Steering Committee for the Review of Government Service Provision

Report on Government Services 2025

Health (part E)

Produced by the Productivity Commission on behalf of the Steering Committee for the Review of Government Service Provision.

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.

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Publication enquiries:
Phone 03 9653 2244 | email publications@pc.gov.au

Report on Government Services 2025

PART E: RELEASED ON 6 FEBRUARY 2025

Produced by the Productivity Commission for the Steering Committee for Review of Government Service Provision. The content for this PDF is generated from the online, interactive publication. Data below are the most recent at the time of preparing the report. In some cases, charts and tables may present data for a single jurisdiction. To access data for all jurisdictions and the most current data available, go to: www.pc.gov.au/rogs

E Health

Data downloads

These data tables relate to the sector as a whole. Data specific to individual service areas is in the data tables under the relevant service area.

Health data tables (XLSX 437.9 KB)

Health dataset (CSV 1.1 MB)

Refer to the Sector overview text and corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Note: Data tables are referenced by table xA.1, xA.2, etc, with x referring to the section or overview. For example, table EA.1 refers to data table 1 for this sector overview.

Main aims of services within the sector

The main objective of the health sector is that Australians are born and remain healthy. To this end, health sector services seek to promote, restore and maintain a healthy society through the delivery of services that prevent illness, promote health, detect and treat illness and injury, rehabilitate and provide palliative care.

The health sector

In Australia, the health sector consists of four main services.

Primary and community health >

Primary and community health services aim to promote health, prevent illness and support people to manage their health issues in the community. These include general practice, pharmaceutical services, dentistry, allied health services, community health services, maternal and child health and alcohol and other drug treatment.

- **Total government real recurrent expenditure** on primary and community health services was **$50.3 billion** in 2022-23.
- There were **29,215** full-time equivalent (FTE) general practitioners (GPs), equating to 109.7 per 100,000 people nationally in 2023.
- Around **226 million services** were subsidised under Section 85 and Section 100 of the Pharmaceutical Benefits Scheme (PBS) in 2023-24.

Ambulance services >

Ambulance service organisations are the primary agencies involved in providing emergency medical care, pre-hospital and out-of-hospital care, and transport services.

- **Total government real recurrent expenditure** on ambulance services was **$5.9 billion** in 2023-24.
- **Total ambulance service organisation revenue** was **$5.6 billion** in 2023-24.
- There were **25,345** registered paramedics in Australia in 2023-24.
- There were **5.8 million ambulance responses to 4.4 million incidents** in 2023-24.

Public hospitals >

Public hospitals aim to alleviate or manage illness and the effects of injury by providing acute, non and sub-acute care along with emergency and outpatient care.

- **Total government real recurrent expenditure** on public hospitals (excluding depreciation) was **$96.1 billion** in 2022-23.
- There were **700 public hospitals** in Australia in 2022-23, comprising **65,051 public hospital beds** (equivalent to 2.5 beds per 1,000 people).
- **Approximately 7.1 million separations** from public (non-psychiatric) hospitals in 2022-23.

Services for mental health >

Services for mental health aim to promote mental health and wellbeing, and where possible prevent the development of mental health problems; and when mental health problems and illness do occur, reduce their impact.

- **Total government real recurrent expenditure** allocated to mental health services was **$12.6 billion** in 2022-23.
- A further **$5.3 billion** was provided to support people with a significant and enduring primary psychosocial disability through the National Disability Insurance Scheme (NDIS) in 2022-23.
- **12.6 million Medicare-subsidised services** for mental health were provided in Australia in 2023-24. This includes Medicare-subsidised mental health services provided by primary and community health providers, state and territory government specialised mental health services and non-government services providing community-based support.

Detailed information on the equity, effectiveness and efficiency of service provision and the achievement of outcomes for the primary and community health, ambulance services, public hospitals, and mental health services is contained in the service-specific sections.

Government expenditure in the sector

Total government recurrent expenditure for **health services** for the latest years covered in this report was **$152 billion.**

For the **2022-23** financial year (the most recent financial year for which data are available across all sections) this represented 40.7% **of total government expenditure** covered in this report.

As much of the expenditure on services for mental health is already captured in public hospital and primary and community health expenditure, it is not included in the health sector expenditure total to avoid double counting.

Flows in the sector

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings that do not have a clearly defined path (figure E.1).

Figure E.1 Client flow within the Australian health care system

Sector-wide data

This overview provides selected population health insights across four themes:

- Babies born of low birthweight
- Selected potentially preventable diseases
- Life expectancy

- Mortality rates.

Babies born of low birthweight

In 2022, **5.1%** of babies born in Australia were of low birthweight (table EA.1). Nationally, the proportion of babies born of low birthweight to Aboriginal and Torres Strait Islander mothers was more than twice that for babies born to non-Indigenous mothers (figure E.2).

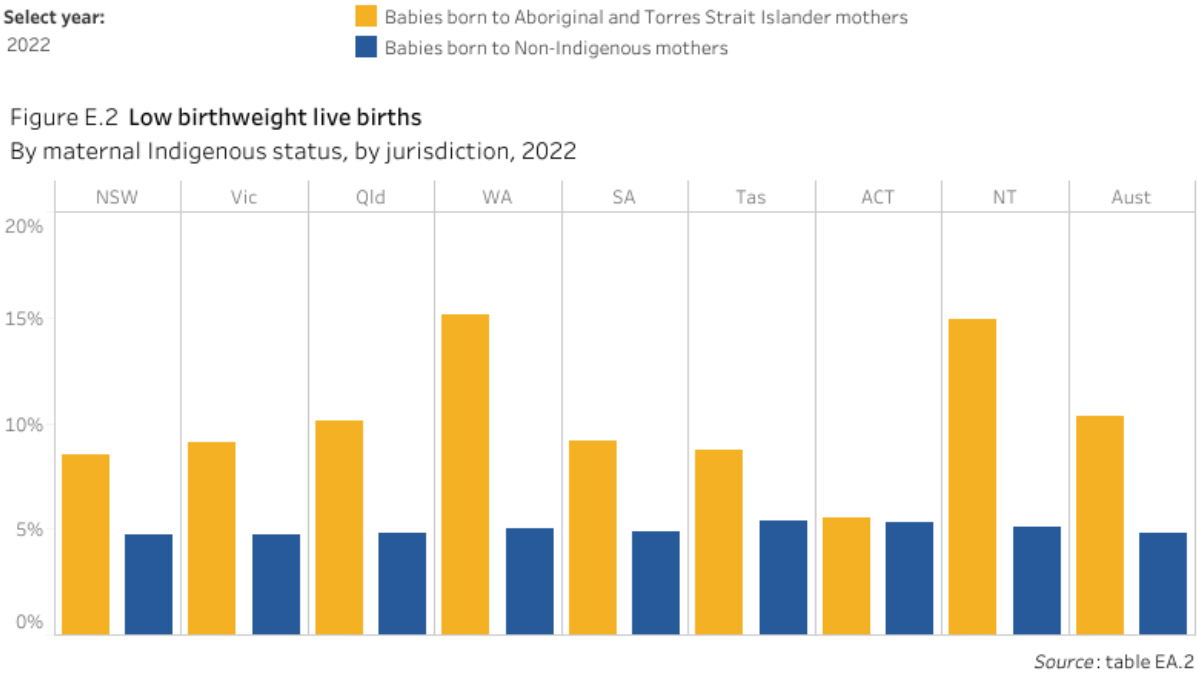


Figure E.2 **Low birthweight live births**
By maternal Indigenous status, by jurisdiction, 2022

Source: table EA.2

Data tables are referenced above by a 'EA' prefix and all data (footnotes and data sources) is available for download from above (in Excel and CSV format).

Further information on the historical and ongoing context for Aboriginal and Torres Strait Islander people is available on the Closing the Gap Information Repository website – Target 2

Selected potentially preventable diseases

Selected potentially preventable diseases are diseases that could potentially have been prevented through the provision of health interventions and early disease management. Diseases covered in this report include selected cancers, heart attacks and type 2 diabetes.

- Nationally in 2021, the age standardised rate of new cases of selected cancers was highest for **female breast cancer** (**123.3 per 100,000 females**), followed by **melanoma**, **bowel cancer** and **lung cancer** (**49.1, 47.7** and **40.9 per 100,000 people**, respectively) and lowest for cervical cancer (**7.1 per 100,000 females**) (table EA.11).
- Nationally in 2022, the age standardised **rate of heart attacks** (acute coronary events) was **266.9 cases per 100,000 people** aged 25 years or over (table EA.14). The national rate has decreased each year over the 10 years included in this report. The rate for females is less than half the rate for males.
- Nationally in 2022, an estimated **4.5% of adults** had **type 2 diabetes** (table EA.16).

Life expectancy

Historically, life expectancy has risen steadily over time but has decreased in recent years. In 2021–23, life expectancy at birth was **81.1 years** for males and **85.1 years** for females – slightly lower than 2020–22 (table EA.20). The life expectancy of Aboriginal and Torres Strait Islander people is considerably lower than that of other people, with a life expectancy at birth of **71.9 years for Aboriginal and Torres Strait Islander males** and **75.6 years for Aboriginal and Torres Strait Islander females** born between 2020–22 (table EA.21).

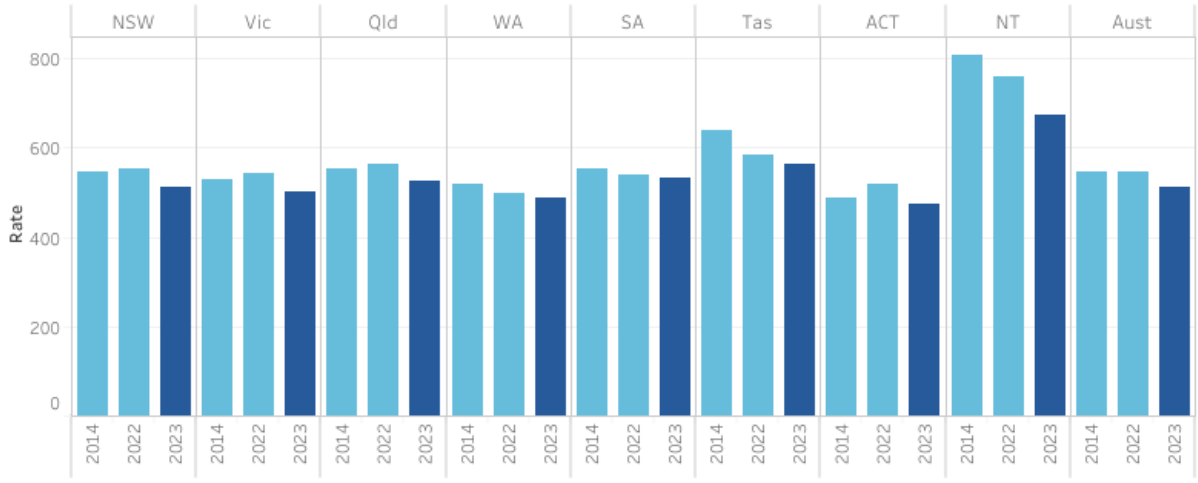
Further information on the historical and ongoing context for Aboriginal and Torres Strait Islander people is available on the Closing the Gap Information Repository website – Target 1

Mortality rates

The national age standardised mortality rate was **512.9 deaths per 100,000 people** in 2023 – a decrease from 2022 (figure E.3). In line with life expectancy data, mortality rates are higher for Aboriginal and Torres Strait Islander people compared to non-Indigenous people (table EA.23).

Select year(s):
Multiple values

Figure E.3 **Mortality rates**
Per 100,000 people, age standardised, by jurisdiction, by year



Source: table EA.22

Data tables are referenced above by a 'EA' prefix and all data (footnotes and data sources) is available for download from above (in Excel and CSV format).

tableau

Child mortality

Mortality data is separately reported for children as follows:

- Registered perinatal deaths, comprising fetal deaths (stillbirths) and neonatal deaths (death of an infant within 28 days of birth)
- Registered infant deaths (children aged less than 1 year)
- Registered infant and child deaths (children aged 0–4 years).

Registered perinatal, infant and child deaths data are sourced from the Australian Bureau of Statistics (ABS) Causes of Death collection, which is based on information from births, deaths, and marriage registrars. Further information on hospital recorded perinatal deaths is available

from the Australian Institute of Health and Welfare (AIHW) National Perinatal Mortality Data Collection (2024).

Nationally, in 2023:

- there were **8.2 registered perinatal deaths per 1,000 births** (table EA.32), of which around 72.2% were fetal deaths and the remainder neonatal deaths (table EA.30–31)
- the **average infant mortality rate was 3.2 registered deaths per 1,000 live births** (table EA.26). Over the past 10 years, the average infant mortality rate has ranged from 3.1 (2016 and 2018) to 3.4 (2014) registered deaths per 1,000 live births.

The Australian infant and child combined mortality rate (3-year average) has decreased over time from 82.5 deaths per 100,000 population in 2012–14 to 74.5 deaths per 100,000 population in 2021–23 (table EA.28).

Causes and prevention

The most common causes of death among all Australians in 2023 were neoplasms (cancer) and circulatory diseases (including heart disease, heart attack and stroke) (table EA.24). Data by Indigenous status is available in table EA.25.

There is potential to prevent some deaths through individualised care and/or to treat health conditions through existing primary or hospital care.

- Nationally, there were **97.2 potentially avoidable deaths per 100,000 people** in 2023 – a decrease on 2022 (101.8 per 100,000 people) (table EA.17).
- The rate of potentially avoidable deaths in 2019–23 for **Aboriginal and Torres Strait Islander people was 301.0 per 100,000 people** – the highest rate over the reported time series (since 2017–21) and more than three times the rate for other Australians (94.5) (table EA.18).

Data on key risk factors affecting population health outcomes (including overweight or obesity, smoking and risky alcohol consumption) are available in tables EA.3–10. In summary, nationally in 2022:

- **33.7% of adults were overweight**, while **31.1% were obese** – a decrease and increase, respectively, since 2017-18. Additionally, 19.5% of children aged 5–17 years were overweight, while 8.3% were obese – an increase since 2017-18 (table EA.3).
- **10.7% of Australians reported that they were current daily smokers**, the lowest proportion recorded in the time series (since 2007-08) (table EA.6).
- **12.9% of Australians exceeded the alcohol lifetime risk guidelines** (as defined by the 2009 National Health and Medical Research Council [NHMRC] guidelines) – the lowest proportion recorded in the time series (since 2007-08) (table EA.8).

Performance outcomes summary

A summary of the primary and community health, ambulance services, hospitals and mental health services performance indicator results are presented. Detailed information is in the service-specific sections.

10 Primary and community health

- **Delaying seeing a GP or filling a prescription due to affordability concerns has become more common.**
  Nationally in 2023-24:
  - 8.8% of respondents who needed to see a GP reported that they delayed or did not see a GP in the last 12 months due to cost, the highest over the reported time series. This proportion is an increase on 2022-23 (7.0%) and continues a year-on-year increase since 2020-21 when the proportion was 2.4%
  - 8.0% of respondents who needed a prescription for medication reported that they delayed filling or did not fill a prescription in the last 12 months due to cost, the highest over the reported time series. This proportion is an increase on 2022-23 (7.6%) and continues a year-on-year increase since 2020-21 when the proportion was 4.4%.

- **Breast cancer screening rates have not returned to pre-pandemic levels.**
  The national age-standardised BreastScreen participation rate for women aged 50–74 years for 2022–2023 was 51.2%, an increase from 2021–2022 (49.5%). While screening rates have increased, they have not returned to pre-pandemic levels (54.2% in 2018–2019).
  - For 2022–2023, the participation rate for Aboriginal and Torres Strait Islander women aged 50–74 years was 35.8%, also an increase from 2021–2022 (33.5%), although notably lower than the screening rates for all women.

- **Workforce sustainability measures have deteriorated.**
  Nationally in 2023:
  - 26.6% of FTE GPs were aged 60 years or older, compared to 1.5% who were less than 30 years of age. This is the equal highest proportion of GPs aged 60 years or older and the lowest proportion of GPs who were less than 30 years old across the reported nine-year time series
  - the proportion of GPs who exited the GP workforce was 1.4%, with the proportion highest for those 60 years and over (2.7%) – the highest since 2019 (when this statistic was first reported).

More information: section 10 Primary and community health

11 Ambulance services

- **Ambulance response times across Australia improved for the majority of jurisdictions compared to previous years.**
  All jurisdictions except the Northern Territory and Tasmania recorded shorter response times compared to previous years. In 2023-24:
  - the time within which 90% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations ranged from 16.7 minutes (Australian Capital Territory) to 36.0 minutes (Tasmania) state-wide
  - for the Northern Territory, the time within which 90% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations increased from 25.7 minutes in 2022-23 to 31.1 minutes in 2023-24, state-wide
  - the time within which 50% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations ranged 9.9 minutes (Western Australia and Australian Capital Territory) to 14.9 minutes (Tasmania) state-wide.

- **Nationally, the proportion of patients who reported a clinically meaningful pain reduction was the lowest recorded.**
  'Pain management' is defined as the proportion of patients who report a clinically meaningful reduction in pain severity. Patients who refuse pain medication are excluded from reporting. Nationally in 2023-24:
  - the proportion of patients who reported clinically meaningful pain reduction at the end of ambulance service treatment was 82.5%. This continues a year-on-year decrease since 2019-20 and is the lowest recorded proportion over the 10-year time series.

- **Nationally, cardiac arrest survival rates improved compared to the prior year.**
  'Cardiac arrest survival rate' is defined as the proportion of adult patients (aged 16 years and over) who were in out-of-hospital cardiac arrest and returned to spontaneous circulation (that is, the patient had a pulse) on arrival at hospital. Nationally, in 2023-24:
  - the cardiac arrest survival rate for paramedic witnessed cardiac arrests was 49.3% nationally (up from 45.8% in 2022-23)
  - the cardiac arrest survival rate for non-paramedic witnessed cardiac arrests where resuscitation was attempted was 25.3% (up from 23.5% in 2022-23).

More information: section 11 Ambulance services

12 Public hospitals

- **Almost all category 1 patients were seen within clinically appropriate timeframes. However, the proportion of patients seen within clinically appropriate timeframes across all triage categories remains lower than it has been over the time series.**
  In 2023-24:
  - all category 1 patients (need for resuscitation) were seen within clinically appropriate timeframes in New South Wales, Victoria, Queensland and Tasmania, but 2% in South Australia, 1% in Western Australia and the Australian Capital Territory and 20% in the Northern Territory were not seen immediately.
  - the proportion of category 2 patients (emergency) seen within 10 minutes was 67% – a decrease over the past 10 years from 79% in 2014-15
  - for all triage categories combined, an estimated 67% of patients were seen within triage category timeframes – a decrease over the past 10 years from 74% in 2014-15.

- **Waiting times for admitted patients have shown some improvements but they remain higher than they have been over the time series.**
  In 2023-24:
  - 50% of patients were admitted within 46 days (down from 49 days in 2022-23) and 90% of patients were admitted within 329 days (down from 361 days in 2022-23). While showing some improvement in recent years, waiting times for admitted patients remain notably higher than they were ten years ago (35 days for 50% of patients and 253 days for 90% of patients in 2014-15)
  - 31% of people who presented to an emergency department and were admitted, waited four hours or less to be admitted to a public hospital; consistent with results for 2022-23 and notably lower than the proportion in 2019-20, which was 46%).

- **Adverse events continue to occur across Australian public hospitals at a similar rate.**
  'Adverse events treated in hospitals' are incidents in which harm resulted to a person during hospitalisation and are measured by separations that had an adverse event (including infections, falls resulting in injuries and problems with medication and medical devices) that occurred during hospitalisation.
  - Nationally in 2022-23, 6.4% of separations in public hospitals had an adverse event reported during hospitalisation (equivalent to the result for 2021-22).

- **Workers aged 60 years and over, and workers aged under 40 years, make up an increasing proportion of the nursing and medical practitioner workforces.**
  Nationally, across all areas in 2023:
  - 8.4% of the FTE nursing workforce was aged 60 years and over. Since 2014, the proportion of nurses and midwives aged under 40 years of age has increased by 11.4 percentage points
  - the attrition rate for nurses and midwives was 28.9% (a decrease from 31.0% in 2022)
  - the proportion of the medical practitioner workforce aged 60 years and over across all areas was 5.8%. Unlike the nursing workforce, the proportion of the medical practitioner workforce aged under 40 years has remained around 61% since 2014
  - the attrition rate for medical practitioners was 22.9% (a decrease from 26.6% in 2014).

More information: section 12 Public hospitals

13 Services for mental health

- **Delaying seeing a mental health professional due to affordability concerns has become more common.**
  Nationally, in 2023-24, 20.4% of all respondents delayed seeing any mental health professional in the last 12 months due to cost, continuing a year on year increase over the available time series (up from 12.0% in 2020-21).
  - Respondents were almost two and a half times as likely to report delaying mental health care due to cost for psychologists, psychiatrists and other mental health professionals (24.6%) than for GPs (10.3%).

- **The proportion of mental health-related presentations to emergency departments that were seen within clinically recommended waiting times has decreased.**
  - Nationally, in 2022-23, 59.0% of people who presented to an emergency department with a mental health-related care need were seen within clinically recommended waiting times, 9.0 percentage points less than in 2016-17.

- **Follow-up rates after psychiatric admission/hospitalisation have improved over the past decade.**
  - Nationally, the rate of community follow-up for people within the first seven days of discharge from an acute inpatient psychiatric unit was 76.2% in 2022-23, an increase over the 10 years from 2013-14 (67.4%).

More information: section 13 Services for mental health

References

AIHW (Australian Institute of Health and Welfare) 2024, *National Perinatal Mortality data collection,* https://www.aihw.gov.au/about-our-data/our-data-collections/national-perinatal-mortality-data-collection-npmdc (accessed 18 October 2024).

Report on Government Services 2025

PART E, SECTION 10: RELEASED ON 6 FEBRUARY 2025

10 Primary and community health

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 is also available in CSV format.

Data downloads

10 Primary and community health data tables (XLSX 905.6 KB)

10 Primary and community health dataset (CSV 2.7 MB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF288.5 KB)

Context

Objectives for primary and community health

Primary and community health services aim to promote health, prevent illness and 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 the 'Explanatory material' tab.

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 Services Australia – mainly as fee-for-service payments via the Medicare Benefits Schedule (Medicare) – and the Department of Veterans' Affairs (DVA). Additional funding is provided to influence the supply, regional distribution and quality of general practice services, and support engagement of the health workforce in primary health care settings, through initiatives such as the Practice Incentives Program (PIP), the Workforce Incentive Program (WIP), and Primary Health Networks (PHNs) (Services Australia 2021). State and territory governments also provide some funding for such programs, mainly to influence the availability of General Practitioners (GPs) in rural and remote areas. The remainder comes primarily from insurance schemes (for example, workers compensation schemes and traffic accident schemes that cover medical expenses in certain circumstances) 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 69% of PBS prescriptions dispensed in 2022-23 were above the co-payment threshold, meaning patients paid the relevant co-payment and the remaining cost was subsidised by the Australian Government. Around 31% of PBS prescriptions dispensed in 2022-23 were under the co-payment threshold, meaning the patient paid the full cost with no government subsidy (AIHW unpublished). 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 (Department of Health and Aged Care 2021).

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 and Federal Funding 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). Data on dental service expenditure in 2023-24 is presented in table 10A.6.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, 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 Medicare to patients with particular needs – for example, people with chronic conditions and complex care needs. The Australian Government also funds the Workforce Incentive Program (WIP) – Practice Steam, which supports general practices, Aboriginal Medical Services and Aboriginal Community Controlled Health Services with the cost of engaging eligible allied health professionals. Data on the number of Medicare rebated allied health services used per person and the availability of public allied health professionals by region is presented in tables 10A.10 and 10A.22, respectively.

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 by funding local health services and community organisations. 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. The Australian Government is primarily responsible for serving Aboriginal and Torres Strait Islander communities, with state and territory governments also providing 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 health and development. 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 withdrawal management, pharmacological treatment, counselling and rehabilitation. Selected data on these services is available in table 10A.13.

Funding

In 2022-23, of the $50.3 billion government recurrent expenditure on primary and community health services, almost three-quarters was funded by the Australian Government and one-quarter by state, territory and local governments (table 10A.1). This included:

- $11.8 billion for community health services (18.3% by the Australian Government and 81.7% by state, territory and local governments)
- $2.4 billion for dental services (57.7% by the Australian Government and 42.3% by state, territory and local governments) (table 10A.6).

Where more recent data is available, for 2023-24, Australian Government expenditure was:

- $12.2 billion on general practice (table 10A.2)
- $18.1 billion through the PBS and RPBS on Section 85 prescription medicines filled at pharmacies (table 10A.3)
- $55.8 million on funding of PBS medicines to Aboriginal and Torres Strait Islander primary health services in remote and very remote areas (table 10A.5)
- $909.0 million on Aboriginal and Torres Strait Islander primary health services (table 10A.7).

Size and scope

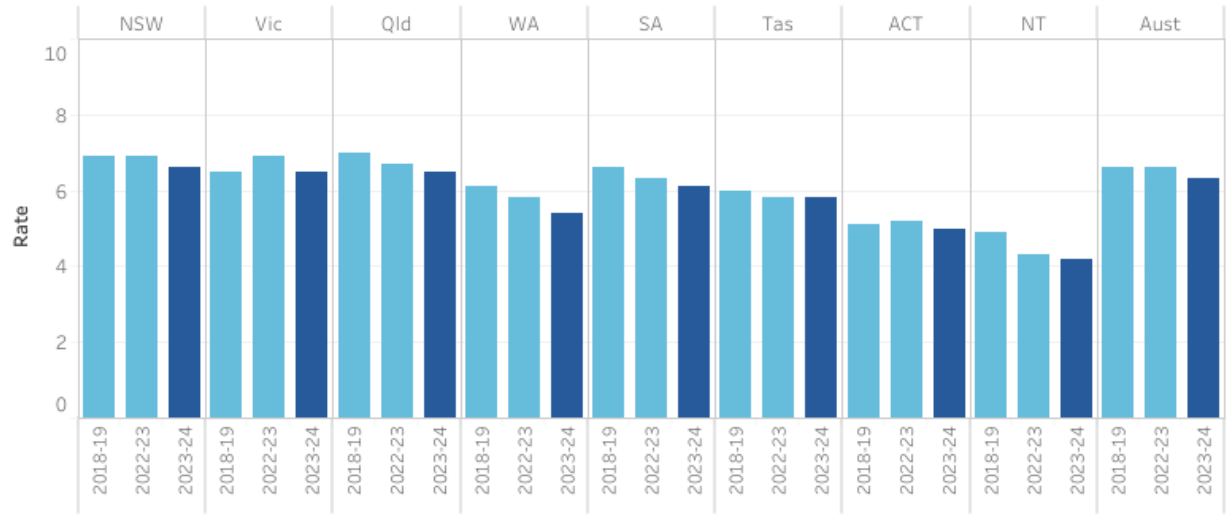
Nationally in 2023, there were 39,449 GPs – 29,215 on a full-time equivalent (FTE) basis, equating to 109.7 GPs per 100,000 people (table 10A.8), a decrease from 115.2 in 2022 (table 10A.8).

Nationally, rates of GP-type services used per person decreased between 2022-23 (6.6 services per person) and 2023-24 (6.3 services per person) (table 10A.9). GP-type services disaggregated by in-person attendances and telehealth appointments are reported in table 10A.9. Nationally in 2023-24, 1.0 telehealth GP-type service was used per person (figure 10.1).

Select year(s):
Multiple values

Select appointment type:
Total
Telehealth appointment
In-person attendance

Figure 10.1 **GP-style service use**
Per person, Total, by jurisdiction, by year (a)



Source: table 10A.9

(a) Data disaggregated by in-person attendances and telehealth appointments is not available prior to 2019-20.

Data tables are referenced above by a '10A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Around 226 million services (8.4 per person) were subsidised under Section 85 of the PBS in 2023-24 – with 87.8% concessional. A further 7 million services were subsidised under the RPBS (tables 10A.11–12).

Nationally in 2022-23 there were:

- 213 Aboriginal and Torres Strait Islander primary health services which provided 3.7 million episodes of healthcare (table 10A.14). Data by remoteness is presented in table 10A.15 and health service staffing numbers are provided in table 10A.16.
- 1,280 alcohol and other drug treatment agencies (31.0% identified as government providers) with a reported 235,461 closed treatment episodes (26.8% identified as government provided) (table 10A.13).

The most recent available data on public dental service usage is for 2013 and showed that nationally, around 97.8 per 1,000 people accessed public dental services that year (AIHW unpublished).

Indicator framework

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

The performance indicator framework shows which data is complete and comparable in this report. For data that is 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 contextual information for this service area (refer to Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

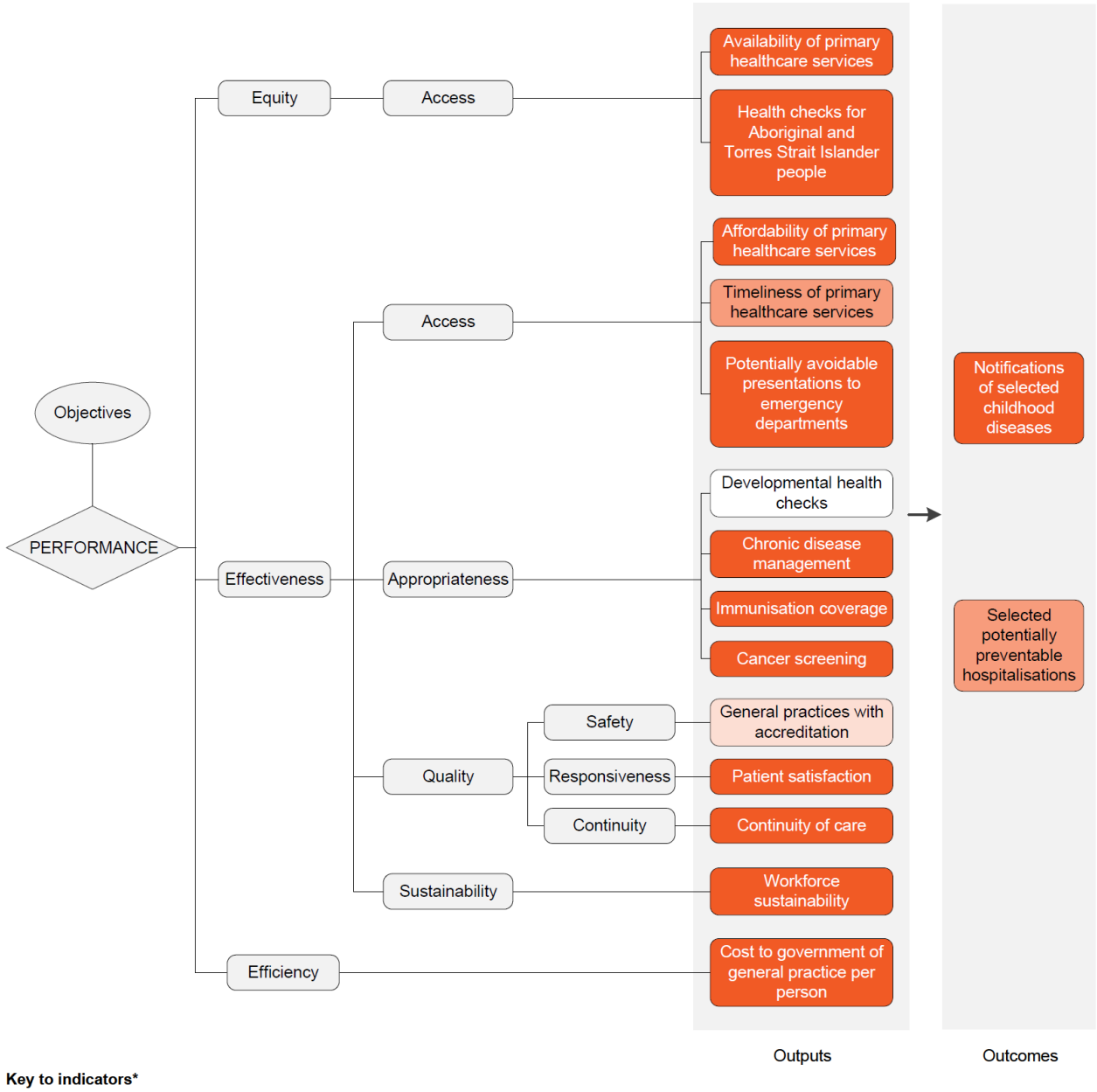
Improvements to performance reporting for primary and community health services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (refer to 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 (refer to section 1).



Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Availability of primary healthcare services – most recent data for all measures is comparable and complete
- Health checks for Aboriginal and Torres Strait Islander people – most recent data for all measures is comparable and complete

Effectiveness – Access

- Affordability of primary healthcare services – most recent data for all measures is comparable and complete
- Timeliness of primary healthcare services – most recent data for at least one measure is comparable and complete
- Potentially avoidable presentations to emergency departments – most recent data for all measures is comparable and complete

Effectiveness – Appropriateness

- Developmental health checks – no data reported and/or no measures yet developed
- Chronic disease management – most recent data for all measures is comparable and complete
- Immunisation coverage – most recent data for all measures is comparable and complete
- Cancer screening – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- General practices with accreditation – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Quality – Responsiveness

- Patient satisfaction – most recent data for all measures is comparable and complete

Effectiveness – Quality – Continuity

- Continuity of care – most recent data for all measures is comparable and complete

Effectiveness – Sustainability

- Workforce sustainability – most recent data for all measures is comparable and complete

Efficiency

- Cost to government of general practice per person – most recent data for all measures is comparable and complete

Outcomes

- Notifications of selected childhood diseases – most recent data for all measures is comparable and complete
- Selected potentially preventable hospitalisations – most recent data for at least one measure is comparable and complete

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section presents an overview of 'Primary and community health' performance indicator results. 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 this data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a '10A' prefix (for example, table 10A.1).

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.

1. 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.

'Availability of primary healthcare services' is defined by four measures:

- Access to approved suppliers of PBS medicines, defined as the ABS Census or ERP divided by the number of approved suppliers of PBS medicines, by metropolitan/rural and remote location under the Modified Monash Model (MMM) classification
- GPs by region, defined as the number of FTE GPs per 100,000 people, by region
- GPs by sex, defined as the number of FTE GPs per 100,000 people, by sex
- Public dentists by region, defined as the number of FTE public dentists per 100,000 people (based on clinical hours worked in the public sector), by region.

A similar rate across regions is desirable as it indicates equity of access by location. A similar rate by sex is desirable as it means patients who prefer to visit GPs of their own sex are more likely to have their preference met. A low rate of GPs of either sex could be associated with increased waiting times to see a GP for patients who prefer to visit GPs of their own sex.

Measures on GPs by region and sex, and public dentists by region do not provide information on whether people are accessing services or whether the services are appropriate for the needs of the people receiving them.

> Measure 1: Nationally, at 30 June 2024, there were 4,317 people per approved PBS provider in metropolitan areas and 3,255 people per approved PBS supplier in rural and remote areas (figure 10.2a). The number of people per approved PBS provider in metropolitan areas has decreased each year over the past four years after reaching a high of 4,449 people per approved PBS provider in 2020. The number of people per approved PBS provider in rural and remote areas has decreased each year over the available time series (3,410 people per approved PBS provider in rural and remote areas in 2017) (table 10A.18). Data is also available for pharmacy suppliers only (table 10A.18) and by MMM area (table 10A.17).

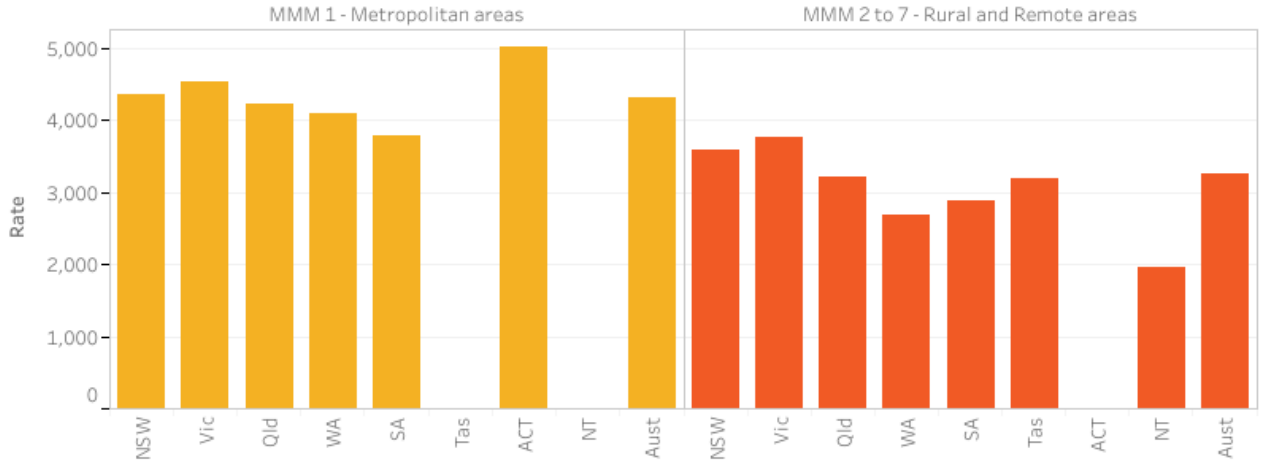
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
2024

MMM 1 - Metropolitan areas
MMM 2 to 7 - Rural and Remote areas

Figure 10.2a Measure 1: **Availability of primary healthcare services (approved suppliers of PBS medicines)**
Number of people per approved PBS supplier, by MMM area, by jurisdiction, At 30 June 2024 (a)



Source: table 10A.18

(a) Tasmania and the NT have no metropolitan areas under the classification used. The ACT has no rural and remote areas under the classification used.

Measures 2–3: Nationally in 2023, the number of FTE GPs per 100,000 people decreased as remoteness increased (111.8 GPs per 100,000 people in major cities compared to 87.3 GPs per 100,000 people in outer regional, remote and very remote areas) (table 10A.19). Nationally in 2023, there were 92.4 FTE female GPs per 100,000 females and 127.2 FTE male GPs per 100,000 males (figure 10.2b).

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

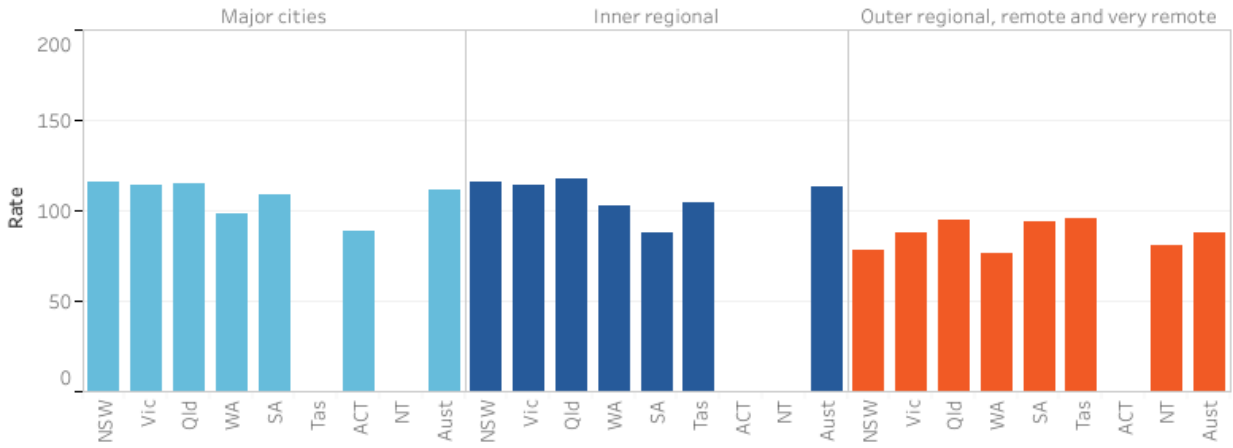
Data is complete (subject to caveats) for the current reporting period.

Select year:
2023

Select measure:
Sex
Region

Major cities
Inner regional
Outer regional, remote and very remote

Figure 10.2b Measures 2-3: **Full-time equivalent GPs**
Per 100,000 people, by Region, by jurisdiction, 2023 (a)



Source: table(s) 10A.19

(a) 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.

tableau

Measure 4: Nationally in 2023, the rate of FTE public dentists per 100,000 people was higher in remote and very remote areas (6.0 per 100,000 people) compared to other areas (between 4.4–5.4 per 100,000 people) (figure 10.2c). Data on FTE public dentists and allied dental practitioners are presented in table 10A.22.

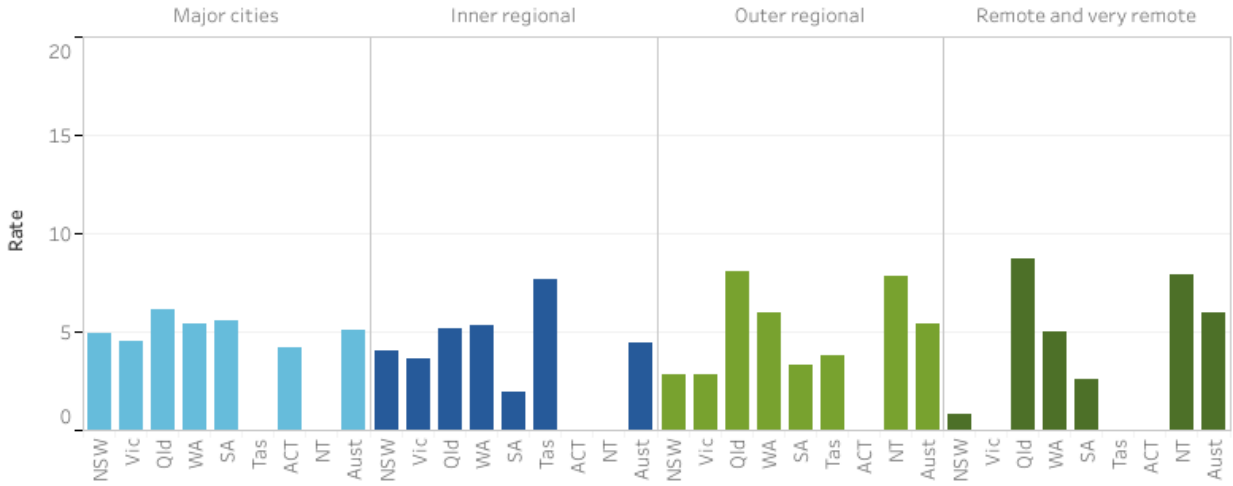
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
2023

Major cities
Inner regional
Outer regional
Remote and very remote

Figure 10.2c Measure 4: **Full-time equivalent public Dentists** per 100,000 people, by Region, by jurisdiction, 2023 (a)



Source: table 10A.22

(a) Victoria has no very remote areas; 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.

2. Health checks for Aboriginal and Torres Strait Islander people

'Health checks 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.

'Health checks for Aboriginal and Torres Strait Islander people' is defined as the number of Aboriginal and Torres Strait Islander people who had an Aboriginal and Torres Strait Islander-specific Medicare health check, by assessment location divided by the number of Aboriginal and Torres Strait Islander people. The measure is presented as a rate per 1,000 people.

An increase over time in the proportion of Aboriginal and Torres Strait Islander people who received a health check is desirable as it indicates improved access to these services.

This indicator provides no information about health checks provided outside 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 health check services.

> Nationally in 2023-24, 251.3 per 1,000 Aboriginal and Torres Strait Islander people had an Indigenous-specific health check, reversing the downward trend from the peak in 2018-19 (255.8 per 1,000 people) (figure 10.3). Nationally in 2023-24, Aboriginal and Torres Strait Islander people mainly received Indigenous-specific health checks at health facilities or residential aged care (99%), with 1% obtaining checks via telehealth.

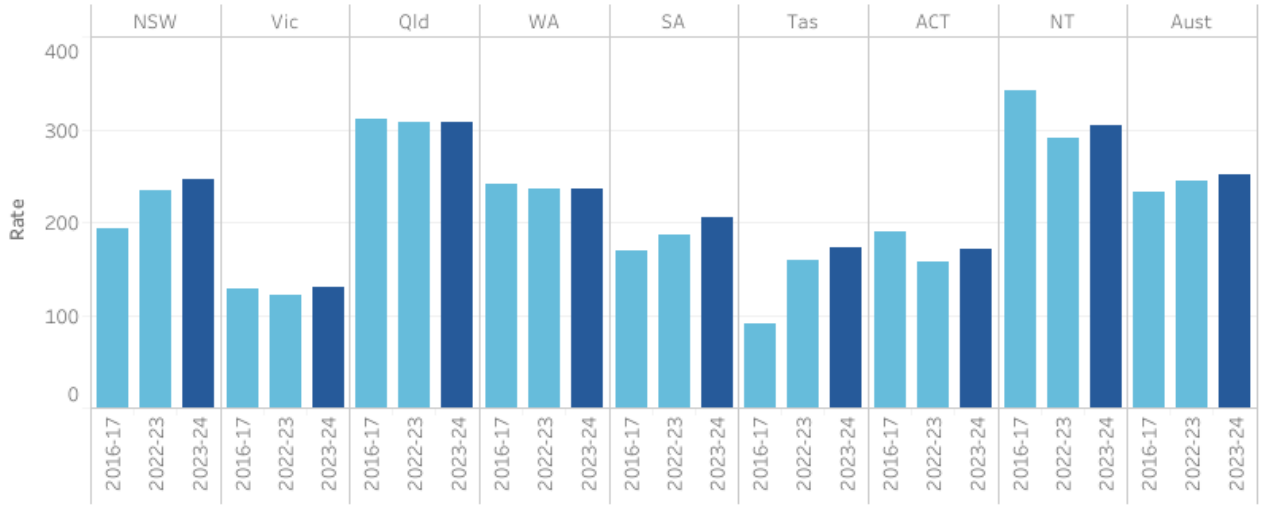
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
Multiple values

Select location:
All locations
Health facility and residential aged care
Telehealth

Figure 10.3 **Aboriginal and Torres Strait Islander people who had Aboriginal and Torres Strait Islander-specific health checks or assessments, All locations**
Rate per 1,000 people, by jurisdiction, by year



Source: table 10A.23

Data by age group is reported in table 10A.25.

3. Affordability of primary healthcare services

'Affordability of primary healthcare services' is an indicator of governments' objective to provide primary healthcare services that are affordable.

'Affordability of primary healthcare' is defined by two measures:

- People delaying or not seeing a GP due to cost, defined as the proportion of people who delayed seeing or did not see a GP when needed at any time in the previous 12 months due to cost
- People delaying or not filling prescription medication due to cost, defined as the proportion of people who delayed filling or did not fill a prescription when needed at any time in the previous 12 months due to cost.

A low or decreasing proportion of people deferring visits to GPs or filling prescription medication due to cost indicates more widely affordable access to GPs and medicines.

Data is sourced from the ABS Patient Experience Survey (PEx) of people aged 15 years or over. The PEx does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

Measure 1: Nationally in 2023-24, 8.8% of respondents who needed to see a GP reported that they delayed or did not see a GP in the last 12 months due to cost, the highest proportion across the time series and continuing a year-on-year increase since 2020-21 when the proportion was 2.4% (figure 10.4a).

Contextual information on bulk-billing and out-of-pocket costs are provided to assist interpretation of this indicator. Bulk billing information is available for both patients and services (one patient may have more than one service in a given year). Bulk billing rates for non-referred GP and specialist services, by jurisdiction, region and age are available in tables 10A.27-30.

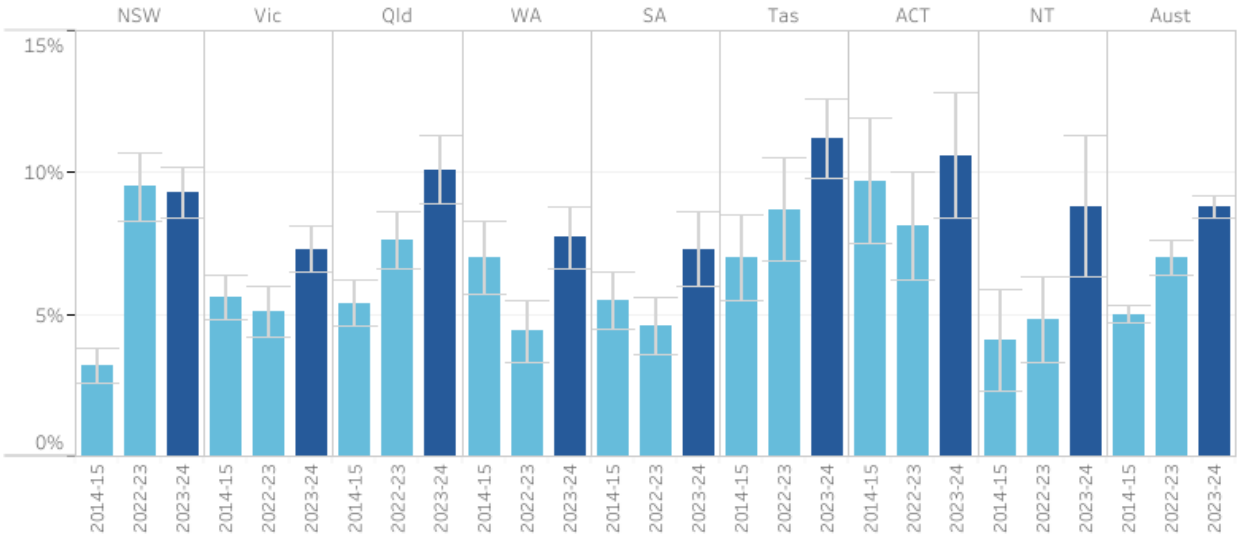
Nationally in 2023-24, 77.3% of non-referred GP services and 28.7% of specialist services were bulk billed. Information on the proportion of non-referred GP patients who were fully bulk billed are available in table 10A.31. Nationally in 2023-24, 47.7% of patients were fully bulk billed, a decrease from 51.7% in 2022-23. Data on average patient out-of-pocket costs are reported in table 10A.32. Nationally in 2023-24, out-of-pocket costs were highest for specialists ($117), followed by allied health services ($68) and non-referred GPs ($45).

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

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

Select year(s):
Multiple values

Figure 10.4a Measure 1: **People who delayed or did not see a GP due to cost**
By jurisdiction, by year



Source: table 10A.26

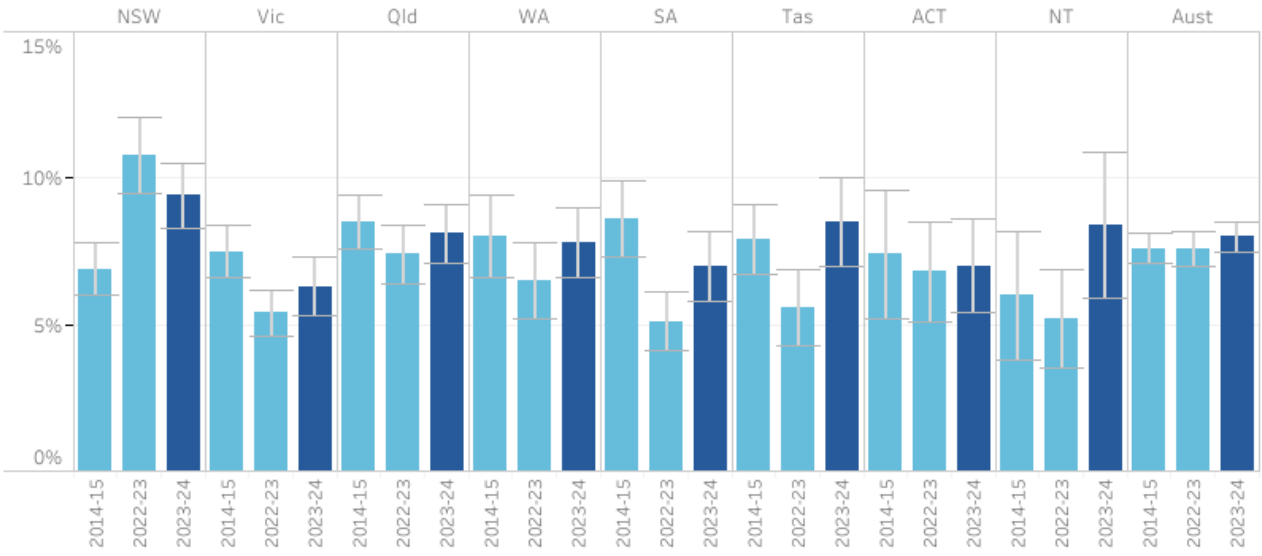
Measure 2: Nationally in 2023-24, 8.0% of respondents who needed a prescription for medication reported that they delayed filling or did not fill a prescription in the last 12 months due to cost, the highest proportion across the time series and continuing a year-on-year increase since 2020-21 when the proportion was 4.4% (figure 10.4b).

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

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

Select year(s):
Multiple values

Figure 10.4b Measure 2: **People who delayed or did not get prescription medication when needed due to cost**
By jurisdiction, by year



Source: table 10A.33

4. 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.

'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 four hours, four 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 four hours for urgent medical care indicates more timely access to GPs.

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 who access the service but pay full price. Data is reported by Aboriginal and Torres Strait Islander status, remoteness area of residence, and Socio-Economic Indexes for Areas (SEIFA) of residence.

Data is sourced from the ABS Patient Experience Survey (PEx) of people aged 15 years or over. The PEx does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the estimated resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

> Measure 1: 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 (figure 10.5a).

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory for 2022-23 is not available.

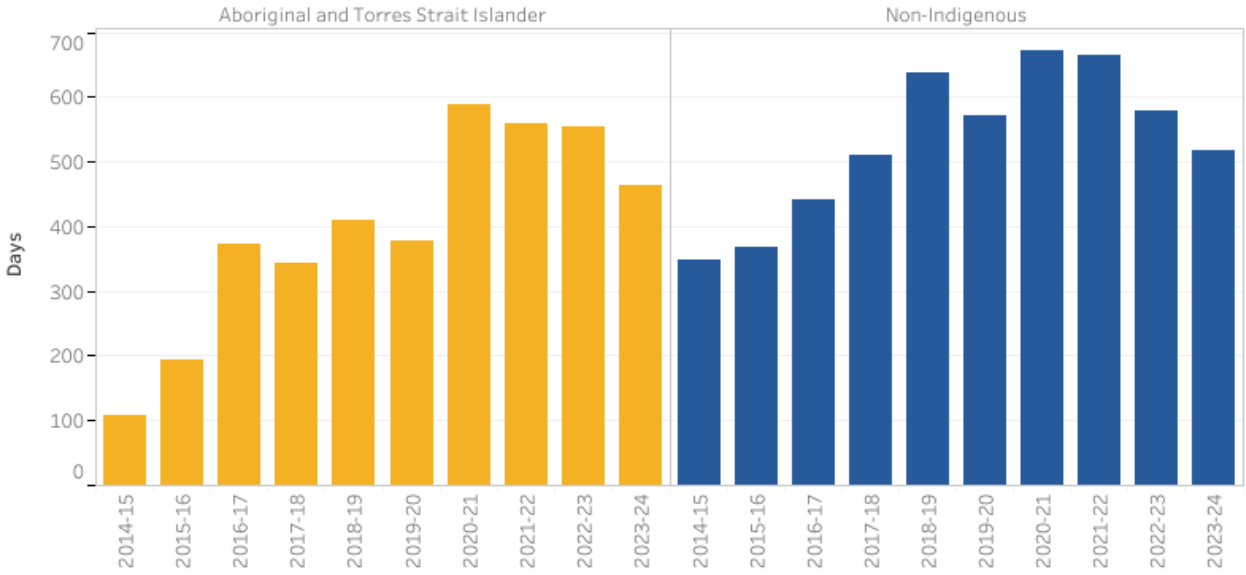
Select jurisdiction:
Qld

Select measure:
- ○ Days waited at the 90th percentile
- ◉ Days waited at the 50th percentile

Select equity group:
- ◉ Indigenous status
- ○ Remoteness area of residence
- ○ SEIFA of residence

- Aboriginal and Torres Strait Islander
- Non-Indigenous

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



Source: tables 10A.35–42

(a) Data is not available for NSW (all years prior to 2020-21), Vic (for 2016-17), the ACT (for 2022-23, 2014-15 and 2013-14) and the NT (all years except 2020-21, 2019-20 and 2017-18). (b) Refer to data tables 10A.35–42 for information on non-publication of data on Indigenous status, remoteness or Socio-Economic Indexes for Areas (SEIFA) for individual jurisdictions.

Measure 2: Nationally in 2023-24, for people who saw a GP for urgent care:

- 41.7% waited less than four hours, similar to 2022-23 (41.5%) although a notable decrease from 63.9% in 2014-15
- 12.5% waited from four to less than 24 hours, similar to 2022-23 (12.7%) and a slight increase from 2014-15 (11.1%)
- 46.0% waited for 24 hours or more, similar to 2022-23 (45.6%) although a notable increase from 25.0% in 2014-15 (figure 10.5b).

Overall, nationally, in 2023-24, 28.0% of people who saw a GP for their own health waited longer than they felt was acceptable to get an appointment, a decrease on 2022-23 (29.6%), although a notable increase across the time series (20.8% in 2014-15) (table 10A.44).

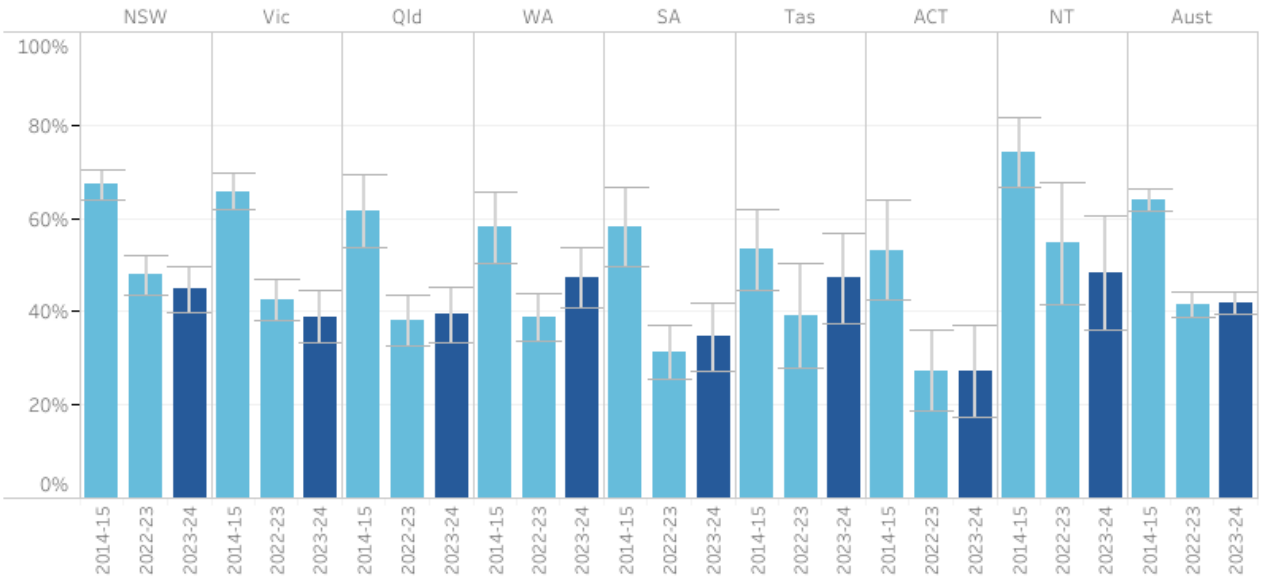
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year(s):
Multiple values

Waiting times:
- (●) Less than four hours
- ( ) Four to less than 24 hours
- ( ) 24 hours or more

Figure 10.5b Measure 2: **GP waiting times for urgent medical care**
Less than four hours, by jurisdiction, by year



Source: table 10A.43

5. Potentially avoidable presentations to emergency departments

'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.

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 and
- 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.

Once a suitable denominator for this measure is agreed, a low or decreasing rate or proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care. Currently, the *number* of potentially avoidable presentations to emergency departments are reported for this indicator. In future, this indicator will be reported as a *proportion* (for example, the number of potentially avoidable GP-type presentations to emergency departments, as a proportion of all presentations to emergency departments), subject to the identification of a suitable denominator.

> Nationally, in 2023-24, there were around 2.8 million GP-type presentations to public hospital emergency departments, similar to 2022-23 (table 10.1). Results varied across jurisdictions.

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

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

Select year(s):
Multiple values

Table 10.1 **Selected potentially avoidable GP-type presentations to emergency departments**
Number of presentations, by jurisdiction, by year

	2014-15	2022-23	2023-24
NSW	1,060,202	1,153,836	1,162,130
Vic	615,857	564,886	546,434
Qld	435,856	418,250	415,139
WA	331,795	357,442	357,143
SA	166,003	184,519	181,725
Tas	61,079	54,742	54,481
ACT	55,753	46,025	46,522
NT	54,832	67,452	67,475
Aust	2,781,377	2,847,152	2,831,049

Source: table 10A.34

6. 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.

‘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.

This indicator is currently under development for reporting in the future.

7. 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 individuals throughout their lifespan.

‘Chronic disease management’ is defined by two measures:

- Rate of chronic disease care services (under Team Care Arrangements (TCAs) and GP Management Plans (GPMPs))
- Management of asthma, defined as the proportion of people with asthma who have a written asthma action plan.

Measure 1 focuses on patients who had a GPMP prepared or a TCA co-ordination service. These are the two most commonly used Medicare items for people with a chronic or terminal medical condition. Claiming patterns of chronic disease management services vary by demographic characteristics, jurisdiction, remoteness and socio-economic areas. Medicare data does not give a comprehensive picture of actual service delivery and data does not include chronic disease care services provided under other arrangements that do not attract a Medicare subsidy.

For measure 2, data is sourced from the ABS National Health Survey (NHS). The NHS does not include people living in very remote areas and discrete Indigenous communities, which affects the representativeness of the Northern Territory results for the asthma measure. Approximately 20% of the estimated resident population of the Northern Territory live in very remote areas and discrete Indigenous communities as of 2020-21.

A high or increasing proportion for each measure is desirable.

Measure 1: Nationally in 2023-24, the rate of patients claiming for GPMP services was 123.4 per 1,000 people. The rate of patients claiming for TCAs was 106.8 per 1,000 people (Figure 10.6a).

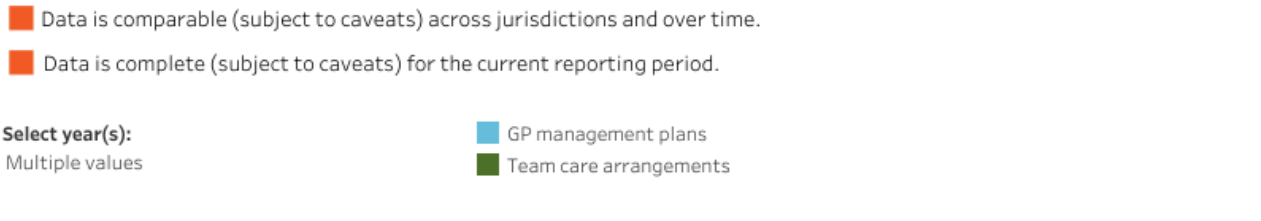
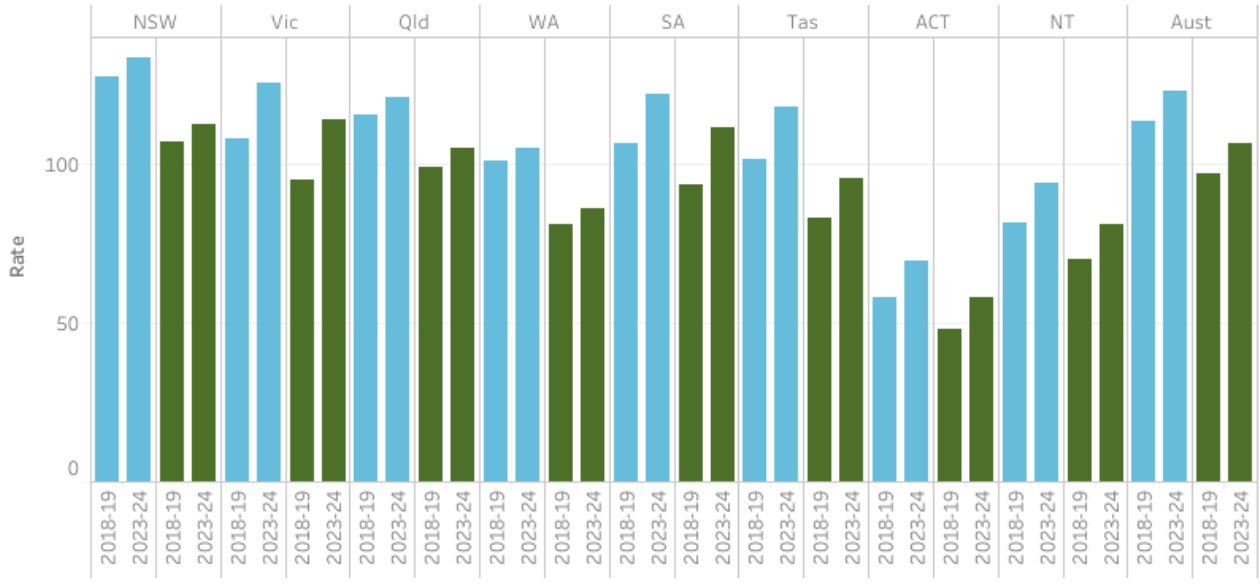


Figure 10.6a Measure 1: **Chronic disease care services**
Per 1,000 people, GP management plans & Team care arrangements, by jurisdiction, by year



Source: table 10A.45

Measure 2: Nationally in 2022, the age-standardised proportion of people with asthma reporting that they have a written asthma action plan was 35.4% (figure 10.6b), compared to 32.3% in 2017-18. In all jurisdictions, the proportion was higher for children aged 0–14 years than for other age groups (nationally, 71.5%) (table 10A.46).

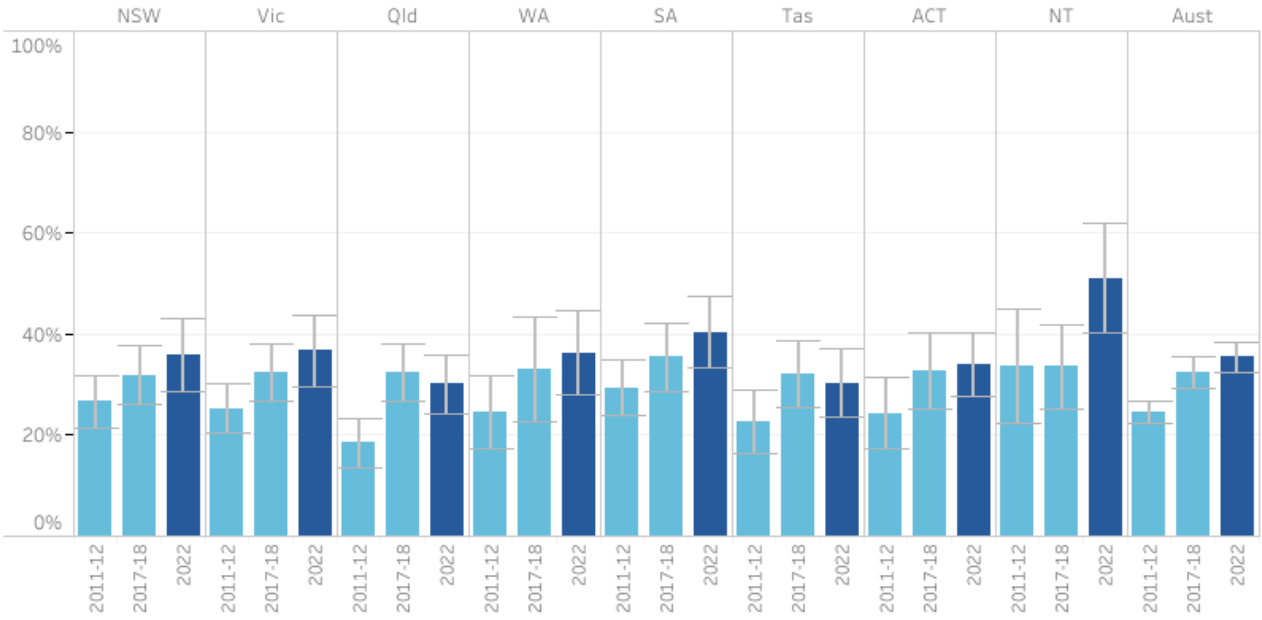
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year(s):
Multiple values

Select age group:
All ages

Figure 10.6b Measure 2: **People with asthma with a written asthma action plan**
All ages, by jurisdiction, by year (a), (b)



Source: table 10A.46

(a) Data is not published for some age groups for some jurisdictions. (b) Data for 'all ages' is age-standardised.

Biomedical data on the management of diabetes is available in earlier reports.

8. 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 life span and communities.

'Immunisation coverage' is defined by four measures:

- Proportion of children aged 12 months to less than 15 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, *Haemophilus influenzae* type b and pneumococcal)
- Proportion of children aged 24 months to less than 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, varicella and pneumococcal)
- Proportion of children aged 60 months to less than 63 months who are fully immunised (at this age, against diphtheria, tetanus, pertussis (whooping cough) and polio)

- Proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.

High or increasing proportions of immunisation coverage are desirable.

Measures 1–3: Nationally, the proportion of children fully immunised in 2023-24 was: 92.8% for children aged 12 to less than 15 months; 91.1% for children aged 24 to less than 27 months; and 93.8% for children aged 60 to less than 63 months (figure 10.7a). Contextual data on vaccinations supplied to children aged under 7 years, by type of provider is reported in table 10A.47.

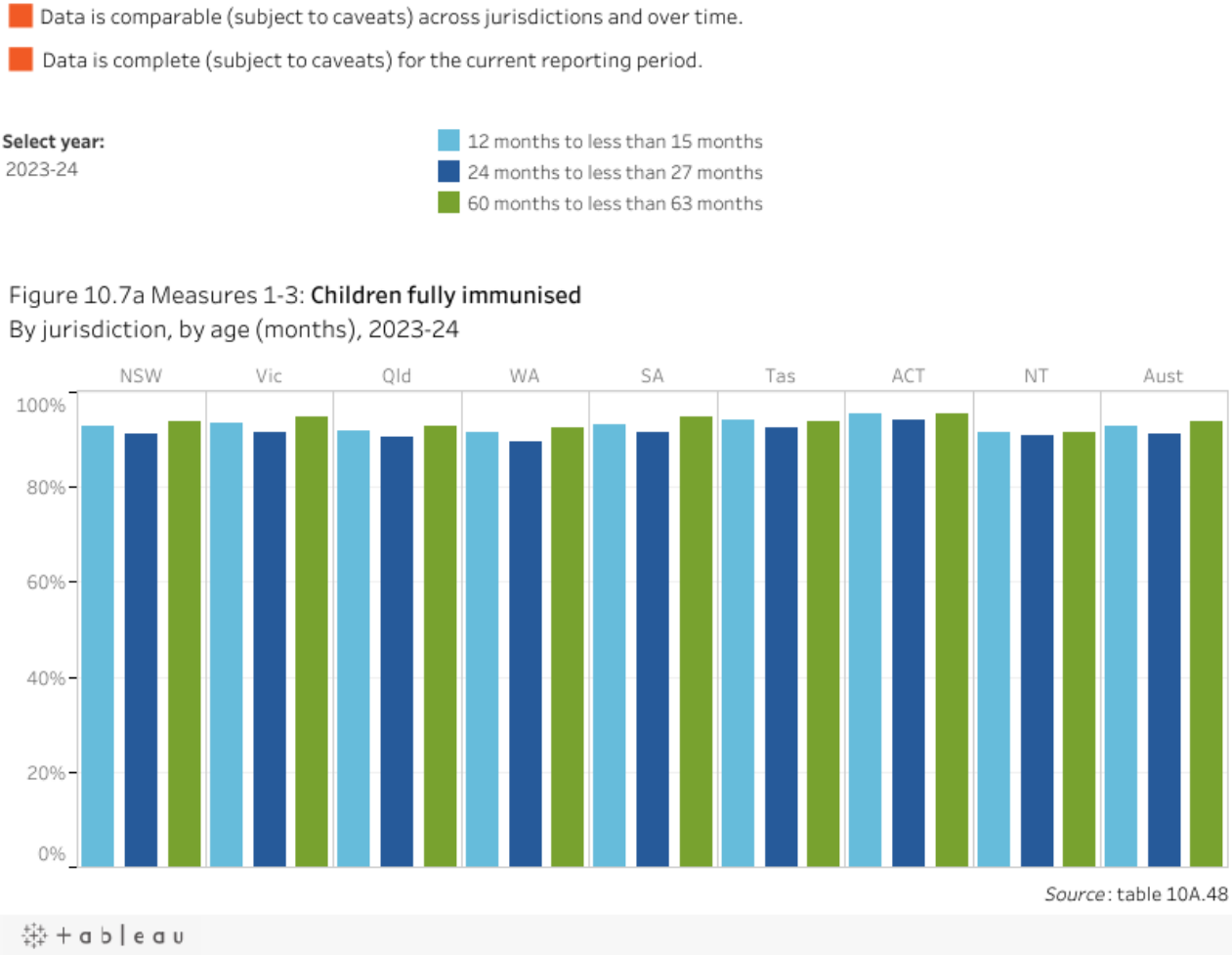


Figure 10.7a Measures 1-3: **Children fully immunised**
By jurisdiction, by age (months), 2023-24

Measure 4: Nationally in 2024, 57.9% of people aged 65 years or over were vaccinated against seasonal influenza, with the proportion slightly higher for non-Indigenous people (57.9%) compared to Aboriginal and Torres Strait Islander people (56.4%) (figure 10.7b).

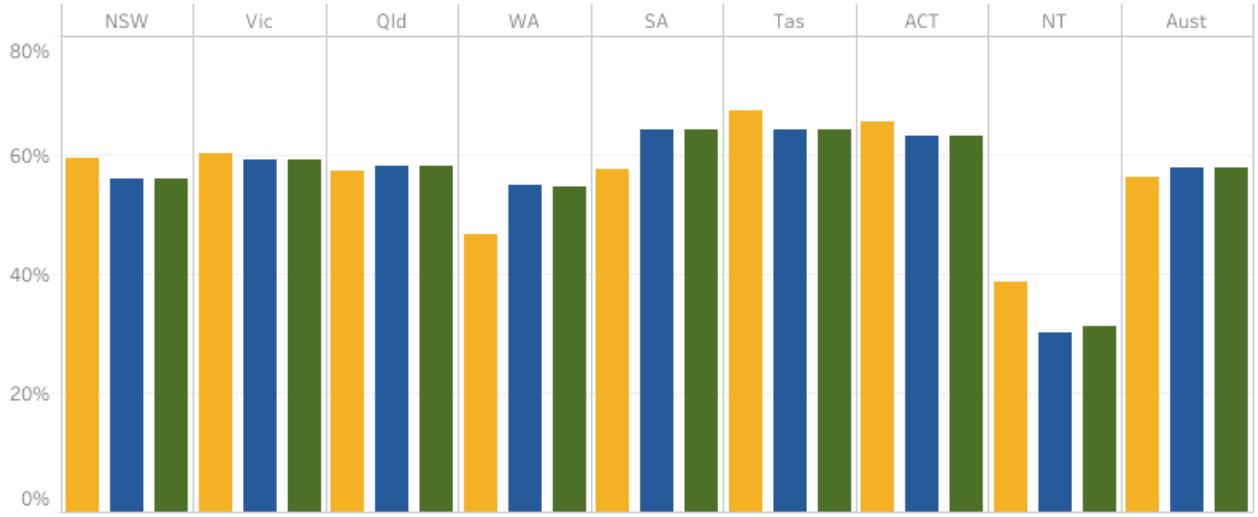
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
2024

Aboriginal and Torres Strait Islander people
Non-Indigenous people
All people

Figure 10.7b Measure 4: **Population 65+ years old vaccinated against influenza**
By jurisdiction, by Indigenous status, 2024



Source: table 10A.49

9. 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 life span and communities.

'Cancer screening' is defined by three measures:

- Participation in breast cancer screening, defined as the proportion of women aged 50–74 years who were screened in the BreastScreen Australia Program over a 24-month period
- Participation in cervical screening, defined as the number of participants aged 25–74 years screened in a five-year period as a percentage of eligible females in the population.
- Participation in bowel cancer screening, defined as people 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 six 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 screening participation rates are desirable.

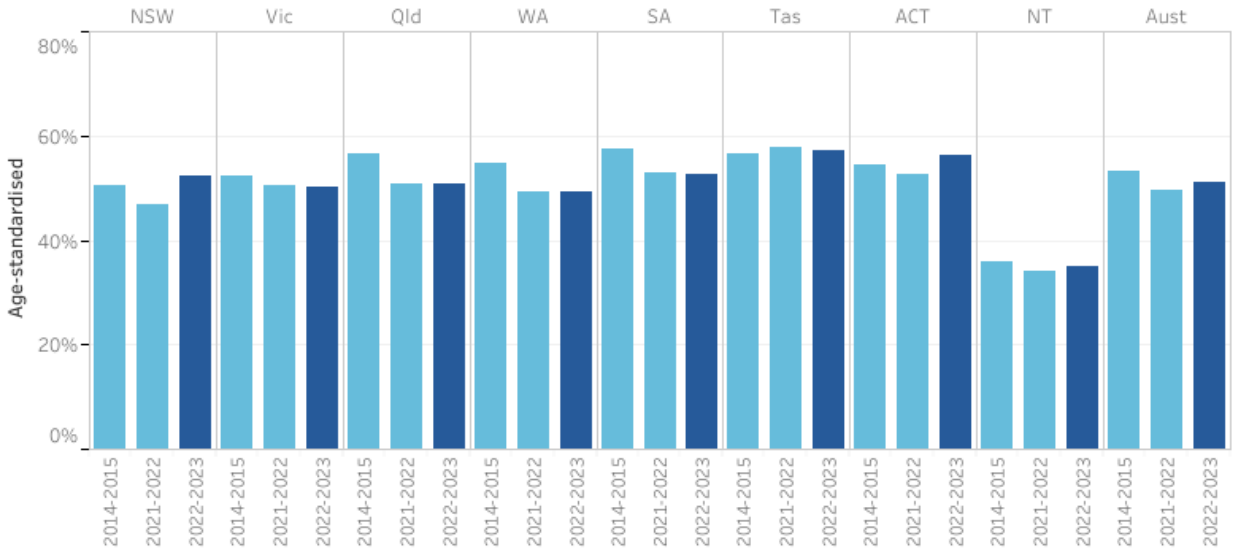
Measure 1: The national age-standardised BreastScreen participation rate for women aged 50–74 years for 2022–2023 was 51.2% (figure 10.8a), an increase from 2021–2022 (49.5%). While screening rates have increased, they have not returned to pre-pandemic levels (54.2% in 2018-2019). For 2022–2023, the participation rate for Aboriginal and Torres Strait Islander women aged 50–74 years was 35.8%, also an increase from 2021–2022 (33.5%). However, this was lower than the screening rates for all women; a trend consistent across the available time series (table 10A.51).

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

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

Select year(s):
Multiple values

Figure 10.8a Measure 1: **Participation of women in BreastScreen Australia**
50-74 years old, by jurisdiction, by 24-month period



Source: table 10A.50

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Measure 2: For the five-year period 2019–2023, the national age-standardised participation rate in cervical cancer screening for people aged 25–74 years was 63.5% (table 10.3).

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

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

Table 10.3 Measure 2: **Participation in the National Cervical Screening Program, by age group**
25-74 years old, by jurisdiction, by year (% (AS))

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2019-2023	61.8	66.0	62.3	63.6	64.3	64.0	66.5	64.1	63.5
2018-2022	67.5	70.2	67.8	68.7	70.2	69.1	71.1	67.2	68.6

Source: table 10A.52
AS = Age-standardised

Data collected under the previous cervical cancer screening program (to June 2017) is available in earlier reports.

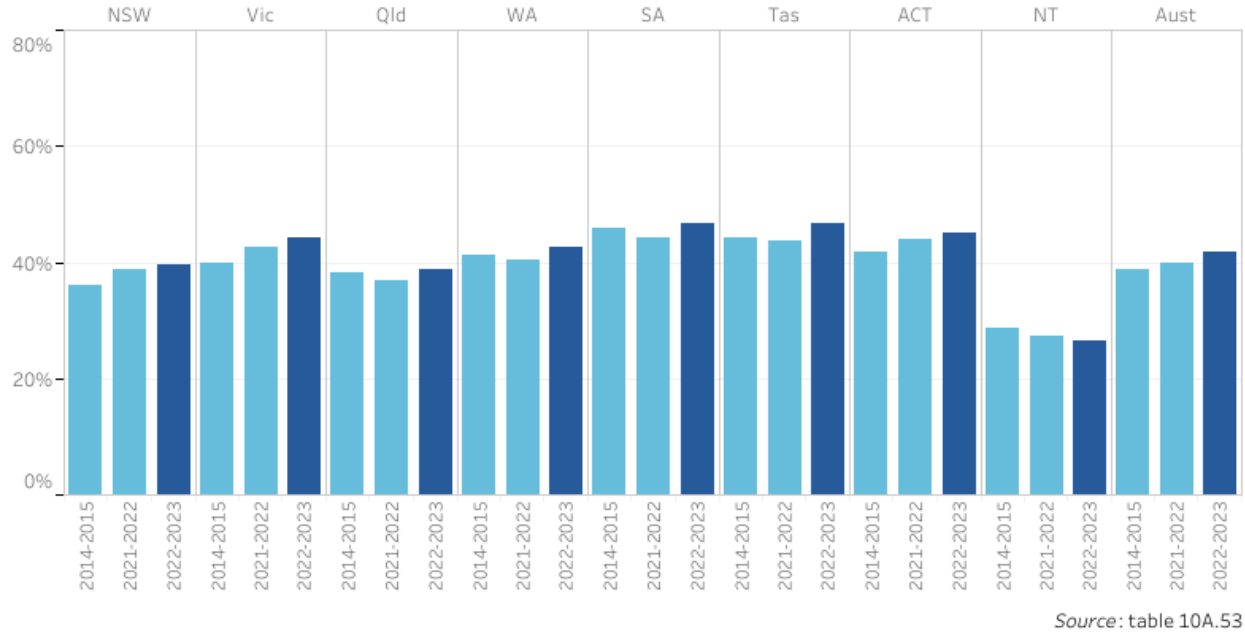
> Measure 3: For 2022-2023, the national participation rate for people aged 50–74 years in bowel cancer screening was 41.7%, an increase from 40.0% in 2021–2022 (figure 10.8b).

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

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

Select year(s):
Multiple values

Figure 10.8b Measure 3: **Participation in the National Bowel Cancer Screening Program, by age group** 50-74 years old, by jurisdiction, by 24-month period



Source: table 10A.53

10. 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.

'General practices with accreditation' is defined as the number of general practices in Australia that are accredited as a rate per 100 general practices. 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 rate 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.

> Nationally in 2019, 83.8 general practices were accredited per 100 general practices (figure 10.9).

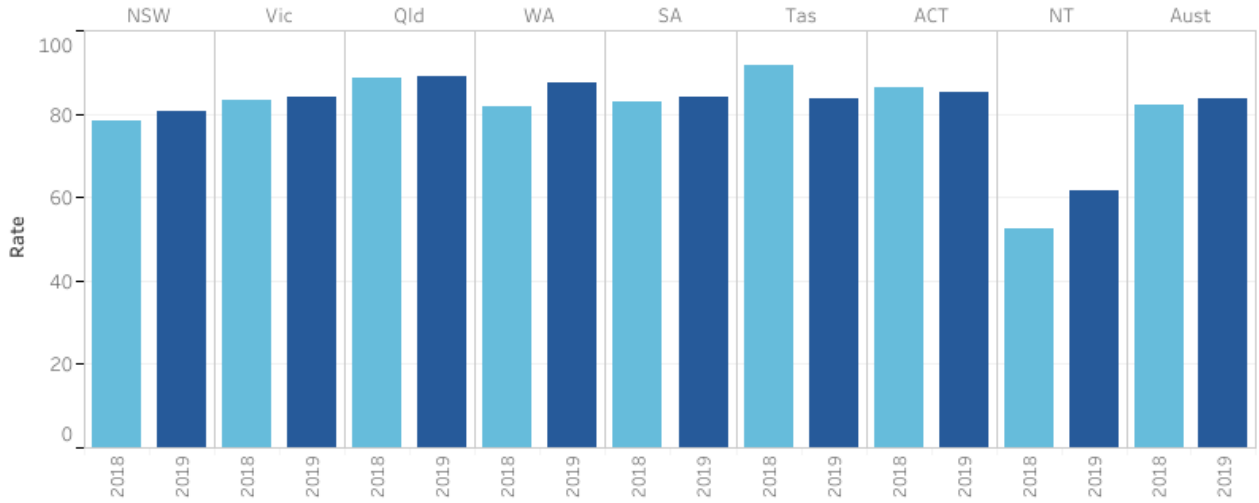
While rates are not available from 2020 onwards (as the total number of general practices (denominator) was not available), the number of accredited general practices at 30 June 2024 was 7,132, a decrease from 7,135 at 30 June 2023 (table 10A.54). The Australian Government is developing a method to source the total number of general practices. Data is expected to be available for reporting in future.

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

Data is not complete for the current reporting period. All required 2024 data for the number of general practices (denominator) is not available and therefore an accreditation rate cannot be calculated.

Select year(s):
All

Figure 10.9 **Accreditation of general practices at 30 June**
Per 100 general practices, by jurisdiction, by year



Source: table 10A.54

11. Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective that primary and community health services are high quality.

'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 needed to and saw a GP in the previous 12 months who reported the GP always or often:
  - listened carefully to them
  - showed respect
  - spent enough time with them

- the proportion of people who needed to and saw a dental professional in the previous 12 months who reported the dental professional always or often:
    - listened carefully to them
    - showed respect
    - spent enough time with them.

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

Data is sourced from the ABS Patient Experience Survey (PEx) of people aged 15 years or over. The PEx does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

Measure 1: Nationally, in 2023-24, the majority of respondents who needed to and saw a GP reported that the GP always or often:

- listened carefully (90.5%)
- showed respect (93.7%)
- spent enough time with them (87.8%) (figure 10.10a).

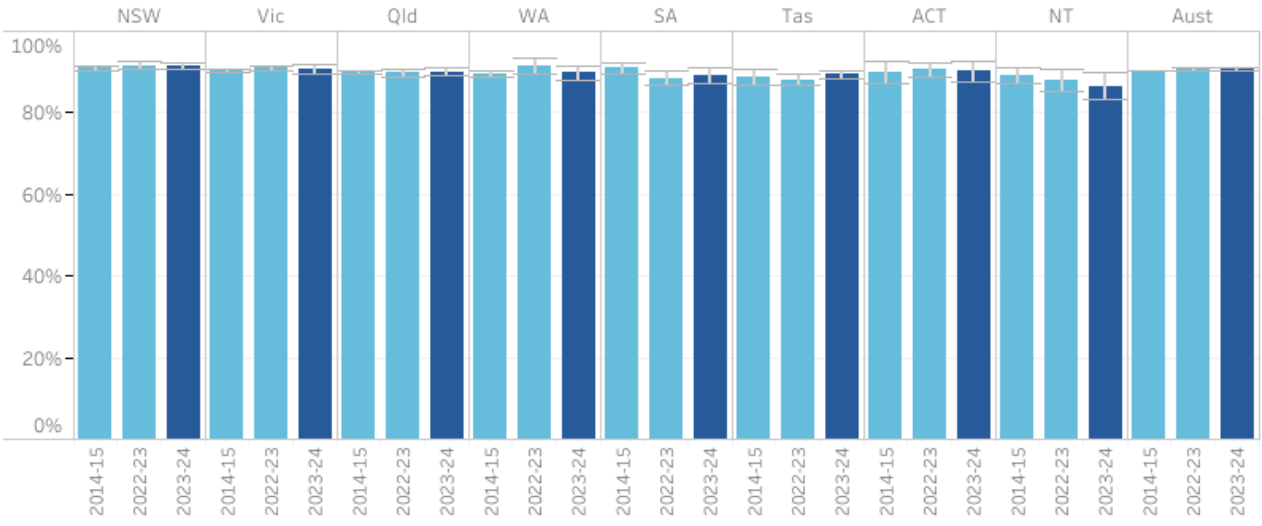
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year(s):
Multiple values

Select disaggregation:
- (●) GP always or often listened carefully
- ( ) GP always or often showed respect
- ( ) GP always or often spent enough time with person

Figure 10.10a Measure 1: **Patient experience of GPs: GP always or often listened carefully**
By jurisdiction, by year



Source: tables 10A.55-10A.56

Measure 2: Nationally, in 2023-24, the majority of respondents who needed to and saw a dental professional reported that the dental professional always or often:

- listened carefully (95.4%) (figure 10.10b)
- showed respect (97.0%).
- spent enough time with them (96.7%).

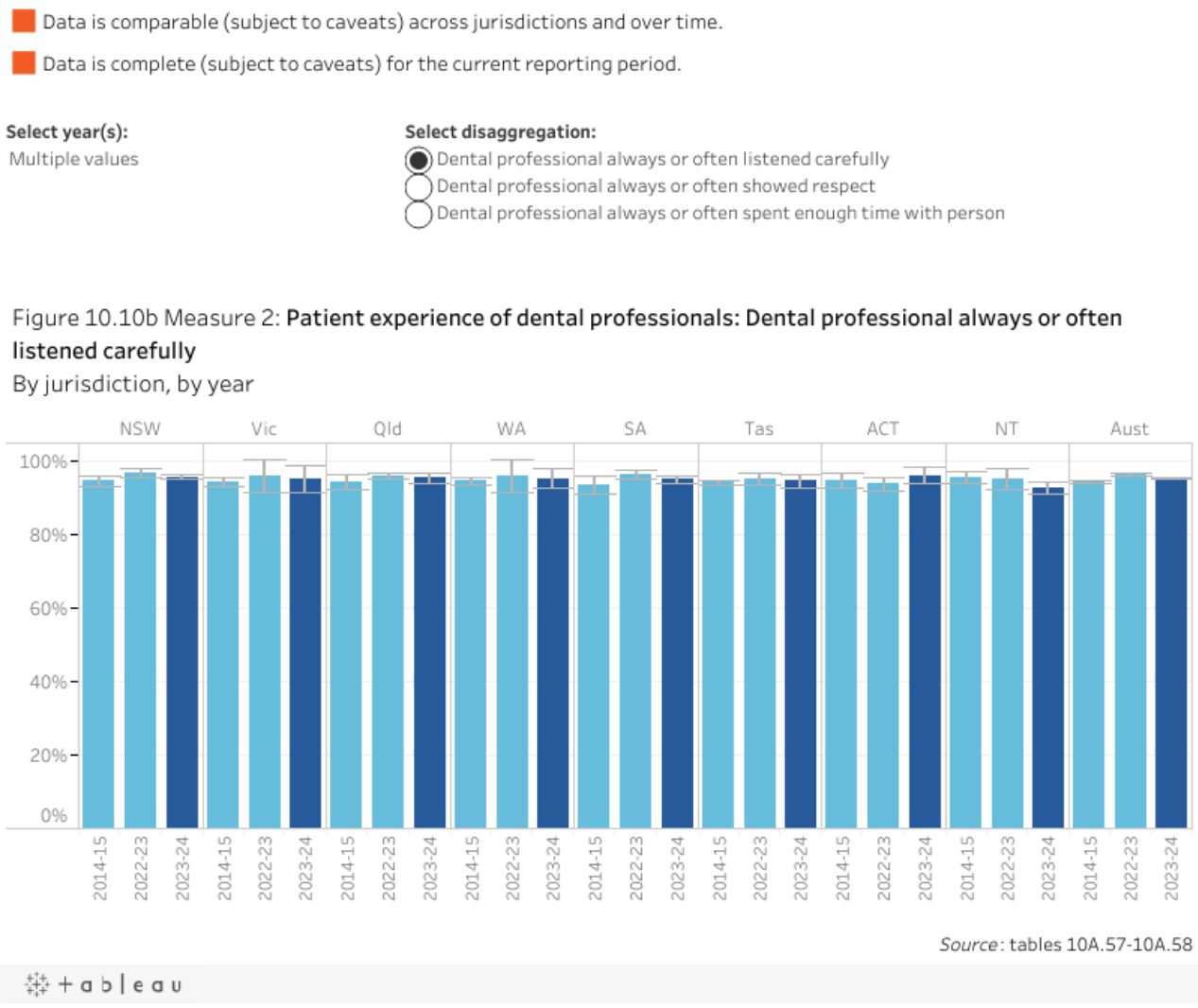


Figure 10.10b Measure 2: **Patient experience of dental professionals: Dental professional always or often listened carefully**
By jurisdiction, by year

Data by remoteness for measures 1 and 2 are presented in tables 10A.55–58.

12. Continuity of care

'Continuity of care' is an indicator of governments' objective to ensure that services are well coordinated when more than one service type and/or ongoing service provision is required.

'Continuity of care' is defined by three measures:

- the proportion of GP management plans and team care assessment plans that have been reviewed in the last 12 months

- 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
- 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.

For the first measure, proportions are calculated by dividing the number of Medicare subsidised GP management plans and team care assessment plans reviewed (Medicare item no. 732), by the total number of Medicare subsidised GP management plans (Medicare item no. 721) and team care assessment plans (Medicare item no. 723), multiplied by 100.

A high or increasing proportion of GP management and team care assessment plans reviewed is desirable.

The second and third measures are enumerated using data from the ABS PEx of people aged 15 years and over. The PEx does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results for both measures. Approximately 20% of the estimated resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

For the second measure, a high or increasing proportion of patients who saw three or more different health professionals in the past 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 is desirable.

For the third measure, a low or decreasing proportion of patients who saw three or more different health professionals in the past 12 months for the same condition and who reported that issues were caused by a lack of communication between health professionals is desirable.

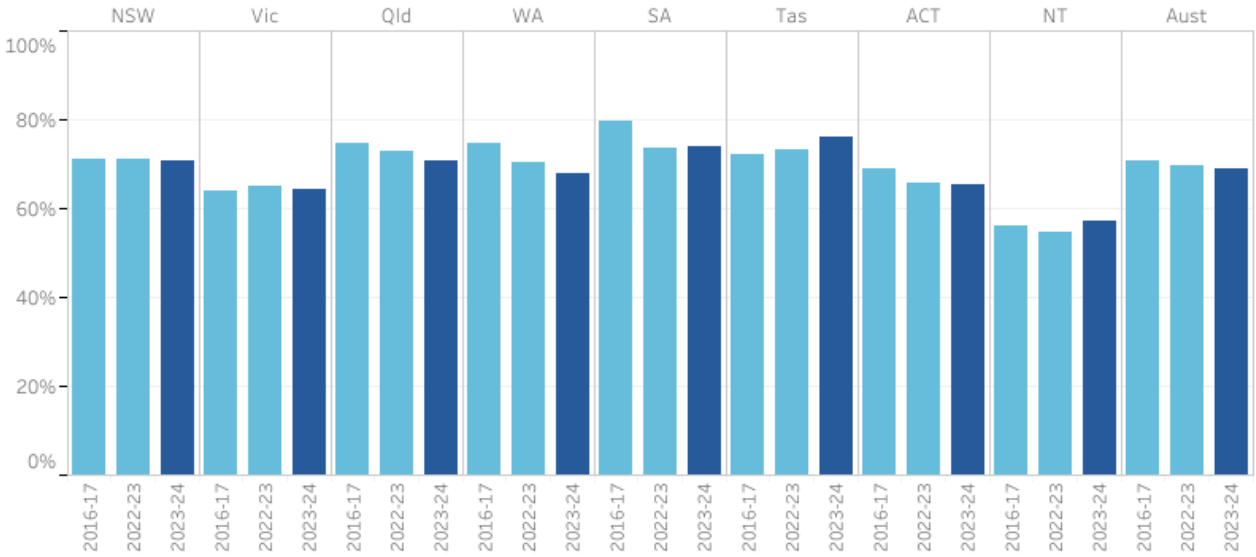
> Measure 1: Nationally in 2023-24, 68.9% of Medicare subsidised GP management plans and team care assessment plans were reviewed. This is the lowest proportion over eight-year time series and reflects a continuing decrease since the peak in 2018-19 (74.1%) (figure 10.11a).

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

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

Select year(s):
Multiple values

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



Source: table 10A.59

Measures 2–3: Nationally, in 2023-24, the proportion of people who saw three or more health professionals in the last 12 months for the same condition and who reported that:

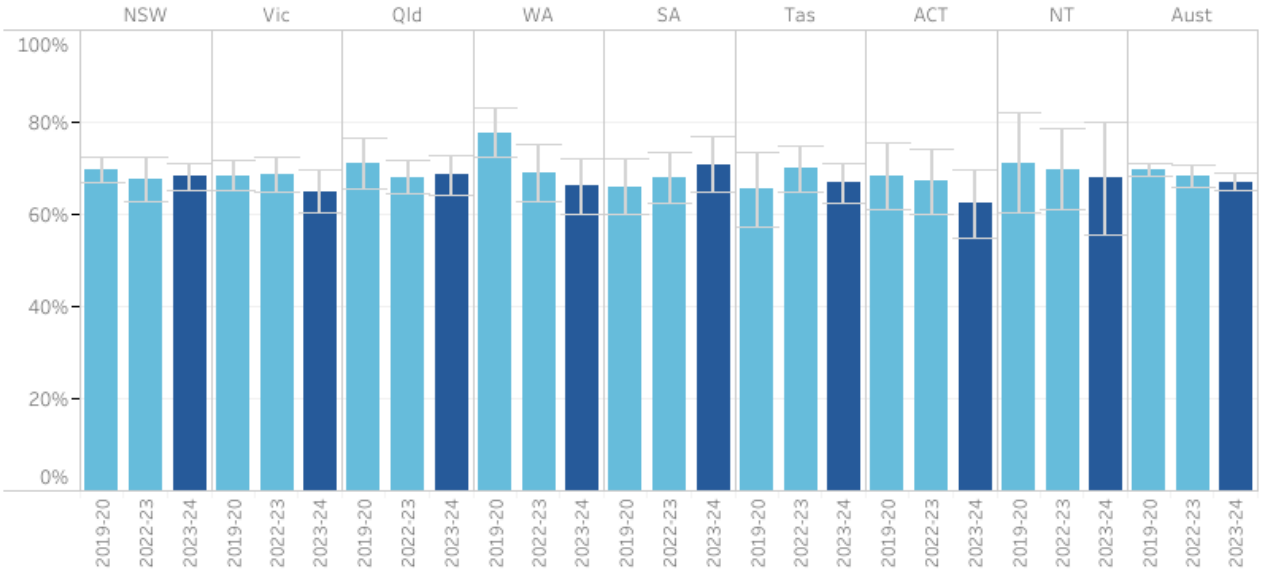
- a health professional helped coordinate their care and that this coordination of care helped to a large extent was 67.0% (figure 10.11b)
- issues were caused by a lack of communication between the health professionals was 16.3% (figure 10.11c).

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

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

Select year(s):
Multiple values

Figure 10.11b Measure 2: **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**
By jurisdiction, by year



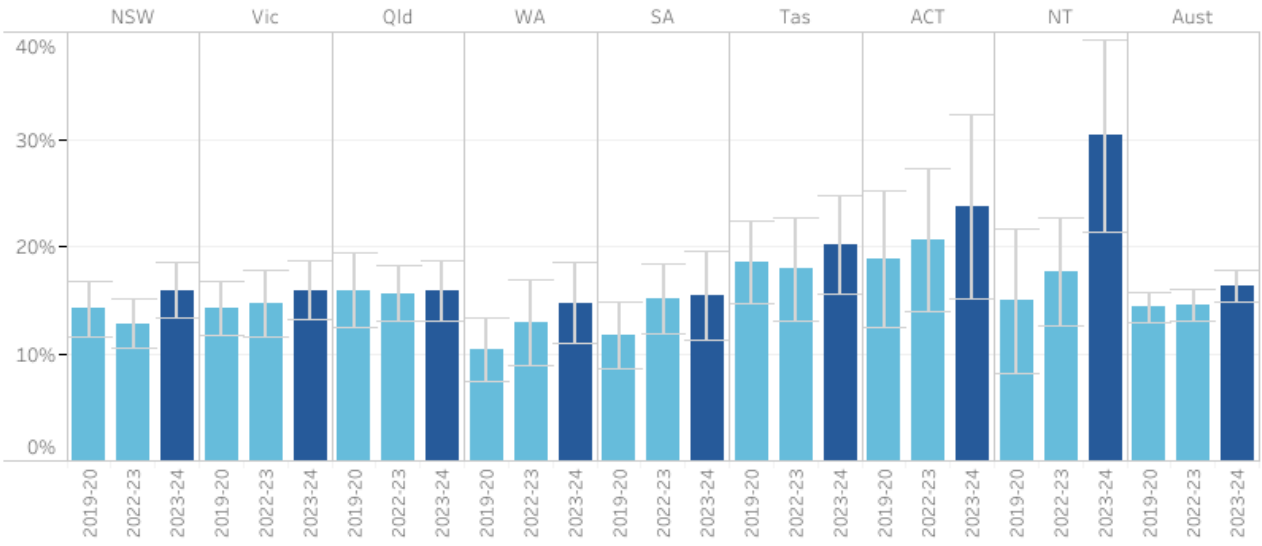
Source: table 10A.60

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

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

Select year(s):
Multiple values

Figure 10.11c Measure 3: **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**
By jurisdiction, by year



Source: table 10A.61

tableau

13. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide sustainable primary and community healthcare services.

'Workforce sustainability' is defined by two measures:

- the proportion of FTE GPs in 10-year age brackets
- the attrition rate of FTE GPs who exit the workforce as a proportion of the number of FTE GPs 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.

Health workforce sustainability relates to the capacity of the health workforce to meet current and projected future service demand. These measures are not a substitute for a full workforce analysis that allows for training, migration, changing patterns of work and expected future demand. They can, however, indicate that further attention should be given to workforce planning for primary and community health services.

The attrition rate is measured as the proportion of GPs who were in scope in 2021, but not in scope in 2022. In scope is defined as Primary Care GPs, being GPs working in the treatment of

non-admitted patients in the community. GPs who 'exited' (i.e. were no longer in scope) in 2022 might still be in the medical workforce and practicing as a GP but are classified as an exit as they are no longer Primary Care GPs.

Measure 1: Nationally in 2023, 26.6% of FTE GPs were aged 60 years or older, compared to 1.5% who were less than 30 years of age (figure 10.12). This is the equal highest proportion of GPs aged 60 years or older and the equal lowest proportion of GPs who were less than 30 years old across the reported nine-year time series (equal with 2022).

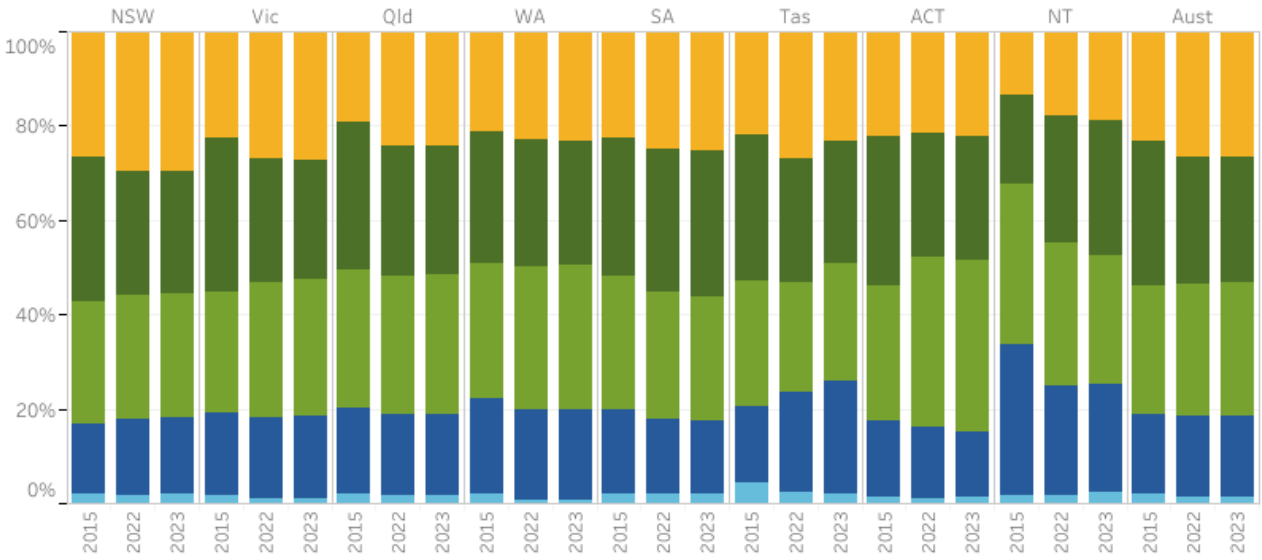
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
Multiple values

60+ years old
50-59 years old
40-49 years old
30-39 years old
<30 years old

Figure 10.12 Measure 1: **Full-time equivalent proportions of the General practitioner workforce**
By age group, by jurisdiction, by year



Source: table 10A.62

Measure 2: Nationally in 2023, the proportion of GPs who exited the GP workforce was 1.4%, with the proportion highest for people aged 60 years or over (2.7%) (table 10.4).

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

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

Select year:

- (●) 2023
- ( ) 2022
- ( ) 2021
- ( ) 2020
- ( ) 2019

Table 10.4 Measure 2: **General practitioner workforce attrition rate**
By age group, by jurisdiction, 2023

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<30 years old	1.7	1.3	2.9	2.9	0.7	0.3	–	0.3	1.8
30-39 years old	1.5	1.3	1.8	2.1	2.9	1.9	1.8	4.9	1.7
40-49 years old	0.8	0.5	0.6	0.5	0.8	1.1	0.7	0.8	0.6
50-59 years old	0.5	0.3	1.0	0.8	0.4	0.7	–	0.1	0.6
60+ years old	2.7	2.6	3.0	2.2	2.8	3.0	4.1	2.6	2.7
Total	1.4	1.2	1.5	1.3	1.5	1.7	1.4	1.9	1.4

Source: table 10A.63
– Nil or rounded to zero

14. 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.

'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 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.

Cost to government of general practice does not capture the costs of salaried GP service delivery models, used particularly in rural or remote areas. Salaried GP service models involve the delivery of primary healthcare services by salaried GPs in community health settings, emergency departments, and Aboriginal and Torres Strait Islander primary healthcare services. Therefore, costs are understated for jurisdictions where a larger proportion of the population live in rural and remote areas.

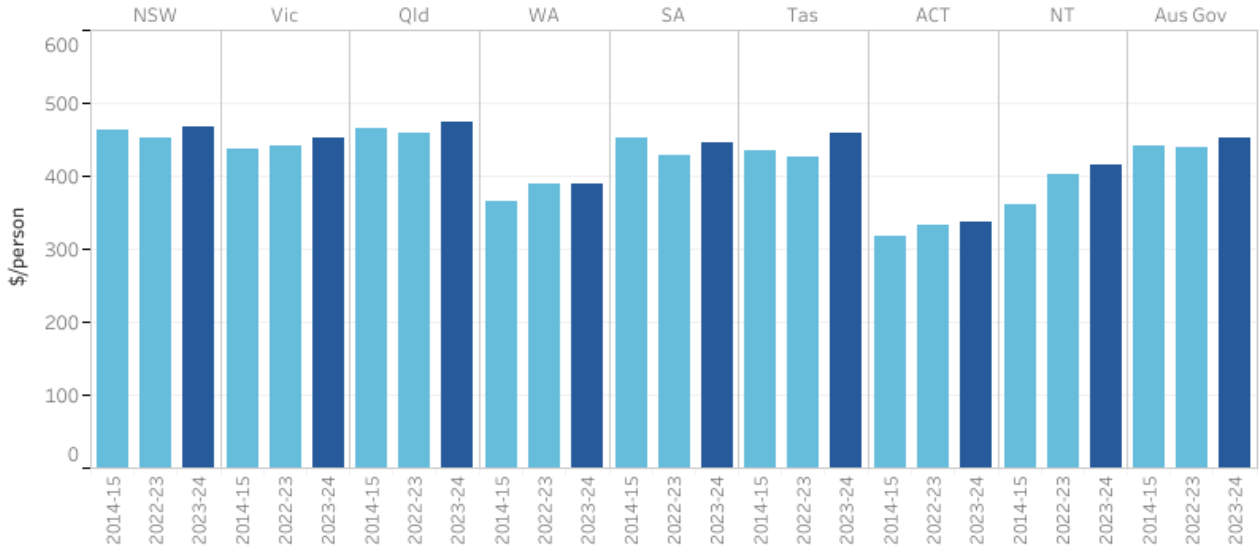
> Nationally, in 2023-24, total expenditure per person on general practice was $452 per person, an increase in real terms from $440 in 2022-23 (figure 10.13).

Data is comparable (subject to caveats) across jurisdictions, and over time.

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

Select year(s):
Multiple values

Figure 10.13 **Australian Government expenditure on GPs**
By jurisdiction, by year (2023-24 dollars)



Source: table 10A.2

15. 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.

'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.

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.

Nationally in 2023-24, the rate of notifications for children aged 0–14 years was:

- 0.1 per 100,000 children for Haemophilus influenzae type b, equivalent to 2022-23
- 0.5 per 100,000 children for measles, an increase on 2022-23 (0.2 per 100,000 children), but consistent with the average annual rate of notifications over the past 10 years
- 200.8 per 100,000 children for pertussis (whooping cough), a significant increase on recent years and the highest rate since 2015-16 (286.4 per 100,000 children) (figure 10.14 and table 10A.64).

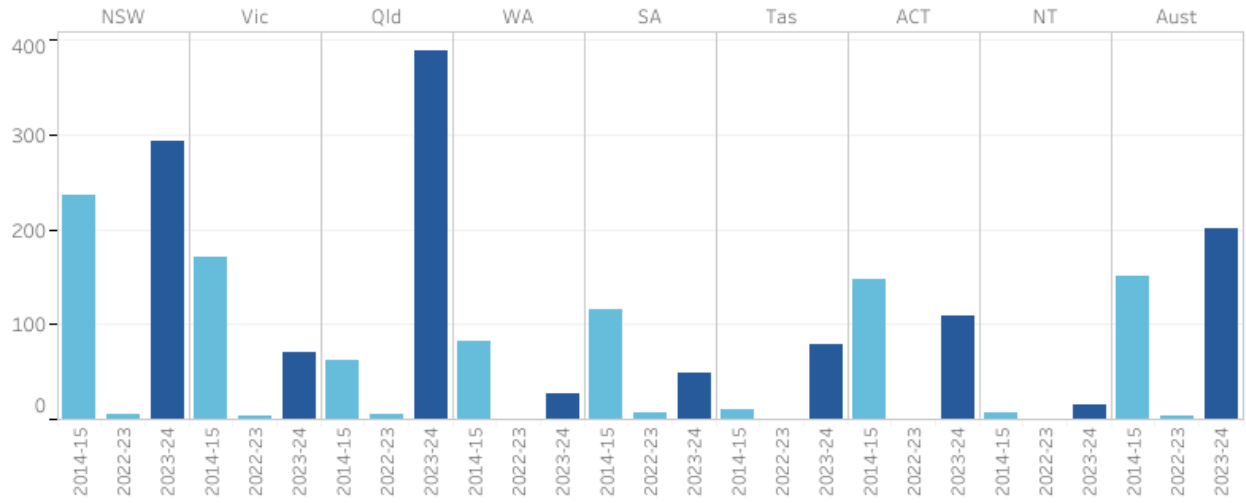
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is 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: Pertussis (whooping cough)**
Per 100,000 children, by jurisdiction, by year (a)



Source: table 10A.64

(a) Data is suppressed for number of notifications where number is less than three.

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16. 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.

'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 state or territory 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.

> Measure 1: Nationally in 2022-23, the age-standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 25.0 per 1,000 people, an increase on 2021-22 (table 10.5). Rates were higher for Aboriginal and Torres Strait Islander people (66.4 per 1,000 people) than other Australians (24.2 per 1,000 people).

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

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

Select year:
2022-23

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

Table 10.5 Measure 1: **Separations for selected potentially preventable hospitalisations**
Rate per 1,000 people (age-standardised), All people, by condition, by jurisdiction, 2022-23

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Vaccine preventable	1.8	1.6	2.5	2.2	1.5	1.0	1.3	10.3	2.0
Acute	10.9	10.9	16.9	12.4	12.9	10.4	11.7	26.2	12.7
Chronic	8.6	11.9	12.6	8.6	9.9	14.6	8.0	22.0	10.6
Total	21.1	24.2	31.6	23.0	24.1	25.9	20.8	56.6	25.0

Source: tables 10A.65 and 10A.66

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> Measure 2: Nationally, in 2022-23, the age-standardised hospital separation rate for diabetes was 132.6 separations per 100,000 people (table 10.6).

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.72).

The most serious complication of Type 2 diabetes most commonly leading to hospitalisation in 2022-23 was circulatory complications, with an age-standardised rate of 17.3 per 100,000 people (table 10A.73). Serious circulatory complications of diabetes can necessitate lower limb amputation. In 2022-23, there were 22.1 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.75).

Data is comparable (subject to caveats) across jurisdictions.

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

Table 10.6 Measure 2: **Separations for Type 2 diabetes mellitus as principal diagnosis**
Rate per 100,000 people (age-standardised), by complication, by jurisdiction, 2022-23

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Circulatory	17.7	14.7	16.5	26.0	15.5	9.1	21.9	28.0	17.3
Multiple	31.2	91.0	49.7	43.2	48.4	67.4	35.4	179.8	54.8
No complications	5.0	8.1	5.4	3.6	4.1	4.6	7.4	16.7	5.8
Ophthalmic	4.8	10.0	23.1	24.8	9.1	20.9	1.9	6.0	12.6
Other specified	33.2	38.0	47.9	35.2	45.3	28.8	40.5	87.7	39.0
Renal	2.3	2.5	4.5	2.7	2.5	4.2	6.7	8.6	3.1
Total	94.3	164.3	147.2	135.6	124.9	135.0	113.8	326.9	132.6

Source: table 10A.73

Indigenous data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section is available in the data tables listed below. Further supporting information can be found in the Indicator results tab and data tables.

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

Table number	Table title
Table 10A.17	Approved suppliers of PBS medicines by MMM area, at 30 June (number)
Table 10A.18	Approved suppliers of PBS medicines by remoteness area, at 30 June (number)
Table 10A.23	Aboriginal and Torres Strait Islander people who had Aboriginal and Torres Strait Islander-specific health checks or assessments, by location of assessment (per 1,000 people)
Table 10A.24	Aboriginal and Torres Strait Islander-specific health checks or assessments, by location of assessment (per 1,000 people)
Table 10A.25	Aboriginal and Torres Strait Islander people who had Aboriginal and Torres Strait Islander-specific health checks or assessments, by age (per cent)
Table 10A.35	Median waiting time for public dental care, NSW (days)
Table 10A.36	Median waiting time for public dental care, Victoria (days)
Table 10A.37	Median waiting time for public dental care, Queensland (days)
Table 10A.38	Median waiting time for public dental care, WA (days)
Table 10A.39	Median waiting time for public dental care, SA (days)

Table number	Table title
Table 10A.40	Median waiting time for public dental care, Tasmania (days)
Table 10A.41	Median waiting time for public dental care, ACT (days)
Table 10A.42	Median waiting time for public dental care, NT (days)
Table 10A.49	Influenza vaccination coverage for people aged 65 years and over (per cent)
Table 10A.51	Participation rates for Aboriginal and Torres Strait Islander women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)
Table 10A.66	Separations for selected potentially preventable hospitalisations by Indigenous status (per 1,000 people)
Table 10A.68	Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1,000 people)
Table 10A.69	Separations for selected vaccine preventable conditions by Indigenous status (per 1,000 people)
Table 10A.70	Separations for selected acute conditions by Indigenous status (per 1,000 people)
Table 10A.71	Separations for selected chronic conditions by Indigenous status (per 1,000 people)
Table 10A.72	Selected potentially preventable hospitalisations, ratio of separations for Aboriginal and Torres Strait Islander people to all Australians, diabetes

Explanatory material

Key terms

Terms	Definition
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.
Allied health practitioner	Trained professionals with university qualifications (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category includes physiotherapists, psychologists, social workers, occupational therapists, Aboriginal and Torres Strait Islander health practitioners, and other diagnostic and health professionals.
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. Medicare items can be claimed on completion of the annual cycle of care according to Medicare requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma action plan	The National Asthma Council Australia recommends people with asthma should have their own individual written action plan that includes instructions on what to do when asthma symptoms worsen. Source: National Asthma Council Australia, 2022, *Australian Asthma Handbook,* Version 2.2. National Asthma Council Australia, Melbourne, accessed 15 December 2023: https://www.asthmahandbook.org.au/management/action-plans
Australian classification of health interventions (ACHI)	Developed by the National Centre for Classification in Health, the ACHI comprises a tabular list of health interventions and an alphabetic index of health intervention.
Cervical screening test	A cervical screening test consists of a human papillomavirus (HPV) test with partial genotyping and, if the HPV test detects oncogenic HPV, liquid based cytology (LBC).

Terms	Definition
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may 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 in hospitals or private facilities.
Comparability	Data is considered comparable if (subject to caveats) it can be used to inform an assessment of comparative performance. Typically, data is considered comparable when it is 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 is considered complete if all required data is available for all jurisdictions that provide the service.
Consultations	Periods of service provided by GPs. Professional attendance by a GP can include any of the following that are clinically relevant: taking a patient history; performing a clinical examination; arranging any necessary investigation; implementing a management plan; and providing appropriate preventive health care.
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.
General practice	The organisational structure with one or more general practitioners (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.

Terms	Definition
General practitioner (GP)	To be recognised as a specialist general practitioner for the purposes of Medicare, medical practitioners must either: • hold specialist registration as a general practitioner with the Australian Health Practitioner Regulation Agency (Ahpra) • participate in an approved workforce or training program (commonly known as 3GA programs). To be registered as a specialist general practitioner by the Ahpra, general practitioners must hold fellowship of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). Medical practitioners who were on the vocational register on 16 June 2021 maintain their access to general practice items in the Medicare Benefits Schedule.
General practitioner full time equivalent (GP FTE)	GP FTE is a workforce specific method to estimate the workload of GPs. The method calculates a GP's workload based on Medicare services claimed as well as patient and doctor factors that affect the duration of a consultation. One GP FTE represents a 40 hour week per week for 46 weeks of the year. For each Medicare provider, the measure attributes an estimate of the amount of time they have spent on their claims compared to what would be worked by a full-time GP, including billable time, non-billable time, and non-clinical time.
General practitioner (GP) Headcount	GP Headcount is a workforce specific method of headcount for GPs working in Australia (number of GPs). The method uses elements from the Medicare data set to count when, where and by what type of practitioner GP services are being delivered. The number of GPs is based on the following aspects of Medicare data: • Medicare items within GP's scope of practice as agreed by Commonwealth Medical Advisors and GPs (Some Medicare items reviewed by Commonwealth Medical Advisors and GPs have been restricted in MM 1–2 to account for the difference in the scope of GP activity across metropolitan, regional, rural and remote areas.) • A review of a GPs services over a whole year to determine their Main Derived Major Speciality (MDMS) • A unique identifier to enable distinct counts by MDMS.
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 2018).

Terms	Definition
Human papillomavirus (HPV) test	An HPV test uses a sample of cervical cells to determine whether the cells are infected with a high-risk strain of HPV, which could cause changes to cervical cells leading to cervical cancer.
ICD-10-AM	The International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian modification (ICD-10-AM) is the current classification of diagnoses in Australia.
Modified Monash Model	The Modified Monash Model (MMM) is a geographical classification that categorises areas in Australia into seven remoteness categories. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.
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 Services Australia 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 2013). 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 Services Australia Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Services Australia Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure used to detect pre-cancerous abnormalities of the cervix.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under Services Australia Medicare for pathology tests requested by GPs, divided by the population.

Terms	Definition
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 from 1 July 2015) designed to improve the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and improve care coordination, particularly for those with chronic and complex conditions.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a 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 general practitioner or an individual, or body, endorsed by the Commonwealth, a State or Territory to administer vaccines in Australia.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the Services Australia 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 a test or tests on apparently well people to detect a medical condition earlier than would otherwise be possible.

Terms	Definition
Socio-Economic Indexes for Areas (SEIFA)	Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Each SEIFA quintile represents approximately 20% of the national population, but does not necessarily represent 20% of the population in each state or territory.
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).

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Report on Government Services 2025

PART E, SECTION 11: RELEASED ON 6 FEBRUARY 2025

11 Ambulance services

This section reports on the performance of ambulance service organisations, which are the primary agencies involved in providing emergency medical care, pre-hospital and out-of-hospital care, and transport services.

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 in the data tables is also available in CSV format.

Data downloads

11 Ambulance services data tables (XLSX 176.3 KB)

11 Ambulance services dataset (CSV 274.7 KB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for ambulance services

Ambulance services aim to promote health and reduce the adverse effects of emergency events on the community by providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are:

- accessible and timely
- meet patients' needs through delivery of appropriate health care
- high quality – safe, co-ordinated and responsive health care
- sustainable.

Governments aim for ambulance services to meet these objectives in an equitable and efficient manner.

Service overview

Ambulance services comprise:

- emergency and non-emergency pre-hospital and out-of-hospital patient care and transport
- inter-hospital patient transport including the movement of critical patients
- specialised rescue services
- responding to multi-casualty events

- community capacity building to respond to emergencies (for example, cardiopulmonary resuscitation (CPR) and first aid training).

Roles and responsibilities

Ambulance service organisations are the primary agencies involved in providing services for ambulance events. State and territory governments provide ambulance services in most jurisdictions. In Western Australia and the Northern Territory, St John Ambulance is contracted by government to be the primary provider of ambulance services.

Across jurisdictions, ambulance service organisations are an integral part of the health system. The role of paramedics has expanded over the past decade to include assessment and management of patients with minor illnesses and injuries to avoid hospitalisation.

Funding

In 2023-24, total ambulance service organisation revenue was $5.6 billion, a decrease of 1.7% from 2022-23 and representing an average annual growth rate over the past five years of 5.0% (table 11.1).

Select year(s):
Multiple values

Table 11.1 **Revenue of ambulance service organisations**
By jurisdiction, by year ($m) (2023-24 dollars)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2023-24	1,587.6	1,482.6	1,277.2	497.2	482.9	160.9	94.9	59.8	5,643.2
2022-23	1,588.9	1,692.2	1,195.8	457.5	506.5	160.1	84.7	54.0	5,739.8
2014-15	1,037.2	901.8	737.3	311.2	293.4	70.9	53.4	33.8	3,439.1

Source: table 11A.1

Data tables are referenced above by an '11A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Jurisdictions have different funding models to resource ambulance service organisations. Nationally in 2023-24, state and territory government grants and indirect government funding formed the greatest source of ambulance service organisation funding (79.7%), followed by transport fees (from

public hospitals, private citizens and insurance) (15.8%), and subscriptions and other income (4.6%) (table 11A.1).

Size and scope

Human resources

Nationally in 2023-24, for ambulance services reported in this section there were:

- 24,145 full time equivalent salaried personnel (81.9% were ambulance operatives)
- 6,275 volunteer personnel (88.5% were ambulance operatives)
- 955 paramedic community first responders. Community first responders are trained volunteers that provide an emergency response (with no transport capacity) and first aid care before ambulance arrival (table 11A.2).

Registered paramedics

Paramedics must be registered with the Paramedicine Board of Australia and meet the Board's registration standards to practise in Australia (Australian Health Practitioner Regulation Agency (AHPRA) Paramedicine Board of Australia, 2024).

In 2023-24, there were 25,345 registered paramedics in Australia (including 708 non-practising registered paramedics) (table 11A.3).

'Qualified ambulance officers' must be registered paramedics (table 11A.2). It is possible some registered paramedics are employed by an ambulance service to work in a different role, such as other clinical or communication roles. Some registered paramedics work in other (non-ambulance) organisations.

Demand for ambulance services

Nationally in 2023-24, there were:

- 4.4 million incidents (events that resulted in demand for ambulance services) reported to ambulance service organisations (164.8 incidents per 1,000 people)
- 5.8 million responses where an ambulance was sent to an incident (216.0 responses per 1,000 people). There can be multiple responses sent to an incident. There can also be responses to incidents where people do not require treatment and/or transport
- 4.2 million patients assessed, treated or transported by ambulance service organisations (156.1 patients per 1,000 people) (figure 11.1).

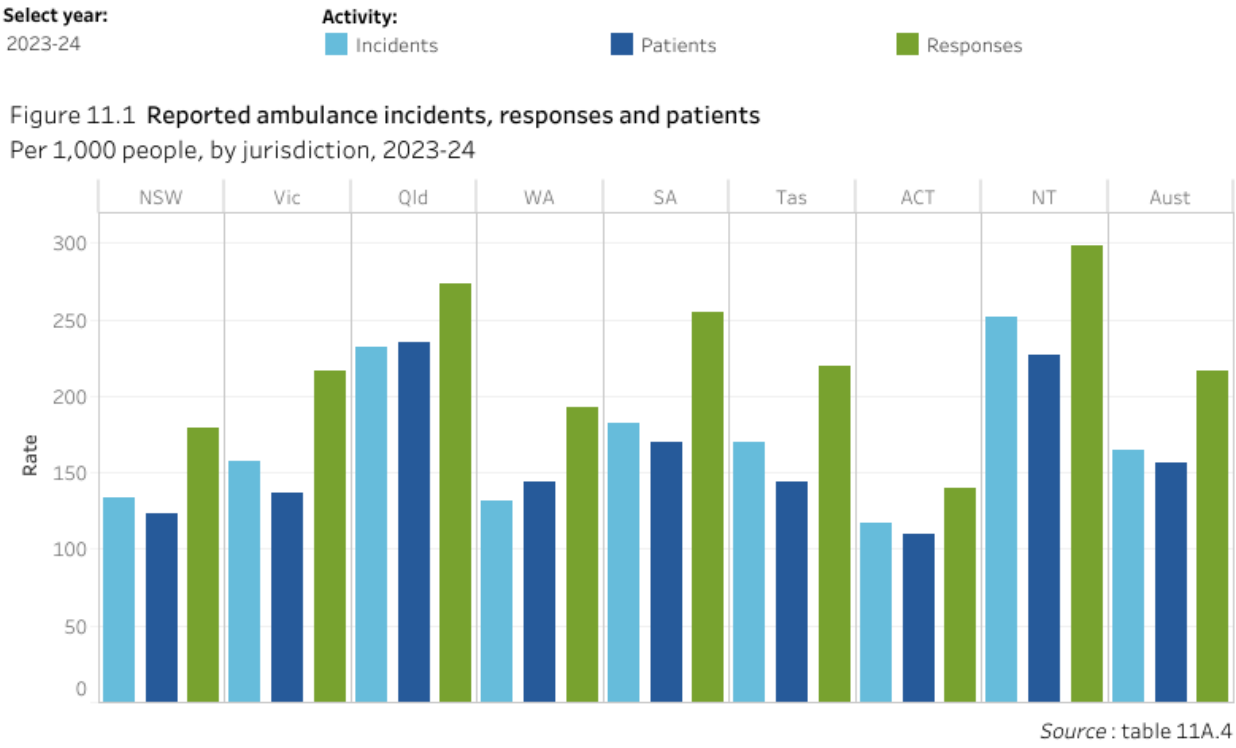


Figure 11.1 **Reported ambulance incidents, responses and patients**
Per 1,000 people, by jurisdiction, 2023-24

Source : table 11A.4

Data tables are referenced above by an '11A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Ambulance service organisations prioritise incidents as:

- emergency – immediate response required under lights and sirens (code 1)
- urgent – undelayed response required without lights and sirens (code 2)
- non-emergency – non-urgent response required (codes 3, 4)
- casualty room attendance.

Nationally in 2023-24, 43.3% of the 4.4 million incidents reported to ambulance service organisations were prioritised as emergency incidents, followed by 31.6% prioritised as urgent and 25.0% prioritised as non-emergency (table 11A.4).

Indicator framework

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

The performance indicator framework shows which data is complete and comparable in this report. For data that is 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 contextual information for this service area (refer to Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

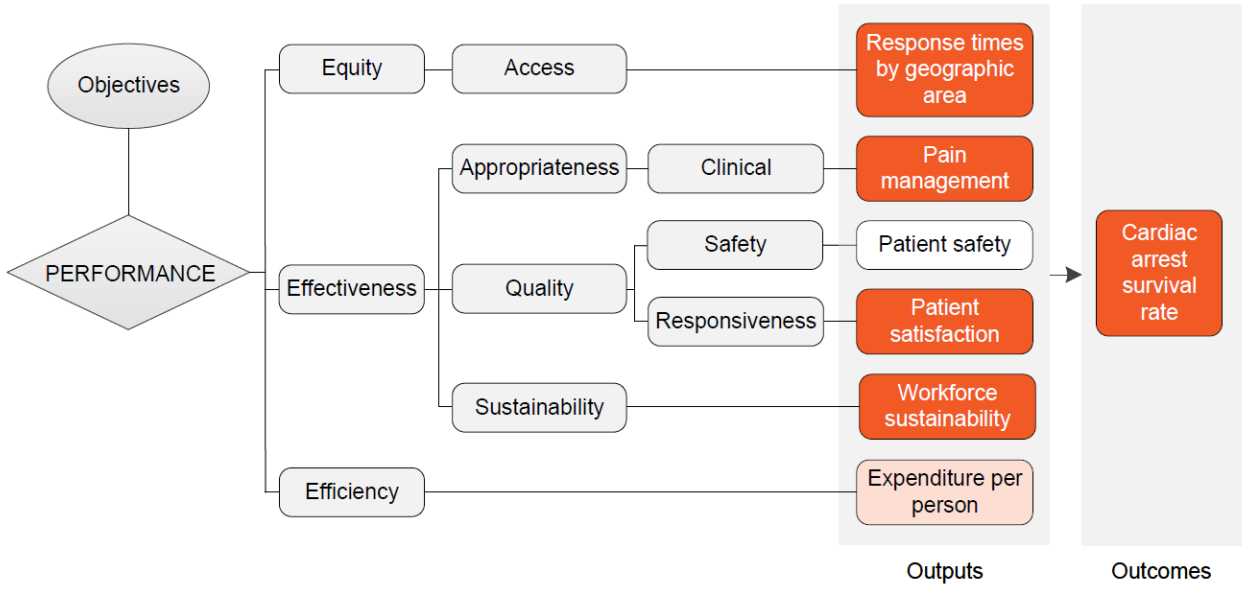
Improvements to performance reporting for ambulance services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (refer to 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 (refer to section 1).



Key to indicators*

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

* A description of the comparability and completeness is provided under the Indicator results tab for each measure

Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Response times by geographic area – most recent data for all measures is comparable and complete

Effectiveness – Appropriateness – Clinical

- Pain management – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- Patient safety – no data reported and/or no measures yet developed

Effectiveness – Quality – Responsiveness

- Patient satisfaction – most recent data for all measures is comparable and complete

Effectiveness – Sustainability

- Ambulance workforce – most recent data for all measures is comparable and complete

Efficiency

- Expenditure per person – most recent data for all measures is either not comparable and/or not complete

Outcomes

- Cardiac arrest survived event rate – most recent data for all measures is comparable and complete

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section presents an overview of 'Ambulance services' performance indicator results. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of ambulance services.

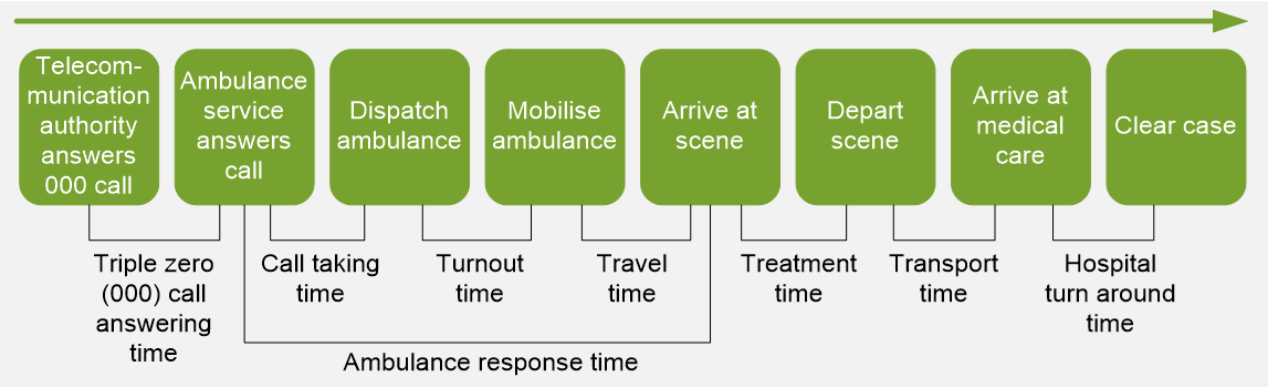
Information to assist the interpretation of these data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a '11A' prefix (for example, table 11A.1).

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.

1. Response times by geographic area

'Response times by geographic area' is an indicator of governments' objective to provide ambulance services in an accessible manner.

'Response times by geographic area' is defined as the time taken between the initial receipt of the call for an emergency at the communications centre, and the arrival of the first responding ambulance resource at the scene of an emergency code 1 incident (illustrated below), by geographic area (capital city and state-wide), at the 90th and 50th percentiles.



Capital city response times are currently measured by the response times within each jurisdictions' capital city – boundaries are based on the ABS Greater Capital City Statistical Areas.

Response times are calculated for the 90th and 50th percentile – the time (in minutes) within which 90% and 50% of the first responding ambulance resources arrive at the scene of an emergency code 1 incident.

Many factors influence response times by geographic location including:

- land area
- population size and density
- dispersion of the population (particularly rural/urban population proportions), topography, road/transport infrastructure and traffic densities

- crew configurations, response systems and processes, and travel distances – for example, some jurisdictions include responses from volunteer stations (often in rural areas) where turnout times are generally longer because volunteers are on call as distinct from being on duty.

Short or decreasing response times are desirable. Short response times potentially minimise adverse effects on patients and the community of delayed emergency responses. Similar response times across geographic areas indicate equity of access to ambulance services.

In 2023-24, the time within which 90% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations ranged from:

- 16.7 minutes (Australian Capital Territory) to 34.3 minutes (South Australia) in capital cities
- 16.7 minutes (Australian Capital Territory) to 36.0 minutes (Tasmania) state-wide (figure 11.2).

In 2023-24, the time within which 50% of first responding ambulance resources arrived at the scene of an emergency in code 1 situations ranged from:

- 9.6 minutes (Western Australia) to 15.2 minutes (Tasmania) in capital cities
- 9.9 minutes (Western Australia and Australian Capital Territory) to 14.9 minutes (Tasmania) state-wide.

Supporting data on triple zero call answering times are available in table 11A.6. Nationally, in 2023-24, 94.9% of calls from triple zero emergency call services were answered by ambulance services communication staff in 10 seconds or less. This is an increase from 93.4% in 2022-23 and is the highest proportion of calls answered in 10 seconds or less over the ten years of available data (table 11A.6). These data do not measure the time taken for triple zero calls to be answered by emergency services telecommunication staff prior to re-direction to ambulance services communication staff.

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

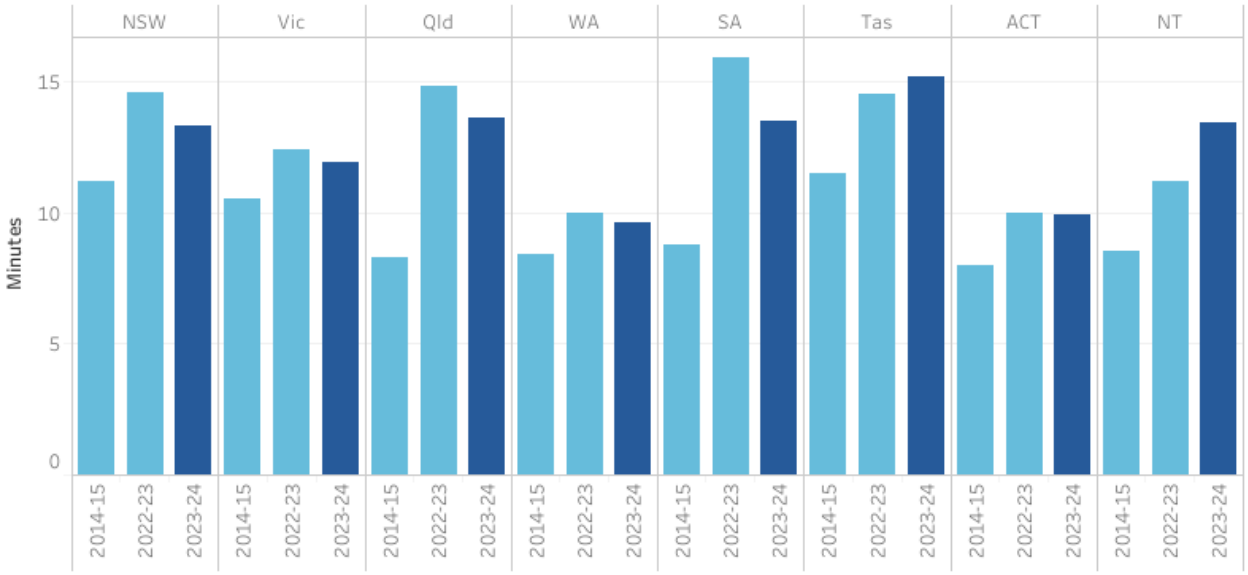
Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select geographic area:
Capital city
Statewide

Select percentile:
50th percentile
90th percentile

Figure 11.2 **Ambulance services Response times**
Capital city, 50th percentile, by jurisdiction, by year



Source: table 11A.5

2. Pain management

'Pain management' is an indicator of governments' objective to provide pre-hospital and out-of-hospital care and patient transport services that meet patients' needs through delivery of appropriate health care.

'Pain management' is defined as the proportion of patients who report a clinically meaningful reduction in pain severity. Clinically meaningful pain reduction is defined as a minimum 2-point reduction in pain score from first to final recorded measurement (based on a 1–10 numeric rating scale of pain intensity).

This indicator includes patients who:

- are aged 16 years or over and received care from the ambulance service, which included the administration of pain medication (analgesia)
- recorded at least 2 pain scores (pre- and post-treatment)
- recorded an initial pain score of 7 or above (referred to as severe pain).

Patients who refuse pain medication for whatever reason or have an unrecorded/missing date of birth are excluded.

A high or increasing proportion of patients who report a clinically meaningful reduction in pain severity at the end of ambulance service treatment is desirable. It suggests ambulance services are

appropriately meeting patient needs.

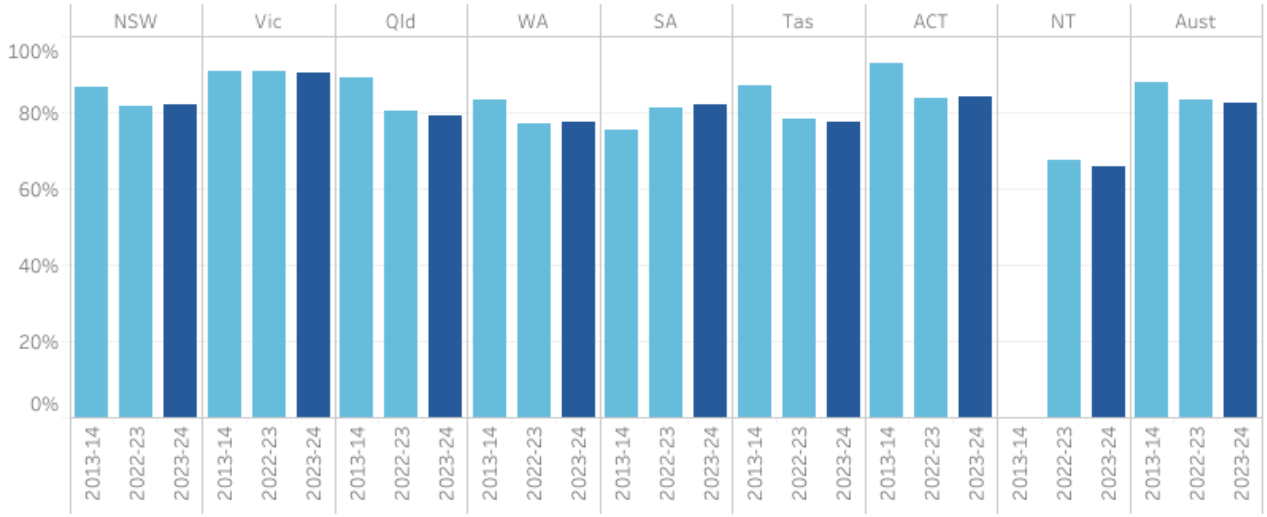
> Nationally in 2023-24, the proportion of patients who reported clinically meaningful pain reduction at the end of ambulance service treatment was 82.5%, continuing a year-on-year decrease since 2019-20 and a more than 5 percentage point decrease over the 10 year time series (from 87.8% in 2013-14) (figure 11.3).

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

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

Select year(s):
Multiple values

Figure 11.3 **Patients who reported a clinically meaningful pain reduction**
By jurisdiction, by year (a)



Source : table 11A.7

(a) Data is not available for the NT for 2013-14.

3. Patient safety

'Patient safety' is an indicator of governments' objective to deliver ambulance services that are high quality and safe.

A measure of patient safety is under development. Data is not yet available for reporting.

A patient safety incident is an event or circumstance that could have resulted, or did result, in unnecessary harm to a person receiving healthcare. Ambulance services have policies and systems in place to manage patient safety incidents.

Table 11.2 provides an overview of the incident management policies that apply to ambulance services in each state and territory. The requirements for notification, escalation and reporting can vary based on the severity of the incident.

High levels of service safety are desirable, as evidenced by low and decreasing rates of patient safety incidents. However, high or increasing rates of reported incidents might reflect more effective incident reporting mechanisms and organisational cultural change.

The feasibility and suitability of an additional measure for this indicator related to notifications about qualified ambulance officers is being investigated. Information about notifications made to the Australian Health Practitioner Regulation Agency (Ahpra) is available at: www.ahpra.gov.au/Notifications/Concerned-about-a-health-practitioner.aspx

Table 11.2 Overview of ambulance patient safety incident policy settings

Jurisdiction	What incidents are reported, how and to whom?
NSW	NSW Health's Incident Management Policy Directive applies to the NSW Ambulance Service. An incident is an unplanned event that results in, or has the potential for: injury, damage or loss, including near misses. A harm score (HS) from 1 to 4 applies to clinical incidents based on the patient outcome and additional treatment or resources required: • HS1 - Unexpected death or sentinel event (defined by the Australian sentinel events list, version 2) • HS2 – Major harm • HS3 – Minor harm • HS4 – No harm or near miss. Staff must notify all clinical incidents by recording them in the NSW Health incident management system. Serious incidents are escalated and reviewed.
Vic	Safer Care Victoria's (SCV) 'Adverse patient safety events' policy applies to Ambulance Victoria. Adverse patient safety events are defined as incidents that result in harm to a person receiving care. Incident Severity Ratings (ISR) are defined according to degree of impact: • ISR1 – Severe impact or death • ISR2 – Moderate • ISR3 – Mild • ISR4 – No harm or near miss. Sentinel events must be notified to SCV within three days. Sentinel events are defined as adverse patient safety events resulting in serious harm or death, including all events on the Australian sentinel events list (version 2). SCV publishes the total number of health service sentinel events each year, although data are not disaggregated by ambulance sentinel events.

Qld	A 'reportable event' in the provision of ambulance services is defined in section 36A of the Ambulance Service Act 1991 (ASA) to mean: • the death of the person, or permanent injury suffered by the person, while giving birth • the death of the person caused by the incorrect management of the person's medication • the death of the person, or neurological damage suffered by the person, caused by an intravascular gas embolism • the death of the person, or permanent loss of function suffered by the person, unrelated to the natural course of the person's medical condition for which he or she was receiving the ambulance service • the death of the person, or permanent injury suffered by the person, contributed to by an unreasonable delay in the provision of the ambulance service or a failure to meet recognised standards for providing the ambulance service • the wrong procedure being performed on the person or a procedure being performed on the wrong part of the person's body. The Queensland Ambulance Service (QAS) is obligated to comply with the *Health Ombudsman Act 2013* (Qld), which requires employers of health practitioners to notify the Health Ombudsman of certain events. Further, the QAS also notifies the State Coroner of deaths that meet the definition of 'reportable deaths', defined under the *Coroners Act 2008* (Qld). The QAS is currently rewriting the clinical incident management systems as part of the draft Patient Safety Strategy. A Pilot of these initiatives is planned for Metro South and Metro North regions. Currently, the QAS defines a clinical incident as '*an event or circumstance that could have resulted, or did result, in unintended harm to a patient during the course of clinical care is considered a clinical incident*'. Clinical incidents are then assigned a Severity Assessment Code (SAC), being one of the following: • SAC 1 – where a clinical incident results in death or permanent harm • SAC 2 – where a clinical incident results in temporary harm • SAC 3 – where a clinical incident results in minimal harm • SAC 4 – where a clinical incident resulted in no harm but raised a potential for harm as a 'near miss'.

WA

WA Department of Health's Clinical Incident Management Policy and associated guidelines apply to St John Ambulance WA, as part of its contract. Health services must ensure they maintain systems and processes that provide a consistent approach to clinical incident management, including managing data quality.

A clinical incident is as an event or circumstance that could have or did lead to unintended or unnecessary physical or psychological harm to a patient. Clinical incidents are those events or circumstances where the harm is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

The WA health system Severity Assessment Codes (SACs) include three categories of clinical incidents:

- SAC 1 – clinical incident that has or could have (near miss) caused serious harm or death, defined as:
    - Sentinel events according to version 2 of the Australian sentinel events list.
    - Patient harm during an episode of care resulting in injury/illness requiring hospitalisation >7 days OR surgical intervention.
    - Unrecognised patient deterioration during ab episode of care requiring hospitalisation >7 days OR death.
    - Incorrect prehospital triage/differential diagnosis resulting in significant harm or death.
    - Unauthorised clinical care provision resulting in harm to the patient.
    - Clinical care provision outside of scope of practice that causes significant harm OR potential to cause significant harm or death (e.g. lack of administration of defibrillation shock when indicated; not providing ventilation to patient in respiratory arrest).
    - Death or serious harm of a patient who was discharged within the community following St John WA attendance within 12 hours (e.g. patient was left at home and subsequently deteriorates into a cardiac arrest six hours later).
    - Delayed care provision inclusive of response time to a patient that leads to identifiable clinical deterioration with actual or potential serious harm or death as per current contractual response time KPIs.
    - Critical equipment failure leading to identifiable or potential serious harm or death (e.g. defibrillation failure).
    - Significant harm or death as a result of administration of sedation in St John WA care.
    - Inappropriate termination of resuscitation efforts outside the approved clinical practice guideline.
    - Inappropriate priority allocation of 000 calls leading to extended response time, which results in serious harm or death.
    - Provision of clinical advice or recommendations leading to serious harm or death.
- SAC 2– clinical incident that has or could have (near miss) caused moderate harm

	• SAC 3 – clinical incident that has or could have (near miss) caused minor or no harm. When a clinical incident or near miss has occurred, staff must notify the incident in the approved clinical incident management system by the end of the workday and allocate a SAC rating within 48 hours of notification. Health services are required to report SAC 1 clinical incidents to the Department of Health.
SA	SA Health's Patient Incident Management and Open Disclosure Policy Directive applies to the SA Ambulance Service. A patient incident is defined as any event or circumstance which could have (near miss) or did lead to unintended or unnecessary psychological or physical harm that occurs during an episode of health care to a person or patient. The Incident Severity Rating (ISR) is a numerical score applied to patient incidents that considers the direct outcome and follow up treatment required following an incident: • ISR1: patient outcome is death or sentinel event (as defined by version 2 of the Australian sentinel events list) • ISR2: major harm. When patient outcome is either: harm, injury or expected permanent loss of function and treatment required is determined as either: immediate emergency or palliative treatment for life-threatening condition, expected long-term high-level care or an unplanned procedure resulting in higher level of care or therapy. • ISR3: Minor harm. Defined as either: ◦ patient outcome is harm, injury or expected permanent loss of function requiring clinical review, additional treatment or therapies ◦ patient outcome is harm or injury and treatment required is determined as either increased monitoring or assessment only or no change in treatment. • ISR4: no harm or injury, or near miss (incident avoided). Services must record all patient related incidents, including near misses, in SA Health's Safety Learning System.
Tas	All patient safety events are required to be reported, categorised and managed through the Department of Health Safety Reporting and Learning System (SRLS), which is oversighted internally by an Ambulance Tasmania management and review committee. The SRLS is subject to required commencement of management and completion KPIs. Version 2 of the Australian sentinel events list applies to all health services in Tasmania, including Ambulance Tasmania. Ambulance Tasmania must provide a brief to the Tasmanian Department of Health within 2 business days of any sentinel event being reported in its safety event reporting system.

ACT	ACT Ambulance Service (ACTAS) manages adverse and near miss events using its own policy and procedure. Patient safety incidents are categorised according to the following Severity Assessment Code (SAC) scale: • SAC1 – clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition. • SAC2 – clinical incidents/near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition of illness. • SAC3 – clinical incidents/near misses where minimal harm is/could be specifically caused by health care rather than the patient's underlying condition or illness. • SAC4 – clinical incidents/near misses where no harm occurs but the health care had the potential to cause harm rather than the patient's underlying condition/illness. ACTAS is not required to notify patient safety incidents or sentinel events to the ACT Government.
NT	Version 2 of the Australian sentinel events list applies to all health services in the NT, including St John Ambulance NT. The NT Health annual report includes the number of sentinel events in NT health services, although data are not disaggregated by ambulance sentinel events.

Source: State and Territory governments (unpublished).

4. Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services that are responsive to patients' needs.

'Patient satisfaction' is defined as the quality of ambulance services, as perceived by the patient. It is measured as patient experience of aspects of response and treatment that are key factors in patient outcomes.

Patients are defined as people who were transported under an emergency event classified as code 1 (an emergency event requiring one or more immediate ambulance responses under lights and sirens where the incident is potentially life threatening) or code 2 (urgent incidents requiring an undelayed response by one or more ambulances without warning devices, with arrival desirable within 30 minutes).

The following measures of patient experience of ambulance services are reported:

- proportion of patients who reported that the length of time they waited to be connected to an ambulance service call taker was much quicker or a little quicker than they thought it would be
- proportion of patients who reported that the length of time they waited for an ambulance was much quicker or a little quicker than they thought it would be
- proportion of patients who reported that the level of care provided to them by paramedics was very good or good
- proportion of patients whose level of trust and confidence in paramedics and their ability to provide quality care and treatment was very high or high

- proportion of patients who were very satisfied or satisfied with the ambulance services they received.

High or increasing proportions for these measures are desirable as they indicate improved responsiveness to patient needs.

> Nationally in 2023-24, the majority of respondents (97.0%) reported they were satisfied or very satisfied with ambulance services received in the previous 12 months (table 11.3).

> Nationally, the proportions of respondents in 2023-24 who reported a quicker than expected phone answer time (67.0%) and ambulance arrival time (63.0%) increased from 2022-23 (table 11.3). The proportion of respondents who indicated a slower than expected phone answer time (5.0%) remained unchanged from 2022-23. Respondents who indicated a slower than expected ambulance arrival time (11.0%) decreased from 2022-23 data (13.0%) (table 11A.8).

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

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

Select year(s):
Multiple values

Table 11.3 **Patient satisfaction**
By jurisdiction, by year (%) (a)

			NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Phone answer time	Much quicker or a little quicker than I thought it would be	2023-24	67.0	66.0	68.0	72.0	67.0	67.0	64.0	63.0	67.0
		2022-23	66.0	69.0	63.0	71.0	65.0	63.0	58.0	59.0	64.0
		2016-17	64.0	66.0	65.0	65.0	68.0	60.0	62.0	64.0	65.0
Ambulance arrival time	Much quicker or a little quicker than I thought it would be	2023-24	63.0	64.0	61.0	71.0	63.0	64.0	59.0	50.0	63.0
		2022-23	61.0	64.0	57.0	69.0	62.0	57.0	54.0	58.0	60.0
		2016-17	56.0	62.0	63.0	63.0	67.0	50.0	61.0	57.0	61.0
Level of care provided by paramedics	Very good or good	2023-24	98.0	98.0	98.0	97.0	98.0	98.0	98.0	98.0	98.0
		2022-23	97.0	98.0	96.0	97.0	98.0	98.0	96.0	97.0	97.0
		2016-17	96.0	98.0	98.0	98.0	98.0	98.0	97.0	95.0	97.0
Level of trust and confidence in paramedics and their ability to provide quality care and treatment	Very high or high	2023-24	94.0	94.0	95.0	91.0	93.0	94.0	94.0	93.0	94.0
		2022-23	91.0	95.0	93.0	93.0	94.0	91.0	91.0	93.0	93.0
		2016-17	91.0	91.0	93.0	94.0	92.0	93.0	92.0	89.0	92.0
Overall satisfaction	Very satisfied or satisfied	2023-24	99.0 ± 1.0	97.0 ± 1.0	98.0 ± 1.0	97.0 ± 1.0	97.0 ± 1.0	97.0 ± 1.0	97.0 ± 1.0	99.0 ± 1.0	97.0 ± 1.0
		2022-23	97.0 ± 1.6	98.0 ± 1.6	97.0 ± 1.5	98.0 ± 1.7	97.0 ± 1.8	97.0 ± 1.6	96.0 ± 2.5	99.0 ± 3.6	97.0 ± 0.6
		2016-17	97.0 ± 4.9	97.0 ± 4.9	98.0 ± 5.0	99.0 ± 5.9	98.0 ± 5.2	97.0 ± 4.7	97.0 ± 5.4	97.0 ± 7.6	97.0 ± 1.8

Source : table 11A.8

(a) Some percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

5. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services that are sustainable.

Health workforce sustainability concerns the capacity of the health workforce to meet current and projected demand.

'Workforce sustainability' is defined by two measures:

- 'workforce by age group' – the proportion of the operational salaried workforce in 10-year age groups (under 30, 30–39, 40–49, 50–59 and 60 and over)
- 'operational workforce attrition' – the proportion of full time equivalent salaried staff who exited the organisation. This includes staff in operational positions where paramedic qualifications are either essential or desirable to the role.

A low or decreasing proportion of the workforce in younger age groups and/or a high or increasing proportion of the workforce in older age groups suggest potential workforce sustainability problems as older age workers enter retirement. High and increasing levels of staff attrition also suggest potential workforce sustainability problems.

The workforce by age group and staff attrition measures should be considered together. Each provides a different perspective on the changing profile of the ambulance workforce. These data should also be considered in conjunction with data on the:

- number of students enrolled in accredited paramedic training courses (table 11A.10)
- availability of paramedics and response locations, which show that for some jurisdictions, there can be a large proportion of volunteers or volunteer ambulance locations (tables 11A.2 and 11A.4).

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.

> Nationally in 2023-24, the proportion of the ambulance workforce aged under 50 years was 79.0% (figure 11.4 and table 11A.9). The proportion of the ambulance workforce aged under 50 years has increased over the ten year time series (77.7% in 2014-15) (figure 11.4 and table 11A.9).

Supporting data on student enrolments in accredited paramedic training courses are available in table 11A.10. Enrolments peaked in 2019 with 342.3 enrolments nationally per million people, while there were 276.3 enrolments per million people in 2023-24.

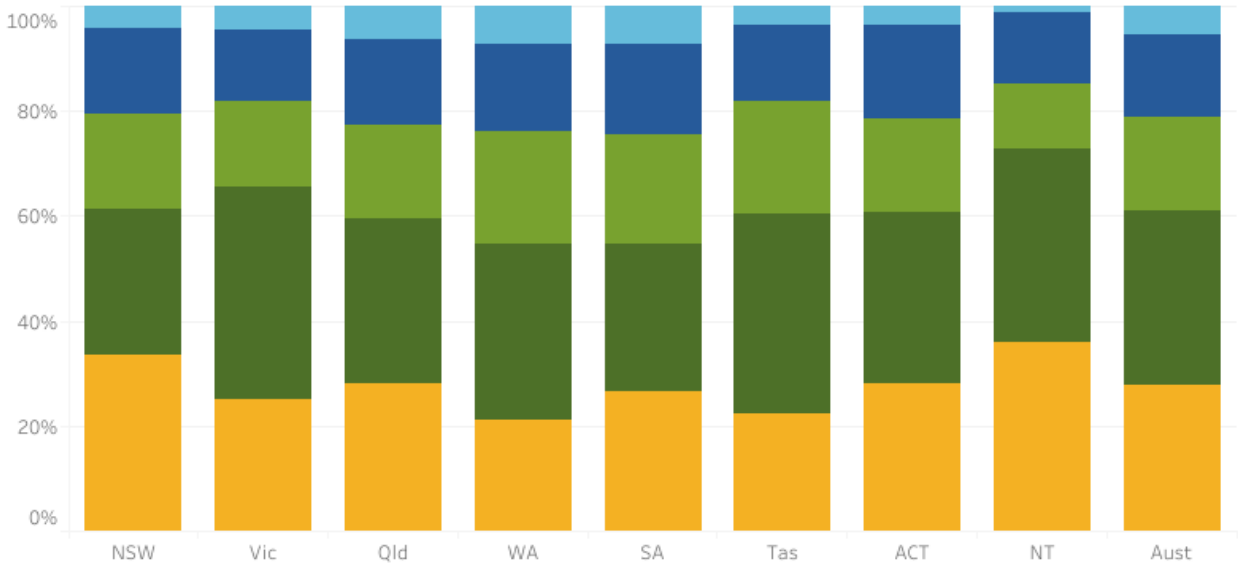
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
2023-24

60+ years old
50-59 years old
40-49 years old
30-39 years old
<30 years old

Figure 11.4 Measure 1: **Ambulance workforce**
By age group, by jurisdiction, 2023-24



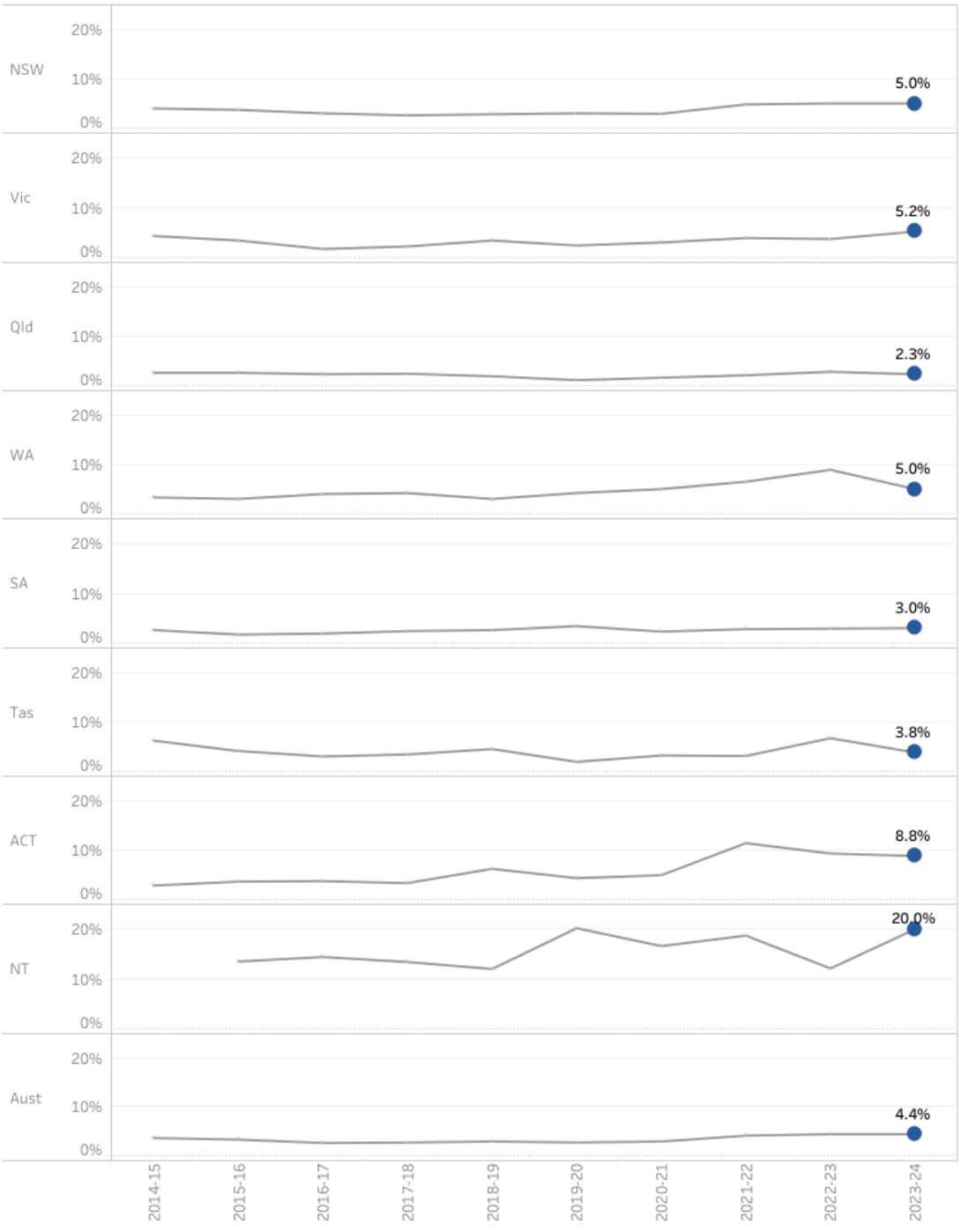
Source: table 11A.9

Nationally in 2023-24, the attrition rate was 4.4%, equal to the attrition rate for 2022-23 and the highest rate in the 10 years reported (figure 11.5 and table 11A.9).

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

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

Figure 11.5 Measure 2: **Ambulance workforce Attrition rate**
By jurisdiction, by year (a)



Source: table 11A.9

(a) Data for the NT is not available for some years.

6. Expenditure per person

'Expenditure per person' is a proxy indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services in an efficient manner.

'Expenditure per person' is defined as total ambulance service organisation expenditure per person in the population.

All else being equal, lower expenditure per person represents greater efficiency. However, efficiency data should be interpreted with caution.

- High or increasing expenditure per person may reflect deteriorating efficiency. Alternatively, it may reflect changes in: aspects of the service (such as improved response); resourcing for first aid and community safety; or the characteristics of events requiring an ambulance service response, such as more serious medical presentations requiring complex clinical interventions.
- Differences in geographic size, terrain, climate, and population dispersal may affect costs of infrastructure and numbers of service delivery locations per person.

> Nationally, total expenditure on ambulance service organisations was $217 per person in 2023-24, a decrease of 1.0% from the previous year (figure 11.6 and table 11A.11).

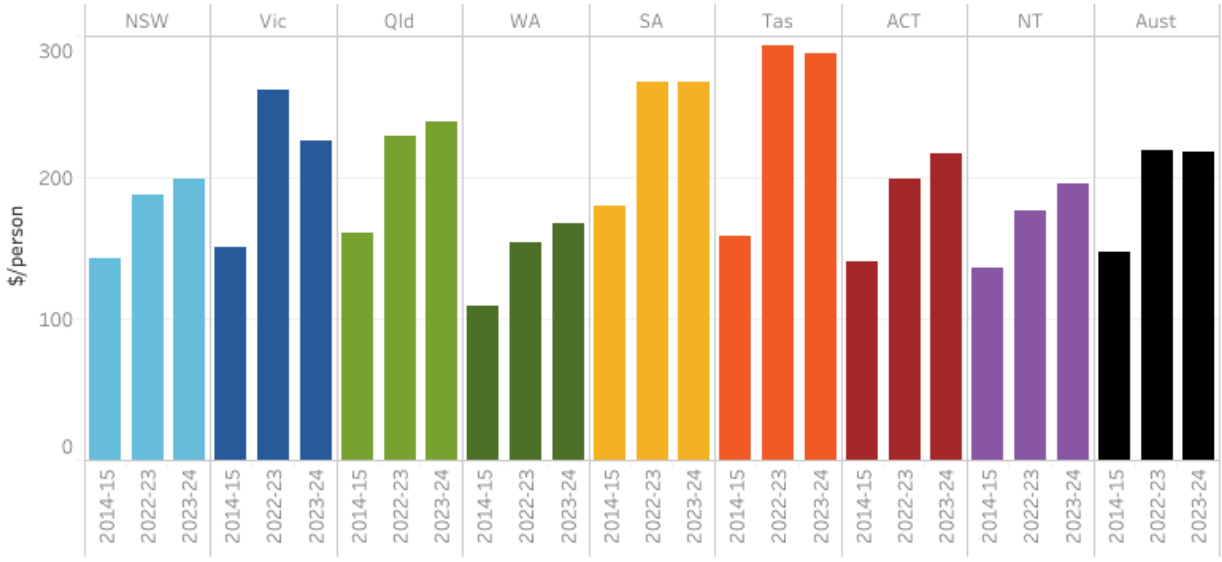
Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

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

Select year(s):
Multiple values

Jurisdiction:
NSW Vic Qld WA SA Tas ACT NT Aust

Figure 11.6 **Expenditure per person**
By jurisdiction, by year (2023-24 dollars)



Source : table 11A.11

7. Cardiac arrest survival rate

'Cardiac arrest survival rate' is an indicator of governments' objective to provide emergency medical care, pre-hospital and out-of-hospital care, and transport services that reduce the adverse effects of emergency events on the community.

'Cardiac arrest survival rate' is defined as the proportion of adult patients (aged 16 years and over) who were in out-of-hospital cardiac arrest and returned to spontaneous circulation (that is, the patient had a pulse) on arrival at hospital.

Three measures are reported:

- Paramedic witnessed adult cardiac arrests where resuscitation was attempted by ambulance or emergency medical services personnel.
- Non-paramedic witnessed adult cardiac arrests where non-paramedic resuscitation was attempted.
- Non-paramedic witnessed adult Ventricular Fibrillation or Ventricular Tachycardia cardiac arrests where non-ambulance resuscitation was attempted.

Ventricular Fibrillation (VF) is a heart rhythm problem that occurs when the heart beats with rapid, erratic electrical impulses. Ventricular Tachycardia (VT) is a type of regular and fast heart beat that arises from improper electrical activity in the ventricles of the heart.

Cardiac arrests that are treated immediately by a paramedic have a better likelihood of survival due to immediate and rapid intervention. Patients who suffer a VF or VT cardiac arrest are more likely to have better outcomes compared with other causes of cardiac arrest as these conditions are primarily correctable through defibrillation.

This indicator measures survival rates to hospital, not survival rates in or post-hospital. A high or increasing cardiac arrest survival rate is desirable.

Nationally in 2023-24, the survival rates for patients in VF or VT cardiac arrest or paramedic witnessed cardiac arrest were higher than for non-paramedic witnessed cardiac arrest where resuscitation was attempted:

- the cardiac arrest survival rate for paramedic witnessed cardiac arrests was 49.3% nationally
- the cardiac arrest survival rate for non-paramedic witnessed cardiac arrests where resuscitation was attempted was 25.3%
- the VF/VT cardiac arrest survival rate for non-paramedic witnessed cardiac arrests was 48.8% (figure 11.7 and table 11A.12).

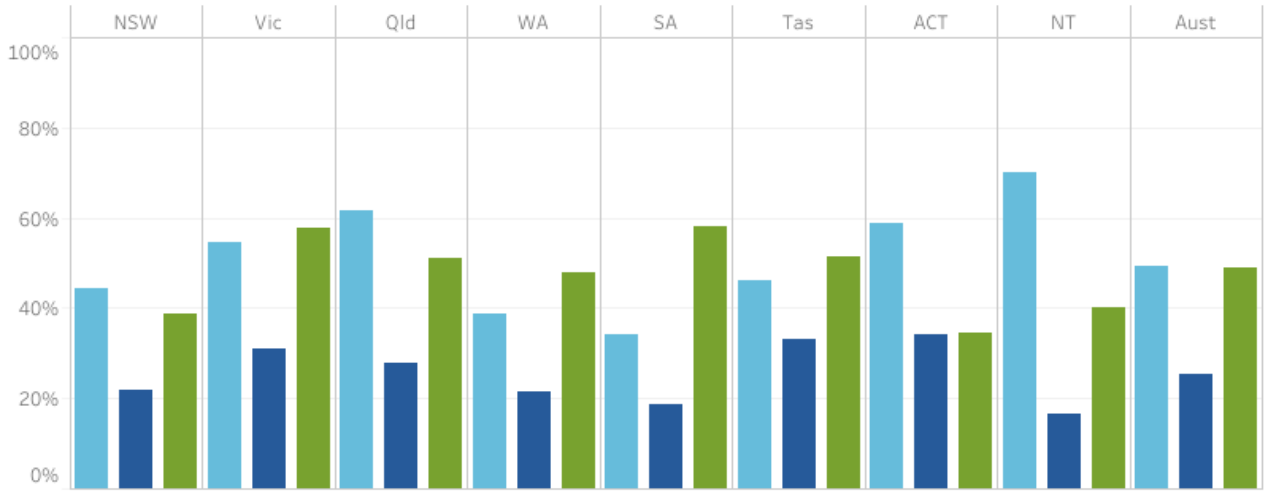
(all measures) Data is comparable (subject to caveats) across jurisdictions from 2018-19 onwards and over time for all jurisdictions except NSW (NSW changed in 2018-19 bringing it in line with national counting rules but creating a break with its historical reporting).

(all measures) Data is complete (subject to caveats) for the current reporting period.

Select year:
2023-24

Event type:
- Paramedic witnessed, Adult cardiac arrest survival rate
- Non-paramedic witnessed, Adult cardiac arrest survival rate where resuscitation attempted
- Non-paramedic witnessed, Adult VF/VT cardiac arrest survival rate

Figure 11.7 **Cardiac arrest survival rate**
By jurisdiction, 2023-24 (a), (b)



Source: table 11A.12

(a) The NT recorded no Paramedic witnessed adult cardiac arrests for 2019-20. (b) Paramedic witnessed adult cardiac arrest data is not available for Tasmania for 2014-15.

Explanatory material

Key terms

Terms	Definition
Estimated resident population (ERP)	The official Australian Bureau of Statistics estimate of the Australian population. The ERP is derived from the 5-yearly Census counts and is updated quarterly between censuses. It is based on the usual residence of the person.
Expenditure	Includes: • salaries and payments in the nature of salaries to ambulance personnel • capital expenditure (such as the user cost of capital) • other operating expenditure (such as running expenditure, contract expenditure, training expenditure, maintenance expenditure, communications expenditure, provision for losses and other recurrent expenditure). Excludes the user cost of capital for land, payroll tax and interest on borrowings.
Human resources	Human resources refers to any person delivering a service, or managing the delivery of this service, including: • salaried ambulance personnel, remunerated volunteer and non-remunerated volunteer ambulance personnel • support personnel (any paid person or volunteer directly supporting operational providers, including administrative, technical and communications personnel).
Locations	Initial assistance can come from two locations: • First responder locations- staffed by non-remunerated individuals who offer immediate assistance without transport capacity before ambulance services arrive. First responder locations are sites where these teams are based and dispatched. Third Party First Responders are third-party organisations who collaborate with the ambulance service. • Response locations- includes all sites operated by the ambulance service, whether owned, leased, or occupied. These locations maybe be serviced by a combination of salaried and volunteer ambulance operatives with a variety of general purpose and special operations resources.

Terms	Definition
Revenue	Revenue received directly or indirectly by ambulance service organisations on an accrual accounting basis, including: • Government grants (grant funding, as established in legislation, from the Australian, State/Territory and Local governments) • Transport fees (Transport fees for the use of ambulances and other ambulance vehicles received directly and indirectly by ambulance agencies. It also includes treatment without transport. Subscriptions and other income (subscriptions and benefit funds received from the community; donations, industry contributions and fundraising received; other income).
User cost of capital	The opportunity cost of funds tied up in the capital used to deliver services. Calculated as 8% of the current value of non-current physical assets (including land, plant and equipment).

References

Australian Health Practitioner Regulation Agency (AHPRA) Paramedicine Board of Australia 2024, *Registration,* https://www.paramedicineboard.gov.au/Registration.aspx (accessed 26 September 2024).

Report on Government Services 2025

PART E, SECTION 12: RELEASED ON 6 FEBRUARY 2025

12 Public hospitals

This section reports on the performance of governments in providing public hospitals, with a focus on acute care services.

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 is also available in CSV format.

Data downloads

12 Public hospitals data tables (XLSX 943.8 KB)

12 Public hospitals dataset (CSV 3.5 MB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for public hospitals

Public hospitals aim to alleviate or manage illness and the effects of injury by providing acute, non and sub-acute care along with emergency and outpatient care that is:

- timely and accessible to all
- appropriate and responsive to the needs of individuals throughout their lifespan and communities
- high quality and safe
- well coordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required
- sustainable.

Governments aim for public hospital services to meet these objectives in an equitable and efficient manner.

Service overview

Public hospitals provide a range of services, including:

- acute care services to admitted patients
- sub-acute and non-acute services to admitted patients (for example, rehabilitation, palliative care and long stay maintenance care)
- emergency, outpatient and other services to non-admitted patients

- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
- public health services
- teaching and research activities.

This section focuses on services (acute, subacute and non-acute) provided to admitted patients and services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity.

In some instances, data for stand-alone psychiatric hospitals are included in this section. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the 'Services for mental health' section of this report (section 13).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $96.1 billion in 2022-23 (table 12A.1), with 94% funded by the Australian, state and territory governments and 6% funded by non-government sources (including depreciation) (Australian Institute of Health and Welfare 2024a).

Government real recurrent expenditure (all sources) on public hospitals per person was $3,649 in 2022-23; an increase of 1% from 2021-22 ($3,616) (table 12A.2).

Size and scope

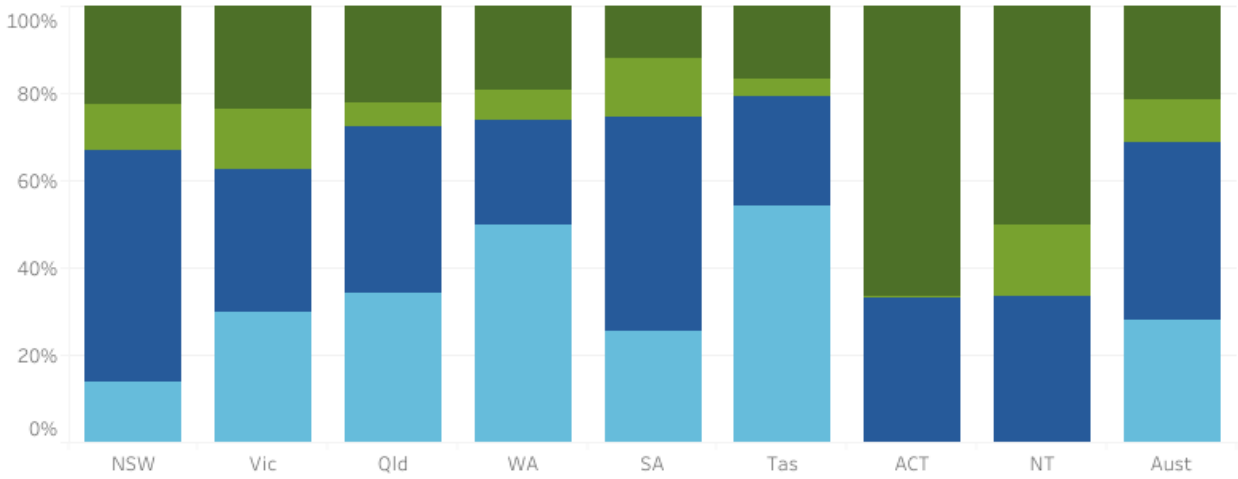
Hospitals

In 2022-23, there were 700 public hospitals in Australia – three more, overall, than in 2021-22 (table 12A.3). Although 68.6% of hospitals had 50 or fewer beds (figure 12.1), these smaller hospitals represented only 12.1% of total available beds (table 12A.3).

Select year:
2022-23

more than 100 beds
more than 50 to 100 beds
more than 10 to 50 beds
10 or fewer beds

Figure 12.1 **Public hospitals (including psychiatric hospitals)**
By Hospital size, by jurisdiction, 2022-23 (a)



Source: table 12A.3

(a) The ACT did not have hospitals with 10 or fewer beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds.

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Hospital beds

There were 65,051 public hospital beds available for admitted patients in public hospitals in 2022-23, equivalent to 2.5 beds per 1,000 people (table 12.1 and tables 12A.3–4). Information on the availability of hospital beds in relation to the population provides some information about the accessibility of public hospital services. However, the concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the extent to which hospitals provide services for patients who usually reside in other areas of the state or territory, in other jurisdictions, or who receive services through different modes of care (such as virtual care or 'hospital in the home' care models) (AIHW 2024b). Nationally, the number of beds available per 1,000 people increased as remoteness increased (table 12A.4). The patterns of bed availability across regions may reflect the availability of other health-care services and patterns of disease and injury (AIHW 2024c).

Select year:
2022-23

Table 12.1 **Available beds, Public hospitals (including psychiatric hospitals)**
Per 1,000 people, by jurisdiction, 2022-23

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
no.	21,207	15,380	13,344	6,676	4,493	1,671	1,233	1,046	65,051
rate	2.6	2.3	2.5	2.4	2.5	2.9	2.7	4.2	2.5

Source: tables 12A.3 and 12A.4

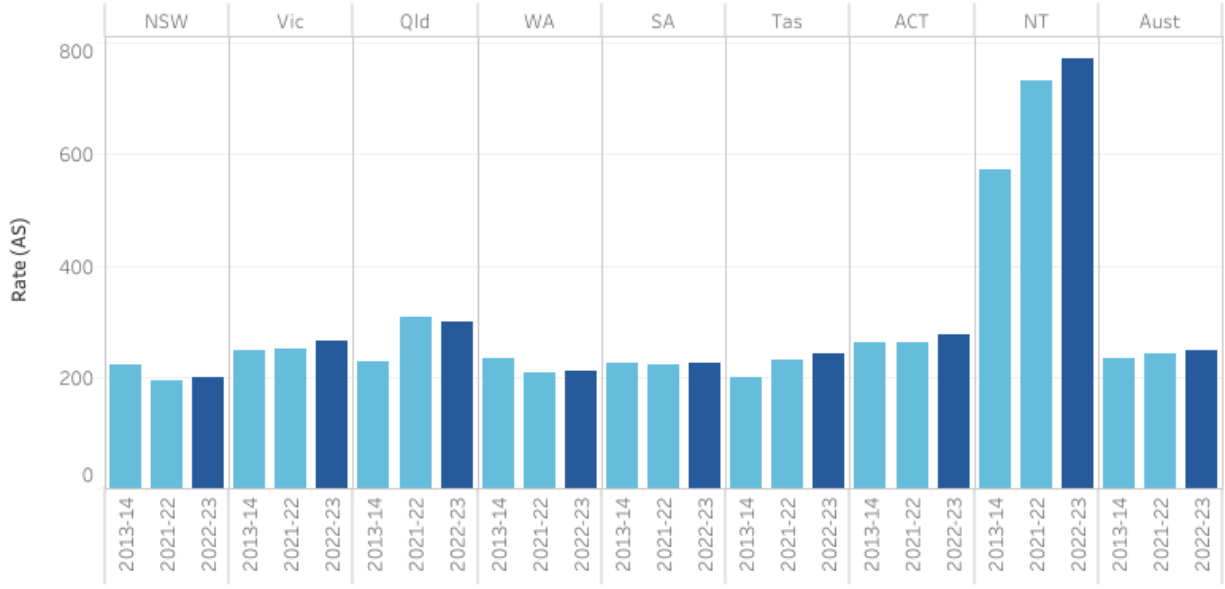
Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Admitted patient care

There were approximately 7.1 million separations from public (non-psychiatric) hospitals in 2022-23, of which over half (56.1%) were same day patients (table 12A.5). Nationally, this equates to 246.8 separations per 1,000 people (figure 12.2). Acute care separations accounted for 94.1% of separations from public hospitals (table 12A.10).

Select year(s):
Multiple values

Figure 12.2 **Separations, Public acute hospitals**
Per 1,000 people, by jurisdiction, by year



Source: table 12A.6

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or non-admitted outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations, where there was significant variation across jurisdictions in the proportion of same day medical separations in 2022-23 (table 12A.7).

In 2022-23, on an age-standardised basis, public hospital separation rates for Aboriginal and Torres Strait Islander people were markedly higher than the corresponding rates for all people. For private hospital separations, rates were higher for all people compared to Aboriginal and Torres Strait Islander people (though separations are lower for private hospitals compared to public hospitals) (table 12A.8).

Non-admitted patient services

Non-admitted patient services include outpatient services, which may be provided on an individual or group basis, and emergency department services. Nationally in 2022-23, 41.1 million non-admitted patient care service events were provided for public patients, 25.8% less than in 2021-22 (55.4 million) (table 12A.11). Of these, 38.2 million individual service events were provided to outpatients in public hospitals (a 27.9% decrease from 2021-22) and 849,029 group service events were provided (a 24.8% increase on 2021-22). Differing admission practices across states and territories lead to variation among jurisdictions in the services reported (AIHW 2024d).

There were 9,018,401 presentations to emergency departments in 2023-24 (table 12A.12).

Staff

In 2022-23, nurses comprised the single largest group of full-time equivalent (FTE) staff employed in public hospitals (figure 12.3). Comparing data on FTE staff across jurisdictions should be undertaken with care, as this data is affected by jurisdictional differences in recording and classifying staff.

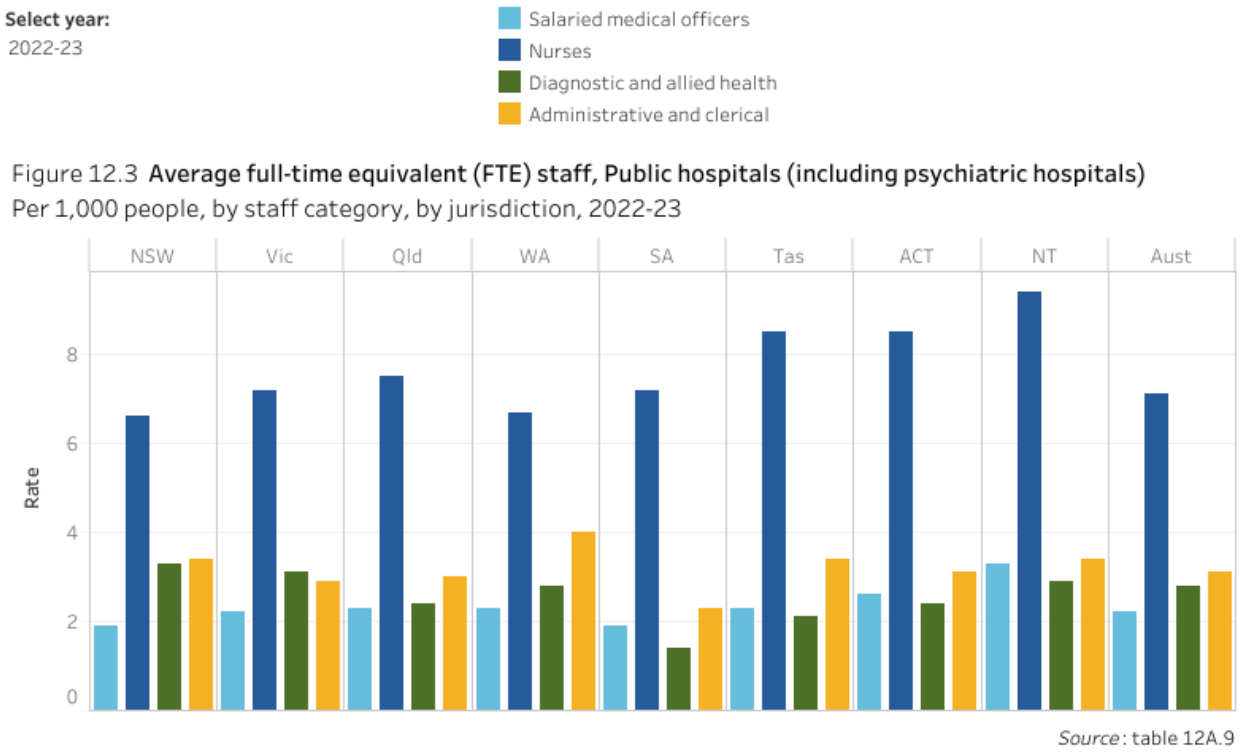


Figure 12.3 **Average full-time equivalent (FTE) staff, Public hospitals (including psychiatric hospitals)**
Per 1,000 people, by staff category, by jurisdiction, 2022-23

Source: table 12A.9

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Indicator framework

The performance indicator framework provides information on equity, effectiveness and efficiency, and distinguishes the outputs and outcomes of public hospital services.

The performance indicator framework shows which data is complete and comparable in this report. For data that is 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 contextual information for this service area (refer to Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

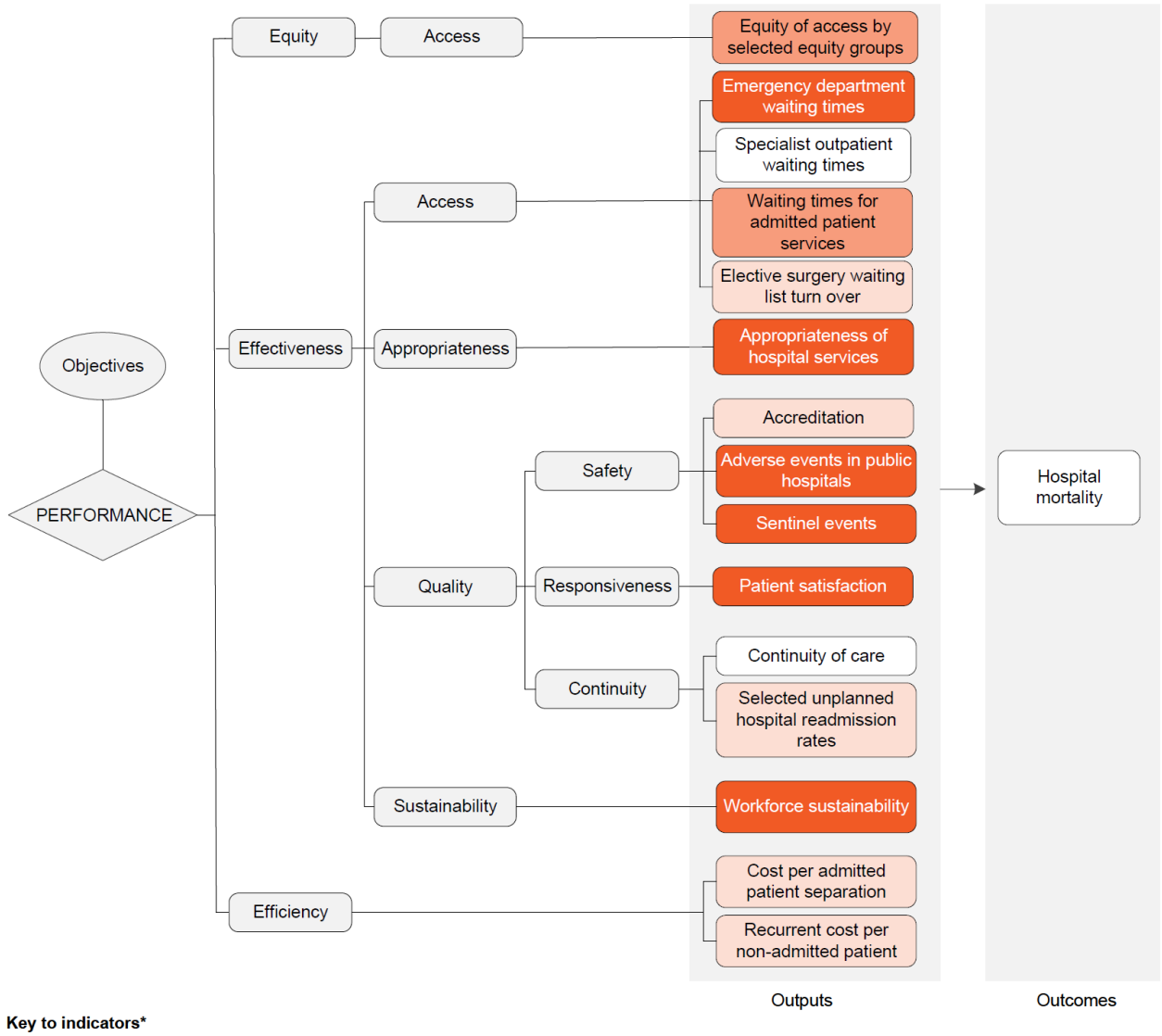
Improvements to performance reporting for public hospital services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (refer to 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 (refer to section 1).



Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Equity of access by selected equity groups – most recent data for at least one measure is comparable and complete

Effectiveness – Access

- Emergency department waiting times – most recent data for all measures is comparable and complete
- Specialist outpatient waiting times – no data reported and/or no measures yet developed
- Waiting times for admitted patient services – most recent data for at least one measure is comparable and complete
- Elective surgery waiting list turn over – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Appropriateness

- Appropriateness of hospital services – most recent data for all measures is comparable and complete

Effectiveness – Quality – Safety

- Accreditation – most recent data for all measures is either not comparable and/or not complete
- Adverse events in public hospitals – most recent data for all measures is comparable and complete
- Sentinel events – most recent data for all measures is comparable and complete

Effectiveness – Quality – Responsiveness

- Patient satisfaction – most recent data for all measures is comparable and complete

Effectiveness – Quality – Continuity

- Continuity of care – no data reported and/or no measures yet developed
- Selected unplanned hospital readmission rates – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Sustainability

- Workforce sustainability – most recent data for all measures is comparable and complete

Efficiency

- Cost per admitted patient separation – most recent data for all measures is either not comparable and/or not complete
- Recurrent cost per non-admitted patient – most recent data for all measures is either not comparable and/or not complete

Outcomes

- Hospital mortality – no data reported and/or no measures yet developed

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section presents an overview of 'Public hospital services' performance indicator results. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of public hospital services.

Information to assist the interpretation of this data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a ‘12A’ prefix (for example, table 12A.1).

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.

1. Equity of access by selected equity groups

‘Equity of access by selected equity groups’ is an indicator of governments’ objective to provide hospital services in an equitable manner. 'Equity of access by selected equity groups' is defined by three measures:

- Emergency department waiting times by triage category, defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale
- Presentations to public hospital emergency departments where the time from presentation to admission, transfer or discharge is less than or equal to four hours
- Overall elective surgery waiting times.

The measures are disaggregations of existing emergency department and elective surgery waiting times indicators. Selected equity groups include people:

- who are Aboriginal and Torres Strait Islander
- from regional and remote areas (based on the ABS Australian Statistical Geography Standard remoteness area structure)
- from low socio-economic areas (based on the ABS Index of Relative Socio-economic Disadvantage, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged).

Results for this indicator should be interpreted with caution:

- Refer to PI 2 'Emergency department waiting times’ for further information on the Australasian Triage Scale and triage categories.
- Refer to PI 4 ‘Waiting times for admitted patient services’ for further information on the scope and calculation of presentations to emergency departments with a length of stay of 4 hours or less ending in admission, overall elective surgery waiting times and elective surgery waiting times by clinical urgency category.

- Refer to PI 5 'Elective surgery waiting list turn over'. This indicator reports the number of additions to, and removals from, public hospital elective surgery waiting lists. Waiting list turn over data is relevant to understanding the extent to which public hospitals are keeping pace with demand for elective surgery.
- Refer to PI 6 ‘Appropriateness of hospital services’. This indicator reports the extent to which emergency department and admitted patients did not wait, left at own risk and discharged against medical advice, rates of which are consistently higher for Aboriginal and Torres Strait Islander people than non-Indigenous people.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

> Measure 1: In 2023-24, all category 1 Aboriginal and Torres Strait Islander patients were seen within clinically appropriate timeframes, except in Western Australia, South Australia and the Northern Territory. Data for the Australian Capital Territory was not published. These results are similar to the results observed for other Australians. Proportions were similar for category 1 patients across remoteness categories and socio-economic areas (table 12.2 and tables 12A.14–17).

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

Data is complete for the current reporting period.

Select year:
2023-24

Select equity group:
(●) Indigenous status
( ) Remoteness area
( ) SEIFA

Table 12.2 Measure 1: **Emergency department waiting times, patients seen on time**
By triage category, by Indigenous status, by jurisdiction, 2023-24 (%)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	Aboriginal and Torres Strait Islander people	100	100	100	99	99	100	np	80	97
	Other Australians	100	100	100	99	98	100	99	81	99
2 - Emergency	Aboriginal and Torres Strait Islander people	75	60	69	69	54	47	72	49	66
	Other Australians	76	62	68	69	43	47	73	42	67
3 - Urgent	Aboriginal and Torres Strait Islander people	70	63	67	49	48	43	50	48	61
	Other Australians	69	69	64	30	38	43	51	34	61
4 - Semi-urgent	Aboriginal and Torres Strait Islander people	76	72	78	63	65	58	64	53	70
	Other Australians	75	76	77	47	59	58	65	43	70
5 - Non-urgent	Aboriginal and Torres Strait Islander people	90	89	93	87	84	78	87	82	88
	Other Australians	90	91	92	81	83	80	88	77	89

Source: table 12A.15
np Not published. .. Not applicable. – Nil or rounded to zero.

Measure 2: Nationally, in 2023-24, the proportion of patients with a length of stay in an emergency department of four hours or less was:

- higher for Aboriginal and Torres Strait Islander patients than other Australians
- higher for patients in outer regional, remote and very remote areas compared to inner regional and major cities
- similar for patients across socio-economic areas (figure 12.4) (tables 12A.19–21).

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

Data is complete for the current reporting period.

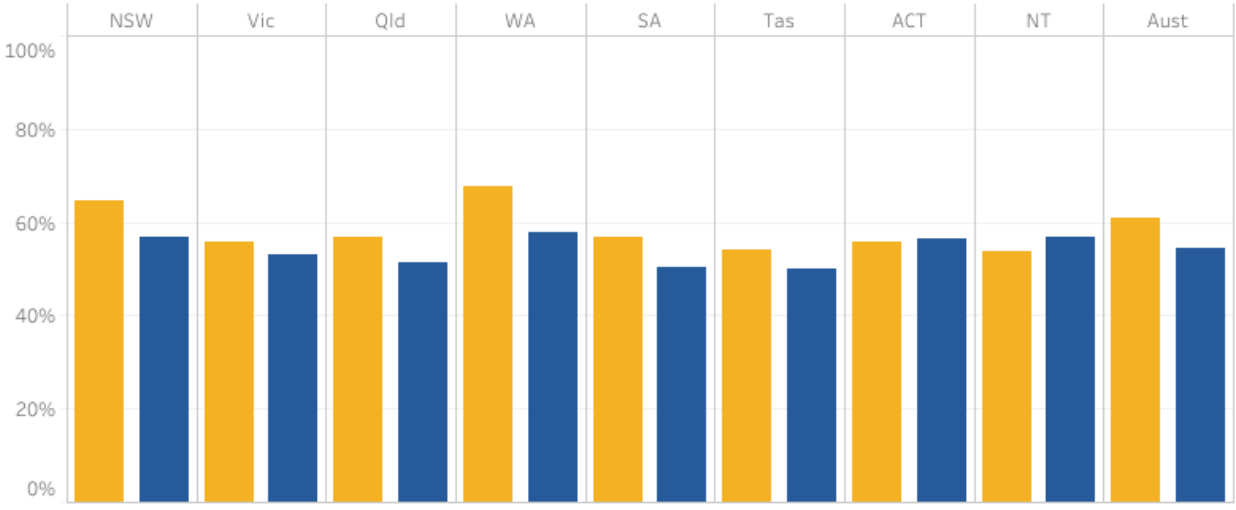
Select equity group:

(●) Indigenous status
( ) Remoteness area of residence
( ) SEIFA

Aboriginal and Torres Strait Islander people
Other Australians

Select year:
2023-24

Figure 12.4 Measure 2: **Emergency department waiting times: ED stay length is within four hours**
By Indigenous status, by jurisdiction, 2023-24 (a), (b)



Source: table 12A.19

(a) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. (b) Disaggregation by SEIFA is based on the patient's usual residence, not the location of the hospital.

+ a b | e a u

Measure 3: Nationally (excluding the Northern Territory), in 2022-23, the time within which 50% of patients were admitted for their awaited procedure varied by remoteness area from 51 days for people in outer regional areas to 41 days for people in remote areas. The time within which 50% of patients were admitted across socio-economic areas ranged from 40 days for people in the highest socio-economic status area to 51 days for people in the lowest socio-economic status area. More recent data (2023-24) is available by Indigenous status (except for the Northern Territory). In 2023-24, overall, the time within which 50% of Aboriginal and Torres Strait Islander people were admitted for their awaited procedure was greater than that for other Australians (56 days and 46 days, respectively) (figure 12.5 and tables 12A.24–26).

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

Data is not complete for the current reporting period. Data is not available for the Northern Territory for 2023-24.

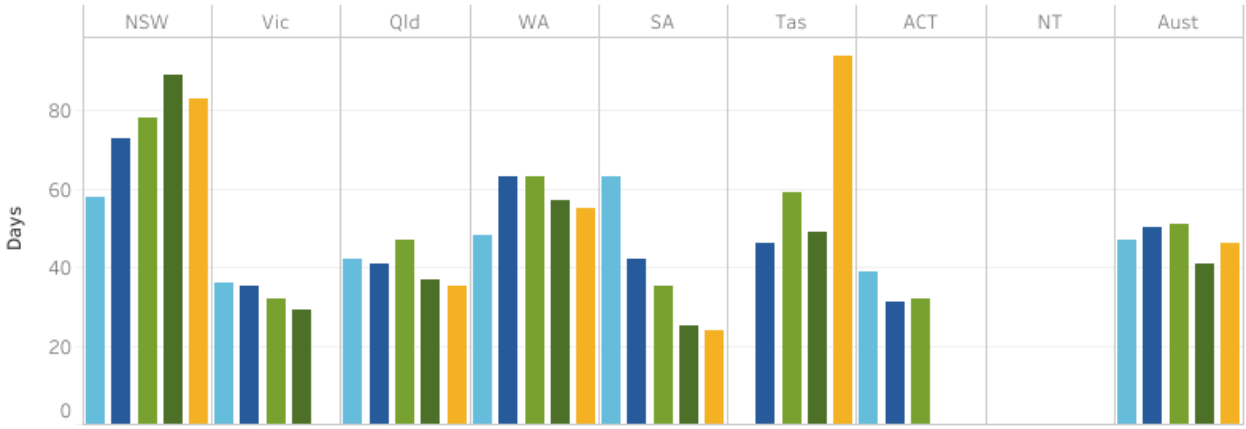
Select equity group:
- Indigenous status
- Remoteness area of residence
- SEIFA

Select percentile:
- 50th percentile
- 90th percentile

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote

Select year:
2022-23

Figure 12.5 Measure 3: **Elective surgery: waiting times**
50th percentile, by Remoteness area of residence, by jurisdiction, 2022-23 (a), (b), (c), (d), (e)



Source: table 12A.25

(a) The most recent year of data available for Remoteness area of residence and SEIFA is for 2022-23 and for Indigenous status is for 2023-24. (b) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. (c) Disaggregation by remoteness area is by the patient's usual residence, not the location of hospital. (d) Disaggregation by SEIFA is based on the patient's usual residence, not the location of the hospital. (e) NT data for the 2023–24 reporting period was not available at the time of publication. National totals exclude the NT.

2. Emergency department waiting times

'Emergency department waiting times' is an indicator of governments' objective to provide timely and accessible services to all.

'Emergency department waiting times' is defined by the following two measures:

- Emergency department waiting times by triage category, defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand. The benchmarks, set according to triage category, are as follows:
  - triage category 1: need for resuscitation – patients seen immediately
  - triage category 2: emergency – patients seen within 10 minutes
  - triage category 3: urgent – patients seen within 30 minutes
  - triage category 4: semi-urgent – patients seen within 60 minutes
  - triage category 5: non-urgent – patients seen within 120 minutes.

- Proportion of patients staying for four hours or less, defined as the proportion of presentations to public hospital emergency departments where the time from presentation to admission, transfer or discharge is less than or equal to four hours. It is a measure of the duration of the emergency department service rather than a waiting time for emergency department care.

High or increasing proportions for both measures are desirable.

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage and clinical practices – in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 12A.13).

> Measure 1: In 2023-24, all category 1 patients were seen within clinically appropriate timeframes in New South Wales, Victoria, Queensland and Tasmania, but not in Western Australia, South Australia, the Australian Capital Territory or the Northern Territory. For all triage categories combined, an estimated 67% of patients were seen within triage category timeframes (table 12.3).

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

Data is complete for the current reporting period.

Select year(s):
Multiple values

Table 12.3 Measure 1: **Emergency department waiting times, Patients seen on time**
By triage category, by jurisdiction, by year (%)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	2023-24	100	100	100	99	98	100	99	80	99
	2022-23	100	100	100	99	99	100	98	98	100
	2014-15	100	100	99	100	100	100	100	100	100
2 - Emergency	2023-24	76	62	68	69	44	47	73	46	67
	2022-23	75	57	64	67	44	49	66	53	64
	2014-15	82	80	77	83	69	83	78	62	79
3 - Urgent	2023-24	69	68	65	32	38	43	51	41	61
	2022-23	69	61	62	32	39	44	41	44	58
	2014-15	76	73	64	57	57	64	48	54	68
4 - Semi-urgent	2023-24	75	75	77	49	59	58	65	47	70
	2022-23	75	70	74	50	60	60	51	48	68
	2014-15	81	73	74	69	69	67	53	59	74
5 - Non-urgent	2023-24	90	91	92	82	83	80	88	79	89
	2022-23	91	87	91	83	81	79	76	82	88
	2014-15	95	89	93	93	89	89	86	88	92
Total excluding unknown triage category	2023-24	74	71	70	48	49	51	62	47	67
	2022-23	74	65	67	48	50	52	51	50	65
	2014-15	81	75	71	68	66	70	59	60	74

Source: table 12A.13
na Not available.

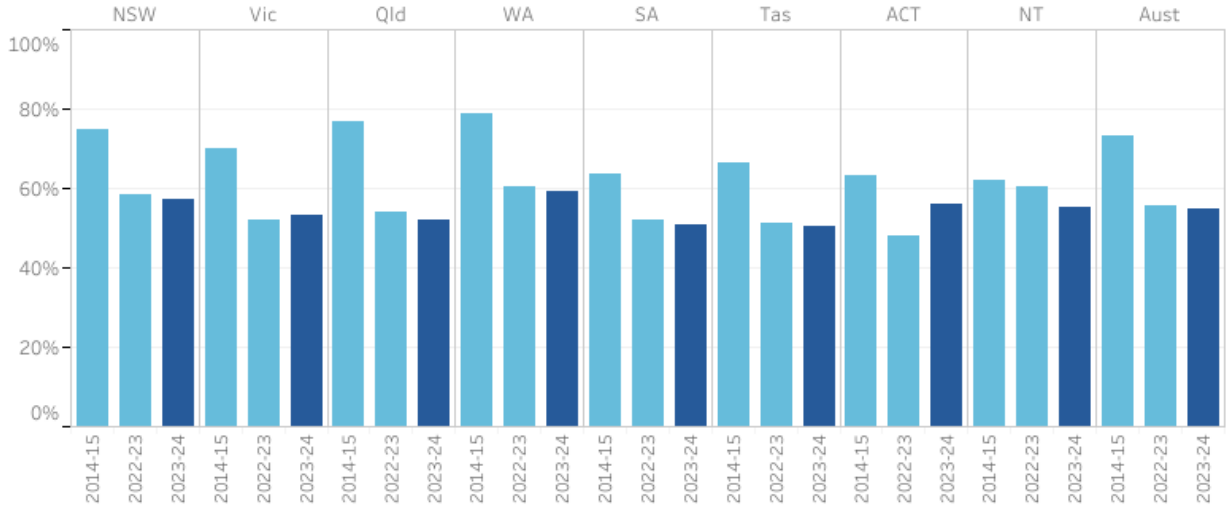
Measure 2: Nationally in 2023-24, the proportion of patients staying for four hours or less in an emergency department was 55.0%, continuing an annual decrease from 73.2% in 2014-15 (figure 12.6).

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

Data is complete for the current reporting period.

Select year(s):
Multiple values

Figure 12.6 Measure 2: **Patients staying for four hours or less, ED stay length is within four hours**
By jurisdiction, by year (a)



Source: table 12A.18

(a) Data was not available for the ACT for 2015-16 and has not been included in the Australian total for that year.

3. Specialist outpatient waiting times

'Specialist outpatient waiting times' is an indicator of governments' objective to provide timely and accessible hospital services.

'Specialist outpatient waiting times' are defined as the period of time (days or months) between the date a specialist outpatient clinic receives a patient referral, and the date that patient is first seen by the specialist outpatient clinic.

A low or decreasing number of days waited is desirable.

This indicator is currently under development for reporting in the future.

Local approaches to measuring and reporting on specialist outpatient waiting times are shown in table 12.4:

Table 12.4 Summary of existing public reporting on outpatient waiting times

Vic	Victoria reports quarterly on the waiting time for a routine first specialist clinic appointment (number of days between the date a specialist clinic receives a routine patient referral, and the date the patient is first seen by the specialist clinic) at the 50th and 90th percentile, disaggregated by medical specialty. Data are also reported on the proportion of routine patients who were seen by the specialist clinic within the recommended time of 365 days from receiving the referral. A routine first appointment is where a patient has been referred to a specialist clinic and the clinician determines the patient should be seen within 365 days from the date the referral was received (non-urgent patients who do not need to be seen by a specialist clinic within 30 days). A specialist clinic is a unit within a hospital that provides planned, non-admitted services. First appointment data is recorded when a first appointment is booked, even if the patient does not attend. Once referred to a specialist clinic by a GP or other health provider, a patient can only have one first appointment. This is recorded at the specialist clinic to which they were referred. https://vahi.vic.gov.au/specialist-clinics/routine-first-appointments

Qld	Queensland reports publicly on: • the number of patients waiting for an initial service event in a specialist outpatient clinic. This data shows the number of patients on a specialist outpatient waiting list on a given day and is a measure of the demand for specialist outpatient services. The number of patients waiting in each specialty type reflects a mix of patients. • The proportion of patients waiting within the clinically recommended time, by procedure type. This measure shows if hospitals provided patients with outpatient services within recommended timeframes for each urgency category. There are three urgency categories, in order of descending urgency from 1 to 3. This measure shows, for each category, the percentage of patients waiting for an outpatient appointment at the census date who waited up to the maximum recommended time. The higher the percentage, the better the performance. The percentage for each clinic shows the mix of patients. • 90th percentile waiting times (in days) for a new case specialist appointment. This is a measure for hospitals which shows the number of days that 90% of patients waited for their initial specialist outpatient appointment. The waiting time for each clinic shows the mix of patients. The start of the waiting time is the date a referral was received by the treating hospital. The end of the waiting time is the appointment date (for the 90th percentile wait) or the census date (for the percentage waiting within time). The number of days between the start and the end of the waiting time is calculated first. Then excluded from this total is any days the patient was not ready for care and any days the patient was waiting as a less urgent category and any days the referral could not progress because the hospital was waiting further information from the referring practitioner. If a patient is offered an appointment and they cancel, or fail to show up for the appointment, their wait continues. An 'initial service event' is the first appointment a patient has with the health professional in an outpatient clinic, for treatment or management of the condition for which they have been referred. When a patient has had their initial service event, they are no longer on the waiting list for that service. http://www.performance.health.qld.gov.au/Hospital/SpecialistOutpatient/99999

SA	South Australia reports publicly on the median and maximum waiting times (months) for reported specialist clinics in metropolitan hospitals for patients that are routine (Category 2) or non-urgent (Category 3) or are on a waiting list and have not been given an appointment, by outpatient specialty. These patients are considered 'unscheduled'. All urgent (category 1) patients are given an appointment and are therefore not added to the outpatient waiting list. The median waiting times are considered a more accurate measure because some people will have very short waiting times or very long waiting times, and this can make the average measure less representative of the time most people wait for an appointment. In most cases, the maximum waiting time represents the time one individual patient has waited as at the date of the Report. SA Health has several patient administration systems that have different reporting capabilities for outpatient waiting list information. As a result, the quality, accuracy, and consistency of outpatient data is a significant challenge. SA Health is continuing to undertake initiatives which improve the quality, reliability, and availability of information. https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/specialist+outpatient+waiting+time+report
Tas	Tasmania publicly reports indicative 75th percentile waiting times (in days), by region (Southern, North West and Northern Regions), specialty type, and urgency category (Urgent condition, Semi-Urgent condition and Non-urgent condition). https://www.health.tas.gov.au/hospitals/outpatients/wait_times

Sources: State and Territory governments (unpublished).

4. Waiting times for admitted patient services

'Waiting times for admitted patient services' is an indicator of governments' objective to provide timely and accessible services to all.

'Waiting times for admitted patient services' is defined by the following three measures:

- Overall elective surgery waiting times
- Elective surgery waiting times by clinical urgency category
- Presentations to emergency departments with a length of stay of four hours or less ending in admission.

Overall elective surgery waiting times

'Overall elective surgery waiting times' are calculated by comparing the date patients are added to a waiting list with the date they were admitted. Days on which the patient was not ready for care are excluded. Overall waiting times are presented as the number of days within which 50% of patients are admitted and the number of days within which 90% of patients are admitted. Patients on waiting lists who were not subsequently admitted are excluded.

For overall elective surgery waiting times, a low or decreasing number of days waited is desirable. Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who

transferred from a waiting list managed by one hospital to a waiting list managed by another hospital, with the time waited on the first list included in the waiting time reported in New South Wales, Western Australia, South Australia and the Northern Territory. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions.

> Measure 1: Nationally (excluding the Northern Territory), in 2023-24, 50% of patients were admitted within 46 days (down from 49 days in 2022-23) and 90% of patients were admitted within 329 days (down from 361 days in 2022-23) (figure 12.7). Data is available on elective surgery waiting times by hospital peer group and procedure, by Aboriginal and Torres Strait Islander status, remoteness area of residence and socio-economic status (tables 12A.23–26).

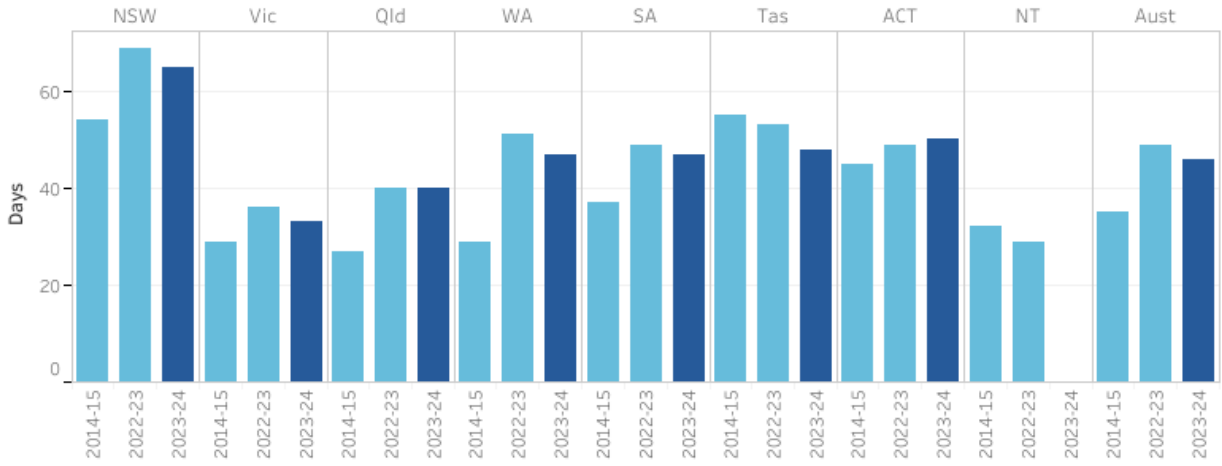
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. Data is not available for the Northern Territory for 2023-24.

Select year(s):
Multiple values

Select percentile:
(●) 50th percentile
( ) 90th percentile

Figure 12.7 Measure 1: **Elective surgery: waiting times (days), 50th percentile**
By jurisdiction, by year (a), (b)



Source: table 12A.23

(a) Data is not available for the ACT for 2015-16. (b) NT data for the 2023–24 reporting period was not available at the time of publication. National totals exclude the NT.

Elective surgery waiting times by clinical urgency category

'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who were admitted from waiting lists after an extended wait. When patients are placed on public hospital waiting lists, clinical assessments are made on how urgently they require elective surgery. The clinical urgency categories are:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days.

The term ‘extended wait’ is used for patients in categories 1, 2 and 3 waiting longer than specified times (30 days, 90 days and 365 days respectively).

For elective surgery waiting times by clinical urgency category, a low or decreasing proportion of patients who experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be considered. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories.

> Measure 2: Jurisdictional differences in the classification of patients by urgency category are shown in table 12.5a. The proportions of patients on waiting lists who already had an extended wait at the date of assessment are reported in tables 12A.28–35.

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data is not available for the Northern Territory for 2023-24.

Select year:
2023-24

Table 12.5a Measure 2: **Patients with extended waits admitted from waiting lists during the year**
By clinical urgency category, by jurisdiction, 2023-24 (%)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Clinical urgency category 1	0.5	–	12.8	15.7	18.5	33.6	25.0	na
Clinical urgency category 2	18.5	35.9	26.0	29.5	37.5	45.6	55.1	na
Clinical urgency category 3	19.3	19.0	18.1	14.8	17.5	16.9	33.9	na
All patients	14.7	20.0	19.0	20.0	25.5	34.1	36.4	na

Source: tables 12A.28-12A.35
– Nil or rounded to zero. **na** Not available.

(a) NT data for the 2023-24 reporting period was not available at the time of publication.

tableau

Presentations to emergency departments with a length of stay of four hours or less ending in admission

‘Presentations to emergency departments with a length of stay of four hours or less ending in admission’ is defined as the proportion of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to four hours.

A high or increasing proportion of presentations to emergency departments with a length of stay of four hours or less ending in admission is desirable.

> Measure 3: Nationally in 2023-24, 31% of people who presented to an emergency department and were admitted, waited four hours or less to be admitted to a public hospital (table 12.5b). This proportion was the same in 2022-23 after declining from 46% in 2019-20.

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

Data is complete for the current reporting period.

Select year:
2023-24

Table 12.5b Measure 3: **Emergency department presentations, ED stay length is within four hours ending in admission, All public hospitals**
By triage category, by jurisdiction, 2023-24 (%)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	35	45	43	46	44	44	50	37	42
2 - Emergency	25	36	37	35	34	26	48	31	33
3 - Urgent	22	34	30	24	26	16	40	29	28
4 - Semi-urgent	27	40	32	28	30	18	45	25	32
5 - Non-urgent	50	56	49	41	41	41	56	35	50
Total	25	36	33	29	30	21	43	29	31

Source: table 12A.22
na Not available.

5. Elective surgery waiting list turn over

‘Elective surgery waiting list turn over’ is an indicator of governments' objective to provide timely and accessible services to all.

‘Elective surgery waiting list turn over’ is defined as the number of additions to, and removals from, public hospital elective surgery waiting lists. It is measured as the number of people removed from public hospital elective surgery waiting lists following admission for surgery during the reference year, divided by the number of people added to public hospital elective surgery waiting lists during the same year, multiplied by 100.

The number of people removed from public hospital elective surgery waiting lists following admission for surgery includes elective and emergency admissions. For context, the total number of removals from elective surgery waiting lists are also reported. Other reasons for removal include patient not contactable or died, patient treated elsewhere, surgery not required or declined, transferred to another hospital's waiting list, and not reported.

When interpreting this data, 100% indicates that an equal number of patients were added to public hospital elective surgery waiting lists as were removed following admission for surgery during the reporting period (therefore the number of patients on the waiting list will be largely unchanged). A figure less than 100% indicates that more patients were added to public hospital elective surgery waiting lists than were removed following admission for surgery during the reporting period (therefore the number of patients on the waiting list will have increased).

A higher and increasing proportion of patient turnover is desirable as it indicates the public hospital system is keeping pace with demand for elective surgery.

> Nationally (excluding the Northern Territory) in 2023-24, 903,507 people were added to public hospital elective surgery waiting lists, while 771,551 people were removed following admission for surgery, resulting in a national public hospital elective surgery waiting list turnover of 85.4% (table 12.6). Results varied across jurisdictions.

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data is not available for the Northern Territory for 2023-24.

Select year(s):
Multiple values

Table 12.6 **Elective surgery waiting list turn over**
By jurisdiction, by year (a)

		Additions to public hospital elective surgery waiting lists	Removals following admission for surgery	Turn over following admissions for surgery
		no.	no.	%
NSW	2023-24	264,591	231,804	87.6
	2022-23	255,190	225,749	88.5
	2014-15	245,214	217,727	88.8
Vic	2023-24	230,346	210,677	91.5
	2022-23	213,889	190,867	89.2
	2014-15	200,630	173,307	86.4
Qld	2023-24	195,724	149,420	76.3
	2022-23	182,659	140,977	77.2
	2014-15	151,125	126,275	83.6
WA	2023-24	101,336	85,991	84.9
	2022-23	91,969	80,793	87.8
	2014-15	100,323	82,742	82.5
SA	2023-24	67,740	56,484	83.4
	2022-23	62,609	55,900	89.3
	2014-15	70,306	62,402	88.8
Tas	2023-24	25,367	22,196	87.5
	2022-23	23,156	21,364	92.3
	2014-15	18,538	15,598	84.1
ACT	2023-24	18,403	14,979	81.4
	2022-23	16,556	12,640	76.3
	2014-15	14,550	11,881	81.7
NT	2023-24	na	na	na
	2022-23	9,500	7,170	75.5
	2014-15	9,492	7,634	80.4
Aust	2023-24	903,507	771,551	85.4
	2022-23	855,528	735,460	86.0
	2014-15	810,178	697,566	86.1

Source: table 12A.36
na Not available.
(a) NT data for the 2023–24 reporting period was not available at the time of publication. National totals exclude the NT.

6. Appropriateness of hospital services

'Appropriateness of hospital services' is an indicator of governments' objective to provide care that is appropriate and responsive to the needs of individuals throughout their lifespan and communities.

'Appropriateness of hospital services' is defined as the proportion of patients who discharge against medical advice and is measured as:

- Emergency department presentations:
    - patients who did not wait, as a proportion of all emergency department presentations
    - patients who left at their own risk, as a proportion of all emergency department presentations
- Admitted patient care separations:
    - patients who left or were discharged against medical advice, as a proportion of all hospital separations.

'Did not wait' refers to patients who did not wait for clinical care to commence or medical assessment following triage in the emergency department. 'Left at own risk' refers to patients who left against advice after treatment had commenced. This includes patients who were planned for admission but who did not physically leave the emergency department prior to departing. 'Discharge against medical advice' refers to patients who were admitted to hospital and left against the advice of their treating physician.

Patients who do not wait, leave at their own risk and discharge against medical advice are at an increased risk of complications, readmission and mortality. Patients leave hospital against medical advice for a variety of reasons, including long waiting times, they begin to feel better, family and employment responsibilities or a lack of cultural safety (AIHW 2024e). These factors, together with interpersonal and institutional racism, contribute to the disproportionately higher rates of Aboriginal and Torres Strait Islander (First Nations) people self-discharging from hospital.

Low or decreasing proportions of patients who do not wait, leave at own risk and discharge against medical advice are desirable.

Broader, system-level definitions of appropriate health care include dimensions such as evidence-based care, variations in clinical practice and resource use. Additional measures for this indicator will be considered for inclusion in future editions of this report.

> Nationally in 2022-23, 5.0% of emergency department presentations did not wait, while 3.5% of emergency department presentations left at their own risk. Additionally, 1.2% of admitted patients left or were discharged against medical advice (Figure 12.8). Proportions for all measures were higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people (table 12A.37).

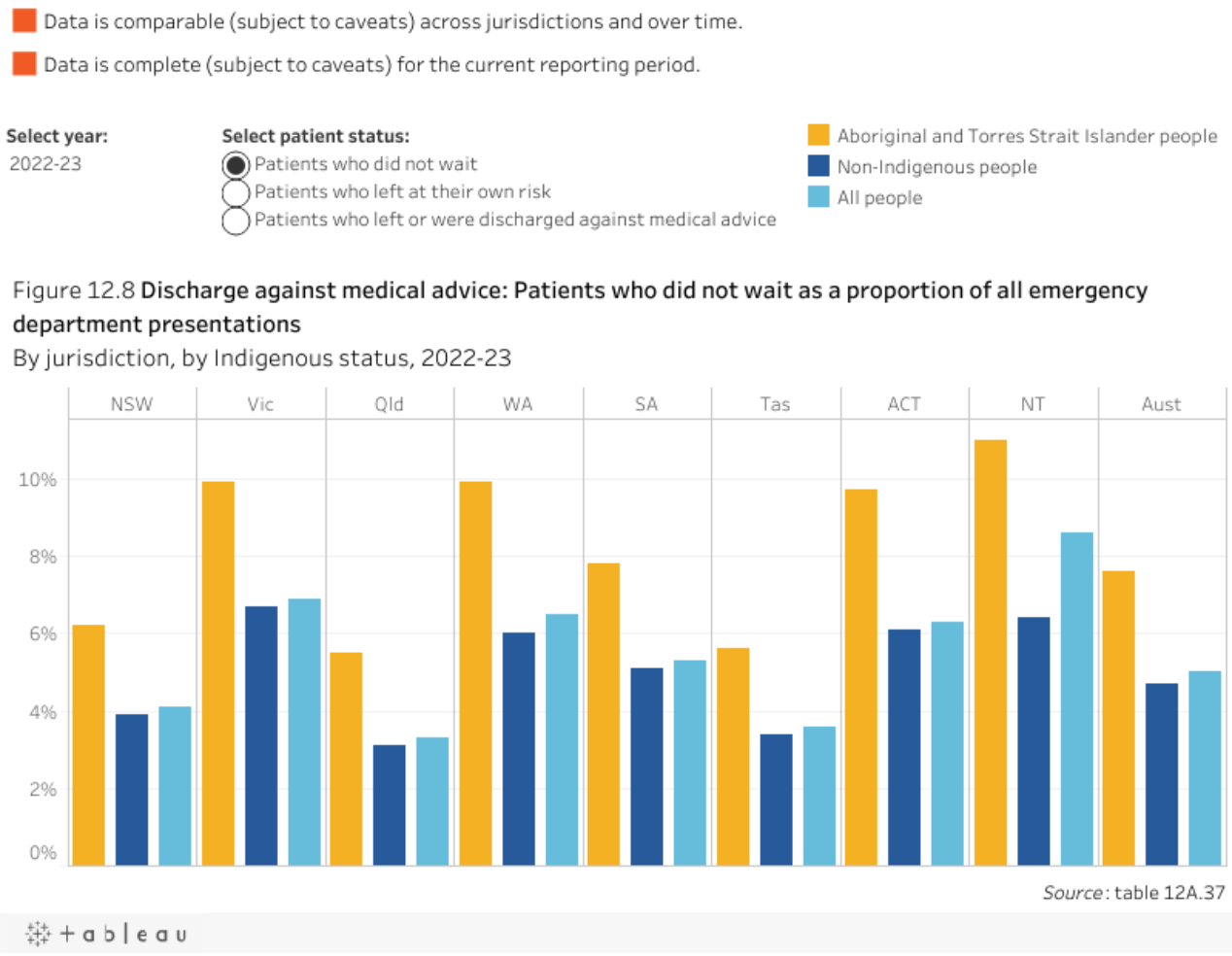


Figure 12.8 **Discharge against medical advice: Patients who did not wait as a proportion of all emergency department presentations**
By jurisdiction, by Indigenous status, 2022-23

7. Accreditation

'Accreditation' is an indicator of governments' objective to provide public hospital services that are high quality and safe.

'Accreditation' is defined as public hospitals accredited to the National Safety and Quality Health Service (NSQHS) Standards (the Standards) and is measured as:

- the number of public hospitals accredited, as a proportion of all public hospitals with completed accreditation assessments in the same calendar year
- the number of public hospitals accredited during the calendar year that required remedial actions to achieve accreditation, as a proportion of all public hospitals accredited during the same calendar year.

It is mandatory for all Australian hospitals and day procedure services to be accredited to the NSQHS Standards. Health service organisations must demonstrate that they meet all relevant requirements in the NSQHS Standards to achieve accreditation. Health service organisations are assessed to the NSQHS Standards every three years. The NSQHS Standards are:

- Clinical governance
- Partnering with consumers
- Preventing and controlling infections

- Medication safety
- Comprehensive care
- Communicating for safety
- Blood management
- Recognising and responding to acute deterioration.

A high or increasing rate of accreditation is desirable. Accreditation against the NSQHS Standards is evidence that a hospital has been able to demonstrate that safety and quality systems and processes are in place to prevent or minimise patient harm. It does not mean that an accredited hospital will always provide high quality and safe care.

In July 2023, short notice accreditation assessments became mandatory for hospitals.

There are differences across jurisdictions in the mix of hospitals that were assessed (for example, large metropolitan hospitals and small rural services). This indicator should be interpreted in conjunction with other indicators of public hospital quality and safety.

Nationally, in 2023, 59.0% of public hospitals that were accredited during the year required remedial actions to achieve accreditation (table 12.7). This is 18.0 percentage points higher than the proportion that required remedial actions in 2022 (41.0%) (table 12A.38). The national accreditation program was suspended between March 2020 and October 2021, due to the COVID-19 pandemic. During this time, hospitals and day procedure services maintained their existing accreditation status (ACSQHC 2020) and were required to continue to comply with the NSQHS Standards.

Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

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

Select year:
2023

Table 12.7 **National Safety and Quality Health Service Standards (NSQHSS) accreditation, All public hospitals**
By jurisdiction, 2023 (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number of public hospitals that were accredited	no.	26	49	46	55	41	17	–	–	234
Proportion of accredited public hospitals that required remedial actions to achieve accreditation	%	54	33	33	100	78	35	..	..	59

Source: table 12A.38
.. Not applicable. – Nil or rounded to zero.

(a) Total includes hospitals in external territories.

8. Adverse events in public hospitals

‘Adverse events in public hospitals’ is an indicator of governments’ objective to provide public hospital services that are high quality and safe. Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported as a separate output indicator.

‘Adverse events in public hospitals’ is defined by three measures:

- Selected healthcare-associated infections
- Adverse events treated in hospitals
- Falls resulting in patient harm in hospitals.

Selected healthcare-associated infections

‘Selected healthcare-associated infections’ is the number of *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals (admitted and non-admitted patients), expressed as a rate per 10,000 patient days for public hospitals.

A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.

SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected less than or equal to 48 hours after admission to hospital and the patient episode of SAB meets at least one of the following criteria:

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
- SAB is associated with neutropenia contributed to by cytotoxic therapy. Neutropenia is defined as at least two separate calendar days with values of absolute neutrophil count (ANC) or total white blood cell count <500 cell/mm^3 (0.5×10^9/L) on or within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the three calendar days before and the three calendar days after.

Cases where a known previous positive test was obtained within the past 14 days are excluded. Patient days for unqualified newborns, hospital boarders and posthumous organ procurement are excluded.

A low or decreasing rate of selected healthcare-associated infections is desirable.

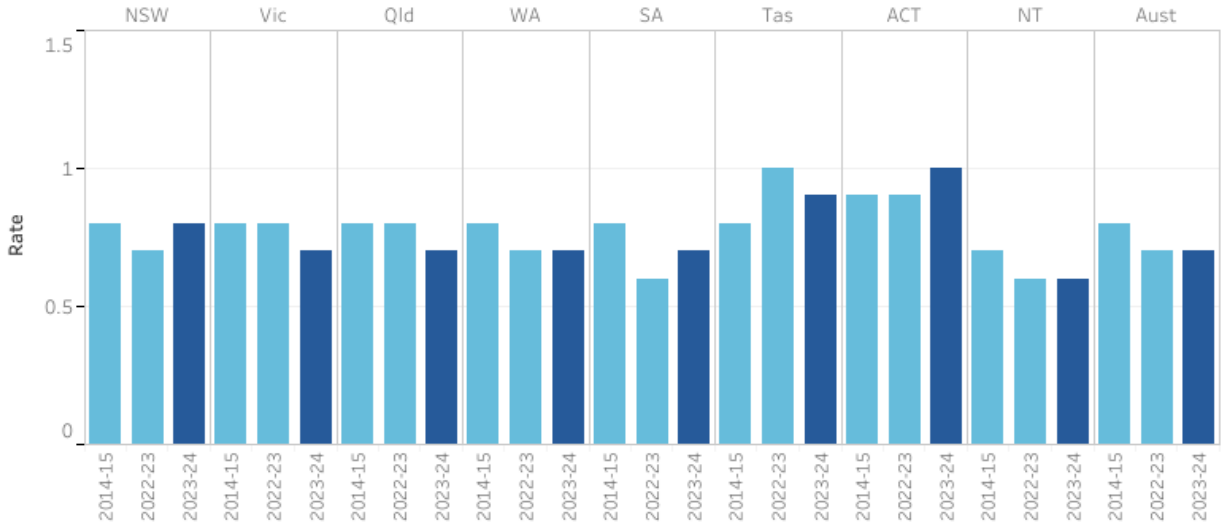
> Measure 1: Nationally in 2023-24, the rate of selected healthcare-associated infections was 0.7 per 10,000 patient days; a rate largely unchanged over the reported ten-year time series (figure 12.9a).

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

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

Select year(s):
Multiple values

Figure 12.9a Measure 1: **Selected healthcare-associated infections: Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals**
Per 10,000 patient days, by jurisdiction, by year



Source: table 12A.39

Adverse events treated in hospitals

'Adverse events treated in hospitals' are incidents in which harm resulted to a person during hospitalisation and are measured by separations that had an adverse event (including infections, falls resulting in injuries and problems with medication and medical devices) that occurred during hospitalisation. Hospital separations data includes information on diagnoses and place of occurrence that can indicate that an adverse event was treated and/or occurred during the hospitalisation, but some adverse events are not identifiable using these codes.

Low or decreasing adverse events treated in hospitals are desirable.

> Measure 2: Nationally, in 2022-23, 6.4% of separations in public hospitals had an adverse event reported during hospitalisation (table 12.8). Results by category (diagnosis, external cause and place of occurrence of the injury or poisoning) are in table 12A.40.

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

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

Select year(s):
Multiple values

Table 12.8 Measure 2: **Adverse events treated in hospitals, Public hospitals (including psychiatric hospitals)**
Per 100 separations, by jurisdiction, by year

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2022-23	rate (AS)	7.0	5.4	6.6	7.6	7.7	7.0	7.2	3.1	6.4
2021-22	rate (AS)	7.1	5.4	6.2	7.9	7.5	7.1	7.0	3.1	6.4
2013-14	rate (AS)	6.4	7.0	6.4	7.0	7.3	8.4	7.3	3.7	6.7

Source: table 12A.40

Falls resulting in patient harm in hospitals

'Falls resulting in patient harm in hospitals' is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area, expressed as a rate per 1,000 hospital separations. It is not possible to determine if the place of occurrence was exclusively within a hospital, only that it was a health service area, which alongside hospitals include day procedure centres, health centres, hospices and outpatient clinics.

A low or decreasing rate of falls resulting in patient harm in hospitals is desirable.

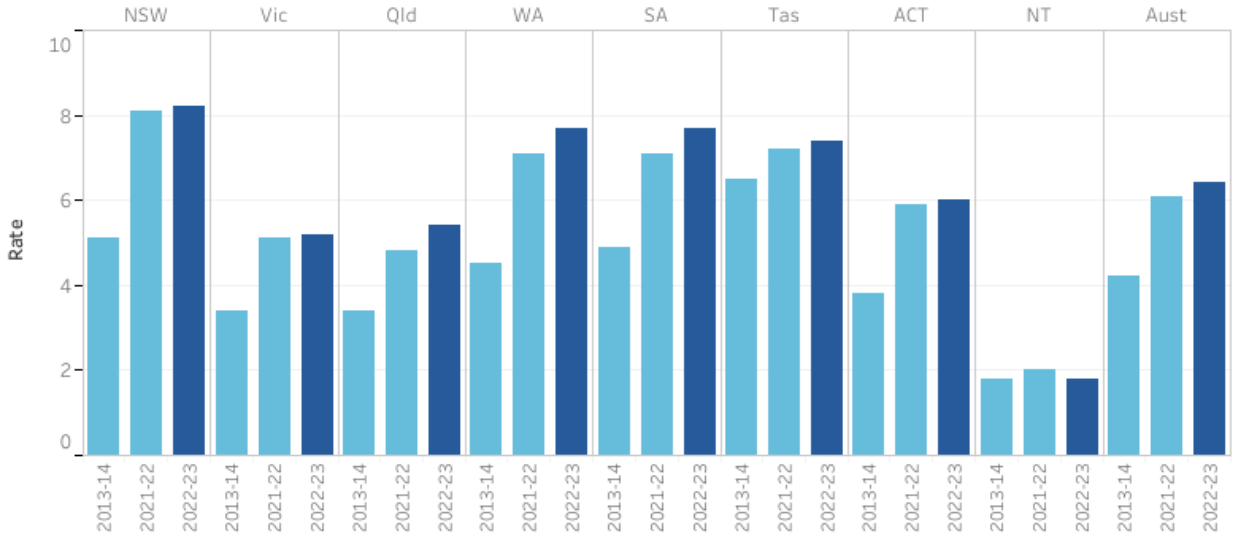
> Measure 3: Nationally in 2022-23, the rate of falls resulting in patient harm was 6.4 per 1,000 hospital separations (public hospitals); results varied across states and territories (figure 12.9b). Data is reported by Indigenous status and remoteness in table 12A.41.

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

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

Select year(s):
Multiple values

Figure 12.9b Measure 3: **Falls resulting in patient harm in hospitals, All public hospitals**
Per 1,000 separations, by jurisdiction, by year



Source: table 12A.41

9. Sentinel events

'Sentinel events' is an indicator of governments' objective to deliver public hospital services that are high quality and safe. Sentinel events are a subset of adverse events that result in death or very serious harm to a patient. Adverse events are reported as a separate output indicator.

'Sentinel events' is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition.

Australian health ministers agreed version 2 of the Australian sentinel events list in December 2018. All jurisdictions implemented these categories on 1 July 2019. The national sentinel events are:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death

- Haemolytic blood transfusion reaction resulting from ABO blood type incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro-or naso-gastric tube resulting in serious harm or death.

A low or decreasing number of sentinel events is desirable.

All state and territory governments have implemented sentinel event reporting programs. The purpose of these programs is to facilitate a safe environment for patients by reducing the frequency of these events. The programs are not punitive and are designed to facilitate self-reporting of errors so that the underlying causes of events can be examined, and action taken to reduce the risk of these events re-occurring.

Changes in the number of sentinel events reported over time do not necessarily mean that Australian public hospitals have become more or less safe, but might reflect improvements in incident reporting mechanisms, organisational cultural change, and/or an increasing number of hospital admissions (this data is reported as numbers rather than rates). Sentinel event should be monitored over time to identify trends and establish underlying reasons.

> Nationally, in 2022-23, there was a total of 84 sentinel events, 13 more than in 2021-22 (table 12.9). As larger states and territories will tend to have more sentinel events than smaller jurisdictions, the number of separations is also presented to provide context. In 2022-23, 60.7% of sentinel events were medication errors resulting in serious harm or death (12A.42). Data disaggregated by the type of sentinel event is reported in table 12A.42.

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

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

Select year(s):
Multiple values

Table 12.9 **Sentinel events and hospital separations**
By jurisdiction, by year (number)

	Total events			Separations		
	2019-20	2021-22	2022-23	2019-20	2021-22	2022-23
NSW	10	18	24	1,809,760	1,768,912	1,861,350
Vic	23	24	28	1,834,131	1,814,006	1,938,594
Qld	8	8	9	1,596,532	1,720,372	1,730,260
WA	7	11	13	612,154	616,935	639,728
SA	5	5	7	446,766	466,236	480,588
Tas	4	1	2	130,473	157,344	165,276
ACT	1	2	1	118,737	121,079	129,467
NT	0	2	0	181,489	172,211	182,742
Aust	58	71	84	6,730,042	6,837,095	7,128,005

Source: tables 12A.5 and 12A.42
– Nil or rounded to zero.

10. Patient satisfaction

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are responsive to individuals throughout their lifespan and communities.

'Patient satisfaction' is defined by two measures:

- Proportion of people who visited a hospital emergency department in the last 12 months for their own health reporting that the emergency department doctors, specialists or nurses 'always' or 'often':
    - listened carefully to them
    - showed respect to them
    - spent enough time with them
- Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses 'always' or 'often':
    - listened carefully to them
    - showed respect to them
    - spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, as it suggests high quality hospital care that meets patient needs and expectations.

The ABS Patient Experience Survey of people aged 15 years and over does not include people living in discrete Indigenous communities, which affects the representativeness of the Northern Territory results. Approximately 20% of the resident population of the Northern Territory live in discrete Indigenous communities as of 2020-21.

Measure 1: Nationally, in 2023-24, the proportion of respondents across all areas reporting that emergency department doctors, specialists or nurses always or often listened carefully and showed respect was above 83.6%. The proportion of respondents who reported that emergency department doctors or specialists always or often spent enough time with them was 79.3% compared to 85.2% who reported that emergency department nurses always or often spent enough time with them (figure 12.10a).

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

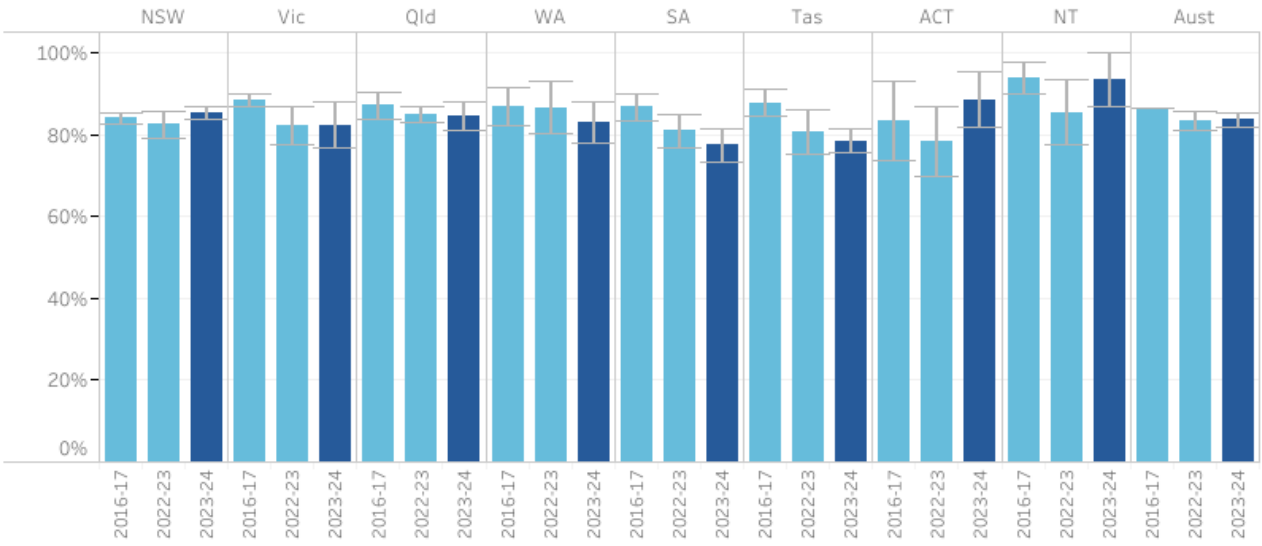
Data is complete (subject to caveats) for the current reporting period.

Select health professional:
(●) ED doctors or specialists
( ) ED nurses

Select disaggregation:
(●) always or often listened carefully
( ) always or often showed respect
( ) always or often spent enough time with person

Select year(s):
Multiple values

Figure 12.10a Measure 1: **Patient satisfaction with ED doctors or specialists — always or often listened carefully**
By jurisdiction, by year



Source: table 12A.43

Measure 2: Nationally, in 2023-24, the proportion of respondents across all areas reporting that hospital doctors, specialists or nurses listened carefully, showed respect and spent enough time with them was above 86.8% (figure 12.10b).

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

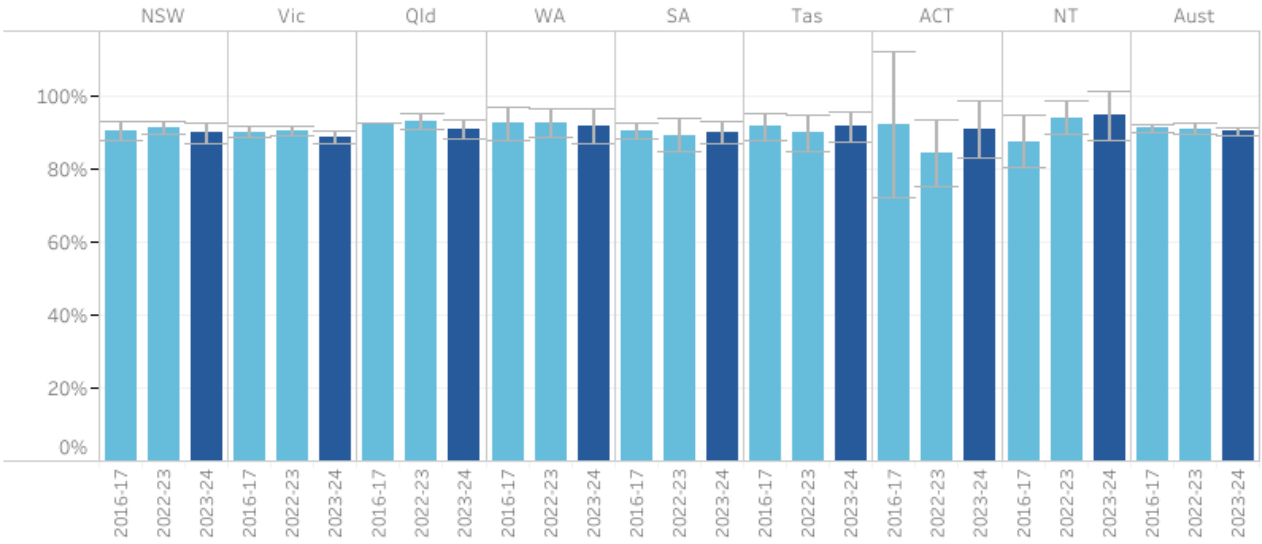
Data is complete (subject to caveats) for the current reporting period.

Select health professional:
- (●) hospital doctors or specialists
- ( ) hospital nurses

Select disaggregation:
- (●) always or often listened carefully
- ( ) always or often showed respect
- ( ) always or often spent enough time with person

Select year(s):
Multiple values

Figure 12.10b Measure 2: **Patient satisfaction with hospital doctors or specialists — always or often listened carefully**
By jurisdiction, by year



Source: table 12A.45

11. Continuity of care

‘Continuity of care’ is an indicator of governments' objective to provide care that is well co-ordinated where more than one service type, and/or ongoing service provision is required.

‘Continuity of care’ is defined as the proportion of patients who reported that arrangements were not made by their hospital for any services needed after leaving hospital when last admitted.

A low or decreasing proportion of patients reporting that arrangements were not made by their hospital for any services needed after leaving hospital when last admitted is desirable.

This indicator is currently under development for reporting in the future.

12. Selected unplanned hospital readmission rates

‘Selected unplanned hospital readmission rates’ is an indicator of governments’ objective to provide public hospital services that are of high quality and well-coordinated to ensure continuity of care.

‘Selected unplanned hospital readmission rates’ is defined as the rate at which patients unexpectedly return to the same hospital within 28 days for further treatment where the original

admission involved one of a selected set of procedures, and the readmission is identified as a post-operative complication. It is expressed as a rate per 1,000 separations in which one of the selected surgical procedures was performed. The indicator is an underestimate of all possible unplanned/unexpected readmissions.

The selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.

Low or decreasing rates of unplanned readmissions are desirable. Conversely, high or increasing rates suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.

Data for 2021-22 and 2022-23 was not provided as states and territories have elected to pause reporting on this indicator while data specifications are reviewed to address data quality concerns. Reporting is expected to resume in time for inclusion in the 2026 report. This may be on the basis of updated specifications or a suitable alternative indicator, for example, the National Health Reform Agreement indicator ‘Avoidable hospital readmissions’ as published by the Independent Health and Aged Care Pricing Authority (IHACPA).

> Of the selected surgical procedures in 2020-21, readmission rates were highest nationally, and for most jurisdictions, for tonsillectomy and adenoidectomy, with the rate increasing from 27.8 to 47.9 readmissions per 1,000 separations over the past 10 years (table 12.10). Selected unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 12A.48.

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

Data is not complete for the current reporting period.

Select year:
2020-21

Table 12.10 **Unplanned hospital readmissions, All public hospitals**
Per 1,000 separations, by selected surgical procedure, by jurisdiction, 2020-21 (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Appendicectomy	rate	21.6	18.1	24.6	26.7	22.3	17.8	20.0	51.2	21.8
Cataract surgery	rate	2.1	2.4	5.9	2.0	2.7	4.4	1.9	np	2.8
Hip replacement	rate	21.0	20.8	28.2	10.1	18.3	30.0	11.5	np	22.0
Hysterectomy	rate	26.0	24.7	37.3	32.3	31.9	42.0	50.0	80.4	30.5
Knee replacement	rate	15.6	17.7	36.3	18.1	23.3	25.9	5.7	np	20.6
Prostatectomy	rate	26.1	27.5	40.3	39.0	34.3	45.2	7.3	np	30.7
Tonsillectomy and Adenoi..	rate	47.1	29.6	69.0	54.9	51.6	79.7	33.1	83.3	47.9

Source: table 12A.47
np Not published. – Nil or rounded to zero.

(a) Data for 2021-22 and 2022-23 was not provided as states and territories have elected to pause reporting on this indicator while data specifications are reviewed to address data quality concerns.

+ a b | e a u

13. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide sustainable public hospital services. Health workforce sustainability relates to the capacity of the health workforce to meet current and projected future service demand. 'Workforce sustainability' is defined by two measures:

- the proportions of registered nurses and midwives, and medical practitioners in ten-year age brackets, by jurisdiction and by region
- the attrition rate of nurses and midwives, and medical practitioners, by jurisdiction.

Both measures report on full time equivalent (FTE) nurses, midwives and medical practitioners performing public clinical hours in public hospital settings.

These measures are not a substitute for a full workforce analysis that allows for training, migration, changing patterns of work and expected future demand. They can, however, indicate that further attention should be given to workforce planning for public hospital services.

High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement are desirable. A low or decreasing rate of workforce attrition is desirable.

Workforce age profiles

Nationally, across all areas in 2023, 8.4% of the full-time equivalent nursing workforce were aged 60 years and over (figure 12.11a). Since 2014, the proportion of nurses and midwives aged under 40 years has increased by 11.4 percentage points (table 12A.49). The proportion of Aboriginal and Torres Strait Islander people who are registered or enrolled as nurses and midwives is presented in table 12A.50.

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

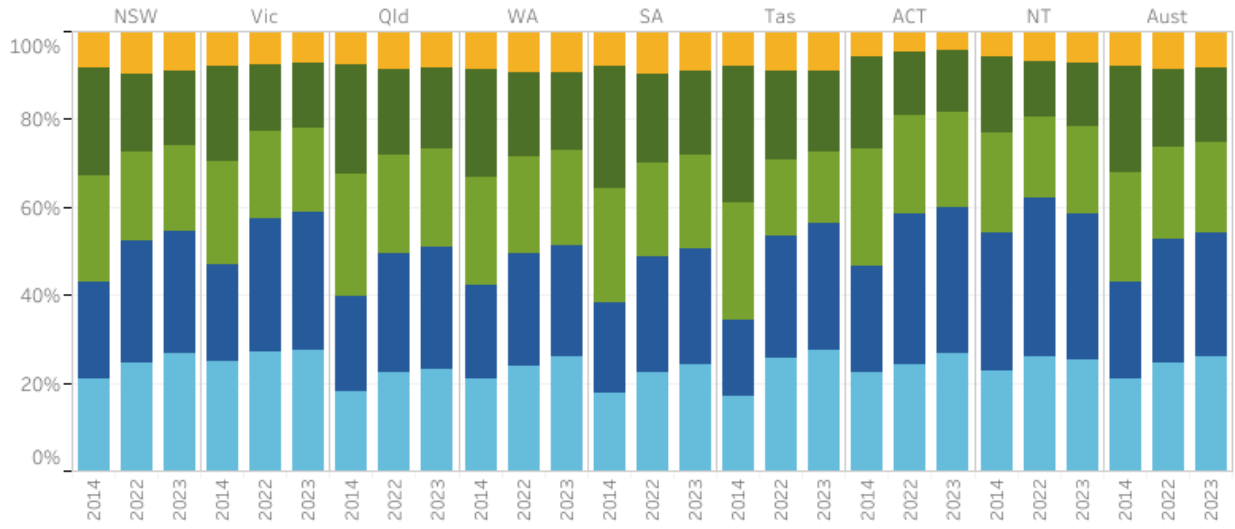
Data is complete (subject to caveats) for the current reporting period.

Select year:
Multiple values

Select remoteness area:
- Major cities
- Inner regional
- Outer regional
- Remote and very remote
- All areas

- 60+ years old
- 50-59 years old
- 40-49 years old
- 30-39 years old
- <30 years old

Figure 12.11a **Nurses (registered and enrolled) and midwives, All areas**
By age group, by jurisdiction, by year (a), (b)



Source: table 12A.49

(a) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT. (b) Nurses and midwives are primarily allocated to a remoteness area based on postcode of main job.

For the medical practitioner workforce, the proportion aged 60 years and over across all areas was 5.8% in 2023 (figure 12.11b). Unlike the nursing workforce, the proportion of the medical practitioner workforce aged under 40 years has remained around 61.0% since 2014 (table 12A.51). The number and proportion of Aboriginal and Torres Strait Islander people who are medical practitioners is in table 12A.52.

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

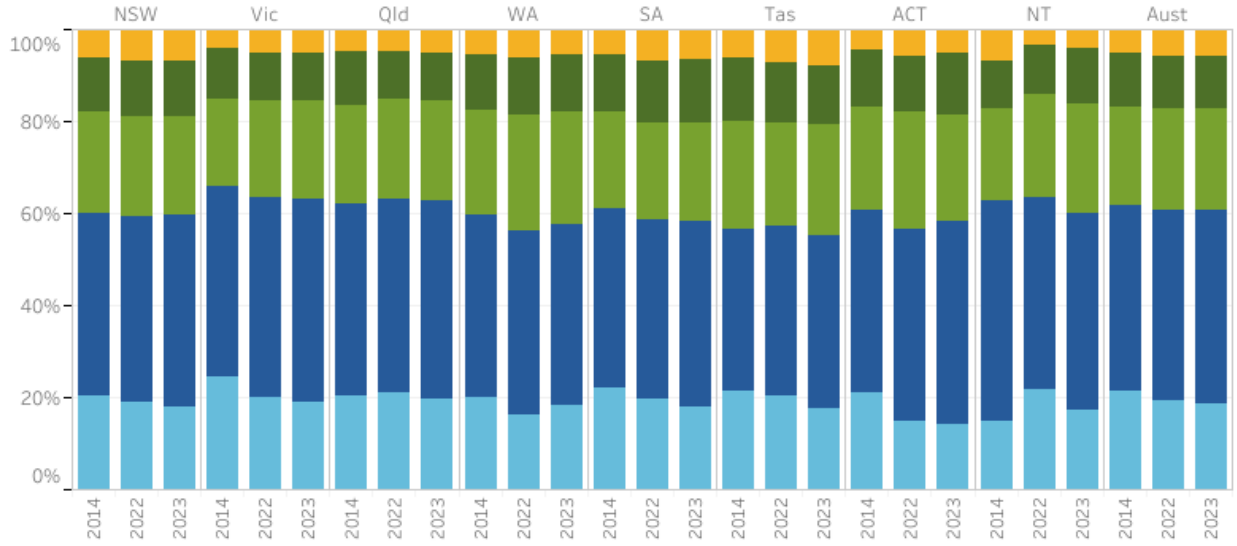
Data is complete (subject to caveats) for the current reporting period.

Select year(s):
Multiple values

Select remoteness area:
- Major cities
- Inner regional
- Outer regional
- Remote and very remote
- All areas

- 60+ years old
- 50-59 years old
- 40-49 years old
- 30-39 years old
- <30 years old

Figure 12.11b **Medical practitioners, All areas**
By age group, by jurisdiction, by year (a)



Source: table 12A.51

(a) There are no very remote areas in Victoria; no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; and no major cities or inner regional areas in the NT.

Workforce attrition rates

Public hospital attrition rates are calculated using the FTE of nurses and midwives, and medical practitioners who left the workforce in a public hospital setting (i.e., who were not in the workforce in a public hospital setting in the current year but who were in the workforce in a public hospital setting in the previous year), divided by the total FTE of nurses, midwives and medical practitioners employed in the workforce in a public hospital setting in the previous year.

> Nationally, in 2023, the attrition rate for nurses and midwives working in public hospital settings was 28.9%, lower than 2022 (31.0%), but the second highest rate over the reported 10 year time series. Nationally, in 2023, the attrition rate for medical practitioners was 22.9%, unchanged from 2022 (figure 12.11c).

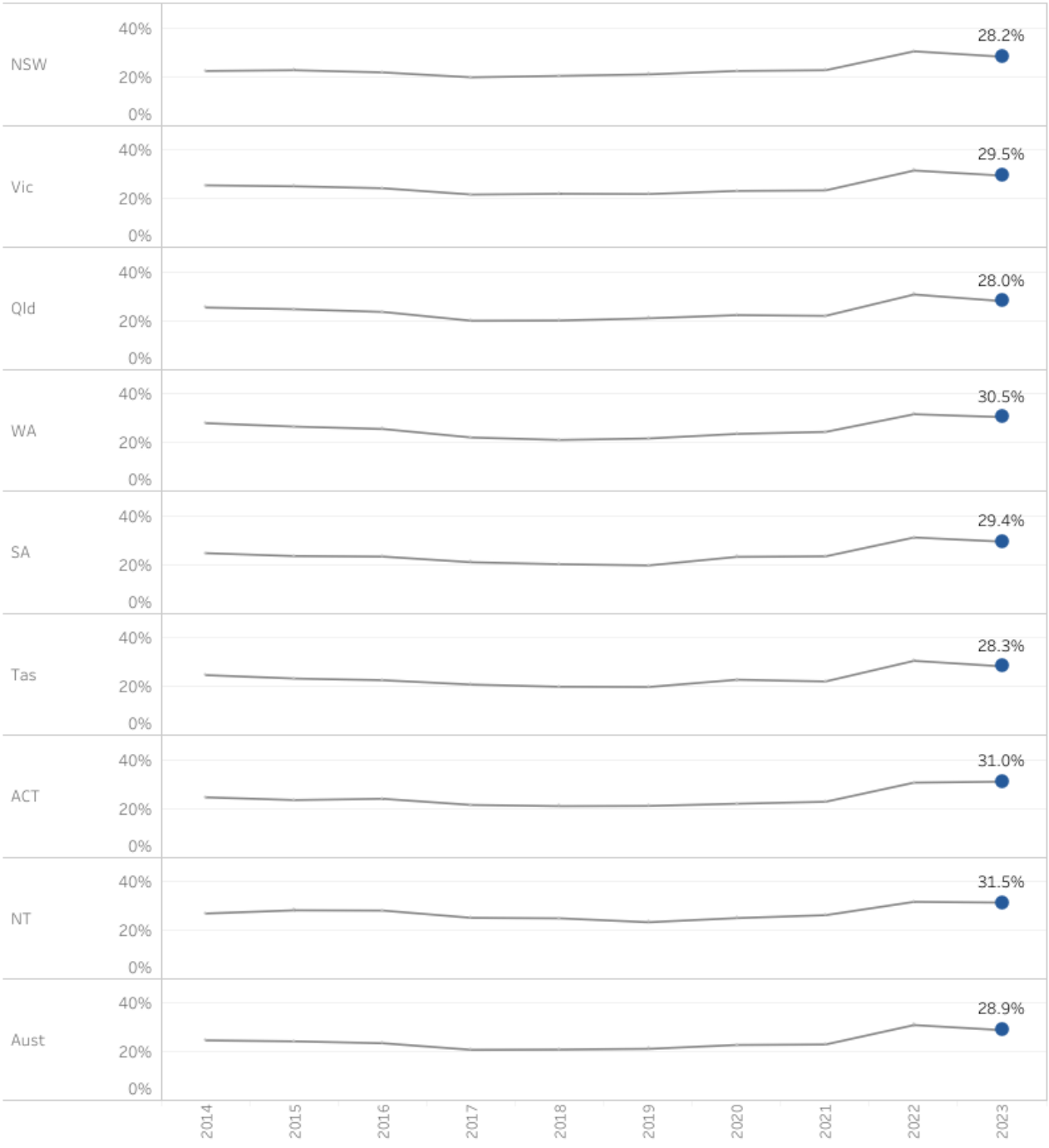
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select a workforce:

(●) Nursing workforce
( ) Medical workforce

Figure 12.11c **Measure 1: Nursing workforce attrition rate**
By jurisdiction, by year (a)



Source: tables 12A.50

14. Cost per admitted patient separation

‘Cost per admitted patient separation’ is an indicator of governments’ objective to deliver services in an efficient manner.

‘Cost per admitted patient separation’ is defined by the following two measures:

- Recurrent cost per weighted separation
- Capital cost per weighted separation.

A low or decreasing recurrent cost per weighted separation or capital cost per weighted separation can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the performance indicator framework as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness.

Recurrent cost per weighted separation

‘Recurrent cost per weighted separation’ is the average cost of providing care for an admitted patient (overnight stay or same day) adjusted for casemix. Casemix adjustment takes account of variation in the relative complexity of a patient’s clinical condition and of the hospital services provided, but not other influences on length of stay.

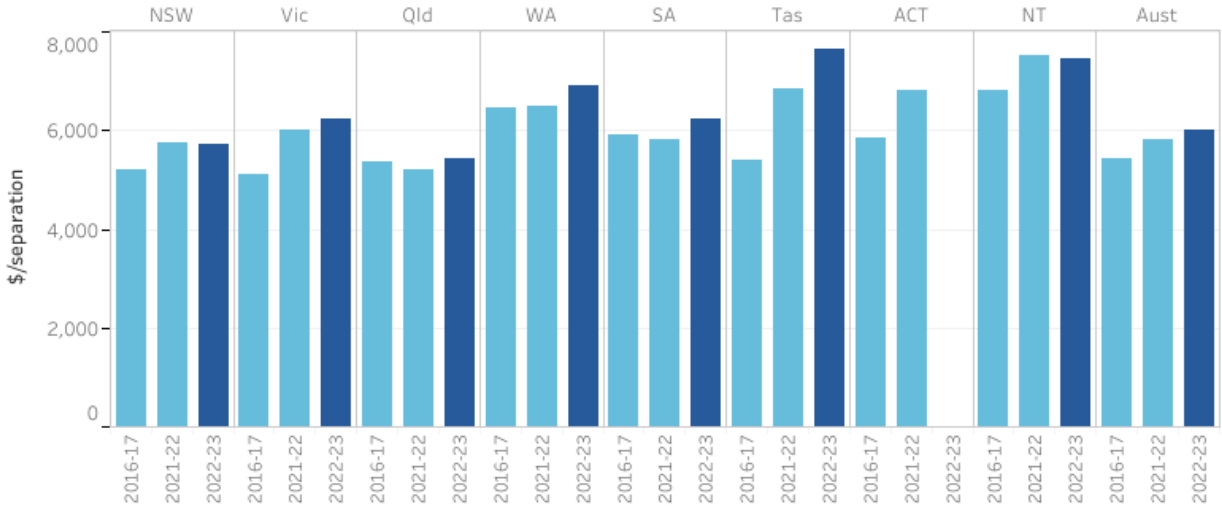
> Measure 1: Nationally, in 2022-23 (excluding the Australian Capital Territory), the average recurrent cost per weighted separation was $6,006, an increase from $5,826 in 2021-22 (figure 12.12a). Data on the average cost per admitted patient separation is available on the subset of presentations that are acute emergency department presentations (table 12A.55).

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

Data is not complete for the current reporting period. Data is not available for the ACT for 2022-23.

Select year(s):
Multiple values

Figure 12.12a Measure 1: **Recurrent cost per weighted separation, All public hospitals**
By jurisdiction, by year (2022-23 dollars) (a)



Source: table 12A.53

(a) Data is not available for the ACT for 2022-23.

Capital cost per weighted separation

'Capital cost per weighted separation' is defined as the user cost of capital (calculated as 8% of the value of non-current physical assets including buildings and equipment but excluding land) plus depreciation, divided by the number of weighted separations.

This measure allows the full cost of hospital services to be considered. Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset and is equivalent to the return foregone from not using the funds to deliver other services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.

> Measure 2: Costs associated with non-current physical assets are important components of the total costs of many services delivered by government agencies. Nationally, in 2022-23 (excluding the Australian Capital Territory), the total capital cost (excluding land) per weighted separation was $1,527 (figure 12.12b).

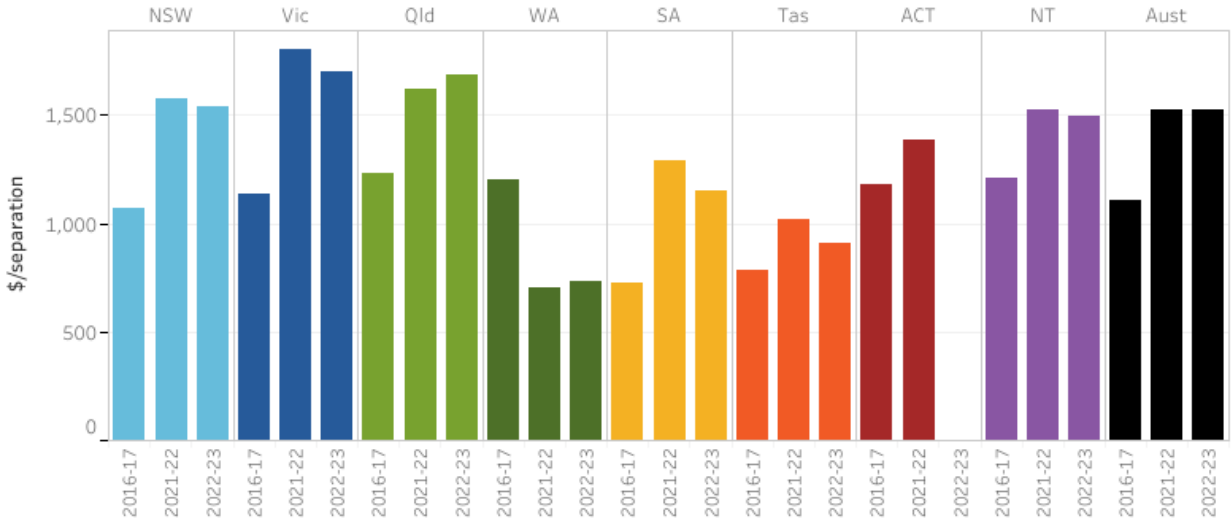
Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data is not available for the ACT for 2022-23.

Select year(s):
Multiple values

Jurisdiction:
NSW Vic Qld WA SA Tas ACT NT Aust

Figure 12.12b Measure 2: **Capital cost per weighted separation, All public hospitals**
By jurisdiction, by year (2022-23 dollars) (a)



Source: tables 12A.54

(a) Data is not available for the ACT for 2022-23.

15. Recurrent cost per non-admitted patient

'Recurrent cost per non-admitted patient' is an indicator of governments' objective to deliver services in an efficient manner.

'Recurrent cost per non-admitted patient' is defined by the following two measures:

- Average cost per non-admitted acute emergency department presentation
- Average cost per non-admitted service event.

A low or decreasing recurrent cost per non-admitted patient can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness. This indicator does not adjust for the complexity of service.

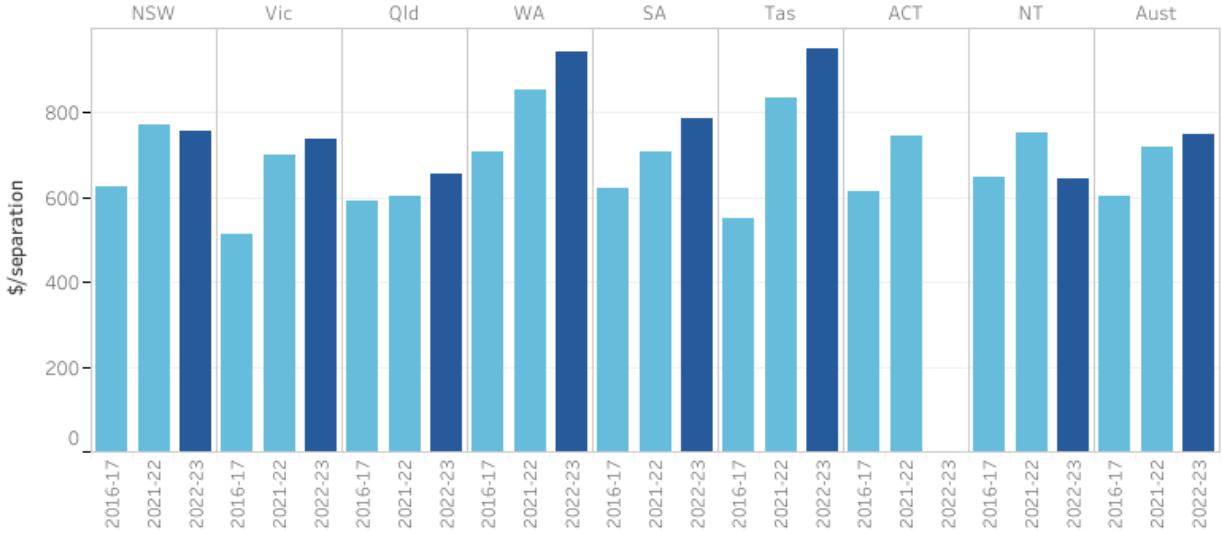
> Measure 1: Nationally, in 2022-23 (excluding the Australian Capital Territory), the average cost per non-admitted emergency department presentation was $749 (figure 12.13a). Costs per non-admitted emergency department presentation have increased over the seven years of reported data.

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

Data is not complete for the current reporting period. Data is not available for the ACT for 2022-23.

Select year(s):
Multiple values

Figure 12.13a Measure 1: **Average cost per presentation, Emergency department (non-admitted)**
By jurisdiction, by year (2022-23 dollars) (a)



Source: tables 12A.55

(a) Data is not available for the ACT for 2022-23.

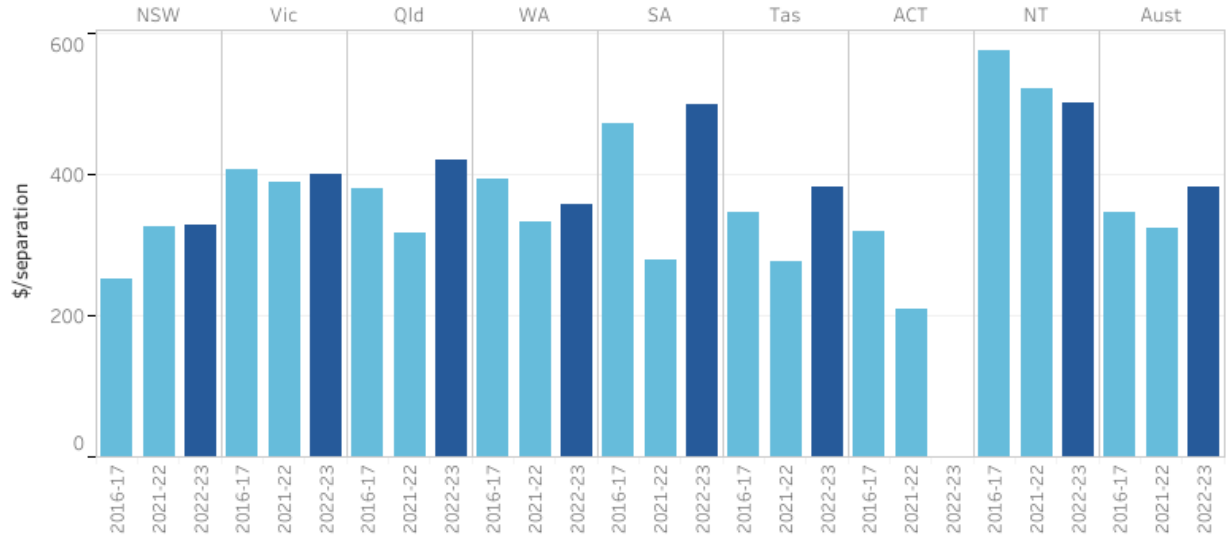
Measure 2: Nationally, in 2022-23 (excluding the Australian Capital Territory), the average cost per non-admitted service event was $382, up from $324 in 2021-22 (figure 12.13b).

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

Data is not complete for the current reporting period. Data is not available for the ACT for 2022-23.

Select year(s):
Multiple values

Figure 12.13b Measure 2: **Recurrent cost per non-admitted patient, Average cost per service event**
By jurisdiction, by year (2022-23 dollars) (a)



Source: table 12A.56

(a) Data is not available for the ACT for 2022-23.

tableau

16. Hospital mortality

‘Hospital mortality’ is an indicator of governments’ objective to alleviate or manage illness and the effects of injury and provide high quality and safe care.

‘Hospital mortality’ is defined as death in low-mortality diagnostic related groups (DRGs) expressed as a rate. Low-mortality DRGs comprise diagnoses that have a very low chance of death (for example, headache, hand procedures, arthroscopy).

Low or decreasing rates of death in low-mortality DRGs can indicate more effective management of illness and the effects of injury.

In 2009, Australian Health Ministers agreed state and territory hospital mortality data should be gathered and presented to hospitals for regular review. The hospital mortality indicators endorsed by Health Ministers include 'death in low mortality DRGs', 'hospital-standardised mortality ratios' and 'in-hospital mortality for four specified conditions' (acute myocardial infarction, stroke, fractured neck of femur and pneumonia) (ACSQHC 2014).

Hospital mortality indicators can act as screening tools to flag potential issues for further clinical review. Hospital mortality data should be considered as part of a suite of patient safety metrics including hospital-acquired infection, patient experience data and readmission rates.

In the absence of national data development to support reporting on this indicator, Table 12.11 provides an overview of the review mechanisms in place across states and territories for examining in-hospital deaths.

Table 12.11 Overview of review mechanisms across states and territories for in-hospital deaths

NSW	NSW reports publicly on selected mortality in hospitals data. The report 'Mortality following hospitalisation for seven clinical conditions' provides information on patient deaths within 30 days of admission across 73 public hospitals for seven clinical conditions during the period July 2015 to June 2018 http://www.bhi.nsw.gov.au/__data/assets/pdf_file/0007/557827/BHI_Mortality_2015-2018_REPORT.pdf). The seven clinical conditions are: acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, congestive heart failure, pneumonia, chronic obstructive pulmonary disease, and hip fracture surgery. Together these conditions account for approximately 11% of acute emergency hospitalisations for people aged 15 years and over in NSW, and approximately 28% of in-hospital deaths following acute emergency hospitalisation. The NSW Bureau of Health Information uses 30-day risk-standardised mortality ratios (RSMRs) to assess mortality in hospital. The RSMRs take into account the volume of patients treated and key patient risk factors beyond the control of a hospital. However, not all relevant risk factors are recorded, such as sociological and environmental factors, so while results are useful for trend analysis and a guide for further investigation, they are not suitable for direct performance comparisons. A ratio of less than 1.0 indicates that mortality is lower than expected in a given hospital, while a ratio of greater than 1.0 indicates that mortality is higher than expected in a given hospital. Three years of data is used to create stable, reliable estimates of performance. Rates are also reported per 100 hospitalisations for each of the seven clinical conditions.
Vic	Victoria does not report publicly on this data. However, Victoria reports internally on three indicators based on the Core Hospital-Based Outcome Indicator (CHBOI) specifications published by the Australian Commission on Safety and Quality in Health Care (ACSQHC) In-hospital Mortality for Fractured Neck-of-Femur, Acute Myocardial Infarction and Pneumonia, as well as two locally developed mortality indicators for ischaemic and haemorrhagic stroke and a Gestationally Standardised Perinatal Mortality Ratio. Outliers for these indicators are reviewed on a regular basis by Safer Care Victoria, the Department of Health and respective health services as part of the performance monitoring process. In addition, the Victorian Perioperative Consultative Council oversees, reviews and analyses cases of perioperative mortality and morbidity in Victoria and the Consultative Council for Obstetric and Perinatal Morbidity and Mortality (CCOPMM) reviews and reports on all child deaths in Victoria, including in-hospital deaths. Victoria also reports internally on four in-hospital mortality indicators (for Stroke, Fractured Neck of Femur, Acute Myocardial Infarction and Pneumonia) via the Victorian Agency for Health Information Private Hospitals Quality and Safety Report.
Qld	Queensland does not report publicly on this data. Queensland Hospital and Health Services undertake 'outlier' reviews of in-hospital deaths which are reviewed by a statewide committee to ensure the review is thorough and actions are identified for any issues found. The need for review is identified through monitoring condition or procedure specific indicators (AMI, Heart Failure, Stroke, Fractured Neck of Femur and Pneumonia) and system-wide mortality indicators i.e. low-mortality DRG and hospital standard mortality ratio (HSMR). In addition, morbidity and mortality meetings are held at a local level. Further, Quality Assurance Committees (QAC) identify common issues across the state to identify lessons learnt and/or recommendations for consideration statewide and locally. Other QACs, for example, Queensland Audit of Surgical Mortality provide individual feedback to practitioners to improve individual performance.

WA	WA does not report publicly on this data. WA Health currently reports six indicators internally that are based on the Core Hospital Based Outcome Indicator (CHBOI) specifications published by the Australian Commission on Safety and Quality in Health Care (ACSQHC); Hospital Standardised Mortality Ratio, In-hospital Mortality (for Stroke, Fractured Neck-of-Femur, Acute Myocardial Infarction and Pneumonia) and Death in Low Mortality Diagnosis-Related Groups. Outliers for these indicators are reviewed on a regular basis through the WA Health system Quality Surveillance Group (QSG). Note that the results of mortality reviews as undertaken by local Mortality Committees are publicly available from the annual WA Health *Your safety in our hands in hospital* patient safety report.
SA	SA does not report publicly on this data. For internal mortality analysis, SA uses national Core hospital based outcome indicators (CHBOI) developed by the ACSQHC. Examples include: monitoring Hospital standardised mortality ratios (HSMR) (included as a key performance indicator in service agreements) and monitoring CHBOI condition-specific mortality measures (fractured neck of femur, stroke, AMI and pneumonia).
Tas	Tasmania does not report publicly on this data. Hospital mortality is reported internally using the Hospital Diagnosis Standardised Mortality Ratio, provided by the Health Roundtable (https://home.healthroundtable.org/), and hospital-wide and condition/procedure specific mortality as per the Core Hospital-Based Outcome Indicator (CHBOI) specifications developed by the ACSQHC. Morbidity and Mortality reviews are undertaken across the health service to promote safety and quality improvement. Tasmania also uses CHBOI-based outcome indicators of safety and quality. This reporting system has included in-hospital mortality and unplanned/unexpected hospital re-admissions, as developed by the ACSQHC. These indicators are designed as screening tools for internal safety and quality improvement, and they are not intended to be used as performance measures.
ACT	The ACT does not report publicly on these data. Mortality information from Canberra Health Services (CHS) is collated by the Health Round Table (HRT) and includes deaths in low mortality DRGs and is defined by the ACSQHC and adopted by the Independent Health and Aged Care Pricing Authority (IHACPA). These may not necessarily be avoidable when investigated. Sentinel events are reported to ACT Health Directorate for inclusion in IHACPA reporting. In addition, Morbidity and Mortality meetings are held at a local level. The ACT Children and Young People Death Review Committee reviews all deaths of children and young people aged from birth to 18 years. This committee reports annually to the Minister for Children, Youth and Families and the statistics are published here: https://www.childdeathcommittee.act.gov.au/publications. The ACT Maternal and Perinatal Mortality Committee reviews all deaths of women who died while pregnant or up to 42 days post-partum and all deaths of fetuses from 20 weeks gestation and babies up to 28 days of life. Maternal death information is included in national reports but is not published specifically for the ACT due to the very small number of deaths in the ACT. The perinatal death rate is published annually here: https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/statistics-and-indicators/perinatal and a detailed report is provided by the Committee to the ACT Chief Health Officer and published every five years https://health.act.gov.au/about-our-health-system/data-and-publications/healthstats/epidemiology-publications.

NT	The NT does not report publicly on this data. The NT uses national Core hospital based outcome indicators (CHBOIs) developed by the ACSQHC. CHBOI 1 - Hospital Standardised Mortality Ratio (HSMR); CHBOI 2 - Death in low-mortality Diagnosis Related Groups (DRGs); CHBOI 3: Condition Specific Mortality Measures. This data is included in the internal NT Health Patient Quality and Safety Surveillance Quarterly Report. The NT also provides data on coronial recommendations, Incident Severity Rating 1 events (ISR1s), and national sentinel events.

Sources: State and Territory governments (unpublished).

Indigenous data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section is available in the data tables listed below. Further supporting information can be found in the Indicator results tab and data tables.

Public hospitals data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 12A.15	Patients treated within national benchmarks for emergency department waiting time, by Indigenous status
Table 12A.19	Length of stay for emergency department care, proportion of patients staying for four hours or less, by Indigenous status
Table 12A.24	Waiting times for elective surgery in public hospitals, by state and territory, by Indigenous status and procedure
Table 12A.37	Patients who did not wait, left or were discharged against medical advice, by Indigenous status (public hospitals)
Table 12A.41	Separations for falls resulting in patient harm in hospitals, per 1,000 separations
Table 12A.48	Unplanned readmission rates in public hospitals, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles

Explanatory material

Key terms

Terms	Definition
Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures.
Admitted patient	A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Allied health professionals	Trained professionals with university qualifications (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category includes physiotherapists, psychologists, social workers, occupational therapists, Aboriginal and Torres Strait Islander health practitioners, and other diagnostic and health professionals.
Australian classification of health interventions (ACHI)	Developed by the National Centre for Classification in Health, the ACHI comprises a tabular list of health interventions and an alphabetic index of health intervention.
Australian Refined Diagnosis Related Group (AR-DRG)	AR-DRG is a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 6.0x is based on the ICD-10-AM classification.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.

Terms	Definition
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Comparability	Data is considered comparable if (subject to caveats) it can be used to inform an assessment of comparative performance. Typically, data is considered comparable when it is 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 is considered complete if all required data is available for all jurisdictions that provide the service.
Cost of capital	The return foregone on the next best investment, estimated at a rate of 8% of the depreciated replacement value of buildings, equipment and land. Also called the 'opportunity cost' of capital.
Elective surgery waiting times	Elective surgery waiting times are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted for the awaited procedure. Days on which the patient was not ready for care are excluded.
Emergency department waiting time to commencement of clinical care	The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse.
Emergency department waiting times to admission	The time elapsed for each patient from presentation to the emergency department to admission to hospital.

Terms	Definition
International Statistical Classification of Diseases - 10th Revision - Australian modification	The International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian modification (ICD-10-AM) is the current classification of diagnoses in Australia.
Hospital boarder	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Length of stay	For an episode of care, the period from admission to separation less any days spent away from the hospital (leave days).
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Newborn qualification status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is qualified if the infant meets at least one of the following criteria: • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care • is admitted to, or remains in hospital without its mother. A newborn patient day is unqualified if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.
Nursing and midwifery workforce	Registered nurses, enrolled nurses and midwives registered with the Australian Health Practitioner Regulation Agency and who are employed in nursing and/or midwifery in Australia excluding those on extended leave.

Terms	Definition
Medical practitioner workforce	Medical practitioners registered with the Australian Health Practitioner Regulation Agency and who are employed in medicine in Australia excluding those on extended leave.
Non-acute care	Includes maintenance care and newborn care (where the newborn does not require acute care).
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.

Terms	Definition
Peer group(s)	Peer groups are used to categorise similar hospitals with shared characteristics. Categorising hospitals in peer groups allows for valid comparisons to be made across similar hospitals providing similar services. The peer groups are: • Acute public hospitals • Acute private hospitals • Very small hospitals • Women's and children's hospitals • Early parenting centres • Drug and alcohol hospitals • Psychiatric hospitals • Other acute specialised hospitals • Same day hospitals • Sub-and non-acute hospitals • Outpatient hospitals • Unpeered hospitals For further details on hospital peer groups, refer to AIHW (2015) *Australian hospital peer groups.* Health services series no. 66. Cat. no. HSE 170. Canberra: AIHW (https://www.aihw.gov.au/reports/hospitals/australian-hospital-peer-groups/data)
Posthumous organ procurement	An activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients.
Real expenditure	Actual expenditure adjusted for changes in prices.

Terms	Definition
Relative stay index	The actual number of patient days for acute care separations in selected AR–DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR-DRGs which have a length of stay component in the definition, and error AR-DRGs.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, acute to rehabilitation). Includes admitted patients who receive same day procedures.
Service event	An interaction between one or more health-care provider(s) with one non-admitted patient, which must contain therapeutic or clinical content and result in dated entry in the patient's medical record.
Subacute care	Specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care.
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).

Terms	Definition
Urgency category for elective surgery	Category 1 patients – admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it can become an emergency. Category 2 patients – admission within 90 days is desirable for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients – admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

References

ACSQHC (Australian Commission on Safety and Quality in Health Care) 2020, *Annual Report 2019-20,* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/acsqhc-annual-report-2019-20 (accessed 12 October 2023).

—— 2014 *Using hospital mortality indicators to improve patient care: A guide for Boards and Chief Executives,* https://www.safetyandquality.gov.au/sites/default/files/migrated/Using-hospital-mortality-indicators-to-improve-patient-care-A-guide-for-Boards-and-Chief-Executives.pdf (accessed 12 October 2023).

AIHW (Australian Institute of Health and Welfare) 2024a, *Hospital resources 2022-23: Australian hospital statistics,* Health services series, https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-workforce (Hospital resources 2022-23 data tables, accessed 17 October 2024).

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—— 2024d, *Emergency department care 2022-23: Appendix information,* https://www.aihw.gov.au/getmedia/77b55e9d-a340-4d47-b1fc-001efba9bf17/emergency-department-care-2022-23-appendix.pdf (accessed 4 November 2024).

—— 2024e, 'Self-discharge from hospital' in *Aboriginal Torres Strait Islander Health Performance Framework,* https://www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital (accessed 22 November 2024).

Report on Government Services 2025

PART E, SECTION 13: RELEASED ON 6 FEBRUARY 2025

13 Services for mental health

This section reports on the Australian, state and territory governments' management of mental health and mental illnesses. Performance reporting focuses on state and territory governments' specialised mental health services, and services for mental health subsidised under the Medicare Benefits Schedule (Medicare) (provided by General Practitioners (GPs), psychiatrists, psychologists and other allied health professionals).

Content warning

If you are experiencing crisis, feel worried about harming yourself or think someone may be in danger, please seek help.

If life is in imminent danger please call 000.

Lifeline 13 11 14

Suicide Call Back Service 1300 659 467

Kids Helpline 1800 551 800

13YARN 13 92 76

QLife 1800 184 527

Beyond Blue 1300 224 636

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 is also available in CSV format.

Data downloads

13 Services for mental health data tables (XLSX 724.0 KB)

13 Services for mental health dataset (CSV 2.4 MB)

Refer to the corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Guide: How to find what you need in RoGS (PDF 288.5 KB)

Context

Objectives for services for mental health

Services for mental health aim to:

- promote mental health and wellbeing, and where possible prevent the development of mental health problems, mental illness and suicide, and

- when mental health problems and illness do occur, reduce the impact (including the effects of stigma and discrimination), promote recovery and physical health and encourage meaningful participation in society, by providing services that:
    - are high quality, safe and responsive to consumer and carer goals
    - facilitate early detection of mental health issues and mental illness, followed by appropriate intervention
    - are coordinated and provide continuity of care
    - are timely, affordable and readily available to those who need them
    - are sustainable.

Governments aim for services for mental health to meet these objectives in an equitable and efficient manner.

Service overview

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC 1999). The World Health Organization describes positive mental health as:

… a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental illness is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments.

There are a range of services provided or funded by Australian, state and territory governments that are specifically designed to meet the needs of people with mental health issues. The key services are:

- Medicare-subsidised mental health specific services that are partially or fully funded under Medicare on a fee-for-service basis and are provided by GPs, psychiatrists, psychologists or other allied health professionals under specific mental health items.
- State and territory government specialised mental health services (treating mostly low prevalence, but severe, mental illnesses), which include:
    - Admitted patient care in public hospitals – specialised services provided to inpatients in standalone psychiatric hospitals or psychiatric units in general acute hospitals. While not a state and territory government specialised mental health service, this section also reports on emergency department presentations for mental health related care needs (where data is available). (Data on emergency department presentations for mental health related care needs is reported where available in table 13A.18.)
    - Community-based public mental health services, comprising:
        - ambulatory care services and other services dedicated to assessment, treatment, rehabilitation and care, and
        - residential services that provide beds in the community, staffed onsite by mental health professionals.

- Not for profit, non-government organisation (NGO) services, funded by the Australian, state and territory governments focused on providing wellbeing, support and assistance to people who live with a mental illness. These include crisis, support and information services such as Beyond Blue, Lifeline, Kids Helpline, and ReachOut.
- The National Disability Insurance Scheme (NDIS), which began full roll out in July 2016. People with a psychiatric disability who have significant and permanent functional impairment are eligible to access funding through the NDIS. In addition, people with a disability other than a psychiatric disability, may also be eligible for funding for mental healthrelated services and support if required.
- The Australian, state and territory governments also share a focus on prevention and early intervention through suicide prevention programs and investment to reduce gaps in care (including emphasising a whole of system approach and the role of social determinants of health on people's mental health and wellbeing).

There are also other services (for example, specialist homelessness services) provided and/or funded by governments that make a significant contribution to the mental health treatment of people with mental illness but are not specialised or specific mental health services. Information on these services can be found on the *Mental Health* section of the Australian Insitute of Health and Welfare (AIHW) website (2024a).

Roles and responsibilities

State and territory governments are responsible for funding, delivering and/or managing specialised services for mental health including inpatient/admitted care in hospitals, community-based ambulatory care and community-based residential care.

The Australian Government is responsible for overseeing and funding of a range of services for mental health and programs that are primarily provided or delivered by private practitioners or NGOs. These services and programs include Medicare-subsidised services provided by GPs (under both general and specific mental health items), private psychiatrists and other allied mental health professionals, Pharmaceutical Benefits Scheme (PBS) funded mental health-related medications and other programs designed to prevent suicide or increase the level of social support and community-based care for people with a mental illness and their carers. The Australian Government also funds state and territory governments for health services, most recently through the approaches specified in the National Mental Health and Suicide Prevention Agreement and the National Health Reform Agreement (NHRA) which includes a mental health component.

A number of national initiatives and nationally agreed strategies and plans underpin the delivery and monitoring of services for mental health in Australia including:

- the *Mental Health Statement of Rights and Responsibilities* (Standing Council on Health 2012)
- the *National Mental Health Policy* 2008 (DoH 2009)
- National Mental Health Plans, the most recent being the *Fifth National Mental Health and Suicide Prevention Plan* 2017–2022 (COAG 2017)
- the *National Mental Health Workforce Strategy 2022–2032* (DoHAC 2023).

Under the *National Mental Health and Suicide Prevention Agreement* [1], the Australian, state and territory governments are jointly responsible for a number of areas including:

- mental health workforce planning, training and accreditation
- mental health promotion, prevention, early intervention and social and emotional wellbeing programs, suicide prevention, stigma reduction
- help and crisis hotlines
- psychosocial support services for people who are not supported through the NDIS
- contributions to the National Agreement on Closing the Gap (reducing suicide of Aboriginal and Torres Strait Islander people towards zero, ensuring all services funded by Australian governments are culturally safe and responsive, and building a strong, sustainable community-controlled sector).

1. National Mental Health and Suicide Prevention Agreement, 2022 https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-03/nmh_suicide_prevention_agreement.pdf

Funding

Nationally in 2022-23, around $12.6 billion in real government recurrent expenditure was allocated to services for mental health, equivalent to $478.47 per person in the population (table 13A.1 and figure 13.1). State and territory governments made the largest contribution ($8.0 billion or 63.5%, which includes Australian Government funding under the NHRA), with Australian Government expenditure of $4.6 billion (table 13A.1).

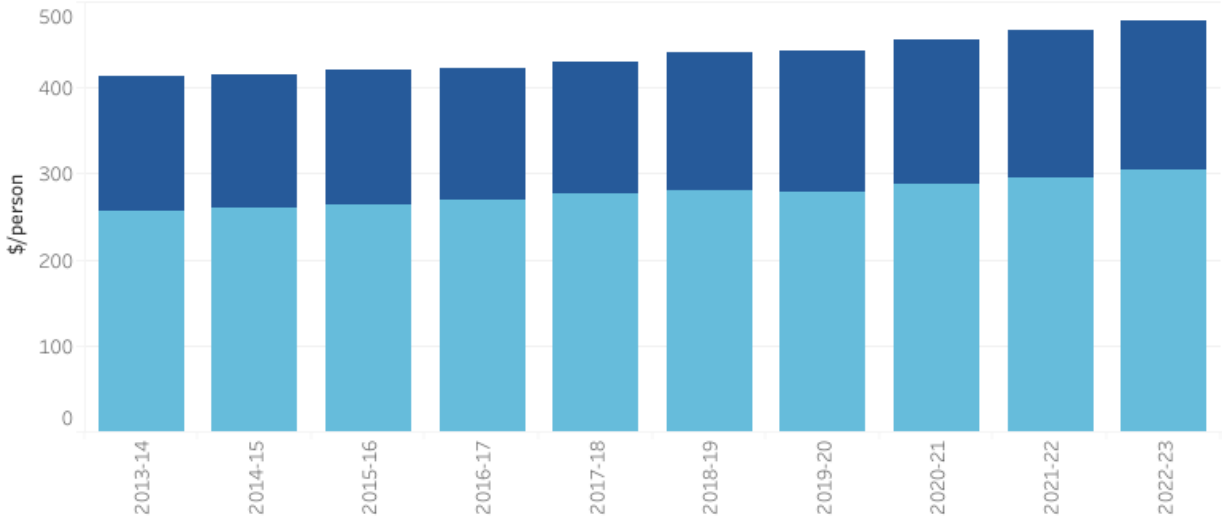
Expenditure on Medicare-subsidised services was the largest component of Australian Government expenditure on services for mental health in 2022-23 ($1.5 billion or 33.7%) (table 13A.2). This comprised Medicare-payments for psychologists and other allied health professionals (17.7%), consultant psychiatrists (9.3%) and GP services (6.7%) (table 13A.2). The Australian Government also spent $659.0 million in 2022-23 on mental health related medications under the PBS (table 13A.2).

Nationally, in 2022-23, expenditure on admitted patient services was the largest component of state and territory governments' expenditure on specialised mental health services ($3.3 billion or 41.4%), followed by expenditure on community-based ambulatory services ($3.2 billion or 39.0%) (table 13A.3). State and territory governments' expenditure on specialised mental health services, by source of funds and depreciation (which is excluded from reporting) are in tables 13A.4 and 13A.5 respectively.

Select year(s):
All

Australian Government
State and territory governments

Figure 13.1 **Expenditure per person on mental health services**
By funding source, by year (2022-23 dollars) (a)



Source: table 13A.1

(a) Data was not available for the ACT for 2021-22 or 2022-23. Total does not include ACT jurisdictional funds.

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Size and scope

In 2023-24, 10.6% of the total population received Medicare/DVA services, with 1.9% of the total population receiving state and territory government specialised mental health services in 2022-23 (the most recent data available) (figure 13.2). While the proportion of the population using state and territory government specialised mental health services has remained relatively constant, the proportion using Medicare/DVA services has increased steadily over time from 9.0% in 2014-15 to 10.6% in 2023-24. Service use per person increased for all service types across the time series, however GPs remain the most commonly accessed service provider (table 13A.7).

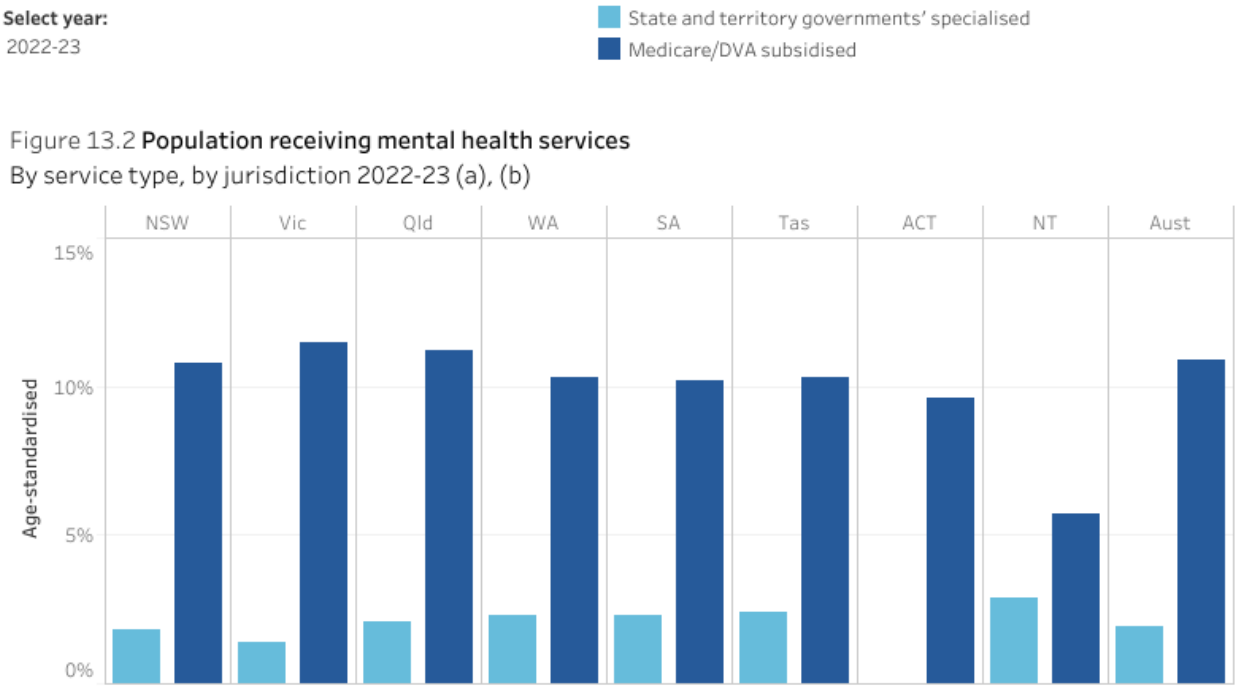


Figure 13.2 **Population receiving mental health services**
By service type, by jurisdiction 2022-23 (a), (b)

Source: table 13A.7

(a) The most recent year of data available for Medicare/DVA subsidised mental health services is for 2023-24 and for state and territory governments specialised public mental health services is 2022-23. (b) Data for state and territory governments specialised public mental health services was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include ACT.

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) is available for download above (in Excel and CSV format).

Information on the proportion of new consumers who accessed state and territory governments' specialised and Medicare-subsidised services for mental health are available in tables 13A.8–9.

For the first time, the 2021 Census collected information on diagnosed long-term health conditions. Over two million people reported having a diagnosed long-term mental health condition (2,231,543) (ABS 2022).

Medicare-subsidised services for mental health

In 2023-24, 12.6 million Medicare-subsidised services for mental health were provided by psychologists (clinical and other services) (6.0 million), psychiatrists (2.8 million) and other allied health professionals (0.5 million). GPs provided a further 3.3 million Medicare-subsidised specific services for mental health. Service usage rates varied across states and territories (table 13A.10).

GPs are often the first service accessed by people seeking help when suffering from a mental illness (AIHW 2024b). They can diagnose, manage and treat mental illnesses and refer patients to more specialised service providers. According to a 2023 report by the Royal Australian College of General Practitioners, mental health issues were the single most common reason patients visited their GP for the seventh year in a row (RACGP 2023).

State and territory governments' specialised mental health services

Across states and territories, the mix of admitted patient and community-based services and care types differ. As the unit of activity varies across these three service types, service mix differences can be partly understood by considering items which have comparable measurement such as

expenditure (table 13A.3), numbers of full time equivalent (FTE) direct care staff (table 13A.11), accrued mental health patient days (table 13A.12) and mental health beds (table 13A.13).

Additional data is also available on the most common principal diagnosis for admitted patients, community-based ambulatory contacts by age group and specialised mental health care by Indigenous status on the *Mental Health* section of the AIHW website (2025).

Crisis and support organisations

Crisis, support and information services such as Beyond Blue, Lifeline and Kids Helpline are provided to support Australians experiencing mental health issues. In 2022-23:

- Lifeline received 1,091,424 calls and answered 867,048 calls.
- Kids Helpline received 273,204 answerable contact attempts (call, webchat and email) with 117,720 contacts answered.
- Beyond Blue received 276,212 contacts and responded to 207,272 contacts (unpublished AIHW).

National Disability Insurance Scheme

The NDIS provides support to people with a significant and enduring primary psychosocial disability. At June 30, 2024, there were 63,837 active NDIS participants with a psychosocial disability (9.7% of all participants) (NDIA 2024), receiving approximately $5.3 billion in payments (table 13A.14).

Indicator framework

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

The performance indicator framework shows which data is complete and comparable in this report. For data that is 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 contextual information for this service area (refer to Context tab), the report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

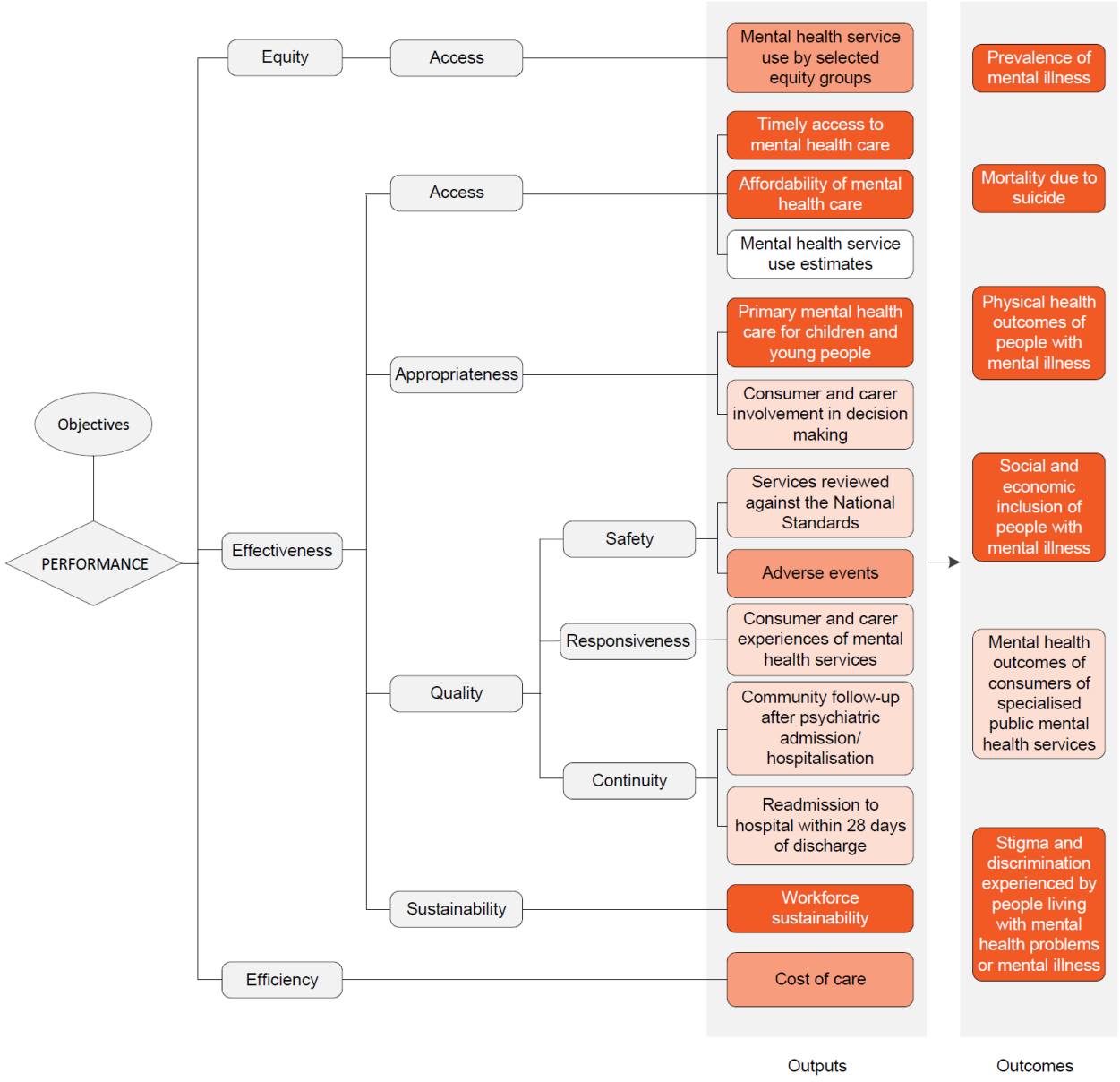
Improvements to performance reporting for services for mental health are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (refer to 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 (refer to section 1).



Key to indicators*

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

* A description of the comparability and completeness is provided under the Indicator results tab for each measure

Text version of indicator framework

Performance – linked to Objectives

Outputs

Equity – Access

- Mental health service use by selected equity groups – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Access

- Timely access to mental health care – most recent data for all measures is comparable and complete
- Affordability of mental health care – most recent data for all measures is comparable and complete
- Mental health service use estimates – no data reported and/or no measures yet developed

Effectiveness – Appropriateness

- Primary mental health care for children and young people – most recent data for all measures is comparable and complete
- Consumer and carer involvement in decision making – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Quality – Safety

- Services reviewed against the National Standards – most recent data for all measures is either not comparable and/or not complete
- Adverse events – most recent data for at least one measure is comparable and complete

Effectiveness – Quality – Responsiveness

- Consumer and carer experiences of mental health services – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Quality – Continuity

- Community follow-up after psychiatric admission/hospitalisation – most recent data for all measures is either not comparable and/or not complete
- Readmission to hospital within 28 days of discharge – most recent data for all measures is either not comparable and/or not complete

Effectiveness – Sustainability

- Workforce sustainability – most recent data for all measures is comparable and complete

Efficiency

- Cost of care – most recent data for all measures is either not comparable and/or not complete

Outcomes

- Prevalence of mental illness – most recent data for all measures is comparable and complete
- Mortality due to suicide – most recent data for all measures is comparable and complete
- Physical health outcomes of people with mental illness – most recent data for all measures is comparable and complete
- Social and economic inclusion of people with mental illness – most recent data for all measures is comparable and complete

- Mental health outcomes of consumers of specialised public mental health services – most recent data for all measures is either not comparable and/or not complete
- Stigma and discrimination experienced by people living with mental health problems or mental illness – most recent data for all measures is comparable and complete

A description of the comparability and completeness is provided under the Indicator results tab for each measure.

Indicator results

This section provides an overview of 'Services for mental health' performance indicator results. Different delivery contexts, locations and types of consumers can affect the equity, effectiveness and efficiency of services for mental health.

Information to assist the interpretation of this data can be found with the indicators below and all data (footnotes and data sources) is available for download above as an excel spreadsheet and as a CSV dataset. Data tables are identified by a '13A' prefix (for example, table 13A.1).

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.

1. Mental health service use by selected equity groups

'Mental health service use by selected equity groups' is an indicator of governments' objective to provide services in an equitable manner.

'Mental health service use by selected equity groups' is defined by two measures:

- the proportion of the population in a selected equity group using the service, compared to the proportion of the population outside the selected equity group, for each of:
    - state and territory governments' specialised public mental health services
    - Medicare/DVA subsidised mental health services.

The selected equity groups reported are Aboriginal and Torres Strait Islander people, people from outer regional, remote and very remote locations and people residing in low socioeconomic areas (Socio Economic Indexes for Areas (SEIFA) quintiles 1 and 2).

Results for this indicator should be interpreted with caution. Variation in use could be due to variation in access but could also be a result of differences in the prevalence of mental illness. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

> A higher proportion of the population accessed Medicare/DVA subsidised mental health services than state and territory governments' specialised public mental health services (table 13A.7). However, the pattern of service use differed across the selected equity groups.

> In 2022-23, for state and territory governments' specialised public mental health services, a higher proportion of Aboriginal and Torres Strait Islander people accessed these services than non-Indigenous people (figure 13.3a). People residing in lower socioeconomic areas (SEIFA quintiles 1 and 2) had greater use of mental health services compared to people residing in higher socioeconomic areas (SEIFA quintiles 4 and 5), and people in outer regional, remote and very remote areas had greater use of mental health services compared to people in inner regional and major cities.

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

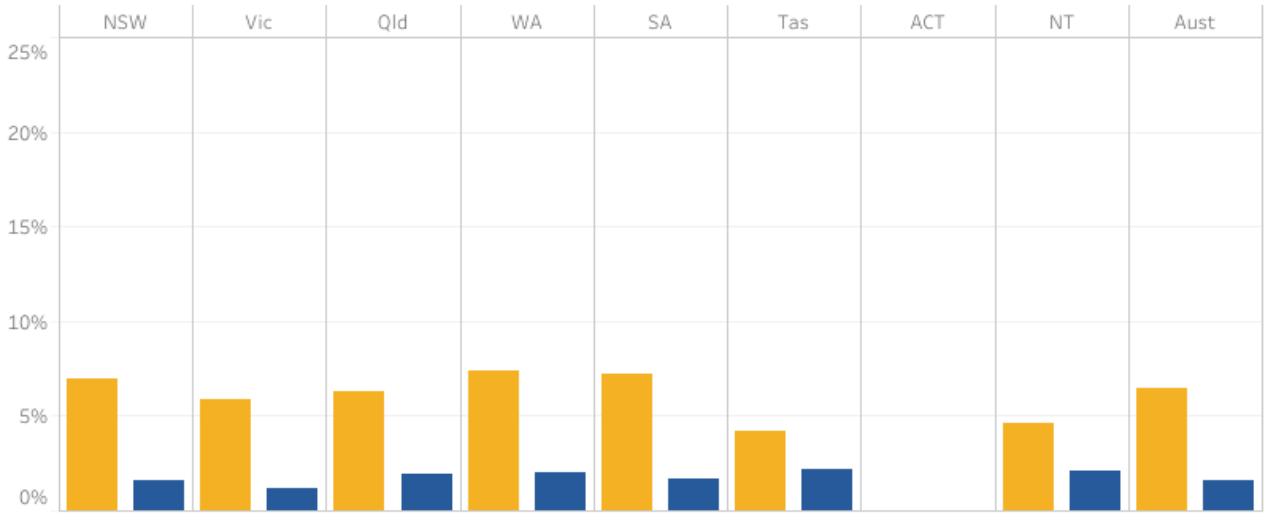
Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year:
2022-23

Select equity group:
Indigenous status
Remoteness area
SEIFA of residence

Aboriginal and Torres Strait Islander people
Non-Indigenous people

Figure 13.3a **State and territory governments' specialised Mental health service use**
By jurisdiction, by Indigenous status, 2022-23 (a), (b)



Source: table 13A.16

(a) Refer to data table 13A.15-17 for information on non-publication of data on Indigenous status, remoteness or SEIFA for individual jurisdictions. (b) Data was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include ACT.

Nationally in 2023-24, the proportion of people who accessed Medicare/DVA mental health services (figure 13.3b) was lower for people in lower socioeconomic areas compared to higher socioeconomic areas (table 13A.15) and lower for people in outer regional, remote and very remote areas compared to people in inner regional and major cities (table 13A.17), although results varied across jurisdictions. Nationally in 2023-24, the proportion of Aboriginal and Torres Strait Islander people who accessed Medicare/DVA services was 12.0% compared to 10.4% for non-Indigenous people, although results varied across jurisdictions (table 13A.16).

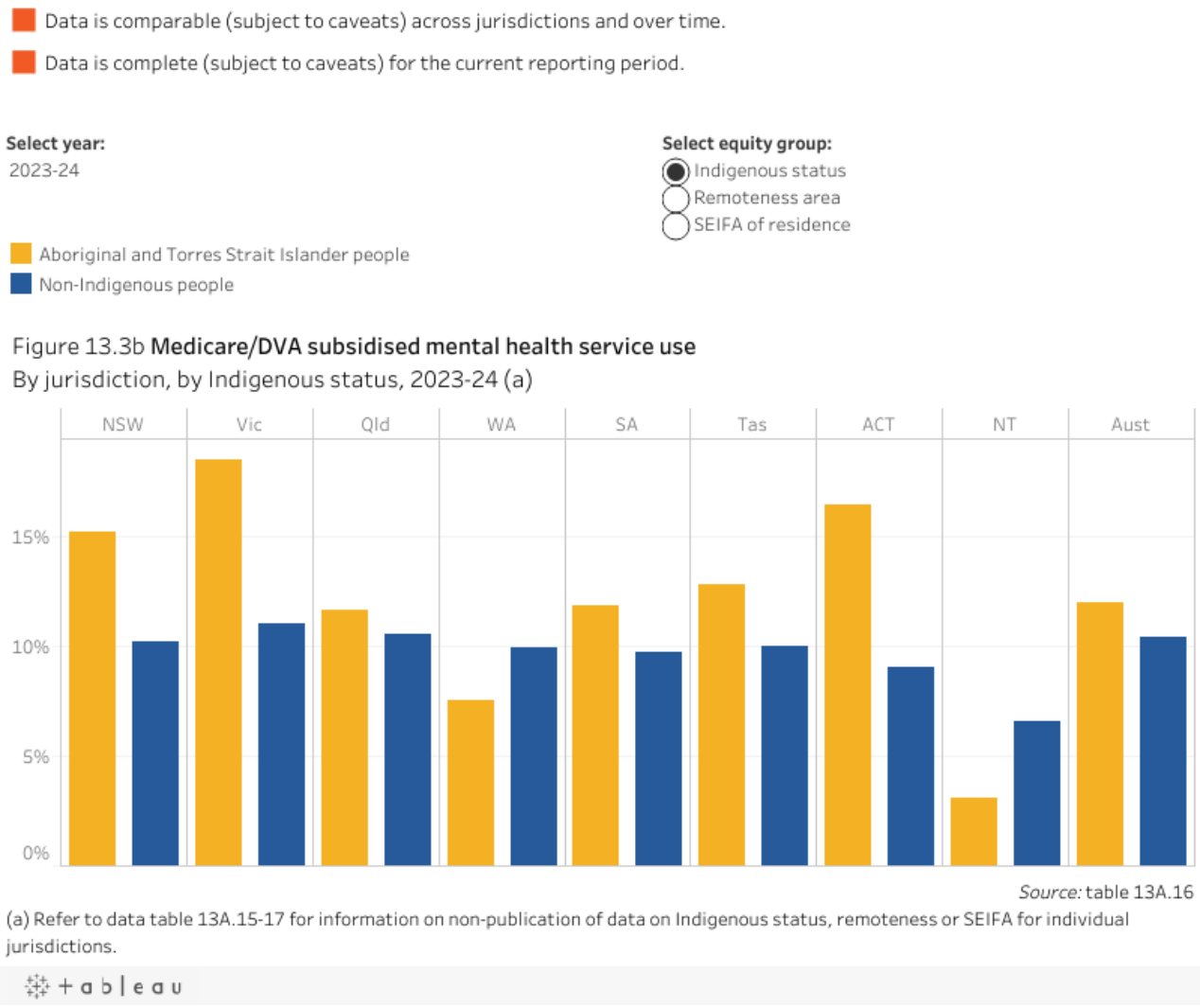


Figure 13.3b **Medicare/DVA subsidised mental health service use**
By jurisdiction, by Indigenous status, 2023-24 (a)

Source: table 13A.16

(a) Refer to data table 13A.15-17 for information on non-publication of data on Indigenous status, remoteness or SEIFA for individual jurisdictions.

Data on the use of private hospital mental health services are available in tables 13A.7 and 13A.15–17.

2. Timely access to mental health care

'Timely access to mental health care' is an indicator of governments' objective to provide services in a timely manner.

'Timely access to mental health care' is defined as the proportion of people who present to an emergency department with a mental health related care need (principal diagnosis of F00–F99) seen within clinically recommended waiting times.

The proportion of people seen within clinically recommended waiting times is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand. The benchmarks, set according to triage category, are as follows:

- triage category 1: need for resuscitation – patients seen immediately
- triage category 2: emergency – patients seen within 10 minutes
- triage category 3: urgent – patients seen within 30 minutes

- triage category 4: semi urgent – patients seen within 60 minutes
- triage category 5: non urgent – patients seen within 120 minutes.

High or increasing proportions of patients seen within the recommended waiting times is desirable. Contextual data for all presentations (not just those with a mental health related care need) is reported in section 12.

This is a partial measure for this indicator as emergency departments are only one of many services that provide access to mental health care. Future reporting will focus on timely access to state and territory governments' specialised public mental health services and Medicare-subsidised services for mental health.

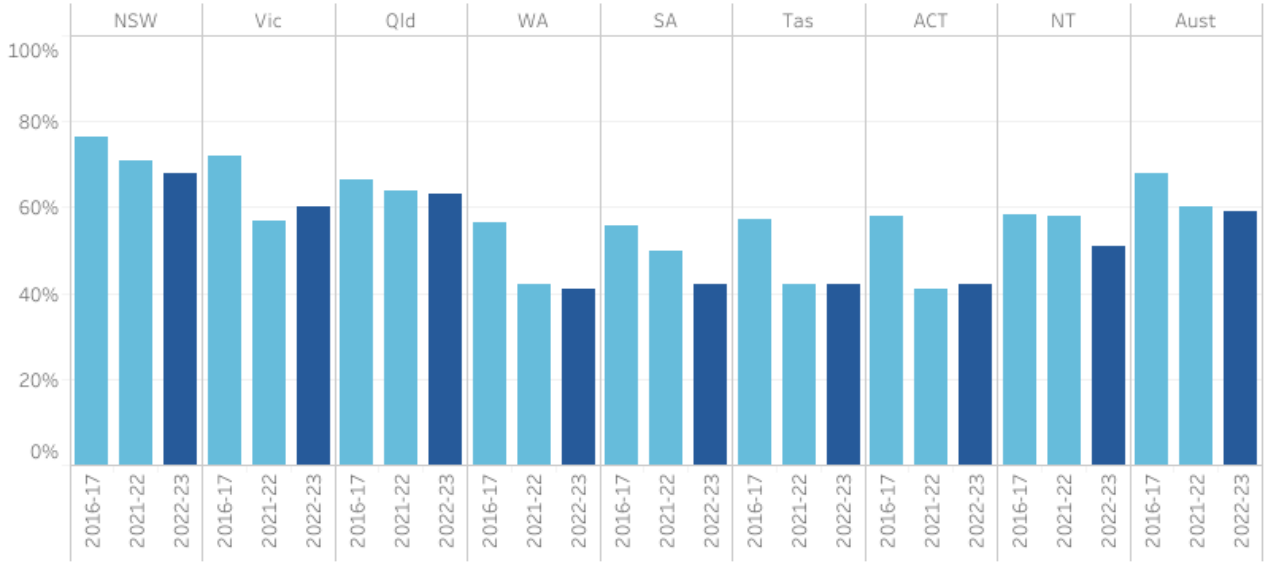
> Nationally in 2022-23, 59.0% of people who presented to an emergency department with a mental health related care need were seen within clinically recommended waiting times, a 9.0 percentage point reduction compared to 2016-17 (figure 13.4).

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

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

Select year(s):
Multiple values

Figure 13.4 **Mental health related emergency department presentations seen within clinically recommended waiting times**
By jurisdiction, by year



Source: table 13A.18

3. Affordability of mental health care

'Affordability of mental health care' is an indicator of governments' objective to provide services that are affordable.

‘Affordability of mental health care’ is defined by three measures:

- The proportion of people who delayed seeing or did not see a GP for their mental health due to cost
- The proportion of people who delayed seeing or did not see a psychologist, psychiatrist or other mental health professional for their mental health due to cost
- The proportion of people who delayed filling or did not fill a prescription for their mental health due to cost.

A low or decreasing proportion for each measure is desirable.

Data is not available for measure 3.

> Nationally in 2023-24, 20.4% of all respondents delayed seeing any mental health professional in the last 12 months due to cost, continuing a year on year increase over the available time series (19.3% in 2022-23 and 16.7% in 2021-22). Respondents were almost two and a half times as likely to report delaying mental health care due to cost for psychologists, psychiatrists and other mental health professionals (24.6%) than for GPs (10.3%) (figure 13.5). Survey respondents who self-reported as having a mental health condition were more likely to delay seeking mental health care from providers other than GPs (Psychologists, Psychiatrists and Other mental health professionals) (26.6%) than people who did not self-report having a mental health condition (but who still reported delaying mental health care due to cost) (20.4%) (table 13A.19).

(measures 1 and 2) Data is comparable (subject to caveats) across jurisdictions and over time.

(measures 1 and 2) Data is complete (subject to caveats) for the current reporting period.

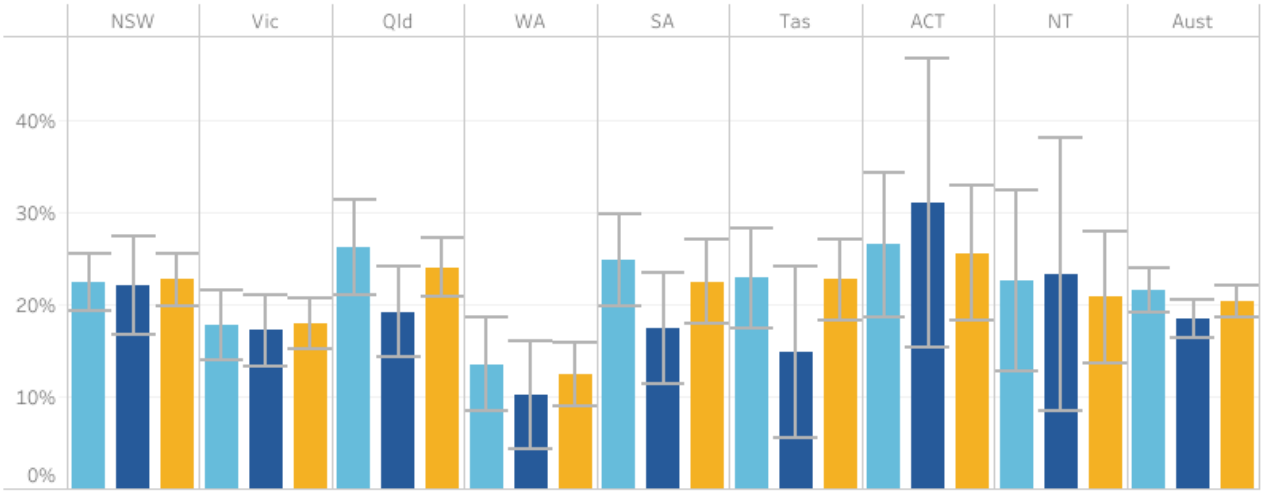
Data is not yet available for Measure 3.

Select year:
2023-24

Mental health status:
People with a mental health condition
People without a mental health condition
All people

Select health professional:
GP
Psychologist
Psychiatrist
Other mental health professional
Total psychologist, psychiatrist or other mental health professional
Total any mental health professional

Figure 13.5 Measures 1 and 2: **People who delayed seeing or did not see a mental health professional at least once in the last 12 months for their mental health due to cost**
By mental health status, by jurisdiction 2023-24 (a), (b)



Source: table 13A.19

(a) Confidence intervals are not available where the proportion has a relative standard error greater than 50%. (b) Refer to data tables for information on the non-publication of data for individual jurisdictions.

4. Mental health service use estimates

'Mental health service use estimates' is an indicator of governments' objective to provide services that are readily available to those who need them.

'Mental health service use estimates' is defined as the estimated proportion of the population with a mental health condition receiving a mental health service.

A high or increasing proportion of the population with a mental health condition receiving services for mental health suggests greater access to treatment. However, not all people with a mental health condition will want or need treatment. Furthermore, accessing a service does not guarantee that the service will be effective.

An agreed method for reporting against this indicator is not yet available.

5. Primary mental health care for children and young people

‘Primary mental health care for children and young people’ is an indicator of governments’ objective to facilitate early detection of mental health issues and mental illness, followed by appropriate intervention.

‘Primary mental health care for children and young people’ is defined as the proportion of young people aged under 25 years who received a Medicare-subsidised mental health care service from a GP, psychologist or other allied health professional.

High or increasing proportions of young people who had contact with Medicare-subsidised primary mental health care services are desirable.

Results for this indicator should be interpreted with caution. Variations in use could be due to variations in access but could also be a result of differences in the prevalence of mental illness. This indicator does not provide information on whether services are appropriate for the needs of young people receiving them, or correctly targeted to young people most in need. Further, some primary mental health services for children and young people are excluded from these data; for example, community health centres, school and university counsellors and nurses and some mental health care provided by state and territory governments’ specialised mental health services (NMHPSC 2011a).

> The proportion of all children and young people who received Medicare-subsidised primary mental health care services has varied over the past 10 years, from 7.1% in 2014-15 to 8.9% in 2023-24. The proportion peaked during 2020-21 when 10.4% of children and young people accessed Medicare-subsidised mental health services. Medicare-mental health service use increases with age. Nationally, 14.8% of young people aged 18–24 years and 6.0% of primary school-aged children received Medicare-subsidised primary health care services in 2023-24 (figure 13.6).

Medicare-telehealth services were introduced in 2019-20. The proportion of people under 25 accessing subsidised primary mental health care consultations via telehealth in 2023-24 was 2.0% compared to 7.1% in person, similar to the proportion in 2019-20 (2.1% of consultation via telehealth compared to 7.4% in person) (13A.20 and figure 13.6).

Proportions of young people accessing Medicare-subsidised mental health care are higher for females compared to males and higher for young people in major cities and inner regional areas compared to other areas (table 13A.21). Data by Aboriginal and Torres Strait Islander status and service type are available in tables 13A.21–22.

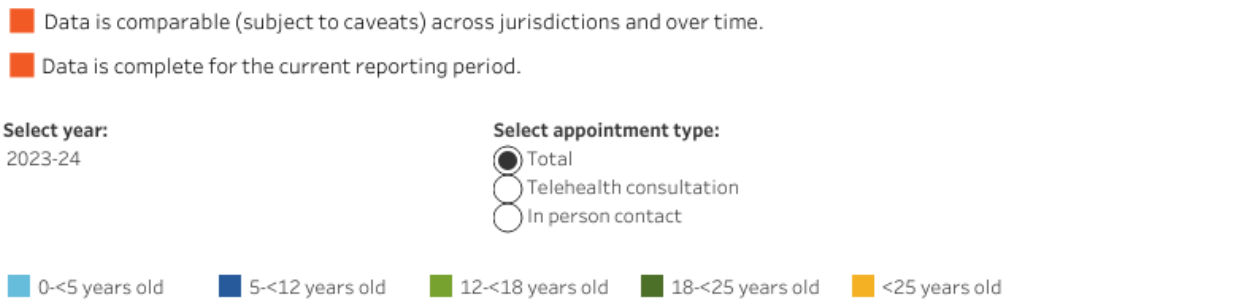
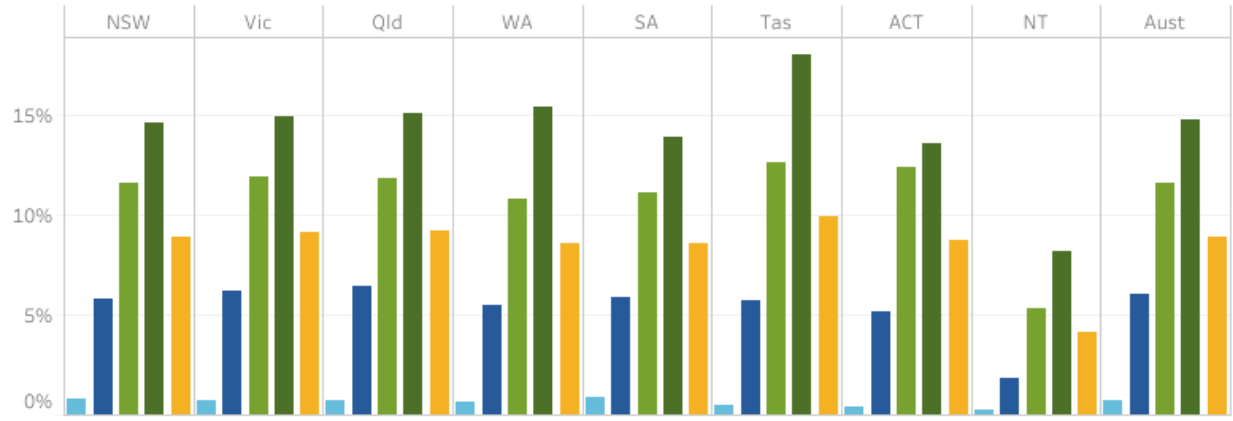


Figure 13.6 **Children and young people who received Medicare subsidised primary mental health care, Total**
By age group, by jurisdiction, 2023-24 (a)



Source: table 13A.20

(a) Prior to 2019-20, no distinction between in person and telehealth was available.

6. Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective to provide universal access to services that are responsive to consumer and carer goals.

'Consumer and carer involvement in decision making' is defined by two measures, the number of paid FTE:

- consumer workers per 1,000 FTE direct care staff
- carer workers per 1,000 FTE direct care staff.

High or increasing proportions of paid FTE direct care staff who are consumer or carer workers implies better opportunities for consumers and carers to influence the services received.

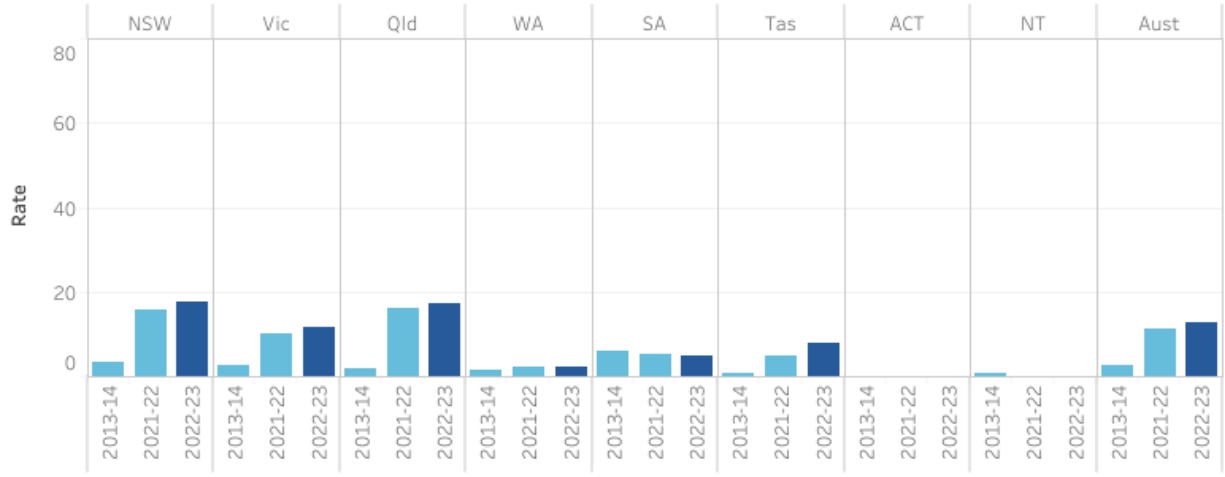
> Nationally in 2022-23 there were 12.6 paid FTE consumer workers per 1,000 paid FTE direct care staff (figure 13.7a)

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

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year(s):
Multiple values

Figure 13.7a Measure 1: **Consumer workers**
Per 1,000 paid FTE direct care staff, by jurisdiction, by year (a), (b)



Source: table 13A.23

(a) Consumer staff could not be separately identified in the ACT for 2013-14 to 2015-16. The Australian total excludes the ACT for these years. The ACT did not employ any consumer workers in 2018-19. (b) Data was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include ACT.

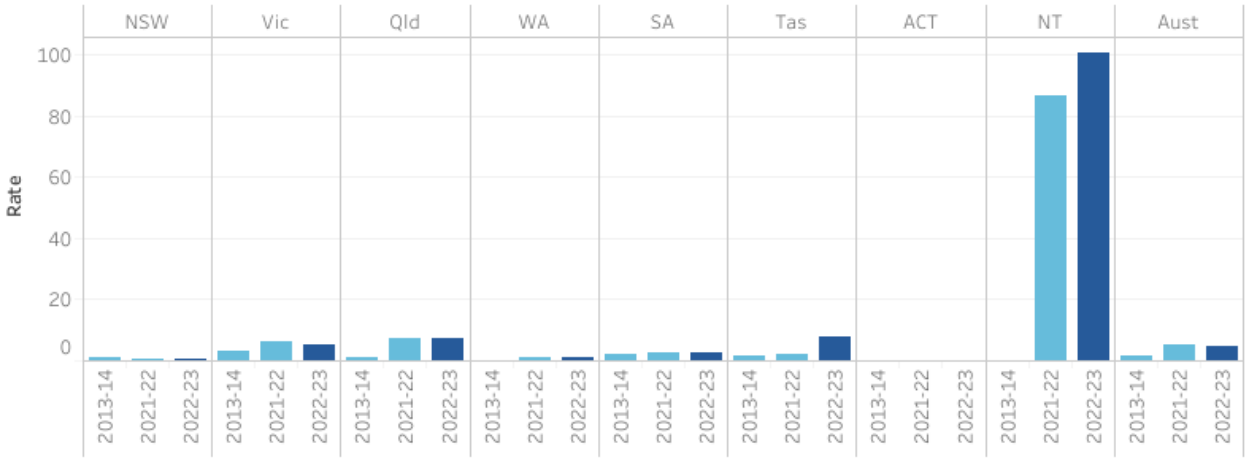
Nationally in 2022-23, there were 4.8 paid FTE carer workers per 1,000 paid FTE direct care staff (figure 13.7b).

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

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year(s):
Multiple values

Figure 13.7b Measure 2: **Carer workers**
Per 1,000 paid FTE direct care staff, by jurisdiction, by year (a), (b)



Source: table 13A.23

(a) WA did not employ carer workers in 2013-14 or 2018-19. The NT did not employ carer workers prior to 2013-14 or between 2016-17 and 2021-21. Carer workers could not be separately identified in the ACT for 2013-14 to 2015-16 (the Australian total excludes the ACT for these years). The ACT did not employ any carer workers in 2017-18 to 2018-19. (b) Data was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include the ACT.

7. Services reviewed against the National Standards

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide universal access to services that are high quality.

‘Services reviewed against the National Standards’ is defined as the proportion of expenditure on state and territory governments’ specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS) and met ‘all standards’ (level 1). The assessment levels are defined in the ‘Key terms and references’ tab.

A high or increasing proportion of expenditure on specialised mental health services that had completed a review by an external accreditation agency and had been assessed against the NSMHS as level 1 is desirable.

This is a process indicator of quality, reflecting progress made in meeting the NSMHS. It does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

> Nationally at 30 June 2023, 96.3% of expenditure on specialised public mental health services was on services that had completed an external review against the NSMHS and met ‘all standards’ (level 1) (figure 13.8).

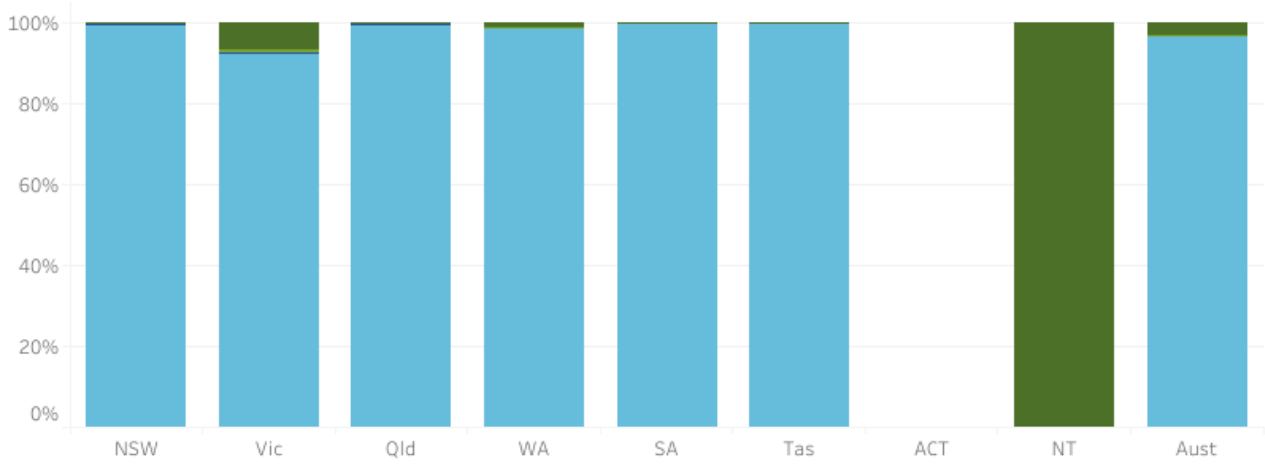
Data is not comparable across jurisdictions, but is comparable (subject to caveats) within jurisdictions over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2023.

Select year:
2023

Level 4
Level 3
Level 2
Level 1

Figure 13.8 **Expenditure on state and territory government specialised public mental health services by level assessed against the National Standards for Mental Health Services (NSMHS)**
By NSMHS level, by jurisdiction, 2023 (a)



Source: table 13A.24

(a) Data was not available for the ACT for 2022 or 2023. The Australian total does not include the ACT.

8. Adverse events

Content warning

If you are experiencing crisis, feel worried about harming yourself or think someone may be in danger, please seek help.

If life is in imminent danger please call 000.

Lifeline 13 11 14
Suicide Call Back Service 1300 659 467
Kids Helpline 1800 551 800
13YARN 13 92 76
QLife 1800 184 527
Beyond Blue 1300 224 636

'Adverse events' is an indicator of governments' objective to provide services that promote recovery, and are high quality, safe and responsive to consumer and carer goals.

‘Adverse events’ is defined by seven measures:

- Measure 1: Restrictive practices:
    - Seclusion, defined as the number of seclusion events per 1,000 bed days in state and territory governments’ specialised mental health acute inpatient units
    - Restraint, defined as:
        - the number of mechanical restraint events per 1,000 bed days in state and territory governments’ specialised mental health acute inpatient units
        - the number of physical restraint events per 1,000 bed days in state and territory governments’ specialised mental health acute inpatient units
        - the number of chemical restraint events. (Measurement of this concept is under development.)

- Measure 2: Suicide in an inpatient facility
    - Suicide in an inpatient facility, defined as suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward, reported as a number, by jurisdiction.

- Measure 3: Self-harm in an inpatient facility
    - Self-harm is defined as deliberately hurting oneself without conscious suicidal intent.

- Measure 4: Assault in an inpatient facility
    - Assault is defined as physical or sexual assault of a patient in an inpatient facility. (Measurement of this concept is under development.)

- Measure 5: Medical errors in an inpatient facility
    - Medical errors are defined as the administration of an incorrect diagnosis, intervention, or medication, or delay in administration resulting in harm or deterioration. (Measurement of this concept is under development.)

- Measure 6: Absent without leave from an inpatient facility
    - Absent without leave is defined as leaving or not returning to an admitted healthcare facility without prior agreement.

- Measure 7: Falls in an inpatient facility
    - Falls is defined as a loss of balance resulting in serious harm. (Measurement of this concept is under development.)

Measure 1: Restrictive practices

Seclusion involves confining a person at any time of the day or night alone in a room or area from which he or she cannot leave (the ‘Explanatory material’ tab provides further details on seclusion and ‘seclusion events’). Legislation or mandatory policy governs the use of seclusion in each state and territory and may result in exceptions to the definition of a seclusion event and variations in the data collected across jurisdictions (NMHPSC 2011b).

Supporting data on the duration of seclusion events are provided in table 13A.26. These data, when considered with the rate of seclusion, provide information on the use and management of seclusion across jurisdictions.

A low or decreasing rate of seclusion events combined with shorter average durations is desirable.

Restraint involves restricting a person's freedom of movement by physical or mechanical means. The ‘Explanatory material’ tab provides further details on mechanical and physical restraint.

A low or decreasing rate of restraint events per 1,000 bed days in specialised public mental health inpatient units is desirable.

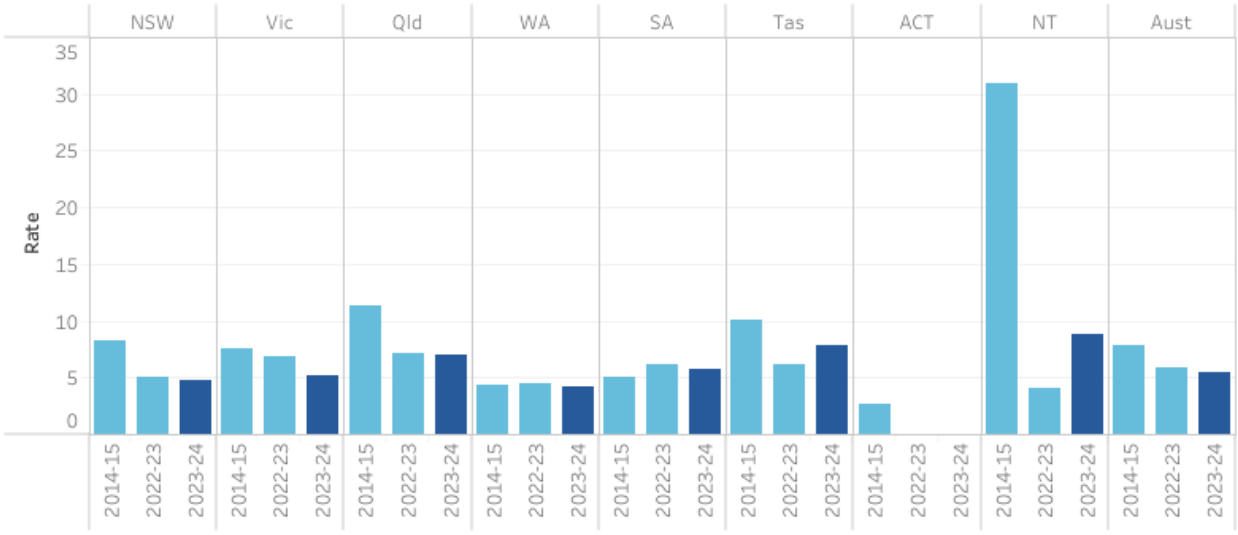
Nationally, in 2023-24 (excluding the Australian Capital Territory), the rate of seclusion was 5.4 events per 1,000 bed days (figure 13.9a). Rates varied across jurisdictions and unit types. In 2023-24, the lowest rates of seclusion were in older people units (0.2 events per 1,000 bed days) and the highest in child and adolescent units (5.7 events per 1,000 bed days, down from 12.0 seclusion events per 1,000 bed days in 2022-23) (table 13A.26).

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

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2023-24.

Select year(s):
Multiple values

Figure 13.9a Measure 1a: **Restrictive practices - Seclusion**
Seclusion events per 1,000 bed days, by jurisdiction, by year (a)



Source: table 13A.25

(a) Data was not available for the ACT for 2022-23 or 2023-24. The Australian total does not include ACT.

Nationally in 2023-24 (excluding the Australian Capital Territory), the rate of physical restraint was 8.5 events per 1,000 bed days, while the rate of mechanical restraint (excluding Western Australia and the Australian Capital Territory) was 0.4 events per 1,000 bed days (figure 13.9b and table 13A.27). The rates of physical and mechanical restraint in public specialised mental health units, by unit type, are in table 13A.28.

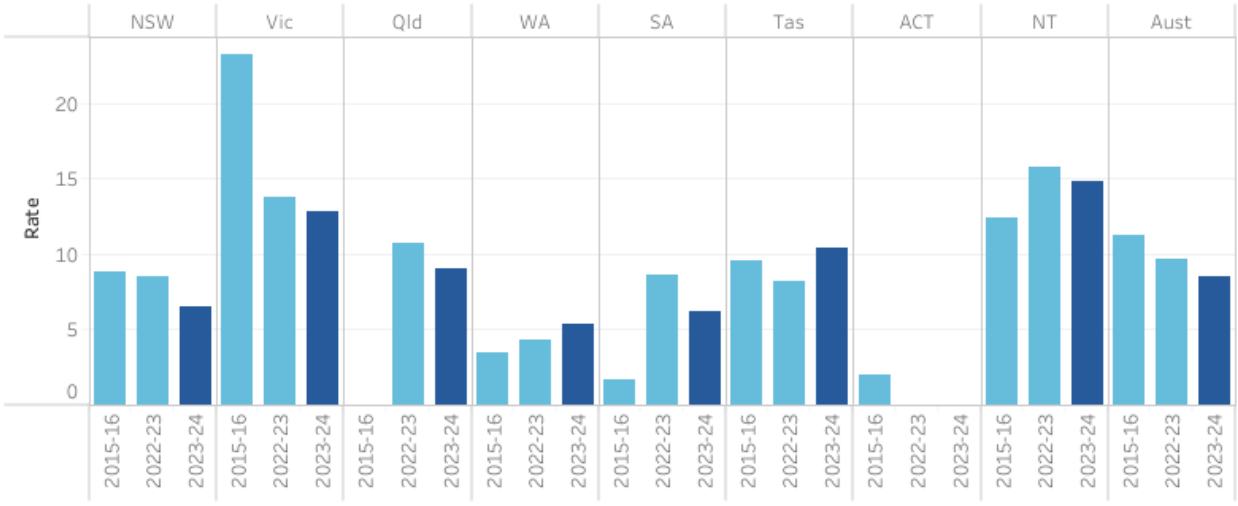
Data is not comparable across jurisdictions or over time.

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2023-24.

Select year(s):
Multiple values

Select restraint type:
(●) Physical restraint
( ) Mechanical restraint

Figure 13.9b Measure 1b: **Restrictive practices - Physical restraint**
Restraint events per 1,000 bed days, by jurisdiction, by year (a), (b)



Source: table 13A.27

(a) Refer to data table 13A.27 for information on non-publication of data on mechanical and physical restraint for individual jurisdictions.
(b) Data was not available for the ACT for 2022-23 or 2023-24. The Australian total does not include ACT.

tableau

Measure 2: Suicide in an inpatient facility

A suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward is known as a 'sentinel event'. Sentinel events are adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient.

Australian health ministers agreed version 2 of the Australian sentinel events list in December 2018. All jurisdictions implemented these categories on 1 July 2019. 'Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward' is one of ten sentinel events in the Australian sentinel events list. Further details are available in section 12.

A low or decreasing number of suspected suicides of patients in acute psychiatric units or acute psychiatric wards is desirable.

> Nationally in 2022-23, there were 13 suspected suicides in psychiatric inpatient facilities, a decrease on the number of inpatient suicides in 2021-22 (table 13.1 and table 13A.29).

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

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

Table 13.1 Measure 2: **Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward**
By jurisdiction, by year (number)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2022-23	6	2	2	2	1	–	–	–	13
2021-22	8	4	2	–	2	–	–	1	17
2020-21	5	3	2	3	–	–	–	–	13
2019-20	2	8	3	2	–	–	–	–	15

Source: table 13A.29
– Nil or rounded to zero.

Measure 3: Self-harm in an inpatient facility

Self-harm is defined as deliberately hurting oneself without conscious suicidal intent. Most people who self-harm do not go on to end their lives. However, previous self-harm is a strong risk factor for suicide (AIHW 2024c). Therefore, identifying and managing risks associated with self-harming are important elements of clinical care. This measure reports on self-harming events (for example, injury, poisoning) in specialised psychiatric care, as a rate per 1,000 bed days.

The AIHW monitoring report *Suicide and intentional self-harm* (2024c) provides information on patients admitted to hospital for self-harm. This measure reports on self-harming events that occurred *after* admission during an episode of care, using an external cause onset flag. Events only include patients who had a mental health diagnosis and who were in specialised psychiatric care. It is not possible to capture intent within this data set (that is, whether the patient was self-harming or attempting suicide).

A low and decreasing rate of self-harming events after admission to specialised psychiatric care is desirable, notwithstanding the high-acuity of people receiving specialised psychiatric care.

> Nationally (excluding South Australia), in 2022-23, there were 916 self-harming events in specialised psychiatric care, equating to 0.5 self-harming events per 1,000 bed days (table 13.2 and table 13A.30).

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

Data is not complete for the current reporting period. Data for South Australia are not available for 2022-23.

Table 13.2 Measure 3: **Self-harming events in specialised psychiatric care, Rate per 1,000 bed days**
By jurisdiction, by year (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2022-23	0.5	0.5	0.6	0.8	na	0.7	na	np	0.5
2021-22	0.6	0.6	0.8	1.0	na	np	na	np	0.7
2020-21	0.6	0.5	0.9	1.0	na	np	0.6	np	0.7
2019-20	0.6	0.4	1.0	1.0	na	0.5	0.8	0.6	0.6
2018-19	0.5	0.4	1.0	1.3	na	0.8	np	np	0.7
2017-18	0.6	0.4	1.0	1.1	na	0.9	np	np	0.7
2016-17	0.5	0.4	0.9	1.0	na	0.8	1.3	0.4	0.6
2015-16	0.5	0.4	1.0	0.9	na	np	0.9	np	0.6
2014-15	0.4	0.5	0.9	1.1	na	np	0.9	np	0.6
2013-14	0.3	0.4	0.9	1.1	na	np	0.7	np	0.5

Source: table 13A.30

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

(a) Data was not available for SA. The Australian total does not include SA.

Measure 6: Discharge against medical advice

Discharge against medical advice refers to patients who were admitted to hospital and left against the advice of their treating physician. Patients who discharge against medical advice are at greater risk of clinical deterioration, presentation to emergency departments, readmission and mortality.

Patients might self-discharge from hospital for a variety of reasons, including dissatisfaction with care, poor communication, and feeling better, as well as external factors such as family and employment responsibilities. Therefore, discharge against medical advice is a measure of safety (for a patient to return to the community), patient satisfaction, and confidence in care that also recognises patient autonomy.

Data are presented as a rate per 1,000 care type separations. This measure might involve some undercounting as it does not capture episodes until a formal separation has been registered.

Low or decreasing proportions of patients who discharge against medical advice are desirable.

> Nationally (excluding the Australian Capital Territory), in 2022-23, 503 involuntary patients and 836 voluntary patients receiving specialised psychiatric care left against medical advice, equating to 9.1 and 11.9 patients leaving against medical advice per 1,000 care type separations, respectively (table 13.3 and table 13A.31).

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

Data is not complete for the current reporting period. Data for South Australia are not available for 2022-23.

Select year(s):
Multiple values

Table 13.3 Measure 6: **Patient discharged against medical advice, Rate per 1,000 separations**
By jurisdiction, by year

			NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2022-23	Involuntary	With specialised psychiatric care	5.1	9.5	8.0	10.5	41.4	np	na	..	9.1
		Without specialised psychiatric care	–	..	..	np	np	np	na	80.3	12.6
	Voluntary	With specialised psychiatric care	9.0	8.4	8.4	22.6	13.9	np	na	..	11.9
		Without specialised psychiatric care	np	np	..	22.2	19.8	np	na	np	17.1
2021-22	Involuntary	With specialised psychiatric care	3.9	5.1	7.7	8.2	22.6	9.2	..	41.5	7.3
		Without specialised psychiatric care	–	..	..	np	14.7	–	..	np	14.2
	Voluntary	With specialised psychiatric care	9.6	8.8	6.0	21.0	14.0	25.0	..	51.0	11.4
		Without specialised psychiatric care	22.4	..	..	25.9	22.5	–	..	122.4	21.8
2013-14	Involuntary	With specialised psychiatric care	11.7	19.6	8.8	4.6	17.9	–	np	np	12.4
		Without specialised psychiatric care	..	..	..	..	..	np	..	..	np
	Voluntary	With specialised psychiatric care	10.0	12.7	13.4	22.5	19.8	–	np	np	13.6
		Without specialised psychiatric care	..	..	..	..	..	..	..	..	..

Source: table 13A.31

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

+ a b | e a u

9. Consumer and carer experiences of mental health services

‘Consumer and carer experiences of mental health services’ is an indicator of governments’ objective to provide access to services that are responsive to consumer and carer goals.

‘Consumer and carer experiences of mental health services’ is defined by two measures:

- the proportion of mental health service consumers reporting positive experiences of mental health services
- the proportion of carers of mental health service consumers reporting positive experiences of mental health services.

A high or increasing proportion of mental health consumers and carers with positive experiences of service is desirable. Data is reported by service delivery setting (residential care, admitted care and

ambulatory care – refer to ‘Explanatory material’ tab for definitions).

> In 2022-23, for jurisdictions where data is available, a higher proportion of consumers reported positive experiences of service in residential and ambulatory care (non-admitted care) than in admitted care (table 13.4).

(measure 1) Data is not comparable across jurisdictions, but is comparable within jurisdictions over time.

(measure 1) Data is not complete for the current reporting period.

Data is not available for the measure of carers experience (measure 2).

Select year(s):
Multiple values

Table 13.4 **Mental health service consumers reporting positive experiences of mental health services**
By type of service, by jurisdiction, by year (%) (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Admitted Care	2022-23	68.7	50.9	51.3	na	na	na	na	na	na
	2021-22	68.9	50.6	46.5	na	na	na	na	na	na
	2015-16	67.0	52.6	46.4	na	na	na	na	na	na
Ambulatory Care	2022-23	81.2	73.7	80.3	na	na	na	na	na	na
	2021-22	78.0	70.1	80.5	na	na	na	na	na	na
	2015-16	78.9	69.0	79.5	na	na	na	na	na	na
Residential Care	2022-23	..	81.6	73.8	na	na	na	na	na	na
	2021-22	..	80.1	76.6	na	na	na	na	na	na
	2015-16	..	77.9	..	na	na	na	na	na	na

Source: table 13A.32
na Not available. .. Not applicable.

(a) Victoria did not conduct the survey during 2019-20 due to the COVID-19 pandemic.

10. Community follow-up after psychiatric admission/hospitalisation

‘Community follow-up after psychiatric admission/hospitalisation’ is an indicator of governments’ objective to provide services that are coordinated and provide continuity of care.

‘Community follow-up after psychiatric admission/hospitalisation’ is defined as the proportion of state and territory governments’ specialised public admitted patient overnight acute separations from psychiatric units for which a community-based ambulatory contact was recorded in the seven days following separation.

A high or increasing rate of community follow-up within the first seven days of discharge from hospital is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. Nor does it distinguish between the mode of contact. Only follow-up contacts made by

state and territory governments' specialised public mental health services are included.

> Nationally, the rate of community follow-up for people within the first seven days of discharge from an acute inpatient psychiatric unit was 76.2% in 2022-23, an increase over the 10 years from 2013-14 (67.4%) (figure 13.10).

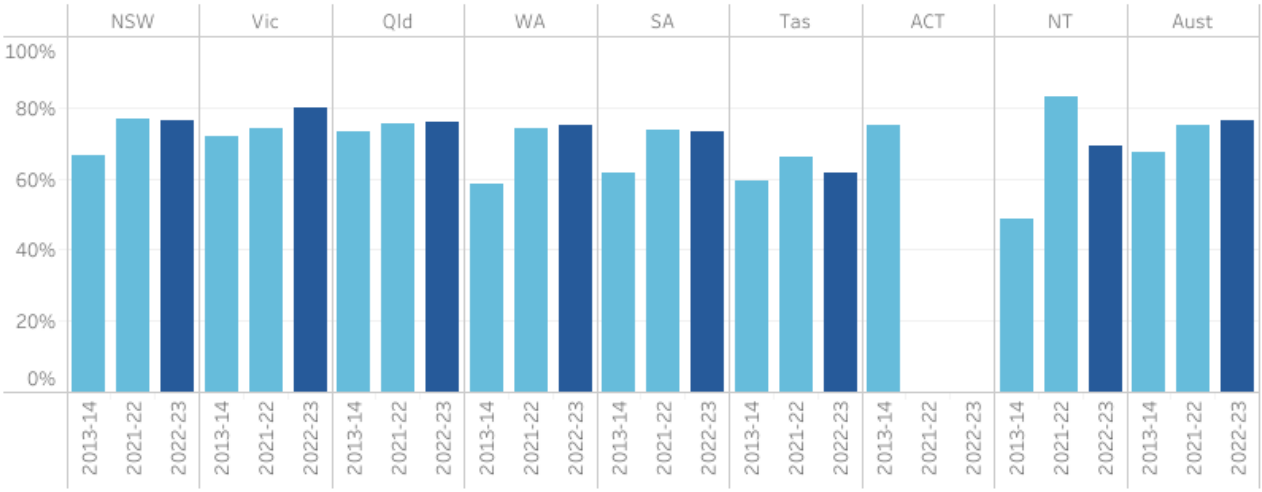
Community follow-up rates by Indigenous status, remoteness areas, SEIFA, age groups and sex are in tables 13A.33-34.

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

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year(s):
Multiple values

Figure 13.10 **Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation**
By jurisdiction, by year (a)



Source: table 13A.35

(a) Data was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include ACT.

11. Readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is an indicator of governments' objective to provide services that are coordinated and provide continuity of care.

'Readmissions to hospital within 28 days of discharge' is defined as the proportion of state and territory governments' admitted patient overnight separations from psychiatric acute inpatient units that were followed by readmission to the same type of unit within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge is desirable.

While readmissions can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate, they can also reflect the cyclic and episodic nature of some illnesses.

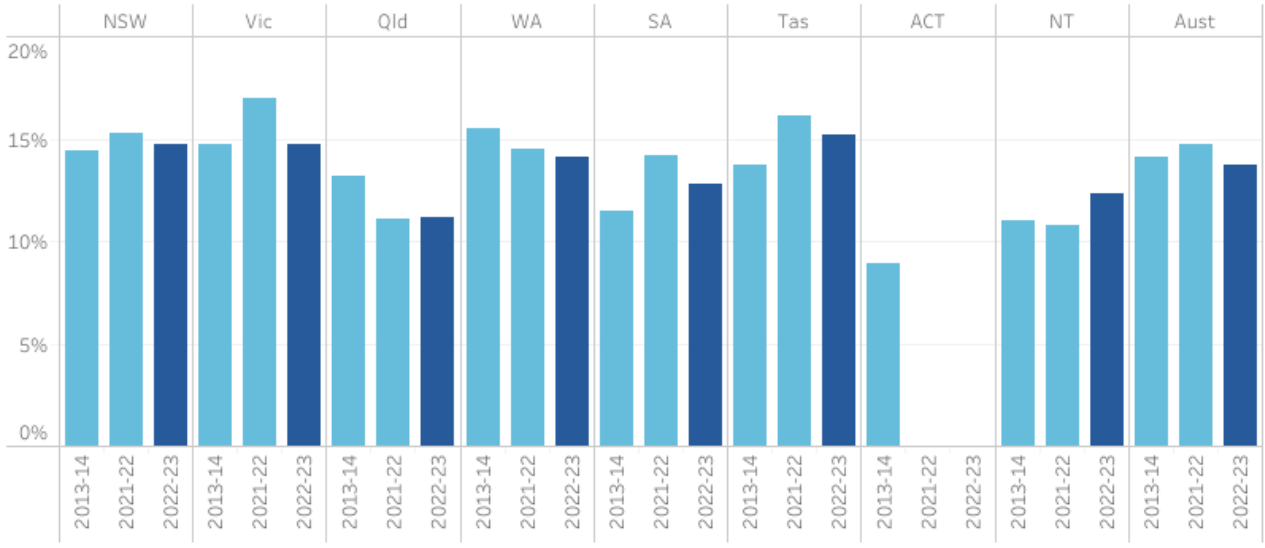
Nationally in 2022-23, the rate of readmission to hospital acute psychiatric units within 28 days of discharge was 13.7% (figure 13.11).

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

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Select year(s):
Multiple values

Figure 13.11 **Readmissions to hospital within 28 days of discharge**
By jurisdiction, by year (a)



Source: table 13A.37

(a) Data was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include ACT.

Data by Indigenous status, remoteness areas, SEIFA, age group and sex is in tables 13A.36.

12. Workforce sustainability

'Workforce sustainability' is an indicator of governments' objective to provide sustainable services. Health workforce sustainability relates to the capacity of the health workforce to meet current and projected service demand.

'Workforce sustainability' is defined by two measures:

- mental health workforce age profiles - the proportion of full time equivalent (FTE) medical practitioners (including psychiatrists), mental health nurses, registered psychologists and other allied mental health practitioners in ten-year age brackets, by jurisdiction
- mental health workforce attrition rates.

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 mental health services.

High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement are desirable. A low or decreasing rate of workforce attrition is desirable.

Workforce age profiles

> Nationally in 2023, allied mental health practitioners had the highest proportion of FTEs who were aged less than 30 years (27.5%), followed by nurses (15.6%), psychologists (9.9%) and medical practitioners (3.7%) (including psychiatrists). The medical practitioner (including psychiatrists) workforce had the highest proportion of FTEs aged 60 years and over (22.2%) (figure 13.12).

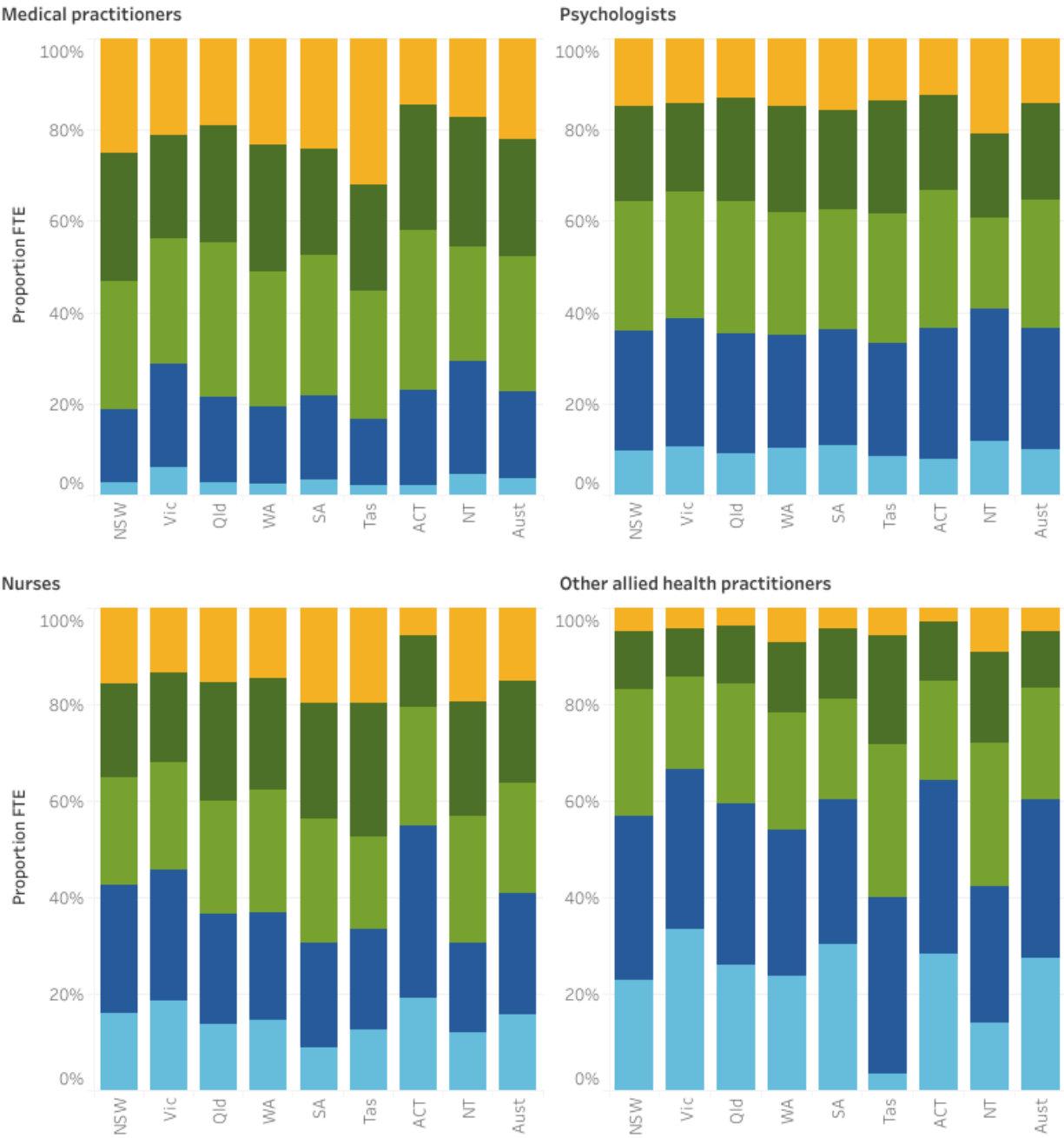
Data is comparable (subject to caveats) across jurisdictions and over time.

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

Select year:
2023

60+ years old
50-59 years old
40-49 years old
30-39 years old
<30 years old

Figure 13.12 **Mental health workforce**
By age group, by jurisdiction, 2023



Source: table 13A.38

Workforce attrition rates

> Nurses employed in the mental health sector had the highest attrition rate (29.7%), followed by allied mental health practitioners (26.6%), medical practitioners (18.2%) and psychologists (5.4%) (table 13A.38).

13. Cost of care

'Cost of care' is an indicator of governments' objective to provide services in an efficient manner.

'Cost of care' has three measures.

- Measure 1: 'Cost of inpatient care', defined by two sub measures:
  - 'Cost per inpatient bed day', defined as expenditure on inpatient services divided by the number of inpatient bed days – data is disaggregated by hospital type (psychiatric and general hospitals) and care type (acute and non-acute units) and by inpatient target population (acute units only)
  - 'Average length of stay', defined as the number of inpatient patient days divided by the number of separations in the reference period – data is disaggregated by inpatient target population (acute units only). Patient days for consumers who separated in the reference period (2020-21) that were admitted during the previous period (2019-20) are excluded. Patient days for consumers who remain in hospital (and therefore are not included in the separations data) are included. Data for this sub measure are not yet reported.

  These sub measures are considered together for the inpatient acute units by target population to provide a 'proxy' measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care. Data for forensic services are included for costs per inpatient bed day only, as the length of stay is dependent on factors outside the control of these services.
- Measure 2: 'Cost of community-based residential care' is defined as the average cost per patient day. Data is reported for both the care of general adult and older people services.
- Measure 3: 'Cost of ambulatory care' is defined by two sub measures:
  - average cost per treatment day
  - average number of treatment days per episode – this measure is provided, along with average costs, as frequency of servicing is the main driver of variation in care costs.

For each measure, a low or decreasing cost per input is desirable as this might indicate more efficient service delivery. However, efficiency data need to be interpreted with care as they do not provide information on service quality or patient outcomes.

Mainstreaming (that is, providing mental health care in general health care settings rather than psychiatric settings) has occurred at different rates across states and territories, with some jurisdictions treating a greater proportion of consumers with severe mental illnesses in community-based services than other jurisdictions (refer to 'Explanatory material' tab for a definition of mainstreaming). This can create differences across states and territories in the mix of consumers, and therefore the costs, within service types.

Nationally in 2022-23, the average recurrent cost per inpatient bed day was higher in acute than non-acute units (figure 13.13a). Older people units have lower costs per inpatient day (table 13A.40) but have considerably longer lengths of stay than general adult or child and adolescent units (table 13A.42). Data on the average cost per inpatient bed day by target population for all care types are reported in tables 13A.40–42.

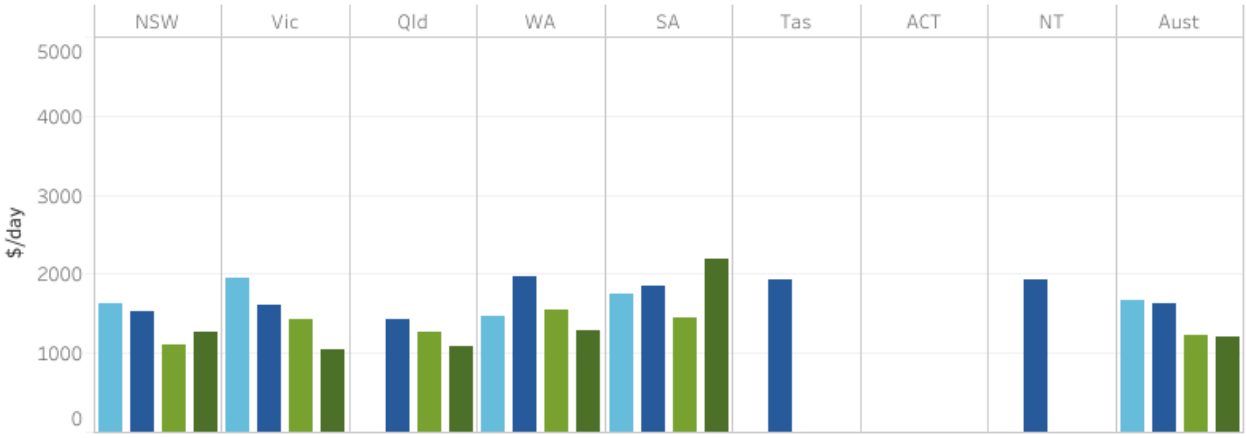
Data is comparable (subject to caveats) across jurisdictions and over time.

Data is not complete for the current reporting period. General acute hospital data for the Australian Capital Territory is not available or 2022-23.

Select year:
2022-23

Psychiatric hospitals (acute units)
General acute hospitals (acute units)
Psychiatric hospitals (non-acute units)
General acute hospitals (non-acute units)

Figure 13.13a Measure 1a: **Average recurrent cost**
Per inpatient bed day, by hospital and care type, by jurisdiction, 2022-23 (2022-23 dollars) (a), (b)



Source: table 13A.39

(a) Queensland does not provide acute services in psychiatric hospitals. Tasmania, the ACT and the NT do not have psychiatric hospitals. SA, Tasmania and the NT do not have non-acute units in general hospitals. The ACT did not have non-acute units in general hospitals prior to 2018-19. (b) General acute hospital data was not available for the ACT for 2021-22 or 2022-23. Australian totals do not include ACT.

Nationally in 2022-23, the average recurrent cost for 24-hour staffed residential care is higher for general adult units ($814.13 per patient day) compared to older people care units ($745.56 per patient day) (figure 13.13b). Nationally, the average recurrent cost per patient day for general adult units staffed 24 hours a day was 2.4 times the cost of those that were not staffed 24 hours a day (table 13A.43).

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

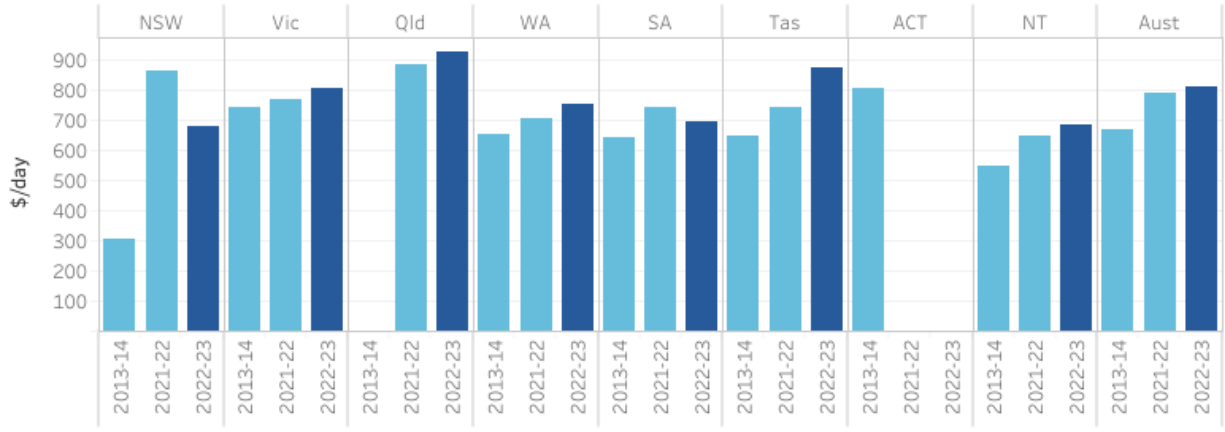
Data is not complete for the current reporting period. General adult unit data for the Australian Capital Territory is not available for 2022-23.

Select year:
Multiple values

Select target population:
(●) General adult units
( ) Older people care units

Select staffing level:
(●) 24-hour staffed units
( ) Non-24-hour staffed units

Figure 13.13b Measure 2: **Cost of community-based residential care**
per inpatient bed day, General adult units, 24-hour staffed units, 2022-23 dollars, by jurisdiction, by year (a), (b)



Source: table 13A.43

(a) Refer to data table 13A.41 for information on non-publication of data for individual jurisdictions. (b) General adult unit data was not available for the ACT for 2021-22 or 2022-23. Australian totals do not include the ACT.

Nationally in 2022-23, the average recurrent cost per treatment day of ambulatory care was $450.66 (figure 13.13c), and the average number of treatment days per episode of ambulatory care was 6.4 days (figure 13.13d).

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

(measure 3a) Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

(measure 3b) Data is complete (subject to caveats) for the current reporting period.

Select year(s) (applies to figures 13.13c and 13.13d):
Multiple values

Figure 13.13c **Measure 3a: Average cost per treatment day of ambulatory care**
By jurisdiction, by year (2022-23 dollars) (a)

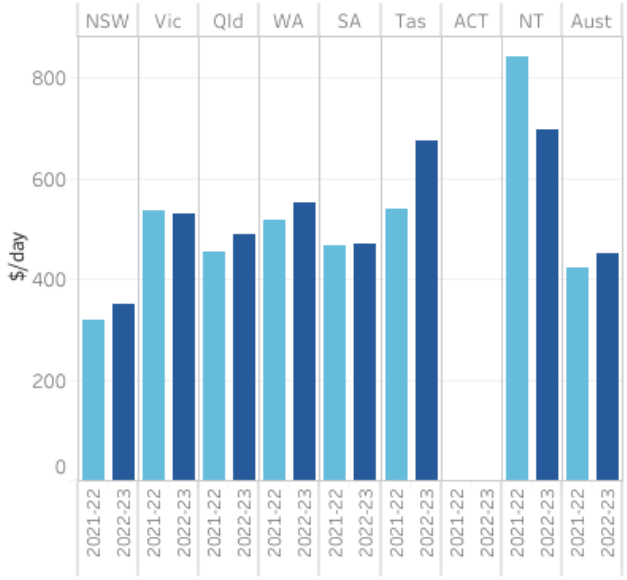
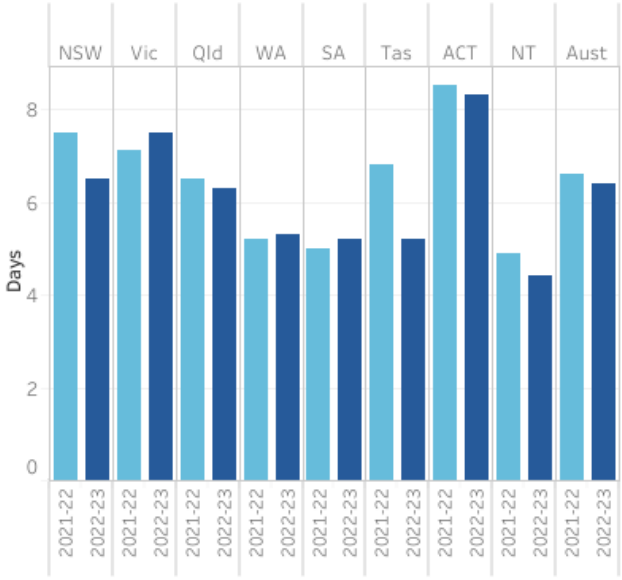


Figure 13.13d **Measure 3b: Average treatment days**
Per episode of ambulatory care, by jurisdiction, by year



Source: table 13A.44

(a) Average cost per treatment day data was not available for the ACT for 2021-22 or 2022-23. The Australian total does not include the AC..

tableau

14. Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective to, where possible, prevent the development of mental health problems, mental illness and suicide.

‘Prevalence of mental illness’ is defined as the proportion of the total population who have a mental illness.

A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system. These include environmental, sociocultural and economic factors, some of which can increase the risk of mental illness while others can support good mental health.

Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Nationally in 2020–2022, more than one in five Australians (21.5%) aged 16 to 85 years reported a mental health disorder with symptoms in the previous 12 months (table 13.5). National data by disorder, age and sex are reported in tables 13A.45–47.

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

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

Table 13.5 **People with 12-month mental disorders among adults aged 16-85 years**
By jurisdiction, by year (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2020-2022	%	19.5 ± 1.6	21.4 ± 1.6	23.7 ± 2.0	23.1 ± 2.5	21.6 ± 3.0	19.8 ± 5.7	25.5 ± 7.0	28.8 ± 13.6	21.5 ± 0.8
2007	%	19.7 ± 2.1	19.9 ± 2.3	19.0 ± 2.6	20.8 ± 4.3	18.9 ± 3.4	13.5 ± 4.8	np	np	19.5 ± 1.1

Source: table 13A.45

np Not published.

(a) Percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

The prevalence of mental illness among children and young people aged 4–17 years was an estimated 13.9% in 2013-14 (Lawrence et al. 2015). Attention deficit/hyperactivity disorder (ADHD) was the most common mental illness for this age group (7.4%) followed by anxiety disorders (6.9%) (Lawrence et al 2015).

A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services (ABS 2012).

Nationally in 2017-18, the age standardised proportion of adults with high/very high levels of psychological distress was 13.0% (table 13A.49), and of those 4.0% had very high levels (table 13A.48). Proportions were higher for:

- females compared to males (table 13A.48)
- people in lower compared to higher socioeconomic areas (tables 13A.49 and 13A.50)
- Aboriginal and Torres Strait Islander people (2018-19) compared to non-Indigenous people (2017-18) (table 13A.51).

High rates of substance use and abuse can contribute to the onset of, and poor recovery from, mental illness. Information on rates of licit and illicit drug use can be found in tables 13A.50–52 and the National Drug Strategy Household Survey (AIHW 2020).

15. Mortality due to suicide

Content warning

If you are experiencing crisis, feel worried about harming yourself or think someone may be in danger, please seek help.

If life is in imminent danger please call 000.

Lifeline 13 11 14

Suicide Call Back Service 1300 659 467

Kids Helpline 1800 551 800

13YARN 13 92 76

QLife 1800 184 527

Beyond Blue 1300 224 636

'Mortality due to suicide' is an indicator of governments' objective to, where possible, prevent the development of mental health problems, mental illness and suicide.

'Mortality due to suicide' is defined as the suicide rate per 100,000 people. Deaths from suicide are defined as causes of death with the International Classification of Diseases (ICD) 10 codes X60–X84 and Y87.0 (ABS 2024a).

A low or decreasing suicide rate per 100,000 people is desirable.

While services for mental health contribute to reducing suicides, other services also have a significant role including public mental health programs and suicide prevention programs (addressed through the initiatives of other government agencies, NGOs and other special interest groups).

Many factors outside the control of services for mental health can affect suicide risk. These include environmental, sociocultural and economic risk factors. Often a combination of these factors can increase the risk of suicidal behaviour.

> People with a mental illness are at a higher risk of suicide compared to the general population. For the period 2019–2023, there were 16,260 suicides recorded in Australia – equivalent to 12.5 deaths per 100,000 people (table 13A.55). There were 2.3 deaths per 100,000 people aged 5–17 years in the population, and 27.2 deaths per 100,000 Aboriginal and Torres Strait Islander people in the population (figure 13.14).

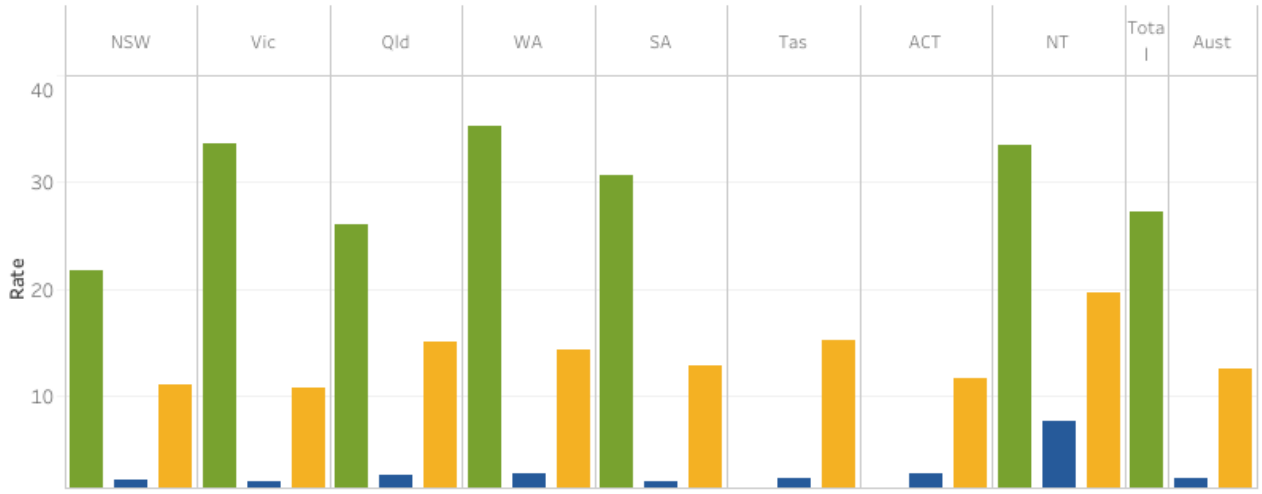
Nationally, suicide rates per 100,000 population for 2022 show that rates are lower for females compared to males (6.1 deaths compared to 19.0 deaths) (ABS 2024b), lower in capital cities compared to other areas (10.0 deaths compared to 15.5 deaths) (table 13A.57) and (for 2019–2023) lower for non-Indigenous compared to Aboriginal and Torres Strait Islander people (11.7 deaths compared to 27.2 deaths) (table 13A.58).

Data is comparable (subject to caveats) across jurisdictions and over time for some years and disaggregations, but is not comparable for other years and disaggregations.

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

Aboriginal and Torres Strait Islander people
5-17 years old
All people

Figure 13.14 **Mortality due to suicide**
Suicide rate per 100,000 people, by selected equity group, by jurisdiction, 2019-2023 (a)



Source: tables 13A.55, 13A.56, 13A.58

(a) Total includes data for NSW, Victoria, Queensland, SA, WA and the NT only. Data for Tasmania and the ACT has been excluded in line with national reporting guidelines.

16. Physical health outcomes for people with a mental illness

'Physical health outcomes for people with a mental illness' is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

'Physical health outcomes for people with a mental illness' is defined as the proportion of adults with a mental illness (compared to those without a mental illness) who experienced a long-term physical health condition: cancer, diabetes, arthritis, cardiovascular disease and asthma.

Low or decreasing proportions of people with a mental illness who experience a long-term physical health condition are desirable.

People with a mental illness have poorer physical health outcomes than people without mental illness (Happell et al. 2015; Lawrence, Hancock and Kisely 2013), but the relationship between the two is complex. Poor physical health can exacerbate mental health problems and poor mental health can lead to poor physical health. In addition, some psychiatric medications prescribed to treat mental health conditions may lead to poorer physical health.

Greater exposure to particular health risk factors can also contribute to poorer physical health. Information on selected risk factors by mental illness status can be found in table 13A.59.

A higher proportion of adults with a mental illness reported having long-term health conditions compared to adults without a mental illness. Nationally in 2022, the age-standardised proportion of people who reported having a long-term health condition was higher for people with a mental illness than people without a mental illness for all reported conditions. For example, almost a quarter of people with a mental illness reported having arthritis (24.7%), compared to 13.4% of people without a mental illness (figure 13.15 and table 13A.60).

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

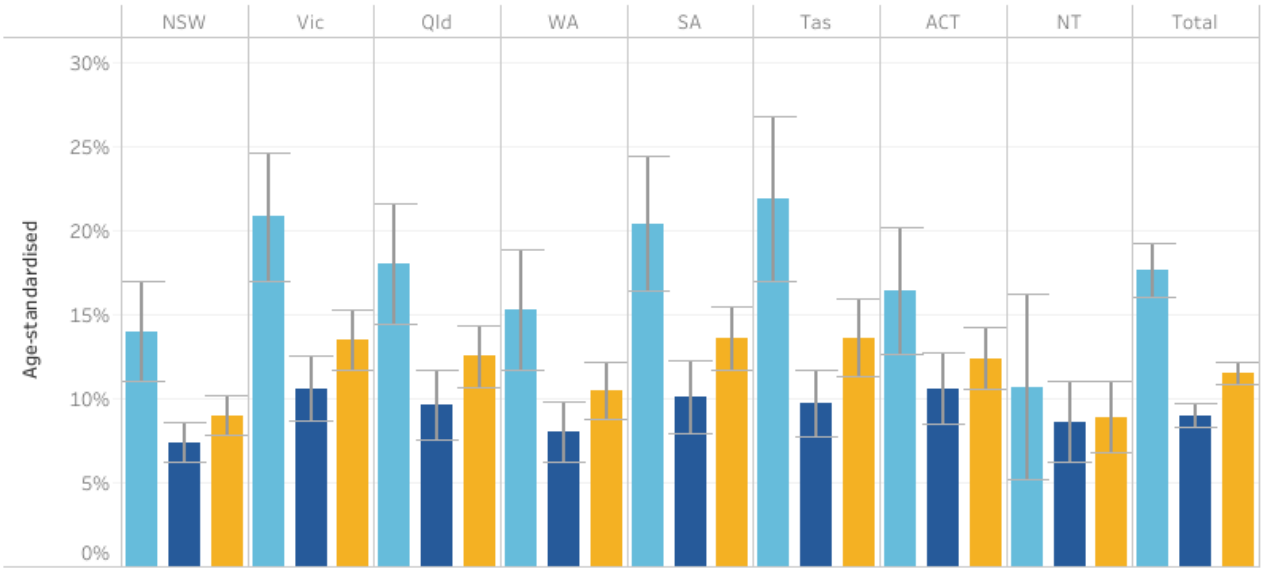
Data is complete (subject to caveats) for the current reporting period.

Select year:
2022

Mental illness status:
People with a mental illness
People without a mental illness
All people

Select condition:
Asthma
Arthritis
At risk of long-term harm from alcohol
Cancer
Cardiovascular disease
Daily smoker
Diabetes
Overweight/obese

Figure 13.15 **Adults with long-term health conditions, Asthma**
By mental illness status, by jurisdiction, 2022 (a)



Source: 13A.60

(a) Data was not published for people with a mental illness with cancer in the ACT (2017-18) and the NT (2017-18 and 2014-15).

17. Social and economic inclusion of people with a mental illness

'Social and economic inclusion of people with a mental illness' is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

'Social and economic inclusion of people with a mental illness' is defined by two measures:

- the proportion of people aged 16–64 years with a mental illness who are employed

- the proportion of people aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the past week.

High or increasing proportions of people with a mental illness who are employed, or who had face-to-face contact with family or friends, are desirable.

This indicator does not provide information on whether the employment, education or social activities were appropriate or meaningful. It also does not provide information on why people who were not employed were not looking for work (for example, those outside the labour force).

> Nationally in 2022, the age-standardised proportion of 16–64 year olds with a mental illness who were employed was 72.3%, a large increase since 2017-18 (63.9%) (figure 13.16).

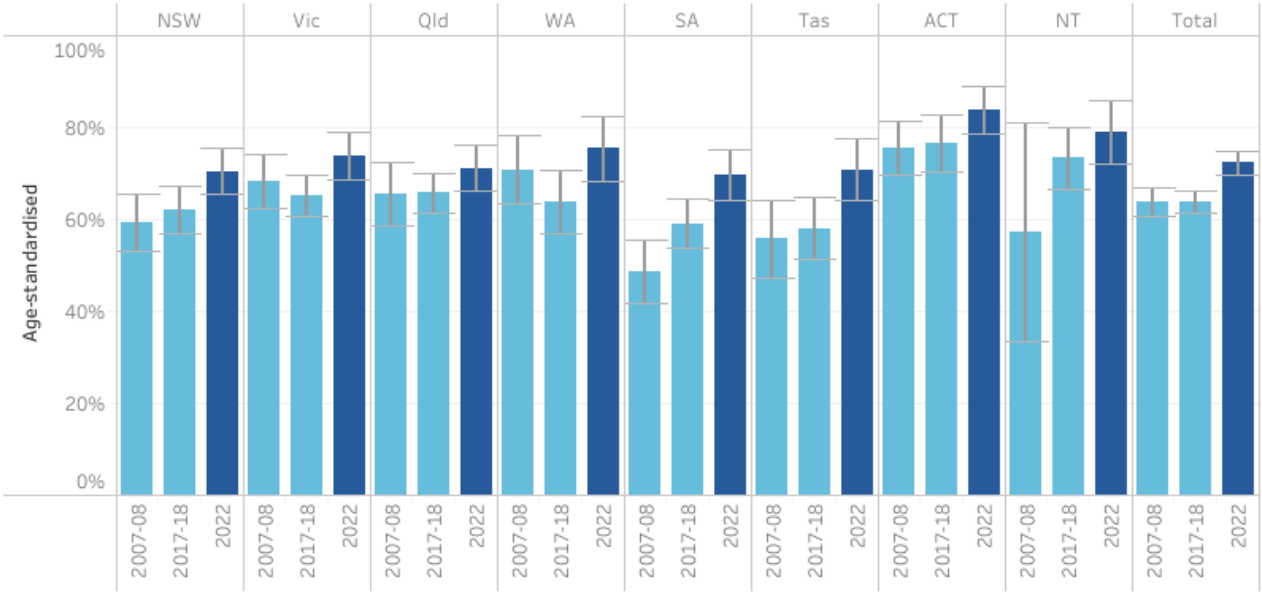
Information on the proportion of people aged 16–30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification can be found in table 13A.61.

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

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

Select year(s):
Multiple values

Figure 13.16 Measure 1: **People 16-64 years old, with a mental illness who are employed**
By jurisdiction, by year



Source: table 13A.62

> Nationally in 2020, the proportion of people aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the last week was 40.6% (table 13.6).

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

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

Table 13.6 Measure 2: **People who had face-to-face contact with family or friends living outside the household in the last week**
By jurisdiction, by year (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2020	%	41.9 ± 8.5	33.7 ± 10.3	34.0 ± 11.2	58.1 ± 13.6	39.7 ± 10.8	52.5 ± 8.8	49.4 ± 13.9	64.4 ± 18.4	40.6 ± 4.1
2019	%	np	np	np	np	np	np	np	np	64.0 ± 7.0
2014	%	75.4 ± 7.3	79.0 ± 5.3	72.5 ± 5.2	77.0 ± 6.6	81.7 ± 8.1	78.1 ± 5.2	76.3 ± 5.9	54.8 ± 11.5	76.5 ± 3.1

Source: table 13A.63
np Not published.

(a) Percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

18. Mental health outcomes of consumers of specialised public mental health services

'Mental health outcomes of consumers of specialised public mental health services' is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

'Mental health outcomes of consumers of specialised public mental health services' is defined as the proportion of people receiving care who had a significant improvement in their clinical mental health outcomes, by service type. The 'Explanatory material' tab provides information on how the consumer outcomes average score is derived.

Outcomes are calculated for the following consumer groups:

- Group A: Consumers separated from hospital. People who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of care commenced, and was completed, within the year.
- Group B: Consumers discharged from community-based ambulatory care. People who received relatively short-term community care from a state or territory mental health service during the reference year. The defining characteristic of the group is that the episode of care commenced, and was completed, within the year.

- Group C: Consumers in ongoing community-based ambulatory care. People receiving relatively long-term community care from a state or territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June).

A high or increasing proportion of people receiving care in state and territory governments' specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

Supplementary data is reported on the proportion of people receiving care who experienced no significant change or a significant deterioration in their mental health outcomes. Information on the proportion of episodes for which completed outcomes data is available is in table 13A.64.

This indicator has a number of issues:

- The outcome measurement tool is imprecise as a single 'average score' does not reflect the complex service system in which services are delivered across multiple settings and provided as both discrete, short-term episodes of care and prolonged care over indefinite periods (AHMC 2012).
- The approach separates a consumer's care into segments (hospital versus the community) rather than tracking his or her overall outcome across treatment settings.
- A consumer's outcomes are measured from a clinician's perspective rather than the consumer's.

> Nationally in 2022-23, 72.1% of people discharged from a hospital psychiatric inpatient unit, 48.5% of people discharged from community-based ambulatory care and 26.4% of people in ongoing community-based ambulatory care showed a significant improvement in their clinical mental health outcomes (figure 13.17).

Since 2019-20, young people aged 0–17 years who had been discharged from community-based ambulatory care or were in ongoing community-based ambulatory care had higher rates of significant improvement than other age groups, while people aged 65 years and older had the highest rate of significant improvement when discharged from hospital (table 13A.65).

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

Data is not complete for the current reporting period. Data for the Australian Capital Territory is not available for 2022-23.

Figure 13.17 **Mental health outcomes of consumers of specialised public mental health services**
By type of mental health care service, by jurisdiction, 2022-23 (a)

Select year:
2022-23

Significant deterioration
No significant change
Significant improvement

Group A: People discharged from hospital

Group B: People discharged from community-based ambulatory care

Group C: People in ongoing community-based ambulatory care

Source: table 13A.66

(a) Data is not published for jurisdictions with small numbers but is included in Australian totals. Refer to data table 13A.66 for information on non-publication of data for individual jurisdictions.

19. Stigma and discrimination experienced by people living with mental health problems or mental illness

'Stigma and discrimination experienced by people living with mental health problems or mental illness' is an indicator of governments' objective to reduce the impact of mental illness (including the effects of stigma and discrimination).

'Stigma and discrimination experienced by people with a mental health condition' is defined by two measures:

- the proportion of people with a mental health condition who have experienced discrimination or been treated unfairly
- the proportion of people with a mental health condition who have experienced discrimination or been treated unfairly because of their mental health condition.

A low or decreasing proportion of people experiencing discrimination or being treated unfairly is desirable.

> In 2020, 20.8% of people with a mental illness reported experiencing discrimination or being treated unfairly (table 13.7). Data is not available on whether the discrimination was perceived to be due to a person's mental illness.

(measure 1) Data is comparable (subject to caveats) across jurisdictions and over time.

(measure 1) Data is complete for the current reporting period. 2019 and 2020 data is only available at the national level.

Data is not yet available for Measure 2.

Table 13.7 Measure 1: **People with a mental health condition who have experienced discrimination or been treated unfairly**
By jurisdiction (a)

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2020	%	np	np	np	np	np	np	np	np	20.8 ± 3.9
2019	%	np	np	np	np	np	np	np	np	31.7 ± 7.0
2014	%	29.6 ± 6.5	24.9 ± 6.6	31.7 ± 6.5	36.2 ± 8.3	25.0 ± 5.7	23.7 ± 5.2	29.3 ± 6.8	31.0 ± 9.6	29.1 ± 3.2

Source: table 13A.67
np Not published.
(a) Percentages reported in these tables include 95% confidence intervals (for example, 80% ± 2.7 percentage points).

Indigenous data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section are available in the data tables listed below. Supporting information can be found in the Indicator results tab and data tables.

Further information on the historical and ongoing context for Aboriginal and Torres Strait Islander people is available on the Closing the Gap Information Repository website – Target 14

Mental health data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 13A.16	Age standardised proportion of people receiving clinical mental health services by service type and Indigenous status
Table 13A.21	Proportion of young people (aged < 25 years) who had contact with Medicare-subsidised primary mental health care services, by selected characteristics and telehealth status
Table 13A.33	Rate of community follow-up within first seven days of discharge from a psychiatric admission, by state and territory, by Indigenous status and remoteness
Table 13A.36	Readmissions to hospital within 28 days of discharge, by selected characteristics
Table 13A.51	Age-standardised rate of adults with high/ very high levels of psychological distress, by state and territory, by Indigenous status
Table 13A.58	Suicide deaths, by Indigenous status

Explanatory material

Key terms

Terms	Definition
Accrued mental health patient days	Mental health patient days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health patient days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, which is from 1 July to the following 30 June for the relevant period, even if the patient or resident was admitted prior to the reference period or discharged after the reference period. The number of accrued mental health patient days are calculated as follows: • for a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days • admission and discharge on the same day are equal to one patient day • leave days involving an overnight absence are not counted • a patient day is recorded on the day of return from leave.
Admitted care	A specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. Psychiatric hospitals and specialised mental health units in acute hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.
Acute services	Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short-term treatment. Acute services can: • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms • target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.

Terms	Definition
Affective disorders	Disorders characterised by prolonged and extreme changes in affect or mood, often referred to as mood disorders. Includes depressive episodes, dysthymia and bipolar disorders.
Allied health professionals	Trained professionals with university qualifications (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category includes physiotherapists, psychologists, social workers, occupational therapists, Aboriginal and Torres Strait Islander health practitioners, and other diagnostic and health professionals.
Ambulatory care	A specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include: • community-based crisis assessment and treatment teams; • day programs; • mental health outpatient clinics provided by either hospital or community-based services; • child and adolescent outpatient and community teams; • social and living skills programs; • psychogeriatric assessment services; • hospital-based consultation-liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings; • ambulatory-equivalent same day separations; • home based treatment services; and • hospital based outreach services.
Anxiety disorders	Disorders associated with feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.
Carer staff	A person specifically employed for the expertise developed from their experience as a mental health carer.
Child and adolescent services	These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

Terms	Definition
Comparability	Data is considered comparable if (subject to caveats) it can be used to inform an assessment of comparative performance. Typically, data is considered comparable when it is 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 is considered complete if all required data is available for all jurisdictions that provide the service.
Consumer staff	A person specifically employed for the expertise developed from their lived experience of mental illness.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill people whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, services that cannot be described as specialised child and adolescent services, youth services, services for older people or forensic services. General mental health services include hospital units with a principal function to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, postnatal depression, anxiety disorders).
General practice	The organisational structure with one or more general practitioners (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.

Terms	Definition
General Practitioners (GPs)	From June 2021, to be recognised as a specialist general practitioner for the purposes of Medicare, medical practitioners must either: hold specialist registration as a general practitioner with the Australian Health Practitioner Regulation Agency (AHPRA); or participate in an approved workforce or training program (commonly known as 3GA programs). To be registered as a specialist general practitioner by AHPRA, general practitioners must hold fellowship of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM). Medical practitioners who were on the vocational register on 16 June 2021 will maintain their access to general practice items in the Medicare Benefits Schedule.
Health management	The ongoing process beginning with initial consumer contact and including all actions relating to the consumer. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Mainstreaming	The First National Mental Health Plan emphasised decreasing the number of psychiatric beds in favour of community-based options, reducing the reliance on stand-alone psychiatric hospitals, and 'mainstreaming' the delivery of acute inpatient care into general hospitals.
Medical practitioner	Registered medical practitioners who are employed in medicine in Australia excluding those on extended leave. Medical practitioners must be registered with the Medical Board of Australia (MBA) and meet the MBA's registration standards.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.

Terms	Definition
National Standards for Mental Health Services (NSMHS)	Services at level 1 – services reviewed by an external accreditation agency and judged to have met all National Standards. Services at level 2 – services reviewed by an external accreditation agency and judged to have met some but not all National Standards. Services at level 3 – services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency. Services at level 4 – services that do not meet criteria detailed under levels 1 to 3 (AHMC 2010).
Non-acute services	Non-acute services are defined by two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to midterm. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations (NGOs)	Private not-for-profit community managed organisations that receive government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the NGO sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

Terms	Definition
Nurses	Registered and enrolled nurses who are employed in nursing in Australia, excluding those on extended leave. Registered nurses: people with at least a three-year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the State registration board to practise in this capacity. Mental health nurses have specified that their principal area of work is mental health.
Older people mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outcomes measurement – calculating the consumers 'score'.	The assessment of a consumer's clinical mental health outcomes is based on the changes reported in a consumer's 'score' on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Outcome scores are classified based on effect size – a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre and post scores to the standard deviation of the pre score. Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between 0.5 and -0.5; and 'significant deterioration' if the effect size index is less than or equal to -0.5 (AHMC 2012).
Outpatient services – community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services – hospital based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

Terms	Definition
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met: • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.
Psychiatrist	A qualified medical practitioner with 5 years of specialist training in psychiatry. Psychiatrists and consultant psychiatrists are medical officers registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with the Health Insurance Commission as a specialist in Psychiatry. Psychiatry registrars and trainees are medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.
Psychologists	People who are registered as psychologists with the relevant State or Territory registration board after completing a 4-year accredited sequence of study followed by an approved 2-year supervised practice program.

Terms	Definition
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 health care services.
Public (non-psychiatric) hospital	A hospital that provides free treatment, around the clock care and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients.
Residential care	Settings that provide specialised treatment, rehabilitation or care on an overnight basis in a domestic-like environment for people affected by a mental illness or psychiatric disability. Services can be community based or specialised. To be defined as community-based residences, services must employ onsite staff for at least some part of the day. Specialised services are staffed by mental health professionals on a 24-hour or non-24-hour basis.

Terms	Definition
Restraint	**Mechanical restraint** The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint. **Physical restraint** The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. **Chemical restraint** Medication given primarily to control a person's movements or behaviour, rather than to treat a mental illness or physical condition. Chemical restraint may involve the administration of higher than usual doses of a person's regular medication; or the administration of psychotropic medication (alone or in combination) to a person who does not have a diagnosed mental illness. Appropriate use of medications to reduce or manage symptoms of diagnosed anxiety, depression or psychosis is not chemical restraint. Some medications that are used to reduce symptoms of physical conditions or medically identified major mental illnesses have side effects. This may include sedating the person to whom they are given.
Seclusion	Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement (NMHPSC 2011b). The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition (AIHW 2015).
Seclusion event	An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions (NMHPSC 2011b).

Terms	Definition
Self-harm	Deliberately hurting oneself without conscious suicidal intent.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, acute to rehabilitation). Includes admitted patients who receive same day procedures.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Substance use disorders	Disorders that involve harmful use and/or dependence on alcohol and/or drugs to such an extent that social and occupational functioning is impaired and control becomes impossible. Reliance can be psychological (as in substance misuse) or physiological (as in substance dependence).
Youth mental health services	Services principally targeting children and young people generally aged 16-24 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

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