# 10 Primary and community health

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| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘10A’ prefix (for example, table 10A.1) and are available on the website www.pc.gov.au/rogs/2018. |
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This chapter reports on the performance of primary and community health services which include general practice, pharmaceutical services, dentistry, allied health services, community health services, maternal and child health and alcohol and other drug treatment. This chapter does not include:

* public hospital emergency departments and outpatient services (reported in chapter 12, ‘Public hospitals’)
* community mental health services (reported in chapter 13, ‘Mental health management’)
* Home and Community Care program services (reported in chapter 14, ‘Aged care’ and chapter 15, ‘Services for people with disability’).

Further information on the Report on Government Services including other reported service areas, the glossary and list of abbreviations is available at www.pc.gov.au/rogs/2018.

## 10.1 Profile of primary and community health

### Roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not‑for‑profit and government service settings. Definitions for common health terms are provided in section 10.4.

#### General practice

General practice is a major provider of primary healthcare in Australia. General practice 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 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 Primary Health Networks (PHNs) (Australian Government DHS 2015). State and Territory governments also provide some funding for such programs, mainly to influence the availability of GPs in rural and remote areas. The remainder comes mainly from insurance schemes and patient contributions.

#### Pharmaceutical services

The Australian Government funds the Pharmaceutical Benefits Scheme (PBS). Around 70 per cent of prescriptions for PBS listed medicines attract a PBS subsidy. Users make a   
co-payment and the Australian Government pays the remaining cost of medicines eligible for the subsidy (Department of Health 2017). Co-payments are subject to a safety net threshold.

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.

#### Dental services

Australia has a mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for funding and delivering 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 Child Dental Benefits Schedule, and from State and Territory governments through dental voucher systems.

#### 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 makes some allied health services available under the MBS to patients with particular needs — for example, people with chronic conditions and complex care needs. Employment data for occupational therapists and psychologists working in the public sector are presented in table 10A.24.

#### Community health services

Community health services generally comprise multidisciplinary teams of health and allied health professionals and aim to protect the health of people 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 (State and Territory governments provide some funding).

#### Maternal and child health services

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.

#### 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 2015‑16, of the $32.1 billion government recurrent expenditure on primary and community health services (excluding public health), around three-quarters was funded by the Australian Government and one-quarter by State, Territory and local governments (table 10A.1). This included:

* $7.9 billion for community health services (11.3 per cent by the Australian Government and 88.7 per cent by State, Territory and local governments)
* $2.3 billion for dental services (around two-thirds by the Australian Government and one-third by the State, Territory and local governments) (table 10A.1).

Where more recent data are available for 2016‑17, Australian Government expenditure was:

* $9.1 billion on general practice (table 10A.2)
* $9.1 billion through the PBS and RPBS on prescription medicines filled at pharmacies (tables 10A.3–4)
* $37.9 million on funding of PBS medicines to Aboriginal and Torres Strait Islander primary healthcare services in remote and very remote areas (table 10A.5)
* $666.7 million on Aboriginal and Torres Strait Islander primary health care services (table 10A.7).

### Size and scope

Nationally in 2016‑17, there were 35 934 GPs — 25 825 on a Full Service Equivalent (FSE)[[1]](#footnote-1) basis, equating to 105.9 per 100 000 people — billing Medicare Australia for around 153.3 million services[[2]](#footnote-2) (table 10A.8 and Department of Health unpublished). Rates of GPs and services used per person have increased every year for years presented in this Report (table 10A.8 and figure 10.1).

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| Figure 10.1 GP type service use**a** |
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| a See table 10A.9 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.9. |
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Around 196 million services (8.0 per person) were provided under the PBS in 2016-17 — with 92.1 per cent concessional (tables 10A.10-11). A further 9.4 million services were provided under the RPBS.

Nationally in 2015‑16, there were:

* 204 Aboriginal and Torres Strait Islander primary healthcare services which provided 3.9 million episodes of healthcare (table 10A.13) (data by remoteness are provided in table 10A.14). Aboriginal and Torres Strait Islander health services that provided selected activities are outlined in table 10A.15 and staffing numbers are provided in table 10A.16.
* 796 alcohol and other drug treatment agencies (41.3 per cent identified as government providers) with a reported 206 635 reported closed treatment episodes (34.5 per cent identified as government provided) (table 10A.12).

The most recent available data on public dental service usage are for 2013 and showed that nationally, around 97.8 per 1000 people accessed public dental services that year (AIHW, unpublished).

## 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 promote health, prevent illness and to support people to manage their health issues in the community, by providing services that are:   * timely, affordable and accessible to all * appropriate and responsive to meet the needs of individuals throughout their lifespan and communities * high quality and safe * well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required * sustainable.   Governments aim for primary and community health services to meet these objectives 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 10.2). The performance indicator framework shows which data are complete and comparable in the 2018 Report.

For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability, data completeness and information on data quality from a Report wide perspective. In addition to section 10.1, the Report’s statistical context chapter (chapter 2) contains data that may assist in interpreting the performance indicators in this chapter. Chapters 1 and 2 are available from the website at www.pc.gov.au/rogs/2018.

Improvements to performance reporting for primary and community health services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

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| Figure 10.2 Primary and community health performance indicator framework |
| More details can be found within the text surrounding this image. |
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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.

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

### Equity

#### Access — Availability of primary healthcare services

‘Availability of primary healthcare services’ is an indicator of governments’ objective to provide access to primary healthcare services in an equitable manner (box 10.2).

| Box 10.2 Availability of primary healthcare services |
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| ‘Availability of primary healthcare services’ is defined by four measures:   * PBS medicines by region, defined as the ABS census population divided by the number of approved providers of PBS medicines, by urban/rural location and Pharmacy Access/Remoteness Index of Australia (PhARIA) area * GPs by region, defined as the number of FSE GPs per 100 000 people, by region * GPs by sex, defined as the number of FSE GPs per 100 000 population, by sex * Public dentists by region, defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region, based on clinical hours worked in the public sector.   *PBS medicines by region*  Similar rates across regions indicates equity of access by location.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions as at 30 June 2017.   *GPs by region and sex*  Similar rates across regions indicates equity of access by location. Similar rates by sex means it is more likely that patients who prefer to visit GPs of their own sex 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. |
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| Box 10.2 (continued) |
| This measure 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 these measures are:   * comparable (subject to caveats) across jurisdictions and over time for both measures, but a break in time series means that data from 2012‑13 onwards are not comparable to data for the ‘Availability of GPs by region’ measure * complete (subject to caveats) for the current reporting period. All required 2016‑17 data are available for all jurisdictions.   *Public dentists by region*  Similar rates across regions indicates equity of access by location.  This measure 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 2016 data are available for all jurisdictions. |
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At 30 June 2017, there were 4211 people per approved PBS provider in urban areas and 3184 people per PBS approved provider in rural areas (figure 10.3). Over the 3 years of available data, this number has increased in urban and rural areas (table 10A.18). Data are available for pharmacy providers only (table 10A.18) and by Pharmacy Access/Remoteness Index of Australia locations (table 10A.17).

In most jurisdictions in 2016‑17, 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 (figure 10.4).

Nationally in 2016‑17, there were 78.5 FSE female GPs per 100 000 females and 133.8  FSE male GPs per 100 000 males (figure 10.5).

Nationally in 2016, there were 5.7 FTE public dentists per 100 000 people (figure 10.6), with the rate in remote and very remote areas (8.0 per 100 000 people) higher than the rate in other areas (5.5–6.1 per 100 000 people). Data for FTE dental hygienists and dental therapists are presented in table 10A.23.

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| Figure 10.3 People per approved PBS provider, 30 June 2017**a, b** |
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| a See box 10.2 and table 10A.18 for detailed definitions, footnotes and caveats. b The ACT has no rural areas under the classification used. |
| *Source*: Department of Health: derived from DHS approved provider data (unpublished) as at 30 June 2017; and the Australia Bureau of Statistics (ABS) Census Population – usual place of residence 2016. Mesh Block 2016 population data has been assigned to Remoteness Area 2011; table 10A.18. |
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| Figure 10.4 GPs by region, 2016-17**a, b** |
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| a See box 10.2 and table 10A.19 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.19. |
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| Figure 10.5 GPs by sex, 2016-17**a, b** |
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| a See box 10.2 and tables 10A.20–21 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; tables 10A.20–21. |
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Nationally in 2016, there were 5.7 FTE public dentists per 100 000 people (figure 10.6). Data for FTE dental hygienists and dental therapists are presented in table 10A.23.

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| Figure 10.6 Public dentists by region, 2016**a, b** |
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| a See box 10.2 and table 10A.22 for detailed definitions, footnotes and caveats. b There were no public dentists in remote areas in Victoria. 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.22. |
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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 access to primary and community healthcare in an equitable manner (box 10.3).

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| Box 10.3 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 proportion of older people who received a health assessment under 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.  A small or narrowing 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.  This indicator provides no information about health assessments provided outside DHS Medicare (predominantly used by Aboriginal and Torres Strait Islander people 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 2016‑17 data are available for all jurisdictions. |
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Nationally in 2016‑17, the proportion of older people receiving a health assessment was 37.3 per cent for Aboriginal and Torres Strait Islander people and 32.7 per cent for other Australians (figure 10.7).

Nationally, over the five years to 2016‑17, the proportion of older Aboriginal and Torres Strait Islander people who received an annual health assessment increased by 11.5 percentage points to 37.3 per cent, compared to an increase of 3.9 percentage points to 33.0 per cent for all older Australians (albeit from a lower base) (table 10A.25).

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| Figure 10.7 Older people who received a health assessment by Indigenous status, 2016-17**a** |
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| a See box 10.3 and table 10A.25 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.25. |
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For Aboriginal and Torres Strait Islander people by age, the proportion who received an annual health assessment is higher for those aged 55 years or over (37.3 per cent) compared to those aged 15–54 years and 0–14 years (25.9 per cent and 27.4 per cent respectively) (table 10A.26).

### Effectiveness

#### Access – Affordability of primary healthcare services

‘Affordability of primary healthcare services’ is an indicator of governments’ objective to provide primary healthcare services that are affordable (box 10.4).

| Box 10.4 Affordability of primary healthcare |
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| ‘Affordability of primary healthcare’ is defined by two measures:   * People deferring visits to GPs due to cost, 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. |
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| Box 10.4 (continued) |
| * People deferring getting prescriptions filled due to cost, 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 visits to GPs or filling PBS prescriptions due to cost indicates more widely affordable access to GPs and medicines.  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 2016-17 data are available for all jurisdictions.   The Patient Experience Survey (PEx) does not include people living in discrete Indigenous communities, which affects the comparability of the NT results for both measures. |
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Nationally in 2016‑17, 4.1 per cent of the population reported that they delayed or did not visit a GP in the previous 12 months due to cost (figure 10.8), and 7.3 per cent of the population reported they had delayed or did not purchase prescribed medicines in the previous 12 months due to cost (figure 10.9).

| Figure 10.8 People deferring visits to GPs due to cost**a, b** |
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| a See box 10.4 and table 10A.27 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey (various years), Cat. no. 4839.0; table 10A.27. |
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| Figure 10.9 People deferring buying prescribed medicines due to cost**a, b** |
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| a See box 10.4 and table 10A.30 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey(various years), Cat. no. 4839.0; table 10A.30. |
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#### Access – Timeliness of primary healthcare services

‘Timeliness of primary healthcare services’ is an indicator of governments’ objective to ensure primary healthcare services are provided in a timely manner (box 10.5).

| Box 10.5 Timeliness of primary healthcare services |
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| ‘Timeliness of primary healthcare services’ is defined by two measures:   * Public dentistry waiting times, defined as the number of days waited at the 50th (median) and 90th percentiles between being placed on a selected public dentistry waiting list and either being offered dental care or receiving dental care * GP waiting times for urgent medical care, 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 times are: less than 4 hours; 4 to less than 24 hours; 24 hours or more.   A shorter time waited to see a dental professional indicates more timely access to public dental services. A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs. |
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| Box 10.5 (continued) |
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| Public dental waiting times only include records on persons eligible for public dental services who were aged 18 years or over. It excludes those on jurisdictional priority client schemes and those that access the service but pay full price.  Data reported for the public dentistry waiting times measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * incomplete for the current reporting period for dental waiting times. All required 2016-17 data were not available for NSW, Victoria and the NT.   Data reported for the GP waiting times measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions.   The PEx does not include people living in discrete Indigenous communities, which affects the comparability of the NT results for the GP waiting times measure. |
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##### Public dentistry waiting times

Data for the time waited at the 50th and 90th percentiles by people on selected public dental waiting lists are presented for states and territories in Tables 10A.32–39.

##### GP waiting times for urgent medical care

Nationally in 2016‑17, for people who saw a GP for urgent care:

* 62.9 per cent waited less than 4 hours
* 11.7 per cent waited from 4 to less than 24 hours
* 25.4 per cent waited for 24 hours or more (table 10A.40).

Overall, 18.2 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 10A.41).

#### Access — Potentially avoidable presentations to emergency departments

Potentially avoidable presentations (also known as ‘GP-type presentations’) to emergency departments is an indicator of governments’ objective for primary and community healthcare to be accessible (box 10.6).

| Box 10.6 Potentially avoidable presentations to emergency departments |
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| Potentially avoidable presentations to emergency departments (interim measure), are 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.   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. 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.  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) * complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions. |
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Nationally, there were around 2.8 million GP‑type presentations to public hospital emergency departments in 2016‑17 (table 10A.31).

#### Appropriateness – Developmental health checks

‘Developmental health checks’ is an indicator of governments’ objective to ensure that services are appropriate and responsive to the needs of children (box 10.7).

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| Box 10.7 Developmental health checks |
| ‘Developmental health checks’ are defined as the proportion of preschool-aged children who received a developmental health assessment.  A high or increasing proportion of preschool-aged children receiving developmental health checks is desirable.  Data are not yet available for reporting against this indicator. |
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Previous reporting of data has been discontinued due to the removal of the Healthy Kids Check service from the MBS in 2015.

#### Appropriateness – Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure that primary and community health services are appropriate and responsive to meet the needs of individual needs throughout their lifespan (box 10.8).

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| Box 10.8 Chronic disease management |
| ‘Chronic disease management’ is defined by two measures:   * Management of diabetes, defined as the proportion of people with diabetes with HbA1c (glycosylated haemoglobin) below 7 per cent * Management of asthma, defined as the proportion of people with asthma who have a written asthma action plan.   A high or increasing proportion for each measure 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 are available for all jurisdictions for management of diabetes (2011‑12) and management of asthma (2014-15). |
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Nationally, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (table 10A.43). However, only 77.5 per cent of people with known diabetes in 2011‑12 had a HbA1c test in the previous 12 months (table 10A.42). HbA1c provides a measure of the average blood glucose level for the preceding three months, and a HbA1c level at or below 7 per cent indicates appropriate management.

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). Nationally, the age-standardised proportion of people with asthma reporting that they have a written asthma action plan was 28.4 per cent in 2014‑15, compared to 22.9 per cent in 2004‑05 (figure 10.10). In all jurisdictions, the proportion was higher for children aged 0–14 years than for other age groups (table 10A.44).

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| Figure 10.10 People with asthma who have a written asthma action plan**a, b, c** |
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| a See box 10.8 and table 10A.44 for detailed definitions, footnotes and caveats. b NT data not published for 2004-05. c Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Australian Health Survey, 2011–2013 (2011‑12 NHS component)*,* Cat. No. 4364.0; ABS (unpublished) National Health Survey, 2014-15, 2007‑08, 2004‑05, Cat. No. 4364.0; table 10A.44. |
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#### Appropriateness – Immunisation coverage

‘Immunisation coverage’ is an indicator of governments’ objective to ensure primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan and communities (box 10.9).

| Box 10.9 Immunisation coverage |
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| ‘Immunisation coverage’ is defined by four measures:   * the proportion of children aged 12<15 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis b, *Haemophilus influenzae* type b and pneumococcal) * the proportion of children aged 24<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, meningococcal C and varicella) * the proportion of children aged 60<63 months who are fully immunised (at this age, against diphtheria, tetanus, whooping cough, polio, measles, mumps and rubella) |
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| Box 10.9 (continued) |
| * influenza vaccination coverage for older people, defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.   A high or increasing proportion of those immunised is desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * incomplete (subject to caveats) for the current reporting period. Data are not available for influenza vaccination coverage for older people. |
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The proportion of children fully immunised in 2016‑17 was: 93.8 per cent for children aged 12 to less than 15 months; 90.9 per cent for children aged 24 to less than 27 months; and 93.6 per cent for children aged 60 to less than 63 months (figure 10.11).

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| Figure 10.11 Children who were fully immunised, by age (months)  2016-17**a** |
| |  | | --- | | More details can be found within the text surrounding this image. | |
| a See box 10.9 and tables 10A.46–48 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) Australian Immunisation Register (AIR) data collection; tables 10A.46–48. |
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#### Appropriateness – Cancer screening

‘Cancer screening’ is an indicator of governments’ objective to ensure primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan and communities (box 10.10).

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| Box 10.10 Cancer screening |
| ‘Cancer screening’ is defined by three measures:   * Participation for women in breast cancer screening, defined as the proportion of women aged 50–74 years who are screened in the BreastScreen Australia Program over a 24 month period, reported as a rate * Participation for women in cervical screening, defined as the proportion of the estimated eligible population of women (not had a hysterectomy) aged 20–69 years who are screened over a 24 month period, reported as a rate * Participation of persons in bowel cancer screening, defined as persons aged 50–74 years who were invited to participate in the National Bowel Cancer Screening Program over a 24 month period and returned a completed test kit within 6 months of the end of that period, divided by the number of invitations issued minus those people who opted out or suspended without completing their screening test.   High or increasing participation rates are desirable.  Data reported against this indicator are:   * comparable (subject to caveats) across jurisdictions and over time. A break in series with the change of target age group for breast cancer screening from 50–69 years to 50–74 years means that data from 2014–2015 onwards are not comparable to earlier time periods * complete (subject to caveats) for the current reporting period. All required data for the 24‑month period 2015–2016 are available for all jurisdictions and cancer screening programs. |
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The national age-standardised participation rate for women aged 50–74 years for 2015–2016 was 54.4 per cent (figure 10.12), an increase from 53.2 per cent for 2014–2015 (table 10A.49).

Aboriginal and Torres Strait Islander women 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, bearing in mind that data are not directly comparable within or across community groups as Indigenous status identification in administrative records varies. For 2015–2016, the participation rate for Aboriginal and Torres Strait Islander women aged 50–74 years was 38.8 per cent (table 10A.50).

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| Figure 10.12 Participation in BreastScreen Australia screening programs — women aged 50–74 years 2015–2016 (24 month period)**a** |
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| a See box 10.10 and table 10A.49 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (2017) Participation in BreastScreen Australia 2015–2016; table 10A.49. |
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For 2015–2016, the national age‑standardised participation rate for women aged 20–69 years in cervical screening was 56.3 per cent (figure 10.13). Data are presented for a ten-year time series in table 10A.51.

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| Figure 10.13 Participation rate for women aged 20–69 years in cervical screening (24 month period)**a** |
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| a See box 10.10 and table 10A.51 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (2017) Participation in the National Cervical Screening Program 2015–2016; AIHW (2016) Cervical screening in Australia 2014–2015; table 10A.51. |
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For 2015–2016, the national participation rate for persons aged 50–74 years in bowel cancer screening was 40.9 per cent, an increase from 38.9 per cent for 2014–2015 (table 10.52).

#### Quality — Safety — General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure primary and community health services are high quality and safe (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 Royal Australasian College of General Practitioners.  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.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * incomplete for the current reporting period as data for the number of general practices are not available. |
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Data for the number of accredited practices and the available historical data for the proportion of general practices with accreditation are reported in table 10A.53.

#### Quality — Responsiveness — Patient satisfaction

‘Patient satisfaction’ is an indicator of governments’ objective that primary and community health services are high quality (box 10.12).

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| Box 10.12 Patient satisfaction |
| ‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of 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 professional always or often: listened carefully to them; showed respect; and spent enough time with them.   High or increasing proportions can indicate improved satisfaction from the patient’s perspective with the quality of care.  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 2016-17 data are available for all jurisdictions.   Data are sourced from the ABS Patient Experience survey, which does not include people living in discrete Aboriginal and Torres Strait Islander communities. This affects the comparability of the NT results. |
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Nationally in 2016‑17, the majority of respondents reported that the GP always or often:

* listened carefully to them (91.6 per cent)
* showed respect (94.1 per cent)
* spent enough time with them (90.6 per cent) (figure 10.14).

Nationally in 2016‑17, the majority of respondents reported that dentists always or often:

* listened carefully to them (95.9 per cent)
* showed respect (96.6 per cent)
* spent enough time with them (96.7 per cent) (figure 10.15).

Data for both measures are presented by remoteness in tables 10A.54–57.

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| Figure 10.14 People whose GP always or often listened carefully, showed respect, spent enough time, 2016-17**a, b** |
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| a See box 10.12 and table 10A.54 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey 2016-17, Cat. no. 4839.0; table 10A.54. |
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| Figure 10.15 People whose dental professional always or often listened carefully, showed respect, spent enough time, 2016-17**a, b** |
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| a See box 10.12 and table 10A.56 for detailed definitions, footnotes and caveats. b Error bars represent the 95 per cent confidence interval associated with each point estimate. |
| *Source*: ABS (unpublished) Patient Experience Survey 2016-17, Cat. no. 4839.0; table 10A.56. |
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#### Quality — Continuity — Continuity of care

‘Continuity of care’ is an indicator of government’s objective to ensure that services are well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required (box 10.13).

| Box 10.13 Continuity of care |
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| ‘Continuity of care’ is defined by two measures:   * the proportion of GP management plans and team care assessment plans that have been reviewed in the last 12 months * patients who have seen three or more health professionals in the last 12 months for the same condition and who were satisfied with the management of their condition.   High or increasing proportions of patient management plans being reviewed and patients who are satisfied with the management of their condition by health professionals are desirable.  Further work is required for developing these measures for reporting against this indicator. |
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#### Sustainability — Workforce sustainability

‘Workforce sustainability’ is an indicator of government’s objective to provide sustainable primary and community healthcare services (box 10.14).

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| Box 10.14 Workforce sustainability |
| ‘Workforce sustainability’ is defined by two measures:   * the proportions of general practitioners in ten year age brackets * the attrition rate of Full Service Equivalent (FSE) general practitioners who exit the workforce as a proportion of the number of FSE employees by age bracket.   A high or increasing percentage of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement is desirable. A low or decreasing rate of workforce attrition is desirable.  These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for general practitioners.  Further work is required for developing these measures for reporting against this indicator. |
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### Efficiency

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

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary and community health services in an efficient manner (box 10.15).

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| Box 10.15 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. Therefore, costs 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 2016-17 data are available for all jurisdictions. |
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Nationally in 2016‑17, total expenditure per person on general practice was $371 per person, increasing in real terms from $316 per person in 2012‑13 (figure 10.16).

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| Figure 10.16 Australian Government fee‑for‑service expenditure per person on GPs (2016-17 dollars)**a** |
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| a See box 10.15 and table 10A.2 for detailed definitions, footnotes and caveats. |
| *Source*: Department of Health (unpublished) MBS Statistics; DVA (unpublished), DVA data collection; table 10A.2. |
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### Outcomes

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

#### Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective for primary and community health services to promote health and prevent illness (box 10.16).

| Box 10.16 Notifications of selected childhood diseases |
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| ‘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 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. |
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| Box 10.16 (continued) |
| 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.  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 2016-17 data are available for all jurisdictions. |
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Nationally in 2016‑17, the rate of notifications for children aged 0–14 years was:

* 0.1 per 100 000 for *Haemophilus influenzae* type b (table 10A.60)
* 0.7 per 100 000 for measles (table 10A.58)
* 181.1 per 100 000 for pertussis (whooping cough) (figure 10.17 and table 10A.59).

Historical data for ten years of reporting are in tables 10A.58–60.

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| Figure 10.17 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**a** |
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| a See box 10.16 and table 10A.59 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.59. |
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#### Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective for primary and community health services to promote health, prevent illness and to support people to manage their health issues in the community (box 10.17).

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| Box 10.17 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. Two 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 (Type 2 diabetes mellitus as principal diagnosis).   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 diabetes measure * complete (subject to caveats) for the current reporting period except for the diabetes measure for which data are not published for Tasmania, the ACT and the NT. All other required 2015‑16 data are available for other jurisdictions. |
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Nationally, the age‑standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 26.4 per 1000 people in 2015‑16 (table 10.1).

| Table 10.1 Separations for selected potentially preventable hospitalisations per 1000 people, 2015-16 (ASR)**a** |
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| |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Vaccine preventable conditions | 1.7 | 1.8 | 2.4 | 1.5 | 2.3 | 1.4 | 1.4 | 8.8 | 2.0 | | Selected acute conditions | 11.3 | 11.4 | 15.3 | 12.7 | 13.3 | 11.2 | 10.3 | 24.8 | 12.6 | | Selected chronic conditions | 10.8 | 12.3 | 14.0 | 11.1 | 11.8 | 10.5 | 9.6 | 22.7 | 12.0 | | **Total** | **23.7** | **25.3** | **31.5** | **25.1** | **27.0** | **22.9** | **21.2** | **54.6** | **26.4** | |
| a See box 10.17 and table 10A.61 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW *Admitted patient care 2015‑16: Australian hospital statistics*; table 10A.61. |
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For 2015‑16 and prior years, the age‑standardised hospital separation rate was higher for Aboriginal and Torres Strait Islander Australians than for other Australians in all jurisdictions for which data by Indigenous status are reported (table 10A.62).

Nationally in 2015‑16, the age-standardised hospital separation rate for diabetes was 117.3 separations per 100 000 people (table 10A.69). The age-standardised separation rate for Aboriginal and Torres Strait Islander people (excluding separations for diabetes complications as an additional diagnosis) was 2.5 times the rate for all Australians (table 10A.68).

The most serious complication of Type 2 diabetes most commonly leading to hospitalisation in 2015‑16 was circulatory complications, with an age standardised rate of 18 per 100 000 people (table 10A.69). Serious circulatory complications of diabetes can necessitate lower limb amputation. In 2015‑16, there were 17.7 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.71).

## 10.4 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. |

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| 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 2013a). |
| 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 2013b). 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 Medicare Locals (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. |
| 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). |

## 10.5 References

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Department of Veterans Affairs (unpublished) DVA Collection.

1. See section 10.4 for a definition of FSE. [↑](#footnote-ref-1)
2. Almost 4 million additional services were billed to the DVA (DVA unpublished). [↑](#footnote-ref-2)