# 10 Primary and community health

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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).

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| Table 10.1 Estimated funding on primary healthcare, 2013‑14 ($ million)**a, b** |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | Australian Government | | | | State, Territory and local government | Total government | Non‑ government | Total government and non‑ government | |  | DVA | Department of Health  and other | Premium rebates | Total | | 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. |
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#### 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).

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| Figure 10.1 PBS expenditure (2014‑15 dollars)**a** |
| |  | | --- | | Figure 10.1 PBS expenditure (2014-15 dollars)  More details can be found within the text surrounding this image. | |
| a See table 10A.5 for detailed footnotes and caveats. |
| *Source*: Department of Health (unpublished) PBS Statistics; tables 10A.5 and 10A.6. |
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#### 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).

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| Figure 10.2 Availability of GPs**a** |
| |  | | --- | | Figure 10.2 Availability of GPs  More details can be found within the text surrounding this image. | |
| a  See table 10A.10 for detailed footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; table 10A.10. |
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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).

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| Figure 10.3 GP type service use (ASR)**a** |
| |  | | --- | | Figure 10.3 GP type service use (ASR)  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| Table 10.2 Estimated episodes of healthcare for Aboriginal and Torres Strait Islander Australians by services for which OSR data are reported (‘000)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | 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. |
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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).

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| Box 10.1 Objectives for primary and community health |
| Primary and community health services aim to support and improve the health of Australians by:   * providing a universally accessible point of entry to the healthcare system * promoting health and preventing illness * providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) * coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals’ healthcare needs.   In addition, governments aim to ensure that interventions provided byprimary and community health services are based on best practice evidence and delivered in an equitable and efficient manner. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of 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).

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| Figure 10.4 Primary and community health performance indicator framework |
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## 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.

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| 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) |
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| 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. |
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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).

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| Figure 10.5 People per approved PBS provider, 2014‑15**a, b** |
| |  | | --- | | Figure 10.5 People per approved PBS provider, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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Nationally, PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 10.6).

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| Figure 10.6 PBS expenditure by region (2014‑15 dollars)**a** |
| |  | | --- | | Figure 10.6 PBS expenditure by region (2014-15 dollars)  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| Box 10.3 Equity of access to GPs |
| ‘Equity of access to GPs’ is defined by two measures:   * availability of GPs by region, defined as the number of 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) |
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| 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. |
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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.

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| Figure 10.7 Availability of GPs by region, 2014‑15**a, b** |
| |  | | --- | | Figure 10.7 Availability of GPs by region, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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| Figure 10.8 Availability of GPs by sex, 2014‑15**a** |
| |  | | --- | | Figure 10.8 Availability of GPs by sex, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| Box 10.4 Availability of public dentists |
| ‘Availability of public dentists’ is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region 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. |
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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.

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| Figure 10.9 Availability of public dentists, 2014**a, b, c** |
| |  | | --- | | Figure 10.9 Availability of public dentists, 2014  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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.

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| Box 10.5 Early detection and early treatment for Aboriginal and Torres Strait Islander Australians |
| ‘Early detection and early treatment for Aboriginal and Torres Strait Islander Australians’ is defined as:   * the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection) * the provision of appropriate and timely prevention and intervention measures (early treatment).   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. |
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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.

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| Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2014‑15**a** |
| |  | | --- | | Figure 10.10 Older people who received an annual health assessment by Indigenous status, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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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).

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| Box 10.6 Developmental health checks |
| ‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health assessment under DHS Medicare, by health assessment type.  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. |
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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).

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| Figure 10.11 Children who received a fourth year developmental health check, by health check type, 2014‑15**a** |
| |  | | --- | | Figure 10.11 Children who received a fourth year developmental health check, by health check type, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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### Effectiveness

#### Access – Effectiveness of access to GPs

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

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| Box 10.7 Effectiveness of access to GPs |
| ‘Effectiveness of access to GPs’ is defined by four measures:   * bulk billing rates, defined as the 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) |
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| 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. |
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##### 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).

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| Figure 10.12 GP visits that were bulk billed**a** |
| |  | | --- | | Figure 10.12 GP visits that were bulk billed  More details can be found within the text surrounding this image. | |
| 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. |
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##### 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.

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| Figure 10.13 People deferring visits to GPs due to cost**a** |
| |  | | --- | | Figure 10.13 People deferring visits to GPs due to cost  More details can be found within the text surrounding this image. | |
| 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. |
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##### 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.

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| Table 10.3 GP‑type presentations to emergency departments,  (‘000)**a** |
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| 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. |
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#### 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).

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| Box 10.8 Financial barriers to PBS medicines |
| ‘Financial barriers to PBS medicines’ is defined as the proportion of people who delayed getting or did not get a prescription filled 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. |
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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.

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| Figure 10.14 People deferring purchase of prescribed medicines due to cost**a** |
| |  | | --- | | Figure 10.14 People deferring purchase of prescribed medicines due to cost  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| 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. |
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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).

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| 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. |
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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).

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| Figure 10.15 FSE GPs with vocational registration**a** |
| |  | | --- | | Figure 10.15 FSE GPs with vocational registration  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| 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. |
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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).

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| Box 10.12 Management of upper respiratory tract infection |
| ‘Management of acute upper respiratory tract infection’ (URTI) is defined by two measures:   * 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. |
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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.

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| Figure 10.16 Acute URTI managements where systemic antibiotics were prescribed**a** |
| |  | | --- | | Figure 10.16 Acute URTI managements where systemic antibiotics were prescribed  More details can be found within the text surrounding this image. | |
| 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. |
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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).

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| Box 10.13 Chronic disease management |
| ‘Chronic disease management’ is defined by four measures:   * management of diabetes — PIP diabetes incentive, defined as the proportion of general practices enrolled in the 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) |
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| 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. |
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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).

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| Figure 10.17 PIP practices registered for the PIP diabetes incentive**a** |
| |  | | --- | | Figure 10.17 PIP practices registered for the PIP diabetes incentive  More details can be found within the text surrounding this image. | |
| 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. |
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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).

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| Figure 10.18 People with known diabetes with HbA1c level 7 per cent or less, 2011‑12**a** |
| |  | | --- | | Figure 10.18 People with known diabetes with HbA1c level 7 per cent or less, 2011-12  More details can be found within the text surrounding this image. | |
| 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. |
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##### 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.

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| Figure 10.19 People with asthma who have a written asthma action plan**a** |
| |  | | --- | | Figure 10.19 Proportion of people with asthma who have a written asthma action plan  More details can be found within the text surrounding this image. | |
| 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. |
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##### 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.

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| 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 diesase (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) |
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| 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). |
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#### 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).

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| 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 overeliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. 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. |
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Available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS Medicare data reflect only those services provided and rebated.

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).

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| Figure 10.20 Benefits paid for GP‑referred pathology tests and diagnostic imaging rebated through DHS Medicare (ASR)**a** |
| |  | | --- | | Figure 10.20 Benefits paid for GP referred pathology tests and diagnostic imaging rebated through DHS Medicare (ASR)  Pathology tests  More details can be found within the text surrounding this image.  Figure 10.20 Benefits paid for GP referred pathology tests and diagnostic imaging rebated through DHS Medicare (ASR)  Diagnostic imaging  More details can be found within the text surrounding this image. | |
| 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. |
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#### Quality — Safety — Electronic health information systems

‘Electronic health information systems’ is an indicator of governments’ objective to improve patient safety through enhanced access to patient health information at the point of care and more efficient coordination of care across multiple providers and services (box 10.16).

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| 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. |
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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).

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| Figure 10.21 PIP practices using electronic health systems**a** |
| |  | | --- | | Figure 10.21 PIP practices using electronic health systems  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| 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. |
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##### 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).

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| Figure 10.22 People whose GP always or often listened carefully, showed respect, spent enough time, 2014‑15**a** |
| |  | | --- | | Figure 10.22 People whose GP always or often listened carefully, showed respect, spent enough time, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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##### 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.

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| Figure 10.23 People whose dental professional always or often listened carefully, showed respect, spent enough time, 2014‑15**a** |
| |  | | --- | | Figure 10.23 People whose dental professional always or often listened carefully, showed respect, spent enough time, 2014-15  More details can be found within the text surrounding this image. | |
| 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. |
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#### 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).

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| Box 10.18 Cost to government of general practice per person |
| ‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.  This indicator needs to be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.  Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. Consequently, costs for primary care are understated for jurisdictions where a large proportion of the population live in rural and remote areas.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time but a break in time series means that data from 2012‑13 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. |
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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.

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| Figure 10.24 Australian Government fee‑for‑service expenditure per person on GPs (ASR) (2014‑15 dollars)**a** |
| |  | | --- | | Figure 10.24 Australian Government fee for service expenditure per person on GPs (ASR) (2014-15 dollars)  More details can be found within the text surrounding this image. | |
| 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**.** |
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### 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).

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| Box 10.19 Child immunisation coverage |
| ‘Child immunisation coverage’ is defined by three measures:   * the proportion of children aged 12 months to less than 15 months who are fully immunised (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. |
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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).

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| Figure 10.25 Children who were fully immunised, by age (months)  2014‑15**a** |
| |  | | --- | | Figure 10.25 Children who were fully immunised, by age (months)  2014-15   More details can be found within the text surrounding this image. | |
| 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. |
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#### Notifications of selected childhood diseases

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

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| Box 10.20 Notifications of selected childhood diseases |
| ‘Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.  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. |
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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.

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| Figure 10.26 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**a** |
| |  | | --- | | Figure 10.26 Notifications of pertussis (whooping cough) per  100 000 children aged 0–14 years  More details can be found within the text surrounding this image. | |
| 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. |
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#### Participation for women in breast cancer screening

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

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).

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| Box 10.21 Participation for women in breast cancer screening |
| ‘Participation for women in breast cancer screening’ is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–69 years and reported as a rate.  A high or increasing participation rate is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data for the 24‑month period 2013 and 2014 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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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).

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| Figure 10.27 Participation in BreastScreen Australia screening programs — women aged 50–69 years (24 month period)**a** |
| |  | | --- | | Figure 10.27 Participation in BreastScreen Australia screening programs — women aged 50–69 years (24 month period)  More details can be found within the text surrounding this image. | |
| 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. |
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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).

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| 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. |
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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).

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| Figure 10.28 Participation rate for women aged 20–69 years in cervical screening (24 month period)**a** |
| |  | | --- | | Figure 10.28 Participation rate for women aged 20–69 years in cervical screening (24 month period)  More details can be found within the text surrounding this image. | |
| 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. |
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#### Influenza vaccination coverage for older people

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

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

Updated data were not available for non‑Indigenous Australians for the 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.

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| Box 10.24 Selected potentially preventable hospitalisations |
| ‘Selected potentially preventable hospitalisations’ is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether. Three measures of selected potentially preventable hospitalisations are reported 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. |
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##### 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).

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| Table 10.4 Separations for selected potentially preventable hospitalisations per 1000 people, 2013‑14 (ASR)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | *NSW* | *Vic* | *Qld* | *WA* | *SA* | *Tas* | *ACT* | *NT* | *Aust* | | 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. |
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| Figure 10.29 Separations for selected potentially preventable conditions by Indigenous status (ASR), 2013‑14**a** |
| |  | | --- | | Figure 10.29 Separations for selected potentially preventable conditions by Indigenous status (ASR), 2013-14  More details can be found within the text surrounding this image. | |
| 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. |
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##### 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).

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| --- |
| Figure 10.30 Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2013‑14 (ASR)**a, b** |
| |  | | --- | | Figure 10.30 Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2013-14 (ASR)  More details can be found within the text surrounding this image. | |
| 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. |
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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).

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| Figure 10.31 Separations for older people with a reported external cause of falls (ASR)**a, b** |
| |  | | --- | | Figure 10.31 Separations for older people with a reported external cause of falls (ASR)  More details can be found within the text surrounding this image. | |
| 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. |
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## 10.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. 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

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| Age standardised | Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age‑specific rates for each jurisdiction by the national age distribution. |
| Annual cycle of care for people with diabetes mellitus within general practice | The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines.  MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines. |
| Asthma Action Plan | An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.  *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, *Australian asthma indicators: Five‑year review of asthma monitoring in Australia*. Cat. no. ACM 12, AIHW. |
| 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 *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement.  Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs. |
| GP‑type services | Non‑referred attendances by vocationally registered GPs and OMPs, and practice nurses. |
| *Haemophilus influenzae* type b | A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013b). |
| 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 | The primary and community healthcare sector includes services that:   * provide the first point of contact with the health system * have a particular focus on illness prevention or early intervention * are intended to maintain people’s independence and maximise their quality of life through care and support at home or in local community settings. |
| 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:   * category 1 — resuscitation (immediate within seconds) * category 2 — emergency (within 10 minutes) * category 3 — urgent (within 30 minutes) * category 4 — semi‑urgent (within 60 minutes) * category 5 — non‑urgent (within 120 minutes). |
| Vocationally registered general practitioner | A medical practitioner who is vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non‑referred attendances. |

## 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).

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