
10 Primary and community health

CONTENTS

10.1 Profile of primary and community health	10.2
10.2 Framework of performance indicators	10.11
10.3 Key performance indicator results	10.12
10.4 Future directions in performance reporting	10.60
10.5 Definitions of key terms	10.61
10.6 List of attachment tables	10.63
10.7 References	10.67

Attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the website (www.pc.gov.au/rogs/2016).

This chapter reports on the performance of primary and community health services. Primary and community health services include general practice, pharmaceutical services, dentistry, allied health services, maternal and child health, alcohol and other drug treatment and other services. Primary and community health services aim to support and improve the health of Australians through the prevention of ill health as well as the detection and effective management of illness and injury — by direct service provision and/or referral to acute (hospital) or other healthcare services, as appropriate.

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').

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

-
- reporting of a new mini case study on a centralised, state-wide chronic disease management program in Queensland
 - reporting a more complete measure of access to Pharmaceutical Benefits Scheme (PBS) medicines by location at a finer level of disaggregation
 - reporting a 10 year time series for male general practitioners (GPs) (previously 5 years) as well as female GPs.

All abbreviations used in this Report are available in a complete list in volume A: Approach to performance reporting.

10.1 Profile of primary and community health

Roles and responsibilities

The primary and community health sector is the most frequently used part of Australia's healthcare system. 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. General practice, pharmacy and community health services are funded largely by government, as are maternal and child health services. Governments also fund public dental and public alcohol and other drug treatment services. Allied health services and private dental services are largely non-government funded. Governments also fund programs to influence the supply, regional distribution and quality of primary and community health services. Primary Health Networks (PHNs) are an Australian Government funded national network of 31 independent primary health care organisations (replacing from 1 July 2015 the 61 Medicare Locals established under the National Health Reform agenda in 2011 and 2012). Their objective is to improve the efficiency and effectiveness of medical services, particularly for those at risk of poor health outcomes and to improve coordination of care to ensure patients receive the right care in the right place at the right time. 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 practices are predominantly privately owned, by GPs or corporate entities.

GPs must be registered with the Medical Board of Australia. Most general practice data reported in this chapter are for services provided by those GPs who are recognised for Medicare — vocationally registered GPs and 'other medical practitioners' (OMP). GP services include preventative care and the diagnosis and treatment of illness and injury,

through direct service provision and/or referral to acute (hospital) or other healthcare services, as appropriate.

The Australian Government provides the majority of general practice income, through DHS Medicare — mainly as fee-for-service payments via the Medicare Benefits Schedule (MBS) — and the Department of Veterans Affairs (DVA). Additional Australian Government funding is provided to influence the supply, regional distribution and quality of general practice services, through initiatives such as the Practice Incentives Program (PIP) and PHNs (Australian Government DHS 2015). State and Territory governments also provide some funding for such programs, particularly in relation to regional distribution of general practices. The remainder comes mainly from insurance schemes and patient contributions.

Pharmaceutical services

The objective of the Australian Government funded PBS is to provide affordable, reliable and timely access to prescription medicines for all Australians. Around 80 per cent of prescription medicines are subsidised through the PBS (Department of Health 2010). Users make a co-payment — \$6.10 for concession card holders and up to \$37.70 for general consumers in 2015 — and the Australian Government pays the remaining cost of medicines eligible for the subsidy (Department of Health 2015). Co-payments are subject to a safety net threshold — \$1453.90 for general consumers and \$366.00 for concession card holders in 2015 — beyond which PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year.

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 DVA. Drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

Dental services

Australia has a mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for funding and delivery of major public dental programs, with public dental services primarily available to children and disadvantaged adults. The private sector receives funding to provide some public dental services, from the Australian Government through the DVA and the Dental Benefits Schedule, and from State and Territory governments through dental voucher systems. The Australian Government also supports private dental services through the private health insurance rebate.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. They are delivered mainly in the private sector. Some government funding of private allied health services is provided through insurance schemes and the private health insurance rebate. 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. Nationally in 2014, there were 25.0 FTE occupational therapists and 24.9 FTE psychologists per 100 000 people working in the public sector (table 10A.29).

Community health services

Community health services generally comprise multidisciplinary teams of health and allied health professionals and aim to protect and promote the health of particular communities who experience barriers that impede access to private sector primary and community health services. Governments (including local governments) provide services directly or indirectly through funding of service provision by a local health service or community organisation. There is no national strategy for community health services and there is considerable variation in the services provided across jurisdictions.

State and Territory governments are responsible for most community health services. Those serving Aboriginal and Torres Strait Islander communities are mainly the responsibility of the Australian Government (though State and Territory governments provide some funding). Of these Aboriginal and Torres Strait Islander primary healthcare services, around 60 per cent are community-controlled or managed — planned and governed by local Aboriginal and Torres Strait Islander communities. These services provide comprehensive primary health care and/or substance use, social and emotional wellbeing and mental health services. Tables 10A.111–10A.119 provide an outline of some of the community health programs targeting groups who face particular health issues, not elsewhere reported.

Maternal and child health

Maternal and child health services are funded by State and Territory governments. They provide services including: parenting support (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).

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, counselling and rehabilitation.

Funding

In 2013-14, government recurrent expenditure on primary and community health services (excluding public health) was \$29.0 billion, of which State, Territory and local governments provided 23.7 per cent and the Australian Government 76.3 per cent (table 10.1).

Table 10.1 Estimated funding on primary healthcare, 2013-14 (\$ million)^{a, b}

	<i>Australian Government</i>				<i>State, Territory and local government</i>	<i>Total government</i>	<i>Non-government</i>	<i>Total government and non-government</i>
	<i>DVA</i>	<i>Department of Health and other</i>	<i>Premium rebates</i>	<i>Total</i>				
Unreferred medical services	857	7 837	–	8 694	–	8 694	1 903	10 597
Dental services	109	503	664	1 275	713	1 989	6 925	8 914
Other health practitioners	256	1 253	312	1 822	9	1 831	3 589	5 420
Community health and other	1	1 252	–	1 253	6 155	7 408	409	7 817
Benefit-paid medications	406	8 047	–	8 452	–	8 452	1 598	10 050
All other medications	–	566	21	587	–	587	9 126	9 713
Total	1 628	19 457	997	22 082	6 878	28 960	23 551	52 511

^a See table 10A.1 for detailed footnotes and caveats. ^b Totals may not add due to rounding. – Nil or rounded to zero.

Source: AIHW (Australian Institute of Health and Welfare) (2015), *Health Expenditure Australia 2013-14*, Cat. no. HWE 63; table 10A.1.

General practice

In 2014-15, 95.8 per cent of general practice encounters where a payment source was recorded were for services at least partly funded by Medicare or the DVA (Britt et al. 2015) (table 10A.2). Australian Government total recurrent expenditure on general practice in 2014-15 was \$8.3 billion or \$351 per person (table 10A.4). This

includes fee-for-service expenditure through DHS Medicare and the DVA of \$7.7 billion (table 10A.3) — translating to \$328 per person (crude rate — not presented in table 10A.3) and accounting for 93.3 per cent of total recurrent expenditure — as well as expenditure on the Practice Incentives Program (PIP) and Medicare Locals. Age standardised fee-for-service expenditure per person data are presented in table 10A.3.

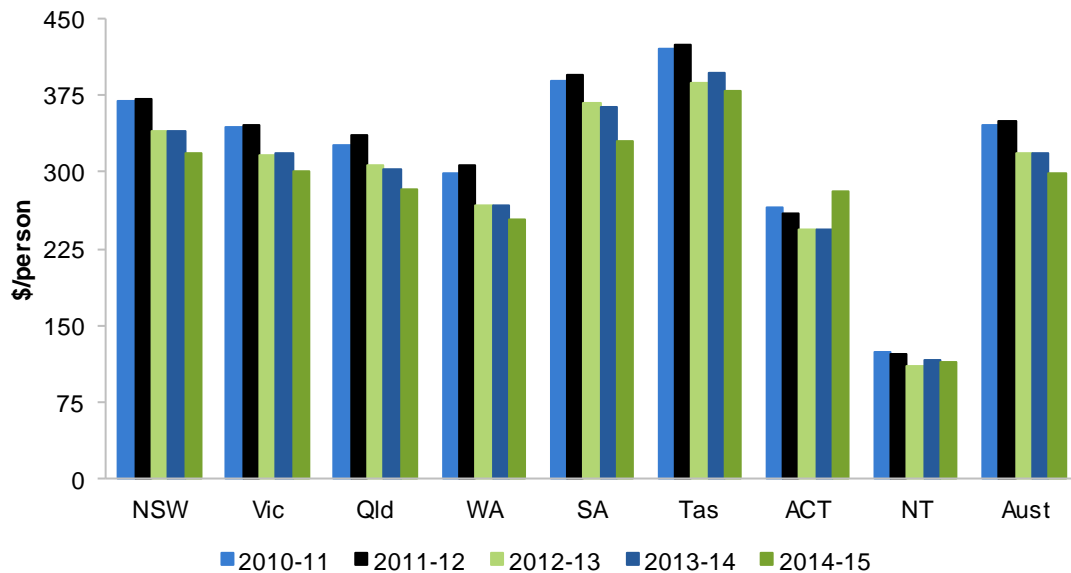
State and Territory governments contribute funding to general practice mainly through support programs such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas. Non-government sources also contribute through insurance schemes (such as, workers compensation and third party insurance) and private individuals.

Pharmaceutical services

Australian Government expenditure through the PBS and RPBS on prescription medicines filled at pharmacies was around \$7.4 billion in 2014-15 (tables 10A.5 and 10A.6). Of this, around \$7.1 billion was through the PBS. Real expenditure on the PBS, which rose relatively steadily from \$6.9 billion (\$337 per person) in 2005-06 to a high of \$7.9 billion (\$350 per person) in 2011-12, decreased to \$7.1 billion (\$299 per person) in 2014-15 (figure 10.1 and table 10A.5). The proportion of PBS expenditure that is concessional fell from 80.0 to 77.4 per cent in the period 2005-06 to 2014-15 (table 10A.5).

The Australian Government also funds the supply of PBS medicines to Aboriginal and Torres Strait Islander primary healthcare services in remote and very remote areas under s.100 of the *National Health Act 1953* (Cwlth), costing \$29.3 million in 2014-15 — a decline from \$38.1 million in 2012-13 (in 2014-15 dollars) (table 10A.7).

Figure 10.1 **PBS expenditure (2014-15 dollars)^a**



^a See table 10A.5 for detailed footnotes and caveats.

Source: Department of Health (unpublished) PBS Statistics; tables 10A.5 and 10A.6.

Dental services

Australian Government expenditure on dental services was \$1.3 billion in 2013-14, of which 48 per cent was through DVA and the Department of Health, and 52 per cent through private health insurance premium rebates (tables 10.1 and 10A.1). State, Territory and local government expenditure on dental services was \$713 million in 2013-14. Dental expenditure data by State and Territory are provided in table 10A.8.

Community health services

In 2013-14, government expenditure on community health services was \$7.4 billion, of which State, Territory and local governments provided 83.1 per cent and the Australian Government 16.9 per cent (tables 10.1 and 10A.1).

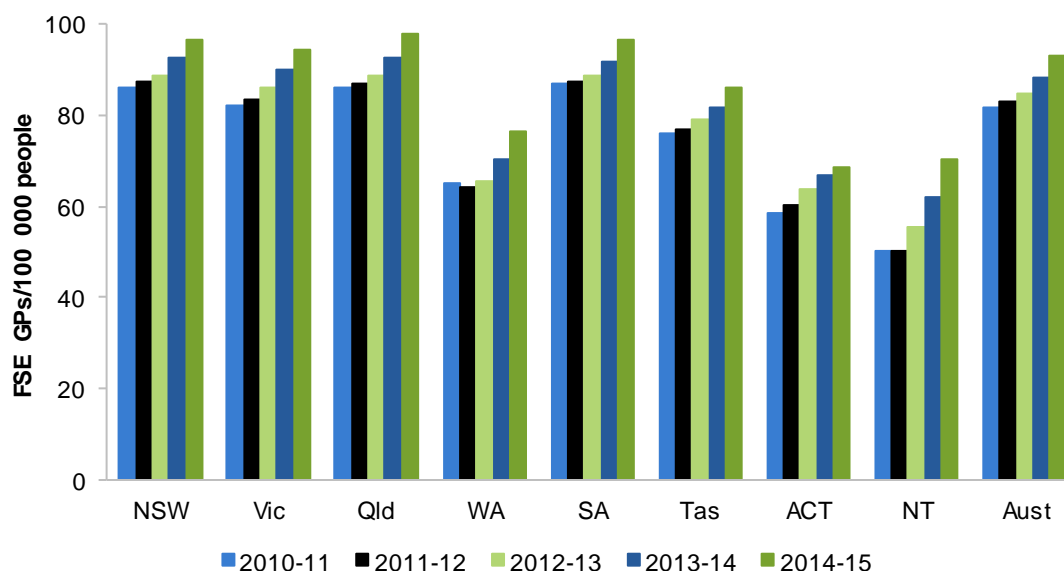
Australian Government expenditure on Aboriginal and Torres Strait Islander primary health care services was \$568 million in 2014-15 (table 10A.9).

Size and scope

General practice

There were 33 275 GPs — 22 005 on a Full Service Equivalent (FSE) basis — billing Medicare Australia, based on MBS claims data, in 2014-15 (see section 10.5 for a definition of FSE). This equated to 93.1 FSE GPs per 100 000 people. Rates have increased over the five year period reported, both nationally and for all jurisdictions (figure 10.2 and table 10A.10).

Figure 10.2 **Availability of GPs^a**

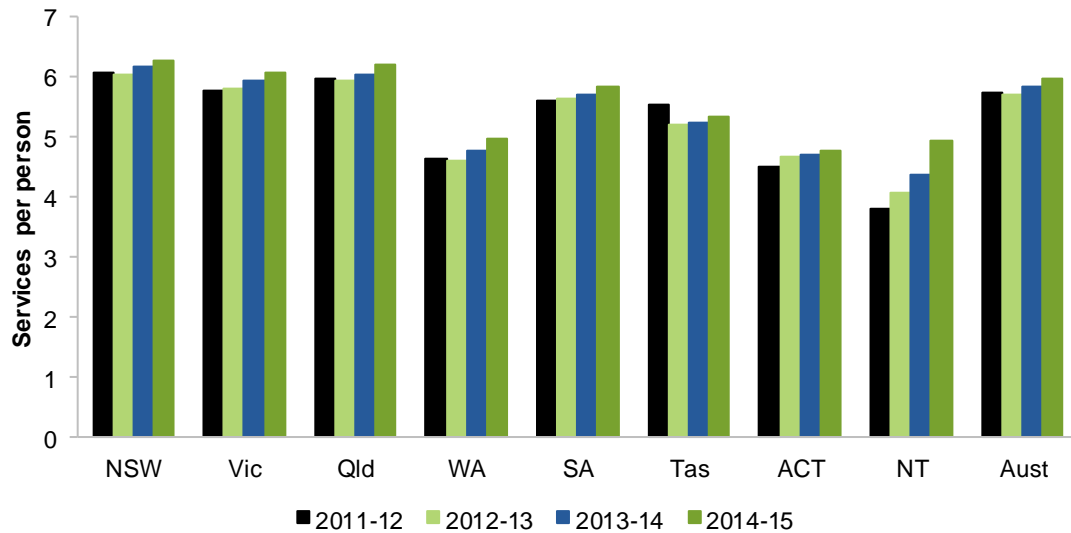


^a See table 10A.10 for detailed footnotes and caveats.

Source: Department of Health (unpublished) MBS Statistics; table 10A.10.

Nationally, around 6242 general practitioner-type services per 1000 population were provided under DHS Medicare in 2014-15 (crude rate — not presented in table 10A.11). Age-standardised rates (ASR) increased across most jurisdictions over the four year period reported (figure 10.3).

Figure 10.3 GP type service use (ASR)^a



^a See table 10A.11 for detailed footnotes and caveats.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 10A.11.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 212 million services — 90.9 per cent of which were concessional — were provided under the PBS in 2014-15 (tables 10A.12 and 10A.13). This amounted to 8.9 filled prescriptions per person. A further 12 million services were provided under the RPBS in the same period.

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.

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. Most jurisdictions provided public dental services in 2013-14 targeted to disadvantaged people. Current data are not available for use of public dental services for the 2016 Report.

Community health services

There is no national data collection for community health services other than Aboriginal and Torres Strait Islander primary health care services. Of 203 Aboriginal and Torres Strait Islander primary healthcare services reported for 2013-14, 45.8 per cent were located in remote or very remote areas (table 10A.16). Of the 3.3 million episodes of healthcare provided in 2013-14 (table 10.2), around 46.8 per cent were provided in remote or very remote areas (table 10A.16).

Table 10.2 Estimated episodes of healthcare for Aboriginal and Torres Strait Islander Australians by services for which OSR data are reported ('000)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
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
2013-14	646	216	690	543	177	59	42	897	3 269

^a See table 10A.15 for detailed footnotes and caveats.

Source: AIHW (2015 and previous issues) *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results*, Cat. nos IHW 56, 79, 104, 139 and 152; table 10A.15.

As at 30 June 2014, the Aboriginal and Torres Strait Islander primary healthcare services reported employed around 4604 full time equivalent healthcare staff, of whom 54.0 per cent were Aboriginal and Torres Strait Islander people. In 2014, 7.3 per cent of employed doctors and 12.2 per cent of employed nurses/midwives were Aboriginal and Torres Strait Islander people (table 10A.19).

Alcohol and other drug treatment

Data for a total of 795 alcohol and other drug treatment agencies were reported for 2013-14, with 44.4 per cent identified as government providers and 55.6 per cent as non-government providers (table 10A.14). There were 180 713 reported closed treatment episodes in 2013-14 (table 10A.14) (see section 10.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use (67.1 per cent of whom were male) accounted for 95.0 per cent of closed treatment episodes (table 10A.14). Nationally, alcohol was the most commonly reported principal drug of concern (40.5 per cent) — followed by cannabis (23.6 per cent), amphetamines (16.8 per cent) and heroin (7.0 per cent) — in closed treatment episodes for clients seeking treatment for their own substance use (AIHW 2015).

10.2 Framework of performance indicators

The performance indicator framework is based on common objectives for primary and community health (box 10.1).

Box 10.1 Objectives for primary and community health

Primary and community health services aim to support and improve the health of Australians by:

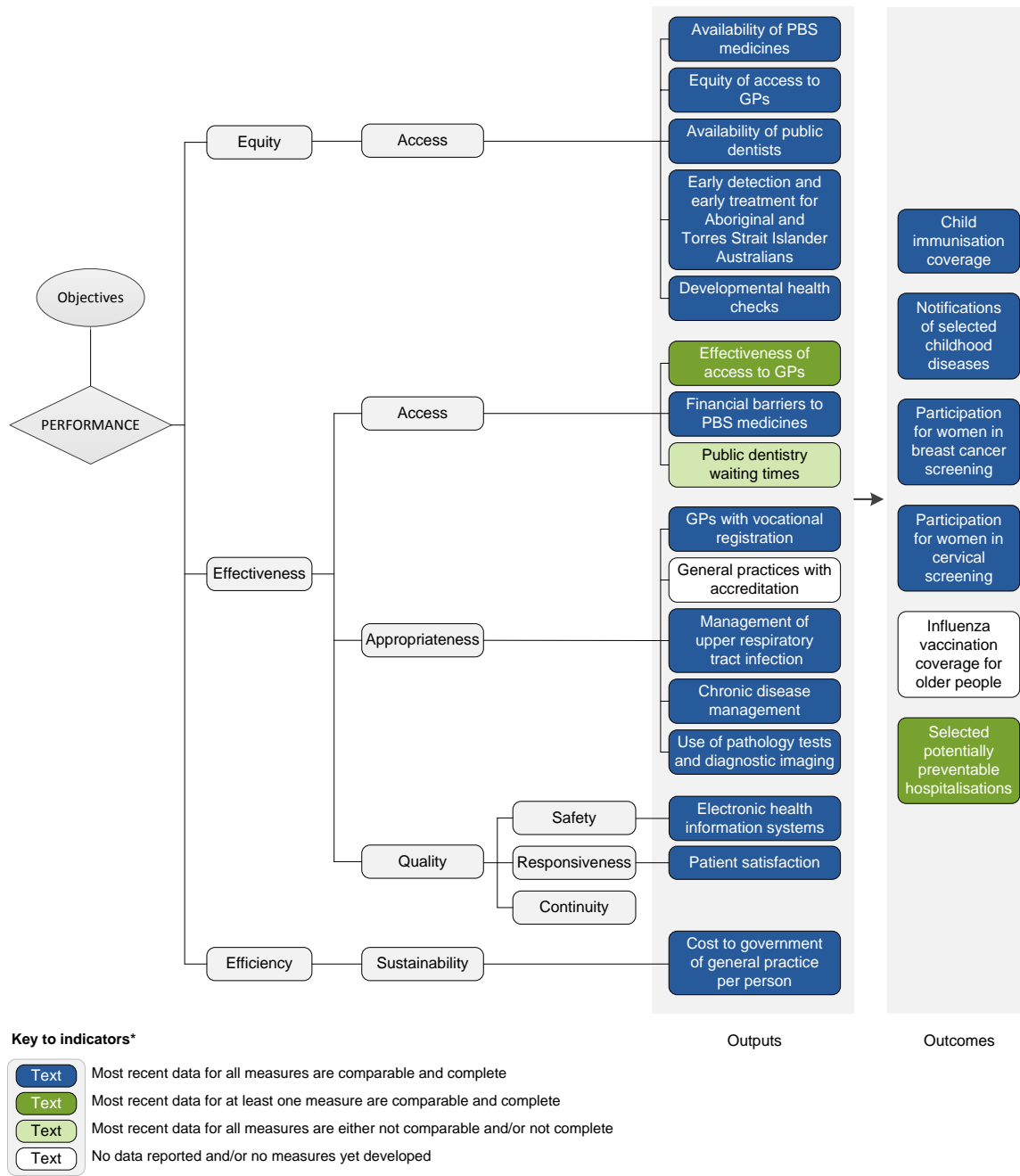
- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating 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 by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of primary and community health services (figure 10.4). The performance indicator framework shows which data are complete and comparable in the 2016 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).

In addition to section 10.1, 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 (chapter 2).

Figure 10.4 Primary and community health performance indicator framework



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.

Data Quality Information (DQI) is included where available for performance indicators in this 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 material in the chapter or sector overview and attachment tables. All DQI for the 2016 Report can be found at www.pc.gov.au/rogs/2016.

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). Output information is also critical for equitable, efficient and effective management of government services.

Equity

Equity is defined for the purpose of this Report in terms of adequate access to government services for all Australians (see chapter 1, section 1.5).

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). Medicines are important in the treatment and prevention of illness. 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.

Box 10.2 **Availability of PBS medicines**

‘Availability of PBS medicines’ is defined by three measures:

- access to PBS medicines by region, defined as the ABS census population divided by the number of approved providers of PBS medicines, by Pharmacy Access/Remoteness Index of Australia (PhARIA) area.
- PBS expenditure per person by region, defined as expenditure on PBS medicines, divided by the ERP, in urban and 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 approved PBS provider 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.

(continued next page)

Box 10.2 (continued)

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

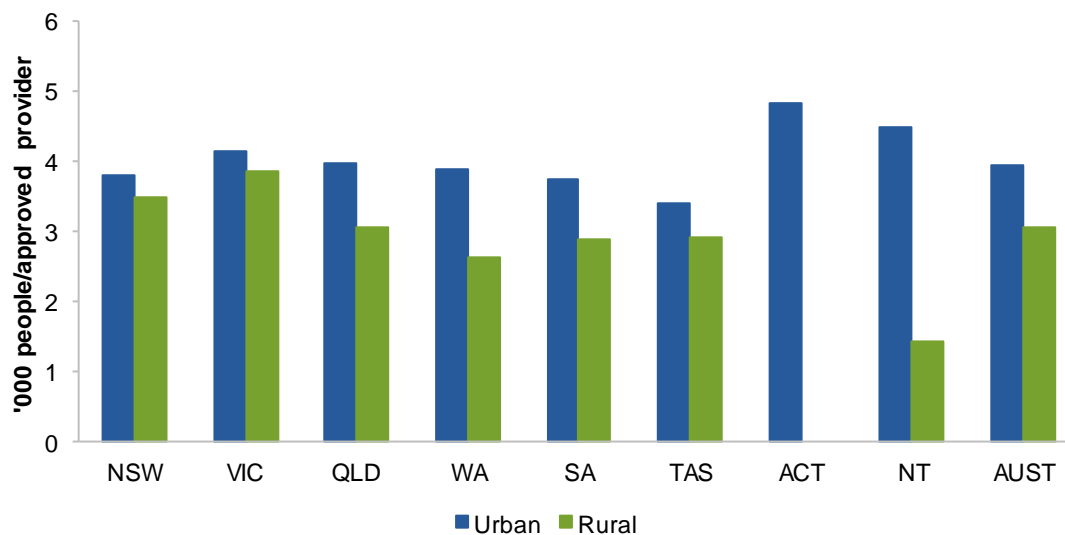
Data reported for this indicator are:

- 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 2015 for the measure access to PBS medicines by region and for 2014-15 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/2016.

Across Australia in the period 2011 to 2015, the number of people per pharmacy increased in urban areas (from 3777 to 3933) and decreased in rural areas (from 4108 to 3688) (table 10A.21). Taking into account the 21 medical practitioners and 160 Aboriginal and Torres Strait Islander primary health care services also approved to provide PBS medicines to the community in remote/very remote areas, there were 3065 people per PBS approved provider in rural areas in 2015 (figure 10.5 and table 10A.20).

Figure 10.5 People per approved PBS provider, 2014-15^{a, b}

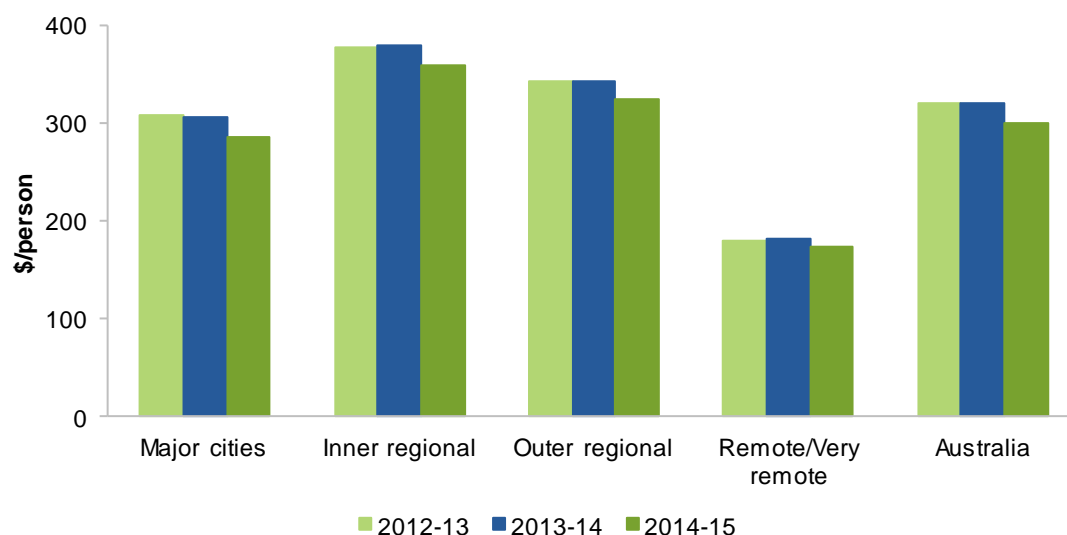


^a See box 10.2 and table 10A.20 for detailed definitions, footnotes and caveats. ^b The ACT has no rural areas under the classification used.

Source: Department of Health (unpublished) derived from DHS Medicare, ABS (unpublished) 2011 Census of Population and Housing and the University of Adelaide's Australian Population and Migration Research Centre; table 10A.20.

Nationally, PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 10.6).

Figure 10.6 **PBS expenditure by region (2014-15 dollars)^a**



^a See box 10.2 and table 10A.22 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) PBS Statistics; table 10A.22.

Access — 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).

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 FSE GPs per 100 000 people, by region
- availability of GPs by sex, defined as the number of FSE 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.

(continued next page)

Box 10.3 (continued)

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:

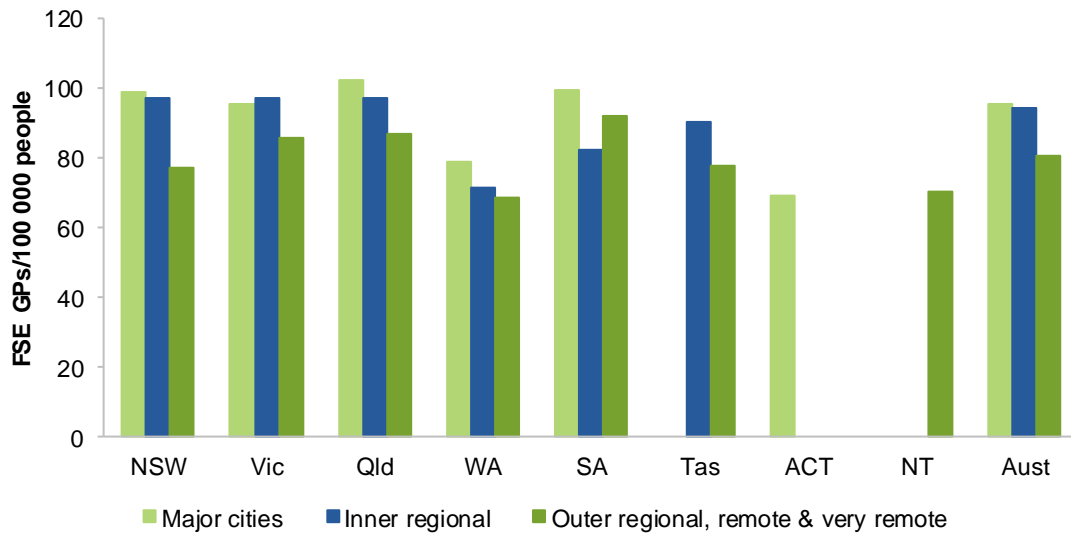
- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 are not comparable to data for previous years for the measure availability of GPs by region
- comparable (subject to caveats) across jurisdictions and over time for the measure availability of GPs by sex
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

In 2014-15, there were more FSE GPs per 100 000 people available in major cities and inner regional areas than in outer regional, remote and very remote areas in most jurisdictions (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 all other areas (table 10A.35).

In 2014-15, 35.2 per cent of Australia's FSE GPs were female (table 10A.25). There were 65.2 FSE female GPs per 100 000 females and 121.3 FSE male GPs per 100 000 males in 2014-15 (figure 10.8). Data are presented for a ten year time series in tables 10A.25 and 10A.26.

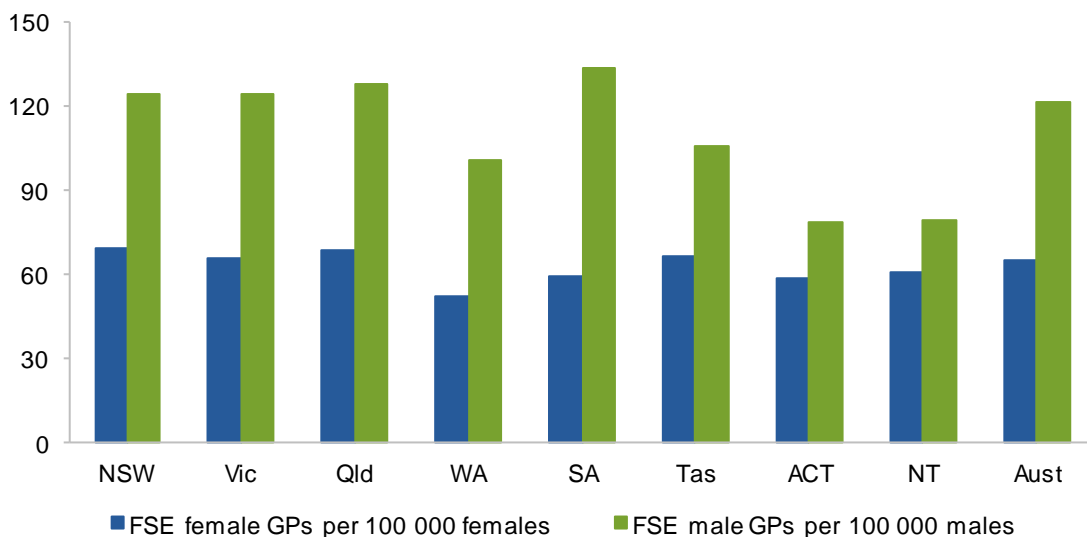
Figure 10.7 Availability of GPs by region, 2014-15^{a, b}



^a See box 10.3 and table 10A.24 for detailed definitions, footnotes and caveats. ^b 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. Major cities and inner regional areas are combined for the ACT.

Source: Department of Health (unpublished) MBS Statistics; table 10A.24.

Figure 10.8 Availability of GPs by sex, 2014-15^a



^a See box 10.3 and tables 10A.25 and 10A.26 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) MBS Statistics; tables 10A.25 and 10A.26.

Access – Availability of public dentists

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

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 and is based on clinical hours worked in the public sector.

High or increasing availability of public dentists can indicate improved access to public dental services. The availability of public dentists by region may affect 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.

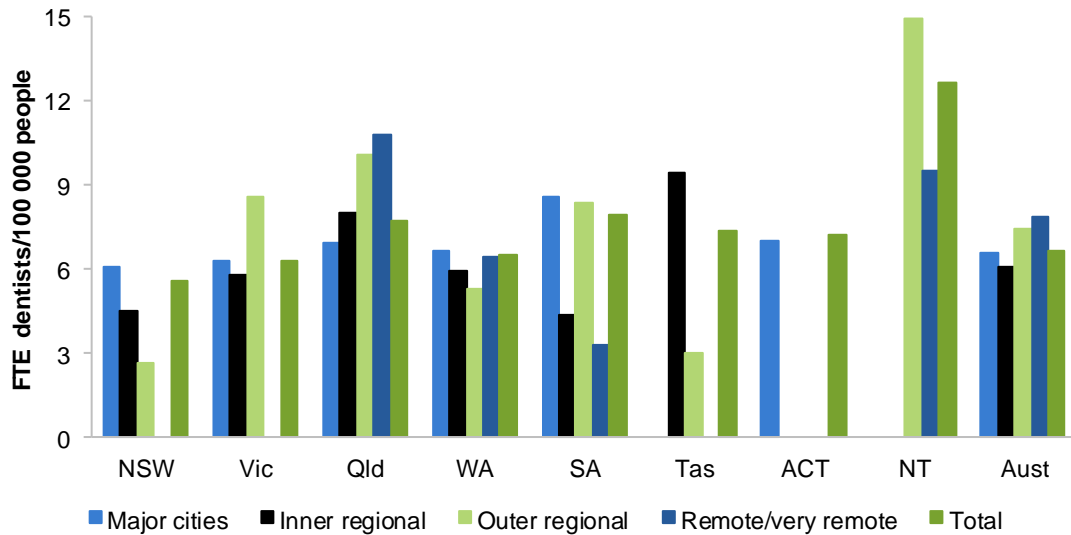
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2014 are not comparable to data for 2013 and previous years
- 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 at www.pc.gov.au/rogs/2016.

Nationally in 2014, the number of FTE public dentists per 100 000 people was highest in remote/very remote areas (7.9), followed by outer regional (7.4) and major cities (6.6), and lowest in inner regional areas (6.1) (figure 10.9, table 10A.27). Nationally there were 3.5 FTE public dental therapists per 100 000 people in 2014 (table 10A.28). Data for FTE dental hygienists and dental therapists are presented in table 10A.28.

Figure 10.9 Availability of public dentists, 2014^{a, b, c}



^a See box 10.4 and table 10A.27 for detailed definitions, footnotes and caveats. ^b There were no public dentists in remote or very remote areas in Victoria. ^c 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.

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

‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is an indicator of governments’ objective to provide equitable access to primary and community healthcare services for Aboriginal and Torres Strait Islander Australians (box 10.5). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people’s health.

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).

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
 - health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning.
- 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.

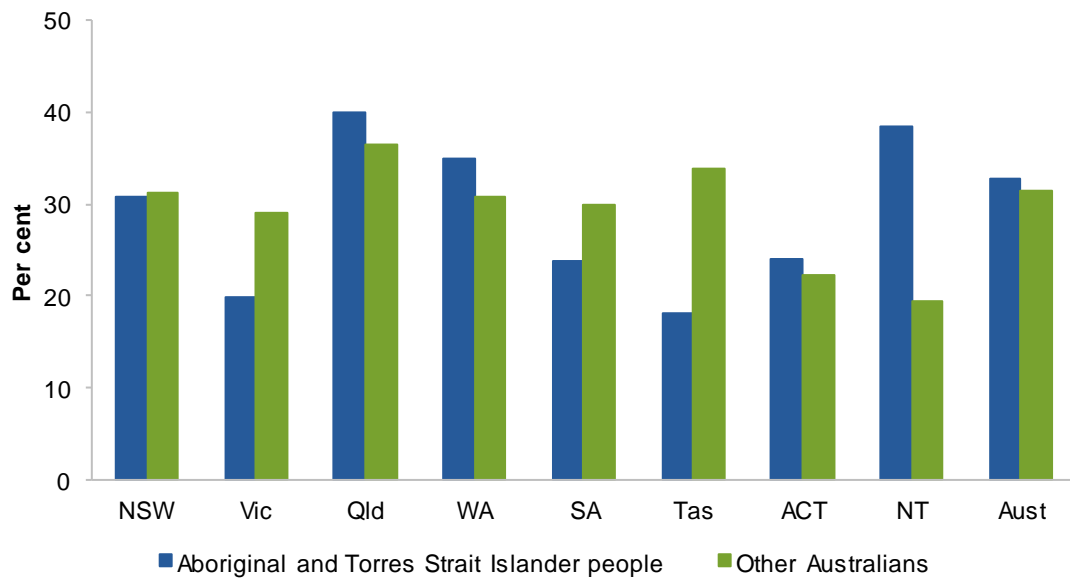
This indicator provides no information about health assessments provided outside DHS Medicare. Such services are provided under service delivery models used predominantly by Aboriginal and Torres Strait Islander people, for example, in remote and very remote areas. Accordingly, this indicator understates the proportion of Aboriginal and Torres Strait Islander people who received early detection and early treatment services.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.
- Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Nationally in 2014-15, the proportion of older people receiving a health assessment was 32.7 per cent for Aboriginal and Torres Strait Islander people and 31.4 per cent for other Australians (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.

Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2014-15^a



^a See box 10.5 and table 10A.30 for detailed definitions, footnotes and caveats.

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.

Over the five years to 2014-15, the proportion of older Aboriginal and Torres Strait Islander people who received an annual health assessment increased more steeply than for all Australians in all jurisdictions, albeit from a lower base (18.1 per cent at the national level for Aboriginal and Torres Strait Islander people and 26.8 per cent for all Australians) (table 10A.30). Data are presented for an eight year time series for Aboriginal and Torres Strait Islander people in table 10A.31 and for a nine year time series for all Australians in table 10A.33.

The proportion of the eligible Aboriginal and Torres Strait Islander population who received a health assessment or check in 2014-15 was highest for older people in all jurisdictions, and lowest for children aged 0–14 years in most jurisdictions (table 10A.32).

Access – 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).

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.

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 ‘Healthy Kids Check’ MBS health assessment item is available to all 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. 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. Children are counted once only.

Fourth year developmental health assessments are intended to assess children’s physical health, general wellbeing and development. Early identification provides the opportunity for timely prevention and intervention measures that can ensure 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. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.

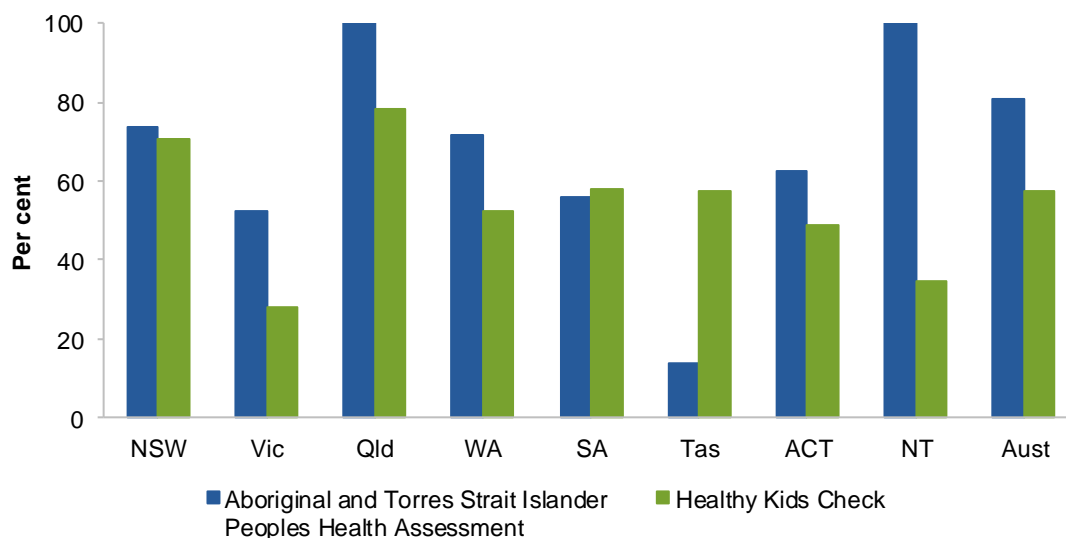
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data from 2012-13 onwards are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Nationally, the proportion of children who received a fourth year developmental health check under DHS Medicare was 58.9 per cent in 2014-15 (table 10A.34). The proportion was higher for Aboriginal and Torres Strait Islander children (80.9 per cent) than for other children (57.6 per cent), although there was considerable variation across jurisdictions (figure 10.11).

Figure 10.11 Children who received a fourth year developmental health check, by health check type, 2014-15^a



^a See box 10.6 and table 10A.34 for detailed definitions, footnotes and caveats.

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.34.

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.

Box 10.7 Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is defined by four measures:

- bulk billing rates, defined as the proportion of non-referred attendances by GPs and practice nurses that were bulk billed
- people deferring visits to GPs due to financial barriers, defined as the proportion of people who delayed seeing or did not see a GP at any time in the previous 12 months due to cost

(continued next page)

Box 10.7 (continued)

- GP waiting times, defined as the proportion of people who, in the previous 12 months, saw a GP for urgent medical care within specified times from making the appointment. Specified waiting 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 emergency presentations:
 - allocated to triage category 4 (semi-urgent) or 5 (non-urgent)
 - not arriving by ambulance, with police or corrections
 - not admitted or referred to another hospital
 - who did not die.

A high or increasing bulk billing rate can indicate more affordable access to GP services. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.

A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs. Data for this measure include 95 per cent confidence intervals (in the form of error bars in figures and percentages in tables).

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 these three measures are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

The Patient Experience Survey (PEXS) does not include people living in discrete Aboriginal and Torres Strait Islander communities, which affects the comparability of the NT results for the measures people deferring visits to GPs due to financial barriers and GP waiting times.

Potentially avoidable presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector. In some cases, this can be determined only retrospectively and presentation to an emergency department is appropriate. 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:

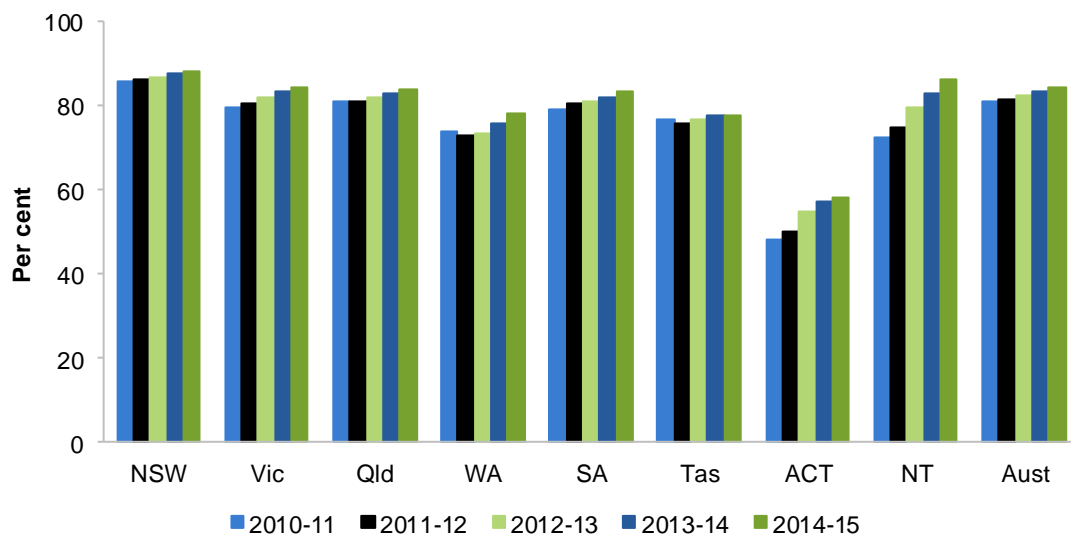
- comparable (subject to caveats) within some jurisdictions over time but not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Effectiveness of access to GPs — bulk billing rates

Where bulk billing is used, patients incur no out-of-pocket expense and, for most GP services, the GP receives the full Schedule fee from DHS Medicare. Nationally in 2014-15, the bulk billed proportion of non-referred attendances was 84.6 per cent. For States and Territories, this proportion generally increased in the period 2010-11 to 2014-15 (figure 10.12). The GP bulk billing rate was highest in very remote areas and lowest in inner regional, outer regional and remote areas in 2014-15 (table 10A.35). Non-referred attendances for children under 16 years and older people were bulk billed at higher rates than people aged 16 to 64 years in 2014-15 (table 10A.36).

Figure 10.12 **GP visits that were bulk billed^a**



^a See box 10.7 and table 10A.36 for detailed definitions, footnotes and caveats.

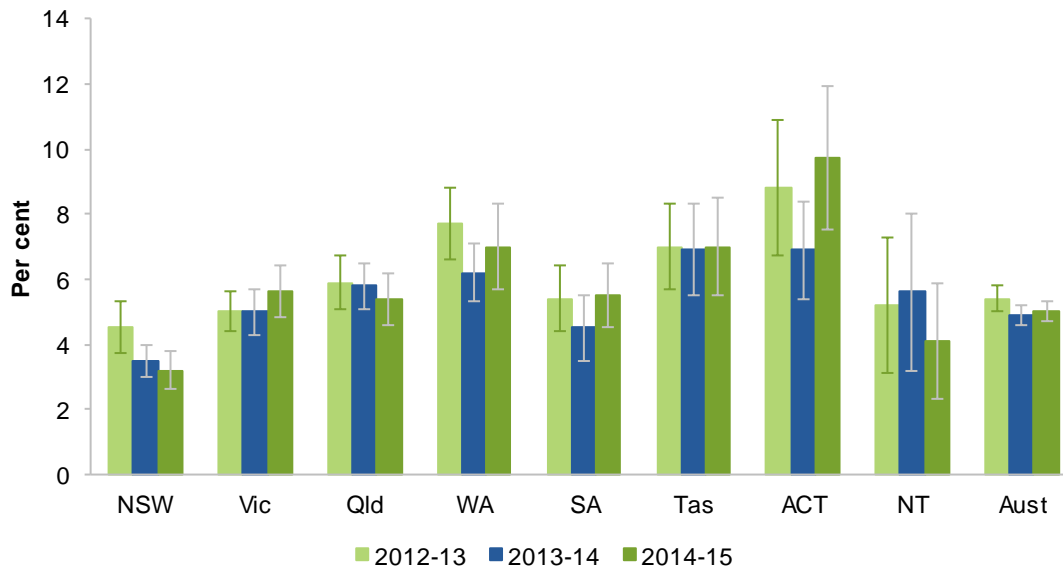
Source: Department of Health (unpublished) MBS Statistics; table 10A.36.

Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Nationally in 2014-15, 5.0 per cent of the population reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 10.13).

Data for Aboriginal and Torres Strait Islander Australians deferring access to GPs due to cost are presented in table 10A.38. These data are sourced from a different data collection to the data for the general population and are not directly comparable.

Figure 10.13 **People deferring visits to GPs due to cost^a**



^a See box 10.7 and table 10A.37 for detailed definitions, footnotes and caveats.

Source: ABS (unpublished) Patient Experience Survey (various years), Cat. no. 4839.0; table 10A.37.

Effectiveness of access to GPs — GP waiting times

Nationally in 2014-15, for people who saw a GP for urgent care:

- 63.9 per cent waited less than 4 hours
- 11.1 per cent waited from 4 to less than 24 hours
- 25.0 per cent waited for 24 hours or more (table 10A.39).

Overall, 20.8 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).

Effectiveness of access to GPs — GP-type presentations to emergency departments

Factors contributing to GP-type presentations at emergency departments include perceived or actual lack of access to GP services, the proximity of emergency departments and trust in emergency department staff. Nationally, there were around 2.8 million GP-type presentations to public hospital emergency departments in 2014-15 (table 10.3). Supplementary survey data for people who visited an emergency department for healthcare they thought could have been provided at a general practice are presented for 2010-11 to 2012-13 in table 10A.42.

Table 10.3 GP-type presentations to emergency departments, ('000)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2013-14	1 047.2	625.8	450.2	314.2	172.4	61.6	53.3	57.5	2 782.3
2014-15	1 060.2	615.9	435.9	331.8	166.0	61.1	55.8	54.8	2 781.4

^a See box 10.7 and table 10A.41 for detailed definitions, footnotes and caveats.

Source: AIHW (unpublished) National non-admitted emergency patient database; table 10A.41.

Access – 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).

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 at any time in the previous 12 months due to cost.

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

Data for this indicator include 95 per cent confidence intervals (in the form of error bars in figures and percentages in tables).

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 2014-15 data are available for all jurisdictions.

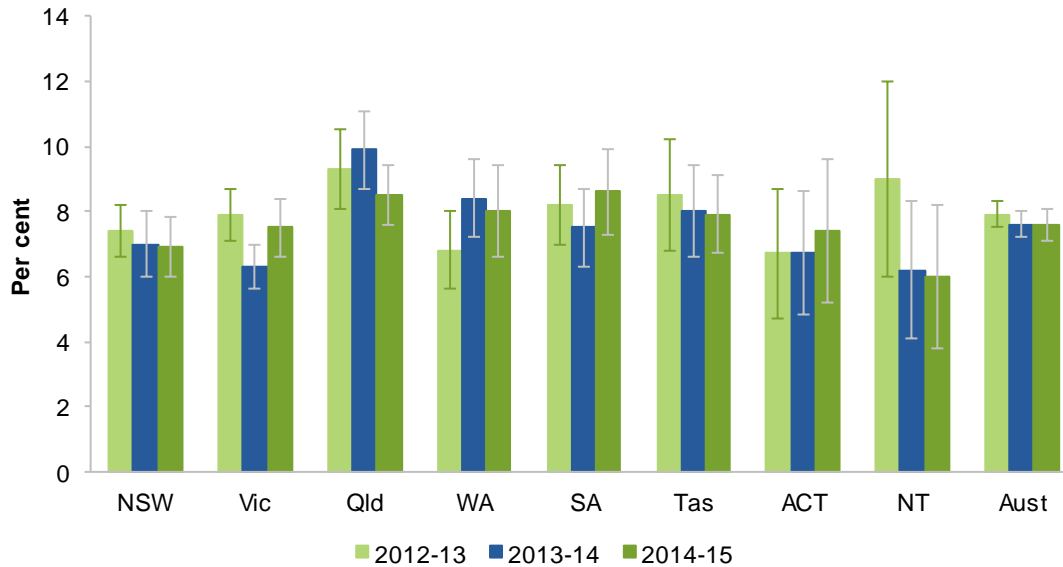
The PExS does not include people living in discrete Aboriginal and Torres Strait Islander communities, which affects the comparability of the NT results.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Nationally in 2014-15, 7.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 10.14).

Data for Aboriginal and Torres Strait Islander Australians are presented in table 10A.44. These data are sourced from a different data collection to the data for the general population and are not directly comparable.

Figure 10.14 **People deferring purchase of prescribed medicines due to cost^a**



^a See box 10.8 and table 10A.43 for detailed definitions, footnotes and caveats.

Source: ABS (unpublished) Patient Experience Survey (various years), Cat. no. 4839.0; table 10A.43.

Access – 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).

Box 10.9 Public dentistry waiting times

‘Public dentistry waiting times’ is defined as the median time waited between being placed on a public dentistry waiting list and receiving dental care (or, if data not available, being offered dental care).

A shorter median time waited to see a dental professional indicates more timely access to public dental services.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- incomplete for the current reporting period. All required 2014-15 data were not available for NSW and the NT.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Data for the median time waited by people on a public dental waiting list are presented for States and Territories in tables 10A.45–10A.52. Due to a change in data source,

administrative data reported here are not comparable with survey data published in previous reports.

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).

Box 10.10 GPs with vocational registration

‘GPs with vocational registration’ is defined as the proportion of FSE 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 FSE 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.

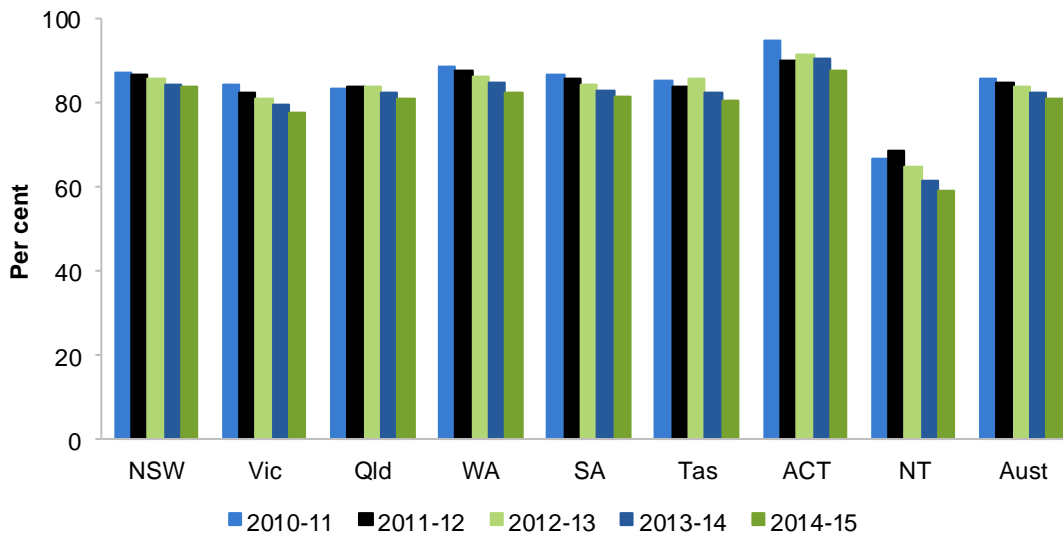
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Nationally, the proportion of FSE GPs with vocational registration decreased from 85.7 to 81.2 per cent in the period 2010-11 to 2014-15 (figure 10.15). The proportion of FSE GPs with vocational registration was highest in major cities and lowest in outer regional and remote areas in 2014-15 (table 10A.53).

Figure 10.15 FSE GPs with vocational registration^a



^a See box 10.10 and table 10A.54 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) MBS Statistics; table 10A.54.

Appropriateness - General practices with accreditation

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

Box 10.11 General practices with accreditation

‘General practices with accreditation’ is defined as the proportion of general practices in Australia that are accredited. Accreditation is a voluntary process of independent third-party peer review that assesses general practices against a set of standards developed by the RACGP.

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 as data for the number of general practices are not available.

Data quality information for this indicator is under development.

The two providers of general practice accreditation services in Australia are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation Pty Ltd. Data for the number of accredited practices and the available historical data for the proportion of practices with accreditation are reported in table 10A.55.

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 all jurisdictions in the period 2009-10 to 2013-14 (table 10A.56).

Appropriateness – 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).

Box 10.12 Management of upper respiratory tract infection

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

- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed
- filled GP prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) per 1000 people.

Low or decreasing rates of acute URTI GP visits where systemic antibiotics are prescribed, and of filled GP prescriptions for the selected antibiotics, 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 for the measure proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed include 95 per cent confidence intervals (in the form of error bars in figures and percentages in tables).

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 onwards 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 2014-15 data are available for all jurisdictions.

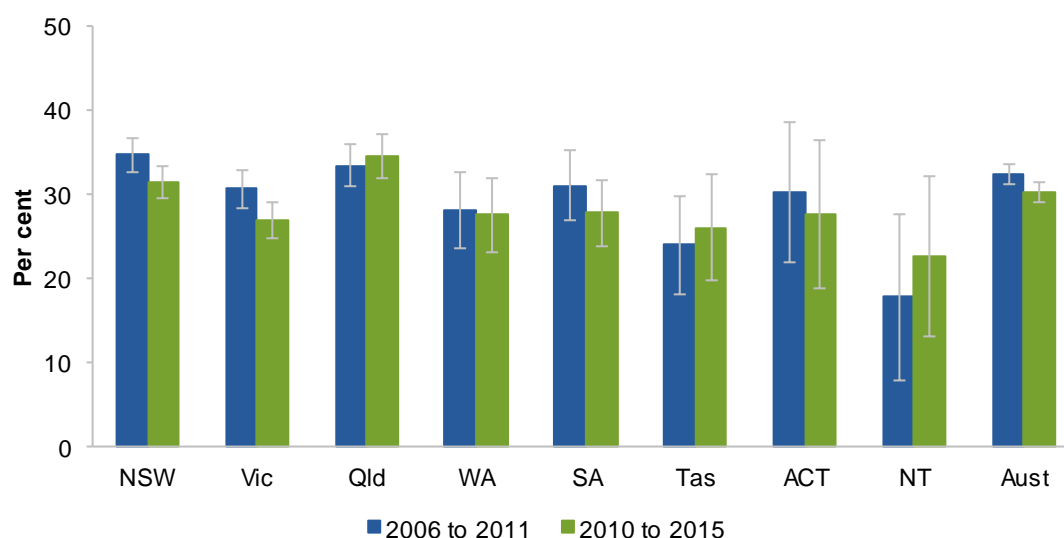
Data quality information for the measure filled GP prescriptions for selected antibiotics is at www.pc.gov.au/rogs/2016. Data quality information for the measure acute URTI GP visits where systemic antibiotics are prescribed is under development.

The annual BEACH (Bettering the Evaluation and Care of Health) survey 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. This has some limitations — short-term change will be reflected only if substantive when averaged over a five-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 five-year periods is due to substantive short-term change or to incremental change over several years.

Nationally, the proportion of people presenting to GPs for acute URTI who were prescribed systemic antibiotics for its treatment decreased from 32.4 per cent over the five-year period April 2006–March 2011, to 30.2 per cent over the five-year period April 2010–March 2015. Results varied across jurisdictions (figure 10.16).

Single year data at the national level are available in table 10A.60.

Figure 10.16 **Acute URTI managements where systemic antibiotics were prescribed^a**



^a See box 10.12 and table 10A.59 for detailed definitions, footnotes and caveats.

Source: Britt et al. (unpublished) BEACH Statistics; table 10A.59.

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 through the PBS.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat acute URTI rose slightly from 302 in 2012-13 to 305 per 1000 people in 2014-15 (table 10A.57).

Appropriateness – 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). Appropriate and effective management in the primary and community health sector can delay the progression of chronic disease and prevent, or minimise the severity of, its complications. In addition to significant improvements in the health and wellbeing of people with chronic disease, the consequent reduced demand for acute services can generate important cost savings. Effective management requires timely, high quality healthcare that meets individual needs and provides continuity of care (Australian Government 2010).

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 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.

HbA1c measures the level of glucose in the blood averaged over the preceding three months, and levels below 7 per cent are indicative of appropriate management of diabetes in that period.

Written asthma action plans 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).

(continued next page)

Box 10.13 (continued)

Data for the measures management of diabetes — HbA1c and management of asthma include 95 per cent confidence intervals (in the form of error bars in figures and percentages in tables).

Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for: management of diabetes — PIP diabetes incentive (2015); management of diabetes — HbA1c (2011-12); management of asthma (2011-12); and, care planning/case conferencing (2014-15).

The total and non-Indigenous components of the Australian Health Survey 2011–2013 did not include people living in discrete Aboriginal and Torres Strait Islander communities or very remote areas, which affects the comparability of the NT results for the measures management of diabetes — HbA1c and management of asthma.

Data quality information is at www.pc.gov.au/rogs/2016 for the measures management of diabetes — HbA1c and management of asthma. DQI is under development for the measures management of diabetes — PIP diabetes incentive and care planning/case conferencing.

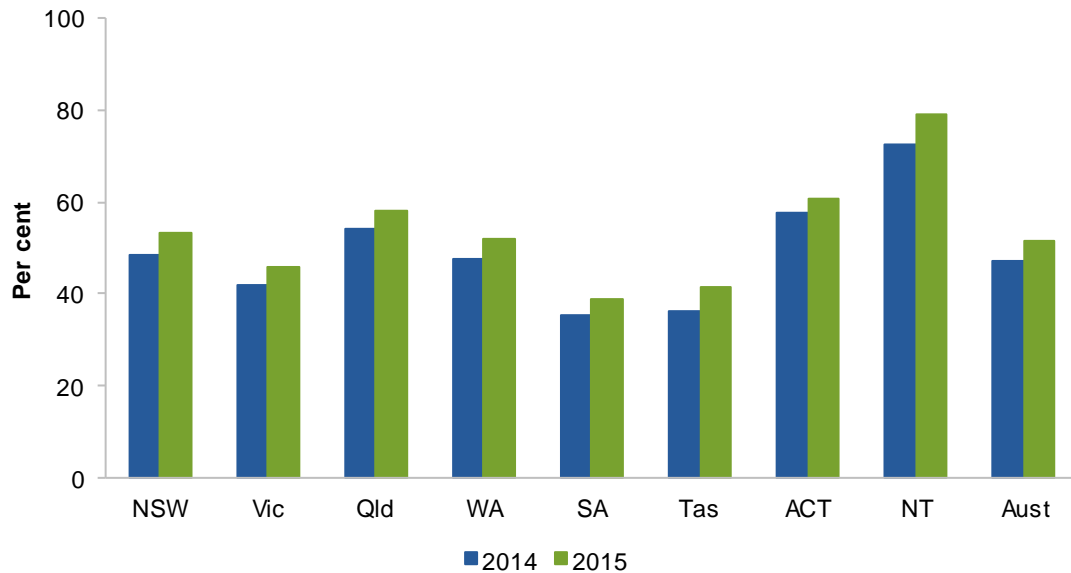
Chronic diseases are generally long term and often progressive conditions. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).

Chronic disease management — diabetes

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 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, the proportion of PIP practices registered for the PIP diabetes incentive increased from 47.3 per cent in May 2014 to 51.5 per cent in May 2015, with similar increases in all States and Territories (figure 10.17).

Figure 10.17 PIP practices registered for the PIP diabetes incentive^a



^a See box 10.13 and table 10A.61 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.61.

HbA1c provides a measure of the average blood glucose level for the preceding three months. Diabetes management guidelines indicate that HbA1c levels should be tested at least every 6 months and that a HbA1c level at or below 7 per cent indicates appropriate management. Nationally, 77.5 per cent of people with known diabetes in 2011-12 had a HbA1c test in the previous 12 months (table 10A.62).

Nationally, 50.5 per cent of people with known diabetes in 2011-12 had a HbA1c level at or below 7 per cent (figure 10.18).

Figure 10.18 **People with known diabetes with HbA1c level 7 per cent or less, 2011-12^a**



^a See box 10.13 and table 10A.63 for detailed definitions, footnotes and caveats.

Source: ABS (unpublished) Australian Health Survey, 2011–13 (2011-12 National Health Measures Survey component), Cat. No. 4364.0; table 10A.63.

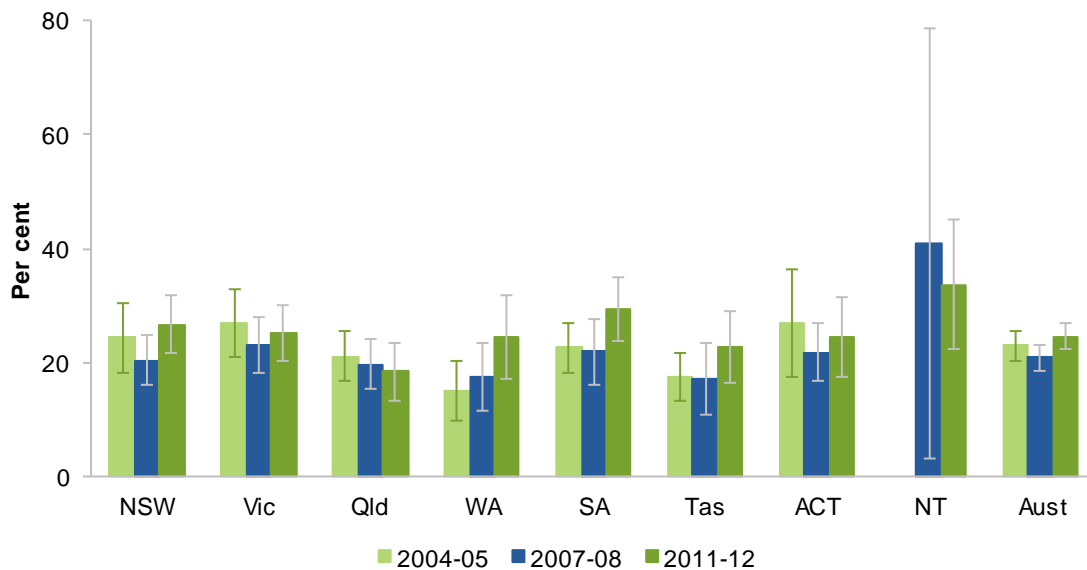
Chronic disease management — asthma

Asthma 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 age standardised 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, compared to 22.9 per cent in 2004-05 (figure 10.19). 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.64).

Nationally, the proportion of Aboriginal and Torres Strait Islander people with asthma reporting that they have a written asthma action plan was 29.4 per cent for people of all ages and 50.9 per cent for children aged 0–14 years in 2012-13 (table 10A.65). Data for people of all ages are reported by Indigenous status for 2004-05 and 2011–13 in table 10A.66. Data for people of all ages are reported by geographical region for 2007-08 in table 10A.67.

Figure 10.19 People with asthma who have a written asthma action plan^a



^a See box 10.13 and table 10A.64 for detailed definitions, footnotes and caveats.

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.64.

Chronic disease management — care planning and case conferencing

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing remained steady over the five years to 2014-15 (97.3 per cent in 2014-15) (table 10A.68).

Mini-case study — a state-wide chronic disease management program in Queensland

Queensland Health conducted a centralised, state-wide implementation of an evidence-based program to improve chronic disease management. The program and results of an independent evaluation are outlined in box 10.14.

Box 10.14 Mini-case study: Queensland Health's implementation of the COACH Program for chronic disease management

Queensland Health's centralised, state-wide implementation of the evidence-based chronic disease management program (COACH) has proven successful in improving chronic disease management for eligible clients throughout Queensland – including those in rural and remote locations and Aboriginal and Torres Strait Islander people.

The COACH Program

The COACH (Coaching Patients on Achieving Cardiovascular Health) Program is a structured coaching program for people with or at high risk of developing chronic disease(s), delivered by telephone and mail-out over a period of 6 months. Clients are coached to effectively manage chronic disease risk factors, thereby preventing or delaying development and progression of the disease(s).

Health professionals trained as coaches deliver structured program content by phone with the support of a customised, web-based software application (which also supports program evaluation). Coaches work with clients to develop an understanding of biomedical and lifestyle risk factors for their chronic disease(s) and an action plan to modify them in line with national management guideline recommendations. Clients are supported to actively engage with their usual health provider in monitoring risk factor levels and adhering to appropriate medication regimens. Coaching sessions are followed by mail-out of a structured report summarising the session, the agreed goals for the next session and a chart of progress against guideline-recommended risk factor levels.

Further information about the COACH Program can be found at www.thecoachprogram.com.

Queensland Health's implementation of the COACH Program

Queensland Health's centralised COACH Program was implemented in 2009 using the existing telephone infrastructure of 13HEALTH, a 24-hour, seven-day-a-week state-wide service providing health information, triage and referral. Initially available to clients with cardiovascular disease, it has since been extended to cover diabetes, pre-diabetes and chronic obstructive pulmonary disease (COPD). Referrals are either online or by fax, email, phone or mail, and are made by hospitals, GPs, specialists and Quitline, or self-referral. Program staff initiate contact with clients following referral.

Modelling of program delivery costs in 2014 determined overall recurrent expenditure to be around \$1200 per completing participant.

An independent evaluation of risk factor management was conducted for 2669 people completing Queensland Health's COACH Program (83 per cent completion rate) between 2009 and 2013, using prospectively collected program data (Ski et al. 2015). Participants were the cohorts enrolled in the program with a primary diagnosis of coronary heart disease (CHD) (1962 people) or type 2 diabetes (707 people). Demographics were reflective of the general Queensland population, including Indigenous status and remoteness of residence. Statistically significant improvements were demonstrated across all biomedical and lifestyle cardiovascular risk factors. Improvements for Aboriginal and Torres Strait Islander people were similar to those for non-Indigenous clients.

(continued next page)

Box 10.14 (continued)

The most clinically significant risk factor improvements were:

- decreased mean low-density lipoprotein cholesterol (2.4 to 1.8 mmol/L (CHD); 2.5 to 2.0 mmol/L (type 2 diabetes))
- decreased mean HbA1c levels (7.8 to 7.4 per cent (CHD); 8.2 to 7.5 per cent (type 2 diabetes))
- decreased mean alcohol intake (standard drinks per day) (1.4 to 1.1 (CHD); 1.3 to 0.9 (type 2 diabetes))
- increased mean physical activity (minutes per week) (142 to 229 (CHD); 127 to 182 (type 2 diabetes)).

Source: Queensland Government (unpublished); Ski et al. (2015); Vale et al. (2004).

Appropriateness - 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 10.15).

Box 10.15 Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is defined by four measures:

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

This indicator needs to be interpreted with care as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. 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 onwards are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

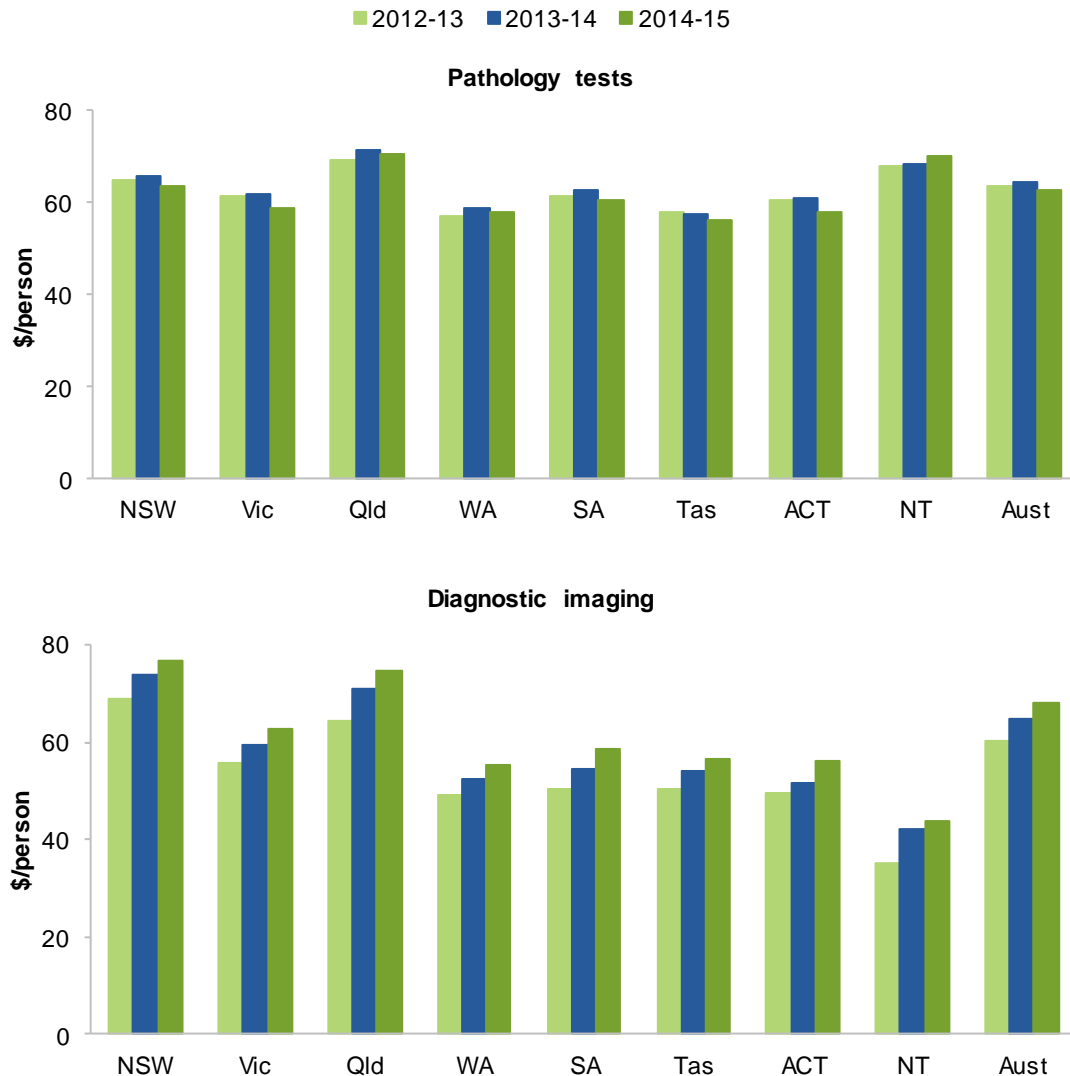
Available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS Medicare data reflect only those services provided and rebated.

Nationally in 2014-15:

- there were 86 652 rebated MBS items for pathology tests requested by GPs and eligible nurse practitioners, costing \$1.6 billion (table 10A.69). This translated to crude rates of 3.7 MBS items per person at a cost of \$66 per person (crude rates are not presented in table 10A.69)
- there were 14 572 rebated MBS items for diagnostic imaging performed on referral from GPs and eligible nurse practitioners, costing \$1.7 billion (table 10A.71). This translated to crude rates of 0.62 MBS items per person at a cost of around \$72 per person (crude rates are not presented in table 10A.71).

Age-standardised rates are presented for reference years from 2012-13 in figure 10.20 and tables 10A.69 (pathology tests) and 10A.71 (diagnostic imaging). Historical data are presented as crude rates and are provided in tables 10A.70 (pathology tests) and 10A.72 (diagnostic imaging).

Figure 10.20 **Benefits paid for GP-referred pathology tests and diagnostic imaging rebated through DHS Medicare (ASR)^a**



^a See box 10A.15 and tables 10A.69 and 10A.71 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) MBS and DVA data collections; tables 10A.69 and 10A.71.

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 more efficient coordination of care across multiple providers and services (box 10.16).

Box 10.16 **Electronic health information systems**

'Electronic health information systems' is defined as the proportion of general practices enrolled in the 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 in 2010-11 (Department of Health unpublished; table 10A.56).

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 2015 data are available for all jurisdictions.

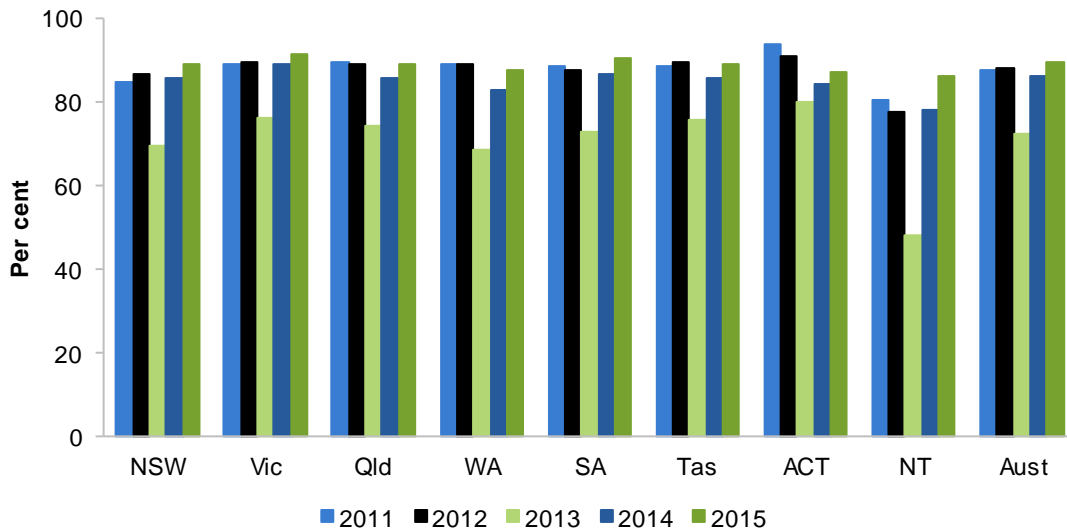
Data quality information for this indicator is under development.

The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Current eligibility requirements require 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 89.6 per cent in May 2015, recovering from the sharp decrease — from 88.3 per cent in May 2012 to 72.2 per cent in May 2013 — that was associated with the time taken to implement new eligibility requirements for many practices (figure 10.21). The proportion of PIP practices using electronic health systems increased in all areas between May 2013 and May 2015, remaining lower in remote and very remote areas than in other areas (table 10A.74).

Figure 10.21 PIP practices using electronic health systems^a



^a See box 10.16 and table 10A.73 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) MBS and PIP data collections; table 10A.73.

Quality — Responsiveness — Patient satisfaction

‘Patient satisfaction’ is an indicator of governments’ objective that primary and community health services are high quality and account for individual patient needs (box 10.17).

Box 10.17 Patient satisfaction

'Patient satisfaction' is defined as the quality of care as perceived by the patient. It is measured as patient experience of '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:

- the proportion 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
- the proportion 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.

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 2014-15 data are available for all jurisdictions.

The PExS does not include people living in discrete Aboriginal and Torres Strait Islander communities, which affects the comparability of the NT results.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

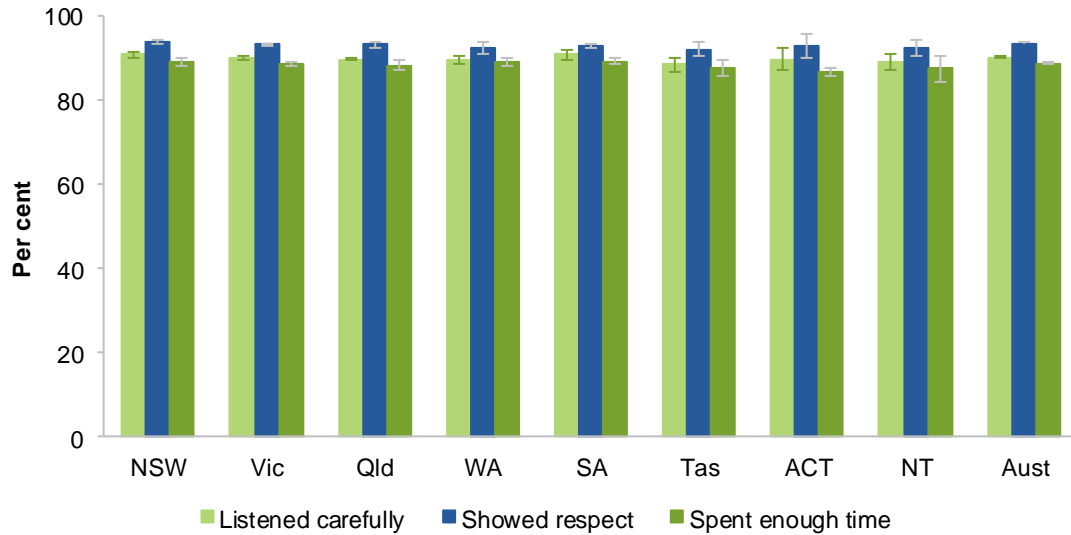
Patient satisfaction — experience with selected key aspects of GP care

Nationally in 2014-15, the majority of respondents reported that the GP always or often:

- listened carefully to them (90.3 per cent)
- showed respect (93.3 per cent)
- spent enough time with them (88.9 per cent) (figure 10.22).

Data are presented by remoteness area in tables 10A.76 and 10A.77. Data for Aboriginal and Torres Strait Islander Australians that are reported in table 10A.78 are not comparable to the data presented here (see DQI for details).

Figure 10.22 **People whose GP always or often listened carefully, showed respect, spent enough time, 2014-15^a**



^a See box 10.17 and tables 10A.76-10A.77 for detailed definitions, footnotes and caveats.

Source: ABS (unpublished) Patient Experience Survey 2014-15, Cat. no. 4839.0; tables 10A.76-10A.77.

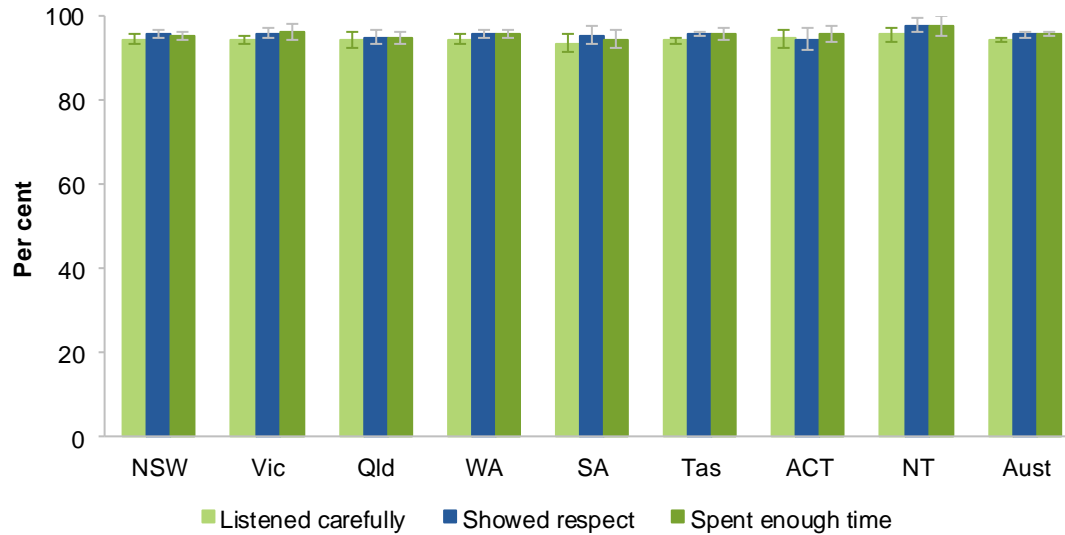
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally in 2014-15, the majority of respondents reported that dentists always or often:

- listened carefully to them (94.5 per cent)
- showed respect (95.7 per cent)
- spent enough time with them (95.7 per cent) (figure 10.23).

Data are presented by remoteness area in tables 10A.79 and 10A.80.

Figure 10.23 **People whose dental professional always or often listened carefully, showed respect, spent enough time, 2014-15^a**



^a See box 10.17 and tables 10A.79-10A.80 for detailed definitions, footnotes and caveats.

Source: ABS (unpublished) Patient Experience Survey 2014-15, Cat. no. 4839.0; tables 10A.79-10A.80.

Appropriateness — Quality — continuity

The Steering Committee has identified quality — continuity as an area for development in future Reports. Data for health assessments for older Australians, previously reported as a measure of quality — continuity, are presented for a nine year time series in table 10A.33.

Efficiency

Sustainability

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

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).

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.

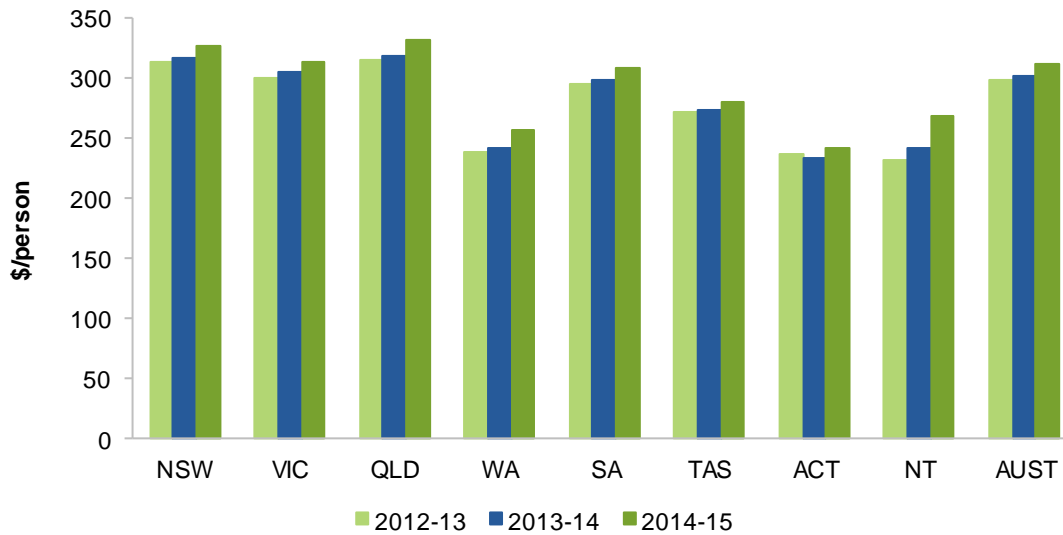
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012-13 onwards are not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Australian Government fee-for-service expenditure on general practice and age standardised expenditure per person, through DHS Medicare and the DVA, are reported in table 10A.3 for 2012-13 and subsequent years. Age standardised expenditure per person data are also presented in figure 10.24. Nationally in 2014-15, fee-for-service expenditure on general practice was \$7.7 billion, translating to a crude rate of \$328 per person (crude rates are not presented in table 10A.3). Data incorporating fee-for-service and GP program expenditure are reported as crude rates in table 10A.4 — data in tables 10A.3 and 10A.4 are not comparable.

Figure 10.24 **Australian Government fee-for-service expenditure per person on GPs (ASR) (2014-15 dollars)^a**



^a See box 10A.18 and table 10A.3 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished), DVA data collection; table 10A.3.

Outcomes

Outcomes are the impact of services on the status of an individual or group (see chapter 1, section 1.5).

Child immunisation coverage

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

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 (at this age, 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 (at this age, against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, measles, mumps and rubella and, from the quarter ending 31 December 2014, meningococcal C and varicella [chickenpox])
- the proportion of children aged 60 months to less than 63 months who are fully immunised (at this age, 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.

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 2014-15 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

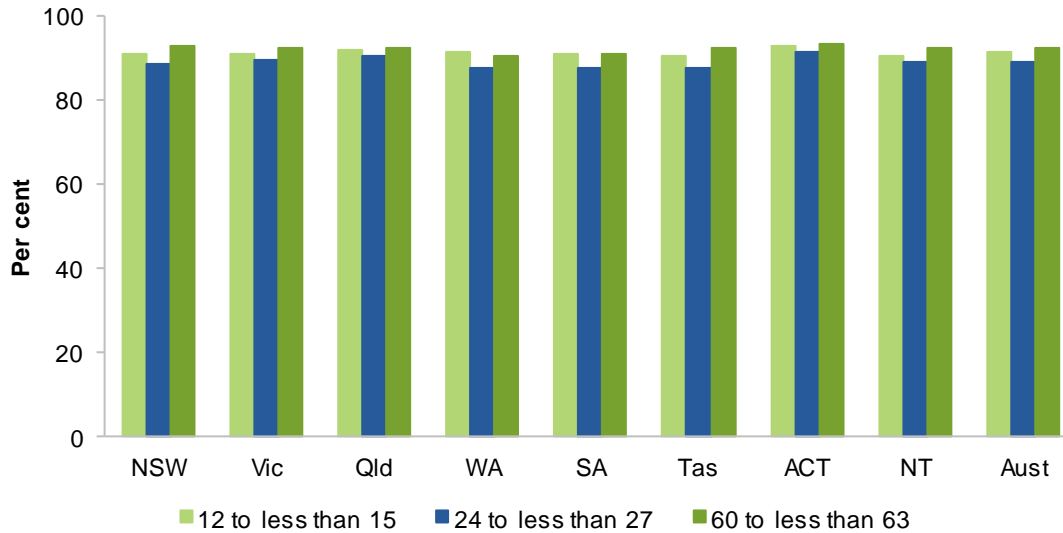
Many providers deliver child immunisation services (table 10A.81). High immunisation coverage levels are encouraged through a range of measures, including incentives for providers to report completed vaccinations to the Australian Childhood Immunisation Register (ACIR) and incentives for parents, which link eligibility for Family Tax Benefit Part A Supplement, Child Care Benefit and Child Care Rebate to the child's immunisation status.

For children aged 12 to less than 15 months, proportions of those fully immunised have fluctuated between 90.4 and 91.8 per cent in the eight year period from 2007-08 (table 10A.82). In 2014-15, the proportion was 91.3 per cent (figure 10.25).

For children aged 24 to less than 27 months, the proportion fully immunised decreased from 92.4 per cent or above in the years 2010-11 to 2013-14 to 89.2 per cent in 2014-15, associated with the addition of new vaccines to the definition of fully immunised in the quarter ending 31 December 2014 (figure 10.25; table 10A.83).

For children aged 60 to less than 63 months, the proportion fully immunised in 2014-15 was 92.3 per cent – continuing the annual increase from 80.3 per cent in 2008-09 (figure 10.25; table 10A.84).

Figure 10.25 **Children who were fully immunised, by age (months)**
2014-15^a



^a See box 10.19 and tables 10A.82–10A.84 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) ACIR data collection; tables 10A.82–10A.84.

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).

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.

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

Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases, and notification to the relevant State or Territory authority is required on diagnosis. The debilitating effects of these diseases can be long-term or even life threatening.

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 2014-15 data are available for all jurisdictions.

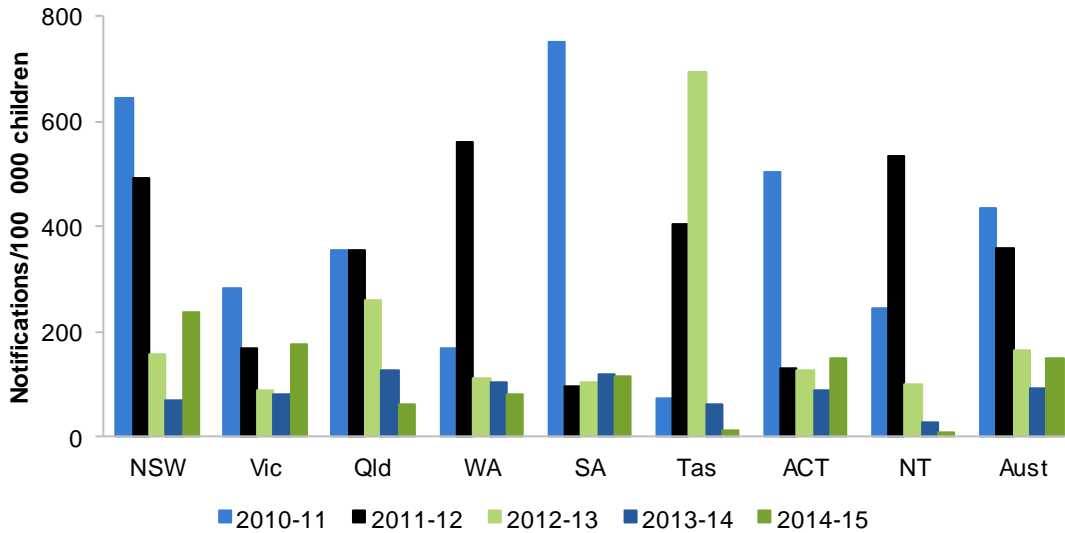
Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

Nationally in 2014-15, the rate of notifications for children aged 0–14 years was:

- 0.2 per 100 000 for *Haemophilus influenzae* type b (table 10A.87)
- 1.4 per 100 000 for measles (a marked decrease from the nine-year high of 4.0 in 2013-14) (table 10A.85)
- 150.1 per 100 000 for pertussis (whooping cough) (figure 10.26 and table 10A.86).

Historical data for the nine years of reporting are in tables 10A.85–10A.87.

Figure 10.26 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years^a**



^a See box 10.20 and table 10A.86 for detailed definitions, footnotes and caveats.

Source: Department of Health (unpublished) NNDSS, ABS (various years) Population by Age and Sex, Australian States and Territories, Cat. no. 3201.0; table 10A.86.

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).

Early detection of breast cancer is associated with a higher likelihood of survival and with reduced morbidity through availability of less invasive treatment options, such as breast conserving surgery (AIHW and NBCC 2007).

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.

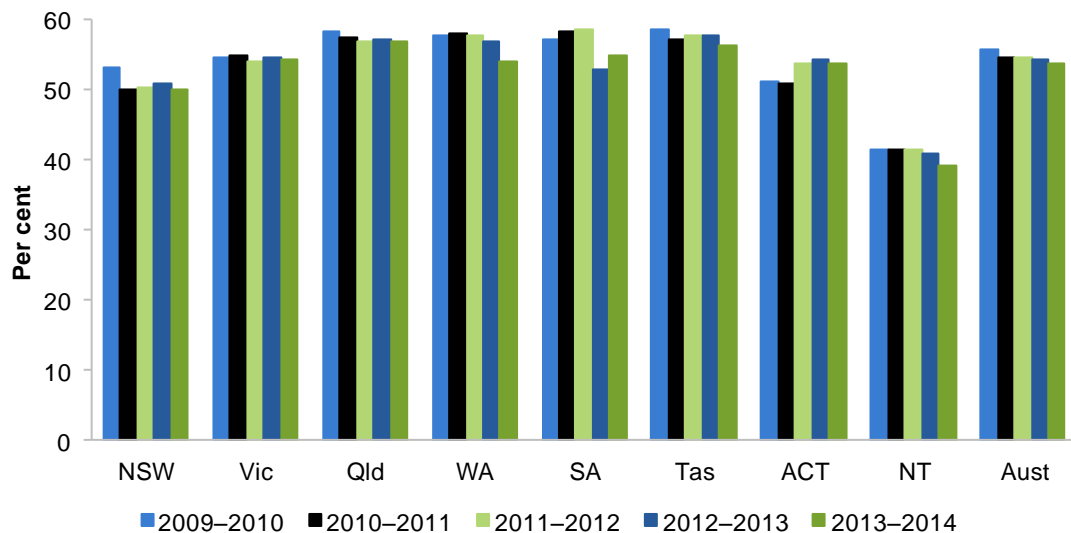
Data reported against this indicator are:

- 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 2013 and 2014 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

The national age standardised participation rate for women aged 50–69 years decreased from 55.8 per cent for the 24 month reference period 2009–2010 to 53.7 per cent for the 24 month period 2013–2014 (figure 10.27).

Figure 10.27 Participation in BreastScreen Australia screening programs — women aged 50–69 years (24 month period)^a



^a See box 10.21 and table 10A.88 for detailed definitions, footnotes and caveats.

Source: State and Territory governments (unpublished); ABS (various years) Population by Age and Sex, Australian States and Territories, Cat. no. 3201.0; table 10A.88.

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. Data are not directly

comparable within or across community groups as Indigenous and NESB status identification in administrative records varies.

For the 24-month period 2013–2014, the participation rate for women aged 50–69 years was 36.3 per cent for Aboriginal and Torres Strait Islander women and 52.1 per cent for NESB women. For both groups, participation rates were higher in most jurisdictions than in the previous 24-month period 2012–2013 (tables 10A.90 and 10A.91). Updated State and Territory data for participation rate by remoteness area were unavailable for the 2016 Report (some historical data are reported in table 10A.92).

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).

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).

Box 10.22 Participation for women in cervical screening

‘Participation for women in cervical screening’ is defined as the proportion of the estimated eligible population of women aged 20–69 years who are screened over a two-year period, 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 2013 and 2014 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

For the 24 month period 2013–2014, the national age-standardised participation rate for women aged 20–69 years in cervical screening was 57.3 per cent, a slight decrease from 57.8 per cent for the 24-month period 2009–2010 (figure 10.28). Data are presented for a nine year time series in table 10A.93.

Nationally in 2012-13, the age standardised proportion of Aboriginal and Torres Strait Islander women aged 20–69 years responding to the National Aboriginal and Torres Strait Islander Health survey who reported having a Pap smear at least every 2 years was 53.4 per cent (table 10A.94).

Figure 10.28 **Participation rate for women aged 20–69 years in cervical screening (24 month period)^a**



^a See box 10.22 and table 10A.93 for detailed definitions, footnotes and caveats.

Source: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 10A.93.

Influenza vaccination coverage for older people

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

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.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

Data quality information for this indicator is under development.

Influenza 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 2016 Report — historical data are presented in tables 10A.96-10A.97. Nationally in 2012-13, an estimated 25.3 per cent of Aboriginal and Torres Strait Islander people aged 50 years or over were fully vaccinated against influenza and pneumococcal disease (table 10A.97).

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). While not all hospitalisations for the selected conditions can be prevented, there is considerable potential for their reduction through a more effective primary and community health sector.

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 by jurisdiction of residence:

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

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 2013-14 data are available for other jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/rogs/2016.

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

Nationally, the age-standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions was 24.4 per 1000 people in 2013-14 (table 10.4). Of these, 49.5 per cent were for acute and 47.2 per cent for chronic conditions (table 10A.98). The age-standardised hospital separation rate was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions for the four years 2010-11 to 2013-14 and, for the three previous years, in all jurisdictions for which Indigenous status data are of sufficient quality for statistical reporting purposes (figure 10.29 and table 10A.99).

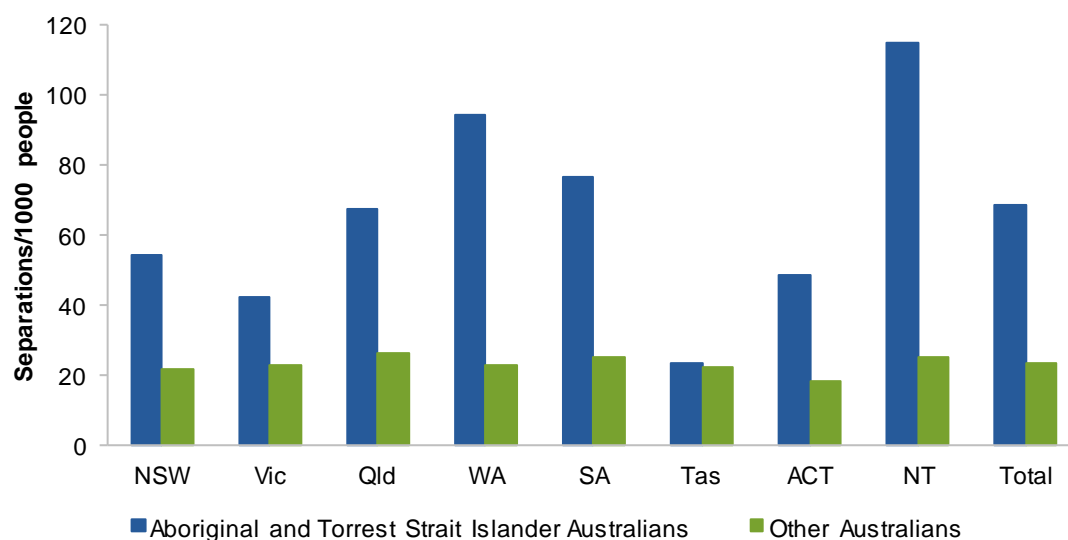
Table 10.4 Separations for selected potentially preventable hospitalisations per 1000 people, 2013-14 (ASR)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Vaccine preventable conditions	1.1	1.3	1.2	1.2	1.5	0.7	0.9	7.6	1.3
Selected acute conditions	10.9	10.6	14.3	12.9	13.0	10.7	9.5	21.6	12.0
Selected chronic conditions	10.5	11.1	12.6	10.7	11.4	10.8	8.1	21.3	11.2
Total	22.4	22.9	27.9	24.6	25.6	22.0	18.5	48.9	24.4

^a See box 10.24 and table 10A.98 for detailed definitions, footnotes and caveats.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.98.

Figure 10.29 Separations for selected potentially preventable conditions by Indigenous status (ASR), 2013-14^a



^a See box 10.24 and table 10A.99 for detailed definitions, footnotes and caveats.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.99.

Potentially preventable hospitalisations for diabetes

Diabetes is a chronic disease of increasing prevalence. 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.

Hospital separations data for diagnoses of diabetes complications are affected by differences in hospitals' clinical coding and admission protocols (between and within jurisdictions), as well as by revisions to clinical coding standards and improvements in data quality over time. Differences in the availability of outpatient services also affect hospital separations data as the data exclude treatment provided in ambulatory care settings (table 10A.107).

Nationally in 2013-14, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 104.2 separations per 100 000 people (figure 10.30). Of these, 25.6 per cent were same day separations (table 10A.107).

Figure 10.30 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2013-14 (ASR)^{a, b}**



^a See box 10.24 and table 10A.106 for detailed footnotes and caveats. ^b Data for Tasmania, the ACT and the NT are not published separately but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 10A.106.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2013-14 were ophthalmic, renal and circulatory complications. Across almost all jurisdictions for which data are published, the highest age standardised hospital separation rates were for circulatory complications (table 10A.106).

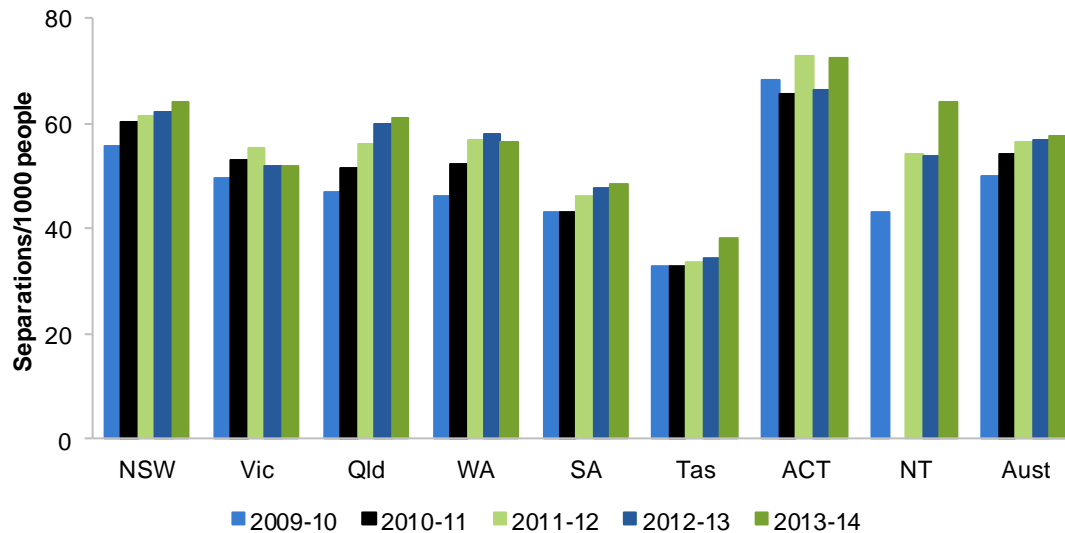
Serious circulatory complications of diabetes can necessitate lower limb amputation. In 2013-14, there were 16.0 age standardised hospital separations per 100 000 people for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (table 10A.108).

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 Australians and all people can indicate greater equity of access to primary healthcare services. Nationally in 2013-14, the age standardised separation rate for Aboriginal and Torres Strait Islander people was almost four times the rate for all Australians (table 10A.105).

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 age standardised rate of hospital separations for older people with a reported external cause of falls per 1000 older people increased from 50.1 in 2009-10 to 57.8 in 2013-14 (figure 10.31).

Figure 10.31 Separations for older people with a reported external cause of falls (ASR)^{a, b}



^a See box 10.24 and table 10A.109 for detailed definitions, footnotes and caveats. ^b 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.109.

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. Priorities for future reporting 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.

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.

10.5 Definitions of key terms

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	<p>The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines.</p> <p>MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.</p>
Asthma Action Plan	<p>An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.</p> <p><i>Source: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW.</i></p>
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for 3 months or more. Clients may have more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Comparability	Data are considered comparable if, (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data are considered complete if all required data are available for all jurisdictions that provide the service.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Full time service equivalents (FSE)	FSE (Full Service Equivalent) is an estimated measure of medical workforce based on Medicare claims information. Although Medicare claims data does not include information on hours worked it does have sufficient time-based items to estimate a proxy for hours worked. The FSE methodology models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Aboriginal and Torres Strait Islander health.
General practitioner (GP)	Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a

	<p>recognised training placement.</p> <p>Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.</p>
GP-type services	Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.
<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013b).
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	A national network of 61 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. Established progressively from July 2011 under the National Health Reform agenda, Medicare Locals (ML) were replaced from 1 July 2015 by PHNs.
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.
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.
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	<p>The primary and community healthcare sector includes services that:</p> <ul style="list-style-type: none"> • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Primary Health Networks	Primary Health Networks (PHNs) are a national network of independent primary health care organisations (replacing MLs from 1 July 2015) with the objective to improve the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and to improve coordination of care, particularly for those with chronic and complex conditions.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence).
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public

	health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A provider recognised by DHS Medicare as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Triage category	The urgency of the patient's need for medical and nursing care: <ul style="list-style-type: none"> • category 1 — resuscitation (immediate within seconds) • category 2 — emergency (within 10 minutes) • category 3 — urgent (within 30 minutes) • category 4 — semi-urgent (within 60 minutes) • category 5 — non-urgent (within 120 minutes).
Vocationally registered general practitioner	A medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances.

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 website (www.pc.gov.au/rogs/2016).

Table 10A.1	Recurrent expenditure on primary and community health by source of funds and area of expenditure, 2013-14 (2013-14 dollars) (\$ million)
Table 10A.2	Types of encounter where a payment source was recorded, 2014-15
Table 10A.3	Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2014-15 dollars)
Table 10A.4	Australian Government total expenditure on GPs and expenditure per person (crude rates) (2014-15 dollars)
Table 10A.5	Australian government expenditure on the Pharmaceutical Benefits Scheme (2014-15 dollars)
Table 10A.6	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2014-15 dollars)
Table 10A.7	Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas (2014-15 dollars)
Table 10A.8	Expenditure on dental services (2013-14 dollars) (\$ million)
Table 10A.9	Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services (2014-15 dollars)
Table 10A.10	Availability of GPs
Table 10A.11	Number of GP-type services used per 1000 people
Table 10A.12	PBS services

Table 10A.13	PBS services, by service type ('000)
Table 10A.14	Alcohol and other drug treatment services, 2013-14 (number)
Table 10A.15	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number)
Table 10A.16	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 10A.17	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities (per cent)
Table 10A.18	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent)
Table 10A.19	Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number)
Table 10A.20	Approved providers of PBS medicines by PhARIA area at 30 June 2015
Table 10A.21	Approved providers of PBS medicines by geolocation, at 30 June
Table 10A.22	PBS expenditure per person, by remoteness area (2014-15 dollars)
Table 10A.23	PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2014-15 dollars)
Table 10A.24	Availability of GPs by region
Table 10A.25	Availability of female GPs
Table 10A.26	Availability of male GPs
Table 10A.27	Availability of public dentists (per 100 000 people)
Table 10A.28	Availability of public dental hygienists and dental therapists (per 100 000 people)
Table 10A.29	Availability of public Occupational Therapists and Psychologists (per 100 000 people)
Table 10A.30	Annual health assessments for older people by Indigenous status (per cent)
Table 10A.31	Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent)
Table 10A.32	Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)
Table 10A.33	Annual health assessments for older people
Table 10A.34	Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
Table 10A.35	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 10A.36	Non-referred attendances that were bulk billed by age (per cent)
Table 10A.37	People deferring access to GPs due to cost (per cent)
Table 10A.38	Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent)
Table 10A.39	Waiting time for GPs for an urgent appointment (per cent)
Table 10A.40	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 10A.41	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 10A.42	People attending a hospital emergency department who thought the care could have been provided at a general practice, 2010-11 to 2012-13
Table 10A.43	People deferring access to prescribed medication due to cost (per cent)
Table 10A.44	Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent)

Table 10A.45	Median waiting time for public dental care, NSW (days)
Table 10A.46	Median waiting time for public dental care, Victoria (days)
Table 10A.47	Median waiting time for public dental care, Queensland (days)
Table 10A.48	Median waiting time for public dental care, WA (days)
Table 10A.49	Median waiting time for public dental care, SA (days)
Table 10A.50	Median waiting time for public dental care, Tasmania (days)
Table 10A.51	Median waiting time for public dental care, ACT (days)
Table 10A.52	Median waiting time for public dental care, NT (days)
Table 10A.53	Proportion of FSE GPs with vocational registration by region (per cent)
Table 10A.54	Number and proportion of full time service equivalent (FSE) GPs with vocational registration
Table 10A.55	General practices that are accredited at 30 June
Table 10A.56	General practice activity in PIP practices (per cent)
Table 10A.57	Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections
Table 10A.58	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2010-11 to 2011-12
Table 10A.59	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 10A.60	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia
Table 10A.61	Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive
Table 10A.62	Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)
Table 10A.63	Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent)
Table 10A.64	Proportion of people with asthma with a written asthma action plan, by age (per cent)
Table 10A.65	Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13
Table 10A.66	Proportion of people with asthma with a written asthma plan, by Indigenous status
Table 10A.67	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 10A.68	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 10A.69	Pathology tests requested by GPs, real benefits paid (2014-15 dollars) and number of rebated MBS pathology items
Table 10A.70	Pathology tests requested by GPs, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS pathology items
Table 10A.71	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2014-15 dollars) and number of rebated MBS imaging items
Table 10A.72	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS imaging items
Table 10A.73	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.74	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region

Table 10A.75	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012
Table 10A.76	Client experience of GPs by remoteness, States and Territories
Table 10A.77	Client experience of GPs by remoteness, Australia
Table 10A.78	Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13
Table 10A.79	Client experience of dental professionals by remoteness, States and Territories
Table 10A.80	Client experience of dental professionals by remoteness, Australia
Table 10A.81	Valid vaccinations supplied to children under seven years of age, by type of provider, 2010–2015
Table 10A.82	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.83	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.84	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 10A.85	Notifications of measles, children aged 0–14 years
Table 10A.86	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 10A.87	Notifications of invasive Haemophilus influenzae type b, children aged 0–14 years
Table 10A.88	Participation rates for women in BreastScreen Australia (24 month period)
Table 10A.89	Participation rates for women in BreastScreen Australia by residential status, 2013 and 2014 (24 month period)
Table 10A.90	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.91	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.92	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 10A.93	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
Table 10A.94	Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent)
Table 10A.95	Influenza vaccination coverage, people aged 65 years or over
Table 10A.96	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
Table 10A.97	Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease
Table 10A.98	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 10A.99	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.100	Separations for selected potentially preventable hospitalisations by remoteness, 2013-14 (per 1000 people)
Table 10A.101	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people)
Table 10A.102	Separations for selected vaccine preventable conditions by Indigenous status, 2013-14 (per 1000 people)
Table 10A.103	Separations for selected acute conditions by Indigenous status, 2013-14 (per 1000 people)
Table 10A.104	Separations for selected chronic conditions by Indigenous status, 2013-14 (per 1000 people)

Table 10A.105	Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2013-14
Table 10A.106	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2013-14 (per 100 000 people)
Table 10A.107	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2013-14 (per cent)
Table 10A.108	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2013-14
Table 10A.109	Separation rates for older people for injuries due to falls
Table 10A.110	General Government Final Consumption Expenditure (GGFCE) chain price deflator (index)
Community health services programs	
Table 10A.111	Australian Government, selected other community health programs
Table 10A.112	New South Wales, selected other community health programs
Table 10A.113	Victoria, selected other community health programs
Table 10A.114	Queensland, selected other community health programs
Table 10A.115	Western Australia, selected other community health programs
Table 10A.116	South Australia, selected other community health programs
Table 10A.117	Tasmania, selected other community health programs
Table 10A.118	Australian Capital Territory, selected other community health programs
Table 10A.119	Northern Territory, selected other community health programs

10.7 References

- ACAM (Australian Centre for Asthma Monitoring) 2008, *Asthma in Australia 2008*, Cat. no. ACM 14, AIHW (Australian Institute of Health and Welfare) Asthma Series 3, Canberra.
- Australian Government 2010, *Building a 21st Century Primary Health Care System — Australia's First National Primary Health Care Strategy*, Canberra.
- Australian Government DHS (Department of Human Services) 2015, *Practice Incentives Program (PIP)* (<http://www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/>, accessed 16 November 2015).
- AIHW 2015, *Alcohol and other drug treatment services in Australia 2013-14*, Cat. no. HSE 158, Drug treatment series no. 25, Canberra.
- AIHW and NBCC (National Breast Cancer Centre) 2007, *Breast cancer survival by size and nodal status in Australia*, Cat. no. CAN 34, Cancer series no. 39, AIHW, Canberra.
- Bradley, C. 2013, *Hospitalisations due to falls by older people, Australia 2009-10*, Cat. no. INJCAT 146, Injury research and statistics series no. 70, AIHW, Canberra.
- Britt, H., Miller, G.C, Henderson, J., Bayram, C., Harrison, C., Valenti, L., Wong, C., Gordon, J., Pollack, A.J., Pan, Y. and Charles, J. 2015, *General practice activity in Australia 2014-15*, General practice series no. 38, Sydney University Press, Sydney.

Department of Health (formerly the Department of Health and Ageing) 2010, *About the PBS*, www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-aboutus.htm-copy2 (accessed 24 September 2010).

— 2012, *The Pap smear*, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/papsmear (accessed 8 January 2014).

— 2013a, *The Australian Immunisation Handbook*, 10th edn, www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home (accessed 8 January 2014).

— 2013b, *Immunisation Myths and Realities: responding to arguments against immunisation*, 5th edn, www.health.gov.au/internet/immunise/publishing.nsf/Content/uci-myths-guideprov (accessed 8 January 2014).

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

— 2015, *About the PBS*, www.pbs.gov.au/info/about-the-pbs (accessed 8 October 2015).

Mitchell, H., Hocking, J. and Saville, M. 2003, 'Improvement in protection of adenocarcinoma of the cervix resulting from participation in cervical screening', *Cancer Cytopathology*, vol. 99, no. 6, pp. 336–341.

RACGP (Royal Australian College of General Practitioners) 2014a, *What is General Practice?* <http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-general-practice> (accessed 21 January 2015).

— 2014b, *Becoming a GP in Australia*, <http://www.racgp.org.au/becomingagp/> (accessed 21 January 2015).

Ski, C.F., Vale, M.J., Bennett, G.R., Chalmers, V.L., McFarlane, K., Jelinek, V.M., Scott, I.A. and Thompson, D.R. 2015, 'Improving access and equity in reducing cardiovascular risk: the Queensland Health model', *Medical Journal of Australia*, vol. 202, no. 3, pp. 148–153 (www.mja.com.au/journal/2015/202/3/improving-access-and-equity-reducing-cardiovascular-risk-queensland-health-model, accessed 16 February 2015).

Tamma, P.D. and Cosgrove, S.E. 2014, Let the games begin: the race to optimise antibiotic use, *The Lancet Infectious Diseases*, vol. 14, no. 8, pp. 667-8.

Tovell, A. Harrison, J.E. and Pointer, S. 2014, *Hospitalised injury in older Australians, 2011-12*, Injury research and statistics series no. 90. Cat. no. INJCAT 166, Canberra: AIHW.

Vale, M.J, Sundararajan, V., Jelinek, M.V. and Best, J.D. 2004, 'Four-year follow-up of the multicenter RCT of Coaching patients On Achieving Cardiovascular Health (The COACH Study) shows that The COACH Program keeps patients out of hospital', *Circulation*, vol. 110, Suppl: III-801.

10A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 10.5 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

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

This file is available on the web page (www.pc.gov.au/rogs/2016).

Attachment contents

Table 10A.1	Recurrent expenditure on primary and community health by source of funds and area of expenditure, 2013-14 (2013-14 dollars) (\$ million)
Table 10A.2	Types of encounter where a payment source was recorded, 2014-15
Table 10A.3	Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2014-15 dollars)
Table 10A.4	Australian Government total expenditure on GPs and expenditure per person (crude rates) (2014-15 dollars)
Table 10A.5	Australian government expenditure on the Pharmaceutical Benefits Scheme (2014-15 dollars)
Table 10A.6	Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2014-15 dollars)
Table 10A.7	Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas (2014-15 dollars)
Table 10A.8	Expenditure on dental services (2013-14 dollars) (\$ million)
Table 10A.9	Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services (2014-15 dollars)
Table 10A.10	Availability of GPs
Table 10A.11	Number of GP-type services used per 1000 people
Table 10A.12	PBS services
Table 10A.13	PBS services, by service type ('000),
Table 10A.14	Alcohol and other drug treatment services, 2013-14 (number)
Table 10A.15	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number)
Table 10A.16	Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 10A.17	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities (per cent)
Table 10A.18	Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent)
Table 10A.19	Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number)
Table 10A.20	Approved providers of PBS medicines by PhARIA area at 30 June 2015
Table 10A.21	Approved providers of PBS medicines by geolocation, at 30 June
Table 10A.22	PBS expenditure per person, by remoteness area (2014-15 dollars)
Table 10A.23	PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2014-15 dollars)
Table 10A.24	Availability of GPs by region
Table 10A.25	Availability of female GPs
Table 10A.26	Availability of male GPs
Table 10A.27	Availability of public dentists (per 100 000 people)
Table 10A.28	Availability of public dental hygienists and dental therapists (per 100 000 people)
Table 10A.29	Availability of public Occupational Therapists and Psychologists (per 100 000 people)
Table 10A.30	Annual health assessments for older people by Indigenous status (per cent)

Attachment contents

Table 10A.31	Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent)
Table 10A.32	Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)
Table 10A.33	Annual health assessments for older people
Table 10A.34	Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
Table 10A.35	Non-referred attendances that were bulk billed, by region and age (per cent)
Table 10A.36	Non-referred attendances that were bulk billed by age (per cent)
Table 10A.37	People deferring access to GPs due to cost (per cent)
Table 10A.38	Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent)
Table 10A.39	Waiting time for GPs for an urgent appointment (per cent)
Table 10A.40	Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent)
Table 10A.41	Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 10A.42	People attending a hospital emergency department who thought the care could have been provided at a general practice, 2010-11 to 2012-13
Table 10A.43	People deferring access to prescribed medication due to cost (per cent)
Table 10A.44	Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent)
Table 10A.45	Median waiting time for public dental care, NSW (days)
Table 10A.46	Median waiting time for public dental care, Victoria (days)
Table 10A.47	Median waiting time for public dental care, Queensland (days)
Table 10A.48	Median waiting time for public dental care, WA (days)
Table 10A.49	Median waiting time for public dental care, SA (days)
Table 10A.50	Median waiting time for public dental care, Tasmania (days)
Table 10A.51	Median waiting time for public dental care, ACT (days)
Table 10A.52	Median waiting time for public dental care, NT (days)
Table 10A.53	Proportion of FSE GPs with vocational registration by region (per cent)
Table 10A.54	Number and proportion of full time service equivalent (FSE) GPs with vocational registration
Table 10A.55	General practices that are accredited at 30 June
Table 10A.56	General practice activity in PIP practices (per cent)
Table 10A.57	Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections
Table 10A.58	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2010-11 to 2011-12
Table 10A.59	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 10A.60	Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia

Attachment contents

Table 10A.61	Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive
Table 10A.62	Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)
Table 10A.63	Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent)
Table 10A.64	Proportion of people with asthma with a written asthma action plan, by age (per cent)
Table 10A.65	Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13
Table 10A.66	Proportion of people with asthma with a written asthma plan, by Indigenous status
Table 10A.67	Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 10A.68	GP use of chronic disease management Medicare items for care planning or case conferencing
Table 10A.69	Pathology tests requested by GPs, real benefits paid (2014-15 dollars) and number of rebated MBS pathology items
Table 10A.70	Pathology tests requested by GPs, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS pathology items
Table 10A.71	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2014-15 dollars) and number of rebated MBS imaging items
Table 10A.72	Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS imaging items
Table 10A.73	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.74	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
Table 10A.75	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012
Table 10A.76	Client experience of GPs by remoteness, States and Territories
Table 10A.77	Client experience of GPs by remoteness, Australia
Table 10A.78	Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13
Table 10A.79	Client experience of dental professionals by remoteness, States and Territories
Table 10A.80	Client experience of dental professionals by remoteness, Australia
Table 10A.81	Valid vaccinations supplied to children under seven years of age, by type of provider, 2010–2015
Table 10A.82	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.83	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.84	Children aged 60 months to less than 63 months who were fully immunised (per cent)
Table 10A.85	Notifications of measles, children aged 0–14 years
Table 10A.86	Notifications of pertussis (whooping cough), children aged 0–14 years

Attachment contents

Table 10A.87	Notifications of invasive <i>Haemophilus influenzae</i> type b, children aged 0–14 years
Table 10A.88	Participation rates for women in BreastScreen Australia (24 month period)
Table 10A.89	Participation rates for women in BreastScreen Australia by residential status, 2013 and 2014 (24 month period)
Table 10A.90	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.91	Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.92	Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)
Table 10A.93	Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)
Table 10A.94	Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent)
Table 10A.95	Influenza vaccination coverage, people aged 65 years or over
Table 10A.96	Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009
Table 10A.97	Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease
Table 10A.98	Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 10A.99	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.100	Separations for selected potentially preventable hospitalisations by remoteness, 2013-14 (per 1000 people)
Table 10A.101	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people)
Table 10A.102	Separations for selected vaccine preventable conditions by Indigenous status, 2013-14 (per 1000 people)
Table 10A.103	Separations for selected acute conditions by Indigenous status, 2013-14 (per 1000 people)
Table 10A.104	Separations for selected chronic conditions by Indigenous status, 2013-14 (per 1000 people)
Table 10A.105	Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2013-14
Table 10A.106	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2013-14 (per 100 000 people)
Table 10A.107	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2013-14 (per cent)
Table 10A.108	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2013-14
Table 10A.109	Separation rates for older people for injuries due to falls
Table 10A.110	General Government Final Consumption Expenditure (GGFCE) chain price deflator (index)
Selected other community health programs	
Table 10A.111	Australian Government, selected other community health programs

Attachment contents

Table 10A.112	New South Wales, selected other community health programs
Table 10A.113	Victoria, selected other community health programs
Table 10A.114	Queensland, selected other community health programs
Table 10A.115	Western Australia, selected other community health programs
Table 10A.116	South Australia, selected other community health programs
Table 10A.117	Tasmania, selected other community health programs
Table 10A.118	Australian Capital Territory, selected other community health programs
Table 10A.119	Northern Territory, selected other community health programs

TABLE 10A.1

Table 10A.1 **Recurrent expenditure on primary and community health by source of funds and area of expenditure, 2013-14 (2013-14 dollars) (\$ million) (a), (b), (c)**

Area of expenditure	Government						Non-government				
	Australian Government				State, Territory and local government	Total government	Private health insurance funds	Total non- government			Total (b)
	DVA	Department of Health and other	Health insurance premium rebates	Total				Individuals	Other (d)	Total non- government	
Unreferred medical services	856.8	7 836.8	–	8 693.6	–	8 693.6	–	685.8	1 217.4	1 903.2	10 596.7
Dental services	108.9	502.6	663.7	1 275.3	713.3	1 988.7	1 546.6	5 335.9	42.9	6 925.4	8 914.0
Other health practitioners	256.4	1 253.4	311.8	1 821.5	9.5	1 831.0	726.4	2 490.2	372.2	3 588.8	5 419.8
Community health and other (e)	0.6	1 252.1	0.2	1 252.9	6 154.7	7 407.6	0.6	223.8	184.7	409.0	7 816.7
Benefit-paid pharmaceuticals	405.8	8 046.6	–	8 452.4	–	8 452.4	–	1 598.1	–	1 598.1	10 050.4
All other medications	–	565.6	21.1	586.7	–	586.7	49.3	8 998.5	78.5	9 126.3	9 713.0
Total	1 628.4	19 457.1	996.9	22 082.5	6 877.5	28 960.0	2 322.8	19 332.3	1 895.5	23 550.6	52 510.6

(a) Excludes expenditure on public health and taxation rebates for medical expenses.

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

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

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

(e) 'Other' denotes 'other recurrent health services not elsewhere classified'.

– Nil or rounded to zero.

Source: AIHW 2015, *Health Expenditure Australia 2013-14*, Health and Welfare Expenditure Series no. 54, Cat. no. HWE 63, Canberra.

TABLE 10A.2

Table 10A.2 **Types of encounter where a payment source was recorded, 2014-15 (a), (b), (c)**

	Number (d) (e)	Per cent of encounters (n = 89 969)		Per cent of direct encounters (n = 88 578)		Medicare/DVA- paid GP items (n = 86 198)
		no.	%	95% LCL	95% UCL	%
Direct encounters (f)	88 578	98.5	98.2	98.7	100.0	..
No charge	309	0.3	0.3	0.4	0.3	..
MBS/DVA items of service (direct encounters only) (f)	86 188	95.8	95.5	96.1	97.3	..
MBS/DVA items of service (GPs only)	86 198	95.8	95.5	96.1	97.3	100.0
Short surgery consultations	1 450	1.6	1.4	1.8	1.6	1.7
Standard surgery consultations	67 937	75.5	74.4	76.6	76.7	78.8
Long surgery consultations	9 249	10.3	9.6	11.0	10.4	10.7
Prolonged surgery consultations	603	0.7	0.5	0.8	0.7	0.7
Home or institution visits (excluding RACF)	861	1.0	0.7	1.2	1.0	1.0
Residential aged care facility	1 372	1.5	1.0	2.0	1.5	1.6
Health assessments	403	0.4	0.4	0.5	0.5	0.5
Chronic disease management items	1 545	1.7	1.5	2.0	1.7	1.8
Case conferences	7	–	–	–	–	–
GP mental health care items	1 330	1.5	1.3	1.6	1.5	1.5
Attendances associated with practice incentive payments	148	0.2	0.1	0.2	0.2	0.2
Other items	1 292	1.4	1.2	1.7	1.5	1.5
Workers compensation	1 487	1.7	1.5	1.8	1.7	..
Other paid (hospital, State, etc.)	595	0.7	0.5	0.8	0.7	..

TABLE 10A.2

Table 10A.2 **Types of encounter where a payment source was recorded, 2014-15 (a), (b), (c)**

	<i>Number</i> (d) (e)	<i>Per cent of encounters</i> (<i>n</i> = 89 969)	<i>95% LCL</i>	<i>95% UCL</i>	<i>Per cent of direct encounters</i> (<i>n</i> = 88 578)	<i>Medicare/DVA-paid GP items</i> (<i>n</i> = 86 198)
Indirect encounters (g)	1 390	1.5	1.3	1.8	..	..
Direct/indirect encounter unspecified	–	–	–	–	..	..
Total encounters	89 969	100.0	..	..	..	..
MBS/DVA items of service (all encounters)	86 202	95.8			..	..

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

- (a) An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals).
- (b) One Medicare item number counted per encounter (where applicable).
- (c) Data missing payment source removed from analysis (*n*=8 760).
- (d) Number of encounters after post stratification weighting for GP activity and GP age and sex.
- (e) Numbers may not add to totals due to rounding
- (f) Direct encounters are encounters where the patient is seen by the health professional. Includes direct encounters at which either a GP or other health professional item (or both) was recorded.
- (g) Indirect encounters are encounters where the patient is not seen but a service is provided (for example, a prescription or referral). Includes indirect encounters involving a GP or other health professional (or both). Includes twelve encounters involving chronic disease management or case conference items.

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

Source: Britt, H., Miller, G.C, Henderson, J., Bayram, C., Harrison, C., Valenti, L., Wong, C., Gordon, J., Pollack, A.J., Pan, Y. and Charles, J. 2015, *General practice activity in Australia 2014–15*, General practice series no. 38, Sydney University Press, Sydney.

TABLE 10A.3

Table 10A.3 **Australian Government expenditure on GPs through DHS Medicare (fee-for-service) and age standardised expenditure per person (2014-15 dollars) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Expenditure through DHS Medicare fee for service — total										
2012-13	\$m	2 398.0	1 753.4	1 449.1	573.3	526.3	152.4	85.4	46.8	6 984.6
2013-14	\$m	2 504.2	1 849.8	1 530.8	622.0	546.0	155.3	88.2	52.1	7 348.4
2014-15	\$m	2 619.9	1 944.0	1 622.8	670.7	569.3	160.6	93.3	58.2	7 738.9
Expenditure through DHS Medicare fee for service — per person (ASR) (f), (g)										
2012-13	\$	313.9	301.1	315.2	239.3	295.1	272.4	237.3	231.8	298.7
2013-14	\$	316.4	304.4	317.9	242.6	298.3	273.4	233.2	241.4	301.3
2014-15	\$	326.1	314.3	331.1	256.8	307.9	280.5	242.4	268.9	312.3

ASR = age standardised rate. **DHS** = Department of Human Services (Australian Government).

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Data include expenditure through DHS Medicare and the DVA. Data exclude expenditure on the Practice Incentives Program (PIP), the General Practice Immunisation Incentive Scheme (GPPI) and Medicare Locals (ML). Data are not comparable with data in table 10A.4 that include this expenditure.
- (c) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.
- (d) Data quality information (DQI) for some data in this table can be found at www.pc.gov.au/rogs/2016.
- (e) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to identify GPs.
- (f) Fee-for-service expenditure per person is directly age standardised to the 2001 Australian standard population.
- (g) Rates are derived using the ABS estimated resident population (ERP) for December 31 of the reference year. The ERP is the first preliminary ERP based on the 2011 Census.

Source: Department of Health unpublished, MBS statistics; DVA unpublished; table 10A.110.

TABLE 10A.4

Table 10A.4 **Australian Government total expenditure on GPs and expenditure per person (crude rates) (2014-15 dollars) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Expenditure (c)										
2010-11	\$m	2 231.3	1 604.5	1 306.0	523.2	495.8	141.7	75.2	38.6	6 416.3
2011-12	\$m	2 313.6	1 665.3	1 372.5	539.7	510.7	146.5	78.5	41.3	6 668.2
2012-13	\$m	2 581.3	1 902.2	1 570.8	636.7	581.2	171.0	91.8	59.8	7 594.9
2013-14	\$m	2 684.2	1 999.8	1 654.9	684.5	600.3	178.2	95.1	66.5	7 963.6
2014-15 (e)	\$m	2 779.2	2 081.6	1 737.3	730.1	618.7	180.3	99.9	71.4	8 298.6
Expenditure per person (crude rates) (b), (h)										
2010-11	\$	310.8	292.0	294.4	225.6	303.7	277.7	206.1	167.6	289.4
2011-12	\$	319.2	298.7	304.1	226.1	310.4	286.3	211.7	177.7	296.6
2012-13	\$	351.2	334.9	340.7	257.5	349.7	333.7	241.9	252.5	331.6
2013-14	\$	359.5	345.3	352.8	268.3	357.9	346.7	247.6	274.1	341.5
2014-15	\$	367.4	353.6	365.7	282.8	365.8	349.9	257.7	292.3	351.3

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Rates are derived using the ABS estimated resident population (ERP) for December 31 of the reference year. The ERP is final rebased to the 2011 Census for 2010-11 and is the first preliminary ERP based on the 2011 Census for subsequent years.
- (c) Data include fee-for-service expenditure through DHS Medicare and the Department of Veterans' Affairs (DVA) as well as expenditure on: the Practice Incentives Program (PIP); the General Practice Immunisation Incentive Scheme (GPPI) for 2012-13 and previous years; and, the Divisions of General Practice Program (DGPP) for 2011-12 and previous years. From 2012-13, total expenditure data include core operational expenditure on Medicare Locals.
- (d) DVA data include expenditure on specialist GPs. Other data include expenditure on vocationally registered GPs and other medical practitioners (OMPs).
- (e) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure will be understated in jurisdictions with larger proportions of rural and remote populations.
- (f) Data quality information (DQI) for some data in this table can be found at www.pc.gov.au/rogs/2016.

TABLE 10A.4

Table 10A.4 **Australian Government total expenditure on GPs and expenditure per person (crude rates) (2014-15 dollars) (a), (b), (c), (d), (e), (f), (g)**

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

(g) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to identify GPs.

(h) Expenditure per person data are crude rates and are not comparable with age standardised rates presented in table 10A.3 for fee for service expenditure.

Source: Department of Health unpublished, MBS, PIP, GPPII, DGPP, ML and DVA data collections; table 10A.110.

TABLE 10A.5

Table 10A.5

Australian government expenditure on the Pharmaceutical Benefits Scheme (2014-15 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
PBS Total (d)										
2005-06	\$m	2 396.8	1 745.6	1 299.8	598.0	593.4	187.9	87.0	25.2	6 933.7
2006-07	\$m	2 345.0	1 694.9	1 289.6	590.3	576.1	181.8	84.2	24.2	6 786.2
2007-08	\$m	2 435.1	1 762.6	1 340.4	616.7	604.0	191.4	86.9	25.7	7 062.7
2008-09	\$m	2 609.8	1 870.0	1 439.1	664.9	636.3	203.8	92.3	27.2	7 543.5
2009-10	\$m	2 714.4	1 948.1	1 507.3	683.6	657.6	213.3	96.8	27.8	7 848.7
2010-11	\$m	2 699.0	1 924.3	1 492.2	692.3	642.2	214.6	96.1	28.6	7 789.1
2011-12	\$m	2 699.2	1 937.2	1 517.6	732.5	651.3	218.0	96.0	28.3	7 880.0
2012-13	\$m	2 498.1	1 802.7	1 413.3	660.8	611.1	198.5	92.6	26.2	7 303.3
2013-14	\$m	2 547.2	1 847.2	1 419.7	684.4	610.2	204.2	94.0	28.0	7 435.0
2014-15 (c)	\$m	2 420.8	1 774.3	1 346.1	655.0	558.9	196.0	109.3	27.7	7 088.1
RPBS Total (e)										
2005-06	\$m	206.6	129.4	130.1	45.1	45.8	18.2	8.6	1.2	585.0
2006-07	\$m	191.3	119.6	122.9	42.6	42.5	16.4	7.9	1.0	544.3
2007-08	\$m	187.2	114.6	120.7	42.3	41.1	16.1	8.1	1.1	531.1
2008-09	\$m	188.3	112.3	121.6	42.2	41.0	15.9	8.2	1.0	530.6
2009-10	\$m	186.3	109.9	122.2	40.5	41.2	15.8	8.1	1.0	525.0
2010-11	\$m	172.3	99.8	115.8	38.2	36.3	14.6	7.6	0.9	485.4
2011-12	\$m	163.3	92.7	113.2	37.4	35.0	14.3	7.1	0.9	463.9
2012-13	\$m	143.8	79.9	101.0	31.8	29.5	12.4	6.7	0.8	405.8
2013-14	\$m	129.4	72.8	92.5	30.2	25.8	11.0	6.1	0.8	368.7
2014-15 (c)	\$m	114.5	64.8	83.5	27.0	21.7	10.1	6.7	0.7	329.0
PBS and RPBS TOTAL										
2005-06	\$m	2 603.3	1 875.0	1 429.9	643.1	639.3	206.1	95.6	26.4	7 518.7

TABLE 10A.5

Table 10A.5

Australian government expenditure on the Pharmaceutical Benefits Scheme (2014-15 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
2006-07	\$m	2 536.4	1 814.6	1 412.5	632.9	618.7	198.2	92.2	25.2	7 330.5
2007-08	\$m	2 622.3	1 877.2	1 461.1	658.9	645.1	207.5	95.0	26.7	7 593.9
2008-09	\$m	2 798.1	1 982.4	1 560.7	707.2	677.3	219.7	100.5	28.3	8 074.1
2009-10	\$m	2 900.7	2 058.0	1 629.5	724.1	698.8	229.0	104.9	28.8	8 373.7
2010-11	\$m	2 871.2	2 024.1	1 608.0	730.4	678.5	229.1	103.7	29.5	8 274.6
2011-12	\$m	2 862.5	2 029.9	1 630.8	769.9	686.4	232.3	103.1	29.2	8 343.9
2012-13	\$m	2 641.9	1 882.6	1 514.3	692.6	640.6	210.9	99.2	27.1	7 709.2
2013-14	\$m	2 676.6	1 920.0	1 512.2	714.6	636.1	215.2	100.1	28.8	7 803.6
2014-15 (c)	\$m	2 535.3	1 839.1	1 429.7	682.0	580.5	206.1	116.0	28.5	7 417.1
PBS total expenditure per person (f), (g)										
2005-06	\$	352.28	342.40	320.28	292.98	379.92	383.92	261.17	120.32	336.63
2006-07	\$	341.40	327.51	311.40	283.26	365.02	369.20	249.85	113.41	324.81
2007-08	\$	350.71	335.25	316.17	288.87	378.67	385.38	254.40	117.63	332.69
2008-09	\$	369.82	347.82	330.01	301.13	393.96	406.59	264.72	122.49	347.76
2009-10	\$	376.73	353.74	336.23	300.60	401.75	421.32	272.25	121.67	353.57
2010-11	\$	370.45	343.84	327.28	298.29	388.46	420.56	264.95	123.88	345.86
2011-12	\$	371.79	346.89	335.62	306.38	395.29	425.44	258.61	121.30	349.85
2012-13	\$	339.24	316.73	305.78	266.76	366.92	386.78	243.43	110.39	318.17
2013-14	\$	340.43	318.27	301.92	267.78	363.12	396.61	244.23	115.21	318.13
2014-15 (c)	\$	319.23	300.72	282.65	253.24	329.70	379.68	281.38	113.04	299.32
Proportion of PBS expenditure that is concessional										
2005-06	%	80.3	80.3	79.6	77.9	82.3	85.0	66.7	67.1	80.0
2006-07	%	80.8	80.8	80.0	77.2	82.4	84.9	66.8	68.6	80.4
2007-08	%	79.9	80.1	78.6	75.0	81.8	84.7	65.5	66.8	79.3

TABLE 10A.5

Table 10A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2014-15 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
2008-09	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9
2009-10	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
2010-11	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
2011-12	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
2012-13	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5
2013-14	%	79.4	78.2	78.8	70.5	80.7	83.0	63.1	63.4	78.1
2014-15 (c)	%	78.8	77.2	78.5	69.6	80.4	82.0	65.6	61.5	77.4

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing \$29.3 million for 2014-15, of which the NT accounted for 51.7 per cent [table 10A.7]).
- (c) A DHS reconciliation process may result in some variance in data for 2014-15.
- (d) PBS total includes PBS general ordinary, general safety net, concessional ordinary, concessional safety net and doctor's bag.
- (e) RPBS includes RPBS general ordinary and RPBS general safety net.
- (f) PBS expenditure per person exclude RPBS and doctor's bag.
- (g) Rates from 2012-13 are derived using ERPs based on the 2011 Census. Rates for previous years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.

Source: Department of Health unpublished, PBS Statistics; table 10A.110.

TABLE 10A.6

Table 10A.6 Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2014-15 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
<i>2010-11</i>										
PBS General Ordinary	\$m	491.2	357.2	295.6	171.1	108.7	34.5	31.3	10.0	1 499.8
PBS General Safety Net	\$m	77.7	54.2	45.0	23.5	15.0	4.1	4.7	0.7	225.0
<i>PBS General total</i>	\$m	569.0	411.4	340.5	194.7	123.8	38.6	36.1	10.7	1 724.8
PBS Concessional Ordinary	\$m	1 624.0	1 154.2	873.8	389.0	396.8	135.3	48.0	15.5	4 636.7
PBS Concessional Free Safety Net	\$m	501.0	354.9	274.3	107.5	120.6	40.3	11.8	2.2	1 412.6
<i>PBS Concessional total</i>	\$m	2 125.0	1 509.1	1 148.2	496.5	517.4	175.6	59.8	17.7	6 049.3
PBS Doctors Bag	\$m	5.0	3.8	3.5	1.1	1.1	0.4	0.2	0.1	15.1
PBS Total (d)	\$m	2 699.0	1 924.3	1 492.2	692.3	642.2	214.6	96.1	28.6	7 789.1
RPBS Total (e)	\$m	172.3	99.8	115.8	38.2	36.3	14.6	7.6	0.9	485.4
PBS and RPBS TOTAL	\$m	2 871.2	2 024.1	1 608.0	730.4	678.5	229.1	103.7	29.5	8 274.6
PBS total expenditure per person (f), (g)	\$	370.4	343.8	327.3	298.3	388.5	420.6	265.0	123.9	345.9
Proportion of PBS expenditure that is concessional	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
<i>2011-12</i>										
PBS General Ordinary	\$m	490.0	364.8	293.4	185.9	109.1	35.1	31.0	9.8	1 519.1
PBS General Safety Net	\$m	72.9	53.5	43.1	23.4	15.1	4.2	4.8	0.7	217.5
<i>PBS General total</i>	\$m	562.8	418.3	336.4	209.3	124.2	39.2	35.9	10.5	1 736.6
PBS Concessional Ordinary	\$m	1 620.3	1 151.6	894.5	410.7	400.3	136.6	47.7	15.5	4 677.2
PBS Concessional Free Safety Net	\$m	511.5	363.8	283.7	111.4	125.7	41.9	12.3	2.2	1 452.6
<i>PBS Concessional total</i>	\$m	2 131.8	1 515.5	1 178.2	522.1	526.0	178.5	60.0	17.7	6 129.8
PBS Doctors Bag	\$m	4.5	3.4	2.9	1.1	1.1	0.3	0.2	0.1	13.6

TABLE 10A.6

Table 10A.6 Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2014-15 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
PBS Total (d)	\$m	2 699.2	1 937.2	1 517.6	732.5	651.3	218.0	96.0	28.3	7 880.0
RPBS Total (e)	\$m	163.3	92.7	113.2	37.4	35.0	14.3	7.1	0.9	463.9
PBS and RPBS TOTAL	\$m	2 862.5	2 029.9	1 630.8	769.9	686.4	232.3	103.1	29.2	8 343.9
PBS total expenditure per person (f), (g)	\$	371.8	346.9	335.6	306.4	395.3	425.4	258.6	121.3	349.8
Proportion of PBS expenditure that is concessional	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
<i>2012-13</i>										
PBS General Ordinary	\$m	441.6	337.9	262.3	170.0	100.9	29.8	29.8	8.8	1 381.1
PBS General Safety Net	\$m	60.6	41.1	33.6	18.6	12.8	3.2	4.0	0.5	174.4
<i>PBS General total</i>	<i>\$m</i>	<i>502.2</i>	<i>379.0</i>	<i>295.9</i>	<i>188.6</i>	<i>113.7</i>	<i>33.0</i>	<i>33.9</i>	<i>9.3</i>	<i>1 555.5</i>
PBS Concessional Ordinary	\$m	1 499.0	1 073.9	840.5	366.0	373.9	124.8	46.5	14.6	4 339.3
PBS Concessional Free Safety Net	\$m	491.9	346.0	273.6	105.0	122.4	40.3	12.0	2.2	1 393.3
<i>PBS Concessional total</i>	<i>\$m</i>	<i>1 990.9</i>	<i>1 419.9</i>	<i>1 114.1</i>	<i>471.0</i>	<i>496.2</i>	<i>165.2</i>	<i>58.5</i>	<i>16.8</i>	<i>5 732.6</i>
PBS Doctors Bag	\$m	5.0	3.9	3.4	1.2	1.2	0.3	0.2	0.1	15.2
PBS Total (d)	\$m	2 498.1	1 802.7	1 413.3	660.8	611.1	198.5	92.6	26.2	7 303.3
RPBS Total (e)	\$m	143.8	79.9	101.0	31.8	29.5	12.4	6.7	0.8	405.8
PBS and RPBS TOTAL	\$m	2 641.9	1 882.6	1 514.3	692.6	640.6	210.9	99.2	27.1	7 709.2
PBS total expenditure per person (f), (g)	\$	339.2	316.7	305.8	266.8	366.9	386.8	243.4	110.4	318.2
Proportion of PBS expenditure that is concessional	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5

2013-14

TABLE 10A.6

Table 10A.6 Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2014-15 dollars) (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
PBS General Ordinary	\$m	465.2	361.9	267.8	183.1	104.7	31.4	30.8	9.7	1 454.6
PBS General Safety Net	\$m	54.4	37.0	29.9	17.2	11.8	3.0	3.6	0.5	157.4
<i>PBS General total</i>	\$m	519.6	398.9	297.7	200.3	116.4	34.4	34.5	10.2	1 612.0
PBS Concessional Ordinary	\$m	1 523.9	1 093.6	840.5	375.1	370.8	127.9	46.8	15.5	4 394.1
PBS Concessional Free Safety Net	\$m	498.1	350.6	278.1	107.7	121.8	41.6	12.5	2.2	1 412.6
<i>PBS Concessional total</i>	\$m	2 021.9	1 444.2	1 118.6	482.8	492.6	169.5	59.3	17.8	5 806.7
PBS Doctors Bag	\$m	5.7	4.1	3.4	1.3	1.2	0.3	0.2	0.1	16.3
PBS Total (d)	\$m	2 547.2	1 847.2	1 419.7	684.4	610.2	204.2	94.0	28.0	7 435.0
RPBS Total (e)	\$m	129.4	72.8	92.5	30.2	25.8	11.0	6.1	0.8	368.7
PBS and RPBS TOTAL	\$m	2 676.6	1 920.0	1 512.2	714.6	636.1	215.2	100.1	28.8	7 803.6
PBS total expenditure per person (f), (g)	\$	340.4	318.3	301.9	267.8	363.1	396.6	244.2	115.2	318.1
Proportion of PBS expenditure that is concessional	%	79.4	78.2	78.8	70.5	80.7	83.0	63.1	63.4	78.1
<i>2014-15 (c)</i>										
PBS General Ordinary	\$m	463.1	369.1	262.1	183.4	99.1	32.3	34.1	10.1	1 453.4
PBS General Safety Net	\$m	44.5	30.8	23.6	14.6	9.5	2.6	3.3	0.5	129.3
<i>PBS General total</i>	\$m	507.6	400.0	285.7	198.0	108.6	34.8	37.4	10.6	1 582.7
PBS Concessional Ordinary	\$m	1 421.6	1 027.1	787.0	349.6	332.6	120.1	55.4	14.8	4 108.1
PBS Concessional Free Safety Net	\$m	485.9	343.1	270.0	106.2	116.5	40.7	16.3	2.2	1 380.9
<i>PBS Concessional total</i>	\$m	1 907.5	1 370.2	1 057.0	455.7	449.1	160.8	71.7	17.0	5 489.0
PBS Doctors Bag	\$m	5.7	4.2	3.4	1.3	1.2	0.3	0.2	0.1	16.4
PBS Total (d)	\$m	2 420.8	1 774.3	1 346.1	655.0	558.9	196.0	109.3	27.7	7 088.1

TABLE 10A.6

Table 10A.6 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2014-15 dollars) (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b)</i>	<i>Aust</i>
RPBS Total (e)	\$m	114.5	64.8	83.5	27.0	21.7	10.1	6.7	0.7	329.0
PBS and RPBS TOTAL	\$m	2 535.3	1 839.1	1 429.7	682.0	580.5	206.1	116.0	28.5	7 417.1
PBS total expenditure per person (f), (g)	\$	319.2	300.7	282.7	253.2	329.7	379.7	281.4	113.0	299.3
Proportion of PBS expenditure that is concessional	%	78.8	77.2	78.5	69.6	80.4	82.0	65.6	61.5	77.4

(a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.

(b) State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwith] — costing \$29.3 million for 2014-15, of which the NT accounted for 51.7 per cent [table 10A.7]).

(c) A DHS reconciliation process may result in some variance in data for 2014-15.

(d) PBS total includes PBS general ordinary, general safety net, concessional ordinary, concessional safety net and doctor's bag.

(e) RPBS includes RPBS general ordinary and RPBS general safety net.

(f) PBS expenditure per person exclude RPBS and doctor's bag.

(g) Rates from 2012-13 are derived using ERPs based on the 2011 Census. Rates for previous years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.

Source: Department of Health unpublished, PBS Statistics; table 10A.110.

TABLE 10A.7

Table 10A.7 **Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas (2014-15 dollars) (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2012-13	\$'000	107.4	–	6 842.8	10 773.1	827.2	91.0	–	19 408.9	38 050.5
2013-14	\$'000	95.3	–	6 963.7	10 542.2	921.3	112.8	–	20 544.1	39 179.4
2014-15	\$'000	52.6	–	4 418.3	8 374.1	1 258.3	77.5	–	15 166.8	29 347.6

(a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.

(b) Includes expenditure on PBS medicines supplied in bulk under s.100 of the *National Health Act 1953* (Cwlth) to Aboriginal Health Services in remote and very remote areas.

(c) This program seeks to address identified barriers to accessing essential medicines experienced by Aboriginal and Torres Strait Islander people living in remote areas (see <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-faq>, accessed 15 December 2015).

(d) Allocation to state and territory is based on location of the Aboriginal Health Service. Clients are not necessarily resident in the same state or territory.
– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 10A.110.

TABLE 10A.8

Table 10A.8 Expenditure on dental services (2013-14 dollars) (\$ million)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
2013-14									
Government									
Australian Government									
DVA	33	17	33	10	9	2	4	–	109
Department of Health and other (a)	209	124	98	8	42	11	5	5	503
Insurance premium rebates (b)	209	131	137	102	57	12	11	4	664
Total	451	272	267	121	108	26	21	9	1 275
State, Territory and Local Government	132	179	192	96	72	17	12	13	713
Total government	583	452	460	217	180	43	32	22	1 989
Non-government	1 989	2 324	916	1 076	291	113	138	79	6 925
Total government and non-government	2 572	2 776	1 376	1 293	470	156	170	101	8 914

DVA = Department of Veterans' Affairs

- (a) 'Department of Health and other' comprises Department of Health funded expenditure such as on MBS and PBS, and other Australian Government expenditure such as for the SPP associated with the National Healthcare Agreement and health-related NP payments, capital consumption, estimates of the medical expenses tax offset, and health research not funded by Department of Health.
- (b) Includes the 30–40 per cent rebate on health insurance premiums that can be either claimed directly from the Australian Government through the taxation system or may involve a reduced premium being charged by the private health insurance fund.
- Nil or rounded to zero.

Source: AIHW 2015, *Health Expenditure Australia 2013-14*, Health and Welfare Expenditure Series no. 54, Cat. no. HWE 63.

TABLE 10A.9

Table 10A.9 **Australian Government funding of Aboriginal and Torres Strait Islander Primary Health Care Services (2014-15 dollars) (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW/ ACT (d)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (d)</i>	<i>NT</i>	<i>Aust</i>
2010-11	\$m	99.9	43.1	101.4	93.0	46.1	9.0	np	138.1	530.8
2011-12	\$m	108.1	42.3	104.8	95.9	43.4	10.3	np	148.0	552.9
2012-13	\$m	111.8	44.4	97.2	93.0	46.5	10.0	np	144.6	547.4
2013-14	\$m	130.5	44.5	127.1	99.0	46.4	15.1	np	129.9	592.4
2014-15	\$m	118.5	40.7	124.1	83.7	29.3	9.8	np	161.7	567.8

(a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.

(b) Data reflect funding provided to all organisations with a primary function of primary health care and/or substance use and/or mental health services (excludes GST). Excludes funding to Peak bodies.

(c) Funding for Capital Works is not included.

(d) Data for NSW and the ACT have been combined in order to avoid the identification of individual services.

np = Not published.

Source: Department of Health unpublished, table 10A.110.

TABLE 10A.10

Table 10A.10 **Availability of GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	
GP numbers											
	2005-06	no.	7 394	5 611	4 631	2 187	1 923	617	362	305	23 032
	2006-07	no.	7 566	5 751	4 705	2 258	1 952	627	361	318	23 540
	2007-08	no.	7 706	5 903	4 906	2 307	2 055	652	368	344	24 244
	2008-09	no.	7 881	6 098	5 199	2 411	2 103	667	371	387	25 116
	2009-10	no.	8 135	6 313	5 421	2 448	2 163	697	381	417	25 975
	2010-11	no.	8 435	6 564	5 666	2 574	2 220	708	408	468	27 044
	2011-12	no.	8 766	6 905	6 075	2 684	2 303	752	433	489	28 409
	2012-13	no.	9 296	7 264	6 484	2 903	2 398	798	444	530	30 117
	2013-14	no.	9 760	7 683	6 821	3 159	2 513	836	461	598	31 833
	2014-15	no.	10 245	8 033	7 107	3 381	2 607	847	489	566	33 275
FSE GPs											
	2005-06	no.	5 279	3 630	3 128	1 295	1 210	330	173	81	15 127
	2006-07	no.	5 473	3 790	3 220	1 335	1 231	337	189	86	15 662
	2007-08	no.	5 728	4 039	3 455	1 417	1 307	357	200	96	16 601
	2008-09	no.	5 844	4 141	3 582	1 440	1 340	362	202	99	17 009
	2009-10	no.	6 008	4 320	3 744	1 495	1 394	378	207	110	17 656
	2010-11	no.	6 168	4 510	3 827	1 514	1 422	387	214	116	18 158
	2011-12	no.	6 336	4 660	3 924	1 532	1 441	394	223	117	18 628
	2012-13	no.	6 524	4 884	4 095	1 623	1 475	406	242	131	19 380
	2013-14	no.	6 905	5 219	4 341	1 793	1 538	419	256	150	20 621
	2014-15	no.	7 301	5 564	4 655	1 973	1 630	443	266	172	22 005
FSE GPs per 100 000 people (e)											
	2005-06	per 100 000 people	78.6	72.3	78.9	63.8	78.3	67.6	51.9	39.1	74.5
	2006-07	per 100 000 people	80.6	74.3	79.4	64.3	78.8	68.6	55.9	40.8	75.9

TABLE 10A.10

Table 10A.10 **Availability of GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007-08	per 100 000 people	83.2	77.7	83.1	66.4	82.8	72.0	58.1	44.3	79.0
2008-09	per 100 000 people	83.5	77.9	83.8	65.2	83.9	72.1	57.5	44.5	79.2
2009-10	per 100 000 people	84.6	79.7	85.7	66.0	86.1	74.6	57.8	48.3	80.7
2010-11	per 100 000 people	85.9	82.1	86.3	65.3	87.1	75.8	58.7	50.4	81.9
2011-12	per 100 000 people	87.4	83.6	86.9	64.2	87.6	77.0	60.2	50.4	82.8
2012-13	per 100 000 people	88.8	86.0	88.8	65.6	88.7	79.2	63.8	55.3	84.6
2013-14	per 100 000 people	92.5	90.1	92.5	70.3	91.7	81.5	66.6	61.8	88.4
2014-15	per 100 000 people	96.5	94.5	98.0	76.4	96.4	86.0	68.6	70.4	93.1

FSE = Full Service Equivalent. 1 FSE is approximately equivalent to a 37.5 hour working week.

- (a) Data include vocationally registered GPs and other medical practitioners (OMPs).
- (b) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FSE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (c) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to compute the number of GPs (associated with a small reduction in historical data for the number of GPs) and use of a new proxy measure for hours worked (FSE) in place of the previously used 'Full time Workload Equivalents' (FWE).
- (d) Full Service Equivalent (FSE) is an estimated measure of medical workforce based on Medicare claims information. FSE models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.
- (e) Rates are derived using the ABS ERP for 31 December. For 2011-12 and subsequent years, the first preliminary ERP based on the 2011 Census is used. For 2010-11 and previous years, the final 2011 Census rebased ERP is used.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.11

Table 10A.11 **Number of GP-type services used per 1000 people (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2011-12	6 082.2	5 762.6	5 969.1	4 642.6	5 600.1	5 532.9	4 513.6	3 824.8	5 730.2
2012-13	6 048.0	5 793.5	5 934.0	4 611.3	5 633.6	5 220.3	4 668.0	4 062.3	5 715.7
2013-14	6 162.6	5 953.4	6 055.8	4 763.2	5 712.0	5 244.1	4 724.6	4 388.7	5 841.8
2014-15	6 276.5	6 078.4	6 201.4	4 966.4	5 844.0	5 338.9	4 781.7	4 945.3	5 978.6

(a) Includes non-referred attendances by vocationally registered GPs and OMPs, practice nurses and, for 2013-14 and subsequent years, nurse practitioners.

(b) DVA data are included.

(c) Rates are derived using the ABS 2011-census based first preliminary estimated resident population (ERP) for December 31 of the reference year.

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

(e) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to identify GPs.

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection.

TABLE 10A.12

Table 10A.12

PBS services (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS Total (d)										
2005-06	'000	57 822.1	42 716.2	31 508.1	14 609.4	14 319.8	4 838.5	1 918.6	590.0	168 322.6
2006-07	'000	58 050.4	42 583.8	32 008.2	14 571.3	14 144.5	4 723.0	1 881.9	572.6	168 535.5
2007-08	'000	58 467.4	43 649.9	32 693.8	14 593.3	14 537.4	4 864.0	1 897.3	592.9	171 296.0
2008-09	'000	62 123.6	46 221.7	34 874.5	15 602.7	15 319.6	5 089.4	1 990.4	614.1	181 836.1
2009-10	'000	62 716.4	46 882.6	35 292.2	15 531.6	15 727.3	5 115.7	2 024.2	621.5	183 911.5
2010-11	'000	64 112.6	47 935.7	36 242.5	15 976.2	15 837.6	5 296.6	2 106.1	635.0	188 142.3
2011-12	'000	65 896.3	49 189.6	37 910.2	17 107.8	16 445.8	5 563.3	2 112.7	647.4	194 873.1
2012-13	'000	66 639.3	49 861.2	38 932.6	16 735.9	16 821.3	5 494.5	2 156.6	664.1	197 305.4
2013-14	'000	70 984.7	53 297.9	40 920.3	18 041.8	17 752.1	5 856.6	2 238.5	724.1	209 816.0
2014-15 (c)	'000	71 185.1	54 123.4	41 217.5	17 986.0	17 473.2	5 923.3	2 852.9	752.4	211 513.8
RPBS Total (e)										
2005-06	'000	5 311.9	3 415.1	3 336.3	1 183.1	1 187.0	510.3	195.7	28.4	15 167.8
2006-07	'000	5 172.0	3 321.8	3 312.7	1 168.2	1 143.4	479.5	197.6	27.6	14 822.8
2007-08	'000	4 915.7	3 177.8	3 234.6	1 123.5	1 116.8	461.9	197.2	28.6	14 256.1
2008-09	'000	4 936.2	3 160.3	3 298.2	1 136.7	1 122.3	454.3	199.2	28.9	14 336.1
2009-10	'000	4 768.4	3 047.3	3 213.5	1 073.9	1 097.4	438.0	197.5	27.8	13 863.9
2010-11	'000	4 572.5	2 900.6	3 111.1	1 032.3	1 020.5	419.1	194.2	26.3	13 276.7
2011-12	'000	4 403.5	2 784.2	3 108.2	1 036.7	1 004.3	410.1	186.5	27.1	12 960.6
2012-13	'000	4 177.1	2 655.0	3 030.2	975.2	942.7	374.7	189.3	27.0	12 371.3
2013-14	'000	4 118.8	2 649.6	3 038.8	1 007.8	932.5	371.7	190.9	28.1	12 338.3
2014-15 (c)	'000	3 830.3	2 475.8	2 924.0	959.3	855.0	351.5	231.8	28.9	11 656.6
PBS and RPBS Total										
2005-06	'000	63 134.0	46 131.3	34 844.4	15 792.5	15 506.8	5 348.8	2 114.3	618.4	183 490.5
2006-07	'000	63 222.3	45 905.6	35 320.9	15 739.5	15 287.9	5 202.5	2 079.4	600.2	183 358.3
2007-08	'000	63 383.1	46 827.7	35 928.4	15 716.9	15 654.2	5 325.9	2 094.5	621.5	185 552.2

TABLE 10A.12

Table 10A.12

PBS services (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
2008-09	'000	67 059.8	49 382.0	38 172.8	16 739.4	16 441.9	5 543.7	2 189.6	643.0	196 172.2
2009-10	'000	67 484.8	49 929.9	38 505.8	16 605.6	16 824.6	5 553.8	2 221.7	649.3	197 775.4
2010-11	'000	68 685.0	50 836.3	39 353.6	17 008.5	16 858.1	5 715.8	2 300.3	661.3	201 418.9
2011-12	'000	70 299.8	51 973.8	41 018.4	18 144.4	17 450.1	5 973.4	2 299.3	674.5	207 833.7
2012-13	'000	70 816.4	52 516.1	41 962.8	17 711.1	17 764.1	5 869.2	2 345.9	691.1	209 676.6
2013-14	'000	75 103.5	55 947.5	43 959.2	19 049.6	18 684.6	6 228.3	2 429.4	752.2	222 154.3
2014-15 (c)	'000	75 015.4	56 599.2	44 141.6	18 945.3	18 328.2	6 274.8	3 084.6	781.3	223 170.4
PBS total services per person (f)										
2005-06	no.	8.5	8.4	7.8	7.2	9.2	9.9	5.8	2.8	8.2
2006-07	no.	8.5	8.2	7.7	7.0	9.0	9.6	5.6	2.7	8.1
2007-08	no.	8.4	8.3	7.7	6.8	9.1	9.8	5.6	2.7	8.1
2008-09	no.	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
2009-10	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
2010-11	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
2011-12	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
2012-13	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
2013-14	no.	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0
2014-15 (c)	no.	9.4	9.2	8.7	7.0	10.3	11.5	7.3	3.1	8.9
Proportion of PBS services that are concessional										
2005-06	%	83.9	84.1	83.7	82.1	86.0	87.7	70.3	71.6	83.8
2006-07	%	85.4	85.6	84.8	83.0	87.2	88.8	72.5	74.4	85.2
2007-08	%	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7
2008-09	%	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
2009-10	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
2010-11	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0

TABLE 10A.12

Table 10A.12

PBS services (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
2011-12	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
2012-13	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
2013-14	%	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3
2014-15 (c)	%	91.2	91.4	90.8	87.8	92.3	93.2	84.6	82.5	90.9

- (a) Data do not capture medicines supplied by Aboriginal Health services in remote and very remote areas to their clients under s.100 of the *National Health Act 1953* (Cwlth). Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas.
- (b) Rates for 2012-13 and subsequent years are derived using ERPs based on the 2011 Census. Rates for previous years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.
- (c) A DHS reconciliation process may result in some variance in data for 2014-15.
- (d) Includes PBS general ordinary, general free safety net, concessional ordinary, concessional free safety net and doctor's bag.
- (e) Includes RPBS general ordinary and RPBS general safety net.
- (f) PBS services per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.13

Table 10A.13

PBS services, by service type ('000), (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
<i>2010-11</i>										
PBS General Ordinary	'000	6 847	5 114	4 199	2 308	1 500	464	463	137	21 032
PBS General Safety Net	'000	1 747	1 196	956	480	345	97	105	16	4 943
<i>PBS General total</i>	'000	8 595	6 310	5 155	2 788	1 845	561	568	153	25 976
PBS Concessional Ordinary	'000	42 608	32 256	23 945	10 442	10 858	3 670	1 245	423	125 447
PBS Concessional Free Safety Net	'000	12 798	9 283	7 065	2 723	3 109	1 058	290	57	36 382
<i>PBS Concessional total</i>	'000	55 406	41 539	31 010	13 164	13 967	4 728	1 535	480	161 829
PBS Doctors Bag	'000	112	86	77	24	26	8	4	2	338
PBS Total (c)	'000	64 113	47 936	36 242	15 976	15 838	5 297	2 106	635	188 142
RPBS Total (d)	'000	4 572	2 901	3 111	1 032	1 020	419	194	26	13 277
PBS and RPBS TOTAL	'000	68 685	50 836	39 354	17 009	16 858	5 716	2 300	661	201 419
PBS total services per person (e), (f)	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
Proportion of PBS services that are concessional	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
<i>2011-12</i>										
PBS General Ordinary	'000	6 867	5 130	4 232	2 445	1 514	465	447	139	21 239
PBS General Safety Net	'000	1 682	1 175	926	484	341	94	104	15	4 821
<i>PBS General total</i>	'000	8 549	6 305	5 158	2 929	1 855	559	550	155	26 060
PBS Concessional Ordinary	'000	43 912	33 102	25 259	11 300	11 296	3 885	1 256	433	130 442
PBS Concessional Free Safety Net	'000	13 329	9 700	7 421	2 853	3 270	1 112	303	58	38 047
<i>PBS Concessional total</i>	'000	57 240	42 802	32 681	14 153	14 565	4 997	1 559	491	168 489
PBS Doctors Bag	'000	107	83	72	26	25	7	3	1	324

TABLE 10A.13

Table 10A.13

PBS services, by service type ('000), (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS Total (c)	'000	65 896	49 190	37 910	17 108	16 446	5 563	2 113	647	194 873
RPBS Total (d)	'000	4 404	2 784	3 108	1 037	1 004	410	187	27	12 961
PBS and RPBS TOTAL	'000	70 300	51 974	41 018	18 144	17 450	5 973	2 299	674	207 834
PBS total services per person (e), (f)	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
Proportion of PBS services that are concessional	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
<i>2012-13</i>										
PBS General Ordinary	'000	6 229	4 608	3 902	2 223	1 415	405	410	133	19 324
PBS General Safety Net	'000	1 535	1 037	849	442	317	81	97	14	4 371
<i>PBS General total</i>	'000	7 763	5 645	4 750	2 664	1 732	486	506	146	23 695
PBS Concessional Ordinary	'000	44 882	34 074	26 304	11 119	11 629	3 858	1 326	454	133 647
PBS Concessional Free Safety Net	'000	13 880	10 051	7 798	2 925	3 432	1 142	321	62	39 612
<i>PBS Concessional total</i>	'000	58 762	44 125	34 102	14 045	15 061	5 001	1 647	516	173 259
PBS Doctors Bag	'000	114	91	80	26	28	8	4	2	352
PBS Total (c)	'000	66 639	49 861	38 933	16 736	16 821	5 495	2 157	664	197 305
RPBS Total (d)	'000	4 177	2 655	3 030	975	943	375	189	27	12 371
PBS and RPBS TOTAL	'000	70 816	52 516	41 963	17 711	17 764	5 869	2 346	691	209 677
PBS total services per person (e), (f)	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8
<i>2013-14</i>										
PBS General Ordinary	'000	5 783	4 325	3 600	2 155	1 312	375	370	131	18 050

TABLE 10A.13

Table 10A.13 **PBS services, by service type ('000), (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS General Safety Net	'000	1 414	966	782	415	295	76	92	14	4 053
<i>PBS General total</i>	'000	7 197	5 290	4 382	2 569	1 606	451	462	145	22 103
PBS Concessional Ordinary	'000	48 971	37 286	28 182	12 288	12 500	4 178	1 425	511	145 340
PBS Concessional Free Safety Net	'000	14 695	10 628	8 277	3 156	3 619	1 219	348	67	42 009
<i>PBS Concessional total</i>	'000	63 667	47 914	36 459	15 444	16 119	5 397	1 772	577	187 349
PBS Doctors Bag	'000	121	94	80	29	27	8	4	2	364
PBS Total (c)	'000	70 985	53 298	40 920	18 042	17 752	5 857	2 238	724	209 816
RPBS Total (d)	'000	4 119	2 650	3 039	1 008	933	372	191	28	12 338
PBS and RPBS TOTAL	'000	75 104	55 947	43 959	19 050	18 685	6 228	2 429	752	222 154
PBS total services per person (e), (f)	no.	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0
Proportion of PBS services that are concessional	%	89.7	89.9	89.1	85.6	90.8	92.2	79.2	79.7	89.3
<i>2014-15 (b)</i>										
PBS General Ordinary	'000	4 896	3 705	3 044	1 789	1 056	325	347	115	15 277
PBS General Safety Net	'000	1 226	854	668	374	255	68	87	14	3 546
<i>PBS General total</i>	'000	6 121	4 559	3 712	2 164	1 312	392	434	130	18 823
PBS Concessional Ordinary	'000	49 530	38 225	28 743	12 441	12 375	4 241	1 919	546	148 022
PBS Concessional Free Safety Net	'000	15 408	11 240	8 681	3 349	3 758	1 281	495	75	44 288
<i>PBS Concessional total</i>	'000	64 938	49 465	37 425	15 791	16 133	5 522	2 415	621	192 310
PBS Doctors Bag	'000	126	100	81	32	28	8	5	2	381
PBS Total (c)	'000	71 185	54 123	41 218	17 986	17 473	5 923	2 853	752	211 514
RPBS Total (d)	'000	3 830	2 476	2 924	959	855	352	232	29	11 657

TABLE 10A.13

Table 10A.13 **PBS services, by service type ('000), (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (a)</i>	<i>Aust</i>
PBS and RPBS TOTAL	'000	75 015	56 599	44 142	18 945	18 328	6 275	3 085	781	223 170
PBS total services per person (e), (f)	no.	9.4	9.2	8.7	7.0	10.3	11.5	7.3	3.1	8.9
Proportion of PBS services that are concessional	%	91.2	91.4	90.8	87.8	92.3	93.2	84.6	82.5	90.9

(a) Data do not capture medicines supplied by Aboriginal Health services in remote and very remote areas to their clients under s.100 of the *National Health Act 1953* (Cwlth). Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas.

(b) A DHS reconciliation process may result in some variance in data for 2014-15.

(c) Includes PBS general ordinary, general free safety net, concessional ordinary, concessional free safety net and doctor's bag.

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

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

(f) Rates from 2012-13 are derived using ERPs based on the 2011 Census. Rates for previous years are derived using ERPs based on earlier Censuses. Rates based on different Censuses are not comparable.

na Not available. – Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.14

Table 10A.14 **Alcohol and other drug treatment services, 2013-14 (number) (a), (b)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA (c)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Treatment services by sector										
Government	no.	215	–	61	13	49	8	2	5	353
Non-government (c), (d)	no.	77	130	80	67	44	14	13	17	442
Total	no.	292	130	141	80	93	22	15	22	795
Closed treatment episodes by sector										
Government	no.	31 797	–	21 065	2 144	6 789	2 025	2 319	1 096	67 235
Non-government (c), (d)	no.	10 609	56 392	15 028	18 723	6 296	816	2 333	3 281	113 478
Total	no.	42 406	56 392	36 093	20 867	13 085	2 841	4 652	4 377	180 713
Closed treatment episodes for client's own drug use by sex										
Male	%	27 339	34 083	24 246	13 037	9 086	1 798	2 971	2 691	115 251
Female	%	13 470	18 123	10 870	6 419	3 888	851	1 574	1 223	56 418
Total (e)	no.	40 824	52 261	35 127	19 456	12 979	2 649	4 545	3 917	171 758

(a) Data are sourced from an annual 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. 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.

(b) Includes only services that receive public funding.

(c) WA has a number of integrated services that include both government and non-government providers.

(d) Includes agencies funded by Department of Health under the Non-Government Organisation Treatment Grants Program.

(e) Total includes episodes for people of unknown sex.

– Nil or rounded to zero.

Source: AIHW 2015, *Alcohol and Other Drug Treatment Services in Australia 2013-14*, Cat. no. HSE 158, Drug Treatment Series no. 25.

TABLE 10A.15

Table 10A.15 **Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare (number) (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander primary healthcare services										
2009-10	no.	50	26	33	37	13	10	1	53	223
2010-11	no.	56	25	37	35	15	11	1	55	235
2011-12	no.	52	25	37	35	13	9	1	52	224
2012-13	no.	45	24	28	31	14	7	1	55	205
2013-14	no.	45	23	28	28	13	7	1	58	203
Episodes of healthcare provided (d)										
2009-10	'000	542	185	379	409	192	36	26	622	2 391
2010-11	'000	522	201	310	473	222	38	30	704	2 498
2011-12	'000	516	234	475	462	216	44	34	641	2 621
2012-13	'000	622	238	575	583	217	53	38	743	3 068
2013-14	'000	646	216	690	543	177	59	42	897	3 269

- (a) Includes only Aboriginal and Torres Strait Islander primary healthcare services that report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) Data are for Aboriginal and Torres Strait Islander primary healthcare services funded or partially funded by the Australian Government to facilitate access to primary health care. Data for these services are collected through the Online Services Report (OSR) questionnaire. Many receive additional funding from State and Territory governments and other sources. OSR data reported here represent funding from all sources.
- (c) The number of services that provide OSR data can change each year. Changes can be due to a number of reasons including: new Australian government funded primary health care services opening; existing services gaining Australian government funding; previously excluded Australian government funded services commencing OSR data reporting where changes to the types of services provided and/or to reporting arrangements are made.
- (d) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.

Source: AIHW 2015 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2009-10, 2010-11, 2011-12, 2012-13 and 2013-14*, Cat. no. IHW 56, 79, 104, 139, 152.

TABLE 10A.16

Table 10A.16 Aboriginal and Torres Strait Islander primary healthcare services and episodes of healthcare, by remoteness category (number) (a), (b), (c), (d), (e)

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Total</i>
Aboriginal and Torres Strait Islander primary healthcare services							
2009-10	no.	29	48	55	33	58	223
2010-11	no.	34	52	59	29	61	235
2011-12	no.	33	48	53	28	62	224
2012-13	no.	23	43	47	27	65	205
2013-14	no.	22	43	45	27	66	203
Episodes of healthcare provided (e)							
2009-10	'000	364	395	583	557	491	2 391
2010-11	'000	399	413	496	532	658	2 498
2011-12	'000	436	460	493	560	671	2 621
2012-13	'000	555	557	563	652	741	3 068
2013-14	'000	498	569	670	735	796	3 269

- (a) Includes only Aboriginal and Torres Strait Islander primary healthcare services that report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) Data are for Aboriginal and Torres Strait Islander primary healthcare services funded or partially funded by the Australian Government to facilitate access to primary health care. Data for these services are collected through the Online Services Report (OSR) questionnaire. Many receive additional funding from State and Territory governments and other sources. OSR data reported here represent funding from all sources.
- (c) The number of services that provide OSR data can change each year. Changes can be due to a number of reasons including: new Australian government funded primary health care services opening; existing services gaining Australian government funding; previously excluded Australian government funded services commencing OSR data reporting where changes to the types of services provided and/or to reporting arrangements are made.
- (d) Remoteness categories are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 Census of population and housing.
- (e) An episode of care involves contact between an individual client and service staff for the provision of health care. Group work is not included. Transport is included only if it involves provision of health care/information by staff. Outreach provision, for example episodes at outstation visits, park clinics, satellite clinics, is included. Episodes of health care delivered over the phone are included.

Source: AIHW 2015 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2009-10, 2010-11, 2011-12, 2012-13 and 2013-14*, Cat. no. IHW 56, 79, 104, 139, 152.

TABLE 10A.17

Table 10A.17 Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities (per cent) (a), (b), (c), (d)

	2012-13	2013-14
Diagnosis and treatment of chronic illness/diseases	88.8	92.1
Transport	89.3	88.2
24 hour emergency care	40.0	44.3
Child immunisation	85.4	88.7
Women's groups	51.7	53.2
Housing	82.9	83.7
Dental assessment/treatment	51.2	54.7
Regional health planning processes	87.3	86.2
Dialysis service on site	5.4	8.9

- (a) Includes only Aboriginal and Torres Strait Islander primary healthcare services that report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) Data are for Aboriginal and Torres Strait Islander primary healthcare services funded or partially funded by the Australian Government to facilitate access to primary health care. Data for these services are collected through the Online Services Report (OSR) questionnaire. Many receive additional funding from State and Territory governments and other sources. OSR data reported here represent funding from all sources.
- (c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.
- (d) The health related activities section of the OSR data collection instrument was extensively revised for the 2012-13 collection period and data are not comparable with data for previous years. From 2012-13, data are collected for a smaller range of health related activities. This does not indicate that activities undertaken by services in previous years are no longer provided. Data for previous years are provided in table 10A.18.

Source: AIHW 2015 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2012-13 and 2013-14*, Cat. no. IHW 139 and 152.

TABLE 10A.18

Table 10A.18 Proportion of Aboriginal and Torres Strait Islander primary healthcare services that undertook selected health related activities, 2008-09 to 2011-12 (per cent) (a), (b), (c), (d)

	2008-09 (f)	2009-10	2010-11	2011-12
Diagnosis and treatment of illness/disease	85.0	82.1	81.2	80.4
Management of chronic illness	89.0	87.0	85.0	86.2
Transportation to medical appointments	86.0	87.0	88.5	90.2
Outreach clinic services	55.0	55.6	52.6	60.7
24 hour emergency care	31.0	27.8	23.5	28.1
Monitoring child growth	64.0	76.2	71.8	79.0
School-based activities	68.0	70.4	74.4	79.0
Hearing screening	72.0	74.9	70.9	76.3
Pneumococcal immunisation	76.0	74.9	70.9	69.6
Influenza immunisation	82.0	81.6	78.2	81.3
Child immunisation	81.0	81.6	76.9	80.8
Women's health group	77.0	76.2	78.2	78.1
Support for public housing issues	58.0	67.7	59.0	71.0
Community development work	60.0	66.8	65.4	75.0
Legal/police/prison/advocacy services	42.0	43.1	44.9	46.0
Dental services	52.0	48.9	45.3	53.1
Involvement in steering groups on health	77.0	81.2	79.5	86.2
Participation in regional planning forums	57.0	57.9	59.0	67.0
Dialysis services	4.0	6.3	4.7	3.6

- (a) Includes only Aboriginal and Torres Strait Islander primary healthcare services that report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) Data are for Aboriginal and Torres Strait Islander primary healthcare services funded or partially funded by the Australian Government to facilitate access to primary health care. Data for these services are collected through the Online Services Report (OSR) questionnaire. Many receive additional funding from State and Territory governments and other sources. OSR data reported here represent funding from all sources.
- (c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.
- (d) The health related activities section of the OSR data collection instrument was extensively revised for the 2012-13 collection period and data for 2008-09 to 2011-12 are not comparable with data for 2012-13. From 2012-13, data are collected for a smaller range of selected health related activities (see table 10A.17). This does not indicate that particular activities are no longer undertaken by services.

Source: AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2008-09, 2009-10, 2010-11 and 2011-12*, Cat. no. IHW 31, 56, 79, 104.

TABLE 10A.19

Table 10A.19 **Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) (a), (b), (c), (d)**

	2010	2011	2012	2013	2014
<i>Aboriginal and Torres Strait Islander staff</i>					
Aboriginal and Torres Strait Islander health workers	836.6	899.4	896.5	1 414.0	894.9
Aboriginal and Torres Strait Islander health practitioners (e)	na	na	na	74.0	118.5
Doctors	16.1	26.0	20.7	26.8	33.1
Nurses/midwives	72.2	72.9	101.3	119.6	120.9
Specialists	1.2	0.2	0.3	–	–
Counsellors/social workers	52.3	59.2	33.4	69.5	57.3
Other social and emotional wellbeing staff (f)	242.3	220.8	203.7	164.3	162.3
Allied health professionals (g)	49.7	31.8	58.1	6.1	8.8
Dentists	4.4	7.4	4.6	6.8	5.8
Dental assistants	47.9	43.9	46.2	52.4	58.7
Traditional healers	8.1	10.8	4.7	12.0	8.0
Sexual health workers	44.5	38.7	43.3	33.9	30.5
Substance misuse workers	77.5	101.2	104.7	100.3	81.2
Tobacco workers/coordinators (e)	na	na	na	66.0	120.1
Health promotion/prevention workers (e)	na	na	na	98.3	105.1
Environmental health workers	24.0	23.8	32.7	33.0	27.0
Driver/field officers	218.1	255.6	250.0	274.6	295.5
Other health staff (h)	6.0	142.3	145.8	349.7	358.3
Total Aboriginal and Torres Strait Islander staff (i)	1 700.9	1 933.9	1 946.0	2 385.8	2 486.0
<i>Non-Indigenous staff</i>					
Aboriginal and Torres Strait Islander health workers	30.7	14.0	34.3	11.5	12.0
Aboriginal and Torres Strait Islander health practitioners (e)	na	na	na	2.0	10.0
Doctors	319.3	335.4	331.8	347.8	418.1
Nurses/midwives	615.3	710.7	681.8	711.8	868.4
Specialists	7.4	13.0	12.1	16.9	24.2
Counsellors/social workers	84.6	89.1	40.6	213.7	115.1
Other social and emotional wellbeing staff (f)	66.2	97.6	82.5	85.5	96.8
Allied health professionals (g)	108.2	144.2	115.9	115.8	161.6
Dentists	39.8	48.7	55.8	60.7	64.4
Dental assistants	27.8	35.1	31.0	30.9	47.1
Traditional healers	–	3.1	0.5	–	–
Sexual health workers	20.0	16.6	11.7	12.7	11.0
Substance misuse workers	43.4	50.7	54.3	49.4	39.5

TABLE 10A.19

Table 10A.19 **Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) (a), (b), (c), (d)**

	2010	2011	2012	2013	2014
Tobacco workers/coordinators (e)	na	na	na	25.9	37.5
Health promotion/prevention workers (e)	na	na	na	47.9	51.7
Environmental health workers	6.0	10.3	8.5	6.0	6.3
Driver/field officers	40.1	39.4	36.7	46.6	42.6
Other health staff (h)	–	67.5	25.4	173.0	112.0
Total non-Indigenous staff (i)	1 408.7	1 675.2	1 522.9	1 958.0	2 118.1
<i>Total health staff (i), (j)</i>					
Aboriginal and Torres Strait Islander health workers	867.4	913.4	930.8	910.1	906.9
Aboriginal and Torres Strait Islander health practitioners (e)	na	na	na	76	128.5
Doctors	335.4	361.4	352.5	374.6	451.2
Nurses/midwives	691.5	787.6	783.1	831.4	989.3
Specialists	8.7	13.2	12.3	16.9	24.3
Counsellors/social workers	136.8	148.3	74.0	283.2	172.4
Other social and emotional wellbeing staff (f)	309.5	319.4	286.2	249.8	259.1
Allied health professionals (g)	157.9	176.0	174.0	121.9	170.4
Dentists	44.2	56.1	60.5	67.5	70.2
Dental assistants	75.7	79.1	77.2	83.3	105.8
Traditional healers	8.2	13.9	5.2	12.0	8.0
Sexual health workers	64.5	55.3	55.0	46.6	41.5
Substance misuse workers	120.9	151.9	159.0	149.7	120.7
Tobacco workers/coordinators (e)	na	na	na	91.9	157.6
Health promotion/prevention workers (e)	na	na	na	146.2	156.7
Environmental health workers	30.0	34.1	41.2	39.0	33.3
Driver/field officers	258.2	294.9	286.7	321.2	338.1
Other health staff (h)	6.0	209.7	171.2	522.7	470.3
Total health staff (i), (j)	3 114.9	3 614.4	3 468.9	4 343.8	4 604.1

- (a) Includes only Aboriginal and Torres Strait Islander primary healthcare services that report data for the Online Services Report (OSR; previously the OATSIH Services Report).
- (b) Data are for Aboriginal and Torres Strait Islander primary healthcare services funded or partially funded by the Australian Government to facilitate access to primary health care. Data for these services are collected through the Online Services Report (OSR) questionnaire. Many receive additional funding from State and Territory governments and other sources. OSR data reported here represent funding from all sources.
- (c) Data may differ from data presented in the national OSR report which excludes drivers/field officers reported here.

TABLE 10A.19

Table 10A.19 **Full time equivalent (FTE) health staff employed by Aboriginal and Torres Strait Islander primary healthcare services which provide data for Online Services Reporting (OSR) as at 30 June (number) (a), (b), (c), (d)**

	2010	2011	2012	2013	2014
(d) The number of services that provide OSR data can change each year. Changes can be due to a number of reasons including: new Australian government funded primary health care services opening; existing services gaining Australian government funding; previously excluded Australian government funded services commencing OSR data reporting where changes to the types of services provided and/or to reporting arrangements are made.					
(e) Data for Aboriginal health practitioners, Tobacco workers/coordinators and Health promotion/ prevention workers were first collected for 2013.					
(f) Other social and emotional wellbeing staff includes: Bringing Them Home and Link Up support workers, psychologists, mental health workers and other social and emotional wellbeing staff.					
(g) Allied health professionals include diabetes educators and other patient educators, health program coordinators, nutrition workers, community care workers, child and family health workers, child protection workers, welfare workers, pharmacy assistants/technicians, Brighter Futures Program caseworkers, foster carers, Healthy for Life workers, sports and recreation workers, youth workers, and masseurs.					
(h) Other health staff' include: outreach workers, special program support workers, patient liaison officers, and other health-related positions.					
(i) Totals may not add due to rounding and cell suppression.					
(j) Totals include health staff for whom Indigenous status was not provided.					
na Not available. – Nil or rounded to zero.					

Source: AIHW 2015 and previous issues, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results, 2009-10, 2010-11, 2011-12, 2012-13 and 2013-14*, Cat. no. IHW 56, 79, 104, 139, 152.

TABLE 10A.20

Table 10A.20 **Approved providers of PBS medicines by PhARIA area at 30 June 2015 (a), (b)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Number of people per approved PBS provider counting pharmacies, GPs and Aboriginal Medical Services									
PhARIA 1	3 790	4 152	3 963	3 898	3 759	3 391	4 820	4 491	3 932
PhARIA 2	4 415	3 895	4 235	5 662	4 409	2 891	..	5 044	4 193
PhARIA 3	3 354	4 141	3 492	3 602	3 376	3 669	..	3 115	3 606
PhARIA 4	3 698	3 659	3 660	3 003	2 391	6 164	..	–	3 512
PhARIA 5	2 645	2 744	3 475	2 103	2 563	1 743	..	2 372	2 655
PhARIA 6	1 892	1 334	1 225	2 014	1 539	700	..	747	1 355
PhARIA 2–6	3 486	3 855	3 049	2 619	2 876	2 919	..	1 423	3 065
Total	3 746	4 112	3 776	3 599	3 565	3 210	4 820	1 892	3 769
Number of people per pharmacy									
PhARIA 1	3 793	4 152	3 963	3 906	3 759	3 391	4 820	4 491	3 933
PhARIA 2	4 415	3 895	4 360	5 662	4 810	2 891	..	5 044	4 239
PhARIA 3	3 354	4 141	3 546	3 741	3 376	3 669	..	3 115	3 628
PhARIA 4	3 963	3 659	3 660	3 003	2 391	6 164	..	–	3 589
PhARIA 5	3 034	2 927	3 932	2 243	2 563	2 034	..	6 325	3 101
PhARIA 6	2 601	1 334	3 285	3 966	2 737	1 749	..	25 761	3 943
Number of pharmacies									
PhARIA 1	1 574	1 126	911	474	349	95	74	17	4 620
PhARIA 2	60	49	34	8	11	16	..	7	185
PhARIA 3	113	82	64	26	35	20	..	2	342
PhARIA 4	42	26	31	13	21	4	..	–	137
PhARIA 5	34	15	38	30	14	12	..	6	149
PhARIA 6	8	1	22	33	9	2	..	2	78
Number of approved GPs (d)									
PhARIA 1	–	–	–	–	–	–	–	–	–
PhARIA 2	–	–	–	–	–	–	..	–	–
PhARIA 3	–	–	–	–	–	–	..	–	–
PhARIA 4	3	–	–	–	–	–	..	–	3
PhARIA 5	3	1	2	2	–	2	..	–	10
PhARIA 6	1	–	2	3	1	1	..	–	8
Number of approved public hospitals (e)									
PhARIA 1	1	52	29	13	11	4	–	1	111
PhARIA 2	–	6	3	1	2	–	..	–	12
PhARIA 3	–	8	7	1	2	–	..	–	18
PhARIA 4	–	1	3	1	–	–	..	–	5
PhARIA 5	–	1	3	–	–	–	..	2	6
PhARIA 6	–	–	4	3	–	–	..	2	9
Number of approved private hospitals (e)									
PhARIA 1	36	32	28	3	9	2	4	1	115
PhARIA 2	–	–	–	–	–	–	..	–	–

TABLE 10A.20

Table 10A.20 **Approved providers of PBS medicines by PhARIA area at 30 June 2015 (a), (b)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust (c)
PhARIA 3	–	1	–	–	–	–	..	–	1
PhARIA 4	–	–	–	–	–	–	..	–	–
PhARIA 5	–	–	–	–	–	–	..	–	–
PhARIA 6	–	–	–	–	–	–	..	–	–
Number of Aboriginal Medical Services operating under Section 100 of the Act (f)									
PhARIA 1	1	–	–	1	–	–	–	–	2
PhARIA 2	–	–	1	–	1	–	..	–	2
PhARIA 3	–	–	1	1	–	–	..	–	2
PhARIA 4	–	–	–	–	–	–	..	–	–
PhARIA 5	2	–	3	–	–	–	..	10	15
PhARIA 6	2	–	35	29	6	2	..	67	141
PhARIA 2–6	4	–	40	30	7	2	–	77	160

(a) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). PhARIA is a composite index of accessibility that incorporates measures of remoteness and measures of professional isolation (represented by the road distance to the five closest pharmacies). The PhARIA classification categories are:

Category 1 - Highly Accessible

Category 2 - Accessible (Group A)

Category 3 - Accessible (Group B)

Category 4 - Moderately Accessible

Category 5 - Remote

Category 6 - Very Remote

PhARIA 1 represents 'urban' and PhARIA 2–6 'rural' for the purpose of these data.

(b) Rates are derived using 2011 Census population data.

(c) Includes other territories.

(d) A GP can obtain approval under S92 of the *National Health Act 1953* (Cwlth) to supply PBS medicines to people in the area in which they practise if it is deemed to be an area that lacks a convenient and efficient pharmaceutical service.

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

(f) Aboriginal Medical Services in remote and very remote areas can obtain approval to supply PBS medicines to patients under S100 of the *National Health Act 1953* (Cwlth). Remote and very remote areas are as defined in the Rural, Remote and Metropolitan Areas Classifications (RRMA), 1991 Census Edition.

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

Source: Department of Health unpublished, derived from Department of Human Services, ABS unpublished *2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre.

TABLE 10A.21

Table 10A.21 **Approved providers of PBS medicines by geolocation, at 30 June (a), (b)**

	<i>NSW (c)</i>	<i>Vic (c)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust (e)</i>
Number of people per pharmacy									
Urban									
2011	3 677	4 031	3 615	3 699	3 725	3 248	5 051	4 681	3 777
2012	3 891	4 363	4 059	4 116	3 921	3 445	5 243	4 861	4 082
2013 (f)	3 855	4 319	4 065	4 066	3 775	3 440	4 952	4 254	4 034
2014	3 803	4 199	4 002	3 970	3 754	3 368	4 952	4 504	3 963
2015	3 793	4 152	3 963	3 906	3 759	3 391	4 820	4 491	3 933
Rural									
2011	4 232	4 462	4 037	4 021	3 269	3 694	..	8 500	4 108
2012	4 051	4 344	4 381	4 202	3 287	3 593	..	9 374	4 148
2013 (f)	3 811	4 077	3 904	3 776	3 332	3 288	..	8 898	3 887
2014	3 735	3 981	3 821	3 531	3 147	3 288	–	8 342	3 771
2015	3 636	3 877	3 759	3 452	3 131	3 189	–	7 866	3 688
Number of pharmacies									
Urban									
2011	1 456	1 035	852	429	318	85	64	19	4 258
2012	1 462	1 047	844	441	320	84	68	20	4 286
2013 (f)	1 546	1 082	887	455	347	93	72	18	4 500
2014	1 567	1 113	901	466	349	95	72	17	4 580
2015	1 574	1 126	911	474	349	95	74	17	4 620
Rural									
2011	280	169	201	91	100	54	..	12	908
2012	300	179	204	99	103	57	..	12	955
2013 (f)	248	165	183	101	85	53	–	15	851
2014	253	169	187	108	90	53	–	16	877
2015	257	173	189	110	90	54	–	17	891
Number of approved GPs — Rural (g)									
2011	9	1	6	17	2	3	..	1	39
2012	11	9	5	11	1	4	..	–	41
2013	10	1	5	11	1	5	..	..	33
2014	8	1	4	7	1	3	–	–	24
2015	7	1	4	5	1	3	–	–	21
Number of approved hospitals — Urban (h)									
Public									
2011	–	53	27	10	8	3	–	1	102
2012	–	53	27	12	8	3	–	1	104
2013	1	52	30	12	10	4	..	1	110
2014	1	52	29	13	10	4	–	1	110
2015	1	52	29	13	11	4	–	1	111

TABLE 10A.21

Table 10A.21 **Approved providers of PBS medicines by geolocation, at 30 June (a), (b)**

	NSW (c)	Vic (c)	Qld	WA	SA	Tas	ACT	NT (d)	Aust (e)
Private									
2011	22	28	24	5	4	1	4	1	89
2012	22	29	25	5	4	1	4	1	91
2013	26	29	25	4	6	1	3	1	95
2014	31	28	26	3	9	2	4	1	104
2015	36	32	28	3	9	2	4	1	115
Number of approved hospitals — Rural (h) (i)									
Public									
2011	–	16	20	6	–	1	..	4	47
2012	–	18	22	6	–	1	..	4	51
2013	..	16	20	6	3	..	..	4	49
2014	–	16	20	6	3	–	–	4	49
2015	–	16	20	6	4	–	–	4	50

(a) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). PhARIA is a composite index of accessibility that incorporates measures of remoteness and measures of professional isolation (represented by the road distance to the five closest pharmacies). The PhARIA classification categories are:

- Category 1 - Highly Accessible
- Category 2 - Accessible (Group A)
- Category 3 - Accessible (Group B)
- Category 4 - Moderately Accessible
- Category 5 - Remote
- Category 6 - Very Remote

PhARIA 1 represents 'urban' and PhARIA 2–6 'rural' for the purpose of these data.

- (b) Rates are derived using 2011 Census population data for 2012 and subsequent years and 2006 Census population data for 2011 and previous years.
- (c) For 2013, one public hospital in NSW is a campus of a Victorian hospital participating in the Pharmaceutical Reforms.
- (d) Care should be taken using data for the NT, as around 43 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).
- (e) Includes other territories.
- (f) 118 pharmacies classified as rural at 30 June 2012 were reclassified as urban at 30 June 2013.
- (g) A GP can obtain approval under S92 of the *National Health Act 1953* (Cwlth) to supply PBS medicines to people in the area in which they practise if they are able to demonstrate that the area lacks a convenient and efficient pharmaceutical service. This criterion cannot be met in 'urban' areas.
- (h) PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.
- (i) There were no PBS approved private hospitals in rural areas in the reference years reported.
.. Not applicable. – Nil or rounded to zero.

Table 10A.21 **Approved providers of PBS medicines by geolocation, at 30 June (a), (b)**

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

Source: Department of Health unpublished, derived from Department of Human Services, ABS unpublished *2006/2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre.

Table 10A.22 PBS expenditure per person, by remoteness area (2014-15 dollars)
(a), (b), (c), (d), (e)

	<i>Unit</i>	2012-13	2013-14	2014-15
<i>Total expenditure</i>				
Major cities	\$m	4 916.2	5 009.5	4 765.1
Inner regional	\$m	1 571.6	1 600.7	1 533.8
Outer regional	\$m	702.9	709.7	677.1
Remote	\$m	69.8	71.1	68.1
Very remote	\$m	25.2	25.5	24.3
Australia (f)	\$m	7 288.1	7 418.7	7 071.7
<i>Expenditure per person</i>				
Major cities	\$	308.1	307.0	286.9
Inner regional	\$	378.7	379.6	359.5
Outer regional	\$	343.5	343.4	325.3
Remote	\$	218.2	220.3	210.3
Very remote	\$	120.7	121.9	116.5
Australia (f)	\$	321.3	320.7	301.0

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.
- (c) Locality level data are only available on a cash accounting basis for general and concessional categories. These figures may differ from those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwth].) Expenditure on medications dispensed to remote and very remote areas under s.100 was \$29.4 million in 2014-15 (table 10A.7).
- (d) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.
- (e) Rates are derived using the final ABS 2011 Census based estimated resident population (ERP). Rates in this table use the 30 June ERP preceding the reference year and differ from rates reported in tables 10A.5 and 10A.6 which use the 31 December ERP for the reference year.
- (f) Data for Australia includes Other Territories and expenditure that could not be allocated to a remoteness area.

Source: Department of Health unpublished, PBS Statistics; ABS 2013, Regional Population Growth, Australia, 2012, Cat. no. 3218.0; table 10A.110.

TABLE 10A.23

Table 10A.23 **PBS expenditure per person, by urban and rural location, 2009-10 to 2011-12 (2014-15 dollars) (a), (b), (c), (d)**

	2009-10	2010-11	2011-12
Capital city	338.9	329.9	333.0
Other metropolitan	387.1	381.1	384.5
Rural and remote	377.1	371.8	378.0
All locations	353.6	345.9	349.8

(a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.

(b) Includes PBS general ordinary, general safety net, concessional ordinary, concessional free safety net and unknown free safety net. Excludes RPBS and doctor's bag.

(c) Locality level data are only available on a cash accounting basis for general and concessional categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk under s.100 of the *National Health Act 1953* [Cwlth]).

(d) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification.

Source: Department of Health unpublished, PBS Statistics; table 10A.110.

TABLE 10A.24

Table 10A.24 **Availability of GPs by region (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Number of GPs									
2012-13									
Major cities	6 749	5 459	3 815	2 057	1 712	..	444	..	20 237
Inner regional	1 963	1 488	1 189	267	256	569	np	..	5 733
Outer regional	np	np	1 116	247	321	194	..	181	2 862
Remote	np	np	147	184	np	np	..	np	622
Very remote	np	..	216	148	np	np	..	np	664
Outer regional, remote and very remote	584	317	1 479	579	429	229	..	530	4 148
Total	9 296	7 264	6 484	2 903	2 398	798	444	530	30 117
Number of FSE GPs									
2012-13									
Major cities	4 969	3 774	2 657	1 275	1 115	..	242	..	14 032
Inner regional	1 230	909	796	150	136	279	np	..	3 499
Outer regional	np	np	575	120	179	119	..	77	1 563
Remote	np	np	37	54	np	np	..	np	186
Very remote	np	..	30	24	np	np	..	np	101
Outer regional, remote and very remote	325	201	642	198	225	127	..	132	1 850
Total	6 524	4 884	4 095	1 623	1 475	406	242	131	19 380
Number of FSE GPs per 100 000 people									
2012-13									
Major cities	92.1	87.9	94.1	68.5	91.9	..	64.7	..	87.9
Inner regional	87.1	84.1	86.2	69.0	75.9	83.1	np	..	84.3
Outer regional	np	np	85.5	65.0	88.5	71.9	..	58.5	76.4
Remote	np	np	46.3	53.1	np	np	..	np	58.2
Very remote	np	..	50.3	36.2	np	np	..	np	48.3
Outer regional, remote and very remote	67.2	80.3	79.1	56.2	85.6	72.0	..	56.2	71.8
Total	89.5	86.8	89.8	66.8	89.1	79.3	64.6	55.8	85.4
Number of GPs									
2013-14									
Major cities	7 074	5 740	3 991	2 273	1 786	..	461	..	21 326
Inner regional	2 056	1 611	1 297	269	272	597	np	..	6 103
Outer regional	np	np	1 155	269	335	202	..	207	3 028
Remote	np	np	161	197	np	np	..	np	681
Very remote	np	..	217	150	np	np	..	np	695

TABLE 10A.24

Table 10A.24 **Availability of GPs by region (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Outer regional, remote and very remote	631	332	1 533	616	455	239	..	598	4 404
Total	9 760	7 683	6 821	3 159	2 513	836	461	598	31 833
Number of FSE GPs									
2013-14									
Major cities	5 231	4 030	2 816	1 409	1 164	..	256	..	14 906
Inner regional	1 326	982	859	160	143	288	np	..	3 758
Outer regional	np	np	597	139	183	122	..	88	1 649
Remote	np	np	39	60	np	np	..	np	201
Very remote	np	..	30	24	np	np	..	np	107
Outer regional, remote and very remote	349	207	666	223	231	131	..	150	1 957
Total	6 905	5 219	4 341	1 793	1 538	419	256	150	20 621
Number of FSE GPs per 100 000 people									
2013-14									
Major cities	95.2	91.7	97.5	72.9	94.9	..	67.2	..	91.3
Inner regional	92.8	89.6	91.0	70.2	78.9	85	np	..	89.1
Outer regional	np	np	87.2	73.9	90.5	74	..	65	79.8
Remote	np	np	48.8	57.8	np	np	..	np	62.3
Very remote	np	..	50.7	35.9	np	np	..	np	51.1
Outer regional, remote and very remote	72.1	82.8	80.9	62.2	87.9	74.3	..	62.3	75.3
Total	93.2	90.9	93.2	71.2	92.1	81.7	67.1	62.3	89.1
Number of GPs									
2014-15									
Major cities	7 477	5 996	4 163	2 443	1 859	..	489	..	22 427
Inner regional	2 127	1 684	1 336	279	281	618	np	..	6 326
Outer regional	np	np	1 189	281	345	195	..	218	3 131
Remote	np	np	161	219	np	np	..	np	685
Very remote	np	..	258	158	np	np	..	np	705
Outer regional, remote and very remote	641	353	1 608	658	466	229	..	566	4 521
Total	10 245	8 033	7 107	3 381	2 607	847	489	566	33 275
Number of FSE GPs									
2014-15									
Major cities	5 517	4 274	3 000	1 559	1 236	..	266	..	15 853
Inner regional	1 406	1 076	932	168	151	305	np	..	4 038
Outer regional	np	np	647	155	193	127	..	106	1 783

TABLE 10A.24

Table 10A.24 **Availability of GPs by region (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Remote	np	np	44	66	np	np	..	np	219
Very remote	np	..	33	25	np	np	..	np	112
Outer regional, remote and very remote	377	214	724	246	243	137	..	173	2 114
Total	7 301	5 564	4 655	1 973	1 630	443	266	172	22 005
Number of FSE GPs per 100 000 people									
2014-15									
Major cities	98.7	95.3	102.2	78.8	99.8	..	69.2	..	95.4
Inner regional	97.4	97.3	97.4	71.5	82.4	90.2	np	..	94.7
Outer regional	np	np	93.5	82.1	95.2	76.5	..	75.5	85.7
Remote	np	np	55.3	62.9	np	np	..	np	67.7
Very remote	np	..	55.5	38.1	np	np	..	np	53.8
Outer regional, remote and very remote	77.4	85.9	87.2	68.5	92.2	77.6	..	70.6	80.9
Total	97.1	95.2	98.6	76.7	96.7	86.1	68.9	70.2	93.7

FSE = Full Service Equivalent. 1 FSE is approximately equivalent to a 37.5 hour working week.

- (a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which are based on a different classification.
- (b) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; and no inner regional or major cities in the NT.
- (c) Data include vocationally registered GPs and other medical practitioners (OMPs).
- (d) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FSE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (e) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to compute the number of GPs (associated with a small reduction in historical data for the number of GPs) and use of a new proxy measure for hours worked (FSE) in place of the previously used 'Full time Workload Equivalents' (FWE).
- (f) Full Service Equivalent (FSE) is an estimated measure of medical workforce based on Medicare claims information. FSE models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.
- (g) For the ACT, inner regional area data are not reported for confidentiality reasons, but are included in major cities data.

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

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.25

Table 10A.25 Availability of female GPs (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Female GPs										
2005-06	no.	2 804	2 122	1 760	806	690	253	176	135	8 746
2006-07	no.	2 909	2 213	1 811	852	715	265	178	150	9 095
2007-08	no.	2 978	2 324	1 915	876	765	278	185	167	9 489
2008-09	no.	3 112	2 430	2 071	964	799	288	188	191	10 043
2009-10	no.	3 272	2 534	2 174	1 000	824	302	187	195	10 488
2010-11	no.	3 481	2 679	2 299	1 075	867	315	212	229	11 156
2011-12	no.	3 691	2 879	2 529	1 115	918	350	228	241	11 953
2012-13	no.	4 010	3 058	2 770	1 219	967	369	231	269	12 891
2013-14	no.	4 259	3 332	2 939	1 349	1 050	386	247	301	13 865
2014-15	no.	4 545	3 534	3 080	1 468	1 102	410	261	293	14 695
Female FSE GPs										
2005-06	no.	1 499	993	885	345	297	105	65	28	4 216
2006-07	no.	1 581	1 068	932	362	312	108	70	31	4 463
2007-08	no.	1 706	1 170	1 036	390	340	117	75	38	4 871
2008-09	no.	1 768	1 226	1 104	414	359	122	76	42	5 111
2009-10	no.	1 861	1 303	1 167	443	385	128	77	47	5 412
2010-11	no.	1 968	1 380	1 218	455	395	134	88	48	5 686
2011-12	no.	2 083	1 466	1 288	464	412	137	94	51	5 995
2012-13	no.	2 214	1 596	1 372	497	436	143	99	56	6 413
2013-14	no.	2 411	1 765	1 498	580	466	152	111	62	7 045
2014-15	no.	2 630	1 952	1 633	662	509	171	115	70	7 742
Female FSE GPs as a proportion of all FSE GPs										
2005-06	%	28.4	27.4	28.3	26.6	24.5	31.8	37.6	34.6	27.9
2006-07	%	28.9	28.2	28.9	27.1	25.3	32.0	37.0	36.0	28.5
2007-08	%	29.8	29.0	30.0	27.5	26.0	32.8	37.5	39.6	29.3

TABLE 10A.25

Table 10A.25 Availability of female GPs (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	%	30.3	29.6	30.8	28.8	26.8	33.7	37.6	42.4	30.0
2009-10	%	31.0	30.2	31.2	29.6	27.6	33.9	37.2	42.7	30.7
2010-11	%	31.9	30.6	31.8	30.1	27.8	34.6	41.1	41.4	31.3
2011-12	%	32.9	31.5	32.8	30.3	28.6	34.8	42.2	43.6	32.2
2012-13	%	33.9	32.7	33.5	30.6	29.6	35.2	40.9	42.7	33.1
2013-14	%	34.9	33.8	34.5	32.3	30.3	36.3	43.4	41.3	34.2
2014-15	%	36.0	35.1	35.1	33.6	31.2	38.6	43.2	40.7	35.2
Female FSE GPs (e)										
2005-06	per 100 000 females	44.2	39.1	44.6	34.3	38.0	42.4	38.5	28.1	41.2
2006-07	per 100 000 females	46.2	41.4	45.9	35.2	39.5	43.4	40.9	30.6	43.0
2007-08	per 100 000 females	49.2	44.6	49.7	36.8	42.5	46.7	43.2	36.6	46.1
2008-09	per 100 000 females	50.1	45.7	51.6	37.8	44.4	48.2	43.0	39.5	47.4
2009-10	per 100 000 females	52.1	47.7	53.4	39.4	47.1	50.2	42.8	43.3	49.3
2010-11	per 100 000 females	54.4	49.7	54.8	39.5	47.9	52.3	48.0	43.9	51.1
2011-12	per 100 000 females	57.0	52.0	56.9	39.1	49.6	53.3	50.4	46.2	53.0
2012-13	per 100 000 females	59.8	55.6	59.4	40.6	52.0	55.7	51.9	49.9	55.7
2013-14	per 100 000 females	64.1	60.3	63.7	46.0	55.1	58.9	57.5	54.1	60.2
2014-15	per 100 000 females	69.0	65.6	68.5	51.9	59.7	66.1	58.9	60.8	65.2

FSE = Full Service Equivalent. 1 FSE is approximately equivalent to a 37.5 hour working week.

- (a) Data include vocationally registered GPs and other medical practitioners billing DHS Medicare.
- (b) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FSE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (c) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to compute the number of GPs (associated with a small reduction in historical data for the number of GPs) and use of a new proxy measure for hours worked (FSE) in place of the previously used 'Full time Workload Equivalents' (FWE).

TABLE 10A.25

Table 10A.25 **Availability of female GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(d)	Full Service Equivalent (FSE) is an estimated measure of medical workforce based on Medicare claims information. FSE models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.									
(e)	Rates are derived using the ABS female ERP for 31 December of the reference year. From 2011-12, the first preliminary ERP based on the 2011 Census is used. For 2010-11 and previous years, the final 2011 Census rebased ERP is used.									

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.26

Table 10A.26 Availability of male GPs (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Male GPs										
2005-06	no.	4 590	3 490	2 872	1 381	1 233	364	186	170	14 286
2006-07	no.	4 657	3 538	2 894	1 406	1 237	362	183	167	14 445
2007-08	no.	4 727	3 579	2 991	1 431	1 289	375	183	178	14 755
2008-09	no.	4 768	3 667	3 128	1 447	1 304	379	183	196	15 073
2009-10	no.	4 863	3 779	3 247	1 448	1 339	395	194	222	15 487
2010-11	no.	4 954	3 886	3 367	1 499	1 353	394	196	239	15 888
2011-12	no.	5 075	4 026	3 546	1 568	1 385	402	205	248	16 456
2012-13	no.	5 286	4 207	3 715	1 684	1 430	429	214	261	17 226
2013-14	no.	5 502	4 351	3 882	1 811	1 463	450	213	297	17 968
2014-15	no.	5 700	4 499	4 027	1 913	1 505	436	228	273	18 580
Male FSE GPs										
2005-06	no.	3 780	2 638	2 243	950	913	225	108	54	10 911
2006-07	no.	3 892	2 723	2 289	974	919	229	119	55	11 198
2007-08	no.	4 022	2 869	2 419	1 028	966	240	126	59	11 730
2008-09	no.	4 076	2 915	2 478	1 026	981	241	126	57	11 898
2009-10	no.	4 148	3 018	2 576	1 052	1 009	250	129	63	12 244
2010-11	no.	4 200	3 129	2 610	1 059	1 026	254	126	68	12 472
2011-12	no.	4 253	3 194	2 636	1 069	1 029	257	129	66	12 633
2012-13	no.	4 309	3 288	2 722	1 126	1 039	263	143	76	12 967
2013-14	no.	4 494	3 454	2 844	1 212	1 073	267	145	87	13 576
2014-15	no.	4 671	3 612	3 022	1 311	1 121	272	151	102	14 262
Male FSE GPs as a proportion of all FSE GPs										
2005-06	%	71.6	72.7	71.7	73.4	75.5	68.2	62.4	66.7	72.1
2006-07	%	71.1	71.8	71.1	73.0	74.7	68.0	63.0	64.0	71.5
2007-08	%	70.2	71.0	70.0	72.5	73.9	67.2	63.0	61.5	70.7

TABLE 10A.26

Table 10A.26 Availability of male GPs (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	%	69.7	70.4	69.2	71.3	73.2	66.6	62.4	57.6	70.0
2009-10	%	69.0	69.9	68.8	70.4	72.4	66.1	62.3	57.3	69.3
2010-11	%	68.1	69.4	68.2	69.9	72.2	65.6	58.9	58.6	68.7
2011-12	%	67.1	68.5	67.2	69.8	71.4	65.2	57.8	56.4	67.8
2012-13	%	66.0	67.3	66.5	69.4	70.4	64.8	59.1	58.0	66.9
2013-14	%	65.1	66.2	65.5	67.6	69.8	63.7	56.6	58.0	65.8
2014-15	%	64.0	64.9	64.9	66.4	68.8	61.4	56.8	59.3	64.8
Male FSE GPs (e)										
2005-06	per 100 000 males	113.6	106.3	113.4	92.9	119.7	93.5	65.5	50.1	108.2
2006-07	per 100 000 males	115.8	107.8	113.1	93.0	119.2	94.4	71.1	50.2	109.3
2007-08	per 100 000 males	117.8	111.4	116.5	95.5	123.9	97.8	74.0	52.3	112.3
2008-09	per 100 000 males	117.3	110.7	116.0	92.1	124.2	96.9	72.3	49.0	111.3
2009-10	per 100 000 males	117.6	112.4	118.1	92.2	126.0	99.4	72.5	52.8	112.5
2010-11	per 100 000 males	117.8	115.0	117.9	90.7	127.0	100.1	69.5	56.2	113.0
2011-12	per 100 000 males	118.3	115.9	117.2	89.0	126.4	100.9	70.0	54.1	113.0
2012-13	per 100 000 males	118.1	117.0	118.3	90.2	126.2	102.9	75.7	61.0	113.7
2013-14	per 100 000 males	121.3	120.5	121.6	94.0	129.1	104.3	75.9	68.0	117.0
2014-15	per 100 000 males	124.4	124.0	127.7	100.5	133.7	106.0	78.4	79.0	121.3

FSE = Full Service Equivalent. 1 FSE is approximately equivalent to a 37.5 hour working week.

- (a) Data include vocationally registered GPs and other medical practitioners billing DHS Medicare.
- (b) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FSE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (c) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to compute the number of GPs (associated with a small reduction in historical data for the number of GPs) and use of a new proxy measure for hours worked (FSE) in place of the previously used 'Full time Workload Equivalents' (FWE).

TABLE 10A.26

Table 10A.26 **Availability of male GPs (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(d)	Full Service Equivalent (FSE) is an estimated measure of medical workforce based on Medicare claims information. FSE models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.									
(e)	Rates are derived using the ABS male ERP for 31 December of the reference year. From 2011-12, the first preliminary ERP based on the 2011 Census is used. For 2010-11 and previous years, the final 2011 Census rebased ERP is used.									

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.27

Table 10A.27 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
FTE dentists per 100 000 population (h)									
2010									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
2011 (i)									
Major cities	4.9	4.8	6.6	6.1	8.6	..	7.2	..	5.6
Inner regional	3.5	4.7	6.3	3.7	3.5	5.4	–	..	4.6
Outer regional	1.9	4.1	7.4	3.2	5.6	np	..	13.2	5.0
Remote and very remote (j)	np	–	np	10.0	np	–	..	8.9	6.1
Total (k)	4.4	4.7	6.5	5.8	7.6	3.7	7.2	11.3	5.4
2012 (l)									
Major cities	5.6	4.5	5.6	5.9	6.5	..	7.0	..	5.5
Inner regional	4.4	3.3	6.0	4.3	2.5	5.6	–	..	4.5
Outer regional	1.8	3.2	7.9	3.3	4.4	np	..	8.0	4.7
Remote and very remote (j)	np	–	3.4	6.3	np	–	..	8.3	5.1
Total (k)	5.1	4.2	6.0	5.6	5.7	3.9	7.0	8.1	5.2
2013 (l)									
Major cities	6.1	4.8	6.3	6.0	8.1	..	3.8	..	5.9
Inner regional	4.8	4.9	7.1	5.7	3.7	6.4	np	..	5.5
Outer regional	2.6	5.4	11.6	3.6	6.9	np	..	10.7	6.8
Remote and very remote (j)	np	–	6.4	8.8	–	–	..	9.0	6.9
Total (k)	5.7	4.8	7.3	6.0	7.2	4.4	4.1	10.0	5.9

TABLE 10A.27

Table 10A.27 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
2014 (m)									
Major cities	6.1	6.3	6.9	6.7	8.6	..	7.0	..	6.6
Inner regional	4.5	5.8	8.0	6.0	4.4	9.5	np	..	6.1
Outer regional	2.7	8.6	10.1	5.3	8.4	3.0	..	15.0	7.4
Remote and very remote (j)	np	–	10.8	6.5	3.3	np	..	9.6	7.9
Total (k)	5.6	6.3	7.8	6.5	8.0	7.4	7.3	12.7	6.6

FTE = Full Time Equivalent. FTE based on a 40-hour week.

- (a) Data include dentists employed in the dentist workforce, on extended leave and looking for work in the dentist workforce.
- (b) For 2014, data are based on all clinical hours worked in the public sector, including by those who also work in the private sector. For 2013 and previous years, data are for dentists working in the public sector only — in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas; hours worked by dentists working in both public and private sectors are excluded. This constitutes a break in time series. Data for 2014 are not comparable with data for previous years.
- (c) Remoteness areas for 2012 and subsequent years are defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing. Remoteness areas for 2011 are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS 2006 Census of population and housing.
- (d) Allocation to State or Territory is derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Where none of these is available, location is coded 'unstated'. Data for Australia include location unstated.
- (e) Allocation to region is based on postcode of main job where available; otherwise, postcode of principal practice is used as a proxy. If principal practice details are unavailable, postcode of residence is used. Where none of these is available, location is coded 'unstated' and data are included in 'Total'.
- (f) There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.
- (g) Data for Australia include those with location 'unstated'.
- (h) FTE based on a 40-hour week.
- (i) Data for 2011 are for total hours worked by dentists employed in the public sector and include provisional registrants. Dentists working in both the public and the private sector are excluded.
- (j) Remote and very remote includes Migratory areas.
- (k) Total includes those with remoteness area unstated.

TABLE 10A.27

Table 10A.27 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d), (e)**

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

- (l) Data for 2012 and 2013 are for clinical hours worked by dentists employed in the public sector and exclude provisional registrants. Dentists working in both the public and the private sector are excluded.
- (m) Data for 2014 and subsequent years are for clinical hours worked in the public sector by dentists working some hours in the public and/or the private sector. This constitutes a break in time series; data for 2014 are not comparable with data for previous years. Data for 2014 exclude provisional registrants.

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

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.28

Table 10A.28 Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
2010									
FTE dental hygienists per 100 000 population									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
FTE dental therapists per 100 000 population									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	na	na	na	na	na	na	na	na	na
2011 (h)									
FTE dental hygienists per 100 000 population									
Major cities	0.1	np	0.2	0.7	0.6	..	np	..	0.2
Inner regional	–	–	–	–	–	–	–	..	–
Outer regional	–	np	np	–	–	–	..	–	0.1
Remote and very remote (i)	–	–	–	–	–	–	..	–	–
Total (j)	0.1	–	0.1	0.5	0.5	–	0.3	–	0.1
FTE dental therapists per 100 000 population									
Major cities	1.7	1.3	5.3	5.2	3.8	..	2.5	..	2.8
Inner regional	3.3	2.2	6.4	5.4	7.8	6.5	–	..	4.3
Outer regional	2.5	1.5	6.0	7.6	7.0	8.8	..	9.5	5.4
Remote and very remote (i)	np	–	3.6	6.8	6.7	–	..	4.7	5.0
Total (j)	2.1	1.5	5.6	5.6	4.8	7.2	2.5	7.4	3.4

TABLE 10A.28

Table 10A.28 Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
2012 (k)									
FTE dental hygienists per 100 000 population									
Major cities	0.2	0.1	np	0.4	0.8	..	np	..	0.2
Inner regional	np	np	–	–	–	–	–	..	–
Outer regional	–	np	np	–	–	–	..	–	0.1
Remote and very remote (i)	–	–	–	–	–	–	..	np	0.3
Total (j)	0.1	0.1	0.1	0.3	0.6	–	0.2	0.7	5.2
FTE dental therapists per 100 000 population									
Major cities	1.7	1.4	5.1	5.2	4.0	..	2.7	..	2.8
Inner regional	3.7	2.2	6.2	5.8	5.0	5.9	np	..	4.2
Outer regional	2.9	0.9	6.3	7.8	8.7	6.0	..	8.7	5.4
Remote and very remote (i)	–	–	3.3	4.2	5.1	np	..	5.7	4.2
Total (j)	2.1	1.5	5.4	5.4	4.7	6.1	3.0	7.4	3.3
2013 (k)									
FTE dental hygienists per 100 000 population									
Major cities	0.1	np	–	0.3	0.5	..	–	..	0.1
Inner regional	–	np	–	–	–	–	–	..	–
Outer regional	–	–	–	–	np	–	..	np	0.1
Remote and very remote (i)	np	–	–	–	–	–	..	–	–
Total (j)	0.1	–	–	0.3	0.4	–	–	0.2	0.1
FTE dental therapists per 100 000 population									
Major cities	1.8	2.0	4.7	5.2	4.0	..	3.3	..	3.0
Inner regional	3.7	2.0	6.0	6.1	4.2	np	–	..	4.1
Outer regional	2.5	1.8	5.7	6.6	8.6	8.1	..	8.7	5.3
Remote and very remote (i)	–	–	4.4	4.4	5.6	7.5	..	7.0	4.7
Total (j)	2.2	2.0	5.1	5.3	4.7	7.2	3.3	7.9	3.4

TABLE 10A.28

Table 10A.28 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
2014 (l)									
FTE dental hygienists per 100 000 population									
Major cities	0.1	0.1	–	0.4	0.2	..	np	..	0.1
Inner regional	–	np	–	–	–	–	–	..	–
Outer regional	–	–	np	–	–	–	..	np	0.1
Remote and very remote (i)	–	–	–	np	–	–	..	–	0.2
Total (j)	0.1	0.1	–	0.4	0.2	–	0.3	0.4	0.1
FTE dental therapists per 100 000 population									
Major cities	1.8	2.3	4.3	5.4	5.0	..	3.9	..	3.1
Inner regional	3.5	2.4	6.0	4.7	4.9	7.4	–	..	4.1
Outer regional	2.5	1.6	6.5	6.9	7.4	8.4	..	8.5	5.5
Remote and very remote (i)	–	–	2.9	4.7	3.3	np	..	7.6	4.1
Total (j)	2.1	2.2	4.9	5.4	5.2	7.8	3.9	8.2	3.5

FTE = Full Time Equivalent. FTE based on a 40-hour week.

- (a) Data include dental hygienists and dental therapists who are employed, on extended leave and looking for work, in the dental hygiene and dental therapy workforces, respectively. Dual registered practitioners (those registered as both dental therapists and dental hygienists) are included in dental therapists data and are excluded from dental hygienists data.
- (b) For 2014, data are based on all clinical hours worked in the public sector, including by those who also work in the private sector. For 2013 and previous years, data are for those working in the public sector only — in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas; those working in both public and private sectors are excluded. This constitutes a break in time series. Data for 2014 are not comparable with data for previous years.
- (c) Remoteness areas for 2012 and subsequent years are defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing. Remoteness areas for 2011 are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS 2006 Census of population and housing.
- (d) Allocation to State or Territory is derived from state and territory of main job where available; otherwise, state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Where none of these is available, location is coded 'unstated'. Data for Australia include location unstated.

TABLE 10A.28

Table 10A.28 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (f)</i>	<i>ACT (f)</i>	<i>NT (f)</i>	<i>Aust (g)</i>
(e)	Allocation to region is based on postcode of main job where available; otherwise, postcode of principal practice is used as a proxy. If principal practice details are unavailable, postcode of residence is used. Where none of these is available, location is coded 'unstated' and data are included in 'Total'.								
(f)	There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.								
(g)	Data for Australia include those with location 'unstated'.								
(h)	Data for 2011 are for total hours worked by dental hygienists and dental therapists employed in the public sector and include provisional registrants. Those working in both the public and the private sector are excluded.								
(i)	Remote and very remote includes Migratory areas.								
(j)	Total includes those with remoteness area unstated.								
(k)	Data for 2012 and 2013 are for clinical hours worked by those employed in the public sector and exclude provisional registrants. Those working in both the public and the private sector are excluded.								
(l)	Data for 2014 and subsequent years are for clinical hours worked in the public sector by those working some hours in the public and/or the private sector. This constitutes a break in time series; data for 2014 are not comparable with data for previous years. Data for 2014 exclude provisional registrants.								

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

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.29

Table 10A.29 **Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (k)</i>	<i>WA (k)</i>	<i>SA (k)</i>	<i>Tas (l)</i>	<i>ACT (l)</i>	<i>NT (l)</i>	<i>Aust (m)</i>
2011									
FTE employed psychologists per 100 000 population (c)									
Major cities	35.7	29.6	27.1	35.4	24.6	..	68.4	..	32.4
Inner regional	27.0	15.1	20.7	23.0	7.0	31.2	–	..	21.8
Outer regional	18.2	7.5	25.7	23.3	4.4	11.2	..	43.8	19.5
Remote/very remote (n)	17.2	–	10.4	21.1	6.0	–	..	17.6	14.9
Total (o)	32.9	25.8	25.1	32.4	19.6	24.1	68.3	32.3	28.9
2012 (i)									
FTE employed occupational therapists per 100 000 population (b), (k)									
Major cities	23.5	29.7	na	na	na	..	np	..	na
Inner regional	21.9	26.9	na	na	na	np	np	..	na
Outer regional	np	20.5	na	na	na	np	..	36.4	na
Remote/very remote (n)	np	–	na	na	na	np	..	14.5	na
Total (o)	22.4	28.7	na	na	na	19.1	27.3	26.8	na
FTE employed psychologists per 100 000 population (c)									
Major cities	26.5	19.2	19.2	23.9	18.1	..	41.6	..	22.7
Inner regional	21.9	12.2	13.8	10.8	4.7	29.4	–	..	16.8
Outer regional	13.3	5.3	17.8	14.5	np	np	..	34.7	14.1
Remote/very remote (n)	10.5	–	12.3	15.0	np	np	..	11.0	11.9
Total (o)	24.7	17.3	17.7	21.4	14.3	23.2	41.5	25.6	20.6
2013									
FTE employed occupational therapists per 100 000 population (b)									
Major cities	23.9	30.5	25.0	28.1	31.9	..	26.6	..	27.0
Inner regional	23.0	28.4	17.7	16.7	17.0	28.9	–	..	23.1
Outer regional	np	21.2	27.7	24.2	20.1	np	..	34.6	22.0

TABLE 10A.29

Table 10A.29 **Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i> (k)	<i>WA</i> (k)	<i>SA</i> (k)	<i>Tas</i> (l)	<i>ACT</i> (l)	<i>NT</i> (l)	<i>Aust</i> (m)
Remote/very remote (n)	np	–	15.6	15.3	18.7	np	..	15.3	14.5
Total (o)	23.0	29.7	23.7	25.9	28.3	22.4	26.6	26.2	25.6
FTE employed psychologists per 100 000 population (c)									
Major cities	33.0	25.8	23.7	32.4	22.0	..	60.4	..	29.1
Inner regional	26.7	18.7	17.1	16.0	6.5	27.5	np	..	21.1
Outer regional	18.4	5.8	25.1	19.0	4.7	13.0	..	45.6	19.2
Remote/very remote (n)	19.3	–	7.6	18.3	7.6	np	..	19.3	14.0
Total (o)	30.9	23.6	22.1	28.9	17.7	22.4	60.5	34.2	26.5
2014 (a)									
FTE employed occupational therapists per 100 000 population									
Major cities	22.3	29.4	25.3	26.1	30.6	..	26.3	..	25.9
Inner regional	22.3	29.9	17.5	14.9	13.6	26.0	–	..	22.7
Outer regional	np	np	28.9	28.1	29.6	np	..	34.2	24.0
Remote/very remote (n)	np	np	18.0	16.4	16.5	np	..	22.0	17.3
Total (o)	21.7	29.3	24.1	24.6	28.2	22.1	26.2	29.0	25.0
FTE employed psychologists per 100 000 population									
Major cities	30.5	26.1	22.0	29.3	21.1	..	50.7	..	27.5
Inner regional	25.5	18.0	15.5	14.9	6.5	31.0	117.0	..	20.4
Outer regional	16.1	8.6	18.1	19.1	np	np	..	37.0	16.1
Remote/very remote (n)	12.7	–	7.2	17.6	np	np	..	16.2	12.8
Total (o)	28.6	23.8	19.7	26.4	17.1	24.7	51.0	28.2	24.9

FTE = Full Time Equivalent

TABLE 10A.29

Table 10A.29 **Availability of public Occupational Therapists and Psychologists (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld (k)</i>	<i>WA (k)</i>	<i>SA (k)</i>	<i>Tas (l)</i>	<i>ACT (l)</i>	<i>NT (l)</i>	<i>Aust (m)</i>
(a)	For 2014, data are based on hours worked in a clinical role (occupational therapists) or direct client services role (psychologists) in the public sector, including by those who also work in the private sector. For 2013 and previous years, data are for practitioners working in the public sector only and exclude practitioners who work in both the public and private sectors. This constitutes a break in time series. Data for 2014 are not comparable with data for previous years.								
(b)	For Occupational Therapists, data for 2013 and previous years are for clinical hours worked by occupational therapists employed in the public sector and exclude practitioners who work in both the public and private sectors.								
(c)	For Psychologists:								
	- data for 2011 are based on total hours worked only by practitioners employed in the public sector								
	- data for 2012 are based on clinical hours worked only by practitioners employed in the public sector								
	- data for 2013 are based on hours worked in a direct client service role only by practitioners employed in the public sector.								
(d)	Data exclude provisional registrants.								
(e)	Historical data have been revised and may differ from previous reports.								
(f)	Occupational therapists joined the National Registration and Accreditation Scheme (NRAS) 1 July 2012. Data are not available for previous years.								
(g)	Remoteness areas are defined using the Australian Statistical Geography Standard (ASGS), based on the ABS 2011 Census of population and housing.								
(h)	Allocation to State or Territory is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, location is coded 'unstated' and data are included for Australia.								
(i)	Allocation to region is based on postcode of main job where available; otherwise, postcode of principal practice is used as a proxy. If principal practice details are unavailable, postcode of residence is used. Where none of these is available, location is coded 'unstated' and data are included in 'Total'.								
(j)	FTE based on a 38-hour week.								
(k)	Occupational therapist workforce data are not available for 2012 for Queensland, WA or SA. Due to transitional arrangements to the National Registration and Accreditation Scheme, many occupational therapists were not required to renew their registration and so did not complete a workforce survey.								
(l)	There are no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.								
(m)	Data for Australia include those with location 'unstated'.								
(n)	Remote/very remote includes Migratory areas.								
(o)	Total includes those with remoteness area unstated.								

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

Source: AIHW unpublished, National Health Workforce Data Set.

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09										
Indigenous older people										
Number of people assessed (g)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (h)	no.	17 726	3 868	13 432	6 329	2 994	2 168	286	5 133	51 967
Proportion of target population assessed	%	8.3	6.9	11.5	12.6	4.7	1.1	8.4	19.3	10.1
Non-Indigenous older people										
Number of people assessed (i)	no.	111 344	73 138	62 716	21 998	27 423	9 486	2 430	283	308 818
Target population (j)	no.	457 989	343 315	232 677	116 062	120 952	34 610	15 362	2 521	1 323 516
Proportion of target population assessed	%	24.3	21.3	27.0	19.0	22.7	27.4	15.8	11.2	23.3
2009-10										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population (h)	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion of target population assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
Non-Indigenous older people										
Number of people assessed (i)	no.	116 756	77 946	65 087	24 451	28 049	9 151	2 724	292	324 456
Target population (j)	no.	467 220	350 473	237 999	119 044	122 469	35 271	15 843	2 666	1 351 013
Proportion of target population assessed	%	25.0	22.2	27.3	20.5	22.9	25.9	17.2	11.0	24.0
2010-11										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465
Target population (h)	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of target population assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
Non-Indigenous older people										
Number of people assessed (i)	no.	130 114	90 493	74 576	29 865	31 394	10 976	3 169	302	370 889
Target population (j)	no.	478 253	358 105	244 178	122 815	123 854	35 826	16 360	2 825	1 382 248
Proportion of target population assessed	%	27.2	25.3	30.5	24.3	25.3	30.6	19.4	10.7	26.8
2011-12										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population (h)	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion of target population assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
Non-Indigenous older people										
Number of people assessed (i)	no.	137 445	96 176	79 933	31 879	32 887	11 499	3 271	314	393 404
Target population (j)	no.	487 126	365 944	250 898	126 677	125 660	36 643	16 919	3 023	1 412 742
Proportion of target population assessed	%	28.2	26.3	31.9	25.2	26.2	31.4	19.3	10.4	27.8
2012-13										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727
Target population (h)	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion of target population assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
Non-Indigenous older people										

TABLE 10A.30

Table 10A.30 Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of people assessed (i)	no.	146 182	101 897	87 240	35 745	35 332	12 887	3 818	373	423 474
Target population (j)	no.	499 610	375 719	258 431	130 987	127 857	37 541	17 635	3 268	1 450 718
Proportion of target population assessed	%	29.3	27.1	33.8	27.3	27.6	34.3	21.7	11.4	29.2
2013-14										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	6 540	846	6 771	2 792	801	365	101	2 745	20 961
Target population (h)	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion of target population assessed	%	28.1	17.5	37.6	32.8	20.9	12.9	20.4	40.5	30.6
Non-Indigenous older people										
Number of people assessed (i)	no.	157 080	112 061	95 169	41 646	39 774	13 764	4 282	547	464 323
Target population (j)	no.	510 562	385 295	266 773	135 602	130 089	38 318	18 316	3 481	1 488 095
Proportion of target population assessed	%	30.8	29.1	35.7	30.7	30.6	35.9	23.4	15.7	31.2
2014-15										
Aboriginal and Torres Strait Islander older people										
Number of people assessed (g)	no.	7 565	1 006	7 614	3 158	957	544	128	2 774	23 746
Target population (h)	no.	24 555	5 078	19 076	9 033	4 021	2 991	531	7 224	72 548
Proportion of target population assessed	%	30.8	19.8	39.9	35.0	23.8	18.2	24.1	38.4	32.7
Non-Indigenous older people										
Number of people assessed (i)	no.	163 253	114 829	101 082	43 402	39 533	13 275	4 256	720	480 350
Target population (j)	no.	523 637	393 878	276 664	140 517	132 364	39 254	19 064	3 726	1 528 757
Proportion of target population assessed	%	31.2	29.2	36.5	30.9	29.9	33.8	22.3	19.3	31.4

TABLE 10A.30

Table 10A.30 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(a)	Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.									
(b)	Indigenous status is determined by self-identification. Aboriginal and Torres Strait Islander people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander people.									
(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)	Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.									
(e)	Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.									
(f)	Rates have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.									
(g)	Includes claims for MBS items 704, 706 and 715, for Aboriginal and Torres Strait Islander people aged 55 years or over.									
(h)	Derived population of Aboriginal and Torres Strait Islander people aged 55 years or over at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.									
(i)	Includes claims for MBS items 700, 702, 701, 703, 705 and 707, for people aged 75 years or over.									
(j)	Estimated population of non-Indigenous people aged 75 years or over as at 31 December, computed by subtracting the derived population of Aboriginal and Torres Strait Islander people aged 75 or over (see footnote (h)) from the December 31 ERP for all Australians aged 75 years or over. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Aboriginal and Torres Strait Islander population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.									

Source: Department of Health unpublished, MBS data collection; ABS various years, *Australian Demographic Statistics*, Cat. no. 3201.0; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.31

Table 10A.31 **Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	16 856	3 666	12 669	5 996	2 870	2 066	247	4 923	49 324
Proportion of target population assessed	%	6.8	7.5	10.0	10.3	4.4	0.3	4.0	17.4	8.7
2008-09										
Number of people assessed	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population	no.	17 726	3 868	13 432	6 329	2 994	2 168	286	5 133	51 967
Proportion of target population assessed	%	8.3	6.9	11.5	12.6	4.7	1.1	8.4	19.3	10.1
2009-10										
Number of people assessed	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion of target population assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
2010-11										
Number of people assessed	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465
Target population	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868
Proportion of target population assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
2011-12										
Number of people assessed	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion of target population assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
2012-13										
Number of people assessed	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727

TABLE 10A.31

Table 10A.31 **Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (g)</i>
Target population	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion of target population assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
2013-14										
Number of people assessed	no.	6 540	846	6 771	2 792	801	365	101	2 745	20 961
Target population	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion of target population assessed	%	28.1	17.5	37.6	32.8	20.9	12.9	20.4	40.5	30.6
2014-15										
Number of people assessed	no.	7 565	1 006	7 614	3 158	957	544	128	2 774	23 746
Target population	no.	24 555	5 078	19 076	9 033	4 021	2 991	531	7 224	72 548
Proportion of target population assessed	%	30.8	19.8	39.9	35.0	23.8	18.2	24.1	38.4	32.7

- (a) Older Aboriginal and Torres Strait Islander people are defined as aged 55 years or over, excluding people living in residential aged care facilities.
- (b) Includes claims for MBS items 704, 706 and 715 for Aboriginal and Torres Strait Islander people aged 55 years or over. Indigenous status is determined by self-identification. Aboriginal and Torres Strait Islander people aged 75 years or over may have received a health assessment available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander people.
- (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 people. Data for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.
- (d) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (f) Target population is the derived population of Aboriginal and Torres Strait Islander people aged 55 years of over at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been revised to the ABS' final 2011 Census rebased estimates and projections and may differ from previous reports. See chapter 2 (tables 2A.1 and 2A.13-14) for details.

TABLE 10A.31

Table 10A.31 **Older Aboriginal and Torres Strait Islander people who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

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

(g) Includes Other Territories.

Source: Department of Health unpublished, MBS data collection; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
2009-10										
Children 0–14 years										
Children assessed	no.	4 159	841	5 913	2 403	392	73	62	2 808	16 651
Target population	no.	75 637	16 552	69 806	30 913	12 846	8 582	1 974	22 764	239 157
Proportion assessed	%	5.5	5.1	8.5	7.8	3.1	0.9	3.1	12.3	7.0
Adults 15–54 years										
People assessed	no.	9 633	1 981	12 639	6 095	1 101	193	202	8 035	39 879
Target population	no.	108 367	24 656	98 192	48 429	20 142	12 605	3 508	39 892	355 929
Proportion assessed	%	8.9	8.0	12.9	12.6	5.5	1.5	5.8	20.1	11.2
Adults 55 years or over (f)										
People assessed	no.	1 652	337	2 053	1 021	153	36	46	1 186	6 484
Target population	no.	18 646	4 092	14 257	6 674	3 141	2 278	328	5 360	54 807
Proportion assessed	%	8.9	8.2	14.4	15.3	4.9	1.6	14.0	22.1	11.8
2010-11										
Children 0–14 years										
Children assessed	no.	6 046	801	8 349	2 371	476	112	68	3 933	22 156
Target population	no.	75 671	16 789	70 518	30 932	13 013	8 629	1 987	22 616	240 239
Proportion assessed	%	8.0	4.8	11.8	7.7	3.7	1.3	3.4	17.4	9.2
Adults 15–54 years										
People assessed	no.	11 073	1 614	11 844	5 020	1 325	315	150	6 599	37 940
Target population	no.	111 226	25 545	101 122	49 543	20 673	12 912	3 680	40 361	365 202
Proportion assessed	%	10.0	6.3	11.7	10.1	6.4	2.4	4.1	16.4	10.4
Adults 55 years or over (f)										
People assessed	no.	3 216	422	3 149	1 509	450	109	36	1 574	10 465

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
Target population	no.	19 654	4 312	15 114	7 068	3 303	2 399	376	5 609	57 868
Proportion assessed	%	16.4	9.8	20.8	21.3	13.6	4.5	9.6	28.1	18.1
2011-12										
Children 0–14 years										
Children assessed	no.	8 520	1 150	12 133	2 436	800	137	197	5 270	30 643
Target population	no.	75 697	17 008	71 105	30 934	13 123	8 669	2 007	22 513	241 139
Proportion assessed	%	11.3	6.8	17.1	7.9	6.1	1.6	9.8	23.4	12.7
Adults 15–54 years										
People assessed	no.	14 933	2 148	18 475	5 355	1 767	449	286	7 229	50 642
Target population	no.	114 004	26 419	104 124	50 694	21 205	13 250	3 819	40 967	374 626
Proportion assessed	%	13.1	8.1	17.7	10.6	8.3	3.4	7.5	17.6	13.5
Adults 55 years or over (f)										
People assessed	no.	4 156	558	4 588	1 632	509	185	48	1 764	13 440
Target population	no.	20 775	4 489	16 001	7 541	3 469	2 519	423	5 934	61 185
Proportion assessed	%	20.0	12.4	28.7	21.6	14.7	7.3	11.4	29.7	22.0
2012-13										
Children 0–14 years										
Children assessed	no.	10 733	1 570	15 197	3 959	1 003	234	214	5 598	38 508
Target population	no.	75 863	17 171	71 812	31 038	13 205	8 733	2 006	22 498	242 410
Proportion assessed	%	14.1	9.1	21.2	12.8	7.6	2.7	10.7	24.9	15.9
Adults 15–54 years										
People assessed	no.	17 762	2 717	22 585	8 597	2 342	664	448	9 202	64 317
Target population	no.	116 702	27 292	107 067	51 912	21 734	13 598	3 961	41 703	384 118
Proportion assessed	%	15.2	10.0	21.1	16.6	10.8	4.9	11.3	22.1	16.7

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
Adults 55 years or over (f)										
People assessed	no.	5 166	718	5 447	2 191	604	262	73	2 266	16 727
Target population	no.	21 979	4 644	16 978	8 032	3 644	2 659	460	6 343	64 773
Proportion assessed	%	23.5	15.5	32.1	27.3	16.6	9.9	15.9	35.7	25.8
2013-14										
Children 0–14 years										
Children assessed	no.	13 112	1 912	18 287	5 200	1 536	236	211	6 747	47 241
Target population	no.	76 189	17 360	72 773	31 147	13 311	8 823	2 019	22 487	244 192
Proportion assessed	%	17.2	11.0	25.1	16.7	11.5	2.7	10.5	30.0	19.3
Adults 15–54 years										
People assessed	no.	21 413	3 540	26 689	11 040	3 368	847	493	11 153	78 543
Target population	no.	119 324	28 149	109 829	53 172	22 250	13 909	4 099	42 416	393 298
Proportion assessed	%	17.9	12.6	24.3	20.8	15.1	6.1	12.0	26.3	20.0
Adults 55 years or over (f)										
People assessed	no.	6 540	846	6 771	2 792	801	365	101	2 745	20 961
Target population	no.	23 245	4 841	18 025	8 520	3 830	2 826	495	6 779	68 597
Proportion assessed	%	28.1	17.5	37.6	32.8	20.9	12.9	20.4	40.5	30.6
2014-15										
Children 0–14 years										
Children assessed	no.	15 245	2 389	22 104	6 011	2 017	337	396	6 702	55 201
Target population	no.	76 789	17 602	73 883	31 248	13 415	8 933	2 043	22 472	246 471
Proportion assessed	%	19.9	13.6	29.9	19.2	15.0	3.8	19.4	29.8	22.4
Adults 15–54 years										
People assessed	no.	24 278	4 068	31 203	11 828	3 912	1 127	869	11 239	88 524

TABLE 10A.32

Table 10A.32 **Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)**
(a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
Target population	no.	121 782	28 962	112 577	54 462	22 788	14 219	4 232	43 128	402 300
Proportion assessed	%	19.9	14.0	27.7	21.7	17.2	7.9	20.5	26.1	22.0
Adults 55 years or over (f)										
People assessed	no.	7 565	1 006	7 614	3 158	957	544	128	2 774	23 746
Target population	no.	24 555	5 078	19 076	9 033	4 021	2 991	531	7 224	72 548
Proportion assessed	%	30.8	19.8	39.9	35.0	23.8	18.2	24.1	38.4	32.7

- (a) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (b) Allocation of patients to state/territory based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided. Indigenous status is determined by self-identification.
- (c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Aboriginal and Torres Strait Islander people. Data are therefore likely to understate the proportion who access health assessments.
- (d) Target population is the derived population of Aboriginal and Torres Strait Islander people in the age group at 31 December, computed by averaging the estimates/projections at 30 June at each end of the reference year. Historical data have been 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.
- (e) Includes Other Territories.
- (f) Aboriginal and Torres Strait Islander people aged 75 years or over may have received a health assessment available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Aboriginal and Torres Strait Islander people.

Source: Department of Health unpublished, MBS data collection; ABS various years, *Australian Demographic Statistics*, Cat. no. 3201.0; ABS 2014, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.33

Table 10A.33 Annual health assessments for older people (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2006-07										
Older people assessed	no.	96 803	64 658	51 221	17 798	24 883	7 907	1 737	176	265 183
Older people	no.	457 509	333 152	235 712	116 423	120 858	35 603	14 772	7 126	1 321 206
Proportion assessed	%	21.16	19.41	21.73	15.29	20.59	22.21	11.76	2.47	20.07
2007-08										
Older people assessed	no.	104 776	66 478	57 405	19 384	26 741	8 301	2 337	1 039	286 461
Older people	no.	466 836	340 221	241 060	119 456	122 578	36 154	15 228	7 409	1 348 993
Proportion assessed	%	22.44	19.54	23.81	16.23	21.82	22.96	15.35	14.02	21.24
2008-09										
Older people assessed	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Older people	no.	475 715	347 182	246 109	122 391	123 946	36 778	15 647	7 654	1 375 483
Proportion assessed	%	23.71	21.14	26.11	18.63	22.24	25.86	15.68	16.67	22.83
2009-10										
Older people assessed	no.	118 408	78 283	67 140	25 472	28 202	9 187	2 770	1 478	330 940
Older people	no.	485 866	354 565	252 255	125 718	125 610	37 549	16 171	8 026	1 405 819
Proportion assessed	%	24.37	22.08	26.62	20.26	22.45	24.47	17.13	18.42	23.54
2010-11										
Older people assessed	no.	133 330	90 915	77 725	31 374	31 844	11 085	3 205	1 876	381 354
Older people	no.	497 907	362 416	259 291	129 883	127 157	38 225	16 736	8 434	1 440 116
Proportion assessed	%	26.78	25.09	29.98	24.16	25.04	29.00	19.15	22.24	26.48
2011-12										
Older people assessed	no.	141 601	96 734	84 521	33 511	33 396	11 684	3 319	2 078	406 844
Older people	no.	507 900	370 433	266 899	134 218	129 129	39 162	17 341	8 957	1 473 927
Proportion assessed	%	27.88	26.11	31.67	24.97	25.86	29.84	19.14	23.20	27.60
2012-13										
Older people assessed	no.	151 348	102 615	92 687	37 936	35 936	13 149	3 891	2 639	440 201
Older people	no.	521 589	380 362	275 409	139 019	131 501	40 200	18 095	9 611	1 515 491

TABLE 10A.33

Table 10A.33 Annual health assessments for older people (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion assessed	%	29.02	26.98	33.65	27.29	27.33	32.71	21.50	27.46	29.05
2013-14										
Older people assessed	no.	163 620	112 907	101 940	44 438	40 575	14 129	4 383	3 292	485 284
Older people	no.	533 806	390 136	284 798	144 121	133 919	41 144	18 811	10 259	1 556 691
Proportion assessed	%	30.65	28.94	35.79	30.83	30.30	34.34	23.30	32.09	31.17
2014-15										
Older people assessed	no.	170 818	115 835	108 696	46 560	40 490	13 819	4 384	3 494	504 096
Older people	no.	548 192	398 955	295 740	149 549	136 384	42 245	19 595	10 949	1 601 305
Proportion assessed	%	31.16	29.03	36.75	31.13	29.69	32.71	22.37	31.91	31.48

- (a) Older people are defined as Aboriginal and Torres Strait Islander people aged 55 years or over and non-Indigenous people aged 75 years or over, excluding people living in residential aged care facilities.
- (b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.
- (c) Allocation to State/Territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.
- (d) Rates have been 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.
- (e) Derived target populations as at 31 December are computed as the average of the population estimates / projections at June 30 at each end of the reference year. Historical data have been 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 data collection; 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.34

Table 10A.34 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (h)</i>	<i>ACT (h)</i>	<i>NT (g)</i>	<i>Aust (h)</i>
2009-10 (h)										
Aboriginal and Torres Strait Islander Child Health Check (i)	%	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (j)	%	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Total	%	20.6	6.9	28.5	16.3	10.5	19.2	12.3	29.2	17.8
2010-11										
Aboriginal and Torres Strait Islander Child Health Check (i)	%	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (j)	%	25.7	7.1	34.4	16.3	12.5	22.8	12.8	31.2	20.7
Total	%	26.3	7.3	35.2	17.5	12.7	21.5	12.8	44.6	21.7
2011-12 (a), (k)										
Aboriginal and Torres Strait Islander Child Health Check (i)	no.	2 326	338	3 198	774	204	47	61	1 367	8 315
Target population	no.	5 173	1 188	4 897	2 150	883	609	123	1 545	16 559
Proportion of target population assessed	%	45.0	28.5	65.3	36.0	23.1	7.7	49.8	88.5	50.2
Healthy Kids Check (j)	no.	46 372	16 885	37 595	12 480	7 201	3 219	1 218	805	125 775
Target population	no.	88 936	69 237	56 498	29 660	18 731	5 844	4 543	2 107	275 592
Proportion of target population assessed	%	52.1	24.4	66.5	42.1	38.4	55.1	26.8	38.2	45.6
Total (k)	no.	48 698	17 223	40 793	13 254	7 405	3 266	1 279	2 172	134 090
Target population (k)	no.	94 109	70 425	61 394	31 810	19 614	6 453	4 666	3 652	292 151
Proportion of target population assessed	%	51.7	24.5	66.4	41.7	37.8	50.6	27.4	59.5	45.9

TABLE 10A.34

Table 10A.34 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (h)</i>	<i>ACT (h)</i>	<i>NT (g)</i>	<i>Aust (h)</i>
2012-13 (a), (k)										
Aboriginal and Torres Strait Islander Child Health Check (i)	no.	2 864	403	3 791	1 106	271	64	48	1 489	10 036
Target population	no.	5 106	1 199	5 050	2 118	917	642	130	1 500	16 664
Proportion of target population assessed	%	56.1	33.6	75.1	52.2	29.6	10.0	37.1	99.3	60.2
Healthy Kids Check (j)	no.	56 223	21 201	42 969	14 021	9 502	3 668	1 823	931	150 338
Target population	no.	90 363	70 506	58 037	30 663	19 013	5 856	4 755	2 162	281 380
Proportion of target population assessed	%	62.2	30.1	74.0	45.7	50.0	62.6	38.3	43.1	53.4
Total (k)	no.	59 087	21 604	46 760	15 127	9 773	3 732	1 871	2 420	160 374
Target population (k)	no.	95 469	71 705	63 087	32 781	19 929	6 497	4 885	3 662	298 044
Proportion of target population assessed	%	61.9	30.1	74.1	46.1	49.0	57.4	38.3	66.1	53.8
2013-14 (a), (g), (k)										
Aboriginal and Torres Strait Islander Child Health Check (i)	no.	3 206	471	4 397	1 290	354	42	57	1 714	11 531
Target population	no.	5 182	1 191	5 131	2 103	919	625	142	1 450	16 746
Proportion of target population assessed (g)	%	61.9	39.5	85.7	61.3	38.5	6.7	40.3	118.2	68.9
Healthy Kids Check (j)	no.	59 486	19 662	45 372	15 377	10 169	3 578	2 063	858	156 565
Target population	no.	91 582	71 916	58 606	31 431	19 119	5 750	4 976	2 232	285 636
Proportion of target population assessed	%	65.0	27.3	77.4	48.9	53.2	62.2	41.5	38.4	54.8

TABLE 10A.34

Table 10A.34 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (h)</i>	<i>ACT (h)</i>	<i>NT (g)</i>	<i>Aust (h)</i>
Total (k)	no.	62 692.0	20 133.0	49 769.0	16 667.0	10 523.0	3 620.0	2 120.0	2 572.0	168 096.0
Target population	no.	96 763	73 107	63 737	33 534	20 038	6 375	5 117	3 682	302 381
Proportion of target population assessed	%	64.8	27.5	78.1	49.7	52.5	56.8	41.4	69.9	55.6
2014-15 (a), (g), (k)										
Aboriginal and Torres Strait Islander Child Health Check (i)	no.	3 772	641	5 029	1 458	512	81	94	1 718	13 305
Target population	no.	5 129	1 226	5 026	2 029	916	586	150	1 377	16 443
Proportion of target population assessed (g)	%	73.5	52.3	100.1	71.9	55.9	13.8	62.7	124.8	80.9
Healthy Kids Check (j)	no.	63 087	20 318	46 584	16 184	11 161	3 386	2 342	862	163 924
Target population	no.	89 206	71 971	59 658	31 044	19 316	5 918	4 787	2 481	284 403
Proportion of target population assessed	%	70.7	28.2	78.1	52.1	57.8	57.2	48.9	34.8	57.6
Total (k)	no.	66 859	20 959	51 613	17 642	11 673	3 467	2 436	2 580	177 229
Target population	no.	94 335	73 197	64 683	33 072	20 232	6 504	4 937	3 858	300 846
Proportion of target population assessed	%	70.9	28.6	79.8	53.3	57.7	53.3	49.3	66.9	58.9

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

(b) Reference year is based on the date the service was provided. Data may differ from other reports in which reference year is based on the date the claim was processed.

TABLE 10A.34

Table 10A.34 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (h)</i>	<i>ACT (h)</i>	<i>NT (g)</i>	<i>Aust (h)</i>
(c)	Allocation to State/Territory is based on patient postcode at the date their last service was processed in the reference period. This is not necessarily where the service was received. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided.									
(d)	Children are counted only once in the numerator.									
(e)	From the 2010-11 reference period, children who received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period are counted against the Aboriginal and Torres Strait Islander health assessment.									
(f)	Target 4 year old population is as at 31 December of the reference year. For Aboriginal and Torres Strait Islander health checks, the target population is computed as the average of the 4 year old population estimates / projections at June 30 at each end of the reference year. For the Healthy Kids Check, the target non-Indigenous population is computed by subtracting the derived population of Aboriginal and Torres Strait Islander 4 year olds from the 4 year old ERP. Historical data 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.									
(g)	For the NT for 2013-14 and 2014-15, and for Queensland for 2014-15, data for the proportion of Aboriginal and Torres Strait Islander children who received a health check exceeds 100 per cent. This is largely because numerator and denominator are not directly comparable — children are eligible to receive this health assessment at the age of 3, 4 or 5 years. However, a child is eligible to receive it once only (children may also be eligible for other health checks) — hence, the denominator uses population estimates and projections for a single year of age — 4 years. Using this methodology, the total number of children aged 3, 4 and 5 years who received a check in 2013-14 exceeds the derived population of Aboriginal and Torres Strait Islander children aged 4 years.									
(h)	Data for Aboriginal and Torres Strait Islander Child Health Checks are not published for Tasmania or the ACT for 2009-10 due to small numbers, but are included in the total for Australia.									
(i)	Includes claims for Medicare Benefits Schedule (MBS) Item 708 (Aboriginal and Torres Strait Islander Child Health Check, available to 30 April 2010) and Item 715 (Aboriginal and Torres Strait Islander People's Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years for 2012-13 and subsequent years, and aged 3 or 4 years for 2011-12 and previous years. 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 for Aboriginal and Torres Strait Islander people are therefore likely to understate the proportion who access health assessments.									

TABLE 10A.34

Table 10A.34 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)**
(a), (b), (c), (d), (e), (f)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld (g)</i>	<i>WA</i>	<i>SA</i>	<i>Tas (h)</i>	<i>ACT (h)</i>	<i>NT (g)</i>	<i>Aust (h)</i>
(j)	Includes claims for MBS items 709 and 711 (Healthy Kids Check, available to 30 April 2010) and items 701, 703, 705, 707 and 10986 (Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years for 2011-12 and subsequent years, and aged 3 or 4 years for 2010-11 and previous years. Data do not include developmental health check activity conducted outside Medicare, such as State and Territory early childhood health assessments in preschools and community health centres. This is known to be a particular issue for several jurisdictions. For example, in Victoria, the Victorian Maternal and Child Health Service provided a 3.5 year old Key Ages and Stages consultation to 47 638 children in the 2011-12 financial year. Data include Aboriginal and Torres Strait Islander children who received a Healthy Kids Check and did not also receive a health check under MBS items 708 or 715.									
(k)	Data for 2011-12 and subsequent years include Aboriginal and Torres Strait Islander and non-Indigenous children aged 3, 4 or 5 years who received a health assessment under the specified MBS items, provided they had not received such a check in a previous reference year. This constitutes a break in time series for the data. Data from 2011-12 should not be compared with data for 2010-11 and previous years, which are limited to children aged 3 or 4 years.									

np Not published.

Source: Department of Health unpublished, MBS Statistics; ABS unpublished, *Australian demographic statistics*, Cat. no. 3101.0; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1996 to 2026*, B series, Cat. no. 3238.0.

TABLE 10A.35

Table 10A.35 **Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d), (e)**

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Aust (f)</i>
2012-13						
0–15 years	89.6	88.0	88.5	91.7	93.9	89.3
16–64 years	78.7	72.3	73.7	74.7	84.9	77.2
65 years or over	90.4	88.2	89.3	91.6	94.0	89.8
All ages (g)	83.4	79.4	80.3	81.4	88.0	82.4
2013-14						
0–15 years	90.2	89.7	90.1	92.3	93.8	90.2
16–64 years	80.2	74.4	75.9	75.8	85.2	78.8
65 years or over	90.6	88.9	89.7	91.7	94.2	90.2
All ages (g)	84.4	81.1	81.9	82.2	88.3	83.6
2014-15						
0–15 years	91.0	91.4	91.7	92.9	94.2	91.2
16–64 years	81.4	75.9	77.4	76.6	85.5	80.1
65 years or over	90.8	89.3	89.9	91.9	94.2	90.4
All ages (g)	85.3	82.2	83.1	82.9	88.5	84.6

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

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

(c) Patient age as at date of service.

(d) Allocation to remoteness area based on patients' Medicare enrolment postcode.

(e) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to identify GPs.

(f) Australia includes attendances where patient postcodes could not be allocated to a remoteness area.

(g) All ages includes attendances where patient age is unknown.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.36

Table 10A.36 **Non-referred attendances that were bulk billed by age (per cent)**
(a), (b), (c), (d), (e)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
2005-06									
0-15 years	87.2	78.2	83.4	86.7	85.9	78.9	52.7	67.4	83.5
16-64 years	78.1	67.2	66.7	60.7	65.3	61.6	34.5	58.3	69.6
65 years or over	87.4	85.5	86.0	89.3	87.0	83.3	63.7	85.4	86.4
All ages	81.9	73.6	74.2	71.7	74.4	69.9	43.3	62.8	76.0
2006-07									
0-15 years	88.5	80.4	85.5	88.5	87.9	81.9	63.0	67.1	85.4
16-64 years	80.0	69.5	68.9	62.1	68.1	64.3	43.6	59.5	71.8
65 years or over	88.6	86.3	87.1	89.9	88.2	85.3	67.4	85.6	87.5
All ages	83.5	75.5	76.1	73.1	76.6	72.5	51.4	63.8	77.9
2007-08									
0-15 years	89.2	81.7	86.5	90.1	89.5	84.4	62.3	69.6	86.4
16-64 years	81.2	71.4	70.6	62.5	70.5	66.9	45.5	62.2	73.3
65 years or over	89.4	86.9	87.8	90.3	89.3	86.7	68.1	86.6	88.2
All ages	84.5	76.9	77.4	73.9	78.5	74.8	52.6	66.3	79.1
2008-09									
0-15 years	89.9	82.9	88.0	90.8	90.6	85.8	62.5	67.3	87.4
16-64 years	81.7	72.3	71.5	61.9	71.6	66.7	45.6	61.5	73.9
65 years or over	90.0	87.5	88.7	90.6	90.0	87.0	67.1	87.0	88.9
All ages	85.1	77.8	78.5	73.8	79.6	75.1	52.6	65.5	79.8
2009-10									
0-15 years	90.4	83.9	89.3	90.7	91.3	87.5	64.8	72.8	88.2
16-64 years	81.1	73.6	73.5	62.2	70.1	68.3	40.1	65.7	74.3
65 years or over	90.4	88.2	89.7	91.0	90.6	88.0	66.7	88.8	89.5
All ages	85.0	79.0	80.3	74.2	79.2	76.7	49.6	69.8	80.5
2010-11									
0-15 years	90.4	84.6	89.4	90.8	91.5	86.9	62.2	76.4	88.4
16-64 years	81.9	74.6	74.5	61.5	70.4	68.1	38.3	68.5	75.0
65 years or over	90.7	88.3	89.9	90.7	90.2	88.0	65.6	89.4	89.6
All ages	85.6	79.7	80.9	73.7	79.3	76.6	48.1	72.5	80.9
2011-12									
0-15 years	90.8	85.8	89.5	90.6	92.0	86.5	65.7	81.4	88.9
16-64 years	82.8	76.1	75.1	61.0	72.6	67.0	40.7	70.8	76.0
65 years or over	90.9	88.5	89.8	89.8	90.0	87.3	65.2	90.1	89.6
All ages	86.2	80.8	81.2	73.1	80.5	75.8	50.0	75.1	81.6
2012-13									
0-15 years	91.0	86.9	89.6	90.6	91.9	86.9	68.3	86.4	89.3

TABLE 10A.36

Table 10A.36 **Non-referred attendances that were bulk billed by age (per cent)**
(a), (b), (c), (d), (e)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
16–64 years	83.8	77.8	76.1	61.7	73.7	68.0	48.1	75.6	77.2
65 years or over	91.1	88.9	90.0	89.6	89.9	88.3	65.9	90.8	89.8
All ages	86.9	82.0	81.8	73.4	81.1	76.8	55.1	79.4	82.4
2013-14									
0–15 years	91.6	88.1	90.6	91.5	92.3	88.1	69.5	89.5	90.2
16–64 years	85.1	79.3	77.7	65.6	75.4	69.0	50.5	79.7	78.8
65 years or over	91.5	89.3	90.6	89.6	90.2	88.6	66.9	91.6	90.2
All ages	87.8	83.2	83.1	75.8	82.2	77.7	57.1	83.0	83.6
2014-15									
0–15 years	92.3	89.4	91.7	92.7	92.9	90.2	69.5	94.1	91.2
16–64 years	85.8	80.5	78.9	69.5	76.9	68.7	51.7	83.2	80.1
65 years or over	91.6	89.6	91.0	90.0	90.3	88.6	67.4	92.7	90.4
All ages	88.4	84.2	84.1	78.3	83.2	77.9	58.1	86.4	84.6

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

(b) Patient age as at date of service.

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

(d) All ages includes attendances where patient age is unknown.

(e) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to identify GPs.

(f) Australia includes attendances where patient postcodes could not be allocated to a State/Territory.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.37

Table 10A.37 **People deferring access to GPs due to cost (per cent) (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
2012-13										
Proportion	%	4.5	5.0	5.9	7.7	5.4	7.0	8.8	5.2	5.4
RSE	%	8.7	6.3	7.0	7.4	9.5	9.6	12.1	20.5	3.3
95 per cent confidence interval	±	0.8	0.6	0.8	1.1	1.0	1.3	2.1	2.1	0.4
2013-14 (g)										
Proportion	%	3.5	5.0	5.8	6.2	4.5	6.9	6.9	5.6	4.9
RSE	%	7.6	6.9	6.2	7.5	11.7	10.4	11.3	21.8	2.9
95 per cent confidence interval	±	0.5	0.7	0.7	0.9	1.0	1.4	1.5	2.4	0.3
2014-15 (g)										
Proportion	%	3.2	5.6	5.4	7.0	5.5	7.0	9.7	4.1	5.0
RSE	%	9.0	7.3	7.9	9.2	9.3	11.3	11.7	22.5	3.1
95 per cent confidence interval	±	0.6	0.8	0.8	1.3	1.0	1.5	2.2	1.8	0.3

RSE = Relative standard error.

- (a) People aged 15 years or over who delayed or did not visit a GP at any time in the last 12 months due to cost.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Rates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (d) Data for 2012-13 and subsequent years are not comparable to data for previous years due to a change in question sequencing/wording. See data quality information at www.pc.gov.au/rogs/2016 for further detail.
- (e) Data are not comparable to data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey due to differences in survey design and collection methodology.
- (f) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities, which comprise around 25 per cent of the estimated resident population of the NT.
- (g) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

TABLE 10A.38

Table 10A.38 **Aboriginal and Torres Strait Islander people deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion	%	11.1	12.3	13.0	13.8	7.7	16.3	20.7	11.0	12.2
RSE (c)	%	24.5	28.4	26.9	20.7	43.8	23.9	24.3	40.2	10.2
95 per cent confidence interval	±	5.3	6.9	6.8	5.6	6.6	7.6	9.9	8.7	2.4

RSE = Relative standard error.

- (a) Aboriginal and Torres Strait Islander people aged 15 years or over who reported needing to see a GP in the last 12 months and delayed doing so or did not do so because of cost, divided by the number of Aboriginal and Torres Strait Islander people aged 15 years or over who reported needing to see a GP in the last 12 months.
- (b) Rates are age-standardised to the 2001 Australian standard population using 5 year ranges.
- (c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (d) Data are not comparable with data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

TABLE 10A.39

Table 10A.39 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
2012-13										
Within four hours										
Proportion	%	63.9	63.7	66.2	61.5	65.2	53.9	60.0	51.9	63.8
RSE	%	2.5	3.1	3.2	4.5	2.5	6.3	7.6	10.0	1.3
95 per cent confidence interval	±	3.2	3.8	4.2	5.5	3.2	6.6	8.9	10.2	1.6
Four to less than 24 hours										
Proportion	%	9.5	11.7	11.2	11.8	13.5	15.4	13.2	13.8	11.2
RSE	%	11.1	11.8	13.8	15.3	10.8	12.9	21.3	25.3	5.1
95 per cent confidence interval	±	2.1	2.7	3.0	3.5	2.9	3.9	5.5	6.8	1.1
24 hours or more										
Proportion	%	26.5	24.5	22.6	26.8	21.2	30.7	26.9	34.3	25.0
RSE	%	5.4	7.5	7.5	9.0	8.1	10.4	13.0	13.9	3.1
95 per cent confidence interval	±	2.8	3.6	3.3	4.7	3.4	6.2	6.9	9.4	1.5
2013-14 (f)										
Within four hours										
Proportion	%	64.7	63.4	65.4	65.2	64.7	51.8	58.3	78.4	64.2
RSE	%	3.3	0.6	2.5	4.9	4.8	5.6	9.6	7.3	1.4
95 per cent confidence interval	±	4.1	0.7	3.2	6.2	6.0	5.7	11.0	11.2	1.7
Four to less than 24 hours										
Proportion	%	8.2	10.4	10.4	8.8	12.2	16.0	19.2	12.7	10.0
RSE	%	18.4	14.5	19.8	19.5	16.7	22.1	21.4	33.0	8.2
95 per cent confidence interval	±	2.9	3.0	4.0	3.4	4.0	6.9	8.1	8.2	1.6
24 hours or more										
Proportion	%	26.7	25.9	24.0	27.1	21.5	34.8	26.4	6.4	25.8
RSE	%	5.6	8.9	7.0	10.5	11.5	8.2	17.1	44.8	2.2
95 per cent confidence interval	±	2.9	4.5	3.3	5.6	4.9	5.6	8.8	5.6	1.1
2014-15 (f)										
Within four hours										
Proportion	%	67.2	65.7	61.7	58.1	58.2	53.3	53.2	74.1	63.9
RSE	%	2.5	3.0	6.5	6.7	7.4	8.2	10.1	5.1	1.9
95 per cent confidence interval	±	3.2	3.9	7.8	7.6	8.4	8.6	10.6	7.4	2.4

TABLE 10A.39

Table 10A.39 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Four to less than 24 hours										
Proportion	%	10.0	9.7	12.4	11.3	13.9	13.5	20.5	9.2	11.1
RSE	%	12.1	15.2	12.4	20.4	17.8	12.4	18.1	37.9	5.5
95 per cent confidence interval	±	2.4	2.9	3.0	4.5	4.8	3.3	7.3	6.8	1.2
24 hours or more										
Proportion	%	22.1	25.6	26.6	30.6	26.7	32.7	25.9	14.9	25.0
RSE	%	10.7	6.4	9.3	10.5	5.8	5.1	14.2	39.8	3.8
95 per cent confidence interval	±	4.6	3.2	4.8	6.3	3.1	3.3	7.2	11.7	1.9

RSE = relative standard error.

- (a) Time waited between making an appointment and seeing the GP for urgent medical care.
- (b) People aged 15 years or over who saw a GP for urgent medical care for their own health in the last 12 months. 'Urgent' as defined by respondent. Discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash).
- (c) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (d) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.
- (e) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities, which comprise around 25 per cent of the estimated resident population of the NT.
- (f) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

TABLE 10A.40

Table 10A.40 **Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent) (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2012-13										
Proportion	%	20.2	21.2	17.5	24.4	20.5	22.5	22.0	22.0	20.5
RSE	%	3.1	3.0	4.6	4.4	4.8	5.3	7.3	9.0	1.9
95 per cent confidence interval	±	1.2	1.3	1.6	2.1	1.9	2.3	3.2	3.9	0.7
2013-14 (e)										
Proportion	%	23.9	22.6	19.2	24.5	21.9	23.4	25.1	26.5	22.6
RSE	%	2.6	3.0	3.7	4.7	3.7	4.8	6.3	8.4	1.5
95 per cent confidence interval	±	1.2	1.3	1.4	2.3	1.6	2.2	3.1	4.3	0.7
2014-15 (e)										
Proportion	%	22.5	20.9	18.1	18.9	21.3	23.3	26.7	19.4	20.8
RSE	%	2.9	2.9	4.9	5.4	3.4	4.9	6.6	9.8	1.4
95 per cent confidence interval	±	1.3	1.2	1.7	2.0	1.4	2.2	3.4	3.7	0.6

RSE = relative standard error.

- (a) Persons aged 15 years or over who saw a GP in the previous 12 months, excluding interviews by proxy.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data from 2012-13 are not comparable to data for previous years due to a change in question sequencing. See data quality information at www.pc.gov.au/rogs/2016 for further detail.
- (d) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities, which comprise around 25 per cent of the estimated resident population of the NT.
- (e) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, Patient Experience Survey (various years), Cat. no. 4839.0.

TABLE 10A.41

Table 10A.41 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	<i>NSW (d)</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2013-14	1 047 230	625 844	450 179	314 196	172 423	61 577	53 325	57 483	2 782 257
2014-15	1 060 202	615 857	435 856	331 795	166 003	61 079	55 753	54 832	2 781 377

- (a) 'GP-type' emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not: admitted to the hospital, referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. Data include appropriate presentations to emergency departments that can only retrospectively be categorised as 'GP-type'.
- (b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.
- (c) Includes all hospitals reporting to the Non-admitted patient emergency department care (NAPEDC) NMDS. Data are not comparable with data in previous reports which were limited to Peer Group A and B hospitals and the Mersey Community Hospital.
- (d) Data for the Albury Base Hospital in NSW are reported in Victorian hospital statistics.

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

TABLE 10A.42

Table 10A.42 **People attending a hospital emergency department who thought the care could have been provided at a general practice, 2010-11 to 2012-13 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2010-11										
Proportion	%	26.3	17.3	19.2	23.5	18.3	23.7	26.9	19.9	21.5
RSE	%	8.2	8.5	9.5	8.4	11.5	14.4	21.5	17.8	4.6
95% confidence interval	±	4.2	2.9	3.6	3.9	4.1	6.7	11.3	7.0	1.9
2011-12										
Proportion	%	21.2	24.1	26.1	27.4	20.2	21.9	25.3	26.2	23.5
RSE	%	7.3	8.2	10.7	8.3	13.5	12.7	16.4	15.2	3.4
95% confidence interval	±	3.0	3.9	5.5	4.5	5.4	5.5	8.1	7.8	1.6
2012-13										
Proportion	%	23.7	22.7	23.6	24.8	23.7	24.1	24.2	22.5	23.6
RSE	%	6.5	6.1	8.0	8.9	12.7	11.8	14.0	14.7	3.5
95% confidence interval	±	3.0	2.7	3.7	4.3	5.9	5.6	6.6	6.5	1.6

RSE = Relative standard error.

- (a) People aged 15 years or over who reported attending a hospital emergency department and thought at the time that the care received could have been provided at a general practice.
- (b) Rates are age-standardised to the 2001 Australian standard population using 5 year age ranges except for ACT and NT, for which 15 year age ranges are used.
- (c) Excludes persons who responded 'Don't know' whether care could have been provided at a GP.
- (d) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities and, in 2010-11 and previous years, very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.

Source: ABS unpublished, Patient Experience Survey 2010-11, 2011-12, 2012-13, Cat. no. 4839.0.

TABLE 10A.43

Table 10A.43 **People deferring access to prescribed medication due to cost (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
2012-13										
Proportion	%	7.4	7.9	9.3	6.8	8.2	8.5	6.7	9.0	7.9
RSE	%	5.3	5.3	6.5	9.4	7.8	10.0	15.4	17.1	2.5
95 per cent confidence interval	%	0.8	0.8	1.2	1.2	1.2	1.7	2.0	3.0	0.4
2013-14 (g)										
Proportion	%	7.0	6.3	9.9	8.4	7.5	8.0	6.7	6.2	7.6
RSE	%	7.0	5.9	6.3	7.6	8.3	9.0	14.7	17.4	2.7
95 per cent confidence interval	±	1.0	0.7	1.2	1.2	1.2	1.4	1.9	2.1	0.4
2014-15 (g)										
Proportion	%	6.9	7.5	8.5	8.0	8.6	7.9	7.4	6.0	7.6
RSE	%	6.4	5.8	5.2	8.8	7.4	7.7	15.2	19.0	3.3
95 per cent confidence interval	±	0.9	0.9	0.9	1.4	1.3	1.2	2.2	2.2	0.5

RSE = Relative standard error.

- (a) People aged 15 years and over who received a prescription for medication from a GP in the last 12 months and delayed using or did not get medication at any time in the last 12 months due to the cost.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (d) Data for 2010-11 and subsequent reference years are comparable over time, but are not comparable with data for 2009 due to a change in the sequencing and wording of the survey question. See data quality information at www.pc.gov.au/rogs/2016 for further detail.
- (e) Data are not comparable to data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (f) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities, which comprise around 25 per cent of the estimated resident population of the NT.
- (g) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

TABLE 10A.44

Table 10A.44 **Aboriginal and Torres Strait Islander people deferring access to prescribed medication due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion	%	24.4	36.3	47.0	45.2	35.3	46.5	24.1	22.8	34.6
RSE (c)	%	19.7	14.8	15.0	19.3	26.0	14.9	37.2	34.1	8.4
95 per cent confidence interval	±	9.4	10.5	13.8	17.1	18.0	13.5	17.6	15.2	5.7

RSE = Relative standard error.

- (a) Aboriginal and Torres Strait Islander people aged 15 years and over who received a prescription for medication in the last 12 months and delayed getting or did not get the medication due to the cost, divided by the number of Aboriginal and Torres Strait Islander people who received a prescription for medication in the last 12 months.
- (b) Rates are age-standardised to the 2001 Australian standard population (10 year ranges).
- (c) Estimates with RSEs between 25 and 50 per cent should be used with caution.
- (d) Data are not comparable to data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.
- (e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).
- (f) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

Table 10A.45 **Median waiting time for public dental care, NSW (days)**

	<i>NSW (a)</i>	<i>Aust (b)</i>
2013-14		
Jurisdiction total	na	np
Indigenous status		
Aboriginal and Torres Strait Islander people	na	np
Non-indigenous	na	np
Not stated	na	np
Remoteness of residence		
Major cities	na	np
Inner regional	na	np
Outer regional	na	np
Remote	na	np
Very remote	na	np
SEIFA of residence		
Quintile 1	na	np
Quintile 2	na	np
Quintile 3	na	np
Quintile 4	na	np
Quintile 5	na	np
2014-15		
Jurisdiction total	np	np
Indigenous status	np	np
Aboriginal and Torres Strait Islander people	np	np
Non-indigenous	np	np
Not stated	np	np
Remoteness of residence		
Major cities	np	np
Inner regional	np	np
Outer regional	np	np
Remote	np	np
Very remote	np	np
SEIFA of residence		
Quintile 1	np	np
Quintile 2	np	np
Quintile 3	np	np
Quintile 4	np	np
Quintile 5	np	np

(a) Data for 2013–14 were not available and data for 2014–15 were unable to be published due to data quality issues.

(b) The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.

na Not available. **np** Not published.

Table 10A.45 **Median waiting time for public dental care, NSW (days)**

	<i>NSW (a)</i>	<i>Aust (b)</i>
--	----------------	-----------------

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.46

Table 10A.46 **Median waiting time for public dental care, Victoria (days) (a), (b), (c), (d)**

	<i>Vic (c)</i>	<i>Aust (e)</i>
2013-14		
Jurisdiction total	133	np
Indigenous status		
Aboriginal and Torres Strait Islander people (c)	..	np
Non-indigenous	133	np
Not stated	133	np
Remoteness of residence (f)		
Major cities	157	np
Inner regional	107	np
Outer regional	47	np
Remote	105	np
Very remote	np	np
SEIFA of residence (f)		
Quintile 1	110	np
Quintile 2	99	np
Quintile 3	146	np
Quintile 4	165	np
Quintile 5	175	np
2014-15		
Jurisdiction total	237	np
Indigenous status		
Aboriginal and Torres Strait Islander people (c)	..	np
Non-indigenous	237	np
Not stated	181	np
Remoteness of residence (f)		
Major cities	266	np
Inner regional	241	np
Outer regional	86	np
Remote	93	np
Very remote	np	np
SEIFA of residence (f)		
Quintile 1	234	np
Quintile 2	181	np
Quintile 3	260	np
Quintile 4	260	np
Quintile 5	266	np

(a) Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care).

Table 10A.46 **Median waiting time for public dental care, Victoria (days) (a), (b), (c), (d)**

	<i>Vic (c)</i>	<i>Aust (e)</i>
(b) Some double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.		
(c) The collection excludes people who are treated under jurisdictional priority client schemes. All Aboriginal and Torres Strait Islander clients in Victoria are treated under jurisdictional priority client schemes.		
(d) Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. See data quality information available at www.pc.gov.au/rogs/2016 for more detail.		
(e) The calculation of an Australian total is not appropriate given that jurisdictions are not comparable.		
(f) SEIFA and remoteness are based on the usual residence of the person, not the location of the service provider. Data exclude records for which a SEIFA quintile or remoteness could not be assigned.		
.. Not applicable. np Not published.		

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.47

Table 10A.47 **Median waiting time for public dental care, Queensland (days) (a), (b), (c), (d)**

	<i>Qld</i>	<i>Aust (e)</i>
2013-14		
Jurisdiction total	401	np
Indigenous status		
Aboriginal and Torres Strait Islander people	108	np
Non-indigenous	417	np
Not stated	322	np
Remoteness of residence (f)		
Major cities	293	np
Inner regional	756	np
Outer regional	358	np
Remote	195	np
Very remote	23	np
SEIFA of residence (f)		
Quintile 1	599	np
Quintile 2	410	np
Quintile 3	353	np
Quintile 4	289	np
Quintile 5	309	np
2014-15		
Jurisdiction total	309	np
Indigenous status		
Aboriginal and Torres Strait Islander people	80	np
Non-indigenous	316	np
Not stated	263	np
Remoteness of residence (f)		
Major cities	312	np
Inner regional	345	np
Outer regional	258	np
Remote	151	np
Very remote	14	np
SEIFA of residence (f)		
Quintile 1	288	np
Quintile 2	318	np
Quintile 3	322	np
Quintile 4	301	np
Quintile 5	344	np

(a) Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care).

TABLE 10A.47

Table 10A.47 **Median waiting time for public dental care, Queensland (days) (a), (b), (c), (d)**

	<i>Qld</i>	<i>Aust (e)</i>
(b) Some double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.		
(c) The collection excludes people who are treated under jurisdictional priority client schemes.		
(d) Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. See data quality information available at www.pc.gov.au/rogs/2016 for more detail.		
(e) The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.		
(f) SEIFA and remoteness are based on the usual residence of the person, not the location of the service provider. Data exclude records for which a SEIFA quintile or remoteness could not be assigned.		

np Not published.

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.48

Table 10A.48 **Median waiting time for public dental care, WA (days)**
(a), (b), (c), (d)

	WA (e)	Aust (f)
2013-14		
Jurisdiction total	398	np
Indigenous status		
Aboriginal and Torres Strait Islander people	379	np
Non-indigenous	403	np
Not stated	343	np
Remoteness of residence (g)		
Major cities	369	np
Inner regional	476	np
Outer regional	511	np
Remote	173	np
Very remote	406	np
SEIFA of residence (g)		
Quintile 1	406	np
Quintile 2	413	np
Quintile 3	388	np
Quintile 4	398	np
Quintile 5	362	np
2014-15		
Jurisdiction total	127	np
Indigenous status		
Aboriginal and Torres Strait Islander people	161	np
Non-indigenous	127	np
Not stated	120	np
Remoteness of residence (g)		
Major cities	116	np
Inner regional	396	np
Outer regional	445	np
Remote	246	np
Very remote	349	np
SEIFA of residence (g)		
Quintile 1	125	np
Quintile 2	140	np
Quintile 3	123	np
Quintile 4	126	np
Quintile 5	123	np

(a) Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care).

Table 10A.48 **Median waiting time for public dental care, WA (days)**
(a), (b), (c), (d)

	WA (e)	Aust (f)
(b)	Some double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.	
(c)	The collection excludes people who are treated under jurisdictional priority client schemes.	
(d)	Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. See data quality information available at www.pc.gov.au/rogs/2016 for more detail.	
(e)	Only includes data for Dental Health Services, the primary but not sole provider of public dental services in Western Australia.	
(f)	The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.	
(g)	SEIFA and remoteness are based on the usual residence of the person, not the location of the service provider. Data exclude records for which a SEIFA quintile or remoteness could not be assigned.	
	np Not published.	

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.49

Table 10A.49 **Median waiting time for public dental care, SA (days)**
(a), (b), (c), (d)

	SA	Aust (e)
2013-14		
Jurisdiction total	100	np
Indigenous status		
Aboriginal and Torres Strait Islander people	63	np
Non-indigenous	104	np
Not stated	21	np
Remoteness of residence (f)		
Major cities	77	np
Inner regional	169	np
Outer regional	329	np
Remote	257	np
Very remote	157	np
SEIFA of residence (f)		
Quintile 1	107	np
Quintile 2	106	np
Quintile 3	95	np
Quintile 4	91	np
Quintile 5	76	np
2014-15		
Jurisdiction total	260	np
Indigenous status		
Aboriginal and Torres Strait Islander people	166	np
Non-indigenous	255	np
Not stated	339	np
Remoteness of residence (f)		
Major cities	234	np
Inner regional	234	np
Outer regional	440	np
Remote	362	np
Very remote	np	np
SEIFA of residence (f)		
Quintile 1	311	np
Quintile 2	257	np
Quintile 3	241	np
Quintile 4	190	np
Quintile 5	212	np

(a) Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care).

Table 10A.49 **Median waiting time for public dental care, SA (days)**
(a), (b), (c), (d)

	SA	Aust (e)
(b)	Some double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.	
(c)	The collection excludes people who are treated under jurisdictional priority client schemes.	
(d)	Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. See data quality information available at www.pc.gov.au/rogs/2016 for more detail.	
(e)	The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.	
(f)	SEIFA and remoteness are based on the usual residence of the person, not the location of the service provider. Data exclude records for which a SEIFA quintile or remoteness could not be assigned.	

np Not published.

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.50

Table 10A.50 **Median waiting time for public dental care, Tasmania (days) (a), (b), (c), (d)**

	<i>Tas</i>	<i>Aust (e)</i>
2013-14		
Jurisdiction total	555	np
Indigenous status		
Aboriginal and Torres Strait Islander people	575	np
Non-indigenous	579	np
Not stated	377	np
Remoteness of residence (f)		
Major cities	..	np
Inner regional	567	np
Outer regional	539	np
Remote	560	np
Very remote	527	np
SEIFA of residence (f)		
Quintile 1	551	np
Quintile 2	557	np
Quintile 3	538	np
Quintile 4	833	np
Quintile 5	986	np
2014-15		
Jurisdiction total	933	np
Indigenous status		
Aboriginal and Torres Strait Islander people	952	np
Non-indigenous	965	np
Not stated	394	np
Remoteness of residence (f)		
Major cities	..	np
Inner regional	933	np
Outer regional	938	np
Remote	949	np
Very remote	528	np
SEIFA of residence (f)		
Quintile 1	942	np
Quintile 2	952	np
Quintile 3	407	np
Quintile 4	968	np
Quintile 5	987	np

(a) Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care).

Table 10A.50 **Median waiting time for public dental care, Tasmania (days) (a), (b), (c), (d)**

	<i>Tas</i>	<i>Aust (e)</i>
(b) Some double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.		
(c) The collection excludes people who are treated under jurisdictional priority client schemes.		
(d) Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. See data quality information available at www.pc.gov.au/rogs/2016 for more detail.		
(e) The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.		
(f) SEIFA and remoteness are based on the usual residence of the person, not the location of the service provider. Data exclude records for which a SEIFA quintile or remoteness could not be assigned.		
.. Not applicable. np Not published.		

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.51

Table 10A.51 **Median waiting time for public dental care, ACT (days) (a), (b), (c), (d)**

	<i>ACT</i>	<i>Aust (e)</i>
2013-14		
Jurisdiction total	151	np
Indigenous status		
Aboriginal and Torres Strait Islander people	144	np
Non-indigenous	134	np
Not stated	154	np
Remoteness of residence (f)		
Major cities	151	np
Inner regional	np	np
Outer regional	np	np
Remote	..	np
Very remote	..	np
SEIFA of residence (f)		
Quintile 1	153	np
Quintile 2	151	np
Quintile 3	160	np
Quintile 4	152	np
Quintile 5	150	np
2014-15		
Jurisdiction total	121	np
Indigenous status		
Aboriginal and Torres Strait Islander people	117	np
Non-indigenous	122	np
Not stated	115	np
Remoteness of residence (f)		
Major cities	121	np
Inner regional	np	np
Outer regional	..	np
Remote	..	np
Very remote	..	np
SEIFA of residence (f)		
Quintile 1	np	np
Quintile 2	119	np
Quintile 3	132	np
Quintile 4	120	np
Quintile 5	120	np

(a) Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care).

Table 10A.51 **Median waiting time for public dental care, ACT (days) (a), (b), (c), (d)**

	<i>ACT</i>	<i>Aust (e)</i>
(b)	Some double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.	
(c)	The collection excludes people who are treated under jurisdictional priority client schemes.	
(d)	Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. See data quality information available at www.pc.gov.au/rogs/2016 for more detail.	
(e)	The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.	
(f)	SEIFA and remoteness are based on the usual residence of the person, not the location of the service provider. Data exclude records for which a SEIFA quintile or remoteness could not be assigned.	
	.. Not applicable. np Not published.	

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.52

Table 10A.52 **Median waiting time for public dental care, NT (days)**

	<i>NT (a)</i>	<i>Aust (b)</i>
2013-14		
Jurisdiction total	np	np
Indigenous status		
Aboriginal and Torres Strait Islander people	np	np
Non-indigenous	np	np
Not stated	np	np
Remoteness of residence		
Major cities	np	np
Inner regional	np	np
Outer regional	np	np
Remote	np	np
Very remote	np	np
SEIFA of residence		
Quintile 1	np	np
Quintile 2	np	np
Quintile 3	np	np
Quintile 4	np	np
Quintile 5	np	np
2014-15		
Jurisdiction total	np	np
Indigenous status		
Aboriginal and Torres Strait Islander people	np	np
Non-indigenous	np	np
Not stated	np	np
Remoteness of residence		
Major cities	np	np
Inner regional	np	np
Outer regional	np	np
Remote	np	np
Very remote	np	np
SEIFA of residence		
Quintile 1	np	np
Quintile 2	np	np
Quintile 3	np	np
Quintile 4	np	np
Quintile 5	np	np

(a) Data for the NT are not published for 2013-14 or 2014-15 due to data quality issues.

Table 10A.52 **Median waiting time for public dental care, NT (days)**

	<i>NT (a)</i>	<i>Aust (b)</i>
(b) The calculation of an Australian total is not appropriate given that jurisdictions are not comparable. See data quality information for more detail.		

np Not published.

Source: AIHW (unpublished) Public dental waiting times data collection.

TABLE 10A.53

Table 10A.53 **Proportion of FSE GPs with vocational registration by region (per cent) (a), (b), (c), (d)**

	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Aust</i>
2005-06	89.7	80.4	74.3	67.7	62.6	86.5
2006-07	89.9	79.8	74.3	67.1	57.8	86.5
2007-08	89.8	79.2	72.8	66.6	59.1	86.3
2008-09	89.9	79.2	73.2	67.8	62.3	86.4
2009-10	89.8	77.1	71.4	67.0	63.5	85.7
2010-11	90.0	76.4	70.7	70.4	67.8	85.7
2011-12	89.4	73.5	71.5	66.7	73.3	84.8
2012-13	88.7	72.6	69.7	66.8	77.4	84.0
2013-14	87.5	70.2	68.3	66.2	75.8	82.5
2014-15	86.3	69.0	66.2	66.4	74.5	81.2

FSE = Full Service Equivalent. 1 FSE is approximately equivalent to a 37.5 hour working week.

- (a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.
- (b) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FSE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (c) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to compute the number of GPs (associated with a small reduction in historical data for the number of GPs) and use of a new proxy measure for hours worked (FSE) in place of the previously used 'Full time Workload Equivalents' (FWE).
- (d) Full Service Equivalent (FSE) is an estimated measure of medical workforce based on Medicare claims information. FSE models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.54

Table 10A.54 **Number and proportion of full time service equivalent (FSE) GPs with vocational registration (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
FSE GPs with vocational registration										
2005-06	no.	4 637	3 096	2 632	1 145	1 071	287	162	58	13 087
2006-07	no.	4 815	3 251	2 707	1 173	1 084	289	177	59	13 554
2007-08	no.	5 041	3 461	2 878	1 246	1 137	309	189	60	14 322
2008-09	no.	5 149	3 548	2 985	1 269	1 166	319	191	66	14 691
2009-10	no.	5 271	3 665	3 085	1 315	1 207	328	195	73	15 139
2010-11	no.	5 376	3 812	3 188	1 343	1 233	330	203	77	15 561
2011-12	no.	5 485	3 838	3 290	1 347	1 234	331	200	80	15 806
2012-13	no.	5 582	3 959	3 432	1 402	1 247	348	221	85	16 275
2013-14	no.	5 829	4 144	3 577	1 518	1 278	347	231	92	17 016
2014-15	no.	6 118	4 334	3 767	1 632	1 331	357	234	102	17 876
Proportion of FSE GPs with vocational registration										
2005-06	%	87.8	85.3	84.1	88.4	88.5	86.9	93.7	71.8	86.5
2006-07	%	88.0	85.8	84.1	87.8	88.1	85.7	93.7	68.1	86.5
2007-08	%	88.0	85.7	83.3	88.0	87.0	86.4	94.4	62.4	86.3
2008-09	%	88.1	85.7	83.3	88.1	87.0	88.0	94.4	66.3	86.4
2009-10	%	87.7	84.8	82.4	88.0	86.6	86.6	94.4	66.1	85.7
2010-11	%	87.2	84.5	83.3	88.7	86.7	85.2	95.0	66.7	85.7
2011-12	%	86.6	82.4	83.8	87.9	85.6	84.0	90.1	68.5	84.8
2012-13	%	85.6	81.0	83.8	86.4	84.6	85.7	91.3	64.7	84.0
2013-14	%	84.4	79.4	82.4	84.7	83.1	82.7	90.4	61.5	82.5
2014-15	%	83.8	77.9	80.9	82.7	81.6	80.8	87.9	59.0	81.2

FSE = Full Service Equivalent. 1 FSE is approximately equivalent to a 37.5 hour working week.

- (a) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FSE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.
- (b) Historical data have been revised and may differ from previous reports. This is due to a change in methodology used to compute the number of GPs (associated with a small reduction in historical data for the number of GPs) and use of a new proxy measure for hours worked (FSE) in place of the previously used 'Full time Workload Equivalents' (FWE).
- (c) Full Service Equivalent (FSE) is an estimated measure of medical workforce based on Medicare claims information. FSE models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.55

Table 10A.55 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009										
Accredited										
AGPAL	no.	1 364	915	782	311	338	115	43	37	3 905
GPA Accreditation <i>plus</i>	no.	315	262	182	86	42	15	22	5	930
Total	no.	1 679	1 177	964	397	380	130	65	42	4 835
General practices	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (b)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
GPA Accreditation <i>plus</i>	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
Quality Practice Accreditation	no.	329	284	197	86	44	32	19	3	994
Total	no.	1 675	1 167	950	416	374	130	59	41	4 812
General practices	no.	2 731	1 691	1 266	569	525	158	91	120	7 151
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
Quality Practice Accreditation	no.	343	291	214	89	44	32	19	4	1 036
2011										
Accredited										
AGPAL	no.	1 318	871	735	327	323	86	38	41	3 739
Quality Practice Accreditation	no.	340	296	206	93	48	33	21	7	1 044
Total	no.	1 658	1 167	941	420	371	119	59	48	4 783

TABLE 10A.55

Table 10A.55 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
General practices	no.	2 712	1 687	1 241	573	537	158	84	105	7 097
Proportion accredited	%	61.1	69.2	75.8	73.3	69.1	75.3	70.2	45.7	67.4
Registered for accreditation (b)										
AGPAL	no.	1 399	926	784	350	339	92	40	57	3 987
Quality Practice Accreditation	no.	373	334	241	102	49	38	23	9	1 169
2012										
Accredited										
AGPAL	no.	1 308	865	719	323	323	85	39	52	3 714
Quality Practice Accreditation	no.	439	344	280	109	65	42	23	10	1 312
Total	no.	1 747	1 209	999	432	388	127	62	62	5 026
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 403	932	781	345	337	87	41	58	3 984
Quality Practice Accreditation	no.	476	362	311	120	71	46	25	11	1 422
2013										
Accredited										
AGPAL	no.	1 284	892	742	333	331	85	38	52	3 757
Quality Practice Accreditation	no.	625	462	382	160	91	59	34	15	1 828
Total	no.	1 909	1 354	1 124	493	422	144	72	67	5 585
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 352	941	784	347	332	86	46	55	3 943
Quality Practice Accreditation	no.	659	485	407	168	98	62	36	19	1 934

TABLE 10A.55

Table 10A.55 **General practices that are accredited at 30 June (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2014 (c)										
Accredited										
AGPAL	no.	1 271	908	748	349	321	84	41	54	3 776
Quality Practice Accreditation	no.	622	460	415	154	107	55	30	26	1 869
Total	no.	1 893	1 368	1 163	503	428	139	71	80	5 645
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 321	946	786	370	337	87	42	57	3 946
Quality Practice Accreditation	no.	663	490	449	167	109	59	30	27	1 994
2015 (c)										
Accredited										
AGPAL	no.	1 307	939	784	381	321	85	43	58	3 918
Quality Practice Accreditation	no.	684	517	468	158	94	56	40	18	2 035
Total	no.	1 991	1 456	1 252	539	415	141	83	76	5 953
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 368	982	815	403	337	87	44	58	4 094
Quality Practice Accreditation	no.	736	551	505	170	99	58	42	20	2 181

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

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

TABLE 10A.55

Table 10A.55 **General practices that are accredited at 30 June (a)**

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

(c) Data for the total number of practices are not available for 2012 or subsequent years. Historical data were collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June". Data were provided by all Divisions of General Practice as required under contractual agreements with Department of Health. The ASD ceased with the transition from Divisions of General Practice to Medicare Locals and no other data source has been identified.

na Not available.

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

TABLE 10A.56

Table 10A.56 **General practice activity in PIP practices (per cent)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Proportion of SWPEs that are in PIP practices (a)										
2004-05	%	76.6	83.9	79.9	80.7	84.3	86.9	80.7	56.5	80.2
2005-06	%	77.2	84.3	80.1	82.2	85.2	88.5	83.4	55.1	80.9
2006-07	%	77.4	84.4	81.3	82.2	85.4	86.0	84.6	53.6	81.2
2007-08	%	77.9	85.0	81.4	82.6	85.1	88.7	86.1	54.9	81.6
2008-09	%	78.5	85.3	82.6	83.7	84.4	88.7	83.4	56.9	82.1
2009-10	%	79.1	85.9	84.0	83.6	84.8	88.4	88.1	59.8	82.9
2010-11	%	79.1	85.8	84.3	83.6	86.0	88.1	88.2	60.5	83.0
2011-12	%	80.6	86.4	85.8	84.8	87.3	89.3	88.3	64.1	84.2
2012-13	%	81.2	86.6	85.7	85.7	87.6	89.2	89.4	66.2	84.6
2013-14	%	81.5	86.9	86.0	86.1	87.3	89.4	89.8	68.8	84.9
Proportion of services provided by PIP practices (b)										
2004-05	%	74.2	82.0	80.0	80.1	83.4	86.5	79.6	58.0	78.7
2005-06	%	75.2	82.7	80.2	81.7	84.8	88.4	82.7	56.6	79.6
2006-07	%	75.6	83.0	81.6	82.0	85.2	86.0	84.4	55.0	80.1
2007-08	%	76.3	83.9	81.8	82.9	85.3	88.8	85.4	56.2	80.8
2008-09	%	76.9	84.3	83.0	84.0	84.6	88.4	83.5	59.5	81.4
2009-10	%	77.9	85.0	84.7	84.0	85.3	88.5	88.1	61.7	82.4
2010-11	%	77.8	84.8	84.6	84.0	86.1	88.2	88.2	61.7	82.4
2011-12	%	79.1	85.4	86.0	84.5	87.3	89.3	88.3	65.6	83.4
2012-13	%	79.7	85.6	85.7	85.5	87.7	89.1	89.7	69.9	83.8
2013-14	%	80.1	86.2	86.0	86.1	87.4	89.1	90.0	73.2	84.2

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

(b) Services may vary in type and quality.

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.57

Table 10A.57 **Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections (a), (b), (c), (d)**

<i>Unit</i>		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2012-13										
All people										
Scripts	no.	2 345 432	1 804 054	1 477 001	492 471	540 712	172 474	66 399	21 061	6 919 604
Population (e)	no.	7 348 899	5 679 633	4 610 932	2 472 717	1 662 169	512 422	379 554	236 869	22 906 352
Rate	per 1000 people	319.2	317.6	320.3	199.2	325.3	336.6	174.9	88.9	302.1
2013-14										
All people										
Scripts	no.	2 393 895	1 919 049	1 414 369	499 336	528 624	164 909	67 164	22 738	7 010 084
Population (e)	no.	7 465 497	5 790 990	4 690 910	2 550 874	1 677 250	513 955	384 147	242 573	23 319 385
Rate	per 1000 people	320.7	331.4	301.5	195.8	315.2	320.9	174.8	93.7	300.6
2014-15										
All people										
Scripts	no.	2 469 245	1 968 117	1 461 719	509 674	543 329	167 039	68 707	22 020	7 209 850
Population (e)	no.	7 565 497	5 886 436	4 750 513	2 581 250	1 691 503	515 235	387 640	244 265	23 625 561
Rate	per 1000 people	326.4	334.3	307.7	197.5	321.2	324.2	177.2	90.1	305.2

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include filled prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) .

(d) A DHS reconciliation process may result in some variance in data for 2014-15.

(e) Estimated resident population at 31 December based on the ABS 2011 Census, first preliminary estimates.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.58

Table 10A.58 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2010-11 to 2011-12 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11										
Scripts	no.	2 280 551	1 853 022	1 353 985	432 750	521 568	163 389	65 432	19 361	6 690 058
Concession card holders	no.	1 793 360	1 410 180	1 067 874	460 274	465 767	159 817	53 085	45 779	5 466 022
Rate	per 1000 holders	1 271.7	1 314.0	1 267.9	940.2	1 119.8	1 022.4	1 232.6	422.9	1 223.9
2011-12										
Scripts	no.	2 349 145	1 761 703	1 400 017	471 336	515 907	171 723	63 802	20 031	6 753 664
Concession card holders	no.	1 810 065	1 434 628	1 082 274	463 942	471 039	163 012	54 111	46 017	5 535 884
Rate	per 1000 holders	1 297.8	1 228.0	1 293.6	1 015.9	1 095.3	1 053.4	1 179.1	435.3	1 220.0

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxicillin; erythromycin; roxithromycin; cefaclor; amoxicillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

(d) Number of concession card holders data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs.

Source: Department of Health unpublished, PBS Statistics.

TABLE 10A.59

Table 10A.59 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2006 to 2011										
Systemic antibiotic prescribed	%	34.7	30.7	33.5	28.1	31.1	24.0	30.3	17.8	32.4
95 per cent confidence interval	±	2.0	2.3	2.6	4.5	4.2	5.9	8.2	9.9	1.2
Encounters for acute URTI management (c)	no.	9 761	6 145	4 388	1 970	1 882	562	641	180	26 025
2007 to 2012										
Systemic antibiotic prescribed	%	35.0	30.1	33.7	28.7	30.1	25.3	33.0	22.8	32.5
95 per cent confidence interval	±	1.9	2.3	2.6	4.3	4.1	5.9	9.9	10.0	1.2
Encounters for acute URTI management (c)	no.	10 384	6 215	4 473	1 979	1 852	542	527	149	26 619
2008 to 2013										
Systemic antibiotic prescribed	%	35.7	29.9	34.1	25.9	28.6	26.5	28.0	21.4	32.5
95 per cent confidence interval	±	2.0	2.3	2.6	3.7	3.7	6.1	8.3	8.8	1.2
Encounters for acute URTI management (c)	no.	10 330	6 003	4 643	2 163	1 673	502	510	140	26 454
2009 to 2014										
Systemic antibiotic prescribed	%	33.0	27.4	33.1	25.6	26.7	26.3	25.7	20.9	30.5
95 per cent confidence interval	±	2.0	2.3	2.5	4.5	3.9	5.8	8.1	9.5	1.2

TABLE 10A.59

Table 10A.59

Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Encounters for acute URTI management (c)	no.	9 691	5 630	4 576	1 953	1 604	533	529	115	25 105
2010 to 2015										
Systemic antibiotic prescribed	%	31.5	26.9	34.5	27.5	27.8	26.1	27.6	22.7	30.2
95 per cent confidence interval	±	1.9	2.1	2.6	4.4	3.9	6.3	8.9	9.4	1.1
Encounters for acute URTI management (c)	no.	9 449	5 753	4 259	2 042	1 718	418	521	128	24 777

URTI = Upper respiratory tract infection.

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

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

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

Source: Britt et al. unpublished, BEACH Statistics.

TABLE 10A.60

Table 10A.60 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia (a), (b), (c)**

	<i>Unit</i>	<i>2006-07</i>	<i>2007-08</i>	<i>2008-09</i>	<i>2009-10</i>	<i>2010-11</i>	<i>2011-12</i>	<i>2012-13</i>	<i>2013-14</i>	<i>2014-15</i>
Encounters for acute URTI management (c)	per 100 GP encounters	5.2	5.6	5.5	5.5	4.9	5.6	5.3	4.4	5.1
95 per cent confidence interval	±	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Systemic antibiotic prescribed for URTI management	%	32.2	29.9	39.0	29.6	31.0	32.8	29.9	29.0	28.2
95 per cent confidence interval	±	2.7	2.5	2.7	2.5	2.4	2.6	2.7	2.6	2.4

URTI = Upper respiratory tract infection.

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

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

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

Source: Britt et al. unpublished, BEACH Statistics.

TABLE 10A.61

Table 10A.61 Uptake by Practices in the Practice Incentives Program (PIP) of the PIP Diabetes Incentive (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP practices (May 2014)	no.	1 812	1 255	1 077	452	367	121	71	55	5 210
SWPE (c)	('000)	5 259	4 346	3 383	1 701	1 301	401	284	101	16 774
PIP Diabetes Incentive — uptake	no.	880	528	585	216	130	44	41	40	2 464
Share of PIP practices	%	48.6	42.1	54.3	47.8	35.4	36.4	57.7	72.7	47.3
PIP practices (May 2015)	no.	1 824	1 282	1 118	482	368	127	71	58	5 330
SWPE (c)	('000)	5 371	4 427	3 481	1 742	1 323	407	288	108	17 146
PIP Diabetes Incentive — uptake	no.	971	586	651	251	143	53	43	46	2 744
Share of PIP practices	%	53.2	45.7	58.2	52.1	38.9	41.7	60.6	79.3	51.5

- (a) Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.56).
- (b) In accordance with the purpose of the PIP Diabetes incentive to encourage general practices to provide earlier diagnosis and effective management of people with established diabetes mellitus, 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 a cycle of care for patients with diabetes mellitus.
- (c) A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.62

Table 10A.62 Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent) (a), (b), (c), (d)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Proportion of people with known diabetes who had a HbA1c test in last 12 months										
Males	%	86.4	72.1	74.7	81.6	84.8	88.2	73.3	84.7	80.4
Females	%	66.9	91.1	58.9	82.6	100.0	85.0	83.2	94.8	73.0
Persons	%	78.4	79.9	69.2	82.1	88.2	86.8	79.1	91.1	77.5
Relative Standard Error (RSE)										
Males	%	12.1	31.7	11.6	15.9	13.2	15.1	42.5	26.7	5.9
Females	%	39.2	13.6	26.0	22.5	0.0	19.5	22.5	7.8	13.4
Persons	%	15.1	14.0	12.5	12.4	9.9	11.1	18.9	8.8	6.3
95% confidence interval										
Males	± %	20.6	44.8	17.0	25.4	22.0	26.1	61.1	44.2	9.2
Females	± %	51.4	24.2	30.0	36.3	–	32.6	36.7	14.5	19.1
Persons	± %	23.2	21.9	16.9	19.9	17.1	19.0	29.2	15.7	9.5

Estimates with RSEs between 25 percent and 50 percent should be used with caution.

- (a) Persons aged 18 years to 69 years. Includes pregnant women.
- (b) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. See data quality information for further detail.
- (c) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79% of people aged 18 years and over who participated in the National Health Measures Survey (NHMS) had fasted.
- (d) Rates are not age standardised.
- (e) Data for the NT should be interpreted with caution as the Australian Health Survey excluded discrete Aboriginal and Torres Strait Islander communities and very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.
– Nil or rounded to zero.

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

TABLE 10A.63

Table 10A.63 **Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent, by sex, 2011-12 (per cent) (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (g)</i>	<i>Aust</i>
<i>Proportion</i>										
Males	%	66.2	41.2	48.5	65.3	41.6	67.4	73.9	23.2	53.8
Females	%	44.9	19.1	43.0	55.6	84.6	72.2	26.5	71.9	45.0
Total	%	56.7	35.5	46.4	61.3	52.1	69.9	44.3	47.7	50.5
<i>Relative standard error</i>										
Males	%	14.1	51.5	22.1	19.5	39.5	19.3	27.9	61.8	11.1
Females	%	31.6	88.0	18.5	30.8	13.9	15.6	63.2	27.6	15.8
Total	%	13.4	46.5	15.3	16.7	28.5	11.4	31.0	31.4	8.8
<i>95 per cent confidence interval</i>										
Males	±	18.3	41.7	21.0	24.9	32.2	25.5	40.3	28.1	11.8
Females	±	27.8	32.9	15.6	33.6	23.1	22.1	32.8	38.8	13.9
Total	±	14.9	32.4	13.9	20.1	29.1	15.7	26.9	29.3	8.7

(a) Estimates with a relative standard error (RSE) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) People aged 18 years to 69 years. Includes pregnant women.

(c) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use.

(d) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the National Health Measures Survey (NHMS) had fasted.

(e) Rates are not age standardised (they are crude rates).

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

(g) Data for the NT should be interpreted with caution as the Australian Health Survey excluded discrete Aboriginal and Torres Strait Islander communities and very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.

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

TABLE 10A.64

Table 10A.64 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a)**

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

TABLE 10A.64

Table 10A.64 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b),(c)</i>	<i>Aust (b)</i>
95 per cent confidence interval	±	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	np	± 4.9
All ages (crude rates)										
Proportion	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	np	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	np	6.0
95 per cent confidence interval	±	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	np	± 2.7
2007-08										
0-14 years										
Proportion	%	46.5	61.6	41.4	29.0	56.1	41.6	47.3	np	47.8
RSE	%	16.3	9.8	17.1	28.1	17.1	20.6	17.1	np	7.6
95 per cent confidence interval	±	± 14.9	± 11.8	± 13.9	± 16.0	± 18.8	± 16.8	± 15.9	np	± 7.1
15-24 years										
Proportion	%	11.9	9.3	14.7	np	7.4	9.6	35.0	np	12.6
RSE	%	47.1	47.0	37.8	np	53.2	69.2	29.0	np	19.5
95 per cent confidence interval	±	± 11.0	± 8.6	± 10.9	np	± 7.7	13.0	± 19.9	np	± 4.8
25-44 years										
Proportion	%	13.8	6.1	14.1	17.0	8.1	11.8	11.3	np	11.5
RSE	%	27.3	35.6	32.6	36.7	35.9	36.8	26.4	np	15.7
95 per cent confidence interval	±	± 7.4	± 4.3	± 9.0	± 12.2	± 5.7	± 8.5	± 5.8	np	± 3.5
45-64 years										
Proportion	%	14.1	21.9	16.2	11.3	np	9.3	12.5	np	16.5
RSE	%	27.7	26.7	28.4	42.3	np	49.7	43.1	np	14.2
95 per cent confidence interval	±	± 7.7	± 11.5	± 9.0	± 9.4	np	± 9.1	± 10.6	np	± 4.6
65 years or over										
Proportion	%	20.0	18.8	13.9	np	np	12.1	15.1	np	17.9
RSE	%	26.0	33.9	35.3	np	np	47.9	53.2	np	15.9
95 per cent confidence interval	±	± 10.2	± 12.5	± 9.6	np	np	± 11.4	± 15.7	np	± 5.6
All ages (ASR) (d)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6

TABLE 10A.64

Table 10A.64 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b),(c)</i>	<i>Aust (b)</i>
95 per cent confidence interval	±	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3
2011-12										
0-14 years										
Proportion	%	35.1	46.9	32.6	48.4	58.3	36.6	37.4	65.5	40.9
RSE	%	20.0	14.0	20.8	21.6	13.2	26.1	18.9	18.9	7.8
95 per cent confidence interval	±	± 13.7	± 12.9	± 13.3	± 20.5	± 15.1	± 18.7	± 13.9	± 24.2	± 6.2
15-24 years										
Proportion	%	15.5	20.4	np	31.0	27.2	np	np	np	18.6
RSE	%	47.3	35.9	np	32.4	38.7	np	np	np	18.8
95 per cent confidence interval	±	± 14.3	± 14.3	np	± 19.7	± 20.6	np	np	np	± 6.9
25-44 years										
Proportion	%	24.4	11.8	11.8	15.7	19.0	23.1	17.5	26.1	16.8
RSE	%	22.7	25.6	30.9	34.4	29.0	25.2	31.9	29.9	12.6
95 per cent confidence interval	±	± 10.8	± 5.9	± 7.2	± 10.6	± 10.8	± 11.4	± 10.9	± 15.3	± 4.1
45-64 years										
Proportion	%	22.6	27.9	21.9	15.7	20.5	15.7	19.0	16.5	22.6
RSE	%	23.9	20.8	23.1	33.4	26.7	32.9	30.9	40.6	10.8
95 per cent confidence interval	±	± 10.6	± 11.4	± 9.9	± 10.3	± 10.7	± 10.1	± 11.5	± 13.1	± 4.8
65 years or over										
Proportion	%	37.0	23.2	16.0	16.7	21.9	20.1	33.1	42.2	26.4
RSE	%	20.3	22.5	30.3	38.3	32.9	34.9	39.6	43.0	12.5
95 per cent confidence interval	±	± 14.7	± 10.2	± 9.5	± 12.6	± 14.1	± 13.7	± 25.6	± 35.6	± 6.5
All ages (ASR) (d)										
Proportion	%	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
RSE	%	9.7	9.9	13.8	15.2	9.5	14.2	14.6	17.0	4.5
95 per cent confidence interval	±	± 5.1	± 4.9	± 5.0	± 7.3	± 5.5	± 6.3	± 7.0	± 11.3	± 2.2

ASR = age standardised rate. **RSE** = relative standard error.

Table 10A.64 Proportion of people with asthma with a written asthma action plan, by age (per cent) (a)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (b),(c)</i>	<i>Aust (b)</i>
(a)	Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published. However, these data contribute to national estimates.									
(b)	Data for the NT for 2011-12 are not comparable to data for previous years due to an increased sample size. Data for the NT are included in Australian totals but not published for 2001 or 2004-05 and published only for all ages for 2007-08, as sample sizes were insufficient to provide reliable estimates.									
(c)	Data for the NT should be interpreted with caution as the Australian Health Survey and National Health Survey excluded discrete Aboriginal and Torres Strait Islander communities and very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.									
(d)	For 'all ages', 2007-08 and 2011-12 data are age standardised to the 2001 Australian standard population.									

np Not published.

Source: ABS 2009, *National Health Survey: Summary of Results, 2007-2008*, Cat. no. 4364.0; ABS 2009, *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. no. 4362.0; ABS unpublished, *National Health Survey 2001, 2004-05, 2007-08*, Cat. no. 4364.0; ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 10A.65

Table 10A.65 **Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Aboriginal and Torres Strait Islander people										
0–14 years										
Proportion	%	56.5	58.0	42.6	37.1	42.4	43.5	51.7	55.7	50.9
RSE	%	14.0	13.7	15.1	27.5	23.5	19.0	27.0	32.3	8.7
95 per cent confidence interval	±	15.5	15.6	12.6	20.0	19.5	16.2	27.4	35.2	8.7
15–34 years										
Proportion	%	11.2	28.2	12.4	23.6	27.8	19.3	22.2	26.4	16.3
RSE	%	31.0	26.3	42.6	30.5	34.2	31.2	42.4	69.7	14.1
95 per cent confidence interval	±	6.8	14.6	10.3	14.1	18.7	11.8	18.5	36.1	4.5
35–54 years										
Proportion	%	21.9	26.3	19.0	11.4	39.2	np	np	29.5	21.1
RSE	%	31.3	29.6	30.7	45.5	22.4	np	np	50.3	15.2
95 per cent confidence interval	±	13.4	15.2	11.4	10.2	17.2	np	np	29.1	6.3
55 yrs or over										
Proportion	%	28.1	32.8	24.6	24.5	28.4	np	np	51.4	28.6
RSE	%	33.8	30.4	55.5	56.2	48.8	np	np	26.3	19.0
95 per cent confidence interval	±	18.6	19.6	26.7	27.0	27.1	np	np	26.5	10.6
All ages (Crude rates)										
Proportion	%	30.5	37.2	24.3	24.2	34.9	25.1	27.5	40.5	29.4
RSE	%	13.3	12.1	16.7	18.4	14.1	15.7	21.9	19.3	7.3
95 per cent confidence interval	±	7.9	8.8	7.9	8.7	9.7	7.7	11.8	15.3	4.2
All ages (ASR) (e)										
Proportion	%	26.6	34.8	23.4	22.9	34.0	22.6	21.6	36.9	27.3
RSE	%	14.1	13.0	19.4	19.0	16.1	16.9	24.1	22.7	7.9
95 per cent confidence interval	±	7.3	8.8	8.9	8.5	10.8	7.5	10.2	16.4	4.2
Non-Indigenous people										
0–14 years										
Proportion	%	34.7	46.9	32.5	48.2	55.3	35.4	32.9	47.0	40.3
RSE	%	20.9	14.0	20.9	22.8	14.6	27.4	23.5	40.0	8.3
95 per cent confidence interval	±	14.2	12.9	13.3	21.5	15.8	19.0	15.1	36.9	6.5
15–34 years										
Proportion	%	18.8	15.5	12.3	25.9	18.5	17.7	20.8	24.6	17.3
RSE	%	23.2	24.7	40.0	30.0	38.4	43.0	31.3	43.9	14.5

TABLE 10A.65

Table 10A.65 **Proportion of people with asthma with a written asthma plan, by Indigenous status, by age, 2011–13 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
95 per cent confidence interval	±	8.6	7.5	9.7	15.2	13.9	14.9	12.8	21.2	4.9
35–54 years										
Proportion	%	25.1	19.6	15.6	12.1	27.0	26.1	np	np	20.1
RSE	%	20.3	25.2	29.1	30.4	19.5	21.3	np	np	9.9
95 per cent confidence interval	±	10.0	9.7	8.9	7.2	10.3	10.9	np	np	3.9
55 yrs or over										
Proportion	%	30.4	23.8	16.7	18.8	20.4	11.4	np	np	23.8
RSE	%	16.5	19.1	23.9	29.9	26.7	35.6	np	np	9.0
95 per cent confidence interval	±	9.9	8.9	7.8	11.0	10.7	7.9	np	np	4.2
All ages (Crude rates)										
Proportion	%	26.6	24.4	18.1	21.7	27.3	22.3	23.5	20.6	23.7
RSE	%	9.9	9.9	14.7	17.1	11.2	14.2	15.0	24.8	4.6
95 per cent confidence interval	±	5.2	4.8	5.2	7.3	6.0	6.2	6.9	10.0	2.1
All ages (ASR) (e)										
Proportion	%	26.5	25.1	18.4	24.6	29.0	22.4	23.5	23.2	24.2
RSE	%	10.4	10.0	14.1	16.3	10.0	14.9	16.0	24.3	4.7
95 per cent confidence interval	±	5.4	4.9	5.1	7.9	5.7	6.5	7.4	11.0	2.2

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(c) Excludes remote and very remote areas. Data on whether the respondent has a written asthma action plan was collected for non-remote respondents only in the National Aboriginal and Torres Strait Islander Health Survey.

(d) Data for Aboriginal and Torres Strait Islander people and for non-Indigenous people use different survey questions to define asthma as current. However, data are comparable.

(e) Rates are age standardised to the 2001 Australian standard population.

(f) Data for the NT should be interpreted with caution as the Australian Health Survey excluded discrete Aboriginal and Torres Strait Islander communities and very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.

np Not published

Source: ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0; ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component).

TABLE 10A.66

Table 10A.66 **Proportion of people with asthma with a written asthma plan, by Indigenous status (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2004-05										
Aboriginal and Torres Strait Islander people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
95 per cent confidence interval	±	± 9.2	± 19.1	± 9.8	± 4.9	± 9.6	± 17.8	± 16.0	± 3.1	± 3.9
Non-Indigenous people										
Proportion	%	23.6	26.3	20.5	15.8	21.9	17.5	28.3	np	22.5
RSE	%	11.8	9.2	10.7	15.8	10.2	12.6	15.6	np	5.4
95 per cent confidence interval	±	± 5.5	± 4.8	± 4.3	± 4.9	± 4.4	± 4.3	± 8.6	np	± 2.4
2011-13										
Aboriginal and Torres Strait Islander people										
Proportion	%	26.6	34.8	23.4	22.9	34.0	22.6	21.6	36.9	27.3
RSE	%	14.1	13.0	19.4	19.0	16.1	16.9	24.1	22.7	7.9
95 per cent confidence interval	±	7.3	8.8	8.9	8.5	10.8	7.5	10.2	16.4	4.2
Non-Indigenous people										
Proportion	%	26.5	25.1	18.4	24.6	29.0	22.4	23.5	23.2	24.2
RSE	%	10.4	10.0	14.1	16.3	10.0	14.9	16.0	24.3	4.7
95 per cent confidence interval	±	5.4	4.9	5.1	7.9	5.7	6.5	7.4	11.0	2.2

RSE = relative standard error.

- (a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.
- (b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.
- (c) Rates are age standardised to the 2001 Australian standard population.
- (d) Data for non-Indigenous people for the NT should be interpreted with caution as the Australian Health Survey and National Health Survey excluded discrete Aboriginal and Torres Strait Islander communities and very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.

np Not published

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *National Health Survey, 2004-05*, 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; ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

TABLE 10A.67

Table 10A.67 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (e)</i>	<i>Aust</i>
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
95 per cent confidence interval	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
95 per cent confidence interval	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
95 per cent confidence interval	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
95 per cent confidence interval	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (f)										
Proportion	%	na	na	na	na	na	na	na	na	na
RSE	%	na	na	na	na	na	na	na	na	na
95 per cent confidence interval	%	na	na	na	na	na	na	na	na	na
Total										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

RSE = relative standard error.

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

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

Table 10A.67 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

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

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 Census of population and housing. The accuracy of the classifications decreases over time due to changes in demographics within postcode boundaries in the intercensal periods. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Data for non-Indigenous people for the NT should be interpreted with caution as the National Health Survey excluded discrete Aboriginal and Torres Strait Islander communities and very remote areas, which comprise around 25 per cent of the estimated resident population of the NT.

(f) Very remote data were not collected in the 2007-08 National Health Survey.

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

Source: ABS unpublished, *National Health Survey, 2007-08*, Cat. no. 4364.0.

TABLE 10A.68

Table 10A.68 GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09										
GPs using CDM items	no.	6 276	4 758	3 671	1 706	1 534	462	259	111	18 777
Total GPs	no.	6 488	4 931	3 937	1 807	1 638	492	292	122	19 707
GPs using CDM items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3
2009-10										
GPs using CDM items	no.	6 439	4 925	3 820	1 764	1 605	487	263	120	19 423
Total GPs	no.	6 617	5 061	4 064	1 858	1 683	511	286	135	20 215
GPs using CDM items	%	97.3	97.3	94.0	94.9	95.4	95.3	92.0	88.9	96.1
2010-11										
GPs using CDM items	no.	6 643	5 151	3 962	1 808	1 631	514	280	125	20 114
Total GPs	no.	6 806	5 277	4 168	1 875	1 712	526	299	132	20 795
GPs using CDM items	%	97.6	97.6	95.1	96.4	95.3	97.7	93.6	94.7	96.7
2011-12										
GPs using CDM items	no.	6 939	5 420	4 170	1 900	1 691	514	301	135	21 070
Total GPs	no.	7 084	5 538	4 378	1 963	1 761	531	319	143	21 717
GPs using CDM items	%	98.0	97.9	95.2	96.8	96.0	96.8	94.4	94.4	97.0
2012-13										
GPs using CDM items	no.	7 208	5 682	4 413	1 977	1 718	525	323	139	21 985
Total GPs	no.	7 354	5 818	4 601	2 055	1 794	543	349	148	22 662
GPs using CDM items	%	98.0	97.7	95.9	96.2	95.8	96.7	92.6	93.9	97.0
2013-14										
GPs using CDM items	no.	7 519	5 993	4 671	2 135	1 787	570	322	142	23 139
Total GPs	no.	7 705	6 149	4 874	2 203	1 859	578	340	154	23 862
GPs using CDM items	%	97.6	97.5	95.8	96.9	96.1	98.6	94.7	92.2	97.0
2014-15										
GPs using CDM items	no.	7 819	6 328	4 945	1 870	2 273	585	170	339	24 329
Total GPs	no.	7 996	6 481	5 123	1 940	2 337	591	178	353	24 999
GPs using CDM items	%	97.8	97.6	96.5	96.4	97.3	99.0	95.5	96.0	97.3

- (a) The chronic disease management (CDM) items include GP only care plans, multidisciplinary care plans (A15 subgroup 1) and case conferences (A15 subgroup 2, excluding items relating to consultant physicians and psychiatrists). Services that qualify under the DVA National Treatment Account or are provided in public hospitals are not included.
- (b) Additional chronic disease management MBS items are introduced from time-to-time and may impact on GP use of care planning or case conferencing MBS items.
- (c) GPs are defined as those General Practitioners and Other Medical Practitioners who have claimed at least 1500 non-referred attendances in the relevant financial year. GPs are counted only in the state/territory where they claimed the most services — this prevents double counting.

Source: Department of Health unpublished, MBS Statistics.

TABLE 10A.69

Table 10A.69 **Pathology tests requested by GPs, real benefits paid (2014-15 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Benefits paid										
2012-13	\$m	504.7	368.6	327.5	142.8	111.6	32.7	22.9	14.9	1 525.7
2013-14	\$m	518.3	377.8	345.3	152.4	115.3	32.6	23.5	15.4	1 580.7
2014-15	\$m	508.8	366.6	346.2	152.7	112.4	32.2	22.6	16.1	1 557.6
Benefits paid per person (ASR)										
2012-13	\$	64.9	61.6	69.2	56.9	61.3	57.9	60.6	68.2	63.6
2013-14	\$	65.6	61.9	71.5	58.8	62.8	57.5	61.0	68.3	64.7
2014-15	\$	63.5	59.0	70.4	57.9	60.7	56.4	57.9	70.3	62.8
MBS pathology items rebated										
2012-13	'000	26 825	20 219	17 521	7 804	6 461	1 847	1 176	778	82 632
2013-14	'000	27 835	20 945	18 377	8 355	6 688	1 882	1 210	824	86 118
2014-15	'000	27 959	20 917	18 532	8 539	6 730	1 891	1 214	870	86 652
MBS pathology items rebated per person (ASR)										
2012-13	no.	3.4	3.4	3.7	3.1	3.5	3.2	3.1	3.6	3.4
2013-14	no.	3.5	3.4	3.8	3.2	3.6	3.3	3.2	3.7	3.5
2014-15	no.	3.5	3.3	3.8	3.2	3.6	3.3	3.1	3.9	3.5

ASR = age standardised rate.

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 10A.70).
- (c) GPs are defined as vocationally registered GPs and other medical practitioners (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.
- (f) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.
- (g) Estimated resident populations used to derive rates are first preliminary estimates based on the 2011 Census.
- (h) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 10A.110.

TABLE 10A.70

Table 10A.70 **Pathology tests requested by GPs, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11										
Benefits paid										
Benefits paid	\$m	474.9	335.6	297.4	131.4	103.8	30.0	21.4	12.6	1407.2
Per person	\$	66.1	61.1	67.0	56.7	63.6	58.7	58.6	54.8	63.5
MBS pathology items rebated										
Number	'000	25 364	18 372	15 940	7 201	6 026	1 669	1 098	676	76 347
Per person	no.	3.53	3.34	3.59	3.11	3.69	3.27	3.01	2.94	3.44
2011-12										
Benefits paid										
Benefits paid	\$m	497.9	349.4	316.4	136.9	106.6	30.9	22.7	14.1	1475.0
Per person	\$	68.7	62.7	70.1	57.3	64.8	60.4	61.4	60.7	65.6
MBS pathology items rebated										
Number	'000	26 520	19 235	16 900	7 487	6 217	1 733	1 172	748	80 012
Per person	no.	3.66	3.45	3.74	3.14	3.78	3.39	3.16	3.22	3.56

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Per person data for 2011-12 and previous years are crude rates and are not comparable to data for 2012-13 and subsequent years which are age standardised (see table 10A.69).
- (c) GPs are defined as vocationally registered GPs and other medical practitioners (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.
- (f) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.

TABLE 10A.70

Table 10A.70 **Pathology tests requested by GPs, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f), (g), (h)**

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

(g) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.

(h) Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates. See chapter 2 (tables 2A.2) for details.

Source: Department of Health unpublished, MBS and DVA data collections; table 10A.110.

TABLE 10A.71

Table 10A.71 **Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid (2014-15 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Benefits paid										
2012-13	\$m	541.1	333.4	306.2	123.0	92.8	28.9	18.3	7.1	1 450.7
2013-14	\$m	588.8	363.0	343.8	135.4	100.8	31.4	19.5	8.8	1 591.5
2014-15	\$m	621.9	389.3	369.1	146.0	109.4	32.9	21.6	9.3	1 699.6
Benefits paid per person (ASR)										
2012-13	\$	68.9	55.6	64.4	49.1	50.5	50.3	49.5	35.0	60.1
2013-14	\$	73.7	59.4	70.9	52.4	54.4	54.2	51.6	42.0	64.7
2014-15	\$	76.5	62.5	74.7	55.4	58.4	56.4	56.1	43.6	68.0
MBS diagnostic imaging items										
2012-13	'000	4 573	3 033	2 687	1 091	857	262	159	66	12 728
2013-14	'000	4 904	3 261	2 944	1 185	914	277	168	83	13 739
2014-15	'000	5 145	3 479	3 135	1 272	977	293	182	89	14 572
MBS diagnostic imaging items per person (ASR)										
2012-13	no.	0.59	0.51	0.57	0.44	0.47	0.46	0.43	0.32	0.53
2013-14	no.	0.62	0.54	0.61	0.46	0.50	0.49	0.44	0.38	0.56
2014-15	no.	0.64	0.56	0.64	0.48	0.53	0.51	0.47	0.41	0.59

ASR = age standardised rate.

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 10A.72).
- (c) GPs are defined as vocationally registered GPs and other medical practitioners (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) Estimated resident populations used to derive rates are first preliminary estimates based on the 2011 Census.
- (f) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 10A.110.

TABLE 10A.72

Table 10A.72 **Diagnostic imaging referred by GPs and rebated through Medicare, real benefits paid, 2010-11 to 2011-12 (2014-15 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f), (g)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11										
Benefits paid										
Benefits paid	\$m	486.2	294.2	272.1	111.5	86.5	26.1	16.0	5.6	1298.2
Per person	\$	67.7	53.5	61.3	48.1	53.0	51.1	43.8	24.1	58.5
MBS diagnostic imaging items rebated										
Number	'000	4 096	2 660	2 384	981	796	235	140	53	11 344
Per person	no.	0.57	0.48	0.54	0.42	0.49	0.46	0.38	0.23	0.51
2011-12										
Benefits paid										
Benefits paid	\$m	519.7	315.6	295.9	118.7	89.7	27.1	17.3	6.1	1390.3
Per person	\$	71.7	56.6	65.6	49.7	54.5	53.1	46.6	26.3	61.8
MBS diagnostic imaging items rebated										
Number	'000	4 377	2 867	2 583	1 044	824	245	149	58	12 145
Per person	no.	0.60	0.51	0.57	0.44	0.50	0.48	0.40	0.25	0.54

- (a) Time series financial data are adjusted to 2014-15 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) (table 10A.110). See chapter 2 (sections 2.5-6) for details.
- (b) Per person data for 2011-12 and previous years are crude rates and are not comparable to data for 2012-13 and subsequent years which are age standardised (see table 10A.71).
- (c) GPs are defined as vocationally registered GPs and other medical practitioners (OMPs).
- (d) Includes Department of Veterans' Affairs (DVA) data.
- (e) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.
- (f) Data for 2012-13 exclude tests ordered by eligible midwives and nurse practitioners. Data for 2013-14 include tests ordered by eligible nurse practitioners.
- (g) Population data used to derive rates are revised to the ABS' final 2011 Census rebased estimates. See chapter 2 (table 2A.2) for details.

Source: Department of Health unpublished, MBS and DVA data collections; table 10A.110.

TABLE 10A.73

Table 10A.73 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP practices (May 2010)	no.	1 700	1 209	981	409	354	123	67	38	4 881
SWPE (c)	no.	4 765 033	4 063 295	3 060 662	1 500 216	1 225 101	389 553	269 970	79 148	15 352 978
PIP eHealth Incentive — uptake	no.	1 280	971	793	333	274	102	57	20	3 830
Share of PIP practices	%	75.3	80.3	80.8	81.4	77.4	82.9	85.1	52.6	78.5
PIP practices (May 2011)	no.	1 664	1 178	957	409	338	123	66	46	4 781
SWPE (c)	no.	4 792 245	4 100 376	3 129 970	1 508 314	1 239 216	396 459	277 984	86 021	15 530 585
PIP eHealth Incentive — uptake	no.	1 412	1 050	856	364	299	109	62	37	4 189
Share of PIP practices	%	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6
PIP practices (May 2012)	no.	1 710	1 211	1 005	424	353	126	66	54	4 949
SWPE (c)	no.	4 948 168	4 213 416	3 260 160	1 562 809	1 276 083	402 315	279 439	90 413	16 032 803
PIP eHealth Incentive — uptake	no.	1 481	1 087	897	378	310	113	60	42	4 368
Share of PIP practices	%	86.6	89.8	89.3	89.2	87.8	89.7	90.9	77.8	88.3
PIP practices (May 2013)	no.	1 798	1 229	1 046	433	363	127	65	56	5 117
SWPE (c)	no.	5 129 251	4 207 334	3 319 305	1 619 421	1 300 886	399 791	270 671	90 909	16 337 568
PIP eHealth Incentive — uptake	no.	1 247	937	776	296	264	96	52	27	3 695
Share of PIP practices	%	69.4	76.2	74.2	68.4	72.7	75.6	80.0	48.2	72.2
PIP practices (May 2014)	no.	1 812	1 255	1 077	452	367	121	71	55	5 210
SWPE (c)	no.	5 258 991	4 345 602	3 383 012	1 700 870	1 300 873	400 531	283 522	100 855	16 774 256

TABLE 10A.73

Table 10A.73 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PIP eHealth Incentive — uptake	no.	1 553	1 117	926	375	318	104	60	43	4 496
Share of PIP practices	%	85.7	89.0	86.0	83.0	86.7	86.0	84.5	78.2	86.3
PIP practices (May 2015) (b)	no.	1 824	1 282	1 118	482	368	127	71	58	5 330
SWPE (c)	no.	5 370 579	4 427 327	3 480 773	1 741 707	1 322 963	406 811	288 152	108 093	17 146 405
PIP eHealth Incentive — uptake	no.	1 628	1 173	996	422	334	113	62	50	4 778
Share of PIP practices	%	89.3	91.5	89.1	87.6	90.8	89.0	87.3	86.2	89.6

(a) Proportion of PIP practices registered for the PIP eHealth Incentive. Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.56).

(b) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements, as reflected in the sharp decrease in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 and the recovery in subsequent years.

Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

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

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.74

Table 10A.74 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region (a), (b), (c)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote</i>	<i>Very remote</i>	<i>Australia</i>
PIP practices (May 2013)	no.	3 425	981	536	104	71	5 117
PIP eHealth Incentive uptake — share of PIP practices	%	72.3	77.5	68.8	55.8	43.7	72.2
PIP practices (May 2014)	no.	3 484	1 012	546	99	69	5 210
PIP eHealth Incentive uptake — share of PIP practices	%	86.9	88.9	82.8	72.7	62.3	86.3
PIP practices (May 2015)	no.	3 567	1 030	560	106	67	5 330
PIP eHealth Incentive uptake — share of PIP practices	%	90.6	90.9	85.5	79.3	70.2	90.0

- (a) Proportion of PIP practices registered for the PIP eHealth Incentive. Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.56).
- (b) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.
- (c) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 compared to historical data under previous requirements (see table 10A.75). Previously, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.75

Table 10A.75 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012 (a), (b)**

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

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Not all practices are involved in PIP, and the proportion may vary across jurisdictions. Around 85 per cent of patient care is provided by practices enrolled in the PIP (table 10A.56).

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

(d) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 (see tables 10A.73 and 10A.74).

Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

Source: Department of Health unpublished, MBS and PIP data collections.

TABLE 10A.76

Table 10A.76 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
2012-13										
GP always or often listened carefully										
Major cities										
Proportion	%	90.8	89.3	89.5	89.2	89.4	..	89.3	..	89.9
RSE	%	0.6	0.7	0.6	0.8	0.8	..	1.3	..	0.3
95% CI	± %	1.0	1.3	1.1	1.4	1.4	..	2.3	..	0.5
Other (e)										
Proportion	%	89.3	90.1	87.5	86.1	86.9	89.4	–	86.4	88.6
RSE	%	1.3	1.0	1.0	1.5	1.5	1.0	–	1.5	0.5
95% CI	± %	2.2	1.8	1.7	2.5	2.5	1.7	–	2.6	0.9
Total										
Proportion	%	90.4	89.5	88.8	88.5	88.8	89.4	89.3	86.4	89.5
RSE	%	0.5	0.6	0.5	0.6	0.8	1.0	1.3	1.5	0.2
95% CI	± %	0.8	1.1	0.9	1.1	1.3	1.7	2.3	2.6	0.4
GP always or often showed respect										
Major cities										
Proportion	%	93.8	93.2	92.4	92.6	92.9	..	93.0	..	93.2
RSE	%	0.4	0.6	0.4	0.6	0.6	..	1.1	..	0.2
95% CI	± %	0.8	1.0	0.7	1.1	1.1	..	1.9	..	0.4
Other (e)										
Proportion	%	92.8	92.2	90.9	90.6	90.3	92.0	–	90.6	91.8
RSE	%	0.8	0.8	1.1	1.4	1.3	0.9	–	1.2	0.4
95% CI	± %	1.4	1.5	1.9	2.5	2.4	1.7	–	2.2	0.7
Total										
Proportion	%	93.5	93.0	91.8	92.2	92.3	92.0	93.0	90.6	92.8
RSE	%	0.3	0.5	0.4	0.5	0.6	0.9	1.1	1.2	0.2
95% CI	± %	0.6	0.9	0.8	1.0	1.0	1.7	1.9	2.2	0.4
GP always or often spent enough time										
Major cities										
Proportion	%	89.8	88.0	88.4	87.5	88.1	..	85.9	..	88.6
RSE	%	0.7	0.8	0.7	0.8	1.1	..	1.5	..	0.3
95% CI	± %	1.2	1.3	1.2	1.3	1.9	..	2.5	..	0.6
Other (e)										
Proportion	%	89.9	88.2	85.5	86.2	88.0	88.0	–	84.7	87.8
RSE	%	1.0	1.3	1.5	2.1	1.4	0.9	–	1.7	0.6
95% CI	± %	1.8	2.2	2.6	3.6	2.5	1.6	–	2.8	1.0

TABLE 10A.76

Table 10A.76 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
Total										
Proportion	%	89.9	88.0	87.3	87.2	88.1	88.0	85.9	84.7	88.4
RSE	%	0.5	0.6	0.6	0.7	1.0	0.9	1.5	1.7	0.3
95% CI	± %	0.9	1.0	1.1	1.3	1.7	1.6	2.5	2.8	0.5
2013-14 (f)										
GP always or often listened carefully										
Major cities										
Proportion	%	91.8	91.9	90.1	88.9	91.5	..	88.8	..	91.1
RSE	%	1.3	0.5	0.9	1.1	0.2	..	1.5	..	0.3
95% CI	± %	2.3	1.0	1.6	2.0	0.3	..	2.6	..	0.6
Other (e)										
Proportion	%	89.5	89.9	89.6	87.3	89.2	91.3	–	84.8	89.4
RSE	%	1.3	1.4	0.9	2.7	1.7	0.7	–	1.5	0.9
95% CI	± %	2.3	2.4	1.6	4.7	3.0	1.2	–	2.5	1.6
Total										
Proportion	%	91.2	91.3	89.8	88.6	90.9	91.3	89.1	84.8	90.6
RSE	%	0.5	0.7	0.8	0.9	0.5	0.7	1.5	1.5	0.3
95% CI	± %	0.9	1.3	1.3	1.5	0.8	1.2	2.6	2.5	0.6
GP always or often showed respect										
Major cities										
Proportion	%	94.2	94.6	92.9	91.8	94.9	..	92.3	..	93.7
RSE	%	1.2	0.6	0.7	0.8	1.5	..	1.0	..	0.3
95% CI	± %	2.2	1.0	1.4	1.5	2.8	..	1.7	..	0.5
Other (e)										
Proportion	%	91.2	93.0	92.7	90.6	92.3	93.5	–	89.6	92.1
RSE	%	1.2	1.1	0.9	2.2	1.5	0.6	–	1.0	0.6
95% CI	± %	2.2	2.0	1.6	3.8	2.8	1.1	–	1.8	1.2
Total										
Proportion	%	93.4	94.2	92.6	91.5	94.4	93.5	92.4	89.6	93.3
RSE	%	0.4	0.6	0.4	0.7	–	0.6	1.0	1.0	0.2
95% CI	± %	0.8	1.1	0.8	1.2	–	1.1	1.8	1.8	0.4
GP always or often spent enough time										
Major cities										
Proportion	%	91.0	89.3	89.6	87.3	90.7	..	87.2	..	89.7
RSE	%	1.3	0.8	0.6	1.0	0.6	..	1.9	..	0.5
95% CI	± %	2.3	1.4	1.1	1.8	1.2	..	3.2	..	0.8

TABLE 10A.76

Table 10A.76 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
Other (e)										
Proportion	%	88.2	88.1	88.0	88.7	89.3	89.7	–	86.3	88.3
RSE	%	1.0	0.9	1.0	2.2	1.5	0.8	–	1.8	0.7
95% CI	± %	1.7	1.6	1.7	3.9	2.6	1.5	–	3.1	1.2
Total										
Proportion	%	90.3	89.1	88.9	87.6	90.3	89.7	87.2	86.3	89.3
RSE	%	0.5	0.8	0.5	0.8	0.6	0.8	1.9	1.8	0.4
95% CI	± %	0.8	1.4	0.8	1.4	1.0	1.5	3.2	3.1	0.7

2014-15 (f)

GP always or often listened carefully

Major cities

Proportion	%	91.1	90.3	89.9	89.8	91.2	..	90.5	..	90.5
RSE	%	0.4	0.5	0.7	0.7	0.5	..	1.5	..	0.2
95% CI	± %	0.7	0.9	1.2	1.3	0.9	..	2.6	..	0.3

Other (e)

Proportion	%	90.6	90.5	89.3	89.0	88.7	88.6	68.6	89.2	89.9
RSE	%	0.8	1.8	0.7	2.5	1.6	1.0	25.1	1.2	0.5
95% CI	± %	1.4	3.2	1.2	4.3	2.8	1.7	33.7	2.0	1.0

Total

Proportion	%	90.9	90.2	89.8	89.5	90.9	88.6	89.8	89.2	90.3
RSE	%	0.3	0.2	0.1	0.6	0.7	1.0	1.6	1.2	0.1
95% CI	± %	0.6	0.4	0.3	1.0	1.3	1.7	2.8	2.0	0.1

GP always or often showed respect

Major cities

Proportion	%	94.3	93.1	93.9	92.6	93.1	..	93.8	..	93.6
RSE	%	0.5	0.1	0.7	1.2	0.8	..	1.5	..	0.3
95% CI	± %	0.9	0.2	1.3	2.1	1.4	..	2.8	..	0.6

Other (e)

Proportion	%	92.7	93.5	92.1	91.0	91.0	92.2	68.6	92.5	92.5
RSE	%	0.7	2.3	0.9	1.6	1.3	0.9	25.1	0.9	0.5
95% CI	± %	1.3	4.2	1.7	2.8	2.4	1.6	33.7	1.7	0.8

Total

Proportion	%	93.8	93.2	93.3	92.4	93.0	92.2	93.1	92.5	93.3
RSE	%	0.2	0.2	0.3	0.7	0.2	0.9	1.6	0.9	0.3
95% CI	± %	0.4	0.3	0.6	1.3	0.3	1.6	2.9	1.7	0.5

GP always or often spent enough time

Major cities

TABLE 10A.76

Table 10A.76 **Client experience of GPs by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (d)</i>	<i>Aust</i>
Proportion	%	88.9	88.3	88.6	88.8	89.9	..	86.5	..	88.8
RSE	%	0.7	1.0	1.4	0.7	0.9	..	0.7	..	0.3
95% CI	± %	1.3	1.7	2.4	1.2	1.5	..	1.2	..	0.5
Other (e)										
Proportion	%	90.0	90.8	87.9	90.1	86.8	87.6	**41.6	87.5	89.1
RSE	%	0.6	2.0	1.3	2.0	1.8	1.0	np	1.9	0.3
95% CI	± %	1.0	3.5	2.2	3.5	3.1	1.8	np	3.2	0.6
Total										
Proportion	%	89.3	88.8	88.4	89.1	89.3	87.6	86.6	87.5	88.9
RSE	%	0.5	0.3	0.8	0.5	0.3	1.0	0.6	1.9	0.2
95% CI	± %	0.9	0.5	1.4	0.9	0.6	1.8	0.9	3.2	0.3

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

- (a) Estimates with a relative standard error (RSE) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are marked with '***'.
- (b) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (c) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (d) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities, which comprise around 25 per cent of the estimated resident population of the NT.
- (e) 'Other' includes inner and outer regional, remote and very remote areas.
- (f) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

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

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

TABLE 10A.77

Table 10A.77 **Client experience of GPs by remoteness, Australia (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
2012-13						
GP always or often listened carefully						
Proportion	%	89.9	88.9	88.4	85.4	89.5
RSE	%	0.3	0.6	0.8	2.8	0.2
95% CI	± %	0.5	1.0	1.4	4.7	0.4
GP always or often showed respect						
Proportion	%	93.2	92.4	90.9	88.5	92.8
RSE	%	0.2	0.5	0.7	1.8	0.2
95% CI	± %	0.4	0.9	1.2	3.1	0.4
GP always or often spent enough time						
Proportion	%	88.6	88.2	87.5	84.3	88.4
RSE	%	0.3	0.7	1.0	2.6	0.3
95% CI	± %	0.6	1.2	1.7	4.4	0.5
2013-14 (d)						
GP always or often listened carefully						
Proportion	%	91.1	90.1	88.7	86.1	90.6
RSE	%	0.3	0.9	0.7	3.4	0.3
95% CI	± %	0.6	1.6	1.3	5.7	0.6
GP always or often showed respect						
Proportion	%	93.7	92.7	91.7	88.7	93.3
RSE	%	0.3	0.7	0.8	2.7	0.2
95% CI	± %	0.5	1.2	1.5	4.8	0.4
GP always or often spent enough time						
Proportion	%	89.7	88.7	88.1	86.0	89.3
RSE	%	0.5	0.7	1.6	4.5	0.4
95% CI	± %	0.8	1.2	2.7	7.6	0.7
2014-15 (d)						
GP always or often listened carefully						
Proportion	%	90.5	90.6	88.1	93.3	90.3
RSE	%	0.2	0.8	0.8	3.6	0.1
95% CI	± %	0.3	1.4	1.4	6.7	0.1
GP always or often showed respect						
Proportion	%	93.6	92.8	91.5	95.1	93.3
RSE	%	0.3	0.9	1.2	2.8	0.3
95% CI	± %	0.6	1.7	2.2	5.1	0.5
GP always or often spent enough time						
Proportion	%	88.8	89.6	87.7	93.5	88.9
RSE	%	0.3	0.7	0.6	3.9	0.2
95% CI	± %	0.5	1.2	1.0	7.2	0.3

Table 10A.77 **Client experience of GPs by remoteness, Australia (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
--	-------------	---------------------	-----------------------	-----------------------	---------------------------	---------------------

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

- (a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data are not comparable with data for Aboriginal and Torres Strait Islander people that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.
- (d) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

Table 10A.78 **Client experience of GPs by remoteness, Aboriginal and Torres Strait Islander people, Australia, 2012-13 (a), (b), (c), (d)**

	<i>Unit</i>	<i>Major cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Total (e)</i>
2012-13 (e)					
GP always or usually listened carefully					
Proportion	%	89.8	88.8	86.4	88.5
RSE	%	1.4	1.9	2.3	1.0
95% CI	± %	2.5	3.3	3.9	1.8
GP always or usually showed respect					
Proportion	%	90.5	88.0	87.5	89.0
RSE	%	1.7	1.9	1.4	1.0
95% CI	± %	3.0	3.3	2.4	1.7
GP always or usually spent enough time					
Proportion	%	86.2	85.0	83.2	85.0
RSE	%	1.8	2.1	2.3	1.1
95% CI	± %	3.0	3.4	3.7	1.9

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

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

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).

(c) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.

(d) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

(e) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

TABLE 10A.79

Table 10A.79 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
2012-13										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	96.3	94.6	94.5	95.5	95.3	..	95.1	..	95.3
RSE	%	0.5	0.6	0.5	0.6	0.6	..	0.9	..	0.3
95% CI	± %	1.0	1.1	1.0	1.1	1.1	..	1.7	..	0.5
Other (d)										
Proportion	%	94.0	92.7	93.1	95.3	91.9	94.5	–	92.4	93.5
RSE	%	0.9	1.3	0.8	1.3	2.5	0.8	–	1.6	0.5
95% CI	± %	1.6	2.3	1.5	2.3	4.5	1.4	–	2.8	0.9
Total										
Proportion	%	95.8	94.2	94.0	95.5	94.5	94.5	95.1	92.4	94.8
RSE	%	0.5	0.5	0.4	0.5	0.7	0.8	0.9	1.6	0.2
95% CI	± %	1.0	1.0	0.7	1.0	1.2	1.4	1.7	2.8	0.4
Dental professional always or often showed respect										
Major cities										
Proportion	%	97.0	96.3	95.6	96.5	96.8	..	96.0	..	96.5
RSE	%	0.4	0.5	0.6	0.5	0.5	..	0.8	..	0.3
95% CI	± %	0.8	1.0	1.2	1.0	1.0	..	1.5	..	0.6
Other (d)										
Proportion	%	95.4	93.6	95.2	96.9	94.9	96.1	–	94.8	95.1
RSE	%	0.6	1.2	0.8	1.1	1.5	0.5	–	1.3	0.3
95% CI	± %	1.2	2.2	1.5	2.1	2.7	1.0	–	2.3	0.7
Total										
Proportion	%	96.7	95.7	95.4	96.6	96.4	96.1	96.0	94.8	96.1
RSE	%	0.4	0.4	0.5	0.4	0.5	0.5	0.8	1.3	0.2
95% CI	± %	0.7	0.8	0.9	0.8	0.9	1.0	1.5	2.3	0.5
Dental professional always or often spent enough time										
Major cities										
Proportion	%	96.8	95.2	95.0	96.3	96.6	..	95.4	..	95.9
RSE	%	0.4	0.5	0.6	0.7	0.6	..	0.9	..	0.2
95% CI	± %	0.7	1.0	1.1	1.3	1.0	..	1.8	..	0.4
Other (d)										
Proportion	%	94.5	93.8	96.3	97.8	96.8	96.9	–	94.4	95.4
RSE	%	0.9	1.4	0.8	0.7	0.9	0.7	–	1.1	0.5
95% CI	± %	1.7	2.6	1.4	1.3	1.8	1.3	–	2.0	0.9
Total										

TABLE 10A.79

Table 10A.79 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Proportion	%	96.2	94.9	95.4	96.6	96.7	96.9	95.4	94.4	95.8
RSE	%	0.4	0.5	0.5	0.6	0.4	0.7	0.9	1.1	0.2
95% CI	± %	0.7	0.9	1.0	1.1	0.8	1.3	1.8	2.0	0.4

2013-14 (e)

Dental professional always or often listened carefully

Major cities

Proportion	%	94.6	95.3	93.0	96.3	97.5	..	95.6	..	95.0
RSE	%	0.9	0.9	0.4	0.3	2.3	..	3.6	..	0.4
95% CI	± %	1.6	1.6	0.8	0.6	4.4	..	6.7	..	0.7

Other (d)

Proportion	%	95.0	91.2	92.6	96.6	92.9	93.7	–	94.5	93.3
RSE	%	0.6	2.0	0.8	1.5	1.1	1.1	–	1.9	0.5
95% CI	± %	1.2	3.6	1.5	2.8	2.0	2.1	–	3.5	1.0

Total

Proportion	%	94.8	94.5	92.9	96.5	96.5	93.7	95.4	94.5	94.6
RSE	%	0.6	0.7	0.8	0.6	1.6	1.1	3.6	1.9	1.0
95% CI	± %	1.2	1.3	1.4	1.1	3.0	2.1	6.8	3.5	1.9

Dental professional always or often showed respect

Major cities

Proportion	%	95.9	96.2	94.5	96.6	97.2	..	96.7	..	96.0
RSE	%	0.7	0.6	3.1	2.3	2.3	..	3.5	..	0.4
95% CI	± %	1.4	1.2	5.7	4.4	4.4	..	6.6	..	0.8

Other (d)

Proportion	%	94.9	92.7	93.6	95.6	94.3	96.2	–	95.4	94.2
RSE	%	–	2.2	0.5	1.9	7.0	0.9	–	2.0	0.3
95% CI	± %	–	3.9	1.0	3.5	12.9	1.7	–	3.8	0.5

Total

Proportion	%	95.8	95.3	94.2	96.7	96.5	96.2	96.3	95.4	95.5
RSE	%	0.6	0.6	0.5	0.3	1.6	0.9	3.5	2.0	0.2
95% CI	± %	1.1	1.1	0.9	0.5	3.0	1.7	6.6	3.8	0.5

Dental professional always or often spent enough time

Major cities

Proportion	%	95.6	96.9	94.0	96.9	98.1	..	96.6	..	96.0
RSE	%	0.6	0.7	3.2	2.3	0.2	..	3.6	..	0.3
95% CI	± %	1.1	1.3	5.9	4.4	0.4	..	6.8	..	0.5

TABLE 10A.79

Table 10A.79 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Other (d)										
Proportion	%	95.6	94.7	93.5	97.9	93.2	95.5	–	96.3	94.9
RSE	%	0.6	1.6	5.3	1.4	0.5	1.6	–	1.7	0.5
95% CI	± %	1.1	2.9	9.7	2.7	0.9	3.0	–	3.1	0.9
Total										
Proportion	%	95.7	96.3	93.9	97.1	97.0	95.5	97.1	96.3	95.7
RSE	%	0.5	0.6	0.5	0.4	1.7	1.6	3.6	1.7	0.1
95% CI	± %	1.0	1.1	0.9	0.8	3.2	3.0	6.9	3.1	0.2
2014-15 (e)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.9	94.7	94.7	95.2	94.1	..	94.2	..	94.7
RSE	%	0.9	0.7	0.4	0.8	0.5	..	1.3	..	0.3
95% CI	± %	1.6	1.4	0.8	1.4	0.9	..	2.3	..	0.6
Other (d)										
Proportion	%	94.1	93.1	94.8	94.7	92.1	94.2	–	95.6	93.7
RSE	%	1.3	2.7	2.7	2.1	1.7	0.4	–	0.8	1.1
95% CI	± %	2.4	4.8	5.1	3.9	3.0	0.7	–	1.5	2.0
Total										
Proportion	%	94.6	94.3	94.5	94.6	93.6	94.2	94.7	95.6	94.5
RSE	%	0.7	0.6	1.1	0.5	1.2	0.4	1.1	0.8	0.2
95% CI	± %	1.3	1.1	2.0	1.0	2.3	0.7	2.0	1.5	0.4
Dental professional always or often showed respect										
Major cities										
Proportion	%	96.5	96.3	95.3	96.3	95.5	..	94.7	..	96.0
RSE	%	0.5	1.0	0.5	0.9	0.8	..	1.5	..	0.3
95% CI	± %	0.9	1.8	1.0	1.8	1.5	..	2.7	..	0.5
Other (d)										
Proportion	%	94.2	94.9	95.9	94.9	95.1	95.8	–	97.9	94.9
RSE	%	1.7	2.9	2.6	2.3	1.6	0.3	–	1.0	1.3
95% CI	± %	3.2	5.4	4.9	4.3	3.0	0.6	–	1.8	2.4
Total										
Proportion	%	95.9	95.9	95.0	95.9	95.4	95.8	94.5	97.9	95.7
RSE	%	0.5	0.6	0.9	0.6	1.1	0.3	1.4	1.0	0.4
95% CI	± %	0.9	1.2	1.7	1.0	2.1	0.6	2.6	1.8	0.8
Dental professional always or often spent enough time										
Major cities										

TABLE 10A.79

Table 10A.79 **Client experience of dental professionals by remoteness, States and Territories (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (c)</i>	<i>Aust</i>
Proportion	%	95.6	96.3	95.0	96.1	95.4	..	95.2	..	95.8
RSE	%	0.6	1.1	0.7	1.2	1.1	..	1.2	..	0.4
95% CI	± %	1.2	2.0	1.2	2.2	2.0	..	2.2	..	0.8
Other (d)										
Proportion	%	94.6	96.6	95.7	96.3	93.0	95.9	–	97.7	95.4
RSE	%	1.4	2.3	2.0	2.0	2.6	0.8	–	1.2	0.9
95% CI	± %	2.6	4.3	3.8	3.8	4.8	1.5	–	2.4	1.7
Total										
Proportion	%	95.4	96.3	95.0	95.8	94.6	95.9	95.6	97.7	95.7
RSE	%	0.5	0.9	0.7	0.4	1.2	0.8	1.0	1.2	0.3
95% CI	± %	0.9	1.7	1.4	0.8	2.2	1.5	1.9	2.4	0.5

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

- (a) Proportion of people who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.
- (b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.
- (c) Data for the NT should be interpreted with caution as the Patient Experience Survey excluded discrete Aboriginal and Torres Strait Islander communities, which comprise around 25 per cent of the estimated resident population of the NT.
- (d) 'Other' includes inner and outer regional, remote and very remote areas.
- (e) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

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

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

TABLE 10A.80

Table 10A.80 **Client experience of dental professionals by remoteness, Australia (a), (b), (c)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
2012-13						
Dental professional always or often listened carefully						
Proportion	%	95.3	93.2	93.8	95.0	94.8
RSE	%	0.3	0.6	1.0	1.3	0.2
95% CI	± %	0.5	1.1	1.8	2.5	0.4
Dental professional always or often showed respect						
Proportion	%	96.5	94.6	96.0	96.8	96.1
RSE	%	0.3	0.5	0.6	1.2	0.2
95% CI	± %	0.6	0.9	1.1	2.3	0.5
Dental professional always or often spent enough time						
Proportion	%	95.9	95.0	96.2	95.8	95.8
RSE	%	0.2	0.6	0.7	1.4	0.2
95% CI	± %	0.4	1.1	1.3	2.6	0.4
2013-14 (c)						
Dental professional always or often listened carefully						
Proportion	%	95.0	93.3	93.5	94.8	94.6
RSE	%	0.4	3.0	1.1	3.5	1.0
95% CI	± %	0.7	5.5	2.1	6.5	1.9
Dental professional always or often showed respect						
Proportion	%	96.0	94.1	94.3	95.2	95.5
RSE	%	0.4	0.3	1.2	3.5	0.2
95% CI	± %	0.8	0.6	2.3	6.5	0.5
Dental professional always or often spent enough time						
Proportion	%	96.0	95.1	94.5	95.8	95.7
RSE	%	0.3	3.0	1.4	2.7	0.1
95% CI	± %	0.5	5.6	2.6	5.0	0.2
2014-15 (c)						
Dental professional always or often listened carefully						
Proportion	%	94.7	94.4	92.9	95.5	94.5
RSE	%	0.3	1.0	1.3	4.3	0.2
95% CI	± %	0.6	1.8	2.3	8.1	0.4
Dental professional always or often showed respect						
Proportion	%	96.0	95.3	94.4	95.5	95.7
RSE	%	0.3	0.9	1.4	4.1	0.4
95% CI	± %	0.5	1.7	2.6	7.6	0.8
Dental professional always or often spent enough time						
Proportion	%	95.8	95.8	95.4	92.8	95.7
RSE	%	0.4	0.7	1.0	6.0	0.3
95% CI	± %	0.8	1.4	1.9	10.8	0.5

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

Table 10A.80 **Client experience of dental professionals by remoteness, Australia (a), (b), (c)**

	<i>Unit</i>	<i>Major Cities</i>	<i>Inner regional</i>	<i>Outer regional</i>	<i>Remote/Very remote</i>	<i>Total</i>
--	-------------	---------------------	-----------------------	-----------------------	---------------------------	---------------------

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

(b) Data are crude rates and may differ from data in previous reports in which rates were age-standardised.

(c) For 2013-14 and subsequent years, cells have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.

Source: ABS unpublished, Patient Experience Survey, various years, Cat. no. 4839.0.

TABLE 10A.81

Table 10A.81 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2010–2015 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
Valid vaccinations provided										
GPs	no.	5 937 214	3 309 035	3 972 287	1 718 080	1 025 974	387 668	223 976	47 156	16 621 390
Council	no.	183 746	1 965 118	266 240	82 029	233 642	24 205	np	np	2 754 980
State or territory health department	no.	np	np	348	89 923	280	np	4 528	1 034	96 113
Public hospital	no.	58 582	68 958	130 271	29 946	9 337	1 888	1 070	20 863	322 066
Private hospital	no.	15	np	812	7	np	np	np	1 882	2 716
Aboriginal health service	no.	33 616	9 269	12 035	11 156	11 343	44	np	69 449	146 912
Community health centre	no.	410 724	14 327	274 970	544 030	92 199	203	135 591	180 566	1 653 404
Other (e)	no.	3 121	1 779	18 259	960	783	np	np	2 372	31 680
Total	no.	6 627 003	5 368 486	4 674 410	2 476 124	1 373 558	414 008	365 165	321 440	21 626 545
Proportion of total valid vaccinations										
GPs	%	89.6	61.6	85.0	69.4	74.7	93.6	61.3	14.7	76.9
Council	%	2.8	36.6	5.7	3.3	17.0	5.8	np	np	12.7
State or territory health department	%	np	np	–	3.6	–	np	1.2	0.3	0.4
Public hospital	%	0.9	1.3	2.8	1.2	0.7	0.5	0.3	6.5	1.5
Private hospital	%	–	np	–	–	np	np	np	0.6	–
Aboriginal health service	%	0.5	0.2	0.3	0.5	0.8	–	np	21.6	0.7
Community health centre	%	6.2	0.3	5.9	22.0	6.7	–	37.1	56.2	7.6
Other (e)	%	–	–	0.4	–	0.1	np	np	0.7	0.1
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) 1 July 2010 to 30 June 2015.

(b) Totals may not add as a result of rounding.

TABLE 10A.81

Table 10A.81 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2010–2015 (a), (b), (c)**

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

(c) Data reported by the State or Territory in which the immunisation provider is located.

(d) Includes data for unknown State or Territory.

(e) Other includes Flying Doctors Services, Aboriginal Health Workers, Community nurses, Private hospitals, Divisions of GP (for 2010 and 2011) and unknown providers.

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

Source: Department of Health unpublished, Australian Childhood Immunisation Register (ACIR) data collection.

TABLE 10A.82

Table 10A.82 **Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
Fully immunised (b)									
2007-08	91.6	91.9	91.1	89.4	91.0	92.3	93.6	90.7	91.3
2008-09	91.7	91.9	90.9	89.5	91.6	91.5	93.9	90.1	91.4
2009-10	91.8	92.1	91.8	89.7	91.2	92.5	93.1	89.9	91.6
2010-11 (g)	91.0	92.0	91.6	89.5	91.4	91.5	93.5	90.6	91.3
2011-12	91.6	92.6	91.6	90.3	92.3	92.5	93.2	91.8	91.8
2012-13	90.8	91.7	92.0	90.2	91.3	92.2	92.8	91.5	91.3
2013-14	89.7	90.8	91.2	90.1	90.2	89.8	93.0	90.8	90.4
2014-15 (h)	91.1	91.2	91.9	91.4	91.2	90.7	92.9	90.5	91.3
Immunised against (2014-15)									
Diphtheria, tetanus and pertussis	91.9	92.1	92.5	92.4	91.9	91.3	94.1	91.0	92.1
Polio	91.9	92.1	92.4	92.4	91.8	91.3	94.0	91.0	92.1
Hepatitis B	91.6	91.7	92.2	92.0	91.6	91.1	93.5	91.0	91.8
<i>Haemophilus influenzae</i> type b	91.8	91.9	92.3	92.1	91.7	91.2	93.7	90.9	92.0
Pneumococcal (h)	91.6	91.8	92.2	91.9	91.5	91.2	93.8	91.1	91.8

- (a) Coverage measured for all children immunised at the age of 12 months to less than 15 months, by the State or Territory in which the child resided.
- (b) 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.
- (c) The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (d) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (e) Reference periods comprise the complete financial year. Data may differ from other reports where a different reference period is used.
- (f) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.
- (g) Coverage rates were relatively low for the June 2011 quarter, associated with parents not receiving immunisation reminders due to administrative error. This may be reflected in relatively low coverage rates for 2010-11.
- (h) Immunisation against pneumococcal is included for assessment of children as fully immunised at 12 months from the quarter ending 31 December 2013.

Source: Department of Health unpublished, ACIR data collection.

TABLE 10A.83

Table 10A.83 **Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (f)	Aust
Fully immunised (b)									
2007-08	92.6	93.7	92.3	91.2	94.3	94.5	94.1	94.1	92.8
2008-09	92.6	93.7	92.1	90.9	92.6	93.7	94.2	93.8	92.6
2009-10	92.2	92.9	91.5	90.9	91.7	93.4	93.8	92.7	92.1
2010-11	92.4	93.5	92.9	91.0	92.6	94.2	93.5	94.1	92.7
2011-12	92.3	93.3	92.8	90.8	92.6	93.8	93.6	94.5	92.6
2012-13	92.3	93.1	92.6	90.6	92.5	94.2	93.2	93.4	92.4
2013-14	91.9	92.8	93.2	91.0	92.2	93.1	93.1	93.6	92.4
2014-15 (g)	88.8	89.6	90.4	87.7	87.9	87.5	91.4	89.3	89.2
Immunised against (2014-15)									
Diphtheria, tetanus and pertussis	95.1	95.6	95.0	94.8	94.8	95.1	96.1	95.2	95.2
Polio	95.0	95.6	95.0	94.7	94.8	95.0	96.1	95.3	95.1
Hepatitis B	94.7	95.2	94.6	94.2	94.4	94.8	95.7	95.3	94.8
<i>Haemophilus influenzae</i> type b	93.7	94.4	94.2	93.5	93.4	93.5	95.0	94.9	94.0
Measles, mumps and rubella	91.0	91.5	91.9	89.8	90.4	90.2	93.1	92.1	91.2

(a) Coverage measured for children immunised at the age of 24 months to less than 27 months, by the State or Territory in which the child resided.

(b) Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, *Haemophilus influenzae* type b, measles, mumps and rubella and, from the quarter ending 31 December 2014, meningococcal C and varicella (chickenpox).

(c) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(d) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.

(e) Reference periods comprise the complete financial year. Data may differ from other reports where a different reference period is used.

(f) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.

(g) A decrease in the proportion of children who were fully immunised from 2013-14 to 2014-15 is associated with the introduction of additional vaccines in the definition of fully immunised.

Source: Department of Health unpublished, ACIR data collection.

TABLE 10A.84

Table 10A.84 **Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT (f)</i>	<i>Aust</i>
Fully immunised (b)									
2007-08	81.4	85.8	84.0	79.6	78.9	82.9	88.2	82.9	82.8
2008-09	77.9	84.1	81.5	79.0	75.3	80.9	85.3	82.8	80.3
2009-10	83.7	87.2	84.5	82.3	81.9	86.4	86.9	82.8	84.6
2010-11	89.1	91.0	89.9	86.0	87.0	91.3	91.0	86.9	89.3
2011-12	90.0	91.4	90.3	86.8	87.6	90.8	91.5	89.3	90.0
2012-13	91.6	92.6	91.5	89.4	90.9	92.9	92.3	90.7	91.5
2013-14	92.2	92.5	92.3	89.8	91.0	92.7	92.7	91.4	92.0
2014-15	92.7	92.6	92.3	90.6	90.9	92.6	93.2	92.4	92.3
Immunised against (2014-15)									
Diphtheria, tetanus and pertussis	93.2	93.2	92.8	91.2	91.5	93.4	93.8	93.1	92.8
Polio	93.2	93.2	92.8	91.2	91.5	93.3	93.8	93.1	92.8
Measles, mumps and rubella	93.2	93.2	92.8	91.1	91.4	93.2	93.5	93.5	92.8

- (a) Coverage measured for children immunised at the age of 60 months to less than 63 months, by the State or Territory in which the child resided.
- (b) Children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio and measles, mumps and rubella.
- (c) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).
- (d) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates.
- (e) Reference periods comprise the complete financial year. Data may differ from other reports where a different reference period is used.
- (f) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.

Source: Department of Health unpublished, ACIR data collection.

TABLE 10A.85

Table 10A.85 **Notifications of measles, children aged 0–14 years (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	np	–	np	np	–	–	–	–	4
2007-08	no.	18	np	4	np	np	–	–	np	27
2008-09	no.	3	18	20	np	–	np	–	–	44
2009-10	no.	5	np	np	np	np	–	–	–	11
2010-11	no.	37	6	7	5	–	–	np	np	58
2011-12	no.	20	np	–	np	–	–	4	–	27
2012-13	no.	85	3	np	3	3	–	–	np	95
2013-14	no.	29	26	24	10	10	–	–	18	177
2014-15	no.	5	22	14	9	–	3	6	np	60
Notifications per 100 000 children (0–14 years) (e)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	np
2007-08	per 100 000 children	1.4	np	np	np	np	–	–	np	0.7
2008-09	per 100 000 children	np	1.8	2.3	np	–	np	–	–	1.1
2009-10	per 100 000 children	0.4	np	np	np	np	–	–	–	0.3
2010-11	per 100 000 children	2.7	0.6	0.8	1.1	–	–	np	np	1.4
2011-12	per 100 000 children	1.5	np	–	np	–	–	np	–	0.6
2012-13	per 100 000 children	6.1	np	np	np	np	–	–	np	2.2
2013-14	per 100 000 children	2.1	2.5	2.6	2.1	3.4	–	–	33.4	4.0
2014-15	per 100 000 children	0.4	2.0	1.5	1.8	–	np	8.2	np	1.4

- (a) Notification of the relevant State/Territory authority is required when measles is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for measles — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.
- (b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.

TABLE 10A.85

Table 10A.85 **Notifications of measles, children aged 0–14 years (a), (b), (c), (d)**

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

(d) Reference periods comprise the complete financial year. Data may differ from other reports that use a different reference period.

(e) Rates are derived using the ERP as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.

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

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.86

Table 10A.86 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	677	181	95	36	41	9	5	82	1 126
2008-09	no.	8 161	681	955	205	586	205	59	162	11 014
2009-10	no.	3 275	1 094	1 496	242	1 841	108	32	60	8 148
2010-11	no.	8 781	2 845	3 147	744	2 183	68	335	129	18 232
2011-12	no.	6 721	1 718	3 178	2 564	279	384	87	280	15 211
2012-13	no.	2 146	932	2 369	529	305	660	88	52	7 081
2013-14	no.	981	864	1 166	492	349	59	63	14	3 988
2014-15	no.	3 359	1 868	581	393	346	10	108	4	6 669
Notifications per 100 000 children (0–14 years) (f)										
2006-07	per 100 000 children	22.9	9.5	13.6	8.0	13.7	7.3	12.6	np	14.8
2007-08	per 100 000 children	50.8	18.5	11.3	8.6	14.3	9.3	7.8	158.2	27.7
2008-09	per 100 000 children	607.1	68.8	110.6	47.4	203.4	211.2	91.3	309.7	266.6
2009-10	per 100 000 children	241.6	109.3	170.6	55.0	635.6	111.4	48.8	113.9	195.0
2010-11	per 100 000 children	643.9	281.8	355.3	166.2	751.7	70.6	504.9	245.8	432.8
2011-12	per 100 000 children	492.9	169.2	355.1	561.1	96.1	403.5	129.3	534.2	359.0
2012-13	per 100 000 children	155.2	89.6	258.9	111.6	103.7	694.9	126.1	97.7	163.7
2013-14	per 100 000 children	69.7	81.6	125.4	101.1	117.9	62.2	88.3	26.0	90.7
2014-15	per 100 000 children	237.5	173.7	61.8	79.5	116.1	10.6	148.3	np	150.1

(a) Notification of the relevant State/Territory authority is required when whooping cough is diagnosed. Diagnosis cannot always be confirmed using available tools. Therefore, the 'notified fraction' is likely to be only a proportion of the total number of cases. The notified fraction may vary between states and territories and over time.

(b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.

TABLE 10A.86

Table 10A.86 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b), (c), (d), (e)**

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
(c) Epidemics of pertussis in Australia historically occur at regular intervals of approximately 4 years on a background of endemic circulation, resulting in large fluctuations in notification numbers over time. The large variations in pertussis notifications in states and territories during this reporting period are mainly due to a nationwide epidemic that commenced in 2008 and peaked in 2011. The timing of each jurisdiction's peak whooping cough activity varied during this time. NSW and Victoria are currently experiencing increased levels of pertussis activity which began during 2014.									
(d) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.									
(e) Reference periods comprise the complete financial year. Data may differ from other reports that use a different reference period.									
(f) Rates are derived using the ERP as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.									

np Not published.

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.87

Table 10A.87 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c), (d)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Notifications										
2006-07	no.	4	3	8	np	–	–	–	–	17
2007-08	no.	7	–	np	–	np	np	–	np	12
2008-09	no.	3	np	3	np	–	–	–	np	11
2009-10	no.	np	–	np	np	np	–	–	np	6
2010-11	no.	6	np	np	np	–	–	–	–	12
2011-12	no.	–	–	np	np	np	–	–	np	7
2012-13	no.	3	3	3	–	–	–	–	–	9
2013-14	no.	4	np	5	np	–	–	–	np	12
2014-15	no.	4	np	3	–	–	–	–	np	9
Notifications per 100 000 children (0–14 years) (e)										
2006-07	per 100 000 children	np	np	1.0	np	–	–	–	–	0.4
2007-08	per 100 000 children	0.5	–	np	–	np	np	–	np	0.3
2008-09	per 100 000 children	np	np	np	np	–	–	–	np	0.3
2009-10	per 100 000 children	np	–	np	np	np	–	–	np	0.1
2010-11	per 100 000 children	0.4	np	np	np	–	–	–	–	0.3
2011-12	per 100 000 children	–	–	np	np	np	–	–	np	0.2
2012-13	per 100 000 children	np	np	np	–	–	–	–	–	0.2
2013-14	per 100 000 children	np	np	0.5	np	–	–	–	np	0.3
2014-15	per 100 000 children	np	np	np	–	–	–	–	np	0.2

- (a) Notification of the relevant State/Territory authority is required when invasive *Haemophilus influenzae* type b (Hib) is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for Hib — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.
- (b) Cases defined based on Communicable Diseases Network Australia (CDNA) National Notifiable Diseases Surveillance System (NNDSS) case definitions.
- (c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.

TABLE 10A.87

Table 10A.87 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c), (d)**

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

(d) Reference periods comprise the complete financial year. Data may differ from other reports that use a different reference period.

(e) Rates are derived using the Estimated Resident Populations (ERP) as at December 31. Rates have been revised to the ABS' final 2011 Census rebased ERP and may differ from previous reports. See chapter 2 (table 2A.2) for details.

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

Source: Department of Health unpublished, NNDSS; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

TABLE 10A.88

Table 10A.88 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA (e)</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust (g)</i>
2009–2010									
40–44 years	6.2	4.9	23.7	10.5	9.0	22.7	6.8	3.0	10.4
45–49 years	10.8	9.8	37.8	21.6	19.1	37.2	10.9	11.2	18.5
50–54 years	46.9	49.9	54.5	53.9	53.0	51.9	42.1	35.4	50.6
55–59 years	55.0	54.9	59.1	57.8	57.1	59.9	53.6	42.5	56.7
60–64 years	58.4	59.8	62.1	61.8	61.4	65.0	58.2	47.0	60.6
65–69 years	56.7	56.8	60.5	60.1	59.9	62.1	57.2	44.9	58.5
70–74 years	16.1	19.5	54.9	20.9	25.0	18.6	23.4	9.6	25.6
75–79 years	7.0	8.1	20.0	11.8	13.9	9.3	9.9	4.3	10.8
80–84 years	2.8	2.9	5.4	4.5	5.5	3.6	2.9	2.6	3.7
85+ years	0.6	0.6	1.4	1.0	1.1	0.7	0.7	0.2	0.8
40+ years (ASR)	28.8	29.4	42.5	34.1	33.6	38.8	28.8	22.3	32.9
Ages 50–69 (ASR)	53.3	54.6	58.4	57.8	57.1	58.6	51.3	41.5	55.8
2010–2011									
40–44 years	5.7	5.0	21.7	10.1	8.6	22.3	7.2	2.6	9.8
45–49 years	9.8	10.6	36.6	21.6	18.6	36.8	11.9	10.2	18.0
50–54 years	43.1	51.1	53.5	53.8	53.2	50.0	41.1	34.7	49.4
55–59 years	51.5	54.6	57.9	57.9	58.3	58.5	53.0	43.6	55.2
60–64 years	55.9	59.6	61.5	62.3	63.3	64.7	59.2	48.3	59.8
65–69 years	54.6	57.6	59.9	60.4	61.9	60.5	57.3	43.8	58.0
70–74 years	15.6	17.3	54.3	21.1	25.4	16.7	20.7	9.0	24.8
75–79 years	6.8	8.0	19.7	12.2	14.1	9.0	9.4	4.6	10.7
80–84 years	2.7	2.9	5.5	4.8	6.0	3.6	3.0	2.9	3.8
85+ years	0.5	0.6	1.3	1.1	1.1	0.7	0.7	0.7	0.8
40+ years (ASR)	27.0	29.5	41.4	34.1	34.0	37.9	28.7	22.1	32.2
Ages 50–69 (ASR)	50.1	55.0	57.5	57.9	58.3	57.3	51.1	41.6	54.7
2011–2012									
40–44 years	6.1	6.3	21.1	10.3	9.0	22.4	8.7	2.5	10.2
45–49 years	10.0	12.9	36.0	22.1	18.6	37.3	13.8	9.9	18.7
50–54 years	42.6	50.4	52.5	53.7	54.2	50.5	43.0	35.7	49.0
55–59 years	51.8	53.7	57.8	57.6	58.5	58.3	56.3	41.8	55.1
60–64 years	56.2	58.4	60.8	61.6	62.9	64.0	63.2	46.6	59.4
65–69 years	55.8	57.0	59.8	61.6	62.3	62.7	59.0	45.7	58.4
70–74 years	16.3	20.0	54.3	21.7	26.3	17.2	21.4	10.1	25.9
75–79 years	7.5	9.0	20.2	13.1	15.8	9.1	10.6	5.5	11.5
80–84 years	2.9	3.4	5.6	5.3	6.8	3.6	3.3	2.0	4.1
85+ years	0.6	0.7	1.4	1.3	1.3	0.6	0.9	0.9	0.9
40+ years (ASR)	27.3	30.0	41.0	34.3	34.5	38.2	30.6	22.1	32.4
Ages 50–69 (ASR)	50.3	54.2	57.0	57.8	58.7	57.6	53.8	41.4	54.5

TABLE 10A.88

Table 10A.88 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c)**

	NSW	Vic (d)	Qld	WA	SA (e)	Tas	ACT (f)	NT	Aust (g)
2012–2013									
40–44 years	6.8	8.9	21.7	11.3	9.6	24.2	10.6	8.6	11.6
45–49 years	10.7	14.9	36.1	22.6	18.1	38.6	16.9	16.1	19.6
50–54 years	44.3	51.1	52.7	53.0	49.2	51.1	44.2	36.8	49.3
55–59 years	51.5	53.9	57.4	56.7	52.1	57.2	55.9	41.4	54.3
60–64 years	56.5	58.3	61.9	60.6	57.0	63.9	63.2	44.8	59.1
65–69 years	56.1	57.6	60.5	59.7	56.7	64.1	61.1	43.9	58.3
70–74 years	25.5	25.3	54.3	22.6	28.1	19.0	27.9	15.3	30.9
75–79 years	8.6	11.0	21.0	14.3	17.0	10.2	11.5	7.1	12.8
80–84 years	3.1	4.4	6.0	5.9	7.2	4.0	3.7	3.1	4.6
85+ years	0.7	1.0	1.6	1.4	1.5	0.6	0.8	1.1	1.0
40+ years (ASR)	28.7	31.6	41.4	34.3	32.2	38.9	32.3	24.5	33.2
Ages 50–69 (ASR)	50.9	54.6	57.3	56.8	53.0	57.8	54.4	41.0	54.3
2013–2014									
40–44 years	6.9	9.7	22.5	11.5	9.7	24.6	11.0	10.7	12.0
45–49 years	10.7	14.2	36.2	21.6	18.6	36.7	16.4	17.6	19.3
50–54 years	43.7	51.3	52.0	49.3	48.4	50.1	42.4	34.6	48.5
55–59 years	50.1	52.5	56.9	53.6	53.5	55.4	54.3	41.0	53.1
60–64 years	55.9	58.2	61.8	58.3	61.1	62.2	62.5	42.2	58.8
65–69 years	55.9	57.6	61.2	58.5	61.6	62.6	64.7	42.3	58.7
70–74 years	37.1	33.4	54.4	45.9	38.3	41.4	46.3	19.5	40.8
75–79 years	9.3	11.6	21.4	15.7	17.2	9.9	14.5	9.8	13.5
80–84 years	3.2	4.5	6.2	6.4	7.4	3.9	4.8	3.3	4.8
85+ years	0.7	1.0	1.6	1.4	1.6	0.7	1.1	1.2	1.1
40+ years (ASR)	29.3	32.1	41.4	34.8	33.9	39.8	33.7	24.8	33.8
Ages 50–69 (ASR)	50.2	54.2	57.0	54.0	54.8	56.4	53.9	39.3	53.7

ASR = age standardised rate.

- (a) The participation rate is the number of women screened during the reference period as a percentage of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) ERP in each of the calendar years in the reference period. Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Participation rates for women 40 years or over and the target age group are age standardised to the 2001 Australian population standard.
- (c) Data include only women who were residents of the jurisdiction in which they were screened. Data may differ from participation rates data published elsewhere that allocate women to jurisdictions based on the jurisdiction in which screening took place.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) The fall in the participation rate for SA in 2012–2013 reflects a temporary reduction in the total number of women screened, instigated to best manage a Digital Mammography System Wide Review and implementation of the review recommendations, concurrent with the introduction of a new client information system. Going forward, BreastScreen SA anticipates a return to forecasted participation rates.

Table 10A.88 **Participation rates for women in BreastScreen Australia
(24 month period) (a), (b), (c)**

	NSW	Vic (d)	Qld	WA	SA (e)	Tas	ACT (f)	NT	Aust (g)
--	-----	---------	-----	----	--------	-----	---------	----	----------

(f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.0 per cent of women screened in the 24 months 2013–2014 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

(g) Data for Australia include women screened in a jurisdiction other than their jurisdiction of residence.

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

TABLE 10A.89

Table 10A.89 **Participation rates for women in BreastScreen Australia by residential status, 2013 and 2014 (24 month period)**

	<i>Unit</i>	<i>NSW (a)</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (a)</i>	<i>NT</i>
40+ years									
Residents screened	no.	552 196	456 425	461 068	203 539	152 265	55 682	29 489	11 250
Non-residents screened	no.	5242	2169	2096	407	220	57	589	110
Non-residents screened (proportion)	%	0.9	0.5	0.5	0.2	0.1	0.1	2.0	1.0
Ages 50–69 years									
Residents screened	no.	443 810	360 928	306 967	150 331	116 723	39 376	22 557	8 461
Non-residents screened	no.	4438	1702	1419	292	178	37	450	96
Non-residents screened (proportion)	%	1.0	0.5	0.5	0.2	0.2	0.1	2.0	1.1

(a) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.0 per cent of women screened in the 24 months 2013–2014 were not ACT residents. From November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW, and 7–9 per cent of women screened were not residents of the ACT.

Source: State and Territory governments unpublished.

TABLE 10A.90

Table 10A.90 **Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA (e)</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2009–2010									
Aged 40–49 years	5.9	3.2	19.8	11.2	7.3	15.3	7.1	3.1	10.3
Aged 50–59 years	26.2	20.3	39.7	25.7	25.8	33.3	28.2	24.6	29.4
Aged 60–69 years	34.1	29.0	45.7	31.3	31.2	41.8	62.9	27.8	36.1
Aged 70–79 years	8.9	10.1	30.8	13.6	13.3	11.9	23.1	5.0	14.8
Aged 80+ years	2.2	3.3	4.3	3.5	2.0	np	–	2.0	3.1
Age 40+ years (ASR)	16.7	13.5	30.3	18.6	17.1	np	24.6	13.6	20.3
Age 50–69 years (ASR)	29.3	23.7	42.1	27.9	27.9	36.6	41.9	25.8	32.1
2010–2011									
Aged 40–49 years	5.8	4.6	19.3	12.1	6.7	14.4	6.9	3.0	10.3
Aged 50–59 years	25.2	22.7	38.8	27.9	26.8	27.7	29.2	25.4	29.3
Aged 60–69 years	33.1	29.2	45.5	34.3	28.8	39.0	52.4	28.1	35.8
Aged 70–79 years	8.7	8.4	32.0	13.5	12.4	13.7	33.3	6.1	15.1
Aged 80+ years	1.6	4.1	3.3	5.6	0.6	np	–	2.8	2.9
Age 40+ years (ASR)	16.1	14.5	30.0	20.1	16.6	np	24.3	14.1	20.2
Age 50–69 years (ASR)	28.3	25.2	41.4	30.4	27.6	32.1	38.3	26.5	31.9
2011–2012									
Aged 40–49 years	6.5	5.9	19.9	13.3	7.0	15.9	6.6	3.6	11.1
Aged 50–59 years	26.4	22.6	39.8	31.5	27.6	27.8	28.8	24.0	30.3
Aged 60–69 years	35.2	31.0	46.5	36.1	28.8	30.8	40.4	29.3	37.4
Aged 70–79 years	9.3	8.1	32.9	16.5	16.0	37.7	106.7	5.1	16.3
Aged 80+ years	2.4	2.6	4.0	6.0	np	–	–	2.3	3.0
Age 40+ years (ASR)	17.2	15.1	30.8	22.3	np	23.7	32.1	13.9	21.2
Age 50–69 years (ASR)	29.9	25.9	42.5	33.3	28.1	29.0	33.4	26.1	33.1
2012–2013									
Aged 40–49 years	7.2	7.4	22.3	13.6	6.7	18.1	8.6	10.5	12.9
Aged 50–59 years	27.9	26.8	41.8	32.2	25.3	30.5	27.9	27.3	32.0
Aged 60–69 years	36.6	36.0	49.9	37.8	30.5	26.2	28.7	31.1	39.7
Aged 70–79 years	12.8	12.9	33.8	16.8	15.1	np	np	10.3	18.7
Aged 80+ years	3.4	2.1	5.0	6.5	1.8	–	–	4.5	3.9
Age 40+ years (ASR)	18.7	18.2	33.0	23.0	16.9	np	np	18.4	23.1
Age 50–69 years (ASR)	31.3	30.4	45.0	34.4	27.4	28.8	28.2	28.8	35.1
2013–2014									
Aged 40–49 years	7.4	8.2	24.0	13.5	7.4	19.3	9.6	13.7	14.0
Aged 50–59 years	29.4	30.3	42.9	31.2	28.1	31.4	31.6	27.2	33.1
Aged 60–69 years	38.7	37.9	51.9	35.9	31.7	28.8	32.9	30.0	41.1
Aged 70–79 years	20.3	14.8	35.4	20.3	16.5	np	np	16.1	23.3
Aged 80+ years	3.7	3.3	5.6	6.0	2.9	np	np	5.6	4.4
Age 40+ years (ASR)	20.6	20.2	34.5	22.8	18.4	np	np	20.1	24.7
Age 50–69 years (ASR)	33.0	33.3	46.5	33.1	29.5	30.4	32.1	28.3	36.3

TABLE 10A.90

Table 10A.90 Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	NSW	Vic (d)	Qld	WA (e)	SA	Tas	ACT (f)	NT	Aust
--	-----	---------	-----	--------	----	-----	---------	----	------

ASR = age standardised rate.

- (a) Rates are derived using populations that are revised to the ABS 2011 Census rebased population estimates and projections and may differ from previous reports.
- (b) The participation rate is the number of women resident in the catchment area screened in the reference period, divided by the number of women resident in the catchment area in the reference period based on Australian Bureau of Statistics (ABS) ERP data. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (c) Aboriginal and/or Torres Strait Islander women are women who self-identified as being of Aboriginal and/or Torres Strait Islander descent.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) Data for WA may include some Aboriginal and/or Torres Strait Islander women usually resident in the NT in in WA catchment areas.
- (f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.0 per cent of women screened in the 24 months 2013–2014 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

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

Source State and Territory governments unpublished; ABS 2014, *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 2001 to 2026*, Cat. no. 3238.0.

TABLE 10A.91

Table 10A.91 **Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

	<i>NSW</i>	<i>Vic (d)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT (f)</i>	<i>NT</i>	<i>Aust</i>
2009–2010									
Aged 40–49 years	7.1	3.3	29.9	14.3	11.8	17.9	3.0	4.5	9.2
Aged 50–59 years	46.9	30.1	60.0	60.1	49.1	37.6	20.2	33.4	43.6
Aged 60–69 years	52.6	40.5	66.9	69.2	62.2	50.4	26.4	43.6	51.2
Aged 70–79 years	7.7	8.9	41.3	14.5	14.3	10.2	4.6	5.9	11.9
Aged 80+ years	1.1	0.7	3.3	2.1	1.8	1.9	0.5	2.1	1.3
Aged 40+ years (ASR)	25.8	17.9	44.5	35.9	30.7	26.9	12.0	19.5	26.0
Aged 50–69 years (ASR)	49.1	34.2	62.7	63.7	54.3	42.7	22.7	37.4	46.6
2010–2011									
Aged 40–49 years	7.6	4.9	29.0	14.3	11.6	19.7	3.1	4.1	9.8
Aged 50–59 years	46.4	40.7	59.3	59.4	48.3	37.9	20.6	34.6	46.5
Aged 60–69 years	52.9	48.9	65.7	69.7	60.4	50.9	27.3	43.0	54.0
Aged 70–79 years	7.6	8.7	41.1	14.7	14.2	11.0	4.1	6.6	11.8
Aged 80+ years	1.1	0.9	2.8	2.2	1.8	1.7	0.7	2.7	1.3
Aged 40+ years (ASR)	25.9	22.8	43.7	35.8	30.1	27.8	12.2	19.7	27.5
Aged 50–69 years (ASR)	49.0	43.9	61.8	63.4	53.1	43.0	23.3	38.0	49.4
2011–2012									
Aged 40–49 years	6.9	7.3	29.4	15.2	12.2	19.1	3.5	4.6	10.5
Aged 50–59 years	43.3	47.8	59.6	59.2	48.2	39.3	21.3	34.7	47.4
Aged 60–69 years	51.9	55.0	65.9	71.3	57.8	51.2	28.3	42.1	55.6
Aged 70–79 years	7.3	10.6	40.3	15.2	13.6	9.8	4.4	6.2	12.3
Aged 80+ years	0.9	1.2	3.2	2.5	2.2	2.1	0.8	1.6	1.5
Aged 40+ years (ASR)	24.6	27.0	43.9	36.4	29.7	27.9	12.8	19.6	28.3
Aged 50–69 years (ASR)	46.7	50.6	62.1	64.0	52.0	44.0	24.0	37.7	50.6
2012–2013									
Aged 40–49 years	7.2	8.9	30.4	16.0	12.1	19.9	5.7	13.0	11.4
Aged 50–59 years	44.4	49.5	60.2	58.6	43.4	43.2	22.8	37.9	48.2
Aged 60–69 years	53.5	56.4	66.8	70.5	50.2	50.9	30.2	42.3	56.3
Aged 70–79 years	13.0	12.8	39.3	15.9	14.6	11.5	6.4	10.6	15.3
Aged 80+ years	1.0	1.5	3.4	3.0	2.5	1.7	0.8	2.5	1.7
Aged 40+ years (ASR)	26.1	28.6	44.4	36.5	27.2	29.4	14.5	24.0	29.4
Aged 50–69 years (ASR)	48.0	52.2	62.8	63.3	46.1	46.2	25.7	39.6	51.4
2013–2014									
Aged 40–49 years	7.0	9.1	30.9	15.8	12.5	21.0	5.8	16.6	11.6
Aged 50–59 years	44.9	50.6	61.0	54.9	46.3	42.9	24.2	37.7	48.8
Aged 60–69 years	54.5	57.1	67.6	69.2	56.0	49.0	34.5	41.3	57.3
Aged 70–79 years	16.8	17.6	38.4	31.5	19.0	19.7	14.9	16.0	20.1
Aged 80+ years	1.0	1.6	3.3	3.4	2.6	1.7	0.6	3.3	1.8
Aged 40+ years (ASR)	26.8	29.8	44.8	37.4	29.8	30.5	16.9	25.8	30.5
Aged 50–69 years (ASR)	48.7	53.2	63.6	60.5	50.1	45.3	28.3	39.2	52.1

Table 10A.91 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

	NSW	Vic (d)	Qld	WA	SA	Tas (e)	ACT (f)	NT	Aust
--	-----	---------	-----	----	----	---------	---------	----	------

ASR = age standardised rate. **NESB** = Non English speaking background.

- (a) The participation rate is the number of NESB women residents in the catchment area screened in the reference period, divided by the estimated number of NESB women resident in the catchment area in that period. The female NESB population estimate is derived by applying the NESB age distribution from the 2011 Census to the Australian Bureau of Statistics (ABS) female ERP data for the relevant year. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (b) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs and rates may differ from those published in previous reports. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1) for details.
- (c) NESB is defined as persons who speak a language other than English at home.
- (d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.
- (e) An apparent drop in participation of NESB women in Tasmania occurred from the 2005–2006 screening period and coincided with a significant reduction in self-reporting of NESB status that followed a change in the client registration form in 2006. Since revision of the form in May 2009, both self-reporting of NESB status and participation rates are returning to earlier levels. The observed drop in participation, therefore, appears to reflect the drop in self reporting of NESB status rather than reduced participation.
- (f) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, 2.0 per cent of women screened in the 24 months 2013–2014 were not ACT residents, a decline from 7–9 per cent of women screened in previous 24 month periods. The decline reflects a change in arrangements between the ACT and NSW, whereby from November 2013 a limited number of ACT screening appointments are available for NSW residents who work in the ACT. Previously, the ACT provided screening services to residents in some southern parts of NSW.

Source: State and Territory governments unpublished; ABS various years, *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; ABS unpublished, *2011 Census of Population and Housing*.

TABLE 10A.92

Table 10A.92 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
2009–10									
Major Cities									
Aged 40–49 years	7.8	7.0	29.7	16.3	13.5	..	9.2	..	12.8
Aged 50–59 years	49.0	50.9	54.4	57.2	53.5	..	48.8	..	51.7
Aged 60–69 years	55.3	57.1	59.3	61.9	58.3	..	59.6	..	57.5
Aged 70–79 years	10.7	13.2	37.7	15.5	17.7	..	18.0	..	17.0
Aged 80+ years	1.5	1.5	3.3	2.3	2.7	..	1.8	..	2.0
Age 40+ years (ASR)	27.5	28.4	40.9	34.5	32.3	..	29.6	..	31.2
Age 50–69 years (ASR)	51.3	53.2	56.2	59.0	55.3	..	52.8	..	53.9
Inner Regional									
Aged 40–49 years	9.1	7.9	27.3	14.2	13.7	29.6	np	..	15.0
Aged 50–59 years	52.4	55.1	55.1	53.2	55.5	56.3	np	..	54.2
Aged 60–69 years	60.1	61.5	61.8	61.9	65.5	64.0	np	..	61.5
Aged 70–79 years	13.4	16.6	39.5	20.7	23.6	13.3	np	..	20.5
Aged 80+ years	1.7	2.2	3.5	3.8	3.6	1.8	np	..	2.4
Age 40+ years (ASR)	30.0	31.2	40.8	33.4	35.0	38.6	np	..	33.8
Age 50–69 years (ASR)	55.2	57.5	57.6	56.4	59.3	59.1	np	..	56.9
Outer Regional									
Aged 40–49 years	13.2	10.2	34.5	13.7	17.2	31.0	..	6.6	21.4
Aged 50–59 years	52.7	55.7	61.5	51.8	59.2	54.4	..	42.4	55.8
Aged 60–69 years	60.3	61.6	65.3	59.6	65.0	62.6	..	50.6	62.1
Aged 70–79 years	16.7	18.9	43.1	22.6	25.7	16.0	..	6.5	24.7
Aged 80+ years	3.0	3.5	4.1	5.0	5.7	2.8	..	np	3.8
Age 40+ years (ASR)	32.1	32.5	46.2	32.8	37.4	38.6	..	23.8	37.1
Age 50–69 years (ASR)	55.5	58.0	62.9	54.7	61.3	57.4	..	45.6	58.2
Remote									
Aged 40–49 years	23.7	np	34.5	20.5	14.6	np	..	9.6	22.2
Aged 50–59 years	53.5	np	55.3	51.9	48.7	np	..	38.0	50.3
Aged 60–69 years	65.7	np	63.7	62.5	55.9	np	..	42.1	59.5
Aged 70–79 years	23.9	np	41.7	24.1	26.0	np	..	np	28.1
Aged 80+ years	np	np	6.3	np	6.1	np	..	np	6.1
Age 40+ years (ASR)	38.1	37.5	44.1	36.1	32.2	36.3	..	22.8	36.1
Age 50–69 years (ASR)	58.2	np	58.5	56.1	51.5	51.0	..	39.5	53.9
Very remote									
Aged 40–49 years	np	..	32.5	20.5	np	np	..	5.7	21.3
Aged 50–59 years	np	..	54.9	46.6	np	np	..	28.4	46.3
Aged 60–69 years	np	..	57.1	44.5	np	np	..	30.4	48.6
Aged 70–79 years	np	..	36.7	na	np	np	..	np	25.4
Aged 80+ years	np	..	np	np	np	np	..	np	5.0

TABLE 10A.92

Table 10A.92 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Age 40+ years (ASR)	49.0	..	41.6	30.5	30.5	np	..	16.1	32.4
Age 50–69 years (ASR)	np	..	55.7	45.8	45.6	np	..	29.0	47.2
2010–2011									
Major Cities									
Aged 40–49 years	na	na	na	na	na	na	na	na	12.3
Aged 50–59 years	na	na	na	na	na	na	na	na	50.8
Aged 60–69 years	na	na	na	na	na	na	na	na	57.0
Aged 70–79 years	na	na	na	na	na	na	na	na	16.7
Aged 80+ years	na	na	na	na	na	na	na	na	2.0
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	30.7
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	53.1
Inner Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	14.9
Aged 50–59 years	na	na	na	na	na	na	na	na	53.6
Aged 60–69 years	na	na	na	na	na	na	na	na	61.3
Aged 70–79 years	na	na	na	na	na	na	na	na	20.2
Aged 80+ years	na	na	na	na	na	na	na	na	2.4
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	33.5
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	56.5
Outer Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	20.7
Aged 50–59 years	na	na	na	na	na	na	na	na	55.0
Aged 60–69 years	na	na	na	na	na	na	na	na	61.4
Aged 70–79 years	na	na	na	na	na	na	na	na	24.9
Aged 80+ years	na	na	na	na	na	na	na	na	4.1
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	36.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	57.4
Remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	21.7
Aged 50–59 years	na	na	na	na	na	na	na	na	52.2
Aged 60–69 years	na	na	na	na	na	na	na	na	59.9
Aged 70–79 years	na	na	na	na	na	na	na	na	30.7
Aged 80+ years	na	na	na	na	na	na	na	na	6.9
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	37.0
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	55.2
Very remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	19.3
Aged 50–59 years	na	na	na	na	na	na	na	na	43.3

TABLE 10A.92

Table 10A.92 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust</i>
Aged 60–69 years	na	na	na	na	na	na	na	na	49.5
Aged 70–79 years	na	na	na	na	na	na	na	na	28.0
Aged 80+ years	na	na	na	na	na	na	na	na	7.7
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	31.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	45.8

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) estimated resident population (ERP) in each of the calendar years in the reference period. Rates for '40+ years' and '50–69 years' are age standardised to the Australian population at 30 June 2001.
- (b) Periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (c) Data are suppressed where numerator is less than 5 or denominator is less than 1000.
- (d) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the *ABS Census of population and housing* for 2006. The accuracy of remoteness classifications decreases over time since the census year due to demographic changes within postcode boundaries. Sources of inaccuracy particularly affect rates based on small numbers and these should be interpreted with caution. Areas where rates are based on small numbers include very remote areas in NSW, SA and Tasmania, remote areas in Victoria and Tasmania, and inner regional areas in the ACT. Minor differences can result in apparently large variations where numerators are small numbers.
- (e) Women were allocated to a remoteness area based on postcode of usual residence. Some women's postcodes could not be matched to a remoteness area; these women were excluded from the state and territory calculations, but included in the state and territory and Australia totals. Some postcodes supplied by women may not accurately reflect their usual residence.
- (f) Data are not available for the 24 month periods 2007 and 2008, and 2011 and 2012. Data are not available for states and territories for the 24 month periods from 2010 and 2011.
- (g) In general, 99 per cent or more of women screened are residents of the jurisdiction in which screening took place. In the ACT, around 7–9 per cent of women screened in each 24 month period were not ACT residents. The ACT provided screening services to residents in some southern parts of NSW until November 2013.

na Not available. ... **Not applicable.** **np** Not published.

Source: AIHW unpublished, derived from State and Territory data and ABS Census of population and housing.

TABLE 10A.93

Table 10A.93 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
Target age group (20–69 years)									
Crude rates									
2005 and 2006	57.3	62.7	57.1	59.0	62.9	60.4	61.1	53.8	59.3
2006 and 2007	58.8	62.7	58.5	58.6	62.3	59.1	61.0	53.1	60.0
2007 and 2008	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
2008 and 2009	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
2009 and 2010	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
2010 and 2011	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
2011 and 2012	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
2012 and 2013	56.9	60.9	56.0	55.5	58.7	57.0	57.0	55.2	57.7
2013 and 2014	56.6	59.6	56.0	55.7	59.1	57.6	56.9	55.4	57.3
Age standardised rates									
2005 and 2006	57.3	62.9	57.1	58.8	63.0	60.5	61.5	53.1	59.3
2006 and 2007	58.9	63.0	58.5	58.5	62.5	59.3	61.3	52.3	60.1
2007 and 2008	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2
2010 and 2011	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
2012 and 2013	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2
2013 and 2014	57.0	60.3	56.4	56.1	59.4	57.9	57.9	55.2	57.8
By age group (years)									
2005 and 2006									
20–24	43.5	47.7	49.2	51.4	51.4	56.8	48.4	50.5	47.5
25–29	54.9	59.2	57.4	58.8	61.7	62.3	58.5	54.5	57.5
30–34	61.8	65.3	60.8	63.3	66.6	64.4	64.2	56.1	63.0
35–39	62.9	67.1	61.1	64.1	67.4	64.4	65.8	56.4	64.1
40–44	62.6	67.8	61.1	63.6	67.4	64.6	66.1	56.2	64.1
45–49	62.6	68.8	61.5	62.9	67.4	63.1	64.7	55.7	64.3
50–54	60.4	67.2	58.3	59.2	65.3	61.7	64.3	53.6	61.9
55–59	56.7	64.4	54.7	56.0	62.3	57.0	63.0	50.3	58.6
60–64	52.7	61.2	51.4	50.9	58.8	52.8	60.6	45.3	54.9
65–69	45.3	55.1	45.1	46.7	53.7	46.0	55.1	41.6	48.7
20–69 years	57.3	62.7	57.1	59.0	62.9	60.4	61.1	53.8	59.3
20–69 years (ASR)	57.3	62.9	57.1	58.8	63.0	60.5	61.5	53.1	59.3
2006 and 2007									
20–24	45.3	48.1	51.4	52.1	51.1	54.7	50.6	51.2	48.7
25–29	56.7	58.9	59.0	59.4	61.2	60.4	58.7	54.4	58.4

TABLE 10A.93

Table 10A.93 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
30-34	62.9	64.5	61.7	62.2	65.1	62.4	63.5	54.8	63.0
35-39	64.2	66.8	62.2	62.9	66.3	62.7	64.9	55.4	64.3
40-44	63.9	67.6	62.1	62.5	66.6	62.7	64.7	54.8	64.4
45-49	64.8	69.4	63.0	62.7	67.1	62.5	64.3	55.3	65.4
50-54	62.0	67.4	59.7	59.1	65.2	60.3	63.8	51.7	62.7
55-59	58.8	65.1	56.6	56.3	62.3	56.9	63.5	50.0	59.9
60-64	54.8	61.7	52.8	51.2	59.2	53.0	60.3	45.2	56.1
65-69	46.8	55.4	46.3	45.8	53.9	46.9	54.6	40.4	49.4
20-69 years	58.8	62.7	58.5	58.6	62.3	59.1	61.0	53.1	60.0
20-69 years (ASR)	58.9	63.0	58.5	58.5	62.5	59.3	61.3	52.3	60.1
2007 and 2008									
20-24	44.5	46.6	51.5	51.3	49.4	53.5	49.7	52.7	47.9
25-29	56.0	57.1	58.4	57.7	59.5	58.0	58.0	56.5	57.2
30-34	62.6	63.2	61.8	60.3	63.7	60.9	62.0	57.1	62.3
35-39	64.3	66.1	62.3	61.8	64.8	61.8	64.6	59.0	64.0
40-44	64.2	67.1	62.5	61.5	65.7	60.6	63.4	57.7	64.2
45-49	65.0	68.7	63.6	61.6	66.8	61.0	64.3	57.7	65.2
50-54	62.6	67.0	61.0	59.0	65.1	57.8	63.4	56.0	63.0
55-59	59.8	65.3	58.0	55.9	62.6	55.7	64.4	53.7	60.5
60-64	55.8	61.8	54.1	52.0	59.1	51.5	59.2	48.5	56.7
65-69	47.1	54.8	47.4	45.2	53.8	44.5	52.5	41.2	49.4
20-69 years	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
20-69 years (ASR)	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009									
20-24	42.1	44.2	48.8	50.2	47.4	51.6	46.6	52.4	45.6
25-29	53.5	55.5	56.2	56.8	57.8	56.2	55.3	56.5	55.3
30-34	61.1	63.3	60.9	60.6	62.8	60.5	60.8	58.6	61.6
35-39	63.2	66.2	61.7	62.1	64.9	61.2	62.7	59.3	63.6
40-44	63.2	67.3	62.1	62.3	65.4	60.5	63.5	61.2	64.0
45-49	64.0	69.0	63.1	62.1	66.3	61.5	64.0	60.0	64.9
50-54	61.9	67.8	61.2	60.1	65.2	59.1	62.8	59.1	63.2
55-59	59.9	66.3	58.4	56.7	62.8	57.0	63.9	53.8	61.0
60-64	56.1	63.2	54.7	53.5	59.8	53.0	61.1	50.4	57.6
65-69	47.9	55.5	47.8	45.4	53.5	45.7	52.8	43.3	50.0
20-69 years	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
20-69 years (ASR)	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010									
20-24	39.8	42.8	46.3	48.4	45.9	50.5	43.4	50.2	43.6
25-29	51.0	53.9	53.8	55.2	56.0	55.3	53.8	53.5	53.2

TABLE 10A.93

Table 10A.93 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
30-34	58.8	62.2	58.1	59.3	61.3	59.9	60.0	56.4	59.8
35-39	61.0	65.2	59.4	60.6	64.2	60.5	60.4	57.3	61.9
40-44	61.7	67.0	60.3	61.1	64.4	60.7	62.6	58.8	62.8
45-49	62.8	69.2	61.6	61.9	65.7	61.5	62.4	58.8	64.1
50-54	61.1	68.4	60.4	59.7	64.4	59.5	62.6	57.2	62.8
55-59	59.4	66.3	57.8	57.0	62.7	57.7	63.1	54.0	60.7
60-64	56.4	64.1	54.9	53.9	60.4	54.3	61.7	50.9	58.1
65-69	48.2	55.8	47.3	45.5	53.1	46.8	54.0	43.4	50.0
20-69 years	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
20-69 years (ASR)	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2
2010 and 2011									
20-24	39.3	41.7	44.9	46.9	45.0	49.8	40.9	49.0	42.6
25-29	50.4	52.3	52.1	53.2	55.1	54.6	52.9	52.2	52.0
30-34	57.9	59.8	56.3	57.1	61.3	57.6	57.7	54.6	58.2
35-39	60.1	63.4	57.8	58.6	63.1	58.4	60.0	56.3	60.4
40-44	61.2	65.6	58.8	59.2	64.1	59.1	60.4	55.9	61.7
45-49	62.3	68.2	60.8	60.7	65.6	58.6	61.8	57.6	63.4
50-54	61.8	67.7	60.0	58.8	64.2	57.0	63.9	55.4	62.6
55-59	59.4	65.8	57.6	56.5	63.1	56.4	62.4	54.8	60.5
60-64	57.3	64.4	55.6	54.0	61.1	52.9	62.5	50.9	58.6
65-69	48.9	55.7	47.5	45.8	53.3	44.7	55.2	42.7	50.3
20-69 years	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
20-69 years (ASR)	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012									
20-24	39.7	42.1	44.8	46.7	45.2	49.6	40.5	50.6	42.8
25-29	50.6	52.6	52.4	53.2	55.0	56.1	52.3	52.4	52.2
30-34	58.1	59.7	56.6	56.9	60.5	57.3	57.0	54.9	58.2
35-39	60.4	63.7	58.1	58.4	62.1	59.4	59.8	55.0	60.6
40-44	61.5	66.1	58.8	59.2	63.0	59.7	60.6	56.2	61.9
45-49	63.0	68.8	61.1	61.1	65.2	60.8	62.1	58.4	63.9
50-54	62.8	68.7	60.2	59.7	63.5	58.3	62.4	55.9	63.3
55-59	60.2	66.8	58.2	56.7	62.8	57.4	61.6	54.1	61.2
60-64	58.4	65.9	55.8	55.1	61.1	54.0	62.5	50.7	59.5
65-69	50.6	57.1	48.0	47.0	53.2	46.4	54.7	43.5	51.5
20-69 years	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
20-69 years (ASR)	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7
2012 and 2013									
20-24	39.5	42.3	44.7	45.8	44.8	49.9	41.3	52.4	42.7
25-29	50.6	52.4	52.4	52.7	54.1	56.5	51.3	53.0	52.0

TABLE 10A.93

Table 10A.93 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

	<i>NSW</i>	<i>Vic (e)</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT (e)</i>	<i>NT</i>	<i>Aust</i>
30–34	58.1	59.4	56.8	56.6	59.8	58.7	57.9	56.6	58.1
35–39	61.2	63.7	58.6	58.7	61.5	60.6	60.7	55.7	61.0
40–44	62.6	66.8	59.8	59.1	62.6	60.3	61.9	58.0	62.6
45–49	63.8	69.5	61.9	61.3	64.5	61.3	63.4	59.6	64.5
50–54	63.6	69.8	61.2	59.6	63.5	59.9	62.6	58.0	64.0
55–59	61.0	67.8	59.1	57.0	62.6	57.2	63.5	55.3	61.9
60–64	59.4	67.0	56.9	55.1	61.5	55.5	63.0	51.7	60.4
65–69	51.7	59.0	49.5	47.7	53.9	47.0	56.5	43.0	52.7
20–69 years	56.9	60.9	56.0	55.5	58.7	57.0	57.0	55.2	57.7
20–69 years (ASR)	57.4	61.6	56.4	55.9	59.0	57.4	58.0	55.1	58.2
2013 and 2014									
20–24	39.0	41.2	44.7	46.1	45.6	50.3	40.6	50.9	42.3
25–29	49.9	51.1	51.8	52.7	54.0	57.2	51.0	53.6	51.4
30–34	57.3	57.8	56.6	56.7	59.9	59.8	58.1	58.2	57.4
35–39	60.7	62.1	58.6	58.7	61.9	60.7	60.3	56.3	60.4
40–44	62.1	65.0	60.0	59.3	62.9	60.7	61.4	57.3	62.1
45–49	63.6	67.9	61.9	61.6	64.7	61.4	63.4	59.8	64.1
50–54	63.6	68.5	61.3	59.8	64.6	60.5	63.0	58.2	63.9
55–59	61.1	67.1	59.3	57.5	62.3	57.6	63.4	54.6	61.8
60–64	59.4	66.4	56.9	55.4	62.3	56.5	62.6	51.4	60.3
65–69	52.7	59.3	50.1	48.9	54.8	48.1	57.8	44.5	53.5
20–69 years	56.6	59.6	56.0	55.7	59.1	57.6	56.9	55.4	57.3
20–69 years (ASR)	57.0	60.3	56.4	56.1	59.4	57.9	57.9	55.2	57.8

ASR = age standardised rate.

- (a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population based on the 2011 Census in each of the calendar years in the reference period. Age-standardised rates are standardised to the 2001 Australian standard population.
- (b) The eligible female population has been adjusted for the estimated proportion of women who have had a hysterectomy, using age-specific hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. Historical data may differ from data in previous reports for which hysterectomy fractions were estimated using a different methodology.
- (c) Data exclude women who have opted off the cervical cytology register.
- (d) Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.
- (e) Number of women screened includes all women screened in each jurisdiction (not just those women resident in each jurisdiction) with the exception of: Victoria, for the reference periods 2005–2006 and 2007–2008, where only residents of the jurisdiction are included; the ACT, where only residents of the jurisdiction (and in some cases some immediate border residents) are included. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.

Source: AIHW unpublished, State and Territory Cervical Cytology Registry data.

TABLE 10A.94

Table 10A.94 **Cervical screening rates among Aboriginal and Torres Strait Islander women aged 20 to 69 years, who reported having a Pap smear at least every 2 years (per cent)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2004-05										
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4
2012-13										
Age standardised rate (a)	%	53.2	59.0	53.0	49.0	58.5	54.7	54.2	53.8	53.4
RSE	%	5.2	6.0	6.2	6.4	6.4	7.3	11.7	6.6	2.8
95 per cent confidence interval	%	± 5.5	± 6.9	± 6.5	± 6.2	± 7.4	± 7.9	± 12.4	± 7.0	± 2.9

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Australian population standard.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

TABLE 10A.95

Table 10A.95 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

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

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

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

Source: AIHW 2004, 2005, 2011, *Adult Vaccination Survey: Summary Results*, Cat. no. PHE 51, PHE 56, PHE 135; Department of Health unpublished, 2006 Adult Vaccination Survey.

TABLE 10A.96

Table 10A.96 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

TABLE 10A.96

Table 10A.96 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

RSE = Relative standard error.

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

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

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

TABLE 10A.97

Table 10A.97 **Proportion of Aboriginal and Torres Strait Islander people aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease (a)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2004-05										
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2
2012-13										
Proportion	%	23.3	24.4	27.1	24.4	25.7	17.5	14.4	33.7	25.3
Relative standard error	%	11.9	16.6	13.6	14.7	18.4	20.5	41.3	14.5	6.3

- (a) Vaccinations against influenza and pneumococcal disease have been available free to Aboriginal and Torres Strait Islander people aged 50 years or over since 1999.
- (b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0; ABS unpublished, *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13* (National Aboriginal and Torres Strait Islander Health Survey component), Cat. no. 4727.0.

TABLE 10A.98

Table 10A.98 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
Vaccine-preventable conditions (f)									
2007-08	0.6	0.7	0.7	0.7	0.9	0.4	0.7	2.7	0.7
2008-09	0.6	0.7	0.6	0.6	0.7	0.5	0.5	2.8	0.6
2009-10	0.6	0.6	0.8	0.7	0.7	0.6	0.5	2.9	0.7
2010-11	0.5	0.7	0.7	0.6	0.8	0.4	0.3	3.0	0.7
2011-12	0.6	0.7	0.8	0.6	0.8	0.5	0.5	3.2	0.7
2012-13	0.7	0.8	1.1	1.0	1.1	1.0	0.8	3.7	0.9
2013-14	1.1	1.3	1.2	1.2	1.5	0.7	0.9	7.6	1.3
Acute conditions									
2007-08	10.5	11.4	11.8	11.3	12.0	9.0	9.0	18.2	11.2
2008-09	10.2	11.2	12.2	11.3	11.9	8.2	9.7	20.2	11.2
2009-10	10.2	11.3	12.4	11.3	12.1	8.5	8.1	19.7	11.2
2010-11	10.7	11.9	12.9	12.7	12.6	8.3	9.1	20.2	11.8
2011-12	10.9	12.1	12.9	13.7	12.9	8.4	9.6	21.2	12.1
2012-13	10.8	10.2	13.8	13.6	13.6	9.9	9.3	20.5	11.8
2013-14	10.9	10.6	14.3	12.9	13.0	10.7	9.5	21.6	12.0
Chronic conditions									
2007-08	12.6	14.6	15.6	13.3	14.6	13.6	9.4	24.6	14.0
2008-09	12.3	14.0	14.8	13.2	14.2	12.3	11.0	24.0	13.5
2009-10	12.2	14.1	14.5	13.3	13.4	11.8	9.8	23.7	13.4
2010-11	10.2	12.1	12.5	11.2	11.7	9.2	8.7	23.3	11.4
2011-12	10.5	11.9	12.7	11.1	11.5	9.2	8.6	21.6	11.4
2012-13	10.4	10.8	12.9	11.3	11.9	10.1	8.3	22.1	11.3
2013-14	10.5	11.1	12.6	10.7	11.4	10.8	8.1	21.3	11.2

TABLE 10A.98

Table 10A.98 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (e)</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (c)</i>
All potentially preventable hospitalisations (g)									
2007-08	23.6	26.6	28.0	25.2	27.4	22.8	19.1	45.0	25.8
2008-09	23.0	25.9	27.6	25.0	26.7	20.9	21.1	46.6	25.3
2009-10	23.0	25.9	27.6	25.2	26.1	20.8	18.2	45.8	25.2
2010-11	21.4	24.6	26.0	24.4	25.0	17.8	18.1	45.9	23.8
2011-12	22.0	24.6	26.3	25.4	25.1	18.0	18.7	45.6	24.1
2012-13	21.9	21.7	27.7	25.7	26.4	20.8	18.2	45.8	23.9
2013-14	22.4	22.9	27.9	24.6	25.6	22.0	18.5	48.9	24.4

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

(b) Data quality information (DQI) for some data in this table is at www.pc.gov.au/rogs/2016.

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

(d) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.

(e) Data for Tasmania are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.

(f) Changes to the coding standard for Viral hepatitis in the 8th edition of ICD-10-AM may account for a proportion of the increase in the rate of vaccine preventable conditions. See Appendix A of AIHW 2015 *Admitted patient care 2013–14: Australian hospital statistics* for more details.

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

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

TABLE 10A.99

Table 10A.99 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g), (h)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust (e)</i>
Vaccine preventable conditions (i)									
Aboriginal and Torres Strait Islander people									
2007-08	1.1	1.1	1.6	3.7	3.0	0.6	1.4	7.2	2.3
2008-09	1.1	1.1	1.4	2.8	2.8	0.2	1.0	7.3	2.1
2009-10	1.4	1.0	3.1	4.5	3.0	0.6	0.1	8.3	3.0
2010-11	1.1	1.1	2.5	3.2	2.8	0.3	0.4	9.4	2.7
2011-12	1.1	1.5	2.0	3.8	2.9	0.4	1.3	9.6	2.7
2012-13	1.4	1.3	2.8	4.7	3.7	1.4	3.3	11.6	3.4
2013-14	2.9	3.5	4.8	13.2	8.6	1.0	1.8	26.5	7.5
Other Australians (j)									
2007-08	0.6	0.7	0.7	0.6	0.9	0.4	0.7	1.1	0.7
2008-09	0.6	0.7	0.6	0.5	0.6	0.5	0.5	1.0	0.6
2009-10	0.6	0.6	0.7	0.6	0.7	0.6	0.5	0.9	0.6
2010-11	0.5	0.7	0.7	0.5	0.8	0.4	0.3	0.9	0.6
2011-12	0.6	0.7	0.8	0.5	0.8	0.5	0.5	1.1	0.7
2012-13	0.7	0.8	1.1	0.9	1.0	0.9	0.7	1.3	0.9
2013-14	1.1	1.3	1.1	0.9	1.3	0.7	0.9	2.2	1.2
Acute conditions									
Aboriginal and Torres Strait Islander people									
2007-08	17.2	13.4	25.8	39.4	27.7	6.1	12.7	38.0	24.4
2008-09	16.4	14.3	26.0	35.4	27.0	5.6	12.4	43.0	24.2
2009-10	16.2	14.3	24.9	35.0	27.6	7.5	8.9	43.3	23.9
2010-11	18.0	18.0	27.2	40.3	29.3	7.6	12.4	42.9	26.2
2011-12	19.6	19.6	27.2	42.0	31.4	7.9	17.4	45.1	27.4
2012-13	20.8	13.9	28.8	41.5	30.7	6.5	19.7	43.1	27.5
2013-14	21.4	16.4	30.3	41.4	29.8	9.2	19.3	44.8	28.5

TABLE 10A.99

Table 10A.99 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g), (h)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust (e)</i>
Other Australians (j)									
2007-08	10.4	11.5	11.4	10.4	11.8	9.1	9.0	10.6	10.9
2008-09	10.2	11.3	11.8	10.5	11.8	8.3	9.6	10.8	10.9
2009-10	10.2	11.4	12.0	10.6	11.9	8.6	8.0	10.3	10.9
2010-11	10.6	11.9	12.4	11.8	12.4	8.3	9.0	11.2	11.5
2011-12	10.8	12.2	12.4	12.7	12.6	8.4	9.5	11.7	11.7
2012-13	10.7	10.3	13.3	12.7	13.4	10.0	9.1	11.4	11.4
2013-14	10.7	10.7	13.6	12.0	12.7	10.8	9.3	12.1	11.6
Chronic conditions									
Aboriginal and Torres Strait Islander people									
2007-08	29.9	21.3	44.1	57.2	50.2	11.7	23.9	52.4	39.1
2008-09	29.6	23.1	44.5	52.8	45.9	13.4	24.5	54.0	38.7
2009-10	28.2	25.0	41.2	50.5	39.1	10.9	16.6	57.7	37.1
2010-11	25.0	22.5	34.5	43.6	34.4	10.7	26.6	54.0	32.6
2011-12	29.3	26.7	35.2	43.0	35.3	14.3	24.3	54.0	34.8
2012-13	27.7	20.5	36.8	41.0	35.1	14.7	14.8	52.9	33.8
2013-14	30.6	22.9	33.4	42.2	39.8	13.6	27.8	50.6	34.4
Other Australians (j)									
2007-08	12.5	14.8	15.0	12.4	14.5	13.6	9.3	16.6	13.7
2008-09	12.2	14.2	14.2	12.4	14.2	12.3	10.8	15.5	13.2
2009-10	12.1	14.2	13.9	12.4	13.3	11.8	9.6	13.8	13.1
2010-11	10.1	12.3	12.0	10.5	11.6	9.2	8.5	13.4	11.1
2011-12	10.3	12.0	12.1	10.4	11.5	9.1	8.5	11.9	11.1
2012-13	10.2	10.9	12.3	10.5	11.8	9.9	8.0	11.7	10.9
2013-14	10.2	11.1	12.0	9.9	11.2	10.6	7.9	10.9	10.8

All potentially preventable hospitalisations (k)

Aboriginal and Torres Strait Islander people

TABLE 10A.99

Table 10A.99

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

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (g), (h)</i>	<i>ACT (g)</i>	<i>NT</i>	<i>Aust (e)</i>
2007-08	48.0	35.7	70.9	98.8	80.3	18.2	38.0	95.8	65.2
2008-09	46.9	38.3	71.2	89.6	75.1	19.1	37.9	102.6	64.3
2009-10	45.6	40.0	68.4	88.9	69.2	18.7	25.6	107.4	63.3
2010-11	44.0	41.4	63.6	86.4	66.1	18.6	39.5	104.3	60.9
2011-12	49.9	47.5	63.8	88.2	69.0	22.4	43.1	107.0	64.4
2012-13	49.7	35.5	67.7	86.4	68.8	22.2	36.6	105.3	64.0
2013-14	54.5	42.2	67.5	94.4	76.8	23.5	48.9	115.1	68.8
Other Australians (j)									
2007-08	23.5	26.9	27.0	23.4	27.1	23.0	18.9	28.2	25.2
2008-09	22.9	26.1	26.6	23.3	26.5	21.1	20.9	27.2	24.6
2009-10	22.8	26.1	26.5	23.6	25.8	20.9	18.0	24.8	24.5
2010-11	21.2	24.8	25.0	22.7	24.8	17.8	17.8	25.4	23.2
2011-12	21.7	24.7	25.1	23.6	24.8	17.9	18.4	24.6	23.4
2012-13	21.5	21.8	26.4	24.0	26.0	20.8	17.8	24.4	23.1
2013-14	21.9	23.0	26.5	22.7	25.1	22.1	18.0	25.0	23.5

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

(b) Data quality information (DQI) for some data in this table is at www.pc.gov.au/rogs/2016.

(c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified.

(d) Cell sizes are small for some categories and rates may be statistically volatile.

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

(f) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.

(g) Data for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed. For 2010-11 and subsequent years, Indigenous status data for Tasmania and the ACT are of sufficient quality for statistical reporting purposes. For 2009-10 and previous years, data for Tasmania and the ACT were not included in national totals and should be interpreted with particular caution.

Table 10A.99 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

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

(h) Data for Tasmania are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.

(i) Changes to the coding standard for Viral hepatitis in the 8th edition of ICD-10-AM may account for a proportion of the increase in the rate of vaccine preventable conditions. See Appendix A of AIHW 2015 *Admitted patient care 2013-14: Australian hospital statistics* for more details.

(j) Other Australians includes separations where Indigenous status was not stated.

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

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period. ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Series B, Cat. no. 3238.0.

TABLE 10A.100

Table 10A.100 **Separations for selected potentially preventable hospitalisations by remoteness, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (e)</i>
Vaccine preventable conditions									
Major cities	1.3	1.5	1.3	1.0	1.5	..	0.9	..	1.3
Inner regional	0.7	0.8	0.8	0.6	0.9	0.8	np	..	0.8
Outer regional	0.7	0.8	0.8	1.4	1.5	np	..	3.7	1.1
Remote	np	np	1.4	2.9	np	np	..	8.3	2.7
Very remote	np	..	2.8	5.0	7.3	np	..	19.1	7.2
Acute conditions									
Major cities	10.2	10.3	13.2	11.9	12.4	..	9.4	..	11.1
Inner regional	12.4	11.7	14.9	12.3	12.8	10.7	np	..	12.6
Outer regional	13.8	13.3	16.0	14.9	15.7	10.6	..	13.5	14.3
Remote	21.2	np	20.6	20.5	13.7	np	..	28.9	20.4
Very remote	28.1	..	28.8	24.9	25.2	np	..	35.4	28.1
Chronic conditions									
Major cities	9.6	10.9	12.1	10.0	10.8	..	8.1	..	10.5
Inner regional	11.7	11.5	12.8	10.8	10.4	10.8	np	..	11.7
Outer regional	14.5	11.9	13.1	13.2	15.3	10.6	..	14.3	13.3
Remote	23.6	np	15.4	15.0	11.5	12.1	..	25.4	16.8
Very remote	27.5	..	21.1	17.4	21.6	np	..	37.7	24.0
All potentially preventable hospitalisations (h)									
Major cities	20.9	22.6	26.5	22.8	24.4	..	18.4	..	22.8
Inner regional	24.8	23.9	28.4	23.7	24.0	22.2	np	..	25.0
Outer regional	29.0	25.9	29.8	29.3	32.4	21.6	..	30.8	28.5
Remote	45.5	26.6	37.2	37.9	26.0	24.0	..	60.9	39.4
Very remote	57.1	..	52.3	46.5	53.3	np	..	87.7	57.8

TABLE 10A.100

Table 10A.100

Separations for selected potentially preventable hospitalisations by remoteness, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)

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

- (a) Rates are age-standardised to the 2001 Australian standard population.
- (b) Remoteness areas are defined using the ABS 2011 Census based Australian Standard Geographical Classification (ASGS). Not all remoteness areas are represented in each state or territory. Caution should be used in comparing 2012-13 data with earlier years in which remoteness areas were defined using a different geographical classification. See data quality information (DQI) at www.pc.gov.au/rogs/2016 for further detail.
- (c) There are: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.
- (d) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified.
- (e) Cell sizes are small for some categories and rates may be statistically volatile.
- (f) Separation rates are based on state or territory and remoteness area of usual residence, not hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.
- (g) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI for more information.
- (h) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.
- .. Not applicable. **np** Not published.

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

Table 10A.101 Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people) (a), (b), (c), (d), (e), (f)

	<i>Major cities</i>	<i>Inner regional/ Outer regional</i>	<i>Remote/ Very remote</i>
Vaccine-preventable conditions (c), (g)			
Aboriginal and Torres Strait Islander people			
2012-13	2.2	2.4	7.2
2013-14	4.9	4.3	17.6
Other Australians (f)			
2012-13	0.9	0.8	1.2
2013-14	1.3	0.8	1.1
Acute conditions (c)			
Aboriginal and Torres Strait Islander people			
2012-13	18.5	23.3	49.3
2013-14	19.0	24.7	50.8
Other Australians (f)			
2012-13	11.0	12.5	14.3
2013-14	11.1	12.6	14.3
Chronic conditions (c)			
Aboriginal and Torres Strait Islander people			
2012-13	22.4	34.2	49.3
2013-14	25.8	32.4	50.6
Other Australians (f)			
2012-13	10.5	11.8	12.8
2013-14	10.5	11.6	11.8
All potentially preventable hospitalisations (c), (h)			
Aboriginal and Torres Strait Islander people			
2012-13	42.7	59.5	104.4
2013-14	48.9	60.5	115.1
Other Australians (f)			
2012-13	22.3	25.0	28.2
2013-14	22.7	24.9	27.1

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

(b) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

(c) Caution should be used in comparing data over time as there have been changes between the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM) editions and the associated Australian Coding Standards. See DQI (available at www.pc.gov.au/rogs/2016) for more information.

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

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

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

Table 10A.101 **Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people) (a), (b), (c), (d), (e), (f)**

	<i>Major cities</i>	<i>Inner regional/ Outer regional</i>	<i>Remote/ Very remote</i>
--	---------------------	---	--------------------------------

(g) Changes to the coding standard for Viral hepatitis in the 8th edition of ICD-10-AM may account for a proportion of the increase in the rate of vaccine preventable conditions. See Appendix A of AIHW 2015 *Admitted patient care 2013–14: Australian hospital statistics* for more details.

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

Source: AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Residential Population, 30 June; ABS 2014, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*, Series B, Cat. no. 3238.0.

TABLE 10A.102

Table 10A.102 **Separations for selected vaccine preventable conditions by Indigenous status, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Vaccine preventable conditions per 1000 Aboriginal and Torres Strait Islander people									
Pneumonia and Influenza (vaccine-preventable)	0.9	0.9	1.2	2.4	2.2	0.4	0.8	6.0	1.8
Other vaccine preventable conditions	2.1	2.6	3.6	10.8	6.5	0.6	1.0	20.8	5.8
Total	2.9	3.5	4.8	13.2	8.6	1.0	1.8	26.5	7.5
Vaccine preventable conditions per 1000 other Australians (i)									
Pneumonia and Influenza (vaccine-preventable)	0.5	0.5	0.4	0.4	0.7	0.3	0.4	0.7	0.5
Other vaccine preventable conditions	0.7	0.8	0.7	0.6	0.7	0.3	0.6	1.5	0.7
Total	1.1	1.3	1.1	0.9	1.3	0.7	0.9	2.2	1.2

(a) Conditions are defined by ICD-10-AM codes that are available on request.

(b) Changes to the coding standard for Viral hepatitis in the 8th edition of ICD-10-AM may account for a proportion of the increase in the rate of Other vaccine preventable conditions. See Appendix A of AIHW 2015 *Admitted patient care 2013–14: Australian hospital statistics* for more details.

(c) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(d) Separation rates are directly age standardised to the 2001 Australian standard population.

(e) Separation rates are based on state or territory of usual residence.

(f) Rates are derived using population estimates and projections based on the 2011 Census.

(g) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

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

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.103

Table 10A.103 **Separations for selected acute conditions by Indigenous status, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Acute conditions per 1000 Aboriginal and Torres Strait Islander people									
Pneumonia (not vaccine-preventable)	–	–	0.2	0.2	0.2	0.1	–	0.3	0.1
Cellulitis	5.5	3.1	8.0	11.2	5.8	2.2	3.7	11.9	7.3
Convulsions and epilepsy	4.7	2.7	5.9	8.1	8.8	1.3	2.8	8.1	5.8
Eclampsia	–	–	–	–	–	–	–	–	–
Dental conditions	2.9	3.3	3.3	3.7	4.1	1.9	3.2	4.8	3.4
Ear, nose and throat infections	2.6	1.9	3.3	4.0	3.1	1.2	1.8	5.7	3.2
Gangrene	0.5	1.0	1.3	3.2	1.1	0.8	0.3	4.0	1.5
Pelvic inflammatory disease	0.4	0.2	0.6	1.0	0.6	0.2	0.1	1.5	0.6
Perforated/bleeding ulcer	0.5	0.4	0.2	0.3	0.2	0.1	0.3	0.2	0.3
Urinary tract infections, including pyelonephritis (i)	4.3	3.8	7.6	10.0	5.8	1.5	7.1	8.4	6.3
Total	21.4	16.4	30.3	41.4	29.8	9.2	19.3	44.8	28.5
Acute conditions per 1000 other Australians (j)									
Pneumonia (not vaccine-preventable)	0.1	0.1	0.1	0.1	0.1	–	–	0.1	0.1
Cellulitis	2.2	1.8	3.0	1.8	2.2	2.1	1.6	3.6	2.2
Convulsions and epilepsy	1.4	1.3	1.7	1.1	1.6	1.3	1.4	1.2	1.4
Eclampsia	–	–	–	–	–	–	–	–	–
Dental conditions	2.3	2.8	2.7	3.8	3.5	3.4	2.1	2.1	2.8
Ear, nose and throat infections	1.5	1.3	1.9	1.6	2.0	1.4	1.0	1.6	1.6

TABLE 10A.103

Table 10A.103 **Separations for selected acute conditions by Indigenous status, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Gangrene	0.2	0.5	0.4	0.4	0.2	0.4	0.2	0.7	0.4
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Urinary tract infections, including pyelonephritis (i)	2.6	2.5	3.4	2.7	2.7	1.9	2.6	2.4	2.7
Total	10.7	10.7	13.6	12.0	12.7	10.8	9.3	12.1	11.6

(a) Conditions are defined by ICD-10-AM codes that are available on request.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the 2001 Australian standard population.

(d) Separation rates are based on state or territory of usual residence.

(e) Rates are derived using population estimates and projections based on the 2011 Census.

(f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) Cell sizes are small for some categories and rates may be statistically volatile.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

(i) Pyelonephritis is kidney inflammation caused by bacterial infection.

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

– Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.104

Table 10A.104 **Separations for selected chronic conditions by Indigenous status, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Chronic conditions per 1000 Aboriginal and Torres Strait Islander people									
Angina	3.5	2.3	4.9	5.8	4.4	1.1	3.2	5.3	4.2
Asthma	2.3	2.1	2.2	3.4	2.0	0.8	0.9	3.4	2.4
Chronic obstructive pulmonary disease	11.5	7.8	9.9	9.0	12.6	5.1	6.5	14.5	10.6
Congestive heart failure	4.0	3.2	5.2	8.0	5.7	2.6	8.0	6.4	5.1
Diabetes complications (i)	6.0	4.1	7.2	8.7	10.5	1.6	7.3	9.2	7.0
Hypertension	0.6	0.4	0.9	1.3	0.6	0.1	–	0.6	0.7
Iron deficiency anaemia	2.2	2.6	2.1	4.2	2.4	2.3	2.0	2.6	2.5
Nutritional deficiencies	0.1	–	0.1	–	–	–	–	0.3	0.1
Rheumatic heart disease (j)	0.2	0.3	0.5	0.9	0.6	0.1	–	3.0	0.7
Bronchiectasis	0.3	0.1	0.4	0.8	0.9	–	–	5.3	0.9
Total (i), (k)	30.6	22.9	33.4	42.2	39.8	13.6	27.8	50.6	34.4
Chronic conditions per 1000 other Australians (l)									
Angina	1.4	1.2	2.0	1.5	1.6	1.2	1.0	2.6	1.5
Asthma	1.2	1.3	1.3	0.8	1.3	1.0	0.9	0.7	1.2
Chronic obstructive pulmonary disease	2.3	2.2	2.5	1.8	2.4	2.2	1.8	3.0	2.3
Congestive heart failure	1.9	2.1	2.0	1.9	1.9	1.7	1.5	1.8	2.0
Diabetes complications (i)	1.4	1.6	1.7	1.7	1.8	1.9	1.1	1.2	1.6
Hypertension	0.3	0.3	0.5	0.2	0.3	0.2	0.2	0.1	0.3
Iron deficiency anaemia	1.4	2.2	1.4	1.7	1.6	2.3	1.0	1.0	1.7
Nutritional deficiencies	–	–	–	–	–	–	–	0.1	–

TABLE 10A.104

Table 10A.104 **Separations for selected chronic conditions by Indigenous status, 2013-14 (per 1000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (h)</i>
Rheumatic heart disease (j)	0.1	0.1	0.1	0.1	0.1	–	0.1	0.1	0.1
Bronchiectasis	0.2	0.2	0.3	0.2	0.1	0.2	0.1	0.2	0.2
Total (i), (k), (l)	10.2	11.1	12.0	9.9	11.2	10.6	7.9	10.9	10.8

(a) Conditions are defined by ICD-10-AM codes that are available on request.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the 2001 Australian standard population.

(d) Separation rates are based on state or territory of usual residence.

(e) Rates are derived using population estimates and projections based on the 2011 Census.

(f) Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes for 2011-12 and subsequent reporting years.

(g) Cell sizes are small for some categories and rates may be statistically volatile.

(h) Data for Australia include all States and Territories and Australian residents of external Territories.

(i) Excludes separations with an additional diagnosis of diabetes complications.

(j) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.

(k) Total may not sum to the individual categories as more than one chronic condition can be reported for a separation.

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

– Nil or rounded to zero.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.105

Table 10A.105 **Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes, 2013-14 (a), (b), (c), (d), (e), (f)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas (b)</i>	<i>ACT (b)</i>	<i>NT (b)</i>	<i>Aust</i>
Diabetes as a principle diagnosis (g)	no. SHSR	794 4.39	168 2.62	1 274 4.86	496 5.38	270 5.09	25 0.89	28 5.98	711 6.06	3 766 4.86
All diabetes — excluding diabetes complications as an additional diagnosis (h)	no. SHSR	4 421 2.06	876 1.73	5 300 2.65	3 790 3.64	1 354 2.73	236 1.08	124 3.03	2 556 2.99	18 657 2.50
All diabetes (i)	no. SHSR	8 749 2.39	1 891 2.10	14 568 3.85	14 463 8.38	2 769 3.35	466 1.17	235 2.90	8 908 5.90	52 049 3.97

SHSR = Standardised Hospital Separation Ratio

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) Data are available for Tasmania and the ACT for the first time. NT data are for public hospitals only.

(c) Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

(d) Ratios are directly age standardised to the 2001 Australian standard population.

(e) Separation rates are based on state of usual residence.

(f) Changes to the Australian Coding Standards between ICD-10-AM editions have resulted in fluctuations in the reporting of diagnoses for diabetes over time. Therefore caution should be used in comparisons of these data with earlier periods.

(g) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

(h) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24' or Additional diagnosis in 'E109', 'E119', 'E139' or 'E149'.

(i) All diabetes refers to separations with either a principal or additional diagnosis of diabetes. Includes ICD-10-AM codes in: 'E10', 'E11', 'E13', 'E14' or 'O24'.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.106

Table 10A.106 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2013-14 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Circulatory	14.5	11.4	9.7	25.9	10.8	np	np	np	13.5
Renal	3.5	2.0	3.1	3.4	3.8	np	np	np	3.1
Ophthalmic	2.8	6.5	7.4	28.8	5.6	np	np	np	7.7
Other specified	37.8	38.9	53.5	38.5	55.6	np	np	np	42.9
Multiple	23.3	33.7	34.5	31.9	43.0	np	np	np	32.5
No complications	5.5	4.5	4.0	3.6	3.1	np	np	np	4.6
Total (h)	87.4	97.1	112.4	132.1	122.0	np	np	np	104.2

(a) Rates are age standardised to the 2001 Australian standard population.

(b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.

(c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.

(e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

(g) Changes to the Australian Coding Standards between ICD-10-AM editions have resulted in fluctuations in the reporting of diagnoses for diabetes over time. Therefore caution should be used in comparisons of these data with earlier periods.

(h) Totals may not add as a result of rounding.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.107

Table 10A.107 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2013-14 (per cent) (a), (b), (c), (d), (e), (f), (g)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (f)</i>
Circulatory	18.9	10.8	15.2	33.5	12.9	np	np	np	18.7
Renal	12.2	29.9	16.0	19.8	28.2	np	np	np	18.8
Ophthalmic	85.8	90.4	93.3	94.0	85.5	np	np	np	91.8
Other specified	12.7	16.3	26.4	8.0	15.9	np	np	np	16.8
Multiple	19.4	26.6	15.6	4.5	38.3	np	np	np	23.1
No complications	33.9	42.5	43.5	24.2	45.6	np	np	np	37.5
Total	19.1	25.6	26.9	32.2	27.9	np	np	np	25.6

- (a) Data are for the number of same day separations with the specified principal diagnosis, as a per cent of all separations with the specified principal diagnosis.
- (b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.
- (c) Results for individual complications may be affected by small numbers, and need to be interpreted with care.
- (d) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.
- (e) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.
- (f) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (g) Changes to the Australian Coding Standards between ICD-10-AM editions have resulted in fluctuations in the reporting of diagnoses for diabetes over time. Therefore caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.108

Table 10A.108 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2013-14 (a), (b), (c), (d), (e)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
ASR	per 100 000 people	13.6	15.0	16.2	18.8	20.5	np	np	np	16.0
Separations	no.	1184	981	817	477	434	np	np	np	4 172

ASR = Age standardised rate

- (a) ASR rates are age standardised to the 2001 Australian standard population.
- (b) Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation.
- (c) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.
- (d) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.
- (e) Changes to the Australian Coding Standards between ICD-10-AM editions have resulted in fluctuations in the reporting of diagnoses for diabetes over time. Therefore caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.109

Table 10A.109 Separation rates for older people for injuries due to falls (a), (b), (c)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	46 425	32 911	20 058	10 409	8 780	2 348	1 516	340	122 787
2006-07									
Separations per 1000 older people	51.6	48.5	43.0	43.8	35.8	32.7	52.2	47.8	46.7
Number of separations	50 938	35 649	22 078	10 954	9 358	2 455	1 697	375	133 504
2007-08									
Separations per 1000 older people	51.6	48.6	42.9	43.7	36.4	34.1	60.1	43.2	46.8
Number of separations	52 463	36 855	22 851	11 319	9 762	2 616	2 051	366	138 283
2008-09									
Separations per 1000 older people	52.4	47.6	45.7	44.6	39.0	32.9	65.0	43.2	47.7
Number of separations	54 998	37 337	25 092	12 009	10 759	2 580	2 318	383	145 476
2009-10									
Separations per 1000 older people	55.9	49.5	47.1	46.2	43.0	32.8	68.2	43.3	50.1
Number of separations	60 117	39 885	26 759	12 877	12 059	2 638	2 546	408	157 289
2010-11 (d)									
Separations per 1000 older people	60.4	53.0	51.7	52.1	43.0	32.7	65.6	np	54.0
Number of separations	np	np	np	np	np	np	np	np	np
2011-12									
Separations per 1000 older people	61.6	55.2	56.2	56.8	46.0	33.7	73.0	54.0	56.5
Number of separations	68 833	45 953	32 782	16 539	13 297	2 845	2 858	513	183 620
2012-13									
Separations per 1000 older people	62.1	51.8	60.1	58.2	47.8	34.3	66.5	53.9	56.8
Number of separations	71 946	44 709	36 424	17 719	14 261	2 992	2 757	575	191 383

TABLE 10A.109

Table 10A.109 **Separation rates for older people for injuries due to falls (a), (b), (c)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust (d)</i>
2013-14									
Separations per 1000 older people	64.0	51.9	61.1	56.6	48.5	38.3	72.4	63.9	57.8
Number of separations	76 152	46 180	38 342	17 870	14 750	3 407	3 108	691	200 500

(a) Excludes separations records for Hospital Boarders and Posthumous organ procurement.

(b) Older people are defined as people aged 65 years or over.

(c) Separation rates are age standardised to the the 2001 Australian standard population aged 65 years or over.

(d) Data for Australia for 2010-11 do not include data for the NT.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

TABLE 10A.110

Table 10A.110 **General Government Final Consumption Expenditure (GGFCE) chain price deflator (index)**

Years	2014-15 = 100.0
2005-06	77.8
2006-07	80.7
2007-08	83.9
2008-09	87.2
2009-10	89.6
2010-11	94.2
2011-12	95.7
2012-13	97.0
2013-14	98.3
2014-15	100.0

Source: Review calculations based on ABS (2015) *Australian National Accounts: National Income, Expenditure and Product, June 2015*, Cat. no. 5206.0, Canberra; table 2A.51.

Selected other community health programs

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Blood-borne Viruses (BBV) and Sexually Transmissible Infection (STI) Prevention and Control	<p>The BBV and STI Prevention and Control Program (the Program) provides funding to support the implementation of Commonwealth commitments to national efforts to reduce the prevalence and burden of BBV and STI on Australian communities and affected populations.</p> <p>The Commonwealth Government works with partners including state and territory governments, research institutions and community-based organisations to prevent exposure to and transmission of blood-borne viruses (BBV) and sexually transmissible infections (STI), as well as, improve the health outcomes of people living with or at risk of these diseases.</p> <p>Funding under this Programme is provided to address hepatitis B, hepatitis C, HIV/AIDS, chlamydia, gonorrhoea, syphilis and trichomonas, and the priority populations to be targeted include:</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander people, • young people aged 30 years and under, • gay men and men who have sex with men, • culturally and linguistically diverse people, • people who inject drugs, and • sex workers. 	State and Commonwealth Co-funded and coordinated at the national level to achieve program objectives and targets	Routine reporting – quarterly – progress and annual reports

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Quality Use of Medicines Programmes	<p>The Australian Government supports the National Medicines Policy, a key objective of which is Quality Use of Medicines (QUM). QUM services improve health outcomes and the ongoing sustainability of the Pharmaceutical Benefits Scheme (PBS).</p> <p>NPS MedicineWise is the Government's QUM implementation arm, providing education and awareness programmes for specialists, general practitioners, pharmacists and consumers. Current key focus areas include the Choosing Wisely Australia initiative which supports health professionals and consumers to reduce inappropriate care by choosing medical treatments and procedures judiciously.</p> <p>NPS MedicineWise also supports the Medicare Benefits Scheme (MBS) through education programmes to improve the quality use of diagnostics and pathology services.</p>	<p>Commonwealth Department of Health</p> <p>\$47.6 million (2014-15)</p>	<p>Annual Report and the Portfolio Budget Statements (under Program 7.4: Research Capacity & Quality Regular service activity and financial reports are provided to the Department of Health in line with an agreed reporting framework.</p>
Royal Flying Doctor Service	<p>The Australian Government funds the Royal Flying Doctor Service of Australia (RFDS) to provide essential primary health care service 'traditional services', that is emergency primary aeromedical evacuations, primary GP and nursing health clinics, remote consultations and medical chests in remote and very remote areas which are beyond the normal medical infrastructure in areas of market failure.</p>	<p>Commonwealth Department of Health</p>	<p>Reporting is quarterly for health, financial data and qualitative information.</p>
Rural Womens GP Service Programme	<p>The Rural Women's GP Service (RWGPS) aims to improve access to primary health care services for women in rural and remote Australia, who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities.</p>	<p>Commonwealth Department of Health to the Royal Flying Doctor Service to deliver the RWGPS.</p>	<p>Reporting quarterly by exception. Six monthly for full health, financial data and qualitative reporting.</p>

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Stronger Futures in the Northern Territory	Stronger Futures in the Northern Territory National Partnership Agreement – Health. This 10 year agreement includes an investment of over \$700 million and aims to address persistent challenges experienced accessing health care services for Aboriginal people in the Northern Territory. Funding supports improved access, coordination and health care service delivery in remote areas, including facilitating delivery of specialist, dental and audiology health services for high disease burden conditions such as oral health and hearing health.	Commonwealth Department of Health The programme is delivered by a range of Aboriginal Community Controlled Health Services, Non-Government Organisations and the Northern Territory Government.	Services undertake a quarterly review of progress against agreed plans. Organisations provide an annual report of service activity. Clinical primary health care service providers report biannually on national key performance indicators.
Eye and Ear Health	<u>Ear Health</u> The Healthy Ears – Better Hearing, Better Listening Programme improves access to ear and hearing health services for Indigenous Australian children and youth, with a focus on rural and remote locations, by providing multidisciplinary outreach services. This is achieved by meeting the costs associated with delivering outreach services, such as travel, accommodation and venue hire. A range of health professionals are supported, such as medical specialists, GPs, nurses, audiologists and speech pathologists. <u>Eye Health</u> The Trachoma National Partnership Agreement aims to eliminate trachoma by 2020 by improving trachoma screening and treatment activities. Trachoma occurs primarily in remote and very remote Aboriginal communities in the Northern Territory, South Australia and Western Australia.	Commonwealth Department of Health Delivered by jurisdictional fundholders. Commonwealth Department of Health and health departments in New South Wales, Northern Territory, Queensland, South Australia and Western Australia. Delivered by state governments.	Quarterly financial and service activity reports 6 monthly reporting on activities and data collection through the Kirby Institute, University of NSW.

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Visiting Optometrist Scheme (VOS)	The VOS improves access to optometric services for people living and working in rural and remote communities. This is achieved by addressing some of the financial disincentives incurred by participating optometrists providing outreach services, including travel, accommodation and facility fees.	Commonwealth Department of Health Delivered by jurisdictional fundholders	Six monthly financial and activity reports.
Australian Nurse Family Partnership Programme	The Australian Nurse Family Partnership Programme (ANFPP) is an evidence-based programme that aims to improve pregnancy outcomes by: helping women engage in good preventive health practices; supporting parents to improve their child's health and development; and helping parents develop a vision for their own future, including continuing education and finding work. The Programme is based on the US Nurse-Family Partnership® (NFP) model developed over the last 30 years by Professor David Olds and his team at the University of Colorado. In the 2014 Budget, the Australian Government provided additional funding from 2015-16 through the Better Start to Life approach for an additional 10 ANFPP sites to a total of 13 sites by 2018.	Department of Health to three Aboriginal Community Controlled Health Organisations to deliver the programme - Wellington Aboriginal Corporation Health Service (Wellington, NSW), Wuchopperen Health Service (Cairns, QLD), and Central Australian Aboriginal Congress (Alice Springs, NT).	Australian Nurse Family Partnership Programme - Quarterly fidelity and progress reports as well as six monthly financial reports.

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Indigenous Australians Health Programme	<p>On 1 July 2014, the Australian Government established the Indigenous Australians' Health Programme (the Programme). The Programme supports Aboriginal community controlled health services (ACCHS), non-government organisations and some state and territory health Departments to provide Indigenous-specific comprehensive primary health care services including population health activities and clinical services, such as the treatment of acute illness, emergency care, management of chronic conditions, crisis intervention and referral. In addition, Commonwealth funded ACCHOs and NT and Qld state health clinics are able to provide Medicare services for primary health care.</p> <p>Funded organisations deliver services across the country, including in remote Aboriginal and Torres Strait Islander communities enabling access to essential health services. All activities under the Programme sit under one of the following five themes:</p> <ul style="list-style-type: none"> • Primary Health Care Services; • Improving Access to Primary Health Care for Aboriginal and Torres Strait Islander people; • Targeted Health Activities; • Capital Works; and • Governance and System Effectiveness. 	<p>Funding is provided by the Department of Health.</p> <p>The programme is delivered by a range of Aboriginal community controlled health services, non-government organisations and some State and Territory health departments.</p>	<p>Department of Health Annual Report. Organisations provide an annual report of service activity. Services providing clinical primary health care report biannually against agreed national key performance indicators. The Department of Human Services records registration of PIP accredited GP practices and non-remote IHS, and eligible registered patients. Expenditure data is reported monthly through DHS.</p>

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Aboriginal and Torres Strait Islander Health Workforce Services	<p>Funding is provided to four Aboriginal and Torres Strait Islander health professional organisations:</p> <ul style="list-style-type: none"> • Australian Indigenous Doctors' Association; • Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; • National Aboriginal and Torres Strait Islander Health Worker Association; and • Indigenous Allied Health Australia <p>These organisations provide representation, advocacy, advice and support for the health workforce they represent and participate in the development and implementation of Aboriginal and Torres Strait Islander health workforce policy.</p> <p>The support provided by Aboriginal and Torres Strait Islander health professional organisations assists in the recruitment and retention of Aboriginal and Torres Strait Islander health professionals, which has the potential to improve primary health care outcomes for those Aboriginal and Torres Strait Islander people who feel more comfortable seeing Indigenous health professionals when accessing health services.</p>	Commonwealth Department of Health	Financial and activity reports submitted regularly to the Department in line with funding agreements between the Commonwealth and individual organisations.

TABLE 10A.111

Table 10A.111 **Australian Government, selected other community health programs***Selected other programs funded by the Australian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Quality Assurance for Aboriginal and Torres Strait Islander Medical Services (QAAMS) Pathology Programme	<ul style="list-style-type: none"> • The Australian Government has funded the QAAMS programme since 1999, supporting the provision of culturally appropriate and clinically effective diabetes management in Aboriginal and Torres Strait Islander communities. • The programme enables participating Aboriginal Medical Services (AMS) and Aboriginal Community Controlled Health Services (ACCHS) to provide accurate diabetes-related pathology testing on site through point of care (PoC) testing (PoCT). • It also delivers face to face and online training, technical support and external quality assurance to Aboriginal and Torres Strait Islander health workers to enable testing operators to meet the competency requirements for operating the PoCT devices used in the programme. • In addition, the QAAMS programme provides leadership training for local Indigenous leaders so that they can better assist with the overall management of the programme. 	Chronic Disease Prevention and Service Improvement (CDPSI) Flexible Fund Flinders University and the Royal College of Pathologists of Australasia	Routine reporting – 6 monthly progress reports, including financial statement.
Australian National Diabetes Audit (ANDA)	<ul style="list-style-type: none"> • The purpose of the ANDA is to undertake the collection, collation, analysis, audit and reporting of clinical diabetes and patient education and self-care data in specialist diabetes centres across all states and territories in Australia. • The data collected is used by specialist diabetes centres to benchmark their practice processes and patient outcome data against that of their peers and provide cross-sectional data on the clinical status of individuals with diabetes attending these services. • Data collection is conducted by the National Association of Diabetes Centres (NADC), which is a national collective of over 60 Diabetes centres across all states and territories. 	Health Surveillance Flexible Fund Monash Health	Routine reporting – 6 monthly progress reports, including financial statement

Source: Australian Government unpublished.

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services. Personal Health Record (PHR) - The NSW PHR (also known as 'the Blue Book') is distributed to all families with a newborn in NSW and provides a schedule of nine recommended child health checks from birth to four years of age. The PHR uses a joint parental-professional approach to detect or anticipate problems. Early Childhood Health Services provide a range of services to support good health outcomes of children, including parenting support and education, breastfeeding support, universal health home visiting, screening for postnatal depression and referral if necessary, and health and development advice for families with young children.	Local Health Districts (LHDs) receive block funding from the NSW Health to provide health services to their population. Each LHD determines how much money is allocated to this program.	The number of occasions on which one or more health care professional provides services to a Non-admitted Patient is reported by LHDs to the Ministry of Health on a quarterly basis.
Universal Health Home Visiting	Universal Health Home Visiting (UHHV) – is the offer of a home visit by a Child and Family Health Nurse to all families in NSW after the birth of their baby. At the UHHV the nurse assesses the baby's health and development, and identifies the level of support the family needs. The nurse can then link parents identified as requiring additional support to appropriate support and/or secondary services.	Local Health District funds	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury.

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Sustaining NSW Families	Sustaining NSW Families is a program of nurse led structured evidenced based sustained health home visiting provided to vulnerable children at risk of poor developmental outcomes and their families in selected low socio-economic areas. The program actively supports parents' aspirational goals for themselves and their child and builds parenting capacity and secure parent/ child relationships. It is prevention and early intervention strategy which commences in the antenatal period and continues until child is 2 years of age with the aim of optimising child health and development outcomes. Services include bi-lingual nurses (English/Arabic and English/Mandarin) and services in a rural area with a focus on engaging vulnerable Aboriginal families.	Local Health District funds	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury.
Building Strong Foundations for Aboriginal Children Families and Communities	Building Strong Foundations for Aboriginal Children Families and Communities is a culturally safe early childhood health service for Aboriginal children birth to school entry age and their families. It aims to support parents and communities to provide an environment that will optimise the health, development and wellbeing of their child so that children are ready able to engage fully in life and learning. It has close links to Aboriginal maternity services including NSW Aboriginal Mothers and Infants Health Services and New Directions as well as mains team services. Teams comprising Aboriginal Health Workers and Child and Family Health nurses provide the main frontline service. Seven new sites were funded late 2011/12 bringing total to 15 across NSW.	State program funding to selected sites.	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury.

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Family Referral Services	<p>Family Referral Services (FRS) are intended to link vulnerable children, young people, and families with appropriate available support services in their local area. FRS refer clients to a range of local support services such as case management, housing, childcare, supported playgroup, drug and alcohol/mental health services, youth services, home visiting, family support, parenting education and respite care.</p> <p>The target group is vulnerable children and young people who are below the threshold for statutory child protection intervention, and their families. Government agencies, non-government organisations, and the private sector (e.g., general practitioners, childcare workers) can refer families to Family Referral Services. Families may also self-refer.</p> <p>There are 8 Family referral Services currently operating in NSW covering the following regional areas: Western NSW, Hunter Central Coast, Western Sydney (2), Illawarra, New England North West, Mid North Coast and Far North Coast.</p>	Keep Them Safe 'protected item' funding. NSW Ministry of Health procures these services from non-government organisations on behalf of the whole of government.	Milestone reporting to Department of Family and Community Services. Quarterly acquittals to Treasury.

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Joint Investigation Response Teams (JIRT)	JIRT is collaborative arrangement between NSW Community Services, NSW Police and NSW Health. The primary aim of JIRT is to minimise the number of investigative interviews child victims of sexual abuse, physical abuse and extreme neglect have to undertake and to provide seamless service delivery to child victims and their non-offending family members. NSW Health became an equal partner in JIRT in 2009. As the 2012 JIRT Secretariat, NSW Health is responsible for leading the review of the JIRT Policy and Procedures Manual (2001), the Memorandum of Understanding between the three partner agencies and the Statewide Management Group's Terms of Reference. NSW Health is also in the final stages of recruiting and placing 24 Senior Health Clinicians in every JIRT office across the state.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. JIRT funding is implemented within service agreement allocations.	Keep Them Safe (KTS) requires an audit of the JIRT Program every three years. An annual JIRT CEO Report Card is collated each year to meet the KTS audit requirements.
Maternal and child health	<p>Maternity services are part of the core services provided by LHDs to their population. Community antenatal and postnatal care is provided including through shared care arrangements with GPs.</p> <p>Targeted programs for vulnerable populations include:</p> <ul style="list-style-type: none"> - Aboriginal Maternal and Infant Health Service (AMIHS) provides culturally appropriate antenatal and postnatal care up to 8 weeks, to Aboriginal mothers and babies. Mental health and drug and alcohol secondary services are being delivered in selected AMIHS sites across the state as part of the Indigenous Early Childhood Development National Partnership Agreement (IECD NP). Quit for new life, a smoking cessation intervention specifically for Aboriginal pregnant women is also being rolled out across AMIHS programs. 	LHD block funding and some IECD NP funds (Commonwealth)	Regular reports on activity, outcomes against indicators

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Medical and forensic services for victims of sexual assault	This program area aims to improve forensic and medical services for victims of sexual assault and child abuse and ensure these services are culturally competent. The program has a particular focus on improving access in rural and remote communities.	Combination of Ministry of Health allocation, LHD block funding and Commonwealth funding (Indigenous Health-National Partnership Agreement)	LHDs report on service provision via a payment determination for a fee to be payable to non-salaried medical practitioners in designated rural LHDs conducting forensic and medical examinations for sexual assault victims.
New Street	New Street provides a coordinated, consistent, quality response to children and young people aged 10–17 years who sexually abuse and their families, through an expanded network of specialised NSW Health New Street services. New Street Services for Children and Young people have been enhanced through the establishment of an additional site in Newcastle (Hunter New England LHD), a new service in Dubbo (Western NSW LHD) and an additional clinical position at the Sydney and Central Coast New Street Service. A Clinical Advisor position for New Street Services and the Pre-Trial Diversion of Offenders Program has been created and filled.	LHD funding and Keep Them Safe funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Screening	<p>Domestic Violence Routine Screening - Women are routinely screened for recent or current domestic violence in antenatal and early childhood health services, and women aged 16 and over are screened in mental health and alcohol and other drugs services. Screening is an early identification and education strategy</p> <p>Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program includes the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies.</p> <p>□ Statewide Eyesight Preschooler Screening (StEPS) - is a free vision screening program for all four year old children in NSW. The program is designed to identify childhood vision problems early which cannot be detected by observation, behaviour, family history or vision surveillance. By identifying and treating vision problems during the critical visual development period, treatment outcomes can be maximised.</p>	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Domestic Violence Routine Screening funding is implemented within service agreement allocations.	A one-month data collection snapshot from all LHDs is conducted in November of each year. This provides information on outcomes such as screening and identification rates, and referrals. Domestic Violence Routine Screening is also included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.

TABLE 10A.112

Table 10A.112 **New South Wales, selected other community health programs***Selected other programs funded by the NSW Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under Keep Them Safe (KTS) NSW Health committed to expanding services for children aged under 10 years who display problematic or harmful sexualised behaviour, including Aboriginal children. To increase service delivery, the Ministry of Health allocated KTS funding to enhance the Sparks program in the Hunter New England LHD, which is the only NSW Health specialist service responding to this client group. The Ministry is also developing a statewide policy directive and guidelines on best practice service delivery, including training requirements for staff, were necessary to resolve current issues and assist LHDs in their local responses to the target group.	LHD funding and Keep Them Safe 'protected item' funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
Sexual Assault Services	NSW Health's 55 Sexual Assault Services provide holistic specialist assistance to adult and child victims of sexual assault including supporting their psycho-social, emotional and cultural wellbeing. Free counselling, court support, medical and forensic examinations and medical treatment are available to anyone who has recently been sexually assaulted in NSW.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Sexual Assault Service funding is implemented within service agreement allocations.	Sexual Assault Services are included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.
Youth health and wellbeing	Provides education and health promotion programs, clinical services and planning of youth friendly services. Also provides specific health services for homeless and at risk young people.	A mix of LHD and Australian Government funding is allocated for Innovative Health Services for Homeless Youth (IHSHY).	The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the LHDs to the Ministry of Health on a quarterly basis.

Source: NSW Government unpublished.

TABLE 10A.113

Table 10A.113 **Victoria, selected other community health programs***Selected other programs funded by the Victorian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Care Partnerships (PCPs) Strategy	<p>Primary Care Partnerships (PCPs) are cross government funded voluntary alliances of health, human services providers and other organisations. There are 28 PCPs in Victoria which engage over 600 organisations. PCPs deliver local service system reforms to:</p> <ul style="list-style-type: none"> • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated; and • improve the management of chronic disease. <p>The strategy to improve the coordination of services is supported by a state-wide policy and operational framework and includes:</p> <ul style="list-style-type: none"> • state-wide practice standards and a continuous improvement manual • tools for screening, referral and coordinated care planning • data standards for sharing client health and care information embedded in agency client management software applications; and • e-referral systems to securely share client information with client consent. <p>PCPs identify local health and well being priorities and ways to address these priorities. 'Place based' partnership approaches are used to assess and engage with communities that experience significant disadvantage. Interventions may be targeted to particular population groups, for example, children or people with a refugee background .</p>	Core funding provided by the Victorian Department of Health & Human Services.	Suite of reports as part of the 2013-17 PCP Program Logic. This includes a four year strategic plan and impact oriented reports against each area of the PCP program logic.

Table 10A.113 **Victoria, selected other community health programs***Selected other programs funded by the Victorian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Refugee Health Program	<p>The Refugee Health Program (RHP) seeks to optimise the long-term health of refugees and asylum seekers by promoting accessible and culturally appropriate health care services that are innovative and responsive to their unique needs. The program supports a coordinated model of care, and acknowledges the importance of early identification and intervention in health issues in the early stages of settlement.</p> <p>The RHP has three aims:</p> <ul style="list-style-type: none"> • to increase refugee access to primary health services • to improve the response of health services to refugees' needs; and • to enable refugee individuals, families and communities to improve their health and wellbeing. <p>The RHP builds the capacity of individuals, families and refugee communities to improve their health through: disease management and prevention; the development of referral networks and collaborative relationships with general practitioners and other health providers; connection with social support and orientation programs.</p>	<p>The Victorian Government funds the RHP through the Department of Health & Human Services. Community health services are funded to deliver the RHP.</p>	<p>Community health services funded under the RHP report hours of service on a quarterly basis.</p>
NURSE-ON-CALL	<p>NURSE-ON-CALL is a statewide telephone-based health line that provides residents of Victoria with timely access to health information, assistance and advice for the cost of a local phone call. The service operates 24 hours, 7 days a week and takes about 1,000 calls per day. NURSE-ON-CALL uses registered nurses to triage callers' symptoms and health issues so as to advise on health care needs. NURSE-ON-CALL also provides callers with health information; and information about local health providers.</p> <p>In the after-hours period, approximately 50 eligible callers to NURSE-ON-CALL per day are transferred to the Commonwealth government's After Hours GP helpline.</p>	<p>NURSE-ON-CALL is delivered by Medibank Health Solutions under contract to the Department of Health & Human Services.</p>	<p>Medibank Health Solutions provides the department with a number of monthly reports.</p>

TABLE 10A.113

Table 10A.113 **Victoria, selected other community health programs***Selected other programs funded by the Victorian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
IHSY Program	The Innovative Health Services for Homeless Youth (IHSY) program is an initiative that promotes health care for young people who are homeless or at risk of homelessness. Funding is provided to community health services to deliver innovative and flexible health services for the target population. The services respond to the complex health needs and improve their access to mainstream health services. IHSY provides a means of engaging young people who may not otherwise access health services.	<ul style="list-style-type: none"> Community health services are funded to deliver the IHSY program. 	Community health services funded to deliver the IHSY program report hours of service on a quarterly basis.
Healthy Mothers Healthy Babies antenatal program	<p>The Healthy Mothers Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing integrated health and social care during pregnancy. The program is delivered by community health services in areas that have high numbers of births and higher rates of relative socioeconomic disadvantage. The objectives of the program are to:</p> <ul style="list-style-type: none"> improve women's access and attendance at antenatal and post natal services improve women's access to a range of support services which may include health, welfare, housing and education services deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. <p>Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their:</p> <ul style="list-style-type: none"> socioeconomic status health status (e.g. mental health) and/or health behaviours (e.g. misuse of alcohol and other drugs) culturally and linguistically diverse backgrounds Aboriginal and Torres Strait Islander descent: or residential distance to services. 	<ul style="list-style-type: none"> The Victorian Government funds the program through the Department of Health & Human Services. 	<ul style="list-style-type: none"> Quantitative performance targets are set by the Department of Health & Human Services and monitored quarterly. The program was monitored through a formal evaluation completed in November 2014.

TABLE 10A.113

Table 10A.113 Victoria, selected other community health programs
Selected other programs funded by the Victorian Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Health Teams	<p>Services for children and families within community health are based on evidence which identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services respond to the needs of young children and their families.</p> <p>Child health teams provide multidisciplinary care through a mix of group and individual interventions. Services promote positive health, growth and functioning within the community. Their focus is the provision of early interventions as well as to improve the capacity of parents and families to understand and manage the health and development needs of their child. Community health practitioners also support families to access additional services they may require in the community.</p>	The Victorian Government funds the program through the Department of Health & Human Services.	Community health services providing child health services report hours of service as part of their overall community health program reporting on a quarterly basis

TABLE 10A.113

Table 10A.113 **Victoria, selected other community health programs***Selected other programs funded by the Victorian Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Program	<p>The Community Health Program provides funding to 88 Community Health Services (CHSs) across Victoria. A strong connection to communities enables community health services to develop models of care that are responsive to their clients and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their clients.</p> <p>CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses. In addition, community health prioritises services to population groups that are known to have poor health status, are subject to disadvantage or are at risk. These include people who are homeless or at risk of homelessness, refugees, Aboriginal people, people with an intellectual disability or a serious mental illness. Funding is provided for the provision of direct care, and for health promotion.</p> <p>CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.</p>	The Victorian Government funds the program through the Department of Health & Human Services.	<ul style="list-style-type: none"> • Community health services report hours of service on a quarterly basis • CHSs report annually to their consumers, carers, community and other stakeholders through the Quality of Care report. • Agencies funded for health promotion are required to develop four year health promotion plans and report on those plans on an annual basis.

TABLE 10A.113

Table 10A.113 Victoria, selected other community health programs
Selected other programs funded by the Victorian Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Early Intervention in Chronic Disease (EliCD)	EliCD focuses upon community based early intervention services for people with chronic diseases. The aim of the initiative is to enhance existing capacity of community health services in supporting people with chronic disease in managing the impact of their condition including the physical, emotional and psychological impact of having a chronic disease. Services aim to reduce the impacts of chronic disease, slow disease progression and reduce potential/future hospitalisation. Models of care are multidisciplinary and provide self-management support, care coordination, education, allied health and nursing.	Community Health Services are funded to deliver the EliCD Program.	Community Health Services funded to deliver the EliCD Program report hours of service on a quarterly basis.

Source: Victorian Government unpublished.

TABLE 10A.114

Table 10A.114 **Queensland, selected other community health programs***Selected other programs funded by the Queensland Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Blood Borne Viruses and Sexually Transmissible Infections (BBVs and STIs)	<p>The program implements five national strategies 2014-17, covering HIV, Hepatitis B, Hepatitis C, Sexually Transmissible Infections and Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections.</p> <p>Services and public health programs are delivered through public, non-government and private organisations including 16 Hospital and Health Services (HHSs) Sexual Health Clinics providing preventative and clinical BBV and STI services.</p> <p>Clinical and funded non-government programs target groups most at risk of BBVs and STIs (e.g. men who have sex with men, injecting drug users, culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people and young people).</p> <p>The HIV Foundation Queensland is tasked with leading the Queensland HIV prevention and testing response in conjunction with other Non-Government Organisations (NGOs) and the Department of Health.</p>	Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.	<p>Six monthly performance reports on activities by funded NGO programs. Quarterly report provided to the BBV and STI Standing Committee (BBVSS).</p> <p>Commonwealth Indigenous funding reports.</p> <p>Notification data for BBVs and STIs provided for the NHA report.</p> <p>Annual reports on Queensland notification data produced by Department of Health.</p>
Child Health Services	<p>A range of child health services are provided to children and young people aged 0-18 years and their families in the community. These services may include interventions such as child development checks, lactation support, parent information sessions; as well secondary and/or tertiary health services such as parenting and behaviour support, nutrition support, or referrals to other service providers. Services are available to all children and young people aged 0-18 years and their families as well as targeted services to particular or 'at risk' populations such as young parents, Aboriginal and Torres Strait Islander families, and refugee families.</p>	<p>State and Commonwealth government funding.</p> <p>Delivered by state government, may be delivered in partnership with other providers</p>	Local Hospital and Health Service reporting arrangements are in place.

TABLE 10A.114

Table 10A.114 **Queensland, selected other community health programs***Selected other programs funded by the Queensland Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Enhanced Maternal and Child Health Service	The Mums and Bubs post-natal in home visiting program provides families with newborns home visits from qualified and experienced community midwives and/or child health nurses. All mothers, whether birthing in the public or private sector, can receive two post natal in-home visits within the first four weeks of giving birth. The Mums and Bubs program also ensures all families have access to community clinics at key stages during the first year of the child's life.	State government Delivered by state government, may be delivered in partnership with other providers. The Queensland Department of Health invested a total of \$8,540,998 in the Mums and Bubs program in 2014/15.	Quarterly reporting.
Preventive Health	Preventive Health Branch (PHB) provides expertise and leadership to improve policy, systems, research, programs and services to encourage healthy behaviours and create environments that are supportive of health. PHB works collaboratively across the Queensland Department of Health, with other government agencies, non-government organisations and the private sector on a range of health promotion, risk assessment, early intervention, personal skills development, and policy and legislative initiatives aimed at empowering individuals, communities and institutions to create and live healthier lives. Strategies target chronic disease risk factors – alcohol, tobacco, overweight and obesity, inadequate nutrition, physical inactivity - and skin cancer prevention. Interventions focus on children and young people, pregnant women, at risk adults, Indigenous and disadvantaged population groups, in key settings - workplaces, schools, healthcare, community and family.	Queensland Department of Health	Contractual performance reports; data collection; independent evaluations; internal reporting processes.

TABLE 10A.114

Table 10A.114 **Queensland, selected other community health programs***Selected other programs funded by the Queensland Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Queensland Aboriginal and Torres Strait Islander health investment strategy	<p>A range of primary and community health services are delivered across Queensland to improve the health outcomes of Aboriginal and Torres Strait Islander people and achieve the life expectancy and child mortality targets agreed through the Council of Australian Governments (COAG), including initiatives to strengthen the continuity of care between the acute and primary care settings.</p> <p>In 2013–14, 140 Aboriginal and Torres Strait Islander health initiatives and services were delivered by 16 HHSs and 19 Aboriginal and Torres Strait Islander community controlled health services and NGOs across Queensland. The range of initiatives and services included:</p> <ul style="list-style-type: none"> • Hospital liaison support, case coordination and assistance for Aboriginal and Torres Strait Islander people entering and exiting acute care • Community-based and outreach antenatal, postnatal and infant care services • Targeted sexual and reproductive health prevention, early intervention, detection and education for young people and adults • Multidisciplinary primary healthcare services for the early detection, treatment and management of chronic diseases • Respiratory, diabetes and renal outreach services for Aboriginal and Torres Strait Islander people living in rural and remote areas • Alcohol, tobacco and substance misuse harm prevention, early intervention and treatment targeting Aboriginal and Torres Strait Islander young people, and • Mental health services. 	Queensland Government and Australian Government funding responsibility (primary funding source Queensland Government—some funds provided by the Australian Government under the former Indigenous Early Childhood Development National Partnership Agreement—NPA).	Six monthly performance and financial reporting from the HHSs. Six monthly performance and quarterly financial reporting from the non-government sector.

Source: Queensland Government unpublished.

TABLE 10A.115

Table 10A.115 **Western Australia, selected other community health programs***Selected other programs funded by the WA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
WA Footprints To Better Health National Partnership Agreements for Closing the Gap in Indigenous Health Outcomes and Indigenous Early Childhood Development Element 3)	<p>Closing the Gap and Indigenous Early Childhood Development (Element 3) programs previously funded under the NPA are now State funded under WA Footprints to Better Health (WAFBH).</p> <p>These programs promote increased access to:</p> <ul style="list-style-type: none"> - timely and relevant health services that support growth and development of Aboriginal children - support services that improve the awareness and knowledge of risks associated with drug, alcohol and tobacco use among young people - Aboriginal-specific services that improve knowledge and practice of healthy lifestyle behaviours - chronic disease screening services and care planning - timely and culturally appropriate continuity of health care. <p>The population group served by the program is Aboriginal people, specifically pregnant women and their partners, babies and parents, children, youth, women, men and elderly people.</p>	<ul style="list-style-type: none"> • WAFBH State funded • Budget and governance oversight WACHS Aboriginal Health Improvement Unit • Programs delivered by a mixture of government (WACHS and Metropolitan Area Health services) and non-government organisations (Aboriginal Community Controlled Health Organisations) 	<ul style="list-style-type: none"> • WACHS required biannual reporting from all Primary Health Care programs. • Reports are reviewed to monitor performance.
NPA Indigenous Early Childhood Development (Element 2)	<p>Commonwealth funding for the IECD (Element 2) NPA ceased in April 2015.</p> <p>The objective of this program is to increase access to teenage sexual and reproductive health and young parent support for Indigenous women.</p> <p>A range of services are offered, including health promotion/prevention, early intervention (screening) and treatment services.</p> <p>The primary population group served by this program is young Aboriginal women.</p>	<ul style="list-style-type: none"> • Element 2 - Commonwealth funded and ceased in April 2015 • Budget and governance oversight WACHS Aboriginal Health Improvement Unit • Programs delivered by a mixture of government (WACHS and Metropolitan Area Health services) and non-government organisations (Aboriginal Community Controlled Health Organisations) 	<ul style="list-style-type: none"> • WACHS required one report from COAG IECD Element 2 programs. Reports are reviewed to monitor performance. • WACHS AHU reported to DoHA for IECD programs in April 2015.

TABLE 10A.115

Table 10A.115 Western Australia, selected other community health programs
Selected other programs funded by the WA Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary health/chronic disease programs	<p>WACHS Aboriginal Health Improvement Unit has carriage of several other contracted programs that provide primary health/chronic disease programs across the State in a community health care setting with a focus on the prevention, early detection, treatment and self-management of chronic disease.</p> <p>The population group served by this program is Aboriginal people, specifically those with or at risk of chronic disease.</p>	<ul style="list-style-type: none"> • Department of Health WACHS funding • Budget oversight WACHS contracting • Governance oversight WACHS Aboriginal Health Improvement Unit. • Programs delivered through Aboriginal Community Controlled Health Organisations (non-government). 	<ul style="list-style-type: none"> • WACHS required biannual reporting from all Primary Health Care programs. • Reports are reviewed to monitor performance.
Metropolitan Health Lifestyle Project	<p>A coordinated patient-centred approach involving early patient identification, care co-ordination through general practice, trained clinic staff, supported allied health and community providers, clear referral pathways, and monitored patients to support lifestyle and risk modification for the target groups.</p> <p>The overall aim of the project is to provide practical support for people at risk of developing chronic disease or those who have chronic disease to make informed lifestyle choices and healthy behaviour change within the Perth metropolitan area.</p> <p>The primary target populations are those newly diagnosed with type 2 diabetes and those with microalbuminuria. The secondary target population is people with multiple risk factors for coronary heart disease. The program also includes:</p> <ul style="list-style-type: none"> • Process and Outcome evaluation of the program to demonstrate the impact of the program on the community • Economic evaluation of the program on cost effectiveness. 	<p>Funding: WA Department of Health</p> <p>Contract : Health Strategy Networks DOH WA</p> <p>Program delivery - Fremantle Medicare Local</p>	<p>Six monthly reports</p> <p>Evaluation report</p> <p>Contract reports not available to the public</p> <p>Publication of research evaluation component of the report available</p>

TABLE 10A.115

Table 10A.115 Western Australia, selected other community health programs
Selected other programs funded by the WA Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Self-Management	<p>Develop, deliver and evaluate programs to coordinate diabetes services and multidisciplinary care for persons with type 1 or type 2 diabetes.</p> <ul style="list-style-type: none"> • Enhance care, access to care closer to home and navigation of the health system for people living with diabetes. • Build the capacity of GPs, practice nurses and other appropriate existing service providers in the community, including use of Chronic Disease Management Medicare Items and Medicare diabetes incentives. • Facilitating and encouraging access to self-management education, care and support with multidisciplinary input from appropriate health professionals. • Delivery of self-management education programs and services. • Linking with other local services/programs such as local government recreational services and support groups. • Development of referral pathways between tertiary, secondary and community based services, including coordinating clients referred from GPs, hospitals and Health Services to appropriate diabetes clinics/services in the metropolitan and regional areas for ongoing management. • Incorporate the relevant WA Health Models of Care where appropriate. 	<p>Funding: DOH WA Contract : Health Strategy Networks DOH WA Program delivery –</p> <ul style="list-style-type: none"> • Medicare Locals • Diabetes WA 	<p>Six monthly reporting Evaluation report Contract reports not available to the public</p>

TABLE 10A.115

Table 10A.115 Western Australia, selected other community health programs
Selected other programs funded by the WA Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health Services for People Experiencing Homelessness	<p>The service includes the following elements:</p> <ul style="list-style-type: none"> • Builds relationships with individuals affected by homelessness based on trust and a sense of community. • Flexible arrangements to respond to movements in location of people experiencing homelessness. • In-reach service to specialist homeless service providers. • Primary health care services • Health care plans to identify and manage individual health needs. • Information on health issues and self-care education. • A collaborative approach to service provision with other providers of health and specialist homelessness services. • Referrals and linkages to other health, specialist homelessness, mental health, and alcohol and drug services. 	<p>Funding: DOH WA Contract : Health Strategy Networks DOH WA Program delivery – Perth Mobile GP, trading as Mobile GP</p>	<p>Six monthly reporting Contract reports not available to the public</p>

TABLE 10A.115

Table 10A.115 Western Australia, selected other community health programs
Selected other programs funded by the WA Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child health services	<p>Child health services aim to promote improved health outcomes for babies, young children and their families through the provision of a range of universal and targeted prevention, early identification and intervention services. Services are delivered in various settings, including child health centres, in homes, parenting groups and other community venues.</p> <p>The WA universal Birth to School Entry community child health service offers child health nurse contacts to all mothers of new babies within 10 days of birth and an additional six contacts at critical points in the child's development throughout the first four years of life. Follow up checks are offered to individual families and groups according to need.</p> <p>Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, lactation, breastfeeding and nutrition.</p>	<p>State funding is provided for both child and school health services. Health services are responsible for delivering child health services.</p> <p>Agreement between the Department of Education and Department of Health, which underpins the delivery of School Health Services.</p> <p>Health services are responsible for managing community health services, and for delivering the majority of services. Service agreements are in place with non-government organisations for the provision of certain services in particular geographical areas to supplement those provided by the health service.</p>	<p>Services are reported as Occasions of Service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews.</p> <p>Quarterly reports against key performance indicators are provided to the Government.</p> <p>Service delivery reports are not accessible to the public.</p>

TABLE 10A.115

Table 10A.115 Western Australia, selected other community health programs
Selected other programs funded by the WA Government during 2014-15

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Targeted services	<p>Targeted services focus on engaging vulnerable children and families who are at greater risk of health and developmental issues, including Refugees, Aboriginal families and young parents with identified risks. Targeted programs include Best Beginnings, which is delivered in collaboration with the Department for Child Protection and Family Support, and the Enhanced Aboriginal Child Health Schedule (EACHS). These programs provide a modified and expanded version of the Universal Child Health Contact Schedule.</p> <p>Families eligible to receive the EACHS are offered 15 scheduled contacts, from pregnancy to five years of age, in a culturally appropriate manner.</p> <p>Other targeted metropolitan services include Lactation Consultancy and Aboriginal ear health clinics, which provide children with otitis media or known suspected hearing problems with access to an Aboriginal Health Worker, Audiologist, Speech Pathologist and Ear, Nose and Throat specialist. This is to mitigate factors that might lead to ongoing poor health and education outcomes.</p>	<p>State funding is provided for both child and school health services. Health services are responsible for delivering child health services.</p> <p>Health services are responsible for managing community health services, and for delivering the majority of services. Service agreements are in place with non-government organisations for the provision of certain services in particular geographical areas to supplement those provided by the health service.</p>	<p>Services are reported as Occasions of Service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews.</p> <p>Quarterly reports against key performance indicators are provided to the Government.</p> <p>Service delivery reports are not accessible to the public.</p>

TABLE 10A.115

Table 10A.115 **Western Australia, selected other community health programs***Selected other programs funded by the WA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
School health services	School health services support the health and development of all students in government and non-government schools through universal health assessments at school entry, support to students with particular health needs, health promotion strategies and early detection. Services are provided on school sites in collaboration with education providers. In secondary government schools, the focus is more on health promotion (e.g. mental health, sexual health) and providing students access to a health professional who can advise, assess and refer, according to the presenting health issue. In Education Support Schools, nurses provide direct health care services for students with disabilities, many of whom have multiple disabilities.	State funding is provided for school health services. Health services are responsible for delivering school health services. Agreement between the Department of Education and Department of Health underpins the delivery of School Health Services. The Department of Education part funds School Health Services in WA, as agreed in the MOU between the Departments.	Services are reported as Occasions of Service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews. Six monthly reports against key performance indicators are provided to the Government. Service delivery reports are not accessible to the public.
Child Development Service	The metropolitan Child Development Service in Perth, Western Australia, provides community-based assessment and intervention services for children 0-18 years with (or at risk of) developmental delays and disorders. The Child Development Service also plays a key role in community education and professional development. The Child Development Service clinical workforce consists of a range of allied health and medical disciplines, including Speech Pathologists, Physiotherapists, Occupational Therapists, Clinical Psychologists, Social Workers and Paediatricians.	State funding is provided. Health Services are responsible for delivering child development services. Health services are responsible for managing child development services, and for delivering the majority of services. Service agreements are in place with non-government organisations for the provision of certain services in particular geographical areas to supplement those provided by the health service.	Services are reported as occasions of service (for non-admitted patients). Reports are produced as required for service planning, governance, management and reviews. Quarterly reports against key performance indicators are provided to the Government. Service delivery reports are not accessible to the public.

Source: WA Government unpublished.

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Aboriginal Health Programs	A number of primary health services are accessible across South Australia aimed at providing health care checks and improving the health outcomes of the Aboriginal community across metropolitan, regional and rural areas. Services provided include: Primary Health Care Access Program; A Better Start to Life – New Direction: Mothers and Babies program; Tackling Indigenous Smoking; Social and Emotional Wellbeing; Kanggawodli providing short term pre and post-acute clinical support for rural and remote Aboriginal people; Trachoma and Trichiasis screening for Aboriginal residents living in the north and the west of the State; Watto Purrinna; Aboriginal Primary Health Care Service; Rheumatic Fever Strategy; and Sexual and reproductive health programs for Aboriginal young people. Additionally, SA Health invests in specific programs contributing to closing the gap in Aboriginal life expectancy including: Primary Health Care program; Tackling Smoking; Aboriginal Infant Support Program; and Aboriginal Well Health Checks Program.	State and Commonwealth Government funding COAG National Partnership Agreement and Project Agreement funding	Monthly activity and financial data reporting Quarterly activity and financial reporting, including annual and ongoing evaluation Six monthly activity and financial data reporting
Bariatric Management and Intervention Service (BMI)	The service was established in response to a need to manage an increasing bariatric surgery wait list at Flinders Medical Centre. The BMI Service offers a triage and assessment process to determine eligibility for bariatric surgery, and allied health services that provide patients with pre-operative lifestyle change/self-management skills in preparation for surgery.	State Government funding	Quarterly activity reporting

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Child Health and Development Services	A number of services aimed at child development are offered across South Australia, which include: Early Childhood Development and Disability Services; Child Development Unit Program; Autism Diagnostic Service; Registered Nurse Delegation of Care Program; Access Assistant Program; Fragile Airways Program; and Child Protection services.	State Government funding Grant funding from the Department of Communities and Social Inclusion (DCSI), the Ministerial Advisory Council for Students with Disabilities (MACSWD) and an in-kind contribution to the NDIS.	Monthly activity and financial data reporting Reporting to DCSI and MACSWD
Child and Family Health Service	From over 120 sites across the state, the Child and Family Health Service provide a range of child wellbeing, development and parenting supports for families of children 0-5 years of age. These include early parenting groups, 1:1 consultations, a residential feeding and settling service, and access to information via the telephone and internet. Specific services provided include: Universal Contact Visit; Family Home Visiting Program; Early Childhood Intervention Program; Parenting SA; Newborn and Children's Hearing Service; and Early Child Parent Services.	Recurrent State Government funding	Monthly activity and financial data reporting
Chronic Disease Health Services	A range of services are delivered aimed at managing and improving the health of chronic disease patients, including: inSCOPE Asthma and Chronic Obstructive Pulmonary Disease; Exercise Physiology for Heart Failure; Better Care in the Community - Chronic Disease; Chronic Liver Disease Service; and The Chronic Disease Team provides a range of allied health services (including: speech pathology; occupational therapy; social work; psychology; exercise physiology; physiotherapy; dietetic/nutrition; and podiatry) via GP Plus Centres including care coordination, individual and group clinical interventions.	State Government funding	Monthly activity and financial data reporting Quarterly activity reporting

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Complex Care Team	Supports people at risk of avoidable multiple hospital presentations as a result of their chronic condition(s)/combined health and social needs. Improved communication, reduction of duplication and more coordinated care are the objectives of this approach. The close linkage of Intermediate Care Services with specialist services as a discharge pathway create a collaborative care path to support more complex patient needs and a sorting and care readiness path.	State Government funding	Quarterly activity reporting
Community Nursing	A range of community nursing services are provided across metropolitan and country areas in settings including: chronic disease and risk factor programs; mental health; pregnancy and antenatal care; palliative care; Diabetes Nurse Educators; breast care nursing; and domiciliary care services. Other specific services include: Virtual Nursing Service; Community Nursing Service; Hospital and Health Care at Home; Community Geriatric Evaluation and Management Service; Community Heart Failure Nursing Service; Community Paediatrician Service; and Regional Falls Prevention Program.	State Government funding	Monthly activity and financial data reporting Quarterly activity reporting
Complex Refugee and Asylum seeker health care	Migrant Health Service provides early intervention specialist refugee health services for refugee and asylum seeking clients with complex health needs. The service model targets clients unable to engage effectively with mainstream primary care services due to complex health, psycho social issues.	State Government funding	Quarterly and annual activity and financial reporting

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Diabetes Services	Services are provided to children, adolescents and adults with Type 1 or Type 2 diabetes. The prime objectives are to: facilitate early discharge from hospital; provide rapid response to acute diabetes problems; enable patients to achieve a greater understanding of/confidence in self-management; provide an agreed plan of care for ongoing management; prevent/slow progression of diabetic complications; and support GP's in the management of patients.	State Government funding	Monthly activity and financial data reporting
Early Childhood Development Services	Multi-disciplinary interventions for children 0-4 years of age with, or at risk of, developmental delays. Service models are 1:1; group and supported playgroups options for families and are provided from primary health care centres. Children are prioritised according to levels of active adversity. Guardianship of the Minister and Aboriginal children are of the highest priority.	State Government funding	Monthly activity and financial data reporting
Homelessness Health Services	The Street to Home service provides assertive outreach services for rough sleepers including people from all backgrounds who are experiencing primary homelessness across metropolitan Adelaide and people with a chronic history of cycling through rough sleeping.	State Government funding Partnership funding from the Department of Communities and Social Inclusion (and the Department of Health)	Quarterly and annual activity and financial reporting Commonwealth H2H National Data Collection Agency
Management of OSA and other sleep disorders	Community based services are provided to patients with sleep disorders, most notably obstructive sleep apnoea (OSA) achieved through the use of home based apnealink studies and auto-titrating continuous positive airway pressure (CPAP) trials when required; with clinical assessment/treatment/management provided by a Nurse Practitioner, in collaboration with a sleep physician.	State Government funding	Quarterly activity reporting

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Maternal Health Programs	A number of programs are accessible across South Australia aimed at providing support and services to pregnant women and their families, including: Aboriginal Family Birthing Program; Community Midwifery Program; and Pregnancy to Parenting Program.	Combination of Commonwealth and State Government funding	Monthly activity and financial data reporting
O'Brien St Practice	O'Brien St General Practice offers comprehensive holistic healthcare to vulnerable inner city populations and LGBTQI communities. In addition to General Practice its GP services specialise in HIV, Post Exposure Prophylaxis, Hepatitis B & C and Sexual Health.	State Government funding	Monthly activity and financial data reporting
Palliative Care Services	Palliative care services involving integrated care across in-hospital and out-of-hospital settings, linking with other primary care providers for people on an end of life care pathway, with a focus on supporting people to die in their place of choice.	State Government funding	Monthly activity and financial reporting
Pregnancy to Parenting Programs	Offers support and education to families in the early pregnancy to early parenting period. Families are particularly targeted where there are vulnerable infant risk factors. One to one counselling and support particularly in relation to antenatal care, emotional well-being, psycho social issues, early parenting and child development.	State Government funding	Monthly activity and financial data reporting
Prison Health Service	Services include clinical health assessments of all prisoners on admission and then yearly, care planning, co-ordination of care pathways, education and referral; with a focus on aged, women, Aboriginal and Torres Strait Islanders, chronic disease, mental health and prisoners with complex health needs.	State Government funding	Quarterly activity and monthly financial data reporting National Prisoner Health Data Collection survey

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rapid Response Paediatric Asthma Service	Provides a rapid outreach service to children with a principal diagnosis of asthma. This comprehensive management improves and enhances population health outcomes, by optimising links between hospital and community services via provision of case management/home visit service and enabling improved self-management.	State Government funding	Quarterly activity reporting
Rehabilitation Services	Specific rehabilitation services provided across South Australia include: Northern Adelaide Rehabilitation Service; Paediatric Rehabilitation Program; Country Health SA Local Health Network inpatient and ambulatory rehabilitation services; and Cardiac Rehabilitation – Outer Metropolitan Service (Flinders Medical Centre).	State and Commonwealth Government funding	Monthly and Annual reporting activity and financial reporting Daily activity reporting
Respiratory Integrated Care Service (RICS)	Optimises links between hospitals and community services. RICS provides case management to complex respiratory patients, with the intent that chronic respiratory disease management will improve and enhance population health outcomes. Services are provided to patients who are large consumers of hospital care. Admission to the case management programme is triggered by three or more admissions within twelve months with exacerbation of Chronic Obstructive Pulmonary Disease, plus four major risk factors.	State Government funding	Quarterly activity reporting
Rural and Remote Services	Services provided aiming to assist with patients in rural and remote areas of South Australia include: Country Access to Cardiac Health; and Country Home Link and Rapid Intensive Brokerage Support (RIBS).	State Government and Targeted Lead Abatement Program funding	Monthly activity and financial data reporting

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Screening Services	Port Pirie Lead Implementation Program monitors blood in lead levels of the Port Pirie community with a particular focus on pregnant women and children 0-5 years, provides intervention to reduce blood lead levels in children and pregnant women and provides ongoing community education around lead safe practices.	State Government funding	Quarterly lead in blood data
Sefton Park Primary Health Care Clinic	Sefton Park Primary Health Care Service provides medical, nursing and allied health services with a focus on people who are vulnerable, with complex co-morbidities and who have no other effective service options available. Services include: opioid substitution; women's health; migrant health; immunisation; physiotherapy; diabetes; podiatry; and counselling.	State Government funding	Quarterly and annual activity and financial reporting
Southern Community Falls Prevention Team	Supports patients and their families in the management of age related decline, which is accomplished via: Proactive screening pathways; and Matching of patients to appropriate falls prevention services. Services are provided to older adults and their carers and/or families, who are experiencing physical decline (predominately indicated by falls), requiring further assessment, service coordination/monitoring.	State Government funding	Quarterly activity reporting
Transition Care Program (TCP)	Short term restorative care packages in a residential aged care facility or at home for clients aged 65+ (50 years for Indigenous patients). The aim is to assist with the transition from an acute hospital stay back to their own homes and/or to be better prepared for residential aged care with an emphasis on re-enablement and restoring functional ability. An aged care assessment is required to access a TCP.	Recurrent Commonwealth Government funding State Government funding Contribution	Monthly and Quarterly activity and financial data reporting Annual Program Report – Internal

TABLE 10A.116

Table 10A.116 **South Australia, selected other community health programs***Selected other programs funded by the SA Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Viral Hepatitis Liaison Service	Facilitates the coordination of patient care between primary care and hospital based specialists. The service is patient centred, holistic, safe, cost effective and culturally and geographically accessible. It is provided to all people affected by chronic Hepatitis C. The target patients include current/past injecting drug users, people in custodial settings, Aboriginal people at risk and people from culturally and linguistically diverse backgrounds.	State Government funding	Quarterly activity reporting
Virtual Clinical Care	Remote home tele-monitoring for people in country South Australia with chronic disease and other health needs. Early detection and appropriate intervention will assist in reducing unplanned hospital presentations and admissions, or reduce length of stay.	State Government funding	Monthly activity data and financial data reporting
Women's Health Services	Specialised women's health services are provided to Aboriginal and Torres Strait Islander women; newly arrived refugee and migrant women and vulnerable women with complex health and social circumstances who would not otherwise access health services. Services include: engagement activities to create referral pathways and a culturally safe service; clinical health assessments and care planning; information and referral; self-management programs and psychosocial therapy; specialised clinical health treatment; and co-ordination of care pathways.	State Government funding Commonwealth government contribution through the Medicare Benefits Schedule (MBS) (section 19(2) exemption)	Monthly activity and financial data reporting Quarterly performance reporting
Youth Health Services	Provides specialised health services to young people aged 12–25 years from key and vulnerable population groups providing services which include engagement pathways and a culturally safe service; clinical health assessments and care planning; information and referral; medical treatment, health programs and counselling to support young people to build their capacity to manage their own health.	State Government funding Commonwealth government contribution through MBS (section 19(2) exemption)	Monthly activity and financial data reporting Quarterly performance reporting

Source: SA Government unpublished.

TABLE 10A.117

Table 10A.117 **Tasmania, selected other community health programs***Selected other programs funded by the Tasmanian Government during 2014-15*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health	<p>Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities.</p> <p>Community Health Centres offer a variety of services including counselling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability and family and child health services.</p> <p>Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers.</p> <p>The size of sites also varies: small sites provide a limited range of services generally based around community nursing.</p>	<p>The majority of funding is allocated from the State budget. During 2014-15 Tasmania's three Health Organisations (North, South and North West) were merged into a single Tasmanian Health Service which is responsible for area spending and overseeing program delivery.</p> <p>Services are provided in accordance with the Tasmanian Government's Output Budgeting Framework.</p> <p>Services are funded through identified outputs within the DHHS budget.</p>	<p>Performance information is collected and reported at the State level through the Budget Papers, Annual Report and the HealthStats Website.</p> <p>National reporting through: National Minimum Data Sets; Report on Government Services; Australian Institute of Health and Welfare (AIHW); Australian Council of Healthcare Standards.</p>
Rural Health Facilities	Rural Health Facilities provide core primary health and community care services within a local community in addition to some inpatient sub-acute beds. In addition, some rural sites provide residential aged care and/or emergency services.	Australian Government funds	Reporting in accordance with specific program requirements.
Palliative Care Services	Palliative Care Services - specialist palliative care clinicians work within a consultancy framework across the health sector to support primary health service providers in urban and rural areas to provide quality palliative care	Australian Government funds	Reporting in accordance with specific program requirements.

TABLE 10A.117

Table 10A.117 **Tasmania, selected other community health programs***Selected other programs funded by the Tasmanian Government during 2014-15*

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	Other Primary Health services include Aged Care Assessment Teams; Community Equipment Scheme; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Contenance Services; Day Centres and Health Promotion activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.	Australian Government and State funding	Reporting in accordance with specific program requirements.
	The Australian Government funds the Rural Health Outreach Fund (RHOF) and the Medical Outreach – Indigenous Chronic Disease Program (MO-ICDP) to provide a broad range of outreach medical, nursing and allied health services to rural and remote areas of Tasmania.	Australian Government funding.	
	Overcoming cultural/language barriers – The Tasmanian DHHS provides access to Interpreter Services for CALD clients in all health settings as required.	Services purchased on an ‘as needs’ basis	As above
	Overcoming geographical barriers – emergency services are provided at some rural sites and three sites also operate an ambulance service.	Australian Government and State funding	As above
	A range of services are provided on an outreach basis to rural communities from an urban hub – including allied health services, Aged Care Assessment Teams and Contenance Services.		

TABLE 10A.117

Table 10A.117 Tasmania, selected other community health programs
Selected other programs funded by the Tasmanian Government during 2014-15

<i>Program area</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
	<p>Telehealth is available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs and external organisations.</p> <p>In addition to Australian Government contributions, the State provides funding to Health Recruitment Plus to assist recruitment and retention of rural general practitioners and to support rural medical practitioners to provide services to rural health facilities around Tasmania.</p>		
	<p>Overcoming socioeconomic barriers- a range of transport services to access health care is available to people who are transport disadvantaged either because of socioeconomic circumstances or because health and disability preclude use of their own or public transport.</p> <p>Any services that charge fees are means tested such that those in receipt of pensions and are health care card holders either pay a reduced fee or are exempt from fees.</p>	As above	As above
	<p>Overcoming social isolation barriers- day centres around the state provide social support and activities for the frail, aged and people with a disability.</p> <p>Community Health provides coordination of community recovery responsibilities covering the human and social elements of disaster recovery.</p>	As above	As above

Source: Tasmanian Government unpublished.

TABLE 10A.118

Table 10A.118 **Australian Capital Territory, selected other community health programs***Selected other programs funded by the ACT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Community Health Intake	Community Health Intake facilitates access to community health services by providing a single point of entry to services. The public can phone Community Health Intake for information about health services or to arrange appointments with health professionals in community settings. Health professionals can fax referral forms to Community Health Intake for processing. Community Health Intake also has a dedicated GP phone line which provides information about community health services, provides information about clients with existing referrals, and transfers GP calls to other services and programs.	Funded by the ACT Government.	Monthly reporting to operational management
Community Care, Division of Rehabilitation, Aged and Community Care	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition and social work), acute, post acute and rapid response services, specialist nursing assessments and self management of chronic conditions program.	Through a designated budget: • Some services HACC funded • Remainder ACT Government funded	Monthly and annual reports against a range of indicators including output targets, budget and quality indicators. The ACT Government Health Directorate's Annual Report includes Accountability Indicators related to the achievement of occasions of service targets for nursing and allied health services.

Table 10A.118 **Australian Capital Territory, selected other community health programs***Selected other programs funded by the ACT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women, Youth and Children Community Health Programs (WYC-CHP)	<p>WYC-CHP offers a range of services to meet the health needs of children and their families or carers in the community setting. Services are provided at various locations across the ACT including clinics, Health Centres, schools, outreach locations and client homes to increase accessibility to clients.</p> <ul style="list-style-type: none"> • Maternal and Child Health (MACH) nursing services include universal first home visit, child health checks, childhood immunisation (0-4 years), general parenting education and support, and intensive parenting support for more vulnerable families in their homes. • Child Health Medical Officers and Community Paediatricians offer a secondary care level child health and development service (aged 0-16 yrs) • Child at Risk Health Unit delivers specialist health services to children, young people and their families affected by abuse and neglect. • Child protection training for all staff of Canberra Hospital and Health Services. • IMPACT Program coordinates care for clients of Mental Health and/or those receiving Opioid Replacement Therapy through pregnancy up to the child reaching 2 years of age. • School based programs include: immunisation; kindergarten health checks; school youth health nurses; Healthcare Access at School supporting students with complex health issues to attend school. • Asthma Nurse Education Service (0-25 years) • Nurse Audiometrists provide a full hearing assessment • Allied Health services include: social work; orthoptic screening; physiotherapy; nutrition advice and education. • Women's Health Service provides nursing, medical and counselling services for women who experience significant barriers to accessing health services. 	Designated budget	Monthly/Annual reports against output targets and budget.

TABLE 10A.118

Table 10A.118 **Australian Capital Territory, selected other community health programs***Selected other programs funded by the ACT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Justice Health Services	<p>Justice Health Services provides:</p> <ol style="list-style-type: none"> 1. Justice Health Services represents a combination of the Justice Health Primary Team and Forensic Mental Health Services delivered at the Alexander Maconochie Centre and Symonston Correctional Centre (Adults), the Bimberi Youth Justice Centre (Adolescents and Youth), the ACT Courts and the Periodic Detention Centre (Adults). The Forensic Mental Health Services also delivers services in the general Community. This program provides improved access to services by delivering at minimum community equivalence in service availability via and integrated multidisciplinary care approach. 2. The Primary Health Team provides and coordinates clinical services at a secondary level to people in the Alexander Maconochie Centre (AMC), Symonston Correctional Centre and Bimberi Youth Justice Centre (BYJC) respectively. The Primary Health Team also co-ordinates tertiary level care for people in these settings. 3. Forensic Mental Health Services (FMHS) provides specialist forensic mental health services within the AMC and BYJC for people with moderate and severe mental illness. FMHS also provides Mental Health services at the Courts and to high risk and complex consumers in the Community via their Forensic Community Outreach Service (FCOS). 	Through a designated budget	Monthly/Annual reports against output targets and budget

Source: ACT Government unpublished.

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Primary Health Care	TEHS and CAHS deliver evidence-based, best practice primary health care to people in remote areas via a network of 54 primary health centres and in collaboration with non-government	Funding sources: • NT Government through the Department of Health	Australian Government bi-annual financial and written reports,
Top End Health Service (TEHS) and Central Australia Health Service (CAHS)	Aboriginal community controlled health services. A multi-disciplinary team provides primary health care, 24 hour emergency care, medical evacuations, care and treatment for chronic disease and public health programs. Primary health care professionals work collaboratively with other departmental program professionals in remote areas to deliver integrated and coordinated care, targeting preventable chronic disease, maternal child and youth health, oral and ear health, sexual health, mental health, alcohol and other drugs and aged and disability services. Consultation occurs with the community to foster and develop community capacity, facilitate community decision making, promote and support the employment of local people and establish effective governance systems so that health services can successfully and confidently make the full transition to community controlled entities.	• Australian Government • Health Network NT Program governance and budget spending/oversight: • Top End Health Service • Central Australia Health Service Program delivery: • Top End Health Service • Central Australia Health Service • grant funded non-government Aboriginal community controlled organisations	Aboriginal and Torres Strait Islander National KPI report, NT Aboriginal Health KPI report, and OSR. Bi-annual written report to Services Reporting Health Network NT NT Department of Health Annual Report (public)
Urban Health	Urban Health is a child, youth and family program that operates within the urban setting to deliver evidence-based, best practice family-centred care. Referrals to the program are through the individual, hospitals and GPs, with linkages to government and non-government organisations. Services include: universal home visits; key age assessment (growth and development); extended visiting for vulnerable families; Early Birds (support program for new mothers); Territory parent support (education program); breast feeding/nutrition support; EPPDS screening (links to perinatal mental health); parenting support and advice; referrals to relevant services; immunisation health promotion provided by school nurses operating in middle school classrooms; and, the immunisation program.	Funding source: • Northern Territory Government through the Department of Health	Monthly activity reporting NT Department of Health Annual Report (public)

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Hearing Health	The Hearing Health program provides services in specialised hearing centres located in remote and urban community health centres or hospitals. Teleotology (store and forward telehealth) is also used in remote communities to improve access to services. The program supports community based primary health, early childhood and education hearing health strategies.	Funding sources: • NT Government through the Department of Health • Australian Government Program management/delivery: • NT Department of Health	Monthly activity reporting NT Department of Health Annual Report (public)
Health Promotion Strategy Unit (HPSU)	HPSU builds and strengthens capacity for delivering effective health promotion and prevention to the NT population. This involves facilitating a uniform understanding of health promotion across government and non-government health and related sectors; providing strategy and policy support; and, investing in research, program planning and evaluation, continuous quality improvement, social marketing, health promoting settings and developing sustainable education and training pathways.	Funding source: • Northern Territory Government through the Department of Health Program management and delivery: • NT Department of Health	NT Department of Health Annual Report (public) Six monthly QIPPS report to internal stakeholders
Public Health Nutrition and Physical Activity	Public Health Nutrition and Physical Activity services are delivered by public health nutritionists (PH nutritionists) in the Department of Health. Department policy officers provide strategic direction, develop policies and guidelines, and contribute to national developments. PH nutritionists provide training and support to primary health care teams to promote healthy nutrition and regular physical activity to the community and assist with the management of people with nutrition related conditions. They also offer individual and group dietetic consultations through community care centres and health clinics in both urban and remote area. PH nutritionists work with other agencies to increase food security by improving food supply and stimulating demand for healthy food in remote community stores. PH nutritionists also work with the education sector to ensure food provided at schools is in line with the Australian Dietary Guidelines for Children.	Funding source: • Northern Territory Government through the Department of Health • Australian Government via National Partnership Agreements • Health Network Northern Territory Program management: • NT Department of Health Program delivery: • NT Department of Health with non-government partners	Quarterly and annual reports to Australian Government Monthly activity reports to Health Network Northern Territory NT Department of Health Annual Report (public)

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Women's Health	The Women's Health Strategy Unit engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders, and coordinates and leads the Department of Health's response to this work. The Unit instigates, leads and project manages key strategic pieces of work to progress priority men and women's health issues, especially vulnerable populations such as Aboriginal and Torres Strait Islanders, migrants, refugees and victims of domestic and family violence.	Funding source: • Northern Territory Government through the Department of Health Program delivery via collaboration with partners	NT Department of Health Annual Report (public)
Men's Health	The Men's Health Strategy Unit provides expert advice, leadership and strategic directions in men's health with a particular focus on Aboriginal male health. The Unit leads the development of a men's health strategy and strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. Improving men's knowledge, access and use of preventive health services by working with departmental and other service providers is a high priority. The Unit supports Aboriginal Male Health Coordinators working in remote communities to engage men and undertake health promotion activities and coordinates the delivery of urban based male health awareness activities through the 'Pitstop' program.	Funding source: • Northern Territory Government through the Department of Health Program delivery via collaboration with partners	NT Department of Health Annual Report (public)
School Health Service	The School Health Service works in NT urban government-funded Middle Schools (school years 7 to 9). As part of the service registered nurses work onsite within a Health Promoting Schools Framework and provide health promotion and education in line with the school curriculum and general school ethos to empower youth to make healthy choices. This program supports the NT Childhood Vaccination Schedule.	Funding source: • Northern Territory Government through the Department of Health Program managed: • NT Department of Health	Financial activity reporting

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Healthy School-Age Kids Program	The Healthy School-Age Kids Program is a health promotion and screening program provided to all school-age children in remote communities. The program includes an integrated approach to screening and health promotion activities from a number of different health service providers, non-government organisations and schools. This program supports the NT Childhood Vaccination Schedule.	Funding source and program management: <ul style="list-style-type: none"> • NT Dept of Health Program service delivery: <ul style="list-style-type: none"> • Top End Health Service • Central Australia Health Service • two Aboriginal Medical Services in the Katherine region 	Activity reporting by community by event NT Department of Health Annual Report (public)
Prison Health Care	The Prison Health Care program delivers evidence-based, best practice primary health care services to prison inmates at the Darwin Correctional Centre, Don Dale Centre and the Alice Springs Correctional Centre. A multi-disciplinary team provides integrated and coordinated primary health care, 24-hour on-call emergency care, medical evacuations and chronic disease care and treatment. The program manages the relationship between itself and private allied health providers involved in primary health care service in the prisons and works collaboratively with other departmental program professionals to deliver public health programs. Consultation occurs with the community, inmate advocate groups and the Department of Correctional Services to foster and develop effective governance systems.	Funding source: <ul style="list-style-type: none"> • Northern Territory Government through the Department of Health Program budget spending/oversight: <ul style="list-style-type: none"> • NT Department of Health Governance oversight and program delivery: • Top End Health Service • Central Australia Health Service 	NT Department of Health Annual Report (public) National Prisoner Health Information Committee

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Chronic Conditions Strategy Unit (CCSU)	CCSU supports the chronic disease network across the Northern Territory to provide evidence-based, best practice within the chronic conditions prevention and management strategy framework. It provides leadership to ensure a consistent approach to chronic care and works closely with its partners within and outside the government health sector, including non-government and Aboriginal community controlled health services.	Funding source: • Australian Government via the National Partnership Agreement • Northern Territory Government through the Department of Health	NT Department of Health Annual Report (public)
Trachoma	<p>The Northern Territory Trachoma Program undertakes trachoma control activities in all remote communities in the NT with the aim of eliminating trachoma by 2020.</p> <p>The program provides early detection and intervention services through the screening and treatment for active trachoma infection in all Aboriginal children aged five to nine years living in remote communities. Treatment is provided to entire communities where required and Aboriginal adults aged 40 years and over are screened and treated for trichiasis.</p> <p>To prevent the transmission of infection, the program promotes health campaigns aimed at increasing facial cleanliness and improving environments.</p> <p>To overcome cultural/language barriers, the program conducts extensive community consultation, engages community based workers and has collaborated with other programs to develop culturally appropriate and/or translated resources.</p> <p>The populations served by the program include Aboriginal Territorians in remote communities.</p>	<p>Funding source: • Australian Government via the National Partnership Agreement for Improving Trachoma Control Services for Indigenous Australians</p> <p>Program management and delivery: • NT Department of Health • NT Aboriginal Medical Services</p>	<p>Six monthly report to Australian Government against partnership agreement milestones</p> <p>12 monthly report to Kirby Institute</p> <p>NT Department of Health Annual Report (public)</p>

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Sexual Health and Blood Borne Viruses Program	<p>The Sexual Health and Blood-Borne Viruses Program is an NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections (STIs) and blood borne viruses (BBVs). Services include:</p> <ul style="list-style-type: none"> • surveillance and public health response to notifiable STIs and BBVs • early detection and treatment through direct clinical services in five sexual health clinics • providing technical and financial support to primary health care services and health promotion programs in remote areas • funding community based organisations to engage communities in STI and BBV prevention programs • needle syringe program • clinical education • sexuality health education and promotion activities • support for research, involving both local and national partnerships. <p>The program overcomes:</p> <ul style="list-style-type: none"> • cultural/language barriers through delivery of culturally appropriate educational and clinical services • service barriers through integration of sexual health service delivery into primary health care to ensure a comprehensive sexual health program • gender-related barriers by ensuring a gender balance of staff. 	<p>Funding sources:</p> <ul style="list-style-type: none"> • Northern Territory Government through the Department of Health. • Office for Aboriginal and Torres Strait Islander Health (OATSIH) • Australian Government <p>Program management and delivery:</p> <ul style="list-style-type: none"> • NT Department of Health 	<p>OATSIH reporting requirements:</p> <ul style="list-style-type: none"> • annual action plan, budget and progress reports • six monthly and annual financial reports • service report <p>Biannual Australian Government report</p>

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Adolescent Sexuality Education Project (ASEP)	<p>The Adolescent Sexuality Education Project (ASEP) provides sexual and reproductive health education to young Aboriginal adolescents in school and community settings across the NT. ASEP is a collaborative effort between the NT Department of Education and Department of Health in association with the Central Australia Aboriginal Congress.</p> <p>The program embraces a community development approach to build the capacity of local people to deliver sexuality education in remote NT communities. Sexual and reproductive health education resources are adapted to suit local needs based on community consultation and the requirements of local community based educators. This approach has resulted in the establishment of a consistent and culturally appropriate sexuality education and illness prevention program that overcomes cultural/language barriers. The program also ensures a mix of male and female community based educators to overcome gender-related barriers. Population groups served by the program are mainly Aboriginal adolescent Territorians living in remote communities.</p>	<p>Funding sources:</p> <ul style="list-style-type: none"> • Australian Government via the Project Agreement for Indigenous Teenage Sexual and Reproductive Health and Young Parents Support (ceased 30 June 2015) • NT Government awarded a three month extension for the program from 01 July 2015 (set to expire 30 September 2015) <p>Program management and delivery:</p> <ul style="list-style-type: none"> • NT Department of Health • Top End and Central Australia Health Services 	<p>Final report to Australian Government on project agreement milestones</p> <p>NT Department of Health Annual Report (public)</p>

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Rheumatic Heart Disease Control Program	<p>The Rheumatic Heart Disease Control Program is a NT wide program that aims to reduce the burden of rheumatic heart disease among the Aboriginal population by reducing the occurrence of acute rheumatic fever.</p> <p>The program provides education, training, resource development and supply, and support of community members and health staff. The primary and community health objectives addressed include:</p> <ul style="list-style-type: none"> • improving timeliness and quality of services through the provision of timely reports to primary health care services • supporting integrated multidisciplinary care by working with internal and external services to ensure evidence based best practice by promoting national guidelines • supporting primary health services by promoting structured, systematic administrative and management processes to ensure continuity of care for patients according to national guidelines. <p>The program overcomes cultural/language barriers by working with community elders and interpreters and developing culturally appropriate resources.</p>	<p>Funding source:</p> <ul style="list-style-type: none"> • Australian Government via the Project Agreement for the Rheumatic Fever Strategy <p>Program management and delivery:</p> <ul style="list-style-type: none"> • NT Department of Health 	<p>12 monthly activity and financial report to Australian Government</p> <p>NT Department of Health Annual Report (public)</p>

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Tuberculosis and Leprosy Program	<p>A range of services are provided by the Centre for Disease Control for the management of tuberculosis (TB), leprosy and non-tuberculous mycobacteria in the NT. The aim of the program is to provide timely, evidence based healthcare that meets individual needs and facilitates access to appropriate services. It also aims to maximise efficiency through combined education and training of mycobacterial staff in the control of TB and leprosy.</p> <p>Services include</p> <ul style="list-style-type: none"> • remote area visits (including home visits) and education sessions • early detection/intervention through client monitoring and contact tracing to identify people at risk • screening for TB exposure in alcohol rehabilitation centres, prison, renal units and aged care • directly observed therapy to prevent the development of drug resistant disease. <p>The program overcomes cultural/language barriers by using interpreter services and translated educational material.</p> <p>Populations served by the program include Aboriginal Territorians, health-care workers, overseas-born non-asylum seekers and asylum seekers.</p>	<p>Funding sources:</p> <ul style="list-style-type: none"> • Northern Territory Government through the Department of Health • Department of Immigration and Boarder Protection via the agreement for the Provision of Health Services to Detainees <p>Program management and delivery:</p> <ul style="list-style-type: none"> • NT Department of Health through the Centre for Disease Control 	<p>NTG Budget Paper No. 3 (public)</p> <p>NT Department of Health, Annual Report (public)</p>

TABLE 10A.119

Table 10A.119 **Northern Territory, selected other community health programs***Selected other programs funded by the NT Government during 2014-15*

<i>Program</i>	<i>Description</i>	<i>Budgetary context</i>	<i>Reporting</i>
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	<p>The service promotes health and prevents illness caused by exposure to the Australian Bat Lyssavirus (ABL) and rabies virus. Preventative education programs are provided NT wide to ensure people avoid contact with bats in Australia and animals in countries where rabies is prevalent. These programs also instruct people bitten or scratched by bats in Australia and returning travellers bitten or scratched by animals in countries where rabies is prevalent to seek appropriate treatment.</p> <p>The Centre for Disease Control delivers technical knowledge on ABL pre and post exposure prophylaxis for the NT community and provides:</p> <ul style="list-style-type: none"> • (privately purchased) vaccine for pre-exposure prophylaxis against ABL to persons at risk of occupational exposure • post-exposure rabies immunoglobulin and (privately purchased) vaccine to those potentially exposed to both rabies virus and ABL. 	<p>Funding sources:</p> <ul style="list-style-type: none"> • Northern Territory Government through the Department of Health <p>Program management and delivery:</p> <ul style="list-style-type: none"> • NT Department of Health through the Centre for Disease Control 	<p>NT Department of Health, Annual Report (public)</p> <p>Post exposure prophylaxis use is reported to the Australian Government</p>

Source: NT Government unpublished.

Data quality information — Primary and community health, chapter 10

Data quality information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Primary and community health chapter. DQI for additional indicators will be progressively introduced in future reports.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI Contents

Availability of PBS medicines	3
Measure 1: Approved providers of PBS medicines by PhARIA area	3
Measure 2: PBS expenditure per person by region	5
Measure 3: Equity of access to PBS medicines	6
Equity of access to GPs	7
Measure 1: Availability of GPs by region	7
Measure 2: Availability of GPs by sex	9
Early detection and early treatment for Indigenous people	11
Proportion of children receiving a fourth year developmental health check	14
Effectiveness of access to GPs	16
Measure 1: Bulk billing rates	16
Measure 2: People deferring visits to GPs due to financial barriers	18
Measure 3: GP Waiting times	22
Measure 4: Selected potentially avoidable GP-type presentations to emergency departments	27
Financial barriers to PBS medicines	30
Public dentistry waiting times	34
GPs with vocational registration	36
Management of upper respiratory tract infections	38
Chronic disease management	40

Measure 1: Management of diabetes — HbA1c level	40
Measure 2: Management of asthma	43
Use of pathology tests and diagnostic imaging	46
Patient satisfaction	48
Cost to government of general practice per person	52
Child immunisation coverage	54
Notifications of selected childhood diseases	56
Participation rates for women in cervical screening	58
Selected potentially preventable hospitalisations	60
Measure 1: Selected potentially preventable hospitalisations for vaccine preventable, acute and chronic conditions	60
Measure 2: Selected potentially preventable hospitalisations for diabetes	65
Measure 3: Potentially preventable hospitalisations of older people for falls	68

Availability of PBS medicines

Data quality information for this indicator has been developed by the Health Working Group with additional Steering Committee comments.

Measure 1: Approved providers of PBS medicines by PhARIA area

Indicator definition and description

Element	Equity — Access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	<p>Definition</p> <ul style="list-style-type: none">Approved providers of PBS medicines by Pharmacy Access/Remoteness Index of Australia (PhARIA) area. <p>Numerator: ABS Census population data by PhARIA area</p> <p>Denominator: Number of approved providers of PBS medicines by PhARIA area.</p> <p>Computation: Numerator ÷ Denominator.</p>
Data source/s	University of Adelaide's National Centre for Social Applications of Geographic Information Systems, using Department of Human Services, Medicare pharmacies data and ABS ERP data.

Data Quality Framework Dimensions

Institutional environment	Australian Government Department of Health, PBS data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	<p>Data are presented by State/Territory by PhARIA area. Data include community pharmacies as well as GPs and Aboriginal Health Services approved to supply PBS medicines under the <i>National Health Act 1953</i> (Cwlth).</p> <p>PhARIA is a composite index, which incorporates measurements of general remoteness, as represented by ARIA+, with a professional isolation component represented by the road distance to the five (5) closest pharmacies (University of Adelaide Australian Population and Migration Research Centre). The University of Adelaide assign a PhARIA classification category (categories 1-6) to the ABS Census population - SA1 population data. The six PhARIA classification categories are:</p> <p>Category 1 - Highly Accessible</p> <p>Category 2 - Accessible (Group A)</p> <p>Category 3 - Accessible (Group B)</p> <p>Category 4 - Moderately Accessible</p> <p>Category 5 - Remote</p> <p>Category 6 - Very Remote</p> <p>General practitioners are able to obtain approval to supply PBS medicines under S92 of the <i>National Health Act 1953</i> (Cwlth). This requires that: 'where there is no pharmacist approved in respect of premises from which, in the opinion of the Secretary, a convenient and efficient pharmaceutical service may be supplied in a particular area and a medical practitioner is practising in that area, the Secretary may approve the medical practitioner for the purpose of supplying pharmaceutical benefits to persons in that area'.</p> <p>To be eligible to supply PBS medicines under section S100 of the <i>National Health Act 1953</i> (Cwlth), an Aboriginal Health Service (AHS) must meet the requirements of the National Health (Remote Aboriginal Health Services Program) Special Arrangements Instrument 2010, which states that the clinic or other health care facility operated by the AHS, from which pharmaceutical benefits are supplied to patients, must be in a remote</p>

	zone as defined in the Rural, Remote and Metropolitan Areas Classifications (RRMA), 1991 Census Edition (RRMA 6 - Remote Centres and RRMA 7 - Other Remote Areas).
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across regions and over time. Data as at June for 2013 and subsequent years are derived using ABS 2011 Census-based PhARIA areas. Data as at June for previous years use ABS 2006 Census-based PhARIA areas.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics .
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home .

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data are for the first time reported for a composite measure of access to PBS medicines that includes GPs and Aboriginal Medical Services approved to supply PBS medicines in locations where community pharmacies are less accessible. Data therefore represent access to PBS medicines after government measures to improve access in areas of market failure such as remote/very remote areas. This has particular relevance for the NT, as more than 40 per cent of the population live in such areas. • Data are for the first time disaggregated for all PhARIA categories (previously reported only for PhARIA 1 and the combined areas PhARIA 2–6).
------------------------------	--

Measure 2: PBS expenditure per person by region

Indicator definition and description

Element	Equity — Access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	Definition: <ul style="list-style-type: none">• Expenditure on Pharmaceutical Benefits Scheme (PBS) medicines divided by the ERP, by remoteness area Numerator: Expenditure on PBS medicines Denominator: ERP Computation: Numerator ÷ Denominator.
Data source/s	Numerator: Australian Government Department of Health, PBS Statistics Denominator: ABS ERP as at 30 June preceding the reference year from 2012-13.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data exclude expenditure on doctor's bag and other categories administered under special arrangements, such as, medications supplied to Aboriginal Health Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> (Cwlth) for the purpose of improving access to PBS medicines for Indigenous people and others located in those areas. This expenditure, \$29.3 million in 2014-15, is not suitable for computation of expenditure per person as 'catchment' areas for Aboriginal Health Services cross regional boundaries. Geographical location is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification from 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification. This constitutes a break in time series; data from 2012-13 are not comparable with data for previous years.
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across regions. The change to ASGS based geographical location from 2012-13 from RRMA based geographical location for previous years constitutes a break in time series. Data from 2012-13 are not comparable with data for previous years. Data are not directly comparable to data published in the Australian Government Department of Health annual report, which are prepared on an accrual accounting basis and include doctor's bag and other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth].)
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics .
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home .

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">• Data are reported only at the national level; reporting by State/Territory is a priority• Data exclude medications supplied to Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth] for the purpose of improving access for Indigenous people and others located in those areas.
------------------------------	--

Measure 3: Equity of access to PBS medicines

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure/s (computation)	Proportion of PBS prescriptions filled at a concessional rate Definition: <ul style="list-style-type: none">• The number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. Numerator: The number of PBS prescriptions filled at a concessional rate Denominator: The total number of prescriptions filled Computation: Numerator ÷ Denominator
Data source/s	Australian Government Department of Health, PBS Statistics.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are reported by State/Territory.
Timeliness	Reliable PBS supply data are available 16 weeks after the close of the reference period
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across jurisdictions and over time.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: <ul style="list-style-type: none">• Data do not capture medicines supplied by Aboriginal Medical Services in remote and very remote areas under s.100 of the <i>National Health Act 1953</i> [Cwlth] for the purpose of improving access to medicines for Indigenous people and others located in these areas. This has particular relevance for the NT as around 43 per cent of the population live in these areas.
------------------------------	---

Equity of access to GPs

Data quality information for this indicator has been developed by the Health Working Group with additional Steering Committee comments.

Measure 1: Availability of GPs by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measure/s (computation)	Availability of general practitioners (GPs) by region. Definition: <ul style="list-style-type: none">• The number of Full Service Equivalent (FSE) GPs per 100 000 people, by region. Numerator: Number of FSE GPs Denominator: Estimated Resident Population (ERP) by region. Computation: $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June preceding the reference year.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to Australian Government Department of Health.
Relevance	Geographical location based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification. GP headcount and FSE figures include vocationally recognised as well as non vocationally recognised general practitioners ('Other medical practitioners' (OMP)). GP headcount is a count of all GPs who have provided at least one DHS, Medicare service during the reference period and have had at least one claim for a DHS, Medicare service processed during the same reference period. GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing DHS, Medicare. FSE is an estimated measure of medical workforce based on Medicare claims information. Although Medicare claims data does not include information on hours worked it does have sufficient time-based items to estimate a proxy for hours worked. The FSE methodology models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5. A GP can work at more than one location. Allocation of GP headcount to state or territory and region is based on the practice location at which the GP provided the most DHS, Medicare services during the reference period. FSE allocates activity based on the practice location at which services were rendered within the reference period.
Timeliness	GP headcount and FSE figures are available 10 weeks after the close of the reference period.
Accuracy	GP headcount figures include only those GPs that both claimed and provided a service in the reference period. A small number of GPs may provide services in one year for which all claims are not processed until the next year. As additional months or DHS, Medicare claims data are processed, a small number of providers will become eligible

for inclusion in the headcounts. Revision of headcount figures will result in very small differences to published figures each year. FSE figures are not revised each year.

Since the commencement of DHS, Medicare, practitioners have provided demographic information to DHS, Medicare including date of birth and gender. Demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare Australia. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data.

To overcome the problems and biases posed by missing data, similar practitioners were grouped based on known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.

Coherence Estimates are compiled the same way across jurisdictions and over time.

This is the first year that the FSE estimate of GP workforce is used. Historical data have been revised and so there is coherence over time in the data presented in this Report. However, data are not comparable with data in previous editions of the report which used a different methodology (Full-time Work Equivalent) to estimate workforce.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- The classification system used to allocate GPs to regions from the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994
- Data are reported for 5 regional categories from 2012-13, compared to only 2 broad regional categories for previous years.

Measure 2: Availability of GPs by sex

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs by sex
Measure/s (computation)	Availability of general practitioners (GPs) by sex. Definition: <ul style="list-style-type: none">• The number of Full Service Equivalent (FSE) female GPs per 100 000 females• The number of FSE male GPs per 100 000 males Numerator: Number of FSE GPs by sex. Denominator: Estimated Resident Population (ERP) by sex. Computation: $100\,000 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December preceding the reference year.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.
Relevance	FSE GP figures include vocationally recognised as well as non-vocationally recognised general practitioners ('Other medical practitioners' (OMP)). GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing DHS, Medicare. FSE is an estimated measure of medical workforce based on Medicare claims information. Although Medicare claims data does not include information on hours worked it does have sufficient time-based items to estimate a proxy for hours worked. The FSE methodology models total hours worked for each practitioner based on the number of days worked, volume of services, and schedule fees. One FSE is approximately equivalent to a workload of 7.5 hours per day, five days per week. The FSE for each practitioner is capped at 2.5.
Timeliness	FSE figures are available 10 weeks after the close of the reference period.
Accuracy	FSE figures are not revised each year. Since the commencement of DHS, Medicare, demographic information has been provided by practitioners to DHS, Medicare including date of birth and gender. The demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data. To overcome the problems and biases posed by missing data, similar practitioners were grouped based on the known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.
Coherence	Estimates are compiled the same way across jurisdictions and over time. This is the first year that the FSE estimate of GP workforce is used. Historical data have been revised and so there is coherence over time in the data presented in this Report. However, data are not comparable with data in previous editions of the report which used a different methodology (Full-time Work Equivalent) to estimate workforce.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data are of acceptable accuracy.

Early detection and early treatment for Indigenous people

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Early detection and early treatment for Indigenous people
Measure/s (computation)	
Measure 1	<p>Definition:</p> <ul style="list-style-type: none">The proportion of older people who received a health assessment by Indigenous status. <p>Numerator:</p> <ul style="list-style-type: none">The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period <p>Denominator:</p> <ul style="list-style-type: none">The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period. <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Measure 2	<p>Definition:</p> <ul style="list-style-type: none">The proportion of older Indigenous people who received a health assessment, time series. <p>Numerator: The number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period.</p> <p>Denominator: The population of Indigenous people aged 55 years or over in the reference period.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Measure 3	<p>Definition:</p> <ul style="list-style-type: none">The proportion of Indigenous people who received a health assessment, by age group. <p>Numerator:</p> <ul style="list-style-type: none">The number of people aged 0–14 years, 15–54 years, or 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period. <p>Denominator:</p> <ul style="list-style-type: none">The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period. <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data sources (all measures)	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator: computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS).</p> <ul style="list-style-type: none">Total: ABS various years, <i>Australian demographic statistics</i>, Cat. no. 3101.0.For data by Indigenous status: ABS 2014, <i>Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026</i>, Cat. no. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	<p>MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to Australian Government Department of Health.</p> <p>The indicator was calculated by the Secretariat from numerator data supplied by Australian Government Department of Health and ABS-sourced denominator data.</p>
Relevance	<p>These measures relate to specific DHS, Medicare services for which claims data are available.</p> <p>Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly because the life expectancy of Indigenous people is, on average, relatively low.</p> <p>Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received, and might not be where the service was provided.</p> <p>For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to each age group.</p> <p>Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.</p>
Timeliness	<p>MBS claims data are available within 14 days of the end of a month.</p>
Accuracy	<p>Data include all claims processed up to 12 months after the service is received. Current year data are preliminary and subject to revision in subsequent reports.</p> <p>Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.</p> <p>Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.</p> <p>Clients are counted once only in the reference period.</p> <p>Data do not include:</p> <ul style="list-style-type: none">• health assessment activity for which practitioners do not claim the rebate• services that qualify under the DVA National Treatment Account and services provided in public hospitals <p>Data have not been adjusted to account for known under-identification of Indigenous status in MBS data.</p> <p>Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.</p>
Coherence	<p>The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis. As of 1 May 2010:</p> <ul style="list-style-type: none">• MBS Items 704, 706, 708, 710 (age based Health Assessments for Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715)• MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received.

Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data do not include health assessments conducted outside the MBS, for example, in some Aboriginal and Torres Strait Islander community health services. Accordingly, the indicator understates developmental health check activity.
- No adjustment was made to this indicator to account for under-identification of Indigenous people in DHS, Medicare data.

Proportion of children receiving a fourth year developmental health check

Data quality information for this indicator has been prepared based on the Steering Committee's 2012 report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Developmental health checks.
Measure/s (computation)	<p>Proportion of children who have received a 4 year old development health check.</p> <p>Numerator: The number of people aged 3, 4 or 5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10 986 (Healthy Kids Check or Health Assessment) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period.</p> <p>Denominator: The population aged 4 years, estimated using ERP data from the ABS. It was calculated by multiplying the 0-4 years ERP disaggregated by Indigenous status by the percentage of children aged 4 years in this age group nationally.</p> <p>Calculation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a percentage.</p>
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare Statistics data.</p> <p>Denominator: For total population: 2011 census based Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December of the reference year.</p> <p>For data by Indigenous status: 2011 census based ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 31 December derived by averaging the 30 June populations preceding and at the end of the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes claims made through the MBS under the <i>Human Services (Medicare) Act 1973</i>. These data are then regularly provided to Australian Government Department of Health.</p> <p>Data for 2009-10 and 2010-11 were calculated by Australian Government Department of Health, using a denominator supplied by the AIHW. Australian Government Department of Health drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) and then further comments were added by the AIHW, in consultation with Australian Government Department of Health.</p> <p>Data from 2011-12 are calculated by the Secretariat using numerator data supplied by Australian Government Department of Health and ABS-sourced denominator data.</p>
Relevance	<p>The measure relates to specific identified DHS, Medicare services for which DHS, Medicare has processed a claim.</p> <p>The MBS items included in this indicator do not cover all developmental health check activity such as that conducted through state and territory early childhood health assessments in preschools and community health centres.</p>
Timeliness	<p>MBS claims data are available within 14 days of the end of a month. The indicator relates to all claims processed in the reference year.</p>
Accuracy	<p>As with any administrative system a small degree of error may be present in the data captured.</p> <p>Analyses by state/territory are based on postcode of residence of the client as recorded by DHS, Medicare at the date the last service was received in the reference period. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.</p>

Data to 2010-11 are based on the date the claim was processed. From 2011-12, data are based on the date the service was rendered. From 2012 13, data include only services for which rebates were claimed in the reference year. This has minimal impact on the data.

Children who received more than one type of health check are counted once only in the calculations for this indicator. Where a child received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period, the child was counted once against the Aboriginal and Torres Strait Islander health assessment.

From 2011-12, children are counted only if they have not received a fourth year developmental health check in a previous reference period at the age of 3, 4 or 5 years.

MBS data presented for Aboriginal and Torres Strait Islander Peoples Health Assessments have not been adjusted to account for known under identification of Indigenous status.

Cells have been suppressed where the numerator is less than 10 for confidentiality reasons and where rates are highly volatile (for example, the denominator is very small) or data are known to be of insufficient quality (for example, where Indigenous identification rates are low).

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

As of 1 May 2010, the following changes to MBS items occurred:

The Healthy Kids Check Item 709 was replaced with four MBS health assessment items (based on time and complexity) that cover all ages — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). This renders it possible that health assessments for refugees and humanitarian entrants and for people with an intellectual disability (previously claimed under items 714, 718 or 719 and now claimed under the new MBS health assessment items) have been counted. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low for children aged 3–5 years.

A Healthy Kids Check provided by a practice nurse or a registered Aboriginal health worker on behalf of a medical practitioner (previously item 711) was replaced with MBS item number 10 986. The change to the MBS item number does not impact time series analysis.

The Aboriginal and Torres Strait Islander Child Health Check (previously item 708) was replaced by the Aboriginal and Torres Strait Islander People's Health Assessment (715) that has no designated time or complexity requirements and covers all ages. The change to the MBS item number does not impact time series analysis.

Accessibility

Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability

General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data do not include developmental health check activity conducted outside the MBS, for example, in preschools and community health centres. Accordingly, the indicator understates developmental health check activity.
- No adjustment was made to this indicator to account for under-identification of Indigenous children in DHS, Medicare data.

Effectiveness of access to GPs

Measure 1: Bulk billing rates

Data quality information has been developed for this measure by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	<p>Bulk billing rates</p> <p>Definition: The number of non-referred attendances to GPs that were bulk billed as a proportion of all non-referred attendances to GPs.</p> <p>Numerator: The number of non-referred attendances to GPs that were bulk billed.</p> <p>Denominator: The number of non-referred attendances to GPs.</p> <p>Computation: Expressed as a percentage.</p> <p>Disaggregations:</p> <ul style="list-style-type: none">• State/Territory by age• Region by age
Data source/s	<p>Numerator: Australian Government Department of Human Services (DHS), Medicare data.</p> <p>Denominator: Australian Government Department of Human Services (DHS), Medicare data.</p>

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> and regularly provides the data to DoHA.
Relevance	<p>These measures relate to DHS, Medicare services that are provided by GPs, who are identified through a Major Specialty Algorithm, and for which claims data are available.</p> <p>Disaggregation by region:</p> <p>Disaggregation by region is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification.</p>
Timeliness	MBS claims data are available within 14 days of the end of a month.
Accuracy	<p>As with any administrative system a small degree of error may be present in the data captured.</p> <p>Allocation to jurisdiction/region: DHS, Medicare claims data used for statistical purposes are based on enrolment postcode of the client at time of processing the final claim in the reference period. This postcode may not be current if the client changed address but did not notify DHS, Medicare.</p> <p>Allocation to age group: Allocation to age group is based on client date of birth in DHS, Medicare records at the date the service was received. Where client age is unknown, attendances are included in totals.</p> <p>Allocation to reference period: Data include all claims processed in the reference period. Data are based on the date on which the MBS claim was processed by DHS, Medicare, not the date on which the service was rendered. The use of data based on when the claim was processed rather than when the service was rendered produces little difference in the total number of services included in the numerator for the reference period.</p>
Coherence	Estimates are compiled the same way across jurisdictions and over time.

A revised Major Specialty Algorithm is used to identify GPs. Historical data have been revised and so there is coherence over time in the data presented in this Report. However, data are not comparable with data in previous editions of the report for which a different Major Specialty Algorithm methodology was used.

Accessibility Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- Data are of acceptable accuracy.

Measure 2: People deferring visits to GPs due to financial barriers

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	People deferring access to GPs due to cost. Definition: Proportion of people that required GP treatment but deferred that treatment due to cost. Numerator: People reporting delaying/not seeing a GP in the last 12 months due to cost. Denominator: People aged 15 years or over who needed to see a GP in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p> <p>Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:</p> <ul style="list-style-type: none">• members of the Australian permanent defence forces• diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts• overseas residents in Australia• members of non-Australian defence forces (and their dependents)

- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas. The exclusion of persons living in discrete Aboriginal and Torres Strait Islander communities has a small impact on estimates, except for the NT, where such persons make up more than 20 per cent of the population.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13, 28 November 2014 for 2013-14 and 13 November 2015 for 2014-15.

Referenced Period: July 2014 to June 2015 (2014-15 data); July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: Data were collected by computer assisted telephone interview for all iterations of the Patient Experience Survey. Data from an additional sample for the 2013-14 Patient Experience Survey were predominantly collected face-to-face (see below for more information).

Data Adjustments: Data were weighted to represent the total in scope Australian population, and were adjusted to account for confidentiality and non-response.

Sample/Collection size: The sample for the 2014-15 survey was 27 341 fully-responding persons.

Response rate: Response rate for the 2014-15 survey was 73 per cent.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95% confidence intervals. Estimates with a relative standard error between 25% and 50% should be used with caution, and estimates with a relative standard error over 50% are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the waiting time category '4 hours or more but within 24 hours' breakdowns are mostly greater than 25% and should either be used with caution or are considered too unreliable for general use. Similarly, data for the 'other' remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Confidentiality:

From 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

Data were self-reported but not attitudinal.

Explanatory footnotes are provided for each table. The data for this indicator is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system.

Data is used from personal interviews only (i.e. excluding proxy interviews).

Explanatory footnotes are provided for each table.

Information specific to the 2013-14 and preceding Patient Experience Surveys:

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77% (27,327 fully responding persons) while the response rate to HSS was 83% (8,541 fully responding persons) resulting in a total sample size of 35,868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30,749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data for 2014-15 are comparable to data for 2013-14 and 2012-13 but not to data for previous years, due to a change in question ordering in 2012-13 which had a noticeable context effect. As a result, ABS recommends that this data item is not comparable over time. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in all surveys, and of very remote communities in surveys for 2010-11 and previous years, will affect the NT more than it affects other jurisdictions (people usually resident in such areas account for more than 20 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these

data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data publicly available. Tables showing patients experiences with health professionals are available in *Health Services: Patient Experiences in Australia, 2009* (cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11*, *Patient Experiences in Australia: Summary of Findings, 2011-12*, *Patient Experiences in Australia: Summary of Findings, 2012-13*, *Patient Experiences in Australia: Summary of Findings, 2013-14* and *Patient Experiences in Australia: Summary of Findings, 2014-15* (cat. no. 4839.0).

The data is shown by age, sex, remoteness and SEIFA. Jurisdictional data is not currently publicly available but may be made available in the future.

Data is not available prior to public access.

Supplementary data is available. Additional data from the Patient Experience Survey is available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13, 2013-14* and *2014-15* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2014-15 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2014-15* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data from the Patient Experience survey are not comparable with data from the 2012-13 NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.

Measure 3: GP Waiting times

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Effectiveness of access to GPs
Measure/s (computation)	GP Waiting Times Definition Length of time a patient needs to wait to see a GP for an urgent appointment. Numerator Number of people aged 15 years or over who reported seeing a GP for urgent medical care (for their own health) within specified waiting time categories (less than 4 hours, 4 to less than 24 hours, 24 hours or more). Denominator Number of people aged 15 years or over who saw a GP for urgent medical care (for their own health) in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Patient Experience Survey, ABS.

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
----------------------------------	--

Relevance

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).

Data Completeness: All data are available for this measure from this source.

Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas. The exclusion of discrete Indigenous communities affects the NT more than other jurisdictions as more than 20 per cent of the population of the NT live in such communities.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13, 28 November 2014 for 2013-14 and 13 November 2015 for 2014-15.

Referenced Period: July 2014 to June 2015 (2014-15 data); July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: Data were collected by computer assisted telephone interview for all iterations of the Patient Experience Survey. Data from an additional sample for the 2013-14 Patient Experience Survey were predominantly collected face-to-face (see below for more information).

Data Adjustments: Data were weighted to represent the total in scope Australian population, and were adjusted to account for confidentiality and non-response.

Sample/Collection size: The sample for the 2014-15 survey was 27 341 fully-responding persons.

Response rate: Response rate for the 2014-15 survey was 73 per cent.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95% confidence intervals. Estimates with a relative standard error between 25% and 50% should be used with caution, and estimates with a relative standard error over 50% are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable

data for most breakdowns. However, RSEs for the waiting time category '4 hours or more but within 24 hours' breakdowns are mostly greater than 25% and should either be used with caution or are considered too unreliable for general use. Similarly, data for the 'other' remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Confidentiality:

From 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

Data were self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Explanatory footnotes are provided for each table. The data for this indicator is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system.

Data is used from personal interviews only (i.e. excluding proxy interviews).

Explanatory footnotes are provided for each table.

Information specific to the 2013-14 and preceding Patient Experience Surveys:

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77% (27,327 fully responding persons) while the response rate to HSS was 83% (8,541 fully responding persons) resulting in a total sample size of 35,868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30,749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Coherence

Consistency over time: 2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13, 2013-14 and 2014-15.

Time series issues: 2014-15 is comparable to 2013-14, 2012-13 and 2011-12, but not to previous years. This has been footnoted in the relevant tables. The reason for the comparability issues stem from a significant change in question wording and coding methodology in the 2011-12 Patient Experience Survey for the 'waiting times for GPs' questions, and this has had an impact on the data.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data publicly available. Tables showing patients experiences with health professionals are available in *Health Services: Patient Experiences in Australia, 2009* (cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11*, *Patient Experiences in Australia: Summary of Findings, 2011-12*, *Patient Experiences in Australia: Summary of Findings, 2012-13*, *Patient Experiences in Australia: Summary of Findings, 2013-14* and *Patient Experiences in Australia: Summary of Findings, 2014-15* (cat. no. 4839.0).

The data is shown by age, sex, remoteness and SEIFA. Jurisdictional data is not currently publicly available but may be made available in the future.

Data is not available prior to public access.

Supplementary data is available. Additional data from the Patient Experience Survey is available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13, 2013-14* and *2014-15* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2014-15 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2014-15* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2011-12, 2012-13, 2013-14 and 2014-15 are comparable.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are based on waiting times for self-defined urgent medical care.
- Disaggregation of this measure by Indigenous status is a priority.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Measure 4: Selected potentially avoidable GP-type presentations to emergency departments

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Attendances at public hospital emergency departments that could have potentially been avoided through the provision of appropriate non-hospital services in the community.
Measure/s (computation)	<p>The number of presentations to public hospital emergency departments in hospitals that reported to the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) where:</p> <ul style="list-style-type: none">• there was a type of visit of Emergency presentation• a triage category of 4 or 5 was allocated• the patient did not arrive by ambulance or police or correctional vehicle; and• the patient was not admitted to the hospital, was not referred to another hospital, and did not die.
Data source/s	This indicator is calculated using data from the NNAPEDCD NMDS.

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the <i>Australian Institute of Health and Welfare Act 1987</i> to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth entity governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p> <p>The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.</p> <p>One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.</p> <p>The <i>Australian Institute of Health and Welfare Act 1987</i>, in conjunction with compliance to the <i>Privacy Act 1988 (Commonwealth)</i>, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.</p> <p>For further information see the AIHW website www.aihw.gov.au.</p> <p>Data for the NNAPEDCD were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following links):</p> <ul style="list-style-type: none">• www.aihw.gov.au/nhissc/• http://meteor.aihw.gov.au/content/index.phtml/itemId/182135 <p>The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and</p>
----------------------------------	---

public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in public hospitals.

From 2013-14 the scope of the NNAPEDCD is patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria:

- purposely designed and equipped area with designated assessment, treatment and resuscitation areas
- ability to provide resuscitation, stabilisation and initial management of all emergencies
- availability of medical staff in the hospital 24 hours a day
- designated emergency department nursing staff 24 hours per day 7 days per week, and a designated emergency department nursing unit manager.

The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD.

The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council.

Timeliness The reference period for these data is 2013-14 and 2014-15.

Accuracy For 2013-14 and 2014-15, the coverage of the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) collection is complete for public hospitals with an emergency department.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence Data are not comparable with data presented for 2013-14 and previous years in previous editions of the Report due to expansion of the scope for reporting to the NNAPEDCD. The scope was previously limited to public hospitals in Peer Groups A and B, using the peer group classification method as reported in Australian hospital statistics 2010–11, with the addition of emergency department activity at the Mersey Community Hospital.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the NPHEd for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator is calculated using the same methodology as data published in Australian hospital statistics: emergency department care 2014-15.

Accessibility The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are: Australian hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at www.aihw.gov.au/hospitals/.

Interpretability Metadata information for the NAPEDC NMDS and the NAPEDC DSS are published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the 2014-15 NNAPEDCD can be accessed on the AIHW website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/546749>

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals reporting to the NNAPEDCD. It does not include emergency presentations to hospitals that have emergency departments that do not meet the criteria specified in the NAPEDC NMDS.
- The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council.
- In previous reports, the scope of the data used to produce this indicator was non-admitted patients registered for care in emergency departments in public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group b (Large hospitals). The scope of data provided for this indicator has changed, therefore data provided in this report are not directly comparable to data calculated in previous reporting periods.

Financial barriers to PBS medicines

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Financial barriers to PBS medicines
Measure/s (computation)	People deferring purchase of prescribed medicines due to cost. Definition: Proportion of people that deferred purchase of prescribed medicines due to cost. Numerator: Number of people who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost. Denominator: Total number of people aged 15 years or over who received a prescription for medication from a GP in the last 12 months. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p>

**Relevance
(cont.)**

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas. The exclusion of persons living in discrete Aboriginal and Torres Strait Islander communities has a small impact on estimates, except for the NT, where such persons make up more than 20 per cent of the population.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13, 28 November 2014 for 2013-14 and 13 November 2015 for 2014-15.

Referenced Period: July 2014 to June 2015 (2014-15 data); July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: Data were collected by computer assisted telephone interview for all iterations of the Patient Experience Survey. Data from an additional sample for the 2013-14 Patient Experience Survey were predominantly collected face-to-face (see below for more information).

Data Adjustments: Data were weighted to represent the total in scope Australian population, and were adjusted to account for confidentiality and non-response.

Sample/Collection size: The sample for the 2014-15 survey was 27 341 fully-responding persons.

Response rate: Response rate for the 2014-15 survey was 73 per cent.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95% confidence intervals. Estimates with a relative standard error between 25% and 50% should be used with caution, and estimates with a relative standard error over 50% are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the waiting time category '4 hours or more but within 24 hours' breakdowns are mostly greater than 25% and should either be used with caution or are considered too unreliable for general use. Similarly, data for the 'other' remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Confidentiality:

From 2013-14, the data has been perturbed. This has been footnoted in the tables. Perturbation is used to minimise the risk of identifying individuals in aggregate statistics. Perturbation involves small random adjustment of the statistics and is considered the most satisfactory technique for avoiding the release of identifiable statistics while maximising the range of information that can be released. These adjustments have a negligible impact on the underlying pattern of the statistics.

After perturbation, a given published cell value will be consistent across all tables. However, adding up cell values to derive a total will not necessarily give the same result as published totals.

Data were self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Explanatory footnotes are provided for each table. The data for this indicator is self-reported but not attitudinal, as respondents are reporting their experiences of using the health system.

Data is used from personal interviews only (i.e. excluding proxy interviews).

Explanatory footnotes are provided for each table.

Information specific to the 2013-14 and preceding Patient Experience Surveys:

Method of Collection: For this iteration of the Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (The majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77% (27,327 fully responding persons) while the response rate to HSS was 83% (8,541 fully responding persons) resulting in a total sample size of 35,868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30,749, which had a response rate 78.9 per cent. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data for 2013-14 are comparable to data for 2012-13, 2011-12 and 2010-11, but not before this (ie not comparable to 2009). This is due to changes in question wording/sequencing in the patient experience survey. As a result, a time series can be started from 2010-11 onwards. This has been footnoted in the relevant tables.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13

surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in discrete Indigenous communities account for more than 20 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data publicly available. Tables showing patients experiences with health professionals are available in Health Services: Patient Experiences in Australia, 2009 (cat. no. 4839.0.55.001), Patient Experiences in Australia: Summary of Findings, 2010-11, Patient Experiences in Australia: Summary of Findings, 2011-12, Patient Experiences in Australia: Summary of Findings, 2012-13, Patient Experiences in Australia: Summary of Findings, 2013-14 and Patient Experiences in Australia: Summary of Findings, 2014-15 (cat. no. 4839.0).

The data is shown by age, sex, remoteness and SEIFA. Jurisdictional data is not currently publicly available but may be made available in the future.

Data is not available prior to public access.

Supplementary data is available. Additional data from the Patient Experience Survey is available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2014-15 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2014-15* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.

Public dentistry waiting times

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Public dentistry waiting times.
Measure/s (computation)	Median number of days waited between being placed on a public dentistry waiting list and: <ul style="list-style-type: none">• receiving dental care, or, if data not available,• being offered dental care.
Data source/s	Public dental waiting times NMDS 2013-

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth entity governed by a management board, and accountable to the Australian Parliament through the Health portfolio.</p> <p>The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.</p>
Relevance	<p>The purpose of the PDWT NMDS is to collect information about the length of time that patients wait for public dental care in Australia. The scope of the NMDS is people who received or were offered public dental care, in the reporting period, in Australia.</p> <p>The data collection excludes people who are treated under jurisdictional priority client schemes, and may also exclude some other people who are not placed on a public dental waiting list. Therefore, the waiting times reported are not the median waiting times experienced by all people aged 18 years or over who received public dental services.</p> <p>The analyses by remoteness and socioeconomic status are based on the usual residence of the patient. However, data are reported by jurisdiction of receipt of dental care regardless of the jurisdiction of usual residence.</p>
Timeliness	The reference period for these data is 2013–14 and 2014–15.
Accuracy	<p>For 2013–14 and 2014–15, data are published for all jurisdictions except New South Wales and Northern Territory.</p> <p>Data providers are primarily responsible for the quality of the data they provide. However, the AIHW has undertaken basic validation of the data. The AIHW does not adjust data to account for possible data errors or missing or incorrect values, however, data were excluded from waiting times calculations where:</p> <ul style="list-style-type: none">• the data provided resulted in a negative waiting time, or• where a record has no date of offer or date of dental care, and so a waiting time could not be calculated. <p>Waiting times of zero days are included in the analysis.</p> <p>Only treatments received after a person is removed from a public dental waiting list should be recorded.</p> <p>Some double counting may occur in this collection due an inability to link cases where:</p> <ul style="list-style-type: none">• a waiting time to being offered dental care was reported for a person in one reference period and then

	<ul style="list-style-type: none"> • a waiting time till dental care was reported for the same person in the next reference period.
Coherence	<p>2013–14 was the first year of collection of national public dental waiting times data under the agreement to collect PDWT NMDS data.</p> <p>In relation to the ability to compare data over time, and between jurisdictions:</p> <ul style="list-style-type: none"> • New South Wales data were not available for 2013–14 and are not published in 2014–15 due to data quality issues. • Northern Territory data are not published in 2013–14 or 2014–15 due to data quality issues. • Data for jurisdictions across years is comparable. • Data is not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. • Waiting times are not shown by waiting list type. Differences in the purpose and processes between different list types limit comparability of waiting times between jurisdictions and over time.
Accessibility	<p>The AIHW will publish data from this collection on the AIHW website at <www.aihw.gov.au>.</p>
Interpretability	<p>Metadata information for the PDWT NMDS is published in the AIHW's Metadata Online Registry (METeOR) and the National health data dictionary.</p> <p>METeOR and the National health data dictionary can be accessed at the following AIHW web addresses, respectively:</p> <p><http://meteor.aihw.gov.au/content/index.phtml/itemId/517220></p> <p><http://www.aihw.gov.au/publication-detail/?id=10737422826>.</p>

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • This indicator is being reported for the first time (for 2013–14 and 2014–15) drawing on data collated under an agreement to report against the Public Dental Waiting Times (PDWT) National Minimum Data Set (NMDS). <ul style="list-style-type: none"> - Data are not comparable across jurisdictions due to differences in the way in which services are arranged and different arrangements that determine which people requiring treatment are placed on a public dental waiting list, including how jurisdictions prioritise certain disadvantaged population groups. - Data for 2013–14 and 2014–15 do not include New South Wales or Northern Territory, due to data quality concerns. - Data for jurisdictions are comparable across years. - Waiting times are not shown by waiting list type. Differences in the purpose and processes between different list types limit comparability of waiting times between jurisdictions and over time. - Waiting times could not be calculated for some records (including where negative waiting times were reported or where a record had no date of offer or date of dental care). - Waiting times of zero days are included in all analyses. - The collection excludes people who are treated under jurisdictional priority client schemes. - In a small number of cases, double counting of people may occur across these reference years due to an inability to link people across reference years in this collection.
------------------------------	--

GPs with vocational registration

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Appropriateness
Indicator	GPs with vocational registration
Measure/s (computation)	<p>The proportion of general practitioners (GPs) with vocational registration.</p> <p>Definition: The number of Full Service Equivalent (FSE) vocationally registered GPs divided by the number of FSE GPs and Other medical practitioners (OMP).</p> <p>Numerator: Number of FSE vocationally registered GPs.</p> <p>Denominator: Number of FSE vocationally registered GPs and OMPs.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.</p> <p>Disaggregations:</p> <ul style="list-style-type: none">• State/Territory• Region
Data source/s	Australian Government Department of Human Services (DHS), Medicare data.

Data Quality Framework Dimensions

Institutional environment	MBS data are an administrative by-product of the DHS, Medicare fee for-service payment systems. DHS, Medicare collects MBS data under the <i>Human Services (Medicare) Act 1973</i> (previously <i>Medicare Australia Act 1973</i>) and regularly provides the data to the Department of Health.
Relevance	<p>Data capture all vocationally registered GPs and OMPs.</p> <p>A vocationally registered GP is a medical practitioner who is vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwth), holds Fellowship of the RACGP, ACCRM, 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.</p> <p>An OMP is 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.</p> <p>Allocation of FWE GPs and OMPs to state or territory and region is based on the practice location at which services were rendered within the reference period.</p> <p>Disaggregation by region is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification.</p>
Timeliness	GP FSE figures are available 10 weeks after the close of the reference period.
Accuracy	As with any administrative system a small degree of error may be present in the data captured.
Coherence	<p>Estimates are compiled the same way across jurisdictions and over time.</p> <p>This is the first year that the FSE estimate of GP workforce is used and historical data have been revised accordingly. Data for 2011-12 and previous years were also revised to use the regional ASGS classification.</p> <p>Hence, there is coherence over time in data presented in this Report. However, data are not comparable with data in previous editions of the report which used a different methodology (Full-time Work Equivalent) to estimate workforce and a different regional classification system for data for the years to 2011-12.</p>
Accessibility	Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .

Interpretability General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues The Steering Committee notes the following issues:

- The classification system used to allocate GPs to regions for all years is current, a major improvement over previous reports in which data for 2011-12 and previous years were based on a system developed in 1994.

Management of upper respiratory tract infections

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Management of upper respiratory tract infections
Measure/s (computation)	<p>Definition: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided per 1000 people.</p> <p>Numerator: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed.</p> <p>Denominator: ERP</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>
Data source/s	<p>Numerator: Australian Government Department of Health Pharmaceutical Benefits Scheme (PBS) Statistics data.</p> <p>Denominator: ABS preliminary ERP based on the 2011 Census at 31 December in the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by Australian Government Department of Health and administered by the Department of Human Services (DHS), Medicare. Provisions governing the operation of the PBS are contained in the National Health Act 1953.</p> <p>The indicator was calculated by the Secretariat using the numerator data supplied by Australian Government Department of Health and ABS ERP.</p>
Relevance	<p>These measures relate to PBS subsidised oral antibiotics used most commonly in treating URTI: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names that were ordered by GPs and dispensed to patients were extracted for each reference period.</p> <p>These antibiotics are used to treat a range of conditions in addition to URTI. Data disaggregated by the condition being treated are not available. The proportion of these antibiotics prescribed for treatment of URTI is unknown.</p> <p>Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.</p>
Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	<p>PBS data from 2012-13 are complete. For previous years, PBS data for general patients was available only for items priced above the PBS general co-payment (\$35.40 in 2012) and therefore, the majority of script data for these patients was missing. Hence, data for 2011-12 and previous years were reported only for concession card holders.</p> <p>Data include only prescriptions provided by GPs and OMPs.</p>
Coherence	<p>Data are estimated the same way across jurisdictions.</p> <p>Data for 2012-13 and subsequent years are not comparable to data for 2011-12 and previous years, which are reported only for concession card holders.</p>
Accessibility	PBS Claims data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp .
Interpretability	Information on PBS data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp at the PBS item reports and PBS group reports links.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- URTI is one of a range of conditions for which these antibiotics are prescribed. Data are not able to be disaggregated by condition.
- The availability of complete data on the selected antibiotics dispensed in the general population significantly improves data quality from 2012-13.

Chronic disease management

Management of diabetes — HbA1c level

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Chronic disease management
Measure/s (computation)	Management of diabetes — HbA1c. Numerator: Number of people aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test, who have an HbA1c level of less than or equal to 7.0 per cent. Denominator: Number of persons aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	For the 2016 Report, the denominator and numerator for this indicator use data from the 2011-12 National Health Measures Survey (NHMS) component of the Australian Bureau of Statistics (ABS) Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope population derived from the Estimated Resident Population (ERP). For information on scope and coverage, see the Australian Health Survey: Users' Guide (cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au .

Data Quality Framework Dimensions

Institutional environment	<p>The 2011-12 NHMS was collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.</p>
Relevance	<p>For this measure, the fasting plasma glucose test is used in the determination of people with known diabetes and the HbA1c test is used in the determination of effective management of diabetes.</p> <p>The 2011-12 NHMS uses a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of known diabetes.</p> <p>A respondent to the survey is considered to have known diabetes if they had ever been told by a doctor or nurse that they have diabetes and:</p> <ul style="list-style-type: none">• they were taking diabetes medication (either insulin or tablets) <p>or</p> <ul style="list-style-type: none">• their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L. <p>Persons with known diabetes who have an HbA1c result of less than or equal to 7.0 per cent are considered to be managing their diabetes effectively.</p> <p>The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.</p>

Timeliness	The NHMS was conducted for the first time in 2011–13. Results from the 2011-12 NHMS were released in August 2013. Results from the NATSIHMS were released in 2014.
Accuracy	<p>The AHS was conducted in all States and Territories, excluding very remote areas and discrete Aboriginal and Torres Strait Islander communities. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas and discrete Aboriginal and Torres Strait Islander communities has a small impact on estimates, except for the NT, where such persons make up more than 20 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.</p> <p>All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 38 per cent went on to complete the biomedical component.</p> <p>Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in Australian Health Survey: Biomedical Results for Chronic Disease (cat. no. 4364.0.55.005).</p> <p>In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.</p> <p>As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.</p> <p>This indicator produces high levels of sampling error for some States and Territories when split by sex. Estimates for males and females in Victoria have RSEs greater than 50 per cent and should be considered unreliable for general use. Likewise, estimates for males in the Northern Territory and females in the Australian Capital Territory also have RSEs greater than 50 per cent.</p> <p>Data for several State and Territories also have RSEs greater than 25 per cent, including the total for Victoria, South Australia, the Australian Capital Territory and the Northern Territory, and these estimates should be used with caution.</p>
Coherence	<p>The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes management.</p> <p>The 2009-10 Victorian Health Monitor (VHM) reported estimates of diabetes management based on the proportion of people with known diabetes meeting the HbA1c management target of less than or equal to 7.0 nmol/L. The VHM age-standardised rate (39 per cent) was similar to the NHMS rate for Victoria (36 per cent).</p>
Accessibility	See Australian Health Survey: Biomedical Results for Chronic Disease (cat. no. 4364.0.55.005). Other information from this survey is also available on request.
Interpretability	<p>Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website.</p> <p>Many health-related issues, including diabetes, are closely associated with age. However, numbers across age ranges were too few to do any meaningful age standardisation at the State/Territory level for this measure. Therefore the data presented are based on crude rates.</p>

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The 2011-12 National Health Measures Survey (NHMS) was conducted for the first time as part of the 2011–13 Australian Health Survey (AHS), with participation voluntary in the NHMS. Of those who took part in the AHS, 38 per cent took part in the NHMS. The NHMS sample was found to be representative of the AHS population.
- The NHMS does not include people living in very remote areas or discrete Aboriginal and Torres Strait Islander communities, which affects the comparability of data for the NT with data for other jurisdictions.

Measure 2: Management of asthma

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Chronic disease management
Measure/s (computation)	Management of asthma Definition <ul style="list-style-type: none">• Proportion of people with asthma who have a written asthma action plan. Numerator: <ul style="list-style-type: none">• Estimated number of people with asthma with a written asthma action plan. Denominator: Estimated number of people with asthma. Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.
Data source/s	Data reported for 2011–13 are from the ABS 2011–13 Australian Health Survey (AHS) (2011-12 National Health Survey (NHS) component) and the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (NATSIHS component). Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS. NHS data are weighted to benchmarks for the total NHS in scope population, derived from the ERP. For information on NHS scope and coverage, see ABS Australian Health Survey: Users' Guide (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au . NATSIHS data are benchmarked to the estimated population of Aboriginal and Torres Strait Islander Australians (adjusted for the scope of the survey).

Data Quality Framework Dimensions

Institutional environment	The NHS and NATSIHS are collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.
Relevance	The NHS 2011-12 and 2007-08 asked all respondents whether they had ever been told by a doctor or nurse that they have asthma, whether symptoms were present or they had taken treatment in the 12 months prior to interview, and whether they still had asthma. Those who answered yes to these questions were asked whether they had 'a written asthma action plan, that is, written instructions of what to do if your asthma is worse or out of control'. A very small number of respondents who were sequenced around these questions may have reported current long-term asthma in response to later general questions about medical conditions. These people are included in and contribute to estimates of the prevalence of asthma, but information about written action plans was not collected from them. In the 2012-13 NATSIHS, non-remote respondents who reported they have been told by a doctor that they have asthma, and who still get asthma or have had symptoms of asthma in the last 12 months were asked about written asthma action plans. In the 2004-05 NATSIHS, non-remote respondents who answered questions about having asthma 'yes' were asked about written asthma action plans.

In both the 2004-05 NHS and NATSIHS, respondents were asked if they had 'a written asthma action plan'. If they queried the interviewer about what to include, they were told to include management plans developed in consultation with a doctor, cards associated with peak flow meters and medication cards distributed through chemists. In 2007, if they queried the interviewer, respondents were asked to include plans that were worked out in consultation with a doctor, but not cards associated with peak flow meters or medications cards handed out by chemists.

Ideally this indicator would relate to the proportion of people with moderate to severe asthma, as people with only very mild asthma are unlikely to require planned care. Consequently, there is no clear direction of improvement in this indicator: a lower proportion of people with asthma with an asthma care plan may simply mean that those people with asthma have less severe asthma (which would actually be a positive outcome).

Timeliness The NHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

The NATSIHS is conducted every six years. Results from the 2012-13 survey were released in November 2013.

Accuracy The NHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of people usually resident in very remote areas has a small impact on estimates, except for the Northern Territory, where such people make up approximately 23 per cent of the population. Results are weighted to account for non-response.

The response rate for the 2011-12 NHS was 85 per cent and for the 2007-08 NHS was 91 per cent.

The NATSIHS is conducted in all States and Territories and includes remote and non-remote areas. The 2012-13 sample was 9317 people/5371 households, with a response rate of 80 per cent. The 200-05 sample was 10 000 people/5200 households, with a response rate of 81 per cent of households. Results are weighted to account for non-response.

As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

Coherence Questions used in the 2011-12 and 2007-08 NHS to collect data for this indicator are consistent with the questions recommended for use by the Australian Centre for Asthma Monitoring (ACAM). Data for 2011-12 and 2007-08 are comparable over time (except for the Northern Territory) but are not comparable to data from the 2004 05 survey due to better alignment of questions and concepts with the ACAM recommendations since 2004-05.

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

The NHS and NATSIHS collect a range of other health-related information (for example, information on smoking) that can be analysed in conjunction with data on asthma and asthma plans.

Accessibility See Australian Health Survey: First Results (Cat. no. 4364.0.55.001) and Australian Health Survey: Health Service Usage and Health Related Actions (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

See *Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001) for an overview of results from the 2012-13 NATSIHS. Other information from the survey is available on request.

Interpretability Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide and the Australian Aboriginal and Torres Strait Islander Health

Survey: Users' Guide on the ABS website.

Many health-related issues are closely associated with age, therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories and the Indigenous and non-Indigenous population. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of asthmatics who have an asthma management plan. However, there is no information about the severity of the condition and people with mild asthma are unlikely to require a written plan.
- NATSIHS data are only collected every six years. An assessment of the relative speed of change in outcomes is required to determine whether more regular data collection is necessary.
- The NHS does not include people living in very remote areas which affects the comparability of the NT results.

Use of pathology tests and diagnostic imaging

Data quality information has been developed for this measure by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Appropriateness
Indicator	Use of pathology tests and diagnostic imaging
Measure 1	<p>MBS items rebated through Department of Human Services (DHS), Medicare for pathology tests requested by general practitioners (GP), and Other Medical Practitioners (OMP), per person (age-standardised)</p> <p>Definition: The number of MBS items rebated through DHS, Medicare for pathology tests requested by specialist GPs and OMPs, per person (age standardised)</p> <p>Numerator: The number of MBS items rebated through DHS, Medicare for pathology tests requested by GPs and OMPs</p> <p>Denominator: Estimated Resident Population (ERP)</p> <p>Computation: Numerator ÷ Denominator, age-standardised</p>
Measure 2	<p>Diagnostic imaging services provided on referral from specialist GPs and OMPs and rebated through DHS, Medicare, per person (age standardised)</p> <p>Definition: The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs, per person (age standardised)</p> <p>Numerator: The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs</p> <p>Denominator: Estimated Resident Population (ERP)</p> <p>Computation: Numerator ÷ Denominator, age-standardised</p>
Measure 3	<p>DHS, Medicare benefits paid per person for pathology tests requested by GPs and OMPs (age-standardised).</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) to provide real expenditure, comparable over time.</p>
Measure 4	<p>DHS, Medicare benefits paid per person for diagnostic imaging referred by GPs and OMPs (age-standardised).</p> <p>Data are deflated using the GGFCE chain price deflator (2014-15 = 100) to provide real expenditure, comparable over time.</p>
Data source/s	<p>Numerator:</p> <ul style="list-style-type: none">• For MBS data: DHS, Medicare data.• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <p>Denominator: ABS 2011 Census-based Estimated Resident Population (ERP) as at 31 December in the reference year.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes and collects MBS data for:</p> <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to Australian Government Department of Health.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.
----------------------------------	--

	<p>MBS claims data are an administrative by-product of DHS, Medicare's fee for-service payment systems.</p> <p>DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.</p>
Relevance	<p>The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:</p> <ul style="list-style-type: none"> • Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'. • Diagnostic imaging services — all items in BTOS 'G'. <p>Claims are allocated to state/territory based on location at which the service was rendered.</p> <p>Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.</p>
Timeliness	Data include all claims processed in the reference period.
Accuracy	<p>Data are limited to claims for services requested/referred by GPs and, for MBS data, OMPs (DVA data include only services requested/referred by specialist GPs). Data do not include claims for services requested/referred by other medical specialists.</p> <p>Data include all claims processed in the reference period.</p> <p><u>Pathology tests</u></p> <p>The pathology episode cone applies to services requested by general practitioners for non-hospitalised patients:</p> <p>when more than three MBS pathology items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for three items — those with the highest schedule fees (there are some items exempted from the episode cone). Where additional tests performed in a patient episode are not rebated through DHS, Medicare, they are not included in the data. This results in some underreporting of the number of pathology tests conducted on request by GPs and OMPs.</p> <p>Data include Patient Episode Initiated Items.</p> <p><u>Diagnostic imaging</u></p> <p>Diagnostic imaging services provided and rebated through DHS, Medicare can differ from the services requested by GPs and OMPs.</p> <p>In certain circumstances, as defined by legislation, a radiologist can identify the need for, and perform, more or different diagnostic imaging services than are requested by a GP/OMP. The data reflect the services provided and rebated through DHS, Medicare, rather than the services requested by GPs/OMPs.</p>
Coherence	Data are compiled the same way across jurisdictions. Rates from 2012-13 are age-standardised to the 2001 Australian Standard Population. These data are not comparable to crude rates reported for previous years.
Accessibility	<p>Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9.</p> <p>DVA data are not publically accessible.</p>
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1
	<u>Data Gaps/Issues Analysis</u>
Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Age-standardisation of rates from 2012-13 is a significant improvement. However, rates are not comparable with crude rates reported for previous years. • This is a proxy measure — data are limited to those services rebated through DHS, Medicare that were provided in response to request/referral by GPs/OMPs. • Provides information about relative requests/referrals for pathology tests and diagnostic imaging across jurisdictions and over time, but not the appropriateness thereof.

Patient satisfaction

Data quality information for this measure has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Quality — responsiveness
Indicator	Patient satisfaction/experience around key aspects of care they received.
Measure/s (computation)	<p>Measure a: people who saw a GP in the last 12 months reporting the GP always or often: listened carefully, showed respect, and spent enough time with them</p> <p>Definition: Proportion of people satisfied with selected aspects of GP/dentist care.</p> <p>Numerator: People who saw a GP/dentist in the last 12 months reporting the GP/dentist always or often: listened carefully; showed respect; spent enough time with them.</p> <p>Denominator: People who saw a GP/dentist for their own health in the last 12 months, excluding people who were interviewed by proxy.</p>
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	<p>Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.</p> <p>For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.</p> <p>Collection authority: The <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>.</p> <p>Data Compiler(s): Data are compiled by the Health section of the ABS.</p> <p>Statistical confidentiality is guaranteed under the <i>Census and Statistics Act 1905</i> and the <i>Australian Bureau of Statistics Act 1975</i>. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re released with the correct data. Key users are also notified where possible.</p>
Relevance	<p>Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).</p> <p>Data Completeness: All data are available for this measure from this source.</p> <p>Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.</p> <p>Numerator/Denominator Source: Same data source.</p>

**Relevance
(cont.)**

Data for this indicator were collected for all people aged 15 years or over in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Aboriginal and Torres Strait Islander communities were still excluded). Inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas. The exclusion of persons usually residing in discrete Aboriginal and Torres Strait Islander communities has a small impact on estimates, except for the NT, where such persons make up more than 20 per cent of the population.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The data used for this indicator became available 22 November 2013 for 2012-13, 28 November 2014 for 2013-14 and 13 November 2015 for 2014-15.

Referenced Period: July 2014 to June 2015 (2014-15 data); July 2013 to June 2014 (2013-14 data); July 2012 to June 2013 (2012-13 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: Data were collected by computer assisted telephone interview for all iterations of the Patient Experience Survey. Data from an additional sample for the 2013-14 Patient Experience Survey were predominantly collected face-to-face (see below for more information).

Data Adjustments: Data were weighted to represent the total in scope Australian population, and were adjusted to account for confidentiality and non-response.

Sample/Collection size: The sample for the 2014-15 survey was 27 341 fully-responding persons.

Response rate: Response rate for the 2014-15 survey was 73 per cent.

As data is drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95% confidence intervals. Estimates with a relative standard error between 25% and 50% should be used with caution, and estimates with a relative standard error over 50% are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for the 'other' remoteness category are high when cross classified by State. Caution should be used when interpreting these data.

The data for this indicator is attitudinal, as it collects whether people felt the health professional in question spent enough time with them, listened carefully and showed them respect.

Data is used from personal interviews only (i.e. excluding proxy interviews).

Explanatory footnotes are provided for each table.

Information specific to the 2013-14 and preceding Patient Experience Surveys:

For the 2013-14 Patient Experience Survey, an additional sample was selected in particular areas using a separate survey called the Health Services Survey (HSS). The HSS collected the same information as the Patient Experience Survey, with

enumeration taking place between September 2013 and December 2013. The additional sample was collected to improve the quality of estimates at the Medicare Local catchment level. Sample from the Patient Experience Survey and HSS were combined to produce output.

The data was predominantly collected by computer assisted telephone interview, although the HSS interviews were predominantly conducted face-to-face. MPHS PEx included one person aged 15 years and over from each household, while the HSS included two persons aged 15 and over from each household.

Analysis was conducted to determine whether there was any difference between the estimates which would have been obtained using the MPHS PEx sample only and estimates obtained using the combined MPHS PEx and HSS sample. This was particularly important given the predominantly different modes used between the two surveys (the majority of MPHS PEx interviews were conducted over the telephone while a larger proportion of HSS interviews were conducted face-to-face and included up to two persons per household). This analysis showed that combining the sample from the two surveys did not produce significantly different estimates. Therefore, estimates can be compared over time with other iterations of the Patient Experience Survey.

Response rate and sample size: The response rate in 2013-14 to the MPHS PEx was 77% (27,327 fully responding persons) while the response rate to HSS was 83% (8,541 fully responding persons) resulting in a total sample size of 35,868 fully responding persons. This included 629 proxy interviews for people aged 15 to 17 where permission was not given by a parent or guardian for a personal interview.

Note this is a substantial increase from the 2012-13 sample size of 30,749. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Data Adjustments: Data was weighted to represent the total in scope Australian population, and was adjusted to account for confidentiality and non-response. . Data for MPHS PEx and HSS were weighted separately and then combined to produce output.

Coherence

2009 was the first year data was collected for this indicator. Questions relating to this indicator were also asked in 2010-11, 2011-12, 2012-13 and 2013-14.

Consistency over time: Data are comparable over time.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and subsequent surveys, and of very remote communities and discrete Indigenous communities in previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in such areas/communities account for more than 20 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Due to differences in survey scope, collection methodology and question wording, these data are not comparable to data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12, 2012-13, 2013-14* and 2014-15 (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2014-15 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2014-15* (Cat. no. 4839.0). The publication includes explanatory and technical notes.

Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in the publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the 2012-13 NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Aboriginal and Torres Strait Islander communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 30 749 in 2012-13 to 35 868 in 2013-14 strengthens reliability of the population level estimates.

Cost to government of general practice per person

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost to government of general practice per person
Measure/s (computation)	<p>Government Expenditure on GPs per person</p> <p>Definition: Cost to government of general practice per person in the population</p> <p>Numerator: Nominal expenditure on services rendered by GPs and OMPs.</p> <p>Denominator: Estimated Resident Population (ERP).</p> <p>Computation: Numerator ÷ Denominator, directly age-standardised from 2012-13; crude rates for previous years.</p> <p>Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2014-15 = 100) to provide real expenditure, comparable over time.</p>
Data source/s	<p>Numerator:</p> <ul style="list-style-type: none">• For MBS data: Department of Human Services (DHS), Medicare data sourced by the Australian Government Department of Health• For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. <p>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December.</p>

Data Quality Framework Dimensions

Institutional environment	<p>DHS, Medicare processes and collects MBS data for:</p> <ul style="list-style-type: none">• claims made through the MBS under the <i>Health Insurance Act 1973</i>. These data are regularly provided to Australian Government Department of Health.• claims for DVA Treatment Card holders, also made through the MBS, under the <i>Veterans' Entitlements Act 1986</i>; <i>Military Rehabilitation and Compensation Act 2004</i> and <i>Human Services (Medicare) Act 1973</i>. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA. <p>MBS claims data are an administrative by-product of the DHS, Medicare fee for-service payment systems.</p>
Relevance	<p>The measure relates to:</p> <ul style="list-style-type: none">• services provided by GPs and, for MBS data, OMPs (DVA data include only services provided by specialist GPs) for which DHS, Medicare has processed a claim. <p>Claims allocated to state/territory based on location at which service rendered.</p> <p>Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.</p> <p>From 2012-13, data exclude expenditure on services provided under the Practice incentive program (PIP), Medicare Locals and the General Practice Immunisation Incentive Scheme (GPII) as these data cannot be subjected to age-standardisation.</p>
Timeliness	Data include all claims processed in the reference period.
Accuracy	From 2012-13, DHS, Medicare data include claimed services by GPs and OMPs as well as by practice nurses or registered Aboriginal health workers for and on behalf of the

	GMP/OMP. For previous years, DHS, Medicare data also include services rendered under PIP, DGPP and GPII. DVA data are limited to claims for services provided by specialist GPs.
	Data include all claims processed in the reference period.
Coherence	A revised Major Specialty Algorithm is used to identify GPs. Historical data have been revised and so there is coherence over time in the data presented in this Report. However, data are not comparable with data in previous editions of the report for which a different Major Specialty Algorithm methodology was used.
	DHS, Medicare and DVA nominal expenditure data are provided separately to and compiled by the Secretariat. Age-standardised rates reported from 2012-13 are not comparable with crude rates reported for 2011-12 and previous years due to the effect of age standardisation and the exclusion of services rendered under PIP, DGPP and GPII from age standardised rates.
	Expenditure per person data computed by the Secretariat using the 2011 Census-based ERP as at 31 December for all reference periods.
Accessibility	Information is available for MBS Claims data from http://www.humanservices.gov.au/corporate/statistical-information-and-data/?utm_id=9 .
	DVA data are not publically accessible.
Interpretability	DHS, Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.
------------------------------	--

Child immunisation coverage

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Child immunisation coverage.
Measure/s (computation)	<p>Proportion of children who are fully vaccinated at the age of:</p> <ul style="list-style-type: none">• 12 months to less than 15 months• 24 months to less than 27 months• 60 months to less than 63 months. <p>Definition: Proportion of children who are fully vaccinated at the specified ages.</p> <p>Numerator: children who turned 1, 2 and 5 years of age in the reference year who were recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) in the reference year.</p> <p>Denominator: number of children who turned 1, 2 and 5 years in the reference year registered on ACIR.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 children aged 1, 2 and 5 years.</p>
Data source/s	The Australian Childhood Immunisation Register (ACIR).

Data Quality Framework Dimensions

Institutional environment	<p>The ACIR is administered and operated by Australian Government Department of Human Services (DHS), Medicare. DHS, Medicare provides Australian Government Department of Health with quarterly coverage reports at the national and state level.</p> <p>Immunisations are notified to DHS, Medicare by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments.</p> <p>For information on the institutional environment of the ACIR, including the legislative obligations of the ACIR, financing and governance arrangements, and mechanisms for scrutiny of ACIR operations, please see www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.</p> <p>The tables for this indicator were prepared by DHS, Medicare and quality assessed by Australian Government Department of Health. Australian Government Department of Health drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies).</p>
Relevance	<p>The ACIR records details of vaccinations given to children under seven years of age who live in Australia.</p> <p>Children assessed as fully immunised at one year of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and, from the quarter ending 31 December 2013, pneumococcal.</p> <p>Children assessed as fully immunised at two years of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b, measles, mumps and rubella and, from the quarter ending 31 December 2014, meningococcal C and varicella (chickenpox).</p> <p>A child is assessed as fully immunised at five years of age if they have received immunisations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.</p> <p>There are possible gaps in coverage due to unknown vaccination status of children less than 5 years migrating to Australia. The extent of this is not currently quantifiable.</p> <p>The analyses by state/territory are based on postcode of residence of the child as recorded on ACIR.</p>

Timeliness	ACIR data are reported quarterly. Data are processed on 30 June in the reference year as a minimum 3-month lag period is allowed for late notification of immunisations to ACIR.
Accuracy	<p>Vaccination coverage rates calculated using ACIR data are believed to underestimate actual vaccination rates because of under-reporting by immunisation providers. However, the extent of any under-reporting has not been estimated.</p> <p>Provider notification payments and links to family assistance payments for parents have helped minimise under-reporting by providing a financial incentive for parents to vaccinate their children and for providers to notify the ACIR.</p> <p>The data contains minimal if any duplication of immunisations, as children are identified via their DHS, Medicare number. Approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.</p> <p>The ACIR covers virtually all children, particularly because participation in the ACIR is via an 'opt-out' arrangement.</p>
Coherence	The definitions of numerators and denominators have been consistent since the inception of the ACIR in 1996.
Accessibility	<p>Information contained in the indicator for disaggregation by Indigenous status and remoteness are not publicly accessible. Current total percentage and total numbers can be viewed on the DHS, Medicare web site.</p> <p>DHS, Medicare publishes current immunisation coverage from the ACIR on its website, www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp.</p> <p>Authorised immunisation providers can access detailed reports via a secured area of the DHS, Medicare web site.</p> <p>Immunisation coverage data derived from the ACIR have been reported in Communicable Disease Intelligence since early 1998. Data for 3 key milestone ages (12 months, 24 months and 5 years [6 years prior to 2008]), nationally and by jurisdiction are published quarterly.</p>
Interpretability	Further information on the ACIR can be found at www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register . Information on the National Immunisation Program and vaccinations can be found at www.immunise.health.gov.au .

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none"> • The data used to calculate this indicator are from an administrative data collection — the Australian Childhood Immunisation Register (ACIR) — for which there is an incentive payment for notification, and there are further incentives for parents to have their child's vaccination status up to date. The Register is linked to the DHS, Medicare enrolment register, and approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age. • Data have been reported using the program definition of fully immunised for children aged 12 to 15 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and, from the quarter ending 31 December 2013, pneumococcal. • Data have been reported using the program definition of fully immunised for children aged 24 to 27 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b, measles, mumps, and rubella and, from the quarter ending 31 December 2014, meningococcal C and varicella (chickenpox). • Data have been reported using the program definition of fully immunised for children aged 60 to 63 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. • From 31 December 2017, reporting of vaccination coverage will be amended to remove the assessment of MMR in the 60 to < 63 month cohort. • Given these changes, trends in vaccination coverage rates over time need to be interpreted carefully.
------------------------------	--

Notifications of selected childhood diseases

Data quality information has been developed for this indicator by the Health Working Group with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Notifications of selected childhood diseases.
Measure/s (computation)	<p>Measures:</p> <ul style="list-style-type: none">• Notifications of measles for children aged 0–14 years• Notifications of whooping cough (pertussis) for children aged 0–14 years• Notifications of invasive <i>Haemophilus influenzae</i> type b (Hib) for children aged 0–14 years <p>Definition: Number of notifications reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years by date of diagnosis, per 100 000 children aged 0–14 years for:</p> <ul style="list-style-type: none">• measles• whooping cough (pertussis)• invasive <i>Haemophilus influenzae</i> type b (Hib). <p>Numerator: number of notifications reported to the NNDSS for children aged 0–14 years in the reference year.</p> <p>Denominator: estimated resident population of children aged 0–14 years at 31 December in the reference year.</p> <p>Computation: $100 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate per 100 000 children aged 0–14 years.</p>
Data source/s	<p>Numerator: The National Notifiable Diseases Surveillance System (NNDSS)</p> <p>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 31 December in the reference period (ABS Australian Demographic Statistics (various years), Cat. no. 3101.0).</p>

Data Quality Framework Dimensions

Institutional environment	<p>The NNDSS is administered and operated by the Department of Health.</p> <p>Notifiable diseases are notified to the relevant State/Territory government health departments by clinicians and laboratories under jurisdictional public health legislation. The Department of Health receives data for these notifiable diseases under the <i>National Health Security Act 2007</i>.</p> <p>For information on the institutional environment of the NNDSS, including the legislative obligations of the NNDSS, financing and governance arrangements, and mechanisms for scrutiny of NNDSS operations, please see www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi2903q.htm.</p>
Relevance	<p>Nationally notifiable diseases require notification of the relevant State/Territory health authority upon diagnosis. Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions. State/Territory health authorities notify the NNDSS of notified cases.</p> <p>Allocation to State/Territory is by postcode of residence of the case as provided by the notifying doctor or laboratory.</p>
Timeliness	<p>State/Territory health authorities notify data to the NNDSS on a daily basis. Data include all notifications for the selected diseases for each reference period (financial year).</p>
Accuracy	<p>Measles and invasive Hib</p> <p>The 'notified fraction' represents the proportion of total cases for which notification is made. This is expected to be high for measles and invasive Hib as it is uncommon for either disease to go undiagnosed, due to the often severe presentations of the disease.</p>

Comprehensive follow up of the contacts of all cases also enables identification of cases.

Pertussis (whooping cough)

The notified fraction for whooping cough is likely to be only a proportion of the total number of cases that occur, as identification of pertussis is limited by patient and physician awareness, testing practices and in some cases, the united sensitivity of diagnostics tests. Pertussis is generally believed to be significantly under-diagnosed.

ERPs to 31 December 2010 are the ABS' final 2011 Census rebased ERPs. ERPs from 31 December 2011 are ABS first preliminary estimates based on the 2011 Census.

Data for the number of notifications are suppressed for confidentiality reasons where the number of notifications was less than 3.

Data for notification rates are suppressed where there were less than 5 notifications.

Coherence

Data are reported for 2006-07 to 2014-15. Reference periods comprise the complete financial year. Data may differ from other reports that use a different reference period.

Changes in surveillance and testing methods over time and by jurisdiction may make comparisons both over time and across jurisdictions difficult. Changes in the national case definition criteria for establishing a case may affect the coherence of the data over time. The current NNDSS case definition, including historical edits, can be found at www.health.gov.au/casedefinitions.

Pertussis

Epidemics of pertussis in Australia historically occur at regular intervals of approximately 4 years on a background of endemic circulation, resulting in large fluctuations in notification numbers over time. The large variations in pertussis notifications in states and territories during this reporting period are mainly due to a nationwide epidemic that commenced in 2008 and peaked in 2011. The timing of each jurisdiction's peak whooping cough activity varied during this time. NSW and Victoria are currently experiencing increased levels of pertussis activity which began during 2014.

Accessibility

The Department of Health publishes aggregated levels of data from the NNDSS on its website www9.health.gov.au/cda/source/cda-index.cfm. Data are updated on a daily basis.

Interpretability

The current NNDSS case definitions, including edits, can be found at www.health.gov.au/internet/main/publishing.nsf/Content/cdna-casedefinitions.htm.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Whooping cough notifications may undercount the actual number of cases that occur as diagnosis cannot always be confirmed using currently available diagnostic tools.

Participation rates for women in cervical screening

Data quality information for this indicator has been drafted by the AIHW, with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Participation rates for women in cervical screening.
Measure/s (computation)	<p>Definition:</p> <p>This indicator presents the number of women within the national target age group (20–69 years) screened in a 2 year period as a proportion of the eligible female population and age standardised to the Australian standard population at 30 June 2001.</p> <p>The eligible female population is the average of the Australian Bureau of Statistics (ABS) estimated resident female population for the 2 year reporting period. This population is adjusted for the estimated proportion of women who have had a hysterectomy using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p> <p>Numerator: Total number of women aged 20–69 years who were screened in the 2 year period.</p> <p>Denominator: Average number of women aged 20–69 years in the same 2 year period, adjusted using national hysterectomy fractions to exclude the estimated number of women who have had a hysterectomy.</p> <p>Computation/s: $100 \times (\text{Numerator} \div \text{Denominator})$ and age-standardised to the Australian population at 30 June 2001.</p>
Data source/s	<p>Numerator: State and territory cervical cytology registers.</p> <p>Denominator: ABS estimated resident population 2011 Census based (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The National Cervical Screening Program (NCSP) is a joint program of the Australian Government and State and Territory governments. The target age group is women aged 20–69 years.</p> <p>Cervical cytology registries in each state and territory are maintained by jurisdictional Program managers. Data are supplied to the registries from pathology laboratories. Data from cervical cytology registers are provided to the Australian Institute of Health and Welfare (AIHW) annually in an aggregated format.</p> <p>The NCSP is monitored annually. Results are compiled and reported at the national level by the AIHW in an annual Cervical screening in Australia report.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio. It is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website (www.aihw.gov.au).</p>
Relevance	<p>The data used to calculate this indicator are accurate and of high quality. The cervical cytology registers collect information on all Pap tests undertaken in Australia except where women advise the clinician they do not wish to have their data collected. The use of ERP based on Census data for denominators provide the most comprehensive data coverage possible. The data are entirely appropriate for this indicator.</p> <p>For participation by state and territory, the numerator is the number of women aged 20–69 years screened in each state and territory in the reference period, except for Victoria and the ACT where data are for residents (and some immediate border residents) of the jurisdiction only. Data are supplied as aggregated data by each state and territory. The denominator is the average of the ABS ERP for women aged 20–69 years in each State</p>

and Territory, adjusted to exclude the estimated number of women who have had a hysterectomy, using national hysterectomy fractions.

Caution is required when examining differences across states and territories of Australia due to the substantial differences in population, area, geographic structure, policies and other factors.

Timeliness	The most recent data available for the 2015 RoGS report are based on the two-year calendar period 1 January 2012 to 31 December 2013. Data are presented as a rate for the two-year period to reflect the recommended screening interval.
Accuracy	<p>This indicator is calculated on data that have been supplied to the AIHW by individual state and territory registers. Prior to publication, the results of analyses are referred back to states and territories for checking and clearance. Any errors found by states and territories are corrected once confirmed. Thus participation by state and territory, based on the state or territory in which the woman was screened, is both robust and readily verified.</p> <p>Women who opt off the cervical cytology register are not included in the participation data, but this is thought to only exclude around 1 per cent of all women screened.</p>
Coherence	<p>Some of these data are published annually in Program monitoring reports prepared by the AIHW and are consistent across reports published at similar times.</p> <p>Rates may differ from those presented in reports published in 2011 or previous years which are derived from ABS 2006 Census based ERPs.</p>
Accessibility	The NCSP annual reports are available via the AIHW website where they can be downloaded free of charge.
Interpretability	While numbers of women screened are easy to interpret, calculation of age standardised rates with allowance for the proportion of the population who have had a hysterectomy is more complex and the concept may be confusing to some users. Information on how and why age-standardised rates have been calculated and how to interpret them as well as the hysterectomy fraction is available in all AIHW NCSP monitoring reports, example, Cervical screening in Australia 2011–2012.

Data Gaps/Issues Analysis

Key data gaps /issues	<p>The Steering Committee notes the following issues:</p> <ul style="list-style-type: none">• Hysterectomy fractions are derived from the AIHW National Hospitals Morbidity Database.• Indigenous status is not collected by cervical cytology registers.
------------------------------	--

Selected potentially preventable hospitalisations

Measure 1: Selected potentially preventable hospitalisations for vaccine preventable, acute and chronic conditions

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome — Australians receive appropriate high quality and affordable hospital and hospital related care.
Indicator	Selected potentially preventable hospitalisations — Admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital services.
Measure/s (computation)	<p>Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions.</p> <p>The numerator is the number of separations for selected potentially preventable hospitalisations, for each of the following three groups and their sub-categories:</p> <ul style="list-style-type: none">• Vaccine-preventable conditions<ul style="list-style-type: none">- Pneumonia and influenza (vaccine-preventable)- Other vaccine preventable conditions (for example, tetanus, measles, mumps, rubella)- Total.• Acute conditions<ul style="list-style-type: none">- Cellulitis- Convulsions and epilepsy- Dental conditions- Ear, nose and throat infections- Eclampsia- Gangrene- Pelvic inflammatory disease- Perforated/bleeding ulcer- Pneumonia (not vaccine-preventable)- Urinary tract infections, including pyelonephritis- Total acute conditions• Chronic conditions<ul style="list-style-type: none">- Angina- Asthma- Bronchiectasis- Chronic obstructive pulmonary disease- Congestive heart failure- Diabetes complications (principal diagnosis only)- Hypertension- Iron deficiency anaemia- Nutritional deficiencies- Rheumatic heart disease- Total• Total selected potentially preventable hospitalisations.

The denominator is the Estimated Resident Population (ERP).

A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay

beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

Potentially preventable hospitalisations are defined by International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) diagnosis codes and/or Australian Classification of Health Interventions (ACHI) procedure codes in scope for each category of potentially preventable hospitalisations (see METeOR id 559032).

Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

Data source/s

Numerator: This indicator is calculated using data from the NHMD, based on the NMDS for Admitted Patient Care.

Denominators:

- For total population: ABS Estimated Resident Population (ERP) as at 30 June 2013.
- For data by Indigenous status: ABS *Aboriginal and Torres Strait Islander Experimental Estimates and Projections* (Indigenous Population) Series B as at 30 June 2013.
- For data by remoteness: ABS ERP as at 30 June 2013, by remoteness areas, as specified in the Australian Statistical Geography Standard 2011 (ASGS).
- For data by socioeconomic status: calculated by AIHW using the ABS Socio-Economic Indexes For Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) 2011 and ERP by Statistical Area 2 (SA2) as at 30 June 2013. Each SA2 in Australia is ranked and divided into quintiles and deciles in a population-based manner, such that each quintile has approximately 20 per cent of the population and each decile has approximately 10 per cent of the population.

Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The AIHW is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth entity governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988 (Commonwealth)*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Data for the NHMD were supplied to the AIHW by state and territory health authorities

under the terms of the National Health Information Agreement (see the following links):

- <http://www.aihw.gov.au/nhissc/>
- <http://meteor.aihw.gov.au/content/index.phtml/itemId/182135>

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

The analyses by state and territory, remoteness and socioeconomic status are based on the Statistical Area 2 (SA2) of usual residence of the patient, not the location of the hospital. Hence rates represent the number separations for patients living in each state/territory, remoteness area or Socio-Economic Indexes for Areas (SEIFA) population group (regardless of the jurisdiction of the hospital they were admitted to) divided by the total number of people living in that remoteness area or SEIFA group in the state/territory.

The SEIFA categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SA2 are derived from 2011 Census data and represent the attributes of the population in that SA2 in 2011.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Timeliness

The reference period for this data set is 2013-14.

Accuracy

For 2013-14, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88 per cent of Indigenous Australians were identified correctly in hospital admissions data in the 2011-12 study period, and the 'true' number of separations for Indigenous Australians was about 9 per cent higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for

example where the denominator is very small. The following rule was applied:

Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

Coherence

The specification for this performance indicator was revised for the 2015 Report. The AIHW recalculated this indicator for the period 2007-08 to 2012-13 using the new specification. Therefore, the data are not comparable to data published in previous editions of the Report.

For ICM-10-AM coding details, please refer to the specification for National Healthcare Agreement Performance Indicator 18 - Selected potentially preventable hospitalisations, 2015 (<http://meteor.aihw.gov.au/content/index.phtml/itemId/559032>)

The information presented for this indicator is calculated using the same methodology as data published in the *National healthcare agreement: performance report 2012–13*.

However, caution should be used when comparing data across reporting periods as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10), ICD-10-AM 7th edition (used in 2010-11, 2011-12 and 2012-13) and ICD-10-AM 8th edition (used in 2013–14) and the associated Australian Coding Standards that resulted in fluctuations in the reporting of diagnoses for diabetes. In addition, changes to the Australian Coding Standard for Viral hepatitis (ACS 0104), implemented in the 8th edition of ICD-10-AM will affect the comparability over time in the reporting of the vaccine-preventable category of potentially preventable hospitalisations, which includes counts for additional diagnoses of Hepatitis B.

In addition, Tasmanian data are not comparable over time as 2008-09 data for Tasmania does not include two private hospitals that were included in 2007-08 and 2009-10 data reported in the National Healthcare Agreement performance reports.

Interpretation of the related performance benchmark over time is also problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time. Changes in a jurisdiction's denominator (separations) can artificially increase or decrease the results of the benchmark. Therefore the data provided in 2013-14 (and interim years) may not be directly comparable to the baseline data from which the target is based.

Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA Census year, the SEIFA index used and the approach taken to derive quintiles and deciles.

National level data disaggregated by Indigenous status for 2007-08 to 2009-10 include data from NSW, Vic, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2010-11 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007-08, 2008-09 and 2009-10 are not comparable to data for 2010-11 and subsequent years.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as RA 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

In 2011, the ABS updated the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2007-08 through to 2010-11 reported for SEIFA quintiles and deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. Data for 2012-13 are reported using SEIFA 2011 at the SA2 level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011, and the change from SLA to SA2 to be series breaks when applied to data supplied for this indicator. Therefore, SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data

for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Accessibility The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- *Australian hospital statistics* with associated Excel tables.
- Interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

These products may be accessed on the AIHW website at: www.aihw.gov.au/hospitals/.

Interpretability Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and variation in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care is published in the AIHW's online metadata repository, METeOR, and the *National health data dictionary*.

The *National health data dictionary* can be accessed online at www.aihw.gov.au/publication-detail/?id=10737422826

The Data Quality Statement for the NHMD can be accessed on the AIHW website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/568730>.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The National Hospital Morbidity Database (NHMD) is a comprehensive data set that has records for all separations of admitted patients from essentially all public and private hospitals in Australia
- The specification for this performance indicator was revised for the 2015 Report. The AIHW recalculated this indicator for the period 2007-08 to 2012-13 using the new specification. Therefore, the data are not comparable to data published in previous editions of the Report.
- Caution should be used in comparing data across reporting periods as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10), ICD-10-AM 7th edition (used in 2010-11, 2011-12 and 2012-13) and ICD-10-AM 8th edition (used in 2013-14) and the associated Australian Coding Standards resulted in fluctuations in the reporting of diagnoses for diabetes (chronic category affected). These changes should also be taken into consideration in interpretation of these data against the National Healthcare Agreement performance benchmark for potentially preventable hospitalisations. In addition, changes to the Australian Coding Standard for Viral hepatitis (ACS 0104), implemented in the 8th edition of ICD-10-AM will affect the comparability over time in the reporting of the vaccine-preventable category of potentially preventable hospitalisations, which includes counts for additional diagnoses of Hepatitis B.
- In addition, interpretation of the related performance benchmark over time is problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Remoteness data for 2011-12 and previous years are not directly comparable to remoteness data for 2012-13 and subsequent years.
- SEIFA data for 2010-11 and previous years are not directly comparable with SEIFA data for 2011-12, and SEIFA data for 2011-12 and previous years are not directly comparable with SEIFA data for 2012-13 and subsequent years.

Measure 2: Selected potentially preventable hospitalisations for diabetes

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations.
Measure/s (computation)	<p>Selected potentially preventable hospitalisations for diabetes.</p> <p>The numerator is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups:</p> <ul style="list-style-type: none">• Circulatory complications (E11.5x)• Renal complications (E11.2x)• Ophthalmic complications (E11.3x)• Other specified complications (E11.0x, E11.1x, E11.4x, E11.6x)• Multiple complications (E11.7x)• No complications (E11.9x)• Total. <p>The denominator is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for diabetes are defined by ICD-10-AM diagnosis codes.</p> <p>Calculation is $100\,000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 100 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 years combined.</p>
Data source/s	<p>Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p>Denominator: For total population: ABS Estimated Resident Population (ERP) as at 30 June 2011.</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the</p>

Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

Timeliness

The reference period for this data set is 2013-14.

Accuracy

Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.

For 2013-14 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. Variations in both admission and administration practices and policies mean that dialysis treatments may be counted as separations with diabetes complications by some hospitals and not others, reducing the comparability of the data at state and territory level. This is particularly significant for Indigenous people because of the high prevalence of diabetes in that population.

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

Coherence

The information presented for this indicator is calculated using the same methodology as other potentially preventable hospitalisations data published in Australian hospital statistics 2013-14.

Reporting of diabetes increased by on average 29.6 per cent for diabetes as a principal diagnosis and 247 per cent for diabetes as an additional diagnosis, between 2011-12 and 2012-13 — in large part due to changes in Australian Coding Standards. Accordingly, data for 2012-13 are not comparable with data for previous years.

Changes between the ICD-10-AM 5th edition (used in 2007-08), ICD 10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- Australian hospital statistics with associated Excel tables.
- Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Some data are also included on the MyHospitals website.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps The Steering Committee notes the following issues:

/issues

- Further work is required to improve the comparability of data due to changes across editions of the ICD-10-AM.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Changes to Australian Coding Standards mean that data for 2012-13 are not comparable to data for previous years.

Measure 3: Potentially preventable hospitalisations of older people for falls

Data quality information for this measure has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations.
Measure/s (computation)	<p>Potentially preventable hospitalisations of older people for falls.</p> <p>The number of hospitalisations for people aged 65 years or over with a reported external cause of falls, per 1000 people.</p> <p>The numerator is the number of hospitalisations for people aged 65 years or over with a reported external cause of falls.</p> <p>The denominator is the Estimated Resident Population.</p> <p>A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).</p> <p>Potentially preventable hospitalisations for falls are defined by ICD-10-AM external cause codes (W00–W19).</p> <p>Calculation is $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a number per 1000 and age standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined.</p>
Data source/s	<p>Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.</p> <p>Denominator: ABS Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period.</p> <p>Computation: $1000 \times (\text{Numerator} \div \text{Denominator})$, presented as a rate.</p>

Data Quality Framework Dimensions

Institutional environment	<p>The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.</p> <p>The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.</p> <p>The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.</p> <p>States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788</p>
Relevance	<p>The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p>
Timeliness	<p>The reference periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12, 2012-13, 2013-14.</p>

Accuracy

For 2006-07 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free standing day hospital facility in the NT, and a small private hospital in Victoria.

For 2007-08 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and a small private hospital in Victoria.

For 2008-09 , almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and two private hospitals in Tasmania.

For 2009-10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT and about 2400 separations for one public hospital in Western Australia. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. In addition, Western Australia was not able to provide about 10 600 separations for one private hospital.

For 2010-11 and 2011-12, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. However, 2010-11 data were not available for the NT.

For 2012-13, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the ACT.

For 2013-14, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the ACT. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88 per cent of Indigenous Australians were identified correctly in hospital admissions data in the 2011 12 study period, and the 'true' number of separations for Indigenous Australians was about 9% higher than reported. The report recommended that data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small). Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

Coherence

NT data are not available for 2010-11, and are excluded from the Australian total for that year. With this exception, data for this indicator are comparable over time.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products

available on the AIHW website are:

- Australian hospital statistics with associated Excel tables.
- Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Some data are also included on the MyHospitals website.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- NT data were not available for 2010-11.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.