# E Health sector overview

CONTENTS

E.1 Introduction E.1

E.2 Sector performance indicator framework E.11

E.3 Cross cutting and interface issues E.59

E.4 Future directions in performance reporting E.60

E.5 Jurisdictions’ comments E.61

E.6 List of attachment tables E.71

E.7 References E.73

|  |
| --- |
| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘EA’ prefix (for example, table EA.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. |
|  |

## E.1 Introduction

This sector overview provides an introduction to the Primary and community health (chapter 10), Public hospitals (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.

Improvements to reporting in this edition’s Health sector overview include:

* data for the incidence of heart attacks (acute coronary events) are reported for the first time for states and territories
* data for the prevalence of type 2 diabetes are reported by Indigenous status for the first time
* allied health workforce data are reported for the first time
* data for the risk factors prevalence of overweight and obesity and rate of daily smokers by Indigenous status are updated.

Other improvements in reporting 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 and public health 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 Aboriginal and Torres Strait Islander‑specific primary health guided by the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, 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 Aboriginal and Torres Strait Islander Australians) such as:

* community health services
* mental health programs
* specialist palliative care
* public hospital services

1. public dental services
2. patient transport
3. health policy research and policy development
4. public health (such as health promotion programs and disease prevention)
5. 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 primary and community health services (including general practice) (chapter 10), public hospitals (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 $147.4 billion in 2012-13 (figure E.1). This total was estimated to account for 9.7 per cent of gross domestic product in 2012-13, an increase of 1.2 percentage points from the 8.5 per cent of GDP in 2003‑04 (AIHW 2014a).

|  |
| --- |
| Figure E.1 Total health expenditure, by source of funds (2012‑13 dollars)**a,** **b,** **c,** **d, e** |
| |  | | --- | | Figure E.1 Total health expenditure, by source of funds (2012-13 dollars)  More details can be found within the text surrounding this image. | |
| a Data are adjusted to 2012-13 dollars using a combination of deflators (see table EA.7). b Includes recurrent and capital expenditure. c Includes expenditure on ambulance services (reported in chapter 9). d 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. e ‘Non-government’ includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers. |
| *Source*: AIHW (2014) *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61; table EA.1. |
|  |
|  |

In 2012-13, the combined health expenditure of the Australian, State and Territory, and local governments was $100.8 billion, representing 68.4 per cent of total health expenditure within Australia. The Australian Government accounted for the largest proportion of health care expenditure — $61.0 billion or 41.4 per cent of the total in 2012‑13. State and Territory, and local governments contributed $39.8 billion or 27.0 per cent of total health expenditure in that year (AIHW 2014a). 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 2003‑04 and 2012‑13, the average annual rate of growth in real expenditure was 4.4 per cent for the Australian Government, 5.6 per cent for State, Territory and local governments, and 5.4 per cent for non‑government sources (table EA.1).

The Health chapters (Part E) provide performance information on Australian, State and Territory, and local governments health services that account for $69.9 billion of total recurrent health expenditure (or 73.5 per cent of all government recurrent expenditure on health — $95.2 billion — in 2012‑13 (table EA.4)). The services covered are:

* primary and community health (chapter 10) — medical services (including payments to general practitioners [GPs] and other health practitioners), community and public health, medications and public dental services
* public hospitals (chapter 11)
* specialist mental health services (chapter 12).

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total recurrent health expenditure per person in Australia increased from $4476 in 2003-04 to $6055 in 2012‑13 (expressed in 2012‑13 dollars) (table EA.5). Government real recurrent health expenditure per person in Australia increased from $3124 in 2003‑04 to $4153 in 2012‑13 (expressed in 2012‑13 dollars). Non‑government recurrent expenditure per person in Australia increased from $1352 in 2003‑04 to $1901 in 2012‑13 (expressed in 2012‑13 dollars) (figure E.2 and table EA.6).

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

|  |
| --- |
| Figure E.2 Recurrent health expenditure per person, by source of funds, 2012‑13 **a,** **b,** **c** |
| |  | | --- | | Figure E.2 Recurrent health expenditure per person, by source of funds, 2012-13  More details can be found within the text surrounding this image. | |
| 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 expenditure includes substantial expenditure for NSW residents which may inflate expenditure per person data. d Excludes expenditure on high level residential aged care. |
| *Source*: AIHW (2014) *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52, Cat. no. HWE 61; table EA.6. |
|  |
|  |

|  |
| --- |
| Table E.1 Health funding for Aboriginal and Torres Strait Islander and other Australians by source of funding, 2010-11 |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Source of funding | *Amount ($ million)* | | |  | |  | Aboriginal and Torres Strait Islander Australians | Other Australians | Total | Aboriginal and Torres Strait Islander Australians 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-governmenta | 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. |
|  |
|  |

|  |
| --- |
| Table E.2 Expenditure on health services for Aboriginal and Torres Strait Islander and other Australians, 2010-11 |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Area of expenditure | Expenditure ($ million) | | |  | Expenditure per person ($) | |  | | Aboriginal and Torres Strait Islander Australians | Other Australians | Total | Aboriginal and Torres Strait Islander Australians share (%) | Aboriginal and Torres Strait Islander Australians | Other Australians | Ratio | | Total hospital services | 2 178.0 | 47 527.6 | 49 705.7 | 4.4 | 3 825.6 | 2 169.4 | 1.8 | | Public  hospitalsa | 2 067.4 | 36 870.4 | 38 937.8 | 5.3 | 3 631.3 | 1 683.0 | 2.2 | | Admitted patientsb | 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  hospitalsc | 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 healthd | 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 under‑identification of Aboriginal and Torres Strait Islander people. 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. |
|  |
|  |

### 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. 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). They are also more likely to have high rates of health risk factors such as smoking and obesity and to have shorter lives (AIHW 2014b). Burden‑of‑disease studies indicate greater burden among people who are relatively disadvantaged in society (Begg et al. 2007).

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 2014b).

Nationally, 2.3 per cent of the population lived in remote and very remote areas in 2013 (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 43.4 per cent — 20.6 per cent in remote and 22.8 per cent in very remote areas.

#### Indigenous status

Aboriginal and Torres Strait Islander people are more likely than are other Australians to experience poor health, to die at younger ages and to experience disability (AIHW 2014b; tables EA.46 and EA.48). A recent study found socioeconomic disadvantage to be the leading health risk for Aboriginal and Torres Strait Islander Australians in the NT, accounting for 42 to 54 per cent of the life expectancy gap between Aboriginal and Torres Strait Islander and other Australians (Zhao et al. 2013).

Aboriginal and Torres Strait Islander people have low employment and income   
levels when compared to other Australians (see chapter 2, tables 2A.32–2A.34 and   
2A.39–2A.46). Aboriginal and Torres Strait Islander 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, 2014a; Zhao et al. 2013). Aboriginal and Torres Strait Islander Australians are more likely to live in inadequate and overcrowded housing (SCRGSP 2014) and in remote areas with more limited access to health services. In 2006, 51 992 Aboriginal and Torres Strait Islander Australians were living in discrete Aboriginal and Torres Strait Islander communities that were 100 kilometres or more from the nearest hospital (ABS 2007).

Nationally, 3.0 per cent of the total population identified as Aboriginal and Torres Strait Islander in 2011. The projected population of those identifying as Aboriginal and Torres Strait Islander people made up less than 5 per cent of the population in each State and Territory except the NT, where the figure was 29.7 per cent, in 2013 (tables 2A.1 and 2A.14).

### 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 Aboriginal and Torres Strait Islander 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 made up of the following elements (figure E.3):

* 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 |
| |  | | --- | | Figure E.3 Health services sector performance indicator framework   More details can be found within the text surrounding this image. | |
|  |

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 (Australian Bureau of Statistics) 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 2015 Report can be found at www.pc.gov.au/  
rogs/2015.

### Sector-wide performance indicators

This section includes high level indicators of health outcomes. While many factors affect outcomes — not solely the performance of government services — 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). Birthweight is a key indicator of infant health and a principal determinant of a baby’s chance of prospective survival, good health, development and wellbeing (AIHW NPESU and AIHW 2013). Low birth weight babies have a greater risk of poor health and dying and are more likely to develop chronic diseases later in life (AIHW 2014c).

|  |
| --- |
| 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 (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. 2013).  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/rogs/2015. |
|  |
|  |

In 2012, 95.2 per cent of liveborn babies in Australia weighed 2500 grams or over and 4.8 per cent weighed less than 2500 grams (table EA.8). This included 1.0 per cent of babies with a very low birth weight — less than 1500 grams (table EA.9). The average birth weight for all live births was 3367 grams in 2012 (table EA.9).

Nationally, rates of low birth weight babies increased with remoteness, rising from 4.6 per cent in major cities to 5.2 per cent in outer regional areas, and 7.7 per cent in very remote areas in 2012 (table EA.11).

Nationally, the average birth weight for liveborn babies of Aboriginal and Torres Strait Islander mothers was 3211 grams in 2012 (table EA.10). Among liveborn singleton babies born to Aboriginal and Torres Strait Islander mothers in 2012, the proportion with low birth weight was more than twice that of those born to other mothers (figure E.4).

|  |
| --- |
| Figure E.4 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2012**a,** **b,** **c,** **d, e** |
| |  | | --- | | Figure E.4 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2012  More details can be found within the text surrounding this image. | |
| 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 Aboriginal and Torres Strait Islander 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.8. |
|  |
|  |

#### 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, excessive sun exposure and unhealthy dietary habits (AIHW 2014b). Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is aimed at raising 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 or 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/rogs/2015. |
|  |
|  |

##### Prevalence of overweight and obesity

Being overweight or obese increases the risk of an individual developing diseases such as 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** |
| |  | | --- | | Figure E.5 Proportion of adults in BMI categories, 2011-12  More details can be found within the text surrounding this image. | |
| 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 for the NT should be used with care as exclusion of very remote areas from the 2011–13 Australian Health Survey (AHS) translates to the exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (Australian Bureau of Statistics) (unpublished) *Australian Health Survey* *2011–13* (2011-12 Core component) Cat. no. 4364.0; 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 Aboriginal and Torres Strait Islander adults (72.4 per cent) than for other 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 2014b). 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 or 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, Aboriginal and Torres Strait Islander Australians had higher age‑standardised rates of daily smoking (42.0 per cent) than other 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** |
| |  | | --- | | Figure E.6 Proportion of adults who are daily smokers, by State and Territory  More details can be found within the text surrounding this image. | |
| 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 AHS 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), Cat. no. 4364.0;ABS (unpublished) *National Health Survey 2007-08*, Cat. no. 4364.0; table EA.20. |
|  |
|  |

##### 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).

Adults are defined as at risk of alcohol related harm over a lifetime if they consume more than two standard drinks a day, based on the 2009 NHMRC guidelines (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, 2011-12a, b, c, d, e, f |
| |  | | --- | | Figure E.7 Proportion of adults at risk of alcohol related harm over a lifetime, by remoteness, 2011-12  More details can be found within the text surrounding this image. | |
| 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 Rates are based on consumption in the week before interview — does not take into account whether more, less than, or the same as, usual consumption. d 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. e Very remote data were not collected. f Data for the NT should be used with care as exclusion of very remote areas from the AHS translates to the exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished*) Australian Health Survey 2011-13* (2011-12 NHS (National Health Survey) 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 Aboriginal and Torres Strait Islander Australians (19.2 per cent) and other Australians (19.5 per cent) in 2011–13, although results varied across jurisdictions (table  EA.24). Nationally, the age standardised proportion of adults who abstained from alcohol in the previous 12 months was higher for Aboriginal and Torres Strait Islander people (26.1 per cent) than for other Australians (16.3 per cent) in 2011–13 (table EA.25).

#### 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 data for 2010 and 2011 are estimated * incomplete for the current reporting period. Data for 2010 and 2011 were not available for NSW or the ACT and estimates are reported for these jurisdictions. * Incidence of heart attacks (acute coronary events) — 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 but are not comparable across jurisdictions * complete for the current reporting period. All required 2012 data are reported for all jurisdictions. * 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/rogs/2015. |
|  |
|  |

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 prevent cancer and minimise its impacts include (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 42.5 new cases per 100 000 people in 2011. Bowel cancer, which has been linked to diet, occurred at a rate of 61.5 new cases per 100 000 people in 2011 (table EA.26). Other cancers such as melanoma are also largely preventable. The incidence of these cancers for 2011, along with breast and cervical cancer, are reported in figure E.8. Tables EA.27–29 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, 2011**a, b, c** |
| |  | | --- | | Figure E.8 Incidence of selected cancers, per 100 000 people, 2011  More details can be found within the text surrounding this image. | |
| a Age‑standardised to the Australian population as at 30 June 2001 using five-year age groups to 85 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 estimates as incidence data are not available for 2011 and are not comparable with data for other jurisdictions. |
| *Source*: AIHW (Australian Institute of Health and Welfare) (unpublished) Australian Cancer Database 2011; ABS (2013) *Australian Demographic Statistics, 2012*, Cat. no. 3101.0; table EA.26. |
|  |
|  |

*Incidence of heart attacks (acute coronary events)*

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 (acute coronary events) was 406 new cases per 100 000 people in 2012 (table EA.30). The incidence of heart attacks (acute coronary events) was more than twice as high for Aboriginal and Torres Strait Islander people as for other Australians (table EA.31).

Data for states and territories are reported for the first time in tables EA.32 to EA.39.

##### 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.40). The prevalence of type 2 diabetes among Aboriginal and Torres Strait Islander adults was around three times higher than for other Australians in the period 2011–13 (tables EA.41-42).

#### 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 deaths from conditions that are potentially preventable through individualised care and/or treatable through timely and effective primary or hospital care.  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  2012 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
|  |
|  |

Nationally, there were 107.8 avoidable deaths per 100 000 people in 2012 (table EA.43). The rate of avoidable deaths was considerably higher for Aboriginal and Torres Strait Islander people than for other Australians in all jurisdictions for which data were available in the period 2008–2012 (figure E.9 and table EA.44).

|  |
| --- |
| Figure E.9 Age standardised mortality rates for potentially avoidable deaths, under 75 years, 2008–2012**a,** **b,** **c,** **d,** **e,** **f, g, h, I, j** |
| |  | | --- | | Figure E.9 Age standardised mortality rates for potentially avoidable deaths, under 75 years, 2008–2012  More details can be found within the text surrounding this image. | |
| 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 Potentially avoidable deaths refer to deaths from certain conditions that are considered avoidable given timely and effective health care. Specifications for avoidable deaths have been revised and data are not comparable to data in previous reports. d Data based on year of registration. e Data are reported by jurisdiction of residence only for NSW, Queensland, WA, SA and the NT — these jurisdictions have sufficient level of identification and number of Aboriginal and Torres Strait Islander deaths to support mortality analysis. f Queensland deaths data for 2010 were adjusted to minimise the impact of late registration of deaths on mortality indicators. g For WA, Aboriginal and Torres Strait Islander deaths data for 2007, 2008 and 2009 have been revised. h Total includes data for NSW, Queensland, WA, SA and the NT only. i See DQI for more information. |
| *Source*: ABS (unpublished) *Causes of Deaths, Australia, 2012*, Cat. no. 3303.0; ABS (unpublished) Estimated Resident Population; ABS (2014) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0; table EA.44. |
|  |
|  |

#### 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  2011–2013 data for life expectancy, 2013 data for median age at death and  2013 data for mortality rates are available for all jurisdictions.   Data quality Information for this indicator is at www.pc.gov.au/rogs/2015. |
|  |
|  |

##### 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 2013b). It has risen steadily in each decade since, reaching 80.1 years for males and 84.3 years for females in 2011–2013 (figure E.10).

|  |
| --- |
| Figure E.10 All Australians average life expectancy at birth, 2011–2013**a** |
| |  | | --- | | Figure E.10 All Australians average life expectancy at birth, 2011–2013  More details can be found within the text surrounding this image. | |
| a Data for Australia include 'other territories'. |
| *Source*: ABS (2014) *Life Tables, Australia, States and Territories, 2011­2013*,Cat. no. 3302.0.55.001; table EA.45. |
|  |
|  |

The life expectancies of Aboriginal and Torres Strait Islander Australians are considerably lower than those of other Australians. ABS estimates are available every 5 years. These indicate a life expectancy at birth of 69.1 years for Aboriginal and Torres Strait Islander males and 73.7 years for Aboriginal and Torres Strait Islander females born from 2010 to 2012. In the same time period, life expectancy at birth for other males was 79.7 years and for other females was 83.1 years (table EA.46). 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** |
| |  | | --- | | Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)  More details can be found within the text surrounding this image.  Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)  Legend to Figure  More details can be found within the text surrounding this image. Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)  Legend to Figure  More details can be found within the text surrounding this image.  Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)  Legend to Figure  More details can be found within the text surrounding this image. Figure E.11 Estimated life expectancies at birth, by Indigenous status and sex, 2010–2012 (years)  Legend to Figure  More details can be found within the text surrounding this image. | |
| a Aboriginal and Torres Strait Islander estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Aboriginal and Torres Strait Islander 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; table EA.46. |
|  |
|  |

##### Median age at death

The median age at death in 2013 was 78.6 years of age for Australian males and 84.7 years of age for Australian females (table EA.47).

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

Caution should be taken when comparing median age at death between Aboriginal and Torres Strait Islander people and other 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 Aboriginal and Torres Strait Islander and other Australians is difficult to interpret
* changes in the median age at death of public health importance might be difficult to distinguish from statistical noise.

Nationally, counting only the jurisdictions for which data were available for Aboriginal and Torres Strait Islander Australians, the median age at death for male Aboriginal and Torres Strait Islander Australians was 54.6 years of age. The median age at death for female Aboriginal and Torres Strait Islander Australians was 61.6 years of age (figure E.12 and table EA.48).

|  |
| --- |
| Figure E.12 Median age at death, by sex and Indigenous status, 2013**a, b** |
| |  | | --- | | Figure E.12 Median age at death, by sex and Indigenous status, 2013  More details can be found within the text surrounding this image.  Figure E.12 Median age at death, by sex and Indigenous status, 2013  Legend to Figure  More details can be found within the text surrounding this image. Figure E.12 Median age at death, by sex and Indigenous status, 2013  Legend to Figure  More details can be found within the text surrounding this image.  Figure E.12 Median age at death, by sex and Indigenous status, 2013  Legend to Figure  More details can be found within the text surrounding this image. Figure E.12 Median age at death, by sex and Indigenous status, 2013  Legend to Figure  More details can be found within the text surrounding this image. | |
| a Victoria, Tasmania and the ACT are excluded due to small numbers of registered Aboriginal and Torres Strait Islander deaths. b The accuracy of Aboriginal and Torres Strait Islander mortality data is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Aboriginal and Torres Strait Islander population caused by changing rates of identification in the Census and births data. |
| *Source*: ABS (2014) *Deaths, Australia, 2013*, Cat. no. 3302.0; table EA.48. |
|  |
|  |

##### Mortalityrates

There were 147 678 deaths registered in Australia in 2013 (ABS 2014c), which translated into an age standardised mortality rate of 540 deaths per 100 000 people (figure E.13). Death rates over the last 20 years have declined for all states and territories (ABS 2014c).

|  |
| --- |
| Figure E.13 Mortality rates, age standardiseda, b, c, d |
| |  | | --- | | Figure E.13 Mortality rates, age standardised  More details can be found within the text surrounding this image. | |
| 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 Aboriginal and Torres Strait Islander and other Australians which use ERPs based on the 2006 Census.d Australian totals includes all states and territories. |
| *Source*: ABS (2014) *Deaths, Australia, 2013*, Cat. no. 3302.0; table EA.49. |
|  |
|  |

##### Mortality rates — Infant and child

The annual infant mortality rate in Australia declined from an average of 4.7 deaths per 1000 live births in 2004 to 3.6 deaths per 1000 live births in 2013 (table EA.52 and figure E.14).

The Australian infant and child combined mortality rate was 87.2 deaths per 100 000 population in 2011–2013 (children aged 0 to 4 years). Of the total deaths for this age group, 84.0 per cent were infant deaths (table EA.54).

|  |
| --- |
| Figure E.14 Infant mortality rate**a,** **b** |
| |  | | --- | | Figure E.14 Infant mortality rate   More details can be found within the text surrounding this image. | |
| a Infant deaths per 1000 live births. b Data for Australia include all states and territories. |
| *Source*: ABS (2014) *Deaths, Australia, 2013,* Cat. no. 3302.0; table EA.52. |
|  |
|  |

##### 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 (7.8 deaths per 1000 people), while major cities had the lowest mortality rates (5.4 deaths per 1000 people) (ABS 2014c).

##### Mortality rates — Aboriginal and Torres Strait Islander Australians

Data for Aboriginal and Torres Strait Islander mortality are collected through State and Territory death registrations. The completeness of identification of Aboriginal and Torres Strait Islander Australian deaths in these collections varies significantly across states and territories so care is required when making comparisons.

For the period 2009–2013, NSW, Queensland, WA, SA and the NT have been assessed as having adequate identification and number of Aboriginal and Torres Strait Islander deaths for mortality analysis. For these five jurisdictions combined, the overall age standardised mortality rate for Aboriginal and Torres Strait Islander people was 985.0 per 100 000 people, significantly higher than for other Australians (585.2 per 100 000 people) (figure E.15 and table EA.50). Due to identification completeness issues, mortality rates presented here are likely to be underestimates of the true mortality of Aboriginal and Torres Strait Islander Australians (ABS and AIHW 2008).

|  |
| --- |
| Figure E.15 Mortality rates, age standardised, by Indigenous status, five year average, 2009–2013**a, b, c, d, e** |
| |  | | --- | | Figure E.15 Mortality rates, age standardised, by Indigenous status, five year average, 2009–2013  More details can be found within the text surrounding this image. | |
| a Deaths are based on year of registration. b Mortality rates are age-standardised to the 2001 Australian standard population. c Rates are derived from population estimates and projections revised to the 2011 Census base. See data quality information (DQI) for further detail. d Data are reported by jurisdiction of residence only for jurisdictions with a sufficient number and level of identification of Aboriginal and Torres Strait Islander deaths to support mortality analysis — NSW, Queensland, WA, SA and the NT. Total includes data only for those jurisdictions. e Error bars represent the 95 per cent variability band associated with each point estimate. See DQI for more information. |
| *Source*: ABS (unpublished), *Deaths, Australia,* various years, Cat. no. 3302.0; table EA.50. |
|  |
|  |

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

For the period 2009–2013, the average infant mortality rate for Aboriginal and Torres Strait Islander infants (less than one year) was higher than for other infants in the jurisdictions for which there were data available (NSW, Queensland, WA, SA and the NT) (table EA.55). For the same period and the same jurisdictions, the average mortality rate for infants and children combined (0–4 years) per 100 000 children aged 0–4 years was 169.1 for Aboriginal and Torres Strait Islander children and 89.2 for other Australian children (table EA.55).

##### Mortality rates — by major cause of death

The most common causes of death among Australians in 2012 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.56).

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 Aboriginal and Torres Strait Islander people than for other Australians in 2009–2013 (table E.4). For these jurisdictions, the leading age-standardised cause of death for Aboriginal and Torres Strait Islander people was circulatory diseases followed by neoplasms (cancer) in 2012 (table EA.57).

|  |
| --- |
| Table E.3 Age standardised mortality rates by major cause of death (deaths per 100 000 people), 2012**a, b** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | Certain infectious and parasitic diseases | 10.6 | 8.4 | 6.9 | 7.8 | 10.9 | 8.2 | 6.6 | np | 9.1 | | Neoplasms | 166.8 | 162.4 | 179.2 | 167.0 | 166.6 | 185.7 | 147.0 | 211.7 | 168.4 | | Diseases of the bloodc | 1.8 | 1.6 | 1.7 | 1.5 | 1.6 | np | np | np | 1.7 | | Endocrine, nutritional and metabolic diseases | 20.2 | 23.0 | 23.3 | 23.6 | 22.6 | 33.7 | 24.6 | 65.2 | 22.7 | | Mental and behavioural disorders | 27.6 | 27.2 | 26.7 | 27.5 | 34.7 | 48.3 | 25.0 | 30.9 | 28.5 | | Diseases of the: |  |  |  |  |  |  |  |  |  | | * nervous system | 23.2 | 26.8 | 25.3 | 30.3 | 28.5 | 25.7 | 24.0 | 23.7 | 25.7 | | * eye and adnexa | np | np | np | np | – | – | – | – | np | | * ear and mastoid process | np | np | np | – | – | – | – | np | np | | * circulatory system | 160.1 | 148.1 | 175.1 | 144.5 | 161.5 | 195.2 | 141.4 | 185.3 | 159.6 | | * respiratory system | 50.7 | 45.0 | 50.4 | 45.9 | 49.2 | 62.1 | 42.0 | 73.5 | 49.0 | | * digestive system | 18.8 | 19.8 | 20.8 | 17.6 | 21.1 | 22.2 | 20.5 | 26.6 | 19.7 | | * skin and subcutaneous tissue | 1.7 | 1.4 | 1.4 | 1.1 | 1.2 | np | np | np | 1.4 | | * musculoskeletal system and connective tissue | 4.0 | 4.2 | 5.1 | 3.3 | 2.7 | 8.0 | 6.6 | np | 4.3 | | * kidney | 13.4 | 15.5 | 11.8 | 13.6 | 14.0 | 13.0 | 13.1 | 23.5 | 13.8 | | Pregnancy, childbirth and the puerperium | np | np | np | – | np | – | – | – | np | | Certain conditions originating in the perinatal period | 2.2 | 2.0 | 2.8 | 1.3 | 2.6 | np | np | np | 2.3 | | Congenital conditionsd | 2.4 | 2.2 | 2.6 | 2.0 | 2.6 | np | np | np | 2.4 | | Abnormal findings nece | 7.2 | 3.5 | 3.7 | 5.5 | 13.3 | 3.5 | np | 13.3 | 5.9 | | External causes of morbidity and mortality | 33.8 | 33.3 | 43.7 | 46.2 | 39.2 | 44.0 | 31.7 | 79.5 | 37.9 | | **Total** | **544.5** | **524.7** | **580.7** | **538.9** | **572.4** | **658.3** | **494.9** | **769.2** | **552.3** | |
| 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, 2012* Cat. no. 3303.0; table EA.56. |
|  |
|  |

Aboriginal and Torres Strait Islander people died from circulatory diseases, endocrine, metabolic and nutritional disorders, cancer and respiratory diseases at higher rates than other Australians (tables E.4 and EA.57).

|  |
| --- |
| Table E.4 Major cause of death by Indigenous status — rate differences and rate ratios, 2008–2012 **a, b, c** |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Rate difference — rate for Aboriginal and Torres Strait Islander people less rate for other Australians | | | | | | | |  | Rate ratio — rate for Aboriginal and Torres Strait Islander people divided by rate for other Australians | | | | | | |  | NSW | | | Qld | WA | SA | NT | Total**c** |  | NSW | Qld | WA | SA | NT | Total**c** | | Circulatory diseases | 62.0 | | | 79.0 | 211.9 | 33.3 | 176.8 | 93.9 |  | 1.3 | 1.4 | 2.3 | 1.2 | 2.1 | 1.5 | | Cancer | 17.9 | | | 48.9 | 81.1 | - 23.2 | 119.1 | 46.2 |  | 1.1 | 1.3 | 1.5 | 0.9 | 1.6 | 1.3 | | External causes | | 16.4 | | 19.4 | 78.2 | 45.1 | 63.9 | 37.0 |  | 1.5 | 1.5 | 2.9 | 2.2 | 2.1 | 2.0 | | Endocrine and other disorders**d** | | 35.7 | | 83.3 | 138.0 | 37.2 | 179.6 | 80.6 |  | 2.7 | 4.5 | 6.8 | 2.5 | 6.9 | 4.6 | | Respiratory diseases | 37.9 | | | 35.0 | 61.7 | 28.7 | 92.7 | 46.5 |  | 1.7 | 1.7 | 2.4 | 1.6 | 2.6 | 1.9 | | Digestive diseases | 9.3 | | | 29.5 | 39.2 | 34.9 | 54.4 | 26.9 |  | 1.4 | 2.4 | 3.0 | 2.7 | 3.2 | 2.3 | | Kidney diseases | 8.8 | | | 15.2 | 29.4 | np | 53.4 | 18.4 |  | 1.8 | 2.6 | 3.9 | np | 6.4 | 2.6 | | Conditions originating in the perinatal period | | 0.1 | | 1.4 | 2.5 | np | 6.6 | 1.7 |  | 1.0 | 1.5 | 2.6 | np | 3.4 | 1.7 | | Infectious and parasitic diseases | | | 4.1 | 11.4 | 15.9 | 11.6 | 18.6 | 10.2 |  | 1.4 | 2.6 | 3.1 | 2.2 | 2.4 | 2.1 | | Nervous system diseases | | - 6.3 | | - 2.1 | 5.4 | 3.7 | 0.9 | - 1.8 |  | 0.7 | 0.9 | 1.2 | 1.1 | 1.0 | 0.9 | | Other causes | 10.1 | | | 24.9 | 64.7 | 12.6 | 74.5 | 29.4 |  | 1.2 | 1.6 | 2.5 | 1.2 | 2.5 | 1.6 | | **All causes** | **196.1** | | | **345.9** | **728.0** | **195.5** | **841.0** | **388.9** |  | **1.3** | **1.6** | **2.3** | **1.3** | **2.3** | **1.7** | |
| 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 are: 2008–2010 (final), 2011 (revised) and 2012 (preliminary). See data quality information (DQI) for further information. b Rate differences and rate ratios are derived from mortality rates data (reported in table EA.57) that are age standardised (using the direct method) to the Australian population as at 30 June 2001. c Data are reported by jurisdiction of residence only for jurisdictions with a sufficient number and sufficient level of identification of Aboriginal and Torres Strait Islander deaths to support mortality analysis — NSW, Queensland, WA, SA and the NT. Total includes data only for those jurisdictions. d Endocrine, metabolic and nutritional disorders. **np** not published. |
| *Source*: ABS (unpublished) *Causes of Death Australia, 2012*,Cat. no. 3303.0; table EA.57. |
|  |
|  |

#### 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 for 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 is at ww.pc.gov.au/rogs/2015. |
|  |
|  |

In 2013, the majority of employed medical practitioners (commonly referred to as   
doctors) that were employed in medicine were clinicians (95.2 per cent), of whom 32.7 per cent were general practitioners, 34.7 per cent were specialists, 17.5 per cent were specialists-in-training, 12.3 per cent were hospital non-specialists and 2.8 per cent were other clinicians (AIHW 2014d). The proportion of women increased from 35.7 per cent in 2009 to 38.6 per cent in 2013. The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.16.

In 2013, the number of nurses and midwives registered in Australia was 344 190. In 2013, the number of nurses and midwives registered and employed in Australia was 296 029, or 1280 per 100 000 population (table EA.59). The majority of employed nurses and midwives were clinicians (90.0 per cent). The principal area of the main job of employed registered and enrolled nurses and midwives was aged care (15.6 per cent) followed by medical (9.8 per cent) and surgical (8.7) roles. The average age of employed nurses and midwives changed little between 2009 (44.3 years) and 2013 (44.5 years). The proportion of employed nurses and midwives aged 50 or older increased from 36.3 per cent to 39.3 per cent over this period (AIHW 2014e). The number of FTE nurses and midwives per 100 000 people by jurisdiction is illustrated in figure E.17.

Nationally there were 426.3 FTE allied health practitioners per 100 000 people in 2013 (table EA.60).

|  |
| --- |
| Figure E.16 Full time equivalent employed medical practitioners**a,** **b,** **c, d, e, f, g** |
| |  | | --- | | Figure E.16 Full time equivalent employed medical practitioners  More details can be found within the text surrounding this image. | |
| 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 Caution should be used in comparing data for the ACT with other jurisdictions. Rates for the ACT are inflated as many services are provided to southern NSW residents not captured in the denominator. In addition, a relatively high proportion of pracitioners work in non-clinical roles, compared to other jurisdictions (AIHW 2014d). 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, when changes to doctors’ registration requirements meant registration in the NT was no longer required for nationally registered doctors providing fly in fly out services. 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 unless unavailable, in which case state and territory of residence is used. h From 2012, data exclude provisional registrants. |
| *Source*: AIHW (unpublished) National Health Workforce Data Set; AIHW (unpublished) Medical Labour Force Survey; ABS (2013, 2014) *Australian demographic statistics*, Cat. no. 3101; table EA.58. |
|  |
|  |

|  |
| --- |
| Figure E.17 Full time equivalent employed nurses and midwives**a,** **b,** **c, d,** **e** |
| |  | | --- | | Figure E.17 Full time equivalent employed nurses and midwives  More details can be found within the text surrounding this image. | |
| 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 unless unavailable, in which case state and territory of residence is used. h From 2012, data exclude provisional registrants. |
| *Source*: AIHW (unpublished) National Health Workforce Data Set; ABS (2013, 2014), *Australian demographic statistics*, Cat. no. 3101; table EA.59. |
|  |
|  |

At the national level, 51.5 per cent of employed medical practitioners were under the age of 45 in 2013 (table EA.58). The medical practitioner workforce grew at an average annual rate of 3.9 per cent from 2009 to 2013 (figure E.18). The nursing and midwifery workforce grew at an average rate of 2.8 per cent annually from 2009 to 2013 (figure E.18), and 47.3 per cent of employed nurses were under the age of 45 in 2013 (table EA.59).

Nationally, 0.9 per cent of the nursing and midwifery workforce were Aboriginal and Torres Strait Islander in 2013 (table EA.62). Of people employed in health-related occupations in 2011, 1.6 per cent were Aboriginal and Torres Strait Islander. Within   
health related occupations in 2011, the occupations with the highest percentage of Aboriginal and Torres Strait Islander Australians were health and welfare support officers, which includes the occupation Aboriginal and Torres Strait Islander Health Workers (tables EA.63–EA.65).

|  |
| --- |
| Figure E.18 Annual average growth in selected workforces,  2009–2013**a,** **b, c, d, e, f** |
| |  | | --- | | Figure E.18 Annual average growth in selected workforces, 2009–2013  More details can be found within the text surrounding this image. | |
| 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, 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 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’. e Data for 2009 are for the workforce, including practitioners who are employed, on extended leave and/or looking for work. From 2010, data 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; table EA.61. |
|  |
|  |

#### 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 Aboriginal and Torres Strait Islander 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, 76 per cent of Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians (ABS 2014a) and from the 2011‑12 National Health Survey for other Australians (ABS 2012). Aboriginal and Torres Strait Islander Australians were less likely than other Australians to report very good or excellent health. Taking into account differences in age structure between the populations, Aboriginal and Torres Strait Islander Australians overall were more than twice as likely to report their health as fair or poor than other Australians in 2011–13 (ABS 2013a, 2014a).

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.66).

Data for Aboriginal and Torres Strait Islander Australians are not comparable with data for other Australians due to a slightly different methodology. Nationally, the proportion of Aboriginal and Torres Strait Islander Australians who accessed services varied significantly by self-assessed health status for hospital admissions, consultations with doctors and 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.69.

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.70–EA.73.

|  |
| --- |
| Figure E.19 Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012‑13**a,** **b,** **c,** **d, e** |
| Figure E.19 Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13  Legend to Figure  More details can be found within the text surrounding this image.   |  | | --- | | 0  15  30  45  60  NSW  Vic  Qld  WA  SA  Tas  ACT  NT  Aust  **Per cent**  **Admitted to hospital**  0  15  30  45  60  75  NSW  Vic  Qld  WA  SA  Tas  ACT  NT  Aust  **Per cent**  **Consulted a doctor**  0  15  30  45  60  NSW  Vic  Qld  WA  SA  Tas  ACT  NT  Aust  **Per cent**  **Consulted other health professional** | |
| 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. e Figure has been revised and differs from the figure presented in the 2014 Report. |
| *Source*: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Surveycomponent), Cat. no. 4727.0; table EA.68. |
|  |
|  |

### 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.[[1]](#footnote-1) 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:

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

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.

#### Primary and community health

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

|  |
| --- |
| Figure E.20 Primary and community health performance indicator framework |
| |  | | --- | | Figure E.20 Primary and community health performance indicator framework   More details can be found within the text surrounding this image. | |
|  |
|  |

An overview of the primary and community health 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 Primary and community healtha, b |
| |  | | | NSW | Vic | | | Qld | | WA | | SA | | Tas | | ACT | | NT | | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Equity — Access indicators** | | | | | | | | | | | | | | | | | | | | | | Availability of PBS medicines — PBS prescriptions filled at concessional rate (per cent), 2013‑14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | |  | | Proportion of total | 89.7 | 89.9 | | | 89.1 | | 85.6 | | 90.8 | | 92.2 | | 79.2 | | 79.7 | | 89.3 | | | Equity of access to GPs, 2013‑14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | Full time workload equivalent GPs by remoteness area per 100 000 people, 2013-14 | | | | | | | | | | | | | | | | | | | | | |  | | Major cities, rate | 109.1 | 101.7 | | | 107.4 | | 78.6 | | 107.6 | | .. | | 72.5 | | .. | | 102.2 | | |  | | Outer regional, rate | 84.3 | 96.7 | | | 97.9 | | 84.0 | | 102.1 | | 82.8 | | .. | | 78.9 | | 91.4 | | | Availability of female GPs per 100 000 females , 2013-14 | | | | | | | | | | | | | | | | | | | | | |  | | Rate | 72.1 | 66.1 | | | 69.4 | | 49.6 | | 60.0 | | 66.4 | | 61.0 | | 62.7 | | 66.3 | | | Availability of male GPs per 100 000 males , 2013-14 | | | | | | | | | | | | | | | | | | | | | |  | | Rate | 140.8 | 135.9 | | | 136.3 | | 102.9 | | 148.1 | | 119.1 | | 83.2 | | 81.0 | | 132.9 | | | Availability of public dentists — per 100 000 people, 2013 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | |  | Rate | | 6.6 | | 6.2 | | | 8.5 | | 7.2 | | 8.3 | | 5.9 | | 5.0 | | 10.0 | | 7.1 | | Early detection and early treatment for Aboriginal and Torres Strait Islander Australians — Proportion of Older Aboriginal and Torres Strait Islander Australians who received a health assessment, 2013‑14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | |  | | Proportion | 28.1 | 17.4 | | | 37.5 | | 32.7 | | 20.8 | | 12.9 | | 20.4 | | 39.8 | | 30.4 | | | Children receiving a fourth year developmental health check, 2013‑14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | |  | | Proportion | 64.8 | 27.5 | | | 78.1 | | 49.7 | | 52.5 | | 56.8 | | 41.4 | | 69.9 | | 55.6 | | | Source: tables 10A.11–10A.32. | | | | | | | | | | | | | | | | | | | | | | **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 10) | | | | | | | | | | | | | | | | | | | | | | Bulk billing rates for non-referred patients, 2013‑14 | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | 87.9 | 83.2 | | | 83.1 | | 75.7 | | 82.2 | | 77.7 | | 57.2 | | 82.8 | | 83.6 | | | GP waiting times for urgent appointment, 2013-14 — less than 4 hours | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | 64.7 | 63.4 | | | 65.4 | | 65.2 | | 64.7 | | 51.8 | | 58.3 | | 78.4 | | 64.2 | | | People deferring treatment due to cost, 2013-14 — deferring visits to GPs | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | 3.5 | 5.0 | | | 5.8 | | 6.2 | | 4.5 | | 6.9 | | 6.9 | | 5.6 | | 4.9 | | | Selected potentially avoidable GP-type presentations to emergency departments, 2013‑14 | | | | | | | | | | | | | | | | | | | | | |  | | ‘000 | 709.3 | | | 572.4 | | 381.4 | | 272.9 | | 113.4 | | 61.2 | | 50.5 | | 39.3 | 2 200.4 | | | (Continued next page) | | | | | | | | | | | | | | | | | | | | | |
|  |
|  |

|  |
| --- |
| Table E.5 (Continued) |
| |  | | | | NSW | | | Vic | | | Qld | | | WA | | | SA | | | Tas | | | ACT | | | | NT | | | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Financial barriers to PBS medicines | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | People deferring treatment due to cost, 2013-14 — deferring purchase of prescribed medicines  Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | | | 7.0 | | | 6.3 | | | 9.9 | 8.4 | | | 7.5 | | | 8.0 | | 6.7 | | | | 6.2 | | | | 7.6 | | | | Public dentistry waiting times, 2013-14 — less than 1 month Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | 27.6 | | | 17.8 | | | 27.2 | | | 19.7 | | 18.4 | | | 26.2 | | | | 32.5 | | | | 24.4 | | 23.4 | | | | | Source: tables 10A.33–10A.46. | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | GPs with vocational registration, 2013-14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | | 90.6 | | | 85.5 | | | 88.0 | | | 89.5 | | | 89.5 | | | 90.8 | | | 91.8 | | | | 69.8 | | | 88.5 | | | Management of upper respiratory tract infections Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Prescriptions for oral antibiotics used to treat upper respiratory tract infections per 1000 people, 2013-14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Rate | | | 319.1 | | | 324.8 | | | 292.3 | | | 187.8 | | | 310.0 | | | 314.9 | | | 175.5 | | | | 92.2 | | | 295.2 | | | Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, April 2009 to March 2014 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | | 33.0 | | | 27.4 | | | 33.1 | | | 25.6 | | | 26.7 | | | 26.3 | | | 25.7 | | | | 20.9 | | | 30.5 | | | Management of chronic disease Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive, 2013-14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | | 48.6 | | | 42.1 | | | 54.3 | | | 47.8 | | | 35.4 | | | 36.4 | | | 57.7 | | | | 72.7 | | | 47.3 | | | 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 diagnostic imaging, 2013-14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | $ per person | | | 72.9 | | | 58.2 | | | 69.8 | | | 51.5 | | | 53.4 | | | 53.6 | | | 51.1 | | | | 42.9 | | | 63.8 | | | Source: tables 10A.47–10A.67. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Electronic health information systems — general practices using electronic systems, May 2014 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | | 85.7 | | | 89.0 | | | 86.0 | | | 83.0 | | | 86.7 | | | 86.0 | | | 84.5 | | | | 78.2 | | | 86.3 | | | | Source: tables 10A.68–10A.70. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (Continued next page) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |
|  |

|  |
| --- |
| Table E.5 (Continued) |
| |  | | | NSW | | | Vic | | | Qld | | | | WA | | | | SA | | | Tas | | | ACT | | | NT | | | | Aust | | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Effectiveness — Quality — Responsiveness indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Patient satisfaction, 2013-14  Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Proportion (%) of people who saw a practitioner in the previous 12 months where the practitioner always or often: listened carefully to them | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | GP | | | 91.2 | | | 91.3 | | | 89.8 | | | | 88.6 | | | 90.9 | | | 91.3 | | | 89.1 | | | | 84.8 | | 90.6 | | | |  | Dental practitioner | | | 94.8 | | | 94.5 | | | 92.9 | | | | 96.5 | | | 96.5 | | | 93.7 | | | 95.4 | | | | 94.5 | | 94.6 | | | | Source: tables 10A.71–10A.75. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Effectiveness — Quality — Continuity indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Health assessments for older people — proportion of older people assessed, 2013-14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | | | 30.52 | | | 28.84 | | | | 35.69 | | | 30.75 | | | 30.20 | | | 34.28 | | | 23.21 | | | 31.60 | | | | 31.06 | | Source: table 10A.76. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Efficiency indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Cost to government of general practice per person — fee-for-service expenditure (ASR), 2013-14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | $ per person | | | 314.8 | | | 301.2 | | | | 314.2 | | | 238.6 | 295.6 | | | 272.5 | | | 230.7 | | | 241.4 | | | 298.6 | | | | | Source: table 10A.2. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Outcome indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Child immunisation coverage — Children aged 60 to 63 months fully immunised, 2013-14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | | | 92.2 | | | 92.5 | | | 92.3 | | | | 89.8 | 91.0 | | | 92.7 | | | 92.7 | | | 91.4 | | | 92.0 | | | | | Notifications of selected childhood diseases —notifications per 100 000 children, 2013-14 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Measles | | | 2.1 | | | 2.5 | | | 2.2 | | | | 2.1 | 3.4 | | | – | | | – | | | 33.4 | | | 2.6 | | | | | Participation rates for women in breast cancer screening — Ages 50–69, 1 January 2012 to 31 December 2013 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Rate | | | 50.9 | | | 54.6 | | | 57.3 | | | | 56.8 | 53.0 | | | 57.8 | | | 54.4 | | | 41.0 | | | 54.3 | | | | | Participation rates for women in cervical screening — Ages 20–69 (ASR), 1 January 2012 to 31 December 2013 Most recent data for this indicator are comparable and complete (subject to caveats) (chapter 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Rate | | | 57.4 | | | 61.6 | | | 56.4 | | | | 55.9 | 59.0 | | | 57.4 | | | 58.0 | | | 55.1 | | | 58.2 | | | | | 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 10) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Rate | | | 72.7 | | | 75.0 | | | 74.6 | | | | 72.9 | 81.3 | | | 77.5 | | | 78.0 | | | 69.3 | | | 74.6 | | | | | (Continued next page) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |
|  |

|  |
| --- |
| Table E.5 (Continued) |
| |  | | NSW | | | Vic | | Qld | | WA | | | SA | | Tas | | ACT | | NT | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Separations for selected potentially preventable hospitalisations, 2012-13, 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 10) | | | | | | | | | | | | | | | | | | | | | |  | Vaccine-preventable | | | 0.7 | | 0.8 | | 1.1 | | 1.0 | 1.1 | | 1.0 | | 0.8 | | 3.7 | | 0.9 | | |  | Acute conditions *excluding dehydration and gastroenteritis* | | | | | | | | | | | | | | | | | | | | |  |  | | 10.8 | | | 10.2 | | 13.8 | | 13.6 | 13.6 | | 9.9 | | 9.3 | | 20.5 | | 11.8 | | |  | Chronic conditions *excluding additional diagnoses of diabetes complications* | | | | | | | | | | | | | | | | | | | | |  |  | | 10.4 | | | 10.8 | | 12.9 | | 11.3 | 11.9 | | 10.1 | | 8.3 | | 22.1 | | 11.3 | | | Source: tables 10A.77–10A.94. | | | | | | | | | | | | | | | | | | | | | |
| a Caveats for these data are available in Chapter 10 and Attachment 10A. Refer to the indicator interpretation boxes in chapter 10 for information to assist with the interpretation of data presented in this table. b Some data are derived from detailed data in Chapter 10 and Attachment 10A.  – Nil or rounded to zero. **na** Not available. **np** Not published. |
| Source: Chapter 10 and Attachment 10A. |
|  |
|  |

#### Public hospitals

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

|  |
| --- |
| Figure E.21 Public hospitals performance indicator framework |
| |  | | --- | | Figure E.21 Public hospitals performance indicator framework  More details can be found within the text surrounding this image. | |
|  |
|  |

An overview of the public hospital 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 11 and the footnotes in attachment 11A.

|  |
| --- |
| Table E.6 Performance indicators for public hospitalsa |
| |  | | | | NSW | | Vic | Qld | WA | | SA | | Tas | | ACT | | | NT | | | Aust | | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Effectiveness — Access indicators** | | | | | | | | | | | | | | | | | | | | | | | Emergency department waiting times, 2013-14 | | | | | | | | | | | | | | | | | | | | | | | Proportion of patients seen on time (per cent)  Most recent data for this measure are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | |  | | Resuscitation | | 100 | | 100 | 100 | 100 | | 100 | | 100 | | 100 | | | 100 | | | 100 | | |  | | Emergency | | 83 | | 84 | 80 | 86 | | 74 | | 85 | | 83 | | | 61 | | | 82 | | |  | | Urgent | | 76 | | 73 | 67 | 58 | | 65 | | 66 | | 50 | | | 51 | | | 70 | | |  | | Semi-urgent | | 80 | | 71 | 75 | 71 | | 77 | | 71 | | 57 | | | 53 | | | 75 | | |  | | Non-urgent | | 94 | | 88 | 92 | 94 | | 92 | | 90 | | 86 | | | 89 | | | 92 | | |  | | Total | | 81 | | 75 | 73 | 70 | | 73 | | 72 | | 61 | | | 57 | | | 75 | | | Percentage of presentations where the time from presentation to physical departure (Emergency   Department Stay length) is within four hours  Most recent data for this measure are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | |  | | % | | 73.9 | | 69.0 | 76.3 | 79.5 | | 64.5 | | 67.7 | | 61.8 | | | 61.6 | | | 72.7 | | | Waiting times for admitted patient services | | | | | | | | | | | | | | | | | | | | | | | Elective surgery waiting times: Number of days waited, 2013-14  Most recent data for this measure are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | |  | | 50th percentile | | 49 | | 35 | 28 | 29 | | 35 | | 45 | | 48 | | | 36 | | | 36 | | |  | | 90th percentile | | 329 | | 222 | 186 | 142 | | 180 | | 401 | | 270 | | | 183 | | | 262 | | | Elective surgery waiting times: Proportion who waited more than 365 days, 2013-14  Most recent data for this measure are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | |  | | % | | 1.8 | | 3.2 | 2.8 | 0.7 | | 0.8 | | 11.5 | | 4.7 | | | 2.8 | | | 2.4 | | | Proportion of presentations to emergency departments with a length of stay of 4 hours or less   ending in admission, public hospitals (per cent), 2013-14  Most recent data for this measure are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | |  | | Resuscitation | | 51 | | 57 | 59 | 66 | | 54 | | 58 | | 63 | | | 46 | | | 56 | | |  | | Emergency | | 43 | | 49 | 53 | 58 | | 37 | | 33 | | 45 | | | 21 | | | 47 | | |  | | Urgent | | 40 | | 44 | 51 | 51 | | 35 | | 25 | | 29 | | | 21 | | | 43 | | |  | | Semi-urgent | | 44 | | 45 | 57 | 52 | | 42 | | 28 | | 33 | | | 22 | | | 46 | | |  | | Non-urgent | | 65 | | 60 | 68 | 60 | | 59 | | 44 | | 45 | | | 50 | | | 62 | | |  | | Total | | 42 | | 46 | 53 | 53 | | 38 | | 28 | | 34 | | | 22 | | | 45 | | | Source: tables 11A.18, 11A.23, 11A.24 and 11A.47. | | | | | | | | | | | | | | | | | | | | | | | **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | | | | | | | | | | | Separation rates for selected procedures, public hospitals, per 1000 people (age‑standardised), 2012-13 Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | |  | | Cataract extraction | | 2.7 | | 3.0 | 1.6 | 4.7 | | 3.4 | | 2.0 | | | | 4.1 | | | 6.7 | 2.8 | | |  | | Cholecystectomy | | 1.4 | | 1.5 | 1.2 | 1.2 | | 1.5 | | 1.4 | | | | 1.4 | | | 1.2 | 1.4 | | |  | | Coronary angioplasty | | 0.9 | | 0.8 | 0.8 | 0.8 | | 0.9 | | 1.0 | | | | 2.0 | | | .. | 0.9 | | |  | | Coronary artery bypass graft | | 0.3 | | 0.3 | 0.3 | 0.2 | | 0.3 | | 0.3 | | | | 0.5 | | | .. | 0.3 | | |  | | Cystoscopy | | 1.6 | | 2.9 | 2.0 | 3.3 | | 2.7 | | 1.6 | | | | 3.0 | | | 2.0 | 2.3 | | |  | | Haemorrhoidectomy | | 1.0 | | 0.8 | 0.3 | 0.5 | | 0.5 | | 0.6 | | | | 0.3 | | | 0.9 | 0.7 | | |  | | Hip replacement | | 0.6 | | 0.7 | 0.5 | 0.8 | | 0.7 | | 0.7 | | | | 1.0 | | | 0.6 | 0.6 | | |  | | Hysterectomy | | 1.0 | | 1.1 | 1.0 | 1.0 | | 1.2 | | 1.2 | | | | 0.9 | | | 0.8 | 1.0 | | |  | | Inguinal herniorrhaphy | | | 1.0 | 1.0 | 0.8 | 1.0 | | 1.0 | | 1.0 | | | | 1.0 | | | 1.0 | 1.0 | | |  | Knee replacement | | 0.7 | | | 0.5 | 0.5 | | 0.7 | | 0.6 | | 0.4 | | 0.7 | | | 0.5 | | | 0.6 | | (Continued next page) | | | | | | | | | | | | | | | | | | | | | | |  | Table E.6 (Continued) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | | | NSW | | | | Vic | | | Qld | | | | | WA | | | SA | | | Tas | | | ACT | | | NT | | Aust | | |  | | | Myringotomy | | | | | | | | | | 0.5 | | | 0.7 | | 0.6 | | | | | 0.8 | | | 1.4 | | | 0.5 | | | 0.5 | | | 0.6 | | 0.7 | | |  | | | Prostatectomy | | | | | | | | | | 0.9 | | | 1.0 | | 0.7 | | | | | 0.9 | | | 1.0 | | | 0.8 | | | 1.1 | | | 0.5 | | 0.9 | | |  | | | Septoplasty | | | | | | | | | | 0.3 | | | 0.4 | | 0.2 | | | | | 0.2 | | | 0.5 | | | 0.1 | | | 0.3 | | | 0.2 | | 0.3 | | |  | | | Tonsillectomy | | | | | | | | | | 0.9 | | | 1.3 | | 0.8 | | | | | 0.9 | | | 1.5 | | | 0.7 | | | 0.8 | | | 1.0 | | 1.0 | | |  | | Varicose veins, stripping and ligation | | | | | | | | | | 0.2 | | | 0.3 | | | 0.1 | | | | | 0.1 | | | 0.3 | | | <0.1 | | | 0.5 | | | 0.2 | | 0.2 | | | Source: table 11A.48. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Unplanned hospital readmissions within 28 days of selected surgical admissions, 2012-13  Most recent data for this indicator are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Surgical, procedure prior to separation, rate per 1000 separations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Knee replacement | | | | | | | | 21.6 | | | | | 15.1 | | | 35.1 | | | | | 22.3 | | | 18.6 | | | 37.0 | | | – | | | np | | 22.4 | | |  | | Hip replacement | | | | | | | | 18.0 | | | | | 16.1 | | | 16.1 | | | | | 15.9 | | | 19.3 | | | 29.6 | | | 12.9 | | | np | | 17.5 | | |  | | Tonsillectomy and adenoidectomy | | | | | | | | 30.3 | | | | | 29.1 | | | 35.7 | | | | | 42.4 | | | 37.5 | | | 51.9 | | | 44.7 | | | 83.0 | | 33.1 | | |  | | Hysterectomy | | | | | | | | 31.6 | | | | | 25.9 | | | 31.8 | | | | | 43.6 | | | 28.7 | | | 52.0 | | | 23.1 | | | np | | 30.6 | | |  | | Prostatectomy | | | | | | | | 27.3 | | | | | 26.5 | | | 40.7 | | | | | 33.9 | | | 28.9 | | | 57.8 | | | np | | | np | | 31.1 | | |  | | Cataract surgery | | | | | | | | 3.4 | | | | | 3.0 | | | 4.6 | | | | | 2.6 | | | 2.9 | | | 4.4 | | | 0.9 | | | 6.0 | | 3.4 | | |  | | Appendicectomy | | | | | | | | 22.4 | | | | | 22.8 | | | 22.0 | | | | | 29.0 | | | 27.0 | | | 26.5 | | | 20.4 | | | 43.5 | | 23.1 | | | Accreditation, proportion of accredited beds, public hospitals 2012-13 Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | % | | | | | | | | 97 | | | | | 100 | | | 95 | | | | | 100 | | | 100 | | | 87 | | | 100 | | | 100 | | 98 | | | Adverse events in public hospitals | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Healthcare associated infections in acute care hospitals per 10 000 patient days, 2013-14  Most recent data for this measure are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | 0.9 | | | | | 0.8 | | | 0.9 | | | | | 0.9 | | | 0.6 | | | 0.9 | | | 0.8 | | | 1.0 | | 0.9 | | | Separations with an adverse event, public hospitals: Events per 100 separations, 2012-13  Most recent data for this measure are complete and comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Total | | | | | | | | 6.3 | | | | | 6.8 | | | 6.3 | | | | | 6.4 | | | 7.2 | | | 8.2 | | | 7.4 | | | 3.4 | | 6.5 | | | Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13  Most recent data for this measure are complete and comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | 4.8 | | | | | 3.5 | | | 3.5 | | | | | 3.6 | | | 4.3 | | | 5.3 | | | 3.8 | | | 1.6 | | 4.0 | | | Source: tables 11A.50–11A.55. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Efficiency sustainability indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Workforce sustainability Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Nursing workforce by age group (per cent), 2013 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | <30 | | | | | | | 15.1 | | | | | | | 17.7 | | 15.1 | | | | | 16.8 | | | 14.4 | | | 12.7 | | | 16.6 | | | 18.5 | | 15.9 | | |  | | 30-39 | | | | | | | 20.1 | | | | | | | 21.0 | | 20.7 | | | | | 20.6 | | | 19.2 | | | 15.2 | | | 21.8 | | | 25.7 | | 20.4 | | |  | | 40-49 | | | | | | | 23.9 | | | | | | | 25.2 | | 27.2 | | | | | 25.7 | | | 25.8 | | | 26.7 | | | 25.5 | | | 21.9 | | 25.4 | | |  | | 50-59 | | | | | | | 29.1 | | | | | | | 26.0 | | 26.8 | | | | | 26.4 | | | 30.7 | | | 34.4 | | | 26.2 | | | 24.4 | | 27.7 | | |  | | 60+ | | | | | | | 11.7 | | | | | | | 10.1 | | 10.3 | | | | | 10.5 | | | 9.9 | | | 11.0 | | | 9.8 | | | 9.5 | | 10.6 | | | Medical practitioner workforce by age group (per cent), 2013 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | <30 | | 8.8 | | | | | | | | 10.6 | | | | 9.8 | | | | 12.1 | | | 10.2 | | | 9.8 | | | 9.7 | | | 11.0 | | 10.0 | | |  | | | | | 30-39 | | 26.3 | | | | | | | | 28.4 | | | | 28.9 | | | | 28.3 | | | 26.6 | | | 24.0 | | | 27.3 | | | 36.5 | | 27.6 | | | (Continued next page) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Table E.6 (Continued) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | NSW | | | | | | Vic | | | | | Qld | | WA | | | SA | | | Tas | | | ACT | | | NT | | | | | Aust | | |  | | | | | 40-49 | | | 24.0 | | | | | | 23.5 | | | | | 25.8 | | 25.5 | | | 25.4 | | | 25.9 | | | 25.5 | | | 23.2 | | | | 24.6 | | |  | | | | | | 50-59 | | 21.1 | | | | | | 20.9 | | | | | 20.9 | | 19.7 | | | 20.5 | | | 23.7 | | | 21.4 | | | 17.5 | | | | 20.9 | | | |  | | | | | | 60+ | | 19.8 | | | | | | 16.6 | | | | | 14.5 | | 14.3 | | | 17.3 | | | 16.6 | | | 16.2 | | | 11.9 | | | | 17.0 | | | | Source: tables 11A.56–11A.59. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Efficiency indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Recurrent cost per casemix adjusted separation, dollars, 2011-12 Most recent data for this indicator are complete but not directly comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | 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, 2012-13 Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Total | | | | | | | | 1.04 | | | | | 0.93 | | | 0.86 | | 0.98 | | | 1.04 | | | 1.01 | | | 1.02 | | | 1.13 | | 0.97 | | | | | Recurrent cost per non-admitted occasion of service, 2012-13 Most recent data for this indicator not complete or not directly comparable (chapter 11). Data are available in tables 11A.65–11A.69. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Source: tables 11A.60–11A.72. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Outcome indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Patient satisfaction, 2013-14 Most recent data for this indicator are complete and comparable (chapter 11). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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 | | | | | | | | 86.6 | | | | | 84.9 | | | 84.4 | | 86.7 | | | 86.8 | | | 76.9 | | | 75.2 | | | 90.6 | | 85.4 | | | | |  | | | | Nurses | | | | | | | | 90.2 | | | | | 89.7 | | | 90.4 | | 87.0 | | | 90.3 | | | 85.3 | | | 81.7 | | | 90.6 | | 89.1 | | | | | ED doctors, specialists or nurses always or often showed respect to them | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Doctors/specialists | | | | | | | | 87.2 | | | | | 86.2 | | | 86.1 | | 87.4 | | | 86.3 | | | 85.5 | | | 77.3 | | | 87.2 | | 86.5 | | | | |  | | | | Nurses | | | | | | | | 90.7 | | | | | 90.1 | | | 91.7 | | 88.7 | | | 90.4 | | | 87.6 | | | 85.1 | | | 92.0 | | 90.2 | | | | | ED doctors, specialists or nurses always or often spent enough time with them | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Doctors/specialists | | | | | | | | 81.5 | | | | | 80.4 | | | 81.3 | | 81.3 | | | 81.7 | | | 77.9 | | | 75.3 | | | 85.0 | | 81.0 | | | | |  | | | | Nurses | | | | | | | | 85.9 | | | | | 86.0 | | | 86.7 | | 85.5 | | | 84.9 | | | 79.7 | | | 82.5 | | | 94.2 | | 85.8 | | | | | 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 | | | | | 90.5 | | | 88.4 | | 90.0 | | | 93.6 | | | 88.5 | | | 83.9 | | | 91.0 | | 90.6 | | | | |  | | | | Nurses | | | | | | | | 92.3 | | | | | 92.5 | | | 90.1 | | 91.3 | | | 91.4 | | | 88.5 | | | 83.9 | | | 91.3 | | 91.5 | | | | | hospital doctors, specialists or nurses always or often showed respect to them | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Doctors/specialists | | | | | | | | 92.7 | | | | | 93.0 | | | 90.3 | | 91.2 | | | 96.0 | | | 89.5 | | | 84.8 | | | 91.8 | | 92.4 | | | | |  | | | | Nurses | | | | | | | | 94.0 | | | | | 93.3 | | | 91.4 | | 91.5 | | | 92.9 | | | 90.9 | | | 83.9 | | | 94.2 | | 92.6 | | | | | hospital doctors, specialists or nurses always or often spent enough time with them | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Doctors/specialists | | | | | | | | 87.7 | | | | | 88.4 | | | 86.1 | | 86.9 | | | 92.3 | | | 84.7 | | | 79.1 | | | 92.3 | | 87.7 | | | | |  | | | | Nurses | | | | | | | | 88.6 | | | | | 91.2 | | | 87.2 | | 88.4 | | | 88.9 | | | 86.2 | | | 81.9 | | | 94.2 | | 89.0 | | | | | Source: tables 11A.73–11A.88. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Sentinel events, 2012-13  Most recent data for this indicator are complete but not directly comparable (chapter 11). Data are available in tables 11A.89–11A.97. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. – Nil or rounded to zero. **na** Not available. **np** Not published. |
| *Source*: Chapter 11 and Attachment 11A. |

#### Maternity services

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

|  |
| --- |
| Figure E.22 Maternity services performance indicator framework |
| |  | | --- | | Figure E.22 Maternity services performance indicator framework  More details can be found within the text surrounding this image. | |
|  |
|  |

An overview of the maternity services 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 maternity servicesa |
| |  | | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | Caesareans for selected primiparae — Proportion (%) of births that were caesareans, 2013 Most recent data for this indicator not complete or not directly comparable (chapter 11) | | | | | | | | | | | | |  | % | 23.2 | 24.9 | 22.8 | 24.8 | 27.3 | na | 24.3 | 30.4 | 24.2 | | | Inductions for selected primiparae — Proportion (%) of births that were induced, rate, 2013 Most recent data for this indicator not complete or not directly comparable (chapter 11) | | | | | | | | | | | | |  | % | 39.4 | 34.6 | 29.9 | 35.9 | 41.6 | na | 29.6 | 35.7 | 35.8 | | | Instrumental vaginal births, 2012 Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | |  | % | 22.7 | 28.2 | 21.7 | 30.2 | 24.5 | 26.1 | 27.4 | 18.4 | 24.9 | | | Vaginal birth after caesarean section, 2012 Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | |  | Non-instrumental | 12.5 | 11.6 | 12.3 | 9.1 | 12.4 | 12.2 | 12.2 | 18.7 | 11.9 | | |  | Instrumental | 3.8 | 4.3 | 2.9 | 3.0 | 3.7 | 3.4 | 5.9 | 3.5 | 3.7 | | | Source: tables 11A.102–11A.112. | | | | | | | | | | | | | **Effectiveness — Quality — Safety indicators** | | | | | | | | | | | | | Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births, 2012Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | |  | % | 2.0 | 1.9 | 2.0 | 2.3 | 2.3 | 1.6 | 4.1 | 2.8 | 2.1 | | | Source: table 11A.113. | | | | | | | | | | | | | **Efficiency indicators** | | | | | | | | | | | | | Cost per maternity separation, without complications, dollars, 2011-12,  Most recent data for this indicator are complete but not directly comparable (chapter 11) | | | | | | | | | | | | |  | Caesarean | 8 848 | 7 889 | 9 651 | 13 675 | 10 712 | 7 746 | 12 936 | 15 333 | 9 546 | | |  | Vaginal delivery | 4 975 | 3 634 | 4 900 | 6 499 | 4 911 | 4 050 | 5 706 | 7 503 | 4 826 | | | Mother’s average length of stay, days, 2012-13 Most recent data for this indicator are complete and comparable (chapter 11) | | | | | | | | | | | | |  | Caesarean | 3.8 | 3.7 | 3.3 | 3.7 | 4.0 | 3.8 | 3.8 | 4.4 | 3.7 | | |  | Vaginal delivery | 1.8 | 1.8 | 1.5 | 1.7 | 1.7 | 1.8 | 1.4 | 2.1 | 1.7 | | | Source: tables 11A.114–11A.115. | | | | | | | | | | | | | (Continued next page) | | | | | | | | | | | | |
|  |
|  |

|  |
| --- |
| Table E.7 (Continued) |
| |  | | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Outcome indicators** | | | | | | | | | | | | Apgar score at 5 minutes, 2013 Most recent data for this indicator are not complete and are not directly comparable (chapter 11) | | | | | | | | | | | | Percentage of live births with an Apgar score of 3 or lower by birthweight | | | | | | | | | | | |  | <1500g | 15.1 | 18.7 | 18.6 | 5.4 | 8.0 | na | 13.8 | 26.0 | na | |  | 1500g–1999g | 1.7 | 1.3 | 1.5 | 1.1 | 0.6 | na | 1.4 | np | na | |  | 2000g–2499g | 0.8 | 0.3 | 0.6 | 0.6 | 0.6 | na | 1.0 | np | na | |  | 2500g+ | 0.3 | 0.2 | 0.2 | 0.2 | 0.1 | na | 0.3 | 0.4 | na |   Perinatal death rates — deaths per ‘000 total births, 2012 Most recent data for this indicator are not complete but are comparable (chapter 11) | | | | | | | | | | | | |  | Fetal deaths | 5.2 | 5.6 | 7.0 | 7.1 | 3.5 | 7.2 | 7.5 | 5.6 | 5.9 | | |  | Neonatal deaths | 2.3 | 2.1 | 3.0 | 1.4 | 2.4 | 2.9 | 2.6 | 3.9 | 2.3 | | |  | Perinatal deaths | 7.5 | 7.7 | 10.0 | 8.4 | 5.9 | 10.1 | 10.0 | 9.4 | 8.2 | | | Source: tables 11A.116–11A.121. | | | | | | | | | | | | |
| 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. – Nil or rounded to zero. **na** Not available. |
| *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 |
| |  | | --- | | Figure E.23 Mental health management performance indicator framework   More details can be found within the text surrounding this image. | |
|  |
|  |

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 managementa |
| |  | | NSW | | Vic | | Qld | | WA | | SA | | Tas | | ACT | | NT | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Equity — Access indicators** | | | | | | | | | | | | | | | | | | | | *New client index* | | | | | | | | | | | | | | | | | | | | Proportion of total clients of State and Territory specialised public mental health services who are new, 2012-13  Most recent data for this measure are not comparable nor complete (chapter 12) | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | 40.0 | | na | | 45.3 | | 42.6 | | 43.6 | | 58.1 | | 41.5 | | 47.9 | | 42.8 | | Proportion of total clients of MBS subsidised mental health services who are new  Most recent data for this measure are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | 35.1 | | 33.7 | | 37.3 | | 38.9 | | 34.2 | | 36.8 | | 38.7 | | 48.6 | | 35.6 | | Mental health service use by selected community groups | | | | | | | | | | | | | | | | | | | | Proportion (%) of the Aboriginal and Torres Strait Islander population using State and Territory specialised public mental health services, compared with the proportion for non-Indigenous population, 2012-13  Most recent data for this measure are comparable (subject to caveats), but not complete (chapter 12) | | | | | | | | | | | | | | | | | | | | Aboriginal and Torres Strait Islander | | 4.9 | | na | | 4.5 | | 5.3 | | 5.9 | | 1.4 | | 6.3 | | 4.1 | | 4.7 | | Non-Indigenous | | 1.5 | | na | | 1.8 | | 1.9 | | 1.8 | | 1.2 | | 2.2 | | 2.4 | | 1.7 | | Proportion (%) of the Aboriginal and Torres Strait Islander population using MBS and DVA funded mental health services, compared with the proportion for non-Indigenous population, 2012-13  Most recent data for this measure are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | | Aboriginal and Torres Strait Islander | | 10.7 | | 12.0 | | 7.1 | | 4.0 | | 8.2 | | 8.8 | | 11.4 | | 1.4 | | 7.7 | | Non-Indigenous | | 7.9 | | 8.7 | | 7.7 | | 5.9 | | 7.6 | | 7.0 | | 6.2 | | 4.1 | | 7.7 | | Source: table 12A.33, and tables 12A.35-36. | | | | | | | | | | | | | | | | | | | | **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, 2012-13 | | | | | | | | | | | | | | | | | | | | Specialised public mental health | | | 1.8 | | na | | 1.9 | | 2.1 | | 2.3 | | 1.3 | | 2.4 | | 2.9 | 1.9 | | MBS and DVA subsidised service | | | 8.0 | | 8.8 | | 7.8 | | 5.9 | | 7.8 | | 7.1 | | 6.3 | | 3.4 | 7.8 | | *Primary mental health care for children and young people* Most recent data for this measure are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | | Proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS*,* 2013-14 | | | | | | | | | | | | | | | | | | | | Proportion (%) | | 6.1 | | 6.9 | | 6.1 | | 4.7 | | 6.3 | | 6.2 | | 5.6 | | 2.2 | | 6.1 | | Source: tables 12A.41 and 12A.44. | | | | | | | | | | | | | | | | | | | | (Continued next page)) | | | | | | | | | | | | | | | | | | | |
|  |

|  |
| --- |
| Table E.8 (Continued) |
| |  | | | | | | NSW | | Vic | | Qld | | WA | | SA | | Tas | | ACT | | NT | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Effectiveness — Appropriateness indicators** | | | | | | | | | | | | | | | | | | | | | | | | Services reviewed against national standards Most recent data for this indicator are complete, but not comparable (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 2013 | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | | 82.6 | | | 78.3 | | 99.7 | | 85.8 | | 42.1 | | 9.2 | | 100.0 | | – | | 80.0 | | | 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, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | |  | | Proportion (%) | | | 41.6 | | 64.1 | | 55.3 | | 52.9 | | 61.5 | | 58.8 | | 73.3 | | 61.6 | | 53.4 | | | 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, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | |  | | | Proportion (%) | | | 19.4 | | na | | 41.2 | | 31.4 | | 37.6 | | 26.8 | | 8.7 | | 19.6 | | 28.3 | | Source: tables 12A.47–49. | | | | | | | | | | | | | | | | | | | | | | | | **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 bed days in specialised public mental health acute inpatient units, 2013-14 | | | | | | | | | | | | | | | | | | | | | | | |  | | no. | | | 7.4 | | 9.2 | | 11.1 | | 5.0 | | 4.5 | | 15.2 | | 1.1 | | 21.6 | | 8.0 | | | Source: table 12A.50. | | | | | | | | | | | | | | | | | | | | | | | | **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), 2012-13 | | | | | | | | | | | | | | | | | | | | | | | |  | | | no. | | | 2.3 | | 3.2 | | 2.8 | | 1.3 | | 6.3 | | – | | – | | 0.7 | | 2.7 | | Source: table 12A.52. | | | | | | | | | | | | | | | | | | | | | | | | **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, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | |  | | | Proportion (%) | | | 59.5 | | na | | 72.8 | | 53.3 | | 54.0 | | 20.8 | | 73.9 | | 46.6 | | 60.7 | | 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, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | |  | | | Proportion (%) | | | 14.7 | | 14.7 | | 14.3 | | 13.4 | | 7.7 | | 12.7 | | 14.4 | | 10.7 | | 13.9 | | Source: tables 12A.53 and 12A.56. | | | | | | | | | | | | | | | | | | | | | | | |
| (Continued next page) |
|  |
|  |

|  |
| --- |
| Table E.8 (Continued) |
| |  | | | | NSW | | | Vic | | | | Qld | | | | WA | | | | SA | | | | Tas | | | | ACT | | | | NT | | | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Efficiency indicators** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Cost of inpatient care Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Cost per inpatient bed day, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | General mental health services (acute units) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | $ per bed day | 1 013.22 | | | 843.83 | | | | 921.38 | | | | 1 238.68 | | | | 899.55 | | | | 895.20 | | | | 868.26 | | | | 1 376.80 | | | | 981.17 | | | Public acute hospital with a psychiatric unit or ward (acute units) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | $ per bed day | 1 013.25 | | | 843.60 | | | | 940.69 | | | | 1 204.42 | | | | 864.21 | | | | 1 123.84 | | | | 843.75 | | | | 1 376.80 | | | | 975.73 | | | 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, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | $ per patient day | | 183.97 | | | 514.54 | | | | .. | | | | 408.18 | | | | 456.02 | | | | 641.44 | | | | 671.96 | | | | 353.46 | | | | 468.79 | | Average cost of ambulatory care  Most recent data for this indicator are not comparable, nor complete (chapter 12)  Average cost per treatment day of ambulatory care, 2012-13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | $ per episode | | 223.84 | | | na | | | | 362.05 | | | | 428.58 | | | | 332.35 | | | | 665.90 | | | | 234.40 | | | | 439.27 | | | | 303.28 | | Source: tables 12A.59, 12A.61–63. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **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, 2013 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Proportion (%) | | 11.4 | | | 11.0 | | | | 12.6 | | | | 13.7 | | | | 12.5 | | | | 13.3 | | | | 12.4 | | | | 19.0 | | | | 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, 2008–2012 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Rate | | 8.9 | | | 9.7 | | | | 13.0 | | | | 13.5 | | | | 11.8 | | | | 14.1 | | | | 9.1 | | | | 18.1 | | | | 10.8 | | Physical health outcomes for people with a mental illness  Most recent data for this indicator are comparable and complete (chapter 12) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Proportion of people with a mental illness (compared to the proportion for people without a mental illness) who were daily smokers, 2011-12 (per cent) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | People with mental illness | | 23.6 ± 4.5 | | | 28.9 ± 6.4 | | | 25.7 ± 4.6 | | | | 26.0 ± 5.8 | | | | 26.7 ± 4.9 | | | | 32.4 ± 5.7 | | | | 20.0 ± 5.6 | | | | 29.1 ± 10.1 | | | | 26.1 ± 2.4 | | | | People without mental illness | | 13.4 ± 1.5 | | | 14.7 ± 1.7 | | | 15.8 ± 2.1 | | | | 15.0 ± 1.9 | | | | 15.5 ± 2.1 | | | | 21.5 ± 2.3 | | | | 11.7 ± 2.7 | | | | 21.8 ± 3.0 | | | | 14.7 ± 0.8 | | | |
| (Continued next page) |
|  |
|  |
|  |

|  |
| --- |
| Table E.8 (Continued) |
| |  | | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | *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, 2012-13 | | | | | | | | | | | |  | Proportion (%) | 70.0 | na | 72.7 | 74.3 | 72.6 | 76.4 | np | 77.3 | 72.1 | | Source: tables 12A.66, 12A.75, 12A.81, 12A.85, 12A.87 and 12A.94. | | | | | | | | | | | |
| 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 |
| Source: Chapter 12 and Attachment 12A. |
|  |
|  |

## 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 Aboriginal and Torres Strait Islander 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.

COAG’s National Health Reform Agreement of 2011 included a commitment to introduce clear and transparent performance reporting against a Performance and Accountability Framework. It is anticipated that this will continue to drive improvements in reporting for the health sector.

National clinical quality and safety standards are under development by the Australian Commission on Safety and Quality in Health Care. The National Health Performance Authority was established to:

* provide clear and transparent public reporting of the performance of Local Hospital Networks, public and private hospitals, and primary health care organisations, and monitor their performance
* develop additional performance indicators as appropriate
* maintain the MyHospitals website.

National Health Performance Framework (NHPF) indicators, developed by the National Health Performance Committee and endorsed by the Australian Health Minister’s Advisory Council (most recently in in 2009), are currently under review. The NHPF is designed as an overarching framework of indicators that presents information about the health of Australians and the health system (AIHW 2014b). The updated indicator set is expected to be agreed in early 2015, with reporting against this indicator set to be included in the AIHW’s *Australia’s health 2016*.

The Department of Prime Minister and Cabinet will review 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  **Delivering world class healthcare for NSW**  NSW Health is committed to supporting healthy communities and providing world class, integrated healthcare for the people of NSW. Over the last twelve months, we have driven substantial improvements in the delivery of our health services to deliver better outcomes for our patients. All parts of NSW Health – including our local health districts, networks, NSW Ambulance, our six pillar organisations, our statewide services and shared services – have worked together to achieve these outcomes.  NSW elective surgery results are among the best in the country, achieving 2013 targets for treating semi-urgent and non-urgent patients within the clinically recommended time and targets for reducing the days waited by overdue urgent and non-urgent patients. The AIHW (Australian Institute of Health and Welfare) Australian Hospital Statistics 2013-14: Elective Surgery Waiting Times report found NSW is leading the nation in elective surgery procedures being performed on-time (for all urgency categories combined). The proportion of patients who have waited longer than 365 days is the lowest recorded in the last 5 years at just 1.8 per cent - a near three-fold improvement since 2009-10. NSW also had the lowest proportion of adverse events in elective surgery.  The improvements in our performance have also delivered faster emergency patient care, with over 200 000 additional people receiving timelier Emergency Department care across the NSW Health system. One of the most recognised indicators of this improvement is the National Emergency Access Target (NEAT), a measure of the number of patients who complete their ED treatment within four hours. The Council of Australian Governments’ Reform Council National Partnership Agreement on Improving Public Hospital Services Report for 2013 found NSW showed the biggest improvement in NEAT results between 2012 and 2013, increasing from 61.1 to 70.8 per cent.  NSW patients have welcomed these improvements. The November 2014 Bureau of Health Information Patient Survey report, based on the responses of 35,000 patients at 80 of the state’s public hospitals, found more than 90 per cent of patients rate their overall experience in NSW public hospitals as ‘very good or good’. And 86 per cent of patients reported they were ‘always’ treated with respect and dignity in NSW public hospitals.  The NSW Health Performance Framework for public sector health services provides an integrated process for performance review and management, with the over-arching objectives of improving patient safety, service delivery, quality and efficiency across the NSW Health system. This promotes a high performance culture focused on quality, integrated care and better patient outcomes. | **”** |
| **“** | Victorian Government comments  Victoria’s health services, like those in all jurisdictions, are facing significant and persistent growth in demand, with a growing and ageing population, driving increased service utilisation, and significant growth in the incidence of chronic disease.  In this context, health spending in 2013-14 totalled $14.3 billion, an increase of 4.8 per cent relative to 2012-13, with hospital budgets increased by 5.3 per cent to $8.4 billion.  The achievement of a more sustainable level of health expenditure growth reflects a program of reform for Victorian health services to address costs and improve system productivity and effectiveness through a range of supply and demand measures. These reforms have reduced growth in costs while maintaining the delivery of high quality services, reducing elective surgery waiting lists and meeting growth in emergency department presentations. These reforms have built on the innovation and efficiency that is inherent to the Victorian health system.  *Healthy Together Victoria* is Victoria’s flagship preventative health effort. It takes a unique systems approach to reducing population-level chronic disease risk where people live, learn, work and play.  The *Mental Health Act 2014* is now operational and with it a new recovery‑oriented framework that will ensure people living with a mental illness are supported to make or participate in decisions about their treatment. In 2013‑14, this included an increase in funding to over $1.2 billion, funding more hospital beds for people with a mental illness and improved access to services. Mental health and drug treatment services were recommissioned to support people to manage their treatment to achieve improved quality of life and connection to other health and community support services.  The Victorian health system continues to transform through a focus on patient‑centred care, greater integration of care, and a strong emphasis on translated research. | **”** |

|  |  |  |
| --- | --- | --- |
| **“** | Queensland Government comments  The 2014-2015 Queensland State Budget will see a record amount of over $13.6 billion invested in the Queensland healthcare system, an increase of 6.4 per cent on the 2013-2014 adjusted budget. The increase is supporting the commitment made under the *Blueprint for better healthcare in Queensland* to build the best health system in the country.  Queensland continues to invest in a range of clinical redesign projects and undertake other reforms to improve health service performance and efficiency. Median waiting times for elective surgery in Queensland are well below the national average and there is a commitment to eliminate long waits for elective surgery by the end of 2014. Significant improvements in wait times for public dental patients have also been achieved with the number of long wait patients now reduced to zero.  Challenges to securing a sustainable public health system remain including a growing and ageing population driving increased demand for services. Significant recent changes and uncertainties around future Commonwealth health funding arrangements are adding to the challenge.  Prevention is key to improving the overall health of Queenslanders and several new initiatives are underway to address preventable health risks. These include the major three year *Healthier. Happier.* campaign which encourages all Queenslanders to make healthier lifestyle changes to reduce the risk of chronic disease.  Queensland has the most decentralised population of any Australian jurisdiction which requires innovative methods of providing health services to those in rural and remote areas. In addition, closing the gap in Aboriginal and Torres Strait Islander health outcomes is an ongoing high priority. New initiatives include the introduction of a Mobile Surgical Van pilot program for rural and remote communities, hearing outreach services for Aboriginal and Torres Strait Islander children and expanding mental health support for rural drought declared communities.  In addition to frontline health initiatives, Queensland is continuing to reform the health system structure and organisation to ensure it is best placed to meet community needs. Further responsibilities in relation to asset ownership and staff employment have recently been transferred to locally run Hospital and Health Services. An independent Queensland Office of the Health Ombudsman has also been established to provide a simpler and more transparent complaints system for healthcare consumers.  Queensland is developing its healthcare infrastructure through a substantial investment program to both upgrade or expand existing facilities and open new state-of-the-art hospitals. The Lady Cilento Children’s Hospital in Brisbane, which opened in late 2014, is the biggest public children’s hospital in the country and will be the cornerstone of an enhanced state-wide network of children’s health services. | **”** |
| **“** | Western Australian Government comments  WA’s public health system performed well for the community in 2013-14, despite strong demand for its services from a fast–growing population and the continuing challenge of delivering its biggest-ever infrastructure program. The sound performance was underpinned by long-term planning, regular and ongoing monitoring and review, innovative reform and a professional workforce. WA Health continues to improve its performance and align its efforts to the four pillars stated in its *Strategic Intent 2010*–*2015:*   * Caring for individuals and the community   Focus continued in 2013-14 on health conditions linked to excess body mass and reducing associated hospital treatment costs. Initiatives were implemented to encourage people to “live lighter” to combat this problem. Medical research also received strong support for new initiatives in addition to existing research funding streams for enhanced capability.   * Caring for those who need it most   In 2013-14, the median waiting time for elective surgery in WA was 29 days, the second lowest for all urgency categories among States and Territories. WA also continued to lead the country in the proportion of emergency department visits completed in four hours or less, which at 79 per cent was above the national average of 73 per cent. For Aboriginal people, WA Health renewed its commitment to closing the gap in life expectancy by announcing its new *Footprints to Better Health* strategy. More than 100 dedicated Aboriginal health services will be delivered under the strategy. There was record investment in school health, with the first of 155 new school health staff starting work in WA schools.   * Making the best use of fund and resources   To be in the best position for the new Activity Based Funding regime, WA Health has focussed on improvements across the board, but especially in information and communication technology governance and planning, and adopting a professional and consistent approach to procurement. 2013-14 also saw major upgrades completed or planned at 24 regional and remote facilities, in addition to major infrastructure projects including Fiona Stanley Hospital and Perth Children’s Hospital.   * Supporting our team   Development of a 10–year strategic workforce plan is underway, based on the WA Health Clinical Services Framework 2010–2020, to ensure workforce planning is aligned with demand. The significant challenges faced by WA Health, including the transfer and reconfiguration of staff and resources to new hospitals, were being handled effectively with specialised transition management systems and databases. | **”** |
| **“** | South Australian Government comments  Guided by the SA Health Care Plan 2007-16, the Department for Health and Ageing consolidated and built on gains made in recent years in its work to improve health outcomes and access to services in SA.  Work continued to deliver the Plan’s centrepiece, the new Royal Adelaide Hospital. Scheduled for completion in 2016, the hospital will provide progressive, efficient and state-of-the-art public health care, with the capacity to treat a third more Emergency Department patients each year.  The new Royal Adelaide Hospital is collocated with the SA Health and Medical Research Institute (SAHMRI), officially opened in November 2013. SAHMRI is the state’s flagship health and medical research institute, housing state of the art laboratories, equipment and capacity for up to 675 researchers. Together, and in partnership with other planned tertiary education facilities, the new Royal Adelaide Hospital and SAHMRI will form the SAn Health and Biomedical Precinct. When complete, the site will be the largest of its kind in the Southern Hemisphere.  Other major infrastructure projects reached key milestones in 2013-14. The redeveloped 129 bed Glenside Health Service was officially opened on 28 July 2013 and is the centrepiece of our state’s mental health reform. The state and federally funded $69 million Whyalla Hospital redevelopment and Port Pire’s $12.5 million GP Plus Health Care Centre were opened in November. In January, the redeveloped Modbury Hospital Emergency Department was opened, followed by the $36 million redeveloped Riverland General Hospital in June.  During 2013-14 the Health Enterprise Patient Administration System (EPAS) went live at seven SA Health sites. More than 4500 doctors, nurses, allied health and administrative staff across SA Health now use EPAS in their day to day work.  Other initiatives devised and further developed across SA’s health system included new models of care, improved access to diagnostic services and increased support for discharge planning. As a result, SA continues its strong performance in Emergency Department and elective surgery waiting times.  In September, Southern Adelaide Local Health Network became the first in SA to be assessed against all ten National Safety and Quality Health Service Standards and the first to meet all 209 core actions.  Work continued to improve health outcomes for residents of rural and remote parts of the state and ensure country patients can access and receive medical care of the highest quality as close as possible to their homes.  SA continued its efforts to address the disparity in the health outcomes of Aboriginal and non-indigenous Australians through our Closing the Gap initiatives, such as immunisation, oral health, and health checks for Aboriginal adults and children. | **”** |
| **“** | Tasmanian Government comments   * During 2013-14, the Department of Health and Human Services (DHHS) has continued to focus on its responsibilities to the people of Tasmania. In health, the role of the Department is system manager and purchaser of services on behalf of the Minster for Health. * The Department does not directly deliver health services, but rather purchases services on behalf of Tasmanians from the three Tasmanian Health Organisations (THOs) and monitors the delivery of those services. The Department also has a regulatory role for the public and private health sector. * Significantly, Tasmanians elected a new government in March 2014 and while many of our activities are ongoing, new reform priorities were established towards the end of the year in a number of areas. * 2013-14 saw further maturing of the purchaser/provider model with significant progress made in the management of relationships between the Department (as system manager and purchaser of services on behalf of the Minster for Health) and THOs (as providers of public hospital services and a broad range of health services, including mental health services). * Service agreements, the key annual accountability document between the Minister for Health and THOs, were successfully negotiated and agreed with all three THOs within the timeframes required by legislation. * Population Health Services continues to provide significant work to educate Tasmanians about healthy living choices and preventative health. While the life expectancy of Tasmanians is improving and self-reported health is generally good, Tasmania continues to face challenges in encouraging healthy lifestyles and to reducing the prevalence of smoking and obesity associated chronic disease. * A new *Mental Health Act* 2013 came into effect from February 2014, ensuring there is a more human rights based approach towards clients suffering from mental illness in Tasmania. * Work continued during the year on the Royal Hobart Hospital redevelopment. The incoming Government placed the development on a care and maintenance footing and created a review taskforce. The Department has continued to provide support for the taskforce and facilitate the review which is expected to be completed towards the end of 2014. * During the year significant reform has begun across all areas of the DHHS, most notably with the introduction of the State Government’s *One State, One Health System, Better* Outcomes reform agenda. This will include the transition to a single Tasmanian Health Service from 1 July 2015. * The reforms will also include a review of the DHHS, the creation of the Health Council of Tasmania and a white paper process to review and redefine the clinical profile of service delivery. | **”** |
| **“** | **Australian Capital Territory Government comments**  ACT Health partners with the community and consumers for better health outcomes by delivering patient and family centred care, strengthening partnerships, promoting good health and well being, improving access to appropriate health care, and having robust safety and quality systems. The total catchment population (Australian Capital Region) extends to the surrounding southern parts of NSW, with Canberra serving as the regional referral centre.  In its 2014-15 budget, the ACT Government provided funding for 500 extra elective surgeries. Hospital capacity will also be boosted through the addition of 36 new hospital beds.  A web-based report called ED Live was released to the public in July 2014. For the first time in the ACT, patients are able to access real-time information on Emergency Department (ED) waiting times across Canberra and Calvary hospitals and make informed decisions on which hospital to visit or to consider alternative service providers.  To support tobacco cessation, smoke-free environments have been introduced in ACT Health facilities with designated smoking areas no longer available from 1 September 2014. In 2013, the ACT Government set a target of 'zero growth' for obesity in the ACT through the *Towards Zero Growth: Healthy Weight Action Plan*. Various initiatives implementing this plan are underway, including promoting healthy food and drink options in school canteens and workplaces.  The Health Infrastructure Program announced in 2008 is progressing with the roll-out of new infrastructure to support health care delivery in the ACT. This ACT Government program with an outlay of over $1 billion will revitalise and rebuild the ACT Health system to prepare for growing demands in the future. A new Canberra Regional Cancer Centre on the Canberra Hospital campus opened to patients in August 2014. This modern facility will provide integrated, multi-disciplinary cancer services, making treatments more efficient for patients. Work on the construction of the Belconnen Community Health Centre and refurbishment of the Tuggeranong Community Health Centre has been completed. These Centres will provide expanded health services to assist people manage acute and chronic conditions in the community. Nurse-led Walk- in-Centres (WiCs) have been opened at the two Health Centres providing free, extended hours primary health care treatments for minor illnesses in the community. The WiC at the Canberra Hospital was closed in June 2014.  Stage 2 of the Centenary Hospital for Women and Children has also been completed, bringing a range of services for women and children under one roof. Canberra Hospital ED and Intensive Care Unit extension work has also been completed. Work has commenced on a multi-storey 700+ capacity car park at Calvary Hospital while construction of the new University of Canberra Public Hospital which will provide sub-acute services is expected to begin in 2015. | **”** |
| **“** | * **Northern Territory Government comments**   During 2013-14, the NT Department of Health services continued to provide primary health care in a range of settings, including 45 remote health centres; and acute health care in five hospitals.  The geography of the NT and a population widely distributed across remote and very remote areas creates challenges for service delivery. These challenges contribute to significant socioeconomic disadvantage within the population which often results in limited life and health choices and poorer wellbeing.  Changes to service delivery within the NT made in 2013-14 are designed to improve responses to local needs and conditions through integration, local decision making, regional perspectives and accountability through Service Delivery Agreements backed by an NT-wide safety and quality system. Operational services are now mostly being delivered by two organisations: the Top End and Central Australia Health Services, combining the delivery of primary, community and acute health care services.  This change to a New Services Framework also implements national health reforms. A more streamlined contemporary Department of Health was established on 1 July 2014 as the overall health system manager, with responsibility for: planning and managing the NT public health system; setting Territory wide policy and frameworks; and monitoring the performance of health services. The Department still delivers a number of Territory-wide services (some of which will move into the Health Services) and provides corporate services for the whole public health system.  Other major initiatives in 2013-14 included:   * the passing of the *Health Services Act* and appointment of the Health Service Boards * the establishment of the Office of Disability and the Ministerial Advisory Council on Disability * preparations for the National Disability Insurance Scheme trial in Tennant Creek commencing 1 July 2014 * the continued implementation of Alcohol Mandatory Treatment across the NT along with the review of the *Alcohol Mandatory Treatment Act* * progress towards the development and construction of the Palmerston Regional Public Hospital * continued work towards full implementation of activity based funding for commencement on 1 July 2014 * implementation of enhanced cardiac and cardiac outreach services including low risk angioplasty services in the Top End. | **”** |
| **“** | **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.  Australia has one of the most efficient and effective health care systems in the world. According to the most recent Global Burden of Disease Study, Australia achieves strong health outcomes with lower than average spending on health per capita. However, advances in medical technologies and treatments, new pharmaceuticals, the rising incidence of chronic disease in the community and an ageing population, have meant that the cost of maintaining the health care system continues to rise. Ensuring Australia’s current world class health care system is sustainable into the future is one of the Government’s highest priorities.  One of the key elements of this strategy is a continued investment in health promotion, keeping people healthy and out of hospital. To achieve this, the Government delivers a comprehensive immunisation programme to protect people against harmful communicable diseases. It also continues to invest in public health programmes aimed at reducing Australia’s growing rate of chronic disease caused by smoking, obesity, dietary risks, physical inactivity, and alcohol misuse. About one-third of Australia’s burden of disease is due to these ‘lifestyle’ health risks, therefore continued investment in preventive health is vital to ensuring not only the health and wellbeing of Australian citizens, but also the long term sustainability of the health system.  Complementing this investment in preventive health is the Government’s strengthening of the primary care system. Through Medicare, the Government provides subsided access to GP, specialists, optometrical services and certain allied health services. And through the Pharmaceutical Benefits Scheme (PBS), Australians have access to subsided medicines at affordable prices.  While state governments have primary responsibility for acute care services, the Australian Government provides vital funding to the system through Medicare and block funding for hospitals. The Government is introducing reforms to the system to increase the autonomy of state governments to manage their hospitals and health systems more effectively.  The Government is also investing innovation to improve the efficiency and effectiveness of health services and the health system. The Personally Controlled Electronic Health Record system will continue to be rolled out to improve the coordination of health care services. The Government is also making record investments in medical research to set Australia’s health system up for the future. Properly funded and coordinated research, including clinical trials, is critical to finding new treatments and better systems of care. | **”** |

## 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).

|  |  |
| --- | --- |
| **Table EA.1** | Total health expenditure, by broad source of funds (2012-13 dollars) |
| **Table EA.2** | Government recurrent health expenditure, by area of expenditure  (2012-13 dollars) |
| **Table EA.3** | Non-government recurrent health expenditure by area of expenditure (2012-13 dollars) |
| **Table EA.4** | Recurrent health expenditure, by source of funds and area of expenditure, 2012-13 |
| **Table EA.5** | Total health expenditure per person (2012-13 dollars) |
| **Table EA.6** | Recurrent health expenditure per person by source of funds (2012-13 dollars) |
| **Table EA.7** | Total health price index and industry-wide indexes (reference year 2012-13 = 100) |
| **Table EA.8** | Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status |
| **Table EA.9** | Birthweights, live births, all mothers, 2012 |
| **Table EA.10** | Birthweights, live births, Aboriginal and Torrest Strait Islander mothers, 2012 |
| **Table EA.11** | Proportion of live-born singleton babies of low birthweight, by remoteness and SEIFA quintiles, and SEIFA deciles, National, 2012 |
| **Table EA.12** | Proportion of adults and children in BMI categories |
| **Table EA.13** | Rate of overweight and obesity for adults and children, by remoteness |
| **Table EA.14** | Rates of overweight and obesity for adults and children, by SEIFA IRSD quinitiles |
| **Table EA.15** | Rates of overweight and obesity for adults, by sex and age |
| **Table EA.16** | Rates of overweight and obesity for adults, by Indigenous status, 2011–13 |
| **Table EA.17** | Rates of overweight and obesity for adults, by Indigenous status, 2004-05 |
| **Table EA.18** | Rate of overweight and obesity for children by Indigenous status, 2011–13 |
| **Table EA.19** | Proportion of adults who are daily smokers, by remoteness |
| **Table EA.20** | Proportion of adults who are daily smokers, by SEIFA IRSD quintiles |
| **Table EA.21** | Proportion of adults who are daily smokers, by Indigenous status |
| **Table EA.22** | Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness |
| **Table EA.23** | Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles |
| **Table EA.24** | Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by Indigenous status |
| **Table EA.25** | Proportion of adult abstainers from alcohol, by Indigenous status |
| **Table EA.26** | Incidence of selected cancers |
| **Table EA.27** | Incidence of selected cancers, by remoteness area, 2011 |
| **Table EA.28** | Incidence of selected cancers, by SEIFA IRSD quintiles, 2011 |
| **Table EA.29** | Incidence of selected cancers, by Indigenous status (per 100 000 population) |
| **Table EA.30** | Incidence of heart attacks (acute coronary events), by age and sex, people aged 25 years and over (per 100 000 people) |
| **Table EA.31** | Incidence of heart attacks (acute coronary events), people 25 years or over, by Indigenous status (per 100 000 people) |
| **Table EA.32** | Incidence of heart attacks (acute coronary events), people 25 years or over, NSW (per 100 000 people) |
| **Table EA.33** | Incidence of heart attacks (acute coronary events), people 25 years or over, Victoria (per 100 000 people) |
| **Table EA.34** | Incidence of heart attacks (acute coronary events), people 25 years or over, Queensland (per 100 000 people) |
| **Table EA.35** | Incidence of heart attacks (acute coronary events), people 25 years or over, WA (per 100 000 people) |
| **Table EA.36** | Incidence of heart attacks (acute coronary events), people 25 years or over, SA (per 100 000 people) |
| **Table EA.37** | Incidence of heart attacks (acute coronary events), people 25 years or over, Tasmania (per 100 000 people) |
| **Table EA.38** | Incidence of heart attacks (acute coronary events), people 25 years or over, ACT (per 100 000 people) |
| **Table EA.39** | Incidence of heart attacks (acute coronary events), people 25 years or over, NT (per 100 000 people) |
| **Table EA.40** | Proportion of people with type 2 diabetes (based on fasting blood glucose test), by sex, 2011-12 (per cent) |
| **Table EA.41** | Proportion of people aged 18 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011–13 (per cent) |
| **Table EA.42** | Proportion of people aged 25 years or over with type 2 diabetes (based on fasting blood glucose test), by Indigenous status, by sex, 2011–13 (per cent) |
| **Table EA.43** | Age-standardised mortality rates of potentially avoidable deaths, under 75 years |
| **Table EA.44** | Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT, 2007–2011 |
| **Table EA.45** | All Australians average life expectancy at birth (years) |
| **Table EA.46** | Estimated life expectancies at birth, by Indigenous status and sex (years) |
| **Table EA.47** | Median age at death (years) |
| **Table EA.48** | Median age at death, by Indigenous status (years) |
| **Table EA.49** | Age standardised mortality rate (all causes), by State and Territory |
| **Table EA.50** | 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) |
| **Table EA.51** | Age standardised all-cause mortality rate, rate ratios and rate differences, by Indigenous status, NSW, Qld, WA, SA, NT, 2013 (per 100 000 people) |
| **Table EA.52** | Infant mortality |
| **Table EA.53** | Infant mortality rate by Indigenous status, three year average (per 1000 live births) |
| **Table EA.54** | All causes infant and child mortality, by age group |
| **Table EA.55** | All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT |
| **Table EA.56** | Age standardised mortality rates by cause of death (with variability bands), by State and Territory |
| **Table EA.57** | Age standardised mortality rates by major cause of death, by Indigenous status, 2008–2012 |
| **Table EA.58** | Employed medical practitioners |
| **Table EA.59** | Employed nurses |
| **Table EA.60** | FTE employed allied health practitioners by age, 2012 (per 100 000 people) |
| **Table EA.61** | Net growth in health workforce, selected professions |
| **Table EA.62** | Employed health workforce, by Indigenous status and state and territory of principal practice |
| **Table EA.63** | Indigenous health workforce, by State/Territory, 2011 |
| **Table EA.64** | Indigenous health workforce, by sex, 2011 |
| **Table EA.65** | Indigenous persons employed in selected health-related occupations, 2011 |
| **Table EA.66** | Proportion of people who accessed health services by health status, 2011-12 |
| **Table EA.67** | Proportion of people who accessed health services by health status, 2004-05 |
| **Table EA.68** | Proportion of Aboriginal and Torres Strait Islander people who accessed health services by health status, 2012-13 |
| **Table EA.69** | Proportion of people who accessed health services by health status, by Indigenous status, 2004-05 |
| **Table EA.70** | Proportion of people who accessed health services by health status, by remoteness of residence, 2011-12 |
| **Table EA.71** | Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05 |
| **Table EA.72** | Proportion of people who accessed health services by health status, by SEIFA, 2011-12 |
| **Table EA.73** | Proportion of people who accessed health services by health status, by SEIFA, 2004-05 |

## E.7 References

ABS (Australian Bureau of Statistics) 2014a, *Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results, 2012-13*, Cat. no. 4727.0.55.006, Canberra.

—— 2014b, *Causes of Death Australia, 2012*, Cat. no. 3303.0, Canberra.

—— 2014c, *Deaths Australia 2013*, Cat. no. 3302.0, Canberra.

—— 2013a, *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13*, Cat. no. 4727.0.55.001, Canberra.

—— 2013b, *Deaths Australia 2012*, Cat. no. 3302.0, Canberra.

—— 2007, *Housing and Infrastructure in Aboriginal and Torres Islander Communities 2006, Australia, (Reissue)*, Cat. no. 4710.0, Canberra.

—— and AIHW (Australian Institute of Health and Welfare) 2008, *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples, 2008*, ABS Cat. no. 4704.0, Canberra.

AHMAC (Australian Health Ministers’ Advisory Council) 2012, *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*,Canberra.

AIHW (Australian Institute of Health and Welfare) 2014a, *Health Expenditure Australia 2012-13*, Health and Welfare Expenditure Series no. 52. Cat. no. HWE 61, Canberra.

*Australia’s health 2014*, Australia’s health series no. 14, Cat. no. AUS 178, Canberra.

—— 2014b, *Australia’s health 2014*, Australia’s health series no. 14, Cat. no. AUS 178, Canberra.

—— 2014c, *Birthweight of babies born to Indigenous mothers*, Cat. no. IHW 138, Canberra.

—— 2014d, *Medical Workforce 2013* *Supplementary tables*, www.aihw.gov.au/workforce/  
medical/additional (accessed 8 December 2014).

—— 2014e, *Nursing and midwifery workforce 2013 Supplementary tables*, www.aihw.gov.au/workforce/nursing-and-midwifery/additional/ (accessed 8 December 2014).

—— 2013b, *Expenditure on health for Aboriginal and Torres Strait Islander people 2010-11*, Health and welfare expenditure series no. 48, Cat. no. HWE 57, Canberra.

—— 2013c, *Health priority areas*, www.aihw.gov.au/health-priority-areas/ (accessed 29 August 2013).

—— 2013d, *Why are mortality data important?*, www.aihw.gov.au/why-are-mortality-data-important/ (accessed 29 August 2013).

—— 2013e, *Nursing and Midwifery Workforce 2012*, National health workforce series no. 6, Cat no. HWL 52, Canberra.

—— 2012, *Australia’s Health 2012*, Australia’s health series no. 13,   
Cat. no. AUS 156, Canberra.

—— 2011, *National outcome measures for early childhood development — development of an indicator based reporting framework,* Cat. no. PHE 134, Canberra.

AIHW NPESU (National Perinatal Epidemiology and Statistics Unit) and AIHW 2013, *National core maternity indicators*, Cat. no. PER 58, Canberra.

AMA (Australian Medical Association) 2001, *The Links Between Health and Education For Indigenous Australian Children*, ama.com.au/node/508 (accessed 12 October 2011).

Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD 2007, *The burden of disease and injury in Australia 2003*. Cat. no. PHE 82. Canberra: AIHW.

Better Health Channel 2013, *Fact sheet: Diabetes type 2*, www.betterhealth.vic.gov.  
au/bhcv2/bhcarticles.nsf/pages/Diabetes\_Type\_2?open (accessed 29 August 2013),Victorian Government, Melbourne.

COAG 2011, *National Health Reform Agreement*, August 2011, Canberra, www.coag.gov.au/docs/national\_health\_reform\_agreement.pdf (accessed 5 October 2011).

Coory and Baade 2003, *Is median age at death a useful way to monitor improvements in mortality among Indigenous Australians*, Australia New Zealand Journal of Public Health, 27: 627-31.

Garner, G. 2006, *The ecology and inter-relationship between housing and health outcomes*, paper delivered to the International Conference on Infrastructure Development and the Environment, eprints.qut.edu.au/7216/ (accessed 1 October 2011).

Goldenberg RL & Culhane JF 2007. *Low birth weight in the United States*. American Journal of Clinical Nutrition 85, 2: 584S–90S.

HealthInsite 2011, *Health effects of smoking*,www.healthinsite.gov.au/  
topics/Health\_Effects\_of\_Smoking, (accessed 30 September 2011).

Li Z., Zeki R., Hilder L. and Sullivan E.A. 2013, *Australia’s mothers and babies 2011*, Perinatal statistics series no. 28, Cat. no. PER 59, Canberra: AIHW National Perinatal Epidemiology and Statistics Unit.

MCFFR (Ministerial Council for Federal Financial Relations) 2012, *National Healthcare Agreement*, Canberra, www.federalfinancialrelations.gov.au/  
content/national\_agreements.aspx (accessed 8 January 2014).

NHISSC (National Health Information Standards and Statistics Committee) 2009, *National Health Performance Framework,* 2nd edn.

NHMRC (National Health and Medical Research Council) 2009, *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*, Commonwealth of Australia, Canberra.

—— 2013, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia (2013)*, Canberra.

NPHT (National Preventative Health Taskforce) 2009, *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview*, Commonwealth of Australia, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2012, *National Agreement performance information 2011-12: National Healthcare Agreement*, Productivity Commission, Canberra.

—— 2014, Overcoming Indigenous Disadvantage: Key Indicators 2014, Productivity Commission, Canberra.

—— 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra.

WHO (World Health Organization) 2000, *Obesity: Preventing and Managing the Global Epidemic*, WHO Technical Report Series No. 894, Geneva.

Zhao, Y. Wright, J. Begg, S. and Guthridge, S. 2013, Decomposing Indigenous life expectancy gap by risk factors: a life table analysis. *Population Health Metrics* 2013, vol. 11, no. 1 (www.pophealthmetrics.com/content/11/1/1, accessed 22 November 2013).

1. 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. [↑](#footnote-ref-1)