11 Primary and community health

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Primary and community health services include general practice, allied health services, dentistry, alcohol and other drug treatment, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services. Reporting in this chapter focuses mainly on general practice, primary healthcare services targeted to Indigenous Australians, public dental services, drug and alcohol treatment and the PBS. The scope of this chapter does not extend to:

- public hospital emergency departments and outpatient services (reported in chapter 10, 'Public hospitals')
- community mental health services (reported in chapter 12, 'Mental health management')
- Home and Community Care program services (reported in chapter 13, 'Aged care' and chapter 14, 'Services for people with disability').

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in preventative healthcare and in the detection and management of illness and injury, through direct service provision and through referral to acute (hospital) or other healthcare services, as appropriate.

Major improvements in reporting on primary and community health in this edition include:

- PBS expenditure on medicines supplied under s.100 of the *National Health Act 1953* [Cwlth] to remote Aboriginal Medical Services are reported for the first time
- government expenditure on dental services by state and territory are reported for the first time
- reporting on episodes of treatment for alcohol and other drugs
- Australian Goverment expenditure on Indigenous primary healthcare services is reported for the first time
- data for the availability of public dental hygienists are reported for the first time, alongside existing reporting for public dentists and dental therapists
- an updated Australian geographical location classification system for reporting Department of Human Services (DHS) — Medicare data is used, improving reporting for the following measures
  - PBS expenditure per person by region
  - availability of general practitioners (GPs) by region
  - GP bulk billing rates by region
  - GPs with vocational registration by region
  - proportion of practices registered for the Practice Incentives Program (PIP) using electronic health systems by region
- age-standardised data are reported for the first time for the indicators 'use of pathology tests and diagnostic imaging' and 'cost to government of general practice per person'
- data are available for all people for the measure number of filled prescriptions by GPs for selected antibiotics (previously concession card holders only)
- data for the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent are reported for the first time
- extending time series for reporting on some indicators

- data quality information (DQI) available for the first time for the indicators 'availability of PBS medicines' and 'notifications of selected childhood diseases', as well as for additional measures under the 'child immunisation coverage' indicator.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by governments include general practice, community health services, the PBS and public dental services. The Australian Government also provides some funding through DHS Medicare for private dental and allied health services — for the general community, through the private health rebate, and for people with specific conditions or needs (for example, long-term health conditions and/or mental health problems). Funding of private dental services for people with long-term health conditions through DHS Medicare ceased 1 December 2012.

The Australian Government also funds a national network of 61 Medicare Locals, established under the National Health Reform agenda. These independent primary health care organisations have responsibility to coordinate primary health care delivery and address health care needs and service gaps within their boundaries. Established progressively from 1 July 2011, all 61 Medicare Locals have been operating across the country since 1 July 2012 with the support of a national body, the Australian Medicare Local Alliance. Medicare Locals evolved from the Divisions of General Practice Program (DGPP) which, over a 20 year period, aimed to support networks of general practices within defined geographical boundaries to improve health service delivery and respond to health service challenges at the local level.

Definitions for common health terms are provided in section 11.5.

General practice

General practice is a major provider of primary healthcare in Australia. It is defined by the Royal Australian College of General Practitioners (RACGP) as providing 'person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities' (RACGP 2011). General

practice is the business structure within which one or more general practitioners (GPs) and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by GPs or corporate entities.

General practitioners must be registered with the Medical Board of Australia. General practice data reported in this chapter relate mainly to services provided by those general practitioners who are recognised for Medicare as defined below:

- vocationally registered GPs — GPs who are recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent, or hold a recognised training placement
- other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.

Services provided in general practice include:

- diagnosis and treatment of illness (both chronic and acute) and injury
- preventative care through to palliative care
- referrals to consultants, allied health professionals, community health services and hospitals.

The Australian Government provides the majority of general practice income through DHS Medicare, including fee-for-service payments via the Medicare Benefits Schedule (MBS) and other payments. Through its funding role, the Australian Government seeks to influence the supply, regional distribution and quality of general practice services. State and Territory governments also provide some funding to influence general practice services, particularly regional distribution, within jurisdictions.

While the majority of GPs provide services as part of a general practice, some are employed by hospitals, community health services or other organisations.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (Department of Health 2010). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2013 was $5.90 for concession card holders and up to $36.10 for general consumers (Department of Health 2013a). The Australian Government pays the remaining cost of medicines eligible for the subsidy.

Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year (Department of Health 2013a).

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2013 safety net threshold was $1390.60 for general consumers and $354.00 for concession card holders (Department of Health 2013a).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the Department of Veterans' Affairs (DVA). Drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

Community health services

Community health services usually comprise multidisciplinary teams of salaried health and allied health professionals, who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). The services may be provided directly by governments (including local governments) or indirectly, through a local health service or community organisation funded by government. State and Territory governments are responsible for most community health services. The Australian Government's main role in the community health services covered in this chapter is in health services for Indigenous Australians. In addition, the Australian Government provides targeted support to improve access to community health services in rural and remote areas. There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private allied health services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with particular needs — for example, people with chronic conditions and complex care needs — and improves access to allied health services in rural and remote areas.

Dental services

State and Territory governments and the Australian Government have different roles in supporting dental services in Australia's mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for the delivery of major public dental programs, primarily directed at children and disadvantaged adults. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

The Australian Government supports the provision of dental services primarily through the private health insurance rebate and, through DHS Medicare, for a limited range of oral surgical procedures. Private dental services were also funded through DHS Medicare for people with chronic conditions and complex care needs until 1 December 2012. The Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force and has a role in the provision of dental services through Indigenous Primary Health Care Services.

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through DHS Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual *Bettering the Evaluation and Care of Health* (BEACH) survey of general practice activity in Australia found that 95.8 per cent of all general practice encounters in 2012-13 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2013) (table 11.1).

Table 11.1 **General practice encounters and funding sources, April 2012 to March 2013[a, b]**

	Number[c]	*Per cent of all encounters*[d]	*95% LCL*	*95% UCL*
Total encounters for which BEACH data were recorded[e]	90 077	100	..	..
Direct encounters	88 568	98.3	98.1	98.6
No charge	334	0.4	0.3	0.4
DHS Medicare or DVA paid	85 870	95.3	94.9	95.8
Workers compensation paid	1580	1.8	1.6	1.9
Other paid (for example, hospital, State)	785	0.9	0.6	1.2
Indirect encounters[f]	1506	1.7	1.4	1.9

LCL = lower confidence limit. UCL = upper confidence limit. DVA = Department of Veterans' Affairs. [a] An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals). [b] Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. [c] Number of encounters after post stratification weighting for GP activity and GP age and sex. [d] Missing data removed from analysis (*n* = 8487). [e] Includes 2 encounters for which direct/indirect was not specified. [f] For indirect encounters, the patient is not seen but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al*. (2013) *General practice activity in Australia 2012-13*, Sydney University; table 11A.1.

The Australian Government also provides funding for general practice services under initiatives such as the PIP, the General Practice Immunisation Incentives Scheme (GPII) (effective to 30 June 2013) and Medicare Locals.

Australian Government total expenditure on general practice in 2012-13 was $7.4 billion (table 11A.2). This includes fee-for-service expenditure ($6.8 billion, or 92 per cent of the total expenditure) through DHS Medicare and the Department of Veteran's Affairs (DVA), as well as expenditure on the PIP, GPII and Medicare Locals ($0.6 billion, or 8 per cent of the total expenditure).

Age standardisation can be applied to fee-for-service expenditure on general practice to adjust for the effect of variations in age profiles on rates (see chapter 2 for details). The age-standardised expenditure on general practice per person was $286 in 2012-13.

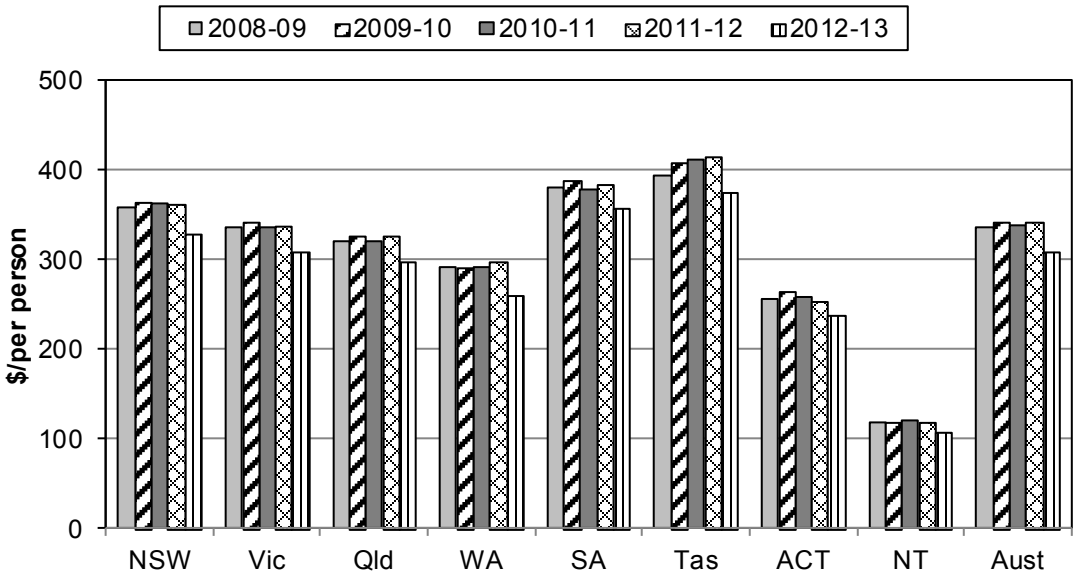
Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas, for example, in hospital emergency departments, Indigenous primary healthcare and other community health services and the Royal Flying Doctor Service. Thus, expenditure on general practice understates expenditure on primary healthcare, particularly in jurisdictions with large populations of Indigenous Australians and people living in rural and remote areas.

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues such as diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $7.5 billion in 2012-13 (tables 11A.4 and 11A.5). Expenditure on the PBS was $7.1 billion — $309 per person — in 2012-13, lower than in the preceding four years in which expenditure was relatively stable, fluctuating between $336 and $342 per person (in 2012-13 dollars) (figure 11.1). Over the same period, the proportion of PBS expenditure that is concessional rose from 77.9 to 78.5 per cent (tables 11A.3 and 11A.5).

Figure 11.1 **PBS expenditure per person (2012-13 dollars)[a, b, c, d, e, f, g]**



[a] Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). [b] Rates are derived using the Australian Bureau of Statistics (ABS) ERP for 31 December 2012 and are not comparable with rates in figure 11.6 that are derived using the 30 June 2012 ERP. [c] State and Territory data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications supplied to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 11A.6]). [d] Includes PBS general ordinary and safety net. [e] Includes PBS concessional ordinary and concessional free safety net. [f] Includes RPBS general ordinary and safety net. [g] Excludes PBS doctor's bag.

Source: Department of Health (unpublished) PBS Statistics; tables 11A.4 and 11A.5.

Community health services

Overall government expenditure data relating only to the primary and community health services covered in this chapter are not available. Expenditure data reported here also cover public health services such as food safety regulation and media campaigns to promote health awareness, as well as private dental services (funded by health insurance premium rebates and non-government expenditure) (table 11.2).

In 2011-12, government expenditure on community and public health was $9.3 billion, of which State, Territory and local governments provided 70.8 per cent, and the Australian Government 29.2 per cent (table 11.2). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the DVA and the Department of Health, was $1.1 billion. State, Territory and local government expenditure on dental services was $718 million in 2011-12. Additional expenditure is incurred by some states and territories through schemes that fund the

provision of dental services to eligible people by private practitioners. Dental expenditure by state and territory is provided in table 11A.7.

Australian Government expenditure on Aboriginal medical services was $531 million in 2012-13 (table 11A.8).

Table 11.2 **Estimated funding on community and public health, and dental services, 2011-12 ($ million)**

	Australian Government				*State, Territory and local government*	*Total government*[c]	*Non-government*	*Total government and non-government*[c]
	DVA	*Department of Health and other*[a]	*Insurance premium rebates*[b]	*Total*[c]				
Community and public health[d]	1	2 624	–	2 625	6 366	8 991	331	9 322
Dental services	104	956	528	1 587	718	2 305	6 031	8 336

[a] 'Other' comprises Australian Government expenditure on the NHA and health-related NPs, capital consumption, estimates of the medical expenses tax offset and health research not funded by Department of Health. [b] Government expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. [c] Totals may not add due to rounding. [d] Includes expenditure on other recurrent health services (not elsewhere classified) in addition to expenditure on community and public health services. – Nil or rounded to zero.

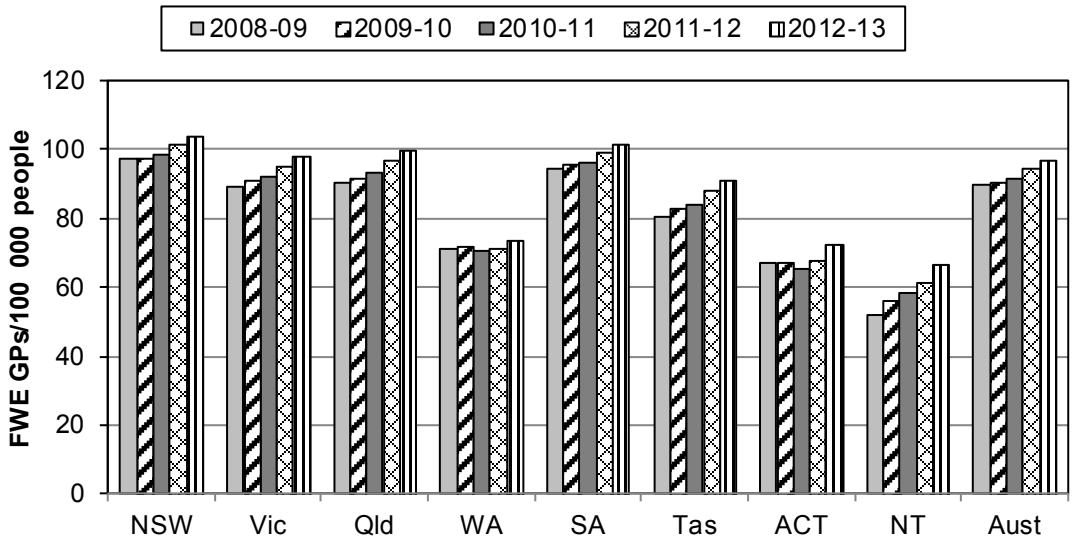
Source: AIHW (2013) *Health Expenditure Australia 2011-12*, Cat. no. HWE 56.

Size and scope

General practice

There were 30 681 vocationally registered GPs and OMPs billing Medicare Australia, based on MBS claims data, in 2012-13. On a full time workload equivalent (FWE) basis, there were 22 087 vocationally registered GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 96.4 FWE registered GPs and OMPs per 100 000 people (table 11A.9). These data exclude services provided by GPs working in Indigenous primary healthcare services, public hospitals and the Royal Flying Doctor Service. In addition, for some GPs — particularly in rural areas — MBS claims provide income for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through DHS Medicare. The numbers of FWE vocationally registered GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.2.

Figure 11.2 **Availability of GPs (full time workload equivalent)[a, b]**

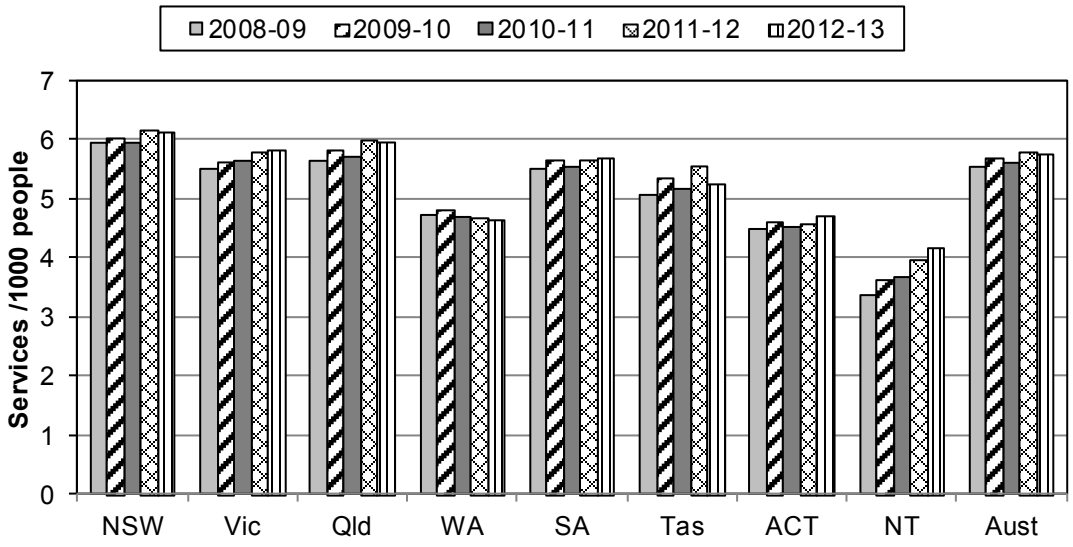


a Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice. **b** The ABS ERPs used to derive rates for 2010-11 and previous years are revised to the ABS' final 2011 Census rebased ERPs and data may differ from previous reports. ERP data used to derive rates from 2011-12 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.2) for details.

Source: Department of Health (unpublished) MBS Statistics; table 11A.9.

Nationally, around 5768 general practitioner-type services were provided per 1000 population under DHS Medicare in 2012-13 (figure 11.3).

Figure 11.3 **GP type service use[a, b]**



a Rates are age standardised to the Australian population at 30 June 2001. Data for 2011-12 have been revised. **b** Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished) ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.10.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Around 197 million services — 87.8 per cent of them concessional — were provided under the PBS in 2012-13 (table 11.3). This amounted to 9.2 filled prescriptions per person. A further 12 million services were provided under the RPBS in the same period.

Table 11.3 **PBS and RPBS services, 2012-13 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	7.8	5.6	4.8	2.7	1.7	0.5	0.5	0.1	23.7
PBS concessional[b]	58.8	44.1	34.1	14.0	15.1	5.0	1.6	0.5	173.3
PBS doctor's bag[c]	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	66.6	49.9	38.9	16.7	16.8	5.5	2.2	0.7	197.3
RPBS total[d]	4.2	2.7	3.0	1.0	0.9	0.4	0.2	–	12.4
Total	70.8	52.5	42.0	17.7	17.8	5.9	2.3	0.7	209.7
PBS services per person[e]	9.6	9.2	9.1	7.2	10.7	11.5	6.2	2.9	9.2

[a] Includes PBS general ordinary and safety net. [b] Includes PBS concessional ordinary and concessional free safety net. [c] Supplies to prescribers for use in a medical emergency. [d] Includes RPBS general ordinary and safety net. [e] Excludes PBS doctor's bag. – Nil or rounded to zero.

Source: Department of Health (unpublished) PBS Statistics; tables 11A.11 and 11A.12.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.105–11A.113 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

- women's health services that provide services and health promotion programs for women across a range of health-related areas
- men's health programs (mainly promotional and educational programs)
- allied health services
- community rehabilitation programs.

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 12 (Mental health management), 13 (Aged care services) and 14 (Services for people with disability).

Maternal and child health

All jurisdictions provide maternal and child health services through their community health programs. These services include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services,

including hearing screening programs, and mothers and babies residential programs. Performance indicators for maternity services in public hospitals are reported in chapter 10 (Public hospitals).

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to preschool and secondary school students (tables 11A.105–11A.113).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2012-13 targeted at disadvantaged people (tables 11A.105–11A.113). As current data are not available for use of public dental services for the 2014 Report, data for 2010 are reported again.

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 11.4).

Table 11.4 **Use of public dental services by service type, per 1000 people, 2010[a, b, c, d]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Emergency services[e]	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4

[a] Rates are age standardised to the Australian population at 30 June 2001. [b] Limited to dentate people aged 5 years or over. [c] Data are for the number of people who used a public dental service at least once in the preceding 12 months, not for the number of services provided. [d] Type of service at the most recent visit. [e] Emergency visit is a visit for relief of pain.

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished), *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.13.

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. Data included here have been sourced from a report

on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) — a collection of data from publicly funded government and non-government treatment services (AIHW 2013a). Treatment activities excluded from that collection include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous Australians that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 659 alcohol and other drug treatment agencies reported 2011-12 data to the AODTS–NMDS. Of these, 317 (48.1 per cent) identified as government providers and 342 (51.9 per cent) as non-government providers (table 11A.14). There were 153 668 reported closed treatment episodes in 2011-12 (table 11A.14) (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.5 per cent of whom were male, accounted for 146 948 closed treatment episodes (table 11A.14) (AIHW 2013a).

Alcohol was the most commonly reported principal drug of concern (45.8 per cent), followed by cannabis (22.0 per cent), amphetamines (11.5 per cent) and heroin (8.8 per cent), in closed treatment episodes for clients seeking treatment for their own substance abuse. Additional drugs of concern were reported in over 80 per cent of the episodes (AIHW 2013a).

Alcohol was the most common principal drug of concern in all states and territories. Cannabis was the second most common principal drug in all states and territories except South Australia, where amphetamines were more common (AIHW 2013a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.105–11A.113.

Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions, planned and governed by local Indigenous communities with the aim of delivering holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2012-13, these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health

services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.105–11A.113).

From the 2008-09 reporting period, data on Indigenous primary healthcare services that receive funding from the Australian Government have been collected through the Online Services Report (OSR) questionnaire. Many of these services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent the health-related activities, episodes and workforce funded from all sources.

For 2011-12, OSR data are reported for 224 Indigenous primary healthcare services (table 11A.15). Of these services, 90 (40.2 per cent) were located in remote or very remote areas (table 11A.16). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.17). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Around 2.6 million episodes of healthcare were provided by participating services in 2011-12 (table 11.5). Of these, around 1.2 million (47.0 per cent) were in remote or very remote areas (table 11A.16).

Table 11.5 **Estimated episodes of healthcare for Indigenous Australians by services for which OSR data are reported ('000)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	452	160	336	306	191	35	23	586	2 089
2009-10	542	185	379	409	192	36	26	622	2 391
2010-11	522	201	310	473	222	38	30	704	2 498
2011-12	516	234	475	462	216	44	34	641	2 621

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

Source: AIHW (2013 and previous issues) *Aboriginal and Torres Strait Islander health services report*: *online services report - key results*, Cat. no.s IHW 31, 56, 79 and 104; table 11A.15.

The services included in the OSR data collection employed around 3469 full time equivalent healthcare staff (as at 30 June 2012). Of these, 1946 were Indigenous Australians (56.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous Australians were relatively low (5.9 per cent and 12.9 per cent, respectively) (table 11A.18).

11.2 Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (box 11.1). The framework will evolve as better indicators are developed and as the focus and objectives for primary and community health change. In particular, the Steering Committee plans to develop and report against more indicators relating to community health services.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, and health indicators in the *National Indigenous Reform Agreement* establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with health performance indicators in the NHA. The NHA was reviewed in 2011, 2012 and 2013 resulting in changes that have been reflected in this Report, as relevant.

Box 11.1 **Objectives for primary and community health**

Primary and community health services aim to support and improve the health of Australians by:

- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals' healthcare needs.

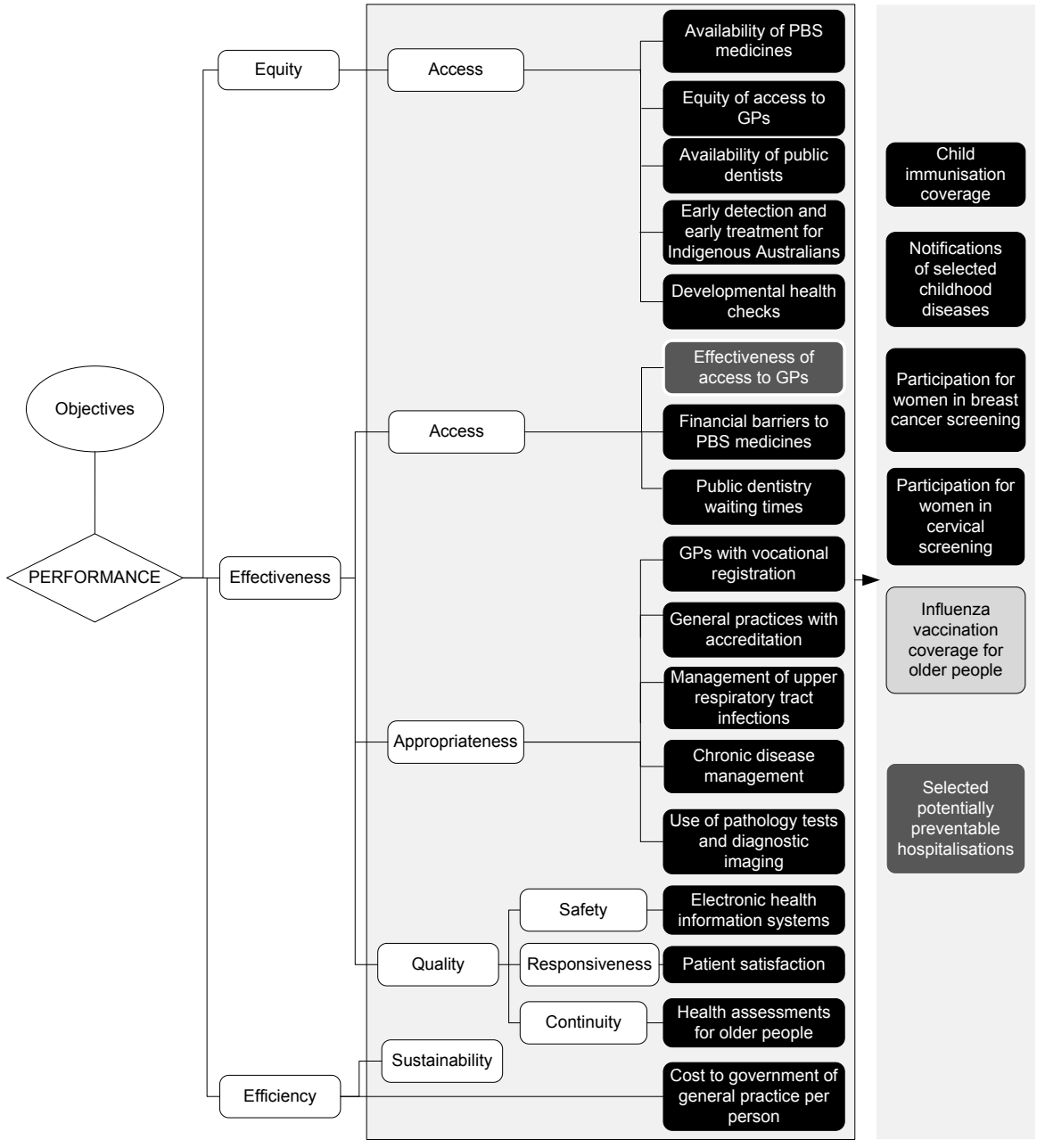
In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 11.4). The performance indicator framework shows which data are comparable in the 2014 Report. For data that are not considered directly

comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6).

The Report's statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (chapter 2).

Figure 11.4 **Primary and community health performance indicator framework**



Key to indicators*

Text Most recent data for all measures are comparable and complete

Text Most recent data for at least one measure are comparable and complete

Text Most recent data for all measures are either not comparable and/or not complete

Text No data reported and/or no measures yet developed

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

Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the Australian Bureau of Statistics (ABS) data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

11.3 Key performance indicator results

Different delivery contexts, locations and client factors may affect the equity, effectiveness and efficiency of primary and community health services.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous Australians relative to other Australians (SCRGSP 2011).

Access

Availability of PBS medicines

'Availability of PBS medicines' is an indicator of governments' objective to provide equitable access to PBS medicines (box 11.2).

Box 11.2 **Availability of PBS medicines**

'Availability of PBS medicines' is defined by three measures:

- people per pharmacy by region, defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions
- PBS expenditure per person by region, defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions
- proportion of PBS prescriptions filled at a concessional rate, defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.

This indicator is difficult to interpret. A low or decreasing number of people per pharmacy may indicate greater availability of PBS medicines. High or increasing PBS expenditure per person may indicate improved availability of PBS medicines. A high or increasing proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people. It is also important that there are not large discrepancies by region in these measures.

Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health and medicines should be available to those who require them, regardless of residential geolocation or socioeconomic circumstance.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2013 data are available for all jurisdictions.

Data quality information for this indicator is under development.

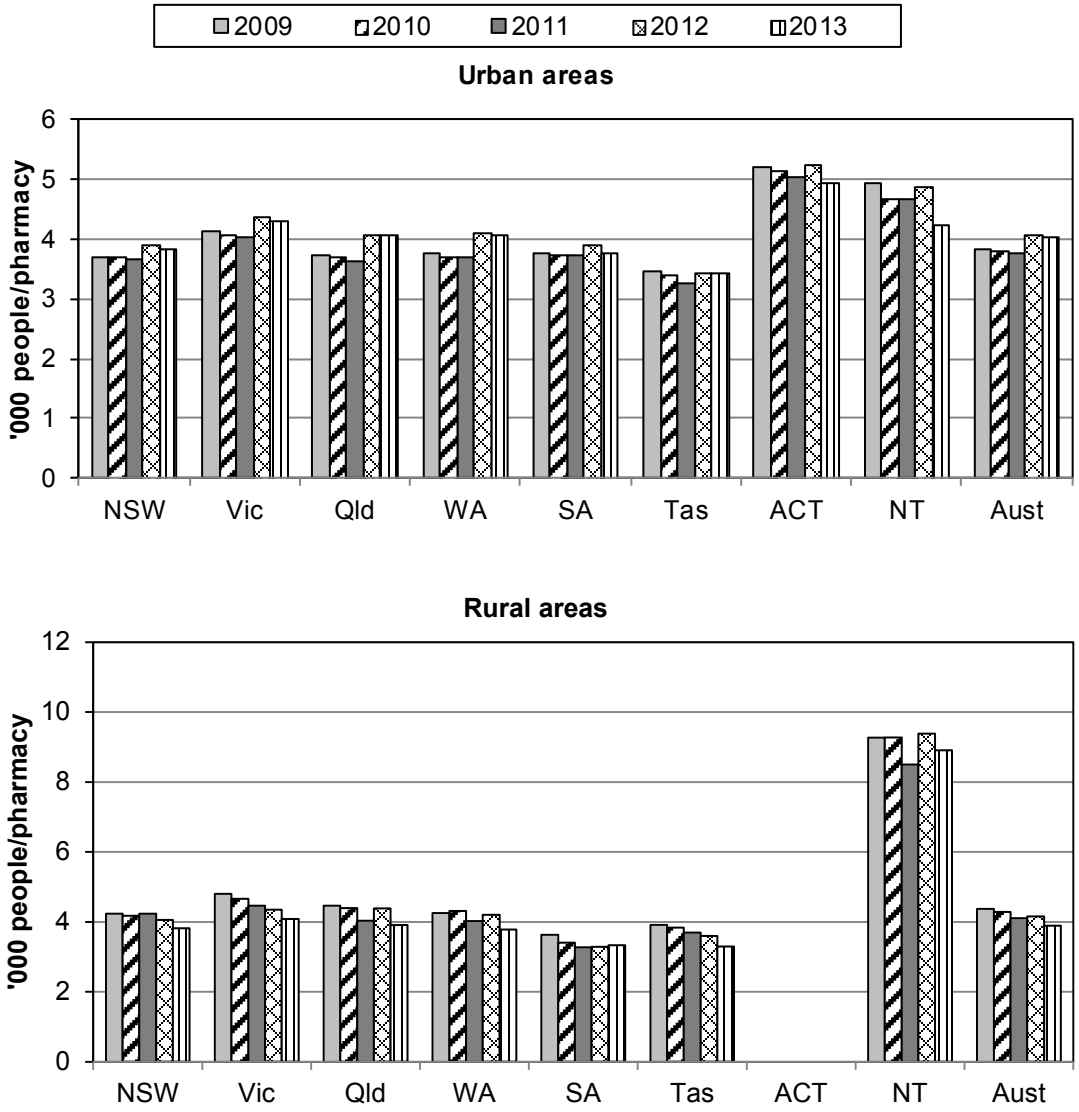
Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 4034 people per pharmacy in urban areas and 3887 people per pharmacy in rural areas at 30 June 2013. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.5, table 11A.19).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 33 medical practitioners and 254 hospitals — 95 private and 159 public[1] — approved to supply PBS medicines to the community at 30 June 2013. The

[1] PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.

approved medical practitioners and 49 of the approved public hospitals were located in rural areas (table 11A.19).

Figure 11.5 **People per pharmacy**[a, b]

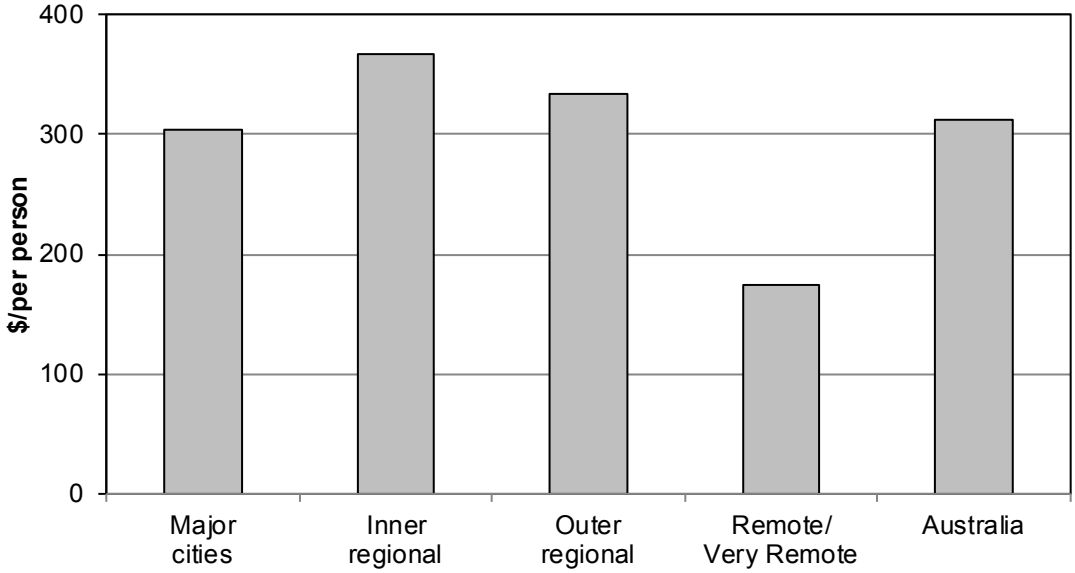


a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. **b** Excludes RPBS and doctor's bag. **c** Care should be taken in using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).

Source: Department of Health (unpublished) derived from DHS Medicare, ABS *2006/2011 Census of Population and Housing* and the University of Adelaide's Australian Population and Migration Research Centre; table 11A.19.

Nationally, PBS expenditure per person was around $312 in 2012-13 (figure 11.6). PBS expenditure per person was highest in inner regional areas and lowest in remote/very remote areas (figure 11.6).

Figure 11.6 **PBS expenditure per person, 2012-13[a, b, c]**



[a] Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. [b] Rates are derived using the ABS ERP for 30 June 2012 and are not comparable with rates in figure 11.1 that are derived using the 31 December 2012 ERP. [c] Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in the Department of Health's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million in 2012-13 [table 11A.6]).

Source: Department of Health (unpublished) PBS Statistics; table 11A.20.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.11. These data are not available by regional location. Nationally, 87.7 per cent of prescriptions subsidised under the PBS were concessional in 2012-13.

Equity of access to GPs

'Equity of access to GPs' is an indicator of governments' objective to provide equitable access to primary healthcare services (box 11.3).

Box 11.3 **Equity of access to GPs**

'Equity of access to GPs' is defined by two measures:

- availability of GPs by region, defined as the number of FWE GPs per 100 000 people, by region
- availability of female GPs, defined as the number of female FWE GPs, per 100 000 females.

High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas.

High or increasing availability of female GPs means it is more likely that female patients who prefer to visit female GPs will have their preference met. Low availability of female GPs can similarly be associated with increased waiting times to see a GP, for women who prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

This indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.

Data reported for this indicator are:

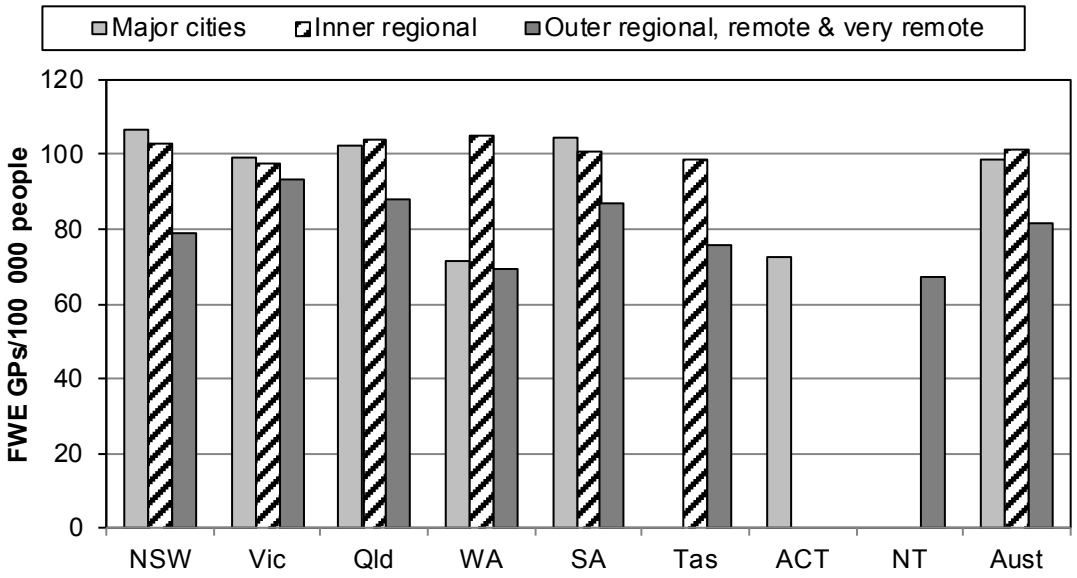
- comparable (subject to caveats) across jurisdictions for 2012-13 but not comparable to data for previous years for the measure availability of GPs by region
- comparable (subject to caveats) across jurisdictions and over time for the measure availability of female GPs
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Equity of access to GPs — availability of GPs by region

In terms of FWE GPs per 100 000 people, there were more GPs available in major cities and inner regional areas than in outer regional, remote and very remote areas in all jurisdictions in 2012-13 (figure 11.7). The bulk billed proportion of non-referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 11A.32).

Figure 11.7 **Availability of GPs (full time workload equivalent), 2012-13[a, b, c]**



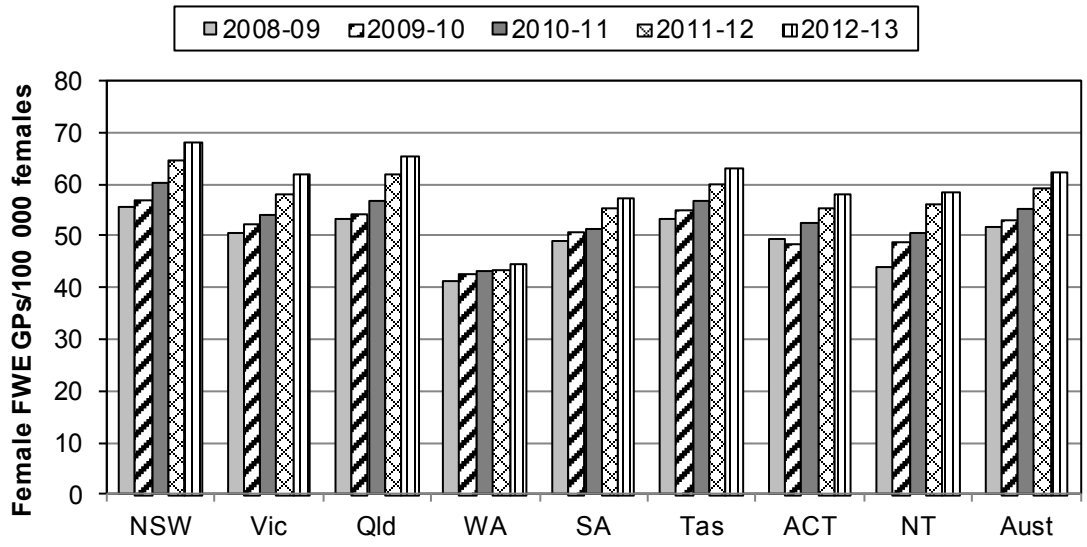
[a] Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification. [b] FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. [c] There are no major cities in Tasmania; no outer regional or remote areas in the ACT; no major cities or inner regional areas in the NT. For the ACT, major cities includes inner regional areas.

Source: Department of Health (unpublished) MBS Statistics; table 11A.22.

Equity of access to GPs — availability of female GPs

In 2012-13, 42.4 per cent of Australia's GPs — 32.5 per cent of FWE GPs — were female (tables 11A.9 and 11A.24). The number of FWE GPs per 100 000 females increased from 51.7 to 62.4 in the period 2008-09 to 2012-13 (figure 11.8).

Figure 11.8 **Availability of female GPs (full time workload equivalent)[a]**



a Data relate to vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.

Source: Department of Health (unpublished) MBS Statistics; table 11A.24.

Availability of public dentists

'Availability of public dentists' is an indicator of governments' objective to provide equitable access to dental services (box 11.4).

Box 11.4 **Availability of public dentists**

'Availability of public dentists' is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region.

High or increasing availability of public dentists can indicate improved access to public dental services. The availability of public dentists by region affects people's access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.

This indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.

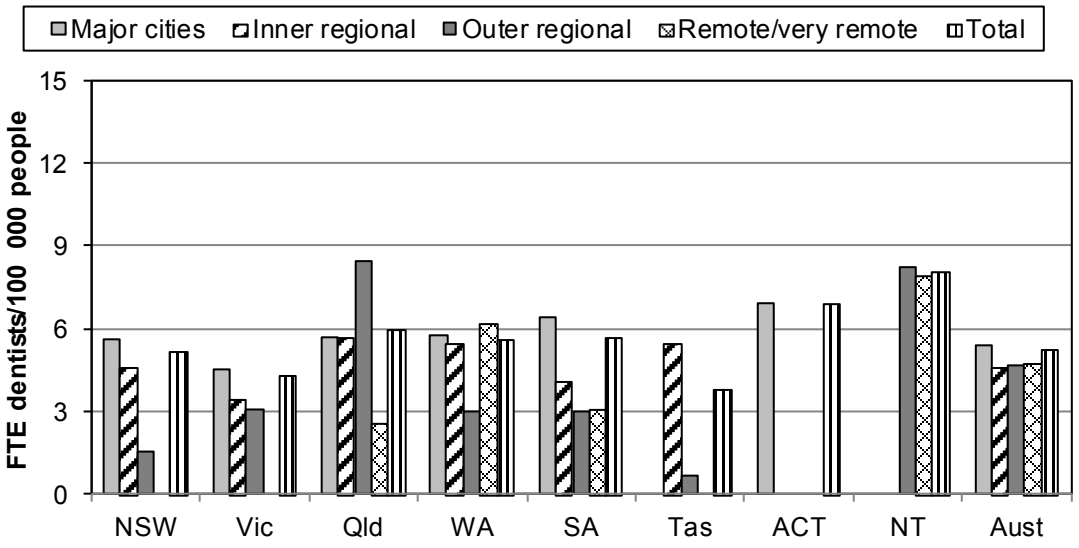
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, there were 5.4 FTE public dentists per 100 000 people in major cities — more than in regional and remote/very remote areas — in 2012 (figure 11.9, table 11A.25). Nationally, the number of FTE public dental therapists per 100 000 people was highest in outer regional areas (5.2), followed by inner regional (4.6) and remote/very remote (4.5) areas and lowest in major cities (2.7) (table 11A.26). Data for FTE dental hygienists and dental therapists are presented in table 11A.26.

Figure 11.9 **Availability of public dentists, 2012**[a, b, c, d]



[a] FTE based on 40 hours per week. [b] Public dentists include those working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. [c] There were no public dentists in remote and very remote areas in NSW, Victoria or Tasmania. There were no public dentists in inner regional areas in the ACT. [d] Tasmania has no major cities. The ACT has no outer regional, or remote and very remote, areas. The NT has no major cities or inner regional areas.

Source: AIHW (unpublished) National Health Workforce Data Set; table 11A.25.

Early detection and early treatment for Indigenous Australians

'Early detection and early treatment for Indigenous Australians' is an indicator of governments' objective to provide equitable access to primary and community healthcare services for Indigenous Australians (box 11.5).

Box 11.5 **Early detection and early treatment for Indigenous Australians**

'Early detection and early treatment for Indigenous Australians' is defined as:

- the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection)
- the provision of appropriate and timely prevention and intervention measures (early treatment).

Four measures of early detection and early treatment for Indigenous Australians are reported:

- the proportion of older people who received a health assessment by Indigenous status, where
  - older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous Australians become eligible for 'older' people's services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector overview)
  - health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing.
- the proportion of older Indigenous Australians who received a health assessment in successive years of a five year period
- the proportion of Indigenous Australians who received a health assessment or check by age group — health assessment/checks are available for Indigenous children (0–14 years), adults (15–54 years) and older people (55 years or over).
- the proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

A low or decreasing gap between the proportion of all older people and older Indigenous Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Indigenous Australians. An increase over time in the proportion of older Indigenous Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Indigenous Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Indigenous population. A high or increasing proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

(Continued next page)

Box 11.5 **(Continued)**

This indicator provides no information about health assessments provided outside DHS Medicare. Such services are provided under service delivery models used, for example, in remote and very remote areas and therefore accessed predominantly by Indigenous Australians. Accordingly, this indicator understates the proportion of Indigenous Australians who received early detection and early treatment services.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions for 2012-13 for the three health assessment measures, and for 2011-12 for the measure primary healthcare services providing early detection services.

Data quality information for this indicator is under development.

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous Australians (AIHW 2008a; SCRGSP 2011). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people's health.

In 2012-13, the proportion of Indigenous older Australians who received an annual health assessment was higher than the proportion of non-Indigenous older Australians who received an annual health assessment in all jurisdictions except Victoria, SA and Tasmania (figure 11.10).

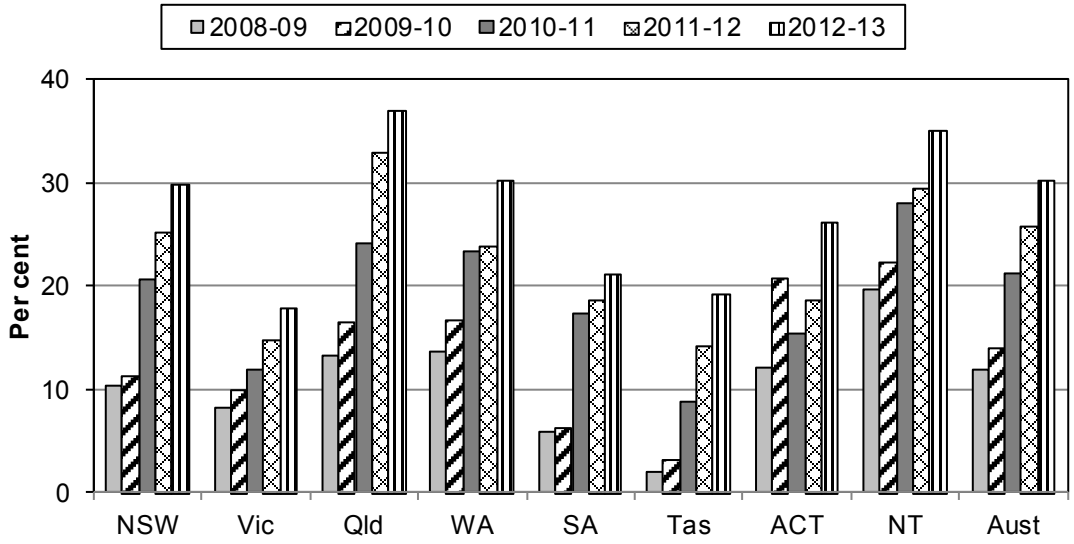
Figure 11.10 **Older people who received an annual health assessment by Indigenous status, 2012-13**[a, b, c, d]

[a] Older people are defined as Indigenous Australians aged 55 years or over and non-Indigenous Australians aged 75 years or over. [b] Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous Australians. [c] Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments. [d] The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census.

Source: Derived from Department of Health (unpublished) MBS Statistics, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (2011) *Australian demographic statistics June quarter 2011*, Cat. no. 3101.0; table 11A.27.

The proportion of older Indigenous Australians who received an annual health assessment increased in all jurisdictions between 2008-09 and 2012-13 (figure 11.11).

Figure 11.11 **Older Indigenous Australians who received an annual health assessment[a, b]**



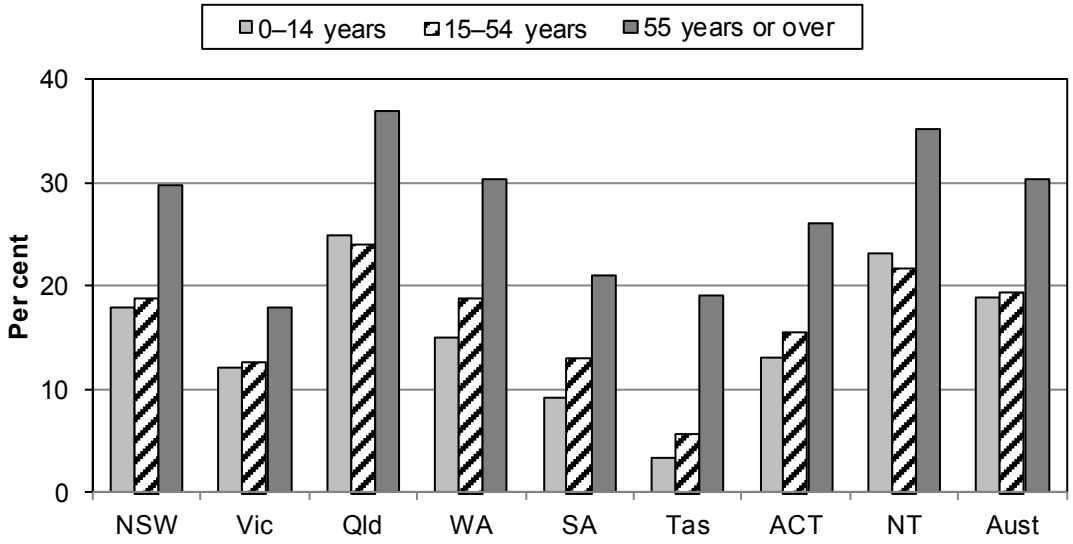
[a] Older people are defined as Indigenous Australians aged 55 years or over. Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians. [b] Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data are therefore likely to understate the proportion who access health assessments.

Source: Derived from Department of Health (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.28.

Health check MBS items were introduced for Indigenous Australians aged 15–54 years in May 2004. Initially available biennially, since 1 May 2010 they have been available annually. Also available annually are health checks for Indigenous children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Indigenous population who received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.12). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

Figure 11.12 **Indigenous Australians who received a health assessment by age, 2012-13[a, b]**

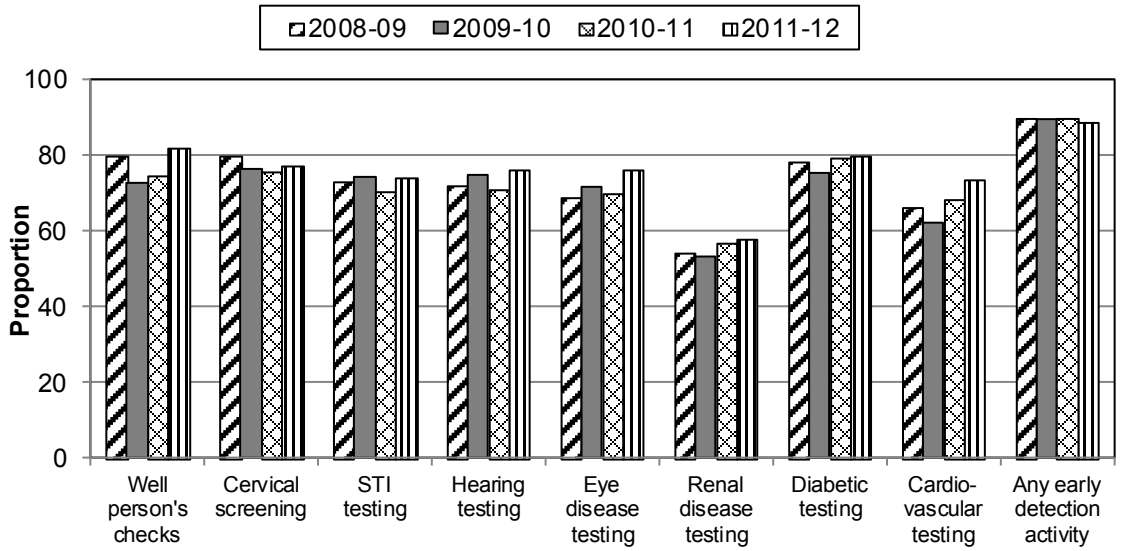


a Indigenous status is determined by self-identification. Indigenous Australians aged 75 years or over may receive the mainstream MBS Health Assessment for people aged 75 years or over. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous Australians. **b** Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data are therefore likely to understate the proportion who access health assessments.

Source: Derived from Department of Health (unpublished) MBS Statistics and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.29.

Nationally, the proportion of Indigenous primary healthcare services providing early detection services varied little in the period 2008-09 to 2011-12 (figure 11.13).

Figure 11.13 **Indigenous primary healthcare services for which OSR data are reported that provided early detection services[a]**



a The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from the 2008-09 reporting period. Historical SAR data are published in previous reports.

Source: AIHW (2012 and previous issues) *Aboriginal and Torres Strait Islander health services report: online services report - key results, 2008-09, 2009-10 and 2010-11*, Cat. no.s IHW 31, 56 and 79; table 11A.30.

Developmental health checks

'Developmental health checks' is an indicator of governments' objective to provide equitable access to early detection and intervention services for children (box 11.6).

Box 11.6 **Developmental health checks**

'Developmental health checks' is defined as the proportion of children who received a fourth year developmental health assessment under DHS Medicare, by health assessment type. The 'Healthy Kids Check' MBS health assessment item is available to children aged 3 or 4 years, while the 'Aboriginal and Torres Strait Islander Peoples Health Assessment' item is available to Indigenous Australians.

A high or increasing proportion of children receiving a fourth year developmental health assessment is desirable as it suggests improved access to these services.

The proportion of Indigenous children aged 3 to 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is reported as a proxy for the proportion of Indigenous children who received a fourth year developmental health assessment. The proportion of non-Indigenous children who received a Healthy Kids Check or, for those who did not receive a Healthy Kids Check, received a Health assessment at the age of 5 years, is reported as a proxy for the proportion of non-Indigenous children who received a fourth year developmental health assessment.

Fourth year developmental health assessment are intended to assess children's physical health, general wellbeing and development. They enable identification of children who are at high risk for or, have early signs of, delayed development and/or illness. Early identification provides the opportunity for timely prevention and intervention measures that can ensure that children are healthy, fit and ready to learn when they start schooling.

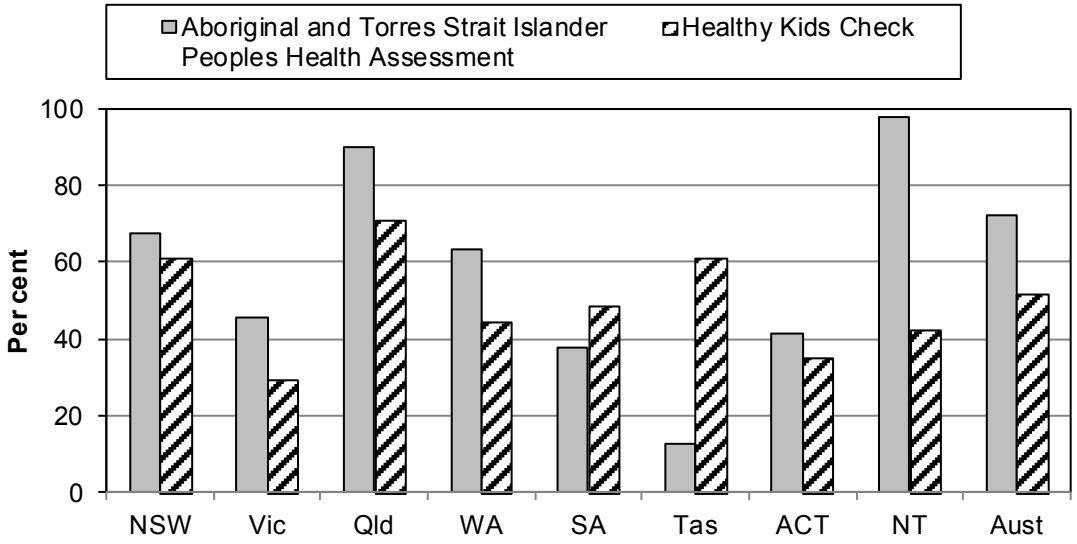
This indicator provides no information about developmental health checks for children that are provided outside DHS Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community health centres, early childhood settings and the school education sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2012-13 are not comparable to historical data
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, 52.8 per cent of children received a fourth year developmental health check under DHS Medicare in 2012-13. The proportion of Indigenous children who received an Aboriginal and Torres Strait Islander Peoples Health Assessment in their fourth year was higher than the proportion of children who received a Healthy Kids Check in most jurisdictions (figure 11.14).

Figure 11.14 **Children who received a fourth year developmental health check, by health check type, 2012-13[a, b, c, d, e, f]**



[a] Limited to health checks available under DHS Medicare. [b] Aboriginal and Torres Strait Islander Peoples Health Assessment data include claims for MBS Item 715 for children aged 3–5 years. [c] Healthy Kids Check data include claims for MBS Items 701, 703, 705, 707 and 10 986 for children aged 3–5 years. [d] Children are counted once only; where a child received both types of health check during the reference period they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. [e] Healthy Kids Check data include Indigenous children who received a Healthy Kids Check provided they did not also receive a Aboriginal and Torres Strait Islander Peoples Health Assessment during the same or a previous reference period. [f] The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census.

Source: Department of Health (unpublished) MBS Statistics; ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.31.

Effectiveness

Access

Effectiveness of access to GPs

'Effectiveness of access to GPs' is an indicator of governments' objective to provide effective access to primary healthcare services (box 11.7). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

Box 11.7 **Effectiveness of access to GPs**

'Effectiveness of access to GPs' is defined by four measures:

- bulk billing rates, defined as the number of GP visits that were bulk billed as a proportion of all GP visits
- people deferring visits to GPs due to financial barriers, defined as the proportion of people who delayed seeing or did not see a GP due to cost
- GP waiting times, defined as the number of people who saw a GP for urgent medical care within specified waiting time categories in the previous 12 months, divided by the number of people who saw a GP for urgent medical care in the previous 12 months. Specified waiting time categories are:
  - less than 4 hours
  - 4 to less than 24 hours
  - 24 hours or more
- potentially avoidable presentations to emergency departments — two measures, defined as:
  - the proportion of people who visited a hospital emergency department for care they thought at the time could have been provided by a GP
  - the number of selected 'GP-type presentations' to emergency departments, where selected GP-type presentations are those:
    - allocated to triage category 4 or 5
    - not arriving by ambulance, with police or corrections
    - not admitted or referred to another hospital
    - who did not die.

A high or increasing proportion of bulk billed attendances can indicate more affordable access to GP services. GP visits that are bulk billed do not require patients to pay part of the cost of the visit, while GP visits that are not bulk billed do. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs.

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions but not comparable over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

(Continued next page)

Box 11.7 **(Continued)**

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

Data reported for this measure are:

- comparable (subject to caveats) across jurisdictions and comparable over time for 2011-12 and 2012-13 but not for previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

A low or decreasing proportion of potentially avoidable presentations to emergency departments can indicate better access to primary and community health care.

Data reported for this measure are:

- comparable (subject to caveats) within some jurisdictions over time but are not comparable within other jurisdictions over time or across jurisdictions (see caveats in attachment tables for specific jurisdictions)
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

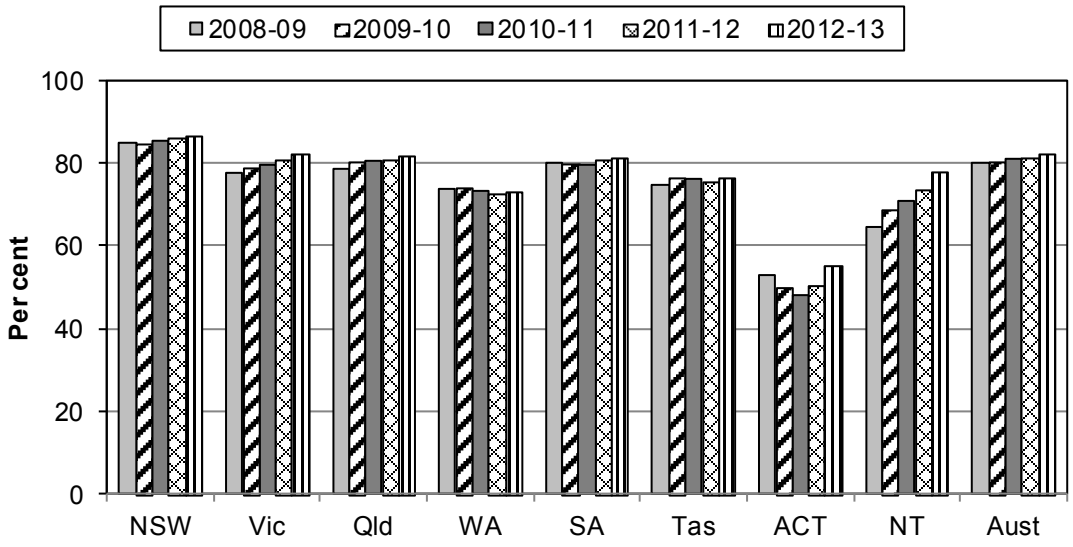
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Effectiveness of access to GPs — bulk billing rates

Patient visits to GPs are either bulk billed, or the patient is required to pay part of the cost of the visit. GP visits are classed as non-referred attendances under DHS Medicare. Where a patient is bulk billed they make no out-of-pocket contribution; the GP bills DHS Medicare directly and, since 1 January 2005, receives 100 per cent of the Schedule fee (the patient rebate) as full payment for the service. The 100 per cent DHS Medicare rebate applies to most GP services.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 82.3 per cent in 2012-13. For most jurisdictions, this proportion increased in the period 2008-09 to 2012-13 (figure 11.15). The bulk billed proportion of non-referred attendances was higher in very remote areas than in major cities, where the proportion was in turn higher than in inner regional, outer regional and remote areas (table 11A.32). The bulk billed proportion of non-referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 11A.34).

Figure 11.15 **GP visits that were bulk billed[a, b]**



a Includes attendances by practice nurses. **b** Allocation to State/Territory based on patients' DHS Medicare enrolment postcode.

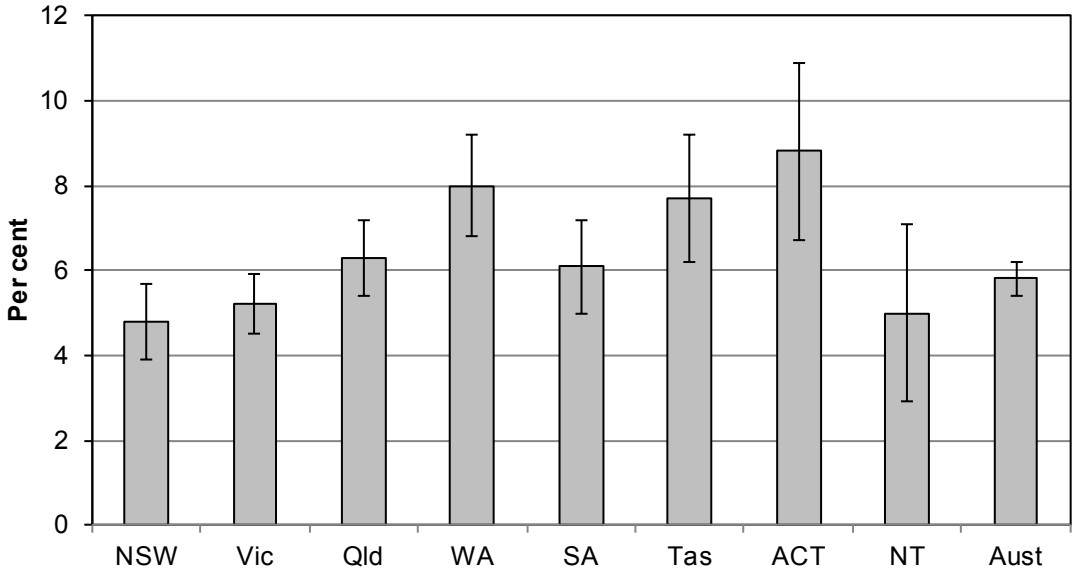
Source: Department of Health (unpublished) MBS Statistics; table 11A.34.

Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Timely access to healthcare services is important to people's health and wellbeing. Deferring or not visiting a GP can result in poorer health. Nationally, in 2012-13, 5.8 per cent of ABS Patient experience survey respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 11.16).

Data for Indigenous Australians deferring access to GPs due to cost, available for the first time from the ABS 2011-12 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS), are presented in table 11A.36. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 11.16 **People deferring visits to GPs due to cost, 2012-13**[a, b, c, d, e, f]



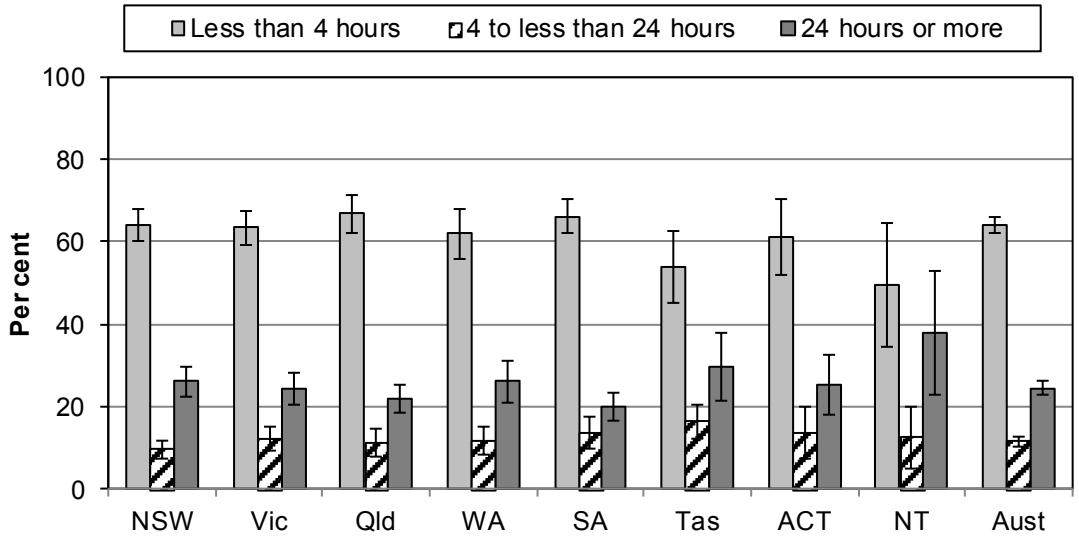
[a] People aged 15 years or over. [b] Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. [c] Rates are age standardised to the Australian population at 30 June 2001. [d] Data are not comparable to data for previous years due to a change in survey question wording and sequencing. [e] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions. [f] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; table 11A.35.

Effectiveness of access to GPs — GP waiting times

Nationally, 64.1 per cent of people who saw a GP for urgent care waited less than 4 hours in 2012-13 (figure 11.17). Around 11.4 per cent waited from 4 to less than 24 hours, and 24.6 per cent waited for 24 hours or more. Overall, 20.9 per cent of people who saw a GP for any reason waited longer than they felt was acceptable to get an appointment (table 11A.38).

Figure 11.17 **Hours waited for urgent treatment by a GP, 2012-13**[a, b, c, d, e, f]



[a] People aged 15 years or over who saw a GP for urgent medical care for their own health in the previous 12 months. [b] Time waited between making an appointment and seeing the GP for urgent medical care. [c] Data are comparable with data for 2011-12 but not with data for previous years due to a changed survey question. [d] Rates are age standardised to the Australian population at 30 June 2001. [e] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions. [f] Error bars represent the 95 per cent confidence interval associated with each point estimate.

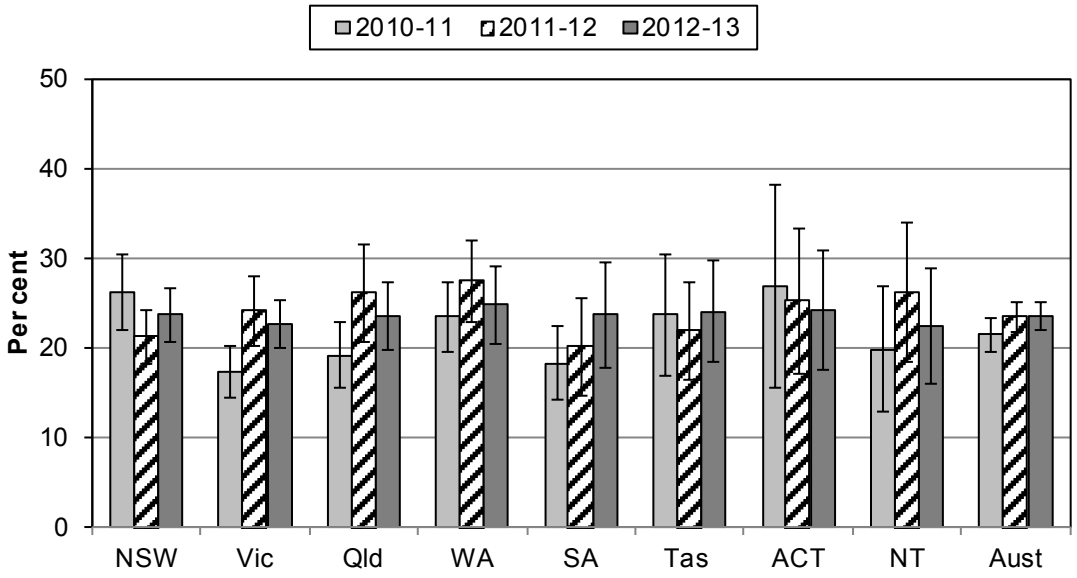
Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; table 11A.37.

Effectiveness of access to GPs — GP-type presentations to emergency departments

GP-type presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). One of several factors contributing to GP-type presentations at emergency departments is perceived or actual lack of access to GP services. Other factors include proximity of emergency departments and trust for emergency department staff.

Nationally, 23.6 per cent of people who went to a hospital emergency department for their own health thought at the time that care could have been provided at a general practice (figure 11.18).

Figure 11.18 **People visiting a hospital emergency department for care they thought could have been provided at a general practice[a, b, c, d]**



a Proportion of people aged 15 years or over who went to a hospital emergency department for their own health and at the time, thought the care could have been provided at a general practice. **b** Rates are age-standardised to the 2001 Australian standard population. **c** Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. **d** Data for 2011-12 and 2012-13 include very remote areas but not discrete Indigenous communities, which will affect the NT more than other jurisdictions.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13*, Cat. no. 4839.0; table 11A.40.

Nationally, there were around 2.2 million GP-type presentations to public hospital emergency departments in 2012-13 (table 11.6).

Table 11.6 **GP-type presentations to emergency departments, ('000)[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2012-13	682.3	574.5	383.8	282.1	105.9	61.6	46.6	39.8	2 176.6

a GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of semi-urgent or non-urgent, and where the episode end status was not admitted to the hospital, or referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. **b** Data are presented by State/Territory of usual residence of the patient. **c** Data are for peer group A and B public hospitals only.

Source: AIHW (unpublished) National non-admitted emergency patient database; table 11A.39.

Financial barriers to PBS medicines

'Financial barriers to PBS medicines' is an indicator of governments' objective to ensure effective access to prescribed medicines (box 11.8).

Box 11.8 **Financial barriers to PBS medicines**

'Financial barriers to PBS medicines' is defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.

A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.

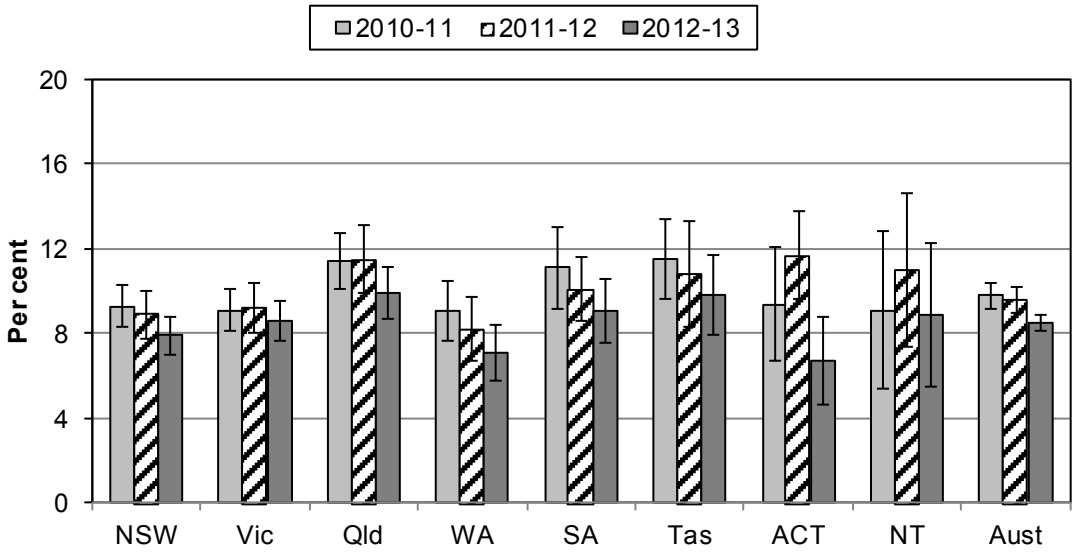
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, in 2012-13, 8.5 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 11.19). National data by remoteness are reported in table 11A.44. Data for Indigenous Australians are available for the first time from the ABS 2011-12 AATSIHS and are presented in table 11A.42. However, differences in survey design and methodology mean data from the Patient experience survey and the AATSIHS are not comparable.

Figure 11.19 **People deferring purchase of prescribed medicines due to cost**[a, b, c, d, e]



[a] People 15 years or over who, in the last 12 months, were prescribed medication and delayed getting or did not get the medication due to cost. [b] Rates are age standardised to the Australian population at 30 June 2001. [c] Data for 2010-11 for the NT should be used with care as the survey excluded very remote areas where around 23 per cent of the NT population usually reside. [d] Data for 2011-12 and 2012-13 include very remote areas but not discrete Indigenous communities, which will affect the NT more than other jurisdictions. [e] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey, 2010-11, 2011-12*, *2012-13*, Cat. no. 4839.0; table 11A.41.

Public dentistry waiting times

'Public dentistry waiting times' is an indicator of governments' objective to ensure timely access to public dental services for eligible people (box 11.9).

Box 11.9 **Public dentistry waiting times**

'Public dentistry waiting times' is defined as the time waited between being placed on a public dentistry waiting list and being seen by a dental professional. It is measured as the proportion of people on a public dental waiting list who saw a dental professional at a government dental clinic, within specified waiting time categories.

A high or increasing proportion of people waiting shorter periods to see a dental professional indicates more timely access to public dental services.

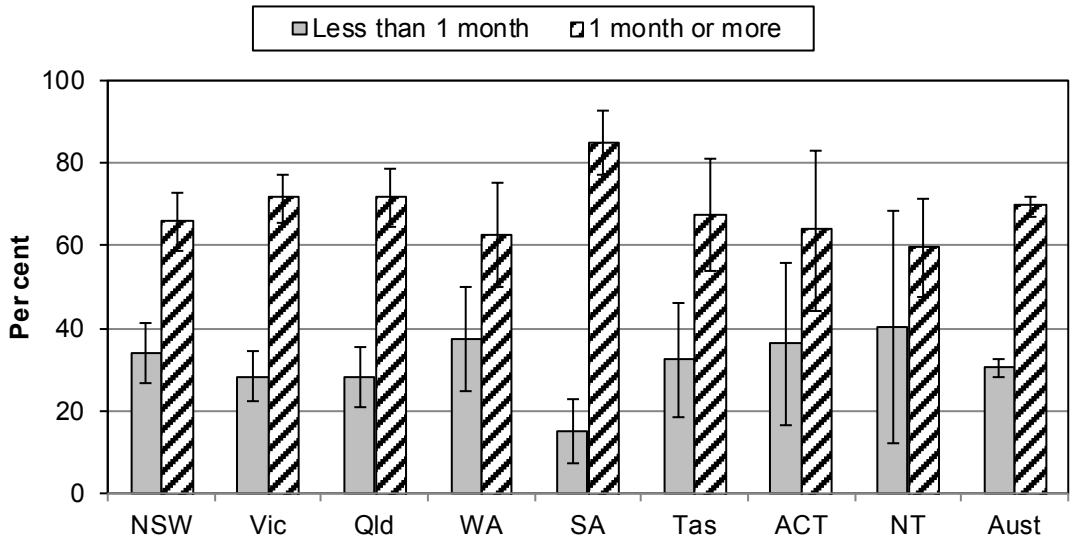
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but not over time. Data for 2012-13 are not comparable with data for 2011-12 and previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, 30.5 per cent of people who were on a public dental waiting list for waited less than 1 month to see a dental professional at a government dental clinic in 2012-13 (figure 11.20). Data are presented by remoteness in table 11A.44. Data for Indigenous Australians that are reported in table 11A.45 are not comparable to data for all Australians (see DQI for details).

Figure 11.20 **Time waited for public dentistry services, 2012-13**[a, b, c, d]



[a] Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months. Excludes treatment for urgent dental care. [b] Rates are age standardised to the Australian population at 30 June 2001. [c] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*; table 11A.43.

Appropriateness

GPs with vocational registration

'GPs with vocational registration' is an indicator of governments' objective to ensure the GP workforce has the capability to deliver high quality services (box 11.10).

Box 11.10 **GPs with vocational registration**

'GPs with vocational registration' is defined as the proportion of FWE GPs with vocational registration. Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007).

A high or increasing proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. GPs without vocational registration may deliver services of equally high quality, however, their access to DHS Medicare rebates for the general practice services they provide is limited compared to vocationally registered GPs.

Data reported for this indicator are:

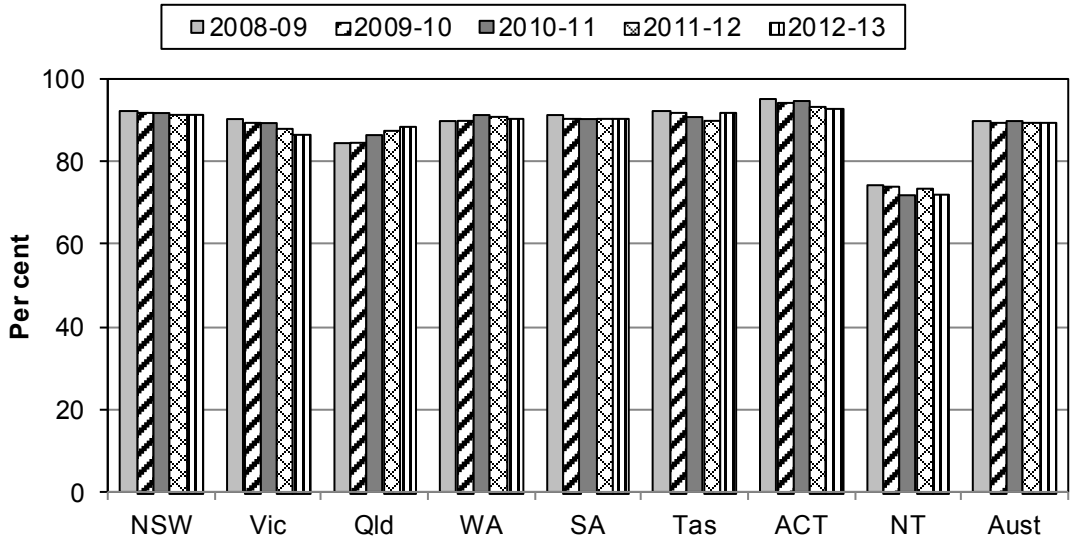
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP or (from April 2007) the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the 'practice eligible' route. Once vocational registration is achieved, GPs must meet mandated registration standards which include Continuing Professional Development in order to maintain registration.

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2012-13 (figure 11.21). The proportion of FWE GPs with vocational registration was highest in major cities and lowest in remote areas in 2012-13 (table 11A.46).

Figure 11.21 **GPs (full time workload equivalent) with vocational registration[a]**



a FWE GP numbers include vocationally registered GPs and OMPs billing DHS Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.

Source: Department of Health (unpublished) MBS Statistics; table 11A.48.

General practices with accreditation

'General practices with accreditation' is an indicator of governments' objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.11).

Box 11.11 **General practices with accreditation**

'General practices with accreditation' is defined as the number of general practices that are accredited as a proportion of all general practices in Australia. Accreditation of general practice is a voluntary process of independent third-party peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards.

(Continued next page)

Box 11.11 **(Continued)**

A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data reported for this indicator are:

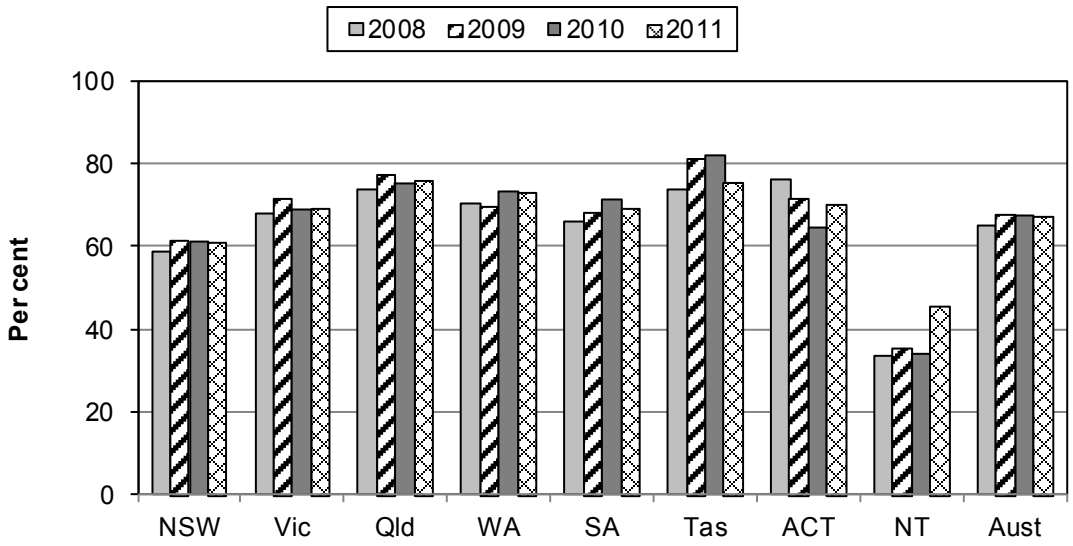
- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

Data quality information for this indicator is under development.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation Pty Ltd.

Current data for the number of general practices remained unavailable for the 2014 Report. In June 2011, 4783 general practices — representing 67.4 per cent of general practices — were accredited nationally (figure 11.22).

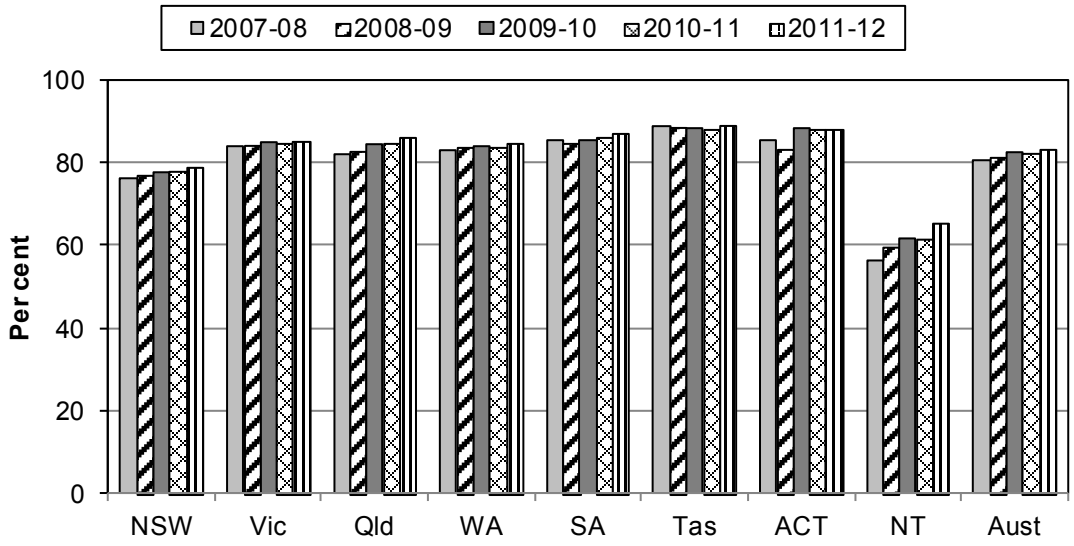
Figure 11.22 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); Quality Practice Accreditation Pty Ltd (unpublished); Primary Health Care Research and Information Service and Department of Health (unpublished) *Annual Survey of Divisions of General Practice 2010-11*; table 11A.49.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has increased slightly in the period from 2007-08 to 2011-12 (figure 11.23).

Figure 11.23 **Proportion of general practice patient care provided by PIP practices[a]**



a Patients are measured as SWPEs. 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: Department of Health (unpublished) PIP and MBS data collections; table 11A.50.

Management of acute upper respiratory tract infection

'Management of acute upper respiratory tract infection' is an indicator of governments' objective to ensure that antibiotics are used appropriately and effectively (box 11.12).

Box 11.12 **Management of upper respiratory tract infection**

'Management of acute upper respiratory tract infection' (URTI) is defined by two measures:

- filled GP prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) per 1000 people
- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.

Low or decreasing rates of prescription of the selected antibiotics and acute URTI GP visits where systemic antibiotics are prescribed can indicate that GPs' management of acute URTI more closely follows guidelines.

URTI without complication (acute URTI or the 'common cold') is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless often prescribed for their treatment. Unnecessarily high rates of antibiotic prescription have the potential to increase both pharmaceutical costs and antibiotic resistance in the community.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for the measure filled GP prescriptions for selected antibiotics is at www.pc.gov.au/gsp/reports/rogs/2014. Data quality information for the measure acute URTI GP visits where systemic antibiotics are prescribed is under development.

Rate of prescription of selected antibiotics

Caution should be used in interpreting the rate of prescription of the selected antibiotics as the oral antibiotics most commonly prescribed to treat acute URTI are also prescribed for other illnesses. Information about the condition for which the antibiotics are prescribed is not available.

Complete data are available for the first time, for 2012-13, for all prescriptions for the selected antibiotics that are filled. Complete historical data were available only for prescriptions provided to holders of PBS concession cards (see table 11A.52).

Nationally, the prescription rate for the oral antibiotics most commonly used to treat acute URTI was 297 per 1000 people in 2012-13 (figure 11.24).

Figure 11.24 **Rate of filled prescriptions of the oral antibiotics used most commonly to treat acute upper respiratory tract infection, per 1000 people, 2012-13[a, b]**

[a] Prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed. [b] Data are not limited to prescriptions for treatment of upper respiratory tract infection.

Source: Department of Health (unpublished) PBS Statistics; table 11A.51.

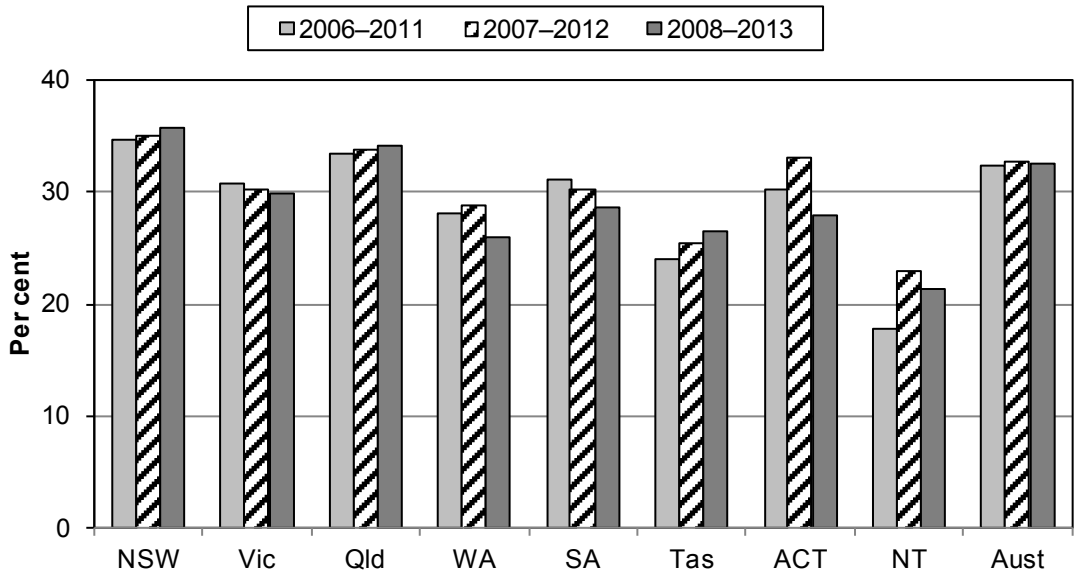
Proportion of GP visits for acute URTI where systemic antibiotics are prescribed

Data for the proportion of GP visits for acute URTI where systemic antibiotics are prescribed are for the first time available at State/Territory level, from the annual BEACH survey of general practice activity in Australia.

The BEACH survey collects information on the reason for the GP visit as well as the treatment prescribed or provided. This allows derivation of the proportion of visits to GPs for acute URTI for which systemic antibiotics were prescribed or supplied. Each year, the national BEACH sample comprises around 1000 GPs, each providing data for around 100 patient visits. Aggregation of data for a period of 5 years allows publication of data for all States and Territories (figure 11.25). This has some limitations — short-term change will be reflected only if substantive when averaged over a 5 year period, and proximate causes of change will not be directly identifiable. These limitations are to a degree mitigated by the reporting of data for each year in the reference period at the national level. This will assist in interpreting whether change reflected over rolling 5 year periods is due to substantive short-term change or to incremental change over several years.

Nationally, for the 5 years April 2008 to March 2013, the proportion of people presenting to GPs for acute URTI where the GP prescribed systemic antibiotics for its treatment was 32.5 per cent (figure 11.25). This proportion was 29.9 per cent for the period April 2012 to March 2013 (figure 11.25). The higher proportion for the 5 year reference period reflects an increase in use of systemic antibiotics for treatment of acute URTI associated with the swine flu outbreak in 2009 (figure 11.26).

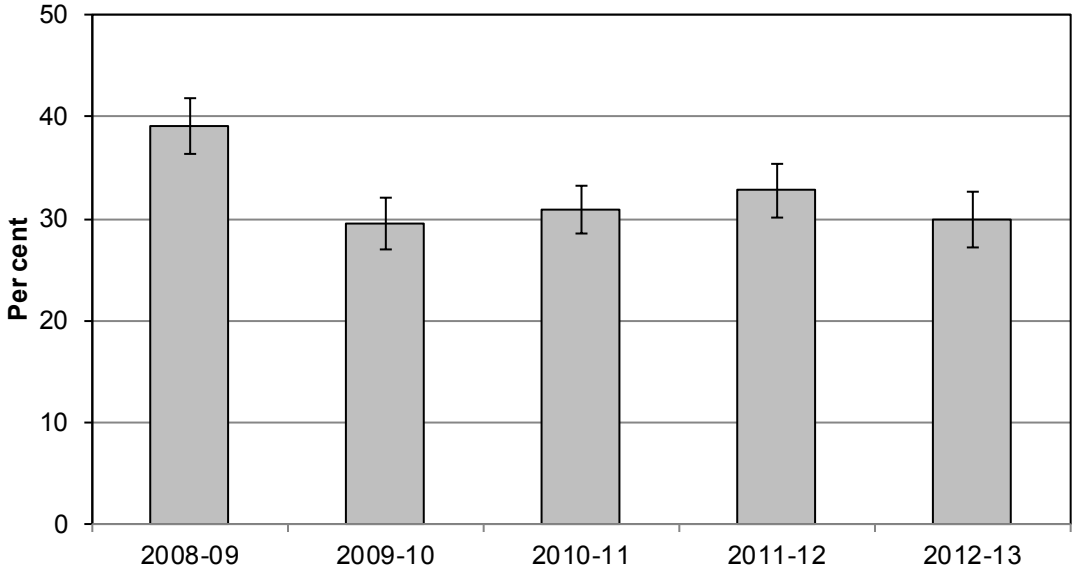
Figure 11.25 **Proportion of acute URTI managements where systemic antibiotics were prescribed[a, b]**



a Error bars represent the 95 per cent confidence interval associated with each point estimate. **b** Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Source: Britt et al (unpublished) BEACH Statistics; table 11A.53.

Figure 11.26 **Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia[a, b]**



a Error bars represent the 95 per cent confidence interval associated with each point estimate. **b** Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Source: Britt et al (unpublished) BEACH Statistics; table 11A.54.

Chronic disease management

'Chronic disease management' is an indicator of governments' objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.13).

Box 11.13 **Chronic disease management**

'Chronic disease management' is defined by four measures:

- management of diabetes — annual cycle of care, defined as the proportion of people with diabetes who received an annual cycle of care within general practice (the number of MBS items claimed for completion of a cycle of care for patients with established diabetes, divided by the estimated number of people with diabetes)
- management of diabetes — HbA1c, defined as the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes with HbA1c below 7 per cent, divided by the estimated number of people with diabetes)
- management of asthma, defined as the proportion of people with asthma who have a written asthma action plan
- care planning/case conferencing, defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.

A high or increasing proportion of people with diabetes who received an annual cycle of care within general practice, people with diabetes with HbA1c below 7 per cent, people with asthma who have a written asthma action plan, and GPs who use chronic disease management items, is desirable.

The MBS annual cycle of care for patients with diabetes is generally based on RACGP clinical guidelines for the appropriate management of Type 2 diabetes in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications. Data should be considered as minimum estimates as appropriate management of diabetes mellitus by GPs who do not claim the rebate is not captured.

HbA1c measures the level of glucose in the blood averaged over the preceding three months. HbA1c levels below 7 per cent are indicative of appropriate management of diabetes in that period.

Written asthma action plans have been included in clinical guidelines for asthma management for nearly 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, and thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008).

(Continued next page)

Box 11.13 **(Continued)**

A high or increasing proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions for management of diabetes — annual cycle of care and care planning/case conferencing. All required 2011-12 data are available for all jurisdictions for management of diabetes — HbA1c and management of asthma.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014, except for the measure proportion of GPs who use chronic disease management items, which is under development.

Reporting against this indicator has improved as data are for the first time available for reporting against the measure proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent.

Chronic diseases are generally long term and often progressive conditions, for example, diabetes and asthma. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).

Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent or minimise the severity of complications (AIHW 2008c, NHPAC 2006). Effective management requires the provision of timely, high quality healthcare to meet individual needs and provide continuity of care (Australian Government 2010). Effective management can have profound effects on individuals and on the broader health system. Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Chronic disease management — diabetes

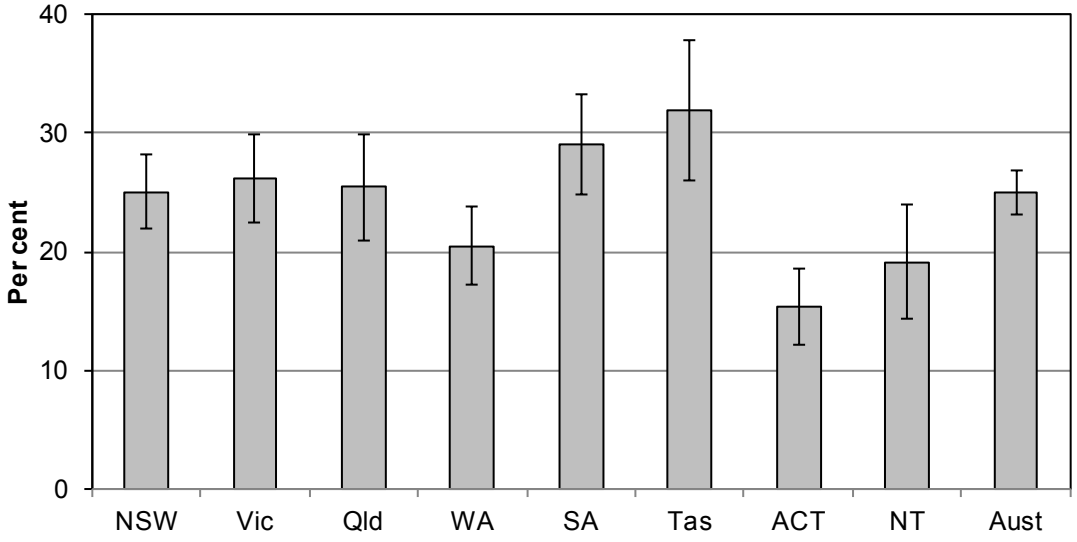
Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this Report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosolated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007).

Nationally, 25.0 per cent of people with diabetes received the annual cycle of care in 2012-13 (figure 11.27). Data for historical years are reported by geographical region in table 11A.56.

Figure 11.27 **People with diabetes mellitus who have received an annual cycle of care within general practice, 2012-13[a, b]**



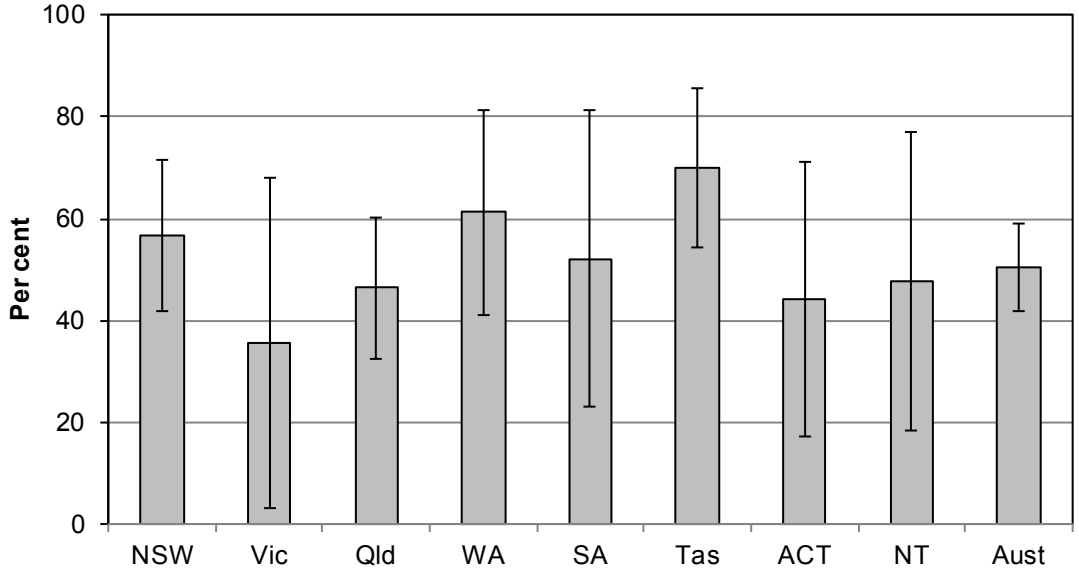
a Excludes annual cycles of care provided by GPs where a standard MBS rebate is claimed. GPs who are not registered for the PIP diabetes incentive are unlikely to claim against the annual cycle of care MBS item. **b** Denominator data are derived from self-reported estimates of diabetes prevalence. **c** Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: Department of Health (unpublished) MBS Statistics and DVA data collections; ABS (unpublished) *Australian Health Survey 2011–13* (National Health Survey (NHS) component 2011-12), Cat. no. 4364.0; table 11A.55.

HbA1c (glycosolated haemoglobin) provides a measure of the average blood glucose level for the preceding three months. RACGP guidelines for management of diabetes indicate that HbA1c levels should be tested at least every 6 months. Nationally, 77.5 per cent of people with known diabetes had a HbA1c test in the previous 12 months (table 11A.57).

An outcome of appropriate management of diabetes, by the primary and community health care sector in conjunction with the patient, is a HbA1c level at or below 7 per cent. Nationally, 50.5 per cent of people with known diabetes had a HbA1c level at or below 7 per cent (figure 11.28).

Figure 11.28 **People with known diabetes with HbA1c level 7.0 per cent or less**



a People aged 18 years to 69 years with known diabetes. Includes pregnant women. **b** Known diabetes based on fasting plasma glucose test results and self-reported information on diagnosis/medication use. **c** Rates are not age-standardised. **d** Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

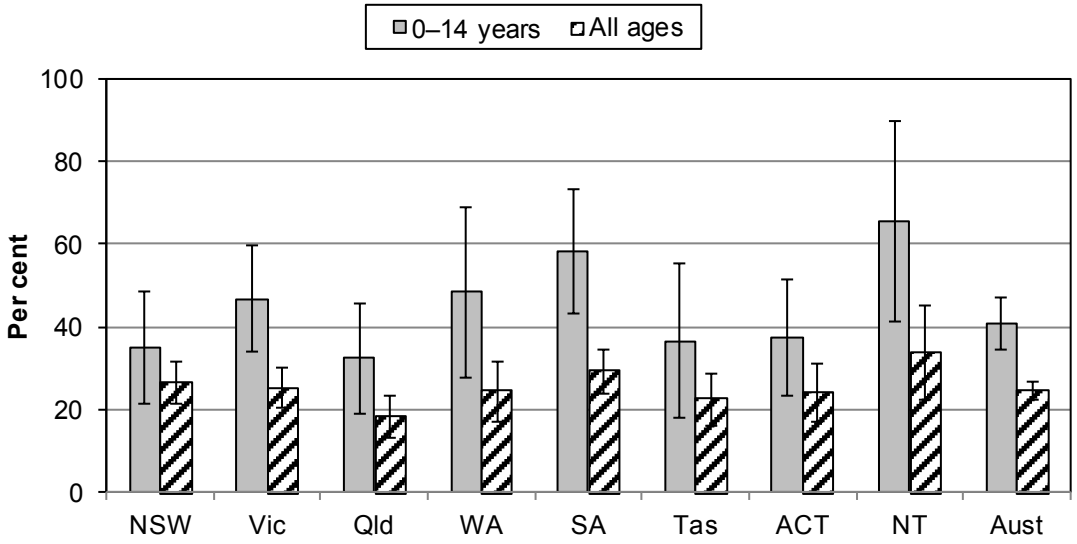
Source: ABS (unpublished) *Australian Health Survey, 2011-13*, (National Health Measures 2011-12 component) Cat. No. 4364.0; table 11A.58.

Chronic disease management — asthma

Asthma, an identified National Health Priority Area for Australia, is a common chronic disease among Australians — particularly children — and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity.

Nationally, the proportion of people with current asthma reporting that they have a written asthma action plan was 24.6 per cent for all ages and 40.9 per cent for children aged 0–14 years in 2011-12 (figure 11.29). Data for 2007-08 are reported by geographical region in table 11A.60. Data for 2004-05 are reported by Indigenous status in table 11A.61.

Figure 11.29 **Proportion of people with asthma who have a written asthma action plan, 2011-12[a, b, c]**



[a] Rates for 'all ages' are age standardised to the Australian population at 30 June 2001. [b] Error bars represent the 95 per cent confidence interval associated with each point estimate. [c] Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to the exclusion of around 23 per cent of the NT population.

Source: ABS (unpublished) *Australian Health Survey, 2011-13*, (NHS component) Cat. No. 4364.0; table 11A.59.

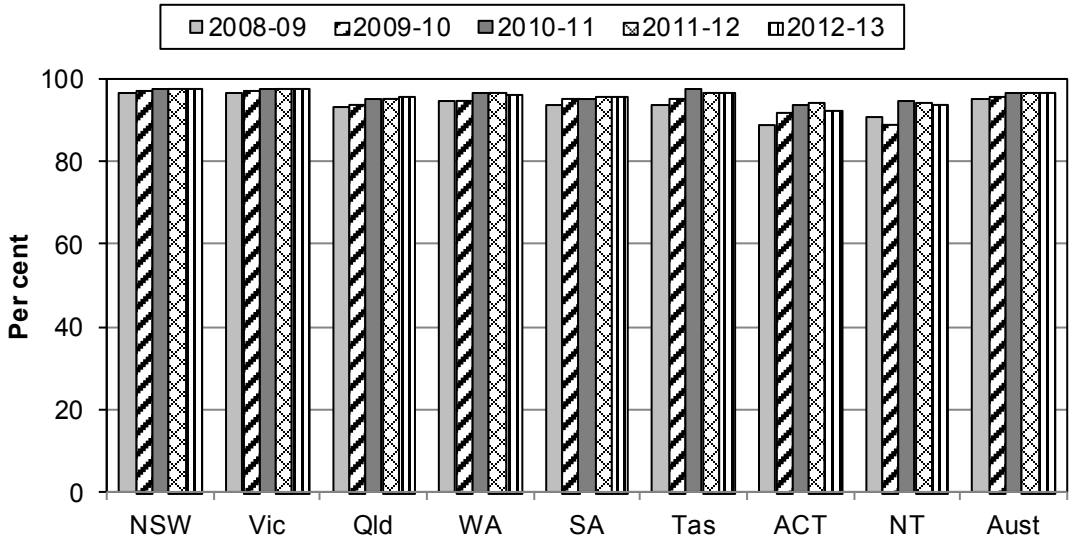
Chronic disease management — care planning and case conferencing

Individuals with chronic or terminal medical conditions commonly have complex, multidisciplinary care needs. Coordination of service provision to provide continuity of care and meet the changing needs of individuals over time is important in the effective management of such conditions. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care planning and case conferencing.

Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing increased from 95.3 in 2008-09 to 97.0 per cent in 2011-12 and 2012-13 (figure 11.30).

Figure 11.30 **GP use of chronic disease management MBS items for care planning and case conferencing[a]**



a The Strengthening Medicare initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. Additional chronic disease management MBS items have become available on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Source: Department of Health (unpublished) MBS Statistics; table 11A.62.

Use of pathology tests and diagnostic imaging

'Use of pathology tests and diagnostic imaging' is an indicator of governments' objective to ensure that primary healthcare services are appropriate (box 11.14).

Box 11.14 **Use of pathology tests and diagnostic imaging**

'Use of pathology tests and diagnostic imaging' is defined by four measures:

- MBS items rebated through DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs, per person
- diagnostic imaging services provided on referral from vocationally registered GPs and OMPs and rebated through DHS Medicare, per person
- DHS Medicare benefits paid per person for pathology tests
- DHS Medicare benefits paid per person for diagnostic imaging.

This indicator needs to be interpreted with care as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Reporting differences across jurisdictions and over time contributes to consideration of these issues. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS Medicare is used as a proxy in reporting against this indicator.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions for 2012-13 but not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

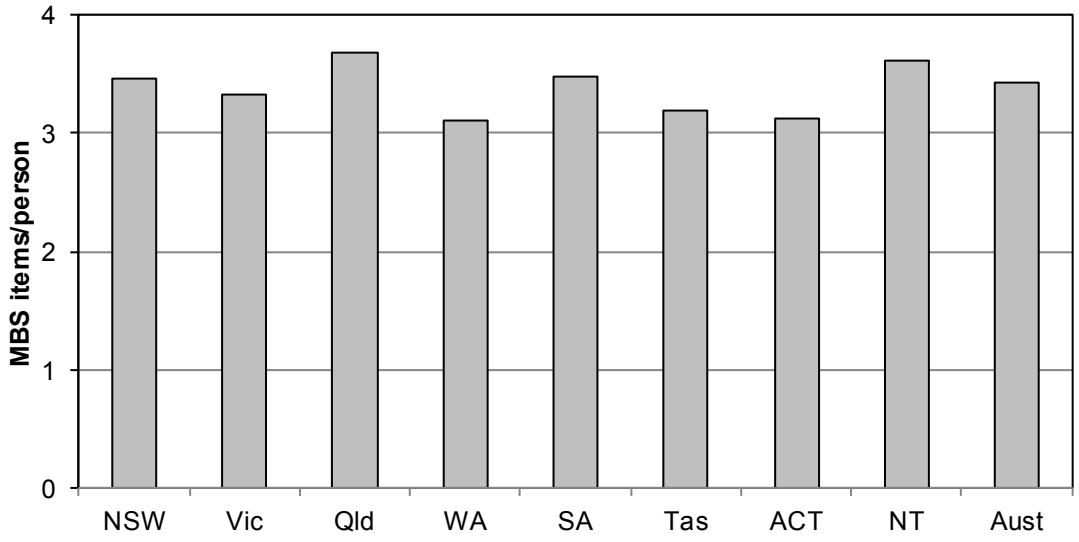
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS Medicare data reflect only those services provided and rebated.

Data for this indicator are improved with the introduction of age-standardisation of rates for 2012-13. Historical data are provided in tables 11A.64 for pathology tests and 11A.66 for diagnostic imaging.

Nationally, the number of rebated MBS items for pathology tests requested by GPs was 3.4 per person in 2012-13 (figure 11.31).

Figure 11.31 **MBS items rebated through DHS Medicare for pathology tests requested by GPs, 2012-13[a, b]**

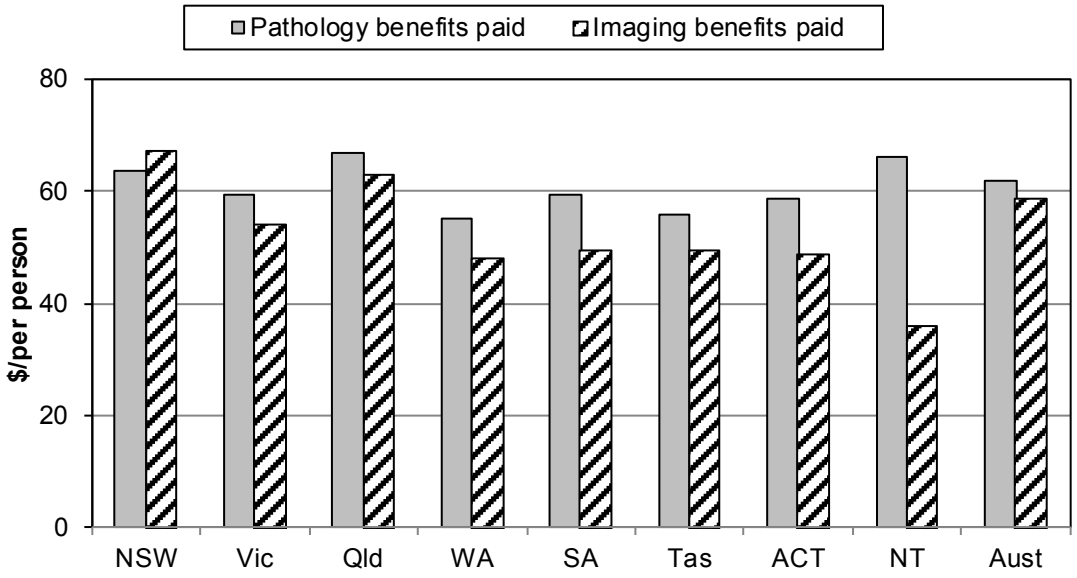


a Data are age standardised to the 2001 Australian standard population. **b** Data include tests requested by vocationally registered GPs and OMPs. Data include patient episode initiated items.

Source: Department of Health (unpublished) MBS and DVA data collections; table 11A.63.

Australian Government expenditure under DHS Medicare for pathology tests requested by vocationally registered GPs and OMPs amounted to $1.5 billion, or around $62 per person, in 2012-13. Nationally, Medicare benefits worth $1.4 billion — around $59 per person — were paid for diagnostic imaging services provided on referral from vocationally registered GPs and OMPs, in 2012-13 (figure 11.32).

Figure 11.32 **Benefits paid for pathology tests and diagnostic imaging, 2012-13[a]**

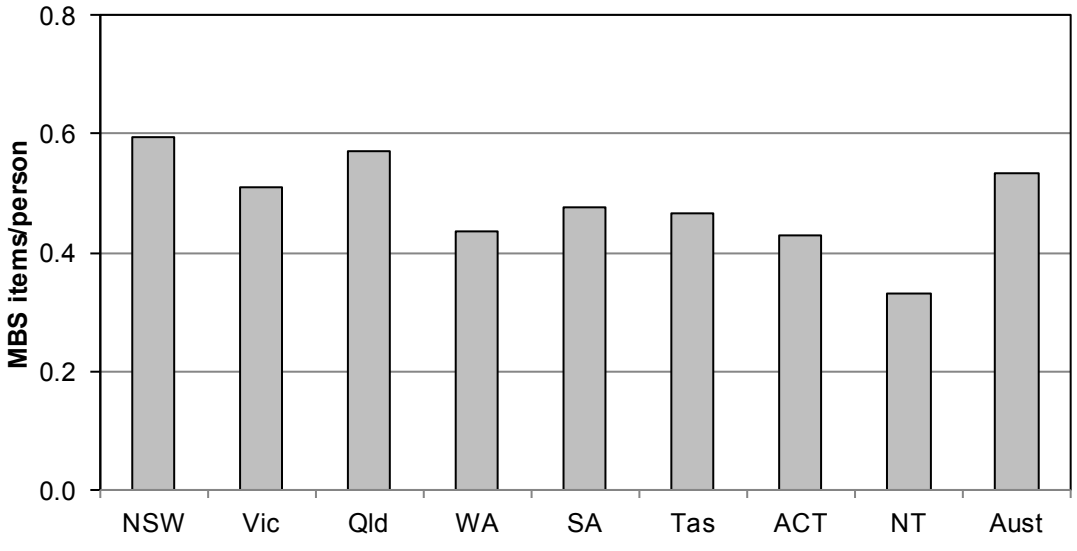


[a] Includes benefits paid through DHS Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally registered GPs and OMPs.

Source: Department of Health (unpublished) MBS and DVA data collections; tables 11A.63 and 11A.65.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs was 0.54 per person in 2012-13 (figure 11.33).

Figure 11.33 **Diagnostic imaging services referred by GPs and rebated through DHS Medicare, 2012-13[a]**



[a] GPs include vocationally registered GPs and OMPs.

Source: Department of Health (unpublished) MBS and DVA data collections; table 11A.65.

Electronic health information systems

'Electronic health information systems' is an indicator of governments' objective to improve patient safety through enhanced access to patient health information at the point of care and the more efficient coordination of care across multiple providers and services (box 11.15).

Box 11.15 **Electronic health information systems**

'Electronic health information systems' is defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP eHealth incentive.

A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.

The PIP does not include all practices in Australia. PIP practices provided around 83.0 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (Department of Health unpublished; table 11A.51).

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is under development.

The use of electronic health information systems can, for example, facilitate best practice chronic disease management as well as minimise errors of prescribing and dispensing that can cause adverse drug reactions (Hofmarcher, Oxley and Rusticelli 2007).

The PIP provides financial incentives to general practices to support quality care, and improve access and health outcomes. The PIP promotes activities such as:

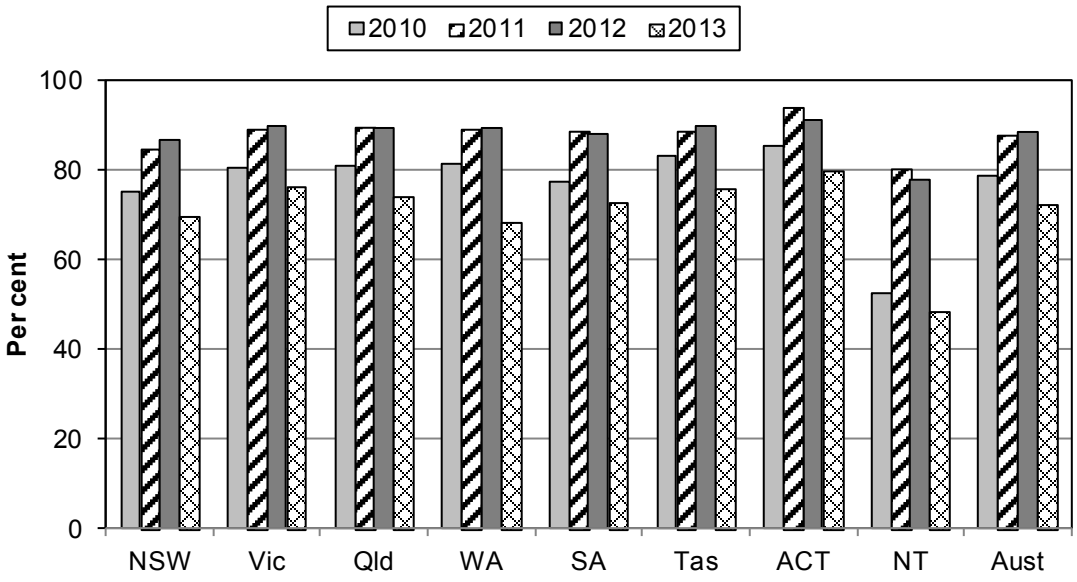
- use of electronic health information systems
- teaching medical students
- improving management for patients with diabetes and/or asthma.

The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. Accordingly, new eligibility requirements were introduced from 1 February 2013, requiring practices to:

- integrate healthcare identifiers into electronic practice records
- have a secure messaging capability
- use data records and clinical coding of diagnoses
- send prescriptions electronically to a prescription exchange service
- participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software.

Nationally, the increase in the proportion of PIP practices using electronic health systems from 78.5 per cent in 2010 to 88.3 per cent in 2012 was followed by a decrease to 72.2 per cent in 2013, as implementation of the new requirements was not yet completed in a number of practices (figure 11.34).

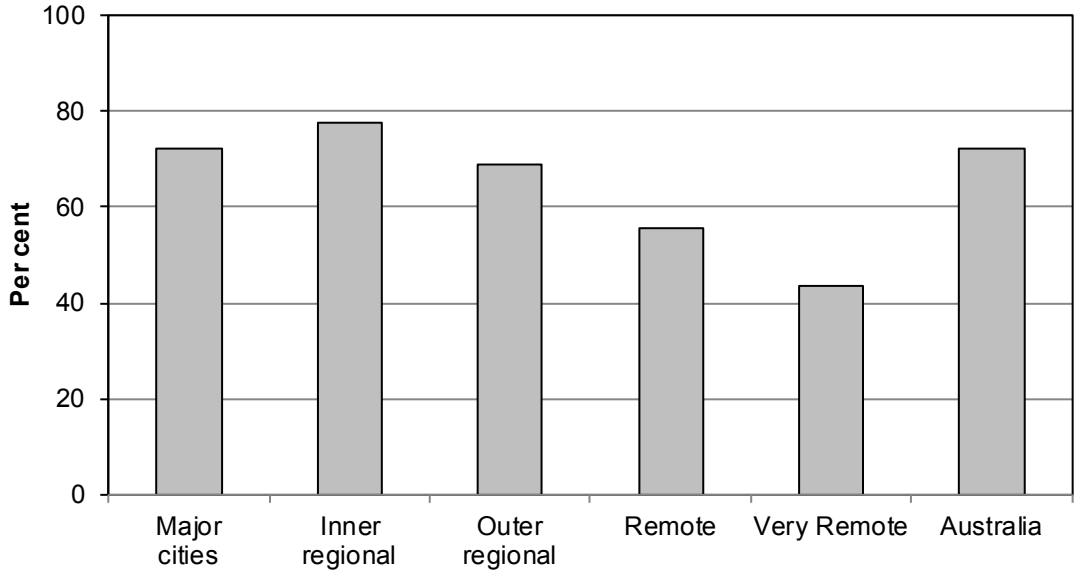
Figure 11.34 **PIP practices using electronic health systems**



Source: Department of Health (unpublished) MBS and PIP data collections; table 11A.67.

The proportion of PIP practices using electronic health systems in remote and very remote areas was lower than in major cities and regional areas in May 2013 (figure 11.35).

Figure 11.35 **PIP practices using electronic health systems by area, 2013[a]**



a Geographical locations are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.

Source: Department of Health (unpublished) MBS and PIP data collections; table 11A.68.

Quality — responsiveness

Patient satisfaction

'Patient satisfaction' is an indicator of governments' objective to ensure primary and community health services are high quality and account for individual patient needs (box 11.16).

Box 11.16 **Patient satisfaction**

'Patient satisfaction' is defined as the quality of care as perceived by the patient. It is measured as patient experience of and/or satisfaction around 'key aspects of care' — that is, aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:

- experience with selected key aspects of GP care, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months
- experience with selected key aspects of dental professional care, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.

High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

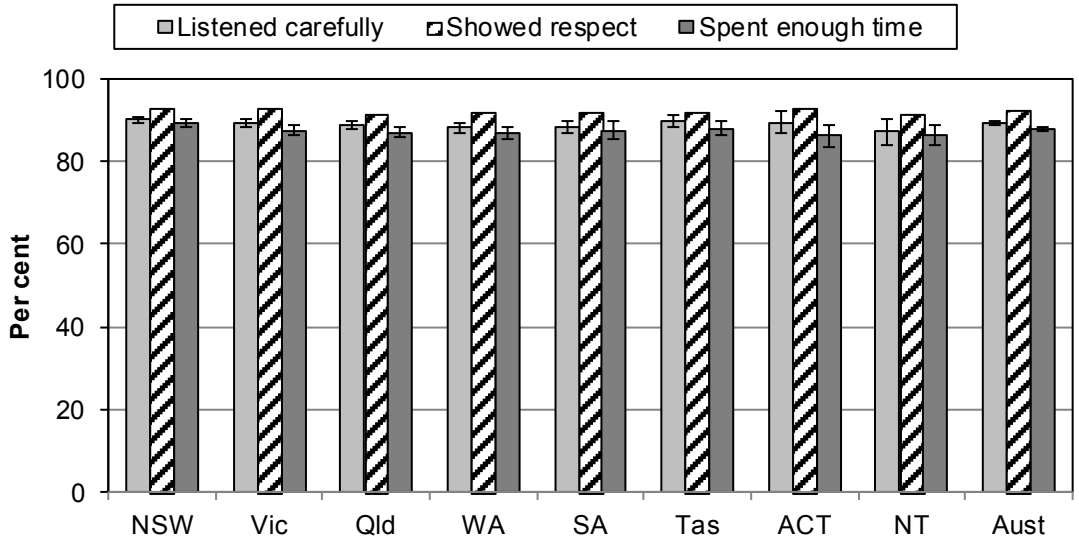
Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that, in 2012-13, the GP always or often (figure 11.36):

- listened carefully to them (89.3 per cent)
- showed respect (92.5 per cent)
- spent enough time with them (88.0 per cent).

Data are presented by remoteness area in tables 11A.70 and 11A.71. Data for Indigenous Australians that are reported in table 11A.72 are not comparable to the data presented here (see DQI for details).

Figure 11.36 **Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2012-13**[a, b, c]



[a] People aged 15 years or over who saw a GP in the last 12 months. [b] Rates are age-standardised to the Australian population at 30 June 2001. [c] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; tables 11A.70, 11A.71.

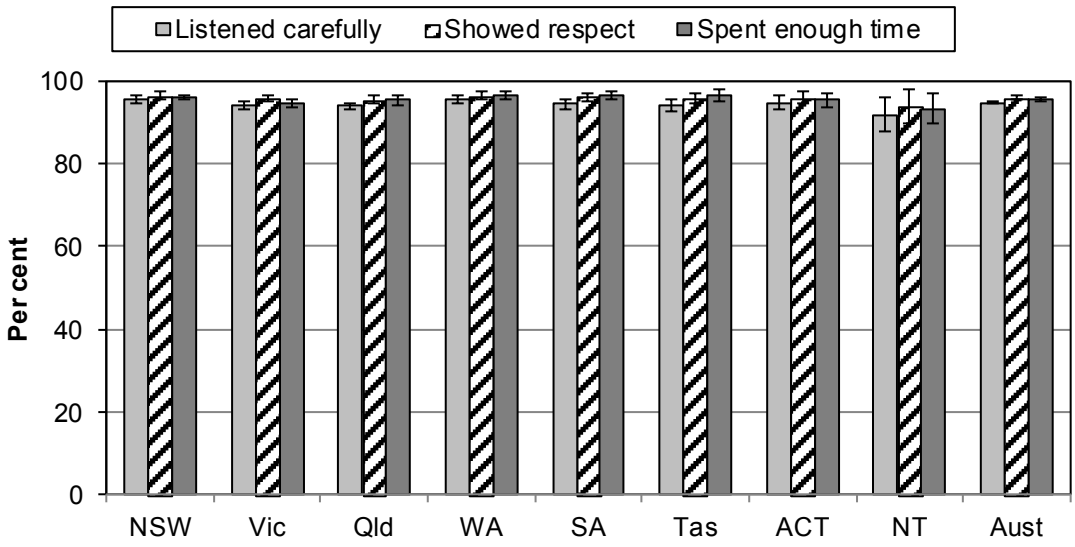
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that, in 2012-13, the dental professional always or often (figure 11.37):

- listened carefully to them (94.8 per cent)
- showed respect (96.1 per cent)
- spent enough time with them (95.6 per cent).

Data are presented by remoteness area in tables 11A.73 and 11A.74.

Figure 11.37 **Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2012-13** [a, b]



[a] People aged 15 years or over who saw a dental professional in the last 12 months. [b] Rates are age-standardised to the Australian population at 30 June 2001. [c] Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions.

Source: ABS (unpublished) *Patient Experience Survey 2012-13*, Cat. no. 4839.0; tables 11A.73, 11A.74.

Quality — continuity

Health assessments for older people

'Health assessments for older people' is an indicator of governments' objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.17).

Box 11.17 **Health assessments for older people**

'Health assessments for older people' is defined as the proportion of older people who received a health assessment. Older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Annual health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.5).

A high or increasing proportion of eligible older people who received a health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Data reported against this indicator are:

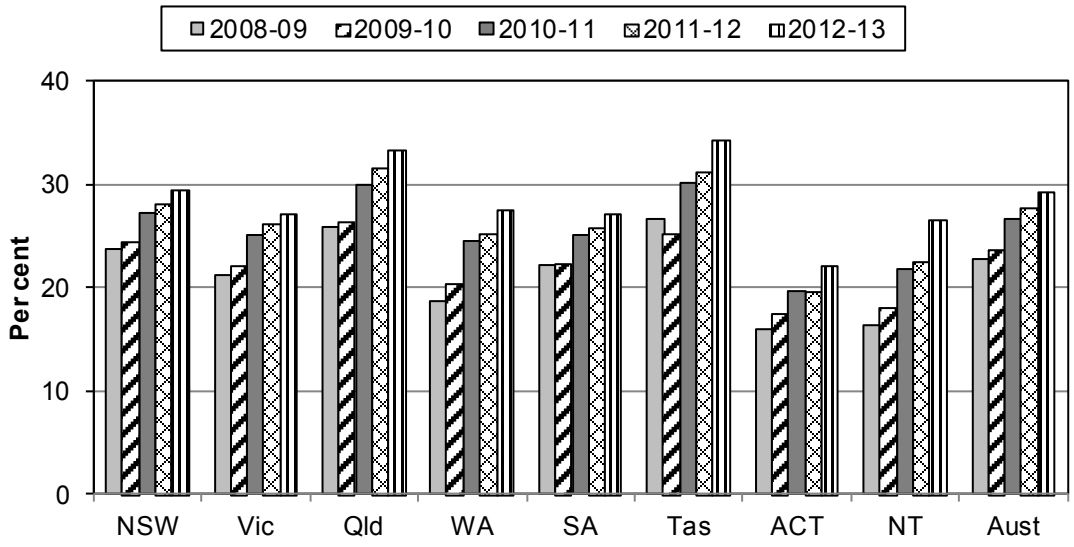
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is under development.

The targeted age range for Indigenous Australians of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector overview). Results for Indigenous Australians are reported under equity indicators (box 11.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2008-09 to 2012-13. Nationally, this proportion increased from 22.8 per cent in 2008-09 to 29.2 per cent in 2012-13 (figure 11.38).

Figure 11.38 **Older people who received a health assessment[a, b]**



a Older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. **b** Populations used to derive the rates are based on the 2006 Census.

Source: Department of Health (unpublished) MBS Statistics; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS various years, *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.75.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

'Cost to government of general practice per person' is an indicator of governments' objective to provide primary healthcare services in an efficient manner (box 11.18).

Box 11.18 **Cost to government of general practice per person**

'Cost to government of general practice per person' is defined as the cost to government of general practice per person in the population.

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

Cost to government of general practice does not capture costs of salaried GP service delivery models, used particularly in rural and remote areas, where primary healthcare services are provided by salaried GPs in community health settings, through emergency departments, and Indigenous primary healthcare services. Consequently, costs for primary care are understated for jurisdictions where a large proportion of the population live in rural and remote areas.

Data reported for this indicator are:

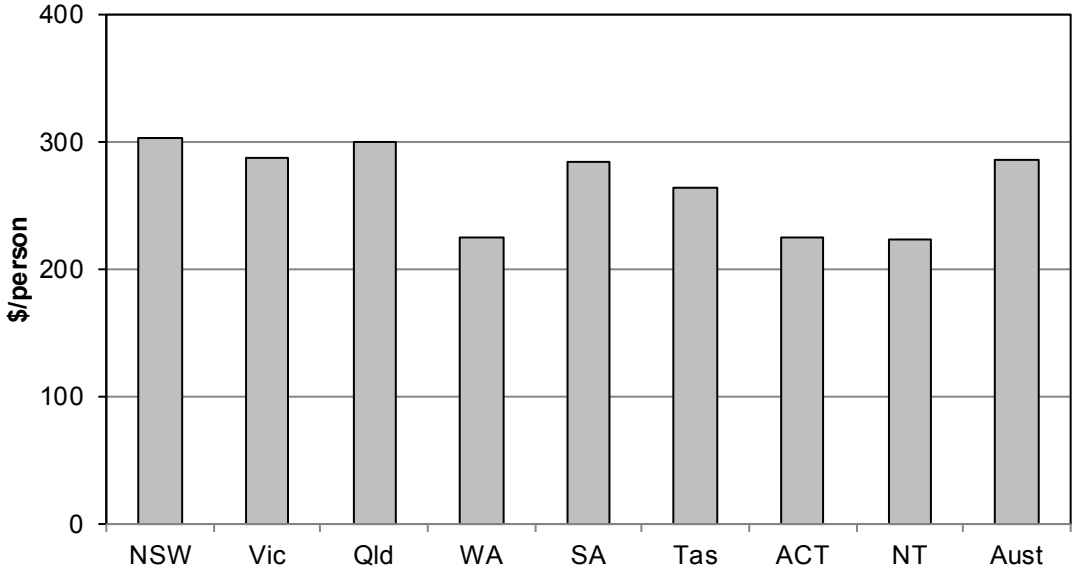
- comparable (subject to caveats) across jurisdictions for 2012-13, but not comparable to data for previous years
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data for this indicator have improved with the introduction of age-standardisation for 2012-13 data. These data are not comparable with data for previous years that are not age-standardised. Historical data are provided in table 11A.3.

Nationally, the recurrent cost to the Australian Government of general practice was $286 per person in 2012-13 (figure 11.39).

Figure 11.39 **Australian Government expenditure per person on GPs, 2012-13[a]**



[a] Data are directly age-standardised to the 2001 Australian standard population. [b] Data include DHS Medicare and DVA payments.

Source: Department of Health (unpublished) MBS Statistics; DVA (unpublished); table 11A.2.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5). Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

Child immunisation coverage

'Child immunisation coverage' is an indicator of governments' objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.19).

Box 11.19 **Child immunisation coverage**

'Child immunisation coverage' is defined by three measures:

- the proportion of children aged 12 months to less than 15 months who are fully immunised, where children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B
- the proportion of children aged 24 months to less than 27 months who are fully immunised, where 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
- the proportion of children aged 60 months to less than 63 months who are fully immunised, where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella.

A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Many providers deliver child immunisation services (table 11.7). High immunisation coverage levels have been encouraged under the General Practice Immunisation Incentives Scheme, which provided incentives for the immunisation of children under 7 years of age to 30 June 2013.

Table 11.7 **Valid vaccinations supplied to children under 7 years of age, by provider type, 2008–2013 (per cent)[a, b, c]**

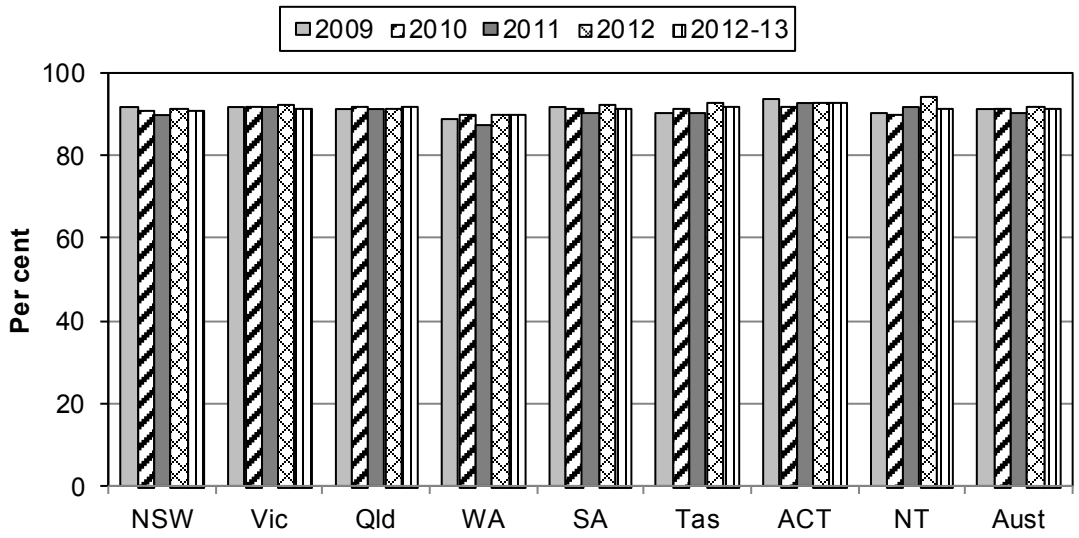
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	89.1	59.2	86.7	68.7	74.2	92.9	58.2	13.2	76.3
Council	3.5	40.3	6.1	3.7	18.5	7.1	–	–	14.2
State or Territory health department	–	–	–	6.4	–	–	1.2	0.5	0.8
Public hospital	np	np	np	np	np	np	np	np	np
Private hospital	–	–	–	–	–	–	–	0.8	–
Indigenous health service	0.6	0.2	0.7	0.4	0.6	–	–	21.9	0.8
Community health centre	6.8	0.3	6.4	20.8	6.6	–	40.6	63.5	7.9
Other[d]	–	0.1	0.1	0.1	0.1	–	–	–	0.1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

[a] Data are for the period 1 July 2008 to 30 June 2013. [b] Data are based on State/Territory in which the immunisation provider was located. [c] A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. [d] Other includes Divisions of GP, Flying Doctors Services, Indigenous Health Workers, Community nurses and unknown. – Nil or rounded to zero. **np** Not published.

Source: Department of Health (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.76.

Nationally, 91.3 per cent of Australian children aged 12 months to less than 15 months were assessed as fully immunised in 2012-13 (figure 11.40).

Figure 11.40 **Children aged 12 months to less than 15 months who were fully immunised**[a, b, c, d]

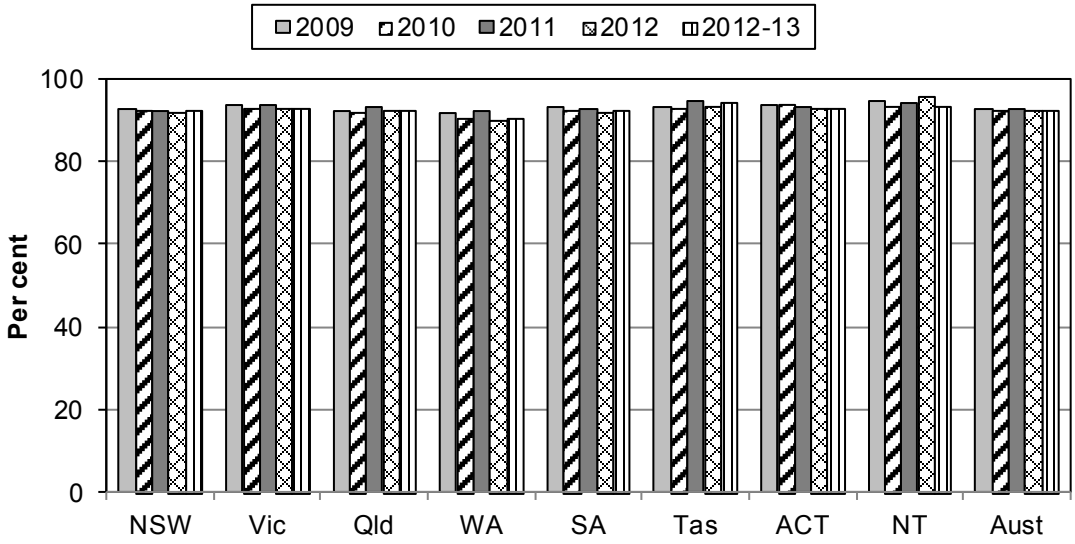


[a] Coverage for years to 2012 measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child resided. For 2013, data include all children aged 12 to 15 months of age fully vaccinated in the 2012-13 financial year. [b] The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare. [c] There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). [d] Relatively low coverage rates for the June 2011 quarter are associated with parents not receiving immunisation reminders due to administrative error.

Source: Department of Health (unpublished) ACIR data collection; table 11A.77.

Nationally, 92.4 per cent of children aged 24 months to less than 27 months were assessed as fully immunised in 2012-13 (figure 11.41).

Figure 11.41 **Children aged 24 months to less than 27 months who were fully immunised[a, b, c]**

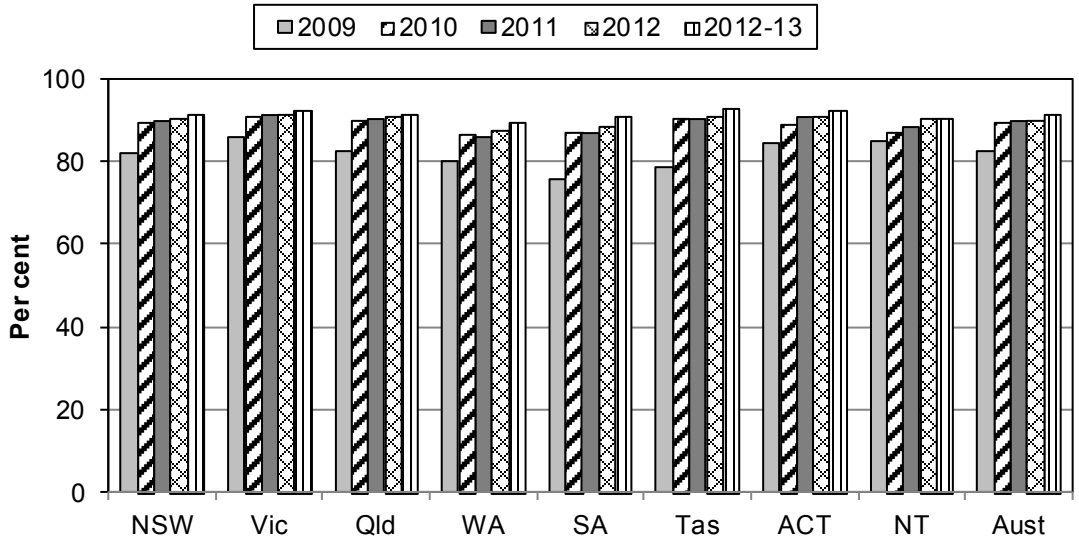


a Coverage for years to 2012 measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child resided. For 2013, data include all children aged 24 to 27 months of age fully vaccinated in the 2012-13 financial year. **b** The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). **c** There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: Department of Health (unpublished) ACIR data collection; table 11A.78.

Nationally, 91.5 per cent of Australian children aged 60 months to less than 63 months were assessed as fully immunised in 2012-13 (figure 11.42).

Figure 11.42 **Children aged 60 months to less than 63 months who were fully immunised[a, b, c]**



a Coverage for years to 2012 measured at 30 June for children turning 60 months of age by 31 March, by State or Territory in which the child resided. For 2013, data include all children aged 60 to 63 months of age fully vaccinated in the 2012-13 financial year. **b** The ACIR includes all children under 7 years of age who are registered with DHS Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS Medicare (NCIRS 2000). **c** There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: Department of Health (unpublished) ACIR data collection; table 11A.79.

Notifications of selected childhood diseases

'Notifications of selected childhood diseases' is an indicator of governments' objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 11.20).

Box 11.20 **Notifications of selected childhood diseases**

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

(Continued next page)

Box 11.20 **(Continued)**

A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in 1 in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases (and consequently the notification rates) through immunisation.

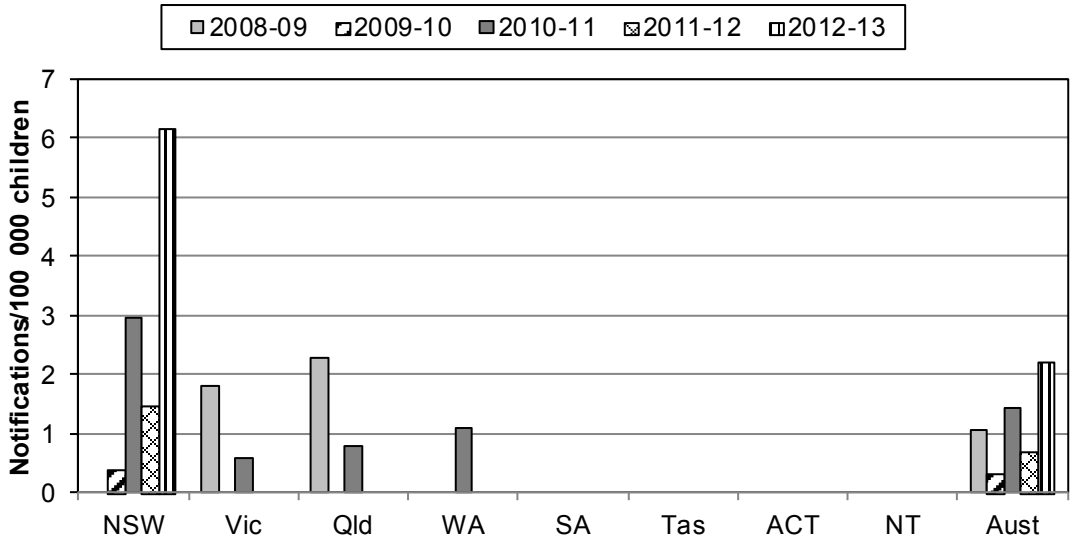
Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is under development.

Nationally, there were 94 notifications for measles for children aged 0–14 years in 2012-13 — a rate of 2.2 notifications per 100 000 children aged 0–14 years (figure 11.43). This was the higher than for any other year in the period 2008-09 to 2012-13 (table 11A.80).

Figure 11.43 **Notifications of measles per 100 000 children aged 0–14 years**[a]

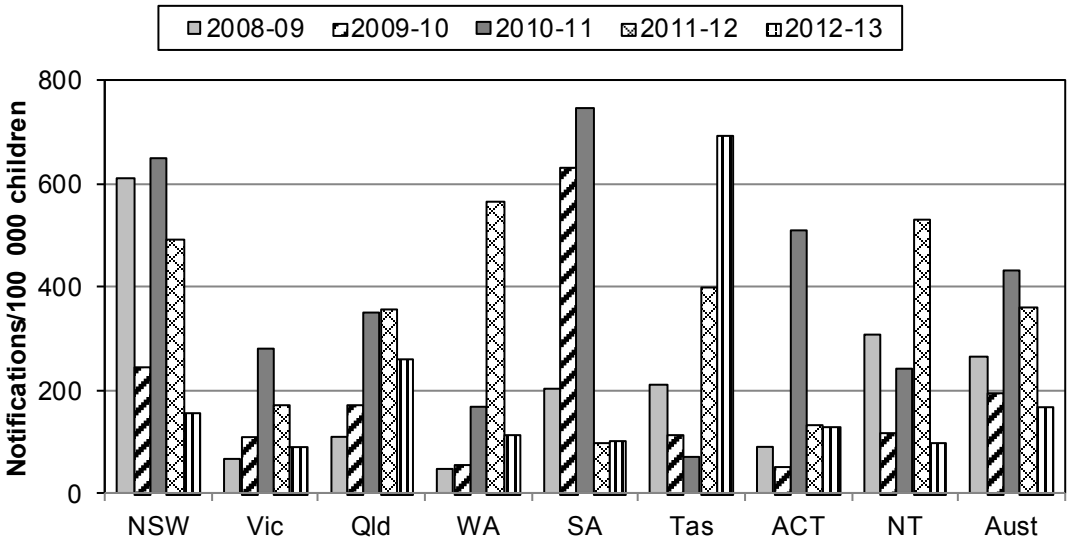


[a] Data are suppressed where the number of notifications reported for a jurisdiction is fewer than 5.

Source: Department of Health (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.80.

Nationally, there were over 7000 notifications for pertussis (whooping cough) for children aged 0–14 years in 2012-13 — a rate of 163 notifications per 100 000 children in this age group (figure 11.44).

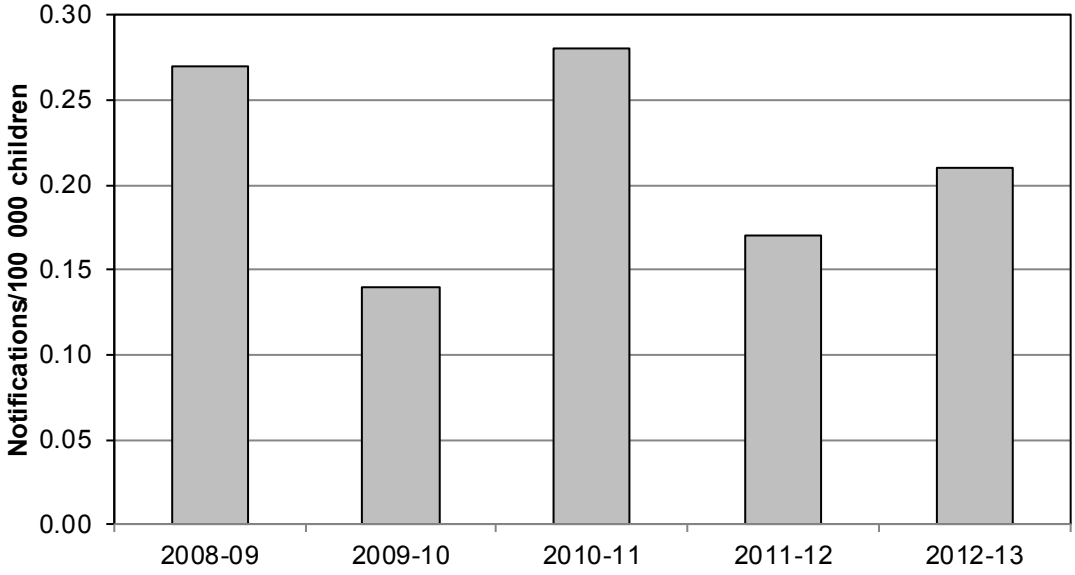
Figure 11.44 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**



Source: Department of Health (unpublished) NNDSS, ABS *Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.81.

In 2012-13, the national notification rate for invasive *Haemophilus influenzae* type b — 0.2 per 100 000 children aged 0–14 years — remained low, consistent with recent years (figure 11.45).

Figure 11.45 **Notifications of invasive *Haemophilus influenzae* type b per 100 000 children aged 0–14 years, Australia**



Source: Department of Health (unpublished) NNDSS, *ABS Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.82.

Participation for women in breast cancer screening

'Participation for women in breast cancer screening' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through the provision of early detection services (box 11.21).

Box 11.21 **Participation for women in breast cancer screening**

'Participation for women in breast cancer screening' is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–69 years and reported as a rate.

A high or increasing participation rate is desirable.

Data reported against this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2011 and 2012 are available for all jurisdictions.

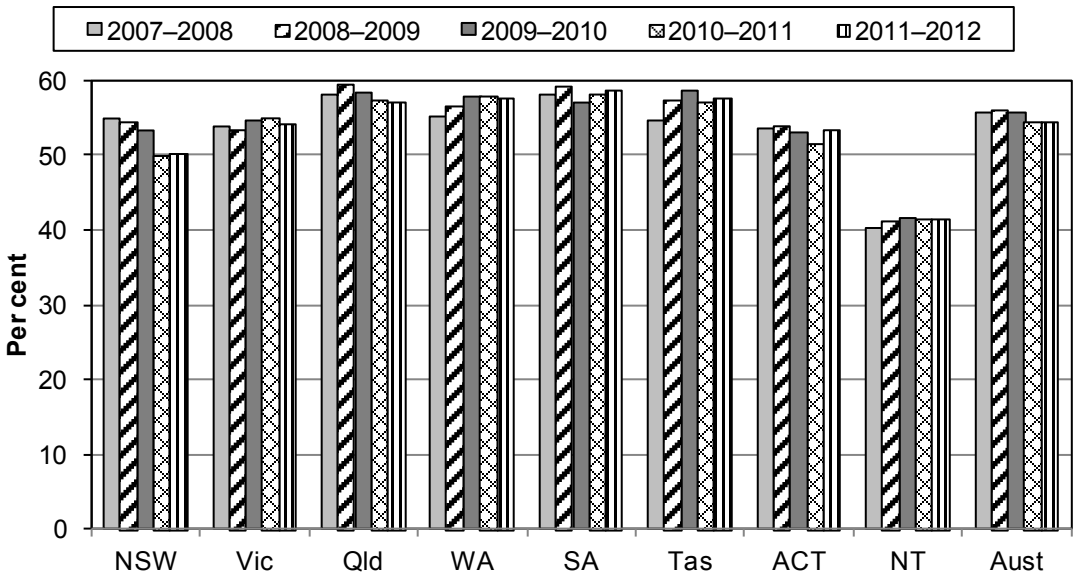
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Early detection of breast cancer is associated with improved morbidity and mortality outcomes. Early detection allows a wider range of treatment options — including less invasive procedures — and a higher likelihood of survival, than does later detection (AIHW and NBCC 2007). The BreastScreen Australia Program is jointly funded by the Australian, State and Territory governments to undertake nationwide breast cancer screening. It aims to achieve at least 70 per cent participation in screening over a period of 24 months in the target group of women aged 50–69 years. Women aged 40–49 years and 70 years or over can also access the program.

An evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (Department of Health 2009). Further, the relatively high proportion of cancers that are detected early, and treated by breast conserving surgery, was associated with reduced treatment related morbidity for Program participants.

The national participation rate for women aged 50–69 years in BreastScreen Australia screening programs decreased from 55.6 per cent in the 24 month period 2007 and 2008 to 54.5 per cent in the 24 month period 2011 and 2012 (figure 11.46). These rates remain below the National Accreditation Standards aim of participation by 70 per cent women in this age group.

Figure 11.46 **Age standardised participation rate for women aged 50–69 years in BreastScreen Australia screening programs (24 month period)[a, b, c, d]**



[a] The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. [b] In general, women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction, except for the ACT (where residents accounted for 91.3 per cent of those screened in the 2010–2011 reference period). [c] The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. ERPs to June 2011 are revised to the ABS' final 2011 Census rebased ERPs. The final ERPs replace the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data for June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details. [d] Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2008, 2009, 2010, 2011) *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0; tables 11A.83, 11A.84.

Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services. Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data, and in the collection of residential postcodes data. Updated State and Territory data for participation rate by remoteness area were unavailable for the 2014 Report — data for 2009–2010 and previous years, as well as national data for 2010–2011 are reported in table 11A.87.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.8. In the 24 month period 2011 and 2012, the national age standardised participation rate for Indigenous women aged 50–69

years was 37.7 per cent (table 11A.85). A low participation rate can in part reflect under-reporting of Indigenous status in screening program records. Rates for Indigenous women are derived using projected populations based on the 2006 Census and are not comparable with rates for all women or NESB women which are derived using ERPs based on the 2011 Census.

In the 24 month period 2011 and 2012, the national age standardised participation rate for NESB women aged 50–69 years was 50.6 per cent, lower than the total participation rate in that age group (54.5 per cent) (table 11A.86).

Table 11.8 **Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2011 and 2012 (24 month period) (per cent)[a, b, c, d, e, f]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[d]	*NT*	*Aust*
Indigenous[e]	36.4	30.5	47.7	36.9	34.0	47.5	50.1	24.6	37.7
NESB[f]	46.8	50.7	62.2	64.2	52.1	44.1	19.0	37.8	50.6
All women aged 50–69 years	50.4	54.3	57.1	57.8	58.8	57.8	53.5	41.6	54.5

[a] First and subsequent rounds. [b] Rates are standardised to the Australian population at 30 June 2001. [c] Data reported for this measure are not directly comparable. [d] Women resident in the jurisdiction represent over 99 per cent of women screened in each jurisdiction except the ACT (91.3 per cent in 2010–2011). [e] Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. [f] NESB is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2011) *Population by Age and Sex, Australian States and Territories*, June 2011, Cat. no. 3201.0; ABS (unpublished) Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021, Cat. no. 3238.0; ABS (unpublished) 2006 Census of Population and Housing; tables 11A.83–11A.86.

Participation for women in cervical screening

'Participation for women in cervical screening' is an indicator of governments' objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.22).

Box 11.22 **Participation for women in cervical screening**

'Participation for women in cervical screening' is defined as the number of women aged 20–69 years who are screened over a two year period, divided by the estimated population of eligible women aged 20–69 years and reported as a rate. Eligible women are those who have not had a hysterectomy.

A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.

Data reported against this indicator are:

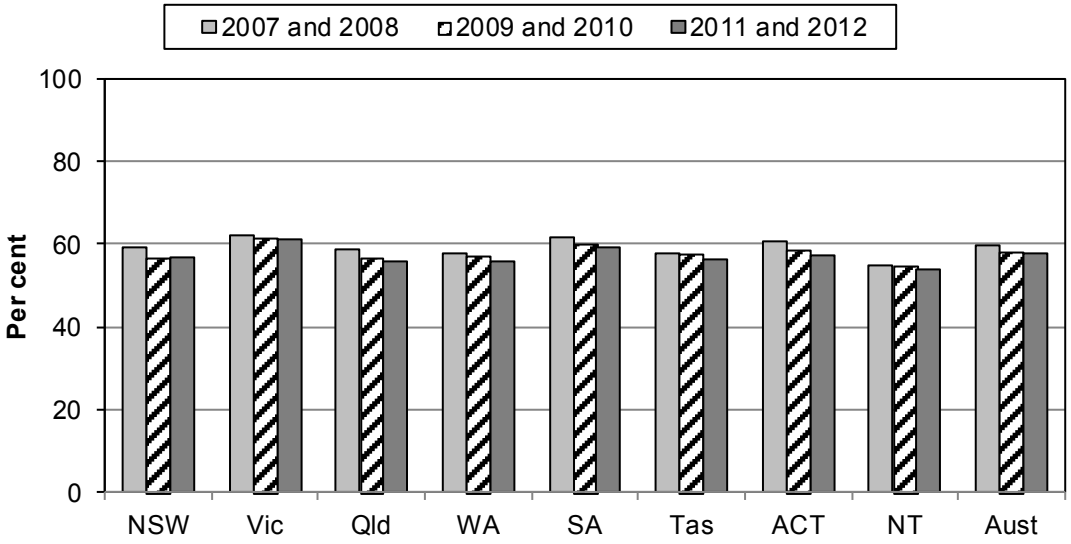
- comparable (subject to caveats) across jurisdictions and over time
- complete (subject to caveats) for the current reporting period. All required data for the 24 month period 2011 and 2012 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated early (Department of Health 2012; Mitchell, Hocking and Saville 2003). A range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening dropped from 59.8 per cent for the 24 month period 1 January 2007 to 31 December 2008 to 57.7 per cent for the 24 months 1 January 2011 to 31 December 2012 (figure 11.47). For most jurisdictions, participation rates have decreased since the screening period of 2007 and 2008. Data for Indigenous women for 2004-05 are presented in table 11A.89.

Figure 11.47 **Participation rates for women aged 20–69 years in cervical screening[a, b, c, d]**



a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP (based on the 2011 Census) in each calendar year in the reference period and age standardised to the 2001 Australian population. **b** Eligible female population adjusted for the estimated proportion who have had a hysterectomy. **c** Excludes women who have opted off the cervical cytology register. **d** Data include all women screened except for Victoria and the ACT, where data are based on residence.

Source: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.88.

Influenza vaccination coverage for older people

'Influenza vaccination coverage for older people' is an indicator of governments' objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.23).

Box 11.23 **Influenza vaccination coverage for older people**

'Influenza vaccination coverage for older people' is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza.

A high or increasing proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications. Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- not available for the current reporting period.

Data quality information for this indicator is under development.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (Department of Health 2013b). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the Immunisation Program. GPs provide the majority of these vaccinations.

Updated data were not available for the 2014 Report. Nationally, 74.6 per cent of eligible people were fully vaccinated against influenza in 2009 (table 11A.90).

Pneumococcal disease is also a vaccine preventable disease that can result in hospitalisation and/or death. Free vaccinations against pneumococcal disease became available to older Australians in 2005. Data for 2009 for older adults fully vaccinated against both influenza and pneumococcal disease are presented by remoteness in table 11A.91. Data for Indigenous Australians fully vaccinated against influenza and pneumococcal disease in 2004-05 are presented in table 11A.92

Selected potentially preventable hospitalisations

'Selected potentially preventable hospitalisations' is an indicator of governments' objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.24).

Box 11.24 **Selected potentially preventable hospitalisations**

'Selected potentially preventable hospitalisations' is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether.

Three measures of selected potentially preventable hospitalisations are reported (the first measure is reported against the indicator of the same name in the NHA):

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2012b; DHS 2002)
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2008b, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people's access to aged care services and other support.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time except for the measure potentially preventable hospitalisations for diabetes
- complete (subject to caveats) for the current reporting period except for the measure potentially preventable hospitalisations for diabetes, for which data are not published for Tasmania, the ACT and the NT. All other required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

This measure has improved for the 2014 Report with data for all states and territories included in Australian totals for the first time. Indigenous identification in 2011-12 hospital administrative data is considered acceptable for analysis in all states and territories from the 2011-12 reporting period.

Studies have shown that hospitalisation rates for selected vaccine preventable, acute and chronic conditions are significantly affected by the availability of care in the primary and community healthcare sector (DHS 2002). These are conditions for

which hospitalisation can potentially be avoided, through prevention of the condition — for example, through vaccination — or, prevention of exacerbations or complications requiring hospitalisation — through effective management of the condition in the primary and community healthcare sector. While not all hospitalisations for the selected conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation for these conditions.

Variation in hospitalisation rates data can also be affected by differences in hospital protocols for clinical coding and admission between and within jurisdictions. This particularly affects diagnoses of dehydration and gastroenteritis and diabetes complications. The effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in Indigenous communities. Caution should also be used in time series analysis because of revisions to clinical coding standards and improvements in data quality over time, as well as changes in hospital coding and admission protocols.

Data are age-standardised to account for differences in the age structures of the populations across states and territories.

Nationally, the age-standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 24.0 per 1000 people in 2011-12 (table 11.9). Of these, 47.1 per cent were for chronic and 49.9 per cent for acute conditions (table 11A.93). Data are presented disaggregated by Indigenous status in table 11A.94 and remoteness in table 11A.95. National data by Indigenous status and remoteness are presented in table 11A.96.

Table 11.9 **Separations for selected potentially preventable hospitalisations per 1000 people, 2011-12[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Vaccine preventable conditions	0.8	0.8	0.9	0.8	0.9	0.5	0.7	3.1	0.8
Selected acute conditions[d]	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0
Selected chronic conditions[e]	10.4	11.9	12.5	10.7	11.4	9.1	8.5	21.0	11.3
Total[f, g]	**22.0**	**24.6**	**26.0**	**24.9**	**25.0**	**18.0**	**18.7**	**43.5**	**24.0**

[a] Separation rates are directly age-standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories. Excludes overseas residents and unknown state of residence. [d] Selected acute conditions excluding dehydration and gastroenteritis. [e] Selected chronic conditions excluding diabetes complications (additional diagnoses only). [f] Total is all potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only). [g] Totals may not add as more than one condition may be reported for a separation.

Source: AIHW (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; AIHW (unpublished); table 11A.93.

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2011-12 (table 11.10). Nationally, influenza and pneumonia accounted for 79.0 per cent of hospital separations for vaccine preventable conditions in 2011-12 (AIHW 2013b).

Table 11.10 **Separations for vaccine preventable conditions per 1000 people, 2011-12[a, b]**

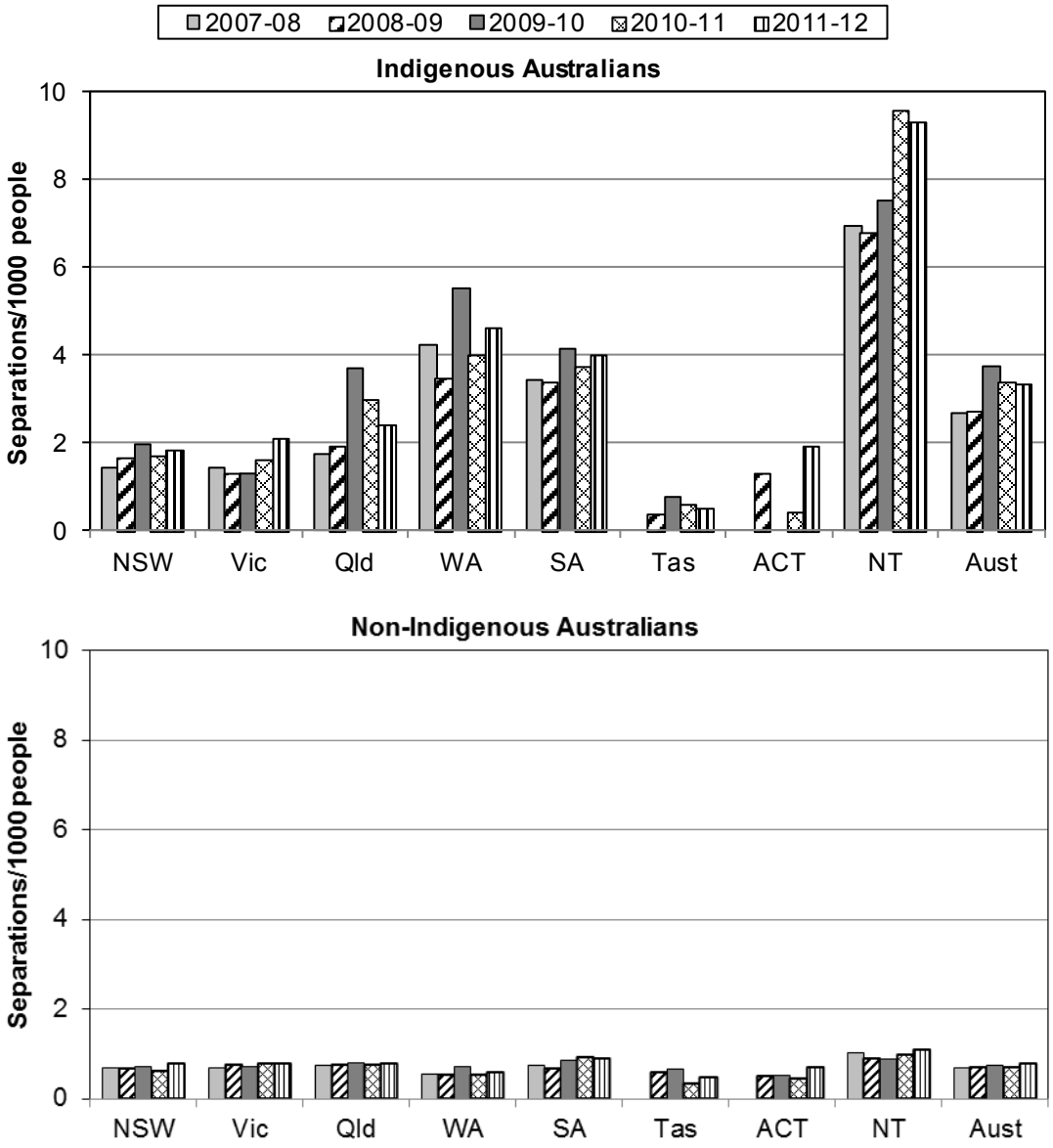
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.6	0.5	0.7	0.6	0.8	0.4	0.6	2.5	0.6
Other conditions	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.6	0.2
Total[d]	**0.8**	**0.8**	**0.9**	**0.8**	**0.9**	**0.5**	**0.7**	**3.1**	**0.8**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories and excludes overseas residents and unknown State of residence. [d] Totals may not add due to rounding.

Source: AIHW (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; table 11A.97.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous Australians than for non-Indigenous Australians in 2011-12, in most jurisdictions (figure 11.48).

Figure 11.48 **Separations for vaccine preventable conditions by Indigenous status**[a, b, c, d, e]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Separation rates are based on State/Territory of usual residence. [d] NT data for 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. [e] For 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.97.

Of the selected acute conditions, dental conditions, dehydration and gastroenteritis, and pyelonephritis recorded the highest rates of hospitalisation nationally in 2011-12 (table 11.11).

Table 11.11 **Separations for selected acute conditions per 1000 people, 2011-12[a, b]**

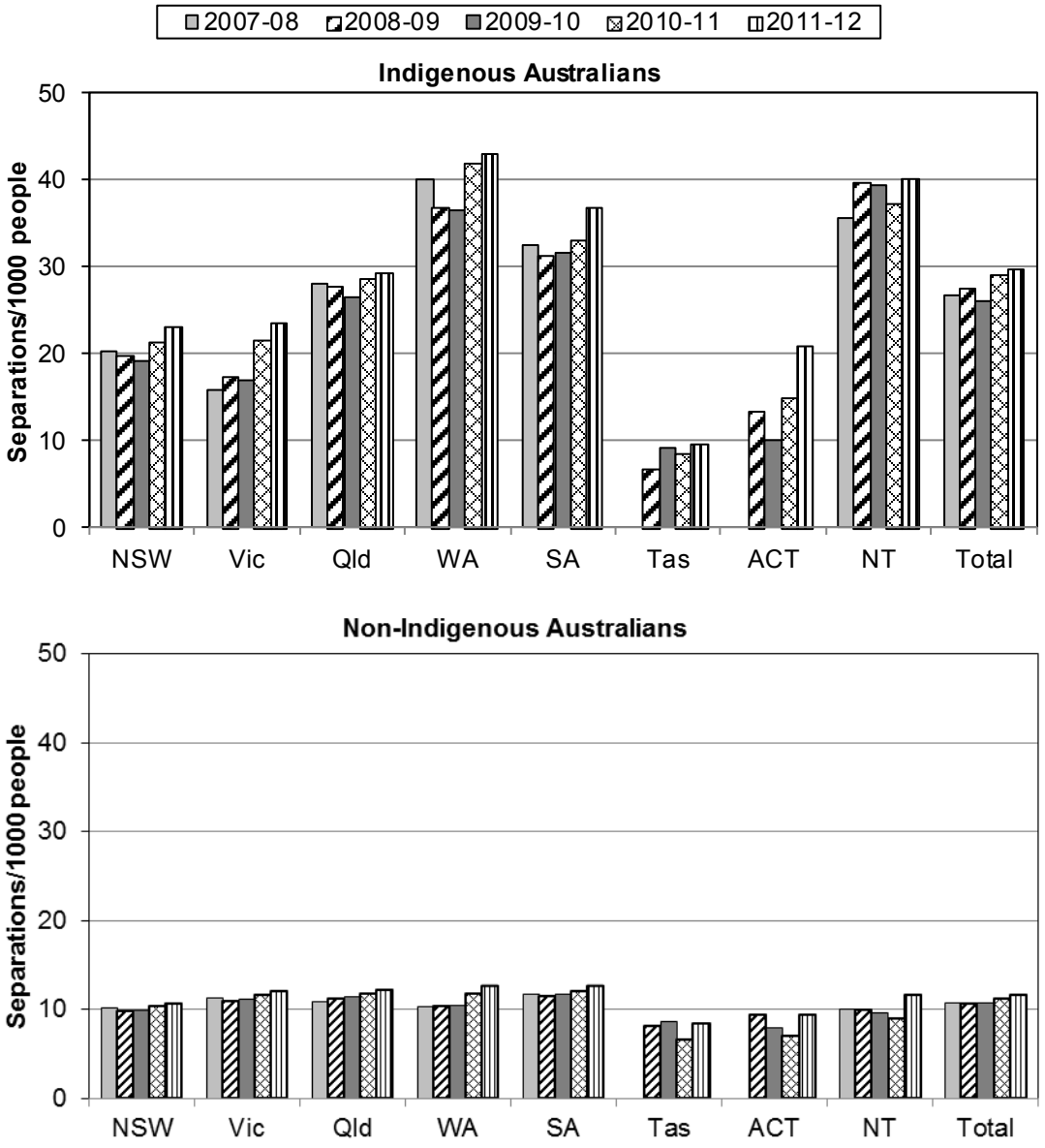
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.4	0.3	0.4	0.4	0.4	0.3	0.2	0.5	0.4
Cellulitis	1.9	1.8	2.1	1.9	1.7	1.3	1.4	4.1	1.9
Convulsions and epilepsy	1.6	1.5	1.7	1.5	1.7	1.2	1.4	3.4	1.6
Dehydration and gastroenteritis[d]	2.6	3.5	3.1	2.7	2.7	2.0	1.8	3.2	2.9
Dental conditions	2.3	3.1	2.9	3.9	3.6	2.3	2.2	3.1	2.9
Ear, nose and throat infections	1.6	1.8	1.9	2.1	2.3	1.1	1.1	2.8	1.8
Gangrene	0.2	0.4	0.3	0.4	0.2	0.2	0.1	0.8	0.3
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.6	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis[e]	2.6	2.8	3.0	3.0	2.5	1.6	2.6	4.4	2.7
Total[d, f]	**13.5**	**15.6**	**15.8**	**16.2**	**15.6**	**10.4**	**11.3**	**23.0**	**14.9**
Total excluding dehydration and gastroenteritis[f]	**10.9**	**12.0**	**12.7**	**13.6**	**12.8**	**8.5**	**9.5**	**19.8**	**12.0**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories and excludes overseas residents and unknown State of residence. [d] Data for dehydration and gastroenteritis, and therefore for total selected acute conditions, are not comparable across jurisdictions due to differences in clinical coding and admission protocols. [e] Kidney inflammation caused by bacterial infection. [f] Totals may not add as more than one acute condition may be reported for a separation.

Source: AIHW (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; AIHW (unpublished) National Hospital Morbidity Database; table 11A.98.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous Australians than for non-Indigenous Australians in all jurisdictions in 2011-12 (figure 11.49).

Figure 11.49 **Separations for selected acute conditions by Indigenous status**[a, b, c, d, e, f]



[a] Excludes separations for dehydration and gastroenteritis. [b] Separation rates are directly age standardised to the Australian population at 30 June 2001. [c] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [d] Separation rates are based on State/Territory of usual residence. [e] NT data for 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. [f] For 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.98.

Of the selected chronic conditions, chronic obstructive pulmonary disease, congestive cardiac failure, asthma and diabetes complications (as well as diabetes complications as principal diagnosis only), recorded the highest rates of hospitalisation nationally in 2011-12 (table 11.12).

Table 11.12 **Separations for selected chronic conditions per 1000 people, 2011-12[a, b]**

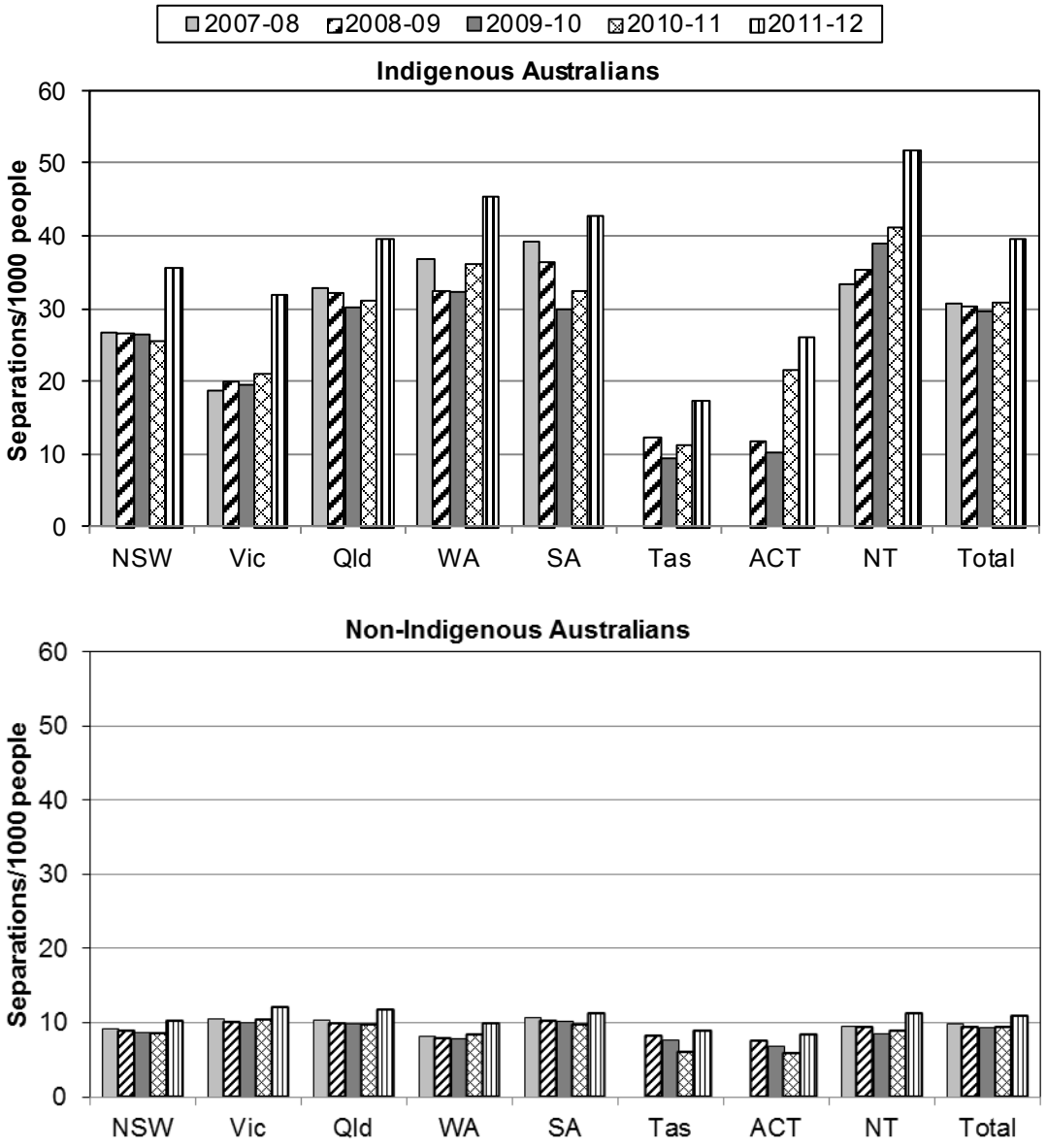
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.0	1.2	1.9	1.3	1.3	0.9	0.7	2.4	1.3
Asthma	1.8	2.0	1.7	1.4	1.9	1.0	1.2	1.9	1.8
Chronic obstructive pulmonary disease	2.7	2.6	3.1	2.4	2.7	2.1	2.4	7.1	2.8
Congestive cardiac failure	1.9	2.2	2.1	1.9	1.8	1.4	1.6	3.5	2.0
Diabetes complications (as principal or additional diagnosis)[d]	2.5	3.1	4.3	8.0	3.1	2.9	2.0	6.8	3.6
Diabetes complications (as principal diagnosis only)	1.4	1.7	1.8	1.6	1.9	1.8	1.2	3.3	1.6
Hypertension	0.3	0.3	0.5	0.3	0.3	0.2	0.2	0.2	0.3
Iron deficiency anaemia	1.1	1.9	1.3	1.6	1.4	1.6	1.1	1.5	1.4
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	–	<0.1	0.1	<0.1
Rheumatic heart disease [e]	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.9	0.1
Total[d, f]	**11.3**	**13.0**	**14.5**	**16.8**	**12.3**	**9.9**	**9.1**	**23.4**	**13.0**
Total excluding diabetes complications as additional diagnosis[f]	**10.4**	**11.9**	**12.5**	**10.7**	**11.4**	**9.1**	**8.5**	**21.0**	**11.3**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on State/Territory of usual residence. [c] Includes other territories. Excludes overseas residents and unknown State of residence. [d] Data for diabetes complications, and therefore for total selected chronic conditions, are not comparable across jurisdictions due to differences in clinical coding and admission protocols. [e] Includes acute rheumatic fever as well as the chronic disease. [f] Totals may not add as more than one chronic condition may be reported for a separation. – Nil or rounded to zero.

Source: AIHW (2013b) *Australian Hospital Statistics 2011-12*, Cat. no. HSE 134; AIHW (unpublished) National Hospital Morbidity Database; table 11A.99.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous Australians than for non-Indigenous Australians in all jurisdictions in 2011-12 (figure 11.50).

Figure 11.50 **Separations for selected chronic conditions by Indigenous status**[a, b, c, d, e, f]



[a] Excludes separations for diabetes complications as additional diagnosis. [b] Separation rates are directly age standardised to the Australian population at 30 June 2001. [c] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [d] Separation rates are based on State/Territory of usual residence. [e] NT data for 2011-12 are for public and private hospitals. For previous years, NT data are for public hospitals only. [f] From 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.99.

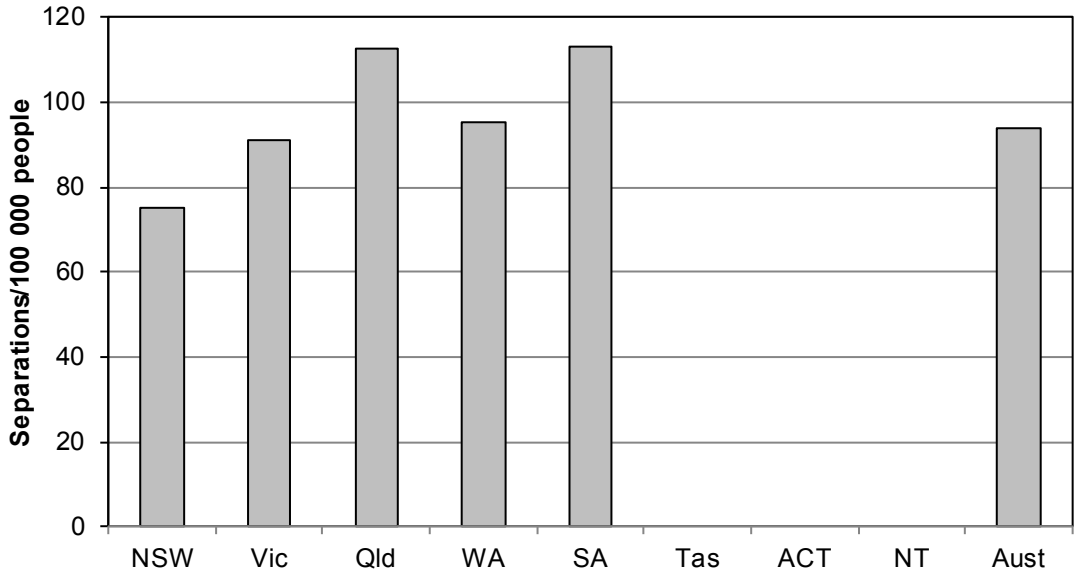
Potentially preventable hospitalisations for diabetes

Diabetes is a chronic disease of increasing prevalence, and is an identified National Health Priority Area for Australia. People with diabetes are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

The provision of high quality, appropriate and effective management of diabetes in the primary and community health sector can prevent or minimise the severity of diabetes complications, thereby reducing demand for hospitalisation (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Nationally, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 93.8 separations per 100 000 people in 2011-12 (figure 11.51).

Figure 11.51 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2011-12[a, b, c]**



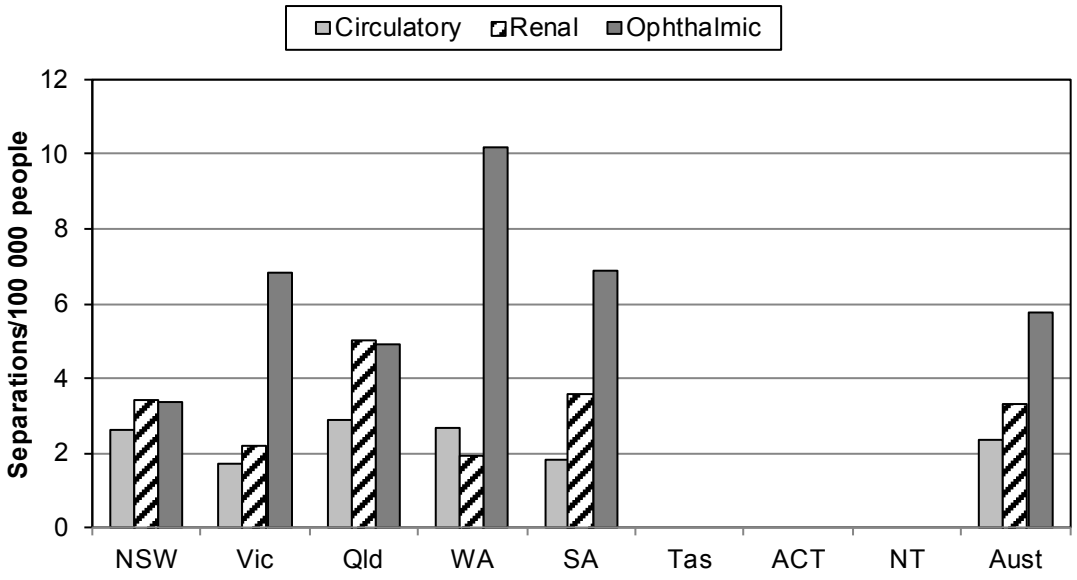
a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. **b** Morbidity data are coded under coding standards that can differ over time and across jurisdictions. **c** Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.101.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2011-12 were ophthalmic, renal and circulatory complications.

Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.52).

Figure 11.52 **Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2011-12[a, b, c, d, e]**



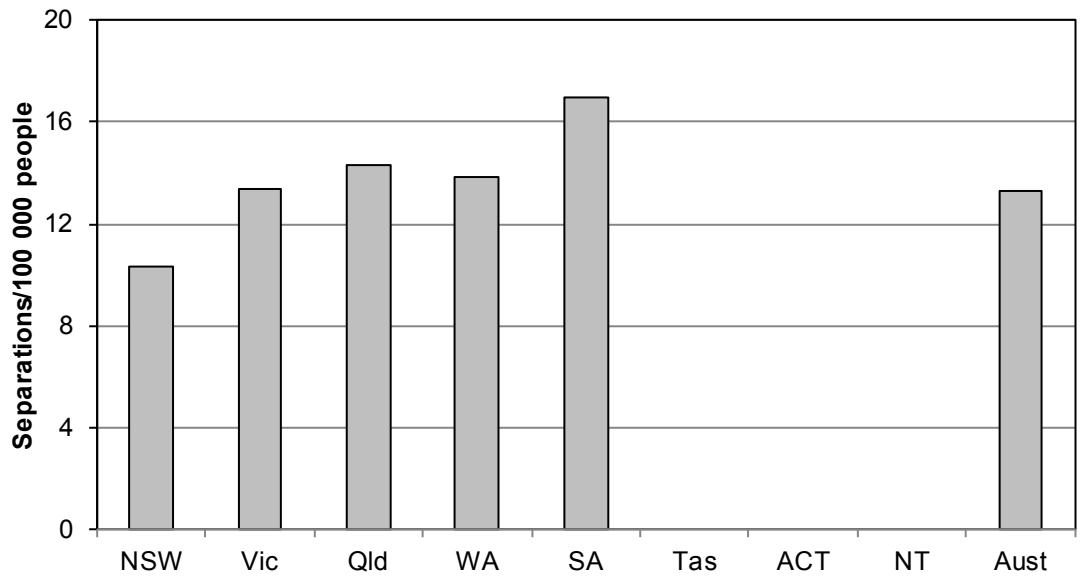
[a] Results for individual complications can be affected by small numbers, and need to be interpreted with care. [b] Patients can have one or more complication(s) for each separation. [c] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of 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 can 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.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.101.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but these data are not included in the hospital separations data. 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 affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 22.4 per cent of separations for Type 2 diabetes were same day separations in 2011-12 (table 11A.102).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2011-12, there were 13.3 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.53).

Figure 11.53 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2011-12[a, b, c]**



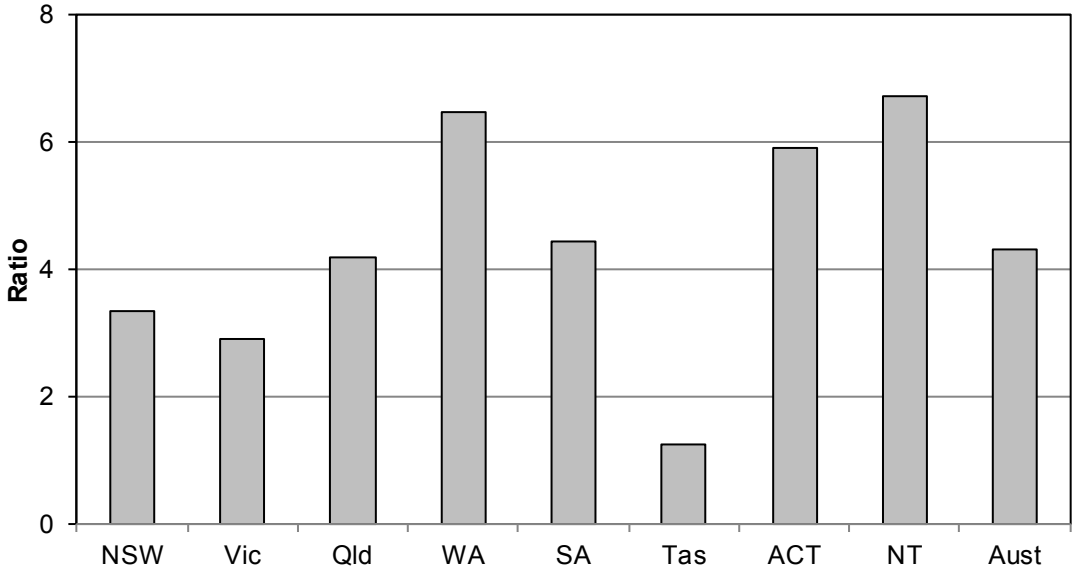
a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Includes unspecified diabetes. Data are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. **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.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.103.

Age standardised hospital separation ratios for diabetes (excluding separations for diabetes complications as an additional diagnosis) illustrate differences between the rate of hospital admissions for Indigenous Australians and that for all Australians, taking into account differences in the age structures of the two populations. Rate ratios close to one indicate that Indigenous Australians have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. A reduction in the gap in hospital separation rates between Indigenous and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2011-12 between the separation rates for Indigenous Australians and those for the total population for diabetes diagnoses (figure 11.54).

Figure 11.54 **Ratio of separation rates of Indigenous Australians to all people for diabetes, 2011-12**[a, b, c, d, e, f]



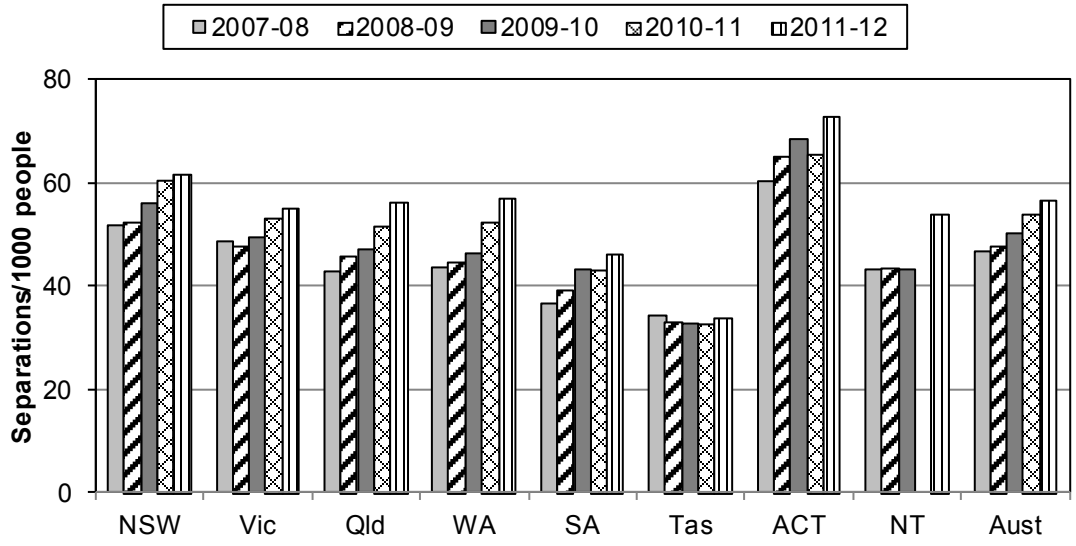
[a] Excludes separations with diabetes complications as an additional diagnosis. [b] Ratios are directly age standardised to the Australian population at 30 June 2001. [c] Separation rates are based on state of usual residence. [d] Patients aged 75 years or over are excluded. [e] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [f] NT data are for public hospitals only.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.100.

Potentially preventable hospitalisations of older people for falls

For people over 65 years, injurious falls accounted for one in ten days spent in hospital in 2009-10 (Bradley 2013). The number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions, increased in the period 2007-08 to 2011-12 in most jurisdictions (figure 11.55).

Figure 11.55 **Separations for older people with a reported external cause of falls[a, b, c]**



[a] Older people are defined as people aged 65 years or over. [b] Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. [c] Excludes separations records for hospital boarders and posthumous organ procurement. [d] Data are not available for the NT for 2010-11.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.104.

11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Allied health professional workforce data are anticipated to be available for the 2015 Report from the new National Registration and Accreditation Scheme. Priorities for future reporting on primary and community health services include:

- further improving the reporting of public dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items.

The scope of this chapter can also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous Australians compared to other Australians (see the Health sector overview). The Steering Committee has identified primary and community health services for Indigenous Australians as a priority area for future reporting and will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers' Advisory Council will inform the selection of future indicators of primary and community health services for Indigenous Australians.

Continued efforts to improve the quality of Indigenous data, particularly Indigenous identification and completeness, are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems.

11.5 Definitions of key terms

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma Action Plan	An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional. *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra.
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs were active until end June 2012. There were 109 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The Divisions of General Practice Program (DGPP) aims were to contribute to improved health outcomes for communities by working with GPs and other health service providers to improve the quality and accessibility of healthcare at the local level. From 30 June 2011, Medicare Locals progressively assumed responsibility for general practice support initiatives previously funded under the DGPP. The DGPP ceased on 30 June 2012.
Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by DHS Medicare in a given period, calculated by dividing the practitioner's DHS Medicare billing by the mean billing

	of full time practitioners for that period. Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine and three doses of *Haemophilus influenzae* type B vaccine.
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, four doses of *Haemophilus influenzae* type B and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella vaccines.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.
GP-type services	Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.
Haemophilus influenzae type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (Department of Health 2013c).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Medicare Locals	Medicare Locals (MLs) are independent regional primary health care organisations with responsibility for supporting improved co-ordination of primary health care service delivery, as well as identifying and addressing gaps in primary health care services, across their regions (www.amlalliance.com.au/about-us, accessed 25 November 2013). Established progressively from 1 July 2011 under the National Health Reform agenda, the national network of 61 MLs and a national body, the Australian Medicare Local Alliance (AML Alliance), were operational at 1 July 2012.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive DHS Medicare reimbursement.

Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (Department of Health 2013d). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 DHS Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
PBS doctor's bag	Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient.
Per person benefits paid for GP ordered pathology	Total benefits paid under DHS Medicare for pathology tests requested by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally registered, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and Quality Practice Accreditation Pty Ltd), divided by the total number of practices.
Proportion of general practices with electronic health information systems	Number of PIP-registered practices that have taken up the eHealth PIP incentive, divided by the total number of practices registered.

Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Recognised immunisation provider	A provider recognised by DHS Medicare as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Triage category	The urgency of the patient's need for medical and nursing care: • category 1 — resuscitation (immediate within seconds) • category 2 — emergency (within 10 minutes) • category 3 — urgent (within 30 minutes) • category 4 — semi-urgent (within 60 minutes) • category 5 — non-urgent (within 120 minutes).
Vocationally registered general practitioner	A medical practitioner who is vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances.

11.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 11A.1 Types of encounter, 2012-13

Table 11A.2 Australian Government real expenditure on GPs — fee-for-service expenditure ($ million) (2012-13 dollars)

Table 11A.3 Australian Government real expenditure on GPs ($ million) (2012-13 dollars)

Table 11A.4 Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars)

Table 11A.5 Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars)

Table 11A.6 Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas, 2012-13

Table 11A.7 Expenditure on dental services, 2011-12 ($ million)

Table 11A.8 Australian Government funding of Aboriginal Medical Services

Table 11A.9 Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs

Table 11A.10 Number of GP-type services used per 1000 people

Table 11A.11 PBS services

Table 11A.12 PBS services, by service type ('000)

Table 11A.13 Use of public dental services, by service type, 2010

Table 11A.14 Alcohol and other drug treatment services, 2011-12 (number)

Table 11A.15 Indigenous primary healthcare services and episodes of healthcare (number)

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Table 11A.21 PBS expenditure per person, by urban and rural location, 2008-09 to 2011-12 (2012-13 dollars)

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Table 11A.23 Availability of GPs by region, 2003-04 to 2011-12

Table 11A.24 Availability of female GPs

Table 11A.25 Availability of public dentists (per 100 000 people)

Table 11A.26 Availability of public dental hygienists and dental therapists (per 100 000 people)

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Table 11A.28 Older Indigenous Australians who received an annual health assessment (per cent)

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Table 11A.33 Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent)
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Table 11A.36 Indigenous Australians deferring access to GPs due to cost, 2012-13 (per cent)
Table 11A.37 Waiting time for GPs for an urgent appointment (per cent)
Table 11A.38 Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment, 2012-13 (per cent)
Table 11A.39 Selected potentially avoidable GP-type presentations to emergency departments (number)
Table 11A.40 People attending a hospital emergency department who thought the care could have been provided at a general practice
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Table 11A.42 Indigenous people deferring access to prescribed medication due to cost, 2012-13 (per cent)
Table 11A.43 "Waiting time for public dentistry, 2012-13 (per cent)
Table 11A.44 Waiting time for public dentistry by remoteness, Australia, 2012-13
Table 11A.45 Waiting times for public dentistry, Indigenous Australians, by remoteness, Australia, 2012-13 (per cent)
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Table 11A.53 Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied
Table 11A.54 Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia
Table 11A.55 Proportion of people with self-reported diabetes who had a GP annual cycle of care (per cent)
Table 11A.56 Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent)
Table 11A.57 Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent)

Table 11A.58 Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent , by State and Territory, by sex, 2011-12 (per cent)
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Table 11A.60 Proportion of people with asthma with a written asthma plan, by region, 2007-08
Table 11A.61 Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05
Table 11A.62 GP use of chronic disease management Medicare items for care planning or case conferencing
Table 11A.63 Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2012-13 dollars) and number of rebated MBS pathology items
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11A Primary and community health — attachment

Definitions for the indicators and descriptors in this attachment are in section 11.5 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

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Table 11A.1 **Types of encounter, 2012-13 (a), (b)**

	Number	*Per cent of encounters* (c) *(n = 90 077)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n = 88 586)*	*Medicare/DVA-paid GP items (n = 85 881)*
	no.	%	%	%	%	%
Direct encounters	88 568	98.3	98.1	98.6	100.0	..
No charge	334	0.4	0.3	0.4	0.4	..
MBS/DVA items of service (direct encounters only) (d)	85 870	95.3	94.9	95.8	96.9	..
MBS/DVA items of service (GPs only)	85 881	95.3	94.9	95.8	97.0	100.0
Short surgery consultations	1 502	1.7	1.4	1.9	0.0	1.7
Standard surgery consultations	69 260	76.9	75.8	78.0	0.8	80.6
Long surgery consultations	8 071	9.0	8.4	9.6	0.1	9.4
Prolonged surgery consultations	491	0.6	0.4	0.6	0.0	0.6
Home or institution visits (excluding RACF)	829	0.9	0.7	1.1	0.0	1.0
Residential aged care facility	1 490	1.7	1.2	2.1	0.0	1.7
Health assessments	346	0.4	0.3	0.4	0.0	0.4
Chronic disease management items	1 232	1.4	1.2	1.5	0.0	1.4
Case conferences	11	<0.05	–	–	0.0	–
GP mental health care items	1 258	1.4	1.2	1.5	0.0	1.5
Attendances associated with practice incentive payments	187	0.2	0.2	0.3	0.0	0.2
Other items	1 203	1.3	1.1	1.6	0.0	1.4
Workers compensation	1 580	1.8	1.6	1.9	1.8	..
Other paid (hospital, State, etc.)	785	0.9	0.6	1.2	0.9	..

Table 11A.1 **Types of encounter, 2012-13 (a), (b)**

	Number	*Per cent of encounters* (c) *(n = 90 077)*	*95% LCL*	*95% UCL*	*Per cent of direct encounters (n = 88 586)*	*Medicare/DVA-paid GP items (n = 85 881)*
Indirect encounters (e)	1 506	1.7	1.4	1.9	–	..
Direct/indirect encounter unspecified	2	<0.05	–	–	..	..
Total encounters	**90 077**	**100.0**	..	..	..	..
MBS/DVA items of service (all encounters)	85 885	95.3	94.9	95.8	..	..

LCL=lower confidence limit; **UCL**=upper confidence limit; **MBS**=Medicare Benefits Schedule; **DVA**=Department of Veterans' Affairs; **RACF** = Residential aged care facility.

(a) An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals).

(b) One Medicare item number counted per encounter (where applicable).

(c) Missing data removed from analysis (*n* =8487).

(d) Direct encounters are encounters where the patient is seen by the health professional. Includes direct encounters at which either a GP or other health professional item (or both) was recorded.

(e) Indirect encounters are encounters where the patient is not seen but a service is provided (for example, a prescription or referral). Includes indirect encounters involving a GP or other health professional (or both). Includes five encounters involving chronic disease management or case conference items.

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

Source: Britt, H., Miller, G.C, Henderson, J., Bayram, C., Valenti, L., Harrison, C., Charles, J., Pan, Y., Zhang, C., Pollack, A.J., O'Halloran, J. 2013, *General practice activity in Australia 2012–13* , General practice series no. 33, Sydney University Press, Sydney.

Table 11A.2 **Australian Government real expenditure on GPs — fee-for-service expenditure ($ million) (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
Expenditure through DHS Medicare fee for service — total										
2012-13	$m	2 355.6	1 714.2	1 413.7	557.7	515.1	149.2	83.5	46.6	6 835.5
Expenditure through DHS Medicare fee for service — per person (ASR) (e), (f)										
2012-13	$	303.1	288.0	299.9	224.7	285.0	265.1	225.1	223.1	286.1

ASR = age standardised rate.

(a) Age standardised expenditure per person data are available for the first time for the 2012-13 reference year. Data for previous years are provided in table 11A.3.

(b) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through 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.

(c) Data include expenditure on Department of Human Services—Medicare (DHS Medicare) and the Department of Veteran's Affairs (DVA). Data exclude expenditure on the Practice Incentives Program (PIP), the General Practice Immunisation Incentive Scheme (GPII) and Medicare Locals (ML). Data are not comparable with data in table 11A.3 that include this expenditure.

(d) Data for Australia includes expenditure on patients of unknown age.

(e) Expenditure per person is directly age standardised to the 2001 Australian standard population. Expenditure on Medicare Locals, GPII and PIP is excluded as these are not related to age and cannot be age-standardised. Data are not comparable to previous years for which crude rates are reported (see table 11A.3).

(f) Rates are derived using the ABS first preliminary estimated resident population based on the 2011 Census.

Source : Department of Health unpublished, MBS statistics; DVA unpublished; table 2A.51.

Table 11A.3 **Australian Government real expenditure on GPs ($ million) (2012-13 dollars) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Expenditure (c)										
2006-07	$m	2 202.2	1 526.9	1 222.4	522.6	494.3	142.7	76.6	34.2	6 221.9
2007-08	$m	2 277.0	1 607.5	1 285.7	545.6	514.5	148.8	80.2	37.6	6 496.8
2008-09	$m	2 273.1	1 614.9	1 306.4	541.5	517.8	146.0	79.6	37.8	6 517.1
2009-10	$m	2 299.0	1 654.8	1 346.6	551.8	524.1	149.6	79.9	40.8	6 646.6
2010-11	$m	2 321.0	1 687.0	1 376.2	555.3	525.4	150.5	80.1	43.2	6 738.8
2011-12	$m	2 361.5	1 709.9	1 415.6	554.3	525.5	152.0	81.8	44.8	6 845.4
2012-13 (e)	$m	2 532.2	1 858.5	1 531.6	619.3	568.1	167.2	89.8	59.3	7 426.0
Expenditure per person (crude rates) (f)										
2006-07	$	324.5	299.2	301.4	251.6	316.6	290.3	226.4	162.1	301.6
2007-08	$	330.8	309.2	309.1	255.5	325.9	300.1	233.0	173.6	309.1
2008-09	$	324.6	303.9	305.6	245.1	324.1	291.0	226.7	169.9	303.5
2009-10	$	323.7	305.4	308.3	243.8	323.8	295.4	223.3	179.1	304.0
2010-11	$	323.3	307.0	310.2	239.5	321.8	295.0	219.6	187.6	303.9
2011-12	$	325.8	306.7	313.7	232.2	319.4	297.0	220.6	192.8	304.4

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Rates are derived using the ABS final 2011 Census rebased estimated resident population (ERP).

(c) Data include expenditure on Department of Human Services—Medicare, the Practice Incentives Program (PIP), the Department of Veterans' Affairs (DVA) and the General Practice Immunisation Incentive Scheme (GPII). Data include expenditure on the Divisions of General Practice Program (DGPP) for 2011-12 and previous years. From 2012-13, total expenditure data include core operational expenditure on Medicare Locals (ML).

(d) From 2010-11, DVA data include expenditure only on specialist GPs. DVA data for 2009-10 and previous years include expenditure on all local medical officers (LMO). Other data include expenditure on vocationally registered GPs and other medical practitioners (OMPs).

(e) Some primary care services are provided by salaried GPs in community health services, particularly in rural and remote areas, through 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.

(f) Expenditure data for 2011-12 and previous years are crude rates and are not comparable with data for 2012-13, which are age-standardised. See table 11A.2 for age-standardised expenditure per person data for 2012-13.

Source : Department of Health unpublished, MBS, PIP, GPII, DGPP, ML and DVA data collections; table 2A.51.

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS Total (d)										
2003-04	$m	2 384.0	1 718.1	1 249.6	596.2	575.0	186.2	86.7	23.5	6 832.1
2004-05	$m	2 404.4	1 736.1	1 301.0	598.4	581.1	183.6	87.7	24.6	6 917.2
2005-06	$m	2 327.9	1 695.5	1 262.5	580.8	576.4	182.5	84.5	24.5	6 734.6
2006-07	$m	2 271.8	1 642.0	1 249.3	571.9	558.2	176.1	81.6	23.4	6 574.4
2007-08	$m	2 351.1	1 701.7	1 294.1	595.4	583.1	184.8	83.9	24.8	6 818.9
2008-09	$m	2 523.0	1 807.8	1 391.2	642.8	615.1	197.0	89.2	26.3	7 292.6
2009-10	$m	2 626.4	1 884.9	1 458.5	661.4	636.3	206.4	93.7	26.9	7 594.5
2010-11	$m	2 631.9	1 876.5	1 455.1	675.1	626.3	209.2	93.7	27.9	7 595.6
2011-12	$m	2 625.1	1 884.0	1 475.9	712.4	633.4	212.0	93.4	27.5	7 663.8
2012-13	$m	2 423.2	1 748.7	1 370.9	640.9	592.7	192.6	89.8	25.5	7 084.2
RPBS Total (e)										
2004-05	$m	216.0	134.0	135.7	46.5	46.6	18.5	8.7	1.1	607.2
2005-06	$m	200.7	125.7	126.3	43.8	44.5	17.7	8.4	1.2	568.2
2006-07	$m	185.4	115.9	119.1	41.3	41.2	15.9	7.7	1.0	527.3
2007-08	$m	180.7	110.7	116.5	40.8	39.6	15.6	7.8	1.0	512.8
2008-09	$m	182.0	108.6	117.6	40.8	39.6	15.4	7.9	1.0	513.0
2009-10	$m	180.3	106.4	118.2	39.2	39.8	15.3	7.9	1.0	508.0
2010-11	$m	168.0	97.3	113.0	37.2	35.4	14.2	7.4	0.9	473.4
2011-12	$m	158.8	90.2	110.1	36.4	34.1	13.9	6.9	0.9	451.2
2012-13	$m	139.5	77.5	97.9	30.9	28.6	12.0	6.5	0.8	393.7
PBS and RPBS TOTAL										
2004-05	$m	2 620.4	1 870.1	1 436.7	644.9	627.7	202.1	96.4	25.8	7 524.5
2005-06	$m	2 528.6	1 821.2	1 388.8	624.6	620.9	200.2	92.9	25.6	7 302.8

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07	$m	2 457.2	1 757.9	1 368.4	613.1	599.4	192.0	89.3	24.4	7 101.7
2007-08	$m	2 531.8	1 812.4	1 410.6	636.2	622.8	200.4	91.7	25.8	7 331.7
2008-09	$m	2 705.0	1 916.4	1 508.8	683.6	654.7	212.4	97.1	27.3	7 805.6
2009-10	$m	2 806.7	1 991.3	1 576.7	700.6	676.1	221.6	101.5	27.8	8 102.4
2010-11	$m	2 799.9	1 973.8	1 568.1	712.3	661.7	223.5	101.1	28.7	8 069.0
2011-12	$m	2 783.9	1 974.2	1 586.0	748.7	667.5	225.9	100.3	28.4	8 115.0
2012-13	$m	2 562.7	1 826.1	1 468.8	671.8	621.4	204.6	96.3	26.3	7 477.9
PBS total expenditure per person (f)										
2004-05	$	353.6	344.5	327.9	296.6	376.4	377.4	269.5	121.6	339.2
2005-06	$	342.2	332.6	311.1	284.6	369.0	372.9	253.7	116.9	327.0
2006-07	$	330.7	317.3	301.7	274.4	353.6	357.7	242.0	109.9	314.7
2007-08	$	338.6	323.7	305.3	278.9	365.6	372.1	245.6	113.6	321.2
2008-09	$	357.5	336.3	319.0	291.1	380.9	393.1	255.9	118.4	336.2
2009-10	$	364.5	342.3	325.3	290.9	388.7	407.7	263.4	117.7	342.1
2010-11	$	361.2	335.3	319.1	290.9	378.8	410.1	258.4	120.8	337.3
2011-12	$	361.6	337.4	326.4	298.0	384.4	413.8	251.5	118.0	340.2
2012-13	$	329.1	307.2	296.6	258.8	355.9	375.2	236.1	107.1	308.6
Proportion of PBS expenditure that is concessional										
2003-04	%	79.9	79.7	79.7	77.9	81.6	84.7	65.8	65.4	79.5
2004-05	%	79.8	79.8	79.4	77.8	81.4	84.6	66.0	66.8	79.6
2005-06	%	80.3	80.3	79.6	77.9	82.3	85.0	66.7	67.1	80.0
2006-07	%	80.8	80.8	80.0	77.2	82.4	84.9	66.8	68.6	80.4
2007-08	%	79.9	80.1	78.6	75.0	81.8	84.7	65.5	66.8	79.3
2008-09	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9

Table 11A.4 **Australian government expenditure on the Pharmaceutical Benefits Scheme (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2009-10	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
2010-11	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
2011-12	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
2012-13	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Rates for 2012-13 are derived using the preliminary ABS 2011 Census based estimated resident populations (ERP) for 31 December 2012. The national rate differs from that reported in table 11A.21, which reports rates derived from the final ABS 2011 Census based ERP for 30 June 2011.

(c) State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 11A.6]).

(d) PBS total includes PBS general ordinary, general safety net, concessional ordinary, concessional safety net and doctor's bag.

(e) Includes RPBS general ordinary and RPBS general safety net.

(f) PBS expenditure per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
PBS General Ordinary	$m	445.6	320.5	271.7	148.8	101.0	29.4	27.4	8.6	1 352.9
PBS General Safety Net	$m	85.9	58.3	47.4	23.3	16.0	4.6	4.9	0.8	241.1
PBS General total	$m	531.5	378.8	319.1	172.0	116.9	34.0	32.2	9.4	1 594.0
PBS Concessional Ordinary	$m	1 505.5	1 087.3	809.0	367.2	382.6	123.0	45.1	14.8	4 334.4
PBS Concessional Free Safety Net	$m	480.5	337.9	259.5	102.4	114.5	39.6	11.7	2.1	1 348.2
PBS Concessional total (a)	$m	1 986.0	1 425.1	1 068.5	469.6	497.0	162.6	56.8	16.9	5 682.5
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	5.6	3.9	3.6	1.2	1.2	0.4	0.2	0.1	16.1
PBS Unknown free safety net plus Doctors bag	$m	5.6	3.9	3.6	1.2	1.2	0.4	0.2	0.1	16.1
PBS Total	**$m**	**2 523.0**	**1 807.8**	**1 391.2**	**642.8**	**615.1**	**197.0**	**89.2**	**26.3**	**7 292.6**
RPBS Total (d)	$m	182.0	108.6	117.6	40.8	39.6	15.4	7.9	1.0	513.0
PBS and RPBS TOTAL	**$m**	**2 705.0**	**1 916.4**	**1 508.8**	**683.6**	**654.7**	**212.4**	**97.1**	**27.3**	**7 805.6**
PBS total expenditure per person (no.) (e)	$	357.5	336.3	319.0	291.1	380.9	393.1	255.9	118.4	336.2
Proportion of PBS expenditure that is concessional (%)	%	78.7	78.8	76.8	73.0	80.8	82.6	63.7	64.1	77.9
2009-10										
PBS General Ordinary	$m	474.1	344.5	291.6	158.4	105.5	32.7	30.5	9.1	1 446.2
PBS General Safety Net	$m	75.5	52.1	43.2	21.5	14.0	4.2	4.3	0.6	215.5
PBS General total	$m	549.5	396.6	334.8	179.9	119.5	36.8	34.8	9.7	1 661.8
PBS Concessional Ordinary	$m	1 588.4	1 143.2	856.6	378.3	399.5	129.5	47.1	15.0	4 557.7

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS Concessional Free Safety Net	$m	483.6	341.5	263.8	102.1	116.1	39.7	11.6	2.1	1 360.4
PBS Concessional total (a)	$m	2 071.9	1 484.7	1 120.4	480.4	515.6	169.2	58.7	17.1	5 918.0
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	5.0	3.6	3.2	1.1	1.1	0.3	0.2	0.1	14.7
PBS Unknown free safety net plus Doctors bag	$m	5.0	3.6	3.2	1.1	1.1	0.3	0.2	0.1	14.7
PBS Total	**$m**	**2 626.4**	**1 884.9**	**1 458.5**	**661.4**	**636.3**	**206.4**	**93.7**	**26.9**	**7 594.5**
RPBS Total (d)	$m	180.3	106.4	118.2	39.2	39.8	15.3	7.9	1.0	508.0
PBS and RPBS TOTAL	**$m**	**2 806.7**	**1 991.3**	**1 576.7**	**700.6**	**676.1**	**221.6**	**101.5**	**27.8**	**8 102.4**
PBS total expenditure per person (no.) (e)	$	364.5	342.3	325.3	290.9	388.7	407.7	263.4	117.7	342.1
Proportion of PBS expenditure that is concessional (%)	%	78.9	78.8	76.8	72.6	81.0	82.0	62.7	63.7	77.9
2010-11										
PBS General Ordinary	$m	479.0	348.4	288.2	166.9	106.0	33.6	30.6	9.8	1 462.5
PBS General Safety Net	$m	75.8	52.9	43.9	22.9	14.7	4.0	4.6	0.7	219.4
PBS General total	$m	554.8	401.2	332.1	189.8	120.7	37.6	35.2	10.5	1 681.9
PBS Concessional Ordinary	$m	1 583.6	1 125.6	852.1	379.3	386.9	131.9	46.8	15.1	4 521.5
PBS Concessional Free Safety Net	$m	488.6	346.0	267.5	104.8	117.6	39.3	11.5	2.2	1 377.5
PBS Concessional total (a)	$m	2 072.2	1 471.6	1 119.6	484.2	504.5	171.2	58.3	17.3	5 899.0
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS Doctors Bag	$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.7
PBS Unknown free safety net plus Doctors bag	$m	4.9	3.7	3.4	1.1	1.1	0.4	0.2	0.1	14.7
PBS Total	**$m**	**2 631.9**	**1 876.5**	**1 455.1**	**675.1**	**626.3**	**209.2**	**93.7**	**27.9**	**7 595.6**
RPBS Total (d)	$m	168.0	97.3	113.0	37.2	35.4	14.2	7.4	0.9	473.4
PBS and RPBS TOTAL	**$m**	**2 799.9**	**1 973.8**	**1 568.1**	**712.3**	**661.7**	**223.5**	**101.1**	**28.7**	**8 069.0**
PBS total expenditure per person (no.) (e)	$	361.2	335.3	319.1	290.9	378.8	410.1	258.4	120.8	337.3
Proportion of PBS expenditure that is concessional (%)	%	78.7	78.4	76.9	71.7	80.6	81.8	62.3	62.1	77.7
2011-12										
PBS General Ordinary	$m	476.5	354.8	285.3	180.8	106.1	34.1	30.2	9.5	1 477.4
PBS General Safety Net	$m	70.9	52.0	41.9	22.7	14.7	4.0	4.7	0.6	211.6
PBS General total	$m	547.4	406.8	327.2	203.5	120.8	38.2	34.9	10.2	1 689.0
PBS Concessional Ordinary	$m	1 575.9	1 120.0	870.0	399.4	389.3	132.8	46.4	15.1	4 548.9
PBS Concessional Free Safety Net	$m	497.5	353.9	275.9	108.4	122.3	40.7	12.0	2.2	1 412.8
PBS Concessional total (a)	$m	2 073.3	1 473.9	1 145.9	507.8	511.6	173.6	58.3	17.2	5 961.7
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	4.4	3.3	2.8	1.1	1.0	0.3	0.2	0.1	13.2
PBS Unknown free safety net plus Doctors bag	$m	4.4	3.3	2.8	1.1	1.0	0.3	0.2	0.1	13.2
PBS Total	**$m**	**2 625.1**	**1 884.0**	**1 475.9**	**712.4**	**633.4**	**212.0**	**93.4**	**27.5**	**7 663.8**
RPBS Total (d)	$m	158.8	90.2	110.1	36.4	34.1	13.9	6.9	0.9	451.2

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS and RPBS TOTAL	**$m**	**2 783.9**	**1 974.2**	**1 586.0**	**748.7**	**667.5**	**225.9**	**100.3**	**28.4**	**8 115.0**
PBS total expenditure per person (no.) (e)	$	361.6	337.4	326.4	298.0	384.4	413.8	251.5	118.0	340.2
Proportion of PBS expenditure that is concessional (%)	%	79.0	78.2	77.6	71.3	80.8	81.9	62.5	62.7	77.8
2012-13										
PBS General Ordinary	$m	428.3	327.8	254.4	164.9	97.9	28.9	28.9	8.6	1 339.7
PBS General Safety Net	$m	58.8	39.8	32.6	18.0	12.4	3.1	3.9	0.5	169.2
PBS General total	$m	487.1	367.6	287.0	182.9	110.3	32.0	32.9	9.1	1 508.9
PBS Concessional Ordinary	$m	1 454.0	1 041.7	815.3	355.0	362.7	121.1	45.1	14.2	4 209.1
PBS Concessional Free Safety Net	$m	477.1	335.6	265.4	101.9	118.7	39.1	11.7	2.1	1 351.5
PBS Concessional total (a)	$m	1 931.1	1 377.3	1 080.7	456.9	481.3	160.2	56.8	16.3	5 560.6
PBS Unknown Free Safety Net	$m	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	$m	4.9	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
PBS Unknown free safety net plus Doctors bag	$m	4.9	3.7	3.3	1.1	1.1	0.3	0.2	0.1	14.8
PBS Total	**$m**	**2 423.2**	**1 748.7**	**1 370.9**	**640.9**	**592.7**	**192.6**	**89.8**	**25.5**	**7 084.2**
RPBS Total (d)	$m	139.5	77.5	97.9	30.9	28.6	12.0	6.5	0.8	393.7
PBS and RPBS TOTAL	**$m**	**2 562.7**	**1 826.1**	**1 468.8**	**671.8**	**621.4**	**204.6**	**96.3**	**26.3**	**7 477.9**
PBS total expenditure per person (no.) (c), (e)	$	329.1	307.2	296.6	258.8	355.9	375.2	236.1	107.1	308.6
Proportion of PBS expenditure that is concessional (%)	%	79.7	78.8	78.8	71.3	81.2	83.2	63.2	64.1	78.5

Table 11A.5 **Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service (2012-13 dollars) (a), (b), (c)**

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

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Rates for 2012-13 are derived using the ABS 2011 Census based estimated resident populations (ERP) for 31 December 2012. The national rate differs from that reported in table 11A.21, which reports rates derived from the final ABS 2011 Census based ERP for 30 June 2011.

(c) State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the Department of Health annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] — costing $36.9 million for 2012-13, of which the NT accounted for 51 per cent [table 11A.6]).

(d) Includes RPBS ordinary and RPBS safety net.

(e) PBS expenditure per person excludes RPBS and PBS doctor's bag.

– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.6 **Australian Government expenditure on PBS medicines supplied to Aboriginal Health Services in remote areas, 2012-13 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
	$m	0.1	–	6.6	10.4	0.8	0.1	–	18.8	36.9

(a) Includes expenditure on PBS medicines supplied in bulk under s.100 of the *National Health Act 1953* (Cwlth) to Aboriginal Health Services in remote and very remote areas.

(b) This program seeks to address identified barriers to accessing essential medicines experienced by Indigenous people living in remote areas (see www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-faq accessed 8 November 2013).

(c) Allocation to state and territory is based on location of the Aboriginal Health Service. Clients are not necessarily resident in the same state or territory.

– Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.7 **Expenditure on dental services, 2011-12 ($ million)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Government									
Australian Government									
DVA	32	17	29	10	8	2	6	–	104
Department of Health and other (a)	462	219	175	14	73	6	6	2	956
Insurance premium rebates (b)	166	106	108	78	47	10	9	3	528
Total	660	342	311	101	129	18	21	5	1 587
State, Territory and Local Government	190	153	188	73	66	25	11	12	718
Total government	**850**	**495**	**500**	**175**	**195**	**43**	**32**	**17**	**2 305**
Non-government	1 708	2 035	801	931	256	102	125	73	6 031
Total government and non-government	2 558	2 530	1 300	1 106	451	144	157	89	8 336

DVA=Department of Veterans' Affairs

(a) 'Department of Health and other' comprises Department of Health funded expenditure such as on MBS and PBS, and other Australian Government expenditure such as for the SPP associated with the National Healthcare Agreement and health–related NP payments, capital consumption, estimates of the medical expenses tax offset, and health research not funded by Department of Health.

(b) Includes the 30–40% rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.

– Nil or rounded to zero.

Source: AIHW 2013 *Health Expenditure Australia 2011-12* , Health and Welfare Expenditure Series no. 50. Cat. no. HWE 59.

Table 11A.8 **Australian Government funding of Aboriginal Medical Services (a), (b), (c), (d)**

	Unit	*NSW/ACT*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	$m	84.6	37.5	93.3	74.4	41.8	7.6	np	131.7	470.9
2009-10	$m	94.0	38.8	105.4	80.5	41.0	8.3	np	143.7	511.6
2010-11	$m	97.4	42.1	98.9	90.7	45.0	8.8	np	134.7	517.6
2011-12	$m	105.1	41.2	101.9	93.3	42.3	10.0	np	144.0	537.7
2012-13	$m	108.4	43.1	94.3	90.2	45.1	9.7	np	140.2	531.0

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Data reflect funding provided to all organisations for which primary function is primary health care and/or substance use and/or mental health services (excludes GST). Excludes funding to Peak bodies.

(c) Funding for Capital Works is not included.

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

np = Not published.

Source: Department of Health unpublished, table 2A.51.

Table 11A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP numbers										
2003-04	no.	7 910	5 596	4 486	2 153	1 915	605	374	300	22 949
2004-05	no.	7 590	5 721	4 644	2 175	1 944	609	375	320	23 378
2005-06	no.	7 708	5 802	4 793	2 240	1 980	625	381	305	23 834
2006-07	no.	7 855	5 914	4 864	2 310	1 990	642	373	324	24 272
2007-08	no.	7 934	6 062	5 052	2 357	2 099	661	383	355	24 903
2008-09	no.	8 105	6 240	5 340	2 458	2 141	679	385	378	25 726
2009-10	no.	8 389	6 449	5 564	2 492	2 201	704	398	416	26 613
2010-11	no.	8 654	6 710	5 810	2 614	2 253	719	416	463	27 639
2011-12	no.	8 998	7 033	6 199	2 744	2 348	770	440	479	29 011
2012-13	no.	9 427	7 344	6 629	2 973	2 448	810	470	580	30 681
FWE GPs										
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
2006-07	no.	6 483	4 407	3 564	1 500	1 416	391	226	104	18 091
2007-08	no.	6 600	4 584	3 683	1 542	1 455	401	232	116	18 613
2008-09	no.	6 792	4 738	3 861	1 574	1 511	404	235	116	19 231
2009-10	no.	6 893	4 901	3 993	1 615	1 546	417	238	127	19 729
2010-11	no.	7 067	5 063	4 126	1 640	1 570	429	239	134	20 267
2011-12	no.	7 338	5 270	4 343	1 698	1 628	449	250	142	21 119
2012-13	no.	7 593	5 544	4 573	1 803	1 681	464	272	158	22 087
FWE GPs per 100 000 people (e)										
2003-04	per 100 000 people	90.8	83.9	86.0	73.8	89.2	77.7	60.4	48.6	85.1
2004-05	per 100 000 people	93.3	84.1	87.5	73.1	89.0	78.0	60.7	46.8	86.2
2005-06	per 100 000 people	93.9	85.3	88.0	72.6	90.9	79.2	62.2	46.6	86.9

Table 11A.9 **Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07	per 100 000 people	95.5	86.3	87.9	72.2	90.7	79.6	66.9	49.1	87.7
2007-08	per 100 000 people	95.9	88.2	88.5	72.2	92.2	81.0	67.5	53.4	88.6
2008-09	per 100 000 people	97.0	89.2	90.3	71.3	94.6	80.5	67.0	52.0	89.5
2009-10	per 100 000 people	97.1	90.4	91.4	71.3	95.5	82.4	66.6	55.6	90.2
2010-11	per 100 000 people	98.4	92.1	93.0	70.7	96.2	84.1	65.5	58.1	91.4
2011-12	per 100 000 people	101.2	94.5	96.2	71.1	99.0	87.8	67.6	61.0	93.9
2012-13	per 100 000 people	103.3	97.6	99.2	72.9	101.1	90.5	71.8	66.5	96.4

(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 data include vocationally registered 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.

(d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

(e) The ABS Estimated Resident Populations (ERPs) used to derive rates for 2006-07 to 2010-11 are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data used to derive rates from 2011-12 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.2) for details.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.10 **Number of GP-type services used per 1000 people (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09	$	5 951.8	5 491.1	5 656.2	4 740.2	5 519.4	5 072.6	4 494.6	3 363.1	5 552.9
2009-10	$	6 043.5	5 612.1	5 845.4	4 808.3	5 666.4	5 341.4	4 621.9	3 633.1	5 678.9
2010-11	$	5 956.6	5 631.5	5 705.4	4 676.2	5 554.2	5 154.3	4 520.8	3 670.6	5 598.9
2011-12 (e)	$	6 161.8	5 809.9	6 000.2	4 663.8	5 651.8	5 574.4	4 560.2	3 955.0	5 783.1
2012-13	$	6 125.6	5 839.5	5 968.5	4 626.3	5 690.2	5 268.3	4 705.6	4 156.1	5 767.6

(a) Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.

(b) Rates are directly age standardised to the Australian population as at 30 June 2001.

(c) From 2011-12, rates are derived using the ABS estimated resident population (ERP) at 31 December, based on the 2011 Census. For previous years, rates are derived using the ABS ERP at 30 June preceding the reference year, based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

(d) DVA data are included.

(e) Data for 2011-12 are age-standardised and may differ from the crude rates published in the 2013 Report.

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection.

Table 11A.11 **PBS services**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS Total (b)										
2003-04	'000	57 522.0	41 578.0	30 517.0	14 544.0	14 028.0	4 745.0	1 940.0	560.0	165 861.0
2004-05	'000	58 751.2	42 867.3	32 156.7	14 851.4	14 314.0	4 777.0	1 971.1	589.8	170 278.5
2005-06	'000	57 822.1	42 716.2	31 508.1	14 609.4	14 319.8	4 838.5	1 918.6	590.0	168 322.6
2006-07	'000	58 050.4	42 583.8	32 008.2	14 571.3	14 144.5	4 723.0	1 881.9	572.6	168 535.5
2007-08	'000	58 467.4	43 649.9	32 693.8	14 593.3	14 537.4	4 864.0	1 897.3	592.9	171 296.0
2008-09	'000	62 123.6	46 221.7	34 874.5	15 602.7	15 319.6	5 089.4	1 990.4	614.1	181 836.1
2009-10	'000	62 716.4	46 882.6	35 292.2	15 531.6	15 727.3	5 115.7	2 024.2	621.5	183 911.5
2010-11	'000	64 112.6	47 935.7	36 242.5	15 976.2	15 837.6	5 296.6	2 106.1	635.0	188 142.3
2011-12	'000	65 896.3	49 189.6	37 910.2	17 107.8	16 445.8	5 563.3	2 112.7	647.4	194 873.1
2012-13	'000	66 639.3	49 861.2	38 932.6	16 735.9	16 821.3	5 494.5	2 156.6	664.1	197 305.4
RPBS Total (c)										
2004-05	'000	5 547.3	3 517.0	3 491.2	1 215.7	1 213.1	524.6	197.3	28.5	15 734.7
2005-06	'000	5 311.9	3 415.1	3 336.3	1 183.1	1 187.0	510.3	195.7	28.4	15 167.8
2006-07	'000	5 172.0	3 321.8	3 312.7	1 168.2	1 143.4	479.5	197.6	27.6	14 822.8
2007-08	'000	4 915.7	3 177.8	3 234.6	1 123.5	1 116.8	461.9	197.2	28.6	14 256.1
2008-09	'000	4 936.2	3 160.3	3 298.2	1 136.7	1 122.3	454.3	199.2	28.9	14 336.1
2009-10	'000	4 768.4	3 047.3	3 213.5	1 073.9	1 097.4	438.0	197.5	27.8	13 863.9
2010-11	'000	4 572.5	2 900.6	3 111.1	1 032.3	1 020.5	419.1	194.2	26.3	13 276.7
2011-12	'000	4 403.5	2 784.2	3 108.2	1 036.7	1 004.3	410.1	186.5	27.1	12 960.6
2012-13	'000	4 177.1	2 655.0	3 030.2	975.2	942.7	374.7	189.3	27.0	12 371.3
PBS and RPBS Total										
2004-05	'000	64 298.5	46 384.2	35 647.9	16 067.1	15 527.2	5 301.5	2 168.4	618.3	186 013.1
2005-06	'000	63 134.0	46 131.3	34 844.4	15 792.5	15 506.8	5 348.8	2 114.3	618.4	183 490.5
2006-07	'000	63 222.3	45 905.6	35 320.9	15 739.5	15 287.9	5 202.5	2 079.4	600.2	183 358.3
2007-08	'000	63 383.1	46 827.7	35 928.4	15 716.9	15 654.2	5 325.9	2 094.5	621.5	185 552.2
2008-09	'000	67 059.8	49 382.0	38 172.8	16 739.4	16 441.9	5 543.7	2 189.6	643.0	196 172.2

Table 11A.11 **PBS services**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
2009-10	'000	67 484.8	49 929.9	38 505.8	16 605.6	16 824.6	5 553.8	2 221.7	649.3	197 775.4
2010-11	'000	68 685.0	50 836.3	39 353.6	17 008.5	16 858.1	5 715.8	2 300.3	661.3	201 418.9
2011-12	'000	70 299.8	51 973.8	41 018.4	18 144.4	17 450.1	5 973.4	2 299.3	674.5	207 833.7
2012-13	'000	70 816.4	52 516.1	41 962.8	17 711.1	17 764.1	5 869.2	2 345.9	691.1	209 676.6
PBS total services per person (d)										
2003-04	no.	8.6	8.5	8.1	7.0	9.0	9.8	6.0	2.0	8.3
2004-05	no.	8.6	8.5	8.1	7.4	9.3	9.8	6.0	2.9	8.3
2005-06	no.	8.5	8.4	7.8	7.2	9.2	9.9	5.8	2.8	8.2
2006-07	no.	8.5	8.2	7.7	7.0	9.0	9.6	5.6	2.7	8.1
2007-08	no.	8.4	8.3	7.7	6.8	9.1	9.8	5.6	2.7	8.1
2008-09	no.	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
2009-10	no.	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
2010-11	no.	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
2011-12	no.	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
2012-13	no.	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional										
2003-04	%	82.8	83.4	83.3	81.8	85.3	87.2	67.9	69.8	82.9
2004-05	%	83.0	83.3	83.1	81.6	85.3	87.2	68.6	70.0	83.1
2005-06	%	83.9	84.1	83.7	82.1	86.0	87.7	70.3	71.6	83.8
2006-07	%	85.4	85.6	84.8	83.0	87.2	88.8	72.5	74.4	85.2
2007-08	%	86.0	86.3	85.2	83.0	87.7	89.6	73.2	75.5	85.7
2008-09	%	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
2009-10	%	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
2010-11	%	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
2011-12	%	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
2012-13	%	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8

Table 11A.11 **PBS services**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwlth).

(b) Includes PBS general ordinary, general free safety net, concessional ordinary, concessional free safety net and doctor's bag.

(c) Includes RPBS general ordinary and RPBS general safety net.

(d) PBS services per person exclude RPBS and doctor's bag.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
2008-09									
PBS General Ordinary	6 825	4 993	4 197	2 229	1 484	443	441	135	20 747
PBS General Safety Net	2 018	1 354	1 071	513	385	112	109	20	5 581
PBS General total	8 842	6 348	5 267	2 742	1 869	555	550	155	26 327
PBS Concessional Ordinary	40 723	30 797	22 727	10 191	10 443	3 473	1 151	401	119 906
PBS Concessional Free Safety Net	12 437	8 986	6 796	2 642	2 979	1 053	285	56	35 234
PBS Concessional total (b)	53 160	39 783	29 524	12 833	13 422	4 526	1 436	457	155 141
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	122	91	84	28	29	9	4	2	368
PBS Unknown free safety net plus Doctors bag	122	91	84	28	29	9	4	2	368
PBS Total	62 124	46 222	34 875	15 603	15 320	5 089	1 990	614	181 836
RPBS Total (c)	4 936	3 160	3 298	1 137	1 122	454	199	29	14 336
PBS and RPBS TOTAL	67 060	49 382	38 173	16 739	16 442	5 544	2 190	643	196 172
PBS total services per person (no.) (d)	8.8	8.6	8.0	7.1	9.5	10.2	5.7	2.8	8.4
Proportion of PBS services that are concessional (%)	85.6	86.1	84.7	82.2	87.6	88.9	72.1	74.4	85.3
2009-10									
PBS General Ordinary	6 927	5 130	4 289	2 281	1 543	457	462	138	21 227
PBS General Safety Net	1 714	1 148	914	449	330	96	95	15	4 763
PBS General total	8 641	6 279	5 203	2 730	1 873	554	557	153	25 990
PBS Concessional Ordinary	41 698	31 666	23 283	10 197	10 864	3 525	1 188	413	122 832

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS Concessional Free Safety Net	12 266	8 856	6 732	2 580	2 964	1 030	276	54	34 757
PBS Concessional total (b)	53 963	40 521	30 015	12 777	13 828	4 555	1 463	467	157 589
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	112	83	74	25	26	7	3	2	332
PBS Unknown free safety net plus Doctors bag	112	83	74	25	26	7	3	2	332
PBS Total	62 716	46 883	35 292	15 532	15 727	5 116	2 024	621	183 912
RPBS Total (c)	4 768	3 047	3 214	1 074	1 097	438	198	28	13 864
PBS and RPBS TOTAL	67 485	49 930	38 506	16 606	16 825	5 554	2 222	649	197 775
PBS total services per person (no.) (d)	8.7	8.5	7.9	6.8	9.6	10.1	5.7	2.7	8.3
Proportion of PBS services that are concessional (%)	86.0	86.4	85.0	82.3	87.9	89.0	72.3	75.1	85.7
2010-11									
PBS General Ordinary	6 847	5 114	4 199	2 308	1 500	464	463	137	21 032
PBS General Safety Net	1 747	1 196	956	480	345	97	105	16	4 943
PBS General total	8 595	6 310	5 155	2 788	1 845	561	568	153	25 976
PBS Concessional Ordinary	42 608	32 256	23 945	10 442	10 858	3 670	1 245	423	125 447
PBS Concessional Free Safety Net	12 798	9 283	7 065	2 723	3 109	1 058	290	57	36 382
PBS Concessional total (b)	55 406	41 539	31 010	13 164	13 967	4 728	1 535	480	161 829
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	112	86	77	24	26	8	4	2	338

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS Unknown free safety net plus Doctors bag	112	86	77	24	26	8	4	2	338
PBS Total	64 113	47 936	36 242	15 976	15 838	5 297	2 106	635	188 142
RPBS Total (c)	4 572	2 901	3 111	1 032	1 020	419	194	26	13 277
PBS and RPBS TOTAL	68 685	50 836	39 354	17 009	16 858	5 716	2 300	661	201 419
PBS total services per person (no.) (d)	8.8	8.6	8.0	6.9	9.6	10.4	5.8	2.8	8.4
Proportion of PBS services that are concessional (%)	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
2011-12									
PBS General Ordinary	6 867	5 130	4 232	2 445	1 514	465	447	139	21 239
PBS General Safety Net	1 682	1 175	926	484	341	94	104	15	4 821
PBS General total	8 549	6 305	5 158	2 929	1 855	559	550	155	26 060
PBS Concessional Ordinary	43 912	33 102	25 259	11 300	11 296	3 885	1 256	433	130 442
PBS Concessional Free Safety Net	13 329	9 700	7 421	2 853	3 270	1 112	303	58	38 047
PBS Concessional total (b)	57 240	42 802	32 681	14 153	14 565	4 997	1 559	491	168 489
PBS Unknown Free Safety Net	na	na	na	na	na	na	na	na	na
PBS Doctors Bag	107	83	72	26	25	7	3	1	324
PBS Unknown free safety net plus Doctors bag	107	83	72	26	25	7	3	1	324
PBS Total	65 896	49 190	37 910	17 108	16 446	5 563	2 113	647	194 873
RPBS Total (c)	4 404	2 784	3 108	1 037	1 004	410	187	27	12 961
PBS and RPBS TOTAL	70 300	51 974	41 018	18 144	17 450	5 973	2 299	674	207 834

Table 11A.12 **PBS services, by service type ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (a)	*Aust*
PBS total services per person (no.) (d)	9.1	8.8	8.4	7.2	10.0	10.9	5.7	2.8	8.7
Proportion of PBS services that are concessional (%)	86.9	87.0	86.2	82.7	88.6	89.8	73.8	75.9	86.5
2012-13									
PBS General Ordinary	6 229	4 608	3 902	2 223	1 415	405	410	133	19 324
PBS General Safety Net	1 535	1 037	849	442	317	81	97	14	4 371
PBS General total	7 763	5 645	4 750	2 664	1 732	486	506	146	23 695
PBS Concessional Ordinary	44 882	34 074	26 304	11 119	11 629	3 858	1 326	454	133 647
PBS Concessional Free Safety Net	13 880	10 051	7 798	2 925	3 432	1 142	321	62	39 612
PBS Concessional total (b)	58 762	44 125	34 102	14 045	15 061	5 001	1 647	516	173 259
PBS Unknown Free Safety Net	–	–	–	–	–	–	–	–	–
PBS Doctors Bag	114	91	80	26	28	8	4	2	352
PBS Unknown free safety net plus Doctors bag	114	91	80	26	28	8	4	2	352
PBS Total	66 639	49 861	38 933	16 736	16 821	5 495	2 157	664	197 305
RPBS Total (c)	4 177	2 655	3 030	975	943	375	189	27	12 371
PBS and RPBS TOTAL	70 816	52 516	41 963	17 711	17 764	5 869	2 346	691	209 677
PBS total services per person (no.) (d)	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Proportion of PBS services that are concessional (%)	88.2	88.5	87.6	83.9	89.5	91.0	76.3	77.7	87.8

(a) Care should be taken in using data for the NT as around 43 per cent of the population live in remote and very remote areas where Aboriginal Medical Services can supply medicines under s.100 of the *National Health Act 1953* (Cwlth).

Table 11A.12 **PBS services, by service type ('000)**

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

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

(c) Includes RPBS general ordinary and RPBS general safety net.

(d) PBS services per person exclude RPBS and doctor's bag.

na Not available. – Nil or rounded to zero.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.13 **Use of public dental services, by service type, 2010 (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Dental services per 1000 population (ASR)									
Emergency services	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	**43.7**	**55.4**	**97.9**	**126.0**	**97.3**	**135.4**	**96.3**	**183.3**	**74.4**
RSE (per cent)									
Emergency services	24.6	28.8	20.9	30.4	29.9	25.9	50.0	28.5	11.3
General services	13.8	12.0	11.9	9.0	10.2	8.1	17.5	9.3	5.0
All services	**11.9**	**11.1**	**10.0**	**8.4**	**9.3**	**8.3**	**16.4**	**8.6**	**4.5**
95 per cent CI									
Emergency services	± 4.6	± 5.9	± 11.0	± 7.4	± 7.8	± 14.9	± 14.3	± 14.3	± 3.2
General services	± 9.2	± 10.6	± 16.6	± 19.9	± 16.8	± 16.9	± 28.0	± 28.7	± 5.9
All services	**± 10.2**	**± 12.0**	**± 19.2**	**± 20.9**	**± 17.8**	**± 22.0**	**± 31.0**	**± 30.8**	**± 6.5**

ASR = Age standardised rate. **RSE** = relative standard error. **CI** = confidence interval.

(a) Data are for number of people who used a public dental service at least once in the previous 12 months, not for number of services provided.

(b) Type of service at the most recent visit. Emergency visit is a visit for relief of pain. Classification of service type as per Australian Dental Association Schedule of Dental Services.

(c) Rates are age standardised to the Australian population as at 30 June 2001.

(d) Limited to dentate persons aged 5 years or over.

Source: AIHW unpublished, National Dental Telephone Interview Survey 2010; ABS unpublished, *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 11A.14 **Alcohol and other drug treatment services, 2011-12 (number) (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (a)	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Treatment services by sector										
Government	no.	195	–	53	14	42	7	1	5	317
Non-government (b), (c)	no.	68	136	44	49	14	9	8	14	342
Total	**no.**	**263**	**136**	**97**	**63**	**56**	**16**	**9**	**19**	**659**
Closed treatment episodes by sector										
Government	no.	30 002	–	18 442	2 352	6 970	1 081	2 414	1 056	62 317
Non-government (b), (c)	no.	8 319	53 574	6 842	16 149	1 741	591	1 666	2 469	91 351
Total	**no.**	**38 321**	**53 574**	**25 284**	**18 501**	**8 711**	**1 672**	**4 080**	**3 525**	**153 668**
Closed treatment episodes for client's own drug use by sex										
Male	no.	25 603	32 910	17 216	11 442	6 063	1 117	2 635	2 257	99 243
Female	no.	11 879	16 999	7 478	5 961	2 548	437	1 375	905	47 582
Total (d)	**no.**	**37 494**	**50 004**	**24 705**	**17 403**	**8 613**	**1 554**	**4 010**	**3 165**	**146 948**

(a) Includes only services that receive public funding.

(b) WA has a number of integrated services that include both government and non-government providers.

(c) Includes agencies funded by Department of Health under the Non-Government Organisation Treatment Grants Program.

(d) Totals include episodes for people of unknown sex

– Nil or rounded to zero.

Source: AIHW 2013, *Alcohol and Other Drug Treatment Services in Australia 2011-12,* Cat. no. HSE 139, Drug Treatment Series no. 21, Canberra.

Table 11A.15 **Indigenous primary healthcare services and episodes of healthcare (number) (a), (b), (c), (d), (e)**

	Units	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous primary healthcare services										
2008-09	no.	39	24	31	28	14	10	2	57	205
2009-10	no.	50	26	33	37	13	10	1	53	223
2010-11	no.	56	25	37	35	15	11	1	55	235
2011-12	no.	52	25	37	35	13	9	1	52	224
Episodes of healthcare provided										
2008-09	'000	452	160	336	306	191	35	23	586	2 089
2009-10	'000	542	185	379	409	192	36	26	622	2 391
2010-11	'000	522	201	310	473	222	38	30	704	2 498
2011-12	'000	516	234	475	462	216	44	34	641	2 621

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

(b) The OSR 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).

(c) The number of services that provide OSR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.

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

(e) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

Source : AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31, 56, 79, 104, Canberra.

Table 11A.16 **Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number) (a), (b), (c), (d), (e)**

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Total*
Indigenous primary healthcare services							
2008-09	no.	26	40	50	29	60	205
2009-10	no.	29	48	55	33	58	223
2010-11	no.	34	52	59	29	61	235
2011-12	no.	33	48	53	28	62	224
Episodes of healthcare provided							
2008-09	'000	290	313	539	503	444	2 089
2009-10	'000	364	395	583	557	491	2 391
2010-11	'000	399	413	496	532	658	2 498
2011-12	'000	436	460	493	560	671	2 621

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

(b) The OSR 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).

(c) Remoteness categories are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing* .

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

(d) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

Source : AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31,56,79,104, Canberra.

Table 11A.17 **Proportion of Indigenous primary healthcare services that undertook selected health related activities (per cent) (a), (b), (c), (d)**

	2008-09 (e)	*2009-10*	*2010-11*	*2011-12*
Diagnosis and treatment of illness/disease	85.0	82.1	81.2	80.4
Management of chronic illness	89.0	87.0	85.0	86.2
Transportation to medical appointments	86.0	87.0	88.5	90.2
Outreach clinic services	55.0	55.6	52.6	60.7
24 hour emergency care	31.0	27.8	23.5	28.1
Monitoring child growth	64.0	76.2	71.8	79.0
School-based activities	68.0	70.4	74.4	79.0
Hearing screening	72.0	74.9	70.9	76.3
Pneumococcal immunisation	76.0	74.9	70.9	69.6
Influenza immunisation	82.0	81.6	78.2	81.3
Child immunisation	81.0	81.6	76.9	80.8
Women's health group	77.0	76.2	78.2	78.1
Support for public housing issues	58.0	67.7	59.0	71.0
Community development work	60.0	66.8	65.4	75.0
Legal/police/prison/advocacy services	42.0	43.1	44.9	46.0
Dental services	52.0	48.9	45.3	53.1
Involvement in steering groups on health	77.0	81.2	79.5	86.2
Participation in regional planning forums	57.0	57.9	59.0	67.0
Dialysis services	4.0	6.3	4.7	3.6

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

(b) The OSR 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).

(c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.

(d) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

(e) In 2008-09, 4 of 205 services reporting to the OSR collection did not provide valid data for this question. The denominator for 2008-09 is the number of services that provided valid data for this question (201).

Source : AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31,56,79,104, Canberra.

Table 11A.18 **Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services which provide data for Online Services Reporting (OSR) (number) (a), (b), (c)**

	2010	*2011*	*2012*
Indigenous staff			
Aboriginal health workers	836.6	899.4	896.5
Doctors	16.1	26.0	20.7
Nurses	72.2	72.9	101.3
Specialists	1.2	0.2	0.3
Counsellors/social workers	52.3	59.2	33.4
Other social and emotional wellbeing staff (d)	242.3	220.8	203.7
Allied health professionals (e)	49.7	31.8	58.1
Dentists	4.4	7.4	4.6
Dental assistants	47.9	43.9	46.2
Traditional healers	8.1	10.8	4.7
Sexual health workers	44.5	38.7	43.3
Substance misuse workers	77.5	101.2	104.7
Environmental health workers	24.0	23.8	32.7
Driver/field officers	218.1	255.6	250.0
Other health staff (f)	6.0	142.3	145.8
Total Indigenous staff (g)	**1 700.9**	**1 933.9**	**1 946.0**
Non-Indigenous staff			
Aboriginal health workers	30.7	14.0	34.3
Doctors	319.3	335.4	331.8
Nurses	615.3	710.7	681.8
Specialists	7.4	13.0	12.1
Counsellors/social workers	84.6	89.1	40.6
Other social and emotional wellbeing staff (d)	66.2	97.6	82.5
Allied health professionals (e)	108.2	144.2	115.9
Dentists	39.8	48.7	55.8
Dental assistants	27.8	35.1	31.0
Traditional healers	0.0	3.1	0.5
Sexual health workers	20.0	16.6	11.7
Substance misuse workers	43.4	50.7	54.3
Environmental health workers	6.0	10.3	8.5
Driver/field officers	40.1	39.4	36.7
Other health staff (f)	–	67.5	25.4
Total non-Indigenous staff (g)	**1 408.7**	**1 675.2**	**1 522.9**
Total health staff (d), (e)			
Aboriginal health workers	867.4	913.4	930.8
Doctors	335.4	361.4	352.5
Nurses	691.5	787.6	783.1
Specialists	8.7	13.2	12.3

Table 11A.18 **Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services which provide data for Online Services Reporting (OSR) (number) (a), (b), (c)**

	2010	*2011*	*2012*
Counsellors/social workers	136.8	148.3	74.0
Other social and emotional wellbeing staff (d)	309.5	319.4	286.2
Allied health professionals (e)	157.9	176.0	174.0
Dentists	44.2	56.1	60.5
Dental assistants	75.7	79.1	77.2
Traditional healers	8.2	13.9	5.2
Sexual health workers	64.5	55.3	55.0
Substance misuse workers	120.9	151.9	159.0
Environmental health workers	30.0	34.1	41.2
Driver/field officers	258.2	294.9	286.7
Other health staff (f)	6.0	209.7	171.2
Total health staff (g), (h)	**3 114.9**	**3 614.4**	**3 468.9**

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

(b) The number of services that provide OSR data changes each year. Changes are due to new Australian government funded primary health care services opening and existing services gaining Australian government funding. In addition, previously excluded Australian government funded services may be required to commence OSR data reporting if there are changes in the types of services provided and/or reporting arrangements.

(c) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

(d) Other social and emotional wellbeing staff includes: Bringing Them Home and Link Up support workers, psychologists, mental health workers and other social and emotional wellbeing staff.

(e) Allied health professionals include diabetes educators and other patient educators, health program coordinators, nutrition workers, community care workers, child and family health workers, child protection workers, welfare workers, pharmacy assistants/technicians, Brighter Futures Program caseworkers, foster carers, Healthy for Life workers, sports and recreation workers, youth workers, and masseurs.

(f) Other health staff' include: outreach workers, special program support workers, patient liasion officers, and other health-related positions.

(g) Totals may not add due to rounding and cell suppression.

(h) Totals include health staff for whom Indigenous status was not provided.

– Nil or rounded to zero.

Source: AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results*, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 56,79,104, Canberra.

Table 11A.19 **Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)**

	NSW (c)	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust* (e)
Number of people per pharmacy									
Urban									
2009	3 690	4 118	3 715	3 770	3 773	3 451	5 214	4 941	3 836
2010	3 700	4 082	3 701	3 691	3 725	3 409	5 131	4 681	3 814
2011	3 677	4 031	3 615	3 699	3 725	3 248	5 051	4 681	3 777
2012	3 891	4 363	4 059	4 116	3 921	3 445	5 243	4 861	4 082
2013 (f)	3 855	4 319	4 065	4 066	3 775	3 440	4 952	4 254	4 034
Rural									
2009	4 232	4 803	4 459	4 255	3 632	3 911	..	9 272	4 367
2010	4 172	4 655	4 386	4 305	3 405	3 836	..	9 272	4 277
2011	4 232	4 462	4 037	4 021	3 269	3 694	..	8 500	4 108
2012	4 051	4 344	4 381	4 202	3 287	3 593	..	9 374	4 148
2013 (f)	3 811	4 077	3 904	3 776	3 332	3 288	..	8 898	3 887
Number of pharmacies									
Urban									
2009	1 451	1 013	829	421	314	80	62	18	4 188
2010	1 447	1 022	832	430	318	81	63	19	4 212
2011	1 456	1 035	852	429	318	85	64	19	4 258
2012	1 462	1 047	844	441	320	84	68	20	4 286
2013	1 546	1 082	887	455	347	93	72	18	4 500
Rural									
2009	280	157	182	86	90	51	..	11	857
2010	284	162	185	85	96	52	..	11	876
2011	280	169	201	91	100	54	..	12	908
2012	300	179	204	99	103	57	..	12	955
2013	248	165	183	101	85	53	–	15	851
Number of approved GPs — Rural (g)									
2009	16	3	10	21	2	7	..	1	60
2010	11	3	8	23	2	5	..	1	53
2011	9	1	6	17	2	3	..	1	39
2012	11	9	5	11	1	4	..	–	41
2013	10	1	5	11	1	5	..	..	33
Number of approved hospitals — urban (h)									
Public									
2009	–	53	26	6	6	–	–	1	92
2010	–	53	27	8	8	–	–	1	97
2011	–	53	27	10	8	3	–	1	102
2012	–	53	27	12	8	3	–	1	104
2013	1	52	30	12	10	4	..	1	110

Table 11A.19 Approved providers of PBS medicines, by urban and rural location, at 30 June (a), (b)

	NSW (c)	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust* (e)
Private									
2009	23	25	19	4	4	1	3	1	80
2010	23	26	21	5	4	1	3	1	84
2011	22	28	24	5	4	1	4	1	89
2012	22	29	25	5	4	1	4	1	91
2013	26	29	25	4	6	1	3	1	95
Number of approved hospitals — rural (h) (i)									
Public									
2009	–	12	62	–	–	–	..	4	78
2010	–	13	63	–	–	–	..	4	80
2011	–	16	20	6	–	1	..	4	47
2012	–	18	22	6	–	1	..	4	51
2013	..	16	20	6	3	..	..	4	49

(a) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2-6. The ACT has no rural PhARIA areas.

(b) The ABS Census population counts used to derived these rates differ across years. For data up to 2012, rates are derived using 2006 Census based counts. From 2013, rates are derived using 2011 Census based counts. Rates derived using counts based on different Censuses are not comparable.

(c) For 2013, one public hospital in NSW is a campus of a Victorian hospital participating in the Pharmaceutical Reforms.

(d) Care should be taken using data for the NT, as 43.9 per cent of the population live in remote and very remote areas and data exclude Aboriginal Medical Services that supply medications in these areas under s.100 of the *National Health Act 1953* (Cwlth).

(e) Includes other territories

(f) 118 pharmacies were reclassified as urban at 30 June 2013. Those pharmacies were classified as rural at 30 June 2012.

(g) GPs in urban areas are not able to demonstrate that they are practising in an area where there is no pharmacist approved and therefore the category 'Number of approved GPs — Urban' is not applicable.

(h) PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.

(i) There were no PBS approved private hospitals in rural areas in the years 2009 to 2013.

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

Source: Department of Health unpublished, derived from Department of Human Services, ABS 2006/2011 Census of Population and Housing and the University of Adelaide's Australian Population and Migration Research Centre.

Table 11A.20 PBS expenditure per person, by remoteness area (2012-13 dollars) (a), (b), (c), (d)

	Unit	*2012-13*
Total expenditure		
Major cities	$m	4 768.7
Inner regional	$m	1 524.5
Outer regional	$m	681.8
Remote	$m	67.7
Very remote	$m	24.5
Australia	$m	7 069.5
Expenditure per person		
Major cities	$	303.7
Inner regional	$	367.3
Outer regional	$	333.2
Remote	$	211.7
Very remote	$	117.0
Australia	$	311.7

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

(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 Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth].) Expenditure on medications dispensed to remote and very remote areas under s.100 was $36.9 million in 2012-13.

(c) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years which were based on a different classification.

(d) Rates are derived using the final ABS 2011 Census based estimated resident populations (ERP) for 30 June 2012. The national rate differs from that reported in tables 11A.4 and 11A.5, which are derived from the final ABS 2011 Census based ERP for December 31 2011.

Source: Department of Health unpublished, PBS Statistics; ABS 2013, *Regional Population Growth, Australia, 2012* , Cat. no. 3218.0.

Table 11A.21 **PBS expenditure per person, by urban and rural location, 2008-09 to 2011-12 (2012-13 dollars) (a), (b), (c), (d)**

	2008-09	*2009-10*	*2010-11*	*2011-12*
Capital city	322.7	327.9	321.7	323.9
Other metropolitan	367.4	374.6	371.6	374.0
Rural and remote	357.6	364.9	362.6	367.6
All locations	336.2	342.1	337.3	340.2

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

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

(c) 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 Department of Health annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements (such as medicines supplied in bulk under s.100 of the *National Health Act 1953* [Cwlth]).

(d) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification.

Source: Department of Health unpublished, PBS Statistics; table 2A.51.

Table 11A.22 **Availability of GPs by remoteness area, 2012-13 (a), (b), (c), (d), (e), (f)**

	NSW (f)	*Vic* (g)	*Qld*	*WA*	*SA* (h)	*Tas* (h)	*ACT* (e)	*NT* (h)	*Aust*
Number of GPs									
Year									
Major cities	6 620	5 355	3 725	1 967	1 709	..	470	..	19 846
Inner regional	2 201	1 639	1 346	337	312	585	np	..	6 420
Outer regional	606	350	1 169	339	313	195	..	215	3 109
Remote	np	np	237	191	114	30	..	365	746
Very remote	np	..	152	139	np	np	..	np	560
Total	**9 427**	**7 344**	**6 629**	**2 973**	**2 448**	**810**	**470**	**580**	**30 681**
Number of full time workload equivalent GPs									
Major cities	5 754	4 254	2 899	1 330	1 271	..	272	..	15 780
Inner regional	1 456	1 055	960	229	181	330	np	..	4 211
Outer regional	383	234	631	155	177	126	..	98	1 771
Remote	np	np	54	60	52	8	..	60	223
Very remote	np	..	29	29	np	np	..	np	102
Total	**7 593**	**5 544**	**4 573**	**1 803**	**1 681**	**464**	**272.0**	**158**	**22 087**
Number of full time workload equivalent GPs per 100 000 people									
Major cities	106.7	99.1	102.7	71.5	104.8	..	72.6	..	98.9
Inner regional	103.2	97.6	103.9	105.4	101.0	98.3	np	..	101.5
Outer regional	79.2	93.5	93.8	83.9	87.5	76.1	..	74.4	86.5
Remote	np	np	67.6	59.0	85.8	74.2	..	122.8	69.7
Very remote	np	..	48.7	43.8	np	np	..	np	48.8
Total	**104.2**	**98.6**	**100.3**	**74.2**	**101.6**	**90.6**	**72.6**	**67.3**	**97.4**

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which are based on a different classification.

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

(c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).

(d) 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.

(e) 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.

(f) For NSW, remote and very remote area data are not reported for confidentiality reasons, but are included in outer regional area data.

(g) For Victoria, remote area data are not reported for confidentiality reasons, but are included in outer regional data.

Table 11A.22 **Availability of GPs by remoteness area, 2012-13 (a), (b), (c), (d), (e), (f)**

	NSW (f)	*Vic* (g)	*Qld*	*WA*	*SA* (h)	*Tas* (h)	*ACT* (e)	*NT* (h)	*Aust*

(h) For SA, Tasmania and the NT, very remote area data are not reported for confidentiality reasons, but are included in remote area data.

(i) For the ACT, inner regional area data are not reported for confidentiality reasons, but are included in major cities data.

.. Not applicable. **np** Not published.

Source : Department of Health unpublished, MBS Statistics.

Table 11A.23 Availability of GPs by region, 2003-04 to 2011-12 (a), (b), (c), (d)

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*
Number of GPs									
Urban									
2003-04	6 231	4 310	2 678	1 604	1 436	316	np	121	16 696
2004-05	6 266	4 413	2 794	1 620	1 443	308	np	127	16 971
2005-06	6 327	4 437	2 846	1 651	1 469	317	np	113	17 160
2006-07	6 412	4 508	2 884	1 698	1 463	313	np	116	17 394
2007-08	6 047	4 598	2 978	1 717	1 503	328	383	121	17 675
2008-09	6 184	4 738	3 142	1 797	1 550	340	385	139	18 275
2009-10	6 349	4 896	3 272	1 803	1 568	349	398	142	18 777
2010-11	6 530	5 043	3 340	1 826	1 592	346	416	160	19 253
2011-12	6 725	5 305	3 544	1 895	1 644	362	440	153	20 068
Rural									
2003-04	1 663	1 286	1 808	549	479	289	..	179	6 253
2004-05	1 699	1 308	1 850	555	501	301	..	193	6 407
2005-06	1 762	1 365	1 947	589	511	308	..	192	6 674
2006-07	1 816	1 406	1 980	612	527	329	..	208	6 878
2007-08	1 887	1 464	2 074	640	596	333	..	234	7 228
2008-09	1 921	1 502	2 198	661	591	339	..	239	7 451
2009-10	2 040	1 553	2 292	689	633	355	..	274	7 836
2010-11	2 124	1 667	2 464	788	661	373	..	303	8 380
2011-12	2 273	1 728	2 655	849	704	408	..	326	8 943
Number of full time workload equivalent GPs									
Urban									
2003-04	5 065	3 212	1 961	1 123	1 029	170	np	49	12 608
2004-05	5 227	3 242	2 026	1 121	1 027	166	np	47	12 856
2005-06	5 283	3 335	2 105	1 132	1 060	171	np	48	13 135
2006-07	5 427	3 426	2 171	1 142	1 071	173	np	50	13 459
2007-08	5 274	3 551	2 241	1 166	1 080	179	232	54	13 778
2008-09	5 411	3 662	2 357	1 186	1 118	179	235	56	14 204
2009-10	5 461	3 788	2 459	1 216	1 149	185	238	62	14 558
2010-11	5 567	3 897	2 518	1 222	1 166	186	239	66	14 861
2011-12	5 748	4 059	2 686	1 259	1 204	195	250	73	15 474
Rural									
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
2006-07	1 283	981	1 393	358	345	218	..	54	4 632
2007-08	1 327	1 033	1 441	376	375	222	..	61	4 835
2008-09	1 381	1 076	1 504	388	393	225	..	60	5 027
2009-10	1 431	1 113	1 534	399	397	232	..	65	5 171
2010-11	1 500	1 166	1 599	417	404	243	..	67	5 397
2011-12	1 590	1 211	1 658	439	424	254	..	69	5 645

Table 11A.23 **Availability of GPs by region, 2003-04 to 2011-12 (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e)	*NT*	*Aust*
Number of full time workload equivalent GPs per 100 000 people									
Urban									
2003-04	93.2	85.7	83.2	76.9	91.0	86.7	np	55.2	87.4
2004-05	95.2	85.4	84.0	75.7	90.1	83.7	np	53.6	88.0
2005-06	95.6	87.0	85.5	75.3	92.5	86.0	np	54.4	89.0
2006-07	97.2	87.3	85.4	73.9	91.5	86.0	np	53.7	89.4
2007-08	99.6	89.0	86.0	73.6	91.2	88.3	67.5	57.1	90.0
2008-09	100.4	89.6	87.9	72.2	93.2	87.3	67.2	58.0	90.7
2009-10	99.0	90.3	89.0	71.7	94.5	89.4	66.7	61.8	90.7
2010-11	99.9	91.7	90.1	71.0	95.0	89.0	65.6	66.4	91.5
2011-12	103.2	95.5	96.1	73.2	98.1	93.6	68.8	73.1	95.3
Rural									
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
2006-07	77.8	76.8	85.4	64.3	83.7	74.6	..	44.3	78.0
2007-08	79.7	79.6	86.2	65.8	89.9	75.5	..	49.1	80.0
2008-09	81.6	80.9	87.5	65.5	93.1	75.6	..	46.9	81.3
2009-10	82.6	81.5	86.5	65.2	92.8	77.1	..	49.5	81.5
2010-11	85.7	84.3	89.1	67.3	93.4	80.4	..	51.1	84.1
2011-12	90.9	87.6	92.4	70.9	98.1	83.8	..	52.1	88.0

(a) Geographical locations are based on the 1994 Rural, Remote and Metropolitan Areas classification. 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.

(b) Data are not comparable with data for 2012-13, for which geographical location is based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

(c) GP and FWE data include vocationally registered GPs and other medical practitioners (OMPs).

(d) 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.

(e) 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.

(f) From 2007-08, data are reported separately for NSW and the ACT. Historical data for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.

.. Not applicable. **np** Not published.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.24 **Availability of female GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Female GPs										
2003-04	no.	2 707	2 008	1 663	793	659	233	173	136	8 372
2004-05	no.	2 751	2 116	1 717	801	671	243	180	151	8 630
2005-06	no.	2 853	2 168	1 799	828	703	254	183	132	8 920
2006-07	no.	2 958	2 247	1 850	877	718	270	181	151	9 252
2007-08	no.	3 010	2 359	1 955	898	775	277	191	171	9 636
2008-09	no.	3 142	2 446	2 117	987	809	294	192	184	10 171
2009-10	no.	3 323	2 569	2 230	1 016	828	306	192	193	10 657
2010-11	no.	3 520	2 720	2 327	1 089	872	318	216	220	11 282
2011-12	no.	3 736	2 925	2 553	1 134	925	357	230	235	12 095
2012-13	no.	4 014	3 071	2 797	1 241	985	368	238	287	13 001
Female FWEs GPs										
2003-04	no.	1 583	1 058	869	380	320	112	69	39	4 430
2004-05	no.	1 679	1 096	923	382	329	114	73	38	4 633
2005-06	no.	1 729	1 158	968	394	335	122	76	34	4 815
2006-07	no.	1 822	1 232	1 010	410	348	125	82	37	5 065
2007-08	no.	1 916	1 312	1 083	426	371	131	85	45	5 369
2008-09	no.	2 003	1 389	1 178	455	401	136	87	48	5 697
2009-10	no.	2 087	1 468	1 232	482	423	142	87	54	5 976
2010-11	no.	2 219	1 538	1 299	499	430	147	96	56	6 285
2011-12	no.	2 362	1 643	1 406	512	459	154	104	62	6 702
2012-13	no.	2 519	1 781	1 516	544	481	162	110	66	7 180
Female FWEs GPs as a proportion of all FWE GPs										
2003-04	%	26.3	25.7	26.7	26.2	23.5	30.0	34.9	40.2	26.3
2004-05	%	27.0	26.3	27.2	26.2	24.1	30.2	36.3	40.3	26.8
2005-06	%	27.4	27.0	27.7	26.8	23.8	31.5	36.5	34.8	27.3

Table 11A.24 **Availability of female GPs (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07	%	28.1	28.0	28.3	27.3	24.6	31.9	36.1	35.4	28.0
2007-08	%	29.0	28.6	29.4	27.6	25.5	32.7	36.4	38.8	28.8
2008-09	%	29.5	29.3	30.5	28.9	26.5	33.7	37.0	41.3	29.6
2009-10	%	30.3	30.0	30.8	29.9	27.4	34.1	36.6	42.7	30.3
2010-11	%	31.4	30.4	31.5	30.5	27.4	34.3	40.1	42.2	31.0
2011-12	%	32.2	31.2	32.4	30.2	28.2	34.3	41.3	43.7	31.7
2012-13	%	33.2	32.1	33.2	30.2	28.6	34.9	40.5	41.7	32.5
Female FWE GPs										
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	49.2	43.0	46.5	38.0	42.3	46.4	44.2	40.1	45.3
2005-06	per 100 000 females	50.3	44.7	47.2	38.6	42.1	49.0	44.9	33.2	46.2
2006-07	per 100 000 females	52.3	46.7	48.1	39.2	43.3	49.9	47.4	35.4	47.8
2007-08	per 100 000 females	54.4	48.9	50.4	39.7	45.7	52.1	48.6	42.4	49.8
2008-09	per 100 000 females	55.7	50.6	53.2	41.1	48.8	53.3	49.2	44.0	51.7
2009-10	per 100 000 females	57.1	52.4	54.3	42.5	50.9	55.2	48.5	48.7	53.2
2010-11	per 100 000 females	60.1	54.2	56.6	43.3	51.2	56.8	52.3	50.6	55.2
2011-12	per 100 000 females	64.7	58.3	62.1	43.2	55.2	60.0	55.5	56.1	59.3
2012-13	per 100 000 females	68.1	62.1	65.6	44.5	57.4	63.0	57.9	58.4	62.4

(a) From 2011-12, rates are computed by the Secretariat using first preliminary December 31 female ERP based on the 2011 Census. Rates for previous years are derived using ERPs based on the 2001 and 2006 Censuses. Rates derived using ERPs based on different Censuses are not comparable.

(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 vocationally registered GPs and 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.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.25 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (g)	*Aust*
FTE dentists per 100 000 population (h)									
2008									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2009									
Major cities	7.7	7.6	11.1	7.5	11.8	..	9.5	..	8.6
Inner regional	4.9	4.9	8.6	6.1	5.4	7.6	–	..	6.0
Outer regional	3.9	4.7	8.3	4.0	2.1	1.8	..	16.6	5.9
Remote and very remote	3.2	–	9.9	10.9	2.0	–	..	6.2	7.7
Total	**6.9**	**6.9**	**10.1**	**7.2**	**9.5**	**5.5**	**9.5**	**12.0**	**7.8**
2010									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2011									
Major cities	4.8	4.8	6.4	5.7	8.7	..	7.1	..	5.6
Inner regional	3.6	4.8	6.6	5.4	4.1	5.4	–	..	4.8
Outer regional	2.0	4.2	7.5	3.5	4.9	0.5	..	13.2	5.1
Remote/very remote	1.9	–	1.5	10.1	5.0	–	..	9.1	6.1
Total	**4.4**	**4.7**	**6.5**	**5.8**	**7.6**	**3.7**	**7.1**	**11.3**	**5.4**
2012									

Table 11A.25 **Availability of public dentists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (g)	*Aust*
Major cities	5.6	4.5	5.7	5.7	6.4	..	6.9	..	5.4
Inner regional	4.5	3.4	5.7	5.5	4.0	5.4	–	..	4.6
Outer regional	1.5	3.1	8.4	3.0	3.0	0.7	..	8.2	4.7
Remote/very remote	–	–	2.6	6.2	3.0	–	..	7.9	4.7
Total	**5.1**	**4.2**	**6.0**	**5.6**	**5.7**	**3.8**	**6.9**	**8.1**	**5.2**

(a) Data include dentists working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas.

(b) Data are not available for 2008 or 2010.

(c) Allocation to State or Territory is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, State/Territory is coded 'unstated'.

(d) Remote/very remote include Migratory areas.

(e) There are no major cities in Tasmania.

(f) There are no outer regional, remote or very remote areas in the ACT.

(g) There are no major cities or inner regional areas in the NT.

(h) FTE based on a 40-hour week.

(i) Total includes remoteness area 'unstated'.

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

Source: AIHW unpublished, National Health Workforce Data Set.

Table 11A.26 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (h)	*Aust* (i)
2009									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	0.2	–	0.2	0.6	0.7	..	0.5	..	0.2
Inner regional	0.0	–	–	–	–	–	–	..	–
Outer regional	0.1	–	0.5	–	–	–	..	1.4	0.2
Remote/very remote	0.8	–	–	–	–	–	..	–	–
Total (l)	**0.1**	**–**	**0.2**	**0.4**	**0.5**	**–**	**0.5**	**0.8**	**0.2**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	2.0	–	6.4	6.5	5.5	..	3.4	..	3.0
Inner regional	5.3	–	9.3	7.3	6.4	6.6	–	..	5.1
Outer regional	3.2	–	8.8	6.6	7.1	11.1	..	6.1	6.1
Remote/very remote	5.6	–	4.1	3.7	3.4	–	..	8.9	5.0
Total (l)	**2.8**	**–**	**7.3**	**6.4**	**5.7**	**8.0**	**3.4**	**7.4**	**3.8**
2010									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote/very remote	na	na	na	na	na	na	na	na	na
Total (l)	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	na	na	na	na	na	na	na	na	na
Inner regional	na	na	na	na	na	na	na	na	na
Outer regional	na	na	na	na	na	na	na	na	na
Remote and very remote	na	na	na	na	na	na	na	na	na
Total	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**

Table 11A.26 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (h)	*Aust* (i)
2011									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	0.1	0.0	0.1	0.6	0.6	..	0.3	..	0.2
Inner regional	–	–	–	–	–	–	–	..	–
Outer regional	–	0.2	0.1	–	–	–	..	–	0.1
Remote and very remote	–	–	–	–	–	–	..	–	–
Total (l)	**0.1**	**0.0**	**0.1**	**0.5**	**0.5**	**–**	**0.3**	**–**	**0.1**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	1.7	1.3	5.2	4.9	3.8	..	2.5	..	2.8
Inner regional	3.4	2.3	6.8	7.9	8.8	6.6	–	..	4.6
Outer regional	2.5	1.6	6.0	8.4	6.1	9.1	..	9.4	5.4
Remote/very remote	2.6	–	4.0	7.0	6.5	–	..	4.5	5.1
Total (l)	**2.1**	**1.5**	**5.6**	**5.6**	**4.8**	**7.2**	**2.5**	**7.6**	**3.4**
2012									
FTE dental hygienists per 100 000 population (j), (k)									
Major cities	0.2	0.1	0.1	0.4	0.8	..	0.2	..	0.2
Inner regional	0.1	0.0	–	–	–	–	–	..	0.1
Outer regional	–	0.3	0.1	–	–	–	..	–	0.1
Remote/very remote	–	–	–	–	–	–	..	1.3	0.3
Total (l)	**0.1**	**0.1**	**0.1**	**0.3**	**0.6**	**–**	**0.2**	**0.6**	**0.2**
FTE dental therapists per 100 000 population (j), (k)									
Major cities	1.6	1.4	5.1	4.8	4.0	..	2.9	..	2.7
Inner regional	4.1	2.3	6.1	8.4	7.8	5.9	–	..	4.6
Outer regional	2.4	0.9	6.3	8.9	6.2	6.5	..	8.9	5.2
Remote/very remote	1.5	–	4.0	4.0	5.8	7.0	..	5.6	4.5
Total (l)	**2.1**	**1.5**	**5.4**	**5.4**	**4.7**	**6.1**	**2.9**	**7.5**	**3.3**

Table 11A.26 **Availability of public dental hygienists and dental therapists (per 100 000 people) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (g)	*NT* (h)	*Aust* (i)

(a) Dual registered practitioners (practitioners registered as both dental therapists and dental hygienists) are included in dental therapists data and not in dental hygienists data.

(b) Data include professionals working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and “other public” areas.

(c) Allocation to State or Territory is by location of main job where available. Otherwise, location of principal practice is used as a proxy. If that is also not available, location of residence is used. If none of these are available, State/Territory is coded 'unstated'.

(d) Remote/very remote include Migratory areas.

(e) Data are not available for 2008 or 2010.

(f) Data are not available for Victoria for 2009 due to changes in Victoria's data collection form.

(g) There are no major cities in Tasmania.

(h) There are no outer regional, remote or very remote areas in the ACT.

(i) There are no major cities or inner regional areas in the NT.

(j) 2009 data for Australia exclude data for Victoria.

(k) FTE based on a 40-hour week.

(l) Total includes remoteness area 'unstated'.

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

Source: AIHW unpublished, National Health Workforce Data Set.

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
2008-09										
Indigenous older people										
Number of people assessed (h)	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population (i)	no.	14 130	3 240	11 706	5 821	2 361	1 099	200	5 066	44 353
Proportion of target population assessed	%	10.4	8.2	13.2	13.7	5.9	2.1	12.0	19.6	11.8
Non-Indigenous older people										
Number of people assessed (j)	no.	111 344	73 138	62 716	21 998	27 423	9 486	2 430	283	308 818
Target population (k)	no.	460 531	344 073	236 932	116 213	122 218	34 614	15 201	2 720	1 332 334
Proportion of target population assessed	%	24.2	21.3	26.5	18.9	22.4	27.4	16.0	10.4	23.2
2009-10										
Indigenous older people										
Number of people assessed (h)	no.	1 652	337	2 053	1 021	153	36	46	1 185	6 483
Target population (i)	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion of target population assessed	%	11.1	9.9	16.5	16.6	6.2	3.1	20.8	22.2	13.9
Non-Indigenous older people										
Number of people assessed (j)	no.	116 753	77 945	65 082	24 451	28 048	9 151	2 724	292	324 446
Target population (k)	no.	468 520	350 827	241 647	118 873	123 651	35 221	15 695	2 854	1 357 123
Proportion of target population assessed	%	24.9	22.2	26.9	20.6	22.7	26.0	17.4	10.2	23.9
2010-11										
Indigenous older people										
Number of people assessed (h)	no.	3 216	422	3 151	1 508	451	109	36	1 572	10 465

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Target population (i)	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271
Proportion of target population assessed	%	20.6	11.8	24.0	23.4	17.4	8.8	15.3	27.9	21.2
Non-Indigenous older people										
Number of people assessed (j)	no.	130 102	90 480	74 565	29 862	31 393	10 974	3 168	302	370 846
Target population (k)	no.	476 109	358 361	247 555	122 034	124 871	35 632	16 146	3 018	1 383 553
Proportion of target population assessed	%	27.3	25.2	30.1	24.5	25.1	30.8	19.6	10.0	26.8
2011-12 (l)										
Indigenous older people										
Number of people assessed (h)	no.	4 156	558	4 589	1 632	508	185	48	1 765	13 441
Target population (i)	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216
Proportion of target population assessed	%	25.2	14.7	33.0	23.8	18.5	14.1	18.6	29.3	25.7
Non-Indigenous older people										
Number of people assessed (j)	no.	137 439	96 169	79 926	31 878	32 887	11 500	3 270	314	393 383
Target population (k)	no.	486 234	365 335	253 931	125 917	126 579	36 074	16 664	3 223	1 413 773
Proportion of target population assessed	%	28.3	26.3	31.5	25.3	26.0	31.9	19.6	9.7	27.8
2012-13 (m)										
Indigenous older people										
Number of people assessed (h)	no.	5 156	713	5 427	2 186	604	261	73	2 232	16 652
Target population (i)	no.	17 314	3 983	14 679	7 236	2 874	1 368	280	6 359	55 027
Proportion of target population assessed	%	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3
Non-Indigenous older people										

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Number of people assessed (j)	no.	145 691	101 547	86 998	35 660	35 200	12 834	3 788	371	422 089
Target population (k)	no.	495 999	374 032	262 013	130 142	128 746	36 755	17 245	3 453	1 448 184
Proportion of target population assessed	%	29.4	27.1	33.2	27.4	27.3	34.9	22.0	10.7	29.1

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

(b) Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

(c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

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

(e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.

(f) Data for WA for non-Indigenous people have been revised and may differ from previous reports.

(g) Includes Other Territories.

(h) Includes claims for MBS items 704, 706 and 715, for Indigenous people aged 55 years or over.

(i) Projected population of Indigenous people aged 55 years or over at 30 June (B series). Projections are based on estimated resident population (ERP) at 30 June 2006.

(j) Includes claims for MBS items 700, 702, 701, 703, 705 and 707, for people aged 75 years or over.

(k) Estimated population of non-Indigenous people aged 75 years or over at 30 June, computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. Data for WA have been revised and may differ from previous reports.

(l) 2011-12 data have been revised to include claims made up to 12 months after the assessment was received.

(m) 2012-13 data are preliminary data.

Table 11A.27 **Annual health assessments for older people by Indigenous status (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)

Source : Department of Health unpublished, MBS data collection; ABS 2008, 2009, 2010, 2011 and unpublished, *Population by Age and Sex, Australian States and Territories* , various years, Cat. no. 3201.0, Canberra; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 1991 to 2021* , Cat. no. 3238.0, Canberra.

Table 11A.28 **Older Indigenous Australians who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
2007-08										
Number of people assessed	no.	1 148	275	1 261	620	127	7	10	855	4 303
Target population	no.	13 460	3 074	11 035	5 517	2 251	1 039	168	4 849	42 096
Proportion of target population assessed	%	8.5	8.9	11.4	11.2	5.6	0.7	6.0	17.6	10.2
2008-09										
Number of people assessed	no.	1 466	265	1 544	798	140	23	24	993	5 253
Target population	no.	14 130	3 240	11 706	5 821	2 361	1 099	200	5 066	44 353
Proportion of target population assessed	%	10.4	8.2	13.2	13.7	5.9	2.1	12.0	19.6	11.8
2009-10										
Number of people assessed	no.	1 652	337	2 053	1 021	153	36	46	1 185	6 483
Target population	no.	14 821	3 412	12 405	6 134	2 479	1 164	221	5 339	46 741
Proportion of target population assessed	%	11.1	9.9	16.5	16.6	6.2	3.1	20.8	22.2	13.9
2010-11										
Number of people assessed	no.	3 216	422	3 151	1 508	451	109	36	1 572	10 465
Target population	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271
Proportion of target population assessed	%	20.6	11.8	24.0	23.4	17.4	8.8	15.3	27.9	21.2
2011-12 (h)										
Number of people assessed	no.	4 156	558	4 589	1 632	508	185	48	1 765	13 441
Target population	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216
Proportion of target population assessed	%	25.2	14.7	33.0	23.8	18.5	14.1	18.6	29.3	25.7
2012-13 (i)										
Number of people assessed	no.	5 156	713	5 427	2 186	604	261	73	2 232	16 652
Target population	no.	17 314	3 983	14 679	7 236	2 874	1 368	280	6 359	55 027

Table 11A.28 **Older Indigenous Australians who received an annual health assessment (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Proportion of target population assessed	%	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3

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

(b) Includes claims for MBS items 704, 706 and 715 for Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment available to 'all older people'. This is considered unlikely to affect overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

(c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

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

(e) Allocation of patients to state or territory is based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment rather than number of health assessments provided.

(f) Target population is the projected target population at 30 June (B series), based on the estimated resident population (ERP) at 30 June 2006.

(g) Includes Other Territories.

(h) 2011-12 data have been revised to include claims made up to 12 months after the assessment was received.

(i) 2012-13 data are preliminary data.

Source: Department of Health unpublished, MBS Statistics; ABS 2009, Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 1991 to 2021, Cat. no. 3238.0, Canberra.

Table 11A.29 **Indigenous Australians who received a health check or assessment, by age (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
2010-11										
Children 0–14 years										
Children assessed	no.	6 045	801	8 349	2 371	476	112	68	3 933	22 155
Target population	no.	58 907	12 610	58 815	26 023	10 496	6 794	1 601	22 979	198 298
Proportion assessed	%	10.3	6.4	14.2	9.1	4.5	1.6	4.2	17.1	11.2
Adults 15–54 years										
People assessed	no.	11 073	1 614	11 844	5 020	1 325	315	150	6 599	37 940
Target population	no.	90 790	20 574	88 688	43 805	17 308	11 387	2 785	40 057	315 532
Proportion assessed	%	12.2	7.8	13.4	11.5	7.7	2.8	5.4	16.5	12.0
Adults 55 years or over										
People assessed	no.	3 216	422	3 151	1 508	451	109	36	1 572	10 465
Target population	no.	15 609	3 577	13 129	6 443	2 599	1 239	235	5 625	49 271
Proportion assessed	%	20.6	11.8	24.0	23.4	17.4	8.8	15.3	27.9	21.2
2011-12 (f)										
Children 0–14 years										
Children assessed	no.	8 520	1 150	12 133	2 436	800	137	197	5 270	30 643
Target population	no.	59 395	12 765	59 649	26 112	10 591	6 893	1 614	23 149	200 245
Proportion assessed	%	14.3	9.0	20.3	9.3	7.6	2.0	12.2	22.8	15.3
Adults 15–54 years										
People assessed	no.	14 933	2 148	18 474	5 355	1 768	449	286	7 228	50 641
Target population	no.	92 886	21 092	91 333	44 733	17 709	11 654	2 854	40 692	323 091
Proportion assessed	%	16.1	10.2	20.2	12.0	10.0	3.9	10.0	17.8	15.7
Adults 55 years or over										
People assessed	no.	4 156	558	4 589	1 632	508	185	48	1 765	13 441
Target population	no.	16 492	3 790	13 901	6 849	2 740	1 309	258	6 014	52 216

Table 11A.29 **Indigenous Australians who received a health check or assessment, by age (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
Proportion assessed	%	25.2	14.7	33.0	23.8	18.5	14.1	18.6	29.3	25.7
2012-13 (g)										
Children 0–14 years										
Children assessed	no.	10 710	1 561	15 077	3 939	994	234	214	5 429	38 158
Target population	no.	60 104	12 950	60 620	26 295	10 726	6 990	1 648	23 415	202 827
Proportion assessed	%	17.8	12.1	24.9	15.0	9.3	3.3	13.0	23.2	18.8
Adults 15–54 years										
People assessed	no.	17 743	2 709	22 496	8 565	2 332	661	448	8 977	63 931
Target population	no.	94 956	21 632	93 981	45 622	18 096	11 937	2 905	41 280	330 547
Proportion assessed	%	18.7	12.5	23.9	18.8	12.9	5.5	15.4	21.7	19.3
Adults 55 years or over										
People assessed	no.	5 156	713	5 427	2 186	604	261	73	2 232	16 652
Target population	no.	17 314	3 983	14 679	7 236	2 874	1 368	280	6 359	55 027
Proportion assessed	%	29.8	17.9	37.0	30.2	21.0	19.1	26.1	35.1	30.3

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

(b) Allocation of patients to state/territory based on the final claim processed for each patient in the reference period. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided. Indigenous status is determined by self-identification.

(c) Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

(d) Target population is the projected target population for the age group at 30 June (B series), based on the estimated resident population at 30 June 2006.

(e) Includes Other Territories.

(f) 2011-12 data have been revised to include claims made up to 12 months after the assessment was received.

(g) 2012-13 data are preliminary data.

Source: Department of Health unpublished, MBS Statistics; ABS 2009, Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021, Cat. no. 3238.0, Canberra.

Table 11A.30 Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported (a), (b), (c), (d)

	Unit	*2008-09* (e)	*2009-10*	*2010-11*	*2011-12*
Early detection activities provided					
Well person's checks	%	80	72.7	74.8	81.7
PAP smears/cervical screening	%	80	76.2	75.6	77.2
STI testing	%	73	74.0	70.5	74.1
Hearing testing	%	72	74.9	70.9	76.3
Eye disease testing	%	69	71.8	69.7	76.3
Renal disease testing	%	54	53.4	56.4	57.6
Diabetic testing	%	78	75.3	79.5	79.9
Cardiovascular testing	%	66	62.3	68.4	73.2
Any early detection activity	%	90	89.7	89.7	88.8

(a) Includes only services which report data for the Online Services Report (OSR; previously the OATSIH Services Report).

(b) The OSR 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).

(c) Some services in the OSR are funded for and provide a full range of comprehensive primary health care activities, while others focus on specific elements of primary health care such as health promotion.

(d) The OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from 2008-09. OSR data are not comparable with SAR data due to changes in collection methodology.

(e) In 2008-09, 4 of 205 services reporting to the OSR collection did not provide valid data for this question. The denominator for 2008-09 is the number of services that provided valid data for this question (201).

Source : AIHW 2013 and previous issues, *Aboriginal and Torres Strait Islander health services report: online services report - key results* , 2008-09, 2009-10, 2010-11 and 2011-12, Cat. no.s IHW 31,56,79,104, Canberra.

Table 11A.31 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT*	*Aust*
2009-10										
Aboriginal and Torres Strait Islander Child Health Check (f), (g)	%	27.8	21.7	35.2	35.5	17.3	np	np	45.5	31.0
Healthy Kids Check (h)	%	20.3	6.7	28.1	15.1	10.2	20.5	12.4	17.6	17.2
Total	**%**	**20.6**	**6.9**	**28.5**	**16.3**	**10.5**	**19.2**	**12.3**	**29.2**	**17.8**
2010-11										
Aboriginal and Torres Strait Islander Child Health Check (g)	%	37.7	23.2	47.7	36.2	17.9	5.2	9.9	63.6	40.1
Healthy Kids Check (h)	%	25.7	7.1	34.4	16.3	12.5	22.8	12.8	31.2	20.7
Total	**%**	**26.3**	**7.3**	**35.2**	**17.5**	**12.7**	**21.5**	**12.8**	**44.6**	**21.7**
2011-12 (i)										
Aboriginal and Torres Strait Islander Child Health Check (g)	no.	2 326	338	3 185	774	204	47	61	1 365	8 300
Target population (e)	no.	4 071	847	4 026	1 691	690	477	113	1 507	13 427
Proportion of target population assessed	%	57.1	39.9	79.1	45.8	29.6	9.9	54.0	90.6	61.8
Healthy Kids Check (h)	no.	46 370	16 878	37 594	12 480	7 201	3 219	1 218	805	125 765
Target population (e)	no.	88 617	68 125	55 505	28 911	18 391	5 752	4 608	2 071	272 003
Proportion of target population assessed	%	52.3	24.8	67.7	43.2	39.2	56.0	26.4	38.9	46.2
Total	no.	48 696	17 216	40 779	13 254	7 405	3 166	1 176	2 170	134 065
Target population	no.	92 359	68 824	59 740	30 819	19 183	6 350	4 530	3 598	285 430
Proportion of target population assessed	**%**	**52.7**	**25.0**	**68.3**	**43.0**	**38.6**	**49.9**	**26.0**	**60.3**	**47.0**
2012-13 (a), (i)										
Aboriginal and Torres Strait Islander Child Health Check (g)	no.	2 864	403	3 791	1 106	271	64	48	1 489	10 036

Table 11A.31 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT*	*Aust*
Target population (e)	no.	4 242	886	4 205	1 743	717	505	116	1 524	13 944
Proportion of target population assessed	%	67.5	45.5	90.2	63.4	37.8	12.7	41.5	97.7	72.0
Healthy Kids Check (h)	no.	56 161	21 191	42 935	14 014	9 498	3 666	1 821	932	150 218
Target population (e)	no.	91 948	72 693	60 619	31 657	19 613	6 007	5 176	2 197	289 805
Proportion of target population assessed	%	61.1	29.2	70.8	44.3	48.4	61.0	35.2	42.4	51.8
Total	no.	59 025	21 594	46 726	15 120	9 769	3 730	1 869	2 421	160 254
Target population	no.	96 190	73 579	64 824	33 400	20 330	6 512	5 292	3 722	303 749
Proportion of target population assessed	**%**	**61.4**	**29.3**	**72.1**	**45.3**	**48.1**	**57.3**	**35.3**	**65.0**	**52.8**

a) Computed by the Secretariat from the 2011-12 reference period. Historical data were sourced from the National Healthcare Agreement and do not include underlying data. The considerable increase in proportion of target population assessed compared to previous years is associated with a considerable increase in the number of children receiving fourth year developmental health checks (Department of Health, pers. comm, 25 October 2012).

(b) Patient allocation based on patient postcode at the date their last service was processed in the reference period. This is not necessarily where the service was received. Data are for number of patients receiving a health assessment/check rather than number of health assessments/checks provided.

(c) Children are counted only once in the numerator.

(d) From the 2010-11 reference period, children who received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period were counted against the Aboriginal and Torres Strait Islander health assessment.

(e) Rates are computed using as denominator the population of children aged 4 years, derived from ABS ERP data based on the 2006 Census. It was derived by multiplying the ERP for 0–4 years, disaggregated by Indigenous status, by the proportion of children aged 4 years in this age group nationally. Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

(f) Data for Aboriginal and Torres Strait Islander Child Health Checks are not published for Tasmania or the ACT for 2009-10 due to small numbers, but are included in the total for Australia.

Table 11A.31 **Proportion of children receiving a fourth year developmental health check, by type of health check (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT*	*Aust*

(g) Includes claims for Medicare Benefits Schedule (MBS) Item 708 (Aboriginal and Torres Strait Islander Child Health Check, available to 30 April 2010) and Item 715 (Aboriginal and Torres Strait Islander People's Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years for the 2012-13 reference period, and 3 or 4 years for the 2011-12 reference period. Data exclude health assessments provided outside DHS Medicare under service models used to increase access for people in remote areas and for Indigenous Australians. Data for Indigenous Australians are therefore likely to understate the proportion who access health assessments.

(h) Includes claims for MBS items 709 and 711 (Healthy Kids Check, available to 30 April 2010) and items 701, 703, 705, 707 and 10986 (Health Assessment, available from 1 May 2010) for children aged 3, 4 or 5 years from 2011-12, and 3 or 4 years for data to 2010-11. Data do not include developmental health check activity conducted outside Medicare, such as State and Territory early childhood health assessments in preschools and community health centres. This is known to be a particular issue for several jurisdictions. For example, in Victoria, the Victorian Maternal and Child Health Service provided a 3.5 year old Key Ages and Stages consultation to 47 638 children in the 2011-12 financial year. Data include Indigenous children who received a Healthy Kids Check and did not also receive a health check under MBS items 708 or 715.

(i) From 2011-12, data include Indigenous and non-Indigenous children aged 3, 4 or 5 years who received a health assessment under the specified MBS items, provided they had not received such a check in a previous reference period. This constitutes a break in time series for the data. Data for 2011-12 and 2012-13 should not be compared with data for previous years, which are limited to children aged 3 or 4 years.

np Not published.

Source: Department of Health unpublished, MBS Statistics; ABS unpublished, Australian demographic statistics, Cat. no. 3101.0, Canberra; ABS 2009, Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, B series, Cat. no. 3238.0, Canberra.

Table 11A.32 **Non-referred attendances that were bulk billed, by region and age (per cent) (a), (b), (c), (d)**

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Aust* (e)
2012-13						
0–15 years	89.4	88.3	88.7	91.6	92.5	89.2
16–64 years	78.6	72.3	73.7	74.4	83.1	77.0
65 years or over	90.5	88.8	89.7	92.0	94.0	90.1
All ages (f)	83.3	79.6	80.5	81.3	86.6	82.3

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

(b) Data include non-referred attendances undertaken by general practice nurses

(c) Patient age at date of service.

(d) Allocation to remoteness area based on patients' Medicare enrolment postcode.

(e) Australia includes attendances where patient postcodes could not be allocated to a remoteness area.

(f) All ages includes attendances where patient age is unknown.

Source : Department of Health unpublished, MBS Statistics.

Table 11A.33 **Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
2006-07								
0–15 years	86.9	82.1	79.1	82.2	82.4	80.3	87.8	85.4
16–64 years	74.3	71.0	63.9	66.1	65.5	63.0	74.5	71.9
65 years or over	89.4	86.2	83.1	85.6	85.3	87.7	89.4	87.8
All ages	79.8	76.9	71.5	74.3	73.8	70.1	79.9	78.0
2007-08								
0–15 years	87.6	83.3	80.8	84.8	84.6	81.4	89.2	86.4
16–64 years	75.4	72.7	66.1	68.9	67.9	65.0	76.8	73.4
65 years or over	89.7	87.3	84.6	87.3	86.7	87.8	90.9	88.6
All ages	80.7	78.3	73.4	76.7	76.0	71.6	82.0	79.2
2008-09								
0–15 years	88.2	84.7	83.2	87.3	86.1	81.7	89.8	87.3
16–64 years	75.7	73.8	67.1	71.2	68.6	63.8	77.4	73.9
65 years or over	90.2	88.0	85.9	88.6	87.8	87.9	91.8	89.2
All ages	81.1	79.4	74.7	78.8	77.0	70.9	82.6	79.9
2009-10								
0–15 years	88.8	86.4	85.1	88.7	87.0	84.0	91.3	88.2
16–64 years	75.5	75.5	67.8	73.1	69.8	65.5	78.9	74.3
65 years or over	90.4	89.3	87.2	89.7	88.8	88.0	92.1	89.8
All ages	81.3	81.1	76.0	80.5	78.3	72.5	83.9	80.5
2010-11								
0–15 years	88.8	86.4	85.7	88.8	86.9	84.6	91.8	88.2
16–64 years	76.2	76.1	68.8	73.3	69.9	65.4	79.4	74.9
65 years or over	90.4	89.5	87.6	89.9	88.8	87.9	92.5	89.9
All ages	81.7	81.5	76.7	80.8	78.3	72.5	84.4	80.9
2011-12								
0–15 years	89.2	87.1	86.8	89.6	87.8	84.8	92.5	88.8
16–64 years	77.2	76.8	71.1	74.0	70.8	64.9	80.2	75.8
65 years or over	90.3	89.6	87.8	90.3	88.8	86.7	93.1	89.9
All ages	82.3	82.0	78.1	81.4	78.9	71.9	85.2	81.5

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. 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) Data are not comparable to data for 2012-13 which are based on the Australian Statistical Geography Standard 2011 (ASGS) classification.

Table 11A.33 **Non-referred attendances that were bulk billed, by region and age, 2006-07 to 2011-12 (per cent) (a), (b), (c), (d), (e)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*

(c) Data include non-referred attendances undertaken by general practice nurses

(d) Patient age at date of service.

(e) Allocation to state/territory based on patients' Medicare enrolment postcode.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.34 **Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
2005-06									
0–15 years	87.1	78.2	83.3	86.6	86.0	78.6	52.9	69.7	83.4
16–64 years	78.2	67.5	66.6	60.6	65.9	61.2	35.7	57.8	69.8
65 years or over	87.5	85.8	86.3	89.4	87.8	83.6	64.9	86.1	86.7
All ages	81.9	73.8	74.2	71.8	74.9	69.6	44.2	63.0	76.2
2006-07									
0–15 years	88.5	80.4	85.4	88.4	88.1	81.7	62.7	69.6	85.4
16–64 years	80.0	69.7	68.7	62.0	68.6	63.9	44.2	59.0	71.9
65 years or over	88.7	86.7	87.5	90.0	89.0	85.4	68.6	86.6	87.8
All ages	83.5	75.7	76.1	73.0	77.1	72.2	51.9	64.0	78.0
2007-08									
0–15 years	89.2	81.7	86.5	90.0	89.6	84.2	62.2	70.7	86.4
16–64 years	81.2	71.4	70.5	62.3	71.0	66.5	46.2	61.0	73.4
65 years or over	89.5	87.3	88.2	90.4	90.0	86.7	69.2	87.6	88.6
All ages	84.5	77.0	77.5	73.9	79.0	74.5	53.2	65.7	79.2
2008-09									
0–15 years	89.9	82.9	87.8	90.7	90.7	85.6	62.2	68.1	87.3
16–64 years	81.7	72.4	71.4	61.6	72.1	66.2	46.0	60.0	73.9
65 years or over	90.1	87.9	89.1	90.9	90.8	87.1	68.3	88.0	89.2
All ages	85.1	77.9	78.5	73.7	80.1	74.8	53.0	64.7	79.9
2009-10									
0–15 years	90.4	83.8	89.3	90.5	91.4	87.2	64.4	72.9	88.2
16–64 years	81.0	73.6	73.4	61.7	70.5	67.7	40.5	64.3	74.3
65 years or over	90.6	88.6	90.1	91.3	91.3	88.1	67.7	89.7	89.8
All ages	85.0	79.0	80.3	73.9	79.7	76.3	49.9	68.9	80.5
2010-11									
0–15 years	90.3	84.5	89.3	90.5	91.6	86.7	61.9	76.0	88.2
16–64 years	81.8	74.5	74.2	61.0	70.7	67.5	38.3	66.4	74.9
65 years or over	90.8	88.7	90.3	90.9	91.0	88.0	66.4	89.9	89.9
All ages	85.5	79.7	80.8	73.4	79.6	76.1	48.1	71.1	80.9
2011-12									
0–15 years	90.8	85.7	89.4	90.3	92.1	86.4	65.4	80.4	88.8
16–64 years	82.7	76.0	74.8	60.4	72.9	66.5	40.8	68.9	75.8
65 years or over	91.0	88.8	90.2	90.1	90.7	87.4	66.3	90.6	89.9
All ages	86.1	80.8	81.0	72.8	80.8	75.4	50.2	73.7	81.5
2012-13									
0–15 years	91.0	86.8	89.5	90.2	92.1	86.9	68.1	85.5	89.2

Table 11A.34 **Non-referred attendances that were bulk billed by age (per cent) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
16–64 years	83.7	77.7	75.7	61.0	73.9	67.4	47.9	73.9	77.0
65 years or over	91.3	89.2	90.4	89.7	90.6	88.3	66.5	91.2	90.1
All ages	86.8	82.1	81.7	73.0	81.4	76.4	55.0	78.2	82.3

(a) Data include non-referred attendances undertaken by general practice nurses.

(b) Patient age at date of service.

(c) Allocation to State/Territory based on patients' Medicare enrolment postcode.

(d) All ages includes attendances where patient age is unknown.

(e) Australia includes attendances where patient postcodes could not be allocated to a State/Territory.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.35 **People deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Proportion	%	4.8	5.2	6.3	8.0	6.1	7.7	8.8	5.0	5.8
RSE	%	9.2	6.4	7.2	7.7	9.5	10.1	12.3	21.5	3.4
95 per cent confidence interval	%	± 0.9	± 0.7	± 0.9	± 1.2	± 1.1	± 1.5	± 2.1	± 2.1	± 0.4

RSE = Relative standard error.

(a) People aged 15 years or over who delayed or did not visit a GP at any time in the last 12 months due to cost.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges except for Queensland, for which 10 year ranges are used.

(c) Rates with RSEs between 25 per cent and 50 per cent should be used with caution.

(d) Data for 2012-13 are not comparable to data for previous years due to a change in question sequencing/wording. See data quality information for further detail.

(e) Data are not comparable to data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

(f) Data exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions, but include very remote areas.

Source : ABS unpublished, *Patient Experience Survey 2012-13* , Cat. no. 4839.0.

Table 11A.36 **Indigenous Australians deferring access to GPs due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	11.1	12.3	13.0	13.8	7.7	16.3	20.7	11.0	12.2
RSE (c)	%	24.5	28.4	26.9	20.7	43.8	23.9	24.3	40.2	10.2
95 per cent confidence interval	± %	5.3	6.9	6.8	5.6	6.6	7.6	9.9	8.7	2.4

RSE = Relative standard error.

(a) Indigenous people aged 15 years or over who reported needing to see a GP in the last 12 months but did not because of cost, divided by the number of Indigenous people aged 15 years or over who reported needing to see a GP in the last 12 months.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges.

(c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

(d) Data are not comparable with data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.

(e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source : ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13,* Cat. no. 4727.0.

Table 11A.37 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12 (d)										
Within four hours										
Proportion	%	63.5	63.5	65.2	63.1	68.4	54.3	48.0	46.6	63.6
RSE	%	4.2	4.0	2.8	4.3	4.7	9.0	13.3	22.6	1.9
95 per cent confidence interval	%	± 5.2	± 5.0	± 3.6	± 5.3	± 6.3	± 9.6	± 12.5	± 20.6	± 2.3
Four to less than 24 hours										
Proportion	%	12.1	11.3	11.0	14.0	11.1	19.8	18.5	16.0	12.0
RSE	%	13.0	11.6	13.0	14.1	17.3	21.8	21.4	30.9	6.1
95 per cent confidence interval	%	± 3.1	± 2.6	± 2.8	± 3.9	± 3.8	± 8.4	± 7.7	± 9.7	± 1.4
24 hours or more										
Proportion	%	24.4	25.1	23.8	22.9	20.5	25.9	33.6	37.3	24.4
RSE	%	9.9	9.5	8.7	9.7	12.9	15.0	18.7	16.8	4.0
95 per cent confidence interval	%	± 4.7	± 4.7	± 4.1	± 4.4	± 5.2	± 7.6	± 12.3	± 12.3	± 1.9
2012-13 (d)										
Within four hours										
Proportion	%	64.3	63.4	66.8	62.0	66.2	54.1	61.2	49.5	64.1
RSE	%	3.1	3.2	3.4	5.0	3.2	8.2	7.5	15.3	1.4
95 per cent confidence interval	±	3.9	4.0	4.4	6.1	4.2	8.7	9.0	14.9	1.8
Four to less than 24 hours										
Proportion	%	9.6	12.3	11.2	11.8	13.7	16.4	13.6	12.5	11.4
RSE	%	11.4	12.7	15.5	15.7	14.2	12.8	24.0	31.0	5.6
95 per cent confidence interval	±	2.1	3.1	3.4	3.6	3.8	4.1	6.4	7.6	1.2
24 hours or more										
Proportion	%	26.1	24.2	22.1	26.2	20.1	29.6	25.2	38.0	24.6
RSE	%	6.9	8.3	8.0	9.9	8.8	14.2	14.7	20.2	3.5
95 per cent confidence interval	±	3.5	3.9	3.5	5.1	3.5	8.2	7.2	15.0	1.7

RSE = relative standard error.

(a) Time waited between making an appointment and seeing the GP for urgent medical care.

(b) People aged 15 years or over who saw a GP for urgent medical care for their own health in the last 12 months. 'Urgent' as defined by respondent. Discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash).

(c) Rates are age-standardised to the 2001 estimated resident population using 5 year ranges except for WA, for which 10 year ranges are used.

Table 11A.37 **Waiting time for GPs for an urgent appointment (per cent) (a), (b), (c), (d), (e), (f)**

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

(d) Data for 2012-13 are comparable with data for 2011-12 but are not comparable with data for previous years, due to a change to the question wording in 2011-12. See data quality information for further details.

(e) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

(f) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

Source : ABS unpublished, *Patient Experience Survey 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.38 **Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment, 2012-13 (per cent) (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion		20.8	21.6	17.8	24.8	21.1	23.6	22.0	21.0	20.9
RSE		3.4	3.3	4.8	4.5	4.9	5.9	7.8	11.9	2.0
95 per cent confidence interval		± 1.4	± 1.4	± 1.7	± 2.2	± 2.0	± 2.7	± 3.4	± 4.9	± 0.8

RSE = relative standard error.

(a) Persons aged 15 years or over who saw a GP in the previous 12 months, excluding interviews by proxy.

(b) Rates are age standardised to the 2001 estimated resident population using 5 year ranges.

(c) Data for 2012-13 are not comparable to data for previous years due to a change in question sequencing. See data quality information for further details.

Source: ABS unpublished, *Patient Experience Survey 2012-13* , Cat. no. 4839.0.

Table 11A.39 **Selected potentially avoidable GP-type presentations to emergency departments (number) (a), (b), (c)**

	NSW (d)	*Vic* (d)	*Qld*	*WA*	*SA* (e)	*Tas* (f)	*ACT*	*NT*	*Aust*
2008-09	648 937	542 164	380 947	193 353	112 517	55 644	44 535	34 703	2 012 800
2009-10	706 134	550 887	371 539	207 545	117 056	62 534	46 217	37 717	2 099 629
2010-11	692 778	555 140	375 169	263 845	117 525	60 182	48 485	42 303	2 155 427
2011-12 (g)	684 991	554 124	378 087	286 820	103 928	59 840	47 807	40 903	2 156 500
2012-13 (h)	682342	574470	383829	282121	105880	61603	46617	39750	2176612

(a) GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of 4 (semi-urgent) or 5 (non-urgent), and where the episode end status was not: admitted to the hospital, referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector.

(b) Data are presented by the state/territory of usual residence of the patient, not by the state/territory of the hospital.

(c) Limited to peer group A and B public hospitals.

(d) From 2009-10, data for the Albury Base Hospital (previously reported in NSW hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for NSW and Victoria.

(e) For SA for 2008-09 and 2009-10, data include presentations for which the type of visit was not reported.

(f) The Mersey Community hospital in Tasmania is reported as a Large hospital (Peer Group B) for these data.

(g) Data for 2011-12 have been revised using hospital classification into peer groups A and B based on 2011-12 peer groups and differ from data published in the 2013 Report which utilised hospital classification into peer groups A and B based on 2010-11 peer groups.

(h) Data for 2012-13 are preliminary. Hospital classification into peer groups A and B is based on 2011-12 peer groups.

Source: AIHW unpublished, National Non-admitted Emergency Department Care Database.

Table 11A.40 **People attending a hospital emergency department who thought the care could have been provided at a general practice (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (d)	*Aust*
2010-11										
Proportion	%	26.3	17.3	19.2	23.5	18.3	23.7	26.9	19.9	21.5
RSE	%	8.2	8.5	9.5	8.4	11.5	14.4	21.5	17.8	4.6
95% confidence interval	±	4.2	2.9	3.6	3.9	4.1	6.7	11.3	7.0	1.9
2011-12										
Proportion	%	21.2	24.1	26.1	27.4	20.2	21.9	25.3	26.2	23.5
RSE	%	7.3	8.2	10.7	8.3	13.5	12.7	16.4	15.2	3.4
95% confidence interval	±	3.0	3.9	5.5	4.5	5.4	5.5	8.1	7.8	1.6
2012-13										
Proportion	%	23.7	22.7	23.6	24.8	23.7	24.1	24.2	22.5	23.6
RSE	%	6.5	6.1	8.0	8.9	12.7	11.8	14.0	14.7	3.5
95% confidence interval	±	3.0	2.7	3.7	4.3	5.9	5.6	6.6	6.5	1.6

RSE = Relative standard error.

(a) People aged 15 years or over who reported attending a hospital emergency department and thought at the time that the care received could have been provided at a general practice.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges except for ACT and NT, for which 15 year age ranges are used.

(c) Excludes persons who responded "Don't know" whether care could have been provided at a GP

(d) Data from 2011-12 exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions, but include very remote areas. Data for previous years exclude very remote areas which translates into the exclusion of around 23 per cent of the NT population — NT data for 2010-11 should therefore be used with care.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12* , *2012-13* , Cat. no. 4839.0.

Table 11A.41 **People deferring access to prescribed medication due to cost (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
2010-11										
Proportion	%	9.3	9.1	11.4	9.1	11.1	11.5	9.4	9.1	9.8
RSE	%	5.3	5.3	5.8	8.1	8.8	8.4	14.6	20.8	2.9
95 per cent confidence interval	%	± 1.0	± 1.0	± 1.3	± 1.4	± 1.9	± 1.9	± 2.7	± 3.7	± 0.6
2011-12										
Proportion	%	8.9	9.2	11.5	8.2	10.1	10.8	11.7	11.0	9.6
RSE	%	6.3	6.5	7.1	9.5	7.6	11.7	9.1	16.4	3.2
95 per cent confidence interval	%	± 1.1	± 1.2	± 1.6	± 1.5	± 1.5	± 2.5	± 2.1	± 3.6	± 0.6
2012-13 (e)										
Proportion	%	7.9	8.6	9.9	7.1	9.1	9.8	6.7	8.9	8.5
RSE	%	5.6	5.5	6.4	9.4	8.3	10.1	15.7	19.2	2.6
95 per cent confidence interval	%	± 0.9	± 0.9	± 1.2	± 1.3	± 1.5	± 1.9	± 2.1	± 3.4	± 0.4

RSE = Relative standard error.

(a) People aged 15 years and over who received a prescription for medication from a GP in the last 12 months and delayed using or did not get medication at any time in the last 12 months due to the cost.

(b) Rates are age standardised to the 2001 estimated resident population using 5 year age ranges except for WA and SA, for which 10 year age ranges were used.

(c) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.

(d) Data for 2010-11 and subsequent reference years are comparable over time, but are not comparable with data for 2009 due to a change in the sequencing and wording of the survey question.

(e) Data from 2011-12 exclude discrete Indigenous communities, which will affect the NT more than other jurisdictions, but include very remote areas. Data for previous years exclude very remote areas which translates into the exclusion of around 23 per cent of the NT population — NT data for 2009 and 2010-11 should therefore be used with care.

(f) Data are not comparable to data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

Source : ABS unpublished, *Patient Experience Survey 2010-11* , *2011-12, 2012-13* Cat. no. 4839.0.

Table 11A.42 **Indigenous people deferring access to prescribed medication due to cost, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	24.4	36.3	47.0	45.2	35.3	46.5	24.1	22.8	34.6
RSE (c)	%	19.7	14.8	15.0	19.3	26.0	14.9	37.2	34.1	8.4
95 per cent confidence interval	± %	9.4	10.5	13.8	17.1	18.0	13.5	17.6	15.2	5.7

RSE = Relative standard error.

(a) Indigenous people aged 15 years and over who received a prescription for medication in the last 12 months and did not get the medication due to the cost, divided by the number of Indigenous people who received a prescription for medication in the last 12 months.

(b) Rates are age-standardised to the 2001 estimated resident population (5 year ranges).

(c) Estimates with RSEs between 25 and 50 per cent should be used with caution.

(d) Data are not comparable to data for all Australians that were sourced from the ABS Patient Experience Survey, due to differences in survey design and collection methodology.

(e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table 11A.43 **Waiting time for public dentistry, 2012-13 (per cent) (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Less than 1 month										
Proportion	%	34.2	28.5	28.3	37.4	15.1	32.5	36.3	40.4	30.5
RSE (c)	%	10.7	10.5	12.9	17.1	25.8	21.6	27.5	35.8	3.9
95% CI	±%	7.2	5.9	7.1	12.6	7.6	13.8	19.5	28.3	2.3
1 month or more										
Proportion	%	65.8	71.5	71.7	62.6	84.9	67.5	63.7	59.6	69.5
RSE	%	5.6	4.2	5.1	10.2	4.6	10.4	15.6	10.3	1.7
95% CI	±%	7.2	5.9	7.1	12.6	7.6	13.8	19.5	12.0	2.3

RSE = Relative standard error. **CI** = confidence interval.

(a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges except for the ACT, for which 10 year age ranges were used.

(c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

(d) Data for 2012-13 are not comparable with data for 2011-12 that excluded treatment for urgent dental care (no longer excluded).

(e) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

Source ABS (unpublished) *Patient Experience Survey 2012-13,* Cat. no. 4839.0.

Table 11A.44 **Waiting time for public dentistry by remoteness, Australia, 2012-13 (a), (b), (c), (d), (e)**

	Unit	*Major CIties*	*Other* (f)	*Inner regional*	*Outer regional/*	***Total***
Less than 1 month						
Proportion	%	31.8	27.9	28.4	27.7	**30.5**
RSE	%	6.5	9.8	11.5	17.6	**3.9**
95% CI	± %	4.0	5.4	6.4	9.5	**2.3**
1 month or more						
Proportion	%	68.2	72.1	71.6	72.3	**69.5**
RSE	%	3.0	3.8	4.6	6.7	**1.7**
95% CI	± %	4.0	5.4	6.4	9.5	**2.3**

RSE = Relative standard error. **CI** = confidence interval.

(a) Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months for their own health.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges.

(c) Rates with RSEs greater than 25 per cent should be used with caution. Rates with RSEs greater than 50 per cent are considered too unreliable for general use.

(d) Data for 2012-13 are not comparable with data for previous years which excluded treatment for urgent dental care (no longer excluded).

(e) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

(f) 'Other' includes inner and outer regional, remote and very remote areas.

Source : ABS unpublished, *Patient Experience Survey 2012-13* , Cat. no. 4839.0.

Table 11A.45 Waiting times for public dentistry, Indigenous Australians, by remoteness, Australia, 2012-13 (per cent) (a), (b), (c), (d), (e)

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Aust* (c)
Less than 1 month					
Proportion	%	57.8	56.6	63.2	59.0
RSE	%	6.5	8.0	8.1	4.5
95% CI	± %	7.4	8.9	10.0	5.2
1 month or more					
Proportion	%	29.5	33.8	21.2	28.0
RSE	%	14.2	13.7	19.8	9.1
95% CI	± %	8.2	9.1	8.2	5.0

CI = confidence interval. RSE = relative standard error. Estimates with RSEs between 25 percent and 50 percent should be used with caution.

(a) Indigenous people aged 15 years or over who reported seeing a dental professional at a government dental clinic within specified waiting time categories for non-urgent treatment in the last 12 months, divided by the number of Indigenous people aged 15 years or over who reported seeing a a dental professional at a government dental clinic in the last 12 months.

(b) Rates are age-standardised to the 2001 estimated resident population using 5 year age ranges.

(c) Includes persons in non-remote areas only, as the survey questions were not asked of people in remote areas.

(d) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.

(e) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table 11A.46 **Proportion of full time workload equivalent (FWE) GPs with vocational registration by region, 2012-13 (per cent) (a), (b), (c), (d)**

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Aust*
2012-13	92.6	82.8	78.8	75.5	83.4	89.4

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

(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 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. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

(d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source : Department of Health unpublished, MBS Statistics.

Table 11A.47 **Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region, 2003-04 to 2011-12 (per cent) (a), (b), (c), (d)**

	Capital city	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural area*	*Remote centre*	*Other remote area*	*Aust*
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
2006-07	92.9	90.0	90.3	83.5	83.3	71.3	68.8	90.4
2007-08	92.7	89.9	87.6	82.2	83.1	71.0	65.5	90.0
2008-09	92.6	89.6	87.5	81.8	83.4	70.4	67.3	89.9
2009-10	92.6	89.6	87.1	80.2	83.3	68.9	69.6	89.7
2010-11	93.2	90.6	87.0	80.5	81.5	67.2	72.6	89.9
2011-12	92.8	90.9	86.6	80.3	80.8	67.6	73.5	89.6

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. 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) 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. In the small proportion of cases where data values were not reported, doctors were reallocated based on available information.

(d) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source: Department of Health unpublished, MBS Statistics.

Table 11A.48 **Number and proportion of full time workload equivalent (FWE) GPs with vocational registration (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
FWE GPs with vocational registration										
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
2006-07	no.	6 007	3 987	3 051	1 362	1 301	356	215	80	16 359
2007-08	no.	6 098	4 131	3 125	1 395	1 322	370	223	82	16 745
2008-09	no.	6 260	4 284	3 265	1 414	1 376	372	223	86	17 279
2009-10	no.	6 346	4 402	3 389	1 455	1 403	385	224	94	17 699
2010-11	no.	6 490	4 528	3 574	1 494	1 418	390	227	96	18 216
2011-12	no.	6 725	4 630	3 810	1 542	1 474	405	234	104	18 924
2012-13	no.	6 928	4 819	4 040	1 636	1 524	428	253	114	19 742
Proportion of FWE GPs with vocational registration										
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
2006-07	%	92.7	90.5	85.6	90.8	91.8	91.0	95.2	76.9	90.4
2007-08	%	92.4	90.1	84.9	90.5	90.9	92.1	95.9	70.5	90.0
2008-09	%	92.2	90.4	84.6	89.8	91.1	92.0	95.0	74.2	89.9
2009-10	%	92.1	89.8	84.9	90.1	90.7	92.2	94.2	74.1	89.7
2010-11	%	91.8	89.4	86.6	91.1	90.3	90.9	94.8	71.8	89.9
2011-12	%	91.6	87.9	87.7	90.8	90.5	90.1	93.4	73.5	89.6
2012-13	%	91.3	86.9	88.4	90.7	90.7	92.2	93.0	72.1	89.4

(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 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.

(c) Data may differ from that published elsewhere due to use of different methods to allocate GP numbers and FWE.

Source : Department of Health unpublished, MBS Statistics.

Table 11A.49 **General practices that are accredited at 30 June (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2007										
Accredited										
AGPAL	no.	1 425	993	820	344	365	125	52	36	4 160
GPA Accreditation *plus*	no.	256	191	118	62	28	5	14	1	675
Total	no.	1 681	1 184	938	406	393	130	66	37	4 835
General practices	no.	2 829	1 707	1 278	591	564	172	94	126	7 361
Proportion accredited	%	59.4	69.4	73.4	68.7	69.7	75.6	70.2	29.4	65.7
Registered for accreditation (b)										
AGPAL	no.	1 533	1 029	883	372	384	130	54	43	4 428
GPA Accreditation *plus*	no.	274	210	135	82	35	6	15	3	760
2008										
Accredited										
AGPAL	no.	1 372	936	795	329	339	113	47	37	3 968
Quality Practice Accreditation	no.	267	212	148	73	36	10	23	3	772
Total	no.	1 639	1 148	943	402	375	123	70	40	4 740
General practices	no.	2 782	1 687	1 278	569	567	167	92	119	7 261
Proportion accredited	%	58.9	68.0	73.8	70.7	66.1	73.7	76.1	33.6	65.3
Registered for accreditation (b)										
AGPAL	no.	1 471	972	858	356	357	121	49	47	4 231
Quality Practice Accreditation	no.	278	228	163	77	37	10	23	3	819
2009										
Accredited										
AGPAL	no.	1 364	915	782	311	338	115	43	37	3 905
Quality Practice Accreditation	no.	315	262	182	86	42	15	22	5	930

Table 11A.49 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	no.	1 679	1 177	964	397	380	130	65	42	4 835
General practices	no.	2 726	1 641	1 247	570	556	160	91	119	7 110
Proportion accredited	%	61.6	71.7	77.3	69.6	68.3	81.3	71.4	35.3	68.0
Registered for accreditation (b)										
AGPAL	no.	1 450	959	833	331	359	118	46	46	4 142
Quality Practice Accreditation	no.	333	286	193	91	44	17	23	7	994
2010										
Accredited										
AGPAL	no.	1 346	883	753	330	330	98	40	38	3 818
Quality Practice Accreditation	no.	329	284	197	86	44	32	19	3	994
Total	no.	1 675	1 167	950	416	374	130	59	41	4 812
General practices	no.	2 731	1 691	1 266	569	525	158	91	120	7 151
Proportion accredited	%	61.3	69.0	75.0	73.1	71.2	82.3	64.8	34.2	67.3
Registered for accreditation (b)										
AGPAL	no.	1 431	942	818	358	346	103	44	58	4 100
Quality Practice Accreditation	no.	343	291	214	89	44	32	19	4	1 036
2011										
Accredited										
AGPAL	no.	1 318	871	735	327	323	86	38	41	3 739
Quality Practice Accreditation	no.	340	296	206	93	48	33	21	7	1 044
Total	no.	1 658	1 167	941	420	371	119	59	48	4 783
General practices	no.	2 712	1 687	1 241	573	537	158	84	105	7 097
Proportion accredited	%	61.1	69.2	75.8	73.3	69.1	75.3	70.2	45.7	67.4
Registered for accreditation (b)										
AGPAL	no.	1 399	926	784	350	339	92	40	57	3 987

Table 11A.49 **General practices that are accredited at 30 June (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Quality Practice Accreditation	no.	373	334	241	102	49	38	23	9	1 169
2012 (c)										
Accredited										
AGPAL	no.	1 308	865	719	323	323	85	39	52	3 714
Quality Practice Accreditation	no.	439	344	280	109	65	42	23	10	1 312
Total	no.	1 747	1 209	999	432	388	127	62	62	5 026
General practices	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 403	932	781	345	337	87	41	58	3 984
Quality Practice Accreditation	no.	476	362	311	120	71	46	25	11	1 422
2013 (c)										
Accredited										
AGPAL	no.	1 284	892	742	333	331	85	38	52	3 757
Quality Practice Accreditation	no.	625	462	382	160	91	59	34	15	1 828
Total	no.	1 909	1 354	1 124	493	422	144	72	67	5 585
General practices (c)	no.	na	na	na	na	na	na	na	na	na
Proportion accredited	%	na	na	na	na	na	na	na	na	na
Registered for accreditation (b)										
AGPAL	no.	1 352	941	784	347	332	86	46	55	3 943
Quality Practice Accreditation	no.	659	485	407	168	98	62	36	19	1 934

(a) Includes practices accredited by either of Australia's two accrediting bodies. Quality Practice Accreditation manages the General Practice Australia ACCREDITATION *plus* accreditation program.

(b) Includes practices registered for accreditation but not yet accredited, in addition to accredited practices.

Table 11A.49 **General practices that are accredited at 30 June (a)**

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

(c) Data for the total number of practices are not available for 2011-12 or 2012-13. Historical data were collected by the Primary Health Care Research and Information Service (PHC RIS) for the Annual Survey of Divisions (ASD), in response to the question "How many general practices were in your Division's catchment area at 30 June". Data were provided by all Divisions of General Practice as required under contractual agreements with Department of Health.

na Not available.

Source: AGPAL (Australian General Practice Accreditation Limited) unpublished; Quality Practice Accreditation Pty Ltd unpublished; PHCRIS, Department of Health unpublished, ASD (various years).

Table 11A.50 General practice activity in PIP practices (per cent)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of SWPEs that are in PIP practices (a)										
2002-03	%	74.0	82.0	80.3	83.7	81.0	86.3	50.3	76.0	78.8
2003-04	%	75.8	83.3	79.8	80.3	84.8	88.3	76.4	51.3	79.7
2004-05	%	76.6	83.9	79.9	80.7	84.3	86.9	80.7	56.5	80.2
2005-06	%	77.2	84.3	80.1	82.2	85.2	88.5	83.4	55.1	80.9
2006-07	%	77.4	84.4	81.3	82.2	85.4	86.0	84.6	53.6	81.2
2007-08	%	77.9	85.0	81.4	82.6	85.1	88.7	86.1	54.9	81.6
2008-09	%	78.5	85.3	82.6	83.7	84.4	88.7	83.4	56.9	82.1
2009-10	%	79.1	85.9	84.0	83.6	84.8	88.4	88.1	59.8	82.9
2010-11	%	79.1	85.8	84.3	83.6	86.0	88.1	88.2	60.5	83.0
2011-12	%	80.6	86.4	85.8	84.8	87.3	89.3	88.3	64.1	84.2
Proportion of services provided by PIP practices (b)										
2002-03	%	71.0	79.4	79.7	82.4	79.7	85.3	51.2	74.8	76.7
2003-04	%	73.3	81.2	79.3	79.5	83.9	87.4	75.3	51.7	78.0
2004-05	%	74.2	82.0	80.0	80.1	83.4	86.5	79.6	58.0	78.7
2005-06	%	75.2	82.7	80.2	81.7	84.8	88.4	82.7	56.6	79.6
2006-07	%	75.6	83.0	81.6	82.0	85.2	86.0	84.4	55.0	80.1
2007-08	%	76.3	83.9	81.8	82.9	85.3	88.8	85.4	56.2	80.8
2008-09	%	76.9	84.3	83.0	84.0	84.6	88.4	83.5	59.5	81.4
2009-10	%	77.9	85.0	84.7	84.0	85.3	88.5	88.1	61.7	82.4
2010-11	%	77.8	84.8	84.6	84.0	86.1	88.2	88.2	61.7	82.4
2011-12	%	79.1	85.4	86.0	84.5	87.3	89.3	88.3	65.6	83.4

(a) 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.

(b) Services may vary in type and quality.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 11A.51 **Filled prescriptions, ordered by GPs, for oral antibiotics that are used most commonly for treatment of upper respiratory tract infections, 2012-13 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All people										
Scripts	no.	2 340 481	1 768 423	1 434 337	472 595	532 288	169 921	67 108	20 855	6 806 008
Population (e)	no.	7 348 899	5 679 633	4 610 932	2 472 717	1 662 169	512 422	379 554	236 869	22 906 352
Rate	per 1000 people	318.5	311.4	311.1	191.1	320.2	331.6	176.8	88.0	297.1

(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 extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

(d) Number of concession card holders data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs.

(e) Estimated resident population at 31 December based on the ABS 2011 Census, first preliminary estimates.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.52 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2007-08 to 2011-12 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
Scripts	no.	2 300 175	1 763 205	1 320 390	444 338	507 069	160 526	58 981	19 142	6 573 826
Concession card holders	no.	1 723 776	1 363 619	996 938	443 090	449 110	153 092	50 798	45 412	5 234 695
Rate	per 1000 holders	1 334.4	1 293.0	1 324.4	1 002.8	1 129.1	1 048.6	1 161.1	421.5	1 255.8
Concession card holders										
2009-10										
Scripts	no.	2 187 899	1 697 904	1 257 889	426 460	512 394	156 175	58 960	18 865	6 316 546
Concession card holders	no.	1 772 335	1 396 751	1 041 249	456 175	457 481	156 888	52 263	46 588	5 389 025
Rate	per 1000 holders	1 234.5	1 215.6	1 208.1	934.9	1 120.0	995.5	1 128.1	404.9	1 172.1
Concession card holders										
2010-11										
Scripts	no.	2 280 551	1 853 022	1 353 985	432 750	521 568	163 389	65 432	19 361	6 690 058
Concession card holders	no.	1 793 360	1 410 180	1 067 874	460 274	465 767	159 817	53 085	45 779	5 466 022
Rate	per 1000 holders	1 271.7	1 314.0	1 267.9	940.2	1 119.8	1 022.4	1 232.6	422.9	1 223.9
Concession card holders										
2011-12										
Scripts	no.	2 349 145	1 761 703	1 400 017	471 336	515 907	171 723	63 802	20 031	6 753 664
Concession card holders	no.	1 810 065	1 434 628	1 082 274	463 942	471 039	163 012	54 111	46 017	5 535 884
Rate	per 1000 holders	1 297.8	1 228.0	1 293.6	1 015.9	1 095.3	1 053.4	1 179.1	435.3	1 220.0

Table 11A.52 **Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders, 2007-08 to 2011-12 (a), (b), (c), (d)**

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

(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 extracted for each year.

(b) These antibiotics are also used for treatment of diseases other than upper respiratory tract infection. The reason for the antibiotic prescription is not known.

(c) Data include prescriptions ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders.

(d) Number of concession card holders data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs.

Source: Department of Health unpublished, PBS Statistics.

Table 11A.53 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006 to 2011										
Systemic antibiotic prescribed	%	34.7	30.7	33.5	28.1	31.1	24.0	30.3	17.8	32.4
95 per cent confidence interval	± %	2.0	2.3	2.6	4.5	4.2	5.9	8.2	9.9	1.2
Encounters for acute URTI management (c)	no.	9 761	6 145	4 388	1 970	1 882	562	641	180	26 025
2007 to 2012										
Systemic antibiotic prescribed	%	35.0	30.1	33.7	28.7	30.1	25.3	33.0	22.8	32.5
95 per cent confidence interval	± %	1.9	2.3	2.6	4.3	4.1	5.9	9.9	10.0	1.2
Encounters for acute URTI management (c)	no.	10 384	6 215	4 473	1 979	1 852	542	527	149	26 619
2008 to 2013										
Systemic antibiotic prescribed	%	35.7	29.9	34.1	25.9	28.6	26.5	28.0	21.4	32.5
95 per cent confidence interval	± %	2.0	2.3	2.6	3.7	3.7	6.1	8.3	8.8	1.2
Encounters for acute URTI management (c)	no.	10 330	6 003	4 643	2 163	1 673	502	510	140	26 454

URTI = Upper respiratory tract infection.

(a) Data are from April of the first year to March of the final year of each 5 year period.

(b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.

(c) A GP encounter is a professional interchange between a patient and a GP.

Source : Britt et al unpublished, BEACH Statistics.

Table 11A.54 **Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia (a) (b)**

	Unit	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*	*2012-13*
Encounters for acute URTI management (c)	per 100 GP encounters	5.2	5.6	5.5	5.5	4.9	5.6	5.3
95 per cent confidence interval	± %	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Systemic antibiotic prescribed for URTI management	%	32.2	29.9	39.0	29.6	31.0	32.8	29.9
95 per cent confidence interval	± %	2.7	2.5	2.7	2.5	2.4	2.6	2.7

URTI = Upper respiratory tract infection.

(a) Data are for the period from April to the following March.

(b) Participation in the survey is voluntary. Data are not necessarily representative of non-participating GPs.

(c) A GP encounter is a professional interchange between a patient and a GP.

Source: Britt et al unpublished, BEACH Statistics.

Table 11A.55 **Proportion of people with self-reported diabetes who had a GP annual cycle of care (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
2011-12 (f)										
Cycles of care	'000	67.6	49.3	34.0	17.4	20.7	6.6	2.0	1.3	198.8
People with diabetes (d), (e)	'000	302.3	210.7	154.6	89.6	76.2	22.8	12.7	6.5	875.4
Relative standard error	%	7.2	8.2	10.7	9.6	8.4	11.3	13.0	16.5	4.1
95 per cent confidence interval	± '000	43.5	34.6	33.1	17.2	12.8	5.2	3.3	2.1	71.8
Received cycle of care	**%**	**22.4**	**23.4**	**22.0**	**19.4**	**27.1**	**29.0**	**15.7**	**19.4**	**22.7**
95 per cent confidence interval	± %	2.8	3.3	3.9	3.1	3.9	5.4	3.2	4.8	1.7
2012-13 (g)										
Cycles of care	'000	77.5	56.6	41.1	19.7	22.7	7.5	2.1	1.8	229.1
People with diabetes (d), (e)	'000	308.7	215.8	161.4	96.4	78.1	23.6	13.3	9.2	916.3
Relative standard error	%	7.2	8.2	10.7	9.6	8.4	11.3	13.0	16.5	4.1
95 per cent confidence interval	± '000	44.4	35.4	34.5	18.5	13.1	5.3	3.5	3.0	75.1
Received cycle of care	**%**	**25.1**	**26.2**	**25.5**	**20.5**	**29.1**	**31.9**	**15.4**	**19.2**	**25.0**
95 per cent confidence interval	± %	3.2	3.7	4.5	3.3	4.2	5.9	3.2	4.8	1.9

(a) Data do not account for GPs who provide the annual cycle of care but do not use the MBS 'annual cycle of care' item. A standard MBS consultation item rebate is more likely to be used by GPs not registered for the PIP Diabetes incentive.

(b) While clinical guidelines are for Type 2 diabetes, the MBS items do not specify Type 2 diabetes. Clinical guidelines represent the minimum level of care required. While the minimum frequency of glycosolated heamoglobin (HbA1c) testing according to clinical guidelines is at least 6 monthly for adults and 3 monthly for children and adolescents, the MBS annual cycle of care requires only annual testing, irrespective of age.

Table 11A.55 **Proportion of people with self-reported diabetes who had a GP annual cycle of care (per cent) (a), (b), (c), (d)**

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

(c) Data for the number of people with diabetes are derived from estimates based on self-report data collected in the 2011-12 National Health Survey (NHS) component of the Australian Health Survey (AHS). Data exclude respondents who reported they had diabetes but that it was not current at the time of interview. Data should not be compared with historical data (table 11A.54) or with data for the proportion of people with known diabetes who had a HbA1c test in the last 12 months (table 11A.55) which use different estimates for the number of people with diabetes.

(d) Includes diabetes mellitus Types 1 and 2 and Type unknown.

(e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(f) Data for 2011-12 exclude annual cycles of care provided under the DVA.

(g) Data for 2012-13 are preliminary. Data for 2012-13 include annual cycles of care provided under the DVA.

Source : Department of Health unpublished, MBS Statistics; ABS *Australian Health Survey: First Results, 2011-12* .

Table 11A.56 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09									
Major cities	16.3	21.0	18.4	19.1	20.8	..	14.9	..	18.5
Inner regional	27.0	24.4	21.8	19.1	27.8	22.3	np	..	24.4
Outer regional	22.0	20.0	21.1	19.3	30.2	25.6	..	11.9	22.0
Remote	17.9	28.8	13.4	6.6	28.6	15.9	..	10.4	14.8
Very remote	20.2	..	2.7	6.9	10.4	16.5	..	13.5	8.2
Total (h)	**18.9**	**21.7**	**19.3**	**18.4**	**23.0**	**23.3**	**14.8**	**11.9**	**19.9**
2009-10									
Major cities	15.6	19.1	17.3	18.2	19.7	..	14.7	..	17.4
Inner regional	25.6	22.7	20.7	17.1	26.7	21.9	np	..	23.0
Outer regional	21.4	17.7	20.2	20.8	27.7	23.8	..	12.3	21.0
Remote	17.2	26.1	11.9	6.4	28.8	14.9	..	11.4	14.4
Very remote	11.4	..	4.1	8.9	8.5	18.4	..	13.9	8.9
Total (h)	**18.1**	**19.9**	**18.3**	**17.7**	**21.9**	**22.4**	**14.7**	**12.5**	**18.9**
2010-11									
Major cities	15.9	18.1	17.0	16.3	20.2	..	14.0	..	17.0
Inner regional	25.7	21.8	20.2	16.1	30.5	24.8	np	..	23.0
Outer regional	20.0	16.0	19.2	22.0	26.4	25.3	..	11.0	20.1
Remote	13.2	17.9	14.5	11.0	27.0	15.6	..	9.6	14.9
Very remote	10.3	..	3.9	17.8	8.5	np	..	11.3	9.4
Total (h)	**18.3**	**18.8**	**17.9**	**16.7**	**22.4**	**24.8**	**14.0**	**10.9**	**18.6**

(a) Data do not account for GPs who provide the annual cycle of care but do not claim the MBS item.

(b) While clinical guidelines are for Type 2 diabetes, the MBS items do not specify Type 2 diabetes. Clinical guidelines represent the minimum level of care required. While the minimum frequency of glycosolated heamoglobin (HbA1c) testing according to clinical guidelines is at least 6 monthly for adults and 3 monthly for children and adolescents, the MBS annual cycle of care requires only annual testing, irrespective of age.

(c) Denominator data (estimated number of people with diabetes) are from the National Diabetes Services Scheme (NDSS). NDSS registration is voluntary; the NDSS is estimated to cover 80 per cent to 90 per cent of people with diagnosed diabetes. Interpretation of rates over time should not be undertaken as the denominator increases each year with the increased coverage of the NDSS.

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing* . Accuracy of the classifications decreases over intercensal periods due to changes in demographics within postcode boundaries over time. Not all remoteness areas are represented in each state or territory. There are: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Excludes records where postcode was invalid or did not map to a remoteness area (except for totals).

(f) Historical data may differ from previous reports as data include services provided under the DVA. Data reported here are not necessarily comparable with data in previous Reports.

(g) Data have been suppressed where the numerator is less than 10.

Table 11A.56 **Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

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

(h) Total includes persons whose place of residence was not stated or who could not be assigned to a remoteness category.

.. Not applicable. **np** Not published.

Source: Department of Health unpublished, MBS Statistics; DVA unpublished, DVA data collection; Department of Health unpublished, NDSS database.

Table 11A.57 **Proportion of people with known diabetes who had a HbA1c test in the last 12 months, 2011-12 (per cent) (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Proportion of people with known diabetes who had a HbA1c test in last 12 months										
Males	%	86.4	72.1	74.7	81.6	84.8	88.2	73.3	84.7	80.4
Females	%	66.9	91.1	58.9	82.6	100.0	85.0	83.2	94.8	73.0
Persons	%	78.4	79.9	69.2	82.1	88.2	86.8	79.1	91.1	77.5
Relative Standard Error (RSE)										
Males	%	12.1	31.7	11.6	15.9	13.2	15.1	42.5	26.7	5.9
Females	%	39.2	13.6	26.0	22.5	0.0	19.5	22.5	7.8	13.4
Persons	%	15.1	14.0	12.5	12.4	9.9	11.1	18.9	8.8	6.3
95% confidence interval										
Males	± %	20.6	44.8	17.0	25.4	22.0	26.1	61.1	44.2	9.2
Females	± %	51.4	24.2	30.0	36.3	0.0	32.6	36.7	14.5	19.1
Persons	± %	23.2	21.9	16.9	19.9	17.1	19.0	29.2	15.7	9.5

Estimates with RSEs between 25 percent and 50 percent should be used with caution.

(a) Persons aged 18 years to 69 years. Includes pregnant women.

(b) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use. See data quality information for further detail.

(c) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79% of people aged 18 years and over who participated in the National Health Measures Survey had fasted.

(d) Rates are non-age standardised.

(e) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source: ABS unpublished, *Australian Health Survey 2011–13* (National Health Measures component 2011-12).

Table 11A.58 **Proportion of people aged 18 to 69 years with known diabetes who have a HbA1c (glycated haemoglobin) level less than or equal to 7.0 per cent , by State and Territory, by sex, 2011-12 (per cent) (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (g)	*Aust*
						Proportion				
Males	%	66.2	41.2	48.5	65.3	41.6	67.4	73.9	23.2	53.8
Females	%	44.9	19.1	43.0	55.6	84.6	72.2	26.5	71.9	45.0
Total	%	56.7	35.5	46.4	61.3	52.1	69.9	44.3	47.7	50.5
						Relative standard error				
Males	%	14.1	*51.5*	22.1	19.5	39.5	19.3	27.9	*61.8*	11.1
Females	%	31.6	*88.0*	18.5	30.8	13.9	15.6	*63.2*	27.6	15.8
Total	%	13.4	46.5	15.3	16.7	28.5	11.4	31.0	31.4	8.8
						95 per cent confidence interval				
Males	±	18.3	41.7	21.0	24.9	32.2	25.5	40.3	28.1	11.8
Females	±	27.8	32.9	15.6	33.6	23.1	22.1	32.8	38.8	13.9
Total	±	14.9	32.4	13.9	20.1	29.1	15.7	26.9	29.3	8.7

(a) Estimates with a relative standard error (RSE) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) People aged 18 years to 69 years. Includes pregnant women.

(c) Known diabetes is derived using a combination of fasting plasma glucose test results and self-reported information on diabetes diagnosis and medication use.

(d) Excludes people who did not fast for 8 hours or more prior to the blood test. For Australia in 2011-12, approximately 79 per cent of people aged 18 years or over who participated in the National Health Measures Survey had fasted.

(e) Rates are non-age standardised.

(f) Denominator includes a small number of persons for whom test results were not reported.

(g) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

Source : ABS (unpublished) *Australian Health Survey 2011-13* , (2011-12 National Health Measures Survey component).

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c), (d), (e)	Aust
2001										
0–14 years										
Proportion	%	24.2	31.8	16.2	20.0	30.5	19.5	44.4	np	24.7
RSE	%	14.6	12.6	22.5	28.1	18.8	29.0	20.1	np	7.7
95 per cent confidence interval	%	± 6.9	± 7.9	± 7.1	± 11.0	± 11.2	± 11.1	± 17.5	np	± 3.7
15–64 years										
Value	%	19.6	12.7	13.2	np	16.1	np	19.1	np	15.0
RSE	%	12.6	13.7	14.9	np	18.0	np	15.8	np	6.5
95 per cent confidence interval	%	± 4.8	± 3.4	± 3.9	np	± 5.7	np	± 5.9	np	± 1.9
65 years or over										
Proportion	%	14.6	7.7	11.8	np	19.0	np	23.8	np	12.1
RSE	%	32.3	44.6	48.9	np	49.7	np	46.3	np	22.1
95 per cent confidence interval	%	± 9.2	± 6.7	± 11.3	np	± 18.5	np	± 21.6	np	± 5.2
All ages (crude rates)										
Proportion	%	20.3	16.4	13.8	11.4	19.7	11.1	25.4	np	17.0
RSE	%	10.5	10.9	11.3	18.1	12.3	27.0	12.3	np	5.3
95 per cent confidence interval	%	± 4.2	± 3.5	± 3.1	± 4.0	± 4.7	± 5.9	± 6.1	np	± 1.8
2004-05										
0–14 years										
Proportion	%	33.6	52.5	29.9	np	39.2	21.9	np	np	36.7
RSE	%	20.7	16.7	17.3	np	19.8	24.9	np	np	9.6
95 per cent confidence interval	%	± 13.6	± 17.2	± 10.1	np	± 15.2	± 10.7	np	np	± 6.9
15–64 years										
Proportion	%	22.6	21.6	18.2	14.5	17.1	15.6	24.6	np	19.7
RSE	%	14.2	16.0	15.8	19.8	14.3	16.6	18.7	np	6.9
95 per cent confidence interval	%	± 6.3	± 6.8	± 5.6	± 5.6	± 4.8	± 5.1	± 9.0	np	± 2.7
65 years or over										
Proportion	%	17.1	7.6	18.5	np	20.6	19.7	np	np	14.2
RSE	%	29.1	54.1	39.0	np	22.3	32.1	np	np	17.5

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c), (d), (e)	*Aust*
95 per cent confidence interval	%	± 9.8	± 8.1	± 14.1	np	± 9.0	± 12.4	np	np	± 4.9
All ages (crude rates)										
Proportion	%	24.3	27.0	21.0	15.0	22.6	17.3	27.0	np	22.9
RSE	%	12.8	11.2	10.8	18.4	9.6	12.5	17.9	np	6.0
95 per cent confidence interval	%	± 6.1	± 5.9	± 4.4	± 5.4	± 4.3	± 4.2	± 9.5	np	± 2.7
2007-08										
0–14 years										
Proportion	%	46.5	61.6	41.4	29.0	56.1	41.6	47.3	np	47.8
RSE	%	16.3	9.8	17.1	28.1	17.1	20.6	17.1	np	7.6
95 per cent confidence interval	%	± 14.9	± 11.8	± 13.9	± 16.0	± 18.8	± 16.8	± 15.9	np	± 7.1
15–24 years										
Proportion	%	11.9	9.3	14.7	np	7.4	9.6	35.0	np	12.6
RSE	%	47.1	47.0	37.8	np	53.2	69.2	29.0	np	19.5
95 per cent confidence interval	%	± 11.0	± 8.6	± 10.9	np	± 7.7	13.0	± 19.9	np	± 4.8
25–44 years										
Proportion	%	13.8	6.1	14.1	17.0	8.1	11.8	11.3	np	11.5
RSE	%	27.3	35.6	32.6	36.7	35.9	36.8	26.4	np	15.7
95 per cent confidence interval	%	± 7.4	± 4.3	± 9.0	± 12.2	± 5.7	± 8.5	± 5.8	np	± 3.5
45–64 years										
Proportion	%	14.1	21.9	16.2	11.3	np	9.3	12.5	np	16.5
RSE	%	27.7	26.7	28.4	42.3	np	49.7	43.1	np	14.2
95 per cent confidence interval	%	± 7.7	± 11.5	± 9.0	± 9.4	np	± 9.1	± 10.6	np	± 4.6
65 years or over										
Proportion	%	20.0	18.8	13.9	np	np	12.1	15.1	np	17.9
RSE	%	26.0	33.9	35.3	np	np	47.9	53.2	np	15.9
95 per cent confidence interval	%	± 10.2	± 12.5	± 9.6	np	np	± 11.4	± 15.7	np	± 5.6
All ages (ASR) (f)										
Proportion	%	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c), (d), (e)	*Aust*
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3
2011-12										
0–14 years										
Proportion	%	35.1	46.9	32.6	48.4	58.3	36.6	37.4	65.5	40.9
RSE	%	20.0	14.0	20.8	21.6	13.2	26.1	18.9	18.9	7.8
95 per cent confidence interval	%	± 13.7	± 12.9	± 13.3	± 20.5	± 15.1	± 18.7	± 13.9	± 24.2	± 6.2
15–24 years										
Proportion	%	15.5	20.4	np	31.0	27.2	np	np	np	18.6
RSE	%	47.3	35.9	np	32.4	38.7	np	np	np	18.8
95 per cent confidence interval	%	± 14.3	± 14.3	np	± 19.7	± 20.6	np	np	np	± 6.9
25–44 years										
Proportion	%	24.4	11.8	11.8	15.7	19.0	23.1	17.5	26.1	16.8
RSE	%	22.7	25.6	30.9	34.4	29.0	25.2	31.9	29.9	12.6
95 per cent confidence interval	%	± 10.8	± 5.9	± 7.2	± 10.6	± 10.8	± 11.4	± 10.9	± 15.3	± 4.1
45–64 years										
Proportion	%	22.6	27.9	21.9	15.7	20.5	15.7	19.0	16.5	22.6
RSE	%	23.9	20.8	23.1	33.4	26.7	32.9	30.9	40.6	10.8
95 per cent confidence interval	%	± 10.6	± 11.4	± 9.9	± 10.3	± 10.7	± 10.1	± 11.5	± 13.1	± 4.8
65 years or over										
Proportion	%	37.0	23.2	16.0	16.7	21.9	20.1	33.1	42.2	26.4
RSE	%	20.3	22.5	30.3	38.3	32.9	34.9	39.6	43.0	12.5
95 per cent confidence interval	%	± 14.7	± 10.2	± 9.5	± 12.6	± 14.1	± 13.7	± 25.6	± 35.6	± 6.5
All ages (ASR) (f)										
Proportion	%	26.6	25.3	18.4	24.5	29.3	22.6	24.3	33.7	24.6
RSE	%	9.7	9.9	13.8	15.2	9.5	14.2	14.6	17.0	4.5
95 per cent confidence interval	%	± 5.1	± 4.9	± 5	± 7.3	± 5.5	± 6.3	± 7	± 11.3	± 2.2

ASR = age standardised rate. **RSE** = relative standard error.

Table 11A.59 **Proportion of people with asthma with a written asthma action plan, by age (per cent) (a) (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c), (d), (e)	Aust

(a) Separate estimates for the NT are not available for the 2001 or 2004-05 surveys, and are available only for 'all ages' for the 2007-08 survey. However, NT data are included in national estimates.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published. However, these data contribute to national estimates.

(c) Data for the NT should be used with care as exclusion of very remote areas from the Australian Health Survey translates to exclusion of around 23 per cent of the NT population.

(d) Data for the NT are not published for 2001 or 2004-05 as sample sizes were insufficient to provide reliable estimates, but are included in the Australian total. For the same reason, 2007-08 data for the NT are published only for all ages, although data by age are included in the Australian total.

(e) Data for 2011-12 for the NT are not comparable to data for previous years due to the increased sample size.

(f) For 'all ages', 2007-08 and 2011-12 data are age standardised to the Australian population at 30 June 2001. These data differ from previous reports which reported crude rates.

np Not published.

Source : ABS 2009, *National Health Survey: Summary of Results, 2007-2008* , Cat. No. 4364.0, Canberra; ABS 2009, *National Health Survey: Summary of Results* ; *State Tables* , *2007-08* , Cat. No. 4362.0, Canberra; ABS unpublished, *National Health Survey 2001, 2004-05, 2007-08* , ABS unpublished, *Australian Health Survey 2011–13* (NHS component 2011-12).

Table 11A.60 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (e)	*Aust*
Major cities										
Proportion	%	20.9	22.7	21.4	14.6	19.4	..	21.8	..	20.7
RSE	%	13.7	12.9	16.4	21.5	14.1	..	12.1	..	5.8
95 per cent confidence interval	%	± 5.6	± 5.8	± 6.9	± 6.2	± 5.3	..	± 5.2	..	± 2.3
Inner regional										
Proportion	%	14.9	np	21.6	27.8	np	19.2	..	..	21.5
RSE	%	26.6	np	22.2	31.0	np	23.1	..	..	10.7
95 per cent confidence interval	%	± 7.8	np	± 9.4	± 16.9	np	± 8.7	..	..	± 4.5
Outer regional										
Proportion	%	33.1	np	np	np	28.3	np	..	50.0	20.9
RSE	%	45.4	np	np	np	41.2	np	..	43.4	19.2
95 per cent confidence interval	%	± 29.4	np	np	np	± 22.9	np	..	± 42.5	± 7.9
Remote										
Proportion	%	–	–	np	np	np	np	..	–	13.4
RSE	%	–	–	np	np	np	np	..	–	51.1
95 per cent confidence interval	%	–	–	np	np	np	np	..	–	± 13.4
Very remote (f)										
Proportion	%	na	na	na	na	na	na	na	na	na
RSE	%	na	na	na	na	na	na	na	na	na
95 per cent confidence interval	%	na	na	na	na	na	na	na	na	na
Total										
Proportion	**%**	**20.4**	**22.9**	**19.7**	**17.4**	**21.9**	**17.1**	**21.8**	**40.9**	**20.8**
RSE	%	11.2	10.9	11.4	17.6	13.4	18.8	12.1	47.0	5.6
95 per cent confidence interval	%	± 4.5	± 4.9	± 4.4	± 6.0	± 5.7	± 6.3	± 5.2	± 37.7	± 2.3

RSE = relative standard error.

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

(c) Rates are age standardised to the Australian estimated resident population at 30 June 2001.

Table 11A.60 **Proportion of people with asthma with a written asthma plan, by region, 2007-08 (a), (b), (c), (d)**

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

(d) Regions are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 Census of population and housing. The accuracy of the classifications decreases over time due to changes in demographics within postcode boundaries in the intercensal periods. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Data for the NT should be used with care as exclusion of very remote areas translates to exclusion of around 23 per cent of the NT population.

(f) Very remote data were not collected in the 2007-08 National Health Survey.

na Not available. .. Not applicable. – Nil or rounded to zero. **np** Not published.

Source : ABS unpublished, *National Health Survey, 2007-08* .

Table 11A.61 **Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous people										
Proportion	%	30.2	22.5	17.2	11.9	20.4	29.8	20.5	7.9	20.4
RSE	%	15.6	43.3	28.9	21.0	24.1	30.5	39.7	19.9	9.7
95 per cent confidence interval	%	± 9.2	± 19.1	± 9.8	± 4.9	± 9.6	± 17.8	± 16.0	± 3.1	± 3.9
Non-Indigenous people										
Proportion	%	23.6	26.3	20.5	15.8	21.9	17.5	28.3	–	22.5
RSE	%	11.8	9.2	10.7	15.8	10.2	12.6	15.6	–	5.4
95 per cent confidence interval	%	± 5.5	± 4.8	± 4.3	± 4.9	± 4.4	± 4.3	± 8.6	–	± 2.4

RSE = relative standard error.

(a) Persons who have been told by a doctor they have asthma, and the asthma is current and long-term.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution.

(c) Rates are age standardised to the Australian estimated resident population at 30 June 2001.

– Nil or rounded to zero.

Source : ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey* , 2004-05; ABS unpublished, *National Health Survey* , 2004-05.

Table 11A.62 **GP use of chronic disease management Medicare items for care planning or case conferencing (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
GPs using CDM items	no.	6 276	4 758	3 671	1 706	1 534	462	259	111	18 777
Total GPs	no.	6 488	4 931	3 937	1 807	1 638	492	292	122	19 707
GPs using CDM items	%	96.7	96.5	93.2	94.4	93.7	93.9	88.7	91.0	95.3
2009-10										
GPs using CDM items	no.	6 439	4 925	3 820	1 764	1 605	487	263	120	19 423
Total GPs	no.	6 617	5 061	4 064	1 858	1 683	511	286	135	20 215
GPs using CDM items	%	97.3	97.3	94.0	94.9	95.4	95.3	92.0	88.9	96.1
2010-11										
GPs using CDM items	no.	6 643	5 151	3 962	1 808	1 631	514	280	125	20 114
Total GPs	no.	6 806	5 277	4 168	1 875	1 712	526	299	132	20 795
GPs using CDM items	%	97.6	97.6	95.1	96.4	95.3	97.7	93.6	94.7	96.7
2011-12										
GPs using CDM items	no.	6 939	5 420	4 170	1 900	1 691	514	301	135	21 070
Total GPs	no.	7 084	5 538	4 378	1 963	1 761	531	319	143	21 717
GPs using CDM items	%	98.0	97.9	95.2	96.8	96.0	96.8	94.4	94.4	97.0
2012-13										
GPs using CDM items	no.	7 208	5 682	4 413	1 977	1 718	525	323	139	21 985
Total GPs	no.	7 354	5 818	4 601	2 055	1 794	543	349	148	22 662
GPs using CDM items	%	98.0	97.7	95.9	96.2	95.8	96.7	92.6	93.9	97.0

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

(b) Additional chronic disease management MBS items are introduced from time-to-time and may impact on GP use of care planning or case conferencing MBS items.

(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 : Department of Health unpublished, MBS Statistics.

Table 11A.63 Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2012-13 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
Benefits paid per person (ASR)										
2012-13	$	63.8	59.4	67.0	55.1	59.3	55.7	58.7	66.0	61.8
MBS pathology items per person (ASR)										
2012-13	no.	3.47	3.33	3.68	3.10	3.48	3.20	3.13	3.62	3.43

ASR = age standardised rate.

(a) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 11A.64).

(b) DVA data are included.

(c) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.

(d) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.

(e) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.

(f) Data exclude tests ordered by eligible midwives and nurse practitioners.

Source : Department of Health unpublished, MBS and DVA data collections.

Table 11A.64 **Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
Benefits paid										
Benefits paid	$m	517.3	365.3	344.7	142.1	108.8	32.1	24.8	13.0	1 548.2
Per person	$	73.0	67.4	78.3	63.6	67.1	63.9	70.7	58.2	70.9
MBS pathology items rebated										
Number	'000	24 632	17 515	15 582	6 847	5 793	1 602	1 121	626	73 719
Per person	no.	3.48	3.23	3.54	3.06	3.57	3.19	3.19	2.79	3.38
2009-10										
Benefits paid										
Benefits paid	$m	498.3	356.0	314.1	135.9	109.5	31.5	22.8	13.0	1 481.1
Per person	$	68.7	64.0	69.2	58.9	66.6	61.9	63.6	56.4	66.1
MBS pathology items rebated										
Number	'000	25 774	18 690	15 935	7 164	6 055	1 693	1 128	671	77 110
Per person	no.	3.56	3.36	3.51	3.10	3.68	3.33	3.15	2.91	3.44
2010-11										
Benefits paid										
Benefits paid	$m	463.1	327.3	290.0	128.2	101.3	29.2	20.9	12.3	1372.2
Per person	$	64.5	59.5	65.4	55.3	62.0	57.3	57.2	53.4	61.9
MBS pathology items rebated										
Number	'000	25 364	18 372	15 940	7 201	6 026	1 669	1 098	676	76 347
Per person	no.	3.53	3.34	3.59	3.11	3.69	3.27	3.01	2.94	3.44
2011-12										
Benefits paid										
Benefits paid	$m	484.3	339.8	307.7	133.1	103.6	30.1	22.1	13.7	1434.5

Table 11A.64 **Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS pathology items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Per person	$	66.8	61.0	68.2	55.8	63.0	58.8	59.7	59.0	63.8
MBS pathology items rebated										
Number	'000	26 520	19 235	16 900	7 487	6 217	1 733	1 172	748	80 012
Per person	no.	3.66	3.45	3.74	3.14	3.78	3.39	3.16	3.22	3.56
2012-13										
Benefits paid (e)										
Benefits paid	$m	495.9	355.7	317.1	138.3	107.8	31.4	22.2	14.4	1482.9
MBS pathology items rebated										
Number	'000	27 177	20 092	17 469	7 788	6 431	1 829	1 176	774	82 737

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Per person data for 2011-12 and previous years are crude rates and are not comparable to 2012-13 data which are age standardised (see table 11A.61).

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

(d) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.

(e) In general, Medicare benefits are payable for a maximum of three MBS pathology items per specimen (generally, the three most expensive items). Data do not include additional tests that are performed but not rebated.

(f) Includes Patient Episode Initiated (PEI) Items. From 1 November 2009 benefits for PEI Items were reduced and bulk billing incentives for PEI Items commenced. This contributed to a change in the mix and amount of benefits for tests ordered by GPs and OMPs.

(g) Estimated Resident Populations (ERPs) used to derive rates for 2010-11 are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details. For data up to 2009-10 the rates are derived using the ERPs based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

(h) Data exclude tests ordered by eligible midwives and nurse practitioners.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

Table 11A.65 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2012-13 dollars) and number of rebated MBS imaging items (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (c)
Benefits paid per person (ASR)										
2012-13	$	67.2	53.9	62.9	48.0	49.2	49.2	48.5	35.8	58.6
MBS diagnostic imaging items per person (ASR)										
2012-13	no.	0.59	0.51	0.57	0.44	0.48	0.47	0.43	0.33	0.54

ASR = age standardised rate.

(a) Data are directly age standardised to the 2001 Australian standard population. Data are not comparable to previous years for which crude rates are reported (see table 11A.66).

(b) DVA data are included.

(c) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.

(d) Data exclude tests ordered by eligible midwives and nurse practitioners.

Source : Department of Health unpublished, MBS and DVA data collections.

Table 11A.66 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2008-09										
Benefits paid										
Benefits paid	$m	466.2	290.8	253.6	107.6	84.3	25.8	17.2	5.1	1250.7
Per person	$	65.8	53.7	57.6	48.1	52.0	51.4	49.0	22.8	57.3
MBS diagnostic imaging items rebated										
Number	'000	3 985	2 605	2 246	961	774	233	144	49	10 997
Per person	no.	0.56	0.48	0.51	0.43	0.48	0.46	0.41	0.22	0.50
2009-10										
Benefits paid										
Benefits paid	$m	489.3	304.5	269.7	112.4	88.4	27.2	17.1	5.7	1314.3
Per person	$	67.5	54.8	59.4	48.7	53.8	53.5	47.7	24.9	58.7
MBS diagnostic imaging items rebated										
Number	'000	4 087	2 691	2 324	982	798	240	143	53	11 320
Per person	no.	0.56	0.48	0.51	0.43	0.49	0.47	0.40	0.23	0.51
2010-11										
Benefits paid										
Benefits paid	$m	474.1	286.9	265.3	108.7	84.4	25.4	15.6	5.4	1265.9
Per person	$	66.0	52.2	59.8	46.9	51.7	49.8	42.7	23.5	57.1
MBS diagnostic imaging items rebated										
Number	'000	4 096	2 660	2 384	981	796	235	140	53	11 344
Per person	no.	0.57	0.48	0.54	0.42	0.49	0.46	0.38	0.23	0.51
2011-12										
Benefits paid										

Table 11A.66 **Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid, 2008-09 to 2011-12 (2012-13 dollars) and number of rebated MBS imaging items (a), (b), (c), (d), (e), (f)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Benefits paid	$m	505.4	307.0	287.8	115.5	87.2	26.4	16.8	5.9	1352.1
Per person	$	69.7	55.1	63.8	48.4	53.0	51.6	45.4	25.6	60.1
MBS diagnostic imaging items rebated										
Number	'000	4 377	2 867	2 583	1 044	824	245	149	58	12 145
Per person	no.	0.60	0.51	0.57	0.44	0.50	0.48	0.40	0.25	0.54
2012-13										
Benefits paid										
Benefits paid	$m	528.5	323.5	297.7	119.8	90.2	28.2	17.8	7.1	1412.8
MBS diagnostic imaging items rebated										
Number	'000	4 613	3 037	2 692	1 095	860	263	160	69	12 789

(a) Data are adjusted to 2012-13 dollars using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) (table 2A.51). The GGFCE replaces the Gross Domestic Product implicit price deflator used in previous reports. See Chapter 2 for details.

(b) Per person data for 2011-12 and previous years are crude rates and are not comparable to 2012-13 data which are age standardised (see table 11A.65).

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

(d) From 2011-12, DVA data exclude tests ordered by local medical officers who are not specialist GPs. DVA data for previous years include all data for tests ordered by all local medical officers, including but not limited to specialist GPs.

(e) Data exclude imaging referred by eligible midwives and nurse practitioners.

(f) Estimated Resident Populations (ERPs) used to derive rates for 2010-11 are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details. For data up to 2009-10 the rates are derived using the ERPs based on the 2006 Census. Rates derived using ERPs based on different Censuses are not comparable.

Source: Department of Health unpublished, MBS and DVA data collections; table 2A.51.

Table 11A.67 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PIP practices (May 2010)	no.	1 700	1 209	981	409	354	123	67	38	4 881
SWPE (c)	no.	4 765 033	4 063 295	3 060 662	1 500 216	1 225 101	389 553	269 970	79 148	15 352 978
PIP eHealth Incentive — uptake	no.	1 280	971	793	333	274	102	57	20	3 830
Share of PIP practices	%	75.3	80.3	80.8	81.4	77.4	82.9	85.1	52.6	78.5
PIP practices (May 2011)	no.	1 664	1 178	957	409	338	123	66	46	4 781
SWPE (c)	no.	4 792 245	4 100 376	3 129 970	1 508 314	1 239 216	396 459	277 984	86 021	15 530 585
PIP eHealth Incentive — uptake	no.	1 412	1 050	856	364	299	109	62	37	4 189
Share of PIP practices	%	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6
PIP practices (May 2012)	no.	1 710	1 211	1 005	424	353	126	66	54	4 949
SWPE (c)	no.	4 948 168	4 213 416	3 260 160	1 562 809	1 276 083	402 315	279 439	90 413	16 032 803
PIP eHealth Incentive — uptake	no.	1 481	1 087	897	378	310	113	60	42	4 368
Share of PIP practices	%	86.6	89.8	89.3	89.2	87.8	89.7	90.9	77.8	88.3
PIP practices (May 2013) (b)	no.	1 798	1 229	1 046	433	363	127	65	56	5 117
SWPE (c)	no.	5 129 251	4 207 334	3 319 305	1 619 421	1 300 886	399 791	270 671	90 909	16 337 568
PIP eHealth Incentive — uptake	no.	1 247	937	776	296	264	96	52	27	3 695
Share of PIP practices	%	69.4	76.2	74.2	68.4	72.7	75.6	80.0	48.2	72.2

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

Table 11A.67 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes (a), (b)**

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

(b) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013.
Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

(c) 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 : Department of Health unpublished, MBS and PIP data collections.

Table 11A.68 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2013 (a), (b), (c)**

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Remote*	*Very remote*	*Australia*
PIP practices (May 2013)	no.	3 425	981	536	104	71	5 117
SWPE (d)	no.	11 535 057	3 200 427	1 399 214	157 697	45 173	16 337 568
PIP eHealth Incentive — uptake (c), (e)							
Share of PIP practices (May 2013)	%	72.3	77.5	68.8	55.8	43.7	72.2

(a) Remoteness areas are based on the Australian Statistical Geography Standard 2011 (ASGS) classification and are not comparable with data for previous years, which were based on a different classification.

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

(c) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 compared to historical data under previous requirements (see table 11A.69).
Previously, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

(d) 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.

(e) Uptake refers to the number of practices that received a PIP eHealth Incentive payment for the May quarter, this may be different from the total number of eligible practices and does not include practices that did not receive a payment due to having a zero SWPE for the May quarter.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 11A.69 **Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region, 2010 to 2012 (a), (b)**

	Unit	*Capital city*	*Other metro centre*	*Large rural centre*	*Small rural centre*	*Other rural*	*Remote centre*	*Other remote*	*Aust*
PIP practices (May 2012)	no.	3 002	378	318	364	701	63	123	4 949
SWPE (c)	no.	10 057 467	1 358 563	1 145 718	1 315 196	1 890 771	147 831	117 257	16 032 803
PIP eHealth Incentive — uptake (d), (e)									
Share of PIP practices (May 2010)	%	77.8	79.7	83.1	80.2	81.0	66.1	63.9	78.5
Share of PIP practices (May 2011)	%	87.7	88.5	90.6	85.7	89.5	72.9	76.7	87.6
Share of PIP practices (May 2012)	%	88.4	90.0	89.6	87.6	90.3	74.6	74.0	88.3

(a) Remoteness areas are based on the 1994 Rural, Remote and Metropolitan Areas classification. 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 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.

(d) In accordance with the purpose of the PIP eHealth incentive to encourage general practices to keep up-to-date with the latest developments in eHealth, new eligibility requirements were introduced from 1 February 2013, requiring practices to: integrate healthcare identifiers into electronic practice records; have a secure messaging capability; use data records and clinical coding of diagnoses; send prescriptions electronically to a prescription exchange service; and, participate in the eHealth record system and be capable of creating and uploading Shared Health Summaries and Event Summaries using compliant software. A number of practices took time to meet these requirements and this is reflected in a drop in the share of PIP practices registered as having taken up the eHealth incentive in May 2013 (see tables 11A.67 and 11A.68).
Under the previous requirements, practices were required to: have a secure messaging capability provided by an eligible supplier; have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate; and, provide practitioners from the practice with access to a range of key electronic clinical resources.

(e) Uptake refers to the number of practices that received a PIP eHealth Incentive payment for the May quarter, this may be different from the total number of eligible practices and does not include practices that did not receive a payment due to having a zero SWPE for the May quarter.

Source: Department of Health unpublished, MBS and PIP data collections.

Table 11A.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c) (d)	*Aust* (e)
2010-11 (c), (e)										
GP always or often listened carefully										
Major cities										
Proportion	%	90.5	90.1	88.6	89.5	88.8	na	na	na	89.8
RSE	%	0.9	0.8	1.0	0.9	1.1	na	na	na	0.3
95% CI	± %	1.5	1.4	1.7	1.5	1.8	na	na	na	0.6
Other (c), (d)										
Proportion	%	88.1	87.3	87.2	88.9	84.7	na	na	na	na
RSE	%	1.1	1.2	1.0	1.5	2.1	na	na	na	na
95% CI	± %	2.0	2.1	1.7	2.6	3.5	na	na	na	na
Total										
Proportion	**%**	**89.8**	**89.4**	**88.0**	**89.3**	**88.0**	**88.6**	**87.6**	**83.3**	**89.1**
RSE	**%**	**0.7**	**0.7**	**0.8**	**0.7**	**0.9**	**1.2**	**1.8**	**2.3**	**0.3**
95% CI	**± %**	**1.2**	**1.2**	**1.4**	**1.3**	**1.5**	**2.1**	**3.1**	**3.7**	**0.5**
GP always or often showed respect										
Major cities										
Proportion	%	93.9	92.5	91.4	92.2	92.1	na	na	na	92.7
RSE	%	0.5	0.6	0.8	0.8	0.7	na	na	na	0.3
95% CI	± %	1.0	1.1	1.4	1.5	1.2	na	na	na	0.6
Other (c), (d)										
Proportion	%	92.2	90.6	90.2	92.2	88.8	na	na	na	na
RSE	%	0.8	1.2	1.2	1.3	1.8	na	na	na	na
95% CI	± %	1.5	2.1	2.1	2.4	3.1	na	na	na	na
Total										
Proportion	**%**	**93.4**	**92.1**	**91.0**	**92.2**	**91.4**	**91.2**	**91.6**	**86.1**	**92.2**
RSE	**%**	**0.5**	**0.5**	**0.6**	**0.7**	**0.5**	**1.0**	**1.4**	**2.1**	**0.3**
95% CI	**± %**	**0.8**	**1.0**	**1.2**	**1.2**	**0.9**	**1.8**	**2.5**	**3.5**	**0.6**
GP always or often spent enough time										
Major cities										
Proportion	%	88.6	86.9	87.8	86.7	85.7	na	na	na	87.5
RSE	%	0.8	1.0	0.9	0.9	1.2	na	na	na	0.4
95% CI	± %	1.3	1.6	1.5	1.5	2.0	na	na	na	0.7
Other (c), (d)										
Proportion	%	86.8	87.8	85.2	88.7	84.4	na	na	na	na
RSE	%	1.2	1.3	1.4	1.4	2.4	na	na	na	na
95% CI	± %	2.1	2.3	2.3	2.4	4.0	na	na	na	na

Table 11A.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT (c) (d)	Aust (e)
Total										
Proportion	**%**	**88.0**	**87.2**	**86.8**	**87.2**	**85.4**	**85.7**	**85.1**	**82.9**	**87.2**
RSE	**%**	**0.7**	**0.7**	**0.8**	**0.8**	**1.0**	**1.3**	**1.9**	**2.5**	**0.3**
95% CI	**± %**	**1.2**	**1.2**	**1.4**	**1.3**	**1.7**	**2.2**	**3.2**	**4.1**	**0.5**
2011-12 (d)										
GP always or often listened carefully										
Major cities										
Proportion	%	89.1	88.1	88.6	87.5	89.1	..	90.0	..	88.6
RSE	%	0.8	0.7	0.8	1.0	0.8	..	1.7	..	0.4
95% CI	± %	1.4	1.2	1.3	1.8	1.3	..	3.0	..	0.7
Other (d)										
Proportion	%	88.9	86.4	85.7	85.7	88.3	88.3	–	86.5	87.1
RSE	%	1.0	1.5	1.1	2.2	1.8	0.9	–	1.7	0.6
95% CI	± %	1.7	2.6	1.9	3.6	3.1	1.5	–	2.9	1.0
Total										
Proportion	**%**	**89.1**	**87.6**	**87.5**	**87.0**	**88.9**	**88.3**	**90.0**	**86.5**	**88.1**
RSE	**%**	**0.6**	**0.5**	**0.6**	**1.0**	**0.8**	**0.9**	**1.7**	**1.7**	**0.3**
95% CI	**± %**	**1.1**	**0.9**	**1.0**	**1.7**	**1.5**	**1.5**	**3.0**	**2.9**	**0.5**
GP always or often showed respect										
Major cities										
Proportion	%	92.5	91.0	91.8	90.5	92.4	..	92.7	..	91.7
RSE	%	0.5	0.7	0.7	1.0	0.6	..	1.6	..	0.3
95% CI	± %	0.9	1.2	1.2	1.8	1.0	..	3.0	..	0.6
Other (d)										
Proportion	%	91.8	91.7	90.7	89.3	91.4	91.0	–	89.6	91.1
RSE	%	1.0	1.2	0.9	1.7	1.2	0.8	–	1.3	0.5
95% CI	± %	1.8	2.1	1.6	3.0	2.1	1.4	–	2.4	0.9
Total										
Proportion	**%**	**92.3**	**91.1**	**91.3**	**90.2**	**92.2**	**91.0**	**92.7**	**89.6**	**91.5**
RSE	**%**	**0.4**	**0.6**	**0.5**	**0.9**	**0.5**	**0.8**	**1.6**	**1.3**	**0.3**
95% CI	**± %**	**0.8**	**1.1**	**0.8**	**1.6**	**1.0**	**1.4**	**3.0**	**2.4**	**0.5**
GP always or often spent enough time										
Major cities										
Proportion	%	88.6	85.2	86.2	86.2	87.0	..	87.6	..	86.8
RSE	%	0.6	0.7	1.0	1.0	0.7	..	1.7	..	0.4
95% CI	± %	1.0	1.1	1.6	1.6	1.2	..	2.8	..	0.6

Table 11A.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c) (d)	*Aust* (e)
Other (d)										
Proportion	%	86.9	84.7	84.9	84.4	86.1	86.0	–	85.4	85.6
RSE	%	1.5	1.6	1.1	2.4	1.9	1.4	–	1.7	0.6
95% CI	± %	2.5	2.6	1.9	4.0	3.3	2.4	–	2.8	1.1
Total										
Proportion	**%**	**88.1**	**85.1**	**85.6**	**85.8**	**86.8**	**86.0**	**87.6**	**85.4**	**86.4**
RSE	**%**	**0.6**	**0.6**	**0.8**	**0.9**	**0.6**	**1.4**	**1.7**	**1.7**	**0.3**
95% CI	**± %**	**1.0**	**1.0**	**1.3**	**1.6**	**1.1**	**2.4**	**2.8**	**2.8**	**0.5**
2012-13 (d)										
GP always or often listened carefully										
Major cities										
Proportion	%	90.7	89.3	89.6	89.0	89.0	..	89.5	..	89.8
RSE	%	0.5	0.7	0.7	0.8	0.9	..	1.4	..	0.3
95% CI	± %	1.0	1.3	1.2	1.5	1.6	..	2.5	..	0.5
Other (d)										
Proportion	%	88.6	89.7	87.1	86.1	85.5	89.7	–	87.2	88.1
RSE	%	1.4	1.0	1.1	1.6	1.9	0.9	–	1.9	0.5
95% CI	± %	2.5	1.7	1.9	2.6	3.1	1.6	–	3.3	0.9
Total										
Proportion	**%**	**90.1**	**89.4**	**88.7**	**88.3**	**88.2**	**89.7**	**89.5**	**87.2**	**89.3**
RSE	**%**	**0.5**	**0.6**	**0.6**	**0.7**	**0.9**	**0.9**	**1.4**	**1.9**	**0.2**
95% CI	**± %**	**0.8**	**1.1**	**1.0**	**1.2**	**1.5**	**1.6**	**2.5**	**3.3**	**0.4**
GP always or often showed respect										
Major cities										
Proportion	%	93.6	93.1	92.3	92.5	92.6	..	93.1	..	93.0
RSE	%	0.5	0.6	0.5	0.7	0.6	..	1.1	..	0.3
95% CI	± %	0.9	1.0	0.9	1.2	1.2	..	2.0	..	0.5
Other (d)										
Proportion	%	92.4	91.7	91.0	90.9	89.4	92.2	–	91.4	91.5
RSE	%	0.9	0.9	1.0	1.5	1.6	0.9	–	1.2	0.4
95% CI	± %	1.6	1.5	1.8	2.6	2.8	1.5	–	2.1	0.7
Total										
Proportion	**%**	**93.2**	**92.8**	**91.7**	**92.1**	**91.8**	**92.2**	**93.1**	**91.4**	**92.5**
RSE	**%**	**0.4**	**0.5**	**0.5**	**0.6**	**0.6**	**0.9**	**1.1**	**1.2**	**0.2**
95% CI	**± %**	**0.7**	**0.9**	**0.9**	**1.1**	**1.1**	**1.5**	**2.0**	**2.1**	**0.4**
GP always or often spent enough time										
Major cities										

Table 11A.70 **Client experience of GPs by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c) (d)	*Aust* (e)
Proportion	%	89.7	87.6	88.2	87.2	87.6	..	86.2	..	88.3
RSE	%	0.7	0.8	0.7	0.9	1.3	..	1.6	..	0.4
95% CI	± %	1.3	1.4	1.3	1.5	2.3	..	2.6	..	0.6
Other (d)										
Proportion	%	88.7	87.3	85.3	86.1	87.4	87.9	–	86.3	87.0
RSE	%	1.2	1.4	1.5	2.3	1.7	1.0	–	1.5	0.6
95% CI	± %	2.1	2.5	2.5	3.9	2.9	1.7	–	2.5	1.1
Total										
Proportion	**%**	**89.4**	**87.6**	**87.1**	**87.0**	**87.6**	**87.9**	**86.2**	**86.3**	**88.0**
RSE	**%**	**0.5**	**0.6**	**0.7**	**0.8**	**1.2**	**1.0**	**1.6**	**1.5**	**0.3**
95% CI	**± %**	**1.0**	**1.1**	**1.1**	**1.4**	**2.1**	**1.7**	**2.6**	**2.5**	**0.5**

RSE = Relative standard error. **CI** = confidence interval.

(a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.

(b) Rates are age standardised to the 2001 estimated resident population.

(c) Very remote data were not collected in the 2010-11 Patient Experience Survey. NT data should be used with care as around 23 per cent of the NT population usually resides in very remote areas. For 2010-11, 'other' Includes inner regional, outer regional and remote areas.

(d) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys, although discrete Indigenous communities are excluded, which will impact the NT more than other jurisdictions. For 2011-12 and 2012-13, 'other' includes inner and outer regional, remote and very remote areas.

(e) National data for 2010-11 were not published for inner regional, outer regional and remote areas combined. National data for 2010-11 for each remoteness area are reported in table 11A.69.

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

Source : ABS unpublished, *Patient Experience Survey 2010-11, 2011-12* , *2012-13* , Cat. no. 4839.0.

Table 11A.71 **Client experience of GPs by remoteness, Australia (a), (b), (c)**

	Unit	*Major cities*	*Inner regional*	*Outer regional*	*Remote/Very remote* (d), (e)	***Total***
2010-11 (d)						
GP always or often listened carefully						
Proportion	%	89.8	87.7	86.8	87.8	**89.1**
RSE	%	0.3	0.7	0.9	1.9	**0.3**
95% CI	± %	0.6	1.2	1.6	3.2	**0.5**
GP always or often showed respect						
Proportion	%	92.7	91.6	89.5	91.8	**92.2**
RSE	%	0.3	0.6	1.0	1.6	**0.3**
95% CI	± %	0.6	1.0	1.7	2.9	**0.6**
GP always or often spent enough time						
Proportion	%	87.5	87.0	84.9	87.2	**87.2**
RSE	%	0.4	0.8	1.2	1.9	**0.3**
95% CI	± %	0.7	1.4	2.0	3.3	**0.5**
2011-12 (e)						
GP always or often listened carefully						
Proportion	%	88.6	87.5	85.8	87.5	**88.1**
RSE	%	0.4	0.8	1.2	1.9	**0.3**
95% CI	± %	0.7	1.3	2.1	3.3	**0.5**
GP always or often showed respect						
Proportion	%	91.7	91.7	89.7	89.5	**91.5**
RSE	%	0.3	0.7	1.2	1.8	**0.3**
95% CI	± %	0.6	1.2	2.2	3.1	**0.5**
GP always or often spent enough time						
Proportion	%	86.8	86.2	84.2	84.4	**86.4**
RSE	%	0.4	0.9	1.3	2.3	**0.3**
95% CI	± %	0.6	1.5	2.1	3.8	**0.5**
2012-13 (e)						
GP always or often listened carefully						
Proportion	%	89.8	88.4	87.8	84.2	**89.3**
RSE	%	0.3	0.6	0.9	4.4	**0.2**
95% CI	± %	0.5	1.1	1.6	7.3	**0.4**
GP always or often showed respect						
Proportion	%	93.0	92.2	90.5	89.0	**92.5**
RSE	%	0.3	0.5	0.7	1.6	**0.2**
95% CI	± %	0.5	1.0	1.2	2.8	**0.4**
GP always or often spent enough time						
Proportion	%	88.3	87.4	86.7	84.2	**88.0**
RSE	%	0.4	0.7	1.1	2.6	**0.3**
95% CI	± %	0.6	1.3	1.9	4.3	**0.5**

RSE = Relative standard error. **95% CI** = confidence interval.

Table 11A.71 **Client experience of GPs by remoteness, Australia (a), (b), (c)**

	Unit	Major cities	Inner regional	Outer regional	Remote/Very remote (d), (e)	**Total**

(a) Proportion of people 15 years or over who saw a GP in the last 12 months for their own health (excluding interviews by proxy) reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.

(b) Rates are age standardised to the 2001 estimated resident population.

(c) Data are not comparable with data for Indigenous Australians that were sourced from the ABS 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey, due to differences in survey design and collection methodology.

(d) Very remote data were not collected in the 2010-11 Patient Experience Survey.

(e) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys. Data for remote and very remote areas are combined.

Source: ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.72 Client experience of GPs by remoteness, Indigenous people, Australia, 2012-13 (a), (b), (c), (d)

	Unit	*Major cities*	*Inner regional*	*Outer regional*	***Total* (e)**
2012-13 (e)					
GP always or often listened carefully					
Proportion	%	89.8	88.8	86.4	**88.5**
RSE	%	1.4	1.9	2.3	**1.0**
95% CI	± %	2.5	3.3	3.9	**1.8**
GP always or often showed respect					
Proportion	%	90.5	88.0	87.5	**89.0**
RSE	%	1.7	1.9	1.4	**1.0**
95% CI	± %	3.0	3.3	2.4	**1.7**
GP always or often spent enough time					
Proportion	%	86.2	85.0	83.2	**85.0**
RSE	%	1.8	2.1	2.3	**1.1**
95% CI	± %	3.0	3.4	3.7	**1.9**

RSE = Relative standard error. **95% CI** = confidence interval.

(a) Persons 15 years and over who saw a GP in the last 12 months for their own health (excluding interviews by proxy), reporting the GP always or often: listened carefully, showed respect, and spent enough time with them.

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).

(c) Data are not comparable with data for all Australians that were sourced from the ABS 2012-13 Patient Experience Survey, due to differences in survey design and collection methodology.

(d) Information on how to interpret and use the data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13* (Cat. no. 4727.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

(e) Includes major cities, inner and outer regional areas only, as these survey questions were not asked in remote and very remote areas.

Source: ABS (unpublished) *Australian Aboriginal and Torres Strait Islander Health Survey, 2012-13*, Cat. no. 4727.0.

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
2010-11 (c), (d)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.1	95.0	95.4	93.8	95.0	na	na	na	94.7
RSE	%	0.6	0.5	0.6	1.0	0.7	na	na	na	0.3
95% CI	± %	1.1	1.0	1.1	1.8	1.4	na	na	na	0.6
Other (c), (d)										
Proportion	%	91.6	92.3	93.4	94.2	95.0	na	na	na	na
RSE	%	1.5	1.3	0.9	1.3	1.8	na	na	na	na
95% CI	± %	2.7	2.4	1.7	2.5	3.3	na	na	na	na
Total										
Proportion	%	**93.6**	**94.5**	**94.7**	**93.8**	**94.9**	**93.3**	**94.8**	**93.1**	**94.2**
RSE	%	**0.5**	**0.5**	**0.5**	**0.8**	**0.8**	**1.3**	**1.2**	**1.4**	**0.3**
95% CI	± %	**1.0**	**1.0**	**0.9**	**1.5**	**1.5**	**2.4**	**2.2**	**2.6**	**0.5**
Dental professional always or often showed respect										
Major cities										
Proportion	%	95.2	96.1	96.1	94.4	95.4	na	na	na	95.6
RSE	%	0.6	0.5	0.5	0.9	0.7	na	na	na	0.3
95% CI	± %	1.1	0.9	0.9	1.6	1.4	na	na	na	0.6
Other (c), (d)										
Proportion	%	93.9	94.2	94.0	95.7	94.6	na	na	na	na
RSE	%	1.1	1.3	0.9	1.1	1.8	na	na	na	na
95% CI	± %	2.1	2.4	1.7	2.1	3.3	na	na	na	na
Total										
Proportion	%	**95.0**	**95.7**	**95.3**	**94.6**	**95.1**	**94.0**	**95.9**	**94.5**	**95.2**
RSE	%	**0.5**	**0.5**	**0.5**	**0.7**	**0.8**	**1.2**	**0.9**	**1.2**	**0.2**
95% CI	± %	**1.0**	**0.9**	**0.9**	**1.3**	**1.4**	**2.2**	**1.6**	**2.3**	**0.5**
Dental professional always or often spent enough time										
Major cities										
Proportion	%	94.9	96.0	95.8	94.5	96.4	na	na	na	95.5
RSE	%	0.6	0.5	0.8	0.8	0.7	na	na	na	0.3
95% CI	± %	1.1	1.0	1.6	1.4	1.2	na	na	na	0.6
Other (c), (d)										
Proportion	%	94.0	93.7	93.5	95.8	94.6	na	na	na	na
RSE	%	0.9	1.3	1.1	1.2	2.1	na	na	na	na
95% CI	± %	1.7	2.5	1.9	2.2	3.9	na	na	na	na

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
Total										
Proportion	%	**94.7**	**95.5**	**95.1**	**94.8**	**95.9**	**92.5**	**95.0**	**94.6**	**95.1**
RSE	%	**0.4**	**0.5**	**0.6**	**0.7**	**0.8**	**1.4**	**1.5**	**1.6**	**0.3**
95% CI	± %	**0.8**	**1.0**	**1.2**	**1.2**	**1.5**	**2.5**	**2.9**	**3.0**	**0.5**
2011-12 (e)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	94.2	93.8	94.0	95.0	95.4	..	93.9	..	94.2
RSE	%	0.6	0.7	0.8	0.8	0.6	..	1.7	..	0.2
95% CI	± %	1.1	1.2	1.4	1.6	1.2	..	3.1	..	0.4
Other (e)										
Proportion	%	92.2	93.3	93.5	92.9	96.8	91.4	0	92.3	93
RSE	%	1.3	1.2	1.1	2.0	1.3	1.5	0	1.6	0.6
95% CI	± %	2.4	2.3	2.1	3.7	2.4	2.7	0	2.8	1.1
Total										
Proportion	%	**93.8**	**93.6**	**93.8**	**94.4**	**95.8**	**91.4**	**93.9**	**92.3**	**93.9**
RSE	%	**0.5**	**0.6**	**0.6**	**0.7**	**0.5**	**1.5**	**1.7**	**1.6**	**0.2**
95% CI	± %	**0.9**	**1.0**	**1.1**	**1.4**	**1.0**	**2.7**	**3.1**	**2.8**	**0.4**
Dental professional always or often showed respect										
Major cities										
Proportion	%	95.5	94.7	94.9	96.1	96.2	..	95.7	..	95.3
RSE	%	0.5	0.7	0.6	0.6	0.5	..	1.2	..	0.3
95% CI	± %	1.0	1.3	1.2	1.2	0.9	..	2.3	..	0.5
Other (e)										
Proportion	%	92.7	93.9	94.8	92.5	96.9	91.8	0	93	93.7
RSE	%	1.4	1.2	1.2	2.0	1.4	1.4	0	1.7	0.5
95% CI	± %	2.5	2.2	2.2	3.6	2.6	2.6	0	3.1	1
Total										
Proportion	%	**94.8**	**94.5**	**94.9**	**95.2**	**96.3**	**91.8**	**95.7**	**93.0**	**94.9**
RSE	%	**0.5**	**0.5**	**0.6**	**0.6**	**0.4**	**1.4**	**1.2**	**1.7**	**0.2**
95% CI	± %	**1.0**	**0.9**	**1.2**	**1.2**	**0.8**	**2.6**	**2.3**	**3.1**	**0.5**
Dental professional always or often spent enough time										
Major cities										
Proportion	%	95.4	95.0	95.0	95.8	96.2	..	94.5	..	95.3
RSE	%	0.6	0.6	0.7	0.5	0.6	..	1.4	..	0.3
95% CI	± %	1.0	1.1	1.3	0.9	1.0	..	2.5	..	0.6
Other (e)										

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
Proportion	%	94.2	94.4	95.5	91.5	96.7	93	0	92.3	94.3
RSE	%	1.2	1.4	1.1	2.3	1.4	1.3	0	1.8	0.4
95% CI	± %	2.1	2.5	2.1	4.1	2.7	2.4	0	3.3	0.7
Total										
Proportion	%	**95.1**	**94.9**	**95.2**	**94.8**	**96.3**	**93.0**	**94.5**	**92.3**	**95**
RSE	%	**0.5**	**0.5**	**0.6**	**0.6**	**0.6**	**1.3**	**1.4**	**1.8**	**0.3**
95% CI	± %	**0.9**	**0.9**	**1.2**	**1.2**	**1.1**	**2.4**	**2.5**	**3.3**	**0.5**
2012-13 (e)										
Dental professional always or often listened carefully										
Major cities										
Proportion	%	96.4	94.7	94.5	95.6	95.2	..	94.8	..	95.4
RSE	%	0.5	0.6	0.5	0.6	0.6	..	1.0	..	0.3
95% CI	± %	0.9	1.2	1.0	1.1	1.1	..	1.8	..	0.5
Other (e)										
Proportion	%	92.9	92.0	93.0	95.5	92.0	94.1	–	91.9	93.0
RSE	%	1.3	1.4	1.0	1.3	2.6	0.8	–	2.3	0.5
95% CI	± %	2.4	2.6	1.8	2.4	4.6	1.5	–	4.2	1.0
Total										
Proportion	**%**	**95.8**	**94.2**	**94.0**	**95.5**	**94.4**	**94.1**	**94.8**	**91.9**	**94.8**
RSE	**%**	**0.5**	**0.5**	**0.4**	**0.5**	**0.7**	**0.8**	**1.0**	**2.3**	**0.2**
95% CI	**± %**	**1.0**	**1.0**	**0.8**	**1.0**	**1.4**	**1.5**	**1.8**	**4.2**	**0.4**
Dental professional always or often showed respect										
Major cities										
Proportion	%	97.0	96.4	95.7	96.6	96.6	..	95.9	..	96.5
RSE	%	0.4	0.5	0.6	0.5	0.6	..	0.8	..	0.3
95% CI	± %	0.8	0.9	1.2	0.9	1.1	..	1.5	..	0.6
Other (e)										
Proportion	%	94.5	92.8	95.2	97.0	94.8	95.8	–	93.9	94.8
RSE	%	1.0	1.3	0.9	1.2	1.5	0.6	–	2.1	0.4
95% CI	± %	1.8	2.5	1.7	2.2	2.8	1.2	–	3.9	0.8
Total										
Proportion	**%**	**96.6**	**95.7**	**95.5**	**96.6**	**96.2**	**95.8**	**95.9**	**93.9**	**96.1**
RSE	**%**	**0.4**	**0.5**	**0.5**	**0.4**	**0.6**	**0.6**	**0.8**	**2.1**	**0.3**
95% CI	**± %**	**0.8**	**0.8**	**0.9**	**0.8**	**1.0**	**1.2**	**1.5**	**3.9**	**0.5**
Dental professional always or often spent enough time										
Major cities										
Proportion	%	96.7	95.1	94.9	96.3	96.3	..	95.4	..	95.8

Table 11A.73 **Client experience of dental professionals by remoteness, States and Territories (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust* (d)
RSE	%	0.4	0.5	0.7	0.7	0.7	..	0.9	..	0.2
95% CI	± %	0.7	1.0	1.3	1.3	1.2	..	1.7	..	0.4
Other (e)										
Proportion	%	93.4	92.9	96.5	97.8	96.6	96.6	–	93.4	95.0
RSE	%	1.3	1.7	0.7	0.6	1.1	0.8	–	2.0	0.6
95% CI	± %	2.5	3.1	1.4	1.2	2.0	1.5	–	3.6	1.0
Total										
Proportion	**%**	**96.1**	**94.7**	**95.4**	**96.6**	**96.4**	**96.6**	**95.4**	**93.4**	**95.6**
RSE	**%**	**0.4**	**0.5**	**0.6**	**0.6**	**0.5**	**0.8**	**0.9**	**2.0**	**0.2**
95% CI	**± %**	**0.7**	**1.0**	**1.1**	**1.1**	**1.0**	**1.5**	**1.7**	**3.6**	**0.4**

RSE = Relative standard error. **CI** = confidence interval.

(a) Proportion of people who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).

(c) Very remote data were not collected in the 2010-11 Patient Experience Survey. NT data should be used with care as around 23 per cent of the NT population usually resides in very remote areas. For 2010-11, 'other' Includes inner regional, outer regional and remote areas.

(d) National data for 2010-11 were not published for inner regional, outer regional and remote areas combined. National data for 2010-11 for each remoteness area are reported in table 11A.71.

(e) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys, although discrete Indigenous communities are excluded, which will impact the NT more than other jurisdictions. For 2011-12 and 2012-13, 'other' includes inner and outer regional, remote and very remote areas.

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

Source : ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.74 Client experience of dental professionals by remoteness, Australia (a), (b), (c)

	Unit	Major CIties	Inner regional	Outer regional	Remote/Very remote (c), (d)	**Total**
2010-11 (c)						
Dental professional always or often listened carefully						
Proportion	%	94.7	92.9	92.2	96.6	**94.2**
RSE	%	0.3	0.6	1.2	1.7	**0.3**
95% CI	± %	0.6	1.0	2.1	3.2	**0.5**
Dental professional always or often showed respect						
Proportion	%	95.6	94.4	93.7	97.2	**95.2**
RSE	%	0.3	0.5	1.0	1.6	**0.2**
95% CI	± %	0.6	0.9	1.8	3.0	**0.5**
Dental professional always or often spent enough time						
Proportion	%	95.5	94.1	93.3	96.8	**95.1**
RSE	%	0.3	0.6	1.1	1.5	**0.3**
95% CI	± %	0.6	1.1	2.1	2.8	**0.5**
2011-12 (d)						
Dental professional always or often listened carefully						
Proportion	%	94.2	93.6	91.9	92.7	**93.9**
RSE	%	0.2	0.7	1.1	2.0	**0.2**
95% CI	± %	0.4	1.3	2.0	3.6	**0.4**
Dental professional always or often showed respect						
Proportion	%	95.3	94.1	93.1	92.4	**94.9**
RSE	%	0.3	0.7	1.0	2.0	**0.2**
95% CI	± %	0.5	1.3	1.8	3.7	**0.5**
Dental professional always or often spent enough time						
Proportion	%	95.3	94.9	94.1	88.0	**95.0**
RSE	%	0.3	0.6	1.0	3.5	**0.3**
95% 95% CI	± %	0.6	1.1	1.9	6.1	**0.5**
2012-13 (d)						
Dental professional always or often listened carefully						
Proportion	%	95.4	92.6	93.4	92.9	**94.8**
RSE	%	0.3	0.8	1.2	3.5	**0.2**
95% CI	± %	0.5	1.4	2.2	6.4	**0.4**
Dental professional always or often showed respect						
Proportion	%	96.5	94.2	95.9	97.1	**96.1**
RSE	%	0.3	0.6	0.7	1.1	**0.3**
95% CI	± %	0.6	1.2	1.2	2.2	**0.5**
Dental professional always or often spent enough time						
Proportion	%	95.8	94.5	96.0	96.2	**95.6**
RSE	%	0.2	0.7	0.8	1.3	**0.2**
95% 95% CI	± %	0.4	1.3	1.5	2.4	**0.4**

RSE = Relative standard error. **95% CI** = confidence interval.

Table 11A.74 **Client experience of dental professionals by remoteness, Australia (a), (b), (c)**

	Unit	Major CIties	Inner regional	Outer regional	Remote/Very remote (c), (d)	**Total**

(a) Proportion of persons who saw a dental professional for their own health in the last 12 months (excluding interviews by proxy) reporting the dental professional always or often: listened carefully, showed respect, and spent enough time with them.

(b) Rates are age standardised to the 2001 estimated resident population (5 year ranges).

(c) Very remote data were not collected in the 2010-11 Patient Experience Survey.

(d) Data were collected for all remoteness areas in the 2011-12 and 2012-13 surveys. For 2011-12 and 2012-13, data for remote and very remote areas are combined.

Source : ABS unpublished, *Patient Experience Survey 2010-11, 2011-12, 2012-13* , Cat. no. 4839.0.

Table 11A.75 **Annual health assessments for older people (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2006-07										
Older people assessed	no.	97 804	64 885	52 209	18 266	25 014	7 914	1 752	790	268 634
Older people	no.	453 905	332 645	235 780	109 442	120 452	34 516	14 366	7 051	1 313 687
Proportion assessed	%	21.55	19.51	22.14	16.69	20.77	22.93	12.20	11.20	20.45
2007-08										
Older people assessed	no.	104 776	66 478	57 405	19 384	26 741	8 301	2 337	1 039	286 461
Older people	no.	464 922	340 348	242 764	118 201	122 533	35 231	14 656	7 411	1 346 876
Proportion assessed	%	22.54	19.53	23.65	16.40	21.82	23.56	15.95	14.02	21.27
2008-09										
Older people assessed	no.	112 810	73 403	64 260	22 796	27 563	9 509	2 454	1 276	314 071
Older people	no.	474 661	347 313	248 638	122 034	124 579	35 713	15 401	7 786	1 376 687
Proportion assessed	%	23.77	21.13	25.84	18.68	22.12	26.63	15.93	16.39	22.81
2009-10										
Older people assessed	no.	118 405	78 282	67 135	25 472	28 201	9 187	2 770	1 477	330 929
Older people	no.	483 341	354 239	254 052	125 007	126 130	36 385	15 916	8 193	1 403 864
Proportion assessed	%	24.50	22.10	26.43	20.38	22.36	25.25	17.40	18.03	23.57
2010-11										
Older people assessed	no.	133 318	90 902	77 716	31 370	31 844	11 083	3 204	1 874	381 311
Older people	no.	491 718	361 938	260 684	128 477	127 470	36 871	16 381	8 643	1 432 824
Proportion assessed	%	27.11	25.12	29.81	24.42	24.98	30.06	19.56	21.68	26.61
2011-12 (d)										
Older people assessed	no.	141 595	96 727	84 515	33 510	33 395	11 685	3 318	2 079	406 824
Older people	no.	502 726	369 125	267 832	132 766	129 319	37 383	16 922	9 237	1 465 989
Proportion assessed	%	28.17	26.20	31.56	25.24	25.82	31.26	19.61	22.51	27.75
2012-13 (e)										
Older people assessed	no.	150 847	102 260	92 425	37 846	35 804	13 095	3 861	2 603	438 741
Older people	no.	513 313	378 015	276 692	137 378	131 620	38 123	17 525	9 812	1 503 211

Table 11A.75 **Annual health assessments for older people (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion assessed	%	29.39	27.05	33.40	27.55	27.20	34.35	22.03	26.53	29.19

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

(c) Data are for number of people receiving a health assessment rather than the number of health assessments provided.

(d) 2011-12 data have been revised to include assessments for which rebates were claimed in 2012-13.

(e) 2012-13 data are preliminary data.

Source : Department of Health unpublished, MBS data collection; ABS 2008, 2009, 2010, 2011 and unpublished, *Population by Age and Sex, Australian States and Territories* , various years, Cat. no. 3201.0, Canberra; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians Australians 1991 to 2021* , Cat. no. 3238.0, Canberra.

Table 11A.76 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2008–2013 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
Valid vaccinations provided										
GPs	no.	5 961 186	3 169 975	3 974 396	1 684 717	1 098 617	410 369	208 187	41 521	16 547 160
Council	no.	236 940	2 160 911	279 374	90 716	274 053	31 230	–	–	3 073 224
State or territory health department	no.	–	–	620	156 231	403	–	4 331	1 642	163 227
Public hospital (e)	no.	na	na	na	na	na	na	na	na	na
Private hospital	no.	22	10	969	7	–	–	2	2 487	3 497
Aboriginal health service	no.	37 566	9 009	30 583	9 832	9 422	46	–	68 836	165 294
Community health centre	no.	457 424	14 732	291 583	508 938	97 325	195	144 957	199 469	1 715 150
Other (f)	no.	832	3 203	5 020	1 681	697	–	–	–	11 433
Total	**no.**	**6 693 970**	**5 357 840**	**4 582 545**	**2 452 122**	**1 480 517**	**441 840**	**357 477**	**313 955**	**21 678 985**
Proportion of total valid vaccinations										
GPs	%	89.05	59.17	86.73	68.70	74.20	92.88	58.24	13.23	76.33
Council	%	3.54	40.33	6.10	3.70	18.51	7.07	–	–	14.18
State or territory health department	%	–	–	0.01	6.37	0.03	–	1.21	0.52	0.75
Public hospital (e)	%	na	na	na	na	na	na	na	na	na
Private hospital	%	–	–	0.02	–	–	–	–	0.79	0.02
Aboriginal health service	%	0.56	0.17	0.67	0.40	0.64	0.01	–	21.93	0.76
Community health centre	%	6.83	0.27	6.36	20.76	6.57	0.04	40.55	63.53	7.91
Other (f)	%	0.01	0.06	0.11	0.07	0.05	–	–	–	0.05
Total	**%**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Table 11A.76 **Valid vaccinations supplied to children under seven years of age, by type of provider, 2008–2013 (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)

(a) 1 July 2008 to 30 June 2013.

(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.

(d) Includes data for unknown State or Territory.

(e) Data for 2008–2013 for vaccinations provided at public hospitals are not available.

(f) Other includes Divisions of GP, Flying Doctors Services, Indigenous Health Workers, Community nurses and unknown providers.

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

Source: Department of Health unpublished, Australian Childhood Immunisation Register (ACIR) data collection.

Table 11A.77 **Children aged 12 months to less than 15 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Fully immunised (a), (b)									
30 June 2008	91.3	91.8	90.8	90.1	91.0	91.0	93.5	91.6	91.2
30 June 2009	91.9	91.9	91.0	88.9	91.5	90.3	93.6	90.3	91.3
30 June 2010	91.2	92.1	91.9	90.1	91.3	91.7	92.2	90.3	91.5
30 June 2011 (g)	89.7	91.6	91.0	87.6	90.5	90.4	92.5	91.8	90.3
30 June 2012	91.7	92.7	91.7	90.1	92.6	93.1	93.1	94.2	91.9
2012-13 (b)	90.8	91.7	92.0	90.2	91.3	92.2	92.8	91.5	91.3
Immunised against (2012-13) (f)									
Diphtheria, tetanus and pertussis	91.4	92.4	92.4	91.0	91.8	92.5	93.6	91.7	91.9
Polio	91.3	92.3	92.4	90.9	91.8	92.4	93.6	91.7	91.8
Haemophilus influenzae type b	91.1	92.2	92.3	90.7	91.6	92.3	93.4	91.6	91.7

(a) Coverage for the years 2008 to 2012 measured at 30 June, for children turning 12 months of age by 31 March, by the State or Territory in which the child resided.

(b) Coverage for 2012-13 includes all children vaccinated against the specified diseases, at 12 months to less than 15 months of age, in the 2012-13 financial year, by the State or Territory in which the child resided. These data may differ from data reported elsewhere which are measured at 30 June 2013, for children turning 12 months of age by 31 March 2013, by the State or Territory in which the child resided.

(c) 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).

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

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

(f) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.

(g) Relatively low coverage rates for the June 2011 quarter are associated with parents not receiving immunisation reminders due to administrative error.

Source: Department of Health unpublished, ACIR data collection.

Table 11A.78 **Children aged 24 months to less than 27 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Fully immunised (a), (b), (e)									
30 June 2008	92.5	93.6	92.6	91.2	93.3	93.4	94.8	94.7	92.8
30 June 2009	92.7	93.8	92.2	91.8	93.2	93.0	93.6	94.6	92.9
30 June 2010	92.5	93.0	92.2	90.5	92.5	92.8	93.8	93.4	92.4
30 June 2011	92.2	93.5	93.0	92.0	92.6	94.6	93.4	94.0	92.8
30 June 2012	92.1	93.0	92.6	90.1	92.2	93.6	92.8	95.7	92.3
2012-13 (b)	92.3	93.1	92.6	90.6	92.5	94.2	93.2	93.4	92.4
Immunised against (at 30 June 2013)									
Diphtheria, tetanus and pertussis	94.7	95.5	94.5	93.4	94.7	95.8	95.8	95.3	94.8
Polio	94.7	95.5	94.5	93.4	94.7	95.8	95.8	95.4	94.7
Haemophilus influenzae type b	94.7	95.2	94.3	93.3	94.4	95.8	95.5	95.3	94.6
Measles, mumps and rubella	93.7	94.5	93.9	92.5	93.8	95.2	94.5	94.7	93.9

(a) Coverage for the years 2008 to 2012 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) Coverage for 2012-13 includes all children vaccinated against the specified diseases, at 24 months to less than 27 months of age, in the 2012-13 financial year, by the State or Territory in which the child resided. These data may differ from data reported elsewhere which are measured at 30 June 2013, for children turning 24 months of age by 31 March 2013, by the State or Territory in which the child resided.

(c) 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).

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

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

(f) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.

Source: Department of Health unpublished, ACIR data collection.

Table 11A.79 **Children aged 60 months to less than 63 months who were fully immunised (per cent) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (f)	*Aust*
Fully immunised (a), (b), (e)									
30 June 2008	79.1	84.3	81.7	76.8	73.0	79.9	86.4	80.7	80.4
30 June 2009	82.0	85.8	82.5	80.3	75.6	78.6	84.4	84.8	82.4
30 June 2010	89.5	91.2	90.2	86.6	87.2	90.6	89.0	87.3	89.6
30 June 2011	89.7	91.1	90.3	86.0	87.0	90.3	90.6	88.1	89.6
30 June 2012	90.6	91.6	91.0	87.6	88.8	90.8	90.9	90.4	90.2
2012-13 (b)	91.6	92.6	91.5	89.4	90.9	92.9	92.3	90.7	91.5
Immunised against (at 30 June 2013)									
Diphtheria, tetanus and pertussis	92.1	93.1	92.0	90.0	91.4	93.2	92.9	91.0	92.1
Polio	92.0	93.0	92.0	90.0	91.3	93.1	92.8	91.1	92.0
Measles, mumps and rubella	91.9	92.9	91.9	89.9	91.2	93.5	92.7	91.2	91.9

(a) Coverage for 2008 to 2012 measured at 30 June for children turning 60 months of age by 31 March, by the State or Territory in which the child was located.

(b) Coverage for 2012-13 includes all children vaccinated against the specified diseases, at 60 months to less than 63 months of age, in the 2012-13 financial year, by the State or Territory in which the child resided. These data may differ from data reported elsewhere which are measured at 30 June 2013, for children turning 60 months of age by 31 March 2013, by the State or Territory in which the child resided.

(c) 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).

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

(e) Children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, pertussis (whooping cough), polio and measles, mumps and rubella.

(f) NT immunisation records differ from published ACIR data due to a review of a rule change implemented in 2009. As a result, all reports affected by the change were recalculated accounting for the anomaly.

Source: Department of Health unpublished, ACIR data collection.

Table 11A.80 Notifications of measles, children aged 0–14 years (a), (b), (c)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	np	–	np	np	–	–	–	–	4
2007-08	no.	18	np	4	np	np	–	–	np	27
2008-09	no.	3	18	20	np	–	np	–	–	44
2009-10	no.	5	3	np	np	np	–	–	–	12
2010-11	no.	40	6	7	5	–	–	np	np	61
2011-12	no.	20	np	–	np	np	–	4	–	28
2012-13	no.	85	np	np	3	np	–	–	np	94
Notifications per 100 000 children (0–14 years)										
2006-07	per 100 000 children	np	–	np	np	–	–	–	–	0.1
2007-08	per 100 000 children	1.4	np	0.5	np	np	–	–	np	0.7
2008-09	per 100 000 children	0.2	1.8	2.3	np	–	np	–	–	1.1
2009-10	per 100 000 children	0.4	0.3	np	np	np	–	–	–	0.3
2010-11	per 100 000 children	2.9	0.6	0.8	1.1	–	–	np	np	1.4
2011-12	per 100 000 children	1.5	np	–	np	np	–	5.9	–	0.7
2012-13	per 100 000 children	6.1	np	np	0.6	np	–	–	np	2.2

(a) Notification of the relevant State/Territory authority is required when measles is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for measles — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.

(b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.

(c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.

(d) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

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

Source : Department of Health unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS (unpublished), *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 11A.81 **Notifications of pertussis (whooping cough), children aged 0–14 years (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	303	92	112	33	39	7	8	np	596
2007-08	no.	677	181	95	36	41	9	5	82	1 126
2008-09	no.	8 161	681	955	205	586	205	59	162	11 014
2009-10	no.	3 282	1 095	1 497	240	1 836	108	32	61	8 151
2010-11	no.	8 771	2 834	3 146	746	2 180	69	335	129	18 210
2011-12	no.	6 709	1 715	3 179	2 564	278	384	87	279	15 195
2012-13	no.	2 138	927	2 370	527	300	660	88	52	7 062
Notifications per 100 000 children (0–14 years) (c)										
2006-07	per 100 000 children	22.9	9.5	13.6	8.0	13.7	7.3	12.6	np	14.8
2007-08	per 100 000 children	50.8	18.5	11.3	8.6	14.3	9.3	7.8	158.2	27.7
2008-09	per 100 000 children	607.1	68.8	110.6	47.4	203.4	211.2	91.3	309.7	266.6
2009-10	per 100 000 children	242.1	109.4	170.7	54.5	633.9	111.4	48.8	115.8	195.1
2010-11	per 100 000 children	643.2	280.7	355.2	166.7	750.6	71.6	504.9	245.8	432.3
2011-12	per 100 000 children	489.4	168.0	353.4	558.2	95.3	401.4	128.5	529.6	356.8
2012-13	per 100 000 children	154.7	89.1	259.0	111.1	102.0	694.9	126.1	97.7	163.3

(a) Notification of the relevant State/Territory authority is required when whooping cough is diagnosed. Diagnosis cannot always be confirmed using available tools. Therefore, the 'notified fraction' is likely to be only a proportion of the total number of cases. The notified fraction may vary between states and territories and over time.

(b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.

(c) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

Source : Department of Health unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS (unpublished), *Australian Demographic Statistics* , Cat. no. 3101.0.

Table 11A.82 **Notifications of invasive *Haemophilus influenzae* type b, children aged 0–14 years (a), (b), (c)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Notifications										
2006-07	no.	4	3	8	np	–	–	–	–	17
2007-08	no.	7	–	np	–	np	np	–	np	12
2008-09	no.	3	np	3	np	–	–	–	np	11
2009-10	no.	np	–	np	np	np	–	–	np	6
2010-11	no.	6	np	np	np	–	–	–	–	12
2011-12	no.	–	–	np	np	np	–	–	np	7
2012-13	no.	3	3	3	–	–	–	–	–	9
Notifications per 100 000 children (0–14 years) (d)										
2006-07	per 100 000 children	0.3	0.3	1.0	np	–	–	–	–	0.4
2007-08	per 100 000 children	0.5	–	np	–	np	np	–	np	0.3
2008-09	per 100 000 children	0.2	np	0.3	np	–	–	–	np	0.3
2009-10	per 100 000 children	np	–	np	np	np	–	–	np	0.1
2010-11	per 100 000 children	0.4	np	np	np	–	–	–	–	0.3
2011-12	per 100 000 children	–	–	np	np	np	–	–	np	0.2
2012-13	per 100 000 children	0.2	0.3	0.3	–	–	–	–	–	0.2

(a) Notification of the relevant State/Territory authority is required when invasive *Haemophilus influenzae* type b (Hib) is diagnosed. Available diagnostic tools make it uncommon for cases to go undiagnosed and therefore the 'notified fraction' for Hib — the proportion of total cases for which notification is made — is expected to be high, with little variation between states and territories as well as over time.

(b) Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions.

(c) Data are suppressed for number of notifications where number is less than 3 and for rates where numerator is less than 5.

(d) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

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

Source: Department of Health unpublished, National Notifiable Diseases Surveillance System (NNDSS), ABS (unpublished), *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 11A.83 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
2007–2008									
40–44 years	6.3	5.4	25.6	11.1	10.3	22.0	3.8	4.1	11.0
45–49 years	11.7	10.3	37.9	21.4	20.1	34.0	9.6	13.1	18.8
50–54 years	50.5	48.5	54.5	52.0	53.7	47.6	45.6	34.4	51.1
55–59 years	56.0	54.8	59.0	55.3	58.4	56.9	57.0	42.5	56.6
60–64 years	58.4	58.3	61.1	57.9	62.1	59.4	58.7	45.8	59.3
65–69 years	56.9	56.8	60.2	58.1	60.8	58.7	58.1	41.6	58.2
70–74 years	13.6	33.6	53.8	19.7	25.4	34.0	18.2	8.7	28.3
75–79 years	6.7	13.2	19.6	10.8	13.5	11.2	8.5	4.9	11.8
80–84 years	2.6	3.0	5.1	4.1	5.0	3.9	2.7	2.8	3.5
85+ years	0.6	0.6	1.4	0.9	0.9	0.6	0.4	0.3	0.8
40+ years (ASR)	29.4	30.5	42.6	32.8	34.4	37.6	28.6	22.2	33.2
Ages 50–69 (ASR)	54.8	53.8	58.2	55.2	58.0	54.6	53.7	40.3	55.6
2008–2009									
40–44 years	6.5	5.1	25.2	11.0	10.0	22.9	6.7	3.3	11.0
45–49 years	11.5	9.8	38.7	21.7	20.0	35.7	10.9	12.3	18.8
50–54 years	49.1	48.3	55.7	52.8	55.9	50.5	44.9	36.0	51.1
55–59 years	56.1	54.4	60.5	57.2	58.8	58.9	56.9	42.0	57.1
60–64 years	58.6	58.5	62.8	60.0	63.5	63.3	60.9	46.4	60.3
65–69 years	56.9	56.6	61.4	59.2	61.5	62.2	58.5	43.5	58.6
70–74 years	15.2	24.1	55.4	20.6	25.3	21.3	22.2	9.6	26.5
75–79 years	7.0	8.5	20.7	11.4	13.6	9.8	9.8	5.2	10.9
80–84 years	2.8	2.9	5.5	4.3	5.2	3.6	3.1	2.1	3.7
85+ years	0.6	0.6	1.6	0.9	1.1	0.7	0.7	0.5	0.8
40+ years (ASR)	29.4	29.3	43.4	33.6	34.9	38.3	29.8	22.4	33.3
Ages 50–69 (ASR)	54.4	53.6	59.5	56.6	59.3	57.6	53.9	41.2	56.0
2009–2010									
40–44 years	6.2	4.9	23.7	10.5	9.0	22.7	7.1	3.0	10.4
45–49 years	10.8	9.8	37.8	21.6	19.1	37.2	11.5	11.3	18.4
50–54 years	46.9	49.9	54.5	53.9	53.0	51.9	44.0	35.5	50.5
55–59 years	55.0	54.9	59.1	57.8	57.1	59.9	55.4	42.5	56.5
60–64 years	58.4	59.8	62.1	61.8	61.4	65.0	60.0	46.9	60.4
65–69 years	56.7	56.8	60.5	60.1	59.9	62.1	58.4	45.0	58.3
70–74 years	16.1	19.5	54.9	20.9	25.0	18.6	23.6	9.6	25.6
75–79 years	7.0	8.1	20.0	11.8	13.9	9.3	10.0	4.3	10.8
80–84 years	2.8	2.9	5.4	4.5	5.5	3.6	2.9	2.6	3.7
85+ years	0.6	0.6	1.4	1.0	1.1	0.7	0.7	0.2	0.8
40+ years (ASR)	28.8	29.4	42.5	34.1	33.6	38.8	29.7	22.3	32.8
Ages 50–69 (ASR)	53.3	54.6	58.4	57.8	57.1	58.6	53.1	41.5	55.6

Table 11A.83 **Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)**

	NSW	*Vic* (e)	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
2010–2011									
40–44 years	5.7	5.0	21.7	10.1	8.6	22.3	7.4	2.7	9.8
45–49 years	9.8	10.6	36.6	21.5	18.6	36.8	12.1	10.2	18.0
50–54 years	43.1	51.1	53.5	53.8	53.2	50.0	42.1	34.8	49.3
55–59 years	51.5	54.6	57.9	57.9	58.3	58.5	53.4	43.5	55.1
60–64 years	55.9	59.6	61.5	62.3	63.3	64.7	59.7	48.3	59.6
65–69 years	54.6	57.6	59.9	60.4	61.9	60.5	57.2	43.9	57.9
70–74 years	15.6	17.3	54.3	21.1	25.4	16.7	20.7	9.1	24.8
75–79 years	6.8	8.0	19.7	12.2	14.1	9.0	9.4	4.6	10.7
80–84 years	2.7	2.9	5.5	4.8	6.0	3.6	3.1	2.9	3.8
85+ years	0.5	0.6	1.3	1.1	1.1	0.7	0.7	0.7	0.8
40+ years (ASR)	27.0	29.5	41.4	34.1	34.0	37.9	28.9	22.1	32.1
Ages 50–69 (ASR)	50.1	55.0	57.5	57.9	58.3	57.3	51.6	41.6	54.6
2011–2012									
40–44 years	6.0	6.2	21.1	10.3	9.0	22.4	8.7	2.5	10.2
45–49 years	10.0	12.9	36.1	22.1	18.7	37.3	14.0	9.9	18.7
50–54 years	42.7	50.4	52.5	53.8	54.3	50.5	43.2	35.8	48.9
55–59 years	51.7	53.6	57.8	57.6	58.4	58.3	55.8	41.7	54.9
60–64 years	56.6	58.9	61.3	62.2	63.4	64.5	63.0	47.1	59.6
65–69 years	55.8	57.0	59.9	60.6	62.4	62.7	58.0	45.8	58.2
70–74 years	16.2	20.0	54.2	21.7	26.2	17.2	21.1	10.2	25.8
75–79 years	7.5	9.0	20.2	13.1	15.8	9.1	10.5	5.4	11.5
80–84 years	2.9	3.4	5.6	5.3	6.8	3.6	3.2	2.0	4.1
85+ years	0.6	0.7	1.4	1.3	1.3	0.6	0.9	0.9	0.9
40+ years (ASR)	27.4	30.0	41.1	34.3	34.5	38.2	30.5	22.1	32.4
Ages 50–69 (ASR)	50.4	54.3	57.1	57.8	58.8	57.8	53.5	41.6	54.5

ASR = age standardised rate.

(a) The participation rate is the number of women screened during the reference period as a percentage of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) ERP in each of the calendar years in the reference period. Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.

(b) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

(c) Participation rates for women 40 years or over and 50–69 years are age standardised to the 2001 Australian population standard.

Table 11A.83 Participation rates for women in BreastScreen Australia (24 month period) (a), (b), (c), (d)

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

(d) Data include only women who were residents of the jurisdiction in which they were screened, with the exception of NSW for reference periods up to and including 2010–2011 where data include all women screened, whether or not they were residents of the jurisdiction. Data may differ from participation rates data published elsewhere that allocate women to jurisdictions based on the jurisdiction in which screening took place.

(e) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.

(f) Data for WA may include some Indigenous women usually resident in the NT in in WA catchment areas.

(g) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

Source : State and Territory governments unpublished; ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0.

Table 11A.84 **Participation rates for women in BreastScreen Australia by residential status, 2011 and 2012 (24 month period)**

	Unit	*NSW* (a)	*Vic*	*Qld*	*WA* (a)	*SA*	*Tas*	*ACT*	*NT*
40+ years									
Residents screened	no.	496 874	409 907	434 523	191 393	149 625	52 250	25 850	9 570
Non-residents screened	no.	na	2105	2120	132	162	49	1771	83
Non-residents screened (proportion)	%	na	0.5	0.5	0.1	0.1	0.1	6.4	0.9
Ages 50–69									
Residents screened	no.	425 013	343 340	290 911	151 117	119 567	38 856	21 353	8 372
Non-residents screened	no.	na	1684	1492	114	127	37	1436	72
Non-residents screened (proportion)	%	na	0.5	0.5	0.1	0.1	0.1	6.3	0.9

(a) Data for NSW exclude women who are not residents of NSW. However, data are not available for non-residents of NSW screened in NSW.

Source: State and Territory governments unpublished.

Table 11A.85 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA* (e)	*SA*	*Tas*	*ACT* (f)	*NT*	*Aust*
2007–2008									
Aged 40–49 years	6.6	3.1	24.7	14.3	9.9	12.6	5.8	4.6	12.5
Aged 50–59 years	34.5	23.9	45.2	27.2	30.8	29.0	23.5	23.1	33.8
Aged 60–69 years	40.8	33.3	48.3	36.5	32.8	55.6	76.0	25.8	39.1
Aged 70–79 years	10.1	15.7	30.6	18.7	13.4	np	np	7.1	16.8
Aged 80+ years	1.8	0.6	5.4	7.8	3.1	np	–	1.6	3.6
Age 40+ years (ASR)	20.5	15.8	34.0	21.9	19.8	np	np	13.6	23.1
Age 50–69 years (ASR)	37.0	27.6	46.4	30.8	31.6	39.5	44.2	24.2	35.9
2008–2009									
Aged 40–49 years	7.2	3.7	24.6	12.0	10.1	16.3	6.8	3.8	12.5
Aged 50–59 years	34.3	23.9	47.1	26.6	31.9	36.2	25.3	23.2	34.5
Aged 60–69 years	41.1	32.8	50.6	31.1	34.1	75.6	85.7	26.5	39.7
Aged 70–79 years	11.1	12.4	32.1	14.4	22.1	np	np	5.3	16.9
Aged 80+ years	2.7	0.2	6.7	3.8	4.1	np	–	1.6	4.1
Age 40+ years (ASR)	20.9	15.4	35.2	19.2	21.6	np	np	13.2	23.4
Age 50–69 years (ASR)	37.0	27.4	48.5	28.4	32.8	51.7	49.1	24.5	36.6
2009–2010									
Aged 40–49 years	7.4	4.1	22.9	12.8	8.9	17.8	7.3	3.1	12.1
Aged 50–59 years	32.5	24.4	44.8	29.0	31.5	37.5	26.9	23.2	33.8
Aged 60–69 years	40.8	32.9	50.5	32.8	35.8	77.4	84.4	25.3	39.9
Aged 70–79 years	10.4	12.9	33.2	14.1	17.7	np	np	4.7	16.6
Aged 80+ years	3.0	3.7	5.2	3.8	3.0	np	–	2.1	3.9
Age 40+ years (ASR)	20.4	16.0	34.0	20.4	20.7	np	np	12.7	23.1
Age 50–69 years (ASR)	35.8	27.7	47.0	30.5	33.2	53.2	49.6	24.0	36.2
2010–2011									
Aged 40–49 years	7.3	5.8	22.3	13.9	8.2	16.7	7.0	3.1	12.1
Aged 50–59 years	31.4	27.4	43.8	31.7	32.9	31.4	27.4	24.3	33.7
Aged 60–69 years	39.3	33.4	50.5	36.0	33.9	68.5	78.4	25.5	39.7
Aged 70–79 years	10.1	10.3	34.7	13.8	15.6	np	np	5.3	16.6
Aged 80+ years	2.2	4.9	4.1	6.3	1.0	np	–	3.0	3.6
Age 40+ years (ASR)	19.7	17.2	33.7	22.2	20.1	np	np	13.2	23.0
Age 50–69 years (ASR)	34.5	29.8	46.4	33.4	33.3	46.1	47.5	24.8	36.1
2011–2012									
Aged 40–49 years	8.1	7.4	22.9	15.4	8.6	18.4	6.8	3.6	13.0
Aged 50–59 years	33.0	27.3	45.0	35.8	33.5	31.9	32.8	23.1	35.1
Aged 60–69 years	41.7	35.4	51.8	38.4	34.6	71.4	76.7	26.8	41.6
Aged 70–79 years	10.8	9.5	35.8	16.2	20.0	np	np	4.3	17.7
Aged 80+ years	3.2	3.1	4.9	7.1	1.0	–	–	2.5	3.8
Age 40+ years (ASR)	21.0	17.9	34.7	24.7	21.1	np	np	13.1	24.2
Age 50–69 years (ASR)	36.4	30.5	47.7	36.9	34.0	47.5	50.1	24.6	37.7

Table 11A.85 **Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

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

ASR = age standardised rate.

(a) The populations used to derive rates for Indigenous Australians are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians and for women who speak a language other than English at home.

(b) The participation rate is the number of women resident in the catchment area screened in the reference period, divided by the number of women resident in the catchment area in the reference period based on Australian Bureau of Statistics (ABS) ERP data. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.

(c) Indigenous women are women who self-identified as being of Aboriginal and/or Torres Strait Islander descent.

(d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.

(e) Data for WA may include some Indigenous women usually resident in the NT in in WA catchment areas.

(f) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

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

Source : State and Territory governments unpublished; ABS unpublished, *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021* , Cat. no. 3238.0.

Table 11A.86 **Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT*	*Aust*
2007–2008									
Aged 40–49 years	7.9	3.5	28.9	14.1	12.0	5.8	1.5	6.5	9.4
Aged 50–59 years	47.7	30.0	57.2	56.1	50.1	16.3	14.4	34.3	43.1
Aged 60–69 years	51.9	42.6	66.2	64.5	67.6	29.3	18.8	42.6	51.4
Aged 70–79 years	7.4	16.9	39.3	13.6	13.7	12.8	2.6	9.0	14.4
Aged 80+ years	1.1	0.8	3.0	1.9	1.5	1.6	0.5	1.9	1.3
Aged 40+ years (ASR)	26.2	19.4	42.9	33.7	31.9	13.5	8.2	20.6	26.3
Aged 50–69 years (ASR)	49.4	35.0	60.7	59.4	57.0	21.4	16.2	37.6	46.4
2008–2009									
Aged 40–49 years	7.6	3.1	30.6	14.3	12.6	12.3	1.7	5.4	9.5
Aged 50–59 years	47.1	28.5	59.7	58.2	51.2	28.1	13.1	33.6	42.9
Aged 60–69 years	52.0	39.8	67.5	67.3	66.8	41.2	17.3	44.2	50.8
Aged 70–79 years	7.7	11.2	40.6	13.9	14.3	8.6	3.7	7.4	12.6
Aged 80+ years	1.1	0.8	3.3	2.2	1.9	1.6	0.5	1.5	1.3
Aged 40+ years (ASR)	26.0	17.6	44.7	34.9	32.4	20.5	7.8	20.1	25.9
Aged 50–69 years (ASR)	49.0	33.0	62.8	61.8	57.3	33.3	14.7	37.8	46.0
2009–2010									
Aged 40–49 years	7.1	3.3	29.9	14.3	11.8	17.9	1.7	4.5	9.2
Aged 50–59 years	46.9	30.1	60.0	60.1	49.1	37.6	12.5	33.4	43.5
Aged 60–69 years	52.6	40.5	66.9	69.2	62.2	50.4	17.5	43.6	51.1
Aged 70–79 years	7.7	8.9	41.3	14.5	14.3	10.2	3.6	5.9	11.9
Aged 80+ years	1.1	0.7	3.3	2.1	1.8	1.9	0.5	2.1	1.3
Aged 40+ years (ASR)	25.8	17.9	44.5	35.9	30.7	26.9	7.7	19.5	25.9
Aged 50–69 years (ASR)	49.1	34.2	62.7	63.7	54.3	42.7	14.4	37.4	46.5
2010–2011									
Aged 40–49 years	7.6	4.9	29.0	14.3	11.6	19.7	2.0	4.1	9.8
Aged 50–59 years	46.4	40.7	59.3	59.4	48.3	37.9	12.1	34.6	46.4
Aged 60–69 years	52.9	48.9	65.7	69.7	60.4	50.9	16.7	43.0	53.8
Aged 70–79 years	7.6	8.7	41.1	14.7	14.2	11.0	3.1	6.6	11.8
Aged 80+ years	1.1	0.9	2.8	2.2	1.8	1.7	0.5	2.7	1.3
Aged 40+ years (ASR)	25.9	22.8	43.7	35.8	30.1	27.8	7.5	19.7	27.4
Aged 50–69 years (ASR)	49.0	43.9	61.8	63.4	53.1	43.0	13.9	38.0	49.3
2011–2012									
Aged 40–49 years	6.9	7.3	29.4	15.2	12.2	19.2	2.9	4.6	10.5
Aged 50–59 years	43.3	47.8	59.6	59.2	48.2	39.3	16.6	34.7	47.3
Aged 60–69 years	52.1	55.2	66.2	71.8	58.0	51.4	22.5	42.4	55.7
Aged 70–79 years	7.3	10.6	40.3	15.2	13.6	9.8	3.1	6.2	12.2
Aged 80+ years	0.9	1.2	3.2	2.5	2.2	2.1	0.9	1.6	1.5
Aged 40+ years (ASR)	24.6	27.0	43.9	36.5	29.8	28.0	10.1	19.7	28.3
Aged 50–69 years (ASR)	46.8	50.7	62.2	64.2	52.1	44.1	19.0	37.8	50.6

Table 11A.86 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c)

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

ASR = age standardised rate. **NESB** = Non English speaking background.

(a) The participation rate is the number of NESB women residents in the catchment area screened in the reference period, divided by the estimated number of NESB women resident in the catchment area in that period. The female NESB population estimate is derived by applying the NESB age distribution from the 2011 Census to the Australian Bureau of Statistics (ABS) female ERP data for the relevant year. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area: a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.

(b) Estimated Resident Populations (ERPs) to June 2011 used to derive rates are revised to the ABS' final 2011 Census rebased ERPs and rates may differ from those published in previous reports. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from June 2012 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1) for details. Data are not comparable with data for Indigenous Australians as rates for Indigenous Australians remain based on the 2006 Census.

(c) NESB is defined as persons who speak a language other than English at home.

(d) Residents of Victorian postcodes allocated to the Albury/Wodonga catchment (NSW jurisdiction) are included in Victoria's population estimate, accounting for the slight decrease in participation rates compared to those published by BreastScreen Victoria.

(e) An apparent drop in participation of NESB women in Tasmania occurred from the 2005–2006 screening period and coincided with a significant reduction in self-reporting of NESB status that followed a change in the client registration form in 2006. Since revision of the form in May 2009, both self-reporting of NESB status and participation rates are returning to earlier levels. The observed drop in participation, therefore, appears to reflect the drop in self reporting of NESB status rather than reduced participation.

(f) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

Source : State and Territory governments unpublished; ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0; ABS unpublished, *2006 Census of Population and Housing* .

Table 11A.87 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
2008–2009									
Major Cities									
Aged 40–49 years	8.2	7.2	30.7	16.2	14.6	..	8.7	..	13.3
Aged 50–59 years	50.4	50.1	55.1	55.4	56.4	..	50.1	..	52.2
Aged 60–69 years	55.4	56.6	59.3	59.9	60.8	..	60.2	..	57.5
Aged 70–79 years	10.3	15.8	37.5	15.2	17.9	..	17.1	..	17.6
Aged 80+ years	1.5	1.5	3.3	2.3	2.6	..	2.0	..	2.0
Age 40+ years (ASR)	28.0	28.6	41.4	33.6	33.9	..	29.8	..	31.6
Age 50–69 years (ASR)	52.2	52.5	56.6	57.1	58.1	..	53.8	..	54.1
Inner Regional									
Aged 40–49 years	9.8	7.5	28.8	14.7	14.3	29.5	np	..	15.5
Aged 50–59 years	54.5	53.0	56.9	51.7	55.7	55.0	np	..	54.5
Aged 60–69 years	60.8	60.0	62.1	59.2	65.3	63.4	np	..	61.2
Aged 70–79 years	12.6	18.7	39.8	19.6	22.9	14.8	np	..	20.7
Aged 80+ years	1.8	2.1	3.5	3.3	3.4	1.9	np	..	2.4
Age 40+ years (ASR)	30.9	30.5	41.9	32.5	35.0	38.3	np	..	34.0
Age 50–69 years (ASR)	56.8	55.6	58.8	54.5	59.3	58.1	np	..	57.0
Outer Regional									
Aged 40–49 years	13.5	10.5	36.5	14.9	16.7	29.5	..	7.3	22.1
Aged 50–59 years	54.4	55.9	62.3	55.5	57.2	53.4	..	42.6	56.6
Aged 60–69 years	60.6	61.6	65.8	61.2	63.5	61.5	..	50.0	62.2
Aged 70–79 years	15.7	21.8	42.7	22.6	23.5	18.1	..	7.0	24.7
Aged 80+ years	2.8	3.3	4.1	5.0	5.1	2.8	..	np	3.6
Age 40+ years (ASR)	32.6	33.1	47.2	34.5	36.1	38.0	..	24.0	37.6
Age 50–69 years (ASR)	56.7	58.0	63.6	57.6	59.5	56.3	..	45.5	58.7
Remote									
Aged 40–49 years	22.6	np	35.8	21.2	18.6	np	..	9.8	23.2
Aged 50–59 years	57.7	np	57.1	52.5	64.8	np	..	37.4	53.9
Aged 60–69 years	66.6	np	63.5	61.0	71.7	np	..	42.3	62.5
Aged 70–79 years	19.9	np	42.9	23.3	31.0	np	..	np	28.8
Aged 80+ years	np	np	6.8	np	7.0	np	..	np	5.9
Age 40+ years (ASR)	38.4	37.8	45.3	36.0	41.5	36.8	..	22.7	38.1
Age 50–69 years (ASR)	61.1	np	59.5	55.8	67.4	53.4	..	39.2	57.2
Very remote									
Aged 40–49 years	np	..	35.3	20.4	np	np	..	6.8	22.8
Aged 50–59 years	np	..	58.1	43.5	np	np	..	28.4	47.2
Aged 60–69 years	np	..	58.1	40.8	np	np	..	31.1	49.3
Aged 70–79 years	np	..	38.3	np	np	np	..	np	27.2
Aged 80+ years	np	..	np	np	np	np	..	np	5.4

Table 11A.87 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Age 40+ years (ASR)	52.3	..	43.8	29.1	34.4	np	..	16.7	33.5
Age 50–69 years (ASR)	np	..	58.0	42.5	51.6	np	..	29.2	48.0
2009–2010									
Major Cities									
Aged 40–49 years	7.8	7.0	29.7	16.3	13.5	..	9.2	..	12.8
Aged 50–59 years	49.0	50.9	54.4	57.2	53.5	..	48.8	..	51.7
Aged 60–69 years	55.3	57.1	59.3	61.9	58.3	..	59.6	..	57.5
Aged 70–79 years	10.7	13.2	37.7	15.5	17.7	..	18.0	..	17.0
Aged 80+ years	1.5	1.5	3.3	2.3	2.7	..	1.8	..	2.0
Age 40+ years (ASR)	27.5	28.4	40.9	34.5	32.3	..	29.6	..	31.2
Age 50–69 years (ASR)	51.3	53.2	56.2	59.0	55.3	..	52.8	..	53.9
Inner Regional									
Aged 40–49 years	9.1	7.9	27.3	14.2	13.7	29.6	np	..	15.0
Aged 50–59 years	52.4	55.1	55.1	53.2	55.5	56.3	np	..	54.2
Aged 60–69 years	60.1	61.5	61.8	61.9	65.5	64.0	np	..	61.5
Aged 70–79 years	13.4	16.6	39.5	20.7	23.6	13.3	np	..	20.5
Aged 80+ years	1.7	2.2	3.5	3.8	3.6	1.8	np	..	2.4
Age 40+ years (ASR)	30.0	31.2	40.8	33.4	35.0	38.6	np	..	33.8
Age 50–69 years (ASR)	55.2	57.5	57.6	56.4	59.3	59.1	np	..	56.9
Outer Regional									
Aged 40–49 years	13.2	10.2	34.5	13.7	17.2	31.0	..	6.6	21.4
Aged 50–59 years	52.7	55.7	61.5	51.8	59.2	54.4	..	42.4	55.8
Aged 60–69 years	60.3	61.6	65.3	59.6	65.0	62.6	..	50.6	62.1
Aged 70–79 years	16.7	18.9	43.1	22.6	25.7	16.0	..	6.5	24.7
Aged 80+ years	3.0	3.5	4.1	5.0	5.7	2.8	..	np	3.8
Age 40+ years (ASR)	32.1	32.5	46.2	32.8	37.4	38.6	..	23.8	37.1
Age 50–69 years (ASR)	55.5	58.0	62.9	54.7	61.3	57.4	..	45.6	58.2
Remote									
Aged 40–49 years	23.7	np	34.5	20.5	14.6	np	..	9.6	22.2
Aged 50–59 years	53.5	np	55.3	51.9	48.7	np	..	38.0	50.3
Aged 60–69 years	65.7	np	63.7	62.5	55.9	np	..	42.1	59.5
Aged 70–79 years	23.9	np	41.7	24.1	26.0	np	..	np	28.1
Aged 80+ years	np	np	6.3	np	6.1	np	..	np	6.1
Age 40+ years (ASR)	38.1	37.5	44.1	36.1	32.2	36.3	..	22.8	36.1
Age 50–69 years (ASR)	58.2	np	58.5	56.1	51.5	51.0	..	39.5	53.9
Very remote									
Aged 40–49 years	np	..	32.5	20.5	np	np	..	5.7	21.3
Aged 50–59 years	np	..	54.9	46.6	np	np	..	28.4	46.3

Table 11A.87 **Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Aged 60–69 years	np	..	57.1	44.5	np	np	..	30.4	48.6
Aged 70–79 years	np	..	36.7	na	np	np	..	np	25.4
Aged 80+ years	np	..	np	np	np	np	..	np	5.0
Age 40+ years (ASR)	49.0	..	41.6	30.5	30.5	np	..	16.1	32.4
Age 50–69 years (ASR)	np	..	55.7	45.8	45.6	np	..	29.0	47.2
2010–2011 (i)									
Major Cities									
Aged 40–49 years	na	na	na	na	na	na	na	na	12.3
Aged 50–59 years	na	na	na	na	na	na	na	na	50.8
Aged 60–69 years	na	na	na	na	na	na	na	na	57.0
Aged 70–79 years	na	na	na	na	na	na	na	na	16.7
Aged 80+ years	na	na	na	na	na	na	na	na	2.0
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	30.7
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	53.1
Inner Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	14.9
Aged 50–59 years	na	na	na	na	na	na	na	na	53.6
Aged 60–69 years	na	na	na	na	na	na	na	na	61.3
Aged 70–79 years	na	na	na	na	na	na	na	na	20.2
Aged 80+ years	na	na	na	na	na	na	na	na	2.4
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	33.5
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	56.5
Outer Regional									
Aged 40–49 years	na	na	na	na	na	na	na	na	20.7
Aged 50–59 years	na	na	na	na	na	na	na	na	55.0
Aged 60–69 years	na	na	na	na	na	na	na	na	61.4
Aged 70–79 years	na	na	na	na	na	na	na	na	24.9
Aged 80+ years	na	na	na	na	na	na	na	na	4.1
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	36.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	57.4
Remote									
Aged 40–49 years	na	na	na	na	na	na	na	na	21.7
Aged 50–59 years	na	na	na	na	na	na	na	na	52.2
Aged 60–69 years	na	na	na	na	na	na	na	na	59.9
Aged 70–79 years	na	na	na	na	na	na	na	na	30.7
Aged 80+ years	na	na	na	na	na	na	na	na	6.9
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	37.0
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	55.2
Very remote									

Table 11A.87 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent) (a), (b), (c), (d), (e), (f)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (g)	*NT*	*Aust*
Aged 40–49 years	na	na	na	na	na	na	na	na	19.3
Aged 50–59 years	na	na	na	na	na	na	na	na	43.3
Aged 60–69 years	na	na	na	na	na	na	na	na	49.5
Aged 70–79 years	na	na	na	na	na	na	na	na	28.0
Aged 80+ years	na	na	na	na	na	na	na	na	7.7
Age 40+ years (ASR)	na	na	na	na	na	na	na	na	31.6
Age 50–69 years (ASR)	na	na	na	na	na	na	na	na	45.8

ASR = age standardised rate.

(a) Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the Australian Bureau of Statistics (ABS) estimated resident population (ERP) in each of the calendar years in the reference period. Rates for '40+ years' and '50–69 years' are age standardised to the Australian population at 30 June 2001.

(b) Periods are from 1 January at commencement to 31 December at end of the 24 month period.

(c) Data are suppressed where numerator is less than 5 or denominator is less than 1000.

(d) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *Census of population and housing* for 2006. The accuracy of remoteness classifications decreases over time since the census year due to demographic changes within postcode boundaries. Sources of inaccuracy particularly affect rates based on small numbers and these should be interpreted with caution. Areas where rates are based on small numbers include very remote areas in NSW, SA and Tasmania, remote areas in Victoria and Tasmania, and inner regional areas in the ACT. Minor differences can result in apparently large variations where numerators are small numbers.

(e) Women were allocated to a remoteness area based on postcode of usual residence. Some women's postcodes could not be matched to a remoteness area; these women were excluded from the state and territory calculations, but included in the state and territory and Australia totals. Some postcodes supplied by women may not accurately reflect their usual residence.

(f) Data are not available for the 24 month periods 2007 and 2008, and 2011 and 2012. Data are not available for states and territories for the 24 month period 2010 and 2011.

(g) In general, over 99 per cent of women screened are residents of the jurisdiction in which screening took place. An exception is the ACT, where, for the 2011–2012 reference period, 6.4 per cent of women screened were not ACT residents (table 11A.84).

na Not available. .. Not applicable. **np** Not published.

Source : AIHW unpublished, derived from State and Territory data and ABS Census of population and housing.

Table 11A.88 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

Age group (years)	*NSW*	*Vic* (e), (f)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e), (g)	*NT*	*Aust*
2007 and 2008									
20–24	44.5	46.6	51.5	51.3	49.4	53.5	49.7	52.7	47.9
25–29	56.0	57.1	58.4	57.7	59.5	58.0	58.0	56.5	57.2
30–34	62.6	63.2	61.8	60.3	63.7	60.9	62.0	57.1	62.3
35–39	64.3	66.1	62.3	61.8	64.8	61.8	64.6	59.0	64.0
40–44	64.2	67.1	62.5	61.5	65.7	60.6	63.4	57.7	64.2
45–49	65.0	68.7	63.6	61.6	66.8	61.0	64.3	57.7	65.2
50–54	62.6	67.0	61.0	59.0	65.1	57.8	63.4	56.0	63.0
55–59	59.8	65.3	58.0	55.9	62.6	55.7	64.4	53.7	60.5
60–64	55.8	61.8	54.1	52.0	59.1	51.5	59.2	48.5	56.7
65–69	47.1	54.8	47.4	45.2	53.8	44.5	52.5	41.2	49.4
20–69 years	58.9	61.9	58.9	57.7	61.4	57.4	60.2	55.8	59.6
20–69 years (ASR)	59.1	62.2	59.0	57.6	61.6	57.6	60.6	55.1	59.8
2008 and 2009									
20–24	42.1	44.2	48.8	50.2	47.4	51.6	46.6	52.4	45.6
25–29	53.5	55.5	56.2	56.8	57.8	56.2	55.3	56.5	55.3
30–34	61.1	63.3	60.9	60.6	62.8	60.5	60.8	58.6	61.6
35–39	63.2	66.2	61.7	62.1	64.9	61.2	62.7	59.3	63.6
40–44	63.2	67.3	62.1	62.3	65.4	60.5	63.5	61.2	64.0
45–49	64.0	69.0	63.1	62.1	66.3	61.5	64.0	60.0	64.9
50–54	61.9	67.8	61.2	60.1	65.2	59.1	62.8	59.1	63.2
55–59	59.9	66.3	58.4	56.7	62.8	57.0	63.9	53.8	61.0
60–64	56.1	63.2	54.7	53.5	59.8	53.0	61.1	50.4	57.6
65–69	47.9	55.5	47.8	45.4	53.5	45.7	52.8	43.3	50.0
20–69 years	57.7	61.6	58.1	57.9	60.8	57.3	59.0	57.0	59.0
20–69 years (ASR)	58.0	62.1	58.3	57.9	61.1	57.5	59.6	56.5	59.3
2009 and 2010									
20–24	39.8	42.8	46.3	48.4	45.9	50.5	43.4	50.2	43.6
25–29	51.0	53.9	53.8	55.2	56.0	55.3	53.8	53.5	53.2
30–34	58.8	62.2	58.1	59.3	61.3	59.9	60.0	56.4	59.8
35–39	61.0	65.2	59.4	60.6	64.2	60.5	60.4	57.3	61.9
40–44	61.7	67.0	60.3	61.1	64.4	60.7	62.6	58.8	62.8
45–49	62.8	69.2	61.6	61.9	65.7	61.5	62.4	58.8	64.1
50–54	61.1	68.4	60.4	59.7	64.4	59.5	62.6	57.2	62.8
55–59	59.4	66.3	57.8	57.0	62.7	57.7	63.1	54.0	60.7
60–64	56.4	64.1	54.9	53.9	60.4	54.3	61.7	50.9	58.1
65–69	48.2	55.8	47.3	45.5	53.1	46.8	54.0	43.4	50.0
20–69 years	56.1	61.1	56.3	56.9	59.9	57.2	57.6	55.1	57.8
20–69 years (ASR)	56.5	61.7	56.6	57.1	60.2	57.4	58.5	54.9	58.2

Table 11A.88 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

Age group (years)	*NSW*	*Vic* (e), (f)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e), (g)	*NT*	*Aust*
2010 and 2011									
20–24	39.3	41.7	44.9	46.9	45.0	49.8	40.9	49.0	42.6
25–29	50.4	52.3	52.1	53.2	55.1	54.6	52.9	52.2	52.0
30–34	57.9	59.8	56.3	57.1	61.3	57.6	57.7	54.6	58.2
35–39	60.1	63.4	57.8	58.6	63.1	58.4	60.0	56.3	60.4
40–44	61.2	65.6	58.8	59.2	64.1	59.1	60.4	55.9	61.7
45–49	62.3	68.2	60.8	60.7	65.6	58.6	61.8	57.6	63.4
50–54	61.8	67.7	60.0	58.8	64.2	57.0	63.9	55.4	62.6
55–59	59.4	65.8	57.6	56.5	63.1	56.4	62.4	54.8	60.5
60–64	57.3	64.4	55.6	54.0	61.1	52.9	62.5	50.9	58.6
65–69	48.9	55.7	47.5	45.8	53.3	44.7	55.2	42.7	50.3
20–69 years	55.8	59.8	55.3	55.5	59.5	55.4	56.6	53.7	56.9
20–69 years (ASR)	56.2	60.5	55.6	55.7	59.9	55.6	57.7	53.6	57.3
2011 and 2012									
20–24	39.7	42.1	44.8	46.7	45.2	49.6	40.5	50.6	42.8
25–29	50.6	52.6	52.4	53.2	55.0	56.1	52.3	52.4	52.2
30–34	58.1	59.7	56.6	56.9	60.5	57.3	57.0	54.9	58.2
35–39	60.4	63.7	58.1	58.4	62.1	59.4	59.8	55.0	60.6
40–44	61.5	66.1	58.8	59.2	63.0	59.7	60.6	56.2	61.9
45–49	63.0	68.8	61.1	61.1	65.2	60.8	62.1	58.4	63.9
50–54	62.8	68.7	60.2	59.7	63.5	58.3	62.4	55.9	63.3
55–59	60.2	66.8	58.2	56.7	62.8	57.4	61.6	54.1	61.2
60–64	58.4	65.9	55.8	55.1	61.1	54.0	62.5	50.7	59.5
65–69	50.6	57.1	48.0	47.0	53.2	46.4	54.7	43.5	51.5
20–69 years	56.4	60.4	55.5	55.6	59.1	56.3	56.2	54.0	57.3
20–69 years (ASR)	56.8	61.1	55.8	55.9	59.4	56.6	57.2	53.8	57.7

ASR = age standardised rate.

(a) Rates are the number of women screened as a proportion of the eligible female population calculated as the average of the Australian Bureau of Statistics estimated resident population based on the 2011 Census in each of the calendar years in the reference period. Rates for women aged 20–69 years are age-standardised to the Australian population at 30 June 2001.

(b) The eligible female population has been adjusted for the estimated proportion of women who have had a hysterectomy, using age-specific hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. Historical data may differ from data in previous reports for which hysterectomy fractions were estimated using a different methodology.

(c) Data exclude women who have opted off the cervical cytology register.

(d) Reference periods are from 1 January at commencement to 31 December at end of the 24 month period.

(e) Number of women screened includes all women screened in each jurisdiction, except for Victoria and the ACT. Data may differ from data published elsewhere in which allocation of women to jurisdictions is by residential postcode.

Table 11A.88 **Participation rates for women in cervical screening programs, by age group (per cent) (24 month period) (a), (b), (c), (d), (e)**

Age group (years)	*NSW*	*Vic* (e), (f)	*Qld*	*WA*	*SA*	*Tas*	*ACT* (e), (g)	*NT*	*Aust*

(f) Data for Victoria include only residents of Victoria and, from the the period 2008 and 2009, immediate border residents.

(g) Data for the ACT include only residents of the ACT and, from the period 2008 and 2009, immediate border residents.

Source : AIHW 2013, *Cervical screening in Australia 2010–2011* , Cat. no. CAN 63, AIHW, Canberra; AIHW unpublished, State and Territory Cervical Cytology Registry data.

Table 11A.89 **Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004-05 (per cent)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Age standardised rate (a)	%	41.5	44.6	53.1	42.6	48.0	52.7	53.2	68.5	49.5
RSE	%	7.3	14.4	7.1	6.4	9.1	9.8	12.2	7.9	3.3
95 per cent confidence interval	%	± 8.9	± 16.5	± 6.8	± 7.6	± 9.7	± 9.5	± 11.7	± 5.9	± 3.4

RSE = Relative standard error.

(a) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source : ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey* , 2004-05; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* , 30 June 2004, Series B, Cat. no. 3238.0.

Table 11A.90 **Influenza vaccination coverage, people aged 65 years or over (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003										
People vaccinated	'000	663	499	328	172	186	52	23	5	1 928
Target population	'000	869	642	448	219	225	67	29	8	2 508
People vaccinated	%	76.3	77.7	73.1	78.4	82.8	76.7	80.7	68.1	76.9
2004										
People vaccinated	'000	716	541	353	181	188	53	24	6	2 062
Target population	'000	907	664	465	230	231	69	30	9	2 605
People vaccinated	%	78.9	81.6	75.8	78.7	81.4	77.3	80.0	67.5	79.1
2006										
People vaccinated	'000	710	565	364	194	200	57	25	6	2 121
Target population	'000	945	693	498	246	238	72	32	10	2 735
People vaccinated	%	75.1	81.4	73.1	78.7	83.9	79.2	77.8	63.3	77.5
2009										
People vaccinated	'000	720	550	410	200	200	60	28	8*	2,200
Target population	'000	990	740	550	270	250	77	36	12	2 900
People vaccinated	%	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3*	74.6

(a) A '*' indicates a relative standard error (RSE) of more than 25 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) The Adult Vaccination Survey was not conducted in 2005, 2007, 2008 or 2010.

Source: AIHW 2004, 2005, 2011, *Adult Vaccination Survey: Summary Results*, Cat. no. PHE 51, PHE 56, PHE 135, Canberra; Department of Health unpublished, 2006 Adult Vaccination Survey.

Table 11A.91 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major city										
Proportion	%	48.9	50.6	52.0	46.2	55.0	..	50.4	..	50.2
RSE	%	4.4	4.5	4.8	7.2	5.2	..	6.0	..	2.4
95 per cent confidence interval	%	± 4.2	± 4.5	± 4.9	± 6.5	± 5.6	..	± 5.9	..	± 2.3
Inner regional										
Proportion	%	48.9	51.7	50.4	57.6	64.3	56.0	np	..	51.6
RSE	%	5.7	6.9	7.8	10.1	9.7	6.4	233.2	..	3.3
95 per cent confidence interval	%	± 5.4	± 7.0	± 7.7	± 11.5	± 12.2	± 7.0	np	..	± 3.4
Outer regional										
Proportion	%	49.9	53.5	46.2	51.5	39.8	47.9	..	41.7	48.9
RSE	%	9.0	13.5	11.5	17.7	17.5	9.9	..	7.3	4.2
95 per cent confidence interval	%	± 8.8	± 14.1	± 10.4	± 17.9	± 13.6	± 9.3	..	± 6.0	± 4.0
Remote, very remote (e)										
Proportion	%	56.3	np	66.4	np	46.3	40.8	..	58.3	57.3
RSE	%	35.7	124.6	17.3	53.0	36.0	44.9	..	16.0	10.9
95 per cent confidence interval	%	± 39.3	np	± 22.5	np	± 32.6	± 35.9	..	± 18.2	± 12.2
Total (f)										
Proportion	%	**49.1**	**51.3**	**51.5**	**48.5**	**54.7**	**52.9**	**50.4**	**43.1**	**50.6**
RSE	%	3.3	3.7	3.9	5.7	4.5	6.0	6.0	6.7	1.7
95 per cent confidence interval	%	± 3.2	± 3.7	± 3.9	± 5.4	± 4.8	± 6.2	± 5.9	± 5.7	± 1.7

Table 11A.91 **Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009 (a), (b), (c), (d)**

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

RSE = Relative standard error.

(a) Estimates are for people aged 65 years or over who are fully vaccinated against both influenza and pneumococcal disease. To be 'fully vaccinated' against pneumococcal disease requires a follow-up vaccination up to 5 years after the initial vaccination. This contributes to potential error in the estimates. Influenza vaccinations have been available free to older adults since 1999 while vaccinations against pneumococcal disease became available free in 2005.

(b) Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There were: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(c) Rates are age-standardised to the Australian population at 30 June 2001.

(d) Estimates with relative standard errors (RSEs) between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use and are not published.

(e) Remote and very remote categories have been aggregated due to small numbers.

(f) Total includes people for whom a remoteness category could not be assigned as the place of residence was unknown or not stated.

.. Not applicable. **np** Not published.

Source: AIHW unpublished, 2009 Adult Vaccination Survey.

Table 11A.92 **Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05 (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion	%	18.8	23.0	36.6	29.6	35.9	32.7	8.6	54.7	31.1
Relative standard error	%	19.7	23.8	11.1	13.1	19.8	14.9	54.0	8.9	6.2

(a) Vaccinations against influenza and pneumococcal disease have been available free to Indigenous people aged 50 years or over since 1999.

(b) Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*.

Table 11A.93 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT*	*NT*	*Aust* (c)
Vaccine-preventable conditions									
2007-08	0.7	0.7	0.8	0.6	0.8	0.4	0.8	2.3	0.7
2008-09	0.7	0.8	0.8	0.6	0.7	0.6	0.5	2.3	0.7
2009-10	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.5	0.8
2010-11	0.6	0.8	0.8	0.6	1.0	0.4	0.5	3.0	0.8
2011-12	0.8	0.8	0.9	0.8	0.9	0.5	0.7	3.1	0.8
Acute conditions *excluding dehydration and gastroenteritis*									
2007-08	10.2	11.1	11.2	10.8	11.8	8.7	8.7	16.5	10.8
2008-09	9.9	10.9	11.6	10.8	11.7	8.0	9.3	18.3	10.7
2009-10	10.6	11.7	12.6	12.7	12.5	8.4	8.9	18.2	11.7
2010-11	10.6	11.8	12.6	12.7	12.5	8.4	8.9	18.2	11.7
2011-12	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0
Chronic conditions *excluding diabetes complications (additional diagnoses only)*									
2007-08	12.2	14.2	14.8	12.4	14.3	13.1	8.8	23.1	13.5
2008-09	12.0	13.7	14.1	12.4	14.1	11.7	10.5	22.8	13.1
2009-10	12.1	14.0	14.4	12.8	13.4	11.2	9.6	22.9	13.2
2010-11	10.1	12.1	12.3	10.6	11.6	9.0	8.5	22.6	11.2
2011-12	10.4	11.9	12.5	10.7	11.4	9.1	8.5	21.0	11.3
All potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)* (f)									
2007-08	23.0	25.9	26.6	23.8	26.7	22.1	18.2	41.5	24.9
2008-09	22.5	25.2	26.3	23.7	26.3	20.2	20.2	43.0	24.5
2009-10	22.8	25.8	27.1	24.8	26.1	20.4	17.9	43.1	24.9
2010-11	21.3	24.6	25.6	23.8	25.0	17.7	17.9	43.4	23.6
2011-12	22.0	24.6	26.0	24.9	25.0	18.0	18.7	43.5	24.0

Table 11A.93 **Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people) (a), (b), (c), (d)**

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

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

(b) Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census.

(c) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.

(d) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), the ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards.

(e) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.

(f) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period.

Table 11A.94 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f), (g)	*ACT* (f)	*NT*	*Aust* (d)
Vaccine preventable conditions									
Indigenous Australians									
2007-08	1.4	1.4	1.8	4.2	3.4	np	np	6.9	2.7
2008-09	1.6	1.3	1.9	3.4	3.3	0.3	np	6.8	2.7
2009-10	2.0	1.3	3.7	5.5	4.2	0.8	np	7.5	3.7
2010-11	1.7	1.6	2.9	4.0	3.7	0.5	0.4	9.6	3.4
2011-12	1.8	2.1	2.4	4.6	4.0	0.5	1.9	9.3	3.3
Non-Indigenous Australians (h)									
2007-08	0.7	0.7	0.8	0.6	0.7	np	np	1.0	0.7
2008-09	0.7	0.8	0.8	0.5	0.7	0.6	0.5	0.9	0.7
2009-10	0.7	0.7	0.8	0.7	0.9	0.7	0.5	0.9	0.8
2010-11	0.6	0.8	0.8	0.5	0.9	0.4	0.5	1.0	0.7
2011-12	0.8	0.8	0.8	0.6	0.9	0.5	0.7	1.1	0.8
Acute conditions *excluding dehydration and gastroenteritis*									
Indigenous Australians									
2007-08	20.3	15.7	28.0	39.9	32.5	np	np	35.5	26.7
2008-09	19.7	17.2	27.7	36.7	31.1	6.6	13.2	39.7	27.5
2009-10	19.2	16.9	26.6	36.5	31.6	9.1	10.1	39.4	26.1
2010-11	21.3	21.5	28.5	42.0	33.1	8.3	14.9	37.3	29.0
2011-12	23.1	23.5	29.3	43.0	36.9	9.5	20.9	40.2	29.8
Non-Indigenous Australians (h)									
2007-08	10.2	11.3	10.9	10.3	11.6	np	np	10.0	10.7
2008-09	9.9	11.0	11.3	10.3	11.5	8.2	9.5	10.1	10.6
2009-10	9.9	11.1	11.4	10.5	11.7	8.6	7.9	9.6	10.7
2010-11	10.5	11.6	11.8	11.8	12.2	6.6	7.0	9.1	11.3
2011-12	10.7	12.1	12.2	12.7	12.6	8.4	9.4	11.6	11.6

Table 11A.94 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f), (g)	*ACT* (f)	*NT*	*Aust* (d)
Chronic conditions excluding diabetes complications *(additional diagnoses only)*									
Indigenous Australians									
2007-08	36.3	25.2	49.0	59.1	60.8	np	np	51.6	44.2
2008-09	36.0	27.0	49.7	55.6	55.8	16.6	23.6	53.4	45.4
2009-10	34.7	29.1	46.1	53.1	47.3	13.1	16.3	56.3	43.7
2010-11	30.4	26.4	38.3	45.9	41.7	12.9	27.3	52.5	38.0
2011-12	35.7	31.9	39.5	45.5	42.9	17.3	26.0	52.0	39.5
Non-Indigenous Australians (h)									
2007-08	12.3	14.5	14.3	11.9	14.3	np	np	15.9	13.3
2008-09	12.1	14.0	13.6	11.9	14.1	11.9	10.7	14.9	13.0
2009-10	11.9	13.9	13.5	12.0	13.2	11.2	9.4	12.8	12.8
2010-11	10.0	12.1	11.5	9.9	11.5	7.3	7.2	11.3	10.9
2011-12	10.3	12.1	11.9	10.0	11.4	9.0	8.4	11.4	11.0
All potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)* (i)									
Indigenous Australians									
2007-08	57.8	42.2	78.1	101.6	96.0	np	np	92.3	72.8
2008-09	57.1	45.3	78.3	94.3	89.6	23.3	38.1	98.2	74.7
2009-10	55.6	47.0	75.6	93.9	82.6	22.4	26.8	101.5	73.6
2010-11	53.2	49.2	69.2	91.1	78.0	21.6	42.6	97.5	69.8
2011-12	60.3	57.2	70.5	92.4	82.8	27.2	48.8	99.7	72.0
Non-Indigenous Australians (h)									
2007-08	23.0	26.4	25.8	22.7	26.5	np	np	26.7	24.6
2008-09	22.6	25.7	25.5	22.7	26.2	20.6	20.6	25.8	24.3
2009-10	22.5	25.7	25.5	23.0	25.6	20.4	17.8	23.1	24.2
2010-11	21.0	24.5	24.0	22.1	24.4	14.2	14.7	21.3	22.9
2011-12	21.7	24.8	24.8	23.2	24.7	17.8	18.4	24.0	23.3

Table 11A.94 **Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f), (g)	*ACT* (f)	*NT*	*Aust* (d)

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

(b) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.

(d) Separation rates are based on state or territory of usual residence, not state or territory of hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.

(e) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), the ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards.

(f) From 2011-12, Indigenous status data are of sufficient quality for statistical reporting purposes for all states and territories. Data for Tasmania and the ACT were not included in national totals in previous years, and were not published for 2007-08.

(g) Tasmanian data are not comparable over time as 2008-09 data exclude two private hospitals that account for approximately one eighth of Tasmania's total hospital separations, while data for subsequent reference years include these hospitals.

(h) Non-Indigenous Australians includes separations where Indigenous status was not stated.

(i) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

np Not published.

Source : AIHW unpublished, National Hospital Morbidity Database; ABS unpublished, Estimated Resident Population, 30 June preceding the reference period. ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021* , Series B, Cat. no. 3238.0.

Table 11A.95 **Separations for selected potentially preventable hospitalisations by remoteness, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (e)
Vaccine preventable conditions									
Major cities	0.8	0.8	0.9	0.7	0.9	..	0.7	..	0.8
Inner regional	0.8	0.6	0.8	0.6	0.9	0.5	np	..	0.7
Outer regional	1.0	0.8	0.8	1.1	0.9	0.9	..	1.4	0.9
Remote	1.0	np	1.4	1.5	1.0	0.3	..	4.5	1.7
Very remote	1.7	..	1.5	2.2	2.9	np	..	6.9	3.0
Acute conditions *excluding dehydration and gastroenteritis*									
Major cities	10.2	11.4	11.4	12.8	12.1	..	9.5	..	11.2
Inner regional	12.5	14.2	13.6	12.7	12.8	8.1	14.4	..	12.8
Outer regional	13.6	15.0	14.9	15.2	16.3	16.0	..	13.1	13.8
Remote	21.3	12.1	21.4	19.1	14.5	10.9	..	25.3	20.0
Very remote	24.6	..	25.8	24.3	26.0	15.9	..	31.8	26.6
Chronic conditions *excluding diabetes complications (additional diagnoses only)*									
Major cities	9.4	11.7	11.5	9.6	10.8	..	8.5	..	10.5
Inner regional	12.0	12.4	13.0	11.0	11.2	9.2	10.9	..	12.0
Outer regional	14.7	13.6	14.3	13.7	15.0	9.1	..	13.6	12.9
Remote	–	–	–	–	–	–	–	–	–
Very remote	30.4	..	24.6	20.8	23.7	22.0	..	38.0	26.6
All potentially preventable hospitalisations *excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only)* (g)									
Major cities	20.3	23.8	23.6	23.0	23.7	..	18.6	..	22.3
Inner regional	25.1	27.1	27.3	24.2	24.8	17.8	27.3	..	25.4
Outer regional	29.2	29.3	29.9	29.8	32.1	25.9	..	27.9	27.5
Remote	46.6	23.6	41.4	35.7	25.8	20.4	..	56.1	39.4
Very remote	56.4	..	51.6	46.9	52.2	38.1	..	75.4	55.7

Table 11A.95 **Separations for selected potentially preventable hospitalisations by remoteness, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

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

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

(b) Rates may differ from previous reports as they have been revised using ERPs based on the 2011 Census.

(c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.

(d) Remoteness areas are defined using the Australian Standard Geographical Classification (ASGC), based on the ABS *2006 Census of population and housing*. Not all remoteness areas are represented in each state or territory. There are: no major cities in Tasmania; no outer regional, remote or very remote areas in the ACT; no major cities or inner regional areas in the NT.

(e) Separation rates are based on state or territory and remoteness area of usual residence, not hospitalisation. Separations for patients usually resident overseas are excluded. Totals include Australian residents of external Territories.

(f) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), the ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards.

(g) More than one category may be reported during the same hospitalisation. Therefore, the total is not necessarily equal to the sum of the components.

.. Not applicable. **np** Not published.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period.

Table 11A.96 Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people) (a), (b), (c), (d), (e), (f)

	Major cities	*Inner regional*	*Outer regional*	*Remote*	*Very remote*
Potentially preventable hospitalisations *excluding dehydration and gastroenteritis and additional diagnoses of diabetes complications*					
Indigenous Australians					
2007-08	43.3	59.4	95.3	195.7	152.4
2008-09	49.2	59.5	96.7	184.9	158.9
2009-10	46.6	60.9	98.0	183.1	153.2
2010-11	44.5	56.9	89.8	184.1	146.3
2011-12	49.2	64.8	98.2	175.7	161.5
Non-Indigenous Australians (g)					
2007-08	22.7	26.0	29.9	32.5	33.5
2008-09	22.9	25.9	29.9	31.1	34.0
2009-10	22.9	25.9	29.3	31.5	33.8
2010-11	21.7	24.8	28.0	30.7	33.3
2011-12	22.5	26.9	30.4	31.1	35.0

(a) Rates are age-standardised to the Australian estimated resident population at 30 June 2001.

The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(b) Historical data have been revised and differ from previous reports.

(c) Cells have been suppressed to protect confidentiality where a patient or service provider could be identified or where rates are likely to be highly volatile, for example, where the denominator is very small.

(d) Separations for patients usually resident overseas are excluded.

(e) Separation rates are based on patient's usual residence (not hospital location).

(f) Caution should be used in comparing data over time due to changes between the ICD-10-AM 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11).

(g) 'Non-Indigenous Australians' includes separations where Indigenous status was not stated.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Resident Population, 30 June preceding the reference period. ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Series B, Cat. no. 3238.0.

Table 11A.97 **Separations for selected vaccine preventable conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Vaccine preventable conditions per 1000 Indigenous Australians									
Influenza and Pneumonia	1.4	1.5	2.0	3.8	3.7	0.5	1.6	7.3	2.7
Other vaccine preventable conditions	0.4	0.6	0.4	0.9	0.3	–	0.2	2.0	0.6
Total	**1.8**	**2.1**	**2.4**	**4.6**	**4.0**	**0.5**	**1.9**	**9.3**	**3.3**
Vaccine preventable conditions per 1000 non-Indigenous Australians (i)									
Influenza and Pneumonia	0.6	0.5	0.7	0.5	0.8	0.4	0.6	0.8	0.6
Other vaccine preventable conditions	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.3	0.2
Total	**0.8**	**0.8**	**0.8**	**0.6**	**0.9**	**0.5**	**0.7**	**1.1**	**0.8**
Vaccine preventable conditions per 1000 people (all people) (j)									
Influenza and Pneumonia	0.6	0.5	0.7	0.6	0.8	0.4	0.6	2.5	0.6
Other vaccine preventable conditions	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.6	0.2
Total	**0.8**	**0.8**	**0.9**	**0.8**	**0.9**	**0.5**	**0.7**	**3.1**	**0.8**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2013 *Australian hospital statistics 2011-12* .

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(f) Indigenous status data reported for Tasmania and the ACT are included in the Australian total for the first time. Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data for Indigenous and non-Indigenous Australians are for public hospitals only.

Table 11A.97 **Separations for selected vaccine preventable conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)

(h) Data for Australia include Australian residents of external Territories.

(i) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(j) The rates presented for Indigenous people and non-Indigenous Australians are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

– Nil or rounded to zero.

Source : AIHW 2013, *Australian hospital statistics 2011-12* , Cat. no. HSE 134; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.98 **Separations for selected acute conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Acute conditions per 1000 Indigenous Australians									
Appendicitis with generalised peritonitis	0.3	0.3	0.5	0.5	0.4	0.4	0.1	0.8	0.5
Cellulitis	4.3	3.2	6.3	7.8	4.8	1.2	1.5	7.2	5.5
Convulsions and epilepsy	6.2	5.1	6.0	10.0	14.0	1.0	5.5	10.6	7.4
Dehydration and gastroenteritis	4.1	4.7	3.8	4.8	5.2	1.3	1.2	5.0	4.2
Dental conditions	3.5	4.8	3.9	4.9	5.5	2.3	5.9	5.7	4.2
Ear, nose and throat infections	2.8	3.3	3.1	6.1	4.3	1.3	1.6	4.7	3.6
Gangrene	0.4	1.2	1.1	2.5	0.7	0.6	0.3	1.8	1.1
Pelvic inflammatory disease	0.4	0.3	0.6	1.5	0.7	0.4	0.3	1.2	0.7
Perforated/bleeding ulcer	0.4	0.3	0.6	0.3	0.3	0.2	–	0.2	0.4
Pyelonephritis (i)	4.8	5.0	7.2	9.5	6.2	2.1	5.5	8.1	6.5
Total	**27.2**	**28.2**	**33.1**	**47.7**	**42.1**	**10.7**	**22.1**	**45.2**	**34.0**
Total — excluding dehydration and gastroenteritis	23.1	23.5	29.3	43.0	36.9	9.5	20.9	40.2	29.8
Acute conditions per 1000 non-Indigenous Australians (j)									
Appendicitis with generalised peritonitis	0.4	0.3	0.4	0.4	0.4	0.3	0.2	0.4	0.4
Cellulitis	1.9	1.8	2.0	1.7	1.6	1.3	1.4	2.7	1.8
Convulsions and epilepsy	1.5	1.5	1.5	1.3	1.5	1.2	1.4	1.1	1.5

Table 11A.98 **Separations for selected acute conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Dehydration and gastroenteritis	2.6	3.5	3.0	2.6	2.7	2.0	1.8	2.2	2.9
Dental conditions	2.3	3.1	2.8	3.8	3.6	2.3	2.2	1.7	2.8
Ear, nose and throat infections	1.5	1.7	1.8	1.9	2.2	1.2	1.1	1.9	1.7
Gangrene	0.2	0.4	0.3	0.3	0.2	0.2	0.1	0.5	0.3
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis (i)	2.6	2.9	2.9	2.9	2.6	1.6	2.6	2.8	2.7
Total	**13.4**	**15.6**	**15.3**	**15.3**	**15.3**	**10.4**	**11.2**	**13.9**	**14.6**
Total — excluding dehydration and gastroenteritis	10.7	12.1	12.2	12.7	12.6	8.4	9.4	11.6	11.6
Acute conditions per 1000 people (all people) (k)									
Appendicitis with generalised peritonitis	0.4	0.3	0.4	0.4	0.4	0.3	0.2	0.5	0.4
Cellulitis	1.9	1.8	2.1	1.9	1.7	1.3	1.4	4.1	1.9
Convulsions and epilepsy	1.6	1.5	1.7	1.5	1.7	1.2	1.4	3.4	1.6
Dehydration and gastroenteritis	2.6	3.5	3.1	2.7	2.7	2.0	1.8	3.2	2.9
Dental conditions	2.3	3.1	2.9	3.9	3.6	2.3	2.2	3.1	2.9
Ear, nose and throat infections	1.6	1.8	1.9	2.1	2.3	1.1	1.1	2.8	1.8
Gangrene	0.2	0.4	0.3	0.4	0.2	0.2	0.1	0.8	0.3

Table 11A.98 **Separations for selected acute conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.6	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis (i)	2.6	2.8	3.0	3.0	2.5	1.6	2.6	4.4	2.7
Total	**13.5**	**15.6**	**15.8**	**16.2**	**15.6**	**10.4**	**11.3**	**23.0**	**14.9**
Total — excluding dehydration and gastroenteritis	10.9	12.0	12.7	13.6	12.8	8.5	9.5	19.8	12.0

(a) Conditions defined by ICD-10-AM codes as in AIHW 2013 *Australian hospital statistics 2011-12* .

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

(e) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(f) Indigenous status data reported for Tasmania and the ACT are included in the Australian total for the first time. Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data for Indigenous and non-Indigenous Australians are for public hospitals only.

(h) Data for Australia include Australian residents of external Territories.

(i) Kidney inflammation caused by bacterial infection.

(j) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(k) The rates presented for Indigenous people and non-Indigenous Australians are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

– Nil or rounded to zero.

Source : AIHW 2013, *Australian hospital statistics 2011-12* , Cat. no. HSE 134; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.99 **Separations for selected chronic conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Chronic conditions per 1000 Indigenous Australians									
Angina	4.1	3.6	5.2	4.5	3.5	1.7	–	2.8	4.1
Asthma	3.5	3.5	3.2	5.2	4.5	0.8	2.0	4.0	3.7
Chronic obstructive pulmonary disease	14.9	12.5	12.0	12.3	17.8	6.2	6.1	20.4	14.1
Congestive heart failure	4.5	2.9	6.2	8.6	5.8	3.1	4.6	8.9	5.9
Diabetes complications (i)	5.6	6.5	8.6	10.0	8.7	2.5	10.0	9.8	7.6
Hypertension	0.9	0.4	0.8	1.0	0.7	0.5	0.3	0.7	0.8
Iron deficiency anaemia	1.9	1.8	2.5	2.9	1.5	2.4	2.0	3.1	2.4
Nutritional deficiencies	0.1	0.2	0.1	–	–	–	–	0.1	0.1
Rheumatic heart disease (j)	0.2	0.3	0.7	0.9	0.4	–	1.1	2.2	0.7
Total (i), (k)	**35.7**	**31.9**	**39.5**	**45.5**	**42.9**	**17.3**	**26.0**	**52.0**	**39.5**
Chronic conditions per 1000 non-Indigenous Australians (l)									
Angina	1.0	1.2	1.8	1.3	1.3	0.9	0.7	2.1	1.3
Asthma	1.8	2.0	1.6	1.3	1.8	1.1	1.2	1.3	1.7
Chronic obstructive pulmonary disease	2.6	2.6	2.9	2.2	2.6	2.0	2.3	3.2	2.6
Congestive heart failure	1.9	2.3	2.0	1.9	2.0	1.4	1.7	1.8	2.0
Diabetes complications (i)	1.3	1.7	1.7	1.4	1.8	1.8	1.1	1.7	1.5
Hypertension	0.3	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.3
Iron deficiency anaemia	1.1	1.9	1.2	1.5	1.4	1.6	1.1	0.9	1.4
Nutritional deficiencies	–	–	–	–	–	–	–	–	0.0
Rheumatic heart disease (j)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1

Table 11A.99 **Separations for selected chronic conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)
Total (i), (k), (l)	**10.3**	**12.1**	**11.9**	**10.0**	**11.4**	**9.0**	**8.4**	**11.4**	**11.0**
Chronic conditions per 1000 people (all people) (m)									
Angina	1.0	1.2	1.9	1.3	1.3	0.9	0.7	2.4	1.3
Asthma	1.8	2.0	1.7	1.4	1.9	1.0	1.2	1.9	1.8
Chronic obstructive pulmonary disease	2.7	2.6	3.1	2.4	2.7	2.1	2.4	7.1	2.8
Congestive heart failure	1.9	2.2	2.1	1.9	1.8	1.4	1.6	3.5	2.0
Diabetes complications	2.5	3.1	4.3	8.0	3.1	2.9	2.0	6.8	3.6
Diabetes complications (i)	1.4	1.7	1.8	1.6	1.9	1.8	1.2	3.3	1.6
Hypertension	0.3	0.3	0.5	0.3	0.3	0.2	0.2	0.2	0.3
Iron deficiency anaemia	1.1	1.9	1.3	1.6	1.4	1.6	1.1	1.5	1.4
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	..	<0.1	0.1	<0.1
Rheumatic heart disease (j)	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.9	0.1
Total (k)	**11.3**	**13.0**	**14.5**	**16.8**	**12.3**	**9.9**	**9.1**	**23.4**	**13.0**
Total (i), (k)	**10.4**	**11.9**	**12.5**	**10.7**	**11.4**	**9.1**	**8.5**	**21.0**	**11.3**

(a) Conditions defined by ICD-10-AM codes as in AIHW 2013 *Australian hospital statistics 2011-12* . Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

(b) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(c) Separation rates are directly age standardised to the Australian population at 30 June 2001.

(d) Separation rates are based on state or territory of usual residence.

Table 11A.99 **Separations for selected chronic conditions by Indigenous status, 2011-12 (per 1000 people) (a), (b), (c), (d), (e), (f)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (g)	*Aust* (f), (h)

(e) The populations used to derive the Indigenous Australians and non-Indigenous Australians' rates are based on the 2006 Census and are not comparable with the 2011 based populations used to derive the rates for all Australians.

(f) Indigenous status data reported for Tasmania and the ACT are included in the Australian total for the first time. Indigenous status data for all states and territories are of sufficient quality for statistical reporting purposes from the 2011-12 reporting year.

(g) NT data for Indigenous and non-Indigenous Australians are for public hospitals only.

(h) Data for Australia include Australian residents of external Territories.

(i) Excludes separations with an additional diagnosis of diabetes complications.

(j) Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease.

(k) Total may not sum to the individual categories as more than one chronic condition can be reported for a separation.

(l) Data for non-Indigenous Australians include separations where Indigenous status was not stated.

(m) The rates presented for Indigenous people and non-Indigenous Australians are based on a slightly different methodology than those for all people. Direct comparisons of rates for all people to either the Indigenous or non-Indigenous rates should therefore be made with caution.

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

Source : AIHW 2013, *Australian hospital statistics 2011-12* , Cat. no. HSE 134; AIHW unpublished, National Hospital Morbidity Database.

Table 11A.100 **Ratio of separations for Indigenous Australians to all Australians, diabetes, 2011-12 (a), (b), (c), (d), (e), (f), (g)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas* (b)	*ACT* (b)	*NT* (b)	*Total*
Diabetes as a primary diagnosis (h)	no.	632	173	1 203	494	181	37	27	645	3 392
	SHSR	4.18	3.91	5.93	6.59	4.32	1.38	7.06	6.86	5.40
All diabetes — excluding diabetes complications as an additional diagnosis (i)	no.	876	219	1 487	781	251	50	33	834	4 531
	SHSR	3.36	2.91	4.20	6.48	4.45	1.27	5.92	6.71	4.32
All diabetes (j)	no.	2 528	670	4 947	10 424	1 062	141	71	3 556	23 399
	SHSR	3.66	3.07	5.20	26.42	7.51	1.72	4.04	9.03	8.24

SHSR = Standardised Hospital Separation Ratio

(a) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(b) Data are available for Tasmania and the ACT for the first time. NT data are for public hospitals only.

(c) Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

(d) Ratios are directly age standardised to the Australian estimated resident population at 30 June 2001.

(e) Patients aged 75 years or over are excluded.

(f) Separation rates are based on state of usual residence.

(g) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

(h) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or O24'.

(i) Includes ICD-10-AM codes of Principal diagnosis in: 'E10', 'E11', 'E13', 'E14' or 'O24' or Additional diagnosis in 'E109', 'E119', 'E139' or 'E149'.

(j) All diabetes refers to separations with either a principal or additional diagnosis of diabetes. Includes ICD-10-AM codes in: 'E10', 'E11', 'E13', 'E14' or O24'.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.101 **Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2011-12 (per 100 000 people) (a), (b), (c), (d), (e), (f), (g), (h)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Circulatory	2.6	1.7	2.9	2.7	1.8	np	np	np	2.3
Renal	3.4	2.2	5.0	1.9	3.6	np	np	np	3.3
Ophthalmic	3.4	6.8	4.9	10.2	6.9	np	np	np	5.7
Other specified	36.6	41.5	52.1	40.8	54.9	np	np	np	43.5
Multiple	25.4	33.5	43.4	35.6	41.1	np	np	np	34.5
No complications	4.0	5.4	4.1	4.1	4.6	np	np	np	4.4
Total (g)	**75.3**	**91.1**	**112.4**	**95.3**	**112.9**	**np**	**np**	**np**	**93.8**

(a) Rates are age standardised to the Australian resident population at 30 June 2001.

(b) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.

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

(d) 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.

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

(f) 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.

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

(h) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.102 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2011-12 (per cent) (a), (b), (c), (d), (e), (f), (g), (h)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (g)
Circulatory	9.2	7.3	16.5	–	18.4	np	np	np	10.0
Renal	13.6	16.4	12.8	17.8	24.3	np	np	np	15.1
Ophthalmic	76.2	82.7	89.4	87.9	97.1	np	np	np	85.2
Other specified	12.2	17.6	24.0	12.7	24.0	np	np	np	18.0
Multiple	16.4	14.1	16.9	14.1	23.7	np	np	np	16.8
No complications	35.9	55.4	29.9	24.5	48.8	np	np	np	40.0
Total	**17.6**	**23.1**	**23.7**	**21.7**	**29.2**	**np**	**np**	**np**	**22.4**

(a) Data are for the number of same day separations with the specified principal diagnosis, as a per cent of all separations with the specified principal diagnosis.

(b) Rates are age-standardised to the Australian resident population at 30 June 2001.

(c) Excludes separations with a care type of Newborn without qualified days, and records for hospital boarders and posthumous organ procurement.

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

(e) 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.

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

(g) 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.

(h) Changes to the Australian Coding Standards between ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09, 2009-10) and between 6th edition and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) resulted in decreased reporting of additional diagnoses for diabetes. Therefore caution should be used in comparisons of these data with earlier periods.

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

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.103 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2011-12 (a), (b), (c), (d), (e)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
ASR	per 100 000 people	10.3	13.4	14.3	13.8	17.0	np	np	np	13.3
Crude	per 100 000 people	11.8	14.9	15.3	14.0	20.9	np	np	np	14.6
Separations	no.	852	823	685	329	342	np	np	np	3 268

ASR = Age standardised rate

(a) ASR rates are age standardised to the Australian estimated resident population at 30 June 2001.

(b) Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation.

(c) Excludes separations with a care type of Newborn without qualified days, and records for Hospital boarders and Posthumous organ procurement.

(d) 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.

(e) Changes to the Australian Coding Standards for diabetes mellitus and impaired glucose regulation between 2009-10 and 2010-11 resulted in marked decreases in the reporting of these conditions. See *Australian hospital statistics 2010-11* (Appendix 2).

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Table 11A.104 **Separation rates of older people for injuries due to falls (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (d)
2005-06									
Separations per 1000 older people	48.5	46.2	40.6	43.3	34.6	32.0	48.8	45.7	44.3
Number	46 425	32 911	20 058	10 409	8 780	2 348	1 516	340	122 787
2006-07									
Separations per 1000 older people	51.6	48.5	43.0	43.8	35.8	32.7	52.2	47.8	46.7
Number of separations	50 938	35 649	22 078	10 954	9 358	2 455	1 697	375	133 504
2007-08									
Separations per 1000 older people	51.6	48.6	42.9	43.7	36.4	34.1	60.1	43.2	46.8
Number of separations	52 463	36 855	22 851	11 319	9 762	2 616	2 051	366	138 283
2008-09									
Separations per 1000 older people	52.4	47.6	45.7	44.6	39.0	32.9	65.0	43.2	47.7
Number	54 998	37 337	25 092	12 009	10 759	2 580	2 318	383	145 476
2009-10									
Separations per 1000 older people	55.9	49.5	47.1	46.2	43.0	32.8	68.2	43.3	50.1
Number of separations	60 117	39 885	26 759	12 877	12 059	2 638	2 546	408	157 289
2010-11 (d)									
Separations per 1000 older people	60.4	53.0	51.7	52.1	43.0	32.7	65.6	np	54.0
Number of separations	np	np	np	np	np	np	np	np	np
2011-12									
Separations per 1000 older people	61.6	55.2	56.2	56.8	46.0	33.7	73.0	54.0	56.5
Number of separations	68 833	45 953	32 782	16 539	13 297	2 845	2 858	513	183 620

(a) Excludes separations records for Hospital Boarders and Posthumous organ procurement.

(b) Older people are defined as people aged 65 years or over.

(c) Separation rates are age standardised to the the Australian population aged 65 years or over at 30 June 2001.

(d) The Australian total for 2010-11 does not include NT data.

np Not published.

Source: AIHW unpublished, National Hospital Morbidity Database.

Community health services programs

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Asthma Australia – Adolescent and Child Asthma Program	The Adolescent and Child Asthma Program is a national health promotion and prevention program delivered by Asthma Australia. The program aims to provide information and training about asthma and linked chronic respiratory conditions across schools and educational settings with a focus on social inclusion and includes tools and training for better self-management of these conditions among children, young people, parents, care givers and school staff in schools and community settings.	Funding is provided through the Department of Health's Chronic Disease Prevention and Service Improvement Fund. The program is administered by Asthma Australia.	Financial and program performance reports are submitted biannually for assessment against an agreed reporting framework and funding agreement.
Asthma Australia – Community Support Program	The Community Support Program is a national health promotion and prevention program delivered by Asthma Australia. The program aims to provide information, support and training within community settings to improve the self-management of asthma and linked chronic respiratory conditions. Target groups for the program are older Australians, culturally and linguistically diverse Australians, Aboriginal and Torres Strait Islander peoples, rural and remote communities, people residing in lower socio-economic areas and those with limited literacy skills. Delivery of the program takes place within primary health care and other community settings to increase the capacity of people with asthma and linked chronic respiratory conditions to access medical support and assistance.	Funding is provided through the Department of Health's Chronic Disease Prevention and Service Improvement Fund. The program is administered by Asthma Australia.	Financial and program performance reports are submitted biannually for assessment against an agreed reporting framework and funding agreement.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Healthy Communities initiative under the National Partnership Agreement on Preventive Health	The Healthy Communities initiative provides grant funding to Local Government Areas (LGAs) to implement a range of community-based healthy lifestyle programs that facilitate increased access to physical activity, healthy eating and healthy weight programs and activities. This preventive health initiative seeks to address the rising prevalence of lifestyle related chronic disease by laying the foundations for healthy behaviours in the daily lives of Australians through the community setting. The initiative targets disadvantaged populations and adults predominantly not in the workforce. Grants to LGAs support the delivery of proven and effective healthy lifestyle programs in every state and territory.	Funding for the Healthy Communities initiative is under the National Partnership Agreement on Preventive Health. The Department of Health is responsible for administering funding agreements with 92 LGAs to deliver programs in their local area.	Financial and activity reports submitted regularly to the Department in line with funding agreements between the Commonwealth and individual LGAs. Progress and financial reporting is not publicly available. Evaluation of the initiative is being undertaken by a consultancy under contract with the Department.
Medical Specialist Outreach Assistance Program	The Medical Specialist Outreach Assistance Program (MSOAP) improves access to medical specialist services for people living in rural and remote locations, by removing the financial disincentives incurred by specialists who provide outreach services. This is achieved by meeting costs associated with delivering outreach services such as travel, accommodation, and venue hire.	Funding for MSOAP is provided by the Department of Health. The program is administered by Rural and Regional Health Australia.	Quarterly financial and service activity reports.
	The MSOAP-Indigenous Chronic Disease (MSOAP-ICD) is an expansion of the MSOAP, focusing on chronic disease in Aboriginal and Torres Strait Islander communities. The MSOAP-ICD supports specialists, allied health professionals and general practitioners as part of a multidisciplinary team.	Funding for MSOAP-ICD is provided by the Department of Health by Rural and Regional Health Australia.	Quarterly financial and service activity reports, as well as Sentinel Sites Evaluation.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Rural Primary Health Services Program (RPHS)	The aim of the RPHS program is to improve the health and wellbeing of people in rural and remote Australia. The program funds a range of organisations such as state health entities, local governments, Indigenous health services, Medicare Locals and other non-government organisations, to provide supplementary primary and allied health care services in rural and remote communities. Services included mental health, social work, community nursing, Aboriginal health, family health, and community health education, promotion and prevention.The type of services delivered depends on the identified needs of the target communities.	Funding for the RPHS program is provided by the Department of Health.	Non-Medicare Local funded organisations provide six and twelve month financial and activity reports, as well as final reports. Medicare Locals provide six and twelve month financial and activity reports.
Royal Flying Doctor Service of Australia (RFDS)	The Royal Flying Doctor Service of Australia (RFDS) is funded to provide 'traditional services'; these are, emergency primary aero-medical transfers, primary health (GP and nursing), medical chests and remote (telehealth) consultations in rural and remote Australia (NSW, QLD, SA, WA and NT from Tennant Creek to the SA border). The services are provided for people, living, working and travelling in rural and remote Australia who are beyond the normal medical infrastructure.	Funding for the delivery of RFDS 'traditional services' is provided by the Department of Health.	Quarterly activity and financial reporting as well as annual activity and financial reports.
Rural Women's GP Service Program (RWGPS)	The Royal Flying Doctor Service of Australia (RFDS) is funded to provide the Rural Women's GP Service Program (RWGPS). The RWGPS aims to improve access to primary health care services for women in rural and remote Australia who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities. The RWGPS is open to all members of the community, including men and children.	Funding for the delivery of the RWGPS is provided by the Department of Health.	Brief quarterly reports and six and twelve month reports.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Medicare Locals Program	Medicare Locals operate as health system planners at the regional level. They are working with service providers and the community to identify the health needs and service gaps of their local area populations, including for disadvantaged or underserviced populations (e.g. Aboriginal or Torres Strait Islander people and people from culturally and linguistically diverse backgrounds). Medicare Locals deliver a variety of health services to address service gaps and barriers (e.g. cultural, language, financial, service availability, geographical) to accessing services. The range of services delivered by Medicare Locals varies according to the health needs of the local community and includes after hours services, psychological services, Aboriginal and Torres Strait Islander health, care coordination and supplementary services, community health promotion and self-management, eHealth change and adoption, nursing, pharmacy support, asthma and diabetes education. Primary and community health objectives targeted by the program include: - Reorientating the health system from acute to primary health care; - Health promotion/prevention; - Early detection/intervention; - Improving access to services; - Improving timeliness and quality of services; - Ensuring locally focused and responsive services; - Improving coordination and integration of primary health care services; - Reducing health inequalities; and - Supporting delivery of best practice services.	The Department of Health provides approximately $327.5 million in 2012-13 (Note: Some Medicare Locals also receive State funding). The Department of Health is responsible for program spending, oversight and delivery.	Medicare Locals are required to provide an Annual Plan and Annual Budget (including Needs Assessment Report), Strategic Plan (Annual), Six Month Report and Twelve Month Report as a part of the reporting requirements under the Medicare Locals Deed for Funding. Components of the Six and Twelve Month Reports are available to the public. As Medicare Locals also receive additional funding from State Health Departments and other departmental program areas for specific service delivery there are additional reporting requirements as dictated by the respective program areas. An independent program evaluation is being undertaken.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Practice Incentives Program (PIP)	The PIP is aimed at supporting general practice activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients. There are 10 separate incentives under PIP that focus on topics including eHealth, diabetes, asthma, cervical screening, Indigenous health, quality prescribing, aged care access, GP procedural services, teaching and rural services.	Funding for PIP is provided by the Department of Health. PIP is administered by the Department of Human Services.	Quarterly reporting by the Department of Human Services, via the Medicare Australia Statistics web portal.
Life Saving Drugs Program	The Life Saving Drugs Program provides patients with very rare and life threatening conditions with financial assistance to access expensive and 'life-saving' drugs not available on the Pharmaceutical Benefits Scheme (PBS). In 2012-13, the Life Saving Drugs Program provided 228 eligible patients with free access to expensive lifesaving medicines for very rare life-threatening conditions at a cost of $79 million. During 2012-13, ten medicines were funded through the program for the treatment of seven separate disorders including: • imiglucerase (Cerezyme®), velaglucerase (VPRIV®) and miglustat (Zavesca®) to treat Gaucher's disease; • agalsidase alfa (Replagal®) and agalsidase beta (Fabrazyme®) for Fabry disease; • laronidase (Aldurazyme®) for Mucopolysaccharidosis Type I; • idursulfase (Elaprase®) for Mucopolysaccharidosis Type II; • galsulfase (Naglazyme®) for Mucopolysaccharidosis Type VI; • alglucosidase alfa (Myozyme®) for infantile-onset Pompe disease; and • eculizumab (Soliris®) for Paroxysmal Nocturnal Haemoglobinuria. Each condition has separate eligibility guidelines, developed and administered with the advice of an expert disease advisory committee.	Funding for the Life Saving Drugs program is provided by the Department of Health.	Annual Report and the Portfolio Budget Statements (under Program 2.3: Targeted assistance – pharmaceuticals) Further information about the Life Saving Drugs Program can be found on the Department of Health's website at www.health.gov.au/lsdp

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The Pharmaceutical Benefits Advisory Committee is an independent, expert advisory body comprising doctors, other health professionals and a consumer representative, which makes recommendations to the Australian Government about medicines funded through the PBS. In order for a medicine to be made available for the treatment of patients through the Life Saving Drugs Program, the medicine must first be rejected for PBS listing because it fails to meet the required cost effectiveness criteria. The Life Saving Drugs Program Criteria and Conditions for Funding must be satisfied, which include that there is acceptable evidence to predict that a patient's life-span will be substantially extended as a direct consequence of the use of the medicine, and that the medicine is clinically effective.		
Fifth Community Pharmacy Agreement (5CPA)	5CPA provides $15.4 billion for the dispensing of PBS medicine and to ensure vital medicines are accessible to the Australian community. The 5CPA includes $663.4m over the life of the Agreement for Professional Services and Programs which promote access to services that assist patient medication management and support the quality use of medicine and through this, improve consumer health outcomes. A number of these programs target particular population groups (such as the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people) and geographical settings (such as the Rural Pharmacy Workforce Program).	· $13.7b over five years for the dispensing of PBS medicines. · $952m for the Community Service Obligation funding pool, which supports the timely supply of medicines to all Australians. · $663.4m for a range of Programs and Services that increase patient health outcomes.	· Data via PBS · Department of Human Services report data on a number of 5CPA Programs · Reporting data or activity for 5CPA programs by funding recipients

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Section 100 Programs	In addition to the drugs and medicinal preparations available under normal PBS arrangements, a number of drugs are also available as pharmaceutical benefits but are distributed under alternative arrangements provided for under section 100 of the *National Health Act 1953*. These programs include the Highly Specialised Drugs Program, Efficient Funding of Chemotherapy, Botulinum Toxin Program, Human Growth Hormone Program, InVitro Fertilisation/Gamete Intra Fallopian Transfer (IVF/GIFT) Program, and Opiate Dependence Program.	· The PBS is an uncapped special appropriation.	· Regular service activity and financial reports provided in line with an agreed reporting framework.
Closing the Gap – PBS Co-payment Measure	The Closing the Gap (CTG) Pharmaceutical Benefits Scheme Co-Payment Measure, is one of 14 measures under the Indigenous Chronic Disease Package. The CTG lowers or removes the patient co-payment for PBS medicines. The CTG improves access to Pharmaceutical Benefits Scheme medicines for eligible Aboriginal and Torres Strait Islanders living with, or at risk of, chronic disease. Eligible Practice Incentive Program (PIP) accredited general practices and non-remote Indigenous Health Services (IHS) may participate in the measure which commenced on 1 July 2010.	· Commonwealth contribution to the National Partnership Agreement – Closing the Gap. · Funding is provided by the Department of Health.	· Department of Human Services records registration of PIP accredited GP practices and non-remote IHS, as well as eligible registered patients. · Measure expenditure data is reported monthly through DHS.

Table 11A.105 **Australian Government, community health services programs**

Programs funded by the Australian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Primary Health Care (Office for Aboriginal and Torres Strait Islander Health)	The program supports Community Controlled Organisations to improve community access to a broad range of clinical and population health services. Organisations funded under this program must deliver primary health care services and/or advocacy services tailored to the needs of the community. These services include population health activities; and clinical services including the treatment of acute illness, emergency care, management of chronic conditions, crisis intervention and referral.	Funding is provided by the Department of Health. The program is delivered by a range of Aboriginal Community Controlled Health Services, Non-Government Organisations and some State and Territory health departments.	· Services are required to undertake a quarterly review of progress against agreed plans. · Organisations provide an annual report of service activity. Services providing clinical primary health care also report biannually against agreed national key performance indicators.
Closing the Gap in Indigenous Health Outcomes - Indigenous Chronic Disease Package	The Indigenous Chronic Disease Package (ICDP) aims to improve the prevention, detection and management of chronic disease in Aboriginal and Torres Strait Islander peoples to close the gap in life expectancy. The ICDP is helping to build a health system that meets the needs of Aboriginal and Torres Strait Islander people, providing support to both Aboriginal community controlled health organisations and mainstream general practices. The package provides funding for prevention programs and community education initiatives to reduce the key risk factors that contribute to chronic disease; improved access to best practice chronic disease management and follow up care; and an expanded Indigenous health workforce to increase the use of health services by Aboriginal and Torres Strait Islander people with, or at risk of developing, chronic disease.	Funding for the ICDP is provided through the Aboriginal and Torres Strait Islander Chronic Disease Fund, and the Practice Incentives Program – Indigenous Health Incentive.	· The Department of Health reports annually on implementation and progress of the Indigenous Chronic Disease Package to the Standing Council on Health.

Source : Australian Government unpublished.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child Adolescent and Family Services	Covers services such as youth health, paediatric allied health (physiotherapy, occupation 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. Personal Health Record (PHR) - The NSW PHR (also known as 'the Blue Book') is distributed to all families with a newborn in NSW and provides a schedule of nine recommended child health checks from birth to four years of age. The PHR uses a joint parental-professional approach to detect or anticipate problems. Early Childhood Health Services provide a range of services to support good health outcomes of children, including parenting support and education, breastfeeding support, universal health home visiting, screening for postnatal depression and referral if necessary, and health and development advice for families with young children.	Local Health Districts (LHDs) receive block funding from the Department of Health to provide health services to their population. Each LHD 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 professional provides services to a Non-admitted Patient is reported by LHDs to the Department of Health (DoH) on a quarterly basis.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Children's health and wellbeing	Children's Health and Wellbeing services include universal services provided to the whole population and targeted services. Universal services including Postnatal child and family health services such as early childhood health services and Universal Home Health Visiting. **Universal Health Home Visiting (UHHV)** – is the offer of a home visit by a Child and Family Health Nurse to all families in NSW after the birth of their baby. At the UHHV the nurse assesses the baby's health and development, and identifies the level of support the family needs. The nurse can then link parents identified as requiring additional support to appropriate support and/or secondary services.	LHD funds	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
	Sustaining NSW Families is a program of nurse led structured evidenced based sustained health home visiting provided to vulnerable children at risk of poor developmental outcomes and their families in selected low socio-economic areas. The program actively supports parents' aspirational goals for themselves and their child and builds parenting capacity and secure parent/ child relationships. It is prevention and early intervention strategy which commences in the antenatal period and continues until child is 2 years of age with the aim of optimising child health and development outcomes. Services include bi-lingual nurses (English/Arabic and English/Mandarin) and services in a rural area with a focus on engaging vulnerable Aboriginal families.	Most funding is Keep Them Safe dedicated funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	Health care needs of children in Out Of Home Care - coordination and provision of health development and wellbeing assessments, reviews and interventions of children and young people in OOHC. This state-wide project is being implemented in phases commencing with children/young people entering Statutory Out of Home care who are expected to remain in care for more than 90 days.	Keep Them Safe funding	Quarterly data reporting to Ministry of Health. Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
	Building Strong Foundations for Aboriginal Children Families and Communities is a culturally safe early childhood health service for Aboriginal children birth to school entry age and their families. It aims to support parents and communities to provide an environment that will optimise the health, development and wellbeing of their child so that children are ready able to engage fully in life and learning. It has close links to Aboriginal maternity services including NSW Aboriginal Mothers and Infants Health Services and New Directions as well as mains team services. Teams comprising Aboriginal Health Workers and Child and Family Health nurses provide the main frontline service. Seven new sites were funded late 2011/12 bringing total to 15 across NSW.	State program funding to selected sites.	Annual Reporting and six monthly financial acquittal.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Screening	Domestic Violence Routine Screening - Women are routinely screened for recent or current domestic violence in antenatal and early childhood health services, and women aged 16 and over are screened in mental health and alcohol and other drugs services. Screening is an early identification and education strategy. Covers screening and assessment programs particularly directed towards children to identify problems early so treatment options are optimized. Program includes the Statewide Eyesight Preschooler Screening (StEPS) program, Statewide Infant Screening Hearing (SWISH) program, universal health home visiting for mothers and babies. - Statewide Eyesight Preschooler Screening (StEPS) - is a free vision screening program for all four year old children in NSW. The program is designed to identify childhood vision problems early which cannot be detected by observation, behaviour, family history or vision surveillance. By identifying and treating vision problems during the critical visual development period, treatment outcomes can be maximised.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Domestic Violence Routine Screening funding is implemented within service agreement allocations. A mix of LHD and Australian Government funding.	A one-month data collection snapshot from all LHDs is conducted in November of each year. This provides information on outcomes such as screening and identification rates, and referrals. Domestic Violence Routine Screening is also included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements. Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Other programs require quarterly reports on tests offered and conducted.
Youth health and wellbeing	Provides education and health promotion programs, clinical services and planning of youth friendly services. Also provides specific health services for homeless and at risk young people.	A mix of LHD and Australian Government funding is allocated for Innovative Health Services for Homeless Youth (IHSHY).	These services are measured as Non Admitted Patient Occasions of Service. The number of occasions on which one or more health care professional provides a services to a Non-admitted Patient and reported by the LHDs to the Department of Health on a quarterly basis. ISHSY program reports annually to MCYPH branch.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Maternal and child health	Maternity services are part of the core services provided by LHDs to their population. Community antenatal and postnatal care is provided including through shared care arrangements with GPs. Targeted programs for vulnerable populations include: - Aboriginal Maternal and Infant Health Service (AMIHS) provides culturally appropriate antenatal and postnatal care up to 8 weeks, to Aboriginal mothers and babies. Mental health and drug and alcohol secondary services are being delivered in selected AMIHS sites across the state as part of the Indigenous Early Childhood Development National Partnership Agreement (IECD NP). Quit for new life, a smoking cessation intervention specifically for Aboriginal pregnant women is also being rolled out across AMIHS programs.	LHD block funding and some IECD NP funds (Commonwealth)	Varies by program. Some services measured as Non Admitted Patient Occasions of Service. Regular reports on activity, outcomes against indicators
Child Protection Counselling Services	CPCS are located in each NSW Local Health District and provide specialist, tertiary-level counselling and casework services to children and young people and their families, where abuse or neglect has been substantiated by Community Services. This usually involves a medium- to long-term intervention (between 3 months and 18 months). Interventions are child-focussed and family-centred, and aim to address and stop the effects of abuse and neglect and exposure to domestic violence on children and young people. The aim is to work toward maintaining the child or young person living with their family wherever this is possible.	LHD receive block funding from the Ministry of Health to provide health services to their population. Each LHD 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 professional provides a services to a Non-admitted Patient and reported by the LHDs to the Ministry of Health on a quarterly basis.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Family Referral Services	Family Referral Services (FRS) are intended to link vulnerable children, young people, and families with appropriate available support services in their local area. FRS refer clients to a range of local support services such as case management, housing, childcare, supported playgroup, drug and alcohol/mental health services, youth services, hoe visiting, family support, parenting education and respite care. The target group is vulnerable children and young people who are below the threshold for statutory child protection intervention, and their families. Government agencies, non-government organisations, and the private sector (e.g., general practitioners, childcare workers) can refer families to Family Referral Services. Families may also self-refer. There are 8 Family referral Services currently operating in NSW covering the following regional areas: Western NSW, Hunter Central Coast, Western Sydney (2), Illawarra, New England North West, Mid North Coast and Far North Coast.	Keep Them Safe 'protected item' funding. NSW Ministry of Health procures these services from non-government organisations on behalf of the whole of government.	Milestone reporting to Department of Family and Community Services. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget
Services for Children under 10 years with Problematic or Harmful Sexual Behaviour	Under Keep Them Safe (KTS) NSW Health committed to expanding services for children aged under 10 years who display problematic or harmful sexualised behaviour, including Aboriginal children. To increase service delivery, the Ministry of Health allocated KTS funding to enhance the Sparks program in the Hunter New England LHD, which is the only NSW Health specialist service responding to this client group. The Ministry is also developing a statewide policy directive and guidelines on best practice service delivery, including training requirements for staff, were necessary to resolve current issues and assist LHDs in their local responses to the target group.	LHD funding and Keep Them Safe 'protected item' funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
New Street	New Street provides a coordinated, consistent, quality response to children and young people aged 10–17 years who sexually abuse and their families, through an expanded network of specialised NSW Health New Street services. New Street Services for Children and Young people have been enhanced through the establishment of an additional site in Newcastle (Hunter New England LHD), a new service in Dubbo (Western NSW LHD) and an additional clinical position at the Sydney and Central Coast New Street Service. A Clinical Advisor position for New Street Services and the Pre-Trial Diversion of Offenders Program has been created and filled.	LHD funding and Keep Them Safe funding	Milestone reporting to Department of Premier and Cabinet; Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget.
Health Child Wellbeing Units	Health Child Wellbeing Units provide support and assistance to health mandatory reporters to assist them to identify and provide appropriate responses for children and young people at risk of significant harm and to determine what other supports should be put in place for vulnerable children and young people below this statutory reporting threshold.	Keep Them Safe 'protected item' funding.	Milestone reporting to Department of Premier and Cabinet. Quarterly acquittals to Treasury on expenditure of Keep Them Safe component of the budget
Medical and forensic services for victims of sexual assault	This program area aims to improve forensic and medical services for victims of sexual assault and child abuse and ensure these services are culturally competent. The program has a particular focus on improving access in rural and remote communities.	Combination of Ministry of Health allocation, LHD block funding and Commonwealth funding (Indigenous Health-National Partnership Agreement)	LHDs report on service provision via a payment determination for a fee to be payable to non-salaried medical practitioners in designated rural LHDs conducting forensic and medical examinations for sexual assault victims.

Table 11A.106 **New South Wales, community health services programs**

Programs funded by the NSW Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Joint Investigation Response Teams (JIRT)	JIRT is collaborative arrangement between NSW Community Services, NSW Police and NSW Health. The primary aim of JIRT is to minimise the number of investigative interviews child victims of sexual abuse, physical abuse and extreme neglect have to undertake and to provide seamless service delivery to child victims and their non-offending family members. NSW Health became an equal partner in JIRT in 2009. As the 2012 JIRT Secretariat, NSW Health is responsible for leading the review of the JIRT Policy and Procedures Manual (2001), the Memorandum of Understanding between the three partner agencies and the Statewide Management Group's Terms of Reference. NSW Health is also in the final stages of recruiting and placing 24 Senior Health Clinicians in every JIRT office across the state.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. JIRT funding is implemented within service agreement allocations.	Keep Them Safe (KTS) requires an audit of the JIRT Program every three years. An annual JIRT CEO Report Card is collated each year to meet the KTS audit requirements.
Sexual Assault Services	NSW Health's 55 Sexual Assault Services provide holistic specialist assistance to adult and child victims of sexual assault including supporting their psycho-social, emotional and cultural wellbeing. Free counselling, court support, medical and forensic examinations and medical treatment are available to anyone who has recently been sexually assaulted in NSW.	LHDs receive global funding from the Ministry of Health via annual Service Agreements to provide health services to their population. Sexual Assault Service funding is implemented within service agreement allocations.	Sexual Assault Services are included within the Service Schedule of the Ministry of Health and LHD annual Service Agreements.

Source : NSW Government unpublished.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Primary Care Partnerships (PCPs) Strategy	Primary Care Partnerships (PCPs) are cross government funded voluntary alliances of heath and human services provider organisations. There are 29 PCPs in Victoria which engage over 1000 organisations. PCPs deliver local service system reforms to: • improve the coordination of services • improve the way health promotion is planned, implemented and evaluated; and • improve the management of chronic disease. The strategy to improve the coordination of services is supported by a state-wide policy and operational framework and includes: state-wide practice standards and a continuous improvement manual tools for screening, referral and coordinated care planning • data standards for sharing client health and care information embedded in agency client management software applications; and • e-referral systems to securely share client information with client consent. PCPs identify local health and well being priorities and ways to address these priorities. 'Place based' partnership approaches are used to assess and engage with communities that experience significant disadvantage. Interventions may be targeted to particular population groups, for example, farmers, people with a refugee background and ethnic communities.	Core funding provided by the Victorian Department of Health. Additional funding provided by other Victorian government departments including the Department of Justice and the Department of Transport, Planning and Local Infrastructure.	Suite of reports as part of the 2009–2012 PCP planning and reporting requirements. This includes a three year strategic plan and impact oriented reports against each area of the PCP program logic. A new PCP Program Logic for 2013-17, with changed reporting requirements for PCPs, will be implemented in 2013-14.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Refugee Health Nurse Program	The Refugee Health Nurse Program (RHNP) seeks to optimise the long-term health of asylum seekers/ refugees by promoting accessible and culturally appropriate health care services that are innovative and responsive to the unique needs of asylum seekers/refugees. The program supports a coordinated model of care, and acknowledges the importance of early identification and intervention in health issues in the early stages of settlement. The RHNP has three aims: • to increase refugee access to primary health services • to improve the response of health services to refugees' needs; and • to enable refugee individuals, families and communities to improve their health and wellbeing. The RHNP builds the capacity of individuals, families and refugee communities to improve their health through: disease management and prevention; the development of referral networks and collaborative relationships with general practitioners and other health providers; connection with social support and orientation programs.	• The Victorian Government funds the RHNP through the Department of Health. • Community health services are funded to deliver the RHNP.	• Community health services funded under the RHNP report hours of service on a quarterly basis.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Dental Health Program	All health care and pensioner concession care holders and their dependants are eligible for public dental services in Victoria. Services are provided to eligible Victorians through community dental clinics in community health services, rural hospitals and the Royal Dental Hospital of Melbourne. There are waiting lists for public dental care at all clinics, however eligible people with urgent needs are given priority and are assessed within 24 hours of contacting a clinic. Urgent dentures are provided within 3 months. In addition to people with urgent dental needs, people who have priority access are offered the next available appointment for care and are not placed on a wait list. Priority access to public dental care is provided to: • Children up to the age of 12 • Young people aged 13 – 17 who are dependants of holders of health care or pensioner concession cards • Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special development schools • Refugees and Asylum Seekers • Aboriginal and Torres Strait Islanders • Pregnant women	• State funded public dental services are output funded and supported by an activity based funding model. • From 1 July 2013, with the implementation of the National Partnership Agreement on Treating More Public Dental Patients, the funding unit is a Dental Weighted Activity Unit (DWAU), calculated using the Australian Dental Association (ADA) three digit item codes and a weighting.	• Performance targets are set by the department and monitored through various reporting mechanisms to demonstrate program delivery. Examples of targets are people treated, waiting times and quality measures. • Funded agencies delivering dental services are set DWAU targets based on their total service delivery funding. For performance monitoring, all activity (treatment items) are converted to DWAUs.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	Fees for public dental services apply to people aged 18 years and over, who are health care or pensioner concession card holders or dependants of concession card holders and children aged 0–12 years who are not health care or pensioner concession card holders or not dependants of concession card holders. An inability to pay fees cannot be used as a basis for refusing a dental service to an eligible person. Exemption from fees for public dental services applies to the following people: • Aboriginal and Torres Strait Islanders • Homeless people and people at risk of homelessness • Refugees and Asylum Seekers • Children & young people aged 0-17 years who are health care or pensioner concession card holders or dependants of concession card holders • All children and young people up to 18 years of age, who are in out-of-home care provided by the Children Youth & Families Division of DHS • All youth justice clients up to 18 years of age in custodial care • Registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special developmental schools • Those receiving care from undergraduate students • Those experiencing financial hardship		

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Nurse on Call	NURSE-ON-CALL is a statewide telephone-based health line that provides residents of Victoria with timely access to health information, assistance and advice for the cost of a local phone call. The service operates 24 hours, 7 days a week and takes about 1,000 calls per day. NURSE-ON-CALL uses registered nurses to triage callers' symptoms and health issues so as to advise on health care needs. NURSE-ON-CALL also provides callers with health information; and information about local health providers.	NURSE-ON-CALL is delivered by Medibank Health Solutions under contract to the Department of Health.	Medibank Health Solutions provides the department with a number of monthly reports.
IHSHY Program	The Innovative Health Services for Homeless Youth (IHSHY) program is a Commonwealth/State funded initiative that promotes health care for young people who are homeless or at risk of homelessness. Funding is provided to community health services to deliver innovative and flexible health services for the target population. The services respond to the complex health needs and improve their access to mainstream health services. IHSHY provides a means of engaging young people who may not otherwise access health services.	Joint state/Commonwealth funded. IHSHY is provided under the National Healthcare Agreement.	Quantitative performance targets are set by the department and monitored quarterly.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Maternal & Child Health	The Healthy Mothers, Healthy Babies program aims to reduce the burden of chronic disease and reduce health inequity by addressing maternal risk behaviours and providing support during pregnancy. The program is delivered by community health services in areas that have high numbers of births and higher rates of relative socioeconomic disadvantage. The objectives of the program are to: • improve women's access and attendance at antenatal and post natal services • improve women's access to a range of support services which may include health, welfare, housing and education services • deliver health promotion messages that aim to reduce risk behaviours, and promote healthy behaviours. Women eligible for the program are those women who are not able to access antenatal care services or require additional support because of their: • socioeconomic status • culturally and linguistically diverse backgrounds • Aboriginal and Torres Strait Islander descent • age, or • residential distance to services.	The Victorian Government funds the program through the Department of Health. Funding of this program continues until June 2014. Extension of funding for this program beyond 30 June 2014 is subject to budget outcomes.	Quantitative performance targets are set by the Department of Health and monitored quarterly. The performance of the program was monitored through a formal evaluation completed in August 2011.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Children's Health & Wellbeing	Services for children and families within community health are based on evidence which identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services respond to the needs of young children and their families. Child health teams provide multidisciplinary care through a mix of group and individual interventions. Services promote positive health, growth and functioning within the community. Their focus is the provision of early interventions as well as to improve the capacity of parents and families to understand and manage the health and development needs of their child. Community health practitioners also support families to access additional services they may require in the community.	The Victorian Government funds the program through the Department of Health.	Quantitative performance targets are set by the department and monitored quarterly.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Community Health Program	The Community Health Program provides funding to approximately 100 Community Health Services (CHSs) operating from approximately 350 sites across Victoria. This strong connection to communities enables community health services to develop models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, community health services combine the social model of health with clinical care to maximise outcomes for their consumers. CHSs play an important role in preventive, rehabilitative, maintenance and support services for people at risk of, or with complex conditions and chronic illnesses. In addition, community health prioritises services to population groups that are known to have poor health status, are subject to disadvantage or are at risk. These include people who are homeless or at risk of homelessness, refugees, aboriginal people, people with an intellectual disability or a serious mental illness. Funding is provided for the provision of direct care, and for health promotion. CHSs are also major providers of Home and Community Care Services, Dental, General Practice, Drugs Program, Disability and other State and Commonwealth programs.	These services are funded under the Primary Health Funding Approach. The Approach includes two components (1) direct care and (2) health promotion.	Quantitative performance targets are set by the department and monitored quarterly. CHSs report annually to their consumers, carers, community and other stakeholders through the Quality of Care report. Agencies funded for health promotion are required to develop four year health promotion plans and report on those plans on an annual basis.

Table 11A.107 **Victoria, community health services programs**

Programs funded by the Victorian Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Family Planning	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. Family planning health promotion focuses on promoting the sexual and reproductive health of Victorians, with a focus on groups at higher risk of ill-health. Funding for family planning services is provided to community health services, and to a statewide service, Family Planning Victoria (FPV).	From 2009-10, funding is provided under the National Healthcare Agreement.	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly. In line with broader Integrated Health Promotion Program requirements, agencies funded for family planning health promotion are required to submit a health promotion plan every four years and report on this plan annually.
Early Intervention in Chronic Disease (EIiCD)	EIiCD focuses upon community based early intervention services for people with chronic diseases. The aim of the initiative is to enhance existing capacity of community health services in supporting people with chronic disease in managing the impact of their condition including the physical, emotional and psychological impact of having a chronic disease. Services aim to reduce the impacts of chronic disease, slow disease progression and reduce potential/future hospitalisation. Models of care are multidisciplinary and provide self management support, care coordination, education, allied health and nursing.	These services are funded under the Primary Health Funding Approach	Quantitative performance targets are set by the department for direct service provision, and monitored quarterly.

Source : Victorian Government unpublished.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol, Tobacco and Other Drug Services	Alcohol, Tobacco and Other Drug Services in Queensland are delivered through approximately 97 public and non-government organisations. Services include a range of prevention and health promotion activities; screening and assessment; care coordination and support; counselling; early and brief intervention; referral and aftercare. Services are provided to a broad population (including men, women and Indigenous Australians) who are referred from a range of sources including self, family and friends, community and health services, GPs and, law and justice agencies. Alcohol and other drug services are delivered within a harm minimisation framework, consistent with the National Drug Strategy 2010-2015.	Funded through State Output Revenue and Commonwealth funds.	National reporting through National Minimum Data Set (NMDS) processes - national publication is prepared from the NMDS.
Oral health services	Oral health services are provided to eligible children and adults via community and school-based mobile and fixed public dental clinics. Services include general and specialist dental care, and health promotion and disease prevention activities.	Services are primarily funded by the Queensland Department of Health, with some Commonwealth funding. Services are delivered by Hospital and Health Services.	Performance targets and overall financial reporting are published in Queensland Health's annual report and Service Delivery Statement.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Retrieval Services and Counter Disaster (RSCD)	The emergency retrieval and aeromedical transport of critically ill or injured patients across Queensland and the north coast of New South Wales is coordinated by RSCD to improve access to, and the quality of available transport resources to support patients ranging from acute, urgent, high dependency care to non-urgent, low dependency care. These transport services are provided under statewide service agreements in partnership with non-government organisations including: Royal Flying Doctor Service (RFDS), community helicopter providers and CareFlight Medical Services; and with Emergency Management Queensland and the Queensland Ambulance Service, Department of Community Safety and Australian Helicopters Pty Ltd. For patients who can travel by themselves and are required to travel away from their home to access specialist medical services, financial assistance is provided to eligible patients through the Patient Travel Subsidy Scheme (PTSS).	Funding source - State Output Revenue (except for the RFDS aeromedical services provided from the Cairns, Mt Isa and Charleville bases which are partially funded by the Commonwealth. RFDS also provides primary health care services funded by the Commonwealth.) Budget oversight - RSCD Governance oversight - RSCD Delivered - RSCD	No patient transport reports are provided externally. Internally, activity reports are provided to the Hospital and Health Services (HHSs) to assist in the monitoring of usage of road ambulance, fixed-and rotary wing aeromedical transport at HHS and facility level. PTSS activity and expenditure reports are provided monthly to HHSs and will be provided to CBRC in the mid-year financial review 2013-14

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Blood Borne Viruses and Sexually Transmissible Infections (BBVs and STIs)	The program implements five national strategies: 1. The Sixth National HIV Strategy 2010-2013; 2. The National Hepatitis B Strategy 2010-2013. 3. The Third National Hepatitis C Strategy 2010-2013; 4. The Second National Sexually Transmissible Infections Strategy 2010-2013; 5. The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013. Services and public health programs are delivered through public, non-government and private organisations including 16 Hospital and Health Service (HHS) Sexual Health Clinics providing preventative and clinical BBV and STI services. Clinical and funded non-government programs target groups most at risk of BBVs and STIs. (e.g. gay men, injecting drug users, culturally and linguistically diverse, Aboriginal and Torres Strait Islanders and young people). The Queensland HIV Strategy 2012-2015 outlines the strategic direction for HIV prevention and management in Queensland.	Funded through the National Healthcare Agreement (NHA) and a combination of other Commonwealth and State Output Revenue.	Six monthly performance reports on activities by funded NGO programs Quarterly report provided to the BBV and STI Standing Committee (BBVSS) Commonwealth Indigenous funding reports Notification data for BBVs and STIs provided for the NHA report.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Get Healthy Services	Under an agreement with New South Wales Ministry of Health, Queensland has implemented the Get Healthy Information and Coaching Service (GHS) available to Queensland adults through 13Health (13 432584) or via www.gethealthy.qld.gov.au. Since commencement on the 8 February 2013 to the 30 June 2013, over 1300 contacts were received resulting in 452 participants enrolling in the Get Health Coaching program. The Service has been promoted through a range of channels to the broader community, community organisations, health service providers, workplaces and state and local government.	Funding for the Get Health Information and Coaching Service is provided through the National Partnership Agreement on Preventive Health, Healthy Workers initiative.	Reports are received as per contractual requirements between Queensland Department of Health and New South Wales Ministry of Health.
Women's health	Queensland Health supports remote Aboriginal and Torres Strait Islander women's participation in cervical screening through the Healthy Women's Initiative (HWI). The HWI is a network of 16 designated Aboriginal and Torres Strait Islander women's health workers who focus on cervical screening and women's health issues to improve the health outcomes for Aboriginal and Torres Strait Islander women. The Department of Health funds the Mobile Women's Health Service (MWHS) to provide an outreach health service to women in rural and remote communities who may be geographically and/or socially isolated. The service is a network of 15 clinical nurse consultants and 2 Indigenous Women's Health Workers who provide cervical screening and women's health clinics in over 200 communities across Queensland.	Funding for the HWI and MWHS are provided through the National Healthcare Agreement and State Output Revenue.	Delivery of the HWI and MWHS is the responsibility of Hospital and Health Services in accordance with Service Level Agreements.

Table 11A.108 **Queensland, community health services programs**

Programs funded by the Queensland Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Enhanced Maternal and Child Health Service	Queensland Health is implementing the Enhanced Maternal and Child Health Service to ensure all families have access to two home visits in the first month following birth and community clinics at key stages during the first year of a child's life.	State government Delivered by state government, may be delivered in partnership with other providers	Quarterly reporting
Child health services	A range of child health services are provided to children and young people aged 0-18 years and their families in the community. These services may include interventions such as child development checks, lactation support, parent information sessions; as well secondary and/or tertiary health services such as parenting and behaviour support, nutrition support, or referrals to other service providers. Services are available to all children and young people aged 0-18 years and their families as well as targeted services to particular or 'at risk' populations such as young parents, Aboriginal and Torres Strait Islander families, and refugee families.	State and Commonwealth government funding. Delivered by state government, may be delivered in partnership with other providers	Local Hospital and Health Service reporting arrangements are in place.

Source : Queensland Government unpublished.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
National Partnership Agreement (NPA) - Closing the Gap in Indigenous Health Outcomes	The Closing the Gap NPA is centred on five priority areas through the delivery of services to Indigenous communities throughout WA: Area 1 – Tackling Smoking • Outcomes – Reduction in smoking prevalence and in the burden of tobacco related disease for Aboriginal communities. • Outputs - 11 State funded Tackling Smoking programs were successfully implemented throughout the State and all are delivering a range of strategies and activities for smoking cessation and/or prevention. Interventions include education, social marketing, brief intervention and smoking cessation quit groups. Area 2 – Healthy Transition to Adulthood • Outcomes – Increased sense of social and emotional wellbeing; Reductions in uptake of alcohol, tobacco and illicit drugs, rates of sexually transmissible infections, hospitalisations for violence and injury and morbidity and mortality amongst Aboriginal men. • Outputs - 24 programs continue to increase the access and uptake of services supporting social and emotional well being among young Aboriginal people. Initiatives include self-esteem, sexual health and drugs and alcohol education, social marketing, training, counselling and peer mentorship and leadership strategies.	• Area 1 – Commonwealth and State funded • Area 2 – State funded • Area 3 – State funded • Area 4 Commonwealth and State • Area 5 – Commonwealth and State • Programs delivered by both WA Health and non-government organisations (Aboriginal Community Controlled Health Organisations)	• WA requires biannual reporting from all COAG Closing the Gap programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WA reports annually through AHMAC for Closing the Gap funded programs.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	Area 3 – Making Indigenous Health Everyone's business • Outcomes - Increase health outcomes for Indigenous people in prison settings and Aboriginal men's health. • Outputs - 14 programs continue to increase health outcomes for Aboriginal men and Aboriginal people in the prison settings and post-release. Ten of these are Aboriginal Health Community Re-Entry programs. Area 4 – Primary Health Care Services that can deliver • Outcomes - Improved access to quality primary health care; increased uptake of MBS-funded services; Implementation of best practice standards and accreditation and increased cultural competence of primary care services. • Outputs – A suite of 26 State funded primary health care services continue to be delivered through culturally secure community health care settings with a focus on the prevention, early detection, treatment and self management of chronic disease. Area 5 – Fixing the gaps and improving the patient journey • Outcomes - Reduced average length of stay; Improved level of engagement to deliver better follow up and referrals; Improved patient satisfaction and health journey and reduced admissions and incomplete treatments. • Outputs - 24 State funded programs continue to support access to patient transport services and improvements in continuum of care particularly for Aboriginal people living in rural and remote WA.		

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
NPA Indigenous Early Childhood Development (IECD)	The IECD NPA is centred on the following element: Element 3: Increase access to, and use of, maternal and child health services by Indigenous families • Outputs - A further 14 programs continue to provide postnatal services and outreach programs with a focus on adolescent mothers. These programs provide clinical policies, guidelines and standards of practice, and work force support and development to maternal and child health services delivering care to Aboriginal women. These services also include the provision of child health checks and immunisation services.	• Element 3 – State funded • Programs delivered by both WA Health and non-government organisations (Aboriginal Community Controlled Health Organisations)	• WA requires biannual reporting from all COAG IECD programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision. • WA reports annually to Australian Government Department of Health for the programs.
Primary health/chronic disease programs for Aboriginal communities	WA has carriage of approximately 18 contracted primary health/chronic disease programs across the State in a community health care setting with a focus on the prevention, early detection, treatment and self management of chronic disease. • Outcomes – the majority of these services aim to increase access to culturally appropriate primary health care services for Aboriginal people in WA. • Outputs – provision of 24-hour accident and emergency services, outpatient services, management of chronic conditions, immunisation, health promotion, screening and associated treatment, maternal and child health and integration of service delivery.	• State funding is provided • Programs delivered through Aboriginal Community Controlled Health Organisations (non-government).	• WA requires biannual reporting from all COAG IECD programs. Service providers report on contract outputs using a defined template. • Templates are reviewed to monitor performance. Quantitative and qualitative data is also collated to provide an overview of levels of service provision.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Child Health Interim Schedule	A comprehensive schedule of maternal and child contacts for Aboriginal families with young children (0-5 years) is provided in Country WA. The approach builds on and strengthens the existing universal child health schedule by offering additional visits to families who do not wish to access mainstream child health services or those families who need additional support.	• State funding is provided directly to individual health services or regions. • Health services or regions are responsible for delivering Aboriginal child health services.	• Services are reported as Occasions of Service for non-admitted patients • Reports are produced for service planning and reviews.
WA Country Health Service programs	Pit Stop Men's Health program encourages men to have regular health checkups through attaching the concept of mechanical tune-ups for their cars to their own health. WA delivers the program and provides resources to other service providers.	• State funding was provided to set up the program. State funding is used to administer the program.	• Reporting provided on an annual basis.
Subsidised Dental Care Program	Dental care is provided to eligible financially disadvantaged people (pensioners and other recipients of a benefit/allowance from Centrelink or Department of Veterans' Affairs) via: • Public dental clinics in the metropolitan and country areas • Private practitioners participating in the Metropolitan and Country Patients' Dental Subsidy Scheme • In addition, a Domiciliary Unit provides dental care for housebound patients. Dental care is also provided for special groups and institutionalised people • Aged Care Dental Program provides dental care to residents of registered aged care facilities. Residents are eligible to receive free annual screening dental examinations and a care plan. Further treatment needs are advised and the patient is referred to an appropriate provider. Ongoing treatment is through one of the Government programs for eligible residents.	State funding is provided.	Program measures include: • Access to dental treatment for eligible people • Average waiting times • Average cost of completed courses of adult dental care.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child and Adolescent Community Health - Child Health Services (statewide)	• Child health services aim to promote improved health outcomes for babies, young children and their families across Western Australia through the provision of a range of universal and targeted prevention, early identification and intervention community health services. • WA offers a universal Birth to School Entry community child health service that begins with a child health nurse contacting all mothers of new babies within 10 days of birth and the offer of an additional 6 contacts at the critical points in the child's development throughout the first four years of life. More intensive services are offered and provided to individual families and groups according to need. • The Enhanced Aboriginal Child Health Schedule provides a modified and expanded version of the Universal Child Health Contact Schedule, offering to families 15 scheduled contacts from pregnancy to five years of age. These are offered in a consistent and culturally appropriate manner. The object is to proactively engage with Aboriginal families who do not access mainstream services and are known to have higher health needs. • Services are delivered in child health centres, community based centres and in homes. Information and support is offered regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breast feeding and nutrition.	• State funding is provided. • WA Health Services are responsible for delivering child health services.	• Services are reported as Occasions of Service for non-admitted patients. • Reports are produced as required for service planning and reviews. • Quarterly reports against key performance indicators are provided to the Government.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
School Health Services (statewide)	• School health services aim to promote improved health outcomes for school aged children and young people through universal and targeted prevention, health promotion, early identification and intervention. • Services are provided by the WA Department of Health on school sites in collaboration with education providers. • Key elements of the program are universal health assessments at school entry to all students in government and non government schools, support to children in schools with particular health needs, access to health care for adolescents and health promotion for all students. In secondary government schools the focus is more on health promotion and providing to students the opportunity for access to a health professional who can advise, assess and refer according to the presenting health issue.	• The program is State funded. • Agreement is between the WA Department of Education and WA Department of Health which underpins the delivery of School Health Services. • The WA Department of Education partly funds School Health Services in WA	• Services are reported as Occasions of Service for non-admitted patients. • Reports are produced as required for service planning and reviews. • Service delivery reports are not accessible to the public.
Child and Adolescent Community Health - Child Development Services (Statewide)	• Community child development services in Western Australia provide a range of assessment, early intervention, and treatment (therapy) services to children with or at risk of developmental delay and disorders. The intention is to assess and intervene early to address developmental issues to maximise a child's potential and reduce the likelihood of conditions becoming consolidated and requiring more intensive and expensive therapeutic services later in life. • Child development services work with mental health, education and disability service providers to maximise opportunities for a child as part of a holistic and family centred approach. • The child development service workforce comprises: speech	• State funding is provided. • WA Health Services are responsible for delivering child development services.	• Services are reported as occasions of service (for non-admitted patients). • Additional reports are produced as required for service planning and review, including for example number of new referrals and wait times.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Disease Management	A range of non-hospital care is provided across the spectrum of chronic disease management including cardiovascular, diabetes, musculoskeletal conditions, respiratory and renal disease. Programs are delivered through the Better Health Improvement Projects (BeHIP) in line with the WA Chronic Health Conditions Framework (2011) and Chronic Conditions Self-Management (CCSM) Strategic Framework, including: • Metropolitan Healthy Lifestyles • Chronic Condition Self-Management (CCSM) • Familial Hypercholesterolemia • Multidisciplinary Diabetes Services • Chronic condition Service Coordination (CCSC) The CCSM programs are multi-disciplinary and often inter-agency, and educate consumers on symptom monitoring, action planning and self efficacy as well as supporting access to health and social care services in a timely manner to prevent deterioration of their condition and ultimately reduce hospitalisation. The multidisciplinary teams include nursing, psychology, dietetics, occupational therapy, physiotherapy, podiatry and social work. Aboriginal Health Liaison Officers facilitate and improve access to services and programs for the Aboriginal population. The CCSC is integrated into other National Partnership Agreement programs and provide multi-agency care co-ordination, planning and case management, individual and group education and physical rehabilitation. Extensive stakeholder engagement, consultation and collaboration with government community health services, government and non-government providers, consumers, carers, and Medicare Locals enables the team to integrate services to support ongoing consumer self-management.	• Funding for these services is mainly via core WA Department of Health funding to Health Services and Medicare Locals.	• The State program measure for all non-admitted patient services is Occasions of Service. • In some areas quantitative and qualitative data is collected including client questionnaires and clinical outcome measures. • Program measures include numbers of programs and services delivered; clients and referrals; referral sources; service providers trained.

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Alcohol and other drug treatment services	The WA Drug and Alcohol Office (DAO) provides or contracts a statewide network of services relating to prevention, treatment, professional education and training, and research activities to prevent and reduce the adverse impacts of alcohol and other drugs in the Western Australian community. DAO clinical services are integrated with key non-government agencies to provide counselling and treatment services to youth, adults and families and also support local communities to prevent alcohol and other drug problems. DAO supports a comprehensive range of outpatient counselling and residential rehabilitation services, including specialist youth, women's and family services, provided primarily by non-government agencies. Most of these agencies are members of the Western Australian Network of Alcohol and other Drug Agencies (WANADA). Treatment includes: • outpatient and inpatient withdrawal; • assessment and counselling; • rehabilitation; • community-based pharmacotherapy; • supported accommodation; and • treatment for people engaged in a range of diversion programs.	• Funding to DAO is allocated from the Western Australian State Government through the Mental Health Commission. • Funds are allocated within DAO to direct government treatment services; and non-government funded service providers.	• As a statutory authority, DAO reports to the Board of the Western Australian Drug and Alcohol Authority. • DAO reports financial, performance indicators and information on activity and outcomes related to State Government goals in its Annual Report to Parliament. • Performance reporting at State level is through the Treasury budget statements. • At a National level, performance reporting is provided against the Intergovernmental Committee on Drugs (IGCD) (through the Australian Government Department of Health).

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	DAO's Next Step Drug and Alcohol Services comprise: • a specialist clinic in East Perth providing outpatient clinical programs for youth and adults • a residential withdrawal service, including dedicated beds for Aboriginal people • clinical services throughout the metropolitan area that are integrated with Community Drug Service Teams (CDST) • support for a state-wide network of general practitioners providing pharmacotherapy. The Drug and Alcohol Youth Service (DAYS) is an integrated outpatient service, operated as a partnership between Mission Australia and Next Step, for young people between the ages of 12 to 18 and their families. DAYS provides a comprehensive range of alcohol and other drug assessment and treatment services. The service provides comprehensive multidisciplinary assessment and treatment both on-site and on an outreach basis. The WA Diversion Program aims to reduce crime by diverting offenders with drug use problems away from the criminal justice system and into treatment to break the cycle of offending and address their drug use. The Alcohol and Drug Information Service (ADIS) is a 24-hour, state-wide, confidential telephone service providing information, advice, counselling and referral to anyone concerned about their own or another person's alcohol and other drug use. ADIS also encompasses the Parent Drug Information Service (PDIS), a specific support service for parents, and the Quitline telephone counselling service and the Quitline Aboriginal Liaison Team for tobacco users.		

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The Alcohol and Drug Information Service (ADIS) is a 24-hour, state-wide, confidential telephone service providing information, advice, counselling and referral to anyone concerned about their own or another person's alcohol and other drug use. ADIS also encompasses the Parent Drug Information Service (PDIS), a specific support service for parents, and the Quitline telephone counselling service and the Quitline Aboriginal Liaison Team for tobacco users. PDIS works in partnership with other programs within DAO and relevant agencies to provide support for parents and families in WA who may be experiencing alcohol and other drug problems. Callers have the option of talking to a professional counsellor, a volunteer parent or both.		

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Prevention and community action	DAO conducts a range of prevention and early intervention programs and services to: • prevent and delay the onset of alcohol and other drug use • support environments that discourage risky use • enhance healthy community attitudes and skills to avoid risky use • support and enhance the community's capacity to address alcohol and other drug problems • support initiatives that discourage inappropriate supply of alcohol and other drugs. Prevention includes a range of activities: • prevention and early intervention programs and services; • community based education programs; and • public health prevention campaigns and support for regional prevention networks. DAO delivers public health campaigns and initiatives to reduce risky alcohol use and prevent illicit drug use including: • The Alcohol.Think Again campaign encourages and supports communities to achieve a safer drinking culture in WA. • The Drug Aware program focuses on reducing the harm from illicit drugs by encouraging sensible informed decisions about illicit drug use, through providing credible, factual information and delivering comprehensive strategies to address drug-related issues. DAO supports a state-wide network of local drug action groups that deliver preventative activities and education for youth and support for families. DAO also supports school drug education through the state, Catholic and independent school sectors.	State funding is provided	• As a statutory authority, DAO reports to the Board of the Western Australian Drug and Alcohol Authority. • DAO reports financial, performance indicators and information on activity and outcomes related to State Government goals in its Annual Report to Parliament. • Performance reporting at State level is through the Treasury budget statements. • At a National level, performance reporting is provided against the Intergovernmental Committee on Drugs (IGCD) (through the Australian Government Department of Health+D23).

Table 11A.109 **Western Australia, community health services programs**

Programs funded by the WA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Programs	DAO provides culturally secure workforce and organisational development programs for human service agencies and staff to respond effectively to Aboriginal people affected by alcohol and other drug use. This involves policy advice and professional education and training, as well as strategic support and planning for treatment and prevention programs. DAO is a Registered Training Organisation offering nationally recognised training that complies with the Australian Quality Training Framework.	State funding is provided, with additional funding from: • WA Department of Families, Housing, Community Services and Indigenous Affairs - Breaking The Cycle of Alcohol and Drug Abuse in Indigenous Communities • COAG, Closing the Gap, Healthy Transition to Adulthood, National Partnership Agreement.	As above. Additional reporting to WA Department of Families, Housing, Community Services and Indigenous Affairs and COAG.
Workforce Development	Workforce development initiatives include: • education and training for a range of human service professionals in health, justice, child protection, community services and for specialist alcohol and drug workers; • clinical placements; and • Indigenous workforce development including nationally recognised certificate III programs for Aboriginal alcohol and drug workers.	Drug and Alcohol Office recurrent State Appropriation	• As a statutory authority, DAO reports to the Board of the Western Australian Drug and Alcohol Authority. • DAO reports financial, performance indicators and information on activity and outcomes related to State Government goals in its Annual Report to Parliament. • Performance reporting at State level is through the Treasury budget statements. • At a National level, performance reporting is provided against the Intergovernmental Committee on Drugs (IGCD) (through the Australian Government Department of Health).

Source : WA Government unpublished.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Aboriginal Health Services	A number of primary health services are accessible across South Australia aimed at providing health care checks and improving the health outcomes of the Aboriginal community across metropolitan, regional and rural areas of SA. Services provided include: • Aboriginal Family Clinic • Aboriginal Primary Health Care Access Program • Watto Purrunna Aboriginal Primary Health Care Service • Aboriginal Well Health Checks Programs • Aboriginal Family Wellness Groups Further targeted services include: • The Strong Fathers, Strong Families Project, encouraging the role and participation of Aboriginal fathers, partners, grandfathers and uncles in their children's and families' lives • Metropolitan Aboriginal Family Birthing Program, providing a culturally respectful and clinically safe program providing continuity of care for Aboriginal women during their pregnancy, birthing, and up to six weeks post natal • Aboriginal Step Down Services, aiming to improve accommodation option, access to appropriate health services and support transition of care • Country Metro Liaison Officers, enhancing the quality, safety and continuum of care for individual Indigenous patients referred to metropolitan and country general hospitals. Additionally, a number of services are provided under the COAG National Partnership on Closing the Gap in Indigenous Health Outcomes, with a specific focus on children, including:	Funding is provided through a mix of: • Commonwealth Government funding • Recurrent State Government and COAG funding • Commonwealth Government funding to a NGO • Commonwealth COAG Indigenous Nation Partnership funding • State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013.	• Monthly, quarterly and annual activity and financial data reporting. • Quarterly activity and financial data reporting to non-government organisation.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	• Aboriginal focus schools and Investing in Aboriginal Youth, providing relationship education, health literacy education and the promotion of health-protective behaviours for Indigenous youth • Children's Services as part of the Making Indigenous Health Everyone's Business initiative, aiming to increase access for Indigenous children and families to health promotion and intensive intervention services through children's services • The Early childhood services including the Aboriginal Family Birthing Program, Aboriginal Step Down Units and initial funding for support for three Aboriginal Patient Pathways Officers • The Aboriginal Health Promotion program. Further information on the above services can be found at www.sahealth.sa.gov.au/wps/wcm/connect/public+content/SA+Health+Internet/Health+services/Aboriginal+health+services/		
Allied Health Services	Non hospital based allied health services (including: speech pathology; occupational therapy; social work; psychology; dietetic/nutrition; and podiatry) are provided through CALHN, CHSALHN and NALHN. Within these services are programs specifically targets at children's health and development, including the Allied Health Services in Children's Centres Program. Allied health services are also provided through the Supported Residential Facilities (SRFs) Allied Health Program, providing assessment and care co-ordination to residents in SRFs who have disability, mental illness and complex chronic health conditions.	Funding provided through: • CALHN Intermediate Care funding • CHSALHN and NALHN funding through recurrent State Government Funding • State Government funding through the Department of Education and Child Development and delivered by CHSALHN.	Quarterly and annual client activity reports.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child Development Services	A number of services aimed at child development services are offered across South Australia, which include: Early Childhood Development Services, providing multidisciplinary interventions for children 0-4 years of age with, or at risk of, developmental delays. Service models are 1:1; group and supported playgroups options for families; and provided from primary health care centres. Children are prioritised according to levels of active adversity with Guardianship of the Minister and Aboriginal children are of the highest priority. The Child Development Unit Program, delivered through WCHN and CHSALHN, providing specialist paediatricians and allied health staff undertake comprehensive assessments of children with complex developmental/ behavioural issues which are impacting on the child's functioning and development.	Funding provided through recurrent State Government funding. The programs are delivered by CALHN, WCHN, and CHSALHN respectively.	Monthly activity and financial data reporting.
	Early Childhood Development and Disability Services, providing multi-disciplinary therapy and health interventions for children 0-5years of age (to school entry) with or at risk of developmental delays or with a disability. Some sites provide services above this age for specific needs.		Financial data reporting only.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Early Childhood Health Services	Under the Child and Family Health Service specific programs are available targeted at support in the early childhood years, including: • The Early Childhood Intervention Program which provides consultants to work within the local community to assist parent access to support services for children aged 0-8 years with a disability and/or developmental delay. • The Early Child Parent Services, providing therapeutic and family support services to families of children aged 0-3 years to improve infant wellbeing, enhance parental capacity and problem solving ability. Teams of Allied Health staff include Aboriginal and culturally specific staff, Psychologists, Social Workers and Family Workers. Services may be provided on an individual or group basis.	Funding is provided through recurrent State Government funding. The service is provided by WCHN staff and delivered under the policy direction of The Department for Education and Child Development (DECD).	Monthly activity and financial data reporting.
Child and Family Health Service	The Child and Family Health Service provides a range of child wellbeing, development and parenting supports for families of children 0-5 years of age, over 120 sites across the state. These are provided in a variety of settings, and include early parenting groups, 1:1 consultations, a residential feeding and settling service, and access to information via the telephone and internet. Where appropriate, families are linked in with other services. Parenting SA is provided through the Child and Family Health Service, offering a population strategy providing information on quality parenting practices for parents and carers of children aged 0-18 years, through free printed Parent Easy Guides for mainstream, Aboriginal and migrant families, free public seminars, and grants to local parent groups.	Funding is provided through recurrent State Government funding. The service is provided by WCHN staff and delivered under the policy direction of The Department for Education and Child Development (DECD).	Monthly activity and financial data reporting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child Health Screening Services `	Newborn and child screening services are available across the state to assist in the early identification of health issues. Such services include: • Universal Contact Visit service providing a visit from a community Child and Family Health Nurse following the birth of a baby • Newborn and Children's Hearing Service providing Universal Neonatal Hearing Screening and the Hearing Assessment service • Autism Diagnostic Service providing specialist paediatricians and allied health staff to undertake comprehensive assessments of children an Autism Spectrum Disorder. The Family Home Visiting Program, under the Child and Family Health provides a nurse led preventative home visiting program over a period of up to two years with a focus on child development and developing family and community relationships.	Funding is provided through recurrent State Government funding and serviced by WCHN staff and delivered under the policy direction of The Department for Education and Child Development (DECD). Autism diagnostic service is State Government funded for 4 years from 1 July 2010 to 30 June 2014.	Monthly activity and financial data reporting.
Community Nursing	A number of community nursing services are provided across the State, which include:		Monthly activity and financial data reporting.
	The CHSALHN Community Nursing Services, providing a broad range of community nursing services across country areas via home care nursing, including post-acute care, pre and post natal care and midwifery in select locations, palliative care, chronic disease management/ support i.e. end stage vascular disease, diabetes, respiratory disease. Provide wound management, burns management, domiciliary oxygen management, continence nursing (including stomal therapy), Diabetes Nurse Educators, breast care nursing and domiciliary care services.	Funding is provided through recurrent State Government funding. The program is delivered by CHSALHN.	

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	Additionally the Community Nursing Service is delivered through RDNS, providing longer term specialised nursing care, education, management and monitoring of clients in the extended community care and palliative care target groups. All referrals go through the Metropolitan Referral Unit.	Funding is provided by the State Government until December 2016. The program is delivered by RDNS.	
	The Health Care at Home program, aiming to provide a short term flexible, rapid response service for clients avoiding an immediate presentation to a metropolitan public hospital or Emergency Department or requiring short term post-acute services. This program operates 24 hours, seven days a week to clients in their homes/community or residential care facilities. The services provided include: neonatal, babies, children, postnatal and antenatal care, general, sub and post-acute care; end of life care, rehabilitation; wound care; medication management; mental health, and specialist nursing services. All referrals go through the Metropolitan Referral Unit.	Funding is provided by the State Government until December 2016. The program is delivered by RDNS.	
Criminal Justice Services	The Journey Home service offers mental health and wellbeing support for young people exiting the juvenile justice system, aiming to provide a culturally relevant, family inclusive and effective transition program for young offenders.	Funding is provided by the State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013 and delivered by RDNS.	Monthly, quarterly and annual activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol Services	The Drug and Alcohol Service South Australia (DASSA) deliver a number of drug and alcohol related initiatives statewide aimed at providing support for those suffering from alcohol and substance abuse and related health issues. Services include: • Drug and alcohol support for the Reunification Initiative providing services which aim to reduce the alcohol and other drug intake of parents involved in the program thereby contributing to a reduction in the numbers of children entering alternative care • Withdrawal Management Service, offering assessment and inpatient medical detoxification for people withdrawing from alcohol and a range of other drugs • Drug and Alcohol Services Program providing funding to non-government organisations to deliver counselling, residential and non-residential rehabilitation, sobering up services, Mobile Assistance Patrol services and training and sector development. Similarly community based drug and alcohol services provided include: • Alcohol and drug information service, providing a 24 hour telephone information line • Community service centres, providing counselling, assessment and referral services across Adelaide (4 clinics) and regional centres (13 clinics) • The Woolshed, a therapeutic community for 18 years and over with alcohol and drug related problems • Day centres at Ceduna and Port Augusta provide diversionary activities and non-residential rehabilitation and support • The Clean Needle Program, a public health initiative aimed at reducing the spread of blood borne viruses Further information about the above services can be found at www.dassa.sa.gov.au/site/page.cfm?u=455	Funding is provided by: • State Government funding until March 2014 • recurrent State Government funding • funding under the National Health Care Agreement • Commonwealth Government funding and reviewed annually. All programs are delivered by DASSA.	• Ad-hoc reports as required. • Expenditure report at end of financial year. • Monthly activity reports. • Quarterly service activity and financial reports. Annual activity report. National Minimum Data Set – Alcohol and Other Drug Treatment Services (NMDS-AODTS). • Quarterly and annual client activity reports. • Monthly activity reporting. • Six monthly activity and annual

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol Services – Criminal Justice	Drug and alcohol services with a specific focus on the interaction with the criminal justice system include: • The Illicit Drug Diversion Initiative, a service for people apprehended by police for minor drug offences to be diverted from the criminal justice system into education, assessment and treatment • The Community Protection Panel Assertive Case Management (CPPACM) Team, providing assertive case management to repeat young offenders (12 -20 years) and their families with the aim of reducing re-offending and promote integration, functionality and participation in their communities • The Driver Assessment Clinic, assessing drivers for alcohol and/or other drug dependency who have been referred by the Courts Administration Authority and the Registrar of Motor Vehicles • The City Watch House Community Nursing Service (CWHCNS), providing assessment, treatment, management and referral of people held in police custody at the City Watch House.	Funding is provided through: • Annual State Government funding and administered by DASSA • Funding is provided under the National Health Care Agreement • Funding is provided by the State Government until 30 June 2013 • Funding is provided through recurrent State Government funding. Programs delivered by DASSA.	• Quarterly client activity and annual financial reports to DASSA. • Quarterly service activity and financial reports. Appointment summary data. Monthly statistical reports. Annual activity report. Six-monthly progress reports. • Quarterly activity report. Annual attendance / non-attendance reports to Courts Administration Authority and the Registrar of Motor Vehicles.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Drug and Alcohol services - Aboriginal Health	Services with a focus on drug and alcohol issues within the Aboriginal Community include: • The Aboriginal Population Health Programs, which identify, develop and evaluate strategies that effectively respond to the needs of Aboriginal people and communities affected by substance misuse • The Aboriginal Connection Program, a dedicated drug and alcohol treatment service for Aboriginal clients with complex needs and who are at risk of homelessness, primarily based in metropolitan Adelaide • The APY Lands Substance Misuse Services provide a range of specialist treatment interventions for Anangu with problematic alcohol and other drug use.	Funding is provided through: • Recurrent State Government funding. • State Government funding until December 2013 • Recurrent State and Commonwealth Government funding. Programs delivered by DASSA.	Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Health Promotion	A number of primary and community services and programs with a focus on health promotion including obesity prevention, smoking prevention and active lifestyle promotion. Such services include: • The Eat Well Be Active program, addressing and advocating for programs that support healthy eating and physical activity with children and their families • The Centre for Health Promotion, statewide programs promoting parenting, breastfeeding, youth health and safe sleeping for infants • The Do it for Life Program, a lifestyle modification program aimed at high risk adults with SNAPS risk factors (Smoking, Nutrition, Alcohol, Physical Inactivity and Stress). Eligible clients are from vulnerable and disadvantaged populations who are assessed at risk of developing chronic disease • The Tackling Smoking initiative, including: o Specific initiatives aimed at the Aboriginal Community o Quit Smoking initiatives and social marketing campaigns, increasing awareness of the harms associated with tobacco use and encouraging quit attempts o The Quit SA service, smoking cessation support for South Australians through telephone counselling, and internet based information.	Funding is provided through a mix of: • Recurrent State Government and GPS funding, with programs delivered by the relevant LHNs • State Government funding under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes until June 2013 • Funding is provided through a contract with SA Health until 30 June 2014. Governance is provided by DASSA and the program is delivered by Cancer Council SA.	• Quarterly activity and financial data reporting. • Quarterly performance and monthly financial data reporting. • Final report completed. • Monthly, quarterly and annual activity and financial data reporting. • Quarterly activity and financial data reporting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Maternal Health Services	A number of programs are accessible across South Australia aimed at providing support and services to pregnant women and their families, these include: • The Pregnancy to Parenting Programs, offering support and education to families in the early pregnancy to early parenting period. Families are particularly targeted where there are vulnerable infant risk factors. One to one counselling and support particularly in relation to antenatal care, emotional well-being, psycho social issues, early parenting and child development. Services/activities provided include: antenatal education classes; postnatal reunion; young and pregnant; birth & babies; breastfeeding education; and postnatal support group • The Maternal Health Program, within CHSALHN, has a Country Maternity Services Committee to advise on models of maternity service provision for country communities. Additionally, through this program the Aboriginal Family Birthing Program provides maternal and family services to high risk pregnant Aboriginal women and families at Port Augusta, Whyalla, Ceduna, and Murray Bridge • The Community Midwifery Program, providing antenatal, birthing and postnatal services to women across Country Health South Australia.	Funding is provided through a mix of: • Recurrent State Government funding and delivered by SALHN and CHSALHN • State and Commonwealth Government funding.	Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Oral Health Services	A significant number of oral health programs are undertaken statewide by the South Australian Dental Service (SADS) with such initiatives including: • The Community Dental Service, Specialist Dental Service and Clinical Placements Program, providing emergency and general dental care (including dentures) for adult holders of a concession card and their dependents in public dental clinics • The Population Oral Health Program, undertaking the development and implementation of a Lift the Lip referral tool for general practitioners, nurses and childcare workers. • The School Dental Service, general dental care for pre-school aged, primary and secondary school children under 18 years of age. Additionally, oral health services are provided with a particular focus on vulnerable groups, including: • Oral Health Care for People with Special Needs, identification and referral to dental services of people living in Supported Residential Facilities and those experiencing homelessness • Aged Care Oral Health Projects, improving oral health of certain aged care populations, both in residential care and community living • Aboriginal Oral Health program, aiming to increase attendance of Aboriginal children and adults in mainstream dental services • Services for newly arrived migrants with a refugee background.	Funding is provided through recurrent State Government and SAIP funding. All programs are delivered by SADS.	Monthly activity, waiting list and financial data reporting. Monthly activity and financial data reporting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Palliative Care Services	Palliative care services are delivered across two Local Health Networks, which include: • The provision of palliative care services delivered through CALHN, involving integrated care across in-hospital, hospice and home. Providing links with other primary care providers for people on an end of life care pathway, with a focus on supporting people to die in their place of choice • NALHN palliative care services involving integrated care across in-hospital and out-of -hospital settings, linking with other primary care providers for people on an end of life care pathway.	Funding is provided through COAG and GPS matched funding. The programs are delivered by CALHN and NALHN.	KPI's set by the Australian Government Department of Health. Monthly activity and financial reporting.
Primary Health Nursing Programs	Multiple primary health nursing programs are delivered across various areas of metropolitan South Australia, with such programs including: • Primary health nurses work in a range of settings, such as chronic disease and risk factor programs, mental health, cancer care, health ageing, pregnancy and antenatal care • The Virtual Nursing Service, providing specialist nursing care to assist patients with Tuberculosis who have complex medication management and compliance issues to prevent a prolonged public hospital admission • Additionally offered are a range of programs aimed at reducing demand on acute services by preventing admissions to hospital and providing appropriate discharge to services closer to where people live in the home or the community.	Funding is provided through: • Recurrent State Government funding and delivered by NALHN • Recurrent State Government funding and delivered by RDNS • Non-recurrent State Government project funding and delivered by NALHN.	Monthly activity and financial data reporting. Quarterly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Refugee and Migrant Health Services	The New Arrival Refugees program is a state wide specialist General Practice service providing a range of health assessment, coordination of health care planning for new arrivals with no known medical history, complex needs and high risk indicators relevant to country or camp of origin. Services include: medical and nursing clinics; health information/ education; immunisation; counselling; and capacity building for other health providers, mainstream GPS etc.	Funding is provided through CALHN Intermediate Care funding. The program is delivered by CALHN.	Quarterly activity and monthly financial data reporting.
Rehabilitation Services	Multiple rehabilitation services are delivered within the metropolitan area, being: The Paediatric Rehabilitation Program, providing rehabilitation consultant services to community clinics to provide specialist medical assessment and intervention. It provides both inpatient and ambulatory intensive rehabilitation programs. Teams are medically led and are comprised of multi-disciplinary Allied Health Professionals. A Movement Disorders Program and Hip Surveillance Service are run through the Paediatric Rehabilitation Department located in the Women's and Children's Hospital The Northern Rehabilitation Service, which provides the maintenance of an individual's independence, function and ability through the provision of inpatient, Rehabilitation in the Home, and outpatient rehabilitation services.	The funding is provided through a combination of recurrent State Government and Federal Government Funding. The program is delivered by WCHN. The funding is provided through a mix of COAG and GPS matched funding and core funding (Casemix). The program is delivered by NALHN.	Monthly activity and financial data reporting. KPI's set by the Australian Government Department of Health. Monthly reporting to COAG and DHA. Annual reporting to COAG and DHA. Daily activity regarding bed capacity. Monthly activity and financial re+D31porting.

Table 11A.110 South Australia, community health services programs

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Rural and Remote Services	Country Health South Australia Local Health Network (CHSALHN) provide a range of primary and community health services in rural and remote areas of South Australia, including: • The GP Plus Services Better Care in the Community Chronic Disease program, servicing 13 sites in country SA, which aims to provide more coordinated and targeted care for people with chronic disease (i.e. respiratory, cardiac and diabetes related conditions) living in country SA thereby avoiding the need for hospitalisation or an extended stay in hospital • The GP Plus Services Country Nurse Initiative, aiming to increase the capacity of primary health care nursing and other service providers to provide quality health services for people with chronic disease in country SA. A key component of this initiative is to enhance the capacity of general practice through targeted support for practice nurses enabling greater involvement in nurse-led chronic disease services. Identified opportunities include direct clinical care and service coordination, maintaining good health through screening, health promotion and education for individuals and the community • The Hep C Nursing Services, establishing nurse-led services for clients with Hepatitis C living in country South Australia. Nurses will have a key role in providing a link between GPs and tertiary services, and will assess and manage Hep C clients as they navigate the pathway through treatment • The Country Home Link and Rapid Intensive Brokerage Support (RIBS) Hospital Avoidance Programs, which provide access to flexible services and equipment for country consumers to avoid the need for hospital admission to metropolitan hospital (Country Home Link) and country hospitals (RIBS). These programs also support early discharge from hospitals.	Funding is provided through recurrent State Government funding and programs are delivered by CHSALHN.	Monthly activity and financial data reporting Quarterly reporting to DH about estimated admissions avoided. Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Screening Services	The Port Pirie Lead Implementation Program (Environmental Health Centre) monitors blood in lead levels of the Port Pirie community with a particular focus on pregnant women and children 0-5 years, provides intervention to reduce blood lead levels in children and pregnant women and provides ongoing community education around lead safe practices.	The funding is provided through recurrent State Government funding. The program is delivered by CHSALHN.	Quarterly lead in blood data used as the basis of the Technical Paper produced by the Public Health Department within the Australian Government Department of Health.
Sexual Health Services	The Yarrow Place Rape and Sexual Assault Service provides 24 hour crisis response for recent sexual assault (age 16 years and above) which can include crisis counselling, ongoing counselling and support, medical care and follow up medical care, collection of forensic evidence, group programs, education, training and consultation for workers.	The funding is provided through recurrent State Government funding. The program is delivered by CALHN.	Monthly activity and financial data reporting.
Men's Primary Health Care Services	The O'Brien Street Medical Practice specialising in Gay Men's Health offers a range of targeted General Practice and primary health care services provided to HIV positive Men in partnership with GP's that are independent contractors. The practice also engages its own multidisciplinary Services: for chronic disease, HIV and HEP C management education/promotion; sexual health clinics; Allied Health, therapeutic and lifestyle counselling within CALHN.	Funding is provided through recurrent State Government funding. The program is delivered by CALHN.	Monthly activity and financial data reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Women's Health Services	The provision of numerous women's health services across metropolitan and country South Australia includes: Women's Primary Health Care Services, offering a range of services provided by a multidisciplinary team from 3 community settings aimed at prevention and early intervention to promote the health and wellbeing of vulnerable populations. Services include health education/promotion; sexual health clinics, well women clinics, nursing and medical clinics, therapeutic and lifestyle counselling and group interventions The Women's Health Statewide Service, focusing on mental health and the effects of violence and abuse, including referral, counselling in the areas of anxiety and depression related to interpersonal trauma, disordered eating; health information and resource development. Projects include a specific Aboriginal Women's health project. Key populations include Aboriginal and Torres Strait Islander, culturally and linguistically diverse and rural and remote clients. A community development project targeting women of newly arrived communities from countries which practice female genital mutilation. Support to HIV positive and affected women via Women's Health Statewide Service The Southern Women's Health Service, offering programs that focus on domestic violence, mental health and well-being, health information, support for some specific groups of women (e.g. older women, same sex attracted women and Indigenous women), and risk factor and chronic disease management.	Funding is provided through recurrent State Government funding. The service is delivered by WCHN. Funding is provided through recurrent State Government funding and budget variations and Commonwealth Public Health Outcome Funding Agreements – HIV. Governance and delivery are provided by WCHN. Funding is provided through recurrent State Government funding. The service is delivered by SALHN.	Monthly activity and financial data reporting. Quarterly performance reporting.

Table 11A.110 **South Australia, community health services programs**

Programs funded by the SA Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Youth Health Services	Youth health and wellbeing is serviced across metro and country areas through a range of Youth Primary Health Care Services offered to the community which include: • Healthy lifestyle and counselling primary health care services for young people 18-25 years • Primary health care, sexual health, mental health and drug and alcohol services for young people are provided through community health services and at a youth health service that will become part of GP Plus Health Care Centre, Marion • The Second Story Youth Health Service, providing primary health services to young people aged 12 – 25 years from key population groups, including Aboriginal and Torres Strait Islander; young people under Guardianship of the Minister, in care, or involved in the justice system; young parents; newly arrived; at risk of harm, same-sex attracted, or at risk of developing chronic disease. Services include health information, assessment and referral, sexual health, medical and nursing clinics, counselling and group programs, and funded projects.	Funding is provided through recurrent State Government funding. The service is delivered by NALHN. Funding is provided through recurrent State Government funding. The service is delivered by SALHN. Funding is provided through Commonwealth Public Health Outcome Funding Agreements –HIV. Governance and delivery are provided by WCHN.	Monthly activity and financial data reporting. Monthly activity and financial data reporting. Monthly activity and financial data reporting. Quarterly performance reporting.

Source : SA Government unpublished.

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
Primary Health	Primary Health brings together a wide range of community and rural health services to meet the needs of both individuals and local communities. Community Health Centres offer a variety of services including counselling and support, health promotion, medical, nursing, allied health services and accommodation and meeting spaces for visiting services including housing, disability and family and child health services.	The majority of funding is allocated from the State budget. During 2012-13 Tasmanian Health Organisations (North, South and North West) were responsible for area spending and overseeing program delivery.	Performance information is collected and reported at the State level through Budget Papers, Annual Report, Key Activity and Performance Information reports
	Services vary from site to site based on community need and accessibility to similar services provided by government or non-government providers. The size of sites also varies: small sites provide a limited range of services generally based around community nursing. Rural Health Facilities provide core primary health and community care services within a local community in addition to some inpatient sub-acute beds. In addition, some rural sites provide residential aged care and/or emergency services.	Services are provided in accordance with the Tasmanian Government's Output Budgeting Framework. Services are funded through identified outputs within the DHHS budget. `	National reporting through: National Minimum Data Sets; Report on Government Services; Australian Institute of Health and Welfare (AIHW); Australian Council of Healthcare Standards.
	Palliative Care Services - specialist palliative care clinicians work within a consultancy framework across the health sector to support primary health service providers in urban and rural areas to provide quality palliative care.	Australian Government funds.	Reporting in accordance with specific program requirements.

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
	Other Primary Health services include Aged Care Assessment Teams; Community Equipment Scheme; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Continence Services; Day Centres and Health Promotion activities. These may be provided at a Community Health Centre, Rural Health Facility or as a visiting service across an entire region.	Australian Government funding.	Reporting in accordance with specific program requirements.
	The Australian Government funds the Rural Health Outreach Fund (RHOF) and the Medical Outreach – Indigenous Chronic Disease Program (MO-ICDP) to provide a broad range of outreach medical, nursing and allied health services to rural and remote areas of Tasmania.	Australian Government and State funding	
	Overcoming cultural/language barriers – The Tasmanian DHHS provides access to Interpreter Services for CALD clients in all health settings as required. Overcoming geographical barriers – emergency services are provided at some rural sites and three sites also operate an ambulance service.	Services purchased on an 'as needs' basis	As above
	A range of services are provided on an outreach basis to rural communities from an urban hub – allied health services, Aged Care Assessment Teams, Continence Services, RHOF and MO-ICDP.	Australian Government and State funding	As above

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
	Telehealth is available at 140 facilities in Tasmania to facilitate clinical, administrative and professional education, supervision and development for State, Federal, NGOs ad external organisations. In addition to Australian Government contributions, the State provides funding to Health Recruitment Plus to assist recruitment and retention of rural general practitioners and to support rural medical practitioners to provide services to rural health facilities around Tasmania.		
Maternal and child health	Maternal and child health. The Child Health and Parenting Service provides child health, growth and developmental assessments, parent support and information and early intervention 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 collected and reported at State level through Budget Papers, Annual Report and the Your Health and Human Services Progress Chart.
Oral Health Services	Oral Health Services Tasmania provides emergency, general dental care and dentures to eligible adults (holders of a Health Care or Pensioner Concession Card). Services are also provided to all children up to (but not including) the age of 18. Oral Health Services Tasmania also engages in health promotion and prevention activities to promote oral health on a population basis.	As above	As above
Alcohol and drug services	Alcohol and drug services provide a range of specialist alcohol and other drug interventions and both individual and population levels.	As above	As above

Table 11A.111 **Tasmania, community health services programs**

Programs funded by the Tasmanian Government during 2012-13

Program area	*Description*	*Budgetary context*	*Reporting*
Population and Health Priorities	Population and Health Priorities focuses on population groups (including Indigenous health and women's and men's health) and implements programs aimed at preventing or reducing risk factors that lead to chronic conditions.	As above	As above
Public and Environmental Health Services	Public and Environmental Health Services monitors the health of the Tasmanian population, and implements programs to protect and promote health.	As above	As above
	Overcoming socioeconomic barriers- a range of transport services to access health care is available to people who are transport disadvantaged either because of socioeconomic circumstances or because health and disability preclude use of their own or public transport. Any services that charge fees are means tested such that those in receipt of pensions and are health care card holders either pay a reduced fee or are exempt from fees.	As above	As above
	Overcoming social isolation barriers- day centres around the state provide social support and activities for the frail, aged and people with a disability. Community Health provides coordination of community recovery responsibilities covering the human and social elements of disaster recovery.	As above	As above

Source : Tasmanian Government unpublished.

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Community Care, Division of Rehabilitation, Aged and Community Care	Provides multidisciplinary continuum of care services (nursing, podiatry, physiotherapy, occupational therapy, nutrition and social work), acute, post acute and rapid response services, specialist nursing assessments, self management of chronic conditions program, and Falls & Falls Injury Prevention Program.	Through a designated budget: • Some services HACC funded • Remainder ACT Government funded	Monthly and annual reports against a range of indicators including output targets, budget and quality indicators. The ACT Government Health Directorate's Annual Report includes Accountability Indicators related to the achievement of occasions of service targets for nursing and allied health services. HACC outputs data reported quarterly, submitted biannually.
Health Call Centre	The ACT is one of the Australian jurisdictions which jointly funds Healthdirect Australia. Healthdirect Australia procures and contract manages third party providers to deliver telehealth services free of charge to the Australian public. These services include: - 24/7 nurse-based telephone triage - Health advice and information - After Hours GP Line - A Pregnancy, Birth & Babies Helpline and Website - Mental health information portal - HealthInsite - a health and wellbeing information website - National Health Service Directory Healthdirect ensures patients access the right health advice at the right time and identifies other health service providers for improved connection of care.	Jointly funded by the ACT Government and the Australian Government.	Reporting is conducted by Healthdirect

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Community Health Intake	Community Health Intake facilitates access to community health services by providing a single point of entry to services. The public can phone Community Health Intake for information about health services or to arrange appointments with health professionals in community settings. Health professionals can fax referral forms to Community Health Intake for processing. Community Health Intake also has a dedicated GP phone line which provides information about community health services, provides information about clients with existing referrals, and transfers GP calls to other services and programs.	Funded by the ACT Government.	Monthly reporting to operational management
Primary Health Care (afterhours)	• Canberra Afterhours Locum Medical Service (CALMS) is an accredited, primary medical care service available to all ACT residents based on clinical need. The service is operated by General Practitioners and nurses. • CALMS provides high quality accredited, afterhours primary medical care to residents of the ACT, including Residential Aged Care Facilities (RACFs) through clinics at Calvary Public Hospital, the Canberra Hospital and Tuggeranong Health centre and the visitation to patient's place of residence. • The service operates throughout the entire afterhours period i.e., from 6:00pm to 8:30am Monday through Friday, and 24-hours a day on weekends and public holidays. The services is open 365 days per year.	• In 2012-2013 CALMS operated under a Service Funding Agreement (SFA) with ACT Health. • ACT Health funds CALMS based on their operational activity in the previous quarter. • CALMS operates under the policy goals of the ACT Primary Health Care Strategy 2011-2014 that take a broad view of comprehensive and inclusive approach in primary health care.	• The current requirements for ACT Health funded SFAs, require NGOs to provide ACT Health with − 6-monthly financial and performance reports; and − annual audited financial reports and performance requirements reports.

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Justice Health Services	The Justice Health Service provides: 1. The Justice Health Service represents a combination of the Primary Health Team and Forensic Mental Health Services delivered at the Alexander Maconochie Centre (Adults), the Bimberi Youth Justice Centre (Adolescents and Youth) and the Periodic Detention Centre (Adults). The Forensic Mental Health Services also delivers services to the Courts and in the general Community. 2. The Primary Health Team provides and coordinates clinical services at secondary and tertiary level to people in the Alexander Maconochie Centre (AMC) and Bimberi Youth Justice Centre (BYJC) respectively. 3. The Forensic Mental Health Services (FMHS) provides specialist forensic mental health services within the AMC and BYJC for people with moderate and severe mental illness. FMHS also provides Mental Health services at the Courts and to high risk and complex consumers in the Community via their Forensic Community Outreach Service (FCOS).	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Women, Youth and Children Community Health Program	Provides: • Maternal and Child Health nursing services including universal first home visit, child health checks, early childhood immunisation, parenting education and support and vulnerable families program. • Child Health Targeted Support services including Child Health Medical Officers and Community Paediatricians; the Child at Risk Health Unit. Provides specialist health services to children and young people and their families or carers who have been affected by abuse and neglect; and the IMPACT Program which supports families who are pregnant or have children less than 2yrs and are clients of Mental Health and or are receiving Opioid Replacement Therapy. • School based programs including immunisation programs; kindergarten health checks, school youth health nurses; nursing in special schools and support for children with complex health issues in schools. • Asthma education, nurse audiometrists and orthoptic screening, social work physiotherapy, and nutrition services. • Specialised services for children dependent on respiratory technology in homes and schools. • Women's Health Service provides nursing, medical and counselling services, including cervical screening, for women who experience significant barriers to accessing health services. • Child Protection Training	Through a designated budget	Monthly/Annual reports against output targets and budget

Table 11A.112 **Australian Capital Territory, community health services programs**

Programs funded by the ACT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Dental Screening	The Dental Health Program conducts screening and health promotion activities targeting early childhood and primary school aged children, Koori pre-schools and alcohol and drug programs. The Dental Health Program has various Memorandum's of Understandings with external stakeholders to facilitate timely and appropriate access. The targeted client groups include refugees, homeless people, clients with disabilities, mental illness and alcohol and drug programs, Winnunga Nimmityjah Aboriginal Health Services and some specified medical conditions. Through the collaboration with Adelaide University, the Dental Health Program hosts dentistry student placements. With the combination of student placements and a recruitment strategy, the public dental workforce capacity is positive with no dentist vacancies.	Through a designated budget	Monthly reporting through scorecard

Source : ACT Government unpublished.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Oral Health Services	Oral Health Services provide free assessment and treatment to all children up to school-leaving age and to adults holding a current Healthcare Concession Card or Pensioner Concession Card. Services are delivered from community and school based clinics in urban areas and clinics in health centres as well as mobile trucks in remote communities. Services are also provided to eligible clients through the Special Needs clinic and treatment under general anaesthetic is provided in both urban and regional centres. Community level and individual oral health promotion activities are also conducted. Primary and community health objectives targeted: • promoting health and preventing illness • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s). Population groups served: • children up to school-leaving age and • adults holding a current Healthcare Concession Card or Pensioner Concession Card.	Funding sources: • NT Department of Health • Australian Government via National Partnership Agreements (NPAs) Budget management/oversight by Director Health Development Branch. Governance oversight by Executive Director Territory-wide Services Program delivery via services managed by Health Development Branch.	Routine reporting: • Executive Monthly Performance Reports (internal) and • Department of Health Annual Report, Health Development and Promotion Output report (public). • Quarterly (internal) and bi-annual (public) against both NPAs Implementation reports, (internal/public).

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Men's Health	The Men's Health Strategy Unit (MHSU) provides expert advice, leadership and strategic directions in men's health with a particular focus on Aboriginal male health. The MSHU leads the development of a men's health strategy and strategic planning of programs and services to improve health outcomes of men living in the NT, especially vulnerable populations of men. The MHSU plays a support role for Aboriginal Male Health Coordinators working in remote communities to engage men and undertake health promotion activities. It coordinates the delivery of urban based male health awareness activities through the 'Pitstop' program. It is involved in staff training on male health aimed at improving service capability for males. The MHSU also encourages and promotes the development of a research effort around gender and health to improve access and use of gendered data to inform program development. Primary and community health objectives targeted: • promoting health and preventing illness Population groups served: • men, with a particular focus on Aboriginal men.	Funding source: Northern Territory Government via Department of Health budget Budget spending / oversight by Director Health Development Branch. Governance oversight by Executive Director Territory-wide Services. Program delivery (limited direct funding) by NT Department of Health and NGO service providers	Routine reporting: Department of Health Annual Report, Health Development and Promotion Output report (public).

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Remote Health	Remote Health delivers evidence based, best practice primary health care services to Aboriginal and non-Aboriginal people in remote areas from a network of 54 Department of Health managed community health centres, and collaborates with non-government Aboriginal community controlled health services. Remote Health workforce consists of rural medical practitioners, remote area nurses, Aboriginal health practitioners, Aboriginal community workers and allied health professionals providing direct care to clients as a collaborative multidisciplinary team. Services include primary health care, 24 hour emergency care, medical evacuations, care and treatment for chronic disease and public health programs. In the remote setting, primary health care professionals work collaboratively with other departmental program professionals to deliver integrated and coordinated care, targeting Preventable Chronic Disease, Maternal Child and Youth Health, Oral and Ear Health, Sexual Health, Mental Health, Alcohol and Other Drugs and Aged and Disability Services.	Funding sources: 1. Northern Territory Government via Department of Health budget 2. Australian Government Department of Health through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) • Primary Health Care base • Stronger Futures Remote Services Primary Health Care • Child and Maternal Health • Substance use 3. Medicare Local Northern Territory (MLNT) Primary Health Care Initiative	Routine Reporting: Bi-annual • Financial report to OATSIH • Written report on Child and Maternal Health to OATSIH • Written report on CQI to OATSIH • Written report to MLNT on PHC initiative Annual • Department of Health Annual Report (public). • Financial report to OATSIH
	Remote Health manages the relationships between the Northern Territory and Australian Government agencies and non-government organisations involved in primary health care, and for developing sustainable systems for effective and efficient service delivery. Consultation also occurs with the community to foster and develop community capacity, facilitate community decision making, promote and support the employment of local people and establish effective governance systems so that health services can successfully and confidently make the full transition to community controlled entities.	Budget spending/oversight by Director Remote Health Branch. Governance oversight by Executive Director Territory-wide Services. Program delivered by -Remote Health services and -Remote Health grant funded non-government Aboriginal community controlled organisations.	

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Child / Youth Health Services	Child and Youth Health supports service providers delivering preventive health programs for children across the Northern Territory. Acknowledging the role of social determinants as drivers of poor child and adult health outcomes, and that these determinants do not sit solely within a health context, there is coordination between governmental and non-governmental services supporting children's and families' health and well-being in the Territory. This strategic approach supports frontline staff working directly with children and families, to deliver evidence-based programs, with a focus on client outcomes and program evaluation. There has been significant work in progression of the Healthy Under 5 Kids program as the universal child health program for all children across the Northern Territory, regardless of geography or service agency. Supporting this, is development of a child health information management system that allows appropriate program monitoring and workforce planning, indicates areas of high need and that provides a clearer of the picture of children's health in the Territory. Development of a number of high-level discussion papers looking at the drivers of youth (12-24 y.o.) morbidity and mortality in the NT provide the evidence-base for the ongoing development a specific Youth Health Strategy for the Territory. Council of Australian Government Indigenous Early Childhood Development NPA provides funding for programs supporting young people in respect of pregnancy and parenting.	Funding sources: -Northern Territory Government Department of Health budget, Remote Health Services Output. -Northern Territory Government Closing The Gap funds. -Australian Government Indigenous Early Childhood Development NPA.	Routine reporting: - Department of Health Annual Report, Health Development and Promotion D7Output report (public). Quarterly (internal) and annual external reports against Australian Government Indigenous Early Childhood Development NPA Implementation Plan.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Public Health Nutrition and Physical Activity	Services are delivered both by public health nutritionists usually located within multi-disciplinary teams, and policy officers based in the Strategy Unit. Public health nutritionists (PHNs) provide training and support to primary health care teams to promote healthy nutrition and regular physical activity to the community, and assist with the management of people with nutrition related conditions. They also offer individual and group dietetic consultations through community care centres and health clinics in both urban and remote area. PHNs also work with agencies outside the health sector (e.g. the Department of Families, Housing, Community Services and Indigenous Affairs Stores Licensing Unit and Outback Stores) to increase food security by improving food supply and stimulating demand for healthy food in remote community stores. PHNs also work with the education sector to ensure meals and food provided at schools, are in line with the Australian Dietary Guidelines for Children. The strategy unit focuses on providing strategic direction, developing relevant Northern Territory policies and guidelines, or contributing to national developments (e.g. the development of a new National Nutrition Strategy). At times, this work involves collaboration with other government agencies (e.g. the Northern Territory Department of Education, and research institutions (e.g. Menzies School of Health Research).	Funding sources 1. Northern Territory Government via Department of Health budget 2. Australian Government Department of Health via • the Stronger Futures NT NPA (previously Enhanced Health Services Delivery Initiative) • the NPA on Preventive Health, under the Healthy Children Initiative 3. NT Medicare Local (under Medical Outreach Indigenous Chronic Disease Program) – provision of clinical dietetic services in remote communities. Budget spending/oversight by Health Development Branch Directorate. Governance oversight by Executive Director Territory-wide Services. Program delivered by NT Department of Health with NGO partnerships.	-Department of Health Annual Report, Urban and Remote Health Services Output reports (public). -Quarterly (internal) and annual (public) reports to Australian Government -Monthly activity reporting to NT Medicare Local (internal/public)

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The strategy unit, in partnership with the South Australian Government and the City of Palmerston, are currently piloting a multi-strategy, community-based obesity prevention initiative called Childhood Obesity Prevention and Lifestyle (COPAL) in Palmerston. COPAL was developed as part of the National Partnership Agreement (NPA) on Preventive Health under the Healthy Children Initiative. It aims to promote healthy eating and increase children's participation in physical activity, with the long term goal of reducing rates of childhood obesity.		
Health Promotion Strategy Unit	The core function of the Health Promotion Strategy Unit (HPSU) is to build and strengthen capacity for effective health promotion and prevention in the Department of Health (Department of Health) and its partners across government and non-government sectors. This involves facilitating a uniform understanding of health promotion across Government and non-Government health and related sectors; providing strategic and policy support to key stakeholders, staff and organisations; and a commitment to planning for health promotion through investment in research, program planning, and evaluation; social marketing; healthy workplaces; and developing sustainable education and training pathways.	Funding sources -NT Department of Health. -Australian Government via NPAs	-Performance targets against key functions of Community Health and Public Health Services. -Financial reports in Department of Health Annual Report. -Six monthly and annual reports related to Australian Government funding. -Reporting against the Preventative Health NPA and Indigenous Early Childhood Development NPA

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The HPSU plays a key role in providing leadership in relation to Priority Area Action 1 in the Department of Health Corporate Plan, which relates to promoting and protecting good health and preventing injury. A key focus has been to develop and implementing a Northern Territory Health Promotion Framework, provide Health Promotion Training and Education options across the Territory health and community sector, establishing and supporting of healthy workers programs, supporting health promotion settings approaches such as health promoting health services and hospitals, providing health promotion information to professionals, communities and individuals in the NT, working with research organisations on identifying affective strategies and enablers to develop a health literate system, and providing a planning and evaluation system for health promotion programs for Department of Health and its partners. The HPSU has continued its commitment to maintain the relationship with education institutions and research bodies. The HPSU also provides jurisdictional leadership in relation to the national preventative health agenda.		

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Hearing Services	Hearing Services are mostly provided in specialised hearing centres located in remote and urban community health centres, or hospital facilities. A multidisciplinary team of specialists provide; hearing loss prevention, otitis media care coordination, diagnostic hearing assessment and support ENT services including E-Teleotology. Hearing services are provided through integrated care pathways and support community based health, early childhood and education strategies for identifying, managing and promoting ear health and hearing. The Universal Neonatal Hearing Screening (UNHS) program for permanent hearing loss is provided through all urban birthing hospitals.	Funding sources - NT Department of Health, and -Australian Government for additional ear health and hearing services for Indigenous children. Budget spending/oversight by Directors of Health Development (remote areas) and Community Health Branches (urban areas) Governance oversight by Executive Director Territory-wide Services. Service delivery by Department of Health NT Hearing Program (Community Health) and Hearing Health Program (Health Development).	Routine reporting: Annually Department of Health Annual Report public. Performance targets for Australian Government-funded programs and consented service event data shared with AIHW are published annually.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Chronic Condition Services (previously Preventable chronic disease)	The Chronic Conditions Strategy Unit (CCSU) provides leadership and evidence-based advice to support the implementation of effective actions for prevention and management of chronic conditions. The CCSU works closely with policy makers, senior managers, health professionals, researchers and education providers in government and non-government services across the Territory. The Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020 is the key document that guides Northern Territory health services, with all services committed to joint implementation. The priority areas include addressing social determinants and an increased focus on primary prevention. Major work completed in 2012-13 including development and trialling of a visual culturally appropriate self management assessment tool, as a collaboration between Flinders University, Menzies school of Health research and NT Department of Health. The Diabetes in Pregnancy NHMRC partnership project has had significant progress with the establishment of a NT clinical register, development of referral pathways for each region, implementation of formal early screening and enrolment in the research project. Commitments of funding from NTG and AG for expanded cardiac services has seen work done on introducing low risk angioplasty, establishment of networked EGCs to enable a centralised database and expansion of cardiac nurse coordinators.	Funding sources Northern Territory Department of Health. Australian Government and NT Government via -Closing the Gap Partnership Agreements to expand services for people with chronic conditions and -NPA / other Health Department funding for chronic conditions prevention related activities.	Routine reporting: Department of Health Annual Report, annual, public. Chronic disease indicators in the Northern Territory Aboriginal Health KPIs. (not public) Quarterly reporting per Closing the Gap NPA.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
School Health Services	Community Health provides a School Health Service to 15 Northern Territory Government middle, secondary and special schools Health Promoting School Nurses work in partnership with school staff using a health promotion approach to integrate health education into the curriculum within an overarching Health Promoting Schools framework. The key outcome areas are: 1. support delivery of health education in: • Smoking, alcohol and other drugs • Nutrition • Physical Activity • Health and Wellbeing • Sexual Health 2. work with the school community to plan, develop, implement and evaluate school identified health promoting programs, policies and strategies 3. contribute to health and wellbeing through early intervention efforts aimed at reducing the longitudinal incidence of chronic disease, and risk taking behaviours during youth/adolescence 4. establish networks to facilitate health and wellbeing information to the school community through *partnerships.*	Funding Source Northern Territory Department of Health Budget spending/oversight by Director Community Health. Governance oversight by Executive Director Territory-wide Services Program delivered by Community Health Branch via School Health Service.	Routine reporting: Quarterly internal. Reported in Community Health section of Department of Health Annual Report, annual, public.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Urban Community Health	The Community Health Branch provides a range of key primary health care services directly and in partnership with other health stakeholders across the urban centres of Darwin, Palmerston, Alice Springs, Katherine, Tennant Creek and Nhulunbuy. Services include Child, Youth and Family Health Services, Community and Primary Care Services (including social work, palliative care, specialist nursing services and a community resource team), Hearing Services, School Health Services, Sexual Assault Referral Centres and Home Birth Services in Darwin. The Branch participates in regional and national primary health care reforms and seeks to improve access and equity to services for urban communities. The Branch also funds a number of non-government organisations to provide services to achieve outcomes within the areas of Child and Family Health, and Community and Primary Care.	Funding sources -NT Department of Health. -Australian Government funding (for Home And Community Care services via Specialist Nursing program) Budget spending/oversight by Director Community Health Branch. Governance oversight by Executive Director Territory-wide Services. Program delivered by Community Health plus small number of non-government organisations in some regional centres.	Routine Reporting: Department of Health Annual Report, annual, public. -Service events, training and client numbers per the Specialist Nursing program supplied biannually to the Australian Government.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Women's Health	The Women's Health Strategy Unit (WHSU) engages in strategic planning and policy development for women's health at the national and Territory level in partnership with government and community stakeholders and coordinates and leads Department of Health responses to this work. WHSU project instigates leads and project manages key strategic pieces of work to progress priority women's health issues such as those for Aboriginal and Torres Strait Islander Women, Migrant and Refugee Women and Domestic and Family Violence. The Unit also manages the work of the Women's Information Service (WISe) in Alice Springs, and acts as a source of information and leadership across the Department in regard to all aspects of women's health. WHSU has instigated and leads a strategic approach to gender as a key determinant of health both in the Department of Health, with other key stakeholders and services providers and as the Department of Health representative on the Office of Women's Policy Gender Equity Panel. Collaborative work has occurred with Branches across the Department to promote screening for family violence and consistent recording in clinical systems to enable better monitoring.	Funding source Northern Territory Government via an identified program within the Department of Health budget. Budget spending/oversight by Director Health Development Branch. Governance oversight by Executive Director Territory-wide Services Program delivery via strong collaboration with NGO partners..	Routine reporting: Department of Health Annual Report, annual public

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Sexual Health and Blood Borne Viruses Program	NT wide program aimed at prevention, treatment, surveillance and control of sexually transmitted infections and blood borne viruses such as HIV/AIDS and Hepatitis C. The program operates five sexual health clinics, known as Clinic 34, in the major towns that aim to improve access to early testing and treatment for STIs and BBVs for member of the priority populations identified in the National STI and BBV strategies. The program provides technical and financial support to primary care services in rural and remote areas. The program funds community based organisations to develop and implement STI and BBV prevention programs, including an NT wide Needle and Syringe Program. Clinical education programs are provided both directly and through supporting the other training organisation. Several research programs are supported, involving both local and national partnerships. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) The Adolescent Sexuality Education Project (ASEP) is a collaboration between the Northern Territory (NT) Department of Education and Children's Services (DECS) and the Department of Health (DoH) in association with the Central Australian Aboriginal Congress (CAAC) and is a component of the National Partnership Agreement on Indigenous Early Childhood Development. The partnership is funded for 5 years by the Office of Aboriginal and Torres Strait Islander Health to provide targeted sexual and reproductive health education to Indigenous adolescents in schools and community settings • promoting health and preventing illness.	Funding source: NT Department of Health. OATSIH and an NPA. • Budget/spending oversight: • NT Department of Health and OATSIH • Delivery oversight: • NT Department of Health • Program delivery: • NT Department of Health, NT AIDS and Hepatitis C Council, Family Planning NT • ASEP: Funding Source: Australian Government NPA • Budget/spending oversight: • NT Department of Health and OATSIH • Delivery oversight: • NT Department of Health • Program delivery: NT Department of Health, NT AIDS and Hepatitis C Council, Family Planning NT	Routine Reporting: Annually and Quarterly reporting against business plan of Sexual Health and Blood Borne Virus Unit, (internal). ASEP Routine Reporting: Quarterly (internal), Quarterly (external) reporting against NPA

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Rheumatic Heart Disease	NT wide program aims to reduce the burden of rheumatic heart disease amongst the Indigenous population by reducing the occurrence of acute rheumatic fever. The program provides health professionals and community members with best practice support, education, resource development and supply and patient care. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) • promoting health and preventing illness	Funding Source: Australian Government NPA • Budget/spending oversight: • CDC – NT DoH • Delivery oversight: • CDC – NT DoH • Program delivery: • CDC – NTDoH	Routine reporting: 6 monthly reporting against NPA
TB Control Unit	The TB Control Unit covers screening of high risk groups (contacts, refugees, prisoners, health workers, Irregular Maritime Arrivals (IMAs) and 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. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) • promoting health and preventing illness	Funding Sources: • NT Department of Health • DIAC for the Illegal Foreign Fisherman (IFF) and IMAs. • Budget/spending oversight: • CDC - NTDoH • Delivery oversight: • CDC- NTDoH • Program delivery: • CDC - NTDoH	Routine reporting: • Estimates data reports, annually, public • NT Department of Health Annual Report, annual, public.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
Australian Bat Lyssavirus Pre and Post Exposure Prophylaxis (and rabies post exposure) Service	CDC provides education and (privately purchased) rabies vaccine for pre-exposure prophylaxis against Australian Bat Lyssavirus (ABL) to persons at risk of occupational exposure. Post-exposure rabies immunoglobulin and vaccine is administered in Darwin and some regional centres to those potentially exposed to both rabies virus and ABL. Education programs are provided to the community and to occupational groups. • promoting health and preventing illness	Funding sources: 1) NT Department of Health. 2) Australian Government Department of Health refunds 50% of the cost of rabies immunoglobulin administered to people who are bitten or scratched by bats only. • Budget/spending oversight: • NTDoH • Delivery oversight: • NTDoH • Program delivery: • NTDoH	Routine reporting: • NT Department of Health Annual Report, annual, public.

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
NT Trachoma Service	The trachoma service is a public health program that is working towards the global elimination of blinding trachoma. Chlamydia trachomatis is an infectious disease that is the most common cause of preventable blindness and blindness resulting from infection. Australia is the only first world nation that still has blinding trachoma. The Surgery; Antibiotics; Facial cleanliness; Environmental control (SAFE) strategy for the elimination of trachoma underpins service provision. This manifests as: • establishing pathways of referral to ophthalmology services; • training the health workforce to identify Trichiasis (eye lashes abrading the cornea); • conducting screening on high risk populations, and determining the prevalence for a predetermined subset of the at risk population, • coordinating the appropriate pharmacological intervention based upon the prevalence of the trachoma in the population. • training the health workforce to identify Trachoma and how to provide appropriate individual and population controls. • developing and implementing health promotion strategies to enhance the frequency of “clean faces”, which is a key intervention in interrupting the transmission of the infection. • identifying and advocating for the presence of suitable health hardware such as taps and basins, which facilitates hand and facial cleanliness.	Funding source: DoHA – OATSIH via NT Department of Health Budget oversight: program section head Centre for Disease Control (CDC) and the territory program coordinator. Governance oversight: OATSIH, the Director of Centre for Disease Control, the program section head (CDC) and the territory program coordinator Program delivered by: NT Department of Health: CDC, Remote Health, Health Development Unit; NGOs including Sunshine Health Board, Katherine West Health Board, CAAC, Indigenous Eye Health Unit – University of Melbourne, and the Kirby Institute. `	Routine: • Quarterly to OATSIH; Annually in Department’s Annual Report (public)

Table 11A.113 **Northern Territory, community health services programs**

Programs funded by the NT Government during 2012-13

Program	*Description*	*Budgetary context*	*Reporting*
	The primary goals of the service are: • to reduce the prevalence of trachoma infection to less than 5%. This is evident when high risk populations have demonstrated continuous and sustained prevalence below 5% for at least five years as per the WHO guidelines. • to demonstrate the continuous and sustained reduction of the frequency of Trichiasis to below 1 in 1000 for at least five years in at risk populations. The target population for the service is those at risk of blinding trichiasis / trachoma. This is comprised of indigenous people living in remote locations. • providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s) • promoting health and preventing illness		

Source : NT Government unpublished.

Data quality information — Primary and community health, chapter 11

Data Quality Information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Primary and community health chapter. DQI for additional indicators will be progressively introduced in future reports.

Where RoGS indicators align with National Agreement indicators, DQI has been sourced from the Steering Committee's reports on National Agreements to the COAG Reform Council.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI are available for the following performance indicators and measures:

Availability of PBS medicines 3
Measure 1: People per pharmacy by region 3
Measure 2: PBS expenditure per person by region 5
Measure 3: Equity of access to PBS medicines 7
Availability of GPs by region 8
Availability of female GPs 11
Early detection and early treatment for Indigenous people 13
Proportion of children receiving a fourth year developmental health check 16
People deferring visits to GPs due to financial barriers 19
GP Waiting times 23
Selected potentially avoidable GP-type presentations to emergency departments 27
People deferring purchase of medicines due to financial barriers 31
Public dentistry waiting times 35
Management of upper respiratory tract infections 39
Management of diabetes — annual cycle of care 41
Management of diabetes — HbA1c level 47
Management of asthma 50

Use of pathology tests and diagnostic imaging 53
Patient satisfaction 57
Health assessments for older people 61
Cost to government of general practice per person 64
Child immunisation coverage 66
Notifications of selected childhood diseases 69
Participation rates for women in cervical screening 72
Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions 74
Selected potentially preventable hospitalisations for diabetes 79
Potentially preventable hospitalisations of older people for falls 82

Availability of PBS medicines

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Measure 1: People per pharmacy by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure (computation)	People per pharmacy by region *Definition* The estimated resident population (ERP) divided by the number of pharmacies, in urban areas and in rural areas *Numerator* ERP for urban areas and for rural areas *Denominator* Number of pharmacies in urban and in rural areas *Computation* Numerator ÷ Denominator
Data source/s	University of Adelaide's National Centre for Social Applications of Geographic Information Systems, using Department of Human Services, Medicare pharmacies data and ABS ERP data.

Data Quality Framework Dimensions

Institutional environment	Australian Government Department of Health, PBS data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are presented by State/Territory by urban and rural location. Urban and rural location for ERP is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year from 2012-13. For previous years, geographical location is based on the ABS Australian Standard Geographical Classification 2006 as at 30 June preceding the reference year. 'Urban' constitutes ASGS 'Major cities'. Rural constitutes inner regional, outer regional, remote and very remote areas combined. Urban and rural location for pharmacies is based on the Pharmacy Access/Remoteness Index of Australia (PhARIA) classification. PhARIA is a composite index that incorporates measurements of general remoteness based on the ASGS and previously the ASGC with a professional isolation component represented by the road distance to the five closest pharmacies. 'Urban' is equivalent to the ASGS 'Major cities'. Rural constitutes the remaining PhARIA categories (2 to 6) combined.
Timeliness	Reliable PBS data are available 16 weeks after the close of the reference period.
Accuracy	

Coherence	Estimates are compiled the same way across regions and over time. The ERPs used to derive rates differ across years. For data up to 2010-11 rates are derived using preliminary ERPs based on the 2006 Census. For data from 2011-12 rates are derived using ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data do not include Aboriginal Medical Services that can supply medications to people in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] for the purpose of improving access to medicines for people in those areas. This has particular relevance for the NT, as 43.9 per cent of the population live in remote and very remote areas.
- Disaggregation of data by region is limited to 'Urban' (equivalent to major cities) and 'Rural' (all other areas). Further disaggregation of rural data would be of value.

Measure 2: PBS expenditure per person by region

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure (computation)	PBS expenditure per person by region *Definition* Expenditure on Pharmaceutical Benefits Scheme (PBS) medicines divided by the ERP, by remoteness area *Numerator* Expenditure on PBS medicines *Denominator* ERP *Computation* Numerator ÷ Denominator
Data source/s	*Numerator* Australian Government Department of Health, PBS Statistics *Denominator* ABS ERP as at 30 June preceding the reference year for 2012-13.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Expenditure data are reported on a cash basis and are available by region only for general and concessional categories. Therefore, data exclude expenditure on doctor's bag and other categories administered under special arrangements, such as, medications dispensed to Aboriginal Medical Services in remote and very remote areas under s.100 of the *National Health Act 1953* (Cwlth) for the purpose of improving access to PBS medicines for Indigenous people and others located in those areas. This expenditure, $36.9 million in 2012-13, is not suitable for computation of expenditure per person as 'catchment' areas for Aboriginal Medical Services cross regional boundaries. Geographical location is based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification from 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification. This constitutes a break in time series; data for 2012-13 are not comparable with data for previous years.
Timeliness	Reliable PBS date of supply data are available 16 weeks after the close of the reference period.
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across regions. The change to ASGS based geographical location for 2012-13 from RRMA based geographical location for previous years constitutes a break in time series. Data for 2012-13 are not comparable with data for previous years. Data are not directly comparable to data published in the DoHA annual

report, which are prepared on an accrual accounting basis and include doctor's bag and other categories administered under special arrangements (such as medications dispensed to remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth].)

Accessibility	Information is available for PBS expenditure data from www.pbs.gov.au/info/browse/statistics.
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data are reported only at the national level; reporting by State/Territory is a priority
- Data exclude medications supplied to Aboriginal Medical Services in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] for the purpose of improving access for Indigenous people and others located in those areas.
- Geographical location is based on the ASGS 2011 classification system from 2012-13, a key improvement over the classification system used for previous years that was developed in 1994.

Measure 3: Equity of access to PBS medicines

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to PBS medicines
Measure (computation)	Proportion of PBS prescriptions filled at a concessional rate *Definition* The number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. *Numerator* The number of PBS prescriptions filled at a concessional rate *Denominator* The total number of prescriptions filled.
Data source/s	Australian Government Department of Health, PBS Statistics.

Data Quality Framework Dimensions

Institutional environment	PBS expenditure data are an administrative by-product of claims for PBS reimbursement and details on under co-payment scripts submitted by pharmacists.
Relevance	Data are reported by State/Territory.
Timeliness	Reliable PBS supply data are available 16 weeks after the close of the reference period
Accuracy	The supply data has an accuracy of approximately 98 per cent after 16 weeks.
Coherence	Estimates are compiled the same way across jurisdictions and over time.
Accessibility	Information is available for PBS data from www.pbs.gov.au/info/browse/statistics
Interpretability	PBS statistics and explanatory notes are published at www.pbs.gov.au/pbs/home

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Data do not capture medicines supplied by Aboriginal Medical Services in remote and very remote areas under s.100 of the *National Health Act 1953* [Cwlth] for the purpose of improving access to medicines for Indigenous people and others located in these areas. This has particular relevance for the NT as around 43 per cent of the population live in these areas.

Availability of GPs by region

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measures (computation)	Availability of general practitioners (GPs) by region. Definition The number of Full-time Workload Equivalent (FWE) GPs per 100 000 people, by region. Numerator: Number of FWE GPs. Denominator: Estimated Resident Population (ERP) by region. Computation: 100 000 × (Numerator ÷ Denominator).
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December in the reference year.

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* (previously *Medicare Australia Act 1973*) and regularly provides the data to DoHA.
Relevance	Geographical location based on the ABS Australian Statistical Geography Standard 2011 (ASGS) classification as at 30 June preceding the reference year for 2012-13. For previous years, geographical location is based on the Rural, Remote and Metropolitan Area (RRMA) classification — urban includes 'Capital city' and 'Other metropolitan area'; rural includes 'Large rural centres', 'Small rural centres', 'Other rural areas', 'Remote centres' and 'Other remote areas'. The RRMA classification was developed in 1994 based on population figures and Statistical Local Area (SLA) boundaries as at the 1991 census. It has not been officially updated and does not reflect population growth or redistribution since 1991 — metropolitan, rural and remote areas are defined as they existed in 1991. GP headcount and FWE figures include vocationally recognised as well as non-vocationally recognised general practitioners. GP headcount is a count of all GPs who have provided at least one DHS, Medicare service during the reference period and have had at least one claim for a DHS, Medicare service processed during the same reference period. GP headcount is generally an unreliable measure of workforce supply in Australia due to the high proportion of casual and part-time practitioners accessing DHS, Medicare. FWE is a standardised measure adjusted for the partial contribution of casual and part-time doctors and is a more reliable estimate of the GP workforce.

FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full-time doctors for the reference period.

Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure.

Example 2: A part-time GP billing half the services of the average for full-time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.

A GP can work at more than one location. Allocation of GP headcount to state or territory and region is based on the practice location at which the GP provided the most DHS, Medicare services during the reference period. FWE allocates activity based on the practice location at which services were rendered within the reference period.

From 2007-08 to 2011-12 under the RRMA based geographical classification, data are reported separately for NSW and the ACT. Data for previous years a for NSW and the ACT are combined for confidentiality reasons. The ACT has no rural areas.

Timeliness

GP headcount and FWE figures are available 10 weeks after the close of the reference period.

Accuracy

GP headcount figures include only those GPs that both claimed and provided a service in the reference period. A small number of GPs may provide services in one year for which all claims are not processed until the next year. As additional months or DHS, Medicare claims data are processed, a small number of providers will become eligible for inclusion in the headcounts. Revision of headcount figures will result in very small differences to published figures each year. FWE figures are not revised each year.

Since the commencement of DHS, Medicare, practitioners have provided demographic information to DHS, Medicare including date of birth and gender. Demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare Australia. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data.

To overcome the problems and biases posed by missing data, similar practitioners were grouped based on known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.

Coherence

The change in geographical location classification constitutes a break in time series. Data for 2012-13 are not comparable with data for previous years.

Estimates are compiled the same way across jurisdictions.

Accessibility

Information is available for MBS Claims data from www.mbsonline.gov.au and www.medicareaustralia.gov.au/.

Interpretability

General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The classification system used to allocate GPs to regions for the reference year 2012-13 is current, a major improvement over data for previous years which were based on a system developed in 1994
- Data are reported for 5 regional categories for 2012-13, compared to only 2 broad regional categories for previous years.

Availability of female GPs

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Equity of access to GPs
Measures (computation)	Availability of female general practitioners (GPs) Definition The number of Full-time Workload Equivalent (FWE) female GPs per 100 000 females. Numerator: Number of FWE female GPs. Denominator: Estimated Resident Population (ERP) of females. Computation: 100 000 × (Numerator ÷ Denominator).
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA.
Relevance	Female FWE GP figures include vocationally recognised as well as non-vocationally recognised female general practitioners. FWE is a standardised measure used to estimate the workforce activity of GPs, adjusting for the partial contribution of casual and part-time doctors. FWE is calculated by dividing each doctor's DHS, Medicare billing by the average billing of full-time doctors for the reference period. Example 1: A busy GP billing 50 per cent more services than the average full-time GP will be recorded as 1 in the headcount figure and 1.5 in the FWE figure. Example 2: A part-time GP billing half the services of the average for full-time GPs will be recorded as 1 in the headcount figure and 0.5 in the FWE figure.
Timeliness	FWE figures are available 10 weeks after the close of the reference period.
Accuracy	FWE figures are not revised each year. Since the commencement of DHS, Medicare, demographic information has been provided by practitioners to DHS, Medicare including date of birth and gender. The demographic details are updated when practitioners review, renew or change their registration details with DHS, Medicare. While the demographic data for current practitioners is generally very accurate and complete, there are some instances of missing data. To overcome the problems and biases posed by missing data, similar

	practitioners were grouped based on the known demographic information and missing demographic field/s were imputed using a standardised method to maintain data integrity. As a result, some minor changes to the distribution of GPs based on GP age or gender may occur when newly released figures are compared with previous versions.
Coherence	Estimates are compiled the same way across jurisdictions and over time.
	For data to 2010-11, rates are derived using the ABS 2006 Census based ERP as at 30 June preceding the reference year. From 2011-12, rates are derived using the preliminary ABS 2011 Census based ERP as at 31 Decmber in the reference year.
	Rates derived using ERPs based on different Censuses are not comparable.
Accessibility	Information is available for MBS Claims data from www.mbsonline.gov.au and www.medicareaustralia.gov.au/
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/ General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following: • Data are of acceptable accuracy.

Early detection and early treatment for Indigenous people

Data quality information has been developed by the Health Working Group for three measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Early detection and early treatment for Indigenous people
Measures (computation)	Definition 1. The proportion of older people who received a health assessment by Indigenous status 2. The proportion of older Indigenous people who received a health assessment, time series 3. The proportion of Indigenous people who received a health assessment, by age group Numerators: The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period. The number of people aged 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period. The number of people aged 0–14 years, 15–54 years, or 55 years or over with an MBS claim for Items 704, 706, 708, 710 or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period. Denominators: The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period. The population of Indigenous people aged 55 years or over in the reference period. The population of Indigenous people aged 0–14 years, 15–54 years, and 55 years or over in the reference period. Computation: 1.–3. 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerators: Australian Government Department of Human Services (DHS), Medicare data. Denominators: Denominators computed by the Secretariat using Estimated Residential Population (ERP) data from the Australian Bureau of Statistics (ABS). Total population: ABS various years, *Australian demographic statistics*, Cat. no. 3101.0. For data by Indigenous status: ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment

MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA.

The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.

Relevance

These measures relate to specific DHS, Medicare services for which claims data are available.

Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly because the life expectancy of Indigenous people is, on average, relatively low.

Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received, and might not be where the service was provided.

For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to each age group.

Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.

Timeliness

MBS claims data are available within 14 days of the end of a month.

Accuracy

Data include all claims processed up to 12 months after the service is received. Current year data are preliminary and subject to revision in subsequent reports.

Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.

Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.

Clients are counted once only in the reference period.

Data do not include:

- health assessment activity for which practitioners do not claim the rebate
- services that qualify under the DVA National Treatment Account and services provided in public hospitals
- Child Health Checks received under the NT Emergency Response.

Data have not been adjusted to account for known under-identification of Indigenous status in MBS data.

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can

be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis.

As of 1 May 2010:

- MBS Items 704, 706, 708, 710 (age-based Health Assessments for Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715)
- MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received.

Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.

Accessibility

Information is available for MBS Claims data from www.health.gov.auinternet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.

Interpretability

DHS, Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 and www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- No adjustment was made to this indicator to account for under-identification of Indigenous people in DHS, Medicare data.

Proportion of children receiving a fourth year developmental health check

Data quality information for this indicator has been prepared based on the Steering Committee's 2012 report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description	
Element	Equity — access
Indicator	Developmental health checks.
Measures (computation)	Proportion of children who have received a 4 year old development health check. Numerator: The number of people aged 3, 4 or 5 years with an MBS claim for Items 709, 711, 701, 703, 705, 707 and 10 986 (Healthy Kids Check or Health Assessment) or 708 and 715 (Aboriginal and Torres Strait Islander Peoples Health Assessment) in the reference period. Denominator: The population aged 4 years, estimated using ERP data from the ABS. It was calculated by multiplying the 0-4 years ERP disaggregated by Indigenous status by the percentage of children aged 4 years in this age group nationally. Calculation: 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare Statistics data. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period. For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June in the year preceding the reference period.
Data Quality Framework Dimensions	
Institutional environment	DHS, Medicare processes claims made through the MBS under the *Human Services (Medicare) Act 1973*. These data are then regularly provided to DoHA. Data for 2009-10 and 2010-11 were calculated by DoHA, using a denominator supplied by the AIHW. DoHA drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) and then further comments were added by the AIHW, in consultation with DoHA. Data from 2011-12 are calculated by the Secretariat using numerator data supplied by DoHA and denominator data sourced from the ABS.
Relevance	The measure relates to specific identified DHS, Medicare services for which DHS, Medicare has processed a claim. The MBS items included in this indicator do not cover all developmental health check activity such as that conducted through state and territory early childhood health assessments in preschools and community health centres.
Timeliness	MBS claims data are available within 14 days of the end of a month. The indicator relates to all claims processed in the reference year.
Accuracy	As with any administrative system a small degree of error may be present in the data captured.

Analyses by state/territory are based on postcode of residence of the client as recorded by DHS, Medicare at the date the last service was received in the reference period. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.

Data to 2010-11 are based on the date the claim was processed. From 2011-12, data are based on the date the service was rendered. Current year data are preliminary and subject to revision in subsequent reports.

Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.

Children who received more than one type of health check are counted once only in the calculations for this indicator. Where a child received both a healthy kids check and an Aboriginal and Torres Strait Islander people's health assessment during the reference period, the child was counted once against the Aboriginal and Torres Strait Islander health assessment.

From 2011-12, children are counted only if they have not received a fourth year developmental health check in a previous reference period.

MBS data presented for Aboriginal and Torres Strait Islander Peoples Health Assessments have not been adjusted to account for known under-identification of Indigenous status.

Cells have been suppressed where the numerator is less than 10 for confidentiality reasons and where rates are highly volatile (for example, the denominator is very small) or data are known to be of insufficient quality (for example, where Indigenous identification rates are low).

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

As of 1 May 2010, the following changes to MBS items occurred:

- The Healthy Kids Check Item 709 was replaced with four MBS health assessment items (based on time and complexity) that cover all ages — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). This renders it possible that health assessments for refugees and humanitarian entrants and for people with an intellectual disability (previously claimed under items 714, 718 or 719 and now claimed under the new MBS health assessment items) have been counted. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low for children aged 3–5 years.
- A Healthy Kids Check provided by a practice nurse or a registered Aboriginal health worker on behalf of a medical practitioner (previously item 711) was replaced with MBS item number 10 986. The change to the MBS item number does not impact time series analysis.
- The Aboriginal and Torres Strait Islander Child Health Check (previously item 708) was replaced by the Aboriginal and Torres Strait Islander People's Health Assessment (715) that has no designated time or complexity requirements and covers all ages. The change to the MBS item number does not impact time series analysis.

Accessibility

Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-

	benefits-schedule-mbs-1.
	Disaggregation of MBS data by remoteness area are not publicly available elsewhere.
Interpretability	DHS, Medicare claims statistics are available at www.health.gov.au /internet/main/publishing.nsf/Content/Medicare+Statistics-1 and www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Data do not include developmental health check activity conducted outside the MBS, for example, in preschools and community health centres. Accordingly, the indicator understates developmental health check activity. • No adjustment was made to this indicator to account for under-identification of Indigenous children in DHS, Medicare data.

People deferring visits to GPs due to financial barriers

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	People deferring access to GPs due to cost.
Measures (computation)	Definition Proportion of people that required GP treatment but deferred that treatment due to cost. Numerator: People reporting deferring access to a GP in the last 12 months due to cost. Denominator: People aged 15 years and over who needed to see a GP in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au. Collection authority: The *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. Data Compiler(s): Data are compiled by the Health section of the Australian Bureau of Statistics (ABS). Statistical confidentiality is guaranteed under the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.
Relevance	Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia). Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: Data are not available by Indigenous status for this indicator. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on people deferring the purchase of prescribed medicines due to cost but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11, people living in very remote communities (including discrete Indigenous communities)
- from 2011-12, people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

As data are drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2012-13 data used for this measure became available 22 November 2013.

The 2010-11 and 2011-12 data used for this indicator became available in November of 2011 and 2012, respectively.

The 2009 data used for this measure became available in July 2010. Referenced Period: July 2012 to June 2013 (2012-13 data), July 2011 to June 2012 (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase will

	improve the reliability of the data, particularly at finer levels of disaggregation. The sample size for the 2010-11 data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey. Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent; response rate for the 2010-11 survey was 81.4 per cent; response rate for the 2009 survey was 88 per cent. Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable State and Territory data and, from 2011-12, remoteness breakdowns. An exception to this would be State data for Tasmania, ACT and NT, where RSEs are consistently higher than other States. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data. Known Issues: Data were self-reported.
Coherence	Consistency over time: Data are not comparable over time, due to changes in question wording and sequencing in 2011-12, and a further change in sequencing in 2012-13. Data were first collected for this measure in 2009. Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other. The numerator and denominator are compiled from a single source. Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT). Jurisdiction/Australia estimate calculation: All estimates are compiled the same way. Collections across populations: Data is collected the same way across all jurisdictions. The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.
Accessibility	Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11*, *2011*-12, and 2012-13 (Cat. no. 4839.0). The data are shown by age, sex, remoteness and SEIFA. Jurisdictional data are not currently publically available but may be made available in the future. Data are not available prior to public access. Supplementary data are available. Additional data from the Patient Experience Survey are available upon request. Access permission/Restrictions: Customised data requests may incur a charge. Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

The 2012-13 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2012-13* (Cat. no. 4839.0). The ABS 2010-11 and 2011-12 Patient Experience data are published in ABS 2011 and 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11* and *2011-12* (Cat. no. 4839.0). These publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in these publications.

An overview of results for the 2009 Patient Experience Survey is published in *ABS 2010 Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are for the first time available for the Indigenous population, from the 2012-13 NATSIHS. Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- Data are not comparable over time due to changes in question wording and sequencing. Comparable time series data is a priority.

GP Waiting times

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	GP Waiting Times
Measures (computation)	Definition Length of time a patient needs to wait to see a GP for an urgent appointment. Numerator Number of people who reported seeing a GP for urgent medical care (for their own health) within specified waiting time categories (less than 4 hours, 4 to less than 24 hours, 24 hours or more). Denominator Number of people aged 15 years or over who saw a GP for urgent medical care (for their own health) in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Patient Experience Survey, ABS.

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au. Collection authority: The *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. Data Compiler(s): Data are compiled by the Health section of the ABS. Statistical confidentiality is guaranteed under the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.
Relevance	Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia). Data Completeness: All data are available for this measure from this source.

Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2009, people living in remote communities
- for 2010-11, people living in very remote communities (including discrete Indigenous communities)
- from 2011-12, people living in discrete Indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas (although discrete Indigenous communities were still excluded). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. The definition of 'urgent medical care' was left up to the respondent, although discretionary interviewer advice was to include health issues that arose suddenly and were serious (e.g. fever, headache, vomiting, unexplained rash), and that seeing a GP to get a medical certificate for work for a less serious illness would not be considered urgent.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2012-13 data used for this indicator became available 22 November 2013.

The 2010-11 and 2011-12 data used for this indicator became available in November of 2011 and 2012, respectively.

The 2009 data used for this indicator became available in July 2010. Referenced Period: July 2012 to June 2013 (2012-13 data), July 2011 to June 2012 (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: The sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation. The sample size for the 2010-11 data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent; response rate for the 2010-11 survey was 81.4 per cent; response rate for the 2009 survey was 88 per cent.

As data are drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a RSE between 25 and 50 per cent should be used with caution, and estimates with a RSE over 50 per cent are considered too unreliable for general use.

This indicator generally has acceptable levels of sampling error and provides reliable data for most breakdowns. However, RSEs for remote/very remote breakdowns are mostly greater than 25 per cent and should either be used with caution or are considered too unreliable for general use.

Known Issues: Data were self-reported and interpretation of urgent medical care was left up the respondent.

The data are self-reported but not attitudinal, as respondents are reporting their experiences of using the health system (in this instance, the time they waited between making an appointment for urgent medical care and the time they got to see the GP).

Coherence

Consistency over time: Data for 2012-13 are comparable to data for 2011-12 but are not comparable to data for previous years, due to a significant change in question wording and coding methodology in the 2011-12 survey. Data were first collected for this measure in 2009.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in*

Australia, 2009 (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11*, *2011-12*, and *2012-13* (Cat. no. 4839.0).

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period which should minimise any seasonality effects in the data.

The 2012-13 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2012-13* (Cat. no. 4839.0). The ABS 2010-11 and 2011-12 Patient Experience data are published in ABS 2011 and 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11* and *2011-12* (Cat. no. 4839.0). These publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in these publications.

An overview of results for the 2009 Patient Experience Survey is published in *ABS 2010 Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2011-12 and 2012-13 are comparable. A significant change in the question wording and coding method for the 2011-12 survey means that data from 2011-12 onwards are not comparable with data for prior years. Comparable time series data is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are based on waiting times for self-defined urgent medical care.
- Disaggregation of this measure by Indigenous status is a priority.

Selected potentially avoidable GP-type presentations to emergency departments

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Attendances at public hospital emergency departments that could have potentially been avoided through the provision of appropriate non-hospital services in the community.
Measures (computation)	The number of presentations to public hospital emergency departments in hospitals that were classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals), where: • there was a type of visit of Emergency presentation (or, for SA for 2008-09 and 2009-10, Emergency presentation or Not reported) • a triage category of 4 or 5 was allocated • the patient did not arrive by ambulance or police or correctional vehicle; and • the patient was not admitted to the hospital, was not referred to another hospital, and did not die.
Data source/s	This indicator is calculated using data from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), based on the national minimum data set (NMDS) for Non-admitted patient emergency department care (NAPEDC).

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Minister for Health. The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection. The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting. One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics. The *Australian Institute of Health and Welfare Act 1987*, in conjunction with

compliance to the *Privacy Act 1988* (Cwlth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website <www.aihw.gov.au>

Data for the NESWTDC were supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement (see the following web pages):

www.aihw.gov.au/nhissc/
meteor.aihw.gov.au/content/index.phtml/itemId/182135

The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

The purpose of the NNAPEDCD is to collect information on the characteristics of emergency department care (including waiting times for care) for non-admitted patients registered for care in emergency departments in selected public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or B (Large hospitals). In 2012–13, hospitals in peer groups A and B provided about 86 per cent of all public hospital emergency occasions of service.

From August 2011 the scope of the NNAPEDCD has expanded due to reporting for the National Health Reform Agreement (NPA IPHS), with hospital coverage including Peer Group A, B and Other. For the duration of the agreement, hospitals that have not previously reported to the NNAPEDCD NMDS can come into scope, subject to agreement between the jurisdiction and the Commonwealth.

The data presented here are not necessarily representative of the hospitals not included in the NNAPEDCD. Hospitals not included do not necessarily have emergency departments that are equivalent to those in hospitals in peer groups A and B.

The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council, to be completed by the end of 2013.

The indicator includes only peer group A (Principal referral and Specialist women's and children's hospitals) and peer group B (Large hospitals).

Analyses by state/territory are based on the statistical local area (SLA) of usual residence of the patient. Hence, data represent the number of presentations for patients living in each state/territory (regardless of the jurisdiction of the hospital where they presented).

Other Australians includes separations for non-Indigenous Australians and those for whom Indigenous status was not stated.

Timeliness

The reference period for these data is 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13**.**

Accuracy

For 2009-10 to 2011–12, the coverage of the NNAPEDCD was 100 per cent in all jurisdictions for public hospitals in peer groups A and B. For 2012–13, the preliminary estimate of the proportion of emergency occasions of service reported to the NNAPEDCD was 100% for public

hospitals in peer groups A and B (for review).

In the baseline year (2007-08), the Tasmanian North West Regional Hospital comprised the combined activity of its Burnie Campus and its Mersey Campus. This hospital was a Peer Group B hospital. There was then a change in administrative arrangements for Mersey and it became the only hospital in the country owned and funded by the Australian Government and, by arrangement, operated by the Tasmanian Government. This administrative change necessitated reporting of these campuses as separate hospitals from 2008-09 onwards. On its own the North West Regional Hospital (Burnie Campus only) is a Peer Group B hospital, whilst, on its own the Mersey Community Hospital is a Peer Group C hospital. Burnie and Mersey did not substantially change their activity, rather, it is simply a case that activity is now spread across two hospitals. For National Healthcare Agreement purposes, although it is a Peer Group C hospital, the Mersey Community Hospital continues to be included in reporting for Peer Group B hospitals to ensure comparability over time for Tasmania.

From 2009-10, the data for the Albury Base Hospital (previously reported in New South Wales hospital statistics) were reported in Victorian hospital statistics. This change in reporting arrangements should be factored into any analysis of data for New South Wales and Victoria.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Comparability across jurisdictions may be impacted by variation in the assignment of triage categories.

Coherence

The data reported for 2012-13 are consistent with data reported for the NNAPEDCD for previous years for individual hospitals.

In addition, the data reported to the NNAPEDCD in previous years has been consistent with the numbers of emergency occasions of services reported to the National Hospital Establishments Database (NPHED) for each hospital for the same reference year.

Time series presentations may be affected by changes in the number of hospitals reported to the collection and changes in coverage.

The information presented for this indicator is calculated using the same methodology as data published in *Australian Hospital Statistics: emergency department care and elective surgery waiting times* (report series) and the *National healthcare agreement: performance report 2011-12*.

However, 2011-12 data reported previously in these publications are different from the equivalent data published here because the hospitals classified as peer groups A and B were based on 2010-11, rather than 2011-12, peer groups.

Caution should be used in comparing these data with earlier years, as the number of hospitals classified as peer group A or B, or the peer group of a hospital, may vary over time.

Accessibility

The AIHW provides a variety of products that draw upon the NNAPEDCD. Published products available on the AIHW website are the *Australian*

hospital statistics suite of products with associated Excel tables. These products may be accessed on the AIHW website at: www.aihw.gov.au/hospitals/

Interpretability

Metadata information for the NAPEDC NMDS and the NAPEDC DSS are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

METeOR and the National health data dictionary can be accessed on the AIHW website at:

meteor.aihw.gov.au/content/index.phtml/itemId/181162

www.aihw.gov.au/publication-detail/?id=6442468385

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The scope of the data used to produce this indicator is non-admitted patients registered for care in emergency departments in public hospitals classified as either peer group A (Principal referral and Specialist women's and children's hospitals) or peer group B (Large hospitals).
- For 2011-12, the coverage of the NNAPEDCD collection is complete for public hospitals in peer groups A and B. It is estimated that 2012-13 has similar coverage, although final coverage cannot be calculated until the 2012-13 NPHED data are available.
- The definition of potentially avoidable GP type presentations is an interim measure, based on data available in the NNAPEDCD. The AIHW is managing revision work for this indicator under the auspices of the Australian Health Ministers' Advisory Council, to be completed by the end of 2013.
- Caution should be used in comparing these data with earlier years as the number of hospitals classified as peer group A or B, and the peer group classification for a hospital, may vary over time.

People deferring purchase of medicines due to financial barriers

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	People deferring purchase of prescribed medicines due to cost.
Measures (computation)	Definition Proportion of people that deferred purchase of prescribed medicines due to cost. Numerator: Number of people who reported delaying or not getting a prescription filled for medication in the last 12 months because of cost. Denominator: Total number of people aged 15 years or over who received a prescription for medication from a GP in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au. Collection authority: The *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. Data Compiler(s): Data are compiled by the Health section of the Australian Bureau of Statistics (ABS). Statistical confidentiality is guaranteed under the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.
Relevance	Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia). Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: Data are not available by Indigenous status for this indicator. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on people deferring the purchase of prescribed medicines due to cost but differences in survey design and collection methodology between the Patient Experience survey and the

NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11, people living in very remote communities (including discrete Indigenous communities)
- from 2011-12, people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

As data are drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2012-13 data used for this indicator became available 22 November 2013.

The 2010-11 and 2011-12 data used for this indicator became available in November of 2011 and 2012, respectively.

The 2009 data used for this indicator became available in July 2010. Referenced Period: July 2012 to June 2013 (2012-13 data), July 2011 to June 2012 (2011-12 data), July 2010 to June 2011 (2010-11 data); July to December 2009 (2009 data).

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial

increase from the 2011-12 sample size of 26 437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation. The sample size for the 2010-11 data was 26 423 fully-responding households; sample size was 7124 for the 2009 survey.

Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent; response rate for the 2010-11 survey was 81.4 per cent; response rate for the 2009 survey was 88 per cent.

Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable State and Territory data and, from 2011-12, remoteness breakdowns. An exception to this would be State data for Tasmania, ACT and NT, where RSEs are consistently higher than other States. Similarly, data for the "other" remoteness category has high RSEs when cross classified by State. Caution should be used when interpreting these data.

Known Issues: Data were self-reported.

Coherence

Consistency over time: Data for 2010-11, 2011-12 and 2012-13 are comparable over time but are not comparable to data for 2009, due to a change in question wording and sequencing. Data were first collected for this measure in 2009.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the 2011-12 and 2012-13 surveys, and of very remote communities in the previous surveys, will affect the NT more than it affects other jurisdictions (people usually resident in very remote areas account for about 23 per cent of people in the NT).

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Accessibility

Data are publicly available in *Health Services: Patient Experiences in Australia, 2009* (Cat. no. 4839.0.55.001), *Patient Experiences in Australia: Summary of Findings, 2010-11*, *2011*-12, and *2012-13* (Cat. no. 4839.0). The data are shown by age, sex, remoteness and SEIFA. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

The 2012-13 ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings, 2012-13* (Cat. no. 4839.0). The ABS 2010-11 and 2011-12 Patient Experience data are published in ABS 2011 and 2012 *Patient Experiences in Australia: Summary of Findings, 2010-11* and *2011-12* (Cat. no. 4839.0). These publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in these publications.

An overview of results for the 2009 Patient Experience Survey is published in *ABS 2010 Health Services: Patient Experiences in Australia, 2009*, Cat. no. 4839.0.55.001.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- The sample size increase from 26 423 in 2011-12 to 30 749 in 2012-13 strengthens reliability of the population-level estimates.
- Disaggregation of this indicator by Indigenous status is a priority.

Public dentistry waiting times

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — access
Indicator	Public dentistry waiting times.
Measures (computation)	Definition Waiting time between being placed on a public dentistry waiting list and being seen by a dental professional. Numerator: Number of people aged 15 years or over on a public dental waiting list who reported seeing a dental professional at a government dental clinic (for their own health) within specified waiting time categories (less than 1 month, 1 month or more). Denominator: Number of people aged 15 years or over who were on a public dentistry waiting list (for their own health) in the last 12 months. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au. Collection authority: The *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. Data Compiler(s): Data are compiled by the Health section of the ABS. Statistical confidentiality is guaranteed under the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.
Relevance	Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and very remote Australia). Data Completeness: All data are available for this indicator from this source. Indigenous Statistics: Data are not available by Indigenous status for this measure. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on public dentistry waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not

comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- people living in discrete Indigenous communities.

The 2011-12 iteration of the Patient Experience survey was the first to include households in very remote areas, (although it still excluded discrete Indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the Northern Territory.

As data are drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

Data were self-reported for this indicator.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: The 2012-13 data used for this indicator became available 22 November 2013.

Referenced Period: July 2012 to June 2013.

There are not likely to be revisions to this data after its release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: The sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase will improve the reliability of the data, particularly at finer levels of disaggregation.

Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent.

As data are drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates

with a RSE between 25 and 50 per cent should be used with caution, and estimates with a RSE over 50 per cent are considered too unreliable for general use.

Standard Errors: RSEs are greater than 25 per cent for waiting times less than 1 month for SA, the ACT and the NT and should therefore be used with caution.

Known Issues: This indicator may not cover those who saw a public dental professional but were not placed on a public dental waiting list.

Coherence

Explanatory footnotes are provided with the data.

Consistency over time: Data are not comparable over time, due to a significant change in question wording and sequencing in the 2012-13 survey. In 2011-12, respondents were instructed to exclude treatment for urgent dental care and were limited to those whose most recent dental visit was to a government clinic. In contrast, in 2012-13 respondents were not instructed to exclude treatment for urgent dental care and included all people who needed to see a dental professional.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of discrete Indigenous communities in the sample will affect the NT more than it affects other jurisdictions.

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data is collected the same way across all jurisdictions.

Accessibility

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Data publicly available. Tables showing waiting times for dental professionals are available in *Patient Experiences in Australia: Summary of Findings, 2011-12* and *2012-13* (Cat. no. 4839.0).

The dental data available in 4839.0 are shown by SEIFA, remoteness, country of birth, self-assessed health status and whether has a long term health condition. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.

Interpretability

Context: The data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. The data were collected over a twelve month period and therefore should minimise any seasonality effects in the data.

Other Supporting information: The ABS Patient Experience data are published in *Patient Experiences in Australia: Summary of Findings,*

2011-12 and *2012-13* (Cat. no. 4839.0). This publication includes explanatory and technical notes. Any ambiguous or technical terms for the data are available from the Technical Note, Glossary and Explanatory Notes in that publication.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2012-13 are not comparable with data for prior years due to changes in question wording and sequencing in the 2012-13 survey. Comparable time series data is a priority.
- The inclusion of very remote areas from the 2011-12 survey improves the comparability of NT data, although the exclusion of discrete Indigenous communities will affect the NT more than it affects other jurisdictions.
- Data are for the first time available for the Indigenous population, from the 2012-13 NATSIHS. Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The sample size increase from 26 423 in 2011-12 to 30 749 in 2012-13 strengthens reliability of the population-level estimates.

Management of upper respiratory tract infections

Data quality information has been developed by the Health Working Group for one of the measures for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Management of upper respiratory tract infections
Measures (computation)	Definition The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided per 1000 people. Numerator: The number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided and dispensed. Denominator: ERP. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.
Data source/s	Numerator: Australian Government Department of Health Pharmaceutical Benefits Scheme (PBS) Statistics data. Denominator: ABS preliminary ERP based on the 2011 Census at 31 December in the reference year.

Data Quality Framework Dimensions

Institutional environment	PBS claims data is a record of all dispensed prescriptions subsidised by the Australian Government. The PBS is managed by DoHA and administered by the Department of Human Services (DHS), Medicare. Provisions governing the operation of the PBS are contained in the *National Health Act 1953*. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and ABS ERP.
Relevance	These measures relate to PBS subsidised oral antibiotics used most commonly in treating URTI: 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 that were ordered by GPs and dispensed to patients were extracted for each reference period. These antibiotics are used to treat a range of conditions in addition to URTI. Data disaggregated by the condition being treated are not available. The proportion of these antibiotics prescribed for treatment of URTI is unknown. Allocation to state or territory is based on the state or territory of the pharmacy supplying the prescription.
Timeliness	PBS claims data are available within three working days of the end of a month.
Accuracy	PBS data for 2012-13 are complete. For previous years, PBS data for general patients was available only for items priced above the PBS general

	co-payment ($35.40 in 2012) and therefore, the majority of script data for these patients was missing.
	Data include only prescriptions provided by GPs and OMPs.
Coherence	Data for 2012-13 are not comparable to data for previous years which were available only for concession card holders.
Accessibility	PBS Claims data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp.
Interpretability	Information on PBS data is available from www.medicareaustralia.gov.au/provider/pbs/stats.jsp at the PBS item reports and PBS group reports links.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • URTI is one of a range of conditions for which these antibiotics are prescribed. Data are not able to be disaggregated by condition. • The availability of complete data on the selected antibiotics dispensed in the general population significantly improves data quality for 2012-13.

Management of diabetes — annual cycle of care

Data quality information for this measure has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Chronic disease management.
Measure (computation)	Management of diabetes — annual cycle of care. Definition Proportion of people with diabetes mellitus who have received a Medicare Benefits Schedule (MBS) annual cycle of care Numerator Number of people with a completed MBS diabetes annual cycle of care processed by the Australian Government Department of Human Services (DHS), Medicare within the reference period. Denominator Number of people diagnosed with Type 1 and Type 2 diabetes in the community. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Numerator DHS, Medicare Statistics data. Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. Denominator For 2011-12 and 2012-13 data: the National Health Survey (NHS) component of the ABS Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope population derived from the Estimated Resident Population (ERP). For information on scope and coverage, see the ABS *Australian Health Survey Users Guide* (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. For data for 2008-09 to 2010-11: the National Diabetes Services Scheme (NDSS), an administrative database that provides counts of people known to have diabetes (through certification of diagnosis by a doctor or diabetes educator) who access NDSS services. ABS ERP by remoteness area, as specified in the Australian Standard Geographical Classification, as at 30 June in the year preceding the reference period.

Data Quality Framework Dimensions

Institutional environment

MBS

DHS, Medicare Statistics data processes claims made through the MBS under the *Human Services (Medicare) Act 1973*. These data are then regularly provided to DoHA. DHS, Medicare also processes claims for DVA Treatment Card holders, also made through the MBS, under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Human Services (Medicare) Act 1973*. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.

AHS

The AHS was collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au.

NDSS

The NDSS is a subsidy scheme administered by Diabetes Australia Ltd, since its establishment in 1987, on behalf of DoHA.

At the point of registration with the Scheme, people provide demographic data, details of the type of diabetes they have and how it is treated. This information is held on a central database by Diabetes Australia Ltd and is uploaded monthly.

Diabetes Australia Ltd is a national federated body supporting people with diabetes and professional and research bodies concerned with the treatment and prevention of diabetes; see www.diabetesaustralia.com.au/en/About-Diabetes-Australia/.

Computations

Data for 2011-12 were calculated by the Secretariat using numerator data supplied by DoHA and denominator data sourced from the ABS.

Data for 2008-09 to 2010-11 were prepared by DoHA and the DVA and quality-assessed by the AIHW. DoHA drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) and then further comments were added by the AIHW, in consultation with DoHA and the DVA. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator. For further information see the AIHW website.

Relevance

DoHA MBS Statistics and DVA TAS data

The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim.

Data for 2011-12 are preliminary and do not include DVA data.

For 2010-11, DVA clients comprised less than 4 per cent of people who received a GP annual cycle of care.

The analyses by state/territory and remoteness are based on postcode of

residence of the client as recorded by DHS, Medicare at the date of last service received in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received. There were a small number of DoHA MBS records with a postcode that was invalid or did not map to a remoteness area (59 records). These records were excluded from the analysis.

AHS

The 2011-12 NHS component of the AHS collected self-reported data for people told by a doctor or nurse that they had diabetes and that it was current and long-term; that is, their diabetes was current at the time of interview and had lasted, or was expected to last, 6 months or more. Data exclude respondents who reported they had diabetes but that it was not current at the time of interview. More accurate information on the number of people with diabetes based on measured blood sugar levels will be available upon release of results from the National Health Measures Survey in 2013.

NDSS

The number of registrants on the NDSS can be counted to estimate diabetes prevalence. However, registration is voluntary and therefore it is likely that a proportion of people with diagnosed diabetes are not registered with the Scheme. Diabetes Australia estimates that the NDSS covers 80 per cent to 90 per cent of people with diagnosed diabetes.

NDSS data allow for disaggregation by area (based on postcode). As with the MBS data, there was a small number of records with a postcode that was invalid or did not concord to a remoteness area (310 records).

The indicator aggregates people with Type 1 and Type 2 diabetes (as using data linkage to disaggregate the data would raise Privacy Act concerns). However, while people with type 1 diabetes are significantly more likely to require a care plan, type 2 diabetes comprises around 85 per cent of all records. Consequently, aggregating data does not give an accurate proportion of people with each type of diabetes who have an MBS annual cycle of care.

The NDSS-sourced denominator includes only Type 1 and Type 2 diabetes. Therefore, people diagnosed with 'other diabetes' were excluded (5043 people in the 2010-11 data; 4434 in the 2009-10 data and 5235 people in the 2008-09 data).

Timeliness

DoHA MBS Statistics and DVA TAS data

The MBS data used in this indicator relate to all claims processed in the financial reference year.

AHS

The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

NDSS

NDSS data are updated continuously. Data are available on a monthly basis from Diabetes Australia Ltd. The NDSS data used for this indicator relate to all registrants as at 30 June.

Accuracy

DoHA MBS Statistics and DVA TAS data

As with any administrative system a small degree of error may be present in the data captured.

DHS, Medicare claims data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.

Data are based on the date on which the MBS claim was processed by DHS, Medicare, not when the service was rendered. The use of data based on when the claim was processed rather than when the service was rendered produces little difference in the total number of people included in the numerator term for the reference period.

AHS

The AHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of people usually residing in very remote areas has a small impact on estimates except for the NT, where they make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The data used in this indicator generally have acceptable levels of sampling error.

Self-reported data can introduce bias into the estimate of diagnosed diabetes prevalence. An estimation of self-reporting bias made from the 1999–2000 AusDiab study found that approximately 9 per cent of participants who self-reported having diabetes did not have blood glucose levels in the diabetes range (AIHW 2009, Diabetes prevalence in Australia: an assessment of national data sources, Cat. no. CVD 46, Diabetes series no. 14). More accurate information on the number of people with diabetes based on measured blood sugar levels will be available upon release of results from the National Health Measures Survey in 2013.

NDSS

The AIHW estimates the number of duplicate records in the NDSS to be small (only 0.4 per cent of records from a subset of NDSS data as at June 2009). A small number of people who no longer have diabetes or who have died are likely to still be in the database.

The NDSS requires certification of a diagnosis of diabetes before an individual can register. This eliminates any self-report bias, but excludes those people with undiagnosed diabetes.

The NDSS may underestimate the prevalence of diabetes in remote areas due to a shortage of doctors/diabetes educators needed to approve registration application.

Postcodes (used for disaggregation by remoteness area) relate to the registrant's place of residence as recorded at the point of registration. This is likely to be accurate, as registrants have an incentive to update this information if and when they move so as to ensure products supplied to them under the NDSS are delivered to their correct place of residence.

Cells have been suppressed where the numerator is less than 10 to protect confidentiality.

Coherence

The 2011-12 denominator data source differs from the source for previous reference periods. The 2011-12 data are not comparable with data for the earlier reference periods. For 2008-09 to 2010-11, interpretation of rates over time should not be undertaken as the prevalence estimate (denominator) increases each year with the increased coverage of the NDSS.

The reference period is not consistent across the data sources — the MBS data relate to all claims processed over the financial year, while the AHS data relate to the previous 12 months and NDSS data include all registrants on the database at a point in time (30 June).

Accessibility

MBS

DHS, Medicare claims statistics are available at:

- www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1;
- www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

Disaggregation by remoteness area is not publicly available elsewhere.

AHS

Data for the NHS component of the AHS are published in the ABS *Australian Health Survey: First Results, 2011–12*, available from the ABS website at www.abs.gov.au. Other information from this survey is also available on request.

NDSS data are not publicly accessible.

Interpretability

Information about services subsidised through DHS, Medicare is available from MBS online at www.health.gov.au/internet/mbsonline/publishing.nsf/content/ medicare-benefits-schedule-mbs-1.

The ABS 2010-11 AHS survey data are published in *Australian Health Survey: First Results, 2011–12* which includes explanatory and technical notes. Data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey. Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website.

Further information on the NDSS is available at www.ndss.com.au.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data for 2012-13 and 2011-12 were computed using different methodology than was used in earlier years and should not be compared with those data.
- This indicator appears reliable at a national level. However comparisons between jurisdictions and population groups may be problematic due to different population structures (including relative prevalence of Type 1 and Type 2 diabetes) which have not been accounted for in the calculation of this indicator.

- Compared with other jurisdictions, results for the ACT and the NT appear to be less reliable, perhaps due to their smaller population and, in the NT, lower coverage of services.
- Disaggregation of this indicator by Indigenous status is a priority. Indigenous identification in MBS data is voluntary and the data significantly underestimate Indigenous utilisation.
- Requirements for the MBS annual cycle of care item are based on but not identical to RACGP clinical guidelines for the management of type 2 diabetes.

Management of diabetes — HbA1c level

Data quality information for this measure has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Chronic disease management
Measure (computation)	Management of diabetes — HbA1c Definition Proportion of people with known diabetes mellitus who have an HbA1c level of less than or equal to 7.0 per cent. Numerator Number of people aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test, who have an HbA1c level of less than or equal to 7.0 per cent. Denominator Number of persons aged between 18 and 69 years with known diabetes, as determined by a fasting plasma glucose test. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	For the 2014 reporting cycle, the denominator and numerator for this indicator use data from the 2011–12 National Health Measures Survey (NHMS) component of the Australian Bureau Statistics (ABS) Australian Health Survey (AHS), which is weighted to benchmarks for the total AHS in-scope population derived from the Estimated Resident Population (ERP). For information on scope and coverage, see the *Australian Health Survey: Users' Guide* (cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au.

Data Quality Framework Dimensions

Institutional environment	The 2011–12 NHMS was collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.
Relevance	For this measure, the fasting plasma glucose test is used in the determination of people with known diabetes and the HbA1c test is used in the determination of effective management of diabetes. The 2011-12 NHMS uses a combination of blood test results for fasting plasma glucose and self-reported information on diabetes diagnosis and medication use to measure prevalence of known diabetes. A respondent to the survey is considered to have known diabetes if they had ever been told by a doctor or nurse that they have diabetes and: • they were taking diabetes medication (either insulin or tablets) **or**

- their blood test result for fasting plasma glucose was greater than or equal to 7.0 mmol/L.

Persons with known diabetes who have an HbA1c result of less than or equal to 7.0 per cent are considered to be managing their diabetes effectively.

The estimates exclude persons who did not fast for 8 hours or more prior to their blood test. Excludes women with gestational diabetes.

Timeliness

The NHMS was conducted for the first time in 2011–13. Results from the 2011-12 NHMS were released in August 2013. Results from the NATSIHMS will be released in 2014.

Accuracy

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up approximately 23 per cent of the population. The final response rate for the 'core' component of the AHS was 82 per cent.

All selected persons aged 5 years and over were invited to participate in the voluntary NHMS. Of all of those who took part in the AHS, 38 per cent went on to complete the biomedical component.

Analysis of the sample showed that the characteristics of persons who participated in the NHMS were similar with those for the AHS overall. The only significant difference was for smoking, where the NHMS sample had a lower rate of current smokers than the AHS sample (12.0 per cent compared with 17.6 per cent). For more information, see the Explanatory Notes in *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005).

In order to get an accurate reading for the fasting plasma glucose test, participants were asked to fast for 8 hours before their test. The results presented for this indicator refer only to those people who did fast (approximately 79 per cent of adults who participated in the NHMS). Analysis of the characteristics of people who fasted compared with those who did not fast showed no difference between fasters and non-fasters.

As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

This indicator produces high levels of sampling error for some States and Territories when split by sex. Estimates for males and females in Victoria have RSEs greater than 50 per cent and should be considered unreliable for general use. Likewise, estimates for males in the Northern Territory and females in the Australian Capital Territory also have RSEs greater than 50 per cent.

Data for several State and Territories also have RSEs greater than 25 per cent, including the total for Victoria, South Australia, the Australian Capital Territory and the Northern Territory, and these estimates should be used with caution.

Coherence	The AHS collected a range of other health-related information that can be analysed in conjunction with diabetes management. The 2009-10 Victorian Health Monitor (VHM) reported estimates of diabetes management based on the proportion of people with known diabetes meeting the HbA1c management target of less than or equal to 7.0 nmol/L. The VHM age-standardised rate (39 per cent) was similar to the NHMS rate for Victoria (36 per cent).
Accessibility	See *Australian Health Survey: Biomedical Results for Chronic Disease* (cat. no. 4364.0.55.005). Other information from this survey is also available on request.
Interpretability	Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website. Many health-related issues, including diabetes, are closely associated with age. However, numbers across age ranges were too few to do any meaningful age standardisation at the State/Territory level for this measure. Therefore the data presented are based on crude rates.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- State and Territory data by Indigenous status are anticipated to be available for the 2013-14 report.
- The 2011-12 National Health Measures Survey (NHMS) was conducted for the first time as part of the 2011–13 Australian Health Survey (AHS), with participation voluntary in the NHMS. Of those who took part in the AHS, 38 per cent took part in the NHMS. The NHMS sample was found to be representative of the AHS population.
- The NHMS does not include people living in very remote areas, which affects the comparability of the NT results.

Management of asthma

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Chronic disease management
Measures (computation)	Management of asthma Definition Proportion of people with asthma who have a written asthma action plan. Numerator Estimated number of people with asthma with a written asthma action plan. Denominator Estimated number of people with asthma. Computation: 100 × (Numerator ÷ Denominator).
Data source/s	Data reported for 2011-12 are from the National Health Survey (NHS) component of the ABS Australian Health Survey (AHS). Data reported for 2007-08 are from the ABS 2007-08 NHS. Data reported for 2004-05 are from the ABS 2004-05 NHS and the ABS 2004-05 NATSIHS. The denominator and numerator use ABS National Health Survey (NHS) data, which is weighted to benchmarks for the total NHS in-scope population derived from the Estimated Resident Population (ERP). For information on NHS scope and coverage, see the ABS *Australian Health Survey: Users' Guide* (Cat. no. 4363.0.55.001) on the ABS website, www.abs.gov.au. Estimates for 2004-05 for Indigenous Australians are drawn from the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), which was benchmarked to the estimated Indigenous Australians (adjusted for the scope of the survey).

Data Quality Framework Dimensions

Institutional environment	The NHS and NATSIHS are collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the Census and Statistics Act 1905 and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment.
Relevance	The NHS 2011-12 and 2007-08 asked all respondents whether they had ever been told by a doctor or nurse that they have asthma, whether symptoms were present or they had taken treatment in the 12 months prior to interview, and whether they still had asthma. Those who answered yes to these questions were asked whether they had "a written asthma action plan, that is, written instructions of what to do if your asthma is worse or out of control". A very small number of respondents who were sequenced around these questions may have reported current long-term asthma in response to later general questions about medical conditions. These people are included in and contribute to estimates of the prevalence of

asthma, but information about written action plans was not collected from them.

In the 2004-05 NATSIHS, non-remote respondents who answered questions about having asthma 'yes' were asked about written asthma action plans.

In both the 2004-05 NHS and NATSIHS, respondents were asked if they had "a written asthma action plan". If they queried the interviewer about what to include, they were told to include management plans developed in consultation with a doctor, cards associated with peak flow meters and medication cards distributed through chemists. In 2007, if they queried the interviewer, respondents were asked to include plans that were worked out in consultation with a doctor, but not cards associated with peak flow meters or medications cards handed out by chemists.

Ideally this indicator would relate to the proportion of people with moderate to severe asthma, as people with only very mild asthma are unlikely to require planned care. Consequently, there is no clear direction of improvement in this indicator: a lower proportion of people with asthma with an asthma care plan may simply mean that those people with asthma have less severe asthma (which would actually be a positive outcome).

Timeliness

The NHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

The NATSIHS is conducted every six years. Results from the 2004-05 survey were released in April 2006.

Accuracy

The NHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of people usually resident in very remote areas has a small impact on estimates, except for the Northern Territory, where such people make up approximately 23 per cent of the population. Results are weighted to account for non-response.

The response rate for the 2011-12 NHS was 85 per cent and for the 2007-08 NHS was 91 per cent.

The NATSIHS is conducted in all States and Territories and includes remote and non-remote areas. The 2004-05 sample was 10 000 people/5200 households, with a response rate of 81 per cent of households.

As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

Coherence

Questions used in the 2011-12 and 2007-08 NHS to collect data for this indicator are consistent with the questions recommended for use by the Australian Centre for Asthma Monitoring (ACAM). Data for 2011-12 and 2007-08 are comparable over time (except for the Northern Territory) but are not comparable to data from the 2004-05 survey due to better alignment of questions and concepts with the ACAM recommendations since 2004-05.

Data for the NT in 2011-12 are not comparable to previous years due to the increase in sample size in 2011-12.

The NHS and NATSIHS collect a range of other health-related information (for example, information on smoking) that can be analysed in conjunction with data on asthma and asthma plans.

Accessibility

See *Australian Health Survey: First Results* (Cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (Cat. no. 4364.0.55.002) for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

See *National Health Survey, Summary of Results* (ABS Cat. no. 4364.0) for an overview of results from the NHS, and *National Health Survey: State tables* (ABS Cat. no. 4362.0) for State and Territory specific tables. See the *National Aboriginal and Torres Strait Islander Health Survey* (Cat. no. 4715) for an overview of results from the NATSIHS. Other information from these surveys is also available on request.

Interpretability

Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide* and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide* on the ABS website.

Many health-related issues are closely associated with age, therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories and the Indigenous and non-Indigenous population. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data provide relevant information on the proportion of asthmatics who have an asthma management plan. However, there is no information about the severity of the condition and people with mild asthma are unlikely to require a written plan.
- NATSIHS data are only collected every six years. An assessment of the relative speed of change in outcomes is required to determine whether more regular data collection is necessary.
- The NHS does not include people living in very remote areas which affects the comparability of the NT results.
- Data are not comparable between Indigenous and non-Indigenous people because of different years of the data collections and different interpretations of what is a 'written' plan.

Use of pathology tests and diagnostic imaging

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element

DHS, Medicare processes and collects MBS data for:

- claims made through the MBS under the *Health Insurance Act 1973*. These data are regularly provided to DoHA.
- claims for DVA Treatment Card holders, also made through the MBS, under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Human Services (Medicare) Act 1973*. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.

MBS claims data are an administrative by-product of DHS, Medicare's fee-for-service payment systems.

For reference periods to 2009-10, DoHA provided raw data and rates inclusive of DVA data.

From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.

Indicator

The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:

Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'.

Diagnostic imaging services — all items in BTOS 'G'.

Claims are allocated to state/territory based on location at which the service was rendered.

Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.

Measures (computation)

Measure 1

MBS items rebated through Department of Human Services (DHS), Medicare for pathology tests requested by general practitioners (GP), and Other Medical Practitioners (OMP), per person (age-standardised)

Definition

The number of MBS items rebated through DHS, Medicare for pathology tests requested by specialist GPs and OMPs, per person (age-standardised)

Numerator:

The number of MBS items rebated through DHS, Medicare for pathology tests requested by GPs and OMPs

Denominator:

Estimated Resident Population (ERP)

Computation:

Numerator ÷ Denominator, age-standardised

Measure 2

Diagnostic imaging services provided on referral from specialist GPs and OMPs and rebated through DHS, Medicare, per person (age-standardised)

Definition

The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs, per person (age-standardised)

Numerator:

The number of MBS items rebated through DHS, Medicare for diagnostic imaging services referred by GPs and OMPs

Denominator:

Estimated Resident Population (ERP)

Computation:

Numerator ÷ Denominator, age-standardised

Measure 3

DHS, Medicare benefits paid per person for pathology tests requested by GPs and OMPs (age-standardised).

Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) to provide real expenditure, comparable over time.

Measure 4

DHS, Medicare benefits paid per person for diagnostic imaging referred by GPs and OMP (age-standardised)s.

Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) to provide real expenditure, comparable over time.

Data source/s

Numerator:

- For MBS data: DHS, Medicare data.
- For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data.

Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP). For reference periods prior to and including 2009-10 ERP as at 30 June, based on the 2006 Census. From the 2010-11 reference year ABS ERP as at 31 December, based on the 2011 Census.

Data Quality Framework Dimensions

Institutional environment

DHS, Medicare processes and collects MBS data for:

- claims made through the MBS under the *Health Insurance Act 1973*. These data are regularly provided to DoHA.
- claims for DVA Treatment Card holders, also made through the MBS, under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Human Services (Medicare) Act 1973*. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA.

MBS claims data are an administrative by-product of DHS, Medicare's fee-for-service payment systems.

For reference periods to 2009-10, DoHA provided raw data and rates inclusive of DVA data.

From 2010-11, DHS, Medicare and DVA data are provided separately to the Secretariat. The Secretariat collates the data and computes rates.

Relevance

The measure relates to specific identified MBS services for which DHS, Medicare has processed a claim:

- Pathology tests — all items in Broad Type of Service (BTOS) 'N' or 'F'.
- Diagnostic imaging services — all items in BTOS 'G'.

Claims are allocated to state/territory based on location at which the service was rendered.

Expenditure data reflect only the benefits paid by the Australian Government. Contributions made by insurance companies and/or individuals are excluded.

Timeliness

Data include all claims processed in the reference period.

Accuracy

Data are limited to claims for services requested/referred by GPs and, for MBS data, OMPs (DVA data include only services requested/referred by specialist GPs). Data do not include claims for services requested/referred by other medical specialists.

Data include all claims processed in the reference period.

Pathology tests

The pathology episode cone applies to services requested by general practitioners for non-hospitalised patients:

> when more than three MBS pathology items are requested by a GP in a patient episode, the benefits payable will be equivalent to the sum of the benefits for three items — those with the highest schedule fees (there are some items exempted from the episode cone). Where additional tests performed in a patient episode are not rebated through DHS, Medicare, they are not included in the data. This results in some underreporting of the number of pathology tests conducted on request by GPs and OMPs. Data include Patient Episode Initiated Items.

Diagnostic imaging

Diagnostic imaging services provided and rebated through DHS, Medicare can differ from the services requested by GPs and OMPs.

In certain circumstances, as defined by legislation, a radiologist can identify the need for, and perform, more or different diagnostic imaging services than are requested by a GP/OMP. The data reflect the services provided and rebated through DHS, Medicare, rather than the services requested by GPs/OMPs.

Coherence

Rates for 2012-13 are age-standardised to the 2001 Australian Standard Population. These data are not comparable to crude rates reported for previous years.

Data were computed by DoHA for this indicator for reference years prior to and including 2009-10, using the 2006 Census based ERP as at 30 June preceding the reference year.

From 2010-11, data are computed by the Secretariat from numerator data obtained separately from DoHA and the DVA, using the ERP as at 31 December based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility

MBS

DHS, Medicare claims statistics are available at www.health.gov.au/ nternet/main/ publishing.nsf/Content/Medicare+Statistics-1;

www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

DVA data are not publically accessible.

Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Age-standardisation of rates for 2012-13 is a significant improvement. However, rates are not comparable with crude rates reported for previous years. • This is a proxy measure — data are limited to those services rebated through DHS, Medicare that were provided in response to request/referral by GPs/OMPs. • Provides information about relative requests/referrals for pathology tests and diagnostic imaging across jurisdictions and over time, but not the appropriateness thereof.

Patient satisfaction

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the ABS) with additional Steering Committee comments.

Indicator definition and description

Element	Quality — responsiveness
Indicator	Patient satisfaction/experience around key aspects of care they received.
Measures (computation)	Measure a: Definition Proportion of people satisfied with selected aspects of GP care. Numerator People who saw a GP in the last 12 months reporting the GP always or often: listened carefully; showed respect; spent enough time with them. Denominator People who saw a GP for their own health in the last 12 months, excluding people who were interviewed by proxy. Measure b: Definition Proportion of people satisfied with selected aspects of dental professional care. Numerator People who saw a dental professional in the last 12 months reporting the dental professional always or often: listened carefully; showed respect; spent enough time with them. Denominator People who saw a dental professional in the last 12 months, excluding people who were interviewed by proxy.
Data source/s	ABS Patient Experience Survey

Data Quality Framework Dimensions

Institutional environment	Data Collector(s): The Patient Experience Survey is a topic on the Multipurpose Household Survey. It is collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website at www.abs.gov.au. Collection authority: The *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. Data Compiler(s): Data are compiled by the Health section of the ABS. Statistical confidentiality is guaranteed under the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. The ABS notifies the public through a note on the website when an error in data has been identified. The data are withdrawn, and the publication is re-released with the correct data. Key users are also notified where possible.

Relevance

Level of Geography: Data are available by State/Territory, and by Remoteness (major cities, inner and outer regional, remote and, from 2011-12, very remote Australia).

Data Completeness: All data are available for this indicator from this source.

Indigenous Statistics: Data are not available by Indigenous status for this indicator. The 2012-13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) collected data on GP waiting times but differences in survey design and collection methodology between the Patient Experience survey and the NATSIHS mean the data are not comparable.

Numerator/Denominator Source: Same data source.

Data for this indicator were collected for all people in Australia, excluding the following:

- members of the Australian permanent defence forces
- diplomatic personnel of overseas governments, customarily excluded from census and estimated population counts
- overseas residents in Australia
- members of non-Australian defence forces (and their dependents)
- people living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, retirement homes, homes for people with disabilities, and prisons
- for 2010-11, people living in very remote communities (including discrete indigenous communities)
- from 2011-12, people living in discrete indigenous communities.

From 2011-12, the Patient Experience survey included households in very remote areas, (although it still excluded discrete indigenous communities). The inclusion of very remote areas will serve to improve the coverage of the estimates, particularly for the NT where people usually resident in very remote areas account for about 23 per cent of the population. Small differences evident in the NT estimates between 2010-11 and 2011-12 may in part be due to the inclusion of households in very remote areas.

Data were self-reported for this indicator. People who were interviewed by proxy were excluded.

Timeliness

Collection interval/s: Patient Experience data are collected annually.

Data available: data for 2012-13 became available 22 November 2013; 2011-12 data became available 23 November 2012; 2010-11 data became available November 2011.

Referenced Periods:

- July 2012 to June 2013.

There are not likely to be revisions to these data after their release.

Accuracy

Method of Collection: The data were collected by computer assisted telephone interview.

Data Adjustments: Data were weighted to represent the total Australian population, and were adjusted to account for confidentiality, non-response and partial response.

Sample/Collection size: The sample size for the 2012-13 patient experience survey was 30 749 fully-responding households. Note this is a substantial increase from the 2011-12 sample size of 26 437. This increase

will improve the reliability of the data, particularly at finer levels of disaggregation. The sample size for 2010-11 was 26 423 fully-responding households.

Response rate: Response rate for the 2012-13 survey was 78.9 per cent; response rate for the 2011-12 survey was 79.6 per cent; response rate for the 2010-11 survey was 81.4 per cent.

As data are drawn from a sample survey, the indicator is subject to sampling error, which occurs because a proportion of the population is used to produce estimates that represent the whole population. Rates should be considered with reference to their corresponding relative standard errors (RSEs) and 95 per cent confidence intervals. Estimates with a relative standard error between 25 and 50 per cent should be used with caution, and estimates with a relative standard error over 50 per cent are considered too unreliable for general use.

Standard Errors: The standard errors for the key data items in this indicator are relatively low and provide reliable State and Territory data.

These data are attitudinal, as the survey collects data for whether people felt the health professional in question spent enough time with them, listened carefully and showed them respect.

Data are used from personal interviews only — proxy interviews are excluded.

Explanatory footnotes are provided with the data.

Coherence

Consistency over time: 2009 was the first year data were collected for this indicator.

Numerator/denominator: The numerator and denominator are directly comparable, one being a sub-population of the other.

The numerator and denominator are compiled from a single source.

Jurisdiction estimate calculation: Jurisdiction estimates are calculated the same way, although the exclusion of very remote communities (in the 2010-11 survey) and discrete indigenous communities (from the 2011-12 survey) will affect the NT more than it affects other jurisdictions. (People usually resident in very remote areas account for about 23 per cent of people in NT.)

Jurisdiction/Australia estimate calculation: All estimates are compiled the same way.

Collections across populations: Data are collected the same way across all jurisdictions.

The Patient Experience survey provides the only national data available for this indicator. At this stage, there are no other comparable data sources.

Accessibility

Data are publicly available in *Patient Experiences in Australia: Summary of Findings, 2010-11*, *2011-12* and *2012-13* (Cat. no. 4839.0). The data are shown by age, sex, remoteness and disadvantage. Jurisdictional data are not currently publically available but may be made available in the future.

Data are not available prior to public access.

Supplementary data are available. Additional data from the Patient Experience Survey are available upon request.

Access permission/Restrictions: Customised data requests may incur a charge.

Contact Details: For more information, please call the ABS National Information and Referral Service on 1300 135 070.

Interpretability

Context: Data were collected from a representative sample of the Australian population and questions were asked in context of the year prior to the survey.

The ABS Patient Experience data are published in ABS 2011, ABS 2012 and ABS 2013 *Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12* and *2012-13* (Cat. no. 4839.0). The publications include explanatory and technical notes. Any ambiguous or technical terms for the data are available from the ABS 2011, 2012 and 2013 *Technical Note, Glossary and Explanatory Notes in Patient Experiences in Australia: Summary of Findings, 2010-11, 2011-12* and *2012-13*, Cat. no. 4839.0.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- Data are for the first time available for the Indigenous population, from the 2012-13 NATSIHS. Data from the Patient Experience survey are not comparable with data from the NATSIHS. Disaggregation of this indicator by Indigenous status is a priority.
- The sample size increase from 26 423 in 2011-12 to 30 749 in 2012-13 strengthens reliability of the population-level estimates.

Health assessments for older people

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	Health assessments for older people
Measures (computation)	Definition The proportion of older people who received a health assessment. Numerator: The number of people aged 75 years or over with an MBS claim for Items 700, 701, 702, 703, 705 or 707 (Health assessment) and the number of Indigenous people aged 55 years or over with an MBS claim for Items 704, 706 (Health assessment for older Aboriginal and Torres Strait Islander People) or 715 (Health Assessment for Aboriginal and Torres Strait Islander People) in the reference period. Denominator: The population of Indigenous people aged 55 years or over and the estimated population of non-Indigenous people aged 75 years or over (computed by subtracting the projected population of Indigenous people aged 75 or over from the ERP aged 75 years or over) in the reference period. Computation: 100 × (Numerator ÷ Denominator), presented as a percentage.
Data source/s	Numerator: Australian Government Department of Human Services (DHS), Medicare data. Denominator: Denominator computed by the Secretariat using Australian Bureau of Statistics (ABS) 2006 Census based ERP. Total population: ABS various years, *Australian demographic statistics*, Cat. no. 3101.0. For data by Indigenous status: ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. No. 3238.0 (B Series).

Data Quality Framework Dimensions

Institutional environment	MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to DoHA. The indicator was calculated by the Secretariat using the numerator data supplied by DoHA and denominator data sourced from the ABS.
Relevance	These measures relate to specific DHS, Medicare services for which claims data are available. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect overall proportions significantly because the life expectancy of Indigenous people is, on average, relatively low.

Allocation of clients to state or territory is based on client postcode of residence as recorded by DHS, Medicare at time of processing the final claim in the reference period. This might differ from the client's residential postcode at the time the service was received.

For services provided from 1 May 2010, age is based on client date of birth in DHS, Medicare records at the date the service was received. Prior to 1 May 2010 unique MBS item numbers applied to health assessments for older people and health assessments for older Indigenous people.

Eligible populations exclude people who are hospital in-patients or living in a residential aged care facility.

In the NT, MBS statistics do not necessarily fully reflect services supplied to Indigenous people as the claim rate is low due to a smaller number of GPs in remote areas.

Timeliness

MBS claims data are available within 14 days of the end of a month.

Accuracy

Data include all claims processed up to 12 months after the service is received. Current year data are preliminary and subject to revision in subsequent reports.

Allocation to state and territory does not necessarily reflect the client residence at the time of receiving the service if a change of address prior to receiving the service was not reported to DHS, Medicare in the reference period or a change of address after receiving the service was reported to DHS, Medicare in the reference period.

Health assessment rebate claims that are not processed within 12 months of the reference period are excluded. This does not significantly affect the data.

Clients are counted once only in the reference period.

Data do not include:

- health assessment activity where practitioners do not claim the rebate
- services that qualify under the DVA National Treatment Account and services provided in public hospitals
- people living in residential aged care facilities.

Non-Indigenous population estimates are available for census years only. For inter-censal years, experimental estimates and projections data for the Indigenous population are derived using various assumptions. These can be used to derive denominators for calculating non-Indigenous rates for the inter-censal years. However, such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

The following changes to MBS items occurred on 1 May 2010, but are unlikely to impact time-series analysis.

As of 1 May 2010:

- MBS Items 704 and 706 (Health Assessments for older Aboriginal and Torres Strait Islander People) have been replaced with one MBS Item that covers Health Assessments for Aboriginal and Torres Strait Islander People of all ages (Item 715)
- MBS Items 700 and 702 (Health assessments for older people) have been replaced with four new MBS items that cover Health assessments for all ages and are based on time and complexity of the visit — Items 701 (brief), 703 (standard), 705 (long) and 707 (prolonged).

	For services provided from 1 May 2010, disaggregation by age is based on client date of birth in DHS, Medicare records at the date the service was received. Health assessments for people who are refugees or humanitarian entrants can also be claimed from 1 May 2010 under MBS Items 701, 703, 705 and 707. This is likely to have little impact on the totals reported as the usage rates for these health assessments are low to extremely low.
Accessibility	Information is available for MBS Claims data from www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1.
Interpretability	DHS, Medicare claims statistics are available at www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 and www.medicareaustralia.gov.au/statistics/mbs_item.shtml.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issue: • No adjustment was made to this indicator to account for under-identification of Indigenous people in DHS, Medicare data.

Cost to government of general practice per person

Data quality information has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost to government of general practice per person
Measures (computation)	Government Expenditure on GPs per person Definition Cost to government of general practice per person in the population Numerator: Nominal expenditure on services rendered by GPs and OMPs. Denominator: Estimated Resident Population (ERP). Computation: Numerator ÷ Denominator, directly age-standardised from 2012-13; crude rates for previous years. Data are deflated using the General Government Final Consumption Expenditure (GGFCE) chain price deflator (2012-13 = 100) to provide real expenditure, comparable over time.
Data source/s	Numerator: • For MBS data: Department of Human Services (DHS), Medicare data sourced by the Australian Government Department of Health • For DVA data: Australian Government Department of Veterans' Affairs (DVA) Statistical Services and Nominal Rolls using the Departmental Management Information System (DMIS). These data are known as Treatment Account System (TAS) data. Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 31 December.

Data Quality Framework Dimensions

Institutional environment	DHS, Medicare processes and collects MBS data for: • claims made through the MBS under the *Health Insurance Act 1973*. These data are regularly provided to DoHA. • claims for DVA Treatment Card holders, also made through the MBS, under the Veterans' Entitlements Act 1986; *Military Rehabilitation and Compensation Act 2004* and *Human Services (Medicare) Act 1973*. All claims data are regularly provided to DVA as per the Memorandum of Understanding between DHS, Medicare and DVA. MBS claims data are an administrative by-product of the DHS, Medicare fee-for-service payment systems.
Relevance	The measure relates to: • services provided by GPs and, for MBS data, OMPs (DVA data include only services provided by specialist GPs) for which DHS, Medicare has processed a claim. Claims allocated to state/territory based on location at which service rendered. Data exclude costs for primary healthcare services provided by salaried

	GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used. For 2012-13, data exclude expenditure on services provided under the Practice incentive program (PIP), Medicare Locals and the General Practice Immunisation Incentive Scheme (GPII) as these data cannot be subjected to age-standardisation.
Timeliness	Data include all claims processed in the reference period.
Accuracy	From 2012-13, DHS, Medicare data include claimed services by GPs and OMPs as well as by practice nurses or registered Aboriginal health workers for and on behalf of the GMP/OMP. For previous years, DHS, Medicare data also include services rendered under PIP, DGPP and GPII. DVA data are limited to claims for services provided by specialist GPs. Data include all claims processed in the reference period.
Coherence	Age-standardised rates reported for 2012-13 are not comparable with crude rates reported for previous years due to the effect of age standardisation and the exclusion of services rendered under PIP, DGPP and GPII from age-standardised rates. Nominal State and Territory total expenditure data were computed by DoHA for the reference periods 2006-07 to 2009-10. For the 2010-11 and 2011-12 reference periods, DHS, Medicare and DVA nominal expenditure data were provided separately to and compiled by the Secretariat. These changes are expected to have negligible impact on the data. Expenditure per person data were computed by the Secretariat using the 2011 Census-based ERP as at 31 December for all reference periods..
Accessibility	MBS DHS, Medicare claims statistics are available at: www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1; www.medicareaustralia.gov.au/statistics/mbs_item.shtml. DVA data are not publically accessible.
Interpretability	General practice statistics, including explanatory notes, are published at www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Data exclude costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Child immunisation coverage

Data quality information for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by the Department of Health) with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Child immunisation coverage.
Measures (computation)	Proportion of children who are fully vaccinated at the age of: - 12 months to less than 15 months - 24 months to less than 27 months - 60 months to less than 63 months. Definition Proportion of children who are fully vaccinated at the specified ages. Different methodology was applied to compute current year data to that used for historical data. *Current year data*: Numerator children who turned 1, 2 and 5 years of age in the reference year who were recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) in the 2012-13 reference year. Denominator number of children who turned 1, 2 and 5 years in the reference year registered on ACIR. *Historical data*: Numerator number of children who turned 1, 2 and 5 years of age by 31 March in the reference year who have been recorded as fully vaccinated on the Australian Childhood Immunisation Register (ACIR) as at 30 June in the reference year. Denominator number of children who turned 1, 2 and 5 years between 1 January and 31 March in the reference year registered on ACIR as at 30 June in the reference year. Computation: 100 × (Numerator ÷ Denominator), presented as a rate per 100 children aged 1, 2 and 5 years.
Data source/s	The Australian Childhood Immunisation Register (ACIR).

Data Quality Framework Dimensions

Institutional environment

The ACIR is administered and operated by Australian Government Department of Human Services (DHS), Medicare. DHS, Medicare provides DoHA with quarterly coverage reports at the national and state level.

Immunisations are notified to DHS, Medicare by a range of immunisation providers including General Practitioners, Councils, Aboriginal Medical Services, State and Territory Health departments.

For information on the institutional environment of the ACIR, including the legislative obligations of the ACIR, financing and governance arrangements, and mechanisms for scrutiny of ACIR operations, please see www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.

The tables for this indicator were prepared by DHS, Medicare and quality-assessed by DoHA. DoHA drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies).

Relevance

The ACIR records details of vaccinations given to children under seven years of age who live in Australia.

Children assessed as fully immunised at one year of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, *Haemophilus influenzae* type b and pneumococcal.

Children assessed as fully immunised at two years of age are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, *Haemophilus influenzae* type b and measles, mumps and rubella.

A child is assessed as fully immunised at five years of age if they have received immunisations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.

There are possible gaps in coverage due to unknown vaccination status of children less than 5 years migrating to Australia. The extent of this is not currently quantifiable.

The analyses by state/territory are based on postcode of residence of the child as recorded on ACIR.

Timeliness

ACIR data are reported quarterly. Data are processed on 30 June in the reference year as a minimum 3-month lag period is allowed for late notification of immunisations to ACIR.

Accuracy

Vaccination coverage rates calculated using ACIR data are believed to underestimate actual vaccination rates because of under-reporting by immunisation providers. However, the extent of any under-reporting has not been estimated.

Provider notification payments and links to family assistance payments for parents have helped minimise under-reporting by providing a financial incentive for parents to vaccinate their children and for providers to notify the ACIR.

The data contains minimal if any duplication of immunisations, as children are identified via their DHS, Medicare number. Approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.

The ACIR covers virtually all children, particularly because participation in the ACIR is via an ‘opt-out’ arrangement.

Coherence

The definitions of numerators and denominators have been consistent since the inception of the ACIR in 1996.

Accessibility

Information contained in the indicator for disaggregation by Indigenous status and remoteness are not publicly accessible. Current total percentage and total numbers can be viewed on the DHS, Medicare web site.

DHS, Medicare publishes current immunisation coverage from the ACIR on its website, www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp. Authorised immunisation providers can access detailed reports via a secured area of the DHS, Medicare web site.

Immunisation coverage data derived from the ACIR have been reported in *Communicable Disease Intelligence* since early 1998. Data for 3 key milestone ages (12 months, 24 months and 5 years [6 years prior to 2008]), nationally and by jurisdiction are published quarterly.

Interpretability

Further information on the ACIR can be found at www.humanservices.gov.au/customer/services/medicare/australian-childhood-immunisation-register.

Information on the National Immunisation Program and vaccinations can be found at www.immunise.health.gov.au.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The data used to calculate this indicator are from an administrative data collection — the Australian Childhood Immunisation Register (ACIR) — for which there is an incentive payment for notification, and there are further incentives for parents to have their child's vaccination status up to date. The Register is linked to the DHS, Medicare enrolment register, and approximately 99 per cent of children are registered with DHS, Medicare by 12 months of age.
- Data have been reported using the program definition of fully immunised for children aged 12 to 15 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b and pneumococcal.
- Data have been reported using the program definition of fully immunised for children aged 24 to 27 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B, Haemophilus influenzae type b, and measles, mumps, and rubella.
- Data have been reported using the program definition of fully immunised for children aged 60 to 63 months; that is, children who have received vaccinations against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella.
- From 31 December 2013, reporting of vaccination coverage rates will be amended to include pneumococcal in the 12 to < 15 month cohort.
- From 31 December 2014, reporting of vaccination coverage will be amended to include meningococcal C and varicella in the 24 to < 27 month cohort.
- From 31 December 2017, reporting of vaccination coverage will be amended to remove the assessment of MMR in the 60 to < 63 month cohort.
- Given these changes, trends in vaccination coverage rates over time need to be interpreted carefully

Notifications of selected childhood diseases

Data quality information for this indicator has been developed by the Health Working Group for this indicator with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Notifications of selected childhood diseases.
Measures (computation)	Notifications of measles for children aged 0–14 years Notifications of whooping cough (pertussis) for children aged 0–14 years Notifications of invasive *Haemophilus influenzae* type b (Hib) for children aged 0–14 years Definition Number of notifications reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years by date of diagnosis, per 100 000 children aged 0–14 years for: - measles - whooping cough (pertussis) - invasive *Haemophilus influenzae* type b (Hib). Numerator number of notifications reported to the NNDSS for children aged 0–14 years in the reference period. Denominator estimated resident population of children aged 0–14 years at 31 December in the reference period. Computation: 100 × (Numerator ÷ Denominator), presented as a rate per 100 000 children aged 0–14 years.
Data source/s	Numerator: The National Notifiable Diseases Surveillance System (NNDSS) Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) at 31 December in the reference period (ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0).

Data Quality Framework Dimensions

Institutional environment

The NNDSS is administered and operated by the Department of Health.

Notifiable diseases are notified to the relevant State/Territory government health departments by clinicians and laboratories under jurisdictional public health legislation. The Department of Health receives data for these notifiable diseases under the *National Health Security Act 2007*.

For information on the institutional environment of the NNDSS, including the legislative obligations of the NNDSS, financing and governance arrangements, and mechanisms for scrutiny of NNDSS operations, please see www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi2903q.htm.

Relevance

Nationally notifiable diseases require notification of the relevant State/Territory health authority upon diagnosis. Cases are defined on the basis of the Communicable Diseases Network Australia (CDNA) NNDSS case definitions. State/Territory health authorities notify the NNDSS of notified cases.

Allocation to State/Territory is by postcode of residence of the case as provided by the notifying doctor or laboratory.

Timeliness

State/Territory health authorities notify data to the NNDSS on a daily basis. Data include all notifications for the selected diseases for each reference period (financial year).

Accuracy

Measles and invasive Hib

The 'notified fraction' represents the proportion of total cases for which notification is made. This is expected to be high for measles and invasive Hib as it is uncommon for either disease to go undiagnosed, due to the often severe presentations of the disease. Comprehensive follow up of the contacts of all cases also enables identification of cases.

Pertussis (whooping cough)

The notified fraction for whooping cough is likely to be only a proportion of the total number of cases that occur, as identification of pertussis is limited by patient and physician awareness, testing practices and in some cases, the united sensitivity of diagnostics tests. Pertussis is generally believed to be significantly under-diagnosed.

ERPs to 31 December 2010 are the ABS' final 2011 Census rebased ERPs. ERPs from 31 December 2011 are ABS first preliminary estimates based on the 2011 Census.

Data for the number of notifications are suppressed for confidentiality reasons where the number of notifications was less than 3.

Data for notification rates are suppressed where there were less than 5 notifications.

Coherence

Data are reported for each financial year in the period 2006-07 to 2012-13.

Changes in surveillance and testing methods over time and by jurisdiction may make comparisons both over time and across jurisdictions difficult. Changes in the national case definition criteria for establishing a case may

	affect the coherence of the data over time. The current NNDSS case definition, including historical edits, can be found at www.health.gov.au/casedefintions.
Accessibility	The Department of Health publishes aggregated levels of data from the NNDSS on its website www9.health.gov.au/cda/source/cda-index.cfm. Data are updated on a daily basis.
Interpretability	The current NNDSS case definitions, including edits, can be found at www.health.gov.au/internet/main/publishing.nsf/Content/cdna-casedefinitions.htm.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: Whooping cough notifications may undercount the actual number of cases that occur as diagnosis cannot always be confirmed using currently available diagnostic tools.

Participation rates for women in cervical screening

Data quality information for this indicator has been drafted by the AIHW, with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Participation rates for women in cervical screening.
Measures (computation)	Definition This indicator presents the number of women within the national target age group (20–69 years) screened in a 2 year period as a proportion of the eligible female population and age-standardised to the Australian standard population at 30 June 2001. The eligible female population is the average of the Australian Bureau of Statistics (ABS) estimated resident female population for the 2 year reporting period. This population is adjusted for the estimated proportion of women who have had a hysterectomy using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database. Numerator Total number of women aged 20–69 years who were screened in the 2 year period. Denominator Average number of women aged 20–69 years in the same 2 year period, adjusted using national hysterectomy fractions to exclude the estimated number of women who have had a hysterectomy. Computation/s: 100 × (Numerator ÷ Denominator) and age-standardised to the Australian population at 30 June 2001.
Data source/s	Numerator State and territory cervical cytology registers. Denominator For total population: ABS estimated resident population 2011 Census based (ERP) for females aged 20–69 years adjusted using national hysterectomy fractions derived from the AIHW National Hospitals Morbidity Database.

Data Quality Framework Dimensions

Institutional environment	The National Cervical Screening Program (NCSP) is a joint program of the Australian Government and State and Territory governments. The target age group is women aged 20–69 years. Cervical cytology registries in each state and territory are maintained by jurisdictional Program managers. Data are supplied to the registries from pathology laboratories. Data from cervical cytology registers are provided to the Australian Institute of Health and Welfare (AIHW) annually in an aggregated format. The NCSP is monitored annually. Results are compiled and reported at the national level by the AIHW in an annual *Cervical screening in Australia* report. The Institute is an independent statutory authority within the Health and Ageing portfolio. It is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website (www.aihw.gov.au).
Relevance	The data used to calculate this indicator are accurate and of high quality. The cervical cytology registers collect information on all Pap tests undertaken in Australia except where women advise the clinician they do not wish to have their data collected. The use of ERP based on Census data for denominators provide the most comprehensive data coverage possible. The data are entirely appropriate for this indicator.

	For participation by state and territory, the numerator is the number of women aged 20–69 years screened in each state and territory in the reference period, except for Victoria and the ACT where data are for residents (and some immediate border residents) of the jurisdiction only. Data are supplied as aggregated data by each state and territory. The denominator is the average of the ABS ERP for women aged 20–69 years in each State and Territory, adjusted to exclude the estimated number of women who have had a hysterectomy, using national hysterectomy fractions.
	Caution is required when examining differences across states and territories of Australia due to the substantial differences in population, area, geographic structure, policies and other factors.
Timeliness	The most recent data available for the 2014 RoGS report are based on the two-year calendar period 1 January 2011 to 31 December 2012. Data are presented as a rate for the two-year period to reflect the recommended screening interval.
Accuracy	This indicator is calculated on data that have been supplied to the AIHW by individual state and territory registers. Prior to publication, the results of analyses are referred back to states and territories for checking and clearance. Any errors found by states and territories are corrected once confirmed. Thus participation by state and territory, based on the state or territory in which the woman was screened, is both robust and readily verified.
	Women who opt off the cervical cytology register are not included in the participation data, but this is thought to only exclude around 1 per cent of all women screened.
Coherence	Some of these data are published annually in Program monitoring reports prepared by the AIHW and are consistent across reports published at similar times.
	Rates may differ from those presented in reports published in 2011 or previous years which are derived from ABS 2006 Census based ERPs.
Accessibility	The NCSP annual reports are available via the AIHW website where they can be downloaded free of charge.
Interpretability	While numbers of women screened are easy to interpret, calculation of age-standardised rates with allowance for the proportion of the population who have had a hysterectomy is more complex and the concept may be confusing to some users. Information on how and why age-standardised rates have been calculated and how to interpret them as well as the hysterectomy fraction is available in all AIHW NCSP monitoring reports, example, *Cervical screening in Australia 2009–2010*.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Hysterectomy fractions are derived from the AIHW National Hospitals Morbidity Database. • Indigenous status is not collected by cervical cytology registers.

Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations
Measures (computation)	Selected potentially preventable hospitalisations for vaccine-preventable, acute and chronic conditions. The *numerator* is the number of separations for selected potentially preventable hospitalisations, for each of the following three groups and their sub-categories: • Vaccine-preventable conditions - Influenza and Pneumonia - Other vaccine preventable conditions (e.g. tetanus, measles, mumps, rubella) - Total. • Acute conditions - Appendicitis with generalised peritonitis - Cellulitis - Convulsions and epilepsy - Dehydration and gastroenteritis - Dental conditions - Ear, nose and throat infections - Gangrene - Pelvic inflammatory disease - Perforated/bleeding ulcer - Pyelonephritis - Total acute conditions - Total acute conditions (excluding dehydration and gastroenteritis) • Chronic conditions - Angina - Asthma - Chronic obstructive pulmonary disease - Congestive heart failure - Diabetes complications (principal diagnosis only) - Hypertension - Iron deficiency anaemia - Nutritional deficiencies - Rheumatic heart disease

- Total

- Total (excluding diabetes complications as additional diagnoses).

- Total selected potentially preventable hospitalisations (excluding dehydration and gastroenteritis and excluding diabetes complications as additional diagnoses).

The *denominator* is the Estimated Resident Population.

A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

Potentially preventable hospitalisations are defined by ICD-10-AM diagnosis codes and/or ACHI procedure codes in scope for each category of potentially preventable hospitalisations (see Appendix B, *Australian hospital statistics 2011-12*).

Calculation is 1000 × (Numerator ÷ Denominator), presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so the Indigenous disaggregation was standardised to 64 years, with ages over 64 combined.

Data source/s

Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care.

Denominator:

For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2011.

For data by Indigenous status: ABS Indigenous Experimental Estimates and Projections (Indigenous Population) Series B as at 30 June 2011.

For data by remoteness: ABS ERP as at 30 June 2011, by remoteness areas, as specified in the Australian Statistical Geography Standard 2011 (ASGS).

Computation:

1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788.

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

'Non-Indigenous' includes hospitalisations of non-Indigenous people and those for whom Indigenous status was not stated.

Analysis by state and territory and remoteness is based on the Statistical Local Area of usual residence of the patient, not the location of the hospital.

Timeliness

The reference period for this data set is 2011-12.

Accuracy

For 2011-12, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory.

The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The AIHW report *Indigenous identification in hospital separations data: quality report* (AIHW 2013) found that nationally, about 88% of Indigenous Australians were identified correctly in hospital admissions data in the 2011–12 study period, and the 'true' number of separations for Indigenous Australians was about 9% higher than reported. The report recommended that the data for all jurisdictions are used in analysis of Indigenous hospitalisation rates, for hospitalisations in total in national analyses of Indigenous admitted patient care. However, these data should be interpreted with caution as there is variation among jurisdictions in the quality of the Indigenous status data.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Data for the chronic diseases category 'diabetes complications' exclude separations with an *additional diagnosis* of diabetes complications. Variations in both admission and administration practices mean that dialysis treatments may be counted as separations with diabetes complications by some hospitals and not others, reducing the comparability

of the data at state and territory level. This is particularly significant for Indigenous people because of the high prevalence of diabetes in that population.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example where the denominator is very small. The following rule was applied:

- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1000.

Coherence

The information presented for this indicator is calculated using the same methodology as data published in the *National healthcare agreement: performance report 2011-12* and *Australian hospital statistics 2011-12*.

However, caution should be used when comparing 2007–08 with later years due to changes between the ICD-10-AM 5th edition (used in 2007–08), the ICD-10-AM 6th edition (used in 2008–09 and 2009–10) and ICD-10-AM 7th edition (used in 2010–11 and 2011–12) and the associated Australian Coding Standards that resulted in:

- decreased reporting of additional diagnoses for diabetes
- increased reporting of diagnoses for dehydration and gastroenteritis.

In light of these comparability issues, the data presented for 2011–12 exclude:

- Diabetes complications (additional diagnoses only) from the chronic conditions category, and
- Dehydration and gastroenteritis from the acute conditions category, and
- Diabetes complications (additional diagnoses only) and dehydration and gastroenteritis from the total.

However it should be acknowledged that these data are not consistent with the original intent of the indicator.

In addition, Tasmanian data are not comparable over time as 2008–09 data for Tasmania does not include two private hospitals that were included in 2007–08 and 2009–10 data reported in the National Healthcare Agreement performance reports.

National level data disaggregated by Indigenous status for 2007–08 included data from NSW, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2008–09, 2009–10 and 2010–11 included data from NSW, Victoria, Qld, WA, SA and NT. National level data disaggregated by Indigenous status for 2011–12 and subsequent years includes data from all eight states and territories. Therefore, data disaggregated by Indigenous status from 2007–08 is not comparable to 2008–09, 2009–10 and 2010–11, and data for 2011–12 and subsequent years are not comparable with data for 2010–11 and prior years.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- Australian hospital statistics with associated Excel tables.
- Interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Some data are also included on the MyHospitals website.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, accessible at meteor.aihw.gov.au/content/index.phtml/itemId/529483 and the National health data dictionary, accessible atwww.aihw.gov.au/publication-detail/?id=10737422826.

Data Gaps/Issues Analysis

Key data gaps /issues

The Steering Committee notes the following issues:

- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- National level data by Indigenous status for 2011-12 include all States and Territories for the first time and are not comparable with data for 2010-11 and prior years.
- Caution should be used in interpretation of data disaggregated by Indigenous status due to variation among jurisdictions in the quality of the Indigenous status data.

Selected potentially preventable hospitalisations for diabetes

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations
Measures (computation)	Selected potentially preventable hospitalisations for diabetes. The *numerator* is the number of hospitalisations for type 2 diabetes mellitus (as principal or additional diagnosis), divided into seven groups: • Circulatory complications (E11.5x) • Renal complications (E11.2x) • Ophthalmic complications (E11.3x) • Other specified complications (E11.0x, E11.1x, E11.4x, E11.6x) • Multiple complications (E11.7x) • No complications (E11.9x) • Total. The *denominator* is the Estimated Resident Population. A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Potentially preventable hospitalisations for diabetes are defined by ICD-10-AM diagnosis codes. Calculation is 100 000 × (Numerator ÷ Denominator), presented as a number per 100 000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 years combined.
Data source/s	Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June 2011. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment

The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

Timeliness

The reference period for this data set is 2011-12.

Accuracy

For 2011-12 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. Variations in both admission and administration practices and policies mean that dialysis treatments may be counted as separations with diabetes complications by some hospitals and not others, reducing the comparability of the data at state and territory level. This is particularly significant for Indigenous people because of the high prevalence of diabetes in that population.

Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very

	small).
Coherence	The information presented for this indicator is calculated using the same methodology as other potentially preventable hospitalisations data published in *Australian hospital statistics 2011-12* and the *National healthcare agreement: performance report 2011-12*. Changes between the ICD-10-AM 5th edition (used in 2007-08), ICD-10-AM 6th edition (used in 2008-09 and 2009-10) and ICD-10-AM 7th edition (used in 2010-11 and 2011-12) and the associated Australian Coding Standards apparently resulted in decreased reporting of additional diagnoses for diabetes.
Accessibility	The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are: • Australian hospital statistics with associated Excel tables. • Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups). Some data are also included on the MyHospitals website.
Interpretability	Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps /issues	The Steering Committee notes the following issues: • Further work is required to improve the comparability of data due to changes across editions of the ICD-10-AM. • The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. • Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Potentially preventable hospitalisations of older people for falls

Data quality information for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Selected potentially preventable hospitalisations
Measures (computation)	Potentially preventable hospitalisations of older people for falls. The number of hospitalisations for people aged 65 years or over with a reported external cause of falls, per 1000 people. The *numerator* is the number of hospitalisations for people aged 65 years or over with a reported external cause of falls. The *denominator* is the Estimated Resident Population. A separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Potentially preventable hospitalisations for falls are defined by ICD-10-AM external cause codes (W00–W19). Calculation is 1000 × (Numerator ÷ Denominator), presented as a number per 1000 and age-standardised to the Australian population as at 30 June 2001 using 5-year age groups to 84 years, with ages over 84 combined.
Data source/s	Numerator: This indicator is calculated using data from the NHMD, based on the National Minimum Data Set for Admitted Patient Care. Denominator: For total population: Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) as at 30 June in the year preceding the reference period. Computation: 1000 × (Numerator ÷ Denominator), presented as a rate.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) has calculated this indicator. The Institute is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. States and territories supplied these data under the terms of the National Health Information Agreement, available online at: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788

Relevance

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

Timeliness

The reference periods for this data set are 2005-06, 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12.

Accuracy

For 2006-07 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and a small private hospital in Victoria.

For 2007-08 almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and a small private hospital in Victoria.

For 2008-09 , almost all public hospitals provided data for the NHMD, with the exception of a mothercraft hospital in the ACT. The great majority of private hospitals also provided data, the exceptions being the private day hospital facilities in the ACT, the single private free-standing day hospital facility in the NT, and two private hospitals in Tasmania.

For 2009-10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory and about 2400 separations for one public hospital in Western Australia. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. In addition, Western Australia was not able to provide about 10 600 separations for one private hospital.

For 2010-11 and 2011-12, almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory. The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. However, 2010-11 data were not available for the NT.

States and territories are primarily responsible for the quality of the data they provide. However, the Institute undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider) or where rates are likely to be highly volatile (for example, the denominator is very small).

Coherence

NT data are not available for 2010-11, and are excluded from the Australian total for that year. With this exception, data for this indicator are comparable over time.

Accessibility

The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:

- Australian hospital statistics with associated Excel tables.
- Interactive data cube for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Some data are also included on the MyHospitals website.

Interpretability

Supporting information on the quality and use of the NHMD are published annually in Australian hospital statistics (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to read caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care are published in the AIHW's online metadata repository — METeOR, and the National health data dictionary.

Data Gaps/Issues Analysis

- Key data gaps /issues

The Steering Committee notes the following issues:

- NT data were not available for 2010-11.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.