10A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 10.5. Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat. Unsourced information was obtained from the Australian, State and Territory governments.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

Attachment contents

Attachment contents

Table 10A.1 **Types of encounter, 2005-06**

	Number	*Rate* (a) *(n= 101 993)*	*95% LCL*	*95% UCL*	*Direct encounters (n=92 617)*	*Encounters paid by Medicare (n=89 011)*
	no.	no. per 100 encounters	no. per 100 encounters	no. per 100 encounters	%	%
General practitioners	1 017	..	..	..	..	..
Direct encounters	92 617	97.8	97.5	98.1	100.0	..
No charge	431	0.5	0.4	0.5	0.5	..
MBS items of service	89 011	94.0	93.4	94.6	96.1	100.0
Short surgery consultations	855	0.9	0.8	1.1	..	1.0
Standard surgery consultations	74 477	78.7	77.5	79.8	..	83.7
Long surgery consultations	8 739	9.2	8.6	9.9	..	9.8
Prolonged surgery consultations	588	0.6	0.5	0.7	..	0.7
Home visits	1 078	1.1	0.9	1.4	..	1.2
Hospital	171	0.2	0.1	0.3	..	0.2
Residential aged care facility	1 138	1.2	0.9	1.5	..	1.3
Health assessments	162	0.2	0.1	0.2	..	0.2
Chronic disease managemer	258	0.3	0.2	0.3	..	0.3
Case conferences	2	–	..	..	..	..
Incentive payments	139	0.1	0.1	0.2	..	0.2
Other items	1 405	1.5	1.3	1.7	..	1.6
Workers compensation	2 190	2.3	2.1	2.5	2.4	..
Other paid (hospital, state, etc.)	995	1.1	0.6	1.5	1.1	..
Indirect encounters (b)	2 066	2.2	1.9	2.5	..	..
Missing (c)	7 310	..	..	..	..	..
Total encounters	101 993	..	..	..	..	..

Table 10A.1 **Types of encounter, 2005-06**

	Number	*Rate* (a) *(n= 101 993)*	*95% LCL*	*95% UCL*	*Direct encounters (n=92 617)*	*Encounters paid by Medicare (n=89 011)*

UCL = upper confidence limit; LCL = lower confidence limit; MBS=Medicare Benefits Schedule.

(a) Missing data removed.

(b) Eleven encounters involving chronic disease management or case conference items were recorded, those items were included as missing data.

(c) If the 'Patient not seen' box was ticked, and MBS items other than chronic disease management items or case conference items were recorded, those items were included as missing data.

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

Source: Britt, H., Miller, G.C., Knox, S., Charles, J., Valenti, L., Pan, Y., Henderson, J., Bayram, C., O'Halloran, J. and Ng, A. 2007, *General Practice Activity in Australia 2005-06*, Cat. no. GEP 18, Australian Institute of Health and Welfare, Canberra.

Table 10A.2 **Australian Government real expenditure per person on GPs (2005-06 dollars) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02	204	195	200	172	208	194	153	106	196
2002-03	202	192	193	169	205	192	146	109	193
2003-04	205	190	195	169	206	189	140	110	194
2004-05	238	219	225	191	235	220	160	120	223
2005-06	254	236	240	202	255	235	175	128	239

(a) The data include expenditure on Medicare, the Practice Incentives Program (PIP), DVA, Divisions of General Practice and the General Practice Immunisation Incentives Scheme.

(b) DVA data include consultations by local medical officers (LMO), whether vocationally registered GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (as opposed to specialists) for procedural items. It is expected, however, that the amounts for LMO procedural services are small compared with payments for LMO consultations.

(c) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through accident and emergency departments and Aboriginal community controlled health services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.

Source: Department of Health and Ageing (DHA) (unpublished); table A.26.

Table 10A.3 Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
		no.	no.	no.	no.	no.	no.	no.	no.	no.
GP numbers										
2001-02	no.	7 991	5 887	4 713	2 353	2 023	653	406	281	24 307
2002-03	no.	7 888	5 878	4 760	2 365	1 983	653	407	326	24 260
2003-04	no.	7 910	5 881	4 823	2 348	1 974	655	395	337	24 323
2004-05	no.	7 975	5 954	4 964	2 353	2 004	656	413	350	24 669
2005-06	no.	8 062	6 065	5 107	2 435	2 042	669	425	341	25 146
FWE GPs										
2001-02	no.	5 898	4 144	3 212	1 443	1 351	382	212	93	16 736
2002-03	no.	5 959	4 144	3 181	1 458	1 354	376	203	97	16 772
2003-04	no.	6 021	4 110	3 260	1 451	1 360	374	198	98	16 872
2004-05	no.	6 222	4 167	3 389	1 457	1 364	378	200	95	17 273
2005-06	no.	6 310	4 283	3 489	1 473	1 404	386	208	97	17 649
FWE GPs per 100 000 people										
2001-02	FWE GPs per 100 000 people	88.9	85.3	86.6	74.9	89.1	80.8	66.1	46.2	85.2
2002-03	FWE GPs per 100 000 people	89.2	84.3	83.7	74.7	88.8	78.8	62.8	48.5	84.4
2003-04	FWE GPs per 100 000 people	89.5	82.6	84.0	73.1	88.8	77.5	61.0	48.6	83.9
2004-05	FWE GPs per 100 000 people	91.7	82.8	85.6	72.3	88.5	77.9	61.5	47.2	84.9
2005-06	FWE GPs per 100 000 people	92.4	84.3	86.3	72.0	90.5	79.1	63.3	46.8	85.8

(a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(b) GP and FWE numbers include GPs and other medical practitioners (OMPs).

(c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

Source: DHA (unpublished).

Table 10A.4 **Indigenous primary healthcare services for which service activity reporting (SAR) data is reported (number) (a), (b), (c)**

	NSW and ACT (d)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2000-01	27	16	24	21	8	5	23	124
2001-02	24	19	25	21	8	5	26	128
2002-03	26	21	26	21	8	5	27	134
2003-04	29	21	26	20	10	5	27	138
2004-05	28	22	26	20	13	5	27	141

(a) The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian government to facilitate access to primary health care (including health promotion, dental and counselling services).

(b) The number of services that provide SAR data has changed each year. This change is due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, a decision is sometimes made to include existing Australian government funded services which may previously have been excluded because of the type of service that they provided, or there may have been a change to their reporting arrangements: for example services involved in Co-ordinated Care Trials. Since 1997 some services have ceased to operate and therefore no longer contribute data to SAR. DHA can provide time series data on the services common to the survey from 1997 to 2002 on request.

(c) The number of Aboriginal and Torres Strait Islander primary health care services that responded to the SAR in 2001-02 was 130 out of 134. However, information from only 128 services out of the 130 respondents have been included in the data. Data for non-responding services was not estimated as these services may differ in important ways from the services that did respond.

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

Source: DHA (unpublished).

Table 10A.5 Services and episodes of healthcare by services for which service activity reporting (SAR) data is reported, by remoteness category (number) (a), (b), (c), (d), (e), (f)

	Highly accessible	*Accessible*	*Moderately accessible*	*Remote*	*Very remote*	*Total*
Services						
2000-01	34	28	11	12	39	124
2001-02	37	27	11	16	37	128
2002-03	38	29	13	17	37	134
2003-04	41	30	13	14	40	138
2004-05	41	34	13	15	38	141
Episodes of healthcare						
2000-01	437 000	301 000	62 000	174 000	369 000	1 343 000
2001-02	460 000	313 000	70 000	256 000	317 000	1 416 000
2002-03	507 000	338 000	91 000	270 000	294 000	1 500 000
2003-04	572 000	345 000	110 000	207 000	378 000	1 612 000
2004-05	554 000	399 000	85 000	213 000	335 000	1 586 000

(a) The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian Government to facilitate access to primary health care (including health promotion, dental and counselling services).

(b) The number of services that provide SAR data has changed each year. This change is due to new Australian Government funded primary health care services opening and existing services gaining Australian Government funding. In addition, a decision is sometimes made to include existing Australian Government funded services which may previously have been excluded because of the type of service that they provided, or there may have been a change to their reporting arrangements: for example services involved in Co-ordinated Care Trials. Since 1997 some services have ceased to operate and therefore no longer contribute data to SAR. OATSIH can provide time series data on the services common to the survey from 1997 to 2002 on request.

(c) The number of Aboriginal and Torres Strait Islander primary health care services that responded to the SAR in 2001-02 was 130 out of 134. However, information from only 128 services out of the 130 respondents have been included in the data. Data for non-responding services was not estimated as these services may differ in important ways from the services that did respond.

(d) An episode of health care involves contact between an individual client and a service by one or more staff, for the provision of health care. Group work is not included. Transport is only included if it involves provision of health care/information by staff. Outreach provision is provided, for example episodes at outstation visits, park clinics, satellite clinics. Episodes of health care delivered over the phone are included.

(e) Episodes of health care in the SAR report were often estimates and while these are thought to be reasonable, there has been no 'audit' to check the accuracy of these figures.

(f) Episodes data has been rounded to the nearest thousand.

Source: DHA (unpublished).

Table 10A.6 Proportion of services for which service activity reporting (SAR) data is reported that undertook selected health related activities, 2004-05 (per cent) (a), (b), (c)

Diagnosis and treatment of illness/disease	83
Management of chronic illness	79
Transportation to medical appointments	93
Outreach clinic services	70
24 hour emergency care	30
Monitoring child growth	72
School-based activities	74
Hearing screening	70
Pneumococcal immunisation	79
Influenza immunisation	81
Child immunisation	84
Women's health group	87
Support for public housing issues	67
Community development work	74
Legal/police/prison/advocacy services	68
Dental services	49
Involvement in steering groups on health	82
Participation in regional planning forums	63
Dialysis services	9

(a) The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian Government to facilitate access to primary health care (including health promotion, dental and counselling services).

(b) The number of services that provide SAR data has changed each year. This change is due to new Australian Government funded primary health care services opening and existing services gaining Australian Government funding. In addition, a decision is sometimes made to include existing Australian Government funded services which may previously have been excluded because of the type of service that they provided, or there may have been a change to their reporting arrangements: for example services involved in Co-ordinated Care Trials. Since 1997 some services have ceased to operate and therefore no longer contribute data to SAR. OATSIH can provide time series data on the services common to the survey from 1997 to 2002 on request.

(c) An episode of health care involves contact between an individual client and a service by one or more staff, for the provision of health care. Group work is not included. Transport is only included if it involves provision of health care/information by staff. Outreach provision is provided, for example episodes at outstation visits, park clinics, satellite clinics. Episodes of health care delivered over the phone are included.

Source: DHA (unpublished).

Table 10A.7 Full time equivalent health staff employed by services for which service activity reporting (SAR) data is reported, as at 30 June 2005 (number) (a), (b)

	Indigenous staff	*Non-Indigenous staff*	*Total staff*
Aboriginal health workers	646	19	665
Doctors	2	212	214
Nurses	41	250	291
Specialists	–	3	3
Emontional and Social Well Being staff (c)	121	71	192
Allied health professionals	1	26	27
Dentists	3	37	40
Dental assistants	43	20	63
Traditional healers	8	–	8
Substance misuse workers	65	28	93
Environmental health workers	29	4	33
Driver/field officers	136	20	156
Other health staff (d)	46	14	60
Total health staff	1 141	704	1 845

(a) The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some of their funding from the Australian Government to facilitate access to primary health care (including health promotion, dental and counselling services).

(b) The number of services that provide SAR data has changed each year. This change is due to new Australian Government funded primary health care services opening and existing services gaining Australian Government funding. In addition, a decision is sometimes made to include existing Australian Government funded services which may previously have been excluded because of the type of service that they provided, or there may have been a change to their reporting arrangements: for example services involved in Co-ordinated Care Trials. Since 1997 some services have ceased to operate and therefore no longer contribute data to SAR. OATSIH can provide time series data on the services common to the survey from 1997 to 2002 on request.

(c) Emotional and Social Well Being staff includes, counsellors, social workers, psychologists and other emotional and social well being staff.

(d) Other health staff includes: hearing coordinators, eye health, nutrition workers, sexual health workers, youth workers, hospital liaison, masseurs, maternal health workers, domestic violence support workers, family health workers.

– Nil or rounded to zero.

Source: DHA (unpublished).

Table 10A.8 **Alcohol and other drug treatment services, by sector, 2004-05 (number)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government	214	–	50	12	37	4	1	3	321
Non-government	73	136	37	28	9	8	8	15	314
Total	**287**	**136**	**87**	**40**	**46**	**12**	**9**	**18**	**635**

– Nil or rounded to zero.

Source: AIHW 2006, *Alcohol and Other Drug Treatment Services in Australia 2004-05: Report on the National Minimum Data Set,* Drug Treatment Series no. 5, Cat. no. HSE 43, Canberra.

Table 10A.9 **PBS services, 2005-06**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general (a)	no. '000	9 191	6 713	5 055	2 581	1 975	584	564	166	26 828
PBS concessional (b)	no. '000	48 497	35 903	26 365	12 000	12 315	4 245	1 350	422	141 098
PBS doctor's bag	no. '000	134	100	87	29	30	9	5	2	396
PBS total	no. '000	57 822	42 716	31 508	14 609	14 320	4 838	1 919	590	168 323
Proportion of concessional PBS services (b)	%	83.9	84.1	83.7	82.1	86.0	87.7	70.3	71.6	83.8

(a) Includes PBS general ordinary and safety net.

(b) Includes concessional ordinary and concessional free safety net.

Source: DHA (unpublished).

Table 10A.10 **Approved providers of PBS medicines, by urban and rural location, 2005-06 (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of pharmacies									
Urban	1 445	1 016	796	414	312	82	59	18	4 142
Rural	269	155	173	89	86	50	na	9	831
Number of people per pharmacy									
Urban	3 667	3 865	3 558	3 479	3 678	3 371	5 287	5 151	3 700
Rural	3 984	4 631	4 745	4 597	3 710	3 586	na	12 850	4 376
Number of approved medical practitioners									
Urban	2	–	–	–	–	–	–	–	2
Rural	24	3	18	20	7	6	na	1	79
Number of approved hospitals									
Urban	9	57	30	7	3	2	3	2	113
Rural	1	9	44	4	1	–	na	4	63

(a) Pharmacies measured using the Accessibility/Remoteness Index of Australia modified for Pharmacies (PHARIA). Urban = PHARIA 1. Rural = PHARIA 2-6.

na Not available. – Nil or rounded to zero.

Source: DHA (unpublished).

Table 10A.11 **PBS expenditure per person, by urban and rural location, (2005-06 dollars) (a), (b)**

	2001-02	*2002-03*	*2003-04*	*2004-05*	*2005-06*
Capital city	243.8	254.5	265.2	267.6	255.8
Other metro	272.7	283.6	298.0	297.3	287.2
Rural and remote	242.7	257.8	272.5	276.5	278.8
All locations	246.1	257.8	269.9	272.5	264.9

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

(b) Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in the DHA's annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements.

Source: DHA (unpublished).

Table 10A.12 **Availability of GPs by region (a), (b), (c), (d)**

	NSW & ACT (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
Number of GPs								
Urban								
2001-02	6 669	4 572	2 773	1 718	1 515	336	136	17 719
2002-03	6 513	4 531	2 804	1 720	1 477	335	141	17 521
2003-04	6 514	4 516	2 809	1 700	1 466	338	139	17 482
2004-05	6 559	4 573	2 932	1 711	1 478	328	141	17 722
2005-06	6 633	4 658	3 019	1 765	1 510	332	132	18 049
Rural								
2001-02	1 728	1 315	1 940	635	508	317	145	6 588
2002-03	1 782	1 347	1 956	645	506	318	185	6 739
2003-04	1 791	1 365	2 014	648	508	317	198	6 841
2004-05	1 829	1 381	2 032	642	526	328	209	6 947
2005-06	1 854	1 407	2 088	670	532	337	209	7 097
Number of full time workload equivalent GPs								
Urban								
2001-02	5 038	3 289	1 989	1 139	1 046	176	54	12 731
2002-03	5 051	3 269	1 941	1 140	1 032	171	51	12 654
2003-04	5 065	3 212	1 961	1 123	1 029	170	49	12 608
2004-05	5 227	3 242	2 026	1 121	1 027	166	47	12 856
2005-06	5 283	3 335	2 105	1 132	1 060	171	48	13 135
Rural								
2001-02	1 073	855	1 223	304	305	206	39	4 005
2002-03	1 111	875	1 240	319	322	205	46	4 118
2003-04	1 154	898	1 299	328	331	204	49	4 263
2004-05	1 195	925	1 363	336	337	212	49	4 416
2005-06	1 234	948	1 384	341	343	215	48	4 514
Number of full tme workload equivalent GPs per 100 000 people								
Urban								
2001-02	94.1	89.9	88.8	80.5	93.4	91.9	61.5	90.5
2002-03	93.6	88.3	84.3	79.4	91.6	88.2	58.4	88.9
2003-04	93.2	85.7	83.2	76.9	91.0	86.7	55.2	87.4
2004-05	95.2	85.4	84.0	75.7	90.1	83.7	53.6	88.0
2005-06	95.6	87.0	85.5	75.3	92.5	86.0	54.4	89.0
Rural								
2001-02	67.0	71.2	83.1	59.4	77.0	73.3	34.4	71.8
2002-03	69.1	72.2	82.7	61.6	80.9	72.4	40.8	73.1
2003-04	71.4	73.2	85.2	62.7	82.6	71.1	43.4	74.9
2004-05	73.6	74.8	88.1	63.0	83.9	73.9	42.4	76.9
2005-06	75.5	76.0	87.6	62.9	85.0	74.4	41.0	77.7

(a) Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas.

Table 10A.12 **Availability of GPs by region (a), (b), (c), (d)**

	NSW & ACT (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*

(b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(c) GP and FWE numbers include GPs and other medical practitioners (OMPs).

(d) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

(e) Data for NSW and the ACT have been combined for confidentiality reasons.

Source: DHA (unpublished).

Table 10A.13 **Female GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs										
2001-02	no.	2 766	2 036	1 651	842	674	237	181	123	8 510
2002-03	no.	2 782	2 079	1 682	843	679	250	184	152	8 651
2003-04	no.	2 829	2 091	1 768	853	680	252	181	151	8 805
2004-05	no.	2 876	2 191	1 834	865	689	264	194	166	9 079
2005-06	no.	2 978	2 262	1 915	898	723	264	205	156	9 401
Female FWEs GPs										
2001-02	no.	1 484	1 018	818	369	320	108	71	32	4 220
2002-03	no.	1 542	1 052	829	381	319	108	70	37	4 338
2003-04	no.	1 583	1 058	869	380	320	112	69	39	4 430
2004-05	no.	1 671	1 086	915	381	326	114	73	38	4 603
2005-06	no.	1 721	1 150	960	394	334	122	76	34	4 790
Female FWEs GPs as a proportion of all FWE GPs										
2001-02	%	25.2	24.6	25.5	25.6	23.7	28.2	33.5	34.4	25.2
2002-03	%	25.9	25.4	26.0	26.2	23.6	28.7	34.4	37.9	25.9
2003-04	%	26.3	25.7	26.7	26.2	23.5	30.0	34.9	40.2	26.3
2004-05	%	26.9	26.1	27.0	26.1	23.9	30.2	36.3	40.3	26.7
2005-06	%	27.3	26.8	27.5	26.8	23.8	31.5	36.6	34.8	27.1
Female FWE GPs per 100 000 females										
2001-02	per 100 000 females	44.5	41.3	44.0	38.4	41.7	44.9	43.7	33.8	42.7
2002-03	per 100 000 females	45.9	42.3	43.5	39.2	41.4	44.7	42.6	39.1	43.4
2003-04	per 100 000 females	46.8	42.0	44.7	38.4	41.3	45.8	42.1	41.5	43.8
2004-05	per 100 000 females	49.0	42.6	46.1	37.8	42.0	46.4	44.2	40.1	45.0
2005-06	per 100 000 females	50.1	44.7	47.5	38.7	42.7	49.2	45.9	34.4	46.3

Table 10A.13 **Female GPs (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(b) GP and FWE numbers include registered GPs and OMPs.

(c) GP numbers are based on doctors' major practice postcodes as at the last quarter of the reference period. The major practice postcode is the location at which a doctor rendered the most services. FWE numbers are based on doctors' practice location postcodes at which services were rendered within the reference period.

Source: DHA (unpublished).

Table 10A.14 **Availability of public dental practitioners per 100 000 people, 2003**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
Number of dentists per 100 000 population										
Major cties		6.7	8.1	10.3	8.4	17.5	..	7.7	..	8.7
Inner regional		2.8	5.0	9.6	4.7	4.9	5.8	–	..	5.4
Outer regional		1.2	2.7	8.7	4.2	5.3	2.5	..	13.0	5.2
Remote and very remote		–	–	6.0	1.8	7.9	–	..	3.9	3.9
Total		5.5	7.1	9.7	7.0	14.1	4.5	7.6	8.8	7.5
Number of dental therapists per 100 000 population										
Major cties		2.0	2.4	8.1	9.7	8.0	..	6.5	..	4.5
Inner regional		5.3	3.9	10.7	12.6	7.6	9.8	–	..	7.1
Outer regional		3.6	1.9	7.9	9.1	10.2	15.4	..	11.4	7.2
Remote and very remote		–	–	8.2	5.0	5.7	–	..	3.9	4.4
Total		2.8	2.7	8.8	9.7	8.1	11.5	6.5	8.0	5.3

(a) There was no collection in the NT in 2003, data for the NT is based on data from the NT 2002 collection.

Source: AIHW (unpublished).

Table 10A.15 **Non-referred attendances that were bulk billed, by region (per cent) (a)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Unknown*	*Aust*
1999-2000	85.2	78.6	60.8	61.7	58.6	59.0	70.1	69.3	79.1
2000-01	83.8	76.2	59.8	60.9	57.7	60.0	69.5	69.4	77.6
2001-02	80.8	72.3	59.0	59.3	56.6	58.9	70.0	61.1	74.9
2002-03	75.0	67.5	53.4	54.1	53.2	57.9	70.5	58.8	69.5
2003-04 (b)	73.0	67.2	54.7	56.6	55.7	60.5	72.0	58.7	68.5
2004-05 (b)	76.4	71.4	65.1	67.6	67.8	65.9	77.0	43.0	73.8
2005-06 (b)	78.3	74.4	68.9	71.5	71.4	67.5	78.4	65.7	76.2

(a) Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Includes non-referred attendances undertaken by general practice nurses.

Source: DHA (unpublished).

Table 10A.16 **Non-referred attendances that were bulk billed (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1995-96	83.7	79.1	80.6	79.5	74.3	66.2	64.9	70.1	80.1
1996-97	83.6	79.9	81.3	80.2	74.9	66.8	65.9	69.6	80.6
1997-98	82.9	79.1	81.1	78.4	74.1	65.1	66.1	67.9	79.8
1998-99	82.4	78.9	80.9	77.6	74.1	63.0	65.6	65.2	79.4
1999-00	82.4	78.6	80.3	76.7	74.2	61.6	63.0	65.4	79.1
2000-2001	81.2	76.7	78.9	75.1	73.2	60.5	59.3	65.5	77.6
2001-02	79.8	73.4	75.3	71.9	69.6	58.5	51.2	63.9	74.9
2002-03	77.2	67.5	65.5	66.6	62.4	54.9	39.2	62.2	69.5
2003-04 (a)	76.7	65.7	64.7	65.0	63.3	52.7	36.8	61.5	68.5
2004-05 (a)	80.1	70.9	71.4	69.9	71.9	66.4	40.6	62.8	73.8
2005-06 (a)	81.9	73.8	74.1	71.8	74.9	69.6	44.2	63.0	76.2

(a) Includes attendances by practice nurses.

Source:

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/C82233E254E0433DCA25705B00

Table 10A.17 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and dispensed to patients (per 1000 people with Pharmaceutical Benefits Scheme [PBS] concession cards) (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02										
Scripts	no.	2 498 017	1 886 896	1 397 193	565 180	604 262	190 942	72 757	24 170	7 239 417
Concession card holders	no.	1 618 480	1 258 967	974 916	466 127	443 707	153 617	53 030	43 865	5 039 363
Rate	per 1000 holders	1 543.4	1 498.8	1 433.1	1 212.5	1 361.8	1 243.0	1 372.0	551.0	1 436.6
2002-03										
Scripts	no.	2 281 939	1 719 444	1 301 195	528 137	518 040	167 083	66 082	22 049	6 603 969
Concession card holders	no.	1 622 475	1 257 778	968 136	463 728	442 449	154 838	53 114	43 301	5 031 633
Rate	per 1000 holders	1 406.5	1 367.0	1 344.0	1 138.9	1 170.8	1 079.1	1 244.2	509.2	1 312.5
2003-04										
Scripts	no.	2 339 379	1 748 225	1 297 581	533 513	513 080	167 226	65 968	21 413	6 686 385
Concession card holders	no.	1 623 022	1 262 959	965 017	456 322	438 967	155 013	51 512	44 033	5 014 400
Rate	per 1000 holders	1 441.4	1 384.2	1 344.6	1 169.2	1 168.8	1 078.8	1 280.6	486.3	1 333.4
2004-05										
Scripts	no.	2 326 004	1 755 455	1 348 240	523 706	512 769	162 848	63 916	22 136	6 715 074
Concession card holders	no.	1 606 563	1 252 515	945 992	444 818	430 703	149 320	50 530	45 317	4 937 298
Rate	per 1000 holders	1 447.8	1 401.5	1 425.2	1 177.3	1 190.5	1 090.6	1 264.9	488.5	1 360.1

Table 10A.17 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and dispensed to patients (per 1000 people with Pharmaceutical Benefits Scheme [PBS] concession cards) (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06										
Scripts	no.	2 283 357	1 784 315	1 320 604	528 534	530 665	167 685	64 561	21 909	6 701 630
Concession card holders	no.	1 608 699	1 257 335	934 262	432 120	428 740	148 220	49 397	46 716	4 916 273
Rate	per 1000 holders	1 419.4	1 419.1	1 413.5	1 223.1	1 237.7	1 131.3	1 307.0	469.0	1 363.2

(a) The oral antibiotics used most commonly in treating upper respiratory tract infection are: phenoxymethylpenicillin (penicillin V); amoxycillin; erythromycin; roxithromycin; cefaclor; amoxycillin+clavulanic acid; doxycycline; clarithromycin; and cefuroxime. All active PBS item codes associated with each of these generic names were pulled out for each year. GPs have tended to prescribe 90–98 per cent of each of these generic pharmaceuticals throughout this period with only minor additional variations by jurisdiction. Consequently, the 'all prescriptions' approach among concessional patients has been chosen for data presentation purposes. Any noticeable changes in trend will predominantly pick up changes in GP behaviour.

(b) Numbers of concession card holders were obtained from the Department of Family and Community Services.

Source: DHA (unpublished).

Table 10A.18 **Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2005-06 dollars) and number of tests (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02										
Benefits paid										
Benefits paid	$m	366.9	242.6	229.7	101.1	81.3	23.8	15.9	8.0	1 069.2
Per person	$	55.3	49.9	61.9	52.5	53.6	50.3	49.4	39.8	54.4
Tests										
Number of tests	'000	18 773	12 559	10 959	4 978	4 091	1 275	766	383	53 784
Tests per person	no.	2.8	2.6	3.0	2.6	2.7	2.7	2.4	1.9	2.7
2002-03										
Benefits paid										
Benefits paid	$m	364.7	246.8	228.0	104.8	78.9	23.5	16.2	8.3	1 071.2
Per person	$	54.6	50.2	60.0	53.7	51.7	49.3	50.2	41.4	53.9
Tests										
Number of tests	'000	19 068	13 115	11 134	5 249	4 064	1 293	797	409	55 128
Tests per person	no.	2.9	2.7	2.9	2.7	2.7	2.7	2.5	2.0	2.8
2003-04										
Benefits paid										
Benefits paid	$m	381.2	257.8	245.1	106.2	79.8	24.0	16.7	8.3	1 119.0
Per person	$	56.6	51.8	63.1	53.5	52.1	49.8	51.5	40.9	55.6
Tests										
Number of tests	'000	20 017	13 726	12 010	5 352	4 159	1 346	824	412	57 846
Tests per person	no.	3.0	2.8	3.1	2.7	2.7	2.8	2.5	2.0	2.9
2004-05										
Benefits paid										
Benefits paid	$m	394.6	266.8	252.1	108.6	83.0	24.2	17.6	9.0	1 155.7
Per person	$	58.2	53.1	63.6	54.0	53.8	49.9	54.0	44.2	56.9
Tests										
Number of tests	'000	20 963	14 395	12 534	5 565	4 395	1 363	875	457	60 548
Tests per person	no.	3.1	2.9	3.2	2.8	2.9	2.8	2.7	2.3	3.0
2005-06										
Benefits paid										
Benefits paid	$m	398.0	270.3	273.8	109.9	82.7	25.1	17.9	10.3	1 188.1
Per person	$	58.3	53.2	67.7	53.8	53.4	51.4	54.7	49.7	57.7
Tests										
Number of tests	'000	21 766	15 059	14 154	5 819	4 524	1 446	921	536	64 225
Tests per person	no.	3.2	3.0	3.5	2.8	2.9	3.0	2.8	2.6	3.1

(a) DVA data are included for number of tests and benefits paid on pathology items.

(b) Standard DVA reports do not distinguish between the various providers who request pathology services and do not record numbers of tests but rather paid for items.

(c) In general, Medicare benefits are payable for a maximum of three tests performed on a specimen.

Table 10A.18 **Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2005-06 dollars) and number of tests (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(d) Includes tests ordered at the request of a patient (patient episode initiated items).

Source: DHA (unpublished); table A.26.

Table 10A.19 **Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2005-06 dollars) and number of referrals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02										
Benefits paid										
Benefits paid	$m	335.5	203.2	164.6	80.5	54.8	20.5	13.6	3.7	876.4
Per person	$	50.6	41.8	44.3	41.8	36.1	43.4	42.4	18.5	44.6
Referrals										
Number of referrals	'000	3 276	2 042	1 674	833	576	200	124	43	8 768
Referrals per person	no.	0.49	0.42	0.45	0.43	0.38	0.42	0.39	0.21	0.45
2002-03										
Benefits paid										
Benefits paid	$m	333.5	204.1	162.8	82.6	55.5	20.4	13.3	3.7	876.0
Per person	$	49.9	41.5	42.8	42.3	36.4	42.8	41.3	18.4	44.1
Referrals										
Number of referrals	'000	3 345	2 087	1 688	863	596	206	124	43	8 952
Referrals per person	no.	0.50	0.42	0.44	0.44	0.39	0.43	0.38	0.22	0.45
2003-04										
Benefits paid										
Benefits paid	$m	328.1	204.1	165.0	81.8	55.1	19.8	12.8	3.6	870.3
Per person	$	48.8	41.0	42.5	41.2	36.0	41.0	39.7	17.8	43.3
Referrals										
Number of referrals	'000	3 322	2 113	1 723	859	601	201	122	42	8 982
Referrals per person	no.	0.49	0.42	0.44	0.43	0.39	0.42	0.38	0.21	0.45
2004-05										
Benefits paid										
Benefits paid	$m	352.2	218.6	181.5	84.3	60.7	19.9	13.4	3.6	934.3
Per person	$	52.0	43.5	45.8	41.9	39.4	41.0	41.2	17.9	46.0
Referrals										
Number of referrals	'000	3 459	2 186	1 824	855	639	199	120	40	9 322
Referrals per person	no.	0.51	0.44	0.46	0.43	0.41	0.41	0.37	0.20	0.46
2005-06										
Benefits paid										
Benefits paid	$m	358.8	225.3	189.6	87.3	63.6	19.8	13.5	3.9	961.7
Per person	$	52.5	44.3	46.9	42.7	41.0	40.5	41.0	18.9	46.7
Referrals										
Number of referrals	'000	3 578	2 291	1 945	904	679	202	123	44	9 766
Referrals per person	no.	0.52	0.45	0.48	0.44	0.44	0.41	0.37	0.21	0.47

Table 10A.19 **Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2005-06 dollars) and number of referrals (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(a) DVA data are included for number of referrals and benefits paid on diagnostic imaging items.

(b) Standard DVA reports do not distinguish between the various providers diagnostic imaging services and do not record numbers of tests but rather items paid for. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

Source: DHA (unpublished); table A.26.

Table 10A.20 Practices under the Practice Incentives Program (PIP) using computers for clinical purposes (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2002)	no.	1 544	1 111	848	374	372	128	78	27	4 482
Standardised whole patient equivalents (b)	no.	3 910 962	3 412 079	2 464 353	1 233 265	1 121 125	349 286	213 975	55 340	12 760 385
Electronic prescribing		1 331	999	753	320	338	121	73	17	3 952
Share of PIP practices	%	86	90	89	86	91	95	94	63	88
Use computers to send and/or receive clinical data	no.	1 341	993	753	319	342	112	70	20	3 950
Share of PIP practices	%	87	89	89	85	92	88	90	74	88
PIP practices (May 2003)	no.	1 584	1 131	874	385	384	129	77	29	4 593
SWPE (b)	no.	4 088 517	3 519 460	2 520 737	1 262 412	1 160 513	360 653	213 722	57 178	13 183 192
Electronic prescribing	no.	1 408	1 037	800	344	352	123	74	20	4 158
Share of PIP practices	%	88.9	91.7	91.5	89.4	91.7	95.3	96.1	69.0	90.5
Use computers to send and/or receive clinical data	no.	1 405	1 019	791	347	350	117	70	22	4 121
Share of PIP practices	%	88.7	90.1	90.5	90.1	91.1	90.7	90.9	75.9	89.7
PIP practices (May 2004)	no.	1 626	1 142	885	386	376	130	72	29	4 646
SWPE (b)	no.	4 293 285	3 523 007	2 570 220	1 280 392	1 165 225	364 524	197 215	60 337	13 454 205
Electronic prescribing	no.	1 476	1 061	821	352	348	122	71	21	4 272
Share of PIP practices	%	91.0	93.0	93.0	91.0	93.0	94.0	99.0	72.0	92.0
Use computers to send and/or receive clinical data	no.	1 458	1 048	815	354	343	116	68	24	4 226
Share of PIP practices	%	90.0	92.0	92.0	92.0	91.0	89.0	94.0	83.0	91.0

Table 10A.20 Practices under the Practice Incentives Program (PIP) using computers for clinical purposes (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2005)	no.	1 643	1 159	900	379	372	129	72	27	4 681
SWPE (b)	no.	4 341 865	3 541 197	2 579 927	1 273 454	1 160 497	360 017	200 382	56 691	13 514 030
Electronic prescribing	no.	1 502	1 092	852	356	349	123	71	20	4 364
Share of PIP practices	%	91.4	94.2	94.7	93.9	93.8	95.3	98.6	74.0	93.2
Use computers to send and/or receive clinical data	no.	1 488	1 073	841	354	345	117	67	22	4 307
Share of PIP practices	%	90.6	92.7	93.4	93.4	92.7	90.7	93.1	81.5	92.0
PIP practices (May 2006)	no.	1 679	1 163	917	388	362	129	73	34	4 745
SWPE (b)	no.	4 453 192	3 641 533	2 670 235	1 312 886	1 180 202	374 440	211 293	67 116	13 910 897
Electronic prescribing	no.	1 556	1 109	880	370	342	124	73	26	4 480
Share of PIP practices	%	92.7	95.4	96.0	95.4	94.5	96.1	100.0	76.5	94.4
Use computers to send and/or receive clinical data	no.	1 537	1 084	872	367	342	119	68	28	4 417
Share of PIP practices	%	91.5	93.2	95.1	94.6	94.5	92.2	93.2	82.4	93.1

(a) Not all practices are involved in PIP, and the proportion may vary across jurisdictions.

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

Source: DHA (unpublished).

Table 10A.21 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

	Unit	*Capital city*	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural*	*Remote centre*	*Other remote*	*Aust*
PIP practices (May 2006)	no.	2 967	360	300	297	668	57	96	4 745
SWPE (c)	no.	8 684 498	1 142 074	994 227	1 116 931	1 735 696	121 274	116 197	13 910 897
Electronic prescribing									
Share of PIP practices (May 2002)	%	86.6	88.5	92.6	93.1	92.3	83.7	83.1	88.2
Share of PIP practices (May 2003)	%	89.1	90.1	94.6	96.2	93.8	84.3	87.1	90.5
Share of PIP practices (May 2004)	%	91.0	92.0	95.0	97.0	95.0	89.0	89.0	92.0
Share of PIP practices (May 2005)	%	92.0	93.0	97.0	97.0	95.0	87.0	93.0	93.2
Share of PIP practices (May 2006)	%	94.0	95.0	97.0	97.0	96.0	88.0	92.0	94.4
Use of computers to send and/or receive clinical data									
Share of PIP practices (May 2002)	%	87.3	86.2	91.9	93.1	90.8	85.7	77.9	88.1
Share of PIP practices (May 2003)	%	89.1	88.5	92.3	94.4	91.4	88.2	80.0	89.7
Share of PIP practices (May 2004)	%	90.0	90.0	94.0	94.0	92.0	89.0	84.0	91.0
Share of PIP practices (May 2005)	%	92.0	91.0	96.0	95.0	93.0	89.0	85.0	92.0
Share of PIP practices (May 2006)	%	93.0	93.0	96.0	95.0	94.0	89.0	89.0	93.1

(a) Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) Not all practices are involved in PIP, and the proportion may vary across jurisdictions.

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

Source: DHA (unpublished).

Table 10A.22 **Proportion of full time workload equivalent (FWE) GPs with vocational recognition, by region (per cent) (a), (b), (c)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
2001-02	92.1	93.9	90.4	88.4	84.0	77.6	62.6	90.7
2002-03	93.0	93.9	90.0	86.1	82.6	76.1	64.9	91.0
2003-04	93.7	93.0	90.0	86.7	83.8	71.2	68.3	91.4
2004-05	93.4	91.7	89.7	85.3	83.4	71.4	67.2	91.0
2005-06	93.1	90.3	90.7	84.2	83.1	68.2	72.9	90.6

(a) Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

(b) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(c) FWE numbers were based on doctors' practice location postcodes at which services were rendered within the reference period. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

Source: DHA (unpublished).

Table 10A.23 **Number and proportion of full time workload equivalent (FWE) GPs with vocational recognition (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
FWE GPs with vocational recognition										
2001-02	no.	5 452	3 682	2 866	1 319	1 244	338	203	80	15 184
2002-03	no.	5 532	3 719	2 815	1 336	1 244	337	193	80	15 257
2003-04	no.	5 595	3 738	2 882	1 338	1 261	344	189	81	15 428
2004-05	no.	5 774	3 789	2 933	1 335	1 262	348	191	81	15 714
2005-06	no.	5 858	3 870	3 004	1 346	1 289	353	199	79	15 997
Proportion of FWE GPs with vocational recognition										
2001-02	%	92.4	88.8	89.2	91.4	92.1	88.5	95.9	86.3	90.7
2002-03	%	92.8	89.8	88.5	91.6	91.9	89.6	95.4	82.8	91.0
2003-04	%	92.9	91.0	88.4	92.2	92.7	92.2	95.5	82.7	91.4
2004-05	%	92.8	90.9	86.6	91.7	92.6	92.1	95.5	84.4	91.0
2005-06	%	92.8	90.4	86.1	91.4	91.8	91.4	95.9	81.8	90.6

(a) FWEs are calculated for each practitioner by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that reference period. For example, a FWE value of 2 indicates that the practitioner's total billing is twice that of the mean billing of a full time practitioner.

(b) FWE numbers were based on doctors' practice location postcodes at which services were rendered within the reference period.

Source: DHA (unpublished).

Table 10A.24 General practices accredited by Australian General Practice Accreditation Limited

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
June 2005										
Registered for accreditation (a)										
	no.	1 575	1 099	925	384	401	137	57	42	4 620
Accredited										
	no.	1 451	1 027	833	347	383	133	54	32	4 260
	%	65.0	74.0	74.0	76.0	76.0	73.0	79.0	78.0	72.0
June 2006										
Registered for accreditation (a)										
	no.	1 594	1 072	918	371	399	135	56	46	4 591
Accredited										
	no.	1 446	1 020	840	338	379	133	52	34	4 242
	%	69.0	85.0	88.0	70.0	82.0	89.0	65.0	68.0	78.0

(a) Includes practices that are registered for accreditation but are not yet accredited and practices that are accredited.

Source: AGPAL (unpublished).

Table 10A.25 GP use of chronic disease management Medicare items for care planning and case conferencing (a)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04										
GPs using EPC items (b)	no.	2 557	1 806	1 262	620	553	197	82	32	7 109
Total GPs (c)	no.	5 846	4 343	3 281	1 622	1 461	468	253	117	17 391
GPs using EPC items	%	43.7	41.6	38.5	38.2	37.9	42.1	32.4	27.4	40.9
2004-05										
GPs using EPC items (b)	no.	4 261	2 928	2 142	1 061	872	288	134	52	11 738
Total GPs (c)	no.	5 946	4 387	3 403	1 644	1 478	472	255	107	17 692
GPs using EPC items	%	71.7	66.7	62.9	64.5	59.0	61.0	52.5	48.6	66.3
2005-06										
GPs using EPC items (b)	no.	5 209	3 811	2 805	1 355	1 173	365	185	76	14 979
Total GPs (c)	no.	6 056	4 509	3 521	1 669	1 514	476	268	110	18 123
GPs using EPC items	%	86.0	84.5	79.7	81.2	77.5	76.7	69.0	69.1	82.7

(a) The chronic disease management items include GP only care plans, multidisciplinary care plans (A15 subgroup 1) and case conferences (A15 subgroup 2, excluding items relating to consultant physician and psychiatrists). It does not include services that qualify under the DVA National Treatment Account or services provided in public hospitals.

(b) The increase in the number of general practitioners using chronic disease management MBS items for care planning and/or case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare allied health and dental care initiative on 1 July 2004. This initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex care needs who are being managed under an EPC team-based care plan. The increase in the number of general practitioners using chronic disease management MBS items for care planning and/or case conferencing in 2005-06 appears to be linked to the introduction of six new chronic disease management MBS items in July 2005. These items enable GPs to provide GP only care planning services to patients, in addition to team-based care planning.

(c) GPs are defined as those General Practitioners and Other Medical Practitioners who have claimed at least 1500 non-referred attendances in the relevant financial year. GPs are counted only in the state/territory where they claimed the most services - this prevents double counting.

Source: DHA (unpublished).

Table 10A.26 **Annual voluntary health assessments for older people (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04										
Older people assessed	no.	71 748	50 654	36 142	12 722	20 170	5 363	1 544	234	198 577
Older people	no.	400 419	287 538	199 193	97 759	104 187	29 850	12 524	6 288	1 137 812
Proportion assessed	%	17.9	17.6	18.1	13.0	19.4	18.0	12.3	3.7	17.5
2004-05										
Older people assessed	no.	81 442	53 349	40 165	13 778	21 553	5 859	1 431	354	217 931
Older people	no.	410 394	295 306	205 170	101 029	106 348	30 524	12 936	6 506	1 168 271
Proportion assessed	%	19.8	18.1	19.6	13.6	20.3	19.2	11.1	5.4	18.7
2005-06										
Older people assessed	no.	89 784	58 841	48 020	15 824	22 393	6 689	1 825	461	243 837
Older people	no.	421 961	303 532	212 939	104 851	107 957	31 263	13 401	6 892	1 202 857
Proportion assessed	%	21.3	19.4	22.6	15.1	20.7	21.4	13.6	6.7	20.3

(a) Older people are defined as non-Indigenous people aged 75 years and over and Indigenous people aged 55 years and over, excluding people living in residential aged care facilities.

(b) Excludes services that qualify under the DVA National Treatment Account and services provided in public hospitals.

Source: DHA (unpublished).

Table 10A.27 **Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2006 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Valid vaccinations provided											
Divisions of General Practice	no.	20	138	3	11	269	–	–	13	–	454
GPs	no.	11 022 166	5 280 076	6 461 943	2 418 968	1 911 036	786 587	256 066	20 073	–	28 156 915
Council	no.	806 774	4 686 605	576 629	269 405	488 140	121 320	–	–	–	6 948 873
State or territory health department	no.	3	–	679	219 610	2 183	717	164 337	2 090	–	389 619
Flying doctor service	no.	3 312	–	25 609	8	3 633	–	–	–	–	32 562
Public hospital	no.	298 899	40 584	238 173	204 959	90 436	1 535	5 807	47 625	3 186	931 204
Private hospital	no.	14 523	84	1 512	70	–	105	25	5 919	–	22 238
Aboriginal health service	no.	62 989	11 733	56 905	22 648	11 839	–	1 455	56 393	–	223 962
Aboriginal health worker	no.	4 427	–	37 127	–	1 593	–	–	1 483	–	44 630
Community health centre	no.	967 297	85 091	428 169	672 487	273 634	5 786	243 244	502 111	1 701	3 179 520
Community nurse	no.	–	282	–	–	–	–	72	–	–	354
Total	**no.**	**13 180 410**	**10 104 593**	**7 826 749**	**3 808 166**	**2 782 763**	**916 050**	**671 006**	**635 707**	**4 887**	**39 930 331**
Proportion of total valid vaccinations											
Divisions of General Practice	%	–	–	–	–	–	–	–	–	–	–
GPs	%	83.6	52.3	82.6	63.5	68.7	85.9	38.2	3.2	–	70.5
Council	%	6.1	46.4	7.4	7.1	17.5	13.2	–	–	–	17.4
State or territory health department	%	–	–	–	5.8	0.1	0.1	24.5	0.3	–	1.0
Flying doctor service	%	–	–	0.3	–	0.1	–	–	–	–	0.1
Public hospital	%	2.3	0.4	3.0	5.4	3.3	0.2	0.9	7.5	65.2	2.3
Private hospital	%	0.1	–	–	–	–	–	–	0.9	–	0.1
Aboriginal health service	%	0.5	0.1	0.7	0.6	0.4	–	0.2	8.9	–	0.6
Aboriginal health worker	%	–	–	0.5	–	0.1	–	–	0.2	–	0.1

Table 10A.27 **Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2006 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Unknown*	*Aust*
Community health centre	%	7.3	0.8	5.5	17.7	9.8	0.6	36.3	79.0	34.8	8.0
Community nurse	%	–	–	–	–	–	–	–	–	–	–
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) 1 January 1996 to 30 June 2006.

(b) Totals may not add as a result of rounding.

(c) Data reported by the State or Territory in which the immunisation provider is located.

– Nil or rounded to zero.

Source: DHA (unpublished).

Table 10A.28 Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fully immunised (e)									
30 June 2002	89.9	90.7	90.6	88.5	90.9	91.7	89.8	88.6	90.2
30 June 2003	91.0	91.8	91.1	89.9	91.5	91.9	91.5	91.6	91.2
30 June 2004	91.0	91.7	91.6	89.3	91.4	93.4	90.8	85.2	90.9
30 June 2005	90.6	91.8	90.8	90.0	91.1	91.2	95.7	91.9	91.0
30 June 2006	90.1	91.8	90.8	89.1	91.0	93.8	90.7	90.6	90.7
Immunised against (at 30 June 2006)									
Diphtheria, tetanus and pertussis	91.8	93.4	92.1	90.6	92.2	95.6	91.4	91.4	92.2
Polio	91.7	93.3	92.0	90.5	91.9	95.4	91.4	91.1	92.1
Haemophilus influenzae type b	93.6	94.9	94.2	93.7	94.8	96.1	93.7	94.9	94.2

(a) Coverage measured at 30 June for children turning 12 months of age by 31 March, by the State or Territory in which the child was located.

(b) The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

(d) NT immunisation records differ from ACIR records. This may stem from delays in notifications reaching and being processed by the Health Insurance Commission (HIC), or because the cohort method of reporting immunisation coverage does not allow for assessment of 'catch up' immunisation occurring after the assessment age of 12 months. Average delay times were greatest in the NT (Hull and McIntyre 2000).

(e) Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, hepatitis b and *Haemophilus influenzae* type b.

Source: DHA (unpublished).

Table 10A.29 Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c), (d)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fully immunised (e)									
30 June 2002	88.0	88.3	88.5	85.0	89.8	91.8	88.6	87.2	88.1
30 June 2003	88.4	90.5	89.8	87.0	90.4	93.6	86.9	89.0	89.3
30 June 2004	90.4	92.3	91.8	90.6	92.7	94.9	90.0	94.5	91.7
30 June 2005	91.2	92.9	91.6	90.0	92.1	94.6	91.6	93.6	91.8
30 June 2006	91.7	93.5	92.2	91.3	92.2	93.6	94.2	94.4	92.4
Immunised against (at 30 June 2006)									
Diphtheria, tetanus and pertussis	95.0	96.0	94.9	94.4	94.7	96.3	96.8	97.3	95.2
Polio	94.9	95.9	94.9	94.4	94.8	96.4	96.8	97.3	95.2
Haemophilus influenzae type b	93.3	94.6	93.9	92.7	93.6	95.3	95.2	95.0	93.8
Measles, mumps and rubella	93.4	95.0	93.8	93.1	94.1	95.0	95.4	95.7	94.0

(a) Coverage measured at 30 June for children turning 24 months of age by 31 March, by the State or Territory in which the child was located.

(b) The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000).

(c) There may be some under-reporting by providers. Therefore, vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

(d) NT immunisation records differ from ACIR records. This may stem from delays in notifications reaching and being processed by the HIC, or because the cohort method of reporting immunisation coverage does not allow for assessment of 'catch up' immunisation occurring after the assessment age of 12 months. Average delay times were greatest in the NT (Hull and McIntyre 2000).

(e) Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B and measles, mumps and rubella.

Source : DHA (unpublished).

Table 10A.30 Notifications of measles, children aged 0–14 years (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
1994	no.	1 154	129	1 282	92	53	30	89	259	3 088
1995	no.	442	103	158	31	2	34	39	66	875
1996	no.	161	69	47	23	8	18	9	17	352
1997	no.	196	74	160	69	20	35	19	4	577
1998	no.	104	27	27	43	3	35	6	–	245
1999	no.	22	33	21	10	2	10	4	19	121
2000	no.	21	7	11	3	3	1	–	–	46
2001	no.	15	17	5	1	1	2	–	–	41
2002	no.	4	1	5	–	–	–	–	–	10
2003	no.	7	10	4	–	5	–	–	1	27
2004	no.	3	1	–	2	1	–	–	–	7
2005	no.	1	–	1	–	–	–	–	–	2
2006 (c)	no.	35	3	1	16	3	7	–	–	65
Notifications per 100 000 children (0–14 years)										
1994	per 100 000 children	89.1	13.7	180.5	23.9	17.6	28.0	131.0	542.2	80.0
1995	per 100 000 children	33.9	10.9	21.8	8.0	0.7	31.9	57.5	136.0	22.5
1996	per 100 000 children	12.3	7.3	6.4	5.9	2.7	17.0	13.3	34.5	9.0
1997	per 100 000 children	14.8	7.8	21.5	17.4	6.7	33.5	27.9	8.0	14.7
1998	per 100 000 children	7.8	2.8	3.6	10.8	1.0	34.2	8.9	–	6.2
1999	per 100 000 children	1.7	3.5	2.8	2.5	0.7	9.9	6.1	37.6	3.1
2000	per 100 000 children	1.6	0.7	1.4	0.7	1.0	1.0	–	–	1.2
2001	per 100 000 children	1.1	1.8	0.6	0.2	0.3	2.0	–	–	1.0
2002	per 100 000 children	0.3	0.1	0.6	–	–	–	–	–	0.3
2003	per 100 000 children	0.5	1.0	0.5	–	1.7	–	–	2.0	0.7
2004	per 100 000 children	0.2	0.1	–	0.5	0.3	–	–	–	0.2

Table 10A.30 Notifications of measles, children aged 0–14 years (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	per 100 000 children	0.1	–	0.1	–	–	–	–	–	0.1
2006 (c)	per 100 000 children	2.7	0.3	0.1	4.0	1.1	7.3	–	–	1.6

(a) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between States and Territories and with time.

(b) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(c) Notifications for 2006 are to 31 August.

– Nil or rounded to zero.

Source: DHA (unpublished).

Table 10A.31 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
1994	no.	832	179	888	398	346	24	14	91	2 772
1995	no.	743	202	796	252	235	71	24	105	2 428
1996	no.	498	651	365	113	318	7	17	8	1 977
1997	no.	2 309	799	1 194	831	920	40	44	17	6 154
1998	no.	1 092	476	678	194	293	14	34	9	2 790
1999	no.	409	371	253	53	117	278	27	2	1 510
2000	no.	1 549	309	217	49	217	40	103	5	2 489
2001	no.	1 807	292	726	121	806	27	28	97	3 904
2002	no.	728	281	711	121	126	9	18	20	2 014
2003	no.	954	182	216	124	31	40	139	1	1 687
2004	no.	777	214	237	843	152	2	17	11	2 253
2005	no.	495	129	342	129	99	5	28	26	1 253
2006 (c)	no.	216	21	138	21	34	3	11	5	449
Notifications per 100 000 children (0–14 years)										
1994	per 100 000 children	64.2	19.0	125.0	103.2	115.2	22.4	20.6	190.5	71.8
1995	per 100 000 children	57.0	21.3	109.9	64.7	78.3	66.6	35.4	216.4	62.4
1996	per 100 000 children	38.0	68.7	49.6	28.8	106.2	6.6	25.1	16.2	50.5
1997	per 100 000 children	174.7	84.1	160.8	209.9	307.9	38.3	64.6	33.9	156.5
1998	per 100 000 children	82.2	49.9	90.6	48.7	98.4	13.7	50.5	17.8	70.7
1999	per 100 000 children	30.8	38.9	33.6	13.3	39.5	274.7	41.0	4.0	38.2
2000	per 100 000 children	116.0	32.3	28.5	12.2	73.8	40.1	157.1	9.9	62.8
2001	per 100 000 children	134.4	30.4	94.0	30.1	276.3	27.3	42.8	189.5	98.1
2002	per 100 000 children	54.4	29.3	91.0	30.3	43.5	9.2	27.7	39.4	50.6
2003	per 100 000 children	71.5	19.0	27.4	31.1	10.8	41.1	217.7	2.0	42.4

Table 10A.31 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004	per 100 000 children	58.6	22.3	29.7	210.9	53.2	2.1	26.9	21.8	56.6
2005	per 100 000 children	37.5	13.5	42.4	32.3	34.9	5.2	44.8	51.5	31.5
2006 (c)	per 100 000 children	16.4	2.2	17.1	5.3	12.0	3.1	17.6	9.9	11.3

(a) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between States and Territories and with time.

(b) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(c) Notifications for 2006 are to 31 August.

Source: DHA (unpublished).

Table 10A.32 **Notifications of *Haemophilus influenzae* type b, children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
1994	no.	49	24	30	10	16	4	1	1	135
1995	no.	23	13	8	4	6	4	1	4	63
1996	no.	10	8	8	1	6	1	2	3	39
1997	no.	11	7	12	3	2	2	–	3	40
1998	no.	11	2	6	5	1	2	–	–	27
1999	no.	8	4	5	1	3	–	1	2	24
2000	no.	4	2	7	–	1	–	–	–	14
2001	no.	6	2	2	1	2	–	–	3	16
2002	no.	5	1	1	6	2	–	–	2	17
2003	no.	4	1	3	1	1	–	–	2	12
2004	no.	2	1	3	–	2	–	–	2	10
2005	no.	4	2	2	–	–	–	–	1	9
2006 (c)	no.	3	1	2	–	–	–	–	–	6
Notifications per 100 000 children (0–14 years)										
1994	per 100 000 children	3.8	2.5	4.2	2.6	5.3	3.7	1.5	2.1	3.5
1995	per 100 000 children	1.8	1.4	1.1	1.0	2.0	3.8	1.5	8.2	1.6
1996	per 100 000 children	0.8	0.8	1.1	0.3	2.0	0.9	2.9	6.1	1.0
1997	per 100 000 children	0.8	0.7	1.6	0.8	0.7	1.9	–	6.0	1.0
1998	per 100 000 children	0.8	0.2	0.8	1.3	0.3	2.0	–	–	0.7
1999	per 100 000 children	0.6	0.4	0.7	0.3	1.0	–	1.5	4.0	0.6
2000	per 100 000 children	0.3	0.2	0.9	–	0.3	–	–	–	0.4
2001	per 100 000 children	0.4	0.2	0.3	0.2	0.7	–	–	5.9	0.4
2002	per 100 000 children	0.4	0.1	0.1	1.5	0.7	–	–	3.9	0.4

Table 10A.32 Notifications of *Haemophilus influenzae* type b, children aged 0–14 years (a), (b)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003	per 100 000 children	0.3	0.1	0.4	0.3	0.3	–	–	4.0	0.3
2004	per 100 000 children	0.2	0.1	0.4	–	0.7	–	–	4.0	0.3
2005	per 100 000 children	0.3	0.2	0.2	–	–	–	–	2.0	0.2
2006 (c)	per 100 000 children	0.2	0.1	0.2	–	–	–	–	–	0.2

(a) Notified cases are likely to represent only a proportion of the total cases that occurred. The notified fraction may vary between states and territories and with time.

(b) Notification criteria are based on the National Health Medical Research Council's: *Surveillance Case Definitions* (1994).

(c) Notifications for 2006 are to 31 August.

– Nil or rounded to zero.

Source: DHA (unpublished).

Table 10A.33 **Participation rates of women in cervical screening programs, by age group (per cent) (a), (b)**

Age group (years)	*NSW*	*Vic* (c)	*Qld*	*WA* (d)	*SA* (e)	*Tas*	*ACT* (c)	*NT*	*Aust*
2000 and 2001									
20–24	46.4	51.1	51.0	53.0	54.8	62.7	47.8	59.9	50.3
25–29	58.8	63.3	59.3	62.7	64.2	66.9	59.5	64.2	61.0
30–34	63.7	67.2	61.2	65.9	68.6	68.5	64.9	65.9	64.9
35–39	63.7	67.6	60.5	66.1	68.3	69.8	64.9	64.1	64.8
40–44	62.9	68.0	59.9	64.8	68.5	67.5	64.6	63.1	64.4
45–49	63.7	69.3	60.0	64.3	68.9	67.6	66.0	64.9	65.0
50–54	61.7	68.1	57.1	61.7	65.8	65.8	68.5	61.9	63.0
55–59	63.2	71.2	58.3	62.7	69.0	66.1	72.1	62.3	64.9
60–64	52.9	61.1	48.8	54.9	60.7	55.2	63.2	55.5	55.3
65–69	43.7	52.3	41.9	46.5	51.2	48.1	54.4	42.6	46.7
70–74	18.1	17.7	20.8	18.9	31.3	13.4	19.0	24.7	19.7
75–79	7.6	7.1	9.4	7.3	–	6.2	7.6	13.6	7.0
80–84	2.4	2.4	3.1	2.5	–	1.9	1.8	5.5	2.3
Ages 20–84 years	53.5	58.0	52.6	56.6	57.5	58.1	58.4	61.8	55.3
Age standardised (f)	53.0	57.7	51.3	55.0	58.2	58.0	56.2	55.9	54.7
Ages 20–69 years	59.2	64.5	57.4	61.7	64.9	65.4	62.2	63.0	61.1
Age standardised (f)	59.1	64.6	57.0	61.4	64.9	65.2	62.8	61.7	61.0
2001 and 2002									
20–24	46.7	51.1	49.5	52.6	54.4	61.9	49.3	59.8	50.0
25–29	58.4	62.9	57.5	61.6	63.6	66.3	59.8	63.5	60.3
30–34	63.0	66.9	59.5	64.6	68.4	68.5	64.5	63.7	64.1
35–39	63.5	67.8	59.3	64.7	68.3	68.8	65.8	63.3	64.4
40–44	63.1	68.2	59.1	64.1	68.5	67.4	65.0	62.1	64.2
45–49	64.3	70.2	59.8	64.0	69.9	67.5	66.7	64.3	65.4
50–54	61.8	68.4	57.0	61.5	66.2	65.5	67.1	61.7	63.0
55–59	64.2	72.1	58.7	62.7	70.7	66.3	73.2	65.7	65.7
60–64	54.2	62.0	49.6	54.1	61.6	56.3	64.2	56.2	56.1
65–69	45.4	52.9	43.3	46.5	53.5	49.2	55.4	43.5	48.0
70–74	18.0	18.4	21.6	18.5	20.1	14.2	18.7	28.3	18.9
75–79	7.3	7.4	9.3	6.9	8.7	5.8	6.7	12.1	7.7
80–84	2.3	2.4	3.1	2.2	2.5	1.9	1.7	4.4	2.5
Ages 20–84 years	53.5	58.1	51.8	55.8	57.7	57.7	58.6	61.1	55.1
Age standardised (f)	53.2	58.0	50.7	54.3	58.4	57.8	56.6	55.7	54.6
Ages 20–69 years	59.4	64.7	56.5	61.0	65.3	65.2	62.6	62.3	61.0
Age standardised (f)	59.4	64.9	56.3	60.7	65.2	65.0	63.3	61.4	61.0
2002 and 2003									
20–24	45.3	49.8	49.9	51.7	52.9	59.3	49.5	59.4	49.0
25–29	56.7	61.3	57.2	60.2	63.1	63.7	59.0	61.6	59.0

Table 10A.33 **Participation rates of women in cervical screening programs, by age group (per cent) (a), (b)**

Age group (years)	*NSW*	*Vic* (c)	*Qld*	*WA* (d)	*SA* (e)	*Tas*	*ACT* (c)	*NT*	*Aust*
30–34	62.2	65.8	59.9	64.1	67.4	66.0	65.4	61.3	63.4
35–39	62.7	66.9	59.9	64.5	68.1	65.7	64.6	62.5	63.9
40–44	62.8	67.3	60.2	64.4	68.1	65.7	65.2	60.6	64.1
45–49	64.2	69.8	61.1	64.8	70.1	65.5	66.7	63.5	65.6
50–54	61.6	68.0	58.5	61.6	67.2	63.1	65.8	61.1	63.1
55–59	64.3	72.6	60.4	63.1	70.9	66.7	71.1	65.6	66.2
60–64	54.2	62.0	51.2	54.0	62.7	56.3	63.4	51.2	56.4
65–69	45.9	54.2	44.9	47.3	54.3	49.1	53.6	44.5	48.8
70–74	17.0	17.8	21.7	17.9	19.9	14.1	16.8	26.9	18.3
75–79	6.6	6.6	9.1	6.6	8.0	5.1	4.9	10.8	7.1
80–84	2.0	2.2	3.0	2.0	2.2	1.7	1.9	4.2	2.2
Ages 20–84 years	52.8	57.4	52.5	55.5	57.4	55.9	58.1	59.7	54.7
Age standardised (f)	52.6	57.4	51.5	54.2	58.3	56.1	55.9	54.5	54.3
Ages 20–69 years	58.8	64.0	57.3	60.8	65.0	63.2	62.2	61.0	60.6
Age standardised (f)	58.8	64.2	57.2	60.6	65.1	63.1	62.7	60.2	60.7
2003 and 2004									
20–24	44.0	48.5	48.9	50.4	51.8	57.2	48.9	58.6	47.8
25–29	55.6	60.3	56.7	58.8	62.7	62.4	59.4	60.9	58.1
30–34	61.1	65.8	59.9	63.2	66.7	64.6	65.9	59.9	62.8
35–39	62.2	67.3	60.2	63.5	68.0	64.6	65.5	62.4	63.8
40–44	62.7	68.4	61.0	63.2	68.4	63.7	66.0	60.8	64.3
45–49	64.0	70.7	62.2	64.4	70.2	65.9	66.9	62.4	65.9
50–54	62.0	69.7	59.8	61.2	68.5	62.8	66.8	61.5	64.0
55–59	64.1	73.7	62.0	63.0	70.9	65.8	68.2	64.5	66.6
60–64	54.3	64.0	53.0	53.7	63.3	55.3	61.8	50.9	57.2
65–69	45.9	56.0	46.3	47.4	55.0	48.1	52.8	46.1	49.6
70–74	16.1	16.3	20.9	16.8	19.3	13.2	17.6	22.0	17.3
75–79	5.8	5.4	8.5	5.9	7.6	4.6	5.2	10.5	6.3
80–84	1.7	1.7	2.7	2.0	2.0	1.5	1.9	3.6	1.9
Ages 20–84 years	52.1	57.6	52.8	54.6	57.2	54.9	58.1	58.9	54.5
Age standardised (f)	52.1	57.7	51.9	53.4	58.2	55.1	56.0	53.8	54.2
Ages 20–69 years	58.2	64.4	57.7	59.9	65.0	62.0	62.3	60.4	60.5
Age standardised (f)	58.4	64.8	57.7	59.8	65.1	62.0	62.7	59.7	60.7
2004 and 2005									
20–24	43.4	48.5	49.1	51.3	50.3	57.5	51.6	57.6	47.7
25–29	55.0	60.2	56.8	58.4	60.8	64.6	61.9	60.6	57.8
30–34	60.9	66.4	60.4	63.2	65.8	64.6	68.0	58.9	62.9
35–39	62.5	68.4	61.0	64.5	67.1	65.8	68.9	60.8	64.4
40–44	62.8	69.4	61.6	64.0	67.4	65.3	67.7	59.0	64.8
45–49	64.0	71.8	63.4	65.4	69.4	66.1	69.1	61.1	66.5

Table 10A.33 Participation rates of women in cervical screening programs, by age group (per cent) (a), (b)

Age group (years)	*NSW*	*Vic* (c)	*Qld*	*WA* (d)	*SA* (e)	*Tas*	*ACT* (c)	*NT*	*Aust*
50–54	62.3	70.4	61.4	62.3	68.0	64.5	68.2	60.7	64.7
55–59	63.9	73.8	62.8	64.6	70.1	66.5	74.8	62.1	66.9
60–64	54.3	64.9	54.3	54.1	62.0	56.4	65.3	50.8	57.7
65–69	45.6	56.2	46.3	48.4	55.8	47.1	56.1	44.2	49.7
70–74	15.6	16.4	27.3	16.1	19.9	13.0	17.3	14.8	17.0
75–79	5.5	5.0	10.5	5.3	7.7	4.4	5.8	9.5	5.9
80–84	1.6	1.6	3.2	2.0	1.9	1.2	1.7	3.0	1.8
Ages 20–84 years	51.9	58.1	54.9	55.1	56.3	55.6	60.4	57.7	54.6
Age standardised (f)	52.0	58.2	52.9	54.0	57.4	55.8	58.4	52.4	54.4
Ages 20–69 years	58.1	65.0	58.4	60.6	64.0	62.9	65.0	59.2	60.8
Age standardised (f)	58.2	65.4	58.4	60.5	64.1	62.9	65.5	58.5	61.0

(a) These numbers may be overestimated because of double counting of of some women between some states. This may be the result of difficulty in identifying state of residence for women in border areas, tests inadvertently transferred to interstate registers and inclusion of women resident overseas; however, the impact of double counting is probably very small.

(b) In 2001 the ABS carried out a full population Census and a national health survey. These led to the revision of the ABS estimated resident population (ERP) data, the introduction of a new Australian standard population for use in age standardisation and the production of new estimates of hysterectomy status among Australian women. The denominators for participation rates presented in this report have been calculated using the 2001 ABS National Health Survey hysterectomy fractions and the revised ERP values, and age-adjusted using the 2001 Australian standard population. National hysterectomy fractions have been used for calculating these participation rates.

(c) The Victorian and ACT registers only register women with a Victorian or ACT address respectively.

(d) In 2000 and 2001 WA registered only register women with a WA address.

(e) For 2000 and 2001 SA has grouped all women aged 70 years or more in the 70–74 age group.

(f) Age-standardised rates are standardised to the 2001 Australian population.

na Not available.

Source: AIHW 2006, *Cervical screening in Australia 2003-2004,* AIHW, Canberra; AIHW (unpublished).

Table 10A.34 **Influenza vaccination coverage, people aged 65 years or over**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2002										
People vaccinated	no.	623 700	509 700	317 500	167 100	180 900	51 300	21 900	5 200	1 877 200
Target population	no.	861 400	626 000	423 100	209 700	220 500	64 900	27 500	7 600	2 440 500
People vaccinated	%	72.4	81.4	75.0	79.7	82.0	79.0	79.6	68.4	76.9
2003										
People vaccinated	no.	663 100	499 300	327 700	171 800	186 200	51 600	23 200	5 400	1 928 300
Target population	no.	869 000	642 300	448 400	219 100	225 000	67 300	28 700	8 000	2 507 900
People vaccinated	%	76.3	77.7	73.1	78.4	82.8	76.7	80.7	68.1	76.9
2004										
People vaccinated	no.	715 500	541 200	352 500	181 100	187 800	53 200	24 200	5 900	2 061 500
Target population	no.	907 300	663 600	465 200	230 100	230 800	68 800	30 200	8 800	2 604 800
People vaccinated	%	78.9	81.6	75.8	78.7	81.4	77.3	80.0	67.5	79.1

Source: AIHW 2005e, *2004 Adult Vaccination Survey: summary results,* AIHW cat. no. PHE 56, AIHW & DoHA, Canberra; AIHW 2004, *2003 Influenza Vaccine Survey: Summary Results,* AIHW Cat. no. PHE 51*,* Canberra; AIHW 2003, *2002 Influenza Vaccine Survey, Summary Results*, AIHW cat. no. PHE 46, Canberra.

Table 10A.35 **Ratio of age standardised hospital separations for Indigenous males to all males 2004-05 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All causes	Number	np	np	25 474	18 222	6 711	np	np	22 023	72 430
	SHSR	np	np	2.00	2.70	2.58	np	np	3.80	2.60
	95% CI	np	np	1.97 to 2.02	2.66 to 2.74	2.52 to 2.64	np	np	3.75 to 3.86	2.58 to 2.62
Circulatory disease	Number	np	np	1 050	662	421	np	np	488	2 621
	SHSR	np	np	2.01	2.34	3.83	np	np	2.03	2.27
	95% CI	np	np	1.03 to 1.23	1.89 to 2.28	2.78 to 3.55	np	np	0.58 to 0.82	1.38 to 1.54
Coronary heart disease	Number	np	np	531	316	216	np	np	189	1 252
	SHSR	np	np	2.69	2.95	5.18	np	np	2.10	2.87
	95% CI	np	np	2.46 to 2.91	2.63 to 3.28	4.49 to 5.87	np	np	1.8 to 2.4	2.71 to 3.03
Rheumatic heart disease	Number	np	np	24	21	19	np	np	39	103
	SHSR	np	np	14.46	24.00	np	np	np	52.92	28.53
	95% CI	np	np	8.67 to 20.24	13.74 to 34.27	np	np	np	36.31 to 69.52	23.02 to 34.04
Self-harm	Number	np	np	121	92	50	np	np	112	375
	SHSR	np	np	1.73	2.41	3.36	np	np	3.24	2.38
	95% CI	np	np	1.42 to 2.03	1.92 to 2.91	2.43 to 4.29	np	np	2.64 to 3.84	2.14 to 2.62
All respiratory disease	Number	np	np	1 748	1 515	440	np	np	1 509	5 212
	SHSR	np	np	1.66	2.80	2.15	np	np	3.33	2.31
	95% CI	np	np	1.58 to 1.73	2.66 to 2.94	1.95 to 2.35	np	np	3.16 to 3.49	2.25 to 2.37
Infectious pneumonia	Number	np	np	402	475	92	np	np	656	1 625
	SHSR	np	np	2.90	6.62	3.37	np	np	10.83	5.44
	95% CI	np	np	2.61 to 3.18	6.02 to 7.21	2.68 to 4.06	np	np	10 to 11.66	5.18 to 5.71
Lung cancer	Number	np	np	70	18	7	np	np	8	103
	SHSR	np	np	4.17	1.98	np	np	np	np	2.78
	95% CI	np	np	3.19 to 5.14	1.06 to 2.89	np	np	np	np	2.24 to 3.32
Diabetes as a primary diagnosis	Number	np	np	435	275	114	np	np	264	1 088
	SHSR	np	np	4.94	5.84	6.26	np	np	6.59	5.62
	95% CI	np	np	4.48 to 5.4	5.15 to 6.53	5.11 to 7.41	np	np	5.79 to 7.38	5.29 to 5.96

Table 10A.35 Ratio of age standardised hospital separations for Indigenous males to all males 2004-05 (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All diabetes except where dialysis is the primary diagnosis	Number	np	np	2 133	1 720	739	np	np	1 690	6 282
	SHSR	np	np	4.66	6.96	7.72	np	np	8.08	6.22
	95% CI	np	np	4.46 to 4.86	6.63 to 7.29	7.17 to 8.28	np	np	7.69 to 8.46	6.07 to 6.38
All diabetes (f)	Number	np	np	2 409	6 158	739	np	np	1 692	10 998
	SHSR	np	np	4.48	21.21	6.56	np	np	6.88	9.27
	95% CI	np	np	4.3 to 4.66	20.68 to 21.74	6.09 to 7.04	np	np	6.55 to 7.21	9.1 to 9.44
Depressive disorder	Number	np	np	71	53	39	np	np	19	182
	SHSR	np	np	0.62	0.86	1.62	np	np	0.35	0.72
	95% CI	np	np	0.48 to 0.77	0.63 to 1.09	1.11 to 2.12	np	np	0.19 to 0.51	0.61 to 0.82
Anxiety disorder	Number	np	np	10	8	6	np	np	3	27
	SHSR	np	np	0.28	0.42	np	np	np	np	0.34
	95% CI	np	np	0.11 to 0.46	0.13 to 0.71	np	np	np	np	0.21 to 0.47
Substance use disorder	Number	np	np	119	63	33	np	np	13	228
	SHSR	np	np	1.71	1.66	2.21	np	np	0.38	1.45
	95% CI	np	np	1.4 to 2.01	1.25 to 2.07	1.46 to 2.97	np	np	0.17 to 0.59	1.27 to 1.64
Psychotic disorder	Number	np	np	661	504	246	np	np	212	1 623
	SHSR	np	np	2.08	2.91	3.63	np	np	1.35	2.27
	95% CI	np	np	1.92 to 2.23	2.66 to 3.16	3.18 to 4.09	np	np	1.17 to 1.53	2.16 to 2.38

(a) The ratios are indirectly standardised using the estimated resident populations of Indigenous people at 30 June 2004, that is, the actual number of Indigenous separations divided by the calculated expected number of separations for Queensland, WA, SA, and the NT public hospitals.

(b) Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. Australian total comprises Queensland, WA, SA and NT (public hospitals) only.

Table 10A.35 **Ratio of age standardised hospital separations for Indigenous males to all males 2004-05 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)

(c) The quality of the data provided for Indigenous status from 2001-02 has continued to improve due to the use of the National Health Data Dictionary definitions by all jurisdictions, however it is still in need of improvement. Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population among the States and Territories suggests that there was variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. It is considered acceptable for only Queensland, WA, SA, and the NT public hospitals. Data on Indigenous status should therefore be interpreted cautiously.

(d) Patients aged 75 years and over are excluded.

(e) Some separation rates and rate ratios have been suppressed due to small number of separations.

(f) All diabetes refers to separations with either a principal or additional diagnosis of diabetes.

SHSR = Standardised Hospital Separation Ratio; CI = confidence interval.

np Not published.

Source: AIHW (unpublished).

Table 10A.36 **Ratio of age standardised hospital separations for Indigenous females to all females, 2004-05 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All causes	Number	np	np	32 511	28 479	7 652	np	np	27 658	96 300
	SHSR	np	np	1.91	3.35	2.00	np	np	3.60	2.60
	95% CI	np	np	1.89 to 1.93	3.31 to 3.39	1.96 to 2.05	np	np	3.56 to 3.64	2.58 to 2.62
Circulatory disease	Number	np	np	1 012	643	320	np	np	500	2 475
	SHSR	np	np	3.20	9.61	1.95	np	np	3.52	3.59
	95% CI	np	np	3 to 3.39	8.87 to 10.35	1.74 to 2.17	np	np	3.21 to 3.83	3.45 to 3.73
Coronary heart disease	Number	np	np	387	272	144	np	np	173	976
	SHSR	np	np	4.59	14.62	3.10	np	np	4.43	5.18
	95% CI	np	np	4.13 to 5.05	12.88 to 16.36	2.6 to 3.61	np	np	3.77 to 5.08	4.85 to 5.5
Rheumatic heart disease	Number	np	np	50	33	34	np	np	58	175
	SHSR	np	np	10.56	13.24	34.31	np	np	27.39	16.93
	95% CI	np	np	7.63 to 13.48	8.72 to 17.76	22.78 to 45.84	np	np	20.34 to 34.44	14.42 to 19.44
Self-harm	Number	np	np	165	142	63	np	np	74	444
	SHSR	np	np	1.23	5.14	0.89	np	np	1.21	1.51
	95% CI	np	np	1.04 to 1.41	4.29 to 5.98	0.67 to 1.12	np	np	0.93 to 1.48	1.37 to 1.65
All respiratory disease	Number	np	np	1 650	1 731	493	np	np	1 481	5 355
	SHSR	np	np	1.82	3.73	2.73	np	np	3.84	2.77
	95% CI	np	np	1.73 to 1.91	3.56 to 3.91	2.49 to 2.98	np	np	3.65 to 4.04	2.69 to 2.84
Infectious pneumonia	Number	np	np	385	480	95	np	np	638	1 598
	SHSR	np	np	3.04	7.37	3.75	np	np	11.76	5.89
	95% CI	np	np	2.74 to 3.35	6.71 to 8.03	3 to 4.51	np	np	10.85 to 12.68	5.6 to 6.18
Lung cancer	Number	np	np	36	13	3	np	np	12	64
	SHSR	np	np	2.96	1.95	np	np	np	2.14	2.36
	95% CI	np	np	1.99 to 3.93	0.89 to 3.01	np	np	np	0.93 to 3.35	1.78 to 2.94
Diabetes as a primary diagnosis	Number	np	np	696	438	163	np	np	399	1 696
	SHSR	np	np	5.15	6.21	5.87	np	np	6.48	5.75
	95% CI	np	np	4.77 to 5.54	5.63 to 6.79	4.97 to 6.77	np	np	5.84 to 7.11	5.48 to 6.02

Table 10A.36 **Ratio of age standardised hospital separations for Indigenous females to all females, 2004-05 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)
All diabetes except where dialysis is the primary	Number	np	np	3 135	2 751	987	np	np	2 643	9 516
	SHSR	np	np	5.45	8.98	8.13	np	np	9.97	7.50
	95% CI	np	np	5.26 to 5.64	8.65 to 9.32	7.62 to 8.64	np	np	9.59 to 10.35	7.35 to 7.65
All diabetes (f)	Number	np	np	3 580	10 773	995	np	np	2 652	18 000
	SHSR	np	np	5.47	30.86	7.19	np	np	8.79	12.47
	95% CI	np	np	5.29 to 5.65	30.28 to 31.44	6.74 to 7.63	np	np	8.45 to 9.12	12.28 to 12.65
Depressive disorder	Number	np	np	193	134	112	np	np	47	486
	SHSR	np	np	0.72	0.96	2.03	np	np	0.39	0.83
	95% CI	np	np	0.62 to 0.83	0.8 to 1.12	1.66 to 2.41	np	np	0.28 to 0.5	0.76 to 0.91
Anxiety disorder	Number	np	np	17	23	14	np	np	1	55
	SHSR	np	np	0.43	1.11	np	np	np	np	0.63
	95% CI	np	np	0.22 to 0.63	0.65 to 1.56	np	np	np	np	0.47 to 0.8
Substance use disorder	Number	np	np	69	42	16	np	np	7	134
	SHSR	np	np	4.68	5.49	np	np	np	np	4.16
	95% CI	np	np	3.57 to 5.78	3.83 to 7.15	np	np	np	np	3.46 to 4.87
Psychotic disorder	Number	np	np	457	442	264	np	np	130	1 293
	SHSR	np	np	1.13	2.08	3.17	np	np	0.70	1.46
	95% CI	np	np	1.03 to 1.23	1.89 to 2.28	2.78 to 3.55	np	np	0.58 to 0.82	1.38 to 1.54

(a) The ratios are indirectly standardised using the estimated resident populations of Indigenous people at 30 June 2004, that is, the actual number of Indigenous separations divided by the calculated expected number of separations for Queensland, WA, SA, and the NT public hospitals.

(b) Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. Australian total comprises Queensland, WA, SA and NT (public hospitals) only.

Table 10A.36 **Ratio of age standardised hospital separations for Indigenous females to all females, 2004-05 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (b)

(c) The quality of the data provided for Indigenous status from 2001-02 has continued to improve due to the use of the National Health Data Dictionary definitions by all jurisdictions, however it is still in need of improvement. Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population among the States and Territories suggests that there was variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. It is considered acceptable for only Queensland, WA, SA, and the NT public hospitals. Data on Indigenous status should therefore be interpreted cautiously.

(d) Patients aged 75 years and over are excluded.

(e) Some separation rates and rate ratios have been suppressed due to small number of separations.

(f) All diabetes refers to separations with either a principal or additional diagnosis of diabetes.

SHSR = Standardised Hospital Separation Ratio.

np Not published.

Source : AIHW (unpublished).

Table 10A.37 Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2004-05 (per 100 000 people) (a), (b), (c), (d), (e)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Circulatory	15.0	25.6	16.7	23.5	29.0	np	np	np	21.5
Renal	16.9	23.2	20.2	20.9	20.0	np	np	np	21.8
Ophthalmic	95.2	98.4	88.4	131.4	82.0	np	np	np	102.5
Other specified	44.3	70.8	64.4	62.3	70.8	np	np	np	63.1
Multiple	23.4	44.0	48.6	39.1	44.4	np	np	np	41.3
No complications	4.5	5.2	3.9	3.1	6.8	np	np	np	4.9
Total	**199.5**	**267.3**	**242.4**	**280.3**	**253.1**	**np**	**np**	**np**	**255.3**

(a) The data are not person based, but episode based. A person who is admitted to hospital, for example, three times in the year will be counted three times.

(b) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(c) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.

(d) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(e) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

np Not published.

Source: AIHW (unpublished).

Table 10A.38 Separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, all episode types, 2004-05 (per cent) (a), (b), (c), (d), (e)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Circulatory	13.2	16.9	11.6	15.5	15.0	np	np	np	14.8
Renal	15.4	13.0	13.0	16.4	19.9	np	np	np	14.8
Ophthalmic	90.5	88.5	90.4	81.9	84.6	np	np	np	88.4
Other specified	12.4	28.6	14.8	12.9	10.7	np	np	np	18.0
Multiple	20.0	50.0	25.0	–	50.0	np	np	np	27.6
Unspecified	7.6	23.9	30.1	11.6	31.7	np	np	np	23.6
No complications	31.0	46.1	17.1	9.8	67.0	np	np	np	36.9
Total	**49.9**	**47.7**	**44.7**	**44.9**	**41.3**	**np**	**np**	**np**	**46.9**

(a) The data are not person based, but episode based. A person who is admitted to hospital, for example, three times in the year will be counted three times.

(b) Results for individual complications may be affected by small numbers, and need to be interpreted with care.

(c) Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations.

(d) Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

(e) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

– Nil or rounded to zero. **np** Not published.

Source : AIHW (unpublished).

Table 10A.39 Standardised hospital separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2004-05 (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
ASR	per 100 000 people	12.1	14.4	17.2	12.9	14.9	np	np	np	15.2
Crude	per 100 000 people	13.1	15.4	17.1	12.6	17.8	np	np	np	15.0
Separations	no.	883	768	673	251	273	np	np	np	3 032

(a) Includes unspecified diabetes. Age standardised separation rates are age adjusted to the Australian total population at 30 June 2001 using direct standardisation. The figures are based on the ICD-10-AM classification.

(b) The data are not person-based, but episode-based. A person who is admitted to hospital, say, three times in the year will be counted three times.

(c) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

ASR = Age standardised rate

np Not published.

Source: AIHW (unpublished).

Table 10A.40 Separation rates of older people for injuries due to falls, 2004-05 (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations per 1000 older people	78.3	78.7	67.8	71.3	58.8	np	np	np	73.0
Number	35 059	25 411	15 232	7 829	6 921	np	np	np	93 255

(a) Separation rates are crude rates using 2004 population of Indigenous aged 55 years or over plus population of non-indigenous aged 75 year or over as denominator.

(b) Older people are defined as non-Indigenous people aged 75 years and over and Indigenous people aged 55 years and over.

(c) Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

np Not published.

Source : AIHW (unpublished).

Table 10A.41 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Regional Health Services Sub-program	The RHS provides funding to local rural communities to identify local primary health priorities and develop and support services relating to these priorities. Programs to date include illness prevention and management, palliative care, women's health, children's health services and mental health.	The RHS program is part of the 2004-05 Australian Government Budget Initiative for Rural Primary Health Program and is funded through an identified program in the DoHA budget.	Performance indicators for RHS are published in the Portfolio Budget Statements.
Primary Health Sub-program	The Primary Health Sub-program comprises community based projects under the Building Healthy Communities in remote Australia (BHC) Initiative, and national projects that target support to remote Australia. These initiatives provide funding to small rural and remote communities, or to well-networked organisations in rural areas, to undertake health education and promotion activities to address the risk factors that contribute to poorer health in these areas. The factors include: injury, high rates of smoking and harmful alcohol consumption; and high rates of obesity and low rates of physical activity.	The BHC program for Preventive Health initiatives is part of the 2004 Australian Government Budget Initiative for Rural Health and is funded through an identified program in the DoHA budget.	Performance indicators for BHC are published in the Portfolio Budget Statements.
More Allied Health Services Sub-program (MAHS)	This Program operates through Divisions of General Practice to improve access by rural and remote communities to a range of additional allied health professionals.	The MAHS program was first announced in the 2000-01 budget, and was continued in the 2004-05 budget under the Rural Health Strategy - Outcome 4.	Divisions of General Practice are required to report to DHA against MAHS activities on a biannual basis.

Table 10A.41 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*

Source : Australian Government (unpublished).

Table 10A.42 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Child, Adolescent and Family services	Covering services such as youth health, paediatric allied health (physiotherapy, occupational therapy, social work and counselling, speech pathology, psychology, audiology), specialist medical services, early childhood nursing, immunisation, post natal programs, early intervention and school surveillance services.	Area Health Services (AHS) receive block funding from NSW Health to provide health services to their population. Each AHS determines how much money is allocated to this program	These services are measured as Non-Admitted Patient Occasions of Service - the number of occasions on which one or more health care professionals provides a service to a Non-admitted Patient - and reported by AHSs to the Department of Health on a quarterly basis.
Program of Appliances for Disabled People	Providing appropriate equipment, aids and appliances such as mobility and toileting aids to prevent inappropriate entry into institutional facilities.	The Department of Health allocates specific funding to AHSs for this program	The services are required to provide waiting list reports twice a year.
Health related transport services	Providing non-emergency transport for health-related issues.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Multicultural health services	roviding interpreter services, cultural competency training, direct service provision for refugees, planning of services to address or cater to the needs of culturally diverse communities.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Youth Health services	Provide education and health promotion programs, clinical services and planning of youth friendly services.	A mix of AHS and Australian Government funding.	As for Child, Adolescent and Family services

Table 10A.42 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Women's health services	Covering services and health promotion programs for women, such as mental health, violence prevention and pregnancy services and physical activity, smoking cessation and health improvement programs.	A mix of AHS funding and Australian Government funding allocated under the Public Health Outcomes Funding Agreement	As for Child, Adolescent and Family services
Physical Abuse and Neglect of Children services	Providing long-term and intensive counselling for families, and a range of interventions where physical abuse or neglect of a child is occurring.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Sexual Assault services	Providing crisis counselling and support for victims of assault, court preparation and community education programs.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Aboriginal health services	Covering services such as health information and education, counselling, pre and post natal programs, early childhood nursing and health promotion programs.	A mix of AHS, NSW Health (via grants to non-government organisations) and Australian Government funding.	As for Child, Adolescent and Family services
Sexual Health services	Covering education, counselling, screening and the management of sexually transmitted diseases including HIV and Hepatitis A, B and C.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services

Table 10A.42 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Aged Care services	Providing assessment and referral, case management, home nursing, allied health services such as physiotherapy, occupational therapy, social work, podiatry, chiropractic, orthotics and prosthetics, dietetics and nutrition, specialist services such as continence therapy and family support for the aged .	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Palliative Care services	Providing holistic care for people who are terminally ill or dying, including clinical care in the home, counselling and support services.	A mix of AHS and Australian Government funding.	As for Child, Adolescent and Family services
Dental services	Providing basic and emergency dental care in the community.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Community Acute/Post Acute Care services	Providing acute care in the community which is a substitution for hospitalisation, including medical, nursing, allied health services such as physiotherapy and occupational therapy, social work and pharmacy and personal care.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Community nursing	Providing generalist nursing care in the community.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services

Table 10A.42 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Rehabilitation	Providing case management, allied health, prosthetic and home modification services in a community setting.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Eating disorder services	Providing case management, medical and counselling support services.	As for Child, Adolescent and Family services	As for Child, Adolescent and Family services
Non-Government Organisations	Providing a range of services such as Aboriginal Medical Centres, HIV/Aids, Women's Health, Diabetes, Drug and Alcohol services.	Funding allocations are via an annual grant program approved by the Minister for Health	As for Child, Adolescent and Family services

Source : NSW Government (unpublished).

Table 10A.43 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Community Health	The Community Health Program is implemented through Community Health Services (CHSs) by over 120 agencies operating from more than 300 sites across Victoria. CHSs play an important role in preventive, rehabilitative, maintenance and support services for people with complex conditions and chronic illnesses. In addition, CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs. Within the Program, there are specific programs targetting young people, for instance, Innovative Health Services for Homeless Youth and Suicide Prevention. Currently, there are also initiatives to complement the Program, namely: - General Practitioners in CHSs Strategy - Aboriginal Health Promotion and Chronic Care Partnership - Refugee Health Nurses - Early Intervention in Chronic Disease - Child Health Teams - Diabetics Self Management	These services are funded under the Primary Health Funding Approach. Currently, the Approach includes three components namely (1) direct care, (2) health promotion, and (3) development and resourcing.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.

Table 10A.43 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
	The Community Health Program is underpinned by the Primary Care Partnership (PCP) Strategy which is a major reform in the way primary care and community support services are delivered. The strategy aims to improve the overall health and wellbeing of Victorians by improving the experience and outcomes for people who use primary care services and reducing the preventable use of hospital, medical and residential services. Integrated health promotion, service coordination and integrated chronic disease management are the three core PCP activities.		
Women's Health	The Women's Health Program aims to improve the health and wellbeing of all Victorian women (with an emphasis on those most at risk), through developing and disseminating health information and research. The Program works directly with women and in partnership with other organizations.	These services are funded under the Primary Health Funding Approach. Currently, the Approach includes the components health promotion, and development and resourcing	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.

Table 10A.43 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Family Planning	Two of the major components are Family Planning and Family and Reproductive Rights Education. Family planning services assist Victorians to make individual choices on sexual and reproductive health matters by providing services that are accessible, culturally relevant and responsive to people who experience difficulty accessing mainstream services.	These services are funded under the Primary Health Funding Approach. Currently, the Approach includes three components namely (1) direct care, (2) health promotion, and (3) development and resourcing.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Family and Reproductive Rights Education	Family and Reproductive Rights Education Program works with communities that traditionally practise female genital mutilation to increase their access to primary health services, to improve the physical and emotional health and wellbeing of women, young girls and their families, and to encourage the health system to be more responsive to their needs.	These services are funded under the Primary Health Funding Approach. Currently, the Approach includes the components health promotion, and development and resourcing	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.

Table 10A.43 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Dental Health	Public dental services are provided in community and school dental clinics that are located in Community Health Services, hospitals and schools. In some cases, dental care is provided by private clinicians through the Victorian Emergency Dental Scheme (VEDS), the Victorian General Dental Scheme (VGDS), and the Victorian Denture Scheme (VDS). The Dental Health Program supports undergraduate education of dental clinicians, including providing funding for clinical placements and scholarships.	Dental services are output funded using a funding formula based on the Department of Veteran Affairs Dental Items Schedule. Programs for special needs groups are block funded.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Care in Your Community Strategy	Care in Your Community sets out a new methodology for planning integrated and community-based health care based on a common set of catchments and supported by area-based planning networks. Care in Your Community provides a vision and principles for integrated health care. It maps out a framework for a consistent approach to the development of an integrated health care system, building on existing strengths and trends in health care provision.	Not applicable. This is a pilot.	Consultants will be appointed to evaluate the pilot.

Table 10A.43 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
NURSE-ON-CALL strategy	The NURSE-ON-CALL strategy provides a new 24 hour a day, 7 days per week, telephone based health advice and information line. Registered Nurses answer all calls and use evidence-based clinical decision support software systems to undertake triage and direct callers to the most appropriate level of health care for their symptoms.	NURSE ON CALL is provided under a three-year contract arrangement with McKesson Asia-Pacific.	Performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Targets are either quantitative or qualitative or both. Reporting intervals range from regular to periodic.
Telephone Counselling	The initiative provides telephone counseling 24 hours a day, 7 days per week to provide individuals with support, information and referral.	Funding is provided to support seven Lifeline sites and one site for a statewide suicide prevention telephone counselling line. The Commonwealth also contributes substantial funding to Lifeline.	Quantitative performance targets are set by the Department and monitored through various reporting mechanisms to demonstrate program delivery. Quarterly reporting intervals are put in place.

Table 10A.43 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Drug Services	Provides a range of drug treatment services including withdrawal, rehabilitation, counselling and supported accommodation for people with substance abuse problems, these treatment services are also provided to offenders referrred to treatment from the criminal justice system through the Drug Diversion program. A range of health protection services including Primary Health and needle and syringe services targeting drug users are also provided. The Program also oversees Pharmacotherapy services and delivers a range of drug prevention programs including those targeted at use of tobacco and alcohol as well as illicit drugs. Support and information is also provided for drug users and their families.	Funding and reporting for these services is managed in accordance with the Output Budgeting framework. Budget and performance for Drugs Services is reported as a separate Output in the Vicotiran Government budget papers. Most Drug Services are funded on the basis of unit priced service models and service providers are required to report against targets linked to the activity. Different activities are funded at different unit prices which recognise the costs to services of producing the outputs. These prices are applied universally to all service providers delivering those activities.	Performance information is collected and reported at the State level through Expenditure Review Committee reporting against the Budget Paper targets, DHS Annual Report and Growing Victoria Together reports, at a Whole of Victorian Government (WOVG) level through WOVG reporting on specific target groups including Women, Youth and Koori, at a Departmental level through Executive Performance reporting, at a National level, performance reporting is provided through National Minimum Data Sets, Report On Government Services, Australian Institute of Health and Welfare, Public Health Outcomes Funding Agreement(PHOFA), Council of Australian Government (COAG) reporting for National Illict Drug Strategy, Drug Diversion and Needle and Syringe Programs.

Source: Victorian Government (unpublished).

Table 10A.44 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Cancer Screening Services Unit	Responsible for the leadership, strategic planning, management and coordination of the state-wide population screening programs: BreastScreen Queensland Program, Queensland Cervical Screening Program and National Bowel Cancer Screening Program. Key functions of the Unit include state-wide strategic policy and protocols, coordination and planning, service development and support, quality assurance, performance management, communication and education, workforce development and training, monitoring, evaluation and research and linkages with follow up management and treatment.	Funding for cancer screening services is provided through state funds and the joint State/Commonwealth Public Health Outcomes Funding Agreement (PHOFA)	Annual Area Health Service Reports. Annual General Practitioner Division Reports. Performance targets and overall financial reporting are published in the annual report and the Ministerial Portfolio Statement. Annual data reporting to the Australian Institute of Health and Welfare. Performance reports to BSQ Services undertaken six monthly. Annual statistical reports undertaken 12 monthly for BSQ & QCSP.
Indigenous Health	Providing a range of primary and community health care services and activities, spanning the prevention, management and maintenance continuum that address particular needs of Indigenous communities. Including prevention and health promotion services; men's and women's health programs; child and adolescent health services; alcohol, tobacco and other drug services; sexual health services; allied health services; and patient transport provided to increase access to health care.	These serves are funded through a range of programs or health services within the Queensland Health budget.	Performance targets and overall financial reporting are published in the annual report and the Ministerial Portfolio Statement.

Table 10A.44 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Alcohol, Tobacco and Drug Services	Including a range of prevention, health promotion, assessment, counselling, early identification and intervention, treatment and educational services to minimise alcohol, tobacco and other drug related harm.	These services are funded through a range of programs or health services within the Queensland Health budget and Commonwealth funds.	Performance targets and overall financial reporting are published in the annual report and the Ministerial Portfolio Statement
HIV/AIDS, Hepatitis C and Sexual Health (HAHCSH)	The program implements the whole of government Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011 in the strategic priority areas of enabling environment; education and prevention; early detection, care management and treatment; training and professional development and research and surveillance. Programs are delivered through public, private and community based organisations, including 16 QH sexual health clinics and a range of prevention/education initiatives within QH coordinated across the Area Health Services by six coordinators.	Funded through the Public Health Outcomes Funding Agreement (PHOFA) and a combination of State and Commonwealth funding programs.	Annual Progress Report to Cabinet on the Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005-2011. PHOFA – particularly in relation to HIV/AIDS and Indigenous populations, Commonwealth and State funding reporting requirements. Six monthly reports on activities by program coordinators. Six monthly funded NGO performance reports.
Poisons Information	A 24 hour service is provided nationally through links between centres in various states, for the provision of information and advice to assist in the management of poisoning and suspected poisoning, education and promotion of poisoning prevention.	These services are funded from Queensland Health Corporate and Health Service District funds.	The Poisons Information centre is required to provide periodic reports on the extent and nature of calls, substances and caller type.

Table 10A.44 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*

Source : Queensland Government (unpublished).

Table 10A.45 **Western Australia, community health services programs**

Programs funded by the WA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Indigenous Health -Maternal and Child Health	The program provides ante and post natal parent education and support, ante and post natal care, early childhood screening for disability and disease, continuing parent education and developmental surveillance (to 6 years).	The Department of Health negotiates with Aboriginal Community Controlled Health Organisations (ACCHO's) utilising service agreements. Funding is provided directly to the service provider.	Service agreements have specified outcome measures that are reported on either quarterly or six monthly.
Alcohol and other drug services	The program includes a range of activities: • Prevention and early intervention community based education programs and campaigns and support for regional prevention networks. • Treatment including outpatient and inpatient withdrawal, assessment and counselling, rehabilitation, a community based pharmacotherapy program, and supported accommodation. Treatment is also provided for people engaged in a range of diversion programs. • Workforce development initiatives include education and training to a range of government, NGO and community organisations. The Drug and Alcohol Office (DAO) continues as the lead agency in the Indigenous National Alcohol and other Drugs Workforce Development Program which delivers nationally recognised AOD training to the Indigenous AOD workforce.	The funding of alcohol and drug services is allocated through the WA Department of Health. Monies are allocated to three main service delivery area: 1. Direct government treatment services 2. Prevention and practice development and 3. Non- government service providers. Additional Commonwealth funding has been secured for diversion initiatives and the Indigenous National Alcohol and other Drugs Workforce Development Program.	DAO Annual Report and WA Alcohol and Drug Strategy Annual Report. Performance information is reported at the State level through the Treasury budget papers. At a national level performance is reported against the Public Health Outcomes Funding Agreement (PHOFA) and the Ministerial Council on Drug Strategy (through the Department of Health and Ageing).

Table 10A.45 **Western Australia, community health services programs**

Programs funded by the WA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Community Midwifery Program	The Community Midwifery Program (CMP) is a government funded community based midwifery service. Healthy low-risk pregnant women who are planning a home birth are provided with one-to-one midwifery care throughout their pregnancy, labour, birth and the early postnatal period. Women receive their antenatal care at home or in a community based midwifery clinic.	The budget is managed through the Department of Health. All midwives are employed under the approved Community Midwifery Roster Agreement and insured through the Government Insurance Agency. The administration of the CMP is managed by Community Midwifery WA (CMWA), a non-government organisation that holds a contract with the Department of Health.	Clinical lines of governance are in place whereby the midwifery staff report to the Midwifery Manager who reports directly to the Executive Director of Women's and Newborn Services. Monthly reports on the Community Midwifery Program are submitted to the Executive Director of Women's and Newborn Services and to the Clinical Advisory Group that provides clinical support for the CMP.
School Dental Service	The School Dental Service provides free dental care to school children throughout the state ranging from pre-primary through to Year 11 and to Year 12 in remote localities. Care is provided by dental therapists under the supervision of dental officers from fixed and mobile dental clinics located at school throughout the State. The program incorporates preventive strategies which oral health education for school children. Non-general and specialist services are referred to the private sector or where a child is eligible to a Government clinic for subsidised care.	The Department of Health negotiates with Dental Health Services branch to provide funding directly to maintain the program.	Program measure include: • number of children enrolled and under care • Dental Health status i.e. number of decayed / missing / filled teeth • Average cost of service per child.

Table 10A.45 **Western Australia, community health services programs**

Programs funded by the WA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of benefit / allowance from Centrelink or Department of Veteran Affairs) via • Public Dental Clinics Metropolitan and Country • Private practitioners participating in the Metropolitan and Country patients Dental Subsidy Schemes and the Private Orthodontic Subsidy Scheme. • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care also is provided for special groups and institutionalised people. • Aged Care Dental Program. This program provides dental care to the Residents of Registered Aged Care Facilities. Residents are eligible to receive annual free dental examination and a care plan. Further treatment needs are advised and referral to an appropriate provider given. Ongoing treatment is through one of the Government programs for eligible residents or referral to private practice for others.	The Department of Health negotiates with Dental Health Services branch to provide funding directly to maintain the program	Program measures include: • Access to dental treatment for eligible people • Average waiting times • Average cost of completed courses of adult dental care.

Source: WA Government (unpublished).

Table 10A.46 **South Australia, community health services programs**

Programs funded by the SA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Maternity			
Community Midwifery Services	A regional home care support for women after the birth of a baby.	Funding for these programs comes for a variety of sources both federal and state and is acquitted according to the appropriate requirements. Dental services are funded through the SA Dental Service, a state wide health unit. Community nursing services are funded by DH and Dept of Families and Communities including HACC. For Palliative Care some funding through Commonwealth. Aboriginal health services are state government services and work closely with Federally funded services and supported through Commonwealth APHCAP funding. Department of Health funded regions to undertake the program.	Detailed service targets are part of health service agreements or contracts between the Department of Health and the particular service. Monthly reporting against these targets. Monthly Management Summaries - Department of Health Palliative Care Minimum Data Set (MDS) 6 monthly reporting on community based palliative care - published in palliative care bulletin Mental Health MDS Health Service Region Performance Agreements HACC MDS reporting requirements. Health Service Agreements Key Performance Indicators.
Early Childhood Programs			
Early Childhood/ youth and women's health	Covering post-natal parenting information and support services, immunisation, and child at risk assessment and support, cancer screening services, counselling for women affected by violence and child therapy intervention.		
Child Development Unit	Multidisciplinary care planning for children with developmental delay in partnership with visiting paediatrician.		
Paediatric Intervention Unit	Provides therapy, parent support, information and advocacy for children that have a disability or developmental delay and their parents.		
Child and youth health	Provides a universal child and maternal health service for babies and children up to 5 years old. Services are both home based and clinic based. Provides youth health services for 12-25 years of age - services include counselling, medical, therapy, group programs and community development. A range of specialist programs are also provided through child health services including hearing screening programs, mothers and babies residential programs.		

Table 10A.46 **South Australia, community health services programs**

Programs funded by the SA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Indigenous Health			
Aboriginal services	A range of primary health care services and programs provided by multidisciplinary teams from community settings focused particularly on Aboriginal and Torres strait Islander people. These programs work both one to one and in a community development way with Aboriginal communities. Aboriginal health teams provide a strong linkage point with other mainstream providers.		
Aboriginal Mental Health	Dedicated Aboriginal Health Worker positions are funded in both mainstream health services and Aboriginal Community Controlled Services.		
Healthy Ways Project	The project focuses on improving nutrition standards and reduction in tobacco use by Aboriginal people in seven select locations in SA.		
Aboriginal Scholarship Scheme	A scholarship scheme has been established to promote and foster the development of Aboriginal people through a tertiary education scholarship program		
Community nursing (excluding Home and Community Care			
Community Services	Provides a range of home support services including home help, personal care, Aboriginal home support, home oxygen, respite and equipment.		
Continence (Adult and Paediatric)	Education, counselling and conditioning therapy in all areas of continence management.		

Table 10A.46 **South Australia, community health services programs**

Programs funded by the SA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Diabetes Education	Counselling for clients and relatives on the self care of diabetes and its associated complications.		
Community health services	A range of primary health care services and programs provided by multidisciplinary teams from community settings that are aimed at prevention, early intervention and community capacity building to protect the health and wellbeing of the community.		
Women's Health	Primary health care services and programs, often linked to community health services, to address the specific health and well being needs of women, with a particular focus on women with poor health outcomes and least access to services. Includes health information, counselling and community development programs for women.		
Community nursing	Nursing care provided in people's homes or in a community setting to maximise their health and quality of life, taking into consideration the needs of the carer.		
Integrated health care program	Covering diabetes services, dietetic services, community nursing, and discharge planning services.		
Palliative Care / Bereavement Counselling	Palliative Care Services provide support and services to clients and their families when faced with a life limiting illness. Palliative care community outreach services provide care and support in people's homes or in community settings to maximise quality of life during end of life phase, including the needs of the carer.		

Table 10A.46 **South Australia, community health services programs**

Programs funded by the SA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
	Bereavement Counselling offers counselling and support to clients and relatives on grief and loss issues.		
Mens Health program	Promotion and education services.		
Mental Health Team	Assessment, counselling, support, information and education on mental health issues.		
Oral health (including public dental services)			
Specialist Dental Services	Specialist Dental Services for concession card holders provided in association with students of the University of Adelaide.		
Community Dental Service	Emergency and general dental care (including dentures) for adult holders of concession card and their dependents in public dental clinics and contracted through private providers.		
School Dental Service	Regular preventively focused general dental care for pre-school aged, primary and secondary school children under 18 years of age.		
Allied health (including physiotherapy and optometry)			
Allied health services	Treatment, therapy and rehabilitation program with multiple allied health professions, equipment loan.		
Counselling	Community Based counselling in a number of areas.		
Dietetics / Nutrition	Therapeutic dietary advice, nutrition education.		

Table 10A.46 **South Australia, community health services programs**

Programs funded by the SA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Health Social Worker	Advice for clients with personal, accommodation and financial issues.		
Occupational Therapy	Work with people of any age to promote independence and maximise performance in activities of daily living.		
Physiotherapy	Provide services to inpatients and outpatients. Paediatric services are provided.		
Podiatry	Foot care clinics are provided. The department also offers special insoles and orthoses if required.		
Speech Pathology	Paediatric services for speech and language difficulties from 0 - 4 years. Any age for swallowing, feeding, voice difficulties. Adults with communication issues.		
Drug and Alcohol Treatment			
Drug and Alcohol services	Counselling, support and education for youth at risk.		
Community Health Services			
Primary Health Care Networks	Primary Health Care Networks continue to be implemented by the regional health services to provide systems of integrated care in partnership with a range of primary care partners. Accountable partnerships between health service regions and general practice and other non-government providers have been created through Memoranda of Understanding. Networks have been working with these partners to develop new care pathways which redefine clinician and service roles and responsibilities for target chronic diseases.		

Table 10A.46 **South Australia, community health services programs**

Programs funded by the SA Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Hospital Avoidance	Provision of home-based and rapid-response support to clients who present to hospital Emergency Departments and/or General Practice and who without this support would otherwise be admitted to hospital. Hospital Avoidance services utilise a brokerage model to develop flexible packages of care that meet the individual needs of clients of all ages. Examples of services may include showering and personal care, transportation, medication management, intravenous therapy, client observation in their own home, nursing care and GP home visits.		
Home Supported Discharge	Provides home-based care to clients who can be discharged from hospital early and/or to those who are at risk of readmission to hospital. Home Supported Discharge services utilise a brokerage model to develop flexible packages of care that meet the individual needs of clients of all ages. Examples of services may include showering and personal care, transportation, medication management, intravenous therapy, client observation in their own home, nursing care and GP home visits.		

Source: SA Government (unpublished).

Table 10A.47 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Aged, Rural and Community Health Services	Aged, Rural and Community Health (ARCH) brings together a wide range of community and rural health services to meet the needs of individuals in a changing environment. Services are provided to both develop and support communities and to help people maintain or improve levels of physical functioning or independence in the community. ARCH incorporates a range of acute services, sub-acute and primary health care services.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania Together, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.
Oral Health Services	Oral Health Services provides emergency, basic general dental care (check up, x-rays, dental health advice, referral) and dentures to eligible adults (holders of a Health Care or Pensioner Concession Card). Services are also provide to all children up to, but not including the age of 18. Oral Health Services also engages in health promotion and prevention activities to promote oral health on a population basis.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania Together, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.

Table 10A.47 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Palliative Care Services	Palliative Care is a State-wide specialist service that provides interdisciplinary care, consultancy, support and advice to people living with a life threatening illness and their families through specialist inpatient and community outreach services. Care and support may be provided directly to individuals and families, or collaboratively with primary providers through education, consultancy and information.	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania Together, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.

Table 10A.47 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Community Assessment and Care Management	Community Assessment and Care Management (CACM) comprises three statewide service groupings: Assessment and Case Management Services (ACMS), Community Rehabilitation Services and Community Care Services. ACMS consists of the Aged Care Assessment Program, case management of complex clients through the Community Options Service and packages of care. Community Rehabilitation Services comprises the Community Rehabilitation Unit Southern Tasmania, Orthotics & Prosthetics Services Tasmania and Equipment Schemes. Community Care Services consists of primary health care service providers in community and rural settings including the Statewide Continence Nursing Service and Community Therapy Services (podiatry, physiotherapy, occupational therapy and speech pathology).	The service is provided in accordance with the Tasmanian Government's Output Budgeting framework. Services are funded through identified outputs within the DHHS budget.	Performance Information is collected and reported at the state level through Budget Papers and Annual Report. As required performance reporting is provided nationally through National Minimum Data Sets, Report On Government Services, Tasmania Together, Australian Institute of Health and Welfare, Australian Health Care Agreement, Public Health Outcome Funding Agreement and Australian Council of Healthcare Standards.

Source : Tasmanian Government (unpublished).

Table 10A.48 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Acute Support Program	Allied health and mutlidisciplinary diabetes services across both the acute and community based settings. Within the acute setting, inpatient services and specialist outpatient services are provided for Canberra and the surrounding region. Provision of assessment, treatment and discharge planning services. Provision of the Victim Services Scheme (VSS) for victims of crime.	Through a designated budget, including VSS services provided on a contracted basis for the Dept of Justice and Community Services.	Monthly/Annual reports against output targets and budget.
Child, youth and women's health services	Covering post-natal parenting support and information service and child health checks. Early childhood immunisation, mass school immunisation and health screening programs. Provision of child at risk medical and forensic assessment, counselling and education. Womens health cervical screening services, counselling for women affected by violence, and nursing, counselling, and GP services for marginalised young people.	Through a designated budget.	Reporting is quantitative and concentrated around occasions of service and client numbers

Source : ACT Government (unpublished).

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Remote Health	Primary health care (PHC) services are delivered to the remote population of the Northern Territory through a network of 54 Remote Health Centres. Core PHC services include 24-hour emergency services, primary clinical care, population health programs, access to retrieval services, medical and allied health specialist services, provision of essential medications.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Urban Community Health Services	Urban Community Health Services provides a range of primary health care, palliative care, health promotion, community nursing, home birthing, early childhood, school entry screening services to all residents of major NT centres, including Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs. Services are provided from Community Health Centres, but are also provided in school settings and clients' homes.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
School Health Services	School Health Services is an education focused health service including nursing, counselling, promotion and assistance with immunisation programs.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Hearing Services	Hearing services are provided across the NT including diagnostic audiological and audiometric services.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Maternal/Child/Youth Health Services	Child health services such as growth promotion and monitoring, vaccination, general child health advice and support are provided by registered nurses in town-based community care centres and by nurses and Aboriginal health workers in remote community health centres. Remote health staff are supported by visiting child health nurses Aboriginal health workers and district medical officers and some communities have a resident community child health worker. Antenatal care is available in all remote health centres and enhanced by the Strong Women, Strong Babies, Strong Culture Program. In 2005 four Outreach midwives were recruited to boost pregnancy care in remote communities. Their role includes staff training and support and clinical services.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Well Women's Cancer Screening	Well Women's Cancer Screening incorporates BreastScreen NT and Cervical Cancer screening.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Women's Health Strategy Unit	Women's Health Strategy Unit develops strategic directions in partnership with community stakeholders. Specific focus in the past year included domestic violence screening tools, drink spiking education, maternal health services development and female genital mutilation.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Oral Health Services	Oral Health Services provides oral health promotion, screening and treatment to all children up to school-leaving age. Services to eligible adults are provided from remote community health centres and town-based clinics.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Preventable Chronic Disease Services	Preventable Chronic Disease Services provides policy and professional advice and support to health professionals in both government and non-government services across the NT. This involves providing direction about early detection and management of chronic diseases, including the development of clinical guidelines, health systems, registers and recall systems, and quality improvement processes. The program also provides direction and support for primary prevention and health promotion.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Public Health Nutrition and Physical Activity services	Public health nutritionists provide training and support to primary health care teams to assist in the promotion of good nutrition to the community and in management of people with nutrition related conditions. In the urban areas they offer individual and group consultations through community care centres. They also work with people outside the health sector to promote improved nutrition and better food supply, for example remote community stores.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Health Promotion Strategy Unit	Health Promotion Strategy Unit is leading the development of a structured systems approach to improving the design, delivery and evaluation of health promotion interventions with the aim of enhancing the effectiveness of health promotion and prevention strategies. This includes the development of a health promotion audit tool to capture evidence of the delivery and quality of community based health promotion interventions.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	CDC Darwin provides rabies vaccine for pre-exposure prophylaxis to Australian Bat Lyssavirus to persons at risk due to occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered Darwin and regional centres. Education programs are provided to the community and to occupational groups.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Sexual Health and Blood Borne Viruses Program	The Sexual Health and Blood Borne Viruses Program provides five sexual health clinics, known as Clinic 34, in the NT. The service is free and confidential, offering testing and treatment for blood borne viruses and sexually tansmitted infections. The program operates in urban, rural and remote areas offering screening, education and prevention strategies. It funds community based organisations such as the NT AIDS/Hepatitis Council, and Needle and Syringe programs offering harm reduction strategies, community and peer support and education.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.
TB Control Unit	The TB Control Unit covers screening of high risk groups (contacts, refugees, prisoners, health workers, fisherpersons); monitoring and administration of directly observed treatment for active TB and leprosy; remote community visits to implement preventive and early diagnostic strategies (treatment of latent TB infection, community screening); and provision of information to the public, service providers and governments.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Table 10A.49 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2005-06

Program	*Description*	*How the programs were dealt with in a budgetary context*	*Reporting associated with the programs*
Rheumatic Heart Disease	The Rheumatic Heart Disease Program identifies, monitors (including a recall program) and treats clients with Acute Rheumatic Fever and Rheumatic Heart Disease throughout the NT.	These services are funded through an identified program within the NT Department of Health and Community Services budget.	Performance targets against key functions of Community Health and Public Health Services. Financial reports are published in Department of Health and Community Services Annual Report.

Source : NT Government (unpublished).