Report on Government Services 2021

PART E, SECTION 10: RELEASED ON 28 JANUARY 2021

10 Primary and community health

This section is presented in a new online format. Dynamic data visualisations replace the static chapter format used in previous editions. Machine readable data are also available for download. A guide is available on accessing information in the new format.

Impact of COVID-19 on data for the Primary and community health services section

COVID-19 may affect data in this Report in a number of ways. This includes in respect of actual performance (that is, the impact of COVID-19 on service delivery in 2020 which is reflected in the data results), and the collection and processing of data (that is, the ability of data providers to undertake data collection and process results for inclusion in the Report).

For the Primary and community health services section, general practice attendance and expenditure data will be impacted by changes in service use, including the increasing use of telehealth services, particularly during COVID-19 shut-downs.

This section 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 section does not include:

- public hospital emergency departments and outpatient services (reported in section 12, 'Public hospitals')
- community mental health services (reported in section 13, 'Services for mental health')
- home and community care services (reported in section 14, 'Aged care' and section 15, 'Services for people with disability').

The **Indicator Results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator Framework.** The same data are also available in CSV format.

Context

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
- well coordinated 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.

Service overview

Primary and community health 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 sub-section 10.2.

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 Department of Human Services (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 primarily from insurance schemes and patient contributions.

Pharmaceutical services

The Commonwealth funds the Pharmaceutical Benefits Scheme (PBS), which subsidises the cost of many medicines in Australia. The PBS schedule sets a price for listed medicines and a maximum co-payment amount that people contribute towards the cost of these medicines. The Commonwealth incurs the expense of any difference where the listed price exceeds the patient co contribution (whether for general or concessional patients). Around 70 per cent of prescriptions for PBS-listed medicines attract a PBS subsidy (the remainder are under the general co-payment level) (Department of Health 2019). Co-payments contribute to a patient's safety net threshold that, once reached, provides eligibility to receive PBS medicines at a lower cost or free of charge.

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 services. State and Territory governments deliver public dental services, which are primarily available to children and disadvantaged adults. The Australian Government works with State and Territory governments to fund dental services. Since 2013, the Australian Government has increased funding for public dental services via National Partnership Agreements with States and Territories and the Child Dental Benefits Schedule. 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. Under the COAG Health Council, Australian governments developed the *National Oral Health Plan 2015 to 2024* that sets out priorities to improve dental health across Australia (COAG 2015).

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.23.

Community health services

Community health services generally comprise multidisciplinary teams of health and allied health professionals who provide targeted health promotion, prevention and management services. Their aim is to protect the health and wellbeing of local populations, particularly people who have or are at risk of the poorest health and/or have the greatest economic and social needs, while taking pressure off the acute care health system. Governments (including local governments) provide community health 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 2018-19, of the $38.7 billion government recurrent expenditure on primary and community health services, around three-quarters was funded by the Australian Government and one-quarter by State, Territory and local governments (table 10A.1). This included:

- $10.2 billion for community health services (18.0 per cent by the Australian Government and 82.0 per cent by State, Territory and local governments)
- $2.4 billion for dental services (65.5 per cent by the Australian Government and 34.5 per cent by State, Territory and local governments) (table 10A.1).

Where more recent data are available, for 2019-20, Australian Government expenditure was:

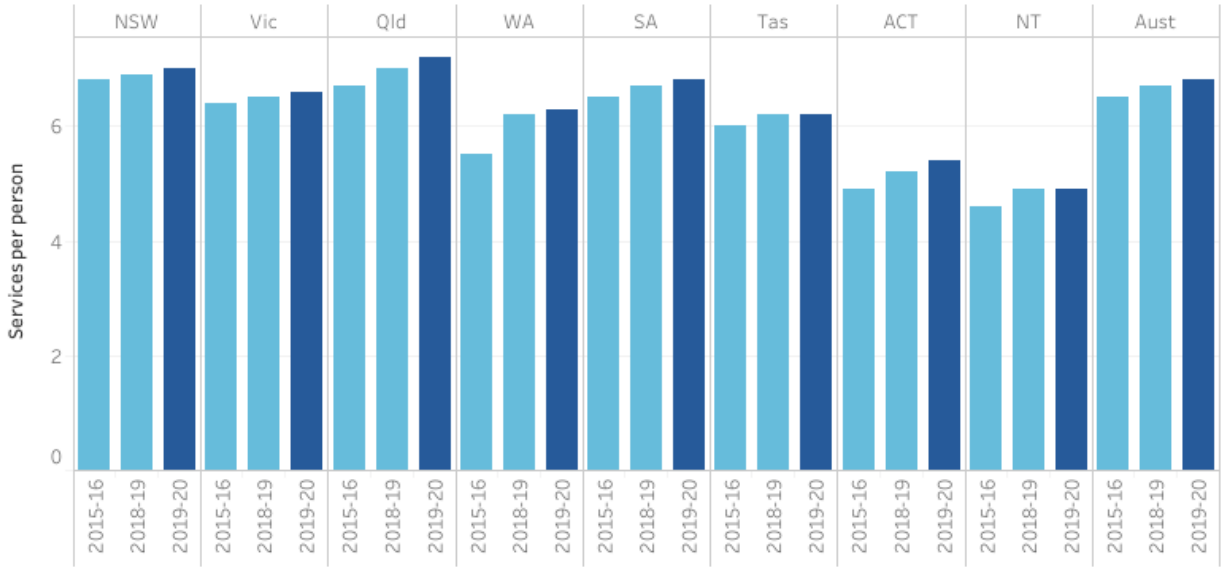
- $10.3 billion on general practice (table 10A.2)
- $8.8 billion through the PBS and RPBS on Section 85 prescription medicines filled at pharmacies (table 10A.3)
- $39.3 million on funding of PBS medicines to Aboriginal and Torres Strait Islander primary health services in remote and very remote areas (table 10A.5)
- $783.3 million on Aboriginal and Torres Strait Islander primary health services in (table 10A.7).

Size and scope

Nationally in 2019, there were 37 472 GPs — 29 854 on a Full Time Equivalent (FTE)[1] basis, equating to 117.0 per 100 000 people (table 10A.8). Nationally in 2019-20, Medicare Australia was billed for around 173.2 million services (Department of Health unpublished and Department of Veterans' Affairs unpublished). Nationally, rates of GPs per person have increased over the years presented in this Report (table 10A.8), as have the rates of GP type services used per person (table 10A.9; figure 10.1).

Select year(s):
Multiple values

Figure 10.1 **GP service use**
by jurisdiction, by year



Source: table 10A.9

Data tables are referenced above by a '10A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

Around 205 million services (8.0 per person) were subsidised under Section 85 of the PBS in 2019-20 — with 91.8 per cent concessional (tables 10A.10-11). A further 8.1 million services were subsidised under the RPBS.

Nationally in 2018-19, there were:

- 209 Aboriginal and Torres Strait Islander primary health services which provided 3.7 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.
- 1283 alcohol and other drug treatment agencies (31.3 per cent identified as government providers) with a reported 219 933 closed treatment episodes (29.0 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).

1. See sub-section 10.2 for a definition of FTE.

References

Australian Government DHS (Department of Human Services) 2015, *Practice Incentives Program (PIP)* , http://www.humanservices.gov.au/health professionals/services/ practice incentives programme/ (accessed 16 November 2015).

AIHW (unpublished) National Dental Telephone Interview Survey.

COAG Health Council 2015, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024* , http://www.coaghealthcouncil.gov.au/Portals/0/Australia%27s%20National%20Oral%20Health%20Plan%202015-2024_uploaded%20170216.pdf (accessed 11 November 2020).

Department of Health 2019, *PBS expenditure and prescriptions 2018-19* , https://www.pbs.gov.au/statistics/expenditure-prescriptions/2018-2019/PBS_Expenditure_and_Prescriptions_Report_1-July-2018_to_30-June-2019.pdf (accessed 4 October 2020).

—— unpublished, MBS Statistics.

Department of Veterans Affairs (unpublished) DVA Collection.

Indicator Framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of primary and community health services.

The performance indicator framework shows which data are complete and comparable in this Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a Report-wide perspective. In addition to the service area's Profile information, the Report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

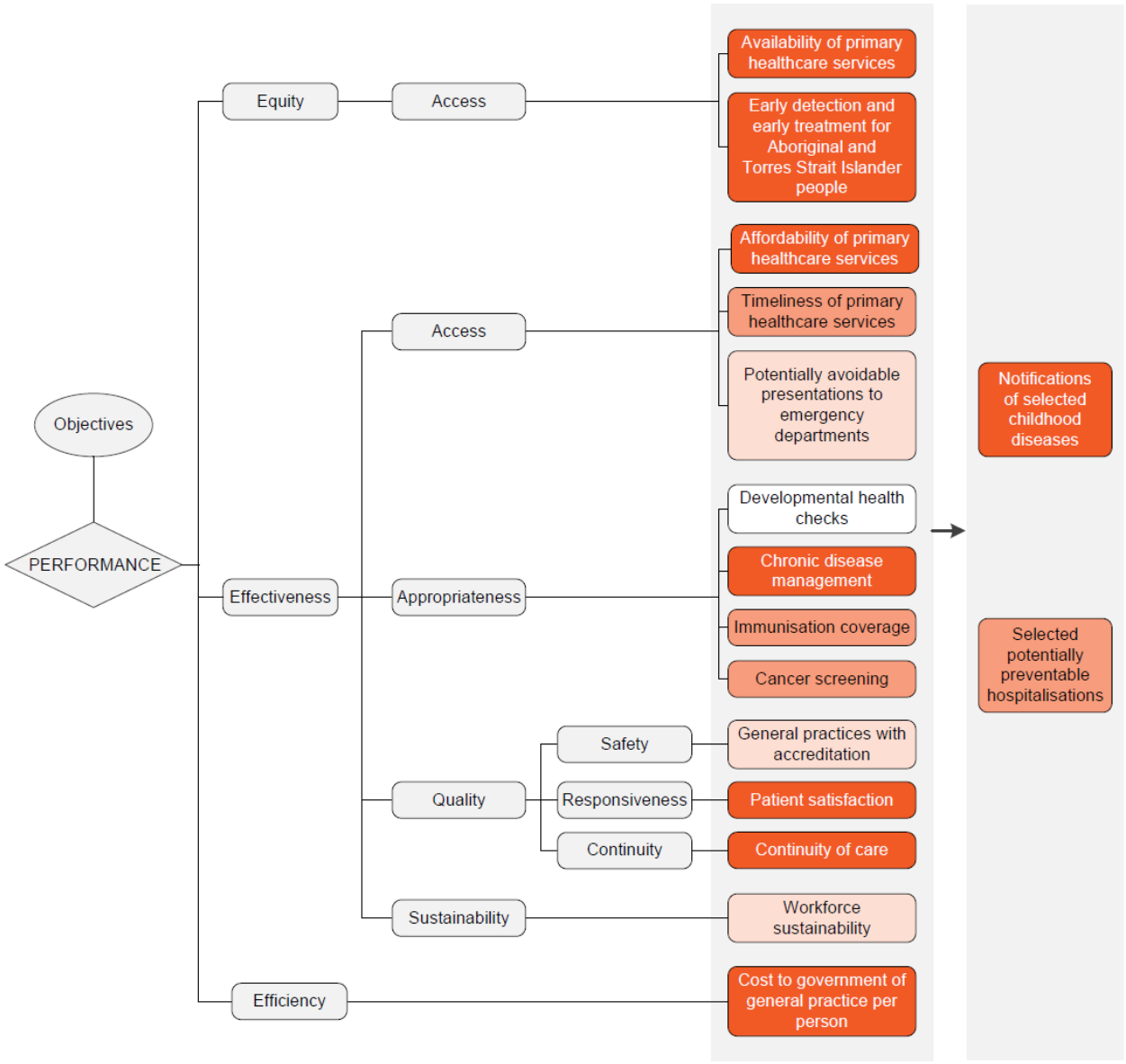
Improvements to performance reporting for primary and community health services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Outcomes

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



Key to indicators*

Text	Most recent data for all measures are comparable and complete
Text	Most recent data for at least one measure are comparable and complete
Text	Most recent data for all measures are either not comparable and/or not complete
Text	No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the section

Indicator Results

An overview of the primary and community health services performance indicator results are presented. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of primary and community health services.

Information to assist the interpretation of these data can be found in the primary and community health services supporting interpretative material and data tables. Data tables are identified by a '10A' prefix (for example, table 10A.1).

All data are available for download as an excel spreadsheet and as a CSV dataset — refer to Download supporting material. Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

Availability of primary healthcare services is an indicator of governments' objective to provide access to primary healthcare services in an equitable manner. It is defined by four measures.

Measure 1: PBS medicines by region — the population divided by the number of approved providers of PBS medicines, by urban/rural location and Pharmacy Access/Remoteness Index of Australia (PhARIA) area.
Measure 2: General Practioners (GPs) by region — the number of full time equivalent (FTE) GPs per 100 000 people, by region.
Measure 3: GPs by sex — the number of FTE GPs per 100 000 population, by sex.
Measure 4: Public dentists by region, defined as the number of FTE public dentists per 100 000 people, by region, based on clinical hours worked in the public sector.

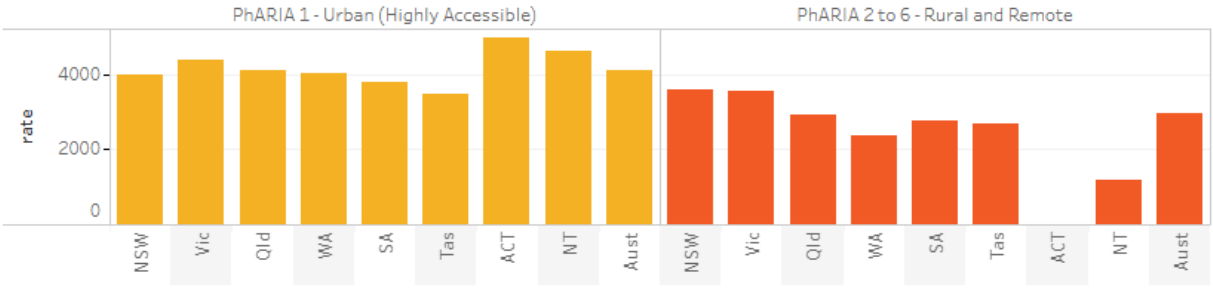
Guidance: Similar rates across regions indicates equity of access by location. Similar rates by sex means it is more likely that patients who prefer to visit GPs of their own sex will have their preference met.

- Data are comparable (subject to caveats) across jurisdictions and over time (and from 2014 for measure 4).
- Data are complete (subject to caveats) for the current reporting period.

Select year (applies to figure 10.2a):
2020

PhARIA 1 - Urban (Highly Accessible)
PhARIA 2 to 6 - Rural and Remote

Figure 10.2a Measure 1: **Number of people per approved PBS provider, 2020** by jurisdiction, by PhARIA area (a)



Source: table 10A.18
(a) The ACT has no rural areas under the classification used.

Nationally, at 30 June 2020, there were 4100 people per approved PBS provider in urban areas and 2946 people per approved PBS provider in rural areas. These numbers have decreased in urban and rural areas following a peak in 2017 (table 10A.18). Data are also available for pharmacy providers only (table 10A.18) and by PhARIA (table 10A.17).

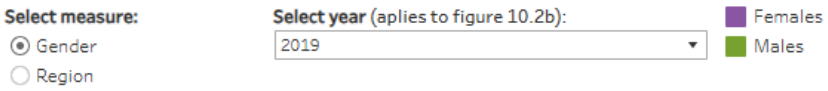
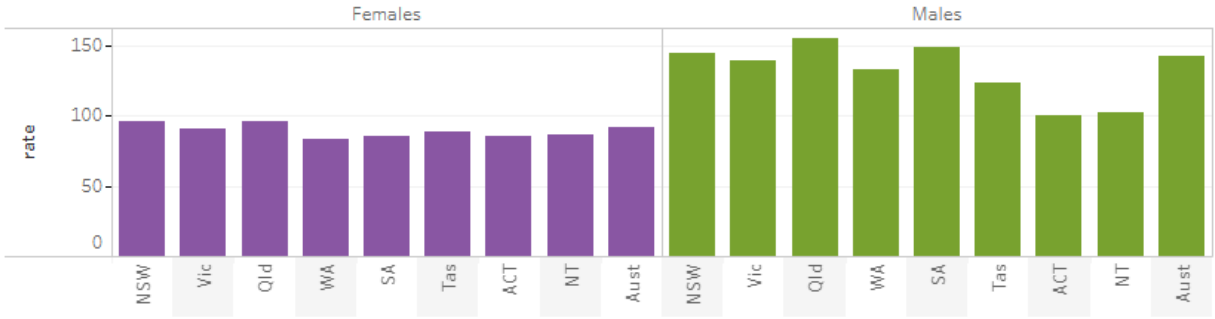


Figure 10.2b Measures 2-3: **Full time equivalent GPs, 2019**
by jurisdiction, by Gender (b)

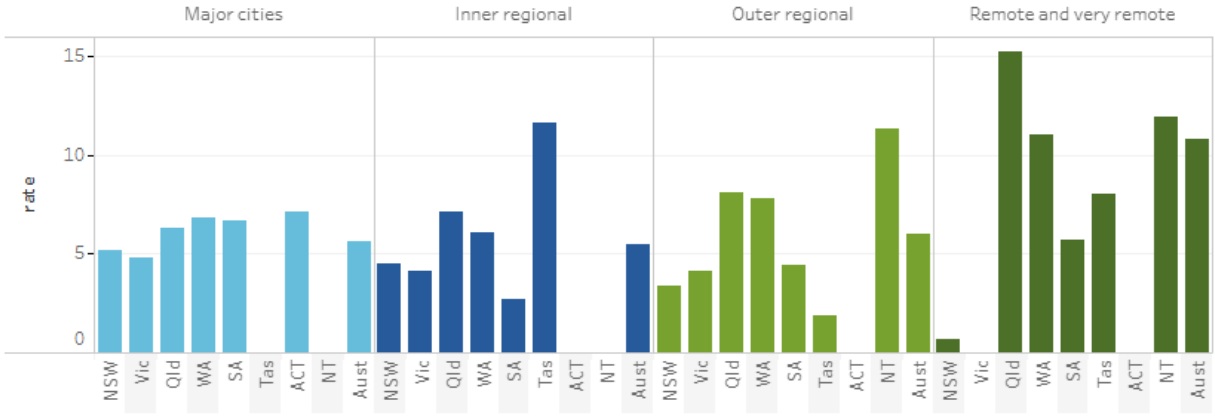


Source: table(s) 10A.20 & 10A.21

(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.

Nationally in 2019, the number of FTE GPs per 100 000 people decreased as remoteness increased, and there were 91.8 FTE female GPs per 100 000 females and 142.5 FTE male GPs per 100 000 males.

Figure 10.2c Measure 4: **Full time equivalent Public dentists, 2019**
by jurisdiction, by Region (c)



Source: table 10A.22

(c) Data for remote/very remote areas are not published for Victoria; Tasmania has no major cities; the ACT has no inner regional, outer regional, remote or very remote areas, and the NT has no major cities or inner regional areas.

Nationally in 2019, the rate of FTE public dentists per 100 000 people was higher in remote/very remote areas (10.8 per 100 000 people) compared to other areas (5.5–6.0 per 100 000 people). Data for FTE allied dental practitioners are presented in table 10A.22.

Early detection and early treatment for Aboriginal and Torres Strait Islander people is an indicator of governments' objective to provide access to primary and community healthcare in an equitable manner.

Measure: The proportion of older people who received a health assessment under Medicare by Indigenous status.

Guidance: A small or narrowing gap between the proportion of Aboriginal and Torres Strait Islander people and non-Indigenous people who received a health assessment can indicate more equitable access.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

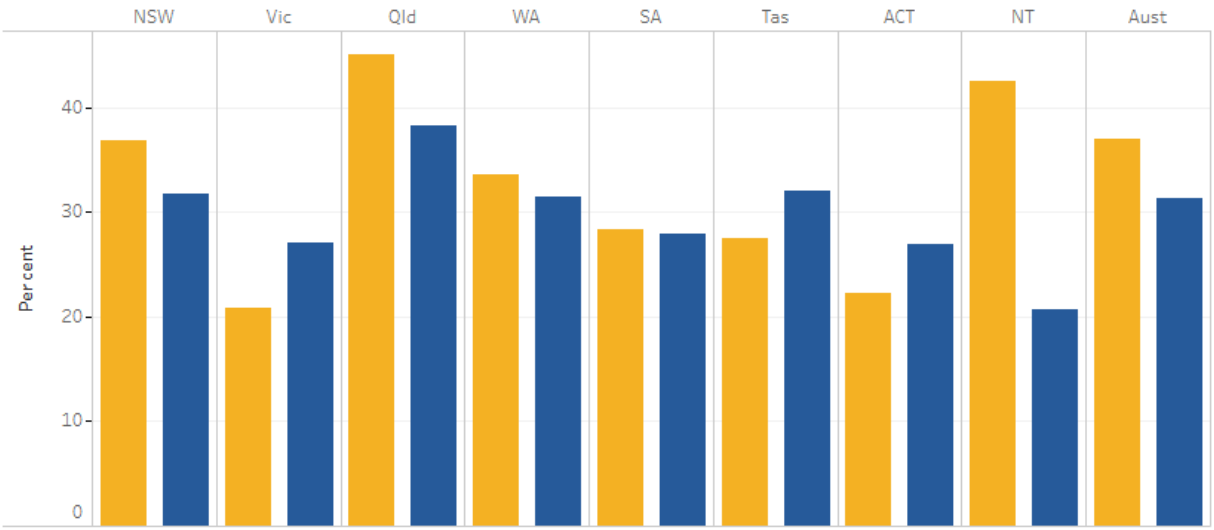
Select year (applies to figures 10.3a and 10.3b):

2019-20

Aboriginal and Torres Strait Islander

Non-Indigenous

Figure 10.3a **Older people who received Annual health assessments, 2019-20** by jurisdiction, by Indigenous status



Source: table 10A.24

Nationally in 2019-20, the proportion of older people receiving a health assessment was 37.0 per cent for Aboriginal and Torres Strait Islander people and 31.4 per cent for non-Indigenous people.

Nationally, over the ten years to 2019-20, the proportion of older Aboriginal and Torres Strait Islander people who received an annual health assessment increased by 20.4 percentage points to 37.0 per cent, compared to an increase of 4.6 percentage points to 31.4 per cent for older non-Indigenous people (with the proportion higher for Aboriginal and Torres Strait Islander older people from 2015-16).

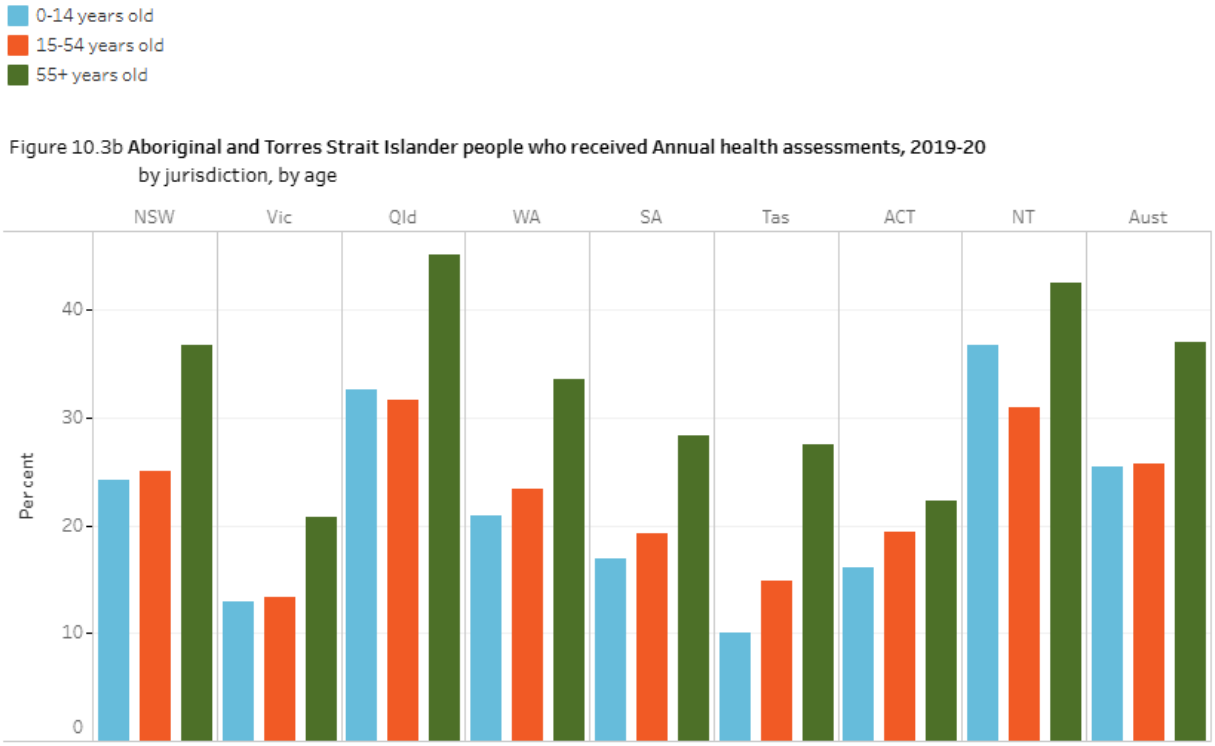


Figure 10.3b **Aboriginal and Torres Strait Islander people who received Annual health assessments, 2019-20** by jurisdiction, by age

Source: table 10A.25

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 (37.0 per cent) compared to those aged 15–54 years and 0–14 years (25.7 per cent and 25.4 per cent respectively), though proportions have increased for all age groups over the years included in this Report.

Affordability of primary healthcare services is an indicator of governments' objective to provide primary healthcare services that are affordable. It is defined by two measures.

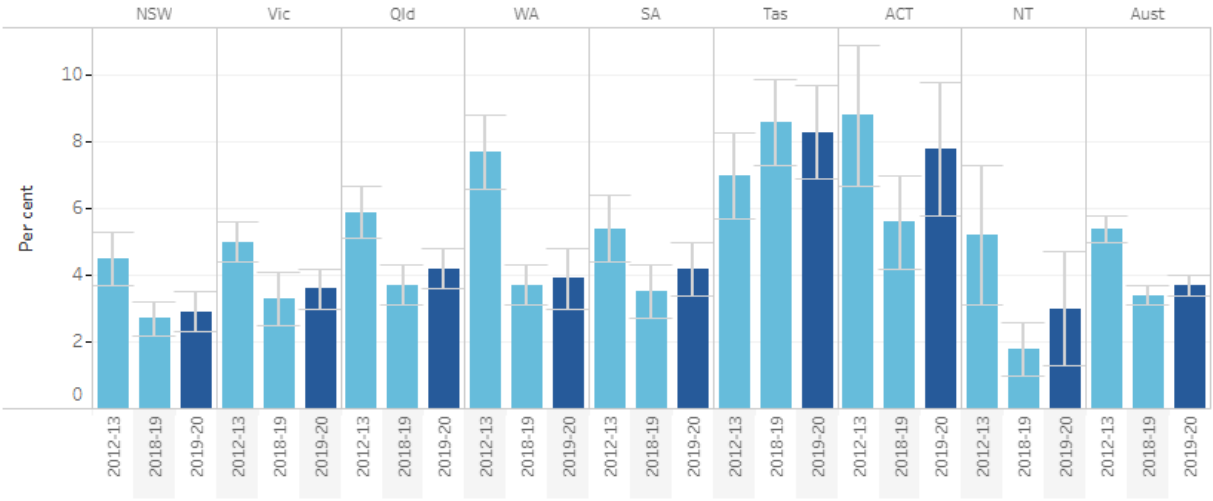
Measure 1: People delaying or not seeing GPs due to cost — the proportion of people who delayed seeing or did not see a GP at any time in the last 12 months due to cost.
Measure 2: People delaying or not filling prescriptions due to cost — the proportion of people who delayed filling or did not fill a prescription at any time in the last 12 months due to cost.

Guidance: A low or decreasing proportion of people deferring visits to GPs or filling prescriptions due to cost indicates more widely affordable access to GPs and medicines. Contextual data covering bulk billing of general practice attendances and specialist attendances, by region, are available in tables 10A.27-30.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s) (applies to figures 10.4a and 10.4 b):
(Multiple values)

Figure 10.4a Measure 1: **People delaying or not seeing GPs due to cost** by jurisdiction, by year



Source: table 10A.26

Nationally in 2019-20, 3.7 per cent of the population reported that they had delayed or did not visit a GP in the last 12 months due to cost.

Figure 10.4b Measure 2: **People delaying filling or not filling prescription due to cost** by jurisdiction, by year

Source: table 10A.31

Nationally in 2019-20, 6.6 per cent of the population reported they had delayed filling or did not fill a prescription in the last 12 months due to cost.

Timeliness of primary healthcare services is an indicator of governments' objective to ensure primary healthcare services are provided in a timely manner. It is defined by two measures.

Measure 1: Public dentistry waiting times — 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.

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

- Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
- Data are incomplete for the current reporting period.

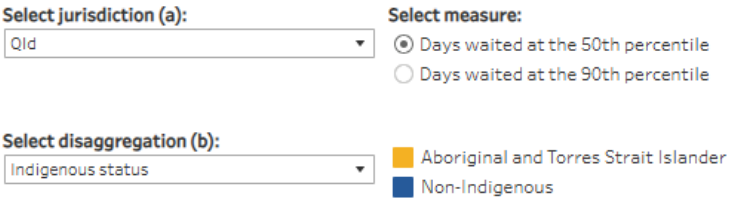
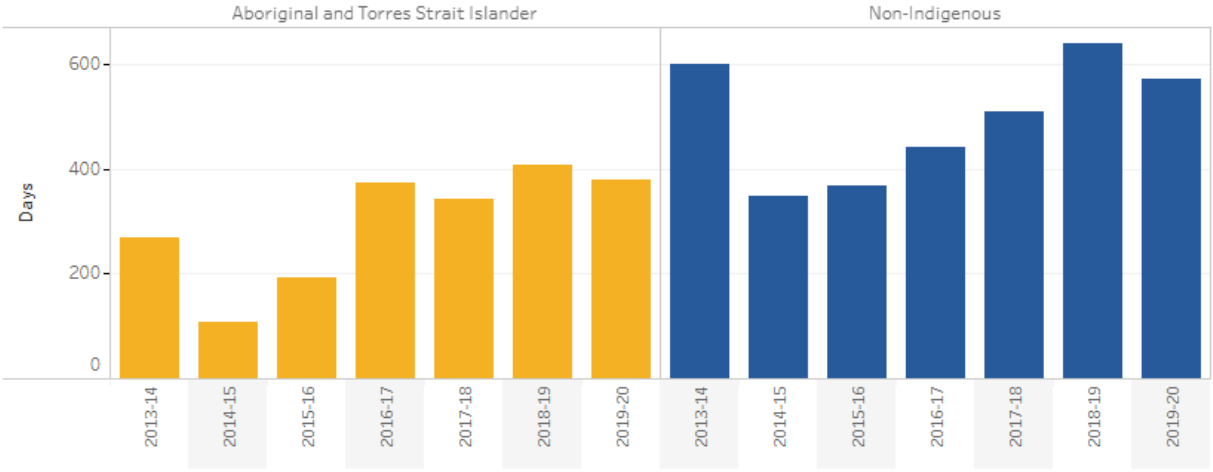


Figure 10.5a Measure 1: **General dental care, Days waited at the 50th percentile (for first visit), Qld** by Indigenous status, by year



Source: tables 10A.33-10A.40

(a) Data are not available for NSW (all years), Vic (for 2016-17), the ACT (for 2013-14 and 2014-15) and the NT (all years except 2017-18 and 2019-20).

(b) See data tables 10A.33-40 for information on non-publication of data on Indigenous status, remoteness or Socio-Economic Indexes for Areas (SEIFA) for individual jurisdictions.

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.

***Measure 2*:** GP waiting times for urgent medical care — 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.

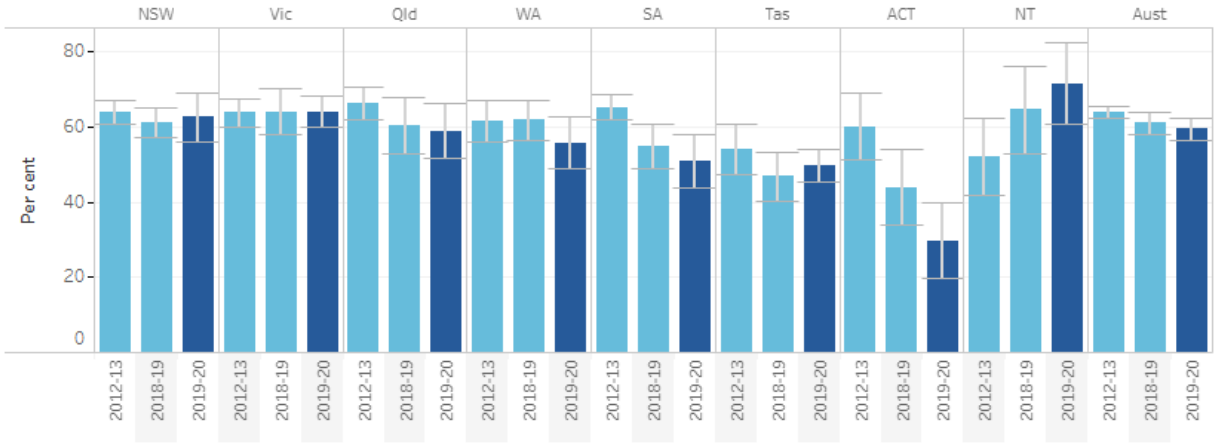
***Guidance*:** A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s): (Multiple values)

Specified waiting times: Within four hours

Figure 10.5b Measure 2: **Waiting time for GPs for an urgent appointment, Within four hours** by jurisdiction, by year



Source: table 10A.41

Nationally in 2019-20, for people who saw a GP for urgent care:

- 59.4 per cent waited less than 4 hours
- 10.8 per cent waited from 4 to less than 24 hours
- 29.8 per cent waited for 24 hours or more.

Overall, 18.7 per cent of people who saw a GP for their own health waited longer than they felt was acceptable to get an appointment (table 10A.42).

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

***Measure (interim)*:** 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), and
- not arriving by ambulance, with police or corrections, and
- not admitted or referred to another hospital, and
- who did not die.

***Guidance*:** Once a suitable denominator for this measure is agreed, a low or decreasing rate/proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.

Data are not comparable across jurisdictions or within some jurisdictions over time, but are comparable within other jurisdictions over time (subject to caveats).

Data are complete (subject to caveats) for the current reporting period.

Table 10.1 **Selected potentially avoidable GP-type presentations to emergency departments (number)** by jurisdiction, by year

	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	1,112,191	1,122,982	1,150,276	1,158,508	1,149,209
Vic	626,545	632,612	629,406	625,305	572,736
Qld	429,665	413,635	406,783	408,702	435,744
WA	337,224	332,654	332,889	376,518	365,924
SA	160,670	158,004	159,689	159,212	157,929
Tas	58,843	59,068	61,590	62,609	55,507
ACT	49,429	54,208	53,041	51,244	43,990
NT	54,374	57,192	56,339	60,507	58,683
Aust	2,828,941	2,830,355	2,850,013	2,902,605	2,839,722

Source: table 10A.32

Nationally in 2019-20, there were around 2.8 million GP type presentations to public hospital emergency departments.

Developmental health checks is an indicator of governments' objective to ensure that services are appropriate and responsive to the needs of children.

***Measure*:** The proportion of preschool-aged children who received a developmental health assessment.

Guidance: 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.

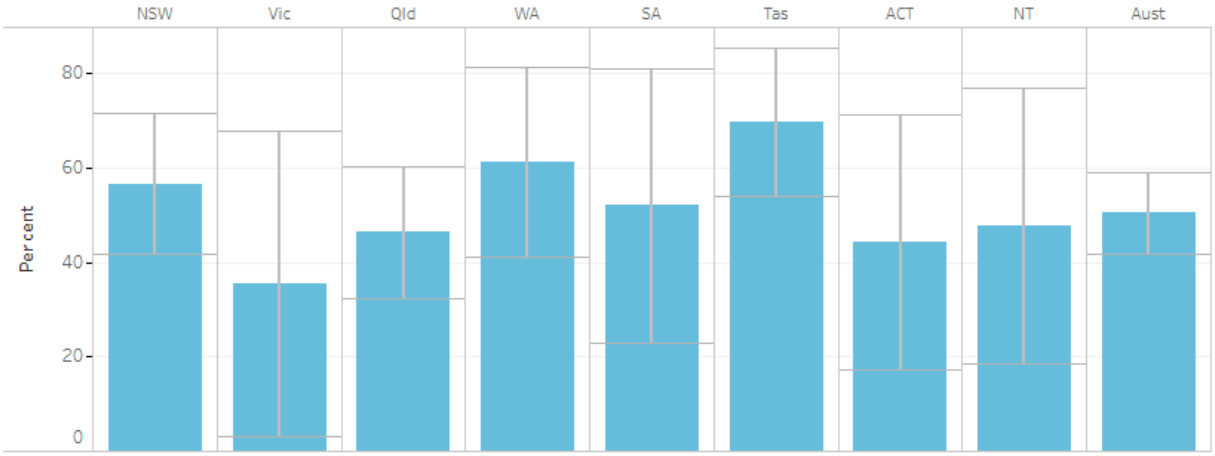
Chronic disease management is an indicator of governments' objective to ensure that primary and community health services are appropriate and responsive to meet the needs of individuals throughout their lifespan. It is defined by two measures.

Measure 1: Management of diabetes — the proportion of people with diabetes with HbA1c (glycosylated haemoglobin) level less than or equal to 7 per cent.
Measure 2: Management of asthma — the proportion of people with asthma who have a written asthma action plan.

Guidance: A high or increasing proportion for each measure is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Figure 10.6a Measure 1: **Proportion of people with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7 per cent, 2011-12**
by jurisdiction



Source: table 10A.44

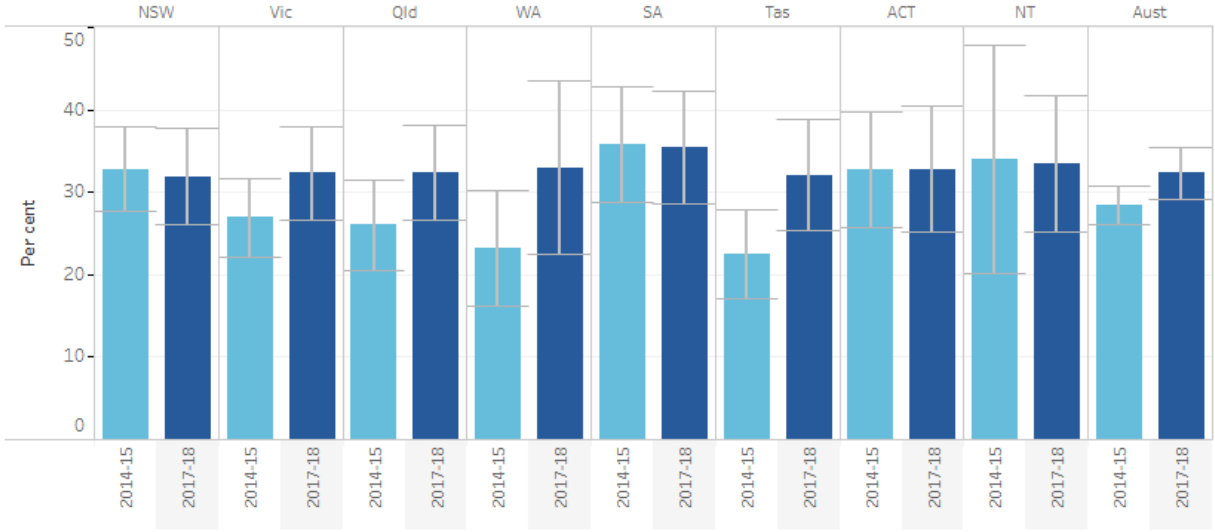
Nationally in 2011-12, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent, but of this group, only 77.5 per cent had a HbA1c test in the previous 12 months (table 10A.43). HbA1c provides a measure of the average blood glucose level for the preceding three months, and a HbA1c level at or below 7 per cent indicates appropriate management.

Select year(s) (applies to figure 10.6b):
(Multiple values)

Select age group:
All ages

Figure 10.6b Measure 2: **Proportion of people with asthma with a written asthma action plan, All ages (per cent Age Standardised) (a)**

by jurisdiction, by year



Source: table 10A.45

(a) Data are not published for some age groups for some jurisdictions.

Nationally in 2017-18, the age-standardised proportion of people with asthma reporting that they have a written asthma action plan was 32.3 per cent, compared to 28.4 per cent in 2014-15. In all jurisdictions, the proportion was higher for children aged 0–14 years than for other age groups.

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. It is defined by four measures.

Measure 1: 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).
Measure 2: The proportion of children aged 24<27 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b, hepatitis B, measles, mumps and rubella (MMR), meningococcal C and varicella).
Measure 3: The proportion of children aged 60<63 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, and to the quarter ending 31 December 2017, including measles, mumps and rubella (MMR)).
Measure 4: Influenza vaccination coverage for older people, defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.

Guidance: A high or increasing proportion or number of people immunised is desirable.

■ (all measures) Data are comparable (subject to caveats) across jurisdictions and over time.

■ (measures 1-3) Data are complete (subject to caveats) for the current reporting period.

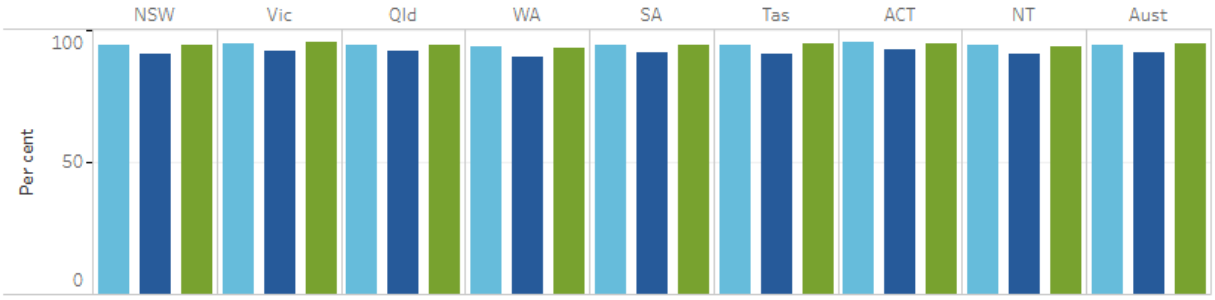
■ (measure 4) Data are incomplete for the current reporting period. Due to provider underreporting of influenza vaccinations for older people to the AIR, data are reported as numbers rather than population coverage rates.

Select year (applies to figure 10.7a):

2019-20

12 months to less than 15 months
24 months to less than 27 months
60 months to less than 63 months

Figure 10.7a Measures 1-3: **Proportion of children fully immunised, 2019-20** by jurisdiction, by age (months)



Source: table 10A.47

The proportion of children fully immunised in 2019-20 was: 94.6 per cent for children aged 12 to less than 15 months; 91.7 per cent for children aged 24 to less than 27 months; and 94.8 per cent for children aged 60 to less than 63 months.

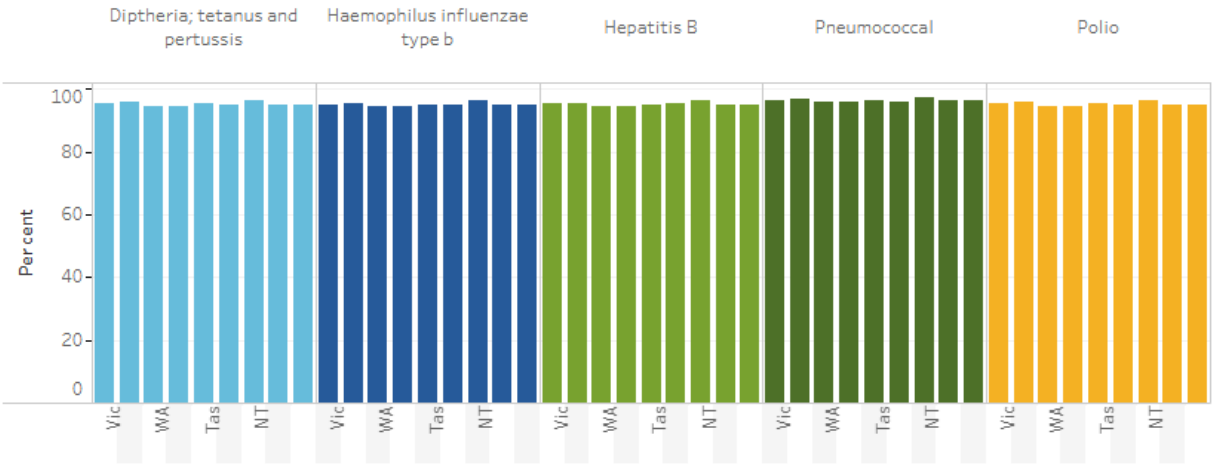
Select measure (age) (applies to figure 10.7b):

- (•) 12 months to less than 15 months
- ( ) 24 months to less than 27 months
- ( ) 60 months to less than 63 months

- Diptheria; tetanus and pertussis
- Haemophilus influenzae type b
- Hepatitis B
- Pneumococcal
- Polio

Figure 10.7b Measures 1-3: **Proportion of children fully immunised against various diseases, 12 months to less than 15 months, 2019-20**

by disease, by jurisdiction



Source: table 10A.47

Table 10.2 Measure 4: **Number of influenza vaccines, administered and reported to the Australian Immunisation Register, 65+ years old, 2019-20**

by jurisdiction

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
911,316	708,480	603,950	306,423	232,150	82,661	45,764	13,185	2,906,362

Source: table 10A.48

Nationally in 2019-20, there were around 2.9 million influenza vaccines administered and reported to the Australian Immunisation Register, for people aged 65 years or over.

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. It is defined by three measures.

Measure 1: Participation for women in breast cancer screening — 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.
Measure 2: Participation for women in cervical screening — the proportion of the estimated eligible population of women (not had a hysterectomy) aged 25–74 years who are screened over a 5-year period, reported as a rate.
Measure 3: Participation of persons in bowel cancer screening — 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.

Guidance: High or increasing participation rates are desirable.

■ (measures 1 and 3) Data are comparable (subject to caveats) across jurisdictions and over time (from 2014-2015 onwards for breast cancer screening).

■ (measures 1 and 3) Data are complete (subject to caveats) for the current reporting period.

■ (measure 2) Data are comparable (subject to caveats) across jurisdictions, but not over time due to a change in the national cervical cancer screening program from December 2017. Data for 2018–2019 onwards are not comparable with data for earlier years.

■ (measure 2) Data are incomplete for the current reporting period. Due to a change in the national cervical cancer screening program from December 2017, participation data are only available for 2018-2019.

Select year(s) (applies to figure 10.8a):
(Multiple values)

Select age:
55-59 years old

Figure 10.8a Measure 1: **Participation rates, for Women in BreastScreen Australia (24 month period), 55-59 years old (a)** by jurisdiction, by year

Source: table 10A.49
(a) Data are not available for 50-74 year olds prior to 2014-15.

The national age-standardised BreastScreen participation rate for women aged 50–74 years for 2018–2019 was 54.3 per cent. Rates have remained relatively stable for the 5 years of data available in this Report. For 2018–2019, the participation rate for Aboriginal and Torres Strait Islander women aged 50–74 years was 37.8 per cent (table 10A.50).

Table 10.3 Measure 2: **Participation rates for Women in cervical screening programs, 25-74 years old, 2018-2019** by jurisdiction

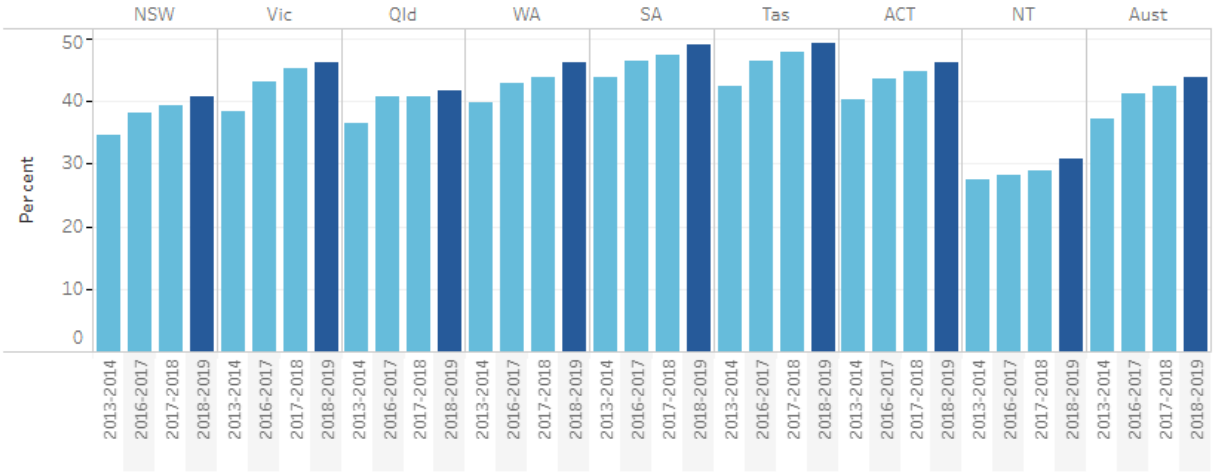
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
%	44.1	46.2	46.1	48.4	50.3	48.1	47.2	43.7	46.3
% (AS)	44.4	46.8	46.2	48.4	50.5	48.5	47.7	43.4	46.5

Source: table 10A.51
AS = Age Standardised

Participation rates for 2018-2019 suggest a national age-standardised participation rate of 46.5 per cent of women aged 25–74 years. Data collected under the previous screening program (to June 2017) are available in table 10A.51.

Select year(s) (applies to figure 10.8b):
(Multiple values)

Figure 10.8b Measure 3: **Participation rates, People in the National Bowel Cancer Screening Program , 50-74 years old** by jurisdiction, by year



Source: table 10A.52

For 2018–2019, the national age-standardised participation rate for persons aged 50–74 years in bowel cancer screening was 43.8 per cent, continuing an annual increase from 37.3 per cent for 2013–2014.

General practices with accreditation is an indicator of governments' objective to ensure primary and community health services are high quality and safe.

***Measure*:** The number of general practices in Australia that are accredited as a rate per 100 general practices.

***Guidance*:** A high or increasing rate of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services.

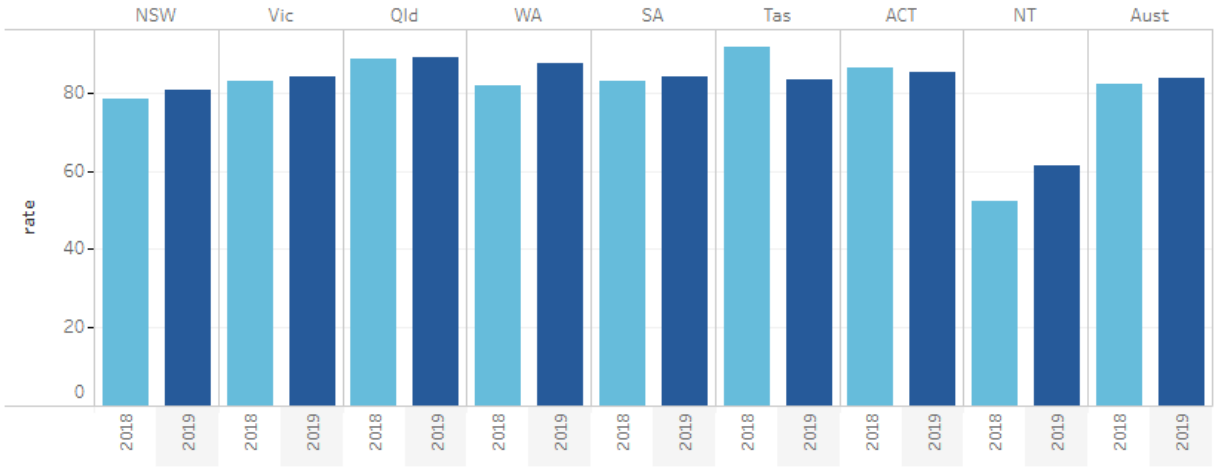
■ Data are comparable (subject to caveats) across jurisdictions and over time (from 2018).

■ Data are incomplete for the current reporting period (2020). All required data for the number of general practices (denominator) are not available and therefore an accreditation rate cannot be calculated.

Select year(s):

(All)

Figure 10.9 **Accreditation of general practices** by jurisdiction, by year



Source: table 10A.53

Nationally in 2019, 83.8 general practices were accredited per 100 general practices. The number of accredited general practices at 30 June 2020 was 6892, up from 6825 the year before (10A.53).

Patient satisfaction is an indicator of governments' objective that primary and community health services are high quality. It is defined by six measures.

Measures 1-3: Proportion of people who saw a GP in the last 12 months who reported the GP always or often:
- listened carefully
- showed respect
- spent enough time with them.

Measures 4-6: Proportion of people who saw a dental professional in the last 12 months who reported the dental professional always or often:
- listened carefully
- showed respect
- spent enough time with them.

Guidance: High or increasing proportions can indicate improved satisfaction from the patient's perspective with the quality of care.

■ Data are comparable (subject to caveats) across jurisdictions and over time.

■ Data are complete (subject to caveats) for the current reporting period.

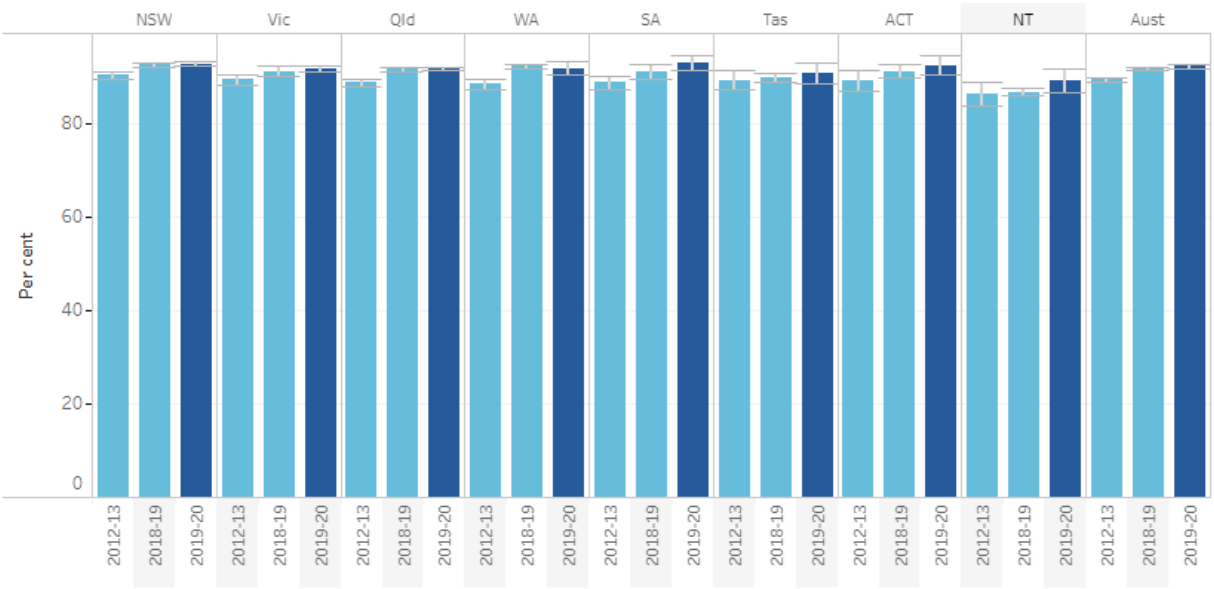
Select year(s) (applies to figures 10.10a and 10.10b):

(Multiple values)

Select measure: (applies to measures 1-3)

- (●) GP always or often listened carefully
- ( ) GP always or often showed respect
- ( ) GP always or often spent enough time

Figure 10.10a Measures 1-3: **Client experience of GPs, GP always or often listened carefully** by jurisdiction, by year



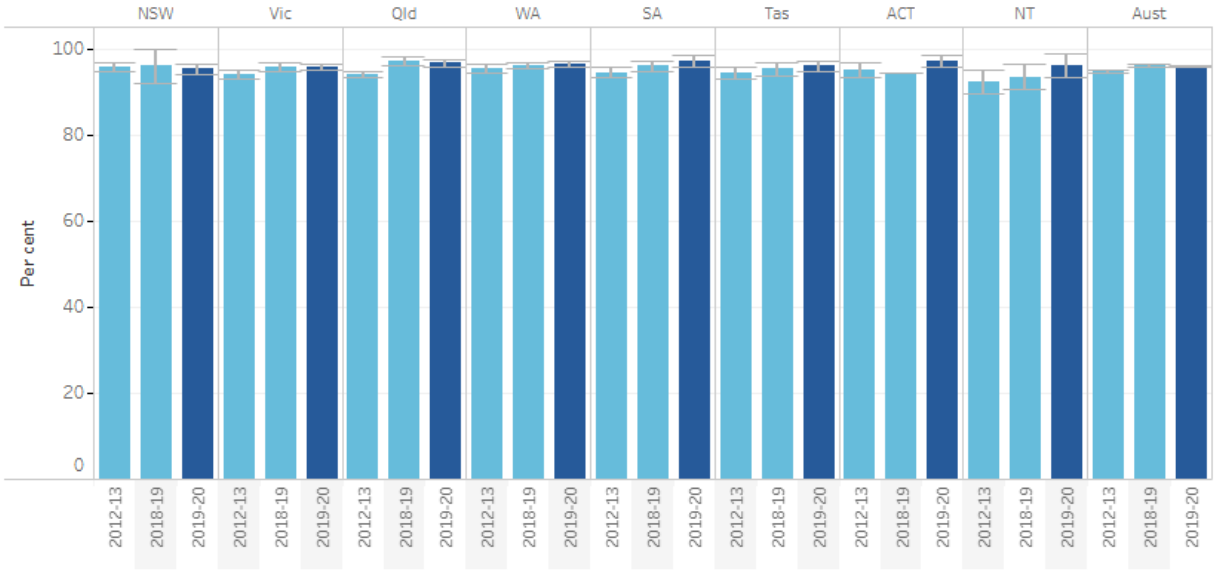
Source: tables 10A.54-10A.55

Nationally in 2019-20, the majority of respondents reported that the GP always or often:
- listened carefully (92.3 per cent).
- showed respect (94.6 per cent).
- spent enough time with them (90.9 per cent).

Select measure (applies to measures 4-6):

- (•) Dental professional always or often listened carefully
- ( ) Dental professional always or often showed respect
- ( ) Dental professional always or often spent enough time

Figure 10.10b Measures 4-6: **Client experience of dental professionals, Dental professional always or often listened carefully** by jurisdiction, by year



Source: tables 10A.56-10A.57

Nationally in 2019-20, the majority of respondents reported that dental professionals always or often:

- listened carefully (96.0 per cent).
- showed respect (97.0 per cent).
- spent enough time with them (96.9 per cent).

Data for measures 1–6 are presented by remoteness in tables 10A.54-57.

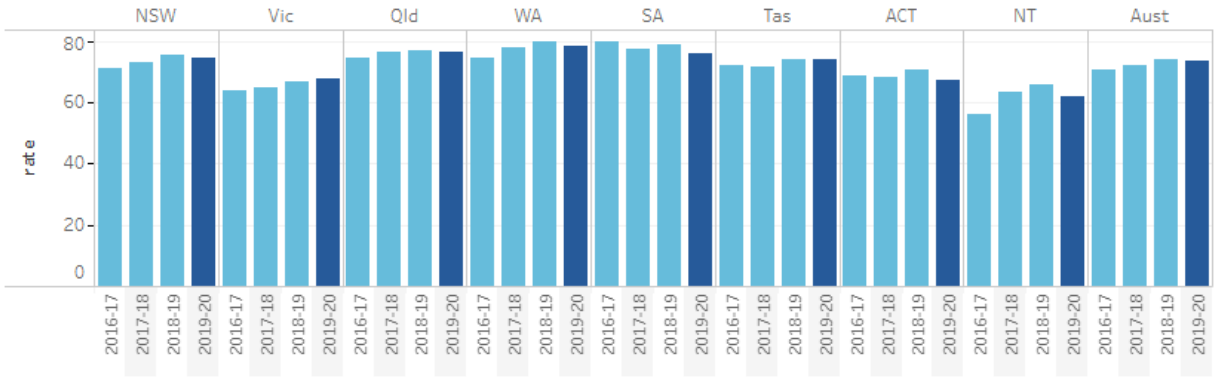
Continuity of care is an indicator of governments' objective to ensure that services are well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required. It is defined by three measures.

Measure 1: the proportion of GP management plans and team care assessment plans that have been reviewed in the past 12 months.
Measure 2: the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent.
Measure 3: the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that issues were caused by a lack of communication between the health professionals.

***Guidance*:** For measures one and two, a high or increasing proportion is desirable. For measure three, a low or decreasing proportion is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

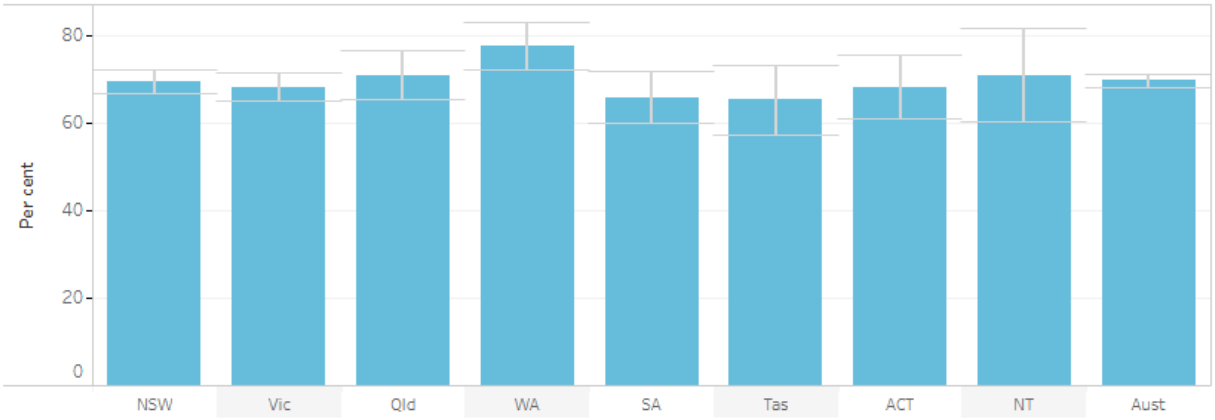
Figure 10.11a Measure 1: **Proportion of GP management and team care assessment plans, reviewed in the past 12 months** by jurisdiction, by year



Source: table 10A.58

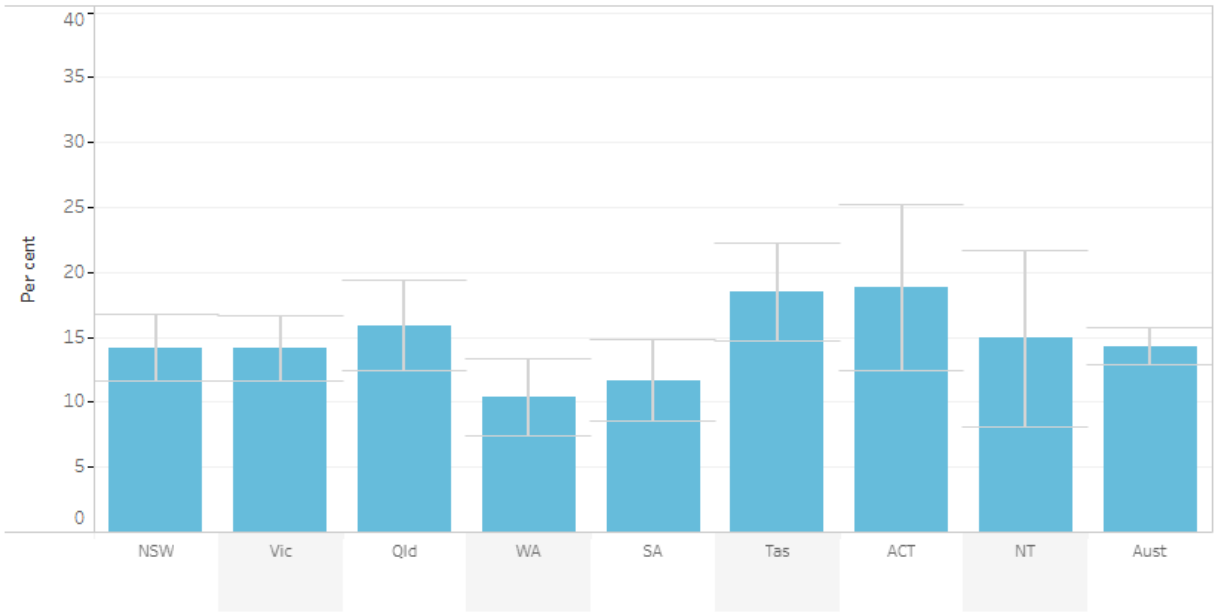
Nationally in 2019-20, 73.6 per cent of MBS subsidised GP management plans and team care assessment plans were reviewed — an increase from 70.8 per cent in 2016-17.

Figure 10.11b Measure 2: **Proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that a health professional helped coordinate their care and that this coordination of care helped to a large extent, 2019-20**
by jurisdiction



Source: tables 10A.59

Figure 10.11c Measure 3: **Proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that issues were caused by a lack of communication between the health professionals, 2019-20**
by jurisdiction



Source: tables 10A.60

Nationally in 2019-20, the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that:

- a health professional helped coordinate their care and that this coordination of care helped to a large extent was 69.8 per cent
- issues were caused by a lack of communication between the health professionals was 14.3 per cent.

Workforce sustainability is an indicator of governments' objective to provide sustainable primary and community healthcare services. It is defined by two measures.

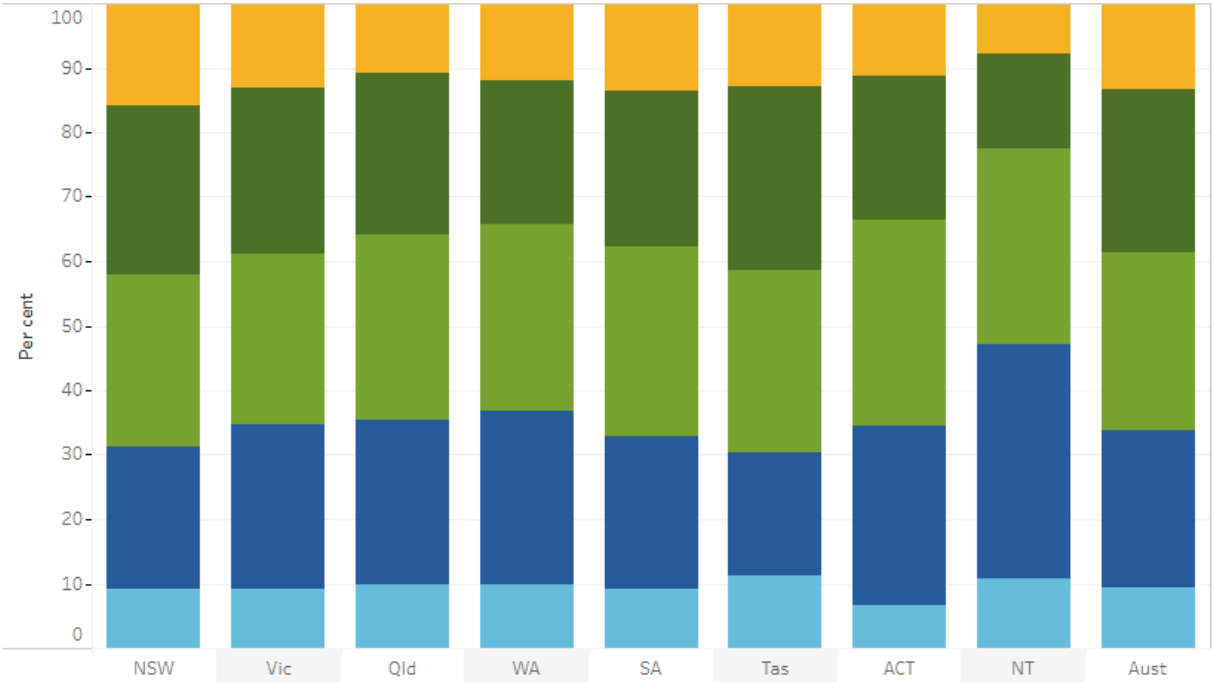
Measure 1: The proportion of full time equivalent (FTE) general practitioners in ten-year age brackets.
Measure 2: The attrition rate of FTE GPs who exit the workforce as a proportion of the number of FTE GPs by age bracket.

Guidance: 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.

Data are not comparable over time (data for 2018 and 2019 are not comparable to earlier years), but are comparable across jurisdictions (subject to caveats).

Data are complete (subject to caveats) for the current reporting period.

Figure 10.12 Measure 1: **Full time equivalent proportions of General practitioners, 2019** by jurisdiction, across age brackets



Source: table 10A.61

Nationally in 2019, 38.6 per cent of full time equivalent (FTE) general practitioners were aged 55 years or older, compared to 9.4 per cent who were less than 35 years of age.

Table 10.4 Measure 2: **Attrition rate of General practitioners, 2019**
by jurisdiction, by age

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<35 years old	na	na	na	na	na	na	na	na	2.2
35-44 years old	na	na	na	na	na	na	na	na	1.0
45-54 years old	na	na	na	na	na	na	na	na	0.5
55-64 years old	na	na	na	na	na	na	na	na	0.9
65+ years old	na	na	na	na	na	na	na	na	3.0
Total	na	na	na	na	na	na	na	na	1.2

Source: table 10A.62
na Not available.

Nationally in 2019, the proportion of general practitioners who exited the GP workforce was 1.2 per cent, with the proportion highest for those 65 years and over.

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.

Measure: The cost to government of general practice per person in the population.

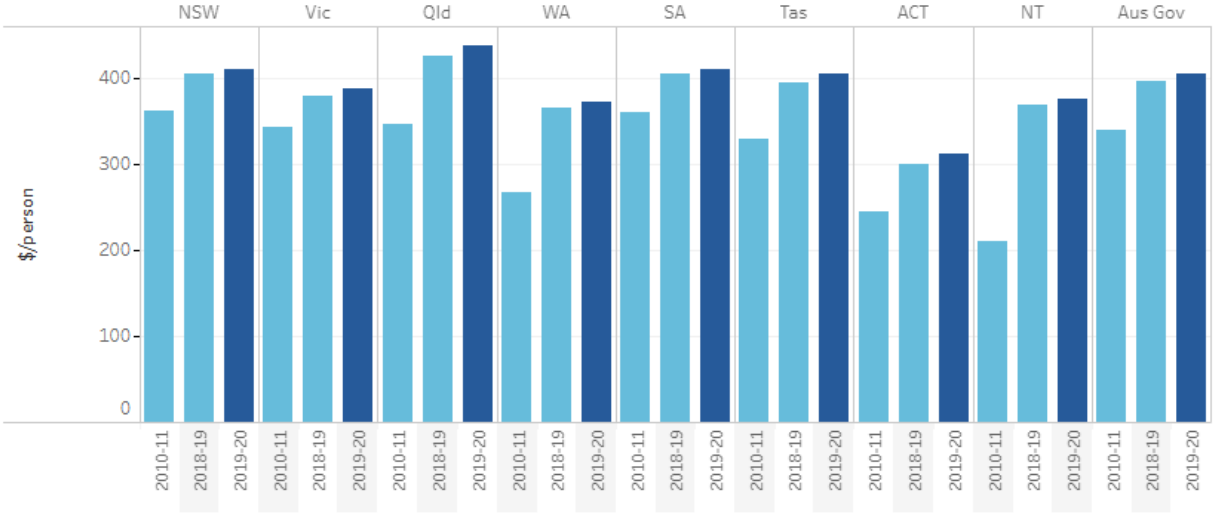
Guidance: This indicator should be interpreted with care. A low or decreasing cost per person can indicate higher efficiency, provided services are equally or more effective. It can also reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense.

- Data are comparable (subject to caveats) across jurisdictions, and over time from 2012-13.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):

(Multiple values)

Figure 10.13 **Australian Government Expenditure per person on GPs, 2019-20 dollars** by jurisdiction, by year



Source: table 10A.2

Nationally in 2019-20, total expenditure per person on general practice was $405 per person, increasing in real terms from $397 in 2018-19.

Notifications of selected childhood diseases is an indicator of governments' objective for primary and community health services to promote health and prevent illness.

Measure: 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.

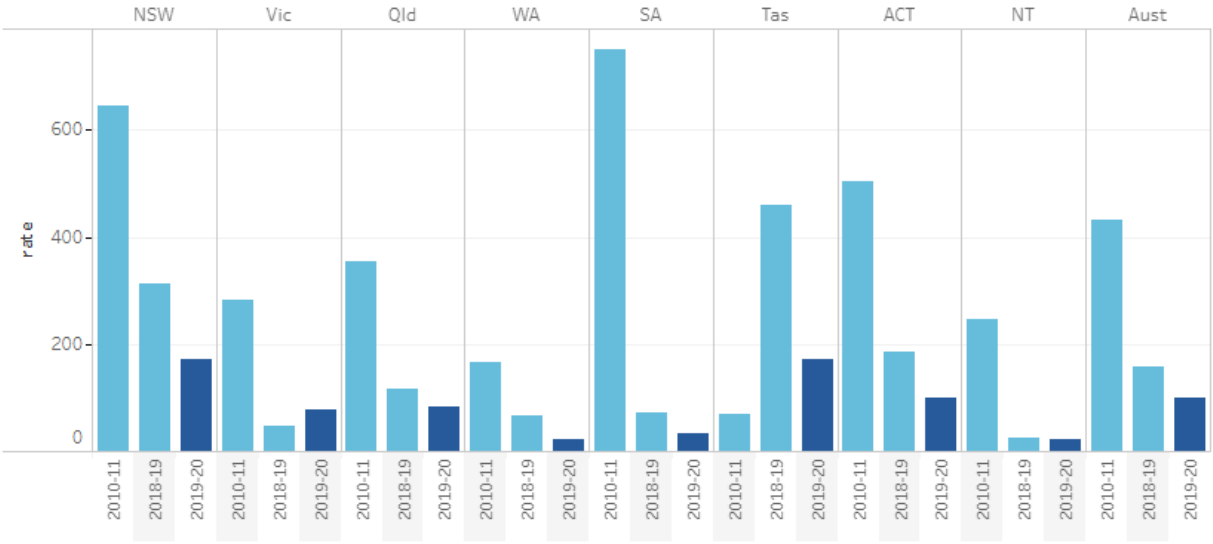
Guidance: A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):
(Multiple values)

Select disease:
- ○ Invasive haemophilus influenzae type b
- ○ Measles
- ◉ Pertussis (whooping cough)

Figure 10.14 **Notifications of selected childhood diseases & Notifications of selected childhood diseases; children aged 0-14 years, Pertussis (whooping cough), Notifications per 100 000 children**
by jurisdiction, by year



Source: table 10A.63
Some rates are suppressed where the numerator is less than 5.

Nationally in 2019-20, the rate of notifications for children aged 0–14 years was:
- 0.1 per 100 000 for Haemophilus influenzae type b
- 0.9 per 100 000 for measles
- 100.9 per 100 000 for pertussis (whooping cough).

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.

The indicator 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.

Measure 1: Selected vaccine preventable, acute and chronic conditions.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Measure 2: For diabetes (Type 2 diabetes mellitus as principal diagnosis).

- Data are not comparable across jurisdictions or within some jurisdictions over time (see footnotes for specific jurisdictions).
- Data are complete (subject to caveats) for the current reporting period.

Guidance: 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.

Select year (applies to table 10.5):
2018-19

Select Indigenous Status:
- (•) All people
- ( ) Aboriginal and Torres Strait Islander
- ( ) Non-Indigenous and unknown Indigenous status

Table 10.5 Measure 1: **Separations for selected potentially preventable hospitalisations, 2018-19 (age standardised Rate per 1000 people)**
by jurisdiction, by condition

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Vaccine preventable	2.2	2.3	2.5	2.6	2.8	1.4	1.5	11.4	2.4
Acute	11.2	11.6	16.6	13.0	12.9	11.5	10.2	27.0	12.9
Chronic	10.5	13.3	14.2	11.1	11.0	13.0	7.7	24.9	12.2
Total	23.6	27.0	33.0	26.4	26.4	25.8	19.4	61.4	27.3

Source: tables 10A.64
np Not published.

Nationally in 2018-19, the age standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 27.3 per 1000 people.

For both Aboriginal and Torres Strait Islander people and other Australians, the age-standardised rates have increased over the 10 years of data in this Report, with the rate for Aboriginal and Torres Strait Islander people around three times the rate for other Australians.

Table 10.6 Measure 2: **Separations for Type 2 diabetes mellitus as principal diagnosis, 2018-19 (age standardised rate per 100 000 people)**

by jurisdiction, by complication

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Circulatory	21.4	15.4	15.5	24.9	17.0	np	np	np	18.5
Multiple	29.3	59.5	47.4	41.3	42.8	np	np	np	44.7
No complications	5.6	8.2	6.7	3.5	9.3	np	np	np	6.6
Ophthalmic	5.6	9.0	11.9	25.3	5.9	np	np	np	9.8
Other specified	39.8	46.5	53.6	41.0	50.9	np	np	np	45.7
Renal	3.9	2.8	4.3	3.1	3.1	np	np	np	3.6
Total	105.8	141.4	139.4	139.1	128.9	np	np	np	129.1

Source: table 10A.72

np Not published.

Nationally in 2018-19, the age-standardised hospital separation rate for diabetes was 129.1 separations per 100 000 people. 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.71).

The most serious complication of Type 2 diabetes most commonly leading to hospitalisation in 2018-19 was circulatory complications, with an age standardised rate of 18.5 per 100 000 people. Serious circulatory complications of diabetes can necessitate lower limb amputation. In 2018-19, there were 20.0 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.74).

Refer to the interpretative material for detailed indicator interpretation, definitions and caveats, www.pc.gov.au/rogs

Data tables are referenced above by a '10A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

Indigenous Data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section are available in the data tables listed below. Contextual data and further supporting information can be found in the section.

Primary and community health data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 10A.17	Approved providers of PBS medicines by PhARIA area at 30 June
Table 10A.18	Approved providers of PBS medicines by geolocation, at 30 June
Table 10A.24	Annual health assessments for older people by Indigenous status (per cent)
Table 10A.25	Aboriginal and Torres Strait Islander people who received a health check or assessment, by age (per cent)
Table 10A.33	Median waiting time for public dental care, NSW (days)
Table 10A.34	Median waiting time for public dental care, Victoria (days)
Table 10A.35	Median waiting time for public dental care, Queensland (days)
Table 10A.36	Median waiting time for public dental care, WA (days)
Table 10A.37	Median waiting time for public dental care, SA (days)
Table 10A.38	Median waiting time for public dental care, Tasmania (days)
Table 10A.39	Median waiting time for public dental care, ACT (days)

Table 10A.40	Median waiting time for public dental care, NT (days)
Table 10A.50	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.65	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 10A.67	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people)
Table 10A.68	Separations for selected vaccine preventable conditions by Indigenous status (per 1000 people)
Table 10A.69	Separations for selected acute conditions by Indigenous status (per 1000 people)
Table 10A.70	Separations for selected chronic conditions by Indigenous status (per 1000 people)
Table 10A.71	Ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes

Download supporting material

10 Primary and community health interpretative material (PDF - 508 Kb)

10 Primary and community health interpretative material (Word - 59 Kb)

10 Primary and community health data tables (XLSX - 976 Kb)

10 Primary and community health dataset (CSV - 1935 Kb)

See the interpretative material and corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).