# 10 Primary and community health

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Primary and community health services include general practice, allied health services, dentistry, alcohol and other drug treatment, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services. Reporting in this chapter focuses mainly on general practice, primary healthcare services targeted to Aboriginal and Torres Strait Islander Australians, public dental services, drug and alcohol treatment and the PBS. The scope of this chapter does not extend to:

* public hospital emergency departments and outpatient services (reported in chapter 11, ‘Public hospitals’)
* community mental health services (reported in chapter 12, ‘Mental health management’)
* Home and Community Care program services (reported in chapter 13, ‘Aged care’ and chapter 14, ‘Services for people with disability’).

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in the prevention of ill health, the detection and management of illness and injury and the effective management of chronic disease — through direct service provision and through referral to acute (hospital) or other healthcare services, as appropriate.

Improvements to reporting on primary and community health services in this edition include:

* expenditure data for primary healthcare services more closely approximate the services covered in this chapter than in previous reports
* data are reported for the first time for occupational therapists and psychologists working in the public sector
* data for the availability of male GPs are reported for the first time alongside data for the availability of female GPs
* the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP diabetes incentive is reported for the first time, in place of the proportion of people with diabetes who received an annual cycle of care within general practice
* updated data for asthma management by Indigenous status are reported
* extending time series for reporting on some indicators
* data quality information (DQI) is available for the first time for the indicator GPs with vocational registration and for the measure effectiveness of access to GPs — bulk billing rates.

## 10.1 Profile of primary and community health

### Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by governments include general practice, community health services, the PBS and public dental services. The Australian Government provides some funding for private dental and allied health services — for the general community through the private health insurance rebate, and for people with specific conditions or needs (for example, mental illness) through DHS Medicare.

The Australian Government also funds a national network of 61 Medicare Locals. These are independent primary health care organisations, established under the National Health Reform agenda in 2011 and 2012, with responsibility to coordinate primary health care delivery and address health care needs and service gaps within their boundaries (AIHW 2014a). Following a review of Medicare Locals, they will be replaced from July 2015 with a smaller number of Primary Health Networks with the objective of improving the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and improving coordination of care, particularly for those with chronic and complex conditions.

Definitions for common health terms are provided in section 10.5.

#### General practice

General practice is a major provider of primary healthcare in Australia. It is defined by the Royal Australian College of General Practitioners (RACGP) as providing ‘person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities’ (RACGP 2014a). General practice is the business structure within which one or more general practitioners (GPs) and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by GPs or corporate entities.

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

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

Services provided in general practice include:

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

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

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

#### Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (Department of Health 2010). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2014 was $6.00 for concession card holders and up to $36.90 for general consumers (Department of Health 2014). The Australian Government pays the remaining cost of medicines eligible for the subsidy. Co‑payment amounts are normally adjusted by the rate of inflation on 1 January each year (Department of Health 2014).

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2014 safety net threshold was $1421.20 for general consumers and $360.00 for concession card holders (Department of Health 2014).

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

#### Community health services

Community health services usually comprise multidisciplinary teams of salaried health and allied health professionals, who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Community health services may be provided directly by governments (including local governments) or indirectly, through a local health service or community organisation funded by government. State and Territory governments are responsible for most community health services. The Australian Government has the main responsibility for Aboriginal and Torres Strait Islander primary healthcare services, which have the objective of addressing the disproportionate ill-health experienced by Aboriginal and Torres Strait Islander people. Around 60 per cent of these are Aboriginal and Torres Strait Islander community-controlled or managed — planned and governed by local Aboriginal and Torres Strait Islander communities with the aim of delivering holistic and culturally appropriate primary healthcare and health related services.

#### Allied health services

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

Nationally, there were 25.5 FTE occupational therapists and 31.5 FTE psychologists per 100 000 people working in the public sector in 2013 (table 10A.29).

#### Dental services

State and Territory governments and the Australian Government have different roles in supporting dental services in Australia’s mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for the delivery of major public dental programs, primarily directed at children and disadvantaged adults. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink. The Australian Government contributes to funding of public dental services through the National Partnership Agreement on Treating More Public Dental Patients that commenced in January 2013.

The Australian Government supports the provision of dental services primarily through the private health insurance rebate and through DHS Medicare. Through DHS Medicare, funding is available for a limited range of oral surgical procedures and, from January 2014, for private and public dental services provided to eligible children aged 2 to 17 years under the Child Dental Benefits Schedule. Funding of private dental services was also available through DHS Medicare for people with chronic conditions and complex care needs until 1 December 2012. Public and private dental services were available through DHS Medicare under the Teen Dental Plan until 31 December 2013. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force and has a role in the provision of dental services through Aboriginal and Torres Strait Islander Primary Health Care Services.

### Funding

Overall primary and community health expenditure data for services approximating those covered in this chapter are available for the first time for the 2015 Report (table 10.1).

Nationally, government expenditure on primary and community health services, including public health, was $30.2 billion in 2012-13, of which State, Territory and local governments provided 24.7 per cent and the Australian Government 75.3 per cent (table 10.1). In that year, Australian Government expenditure on dental services was $1.6 billion, of which 60.8 per cent was through the DVA and the Department of Health. State, Territory and local government expenditure on dental services was around $700 million in 2012-13. Dental expenditure data by state and territory are provided in table 10A.7. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

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| Table 10.1 Estimated funding on Primary healthcare, 2012-13 ($ million) (2012-13 dollars)**a** | |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Australian Government | | | |  |  |  |  | |  | DVA | Department of Health and otherb | Premium rebatesc | Totald | State, Territory and local government | Total governmentd | Non‑ government | Total government and non‑ governmentd | | Unreferred medical services | 838 | 7419 | .. | 8257 | .. | 8257 | 1909 | 10166 | | Dental services | 100 | 843 | 606 | 1550 | 657 | 2207 | 6500 | 8706 | | Other health practitioners | 241 | 1160 | 287 | 1688 | 13 | 1701 | 3508 | 5209 | | Community health and othere | 1 | 1181 | – | 1182 | 5909 | 7092 | 352 | 7444 | | Public health | .. | 1150 | .. | 1150 | 884 | 2034 | 109 | 2143 | | Benefit-paid medications | 429 | 7994 | .. | 8423 | .. | 8423 | 1547 | 9970 | | All other medications | .. | 507 | 22 | 529 | .. | 529 | 8781 | 9309 | | **Total** | **1608** | **20 255** | **915** | **22 779** | **7463** | **30 242** | **22706** | **52 948** | | |
| a Data are not comparable to other expenditure data reported in this chapter, which are expressed in 2013‑14 dollars. b ‘Other’ comprises expenditure on the National Healthcare Agreement and health‑related National Partnerships, capital consumption, estimates of the medical expenses tax offset and health research not funded by the Department of Health. c Expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. d Totals may not add due to rounding. e Includes expenditure on community health and other recurrent health services (not elsewhere classified). .. Not applicable. – Nil or rounded to zero. | |
| *Source*: AIHW (Australian Institute of Health and Welfare) (2014), Health Expenditure Australia 2012-13, Cat. no. HWE 61. |
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#### General practice

The Australian Government funds the majority of general practice services, primarily through DHS Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.4 per cent of direct general practice encounters where a payment source was recorded in 2013-14 were for services at least partly funded by Medicare or the DVA (Britt et al. 2014) (table 10.2).

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| Table 10.2 General practice encounters and funding sources, April 2013 to March 2014a, b |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | Numberc | Per cent of all encountersd | 95% LCL | 95% UCL | | Total encounters for which BEACH data were recordede | 88 151 | 100 | .. | .. | | Direct encounters | 86 607 | 98.2 | 98.0 | 98.5 | | No charge | 332 | 0.4 | 0.3 | 0.5 | | DHS Medicare or DVA paid | 84 136 | 95.4 | 95.1 | 95.8 | | Workers compensation paid | 1 537 | 1.7 | 1.6 | 1.9 | | Other paid (such as, hospital, State) | 603 | 0.7 | 0.5 | 0.8 | | Indirect encounters**f** | 1 542 | 1.7 | 1.5 | 2.0 | |
| LCL = lower confidence limit. UCL = upper confidence limit. DVA = Department of Veterans’ Affairs. a An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals). b Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. c  Number of encounters after post stratification weighting for GP activity and GP age and sex. d Missing data removed from analysis (*n* = 7728). e Includes 2 encounters for which direct/indirect was not specified. f For indirect encounters, the patient is not seen but a service is provided (for example, a prescription or referral). .. Not applicable. |
| *Source*: Britt et al. (2014) *General practice activity in Australia 2013‑14*, Sydney University; table 10A.1. |
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The Australian Government also provides funding for general practice services under initiatives such as the Practice Incentives Program (PIP) and Medicare Locals. PIP provides financial incentives to eligible general practices to support quality care, and improve access and health outcomes (Australian Government DHS 2014).

Australian Government total expenditure on general practice in 2013-14 was $7.9 billion (table 10A.2). This includes fee-for-service expenditure ($7.3 billion, or 92 per cent of the total expenditure) through DHS Medicare and the Department of Veteran's Affairs (DVA), as well as expenditure on the PIP and Medicare Locals (around $600 million, or 8 per cent of the total expenditure).

Age standardisation can be applied to fee-for-service expenditure on general practice to adjust for the effect of variations in age profiles on rates (see chapter 2 for details). The age-standardised expenditure on general practice per person was $299 in 2013‑14.

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

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

#### Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on medications through the PBS and RPBS was around $7.7 billion in 2013‑14 (tables 10A.4 and 10A.5). Expenditure on the PBS decreased from around $7.7 billion ($346 per person), to $7.3 billion ($313 per person) in the period 2009-10 to 2013‑14 (in 2013‑14 dollars) (figure 10.1). Over the same period, the proportion of PBS expenditure that is concessional rose from 77.9 to 78.5 per cent (tables 10A.4 and 10A.5). Data are presented for a ten year time series in Table 10A.4.

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| Figure 10.1 PBS expenditure per person (2013‑14 dollars)**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.1 PBS expenditure per person (2013-14 dollars)  More details can be found within the text surrounding this image. | |
| a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details. b  From 2012-13, rates are derived using the ABS (Australian Bureau of Statistics) 2011 Census based ERP for 31 December and are not comparable with rates in figure 10.6 which use the 30 June ERP. Rates for earlier years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable. c State and Territory data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health’s annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications supplied to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $38.5 million for 2013-14, of which the NT accounted for 52.4 per cent [table 10A.6]). d Includes PBS general ordinary and safety net. e Includes PBS concessional ordinary and concessional free safety net. f Includes RPBS general ordinary and safety net. g Excludes PBS doctor’s bag. |
| *Source*: Department of Health (unpublished) PBS Statistics; tables 10A.4 and 10A.5. |
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#### Community health services

In 2012-13, government expenditure on community health and public health was $9.1 billion, of which State, Territory and local governments provided 74.4 per cent and the Australian Government 25.6 per cent (table 10.1).

Australian Government expenditure on Aboriginal and Torres Strait Islander Primary health care services was $582 million in 2013-14 (table 10A.8).

### Size and scope

#### General practice

There were 32 401 vocationally registered GPs and OMPs — 23 194 on a full time workload equivalent (FWE) basis — billing Medicare Australia, based on MBS claims data, in 2013-14 (see section 10.5 for a definition of FWE). This equated to 99.5 FWE registered GPs and OMPs per 100 000 people (figure 10.2, table 10A.9). MBS claims data do not include services provided by GPs working in Aboriginal and Torres Strait Islander primary healthcare services, public hospitals and the Royal Flying Doctor Service. In addition, for some GPs — particularly in rural areas — MBS claims provide income for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through DHS Medicare.

Nationally, around 5889 general practitioner‑type services per 1000 population were provided under DHS Medicare in 2013-14 (figure 10.3).

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| Figure 10.2 Availability of GPs (full time workload equivalent)**a, b** |
| |  | | --- | | Figure 10.2 Availability of GPs (full time workload equivalent)  More details can be found within the text surrounding this image. | |
| a Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice. b ERPs used to derive rates are revised to the ABS’ final 2011 Census rebased estimates for 31 December. See chapter 2 (table 2A.2) for details. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.9. |
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| Figure 10.3 GP type service use**a, b** |
| |  | | --- | | Figure 10.3 GP type service use  More details can be found within the text surrounding this image. | |
| a Rates are age standardised to the Australian population at 30 June 2001. Rates from 2011-12 are derived using ABS’ 2011 Census based ERPs. Rates for previous years use ABS 2006 Census based ERPs. Rates derived using ERPs based on different Censuses are not comparable. See chapter 2 (table 2A.2) for details. b Includes non‑referred attendances by vocationally registered GPs and OMPs, and practice nurses. From 2013-14, includes non‑referred attendances by nurse practitioners. |
| *Source*: Department of Health (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.10. |
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#### Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 210 million services — 89.3 per cent of which were concessional — were provided under the PBS in 2013‑14 (table 10.3). This amounted to 9.0 filled prescriptions per person. A further 12 million services were provided under the RPBS in the same period.

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| Table 10.3 PBS and RPBS services, 2013‑14 (million services) |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | PBS generala | 7.2 | 5.3 | 4.4 | 2.6 | 1.6 | 0.5 | 0.5 | 0.1 | 22.1 | | PBS concessionalb | 63.7 | 47.9 | 36.5 | 15.4 | 16.1 | 5.4 | 1.8 | 0.6 | 187.3 | | PBS doctor's bagc | 0.1 | 0.1 | 0.1 | – | – | – | – | – | 0.4 | | **PBS total** | 71.0 | 53.3 | 40.9 | 18.0 | 17.8 | 5.9 | 2.2 | 0.7 | 209.8 | | RPBS totald | 4.1 | 2.6 | 3.0 | 1.0 | 0.9 | 0.4 | 0.2 | 0.0 | 12.3 | | **Total** | 75.1 | 55.9 | 44.0 | 19.0 | 18.7 | 6.2 | 2.4 | 0.8 | 222.2 | | PBS services per person (no.)e | 9.5 | 9.2 | 8.7 | 7.1 | 10.6 | 11.4 | 5.8 | 3.0 | 9.0 | |
| a Includes PBS general ordinary and safety net. b Includes PBS concessional ordinary and concessional free safety net. c  Supplies to prescribers for use in a medical emergency. d  Includes RPBS general ordinary and safety net. e Excludes PBS doctor's bag. – Nil or rounded to zero. |
| *Source*: Department of Health (unpublished) PBS Statistics; tables 10A.11 and 10A.12. |
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#### Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.107–10A.115 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

* women’s health services that provide services and health promotion programs for women across a range of health-related areas
* men’s health programs (mainly promotional and educational programs)
* allied health services
* community rehabilitation programs.

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 12 (Mental health management), 13 (Aged care services) and 14 (Services for people with disability).

##### Maternal and child health

All jurisdictions provide maternal and child health services. These include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs. Performance indicators for maternity services in public hospitals are reported in chapter 11 (Public hospitals).

##### Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to preschool and secondary school students (tables 10A.107–10A.115).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. The Australian Government contributes funding through the National Partnership Agreement on Treating More Public Dental Patients. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2013-14 targeted at disadvantaged people (tables 10A.107–10A.115). Current data are not available for use of public dental services for the 2015 Report — 2010 data are again reported in table 10.4.

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 10.4).

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| Table 10.4 Use of public dental services by service type, per 1000 people, 2010**a, b, c, d** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | Emergency servicese | 9.6 | 10.4 | 26.9 | 12.4 | 13.3 | 29.3 | 14.6 | 25.6 | 14.5 | | General services | 34.1 | 45.0 | 71.0 | 113.6 | 84.1 | 106.2 | 81.7 | 157.7 | 59.9 | | All services | 43.7 | 55.4 | 97.9 | 126.0 | 97.3 | 135.4 | 96.3 | 183.3 | 74.4 | |
| aRates are age standardised to the Australian population at 30 June 2001. b Limited to dentate people aged 5 years or over. c Data are for the number of people who used a public dental service at least once in the preceding 12 months, not for the number of services provided. d Type of service at the most recent visit. e Emergency visit is a visit for relief of pain. |
| *Source*: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0; table 10A.13. |
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##### Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to   
long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. Data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) — a collection of data from publicly funded government and non-government treatment services (AIHW 2014b). Treatment activities are excluded from that collection if the agencies provide medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, are located within prisons or detention centres, or in acute care and psychiatric hospitals providing treatment only to admitted patients. While in scope, the majority of primary healthcare services for Aboriginal and Torres Strait Islander Australians that are funded by the Australian government do not report to the AODTS NMDS.

A total of 714 alcohol and other drug treatment agencies reported 2012-13 data   
to the AODTS–NMDS. Of these, 317 (44.4 per cent) identified as government providers and 397 (55.6 per cent) as non-government providers (table 10A.14). There were 162 362 reported closed treatment episodes in 2012-13 (table 10A.14) (see section 10.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 68.1 per cent of whom were male, accounted for 155 151 closed treatment episodes (table 10A.14) (AIHW 2014b).

Alcohol was the most commonly reported principal drug of concern (41.1 per cent), followed by cannabis (23.6 per cent), amphetamines (14.4 per cent) and heroin (8.3 per cent), in closed treatment episodes for clients seeking treatment for their own substance abuse. Additional drugs of concern were reported in 62.9 per cent of the episodes (AIHW 2014b).

Alcohol was the most common principal drug of concern in all states and territories. Cannabis was the second most common principal drug in all states and territories except SA, where amphetamines were more common and the NT, where volatile solvents were more common (AIHW 2014b). Further information on alcohol and other drug treatment services funded by governments is included in tables 10A.107–10A.115.

##### Aboriginal and Torres Strait Islander Primary Health Care Services

Aboriginal and Torres Strait Islander people use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Primary Health Care Services. The latter, available in all jurisdictions, provide comprehensive primary health care and/or substance use, social and emotional wellbeing and mental health services, to Aboriginal and Torres Strait Islander people. They are funded by Australian, State and Territory governments, with the Australian Government contributing the greater share.

In addition, other health programs for Aboriginal and Torres Strait Islander Australians are funded by a number of jurisdictions. In 2012‑13, these programs included services such as health promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 10A.107–10A.115).

From the 2008‑09 reporting period, data on Aboriginal and Torres Strait Islander primary healthcare services that receive funding from the Australian Government have been collected through the Online Services Report (OSR) questionnaire. Many of the services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent funding from all sources.

For 2012‑13, OSR data are reported for 205 Aboriginal and Torres Strait Islander primary healthcare services (table 10A.15). Of these services, 92 (44.9 per cent) were located in remote or very remote areas (table 10A.16). They provided a range of primary healthcare services (table 10A.17 — historical data are reported in table 10A.18). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Around 3.1 million episodes of healthcare were provided by participating services in 2012‑13 (table 10.5). Of these, around 1.4 million (45.4 per cent) were in remote or very remote areas (table 10A.16).

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| Table 10.5 Estimated episodes of healthcare for Aboriginal and Torres Strait Islander Australians by services for which OSR data are reported (‘000)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | 2008-09 | 452 | 160 | 336 | 306 | 191 | 35 | 23 | 586 | 2 089 | | 2009-10 | 542 | 185 | 379 | 409 | 192 | 36 | 26 | 622 | 2 391 | | 2010-11 | 522 | 201 | 310 | 473 | 222 | 38 | 30 | 704 | 2 498 | | 2011-12 | 516 | 234 | 475 | 462 | 216 | 44 | 34 | 641 | 2 621 | | 2012-13 | 622 | 238 | 575 | 583 | 217 | 53 | 38 | 743 | 3 068 | |
| a An episode of healthcare involves contact between an individual client and service staff to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare and/or information by staff. Outreach provision is included, for example episodes at outstation visits, park clinics and satellite clinics. Episodes of healthcare delivered over the phone are included. |
| *Source*: AIHW (2014 and previous issues) *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results*, Cat. nos IHW 31, 56, 79, 104 and 139; table 10A.15. |
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The services included in the OSR data collection employed around 4344 full time equivalent healthcare staff (as at 30 June 2013). Of these, 2386 were Aboriginal and Torres Strait Islander Australians (54.9 per cent). The proportions of doctors and nurses employed by surveyed services who were Aboriginal and Torres Strait Islander Australians,   
while remaining relatively low, have increased in the period 2010–2013 — rising from 4.8 per cent to 7.2 per cent for doctors and from 10.4 per cent to 14.4 per cent for nurses (table 10A.19).

## 10.2 Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (box 10.1). The framework will evolve as better indicators are developed and as the focus and objectives for primary and community health change. In particular, the Steering Committee plans to develop and report against more indicators relating to community health services.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, and health indicators in the *National Indigenous Reform Agreement* establish specific outcomes for reducing the level of disadvantage experienced by Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. The Steering Committee collates NIRA performance information for analysis by the Department of Prime Minister and Cabinet. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

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| Box 10.1 Objectives for primary and community health |
| Primary and community health services aim to support and improve the health of Australians by:   * providing a universally accessible point of entry to the healthcare system * promoting health and preventing illness * providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) * coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals’ healthcare needs.   In addition, governments aim to ensure that interventions provided byprimary and community health services are based on best practice evidence and delivered in an equitable and efficient manner. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 10.4). The performance indicator framework shows which data are comparable in the 2015 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness from a Report‑wide perspective (see section 1.6).

The Report’s statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous- and ethnic‑status) (chapter 2).

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| Figure 10.4 Primary and community health performance indicator framework |
| |  | | --- | | Figure 10.4 Primary and community health performance indicator framework   More details can be found within the text surrounding this image. | |
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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, in addition to the material in the chapter and attachment tables. DQI in this Report cover the seven dimensions in the Australian Bureau of Statistics (ABS) data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and 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.

## 10.3 Key performance indicator results

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

### Outputs

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

### Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Aboriginal and Torres Strait Islander Australians relative to other Australians (SCRGSP 2014).

#### Access

##### Availability of PBS medicines

‘Availability of PBS medicines’ is an indicator of governments’ objective to provide equitable access to PBS medicines (box 10.2).

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| Box 10.2 Availability of PBS medicines |
| ‘Availability of PBS medicines’ is defined by three measures:   * people per pharmacy by region, defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions * PBS expenditure per person by region, defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions * proportion of PBS prescriptions filled at a concessional rate, defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.   This indicator is difficult to interpret. A low or decreasing number of people per pharmacy may indicate greater availability of PBS medicines. High or increasing PBS expenditure per person may indicate improved availability of PBS medicines. A high or increasing proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people. It is also important that there are not large discrepancies by region in these measures.  Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people’s health and medicines should be available to those who require them, regardless of residential geolocation or socioeconomic circumstance.  This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2014 for people per pharmacy by region and for 2013-14 for the measures PBS expenditure per person by region and proportion of PBS prescriptions filled at a concessional rate.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, the number of people per pharmacy in rural areas decreased from 4277 to 3771 in the period 2010 to 2014, falling below the number of people per pharmacy in urban areas, which rose from 3814 to 3963 in the same period (figure 10.5).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 24 medical practitioners and 263 hospitals — 104 private and 159 public[[1]](#footnote-1) — approved to supply PBS medicines to the community at 30 June 2014. The approved medical practitioners and 49 of the approved public hospitals were located in rural areas (table 10A.20).

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| Figure 10.5 People per pharmacy**a, b, c, d, e** |
| |  | | --- | | Figure 10.5 People per pharmacy  Urban areas  More details can be found within the text surrounding this image.  Figure 10.5 People per pharmacy  Rural areas  More details can be found within the text surrounding this image. | |
| a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. b Number of pharmacies as measured at 30 June is used to derive rates. c Excludes RPBS and doctor’s bag. d The ERP used to derive rates in the early and latter parts of this time series are based on different ABS Censuses. Rates derived using ERPs based on different Censuses are not comparable. e Care should be taken in using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth). |
| *Source*: Department of Health (unpublished) derived from DHS Medicare, ABS (unpublished) *2006/2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre; table 10A.20. |
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Nationally, PBS expenditure per person was around $315 in 2013‑14 (figure 10.6). PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 10.6).

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| Figure 10.6 PBS expenditure per person (2013‑14 dollars)**a, b, c, d** |
| |  | | --- | | Figure 10.6 PBS expenditure per person (2013-14 dollars)  More details can be found within the text surrounding this image. | |
| a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See Chapter 2 (sections 2.5-6) for details. b Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. c Rates are derived using ABS 2011 Census based ERPs for 30 June and are not comparable with rates in figure 10.1 which are derived using 31 December ERPs. d Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health’s annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $38.5 million in 2013-14 [table 10A.6]). |
| *Source*: Department of Health (unpublished) PBS Statistics; table 10A.21. |
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The proportion of PBS prescriptions filled at a concessional rate is reported by   
State and Territory in table 10A.11. These data are not available by regional   
location. Nationally, 89.3 per cent of prescriptions subsidised under the PBS were concessional in 2013-14.

##### Equity of access to GPs

‘Equity of access to GPs’ is an indicator of governments’ objective to provide equitable access to primary healthcare services (box 10.3).

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| Box 10.3 Equity of access to GPs |
| ‘Equity of access to GPs’ is defined by two measures:   * availability of GPs by region, defined as the number of FWE GPs per 100 000 people, by region * availability of GPs by sex, defined as the number of FWE GPs per 100 000 population, by sex.   High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas.  High or increasing availability of GPs of each sex means it is more likely that patients who prefer to visit GPs of their own sex for discussion of health matters and to receive primary care will have their preference met. Low availability of GPs of each sex can be associated with increased waiting times to see a GP, for patients who prefer to visit GPs of their own sex.  This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years for the measure availability of GPs by region * comparable (subject to caveats) across jurisdictions and over time for the measure availability of GPs by sex * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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##### Availability of GPs by region

In terms of FWE GPs per 100 000 people, there were more GPs available in major cities and inner regional areas than in outer regional, remote and very remote areas in most jurisdictions in 2013-14 (figure 10.7). The bulk billed proportion of non‑referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 10A.34).

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| Figure 10.7 Availability of GPs (full time workload equivalent), 2013-14**a, b, c** |
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| a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. b FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. c There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. For the ACT, major cities includes inner regional areas. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.23. |
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##### Availability of GPs by sex

In 2013-14, 43.2 per cent of Australia’s GPs — 33.5 per cent of FWE GPs — were female (table 10A.25). The number of FWE female GPs per 100 000 females increased from   
53.2 to 66.3 in the period 2009-10 to 2013-14 (figure 10.8). In the same period, the number   
of FWE male GPs per 100 000 males increased from 126.3 to 132.9 (figure 10.8, table 10A.26). Data for female GPs are presented for a ten year time series in table 10A.25.

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| Figure 10.8 Availability of GPs by sex (full time workload equivalent)**a** |
| Figure 10.8 Availability of GPs by sex (full time workload equivalent)  Legend to Figure  More details can be found within the text surrounding this image.   |  | | --- | | Figure 10.8 Availability of GPs by sex (full time workload equivalent)  FWE Female GPs/100 000 females  More details can be found within the text surrounding this image.  Figure 10.8 Availability of GPs by sex (full time workload equivalent)  FWE Male GPs/100 000 females  More details can be found within the text surrounding this image. | |
| a Data relate to vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. |
| *Source*: Department of Health (unpublished) MBS Statistics; tables 10A.25, 10A.26. |
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##### Availability of public dentists

‘Availability of public dentists’ is an indicator of governments’ objective to provide equitable access to dental services (box 10.4).

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| Box 10.4 Availability of public dentists |
| ‘Availability of public dentists’ is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region.  High or increasing availability of public dentists can indicate improved access to public dental services. The availability of public dentists by region affects people’s access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.  This indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * not available for the current reporting period (2013).   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Nationally, there were 7.3 FTE public dentists per 100 000 people in major cities — more than in regional and remote/very remote areas — in 2013 (figure 10.9, table 10A.27). Nationally, the number of FTE public dental therapists per 100 000 people was highest in outer regional areas (5.8), followed by remote/very remote (4.7) and inner regional (4.6) and lowest in major cities (3.1) in 2013 (table 10A.28). Data for FTE dental hygienists and dental therapists are presented in table 10A.28.

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| Figure 10.9 Availability of public dentists, 2013**a, b, c, d** |
| |  | | --- | | Figure 10.9 Availability of public dentists, 2013  More details can be found within the text surrounding this image. | |
| a FTE based on 40 hours per week. b Public dentists include those working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. c There were no public dentists in remote or very remote areas in Victoria or Tasmania. Data for inner regional areas in the ACT are suppressed for confidentiality purposes. d Tasmania has no major cities. The ACT has no outer regional, remote or very remote areas. The NT has no major cities or inner regional areas. |
| *Source*: AIHW (unpublished) National Health Workforce Data Set; table 10A.27. |
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##### Early detection and early treatment for Aboriginal and Torres Strait Islander Australians

‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is an indicator of governments’ objective to provide equitable access to primary and community healthcare services for Aboriginal and Torres Strait Islander Australians (box 10.5).

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| Box 10.5 Early detection and early treatment for Aboriginal and Torres Strait Islander Australians |
| ‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is defined as:   * the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection) * the provision of appropriate and timely prevention and intervention measures (early treatment).   (Continued next page) |
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| Box 10.5 (Continued) |
| Three measures of early detection and early treatment for Aboriginal and Torres Strait Islander Australians are reported:   * the proportion of older people who received a health assessment under DHS Medicare by Indigenous status * older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Aboriginal and Torres Strait Islander Australians become eligible for ‘older’ people’s services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between Aboriginal and Torres Strait Islander and other Australians (see the Health sector overview) * health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing. * the proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment under DHS Medicare in successive years of a five year period * the proportion of Aboriginal and Torres Strait Islander Australians who received a health assessment or check under DHS Medicare by age group — health assessment/checks are available for Aboriginal and Torres Strait Islander children (0–14 years), adults (15–54 years) and older people (55 years or over).   A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander and other Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Aboriginal and Torres Strait Islander Australians. An increase over time in the proportion of older Aboriginal and Torres Strait Islander Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Aboriginal and Torres Strait Islander Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Aboriginal and Torres Strait Islander population.  This indicator provides no information about health assessments provided outside DHS Medicare. Such services are provided under service delivery models used, for example, in remote and very remote areas and therefore accessed predominantly by Aboriginal and Torres Strait Islander Australians. Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander Australians who received early detection and early treatment services.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2013‑14.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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The high prevalence of preventable and/or treatable health conditions in the Aboriginal and Torres Strait Islander population is strongly associated with relatively poor health outcomes for Aboriginal and Torres Strait Islander Australians (AIHW 2008a; SCRGSP 2014). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people’s health.

Nationally, the proportion of older people receiving a health assessment was 30.4 per cent for Aboriginal and Torres Strait Islander people and 31.1 per cent for other Australians in 2013-14 (figure 10.10). There was considerable variation across States and Territories in the relative proportion of older people receiving a health assessment for these populations.

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| Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2013-14**a, b, c, d** |
| |  | | --- | | Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2013-14  More details can be found within the text surrounding this image. | |
| a Older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over. b The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander Australians. c Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data for Aboriginal and Torres Strait Islander Australians are therefore likely to understate the proportion who access health assessments. d Rates are derived using the ABS’ final 2011 Census rebased estimates and projections. See chapter 2 (tables 2A.2 and 2A.13-14) for details. |
| *Source*: Derived from Department of Health (unpublished) MBS Statistics, ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (various years) *Australian demographic statistics*,Cat. no. 3101.0; table 10A.30. |
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The proportion of older Aboriginal and Torres Strait Islander Australians who received an annual health assessment increased in all jurisdictions between 2009-10 and 2013-14 (figure 10.11).

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| Figure 10.11 Older Aboriginal and Torres Strait Islander Australians who received an annual health assessment**a, b, c** |
| |  | | --- | | Figure 10.11 Older Aboriginal and Torres Strait Islander Australians who received an annual health assessment  More details can be found within the text surrounding this image. | |
| a For Aboriginal and Torres Strait Islander people, older is defined as aged 55 years or over. The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander Australians. b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data are therefore likely to understate the proportion who access health assessments. c Rates are revised to the ABS’ final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.13-14) for details. |
| *Source*: Derived from Department of Health (unpublished) MBS data collection and ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; table 10A.31. |
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Health check MBS items were introduced for Aboriginal and Torres Strait Islander people aged 15–54 years in May 2004. Initially available biennially, since 1 May 2010 they have been available annually. Also available annually are health checks for Aboriginal and Torres Strait Islander children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Aboriginal and Torres Strait Islander population who received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 10.12). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided selected early detection services, sourced from OSR data, was included in previous reports as a supplementary measure for this indicator. However, the data are no longer available due to changes in the OSR data collection instrument, and the measure is not included in the 2015 Report.

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| Figure 10.12 Aboriginal and Torres Strait Islander Australians who received a health assessment by age, 2013-14**a, b, c** |
| |  | | --- | | Figure 10.12 Aboriginal and Torres Strait Islander Australians who received a health assessment by age, 2013-14  More details can be found within the text surrounding this image. | |
| a The population of Aboriginal and Torres Strait Islander people is determined by self-identification. Aboriginal and Torres Strait Islander Australians aged 75 years or over my receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander Australians. b Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander Australians. Data are therefore likely to understate the proportion who access health assessments. c Rates are derived using the ABS’ final 2011 Census rebased estimates and projections. See chapter 2 (tables 2A.13-14) for details. |
| *Source*: Derived from Department of Health (unpublished) MBS Statistics and ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; table 10A.32. |
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##### Developmental health checks

‘Developmental health checks’ is an indicator of governments’ objective to provide equitable access to early detection and intervention services for children (box 10.6).

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| Box 10.6 Developmental health checks |
| ‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health assessment under DHS Medicare, by health assessment type. The ‘Healthy Kids Check’ MBS health assessment item is available to children aged 3 or 4 years, while the ‘Aboriginal and Torres Strait Islander Peoples Health Assessment’ item is available to Aboriginal and Torres Strait Islander people of all ages.  A high or increasing proportion of children receiving a fourth year developmental health assessment is desirable as it suggests improved access to these services.  The proportion of Aboriginal and Torres Strait Islander children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Aboriginal and Torres Strait Islander children who received a fourth year developmental health assessment. The proportion of other children who received either a Healthy Kids Check (at the age of 3 or 4 years), or a Health assessment at the age of 5 years, is reported as a proxy for the proportion of other children who received a fourth year developmental health assessment.  Fourth year developmental health assessments are intended to assess children’s physical health, general wellbeing and development. They enable identification of children who are at high risk for, or have early signs of, delayed development and/or illness. Early identification provides the opportunity for timely prevention and intervention measures that can ensure that children are healthy, fit and ready to learn when they start schooling.  This indicator provides no information about developmental health checks for children that are provided outside DHS Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, in maternal and child health services, community health centres, early childhood settings and the school education sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data from 2012-13 are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Nationally, the proportion of children who received a fourth year developmental health check under DHS Medicare was 55.6 per cent in 2013-14 (table 10A.33). The proportion was higher for Aboriginal and Torres Strait Islander children than for other children in 2013-14, although there was considerable variation across jurisdictions (figure 10.13).

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| Figure 10.13 Children who received a fourth year developmental health check, by health check type, 2013-14**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.13 Children who received a fourth year developmental health check, by health check type, 2013-14  More details can be found within the text surrounding this image. | |
| a Limited to health checks available under DHS Medicare. b Aboriginal and Torres Strait Islander Peoples Health Assessment data include claims for MBS Item 715 for children aged 3–5 years. c Healthy Kids Check data include claims for MBS Items 701, 703, 705, 707 and 10 986 for children aged 3–5 years. d Children are counted once only. A child is counted only if not counted for a previous year. Where a child received both types of health check they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. e Healthy Kids Check data include Aboriginal and Torres Strait Islander children who received a Healthy Kids Check and do not receive a Aboriginal and Torres Strait Islander Peoples Health Assessment. f The denominator is the population of 4 year olds and is not directly comparable to the numerator, which is the sum of children who, for the first time at the age of 3, 4 or 5 years, received a health assessment under the MBS. Using this methodology, the estimated proportion of Aboriginal and Torres Strait Islander children in the NT who received a health check exceeds 100 per cent. g Rates are derived using the ABS’ final 2011 Census rebased estimates and projections. See chapter 2 (tables 2A.2 and 2A.14) for details. |
| *Source*: Department of Health (unpublished) MBS Statistics; ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.33. |
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### Effectiveness

#### Access

##### Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is an indicator of governments’ objective to provide effective access to primary healthcare services (box 10.7). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

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| Box 10.7 Effectiveness of access to GPs |
| ‘Effectiveness of access to GPs’ is defined by four measures:   * bulk billing rates, defined as the number of GP visits that were bulk billed as a proportion of all GP visits * people deferring visits to GPs due to financial barriers, defined as the proportion of people who delayed seeing or did not see a GP due to cost * GP waiting times, defined as the number of people who saw a GP for urgent medical care within specified waiting time categories in the previous 12 months, divided by the number of people who saw a GP for urgent medical care in the previous 12 months. Specified waiting time categories are: * less than 4 hours * 4 to less than 24 hours * 24 hours or more * potentially avoidable presentations to emergency departments (interim measure), defined as: * the number of selected ‘GP-type presentations’ to emergency departments, where selected GP-type presentations are those: * allocated to triage category 4 or 5 * not arriving by ambulance, with police or corrections * not admitted or referred to another hospital * who did not die.   A high or increasing proportion of bulk billed attendances can indicate more affordable access to GP services. GP visits that are bulk billed do not require patients to pay part of the cost of the visit, while GP visits that are not bulk billed do. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and comparable over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   (Continued next page) |
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| Box 10.7 (Continued) |
| A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and comparable over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Potentially avoidable presentations to emergency departments — an interim measure for this indcator — are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.  Data reported for this measure are:   * comparable (subject to caveats) within some jurisdictions over time but not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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##### Effectiveness of access to GPs — bulk billing rates

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

Nationally, the bulk billed proportion of non‑referred attendances, including those by practice nurses, was 83.6 per cent in 2013‑14. For most jurisdictions, this proportion increased in the period 2009-10 to 2013‑14 (figure 10.14). The bulk billed proportion of non‑referred attendances was highest in very remote areas and lowest in inner regional, outer regional and remote areas (table 10A.34). The bulk billed proportion of non‑referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 10A.36).

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| Figure 10.14 GP visits that were bulk billed**a, b** |
| |  | | --- | | Figure 10.14 GP visits that were bulk billed  More details can be found within the text surrounding this image. | |
| a Includes attendances by practice nurses. b Allocation to State/Territory based on patients’ DHS Medicare enrolment postcode. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.36. |
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##### Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Timely access to healthcare services is important to people’s health and wellbeing. Deferring or not visiting a GP can result in poorer health. Nationally, in 2013-14, 4.9 per cent of ABS Patient experience survey respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 10.15).

Data for Aboriginal and Torres Strait Islander Australians deferring access to GPs due to cost, collected for the first time from the ABS 2011-12 AATSIHS (Australian Aboriginal and Torres Strait Islander Health Survey), are presented in table 10A.38. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

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| Figure 10.15 People deferring visits to GPs due to cost**a, b, c, d, e, f** |
| |  | | --- | | Figure 10.15 People deferring visits to GPs due to cost  More details can be found within the text surrounding this image. | |
| a People aged 15 years or over. b Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. c Data are crude rates and may differ from data in previous reports in which rates were age­standardised. d Data for 2012-13 and 2013-14 are comparable. Data are not comparable with previous years due to a change in survey question wording and sequencing. e Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. f Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) *Patient Experience Survey* *2012-13, 2013-14*, Cat. no. 4839.0; table 10A.37. |
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##### Effectiveness of access to GPs — GP waiting times

Nationally, 64.2 per cent of people who saw a GP for urgent care waited less than 4 hours in 2013-14 (figure 10.16). Around 10.0 per cent waited from 4 to less than 24 hours, and 25.8 per cent waited for 24 hours or more. Overall, 22.6 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 10A.40).

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| Figure 10.16 Hours waited for urgent treatment by a GP, 2013-14**a, b, c, d, e, f** |
| |  | | --- | | Figure 10.16 Hours waited for urgent treatment by a GP, 2013-14  More details can be found within the text surrounding this image. | |
| a People aged 15 years or over who saw a GP for urgent medical care for their own health in the previous 12 months. b Time waited between making an appointment and seeing the GP for urgent medical care. c Data are comparable with data from 2011-12 but not with data for previous years due to a changed survey question. d Data are crude rates. e Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. f Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) *Patient Experience Survey* *2013-14*, Cat. no. 4839.0; table 10A.39. |
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##### Effectiveness of access to GPs — GP-type presentations to emergency departments

GP-type presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). It is important to note that these include appropriate presentations to emergency departments that can only be retrospectively categorised as ‘GP-type’. Factors contributing to GP‑type presentations at emergency departments where this is not the case include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff.

Nationally, there were around 2.2 million GP-type presentations to public hospital emergency departments in 2013-14 (table 10.6).

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| Table 10.6 GP-type presentations to emergency departments,  (‘000)**a, b, c, d** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | 2013-14 | 709.3 | 572.4 | 381.4 | 272.9 | 113.4 | 61.2 | 50.5 | 39.3 | 2 200.4 | |
| a GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of semi-urgent or non-urgent, and where the episode end status was not admitted to the hospital, or referred to another hospital, or died. b This is an interim measure, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. Data include appropriate presentations to emergency departments, where the categorisation ‘GP-type’ can only be applied retrospectively. c Data are presented by State/Territory of usual residence of the patient. d Data are for peer group A and B public hospitals only, based on 2012-13 peer groups. |
| *Source*: AIHW (unpublished) National non-admitted emergency patient database; table 10A.41. |
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Nationally, 23.6 per cent of people who went to a hospital emergency department for their own health in 2012-13 thought at the time that care could have been provided at a general practice (figure 10.17).

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| Figure 10.17 People visiting a hospital emergency department for  care they thought could have been provided at a  general practicea, b, c, d |
| |  | | --- | | Figure 10.17 People visiting a hospital emergency department for  care they thought could have been provided at a general practice  More details can be found within the text surrounding this image. | |
| a Proportion of people aged 15 years or over who went to a hospital emergency department for their own health and at the time, thought the care could have been provided at a general practice. b Rates are age‑standardised to the 2001 ERP. c Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. d Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. |
| *Source*: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0; table 10A.42. |
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##### Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure effective access to prescribed medicines (box 10.8).

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| Box 10.8 Financial barriers to PBS medicines |
| ‘Financial barriers to PBS medicines’ is defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.  A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Nationally, in 2013-14, 7.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 10.18). Data for Aboriginal and Torres Strait Islander Australians were collected for the first time from the ABS 2011‑12 AATSIHS and are presented in table 10A.45. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

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| Figure 10.18 People deferring purchase of prescribed medicines due to cost**a, b, c, d** |
| |  | | --- | | Figure 10.18 People deferring purchase of prescribed medicines due to cost  More details can be found within the text surrounding this image. | |
| a People 15 years or over who, in the last 12 months, were prescribed medication and delayed getting or did not get the medication due to cost. b Data are comparable over time from the 2010-11 reference year. Data are crude rates and may differ from data in previous reports which were age­standardised. c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. d Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) *Patient Experience Survey, 2012-13, 2013-14*, Cat. no. 4839.0; table 10A.43. |
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##### Public dentistry waiting times

‘Public dentistry waiting times’ is an indicator of governments’ objective to ensure timely access to public dental services for eligible people (box 10.9).

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| Box 10.9 Public dentistry waiting times |
| ‘Public dentistry waiting times’ is defined as the time waited between being placed on  a public dentistry waiting list and being seen by a dental professional. It is measured  as the proportion of people on a public dental waiting list who received a public dental service within specified waiting time categories.  A high or increasing proportion of people waiting shorter periods to see a dental professional indicates more timely access to public dental services.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but not over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Nationally, 23.4 per cent of people who were on a public dental waiting list waited for less than 1 month to see a dental professional at a government dental clinic in 2013-14 (figure 10.19). Data are presented by remoteness in table 10A.46. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.47 are not comparable to data for all Australians (see DQI for details).

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| Figure 10.19 Time waited for public dentistry services, 2013-14**a, b, c, d, e** |
| |  | | --- | | Figure 10.19 Time waited for public dentistry services, 2013-14  More details can be found within the text surrounding this image. | |
| a Time waited for a public dental service, for people 15 years or over who were on a public dental waiting list in the last 12 months. b Data are not comparable with data for previous years. See DQI for further information. c Data are crude rates. d Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. e Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) *Patient Experience Survey 2013-14*; table 10A.45. |
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#### Appropriateness

##### GPs with vocational registration

‘GPs with vocational registration’ is an indicator of governments’ objective to ensure the GP workforce has the capability to deliver high quality services (box 10.10).

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| Box 10.10 GPs with vocational registration |
| ‘GPs with vocational registration’ is defined as the proportion of FWE GPs with vocational registration. Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2014b).  A high or increasing proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. GPs without vocational registration may deliver services of equally high quality, however, their access to DHS Medicare rebates for the general practice services they provide is limited compared to vocationally registered GPs.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP or (from April 2007) the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the ‘practice eligible’ route. Once vocational registration is achieved, GPs must meet mandated registration standards which include Continuing Professional Development in order to maintain registration.

Nationally, the proportion of FWE GPs with vocational registration decreased slightly, from 89.7 to 88.5 per cent, in the period 2009-10 to 2013‑14 (figure 10.20). The proportion of FWE GPs with vocational registration was highest in major cities and lowest in remote areas in 2013-14 (table 10A.48).

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| Figure 10.20 GPs (full time workload equivalent) with vocational registration**a** |
| |  | | --- | | Figure 10.20 GPs (full time workload equivalent) with vocational registration  More details can be found within the text surrounding this image. | |
| a FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.50. |
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##### General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure the general practitioner workforce has the capability to provide high quality services (box 10.11).

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| Box 10.11 General practices with accreditation |
| ‘General practices with accreditation’ is defined as the number of general practices that are accredited as a proportion of all general practices in Australia. Accreditation of general practice is a voluntary process of independent third-party peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards.  (Continued next page) |
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| Box 10.11 (Continued) |
| A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * not available for the current reporting period.   Data quality information for this indicator is under development. |
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The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation Pty Ltd.

Data are not available for the 2015 Report because no current source of data can be identified for the number of general practices. Data for 2011 and previous years were sourced from the annual survey of Divisions of General Practice, which ceased on transition from Divisions of General Practice to Medicare Locals. Historical data are reported in table 10A.51.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has increased slightly in the period from 2008‑09 to 2012-13 (figure 10.21).

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| Figure 10.21 Proportion of general practice patient care provided by PIP practices**a** |
| |  | | --- | | Figure 10.21 Proportion of general practice patient care provided by PIP practices  More details can be found within the text surrounding this image. | |
| a Patients are measured as SWPEs. A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios. |
| *Source*: Department of Health (unpublished) PIP and MBS data collections; table 10A.52. |
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##### Management of acute upper respiratory tract infection

‘Management of acute upper respiratory tract infection’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 10.12).

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| Box 10.12 Management of upper respiratory tract infection |
| ‘Management of acute upper respiratory tract infection’ (URTI) is defined by two measures:   * filled GP prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) per 1000 people * proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.   Low or decreasing rates of prescription of the selected antibiotics and acute URTI GP visits where systemic antibiotics are prescribed can indicate that GPs’ management of acute URTI more closely follows guidelines.  URTI without complication (acute URTI or the ‘common cold’) is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless often prescribed for their treatment. Unnecessarily high rates of antibiotic prescription have the potential to increase both pharmaceutical costs and antibiotic resistance in the community (Tamma and Cosgrove 2014).  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years for the measure filled GP prescriptions for selected antibiotics * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for the measure filled GP prescriptions for selected antibiotics is at www.pc.gov.au/rogs/2015. Data quality information for the measure acute URTI GP visits where systemic antibiotics are prescribed is under development. |
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##### Rate of prescription of selected antibiotics

Caution should be used in interpreting the rate of prescription of the selected antibiotics as the oral antibiotics most commonly prescribed to treat acute URTI are also prescribed for other illnesses. Information about the condition for which the antibiotics are prescribed is not available.

Nationally, the prescription rate for the oral antibiotics most commonly used   
to treat acute URTI was 295 per 1000 people in 2013-14 (figure 10.22; table 10A.53).

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| Figure 10.22 Rate of prescription of oral antibiotics used most commonly to treat acute upper respiratory tract infection**a, b, c** |
| |  | | --- | | Figure 10.22 Rate of prescription of oral antibiotics used most commonly to treat acute upper respiratory tract infection  More details can be found within the text surrounding this image. | |
| a Prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed. b Data are not limited to prescriptions for treatment of upper respiratory tract infection. c Data from 2012-13 are for all people and are not comparable with data for previous years that were limited to prescriptions provided to holders of concession cards, and are reported in table 10A.54. |
| *Source*: Department of Health unpublished, PBS Statistics; table 10A.53. |
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##### Proportion of GP visits for acute URTI where systemic antibiotics are prescribed

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

The BEACH survey collects information on the reason for the GP visit as well as the treatment prescribed or provided. This allows derivation of the proportion of visits to GPs for acute URTI for which systemic antibiotics were prescribed or supplied. Each year, the national BEACH sample comprises around 1000 GPs, each providing data for around 100 patient visits. Aggregation of data for a period of 5 years allows publication of data for all States and Territories (figure 10.23). This has some limitations — short-term change will be reflected only if substantive when averaged over a 5 year period, and proximate causes of change will not be directly identifiable. These limitations are to a degree mitigated by the reporting of data for each year in the reference period at the national level. This will assist in interpreting whether change reflected over rolling 5 year periods is due to substantive short‑term change or to incremental change over several years.

The proportion of people presenting to GPs for acute URTI who were prescribed   
systemic antibiotics for its treatment decreased at the national level, from 32.4 per cent for the 5 years April 2006 to March 2011 to 30.5 per cent for the 5 years April 2009 to March 2014, reflecting an overall decreasing trend in most states and territories for the same period (figure 10.23).

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| Figure 10.23 Proportion of acute URTI managements where systemic antibiotics were prescribed**a, b** |
| |  | | --- | | Figure 10.23 Proportion of acute URTI managements where systemic antibiotics were prescribed  More details can be found within the text surrounding this image. | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non‑participating GPs. |
| *Source*: Britt et al. (unpublished) BEACH Statistics; table 10A.55. |
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Nationally, the proportion of acute URTI presentations for which systemic antibiotics were prescribed by GPs, in each 12 month period from April to the following March increased from 29.6 per cent in 2009-10 to 32.8 per cent in 2011-12, decreasing to 29.0 in 2013-14 (figure 10.24).

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| Figure 10.24 Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia**a, b** |
| |  | | --- | | Figure 10.24 Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia  More details can be found within the text surrounding this image. | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non‑participating GPs. |
| *Source*: Britt et al. (unpublished) BEACH Statistics; table 10A.56. |
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##### Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 10.13).

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| Box 10.13 Chronic disease management |
| ‘Chronic disease management’ is defined by four measures:   * management of diabetes — PIP diabetes incentive, defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP diabetes incentive * management of diabetes — HbA1c, defined as the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes with HbA1c below 7 per cent, divided by the estimated number of people with diabetes) * management of asthma, defined as the proportion of people with asthma who have a written asthma action plan * care planning/case conferencing, defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.   A high or increasing proportion of PIP practices registered for the PIP diabetes incentive, people with diabetes with HbA1c below 7 per cent, people with asthma who have a written asthma action plan, and GPs who use chronic disease management items, is desirable.  Registration for the PIP diabetes incentive requires the implementation of management strategies for patients with diabetes that are based on RACGP clinical guidelines for appropriate Type 2 diabetes management in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.  HbA1c measures the level of glucose in the blood averaged over the preceding three months. HbA1c levels below 7 per cent are indicative of appropriate management of diabetes in that period.  Written asthma action plans have been included in clinical guidelines for asthma management for around 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008).  A high or increasing proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.  (Continued next page) |
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| Box 10.13 (Continued) |
| Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions for management of diabetes — PIP diabetes incentive and for care planning/case conferencing. All required 2011‑12 data are available for all jurisdictions for management of diabetes — HbA1c and management of asthma.   Data quality information (DQI) is at www.pc.gov.au/rogs/2015 for the measures management of diabetes — HbA1c and management of asthma. DQI is under development for for the measures management of diabetes — PIP diabetes incentive and care planning/case conferencing. |
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Reporting against this indicator has improved as the measure management of diabetes — PIP diabetes incentive is reported for the first time. Updated data for asthma management by Indigenous status are also reported.

Chronic diseases are generally long term and often progressive conditions, for example, diabetes and asthma. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).

Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent or   
minimise the severity of complications (AIHW 2008b, NHPAC 2006). Effective management requires the provision of timely, high quality healthcare to meet individual needs and provide continuity of care (Australian Government 2010). Effective management can have profound effects on individuals and on the broader health system. Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

##### Chronic disease management — diabetes

Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes (‘diabetes’ refers to diabetes mellitus; this Report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

The PIP Diabetes incentive provides incentives to eligible practices to improve management of patients with diabetes. In order to register for the PIP Diabetes incentive, general practices are required to maintain an active patient register and recall and reminder system for all known patients with diabetes mellitus, and to agree to implement an annual cycle of care for patients with diabetes mellitus. The annual cycle of care is generally based on the RACGP’s clinical guidelines for the management of Type 2 diabetes in general practice, which represent the minimum required level of care.

Nationally, 47.3 per cent of PIP practices were registered for the PIP diabetes incentive although there was considerable variation across States and Territories, in 2013-14 (figure 10.25).

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| Figure 10.25 PIP practices registered for the PIP diabetes incentive,  2013-14**a** |
| |  | | --- | | Figure 10.25 PIP practices registered for the PIP diabetes incentive, 2013-14  More details can be found within the text surrounding this image. | |
| a Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52). |
| *Source*: Department of Health (unpublished) MBS and PIP data collections; table 10A.57. |
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HbA1c (glycosolated haemoglobin) provides a measure of the average blood glucose level for the preceding three months. RACGP guidelines for management of diabetes indicate that HbA1c levels should be tested at least every 6 months. Nationally, 77.5 per cent of people with known diabetes had a HbA1c test in the previous 12 months (table 10A.58).

An outcome of appropriate management of diabetes, by the primary and community health care sector in conjunction with the patient, is a HbA1c level at or below 7 per cent. Nationally, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (figure 10.26).

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| Figure 10.26 People with known diabetes with HbA1c level 7 per cent or less**a, b, c, d** |
| |  | | --- | | Figure 10.26 People with known diabetes with HbA1c level 7 per cent or less  More details can be found within the text surrounding this image. | |
| a People aged 18 years to 69 years with known diabetes. Includes pregnant women. b Known diabetes based on fasting plasma glucose test results and self-reported information on diagnosis/medication use. c Rates are not age-standardised. d Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished) *Australian Health Survey, 2011-13* (2011‑12 National Health Measures Survey component), Cat. No. 4364.0; table 10A.59. |
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##### Chronic disease management — asthma

Asthma, an identified National Health Priority Area for Australia, is a common chronic disease among Australians — particularly children — and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity.

Nationally, the proportion of people with asthma reporting that they have a written asthma action plan was 24.6 per cent for people of all ages in 2011-12, a slight increase from 22.9 per cent in 2004-05 (figure 10.27). The proportion of people with asthma reporting that they have a written asthma action plan was higher for children aged 0–14 years than for other age groups in all jurisdictions (table 10A.60).

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| Figure 10.27 Proportion of people with asthma who have a written asthma action plan, all ages**a, b, c, d** |
| |  | | --- | | Figure 10.27 Proportion of people with asthma who have a written asthma action plan, all ages  More details can be found within the text surrounding this image. | |
| a Rates are age standardised to the Australian population at 30 June 2001. b Error bars represent the 95 per cent confidence interval associated with each point estimate. c Data for the NT should be used with care as the NHS (National Health Survey) excludes very remote areas and therefore around 23 per cent of the NT population. Data for the NT are not available for 2004-05. d Data for the NT for 2011-12 are not comparable to data for previous years due to the increased sample size. |
| *Source*: ABS (unpublished) *Australian Health Survey,* *2011–2013* (2011-12 NHS component)*,* Cat. No. 4364.0; ABS (unpublished) *National Health Survey, 2007-08*, *2004-05*, Cat. No. 4364.0; table 10A.60. |
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Nationally, the proportion of Aboriginal and Torres Strait Islander people with asthma reporting that they have a written asthma action plan was 27.3 per cent for people of all ages and 50.9 per cent for children aged 0–14 years in 2012-13 (figure 10.28; table 10A.61). Data for people of all ages are reported by Indigenous status for 2004-05 and 2011–13 in table 10A.62. Data for people of all ages are reported by geographical region for 2007-08 in table 10A.63.

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| Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13**a, b, c** |
| |  | | --- | | Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  More details can be found within the text surrounding this image.  Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. Figure 10.28 Proportion of people with asthma who have a written asthma action plan by age, by Indigenous status, 2011–13  Legend to figure  More details can be found within the text surrounding this image. | |
| a Rates for ‘all ages’ are age standardised to the Australian population at 30 June 2001. b Error bars represent the 95 per cent confidence interval associated with each point estimate. c Data for ‘other Australians’ for the NT should be used with care as exclusion of very remote areas from the NHS translates to the exclusion of around 23 per cent of the NT population. |
| *Source*: ABS (unpublished) *Australian Health Survey, 2011–13* (2011-12 NHS component), Cat. no. 4364.0; ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0; table 10A.61. |
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##### Chronic disease management — care planning and case conferencing

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

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

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing increased slightly — from 96.1 to 97.0 per cent — in the period 2009-10 to 2013-14 (figure 10.29).

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| Figure 10.29 GP use of chronic disease management MBS items for care planning and case conferencing**a, b** |
| |  | | --- | | Figure 10.29 GP use of chronic disease management MBS items for care planning and case conferencing  More details can be found within the text surrounding this image. | |
| a The Strengthening Medicare initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. b Additional chronic disease management MBS items have become available on several occasions since introduction of the Strengthening Medicare initiative in 2004. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.64. |
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##### Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 10.14).

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| Box 10.14 Use of pathology tests and diagnostic imaging |
| ‘Use of pathology tests and diagnostic imaging’ is defined by four measures:   * MBS items rebated through DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs, per person * diagnostic imaging services provided on referral from vocationally registered GPs and OMPs and rebated through DHS Medicare, per person * DHS Medicare benefits paid per person for pathology tests * DHS Medicare benefits paid per person for diagnostic imaging.   This indicator needs to be interpreted with care as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overeliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Reporting differences across jurisdictions and over time contributes to consideration of these issues. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS Medicare is used as a proxy in reporting against this indicator.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS Medicare data reflect only those services provided and rebated.

Age-standardised rates are available from 2012‑13. Historical data are crude rates and are provided in tables 10A.66 (pathology tests) and 10A.68 (diagnostic imaging).

Nationally, the number of rebated MBS items for pathology tests requested by GPs and eligible nurse practitioners was 3.5 per person in 2013-14 (figure 10.30).

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| Figure 10.30 MBS items rebated through DHS Medicare for pathology tests requested by GPs, per person**a, b** |
| |  | | --- | | Figure 10.30 MBS items rebated through DHS Medicare for pathology tests requested by GPs, per person  More details can be found within the text surrounding this image. | |
| a Data are age standardised to the 2001 Australian standard population. b Data include tests requested by vocationally registered GPs and OMPs and, from 2013-14, eligible nurse practitioners. Data include patient episode initiated items. |
| *Source*: Department of Health (unpublished) MBS and DVA data collections; table 10A.65. |
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Australian Government expenditure under DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs and eligible nurse practitioners amounted to $1.6 billion — around $64 per person — in 2013‑14 (figure 10.31). Australian Government expenditure under DHS Medicare for diagnostic imaging tests requested by vocationally registered GPs and OMPs and eligible nurse practitioners was also $1.6 billion in 2013-14 although expenditure per person was less for diagnostic imaging than for pathology tests in most jurisdictions (figure 10.31).

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| Figure 10.31 Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare, 2013-14**a** |
| |  | | --- | | Figure 10.31 Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare, 2013-14  More details can be found within the text surrounding this image. | |
| a Includes benefits paid through DHS Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally registered GPs and OMPs and from eligible nurse practitioners. |
| *Source*: Department of Health (unpublished) MBS and DVA data collections; tables 10A.65 and 10A.67. |
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Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs and, for 2013-14, eligible nurse practitioners, was 0.54 per person in 2013-14 (figure 10.32).

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| Figure 10.32 Diagnostic imaging services referred by GPs and rebated through DHS Medicare**a, b** |
| |  | | --- | | Figure 10.32 Diagnostic imaging services referred by GPs and rebated through DHS Medicare  More details can be found within the text surrounding this image. | |
| a Data are age standardised to the 2001 Australian standard population. b Data include tests requested by vocationally registered GPs and OMPs and, from 2013-14, eligible nurse practitioners. |
| *Source*: Department of Health (unpublished) MBS and DVA data collections; table 10A.67. |
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#### Quality — safety

##### Electronic health information systems

‘Electronic health information systems’ is an indicator of governments’ objective to improve patient safety through enhanced access to patient health information at the point of care and the more efficient coordination of care across multiple providers and services (box 10.15).

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| Box 10.15 Electronic health information systems |
| ‘Electronic health information systems’ is defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP eHealth incentive.  A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.  The PIP does not include all practices in Australia. PIP practices provided around 83.0 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (Department of Health unpublished; table 10A.52).  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2014 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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The use of electronic health information systems can, for example, facilitate best practice chronic disease management as well as minimise errors of prescribing and dispensing that can cause adverse drug reactions (Hofmarcher, Oxley and Rusticelli 2007).

The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Accordingly, new eligibility requirements were introduced from 1 February 2013, requiring practices to:

* integrate healthcare identifiers into electronic practice records
* have a secure messaging capability
* use data records and clinical coding of diagnoses
* send prescriptions electronically to a prescription exchange service
* participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software.

Nationally, the proportion of PIP practices using electronic health systems was 86.3 per cent in May 2014, recovering most of the sharp decrease, from 88.3 per cent in May 2012 to 72.2 per cent in May 2013, that was associated with time taken to implement the new eligibility requirements for many practices (figure 10.33).

The proportion of PIP practices using electronic health systems increased in all areas between May 2013 and May 2014, remaining lower in remote and very remote areas than in other areas (figure 10.34).

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| Figure 10.33 PIP practices using electronic health systemsa |
| |  | | --- | | Figure 10.33 PIP practices using electronic health systems  More details can be found within the text surrounding this image. | |
| a Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52). |
| *Source*: Department of Health (unpublished) MBS and PIP data collections; table 10A.69. |
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| Figure 10.34 PIP practices using electronic health systems by area**a, b** |
| |  | | --- | | Figure 10.34 PIP practices using electronic health systems by area  More details can be found within the text surrounding this image. | |
| a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. b Not all practices are enrolled in the PIP, and the enrolled proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.52). |
| *Source*: Department of Health (unpublished) MBS and PIP data collections; table 10A.70. |
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#### Quality — responsiveness

##### Patient satisfaction

‘Patient satisfaction’ is an indicator of governments’ objective to ensure primary and community health services are high quality and account for individual patient needs (box 10.16).

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| Box 10.16 Patient satisfaction |
| ‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of and/or satisfaction around ‘key aspects of care’ —that is, aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:   * experience with selected key aspects of GP care, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months * experience with selected key aspects of dental professional care, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.   High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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##### Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2013-14, the GP always or often (figure 10.35):

* listened carefully to them (90.6 per cent)
* showed respect (93.3 per cent)
* spent enough time with them (89.3 per cent).

Data are presented by remoteness area in tables 10A.72 and 10A.73. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.74 are not comparable to the data presented here (see DQI for details).

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| Figure 10.35 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2013-14**a, b, c** |
| |  | | --- | | Figure 10.35 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2013-14  More details can be found within the text surrounding this image. | |
| a People aged 15 years or over who saw a GP in the last 12 months. b Data are crude rates. c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. |
| *Source*: ABS (unpublished) *Patient Experience Survey 2013-14*, Cat. no. 4839.0; tables 10A.72, 10A.73. |
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##### Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that, in 2013-14, the dental professional always or often (figure 10.36):

* listened carefully to them (94.6 per cent)
* showed respect (95.5 per cent)
* spent enough time with them (95.7 per cent).

Data are presented by remoteness area in tables 10A.75 and 10A.76.

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| Figure 10.36 Proportion of people whose dental professional  always or often listened carefully, showed respect,  spent enough time, 2013-14**a, b, c** |
| |  | | --- | | Figure 10.36 Proportion of people whose dental professional  always or often listened carefully, showed respect, spent enough time, 2013-14  More details can be found within the text surrounding this image. | |
| a People aged 15 years or over who saw a dental professional in the last 12 months. b Data are crude rates. c Data exclude discrete Aboriginal and Torres Strait Islander communities, which will affect the NT more than other jurisdictions. |
| *Source*: ABS (unpublished) *Patient Experience Survey* *2013-14*, Cat. no. 4839.0; tables 10A.75, 10A.76. |
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#### Quality — continuity

##### Health assessments for older people

‘Health assessments for older people’ is an indicator of governments’ objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 10.17).

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| Box 10.17 Health assessments for older people |
| ‘Health assessments for older people’ is defined as the proportion of older people who received a health assessment. Older people are defined as Aboriginal and Torres Strait Islander Australians aged 55 years or over and other Australians aged 75 years or over, excluding hospital inpatients and people living in aged care facilities. Annual health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient’s health. Health assessments cover the patient’s health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 10.5).  A high or increasing proportion of eligible older people who received a health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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The targeted age range for Aboriginal and Torres Strait Islander Australians of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Aboriginal and Torres Strait Islander and non-Indigenous populations (see the Health sector overview). Results for Aboriginal and Torres Strait Islander people are reported under equity indicators (box 10.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2009-10 to 2013-14. Nationally, this proportion increased from 23.5 per cent in 2009-10 to 31.1 per cent in 2013-14 (figure 10.37). Data are presented for an 8 year time series in table 10A.77.

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| Figure 10.37 Older people who received an annual health assessment**a, b** |
| |  | | --- | | Figure 10.37 Older people who received an annual health assessment  More details can be found within the text surrounding this image. | |
| a Older people are defined as non-Indigenous Australians aged 75 years or over and Aboriginal and Torres Strait Islander Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. b Rates are revised to the ABS’ final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.2 and 2A.13‑14) for details. |
| *Source*: Department of Health (unpublished) MBS Statistics; ABS (2014) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *Australian Demographic Statistics*, Cat. no. 3101.0; table 10A.77. |
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#### Sustainability

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

### Efficiency

#### Cost to government of general practice per person

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary healthcare services in an efficient manner (box 10.18).

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| Box 10.18 Cost to government of general practice per person |
| ‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.  This indicator needs to be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.  Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. Consequently, costs for primary care are understated for jurisdictions where a large proportion of the population live in rural and remote areas.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Data for this indicator have improved with the introduction of age-standardisation for fee-for-service expenditure data through DHS Medicare and the DVA from 2012-13. These data are not comparable with data for previous years that are not age‑standardised and include expenditure on GP programs. Historical data are provided in table 10A.3.

Nationally, Australian Government fee-for-service expenditure on general practice was $7.3 billion — $299 per person — in 2013-14 (figure 10.38). Total Australian Government expenditure on general practice included PIP and Medicare Locals funding of a further $600 million (table 10A.3).

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| Figure 10.38 Australian Government fee-for-service expenditure per person on GPs (2013-14 dollars)**a, b, c** |
| |  | | --- | | Figure 10.38 Australian Government fee-for-service expenditure per person on GPs (2013-14 dollars)  More details can be found within the text surrounding this image. | |
| a Time series financial data are adjusted to 2013-14 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2013-14 = 100) (table 2A.51). See chapter 2 (sections 2.5-6) for details. b Data are directly age-standardised to the 2001 Australian standard population. c Data include DHS Medicare and DVA payments. |
| *Source*: Department of Health (unpublished) MBS Statistics; DVA (unpublished), DVA data collection; table 10A.2**.** |
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### Outcomes

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

##### Child immunisation coverage

‘Child immunisation coverage’ is an indicator of governments’ objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 10.19).

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| Box 10.19 Child immunisation coverage |
| ‘Child immunisation coverage’ is defined by three measures:   * the proportion of children aged 12 months to less than 15 months who are fully immunised, where children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b, Haemophilus influenzae type b and, from the quarter ending 31 December 2013, pneumococcal * the proportion of children aged 24 months to less than 27 months who are fully immunised, where children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella * the proportion of children aged 60 months to less than 63 months who are fully immunised, where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella.   A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Many providers deliver child immunisation services (table 10.7). High immunisation coverage levels are encouraged through a range of measures, including incentives for parents that link immunisation to tax and childcare benefits and rebates. Incentives for providers were in place under the General Practice Immunisation Incentives Scheme to 30 June 2013.

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| Table 10.7 Valid vaccinations supplied to children under 7 years of age, by provider type, 2009–2014 (per cent)**a, b, c** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Provider** | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | GP | 88.8 | 59.5 | 84.6 | 69.2 | 73.0 | 93.1 | 59.6 | 71.8 | 75.9 | | Council | 3.2 | 38.8 | 5.8 | 3.6 | 18.5 | 6.4 | – | – | 13.5 | | State or Territory health department | – | – | – | 4.9 | – | – | 1.2 | 0.1 | 0.6 | | Public hospital | 0.9 | 1.2 | 2.8 | 1.3 | 0.7 | 0.4 | 0.3 | 2.4 | 1.5 | | Aboriginal and Torres Strait Islander health service / worker | 0.5 | 0.2 | 0.3 | 0.4 | 0.7 | – | – | 6.8 | 0.7 | | Community health centre | 6.5 | 0.3 | 6.0 | 20.5 | 7.0 | 0.1 | 38.9 | 18.8 | 7.7 | | Otherd | 0.1 | – | 0.5 | 0.1 | 0.1 | – | – | 0.1 | 0.2 | | **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | |
| a Data are for the period 1 July 2009 to 30 June 2014. b Data are based on State/Territory in which the immunisation provider was located. c A valid vaccination is a National Health and Medical Research Council’s Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. d Other includes Divisions of GP, Flying Doctors Services, Aboriginal and Torres Strait Islander Health Workers, community nurses, private hospitals and unknown. – Nil or rounded to zero. |
| *Source*: Department of Health (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 10A.78. |
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Nationally, the proportion of Australian children aged 12 months to less than 15 months who were assessed as fully immunised in 2013-14 — 90.4 per cent — fell below 91 per cent for the first time in the 5 year period from 2009-10 (figure 10.39).

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| Figure 10.39 Children aged 12 months to less than 15 months who were fully immunised**a, b, c** |
| |  | | --- | | Figure 10.39 Children aged 12 months to less than 15 months who were fully immunised  More details can be found within the text surrounding this image. | |
| a The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare. b There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). c Data are for financial years and may differ from previous reports which presented data for the June quarter. |
| *Source*: Department of Health (unpublished) ACIR data collection; table 10A.79. |
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Nationally, 92.4 per cent of children aged 24 months to less than 27 months were assessed as fully immunised in 2013-14 (figure 10.40).

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| Figure 10.40 Children aged 24 months to less than 27 months who were fully immunised**a, b, c** |
| |  | | --- | | Figure 10.40 Children aged 24 months to less than 27 months who were fully immunised  More details can be found within the text surrounding this image. | |
| a The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). b There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). c Data are for financial years and may differ from previous reports which presented data for the June quarter. |
| *Source*: Department of Health (unpublished) ACIR data collection; table 10A.80. |
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Nationally, the proportion of children aged 60 months to less than 63 months who were assessed as fully immunised rose from 84.6 to 92.0 per cent in the period 2009-10 to 2013‑14 (figure 10.41).

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| Figure 10.41 Children aged 60 months to less than 63 months who were fully immunised**a, b, c** |
| |  | | --- | | Figure 10.41 Children aged 60 months to less than 63 months who were fully immunised  More details can be found within the text surrounding this image. | |
| a The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). b There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). c Data are for financial years and may differ from previous reports which presented data for the June quarter. |
| *Source*: Department of Health (unpublished) ACIR data collection; table 10A.81. |
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##### Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 10.20).

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| Box 10.20 Notifications of selected childhood diseases |
| ‘Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.  (Continued next page) |
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| Box 10.20 (Continued) |
| A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in 1 in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases (and consequently the notification rates) through immunisation.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Nationally, there were 113 notifications for measles for children aged 0–14 years in 2013‑14 — a rate of 2.6 notifications per 100 000 children aged 0–14 years (figure 10.42). This was higher than for any other year in the period 2009-10 to 2013‑14 (table 10A.82). Data are presented for an eight year time series in table 10A.82.

Nationally, notifications for pertussis (whooping cough) for children aged 0–14 years declined steadily from a peak of 18 200 (433 per 100 000 children 0–14 years) to less than 4000 (90 per 100 000 children 0–14 years) in the period 2010-11 to 2013-14 (figure 10.43). Data are presented for an eight year time series in table 10A.83.

In 2013-14, the national notification rate for invasive *Haemophilus influenzae* type b — 0.27 per 100 000 children aged 0–14 years — remained low, consistent with recent years (figure 10.44). Data are presented for an eight year time series in table 10A.84.

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| Figure 10.42 Notifications of measles per 100 000 children aged  0–14 years**a** |
| |  | | --- | | Figure 10.42 Notifications of measles per 100 000 children aged  0–14 years  More details can be found within the text surrounding this image. | |
| a Data are suppressed where the number of notifications reported for a jurisdiction is fewer than 5. |
| *Source*: Department of Health (unpublished) National Notifiable Diseases Surveillance System (NNDSS); ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.82. |
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| Figure 10.43 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years |
| Figure 10.43 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years   More details can be found within the text surrounding this image. |
| *Source*: Department of Health (unpublished) NNDSS, ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.83. |
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| Figure 10.44 Notifications of invasive *Haemophilus influenzae* type b  per 100 000 children aged 0–14 years, Australia |
| |  | | --- | | Figure 10.44 Notifications of invasive Haemophilus influenzae type b per 100 000 children aged 0–14 years, Australia   More details can be found within the text surrounding this image. | |
| *Source*: Department of Health (unpublished) NNDSS, ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; table 10A.84. |
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##### Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through the provision of early detection services (box 10.21).

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| Box 10.21 Participation for women in breast cancer screening |
| ‘Participation for women in breast cancer screening’ is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–69 years and reported as a rate.  A high or increasing participation rate is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2012 and 2013 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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Early detection of breast cancer is associated with improved morbidity and mortality outcomes. Early detection allows a wider range of treatment options — including less invasive procedures — and a higher likelihood of survival, than does later detection (AIHW and NBCC 2007). The BreastScreen Australia Program is jointly funded by the Australian, State and Territory governments to undertake nationwide breast cancer screening. This is provided at no cost to the target group of women aged 50–69 years, for which it aims to achieve at least 70 per cent participation over a period of 24 months. Women aged 40–49 years and 70 years or over are also eligible for free screening.

An evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (Department of Health 2009). Further, the relatively high proportion of cancers detected early and treated with breast conserving surgery among Program participants was associated with reduced treatment related morbidity.

A decline in the national participation rate for women aged 50–69 years in BreastScreen Australia screening programs in the 24 month periods from 2008–2009 (56.0 per cent) to 2011–2012 (54.2 per cent) did not continue in the 24 month period 2012–2013 (54.3 per cent) (figure 10.45). These rates remain below the National Accreditation Standards aim of participation by 70 per cent of women in this age group.

Aboriginal and Torres Strait Islander women, women from non‑English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services. Care needs to be taken when comparing data across jurisdictions as identification of Aboriginal and Torres Strait Islander women and NESB women varies, as does the collection of residential postcodes data. Updated State and Territory data for participation rate by remoteness area were unavailable for the 2015 Report — data for 2009–2010 and previous years, as well as national data for 2010–2011, are reported in table 10A.89.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 10.8. In the 24 month period 2012 and 2013, the national age standardised participation rate for Aboriginal and Torres Strait Islander women aged 50–69 years was 35.1 per cent (table 10A.87). A low participation rate can in part reflect under-reporting of Aboriginal and Torres Strait Islander status in screening program records.

In the 24 month period 2012 and 2013, the national age standardised participation rate for NESB women aged 50–69 years was 51.4 per cent, lower than the total participation rate in that age group (54.3 per cent) (table 10A.88).

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| Figure 10.45 Age standardised participation rate for women aged  50–69 years in BreastScreen Australia screening programs (24 month period)**a, b, c, d, e** |
| |  | | --- | | Figure 10.45 Age standardised participation rate for women aged  50–69 years in BreastScreen Australia screening programs (24 month period)   More details can be found within the text surrounding this image. | |
| a The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. Data may differ from data published elsewhere reporting participation rates by screening jurisdiction. b The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. ERPs are revised to the ABS’ final 2011 Census rebased ERPs and rates data may differ from previous reports. See Chapter 2 (table 2A.1) for details. c Rates are standardised to the 2001 ERP. d In general, women resident in the jurisdiction represent 99 per cent or more of the women screened in each jurisdiction. For the ACT, 2.2 per cent of those screened in the 2012–2013 reference period were not ACT residents, a decrease from 7–9 per cent in preceding reference periods associated with changed arrangements between NSW and the ACT. e Reduced participation rates for SA in 2012–2013 are associated with a temporary reduction in total women screened during a review of the Digital Mammography System and implementation of both the review findings and a new client information system. |
| *Source*: State and Territory governments (unpublished); ABS (various years) *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; tables 10A.85, 10A.86. |
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| Table 10.8 Age standardised participation rate for women aged  50–69 years from selected communities in BreastScreen Australia programs, 2012 and 2013 (24 month period) (per cent)**a, b, c, d, e, f** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT**d** | NT | Aust | | Aboriginal and Torres Strait Islander womene | 31.3 | 30.4 | 45.0 | 34.4 | 27.4 | 28.8 | 28.2 | 28.8 | 35.1 | | NESBf | 48.0 | 52.2 | 62.8 | 63.3 | 46.1 | 46.2 | 25.7 | 39.6 | 51.4 | | All women aged 50–69 years | 50.9 | 54.6 | 57.3 | 56.8 | 53.0 | 57.8 | 54.4 | 41.0 | 54.3 | |
| a First and subsequent rounds. b Rates are standardised to the Australian population at 30 June 2001. c Data reported for this measure are not directly comparable. d In general, women resident in the jurisdiction represent 98.9 per cent or more of the women screened in each jurisdiction, except for the ACT (where 2.2 per cent of those screened in the 2012–2013 reference period were not ACT residents). e Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. f NESB is defined as speaking a language other than English at home. |
| *Source*: State and Territory governments (unpublished); ABS (2011) *Australian Demographic Statistics*, *June*, Cat. no. 3201.0; ABS (2014) *Experimental Estimates and Projections, Aboriginal And Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0; ABS (unpublished) *2011 Census of Population and Housing*; tables 10A.85–10A.88. |
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##### Participation for women in cervical screening

‘Participation for women in cervical screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 10.22).

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| Box 10.22 Participation for women in cervical screening |
| ‘Participation for women in cervical screening’ is defined as the number of women aged 20–69 years who are screened over a two year period, divided by the estimated population of eligible women aged 20–69 years and reported as a rate. Eligible women are those who have not had a hysterectomy.  A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2012 and 2013 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated early (Department of Health 2012; Mitchell, Hocking and Saville 2003). A range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening decreased from 59.3 per cent for the 24 month period 1 January 2008 to 31 December 2009 to 58.2 per cent for the period 1 January 2012 to 31 December 2013 (figure 10.46). Data are presented for a ten year time series in table 10A.90.

In 2011-12, around 53.4 per cent of Aboriginal and Torres Strait Islander women aged   
20–69 years who responded to the National Aboriginal and Torres Strait Islander Health survey reported having a Pap smear at least every 2 years (table 10A.91).

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| Figure 10.46 Participation rates for women aged 20–69 years in cervical screening (24 month period)**a, b, c, d** |
| |  | | --- | | Figure 10.46 Participation rates for women aged 20–69 years in cervical screening (24 month period)  More details can be found within the text surrounding this image. | |
| a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP (based on the 2011 Census) in each calendar year in the reference period and age standardised to the 2001 Australian population. b Eligible female population adjusted for the estimated proportion who have had a hysterectomy. c Excludes women who have opted off the cervical cytology register. d Data include all women screened in the jurisdiction except for Victoria and the ACT, for which data include only residents of the jurisdiction (and immediate border residents). |
| *Source*: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 10A.90. |
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##### Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 10.23).

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| Box 10.23 Influenza vaccination coverage for older people |
| ‘Influenza vaccination coverage for older people’ is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.  A high or increasing proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications. Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths.  Data reported for this indicator are:  • comparable (subject to caveats) across jurisdictions and over time  • not available for the current reporting period.  Data quality information for this indicator is under development. |
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Influenza and pneumococcal disease vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (Department of Health 2013a). Free vaccines for all Australians aged 65 years or over and for Aboriginal and Torres Strait Islander people aged 50 years or over became available for influenza in 1999 and for pneumococcal disease in 2005.

Updated data were not available for non-Indigenous Australians for the 2015 Report — historical data are presented in tables 10A.92-10A.93. Nationally, 25.3 per cent of Aboriginal and Torres Strait Islander people aged 50 years or over were fully vaccinated against influenza and pneumococcal disease in 2011-12 (table 10A.94).

#### Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 10.24).

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| Box 10.24 Selected potentially preventable hospitalisations |
| ‘Selected potentially preventable hospitalisations’ is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether.  Three measures of selected potentially preventable hospitalisations are reported (the first measure is reported against the indicator of the same name in the NHA):   * potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2012b; DHS 2002) * potentially preventable hospitalisations for diabetes * potentially preventable hospitalisations of older people for falls.   Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.  Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2014a, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people’s access to aged care services and other support.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time except for the measure potentially preventable hospitalisations for diabetes * complete (subject to caveats) for the current reporting period except for the measure potentially preventable hospitalisations for diabetes, for which data are not published for Tasmania, the ACT and the NT. All other required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2015. |
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##### Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

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

Variation in hospitalisation rates data can also be affected by differences in hospital protocols for clinical coding and admission between and within jurisdictions. This particularly affects diagnoses of dehydration and gastroenteritis and diabetes complications. The effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in Aboriginal and Torres Strait Islander communities. Caution should also be used in time series analysis because of revisions to clinical coding standards and improvements in data quality over time, as well as changes in hospital coding and admission protocols.

Data are age‑standardised to account for differences in the age structures of the populations across states and territories.

Nationally, the age‑standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 23.9 per 1000 people in 2012‑13 (table 10.9). Of these, 49.5 per cent were for acute and 47.2 per cent for chronic conditions (table 10A.95). Data are presented disaggregated by Indigenous status in table 10A.96 and remoteness in table 10A.97. National data by Indigenous status and remoteness are presented in table 10A.98.

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| Table 10.9 Separations for selected potentially preventable hospitalisations per 1000 people, 2012-13**a, b, c** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Austd | | Vaccine preventable conditions | 0.7 | 0.8 | 1.1 | 1.0 | 1.1 | 1.0 | 0.8 | 3.7 | 0.9 | | Selected acute conditionse | 10.8 | 10.2 | 13.8 | 13.6 | 13.6 | 9.9 | 9.3 | 20.5 | 11.8 | | Selected chronic conditionsf | 10.4 | 10.8 | 12.9 | 11.3 | 11.9 | 10.1 | 8.3 | 22.1 | 11.3 | | **Total**g, h | **21.9** | **21.7** | **27.7** | **25.7** | **26.4** | **20.8** | **18.2** | **45.8** | **23.9** | |
| a Separation rates are directly age-standardised to the Australian population at 30 June 2001. b Rates are based on State/Territory of usual residence. c A nationally agreed revised definition of selected potentially preventable hospitalisations applies. See DQI for more information. d Includes other territories. Excludes overseas residents and unknown state of residence. e Selected acute conditions excluding dehydration and gastroenteritis*.* f Selected chronic conditions excluding diabetes complications (additional diagnoses only).g Total is all potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only). h Totals may not add as more than one condition may be reported for a separation. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.95. |
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Identification of Aboriginal and Torres Strait Islander people in hospital administrative data is considered acceptable for analysis in all states and territories from the 2010-11 reporting period. The age standardised hospital separation rate for vaccine preventable conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions in 2012‑13 (figure 10.47). The age standardised hospital separation rate for the selected acute conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in almost all jurisdictions in 2012‑13 (figure 10.48). The age standardised hospital separation rate for the selected chronic conditions was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions in 2012‑13 (figure 10.49).

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| Figure 10.47 Separations for vaccine preventable conditions by Indigenous status**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.47  Separations for vaccine preventable conditions by Indigenous status  Aboriginal and Torres Strait Islander Australians  More details can be found within the text surrounding this image.  Figure 10.47 Separations for vaccine preventable conditions by Indigenous status  Other Australians  More details can be found within the text surrounding this image. | |
| a Separation rates are directly age standardised to the Australian population at 30 June 2001. b Separation rates are based on State/Territory of usual residence. c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; tables 10A.95 and 10A.99. |
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| Figure 10.48 Separations for selected acute conditions by Indigenous status**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.48 Separations for selected acute conditions by Indigenous status  Aboriginal and Torres Strait Islander Australians  More details can be found within the text surrounding this image.  Figure 10.48 Separations for selected acute conditions by Indigenous status  Other Australians  More details can be found within the text surrounding this image. | |
| a Separation rates are directly age standardised to the Australian population at 30 June 2001. b Separation rates are based on State/Territory of usual residence. c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; tables 10A.95 and 10A.100. |
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| Figure 10.49 Separations for selected chronic conditions by Indigenous status**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.49 Seperations for selected chronic conditions by Indigenous status  Aboriginal and Torres Strait Islander Australians  More details can be found within the text surrounding this image.  Figure 10.49 Separations for selected chronic conditions by Indigenous status  Other Australians  More details can be found within the text surrounding this image | |
| a Separation rates are directly age standardised to the Australian population at 30 June 2001. b Separation rates are based on State/Territory of usual residence. c Data are revised in line with a nationally agreed revised definition of selected potentially preventable hospitalisations and may differ from previous reports. See DQI for more information. d Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. e Caution should be used in comparing data over time due to changes in international classifications and associated Australian coding standards. See DQI for more information. f NT data from 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. g From 2010-11, identification of Aboriginal and Torres Strait Islander people in hospital administrative data is of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; tables 10A.95 and 10A.101. |
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##### Potentially preventable hospitalisations for diabetes

Diabetes is a chronic disease of increasing prevalence, and is an identified National Health Priority Area for Australia. People with diabetes are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

The provision of high quality, appropriate and effective management of diabetes in the primary and community health sector can prevent or minimise the severity of diabetes complications, thereby reducing demand for hospitalisation (AIHW 2008b). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Nationally, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 107.0 separations per 100 000 people in 2012‑13 (figure 10.50).

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| Figure 10.50 Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2012-13**a, b, c** |
| |  | | --- | | Figure 10.50 Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2012-13  More details can be found within the text surrounding this image. | |
| a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. b Morbidity data are coded under coding standards that can differ over time and across jurisdictions — reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011–12 and 2012–13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. c Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.103. |
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The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2012‑13 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 10.51).

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| Figure 10.51 Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals,  2012-13**a, b, c, d, e** |
| Figure 10.51 Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2012-13  More details can be found within the text surrounding this image. |
| a Results for individual complications can be affected by small numbers, and need to be interpreted with care. b Patients can have one or more complication(s) for each separation. c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. d Morbidity data are coded under coding standards that can differ over time and across jurisdictions — reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years.. e Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.103. |
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Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but these data are not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are ‘same day’ across jurisdictions. Nationally, 24.6 per cent of separations for Type 2 diabetes were same day separations in 2012‑13 (table 10A.104).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2012‑13, there were 16.4 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 10.52).

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| Figure 10.52 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012‑13**a, b, c** |
| |  | | --- | | Figure 10.52 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2012-13  More details can be found within the text surrounding this image. | |
| a Separation rates are directly age standardised to the Australian population at 30 June 2001. b Includes unspecified diabetes. Data are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370‑00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. Reporting of diabetes increased by an average of 29.6 per cent as a principal diagnosis and 247 per cent as an additional diagnosis between 2011–12 and 2012–13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. c Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.105. |
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Age standardised hospital separation ratios for diabetes (excluding separations for diabetes complications as an additional diagnosis) illustrate differences between the rate of hospital admissions for Aboriginal and Torres Strait Islander Australians and that for all Australians, taking into account differences in the age structures of the two populations. Rate ratios close to one indicate that Aboriginal and Torres Strait Islander Australians have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. A reduction in the gap in hospital separation rates between Aboriginal and Torres Strait Islander and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2012-13 between the separation rates for Aboriginal and Torres Strait Islander people and those for the total population for diabetes diagnoses (figure 10.53).

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| Figure 10.53 Ratio of separation rates of Aboriginal and Torres Strait Islander people to all people for diabetes, 2012-13**a, b, c, d, e, f, g** |
| |  | | --- | | Figure 10.53 Ratio of separation rates of Aboriginal and Torres Strait Islander people to all people for diabetes, 2012-13  More details can be found within the text surrounding this image. | |
| a Excludes separations with diabetes complications as an additional diagnosis. b Ratios are directly age standardised to the Australian population at 30 June 2001. c Separation rates are based on state of usual residence. d Reporting of diabetes as a principal diagnosis increased by an average of 29.6 per cent between 2011-12 and 2012-13, primarily due to changes in coding standards. Data for 2012-13 are not comparable with data for previous years. e Patients aged 75 years or over are excluded. f Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. g NT data are for public hospitals only. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.102. |
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##### Potentially preventable hospitalisations of older people for falls

Falls were the leading external cause of unintentional injury in older Australians in 2011‑12 (Tovell, Harrison & Pointer 2014). For people over 65 years, injurious falls accounted for one in ten days spent in hospital in 2009-10 (Bradley 2013). The number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions, increased from 47.7 in 2008-09 to 56.8 in 2012-13 (figure 10.54).

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| Figure 10.54 Separations for older people with a reported external cause of falls**a, b, c** |
| |  | | --- | | Figure 10.54 Separations for older people with a reported external cause of falls  More details can be found within the text surrounding this image. | |
| a Older people are defined as people aged 65 years or over. b Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. c Excludes separations records for hospital boarders and posthumous organ procurement. d Data for the NT are not available for 2010-11 and are not included in the Australian total. |
| *Source*: AIHW (unpublished) National Hospital Morbidity Database; table 10A.106. |
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## 10.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Allied health professional workforce data are anticipated to be available for the 2016 Report from the new National Registration and Accreditation Scheme. Priorities for future reporting on primary and community health services include:

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

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

### Aboriginal and Torres Strait Islander health

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

Continued efforts to improve the quality of Aboriginal and Torres Strait Islander data, particularly Aboriginal and Torres Strait Islander identification and completeness, are necessary to better measure the performance of primary and community health services in relation to the health of Aboriginal and Torres Strait Islander Australians. Work being undertaken by the ABS and the Australian Institute of Health and Welfare (AIHW) includes an ongoing program to improve identification of Aboriginal and Torres Strait Islander status in Australian, State and Territory government administrative systems.

## 10.5 Definitions of key terms

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| Age standardised | Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution. |
| Annual cycle of care for people with diabetes mellitus within general practice | The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines.  MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines. |
| Asthma Action Plan | An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.  *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW (Australian Institute of Health and Welfare), Canberra. |
| Cervical screening rates for target population | Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy. |
| Closed treatment episode | A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period. |
| Community health services | Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities. |
| Comparability | Data are considered comparable if, (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| Completeness | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| Consultations | The different types of services provided by GPs. |
| Cost to government of general practice per person | Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person. |
| Divisions of General Practice | Geographically-based networks of GPs were active until end June 2012. There were 109 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN).  The Divisions of General Practice Program (DGPP) aims were to contribute to improved health outcomes for communities by working with GPs and other health service providers to improve the quality and accessibility of healthcare at the local level. From 30 June 2011, Medicare Locals progressively assumed responsibility for general practice support initiatives previously funded under the DGPP. The DGPP ceased on 30 June 2012. |
| Full time workload equivalents (FWE) | A measure of medical practitioner supply based on claims processed by DHS Medicare in a given period, calculated by dividing a practitioner’s DHS Medicare billing by the mean billing of full time practitioners for that period.  Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner. |
| Fully immunised at 12 months | A child who has, by the age of 1 year, completed: three doses of diphtheria, tetanus, pertussis vaccine; three doses of polio vaccine; two or three doses (depending on the type of vaccine used) of Hepatitis B vaccine; two or three doses doses (depending on the type of vaccine used) of *Haemophilus influenzae* type B vaccine; and, from the quarter ending 31 December 2013, pneumococcal disease. |
| Fully immunised at 24 months | A child who has, by the age of 2 years, received three or four doses (depending on the type of vaccine used) of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, three or four doses (depending on the type of vaccine used) of *Haemophilus influenzae* type B and one dose of measles, mumps and rubella vaccine. |
| Fully immunised at 60 months | A child who has, by the age of 5 years, received the necessary doses of diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella vaccines — four or five doses (depending on the type of vaccine used) of diphtheria, tetanus, pertussis vaccine, four doses of polio vaccine, three doses of Hepatitis B vaccine, three or four doses (depending on the type of vaccine used) of *Haemophilus influenzae* type B and two doses of measles, mumps and rubella vaccine. |
| General practice | The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population’ of patients and may include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander health. |
| General practitioner (GP) | Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement.  Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs. |
| GP‑type services | Non‑referred attendances by vocationally registered GPs and OMPs, and practice nurses. |
| *Haemophilus influenzae* type b | A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013b). |
| Immunisation coverage | The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group. |
| Management of upper respiratory tract infections | Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards. |
| Medicare Locals | Medicare Locals (MLs) are independent regional primary health care organisations with responsibility for supporting improved co‑ordination of primary health care service delivery, as well as identifying and addressing gaps in primary health care services, across their regions (www.amlalliance.com.au/about-us, accessed 25 November 2013).  Established progressively from 1 July 2011 under the National Health Reform agenda, the national network of 61 MLs and a national body, the Australian Medicare Local Alliance (AML Alliance), were operational at 1 July 2012. |
| Non-referred attendances | GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be ‘referred’ to receive DHS Medicare reimbursement. |
| Non-referred attendances that are bulk billed | Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances. |
| Nationally notifiable disease | A communicable disease that is on the Communicable Diseases Network Australia’s endorsed list of diseases to be notified nationally (Department of Health 2013c). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority. |
| Notifications of selected childhood diseases | Number of cases of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities. |
| Other medical practitioner (OMP) | A medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 DHS Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs. |
| Pap smear | A procedure for the detection of cancer and pre-cancerous conditions of the female cervix. |
| PBS doctor’s bag | Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient. |
| Per person benefits paid for GP ordered pathology | Total benefits paid under DHS Medicare for pathology tests requested by GPs, divided by the population. |
| Per person benefits paid for GP referred diagnostic imaging | Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population. |
| Primary healthcare | The primary and community healthcare sector includes services that:   * provide the first point of contact with the health system * have a particular focus on illness prevention or early intervention * are intended to maintain people’s independence and maximise their quality of life through care and support at home or in local community settings. |
| Prevalence | The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence). |
| Proportion of GPs who are female | Number of all FWE GPs who are female, divided by the total number of FWE GPs. |
| Proportion of GPs with vocational recognition | Number of FWE GPs who are vocationally registered, divided by the total number of FWE GPs. |
| Proportion of general practices registered for accreditation | Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and Quality Practice Accreditation Pty Ltd), divided by the total number of practices. |
| Proportion of general practices with electronic health information systems | Number of PIP-registered practices that have taken up the eHealth PIP incentive, divided by the total number of practices registered. |
| Public health | The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services. |
| Recognised immunisation provider | A provider recognised by DHS Medicare as a provider of immunisation to children. |
| Recognised specialist | A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner’s field of specialist recognition. |
| Screening | The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible. |
| Triage category | The urgency of the patient’s need for medical and nursing care:   * category 1 — resuscitation (immediate within seconds) * category 2 — emergency (within 10 minutes) * category 3 — urgent (within 30 minutes) * category 4 — semi-urgent (within 60 minutes) * category 5 — non-urgent (within 120 minutes). |
| Vocationally registered general practitioner | A medical practitioner who is vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances. |

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## 10.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘10A’ prefix (for example, table 10A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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