65 years and over	164.8	294.0	135.8	307.0	166.8	295.1	525.3	65.8	212.8
Total (b)	**341.4**	**362.1**	**234.3**	**325.4**	**354.8**	**301.9**	**659.9**	**168.1**	**326.8**

(a) Includes service contacts for which age group was not reported.

(b) Includes service contacts for which sex and/or age group was not reported.

(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Technical information — Technical notes section of *Mental Health Services in Australia* online.

Source: AIHW various issues, *Mental Health Services in Australia* (various years), (available at mhsa.aihw.gov.au/home/).

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2005-06										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	23	11	..	np	8	16	np	..	64
Non-Indigenous	no.	403	778	..	172	130	565	48	..	2 096
Not reported	no.	10	2	..	–	2	160	11	..	185
Total	no.	436	791	..	177	140	741	60	..	2 345
Rate per 10 000 people (e)										
Indigenous (d)	per 10 000 people	2.0	3.7	..	np	3.6	18.5	np	..	1.9
Non-Indigenous	per 10 000 people	0.6	1.6	..	0.9	0.9	15.4	1.8	..	1.1
Rate ratio (f)		3.3	2.3	..	0.8	4.0	1.2	1.2	..	1.7
Total	per 10 000 people	0.6	1.6	..	0.9	1.0	14.1	1.8	..	1.1
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	97 430	21 682	49 225	23 006	11 255	950	5 275	10 654	219 477
Torres Strait Islander	no.	1 697	2 146	5 314	171	158	22	39	27	9 574
Both Aboriginal and Torres Strait Islander	no.	9 518	2 474	2 704	1 953	762	7	412	382	18 212
Indigenous (d)	no.	108 645	26 302	57 243	25 130	12 175	979	5 726	11 063	247 263
Neither Aboriginal nor Torres Strait Islander	no.	1 040 517	1 800 406	832 841	440 820	271 101	47 412	135 872	24 807	4 593 776
Not reported	no.	683 015	6 497	2 309	26 518	19 124	17 185	69 235	486	824 369
Total	**no.**	**1 832 177**	**1 833 205**	**892 393**	**492 468**	**302 400**	**65 576**	**210 833**	**36 356**	**5 665 408**
Rate per 10 000 people (e)										
Indigenous (d)	per 1 000 people	822.1	936.6	435.5	375.9	446.3	153.5	1138.6	187.2	531.7

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Non-Indigenous (h)	per 1 000 people	254.2	356.4	216.6	239.5	191.4	133.0	612.6	168.4	270.3
Rate ratio (f)		3.2	2.6	2.0	1.6	2.3	1.2	1.9	1.1	2.0
Total	**per 1 000 people**	**265.1**	**357.3**	**221.5**	**242.2**	**195.6**	**130.5**	**616.3**	**170.8**	**274.9**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	1 709	316	1 007	623	328	np	np	np	4 478
Separation rate (e)	per 1 000 people	13.6	10.9	8.2	9.3	12.2	np	np	np	10.4
Patient days	no.	30 049	4506	22 285	14 339	4 641	np	np	np	80 616
Psychiatric care days	no.	29 549	4502	22 167	14 288	4 641	np	np	np	79 907
Average length of stay (overnight)	no.	18.0	14.5	22.5	23.3	15.0	np	np	np	18.5
Non-Indigenous (h)										
Separations	no.	36 704	25 380	25 438	10 976	9 990	np	np	np	109 139
Separation rate (e)	per 1 000 people	5.5	5.0	6.6	5.6	6.4	np	np	np	5.7
Patient days	no.	790 150	466 353	458 231	205 605	236 494	np	np	np	2 162 881
Psychiatric care days	no.	766 667	465 514	454 165	202 744	236 494	np	np	np	2 131 599
Average length of stay (overnight)	no.	23.0	19.4	21.3	19.9	27.2	np	np	np	21.7
Rate ratio (f)		2.5	2.2	1.2	1.7	1.9	np	np	np	1.8
2006-07										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	15	26	..	np	2	10	np	np	60
Non-Indigenous	no.	377	968	..	178	115	627	73	6	2 344

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Not reported	no.	1	9	..	np	4	106	7	np	127
Total	no.	393	1 003	..	181	121	743	81	9	2 531
Rate per 10 000 people										
Indigenous (d)	per 10 000 people	1.8	10.3	..	np	0.8	15.4	1.6	np	1.8
Non-Indigenous	per 10 000 people	0.6	1.9	..	0.9	0.8	12.8	2.1	0.5	1.2
Rate ratio (f)		3.0	5.4	..	np	1.0	1.2	0.8	np	1.5
Total	per 10 000 people	0.6	2.0	..	0.9	0.8	14.7	2.3	0.5	1.2
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	114 468	25 636	65 117	23 967	14 042	2 598	3 710	10 897	260 435
Torres Strait Islander	no.	2 402	1 681	7 514	123	166	31	8	62	11 987
Both Aboriginal and Torres Strait Islander	no.	12 137	1 760	4 299	1 335	763	23	199	297	20 813
Indigenous (d)	no.	129 007	29 077	76 930	25 425	14 971	2 652	3 917	11 256	293 235
Neither Aboriginal nor Torres Strait Islander	no.	1 288 558	1 789 065	970 751	489 271	333 057	77 479	177 633	24 799	5 150 613
Not reported	no.	410 903	12 136	3 279	21 113	34 276	13 055	25 937	1 730	522 429
Total	**no.**	**1 828 468**	**1 830 278**	**1 050 960**	**535 809**	**382 304**	**93 186**	**207 487**	**37 785**	**5 966 277**
Rate per 1000 people (e)										
Indigenous	per 1 000 people	996.3	1 022.1	595.3	359.7	528.9	181.3	902.5	180.8	629.3
Non-Indigenous (h)	per 1 000 people	255.4	349.3	245.8	253.3	243.1	189.4	596.8	167.2	279.8
Rate ratio (f)		3.9	2.9	2.4	1.4	2.2	1.0	1.5	1.1	2.2
Total	**per 1 000 people**	**269.7**	**353.3**	**256.7**	**257.9**	**249.3**	**189.2**	**602.9**	**172.3**	**288.0**

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	1 915	361	1 219	607	362	np	np	440	4 904
Separation rate (e)	per 1 000 people	15.1	12.6	10.1	8.4	13.5	np	np	7.0	11.3
Patient days	no.	37 458	6 008	40 405	14 216	6 833	np	np	5 369	110 289
Psychiatric care days	no.	36 981	5 997	40 265	14 134	6 833	np	np	5 339	109 549
Average length of stay (overnight)	no.	19.7	16.7	34.9	23.6	19.5	np	np	12.8	23.0
Non-Indigenous (h)										
Separations	no.	37 344	27 095	24 791	11 389	10 775	np	np	544	111 938
Separation rate (e)	per 1 000 people	5.6	5.2	6.2	5.6	6.8	np	np	3.3	5.7
Patient days	no.	808 262	536 843	481 912	226 377	207 442	np	np	5 957	2 266 793
Psychiatric care days	no.	782 915	536 176	477 831	223 946	207 442	np	np	5 886	2 234 196
Average length of stay (overnight)	no.	22.6	20.6	23.4	21.3	22.3	np	np	11.2	22.0
Rate ratio (f)		2.7	2.4	1.6	1.5	2.0	np	np	2.1	1.8
2007-08										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	np	np	..	np	np	np	np	np	87
Non-Indigenous	no.	np	np	..	np	np	np	np	np	2 962
Not reported	no.	np	np	..	np	np	np	np	np	np
Total	no.	305	1 498	..	240	192	907	75	5	3 222

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Rate per 10 000 people										
Indigenous (d)	per 10 000 people	np	np	..	np	np	np	np	np	1.9
Non-Indigenous (h)	per 10 000 people	np	np	..	np	np	np	np	np	1.4
Rate ratio (f)		np	np	..	np	np	np	np	np	1.4
Total	per 10 000 people	0.4	2.8	..	1.1	1.3	17.3	2.1	0.3	1.5
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	154 648	25 248	81 047	27 339	19 616	3 371	4 399	10 788	326 456
Torres Strait Islander	no.	3 088	1 516	7 942	98	248	41	24	37	12 994
Both Aboriginal and Torres Strait Islander	no.	12 511	2 646	5 164	1 394	817	113	–	334	22 979
Indigenous (d)	no.	170 247	29 410	94 153	28 831	20 681	3 525	4 423	11 159	362 429
Neither Aboriginal nor Torres Strait Islander	no.	1 602 002	1 691 539	1 066 035	508 389	388 682	120 633	179 059	21 081	5 577 420
Not reported	no.	300 191	15 507	2 369	17 338	47 579	23 543	23 985	3 906	434 418
Total		**2 072 440**	**1 736 456**	**1 162 557**	**554 558**	**456 942**	**147 701**	**207 467**	**36 146**	**6 374 267**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1228.5	940.5	678.2	412.4	729.0	193.7	1077.2	172.0	735.7
Non-Indigenous (h)	per 1 000 people	262.9	302.5	253.5	231.6	261.1	254.1	552.0	151.1	271.6
Rate ratio (f)		4.7	3.1	2.7	1.8	2.8	0.8	2.0	1.1	2.7
Total	**per 1 000 people**	**289.8**	**327.1**	**276.7**	**256.6**	**279.4**	**280.9**	**591.8**	**158.6**	**295.7**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	1 940	362	1 227	590	302	np	np	404	4 825
Separation rate (e)	per 1 000 people	14.1	11.9	9.3	8.3	11.3	np	np	5.9	10.5

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Patient days	no.	38 573	6 463	45 785	14 307	4 984	np	np	5 074	115 186
Psychiatric care days	no.	37 795	6 351	45 011	14 171	4 984	np	np	5 050	113 362
Average length of stay (overnight)	no.	20.0	18.2	39.1	24.4	16.7	np	np	12.9	24.3
Non-Indigenous										
Separations	no.	38 256	28 910	24 429	12 494	9 549	np	np	553	114 191
Separation rate (e)	per 1 000 people	5.6	5.5	5.9	6.0	6.0	np	np	3.4	5.7
Patient days	no.	874 557	537 322	469 727	238 391	188 967	np	np	5 376	2 314 340
Psychiatric care days	no.	856 734	536 505	465 016	235 522	188 967	np	np	5 343	2 288 087
Average length of stay (overnight)	no.	24.0	19.5	22.7	21.9	22.7	np	np	10.2	22.2
Rate ratio (f)		2.5	2.2	1.6	1.4	1.9	np	np	1.7	1.8
2008-09										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	13	34	..	5	11	9	–	9	81
Non-Indigenous	no.	200	1 685	..	249	219	822	45	40	3 260
Total	no.	213	1 730	..	254	237	968	46	49	3 497
Rate per 10 000 people (e)										
Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.7
Non-Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.5
Rate ratio (f)		np	np	..	np	np	np	np	np	1.1
Total	per 10 000 people	0.3	3.2	..	1.1	1.6	18.4	1.3	2.2	1.6

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	155 180	26 648	67 758	32 355	26 639	3 645	5 332	12 100	329 657
Torres Strait Islander	no.	3 647	1 755	7 181	81	417	48	33	70	13 232
Both Aboriginal and Torres Strait Islander	no.	12 899	2 570	4 419	1 469	890	641	–	348	23 236
Indigenous (d)	no.	171 726	30 973	79 358	33 905	27 946	4 334	5 365	12 518	366 125
Neither Aboriginal nor Torres Strait Islander	no.	1 441 593	1 643 674	872 221	557 448	434 958	142 697	191 895	21 500	5 305 986
Not reported	no.	438 260	14 681	7 342	17 923	62 313	26 757	26 068	5 310	598 654
Total		**2 051 579**	**1 689 328**	**958 921**	**609 276**	**525 217**	**173 788**	**223 328**	**39 328**	**6 270 765**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1 224	975.0	556.7	482.7	943.6	269.5	1108.3	188.1	731.2
Non-Indigenous	per 1 000 people	211.5	308.8	212.1	264.5	283.8	300.5	549.2	131.3	254.0
Rate ratio (f)		5.8	3.2	2.6	1.8	3.3	0.9	2.0	1.4	2.9
Total	per 1 000 people	**294.8**	**313.6**	**223.5**	**277.1**	**335.5**	**351.5**	**632.5**	**167.4**	**291.9**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	np	np	np	np	np	np	np	np	4 951
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 255
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	6.0
Rate ratio (f)		np	np	np	np	np	np	np	np	1.8

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2009-10										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	18	27	..	8	19	16	–	33	121
Non-Indigenous	no.	196	2 200	..	215	190	780	55	49	3 685
Total	no.	214	2 240	..	223	219	929	57	82	3 964
Rate per 10 000 people (e)										
Indigenous (d)	per 10 000 people	np	np	np	np	np	np	np	np	2.5
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	1.7
Rate ratio (f)		np	np	np	np	np	np	np	np	1.5
Total	per 10 000 people	np	np	np	np	np	np	np	np	1.8
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	190 299	25 973	67 059	38 366	27 363	18 496	7 632	14 483	389 671
Torres Strait Islander	no.	3 227	2 091	6 382	202	310	587	172	107	13 078
Both Aboriginal and Torres Strait Islander	no.	16 017	4 138	4 633	1 552	860	527	–	418	28 145
Indigenous (d)	no.	209 543	32 202	78 074	40 120	28 533	19 610	7 804	15 008	430 894
Neither Aboriginal nor Torres Strait Islander	no.	1 604 984	1 681 351	803 254	617 936	446 762	178 757	226 842	23 514	5 583 400
Not reported	no.	427 507	22 457	2 130	22 078	68 053	14 232	22 851	462	579 770
Total		**2 242 034**	**1 736 010**	**883 458**	**680 134**	**543 348**	**212 599**	**257 497**	**38 984**	**6 594 064**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1 459.1	971.2	530.2	554.4	941.3	1211.1	1767.0	217.4	841.8
Non-Indigenous (h)	per 1 000 people	231.7	309.4	190.6	284.5	288.8	380.4	649.0	141.6	262.0

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Rate ratio (f)		6.3	3.1	2.8	1.9	3.3	3.2	2.7	1.5	3.2
Total	**per 1 000 people**	**315.5**	**314.4**	**200.5**	**300.5**	**343.1**	**434.2**	**724.8**	**161.9**	**299.9**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	np	np	np	np	np	np	np	np	5 075
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 489
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	5.9
Rate ratio (f)		np	np	np	np	np	np	np	np	1.8
2010-11										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	17	27	..	6	15	14	np	np	121
Non-Indigenous	no.	215	2 425	..	231	323	656	np	np	3 969
Total (h)	no.	232	2 475	..	237	369	760	75	86	4 234
Rate per 10 000 people (e)										
Indigenous (d)	per 10 000 people	np	np	np	np	np	np	np	np	2.6
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	1.8
Rate ratio (f)		np	np	np	np	np	np	np	np	1.4
Total	per 10 000 people	np	np	np	np	np	np	np	np	1.9
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	200 879	26 355	82 921	49 083	28 886	3 580	9 173	16 098	416 975
Torres Strait Islander	no.	3 186	1 741	7 777	135	451	392	157	71	13 910

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Both Aboriginal and Torres Strait Islander	no.	16 143	2 128	6 327	1 592	54	978	–	461	27 683
Indigenous (d)	no.	220 208	30 224	97 025	50 810	29 391	4 950	9 330	16 630	458 568
Neither Aboriginal nor Torres Strait Islander	no.	1 755 783	1 731 303	924 592	679 170	461 470	121 216	211 748	24 296	5 909 578
Not reported	no.	432 497	233 225	1 885	22 206	69 637	24 523	21 779	295	806 047
Total		**2 408 488**	**1 994 752**	**1 023 502**	**752 186**	**560 498**	**150 689**	**242 857**	**41 221**	**7 174 193**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1 511.5	892.2	634.1	676.6	968.8	289.2	1807.5	242.4	870.9
Non-Indigenous (h)	per 1 000 people	254.4	317.5	220.2	306.1	297.7	251.3	587.8	142.9	276.7
Rate ratio (f)		5.9	2.8	2.9	2.2	3.3	1.2	3.1	1.7	3.1
Total	**per 1 000 people**	**341.4**	**362.1**	**234.3**	**325.4**	**354.8**	**301.9**	**659.9**	**168.1**	**326.8**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	np	np	np	np	np	np	np	np	6 109
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	12.9
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 610
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	5.8
Rate ratio (f)		np	np	np	np	np	np	np	np	2.2

(a) Data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions.

(b) Queensland does not have any government-operated residential mental health services. Tasmanian information contains data for government-funded residential units operated by the non-government sector in that state, being the only jurisdiction providing this level of reporting. The NT did not have any community residential units in 2005-06.

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

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

(c) For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards. Comparison of NSW data over time therefore should be approached with caution.

(d) Includes patients identified as being either of Aboriginal but not Torres Strait Islander origin, Torres Strait Islander but not Aboriginal origin, Aboriginal and Torres Strait Islander origin and patients identified as of Aboriginal or Torres Strait Islander origin.

(e) The rates were directly aged standardised against the Australian Estimated Resident Population as at 30 June 2001.

(f) The rate ratio is equal to the service use (episodes, contacts or separations) rate for Indigenous Australians divided by the service use rate for non-Indigenous Australians.

(g) Data for community mental health service contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. See *Mental Health Services in Australia* (mhsa.aihw.gov.au/home) for further information.

(h) Includes data for people where Indigenous status was missing or not reported.

(i) Admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded. Comprises separations with and without mental health-related principal diagnoses but with specialised psychiatric care.

(j) Interpretation of differences between jurisdictions needs to be undertaken with care as they may reflect different service delivery and admission practices and/or differences in the types of establishments categorised as hospitals.

(k) Includes only public hospital separations for the NT.

(l) Indigenous status data for NSW, Victoria, Queensland, WA, SA and the NT public hospitals are considered to be of acceptable quality for analytical purposes. Indigenous identification is likely to be incomplete and to vary among jurisdictions. Total includes data for these jurisdictions only.

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

Source: AIHW various issues, *Mental Health Services in Australia* (various years), (available at mhsa.aihw.gov.au/home/).

Table 12A.22 **Available beds in specialised mental health services (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas* (h), (i)	*ACT* (i)	*NT* (i)	*Aust*
No. of beds									
Public psychiatric hospitals									
2005-06	1 072	116	375	245	455	..	..	..	2 263
2006-07	1 060	134	375	254	388	..	..	..	2 211
2007-08	1 024	154	376	245	357	..	..	..	2 156
2008-09	911	154	375	246	343	..	..	..	2 029
2009-10	967	150	375	243	267	..	..	..	2 002
2010-11	1 064	152	375	246	247	..	..	..	2 083
2011-12	902	150	345	246	230	..	..	..	1 873
Public acute hospitals with psychiatric units or wards									
2005-06	1 151	1 048	1 014	403	188	125	50	32	4 011
2006-07	1 227	1 050	1 022	415	247	126	70	34	4 191
2007-08	1 400	1 062	1 033	425	243	128	70	34	4 395
2008-09	1 542	1 064	1 029	432	233	130	63	34	4 527
2009-10	1 558	1 082	1 033	452	246	128	63	34	4 597
2010-11	1 586	1 110	1 044	454	252	127	65	33	4 672
2011-12	1 747	1 091	1 057	463	250	131	65	32	4 836
Publicly funded community-based residential units									
2005-06	440	1 319	..	80	43	174	80	10	2 146
2006-07	437	1 359	..	85	63	176	75	5	2 200
2007-08	251	1 404	..	130	71	176	77	5	2 114
2008-09	196	1 456	..	178	99	165	83	13	2 190
2009-10	195	1 430	..	260	89	169	83	13	2 239
2010-11	175	1 448	..	283	97	170	83	15	2 271
2011-12	176	1 476	..	303	138	162	82	15	2 352
Proportion of all beds in different settings (%)									
Public psychiatric hospitals									
2005-06	40.3	4.7	27.0	33.7	66.3	..	..	..	26.9
2006-07	38.9	5.3	26.8	33.7	55.6	..	..	..	25.7
2007-08	38.3	5.9	26.7	30.6	53.2	..	..	..	24.9
2008-09	34.4	5.8	26.7	28.7	50.8	..	..	..	23.2
2009-10	35.6	5.6	26.6	25.4	44.3	..	..	..	22.7
2010-11	37.7	5.6	26.4	25.0	41.4	..	..	..	23.1
2011-12	31.9	5.5	24.6	24.3	37.2	..	..	..	20.7
Public acute hospitals with psychiatric units or wards									
2005-06	43.2	42.2	73.0	55.4	27.4	41.8	38.5	76.2	47.6
2006-07	45.0	41.3	73.2	55.0	35.4	41.7	48.3	87.2	48.7
2007-08	52.3	40.5	73.3	53.1	36.2	42.1	47.6	87.2	50.7
2008-09	58.2	39.8	73.3	50.5	34.5	44.1	43.2	72.3	51.8
2009-10	57.3	40.6	73.4	47.3	40.9	43.1	43.2	72.3	52.0
2010-11	56.1	41.0	73.6	46.2	42.3	42.8	43.9	68.9	51.8

Table 12A.22 **Available beds in specialised mental health services (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas* (h), (i)	*ACT* (i)	*NT* (i)	*Aust*
2011-12	61.8	40.2	75.4	45.8	40.5	44.7	44.2	68.1	53.4
Publicly funded community-based residential units									
2005-06	16.5	53.1	..	11.0	6.3	58.2	61.5	23.8	25.5
2006-07	16.0	53.4	..	11.3	9.0	58.3	51.7	12.8	25.6
2007-08	9.4	53.6	..	16.3	10.6	57.9	52.4	12.8	24.4
2008-09	7.4	54.5	..	20.8	14.7	55.9	56.8	27.7	25.0
2009-10	7.2	53.7	..	27.2	14.8	56.9	56.8	27.7	25.3
2010-11	6.2	53.4	..	28.8	16.3	57.2	56.1	31.1	25.2
2011-12	6.2	54.3	..	29.9	22.3	55.3	55.8	31.9	26.0
Beds per 100 000 people									
Public psychiatric hospitals									
2005-06	16.0	2.3	9.5	12.1	29.5	..	..	..	11.1
2006-07	15.6	2.6	9.2	12.2	24.9	..	..	..	10.7
2007-08	14.9	3.0	9.0	11.5	22.6	..	..	..	10.3
2008-09	13.0	2.9	8.8	11.1	21.5	..	..	..	9.4
2009-10	13.6	2.8	8.6	10.7	16.5	..	..	..	9.2
2010-11	14.8	2.8	8.5	10.6	15.1	..	..	..	9.4
2011-12	12.4	2.7	7.6	10.3	14.0	..	..	..	8.3
Public acute hospitals with psychiatric units or wards									
2005-06	17.1	20.9	25.6	19.9	12.2	25.6	15.0	15.4	19.7
2006-07	18.1	20.6	25.2	20.0	15.8	25.6	20.7	16.1	20.3
2007-08	20.3	20.4	24.8	19.9	15.4	25.8	20.3	15.7	20.9
2008-09	22.0	20.0	24.1	19.6	14.6	25.9	17.9	15.3	21.1
2009-10	21.9	20.0	23.7	20.0	15.2	25.3	17.6	14.9	21.0
2010-11	22.1	20.2	23.5	19.6	15.4	24.9	17.8	14.5	21.1
2011-12	24.1	19.6	23.4	19.4	15.2	25.6	17.5	13.8	21.5
Publicly funded community-based residential units									
2005-06	6.5	26.3	..	3.9	2.8	35.6	24.0	4.8	10.6
2006-07	6.4	26.6	..	4.1	4.0	35.8	22.2	2.4	10.7
2007-08	3.6	27.0	..	6.1	4.5	35.5	22.4	2.3	10.1
2008-09	2.8	27.4	..	8.1	6.2	32.9	23.6	5.8	10.2
2009-10	2.7	26.4	..	11.5	5.5	33.3	23.2	5.7	10.2
2010-11	2.4	26.3	..	12.2	6.0	33.3	22.8	6.5	10.2
2011-12	2.4	26.5	..	12.7	8.4	31.7	22.1	6.5	10.5
Total									
2005-06	39.6	49.4	35.0	35.9	44.4	61.3	39.0	20.3	41.5
2006-07	40.1	49.8	34.4	36.3	44.7	61.4	42.9	18.5	41.7
2007-08	38.9	50.4	33.9	37.5	42.5	61.3	42.7	18.0	41.2
2008-09	37.8	50.3	32.8	38.8	42.2	58.8	41.6	21.1	40.7
2009-10	38.3	49.1	32.2	42.2	37.2	58.6	40.8	20.6	40.4
2010-11	39.3	49.3	32.0	42.4	36.5	58.2	40.6	21.0	40.7

Table 12A.22 **Available beds in specialised mental health services (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas* (h), (i)	*ACT* (i)	*NT* (i)	*Aust*
2011-12	39.0	48.7	31.1	42.4	37.6	57.3	39.7	20.2	40.3

(a) Bed numbers represent the average number of beds which are immediately available for use by an admitted patient or resident within the establishment. See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the bed estimates. Available beds are counted as the average of monthly available bed numbers. Available beds counts exclude beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only).

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) Hospital bed can include government funded beds managed and operated by private and non-government entities.

(d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) Queensland does not fund community residential services, however, it funds a number of campus based and non-campus based extended treatment services. These services are reported either as wards of public acute hospitals or beds in public psychiatric hospitals. Furthermore, limiting the classification of all inpatient beds to either co-located or standalone results in the reporting of some psychogeriatric beds co-located with nursing homes being reported as 'standalone' which results in the reporting of these beds as psychiatric hospital beds in this report. In 2005-06, there was temporary closure of acute beds in one Queensland hospital and some transitional extended treatment beds were permanently closed. In addition, Queensland did not change its method for counting beds until 2007-08 (see 2011 Report for details of previous method).

(g) Beds numbers in WA include publicly funded mental health beds in private hospitals for all years. Bed numbers in WA include emergency department observation beds in one hospital for all years prior to 2010-11.

(h) In Tasmania, for 2005-06, non-government organisations' residential beds funded by government were included for the first time in the publicly funded community residential facilities category.

(i) Tasmania, the ACT and the NT do not have public psychiatric hospitals.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS; ABS (various issues), *Australian Demographic Statistics*, December (various years), Cat. no. 3101.0; table 12A.75.

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Medical									
Consultant psychiatrist	5.5	4.6	4.3	4.9	5.1	5.0	3.2	3.7	4.9
Psychiatry registrar	4.7	4.7	5.0	4.4	5.7	3.0	5.1	3.1	4.8
Other medical officers	0.8	1.9	0.8	2.9	1.6	0.8	1.3	2.7	1.4
Total	11.0	11.2	10.1	12.2	12.4	8.8	9.7	9.5	11.0
Nursing									
Registered nursing	53.1	53.7	47.8	63.2	56.9	60.4	37.8	40.6	53.3
Non-registered	8.3	12.0	7.6	7.9	14.5	10.3	7.0	3.9	9.5
Total	61.4	65.7	55.4	71.1	71.4	70.7	44.8	44.4	62.8
Allied health									
Occupation therapist	3.2	4.4	3.6	5.9	3.0	1.8	2.1	0.5	3.8
Social worker	5.3	7.9	6.9	8.4	12.5	4.0	7.4	2.4	7.1
Psychologist	8.5	7.8	7.7	7.1	5.4	5.6	21.9	5.8	7.9
Other allied health staff	5.1	2.2	2.9	5.7	3.6	5.9	4.1	8.2	3.9
Total	22.1	22.3	21.1	27.2	24.6	17.3	35.5	16.9	22.7
Other personal care	1.8	5.1	4.7	4.4	0.9	27.7	8.9	2.4	4.1
Total	**96.2**	**104.3**	**91.4**	**114.9**	**109.3**	**124.5**	**98.9**	**73.2**	**100.6**
2006-07									
Medical									
Consultant psychiatrist	5.5	4.6	4.6	4.8	5.8	4.5	3.8	3.9	5.0
Psychiatry registrar	5.4	4.5	5.6	4.8	6.1	2.8	4.5	4.0	5.1
Other medical officers	0.7	1.6	0.8	3.4	1.6	1.0	0.5	2.2	1.3
Total	11.6	10.7	11.1	12.9	13.5	8.4	8.8	10.1	11.4
Nursing									
Registered nursing	54.4	52.0	50.1	61.6	61.1	65.0	41.7	41.8	54.1
Non-registered	8.2	14.1	7.5	8.7	13.8	10.6	8.4	4.5	10.0
Total	62.5	66.1	57.6	70.3	74.9	75.6	50.1	46.3	64.1
Allied health									
Occupation therapist	3.3	4.7	3.5	6.3	3.6	3.0	1.8	0.5	3.9
Social worker	5.2	8.2	7.0	9.5	12.7	6.1	5.9	3.4	7.3
Psychologist	8.3	8.3	8.1	8.1	5.1	5.5	17.9	5.9	8.1
Other allied health staff	5.4	1.7	2.9	5.3	3.9	5.8	2.0	5.7	3.8
Total	22.2	22.9	21.6	29.3	25.3	20.3	27.7	15.4	23.2
Other personal care	2.4	4.2	5.0	4.3	1.5	29.2	8.5	3.3	4.2
Total	**98.7**	**103.9**	**95.3**	**116.8**	**115.2**	**133.5**	**95.1**	**75.1**	**102.9**
2007-08									
Medical									
Consultant psychiatrist	5.6	4.3	5.7	4.8	6.1	5.4	4.3	4.0	5.2

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Psychiatry registrar	5.4	4.8	5.6	4.8	6.6	3.2	4.8	4.1	5.2
Other medical officers	1.2	2.2	0.9	3.6	1.1	0.2	0.4	2.3	1.6
Total	12.1	11.3	12.1	13.2	13.8	8.9	9.5	10.4	12.0
Nursing									
Registered nursing	54.4	51.0	52.2	61.1	63.8	59.2	40.6	42.7	54.3
Non-registered	8.1	14.4	8.3	8.8	15.0	11.0	8.6	4.2	10.3
Total	62.5	65.4	60.4	70.0	78.7	70.2	49.2	46.9	64.6
Allied health									
Occupation therapist	3.3	4.5	3.9	6.8	4.4	2.2	2.2	0.8	4.1
Social worker	4.7	8.4	7.7	9.5	14.3	5.6	6.8	3.8	7.4
Psychologist	8.7	7.5	9.5	7.4	6.9	5.0	14.2	5.8	8.3
Other allied health staff	5.6	2.2	3.1	5.7	4.4	5.9	0.2	6.1	4.1
Total	22.3	22.6	24.2	29.5	30.0	18.7	23.4	16.5	23.9
Other personal care	1.0	4.7	4.8	6.2	1.5	31.2	9.4	3.6	4.1
Total	**97.9**	**104.0**	**101.5**	**118.8**	**124.0**	**129.0**	**91.4**	**77.3**	**104.6**
2008-09									
Medical									
Consultant psychiatrist	6.2	4.8	5.7	5.3	6.1	4.6	5.8	5.8	5.6
Psychiatry registrar	5.8	5.1	5.9	4.7	7.1	2.8	4.5	4.3	5.5
Other medical officers	0.9	1.5	0.5	3.5	0.2	2.7	0.8	2.7	1.3
Total	12.9	11.4	12.1	13.5	13.4	10.1	11.1	12.8	12.4
Nursing									
Registered nursing	56.0	50.9	52.7	61.9	62.3	60.2	37.4	46.6	54.9
Non-registered	8.2	15.4	8.4	9.3	15.3	11.0	9.3	2.4	10.7
Total	64.2	66.2	61.1	71.2	77.6	71.2	46.6	48.9	65.5
Allied health									
Occupation therapist	3.9	4.6	4.5	6.8	4.2	3.3	4.2	1.0	4.5
Social worker	5.7	8.8	7.8	9.2	14.7	5.9	5.9	5.2	7.9
Psychologist	8.3	7.8	9.3	7.9	5.6	4.6	13.5	4.5	8.1
Other allied health staff	4.0	1.7	3.7	6.2	3.0	4.5	0.4	5.0	3.5
Total	22.0	22.9	25.3	30.0	27.5	18.3	24.0	15.7	24.0
Other personal care	0.8	4.8	4.1	6.0	4.7	30.2	7.7	9.4	4.2
Total	**99.9**	**105.5**	**102.7**	**120.7**	**123.2**	**129.9**	**89.4**	**86.9**	**106.1**
2009-10									
Medical									
Consultant psychiatrist	6.1	5.4	5.6	5.6	6.2	5.4	6.8	5.8	5.8
Psychiatry registrar	6.6	4.7	5.8	4.5	6.8	2.8	5.2	4.6	5.6
Other medical officers	0.4	1.7	0.7	3.5	0.4	2.2	0.5	2.3	1.1
Total	13.1	11.9	12.1	13.7	13.4	10.4	12.5	12.7	12.6

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Nursing									
Registered nursing	59.3	50.3	50.0	60.5	62.9	58.3	40.9	45.5	55.1
Non-registered	7.3	15.3	7.5	9.7	14.6	11.1	8.5	3.3	10.2
Total	66.6	65.6	57.5	70.3	77.6	69.4	49.4	48.8	65.3
Allied health									
Occupation therapist	4.1	4.8	4.1	6.4	4.7	2.9	3.2	1.4	4.5
Social worker	6.0	8.6	8.6	8.8	15.0	6.2	6.0	4.2	8.1
Psychologist	8.4	7.6	8.7	7.2	5.6	4.7	14.4	4.7	7.9
Other allied health staff	4.1	1.6	3.6	6.4	2.5	6.6	0.4	5.7	3.5
Total	22.5	22.5	25.1	28.8	27.8	20.4	24.0	16.0	24.0
Other personal care	0.9	4.6	4.8	7.4	5.9	34.3	7.6	8.7	4.6
Total	**103.1**	**104.6**	**99.4**	**120.1**	**124.7**	**134.5**	**93.5**	**86.2**	**106.5**
2010-11									
Medical									
Consultant psychiatrist	6.4	5.5	6.0	6.0	7.6	6.4	6.0	4.5	6.1
Psychiatry registrar	6.8	5.0	5.8	4.3	5.8	2.5	5.1	5.6	5.7
Other medical officers	0.5	1.5	1.0	3.8	0.3	1.9	0.2	2.1	1.2
Total	13.7	12.0	12.9	14.1	13.7	10.7	11.3	12.2	13.0
Nursing									
Registered nursing	61.0	51.7	53.2	59.6	65.7	59.1	40.4	45.1	56.8
Non-registered	6.6	15.3	7.3	9.7	14.9	10.5	7.6	3.3	9.9
Total	67.6	67.0	60.5	69.3	80.6	69.6	48.0	48.3	66.7
Allied health									
Occupation therapist	4.2	5.2	4.5	6.4	4.7	3.0	3.3	1.2	4.7
Social worker	6.2	8.7	8.9	9.0	14.6	6.4	6.1	5.9	8.3
Psychologist	8.5	7.7	9.2	7.4	5.8	4.3	16.8	7.2	8.2
Other allied health staff	4.7	1.9	3.9	6.1	2.5	7.2	0.2	4.2	3.8
Total	23.6	23.4	26.6	28.9	27.6	20.9	26.4	18.5	24.9
Other personal care	0.6	4.5	5.3	10.7	7.2	33.2	7.1	10.1	5.0
Total	**105.5**	**106.9**	**105.3**	**123.0**	**129.1**	**134.5**	**92.8**	**89.1**	**109.7**
2011-12									
Medical									
Consultant psychiatrist	6.0	5.2	6.2	6.2	7.1	5.8	8.2	6.7	6.0
Psychiatry registrar	6.1	5.3	6.6	4.8	6.2	3.0	4.6	6.3	5.8
Other medical officers	0.9	1.7	0.8	3.6	0.3	1.1	0.2	0.4	1.3
Total	13.0	12.3	13.6	14.6	13.6	10.0	13.0	13.4	13.1
Nursing									
Registered nursing	63.5	52.0	56.0	60.5	62.6	56.8	38.7	47.7	58.0
Non-registered	7.0	15.6	8.0	10.0	13.4	9.2	7.6	3.7	10.1

Table 12A.23 Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	70.5	67.5	64.0	70.5	76.0	66.0	46.4	51.3	68.2
Allied health									
Occupation therapist	3.8	5.6	4.5	5.9	4.5	2.5	3.6	1.6	4.6
Social worker	6.2	8.6	9.2	9.0	14.8	6.1	6.8	6.9	8.3
Psychologist	8.9	7.6	9.7	7.4	5.9	3.9	16.1	5.7	8.3
Other allied health staff	5.3	1.9	3.9	7.2	0.9	6.0	0.2	4.6	4.0
Total	24.1	23.6	27.4	29.6	26.0	18.5	26.6	18.7	25.2
Other personal care	0.8	4.4	5.0	11.5	7.4	31.6	7.0	9.5	5.1
Total	**108.5**	**107.8**	**110.0**	**126.3**	**123.1**	**126.0**	**93.1**	**93.0**	**111.6**

(a) Professional categories are defined by profession rather than role. See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of staffing estimates.

(b) Total FTE figures presented in this table can differ from those in table 12A.24. In addition, totals may not add due to rounding.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(e) Queensland implemented a new method to calculate FTE from the 2009-10 data. The new method is associated with the reduction in reported FTE so caution should be exercised when conducting time series analysis.

Source: AIHW unpublished, derived from the MHE NMDS*;* ABS (various issues), *Australian Demographic Statistics,* December (various years), Cat. no. 3101.0.

Table 12A.24 **Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people) (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f), (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Inpatient services	53.5	37.0	55.5	62.5	62.9	48.8	25.4	30.6	50.6
Ambulatory mental health services	38.7	44.1	35.9	49.5	45.0	40.9	50.0	40.6	41.3
Community residential services	4.0	22.9	..	2.9	1.4	34.6	19.2	1.9	8.6
Total	**96.2**	**103.9**	**91.4**	**114.9**	**109.3**	**124.3**	**94.5**	**73.2**	**100.4**
2006-07									
Inpatient services	55.6	37.3	54.7	63.9	67.4	58.6	28.2	32.3	52.0
Ambulatory mental health services	38.8	44.7	40.6	49.7	46.4	40.2	50.5	41.3	42.5
Community residential services	4.3	21.9	..	3.3	1.4	32.3	16.4	1.4	8.3
Total	**98.7**	**103.9**	**95.3**	**116.8**	**115.2**	**131.1**	**95.1**	**75.0**	**102.9**
2007-08									
Inpatient services	55.8	37.5	57.0	63.9	70.1	56.5	28.3	31.9	52.7
Ambulatory mental health services	39.9	44.2	44.5	49.4	50.9	38.9	49.0	43.8	43.8
Community residential services	2.3	22.2	..	5.5	3.0	31.6	14.0	1.7	8.0
Total	**97.9**	**104.0**	**101.5**	**118.8**	**124.0**	**126.9**	**91.4**	**77.4**	**104.6**
2008-09									
Inpatient services	57.9	38.6	55.8	64.8	67.1	56.6	26.4	38.0	53.4
Ambulatory mental health services	40.1	44.6	46.9	49.6	51.2	40.9	48.7	42.8	44.6
Community residential services	1.8	22.2	..	6.4	5.0	30.3	14.2	6.1	8.1
Total	**99.9**	**105.5**	**102.7**	**120.7**	**123.2**	**127.8**	**89.4**	**86.9**	**106.0**
2009-10									
Inpatient services	59.8	38.5	51.8	63.8	64.2	57.6	28.5	36.6	52.9
Ambulatory mental health services	41.7	44.6	47.6	49.4	55.5	42.2	50.1	43.1	45.6
Community residential services	1.6	21.5	..	6.9	5.0	32.9	14.9	6.4	8.0
Total	**103.1**	**104.6**	**99.4**	**120.1**	**124.7**	**132.6**	**93.5**	**86.1**	**106.4**
2010-11									
Inpatient services	61.2	39.4	53.6	64.1	62.5	58.3	29.8	38.0	53.8
Ambulatory mental health services	43.1	46.2	51.6	50.9	60.6	42.3	48.9	44.2	47.8
Community residential services	1.2	21.3	..	8.1	6.0	31.6	14.1	6.8	8.0
Total	**105.5**	**106.9**	**105.3**	**123.0**	**129.1**	**132.2**	**92.7**	**89.1**	**109.6**

Table 12A.24 **Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people) (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f), (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12									
Inpatient services	65.1	39.9	56.2	65.7	55.5	54.9	26.9	37.2	55.3
Ambulatory mental health services	42.3	46.9	53.9	51.8	57.7	40.1	51.6	49.2	48.1
Community residential services	1.1	21.0	..	8.8	9.9	26.8	14.1	6.6	8.1
Total	**108.5**	**107.8**	**110.0**	**126.2**	**123.1**	**121.8**	**92.6**	**93.0**	**111.5**

(a) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of staffing estimates.

(b) Total FTE figures in this table can differ from those in table 12A.23. In addition, totals may not add due to rounding.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) The apparent absence of community residential services in Queensland reflects Queensland's preference to describe such facilities as 'extended inpatient care'.

(g) Queensland implemented a new method to calculate FTE from the 2009–10 data. The new method is associated with the reduction in reported FTE so caution should be exercised when conducting time series analysis.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.25 New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, (a), (b)

	Unit	*NSW* (c), (d), (e)	*Vic* (f)	*Qld* (g)	*WA* (h), (i), (j)	*SA* (k)	*Tas* (l)	*ACT*	*NT* (m)	*Aust* (f)
2009-10										
New clients	no.	46 853	14 985	33 457	17 748	13 206	3 593	3 254	2 657	135 753
Total clients	no.	116 653	61 636	73 550	42 600	31 186	10 498	7 657	5 544	349 324
Proportion of total clients who are new	%	40.2	24.3	45.5	41.7	42.3	34.2	42.5	47.9	38.9
2010-11										
New clients	no.	49 018	15 015	35 372	18 700	13 302	3 658	3 352	2 821	141 238
Total clients	no.	119 792	61 687	77 638	44 839	31 689	11 711	8 079	5 817	361 252
Proportion of total clients who are new	%	40.9	24.3	45.6	41.7	42.0	31.2	41.5	48.5	39.1
2011-12										
New clients	no.	48 389	na	37 341	19 673	14 557	2 428	3 548	3 264	129 200
Total clients	no.	121 703	na	82 042	47 238	34 092	11 112	8 407	6 579	311 173
Proportion of total clients who are new	%	39.8	na	45.5	41.6	42.7	21.9	42.2	49.6	41.5

(a) Clients in receipt of services include all people who received one or more community service contacts or had one or more days of inpatient or residential care in the data period.

(b) A new client is defined as a consumer who has not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service in the data period.

(c) NSW has implemented a Statewide Unique Patient Identifier (SUPI) for mental health care. The identification of prior contacts for MH clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level for 2009-10, 2010-11 and 2011-12 is 99.8 per cent. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which may include some duplicates of those who attended multiple facilities).

(d) For NSW, residential clients are not included because their data are manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW MH residential is very small which will have minimal effect on the final result (total residential MH clients in 2010-11 is 185 with 59 potential new clients and 243 total residential MH clients with 130 potential new clients in 2011-12).

Table 12A.25 **New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, (a), (b)**

	Unit	*NSW* (c), (d), (e)	*Vic* (f)	*Qld* (g)	*WA* (h), (i), (j)	*SA* (k)	*Tas* (l)	*ACT*	*NT* (m)	*Aust* (f)

(e) NSW data have been revised for all years, to include all inpatient and ambulatory clients who received mental health services as recorded in NSW State Health Information Exchange (HIE). One large Local Health District (LHD), has incomplete community data (June 2012 data are missing) in the NSW State HIE in 2011-12. Processes are currently underway to rectify the problem. The 2011-12 rate will be revised/updated for the next Report.

(f) Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.

(g) For Qld, a linkage program is utilised to link between admitted and community activity and patients.

(h) For WA, the matching of mental health community contacts to inpatient episodes is now done between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result. Data before 2011-12 are based on data submitted for the NMDS and have not been revised.

(i) Unlike previous reports, mental health community contacts and acute separations are now sourced from two different data collection systems. Each system has different unique patient identifier and requires the use of linkages to allow unique tracking of consumers across all public mental health services in WA. This could result to an under-estimate in the proportion of new clients

(j) Community/ambulatory, community residential and inpatient mental health activity are entered and collected in different systems. An attempt is made to uniquely identify patients across the WA Health system through data linkage, however mental health patients use alias information, lag in clinical coding and quality assurance processes and additional information can become available for that person and unique identifiers can be updated.

(k) For SA, the new client (numerator) count is not unique: it is an aggregation of three separate databases with no linkage between them. Similarly, the total client (denominator) count is not unique: it is an aggregation of three separate databases with no linkage between them. However, impact on the result should be minimal due to populations being relatively stable within the three respective catchments.

(l) For Tasmania, the information has been extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients. For 2009-10, the new and total client count includes Mental Health Service Helpline contacts with individuals who received a one off contact through the 24 hour telephone helpline. Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12.

(m) For the NT, for 2009-10, the count of all clients will not be exactly the same as provided in other reported collections due to non-availability of 'snapshot' or archived annual data sets.

Source: State and Territory governments, unpublished.

Table 12A.26 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
					Age standardised proportion (%) (a)					no.
2007-08										
Public (b), (c)										
Indigenous	4.5	3.1	3.9	3.5	5.0	1.5	5.1	2.9	3.8	19 187
Non-Indigenous	1.2	1.1	1.7	1.6	1.5	2.0	1.6	1.9	1.3	276 005
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	np	np	np	np	np	np	np	np	np	np
Non-Indigenous	np	np	np	np	np	np	np	np	np	np
2008-09										
Public (b), (c)										
Indigenous	4.7	3.2	3.8	3.8	5.7	1.3	5.6	3.1	4.0	20 616
Non-Indigenous	1.2	1.1	1.6	1.6	1.6	1.3	1.7	1.9	1.3	277 321
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	7.2	9.2	4.5	2.7	5.5	6.5	7.8	1.0	5.1	24 603
Non-Indigenous	5.9	6.4	5.3	4.9	5.6	5.0	4.6	2.7	5.7	1 200 337
2009-10										
Public (b), (c)										
Indigenous	4.9	3.2	4.0	4.2	5.7	np	5.8	3.7	4.3	22 930
Non-Indigenous	1.2	1.0	1.6	1.7	1.6	1.3	1.8	2.0	1.3	282 620

Table 12A.26 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	8.1	10.2	4.7	3.0	6.1	7.2	8.6	1.3	5.6	28 303
Non-Indigenous	6.3	7.0	5.9	5.3	6.3	5.6	5.1	3.2	6.2	1 337 882
2010-11										
Public (b), (c)										
Indigenous	4.8	3.1	4.4	4.8	5.8	1.9	6.4	3.7	4.4	24 250
Non-Indigenous	1.2	1.0	1.6	1.7	1.6	1.6	1.8	2.0	1.4	291 381
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	10.1	11.3	5.9	4.0	7.8	8.9	11.5	1.5	6.9	36 044
Non-Indigenous	6.9	7.6	6.6	5.7	6.9	6.3	5.5	3.4	6.8	1 486 676
2011-12										
Public (b), (c)										
Indigenous	5.4	na	4.8	5.4	6.9	1.2	7.9	3.8	na	na
Non-Indigenous	1.2	na	1.7	1.8	1.7	0.8	1.9	2.3	na	na
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	10.7	12.5	6.7	4.0	8.2	8.4	12.5	1.5	7.4	39 632

Table 12A.26 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Non-Indigenous	7.0	7.8	6.7	5.5	7.0	6.2	5.6	3.6	6.9	1 522 735

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

(b) Excludes people for whom Indigenous status was missing or not reported, for example, in 2011-12 for Tasmania Indigenous status was missing or not reported for 46 per cent of people receiving services. The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions.

(c) SA submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data in 2011-12. Therefore caution needs to be taken when making inter-jurisdictional comparisons.

(d) Indigenous information is not collected for private psychiatric hospitals.

(e) DVA data not available by Indigenous status. MBS data are not published for 2007-08. Medicare data presented by Indigenous status have been adjusted for under-identification in the Department of Human Services (DHS) Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions.

na Not available. .. Not applicable. **np** Not published.

Source : State and territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management Service data; Department of Health (DoH) unpublished, MBS statistics; Department of Veterans' Affairs (DVA) unpublished data; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, 30 June (prior to relevant period)* , Series B, Cat. no. 3238.0.

Table 12A.27 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
	Age standardised proportion (%) (b)									no.
2007-08										
Public (c), (d)										
Major cities	1.2	0.9	1.5	1.3	1.6	..	1.8	..	1.2	173 288
Inner regional	2.6	1.7	2.5	3.9	1.7	np	np	..	2.2	85 003
Outer regional	3.5	2.2	2.2	2.2	2.6	np	..	2.0	2.3	43 447
Remote	4.4	4.3	1.9	0.9	2.0	np	..	2.2	1.9	5 744
Very remote	13.0	..	3.9	4.8	2.1	np	..	2.2	3.6	6 297
Private (c), (e)										
Major cities	0.1	0.1	0.1	0.1	np	..	np	..	0.1	19 261
Inner regional	0.1	–	0.1	0.1	np	np	np	..	0.1	2 973
Outer regional	–	–	–	–	np	np	..	..	–	579
Remote	–	–	–	–	np	np	..	..	–	69
Very remote	–	..	–	–	np	np	..	..	–	30
MBS and DVA (c)										
Major cities	5.3	5.8	5.1	4.6	5.2	..	4.0	..	5.3	764 089
Inner regional	5.1	5.3	4.6	3.7	4.5	4.8	4.6	..	4.9	192 134
Outer regional	3.7	3.7	3.1	3.6	3.2	3.4	..	2.4	3.3	62 986
Remote	2.5	4.7	1.9	1.4	2.5	2.1	..	0.9	1.8	5 668
Very remote	2.6	..	1.2	0.7	2.7	5.5	..	1.2	1.3	2 070
2008-09										
Public (c), (d)										
Major cities	1.2	0.9	1.4	1.3	1.9	..	1.9	..	1.2	180 087
Inner regional	2.7	1.5	2.4	4.0	2.0	np	np	..	2.2	85 135
Outer regional	4.0	2.1	2.2	2.3	2.6	np	..	2.0	2.4	44 963

Table 12A.27 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Remote	5.8	1.5	1.6	0.9	2.5	np	..	2.5	2.0	6 193
Very remote	16.2	..	3.1	5.1	2.3	np	..	2.2	3.7	6 544
Private (c), (e)										
Major cities	0.1	0.1	0.2	0.1	np	..	np	..	0.1	20 251
Inner regional	0.1	–	0.1	0.1	np	np	np	..	0.1	3 205
Outer regional	–	–	–	–	np	np	..	..	–	645
Remote	0.1	–	–	–	np	np	..	..	–	98
Very remote	–	..	–	–	np	np	..	..	–	30
MBS and DVA (c)										
Major cities	6.2	6.7	6.1	5.3	6.3	..	4.8	..	6.2	916 074
Inner regional	6.2	6.6	5.7	4.7	5.5	5.6	5.7	..	6.0	239 453
Outer regional	4.7	4.5	4.0	4.4	4.1	4.2	..	3.0	4.2	80 394
Remote	3.0	6.1	2.5	1.9	3.4	2.7	..	1.3	2.4	7 460
Very remote	4.3	..	1.6	0.8	2.4	6.3	..	1.6	1.5	2 557
2009-10										
Public (c), (d)										
Major cities	1.4	0.9	1.6	1.3	1.8	..	2.0	..	1.3	198 917
Inner regional	2.2	1.6	1.8	4.3	2.1	1.4	np	..	2.0	81 749
Outer regional	2.6	2.1	1.8	2.3	2.5	1.2	..	2.0	2.1	39 579
Remote	3.8	1.0	1.5	1.0	2.6	–	..	2.8	1.9	5 798
Very remote	5.5	..	2.4	5.8	2.1	0.7	..	2.6	3.5	6 416
Private (c), (e)										
Major cities	0.1	0.1	0.2	0.2	np	..	np	..	0.1	21 149
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	3 416
Outer regional	–	–	–	–	np	np	..	..	–	674

Table 12A.27 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Remote	0.1	0.1	–	–	np	np	..	..	–	105
Very remote	–	..	–	–	np	np	..	..	–	31
MBS and DVA (c)										
Major cities	6.6	7.3	6.7	5.7	6.9	..	5.2	..	6.7	1 011 181
Inner regional	6.8	7.4	6.3	5.2	6.5	6.3	6.4	..	6.7	270 641
Outer regional	5.2	5.4	4.7	4.9	4.6	4.8	..	3.4	4.8	93 109
Remote	3.2	6.3	2.8	2.3	4.4	2.8	..	1.6	2.7	8 759
Very remote	4.9	..	1.7	1.0	2.3	4.9	..	2.0	1.7	2 963
2010-11										
Public (c), (d)										
Major cities	1.4	0.9	1.7	1.8	1.8	..	2.1	..	1.4	214 072
Inner regional	2.2	1.6	1.8	1.6	2.1	1.9	np	..	1.9	76 427
Outer regional	2.5	2.0	1.9	2.5	2.4	1.6	..	2.0	2.1	40 932
Remote	3.5	1.2	1.9	3.0	2.6	0.6	..	2.7	2.6	8 115
Very remote	5.1	..	2.9	2.0	2.5	0.7	..	3.1	2.5	4 820
Private (c), (e)										
Major cities	0.1	0.2	0.2	0.2	np	..	np	..	0.1	22 910
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	3 950
Outer regional	–	–	–	–	np	np	..	..	–	858
Remote	0.1	0.1	–	0.1	np	np	..	..	–	115
Very remote	–	..	–	–	np	np	..	..	–	45
MBS and DVA (c)										
Major cities	7.3	7.9	7.4	6.1	7.6	..	5.6	..	7.3	1 124 293
Inner regional	7.6	8.1	6.9	5.9	7.1	6.9	6.4	..	7.4	301 981
Outer regional	5.7	6.3	5.3	5.5	5.1	5.5	..	3.6	5.4	104 578

Table 12A.27 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Remote	3.2	5.8	3.6	2.6	4.0	3.4	..	1.8	3.0	9 668
Very remote	4.4	..	1.9	1.2	2.3	7.4	..	2.0	1.8	3 314
2011-12										
Public (c), (d)										
Major cities	1.4	na	1.6	1.8	1.9	..	2.1	..	na	na
Inner regional	2.2	na	2.1	2.0	2.1	1.7	np	..	na	na
Outer regional	2.6	na	2.2	2.8	2.8	1.4	..	2.3	na	na
Remote	3.3	na	2.1	2.8	2.7	1.5	..	2.8	na	na
Very remote	5.2	..	3.0	2.9	2.4	0.9	..	3.3	na	na
Private (c), (e)										
Major cities	0.1	0.2	0.2	0.2	np	..	np	..	0.2	25 188
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	4 112
Outer regional	–	–	0.1	0.1	np	np	..	..	0.1	1 104
Remote	0.1	0.2	–	0.1	np	np	..	..	–	122
Very remote	–	..	0.1	–	np	np	..	..	–	75
MBS and DVA (c)										
Major cities	7.3	8.1	7.7	5.7	7.7	..	5.6	..	7.4	1 166 357
Inner regional	7.6	8.0	6.8	5.5	7.1	6.6	6.3	..	7.3	287 388
Outer regional	5.8	6.1	5.3	4.5	5.1	5.8	..	2.8	5.2	101 572
Remote	3.4	5.3	3.3	2.3	3.9	4.0	..	1.8	2.9	8 947
Very remote	2.7	..	1.8	1.2	2.1	6.5	..	0.6	1.4	2 766

(a) Not all remoteness areas are represented in each State or Territory. Where a state/territory does not have a particular remoteness category a rate cannot be calculated. Excludes contacts for which demographic information was missing and/or not reported.

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

Table 12A.27 **Proportion of people receiving clinical mental health services by service type and remoteness area (a)**

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

(c) For 2007-08 and 2008-09, disaggregation by remoteness area is based on a person's usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate remoteness area varied across jurisdictions. For 2009-10 to 2011-12 data, disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. State/territory is the state/territory of the service provider.

(d) Caution needs to be taken when making inter-jurisdictional comparisons. SA submitted data that were not based on unique patient identifier or data matching approaches. Due to system-related issues impacting data quality, Tasmania was unable to provide data by remoteness area for 2007-08 and 2008-09. Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data.

(e) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons, but are included in the Australia figures.

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

Source : State and Territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management Service data; DoHA unpublished, MBS statistics; DVA unpublished data; ABS unpublished, Estimated Resident Population, 30 June (prior to relevant period).

Table 12A.28 **Proportion of people receiving clinical mental health services by service type and SEIFA (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
					Age standardised proportion (b)					no.
2007-08										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.8	1.5	1.9	2.0	2.9	2.0	np	1.5	1.9	76 635
Quintile 2	1.9	1.4	2.6	1.4	1.2	2.9	4.3	6.1	1.8	74 505
Quintile 3	1.5	1.2	2.0	2.1	1.0	1.3	3.7	3.8	1.6	67 420
Quintile 4	1.4	0.9	1.7	2.0	1.3	0.9	2.3	0.6	1.4	55 904
Quintile 5 (least disadvantaged)	1.2	0.7	1.2	1.4	2.0	..	1.5	2.5	1.2	48 530
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	0.1	2 556
Quintile 2	–	–	0.1	–	np	np	np	np	0.1	2 351
Quintile 3	0.1	–	0.1	0.1	np	np	np	np	0.1	3 572
Quintile 4	0.1	0.1	0.2	0.1	np	np	np	np	0.1	5 383
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.2	np	..	np	np	0.2	9 074
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	4.4	4.9	4.3	2.3	4.5	3.8	3.7	0.7	4.3	176 364
Quintile 2	5.3	5.2	4.1	3.9	4.8	3.9	4.2	2.0	4.9	200 248
Quintile 3	5.2	5.4	4.6	3.9	4.5	4.2	3.9	1.6	4.8	202 268
Quintile 4	5.3	5.5	4.9	3.9	5.0	6.1	4.0	1.7	5.0	206 586
Quintile 5 (least disadvantaged)	5.4	6.3	4.9	4.8	5.4	..	3.9	1.4	5.4	231 002
2008-09										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.9	1.5	1.7	2.2	2.7	np	np	1.6	1.8	72 356
Quintile 2	2.0	1.4	2.7	1.5	1.3	np	4.6	6.2	1.9	77 089
Quintile 3	1.5	1.2	2.3	2.1	1.3	np	3.8	4.0	1.7	71 113

Table 12A.28 **Proportion of people receiving clinical mental health services by service type and SEIFA (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Quintile 4	1.4	0.8	1.3	2.0	0.8	np	2.4	0.6	1.2	51 399
Quintile 5 (least disadvantaged)	1.2	0.7	1.0	1.4	3.5	..	1.6	2.4	1.2	50 798
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	–	2 036
Quintile 2	–	–	0.1	0.1	np	np	np	np	0.1	2 578
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	3 888
Quintile 4	0.1	0.2	0.2	0.1	np	np	np	np	0.1	6 212
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.2	np	..	np	np	0.2	9 553
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	5.3	5.8	5.4	2.7	5.6	4.6	4.6	0.9	5.2	218 084
Quintile 2	6.3	6.2	5.1	4.7	5.9	4.7	4.8	2.5	5.9	244 695
Quintile 3	6.1	6.5	5.7	4.8	5.7	4.9	4.8	2.2	5.8	247 895
Quintile 4	6.1	6.5	5.8	4.5	5.7	6.7	4.9	2.0	5.9	250 106
Quintile 5 (least disadvantaged)	6.3	7.2	5.6	5.5	6.3	..	4.6	1.8	6.2	270 901
2009-10										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.9	1.5	2.6	2.2	2.7	1.0	np	2.6	2.0	85 633
Quintile 2	1.9	1.4	1.8	1.5	2.1	4.2	4.8	2.4	1.8	75 384
Quintile 3	1.5	1.2	1.7	2.2	1.7	1.3	3.8	3.3	1.6	69 386
Quintile 4	1.4	0.8	1.4	2.1	1.2	1.0	2.5	1.6	1.3	56 689
Quintile 5 (least disadvantaged)	1.1	0.7	1.0	1.4	1.0	..	1.7	1.7	1.0	45 247
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	0.0	0.1	0.0	0.1	np	np	np	np	–	1 939
Quintile 2	0.1	0.1	0.1	0.1	np	np	np	np	0.1	2 864
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	4 121

Table 12A.28 **Proportion of people receiving clinical mental health services by service type and SEIFA (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Quintile 4	0.1	0.1	0.2	0.2	np	np	np	np	0.1	5 993
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.3	np	..	np	np	0.2	10 565
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	5.9	6.5	6.0	3.1	6.4	5.2	5.2	1.1	5.8	246 684
Quintile 2	6.8	6.9	5.7	5.1	6.6	5.1	5.3	3.0	6.5	274 627
Quintile 3	6.6	7.2	6.4	5.2	6.2	5.6	5.2	2.5	6.4	277 661
Quintile 4	6.5	7.1	6.4	4.9	6.2	7.5	5.3	2.3	6.4	278 258
Quintile 5 (least disadvantaged)	6.7	7.6	6.1	5.8	6.9	..	5.0	2.1	6.6	293 715
2010-11										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.9	1.5	2.9	3.5	2.7	2.0	np	2.9	2.2	93 565
Quintile 2	1.9	1.4	1.9	2.2	2.1	1.4	4.4	2.5	1.9	79 324
Quintile 3	1.6	1.2	1.7	1.9	1.7	1.2	3.7	3.0	1.6	69 526
Quintile 4	1.4	0.8	1.3	1.6	1.3	1.7	2.6	1.7	1.3	55 664
Quintile 5 (least disadvantaged)	1.1	0.7	1.0	1.4	1.0	..	1.7	1.8	1.0	45 973
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	–	2 179.0
Quintile 2	0.1	0.1	0.1	0.1	np	np	np	np	0.1	3 217.0
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	4 752.0
Quintile 4	0.1	0.1	0.2	0.2	np	np	np	np	0.1	6 743.0
Quintile 5 (least disadvantaged)	0.2	0.3	0.2	0.3	np	..	np	np	0.2	10 987.0
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	6.5	7.2	6.6	3.7	7.0	5.9	5.8	1.2	6.5	277 164
Quintile 2	7.6	7.6	6.5	5.5	7.3	5.6	5.9	3.4	7.2	309 010
Quintile 3	7.1	7.9	7.2	5.5	6.7	6.3	5.4	2.8	7.0	307 839

Table 12A.28 **Proportion of people receiving clinical mental health services by service type and SEIFA (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Quintile 4	7.2	7.7	7.2	5.3	6.9	8.0	5.7	2.4	7.0	312 702
Quintile 5 (least disadvantaged)	7.2	8.1	6.6	6.2	7.6	..	5.5	2.2	7.1	319 001
2011-12										
Public (c), (d), (g)										
Quintile 1 (most disadvantaged)	1.9	na	2.8	4.1	3.1	1.7	np	2.9	na	na
Quintile 2	1.9	na	2.0	2.4	2.1	1.3	3.5	2.9	na	na
Quintile 3	1.5	na	1.8	2.1	1.7	1.4	3.3	2.9	na	na
Quintile 4	1.5	na	1.4	1.7	1.5	1.3	2.9	2.6	na	na
Quintile 5 (least disadvantaged)	1.1	na	1.1	1.5	1.1	..	1.8	2.2	na	na
Private (c), (e)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	0.1	2 394
Quintile 2	na	na	na	na	na	na	na	na	0.1	3 524
Quintile 3	na	na	na	na	na	na	na	na	0.1	5 461
Quintile 4	na	na	na	na	na	na	na	na	0.2	7 354
Quintile 5 (least disadvantaged)	na	na	na	na	na	..	na	na	0.3	11 868
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	6.7	291 207
Quintile 2	na	na	na	na	na	na	na	na	7.4	322 586
Quintile 3	na	na	na	na	na	na	na	na	6.9	307 367
Quintile 4	na	na	na	na	na	na	na	na	7.2	324 458
Quintile 5 (least disadvantaged)	na	na	na	na	na	..	na	na	7.1	320 937

(a) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-economic Disadvantage, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each State or Territory. Excludes people for whom demographic information was missing and/or not reported.

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

Table 12A.28 **Proportion of people receiving clinical mental health services by service type and SEIFA (a)**

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

(c) For 2007-08 and 2008-09, disaggregation by SEIFA is based on a person's usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate SEIFA varied across jurisdictions. From 2009-10 onwards, disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider. Due to system-related issues impacting data quality, Tasmania was unable to provide data by SEIFA for 2008-09.

(d) SA submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Therefore caution needs to be taken when making inter-jurisdictional comparisons.

(e) Disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider.

(f) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons but are included in the Australia figures.

(g) For public sector community mental health services, Victorian data for 2011-12 are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data. Therefore caution needs to be taken when making inter-jurisdictional comparisons and comparisons over time.

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

Table 12A.29 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	Public (d)	*Private*	*MBS and DVA*
2007-08			
Decile 1	1.9	0.1	4.1
Decile 2	1.9	–	4.5
Decile 3	1.9	0.1	4.8
Decile 4	1.8	0.1	5.0
Decile 5	1.6	0.1	4.8
Decile 6	1.6	0.1	4.9
Decile 7	1.3	0.1	4.9
Decile 8	1.5	0.1	5.1
Decile 9	1.2	0.2	5.5
Decile 10	1.1	0.2	5.3
2008-09			
Decile 1	1.7	–	5.0
Decile 2	1.8	–	5.5
Decile 3	1.8	0.1	5.8
Decile 4	1.9	0.1	5.9
Decile 5	1.7	0.1	5.8
Decile 6	1.6	0.1	5.9
Decile 7	1.2	0.1	5.7
Decile 8	1.2	0.1	6.0
Decile 9	1.2	0.2	6.4
Decile 10	1.2	0.2	6.0
2009-10			
Decile 1	2.1	–	5.6
Decile 2	2.0	–	6.1

Table 12A.29 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	Public (d)	*Private*	*MBS and DVA*
Decile 3	1.8	0.1	6.4
Decile 4	1.7	0.1	6.5
Decile 5	1.6	0.1	6.3
Decile 6	1.6	0.1	6.4
Decile 7	1.4	0.1	6.2
Decile 8	1.2	0.1	6.5
Decile 9	1.1	0.2	6.8
Decile 10	1.0	0.2	6.5
2010-11			
Decile 1	2.2	–	6.3
Decile 2	2.2	0.1	6.7
Decile 3	1.8	0.1	7.2
Decile 4	1.9	0.1	7.2
Decile 5	1.7	0.1	6.9
Decile 6	1.4	0.1	7.0
Decile 7	1.3	0.1	6.9
Decile 8	1.2	0.2	7.1
Decile 9	1.1	0.2	7.3
Decile 10	1.0	0.3	6.9
2011-12			
Decile 1	na	–	6.6
Decile 2	na	0.1	6.8
Decile 3	na	0.1	7.3
Decile 4	na	0.1	7.5
Decile 5	na	0.1	6.8

Table 12A.29 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	Public (d)	*Private*	*MBS and DVA*
Decile 6	na	0.1	6.9
Decile 7	na	0.1	7.2
Decile 8	na	0.2	7.2
Decile 9	na	0.2	7.2
Decile 10	na	0.3	7.1

(a) SEIFA deciles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with decile 1 being the most disadvantaged and decile 10 being the least disadvantaged. SEIFA deciles represent approximately 10 per cent of the national population, but do not necessarily represent 10 per cent of the population in each State or Territory. Excludes people for whom information was missing and/or not reported.

(b) Disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider.

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

(d) Victoria did not submit data for 2011–12 due to significantly reduced collection rates arising from industrial action during the period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of community data.

na Not available. – Nil or rounded to zero.

Source: State and Territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management Service data; Health unpublished, MBS Statistics; DVA unpublished, data; ABS unpublished, Estimated Resident Population, 30 June 2011.

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08										
Public (b)										
Number	no.	108 755	57 197	75 541	37 566	27 793	9 499	6 801	4 721	327 873
Rate	%	1.6	1.1	1.9	1.8	1.8	2.0	1.9	2.2	1.6
Private (c)										
Number	no.	7 256	6 170	4 791	2 183	np	np	np	..	23 044
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS and DVA										
Number: Total MBS and DVA (d)	no.	349 679	287 210	189 005	87 638	75 116	20 527	14 163	3 981	1 027 330
Rate: Total MBS and DVA (d)	%	5.1	5.5	4.6	4.1	4.8	4.3	4.0	1.8	4.9
Rate: Psychiatrist (e)	%	1.4	1.5	1.3	1.1	1.6	1.0	1.1	0.4	1.4
Rate: Clinical psychologist (f)	%	0.6	0.6	0.4	1.0	0.7	0.9	0.6	0.1	0.6
Rate: GP (g)	%	3.7	4.0	3.2	3.0	3.2	3.2	2.8	1.4	3.5
Rate: Other allied health (h)	%	1.4	1.8	1.4	0.6	0.9	1.1	1.2	0.4	1.3
2008-09										
Public (b)										
Number	no.	113 759	57 860	72 989	39 547	30 423	9 362	7 348	5 008	336 296
Rate	%	1.7	1.1	1.7	1.8	2.0	1.9	2.1	2.2	1.6
Private (c)										
Number	no.	7 575	6 308	5 270	2 629	np	np	np	..	24 348
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS and DVA										
Number: Total MBS and DVA (d)	no.	419 027	346 064	235 222	107 077	91 841	24 501	17 119	5 104	1 247 142
Rate: Total MBS and DVA (d)	%	6.0	6.6	5.6	4.9	5.8	5.1	4.8	2.3	5.9
Rate: Psychiatrist (e)	%	1.4	1.5	1.3	1.1	1.6	1.0	1.1	0.4	1.4

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate: Clinical psychologist (f)	%	0.8	0.8	0.6	1.2	1.1	1.2	0.7	0.2	0.8
Rate: GP (g)	%	4.6	4.9	4.2	3.7	4.2	3.9	3.4	1.9	4.4
Rate: Other allied health (h)	%	1.7	2.3	1.8	0.8	1.1	1.3	1.5	0.5	1.7
2009-10										
Public (b)										
Number	no.	113 875	59 080	72 232	42 271	30 818	7 425	7 639	5 830	339 170
Rate	%	1.6	1.1	1.7	1.9	2.0	1.5	2.1	2.5	1.6
Private (c)										
Number	no.	8 145	6 544	5 392	3 047	np	np	np	..	25 536
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		460 708	385 085	265 357	119 533	103 225	27 741	18 871	6 146	1 387 297
Rate: Total MBS and DVA (d)		6.6	7.2	6.1	5.3	6.5	5.7	5.2	2.7	6.4
Rate: Psychiatrist (e)		1.4	1.5	1.3	1.1	1.7	1.1	1.1	0.4	1.4
Rate: Clinical psychologist (f)		1.0	1.0	0.7	1.4	1.3	1.3	0.9	0.3	1.0
Rate: GP (g)		5.0	5.4	4.7	4.0	4.7	4.3	3.7	2.2	4.8
Rate: Other allied health (h)		2.0	2.6	2.1	1.0	1.2	1.5	1.7	0.7	2.0
2010-11										
Public (b)										
Number	no.	115 090	59 696	77 036	44 493	31 434	8 923	8 076	5 840	350 588
Rate	%	1.6	1.1	1.8	2.0	2.0	1.8	2.2	2.4	1.6
Private (c)										
Number	no.	8 354	7 692	5 673	3 250	np	np	np	..	27 924
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		511 672	426 982	300 311	131 892	115 088	31 175	20 838	6 775	1 544 744

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate: Total MBS and DVA (d)		7.2	7.8	6.8	5.7	7.1	6.4	5.6	2.9	7.0
Rate: Psychiatrist (e)		1.4	1.5	1.3	1.1	1.6	1.1	1.2	0.4	1.4
Rate: Clinical psychologist (f)		1.1	1.1	0.9	1.4	1.7	1.4	1.2	0.3	1.1
Rate: GP (g)		5.6	6.1	5.4	4.4	5.4	5.0	4.2	2.4	5.5
Rate: Other allied health (h)		2.3	2.8	2.3	1.2	1.4	1.9	1.7	0.7	2.2
2011-12										
Public (b)										
Number	no.	116 194	na	81 228	46 907	33 791	7 841	8 385	6 580	300 926
Rate	%	1.6	na	1.8	2.0	2.1	1.6	2.2	2.7	1.8
Private (c)										
Number	no.	9 537	8 301	6 578	3 616	np	np	np	..	30 640
Rate	%	0.1	0.1	0.1	0.2	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		522 941	442 667	311 834	130 752	116 679	31 016	21 466	6 992	1 584 399
Rate: Total MBS and DVA (d)		7.3	8.0	7.0	5.5	7.2	6.3	5.7	3.0	7.1
Rate: Psychiatrist (e)		1.4	1.5	1.4	1.1	1.6	1.1	1.1	0.4	1.4
Rate: Clinical psychologist (f)		1.2	1.3	1.0	1.5	1.9	1.5	1.5	0.4	1.3
Rate: GP (g)		5.4	5.9	5.1	4.0	5.2	4.6	4.1	2.4	5.2
Rate: Other allied health (h)		2.3	2.9	2.4	1.2	1.5	2.0	1.6	0.7	2.3

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

(b) Caution needs to be taken when making inter-jurisdictional comparisons. South Australia submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of the 2011-12 data. Australian totals for 2011-12 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 should not be compared to previous years.

(c) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons but are included in the Australia totals.

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

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

(d) MBS and DVA services are those provided under any of the Medicare/DVA-funded service types described at (e) to (h). People seen by more than one provider type are counted only once in the total.

(e) Consultant psychiatrist services are MBS items 134, 136, 138, 140, 142, 289, 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344, 346, 348, 350, 352, 353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 14224 (as relevant across years).

(f) Clinical psychologist services are MBS items 80000, 80005, 80010, 80015, 80020 and and DVA items US01, US02, US03, US04, US05, US06, US07, US08, US50, US51, US99.

(g) GP services are MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727, 20104 (as relevant across years).

(h) Other allied health services are MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015 and DVA items CL20, CL25, CL30, US11, US12, US13, US14, US15, US16, US17, US18, US21, US22, US23, US24, US25, US26, US27, US31, US32, US33, US34, US35, US36, US37, US52, US53, US96, US97, US98 (as relevant across years).

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

Source : State and territory unpublished, community mental health care data; Private Mental Health Alliance unpublished; Centralised Data Management Service data; Department of Health unpublished, DVA unpublished; MBS Statistics; ABS unpublished, Estimated Residential Population, 30 June (prior to relevant period).

Table 12A.31 **Services used for mental health problems, Australia, 2007 (per cent) (a), (b)**

	With lifetime mental disorder		*No lifetime mental disorder* (e)	*Total*
	Symptoms in previous 12 months (c)	*No symptoms in previous 12 months* (d)		
GP	24.7 ± 2.4	6.2 ± 1.5	2.8 ± 0.9	8.1 ± 0.7
Psychiatrist	7.9 ± 2.7	1.4 ± 0.7	0.6 ± 0.3	2.3 ± 0.6
Psychologist	13.2 ± 2.1	1.8 ± 0.6	0.8 ± 0.3	3.5 ± 0.5
Other mental health professional	7.7 ± 1.6	1.5 ± 0.5	np	2.2 ± 0.4
Other health professional	6.6 ± 1.6	2.1 ± 1.0	1.0 ± 0.4	2.4 ± 0.5
Hospitalisation	2.6 ± 1.1	np	np	0.7 ± 0.3
Total who used health services	34.9 ± 3.1	9.2 ± 1.8	4.7 ± 1.1	11.9 ± 0.9
Total who did not use services for mental health	65.1 ± 3.1	90.8 ± 1.8	95.2 ± 1.1	88.1 ± 0.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(e) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.32 **Services used for mental health, by mental disorder status, 2007 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total who used services for mental health in previous 12 months (c)									
Any 12-month mental disorder (d)	32.5 ± 6.4	37.0 ± 7.1	34.4 ± 7.0	35.8 ± 10.5	35.2 ± 9.1	np	np	np	34.9 ± 3.1
Lifetime mental disorder, with no 12-month symptoms (e)	7.6 ± 2.0	11.5 ± 4.0	9.0 ± 3.3	7.4 ± 3.6	np	np	np	np	9.2 ± 1.8
No lifetime mental disorder (f)	np	4.6 ± 1.8	5.6 ± 1.8	4.8 ± 2.3	np	np	np	np	4.7 ± 1.1
Total	**10.9 ± 1.8**	**13.1 ± 2.2**	**12.1 ± 2.0**	**12.0 ± 2.5**	**11.0 ± 2.7**	**np**	**np**	**np**	**11.9 ± 0.9**
Total who did not use services for mental health in previous 12 months									
Any 12-month mental disorder (d)	67.5 ± 6.4	63.0 ± 7.1	65.6 ± 7.0	64.2 ± 10.5	64.8 ± 9.1	65.5 ± 23.2	np	np	65.1 ± 3.1
Lifetime mental disorder, with no 12-month symptoms (e)	92.4 ± 2.0	88.5 ± 4.0	91.0 ± 3.3	92.6 ± 3.6	90.3 ± 5.7	87.8 ± 13.3	np	np	90.8 ± 1.8
No lifetime mental disorder (f)	95.4 ± 2.3	95.4 ± 1.8	94.4 ± 1.8	95.2 ± 2.3	96.1 ± 2.8	95.2 ± 7.1	np	np	95.2 ± 1.1
Total	**89.1 ± 1.8**	**86.9 ± 2.2**	**87.9 ± 2.0**	**88.0 ± 2.5**	**88.6 ± 2.8**	**88.7 ± 6.9**	**81.6 ± 12.2**	**95.3 ± 6.2**	**88.1 ± 0.9**

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) Includes hospitalisations.

(d) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.33 **Young people who had contact with MBS-subsidised primary mental health care services, by age group**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11										
Number of contacts with MBS-subsidised primary mental health services (a), (b), (c), (d), (e), (f)										
Pre-school (0-<5 years)	no.	1 824	1 627	825	415	496	65	46	17	5 320
Primary school (5-<12 years)	no.	19 915	17 630	11 791	4 700	4 745	1 092	734	199	60 850
Secondary school (12-<18 years)	no.	27 156	23 230	16 698	6 884	6 218	1 837	1 275	331	83 670
Youth/young adult (18-<25 years)	no.	49 329	41 811	29 956	13 691	11 617	3 745	2 489	726	153 416
All children and young people aged <25 years	**no.**	**98 224**	**84 298**	**59 269**	**25 690**	**23 076**	**6 739**	**4 545**	**1 274**	**303 256**
Number of people (g)										
Pre-school (0-<5 years)	no.	473 653	350 919	303 288	154 374	97 349	32 145	23 886	18 489	1 454 240
Primary school (5-<12 years)	no.	622 167	459 508	406 343	203 932	133 261	44 144	29 797	24 270	1 923 685
Secondary school (12-<18 years)	no.	542 161	407 788	356 207	180 515	122 233	40 625	26 481	19 513	1 695 748
Youth/young adult (18-<25 years)	no.	686 620	558 154	441 439	237 447	158 157	45 750	44 598	26 121	2 198 653
All children and young people aged <25 years	**no.**	**2 324 601**	**1 776 369**	**1 507 277**	**776 268**	**511 000**	**162 664**	**124 762**	**88 393**	**7 272 326**
Proportion of population who had contact with MBS-subsidised primary mental health services										
Pre-school (0-<5 years)	%	0.4	0.5	0.3	0.3	0.5	0.2	0.2	0.1	0.4
Primary school (5-<12 years)	%	3.2	3.8	2.9	2.3	3.6	2.5	2.5	0.8	3.2
Secondary school (12-<18 years)	%	5.0	5.7	4.7	3.8	5.1	4.5	4.8	1.7	4.9
Youth/young adult (18-<25 years)	%	7.2	7.5	6.8	5.8	7.3	8.2	5.6	2.8	7.0
All children and young people aged <25 years	**%**	**4.2**	**4.7**	**3.9**	**3.3**	**4.5**	**4.1**	**3.6**	**1.4**	**4.2**
2011-12										
Number of contacts with MBS-subsidised primary mental health services (a), (b), (c), (d), (e), (f)										
Pre-school (0-<5 years)	no.	2 038	1 792	914	462	484	81	63	20	5 858
Primary school (5-<12 years)	no.	22 528	20 999	13 806	5 219	5 232	1 257	801	257	70 153
Secondary school (12-<18 years)	no.	30 360	26 529	18 755	7 650	6 830	2 114	1 354	394	94 039
Youth/young adult (18-<25 years)	no.	53 711	45 944	33 039	14 392	12 588	3 811	2 734	851	167 143

Table 12A.33 **Young people who had contact with MBS-subsidised primary mental health care services, by age group**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All children and young people aged <25 years	**no.**	**108 638**	**95 264**	**66 514**	**27 724**	**25 134**	**7 263**	**4 953**	**1 523**	**337 193**
Number of people (g)										
Pre-school (0-<5 years)	no.	473 835	354 162	307 175	158 723	98 116	31 867	24 406	18 474	1 466 902
Primary school (5-<12 years)	no.	622 766	462 730	411 074	207 812	132 686	43 470	30 182	24 261	1 935 222
Secondary school (12-<18 years)	no.	541 296	407 143	358 149	182 726	121 664	40 415	26 165	19 397	1 697 163
Youth/young adult (18-<25 years)	no.	686 756	557 458	446 308	241 859	157 848	45 271	44 566	25 660	2 206 069
All children and young people aged <25 years	**no.**	**2 324 653**	**1 781 493**	**1 522 706**	**791 120**	**510 314**	**161 023**	**125 319**	**87 792**	**7 305 356**
Proportion of population who had contact with MBS-subsidised primary mental health services										
Pre-school (0-<5 years)	%	0.4	0.5	0.3	0.3	0.5	0.3	0.3	0.1	0.4
Primary school (5-<12 years)	%	3.6	4.5	3.4	2.5	3.9	2.9	2.7	1.1	3.6
Secondary school (12-<18 years)	%	5.6	6.5	5.2	4.2	5.6	5.2	5.2	2.0	5.5
Youth/young adult (18-<25 years)	%	7.8	8.2	7.4	6.0	8.0	8.4	6.1	3.3	7.6
All children and young people aged <25 years	**%**	**4.7**	**5.3**	**4.4**	**3.5**	**4.9**	**4.5**	**4.0**	**1.7**	**4.6**
2012-13										
Number of contacts with MBS-subsidised primary mental health services (a), (b), (c), (d), (e), (f)										
Pre-school (0-<5 years)	no.	2 374	2 139	1 203	468	557	66	43	17	6 877
Primary school (5-<12 years)	no.	25 922	24 797	16 465	6 065	5 852	1 464	911	263	81 837
Secondary school (12-<18 years)	no.	35 434	31 391	22 701	9 662	7 909	2 486	1 760	396	111 839
Youth/young adult (18-<25 years)	no.	60 738	51 252	38 012	15 759	13 677	4 300	3 193	954	187 991
All children and young people aged <25 years	**no.**	**124 469**	**109 579**	**78 381**	**31 954**	**27 995**	**8 316**	**5 907**	**1 630**	**388 544**
Number of people (g)										
Pre-school (0-<5 years)	no.	476 842	364 084	312 021	165 094	99 518	31 469	25 615	18 749	1 493 548
Primary school (5-<12 years)	no.	637 143	476 560	424 047	217 047	135 270	43 817	31 283	24 597	1 990 004
Secondary school (12-<18 years)	no.	542 580	407 250	361 375	185 460	121 123	39 945	26 219	19 521	1 703 688
Youth/young adult (18-<25 years)	no.	692 623	559 619	455 615	248 338	157 643	45 028	44 104	25 825	2 229 099

Table 12A.33 **Young people who had contact with MBS-subsidised primary mental health care services, by age group**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All children and young people aged <25 years	**no.**	**2 349 188**	**1 807 513**	**1 553 058**	**815 939**	**513 554**	**160 259**	**127 221**	**88 692**	**7 416 339**
Proportion of population who had contact with MBS-subsidised primary mental health services										
Pre-school (0-<5 years)	%	0.5	0.6	0.4	0.3	0.6	0.2	0.2	0.1	0.5
Primary school (5-<12 years)	%	4.1	5.2	3.9	2.8	4.3	3.3	2.9	1.1	4.1
Secondary school (12-<18 years)	%	6.5	7.7	6.3	5.2	6.5	6.2	6.7	2.0	6.6
Youth/young adult (18-<25 years)	%	8.8	9.2	8.3	6.3	8.7	9.5	7.2	3.7	8.4
All children and young people aged <25 years	**%**	**5.3**	**6.1**	**5.0**	**3.9**	**5.5**	**5.2**	**4.6**	**1.8**	**5.2**

(a) Totals do not equal the sum of all MBS-subsidised mental health service providers as data excludes psychiatrists

(b) Data are based on the date the claim was processed.

(c) Age of the patient is based on age at 30 June of the reference period.

(d) A person is counted if any mental health item has been used in the reference period, excluding psychiatrists.

(e) A patient is allocated to a state/territory based on their location as at the last service in the reference period.

(f) The allocation to the state or territory uses a concordance and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.

(g) The population data represent the mid-point of the relevant financial year. For 2012-13 data, the mid-point is December 2012. Estimated Resident Populations (ERPs) used to derive the 2010-11 rates (December 2010) are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details

Source : Department of Health unpublished; ABS unpublished, *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 12A.34 **Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a), (b)**

		NSW (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Expenditure on services assessed at level 1										
2006	$'000	641 641	574 931	380 642	129 288	153 479	32 236	36 950	22 820	1 971 986
2007	$'000	556 183	586 248	410 814	95 750	190 360	33 997	46 838	25 537	1 945 727
2008	$'000	770 511	635 893	526 682	134 530	104 592	42 635	48 458	28 062	2 291 362
2009	$'000	880 733	681 385	586 763	187 961	100 433	50 559	54 558	30 202	2 572 592
2010	$'000	851 044	714 515	611 262	178 483	270 545	16 252	54 835	32 326	2 729 262
2011	$'000	920 824	762 949	699 580	212 630	276 680	45 469	57 536	35 230	3 010 898
2012	$'000	904 272	525 579	759 987	299 748	124 058	–	62 122	39 291	2 715 056
Expenditure on services assessed at level 2										
2006	$'000	–	–	602	12 993	2 013	11 126	–	–	26 734
2007	$'000	18 413	–	236	168 105	1 409	3 363	–	–	191 526
2008	$'000	33 962	190	1 770	170 831	1 594	–	–	–	208 347
2009	$'000	44 946	70	1 234	171 349	1 175	6 171	–	–	224 946
2010	$'000	217 392	4 117	1 671	174 807	–	–	–	–	397 987
2011	$'000	236 547	86	–	–	–	49 232	–	–	285 866
2012	$'000	60 110	272	1 330	53 701	157 099	–	–	–	272 511
Expenditure on services assessed at level 3										
2006	$'000	94 363	18 628	14 377	147 659	42 422	14 212	–	–	331 661
2007	$'000	220 311	13 383	51 891	45 173	31 781	8 970	–	–	371 509
2008	$'000	63 334	148	16 771	38 271	135 413	18 753	–	–	272 689
2009	$'000	71 549	21 630	1 772	16 283	164 555	21 880	–	–	297 669
2010	$'000	486	23 010	52 296	38 423	2 116	74 572	–	–	190 903
2011	$'000	490	16 128	3 692	124 290	10 518	–	–	–	155 119
2012	$'000	174 141	15 709	–	84 463	–	88 003	–	–	362 317
Expenditure on services assessed at level 4										
2006	$'000	46 246	1 073	4 326	–	1 418	2 328	–	–	55 391
2007	$'000	61 105	1 107	3 694	–	2 180	24 165	–	–	92 252
2008	$'000	37 887	4 911	462	2 220	3 507	16 235	–	–	65 223
2009	$'000	3 107	4 143	655	6 304	2 220	2 653	–	–	19 082
2010	$'000	12 602	8 940	815	7 927	6 611	–	–	–	36 895
2011	$'000	12 111	15 616	1 971	98 024	1 124	–	–	–	128 846
2012	$'000	101 544	287 982	926	38 667	16 194	–	–	–	445 313
Expenditure on specialised public mental health services										
2006	$'000	782 250	594 633	399 947	289 939	199 332	59 901	36 950	22 820	2 385 771
2007	$'000	856 012	600 739	466 636	309 027	225 730	70 494	46 838	25 537	2 601 014
2008	$'000	905 693	641 143	545 686	345 852	245 106	77 623	48 458	28 062	2 837 621
2009	$'000	1 000 336	707 227	590 424	381 897	268 383	81 263	54 558	30 202	3 114 289
2010	$'000	1 081 524	750 582	666 043	399 640	279 273	90 824	54 835	32 326	3 355 046
2011	$'000	1 169 972	794 780	705 243	434 944	288 323	94 701	57 536	35 230	3 580 728
2012	$'000	1 240 067	829 543	762 243	476 579	297 351	88 003	62 122	39 291	3 795 198
Per cent of expenditure on services assessed at level 1										
2006	%	82.0	96.7	95.2	44.6	77.0	53.8	100.0	100.0	82.7

Table 12A.34 **Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a), (b)**

		NSW (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007	%	65.0	97.6	88.0	31.0	84.3	48.2	100.0	100.0	74.8
2008	%	85.1	99.2	96.5	38.9	42.7	54.9	100.0	100.0	80.7
2009	%	88.0	96.3	99.4	49.2	37.4	62.2	100.0	100.0	82.6
2010	%	78.7	95.2	91.8	44.7	96.9	17.9	100.0	100.0	81.3
2011	%	78.7	96.0	99.2	48.9	96.0	48.0	100.0	100.0	84.1
2012	%	72.9	63.4	99.7	62.9	41.7	–	100.0	100.0	71.5
Per cent of expenditure on services assessed at level 2										
2006	%	–	–	0.2	4.5	1.0	18.6	–	–	1.1
2007	%	2.2	–	0.1	54.4	0.6	4.8	–	–	7.4
2008	%	3.7	–	0.3	49.4	0.7	–	–	–	7.3
2009	%	4.5	–	0.2	44.9	0.4	7.6	–	–	7.2
2010	%	20.1	0.5	0.3	43.7	–	–	–	–	11.9
2011	%	20.2	–	–	–	–	52.0	–	–	8.0
2012	%	4.8	–	0.2	11.3	52.8	–	–	–	7.2
Per cent of expenditure on services assessed at level 3										
2006	%	12.1	3.1	3.6	50.9	21.3	23.7	–	–	13.9
2007	%	25.7	2.2	11.1	14.6	14.1	12.7	–	–	14.3
2008	%	7.0	–	3.1	11.1	55.2	24.2	–	–	9.6
2009	%	7.2	3.1	0.3	4.3	61.3	26.9	–	–	9.6
2010	%	–	3.1	7.9	9.6	0.8	82.1	–	–	5.7
2011	%	–	2.0	0.5	28.6	3.6	–	–	–	4.3
2012	%	14.0	1.9	–	17.7	–	100.0	–	–	9.5
Per cent of expenditure on services assessed at level 4										
2006	%	5.9	0.2	1.1	–	0.7	3.9	–	–	2.3
2007	%	7.1	0.2	0.8	–	1.0	34.3	–	–	3.5
2008	%	4.2	0.8	0.1	0.6	1.4	20.9	–	–	2.3
2009	%	0.3	0.6	0.1	1.7	0.8	3.3	–	–	0.6
2010	%	1.2	1.2	0.1	2.0	2.4	–	–	–	1.1
2011	%	1.0	2.0	0.3	22.5	0.4	–	–	–	3.6
2012	%	8.2	34.7	0.1	8.1	5.4	–	–	–	11.7

(a) Data for all years (other than 2012) have been revised as this indicator is reported for the first time in this Report weighted by expenditure.

(b) There is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the expenditure on the organisation's units is 'counted' at that assessment level. In other jurisdictions, assessment levels are assigned at the service unit and this may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.

(c) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

– Nil or rounded to zero.

Source : AIHW unpublished, derived from the MHE NMDS.

Table 12A.35 **Recurrent expenditure on community-based services as a proportion of total spending on mental health services (per cent) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06	43.5	63.5	43.3	51.3	45.1	62.4	79.2	60.4	51.0
2006-07	43.7	63.3	48.1	52.0	45.6	59.3	73.3	65.7	51.5
2007-08	46.1	62.6	49.1	53.1	47.9	57.8	71.5	64.0	52.4
2008-09	44.5	62.6	51.8	53.6	49.9	57.7	74.2	62.6	52.7
2009-10	44.6	62.8	54.0	54.4	52.4	54.8	74.7	65.4	53.4
2010-11	44.1	63.2	55.5	53.4	56.5	56.5	73.2	64.3	53.8
2011-12	43.5	64.2	56.3	53.4	58.8	56.8	74.4	63.9	54.2

(a) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure estimates.

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) Recurrent expenditure exclude indirect and aged care residential expenditure.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(e) Queensland does not fund community-based residential services, but funds extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.36 Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)

	Unit	NSW	Vic (c)	Qld	WA	SA	Tas (c)	ACT	NT	Aust (c)
2007-08										
Group A: People discharged from hospital (d)										
	no.	5 989	3 740	4 419	2 564	2 657	324	40	92	19 825
	%	29.7	28.0	42.0	43.0	50.4	19.7	4.6	16.1	34.0
Group B: People discharged from community care (e)										
	no.	2 126	3 938	6 065	1 196	1 457	366	–	51	15 199
	%	12.0	33.9	39.5	21.5	30.4	22.3	–	6.2	25.7
Group C: People in ongoing community care (f)										
	no.	5 073	5 307	5 917	2 760	3 097	705	159	305	23 323
	%	16.5	27.4	31.5	26.1	39.7	19.3	5.6	23.3	24.8
2008-09										
Group A: People discharged from hospital (d)										
	no.	5 605	6 350	2 205	2 944	2 360	321	46	104	19 935
	%	27.8	47.8	20.6	47.9	46.3	20.2	4.9	18.2	34.0
Group B: People discharged from community care (e)										
	no.	1 985	6 804	3 577	1 162	1 420	305	–	25	15 278
	%	10.3	62.3	19.3	18.8	27.2	21.2	–	3.3	23.7
Group C: People in ongoing community care (f)										
	no.	5 108	6 472	5 759	3 558	3 340	712	175	383	25 507
	%	16.1	34.0	34.0	30.9	37.7	21.3	5.6	25.0	27.1
2009-10										
Group A: People discharged from hospital (d)										
	no.	6 146	7 845	1 736	2 945	2 490	316	67	146	21 691
	%	30.2	55.7	16.2	44.4	46.9	np	7.6	26.3	36.5
Group B: People discharged from community care (e)										
	no.	2 024	8 618	2 706	1 329	1 510	291	–	48	16 526
	%	9.9	77.3	17.7	20.6	28.9	24.0	–	6.0	27.0
Group C: People in ongoing community care (f)										
	no.	5 943	7 895	6 544	4 064	3 201	685	335	396	29 063
	%	17.5	44.1	32.0	35.0	36.3	30.1	10.0	23.8	29.4
2010-11										
Group A: People discharged from hospital (d)										
	no.	5 937	8 249	2 515	3 236	2 288	443	87	200	22 955
	%	30.1	57.1	22.6	45.3	39.3	30.8	8.9	34.6	37.5
Group B: People discharged from community care (e)										
	no.	2 309	10 243	3 537	1 351	1 473	583	–	50	19 546
	%	11.0	80.4	21.7	18.4	25.2	39.2	–	6.6	28.6
Group C: People in ongoing community care (f)										
	no.	6 020	8 165	7 146	4 453	3 150	703	466	354	30 457
	%	18.1	45.7	35.1	36.3	36.3	31.8	13.8	20.3	30.8

Table 12A.36 Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)

	Unit	NSW	Vic (c)	Qld	WA	SA	Tas (c)	ACT	NT	Aust (c)
2011-12 (c)										
Group A: People discharged from hospital (d)										
	no.	6 095	na	3 377	3 614	2 307	774	33	223	16 423
	%	29.4	na	28.8	49.5	42.5	52.8	3.3	36.2	34.0
Group B: People discharged from community care (e)										
	no.	2 501	na	3 227	1 332	1 438	294	–	48	8 840
	%	12.7	na	18.1	16.7	22.6	17.7	–	5.1	15.9
Group C: People in ongoing community care (f)										
	no.	7 498	na	7 133	3 651	3 200	541	276	402	22 701
	%	21.1	na	34.1	29.1	34.8	23.3	7.8	19.7	26.5

(a) These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a 'matching pair' — that is, a beginning and end rating are needed to enable an outcome score to be determined.

(b) Estimates of the number of episodes with complete outcome data for state and territory mental health services for all years are based on a revised analytic approach that compares the number of episodes with 'matched pairs' outcomes data to data submitted for the various mental health National Minimum Data Sets. This approach provides more robust estimates than published in previous years.

(c) Data are not available for Victoria for 2011-12. All totals for 2011-12 exclude Victoria. Industrial action in Tasmania has limited the available data quality and quantity of the 2011-12 data.

(d) Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.

(e) Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.

(f) Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.

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

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

Table 12A.37 **Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days) (a), (b)**

	NSW (c)	*Vic* (d)	*Qld*	*WA* (e)	*SA* (f), (g)	*Tas* (h)	*ACT* (i), (j), (k)	*NT* (l)	*Aust*
2008-09	11.0	18.8	18.2	15.3	na	15.4	13.3	na	15.5
2009-10	11.5	19.4	15.0	11.6	7.6	11.5	1.7	22.9	13.5
2010-11	9.4	15.1	17.2	8.3	7.7	14.7	0.7	20.6	11.8
2011-12	9.2	13.3	13.3	4.7	10.1	11.9	1.3	25.7	10.4
2012-13	8.5	10.9	12.7	6.0	9.1	19.7	0.9	15.8	9.6

(a) Data are from a number of ad hoc seclusion data collections for specialised mental health public acute hospital services conducted by the Safety and Quality Partnership Standing Committee (SQPSC), of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC), in partnership with the relevant state and territory authorities for presentation at benchmarking forums. State and territory governments have agreed to the report these data because of their importance to the consumers, carers, policy makers, stakeholders and the general public (AIHW 2013).

(b) Variation in jurisdictional legislation may result in differences in the definition of a seclusion event. Data reported by jurisdictions may therefore vary and comparisons should therefore be made with caution.

(c) NSW does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors. Seclusion rates are a Key Performance Indicator (KPI) in regular performance reporting to NSW Local Health Districts.

(d) For Victoria, both the National Beacon Projects and the Creating Safety Project supported Victorian services to review their use of seclusion and employ different strategies to support reduction, with targets set in the Statement of Priorities to support health services reduce seclusion events. In Victoria, variation between health services will improve over time, with a new Mental Health Act being developed and a reduction in the use of restrictive practices.

(e) For WA, it does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases.

(f) For SA, data reporting improvements over the past few years will affect SA data. Importantly, the number of bed days is an estimate which affects the rate of seclusion reported for South Australia and fluctuations in bed numbers related to new infrastructure projects. During 2010-11, a substantial number of seclusion events in one particular hospital were for a single patient and over half of those were patient-requested events. This may have impacted on the overall seclusion rate reported for the state for 2010-11.

(g) For 2008-09, SA was unable to supply seclusion data.

(h) The increase in the state-wide Tasmanian seclusion rate for 2012-13 data is due to a small number of clients having an above average number of seclusion events.

(i) For the ACT, when interpreting these data, the relative small size of the Australian Capital Territory should be noted, with a total of between 60 and 65 acute inpatient beds reported between 2008-09 and 2011-12.

(j) ACT activities initiated as part of the Beacon Site project included the implementation of a clinical review committee inclusive of clinical staff, consumers and carer representation to review episodes of seclusion for systemic issues on a case-by-case basis. This has led to a number of reforms over several years that have had a direct impact on the use of seclusion and its reduction to the low levels now reported.

(k) In the ACT, work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.

(l) The NT, was unable to supply seclusion data for 2008-09.

Table 12A.37 **Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days) (a), (b)**

	NSW (c)	*Vic* (d)	*Qld*	*WA* (e)	*SA* (f), (g)	*Tas* (h)	*ACT* (i), (j), (k)	*NT* (l)	*Aust*

na Not available.

Source: AIHW 2013, *Mental Health Services in Australia* Online, mhsa.aihw.gov.au/home/ (accessed 16 September and 28 November 2013).

Table 12A.38 **Consumer and carer participation (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT* (g)	*Aust*
Number of consumer and carer consultants (h)									
Number of paid consumer workers (FTE)									
2005-06	27.3	19.6	9.8	0.5	2.8	–	1.3	–	61.3
2006-07	24.8	19.0	10.3	0.8	2.1	–	–	–	57.0
2007-08	27.9	20.0	9.7	1.2	4.7	–	–	–	63.5
2008-09	23.5	17.1	13.6	3.6	6.3	0.5	–	–	64.6
2009-10	21.5	17.7	14.1	5.1	5.7	0.5	–	–	64.6
2010-11	20.5	17.9	17.8	3.3	8.4	0.5	–	–	68.5
2011-12	23.9	19.1	19.5	2.0	8.2	1.5	–	–	74.2
Number of paid carer workers (FTE)									
2005-06	2.7	11.7	0.4	–	–	–	–	–	14.8
2006-07	8.6	13.6	0.9	–	–	–	–	–	23.1
2007-08	7.0	15.5	1.5	0.8	1.8	–	–	–	26.6
2008-09	10.3	14.3	2.7	0.5	2.4	0.5	–	–	30.6
2009-10	13.7	15.8	4.8	1.0	1.5	0.5	–	–	37.3
2010-11	13.7	17.9	5.3	1.0	5.0	0.5	–	–	43.4
2011-12	15.9	18.5	6.4	0.2	4.2	0.6	–	–	45.8
Number of paid direct care, consumer and carer worker positions (FTE)									
2005-06	6 494.5	5 270.0	3 633.8	2 332.3	1 691.3	607.7	331.3	151.9	20 512.8
2006-07	6 732.0	5 338.0	3 875.8	2 427.1	1 800.9	656.2	321.8	158.5	21 310.3
2007-08	6 777.3	5 440.8	4 233.4	2 537.7	1 963.3	639.7	314.7	167.5	22 074.4
2008-09	7 025.6	5 634.4	4 405.7	2 670.5	1 977.3	652.6	313.8	193.3	22 873.2
2009-10	7 357.2	5 703.9	4 361.7	2 724.8	2 025.3	682.5	334.5	196.3	23 386.1
2010-11	7 610.2	5 912.7	4 694.2	2 856.0	2 121.6	687.3	338.4	205.3	24 425.6
2011-12	7 903.9	6 049.5	4 991.9	3 017.4	2 037.6	646.8	345.1	216.1	25 208.1

Table 12A.38 **Consumer and carer participation (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT* (g)	*Aust*
Paid consumer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE) (g)									
2005-06	4.2	3.7	2.7	0.2	1.7	–	3.9	–	3.0
2006-07	3.7	3.6	2.7	0.3	1.2	–	–	–	2.7
2007-08	4.1	3.7	2.3	0.5	2.4	–	–	–	2.9
2008-09	3.3	3.0	3.1	1.4	3.2	0.8	–	–	2.8
2009-10	2.9	3.1	3.2	1.9	2.8	0.7	–	–	2.8
2010-11	2.7	3.0	3.8	1.2	4.0	0.7	–	–	2.8
2011-12	3.0	3.2	3.9	0.7	4.0	2.3	–	–	2.9
Paid carer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE) (g)									
2005-06	0.4	2.2	0.1	–	–	–	–	–	0.7
2006-07	1.3	2.5	0.2	–	–	–	–	–	1.1
2007-08	1.0	2.9	0.4	0.3	0.9	–	–	–	1.2
2008-09	1.5	2.5	0.6	0.2	1.2	0.8	–	–	1.3
2009-10	1.9	2.8	1.1	0.4	0.8	0.7	–	–	1.6
2010-11	1.8	3.0	1.1	0.4	2.4	0.7	–	–	1.8
2011-12	2.0	3.1	1.3	0.1	2.1	0.9	–	–	1.8

(a) Non-government organisations are included only where they provide staffed residential services.

(b) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of relevant items.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

Table 12A.38 **Consumer and carer participation (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT* (g)	*Aust*

(f) WA has advised that this information does not represent the full range of consumer and carer participation. Genuine engagement with consumers and carers is one of the key principles of the Mental Health Commission's Strategic Policy document Mental Health 2020. The Commission has allocated funding to establish and support Consumers of Mental Health WA Inc., a peak body that provides systemic advocacy and is run for and by consumers. Other examples include provision of funding to develop the capacity of non government organisations to employ people with a lived experience of mental illness and awarding scholarships to people with a lived experience to complete approved university and polytechnic studies in mental health. Several key consumer and carer advisory groups are supported and provided with financial assistance and collectively, these groups provide advice and representations on consumer and carer issues. The Commission funds Carers Association of WA for the provision of systemic advocacy services and the Mental Health Carers ARAFMI (WA) for a range of services including individual advocacy.

(g) Consumer and carer workers are not employed in the ACT (except in 2005-06) and the NT.

(h) Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 with data from 2010-11 should not be made.

– Nil or rounded to zero.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)
2005-06										
Overnight separations from acute psychiatric inpatient services	no.	24 891	14 957	14 326	6 275	5 352	2 617	1 136	1 092	70 646
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	10 695	8 938	6 488	2 715	1 611	na	769	370	31 586
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	43.0	59.8	45.3	43.3	30.1	na	67.7	33.9	44.7
2006-07										
Overnight separations from acute psychiatric inpatient services	no.	26 656	15 602	13 534	6 051	5 430	2 381	1 100	997	71 751
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 539	9 303	6 833	2 772	1 532	na	759	447	33 185
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	43.3	59.6	50.5	45.8	28.2	na	69.0	44.8	46.3
2007-08										
Overnight separations from acute psychiatric inpatient services	no.	27 103	16 400	13 600	5 902	5 590	2 116	1 148	946	72 805
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	10 856	9 803	7 094	2 789	1 941	433	827	429	34 172

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	40.1	59.8	52.2	47.3	34.7	20.5	72.0	45.3	46.9
2008-09										
Overnight separations from acute psychiatric inpatient services	no.	27 035	16 429	14 147	6 318	5 435	2 121	1 233	894	73 612
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 078	10 132	6 228	3 064	2 222	461	901	414	34 500
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	41.0	61.7	44.0	48.5	40.9	21.7	73.1	46.3	46.9
2009-10										
Overnight separations from acute psychiatric inpatient services	no.	26 403	16 552	14 061	6 503	5 509	2 011	1 184	837	73 060
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 864	10 591	6 417	3 248	2 301	584	873	365	36 243
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	44.9	64.0	45.6	49.9	41.8	29.0	73.7	43.6	49.6
2010-11										
Overnight separations from acute psychiatric inpatient services	no.	26 932	17 156	14 634	7 584	5 825	1 747	1 185	855	75 918

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	12 811	11 730	7 696	3 705	2 662	765	932	400	40 701
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	47.6	68.4	52.6	48.9	45.7	43.8	78.6	46.8	53.6
2011-12										
Overnight separations from acute psychiatric inpatient services	no.	27 432	na	15 324	7 884	5 997	1 936	1 306	898	60 777
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	14 363	na	9 872	3 997	3 031	531	1 015	396	33 205
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	52.4	na	64.4	50.7	50.5	27.4	77.7	44.1	54.6

(a) Data are based on all ‘in scope’ separations from state and territory psychiatric acute inpatient units, where ‘in scope’ is defined as those separations for which it is meaningful to examine community follow-up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge – type change; left against medical advice/discharge at own risk and death.

(b) Community mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated. These may be face-to-face or ‘indirect’ (for example, by telephone), but not contacts delivered ‘on behalf of the client’ in which they did not participate. (The exception is the NT, where data includes all contacts — NT has advised that the impact on the indicator is marginal.) Contacts made on the day of discharge are also excluded.

(c) States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers. Three jurisdictions — WA, SA and Tasmania — indicated that the data submitted were not based on unique patient identifier (see also relevant notes below). This factor can contribute to an appearance of lower follow-up rates for these jurisdictions.

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)

(d) For NSW, the indicator is dependent on Statewide Unique Patient Identifier (SUPI) coverage both in the inpatient and community data for the calculation of post-discharge community contact rate. The NSW implementation of the SUPI for mental health care is in a robust state with coverage of above 99.9 per cent in all LHDs in both community and inpatient (except one LHD with 99 per cent coverage) data.

(e) Victorian data have been revised, for all years from 2005-06 to 2010-11 due to a number of in-scope separations from Aged and Specialist acute units previously being excluded from the calculations. For public sector community mental health services, Victorian data is unavailable due to service level collection gaps resulting from protected industrial action during this period. Due to data supply issues, Australian totals for 2011-12 should be interpreted with caution.

(f) For Qld, a linkage program is utilised to link between admitted and community activity and patients.

(g) For WA, the data source for admissions was changed to a more robust and reliable source. All years of data have been revised. The denominator for acute in-scope separations excludes publically funded patients in private hospitals. Figures reported in previous reports are not comparable. The source of acute admissions is now using separations data from the Inpatient Data Collection. The source for Community Contacts remains the same as previous reports, however the methodology in linking acute separations and community contacts has changed.

(h) For WA, unlike previous reports, mental health community contacts and acute separations are now sourced from two different data collection systems. Each system has different unique patient identifiers and requires the use of linkages to allow unique tracking of consumers across all public mental health services in WA. The timing of making the linkages and delays in the time it takes to link records could result in not making a match between the two data sources, when one should be possible. This could result to an under-estimate in the proportion of post-discharge contacts.

(i) For SA, whilst the a state-wide unique identifier does not exist, the data are reliable for the majority of services in SA, being metropolitan-based services. However some under-counting occurs where discharge from ward to community is across catchment/database boundaries.

(j) Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12.

(k) For the NT, data filters for mode of separation were reviewed for the whole of the data series and corrected per specification. This resulted in a small reduction in the denominator values. In addition, the time-series data have been reviewed and revised as a result of an audit of actual records indicating significant undercounting in the reported data. A technical error in the reporting system settings limiting the number of rows provided was found and corrected.

na Not available.

Source : State and territory unpublished, admitted patient and community mental health care data.

Table 12A.40 **Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status, remoteness, 2011-12 (a), (b)**

	Unit	*NSW*	*Vic* (c)	*Qld*	*WA*	*SA* (d)	*Tas* (e)	*ACT*	*NT*	*Aust*
Indigenous status										
Indigenous	%	45.9	na	61.0	39.9	45.2	22.8	87.9	34.7	na
Non-Indigenous	%	53.0	na	65.0	51.8	52.0	27.7	78.2	55.5	na
Remoteness										
Major cities	%	52.9	na	62.8	52.6	52.9	26.5	79.5	70.0	na
Inner regional	%	54.0	na	69.7	50.8	41.2	24.3	51.9	50.0	na
Outer regional	%	51.7	na	67.1	43.9	41.1	37.2	100.0	58.1	na
Remote	%	40.0	na	65.7	48.7	34.4	24.9	100.0	45.8	na
Very remote	%	41.7	na	62.2	26.3	30.5	–	..	26.3	na

(a) The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. Excludes people for whom demographic information was missing or not reported.

(b) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. State/territory is the state/territory of the service provider. Excludes people for whom demographic information was missing or not reported.

(c) For public sector community mental health services, Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period.

(d) South Australia submitted data that was not based on unique patient identifier or data matching approaches.

(e) Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of community data.

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

Source: State and Territory governments unpublished, admitted patient and community mental health care data.

Table 12A.41 **Readmissions to hospital within 28 days of discharge (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*
2005-06										
Overnight separations from psychiatric acute inpatient services	no.	25 087	14 957	14 211	6 645	5 352	2 617	1 136	1 092	71 097
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 057	2 098	2 696	933	629	334	152	132	11 031
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.2	14.0	19.0	14.0	11.8	12.8	13.4	12.1	15.5
2006-07										
Overnight separations from psychiatric acute inpatient services	no.	26 767	15 602	13 432	6 476	5 430	2 381	1 100	997	72 185
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 526	2 309	2 110	822	491	325	123	126	10 832
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.9	14.8	15.7	12.7	9.0	13.6	11.2	12.6	15.0
2007-08										
Overnight separations from psychiatric acute inpatient services	no.	27 202	16 400	13 296	6 446	5 590	2 116	1 148	946	73 144

Table 12A.41 **Readmissions to hospital within 28 days of discharge (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 716	2 484	2 059	856	617	353	114	117	11 316
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	17.3	15.1	15.5	13.3	11.0	16.7	9.9	12.4	15.5
2008-09										
Overnight separations from psychiatric acute inpatient services	no.	27 101	16 429	13 827	6 889	5 435	2 121	1 233	894	73 929
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 344	2 317	2 124	959	510	302	68	88	10 712
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.0	14.1	15.4	13.9	9.4	14.2	5.5	9.8	14.5
2009-10										
Overnight separations from psychiatric acute inpatient services	no.	26 447	16 552	13 928	7 329	5 509	2 011	1 184	837	73 797
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 094	2 300	2 106	1 015	461	316	51	75	10 418

Table 12A.41 **Readmissions to hospital within 28 days of discharge (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.5	13.9	15.1	13.8	8.4	15.7	4.3	9.0	14.1
2010-11										
Overnight separations from psychiatric acute inpatient services	no.	27 083	17 156	14 457	8 446	5 825	1 747	1 185	855	76 754
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 274	2 427	2 207	1 205	523	263	63	105	11 067
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.8	14.1	15.3	14.3	9.0	15.1	5.3	12.3	14.4
2011-12										
Overnight separations from psychiatric acute inpatient services	no.	27 463	17 910	15 192	8 754	5 997	1 907	1 306	898	79 427
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 298	2 554	2 294	1 199	560	269	165	88	11 427
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.7	14.3	15.1	13.7	9.3	14.1	12.6	9.8	14.4

Table 12A.41 **Readmissions to hospital within 28 days of discharge (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*

(a) Data are based on all 'in scope' separations from State and Territory psychiatric inpatient units, defined as those for which it is meaningful to examine readmission rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge — type change; left against medical advice/discharge at own risk and death.

(b) For the purposes of this indicator, a readmission for any of the separations identified as 'in-scope' is defined as an admission to any other public psychiatric acute unit within the jurisdiction that occurs within 28 days of the date of the original separation. States and territories vary in their capacity to accurately track readmissions statewide across hospitals. SA have indicated that data are not derived using unique patient identifiers and Tasmania indicated that data for 2005-06 and 2006-07 are not calculated using unique identifiers. This can lead to the appearance of lower re-admission rates.

(c) No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.

(d) For NSW, the construction of this indicator complies with the calculation conditions outlined in the *Key Performance Indicators for Australian Public Mental Health Services,* Second Ed. 2011. These conditions specify the exclusion of separations where the procedure code is ECT and the stay is one day or less. These data are calculated using a Statewide Unique Patient Identifier (SUPI) for Mental Health care. The inpatient SUPI coverage was above 99.9 per cent in all Local Health Districts except one where the coverage was at 99 per cent.

(e) Victorian data have been revised, for all years from 2005-06 to 2010-11 due to a number of in-scope separations from Aged and Specialist acute units previously being excluded from the calculations.

(f) For Qld, data have been recalculated across all years to exclude episodes of one night only where an electroconvulsive therapy procedure was recorded. The rate of readmission for 2011-12 is higher than was published for the 2011-12 Queensland Health Service Delivery Statements and Annual Report. This is due to recent improvements in the method used to identify readmissions, which has been used to calculate readmission for more recent data.

(g) For Qld, inpatient identifiers are unique at a hospital level. A routine linkage program is utilised to create a unique identifier for reporting purposes.

(h) For WA, data from previous reports are not comparable to these figures due to change in data source. Data for this report are from a more robust and reliable source as data is subjected to rigorous quality assurance processes. Data for previous financial years have been revised. Within the single data source for inpatient mental health separations there is a unique identifier for clients.

(i) For SA, data have been revised for 2006-07 to 2010-11. Lack of unique identifier in numerous hospital systems means that only readmissions to same inpatient service unit can be identified — not readmission to a different service unit / hospital.

(j) For NT, data filters for mode of separation were reviewed for the whole of the data series and corrected per specification. This resulted in a small reduction in the denominator values.

Source: Department of Health unpublished, from data provided by State and Territory health authorities.

Table 12A.42 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g), (h)	*WA*	*SA*	*Tas* (i)	*ACT* (i), (j)	*NT* (i)	*Aust*
General mental health services									
2005-06	754	653	651	896	726	698	702	1 085	727
2006-07	763	670	666	909	827	867	921	987	752
2007-08	752	720	740	961	857	894	959	1 180	783
2008-09	788	757	733	1 003	942	846	859	1 206	810
2009-10	793	771	775	995	931	1 037	850	1 233	825
2010-11	840	783	775	1 098	891	1 013	892	1 275	854
2011-12	883	796	806	1 099	897	872	910	1 526	881
Child and adolescent mental health services									
2005-06	1 370	1 398	1 377	1 239	1 202	..	..	..	1 361
2006-07	1 399	1 401	1 473	1 515	1 521	..	..	..	1 434
2007-08	1 406	1 412	1 553	1 140	2 035	..	..	..	1 429
2008-09	1 381	1 544	1 640	1 530	1 829	..	..	..	1 503
2009-10	1 615	1 510	1 577	1 523	1 977	..	..	..	1 583
2010-11	1 892	1 506	1 577	1 976	1 773	..	..	..	1 720
2011-12	1 720	1 416	1 592	2 133	1 774	..	..	..	1 657
Older people's mental health services									
2005-06	617	566	492	769	535	..	..	..	588
2006-07	637	595	538	756	568	..	2 555	..	617
2007-08	627	637	576	759	613	..	968	..	637
2008-09	677	644	580	816	695	..	1 009	..	677
2009-10	684	653	592	789	708	..	618	..	678
2010-11	750	680	606	808	660	..	618	..	703
2011-12	771	680	614	904	677	..	604	..	727

Table 12A.42 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g), (h)	*WA*	*SA*	*Tas* (i)	*ACT* (i), (j)	*NT* (i)	*Aust*
Forensic mental health services									
2005-06	579	832	860	1 144	919	519	..	1 014	780
2006-07	518	843	883	1 022	1 027	1 037	..	697	775
2007-08	526	852	999	981	1 057	1 496	..	..	818
2008-09	777	756	979	1 167	994	1 527	..	..	883
2009-10	840	884	1 031	1 085	993	1 944	..	..	937
2010-11	927	840	1 128	993	971	2 278	..	..	968
2011-12	868	794	1 254	1 154	970	1 404	..	..	937

(a) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(b) Depreciation is excluded for all years.

(c) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

(d) Due to the ongoing validation of the NMDS data could differ from previous reports.

(e) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.

(f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(g) Queensland Government has advised that it provides older people's mental health inpatient services using a number of different service models including campus and noncampus based options. All service types are reported as older people's mental health services, which may have the effect of lowering the average patient day costs compared to jurisdictions who report ‘older people's care units’ separately.

(h) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

(i) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the ACT for 2005-06, and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Forensic mental health services were not provided seperately in the ACT and in the NT from 2007-08.

Table 12A.42 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g), (h)	*WA*	*SA*	*Tas* (i)	*ACT* (i), (j)	*NT* (i)	*Aust*

(j) ACT average costs for older person's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older people's mental health services relative to other jursidictions and other years.

.. Not applicable.

Source : AIHW unpublished, derived from the MHE NMDS.

Table 12A.43 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*
General mental health services									
Acute									
2005-06	854	677	733	899	800	691	702	1 085	792
2006-07	871	689	743	907	904	927	921	987	820
2007-08	851	751	851	953	904	888	959	1 180	854
2008-09	863	783	835	1 005	983	886	859	1 206	873
2009-10	876	797	845	1 007	969	1 111	850	1 233	886
2010-11	918	804	848	1 141	910	1 123	892	1 275	914
2011-12	949	800	859	1 123	865	931	910	1 526	921
Non-acute									
2005-06	527	498	523	883	546	718	..	..	557
2006-07	505	544	542	914	589	731	..	..	565
2007-08	522	531	558	1 013	680	916	..	..	579
2008-09	604	588	571	990	766	735	..	..	627
2009-10	606	605	681	924	763	830	..	..	662
2010-11	664	645	677	970	808	738	..	..	705
2011-12	723	770	730	1 016	1 092	725	..	..	769
Child and adolescent mental health services									
Acute									
2005-06	1 543	1 398	1 389	1 239	1 202	..	..	..	1 411
2006-07	1 339	1 401	1 567	1 459	1 521	..	..	..	1 430
2007-08	1 451	1 412	1 561	1 035	2 035	..	..	..	1 429
2008-09	1 483	1 544	1 612	1 431	1 829	..	..	..	1 538
2009-10	1 708	1 510	1 454	1 318	1 977	..	..	..	1 563

Table 12A.43 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*
2010-11	1 855	1 506	1 494	1 783	1 773	..	..	..	1 660
2011-12	1 780	1 416	1 449	2 022	1 774	..	..	..	1 630
Non-acute									
2005-06	1 069	..	1 330	..	..	..	..	..	1 143
2006-07	1 547	..	1 195	1 755	..	..	..	..	1 450
2007-08	1 308	..	1 527	1 923	..	..	..	..	1 426
2008-09	1 169	..	1 751	2 006	..	..	..	..	1 369
2009-10	1 370	..	2 099	2 968	..	..	..	..	1 679
2010-11	2 056	..	1 965	4 456	..	..	..	..	2 148
2011-12	1 545	..	2 375	4 462	..	..	..	..	1 809
Older people's mental health services									
Acute									
2005-06	659	566	712	797	687	..	..	..	661
2006-07	690	595	796	795	787	..	2 555	..	702
2007-08	705	637	875	784	797	..	968	..	725
2008-09	736	644	795	843	778	..	1 009	..	737
2009-10	731	653	827	879	862	..	618	..	750
2010-11	810	680	823	869	780	..	618	..	773
2011-12	801	680	847	982	806	..	604	..	796
Non-acute									
2005-06	560	..	418	629	451	..	..	..	481
2006-07	562	..	447	624	451	..	..	..	493
2007-08	560	..	470	676	506	..	..	..	527
2008-09	619	..	495	723	636	..	..	..	593
2009-10	633	..	504	504	582	..	..	..	571

Table 12A.43 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*
2010-11	686	..	524	446	540	..	..	..	591
2011-12	738	..	528	435	519	..	..	..	609
Forensic mental health services									
Acute									
2005-06	416	923	..	1 168	1 084	519	..	1 014	744
2006-07	466	1 007	..	1 034	1 170	1 037	..	697	786
2007-08	444	907	..	981	1 115	1 496	..	..	769
2008-09	703	824	..	1 167	1 233	1 527	..	..	876
2009-10	847	940	..	1 085	1 307	1 944	..	..	990
2010-11	973	895	..	1 079	1 305	2 278	..	..	1 037
2011-12	886	774	..	1 255	1 342	1 404	..	..	942
Non-acute									
2005-06	653	749	860	1 118	877	..	..	..	794
2006-07	555	699	883	1 009	988	..	..	..	769
2007-08	594	807	999	980	1 041	..	..	..	844
2008-09	849	652	979	1 168	932	..	..	..	888
2009-10	833	792	1 031	1 085	915	..	..	..	891
2010-11	883	750	1 128	646	885	..	..	..	903
2011-12	854	825	1 254	751	876	..	..	..	932

(a) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(b) Depreciation is excluded for all years.

(c) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

Table 12A.43 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*

(d) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.

(e) Caution is required when interpreting NSW data. Seven residential mental health services in 2006-07 were reclassified as non-acute older person specialised hospital services in 2007-08, reflecting a change in function of those units.

(f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(g) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Victoria and SA did not have non-acute child and adolescent mental health services units. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the NT. Older People's Mental Health Services in non-acute units were not available in Victoria and the ACT. Forensic mental health services were not provided seperately in the ACT and in the NT from 2007-08.

(h) Queensland Government has advised that it provides older people's mental health inpatient services using a number of different service models including campus and noncampus based options. All service types are reported as older people's mental health services, which may have the effect of lowering the average patient day costs compared to jurisdictions who report 'older people's care units' separately.

(i) Caution is required when interpreting Queensland data. Several Forensic services reported in 2008-09 were reclassified as General services in 2009-10 to more accurately reflect the function of these services. Forensic mental health services in acute units were not provided seperately in Queensland.

(j) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

(k) Caution is required when interpreting WA data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services. In addition, during 2010-11, the child and adolescent non acute inpatient service initiated the closure of beds in order to carry out a complete refurbishment. The service ceased operating in late 2011.

(l) ACT average costs for older people's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older people's mental health services relative to other jursidictions and other years.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.44 **Average length of stay, public hospitals acute units, by target population (no. of days) (a), (b)**

	NSW (c)	*Vic*	*Qld* (d)	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (e)	*Aust*
2010-11									
General mental health services	14.8	14.5	11.4	14.9	13.4	12.0	15.2	12.6	13.8
Child and adolescent mental health services	21.7	10.4	11.2	8.0	4.2	..	..	..	11.8
Older people's mental health services	35.4	32.6	20.7	51.3	45.6	..	36.3	..	35.5
Total	**16.0**	**16.1**	**11.8**	**17.3**	**15.2**	**12.0**	**17.5**	**12.6**	**15.1**
2011-12									
General mental health services	14.7	14.4	11.6	13.8	12.2	12.6	14.5	10.7	13.6
Child and adolescent mental health services	22.1	7.3	11.5	7.2	3.1	..	..	..	10.5
Older people's mental health services	41.2	30.5	11.3	49.8	41.2	..	36.8	..	31.9
Total	**16.1**	**15.4**	**11.6**	**16.0**	**13.8**	**12.6**	**16.9**	**10.7**	**14.7**

(a) The quality of the separations data used to derive the results in this table is variable across jurisdictions. Until recently, these separations data were not subject to in depth scrutiny. It is expected that the quality of these data will improve over time.

(b) There is a mismatch between the inpatient bed days and the separations used to derive this indicator for the relevant reference period (eg 2010-11).
– Patients days for clients who separated in the reference period that were during the previous period (eg 2009-10) are excluded.
– Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

(c) The quality of the NSW 2010-11 MHE NMDS data has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(d) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

(e) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the NT.

Table 12A.44 **Average length of stay, public hospitals acute units, by target population (no. of days) (a), (b)**

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

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.45 **Average recurrent cost per inpatient bed day, by public hospital type (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g)	*Vic* (h)	*Qld* (i)	*WA* (j)	*SA* (k)	*Tas* (l)	*ACT* (k), (l)	*NT* (k), (l)	*Aust*
Psychiatric hospitals (acute units)									
2005-06	806	923	..	901	895	..	..	..	854
2006-07	773	1 007	..	932	1 018	..	..	..	872
2007-08	723	907	..	913	1 100	..	..	..	851
2008-09	735	824	..	976	1 064	..	..	..	875
2009-10	953	940	..	974	1 108	..	..	..	979
2010-11	934	895	..	1 146	930	..	..	..	972
2011-12	1 039	774	..	1 183	889	..	..	..	1 009
Psychiatric hospitals (non-acute units)									
2005-06	566	749	691	923	542	..	..	..	626
2006-07	533	699	703	927	566	..	..	..	619
2007-08	546	807	774	915	634	..	..	..	653
2008-09	628	652	760	978	725	..	..	..	697
2009-10	620	792	780	965	704	..	..	..	698
2010-11	684	750	798	920	705	..	..	..	738
2011-12	723	825	880	954	783	..	..	..	798
Psychiatric hospitals (all units)									
2005-06	648	832	691	910	675	..	..	..	701
2006-07	618	843	703	930	721	..	..	..	701
2007-08	607	852	774	914	784	..	..	..	719
2008-09	658	756	760	977	848	..	..	..	755
2009-10	713	884	780	972	840	..	..	..	787
2010-11	756	840	798	1 037	786	..	..	..	809
2011-12	827	794	880	1 086	826	..	..	..	869
Public acute hospital with a psychiatric unit or ward (acute units)									
2006-07	865	696	787	891	831	952	994	984	811
2007-08	857	751	888	933	815	1 008	960	1 180	849
2008-09	885	782	872	998	907	1 014	885	1 206	876
2009-10	871	797	875	1 005	918	1 267	802	1 233	882
2010-11	942	808	881	1 079	896	1 312	830	1 275	919
2011-12	944	802	891	1 104	871	1 036	839	1 526	918
Public acute hospital with a psychiatric unit or ward (non-acute units)									
2006-07	651	544	517	756	..	731	..	..	569
2007-08	600	531	531	991	..	916	..	..	589
2008-09	758	588	547	949	..	735	..	..	643
2009-10	830	605	597	734	..	830	..	..	679
2010-11	878	645	596	889	..	738	..	..	699
2011-12	864	770	627	888	..	725	..	..	754
Public acute hospital with a psychiatric unit or ward (all units)									
2005-06	823	664	676	877	703	670	702	1 083	741

Table 12A.45 **Average recurrent cost per inpatient bed day, by public hospital type (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g)	*Vic* (h)	*Qld* (i)	*WA* (j)	*SA* (k)	*Tas* (l)	*ACT* (k), (l)	*NT* (k), (l)	*Aust*
2006-07	850	681	699	877	831	897	994	984	777
2007-08	820	728	774	939	815	991	960	1 180	808
2008-09	872	763	772	993	907	951	885	1 206	842
2009-10	867	777	792	973	918	1 169	802	1 233	853
2010-11	935	792	794	1 063	896	1 168	830	1 275	888
2011-12	930	799	811	1 086	871	962	839	1 526	892

(a) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(b) Depreciation is excluded for all years.

(c) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/ resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

(d) Due to the ongoing validation of the NMDS data could differ from previous reports.

(e) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.

(f) Caution is required when interpreting NSW data. Seven residential mental health services in 2006-07 were reclassified as non-acute older person specialised hospital services in 2007-08, reflecting a change in function of those units.

(g) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(h) Mainstreaming has occurred at different rates in different jurisdictions. In Victoria's case, the data for psychiatric hospitals comprises mainly forensic services, since nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means that the client profile and service costs are very different from those of a jurisdiction where general psychiatric treatment still occurs mostly in psychiatric hospitals.

(i) Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals.

(j) Caution is required when interpreting WA data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services.

(k) SA, the ACT and the NT do not have non-acute units in public acute hospital with a psychiatric unit or ward.

(l) Tasmania, the ACT and the NT do not have public psychiatric hospitals.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS.

Table 12A.46 **Average recurrent cost per patient day for community residential services (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g), (h)	*Vic*	*Qld* (i)	*WA* (j), (k)	*SA* (k)	*Tas* (l), (m)	*ACT* (h), (m)	*NT* (k), (n)	*Aust*
General adult units									
2005-06									
24-hour staffed units	292	470	..	360	258	434	526	..	422
non-24-hour staffed units	95	165	..	133	300	342	84	124	149
2006-07									
24-hour staffed units	289	457	..	469	255	452	581	..	426
non-24-hour staffed units	92	151	..	150	307	227	116	286	143
2007-08									
24-hour staffed units	267	443	..	503	399	519	588	292	428
non-24-hour staffed units	176	148	..	186	490	230	109	..	165
2008-09									
24-hour staffed units	302	474	..	427	402	552	716	264	455
non-24-hour staffed units	228	147	..	170	297	259	104	..	170
2009-10									
24-hour staffed units	259	505	..	332	390	425	681	343	446
non-24-hour staffed units	196	153	..	155	264	235	117	..	166
2010-11									
24-hour staffed units	298	540	..	529	463	480	653	361	502
non-24-hour staffed units	200	158	..	139	269	225	111	..	161
2011-12									
24-hour staffed units	225	488	..	368	484	490	650	308	447
non-24-hour staffed units	178	158	..	148	331	198	133	..	163

Table 12A.46 **Average recurrent cost per patient day for community residential services (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g), (h)	*Vic*	*Qld* (i)	*WA* (j), (k)	*SA* (k)	*Tas* (l), (m)	*ACT* (h), (m)	*NT* (k), (n)	*Aust*
Older people's care units									
2005-06									
24-hour staffed units	321	340	..	..	..	480	170	..	342
non-24-hour staffed units	120	..	..	..	..	..	..	..	120
2006-07									
24-hour staffed units	380	317	..	..	..	507	179	..	334
non-24-hour staffed units	313	..	..	..	..	..	..	..	313
2007-08									
24-hour staffed units	211	315	..	..	..	796	184	..	329
non-24-hour staffed units	168	..	..	..	..	..	..	..	168
2008-09									
24-hour staffed units	188	343	..	..	..	528	244	..	349
non-24-hour staffed units	223	..	..	..	..	..	..	..	223
2009-10									
24-hour staffed units	218	337	..	..	..	756	197	..	351
non-24-hour staffed units	216	..	..	..	..	..	..	..	216
2010-11									
24-hour staffed units	231	349	..	..	..	702	211	..	361
non-24-hour staffed units	284	..	..	..	..	..	..	..	284
2011-12									
24-hour staffed units	234	347	..	..	..	682	249	..	358
non-24-hour staffed units	..	..	..	..	..	..	..	..	..

Table 12A.46 **Average recurrent cost per patient day for community residential services (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g), (h)	*Vic*	*Qld* (i)	*WA* (j), (k)	*SA* (k)	*Tas* (l), (m)	*ACT* (h), (m)	*NT* (k), (n)	*Aust*

(a) Depreciation is excluded for all years.

(b) Unit costs are not casemix adjusted.

(c) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(d) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

(e) Due to the ongoing validation of the NMDS data could differ from previous reports.

(f) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(g) The quality of the NSW 2010-11 *MHE NMDS* data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(h) A small number of residential beds reported by NSW and the ACT as Child and adolescent residential mental health service beds were included in the General category at the request of those jurisdictions.

(i) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day 7 days a week. Queensland does not report these beds as community residential beds as it considers these beds to be substantially different to beds described as such in other states and territories.

(j) Caution is required when interpreting WA data. Several residential services reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010. For 2011-12, a small number of Youth services have been included in the General services category at the request of WA.

(k) WA, SA and the NT do not have any community residential services that are aged care units.

(l) Tasmanian services include both acute and rehabilitation units which have higher unit costs than extended care units.

(m) Tasmania and the ACT do not have any community-based residential services that are non-24 hour staffed older people's units. From 2011-12, NSW no longer has non-24 hour staffed older people's units.

(n) General adult 24-hour residential services were not provided in the NT until 2007-08. From 2007-08, general non-24-hour staffed units are not provided.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.47 **Average cost, and treatment days per episode, of ambulatory care (a), (b), (c)**

	NSW (d)	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*
Average treatment days per episode of ambulatory care									
2005-06	6.7	7.8	4.9	4.5	4.8	4.7	8.2	4.0	6.0
2006-07	6.8	7.7	5.2	4.5	5.0	4.1	8.0	4.0	6.1
2007-08	8.0	7.7	5.4	4.6	5.2	5.9	8.0	3.9	6.5
2008-09	7.2	7.6	4.5	4.8	5.3	6.0	8.0	3.9	6.1
2009-10	7.6	7.6	4.9	4.9	5.3	5.2	8.2	3.5	6.3
2010-11	7.5	7.7	5.2	5.0	5.5	5.5	8.2	3.6	6.4
2011-12	8.0	na	5.8	5.0	5.4	4.5	8.6	3.6	6.4
Average cost per treatment day of ambulatory care (2011-12 $) (g)									
2005-06	249	265	290	442	407	636	270	451	297
2006-07	260	268	322	437	353	561	295	517	307
2007-08	251	288	345	466	315	434	277	582	310
2008-09	263	300	430	453	305	404	287	535	329
2009-10	250	303	494	424	312	391	252	587	330
2010-11	258	326	455	415	329	335	251	592	333
2011-12	245	na	424	431	324	467	249	543	326

(a) Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care and treatment days data.

(b) Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for proportion of clients in the *CMHC NMDS* that were defined as 'non-uniquely identifiable consumers'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(e) Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.

(f) Industrial action in Tasmania has limited the available data quality and quantity of the 2011-12 data.

(g) Real expenditure (2011-12 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.73).

na Not available.

Source: AIHW unpublished, CMHC NMDS and MHE NMDS.

Table 12A.48 **Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Lifetime status									
Abstainers (a)	21.8	20.9	16.8	17.0	19.0	14.4	13.5	13.7	19.5
Low risk (b)	59.6	60.6	60.0	60.3	61.7	66.1	67.0	56.9	60.4
Risky (c)	18.6	18.4	23.2	22.7	19.3	19.4	19.5	29.4	20.1
Single occasion									
Abstainers (a)	21.8	20.9	16.8	17.0	19.0	14.4	13.5	13.7	19.5
Low risk (d)	41.7	41.1	38.3	39.7	42.7	45.1	42.0	35.5	40.7
Risky									
At least yearly (e)	10.6	11.4	11.8	12.3	11.0	11.5	15.1	11.3	11.3
At least monthly (f)	11.0	12.3	15.0	13.2	11.2	13.1	15.9	14.9	12.5
At least weekly (g)	15.0	14.4	18.1	17.9	16.1	15.8	13.6	24.7	15.9
Total risky	36.6	38.0	44.9	43.3	38.4	40.4	44.5	50.8	39.8

(a) Not consumed alcohol in the previous 12 months.

(b) On average, had no more than 2 standard drinks per day.

(c) On average, had more than 2 standard drinks per day.

(d) Never had more than 4 standard drinks on any occasion.

(e) Had more than 4 standard drinks at least once a year, but not as often as monthly.

(f) Had more than 4 standard drinks at least once a month, but not as often as weekly.

(g) Had more than 4 standard drinks at least once a week.

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.49 **Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Alcohol	78.2	79.1	83.2	83.0	81.0	85.6	86.5	86.3	80.5
Illicit drugs									
Cannabis	9.3	9.4	11.0	13.4	11.3	8.6	9.5	16.5	10.3
Ecstasy	2.9	3.1	2.7	3.7	3.3	*1.7	*2.3	3.2	3.0
Meth/amphetamines (c)	1.6	2.3	1.9	3.4	2.5	*1.1	*1.2	*2.1	2.1
Cocaine	2.7	2.3	1.3	2.2	1.7	*0.8	*1.8	**0.5	2.1
Hallucinogens	0.8	1.8	1.4	1.9	1.0	*1.0	*1.5	*2.6	1.4
Inhalants	0.6	0.6	0.6	*0.4	*0.6	*0.8	**0.6	*1.5	0.6
Heroin	*0.2	*0.3	*0.1	*0.3	*0.2	**0.1	**0.3	**0.1	0.2
GHB	*0.2	*0.2	*0.1	**0.1	**0.1	–	**<0.1	–	0.1
Any illicit (d)	11.4	11.0	12.3	15.4	12.7	9.6	11.4	18.8	12.0

(a) Recent means used in the previous 12 months. For alcohol 'recent use' includes daily, weekly and less than weekly drinkers.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(c) Use for non-medical purposes.

(d) Includes ketamine and injected drugs, but excludes pharmacueticals.

– Nil or rounded to zero.

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.50 **Selected illicit drug use, by substance and age group, 2010 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cannibis									
14–19 years	13.9	16.0	14.6	23.5	*19.6	**3.1	*12.0	*14.8	15.7
20–29 years	18.3	20.4	23.9	27.6	23.2	17.4	18.3	26.0	21.3
30–39 years	11.5	12.9	15.3	17.0	15.9	14.0	11.4	18.5	13.6
40 years or over	5.0	3.4	4.7	5.6	5.4	6.0	4.6	11.6	4.7
14 years or over	9.3	9.4	11.0	13.4	11.3	8.6	9.5	16.5	10.3
Ecstacy									
14–19 years	*2.3	*3.6	*1.8	*3.5	*4.7	**1.6	**2.8	**3.7	2.8
20–29 years	9.1	9.5	10.1	12.5	11.5	*7.2	*7.7	*8.0	9.9
30–39 years	4.5	3.9	2.8	4.1	*5.5	**2.1	*2.2	*3.1	3.9
40 years or over	0.5	0.5	*0.4	*0.6	**0.1	**0.2	–	*0.9	0.5
14 years or over	2.9	3.1	2.7	3.7	3.3	1.7	2.3	3.2	3.0
Meth/amphetamines									
14–19 years	**1.0	*3.1	*1.3	**0.8	**2.2	–	–	**1.1	1.6
20–29 years	3.9	6.4	5.7	11.7	*7.3	**2.6	**2.6	*5.0	5.9
30–39 years	3.0	3.2	2.9	6.1	*4.2	**2.8	**1.6	**2.9	3.4
40 years or over	0.5	*0.4	*0.5	*0.2	*0.8	**0.5	**0.7	**0.6	0.5
14 years or over	1.6	2.3	1.9	3.4	2.5	1.1	1.2	2.1	2.1
Cocaine									
14–19 years	*1.4	*2.1	**0.8	**0.3	**1.5	–	**1.9	**1.1	1.3
20–29 years	7.6	6.9	4.7	*7.6	*5.1	**4.3	*6.2	**0.7	6.5
30–39 years	5.2	3.7	*1.7	*3.5	*4.3	**0.7	**1.3	**0.9	3.7
40 years or over	0.6	*0.3	*0.2	**0.4	**0.2	**0.1	**0.1	**0.2	0.4
14 years or over	2.7	2.3	1.3	2.2	1.7	*0.8	*1.8	**0.5	2.1

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

– Nil or rounded to zero.

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.51 **Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2010 (per cent) (a), (b)**

	Not used drug in last 12 months	*Used drug in last 12 months*	*All people (18+)*
Any illicit drug			
Level of psychological distress			
Low	71.8	57.3	69.6
Moderate	19.6	25.8	20.5
High	6.5	12.8	7.4
Very high	2.1	4.1	2.4
Self-reported health condition			
Diabetes	5.7	3.3	5.4
Heart diseases	20.4	10.1	19.1
Asthma	8.3	10.3	8.6
Cancer	3.0	1.4	2.8
Mental illness	10.8	18.7	12.0
Cannabis			
Level of psychological distress			
Low	71.1	56.7	69.6
Moderate	19.8	27.0	20.5
High	6.8	12.7	7.4
Very high	2.3	3.6	2.4
Self-reported health condition			
Diabetes	5.8	2.0	5.4
Heart diseases	20.5	5.9	19.1
Asthma	8.5	10.0	8.6
Cancer	3.0	0.9	2.8
Mental illness	11.3	18.7	12.0
Ecstacy			
Level of psychological distress			
Low	70.1	55.9	69.6
Moderate	20.2	28.9	20.5
High	7.3	12.1	7.4
Very high	2.4	3.0	2.4
Self-reported health condition			
Diabetes	5.5	**1.0	5.4
Heart diseases	19.5	*1.2	19.1
Asthma	8.6	11.0	8.6
Cancer	2.9	**0.2	2.8
Mental illness	11.9	16.2	12.0

Table 12A.51 **Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2010 (per cent) (a), (b)**

	Not used drug in last 12 months	*Used drug in last 12 months*	*All people (18+)*
Meth/amphetamines			
Level of psychological distress			
Low	70.1	51.2	69.6
Moderate	20.3	28.0	20.5
High	7.3	13.3	7.4
Very high	2.3	7.5	2.4
Self-reported health condition			
Diabetes	5.5	*1.5	5.4
Heart diseases	19.3	4.5	19.1
Asthma	8.6	11.2	8.6
Cancer	2.9	*0.7	2.8
Mental illness	11.7	25.6	12.0
Cocaine			
Level of psychological distress			
Low	70.0	55.0	69.6
Moderate	20.3	27.4	20.5
High	7.3	14.1	7.4
Very high	2.4	3.4	2.4
Self-reported health condition			
Diabetes	5.5	**0.5	5.4
Heart diseases	19.4	*2.3	19.1
Asthma	8.7	6.7	8.6
Cancer	2.9	**0.4	2.8
Mental illness	11.9	17.4	12.0

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.52 **Risk status recent drinkers aged 14 years or over, 2007 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Long term harm									
Abstainers (a)	20.1	17.2	15.1	13.7	15.7	14.4	11.8	14.4	17.1
Low risk	69.9	73.7	73.1	74.8	75.1	73.7	78.3	69.1	72.6
Risky (b)	10.0	9.1	11.8	11.5	9.2	12.0	9.9	16.5	10.3
Short term harm									
Abstainers (a)	20.1	17.2	15.1	13.7	15.7	14.4	11.8	14.4	17.1
Low risk	48.1	48.8	47.7	49.2	48.9	46.1	52.1	40.2	48.3
Risky (c)									
At least yearly	13.1	14.5	15.2	14.4	13.8	16.5	15.0	16.9	14.2
At least monthly	11.3	11.8	13.7	14.7	14.6	13.3	13.3	16.3	12.6
At least weekly	7.4	7.6	8.3	8.1	7.0	9.7	7.8	12.1	7.8
Total risky	31.8	33.9	37.2	37.1	35.4	39.6	36.1	45.3	34.6

(a) Not consumed alcohol in the previous 12 months.

(b) For males, consumption of 29 or more standard drinks per week; for females, consumption of 15 or more standard drinks per week. A standard drink is 10 grams (or 12.5 millilitres) of pure alcohol.

(c) For males, consumption of 7 or more standard drinks on one occasion; for females, consumption of 5 or more standard drinks on one occasion. A standard drink is 10 grams (or 12.5 millilitres) of pure alcohol.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey State and territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.53 **Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2007 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Alcohol	79.9	82.8	84.9	86.3	84.3	85.7	88.2	85.6	82.9
Illicit drugs									
Cannabis	8.0	8.8	9.5	10.8	10.2	10.8	9.1	13.8	9.1
Ecstasy	3.4	3.6	3.7	4.1	2.9	2.4	4.7	4.2	3.5
Meth/amphetamines (c)	1.8	2.3	2.0	4.2	2.6	1.7	2.3	2.3	2.3
Cocaine	2.0	1.6	1.4	1.8	1.3	0.8	1.4	0.9	1.6
Hallucinogens	0.5	0.5	0.6	1.0	0.9	1.0	0.8	0.9	0.6
Inhalants	0.4	0.5	0.5	0.3	*0.1	0.6	0.6	*0.1	0.4
Heroin	0.2	0.3	0.2	*0.2	*0.1	*0.3	–	*0.3	0.2
GHB	0.2	*0.1	*< 0.1	*0.1	*0.1	–	*< 0.1	*0.1	0.1
Any illicit	12.1	12.8	13.7	16.2	14.7	14.8	13.8	20.4	13.4

(a) Recent means used in the previous 12 months. For alcohol 'recent use' includes daily, weekly and less than weekly drinkers.

(b) Results subject to relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " * " .

(c) Use for non-medical purposes.

– Nil or rounded to zero.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey, State and Territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.54 **Use of cannabis and any illicit drug excluding cannabis, by age group, 2007 (per cent) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cannibis									
14–24 years	13.1	17.9	19.4	22.1	17.5	18.3	17.6	19.7	17.0
25–39 years	13.0	14.9	13.9	16.3	16.6	21.0	15.0	17.1	14.5
40 years or over	4.0	2.9	3.9	4.3	5.4	4.6	2.8	8.9	3.9
14 years or over	8.0	8.8	9.5	10.8	10.2	10.8	9.1	13.8	9.1
Any illicit, excluding cannabis (b)									
14–24 years	4.1	2.9	4.6	5.5	4.6	4.2	7.5	10.3	4.2
25–39 years	5.1	4.7	5.1	6.8	5.9	2.2	4.0	6.1	5.2
40 years or over	3.2	3.3	3.2	4.0	3.3	4.1	3.3	4.3	3.3
14 years or over	3.8	3.6	3.9	5.0	4.2	3.7	4.3	6.1	4.0

(a) Recent use means used in the previous 12 months.

(b) Excludes those who have used cannabis in the past 12 months, whether or not they had also used other drugs.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey, State and Territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.55 **Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2007 (per cent) (a), (b)**

	Not used drug in last month	*Used drug in last month*
Any illicit drug		
Level of psychological distress		
Low	70.8	51.2
Moderate	20.5	28.6
High	6.9	14.6
Very high	1.8	5.6
Self-reported health condition		
Diabetes	5.4	2.7
Heart diseases	17.8	8.6
Asthma	8.4	11.1
Cancer	2.6	1.0
Mental illness (c)	10.1	17.6
Cannabis		
Level of psychological distress		
Low	70.1	51.2
Moderate	20.8	27.2
High	7.2	15.7
Very high	1.9	5.8
Self-reported health condition		
Diabetes	5.5	1.6
Heart diseases	17.8	5.8
Asthma	8.6	10.6
Cancer	2.6	0.7
Mental illness (c)	10.4	16.8
Ecstacy		
Level of psychological distress		
Low	69.5	45.4
Moderate	20.9	34.4
High	7.5	16.3
Very high	2.1	3.9
Self-reported health condition		
Diabetes	5.3	* 1.8
Heart diseases	17.4	4.0
Asthma	8.7	9.7
Cancer	2.5	–
Mental illness (c)	10.7	15.5

Table 12A.55 **Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2007 (per cent) (a), (b)**

	Not used drug in last month	*Used drug in last month*
Meth/amphetamines		
Level of psychological distress		
Low	69.6	43.5
Moderate	21.0	35.3
High	7.4	15.8
Very high	2.1	5.4
Self-reported health condition		
Diabetes	5.3	* 1.5
Heart diseases	17.4	4.9
Asthma	8.6	9.9
Cancer	2.5	–
Mental illness (c)	10.6	21.0
Cocaine		
Level of psychological distress		
Low	69.3	47.1
Moderate	21.1	30.9
High	7.5	15.3
Very high	2.1	* 6.7
Self-reported health condition		
Diabetes	5.3	* 1.5
Heart diseases	17.2	* 4.1
Asthma	8.7	11.9
Cancer	2.5	* 0.8
Mental illness (c)	10.7	14.7

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " * " .

(c) Includes depression, anxiety disorder, schizophrenia, bi-polar disorder, an eating disorder and other form of psychosis.

Source : AIHW 2008, *2007 National Drug Strategy Household Survey, State and Territory supplement* , Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.56 **Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Any 12-month mental disorder (c)									
Anxiety disorders	14.4 ± 1.7	15.4 ± 2.0	13.1 ± 2.5	15.1 ± 3.7	14.4 ± 3.3	np	np	np	14.4 ± 0.9
Affective disorders	6.4 ± 1.2	6.6 ± 1.7	6.1 ± 1.6	6.2 ± 1.8	6.3 ± 2.3	np	np	np	6.2 ± 0.7
Substance use disorders	4.2 ± 1.1	5.5 ± 1.3	5.8 ± 1.8	6.0 ± 2.2	5.5 ± 2.0	np	np	np	5.1 ± 0.7
Any 12-month mental disorder (c), (d)	20.1 ± 2.2	20.7 ± 2.3	19.2 ± 2.6	21.4 ± 4.1	19.1 ± 3.4	14.1 ± 5.4	np	np	20.0 ± 1.1
Lifetime mental disorder, with no 12-month symptoms (e)	23.2 ± 1.9	26.3 ± 2.9	28.1 ± 3.4	23.6 ± 4.1	26.3 ± 4.1	30.7 ± 6.9	np	33.3 ± 12.9	25.5 ± 1.4
Without lifetime mental disorders (f)	56.7 ± 2.2	53.0 ± 3.6	52.6 ± 3.8	55.1 ± 5.2	54.6 ± 4.5	55.2 ± 8.2	53.1 ± 11.9	49.0 ± 18.8	54.5 ± 1.4

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.57 **Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent) (a)**

	Males	*Females*	*People*
Any 12-month mental disorder (b), (c)			
Anxiety disorders			
Panic disorders	2.3 ± 0.7	2.8 ± 0.6	2.6 ± 0.5
Agoraphobia	2.1 ± 0.7	3.5 ± 0.7	2.8 ± 0.5
Social phobia	3.8 ± 1.0	5.7 ± 0.8	4.7 ± 0.6
Generalised anxiety disorder	2.0 ± 0.7	3.5 ± 0.8	2.7 ± 0.6
Obsessive compulsive disorder	1.6 ± 0.6	2.2 ± 0.5	1.9 ± 0.4
Post traumatic stress disorder	4.6 ± 1.0	8.3 ± 1.0	6.4 ± 0.6
Any anxiety disorder (c)	10.8 ± 1.4	17.9 ± 1.3	14.4 ± 0.9
Affective disorders			
Depression (d)	3.1 ± 0.8	5.1 ± 0.8	4.1 ± 0.6
Dysthymia	1.0 ± 0.4	1.5 ± 0.5	1.3 ± 0.3
Bipolar	1.8 ± 0.6	1.7 ± 0.4	1.8 ± 0.4
Any affective disoder (c)	5.3 ± 1.0	7.1 ± 1.0	6.2 ± 0.7
Substance use disorders			
Alcohol harmful use	3.8 ± 0.8	2.1 ± 0.6	2.9 ± 0.5
Alcohol dependence	2.2 ± 0.7	0.7 ± 0.2	1.4 ± 0.3
Drug use (e)	2.1 ± 0.6	0.8 ± 0.3	1.4 ± 0.3
Any substance use disorder (c), (e)	7.0 ± 1.2	3.3 ± 0.7	5.1 ± 0.7
Any 12-month mental disorder (c)	17.6 ± 1.9	22.3 ± 1.3	20.0 ± 1.1
Lifetime mental disorder, with no 12-month symptoms (f)	30.5 ± 2.2	20.7 ± 1.4	25.5 ± 1.4
No lifetime mental disorder (g)	51.9 ± 2.0	57.0 ± 1.7	54.5 ± 1.4

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(d) Includes severe depressive episode, moderate depressive episode and mild depressive episode.

(e) Includes harmful use and dependence.

(f) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(g) People who did not meet criteria for diagnosis of a lifetime mental disorder.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.58 **Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent) (a), (b)**

	16–24 years	*25–34 years*	*35–44 years*	*45–54 years*	*55–64 years*	*65–74 years*	*75–85 years*
Any 12-month mental disorder (c), (d)							
Anxiety disorders	15.4 ± 2.0	16.3 ± 2.8	18.1 ± 3.0	17.6 ± 3.0	11.3 ± 1.9	6.3 ± 1.5	4.0 ± 1.8
Affective disorders	6.3 ± 1.5	7.9 ± 2.1	8.3 ± 2.1	7.1 ± 2.2	4.2 ± 1.3	2.8 ± 1.2	np
Substance use disorders	12.7 ± 2.0	7.3 ± 2.2	4.6 ± 1.6	3.8 ± 1.6	np	np	np
Any 12-month mental disorder (c), (d)	26.4 ± 2.7	24.8 ± 3.2	23.3 ± 3.3	21.5 ± 3.5	13.6 ± 2.1	8.6 ± 1.6	5.9 ± 2.1
Lifetime mental disorder, with no 12-month symptoms (e)	13.2 ± 2.0	29.0 ± 4.4	30.7 ± 3.3	30.4 ± 4.2	27.6 ± 3.6	23.1 ± 2.6	16.2 ± 4.1
No lifetime mental disorder (f)	60.5 ± 3.0	46.2 ± 3.9	46.0 ± 3.3	48.2 ± 4.6	58.8 ± 4.1	68.3 ± 3.0	77.8 ± 4.6

(a) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(b) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.59 **Suicides and mortality rate, by sex, Australia (a), (b)**

	2002	*2003*	*2004*	*2005*	*2006* (c)	*2007* (c)	*2008* (c)	*2009* (c)	*2010* (d)	*2011* (e)
Suicides (no.)										
Males	1 817	1 737	1 661	1 658	1 624	1 699	1 833	1 785	1 867	1 727
Females	503	477	437	444	494	530	508	552	553	546
People	2 320	2 214	2 098	2 102	2 118	2 229	2 341	2 337	2 420	2 273
Suicide death rate (per 100 000 people) (f)										
Males	18.6	17.6	16.6	16.4	15.8	16.2	17.1	16.3	16.8	15.3
Females	5.1	4.8	4.3	4.3	4.7	5.0	4.7	5.0	4.9	4.8
People	11.8	11.1	10.4	10.3	10.2	10.6	10.9	10.6	10.9	10.0

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data. See ABS *Causes of Death, 2011* (Cat. no. 3303.0) Explanatory Notes 92–95.

(b) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(c) Data for 2006, 2007, 2008 and 2009 have undergone revisions and are now considered final. See ABS' *Causes of Death, Australia 2011* , publication for more information.

(d) Data for 2010 have been revised and are subject to further revisions. See ABS' *Causes of Death, Australia 2011* , publication for more information.

(e) Data for 2011 are preliminary and subject to a revisions process. See ABS' *Causes of Death, Australia 2011,* publication for more information.

(f) Crude death rate per 100 000 people using estimated resident populations (ERPs) for Australia (people) at 30 June of relevant year. Rates are derived using ERPs based on the *2006 Census* and cannot be compared with rates derived using ERPs based on the 2011 Census. Details are included in the relevant tables.

Source : ABS 2013, *Causes of Death, Australia 2011,* Cat. no. 3303.0, Canberra.

Table 12A.60 **Suicides and mortality rate, by age and sex, Australia (a), (b)**

	15–24 years	*25–34 years*	*35–44 years*	*45–54 years*	*55–64 years*	*65–74 years*	*75–84 years*	*85 years +*	*All ages* (c)
2011									
Suicides (no.)									
Males	231	332	340	328	222	128	92	47	1 727
Females	90	78	121	94	72	39	21	21	546
People	321	410	461	422	294	167	113	68	2 273
Suicide death rate (per 100 000 people) (d), (e)									
Males	14.7	20.6	21.7	21.8	17.4	15.4	20.5	33.8	15.5
Females	6.0	4.9	7.6	6.1	5.6	4.6	3.8	7.9	4.9
People	10.5	12.8	14.6	13.9	11.5	9.9	11.3	16.8	10.2
2007–2011									
Suicides (no.)									
Males	1 125	1 674	1 973	1 718	1 120	601	483	187	8 911
Females	362	455	564	550	370	176	120	66	2 689
People	1 487	2 129	2 537	2 268	1 490	777	603	253	11 600
Suicide death rate (per 100 000 people) (e)									
Males	14.4	21.7	25.5	23.2	18.4	15.8	22.3	30.2	16.5
Females	4.9	6.0	7.2	7.3	6.0	4.5	4.4	5.4	4.9
People	9.8	13.9	16.3	15.2	12.2	10.1	12.4	13.7	10.7

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data. See ABS *Causes of Death, 2011* (Cat. no. 3303.0) Explanatory Notes 92–95.

(b) Data for 2006, 2007, 2008 and 2009 have undergone revisions and are now considered final. Data for 2010 have been revised and are subject to further revisions. Data for 2011 are preliminary and subject to a revisions process. See ABS' Causes of Death, Australia 2011, publication for more information.

(c) All ages includes deaths of people aged under 15 years and age not stated.

(d) Crude death rate per 100 000 estimated resident population as at 30 June 2011 for each age group and sex. Rates are derived using ERPs based on the 2011 Census and cannot be compared with rates derived using ERPs based on the 2006 Census (for example, in table 12A.59).

Table 12A.60 **Suicides and mortality rate, by age and sex, Australia (a), (b)**

	15–24 years	*25–34 years*	*35–44 years*	*45–54 years*	*55–64 years*	*65–74 years*	*75–84 years*	*85 years +*	*All ages* (c)

(e) Rate per 100 000 estimated resident population at 30 June of the relevant mid point year (for 2007–2011 it is 2009). Rates are derived using ERPs based on the 2011 Census and cannot be compared with rates derived using ERPs based on the 2006 Census.

Source : ABS 2013, *Causes of Death, Australia 2011,* Cat. no. 3303.0, Canberra; ABS unpublished, *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 12A.61 **Suicide deaths and death rate (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT* (c)	*NT* (c)	*Aust*
Suicide deaths (no.)									
2002	692	528	537	242	170	70	26	55	2 320
2003	640	540	466	227	193	69	35	44	2 214
2004	587	521	453	194	178	88	26	51	2 098
2005	549	506	459	203	231	74	35	45	2 102
2006 (d)	577	485	494	245	180	72	32	33	2 118
2007 (d)	611	474	520	266	205	66	32	55	2 229
2008 (d)	620	545	553	300	175	73	36	38	2 341
2009 (d)	623	576	525	279	185	79	32	37	2 337
2010 (e)	639	536	583	315	197	64	41	45	2 420
2011 (f)	566	483	559	306	209	73	34	43	2 273
2007–2011	3 059	2 614	2 740	1 466	971	355	175	218	11 600
Suicide death rate per 100 000 people (g), (h), (i)									
2002	10.4	10.9	14.5	12.6	11.2	14.8	8.1	27.7	11.8
2003	9.6	11.0	12.3	11.6	12.6	14.5	10.8	21.2	11.1
2004	8.7	10.5	11.7	9.8	11.6	18.2	8.0	25.5	10.4
2005	8.0	9.8	11.6	10.1	14.9	15.8	10.5	21.7	10.3
2006 (d)	8.4	9.5	12.4	12.1	11.5	14.8	9.7	14.2	10.3
2007 (d)	8.8	9.0	12.5	12.6	12.9	14.1	9.1	26.5	10.5
2008 (d)	8.9	10.3	13.3	14.2	11.0	15.2	10.3	17.9	11.1
2009 (d)	8.7	10.5	12.1	12.3	11.5	15.4	8.9	17.4	10.7
2010 (e)	8.8	9.7	13.3	13.7	11.8	13.0	11.3	18.8	10.9
2011 (f)	7.7	8.5	12.5	12.8	12.7	13.9	9.5	18.1	10.0
2007–2011 (g)	8.6	9.5	12.7	13.0	12.0	14.1	9.9	20.1	10.6

(a) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(b) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data.

(c) Low population results in small variations in the number of suicides appearing as large changes across the single year rates.

(d) Data for 2006, 2007, 2008 and 2009 have undergone revisions and are now considered final.

(e) Data for 2010 have been revised and are subject to further revisions.

(f) Data for 2011 are preliminary and subject to a revisions process.

(g) Rate per 100 000 estimated resident population at 30 June of the relevant single year or for five year average the mid-point year (2007–2011). 2007–2011 rate includes final 2007, 2008 and 2009 data, revised 2010 data and preliminary 2011 data.

(h) Death rates standardised to the mid-year 2001 population.

(i) The ERPs used to derived these rates differ across years. For data up to 2005 the rates are derived using ERPs based on the 2001 Census. For data up to 2008 the rates are derived using ERPs based on the 2006 Census. For data from 2009 (and for the five year averages 2007–2011) the rates are derived using the ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

Source: ABS 2013, *Causes of Death, Australia 2011*, Cat. no. 3303.0, Canberra; ABS unpublished, *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.62 **Suicide deaths and death rate of people aged 15–24 years (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (f)	*Aust* (g)
Number of suicide deaths of people aged 15–24 years									
2002	83	58	85	46	23	8	–	12	317
2003	78	64	64	39	27	6	9	13	300
2004	75	66	54	23	22	np	3	np	265
2005	66	61	67	30	37	9	5	15	290
2006	74	61	74	41	25	9	6	8	298
2007	54	74	81	46	19	4	3	21	300
2008	62	63	80	44	21	np	6	9	288
2009	63	60	63	47	21	8	np	11	276
2010	61	77	84	38	22	7	np	11	302
2011	58	62	82	52	36	10	5	16	321
2007–2011	298	336	390	227	119	29	14	68	1 487
Suicide death rate per 100 000 people aged 15–24 years (h), (i)									
2002	9.3	8.8	16.3	16.8	11.5	12.8	–	39.0	11.8
2003	8.7	9.6	12.0	14.0	13.3	9.4	17.4	42.7	10.9
2004	8.3	9.7	9.9	8.2	10.8	np	5.8	np	9.5
2005	7.2	8.9	11.9	10.5	17.9	13.9	9.7	48.1	10.2
2006	8.0	8.5	12.8	13.8	11.7	13.8	11.1	24.5	10.3
2007	5.7	10.1	13.6	15.1	8.8	4.6	3.6	62.6	10.1
2008	6.4	8.3	13.0	14.0	9.6	np	11.0	26.1	9.5
2009	6.5	7.8	10.3	14.5	9.6	12.1	7.0	30.8	9.1
2010	6.3	10.0	13.5	11.6	9.9	10.5	1.7	30.4	9.9
2011	6.0	8.1	13.1	15.7	16.3	15.1	8.5	45.1	10.5
2007–2011 (h)	6.2	8.8	12.7	14.0	10.8	9.4	6.3	38.1	9.8

(a) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(b) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. For further information, see Explanatory Notes 92-95 of Causes of Death, Australia, 2011 (cat. No. 3303.0).

(c) From 2006 data onwards, data cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Rates use the actual count and not the randomly assigned value. Cells with a zero value have not been affected by confidentialisation.

(d) All footnotes and caveats, including this notice, must remain attached to data at all times.

(e) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2009 (final), 2010 (revised), 2011 (preliminary). 'See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (cat. 3303.0) and Causes of Death Revisions, 2009 and 2010 in Causes of Death, Australia, 2011 (cat. no. 3303.0).

(f) Low population results in small variations in the number of suicides appearing as large changes across the single year rates.

(g) Includes 'Other Territories'.

Table 12A.62 **Suicide deaths and death rate of people aged 15–24 years (a), (b), (c), (d), (e)**

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

(h) Rate per 100 000 ERP at 30 June of the relevant single year or for five year average the mid-point year (2007–2011). 2007–2011 rate includes final 2007, 2008 and 2009 data, revised 2010 data and preliminary 2011 data.

(i) The ERPs used to derived these rates differ across years. For data up to 2005 the rates are derived using ERPs based on the 2001 Census. For data up to 2008 the rates are derived using ERPs based on the 2006 Census. For data from 2009 (and for the five year averages 2007–2011) the rates are derived using the ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

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

Source : ABS 2013, Causes of Death, Australia 2011, Cat. no. 3303.0, Canberra; ABS unpublished, *Causes of Death, Australia* , Cat. no. 3303.0.

Table 12A.63 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (k)	*ACT*	*NT*	*Aust*
Number of suicide deaths by area									
2003									
Capital city	379	372	220	164	137	27	35	20	1 354
Other urban	218	111	185	48	39	22	..	12	635
Rural	38	54	55	11	16	19	..	12	205
2004									
Capital city	358	345	194	141	125	29	26	22	1 240
Other urban	192	122	199	38	np	37	..	–	629
Rural	32	50	55	15	21	22	..	16	211
2005									
Capital city	342	332	179	142	173	29	35	23	1 255
Other urban	186	124	204	45	33	31	..	11	634
Rural	19	49	69	14	25	12	..	11	199
2006									
Capital city	340	330	187	157	133	28	32	14	1 221
Urban centres	129	64	171	19	..	20	..	..	403
Rural	108	91	136	69	47	24	..	19	494
2007									
Capital city	393	327	189	180	148	22	32	27	1 318
Urban centres	140	63	191	20	–	25	..	..	439
Rural	76	84	137	65	57	18	..	27	464
2008									
Capital city	362	374	216	219	125	27	36	23	1 382
Urban centres	127	76	215	27	..	26	..	..	471
Rural	131	95	122	54	50	20	..	15	487
2009									
Capital city	326	385	198	194	145	35	32	15	1 330
Urban centres	208	107	198	35	18	22	..	2	591
Rural	87	81	124	44	20	22	–	19	398
2010									
Capital city	348	345	219	227	151	33	41	20	1 384
Urban centres	191	100	225	40	17	15	..	3	592
Rural	97	88	131	45	26	16	–	21	424
2011									
Capital city	309	321	244	193	155	31	33	11	1 297
Urban centres	182	82	209	47	18	25	..	2	567
Rural	70	78	104	65	35	17	2	27	397
2007–2011									
Capital city	1 666	1 726	1 073	1 022	731	147	174	91	6 630
Urban centres	943	471	1 064	184	85	100	..	17	2 864

Table 12A.63 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (k)	*ACT*	*NT*	*Aust*
Rural	432	405	582	246	149	107	2	108	2 032
Suicide death rate per 100 000 people by area (l)									
2003									
Capital city	9.0	10.5	12.7	11.5	12.2	13.5	10.8	18.5	10.7
Other urban	10.0	10.9	11.7	12.6	16.8	12.0	..	26.1	11.3
Rural	12.2	16.0	11.3	7.9	9.2	20.4	..	26.9	12.9
Total	9.6	11.0	12.3	11.6	12.6	14.5	10.8	21.2	11.1
2004									
Capital city	8.5	9.6	10.9	9.7	11.1	14.3	8.0	20.1	9.7
Other urban	8.8	11.8	12.3	9.9	np	19.9	..	np	11.1
Rural	10.2	14.7	11.1	10.9	12.0	23.4	–	37.1	13.2
Total	8.7	10.5	11.7	9.8	11.6	18.2	8.0	25.5	10.4
2005									
Capital city	7.8	8.9	9.8	9.5	15.0	14.5	10.5	19.6	9.5
Other urban	8.6	12.2	12.3	11.6	14.8	17.0	..	22.2	11.2
Rural	6.5	14.7	13.9	9.6	13.5	12.9	..	27.2	12.5
Total	8.0	9.8	11.6	10.1	14.9	15.8	10.5	21.7	10.3
2006									
Capital city	7.8	8.8	10.3	10.5	11.5	13.8	9.7	np	9.2
Urban centres	10.0	11.0	12.8	np	..	10.9	..	..	11.3
Rural	9.3	11.7	16.6	20.9	11.5	23.8	..	np	13.2
Total	8.4	9.5	12.4	12.1	11.5	14.8	9.7	14.2	10.3
2007									
Capital city	8.8	8.3	10.1	11.4	12.5	10.7	9.1	22.8	9.6
Urban centres	10.8	10.7	12.9	10.3	..	13.9	..	..	11.7
Rural	6.4	10.9	17.0	18.9	13.8	18.5	..	29.1	12.5
Total	8.8	9.0	12.5	12.6	12.9	14.1	9.1	26.5	10.5
2008									
Capital city	8.3	9.5	11.5	14.0	10.6	13.3	10.3	20.2	10.2
Urban centres	9.8	12.9	14.4	13.9	..	13.6	..	..	12.6
Rural	10.9	11.9	15.2	16.5	12.6	22.4	..	np	13.2
Total	8.9	10.3	13.3	14.2	11.0	15.2	10.3	17.9	11.1
2009									
Capital city	7.8	9.6	9.9	11.2	11.9	17.0	8.9	np	9.6
Urban centres	11.1	13.8	12.3	13.7	np	13.9	..	np	12.2
Rural	9.2	12.0	17.5	15.6	8.1	14.7	–	np	12.8
Total	8.7	10.5	12.1	12.3	11.5	15.4	8.9	17.4	10.7
2010									
Capital city	8.2	8.5	10.8	13.1	11.9	16.5	11.4	17.7	9.9
Urban centres	9.9	12.6	14.0	15.3	np	np	..	np	12.1

Table 12A.63 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (k)	*ACT*	*NT*	*Aust*
Rural	10.0	12.5	17.7	15.5	10.0	np	–	21.1	13.4
Total	8.8	9.7	13.3	13.7	11.8	13.0	11.3	18.8	10.9
2011									
Capital city	7.1	7.7	11.8	10.6	12.4	14.4	9.3	np	9.0
Urban centres	9.4	10.0	12.6	17.2	np	15.9	..	np	11.4
Rural	7.3	11.0	14.4	22.0	13.7	np	np	30.7	12.8
Total	7.7	8.5	12.5	12.8	12.7	13.9	9.5	18.1	10.0
2007–2011									
Capital city	8.0	8.6	10.8	11.9	11.9	14.4	9.8	17.0	9.6
Urban centres	10.0	12.1	13.3	14.4	13.0	12.8	..	np	11.8
Rural	9.0	11.8	16.2	17.4	11.7	15.3	np	27.4	13.1
Total	8.6	9.5	12.7	13.0	12.0	14.1	9.9	20.1	10.6

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 92-95, *Causes of Death, Australia*, 2011 (Cat. no. 3303.0).

(b) The total for each state and territory includes deaths registered to that state but which had a usual address which was undefined, overseas, of no fixed abode or off-shore and migratory. Such 'special purpose' Statistical Area 2s are only included in the state total.

(c) The Australian total includes the 'Other Territories' — Jervis Bay, Christmas Island and the Cocos (Keeling) Islands.

(d) Data for 2009, 2010, 2011 and 2007–2011 were supplied this year based on a new method of obtaining Capital City, Urban Centre and Rural data (using SUA from ASGS). Data supplied in previous years also appear in this table (2003–2008), and for these years the geographical breakdown was based on a different method, using the ASGC (see footnotes g, h and i in this table). The total rates data for the 2007–2011 data differ to those in table 12A.60 due to the use of a different population. For years prior to 2008, death rates data are based on the previous year's ERP (i.e. 2007 ERP data for 2008 causes of death). This was necessary because of the change in sub-state statistical geography between years. However, for 2009, 2010, 2011 and 2007-2011 data, when using the ASGS the statistical geography between years is stable and therefore the same year's ERP data was used (that is, 2011 ERP for 2011 *Causes of Death* data).

(e) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised), 2011 (preliminary). See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in *Causes of Death, Australia, 2010* (Cat. no. 3303.0) and Causes of Death Revisions, 2009 and 2010 in *Causes of Death, Australia, 2011* (Cat. no. 3303.0).

(f) For data from 2006, cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Cells with a zero value have not been affected by confidentialisation.

Table 12A.63 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

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

(g) For single year data prior to 2006, the categories were as follows: 'capital city' comprises capital city statistical divisions; 'other urban' comprises centres with more than 20 000 people; 'rural' comprises all areas except capital cities and other urban. 'Other urban' comprises statistical local areas with 50 per cent or greater of their 2001 census enumerated population contained in urban centres, based on Australian Standard Geographical Classification (ASGC) 2001 boundaries. 'Rural' comprises statistical local areas with 50 per cent or greater of their 2001 census enumerated population contained in rural areas. Changes in the population within geographical areas may not be reflected in the rates provided. There is some risk that urban growth areas have been classified as rural as the geography was based on the population in those areas in 2001. Therefore, analysis of data should be undertaken with caution.

(h) For single year 2006, 2007 and 2008, the categories were derived as follows: 'capital cities' — comprising capital city statistical divisions, 'urban centres' — based on 'statistical districts' that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states/territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); 'rural' — balance of state, that is all areas other than capital cities and urban centres.

(i) For the single years 2009, 2010, 2011 and the five year sum and averages (2007–2011), the capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities are comprised of those Statistical Area 2s classified as capital cities. Urban centres are comprised of all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10,000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. For further information, see Cat. no. 1270.0.55.004 - Australian Statistical Geography Standard (ASGS): Volume 4 — Significant Urban Areas, Urban Centres and Localities, Section of State, July 2011. Some Significant Urban Areas cross state boundaries: Canberra – Queanbeyan (ACT/NSW); Albury – Wodonga (NSW/Vic); and Gold Coast – Tweed Heads (Qld/NSW). In these cases, deaths have been included in the Urban Centre category in the relevant state. The exception is Canberra - Queanbeyan: the Canberra portion forms the Capital City area for ACT, while the Queanbeyan portion has been included in the Urban Centres data for NSW.

(j) All footnotes and caveats, including this notice, must remain attached to data at all times.

(k) The three criteria for this data tend to distort the Tasmanian picture due to the low level of urbanisation.

(l) Age-standardised death rates per 100 000 are standardised to Australian 30 June 2001 population.

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

Source : ABS unpublished, *Causes of Death, Australia* , Cat. no. 3303.0.

Table 12A.64 Suicide deaths, by Indigenous status, 2007–2011 (a), (b), (c), (d), (e), (f)

	NSW	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (h)
Number									
Indigenous	83	np	168	130	32	np	np	116	529
Non-Indigenous	2 976	np	2 560	1 336	939	np	np	102	7 913
Total	3 059	np	2 728	1 466	971	np	np	218	8 442
Suicide rate per 100 000 (i), (j)									
Indigenous	13.3	np	21.5	35.9	21.7	np	np	29.0	22.3
Non-Indigenous (k)	8.4	np	11.9	12.1	11.6	np	np	14.4	10.3

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised), 2011 (preliminary). See Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (Cat. no. 3303.0). See also Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2009 and 2010 in Causes of Death, Australia, 2011 (Cat. no. 3303.0).

(b) See Explanatory Notes 81-99 in Causes of Death, Australia, 2011 (Cat. no. 3303.0) for further information on specific issues relating to 2011 data.

(c) Data are reported by jurisdiction of usual residence for NSW, Qld, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. See Explanatory Notes 68-76 of Causes of Death, Australia, 2011 (Cat. no. 3303.0) for further information on interpreting data relating to deaths of Indigenous persons.

(d) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. For further information, see Explanatory Notes 92-95 of Causes of Death, Australia, 2011 (Cat. no. 3303.0).

(e) Data are presented in a five-year aggregation (2007-2011) due to volatility of the small numbers involved.

(f) All footnotes and caveats, including this notice, must remain attached to data at all times.

(g) Care should be taken when interpreting deaths data for Queensland as they are affected by changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 were adjusted to minimise the impact of late registration of deaths on mortality indicators. See Retrospective deaths by Causes of Death, Queensland, 2010 (Technical Note) in Causes of Death, Australia, 2010 (cat. no. 3303.0) for a more detailed explanation.

(h) Total includes only the five jurisdictions for which data are available: NSW, Qld, WA, SA and NT.

(i) The Indigenous population denominator used for calculating death rates in this table is from ABS Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (cat. no. 3238.0), Series B. These are 2006-census-based population projections. The non-Indigenous denominator has been derived by subtracting the Indigenous population projections from the total persons 2006-census-based population estimates.

(j) Standardised death rate. Deaths per 100,000 of estimated mid-year population. See Glossary of Causes of Death, Australia, 2011 (cat. no. 3303.0) for further information.

(k) Includes deaths where Indigenous status was not stated.

np Not published.

Source: ABS unpublished, *Causes of Death, Australia,* Cat. no. 3303.0.

Table 12A.65 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People aged 16–64 years who are employed									
People with mental or behavioural problems (d), (e)	65.2 ± 7.7	59.4 ± 6.4	57.7 ± 6.7	65.0 ± 5.9	61.2 ± 7.2	51.6 ± 8.7	72.5 ± 8.2	63.2 ± 10.3	61.7 ± 3.1
People without mental or behavioural problems	78.7 ± 1.7	81.0 ± 1.8	81.8 ± 2.0	81.5 ± 1.9	78.7 ± 2.4	76.1 ± 2.9	85.6 ± 2.1	84.8 ± 3.1	80.3 ± 0.9
All people	76.6 ± 2.0	77.7 ± 1.8	77.7 ± 2.1	78.7 ± 1.9	76.0 ± 2.5	71.8 ± 3.2	83.4 ± 2.3	81.9 ± 3.1	77.4 ± 1.0
People aged 16–64 years who are unemployed									
People with mental or behavioural problems (d), (e)	4.3* ± 2.7	6.0* ± 3.2	9.6 ± 3.3	5.5* ± 3.6	7.0* ± 3.6	8.7* ± 4.6	2.9* ± 2.7	5.6** ± 7.0	6.3 ± 1.4
People without mental or behavioural problems	2.8 ± 0.9	2.8 ± 1.0	3.2 ± 1.0	2.8 ± 1.1	3.8 ± 1.3	3.6 ± 1.2	1.4* ± 0.9	2.0* ± 1.2	3.0 ± 0.4
All people	3.0 ± 0.8	3.4 ± 1.0	4.3 ± 1.0	3.3 ± 1.0	4.3 ± 1.2	4.4 ± 1.3	1.8* ± 0.9	2.4* ± 1.2	3.5 ± 0.4
People aged 16–64 years who are in the labour force									
People with mental or behavioural problems (d), (e)	69.5 ± 7.3	65.4 ± 6.5	67.3 ± 6.6	70.6 ± 6.2	68.2 ± 7.2	60.3 ± 8.7	75.4 ± 7.9	68.7 ± 11.2	68.0 ± 3.2
People without mental or behavioural problems	81.5 ± 1.6	83.8 ± 1.7	85.1 ± 1.8	84.4 ± 1.8	82.5 ± 2.1	79.6 ± 2.9	87.0 ± 2.0	86.8 ± 2.7	83.3 ± 0.9
All people	79.7 ± 1.8	81.1 ± 1.7	82.0 ± 1.8	81.9 ± 1.6	80.3 ± 2.2	76.2 ± 3.0	85.1 ± 2.0	84.3 ± 2.7	80.8 ± 0.9
People aged 16–64 years who are not in the labour force									
People with mental or behavioural problems (d), (e)	30.5 ± 7.3	34.6 ± 6.5	32.7 ± 6.6	29.4 ± 6.2	31.8 ± 7.2	39.7 ± 8.8	24.6 ± 7.9	31.3 ± 11.1	32.0 ± 3.2
People without mental or behavioural problems	18.5 ± 1.6	16.2 ± 1.7	14.9 ± 1.8	15.6 ± 1.8	17.5 ± 2.1	20.4 ± 2.9	13.0 ± 2.0	13.2 ± 2.7	16.7 ± 0.9
All people	20.3 ± 1.8	18.9 ± 1.7	18.0 ± 1.8	18.1 ± 1.6	19.7 ± 2.2	23.8 ± 3.0	14.9 ± 2.0	15.7 ± 2.7	19.2 ± 0.9

Table 12A.65 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent) (a), (b), (c)**

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

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) Numerators — number of people aged 16–64 years who are employed/unemployed/in the labour force/not in the labour force (by mental health status). Denominators — number of people aged 16–64 years in the population (by mental health status).

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Source : ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)* , Cat. no. 4364.0.

Table 12A.66 **Age standardised proportion of the population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2011-12 (per cent) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People with mental or behavioural problems (d), (e)	80.8 ± 9.1	80.4 ± 12.2	79.4 ± 8.3	70.9 ± 11.9	84.2 ± 10.2	74.8 ± 11.0	82.2 ± 12.3	55.2* ± 27.9	79.2 ± 4.2
People without mental or behavioural problems	93.2 ± 2.4	90.5 ± 2.7	87.0 ± 3.4	88.7 ± 3.7	85.5 ± 4.7	86.6 ± 4.8	97.2 ± 2.1	87.5 ± 5.4	90.2 ± 1.2
All people	91.8 ± 2.3	89.2 ± 2.8	85.8 ± 3.3	85.7 ± 4.0	85.4 ± 4.4	84.5 ± 4.3	94.9 ± 2.6	83.2 ± 6.1	88.7 ± 1.1

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) Numerators – number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status. Denominators – number of people aged 16–30 years, by mental health status.

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Source : ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)* , Cat. no. 4364.0.

Table 12A.67 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People aged 16–64 years who are employed									
People with mental or behavioural problems (d), (e)	59.3 ± 6.2	68.2 ± 5.8	65.4 ± 6.9	70.8 ± 7.5	48.6 ± 6.9	55.7 ± 8.3	75.4 ± 5.9	57.2 ± 23.7	63.8 ± 3.2
People without mental or behavioural problems	78.0 ± 2.3	79.8 ± 2.0	79.0 ± 2.3	83.1 ± 2.3	79.3 ± 2.6	74.2 ± 3.1	85.9 ± 2.1	83.4 ± 11.1	79.4 ± 1.0
All people	75.6 ± 2.2	78.4 ± 1.8	77.0 ± 2.2	81.3 ± 2.4	75.1 ± 2.6	71.6 ± 3.1	84.5 ± 2.0	83.9 ± 8.8	77.3 ± 1.0
People aged 16–64 years who are unemployed									
People with mental or behavioural problems (d), (e)	7.2 ± 3.3	4.2 ± 2.0	4.2* ± 3.2	3.1* ± 2.5	8.7 ± 3.5	6.6* ± 5.9	3.6* ± 3.5	–	5.3 ± 1.2
People without mental or behavioural problems	2.4 ± 0.8	2.3 ± 0.8	2.9 ± 1.1	2.3 ± 1.1	3.1 ± 1.0	4.1 ± 2.0	np	np	2.5 ± 0.4
All people	3.1 ± 0.8	2.5 ± 0.7	3.1 ± 1.0	2.4 ± 1.0	3.9 ± 1.0	4.3 ± 1.7	np	np	2.9 ± 0.4
People aged 16–64 years who are in the labour force									
People with mental or behavioural problems (d), (e)	66.4 ± 5.7	72.4 ± 6.1	69.6 ± 6.2	73.9 ± 7.2	57.3 ± 7.2	62.3 ± 9.5	79.1 ± 5.9	57.2 ± 23.7	69.1 ± 2.8
People without mental or behavioural problems	80.4 ± 2.2	82.1 ± 2.0	81.9 ± 2.1	85.4 ± 2.1	82.4 ± 2.2	78.3 ± 2.8	87.4 ± 2.0	85.1 ± 10.5	81.9 ± 1.0
All people	78.7 ± 2.1	80.9 ± 1.8	80.1 ± 1.9	83.7 ± 2.2	79.0 ± 2.1	75.9 ± 3.1	86.2 ± 1.9	85.6 ± 8.1	80.2 ± 1.0
People aged 16–64 years who are not in the labour force									
People with mental or behavioural problems (d), (e)	33.6 ± 5.7	27.6 ± 6.1	30.4 ± 6.2	26.1 ± 7.2	42.7 ± 7.2	37.7 ± 9.5	np	np	30.9 ± 2.8
People without mental or behavioural problems	19.6 ± 2.2	17.9 ± 2.0	18.1 ± 2.1	14.6 ± 2.1	17.6 ± 2.2	21.7 ± 2.8	np	np	18.1 ± 1.0
All people	21.3 ± 2.1	19.1 ± 1.8	19.9 ± 1.9	16.3 ± 2.2	21.0 ± 2.1	24.1 ± 3.1	13.8 ± 1.9	14.4* ± 8.1	19.8 ± 1.0

Table 12A.67 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent) (a), (b), (c)**

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

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) Numerators — number of people aged 16–64 years who are employed/unemployed/in the labour force/not in the labour force (by mental health status). Denominators — number of people aged 16–64 years in the population (by mental health status).

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

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

Source : ABS unpublished, *National Health Survey 2007-08* , Cat. no. 4364.0.

Table 12A.68 **Population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2007-08 (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People with a mental illness	78.1 ± 11.8	80.7 ± 10.0	83.6 ± 11.3	84.0 ± 10.6	66.1 ± 9.8	63.0 ± 17.5	88.3 ± 7.2	np	79.6 ± 5.7
People without a mental illness	89.8 ± 2.9	91.8 ± 2.7	86.9 ± 4.4	89.8 ± 3.9	89.1 ± 3.1	87.0 ± 5.1	94.7 ± 2.3	88.0 ± 24.9	89.7 ± 1.7
All people	88.4 ± 2.8	90.3 ± 2.6	86.4 ± 3.9	88.9 ± 4.0	85.9 ± 3.3	83.3 ± 6.0	93.8 ± 2.1	88.0 ± 24.9	88.4 ± 1.6

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) Numerators – number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status. Denominators – number of people aged 16–30 years, by mental health status.

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

np Not published.

Source: ABS unpublished, *2007-08 National Health Survey,* Cat. no. 4364.0.

Table 12A.69 **Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent) (a)**

	Employed (b)			*Unemployed* (b)	*In labour force*	*Not in the labour force*
	Full-time	*Part-time*	*Total*			
Any 12-month mental disorder (c)						
Anxiety disorders	59.9 ± 5.5	35.4 ± 5.3	95.3 ± 2.0	4.7 ± 2.0	71.0 ± 3.4	29.0 ± 3.4
Affective disorders	57.4 ± 6.8	32.6 ± 7.0	90.0 ± 4.3	10.0 ± 4.3	69.8 ± 4.3	30.2 ± 4.3
Substance use disorders	62.3 ± 6.9	30.8 ± 7.3	93.1 ± 3.3	6.9 ± 3.3	83.0 ± 5.4	17.0 ± 5.4
Any 12-month mental disorder (c), (d)	59.8 ± 4.7	34.7 ± 4.4	94.5 ± 1.7	5.5 ± 1.7	73.6 ± 2.7	26.4 ± 2.7
Lifetime mental disorder, with no 12-month symptoms (e)	68.7 ± 3.8	27.4 ± 3.7	96.1 ± 1.7	3.9 ± 1.7	80.9 ± 2.4	19.1 ± 2.4
No lifetime mental disorder (f)	63.7 ± 2.3	33.1 ± 2.3	96.8 ± 0.9	3.2 ± 0.9	78.4 ± 1.6	21.6 ± 1.6

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) The employed and unemployed rates are as a proportion of those in the labour force.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person may have more than one mental disorder. Therefore the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.70 **Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) (a), (b)**

	Studying (c)	*Not studying*			*Total*
		Employed	*Unemployed/Not in the labour force*	*Total*	
Any 12-month mental disorder (d)	42.0 ± 4.9	44.3 ± 5.0	13.7 ± 3.0	58.0 ± 4.9	100.0
Lifetime mental disorder, with no 12-month symptoms (e)	29.5 ± 6.6	55.9 ± 7.3	np	70.5 ± 6.6	100.0
No lifetime mental disorder (f)	51.6 ± 3.8	39.2 ± 3.3	9.2 ± 2.2	48.4 ± 3.8	100.0

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) Includes people studying full-time and part-time and people still at school.

(d) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.71 **Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) (a)**

	Employed (b)	*Unemployed* (b)	*Not in the labour force*
Any 12-month mental disorder (c)	92.1 ± 3.2	7.9 ± 3.2	19.2 ± 3.4
Lifetime mental disorder, with no 12-month symptoms (d)	92.2 ± 9.0	np	17.6 ± 6.2
No lifetime mental disorder (e)	93.6 ± 1.9	6.4 ± 1.9	22.1 ± 2.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). Estimates with RSEs greater than 25 per cent are not published.

(b) The employed and unemployed rates are as a proportion of those in the labour force.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(e) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source : ABS unpublished, *2007 Survey of Mental Health and Wellbeing* , Cat. no. 4326.0.

Table 12A.72 **Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (f)	*Aust* (d)
2007-08									
Group A: People discharged from hospital (g)									
Significant improvement	75.6	76.1	71.3	74.8	66.7	72.2	np	np	73.3
No significant change	20.2	20.5	22.7	20.4	29.0	21.6	np	np	22.1
Significant deterioration	4.2	3.5	6.0	4.8	4.4	6.2	np	np	4.6
Group B: People discharged from community care (h)									
Significant improvement	55.6	53.6	55.1	47.7	47.4	47.0	np	np	53.3
No significant change	42.0	42.5	38.9	44.7	47.0	46.4	np	np	41.7
Significant deterioration	2.4	3.9	6.0	7.6	5.6	6.6	np	np	5.0
Group C: People in ongoing community care (i)									
Significant improvement	24.5	27.9	29.3	28.5	24.9	27.7	np	23.3	27.1
No significant change	60.7	58.0	52.2	56.4	58.7	51.8	np	56.4	56.8
Significant deterioration	14.8	14.0	18.5	15.1	16.4	20.6	np	20.3	16.1
2008-09									
Group A: People discharged from hospital (g)									
Significant improvement	74.7	76.2	73.9	75.8	70.3	76.9	np	np	74.7
No significant change	21.2	20.1	21.2	20.2	25.4	20.2	np	np	21.2
Significant deterioration	4.0	3.7	4.9	4.0	4.4	2.8	np	np	4.0
Group B: People discharged from community care (h)									
Significant improvement	55.9	50.3	57.8	52.9	46.3	45.9	np	np	52.6
No significant change	41.6	44.2	36.3	39.8	48.9	46.9	np	np	42.1
Significant deterioration	2.6	5.5	5.9	7.2	4.8	7.2	np	np	5.3
Group C: People in ongoing community care (i)									
Significant improvement	23.6	29.4	29.4	25.6	27.1	27.2	np	27.2	27.3
No significant change	61.9	56.2	53.3	58.7	57.7	58.0	np	49.9	57.2
Significant deterioration	14.5	14.4	17.3	15.7	15.2	14.7	np	23.0	15.5
2009-10									
Group A: People discharged from hospital (g)									
Significant improvement	68.7	73.5	74.1	72.9	70.0	77.2	np	np	71.7
No significant change	26.2	22.6	21.4	22.5	26.0	19.9	np	np	23.9
Significant deterioration	5.1	3.9	4.5	4.6	4.0	2.8	np	np	4.4
Group B: People discharged from community care (h)									
Significant improvement	54.6	50.0	58.3	52.7	47.7	47.4	np	np	52.0
No significant change	42.1	43.8	35.7	42.3	48.2	48.5	np	np	42.6
Significant deterioration	3.3	6.1	5.9	5.0	4.0	4.1	np	np	5.4
Group C: People in ongoing community care (i)									
Significant improvement	22.6	28.3	31.9	27.2	25.2	27.4	18.5	25.5	27.3
No significant change	61.8	56.8	52.7	58.2	58.7	56.6	68.7	52.0	57.4
Significant deterioration	15.5	14.9	15.4	14.5	16.1	15.9	12.8	22.5	15.3

Table 12A.72 **Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (f)	*Aust* (d)
2010-11									
Group A: People discharged from hospital (g)									
Significant improvement	69.4	73.5	73.8	74.7	72.2	75.6	np	77.0	72.5
No significant change	25.1	22.8	20.1	21.6	24.1	20.1	np	19.5	23.1
Significant deterioration	5.4	3.7	6.2	3.7	3.8	4.3	np	3.5	4.5
Group B: People discharged from community care (h)									
Significant improvement	56.6	45.5	59.2	51.7	46.0	52.7	np	np	50.0
No significant change	40.5	43.8	35.5	42.4	49.6	43.9	np	np	42.2
Significant deterioration	2.9	10.7	5.3	5.8	4.3	3.4	np	np	7.7
Group C: People in ongoing community care (i)									
Significant improvement	22.8	27.4	30.6	24.7	24.6	25.9	18.7	28.5	26.4
No significant change	62.2	57.3	53.5	59.3	61.1	57.3	67.8	50.3	58.1
Significant deterioration	15.0	15.3	15.9	16.0	14.3	16.8	13.5	21.2	15.4
2011-12									
Group A: People discharged from hospital (g)									
Significant improvement	68.1	na	73.4	72.1	71.3	73.0	np	77.6	70.8
No significant change	27.0	na	19.7	22.8	24.7	22.1	np	16.1	24.0
Significant deterioration	4.9	na	6.9	5.1	4.0	4.9	np	6.3	5.2
Group B: People discharged from community care (h)									
Significant improvement	54.3	na	54.5	45.7	47.1	43.2	np	np	51.5
No significant change	42.4	na	39.5	48.7	48.8	51.7	np	np	43.7
Significant deterioration	3.3	na	5.9	5.6	4.0	5.1	np	np	4.8
Group C: People in ongoing community care (i)									
Significant improvement	23.0	na	30.4	24.6	23.7	27.5	29.0	27.4	26.0
No significant change	61.1	na	54.0	60.4	60.9	50.8	56.5	53.5	58.3
Significant deterioration	15.8	na	15.6	15.0	15.3	21.6	14.5	19.2	15.7

(a) These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. Assessment of clinical outcomes is based on the changes reported in a consumer's score on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or in the case of children and adolescent consumers, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Developed originally in England in the 1990s, these ratings scales comprise standard items that are rated by a clinician to measure the severity of the consumer's symptoms or disability across a range of domains (for example, depressed mood, hallucinations, substance use, suicidality, overactivity, activities of daily living, cognitive impairment). The HoNOS/HoNOSCA form part of small suite of standardised rating scales used to monitor outcomes across state and territory public sector mental health services and private hospitals with a specialised psychiatric unit.
To be considered valid, Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) data needs to be completed correctly (a specified minimum number of items completed) and have a "matching pair" — that is, a beginning and end rating are needed to enable an outcome score to be determined.

Table 12A.72 **Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)**

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

(b) Proportions may not add to 100 per cent due to rounding.

(c) For all consumer groups, outcome scores for each episode are classified as either 'significant improvement', 'significant deterioration or 'no significant change', based on Effect Size. Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre- score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Based on this rule, a medium effect size of 0.5 was used to assign outcome scores to the three outcome categories. Thus individual episodes were classified as either: 'significant improvement' if the Effect Size index was greater than or equal to positive 0.5; 'significant deterioration' if the Effect Size index was less than or equal to negative 0.5; or 'no change' if the index was between -0.5 and 0.5.

(d) Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. All national averages for 2011-12 exclude Victoria.

(e) Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12.

(f) Some data for the ACT and the NT are np (not published) due to insufficient observations. The number of observations of consumer outcomes for some care types is too low to publish because conclusions based on such low numbers are known to have high levels of unreliability. For the purposes of this indicator, the threshold for the minimum number of observations to be reached was set at 200.

(g) Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.

(h) Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.

(i) Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.

np Not published.

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

Table 12A.73 **Deflators used to calculate real State and Territory mental health expenditure (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
2005-06	85.2	85.9	80.9	82.2	83.2	84.6	83.8	85.0
2006-07	88.9	88.6	84.7	85.3	86.3	88.1	86.9	88.3
2007-08	91.5	90.9	87.7	88.1	89.4	90.7	89.9	89.9
2008-09	93.7	93.8	91.1	91.6	92.9	93.4	93.2	93.5
2009-10	96.8	96.8	95.3	95.5	96.5	96.6	96.6	96.4
2010-11	97.8	98.3	97.4	96.5	97.4	97.6	97.5	97.4
2011-12	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The deflators used are the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services.

Source: ABS unpublished, *Australian National Accounts: National Income, Expenditure and Product,* Cat. no. 5204.0.

Table 12A.74 Deflator used to calculate real Australian Government mental health expenditure (a)

	Aus Gov
2005-06	83.9
2006-07	87.3
2007-08	90.0
2008-09	92.9
2009-10	96.3
2010-11	97.6
2011-12	100.0

(a) The deflators used are the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services.

Source: ABS unpublished, *Australian National Accounts: National Income, Expenditure and Product*, Cat. no. 5204.0.

Table 12A.75 **Estimated resident populations used in mental health per head calculations (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
2005-06	6 718 023	5 023 203	3 964 175	2 029 936	1 544 852	488 098	333 505	207 385	20 311 543
2006-07	6 786 160	5 103 965	4 055 845	2 076 867	1 561 300	491 515	338 381	211 029	20 627 547
2007-08	6 883 852	5 199 503	4 159 990	2 135 006	1 578 489	495 858	344 176	216 618	21 016 121
2008-09	7 001 782	5 313 285	4 275 551	2 208 928	1 597 880	501 774	351 101	222 526	21 475 625
2009-10	7 101 504	5 419 249	4 367 454	2 263 747	1 618 578	506 461	357 859	227 783	21 865 623
2010-11	7 179 891	5 495 711	4 436 882	2 319 063	1 632 482	510 219	364 833	230 299	22 172 469
2011-12	7 247 669	5 574 455	4 513 009	2 387 232	1 645 040	511 718	370 729	232 365	22 485 340

(a) The data represent the mid-point of the relevant financial year. For 2011-12 data, the mid-point is 31 December 2011. The Estimated Resident Populations (ERPs) up to 2010-11 have been revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 (2011-12) are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

(b) Includes other territories.

Source : ABS (various issues), *Australian Demographic Statistics, December (various years)* , Cat. no. 3101.0.

Data quality information — Mental health management, chapter 12

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 Mental health management chapter. DQI for additional indicators will be progressively introduced in future reports.

Where the Report on Government Services (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:

New client index

DQI for this indicator has been sourced from the Australian Government (Department of Health) and State and Territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	New client index
Measure (computation)	Description: Proportion of total clients under the care of State or Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period. Numerator: Number of new clients — clients who had not been seen by a public mental health service in the five years preceding the initial contact with a service in the relevant reference period. Denominator: Number of total clients under the care of State or Territory specialised public mental health services in the relevant reference period. Computation: Expressed as a proportion: (Numerator ÷ Denominator)*100.
Data source/s	Department of Health using data provided by State and Territory governments from the community mental health care, residential mental health and admitted patients mental health collections.

Data Quality Framework Dimensions

Institutional environment	Department of Health calculated the indicator based on data supplied by state and territory health authorities. The State and Territory health authorities provide these data according to specifications agreed under the *National Key Performance Indicators for Australian Public Mental Health Services*. State and Territory health authorities receive these data from specialised mental health organisations/units in psychiatric and acute hospitals, community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.
Relevance	Estimates are based on all 'in-scope' clients (new and total) who are in receipt of services from state and territory public psychiatric inpatient units, residential units and community mental health services. New clients are those who have not been seen by a public specialised mental health service in the five years preceding the initial contact with a service in the relevant reference period. A consumer is not considered to be 'new' client if they present with a new condition but have previously received treatment for other conditions. Data for all years reflect full financial year activity — that is, all in scope clients from public specialised mental health services between the period 1 July and

30 June for each financial year.

Only state and territory specialised public mental health services are included. New clients may have been treated in the preceding five years outside the state/territory specialised public mental health system in the primary mental health care or the specialist private mental health sector.

States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems. SA indicated that the data submitted were not based on unique patient identifier or data matching approaches.

For NSW, residential clients are not included because their data is manually collected without a Statewide Unique Patient Identifier (SUPI) assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible.

For WA, the matching of mental health community contacts to inpatient episodes is done for 2011-12 between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result. Data before 2011-12 are based on data submitted for the National Minimum Data Set (NMDS) and have not been revised.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

All states except Victoria count triage and referral patients, that is those who are assessed and referred on.

For Tasmania in 2009-10, the new and total client count includes Mental Health Service Helpline contacts with individuals who received a one off contact through the 24 hour telephone helpline. Industrial action in Tasmania in 2011-12 has limited the quality and quantity of community data.

Timeliness

State and territory governments provide the data to Department of Health for national collation, approximately twelve months after the reference period. The reference period for the latest data is 2011-12.

Accuracy

State and territory governments are primarily responsible for the quality of the data they provide. Department of Health analyses the data, but cannot independently verify them.

Data are subject to ongoing historical validation. Due to this ongoing validation, 2009-10 and 2010-11 data might differ from previous reports.

States and territories differ in their capacity to accurately track clients across organisations or service types, due to the lack of unique patient identifiers or data matching systems. This has led to over/undercounting of clients in some jurisdictions.

- NSW has implemented a SUPI for mental health care. The identification of prior contacts for mental health clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level for 2009-10, 2010-11 and 2011-12 is 99.8 per cent. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which

may include some duplicates of those who attended multiple facilities).

- For NSW, residential clients are not included because their data is manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW mental health residential is very small which will have minimal effect on the final result (total residential MH clients in 2010-11 is 185 with 59 potential new clients and 243 total residential MH clients with 130 potential new clients in 2011-12).
- For SA, the client counts are not unique: they are an aggregation of three separate databases with no linkage between them. The impact on the result should be minimal due to populations being relatively stable within the three respective catchments.
- For WA, the matching of mental health community contacts to inpatient episodes for 2011-12 is done between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result.
- For Tasmania, the information has been extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients.

For NSW, one large Local Health District has incomplete community data (June 2012 data is missing) in the NSW State Health Information Exchange in 2011-12.

Coherence

Data are reported for each year from 2009-10 to 2011-12. There has been no major change to the methodology used to collect the data across years except as outlined below for WA.

The Australian total for 2011-12 excludes Victoria and is not comparable to previous years.

Jurisdictions can differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.

States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the accuracy dimension).

For WA, data before 2011-12 are based on data submitted for the NMDS and have not been revised. Data from 2011-12 are based on a different method (see relevance dimension).

Accessibility

Data are also available for this indicator in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Interpretability

Information for understanding this indicator is available in:

- the *Key* Performance *Indicators for Australian Public Mental Health Services, Second Edition* at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf

- forthcoming in 2013 in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems.
- Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.
- Industrial action in Tasmania in 2011-12 has limited the available data quality and quantity of community data.

Mental health service use by special needs groups and total population

DQI 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 AIHW) with additional Steering Committee comments.

Indicator definition and description

Elements	Equity — Access and Effectiveness — Access
Indicators	Mental health service use by special needs groups Mental health service use by total population
Measure (computation)	The *numerator* is the number of people receiving mental health services, separately for three service types. The *denominator* is the Estimated Resident Population (ERP) as at 30 June 2011. *Calculation* is 100 × (Numerator ÷ Denominator), presented as a percentage 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. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so Indigenous disaggregations were standardised to 64 years with ages over 64 years combined. These are calculated separately for public, private, Medicare Benefits Scheme- and Department of Veterans' Affairs (DVA)-funded services.
Data source/s	*Numerators*: For Public data: State/Territory community mental health care data. For Private data: Private Mental Health Alliance (PMHA) Centralised Data Management Service (CDMS) data. For Medicare Benefits Schedule (MBS) ata: Australian Government Department of Health (Health) MBS Statistics. For DVA data: Australian Government DVA Statistical Services and Nominal Rolls using the Departmental Management Information System These data are known as Treatment Account System (TAS) data. *Denominator*: Australian Bureau of Statistics (ABS) ERP as at 30 June 2011. ABS Indigenous Experimental Estimates and Projections Series B.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) prepared the denominator and calculated the indicator based on numerators supplied by other data providers. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. Numerators for this indicator were prepared by State and Territory health authorities, the PMHA, Health and DVA and quality-assessed by the

AIHW.

The AIHW drafted the initial data quality statement. The statement was finalised by AIHW following input from State and Territory health authorities, PMHA, Health and DVA. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator.

Public data

The State and Territory health authorities receive these data from public sector community mental health services. States and territories use these data for service planning, monitoring and internal and public reporting.

Private data

The PMHA's Centralised Data Management Service provided data submitted by private hospitals with psychiatric beds. The data are used by hospitals for activities such as quality improvement.

Health MBS and DVA TAS data

The Department of Human Services (DHS) processes claims made under the *Medicare Australia Act 1973*. These data are then regularly provided to Health. DHS also processes claims for DVA Treatment Card holders made through the MBS under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Medicare Australia Act 1973*. All claiming data is regularly provided to DVA as per the Memorandum of Understanding between DHS and DVA.

Relevance

Estimates are based on counts of individuals receiving care within the year, by each service type, where each individual is generally counted once regardless of the number of services received. Persons can receive services of more than one type within the year; a count of persons receiving services regardless of type is not available.

A number of persons receiving mental health treatment are not captured in these data sources. These include:

- individuals receiving only admitted and/or residential services from State and Territory public sector specialised mental health services.
- individuals receiving mental health services (other than as admitted patients in private hospitals) funded through other third party funders (for example, transport accident insurers, workers compensation insurers) or out of pocket sources.

There is likely to be considerable overlap between the Health MBS and DVA TAS data and private data, as most patients accessing private hospital services would also access MBS services.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

Public data

Person counts for State and Territory mental health services are counts of persons receiving one or more service contacts provided by public sector community mental health services. SA submitted data that were not based on unique patient identifier or data matching approaches.

Private data

Private hospital estimates are counts of individuals receiving admitted patient specialist psychiatric care in private hospitals.

Health MBS and DVA TAS data

Data are counts of individuals receiving mental health-specific MBS services for which DHS has processed a claim.

Analyses by state/territory, remoteness and socioeconomic status are based on postcode of residence of the client as recorded by DHS at the date of last service processed 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.

DVA clients comprised less than 2 per cent of people receiving Australian Government (Medicare Benefits Scheme- and DVA-funded) clinical mental health services.

Timeliness

The reference periods for these data are 2007-08, 2008-09, 2009-10, 2010-11 and 2011-12.

Accuracy

Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider).

Public data

State and Territory jurisdictions differ in their capacity to provide accurate estimates of person receiving services (see above). Additionally, jurisdictions differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.

Indigenous status data should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. Indigenous status was missing or not reported for more than 11 per cent of all clients.

Private data

Not all private psychiatric hospitals are included in the PMHA's CDMS.

In 2011-12, those that are included account for approximately 98 per cent of all activity in the sector. The data provided are an estimate of overall activity.

Actual counts are multiplied by a factor that accounts for the proportion of data missing from the CDMS collection. That adjustment is performed at the level of State and Territory and also financial year, since non-participation rates varied from state to state and financial year.

Indigenous status information is not collected for these data.

Health MBS and DVA TAS data

As with any administrative system a small degree of error may be present in the data captured.

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.

The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.

People who received more than one type of service are counted once only in the calculations for this indicator.

Health MBS data presented by Indigenous status have been adjusted for under-identification in the DHS Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. The methodology for this adjustment was developed and verified by the AIHW and Health for assessment of MBS and Pharmaceutical Benefits Scheme (PBS) service use and expenditure for Indigenous Australians. For an explanation of the methodology, see *Expenditure on health for Aboriginal and Torres Strait Islander people 2006-07.*

DVA TAS data are not available by Indigenous status.

Coherence

Following the 2011 Census of Population of Housing, the ABS has rebased the Australian population back to 1991. This rebasing had a significant impact on the population time series, therefore data have been resupplied for previous years using the rebased ERP. The exception is for data presented by Indigenous status. Rebased Indigenous population data are not yet available, thus data presented by Indigenous status uses 2006 based ERP.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as Remoteness Areas (RA) 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2007-08 through to 2010-11 reported by remoteness are reported for RA 2006. Data for 2011-12 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2010-11 and previous years are not directly comparable to remoteness data for 2011-12 and subsequent years.

Data for 2007-08 through to 2010-11 reported for SEIFA deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011 to be a break in the series, therefore SEIFA data for 2011-12 are not directly comparable with SEIFA data from previous reporting years.

Public data

There has been no major change to the methodology used to collect the data in 2011-12 for the majority of jurisdictions, therefore data is

comparable across years.

However, one large Local Health District in NSW has incomplete data, so 2011-12 data will be updated for the 2015 report.

For public sector community mental health services, Victorian data is unavailable (for 2011-12) due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data. Australian totals for 2011-12 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 should not be compared to previous years.

In past years there has been variation in the underlying concept used to allocate remoteness and socioeconomic status across jurisdictions (i.e. location of service provider, location of client or a combination of both). In addition, the underlying concordances used by jurisdictions to allocate remoteness may vary. Since 2009-10, remoteness and socioeconomic status have been allocated using the SLA of the client at last contact. For 2011-12 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

- NSW and the NT used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.

Comparisons over time for remoteness and socioeconomic status should therefore be interpreted with caution.

Private data

There has been no change to the methodology used to collect the data in 2011-12. Therefore, the data are comparable to previous reporting periods.

Health MBS and DVA TAS data

The same methodology to attribute demographic information to the data has been used in 2011-12 as in previous reporting periods.

For 2010-11 and previous years, remoteness and socioeconomic status for both Health MBS and DVA TAS data were allocated using a postcode concordance. For 2011-12, DVA TAS data were allocated to remoteness using geocoding, and to socioeconomic status using an SLA concordance.

MBS items 81325 and 81355 were added from 1 November 2008. These items relate to mental health or psychological services provided to a person who identified as being of Aboriginal or Torres Strait Islander descent.

On 1 January 2010, a new MBS item (2702) was introduced for patients of GPs who have not undertaken mental health skills training. Changes have been made to the existing MBS item 2710 to allow patients of GPs who have undertaken mental health skills training to access a higher rebate. Both of these items relate to the preparation of a General Practitioner (GP) mental health treatment plan.

On 1 November 2011, MBS items 2715 and 2717 were introduced to cover preparation of a GP mental health treatment plan by a GP who has undertaken mental health skills training. At the same time MBS items 2700 and 2701 were introduced to cover preparation of a GP mental health treatment plan by a GP who has not undertaken mental health skills training.

MBS item 2719 existed from 1 November 2011 to 30 April 2012.

From 2011-12 MBS item 20104 is included to align with other national indicators.

Caution should be taken when interpreting Indigenous rates over time. All other data can be meaningfully compared across reference periods.

Other publications

The AIHW publication series *Mental health services in Australia* contains data that is comparable in coverage (using different MBS item splits) and includes a summary of MBS mental health-related items.

The data used in this indicator is also published in the COAG National Action Plan on Mental Health — final progress report covering implementation to 2010-11. There may be some differences between the data published in these two sources as:

- rates may be calculated using different ERPs other than the June ERPs used for this indicator,
- MBS numbers are extracted using a different methodology. *The COAG National Action Plan on Mental Health — final progress report covering implementation to 2010-11* counts a patient in each state they resided in during the reference period but only once in the total whereas this indicator counts a patient in only one State/Territory.

The indicator specifications and analysis methodology used for this report are equivalent to the *Healthcare 2011-12: comparing performance across Australia.*

Accessibility

MBS statistics are available at:

www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1

www.medicareaustralia.gov.au/statistics/mbs_item.shtml

Disaggregation of MBS data by SEIFA is not publicly available elsewhere.

Interpretability

Information is available for MBS data from:

www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee also notes the following issues:

- This is a proxy measure of access to appropriate care.
- Data for 2011-12 are not available for Victoria due to significantly reduced collection rates arising from industrial action during the period. This affects all data collected in community-based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. No substitute or proxy data have been included at the jurisdictional level or to fill the gap in calculation of the national results.
- Data have been provided according to the State or Territory of service, but at the sub-state level (remoteness area) have been classified by the client's place of usual residence. For example, a person who usually resides in a very remote area of the NT and is treated by a service in a major city in Victoria would be classified at the sub-state level as a very remote area of Victoria (even though Victoria itself has no very remote areas under the ABS remoteness classification). Further work is required

to determine whether geographic location for this indicator should be based on usual residence of the client (used for most indicators) or location of the service.

- Disaggregation of this indicator by Indigenous status for private patients and those recorded in DVA data is a priority.
- Data linkage work is underway to obtain comprehensive and consistent data on people with mental illness across the full scope of service types.

Primary mental health care for children and young people

DQI for this indicator has been sourced from the Australian Government (Department of Health) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Primary mental health care for children and young people
Measure (computation)	Description: Proportion of young people aged under 25 years who received a primary mental health care services subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years). Numerator: Number of young people aged under 25 years who received a primary mental health care services subsidised through the MBS and by age cohort (pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years). Denominator: Estimated Resident Population aged under 25 years and by age cohort (pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years). Computation: Expressed as a proportion: (Numerator/s ÷ Denominator/s)*100. Calculated for all young people (aged under 25 years) and separately by age cohort.
Data source/s	*Numerator*: Department of Health MBS Statistics data. *Denominator*: ABS *Australian Demographic Statistics*.

Data Quality Framework Dimensions

Institutional environment	MBS 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 Department of Health. 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 at www.abs.gov.au.
Relevance	Includes primary mental health care covered by the MBS only. Other relevant forms of primary mental health care for young people are not incorporated due to a lack of available data, including community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses,

university and Technical and Further Education counselling services and a component of the mental health care provided by state/territory specialised public mental health services.

MBS data are counts of young people receiving mental health-specific MBS services for which DHS has processed a claim, excluding those for psychiatrists. The relevant MBS items are as follows:

- GP and other services include MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727.
- Clinical psychologist services include MBS items 80000, 80005, 80010, 80015, 80020.
- Other allied health services include MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.

Analyses by state/territory of MBS data is based on postcode of residence of the client as recorded by DHS at the date of last service processed 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. The allocation to the state/territory uses a concordance and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.

MBS data are based on the date the claim was processed. Age of the patient is based on age at 30 June of the reference period, which may differ from their age at the date of the service.

The population data represent the mid-point of the relevant financial year. For 2012-13 data, the mid-point is December 2012. All ERP data are based on the *2011 Census of Population and Housing* (EPRs for 2010-11 have been rebased).

Timeliness

MBS claims data are available within 14 days of the end of a month. The reference period for the latest data is 2012-13.

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.

The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.

People who received more than one type of service are counted once only in the calculations for this indicator.

Coherence

Estimates are compiled the same way across jurisdictions and over time.

The MBS items included can change over time, for example 2700, 2701, 2715 and 2719 were included for the latest year of data.

Proportions in the 2014 RoGS for 2010-11 may differ to those reported in previous reports as the ERPs have been rebased to the 2011 Census.

Accessibility MBS statistics are available at:

- www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
- www.medicareaustralia.gov.au/statistics/mbs_item.shtml

Interpretability Information for understanding this indicator is available in the:

- *Fourth national mental health plan: measurement strategy*, www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub-plan4-meas
- National mental health reports www.health.gov.au/internet /main/publishing.nsf/Content/mental-data.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- Not all relevant forms of primary mental health care for young people are not incorporated due to a lack of available data.
- Annual data are available. The most recent data available are for 2012-13.
- The data are consistent and comparable over time.

Services reviewed against the National Standards

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Services reviewed against the *National Standards for Mental Health Services (NSMHS)*
Measure (computation)	Description: Proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS. Numerator/s: Expenditure on service units, by assessed level (level 1, level 2, level 3, level 4). Denominator: Total expenditure on service units in scope for the NSMHS. Computation: Expressed as a proportion: (Numerator/s ÷ Denominator)*100. Calculated separately by assessed level.
Data source/s	AIHW from the Mental Health Establishments (MHE) NMDS

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.

The NSMHS were first introduced in 1996 and were adopted by all public specialised mental health services and private psychiatric hospitals. Most non-government community mental health services found it difficult to apply many of the NSMHS to the context within which they operated[1]. Revised standards were endorsed in September 2010 and these are designed to be applied across the broad range of mental health services (where mental health is the main focus of care), including non-government organisations and private office based services (such as GPs). Coverage of all publicly funded mental health services to which the revised NSMHS now apply would improve the relevance of these data to measurement of this indicator for future reports.

Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all NSMHS.
- *Services at level 2* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all NSMHS.
- *Services at level 3* — the number of specialised public mental health services that are (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3, except those for whom the NSMHS do not apply — code 8 in the MHE NMDS.

Assessments against the NSMHS are based on periodic reviews, usually conducted every three to five years. Services assigned a level 1 for the 2011-12 data may have been assessed at this level in a review that was conducted in 2005-06 and therefore this assessed level may not necessary reflect the quality of the actual services delivered in the 2011-12 reference period, nor the extent to which the NSMHS are used for ongoing quality improvement.

The data element '*National standards for mental health service review status'* is collected at the statistical unit of service unit (admitted patient, ambulatory and residential). Specialised mental health service units relate to units in public psychiatric hospitals, designated psychiatric units in acute care hospitals, public community-based ambulatory and residential services and publicly funded private hospital and non-government residential service units. Non-government operated community residential service units are excluded from the analysis. Aged care community residential services in receipt of funding under the *Aged Care Act 1997* are subject to residential aged care reporting and service standard requirements and are therefore excluded from the NSMHS analysis. Ambulatory services managed by non-government organisations are not defined as statistical units for the MHE NMDS and therefore data on this element are not available for these service types.

Timeliness State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy Coverage of the MHE NMDS in-scope services for the '*National standards for*

1 DoHA 2010, *National Standards for Mental Health Services: Implementation guidelines for Non-government Community Services,* Australian Government, Canberra.

mental health service review status' data element is complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

Coherence

Data are reported for each year from 2005-06 to 2011-12.

The data reported from 2005-06 to 2009-10 all relate to specialised mental health services assessed against the old NSMHS. Data from 2010-11 will progressively include larger proportions of services assessed against the revised NSMHS that were endorsed in September 2010.

External accreditation agencies can undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised mental health service units. Accreditation of the parent organisation does not currently require an individual service unit (for example, a community-based ambulatory service managed by the hospital) to be assessed separately against the NSMHS. Assessment against the NSMHS for a service unit must be specifically requested and involves a separate review process. This leads to variation across states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some states and territories, if an organisation with multiple service units is assessed at a particular level all the organisation's units are 'counted' at that assessment level. In other jurisdictions, assessments are conducted at the service unit level and the level assigned may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.

The external accreditation agencies such as Australian Council on Healthcare Standards (ACHS) and Quality Improvement Council (QIC) can use differing review methods. In addition, external review is a process of negotiation between a mental health service organisation and the accrediting agency. There may be differences in the extent to which all or some of the NSMHS are considered to be applicable to individual service units.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial

publication

- National Mental Health Reports.

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell sizes with small numbers may be suppressed.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- There is variation across and within states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. This may affect the comparability of the results across jurisdictions.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Services provided in an appropriate setting

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Services provided in an appropriate setting
Measure (computation)	Description: Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services. Numerator: Governments' recurrent expenditure on community-based specialised mental health services. Community-based recurrent expenditure for this indicator includes expenditure on ambulatory care, non-government organisations and adult residential services. Aged residential care expenditure is excluded. Denominator: Total government recurrent expenditure on specialised mental health services, excluding aged residential care expenditure and unapportioned indirect expenditure. Computation: Expressed as a proportion: (Numerator/Denominator)*100.
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS. The data elements on direct and indirect recurrent expenditure and grants to

non-government organisations are collected at levels in the hierarchy used to capture jurisdiction-wide information on mental health services (state/territory, region, organisation and service units). Non-government grants are collected at the regional and state and territory levels. Direct recurrent expenditure comprises salaries and wages and non-salary expenditure, and is collected at the individual service unit level. Indirect recurrent expenditure is additional expenditure associated with the provision of mental health services not incurred or reported at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The estimates do not include residual indirect expenditure incurred at the state and territory level or that unapportioned from the organisational or regional level.

Certain categories of expenditure collected under the MHE NMDS are excluded to derive this indicator and improve the relevance of these data to its measurement.

- Community aged residential care expenditure is excluded from community-based expenditure to improve comparability across states and territories. A significant share of jurisdictions do not have this service type.
- Indirect expenditure at the State and Territory level and indirect expenditure at the organisational or regional level that cannot be apportioned to individual services is also excluded. This indicator is seeking to measure the service mix by showing the proportion of expenditure that is community-based relative to the other categories of service expenditure (admitted patients) and not relative to total expenditure, which includes indirect expenditure at the State or Territory level on areas such as program administration and property leasing costs.

Government expenditure on mental health services that are out of scope of the MHE NMDS, such as Medicare-subsidises for community-based services provided by GPs or the personal helpers and mentors program is not included in the analysis.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services' recurrent expenditure is essentially complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Data are also subject to ongoing historical validation. Due to this ongoing

validation, 2005-06 to 2010-11 data could differ from previous reports.

Coherence

Data are reported for each year from 2005-06 to 2010-11. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.

For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- National Mental Health Reports.

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.

Interpretability

Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Collection of outcomes information

DQI for this indicator has been sourced from the Australian Mental Health Outcomes and Classification Network (AMHOCN), Department of Health, and State and Territory governments with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Collection of information on consumers' outcomes. This DQI should be considered in conjunction with the DQI for Mental health outcomes of consumers of specialised public mental health services
Measure (computation)	Description: Proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital). Numerator: Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type. Denominator: Estimated number of specialised public mental health service episodes, by consumer type. Computation: Expressed as a proportion: (Numerator/s ÷ Denominator)*100. Calculated separately by consumer type.
Data source/s	Numerator: State and territory health authorities' data reported to the National Outcomes and Casemix Collection (NOCC) and analysed by the AMHOCN. Denominator: State and territory health authorities' data as reported to Community Mental Health Care (CMHC) NMDS and the Admitted Patient Mental Health Care (APMHC) NMDS and analysed by the Department of Health.

Data Quality Framework Dimensions

Institutional environment	Health Ministers adopted the routine measurement of consumer outcomes as a priority under the *National Mental Health Strategy (1992)* and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments' documented policy emphasis on high quality health services and increased consumer and carer participation. The AMHOCN prepared this indicator using the NOCC data on the Health of the Nation Outcome Scales (HoNOS) family of measures. The Australian Government contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau — receives and processes information 2) analysis and reporting — analyses and reports on the submitted data and 3) training and service development — supports training in the measures and their use for clinical practice, service management and development purposes. The NOCC was endorsed by all State and Territory governments in 2003, and

all jurisdictions have reported data since 2004-05. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis.

Relevance

The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities. Australian Government funded aged residential services are excluded.

The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to the collection of data for the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcomes measures are also collected, including those completed by consumers. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS-32); for children and adolescents, the parent and youth versions of the Strengths and Difficulties Questionnaire (SDQ). The uptake of these measures is not captured by this indicator.

For an episode to be counted as one for which consumer outcome measures are collected, a minimum of two data collection occasions with 'valid' measures within the reference period are required. 'Valid' measures are those with a correctly completed specified number of items, for the:

- HoNOS/HoNOS 65+ — a minimum of 10 of the 12 items
- HoNOSCA — a minimum of 11 of the first 13 items.

Brief ambulatory and inpatient care episodes (defined as follows) are excluded.

- inpatient care — episodes 3 days or less.
- ambulatory — episodes where the consumers had a treatment period between 1 and 14 days inclusive.

The completion of outcomes data are calculated for three consumer groups. Further, the calculation varies depending on the setting and the duration of the episode of care:

- people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode-counts, rather than person-counts) — measures need to be 'valid' for both the admission and discharge occasions rated during the reference period
- people in ongoing community-based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — measures need to be 'valid' for both the first (either an admission or a review) and last (either an admission or a review) occasions rated during the year
- people discharged from community-based care, episodes for people who were discharged from community care (not including those discharged to hospital) who received an episode of community care that started and ended in the reference period — measures need to be 'valid' for both the admission and discharge occasions rated during the reference period.

Outcomes are measured for consumers discharged from residential mental health care also, but there were too few public mental health service episodes with completed clinical mental health outcome measures data to derive coverage estimates.

The number of 'in-scope' specialised public mental health service episodes, for

which outcomes data should be collected (the denominator) is not provided directly to the NOCC, but is an estimate based on the CMHC or APMHC NMDSs. For determining the denominators for consumers in ongoing ambulatory care and those discharged from ambulatory care the following distinguishing definitions are used:

- ongoing — the estimated unique count of consumers with CMHC treatment periods of greater than 91 days (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care were left censored (that is, commenced in an earlier reporting period by finished within the current reporting periods)
- discharged — the estimated unique count of consumers with CMHC treatment periods of 91 days or less (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care resulted in a discharge to an inpatient setting.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

Timeliness

State and territory health authorities provide the CMHC and APMHC NMDS data to the AIHW for national collation, on an annual basis approximately six months after the reference period.

State and territory health authorities provide the NOCC data to AMHOCN for national collation, on an annual basis and all data are to be submitted approximately six months after the reference period.

The reference period for the latest data is 2011-12.

Accuracy

States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging invalid domain values and/or missing data.

Coherence

Data are available for 2007-08 to 2011-12.

The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).

The Australian totals for 2011-12 are not comparable to earlier years as they exclude data for Victoria.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the CMHC and APMHC NMDS. Published products available on the AIHW or Department of Health websites include:

- *Mental Health Services in Australia* — annual publication mhsa.aihw.gov.au/home/
- *Australia's Health* — a mental health chapter is included in this biennial publication aihw.gov.au/publication-detail/?id=10737422172
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data

Unpublished NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell

sizes with small numbers may be suppressed.

NOCC data are available on the AMHOCN website amhocn.org/. The following on-line products are available:

- web decision support tool
- NOCC Standard Reports
- NOCC Volume and Percentage Clinical Ratings: Australia
- NOCC data are also published in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Interpretability Metadata information for the CMHC and APMHC NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.

Information for understanding this indicator is available in the Key Performance Indicators for Australian Public Mental Health Services, Second Edition at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).

Consumer and carer involvement in decision making

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Quality — Responsiveness
Indicator	Consumer and carer involvement in decision making
Measure (computation)	Description: Number of paid full time equivalent (FTE) consumer OR carer staff per 1000 FTE direct care, carer and consumer staff Numerator: 1) Number of paid FTE consumer staff. 2) Number of paid FTE carer staff. Denominator: Number of paid FTE direct care, carer and consumer staff. Computation: Expressed as a proportion per 1000 FTE. Calculation is: (Numerator/Denominator*1000).
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS. Direct care staff comprise consultant psychiatrists and psychiatrists, psychiatry registrars and trainees, other medical officers, registered nurses, enrolled nurses, occupational therapists, social workers, psychologists, other diagnostic and health professionals and other personal care staff. Other categories of staff

who work in mental health services are collected under the MHE NMDS, such as administrative and clerical staff, but are not included.

Mental health consumer and carer workers are individuals who are employed on a paid basis to represent the interests of consumers and carers, respectively, and advocate for their needs. The person must be employed for the expertise developed from their lived experience of mental illness. The person should also receive a salary or contract fee on a regular basis and it excludes individuals who only received reimbursement of expenses or occasional sitting fees for attendance at meetings.

The MHE NMDS does not collect information on the staffing of, or consumer and carer participation in, specialised ambulatory mental health services managed by government-funded NGOs.

Timeliness State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy Coverage of the MHE NMDS in-scope mental health services for direct care staff and consumer and carer workers may not be complete across jurisdictions and years due to the transition from a count of consumer/carer consultants up to 2009-10 to a count of mental health consumer/carer workers from 2010-11.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

WA have advised that data on FTE consumer or carer workers per 1000 direct care, consumer and carer staff for the years 2006-07 to 2008-09 do not accurately represent consumer and carer participation strategies used in WA.

Coherence Data are reported for each year from 2005-06 to 2011-12. Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 and data from 2010-11 should not be made.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- From 2010-11, the definitions of consumer/carer workers were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 and data from 2010-11 should not be made.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Post discharge community care

DQI 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 AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Quality — Continuity
Indicator	Post discharge care — rate of community follow up within first seven days of discharge from a psychiatric admission.
Measure (computation)	Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation. The numerator is the number of in-scope separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation. The denominator is the number of in-scope separations for the mental health service organisation's acute psychiatric inpatient unit(s). Calculation is 100 x (Numerator ÷ Denominator).
Data source/s	State/territory admitted patient and community mental health care data.

Data Quality Framework Dimensions

Institutional environment	The tables for this indicator were prepared by the AIHW prepared the denominator and calculated the indicator based on numerators supplied by other data providers. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. AIHW drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) in consultation with State and Territory health authorities. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities receive these data from public sector community mental health services and public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator. Community mental health services and public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.
Relevance	Estimates are based on all 'in scope' separations from state and territory psychiatric acute inpatient units, where 'in scope' is defined as those separations for which it is meaningful to examine community follow-up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge – type change; left against medical advice/discharge at own risk and death Data for all years reflect full financial year activity – that is, all in scope separations from public sector acute psychiatric units between the period

1 July and 30 June for each financial year.

Community mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated. These may be face-to-face or 'indirect' (for example, by telephone), but not contacts delivered 'on behalf of the client' in which they did not participate, with the exception of the NT which includes all contacts, but advised that the impact on the indicator is believed to be marginal. Contacts made on the day of discharge are also excluded for all jurisdictions.

Only community mental health contacts made by state and territory public mental health services are included. Where responsibility for clinical follow-up is managed outside the state/territory mental health system (for example, by private psychiatrists, general practitioners), these contacts are not included.

States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers or data matching systems. SA indicated that the data submitted were not based on unique patient identifier or data matching approaches. This factor can contribute to an appearance of lower follow-up rates for this jurisdiction.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the ASGC to the ASGS. Also updated at this time were remoteness areas and the SEIFA. The new remoteness areas are referred to as RA 2011. The new SEIFA are referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2011-12 are reported for RA 2011. Data for 2011-12 are reported using SEIFA 2011 at the Statistical Local Area level (an ASGC substate geographical unit).

Remoteness and socioeconomic status have been allocated using the SLA of the client at last contact. For 2011-12 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

NSW used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

Timeliness The reference period for these data is 2011-12.

Accuracy State and territory jurisdictions differ in their capacity to accurately track post-discharge follow up between hospital and community service organisations (see Relevance section above for further information).

Coherence Agreement to align with specifications for the nationally agreed key performance indicators for public mental health services. Specifically, the revised indicator focuses on follow up care for people discharged from acute psychiatric units only, rather than discharges from all psychiatric units.

This indicator is currently reported in the Report on government services. It is also equivalent to the Key Performance Indicators for Australian Public Mental Health Services: MHS PI 12 — Rates of post-discharge community care (which this new indicator is based on) and the Fourth National Mental Health Plan: NMHP PI 16 — Rates of post-discharge community care.

There has been no major change to the methodology used to collect the data in 2011-12, therefore data is comparable across years.

However, one large Local Health District in NSW has incomplete community

data, so 2011-12 data will be updated for the 2015 report.

For public sector community mental health services, Victorian data is unavailable (for 2011-12) due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of community data. Australian totals for 2011-12 should therefore be interpreted with caution.

All jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

- NSW used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.

Accessibility Report on government services available at: www.pc.gov.au/gsp/rogs.

Interpretability Definitions for this indicator are published in the indicator specifications in METeOR.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- Community mental health care data for 2011-12 are not available for Victoria due to service level collection gaps resulting from protected industrial action during this period. This affects all data collected in community-based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. No substitute or proxy data have been included at the jurisdictional level or to fill the gap in calculation of the national results.
- Further disaggregation of this indicator by State and Territory, by Indigenous status and Socio Economic Status (SES) is a priority.
- Data have been provided according to the State or Territory of the service, but at the sub-state level (remoteness area) have been classified by the client's place of usual residence. For example, a person who usually resides in a very remote area of the NT and is treated in a service in a major city of Victoria would be classified for remoteness purposes as very remote area of Victoria (even though Victoria itself has no very remote areas under the ABS remoteness classification). Further work is required to determine whether geographic location for this indicator should be based on usual residence of the client (used for most indicators) or location of the service.

Readmissions to hospital within 28 days of discharge

DQI for this indicator has been sourced from state and territory health authorities and Department of Health with additional Steering Committee comments.

Indicator definition and description

Element	Quality— continuity
Indicator	Readmissions to hospital within 28 days of discharge
Measure (computation)	Description: Proportion of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge. Numerator: Number of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge. Denominator: Number of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services. Computation: Expressed as a proportion: (Numerator ÷ Denominator)*100.
Data source/s	State and territory governments admitted patient mental health care data set.

Data Quality Framework Dimensions

Institutional environment	Department of Health calculated the indicator based on data supplied by state and territory health authorities. The state and territory health authorities receive these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.
Relevance	Estimates are based on all 'in scope' overnight separations from state and territory psychiatric acute inpatient units, where 'in scope' is defined as those separations for which it is meaningful to examine readmission after 28 days of discharge rates. The following separations were excluded: same day separations, including index separation and subsequent readmission; statistical and change of care type separations; separations that end by transfer to another acute or psychiatric hospital; separations that end by death, or instances where the person left against medical advice or discharged at own risk. A readmission for any of the separations identified as 'in-scope' is an admission to any other public acute psychiatric unit within the jurisdiction. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be 'tracked' across units. Such systems have been available in all states/territories for the full period (2005-06 to 2011-12), with the exception of Tasmania (which introduced such a system in 2007-08) and SA (which has not yet introduced such a system). Readmissions across state and territory boundaries or movements between

public and private hospitals are not captured.

No distinction is made between planned and unplanned readmissions because data collection systems in most Australian public mental health services do not include a reliable or consistent method to distinguish a planned from an unplanned admission to hospital.

Timeliness State and territory health authorities provide these data to Department of Health for national collation, on an annual basis approximately twelve months after the reference period.

The latest year of data available is 2011-12.

Accuracy Coverage of the 'in-scope' separations and readmissions is essentially complete across jurisdictions and years.

States and territories are primarily responsible for the quality of these data. Department of Health analyses the data, but cannot independently verify them.

Undercounting of readmissions may have occurred in SA and Tasmania in the years that the system of unique identifiers is not in place (see the relevance dimension). Additional undercounting of readmissions may have occurred in SA as admitted patient reporting systems only identify mental health activity based on the discharging ward. However, this factor is believed to be immaterial as the majority of admissions to mental health wards end in hospital discharge from there.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

Coherence Data are available from 2005-06 to 2011-12. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.

States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the relevance and accuracy dimensions).

States and territories differ in the overnight separations that they count as 'in scope'. NSW and Queensland exclude separations where length of stay is one night only and the procedure code for ECT is recorded and the ACT excludes all overnight separations with the procedure code for ECT, whereas the others (Victoria, WA, SA, Tasmania and the NT) include all overnight separations for the procedure code for ECT.

Accessibility These data are also published in the:

- COAG national action plan on mental health progress reports available at www.coag.gov.au
- National mental health reports available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Interpretability Further information to understand this indicator are available in:

- the *COAG national action plan on mental health — progress report 2010-11*
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data
- the Key Performance Indicators for Australian Public Mental Health Services, Second Edition at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf
- forthcoming in 2013 in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- No distinction is made between planned and unplanned readmissions.
- States and territories differ in their capacity to accurately track clients across organisations or service types.
- States and territories differ in the overnight separations that they count as 'in scope'.

Cost of inpatient care — average recurrent cost per inpatient bed day

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element Efficiency

Indicator Cost for inpatient care — average recurrent cost per inpatient bed day

Measure (computation)

Description:

Average recurrent cost per inpatient bed day.

Numerator:

Expenditure on State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type.

Denominator:

Number of inpatient bed days in State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type.

Disaggregations for numerator and denominator are:

By inpatient target population:

- general, by acute and non-acute
- child and adolescent, by acute and non-acute
- older persons' psychiatry, by acute and non-acute
- forensic psychiatry, by acute and non-acute

By hospital type:

- psychiatric hospitals, by acute units and non-acute units
- public acute hospital with a psychiatric unit or ward, by acute and non-acute units

Computation:

Expressed as $ per bed day. Calculation is Numerator/Denominator.

Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:

$$R_t = \frac{D_t}{N_t} \times 100$$

Where:

R_t is real dollars in year t

D_t is nominal dollars in year t

N_t is the new index based in year t. N_t is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator in table 12A.73 for 2011-12 dollars (2011-12=100).

Data source/s Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional The AIHW has provided the data for this indicator. The AIHW is an

environment 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 AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.

Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator.

Expenditure data are for services provided in specialised mental health service units in public psychiatric hospitals, public acute hospitals and publicly funded private hospital units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Cost per inpatient bed day data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be casemix adjusted, for which cost is adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Timeliness State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy Coverage of the MHE NMDS in-scope mental health services for expenditure and bed days is essentially complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The

compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence

Data are reported for each year from 2005-06 to 2011-12. Data should be reported consistently across most jurisdiction and across years within most jurisdictions.

Costs per inpatient bed day may not be comparable across jurisdictions. Classification of expenditure into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons' or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the cost per patient day for general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria), may not be comparable to the average cost in a jurisdiction that has general services only (for example, NT).

For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.

Caution is required when interpreting historical Queensland data, particularly as several services reported as forensic up to 2008-09 were reclassified as general services in 2009-10 to more accurately reflect the function of these services. For 2010-11 and 2011-12, a small number of Youth services have been included in the General category at the request of Queensland. Queensland public acute hospital data includes costs associated with extended treatment services (campus and non-campus based) reported as non-acute admitted patient services in public acute hospitals. Queensland does not provide any acute services in public psychiatric hospitals. Additionally, Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Queensland does not report any acute forensic services, however forensic patients can and do access acute care through general units.

For 2010-11 and 2011-12, a small number of Youth services have been included in the General category at the request of Queensland.

For WA data, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services.

ACT average costs for older person's mental health services during 2006-07 are based on a new 20 bed unit opened in March 2007, in which only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older persons' mental health services relative to other jurisdictions and other years for the ACT.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The average recurrent cost per inpatient bed day measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Cost of inpatient care — average length of inpatient stay

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element Efficiency

Indicator Cost of inpatient care — average length of inpatient stay

Measure (computation)

Description:

Average length of inpatient stay in acute units, by target population.

Numerator:

Number of inpatient bed days in State and Territory funded specialised mental health admitted patient acute units, by target population.

Denominator:

Number of separations from State and Territory funded specialised mental health admitted patient acute units, by target population.

Disaggregations for numerator and denominator are:

By inpatient target population:

- general acute
- child and adolescent acute
- older persons' psychiatry acute
- total acute (excluding forensic)

Computation:

Expressed as number of days per stay. Calculation is Numerator/Denominator.

Data source/s Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment

The AIHW has provided the data for this indicator.

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and

episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.

Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator.

Average length of stay data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be relative stay index, for which the length of stay index takes into account the type and complexity of cases. Data for these measures are not yet available, as casemix analysis has not been applied to specialised mental health services.

Patients days for clients who separated in the reference period that were during the previous period (for example, 2009-10), are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

Average length of stay is not calculated for forensic services as the length of stay is determined by factors outside the control of the specialised mental health service. However, the child and adolescent and older persons' psychiatry target population services may include a forensic component.

Average length of stay is not calculated for non-acute inpatient units due to variability across jurisdictions in the models and mix of care (in particular, variability across jurisdiction in mix of non-acute inpatient and community-based residential care units) that would significantly affect the comparability of the average length of stay data.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services bed days and separations is essentially complete across jurisdictions.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the separations data used to derive this indicator is variable across jurisdictions. Until recently, these separations data were not subject to the level of in depth scrutiny that has applied to other data elements in the MHE NMDS. Therefore, data is only available from 2010-11. It is expected that the quality of these data will improve over time.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence Data are reported for 2010-11 and 2011-12.

Average length of stay data may not be comparable across jurisdictions. Classification of inpatient days and separations into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons' or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the average length of stay for a general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria) may not be comparable to the average length of stay that has general services only (for example, NT).

Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently."

A small number of Youth services have been included in the General category at the request of Queensland.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The average length of stay measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- The quality of the separations data used to derive this indicator is variable across jurisdictions.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Cost of community-based residential care

DQI for this indicator has been sourced from the AIHW and state and territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element Efficiency

Indicator Cost of community-based residential care

Measure (computation)

Description:

Average recurrent cost per patient day for community-based residential care

Numerator:

Expenditure on community-based residential care, by target population and staffing provided

Denominator:

Number of patient days in community-based residential care, by target population and staffing provided.

Disaggregations for the numerator and denominator are:

- General adult units
  - 24 hour staffed
  - Non-24 hour staffed
- Older people's care units
  - 24 hour staffed
  - Non-24 hour staffed

Computation:

Expressed as $ per bed day. Calculation is Numerator/Denominator.

Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:

$$R_t = \frac{D_t}{N_t} \times 100$$

Where:

R_t is real dollars in year t

D_t is nominal dollars in year t

N_t is the new index based in year t. N_t is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator in table 12A.X for 2011-12 dollars (2011-12=100).

Data source/s Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment

The AIHW has provided the data for this indicator.

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the AIHW by state and territory health authorities.

The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance

The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes).

Patient days and expenditure relating to community residential services includes that for publicly funded residential services operated by non-government organisations.

Expenditure data are for services provided in community residential units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Cost per patient day data are not adjusted for differences in the client mix. The client mix in community residential settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in community residential services. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Data for child and adolescent community-based residential units are included in the data for general acute units for NSW and the ACT. Other jurisdictions do not have these types of units.

For 2011-12, a small number of Youth services have been included in the General category at the request of WA.

Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services community residential expenditure and bed days is complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE

NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year. Delays caused by this change in completing the NSW 2010-11 MHE NMDS has also meant that the figures provided for the RoGS have not completed full validation and may be different to the finalised data that will be provided for the *National Mental Health Report*.

Coherence Data are reported for each year from 2005-06 to 2011-12. Data should be reported consistently across years within most jurisdictions.

Average cost of community-based residential care may not be comparable across jurisdictions. Classification of expenditure and inpatient days into target populations is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a general or older persons' mental health service, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. For NSW and the ACT, some child and adolescent services are reclassified to general adult to protect agency confidentiality.

For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including patient days. Comparison of NSW data over time therefore should be approached with caution.

Several WA residential services reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The cost of community-based residential care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Cost of ambulatory care

DQI for this indicator has been sourced from the AIHW, state and territory health authorities and Department of Health with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost of ambulatory care
Measure (computation)	Description: Average treatment days per episode of ambulatory care. Average cost per treatment day of ambulatory care Numerator: (1) Number of treatment days in ambulatory care. (2) Adjusted recurrent expenditure on ambulatory care. Denominator: (1) Number of statistical episodes of ambulatory care. (2) Number of treatment days in ambulatory care. Computation: Expressed as treatment days per episode OR cost per episode. Calculation is Numerator (1 OR 2)/Denominator (1 OR 2).
Data source/s	Numerator (1): AIHW from the Community Mental Health Care NMDS. Numerator (2): AIHW from the MHE NMDS Denominator/s: AIHW from the Community Mental Health Care NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations 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 auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Ambulatory services managed by non-government organisations

are not defined as statistical units for the MHE NMDS and therefore excluded.

The scope of the CMHC NMDS is government-operated community (also termed ambulatory) mental health services. Data collected includes information relating to each individual service contact provided by an in-scope mental health service. Examples of data elements are demographic characteristics of patients, such as age and sex, clinical information, such as principal diagnosis and mental health legal status, and service provision information, such as contact duration and session type. Ambulatory services managed by non-government organisations are not considered in-scope for the CMHC NMDS and are therefore excluded.

All activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers is excluded.

Expenditure data are for services provided in public specialised mental health ambulatory services. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Treatment days per episode or expenditure per treatment day are not adjusted for differences in the client mix. The client mix in ambulatory settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in ambulatory settings as distinct from treating them in hospitals. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding/analysis has not been applied to specialised mental health services.

Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode. 'One treatment day' episodes are included. These episodes are a confounding issue and a method for accounting for 'one treatment day' ambulatory episodes might provide more relevant measures.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under 'active care' (one or more treatment days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. The three month period used in this indicator to define a treatment episode is arbitrary. Further development of episode-based funding models may enable more meaningful/relevant measures in future.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period.

State and territory health authorities provide the CMHC NMDS data to the AIHW for national collation on an annual basis, approximately six months after the reference period.

The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope expenditure is essentially complete

across years. Coverage of the CMHC NMDS in-scope mental health services contacts is variable among the jurisdictions, with coverage issues for both the services in-scope for collection and the reporting of service contacts between clinicians and clients. Work is ongoing to clarify coverage for jurisdictions.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

States and territories are primarily responsible for the quality of the CMHC NMDS data they provide. However, the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is concerned with ensuring that the data file supplied is structurally compliant and correctly formatted. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is series of edit checks to ensure that the data supplied are consistent, logical and with valid values. Potential validation errors are queried with jurisdictions, and where the priority for correction is considered high, resubmissions are requested in response to these edit queries. A series of additional edit checks are conducted by the AIHW including coverage checks, historical validation and state/territory comparisons. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence

Data are reported for each year from 2005-06 to 2011-12.

'Non-uniquely identifiable consumers' are defined as those with service contacts for which a unique person identifier was not recorded. The proportion of contacts attributed to these consumers varies across jurisdictions (for example, from zero to 15 per cent) and can vary in one jurisdiction across time (for example, from 76 to 99 per cent). As all activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers are excluded using these proportions, the coherence and comparability of the results across jurisdictions and across time may be affected.

The Australian totals for 2011-12 are not comparable to earlier years as they exclude data for Victoria.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or

Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incur in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The cost of ambulatory care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.
- The exclusion of activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers means that the coherence and comparability of the results across jurisdictions and across time may be affected.

Rates of illicit and licit drug use

DQI for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Rates of illicit and licit drug use
Measure (computation)	Description: Proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin. Numerator: Number of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type. Denominator: Total population aged 14 years or over. Computation: (Numerator ÷ Denominator)*100 Calculated separately, by drug type.
Data source/s	AIHW 2011, *2010 National Drug Strategy Household Survey* (NDSHS) *Report*, Drug statistics series no. 25, Cat. no. PHE 145. AIHW 2008, *2007 National Drug Strategy Household Survey State and territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102.

Data Quality Framework Dimensions

Institutional environment	The NDSHS data was collected, processed, and published by the AIHW. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister. For further information see the AIHW website. The NDSHS is one of the key data collections that support the *National Drug Strategy*. The last survey in this program was conducted in 2010, with previous surveys in 1985, 1988, 1991, 1993, 1995, 2001, 2004 and 2007. The data collected from these surveys have contributed to the development of policies for Australia's response to drug-related issues.
Relevance	The estimates are based on information obtained from people aged 12 years or over (or 14 years or over) from all states and territories on their drug use patterns, attitudes and behaviours. It covers people's use of, their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours. Most of the analysis presented is for people aged 14 years or over, so that results can be compared across surveys. The scope of the survey is residential households, and excludes institutional settings, hostels, motels and homeless people.
Timeliness	The NDSHS is conducted every three years. Data are released the year following the reference period. The latest data available are for 2010.
Accuracy	Data were collected from a national stratified random selection of households, using self-completion booklets, using a 'drop and collect' methodology. Estimates based on survey samples are subject to various types of variation, mainly sampling and non-sampling error.

- For sampling errors, estimates that have relative standards errors between 25–50 per cent and greater than 50 per cent are identified and should be used with caution or be considered as unreliable for most practical purposes, respectively.
- Non-sampling errors can arise from errors in reporting of responses, for example:
  - the reported findings are based on self-reported data and not empirically verified by blood tests or other screening measures — respondents might be unwilling to reveal certain information
  - higher levels of non-response can occur from population subgroups.

Response rates are reported in the relevant *National Drug Strategy Household Survey* reports.

Coherence

Data are reported for each year 2007 and 2010. Within the results for each survey, the data are largely comparable across most jurisdictions.

The 2010 survey was built on the design of the 2007 survey. However, the 2010 survey differed to 2007 in the following ways:

- it used the drop and collect method exclusively — in 2007, a combination of computer-assisted telephone interviews and drop and collect was used (this change in methodology does affect the time series data, and users should exercise some degree of caution when comparing data over time).
- the timing of the fieldwork differed
- sampling methodology differed, oversampling was undertake for some states and territories and the coverage of the survey was improved for very remote areas
- some refinements were made to the questionnaire, for example, the standard drinks guide was updated in line with the new Australian alcohol guidelines published in March 2009.

For further details on the differences across these surveys see AIHW 2011, *2010 National Drug Strategy Household Survey report*, Drug statistics series no. 25. Cat. no. PHE 145. Canberra.

Accessibility

Comprehensive data for the 2010 and 2007 National Drug Strategy Household Survey reports and supplementary tables are available on the AIHW's website.

Data for this indicator are also reported in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data

Interpretability

Further information to understand this indicator are available in:

- the COAG national action plan on mental health — progress report 2010-11
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- Data are not comparable across the 2010 and 2007 National Drug Strategy Household Survey reports.

Prevalence of mental illness

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Prevalence of mental illness
Measure (computation)	*Numerator*: Number of people aged 16–85 years who had a mental health disorder diagnosed by the World Mental Health Composite Interviewing Diagnostic Instrument (CIDI), with symptoms in last 12 months. *Denominator*: Total population aged 16–85 years. *Computation*: (Numerator ÷ Denominator)*100 Disaggregated by disorder type and age or sex (national only), State and Territory, by disorder type.
Data source/s	ABS unpublished, *2007 National Survey of Mental Health and Wellbeing* (Cat. no. 4326.0).

Data Quality Framework Dimensions

Institutional environment	For 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, see ABS Institutional Environment (available www.abs.gov.au).
Relevance	The 2007 National Survey of Mental Health and Wellbeing (SMHWB) provides information about the prevalence of selected *high prevalence* mental disorders in the Australian population aged 16–85 years, the level of impairment associated with these disorders, physical conditions, and the use of health services, such as consultations with health practitioners or visits to hospital. The survey also provides information on the strength of social networks, caring responsibilities and a range of socio-economic and demographic characteristics. The SMHWB was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The SMHWB was not designed to measure the prevalence of all mental health conditions, therefore some severe mental disorders, such as schizophrenia, were not collected. The SMHWB is based on an international survey instrument, the CIDI, developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative. The 2007 survey was designed to provide data that were internationally comparable, rather than to provide comparisons with the 1997 survey. The survey was also designed to provide estimates of the prevalence of mental disorders at a national rather than a state/territory level.

Timeliness The SMHWB was conducted in 1997 and 2007.

Results from the 2007 survey were released ten months after the completion of enumeration, in the publication *National Survey of Mental Health and Wellbeing: Summary of Results* (cat. no. 4326.0).

Accuracy Estimates from the 2007 SMHWB are subject to sampling and non-sampling errors. The Relative Standard Error (RSE) is a measure of the size of the sampling error affecting an estimate; that is, the error introduced by basing estimates on a sample of the population rather than the full population. Estimates should be considered with reference to their RSEs. Estimates with an RSE between 25 per cent and 50 per cent should be used with caution, and those with an RSE greater than 50 per cent are considered too unreliable for general use. Non-sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, as well as errors made in coding and processing the data.

The SMHWB was designed primarily to provide estimates at the national level. Due to the higher than expected non-response rate, RSEs were somewhat larger than originally designed. While broad estimates are available for the larger states, users should exercise caution when using estimates at this level due to relatively high sampling errors.

Coherence The 2007 SMHWB was the second survey of this type conducted by the ABS, with the previous survey conducted in 1997. Care should be exercised when comparing data between surveys as there have been a number of changes to the scope, design, collection, methodology and content.

Supporting documentation released with the survey data can assist in understanding the relationships between data variables within the dataset and in comparisons with data from other sources.

Accessibility The main products available from this survey are:

- *National Survey of Mental Health and Wellbeing: Summary of Results, 2007* (Cat. no. 4326.0)
- *National Survey of Mental Health and Wellbeing: Users' Guide, 2007* (Cat. no. 4327.0)
- *Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded Confidentialised Unit Record Files, 2007* (Cat. no. 4326.0.30.001)
- *Technical Manual: National Survey of Mental Health and Wellbeing, Confidentialised Unit Record Files* (Cat. no. 4329.0).

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability The *National Survey of Mental Health and Wellbeing: Summary of Results* (Cat. no. 4326.0) includes explanatory material to aid the interpretation of the survey results. More detailed information is available in the *National Survey of Mental Health and Wellbeing: Users' Guide* (Cat. no. 4327.0).

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following issues:

- The SMHWB was designed to provide estimates at the national level. Broad estimates are available for the larger states, but users should exercise caution when using estimates at this level due to relatively high sampling errors.

- The SMHWB was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). It does not measure the prevalence of some severe mental disorders, such as schizophrenia (which are the mental illnesses most frequently treated by specialised public mental health services).

Mortality due to suicide

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mortality due to suicide
Measure (computation)	*Numerator*: Number of people who have died by suicide over the relevant reference period: • five year period (2007–2011) • single reference year (2011) *Denominator*: Estimated resident population. *Computation*: (Numerator ÷ Denominator)*100 000 Expressed as crude, age-specific or age standardised rates. Disaggregated by age and sex (national only), State and territory for all persons, young people (15–24 years), by geographical region and Indigenous status.
Data source/s	*Numerator:* ABS *Causes of Death* collection (Cat. no. 3303.0) *Denominator:* ABS Estimated Resident Population (Cat. no. 3101.0); Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (Cat. no. 3238.0); ASGC (Cat. no. 1216.0).

Data Quality Framework Dimensions

Institutional environment	Statistics presented in *Causes of Death, Australia, 2011* (Cat. no. 3303.0) are sourced from deaths registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred on a *Death Registration Form*. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a *Medical Certificate of Cause of Death*, or supplied as a result of a coronial investigation. Death records are provided electronically to the ABS by individual Registrars on a monthly basis. Each death record contains both demographic data and medical information from the *Medical Certificate of Cause of Death* where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS). For 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, see ABS Institutional Environment (available www.abs.gov.au).

Relevance

The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.

From the 2007 reference year, the scope of the collection is:

- all deaths registered in Australia for the reference year and are received by the ABS by the end of the March quarter of the subsequent year; and
- deaths registered prior to the reference year but not previously received from the Registrar nor included in any statistics reported for an earlier period.

For example, records received by the ABS during the March quarter of 2011 which were initially registered in 2010 or prior (but not forwarded to the ABS until 2011) are assigned to the 2010 reference year. Any registrations relating to 2010 which are received by the ABS after the end of the March 2011 quarter are assigned to the 2011 reference year.

Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Classification of Diseases (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used since 1997.

Non-Indigenous data from the Causes of Death collection do not include death registrations with a 'not stated' Indigenous status.

Timeliness

Causes of death data are published on an annual basis.

There is a focus on fitness for purpose when causes of death statistics are released. To meet user requirements for accurate causes of death data it is necessary to obtain information from other administrative sources before all information for the reference period is available (for example, information from finalisation of coronial proceedings to code an accurate cause of death). A balance therefore needs to be maintained between accuracy (completeness) of data and timeliness. ABS provides the data in a timely manner, ensuring that all coding possible can be undertaken with accuracy prior to publication.

In addition, to address the issues which arise through the publication of causes of death data for open coroners cases, these data are subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing.

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data. Every effort is made to minimise non-sample error by working closely with data providers, running quality checks throughout the

data processing cycle, training of processing staff, and efficient data processing procedures.

Causes of death data for 2006, 2007, 2008, 2009 and 2010 have been subject to revision. All coroner certified deaths registered after 1 January 2006 are subject to a revision process. This is a change from previous years where all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (for example, a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

For this year's report, causes of death data for 2009 and 2010 were updated as more information became available. Final data for 2006, 2007, 2008 and revised data for 2009 and 2010 have been published in the *2011 Causes of Death* publication, released in March 2013. 2010 and 2011 causes of death will be revised in the 2012 Causes of Death publication due for release in 2014. Revisions will only affect coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See *Causes of Death, Australia* (Cat. no. 3303.0).

Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading for example where the non-Indigenous mortality rate is higher than the Indigenous mortality rate. All rates for this indicator must be used with caution.

Non-Indigenous population estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. 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 methods used to construct the indicator are consistent and comparable with other collections and with international practice.

The completeness or quality of older (unrevised) versus newer data (subject to a revisions process) can affect comparisons across time. The accuracy dimension contains information pertinent to coroner certified deaths affected by the revision process.

The ERPs used to derived rates differ across years and tables. Some are derived using ERPs based on the 2001 Census, 2006 Census or 2011 Census. See particular tables for details. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility

Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. ERP data is available in a variety of formats on the ABS website under the 3101.0 and 3201.0 product families. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability

Information on how to interpret and use cause of death data is available

from Explanatory Notes in *Causes of Death, Australia* (Cat. no. 3303.0).

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following issue:

- Causes of death data are subject to a revisions process. Final data for 2006, 2007 and 2008 and revised data for 2009 and 2010 have been published in the 2011 Causes of Death publication. Data for 2010 and 2011 causes of death will be revised in 2014.

Social and economic inclusion of people with a mental illness — participation in employment of working age population

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Social and economic inclusion of people with a mental illness — participation in employment of working age population.
Measure (computation)	*Numerator*: Number of people aged 16-64 years who are employed (by mental health status) *Denominator*: Number of people aged 16-64 years in the population (by mental health status) *Computation*: (Numerator ÷ Denominator)*100 Note: People with a mental health condition are defined as having a self-reported mental or behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.
Data source/s	ABS unpublished, *Australian Health Survey (AHS) 2011-13* (2011-12 National Health Survey component).

Data Quality Framework Dimensions

Institutional environment	The AHS was collected, processed, and published by the 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 at www.abs.gov.au.
Relevance	Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011-12 AHS collected data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with 'mental illness' will differ to those that are derived under the SMHWB using the CIDI. The definitions of employment, unemployment and the labour force are consistent with those used in ABS labour force surveys.
Timeliness	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.
Accuracy	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 persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons 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 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 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 attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.

For information on AHS survey design, see the Australian Health Survey: Users' Guide on the ABS website.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Accessibility

See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability

Information to aid interpretation of the data is available from the Australian Health Survey: Users' 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. 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 AHS collects data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the SMHWB that uses a diagnostic tool to identify mental illnesses.

Social and economic inclusion of people with a mental illness — participation in education and employment by young people

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Social and economic inclusion of people with a mental illness — participation in education and employment by young people.
Measure (computation)	*Numerator*: Number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time) (by mental health status). *Denominator*: Number of people in aged 16–30 years in the population (by mental health status). *Computation*: (Numerator ÷ Denominator)*100 Note: People with a mental health condition are defined as having a self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more.
Data source/s	ABS unpublished, *AHS 2011-13* (2011-12 National Health Survey component).

Data Quality Framework Dimensions

Institutional environment	The AHS was collected, processed, and published by the 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 at www.abs.gov.au.
Relevance	Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011-12 AHS collected data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with 'mental illness' will differ to those that are derived under the SMHWB using the CIDI. The definitions of employment are consistent with those used in ABS labour force surveys.
Timeliness	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.

Accuracy

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 persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons 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 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 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 attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.

For information on AHS survey design, see the Australian Health Survey: Users' Guide on the ABS website.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Accessibility

See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability

Information to aid interpretation of the data is available from the Australian Health Survey: Users' 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. 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 AHS collects data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the National Survey of Mental Health and Wellbeing that uses a diagnostic tool to identify mental illnesses.

Mental health outcomes of consumers of specialised public mental health services

DQI for this indicator has been sourced from the AMHOCN and Australian, State and Territory governments with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mental health outcomes of consumers of specialised public mental health services. This DQI should be considered in conjunction with DQI for Collection of information on consumers' outcomes.
Measure (computation)	Description: Proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by consumer type: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit. Numerator/s: Number of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes, by consumer type. Number of people receiving care in specialised public mental health services who had no significant change in their clinical mental health outcomes, by consumer type. Number of people receiving care in specialised public mental health services who had a significant deterioration in their clinical mental health outcomes, by consumer type. Denominator: Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type. Computation: Expressed as a proportion: (Numerator ÷ Denominator)*100. Calculated separately by consumer type.
Data source/s	State and Territory data reported to NOCC and analysed by AMHOCN.

Data Quality Framework Dimensions

Institutional environment	Health Ministers adopted the routine measurement of consumer outcomes as a priority under the *National Mental Health Strategy (1992)* and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments' documented policy emphasis on high quality health services and increased consumer and carer participation. The AMHOCN prepared this indicator using the NOCC data on the Health of the Nation Outcome Scales (HoNOS) family of measures. The Australian Government (Department of Health) contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau — receives and processes information 2) analysis and reporting — analyses and reports on the submitted data and 3)

training and service development — supports training in the measures and their use for clinical practice, service management and development purposes.

The NOCC 1.50 was endorsed by all State and Territory governments in 2003, and all jurisdictions have reported data since 2004-05. The NOCC Technical Specification was revised to 1.60 in 2009. All jurisdictions have supplied, or resupplied NOCC data according to 1.60 from 2007-08. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis.

Relevance

The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities Australian Government funded aged residential services are excluded.

The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to consumer outcomes data collected through the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcome measures are also collected. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS-32), or Mental Health Inventory (MHI-38); for children and adolescents, the parent and youth versions of the SDQ. The uptake of these measures is not captured by this indicator.

Only episodes that have valid measures for two specified data collection occasions are included. 'Valid' measures are those with a correctly completed specified number of items, for the:

- HoNOS/HoNOS 65+ — a minimum of 10 of the 12 items
- HoNOSCA — a minimum of 11 of the first 13 items.

Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect. The effect size is the ratio of the difference between the pre- and post- scores to the standard deviation of the pre-score. Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between -0.5 and 0.5; and 'significant deterioration' if the effect size index is less than or equal to -0.5.

Outcomes are calculated for each of the following three consumer groups and the calculation varies depending on the setting and the duration of the episode of care:

- people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode-counts, rather than person-counts) — the admission and discharge occasions rated during the reference period are used
- people in ongoing community-based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — the first and last occasions rated during the reference period are used
- people discharged from community-based care, episodes for people who were discharged from community care (not including those discharged to hospital and who received an episode of community care that started and ended in the reference period — the admission and discharge occasions rated during the reference period are used.

Outcomes are measured for consumers discharged from residential mental health care, but there were too few episodes with completed clinical mental

health to derive outcome results.

A single 'average score' by consumer type does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods. The approach separates a consumer's care into segments (hospital versus the community) rather than tracking the person's overall outcomes across treatment settings. In addition, consumers' outcomes are measured from the clinician's perspective and not as the 'lived experience' from the consumer's viewpoint.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

Timeliness State and territory health authorities provide the NOCC data to AMHOCN for national collation on an quarterly/annual basis and all data are to be submitted approximately six months after the reference period.

The latest reference period for this data set is 2011-12.

Accuracy States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertakes extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging , including invalid domain values and/or, missing data.

The proportion of episodes for which 'valid' outcomes data are collected is less than 50 per cent of expected coverage. It is not known if the results for those for whom data are collected are representative of the consumer population.

Coherence Data are available for 2007-08 to 2011-12. The comparability of the outcomes data across jurisdictions and years may be affected by the relatively low proportion of episodes for which 'valid' outcomes data are collected and the degree to which this proportion varies across jurisdictions and years.

The Australian totals for 2011-12 are not comparable to earlier years as they exclude data for Victoria.

Accessibility Data for this indicator are published in the National mental health reports: www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

NOCC data are available on the AMHOCN website amhocn.org/. The following on-line products are available:

- web decision support tool
- NOCC Standard Reports
- NOCC Volume and Percentage Clinical Ratings: Australia

Interpretability Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.

Information for understanding this indicator is available in the *Key Performance Indicators for Australian Public Mental Health Services, Second Edition* at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf and forthcoming in 2013 in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- There are differences in the relative proportions of "matched pair"

HoNOS/CA/65+ ratings.

- NOCC completion rates are for people discharged from hospital and people on ongoing community based care are approximately 85 per cent.
- NOCC completion rates for people discharged from community based care, are lower, at approximately 65 per cent. This pattern has been stable over time and generally consistent for all consumer age groups and jurisdictions, with the exception of ACT where technical issues have not enabled linkage of admission and discharge ratings for this consumer group. It is likely that the overall lower completion rate for this consumer group arises when consumers are administratively discharged from care following a period of no active care in the preceding period.